

ten targets: 2011 United Nations Political Declaration on HIV and AIDS

Global progress and lessons learned, 2011–2015



Achieve, by 2015, universal access to HIV prevention, treatment, care and support

2011 United Nations Political Declaration on HIV and AIDS

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Foreword

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UNAIDS Executive Director

In 1982, when AIDS was first described, no one imagined the global impact it would have. To date, the AIDS epidemic has claimed the lives of an estimated 34 million people, mostly adults in their prime. AIDS reversed many hard-won gains in global health and development, leading to dramatic falls in life expectancy in many low- and middle-income countries.

However, the world's response to the AIDS epidemic has been remarkable, with mass mobilization of affected communities, activists, politicians, scientists, health-care workers, donors and people from all walks of life that would drive unprecedented social change, scientific innovation and global investment to mitigate the impact of HIV. Global solidarity behind the AIDS movement encouraged accelerated research and development of effective and affordable ways to diagnose, prevent and treat HIV. Furthermore, it stimulated the will to find and fund equitable and human rights-based solutions to the social, behavioural and biological factors that put people at risk of HIV.

In 2001, the threat that AIDS posed to global health, economies and security led to the United Nations General Assembly calling an exceptional special session focusing only on the AIDS response, which resulted in the adoption of the first Declaration of Commitment on HIV/AIDS "Global Crisis – Global Action". This declaration consolidated the global AIDS community behind a series of clearly defined commitments for the following five years. Progress against those commitments has been reviewed and revised by the United Nations General Assembly, which committed to achieving universal access to HIV prevention, treatment, care and support in its 2006 Political Declaration.

At the 2011 High-Level Meeting on AIDS, the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS established 10 ambitious targets covering the most critical aspects of the HIV response.

In this report we review global progress made towards those 10 targets in advance of the critical milestone of the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS and in the context of the target of ending AIDS by 2030 as part of the Sustainable Development Goals. This is an important opportunity to reflect on progress, but also to identify where gaps remain and to take action to ensure that no one is being left behind by the global AIDS response. The UNAIDS 2016–2021 Strategy aims to harness the momentum we have achieved to date. If we do not Fast-Track our efforts the number of new HIV infections and AIDS-related deaths will rebound. Investment in AIDS must not falter; in fact, in the short-term it needs to increase. Front-loading investment now will ultimately lead to greater impact and long-term cost-saving.

United Nations Member States have adopted the bold new target of ending the AIDS epidemic by 2030 within the new Sustainable Development Goals. These 17 global goals reflect a greater understanding of how efforts to end poverty, improve global health, eliminate inequalities and address climate change are interconnected.

This is an exciting time in the AIDS response but we cannot afford to be complacent. Global solidarity in the AIDS response has achieved significant progress, but AIDS remains unfinished business. We need to quicken our pace. Action is needed across the spectrum of the AIDS response—financing, treatment, prevention, inclusion, non-discrimination, rights protection and gender equality. Ending the AIDS epidemic relies on leaving no one behind and reaching the people at the margins of society.

Introduction

When Member States gathered at the United Nations General Assembly in 2011 for a High-Level Meeting on AIDS, the number of people newly infected with HIV was declining, the number of people dying from AIDS-related causes was falling and substantial financial resources were being mobilized to address the epidemic.

However, the global burden remained unacceptable. In 2010, 2.7 million people were newly infected with HIV—more than 7000 a day (1). Nearly 400 000 children acquired HIV in 2010, fewer than one in five people living with HIV had access to antiretroviral therapy and 1.8 million people died from AIDS-related causes (1). Alongside this monumental challenge were signs of wavering global commitment. International assistance for the AIDS response dropped in 2010 for the first time since the General Assembly's first Special Session on HIV/AIDS in 2001 (1).

In the weeks leading up to the 2011 High-Level Meeting, United Nations Secretary-General Ban Ki-moon declared “a moment of truth” for the AIDS response, and he challenged Member States to support UNAIDS' call for a more focused, efficient and sustainable response that squarely addressed the stigma, discrimination and gender inequity undermining access to services (2).

At this pivotal moment, Member States came together in solidarity to adopt the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (2011 Political Declaration)—a global pledge to redouble efforts to achieve universal access to HIV prevention, treatment, care and support services, to eliminate gender inequality and gender-based violence and to increase the capacity of women and adolescent girls to protect themselves from HIV infection. It also recognized that HIV prevention efforts to date had been inadequately focused on key populations at higher risk of infection—specifically sex workers, people who inject drugs and men who have sex with men.

These global aspirations for accelerated action were underpinned by a set of 10 ambitious targets and elimination commitments.

1. Reduce sexual transmission of HIV by 50% by 2015.
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015.
3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths.
4. Reach 15 million people living with HIV with life-saving antiretroviral therapy by 2015.
5. Reduce tuberculosis deaths among people living with HIV by 50% by 2015.
6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries.
7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV.
8. 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.
9. Eliminate HIV-related restrictions on entry, stay and residence.
10. 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.

To monitor progress, countries agreed to a stronger accountability framework managed by UNAIDS. Reporting rates through this Global AIDS Response Progress Reporting remain among the highest for any international monitoring exercise; in 2014, for example, 180 countries reported results against the 10 targets and elimination commitments of the 2011 Political Declaration (3). Global resolve to accelerate progress has been reflected in more frequent and more detailed reporting in recent years, from biennial to annual for all targets and every six months for the coverage of key programmes, such as antiretroviral therapy.

As the five-year time frame of the 2011 Political Declaration comes to a close, this report summarizes progress against each of the 10 targets and elimination commitments. Extraordinary results have been achieved. The target for antiretroviral therapy was reached nine months before the December 2015 deadline and ultimately exceeded. Further, the estimated US\$ 21.7 billion available for HIV programmes in low- and middle-income countries in 2015 effectively reached the lower end of the resource target. Substantial progress was also made towards eliminating the mother-to-child transmission of HIV, reducing AIDS-related maternal deaths, halving tuberculosis (TB) deaths among people living with HIV, eliminating HIV-related restrictions on entry, stay and residence and integrating the HIV response into broader health and development frameworks.

Serious challenges remain. The numbers of people newly infected with HIV were reduced, but by much less than envisioned. Efforts to address gender inequities and HIV-related stigma and discrimination have strengthened, but rights violations continue to frustrate the provision of HIV services to women, adolescent girls and key populations.

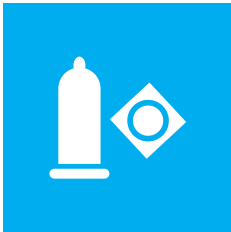
As one chapter of the global AIDS response comes to a close, a new chapter is being written. The progress achieved—combined with the rapid expansion of scientific knowledge and development of innovative tools and approaches—has inspired even greater ambition. The Sustainable Development Goals agreed by the United Nations General Assembly in 2015 include a commitment to end the AIDS epidemic by 2030.

But the epidemic is far from over. Evidence indicates that many of the most vulnerable and marginalized populations are being left behind by the AIDS response. Global action has to accelerate to reach key populations. If the world does no more than continue its current course of action we risk accepting that progress halts and then slips backwards, with rising numbers of people newly infected and more people dying from AIDS-related causes (4). A fragile window of opportunity exists to put the global AIDS response on a Fast-Track towards ending the epidemic.

In October 2015, the Programme Coordinating Board of UNAIDS approved a new strategy for the United Nations System's efforts to Fast-Track the AIDS response. The UNAIDS 2016–2021 Strategy is an urgent call to front-load investment in the AIDS response, to address the inequality and injustice that violates human rights and denies access to services and to achieve a set of ambitious yet achievable HIV prevention and treatment targets (5). The United Nations cannot achieve these aims on its own. As Member States prepare for the United Nations General Assembly High-Level Meeting on Ending AIDS, to be held from 8 to 10 June 2016, the key question is whether the international community can once again forge a combined commitment to specific actions that will put the world on a Fast-Track to end the AIDS epidemic by 2030.

2011 United Nations Political Declaration on HIV and AIDS: targets and elimination commitments

1.



Reduce sexual transmission of HIV by 50% by 2015

2.



Reduce transmission of HIV among people who inject drugs by 50% by 2015

3.



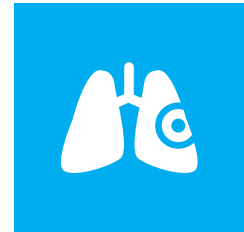
Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

4.



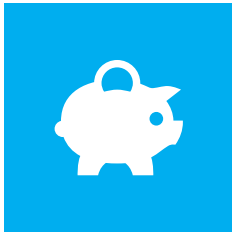
Reach 15 million people living with HIV with life-saving antiretroviral therapy by 2015

5.



Reduce tuberculosis deaths among people living with HIV by 50% by 2015

6.



Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries

7.



Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

8.



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

9.



Eliminate HIV-related restrictions on entry, stay and residence

10.



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



1.

Reduce sexual transmission of HIV by 50% by 2015

Progress towards achieving the target

Since the turn of the millennium, the world has made substantial gains in reducing the number of people newly infected with HIV. The number of 2.0 million [1.9 million–2.2 million] people who acquired HIV in 2014 was 35% fewer than in 2000 (1). However, the pace of progress on HIV prevention in recent years has been much slower than envisioned in the 2011 Political Declaration. From 2010 to 2014, the annual number of young people and adults (aged 15+) newly infected worldwide fell by about 8%, much lower than the target of reducing sexual transmission of HIV by 50% by 2015 (2).¹

Factors contributing to progress

The results of representative, national household surveys undertaken in diverse countries in 2008–2014 compared with the results from surveys in 1999–2007 show a clear, although not universal, trend towards reduced sexual risk. Generally, more young people in the recent surveys correctly identify ways of preventing sexual transmission of HIV, and more adults reported condom use the last time they had sex (1). These surveys also suggest that fewer young men are initiating sex before age 15 years, although early sexual debut has increased among young women (1).

