UNAIDS July 2026

UNAIDS Special Report for the
26th International AIDS Conference

UNITED TO END AIDS

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UNITED TO END AIDS

Contents

Introduction

Renewed commitment to avoid reversing decades of progress

While the world has turned the tide against HIV, the progress is fragile and the ground beneath our feet is still shifting. The international community has entered a period of profound political and financial upheaval that threatens decades of hard-won gains against HIV. Without renewed commitment and action, the world risks a resurgence of the HIV epidemic. In 2025, HIV responses around the world were disrupted by unprecedented shifts in funding, while shrinking civic space and growing attacks on human rights created additional barriers to reaching the people most affected by HIV and threatened to stall years of progress. In 2025, external financing for the global HIV response in low- and middle-income countries fell by 18% compared with 2024 *(1)*.

Data collected by the Joint United Nations Programme on HIV/AIDS (UNAIDS) from countries show that HIV funding disruptions severely impacted HIV prevention, testing and key components of treatment programmes, such as the range of community-led services that reach the people most affected by HIV. These funding shifts prompted countries to prioritize short-term domestic resource mobilization to preserve essential HIV treatment services—a necessary first step in sustaining national HIV responses. The full effects of the funding cuts on the global HIV response will become evident over the next few years as HIV programmes re-emerge with new sources of funding.

Gender equality, sexual and reproductive health and rights, and rights of LGBTQI+ people are under increasing attack in many parts of the world, and new laws against same-sex relations continue to emerge. This threatens to unravel decades of progress, creating new legal and structural barriers that alienate the very communities that need HIV services most. Compounding this, severe funding cuts have already suspended or permanently closed vital, community-led programmes.

In this report, UNAIDS provides the latest global, regional and national data on the HIV epidemic and response as of the end of 2025.[1] The report highlights the extraordinary progress achieved over the past three decades, including the unprecedented scale-up of HIV treatment and greater understanding about what drives the epidemic and how to prevent new HIV infections. Protecting and building on these gains will be critical to ending AIDS as a public health threat by 2030 and sustaining progress beyond.

Efforts to reach the 2030 targets are threatened by converging crises, including declines in external financing, high debt burden in the countries most affected by HIV, a growing number of humanitarian crises and displacements globally emerging epidemics such as Ebola, and a backsliding on human rights and gender equality, which all impact HIV services. The global health financing architecture is changing, driven by significant reductions in external funding, with several donors reducing their aid commitments for HIV, placing profound pressures on national systems that are already struggling to advance progress to end AIDS as a public health threat[2] and to uphold the right to health

Strong country leadership and a shift from donor-led to country-owned responses are increasing self-reliance and helping to strengthen national systems, local capacity and long-term sustainability. Data from 2025 show that countries have stepped in to sustain treatment services, but urgent action is needed to protect progress in HIV prevention and community-led services, which often are not prioritized.

In the face of these multiple challenges, the Global AIDS Strategy 2026–2031 is a powerful blueprint for ending AIDS as a public health threat by 2030. The Strategy is a framework to establish a sustainable response towards and beyond 2030 that serves the needs of people living with, at risk of or affected by HIV, based on country ownership, person-centred services and community leadership.

At a time of growing pressure on international cooperation, the United Nations High-level Meeting on HIV/AIDS that took place on 22–23 June 2026 adopted the new Political Declaration on HIV and AIDS *(2)* with strong support. The Declaration reaffirms global commitment to ending AIDS as a public health threat by 2030 and sets ambitious and important new targets.

The outcome follows weeks of negotiations with all Member States and engagement with communities, civil society and partners. It demonstrates that countries continue to recognize the urgency of sustaining progress against HIV, even in an environment marked by reduced international financing and reduced commitment to multilateralism.

1 All data presented in this report that are not sourced are available at https://aidsinfo.unaids.org/.

2 Defined as reducing numbers of new HIV infections and AIDS-related deaths by 90% from their levels in 2010.

The Declaration provides a roadmap for the global HIV response over the next five years. It reflects the ambitious targets of the Global AIDS Strategy 2026–2031 and commits to convening a high-level meeting in 2031 to review progress beyond the 2030 milestone.

Ending AIDS as a public health threat by 2030 remains within reach—but only if countries, communities and all partners act decisively and make the political choices required to put people first. Without this commitment, countries risk seeing a resurgence of the HIV epidemic and losing decades of progress.

Summary numbers

	2010	2015	2020	2024	2025
People living with HIV	32.5 million [27.9 million –37.6 million]	35.9 million [30.8 million –41.5 million]	38.9 million [33.4 million –45.0 million]	40.7 million [35.0 million –47.1 million]	41.0 million [35.3 million – 47.5 million]
New HIV infections	2.1 million [1.6 million –2.9 million]	1.8 million [1.4 million –2.4 million]	1.5 million [1.1 million –2.0 million]	1.3 million [980 000 –1.7 million]	1.2 million [950 000 –1.7 million]
AIDS-related deaths	1.3 million [1.0 million –1.8 million]	940 000 [720 000 –1.3 million]	720 000 [550 000 –1.0 million]	600 000 [460 000 –830 000]	570 000 [430 000 –780 000]
Coverage of prevention of vertical transmission	51% [43–64%]	79% [67–>98%]	84% [71–>98%]	85% [71–>98%]	87% [73–>98%]
Coverage of antiretroviral therapy	24% [18–28%]	47% [36–57%]	68% [51–82%]	77% [58–92%]	78% [59–94%]
Total HIV resources for low- and middle-income countries (in constant 2024 US$ billions)	US$ 15.6	US$ 18.9	US$ 19.6	US$ 18.8	US$ 17.6

Ending AIDS as a public health threat by 2030 remains within reach—but only if countries, communities and all partners act decisively.

1

Chapter 1

Momentum to end AIDS as a public health threat is faltering

Decades of hard work and global solidarity have reduced the annual numbers of people acquiring HIV and people dying from AIDS-related causes to their lowest levels in more than 30 years. AIDS is not over, however. The world is not on track to achieve the 2030 goal of ending AIDS as a public health threat. In 2025 alone there were 1 million more new HIV infections and 400 000 more AIDS related deaths than if we were on track to reach the global targets.

Since 2010, the estimated number of new HIV infections fell by 42% globally (Figure 1),[3] with an even steeper decline of 59% in sub-Saharan Africa (which accounted for about half of new infections globally in 2025). The number of new paediatric infections as a result of vertical transmission has dropped by 69% since 2010 to 93 000 [63 000–140 000] in 2025. Prevention of vertical transmission programmes averted nearly 4.8 million acquisitions of HIV in children between 2000 and 2025.

The world is not on track to achieve the 2030 goal of ending AIDS as a public health threat.

3 See 2026 Report Methods Annex for further information about UNAIDS data. https://www.unaids.org/en/resources/documents/2026/20260727_methods-annex

Despite progress, the world missed the 2025 targets

Figure 1
Number of new HIV infections, global, 1990–2025 and 2030 target

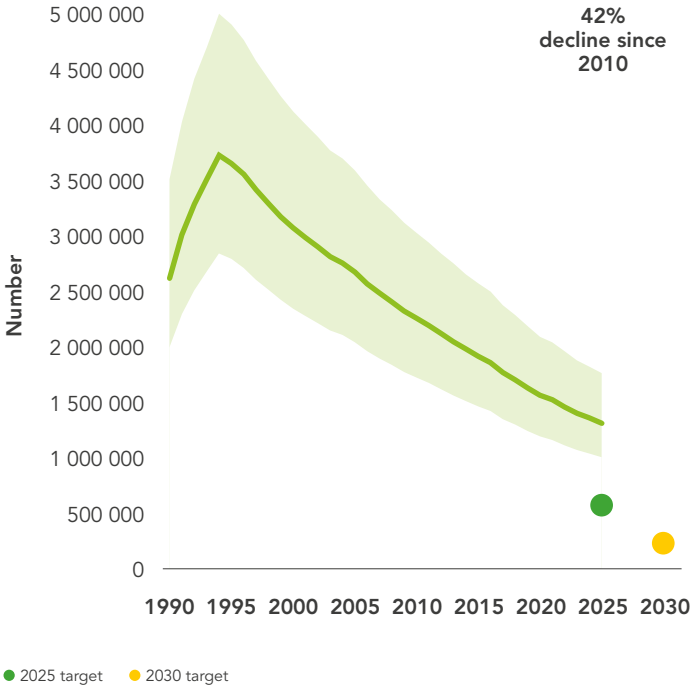
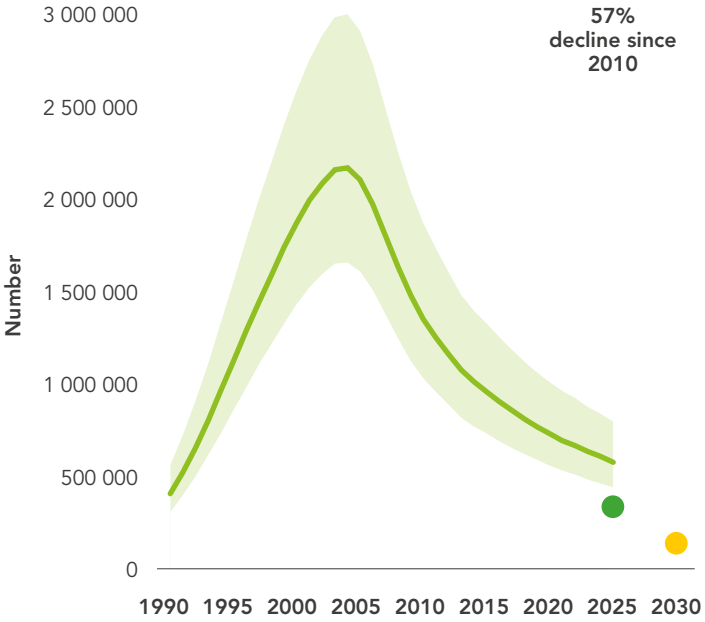


Figure 2
Number of AIDS-related deaths, global, 1990–2025 and 2030 target



Source: UNAIDS epidemiological estimates 2026.

The number of AIDS-related deaths in 2025 was 57% lower than in 2010, decreasing from 1.3 million [1.0 million–1.8 million] in 2010 to 570 000 [430 000–780 000] in 2025 (Figure 2), with a decline in deaths among adult women aged 15 years and older from 510 000 [380 000–730 000] to 220 000 [160 000–310 000] and among adult men from 590 000 [440 000–810 000] to 290 000 [220 000–390 000]. Mortality remains unacceptably high for a treatable condition, however, and progress is at risk of stalling, leaving the 2030 goal off track without sustained acceleration.

Globally in 2024, there were an estimated 150 000 [120 000–183 000] tuberculosis (TB)-related deaths among people living with HIV, a 76% decline compared with 2010. TB remained the leading cause of death among people living with HIV globally in 2024.[4]

These achievements were supported by a 13% increase in total HIV resources since 2010, with US$ 17.6 billion available for the HIV response in low- and middle-income countries in 2025. This was US$ 4.3 billion short of the estimated US$ 21.9 billion needed annually by 2030, a funding gap of well below the total need. The unprecedented funding reductions (18% of total external funding for HIV) in 2025 have made HIV programmes fragile in many low- and middle-income countries.

4 Data on tuberculosis and HIV are available only through 2024.

Fragile HIV prevention programmes are at risk

Domestic and international funding for HIV prevention programmes in sub-Saharan Africa was substantially reduced in 2025. Pre-exposure prophylaxis (PrEP) programmes and condom purchases declined drastically and suddenly between 2024 and 2025 in some countries. National data submitted to UNAIDS show major declines between 2024 and 2025 in PrEP in Cameroon, Nigeria and Zambia, with each country showing more than a 50% decline in the number of people receiving PrEP at least once during the year. However, Uganda took action and substantially expanded access to PrEP through domestic and other funding. South Africa, which has the largest number of people receiving PrEP globally, also had a considerable reduction in international financing for PrEP but managed to see only an 8% decline in the number of people reached between 2024 and 2025. Brazil also increased the number of people receiving PrEP at least once in the past year from 165 000 to 233 000 (by 41%).

In one bilateral donor programme, between 2024 and 2025 HIV testing declined by 22% in countries with a high level of HIV, funding for condom programming declined by 93%, and funding for programmes that ensure people can reach prevention services (e.g. supportive laws, regulations and policy environments) reduced by 80% *(3)*.

