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FOREWORD

Over the last two years, the multiple and overlapping crises that have rocked the world have had a devastating impact on people living with and affected by HIV, and they have knocked back the global response to the AIDS pandemic. The new data revealed in this report are frightening: progress has been faltering, resources have been shrinking and inequalities have been widening. Insufficient investment and action are putting all of us in danger: we face millions of AIDS-related deaths and millions of new HIV infections if we continue on our current trajectory.

Together, world leaders can end AIDS by 2030 as promised, but we need to be frank: that promise and the AIDS response are in danger. Faltering progress meant that approximately 1.5 million new HIV infections occurred last year—more than 1 million more than the global targets. In too many countries and for too many communities, we now see rising numbers of new HIV infections when we needed to see rapid declines. We can turn this around, but in this emergency, the only safe response is to be bold. We can only prevail together, worldwide.

Marked inequalities, within and between countries, are stalling progress in the HIV response, and HIV is further widening those inequalities.

Every two minutes in 2021, an adolescent girl or young woman was newly infected with HIV. The COVID-19 pandemic led to disruptions to key HIV treatment and prevention services, millions of girls out of school, and spikes in teenage pregnancies and gender-based violence.

The AIDS pandemic took a life every minute in 2021, with 650 000 AIDS-related deaths despite effective HIV treatment and tools to prevent, detect and treat opportunistic infections. The number of people on HIV treatment grew more slowly in 2021 than it has in over a decade: while three quarters of all people living with HIV have access to antiretroviral treatment, approximately 10 million people do not. Only half (52%) of children living with HIV have access to life-saving medicine, and the inequality in HIV treatment coverage between children and adults is increasing rather than narrowing.

Amidst crisis, however, we also see strong resilience in a diverse range of countries—and in pockets within many more countries. This is especially true where the required level of funding from national governments, the United States President's Emergency Plan for AIDS Relief (PEPFAR) or the Global Fund to Fight AIDS, Tuberculosis or Malaria (the Global Fund) comes together with robust community-led responses and cutting-edge science. These exemplars of effective pandemic response have achieved remarkable progress in reducing new HIV infections and increasing access to treatment. They prove that it can be done and guide us in what we need to take to scale worldwide.

But this report also shows far too many instances where we are not moving fast enough to end the inequalities that drive pandemics—or where we are moving in the wrong direction: tech monopolies instead of tech sharing, austerity instead of investment, clamping down on marginalized communities instead of repealing outdated laws, and inhibiting control instead of promoting and enabling inclusive, community-centred delivery.

When international support has been most needed, global solidarity has stalled. Overseas development assistance for HIV from bilateral donors other than the United States of America has plummeted by 57% over the last decade. Leaders must not mistake the huge red warning light for a stop sign.

The data revealed in this report will disturb and shock—but the report is not a counsel of despair. It is call to action. Failure would be fatal, but it is not inevitable. Ending AIDS will cost much less money than not ending AIDS. Importantly, the actions needed to end AIDS will also better prepare the world to protect itself against the threats of future pandemics.

What we need to do is not a mystery. We know it from what we've repeatedly seen succeed across different contexts: shared science, strong services and social solidarity. This is the pledge made at the United Nations General Assembly High-Level Meeting on HIV/AIDS in June last year: end the AIDS pandemic by ending the inequalities that perpetuate it.

We can end AIDS by 2030. But the curve will not bend itself. We have to pull it down.



Winnie Byanyima
UNAIDS Executive Director

INTRODUCTION

The global AIDS response is under threat.

Over the past two and a half years, the colliding AIDS and COVID-19 pandemics—along with economic and humanitarian crises—have placed the global HIV response under increasing threat. COVID-19 and other instabilities have disrupted health services in much of the world, and millions of students have been out of school, increasing their HIV vulnerability (1). Low- and middle-income countries have been challenged to respond as 60% of the world's poorest countries are in debt distress or at high risk of it, and an estimated 75 to 95 million people have been pushed into poverty, an increase without precedent (2, 3). As a result, the AIDS response has faced serious pressure while communities that were already at greater risk of HIV are now even more vulnerable.

In some parts of the world and for some communities, the response to the AIDS pandemic has shown remarkable resilience in adverse times, which has helped avoid the worst outcomes. However, global progress against HIV is slowing rather than accelerating: the latest data collected by UNAIDS show that while new HIV infections fell globally last year, the drop was only 3.6% compared to 2020—the smallest annual reduction since 2016. As a result, many regions, countries and communities are left to address rising HIV infections alongside other ongoing crises.

Eastern Europe and central Asia, the Middle East and North Africa and Latin America have all seen increases in annual HIV infections over the past decade.

Eastern Europe and central Asia, the Middle East and North Africa and Latin America have all seen increases in annual HIV infections over the past decade (Figure 0.1). In Asia and the Pacific—the world's most populous region—UNAIDS data now show that new HIV infections are rising where they had been falling over the past 10 years. Malaysia and the Philippines are among the countries with rising epidemics among key populations, particularly in key locations.¹ Increases in infections in these regions are alarming.