Condoms are among the most cost-effective of all health technologies. From 2010 to 2013, the number of both male and female condoms distributed in low- and middle-income countries fluctuated, but generally increased (3). The number of donor-provided male condoms rose from 2.8 billion in 2010 to 3.3 billion in 2013—an 18% increase (3). During the same period, the number of donor-supplied female condoms increased by more than 50% (3). Increased provision and use of condoms has contributed to significant reductions in new infections in a range of settings, including India, South Africa, Thailand and Zimbabwe, although most of these gains were achieved before 2010 (4). Among key populations, sex workers in all regions except the Middle East and North Africa report consistently high levels of condom use (1).

¹ Since an estimated 94% of the adults newly infected with HIV in 2014 acquired it from transmission unrelated to injecting drug use, the decline in the number of people newly infected with HIV from 2010 to 2014 roughly reflects the reduction in sexual HIV transmission.

Striking gains have been made in sub-Saharan Africa in rolling out voluntary medical male circumcision, which reduces the risk of female-to-male HIV transmission by about 60% (5–7). Although only 555 000 males were circumcised in priority countries in 2008–2010 (2), 3.2 million men in these countries were circumcised in 2014 alone (1). Altogether, 9.1 million voluntary male circumcision procedures had been performed in priority countries as of December 2014, with 85% of the scale-up occurring in 2012–2014 (1).

In the years since the 2011 Political Declaration was adopted, the evidence base on effective HIV prevention measures expanded dramatically, laying the foundation for swifter progress in the future. In 2011, a major international clinical trial found that antiretroviral therapy reduces the risk of HIV transmission by about 96% (8). Further, drawing on a large body of scientific evidence, WHO recommended offering antiretroviral medicines as pre-exposure prophylaxis to people at substantial risk of HIV infection (9). In addition, a promising new generation of vaginal microbicides and long-acting injectable antiretroviral medicines are undergoing clinical trials, and important progress has also been made towards developing a preventive vaccine.

New insights have also been gleaned regarding ways to improve the strategic impact of HIV prevention services. Improved HIV surveillance strategies enable decision-makers to better focus prevention services on the locations and populations with the greatest impact (10). Through the development of national HIV investment cases, diverse countries have pledged to improve the strategic targeting of prevention efforts to enhance effectiveness and the return on investment (11).

Persistent challenges

Although important advances have been made in promoting safer sexual behaviour, high levels of risk behaviour persist among adults. In 31 countries with comparable survey data, the proportion of adult men (15–49 years old) reporting multiple sexual partners in the previous 12 years increased in 2000–2014; in several countries with a high burden of HIV infection, the increase in multiple sexual partners among men in recent years has been substantial (1).

Although reported condom use has generally increased in countries for which comparable survey data are available, the proportion of adults who report using a condom the last time they had sex remains far too low, especially among women (1). In much of sub-Saharan Africa there are worrying signs of condom fatigue—a flatlining of donor support and lack of innovation and investment in condom social marketing and distribution (1).

34%

Young people (15–24 years old) accounted for 34% of the adults newly infected with HIV globally in 2014.

Young people (15–24 years old) accounted for 34% of the adults newly infected with HIV globally in 2014 (1). Young people’s HIV-related knowledge remains far too low: only about 36% of young men and 28% of young women can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission (1). In sub-Saharan Africa, young women are substantially less likely than young men to have accurate and comprehensive knowledge of HIV (1).

In sub-Saharan Africa, home to nearly 70% of the people living with HIV worldwide, women account for 59% of people living with HIV (1). In addition to their heightened physiological susceptibility to HIV infection compared with men, women often face additional barriers to HIV prevention services because of profound gender inequalities (an issue addressed in greater depth in the section on target 7). Young women in sub-Saharan Africa are particularly vulnerable, acquiring HIV five to seven years earlier than men in the region (12). The inadequacy of female-controlled interventions that combine prevention of HIV, sexually transmitted infections and unwanted pregnancy that women can discretely control on their own continues to limit the ability of women and girls to protect themselves from HIV infection.

Key populations—including gay men and other men who have sex with men, people who inject drugs, prisoners, sex workers and transgender people—continue to be at exceptionally high risk of acquiring HIV and face considerable barriers to accessing HIV prevention services that are tailored to their specific needs. UNAIDS estimates that sex workers and their clients, people who inject drugs and men who have sex with men accounted for about one third of the adults newly infected with HIV in 2013 (1).

HIV prevalence among sex workers globally has declined modestly since 2011 in several regions, including sub-Saharan Africa, but in 2014 it remained 12 times greater than that of the general population (1). HIV epidemics among gay men and other men who have sex with men continue to expand in most low-, middle- and upper-income countries. Reported condom use and HIV status awareness among gay men and other men who have sex with men are substantially below global targets (1). Less than half of men who have sex with men know their HIV status in all but one global region (1). In 15 countries with available data, an estimated 19% of transgender women are living with HIV (1). HIV prevention and treatment services for key populations are fragmented and lack adequate coverage.

Lessons learned

Laying the foundation to end the AIDS epidemic as a public health threat by 2030 will require reducing the annual number of people newly infected with HIV from 2.0 million in 2014 to fewer than 500 000 in 2020. Such a steep downward trajectory in the rate of new HIV infections can only be achieved by dramatically intensifying both the scale and effectiveness of HIV prevention efforts by:

- ▶ Tailoring combinations of effective, rights-based prevention programmes for and with the people who are most vulnerable and at highest risk of infection.²
- ▶ Utilizing the growing array of proven tools for preventing sexual transmission, including male and female condoms, voluntary medical male circumcision and behaviour change programmes.
- ▶ Expanding access to antiretroviral medicines for both treatment and prevention (pre- and post-exposure prophylaxis), combined with HIV testing and adherence support.
- ▶ Leveraging digital and social media and mobile technologies to facilitate safe and anonymous HIV risk self-assessment, prompt uptake and ongoing use of prevention methods, linkage to HIV testing and treatment providers, enhanced treatment adherence and reduced loss to follow-up.
- ▶ Addressing the persistent and unacceptably high rates of young people newly infected with HIV, including by providing comprehensive age-appropriate sexuality education and access to sexual and reproductive health and rights services.
- ▶ More rigorous and decentralized monitoring of the epidemic, with intensified focus on locations and populations in which HIV transmission and people living with HIV are concentrated, especially in cities.
- ▶ More effective efforts to implement structural interventions and gender-sensitive programmes that reduce HIV risk and vulnerability, including well-designed cash transfer schemes, initiatives to promote universal access to primary and secondary education and programmes to eliminate gender-based and other forms of discrimination.
- ▶ Updating national combination prevention frameworks and strengthening the management and capacity of HIV prevention programmes.
- ▶ Investing at least one quarter of available HIV resources in HIV prevention strategies.

² UNAIDS has identified 12 populations in danger of being left behind by the AIDS response: people living with HIV; adolescent girls and young women; prisoners; migrants; people who inject drugs; sex workers; gay men and other men who have sex with men; transgender people; children and pregnant women living with HIV; displaced persons; people with disabilities; and people aged 50 years and older.



2.

Reduce transmission of HIV among people who inject drugs by 50% by 2015

Progress towards achieving the target

The target of halving the number of people who inject drugs who become newly infected with HIV was not achieved at the end of 2015. Grossly inadequate scale-up of proven HIV prevention and harm reduction strategies for people who inject drugs remains one of the most serious gaps in the AIDS response.

Globally, UNAIDS estimates that there was no decline in the annual number of new HIV infections among people who inject drugs from 2010 to 2014. This lack of global progress hides important differences among countries and regions (1). In eastern Europe and central Asia, available evidence suggests that the annual number of new infections among people who inject drugs may have risen; however, in western Europe, where many countries have expanded harm reduction programmes, available evidence suggests a decline in new infections (1). In 2014, an estimated 140 000 [112 000–168 000] people who inject drugs were newly infected with HIV, and people who inject drugs and their sexual partners accounted for about 30% of people newly infected with HIV outside sub-Saharan Africa (1).

Factors contributing to progress

Available evidence suggests a modest global increase in coverage for some harm reduction components. Among 30 countries reporting pertinent data in 2011, a median of 51 syringes and needles were distributed per person who injects drugs in 2010 (2). By contrast, among 55 countries reporting in 2014, the median number of syringes and needles distributed per person who injects drugs had risen to 74 (3).

Although progress globally has been insufficient, some countries have implemented harm reduction measures at scale and achieved impressive results. Malaysia established and scaled up combined methadone maintenance therapy and needle–syringe programmes, which prevented more than 12 600 people from acquiring HIV, added more than 50 000 quality-adjusted life-years and reduced health-care costs by about US\$ 10 million from 2006 to 2013 (4). In

Viet Nam, injecting drug use was the mode of transmission for most of the people newly infected with HIV in 2000; a significant decline in HIV prevalence among people who inject drugs has been attributed largely to the establishment and scaling up of targeted harm reduction programmes (5). The Islamic Republic of Iran has been a global leader in providing opioid substitution therapy in prison settings, with the number of individuals reached by such services rising from a few hundred in 2004 to more than 41 000 in 2014 (6). China's expansion of opioid substitution therapy has been associated with a sharp reduction in the proportion of newly diagnosed HIV cases resulting from injecting drug use, from 44% in 2003 to 8% in 2013 (7). The Republic of Moldova makes a comprehensive package of prevention services available in prisons (6), and Kyrgyzstan has implemented a programme to train and sensitize law enforcement officials to ensure the smooth and effective operation of harm reduction programmes (6).

