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on HIV/AIDS and the Political Declarations on HIV and AIDS

On the Fast-Track to End the AIDS epidemic

Report of the Secretary-General

I. Introduction: robust progress provides solid foundation to Fast-Track

1. The global commitment to ending the AIDS epidemic, as affirmed in the 2030 Agenda for Sustainable Development, represents an unparalleled opportunity to end one of modern day's most devastating health challenges and also to build on the momentum of the AIDS response to accelerate results across the sustainable development agenda.

2. Even when confronted with the immense scale of the global AIDS epidemic, the response to HIV has never lost sight of the value and experience of each individual affected—their hopes and frustrations and their right to health and well-being. I have had the privilege of spending time with people engaged in the AIDS response, including people living with HIV. I have learned about their difficulties in getting access to the antiretroviral medicines that keep them alive and about the fear and stigma they live with each day. Many have also expressed their unwavering belief that we can end this epidemic. Their stories of courage and hope embody the resolve of all those involved in the AIDS response. Today, we can appreciate the remarkable progress we have made together, but also how far we have to go to ensure that no one is left behind.

3. The AIDS response has delivered more than results. It has delivered the aspiration and the practical foundation—the medical advancements, interventions and partnerships—to end the epidemic by 2030. All that truly remains—the missing link that will determine whether Fast-Track targets will be met or missed—is the political commitment to implement our proven tools adequately and equitably.

4. The AIDS response engages state and non-state actors, works across sectors, and tackles social drivers and human rights abuses. I am proud to see investments in the AIDS response do so much to drive the development of health systems, social protection and community resilience. I believe that the approaches and mechanisms pioneered by the AIDS response can serve to overcome systemic challenges that give rise to repeated disease outbreaks and new epidemics of chronic diseases, while building towards equitable Universal Health Coverage.

5. Yet AIDS is far from over. We cannot afford to lose in the AIDS response. The next five years present a narrow

window of opportunity to radically change the trajectory of the epidemic. Despite remarkable progress, if we accept the status quo unchanged, the epidemic will rebound in several low- and middle-income countries. More people will acquire HIV and die from AIDS-related illness in 2030 than in 2015. Treatment costs will rise sharply. Failure to control the AIDS epidemic will undermine efforts to end tuberculosis and reduce rates of maternal and child mortality, hepatitis C or cervical cancer. Our tremendous investment, and the world's most inspiring movement for the right to health, will have been in vain.

6. But this bleak future need not be ours. Today, ending the AIDS epidemic as a public health threat by 2030 is within our reach—if we Fast-Track the response by embracing ambitious targets for 2020 and increasing and front-loading investments. We must reinforce rights-based approaches, including those that foster gender equality and empower women. Access to services must be ensured for the people most affected, marginalized and discriminated against – including people living with HIV, young women and their sexual partners in sub-Saharan Africa, children and adolescents everywhere, and gay men and other men who have sex with men, sex workers and their clients, people who inject drugs, transgender people, people in prison, people with disabilities, migrants and refugees.

7. Ending AIDS requires meeting HIV and other health and social needs throughout a lifetime –when a person is at risk of acquiring HIV; when a person requires lifetime access to treatment and; when an individual, family or community may have to care for orphans and people living with HIV. Ending AIDS demands focusing resources in the countries, districts, sub-districts and city-boroughs most affected and tailoring services to populations at risk and communities living in fragile contexts. It requires people-centred innovation—from transforming and reinforcing community- and facility-based service delivery to developing more effective, affordable health products, including a vaccine and cure.

8. Punitive and discriminatory laws need to change. Stigma and discrimination and gender-based violence must be finally ended. Social and economic drivers of health, such as food and nutrition security, housing, education, employment and economic empowerment must be addressed. Doing so will demand new kinds of partnership that capitalize on the contributions of civil society, governments, regional political institutions, international organizations, academia, faith-based organizations and the private sector.

9. Through a Fast-Track, multi-sectoral response to AIDS, and more strategically using the machinery built by the response, considerable contributions to a range of Sustainable Development Goals (SDGs) will be made – including on poverty elimination, food and nutrition security, health, gender equality, decent work, reducing inequalities, cities, justice and inclusive institutions and partnership. To do so, I call on all partners to work together more coherently across political, cultural, religious and institutional divides. I urge the international community to support the UN in becoming fit to deliver on the 2030 Agenda, including by reinforcing and expanding on the unique multi-sector, multi-actor approach of the Joint United Nations Programme on HIV/AIDS (UNAIDS), as reaffirmed by ECOSOC in 2015[1].

10. The year 2015 marked the target date of the 2011 United Nations Political Declaration on HIV and AIDS as well as the Millennium Development Goals., This report provides a review of the 10 targets of the 2011 Political Declaration and, in the context of several SDGs, looks forward, highlighting areas of urgency and opportunity.

11. The UN General Assembly High-Level Meeting on Ending AIDS in June 2016 is a pivotal occasion to rally global commitment to the Fast-Track targets and actions for ending AIDS by 2030 outlined in the UNAIDS 2016-2021 Strategy. It provides the opportunity to build on the lessons learned from the AIDS response and to work with the people, institutions and networks that sustain it, to truly advance a paradigm shift to the integrated development approach envisioned by the SDGs. Together success can be achieved, measured by the assurance of people's health, human rights, dignity and ability to thrive over the long-term.

[1] Resolution E/RES/2015/2. Joint United Nations Programme on HIV/AIDS. New York: ECOSOC; 2015.

II. We must not let up: inspiring progress and addressing shortfalls in implementation of the 2011 Political Declaration

12. The 2011 Political Declaration on HIV and AIDS accelerated action worldwide by establishing ten ambitious targets for 2015. To monitor progress, countries embraced a stronger accountability framework supported by UNAIDS. This Global AIDS Response Progress Reporting system remains among the most innovative international development monitoring exercises through its inclusion of civil society assessments.

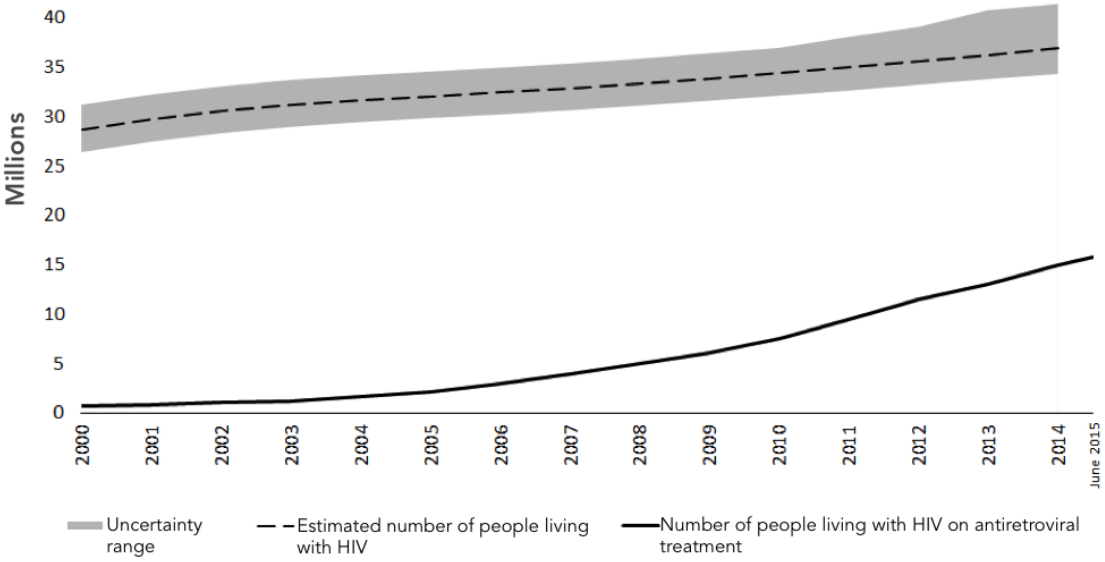
13. A review of progress reveals extraordinary achievements and stubborn challenges as well as lessons learned for wider development efforts (Annex 1 provides a summary for each target). The achievement of reaching 15 million people living with HIV with antiretroviral therapy nine months before the December 2015 deadline marks a major global victory (Figure 1). The rapid scale up in life-saving treatment has contributed to reducing AIDS-related deaths by 42% since 2004 and played a major role in sharply increasing life expectancy in countries with a high HIV burden.[2] The commitment of governments, civil society organizations, the US President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS and so many others has transformed an epidemic of despair and death into a response of health, hope and dignity.