¹ UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

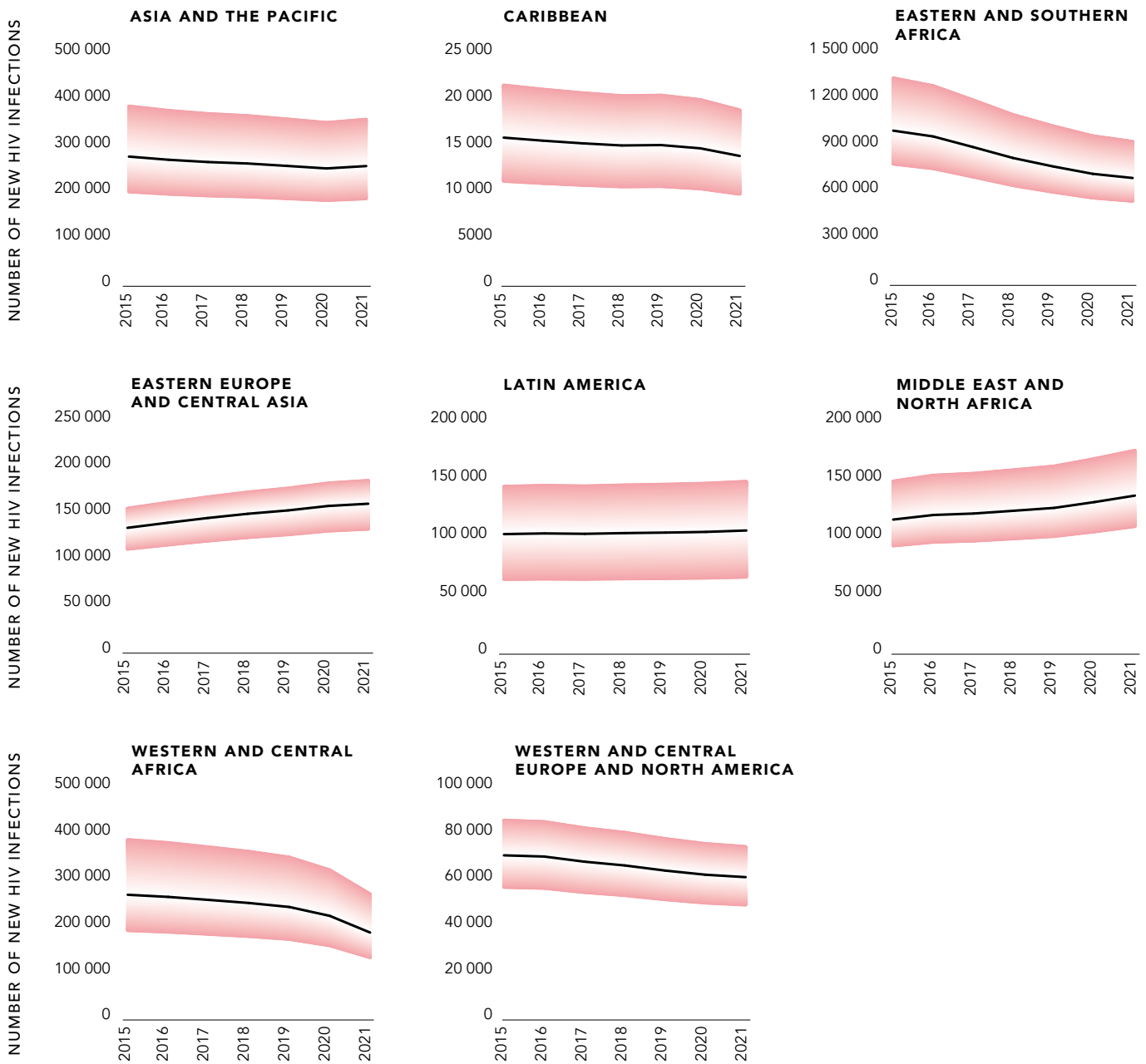
Latin America, an early success story in the roll-out of treatment, has lost momentum, allowing epidemics among young gay men and other men who have sex with men and other key populations to rebound. Large portions of eastern Europe and central Asia do not have the harm reduction services needed to turn the tide of epidemics that are predominantly among people who inject drugs and their sexual partners. In eastern and southern Africa, the region with the highest prevalence of HIV, the AIDS response has shown remarkable resilience in the face of adversity, with HIV treatment and prevention programmes adapting to COVID-19 mitigation efforts. But even there, progress in reducing new infections has slowed significantly rather than accelerating as required to stop the pandemic. Meanwhile, UNAIDS data show that HIV programmes in this region face growing headwinds as the domestic and international financing that have enabled progress to date are under threat.

There are bright spots, including robust declines in annual HIV infections in the Caribbean and western and central Africa—the latter driven largely by improvements in Nigeria. These decreases in infections represent accelerating progress. In global figures, however, this progress is being drowned out by a lack of progress in other regions: HIV infections have now increased since 2015 in 38 countries globally.²



² Countries that have robust estimates of increasing new HIV infections since 2015 are: Afghanistan, Algeria, Belize, Brazil, Cape Verde, Chile, the Congo, Costa Rica, Cuba, the Dominican Republic, Equatorial Guinea, Fiji, Georgia, Greece, Guatemala, Guyana, Honduras, Ireland, Jamaica, Kazakhstan, Madagascar, Malaysia, Mauritania, Oman, Papua New Guinea, Paraguay, Peru, the Philippines, Senegal, Serbia, South Sudan, Sudan, Suriname, Tajikistan, Timor-Leste, Tunisia, Uruguay and Yemen.

FIGURE 0.1 New HIV infections, by region, 2015–2021



Source: UNAIDS epidemiological estimates, 2022 (<https://aidsinfo.unaids.org/>).

4000

PEOPLE BECOME INFECTED WITH HIV EVERY DAY

Every day, 4000 people—including 1100 young people (aged 15 to 24 years)—become infected with HIV. If current trends continue, 1.2 million people will be newly infected with HIV in 2025—three times more than the 2025 target of 370 000 new infections.

The human impact of the stalling progress on HIV is chilling. In 2021, 650 000 [500 000–860 000] people died of AIDS-related causes—one every minute. With the availability of cutting-edge antiretroviral medicines and effective tools to properly prevent, detect and treat opportunistic infections such as cryptococcal meningitis and tuberculosis, these are preventable deaths. Without accelerated action to prevent people from reaching advanced HIV disease, AIDS-related causes will remain a leading cause of death in many countries. In addition, continued rising new HIV infection in some regions could halt or even reverse progress made against AIDS-related deaths.