An overall lack of domestic funding for prevention programmes and declines in donor HIV assistance have put HIV prevention services at risk. Prevention programmes have historically relied heavily on donor assistance in most regions, with especially high dependency in sub-Saharan Africa (83% in 2024). In 2024, HIV prevention represented 11% of all HIV funding (domestic and international) in low- and middle-income countries, with a large proportion (66%) coming from external financing.[5]

Regional disparities persist

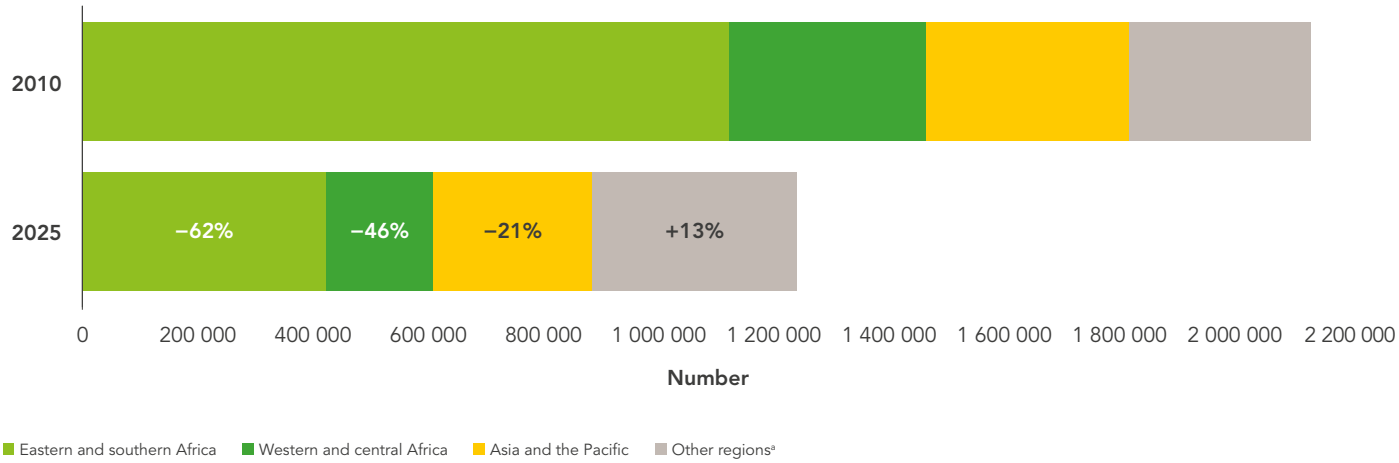
Between 2010 and 2025, numbers of new HIV infections continued to decline in some regions but increased in others. Declines occurred overall in Asia and the Pacific, the Caribbean, eastern and southern Africa, and western and central Africa, but this progress is fragile and at risk due to funding cuts, especially in sub-Saharan Africa. Increases were recorded in eastern Europe and central Asia, Latin America, and the Middle East and North Africa (Figure 3).

Sub-Saharan Africa continues to be the region most heavily affected by HIV, representing half of new HIV infections.

5 UNAIDS financial estimates.

Progress in reducing numbers of new HIV infections has been greatest in sub-Saharan Africa

Figure 3
New HIV infections by region and percentage change, 2010 and 2025



[a]*Other regions* combines regions with lower absolute numbers of new HIV infections than the regions shown separately. Trends within this group varied between 2010 and 2025: the number of new infections declined in the Caribbean (−30%) and western and central Europe and North America (−10%), but increased in eastern Europe and central Asia (+17%), Latin America (+25%) and the Middle East and North Africa (+78%).

Source: UNAIDS epidemiological estimates 2026.

Progress in reducing new HIV infections varies greatly between countries

In 2025, seven countries achieved at least a 78% reduction in the number of new HIV infections since 2010, placing them well on track towards the goal of a 90% reduction by 2030 (Table 1). These were the following high burden countries in Sub-Saharan Africa: Benin, Eswatini, Kenya, Lesotho, Rwanda and Zimbabwe, as well as Nepal. Another 27 countries have reduced their numbers of annual new HIV infections by more than 60% since 2010—and with concerted efforts, they could achieve the target of a 90% reduction by 2030.

Conversely, 21 countries still face rising numbers of new HIV infections. More effort is needed to reach people at the highest risk of HIV in these countries and to lift societal barriers such as stigma and discrimination and criminalizing laws that impede progress to end AIDS.

Gender and age disparities require urgent action

The number of new HIV acquisitions has declined faster among women than men outside of sub-Saharan Africa and globally (Figure 4). In sub-Saharan Africa, however, the number of new HIV acquisitions has declined more slowly among women than men.

21 countries are still seeing rising new HIV infections

Table 1
Countries in reach and countries not in reach of reducing new HIV infections

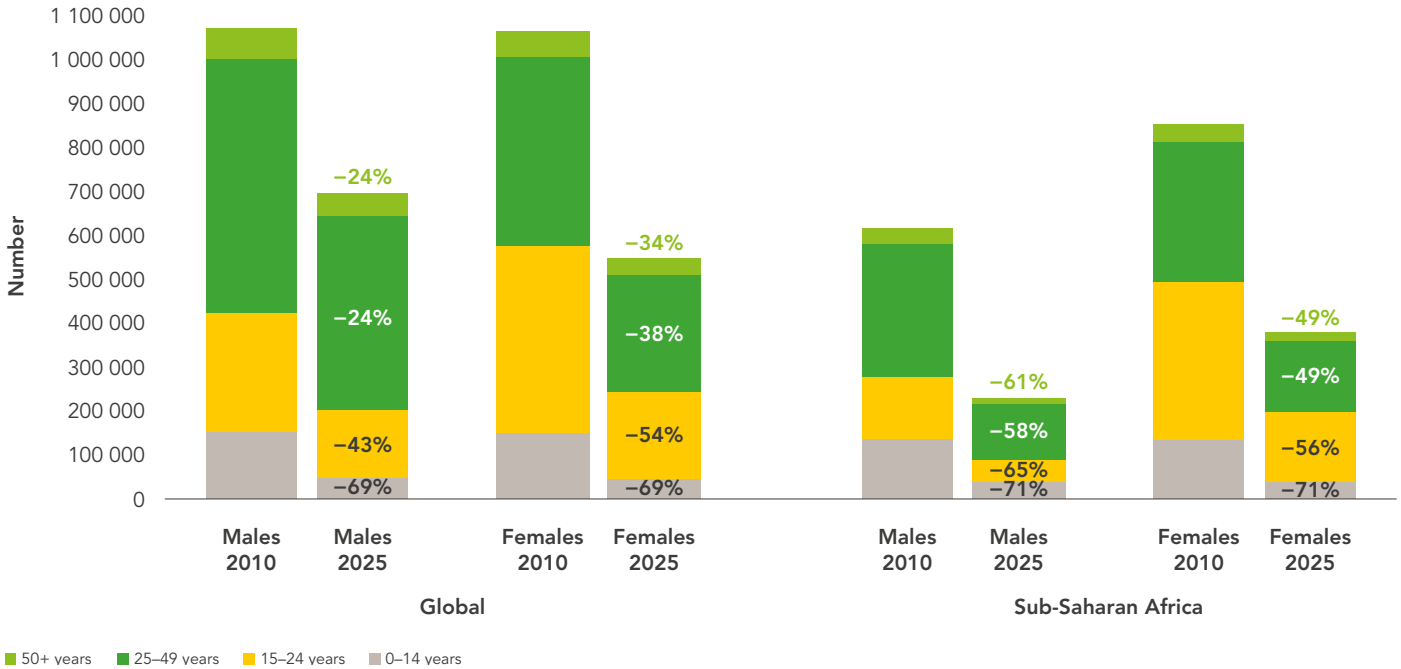
Countries on track to achieve 90% reduction in new infections (>78% decline in new infections from 2010 to 2025)	Countries with increasing numbers of new infections (>20% increase in new infections from 2010 to 2025)		
Benin	Afghanistan	Egypt	Philippines
Eswatini	Algeria	Kyrgyzstan	Senegal
Kenya	Armenia	Madagascar	Sri Lanka
Lesotho	Bangladesh	Niger	Sudan
Nepal	Brazil	Pakistan	Tunisia
Rwanda	Congo	Paraguay	Venezuela (Bolivarian Republic of)
Zimbabwe	Costa Rica	Peru	Yemen

Note: this table includes only countries with published estimates in 2010 and 2025 and with 200 or more new infections in both 2010 and 2025. See methods annex online for additional information on publication of estimates.

Source: UNAIDS epidemiological estimates 2026.

Declines in numbers of new HIV infections are slowest among men outside of sub-Saharan Africa, while women within sub-Saharan Africa have slower declines than their male counterparts

Figure 4
New HIV infections over time, by sex and age, global and sub-Saharan Africa, 2010 and 2025



Source: UNAIDS epidemiological estimates 2026.

As funding for HIV prevention in Africa falters, women continue to be disproportionately affected by HIV in sub-Saharan Africa, accounting for 6 out of 10 new acquisitions.

Adolescent girls and young women (aged 15–24 years) remain at high risk, especially in sub-Saharan Africa, where they represented about 160 000 [100 000–230 000] new acquisitions in 2025, which is 3000 new HIV acquisitions per week. Incidence among adolescent girls and young women is three to four times higher compared with their male counterparts in this region.

Service gaps in HIV programmes led to 93 000 [63 000–140 000] children acquiring HIV in 2025, with 84% of these in sub-Saharan Africa. In 2025, 87% [73–>98%] of women living with HIV who were pregnant were receiving treatment—a very slow increase from 84% [71–>98%] in 2020.

Key populations are still not benefiting from the science

The share of new HIV acquisitions among people from key populations[6] and their sexual partners increased globally from 44% in 2010 to 49% in 2024[7,8] (Figure 5).

People from key populations face a considerably higher risk of HIV acquisition. Globally in 2024, the risk of HIV acquisition compared with the adult population (aged 15–49 years) was estimated to be 34 times higher among people who inject drugs, 18 times higher among gay men and other men who have sex with men, 17 times higher among sex workers, and 17 times higher among transgender women.

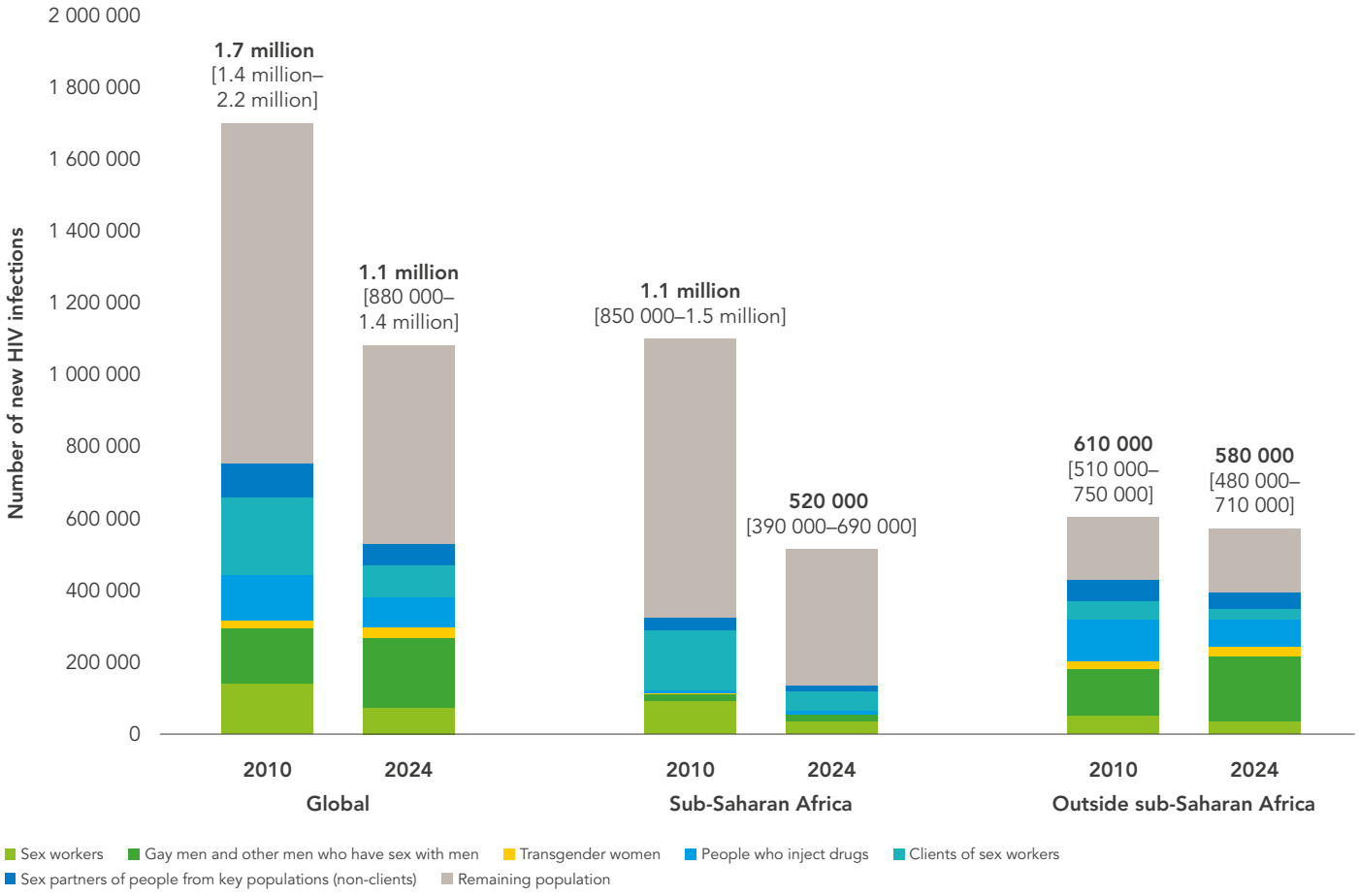
Programmes to reach people from key populations with HIV prevention, testing, treatment and care are needed urgently.