2011 Political Declaration on HIV and AIDS: 10 targets

- Reduce sexual transmission of HIV by 50% by 2015
- Reduce transmission of HIV among people who inject drugs by 50% by 2015
- Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths
- Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
- Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries
- Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
- Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
- Eliminate HIV-related restrictions on entry, stay and residence
- Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems.
- Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015.

[2] UNAIDS, *How AIDS changed everything* (Geneva, July 2015).

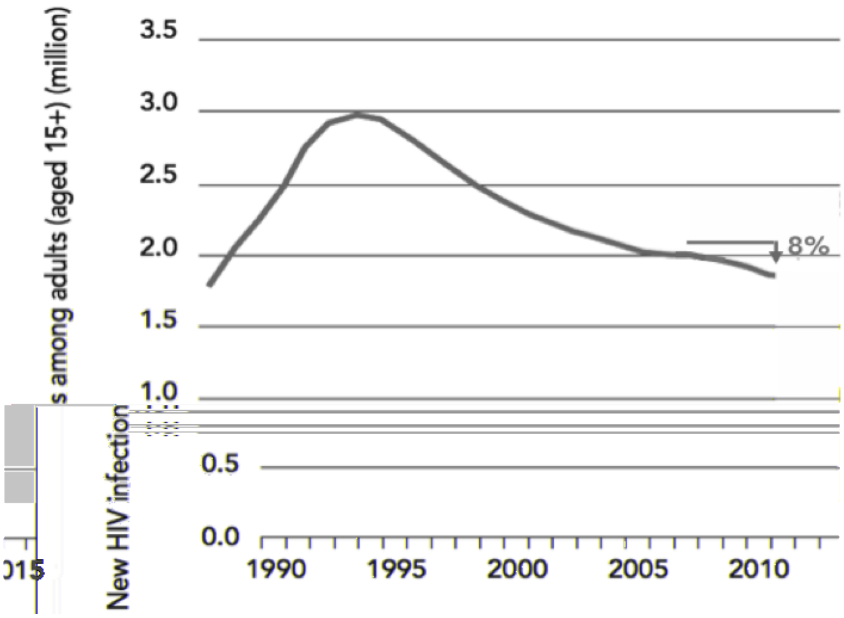
Fig. 1. Coverage of antiretroviral therapy among people living with HIV



14. The most significant gains in reversing the epidemic have been among infants. Launched at the 2011 UN General Assembly High-Level Meeting on HIV and AIDS, the *Global Plan towards the elimination of new HIV infections in children by 2015 and keeping their mothers alive* has guided unprecedented success. In just four years, new paediatric infections have been halved in the countries with 90% of global new HIV infections in children. In 2014, fewer than 500 children in the Caribbean and fewer than 2000 children across Latin America were newly infected with HIV. Globally, an estimated 85 countries are within reach of elimination, with fewer than 50 new infections among children each year. The number of women aged 15-49 dying from AIDS-related causes has declined by 35% since 2010.

15. The world made substantial gains in reducing the number of adults newly infected with HIV in the 10 years after the turn of the millennium. Yet progress is inadequate and slowing in many places, while new infections are rising in some areas. From 2010 to 2014, the annual number of young people and adults acquiring HIV fell by just 8% (Figure 2). Globally, the proportion of young people with accurate and comprehensive knowledge about HIV transmission has stagnated for the past 15 years, while condom promotion and distribution remain insufficient to meet young people's needs in much of sub-Saharan Africa. Even as new prevention tools and approaches have emerged, prevention programmes have weakened in recent years due to such factors as inadequate leadership, weak accountability and declining funding.

Figure 2. New HIV infections among adults (aged 15+) from 1990 to 2014



16. Although 90% of people newly infected with HIV live in just 35 countries, the HIV epidemic remains global, affecting every corner of the world and adding substantially to health burdens in many regions. Epidemic patterns, progress and challenges however vary considerably (Figure 4).

17. The AIDS epidemic continues to disproportionately affect sub-Saharan Africa, which is home to 26 million people living with HIV. In 2014, there were an estimated 1.4 million new HIV infections, approximately 66% of the global total. Adolescent girls and young women continue to experience elevated HIV risk and vulnerability. Of the 2.8 million young people aged 15–24 years living with HIV in sub-Saharan Africa in 2014, 63% were female.

18. The number of people newly infected in eastern Europe and central Asia rose by 30% from 2000 to 2014, largely among people who inject drugs. Along with the Middle East and North Africa, where new infections are concentrated among sex workers, men who have sex with men and people who inject drugs, these are the only two regions where new HIV infections have increased since 2000.

19. Following a marked reduction from 2000-2010, the number of people acquiring HIV has also increased slightly in Asia and the Pacific in the past few years, while cities in North America and western Europe face resurging epidemics. Gay men and other men who have sex with men, transgender people, sex workers and their clients, and people who inject drugs are at particularly high risk. In the United States, for example, if current trends persist, about 1 in 2 black men who have sex with men and 1 in 4 Latino men who have sex with men will be diagnosed with HIV during their lifetime.[3]

[3] Centers for Disease Control and Prevention, Half of black gay men and a quarter of Latino gay men projected to be diagnosed within their lifetime (Atlanta, 2016). Accessed: 15 March 2016. http://www.cdc.gov/nchhstp/newsroom/2016/croi-press-release-risk.html

20. Twenty-two million people living with HIV are not accessing antiretroviral therapy. Among children, access is appallingly low, with coverage ranging from a 54% in Latin America to 15% in the Middle East and North Africa in 2014. Treatment coverage among adults is lowest in the Middle East and North Africa at 14%. Countries such as Algeria and Oman however demonstrate that high rates of coverage are possible in the region – and as such I was encouraged to see the high level of ambition of the Arab AIDS Strategy (2014-2020) despite humanitarian and other crises besetting the region.

21. 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. Low coverage of early infant diagnostic screening remains a particularly grave challenge to scaling up paediatric treatment coverage.

22. Further, a substantial proportion of people on antiretroviral therapy struggle to adhere to their treatment and fail to achieve viral suppression. Countries of all income levels face challenges in supporting people living with HIV to achieve viral suppression: in the United Kingdom, 61% of people living with HIV are virally suppressed compared to 30% in the United States and sub-Saharan Africa.[4] Failure to fully address the needs of all people living with and at risk of HIV results in low percentages of people being diagnosed, retained in care and virally suppressed, with serious implications both for individuals and the public health. Closing treatment access gaps is further constrained by lack of data disaggregated by sex, age and population group. Weaknesses in the health and community systems – as exemplified by the Ebola outbreak in West Africa – are predictors of future challenges.

