High-Level Meeting on AIDS
END INEQUALITIES. END AIDS.

GLOBAL COMMITMENTS, LOCAL ACTION

After 40 years of AIDS, charting a course to end the pandemic

TWENTY YEARS AGO, the United Nations General Assembly set a common agenda that has propelled global efforts to reverse the course of the AIDS pandemic.

FOUR DECADES OF AIDS

Forty years have passed since doctors first detected a strange and deadly new disease destroying the immune systems of men in New York and California *(1)*. Its cause, the human immunodeficiency virus (HIV), was soon isolated and traced back to simian viruses circulating in central Africa. Within a decade, acquired immunodeficiency syndrome (AIDS) was killing millions around the world by exploiting societal fault lines and the indifference of many world leaders.

It took 10 more years for the world to take concerted action. In 2001, the United Nations (UN) General Assembly convened the first-ever special session on a pandemic. By then, AIDS-related illnesses had become the number one cause of death in Africa and the fourth leading cause of death worldwide. The collective voice of affected communities had also grown, marshalling networks of support and demanding stronger action from governments. An innovative joint programme of entities across the UN system, UNAIDS, became operational in 1996, urging countries and communities in every region to join a new global pandemic response.[1]

The General Assembly's 2001 Declaration of Commitment on HIV/AIDS was a major milestone in global leadership on the right to health, and it set a common agenda that propelled global efforts to reverse the pandemic's course. Activists living with HIV successfully pushed for affordable HIV treatment to reach developing countries, and the number of AIDS-related deaths tumbled. New HIV infections also decreased. Global momentum was sustained through high-level meetings of the General Assembly in 2006 and 2011. When world leaders gathered at the UN General Assembly for a fourth time to confront HIV in 2016, ambitious targets were set for 2020, with the aim of ending AIDS by 2030, as called for in the Sustainable Development Goals *(2)*.

DOZENS OF DIVERSE COUNTRIES HAVE MET or exceeded the ambitious targets set by the General Assembly every five years. These high-performing countries have provided paths for others to follow.

Five years later, dozens of countries across a range of epidemic settings and economic classifications have reached or exceeded many of those targets. These countries have shown that a pandemic that seemed almost unassailable 20 years ago can be brought under control. However, other countries and entire regions are off-track. In some places, previous gains are being

[1] The Joint United Nations Programme on HIV/AIDS (UNAIDS) currently includes: Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO) and the World Bank. With strategic guidance and support from the UNAIDS Secretariat, the Joint Programme fosters integration and the coordination of efforts across the wide range of areas in people's lives that affect and are affected by HIV.

reversed, and COVID-19, conflicts and humanitarian emergencies have created additional challenges. Across all regions, the most vulnerable and stigmatized populations are most often left behind. Key populations continue to be marginalized and criminalized for their gender identities, sexual orientation, livelihoods and dependencies, or for simply living with HIV.[2] Gender inequalities and gender-based violence restrict the rights of women and adolescent girls, including their ability to refuse unwanted sex or negotiate safer sex, and to access HIV and sexual and reproductive health services.

HIV remains a pandemic driven by inequalities. When the data from UN Member States' 2020 reports to UNAIDS are aggregated, the unfortunate conclusion is that all of the global targets for 2020 have been missed. Time is running out on the global effort to end AIDS by 2030.

[2] Key populations are groups of people who are more likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response. In all epidemic settings, (i) key populations include people living with HIV, and (ii) key populations at higher risk of HIV infection include gay men and other men who have sex with men, transgender people, people who inject drugs, sex workers and their clients, and people in prisons and other closed settings.

MANY COUNTRIES AND ENTIRE REGIONS ARE OFF-TRACK. Within countries, the most vulnerable are most often left behind. HIV remains a pandemic driven by inequalities.

The General Assembly holds its fifth high-level session on HIV and AIDS on 8–10 June 2021. As the world's leaders face the clear need to do better against HIV, they must also grapple with a new pandemic threat: COVID-19. The parallels between the two pandemics—both their successes and their challenges—are many, reinforcing the urgent need for the world to do far more to prepare for and respond to pandemics in a way that addresses inequalities rather than deepens them.

UNAIDS has proposed ambitious and achievable targets for 2025, and it has developed a global strategy for achieving them. High-performing countries have provided paths for others to follow. Their HIV responses share vital features: strong political leadership on AIDS, adequate funding, genuine community engagement, rights-based and multisectoral approaches, and the use of scientific evidence to guide focused strategies. These are elements that are invaluable against HIV, COVID-19 and many other communicable and noncommunicable diseases.

Achievement of the 2025 targets will bring comprehensive HIV services to 95% of the people who need them and reduce annual HIV infections from 1.5 million to fewer than 370 000 and AIDS-related deaths from 690 000 to fewer than 250 000. When these individual and public health gains are translated into economic terms, each additional US$ 1 of investment in implementing the Global AIDS Strategy in low- and middle-income countries brings a return of more than US$ 7 in health benefits (Figure 1) *(3)*.[3] Such high returns should make national leaders and ministries of finance and development assistance take notice. The families and communities affected by HIV already understand that long and healthy lives are simply priceless.

The General Assembly must seize this moment, declare that the world can no longer afford to under-invest in pandemic preparedness and responses, and commit to taking the actions needed to reach the global goal to end AIDS.

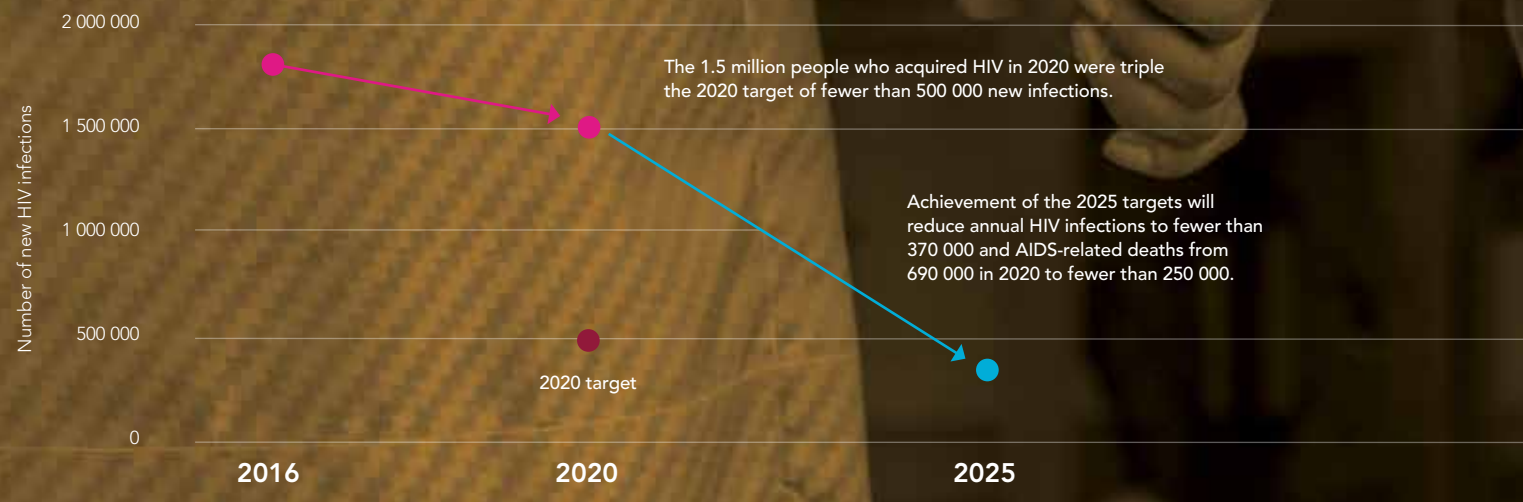
A GLOBAL STRATEGY FOR ACHIEVING AMBITIOUS AND ACHIEVABLE 2025 TARGETS has been developed by UNAIDS.

[3] Health benefits are valued in statistical life (VSL). A VSL represents the amount an average person would pay to reduce their risk of death by one in 10 000 for one year. The return on investment analysis allows willingness to pay for mortality risk reduction to decline at either 1% or 1.5% for every percentage decline of a country's gross domestic product per capita.

Time is running out on the global effort to end AIDS by 2030

Global progress since the 2016 UN General Assembly High-Level Meeting has been too slow. Targets for 2020 have been missed.

FIGURE 1



Source: Special analysis by Avenir Health using preliminary UNAIDS epidemiological estimates, 2021.

THE WORLD CAN NO LONGER AFFORD TO UNDER-INVEST in pandemic preparedness and responses.

WHEN THE GENERAL ASSEMBLY MEETS at its High-Level Meeting on AIDS on 8–10 June 2021, it must seize the moment and commit to taking the actions needed to end AIDS by 2030.

Each additional
US$ 1
invested in the HIV responses of low- and middle-income countries between 2021 and 2030
will bring a return of more than
US$ 7
in health benefits

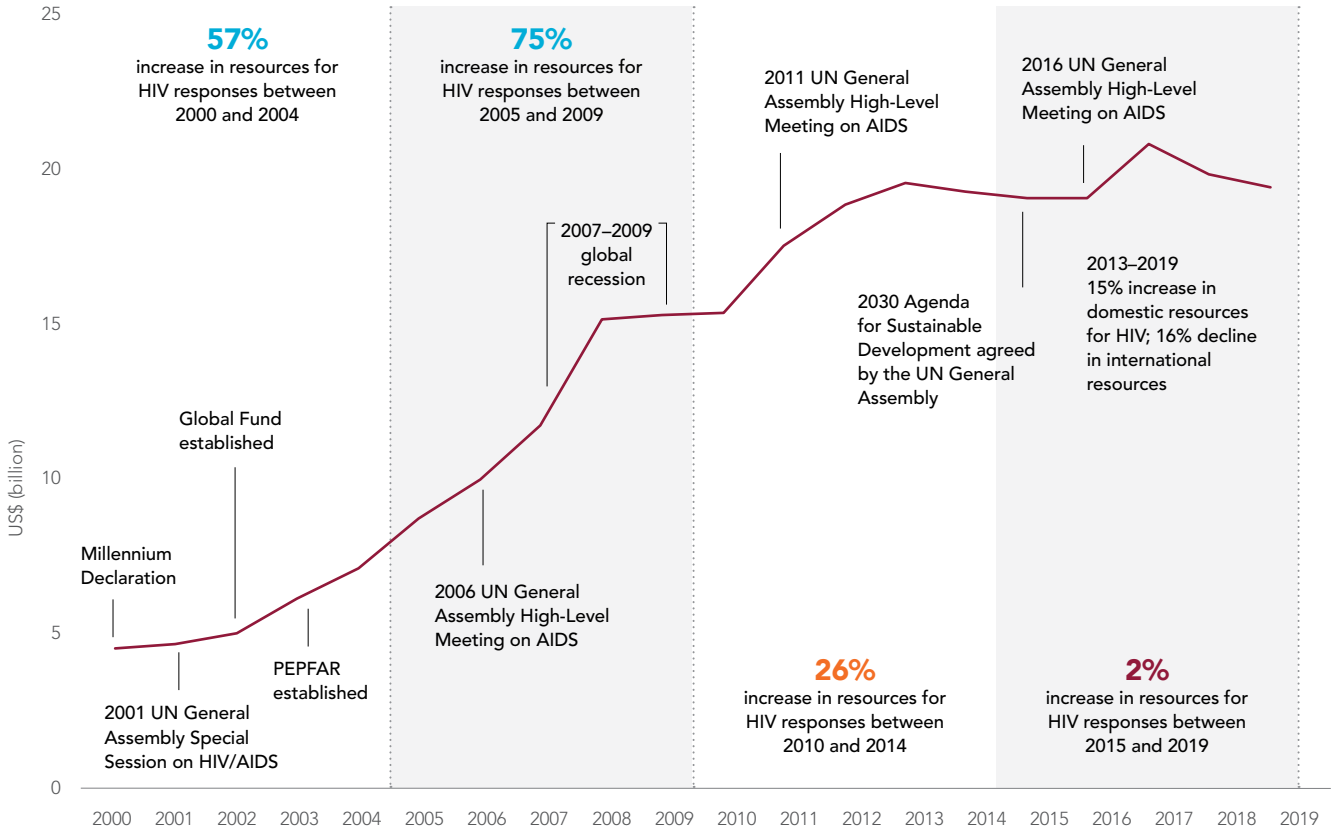
Source: Lamontagne E, Over M, Stover J. Special analysis for UNAIDS, 2021. Unpublished.

TWO DECADES OF GLOBAL SOLIDARITY AGAINST AIDS

Political will and funding

The 2001 General Assembly Special Session produced a commitment to establish the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), one of many examples of increased international and domestic financial commitments over the last 20 years that have made HIV services and commodities more accessible, and that have strengthened health systems more generally. Life-saving medicines (particularly antiretroviral therapy) that were almost exclusively available in high-income countries 20 years ago are now affordable in most countries. Health technologies like HIV tests and condoms are similarly available, and access to pre-exposure prophylaxis (PrEP) and voluntary medical male circumcision continues to expand. However, declines in international resources in recent years have contributed to the total resources available for HIV responses in low- and middle-income countries levelling off well short of the 2020 target of US$ 26 billion annually (Figure 2).

FIGURE 2 | **RESOURCE AVAILABILITY FOR HIV RESPONSES, LOW- AND MIDDLE-INCOME COUNTRIES, 2000–2019**



Source: UNAIDS financial estimates and projections, 2021.
Note: The countries included across all years (2000–2019) are those that were classified by the World Bank in 2015 as being low- and middle-income. The resource estimates are presented in constant 2019 US dollars.

Rallying to achieve 90–90–90

The 90–90–90 targets, agreed by the General Assembly in 2016, called for the vast majority of people living with HIV to be tested, start treatment and reduce the HIV within their bodies to undetectable levels by 2020. Achieving these targets means that a minimum of 73% of people living with HIV have suppressed viral loads, which helps to keep them healthy and prevents the further spread of the virus.