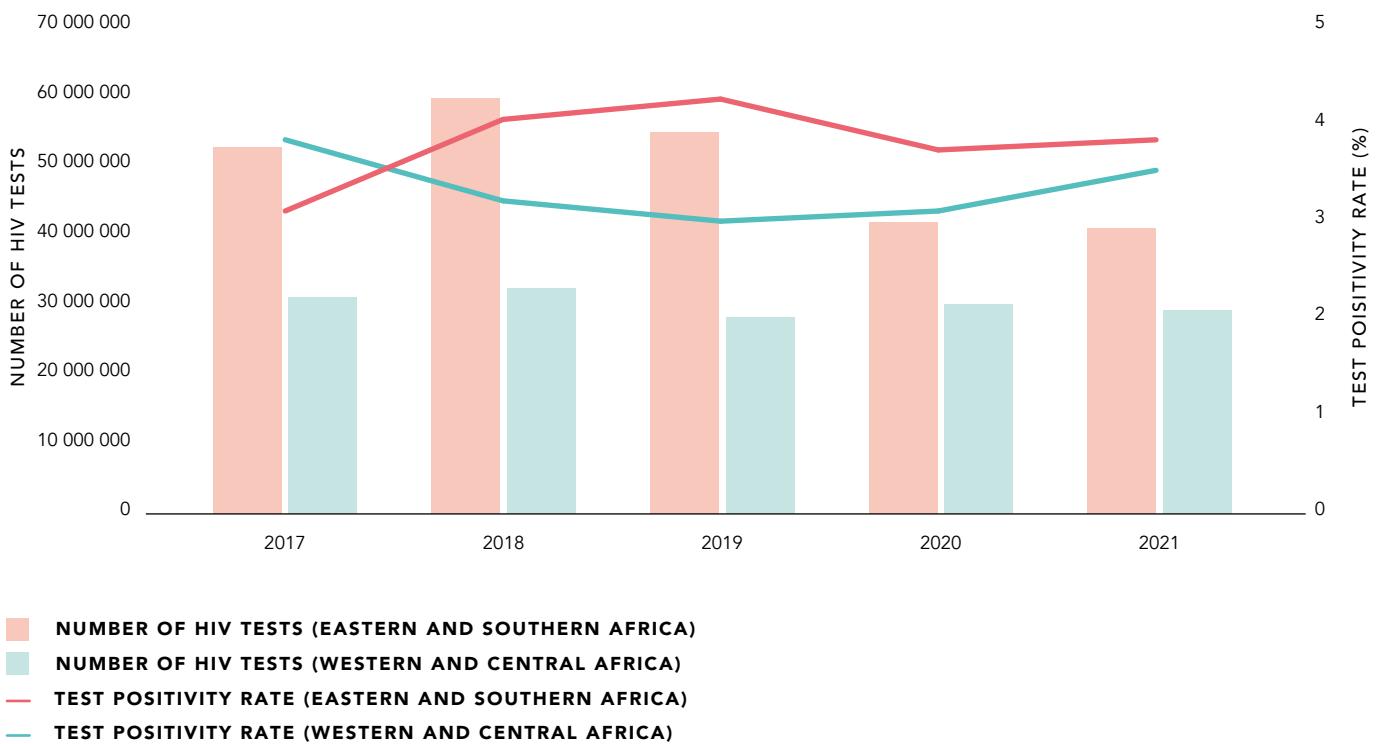
650 000

PEOPLE DIED OF AIDS-RELATED CAUSES IN 2021

Trends in HIV infections and AIDS-related deaths are driven by the availability of HIV services. Here, too, signs are worrying as expansion of HIV testing and treatment services stalls. The number of people on HIV treatment increased by only 1.47 million in 2021, compared to net increases of more than 2 million people in previous years. This represents the smallest increase since 2009. The largest increase was in western and central Africa, while the increase in eastern and southern Africa was much lower than it had been in previous years. As a result, treatment coverage in both regions is now the same: 78% of people living with HIV are receiving treatment (Figure 0.3).

Fewer HIV tests were conducted in eastern and southern Africa in 2020 and 2021 than in 2019 (Figure 0.2). The number of men in 2020 and 2021 who underwent voluntary medical male circumcision—a key HIV prevention tool in the 15 countries with high HIV prevalence that are home to 43% of the world’s new adult HIV infections—were two thirds of the number circumcised in 2018 and 2019.³

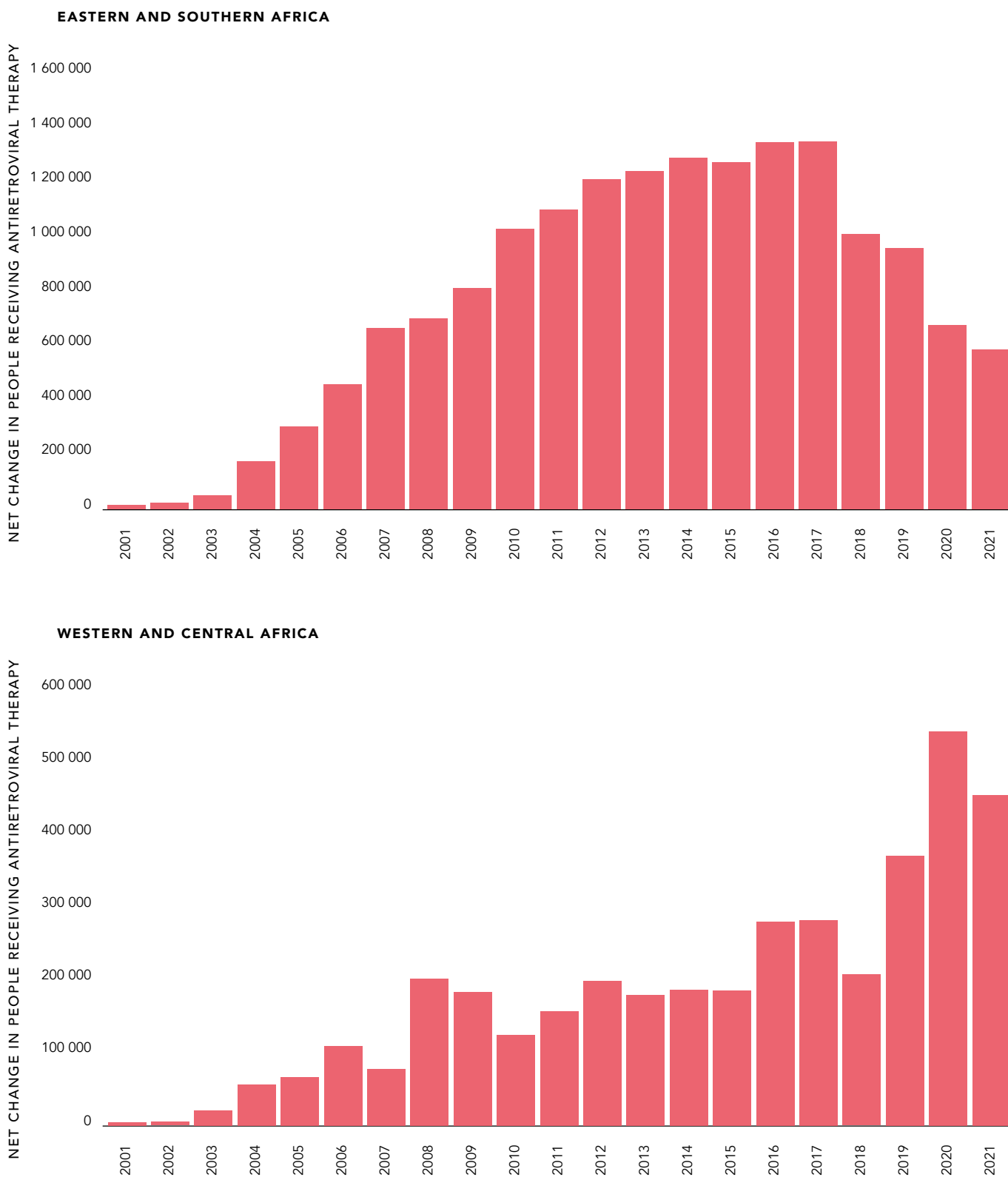
FIGURE 0.2 Number of HIV tests and test positivity rate by region, sub-Saharan Africa, 2017–2021



Source: Routine national programme data used in the UNAIDS epidemiological estimates, 2022.