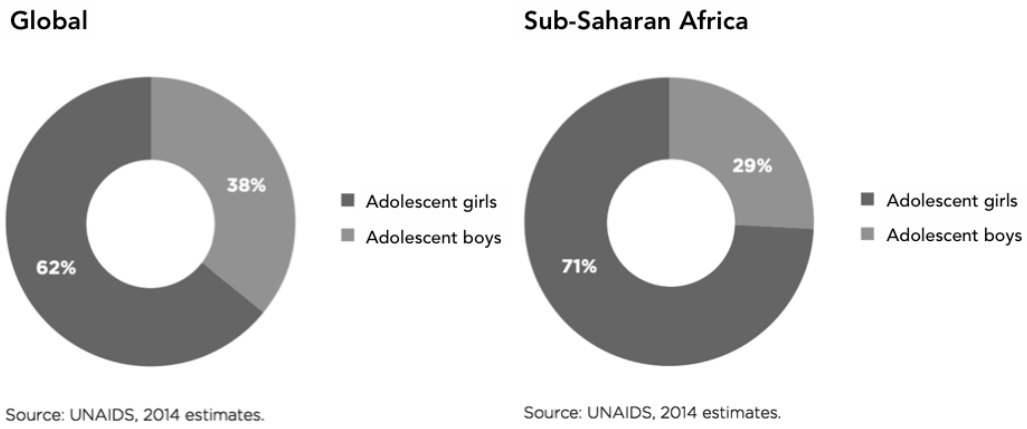
23. The AIDS response has strengthened health systems in many countries and made substantial gains towards integrating HIV and broader health services. Growing numbers of countries report facility-level integration of HIV and sexual and reproductive health services, as well as extensive integration of HIV counselling and testing services with those for non-communicable diseases. Countries report a high degree of integration between HIV and tuberculosis services. However, the number of people dying from HIV-associated tuberculosis declined by just 18% since 2010.[5]

24. Modest improvements have been made in reducing discriminatory attitudes towards people living with HIV and in shaping more enabling national laws and policies. I commend the recommendations outlined by the Global Commission on HIV and the Law, which have encouraged progress. The Inter-Parliamentary Union performs a critical function, as legislators, community leaders and overseers of government action, in supporting parliaments to unlock political obstacles to effective HIV responses. Yet the world remains far from eliminating punitive laws that perpetuate HIV-related stigma and discrimination.

25. Gender norms that perpetuate inequality continue to prevail across many societies, increasing HIV risk among both women and men. Everywhere, women and girls face discrimination and violence and, in some countries, harmful practices such as early and forced marriage and female genital mutilation. In 2014, 56% of all new infections among 15-24 year olds and 62% of new infections among 15-19 year olds were among girls and young women (Figure 3). AIDS remains the leading cause of death among women of reproductive age in Africa. The 2015 Political Declaration of the United Nations Commission on the Status of Women recognizes that no country has fully achieved equality for women and girls, and it pledges to strive for the full realization of gender equality and the empowerment of women and girls by 2030.

[4] UNAIDS, *How AIDS changed everything* (Geneva, July 2015).
[5] WHO, *Global Tuberculosis Report 2015* (Geneva, 2015).

Figure 3. Distribution of the 220,000 new HIV infections among adolescents aged 15-19 in 2014 by sex



26. The adoption of Security Council Resolution 1983 in 2011 increased international political attention and action towards ending conflict-related sexual and gender-based violence and empowering women to reduce their vulnerability to HIV. UNAIDS and the United Nations Department of Peacekeeping Operations are evaluating implementation of Resolution 1983 and will report on progress and make recommendations later this year.

27. The promotion of laws, policies and programmes that address human rights and fundamental freedoms has generated momentum for the eradication of stigma, discrimination, violence and exclusion faced by marginalized populations and enabled access to HIV-related services, as well as wider progress towards more inclusive societies. Strong progress in eliminating HIV-related travel restrictions is a concrete result in the difficult task of breaking down structural barriers to equality.

28. Progress has been driven by the achievement of the target to make US$ 22 to 24 billion available for the AIDS response for low- and middle-income countries by 2015. The principles of shared responsibility and global solidarity have guided resource mobilization efforts, exemplified by the African Union's implementation of its Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria. Critically, HIV programmes have become more efficient. From 2011 to 2014, HIV funding rose by 11%, and the number of people receiving antiretroviral therapy increased by 60%.[6]

29. With 58% of people living with HIV residing in middle-income countries, the recent decisions of many international partners to transition away from investing in middle-income countries after 2017 has major implications for ensuring continued service delivery and the survival of critical programmes. While governments are increasing domestic funding to AIDS responses, that increase does not often include increased investment in advocacy, human rights or programmes focused on key populations. In Eastern Europe and Central Asia, for example, national and local governments fund just 19% of programmes focused on key populations, with the remaining 81% funded by international partners.

30. Across the 10 targets, substantial progress provides powerful momentum for moving forward. Limited progress in several critical areas, however, threatens our ambition of ending the AIDS epidemic by 2030. A fragile five-year window of opportunity exists to address key challenges and Fast-Track the AIDS response.

[6] UNAIDS, *"15x15": a global target achieved,* (Geneva, 2015).

The importance of location and population
ASIA AND THE PACIFIC
LATIN AMERICA
NORTH AMERICA
WESTERN EUROPE
CARIBBEAN
MIDDLE EAST AND NORTH AFRICA
EASTERN AND SOUTHERN AFRICA
WESTERN AND CENTRAL AFRICA
EASTERN EUROPE AND CENTRAL ASIA
Young women and adolescent girls
Sex workers
People who inject drugs
Gay men and other men who have sex with men
Transgender people
Migrants
Prisoners
Displaced people
Pregnant women
People 50+
Disabled people
African-American women
Intimate partners

Figure 1.

III. On the Fast-Track: working across the sustainable development agenda to ensure no one left behind

31. Successful implementation of the SDGs will demand a rewrite of our approaches to development. As a set of universal and indivisible goals, the SDGs give all stakeholders a mandate to collaborate. The AIDS response provides a pathfinder for multi-sectoral, people-centred action across the full agenda.

32. Accelerating the response and addressing the holistic needs of people living with and at risk of HIV throughout their lifetime will require close collaboration with efforts to eliminate poverty, provide access to social protection for all, improve food and nutrition security and access to quality education, ensure good health, reduce inequalities, achieve gender equality, ensure decent work, and promote healthy cities and just and inclusive societies. Economic empowerment, social protection and comprehensive care and support help keep people living with and affected by HIV healthy, while integrated systems to deliver nutritional support and HIV services can enhance health outcomes. Completion of secondary education empowers young people, improves their socioeconomic status and reduces their risk of acquiring HIV. City-led AIDS responses strengthen health and social protection systems in reaching the most marginalized populations.

33. Quickening the pace of sustainable progress to end AIDS, poverty and inequality requires transformative shifts at community, district, country and regional levels. Such shifts include: enhancing an evidence- and rights-based, laser-like focus on locations, populations and interventions for greatest impact; investing in and enabling the leadership and engagement of civil society as a global public good; and, front-loading a diverse bundle of investments to deliver historic health and development gains and generate vast economic returns. Although the pace needs to quicken in all countries, focused and accelerated efforts are especially needed in 35 countries that together account for more than 90% of people acquiring HIV infection worldwide (Figure 5). Countries that account for 90% or more of regional epidemics are listed in Annex 1.

34. The UNAIDS 2016-2021 Strategy aims to guide global Fast-Track action. Adopted by the UNAIDS Programme Coordinating Board in October 2015, the Strategy is organized around five SDGs that represent the most strategic areas to enhance collaboration for shared impact. Collaborative priority areas of work, as presented below, are at the heart of the Fast-Track approach.