Regional transmission patterns differ significantly. In sub-Saharan Africa, heterosexual transmission outside key populations predominates, with 26% of new acquisitions among people from key populations and their sexual partners. Within sub-Saharan Africa, sex workers and their clients represent 18% of new HIV acquisitions in 2024.

6 Key populations include sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and people in prisons and other closed settings.
7 Data on new HIV infections among people from key populations are available only through 2024.
8 UNAIDS special analysis 2025.

New HIV acquisitions among key populations persist

Figure 5
Distribution of adult new HIV acquisitions, global, sub-Saharan Africa and outside sub-Saharan Africa, 2010 and 2024



Source: UNAIDS special analysis 2025.

Outside sub-Saharan Africa, however, people from key populations and their sexual partners account for about two-thirds of new acquisitions, with gay men and other men who have sex with men representing approximately 31%.

In eastern Europe and central Asia, men and women who inject drugs account for the largest share of new acquisitions among people from key populations (25% of regional new HIV infections in 2024).

Programmes to reach people from key populations, adult men and young women with HIV prevention, testing, treatment and care are needed urgently, as are programmes for older people who are ageing with HIV.

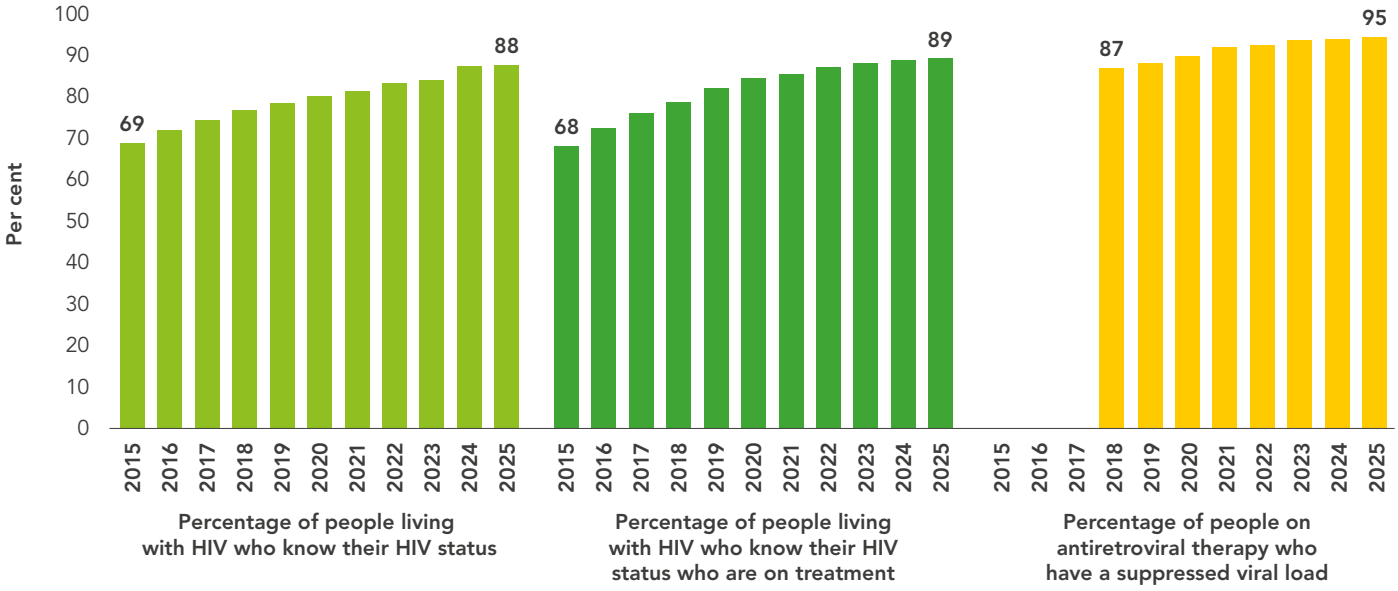
Progress on treatment has been maintained—but for how long?

Globally, at the end of 2025, 88% [67–>98%] of people living with HIV knew their HIV status, 89% [67–>98%] of people who knew their HIV status were on treatment, and 95% [72–>98%] of people on treatment had viral suppression[9] (Figure 6).

Thanks to the unprecedented mobilization of countries and communities and a re-emergence of funding for essential lifesaving HIV treatment services, progress has been maintained across treatment services, despite the disruptions of 2025. In December 2025, 32.1 million people living with HIV were receiving treatment—an annual increase of 3% from 2024 (lower than in earlier years, with an average annual increase of 4%).

Progress towards the 95–95–95 targets for HIV testing, treatment and viral suppression has been maintained

Figure 6
Progress towards the 95–95–95 testing, treatment and viral load suppression targets, global, 2015–2025



Source: UNAIDS epidemiological estimates 2026.

9 A person's viral load is undetectable when it is so low that a polymerase chain reaction test cannot measure it. A suppressed viral load is defined as equal to or less than 1000 copies/mL.

In 2025, 74% [64–86%] of all people living with HIV had a suppressed viral load and 95% [72–>98] of people on treatment had a suppressed viral load—an important gap to close by ensuring HIV testing is available and people are able to access treatment. People with an undetectable viral load have zero risk of transmitting HIV to their sexual partners, and people with a suppressed viral load have a near-zero risk of doing so. Vertical transmission can also be prevented when pregnant and breastfeeding women have a suppressed viral load *(4)*.

Community-led organizations, including women-led organizations, play a critical role in supporting people living with HIV, including pregnant women and young people, with access to HIV prevention and support services and adherence to treatment. The work of these organizations is in jeopardy due to the recent funding disruptions (see below). Treatment sustainability is fragile, with strong reliance on external funding—for example, 90% in western and central Africa and 38% in eastern and southern Africa in 2024.[10]

In 2025, just over half of children living with HIV were on antiretroviral therapy.

Treatment gaps are substantial among some populations

In 2025, just over half of children living with HIV were on antiretroviral therapy (55% [39–78%]), up from 17% in 2010—leaving more than 570 000 of an estimated 1.3 million children untreated. Children accounted for about 11% of AIDS-related deaths in 2025, despite representing only 3% of people living with HIV (Figure 7). The number of children living with HIV decreased from 2.6 million [2.2 million–3.4 million] in 2010 to 1.3 million [1.0 million–1.6 million] in 2025. This change reflects the strong vertical transmission programmes in recent years and children ageing out of the 0–14 years age group but urgent additional efforts are needed to end paediatric HIV acquisitions and AIDS.

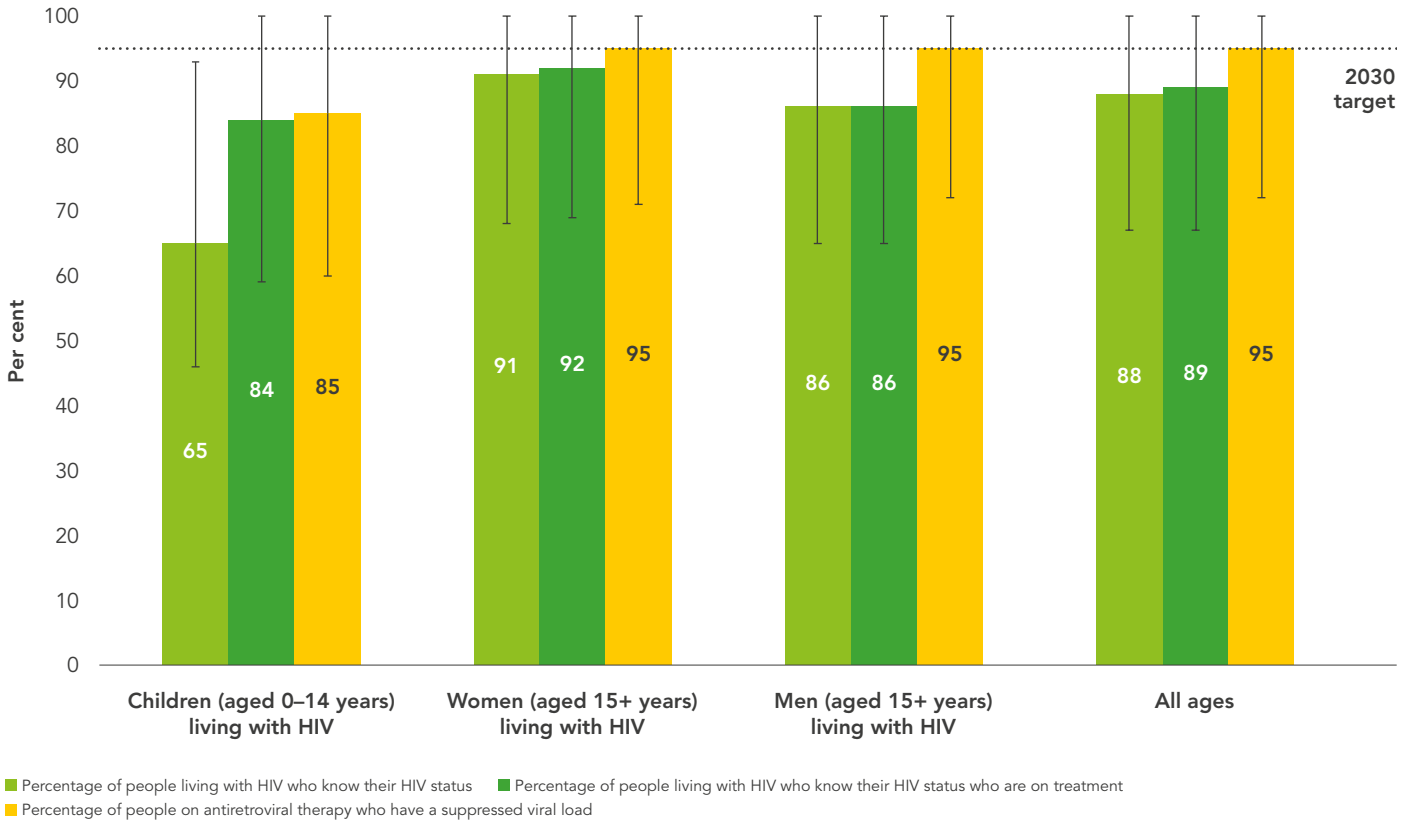
Globally, men living with HIV had lower treatment coverage than women (74% [57–85%] vs 84% [66–97%]) in 2025 (Figure 7). Regional and country variations exist, however: in Latin America and the Middle East and North Africa, women living with HIV had lower treatment coverage than men living with HIV due to societal barriers and gender inequalities..

People from key populations had lower treatment coverage, even in regions such as sub-Saharan Africa where treatment access was high in the general population *(5)*.

10 Global AIDS Monitoring and UNAIDS-supported national AIDS spending assessments 2019–2024, based on seven countries reporting in eastern and southern Africa and eight countries reporting in western and central Africa.

Despite progress towards the 95–95–95 targets for HIV testing, treatment and viral suppression, inequalities among populations remain

Figure 7
Progress towards the 95–95–95 testing, treatment and viral load suppression targets, children, men, women and global, 2025



Source: UNAIDS epidemiological estimates 2026.

Eleven countries achieved the 95–95–95 targets in 2025, but not across all populations

The 95–95–95 targets were achieved by 11 countries by 2025, including several countries in eastern and southern Africa (Table 2). A further three countries had achieved the targets in one of the age groups. Given the shifting financial and programmatic context, especially in high-burden countries, this progress is a testament to the tremendous mobilization of countries, communities and stakeholders to ensure continuity of services and secure further progress in the HIV response.

Disparities continue to exist between men and women in some countries. Overall, children have lower rates of access to HIV testing, treatment and viral load suppression. Achieving the goal of ending AIDS by 2030 requires achieving the 95–95–95 targets across all populations, including vulnerable and key populations.