³ The 15 priority countries for voluntary medical male circumcision are: Botswana, Eswatini, Ethiopia (only Gambela State), Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

FIGURE 0.3 change in the number of people receiving antiretroviral therapy by region, sub-Saharan Africa, 2001–2021



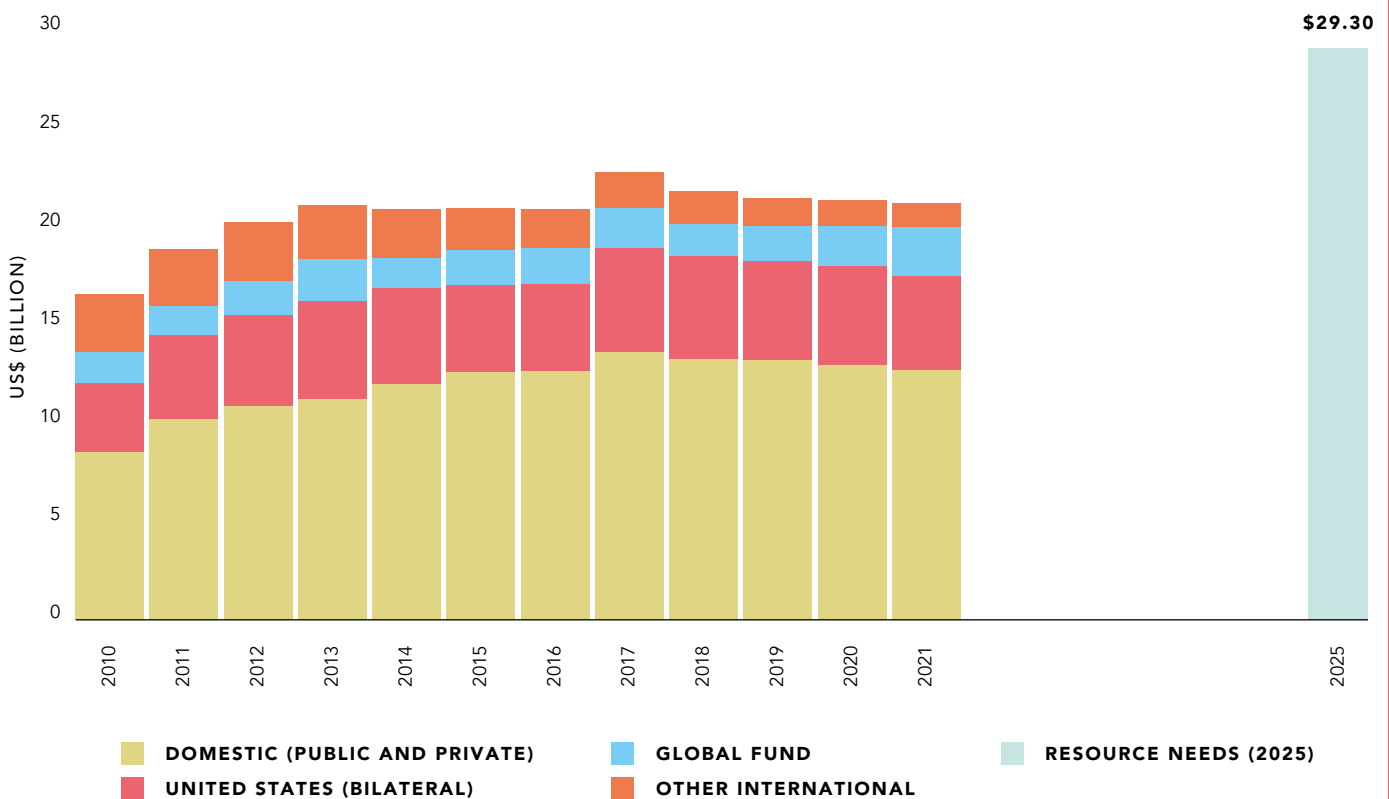
Source: UNAIDS epidemiological estimates, 2022 (<https://aidsinfo.unaids.org/>).

FINANCING THREATS COULD FURTHER UNDERMINE THE RESPONSE IN AN INCREASINGLY STRAINED ECONOMIC CONTEXT

Progress is slowing as resources available for HIV in low- and middle-income countries decline (Figure 0.4), leaving their HIV responses US\$ 8 billion short of the amount needed by 2025. Many major bilateral donors are reducing international assistance for AIDS; meanwhile, low- and middle-income countries struggle under the greater fiscal burdens caused by the COVID-19 pandemic. COVID-19 and now the war in Ukraine are creating extraordinary headwinds.

Many major bilateral donors are reducing international assistance for AIDS.

FIGURE 0.4 Resource availability for HIV in low- and middle-income countries, 2010–2021 and 2025 target



Source: UNAIDS financial estimates and projections, 2022 (<http://hivfinancial.unaids.org/hivfinancialdashboards.html>); Stover J, Glabius R, Teng Y, Kelly S, Brown T, Hallett TB et al. Modelling the epidemiological impact of the UNAIDS 2025 targets to end AIDS as a public health threat by 2030. *PLoS Med.* 2021;18(10):e1003831.

Note: The resource estimates are presented in constant 2019 US dollars. The countries included are those that were classified by the World Bank in 2020 as being low- and middle-income.

52

COUNTRIES ARE PROJECTED TO EXPERIENCE A SIGNIFICANT DROP IN PUBLIC SPENDING CAPACITY THROUGH 2026

Official development assistance for HIV from bilateral donors other than the United States of America has plummeted by 57% over the last decade, making the 2022 replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) more critical than ever. In 2021, international resources available for HIV were 6% lower than in 2010.

Unlike previous years, however, domestic HIV investments are not replacing lost international funding. Instead, domestic funding in low- and middle-income countries has fallen for two consecutive years, including by 2% in 2021. Global economic conditions and the vulnerabilities of developing countries—which are exacerbated by growing inequalities in access to vaccines and health financing—threaten both the continued resilience of HIV responses and their ability to close HIV-related inequalities. The World Bank projects that 52 countries, home to 43% of people living with HIV, will experience a significant drop in their public spending capacity through 2026 (4).

High levels of indebtedness are further undermining the capacity of governments to increase HIV investments. Debt servicing for the world's poorest countries has reached 171% of all spending on health care, education and social protection combined (5). Increasingly, paying off the national debt is crowding out health and human capital investments that are essential to ending AIDS (see Zambia feature story in Chapter 5). Middle-income countries—home to 71% of people living with HIV and 71% of people newly infected with HIV—are in danger of being declared ineligible for health and HIV grants as donor countries redirect their resources to Ukrainian refugees and rebuilding rather than expanding international assistance.

New investments are needed now to end AIDS by 2030.

All this is happening at a moment where individuals are experiencing personal economic shocks. Sharp increases in the price of fuel and food have caused 180 million people worldwide to become food insecure (6). These and other inequalities are increasing HIV vulnerability and diminishing service access. As food insecurity rises in the Central African Republic, for example, new data show that people living with HIV who are malnourished are much more likely to experience interruptions in their HIV treatment (7).