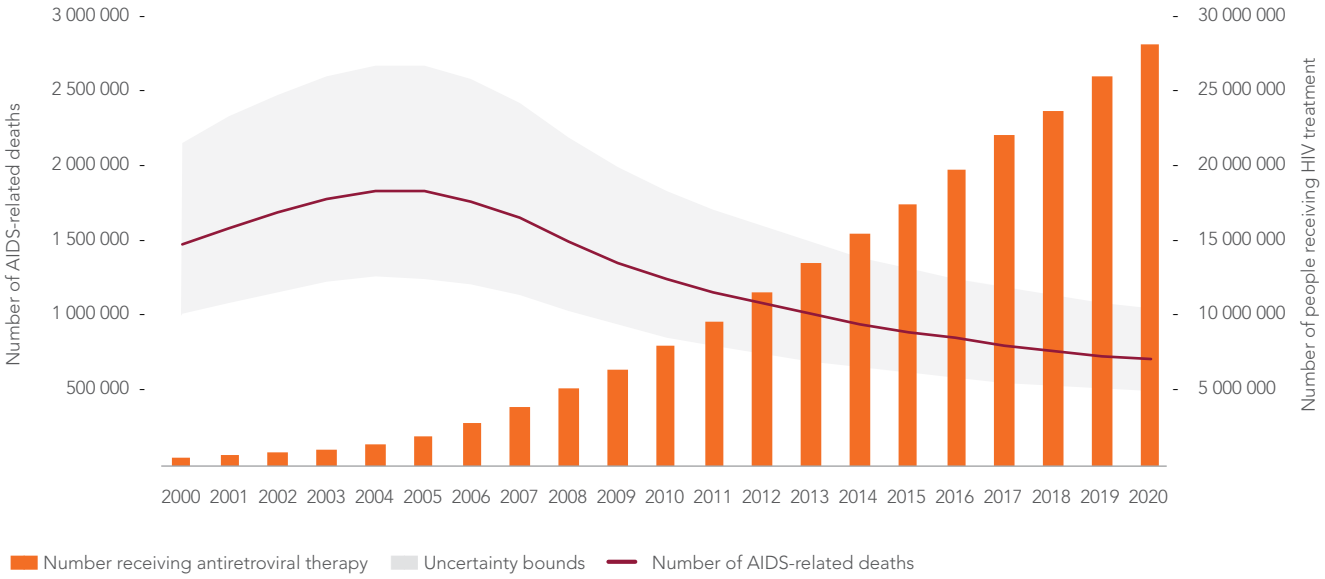
At the end of 2020, 84% [68–>98%] of people living with HIV knew their HIV status, 73% [57–88%] were accessing antiretroviral therapy and 66% [53–79%] were virally suppressed. Among the 37.6 million [30.2 million–45.0 million] people living with HIV globally in 2020, an estimated 27.4 million [26.5 million–27.7 million] people living with HIV were on treatment—a number that has more than tripled since 2010, but that is still short of the 2020 target of 30 million.

The global roll-out of HIV treatment has saved millions of lives: an estimated 16.2 million [11.2 million–23.8 million] AIDS-related deaths have been averted since 2001. In 2020 there were 690 000 [480 000–1 000 000] deaths from AIDS-related causes, a decline of 55% from 2001 to 2020 (Figure 3). At least 40 countries are on track to achieve a 90% reduction in AIDS-related mortality by 2030, including nine countries in eastern and southern Africa.[4]

At the end of 2020, **84%** of people living with HIV knew their HIV status, **73%** were accessing treatment, **66%** were virally suppressed.

[4] On track is defined as a decline of 49.5% or greater by 2020, compared to a 2010 baseline.

FIGURE 3 | **NUMBERS OF AIDS-RELATED DEATHS AND PEOPLE RECEIVING HIV TREATMENT, GLOBAL, 2000–2020**



Source: Preliminary UNAIDS epidemiological estimates, 2021.

Community leadership

Communities living with and affected by HIV, including key populations, are the backbone of the response. They have campaigned for their rights, expanded the evidence base for effective action against HIV, supported the design and implementation of programmes, and enhanced the reach and quality of health services. They have ensured that the Greater Involvement of People living with AIDS (or GIPA) principle became an organizing norm for HIV programmes, and that rights-based approaches were more widely adopted.

The response to the COVID-19 pandemic has underscored the importance of community-led organizations in navigating difficult and rapidly changing environments, and reaching affected communities with essential services, such as: COVID-19 testing and vaccination; HIV prevention, testing and treatment; and other health and social services.

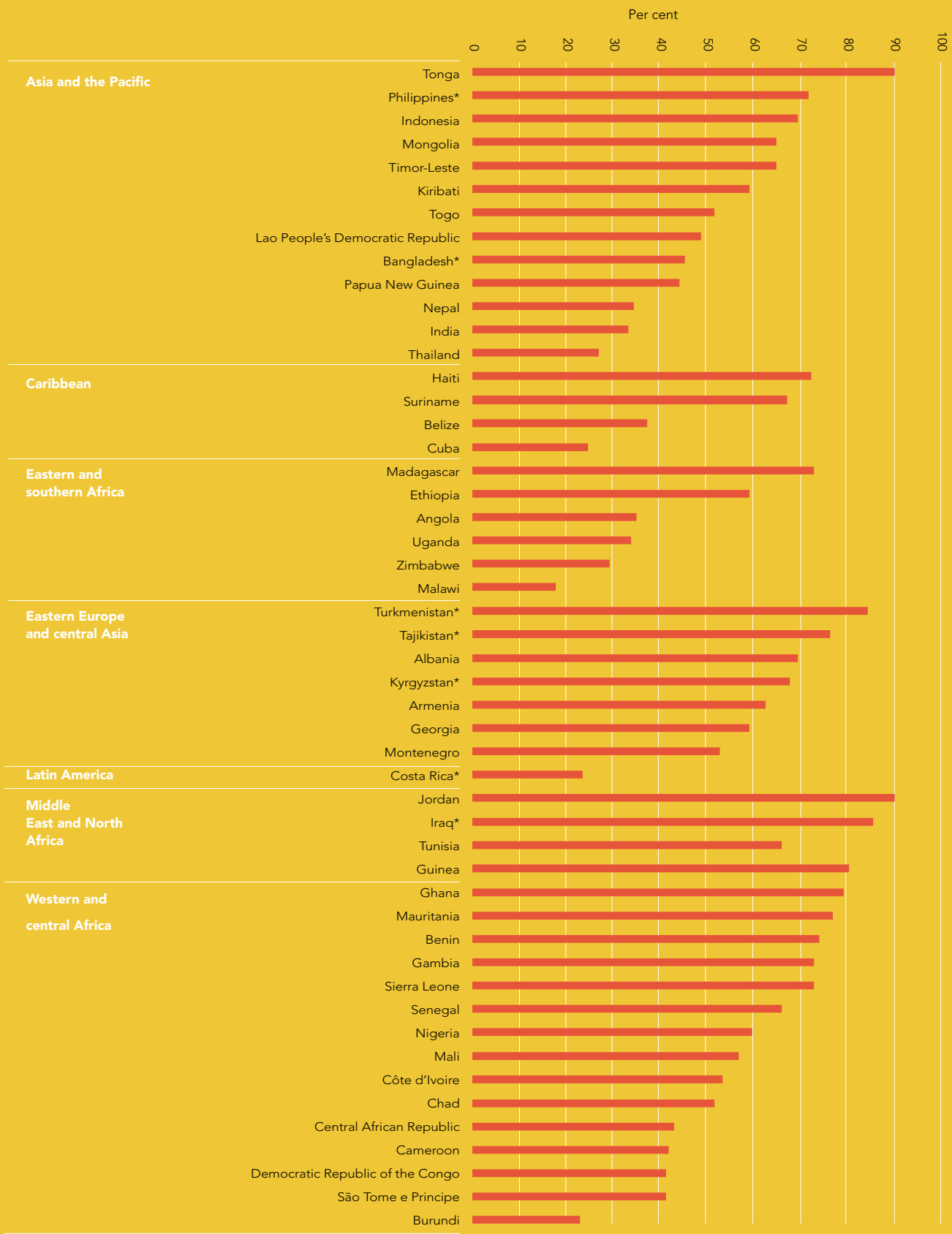
Rights-based approaches

A guiding vision of the HIV response is to end stigma and discrimination based on fear, racism, homophobia/transphobia and denialism. Experience shows that HIV-related stigma and discrimination is reduced when public figures raise awareness about the epidemic, when communities challenge discriminatory attitudes and practices, when legislators reform restrictive laws that criminalize or violate the rights of people living with HIV and people at risk of infection, and when rights-based approaches underpin the delivery of HIV services.

Data from population-based surveys show that discriminatory attitudes towards people living with HIV are relatively low in several countries in sub-Saharan Africa, Asia, Latin America and the Caribbean. However, across nearly all regions there are countries where disconcertingly large proportions of adults continue to hold discriminatory attitudes towards people living with HIV (Figure 4). Key populations also continue to experience high levels of stigma and discrimination and violence.

* Data are for women aged 15 to 49 only.
Source: Population-based surveys, 2015–2019.
Note: Discriminatory attitudes are measured through "No" responses to either of two questions: (1) Would you buy fresh vegetables from a shopkeeper or vendor if you knew this person had HIV?; and (2) Do you think that children living with HIV should be able to attend school with children who are HIV-negative?

FIGURE 4 | **PERCENTAGE OF PEOPLE AGED 15–49 YEARS WHO REPORT HAVING DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV, COUNTRIES WITH AVAILABLE DATA, 2015–2019**



Guided by science and data

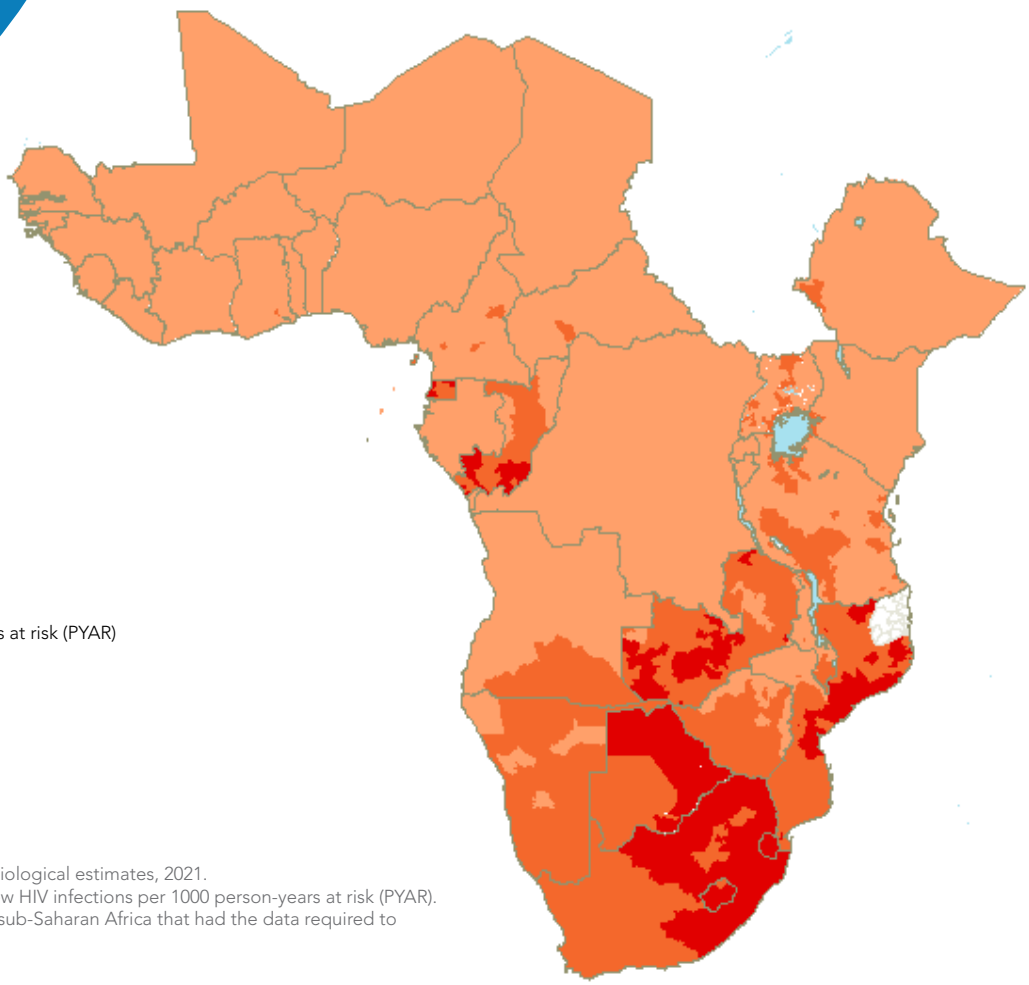
Investments in science have accelerated the HIV response and contributed to many other global health efforts, including the response to COVID-19. Milestones include the following:

- Identification of HIV as the cause of AIDS in 1983.
- Development of the first HIV diagnostics in the late 1980s and the introduction of rapid HIV tests in 2003.
- Roll-out of the first antiretroviral medicine in 1987. This was followed by one-a-day triple-therapy pills in the early 2000s, and by the steady development of new medicines, such as dolutegravir.
- Confirmation in 2005 that male circumcision provides partial, life-long protection against female-to-male sexual transmission of HIV.
- Expanded use of antiretroviral medicines over the last decade for PrEP and post-exposure prophylaxis (PEP).
- New technologies, including long-acting injectables and vaginal rings, that could soon hit the market.

The continuing search for an HIV vaccine and a cure has yet to yield a clear breakthrough, but the tools and techniques pioneered for HIV testing and vaccines have been leveraged for the rapid development and roll-out of COVID-19 diagnostics and vaccines *(4)*. Conversely, the supercharged vaccine programmes for COVID-19 are now being leveraged to accelerate the development of an HIV vaccine.