Figure 5. Thirty-five countries account for 90% of new HIV infections globally, 2014

Ensure healthy lives and promote well-being for all (SDG 3)

35. Ensuring healthy lives, including of people living with and affected by HIV, is essential to sustainable development. Achieving the 90–90–90 treatment target[7] 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 consistent with WHO 2015 guidelines, including through targeted testing strategies, adapting treatment services to reach different populations and settings, ensuring that people are offered treatment upon diagnosis, addressing socioeconomic barriers to care, providing support services to encourage adherence and regularly monitoring people on treatment.

36. Low treatment coverage among children must be rectified by ensuring early infant diagnostic services are accessible to all children exposed to HIV, and providing treatment to all children living with HIV. All services for HIV-exposed children need to be improved, including by expanding case-finding, adopting innovative systems that track and provide comprehensive services to mother-infant pairs through the continuum of care, increasing and improving adherence support for children and caregivers, and ensuring availability of the most efficacious antiretroviral formulations suitable for children.

[7] The 90-90-90 treatment target for 2020 calls for 90% of people living with HIV to know their status; 90% of people who know their HIV status to access treatment; and 90% of people on treatment to have suppressed viral loads.

37. Scaling up treatment will require countries to streamline the treatment modality and to complement facility-based services with an array of non-facility based approaches, while reinforcing systems to provide chronic disease care management. Enabling efficient scale-up requires expanding community-based HIV service delivery from a global average of 5% in 2013 up to 30% in 2030. 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.

38. The international community must urgently strengthen and sustain efforts to ensure all children can live free of HIV and their mothers are alive and well, with a focus on underperforming locations and women at risk of being left behind. Integrating services for elimination of mother-to-child HIV transmission into antenatal and postnatal care, and family planning services, will make services routinely available, while women's groups that provide psychosocial support have been shown to measurably reduce HIV-related mortality. Efforts to achieve dual elimination of HIV and congenital syphilis among children by integrating consent-based screening and treatment services for pregnant women are an especially cost-effective opportunity to reduce stillbirths and neonatal deaths. In partnership with the movement to implement the Global Strategy for Women's Children's and Adolescents' Health, the AIDS response must do more to enhance financing, strengthen policy and improve integrated services including for HIV, hepatitis, HPV and cervical cancer as well as emerging diseases such as Zika, for the most vulnerable women, adolescents and children. More attention needs to be paid to the needs of children orphaned by HIV and their carers.

39. Ending the AIDS epidemic is only possible if all people living with and affected by HIV can access affordable, quality health products. Innovation is required to enable access to point-of-care diagnostics and affordable, optimized prevention tools, including women-initiated technologies, and medicines including second- and third-line antiretroviral therapy regimens and for tuberculosis and hepatitis B and C, as well as a vaccine and cure. Recognizing that countries of all income levels struggle to provide access to affordable, quality medicines, vaccines and diagnostics, I have convened a High-Level Panel on Access to Medicines. The panel is mandated to assess and recommend solutions for remedying the policy incoherence between the rights of inventors, international human rights law, trade rules and public health and will deliver its final report in June 2016.

Achieve gender equality and empower women and girls (SDG 5)

40. Gender inequality and HIV are inextricably linked, and efforts to address their intersections should be radically and systematically scaled up. Ensuring gender equality enables people to prevent HIV, improves access to health services, education and employment and paves a path towards lives free of violence. Laws, policies and practices must uphold women's rights, including property and inheritance rights, protection against violence, and freedom from discrimination in education and the workplace, and support access to services by women and girls in all their diversity, especially those from the most vulnerable communities.

41. Protecting and promoting women's sexual and reproductive rights, including their right to make independent decisions on sexual activity, marriage, divorce and childbearing, is central to enabling women to prevent HIV. Recent evidence demonstrates the significant impact of providing a combination of cash transfers, school feeding and psychosocial support on empowering both adolescent girls and boys to reduce high-risk behaviour, as well as the impact of cash transfers on reducing unprotected sex and intimate partner violence.[8]

42. Multifaceted approaches to address the linkages between human rights, gender equality and HIV that involve men and women, boys and girls and engage diverse stakeholders have the greatest impact. The integration of violence prevention and HIV programming within existing development platforms, such as savings-led microfinance, social protection and education, greatly facilitates scalability and sustainability. Engaging men in HIV prevention efforts, both as sexual partners as well as people with their own needs, is critically important.

[8] UNAIDS 2016-2021 Strategy: On the Fast-Track to end AIDS. UNAIDS: Geneva, 2015.

Challenging notions of traditional masculinity requires men to engage as gender advocates and to take responsibility for transforming social norms, behaviour and gender stereotypes that perpetuate discrimination and inequality. Men and boys face gender-related vulnerability as well, including sexual violence, which should be addressed through gender-sensitive HIV services.

43. Sexual violence often becomes more pronounced in humanitarian emergencies when traditional protection systems are weakened. It is critical to leverage women's participation in peace-building, reduce women's and girl's vulnerability in these settings and ensure access to clinical care for survivors of sexual assault including psychosocial support and post-exposure prophylaxis to prevent HIV transmission.

44. 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; investments in organizations that advocate for gender equality, women's rights and empowerment should be scaled up; and grass-roots mobilizing and alliance-building with other social movements should be facilitated.

Reduce inequality in access to services and commodities (SDG 10)

45. Progress in the response will increasingly rely on promoting the right of all people, including young people, women and key populations, to access comprehensive HIV services without discrimination. Ensuring equitable access for sex workers, men who have sex with men, people who inject drugs, transgender people, prisoners as well as migrants, people affected by emergencies, homeless people and other people 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.

46. To scale up effective and rights-based combination prevention programmes, decision-makers must utilize national and sub-national epidemiologic, economic and social data to saturate high-transmission areas with a combination of interventions tailored to the needs of specific populations. Better focusing prevention programmes by population and location can increase prevention impact without increasing expenditure. This requires not only allocating resources to intensify programmes where they are needed most, but also reducing spending where programmes are needed less.

47. 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 intersectoral coordination, monitoring and mentoring of local programmes to reach high coverage, strengthened procurement and supply chain of prevention products, and effective communication around prevention, including through new and digital media. UNAIDS estimates that one quarter of global HIV investments should be allocated to prevention other than antiretroviral therapy, with the specific proportion varying from country to country.

48. Numerous effective prevention methods are available and must be increasingly accessible. Male and female condom and lubricant programming is highly effective in preventing sexual transmission of HIV, other sexually transmitted infections and unintended pregnancy. Voluntary medical male circumcision is providing significant protection for millions of young men in sub-Saharan Africa, reducing risk of HIV transmission by up to 60%.[9] Pre-exposure prophylaxis can be a game-changer for people at high risk of acquiring HIV. UNAIDS estimates that 20 billion condoms need to be made available in low and middle income countries, as well as pre-exposure prophylaxis for 3 million people by 2020. 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%. Comprehensive harm reduction services have proven to be highly effective in preventing HIV and other blood-borne diseases.

9 WHO, Fact-Sheet: Voluntary medical male circumcision for HIV prevention, July 2012.

49. We must ensure laws, policies and norms protect, rather than undermine, adolescents' and young people's sexual and reproductive health and rights. Age-of-consent laws must not prohibit young people from independently accessing comprehensive, youth-friendly HIV-related information and services. Comprehensive sexuality education is recognized as an appropriately age-sequenced, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information, and demonstrated to contribute to reducing HIV and other sexually transmitted infections and unintended pregnancy. In light of continued inadequate levels of knowledge about HIV transmission among young people, such education remains critical. Young people are clear in their demand for more and better comprehensive sexuality education and HIV-related services, including psychosocial and adherence support.