New investments are needed now to end AIDS by 2030. Making good on the promises made within the United Nations (UN) General Assembly in 2021 will be markedly less expensive than underinvesting now and risking further backsliding. Over the last year, indifference has slid towards neglect, and this lack of solidarity is both morally wrong and harmful to all countries. If there is one lesson that the COVID-19 pandemic has taught us, it is that pandemics can't be ended anywhere until they are ended everywhere.

INEQUALITIES ARE A CONSEQUENCE AND A CAUSE OF THE SLOWING PROGRESS IN THE AIDS RESPONSE

The most vulnerable and marginalized are being hit the hardest. In the words of UN Secretary-General António Guterres, a “perfect storm” of crises is widening global inequalities (8).

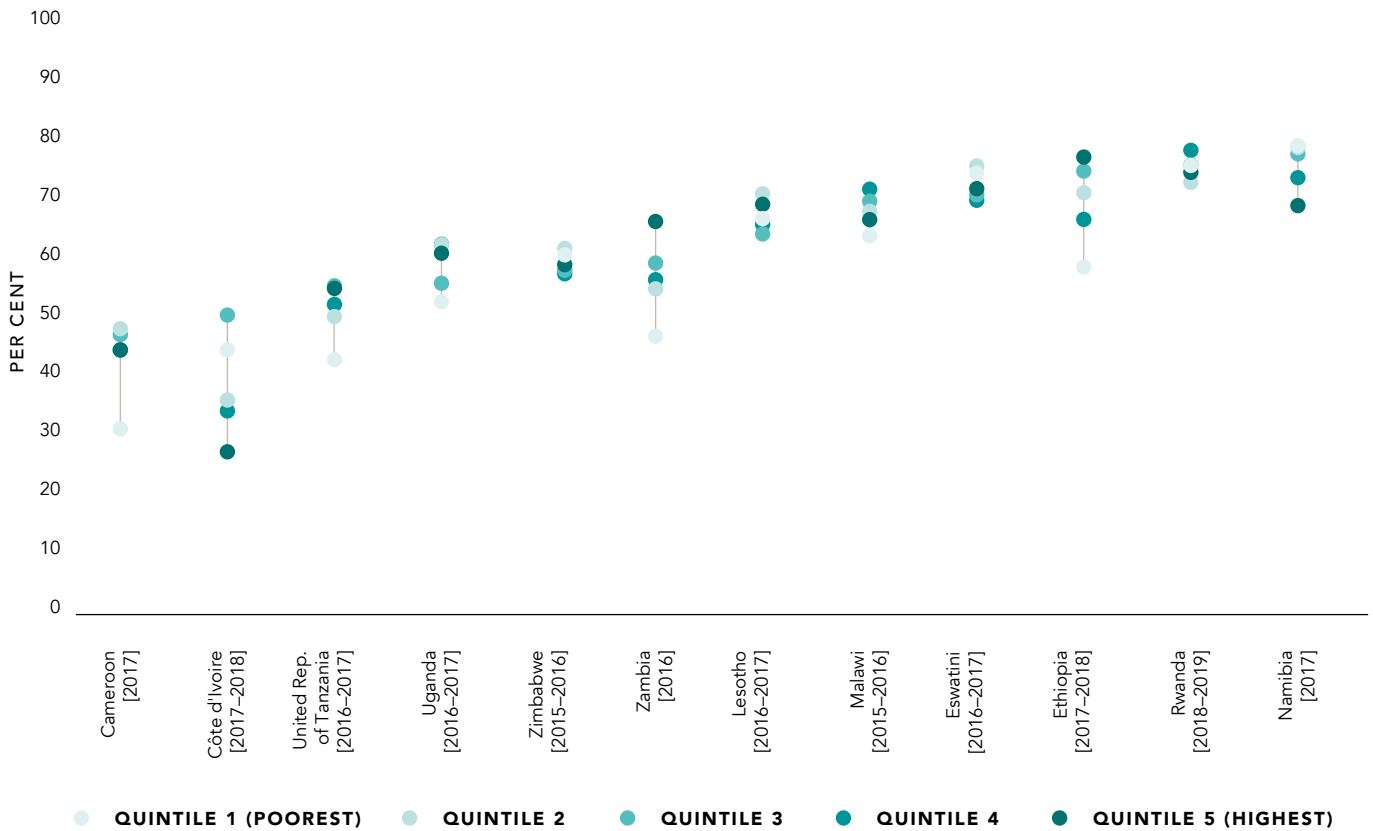
In roughly half of the countries with available data, people living with HIV in the poorest wealth quintile households had the lowest levels of HIV viral suppression (Figure 0.5). In some countries—such as Cameroon, Ethiopia, the United Republic of Tanzania and Zambia—the viral suppression gap between the richest and poorest quintiles is substantial. However, this is not inevitable: in countries with well-funded treatment programmes that focus on the most vulnerable—such as Eswatini, Lesotho, Namibia and Zimbabwe—the poorest quintile of people living with HIV have higher levels of viral suppression.

Making good on the promises made within the UN General Assembly in 2021 will be markedly less expensive than underinvesting now and risking further backsliding.

Inequalities undermine the AIDS response for all. Countries with the smallest viral suppression gaps between wealthy and poor households have achieved some of the world’s most substantial declines in new HIV infections.



FIGURE 0.5 Viral load suppression among all people living with HIV, by wealth quintile, selected countries, 2015–2019