Steady advances in epidemiological surveillance and programme monitoring have guided efforts to focus programmes on the people and places in greatest need of services. Data from district health information systems are informing epidemiological models that reveal HIV transmission hotspots that require intensification of combination HIV prevention interventions (Figure 5). Phylogenetic analysis of blood samples from people living with HIV is revealing the history of the virus' spread through communities, countries and continents, providing insights about transmission dynamics that inform HIV prevention efforts *(5)*.

FIGURE 5 | **HIV INCIDENCE AMONG ADOLESCENT GIRLS AND YOUNG WOMEN (AGED 15–24 YEARS), SUBNATIONAL LEVELS, SUB-SAHARAN AFRICA, 2020**



Incidence rate per 1000 person-years at risk (PYAR)

- No data
- < 3 per 1000 PYAR (low)
- 3–< 10 per 1000 PYAR (high)
- 10–30 per 1000 PYAR (very high)

Source: Preliminary UNAIDS epidemiological estimates, 2021.
Note: HIV incidence estimated as new HIV infections per 1000 person-years at risk (PYAR).
Countries: For selected countries in sub-Saharan Africa that had the data required to produce subnational HIV estimates.

Building robust and resilient health systems

The HIV response, however, is much more than an effort to end a single disease.

The HIV response and resources have established huge cadres of community health workers and HIV prevention specialists who work closely with primary health-care services and local authorities. Communities of people living with HIV, women's organizations and key populations have also tackled key inequalities and service deficiencies, and they have advocated for affordable medicines, commodities and services. HIV and other health information systems have been upgraded, including localized and real-time data gathering, and procurement and supply chain management systems have been overhauled. These strengthened systems have proved vital during the COVID-19 pandemic, ensuring that information and personal protective equipment reach vulnerable communities, and that HIV and other key services are preserved.

The Global Fund—which was established to focus on HIV, tuberculosis and malaria—is now the largest funder of grants for health systems, investing more than US$ 1 billion a year. In 2020, the Global Fund actively supported COVID-19 responses, making up to US$ 1 billion available to adapt existing grants to include COVID-19 testing, tracing and patient care, and to reinforce key components of health and community systems, such as laboratory networks and community-led monitoring *(6)*.

The biggest bilateral HIV programme, the United States President's Emergency Plan for AIDS Relief (PEFPAR) initiative, has invested billions of dollars to build the infrastructure and capacity of country health systems, helping train 290 000 health-care workers, supporting more than 3000 laboratories, 28 national reference laboratories and 70 000 health-care facilities, and building country expertise in surveillance, diagnoses and rapid public health responses *(7)*. These efforts have enhanced global health security while protecting and advancing the gains made against HIV.

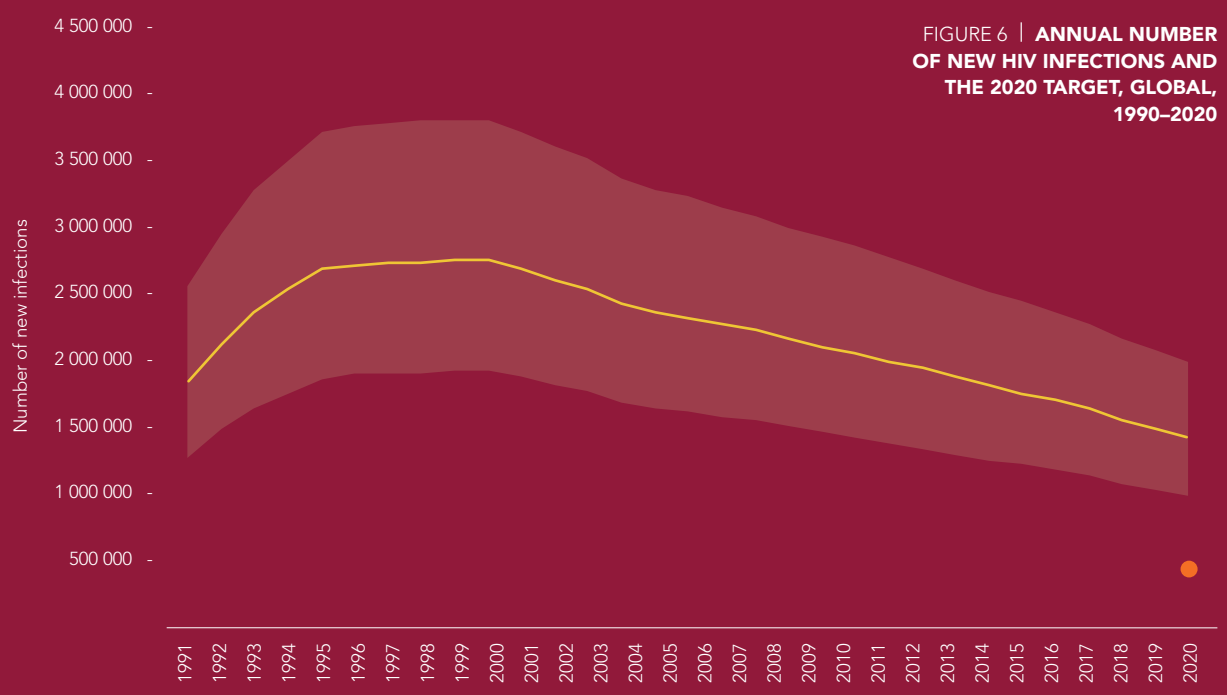
DEEPENING INEQUALITIES

Poor progress on prevention

Condom use has averted an estimated 117 million HIV infections globally since the beginning of the pandemic *(8)*. Antiretroviral therapy has made a significant contribution to reductions in HIV infections among adults and children over the last two decades. Sustained treatment suppresses HIV within the bodies of people living with HIV, making the virus undetectable and HIV infection untransmittable. Programmes to eliminate vertical HIV transmission have averted some 2.7 million [1.8 million–4.2 million] new infections in children since 2001.

There were 44% fewer new HIV infections among adults and children globally in 2020 compared with 2001, including a 70% reduction in vertical transmission. Some countries have made particularly strong progress, with 23 on track to achieve a 90% reduction in new infections by 2030, but dozens more are struggling to keep pace with their evolving epidemics. Momentum is being lost: at the global level, the 2020 targets for HIV prevention agreed by the General Assembly in the 2016 Political Declaration on Ending AIDS were missed. The 1.5 million [1.1 million–2.1 million] people who newly acquired HIV in 2020 were triple the 2020 target of fewer than 500 000 new infections (Figure 6). The people being left behind are preponderantly those subjected to gender inequalities, ostracization and criminalization.

FIGURE 6 | **ANNUAL NUMBER OF NEW HIV INFECTIONS AND THE 2020 TARGET, GLOBAL, 1990–2020**



New HIV infections Uncertainty bounds 2020 target

Source: Preliminary UNAIDS epidemiological estimates, 2021.

Key populations left behind

In every region of the world there are key populations who are particularly vulnerable to HIV infection. Gay men and other men who have sex with men, people who inject drugs, female sex workers, transgender people and people in prisons and other closed settings are many times more at risk of acquiring HIV than the general population (Figure 7). Overall, key populations and their sexual partners accounted for 62% of all new infections worldwide in 2019 (Figure 8).

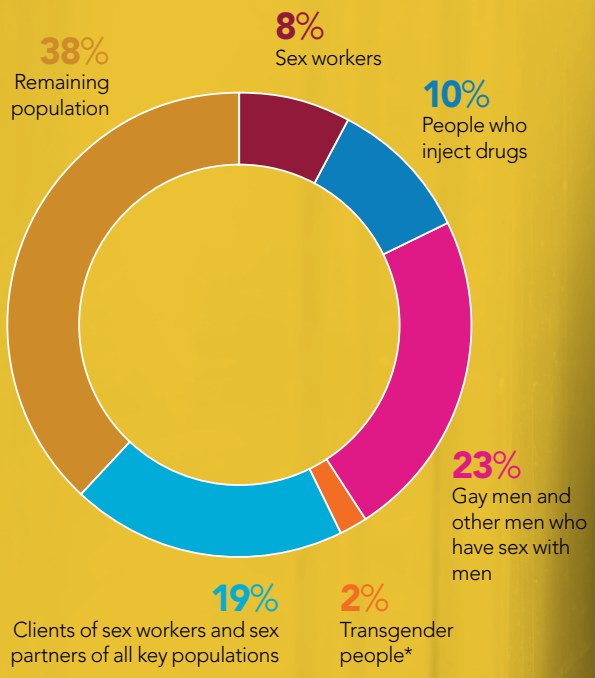
Despite their extremely high HIV risk, key populations in many countries remain underserved by HIV programmes. In six of 13 countries that have conducted surveys since 2016 and have reported those data to UNAIDS, less than half of transgender women stated that they were able to access at least two HIV prevention services. The same is true for female sex workers in 16 of 30 reporting countries, for gay men and other men who have sex with men in 26 of 38 reporting countries, and for men who inject drugs in 10 of 14 reporting countries.

FIGURE 7 | **RELATIVE RISK OF HIV ACQUISITION, GLOBAL, 2019**

Source: UNAIDS estimates, 2020.

Laws and policies that criminalize these populations and permit their harassment stand in the way of services that are ostensibly available. Severe criminal penalties for same-sex sexual relations have been associated with a 4.7 times greater risk of HIV infection than settings that lack such penalties *(8)*. According to a meta-analysis, harsh policing of sex work increases the prevalence of HIV and other sexually transmitted infections by more than 80%, and it increases the risk of sexual or physical violence nearly threefold *(9)*. There also is overwhelming evidence correlating the criminalization of drug use with increased risk of HIV transmission *(10)*.

FIGURE 8 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, GLOBAL, 2019**



* Data only included from Asia and the Pacific, the Caribbean, eastern Europe and central Asia, Latin America, and western and central Europe and North America.
Source: UNAIDS epidemiological estimates, 2020 (see https://aidsinfo.unaids.org/); UNAIDS special analysis, 2020.

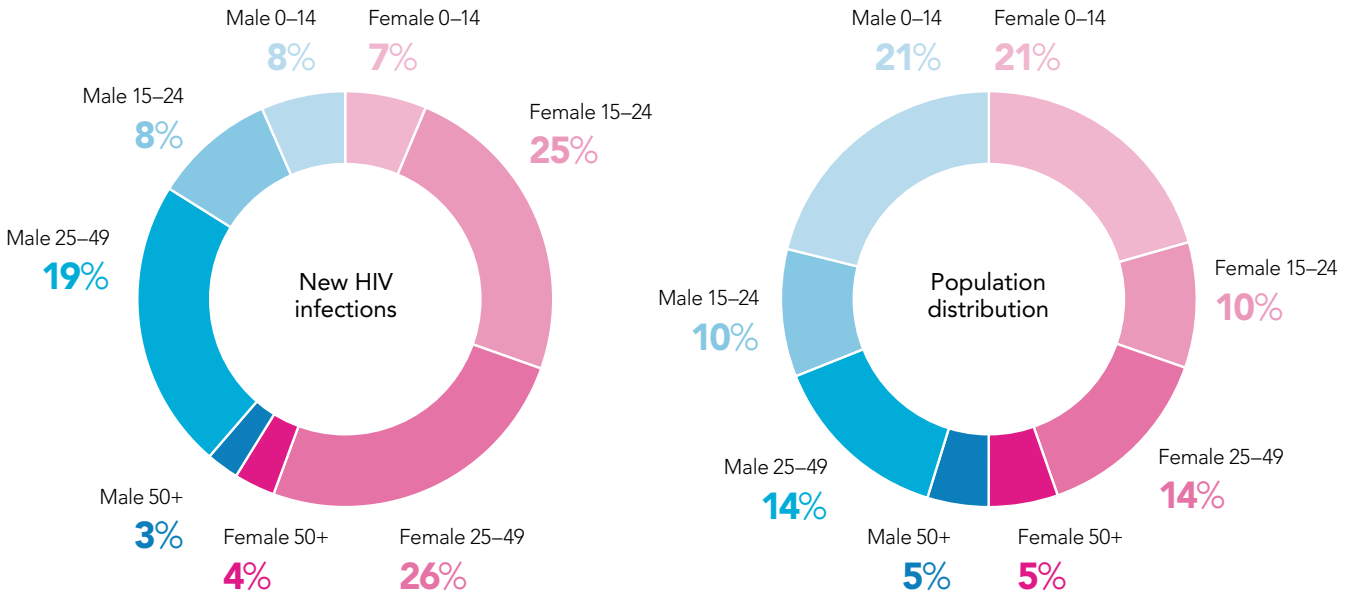
Gender inequality leaves women and girls vulnerable to HIV

Gender inequality, underpinned by harmful gender norms, restricts women's access to HIV and sexual and reproductive health services by perpetuating gender-based violence and limiting their agency and decision-making power, including the ability of women and girls to refuse unwanted sex, negotiate safer sex and mitigate HIV risk. Globally, only 55% of adult women (aged 15 to 49 years) have the agency and autonomy to say no to sex, decide on the use of contraception and decide on their own health care *(11)*. In many countries, girls are less likely to complete secondary education than boys, and the quality of their education suffers due to discrimination in schools. COVID-19 has amplified many of these inequalities.

In sub-Saharan Africa, these factors combine to leave adolescent girls and young women at higher risk of HIV. In this region, which has a high HIV burden: six out of seven new infections among adolescents (aged 15 to 19 years) are among girls; adolescent girls and young women (aged 15 to 24 years) account for 25% of HIV infections, despite representing just 10% of the population; and AIDS-related causes are the leading cause of death for adult women (aged 15 to 49 years).

SIX OUT OF SEVEN NEW INFECTIONS among adolescents (aged 15 to 19 years) in sub-Saharan Africa are among girls.