The 95–95–95 targets were achieved by 11 countries by 2025

Table 2
Countries that reached the 95–95–95 targets in 2025

	Total population	Men	Women	Children
Botswana	>98–>98–>98	96–98–>98	>98–>98–>98	>98–82–97
Cambodia	95–>98–98	97–>98–98	93–>98–98	62–>98–92
Denmark[a]	96–96–98	95–94–98	98–>98–98	
Eswatini	98–97–98	97–92–98	>98–>98–98	76–84–93
Lesotho	98–>98–>98	95–97–98	>98–>98–>98	80–77–96
Namibia	97–98–98	94–97–97	>98–>98–98	90–69–94
Rwanda	96–98–98	96–98–98	97–>98–98	62–>98–94
Saudi Arabia	98–>98–>98	98–>98–>98	98–98–>98	82–>98–>98
Sweden[a]	96–>98–>98	95–>98–>98	98–>98–>98	90–98–>98
Zambia	96–>98–97	97–>98–97	98–>98–98	72–79–95
Zimbabwe	95–>98–96	90–>98–96	>98–>98–96	57–95–88

[a] Countries for which progress towards targets is based on latest available data (2023 or 2024).
Source: UNAIDS epidemiological estimates 2026.

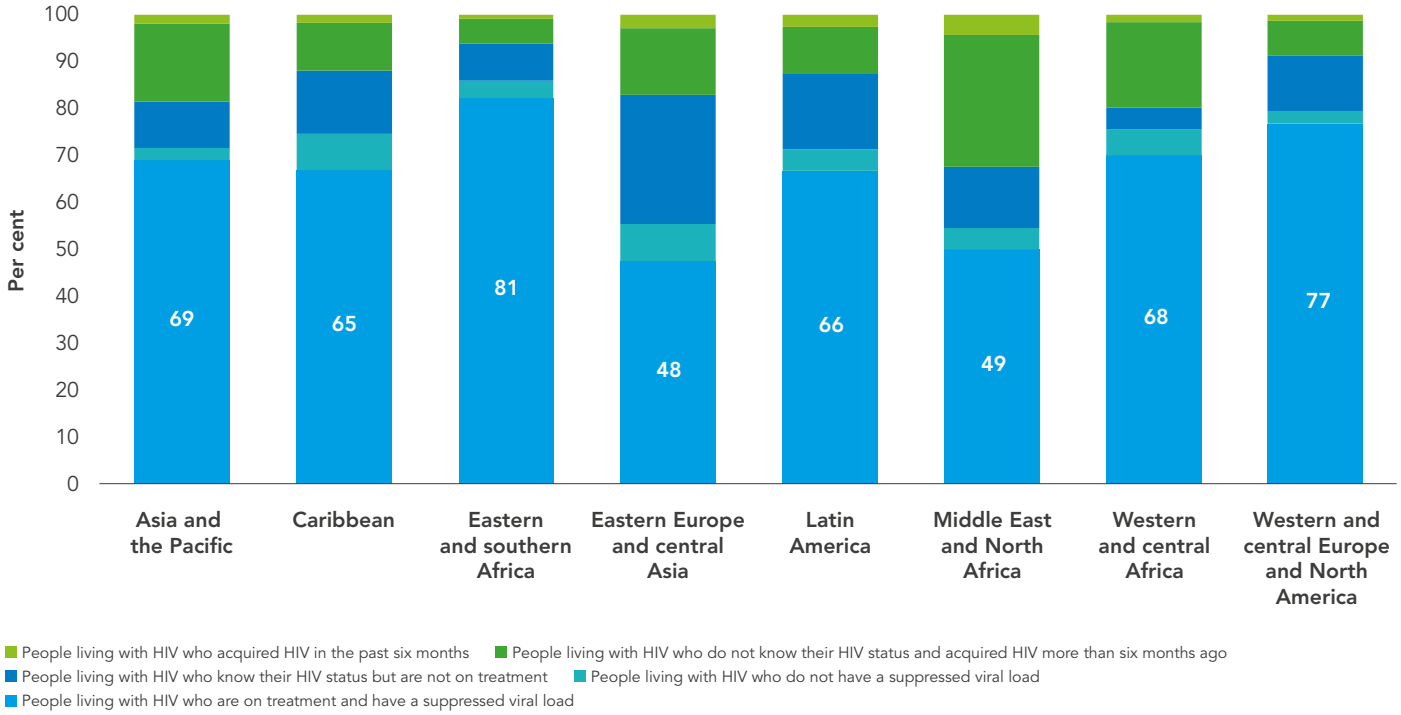
More effort is needed to reach viral suppression across regions

Viral suppression is central to the HIV response. Effective viral suppression improves individual health outcomes and prevents HIV transmission, but it requires timely diagnosis, strong linkage to care, and sustained treatment adherence. The U=U (undetectable = untransmissible) message is critical across all aspects of the HIV response.

Progress to ensure people living with HIV have access to HIV testing and treatment and have a suppressed viral load varies by region. Access to regular viral load testing based on national and WHO recommendations is not yet universal. In 17 of 105 countries reporting, less than 50% of people living with HIV who were on antiretroviral therapy have had their viral load measured at least once in the past year. In eastern Europe and central Asia and the Middle East and North Africa, relatively high levels of new infections with low testing coverage resulted in a large proportion of people with a detectable viral load (Figure 8).

Disparities in viral suppression across regions

Figure 8
Distribution of awareness, treatment and viral suppression among people living with HIV, by region, 2025



Source: UNAIDS epidemiological estimates 2026.

More effort is needed to reach people with voluntary and confidential testing services and to ensure people on treatment have a suppressed viral load. The majority of the 8.9 million people living with HIV who continued to lack access to treatment in 2025 live in sub-Saharan Africa (about half) and Asia and the Pacific (about a quarter), with recent funding losses threatening to further destabilize programmes.

Advanced HIV disease is a reality for too many people

Advanced HIV disease, or AIDS, increases mortality risk, most commonly due to TB, cryptococcal meningitis or severe bacterial infection *(6)*. The risk of advanced HIV disease is higher among people who are not on effective treatment, including people never treated, people starting treatment late, people receiving suboptimal care and people whose treatments were interrupted. Over the past decade and across regions, a persistent 25–40% of people living with HIV have had advanced HIV disease (CD4 count below 200 cells/mm^3) when diagnosed or initiating antiretroviral therapy, according to several large datasets *(7, 8)*.[11]

11 A CD4 count below 500 cells/mm^3 indicates a weakened immune system. A count below 200 cells/mm^3 indicates advanced HIV disease.

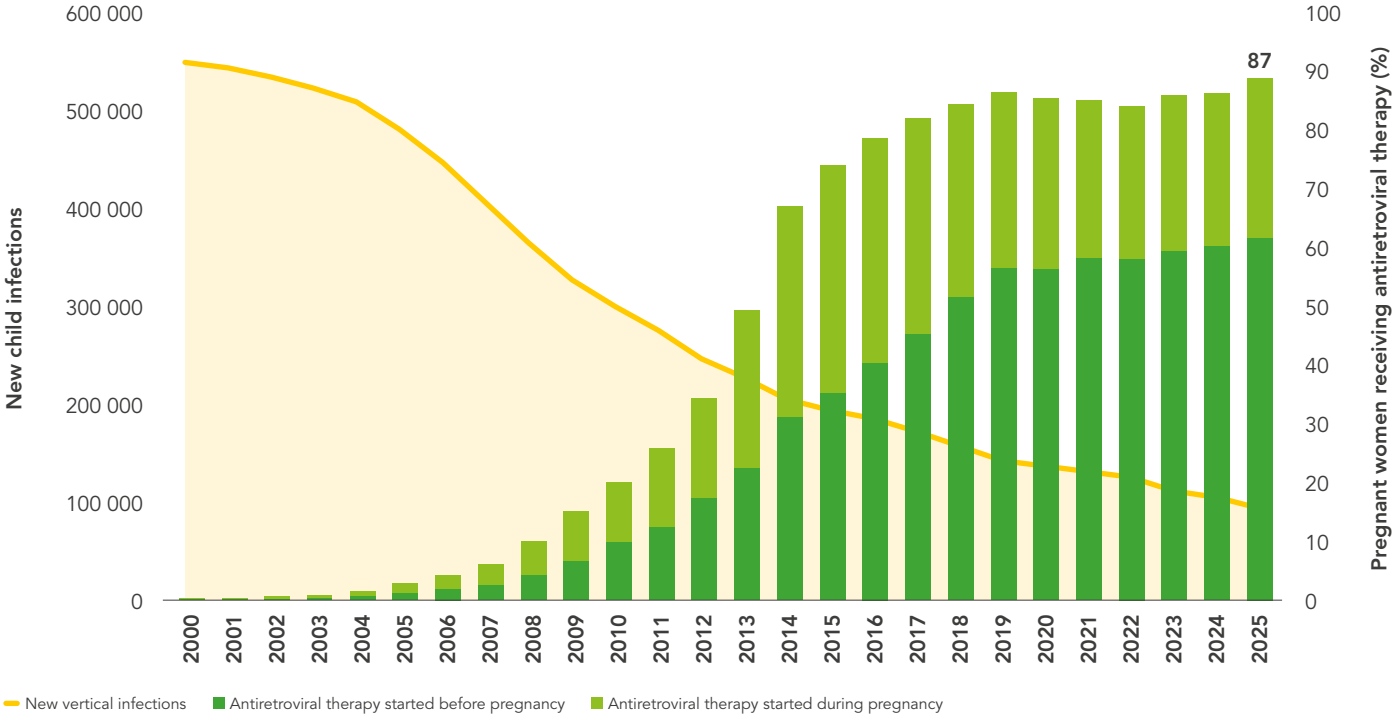
Early diagnosis, rapid initiation of antiretroviral therapy, CD4 and other screening tests, treatment and prophylaxis for opportunistic infections, strengthened adherence support, tracing and re-engagement in care are essential to prevent and respond to advanced HIV disease. For people who are severely ill, it is essential to strengthen the transition between hospital and outpatient care, because this is a period of heightened vulnerability.

Ensuring women receive treatment before pregnancy can further reduce vertical transmission

The elimination of vertical transmission of HIV remains an urgent global commitment. The global number of new HIV vertical infections has fallen below 100 000 for the first time since the early 1980s, but the continued decline in numbers of new infections has slowed in the past few years (Figure 9). The number of women reached with antiretroviral therapy for their own health and to prevent onward transmission has remained fairly stable,

Providing women with HIV treatment for their own health and to reduce vertical transmission

Figure 9
New vertical infections and pregnant women reached with antiretroviral therapy, 2000–2025



Source: UNAIDS epidemiological estimates 2026.

with little increase in recent years. More women are accessing antiretroviral therapy before becoming pregnant, reducing the probability of vertical transmission—but at the same time, the absolute number of women living with HIV and therefore the number of women in need of vertical transmission services are declining.

Some of the countries with the highest estimated need for prevention of vertical transmission services have achieved over 90% coverage, including Kenya, Mozambique, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

Based on national data reported to UNAIDS, funding cuts in 2025 impacted prevention of vertical transmission in some high-burden countries in the early part of 2025, but data for the full year suggest that countries were able to prioritize the resumption of vertical transmission services.

Essential community-led organizations supporting HIV prevention, testing and treatment services are in jeopardy

Communities play a critical role at the forefront of the HIV response, organizing, advocating, demanding and facilitating access to HIV services and the latest scientific advances *(9)*. There is extensive evidence of the continued important role played by community-led organizations, especially those led by people living with HIV, young people, women and people from key populations. These organizations are uniquely positioned to reach the people most at risk for HIV and are crucial providers of HIV treatment, adherence support and prevention services in spaces that are free of stigma and discrimination including in humanitarian settings during crises, where community-led organizations are the links to reaching hard to reach communities affected by crises (see below).