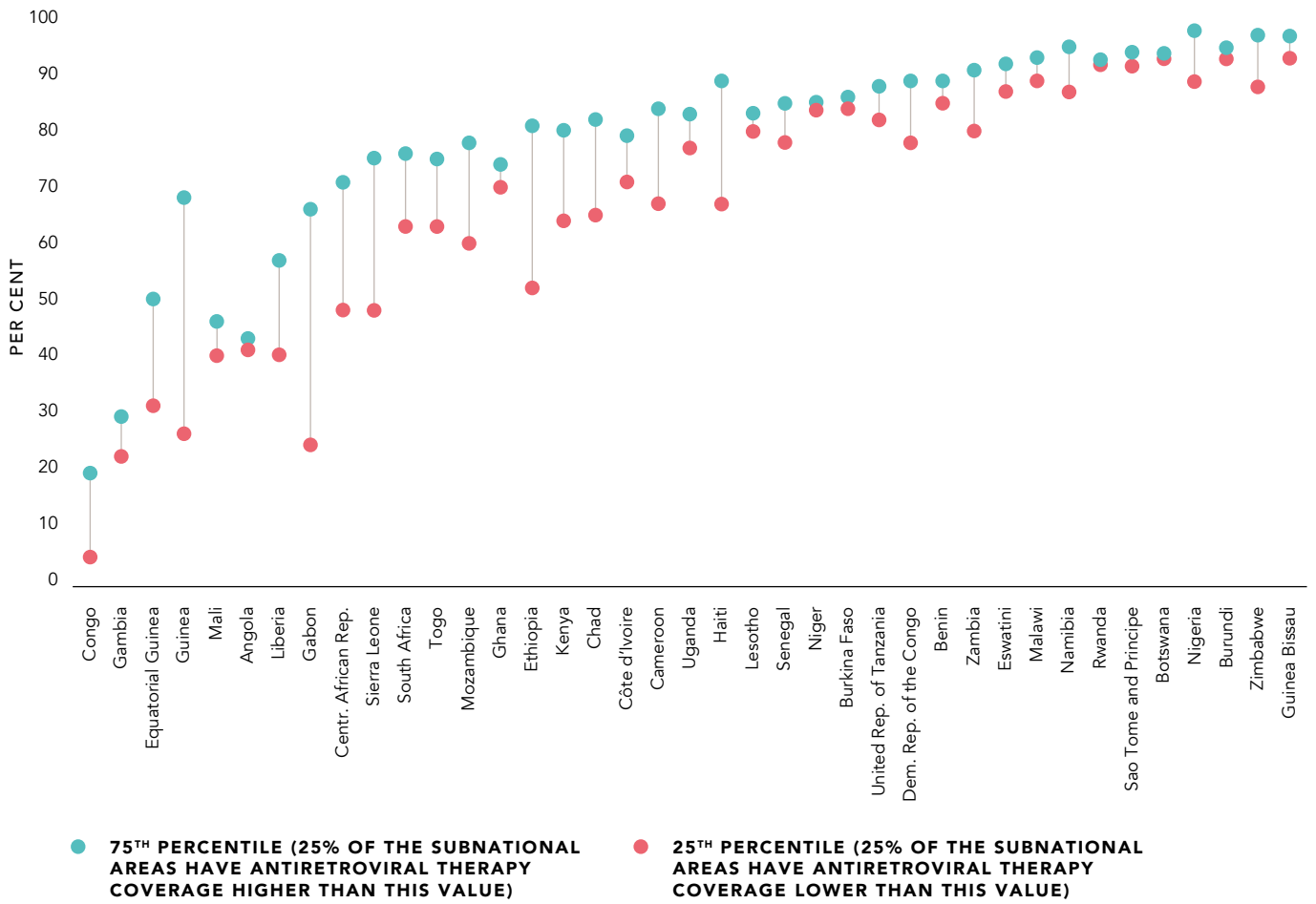
Source: Population-Based HIV Impact Assessment (PHIA) surveys, 2015–2019; PHIA Project [database]. New York (NY): ICAP; c2022 (<https://phia-data.icap.columbia.edu/>).

Note: Data for quintile 5 in Côte d'Ivoire is based on 32 individuals.

Similarly, there are often substantial differences in HIV treatment access between districts in the same country, suggesting that people living in some parts of the country are not benefiting equally. Reasons for these differences include an urban–rural divide, as well as political, economic, cultural or other divisions (Figure 0.6). While such inequalities are pronounced in countries such as the Central African Republic, Gabon, Guinea, Ethiopia, Haiti, Nigeria and Sierra Leone, some countries that have minimized coverage gaps between districts—such as Lesotho, Malawi and Rwanda—have also achieved some of the largest reductions in new HIV infections and AIDS-related deaths.

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FIGURE 0.6 Inequalities in subnational antiretroviral therapy coverage, selected high HIV prevalence countries, 2021



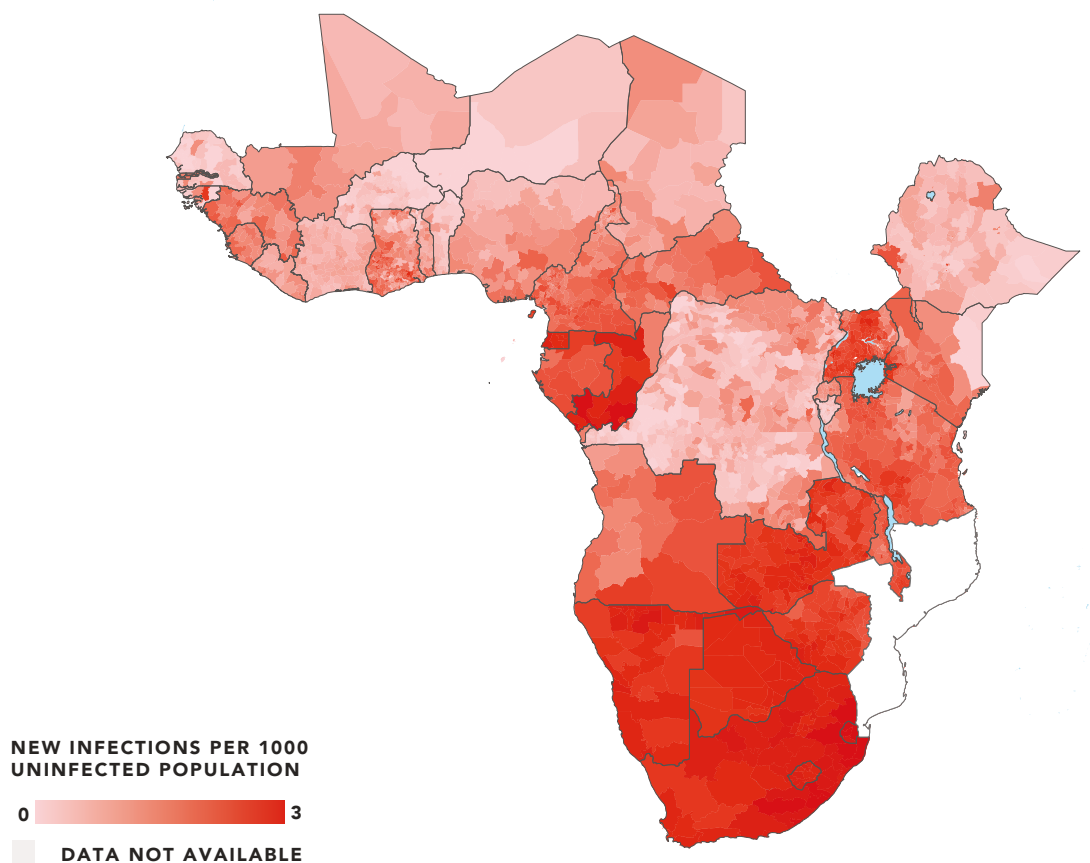
Source: UNAIDS epidemiological estimates 2022 (<https://aidsinfo.unaids.org/>).

As HIV testing and treatment programmes expand, children living with HIV are often being left behind. In 2021, an estimated 800 000 [640 000–990 000] children living with HIV were still not receiving HIV treatment. Children comprised 4% of people living with HIV in 2021 but 15% of AIDS-related deaths, and the gap in HIV treatment coverage between children and adults is increasing rather than narrowing (see Chapter 1).