FIGURE 9 | **DISTRIBUTION OF NEW HIV INFECTIONS AND OF THE POPULATION, BY AGE AND SEX, SUB-SAHARAN AFRICA, 2020**



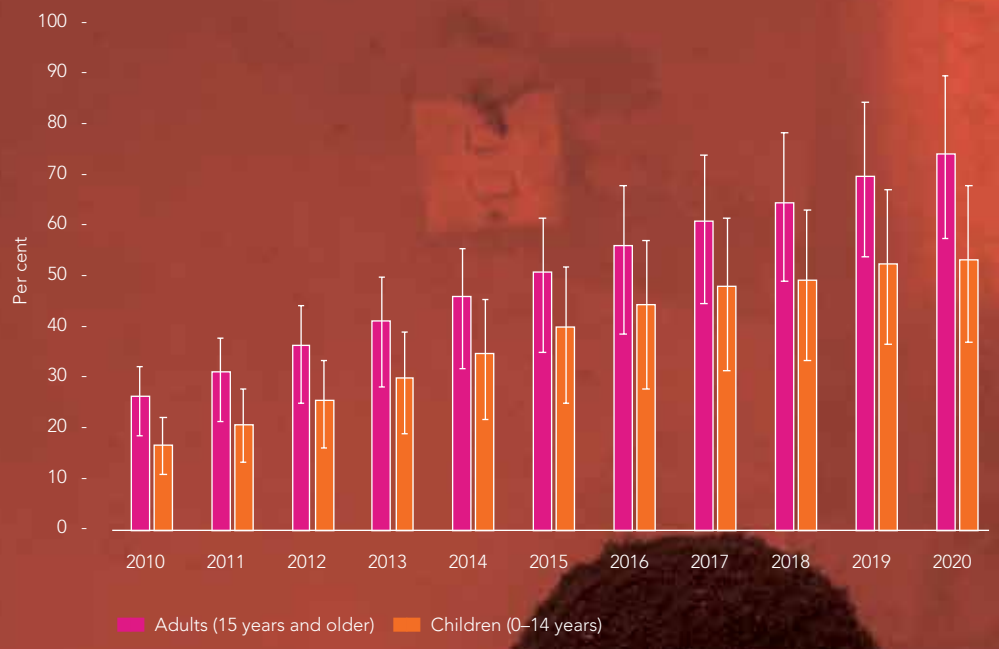
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 10 | **TOP 10 CAUSES OF DEATH, ADULT WOMEN (AGED 15–49 YEARS), AFRICA, 2019**

Rank	Cause	Number of deaths
1	HIV- and AIDS-related causes	136 000
2	Maternal conditions	109 700
3	Tuberculosis	73 600
4	Breast cancer	26 500
5	Lower respiratory infections	25 500
6	Diarrhoeal diseases	25 100
7	Cervix uterine cancer	24 500
8	Road injury	24 000
9	Stroke	19 200
10	Interpersonal violence	16 700

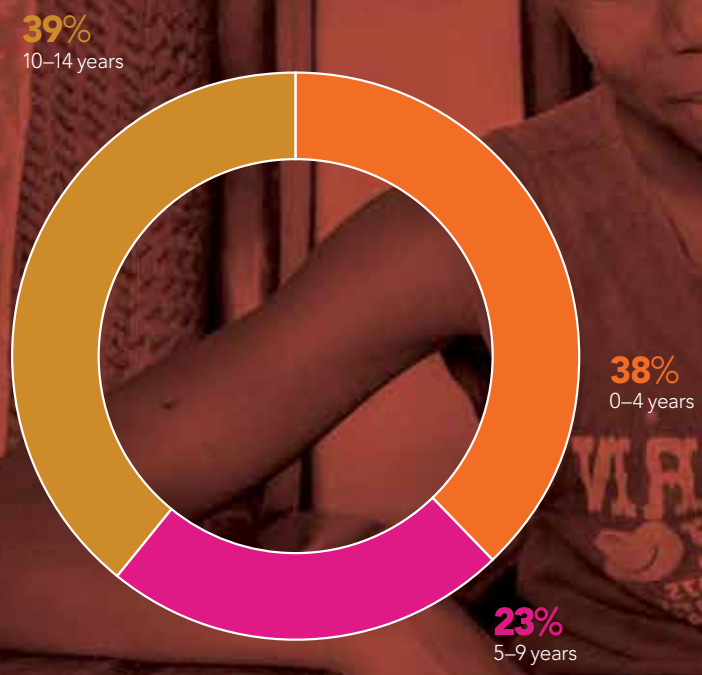
Source: Rounded values of the Global Health Estimates 2019: Deaths by Cause, Age, Sex, by Region, 2000-2019. Geneva, World Health Organization; 2020.

FIGURE 11 | **COVERAGE OF ANTIRETROVIRAL THERAPY, ADULTS AND CHILDREN, GLOBAL, 2010–2020**



Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 12 | **CHILDREN LIVING WITH HIV NOT RECEIVING TREATMENT, BY AGE GROUP, 2020**



Source: Preliminary UNAIDS epidemiological estimates, 2021.

Children living with HIV remain underserved

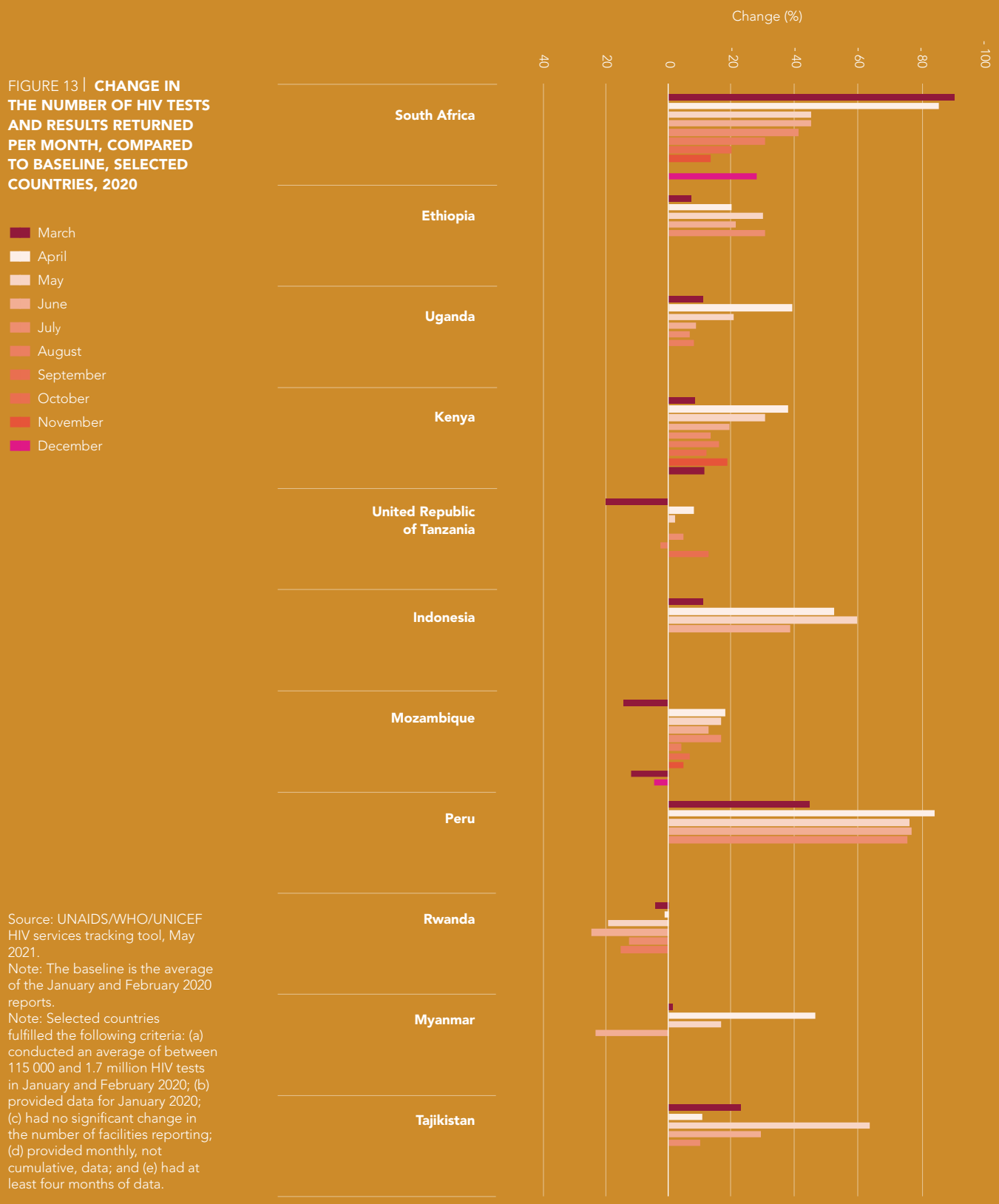
New HIV infections among children fell by more than half from 2010 to 2020, progress that largely reflects the increased provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV. However, efforts to eliminate vertical HIV transmission have slowed in recent years. Treatment coverage among children living with HIV (53% [37–68%] in 2020) remains well below the coverage for adults (74% [57–90%]), a global failure to provide life-sustaining treatment and care to 810 000 [580 000–1 000 000] children (Figure 11). Almost two thirds of children living with HIV who are not on treatment are aged 5 years and older (Figure 12).

COVID-19 obstacles and opportunities

COVID-19 has exposed the inadequacy of investments in public health and added enormous pressure on health systems, HIV services and the people who rely on them. HIV services and commodity supply chains were disrupted by measures to reduce the spread of COVID-19, with many countries reporting dips in new HIV diagnoses and treatment initiations in 2020 (Figure 13). Violence against women has surged, leaving women particularly vulnerable to HIV risk and impact.

COVID-19 has also demonstrated the resilience and innovations of the HIV response, especially community-led services that are reaching affected communities with essential services under the most difficult circumstances. This includes: COVID-19 testing and vaccination; HIV prevention, testing and treatment; and other health and social services. The COVID-19 crisis also sped up the adoption of HIV innovations, such as multimonth dispensing of antiretroviral medicines, which reduces clinic visits, saves patients time and money, and reduces the strain on health systems. These will remain valuable assets for many years to come.

FIGURE 13 | **CHANGE IN THE NUMBER OF HIV TESTS AND RESULTS RETURNED PER MONTH, COMPARED TO BASELINE, SELECTED COUNTRIES, 2020**



Source: UNAIDS/WHO/UNICEF HIV services tracking tool, May 2021.
Note: The baseline is the average of the January and February 2020 reports.
Note: Selected countries fulfilled the following criteria: (a) conducted an average of between 115 000 and 1.7 million HIV tests in January and February 2020; (b) provided data for January 2020; (c) had no significant change in the number of facilities reporting; (d) provided monthly, not cumulative, data; and (e) had at least four months of data.

Humanitarian crises increase vulnerability

In 2020, 239 million people in 57 countries required humanitarian assistance *(12)*. Humanitarian emergencies can result in forced displacement, food insecurity, poverty, sexual violence, disruption of services and health system collapse, which can increase the vulnerability of people to HIV infection and interrupt their access to HIV testing, treatment and other HIV services.

The world is facing more climate-based disasters in areas with high HIV burden. Southern Africa has the heaviest burden of HIV, and it is one of the regions most vulnerable to climate change *(13)*. The most vulnerable people are often the most affected by recurrent crises, facing increased poverty, food insecurity and vulnerability to HIV. In order to address these issues, HIV services need to ensure that refugees, internally displaced persons and other populations in humanitarian settings are not left behind, and that HIV services are adapted to meet the needs of people affected by crises.

Insufficient investment

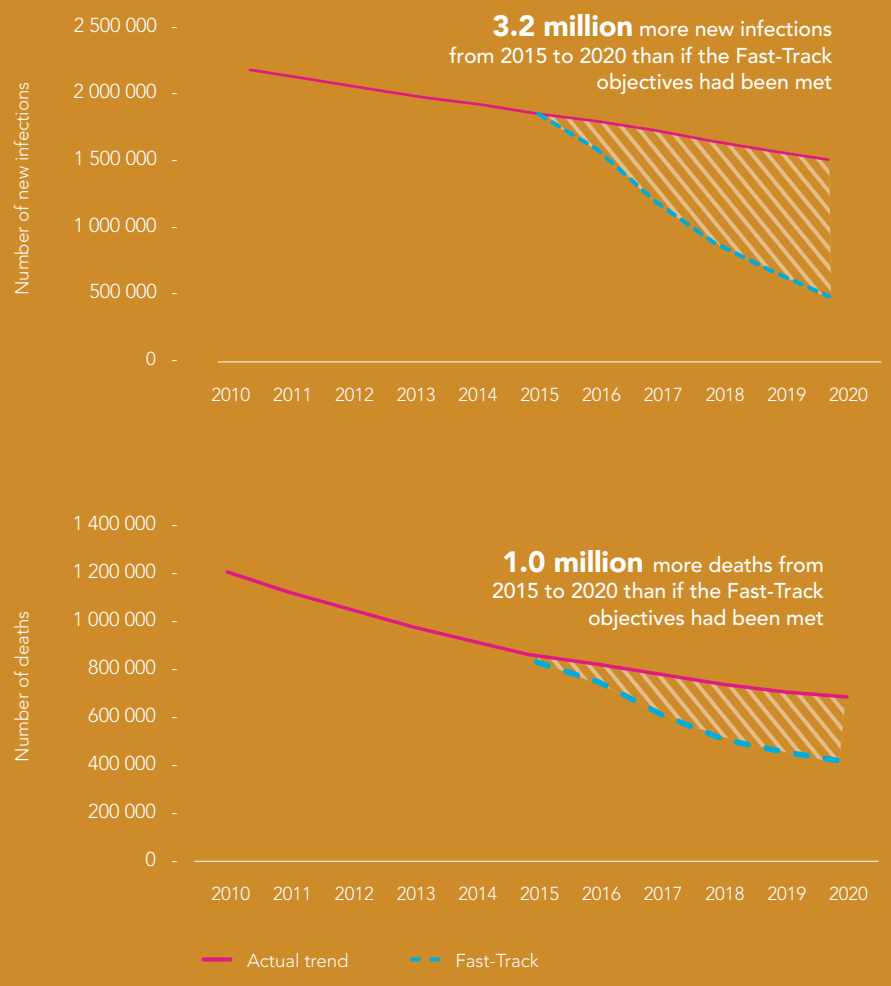
Under-investment in HIV responses was a major reason why the 2020 targets were missed. In 2019, US$ 18.6 billion (constant 2016 US dollars) was available for the HIV response in low- and middle-income countries—nearly 30% short of the US$ 26 billion per annum that Member States agreed to mobilize by 2020. In eastern and southern Africa, where investments have been in line with the region's total resource needs, recent progress against HIV has been strongest. Conversely, the regions with the largest resource gaps—eastern Europe and central Asia and the Middle East—have experienced expansions of their HIV epidemics.

