# UNAIDS PROGRAMME COORDINATING BOARD

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**THIRTY-SEVENTH MEETING**

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**Venue:** Executive Board Room, WHO, Geneva

**Agenda item 3**

## UNAIDS Strategy 2016-2021

**Additional documents for this item:** none

**Action required at this meeting** – the Programme Coordinating Board is invited to:

*Adopt* the UNAIDS 2016-2021 Strategy

**Cost implications of decisions:** Please refer to UNAIDS Unified Budget, Results and Accountability Framework 2016–2021 (UNAIDS/PCB (37)/15.19)

## UNAIDS 2016–2021 Strategy

# On the Fast-Track to end AIDS

**27 October 2015**

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***Charter of the United Nations: Preamble***

***WE THE PEOPLES OF THE UNITED NATIONS DETERMINED***

[…] to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small, and […] to promote social progress and better standards of life in larger freedom,

***AND FOR THESE ENDS***

to practice tolerance and live together in peace with one another as good neighbours, and […] to employ international machinery for the promotion of the economic and social advancement of all peoples,

***HAVE RESOLVED TO COMBINE OUR EFFORTS TO ACCOMPLISH THESE AIMS***

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Recalling that all aspects of UNAIDS work are directed by the following guiding principles:

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge;
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of non-discrimination.

## Foreword

***Ending AIDS and delivering dignity, equity and sustainable development***

The AIDS movement, led by people living with and affected by HIV, continues to inspire the world and offer a model for a people-centred, rights-based approach to global health and social transformation. And yet, today, amid a swirl of competing and complex global concerns, we confront a serious new obstacle: the oppressive weight of complacency. This is happening when we know that if we make the right decisions and the right investments now, the end of AIDS can be within our grasp. This moment is, however, fleeting. We have a fragile window of opportunity—measured in months—in which to scale up.

If we do not Fast-Track our response, the costs of the epidemic—to national finances and to human lives—will grow into a debt we can never repay. We will fail to reach the sustainable development agenda target of ending the AIDS epidemic. The epidemic will resurge, this time as an orphan disease. We will have squandered the global political capital we have worked so hard to win, and the AIDS response will have lost its unique power to transform global health and save millions of lives.

The UNAIDS 2016–2021 Strategy is a bold call to action to get on the Fast-Track and reach people being left behind. It is an urgent call to front-load investments. It is a call to reach the 90-90-90 treatment targets, to close the testing gap and to protect the health of the 22 million people living with HIV who are still not accessing treatment. It is a call to redress the deplorably low treatment coverage for children living with HIV.

The Strategy focuses on our unfinished agenda—drastically reducing new infections to bend the trajectory of the epidemic. We must protect future generations from acquiring HIV by eliminating once and for all new HIV infections among children, and by ensuring young people can access the HIV-related and sexual and reproductive health services they need. Empowering young people, particularly young women, is of utmost importance to prevent HIV, including by ending gender-based violence and promoting healthy gender norms.

Ending the AIDS epidemic will involve progress across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive. Defending the rights of all people—including children, women, young people, men who have sex with men, people who use drugs, sex workers and clients, transgender people and migrants—is critical to ensuring access to life-saving services. Through the realization of their rights, people being left behind will

move ahead, to the very forefront of the journey to end AIDS—informed and empowered, mobilized and engaged.

Investing in science, innovation and strategic information now will help achieve these ambitious aims. By reaching our targets in 2020, we will be firmly on track towards ending the epidemic by 2030. Acting now will bring future savings.

The 2016–2021 Strategy builds on strong foundations. Its bold goals and targets sit squarely within the Sustainable Development Goals framework. It is universal—designed to guide and support locally tailored responses across the globe while fostering new forms of leadership and accountability—especially at regional levels.

The countdown to 2020 has begun and it requires us to work in new ways. The Agenda for Sustainable Development commits the global community to leaving no one behind and open space to scale up what we know works for AIDS—redistributing opportunity, collaborating across sectors and investing at the intersections of AIDS and other development challenges.

I am grateful to Member States and the thousands of people and organizations who collaborated with us to develop this game-changing Strategy. It is achievable. Together we can bring health, dignity and justice to all.

*Michel Sidibé*

*UNAIDS Executive Director*

## Putting people at the centre of the three zeros

Ending the AIDS epidemic and leaving no one behind in the response will profoundly affect the entire lifespan of millions of people around the world, for generations to come. The post-AIDS world will be very different from the one we know today—and it is one we can create.

It will be a world in which every child is born HIV-free to healthy parents, and any child living with HIV receives the treatment, protection, care and support to survive and thrive into adulthood and old age.

Where, as children grow into adolescence, they are educated and receive adequate nutrition, they can access appropriate HIV and sexual and reproductive health services and they live free from violence and extreme poverty.

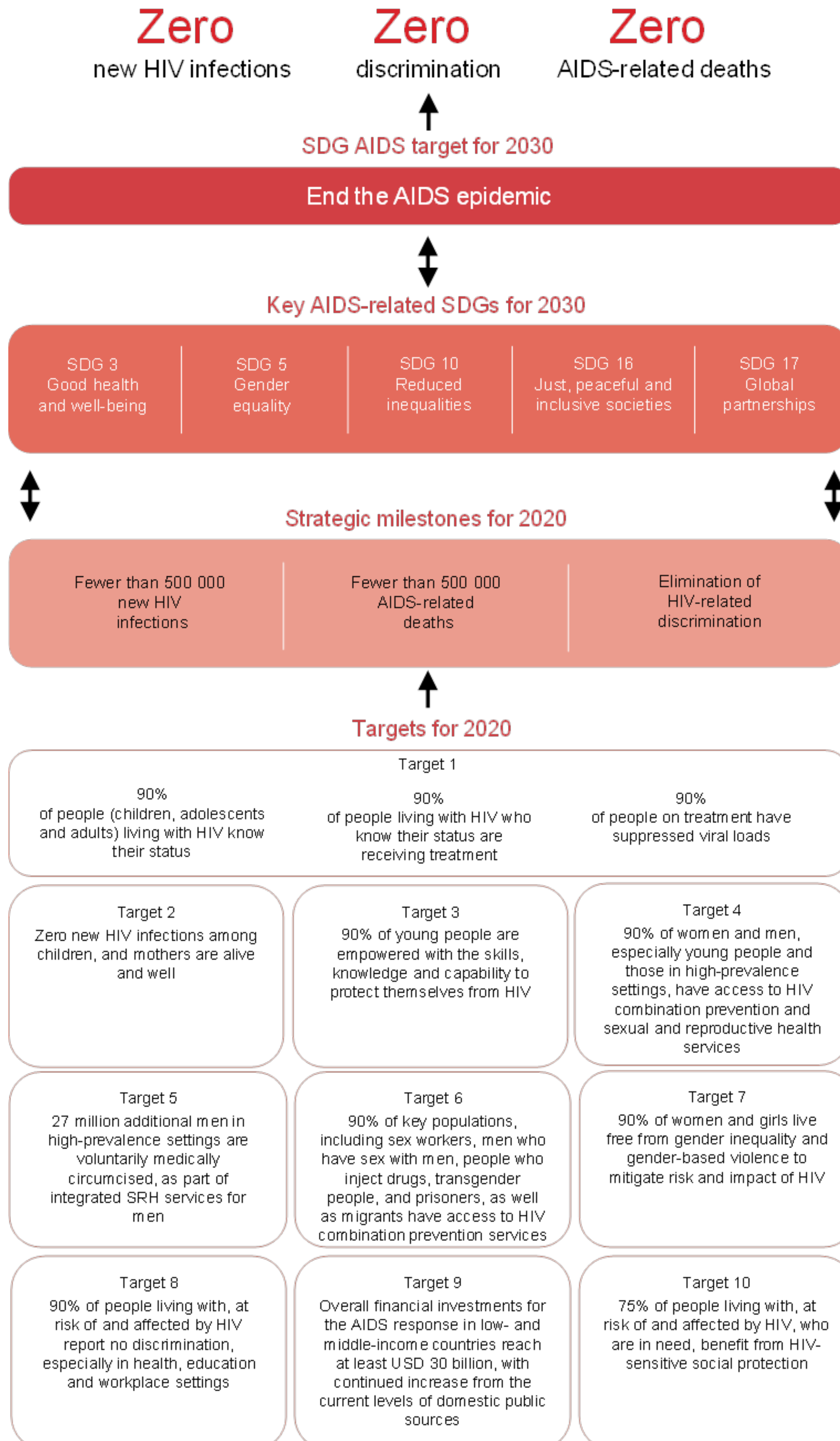
Where young people, regardless of where they live or who they are, have the knowledge, skills, services, rights and power to protect themselves from HIV.

Where a pregnant woman or breastfeeding mother living with HIV can access the services she needs to protect her health and that of her baby.

Where all people, regardless of their identity, choices or circumstances, have access to relevant HIV prevention services, voluntary HIV testing and affordable treatment and high-quality care and support services—including psychosocial, financial and legal services.

Where all people have the equal opportunity to grow, develop, flourish, work and enjoy prosperous and fulfilling lives, supported by enabling laws, policies and programmes that respect their human rights and address the social determinants of HIV, health and well-being.

Where all people, living with or without HIV, are able to live their lives to the fullest, from birth to adulthood and into old age, free from discrimination and with dignity and equality.


UNAIDS STRATEGY: VISION, GOALS AND TARGETS
Zero
new HIV infections
Zero
discrimination
Zero
AIDS-related deaths
SDG AIDS target for 2030
End the AIDS epidemic
Key AIDS-related SDGs for 2030
SDG 3
Good health
and well-being
SDG 5
Gender
equality
SDG 10
Reduced
inequalities
SDG 16
Just, peaceful and
inclusive societies
SDG 17
Global
partnerships
Strategic milestones for 2020
Fewer than 500 000
new HIV
infections
Fewer than 500 000
AIDS-related
deaths
Elimination of
HIV-related
discrimination
Targets for 2020
Target 1
90%
of people (children, adolescents
and adults) living with HIV know
their status
90%
of people living with HIV who
know their status are
receiving treatment
90%
of people on treatment have
suppressed viral loads
Target 2
Zero new HIV infections among
children, and mothers are alive
and well
Target 3
90% of young people are
empowered with the skills,
knowledge and capability to
protect themselves from HIV
Target 4
90% of women and men,
especially young people and
those in high-prevalence
settings, have access to HIV
combination prevention and
sexual and reproductive health
services
Target 5
27 million additional men in
high-prevalence settings are
voluntarily medically
circumcised, as part of
integrated SRH services for
men
Target 6
90% of key populations,
including sex workers, men who
have sex with men, people who
inject drugs, transgender
people, and prisoners, as well
as migrants have access to HIV
combination prevention services
Target 7
90% of women and girls live
free from gender inequality and
gender-based violence to
mitigate risk and impact of HIV
Target 8
90% of people living with, at
risk of and affected by HIV
report no discrimination,
especially in health, education
and workplace settings
Target 9
Overall financial investments for
the AIDS response in low- and
middle-income countries reach
at least USD 30 billion, with
continued increase from the
current levels of domestic public
sources
Target 10
75% of people living with, at
risk of and affected by HIV, who
are in need, benefit from HIV-
sensitive social protection

# STRATEGY AT A GLANCE: RESULT AREAS

Good health and well-being (SDG 3)

### Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

- Voluntary HIV testing services accessible for people at risk of HIV infection
- Early infant diagnostic services accessible to all children exposed to HIV, and all children under 5 years living with HIV on treatment
- All adults, adolescents and children offered ART and linked to treatment services upon HIV diagnosis
- People on treatment supported and monitored regularly, including scaled-up viral load monitoring, and treatment literacy and nutritional support
- Accessibility, affordability and quality of HIV treatment improved, including through community delivery systems
- HIV services scaled up and adapted to local contexts including in cities, fragile communities and humanitarian emergencies
- Adequate investments made in R&D for better diagnostics, ARVs, prevention commodities, monitoring tools, vaccines and cure

### New HIV infections among children eliminated and their mother's health and well-being is sustained

- Immediate treatment accessible to all pregnant women living with HIV (option B+)
- HIV, SRH including family planning, TB and maternal and child health services integrated and accessible for women, especially women living with HIV
- HIV prevention services for male partners promoted including testing and treatment

Reduced inequalities (SDG 10)

### Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

- Youth-friendly HIV, SRH and harm reduction information and services accessed independently and equally by young women and men
- All people, especially young people reduce HIV-related risk behaviour and access HIV combination prevention services, including primary prevention and SRH services
- 20 billion condoms available annually in low- and middle-income countries for people of all ages
- Additional 27 million men in high-prevalence settings voluntarily medically circumcised as part of access to integrated SRH services for men
- Quality comprehensive sexuality education* accessed by all adolescent and young people
- Information accessed, awareness raised and demand created through traditional and new forms of communication and outreach
- Young people meaningfully engaged in the response to ensure effectiveness and sustainability

### Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants

- Combination prevention services adequately resourced and available, tailored to populations, locations and interventions with maximum impact
- Outreach and new media inform and create demand for use of traditional and new prevention technologies, including condoms and PrEP
- 3 million people on PrEP annually, focused particularly on key populations and people at high risk in high prevalence settings
- People who inject drugs access clean needles and syringes, as well as opioid substitution therapy and other evidence-informed drug dependence treatment
- Migrants, refugees and crisis-affected populations have access to HIV-related services
- People living with HIV and other key populations meaningfully engaged in decision-making and implementation of HIV prevention programmes

*See glossary

Gender equality (SDG 5)

### Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

- Women and girls and men and boys engaged and empowered to prevent gender-based, sexual and intimate partner violence, and promote healthy gender norms and behaviour
- Laws, policies and practices enable women and girls to protect themselves from HIV and access HIV-related services, including by upholding their rights and autonomy
- Sexual and reproductive health and rights needs fully met to prevent HIV transmission
- Young women in high-prevalence settings access economic empowerment initiatives
- Women meaningfully engaged in decision-making and implementation of the AIDS response

Just, peaceful & inclusive societies (SDG 16)

### Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

- Punitive laws, policies and practices removed including overly broad criminalization of HIV transmission, travel restrictions, mandatory testing and those that block key populations' access to services
- People living with, at risk of and affected by HIV know their rights and are able to access legal services and challenge violations of human rights
- HIV-related stigma and discrimination eliminated among service providers in health care, workplace and educational settings
- Laws, policies and programmes to prevent and address violence against key populations issued and implemented

Global partnership (SDG 17)

### AIDS response is fully funded and efficiently implemented based on reliable strategic information

- Investment of at least $31.1 billion available for the global AIDS response annually in 2020 in low- and middle- income countries, with one quarter invested in prevention globally
- Low-income countries mobilize at least on average 12% of country resource needs; lower-middle-income mobilize 45%, and; upper-middle-income countries mobilize 95% from domestic sources
- International investment for the AIDS response reaches $12.7 billion
- Financial sustainability transition plans and country compacts implemented
- Countries use timely, appropriate and reliable strategic information to prioritize resource allocation, evaluate responses and inform accountability processes
- Allocative and productive efficiency gains fully exploited and commodity costs reduced in countries of all income levels, including by overcoming restrictive intellectual property and trade barriers
- Country capacity built, including through technology transfer arrangements
- Investment and support to civil society, including networks of people living with, at risk of and affected by HIV, scaled up to enhance their essential role in the response

### People-centred HIV and health services are integrated in the context of stronger systems for health

- HIV-sensitive UHC schemes implemented
- People living with, at risk of and affected by HIV empowered through HIV-sensitive national social protection programmes, including cash transfers
- People living with, at risk of and affected by HIV access integrated services, including for HIV, TB, SRH, MNCH, hepatitis, drug dependence, food and nutrition support and NCDs, especially at the community level
- Comprehensive systems for health strengthened through integration of community service delivery with formal health systems
- Human resources for health trained, capacitated and retained to deliver integrated health and HIV services
- Stock-outs prevented through strengthened procurement and supply chain systems

## Executive summary

### A defining moment

1. The UNAIDS 2016–2021 Strategy comes at a critical moment in the history of the HIV epidemic and response. Evidence demonstrates that if the current, unprecedented level of HIV service coverage is simply maintained, progress will slip backwards with rising numbers of people newly infected, and more people dying from AIDS-related causes. Nevertheless, we have never had more opportunities to leverage our momentum to accelerate the response over the next five years: a new sustainable development agenda; fresh, innovative solutions; and the rise of regional, national and local leadership and institutions – including strong political commitment to the 90–90–90 treatment target. By seizing this moment, we can end the AIDS epidemic as a public health threat by 2030. The next five years provide a fragile window of opportunity to Fast-Track the AIDS response and empower people to lead dignified and rewarding lives.

### Building on solid foundations

2. We look forward with cautious optimism, propelled both by our obligation to people living with and affected by HIV and by knowledge of what is possible given recent progress. In 15 years, the annual number of people newly infected by HIV has dropped from 3.1 million to 2.0 million. Globally, between 2000 and 2014, the number of children acquiring HIV fell by 58% to 220 000 per year. The target of 15 million people receiving HIV treatment by 2015 was reached nine months early—a testament to the force of global collective action guided by an ambitious and robust Strategy. The UNAIDS 2011–2015 Strategy unified the response around 10 outcome-oriented goals and promoted people-centred and prioritized responses. The Strategy further inspired and informed the 2011 United Nations General Assembly Political Declaration on HIV and AIDS.

3. Such progress, coupled with major scientific breakthroughs and accumulated lessons learned over three decades of scaling up the AIDS response, has inspired UNAIDS and its partners to assert that the AIDS epidemic can be ended as a public health threat in all places and among all populations by 2030. Wide-ranging political support has been mobilized for this goal, including by the high-level UNAIDS and Lancet Commission: Defeating AIDS—Advancing Global Health.

## The imperative for change

4. The case for change and acceleration is commanding. The AIDS epidemic is far from over, despite dramatic achievements. Rates of progress are markedly different across populations and locations and significant gaps and shortcomings of the response persist. As epidemics have become more heterogeneous, we must improve our understanding of them to mount more differentiated, tailored and efficient responses.

5. The next phase of the response must account for new realities, including the fact that too many people are left behind, and for emerging opportunities. The 2016–2021 Strategy responds to a vastly changed context: the shifting geography of poverty, wealth and influence; growing inequality; rising migration; escalating humanitarian emergencies; and rapidly expanding innovations in science and communication.

6. The Sustainable Development Goals (SDGs) give all stakeholders a mandate to collaborate for global collective action. The AIDS response is integral to this mandate. The epidemic cannot be ended without addressing the determinants of vulnerability and the holistic needs of people living with and at risk of HIV. We must continue to take the AIDS response further out of isolation and unleash its potential as a pathfinder to deliver on other SDGs.

7. The imperative for change in the AIDS response is further buttressed by inadequate and uneven progress along our three Strategic Directions: HIV Prevention; Treatment, Care and Support; and Human Rights and Gender Equality.

8. Of the estimated 2 million people acquiring HIV globally in 2014, nearly half lived in eastern and southern Africa. In much of the region, adolescent girls and young women are at disproportionate risk. The number of people newly infected in eastern Europe and central Asia began increasing towards the end of the last decade, largely among people who inject drugs. The number of people acquiring HIV is increasing in several countries across the Middle East and North Africa, in Asia and the Pacific and in cities in North America and western Europe—primarily among gay men and other men who have sex with men, transgender people, sex workers and their clients, and people who inject drugs.

9. Twenty-two million people living with HIV are not accessing antiretroviral therapy. Among children, access is appallingly low, with coverage ranging from 54% in Latin America to 15% in the Middle East and North Africa. Although progress has been made in promoting knowledge of HIV status, half of all people living with HIV are unaware of their status, underscoring the urgency of closing the testing gap. Late diagnosis of HIV infection is the most substantial barrier to scaling up HIV treatment.

10. In all regions of the world, punitive laws, policies and practices continue to violate human rights and maintain structural conditions that leave populations without access to HIV services. HIV-related discrimination is often deeply interwoven with other forms of discrimination based on gender, sexual orientation and gender identity, race, disability, drug use, immigration status and being a sex worker, prisoner or former prisoner. Violations of women's rights, including violence, continue to render women and girls more vulnerable to HIV and prevent them from accessing services and care. Discriminatory laws and practices that restrict women's equal access to decision-making, education, employment, property, credit or autonomy foster and reinforce these conditions.

### Time to take the Fast-Track: strategic leadership agenda

11. In light of the need for change, this Strategy seeks to achieve a set of far-reaching and people-centred goals and targets that must be met by 2020 if we are to reach our 2030 ambition of ending the AIDS epidemic. The goals correspond to each of the three Strategic Directions, and include achieving by 2020:

    - **Fewer than 500 000 people newly infected with HIV**
    - **Fewer than 500 000 people dying from AIDS-related causes**
    - **Elimination of HIV-related discrimination**

12. Fast-Tracking the response will require working closely with communities, countries and partners to undertake a series of transformative shifts at all levels: (1) front-loading an increasingly diverse bundle of investments; (2) laser-like focusing on the locations, populations and interventions that will deliver the greatest impact; (3) catalysing innovation for people who need it most; (4) leveraging regional leadership and political institutions for more targeted, sustainable and accountable responses; (5) launching a new era of intersectoral partnerships to address the determinants of vulnerability, including discrimination and gender inequality; and (6) committing to the GIPA principle (Greater Involvement of People living with HIV) and people-centred accountability under the 2030 Agenda for Sustainable Development.

13. The UNAIDS Strategy is a global one—guiding and supporting the global AIDS response. It is underpinned by principles that have served the AIDS response well and delivered the results seen today. These principles include tolerance, equality and non-discrimination, inclusion and solidarity. The Strategy recognizes the need for locally-tailored responses within a framework that fosters regional leadership and accountability frameworks. To renew political commitment and inspire novel forms of collective leadership, which vary in composition across countries and regions, the Strategy will encourage all actors to take the courageous decisions to front-load

sufficient investments, tailor and focus rights-based responses and ensure access for people left behind.

14. The 2016-2021 Strategic Leadership Agenda is deliberately organized within the SDG framework around five SDGs most relevant to the AIDS response. Fast-Tracking the response will require development efforts to ensure good health, reduce inequalities, achieve gender equality, promote just and inclusive societies and revitalize global partnerships. Other SDGs are, however, pertinent to the AIDS response. Ten critical targets have been set—measurable targets that have been modelled as those most critical to ensure that the ambitious Fast-Track goals will be met. The targets, however, do not represent the totality of concerted effort needed across the result areas. The result areas constitute core dynamic and cross-cutting programmes of work, which will contribute to the achievement of all the targets. Achieving a set of prioritized targets and results will translate into better social, educational and economic outcomes and into health, human rights and dignity for millions of people—a continuation of the role of the AIDS response as a pathfinder for social justice and sustainable development.

***Ensure Healthy Lives and Promote Well-Being for All at All Ages (SDG 3)***

*Result areas*

- Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment
- New HIV infections among children are eliminated and their mother's health and well-being is sustained

15. Ensuring healthy lives and promoting well-being for all at all ages, including people living with and at high risk of HIV, is essential to sustainable development. Achieving the 90–90–90 treatment target for children, adolescents and adults is central to ending the epidemic, and provides multiple entry points to encourage action on the human rights, gender and socioeconomic barriers people face in accessing HIV services. Success demands a global effort to close gaps in the treatment cascade, with scale-up focused on community capacity-building, including through targeted testing strategies, and ensuring that people are offered treatment upon diagnosis, that treatment is available to all children under five upon diagnosis, and that people on treatment are supported and monitored regularly. Innovation is required to enable access to point-of-care diagnostics and affordable, optimized and long-lasting formulations of antiretroviral medicines, particularly for children, as well as a vaccine and cure. Eliminating new HIV infections among children and keeping mothers alive and well relies on providing immediate treatment to pregnant women living with HIV,

further integrating HIV and health services, and engaging male partners in prevention and treatment services, with a focus on underperforming locations and women in the lowest socioeconomic quintile.

***Reduce Inequalities in Access to Services and Commodities (SDG 10)***

*Result areas*

- Young people, particularly young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV
- Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

16. The AIDS response can only be Fast-Tracked by promoting the right of all people to access high-quality HIV services without discrimination. Scaled-up action is necessary to address the specific barriers faced by adolescents, young people and key populations in protecting themselves from HIV and accessing HIV-related services. Country and local leaders are encouraged to saturate high transmission areas with a combination of tailored prevention interventions. Interventions encompass outreach, including via social media, condom programming, voluntary medical male circumcision, harm reduction, pre-exposure prophylaxis, antiretroviral therapy and comprehensive sexuality education. Particular opportunity further lies in empowering young women and men to independently access HIV and other health services, and ensuring people can realize their sexual and reproductive health and rights. The effectiveness, sustainability and relevance of services rely on supporting civil society, including networks of people living with HIV, young people and key populations, to play a leadership role in the response.

***Achieve Gender Equality and Empower Women and Girls (SDG 5)***

*Result area*

- Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

17. Achieving gender equality is essential through the life cycle. Gender equality supports and enables people in preventing HIV transmission, improves access to services, education and employment and paves the path for lives free of violence. Action on gender equality in the AIDS response is critical in three interrelated areas: (1)

improving access to and uptake of sexual and reproductive health and HIV services and commodities; (2) mobilizing communities to promote egalitarian gender norms, engage men and boys and end gender-based, sexual and intimate partner violence; and (3) empowering women, young women and girls, in all their diversity, including by investing in women's leadership in the AIDS response.

***Promote Just, Peaceful and Inclusive Societies (SDG 16)***

*Result area*

- Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

18. This Strategy promotes universal respect for human rights, dignity and equal opportunity to build more inclusive societies. Countries are encouraged to work with service providers in health-care, workplace and educational settings to eliminate HIV-related stigma and discrimination, including against people living with HIV and key populations. To prevent and challenge violations of human rights, programmes to empower people living with, at risk of and affected by HIV to know their rights and access legal services should be brought to scale. Countries are further encouraged to remove punitive laws, policies and practices that block an effective AIDS response, including travel restrictions and mandatory testing, and those related to HIV transmission, same-sex sexual relations, sex work and drug use.

***Revitalize the Global Partnership for Sustainable Development (SDG 17)***

*Result areas*

- AIDS response is fully funded and efficiently implemented based on reliable strategic information
- People-centred HIV and health services are integrated in the context of stronger systems for health

19. In accordance with the 2030 Agenda for Sustainable Development and the policies and action in the 2015 Addis Ababa Action Agenda, accelerating progress in the AIDS response will require action regarding resource mobilization, efficiency gains, universal health coverage, human resources for health, technology transfer and capacity-building. Fast-Tracking the AIDS response will require reaching global investment of US$ 31.1 billion in 2020. Estimates of resources needed account for significant efficiency gains and reduced commodity costs, which will be critical to expanding fiscal space for the response in countries of all income levels. Countries are encouraged to develop compacts and sustainability transition plans that outline

domestic and international commitments in support of national costed plans and country-owned targets. Strategic engagement with the private sector should be enhanced, in terms of funding, as well as service delivery, strengthening supply chains, workplace initiatives and social marketing. People-centred systems for health will need to be strengthened, by rolling out HIV-sensitive universal health coverage schemes and social protection programmes for people living with HIV, women and girls, vulnerable families, caregivers and key populations; enabling human resources to deliver integrated health and HIV services; and preventing health product stock-outs by reinforcing procurement and supply chain systems.

## How UNAIDS will deliver on its Strategy

20. UNAIDS aims to lead the world in its historic quest to end the AIDS epidemic as a public health threat and attain the Three Zeros vision. Its strength derives from the diversity of its Cosponsors, the added value of the UNAIDS Secretariat in supporting multisectoral responses, and its unique governance body, which comprises Member States, UNAIDS Cosponsors and regional nongovernmental organizations.

21. In implementing this Strategy, especially in the context of the 2030 Agenda for Sustainable Development, the role of the Joint Programme must continue to evolve. UNAIDS will strengthen its political advocacy, strategic policy advice, and technical leadership, continue to convene and extend the scope of its partnerships, and improve support to countries to make optimal use of domestic and international resources including from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEFPAR). UNAIDS will focus on five core aspects of the response: information, investment, inclusion, integration and innovation. As a convener and coordinator, UNAIDS will continue to create new spaces for discussion and new models of collaboration that acknowledge and work within our increasingly complex environment.

22. The Joint Programme will operationalize the Strategy through its Unified Budget, Results and Accountability Framework. The Framework outlines the Programme's role in the AIDS response and guides operational planning at all levels, providing the framework against which budgetary allocations and performance monitoring are made.

## Annexes

23. Annex 1 provides an overview of the consultative process to develop this Strategy. Annex 2 consists of regional synopses of the epidemic, people left behind, key cities and countries in which particular gains are needed, game-changers for accelerating

progress and opportunities to strengthen partnerships to meet regional goals and ensure accountability. The annexes further present illustrative indicators to measure progress towards 2020, a glossary and a list of abbreviations.