Persistent challenges

The very low coverage of the recommended package of highly effective harm reduction measures (see below) reflects a profound lack of political will to implement these evidence-informed public health interventions. In 2014, only 79 of 192 reporting countries provided opioid substitution therapy, and only 55 countries offered needle-syringe programmes (8).

Where services exist, coverage is often extremely low. The number of syringes and needles distributed per person who inject drugs per year remains well below the internationally recommended 200, although 15 countries report having met the coverage target for needle-syringe programmes at least once in the past four rounds of Global AIDS Response Progress Reporting (9, 10). Only one third of countries reporting the provision of opioid substitution therapy indicate that coverage is acceptable (>40%) (8).

Although information is limited regarding expenditure patterns for harm reduction programmes, available data suggest that many countries heavily depend on international sources for funding harm reduction programmes (11). The Global Fund is the world's largest funder of harm reduction services (12). Many of the countries with large and growing HIV epidemics among people who inject drugs are middle-income countries. International donors, however, are increasingly giving priority to low-income countries and countries with a high burden of HIV infection for their HIV assistance. Middle-income countries with serious epidemics among people who inject drugs may soon experience diminished access to external funding for prevention programmes (13).

The marginalization of people who inject drugs, often institutionalized by national laws and policy frameworks, impedes sound HIV and harm reduction responses. Countries have overwhelmingly opted for a strategy of criminalizing drug use, which in turn discourages people who inject drugs from seeking the services and support they need. Compulsory detention centres and prisons for people who use drugs continue to exist in some parts of Asia, while some countries in Latin America have adopted so-called compulsory rehabilitation (13).

Although an estimated 56–90% of the people who inject drugs will be incarcerated at some point during their lives (14), harm reduction services are scarce and often entirely unavailable in prison settings (6). Alternatives to incarceration within a public health approach to drug use could reduce the number of prisoners acquiring HIV, TB and viral hepatitis. In all regions, less than half the people who inject drugs report using a condom the last time they had sex, underscoring the need to promote a comprehensive package of combination HIV prevention to reduce the risk of sexual transmission as well as harm reduction programmes (9).

Lessons learned

Reaching global HIV prevention targets will require urgent action to provide people who inject drugs with the comprehensive package of nine programmes recommended by WHO, the United Nations Office on Drugs and Crime and UNAIDS:

- ▶ Needle–syringe programmes.
- ▶ Opioid substitution therapy and other evidence-informed drug dependence treatment programmes.
- ▶ HIV testing and counselling.
- ▶ Antiretroviral therapy.
- ▶ Prevention and treatment of sexually transmitted infections.
- ▶ Condom programmes for people who inject drugs and their sexual partners.
- ▶ Targeted information, education and communication for people who inject drugs and their sexual partners.
- ▶ Prevention, vaccination, diagnosis and treatment of viral hepatitis.
- ▶ Prevention, diagnosis and treatment of TB (15).

These programmes should be delivered using a range of modalities, including community outreach and peer-to-peer education and support. Specific efforts are required to extend harm reduction services to people in prisons and other closed settings. Establishing an enabling environment for service delivery to people who inject drugs will require:

- ▶ Supportive legislation and policy.
- ▶ Financial commitment.
- ▶ Addressing stigma and discrimination.
- ▶ Community empowerment.
- ▶ Access to justice (16).

Reaching people who inject drugs with the comprehensive package of services requires adjusting international and national policy frameworks for drug control that focus on repressing and punishing people who use drugs. These should be replaced with people-centred, public health and human rights-based drug control frameworks (17). In this regard, the 2016 Special Session of the United Nations General Assembly on the World Drug Problem provides a unique opportunity for the global community to revisit and reorient international drug policy in a manner that catalyses a Fast-Track approach to the AIDS response.



3.

Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Progress towards achieving the target

Substantial progress has been made towards the elimination of new infections among children. The number of 220 000 [190 000–260 000] children newly infected with HIV in 2014 was 45% fewer than in 2009 (1) and 58% fewer than the number who acquired HIV in 2000 (2).

In 2015, Cuba became the first country to be certified as having eliminated mother-to-child transmission of both HIV and syphilis, and other countries are preparing the necessary evidence to validate elimination. An estimated 85 countries have fewer than 50 children newly infected with HIV each year (2). Among the 21 priority countries in sub-Saharan Africa, at least seven have reduced the annual number of children newly infected with HIV by at least 60% (2).³

Since 2010, the number of women of reproductive age dying from AIDS-related causes has declined by 35%. This is largely caused by the increase in antiretroviral therapy coverage among pregnant women living with HIV and other women of reproductive age living with HIV. This includes a notable increase in the number of women living with HIV who were already receiving treatment when they become pregnant.

Only marginal progress has been made in the reducing the number of women of reproductive age newly infected with HIV. Within the 21 priority countries in sub-Saharan Africa, 670 000 [630 000–720 000] women of childbearing age acquired HIV in 2009; in 2014, by comparison, 570 000 [530 000–620 000] acquired HIV, a reduction of only 15% (3).

Factors contributing to progress

The *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* (Global Plan) was developed as an urgent priority by a high-level global task team that included representatives of 25 countries and 30 civil

³ Ethiopia, Mozambique, Namibia, South Africa, Swaziland, Uganda and the United Republic of Tanzania.

society groups, the private sector, networks of people living with HIV and international organizations. Its launch in 2011 provided renewed determination and enhanced coordination among diverse stakeholders to implement a four-pronged strategy:

- ▶ **Prong 1:** primary prevention of HIV among women of reproductive age.
- ▶ **Prong 2:** meet the unmet need of women living with HIV for family planning and spacing of births and to optimize health outcomes for these women and their children.
- ▶ **Prong 3:** ensure access to HIV testing and antiretroviral medicines to prevent mother-to-child transmission before, during and after birth and access to early infant diagnosis for children.
- ▶ **Prong 4:** HIV care, treatment and support for women, children living with HIV and their families.

Greater provision of antiretroviral medicines to pregnant women living with HIV has largely driven progress in preventing mother-to-child transmission. Whereas only 49% [45–54%] of pregnant women living with HIV received antiretroviral medicines in 2010, 73% [70–81%] received antiretroviral medicines in 2014, including 75% [69–81%] in sub-Saharan Africa (2). As a result, the rate of mother-to-child HIV transmission has been cut in half in the 21 Global Plan priority countries: from 28% in 2009 to 14% in 2014 (2). Between 2009 and 2014, providing antiretroviral medicines prevented 1.2 million children from becoming infected with HIV (2). Significantly, the number of children newly infected with HIV has been sharply reduced even as the number of women living with HIV who give birth has remained steady in countries with a high burden of HIV infection (2).

Progress has also been made against the transmission of HIV during breastfeeding, with the percentage of women receiving antiretroviral medicines during breastfeeding rising from 21% [19–23%] in 2009 to 71% [66–77%] in 2014 among the 21 Global Plan priority countries in sub-Saharan Africa (3).

The evidence base for preventing children from becoming newly infected with HIV expanded in 2011–2015, resulting in important changes in normative guidance and clinical practices. For example, after Malawi began offering lifelong antiretroviral therapy rather than time-limited prophylactic regimens to pregnant and breastfeeding women living with HIV, the number of pregnant and breastfeeding women accessing antiretroviral therapy in the country rose nearly eight-fold in slightly more than one year (4). In 2015, WHO updated its guidelines on the use of antiretroviral medicines to recommend Malawi's approach that all pregnant women living with HIV be

49%

In 2014, only 49% of HIV-exposed children received early infant diagnostic screening within the first two months of life in the 21 Global Plan priority countries in sub-Saharan Africa.

offered immediate and lifelong antiretroviral therapy (5). By the end of 2015, all but two of the Global Plan countries—Ghana and Nigeria—had adopted this recommendation.

The proportion of children living with HIV who receive antiretroviral therapy more than doubled from 14% [13–15%] in 2010 to 32% [30–34%] in 2014 (2). WHO also streamlined and simplified recommendations for antiretroviral regimens for children in its 2013 treatment guidelines (6). New energy to close treatment gaps for children has also emerged; in 2014, PEPFAR and the Children’s Investment Fund Foundation launched a two-year initiative to double the number of children receiving antiretroviral therapy in 10 countries in Africa.

Persistent challenges

The consistently high number of women living with HIV giving birth in priority countries illustrates the failure to make clear progress in strengthening primary prevention for women of reproductive age and in helping women with HIV avoid unintended pregnancies (2). Between 2009 and 2014, 3.8 million women of reproductive age became newly infected with HIV in the 21 Global Plan priority countries in sub-Saharan Africa. The most recent national household surveys from these priority countries show that more than two thirds of married women have unmet needs for family planning (3). Without a massive reduction in the proportion of pregnant women who are living with HIV, countries with a high burden of HIV infection are very unlikely to achieve the Global Plan target for elimination.⁴

As antiretroviral medicines have sharply lowered the number of children who acquire HIV during pregnancy or delivery, the proportion of newly infected children who acquired HIV during breastfeeding has increased (2). The continuing risk of HIV transmission during breastfeeding highlights the need for intensified efforts to retain breastfeeding women living with HIV on antiretroviral therapy for their own health and that of their child.