Domestic investments in HIV responses in low- and middle-income countries have grown by 50% since 2010, but they have been declining in the past few years. Donor support increased by just 7% between 2010 and 2019, with the United States bilateral contributions through its PEPFAR programme accounting for the majority of this increase.

The cost of missing the 2020 targets

Falling short of the 2020 targets has a huge human cost: since 2015, an additional 3.2 million people acquired HIV infection, and an additional 1.0 million people died of AIDS-related causes because the world did not achieve those targets (Figure 14). Millions of additional people living with HIV now require life-long antiretroviral therapy, which increases the cost of the HIV response in the future, adds strain to health systems and brings hardship to affected communities and societies.

FIGURE 14 | **NEW HIV INFECTIONS AND AIDS-RELATED DEATHS PROJECTED THROUGH 2020, AND MODELLED PREDICTION RESULTING FROM FAST-TRACK INTERVENTIONS, GLOBAL, 2010–2020**



Source: Special analysis by Avenir Health using preliminary UNAIDS epidemiological estimates, 2021.

THE 2025 TARGETS

Access to HIV services and solutions

The global AIDS community and UNAIDS have used an inequalities lens to develop bold new targets for 2025 and a comprehensive strategy to achieve them *(14)*. If every country achieves the full range of targets across all geographic areas and populations, the annual number of people newly infected with HIV will be reduced to fewer than 370 000 by 2025, and the annual number of people dying from AIDS-related causes would be reduced to fewer than 250 000 in 2025. This would put the global AIDS response back on track to end AIDS by 2030.

95% of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options

95% of women of reproductive age have their HIV and sexual and reproductive health service needs met

95% of pregnant and breastfeeding women living with HIV have suppressed viral loads

95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding

75% of all children living with HIV have suppressed viral loads by 2023 (interim target)

95–95–95 testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV

90% of people living with HIV receive preventive treatment for tuberculosis

IMPACT GOALS

Reduce annual new HIV infections **to under 370 000**

Reduce annual new AIDS-related deaths **to under 250 000**

Breaking down barriers

Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services

Less than 10% of people living with HIV and key populations experience stigma and discrimination

Less than 10% of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence

30% of testing and treatment services to be delivered by community-led organizations[5]

80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations

60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations

Fully resourcing and sustaining efficient and integrated HIV responses

Increase HIV investments in low- and middle-income countries to **US$ 29 billion** per year by 2025

90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and well-being

45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits

95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options

90% of people in humanitarian settings have access to integrated tuberculosis, hepatitis C and HIV services, in addition to programmes to address gender-based violence (including intimate partner violence). This includes PEP, emergency contraception and psychological first aid.

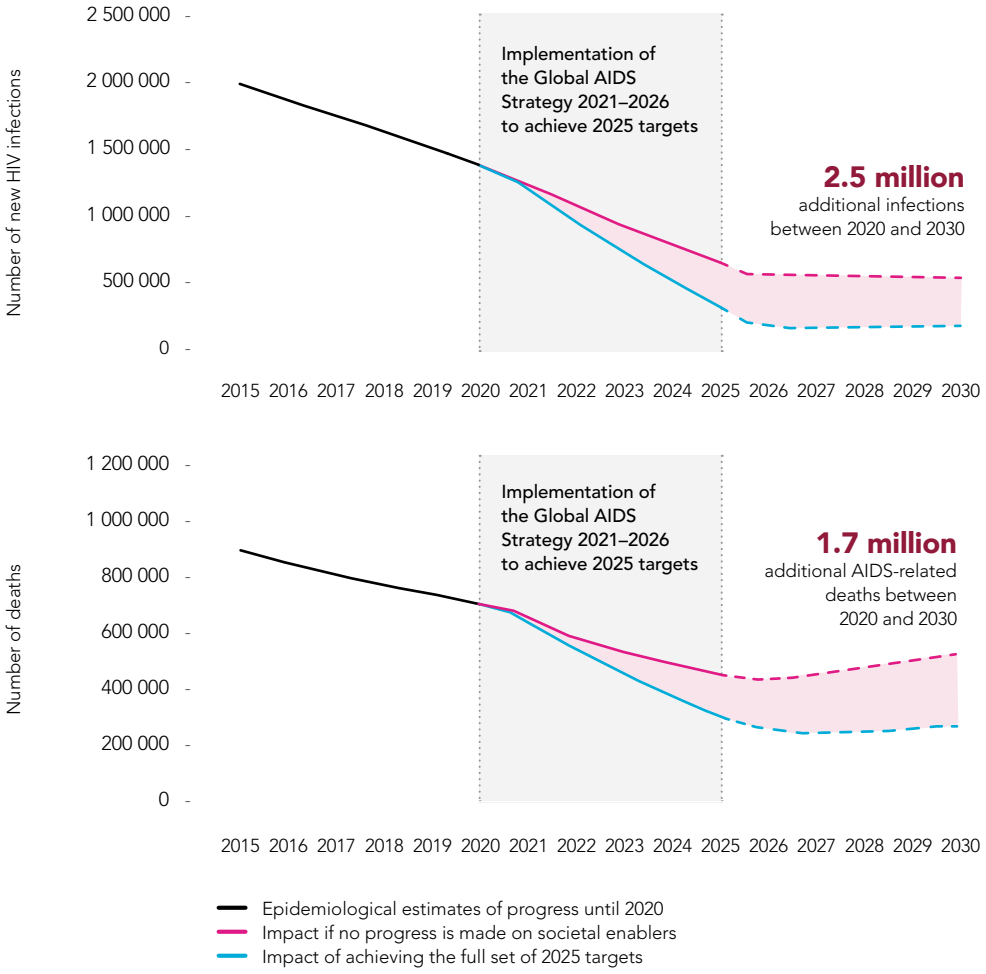
95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics, including COVID-19

[5] With focus on enhanced access to HIV testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of antiretroviral medicines.

Targets reinforce each other

The 2025 targets reinforce each other within a cohesive whole; countries cannot pick and choose among them. For example, a continued failure to address societal barriers—HIV-related stigma and discrimination, gender inequality and gender-based violence, and laws and policies that criminalize the populations at highest risk of HIV infection—would undermine efforts to reach the HIV service targets, leading to an additional 2.5 million new HIV infections between 2020 and 2030, and an additional 1.7 million AIDS-related deaths over the same period (Figure 15).

FIGURE 15 | **HIV INFECTIONS AND AIDS-RELATED DEATHS ESTIMATED THROUGH 2020, AND MODELLED PREDICTIONS RELATED TO PROGRESS TOWARDS 2025 TARGETS, WITH AND WITHOUT SOCIETAL ENABLERS, 2021–2030**



Source: Special analysis by Avenir Health using data from UNAIDS/WHO/UNICEF HIV services tracking tool, January 2021; and UNAIDS epidemiological estimates, 2020.

ACHIEVING THE TARGETS

The General Assembly's High-Level Meeting on AIDS on 8–10 June 2021 is a critical moment for countries to put the world back on track to ending AIDS by 2030. A new course has been set by the Global AIDS Strategy 2021–2026, including bold targets for 2025. Consistent attention to the priorities within the Global AIDS Strategy and achievement of the 2025 targets requires clear commitments, action and accountability from Member States in the following key areas.

Focus on inequalities

Ending inequalities requires HIV responses that can reach the populations currently being left behind. This includes the following:

- Establishing epidemiological, behavioural and programmatic monitoring and evaluation systems that provide the granular data needed to identify who is being missed by HIV services, and to maximize the equity and impact of available resources by providing those being left behind with the services they need.
- Establishing policy and programmatic frameworks that protect the rights of people living with, at risk of and affected by HIV throughout their life course.
- Prioritizing funding and actions that bring proven innovative solutions for impact to scale, based on the best available scientific evidence and technical knowledge.
- Reporting progress on national HIV epidemics and responses to UNAIDS annually.

Prioritize HIV prevention

Greater attention must be given to combinations of prevention measures that are evidence-informed and focused on the populations at greatest risk of infection, and that will have the biggest potential impact. A critical aspect of combination prevention is choice: individuals should have a wide range of HIV prevention options available to them so they can choose the options that best fit their circumstances and needs. Choice is not fixed and will vary for individuals over time and with different partners, so it is appropriate that some approaches will be used on some occasions and not others.

CHOICE

Individuals should have a wide range of HIV prevention options available to them. These include behavioural as well as biomedical approaches.

Choice is not fixed and will vary for individuals over time and with different partners. It is appropriate that some approaches will be used on some occasions and not others.

Accelerating HIV prevention can be achieved by:

- Increasing national leadership and resource allocation for proven HIV combination prevention, including condom promotion and distribution, PrEP, voluntary medical male circumcision, harm reduction, comprehensive sexuality education, STI screening and treatment, and viral suppression through antiretroviral therapy.
- Meeting the diverse HIV prevention needs of key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings, and all people living with HIV.
- Delivering integrated services that prevent HIV and unintended pregnancy among adolescent girls and women, including economic empowerment, protection and promotion of their sexual and reproductive health and rights, and interventions that transform unequal gender norms and prevent gender-based violence.
- Providing access to quality, gender-responsive and age-appropriate comprehensive sexuality education, both in and out of school.
- Removing parental and spousal consent requirements for services for sexual and reproductive health and for HIV prevention, testing and treatment.

Treat all subpopulations of people living with HIV

Progress towards the 90–90–90 testing and treatment targets was among the most successful aspects of the global HIV response in recent years. Countries are urged to raise their ambitions to targets of 95–95–95 for people living with HIV within all subpopulations and age groups by 2025. This greater emphasis on subpopulations reflects the current heterogeneity of testing and treatment coverage, which undermines the population-level preventative impact of treatment.

This ambitious target can be achieved by:

- Establishing differentiated service delivery models for HIV testing and antiretroviral therapy, including community-led and community-based services that overcome challenges to access, such as those created by the COVID-19 pandemic.
- Achieving equitable and reliable access to affordable, high-quality medicines, health commodities and technologies, including new innovations, such as long-acting antiretroviral medicines and the latest technologies for tuberculosis prevention, screening, diagnosis and treatment.

Eliminate vertical HIV transmission and end paediatric AIDS

The Global AIDS Strategy 2021–2026 prioritizes sexual and reproductive health and rights for women living with HIV and women at elevated risk of HIV infection. It also calls for reinvigorated efforts to eliminate new HIV infections among children and ensure that children living with HIV have timely access to life-saving treatment services. This can be achieved by:

- Meeting the HIV prevention and sexual and reproductive health needs of women of reproductive age who are in high HIV prevalence settings, within key populations and living with HIV.
- Identifying and addressing gaps in the continuum of services for preventing HIV infection among pregnant and breastfeeding women, diagnosing and treating pregnant and breastfeeding women living with HIV, and preventing vertical transmission of HIV to children.
- Testing HIV-exposed children by two months of age and after the cessation of breastfeeding, and ensuring that children living with HIV are provided with treatment regimens and formulas that are optimized to their needs.
- Finding undiagnosed older children and providing all adolescents living with HIV with a continuum of treatment, care and social protection that is proven to improve health outcomes as they grow and progress through youth and into adulthood.

Accelerate towards gender equality and the empowerment of women and girls

Gender equality and the human rights of women and girls in all their diversity must be at the forefront of efforts to mitigate the risk and impact of HIV. This can be achieved by:

- Fulfilling the right to education of girls and young women, and economically empowering women through skills training and employment opportunities.
- Engaging men and boys in intensified efforts to confront unequal sociocultural gender norms and undo harmful masculinities.
- Providing tailored services to prevent and respond to gender-based and sexual violence, including violence against women and girls.
- Fulfilling the sexual and reproductive health and rights of women and girls.

Leverage community leadership

Empower communities of people living with HIV, women, adolescents and young people, and key populations to play their critical roles in the HIV response by:

- Ensuring their global, regional, national and subnational networks are included in decision-making and provided with sufficient technical and financial support.
- Providing sustainable financing of people-centred, community-led HIV service delivery, including through social contracting and other domestic public funding mechanisms.
- Supporting community-led monitoring and research, and ensuring that community-generated data inform HIV responses.
- Greatly increasing the proportion of HIV services delivered by community-, key population- and women-led organizations.