## 1. Building on solid foundations: an updated and more ambitious Strategy in a changing world

### A defining moment

24. The HIV epidemic, the world's response and the broader global environment have changed considerably in recent years. Rising inequality, a shifting geography of poverty and wealth and fragility of communities and entire states, coupled with rapidly expanding innovations, are among the major shifts of the last several years—and have inspired the transformative 2030 Agenda for Sustainable Development.[1] Our knowledge and tools for responding to HIV have greatly expanded, revealing vast heterogeneity in epidemics across regions, countries, cities and districts, and giving rise to the need for differentiated and targeted responses. To be meaningful, a universal agenda must be a differentiated one.

25. This Strategy[i] comes at a critical moment in the history and future of the AIDS response. Maintaining current coverage of all interventions will result in more people acquiring HIV and dying from AIDS-related causes in 2021 than in 2015.[2] Yet accelerating the response over the next five years can reduce the annual number of people newly infected by 90% and of people dying from AIDS-related causes by 80% by 2030 (compared with 2010). Such progress requires capitalizing on several concurrent opportunities: a new development context; emerging regional, national and local leadership; and fresh innovation. The next five years offer a fragile window of opportunity to build a future in which all people can lead decent, dignified and rewarding lives.

### On solid ground: unprecedented progress under the UNAIDS 2011-2015 Strategy

26. Our vantage point is clear and our ambitions for the future of the AIDS response are high owing to the foundation built in recent years. The UNAIDS 2011—2015 Strategy advanced human rights and gender equality as a strategic direction alongside HIV prevention and treatment. It called for a limited number of outcome-oriented goals and promoted people-centred and prioritized responses. It focused on country-level results while galvanizing collaboration among people living with and affected by HIV, activists, scientists, programme managers and partners, such as the Global

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[i] The UNAIDS 2016-2021 Strategy was developed through a multistakeholder consultative process. For more details, see Annex 1.

Fund to Fight AIDS, Tuberculosis and Malaria and PEPFAR. Political leaders and activists across the globe adopted the Strategy's vision of the three zeros.

27. An output of the UNAIDS Strategy, the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive mobilized a global movement and has driven an unprecedented reduction in the number of children acquiring HIV through rigorous focus on priority countries. The Strategy galvanized the idea of the AIDS response as a pathfinder for sustainable investments in health and development, ushering in the African Union's Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria. The UNAIDS Strategy opened new political spaces, such as the League of Arab States' first AIDS Strategy and the Global Commission on HIV and the Law, which demonstrated the fundamental role the legal environment plays in the response and urged governments to end HIV-related discrimination in all its forms.

28. The UNAIDS Strategy formed the foundation for the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS[3] of the United Nations General Assembly. The global community's push to achieve its 10 time-bound targets delivered results that had once been considered impossible and enabled the achievement of Millennium Development Goal 6 on AIDS.[4] Globally, between 2000 and 2014, the annual number of people acquiring HIV has been reduced from 3.1 million to 2.0 million, with similar rates of reduction for women and men. In the same period, the number of children acquiring HIV fell by 58% to 220 000 per year. In 85 countries, new HIV infections among children have been virtually eliminated, with fewer than 50 children acquiring HIV per year.[5] The target of 15 million people receiving HIV treatment by 2015 was reached nine months early—a testament to the force of global collective action guided by an ambitious and robust Strategy.[6] Progress was enabled in part because of major efficiency gains. While total resources for the response rose by 11% from 2011 to 2014, the number of people receiving antiretroviral therapy increased by 58% during the same period.[7] Treatment access is contributing to steady declines in the number of people dying from AIDS-related causes and buttressing efforts to prevent people from acquiring HIV.

29. Such progress, coupled with major scientific breakthroughs and accumulated lessons learned over the past three decades, has inspired the Joint Programme and its partners to establish that the AIDS epidemic can be ended as a public health threat in all places and among all populations by 2030.[8] Wide-ranging political support has been mobilized for this achievement, including by the high-level UNAIDS and Lancet Commission: Defeating AIDS—Advancing Global Health.[9]

### Imperative for change

30. Despite progress, the case for change is compelling and commanding. Accelerating the AIDS response in low- and middle-income countries could avert 28 million new HIV infections and 21 million AIDS-related deaths between 2015 and 2030, saving US$ 24 billion annually in additional HIV treatment costs (Figures 1 and 2).[10] A failure to scale up in the next five years will inevitably push back the date that the epidemic can be ended, with a heavy human, social and economic toll.[11]

**Figure 1. Number of people acquiring HIV in low- and middle-income countries, 2010–2030, with achievement of ambitious Fast-Track targets, compared to maintaining 2013 coverage**

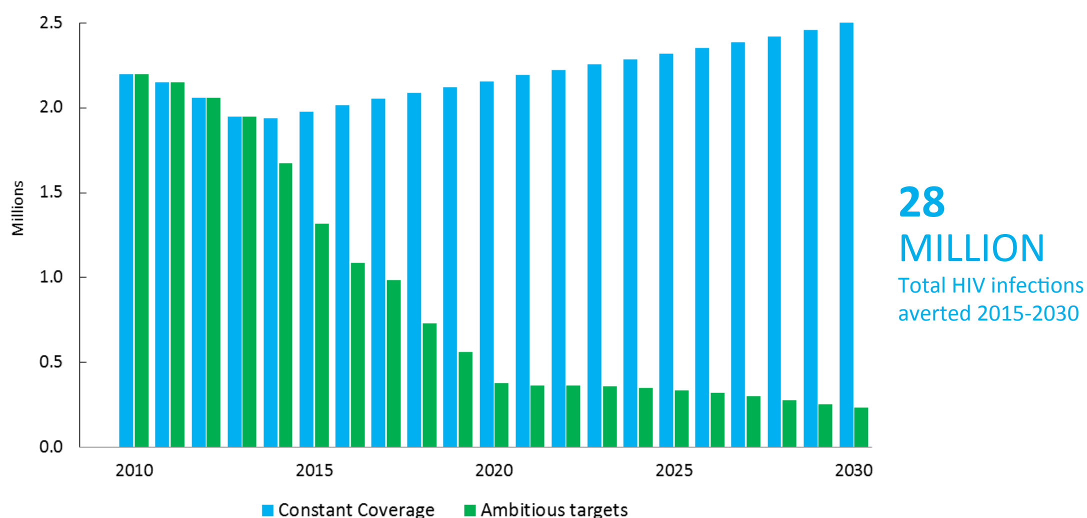
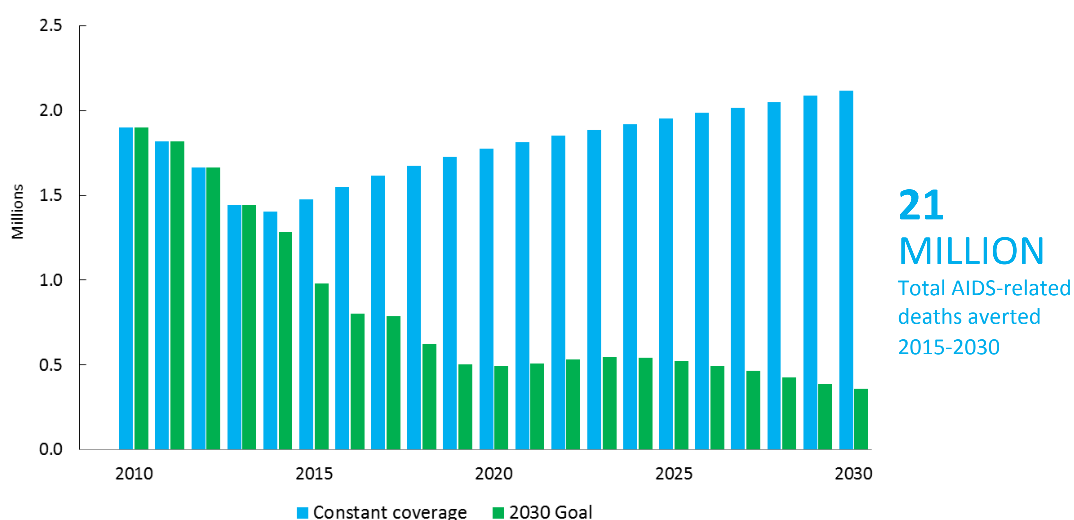



**Figure 2. Number of people dying from AIDS-related causes in low- and middle-income countries, 2010–2030, with achievement of ambitious Fast-Track targets, compared to maintaining 2013 coverage**



31. The remarkable results of the global AIDS response must inspire us to be even more ambitious. Complacency will be our undoing. The AIDS epidemic is still far from over, and significant gaps and shortcomings of the response must be rectified. The next phase of the response must account for new realities, opportunities and evidence, including a rapidly shifting context and a new sustainable development agenda, uneven progress under the 2011–2015 Strategic Directions and new sources and solutions for leadership and impact.

*An ever-evolving and increasingly complex and interconnected world*

32. The AIDS response must keep pace with development trends and changes in the legal, social and economic context. Today's largest-ever generation of young people offers a demographic dividend but they face myriad challenges in accessing equal opportunities for jobs and having a voice in the decisions that affect their lives. Rapid population growth in low-income countries, including many with heavy burdens of HIV, offers opportunities to reap dividends by investing in empowerment, education and employment for young people, though also increases the number of people in need of services and strains already fragile health and social systems. At the same time, many upper-middle-income and high-income countries, including those with significant HIV epidemics, face population decline, reducing the population of workers available to pay for health-care costs, including those associated with HIV, noncommunicable diseases (NCDs) and ageing populations.

33. Deepening inequality is a predominant characteristic of our age. In countries of all income levels, the poorest half of the population often controls less than 10% of total wealth.[12] Around the world, countries experience the effects of growing inequality, including disenfranchisement, marginalization, vulnerability, insecurity and declining social solidarity. These effects highlight the need to underwrite essential safety net programmes but also make establishing them more difficult.

34. Gender inequality—including denial of women's and girls' rights to protect their sexual and reproductive health and bodily autonomy—remains the most pervasive form of inequality, with direct implications for women's risk of acquiring HIV. Humanitarian emergencies exacerbate all forms of inequality and affect a growing number of people each year. Of the 314 million people affected in 2013,[13] 1.6 million were living with HIV, accounting for 1 of every 22 people living with HIV globally.[14] During humanitarian emergencies, people face disruption of services, including HIV-related services; increased food insecurity; destruction of livelihoods; and higher levels of extreme poverty. Women and girls often are targets of gender-based violence in the context of emergencies.[15]

35. In 2020, middle-income countries will be home to 70% of people living with HIV and more than half of all people living in poverty. Clearly, efforts to end the epidemic will largely succeed or fail in middle-income countries.[16] The shift in the geography of poverty has major implications for funding, delivering and governing the AIDS response and for broader global health. The notion of traditional development assistance, in which poor countries have development challenges and affluent countries have solutions and resources, is outdated. The Addis Ababa Action Agenda[17] recognized that development assistance must transition from a supplementary role to a catalytic one. As middle-income countries' economies and influence grow, they are adopting new approaches to global cooperation, establishing new institutions and emphasizing South–South cooperation for economic and social development. Their leadership will be key to accelerating regional and local AIDS responses.

36. By 2020, 56% of the world population will live in urban settings, where HIV rates are higher and poverty is growing more rapidly than in rural areas.[18] One billion people live in urban slums, which are typically overcrowded, polluted and dangerous; lack basic services such as clean water, food, durable housing and sanitation; and may increase vulnerability to HIV.[19] In sub-Saharan Africa, nearly half (45%) of the people living with HIV reside in urban areas, while in Brazil and the Russian Federation more than half of the people living with HIV in each country live in just 15 cities. Worldwide, 200 cities account for more than one quarter of all people living with HIV.[20] City and municipal leaders are well positioned to design and implement relevant, optimally inclusive and highly localized AIDS responses.

*The AIDS response in the 2030 Agenda for Sustainable Development: joint work, shared gains*

37. The 2030 Agenda for Sustainable Development reflects the interdependence and complexity of a changing world and the imperative for global collective action. In shifting from so-called development for the poorest countries to sustainable development for all, the global agenda has expanded in scope and complexity. As a set of indivisible goals, the SDGs give all stakeholders a mandate for integration of efforts. The AIDS response is no exception: the epidemic cannot be ended without addressing the determinants of health and vulnerability, and the holistic needs of people at risk of and living with HIV (Figure 3). People living with HIV often live in fragile communities[ii], and are most affected by discrimination, inequality and instability. Their concerns must be at the forefront of sustainable development efforts.

[ii] While the term 'fragile community' has not been the subject of an international discussion, for the purpose of this Strategy, we define it as follows: Populations affected by humanitarian emergencies are at the core of what defines fragile communities, but the term is also meant to include specific population groups in specific geographical locations in stable situations who are vulnerable to HIV due to specific discriminatory and/or restrictive policies and practices be they cultural, socioeconomic or ethnic. Fragile communities can be found in all countries and equity, protection and human rights should drive the inclusion of fragile communities in AIDS responses universally.

**Figure 3.**

HIV AND THE SDGs:

# JOINT ACTION, SHARED PROGRESS

Illustrative examples of:

- how select SDGs impact the HIV epidemic and response
- how HIV impacts progress towards select SDGs
- opportunities for cross-sectoral collaboration towards shared goals for 2030

**1**

- Poverty can increase vulnerability to HIV infection. Unequal socioeconomic status of women compromises their ability to prevent HIV or mitigate the impact of AIDS
- Households affected by HIV are more vulnerable to falling into and remaining in poverty
- Economic empowerment and social protection can reduce poverty and HIV vulnerability and help keep people with HIV healthy

**2**

- Hunger can lead to risk-taking behaviour, undermine HIV treatment adherence and hasten progression to AIDS
- Advanced HIV-related illness impairs nutritional status and undermines household food security by reducing productivity
- Nutritional support to households and integrated systems to deliver nutritional support and HIV services can enhance health outcomes

**3**

- Lack of UHC, including SRH services, restricts access to HIV prevention and treatment
- Most people acquiring HIV infection acquire it through sexual transmission or transmission from mother to infant during pregnancy, childbirth or breastfeeding
- HIV-sensitive UHC can play a vital role in promoting health equity, while integration with rights-based services for SRH, NCDs, TB and other conditions can improve broad health outcomes

**4**

- Globally, about 7 in 10 adolescent girls and women 15–24 years old do not have knowledge of HIV
- HIV-related illness impedes school attendance and learning, as does stigma and discrimination in school settings
- High-quality education, including on SRH, empowers young people and provides life skills for responsible and informed sexual and reproductive health decisions

**5**

Gender inequalities, discrimination, violence and harmful practices negatively impact women and girls, and men and boys, and increase risk of HIV infection and its impact

HIV is the leading cause of death among women of reproductive age (15–44 years old); women living with HIV often face increased violence

Gender-transformative HIV programmes that engage men can reduce violence and empower women, while integration of rights-based services for HIV and SRH increases dual uptake and impact

**8**

Safe and secure working environments facilitate access to HIV services, especially for workers in informal employment such as undocumented migrants and sex workers

People living with HIV experience unemployment rates three times higher than national unemployment rates

Addressing HIV in the world of work and protecting labour rights can help ensure people living with and affected by HIV enjoy full and productive employment

**10**

Income inequality is linked to higher HIV prevalence; HIV affects vulnerable and disempowered communities most severely

Stigma and discrimination against key populations is a major contributor to high HIV prevalence among them and linked to lower access to health care and housing

Protection against discrimination alongside legal services, rights literacy, access to justice and international protection can empower people to claim their rights and enhance access to HIV services

**11**

HIV especially affects cities and urban areas, with 200 cities accounting for more than one quarter of the world's people living with HIV

With rapid urbanization, many cities contend with growing HIV epidemics; People living in slums often acquire HIV infection at higher rates than the rest of the city

City-led local AIDS responses support positive social transformation by strengthening health and social systems to reach the most marginalized populations

**16**

Exclusion, stigma, discrimination and violence fuel the HIV epidemic among adults and children

The AIDS response, led by people living with and affected by HIV, has demanded access to justice and pioneered people-centred accountability mechanisms—providing lessons on which to build

Participatory governance—which includes community-led responses—can drive more relevant, rights-based programmes and stronger accountability for health and development

**17**

Global collective action to improve access to affordable HIV commodities is critical to ending the epidemic

HIV movement has led advocacy for reform of patent laws and regulatory systems; full use of TRIPS flexibilities; monitoring free-trade agreement negotiations; and taking legal action

Efforts to secure affordable HIV commodities, including second- and third-line drugs, can benefit wider health and equity agendas, including TB, hepatitis C and NCDs.

38. By extension, lessons learned from the multisectoral, multistakeholder AIDS response are key to progress across the SDGs. The AIDS response has advanced such issues as the right to health, gender equality, health information systems, service delivery platforms, commodity access and security and social protection.[21] The response has garnered substantial experience in addressing entrenched social norms, social exclusion and legal barriers that undermine health and development outcomes, and its investment approach is increasingly being adopted to accelerate gains across global health and development. The AIDS response can be a leader in leveraging strategic intersections with the SDGs, while disseminating lessons learned from three decades of unprecedented progress.

### *Unfinished agenda of UNAIDS three Strategic Directions: too many people left behind*

39. Together with the changing context and a new development agenda, the imperative for change in the AIDS response is driven by the fact that too many people continue to be left behind, with significant variation across regions (Figure 4). Despite historic gains along the three Strategic Directions of the UNAIDS 2011–2015 Strategy, the HIV epidemic is far from over.

***① Strategic Direction: HIV prevention***

40. The rate of decline in the number of people acquiring HIV is insufficient. The number of people newly infected continues to outpace the number of people initiating HIV treatment. Progress is slowing in many places, while new infections are rising in some areas (Figure 5). Evidence-informed and rights-based prevention frameworks, such as combination prevention[22] (i.e., a strategic combination of behavioural, biomedical, and structural approaches that includes the range of primary prevention methods focused on HIV-negative people as well as positive health, dignity and prevention) remain inadequately implemented and rarely brought to scale.

41. Nearly half of the estimated two million people acquiring HIV in 2014 lived in eastern and southern Africa. Here, adolescent girls and young women are at disproportionate risk and acquire HIV five to seven years earlier than men. Globally, 62% of all adolescents acquiring HIV infection are girls; in sub-Saharan Africa it is 71%. Ensuring that young people, especially adolescent girls, complete a quality secondary education is correlated with better health outcomes. Nevertheless, in sub-Saharan Africa, some 80% of young women have not completed secondary education, and one in three cannot read.[23]

42. Young people[iii] (15–24 years old) account for 16% of the global population, but represent 34% of adults acquiring HIV. AIDS is now the leading cause of death among adolescents (10–19 years old) in Africa and the second leading cause among adolescents globally. Yet in many contexts, laws, policies and practices, including age-of-consent laws[iv], still hinder access to comprehensive sexuality education (CSE),[v] HIV testing and treatment and other sexual and reproductive health services for adolescents and young people.[24] Such laws and policies compound vulnerability, particularly for adolescent and young key populations.[25] Furthermore, food insecurity, including among orphans and vulnerable children and adolescents, can increase high-risk behaviour, such as transactional, age-disparate, and unprotected sex.[26]

43. The AIDS response must continue to build on progress to eliminate mother-to-child transmission during pregnancy, delivery, and breastfeeding. Western and central African countries have the lowest service coverage, and although eastern and southern African countries have seen dramatic improvements over the past several years, the region was still home to 42% of all children acquiring HIV in 2014. These data underline the importance of intensifying and mainstreaming efforts in areas with high HIV burden. As the risk of HIV transmission in pregnancy and delivery drops, transmission among children is increasingly concentrated in the breastfeeding period.[27]

44. Globally, gay men and other men who have sex with men, sex workers and their clients and people who use drugs and their sexual partners are associated with an estimated 40–50% of adults who acquired HIV in 2014.[28] HIV prevalence among men who have sex with men is highest in western and central Africa (15%) and eastern and southern Africa (14%). New infections are increasing in several countries across the Middle East and North Africa, Asia and the Pacific, and in cities in North America and western Europe—primarily among men who have sex with men,[vi] transgender people,[vii] sex workers and their clients and people who inject drugs.[29,30] HIV prevalence among sex workers is on average 12 times greater than the general population. In several southern African countries, more than 50% of sex workers are living with HIV. Transgender women are up to 49 times more likely to be living with HIV than other adults.[31]

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[iii] See glossary in Annex 4.
[iv] The use of age of consent in this Strategy exclusively refers to the age of consent to access HIV and other health services. Age-of-consent laws are laws and regulations that define the age at which people can access sexual and reproductive health services without third-party authorization.
[v] See glossary in Annex 4.
[vi] See glossary in Annex 4.
[vii] See glossary in Annex 4.

45. The number of new HIV infections in Eastern Europe and Central Asia began increasing towards the end of the last decade, largely driven by vulnerability to HIV among people who inject drugs and their sexual partners. Around the world, 13.5% of the 12.1 million people worldwide who inject drugs are living with HIV. People who use cocaine and amphetamine-type stimulant drugs are also at increased risk of HIV, including in the context of "chemsex" (the collective use of recreational drugs to enhance sexual experience).[32] Among prisoners, prevalence may be up to 50 times higher than the general population. Prevailing homophobia, stigma, discrimination, and punitive social and legal environments block access to HIV services and heighten vulnerability of key populations[viii] to HIV.

46. People with disabilities are at higher risk of HIV infection because they are vulnerable to violence, sexual abuse and stigma and discrimination while often struggling to obtain meaningful service access.[33] Increasing numbers of people are living with HIV in older age, yet many HIV services are unequipped to address the needs of an ageing population. Displaced people and people affected by humanitarian emergencies face multiple challenges, including heightened exposure to HIV vulnerability and risks and limited access to quality health-care and nutritious food.[34] In many parts of the world, migrants and other mobile populations do not have the same access to health and other services as other people, increasing their risk of acquiring HIV. Rural populations, indigenous peoples and ethnic minorities may also be more vulnerable in some places. In all countries, vulnerable and fragile communities disproportionately suffer from displacement, insecure and undocumented migration, food insecurity, sexual violence, violations of human rights and poor access to health services and health products.

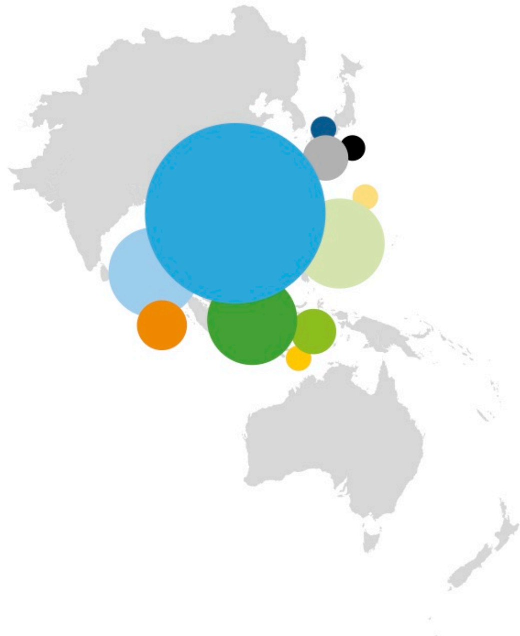
[viii] Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, as discussed in the *Gap Report* from UNAIDS, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

**Figure 4.**

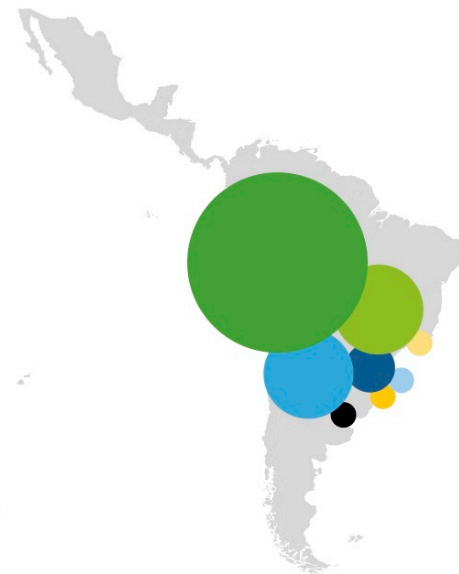
## The importance of location and population

This graphic illustrates the relative burden and impact of the HIV epidemic on various population groups, and thus those populations in need of political and programmatic priority within each region. Bubbles are not standardized to the relative size of the epidemic across regions, and are not precisely to scale.

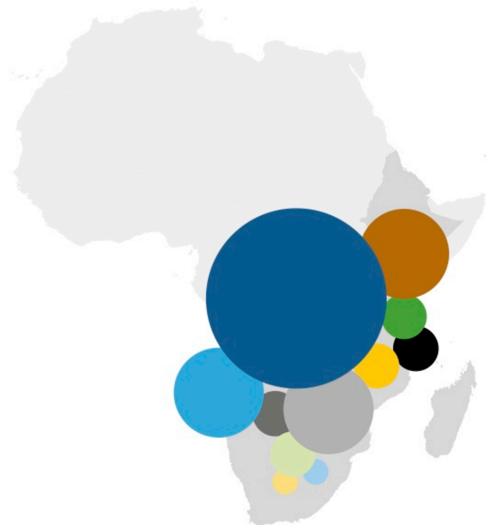
**ASIA AND THE PACIFIC**



**LATIN AMERICA**

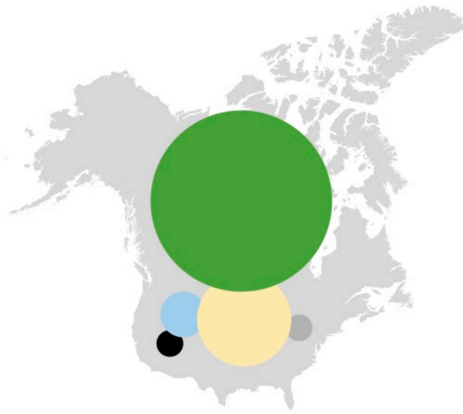


**EASTERN AND SOUTHERN AFRICA**

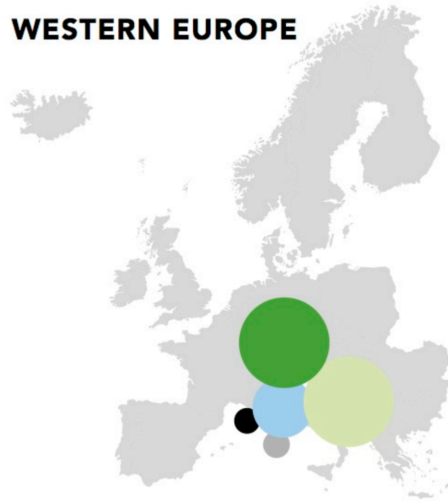


**WESTERN AND CENTRAL AFRICA**

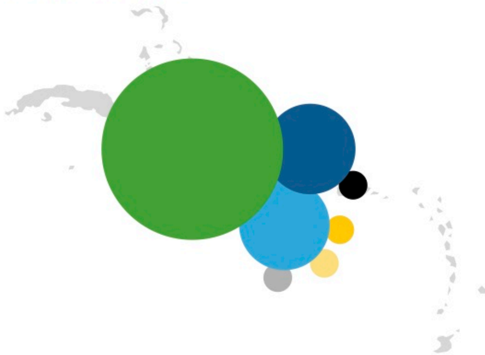
## NORTH AMERICA



## WESTERN EUROPE

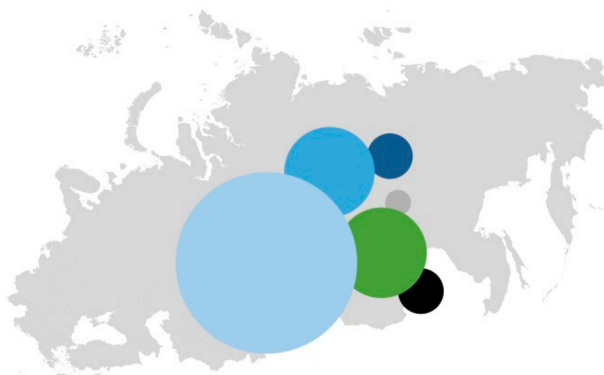


## CARIBBEAN



## MIDDLE EAST AND NORTH AFRICA

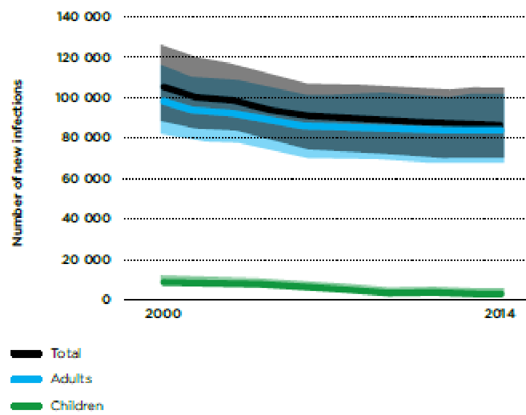
## EASTERN EUROPE AND CENTRAL ASIA



- Young women and adolescent girls
- Sex work
- People who inject drugs
- Gay men and other men who have sex with men
- Transgender
- Migrants
- Prisoners
- Displaced
- Pregnant women
- 50+
- Disabled
- African-American women
- Intimate partners
- Young adult men

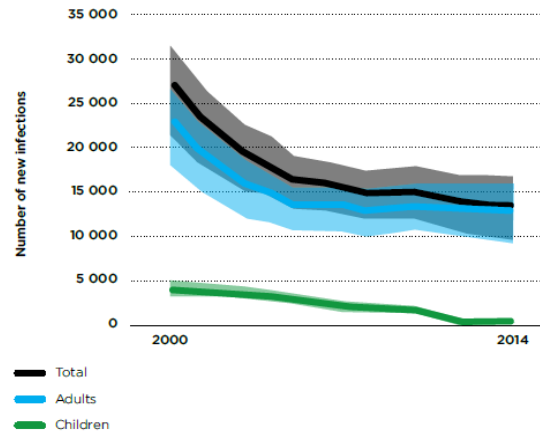
**Figure 5. Number of people newly infected with HIV, 2000–2014, by region**

**Number of new HIV infections in Latin America, 2000–2014**



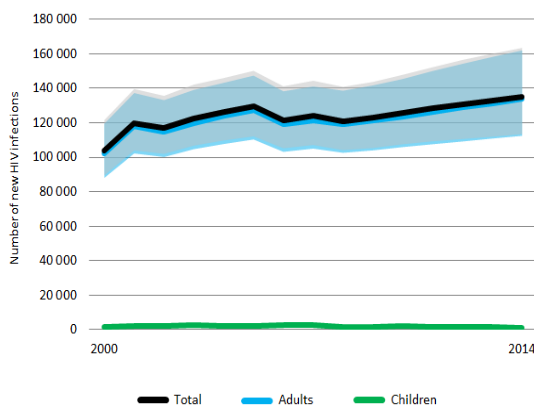

Source: UNAIDS 2014 estimates.