50. Ensuring equal access to HIV services further depends on continuing 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 people living with HIV, women, young people and key populations) must be free to self-organize and empowered financially and politically to serve as advocates, accountability watchdogs and full partners.

Promote just, peaceful and inclusive societies (SDG 16)

51. The 2030 Agenda for Sustainable Development provides an unprecedented imperative and opportunity to expand rights-based HIV responses and strengthen links with human rights, social justice and rule-of-law movements. Existing legal obligations and political commitments for human rights and gender equality must be translated into concrete strategies, programmes and actions. Leadership at all levels and across sectors must rise to the occasion – executive branches, members of parliament, the judiciary, and religious, community and health-care leaders are critical to advancing social justice.

52. Discriminatory and punitive laws, policies and practices that block access – particularly for people living with HIV, key populations, young people and people in humanitarian settings – must be immediately and irrevocably removed. Hate crimes and all violence perpetrated against key populations, including people of diverse sexual and gender orientation, must be ended.

53. Misuse of criminal law often negatively impacts health and violates human rights. Overly broad criminalization of HIV exposure, non-disclosure and transmission is contrary to internationally accepted public health recommendations and human rights principles. Criminalization of adult consensual sexual relations is a human rights violation, and legalization can reduce vulnerability to HIV infection and improve treatment access. Decriminalizing possession and use of injecting drugs and developing laws and policies that allow comprehensive harm reduction services have been shown to reduce HIV transmission. Similarly, decriminalization of sex work can reduce violence, harassment and HIV risk.Sex workers should enjoy human rights protections guaranteed to all individuals, including the rights to non-discrimination, health, security and safety.

54. Migrants, refugees and asylum-seekers living with HIV face significant discrimination as some states restrict the entry of or forcibly return people living with HIV. In a number of countries, migrants, refugees and asylum-seekers are subjected to mandatory HIV testing without counselling or guarantees for privacy. Providing voluntary HIV and sexual and reproductive health services to migrants and persons affected by humanitarian emergencies is firmly rooted in international humanitarian and human rights laws, policies and medical ethics.

55. Around the world, neglect and discrimination in all their forms place people with disabilities at risk of HIV infection. Common misperceptions affecting public health planning include the belief that people with disabilities are sexually inactive or unlikely to use drugs or alcohol. As a result, people with disabilities are often neglected in

HIV policy planning as well as wider health-care provisioning. This gap must be redressed, including by improving disability data collection.

56. We must protect the right of all people to access justice and challenge human rights violations, such as discrimination and denial of services in all settings, including employment, health and education. Investments must be scaled up in human rights programmes that restore dignity and improve health outcomes such as law and policy reform, reduction of stigma and discrimination, reduction of gender discrimination and inequalities, legal literacy, availability and accessibility of legal services and sensitization of law makers, law enforcement agents and health-care workers.

57. Human rights and ethics training for health care providers must be scaled up, both to ensure that providers know their own rights to health, and to empower providers with the skills and tools necessary to ensure patients' rights to informed consent for all health services, confidentiality and non-discrimination are upheld.

58. Efforts must be expanded to eliminate HIV-related workplace discrimination, applying relevant international labour standards, and to optimize workplace programmes to ensure all employees have access to voluntary HIV testing and counselling, linkages to care and guarantees of continued 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.

Revitalize the partnership for sustainable development (SDG 17)

59. The integrated and indivisible nature of the SDGs demands that all health and development efforts embrace innovative means of implementation, building on principles of partnership, cross-sector collaboration and solidarity. Multistakeholder partnerships and issue-based coalitions, including those within the UN system such as UNAIDS, that engage governments, civil society, faith communities, the private sector, the scientific community, academia, foundations and local authorities will be critical to progress across the SDGs.

60. We cannot end the AIDS epidemic without increasing and front-loading diversified resources. The Fast-Track approach will require reaching a peak investment of US$ 7.4, 8.2 and 10.5 billion in low-, lower-middle- and upper-middle-income countries respectively by 2020 (Table 1). Implementation of a fully funded global AIDS response in all countries will avert 17.6 million new infections and 11 million premature deaths between 2016 and 2030 in low- and middle-income countries.

61. There is a perception that global solidarity for AIDS has reached its limits. This is far from true. Many countries have the ability to invest much more than they currently do. Among high-income countries, only four invest a share of the total international resources available for AIDS that exceeds their country's proportion of world GDP. Of urgent concern, the international community must ensure that resource needs of US$13 billion are mobilized for the Global Fund's Fifth Replenishment. By leveraging advances in science and applying innovative solutions, the partnership is on track to reach 22 million lives saved since its establishment by the end of 2016. A fully funded Replenishment will save an additional 8 million lives by 2020, and deliver economic gains of up to US$290 billion over the coming years.

Table 1. Annual Fast-Track resource needs low- and middle-income countries by 2020, by income level*

	Resources available in 2014	Target for 2020**
Low-income countries* **	**US$ 5.5 billion**	**US$ 7.4 billion**
Domestic Public	US$ 0.2 billion	US$ 0.9 billion
International	US$ 4.7 billion	US$ 6.5 billion
Lower-middle-income countries* **	**US$ 4.3 billion**	**US$ 8.0 billion**
Domestic Public	US$ 0.7 billion	US$ 3.7 billion
International	US$ 2.6 billion	US$ 4.5 billion
Upper-middle-income countries* **	**US$ 9.4 billion**	**US$ 10.5 billion**
Domestic Public	US$ 7.6 billion	US$ 10.0 billion
International	US$ 1.4 billion	US$ 0.5 billion
Total resource needs in LMICs* **	**US$ 19.2 billion**	**US$ 26.2 billion**
Domestic Public	US$ 8.6 billion	US$ 14.6 billion
International	US$ 8.8 billion	US$ 11.6 billion

* Using World Bank 2015 IL classification thus not including countries now classified as high income; the 2014 resource availability was adjusted for the countries remaining low or middle income from 2016-2020.

** Resource estimates for 2020 are produced for all low- and middle-income countries, using country-specific inputs or estimates for each country, and assume reallocation of existing resources for more efficient responses according to location and population and adoption of streamlined ART care service modalities.

***Includes domestic private, mainly out-of-pocket expenditures.

62. Low- and middle-income countries will need to significantly increase domestic funding according to their capacity and burden of disease. Countries are encouraged to develop sustainability transition plans and compacts that outline domestic and international commitments in support of national costed plans with country-owned targets, as well as expand co-financing approaches. 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 also essential.

63. Efficiency gains will further help ensure fiscal space for AIDS. Most countries need to scale up quality health services, streamline care models according to the most recent antiretroviral therapy guidelines, reduce waste and inefficiency and reduce costs of health products by, inter alia, expanding community service delivery and promoting competition among product 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. Partnerships among governments, communities of people living with HIV and generic and originator pharmaceutical companies should be expanded. More efficient responses will also rely on: 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 least-developed countries; and accelerating the entry of innovative products into the market, including by simplifying and strengthening health regulatory procedures.

64. Delivery of innovative products must be further encouraged through scaled up investments in 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 a cure.

65. Adopting newer prevention tools, diagnostics, treatment regimens, and viral load tests with lower production costs will be key to achieving major savings. 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.

66. More efficient responses will rely on better use of implementation science to collect continuous and quality evidence on what approaches work best in particular contexts. This can be supported by practical country-level evaluations, as called for in UNGA resolution 69/237s.