Respect human rights and end stigma and discrimination

Respect, protect and fulfil the human rights of people living with, at risk of and affected by HIV by:

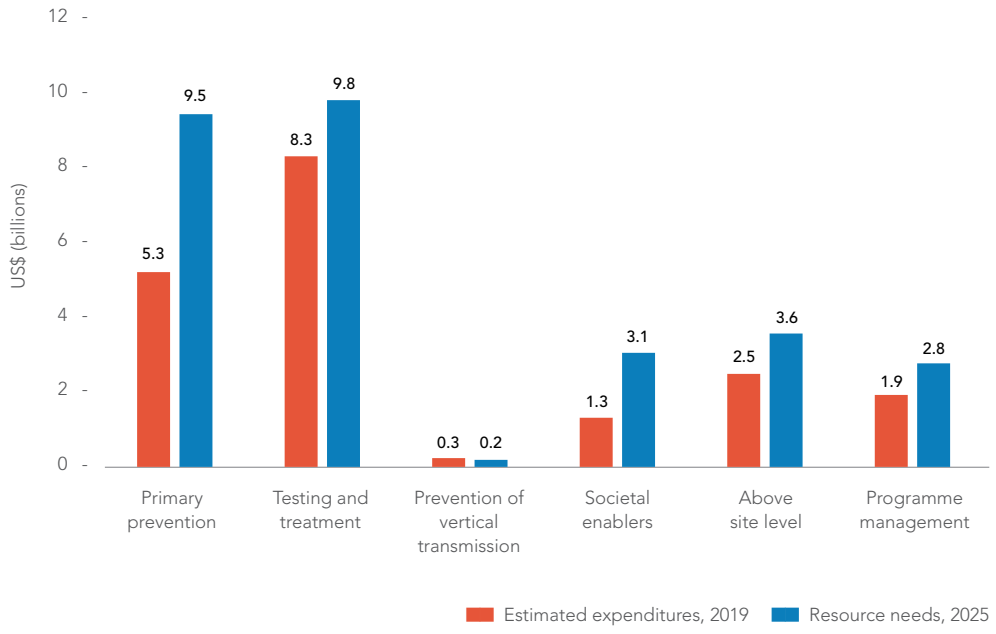
- Removing punitive and discriminatory laws, policies and practices that block effective responses to HIV. This includes those that criminalize sex work, gender identity, sexual orientation, drug use, consensual same-sex sexual relations, and HIV exposure, non-disclosure or transmission, and those that impose HIV-related travel restrictions and mandatory testing.
- Expanding investment in societal enablers, and adopting and enforcing legislation, policies and practices that realize the rights to health, education, food and nutrition support, housing, employment and social protection, and that prevent the use of criminal and general laws to discriminate against key populations, women and girls, and people living with HIV.
- Securing access to justice for key populations, women and girls, and people living with or affected by HIV by establishing legal literacy programmes, increasing their access to legal support and representation, and expanding sensitization training for health-care workers and other duty-bearers.

Invest sufficient resources to end AIDS

The shortcomings of the past—and the resulting greater numbers of people in need of services—has caused the financial resources needed for HIV responses in low- and middle-income countries to climb to US$ 29 billion by 2025 (in constant 2019 US dollars).[6] The bill for ending AIDS will keep climbing as long as commitments, funding and action continue to fall short. However, if sufficient resources are mobilized and efficiently used in line with the Global AIDS Strategy 2021–2026, the current year-on-year growth in resource needs can be halted by 2025.

Achieving the goals and targets of the new Global AIDS Strategy 2021–2026 requires increasing annual spending on primary HIV prevention to US$ 9.5 billion by 2025—a near doubling of prevention expenditures in 2019. Spending on societal enablers requires an even greater percentage increase, from US$ 1.3 billion in 2019 to US$ 3.1 billion in 2025 (in constant 2019 US dollars) (Figure 16).[7]

FIGURE 16 | **2019 EXPENDITURE AND 2025 RESOURCE NEEDS, BY PROGRAMME AREA, LOW- AND MIDDLE-INCOME COUNTRIES**



Source: UNAIDS financial estimates and projections, 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

[6] The 2019 baseline for this target is US$ 21.6 billion (constant 2019 US dollars), and the countries included are those classified by the World Bank in 2020 as low- and middle-income.

[7] Primary HIV prevention includes biomedical prevention methods—such as condoms, harm reduction (e.g., needle–syringe programmes, and opioid substitution therapy), voluntary medical male circumcision and PrEP—as well as behavioural and structural approaches, such as behaviour change communications and comprehensive sexuality education.

These resource mobilization and spending targets can be achieved by:

- Mobilizing additional domestic resources through a wide range of mechanisms—including public–private partnerships, debt cancellation and restructuring—and the progressive integration of HIV response financing within domestic financing systems for health, social protection, and emergency and pandemic responses.
- Complementing domestic resources through greater South–South, North–South and triangular cooperation, and renewed commitments from bilateral and multilateral donors—including through the Global Fund—to fund the remaining resource needs, especially for HIV responses in countries with limited fiscal ability, with due attention to the financing of services for key populations and community-led responses.

Integrate services

The people in greatest need of HIV services also require broader health care, education, sustainable livelihood and social safety nets. Integration is a critical approach to providing people-centred, holistic and coordinated services, including services for other communicable and noncommunicable diseases, mental health conditions, harm reduction, alcohol and drug dependence, sexual and reproductive health, and gender-based violence, as well as critical supportive services, such as social protection and education.

Integration can be accelerated by:

- Utilizing the experience, expertise, infrastructure and multisectoral coordination of HIV actions across diverse sectors—such as health, education, law and justice, economics, finance, trade, information, social protection and health, as well as among development, humanitarian and peace-building actions—to support the integrated delivery of the full range of needed services.

- Ensuring that integration is context-specific and focused on the diverse needs of the people who are at risk of being left behind, rather than a one-size-fits-all approach that is focused solely on cost-savings.
- Including HIV services within universal health care benefits packages.

Build global pandemic response capacity

COVID-19 has exposed the fragility of national health systems and the global health architecture to pandemics. The world was unprepared in 2020, just as it was unprepared and unable to mount an effective response to HIV in the 1980s and 1990s. Learning lessons and building forward better and fairer requires:

- Building on the leadership, resilience and innovation demonstrated by community systems during the COVID-19 pandemic in reaching affected communities with essential services. This includes conducting COVID-19 testing, rolling out vaccines, providing other health and social services, and monitoring service delivery and gaps in coverage.
- Ensuring that health systems strengthening efforts undertaken in response to COVID-19 also strengthen HIV response capacities.
- Accelerating the differentiation of service delivery, including HIV testing and other diagnostics, and the multimonth dispensing of antiretroviral medicines, opioid substitution therapy and other life-saving medications.
- Increasing the availability of essential medicines and health technologies, and ensuring their fair allocation among and within countries through pooled procurement mechanisms, voluntary licensing, financial incentives and the full use of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities.

Coordinate and track the global HIV response

Since its establishment 25 years ago, UNAIDS has galvanized political leadership and global solidarity against AIDS, mobilized and guided the use of domestic and donor resources, supported national HIV programmes, strengthened partnerships among government, civil society, academia and the private sector, promoted and supported the critical role of people living with HIV and other affected communities in the HIV response, and tracked progress against global targets and commitments.

The Joint Programme's model has reinforced the importance of a multisectoral, multidisciplinary approach, and it remains a pathfinder for UN reform. Fully resourcing the Joint Programme so it can continue to play its unique role is a critical part of global efforts to end AIDS by 2030.

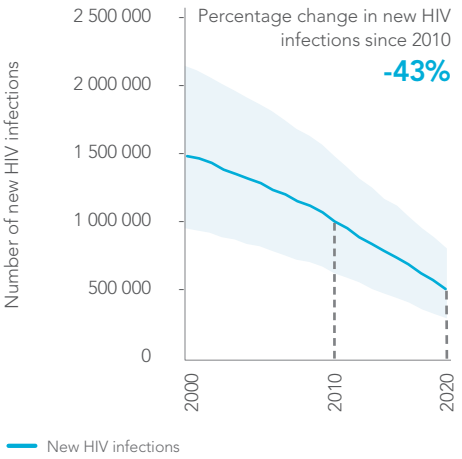
REGIONAL PROFILES

EASTERN AND SOUTHERN AFRICA

PRIORITY ACTIONS FOR ENDING AIDS

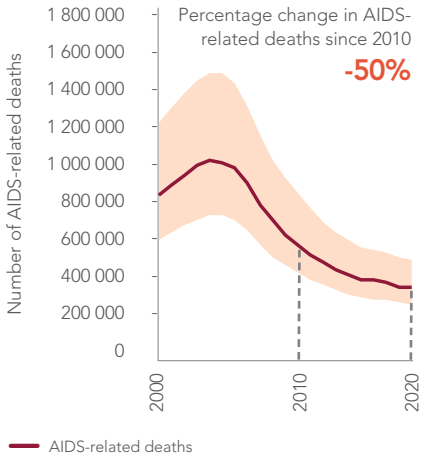
- Expand high-impact combination HIV prevention for key populations, adolescent girls and young women, and young men.
- Preserve gains in testing, treatment and care during the COVID-19 pandemic, and address coverage gaps within priority subpopulations.
- Ensure the sustainability of the HIV response, including through greater domestic funding and service integration.
- Address social and structural barriers, including unequal gender and social norms and gender-based violence.
- Empower communities and place them at the centre of national and subnational HIV responses.

FIGURE 17 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



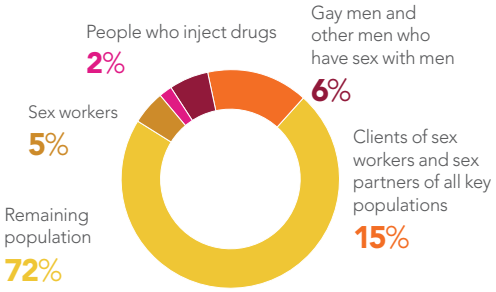
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 18 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



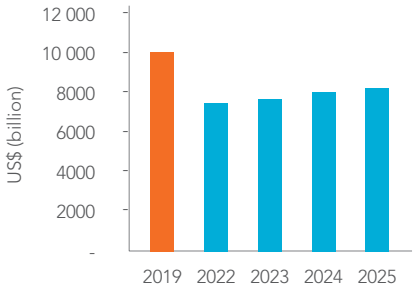
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 19 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



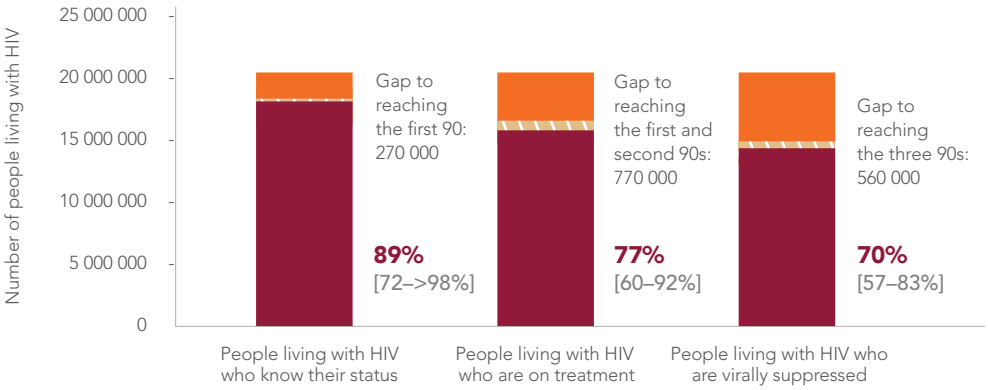
Source: UNAIDS special analysis, 2020.

FIGURE 20 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 21 | **HIV TESTING AND TREATMENT CASCADE, 2020**



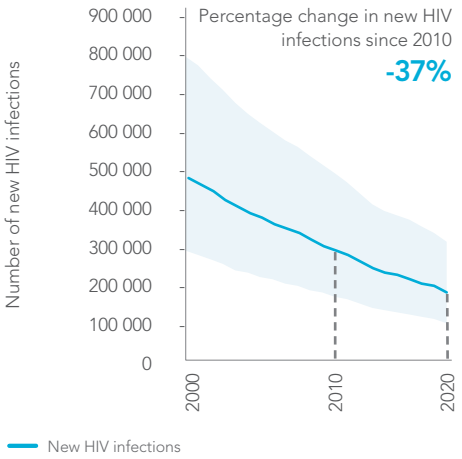
Source: Preliminary UNAIDS special analysis, 2021.

WESTERN AND CENTRAL AFRICA

PRIORITY ACTIONS FOR ENDING AIDS

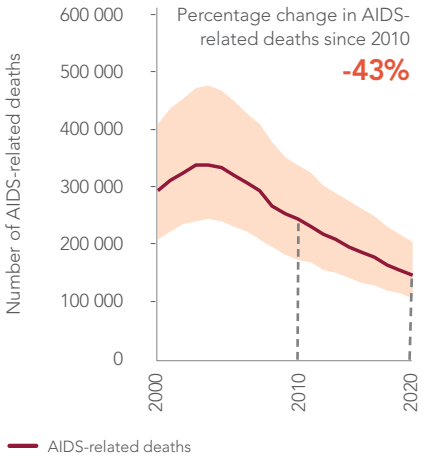
- Reduce stigma and discrimination and gender-based violence by transforming harmful gender and other discriminatory social norms.
- Ensure preparedness for comprehensive HIV service delivery during humanitarian emergencies and pandemics.
- Scale up high-impact combination HIV prevention for key populations, adolescent girls and young people.
- Strengthen people-centred health systems, including community systems, to deliver results for the most vulnerable.
- Close gaps in service availability and uptake of paediatric HIV treatment and preventing vertical transmission.
- Promote an accountable, inclusive and sustainable HIV response.

FIGURE 22 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



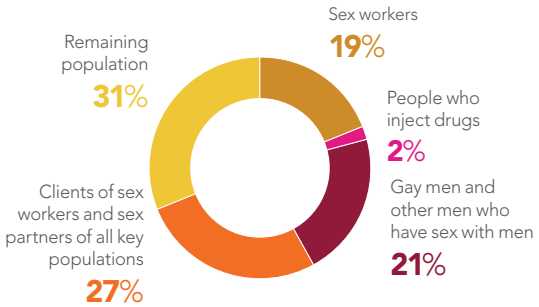
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 23 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



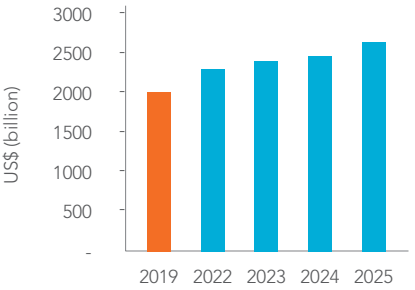
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 24 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



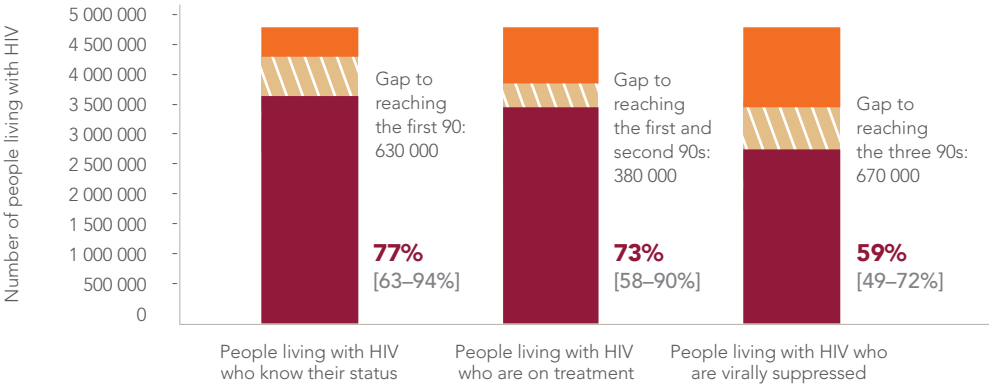
Source: UNAIDS special analysis, 2020.