WOMEN, GIRLS AND KEY POPULATIONS AT INCREASED RISK

People with less social power and fewer protections under the law are often at higher risk of HIV infection. Adolescent girls and young women (aged 15 to 24 years)—one of whom becomes infected with HIV every three minutes—are three times more likely to acquire HIV than adolescent boys and young men of the same age group in sub-Saharan Africa (Figure 0.7). Global estimates based on data from 2000–2018 also indicate that more than one in 10 ever-married or partnered women aged 15 to 49 years have experienced intimate partner physical and/or sexual violence within the past 12 months. Furthermore, the epidemic of domestic violence against women worldwide greatly intensified during the COVID-19 pandemic (9).

FIGURE 0.7 HIV incidence among adolescent girls and young women (aged 15–24 years), subnational levels, sub-Saharan Africa, 2021



Source: UNAIDS epidemiological estimates, 2022.

Note: Analysis available for 37 countries in sub-Saharan Africa with required data at the subnational level. Countries in sub-Saharan Africa not included are Comoros, Djibouti, Eritrea, Madagascar, Mauritania, Mauritius, Mozambique, Seychelles, Somalia, South Sudan and Sudan.

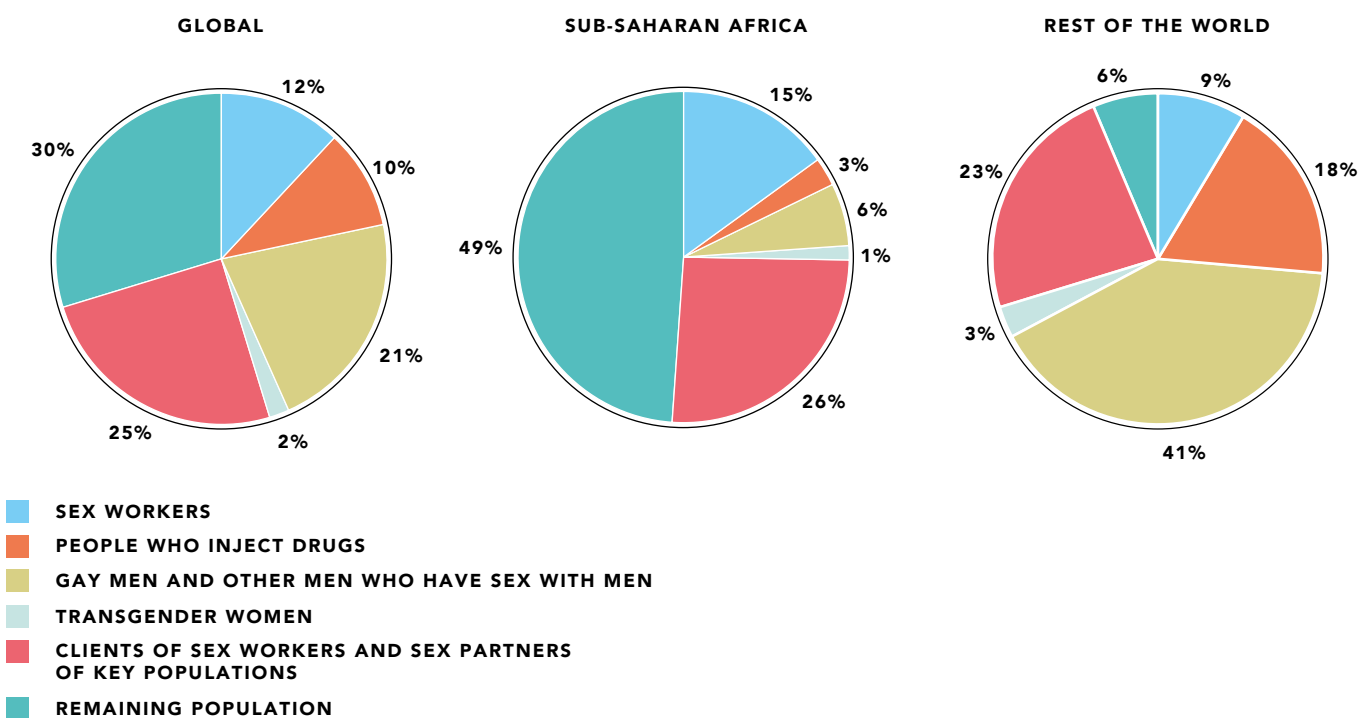
70%

OF NEW HIV INFECTIONS IN 2021 WERE AMONG KEY POPULATIONS AND THEIR SEXUAL PARTNERS

Key populations account for less than 5% of the global population, but they and their sexual partners comprised 70% of new HIV infections in 2021 (Figure 0.8). In every region of the world, there are key populations who are particularly vulnerable to HIV infection (Figure 0.9).

Racial and ethnic minorities often experience substantial HIV-related inequalities, such as in the United Kingdom of Great Britain and Northern Ireland and the United States, where declines in new HIV diagnoses have been smaller among Black people than among white populations (10, 11). In Australia, Canada and the United States, HIV acquisition rates are higher in indigenous communities than in non-indigenous communities (12, 13).

FIGURE 0.8 Distribution of acquisition of new HIV infections by population, global, sub-Saharan Africa and rest of the world, 2021



Source: UNAIDS special analysis, 2022 (see Annex on Methods).

Note: Due to variations in the availability of data from one year to the next, we do not provide trends in this distribution. See Annex on Methods for a description of the calculation.

FIGURE 0.9 Relative risk of HIV acquisition, global, 2021



Source: UNAIDS special analysis, 2022 (see Annex on Methods).

WE HAVE THE MEANS TO TACKLE PERSISTENT INEQUALITIES AND GET THE AIDS RESPONSE ON TRACK

Among the deeply concerning broader trends of the global AIDS response, there is some good news to report. National responses that were adequately resourced, adopted sound policies, and made prevention and treatment technologies widely available have demonstrated remarkable resilience and impact. Countries as diverse as Italy, Lesotho, Viet Nam and Zimbabwe cut new HIV infections by more than 45% between 2015 and 2021.

Countries as diverse as Italy, Lesotho, Viet Nam and Zimbabwe cut new HIV infections by more than 45% between 2015 and 2021.

In the midst of the COVID-19 pandemic, steady increases were achieved in the scale-up of oral pre-exposure prophylaxis (PrEP), notably in countries such as Kenya and South Africa. Since the decision to use PrEP rests with the individual and does not have to be negotiated with a partner, it has huge potential to help reduce HIV infections among key populations everywhere and girls and women in sub-Saharan Africa. However, access to oral PrEP remains concentrated mainly in several high-income countries and five countries in sub-Saharan Africa: Kenya, Nigeria, South Africa, Uganda and Zambia. As oral PrEP expands, more choices for HIV prevention—such long-acting PrEP that can be administered through injection or vaginal rings—are becoming available. However, cost and availability currently keep them out of reach of the majority who need these new tools.