**Number of new HIV infections in the Caribbean, 2000–2014**



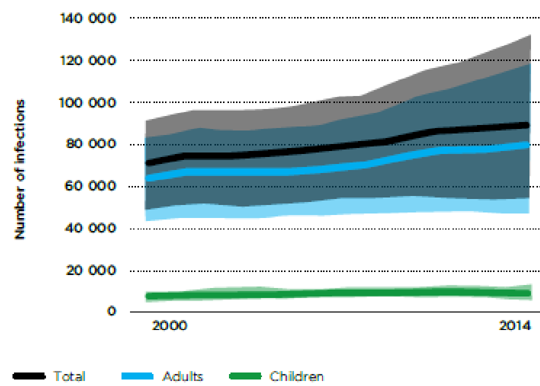

Source: UNAIDS 2014 estimates.

**Number of new HIV infections in eastern Europe and central Asia, 2000–2014**



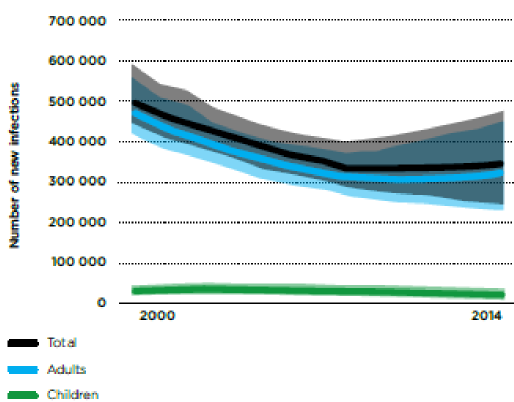

*Source:* UNAIDS 2014 estimates.

**New HIV infections in the Middle East and North Africa, 2000–2014**



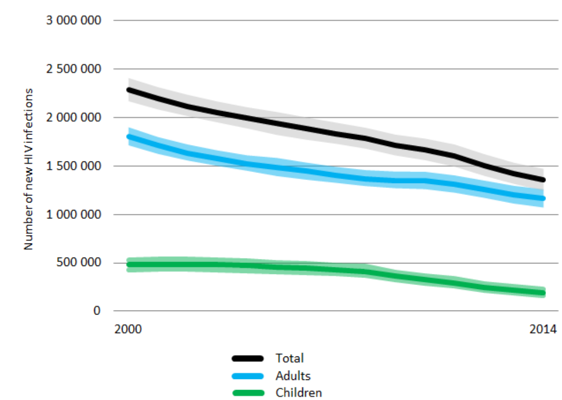

Source: UNAIDS 2014 estimates.

**Number of new HIV infections in Asia and the Pacific, 2000–2014**




Source: UNAIDS 2014 estimates.

**Number of new HIV infections in sub-Saharan Africa 2000–2014**




*Source:* UNAIDS 2014 estimates.

***② Strategic Direction: Treatment, care and support***

47. In 2015, antiretroviral therapy reached 15 million people—the first time a global health treatment target was reached before the agreed deadline. More people started treatment between 2011 and 2015 than in the previous 15 years. These gains must be sustained while concerted efforts are made to close treatment, care and support gaps. Twenty-two million people living with HIV are not accessing antiretroviral therapy (Figure 6). Among children, access is appalling low. Thirty-two per cent of children living with HIV are receiving treatment; coverage ranges from 54% in Latin America to 15% in the Middle East and North Africa. Although the vast majority of people needing treatment live in sub-Saharan Africa, coverage is lowest in the Middle East and North Africa (14%) followed by eastern Europe and central Asia (Figure 7).

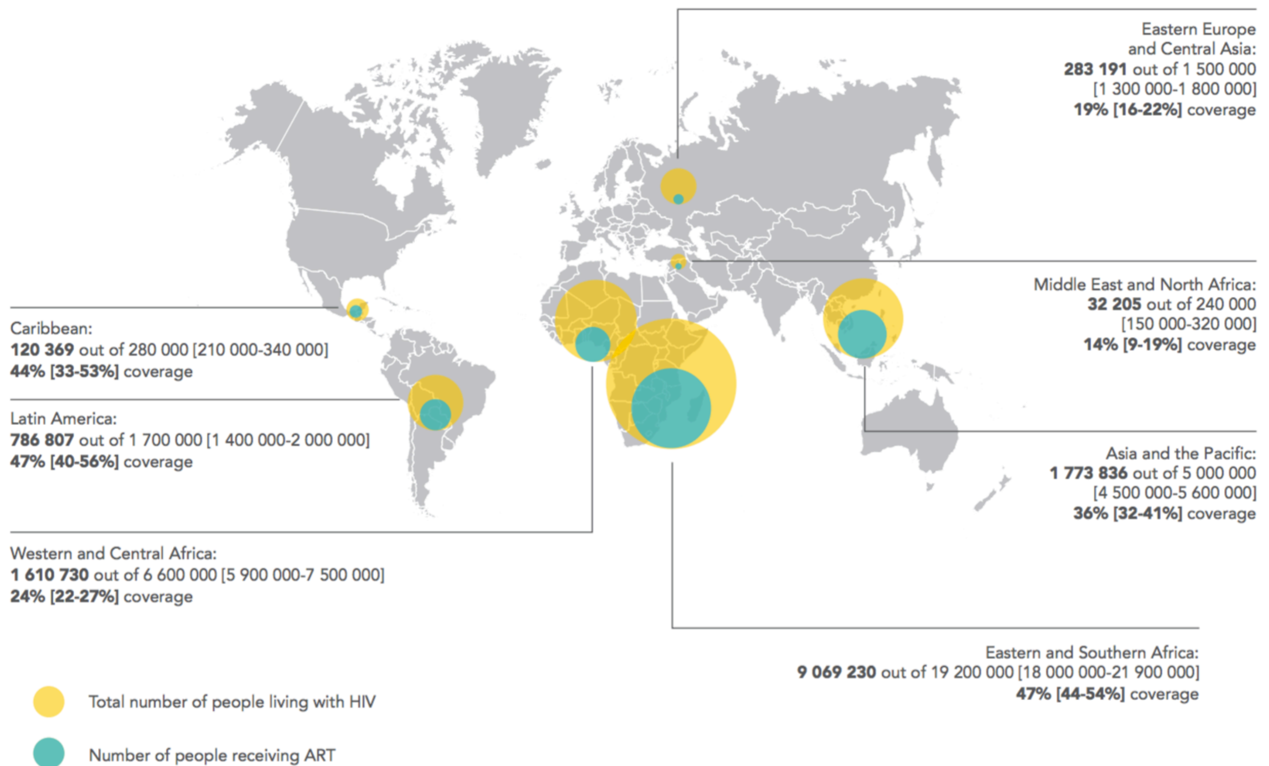
48. Late diagnosis of HIV remains the most substantial barrier to scaling up HIV treatment, and contributes to HIV transmission. Many people delay testing because they fear the discrimination that may follow. Despite progress in promoting knowledge of HIV status, half of all people living with HIV are unaware of their status. In eastern and southern Africa, only 10% of young men and 15% of young women are aware of their HIV status. Action is urgently needed to close the testing gap.

49. Key populations and adolescents and young people experience considerable barriers to learning their HIV status. In addition, many people who receive a positive HIV diagnosis are not effectively linked to care, and only about two thirds of people who initiate treatment are still receiving it after three years. The people who are most marginalized are falling through the cracks. Major contributors include barriers to the availability, accessibility, acceptability and quality of health services as well as stigma and discrimination in health-care settings. In eastern and southern Africa, men are less likely to be tested, less likely to access treatment, have worse adherence and are more likely to die from AIDS than their female counterparts.[35] Although men's behaviour in seeking health-care can account for some of these differences, many are reinforced by health systems that are inaccessible or inhospitable to men.[36]

50. As a result of these gaps in the treatment cascade, the proportion of people living with HIV who achieve viral suppression remains too low. In sub-Saharan Africa, only 32% of adults living with HIV had viral suppression.[37] Food insecurity is a critical barrier to linkage to care, treatment adherence, retention in care and viral load suppression. Malnourished people living with HIV are two to six times more likely to die within the first six months of treatment.[38] Treatment and retention gaps are particularly acute in humanitarian emergencies.

**Figure 6.**

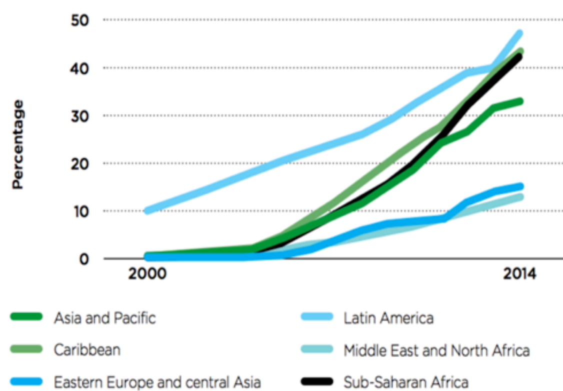
## Number of people receiving antiretroviral therapy out of total number of people living with HIV, by region, 2014




Source: UNAIDS, How AIDS changed everything — MDG6: 15 years, 15 lessons of hope from the AIDS response, Geneva 2015.

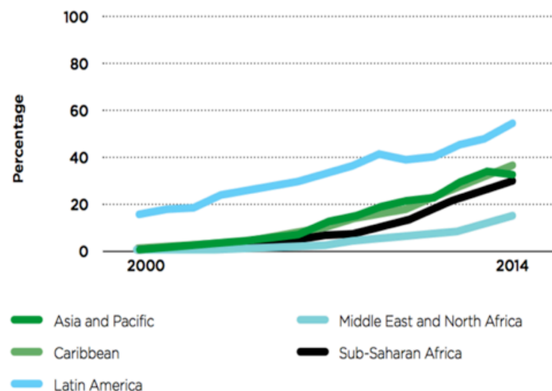
**Figure 7.**

### Antiretroviral therapy coverage in adults, by region, 2000-2014




Source: UNAIDS 2014 estimates.

### Antiretroviral therapy coverage in children, by region, 2000-2014




Source: UNAIDS 2014 estimates.

51. HIV responses have often been slow to address the myriad health, care and support needs of people living with HIV, including tuberculosis (TB), hepatitis, sexually transmitted infections (STIs) and food security, in a holistic manner. Scaling up collaborative HIV and TB activities has reduced TB deaths by one third among people living with HIV since 2004,[39] but TB remains the leading cause of death among them. An estimated 2.6 million people living with HIV also have chronic hepatitis B infection, and 2.8 million people living with HIV have hepatitis C virus.[40] Advances in HIV treatment have contributed to longer lifespans and a blurring of the line between infectious and chronic diseases. At the same time, many low- and middle-income countries are facing a double burden as the prevalence of non-communicable diseases (NCDs) rises more rapidly than infectious diseases such as HIV are declining. Women living with HIV are four to five times more likely to develop cervical cancer than HIV-negative women.[41] Co-morbidities with chronic conditions are of particular concern for the estimated 5.5 million people aged 50 years and older living with HIV today, and the 120 000 people in this age group who acquire HIV every year.

***③ Strategic Direction: Human rights and gender equality for the HIV response***

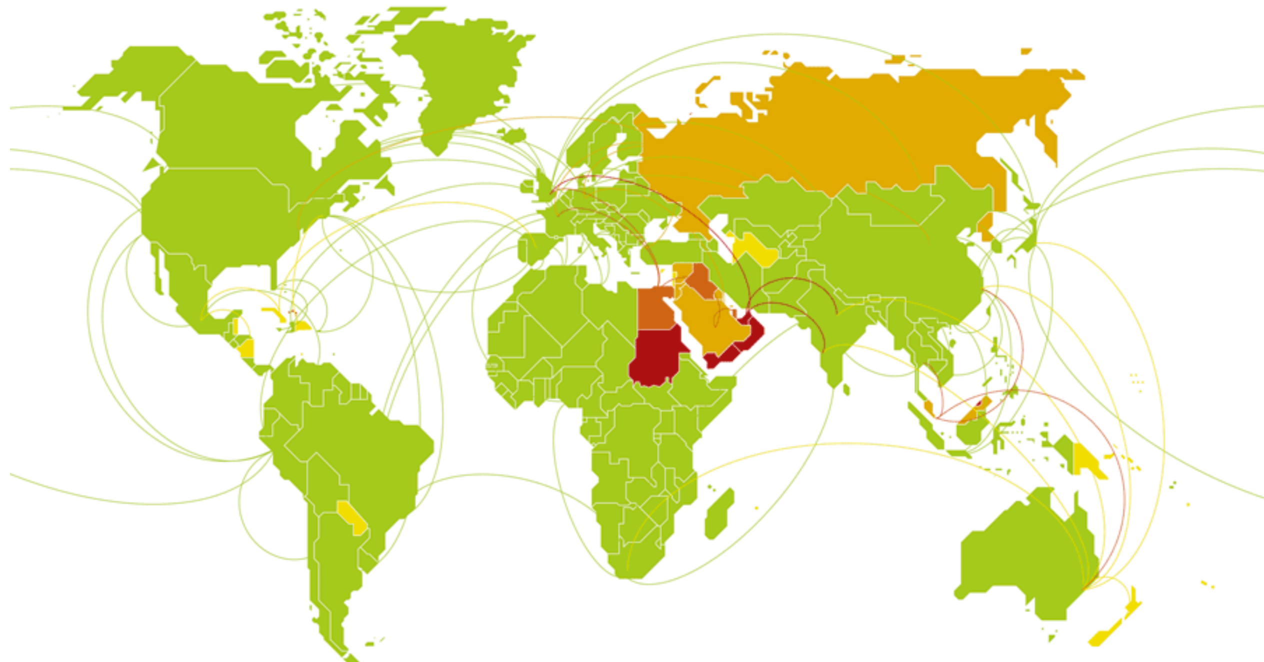
52. The AIDS response has demonstrated the importance and feasibility of overcoming human rights, gender-related and legal barriers to HIV services. The vision of zero discrimination has inspired action in advocacy, litigation and law reform for the right to health, including access to essential medicines. Today, 86 countries are following up on the findings and recommendations of the Global Commission on HIV and the Law.[42] Women living with HIV are calling for gender equality and catalysing law reform and litigation, including in Botswana, Malawi and Swaziland. Significant progress was made in Namibia when the Supreme Court ruled that involuntary sterilization violates human rights.[43] In 2014, 68% of reporting countries indicated that they have non-discrimination laws or regulations that specify protection for people living with HIV.[44] The number of countries, territories and areas with HIV-related travel restrictions has fallen by 40% from since 2009, from 59 to 36 (Figure 8).[45]

53. Yet in all regions of the world, punitive laws, policies and practices continue to violate human rights, entrench gender inequality, and maintain structural conditions that leave populations without access to HIV services.[46] Overly broad criminalization of HIV non-disclosure, exposure and transmission remains the norm in many settings.[47] Stigma and discrimination persist within many health-care facilities, deterring people from seeking services, eroding trust in health systems and jeopardizing efforts to scale up the response.[48] HIV-related stigma and discrimination are directly linked with delayed HIV testing, non-disclosure to partners and poor engagement with HIV services, including treatment retention.[49]

**Figure 8.**

# Welcome (not)

For many of the millions of people living with HIV around the world, travel restrictions are a daily reminder that they do not have equal freedom of movement. In 2011, United Nations member states agreed to eliminate HIV-related travel restrictions.



Source: UNAIDS, September 2015

54. Criminalization of sexual and gender minorities, sex work, and drug use contributes to stigma, discrimination and violence against key populations, including by state actors, and is a key barrier to an evidence-informed, rights-based AIDS response. People living with, at risk of or affected by HIV who experience violations of human rights often lack access to legal assistance and justice. Particularly concerning is the misuse of criminal law and resulting incarceration of key populations. Prisons and other closed settings often lack adequate health services, while mandatory HIV testing, often conducted without confidentiality or privacy, is common. Labour migrants, refugees and asylum-seekers living with HIV face discrimination by states that restrict their entry, enforce mandatory HIV testing or forcibly return them.[50]

55. Similar to adults, stigma and discrimination are widespread against children living with HIV or with parents with HIV.[51] Children's experience of stigma and discrimination related to HIV can cause severe mental distress and prevent them from attending school, learning their HIV status or adhering to treatment.

56. Globally, AIDS is the leading cause of death among women of reproductive age. Violations of human rights continue to render women and girls more vulnerable to HIV and prevent them from accessing HIV services and care. These include discriminatory laws and harmful practices, such as forced marriage and female genital mutilation and restrictions on women's equal access to decision-making, education, employment, property, credit or autonomy. As the 20-year review of the Beijing Platform for Action found, even where legal equality has been achieved, discriminatory social norms remain pervasive, which affects all aspects of gender equality, women's empowerment and women's and girls' human rights.

57. All forms of violence, including gender-based, sexual and intimate partner violence, may increase a woman's risk of acquiring HIV.[52] Young women and adolescent girls have the highest incidence of intimate partner violence; in some settings, up to 45% of adolescent girls report that their first sexual experience was forced.[53] Young women who experience intimate partner violence are 50% more likely to acquire HIV than other women.[54] Women living with HIV are also discriminated against in health-care settings, including experiencing forced or coerced sterilization or abortion and denial of reproductive health-care, including family planning services.[55]

58. Funding for civil society—an essential component of any human rights and gender equality effort—in the context of HIV is scarce and dwindling. The space for civil society activity is further limited in many places by increasingly restrictive environments for organizations working to advance human rights and gender equality.[56]

## 2. Time to Fast-Track: strategic leadership agenda

### By Fast-Tracking today, we can end the AIDS epidemic by 2030

59. This Strategy seeks to achieve a focused set of ambitious and people-centred goals and targets by 2020, in order to end the AIDS epidemic as a public health threat in all places and among all populations by 2030. The Strategy aligns with the cycles of United Nations funds and programmes, as required by the United Nations Quadrennial Comprehensive Policy Review.[57]

60. Goals and targets are set for 2020, rather than 2021 (the year the Strategy ends) to align with the 2020 mid-term review of the SDGs, and to enable evaluation of progress and preparation of the subsequent UNAIDS Strategy. Achieving these goals will improve social, educational and economic outcomes, strengthen systems for health, and promote human rights and dignity for millions of people—a continuation of the role of the global AIDS response as a pathfinder for social justice and sustainable development. Guided by the Strategy's goals and targets for 2020, countries will need to set targets, taking into consideration domestic circumstances, populations left behind and opportunity and need for programmatic saturation.

**Targets for 2020**

Target 1

90% of people (children, adolescents and adults) living with HIV know their status

90% of people living with HIV who know their status are receiving treatment

90% of people on treatment have suppressed viral loads

Target 2

Zero new HIV infections among children, and mothers are alive and well

Target 3

90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV

Target 4

90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services

Target 5

27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated SRH services for men

Target 6

90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants have access to HIV combination prevention services

Target 7

90% of women and girls live free from gender inequality and gender-based violence to mitigate risk and impact of HIV

Target 8

90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings

Target 9

Overall financial investments for the AIDS response in low- and middle-income countries reach at least USD 30 billion, with continued increase from the current levels of domestic public sources

Target 10

75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection

61. Fast-Tracking the response will require six transformative shifts—at the community, district, national, regional and global levels: 1) front-loading a diverse bundle of investments; 2) rights-based, laser-like focus on the locations, populations and interventions that deliver the greatest impact; 3) catalysing innovation for people who need it most; 4) leveraging regional leadership and political institutions for more targeted, sustainable and accountable responses; 5) launching a new era of intersectoral partnerships that leverage the unique contributions of people living with HIV, the private sector, faith-based communities, academia and science alongside government and civil society organizations, to address determinants of health; and 6) committing to the GIPA principle and people-centred accountability in a new era of the Agenda for Sustainable Development.

62. Renewed political commitment and novel forms of collective leadership, which will vary in composition across countries and regions, will be necessary to take the courageous decisions to front-load sufficient investments, prioritize and focus rights-based responses and ensure access for people left behind.

***Front-loading investment: shared responsibility and global solidarity***

63. Fast-Tracking the AIDS response will require a rapid increase in investment during the coming years. Total investment in the AIDS response in 2015 is projected to reach US$ 21.7 billion.[58] More than half of global HIV investment comes from domestic sources in low- and middle-income countries as the principle of shared responsibility and global solidarity gains strength. Increasing HIV investments by US$ 9 billion in 2020 compared with current resource availability, and by US$ 8 billion in 2030 to meet Fast-Track targets would produce economic returns of more than US$ 3.8 trillion that extend well beyond 2030.[59] Investing to accelerate scale-up at the front-end will deliver historic health benefits, reduce the number of children being orphaned by AIDS and generate vast economic returns over the long term. Except in low-income countries where funding needs for the response will remain relatively stable from 2020 to 2030, front-loading investments during the next five years will enable total resource needs to peak and begin to decline by 2021.

64. Low- and middle-income countries will need to significantly increase domestic funding according to their capacity and proportional to their burden of disease, while development partners must commit to sustainably funding remaining resource needs. Securing the necessary investment will require intensified focus on improving efficiency and decreasing service delivery and commodity costs; increasing and effectively using public funding; and developing innovative means of mobilizing funding, including intersectoral co-funding approaches. The response will greatly benefit from enhanced and strategic engagement of the private sector, including

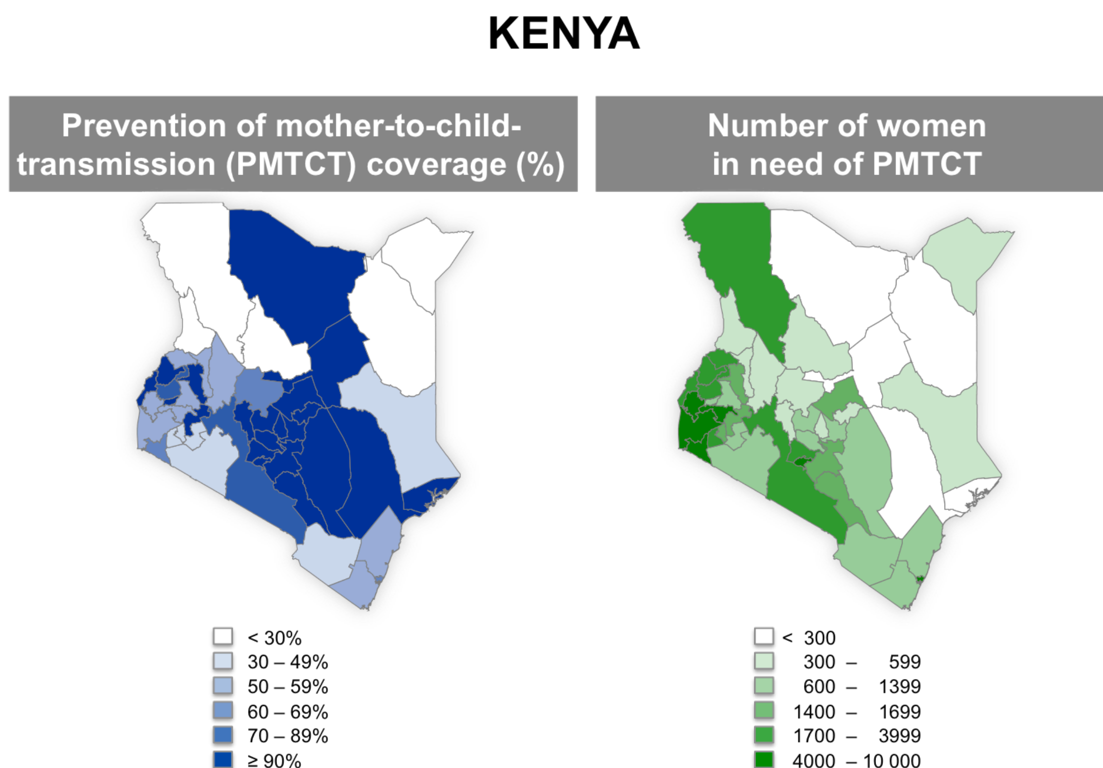
beyond funding, in areas such as investing for social impact, delivering services, strengthening and managing supply chains, workplace initiatives, social marketing and global advocacy.

65. In mobilizing the necessary resources, particular attention is warranted for middle-income countries, including small island developing states and those of newly designated middle-income status, which face a potential HIV funding crisis. Their ineligibility for assistance from some sources of international development cooperation threatens gains and poses particular risks for domestic programmes focused on key populations, some of which have suffered from inadequate political leadership.

### *Priority-setting and focus: location and population more important than ever before*

66. Without good data, decision-makers cannot determine whether epidemics are waning or worsening, or whether responses are leaving certain people behind. Fortunately, an increasingly sophisticated understanding of the epidemic provides a new lens to view the response through a location risk analysis and guide scale-up of precise investment and programming to hasten progress. The response has ushered in a new era of disaggregated data collection and innovative methods to identify underserved and overburdened populations, gaps in community and health systems and areas needing service saturation (Figure 9). Programmatic mapping is helping planners to select the most relevant mix of services for specific localized epidemics and to focus on interventions and delivery mechanisms that will provide the greatest impact and efficiency. However, many countries still face challenges in routine surveillance and patient monitoring. Challenges are further exacerbated in humanitarian emergencies due to difficulties in accessing communities as well as movements of people. Some countries are investing in routine monitoring of new diagnoses, people starting antiretroviral therapy, adherence levels and viral load, garnering significant experience in identifying and overcoming gaps and challenges, which should inform scale up across regions. In hand with improved monitoring of people on treatment, collection, analysis and use of sex- and age-disaggregated data in all aspects of the response must continue to be improved. Such information, however, can also be used to identify and discriminate against key populations. All efforts must be made to protect people's safety, security and rights, and respect the principle of the greater involvement of people living with HIV.

**Figure 9. Map layering provides strategic information on programmatic gaps according to population and location risk analysis**




67. The need for a strong AIDS response remains universal as a result of people left behind in fragile communities the world over. Although the pace needs to quicken in all countries, focused and accelerated efforts are especially needed in 35 Fast-Track countries, that, together, account for more than 90% of people acquiring HIV infection and 90% of people dying from AIDS-related causes worldwide. In addition to countries with the largest HIV epidemics, Fast-Track countries include rapidly emerging economies that will help lead the AIDS response into the future and other countries of key geopolitical relevance, such as those affected by humanitarian emergencies. Nineteen (more than half) of these Fast-Track countries are considered among the top 50 most fragile states on the planet.[60] As of September 2015, these Fast-Track countries include those in Table 1. Annex 2 lists regionally-identified priority countries and key cities. The role of the Joint Programme to support the global response, including accelerated efforts in Fast-Track countries, is elaborated in Section 3.

**Table 1. Fast-Track countries by income category, 2015[a]**

| High-income | Upper-middle-income | Lower-middle-income | Low-income |
|---|---|---|---|
| 1. Russian Federation<br>2. United States of America | 3. Angola<br>4. Botswana<br>5. Brazil<br>6. China<br>7. Iran (Islamic Republic of)<br>8. Jamaica<br>9. Namibia<br>10. South Africa | 11. Cameroon<br>12. Côte d'Ivoire<br>13. Ghana<br>14. India<br>15. Indonesia<br>16. Kenya<br>17. Lesotho<br>18. Myanmar<br>19. Nigeria<br>20. Pakistan<br>21. Swaziland<br>22. Ukraine<br>23. Viet Nam<br>24. Zambia | 25. Chad<br>26. Democratic Republic of the Congo<br>27. Ethiopia<br>28. Haiti<br>29. Malawi<br>30. Mali<br>31. Mozambique<br>32. South Sudan<br>33. Uganda<br>34. United Republic of Tanzania<br>35. Zimbabwe |

[a] The income categories are based on the 2015 World Bank classification. The Fast-Track countries are subject to change during the Strategy period.