Although HIV treatment for children has expanded, coverage remains much lower than for adult HIV treatment. Challenges in ensuring the timely diagnosis of HIV among children are a key reason why treatment coverage is lower among children than among adults. In 2014, only 49% of HIV-exposed children received early infant diagnostic screening within the first two months of life in the 21 Global Plan priority countries in sub-Saharan Africa (3).

⁴ Elimination is defined as less than 50 children living with HIV per 100 000 live births.

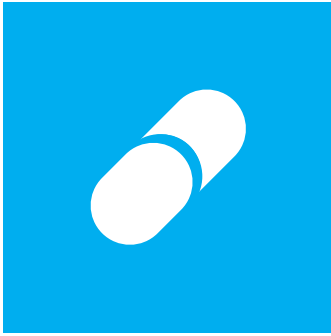
Lessons learned

The Fast-Track to eliminate mother-to-child transmission and keep mothers healthy will require:

- ▶ Intensified HIV prevention, family planning and other sexual and reproductive health services for women of reproductive age.
- ▶ Integrating routine HIV testing and treatment services into antenatal and postnatal care to ensure that HIV services and relevant HIV prevention programmes are offered to pregnant women depending on their HIV status.
- ▶ Integrating HIV and syphilis screening and treatment services for pregnant women to reduce neonatal deaths, stillbirths and congenital syphilis.
- ▶ Engaging the sexual partners of pregnant women in counselling and testing services to help identify discordant couples and provide prevention, treatment and care services as required.
- ▶ Immediately offering to initiate lifelong antiretroviral therapy for all pregnant and breastfeeding women diagnosed with HIV.
- ▶ Strengthening health registries and electronic medical record systems to improve retention on treatment by improving the tracking of mother–infant pairs.

To close the treatment gap for children, additional efforts are needed to:

- ▶ Ensure prompt diagnosis of HIV, including by introducing and increasing the uptake of point-of-care early infant diagnostic tests, optimizing the use of centralized, quality-controlled laboratories and taking action to reduce loss to follow-up among HIV-exposed infants.
- ▶ Integrate routine HIV testing within child-focused services such as immunization and school health programmes to better reach older children, who are often missed by other testing strategies.
- ▶ Ensure more affordable, efficacious and palatable antiretroviral medicine formulations and adherence support for children, especially for very young children.
- ▶ Ensure that more effective monitoring systems can follow HIV-exposed infants and infants diagnosed with HIV, to ensure they are well served and not lost to follow-up.



4.

Reach 15 million people living with HIV with life-saving antiretroviral therapy by 2015

Progress towards achieving the target

In March 2015, antiretroviral therapy reached 15 million people—the first time a global health treatment target was reached before the agreed deadline (1). Scale-up continued to 15.8 million in June 2015, demonstrating relentless effort by countries to exceed the “15 by 15” target in the 2011 Political Declaration.

The rapid, continuing expansion of antiretroviral therapy in resource-limited settings resulted from a combination of global solidarity, commitment to scientific evidence, a people-centred approach and HIV activism. The percentage of people living with HIV who are receiving antiretroviral therapy rose from 2% [2–3%] in 2000 to 40% [37–45%] in 2014, preventing 7.8 million people from dying (2). Between 2011 and 2014, the number of people receiving antiretroviral therapy more than doubled.

Scaled-up antiretroviral therapy was the main factor behind a 42% global reduction in the number of people dying from AIDS-related causes from 2004 to 2014 as well as sharp increases in life expectancy in countries with a high burden of HIV infection in sub-Saharan Africa (2). Improved access to HIV treatment is also bolstering HIV prevention efforts, with studies in diverse findings correlating reductions in HIV incidence with increases in treatment coverage (3, 4). The benefits of scaling up treatment extend well beyond the AIDS response. Increases in treatment access for children living with HIV, combined with dramatic gains in prevention coverage for pregnant women living with HIV, has played an important role in the steep decline in deaths worldwide among children younger than five years. Scaling up HIV treatment has also strengthened global efforts to reduce the burden of TB (a result addressed in greater depth in the section on target 5). The resources mobilized to expand HIV treatment access are also buttressing health systems in low- and middle-income countries—building essential health infrastructure, improving data systems and analytical capacity and supporting massive capacity-building programmes across all cadres of health-care workers (2).

Factors contributing to progress

Robust, sustained global commitment to HIV treatment enabled the “15 by 15” target to be achieved (2). Even as new challenges and international priorities emerged in recent years, diverse stakeholders at the global, regional and country levels worked together to expand access to HIV treatment. Civil society has played a central role in the HIV treatment success story, driving equal access, delivering essential services, building demand for testing and treatment, advocating for accelerated scale-up and helping to hold decision-makers accountable for their HIV commitments.

Innovation in service delivery—such as community-based service delivery, adherence clubs and community distribution of antiretroviral medicines—has improved treatment outcomes, benefiting people living with HIV and enhancing the value of HIV investment (5). The prices of antiretroviral medicines have continued to fall, although at a slower pace than a decade ago, with India’s generic pharmaceutical industry supplying the large majority of antiretroviral medicines used in HIV treatment programmes in sub-Saharan Africa (2, 6).

An important factor in the successful global effort to reach the “15 by 15” target has been the steady rise in knowledge of HIV status. In 2014, for the first time, more than half (54% [49–58%]) of people living with HIV knew their HIV status (2). In sub-Saharan Africa, the proportion of people living with HIV 15–49 years old aware of their HIV status rose by 26 percentage points between 2003–2008 and 2009–2014, according to nationally representative household surveys (2).

Between 2011 and 2015, the full benefits of expanded access to HIV treatment for individuals and for entire communities became clearer. In 2011, an international clinical trial found that antiretroviral therapy reduced the risk of HIV transmission by about 96% (7). In 2015, a separate international clinical trial was halted after the results demonstrated that early initiation of HIV treatment has clear therapeutic benefit. This scientific evidence contributed to WHO recommending in 2015 the immediate offering of HIV treatment for all people diagnosed with HIV, regardless of their CD4 count (8).

Persistent challenges

Although the achievements to date are remarkable, an estimated 60% of people living with HIV are not accessing antiretroviral therapy, necessitating even more rapid and more comprehensive scale-up.

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Although the achievements to date are remarkable, nearly 60% of people living with HIV are not accessing antiretroviral therapy, necessitating even more rapid and more comprehensive scale-up.

Gaps remain across the HIV treatment cascade. Globally, nearly half the people living with HIV do not know their HIV status, many who discover their HIV-positive status are not linked to HIV treatment services and, too frequently, people do not discover their status and access treatment until they have experienced extensive damage to their immune system. A substantial proportion of people who start HIV treatment do not remain engaged in care or face challenges in adhering to the prescribed regimens. As a result, only a minority of people living with HIV are known to have achieved viral suppression, which keeps people living with HIV healthy and maximizes the HIV prevention impact of treatment (2). In sub-Saharan Africa, for example, an estimated 51% of adults living with HIV know their HIV status, about 43% of adults living with HIV are receiving antiretroviral therapy and an estimated 32% of adults living with HIV are virally suppressed (1).

The long-term financial sustainability of HIV treatment is uncertain. Regional trade agreements increasingly aim to impose limitations on generic drug manufacturing that exceed those allowed under the Trade-Related Aspects of Intellectual Property (TRIPS) Agreement. The overall market for generic antiretroviral medicines is becoming increasingly concentrated and less competitive, and the generic market for second-line drugs is more concentrated than the first-line market. Suboptimal adherence to prescribed regimens increases resistance to first-line antiretroviral regimens, increasing the need for more expensive and less tolerable second- and third-line regimens (2). The prices low- and middle-income countries currently pay for antiretroviral medicines also vary considerably, indicating that some countries may not be using the most affordable procurement options available to them.

Stigma and discrimination continue to undermine efforts to accelerate HIV testing and treatment scale-up and sustainability. In addition to legal reform and anti-stigma programming, the persistence of HIV-related stigma also underscores the need to accelerate HIV treatment uptake, since studies in diverse countries have found that stigma declines as HIV treatment coverage increases (1).

Lessons learned

To lay the foundation for ending the AIDS epidemic as a public health threat by 2030, the world has embraced a new HIV treatment target. By 2020: (a) 90% of people living with HIV will know their HIV status; (b) 90% of people who know their HIV status will access antiretroviral therapy; and (c) 90% of all people receiving antiretroviral therapy will achieve viral suppression (the 90–90–90 treatment target). Strong, sustained political leadership and the front-loading of investment will be needed to meet this ambitious target.

Reaching more young people, key populations, migrants and crisis-affected populations requires specific investment to expand community-centred, non-facility-based HIV testing, including door-to-door testing, mobile testing, multidisease screening campaigns and self-testing. All people who test positive for HIV should be offered treatment immediately on diagnosis as well as comprehensive HIV prevention advice and programmes. All people who test HIV-negative need to access a combination HIV prevention package tailored to their needs.

To optimize health outcomes and minimize the emergence of drug resistance, treatment programmes should intensify efforts to assist people living with HIV in remaining engaged in care and in adhering to treatment regimens, by ensuring state-of-the-art treatment monitoring and applying good practices. Viral load testing must be rapidly brought to scale, including point-of-care viral load testing technologies and negotiated price reductions. Viral load tests provide a more accurate and earlier indication of treatment failure than the CD4 tests that are more commonly available in low- and middle-income countries. This provides an opportunity to undergo enhanced adherence support and conserve first-line regimens, or, if adherence problems are ruled out, to ensure prompt and correct switching to alternative treatment regimens.