Community-led organizations are often the last organizations to be funded by domestic resources and consequently have been among the first to experience the impact of the 2025 international funding cuts. In 2024, approximately 25% of external HIV financing was channelled to nongovernmental organizations and civil society organizations, much of which has subsequently been reduced or cut. The data suggest that in the absence of sustained donor support and stronger domestic investment, many community-led HIV services face significant risks of disruption or collapse.[12]

A 2026 study surveying 79 community-led organizations across 47 countries showed delivery of PrEP by community-led organizations has reduced by 50% and support to people living with HIV has reduced by 50% *(10)*. The study showed an 85% reduction in services for gay men and other men

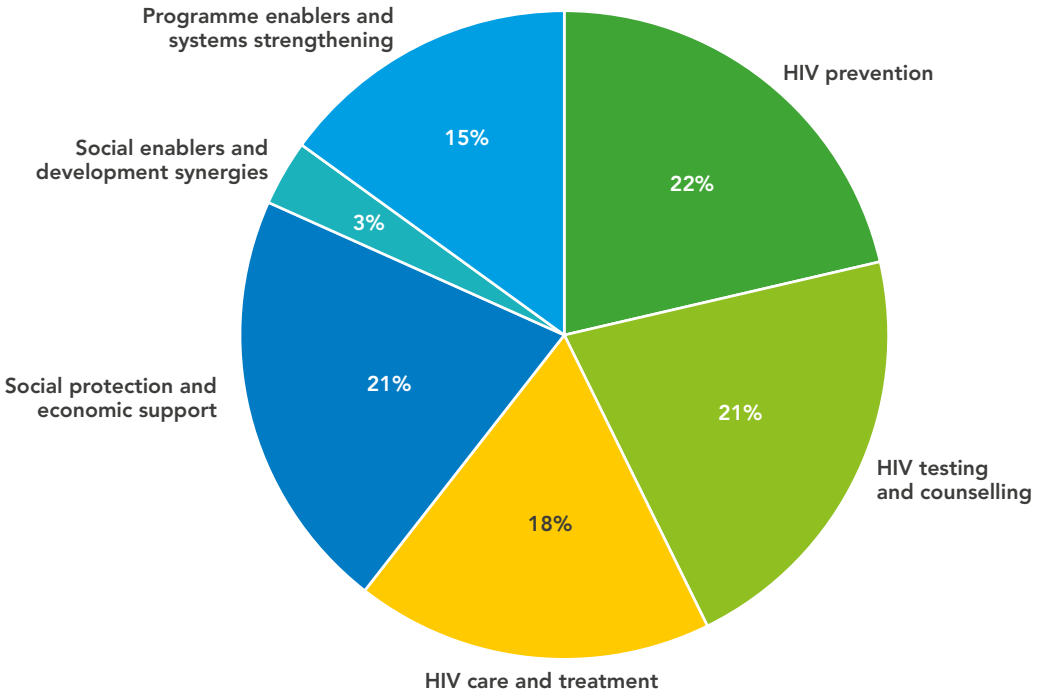
12 UNAIDS financial estimates, with data from eight national AIDS spending assessments.

who have sex with men, an 82% reduction in services for sex workers, and a 72% reduction in services for people who have experienced gender-based violence. Throughout 2025, community-led organizations rallied all over the world, and especially in countries heavily affected by HIV, to support each other and HIV responses, and to maintain access to HIV services for the people who need them most *(11)*.

Data from 12 countries that have recently undertaken national AIDS spending assessments show that community-led organizations provide a range of critical HIV services across the main HIV programme areas. Over half of the expenditure was on HIV prevention testing and care services (Figure 10). A further one-fifth of the expenditure was to provide critical social protection and economic support. In these same countries, community-led organizations were heavily dependent on international financing entities for their funding (99.4% of their total resources). Given the changing direction of international aid, the essential work of communities is particularly vulnerable to shifts in funding and needs more stable investment from domestic sources.

Community-led organizations deliver life-saving services

Figure 10
Community-led organizations spending share per HIV programme area (from 12 countries' national AIDS spending assessment reports)



Note: these data are from civil society organizations that identified as community-led. The data omit all other community-based services delivered by civil society organizations that are not community-led.

Source: UNAIDS analysis of national AIDS spending assessments for 12 countries reporting community-led organzation spending: Bangladesh (2023), Belize (2023), Benin (2024), Burundi (2023), Cambodia (2025), Côte d'Ivoire (2023), Mozambique (2022), Nepal (2023), Nigeria (2021), Pakistan (2022), Papua New Guinea (2023), Togo (2022).

2

Chapter 2

A window for solidarity and transformation

The current financial landscape requires a shift away from donor dependence towards country ownership and domestic financing, with continued global solidarity. Effective integration into national systems and long-term sustainability of the HIV response requires deep transformations. Some of these transformations are already under way but need further effort, including:

- addressing societal barriers to access to HIV services;
- accelerating access to innovation;
- faster integration of the HIV response into strengthened national systems;
- closing the funding gap and securing sustainable financing.

As international funding declines, transitions to domestic financing have accelerated and HIV responses are becoming more sustainable and country-owned. More than 25 countries have developed and are implementing sustainability HIV roadmaps *(12)*, articulating a coherent, costed pathway to an HIV response and providing a natural anchor for aligning donor agreements behind a single national vision.

Lifting societal barriers to secure progress

Many societal barriers are still holding back progress against HIV. Stigma, discrimination, punitive laws, harmful gender norms, gender inequalities and violence continue to prevent people from accessing HIV prevention and treatment services services, which means not reducing viral load and a potential increase in HIV incidence *(13, 14)*.

Stigma and discrimination are still hampering access to services

Discriminatory attitudes towards people living with HIV remain common in all settings. Across 34 countries, a weighted average of 39% of adults aged 15–49 years hold such attitudes (Figure 11).[13,14] Stigma is also experienced in daily life—HIV Stigma Index 2.0 data show that in 21 of 35 countries, at least 1 in 10 people living with HIV experienced stigma or discrimination in community settings in the 12 months before the survey *(15)*.

Programmes to address discriminatory attitudes need to be maintained over time because evidence shows these attitudes can rise again after initially declining, with data from at least six countries reflecting a decline followed by an increase in discriminatory attitudes.[15]

Rights-based and gender-responsive approaches to integration are essential to reach people from key and vulnerable populations

Analysis of HIV Stigma Index 2.0 data from 25 countries shows that 13% of people living with HIV experienced stigma and discrimination when seeking HIV-related care in the past 12 months, and 25% reported such experiences when seeking non-HIV-related health care, including 12% who reported being denied non-HIV-related health care completely *(16)*.

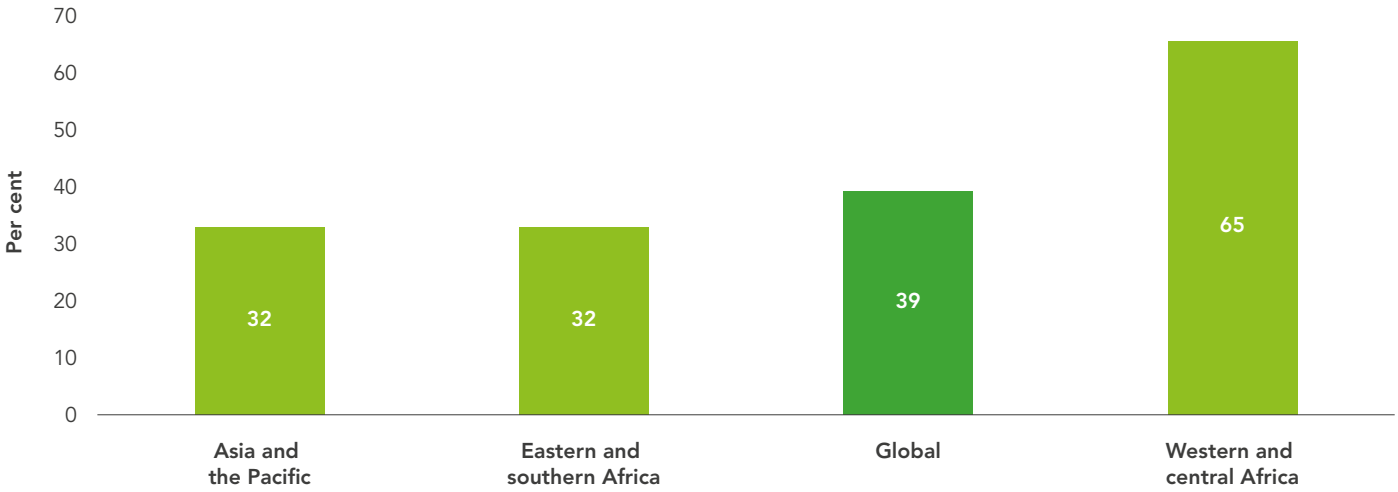
Community-led monitoring shows that as community-led services shrink, people from key populations are going into public clinics where stigma and abuse can be far more common *(17)*. Integrated services must preserve person-centred approaches and accessibility, affordability, acceptability and confidentiality of services to sustain service demand and coverage, especially for people from key populations, young people, and women and men living with HIV who face stigma and discrimination.

Programmes to address discriminatory attitudes need to be maintained over time.

13 Discriminatory attitudes towards people living with HIV are measured as disagreement with two statements on whether the respondent would buy fresh vegetables from a shopkeeper if they knew the person was living with HIV, and whether children living with HIV should be allowed to attend school with children who are HIV-negative.
14 Population-based surveys 2021–2024.
15 Population-based surveys 2000–2024.

Discriminatory attitudes continue to exist in different regions

Figure 11
Percentage of women and men aged 15–49 years who report discriminatory attitudes towards people living with HIV, by region, 2021–2024

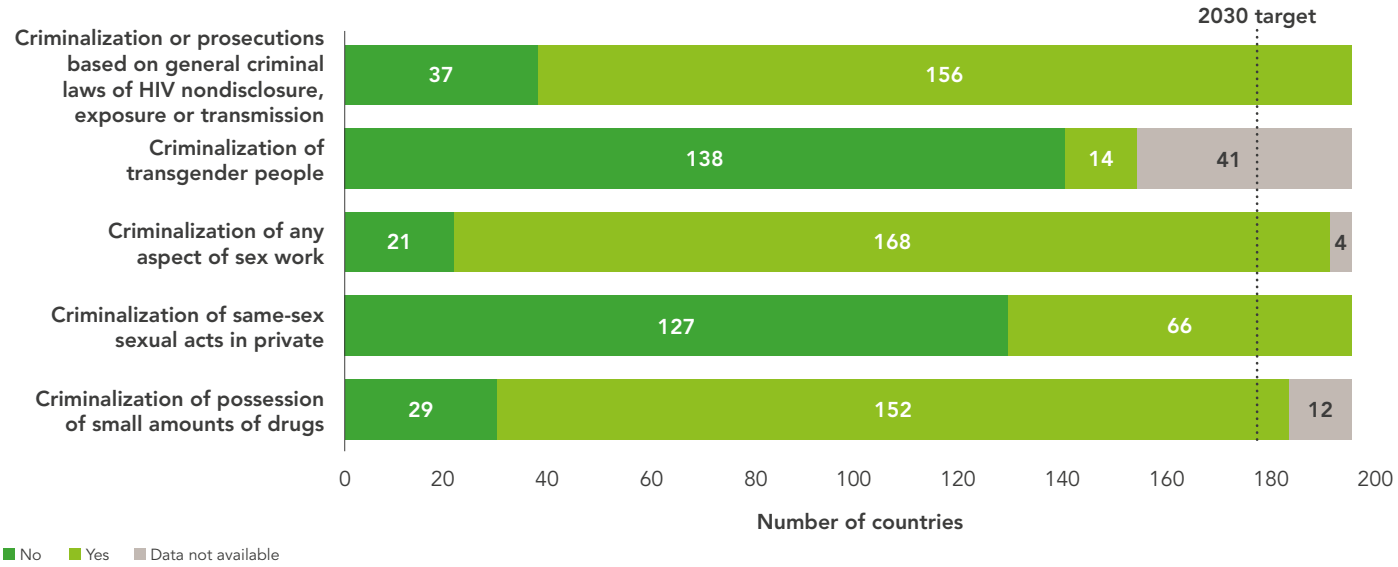


Note: data coverage of regional aggregates: global—34 countries, 33% of 2022 (the midpoint of this analysis) population; Asia and the Pacific—9 countries, 42% of 2022 population; eastern and southern Africa—10 countries, 49% of 2022 population; western and central Africa—8 countries, 73% of 2022 population. Aggregates for the Caribbean, eastern Europe and central Asia, Latin America, the Middle East and North Africa, North America and western and central Europe are not shown because data were available from only three or fewer countries in the region.

Source: population-based surveys 2021–2024.

Criminalizing laws restrict access to HIV services

Figure 12
Number of countries with discriminatory and punitive laws, June 2026



Note: this figure does not capture where key populations may be de facto criminalized through other laws, such as vagrancy or public morality laws, or the use of the above laws for different populations.

Source: National Commitments and Policy Instrument 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see http://lawsandpolicies.unaids.org/).

Legal barriers are growing

Criminalization remains a major barrier to HIV services for people living with, affected by or at risk of HIV. Punitive laws expanded in 2025, two additional countries (Burkina Faso, Niger) introduced criminalization related to same-sex sexual activity and gender expression in 2025, and one country (Senegal) increased penalties for same-sex sexual activity in 2026 (Figure 12).

In 2026, only 7 out of 193 countries did not criminalize at least one of same-sex sexual activity in private, transgender people, sex work, possession of small amounts of drugs, or HIV nondisclosure/exposure/transmission.[16] Criminalization of people from key populations is widespread globally, with criminalization of sex work in 168 countries, possession of small amounts of drugs in 152 countries, same-sex sexual activity in 66 countries, and transgender people in 14 countries. HIV nondisclosure/exposure/transmission is criminalized or has been prosecuted based on general criminal laws in 156 countries, despite limited evidence that such laws reduce HIV transmission.

Discriminatory laws and practices such as parental consent laws for HIV services that limit adolescents' and young people's autonomy and decision-making regarding their health, and a lack of legal protection against gender-based discrimination and violence, increase women's and girls' HIV-related stigma and vulnerability and deter them from accessing HIV services and care.