### *Regional epidemics, leadership and accountability*

68. Regional priorities and target-setting ultimately contribute to achieving global goals. Regional priorities can generate greater ownership, promote mutual accountability and enable cooperation on issues requiring collective action (for example, market integration or addressing the HIV-related needs of cross-border migrants and forcibly displaced people), leading to greater efficiency and cost savings (for example, regional registration or procurement of medicines). In partnership with the international community, regional leadership is key to identifying where people are acquiring HIV, why and whether certain groups are being excluded from national HIV programmes.

69. Regional bodies will play an important role in enabling regional knowledge sharing and mobilizing essential resources for the scale-up of evidence-informed, rights-based regional responses. Regional strategies, such as the Asia–Pacific Regional Framework for Action to End AIDS by 2030, and peer-led accountability mechanisms such as the African Peer Review Mechanism may strengthen ownership and sustainability of the response.

### *Innovation: speeding up science for people*

70. Fast-Tracking the response relies on a comprehensive approach to innovation in terms of basic science, health products and medicines, human resources for health and service delivery. Innovative community-level service delivery models able to reach people being left behind need to form an integral, cost-effective, and long-term foundation of overall health systems. Using multiple strategies and modalities, testing initiatives need to be more strategically focused to reach the millions of people living with HIV who do not know their status. Home- or self-testing for HIV provides increased opportunities for people to access prevention and treatment services. Providing pretest information and counselling can facilitate linkages to care, as can post-test referrals and follow-up. Swifter scale-up is essential for male and female condoms, condom-compatible lubricants, rapid point-of-care diagnostics and viral load testing, pre- and post-exposure prophylaxis, microbicides, voluntary medical male circumcision devices, contraceptive options, opioid substitution therapy and other harm-reduction measures. A special emphasis is needed to enable early infant diagnosis of HIV, including through the prompt introduction and scale-up of point-of-care infant diagnostic tools, and to develop drug formulations appropriate for children. Innovation is further required to produce better, optimized and long-lasting formulations of antiretroviral medicines, vaccine and cure, as well as more effective and affordable treatment for common coinfections such as TB, STIs and hepatitis.

71. The AIDS epidemic cannot be ended without ensuring that the most innovative and effective tools are made available without delay. Countries must also have the capacity, flexibility and agility to access health technologies as they are made available. To realize the full impact of innovations in research, science and technology, countries must ensure that trade and other commercial policies support public health goals.

72. Digital and social media and mobile technologies connect people in innovative ways to share experiences, access information, deliver services and catalyse social movements. They provide a potentially inexpensive and efficient way to facilitate risk self-assessment, encourage prompt uptake and ongoing use of prevention methods, enhance treatment adherence and reduce loss-to-follow-up. These tools can provide safe, anonymous spaces to share sexual health information, monitor real-time gaps and progress in the AIDS response, equip citizens with data, enhance their participation in the public sphere and extend their agency over development-related decision-making. However, online and social media tools can also promote inaccurate and harmful messages, increasing the importance of adolescents and young people receiving quality, evidence-informed education and information.

### *Intersectoral partnerships: leveraging the contributions of diverse stakeholders*

73. In the context of the 2030 Agenda for Sustainable Development, accelerating the impact of the AIDS response will require mobilizing collective leadership from a broad range of sectors to address links and build political urgency and multisectoral coalitions for action. For example, the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, which has contributed to significant progress for women's and children's survival and well-being, is renewing its focus on adolescents and supporting intersectoral action on empowerment, education, nutrition and employment—issues critical to progress in the AIDS response. Across the many development areas relevant to the AIDS response, the evidence base must be strengthened to identify cost-effective interventions that address shared determinants of vulnerability, promote dignity and equality and deliver gains across the SDGs. The Agenda for Sustainable Development further demands action to negotiate and deliver global public goods, such as strengthening disease surveillance and strategic information systems, research and development of health technologies, measures to enhance access to affordable technologies (including overcoming restrictive intellectual property rules and other international trade barriers), civil society activism and promoting health as a political and economic priority.

### *People-centred accountability for more inclusive, effective and legitimate responses*

74. Accountability rests on monitoring, review and remedial action. Accountability is not simply a technocratic exercise; it should be as transparent, accessible and participatory as possible. Citizen engagement to drive social change is simultaneously one of the greatest challenges and one of the greatest opportunities of the 2030 Agenda for Sustainable Development. To track progress and drive action, political leaders have committed to a people-centred review process at the global, regional and country levels that is transparent, ensures accountability to citizens and fosters exchange of best practices and mutual learning. As a challenge of extraordinary complexity, the SDGs need to be supported by diverse webs of accountability arrangements, including independent review of stakeholders' progress, promises and commitments.

75. In this context, progress towards achieving the UNAIDS Strategy goals will rely on a coalition of 'factivists' to hold leaders—in the public, private and civil society spheres – to account for their commitments. Inspired, animated and guided by affected communities, the AIDS movement has been a pioneer in political accountability by demanding and creating the political space for open and inclusive dialogue on the right to health. The experience of the AIDS response thus has the

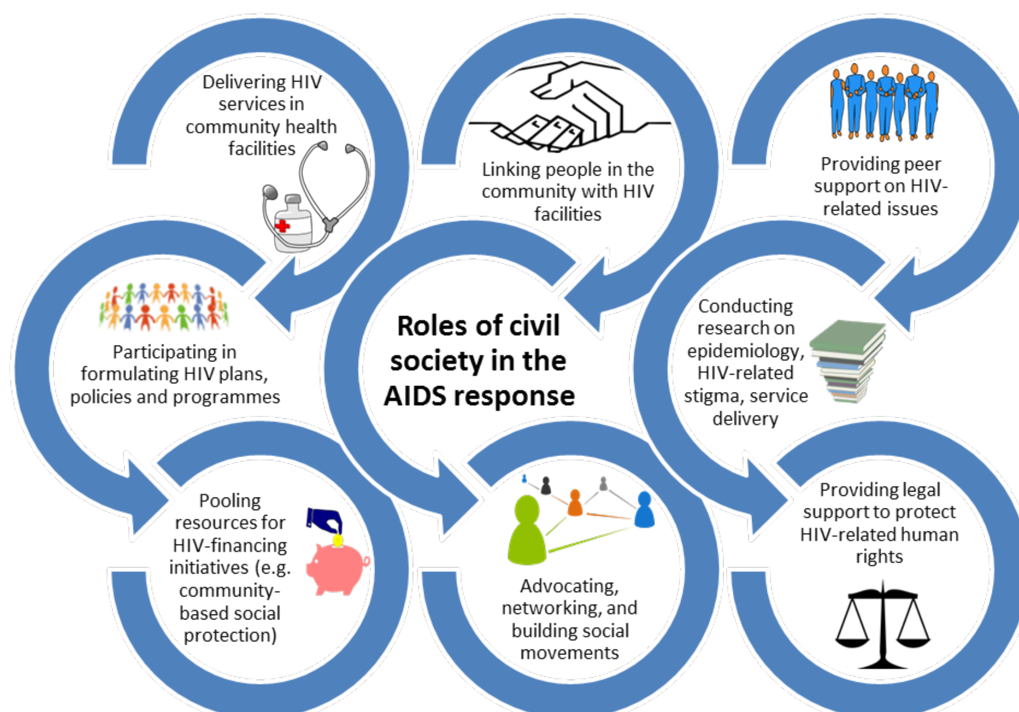
potential to leverage existing accountability frameworks to address complex multisectoral sustainable development challenges post-2015.

76. The AIDS response has in place one of most rigorous reporting and accountability mechanisms in all of global health and development: the Global AIDS Response Progress Reporting (GARPR, formerly UNGASS reporting). Built by UNAIDS and its partners, GARPR has among the highest response rates for any international monitoring mechanism and has been highly effective in galvanizing commitments, action, reporting compliance and, ultimately, accountability for results. Reporting annually to the United Nations General Assembly, the AIDS response has created a clear line of accountability from the local to the global level. To ensure coherent and transparent accountability mechanisms that document and analyse progress across sectors in an integrated way and to enhance AIDS accountability, it is important to make use of existing human rights reporting mechanisms at both global (such as the Universal Periodic Review and the human rights treaty bodies) and regional levels (such as the African Commission on Human and People's Rights).

77. Strong civil society engagement is critical to implementing this Strategy. Such engagement, a global public good, requires legal and social space as well as financial resources secured to ensure its effectiveness. Civil society plays numerous roles in the AIDS response (Figure 10) with mounting evidence of its positive impact. Community-based services achieve substantial scale in service delivery on their own while also buttressing clinic-based care and extending the reach of formal health services. A particular strength of civil society lies in its diversity, often representing and providing services to different marginalized communities. It is important to ensure that civil society advocacy is enabled to mobilize political support to drive ambition, financing and equity in the response. Efforts need to be made to ensure that young people—including from key populations— can participate meaningfully in decision-making platforms and accountability mechanisms.

78. Multisectoral, multistakeholder partnerships are critical to accountability at all levels. It will be important to ensure a seat at the table for affected communities in more inclusive and representative country, regional, minilateral and global governance arrangements. In the latter, ensuring that the interests and needs of implementing countries can be voiced, recognized and addressed can ensure more inclusive, effective, credible and legitimate institutions.

**Figure 10.**




## Result areas to Fast-Track the response and accelerate progress on the SDGs

79. The vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths guides the AIDS response. The Strategy for 2016–2021 is organized around five SDGs to catalyse progress across the three Strategic Directions and towards goals and targets for 2020. The selection of the SDGs and related results areas is based on two overarching considerations: first, an analysis of experience in implementing the 2011-2015 Strategy and aspects in which progress has been too slow, and second, appreciation of new dynamics and opportunities for the response, including shifts in the development context.

80. Under each SDG, result areas and core actions for the global response are presented. Result areas cover core dynamic and cross-cutting programmes of work that will contribute to achievement of the Strategy targets for 2020. These focus on scale-up and transformation that needs to occur at country level, recognizing that progress requires diverse and layered forms of cooperation—including North–South, South–South, South–North—and close partnership with civil society, the private sector, and stakeholders across legal, trade, education, employment and finance sectors.

## Ensure healthy lives and promote well-being for all at all ages

**Result area 1**

Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on quality treatment

**Result area 2**

New HIV infections among children are eliminated and their mother's health and well-being is sustained

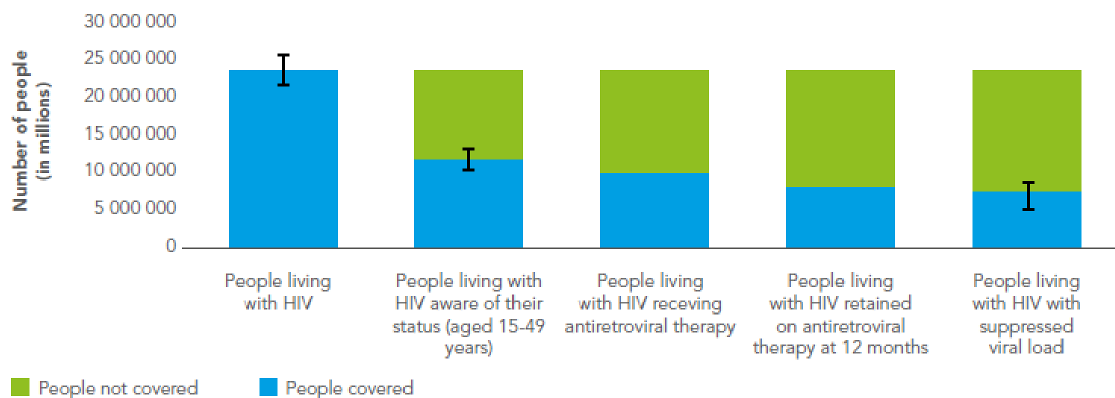
81. Ensuring healthy lives and promoting well-being for all at all ages is essential to sustainable development. Ensuring the healthy lives of people living with and at higher risk of acquiring HIV requires a combination of interventions, from individual-level approaches to those at the systemic level. Providing holistic treatment, care and support for people living with HIV and promoting their rights and participation in the AIDS response will improve individual health outcomes and prevention impact, enable economic participation and generate healthier communities.

82. Achieving the 90–90–90 treatment target—where 90% of people living with HIV know their status; 90% of people who know their HIV status are accessing treatment; and 90% of people on treatment have suppressed viral loads—provides an entry point to progress towards all goals and targets for 2020. Doing so will require urgently closing the gaps in the treatment cascade (Figure 11). Timely and accurate data for each stage of the cascade need to be collected and analysed at the local level, and results should inform programme management and targeted interventions to prevent loss to follow-up. National procurement and supply management systems must be robust and efficient. Surveillance to monitor drug resistance must be in place, alongside viral load testing.

83. All people who test positive for HIV should be immediately offered treatment upon diagnosis. In hand, HIV testing must be significantly expanded to ensure that all people living with HIV—particularly people with lower CD4 counts—learn their status as soon as possible and are linked to treatment and prevention services. Extra efforts will be required to enable young people, key populations, migrants and crisis-affected populations to access testing and treatment services. Urgent efforts are needed to accelerate the update of national treatment approaches. National HIV treatment policies take time to incorporate scientific learning and normative guidance. Within 18 months of WHO recommending raising the threshold for antiretroviral therapy initiation from 350 to 500 cells/mm3 in 2013, 53% of 144 low- and middle-income countries had adopted it. With scientific evidence now demonstrating the significant health and preventive benefits of initiating antiretroviral therapy upon

diagnosis, an additional 10 countries have recommended initiating HIV treatment for all people living with HIV, regardless of CD4 level.[61]

**Figure 11. HIV treatment cascade for people aged 15 years and older in sub-Saharan Africa, 2014**




84. Scaling up treatment will require countries to complement facility-based services with an array of non-facility-based approaches. Enabling efficient scale-up requires expanding community-based HIV service delivery from a global average of 5% in 2013 to cover at least 30% of all service delivery in 2030.[62] Intensified efforts to implement task-shifting in clinical settings will be essential to maximize efficiency gains and to respond to shortages of human resources for health. Policy change and capacity-strengthening initiatives should focus on training and elevating the status of community health workers and outreach workers in delivering integrated services. Combined with community mobilization, expanding testing and linkage to care will require focusing on treatment education and literacy. Treatment literacy not only reinforces a person's right to know their HIV status and to decide whether and when to begin antiretroviral therapy, but also provides an entry point for reducing stigma and discrimination. HIV testing and treatment programmes must be accessible and relevant to adolescents and young people since they have distinct health-care, sexual and reproductive health and rights, educational, developmental and psychosocial needs.

85. The international community must urgently sustain and strengthen efforts to ensure all children can live free of HIV and keep mothers alive and well. Integrating services for elimination of mother-to-child HIV transmission into ante- and post-natal care will make services routinely available. Efforts to achieve dual elimination of HIV and syphilis among children by integrating screening and treatment services for pregnant women are an especially cost-effective opportunity to reduce neonatal deaths, stillbirths and congenital syphilis. Including partners in counselling and testing

services for pregnant women is important to identify discordant couples and provide care. Retention in care during the lengthy breastfeeding period is also critical. Breastfeeding for women living with HIV is made safer by providing antiretroviral medicines throughout the nursing period, in accordance with the recommendation that all pregnant and breastfeeding women living with HIV initiate and remain on lifelong treatment. Health registries should be strengthened to allow better tracking of parents and babies together, aided by national systems of vital registration and electronic medical records.

86. Closing the treatment gap for children requires expediting introduction and uptake of point-of-care infant diagnostic tests, expanding and streamlining centralized laboratories for infant diagnosis and increasing case-finding. All services for HIV-exposed children need to be improved, including more affordable, efficacious and palatable drug formulations, testing literacy, and uptake and retention support for children, parents and caretakers and health worker training on care and treatment for children.

87. A more diverse profile of care and support needs has emerged with widespread availability of antiretroviral therapy and the management of HIV as a chronic condition. HIV-related services need to transform to decrease loss to follow-up, improve treatment adherence and ensure better individual health outcomes, by integrating with prevention and management of opportunistic infections, particularly TB; access to social grants and livelihood-strengthening activities; and food security.[63] Care and support interventions such as treatment buddies, mother support groups, psychosocial support and child support grants should be scaled up.

88. The enormity and scale of humanitarian emergencies highlights the need to integrate preparedness and risk management into development programming, and to reach affected fragile communities.[64] In such circumstances, action is needed to ensure that HIV programmes are risk-informed and maintain the provision of HIV services, including for TB, STIs, opportunistic infections, malnutrition and violence prevention and care. Enhanced preparedness and access to information and rapid and flexible funding are prerequisites for effective responses in humanitarian emergencies.[65]

89. As demand increases for antiretroviral drugs for treatment and prevention purposes, the international community must ensure a sustainable, uninterrupted supply of affordable and quality-assured antiretroviral medicines. Since 2000, generic competition has drastically reduced the price of first-line antiretroviral medicines and this, along with increased investments and health system and service delivery improvements, has made HIV management the first large-scale chronic care programme in many low- and middle-income countries. India's generic

pharmaceutical industry has played a central role in achieving price reductions and saving millions of lives, producing 80% of HIV medicines consumed in Africa.

90. Maintaining generic competition has become increasingly complex as more countries assume their obligations under the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), or are pressured to adopt TRIPS-Plus measures in free trade agreements. Given the many well-documented market failures in medicine research, development, manufacture and pricing, and to secure the ability of governments to ensure the right to access to medicines, it is essential to remedy the policy incoherence between trade, human rights and public health in the context of HIV. A combination of approaches is needed, including: supporting countries to make use of TRIPS flexibilities; supporting countries in negotiating free trade agreements without TRIPS-plus provisions that limit access to affordable medicines; steps to preserve and strengthen local generic pharmaceutical manufacturing capacity; supporting the extension of a transition period on TRIPS obligations for pharmaceuticals for as long as a country remains a least-developed country; negotiations with pharmaceutical companies to lower prices; and accelerating the entry of innovative products into the market, including by simplifying and strengthening health regulatory procedures.

The following are core actions for the global response to ensure healthy lives and well-being for all at all ages:

- Broaden options for targeted rights-based, evidence-informed and gender- and age-specific HIV testing through expanded community-led counselling and testing, home testing and innovative public-private partnerships.

- Strengthen and broaden the delivery of antiretroviral therapy, viral load monitoring, adherence and other forms of care and support, such as income-generation programmes for people living with HIV, including by scaling up task-shifting and community-based service delivery, accelerating the adaptation of recommended regimens and revitalizing treatment literacy programmes, with particular focus on reaching underserved, higher-risk populations.

- Urgently accelerate early diagnosis of children living with HIV and close the treatment and retention gap, rolling out of comprehensive diagnostic strategies that extend the entire period of exposure risk and a sufficient array of age-appropriate medicines, including fixed-dose combinations, for children and adolescents.

- Strengthen programmes to eliminate mother-to-child HIV transmission and prevent maternal seroconversion during pregnancy and breastfeeding by accelerating adaptation of recommended antiretroviral regimens and integration with ante- and

postnatal care; maternal, neonatal and child health services; and family planning platforms.

- Set and pursue targets for prevention, screening, diagnosis and treatment of TB among people living with HIV; knowledge of HIV status and ART among TB patients living with HIV; and reduction in TB deaths among people living with HIV.
- Strengthen programme effectiveness by monitoring and visualizing local prevention and treatment cascades, which enable corrections and Fast-Track monitoring.
- Support preparedness and capacity-building to minimize disruption in HIV services in times of emergency, integrate HIV into national emergency preparedness and response plans and ensure that plans are synchronized with development plans.
- Encourage research and development of more tolerable, efficacious and affordable health products, including: simpler, longer-lasting drug formulations for children, adolescents and adults; second- and third-line therapy; diagnostics; prevention technologies, including vaccines; and cure.
- Fully leverage use of TRIPS flexibilities to meet public health objectives and avoid adopting or implementing more extensive intellectual property provisions than those required by the TRIPS Agreement. In tandem, encourage and promote alternative financing mechanisms for funding research and development that balance the protection of intellectual property with public health interests, and accelerate market entry of newer HIV-related products.
- Strengthen North–South and South–South cooperation and regional and local capacity to develop, manufacture and deliver quality-assured affordable medicines to enhance the reliability of drug supplies, while encouraging development of regional markets.

## Reduce inequality in access to services and commodities

> **Result area 3**
>
> Young people, particularly young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV
>
> **Result area 4**
>
> Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants

91. The response can only be Fast-Tracked by protecting and promoting the right of all people to access appropriate, high-quality HIV services without discrimination. Reducing young people and key populations' vulnerability to HIV and its impact in all epidemiological settings is essential to end the AIDS epidemic. Ensuring equitable access for sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners as well as migrants and others left behind demands the availability of effective and appropriate HIV and health services and commodities in an enabling social, legal and policy environment as well as the meaningful engagement of these groups in the response. Reaching and engaging adolescent and youth members of key populations is especially critical, since they face additional barriers to services.

92. Declines in HIV prevalence among young people in many settings reflect in part the success of behavioural prevention programmes.[66] Population-based surveys report increasing age at first sex and decreasing numbers of partners[67] and increased condom use among youth in several African countries in which the number of people acquiring HIV has declined. These gains now need to be sustained and accelerated, including through up-to-date communication and empowerment strategies.

93. Effective and rights-based combination prevention programmes for and with the people who are most vulnerable and at highest risk must be rapidly scaled up and focus on where the HIV epidemic is concentrated. Real-time monitoring of services and programmes enables critical data to be collected and disseminated using widely available tools such as mobile phones and the cloud. Greater granularity enables rapid identification of which local programmes are working, which are not and where services are lacking. Decision-makers can leverage strategic information to saturate high-transmission areas with a combination of interventions tailored to the needs of specific populations (Figure 12). Better focusing prevention programmes by population and location can increase prevention impact without increasing

expenditure.[68] This requires not only allocating resources to intensify programmes where they are needed most but also reducing spending where programmes are needed less.

94. In all epidemic contexts, effective action in cities not only promotes rapid scale-up of prevention programmes but can also serve as an important entry point to influence national outcomes. Cities are home to many young people as well as large numbers of people belonging to key populations. The typically more tolerant, inclusive nature of urban life offers opportunities to develop participatory responses and to reach groups that are often given priority at the national level.

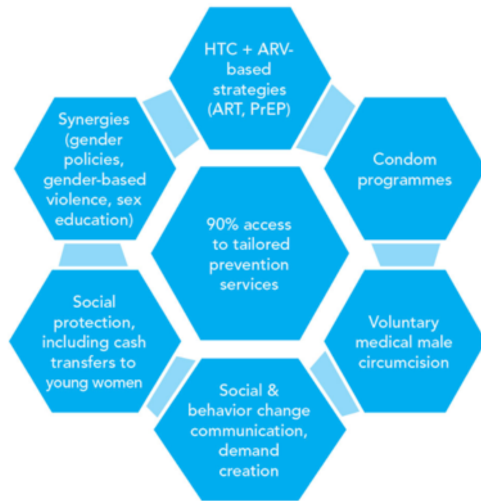
95. Numerous effective prevention methods are available. Male and female condoms remain the most efficient device to simultaneously prevent sexual transmission of HIV, other STIs and unintended pregnancy.[69] Nevertheless, condom availability remains limited, especially in parts of sub-Saharan Africa.[70] Among young people, condom access is even more limited, and in some settings such as prisons, prohibited. HIV prevention programmes should ensure that a sufficient number of quality-assured male and female condoms are accessible to people who need them when they need them. Condom promotion, including innovative marketing and private-sector partnerships, is also insufficient, with experts estimating that, for each male condom procured at US$ 0.03–0.06, another US$ 0.20 should be invested in creating demand and in distribution.[71]

96. Voluntary medical male circumcision (VMMC), as an element of integrated SRH services for men, is providing significant protection for millions of young men in sub-Saharan Africa, reducing risk of HIV transmission by up to 60%.[72,73] Achieving scale for VMMC programmes requires service availability, demand creation, innovative delivery models and, potentially, choice between surgery and new devices. The renowned Copenhagen Consensus identified male circumcision in HIV hyper-endemic countries as one of 19 best investments to achieve the post-2015 development agenda, with a benefit of US$ 28 for every dollar invested.[74]

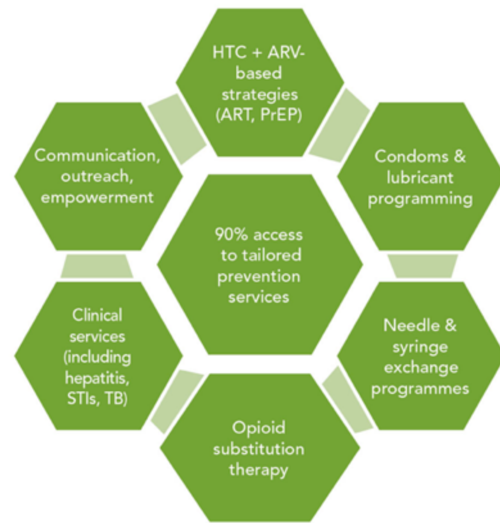
97. Pre-exposure prophylaxis, if targeted appropriately and implemented at scale as part of combination prevention programmes, may be a game-changer for people at very high risk of acquiring HIV. For people living with HIV, early access to antiretroviral therapy and connection to quality care suppresses HIV viral load to a point where risk of onward transmission is lowered by as much as 96%. Among people who inject drugs, a comprehensive package of interventions, including needle and syringe programmes and opioid substitution therapy, provided in a legal and policy environment that enables access to services, prevents infection and reduces deaths from AIDS-related illnesses, TB, viral hepatitis and STIs.[75]

**Figure 12. Illustrative combination prevention programmes for affected populations**

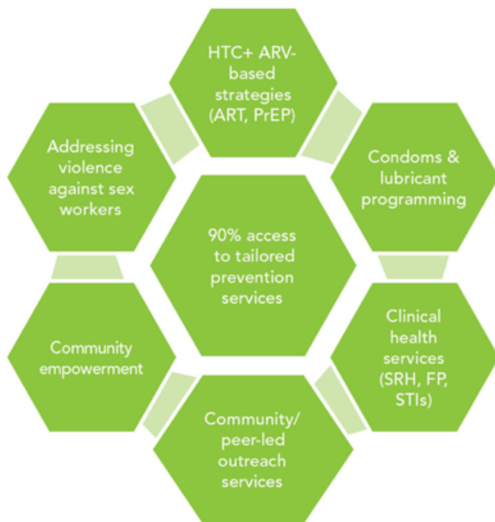
### Illustrative combination prevention programme for young women and their male sexual partners in a high-prevalence site



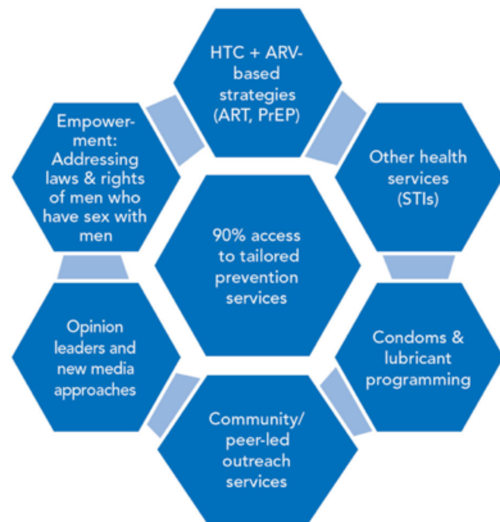

### Illustrative combination prevention programme for people who inject drugs




### Illustrative combination prevention programme for female sex workers




### Illustrative combination prevention programme for men who have sex with men




Source: Fast Tracking Combination Prevention; Towards Reducing New HIV Infections to Fewer than 500 000 by 2020, UNAIDS. 2015.

98. Structural and gender-sensitive interventions contribute significantly to reducing HIV infection, particularly for young women and adolescent girls, including interventions that reduce marginalization and social exclusion, promote economic empowerment of girls, support migrant and displaced populations, eliminate violence and gender inequality and ensure an enabling legal and law enforcement environment for young women and key populations.[76] Completion of secondary education is one such intervention, fostering knowledge, influencing sexual behaviour, affecting social networks and contributing to improved socioeconomic status. Benefits of formal schooling for HIV prevention are strongest for women.[77] Interventions that increase enrolment, retention and learning for girls, such as offsetting opportunity costs of education and cross-sector funding of education, reduce the risk that women will acquire HIV infection.[78]

99. Comprehensive sexuality education (CSE) is recognised as an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgemental information. Several studies on the impact of sex and HIV education interventions in schools in low- and middle-income countries have shown significant positive results in terms of delayed first sex, increased use of condoms or contraceptives, and reduced incidence of unprotected sex.[79] Results from a meta-analysis of 64 studies, the majority from sub-Saharan Africa, demonstrate that students who received school-based sex education interventions had significantly greater HIV knowledge, delayed sexual debut, self-efficacy related to refusing sex and/or condom use, condom use and fewer sexual partners.[80,ix] A review of 22 curriculum-based sexuality education programmes in low-, middle- and high-income countries, found that 80% of programmes that addressed gender or power relations were associated with a significant decrease in pregnancy, childbearing or STIs. In contrast, only 17% of the programmes that did not address gender and power significantly reduced rates of pregnancy or STIs.[81] There is additional evidence of the positive impact of CSE on SRH outcomes, notably on reducing STIs, HIV and unintended pregnancy.[82] Young people are clear in their demand for more—and better—comprehensive sexuality education, services and resources to meet their prevention needs. Special efforts need to be made to reach children out of school, who are often the most vulnerable to misinformation and exploitation.