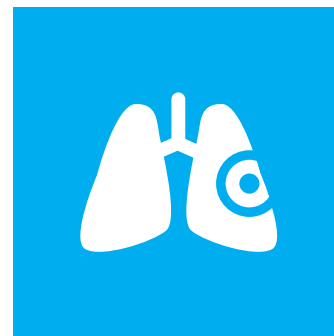
Communities must be empowered to help lead the way towards the 90–90–90 treatment target, including by building demand for HIV testing and treatment services. Treatment services, including adherence support, should be further decentralized, with particular emphasis on scaling up integrated community-based service delivery. Task-shifting should be fully implemented to facilitate community-based service delivery, and the status of community health workers should be elevated and formalized. Data regarding treatment access gaps and programme performance must be more fully leveraged to enhance treatment access and adherence and improve health outcomes for people living with HIV.

Closing the gaps in the treatment cascade will also require timely and accurate data collection and analysis at the local level for each stage of the cascade. Programme managers need to carefully track and document these data, with emphasis on subnational differences and differences among key populations. Surveillance to monitor drug resistance must be in place alongside viral load testing.

Immediate steps are needed to secure a sustainable, uninterrupted supply of affordable HIV test kits (including for early infant diagnosis), viral load monitoring and antiretroviral medicines. This will require multiple approaches, including exploring local and regional manufacturing, full use of the flexibilities available under TRIPS, direct negotiations with manufacturers and advocacy to maintain the viability of generic antiretroviral medicines and diagnostics. National procurement and supply management systems must be robust and efficient.

5.

Reduce tuberculosis deaths among people living with HIV by 50% by 2015



Progress towards achieving the target

Major gains have been made in reducing the toll of TB among people living with HIV. The number of people dying from HIV-associated TB in 2014 fell to 390 000, 32% lower than its peak of 570 000 in 2004 (1). In 17 of the 41 WHO priority countries with a high burden of TB and HIV, the number of people with HIV dying from TB declined by 50% or more from 2004 to 2014 (2).

However, TB remains the leading cause of death among people living with HIV (3). The number of TB-related deaths among people living with HIV in 2014 was 18% lower than in 2010, underscoring the need for intensified action to effectively address the linked epidemics of HIV and TB.

Factors contributing to progress

Reductions in HIV-associated TB deaths have been supported by expansion of collaborative HIV and TB activities. In 2012, WHO released updated guidelines that reinforce the need to deliver integrated TB and HIV services, preferably at the same time and location (1).

The proportion of notified TB patients⁵ who knew their HIV status increased from 33% in 2010 (4) to 51% in 2014 (2). Among the 41 WHO priority countries, 60% of the people diagnosed with TB had a documented HIV test result in 2014 (2). More people diagnosed with TB who are living with HIV are benefiting from cotrimoxazole preventive therapy, which protects against a range of secondary bacterial and parasitic infections, and immediately offering antiretroviral therapy is more effectively reducing viral load and restoring immune function.

Coverage of cotrimoxazole preventive therapy among people diagnosed with TB who are living with HIV increased from 79% in 2011 (5) to 87% in 2014 (2). Coverage of antiretroviral therapy grew from just a few thousand in 2004 to 392 000 in 2014—77% of all people diagnosed with TB who are known to be living with HIV (2). The largest increases have been achieved in India, South Africa, the

5 Notification means that TB is diagnosed and is reported within the national surveillance system and then on to WHO. In this report, "a notified TB patient" is subsequently referred to as "a person diagnosed with TB".

United Republic of Tanzania and Zambia (6). Antiretroviral therapy also reduces the risk that a person living with HIV will develop TB disease by 65% (7). Overall expansion of antiretroviral therapy has thus also reduced the incidence of TB among people living with HIV (8, 9).

Systematic symptom screening for TB among people living with HIV is an essential component of HIV care and treatment. In 2014, 78 countries reported about 7 million people enrolled in HIV care who were screened for TB (2), up from 2.3 million within reporting countries in 2010 (5). Screening is important for determining whether a person living with HIV needs isoniazid preventive therapy to prevent TB disease or has symptoms of TB that require further investigation to diagnose TB disease. Isoniazid preventive therapy reduces the risk that a person living with HIV will develop TB by up to 64% (10, 11). The number of people living with HIV receiving isoniazid preventive therapy reached 933 000 in 2014, an increase of about 60% compared with 2013 (2).

Prompt and accurate diagnosis of TB among people living with HIV is a longstanding challenge. The development of the Xpert MTB/RIF rapid molecular test—strongly recommended by WHO since 2010—has enhanced the speed and accuracy of diagnosing drug-sensitive and drug-resistant TB among people living with HIV. Of 41 countries with a high burden of TB and HIV, 33 (80%) had in place a national policy on the use of Xpert MTB/RIF as of December 2014 (2).

Persistent challenges

People living with HIV are 26 times more likely to develop TB disease than people who are HIV-negative (2). In 2014, an estimated 1.2 million people living with HIV developed TB—12% of the 9.6 million people estimated to have TB worldwide (2). TB accounted for one third of all AIDS-related deaths in 2014, which is partly accounted for by the huge gap between the estimated burden of TB among people living with HIV (1.2 million) and the reported 392 000 people living with TB and HIV receiving antiretroviral therapy in 2014 (2).

Coverage of essential prevention, diagnosis and treatment tools remains suboptimal. Only half of all people diagnosed with TB know their HIV status (2). The high proportion of people with undiagnosed TB found in autopsy studies of people living with HIV shows that substantial efforts are needed to strengthen TB screening, diagnosis and treatment among people living with HIV (2). Intensified research is also needed to develop more effective and affordable forms of

TB diagnostics, treatments and vaccines (2). Discrepancies between the data reported by TB and HIV programmes highlight the need to improve collaboration and data quality assurance systems (2).

Lessons learned

Strong HIV and TB programme collaboration requires patient-centred integration and co-location of HIV and TB services. Of particular importance are the three Is (intensified TB case-finding among people living with HIV; isoniazid preventive therapy for people living with HIV who do not have active TB; and infection control in health-care and congregate settings), plus immediate offer of antiretroviral therapy to all people living with HIV.

Wider adoption of the WHO-recommended Xpert MTB/RIF as the initial diagnostic test would improve the speed and accuracy of testing for TB disease among people living with HIV. HIV testing for all people diagnosed with TB is an important entry point to HIV treatment. Community mobilization for integrated TB screening and HIV testing should be intensified in areas with a high burden of TB and HIV.



6.

Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries

Progress towards achieving the target

The world largely achieved the goal of mobilizing US\$ 22–24 billion annually for the AIDS response by 2015. An estimated US\$ 21.7 billion was available for HIV programmes in low- and middle-income countries in 2015, effectively reaching the lower end of the resource target.

HIV treatment and prevention together comprise about three quarters of HIV spending: 53% for treatment in 2013 and 20% for prevention (1).

Factors contributing to progress

The principles of shared responsibility and global solidarity guided resource mobilization efforts in 2011–2015 and enabled the resource target to be achieved. Low- and middle-income countries have led the way in mobilizing essential funding for the response in recent years, with domestic sources accounting for 57% of all HIV resources in 2014. Domestic HIV investment nearly tripled from 2006 to 2014 (1).

Countries have exhibited both profound commitment and ingenuity in mobilizing new domestic resources for the AIDS response. For example, South Africa has steadily ramped up its domestic funding for HIV, currently covering 74% of the total costs of the response, with plans to further increase the domestic share to 80% in 2015–2016 (2). Countries such as Kazakhstan and Namibia have taken similar steps, so that domestic resources now cover 73% and 64%, respectively, of the costs associated with the national responses (2). In Zimbabwe, a 3% national tax levy supports a national AIDS trust fund that currently covers HIV treatment costs for 25% of the individuals receiving antiretroviral therapy (2).

International HIV assistance has recovered after falling as a result of the global financial and economic downturn in 2008. Donor support for HIV rose from US\$ 6.9 billion in 2010 to US\$ 8.75 billion in 2014 (3). Several countries in 2014 contributed a share of international HIV investment that exceeded their share of the global economy, including Denmark, Ireland, the Netherlands, Norway, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States of America (3). The United States remains the

largest international funder of HIV programmes in low- and middle-income countries, accounting for 64.5% of donor government disbursements in 2014 (3).

There are signs that HIV programmes have become more efficient over time, enhancing the impact of finite HIV funding. From 2011 to 2014, HIV funding rose by 11% but the number of people receiving antiretroviral therapy increased by 60%, suggesting that treatment programmes are achieving economies of scale (4). The prices for recommended antiretroviral medicine regimens have also continued to decline, although more slowly than in previous years, and steps have also been taken to strengthen procurement and supply management systems and practices, including through pooled procurement.

Persistent challenges

There is a major gap between the available resources and the investment needed by 2020 to achieve the end of the AIDS epidemic as a public health threat by 2030. Even as domestic investment in the AIDS response has increased, most countries have yet to mobilize domestic investment that is commensurate with their disease burden and ability to pay. Taking these factors into account, a recent analysis of 12 countries in sub-Saharan Africa with a high prevalence of HIV (including low-income, lower-middle-income and upper-middle-income countries) found that nearly all were spending less domestically on AIDS than a set of proposed benchmarks (5).