The Global AIDS Strategy, 2021–2026 provides a clear, evidence-informed blueprint for getting the AIDS response on track. The world's governments have pledged to take concrete steps to translate this blueprint into action. No miraculous "silver bullet" is needed: using the tools already at its disposal, the global community simply needs to translate its commitments into concrete results for people.

The COVID-19 pandemic and the Ukraine war are generational challenges, and their negative impacts are far-reaching. Along with the bad, however, comes some good: these crises have also demonstrated the world's ability to mobilize massive resources and shift policies quickly in the face of extraordinary adversity. The innovation and leadership galvanized by the COVID-19 experience also underscore the pivotal role that communities can play in preserving service access and reaching the most vulnerable and marginalized people.

CLOSING THE GAPS IN THE RESPONSE: KEY ACTIONS TO GET THE RESPONSE ON TRACK TO END AIDS BY 2030

- **Make a new push for HIV prevention.** Countries urgently need to elevate the political and financial prioritization of HIV prevention and shift from fragmented projects to large-scale implementation (see the Cambodia feature story in Chapter 2). Redoubled efforts are needed to address inequalities in HIV prevention access and to close gaps in the cascade of services in order to prevent mother-to-child HIV transmission. As new prevention tools become available, such as long-acting injectable PrEP, focused efforts will be needed to roll them out as swiftly and effectively as possible.
- **Realize human rights and gender equality.** Punitive and discriminatory laws and policies are undermining the AIDS response by pushing people away from services and undermining public health efforts to reach those most at risk of new infection or death (see the Belgium feature story in Chapter 3). Removing these laws will help get the AIDS response back on track. The human rights of women and girls—including their sexual and reproductive health and rights—are key to an effective response. Putting them at the centre of the AIDS response, alongside well-resourced efforts to eliminate gender-based violence, is crucial.
- **Support and effectively resource community-led responses.** Community-led responses are proving to be game changers in reducing inequalities and supporting effective and resilient HIV responses (see the Uganda feature story in Chapter 4). They are reaching those who are poorly served by mainstream services and monitoring service quality to hold providers accountable for success. Resourcing these efforts and removing policies that impede the ability of community-led organizations to provide a full range of services will be key to accelerating progress.
- **Ensure sufficient and sustainable financing.** Major new HIV investments are essential from both international donors and the governments of low- and middle-income countries. International action is needed to alleviate the debt crisis that is confronting many low- and middle-income countries and to avoid counterproductive austerity policies. Steps are also needed to further increase the return on HIV investments, including through price reductions, cost efficiencies and increased investments in HIV prevention. Financial barriers to service utilization must be removed (see the Cameroon feature story in Chapter 5).
- **Address inequalities in HIV prevention, testing and treatment access and outcomes, and close the gaps that exist in specific localities and for certain groups.** In diverse settings, countries and communities are taking action to end inequalities and close gaps (see the Kenya feature story in Chapter 3). Building on this momentum, stakeholders need to leverage better, more granular data to zero in on the inequalities that slow progress.

ENDING AIDS REQUIRES POLITICAL COURAGE

Greater political courage is needed to end HIV-related inequalities and revive and further strengthen global solidarity around this goal. There is momentum on which to build. Communities of people living with HIV and key populations are generating the context that compels political leaders to take bold and courageous action. New tools, such as long-acting injectable antiretroviral medicines, can have potentially transformative effects—if they are broadly shared and equitably distributed. Innovative data methods have increased the ability of countries and communities to zero in on the inequalities that slow progress in closing the gaps.

Communities of people living with HIV and key populations are generating the context that compels political leaders to take bold and courageous action.

We know what needs to be done to end AIDS, and we have the tools we need. Now our challenge is to summon the courage required to close the gaps in the response and end HIV-related inequalities.



RESPONDING TO CRISES: COMMUNITIES AT THE CORE OF THE HIV RESPONSE IN UKRAINE AND BEYOND

THE WORLD'S ONGOING CRISES

Ukraine is not alone. Emergencies in the Bolivarian Republic of Venezuela, Ethiopia, Libya, Mozambique, Myanmar, the Syrian Arab Republic, the Sahel region of Africa and many other parts of the world have disrupted millions of lives with devastating effects. Many countries face recurrent emergencies ranging from civil conflict, droughts and food shortages to floods and mass displacement.

Progress in the global HIV response requires that HIV services stay operational in all settings. One of UNAIDS' key recommendations is involving communities in preparing and rolling out responses. Responses need to be contextualized to local needs and structured to enable everyone in the community to be involved: inclusive, rights-based, gender-informed, participatory and collaborative.

The war in Ukraine has led to more than 12 million people being displaced and millions of Ukrainians seeking refuge in neighbouring countries, including Czechia, Hungary, Poland, the Republic of Moldova, Romania and Slovakia.

Shelling, missiles and air strikes have destroyed up to 5000 residential buildings and more than 250 health-care institutions. Currently, 52 out of 403 sites that normally distribute life-saving antiretroviral medicines for HIV do not function, and others remain damaged. International help and funding has brought important relief, with key donors—PEPFAR and the Global Fund—stepping in to provide medicine.

The UNAIDS Emergency Fund disbursed US\$ 250 000 to preserve key HIV services in four hard-hit cities in the country. UNAIDS also reallocated funds to help some of the most vulnerable people evacuate or find shelter. An urgent need remains, however, to fund overstretched civil society groups in Ukraine and neighbouring countries that are assisting displaced people living with HIV and key populations.

The emergency HIV response would not have been possible without grass-root providers on the ground. "Civil society and community-based organizations have long been at the core of the HIV response in Ukraine, and even more so since the war started," said Raman Hailevich, UNAIDS Ukraine Country Director. "Not only have they been on the front lines of HIV service delivery, but they have also helped with humanitarian support", he explained. "Offices have been turned into humanitarian hubs working 24/7".

Before the war, Ukraine had one of the most prominent national AIDS responses in the region, with a 47% decline in new HIV infections between 2010 and 2021, effective harm reduction programmes distributed across the country and nascent programmes addressing the needs of gay men and other men who have sex with men and transwomen. For many, the government's decade-long partnership with community-led services has proven to be the difference between life and death. The networks, partnerships and expertise that have been built up have meant that even in this crisis, the HIV response has not collapsed and has instead stayed resilient. But the war has taken a toll.



Mobile HIV case-finding project in Ukraine, May 2022.

"The work is dangerous and volunteers are putting their lives at risk," said Dmytro Sherembey, Head of the 100% Life Coordination Council. Four months into the conflict, he is feeling overwhelmed. "If we don't get more help, I am not sure how much longer we can continue, especially reaching people in the front-line zones," he added.

International support for civil society-led humanitarian responses urgently needs to be increased.

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