67. People-centred systems for health will need to be strengthened by rolling out universal health coverage and social protection programmes for people living with HIV, women and girls, vulnerable families, caregivers and key populations. Countries will need to reinforce procurement and supply chain systems to prevent health product stock-outs, and human resources to deliver integrated health and HIV services. Integrated services should address co-infections and co-morbidities such as hepatitis as well as pain management, mental health and sexual and reproductive health, including sexually transmitted infections, cervical cancer and care for survivors of sexual assault. Access to prevention, diagnosis and care of HIV-associated tuberculosis should be increased through joint programming, patient-centred integration and co-location of HIV and tuberculosis 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 progressive diseases, including non-communicable diseases.

IV. Towards more meaningful measures: From global to regional and national targets and enhanced monitoring for accountability to people

Global Fast-Track Targets

68. In the first half of 2015, ECOSOC, the UNAIDS Programme Coordinating Board and the UNAIDS-Lancet Commission on Defeating AIDS—Advancing Global Health concluded that a major acceleration and front-loading of investments and efforts is required to end the AIDS epidemic by 2030. Fast-Track targets, based on modelling to identify the rate of progress necessary by 2020, were adopted by the UNAIDS Programme Coordinating Board in October 2015 (Figure 6).

Figure 6. UNAIDS 2016-2021 Strategy Fast-Track targets for 2020

69. To scale-up and monitor collaboration across HIV and health issues, stakeholders are further encouraged to adopt medium-term targets on related health challenges on the journey towards 2030, such as:

- By 2020, reduce by 30% new cases of chronic viral hepatitis B and C infections and reach 3 million people with hepatitis C virus treatment[10]

- By 2020, 70% of countries have at least 95% of pregnant women screened for syphilis; 95% of pregnant women screened for HIV and 90% of pregnant women living with HIV receiving effective treatment[11]

- By 2020, screen every woman living with HIV, in care, for cervical cancer[12]

[10] WHO, Draft global health sector strategies on viral hepatitis, 2016–2021.

[11] WHO, Draft global health sector strategy on sexually transmitted infections, 2016– 2021

12 WHO, Guidelines for Screening and Treatment of Pre-Cancerous Lesions for Cervical Cancer Prevention, 2014

- By 2020, expand access to family planning information, services, and supplies to an additional 120 million women and girls in 69 priority countries[13]

- By 2020, reduce the number of tuberculosis deaths among people living with HIV by 75%[14]

- By 2025, achieve a 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases[15]

- By 2025, reach an 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities[16]

Regional Fast-Track Targets

70. The different epidemic patterns across regions of the world provide the rationale and opportunity for regional approaches to Fast-Track the AIDS response. Regional leadership and engagement plays an increasingly critical role in development as an effective link between the global and national levels and as a source of political leadership, knowledge-sharing, technical and financial support, and peer-led accountability. To generate regional political commitment and accountability, I encourage all regions of the world to adopt Fast-Track targets for 2020 tailored to the epidemic settings of their regions. Annex 1 presents a table to encourage and support regional target-setting.

[13] Family Planning 2020 (global partnership hosted by the UN Foundation and core partner of the UN Secretary-General's movement for women and children's health, Every Woman Every Child).

[14] WHO, Draft global health sector strategy on HIV, 2016-2021.

[15] From the WHO Global monitoring framework on NCDs, which tracks implementation of the NCD Global Action Plan through monitoring and reporting on the attainment of the 9 global targets for NCDs, by 2025, against a baseline in 2010

[16] WHO Global monitoring framework on NCDs.

Table 2a. Towards regional targets for new HIV infections: adults (aged 15+)[17]

Region	People acquiring HIV, 2010		2020 target: 75% reduction
TOTAL	2 000 000		500 000
ASIA AND THE PACIFIC	280 000		88 000
	Women: 93 000	Men: 180 000	
EASTERN AND SOUTHERN AFRICA	990 000		
	Women 15-24: 240 000 25+: 310 000		
LATIN AMERICA & THE CARIBBEAN	98 000		
	Women: 32 000	Men: 66 000	
MIDDLE EAST AND NORTH AFRICA	19 000		5200
	Women: 5800	Men: 13 000	
WESTERN AND CENTRAL AFRICA	360 000		67 000
	Women 15-24: 80 000 25+: 130 000	Men: 160 000	
WESTERN AND CENTRAL EUROPE &	86 000		53 000

[17] Please note that the numbers in this and other tables in this report represent the median in a range. For further information on the range, please contact UNAIDS.

Table 2b. Towards regional targets for treatment coverage: adults (aged 15+)

Region	People on treatment (% coverage), 2014		2020 target
TOTAL	14 100 000		27 900 000
ASIA AND THE PACIFIC	1 700 000		4 100 000
	Women: 740 000 (43%)	Men: 980 000 (32%)	
EASTERN EUROPE AND CENTRAL ASIA	270 000		1 400 000
	Women: 110 000 (19%)	Men: 150 000 (17%)	
EASTERN AND SOUTHERN AFRICA	8 500 000		14 100 000
	Women: 5 400 000 (52%)	Men: 3 100 000 (42%)	
LATIN AMERICA & THE CARIBBEAN	890 000		1 600 000
	Women: 330 000 (49%)	Men: 560 000 (45%)	
MIDDLE EAST AND NORTH AFRICA	30 000		210 000
	Women: 13 000 (18%)	Men: 17 000 (12%)	
WESTERN AND CENTRAL AFRICA	[1 500 000 –]		[4 500 000]
	Women: 1 100 000 (31%)	Men: 460 000 (19%)	
WESTERN AND CENTRAL EUROPE & NORTH AMERICA	[810 000 – 1 500 000]		2 000 000
	Women: [180 000 – 330 000]	Men: [630 000 – 1 200 000]	

Table 2c. Towards regional targets for new HIV infections and treatment coverage: children aged 0-15[18]

Region	Children acquiring HIV		Children living with HIV on ART	
	[illegible]	[illegible]	[illegible]	[illegible]
TOTAL	360 000	20 000	820 000	1 200 000
ASIA AND THE PACIFIC	26 000	2000	73 000 (35%)	95 000
EASTERN EUROPE AND CENTRAL ASIA	1900	<500	14 000 (83%)	7600
EASTERN AND SOUTHERN AFRICA	200 000	10 000	600 000 (38%)	690 000
LATIN AMERICA AND THE CARIBBEAN	4900	<500	23 000 (54%)	17 000
MIDDLE EAST AND NORTH AFRICA	2300	<500	2000 (15%)	8000
WESTERN AND CENTRAL AFRICA	130 000	6000	93 000 (13%)	340 000
WESTERN AND CENTRAL EUROPE & NORTH AMERICA	<500	<500	[2500 – 7500]	1300

V. Embracing sustainable development solutions to Fast-Track an accelerated, rights-based AIDS response: Recommendations

71. Our commitment to ending the AIDS epidemic by 2030 demands that we collectively Fast-Track the response and embrace the opportunities inherent in the 2030 Agenda. Accelerating shared progress that builds on solid achievements, tackles the poverty and inequality that blight our planet and ensures no one is left behind requires joint action by countries, people living with and affected by HIV, civil society, development partners, the United Nations system, the private sector, and other key partners.

72. To guide progress, countries are encouraged to embrace the Fast-Track goals for 2020 of reducing the numbers of people newly infected with HIV and people dying from AIDS-related causes, respectively, to fewer than 500,000 per annum, as well as eliminating HIV-related discrimination. The upcoming UN General Assembly High-Level Meeting on Ending AIDS provides a critical opportunity to set ambitious quantitative global targets in support of these goals, drawing on those proposed in the UNAIDS 2016-2021 Strategy. I urge countries to ensure high-level and diverse participation in the meeting. To encourage leadership and results at all levels, targets should subsequently be regionally disaggregated and inform country targets tailored to national circumstances.