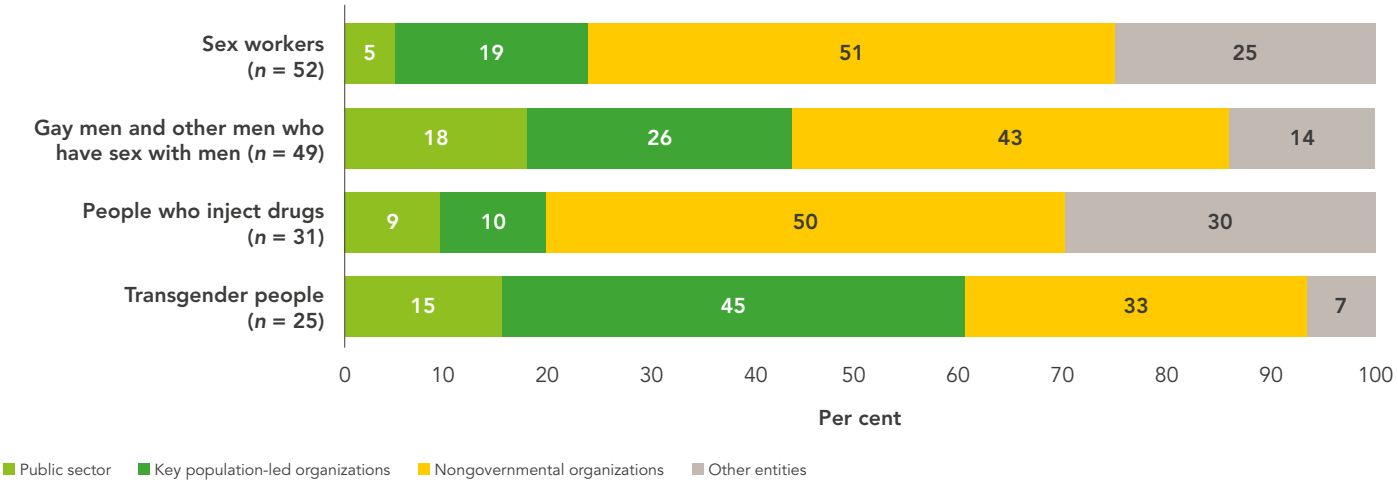
Community-led organizations overcome barriers

An extensive scoping review of 279 studies of community-led interventions showed more than 40 beneficial outcomes linked to community-led HIV prevention, treatment, care, support, monitoring and advocacy. More than half were prevention-related improvements *(9)*. In Stigma Index 2.0 studies from 20 countries, a median of 22% of people living with HIV accessed their HIV care services in a community-led clinic. Data reported from countries to UNAIDS found that more than 60% of sex workers (52 countries), gay men and other men who have sex with men (49 countries), people who inject drugs (31 countries) and transgender people (25 countries) relied on nongovernmental organizations, including those led by people from key populations, for HIV prevention services (Figure 13). The ability of communities to keep doing this critical work hangs in the balance in many countries, as foreign assistance for HIV continues to decline.

16 Chile, Colombia, the Netherlands (Kingdom of), Paraguay, Slovenia, Uruguay and Venezuela (Bolivarian Republic of) have, however, reported prosecutions related to HIV nondisclosure/exposure/transmission in the past 10 years.

Community-led organizations are a critical delivery mechanism for HIV prevention, especially for key populations

Figure 13
Distribution of the reported numbers of people from key populations reached with HIV prevention interventions, by type of provider, 2020–2024



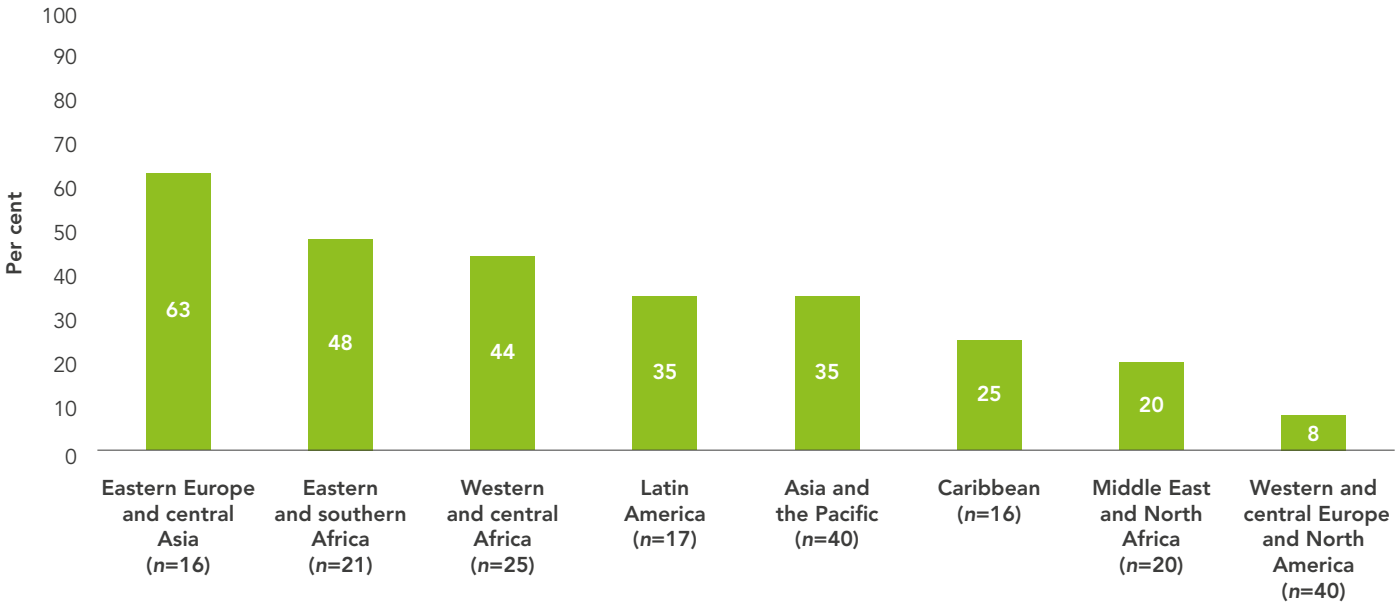
Note: *n* = number of countries.
Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/).

Burdens on civil society—including onerous registration procedures, restrictions on organizations receiving international assistance, and prohibitions of some civil society activities—are increasing worldwide. CIVICUS, an international non-profit-making organization focused on civil rights and citizen action, reported in 2025 that civil space was narrowed, obstructed, repressed or completely closed in 159 of 198 countries and territories *(18)*. If civil society does not have the ability to act and have a voice, the HIV response will be held back.

Social contracting—whereby governments contract civil society organizations to provide certain services—is an underused but potentially important basis to functionally link community systems with public health systems. Sixty-two of 106 countries with available data report having laws, regulations or policies on social contracting that allow for funding of service delivery by communities from domestic funding (Figure 14) *(19)*.

Efforts to put in place social contracting mechanisms must be continued

Figure 14
Percentage of countries reporting having social contracting laws or policies allowing for funding of service delivery by communities from domestic funding, by region, 2022–2025



Note: *n* = number of countries.
Source: UNAIDS National Commitments and Policy Instrument 2022–2025.

Violence against people from key and vulnerable populations must be stopped

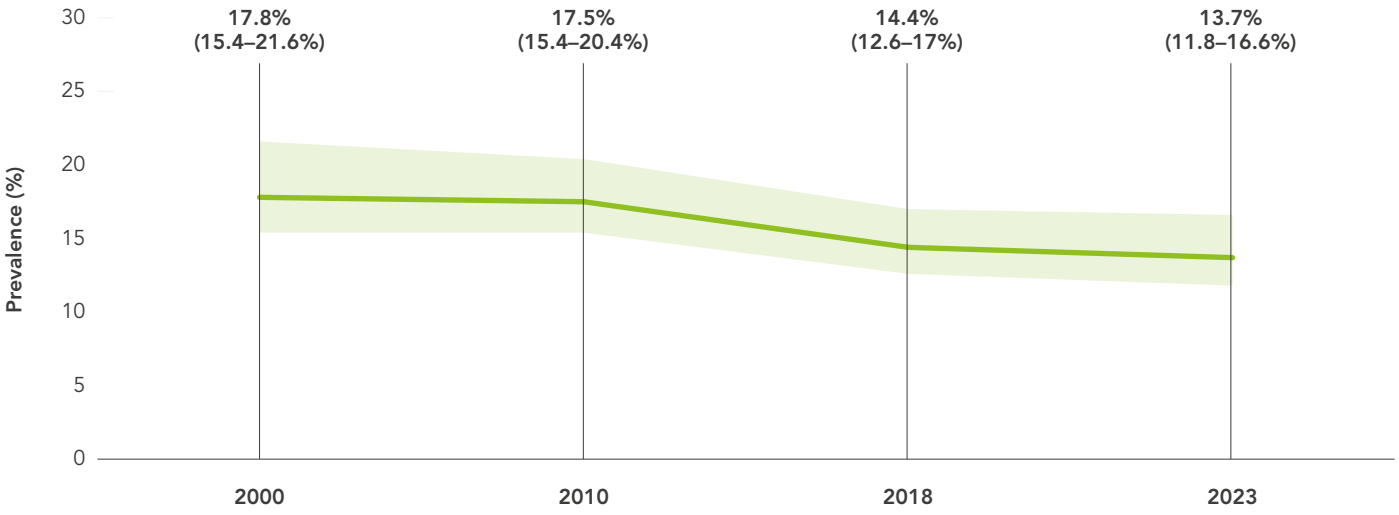
Violence against people living with HIV reduces access to—and the benefits of—HIV treatment. Women living with HIV who have experienced physical intimate partner violence are about 9% less likely to have viral suppression, based on seven surveys in sub-Saharan Africa *(20)*. Evidence supports integrating violence prevention into health care, including adolescent HIV services *(21)*. Global progress in reducing intimate partner violence is far too slow (Figure 15): since 2000, prevalence (violence over a person's lifetime and in the past 12 months) has not changed. Among key populations, violence remains pervasive: in 2024, 23% of people who inject drugs (18 countries), 22% of transgender people (21 countries) and 20% of sex workers (40 countries) reported physical or sexual violence in the past year.[17]

Nearly 20% of women living with HIV who participated in a Stigma Index 2.0 study across 23 countries between 2020 and 2023 reported experiencing some form of coercive practice in their lifetime *(22)*. Just over 50% of women and adolescent girls (aged 15–49 years) can make their own decisions regarding sexual relations, contraceptive use and use of health care *(23)*.

17 Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/).

There has been no significant progress in reducing domestic violence since 2000 globally

Figure 15
Changes over time in the prevalence of physical and/or sexual violence against ever-married or ever-partnered women aged 15–49 years in the past 12 months, 2000–2023



Source: Violence against women prevalence estimates, 2023: global, regional and national prevalence estimates for intimate partner violence against women and non-partner sexual violence against women. Geneva: World Health Organization; 2025.

Access to innovations can amplify impact and optimize efficiency

The effective use of both combination HIV prevention and treatment is essential to reduce the number of new HIV infections and AIDS-related deaths. Innovations have the potential to make finite resources go further and maximize the public health impact of HIV investments.

HIV treatment, although critical, will not end AIDS on its own. Scaled-up HIV treatment must be complemented by an equally robust commitment to bring HIV prevention services to everyone who needs them.

In recent years, the development of new PrEP options—including long-acting injectable regimens such as lenacapavir, and monthly pill-based regimens *(24)*—has brought new urgency and reinvigorated partnership for HIV prevention. By the end of June 2026, more than 50 000 people received twice-yearly lenacapavir, across 9 sub-Saharan African countries *(25)*. The majority of the recipients were women aged over 25 years who received the injections at a public clinic or hospital.

Market-shaping approaches led by partners, including CHAI, the Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Unitaid and the United States Government, have brought down the price of lenacapavir to US$ 40 per person per year for lower-income countries from 2027 *(26)*. This is a major achievement, but there is a lack of clarity on prices for middle- and upper-income countries.

When new technologies such as long-acting PrEP are developed, community-led organizations work to build demand and deliver services in equitable, acceptable and accessible ways *(27)*, ensuring they reach the people who need them most.