FIGURE 25 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 26 | **HIV TESTING AND TREATMENT CASCADE, 2020**



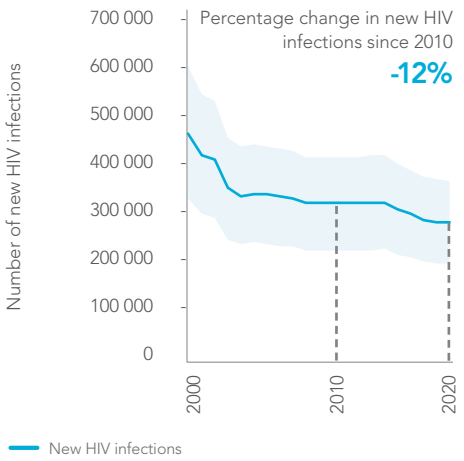
Source: Preliminary UNAIDS special analysis, 2021.

ASIA AND THE PACIFIC

PRIORITY ACTIONS FOR ENDING AIDS

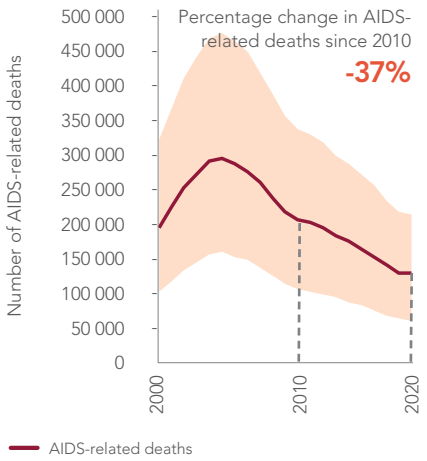
- Emphasize rights-based approaches in policies and programmes and tackle harmful social norms.
- Modernize differentiated service delivery, including scale up of combination HIV prevention (particularly PrEP), self-testing, multi-month dispensing.
- Eliminate stigma and discrimination and other barriers to equitable service coverage.
- Mobilize sustainable domestic financing for prevention and treatment.
- Ensure inclusive and gender-responsive approaches, especially for young key populations.
- Reframe country responses to address inequalities through civil society and community engagement.

FIGURE 27 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



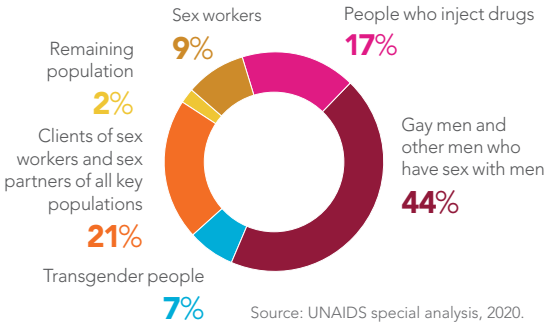
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 28 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



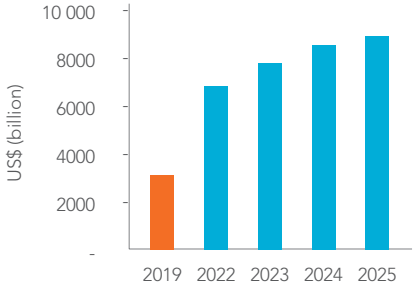
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 29 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



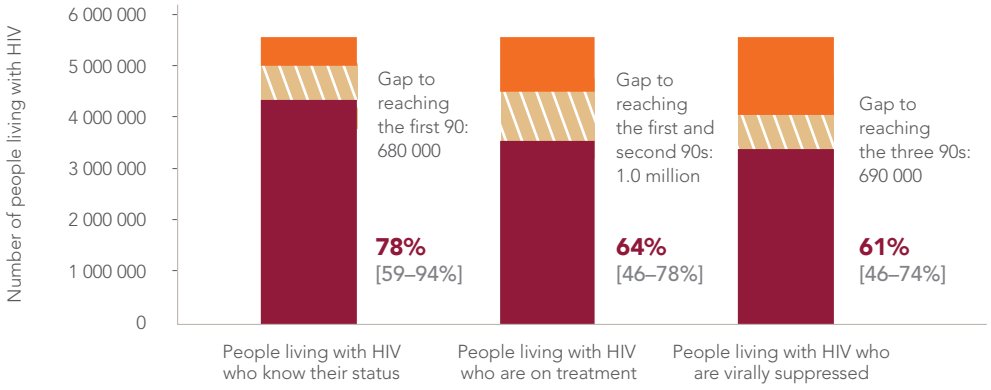
Source: UNAIDS special analysis, 2020.

FIGURE 30 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 31 | **HIV TESTING AND TREATMENT CASCADE, 2020**



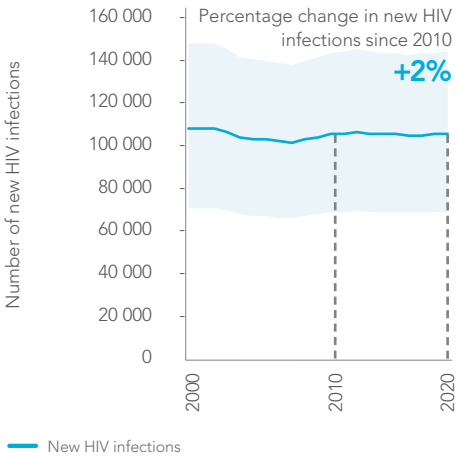
Source: Preliminary UNAIDS special analysis, 2021.

LATIN AMERICA

PRIORITY ACTIONS FOR ENDING AIDS

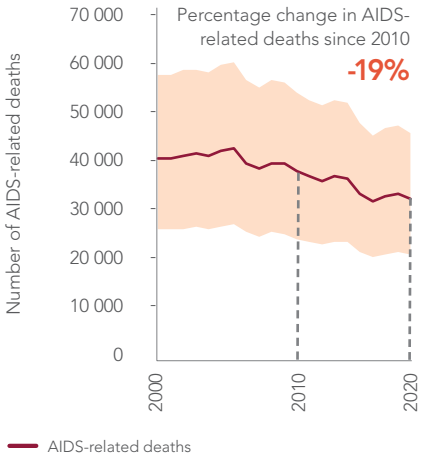
- Promote equitable access to effective and innovative combination HIV prevention within the frameworks of the Sustainable Development Goals and universal health coverage.
- Enact protective legislation, including antidiscrimination and gender identity laws.
- Empower and fully resource gender-sensitive and innovative community-led responses.
- Implement evidence-informed and human rights-based national responses, with efficient allocation of domestic resources and sustainable financing.
- Expand multimonth dispensing and transition to dolutegravir-based first-line regimens.
- Guarantee access to comprehensive HIV services for migrants and asylum seekers.

FIGURE 32 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



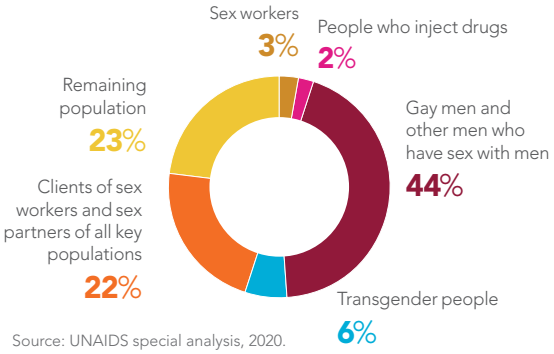
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 33 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



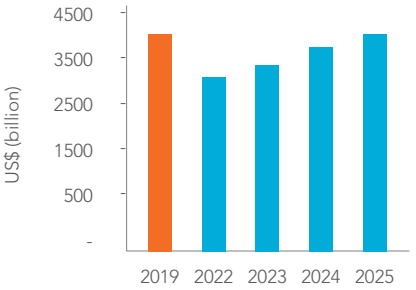
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 34 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



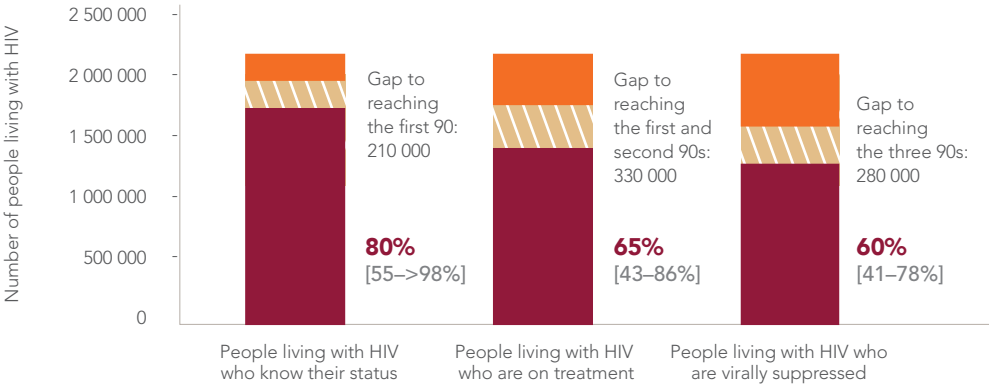
Source: UNAIDS special analysis, 2020.

FIGURE 35 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 36 | **HIV TESTING AND TREATMENT CASCADE, 2020**



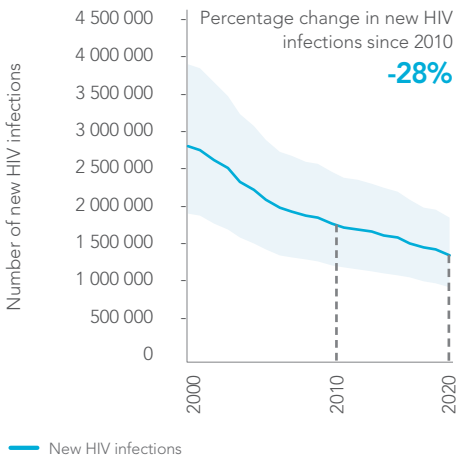
Source: Preliminary UNAIDS special analysis, 2021.

CARIBBEAN

PRIORITY ACTIONS FOR ENDING AIDS

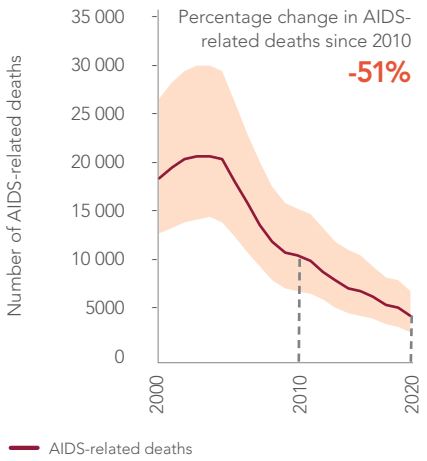
- Strengthen regional and national ownership and governance of HIV responses.
- Implement policies that remove structural barriers to HIV services.
- Repeal laws and policies that criminalize people living with and at risk of HIV.
- Strengthen strategic HIV and sexually transmitted infection programme planning, monitoring and evaluation, and accountability.
- Strengthen information systems for monitoring the HIV response and providing evidence for strategic decision-making.
- Eliminate vertical transmission in additional countries and ensure the re-validation of countries that have already been validated.

FIGURE 37 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



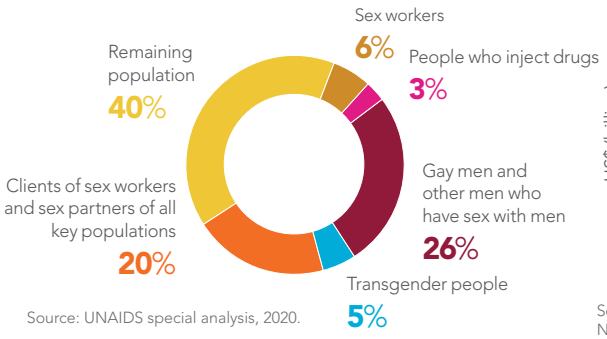
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 38 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



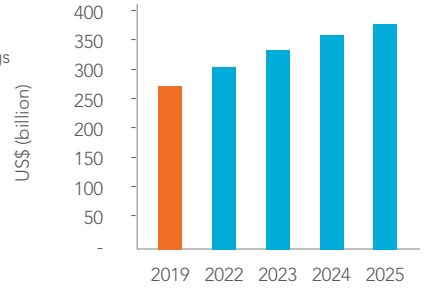
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 39 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



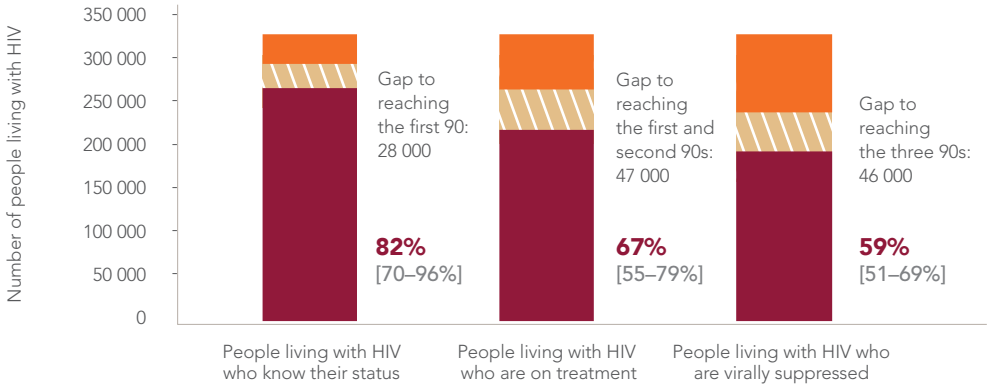
Source: UNAIDS special analysis, 2020.