International HIV funding has recovered from the dip it experienced in the latter years of the previous decade, but has remained relatively flat in recent years (3). Several high-income countries are contributing a share of international HIV assistance that is below their share of the global economy, including Australia, Canada, Germany, Italy and Japan (3).

Both allocative and programmatic efficiency remain suboptimal, preventing HIV investment from achieving its optimal impact. Weaknesses contributing to suboptimal efficiency include misappropriation of HIV funds as well as poorly organized, inadequately monitored and inefficient operations. The prices paid for antiretroviral medicines and other key health commodities often vary among similarly situated countries, as do per-person clinical costs, indicating that some settings are having greater success than others in obtaining optimal pricing.

Lessons learned

A narrow window of opportunity exists to lay the foundation to end the AIDS epidemic as a public health threat by 2030 (6). Immediate steps to front-load investment are essential. The world needs to increase HIV investments now or risk reversing the major successes

64.5%

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achieved in the first 15 years of the millennium. In 2015, an estimated US\$ 21.7 billion was invested in the AIDS response in low- and middle-income countries. Investments need to increase year on year from 2015, up to a peak of 40% higher in 2020, to reach the Fast-Track Targets. If all the Fast-Track Targets are achieved on time it is predicted that HIV investment will decline from 2021 as a result of front-loading investment in 2016–2020 (7).

Estimates of the resources needed to Fast-Track assume the achievement of significant efficiency gains and reduced commodity costs. Countries urgently need to develop national AIDS sustainability plans, identifying both fiscal space for expanded investment and strategies to enhance the impact of investment, such as focusing resources and services towards the locations and populations with the greatest need. The share of domestic public resources of total investment in HIV in 2020, according to the UNAIDS funding targets, should increase by one fifth (from 10% to 12%) in low-income countries, double (from 22% to 45%) in lower-middle-income countries and increase by about one tenth (from 85% to 95%) in upper-middle-income countries. The estimated total investment from domestic public sources in 2020 would need to reach US\$ 18.4 billion—more than twice the current levels.

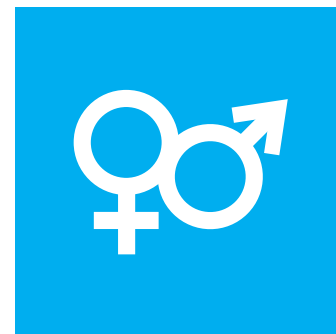
Countries should actively explore innovative options to close the AIDS resource gap, including implementing dedicated tax levies, integrating HIV services into broader health services, fully leveraging synergy with other development sectors, moving towards universal health coverage and taking steps to ensure that health coverage packages include comprehensive HIV-related services and reach all households affected by HIV.

Consistent with the principles of global solidarity, Fast-Track will also require increases in international HIV assistance. UNAIDS projects that annual international HIV assistance should rise from US\$ 8.75 billion in 2014 to US\$ 12.7 billion in 2020: US\$ 6.5 billion for low-income countries, US\$ 5.5 billion for lower-middle-income countries and US\$ 0.7 billion for upper-middle-income countries. Donors should ensure that their share of total international assistance matches or exceeds their share of the global economy, and specific action is needed to mobilize robust, sustained funding for the Global Fund.

Modest shifts will be needed in the allocation of these resources among evidence-informed HIV services. Investment in HIV prevention should rise to one quarter of total investment, including increased funding for pre-exposure antiretroviral prophylaxis. To optimize allocative and programmatic efficiency, concerted steps will be required to maximize the return on finite investment, including enhancing programmatic monitoring, using an investment approach for allocating resources and leveraging more granular surveillance data for targeting HIV programmes.

7.

Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV



Progress towards achieving the target

Gender inequalities and gender-based violence continue to undermine progress towards realizing the global AIDS targets. In 2011–2015, the evidence base for action to address gender inequalities and gender-based violence expanded, but this evidence has not been effectively translated into robust national responses.

Gender inequalities and greater biological susceptibility place women and girls at higher risk of HIV infection. In 2014, women accounted for 51% of all people living with HIV worldwide. However, among young people, there are important differences: 56% of all people 15–24 years old who became newly infected and 62% of those 15–19 years old who acquired HIV were women. In sub-Saharan Africa, these figures increase to 64% and 71%, respectively (1).

Violence against women remains endemic across the world, with unacceptably high rates in every region. Globally, 35% of women have experienced physical or sexual violence at some point in their lives (2). Gender norms that condone and promote the mistreatment of women and girls are at the root of the worldwide epidemic of violence against women, which has been linked with women's increased vulnerability to HIV.

Factors contributing to progress

The United Nations Secretary-General's review of progress over 20 years of implementing the Beijing Declaration and Platform of Action (2) indicates that important gains have been made towards gender equality. More countries have removed policies that discriminate against women and implemented measures to address gender-based violence. Significant gains have been made in girls' enrolment in primary and secondary education, and women's participation in the labour force has risen in some regions. Declines have also been reported in harmful practices, such as female genital mutilation.

At the policy level, gender is well understood to be an important aspect of a national AIDS response. In 2014, 93% of countries reporting results through the National Commitments and Policies Instrument indicated that their multisectoral HIV strategy addressed women and girls, with 91% of national strategies specifically addressing gender empowerment and/or gender equality.

There was encouraging progress in 2011–2015 in the expansion of the evidence base for action against gender inequality and gender-based abuse and violence. A cluster-randomized trial found that men exposed to SASA!, a community mobilization intervention, had lower HIV risk behaviour and were more likely to engage in joint household decision-making, to participate in household tasks and to value and appreciate their partner's work inside and outside the home (3). In Uganda, participants in an integrated programme that sought to prevent both HIV and intimate partner violence were significantly less likely than non-participants to report physical and sexual intimate partner violence in the previous 12 months (4). A separate clinical trial in South Africa found that men participating in the Stepping Stones programme were less likely to report perpetrating intimate partner violence during the two-year follow-up period (5).

Cash transfer schemes in Malawi and Lesotho have been shown to reduce young people's risk of acquiring HIV, with especially pronounced benefits for young women (6). Two recent randomized control trials in South Africa found that cash transfer schemes did not have any effect on HIV incidence, but their results did reinforce a growing body of evidence showing that education has a protective effect against HIV infection both during school years and afterwards for young women (7).

Some successes have also been reported in women's access to essential HIV services. The proportion of pregnant women living with HIV who receive antiretroviral medicines has steadily increased, reaching 73% coverage in 2014 (1). In part because of the intensive focus on scaling up HIV testing and providing antiretroviral medicine in antenatal settings, HIV treatment coverage is higher among women living with HIV than among their male counterparts; however, many women who initiate antiretroviral therapy experience substantial challenges in adhering to therapeutic regimens, including food insecurity, stigma and discrimination and lack of access to accurate information (8). The distribution of female condoms has also steadily risen (9). More than three in four countries (76%) reported that many health facilities in 2014 integrated HIV testing and counselling with sexual and reproductive health services, increasing comprehensive service uptake among women.

93%

In 2014, 93% of countries reporting results through the National Commitments and Policies Instrument indicated that their multisectoral HIV strategy addressed women and girls.

Persistent challenges

Continuing high rates of gender-based violence and abuse increase women's risk of acquiring HIV (10–12). In some settings, nearly half of adolescent girls report that their first sexual experience was coerced (13).

Although national policy frameworks routinely pledge to address gender equality and take steps to prevent gender-based abuse and violence, these commitments have yet to be translated into robust action. According to the 2014 National Commitments and Policies Instrument, only 49% of countries allocated a specific budget to the women's sector for HIV-related activities. Programming to address gender-based violence also constitutes an extremely small share of official development assistance for most donors (14). Political commitment on sexual and reproductive health and rights remains fragile and inadequate, and the failure to broadly implement evidence-informed strategies to prevent gender-based violence and forge social norms of gender equality has slowed progress.

As a result of deep and persistent gender inequality, many women and girls are unable to negotiate safer sex with their male partners. This disadvantage is compounded by the inadequacy of female-controlled HIV prevention methods.

Numerous reports correlate increased educational attainment with improved HIV and reproductive health outcomes for women (15). However, although some progress has been made in closing the gender gap in literacy and completion of primary schooling (16), girls and young women continue to confront considerable impediments to education, including early and forced marriage, which often causes women to drop out of school (15). In sub-Saharan Africa, young women (15–24 years old) are notably less likely than young men to have accurate and comprehensive knowledge about HIV (1).

Even as gains have been made in linking women with some essential services, women, especially adolescent girls and young women, are often unable to obtain the services they need (16). For example, as previously noted (target 3), little progress has been made in reducing the unmet need of women living with HIV for family planning services. Age-of-consent laws and discriminatory practices, such as efforts in some countries to coerce women living with HIV to be sterilized, block or deter many women from obtaining necessary services. Household-level evidence indicates that adolescent girls and young women are often deprived of the right to make decisions regarding their own health.



Only 49% allocated a specific budget to the women's sector for HIV-related activities.

Gender norms and harmful masculinities also increase HIV risk among men and stand as barriers to HIV and health service access. Men are less likely to seek an HIV test, are less likely to enrol in HIV treatment and are more likely to interrupt treatment and to be lost to follow-up (17). When men do not know their HIV status, they are less likely to practise safer sex and more likely to have high viral loads, which in turn increases the risk of their partners acquiring HIV. Young men in sub-Saharan Africa are twice as likely to die from AIDS-related complications than young women, despite the higher HIV infection rates among young women (18).