73. To promote accountability, follow-up and review of progress towards Fast-Track goals and targets must be inclusive, participatory and transparent. I call on UNAIDS to provide continued leadership on regular country-led evaluation of progress and annual reporting on the AIDS response to inform the General Assembly and the High-Level Political Forum. To complement reporting at the global level, regular regional peer-based reviews that engage health and non-health ministries, city/local leaders and civil society will be critical. Looking forward, member states should consider a High-Level Meeting on AIDS and the SDGs in 2022 to review progress on the

[18] Targets for 2020 were derived from a 2016 update of the Fast-Track modelling, implementing coverage targets contained in the UNAIDS strategy, the most recent WHO guidelines, and additional new evidence.

social, economic and political dimensions of Fast-Track AIDS responses, and on contributions to progress across the 2030 Agenda.

74. The AIDS response remains a source of innovation and inspiration, demonstrating what is possible by uniting the power of science, community activism and political leadership. From the grassroots to the global level, the response has developed a machinery to address AIDS in all its dimensions. This machinery engages state and non-state actors, works across sectors, and tackles social drivers and human rights abuses. It is unique to global health and must be better utilized as we rise to meet the challenges presented by repeated disease outbreaks and new epidemics of chronic diseases, while building towards equitable Universal Health Coverage. I further encourage the international community to consider and recognize the value of a comprehensive Framework Convention on Global Health.

75. Continued progress in the AIDS response inspires faith that the SDGs are within reach. By leveraging momentum and pursuing the synergies between the AIDS response and the 2030 Agenda, we can end the AIDS epidemic as a public health threat by 2030 as well as accelerate progress across a range of SDGs in a virtuous cycle. As we endeavour towards these aims, I encourage member states, and all stakeholders, to urgently implement the following recommendations:

1. **Front-load investments reaching US$ 7.4, 8.2 and 10.5 billion for the AIDS response in low-income, lower-middle-income and upper-middle-income countries respectively in 2020, including through a successful fifth replenishment of the Global Fund,** guided by financial sustainability compacts that outline predictable domestic, international and private commitments in support of national costed plans;

2. **Reach the '90-90-90' testing and treatment target in all countries and among all populations** – ensuring 28 million adults and 1.2 million children living with HIV on treatment by 2020

3. **Eliminate new HIV infections among children and keep mothers healthy,** reaching fewer than 20 000 new HIV infections among children by 2020, by integrating HIV and sexual and reproductive health services, ensuring that antiretroviral treatment is accessible to all pregnant and breastfeeding women living with HIV and engaging male partners in HIV prevention while strengthening links to holistic and adaptable child development efforts;

4. **Scale up and adequately resource HIV combination prevention programmes, that include access to condoms, pre-exposure prophylaxis, voluntary male medical circumcision, harm reduction and comprehensive sexuality education, tailored to populations, locations and interventions for maximum impact**, ensuring at least one quarter of AIDS resources are allocated to prevention depending on country context, with particular attention to engaging adolescent and young women, sex workers and their clients, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, people with disabilities and emergency- and conflict-affected populations, and realize the sexual and reproductive health and rights of everyone;

5. **Reduce the number of young women newly infected with HIV each year to 100 000 by 2020, by advancing gender equality, ending gender-based violence and empowering women and girls**, including by working to eliminate discriminatory laws and gender norms that perpetuate the unequal status of women and girls, and implementing strategies that promote an enabling environment for the social, political and economic empowerment of women, including through the engagement of boys and men;

6. **Leave no one behind and ensure access to services by removing punitive laws, policies and practices that violate human rights**, including criminalization of same-sex sexual relations, diverse genders and sexual orientations, drug use and sex work, broad criminalization of HIV non-disclosure, exposure and transmission, HIV-related travel restrictions and mandatory testing, age of consent laws that restrict adolescents' right to health care, and all forms violence against key populations;

7. **Invest in community-led service delivery, human resources for health, and universal health coverage to strengthen people-centred service delivery,** including by integrating services for HIV, TB, sexual and reproductive health, cervical cancer and other NCDs, hepatitis, drug use disorders and food and nutrition support, in order to meet the lifetime healthcare needs of people in ways that are acceptable to them;

8. **Scale up financing to address the social and structural drivers of HIV that have multiple development outcomes,** including education, non-discriminatory and HIV-sensitive social protection and promotion of human rights, and use the apparatus of the AIDS response to address other health- security and humanitarian emergencies;

9. **Ramp up investments in the advocacy and leadership role of people living with and affected by HIV, young people, women and of civil society** to legitimately represent the interests of all fragile communities, drive ambition, financing and equity in the AIDS response, as part of a broader effort to ensure up to 6% of all global AIDS resources are allocated for social enablers, including advocacy, political mobilization, law and policy reform, public communication and stigma reduction;

10. **Boldly pursue new scientific solutions and expand investment in research and development for improved diagnostics, easier and more tolerable treatment regimens, therapeutic vaccines and other prevention technologies as well as a functional cure** and ensure affordability by aligning trade rules and public health objectives under a human rights framework;

11. **Ensure the UN is able to deliver results on the 2030 Agenda by reinforcing and expanding the unique multi-sector, multi-stakeholder approach of the UNAIDS Joint Programme** to strategic coherence, coordination, results-based focus and inclusive governance in the AIDS response for country-level impact on health, human rights and sustainable development.

Annex 1.

Table A: Ten targets for 2015: progress and remaining challenges

From UNAIDS' Ten targets: 2011 United Nations Political Declaration on HIV and AIDS – Global progress and lessons learned, 2011–2015

Progress achieved	Factors contributing to progress	Persistent challenges
Reach 15 million people living with HIV with ART		
Target achieved. ART accessed by 15.8 million people by June 2015.	Expansion of HIV testing, especially in sub-Saharan Africa. Increased access to affordable medicines and diagnostics. Simplified, standardized and well-tolerated treatment regimens (with global and national guidelines). Innovative service delivery, such as community-based service delivery and adherence clubs.	Stigma and discrimination undermine efforts. Nearly half of people living with HIV do not know their HIV status, and nearly 60% are not accessing ART. Disproportionately low ART access among children compared to adults. Many people start treatment late, and a substantial proportion struggle to overcome social and structural barriers to remain in care. Only a minority of people living with HIV achieve viral suppression.
Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22 billion to US$ 24 billion in low- and middle-income countries		
Target largely achieved. An estimated US$ 21.7 billion was available for HIV programmes in low- and middle-income countries in 2015.	Domestic HIV investment nearly tripled from 2006 to 2014, with domestic sources accounting for 57% of all resources in 2014. International HIV assistance rose from US$ 7.9 billion in 2010 to US$ 8.8 billion in 2014. Efficiency gains have enhanced the impact of finite HIV funding.	Most countries have yet to mobilize domestic resources commensurate with national wealth and burden of HIV. Several high-income countries' HIV assistance is below their share of the global economy. Allocative and programmatic efficiency are suboptimal, including limited resources focused on populations with highest burden of disease.
Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths		
Substantial progress. 220 000 children acquired HIV in 2014 – 45% lower than in 2009. Since 2010, the number of women age15-49	Greater provision of more efficacious ARVs to pregnant women living with HIV, including increased coverage of treatment among women living with HIV before they became pregnant and	Primary prevention for women of reproductive-age and access to family planning inadequate. Weak implementation of WHO

Progress achieved	Factors contributing to progress	Persistent challenges
dying from AIDS-related causes declined by 35%.	policy change in many countries to maintain pregnant women on lifelong ART. The proportion of children living with HIV who receive ART more than doubled, from 14% in 2010 to 32% in 2014.	recommended 4 ANC visits and recommended 13 interventions. Low early infant diagnosis impedes access to ART for children living with HIV, while lack of care and support undermines adherence. In 2014, only 49% of HIV-exposed children in 21 priority countries in Africa received diagnostic screening within the first two months of life.
Eliminate HIV-related restrictions on entry, stay and residence		
Important gains. 14 countries either repealed restrictions or officially clarified that their national travel policies do not discriminate based on HIV status, reducing the number of countries with such restrictions to 35.	Corporate leaders promoted the business case for non-discrimination, citing their need to send well-qualified employees overseas without regard to their HIV status.	Discriminatory laws and policies continue to restrict movement of people living with HIV and result in substantial harm and denial of HIV services. They reinforce unfounded beliefs that migrants increase HIV-related risks for host communities and hamper solidarity and compassion.