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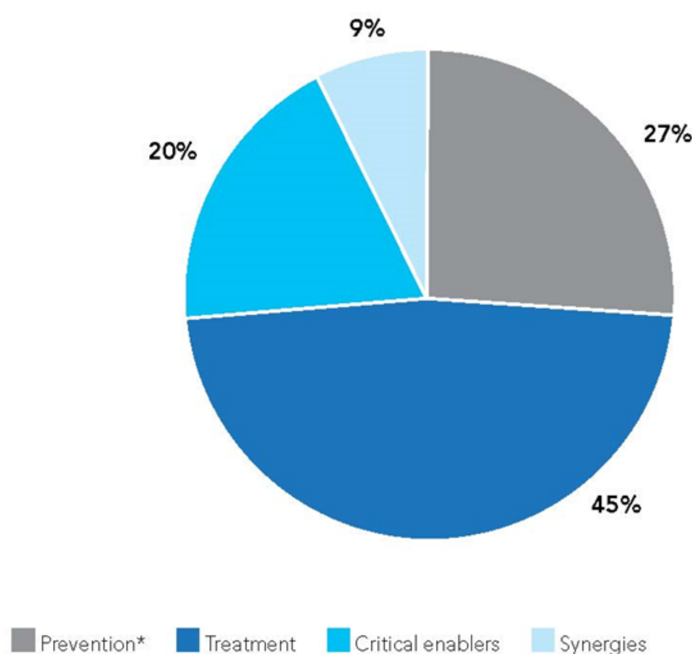
[ix] The meta-analysis covered evidence for school-based sex education interventions to determine the efficacy of these interventions in changing HIV-related knowledge and risk behaviors. Nine interventions either focused exclusively on abstinence (abstinence-only) or emphasized abstinence (abstinence-plus), whereas the remaining 55 interventions provided comprehensive sex education. The majority of studies took place in sub-Saharan Africa (n=29, 45.3%). Most studies (n=56) took place among primary or secondary school students.

100. The AIDS response must continue to mobilize and engage people living with HIV and populations left behind as a force for transformation in governing, designing and implementing the response. Community-led networks and organizations (especially of women, young people and key populations) must be supported financially and politically to become more central in service delivery and in reaching constituents to inform, empower and link to services.

101. Even as new prevention tools and approaches have emerged, prevention programmes have weakened in recent years due to such factors as inadequate leadership, poor management, weak accountability and declining funding.[83] Country combination prevention frameworks need to be updated, the management and capacity of prevention programmes strengthened and adequate funding allocated. Dedicated capacity needs to be established for mapping and target-setting with priority populations, intersectoral coordination, monitoring and mentoring of local programmes to reach high coverage, strengthened procurement, supply chain of prevention products and effective communication and coherent messaging around prevention, including through new and digital media. UNAIDS estimates that one quarter of global HIV funds should be allocated to prevention other than antiretroviral therapy (Figure 13), with the specific proportion varying from country to country.

**Figure 13. Total Fast-Track requirement by 2020**



The following are core actions for the global response to reduce inequality in access to services and commodities:

- Strengthen and enable access to combination prevention programmes tailored to people and populations at higher risk of HIV, including behaviour change communication, condoms, VMMC programmes, harm reduction, testing and offer of PrEP or treatment as needed, as well as ensuring an enabling social, legal and policy environment.
- Strengthen subnational and local data collection, disaggregated by sex, age and key population, and its rights-based use, to improve population size estimates, resource allocation by population and location and service delivery access and linkages.
- Scale up programmes to promote women's knowledge, skills and ability to negotiate safer sex, including through HIV-sensitive social protection and economic empowerment programmes, as well as investment in women-initiated prevention commodities.
- Strengthen services for men and boys, including both focusing on improving male health-seeking behaviour and addressing structural barriers that hinder men in using HIV services.
- Scale up adolescents' and young people's access to quality comprehensive sexuality education, through its integration into the school curricula and monitoring systems, the engagement of communities and rolling out teacher training.
- Address laws, policies and norms that undermine adolescents' and young people's sexual and reproductive health and rights, including those that limit their ability to independently access youth-friendly HIV-related information and services.
- Expand financial support to strengthen and sustain innovative community-based programmes and the leadership and engagement of networks of people living with HIV, key populations and other populations disproportionately affected by inequality and HIV, including support to reinforce youth movements through mentoring and capacity-building activities.
- Strengthen the oversight of combination prevention programmes, including at the city and municipal level, and ensure sufficient investment in HIV prevention, which should reach one quarter of global total AIDS investments.

## Achieve gender equality and empower women and girls

> **Result area 5**
>
> Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

102. Achieving gender equality by empowering women and girls and engaging men and boys is essential through the life cycle, benefiting all of society. Gender equality supports and enables people to prevent HIV transmission, improves access to services, education and employment and paves the path for lives free of violence.

103. Action on gender equality and women's empowerment is critical in three interrelated areas to reduce vulnerability to HIV and its impact: (1) improving women's and men's access to and uptake of sexual and reproductive health and HIV services and commodities; (2) transforming unequal gender relations and norms and ending gender-based, sexual and intimate partner violence; and (3) empowering women, young women and adolescent girls, in all their diversity, and enhancing their agency to make decisions and act on them in all spheres of their lives.

104. Protecting and promoting women's sexual and reproductive health and rights, including deciding when and with whom to have sex and to marry and how many children to have, is central to enabling women to prevent acquiring HIV. This entails ending harmful practices such as early, child and forced marriage, which increase the risk that girls will acquire HIV infection.[84] Autonomy and empowerment are key factors in condom use, especially for young women. Evidence shows that women with greater autonomy in decision-making are more likely to negotiate safer sex and have higher HIV-related knowledge and condom use.[85]

105. Engaging men in HIV prevention efforts is critically important, both as sexual partners as well as clients with their own needs. Challenging notions of masculinity and traditional perceptions of manhood requires men to engage as gender advocates and to take responsibility for transforming social norms, behaviour and gender stereotypes that perpetuate discrimination and inequality. Engaging men and boys in gender-transformative interventions linked to income-generating activities encourages men's involvement and uptake of HIV services.[86] Men and boys face gender-related vulnerability as well, including sexual violence, which should be addressed through gender-sensitive HIV services.

106. Growing evidence on the links between human rights, gender equality and HIV should inform the rapid scaling up of systematic action. Multifaceted approaches that involve men and women, boys and girls and engage diverse stakeholders have the greatest impact. The Safe Homes and Respect for Everyone (SHARE) project in Uganda revealed that activities to prevent intimate partner violence, when integrated into an enhanced antiretroviral therapy delivery programme, significantly reduced HIV incidence. [87] Violence prevention and HIV programming, when integrated into existing development platforms, such as microfinance, social protection and education, greatly facilitate scalability and sustainability.[88] Sexual violence often becomes more pronounced in humanitarian emergencies, where traditional protection systems are weakened; as such, it is critical to leverage women's participation in peace-building, reduce women's and girl's vulnerability in these settings and ensure provision of post-exposure prophylaxis as an integral part of HIV-related services.

107. Investing in the empowerment of women and promoting their access to health services, education and economic opportunities, ensuring and promoting their legal rights and supporting women's autonomy and decision-making, will help reduce HIV infection and mitigate the epidemic's impact. Women and girls, including those living with HIV, must be empowered as leaders; spaces need to be reserved for women's participation in key HIV-related agenda-setting platforms; and grassroots mobilizing and alliance-building with other social movements should be facilitated.

The following are core actions for the global response to achieve gender equality and empower women and girls:

- Ensure laws, policies and practices uphold women's rights and autonomy; advance gender equality; meet the sexual and reproductive health and rights and HIV-related needs of women in all their diversity; and support access and adherence of women, young women and girls to prevention, treatment and care across their lifecycle, especially those from the most vulnerable communities.

- Empower women and girls, including those living with HIV, to uphold equally their economic, legal, political and social and sexual and reproductive health and rights as well as opportunities for participation, leadership and decision-making of their own.

- Ensure that country HIV responses address links with gender inequality and gender-based violence, such as provisions for survivors of sexual and gender-based violence, including in humanitarian emergencies.

- Scale up interventions to reduce gender-based violence as a cause and consequence of HIV infection and harmful practices including forced marriage, forced sterilization and forced abortion.

- Transform unequal gender norms in the context of HIV, working with men and boys, women and girls, community, cultural and faith leaders and the private sector.

- Invest in organizations that advocate for gender equality, women's rights and empowerment and build bridges between networks of women living with HIV, the women's movement and the AIDS movement, as well as with governments and international organizations to assure women's participation in the governance of the HIV response.

## Promote just, peaceful and inclusive societies

> **Result area 6**
>
> Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

108. In accordance with the 2030 Agenda for Sustainable Development, this Strategy promotes universal respect for human rights and dignity, the rule of law, justice, equality and non-discrimination on all grounds; respect for race, ethnicity, gender and cultural diversity; and equal opportunity and shared prosperity. The Agenda provides an unprecedented opportunity to expand rights-based HIV responses and strengthen links with human rights, social justice and rule-of-law movements to promote inclusive societies for sustainable development.

109. Promoting human rights and gender equality is an end in itself and critical to effective and sustainable HIV responses. Existing legal obligations and political commitments for human rights and gender equality—especially the indivisible rights to access health-related information and services, autonomy in decision-making and non-discrimination—must be translated into concrete strategies, programmes and actions at global, regional and country levels. HIV testing, prevention, treatment and care programmes should be grounded in human rights principles and approaches. This requires engagement at the highest levels among executive branches, members of parliament, political, religious and other community and healthcare leaders and the judiciary, whose voices on complex social and legal issues are critical to advancing social justice.

110. Criminal law in the context of HIV is often prejudicial rather than informed by evidence. Overly broad criminalization of HIV exposure, non-disclosure and transmission ignores the fact that HIV treatment sharply lowers the risk of HIV transmission. Criminalization of adult consensual same-sex relations is a human rights violation,[89] and decriminalization of same-sex relations can reduce vulnerability to HIV infection.[90] Evidence-informed analyses also indicate that decriminalization of sex work could prevent people from acquiring HIV through combined effects on violence, police harassment, safer work environments, and HIV transmission pathways.[91,92] Similarly, decriminalizing injecting drug use and passing laws that allow comprehensive harm reduction have been shown to reduce HIV transmission.[93] A public health approach and alternatives to incarceration could reduce the number of prisoners acquiring HIV (as well as TB and viral hepatitis) by relieving overcrowding and ensuring access to harm reduction, condoms, food and other health services.

111. Refugees and asylum seekers living with HIV often face significant discrimination as many states restrict the entry of or forcibly return people living with HIV, presenting the need for HIV-related interventions to have a solid human rights and protection-oriented focus. Mandatory HIV testing of refugees and asylum seekers without pre- and post-test counselling and without guarantees for privacy is also a reality in a number of countries. Providing HIV services to migrants and persons affected by humanitarian emergencies is firmly rooted in international humanitarian and human rights laws, policies and medical ethics. Firm action is required to ensure that this becomes a reality.

112. Access to justice enables people living with HIV and other key populations to challenge human rights violations, including discrimination and denial of services through formal and informal justice systems, that hinder their access to HIV services and provides people with remedies. Several human rights programmes have been found to restore dignity and improve health outcomes.[94] Programmes include investing in law and policy reform, legal literacy, ensuring availability and accessibility of legal services and sensitizing law enforcement agents and health-care workers.

113. Stigma and discrimination are perpetuated by and against health workers. Discrimination in health-care settings can be eliminated through the joint efforts and commitment of governments, professional associations, international and national organizations delivering health services, health workers, people living with and affected by HIV, key populations, local authorities and everyone working to ensure non-discriminatory access and the quality of care for all. Efforts must be expanded to eliminate HIV-related workplace discrimination and to optimize workplace interventions to ensure all employees have access to voluntary testing and counselling, are linked to care and remain in employment. Ensuring healthy working environments requires stronger partnerships between networks of people living with HIV, private businesses and ministries responsible for labour, trade unions, employers and businesses.

The following are core actions for the global response to promote just, peaceful and inclusive societies:

- Remove punitive laws, policies and practices that violate human rights, increase people's vulnerability to and risk of acquiring HIV and impede utilization of services, including travel restrictions and those that block key populations' access to service.

- Eliminate discrimination and stigma against people living with, at risk of and affected by HIV, including in health-care, workplace and educational settings and equip service providers with the skills and tools to respect people's HIV-related rights.

- Expand programmes that enable people living with HIV, other key populations, women and girls and affected populations to know their rights, access justice and challenge violations of rights regardless of age, health status, gender, sexual orientation and gender identity, drug use, immigration status or involvement in sex work.

- Identify HIV-related legal and human rights obstacles and challenges in country plans and increase funding for and implementation of programmes supporting social, political and legal environments that enable people—especially key populations, including their young members—to access HIV services and safeguard human rights.

- Promote tolerance and protection against discrimination and violence, and ensure access to HIV services for all, including key populations.

- Fully monitor HIV-related violations of human rights, legal and policy barriers and discrimination, as well as people's experience of stigma (including self-stigma) by fully implementing such tools as the People Living with HIV Stigma Index.

- Forge partnerships and alliances to promote and defend human rights in the context of HIV, including with civil society, faith-based actors, law enforcement, executive branches, members of parliament, the judiciary, universities and the private sector.

## Revitalize the global partnership for sustainable development

### Result area 7

AIDS response is fully funded and efficiently implemented based on reliable strategic information

### Result area 8

People-centred HIV and health services are integrated in the context of stronger systems for health

114. Accelerating progress in the AIDS response will require action regarding resource mobilization, efficiency gains, universal health coverage and social protection, human resources for health, technology transfer and capacity-building. Countries must determine, own and lead their AIDS responses. Countries will need to pursue differentiated approaches in their relationships with their development partners, civil society organizations and the private sector. Such approaches should be based on values of equity and fairness guided by principles enshrined in the Agenda for Sustainable Development and the Addis Ababa Action Agenda including Common But Differentiated Responsibilities and Global Solidarity and Shared Responsibility as well as regional commitments such as the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria.

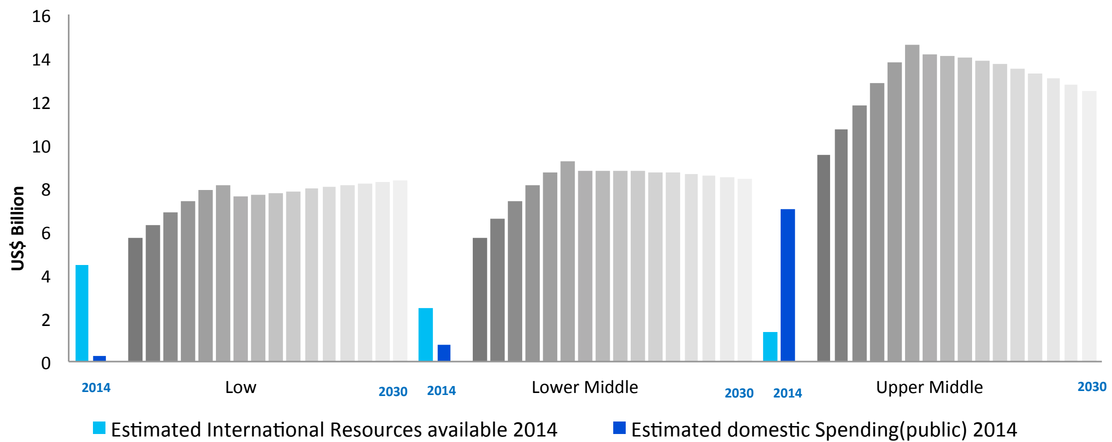
*Resource mobilization*

115. Fast-Tracking the AIDS response will require reaching an annual investment of US$ 7.4 billion in 2020 in low-income countries and US$ 10 billion in lower-middle-income countries (Figure 14). Upper-middle-income countries will require US$ 13.7 billion in 2020, after which their needs will decline to US$ 12.5 billion by 2030. Sub-Saharan Africa will need the largest share of global investments: US$ 15.8 billion in 2020. These estimates take into account the 90–90–90 treatment target, prevention targets, and the critical enablers needed to achieve them. Resources will enable the delivery of antiretroviral therapy to twice as many people in low- and middle-income countries in 2020 as in 2015, and significantly increase coverage of combination prevention programmes. The funding targets presented in the Strategy assume significant increases in the share of domestic public funding by country income level (based on the World Bank 2015 classification), based on fiscal space analysis and financial sustainability.[x] Countries affected by natural disasters

[x] Analysis to determine financial targets takes into account integration of HIV expenditures as part of the universal health coverage strategy, economic growth and subsequent increase in social spending, including health, maintaining

or humanitarian emergencies and that host refugees and other displaced people may require additional resources to meet the HIV-related needs of these populations.[95]

**Figure 14. Resources available for HIV in 2014 and resource needs for 2015-2030, by income level**

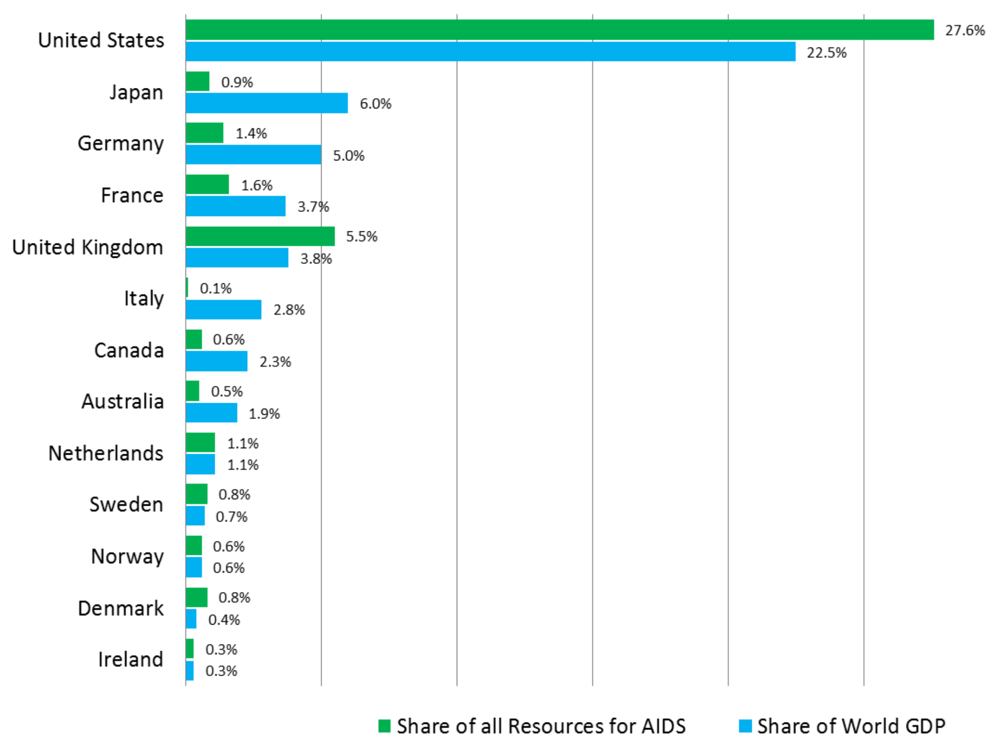



UNAIDS Estimates June 2015, UNAIDS-KFF study on Financing the Response to AIDS in Low- and Middle-Income Countries in 2014, OECD CRS last accessed June 2015, GARPR/UNGASS reports. WB income level classification July 2014.
Estimates of international disbursements shown in the above chart exclude disbursements from philanthropic foundations.

116. By 2020, annual international HIV assistance should reach at least US$ 12.7 billion (or 40% of the resource needs for low- and middle-income countries) versus US$8.75 billion in 2014. This includes $6.5 billion for low-income countries, $5.5 billion for lower-middle income countries, and $0.7 billion for upper-middle income countries. Development partners should ensure that their financial share of the AIDS response matches or exceeds their share of the global economy (Figure 15). Adequate domestic investment is also required in high-income countries to support an effective AIDS response, with a focus on reducing inequalities experienced by key populations, indigenous communities, migrants and other marginalized groups.

similar shares of HIV spending in the health budget, efficiency in service delivery, price reductions in antiretroviral medicines and commodities and the transition of countries into higher income levels.

**Figure 15. Matching donors' HIV contributions to their share of the global economy**




Source: UNAIDS and Kaiser Family Foundation. International assistance from donor governments 2014, July 2015.

117. To achieve financial targets by 2020, governments of low-income countries will likely need to fund 12% of their total resource needs for HIV, lower-middle income countries 45% and upper-middle-countries 95%. Upper-middle-income countries are already funding most of their AIDS responses from domestic public sources (80% in 2013 versus 22% in lower-middle-income countries and 10% in low-income countries). Low- and middle-income countries can increase their domestic spending for HIV through capturing larger tax revenue, targeted budget allocations, innovative funding and increased efficiency.

118. To scale up innovative funding, some countries have implemented special tax levies, with proceeds earmarked for HIV programmes, as well as levies on remittances, air passenger travel, mobile phone usage, and alcohol and tobacco purchases. Innovative mechanisms combining public and private resources such as vaccine bonds can also generate predictable, long-term funding. Countries may further explore co-funding development efforts and integrating HIV into broader national health-funding systems that will yield more broadly based health benefits. Pooling different streams of resources into one health-funding scheme enables risk to be shared and redistributes resources among members.

119. As countries increase domestic funding for their HIV programmes and reduce their dependence on international assistance, systems and processes must ensure that these transitions are smooth, transparent and sustainable, including the means for monitoring commitments made by international partners and countries.

120. With international public funding for HIV slowing and countries most severely affected lacking the capacity to increase fiscal space through traditional means, partnering with the private sector is essential. Partnering with key actors in the private financial sectors and in multilateral funding (such as the New Development Bank of the BRICS countries) could mobilize more than US$ 3 billion to address the AIDS response by issuing regional and national HIV bonds, investment by private equity funds and loan guarantees.

*Generating efficiency gains*

121. Efficiency gains can help ensure fiscal space for AIDS. Especially in high-prevalence countries, setting geographical and population priorities in the allocation of resources helps generate efficiency gains and makes finite HIV resources go further. Countries with concentrated epidemics will realize the greatest efficiency gains by shifting resources towards key populations.

122. Most countries need to scale up quality services and reduce costs of health products by, inter alia, expanding community service delivery and promoting competition among pharmaceutical suppliers. To drive down prices, countries need to fully leverage their negotiating potential, including pooling procurement, strategically designing tendering processes and other market shaping mechanisms. Adopting newer treatment regimens, diagnostics and viral load tests with lower production costs, by using TRIPS flexibilities and/or voluntary licensing mechanisms, will also be key to achieving major savings. Accelerating scale-up promotes the efficient use of resources by lowering unit costs of services. Economies of scale to provide antiretroviral therapy to 29 million people by 2030 will imply reducing antiretroviral therapy unit costs by an estimated 42% in facilities. Community-based delivery of integrated health services will promote efficiency by enhancing their reach, especially in countries with insufficient health personnel.

*Expanding HIV-sensitive universal health coverage and social protection in all settings*

123. Universal health coverage is both a target and an organizing framework for the Sustainable Development Goal on health.[96] UHC aims to ensure that all people receive high-quality health services without experiencing financial hardship. Countries need to progressively address three UHC dimensions in planning HIV

responses: (1) define the essential, high-impact HIV interventions that should be integrated into the national health benefit package; (2) ensure this package is adapted and equitably delivered to populations in need; and (3) ensure the national health financing system covers costs of HIV services to minimize out-of-pocket expenditure and risk of financial hardship.[xi]

124. Prevention, treatment, care and support services should be integrated with services to address coinfections and comorbidities as well as sexual and reproductive health services, such as prevention, screening and treatment for STIs and cervical cancer. Access to prevention, diagnosis and care of HIV-associated TB should be increased through joint programming, patient-centred integration and co-location of HIV and TB services. As the number of people living with HIV who are 50 years or older grows, services will need to be integrated within care systems for other chronic diseases. Many of the lessons from the HIV response are applicable to countries' programmes for noncommunicable diseases, and vice-versa.

125. Social protection programmes can reduce risk behaviour, including transactional and age-disparate sex, improve access to HIV services and enhance the effectiveness of HIV programmes.[97] HIV-sensitive comprehensive social protection involves a range of policy and programming measures, such as legal reforms to protect the rights of people living with HIV, women and key populations; economic empowerment programmes, social insurance, transfers and subsidies; food and nutrition support; and referrals and links to maximize the impact of investments in and across sectors. Recent evidence demonstrates the significant impact of providing a combination of cash transfers, school feeding and psychosocial support on reducing high-risk behaviour for both adolescent girls and boys,[98] as well as the impact of cash transfers on reducing unprotected sex and intimate partner violence.[99]

*Human resources for health*

126. The expansion of HIV service delivery during the last 15 years to meet the needs of millions has resulted in stronger health systems. Access to quality-assured medicines, diagnostics and other products increased significantly. Countries have expanded uptake of health services by carefully using decentralization, reassigning responsibilities and deploying community health workers.

[xi] In developing strategies for HIV-sensitive UHC, WHO's Global Strategy on Human Resources for Health: Workforce 2030 and the Global Strategy on Integrated, People-Centred Health Services are important reference frameworks.

127. Yet the current model of human resources for health remains too facility-based, doctor-dependent and disease-focused, and is neither sustainable nor able to support rapid scale-up. Critically, approaches to delivery must become more inclusive of the community and private sectors and maximize opportunities to utilize HIV services as an entry point into other health services. Experience from Rwanda has demonstrated that smart integration of patient-centred services increases efficiency.[100] More community-led services, task shifting, task sharing and robust health systems are required to achieve the goals of this Strategy.

*Technology transfer*

128. Long-term sustainability of access to HIV-related products, including through local production of pharmaceutical products, requires promoting technology transfer North–South, South–South and increasingly South–North. Existing platforms, such as the BRICS, China–Africa and India–Africa partnerships as well as the newly agreed Technology Facilitation Mechanism, should include sharing of know-how and expertise to strengthen local manufacturing capacity. Technological transfer agreements, including but not limited to voluntary licensing agreements, between originator and generic companies should be pursued to increase availability and affordability of medicines. Concerted efforts will be needed to harmonize and strengthen regional regulatory systems to monitor quality and enable regional market integration, especially in sub-Saharan Africa.

*Technical support and capacity-building*

129. The changing context, epidemic and response demand expanded quality technical support to strengthen capacity and institutions aligned with principles of country ownership, aid effectiveness and value for money. Technical support will involve a range of collaborative partnerships as well as activities such as sharing good practices and providing training, guidance and support to countries. Efforts are needed to enhance provision, coordination and effectiveness of technical support to strengthen country capacity to: 1) generate timely and reliable disaggregated data to monitor progress and ensure that no one is left behind, while strengthening case-based reporting and health management information systems; 2) allocate investments strategically and expand quality service delivery; 3) implement robust procurement, supply chain and management systems; 4) ensure effective governance within and beyond the health sector; 5) secure human rights, gender equality and community mobilization; 6) ensure the meaningful engagement and leadership of civil society; and 7) promote the timely introduction of innovative technologies and systems.

The following are core actions for the global response to reinforce the global partnership for sustainable development:

- Set bold country targets for prevention and treatment for 2020 and 2030 and improve public accountability for regularly assessing progress on agreed commitments.
- Mobilize domestic resources for the AIDS response in proportion to national income and burden of HIV, and improve capacity to collect taxes and other revenue, including co-funding approaches.
- Mobilize additional resources for the AIDS response from the international community, aligning donor commitments with their national share of the global economy and through concessional and non-concessional lending for human development.
- Develop country compacts and sustainability transition plans between international partners and national governments that outline programmatic and financial commitments by both parties to support national costed plans and promote mutual accountability.
- Strengthen health systems, UHC schemes and national health benefit packages, to ensure that all people living with or at high risk of HIV have access to comprehensive and integrated (where appropriate) HIV and health services, including HIV-related medicines and technologies.
- Scale up and progressively broaden sustainable HIV-sensitive social protection programmes for people living with HIV, key populations, women and girls, vulnerable families and care-givers, including insurance programmes, food and nutrition support, housing, education, employment and economic empowerment.
- Invest in and build robust systems for health by strengthening human resources to deliver integrated HIV and health services as well as procurement, supply chain and management systems that are responsive to local risk and burden of disease.
- Expand service delivery options through partnerships with the private sector, civil society and faith-based organizations to broaden strategic engagement in the AIDS response as a global public health good.
- Increase efficiency and effectiveness of quality and integrated HIV and health services through South–South Cooperation and increased investment in science, technology, innovations, knowledge-sharing and capacity-building.