FIGURE 40 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 41 | **HIV TESTING AND TREATMENT CASCADE, 2020**



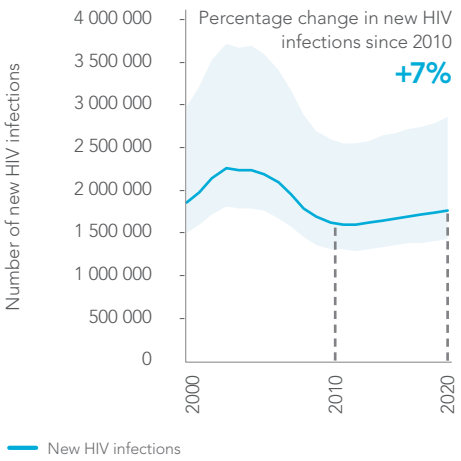
Source: Preliminary UNAIDS special analysis, 2021.

MIDDLE EAST AND NORTH AFRICA

PRIORITY ACTIONS FOR ENDING AIDS

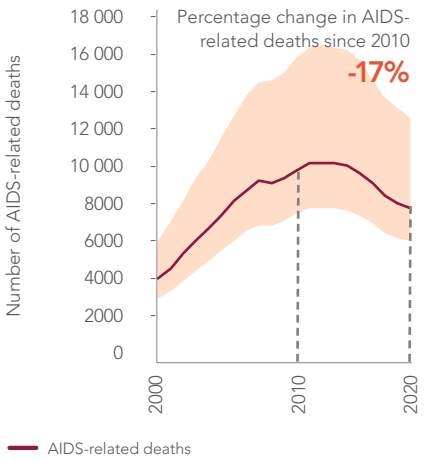
- Scale up access to high-quality, combination HIV prevention, testing and treatment, with a focus on key populations and other priority groups.
- Gather and leverage granular data to achieve transformative results.
- Strengthen and empower communities, including people living with HIV and key populations, to lead HIV responses.
- Ground the response in human rights and gender equality.
- Ensure preparedness for comprehensive HIV service delivery during humanitarian emergencies and pandemics.

FIGURE 42 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



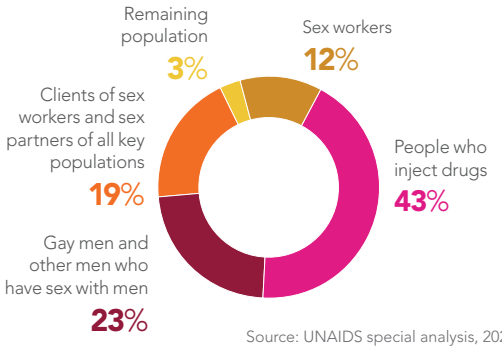
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 43 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



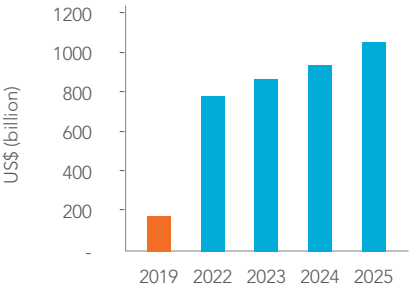
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 44 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



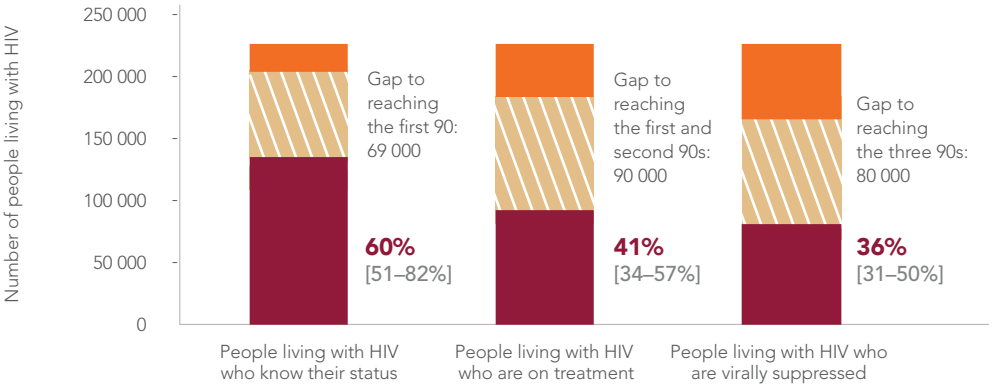
Source: UNAIDS special analysis, 2020.

FIGURE 45 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 46 | **HIV TESTING AND TREATMENT CASCADE, 2020**



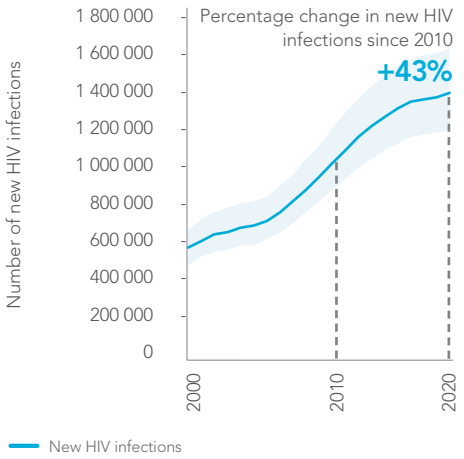
Source: Preliminary UNAIDS special analysis, 2021.

EASTERN EUROPE AND CENTRAL ASIA

PRIORITY ACTIONS FOR ENDING AIDS

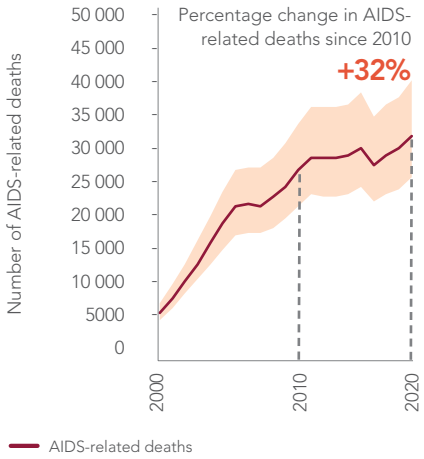
- Urgently expand access to combination HIV prevention, including PrEP and harm reduction.
- Close gaps in the testing and treatment cascade by fully rolling out a treat-all approach, including improving testing strategies and expanding access to affordable and quality-assured antiretroviral medicines.
- Institutionalize community-led services within national health care and HIV prevention systems.
- Build human rights-based responses by transforming harmful gender norms, reducing gender-based violence and removing discriminatory and punitive laws, policies, and other structural and social barriers.

FIGURE 47 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



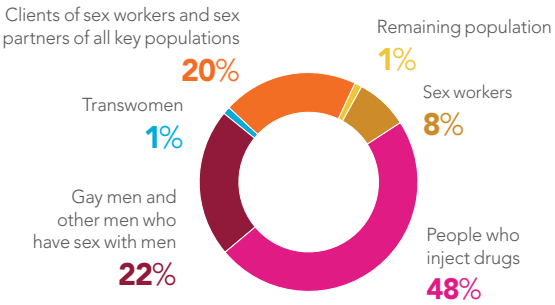
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 48 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



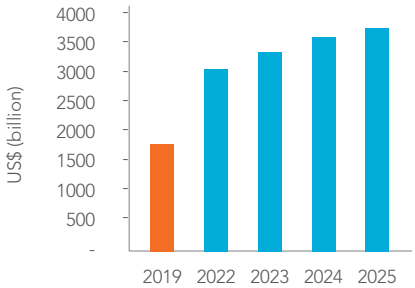
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 49 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



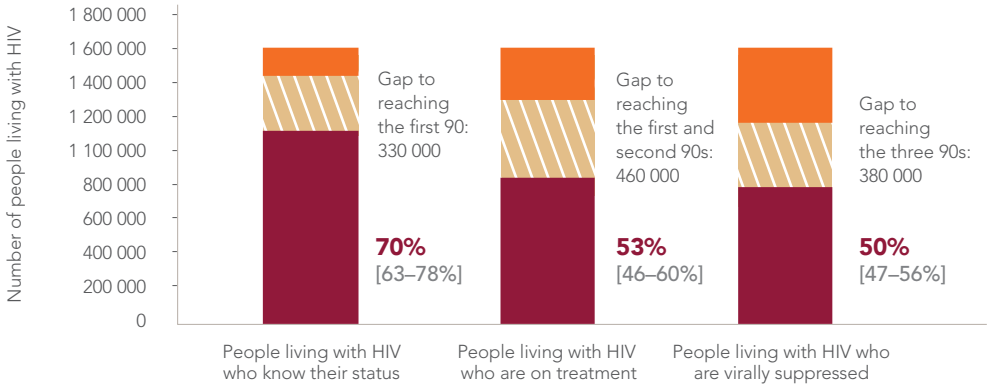
Source: UNAIDS special analysis, 2020.

FIGURE 50 | **RESOURCE AVAILABILITY, 2019, AND RESOURCE NEEDS, 2022–2025**



Source: UNAIDS financial estimates, May 2021.
Note: The resource estimates are presented in constant 2019 US dollars.

FIGURE 51 | **HIV TESTING AND TREATMENT CASCADE, 2020**



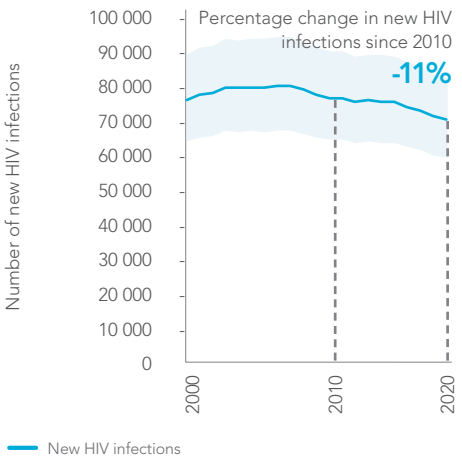
Source: Preliminary UNAIDS special analysis, 2021.

WESTERN AND CENTRAL EUROPE AND NORTH AMERICA

PRIORITY ACTIONS FOR ENDING AIDS

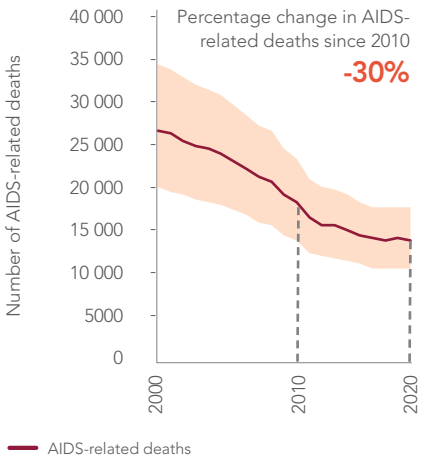
- Improve testing strategies, including for viral load.
- Overcome stigma and discrimination in health-care settings, and integrate care for coinfections and comorbidities.
- Ensure that key populations, migrants and people in closed settings have access to HIV services, regardless of their legal or insurance status.
- Remove laws and policies that punish and discriminate against LGBTI communities, sex workers, people who use drugs, people living with HIV and migrants.
- Increase investments in HIV research, with particular attention to long-acting antiretrovirals, HIV vaccines and a cure.

FIGURE 52 | **NUMBER OF NEW HIV INFECTIONS, 2000–2020**



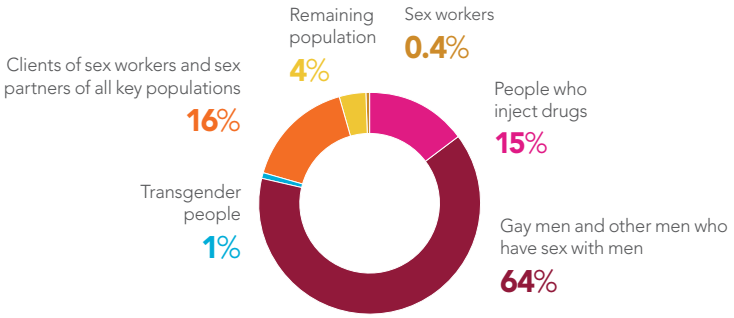
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 53 | **NUMBER OF AIDS-RELATED DEATHS, 2000–2020**



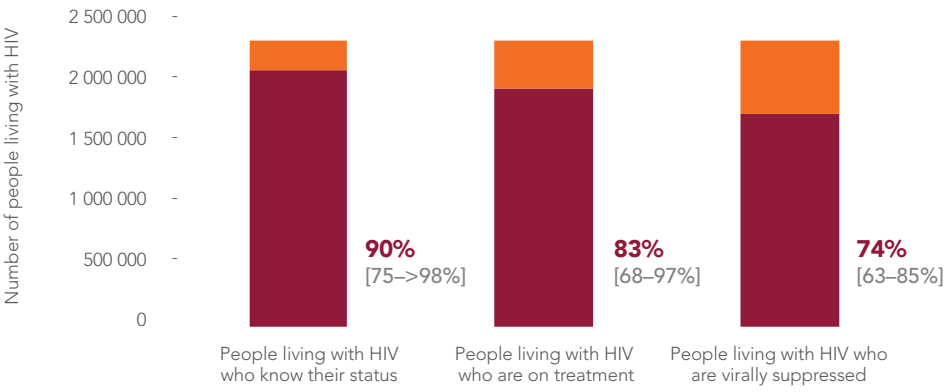
Source: Preliminary UNAIDS epidemiological estimates, 2021.

FIGURE 54 | **DISTRIBUTION OF NEW HIV INFECTIONS BY POPULATION, 2019**



Source: UNAIDS special analysis, 2020.

FIGURE 55 | **HIV TESTING AND TREATMENT CASCADE, 2020**



Source: Preliminary UNAIDS special analysis, 2021.

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