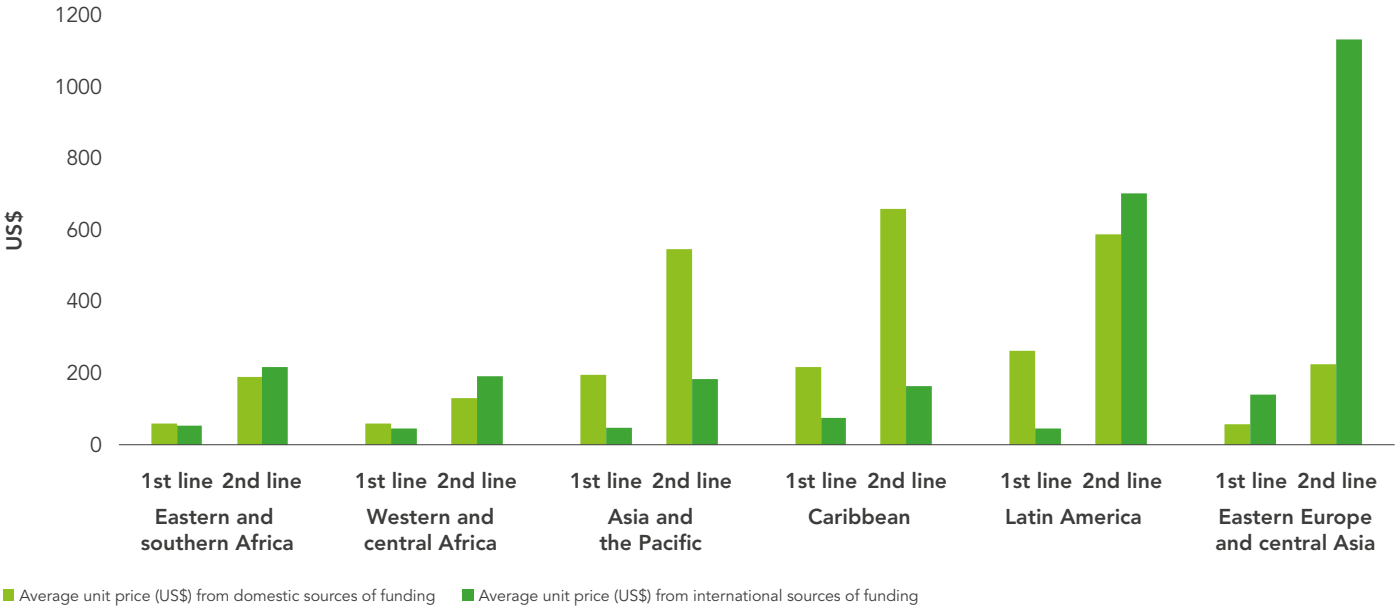
Equitable pricing and market access

The procurement of antiretroviral medicines for lifelong treatment is a recurring, long-term cost that represents the single largest and most non-discretionary line item in most country's HIV budget. Stability, affordability and predictability of financing for antiretroviral medicines are key determinants of treatment continuity and sustained epidemic control.

For first-line regimens, the reported data show that international procurement channels achieve lower average prices than domestic channels, indicating opportunities for efficiency gains through transparent pricing, competitive tendering, pooled procurement and strategic contracting. Consolidated evidence reveals considerable price variation across countries, particularly for second-line regimens, where prices increase significantly with income level (Figure 16).[18] This is a risk for middle-income countries transitioning out of external funding and building sustainability.

The price of HIV-related medicines varies greatly across regions

Figure 16
Average procurement prices of antiretroviral medicines, by region and source of funding



Source: Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).

18 UNAIDS Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).

Integration of HIV services into national systems shows promising results

A critical transformation for the long-term sustainability of the HIV response, as identified by more than 25 countries *(28)*, is careful and effective integration of HIV programmes with broader systems for health, drawing on decades of lessons learned from the HIV response and maintaining the strengths of multisectoral programmes and systems. This includes embedding community-led responses within formal systems and linking health with social protection, education, and gender equality actions and services *(29)*.

Many countries are crystalizing this by embedding HIV strategic priorities into national development and humanitarian plans, social protection and education programmes, and other legislative reform agendas.

Eswatini, Tajikistan and Uganda are good examples of integrating HIV into broader development systems. Eswatini has shifted HIV from a biomedical focus to a whole-of-development agenda, linking it to social and economic priorities and coordinating action through a central multisectoral body (NERCHA), with a strong emphasis on youth and education platforms as HIV prevention channels *(30)*. Tajikistan is advancing a rights-based, socially integrated approach, embedding HIV within social protection, justice, education and labour systems, and addressing structural barriers through mechanisms such as legal reform and community-led human rights monitoring (REACT) *(31)*. Uganda is positioning HIV within health security and system resilience, leveraging HIV platforms, including laboratories, community systems and supply chains, to support broader responses to health emergencies, such as COVID-19 and Ebola *(32)*.

Integration of HIV services into broader health and social systems can improve access and reduce costs for people, while generating efficiencies and savings for service providers only if the quality and reach of the services remain at the pre-integration levels or increase *(33, 34)*. Integration of systems (e.g. supply chains, laboratories, financing, workforce) can enhance efficiency and strengthen overall health system performance. Integrating HIV with other services (e.g. TB, hepatitis, cervical cancer, sexual and reproductive health) is cost-effective and improves overall health outcomes *(35–37)*. The steadily rising median age of people living with HIV provides an additional impetus for HIV service integration because people living with HIV are increasingly vulnerable over time to noncommunicable diseases *(37, 38)*. The backbone of integrating HIV into broader systems for health, is to have nationally governed and community-inclusive multisectoral data systems for tracking the epidemic, measuring inequalities and guiding rapid actions. Recent shifts in funding policies highlighted the vulnerability of fragmented HIV data systems across several countries *(39–40)*.

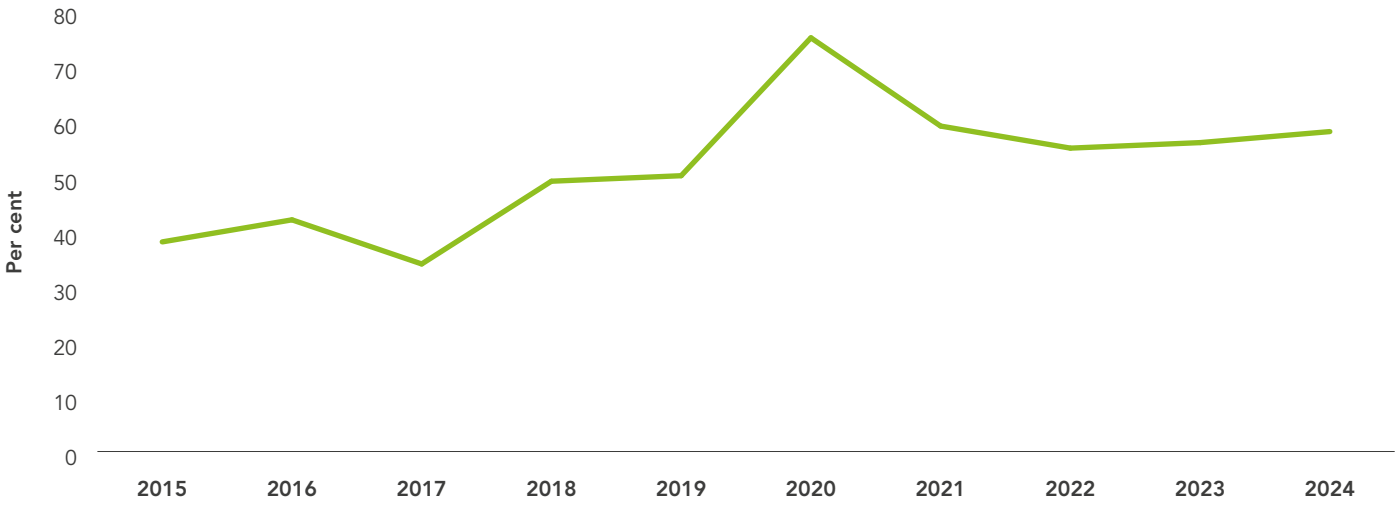
Integration of HIV and TB services is progressing

Among people living with HIV who were diagnosed with TB in 2024, the coverage of antiretroviral therapy was 91%—up from 46% in 2010 *(41)*.[19] Globally, an annual total of about 2 million people in HIV care were provided with TB preventive treatment (TPT) in 2021–2024, a 10-fold increase compared with 2010. The median completion rate among people who started TPT in 2023 in 38 countries that reported data was 84%—an increase from 83% in 42 countries that reported data for 2022.[20]

Some countries heavily affected by TB and HIV still have important gaps in detecting TB among people living with HIV or providing TPT for people in HIV care. Globally in 2024, about two-thirds of new episodes of TB among people living with HIV were detected, and the coverage of TPT among people newly enrolled in HIV care was 58% (Figure 17).[21] This gap has a knock-on effect. Globally, 78% of people living with HIV are receiving antiretroviral medicines, but the data show that coverage of antiretroviral therapy among the total number of people living with HIV who are estimated to have developed TB in 2024 was only 61%.

Progress in integration of HIV with TB services

Figure 17
Percentage of people newly enrolled on antiretroviral therapy who started TB preventive treatment, global, 2015–2024



Source: Global AIDS Monitoring 2016–2025.

19 Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).
20 Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).
21 Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).

Countries are integrating HIV into health and other services

About a quarter of 152 countries with available data have integrated HIV into broader health strategies. More than 80 countries include cervical cancer screening and treatment recommendations for women living with HIV in national guidelines.

Greater access to antenatal care and integration of HIV testing and treatment with antenatal services improves health outcomes for mothers and their children. In 8 of 30 countries with available data, over 80% of women who gave birth in the past two years received HIV testing.[22] Services need to be equipped to sustain demand and coverage, especially for people from key populations, adolescent girls and young women, and people living with HIV facing stigma, discrimination or violence (see above) *(16)*.

At least 17 countries heavily affected by HIV were also in the top 50 fragile states index in 2024 *(42)*. Humanitarian crises deepen the impact of HIV by disrupting access to HIV services and increasing vulnerability through displacement, food insecurity, gender-based violence and weakened health systems. Women, girls, people from key populations and other marginalized people are often disproportionately affected, facing heightened risks of HIV transmission and reduced access to care, social support and livelihoods.

Communities play a lead role in country resilience and health security

The role of communities of people living with or affected by HIV was made evident during the COVID-19 pandemic, when many community networks mobilized to support outreach and continuity of services for their peers and the wider community. A 2021 survey among community-led organizations found they rapidly adapted HIV service delivery, including supporting access to antiretroviral treatment and other essential services, while also responding to the COVID-19 pandemic through COVID-19 awareness campaigns, counselling, distribution of protective supplies, and material support for the people most affected *(43)*. During the Ebola outbreak in 2014, many community-led, civil society and faith-based organizations in the HIV response leveraged their experience in behaviour change communication and community engagement to support the response *(44)*. More recently, in the Mpox response in the Democratic Republic of the Congo, community-led organizations and peer educators led outreach and contact tracing, including through adapted approaches such as the "stellar approach", which reflected the mobility of key populations, and integrating HIV services to better reach mobile and underserved populations *(45)*. In humanitarian crises, community-led organizations are the last mile delivery for people living with HIV and hard to reach communities. Community-led organizations are critical to the HIV response and beyond, for country and global resilience in the face of new and emerging epidemics.

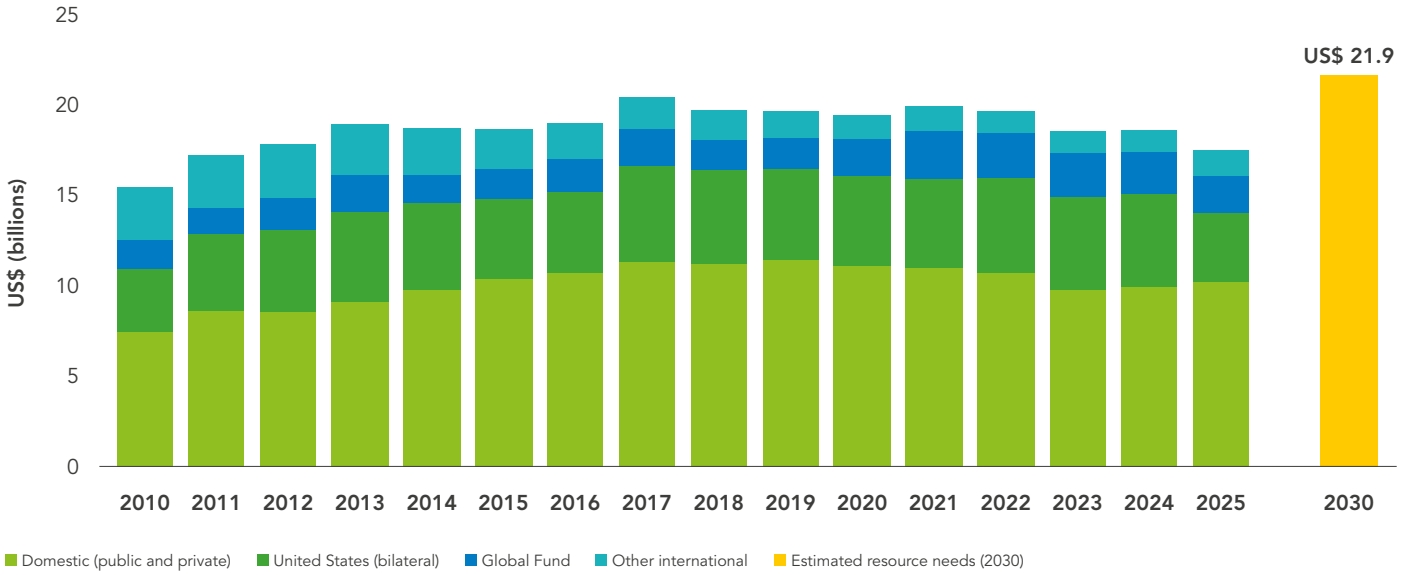
22 Population-based surveys 2021–2024.