- Scale up investment and support for civil society and community groups to enhance and sustain their essential roles in providing services, advancing human rights, advocacy and accountability.

## 3. How UNAIDS will deliver on this Strategy

### Optimizing the comparative advantages of the Joint Programme: new ways of working

130. UNAIDS aims to lead the world in its historic quest to end the AIDS epidemic as a public health threat and attain the three zeros vision. UNAIDS' approach is evidence-informed and rights-based, underpinned by the values of equality and sustainability, and has inclusive governance and mutual accountability at the core. Ultimately it seeks to provide support to robust country-owned and -led AIDS responses. The only cosponsored Joint Programme of the United Nations System, UNAIDS is a tangible example of a coherent intersectoral response to the multifaceted issue of HIV. Its strength derives from the diverse expertise and mandates of its 11 Cosponsors and the added value of the Secretariat as well as its unique governance body comprising 22 Member States, representation of the Cosponsors and five seats for regional nongovernmental organizations. Its governance approach provides an unparalleled platform for engaging non-state actors in discussions on difficult issues in national and intergovernmental forums.

131. The Joint Programme's policy and operational coherence are reinforced through the UNAIDS Division of Labour, which assures reciprocal accountability among Cosponsors and the UNAIDS Secretariat at the global, regional and country levels. Guided by this Strategy, United Nations joint teams on AIDS and joint programmes of support will implement UNAIDS' efforts at the country level, under the leadership of the United Nations resident coordinators.

132. The HIV strategies of the Cosponsors will be aligned with and guided by this Strategy. Cosponsor strategies include those that are sector- or population-specific, such as HIV health and education sector strategies and those relating to refugees, internally displaced people, nutrition, children, women, adolescents, young people, and drugs and crime. Other Cosponsor strategies address the multi-sectoral aspects of the HIV response, such as the SDGs, governance, human rights, development planning, resilience, social protection and funding.

133. The AIDS response has recognized UNAIDS as uniquely able to confront and build consensus around politically difficult issues that others cannot. Increasingly, it exercises political leadership and exerts advocacy for global health and social justice. In its 2015 resolution on UNAIDS, the United Nations Economic and Social Council affirmed that the Joint Programme offers the United Nations a useful example of enhanced strategic coherence, coordination, results-based focus, inclusive governance and country-level impact for the post-2015 era.[101]

134. We must continue to strengthen and adapt our many partnerships to Fast-Track the response. The SDGs recognize that the world is complex; UNAIDS and stakeholders in the broader AIDS response understand that keeping people—with all their different needs, roles and contexts—at the centre of everything we do can address this complexity. As a convener and coordinator, UNAIDS has created new spaces for discussion and new models of collaboration that acknowledge and work within this complex environment.

135. In leading the implementation of this Strategy, in the context of the 2030 Agenda for Sustainable Development, the role of the Joint Programme and its strategic partners will continue to evolve. At global, regional and country level, UNAIDS will strengthen and focus its leadership, particularly in the form of political advocacy, strategic policy advice, and technical support to optimize resources and deliver results. Such leadership aims to support countries to strengthen systems, enhance sustainability, manage transitions, encourage work across sectors, and ensure access to services within a human rights framework. UNAIDS offices perform a range of functions towards these ends guided by its mission statement, such as convening diverse stakeholders in decision-making, mobilizing resources, generating strategic information, promoting accountability for results and ensuring the inclusion of people and populations left behind. UNAIDS will accelerate efforts in low- and middle-income Fast-Track countries, with a view to achieving the targets in the Strategy while ensuring a maximum return on investment. Broadening its partnership across the development arena, UNAIDS will focus on five core aspects of the response: **information; investment; inclusion; integration;** and **innovation**.

*Information*

136. The Agenda for Sustainable Development commits the global community, by 2020, to enhance capacity-building support to significantly increase the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts. Similar efforts will be critical in the AIDS response. UNAIDS houses the most extensive and disaggregated data collection available on the HIV epidemic and its response. Data collection innovations include collecting subnational data and increasing the availability of real-time data through new technologies such as crowdsourcing. UNAIDS' approach of "know your epidemic, know your response"[102] emphasizes the critical need for data to guide and inform evidence- and rights-based programming. Harnessing the power of data, UNAIDS will continue to strengthen countries' capacity to collect and use information on the epidemic and response to produce results. Particular attention will be warranted in

humanitarian emergency contexts, given the increased challenges in obtaining accurate data on the HIV response.[103]

137. The AIDS response must leverage evolving information and communications technology to engage and empower people. New communication platforms and channels provide opportunities to strengthen data collection, focus outreach and enhance accountability, especially with young people and populations at higher risk. UNAIDS will work with young people, empowering them to strengthen programmes to prevent HIV infection and inspire a social movement to drive better results through critical changes in public policy. UNAIDS will advance partnerships with coalitions of youth organizations around the goal of ensuring the health, well-being and human rights of all young people, such as the All-In! initiative. Particular emphasis will be placed on continuing to strengthen the capacity of The PACT and other networks of young people living with HIV to ensure that young people are at the centre of the response, especially with respect to evidence-informed prevention and treatment.

*Investment*

138. A core priority and function of UNAIDS is ensuring the AIDS response is adequately resourced in the context of nationally owned, sustainable development strategies and funding frameworks. The Joint Programme will help countries diversify funding for their HIV strategies by supporting expansion of domestic funds, fostering closer engagement of the private sector, aiding the design of new funding models and continuing to advocate for adequate international public finance to close the AIDS resource gaps. The Joint Programme will provide advice during transitional planning to enable countries to maintain key programmes, delivery capacity and health benefits, despite changing levels of external funding, shifts in service delivery modalities and evolving governance and institutional arrangements.

139. UNAIDS will further advance its strategic investment approach—providing countries with the tools and analytical support to ensure optimal resource allocation in accordance with the epidemic priorities and to maximize multiplier effects across broader health and development issues. The Joint Programme will conduct allocative efficiency analysis and guide the implementation of recommendations to reduce costs and enhance the reach and impact of HIV prevention, treatment, care and support activities. The Joint Programme will also build evidence and provide technical expertise to help decision-makers, programme managers and funding partners in achieving maximum impact toward the UNAIDS Strategy targets.

140. UNAIDS will work hand-in-hand with key global partners, including the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The ambitious targets set by PEPFAR to prevent new HIV infections among adolescent girls and young women and scale up access to treatment for children, pregnant women and adults are aligned with, and will make a significant contribution to UNAIDS Strategy.[104] Ending the AIDS epidemic requires continuing the mobilization of all bilateral organizations in the AIDS response, while new opportunities in beyond official development assistance are also emerging. UNAIDS will strengthen its collaboration with countries, PEPFAR and other bilateral agencies to improve strategic information that will empower countries to respond to local HIV epidemics. Improved information will also guide use of resources from the Global Fund to Fast-Track action and ensure programmatic sustainability.

141. UNAIDS will work to ensure a fully funded and effective Global Fund partnership, which is essential for the AIDS response and for global health. To effectively utilize the resources available under the Global Fund's new funding model (2014), UNAIDS will: (1) strengthen its strategic technical and advocacy support to countries in accessing and making the best use of Global Fund resources in support of accelerated national HIV responses (including through strategic information and convening country dialogues); (2) continue to engage with the Global Fund Board and Secretariat to define and implement strategies, policies and approaches informed by strategic information and Fast-Track guidance provided by UNAIDS; and 3) work closely with partners to support middle-income countries in developing financial sustainability transition plans and identifying and mobilizing necessary domestic resources.

142. UNAIDS will catalyse North–South, South–South and triangular regional and international cooperation, enabling diverse stakeholders to join in sharing knowledge on science, technology and innovation. UNAIDS will expand its strategic engagement with emerging regional political bodies and cooperation arrangements, such as the Ministerial Forum on China–Africa Cooperation. Annex 2 describes opportunities to engage with regional institutions.

143. UNAIDS will pursue innovative opportunities to join its work with the private sector. We will increase our collaboration with private-sector associations, such as the Global Business Coalition for Health, to identify how private-sector expertise and resources can accelerate and strengthen the response, including through social responsibility and social impact investing. Public–private partnership initiatives will be expanded, including those that promote health and access to health services in the workplace.

*Inclusion*

144. The enhanced and revitalized global partnership for sustainable development provides a vehicle for strengthening international cooperation for implementing the Agenda for Sustainable Development, including the acceleration of the AIDS response. Multistakeholder partnerships that engage governments, civil society, the private sector, the scientific community, academia, foundations and local authorities will be important to mobilize and share knowledge, expertise, technology and financial resources.

145. The Joint Programme will strengthen its partnerships with civil society, including organizations representing people living with HIV and other key populations, women, youth and faith-based actors. UNAIDS will: (1) advocate for strategic funding for civil society to perform crucial advocacy, demand creation and service provision roles; (2) expand support for organizational capacity building and informed participation in decision-making platforms at global, regional and national levels; (3) foster collaboration between civil society and governments to identify, adapt and scale up innovative models of community-based service delivery; and (4) engage civil society in implementing the UNAIDS Strategy.

146. An inclusive AIDS response will further rely on identifying the needs of fragile communities and ensuring they are met in all countries. The Joint Programme will continue to speak out for and work with fragile, vulnerable and affected communities to ensure that AIDS responses are tailored to their needs, assisting governments, civil society and other HIV actors in addressing diverse gender and human rights issues in their national HIV, human rights and gender plans.

147. Even with biomedical innovations and a service delivery system in place, legal environments, culture and society play a role in how and whether innovations are implemented and mainstreamed. Success will always depend on solid human rights architecture and on partnerships with local civil society organizations and faith-based organizations. Engagements with the United Nations Human Rights Council mechanisms and United Nations treaty-monitoring bodies—and with regional and national human rights mechanisms—will be reinvigorated. Parliament, the judiciary, the police and other law enforcement bodies will be given priority. The role of human rights organizations, funders and defenders working from multiple perspectives—from freedom of association to sexual and reproductive health and rights —will be leveraged. UNAIDS will also pursue partnerships with private law firms and universities to support justice strategies in HIV-related cases.

148. UNAIDS will continue to deepen partnerships with faith-based organizations and their networks to expand community- and facility-based care as an essential component of rapidly scaling up service delivery. This includes support for developing best practice models of service delivery and to address bottlenecks at the community level, such as transforming gender norms and ending gender-based violence.

149. Cities will be central in ensuring that services meet the needs of people. The alliance rising from the Paris Declaration on Fast-Tracking Cities: Ending the AIDS Epidemic will expand partnership with the United Nations Human Settlements Programme (UN-Habitat) and the International Association of Providers of AIDS Care, among others.

*Integration*

150. New approaches are needed to guide investments at the intersections between HIV and the SDGs, addressing the broad determinants of global health through multistakeholder partnerships and advocating for and negotiating global public goods. The Joint Programme is uniquely placed to lead and convene on these agendas.

151. To meet the holistic health needs of people living with HIV and at high risk of acquiring HIV—while also contributing to stronger health systems—the Joint Programme will promote collaboration across national health programmes for integrated service delivery and for policies that support such links. In particular, the Joint Programme will promote integration of HIV care with services for sexual and reproductive health, maternal and child health, and sexually transmitted and non-communicable diseases. In addition, the Joint Programme will advance national plans to decentralize and bundle services for TB, hepatitis, mental health and other health issues, as well as procurement. The Joint Programme will strive to guide integration of food and nutrition support with HIV and TB treatment and HIV, hepatitis and TB services with harm-reduction strategies for people who inject drugs. The Joint Programme will build countries' capacity to roll out integrated interventions in contexts of national emergencies and with social protection programmes.

152. The Stop TB Partnership and UNAIDS will strengthen ongoing collaboration and coordination—particularly on high-level advocacy, political leadership and accountability—to advance integrated approaches, sustainability, country ownership and domestic funding to address both diseases in national and regional plans and strategies and Global Fund processes.

153. Critical elements of the AIDS response must be embedded into the wider health system and UHC initiatives. We must nurture and reinforce well-established collaborations—such as for human resources—and forge new alliances with complementary health-oriented movements when possible. For example, working with stakeholders responding to the increasing burden of noncommunicable diseases will provide new opportunities for synergistic joint efforts to address the links between HIV, noncommunicable diseases and ageing.

154. UNAIDS will expand its partnerships with key movements in women's and children's health—working with such initiatives as Every Woman Every Child Every Adolescent and the Partnership on Maternal, Newborn and Child Health—to bring collective momentum to scaling up the response and improving maternal and child health outcomes. UNAIDS will renew the dialogue with the family planning community and its '2020 Agenda' to maximize synergy for contraceptive choice; protection against HIV, other STIs and unwanted pregnancies; and delivery of reproductive health-care. UNAIDS will further strengthen joint action and partnerships on HIV, sexual and reproductive health and noncommunicable diseases such as cervical cancer, working with such networks as Pink Ribbon Red Ribbon.

155. UNAIDS will help strengthen the capacity of regional and global partnerships to meet the needs of young women and adolescent girls. UNAIDS will leverage momentum and consolidate commitment by supporting regional and global platforms that bring together young women, governments, women's rights organizations, women living with HIV and the wider AIDS movements. The Global Coalition on Women and AIDS will play an important role in further building and strengthening these partnerships.

*Innovation*

156. In working to close the persistent digital divide—and the uneven capacity, connectivity and access to technology among countries—the Joint Programme will promote innovation in HIV service delivery technology, including mobile health, eHealth and telehealth. By fostering partnerships among communities, government agencies, health providers and the private sector, the Joint Programme will encourage countries to develop and use innovative HIV prevention technologies, promote community awareness of and support for new innovations, and examine broader HIV testing methods, such as peer-assisted testing and self-testing.

157. The Joint Programme will expand its work on and advocacy for the continued innovation and refinement of HIV-related medicines and technologies, and ensuring their availability, quality and affordability. These efforts will include mobilizing

scientific and ethical consensus on efforts towards a vaccine and AIDS cure. UNAIDS will support countries in adopting and using health-related TRIPS flexibilities and in defending their ability to challenge provisions in trade agreements that impede access to affordable medicines and go beyond the international obligations provided under the TRIPS agreement. UNAIDS will join the effort to explore new incentive systems for needed research and development in which research and development costs are delinked from product prices. UNAIDS will also support efforts to overcome regulatory barriers that delay market entry of quality-assured medicines and health technologies, including by strengthening local and regional regulatory capacities. UNAIDS will work with partners in the Diagnostics Access Initiative to fully leverage the potential of laboratory medicine to accelerate progress towards the 90–90–90 treatment target, with particular attention to viral load testing, early infant diagnosis and other health products amenable to greater market influence.

158. UNAIDS will reinforce its partnership with UNITAID to leverage its impact on expanding access to point-of-care diagnostics, second- and third-line antiretroviral medicines, treatment for children, and PrEP and other product-based preventive tools. Furthermore, UNAIDS will pursue additional collaboration with the Medicines Patent Pool, an initiative funded by UNITAID, to elaborate analyses on the patent landscape of HIV medicines and forecasting of newer HIV-related products.

159. UNAIDS will support partners in strengthening systems and scaling up services on an unprecedented scale. UNAIDS will work with key African institutions such as the African Union Commission, the NEPAD Agency and the African Development Bank, together with international partners, to support countries in determining, owning and leading health systems that are adequately staffed and funded, accessible to all people and better prepared to confront and deal with disease outbreaks and other public health emergencies.

### Results and accountability of the Joint Programme

160. The 2016–2021 Unified Budget, Results and Accountability Framework (UBRAF) is the Joint Programme's instrument to operationalize the Strategy. The UBRAF outlines the Programme's role in the AIDS response, organized around this Strategy's result areas and guides operational planning at headquarters, regional and country levels by identifying the expected results of the Programme and providing the framework on which budgetary allocations and performance monitoring are based.

161. The UBRAF comprises a business plan and a result, accountability and budget matrix. It provides the basis for strengthened accountability among and between the Cosponsors and Secretariat. Core and non-core resources are linked to results and allocated where the biggest return on investments can be achieved.

162. To support country priorities, the UBRAF is used to maximize the effectiveness and impact of the HIV-related resources of the United Nations Delivering-as-One. Through a division of labour between and among the Cosponsors and Secretariat, the UBRAF presents the efforts of the Joint Programme in a framework based on each organization's comparative advantage and mandates, in-country presence, existing country capacity and resources and availability of funding from different sources.

# Annexes to the UNAIDS 2016-2021 Strategy

## Annex 1. Overview of the process of developing the UNAIDS 2016–2021Strategy

At its 35th meeting, the UNAIDS Programme Coordinating Board (PCB) requested: "the Executive Director to undertake a multistakeholder consultative process to update and extend the UNAIDS 2011–2015 Strategy through the Fast-Track period 2016–2021." This annex presents an overview of the consultations. *Report on the consultative process to update and extend the UNAIDS 2011–2015 Strategy through the Fast-Track period 2016–2021* presented at the 36th session of the PCB in June 2015 under agenda item 3 provides greater detail on the first half of the process. The key messages of each of the 11 consultations were presented in the accompanying conference room paper entitled *Agenda item 3–Report on the consultative process to update and extend the UNAIDS 2011–2015 Strategy through the Fast-Track period 2016–2021–Multi-stakeholder Consultations, January through April 2015, Compilation of Discussion Notes*. Both publications are available on the UNAIDS website.

### Approach

The aim of the consultative process was to collectively define what must be achieved by 2021 and what must be done differently to get there. To reach this shared understanding, a series of global, regional and virtual consultations was held. Efforts were made throughout the process to reach out to and engage a diverse range of partners, including networks of people living with HIV, Member States, civil society, including: organizations representing young people, women and girls and key populations; faith-based organizations; development partners; and international and regional organizations. The UNAIDS Secretariat developed the Strategy in close cooperation with Cosponsors and engaged their Executive Heads on several occasions.

In addition to face-to-face meetings, UNAIDS organized two online global consultations in order to give the consultation process a broader reach and engage with people who would not normally have the means to participate in a regional consultation. The two online consultations were advertised through electronic mailing lists relating to HIV and human rights, gender, governance, faith-based communities and youth, as well as to the PCB electronic mailing list. The consultations were also publicized through social media and shared with civil society networks by UNAIDS staff around the world.

A discussion paper, entitled "Getting to zero: How will we Fast-Track the AIDS response?" – (presented to the PCB as the conference room paper *Agenda Item 3–discussion paper for global consultation on UNAIDS 2016-2021 Strategy)* provided background information and questions to guide all consultations. The paper presented a draft strategic framework. The questions were slightly adapted according to the target audience of each consultation. They generally covered anticipated trends in epidemics globally and regionally, populations left behind, challenges and gaps in the response and the game-changers that should be considered to Fast-Track the response. Questions also covered the opportunities the Sustainable Development Goals provide for the AIDS response and how the Joint Programme could best support countries in implementing the Strategy.

**Regional consultations**

Ten regional consultations were held, including seven in the UNAIDS regions, led by UNAIDS Regional Support Teams, two in North America and one in western Europe. Although the method used varied for each, all consultations featured a face-to-face meeting and engaged Member States, Cosponsors and civil society organizations. For each consultation, the Regional Support Team prepared a short report.

The consultation in the Asia and the Pacific region was held in parallel with an intergovernmental meeting on AIDS convened by the United Nations Economic and Social Commission for Asia and the Pacific on 30 January in Bangkok, Thailand. The Latin America consultations, held from 23 February to 24 March, were a series of regional, sub-regional and country consultations, and several virtual consultations. The Middle East and North Africa region hosted eight national consultations, a virtual regional consultation and an in-person regional consultation in partnership with the League of Arab States on 11 March in Cairo, Egypt. The regional consultation in the Caribbean took place on 16 March in Kingston, Jamaica. The Eastern and Southern Africa region held three constituency-specific consultations, followed by a high-level regional consultation on 23 March in Johannesburg, South Africa. The western and central Africa consultation was a two-day high-level event held on 1–2 April in Dakar, Senegal, which followed several country- and regional-level discussions and consultations. The Eastern Europe and Central Asia regional consultation was facilitated by UNAIDS in partnership with the Government of Belarus and was held in Minsk, Belarus on 9 April.

Two consultations were held in North America: on 13 March in Washington, DC and on 18 March in New York. The consultation in Washington DC was convened by the UNAIDS United States Liaison Office with civil society, and hosted by the Global AIDS Policy Partnership with support from the Federal AIDS Policy Partnership. The one-day consultation in New York was convened by the UNAIDS New York Office and attended by New York–based stakeholders. The Government of Switzerland hosted the Western Europe regional consultation in Montreux, Switzerland on 26–27 March.

**Global consultation**

A multistakeholder global consultation on the UNAIDS 2016-2021 Strategy took place in Geneva, Switzerland on 22–23 April 2015 chaired by Taonga Mushayavanhu, Ambassador of the Republic of Zimbabwe. Participants included some 50 Member States, all Cosponsors and four PCB NGOs.

**First virtual consultation**

The first virtual consultation was held from March 23 to April 2 on an online platform designed for the consultation. It consisted of four discussion forums running in parallel, centred on the themes of “Reinforcing achievements”, “Closing the gaps”, “Seizing the game-changers” and the “Youth Forum”, held in partnership with The PACT.

The consultation generated a lively debate, with more than 280 inputs submitted by participants from 50 countries in five languages. Organizations submitted an additional thirty inputs directly to the UNAIDS Strategy development mailbox. Many highly substantive and meaningful inputs

from people living with HIV, members of key populations and young people were among the responses received.

**Developing the first draft Strategy**

All inputs served to build the foundation for the draft outline of the UNAIDS 2016–2021 Strategy. This outline, as well as a summary of inputs, was presented to the PCB in June 2015. The first draft of the UNAIDS 2016–2021 Strategy was then developed in partnership with UNAIDS Cosponsors in mid-July and shared with all stakeholders on 3 August, online, and by email to all missions in Geneva, followed by a note verbale.

**Second virtual consultation**

The second virtual consultation was held on 3–21 August on the same website platform as previously used. It aimed to obtain feedback on the first draft of the UNAIDS 2016–2021 Strategy. Participants were invited to submit comments on the website or via email to the strategy development mailbox. French, Russian and Spanish translations of the Strategy were also available on the website.

A total of 141 inputs in four languages were submitted to the website and the UNAIDS Strategy development mailbox. Responses were received from individuals, civil society networks, governmental bodies and United Nations agencies. The extensive feedback from civil society organizations and networks was particularly noteworthy, as many of these inputs were the consolidated position of networks representing sometimes up to hundreds of organizations.

**PCB Member Missions briefings**

Throughout the process, UNAIDS has continually consulted with Member States and civil society in a variety of forms, including through briefings and informal discussions.

A final draft of the Strategy was shared with PCB members on 17 September before the 37th session of the PCB on 26–28 October 2015.

## Annex 2. Enhancing the leadership role of the regions: Profiles of regional epidemics, responses and game-changers

The different epidemic patterns and institutions across regions of the world and their varying dynamics provide the rationale and opportunity for regional collaborative approaches to Fast-Track the response. This section provides regional profiles of the epidemic, including people left behind, priority targets, the key cities and countries where particular gains are needed and game-changers for accelerating progress, as well as opportunities to further strengthen partnerships to meet regional goals and ensure accountability.

# Asia and the Pacific

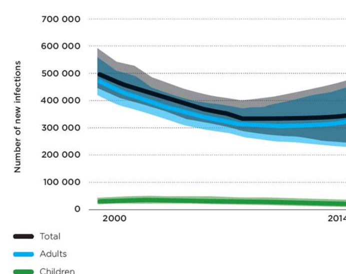
**The epidemic in numbers**

- **5 million [4.5 million–5.6 million] people living with HIV** in 2014; 90% are in six countries: China, India, Indonesia, Myanmar, Thailand, and Viet Nam. Women account for a growing proportion of new HIV infections, up from 17% in 1990 to 34% in 2014.
- **30 cities** account for almost a quarter of people living with HIV in Asia and the Pacific.
- New infections **rose by 3% between 2010–2014**, reaching 340 000 [240 000 – 480 000] in 2014, primarily among men who have sex with men, transgender people, sex workers and their clients and people who inject drugs.
- In 2014, **36% [32%–41%] of people living with HIV** obtained antiretroviral therapy, lower than the global average.

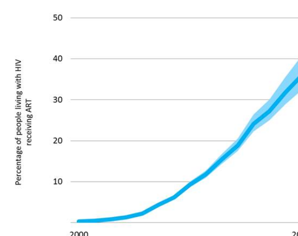
## Gaps and challenges

- **37 of 38 countries** in the region criminalize some aspect of sex work. Criminalization and discrimination experienced by people living with HIV and key populations undermines implementation of and access to services and increases risk of violence, human rights violations and vulnerability to HIV.
- **One third of key populations know their HIV status**. Rates of HIV testing among sex workers is below 50% in nine countries; Proportion of men who have sex with men accessing HIV testing during the past 12 months ranged from 2% to 87%, with only four of 25 countries reporting more than 50%. HIV prevention and testing coverage remains alarmingly low among people who inject drugs; only 3 of 18 countries report testing coverage exceeding 50%. Four countries in the region distributed an average of more than 200 needles and syringes per person who injects drugs per year.
- Prevention spending on key populations **heavily depends** on international funding. Only **24% of prevention investment** (in 25 countries with available data) from domestic sources is directed towards key populations–less than 5% is allocated to programming for men who have sex with men, among whom new HIV infections are increasing most rapidly.
- Of the US$ 2.2 billion available from all sources for the AIDS response in 2013, **57% was from domestic resources**. Domestic funding needs to be rapidly increased, especially for programmes for key population, to sustain the response.

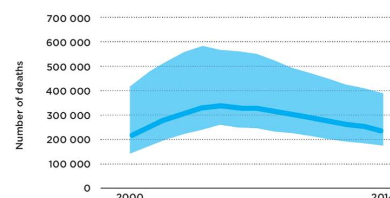
**Number of new HIV infections in Asia and the Pacific, 2000–2014**




**Antiretroviral therapy coverage, Asia and the Pacific 2000–2014**




**Number of AIDS-related deaths in Asia and the Pacific 2000–2014**




*Source:* UNAIDS 2014 estimates.

**By 2020, Fast-Tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **83 000**
- Number of people dying from AIDS-related causes to **72 000**

**Priority countries**

| | |
|---|---|
| Large proportion of the regional epidemic | China, India and Indonesia account for 78% of people newly infected with HIV in the region. These three countries plus Pakistan and Viet Nam are among the UNAIDS Fast-Track countries. |
| Severe epidemics | Cambodia, Malaysia, Myanmar, Papua New Guinea and Thailand. |

**Key cities**

The following cities account for **more than 1.1 million people living with HIV**: Cambodia (Phnom Penh), China (Beijing, Chengdu, Chongqing, Guangzhou, Kunming, Shanghai, Shenzhen, Urumqi), India (Amritsar, Bangalore, Bhopal, Chennai, Delhi, Hyderabad, Imphal (East and West), Kolkata, Mumbai, Pune), Indonesia (Jakarta, Surabaya), Myanmar (Yangon), Pakistan (Faisalabad, Karachi, Lahore), Thailand (Bangkok), Viet Nam (Dien Bien province, Hanoi, Ho Chi Minh City, Thai Nguyen).

**Game-changers**

- Re-animate and innovate HIV prevention for and with key populations, with a focus on urban areas
    - Scale up prevention programmes for men who have sex with men and transgender people, including condoms and PrEP, especially for young people among these groups, through innovation in social media (online outreach) and community case management.
    - Scale up comprehensive prevention programmes, treatment and care for people who inject drugs and replace drug detention centres with voluntary community-based treatment and support services.
    - Increase the proportion of domestic funding for HIV prevention and identify mechanisms to channel government funds to civil society organizations working on programmes for key populations in priority cities and provinces.
- Expand strategic testing and treatment
    - Expand community-led HIV testing and treatment with key populations (including male and female partners of key populations) in areas with high rates of risk behaviour and HIV prevalence.
    - Expand treatment as prevention regardless of CD4 count, focusing on sex workers, people who use drugs, men who have sex with men, transgender people, sero-discordant couples and pregnant women.
    - Intensify work on IP to guarantee access to affordable medicines and diagnostics including second and third line ART regimens, TB and HCV drugs.

- Promote policy, frameworks and legislation that actively integrate people living with HIV and other key populations, orphans and children made vulnerable by HIV into social protection schemes and programmes.

**Regional opportunities and accountability mechanisms**

- The Asia-Pacific Regional Framework for Action to End AIDS by 2030—the regional framework adopted by 53 Member States of the United Nations Economic and Social Commission for Asia and the Pacific—will guide national efforts towards accelerating action and investment in the HIV response to end the AIDS epidemic as a public health threat by 2030.
- The ASEAN Declaration of Commitment: Getting to Zero New Infections, Zero Discrimination, Zero AIDS-related Deaths and the ASEAN Cities Getting to Zero initiative provide a framework for ASEAN cities to end the AIDS epidemic and periodic reviews.
- The Kathmandu Declaration of the 18th SAARC (South Asian Association for Regional Cooperation) Summit on universal health coverage and continued progress in the AIDS response recognizes the importance of achieving universal health coverage and continued progress in the AIDS response with the aim of ending the AIDS epidemic in the region by 2030.
- Secretariat of the Pacific Community—approval by health ministries of the Regional Shared Agenda will provide for more integrated HIV, sexually transmitted infections and reproductive health services.
- India–China–Africa partnerships on antiretroviral medicine security provide the opportunity to sustain access as well as transfer of technology on HIV-related medicines and commodities.