Lessons learned

Ending the AIDS epidemic as a public health threat requires substantial, sustained strides towards eliminating gender inequalities and gender-based abuse and violence. Achieving gender equality requires policies and programmes, supported by strong political commitment, that advance women's physical, economic and political autonomy, which can only be secured by respecting, protecting and promoting the rights of women and girls and changing entrenched and harmful concepts of masculinity.

In the context of HIV, it is essential to fulfil the right of women to decide when and with whom to have sex, when and with whom to marry, when to have children and how many children to have. Women must also have ready and unfettered access to the tools and information they need to protect themselves against HIV, sexually transmitted infections, unintended pregnancy and violence. Concerted efforts are needed to improve access to and the uptake of sexual and reproductive and HIV services among both men and women. Focused, well-resourced action and programmes are needed to transform unequal gender relations and norms and to end gender-based, sexual and intimate partner violence.

Proven programmes to reduce gender inequality, empower women and girls and prevent gender-based, sexual and intimate partner violence need to be rapidly scaled up. National commitments to address the diverse and comprehensive HIV-related needs of women and girls need to be translated into budgeted, robust programmes.

Transformative approaches are required to engage men and create social and behaviour change by questioning traditional gender norms, roles and relationships. Such approaches have been shown to increase spousal support, reduce gender-based violence and strengthen communication and decision-making skills towards safer sex practices and delayed marriage (19). Male-friendly services are

also needed, including expanded entry points for care, flexible service hours, workplace testing and counselling and home-based testing. HIV counselling, testing and treatment aimed at couples can improve service uptake by men and address intimate partner transmission of HIV.

Age- and sex-disaggregated data must be routinely collected and analysed to inform the development and adaptation of policies and to improve programmatic performance for women and girls. Recognizing the extraordinary diversity of women around the world, age- and sex-disaggregated data should be complemented by collecting data on the various determinants that increase women's risk of and vulnerability to HIV infection and violence.



8.

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

Progress towards achieving the target

In countries with repeated population surveys carried out between 2003 and 2014, most reveal a decline in discriminatory attitudes towards people living with HIV (1). Modest improvements have also been reported in removing punitive laws, regulations and policies and enabling legal frameworks pertaining to key populations. From 2010 to 2014, there was an increase in the number of countries reporting through the National Commitments and Policies Instrument on the existence of general anti-discrimination laws and mechanisms applicable to sex workers (from 21 to 25 countries), migrants (from 38 to 48 countries), people in prison (from 40 to 50 countries), women (from 60 to 88 countries) and young people (from 55 to 82 countries) (1). The number of countries reporting such protections for people living with HIV remained stable. From 2006 to 2015, the number of countries criminalizing same-sex sexual acts fell from 92 to 75 (2).

However, the world remains far from eliminating stigma and discrimination, undermining efforts to respond effectively to the epidemic. In about 40% of countries where Demographic and Health Surveys have been conducted, more than half of adults report having discriminatory attitudes towards people living with HIV (1). In scores of countries, punitive and counterproductive legal and policy frameworks reflect and reinforce stigma, discrimination and exclusion, with especially severe consequences for vulnerable and marginalized communities. Almost every country in the world criminalizes some aspect of sex work and drug use. People who use drugs comprise half the prison population worldwide (1). Overly broad laws and prosecutions for HIV non-disclosure, exposure and transmission have been recorded in all global regions; about 61 countries have adopted legislation that specifically enables such criminalization.

Stigma and discrimination expose individuals to considerable mental, economic and physical harm. In more than 50 countries where People Living with HIV Stigma Index surveys have been conducted,

one in eight people living with HIV report having been denied health services because of their HIV status (3). In countries where the People Living with HIV Stigma Index was implemented and where unemployment rates for the general population are available, the rates of unemployment among people living with HIV are three times higher than for the population as a whole.

Within the health-care system, stigma and discrimination restrict the uptake and utilization of services, and they also lead to rights violations such as mandatory HIV testing, lack of confidentiality in care, denial of health care, forced sterilization and abortion. A 2013 systematic review of studies on stigma and discrimination covering almost 27 000 people living with HIV in 32 countries (4) found that HIV-related stigma had such a deep mental impact that it compromised adherence to antiretroviral therapy. In Bangkok, 25% of people who inject drugs told researchers that they avoid health care because of the fear of compulsory treatment (5). Among transgender men and women surveyed in the United States, 58% said it was reasonable for people to avoid HIV testing and 44% said it was reasonable for people to avoid antiretroviral therapy if they live in areas that criminalize HIV transmission, exposure or non-disclosure (6).

Factors contributing to progress

In recent years, the evidence base for programmes to reduce stigma and discrimination has increased significantly (7). In diverse settings and regions, networks of people living with HIV and key populations continue to play a key role in raising awareness, dispelling myths and advocating for inclusive, rights-based responses to AIDS. In addition, increased treatment coverage has been associated with reduced levels of stigma and discrimination (1).

Although progress is limited in dismantling punitive and discriminatory policy frameworks, some gains have been made. In 2015, for example, Mozambique decriminalized same-sex sexual relations. Also in 2015, the High Court of Kenya invalidated a law that imposed criminal penalties if a person living with HIV exposed another person to the virus (1). The Supreme Court of Namibia ruled in 2014 that compulsorily sterilization of pregnant women living with HIV is a violation of their rights (1).

Nearly two thirds (64%) of countries report having laws, regulations or policies in place that prohibit discrimination against people living with HIV (1). The percentage of countries reporting such anti-discrimination protections has remained relatively stable for many years.

Persistent challenges

Although the decline in stigma and discrimination over time is encouraging, discriminatory attitudes towards people living with HIV persist at very high levels. In at least eight countries in sub-Saharan Africa, a majority of people surveyed said they would refuse to purchase vegetables from someone known to be living with HIV—an indication that the high prevalence of discriminatory attitudes affects the right of people living with HIV to work and enjoy other basic human rights protections (1).

Punitive legal and policy frameworks continue to hold back efforts to address the epidemic in an evidence-informed, rights-based manner. 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 (1). Even as the number of countries reporting the existence of anti-discrimination protections for sex workers modestly increased from 2010 to 2014, most countries continue to criminalize sex work (2). Across the world, most countries criminalize the possession of illegal drugs, and several Asian and Latin American countries have systems for compulsory detention or rehabilitation (2).

Since 2010, the world has seen a wave of discriminatory legislation regarding same-sex sexual relations. After Nigeria enacted severe criminal penalties for same-sex practices, reports of human rights violations towards men who have sex with men increased substantially, and the use of HIV services focused on this population declined sharply (8, 9).

Lessons learned

Building a strong foundation to end the AIDS epidemic as a public health threat urgently requires immediate steps to eliminate punitive and discriminatory laws, policies and practices that undermine an effective response. Further investment is needed in focused human rights programmes that enable people living with HIV, key populations, women and girls and other affected groups to know their rights, access justice and challenge rights violations, in addition to rights-based health care and HIV prevention, treatment and care services. Programmes to combat stigma and discrimination and to ensure access to services and justice for marginalized groups must be well resourced. Moreover, new investment is needed to implement and scale up approaches that have been proven to result in equitable, rights-based access to services for all communities, especially key populations.

Political leadership, broad-based coalitions and legal reform are needed to promote social norms of tolerance, inclusion and anti-discrimination. HIV-related human rights violations, legal and policy barriers and people's experience of stigma and discrimination need to be closely monitored. Diverse groups will need to join together in a common effort to eliminate stigma and discrimination, including civil society, faith-based groups, law enforcement, the executive and legislative branches of government, the judiciary, academia and the private sector.



9.

Eliminate HIV-related restrictions on entry, stay and residence

Progress towards achieving the target

There is a clear trend towards removing HIV-related restrictions on entry, stay and residence. Since 2011, 14 countries have either repealed HIV-related 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 as of December 2015 (1). Progress in removing such discriminatory laws is a litmus test for wider progress being made in grounding the AIDS response in human rights principles.

Factors contributing to progress

Including the goal of eliminating HIV-related restrictions on entry, stay and residence in the 2011 Political Declaration played an important role in building momentum towards repealing such laws and policies. In 2014, Tajikistan enacted legislation to eliminate HIV-related restrictions on entry, stay and residence, while Comoros adopted HIV legislation that included specific protections for people living with HIV. In the run-up to the 20th International AIDS Conference in 2014, Australia formally clarified that its regulations do not automatically exclude people living with HIV or sanction discriminatory treatment with respect to visa applications. Belarus and Lithuania both confirmed in 2015 that they do not apply restrictions on entry, stay and residence for people living with HIV. In addition, Belarus confirmed that foreign nationals have equal access to health-care services, including antiretroviral therapy for people living with HIV.

Since 2011, the global coalition advocating the removal of discriminatory travel restrictions expanded. In 2012, 40 chief executive officers urged all countries with HIV-related travel restrictions to take immediate steps to remove them. Representing nearly 2 million employees altogether, these chief executive officers emphasized the business case for non-discrimination, citing their need for the ability to send employees and the best talent overseas without regard to their HIV status (2).

Persistent challenges

Restrictions on people living with HIV with respect to entry, stay and residence remain in place in 35 countries. These discriminatory restrictions result in substantial harm and denial of life-saving HIV services. Such approaches also reinforce unfounded beliefs that migrants increase HIV-related risks for host communities and reduce the development of the solidarity and compassion required to effectively respond to AIDS.