Progress achieved	Factors contributing to progress	Persistent challenges
Reduce tuberculosis deaths among people living with HIV by 50% by 2015		
Important gains. The number of people dying from HIV-associated TB fell from 570 000 in 2004 to 390 000 in 2014. However, the reduction in TB-related deaths among people living with HIV in 2014 was just 18% lower than in 2010.	In 2014, ~ 7 million people enrolled in HIV care within reporting countries were screened for TB, up from 2.3 million in 2010. The proportion of TB patients aware of their HIV status rose from 33% to 51%, and coverage of ART rose from a few thousand in 2004 to 392 000 in 2014. The number of people living with HIV receiving isoniazid preventive therapy to treat TB infection reached 933 000 in 2014, an increase of ~ 60% from 2013.	TB remains the leading cause of death among people living with HIV, accounting for one third of all AIDS-related deaths in 2014. Coverage of essential prevention, diagnosis and treatment tools remains suboptimal. Only one in three people living with HIV and contracted TB in 2014 received antiretroviral therapy. Separate TB and HIV planning and programming continue to hamper access to integrated services and a continuum of care. Emergence of multidrug resistant strains of TB in some countries.
Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts as well as to strengthen social protection systems		

Progress achieved	Factors contributing to progress	Persistent challenges
Important gains. More than 90% of countries reporting at the end of 2014 stated that HIV had been mainstreamed into broader development frameworks, and 70% were on track to achieve national integration commitments.	Integration between HIV counselling and testing and TB services in 90% of reporting countries, with more than half reporting joint HIV and TB screening and treatment services. Two thirds of countries reported facility-level integration of HIV and SRH services; 33 countries reported integration of HIV and NCD counselling and testing services. HIV integrated into comprehensive services for people who use drugs.	The holistic needs of key populations and young people remain insufficiently addressed.
Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV		
Some progress. National policy frameworks increasingly recognize the centrality of gender issues to the AIDS response. However, persistent gender inequalities and gender-based violence place women and girls at higher risk.	More countries have removed policies that discriminate against women and implemented measures to address gender-based violence. Significant gains have been made in girls' school enrolment, and women's participation in the labour force has risen in some regions.	Many women and girls are unable to negotiate safer sex. Continuing absence of women-initiated prevention methods. Globally, 35% of women have experienced physical or sexual violence, which is linked with women's increased vulnerability to HIV. Girls and young women continue to confront considerable impediments to education. In sub-Saharan Africa, men are less likely to seek an HIV test, less likely to enrol in HIV treatment and more likely to interrupt treatment. Harmful use of alcohol contributes to gender-based violence.

Progress achieved	Factors contributing to progress	Persistent challenges
Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms		
Some progress. There is a general decline in discriminatory attitudes towards people living with HIV. However, in about 40% of countries where surveys have been conducted, more than half of adults reported	Legal and rights literacy programmes and legal services are effective in empowering people and protecting their rights. Among 74 countries in 2014, 64% reported laws in place prohibiting discrimination against people living with HIV. Anti-discrimination measures for	Punitive legal and policy frameworks continue to hold back the response. Thirty per cent of countries report having laws, regulations or policies that impede effective HIV prevention, treatment, care and support for men who have sex with men, people who inject drugs, sex workers and transgender people. Overly broad criminalization of

Progress achieved	Factors contributing to progress	Persistent challenges
discriminatory attitudes towards people living with HIV.	sex workers, migrants, women, prisoners and young people have increased. From 2006 to 2015, countries criminalizing same-sex sexual acts fell from 92 to 75.	HIV transmission exists in 61 countries.
Reduce sexual transmission of HIV by 50% by 2015		
Slow progress. From 2010 to 2014, the annual number of people (aged 15+) newly infected worldwide fell by just 8%.	Modest scale-up in effective prevention programmes for young people and key populations. Voluntary medical male circumcision performed on more than 10 million men in sub-Saharan Africa by end of 2015. Increasing ART coverage contributes to reducing onward transmission. ARVs as pre-exposure prophylaxis shown to be effective prevention tools. Social protection reduces adolescent risk behaviour fivefold.	Evidence-informed and rights-based combination prevention frameworks remain inadequately implemented and rarely brought to scale. Efforts to promote safer behaviours have struggled, condom promotion remains inadequate, and barriers to key populations' access to services persist. Prevention investments have stagnated or declined.
Reduce transmission of HIV among people who inject drugs by 50% by 2015		
Mixed progress. HIV infections among people who inject drugs has not declined since 2010-. While some countries have seen a reduction, others have seen an increase.	Modest global increase in coverage for some harm reduction components such as syringes and needles distributed per person who injects drugs.	Coverage of highly effective harm reduction programmes remains insufficient. In 2014, 79 of 192 reporting countries provided OST, and 55 offered NSPs. Marginalization and criminalization of people who inject drugs hamper access to HIV services. Gender-based stigma and discrimination often acts as an additional barrier for women who inject drugs.

Table B. Epidemics by region: countries that account for 90% of people acquiring HIV in each region, 2014

	Number of new HIV infections, 2014
Asia and the Pacific	**290 000 (210,000-410,000)**
India	89 000
Indonesia	69 000
China	...
Pakistan	20 000
Viet Nam	15 000
Myanmar	8700
Caribbean	**13 000 (9,600-17,000)**
Haiti	6800
Dominican Republic	2400
Cuba	2100
Jamaica	1500
Eastern Europe and central Asia	**140 000 (110,000-160,000)**
Russian Federation	110 000
Ukraine	...
Latin America	**87 000 (70,000-100,000)**
Brazil	...
Mexico	7500
Colombia	6500
Argentina	6400
Guatemala	2900
Chile	2400
Peru	2300
Paraguay	1900
Middle East and North Africa	**22 000 (13,000-33,000)**
Iran (Islamic Republic of)	7400
Sudan	5200
	3300
Morocco	2000
Egypt	
Algeria	1000

Congo	
Cote d'Ivoire	25 000
Chad	14 000
Mali	12 000
Ghana	11 000
Central African Republic	8200
Guinea	7200
Eastern and southern Africa	**940 000 (860,000-1,000,000)**
South Africa	340 000
Uganda	100 000
Mozambique	88 000
Zimbabwe	64 000
United Republic of Tanzania	62 000
Kenya	56 000
Zambia	56 000
Malawi	42 000
Angola	26 000
Ethiopia	...
Western and central Europe and North America	**85 000 (48,000-130,000)**
United States of America	...
United Kingdom	...
France	...
Italy	...
Germany	...
Spain	...
Canada	...
Portugal	...
Turkey	...
Belgium	...
Greece	...