# The Caribbean

**The epidemic in numbers**

- **280 000** [210 000–340 000] **people living with HIV** in 2014.
- **43% reduction in adults acquiring HIV** and 90% among children between 2000 and 2014; vast majority of children living with HIV (90%) live in Haiti and the Dominican Republic.
- **8800** [5700–13 000] **AIDS-related deaths** among adults in 2014, a 59% decline from a peak of 22 000 [14 000–33 000] in 2004.
- **44%** [33%-54%] **of adults** and **36%** [32%-42%] **of children** living with HIV accessing treatment in 2014.

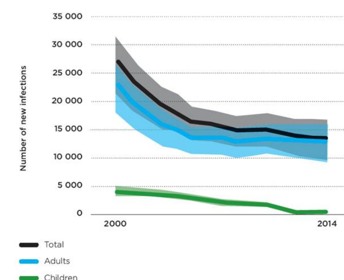
**Gaps and challenges**

- **People are still being left behind**. HIV prevalence is high among key populations such as sex workers (8% in Haiti) and men who have sex with men (33% in Jamaica). Other groups are also being excluded such as young people.
- Challenges regarding **stigma and discrimination, violations of human rights and gender-based violence** continue to hinder access to services. In particular, **punitive laws and policies**, including those related to sex work, same-sex sexual relations, drug use and age-of-consent to access health services, undermine service access.
- HIV prevention and treatment investments **depends heavily on external funding**.
- **Vertical transmission rates remain high** in Haiti and the Dominican Republic.

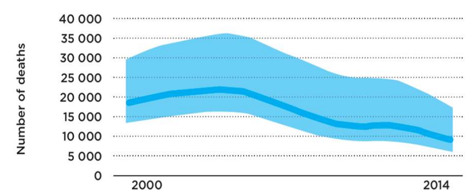
**By 2020, Fast-Tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **3800**
- Number of people dying from AIDS-related causes each year to **3100**

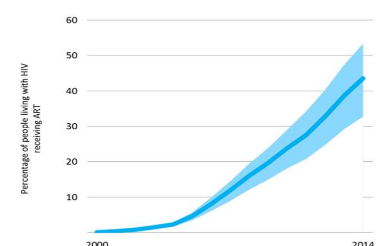
**Number of new HIV infections in the Caribbean, 2000–2014**




**Number of AIDS-related deaths in the Caribbean, 2000–2014**




**Antiretroviral therapy coverage, Caribbean 2000–2014**




*Source:* UNAIDS 2014 estimates.

**Priority countries**

Dominican Republic, Haiti and Jamaica have 82% of people living with HIV in the Caribbean. Key populations at high risk include: Haiti (heterosexuals having casual sex, men who have sex with men, transgender people and sex workers); Dominican Republic (sex workers, women with no formal education, residents of bateyes, men who have sex with men, transgender people, drug users), and Jamaica (men who have sex with men, transgender people, heterosexuals having casual sex and sex workers).

**Key cities**

Kingston, Spanish Town and Montego Bay (Jamaica), Port au Prince, Port-de-Paix, Fort-Liberté and Jacmel (Haiti) and Samaná and Dajabón (Dominican Republic) have the highest HIV prevalence rates in the region.

**Game-changers**

- Expand and use community expertise and capacity to scale up community-led prevention, testing and care services for key populations.
- Fast-Track implementation of the 90-90-90 treatment target in high-prevalence countries.
- Intensify political advocacy on human rights, legal and policy reform to change perception of and policies on key populations.
- Scale up PrEP for key populations and sero-discordant couples in select cities.
- Increase domestic funding through innovative funding mechanisms while optimizing resource allocation (focus on key populations) and reducing costs.

**Regional opportunities and accountability mechanisms**

- Caribbean Community and Common Market and the Pan-Caribbean Partnership against HIV/AIDS have committed to Fast-Track and 90–90–90 and will be a critical regional coordination and accountability mechanism.
- Caribbean Development Bank will be an important instrument in planning and developing funding transition plans for the region.
- Caribbean Public Health Agency is being strengthened to offer health-care systems bio-medical and laboratory support while furthering the health research agenda.
- Organization of Eastern Caribbean States Secretariat is coordinating the response in the sub-region. The United Nations system has aligned the United Nations development assistance framework to this sub-regional response.

# Eastern and southern Africa

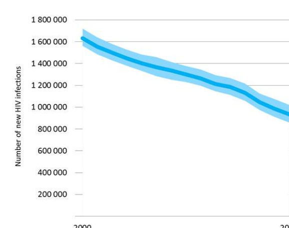
**The epidemic in numbers**

- **19.2 million** [18.0 million–21.9 million] people living with HIV in 2014–more than half of all people living with HIV globally; women constitute 59% of people living with HIV in the region.
- **940 000** [860 000–1.0 million] people newly infected with HIV, including 93 000 [78 000–110 000] children, and **460 000** [410 000–570 000] people died from AIDS-related causes in 2014.
- Rapid scale up of treatment has resulted in **9.07 million** (47% [44%–54%]) people receiving antiretroviral therapy, and coverage of services to prevent mother-to-child transmission of HIV reaching 88% [82%–95%].
- Domestic funding accounted for **46%** of the AIDS response in 2013.

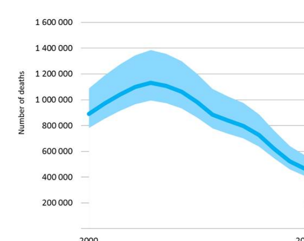
**Gaps and challenges**

- **High rates of new infections among adolescent girls and young women.** 3700 women 15–24 years old acquire HIV per week in 14 countries.
- **Significant new HIV infections among key populations.** Men who have sex with men, sex workers, people who inject drugs, and transgender people contributed to 30% of all new HIV infections in Kenya, 25% in South Africa, 20% in Mozambique and 12% in Swaziland—yet remain underserved, underinvolved and underrepresented in the response.
- **Rising high-risk behaviour.** Increase in the number of sexual partners among men between 2008 and 2014 combined with low condom use, especially among young people in some countries, and significant gaps in condom availability.
- **Rapid but inadequate progress on voluntary male medical circumcision.** 9.1 million men and boys circumcised by 2015, short of target of 21 million by 2016.
- **HIV testing remains low despite rapid scale up**. Only 10% of young men and 15% of young women 15–24 years old were aware of their HIV status in 2013.
- **Treatment coverage is low, with significant**

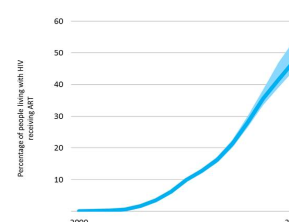
**Number of new HIV infections in East and Southern Africa 2000–2014**




**Number of AIDS-related deaths in East and Southern Africa 2000–2014**




**Antiretroviral therapy coverage in East and Southern Africa 2000–2014**




*Source:* UNAIDS 2014 estimates.

**variation between countries**. Significant resources are locked in for long-term treatment, complicating efforts to front-load and limiting availability for prevention, social and structural interventions.

- **Gender inequalities**, compounded by human rights violations including gender-based violence, impede access and adherence to services, while the role of communities and civil society is in transition.
- **Poor access to HIV services in humanitarian emergencies.** Of the 1.6 million people living with HIV affected by humanitarian emergencies in 2013, 1.3 million (81%) were in sub-Saharan Africa. Many were displaced and lacked access to essential HIV services, in part because of shortages that could have been avoided.

**By 2020, Fast-Tracking the regional response can reduce:**

- Number of people newly infected with HIV each year to **300 000**
- Number of people dying from AIDS-related causes each year to **200 000**

**Priority countries**

Angola, Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Swaziland South Africa, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

**Key cities**

Addis Ababa, Dar es Salaam, Durban, Harare, Johannesburg, Kigali, Lilongwe, Lusaka, Maputo and Nairobi.

In South Africa, 16% of people living with HIV reside in Johannesburg, and five cities (Johannesburg, Durban, Pretoria, Cape Town and Port Elizabeth) account for one third of the country's epidemic. In Malawi and Zambia more than 20% of the people living with HIV reside in five cities.

**Game-changers**

- **Increase condom (male and female) availability and distribution** as part of combination prevention programmes for young women and their sexual partners. Introduce and scale up access to **PrEP** as an additional prevention tool for groups at high risk, such as sex workers.
- Increase **male engagement along with youth-friendly programmes for adolescents and young women** in addressing relevant social and economic vulnerability, and in improving prevention and treatment service uptake and adherence.
- Enforce and expand **comprehensive sexuality education** both in and out of schools.
- Further strengthen **engagement of communities and traditional leaders** in scaling up acceptance of condoms, voluntary male medical circumcision, PrEP and other critical interventions to prevent new infections.

- Use **new technologies and innovation** in service delivery models to reach key populations, strengthen community-based delivery models and identify potential for efficiency gains.
- Engage **political leaders and regional economic communities,** and develop a new coalition of domestic and regional partners to implement the Sustainability Framework of the Southern African Development Community and East African Community to fund and sustain the response.
- Seize opportunities for **sustainable access to medicines**, including fully leveraging TRIPS flexibilities, and strengthening regional and local capacity to develop and manufacture quality affordable health products.

**Regional opportunities and accountability mechanisms**

- The **Regional Economic Communities** (East African Community, Southern African Development Community and Organisation of Islamic Cooperation) have committed to ending AIDS and provide a platform for collaboration and accountability.
- The **African Union**, including its technical body, the New Partnership for Africa's Development is a critical partner in enhancing the sustainability of the response, including through commodity security and its visionary Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria.
- The **Champions for an AIDS Free Generation in Africa**, the **Organization of African First Ladies against HIV/AIDS**, the **Southern African Development Community Parliamentary Forum,** the **East African Legislative Assembly, the Pan African Parliament,** the **Human Rights and Social Justice Think Tank**, regional civil society and community networks play a key role in advocating HIV and human rights issues as well as in creating the policy space for HIV.
- The **East Africa Business Coalition on AIDS** and the Private Sector Task Force of the Southern African Development Community coordinate and engage the private-sector response, including identifying key opportunities for leveraging private-sector resources (financial, skills and systems) to scale up and sustain the response.
- India–China–Africa partnerships on antiretroviral drug security provide the opportunity to sustain access as well as transfer of technology on HIV-related drugs and commodities.

# Eastern Europe and central Asia

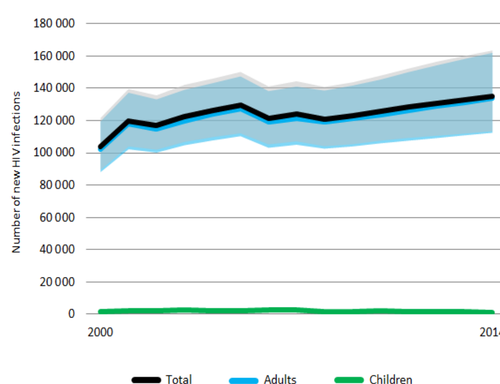
**The epidemic in numbers**

- **1.5 million** [1.3 million–1.8 million] people living with HIV in 2014.
- **Number of people acquiring HIV rose by 8%** between 2010 and 2014, reaching 140 000 [110 000–160 000] in 2014, primarily among people who inject drugs and their sexual partners.
- Only **19%**[16%–22%] of people living with HIV received antiretroviral therapy in 2014.
- Coverage of services for **prevention of mother-to-child transmission is 93%** [78%–95%]; Mother-to-child transmission rate is less than 2% in Belarus and less than 4% in seven other countries.
- The vast majority of people living with HIV live in **capitals and large cities,** as well as along drug-trafficking corridors.

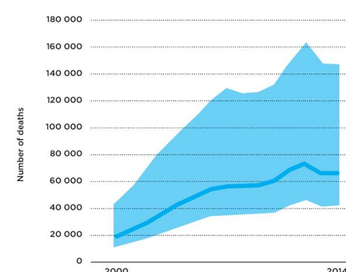
**Gaps and challenges**

- The number of people acquiring HIV is increasing, complicated by continued growth of new cases among people who inject drugs, and parallel increase in sexual HIV transmission.
- A wave of discriminatory legislation related to sexual diversity, sex work, drug use and mandatory HIV testing risks enhancing barriers to HIV services for key populations.
- Coverage of prevention programmes and frequency of HIV testing is low among key populations (in Ukraine, an estimated 47% of people living with HIV know their status). The share of key populations among those tested for HIV is low. The share of late presenters is high.
- HIV services, as well as those for comorbidities, including TB and Hepatitis, are failing to reach key populations, mainly due to stigma and discrimination.
- High-level political commitments to Fast-Track the AIDS response by 2020 remain uncertain, especially against the backdrop of limited government budgets and diminishing donor funding.
- Prices for antiretroviral medicines and unit costs of other HIV services remain prohibitively high, slowing scale-up.
- Space is shrinking for civil society organizations that already face extensive limitations in how they may influence policy-making related to HIV services.
- Frozen conflicts throughout the region and active conflict in areas of Ukraine with the highest HIV prevalence threatening gains of the HIV response.

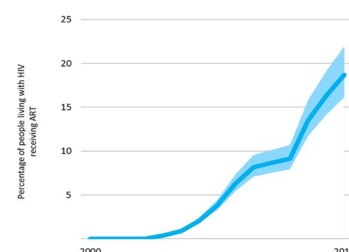
**Number of new HIV infections in eastern Europe and central Asia, 2000–2014**




**Number of AIDS-related deaths in eastern Europe and central Asia, 2000–2014**




**Antiretroviral therapy coverage in eastern Europe and central Asia, 2000–2014**




*Source:* UNAIDS 2014 estimates.

**By 2020, Fast-Tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **31 000**
- Number of people dying from AIDS-related causes each year to **15 000**

**Priority countries**

| | |
|---|---|
| Large proportion of the regional epidemic | 85% of people living with HIV reside in the Russian Federation and Ukraine |
| Severe epidemics among key populations | People who inject drugs in Belarus, the Russian Federation, Ukraine and Uzbekistan |

**Key cities**

Moscow and Kazan (Russian Federation), Kyiv (Ukraine), Almaty (Kazakhstan), Tashkent (Uzbekistan), Minsk (Belarus) and Chisinau (Republic of Moldova) are urban centres with a significant share of their respective national HIV epidemics and are also home to a large proportion of key populations and people living with HIV.

**Game-changers**

- **Scale up access of people who inject drugs** to a comprehensive package of HIV prevention and treatment services, including needle and syringe programming and opioid substitution therapy.
- **Revise national testing policies** (such as express tests, self-testing and community-led testing) to reach those at highest risk of acquiring and transmitting HIV and implement regional "know your HIV status" campaigns.
- **Repeal restrictive laws** that create and punish vulnerability to HIV and eliminate legal barriers to services.
- **Pursue a favourable legal framework** for strengthening the role of civil society organizations in HIV prevention, treatment adherence and protecting human rights.
- **Simplify laboratory testing and monitoring** to make access to antiretroviral therapy simpler, faster and less expensive.
- **Use TRIPS flexibilities** to expand domestic production of high-quality, low-cost antiretroviral therapy to reach the 90-90-90 treatment target.

**REGIONAL OPPORTUNITIES AND ACCOUNTABILITY MECHANISMS**

- Build on progress through the **Commonwealth of Independent States** to advance and monitor progress on Fast-Tracking the AIDS response.
- Enhance the leadership of the **Shanghai Cooperation Organization** in the HIV response.
- Promote the **Eurasian Economic Union** as a zone to Fast-Track the AIDS response by 2020, including 90–90–90.

Institutionalize the potential of the **Eastern Europe and Central Asia HIV/AIDS Conference** as a high-level collaborative forum for programmatic and policy progress on HIV.

# Latin America

**The epidemic in numbers**

- **1.7 million** [1.4 million–2.0 million] people living with HIV in 2014.
- **87 000** [70 000–100 000] people acquired HIV in 2014—one third were people aged 15 to 24.
- **47%** [40%–56%] of adults older than 15 years living with HIV and **54%** [46%–64%] of children are receiving antiretroviral therapy.
- **HIV prevalence among men who have sex with men exceeds 10%** in 9 of 15 countries reporting, and prevalence ranges from **10%** to **38% among transgender women.**
- **11 countries** in the region have HIV-specific criminal statutes.

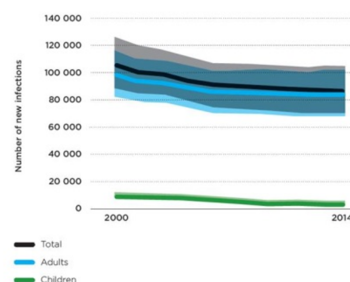
**Gaps and challenges**

- **Stigma and discrimination**. 10% to 44% of people living with HIV in 12 countries report having experienced discrimination.
- **Violence**. 26%–53% of ever-married women aged 15–49 years old report experiencing physical or sexual violence from a partner in the past 12 months. Intolerance of sexual diversity is a challenge—in 2013–2014 there were more than 770 incidents of violence (resulting in 594 deaths) related to the victim's sexual orientation, gender identity or gender expression.
- **Funding and efficiency**. Although key populations account for most of the people acquiring HIV, only 2% of prevention investment is directed towards key populations. More than two thirds of these programmes rely on external funding.

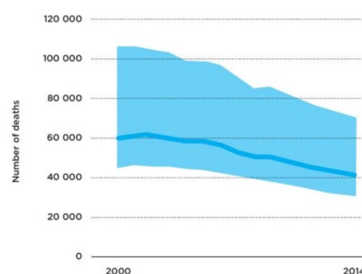
**By 2020, Fast-Tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **22 000**
- Number of people dying from AIDS-related causes each year to **12 000**

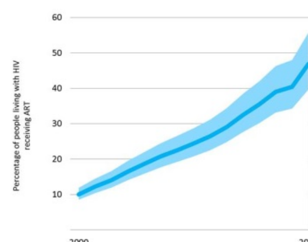
**Number of new HIV infections in Latin America, 2000–2014**




**Number of AIDS-related deaths in Latin America, 2000–2014**




**Antiretroviral therapy coverage, Latin America 2000–2014**




Source: UNAIDS 2014 estimates.

UNAIDS

**Priority countries**

| Large proportion of the regional epidemic | Argentina, Brazil, Colombia, Mexico and the Bolivarian Republic of Venezuela account for 75% of people acquiring HIV in the region. |
|---|---|

**Key cities**

- Almost 30% of people living with HIV in Brazil live in **São Paulo** and **Rio de Janeiro**, cities with significant potential to accelerate scale-up and be sources for South-South learning; and **Curitiba,** which signed the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic, prepared and begun implementation of a roadmap to reach Fast-Track targets.
- **Mexico City** is home to 19% of people living with HIV in Mexico, with HIV prevalence three times higher than the national average.
- **Buenos Aires** is home to 43% of people living with HIV in Argentina.
- Other priority cities include **Lima** with 73% of burden of HIV in Peru; and **Panama City/San Miguelito,** home to the majority of people living with HIV in Panama and whose Mayors have committed to reach Fast-Track targets.

**Game-changers**

- **Reform punitive laws** and policies that criminalize HIV transmission and exposure, and approve protective laws, including those related to gender identity and anti-discrimination.
- **Expand early HIV testing** and linkage to care and treatment in key populations and other vulnerable groups such as adolescents, migrants, and prisoners.
- **Promote PrEP** within packages of prevention services for key populations; make use of new media to reach mem who have sex with mem.
- **Increase domestic funding** for prevention and human rights programmes for key populations and explore alternative funding such as private-sector partnerships and regional development banks.
- **Use TRIPS flexibilities** to reduce the cost of antiretroviral medicines and other commodities and optimize investments.

**Regional opportunities and accountability mechanisms**

- **Fast-Track:** The Central American Regional Coordination Mechanism (RCM), the HIV advisory body of the Central American Health Ministers Commission, is implementing a regional sustainability strategy. UNAIDS, Global Fund and PEPFAR are key partners supporting the strategy. The RCM is strongly committed to the 90-90-90 treatment target.
- **Human Rights:** The Organization of American States (OAS) and the Inter-American Commission of Human Rights (IACHR) provide legal protection for people living with and affected by HIV. In 2013, OAS adopted a bold resolution on HIV and the promotion and

protection of Human Rights in the AIDS response. A rapporteurship has been established within the IACHR to monitor violence against LGBTI persons.

- **Sustainability:** The region has strong interinstitutional and civil society networks, which should continue to be supported to enhance sustainability. These include HTCG (Horizontal Technical Cooperation Group), REDLACTRANS (regional network of transgender people), REDTRASEX (regional network of sex workers), RedCA+ (Central American network of people living with HIV).

# Middle East and North Africa

**The epidemic in numbers**

- In 2014, **240 000** [150 000–320 000] people living with HIV–almost 70% live in the Islamic Republic of Iran, Somalia and Sudan.
- Nearly **22 000** [13 000–33 000] people acquired HIV in 2014; MENA is one of two UNAIDS regions in which new infections are not declining.
- The number of people dying from **AIDS-related causes more than tripled** between 2000 and 2014 with **12 000** [5300–24 000] deaths in 2014.
- **14%** [9%–19%] of **adults** and **15%** [11%–18%] of **children** aged 0–14 living with HIV have access to antiretroviral therapy, lower than any other region.
- While high-income and some upper-middle-income countries (Algeria, Gulf Cooperation Council countries, and the Islamic Republic of Iran) domestically fund more than 90% of their responses, some lower-income countries fund less than 20% of their responses.

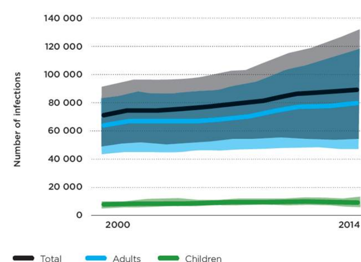
**Gaps and challenges**

- Rising numbers of people acquiring HIV, mostly among key populations.
- Low testing and treatment coverage, including for pregnant women. Only 13% [10%–16%] have access to services to prevent mother-to-child transmission.
- Low prevention coverage and deeply rooted stigma, punitive and discriminatory laws against key populations and people living with HIV, including travel restrictions in many countries and mandatory HIV testing for residence or refugee permits.
- Political turmoil and conflict have led to significant mobility, refugee movements and migration, disrupting social and health services and increasing vulnerability to sexual violence, food and housing insecurity, human trafficking and other human rights violations—all with potential implications for the epidemic and response.
- High dependence on external funding in low-income countries (Djibouti, Somalia, Sudan and Yemen) and low priority of HIV within domestic budgets presents a threat to Fast-Tracking the response.

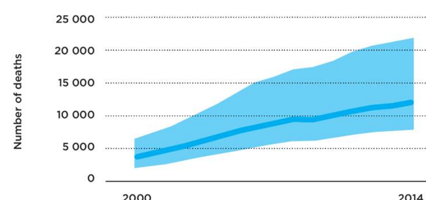
**By 2020, Fast-Tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **5300**

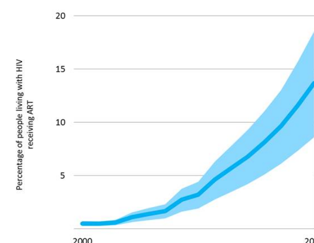
**New HIV infections in the Middle East and North Africa, 2000–2014**




**Number of AIDS-related deaths in the Middle East and North Africa, 2000–2014**




**Antiretroviral therapy coverage, Middle East and North Africa 2000–2014**




*Source:* UNAIDS 2014 estimates.

UNAIDS

- Number of people dying from AIDS-related causes each year to **2500**

**Priority countries**

| Large proportion of the regional epidemic | Six countries—Algeria, Djibouti, Islamic Republic of Iran, Morocco, Somalia and the Sudan—account for almost 90% of people living with HIV in the region. |
|---|---|
| Severe epidemics among key populations | Tunisia (men who have sex with men), Libya (people who inject drugs), Egypt (men who have sex with men, people who inject drugs) and Yemen (men who have sex with men). |

**Key cities**

Alexandria, Algiers, Cairo, Casablanca and Tehran are among the largest urban settings in priority countries, with documented higher HIV prevalence among key populations. Some of them such as Algiers have signed the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic, with growing commitment to population- and location-specific HIV responses.

**Game-changers**

- **Transformative political leadership**. Strategic partnership with the League of Arab States to Fast-Track the response by implementing the Arab AIDS Strategy (2014-2020).
- **Legal and policy reform**. Engaging parliamentarians and the ratification of the Arab Convention on HIV prevention and protection of people living with HIV can change the landscape in law reform, including around abolishing punitive laws and applying a broader and positive interpretation of existing laws and policies.
- **Sharpening focus on key populations.** Transforming HIV testing and treatment through community and private health-care service delivery, more rigorous referral and linkage to services especially among key populations, simplifying treatment regimens and integrating services.
- **Empowering civil society.** Further enabling civil society partners, including religious leaders, community and grassroots organizations led by people living with HIV, women and young people to be central to designing, implementing and monitoring the response.
- **Innovation in data, testing, service delivery and reengineering current models.** Well-targeted testing and innovative approaches to delivering medicines, including using information technology to tailor services.

**Regional opportunities and accountability mechanisms**

- The **Council of the Arab Minsters of Health, under the League of Arab States**, is ensuring accountability of countries to implement the Arab AIDS Strategy. UNAIDS is working with the League to establish an accountability mechanism to monitor the progress of implementation and working with countries to expand regional solidarity and shared responsibility.
- The **Arab Parliament**, League of Arab States, UNDP and UNAIDS will intensify advocacy and partnerships with selected national parliaments to ratify the Arab Convention on HIV Prevention and Protection of People Living with HIV and use it as an umbrella legal framework for legal and policy reviews to advance human rights.

- **Regional economic communities,** such as the Intergovernmental Authority on Development, which includes Djibouti, Somalia and Sudan, are working with UNAIDS to sustain and scale up regional and subregional efforts to address HIV vulnerability among migrants and mobile populations.

## North America[xii]

**The epidemic in numbers**

- Nearly **1.3 million** [880 000–2.0 million] **people living with HIV**, with 1.2 million living in the United States of America (U.S.) and 75 000 in Canada.
- Estimated **one in eight** people living with HIV in the U.S. and **one in five** in Canada are unaware of their HIV status.
- **Men constitute 75%** people living with HIV in Canada and the U.S. – gay men and other men who have sex with men accounted for more than half the people living with HIV in the U.S. and nearly half those living in Canada in 2014.
- In 2013, the highest rates of new diagnoses in the U.S. occurred among **people aged 25–29 years old** followed by people aged 20–24, whereas in Canada, the greatest proportion (more than one third) of people acquiring HIV were between **30 and 39 years** old.
- 15% of the people living with HIV in Canada contracted HIV through injection drug use.

**Gaps and challenges**

- Although 86% of people estimated to be living with HIV are aware of their serostatus in the United States, only **51% of people who have been diagnosed are retained** in HIV medical care and 43% are virally suppressed.
- **Significant racial disparities** in HIV infection exist in the United States. There are also racial and ethnic disparities along the care continuum and in rates of premature death. People living with and most vulnerable to HIV face higher rates of violence, trauma, homelessness, police discrimination and lack of public services.
- **Gay and other men who have sex with men** represented about 4% of the male population in the United States in 2013 and 81% of men newly infected. **African-American men who have sex with men** acquire HIV at a rate several times higher than that among other men who have sex with men in the United States. African Americans represent about 12% of the United States population but accounted for 46% of people acquiring HIV in 2013.
- In Canada, **indigenous peoples** (First Nations, Inuit and Métis) acquire HIV at rates estimated to be 2.7 times higher than that of the non-indigenous population.

[xii] Diagnoses of HIV infection in the United States and dependent areas, 2013. Atlanta: Centers for Disease Control and Prevention; 2013 (HIV Surveillance Report, Vol. 25; (http://www.cdc.gov/hiv/library/reports/surveillance/2013/surveillance_Report_vol_25.html, accessed 25 September 2015).
HIV/AIDS Epi Updates. Chapter 1: Estimates of HIV prevalence and incidence in Canada, 2011.
Public Health Agency of Canada. Summary: estimates of HIV prevalence and incidence in Canada, 2011.

- The current state of **sexuality education** in the U.S. insufficiently addresses health risks faced by people younger than 29 years old, particularly African American and lesbian, gay, bisexual, transgender and intersex youth.
- Fear of **stigma, discrimination and criminalization** remain significant barriers to HIV testing and treatment in both countries. In some settings, health-care providers' knowledge of HIV is low, and HIV-related stigma and discrimination in health-care settings is high.
- The epicentre of HIV in the United States has shifted from urban centres on the east and west coasts to **those in the south**. During the past 10 years, **adults 50 years and older** in Canada have acquired HIV at a rate that is slowly but steadily increasing.
- **Accessing treatment remains a challenge for many people**. Lowering medicine costs is critical to financial sustainability in the AIDS response, including addressing co-morbidities such as hepatitis C. Although the federally-mandated Patient Protection and Affordable Care Act in the United States has linked more people living with HIV to health-care services, the fact that some states have not opted to expand their Medicaid coverage means that other low-income people living with HIV may continue to struggle to access care and treatment.