All members of the Gulf Cooperation Council have HIV-related travel restrictions. Since the Gulf Cooperation Council region is affected by considerable migration, including a substantial migrant workforce, the potential harm associated with these discriminatory policies may be magnified. UNAIDS, in collaboration with the International Labour Organization, Office of the United Nations High Commissioner on Refugees and United Nations Development Programme, has initiated a study to review policies, regulatory frameworks and practices in Gulf Cooperation Council countries as well as Jordan and Lebanon.

Lessons learned

Policy-makers in the 35 countries with such laws and policies in place need to adopt an approach based on human rights and public health to enable immediate steps to remove such laws and policies. Intensified advocacy with parliamentarians and political leaders will be crucial, as will close partnerships with civil society organizations and key civil service officials in countries with such discriminatory rules.



10.

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 towards achieving the target

Substantial gains were made in 2011–2015 towards the overarching aim of taking AIDS out of isolation and linking it more closely with broader health and development efforts. More than 90% of countries reporting to UNAIDS at the end of 2014 stated that HIV had been mainstreamed into broader development frameworks, and 70% reported being on track to achieve national integration commitments.

Progress has been made in integrating HIV services with other service systems. More than 90% of countries reported a high degree of integration between HIV counselling and testing and TB services, with more than half (53%) also reporting extensive provision of joint HIV and TB screening, testing and treatment services. Two thirds of countries reported facility-level integration of HIV and sexual and reproductive health services.

Commitment to and scaling up of HIV-sensitive social protection has occurred in a range of contexts, including China, India, Indonesia, Kenya, Malawi, Nepal, South Africa, Thailand, Ukraine, Zambia and Zimbabwe. In 2014, in-country social protection lending by the World Bank reached US\$ 12 billion, with the social protection systems of 70 countries being strengthened. Cash transfers to households affected by HIV and TB have been provided to countries through social protection projects included in the concept notes sent to the Global Fund.

Factors contributing to progress

Steps have been taken to eliminate duplicative or conflicting systems and planning cycles. Countries such as Brazil, Cameroon, Côte d'Ivoire, Madagascar, Malawi and Mauritania have implemented aligned strategic planning and budget cycles for HIV and health generally. Other countries—including Ethiopia, Gabon, Georgia, Morocco, Senegal, South Africa, Thailand and Zambia—are in the

process of integrating HIV services into national health insurance, health funds or other domestic funding schemes.

To promote further integration of HIV and TB efforts, the Global Fund in 2014 advised countries with a high burden of HIV and TB to submit a single concept note outlining integrated and joint programming for these linked epidemics. At least 16 countries (Burkina Faso, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Mozambique, South Africa, Swaziland, Thailand, Togo, Uganda, Ukraine, United Republic of Tanzania, Viet Nam and Zambia) have submitted joint concept notes that had either been approved or were nearing approval as of November 2015.

The AIDS response has contributed to broader health system strengthening. Thirty-three countries reported extensive integration of HIV counselling and testing services with services for chronic noncommunicable diseases. Seventy-one countries (more than half) indicated that many HIV counselling and testing services are integrated into general outpatient care facilities. Nearly one third of reporting countries stated that antiretroviral therapy is provided in general outpatient care.

In collaboration with partners, UNAIDS has promoted the elimination of parallel systems and broader system strengthening. Technical support has aided service integration, and multipartner initiatives, such as the Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children and the Interagency Working Group on Sexual and Reproductive Health and Rights, have supported and monitored national efforts to integrate HIV with other service systems. Likewise, the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases has promoted closer linkage and coordination between HIV and other chronic diseases.

United Nations partners have contributed to progress in linking the AIDS response more closely with broader health and development efforts. In Zambia, where more than 1.4 million children are orphaned (including many as a result of HIV), the World Food Programme rolled out the Home Grown School Feeding Programme, reaching more than 861 000 schoolchildren in 22 primarily rural districts. Similarly, in Malawi, where 24% of households have at least one chronically ill member, World Food Programme food assistance benefited 1.7 million people.

Persistent challenges

Work to eliminate parallel systems and increase the integration of the HIV response in broader health and development efforts

remains incomplete, underscoring the need for strong national leadership towards these ends. Diverse models of integration that can be tailored to address national circumstances are needed, along with improved data collection and monitoring systems to assess integrated delivery models.

Key populations and young people remain insufficiently recognized in policies and programmes. To make HIV integration and linkage both feasible and effective, action on critical enablers is needed, addressing such issues as social exclusion, marginalization, criminalization, stigma and discrimination, inequities and age of consent for services.

Although the Global Fund innovation of joint concept notes for HIV and TB offers an important platform for further integrating HIV and TB responses, final grant budgets from the concept notes that have been approved continue to support disease-specific grants, and joint programming at the community level or for key populations remains limited. These patterns underscore the need for further efforts to promote genuine integration of HIV and TB services.

24%

In Malawi, where 24% of households have at least one chronically ill member, World Food Programme food assistance benefited 1.7 million people.

Lessons learned

The common challenges of HIV and other health and development issues within the 2030 Agenda for Sustainable Development can be more efficiently addressed through greater integration. New approaches are needed to guide investment and maximize synergy at the intersections between HIV and the Sustainable Development Goals, addressing the broad determinants of global health through multistakeholder partnerships and advocating for and negotiating global public goods.

In particular, greater collaboration is required across national health programmes to integrate and decentralize HIV testing and treatment with services for TB, sexual and reproductive health, maternal and child health, sexually transmitted infections and noncommunicable diseases. As HIV increasingly becomes a chronic, manageable condition, HIV care can be linked more integrally with broader chronic health-care approaches. HIV services for key populations are best delivered in close collaboration with civil society organizations and bundled with the other health services they need. For example, strong referral systems can link HIV prevention, testing and treatment for people who inject drugs to hepatitis and TB diagnosis and treatment and wider harm reduction efforts, including opioid substitution therapy and overdose prevention, mental health services and social protection programmes. Special efforts are also needed to maintain the availability of HIV services within the responses to national emergencies.

The development of national integration road maps can accelerate efforts to embed the AIDS response within efforts to strengthen health systems and establish universal health care, including by fully capitalizing on funding opportunities. Best practices and lessons learned should be documented and shared, especially through South–South collaboration. Electronic medical record systems and health information systems require strengthening in order to improve patient monitoring and referrals across health programmes and to track progress and identify barriers to greater integration.

Conclusion

The progress made towards the 10 targets and elimination commitments in the 2011 Political Declaration has established a sound foundation for the next phase of the global AIDS response. Efforts to expand HIV treatment and other programme areas achieved a 42% global reduction in the number of people dying from AIDS-related causes from 2004 to 2014 as well as sharp increases in life expectancy within countries with a high burden of HIV infection. The mobilization of unprecedented resources has fuelled both HIV-specific service expansion and strengthened health systems in low- and middle-income countries. These achievements have inspired optimism.

The Sustainable Development Goals include an ambitious new target: ending the AIDS epidemic by 2030. However, at its current pace, the global AIDS response will not achieve this target. Between 2010 and 2014, new HIV infections fell by only 8%. Up to 60% of people living with HIV remain without life-saving antiretroviral therapy, and the long-term financial sustainability of HIV treatment remains uncertain. Key populations at higher risk of infection and young people remain underserved, as stigma, discrimination, gender inequalities and human rights violations continue to undermine efforts to reach them.

A narrow five-year window of opportunity exists to front-load investment in HIV to fully scale-up the evidence-informed HIV prevention and treatment programmes that exist today. If these investments are not made we risk losing all the gains made to date and the epidemic backsliding. HIV investments need to increase yearly up to a peak of 40% higher by 2020, compared to the total invested in 2015. If we achieve this and all the Fast-Track Targets on time it is predicted that from 2021 total HIV investments will begin to decline. In October 2015, the Programme Coordinating Board of UNAIDS approved a new strategy with a set of ambitious yet achievable HIV prevention and treatment targets. Achieving these targets would prevent 28 million people from acquiring HIV, including 5.9 million children, through to 2030 and prevent 21 million people dying from AIDS-related causes (1). The Fast-Track response in 2016–2020 will also generate economic returns, avoid future health-care costs, preserve and increase productivity and improve outcomes for children.

By contrast, a failure to build on gains to date would reverse decades of progress. If coverage is maintained at current levels, the numbers of people newly infected with HIV and dying from AIDS-related causes will be substantially higher in 2030 than currently, and the epidemic's toll 15 years down the road will rise rapidly from year to year (2).

The Fast-Track approach requires wiser investment in the most effective HIV testing, prevention and treatment strategies, with laser-like focus on the populations and locations in greatest need. Reaching the people at greater risk of HIV must be anchored within wider efforts to reverse deepening inequality throughout the world. Although many countries have achieved economic success over the last 15 years, the fruits of that success have not been evenly shared. Less than 1% of the world's population owns 41% of the world's wealth, and the poorest two thirds of humanity owns just 3% (3). In 2020, middle-income countries will be home to more than half of all people living in poverty and 70% of people living with HIV (1). Urbanization is straining traditional social structures, and a growing number of people are affected by humanitarian emergencies each year, exacerbating inequality.

The United Nations General Assembly High-Level Meeting on Ending AIDS, taking place from 8 to 10 June 2016, will provide an important opportunity to Fast-Track the response to HIV over the next five years and end the AIDS epidemic by 2030 as part of the Sustainable Development Goals. The interconnected nature of the 17 global goals can be leveraged not only to end the AIDS epidemic but also to empower women to protect their sexual and reproductive health rights, to ensure that key populations have full access to health services delivered with dignity and respect, to ensure all people living with HIV have access to antiretroviral treatment and to ensure that no child is born with HIV.

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Conclusion

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