**Priority populations** (at high risk)

U.S.: Gay men and other men who have sex with men (particularly young men of colour who have sex with men), people who inject drugs, sex workers, transgender people and African-Americans are at increased risk.

Canada: Gay men and other men who have sex with men, Aboriginal peoples, people from countries where HIV is endemic, people who inject drugs, people in prisons, women and youth.

**Game-changers**

- **Address underlying social determinants** of health, strengthen HIV awareness and increase HIV testing and linkage to care to enable people living with HIV to access treatment early.
- **Offer broad support for people living with HIV** to remain engaged in comprehensive care, including support for treatment adherence to achieve universal viral suppression among people living with HIV.
- **Continue to refine data collection efforts, including improved monitoring at each point in the HIV cascade,** as well as coordination and transparency of data across data systems to improve health outcomes and guide the application of resources for maximum impact.
- **Adopt an integrated, holistic approach** to HIV, viral hepatitis and other sexually transmitted and bloodborne infections.
- **Increase investment in networks of people living with HIV**, key population organizations and focused programmes for young men of colour who have sex with men and other key populations and fragile communities, including for full access to PrEP for those for whom it is appropriate and desired with support for medication adherence.

- **Address needs of young people** through better use of social media and links to health-care delivery. Implement strategies for addressing the needs of older people living with HIV.
- **Reduce AIDS-related stigma and discrimination** broadly, including among providers of health care. Engage faith-based and indigenous community leaders to raise awareness of the link between reduced stigma and improved individual and public health outcomes.
- **Ensure federal and state or provincial criminal laws reflect current scientific knowledge** related to HIV, and avoid creating new laws that specifically criminalize people based on HIV status and enacting new such laws.

**Regional opportunities and accountability mechanisms**

- **National HIV/AIDS Strategy for the United States: updated to 2020** outlines an ambitious agenda for ending the AIDS epidemic and will form a critical accountability mechanism along with the HIV Care Continuum Initiative in the United States (2013).
- The **Federal Initiative to Address HIV/AIDS in Canada (FI)** is an horizontal initiative to enhance coordination and collaboration on HIV in Canada among four Federal partners: the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and Correctional Service Canada. Outcomes from the FI are reported to the Canadian public through existing Government of Canada accountability mechanisms.

# Western and central Africa

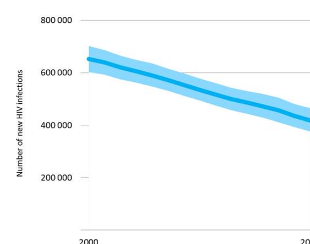
**The epidemic in numbers (2014)**

- **6.6 million** [5.9 million–7.5 million] people living with HIV, including **3.8 million** [3.4 million–4.3 million] women and 730 000 [660 000–800 000] children.
- **420 000** [380 000–460 000] **people acquired HIV**, including 110 000 [79 000–130 000] young people, and 330 000 [240 000–450 000] people died from AIDS-related causes.
- About **1 in 4 adults** and **1 in 8 children** living with HIV have access to treatment; only 42% [38%–47%] of pregnant women living with HIV received treatment.
- In **16 countries** with data, HIV prevalence was several fold higher among female sex workers and men who have sex with men than in the general population.
- **13 countries** criminalize same-sex sexual relationships, and **14** criminalize sex work.

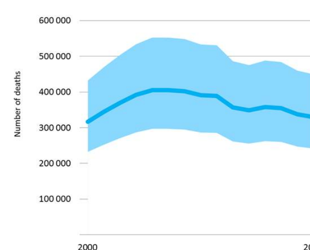
## Gaps and challenges

- **Insufficient behavioural impact of prevention interventions** for adolescents and young people. High rate of early marriage, low condom use and multiple sexual partners with early sexual debut. HIV testing uptake ranges from 6% to 22%.
- **Large coverage gap for testing, services to prevent mother-to-child transmission and antiretroviral therapy** for adults and children. Health and community systems, including procurement and supply management remain weak.
- **Over-reliance on international funding** (GFATM, PEPFAR) **at 70%** because of variable political commitment. Poor governance, low allocative efficiency and limited absorption of funds undermine the sustainability of the response.
- **Persistent stigma and discrimination, gender inequalities and violence against women.**
- **Poor sex- and age-disaggregated epidemiological and programmatic national and subnational data** especially on key populations, young people and adolescents. Only seven countries have a size estimate for men who have sex with men and 10 countries have an estimate for sex workers.
- **Escalating terrorism**, **fragile political situations** as well as **diseases such as Ebola** in a region already heavily affected by recurrent humanitarian emergencies (seasonal shocks–drought, food insecurity, floods, disease outbreaks–and conflicts) affect the epidemic and

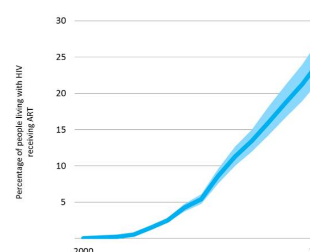
Number of new HIV infections in West and Central Africa 2000–2014




Number of AIDS-related deaths in West and Central Africa 2000–2014




Antiretroviral therapy coverage, West and Central Africa 2000–2014




*Source:* UNAIDS 2014 estimates.

UNAIDS

threaten the response.

**By 2020, fast-tracking the regional response can reduce the:**

- Number of people newly infected with HIV each year to **120 000**
- Number of people dying from AIDS-related causes each year to **87 000**

**Priority countries**

| | |
|---|---|
| Large epidemics and high-prevalence countries | **Five countries account for over 78% of the HIV burden, and 82% of people newly infected**: Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo and Nigeria are the Fast-Track countries. Nigeria accounts for 52% of new infections: priority will be placed on states with a prevalence above 8%: Nasarawa, Benue, Cross River, Akwa Ibom and Federal Capital Territory.<br>**Other high-prevalence countries require focused actions:** Equatorial Guinea (6.2%), CAR (4.3%), Gabon (3.9%), and Guinea-Bissau (3.7%). |
| Humanitarian emergencies | All countries affected by or at risk of a humanitarian situation will be given priority. |

**Key cities**

The epidemic in the region is primarily urban except for Cape Verde, Equatorial Guinea and Mali. Focus on 15 cities based on burden and need/opportunity: Abidjan, Abuja, Accra, Bamako, Brazzaville, Cotonou, Dakar, Douala, Kinshasa, Lagos, Libreville, Lomé, Lubumbashi, Ouagadougou and Yaoundé. All city leaders will be encouraged to act based on the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic.

**Game-changers**

- Collaborative frameworks at national and local levels to ensure practical solutions for key populations to access services despite challenging legal environments.
- Self-testing and community-based testing and delivery of antiretroviral therapy through task-shifting and the use of new technologies.
- Services to prevent mother-to-child transmission of HIV integrated into all maternal, newborn and child health services and sexual and reproductive health services as an entry point for achieving integration of the HIV response in the health sector at all levels.
- Innovative funding mechanisms to increase domestic funding while optimizing resource allocation and reducing costs in the context of implementing the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria.
- The full potential of adolescents and young women and men unleashed to help realize the demographic dividend and reduce risk of and vulnerability to HIV infection.
- Fully leveraging TRIPS flexibilities to secure sustainable access to affordable medicines, and strengthening regional and local capacity to develop and manufacture quality affordable health products.

**Regional and global opportunities and accountability mechanisms**

- Implementation of the **African Union Roadmap on AIDS, TB and Malaria** and the **African Union Framework on Social Protection** provides an opportunity to Fast-Track the response.
- **The Economic Community of West African States/West African Health Organization and Economic Community of Central African States** in collaboration with regional and global partners represent a collaborative forum to maximize access to commodities, including through the antiretroviral medicines security stock and **ECOWAS Regional Pharmaceutical Plan**.
- The **Cities Initiative** based on the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic will help to mobilize engagement and catalytic funding and serve as an accountability framework for monitoring progress.
- The memorandum of understanding with **International Organisation of La Francophonie** is an opportunity for high-level political advocacy, especially for human rights and funding in francophone countries.
- The **Global Maternal Newborn & Child Health initiative** will be instrumental to Fast-Track the provision of integrated quality services, and leverage the support of **Organization of African First Ladies Against HIV/AIDS**.

## Western and Central Europe

**The epidemic in numbers**

- More than **1 million** [620 000–1 400 000] **people living with HIV in 2014—**nearly 80% of them men.
- The number of **men who have sex with men acquiring HIV increased by 33%** in the past decade and represented 52% of people reported to have acquired HIV with known mode of transmission in 2013.
- Since 2004, the number of **heterosexual people acquiring HIV has declined by 45%.** Among migrants from countries with generalized epidemics, the decline has been even greater (60%). This small population, however, accounts for 15% of new HIV diagnoses.
- The number of **people who inject drugs acquiring HIV declined by 36%** during the past decade; in 2013, transmission related to injecting drug use accounted for 5% of all new reported HIV diagnoses.
- In 2013, **47%** of new HIV diagnoses were among people presenting late.

**Gaps and challenges**

- Decreased interest in HIV on national and regional political agendas has led to decreased allocation of investment and policy reforms. Growing inequalities between and within countries and across many population groups result in people being left behind, even where solid responses are in place.
- Men who have sex with men are the only key population that has not experienced a decline in new infections. Especially concerning, the number of young men who have sex with men aged 20–24 years diagnosed with HIV has nearly doubled between 2004 and 2013, and increased by 83% among those aged 15–19 years.[xiii]
- Trends to criminalize male clients of sex workers may drive sex workers and clients further out of reach of services.[xiv]
- Undocumented migrants face difficulty in accessing HIV-related services because of lack of legal residence status and health insurance. In many countries, undocumented migrants are only entitled to emergency healthcare and therefore cannot access long-term HIV treatment.
- Even in high-income countries with well-functioning health systems, effective viral load suppression among people living with HIV is only between 52% and 59%.[xv]

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[xiii] European Centre for Disease Prevention and Control. From Dublin to Rome: ten years of responding to HIV in Europe and Central Asia: Stockholm, ECDC; 2014

[xiv] From Dublin to Rome: ten years of responding to HIV in Europe and central Asia. Stockholm: European Centre for Disease Prevention and Control; 2014.

[xv] Raymond A, Hill A, Pozniak A. Large disparities in HIV treatment cascades between eight European and high-income countries—analysis of break points. J Int AIDS Soc. 2014;17(Suppl 3):19507.

- PrEP is only available in Europe through small trials and demonstration projects or informal use, and most countries maintain conservative treatment thresholds.[xvi]
- Low uptake of testing remains a barrier; countries in 2014 reported testing rates of 20%–50% among men who have sex with men and 30%–60% among people who inject drugs.
- Non-competitive pricing of treatment for HIV, hepatitis C and other comorbidities and coinfections is becoming an increasing concern as the size of the eligible population grows.

**Priority countries**

| | |
|---|---|
| Large proportion of the regional epidemic | France, Germany, Italy and the United Kingdom account for about half of people living with HIV. |
| Severe epidemics among key populations | People who Inject drugs: Estonia, Greece, Latvia, Portugal and Romania<br>Men who have sex with men: Cyprus, Czech Republic, Hungary, Ireland, Latvia, Slovakia and Slovenia (more than 100% increase in new infections between 2004-2011); Austria and Belgium (50% increase).<br>Sex workers: Latvia, Portugal and Spain.<br>Transgender: Netherlands (prevalence exceeds 20% among sex workers). |

**Game-changers**

- **Keep HIV high on the political agenda, emphasizing shared responsibility and global solidarity.** Greater communication needed on risks of not investing in AIDS, combatting complacency and a new regional narrative.
- **Address inequality and exclusion.** Strategies need to be flexible to address inequality in middle-income countries, migration and young people**, as well as changing epidemic trends,** including shifts from injecting to non-injecting drug use.
- **Focus responses on key populations and young members** thereof. Saturate high transmission urban areas with prevention programmes, including condoms, testing, PrEP, PEP, needle exchange and opioid substitution therapy.
- **Enhance strategic testing and use of antiretroviral therapy**. Expand testing in key populations wherever prevalence is high, including rapid testing in community led, non-medical settings; provide treatment regardless of CD4 count for all people living with HIV.
- **Increase access to comprehensive sexuality education:** Access to such education for young people and adolescents remains largely theoretical for much of the population.
- **Revive the AIDS movement** and invest in civil society's activism as a global public good.

**Regional opportunities and accountability mechanisms**

[xvi] In 2014, the majority of countries retained the threshold for starting antiretroviral therapy at a CD4 count of ≤350 cells/mm$^3$, and only 18 countries had adopted the 2013 WHO guidelines. Only a few countries such as Austria, France and Greece offer treatment regardless of CD4 count.

- The **Dublin Declaration** has provided a framework for monitoring progress and challenges in the region and the **European Centre for Disease Prevention and Control** has monitored and collected country reports on this periodically. An updated European Union policy framework to replace the Dublin Declaration targets is needed.
- Intersectoral mobilization and action across governments, civil society and the private sector can be strengthened. The European Union, European Commission and European governments continue to be key partners.

## Annex 3. Illustrative list of indicators for measuring progress of the UNAIDS 2016–2021 Strategy[xvii]

The set of indicators and indicator areas proposed here are aligned with the result areas and targets of the UNAIDS 2016–2021 Strategy. These illustrative indicators are part of an ongoing review of the Global AIDS Response Progress Reporting, which explores the use and quality of indicators, new areas of the AIDS response such as those outlined in this Strategy, indicators proposed in the recently-released health sector indicator guidelines and other relevant information. The review is aimed at developing a complete set of indicators to measure the intersectoral AIDS response for the coming years, measuring progress towards the Fast-Track targets for 2020 and the SDGs in the framework of harmonization of indicators and reducing countries' reporting burden. Once the review is completed, the international HIV indicators review body will assess the indicator set. The review process includes the revision and pilot testing of the National Commitments and Policy Index (a survey conducted every two years by governments and civil society), which measures progress on a number of potential results identified in this Strategy. The illustrative indicators may therefore be modified or replaced depending on the outcomes of the review process and the recommendations of the indicator review body.

Indicators in italicized font are in the process of being developed and have not been extensively used. References for indicators are included in parentheses after the indicator. Indicators in red are included in the currently proposed SDG indicators.

**Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment**

*Percentage of people living with HIV who know their status (GARPR 2016, WHO 2015)*

Percentage of HIV-exposed children tested receiving virological test by two months of age (GARPR, WHO 2015

Percentage of people living with HIV receiving antiretroviral therapy (GARPR, WHO 2015)

Percentage of people living with HIV enrolled in HIV care (GARPR 2016, WHO 2015)

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[xvii] **Abbreviations:**

GARPR: Global AIDS Response Progress Reporting, Items noted with GARPR 2016 will be included in the next round of GARPR

GPRM: Global Price Reporting Mechanism

NASA: National AIDS Spending Assessment

NCPI: National Commitment and Policy Index

PORTIA: Performance-Oriented Resource Tracking Investment assessment

SDG: Proposed Sustainable Development Goal

SHA: System of Health Accounts

WHO 2015: WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector

*Percentage of people receiving antiretroviral therapy with suppressed viral load (GARPR 2016, WHO 2015)*

Percentage of people receiving antiretroviral therapy who were retained on therapy 12 months after initiation (GARPR, WHO 2015)

*Existence of HIV response strategy (including for the provision of condoms and antiretroviral therapy) for emergency situations (GARPR 2016/NCPI)*

Estimated annual number of AIDS-related deaths per 100 000 population (GARPR 2016, WHO 2015)

**New HIV infections among children are eliminated and their mother's health and well-being is sustained**

Percentage of pregnant women living with HIV receiving effective antiretroviral regimens or started on them (GARPR, WHO 2015)

Estimated annual number of new HIV infections among children (GARPR 2016, WHO 2015)

**Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV**

Estimated annual number of new infections per 1000 susceptible (uninfected) population (SDG, GARPR 2016, WHO 2015)

*Existence of national strategies for comprehensive sexuality education in schools including promotion of gender equitable attitudes and behaviours (GARPR 2016/NCPI)*

Or *Number of high-prevalence countries where over 70% of schools provided life skills-based HIV and comprehensive sexuality education in the previous academic year*

Percentage of young women and men using a condom at last high-risk sex (GARPR, WHO 2015)

Annual number of men voluntarily circumcised (GARPR, WHO 2015)

Percentage of young women and men with comprehensive knowledge of HIV prevention (GARPR)

Percentage of young men and women who had sex before age 15 (GARPR)

*Percentage of young women and girls in high-prevalence areas who benefit from HIV-sensitive social protection or economic empowerment programs*

*Engagement of adolescent girls and boys in the national response in: policy development, planning, budgeting, implementation of services and interventions, monitoring and evaluation (GARPR 2016/NCPI)*

Percentage *of people using PrEP among national priority PrEP populations (GARPR 2016, WHO 2015)*

*Number of condoms available per adult male in high-prevalence countries*

**Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants**

HIV testing among sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners (GARPR, WHO 2015)

Condom use among sex workers, men who have sex with men, people who inject drugs (GARPR, WHO 2015)

Needles and syringes distributed per person injecting (GARPR, WHO 2015)

*Condoms available in prisons (GARPR 2016/NCPI)*

*Engagement of national priority population groups in the national AIDS response: policy development, planning, budgeting, implementation of services and interventions, monitoring and evaluation (GARPR 2016/NCPI)*

*Percentage of people using PrEP among national priority PrEP populations (GARPR 2016, WHO 2015)*

*Percentage of estimated number of key populations (sex workers, men who have sex with men, people who infect drugs, transgender people, prisoners, migrants) in contact with/reached by prevention services (in last month)*

**Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV**

Percentage of women reporting recent intimate partner violence (SDG, GARPR)

*Existence of laws or policies to prevent and address issues of violence against women and gender-based violence (GARPR 2016/NCPI)*

*Engagement of women living with HIV in the national response: policy development, planning, budgeting, implementation of services and interventions, monitoring and evaluation (GARPR 2016/NCPI)*

**Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed**

*Existence of laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or accessibility to these services (GARPR 2016/NCPI)*

*Existence of mechanisms to promote access to justice e.g. free legal services, legal literacy programmes (GARPR 2016/NCPI)*

Percentage of women and men aged 15-49 years who report discriminatory attitudes toward people living with HIV (GARPR, WHO 2015)

*Percentage of adults living with HIV and key populations reporting denial of health services*

Percentage of health facility staff that hold stigmatizing views about people living with HIV (GARPR 2016)

**AIDS response is fully funded and efficiently implemented based on timely, reliable strategic information**

*Country has internationally acceptable data for global priority indicators using relevant disaggregation (GARPR)*

Annual total HIV investments for in-country response in low- and middle-income countries disaggregated by key programme area and by source of funding (international and domestic), with full distribution by disease/program (GARPR/NASA, WHO SHA)

*Percentage of change in direct and indirect costs per person living with HIV receiving antiretroviral therapy and virally suppressed (GARPR 2016/PORTIA)*

*Percentage of change in ARV prices for first, second and third lines and reagents for laboratory monitoring of patients (CD4 and viral load) (WHO GPRM / improved tracking system)*

*Existence of a transitional plan for a fully funded HIV response developed, among countries transiting into lower- and upper-middle-income levels (GARPR 2016/NCPI)*

*Percentage of the population and of people living with HIV covered by public, social, or private health insurance for antiretroviral therapy (GARPR 2016)*

*Percentage of change in total (direct and indirect) costs per infection averted (PORTIA)*

*Percentage of change in total (direct and indirect) costs per death averted (PORTIA)*

*Percentage of change in total (direct and indirect) cost savings due to optimal resource allocation (PORTIA)*

**People-centred HIV and health services are integrated in the context of stronger systems for health**

Percentage of poorest households receiving external economic support (GARPR)

*Existence of integration of HIV and other health/disease services delivery: sexual and reproductive health, TB, hepatitis C, non-communicable diseases, violence screening and mitigation, nutrition (GARPR 2016/NCPI)*

Co-management of TB and HIV (GARPR, WHO 2015)

*Percentage of HIV programmes/services estimated to be provided by civil society disaggregated by different programme areas (GARPR 2016/NCPI)*

*Percentage of persons tested for HIV though community-based service delivery (GARPR 2016/NCPI)*

*Percentage of persons receiving antiretroviral therapy though community-based service delivery (GARPR 2016/NCPI)*

*Existence of a mechanism for participatory monitoring by civil society for quality assurance and responsiveness of HIV services, e.g. mobile reporting, logistics analysis (GARPR 2016)*

## Annex 4. Glossary

For more information on key concepts, please see the *UNAIDS terminology guidelines 2015*.

**Combination HIV prevention** seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's strategy for HIV prevention—combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices.

Combination prevention includes both primary prevention (focused on people who are HIV-negative) as well as prevention of onward transmission from people living with HIV.

*Source: UNAIDS terminology guidelines 2015. Geneva: UNAIDS 2015.*

Key features of combination prevention programmes:

- tailored to national and local needs and contexts,
- combine biomedical, behavioural and structural interventions
- fully engage affected communities, promoting human rights and gender equality;
- operate synergistically, consistently over time, on multiple levels—individual, family and society;
- invest in decentralized and community responses and enhances coordination and management;
- flexible—adapt to changing epidemic patterns and can rapidly deploy innovations.

*Sources:*

*Combination HIV Prevention: tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. Geneva: UNAIDS; 2010.*

*Combination Prevention: addressing the urgent need to reinvigorate HIV prevention responses globally by scaling up and achieving synergies to halt and begin to reverse the spread of the AIDS epidemic. Geneva: UNAIDS; 2013 (UNAIDS/PCB(30)/12.13)*

**Comprehensive sexuality education** is defined as "an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision making, communication and risk reduction skills about many aspects of sexuality"

*Source: UNESCO, UNAIDS, UNFPA, UNICEF and WHO. International technical guidance on sexuality education. Volume I. Paris: United Nations Educational, Scientific and Cultural Organization; 2009.*

Many different names are used, reflecting an emphasis on various aspects of CSE by different countries. As with all curricula, CSE must be delivered in accordance with national laws and policies.

UNESCO has developed a set of 'essential' and 'desirable' topics of a life skills-based HIV and sexuality education programme: The 'essential' topics are those that have the greatest direct impact on HIV prevention. 'Desirable' topics are those that have an indirect impact on HIV prevention but that are important as part of an overall sexuality education programme.

| **Generic life skills** | |
|---|---|
| Essential topics | Decision-making/assertiveness |
| | Communication/negotiation/refusal |
| | Human rights empowerment |
| Desirable topics | Acceptance, tolerance, empathy and non-discrimination |
| | Other gender life skills |
| **Sexual and reproductive health (SRH)/Sexuality Education (SE)** | |
| Essential topics | Human growth and development |
| | Sexual anatomy and physiology |
| | Family life, marriage, long-term commitment and interpersonal relationships |
| | Society, culture and sexuality: values, attitudes, social norms and the media in relation to sexuality |
| | Reproduction |
| | Gender equality and gender roles |
| | Sexual abuse/resisting unwanted or coerced sex |
| | Condoms |
| | Sexual behaviour (sexual practices, pleasure and feelings) |
| | Transmission and prevention of sexually transmitted infections (STIs) |
| Desirable topics | Pregnancy and childbirth |
| | Contraception other than condoms |
| | Gender-based violence and harmful practices/rejecting violence |
| | Sexual diversity |
| | Sources for SRH services/seeking services |
| | Other content related to SRH/SE |
| **HIV and AIDS-related specific content** | |
| Essential topics | Transmission of HIV |
| | Prevention of HIV: practising safer sex, including condom use |
| | Treatment of HIV |
| Desirable topics | HIV-related stigma and discrimination |
| | Sources of counselling and testing services/seeking counselling, treatment, care and support |
| | Other HIV and AIDS-related specific content |

*Source: Measuring the Education Sector response to HIV and AIDS–Guidelines for the construction and use of core indicators. Paris: United Nations Educational, Scientific and Cultural Organization; 2013.*

**HIV-sensitive social protection** enables people living with HIV and other vulnerable populations to be provided with services together with the rest of the population; this prevents the exclusion of equally needy groups. HIV-sensitive social protection is the preferred approach as it avoids the stigmatization that can be caused by focusing exclusively on HIV. Approaches to HIV-sensitive social protection include the following: financial protection through predictable transfers of cash, food or other commodities for those affected by HIV and those who are most vulnerable; access to affordable quality services, including treatment, health and education services; and policies, legislation and regulation to meet the needs (and uphold the rights) of the most vulnerable and excluded people.

*Source: UNAIDS terminology guidelines 2015. Geneva: UNAIDS; 2015.*

**Key populations, or key populations at higher risk**, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

*Source: UNAIDS Strategy 2011–2015: getting to zero. Geneva: UNAIDS; 2010.*

UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the **four main key population groups.** These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term key populations is also used by some agencies to refer to populations other than the four listed above. For example, prisoners and other incarcerated people also are particularly vulnerable to HIV; they frequently lack adequate access to services, and some agencies may refer to them as a key population. The term key populations at higher risk also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment. In addition to the four main key populations, this term includes people living with HIV, seronegative partners in serodiscordant couples and other specific populations that might be relevant in particular regions (such as young women in southern Africa, fishermen and women around some African lakes, long-distance truck drivers and mobile populations).

*Source: UNAIDS terminology guidelines 2015. Geneva: UNAIDS; 2015.*

**Men who have sex with men** describes males who have sex with males (including young males), regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men. **Gay** can refer to same-sex sexual attraction, same-

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|---|
| sex sexual behaviour and same-sex cultural identity.<br>*Source: UNAIDS terminology guidelines 2015. Geneva: UNAIDS; 2015.* |
| **Transgender** is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or, in specific cultures, as hijra (India), kathoey (Thailand), waria (Indonesia) or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.<br>*Source: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014.* |
| **Young people** are people aged 15-24 as per the GARPR indicators.<br>*http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en.pdf*<br>The World Health Organization (WHO) identifies **adolescence** as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.<br>*http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/* |

## Annex 5. Abbreviations

| | |
|---|---|
| AfDB | African Development Bank |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral |
| ASEAN | Association of Southeast Asian Nations |
| BRICS | Brazil, Russian Federation, India, China and South Africa |
| CARICOM | Caribbean Community and Common Market |
| CARIMIS | Caribbean Men's Internet Survey |
| CDC | Centers for Disease Control and Prevention |
| CIS | Commonwealth of Independent States |
| CSE | Comprehensive sexuality education |
| CSO | civil society organization |
| EAC | East African Community |
| ECCAS | Economic Community of Central African States |
| ECOWAS | Economic Community of West African States |
| EEA | European Economic Area |
| EECAAC | Eastern Europe and Central Asia HIV/AIDS Conference |
| EEU | Eurasian Economic Union |
| ESCAP | Economic and Social Commission for Asia and the Pacific |
| EU | European Union |
| FP | family planning |
| GARPR | global AIDS Response Progress Reporting |
| GDP | gross domestic product |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GIPA | greater involvement of people living with HIV |
| HCV | hepatitis C virus |
| HTC | HIV testing and counselling |
| HTCG | Horizontal Technical Cooperation Group |
| IACHR | Inter-American Commission on Human Rights |
| IGAD | Intergovernmental Authority on Development |
| IP | intellectual property |
| LGBTI | lesbian, gay, bisexual, transsexual, transgender, and intersex people |
| MENA | Middle East and North Africa |
| MNCH | maternal, newborn and child health |
| NCDs | noncommunicable diseases |
| NEPAD | New Partnership for Africa's Development |
| NGO | nongovernmental organization |
| OAFLA | Organization of African First Ladies Against HIV/AIDS |
| OAS | Organization of American States |
| OIC | Organisation of Islamic Cooperation |
| OIF | International Organization of La Francophonie |
| PCB | Programme Coordinating Board of UNAIDS |
| PEP | post-exposure prophylaxis |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PLHIV | people living with HIV |

| | |
|---|---|
| PMTCT | prevention of mother-to-child transmission |
| PrEP | pre-exposure prophylaxis |
| RCM | Regional Coordination Mechanism |
| RedCA+ | Central American Network of People Living with HIV |
| REDLACTRANS | Latin American and Caribbean network of transgender people |
| REDTRASEX | Latin American and Caribbean Female Sex Workers Network |
| R&D | research and development |
| SAARC | South Asian Association for Regional Cooperation |
| SADC | Southern African Development Community |
| SCO | Shanghai Cooperation Organization |
| SDG | Sustainable Development Goals |
| SRH | sexual and reproductive health |
| SRHR | sexual and reproductive health and rights |
| STI | sexually transmitted infections |
| TB | tuberculosis |
| TRIPS | Agreement on Trade-Related Aspects of Intellectual Property Rights |
| UBRAF | Unified Budget, Results and Accountability Framework |
| UHC | universal health coverage |
| UNGASS | United Nations General Assembly Special Session |
| VMMC | voluntary medical male circumcision |
| WAHO | West African Health Organization |
| WTO | World Trade Organization |

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