Closing the funding gap and securing sustainable financing

Achieving the 2030 global HIV targets requires US$ 21.9 billion annually by 2030 in low- and middle-income countries—US$ 4.3 billion more than the US$ 17.6 billion available in 2025 (Figure 18). The year 2025 marked a profound shock to global health financing, with abrupt reductions in international assistance destabilizing HIV responses across many countries.

Treatment sustainability is fragile, with strong reliance on external funding. The funding withdrawals observed in early 2025 have disrupted service delivery, supply chains and community-led systems, particularly those serving the most vulnerable populations.

Figure 18
Estimated HIV financial resources available in low- and middle-income countries, 2010–2025 and projected need in 2030

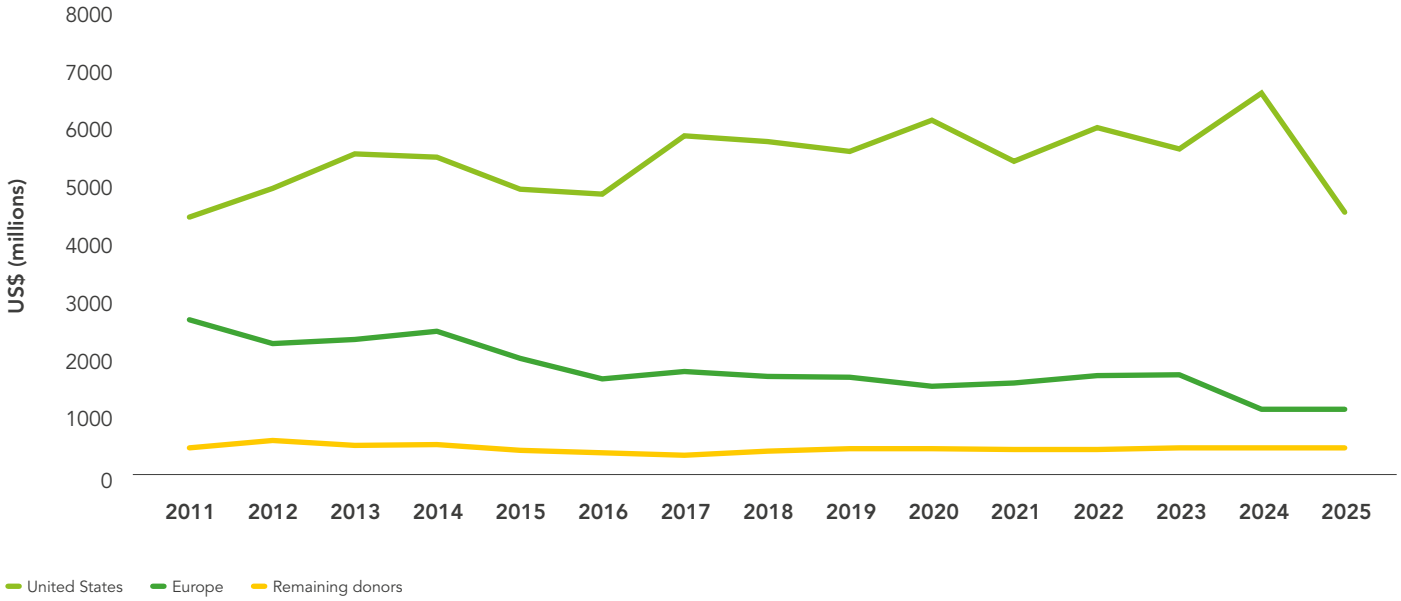


Note: all amounts in constant 2024 US$ billions.
Source: UNAIDS financial estimates, July 2026.

HIV funding architecture is evolving

The global landscape of external financing for HIV in 2025 is marked by growing uncertainty and increasing funding pressures. Total financial resources for HIV in low- and middle-income countries were US$ 17.6 billion, of which 59% came from domestic resources. Compared with 2024, the total resources for HIV fell by more than US$ 1 billion, a 6% decline in just one year. The overall decline was limited to 6% because increases in domestic resources for HIV partially offset a much steeper US$ 1.6 billion (18%) decline in international resources for HIV, the largest decline in almost two decades. The reduction in international funding was driven primarily by

Figure 19
External funding for HIV from major donor governments, 2011–2025



Source: UNAIDS and KFF Joint annual collection of donor government funding for HIV

declines in donor government financing. When both bilateral disbursements to countries and donor government contributions to multilateral institutions are taken into account, the decline in donor government funding was substantially greater than the 18% decline observed in overall international HIV financing *(1)*.

Donor government financing for HIV through bilateral and multilateral channels in low- and middle-income countries has become increasingly concentrated over the past 15 years (Figure 19). Since 2011, HIV disbursements from European donor governments declined by 58%. Between 2011 and 2024, the United States steadily increased its share of international HIV financing by 48%, becoming the cornerstone of the global HIV response. In 2025, the sharp reduction in total United States funding (bilateral and multilateral) accounted for most of the global decline in HIV financing. Despite these reductions, the United States still provides 74% of donor government financing for HIV, highlighting both its indispensable leadership and the risks of an increasingly concentrated financing architecture. Renewed solidarity from all donor governments, including European and other countries, will be critical to help close the financing gap and sustain the global commitment to end AIDS as a public health threat by 2030.

Recent donor commitments, including through the 2025 Global Fund Eighth Replenishment *(46)* and the United States America First Global Health Strategy *(47)*, provide opportunities to sustain and expand high-quality HIV programmes and demonstrate a more predictable understanding across multiple years of what a sustainable, co-investment strategy could be over time. For example, some upper-middle-income and lower-middle-income countries are transitioning out of external support and will stop receiving

Global Fund support in 2028 and 2029, as part of its current round of funding *(48)*. As of April 2026, a total of 28 countries have signed global health memorandums of understanding that include an HIV component with the United States Government *(49)*. These multiyear agreements under the 2025 America First Global Health Strategy link continued support to countries to meet co-financing commitments and progress towards the 95–95–95 targets.

Emerging economies and south–south cooperation are making a limited but important contribution. In 2025, China announced a two-year US$ 3.49 million partnership to expand HIV prevention services in South Africa *(50)*. India has contributed through commitments to supply antiretroviral medicines to support HIV responses. At the Global Fund Eighth Replenishment, African countries pledged US$ 51.6 million, including US$ 36.6 million from South Africa via a public–private commitment *(51)*. Although these efforts signal a growing role for emerging economies and south–south cooperation, their financial scale remains insufficient to offset recent reductions.

Regional leadership, and in particular the African Union, stepped up actions throughout 2025, with the African Union Roadmap to 2030 and Beyond, which pledged to ensure diversified and sustainable financing for HIV and other health programmes *(52)*; a new African Epidemic Fund, established to support countries in preparing for and responding to future health emergencies *(53)*; and the launch of the Accra Reset, where African leaders, convened by President Mahama of Ghana, called for the creation of new governance and financing models for regional health and development *(54)*. In October 2025, the Africa Centres for Disease Control and Prevention launched an intelligence and analytics platform to bolster efforts to build greater pharmaceutical manufacturing capacity in the region *(55)*. In Latin America and the Caribbean, the new Alliance for the Elimination of HIV in the Americas has been initiated by the Pan American Health Organization to accelerate progress *(56)*.

Domestic funding for HIV is growing

In 2025, domestic financing represented 59% of total funding for the HIV response. From 2010 to 2025, domestic HIV financing in low- and middle-income countries increased by 38% (Figure 20), although that growth stalled and there were decreases attributed to efficiency improvements as a result of commodity price decreases, and sharper decreases due to COVID-19 and fiscal strain in 2020–2023, before increasing again in 2024 by 2.2% and again in 2025 by 4%. The increases observed in 2025 in several countries were largely a response to the sudden reductions in international financing, with governments mobilizing additional domestic resources to sustain essential HIV services. Although these efforts demonstrate strong domestic commitment, they were not sufficient to fully offset the scale of the decline in international financing.

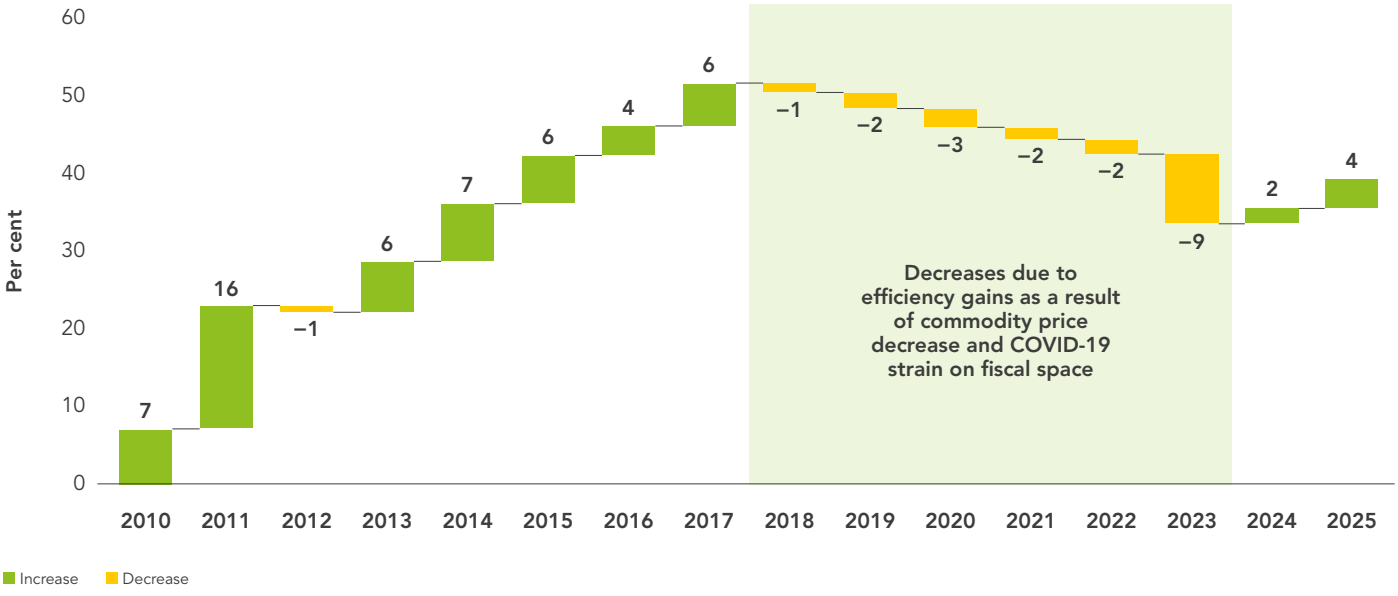
Domestic resource mobilization is constrained in many countries by slow economic growth, rising debt-servicing obligations, inflationary pressures and competing development priorities. In several countries highly affected

by HIV, debt servicing now exceeds public health expenditure, severely limiting fiscal space for HIV investment.[23] Twenty-eight African countries spend more on debt than on health. In western and central Africa, for example, public debt service in some countries is on average 5.5 times greater than public health allocations, crowding out fiscal space for HIV investment.[24] Governments are simultaneously managing transitions from multiple donors across HIV and other health programmes, while also watching inflation, fragility, emergencies and climate adaptation costs.

Since 2025, more than 55 countries have committed to increase their domestic contributions (Table 3), including establishing mixed financing instruments to increase and sustain domestic resources for the HIV response *(28)*. Increased domestic allocations planned for 2026–2027 in many countries reflect their emergency efforts to prevent treatment disruptions in the face of contracting donor support. Fiscal constraints, however, limit how far domestic funding can substitute for external support.

Domestic spending on HIV grew in 2025 for the second year running

Figure 20
Annual change in domestic spending on HIV in low- and middle-income countries, 2010–2025



Source: UNAIDS financial estimates 2025.

23 UNAIDS financial dashboard, WHO health expenditure database and International Monetary Fund.
24 Global AIDS Monitoring (https://aidsinfo.unaids.org/) and UNAIDS-supported national AIDS spending assessments 2019–2024.

Over 55 countries reported planned increases in domestic funding for HIV since 2025

Table 3
Countries that have reported an increase in domestic public budget for HIV since 2025

	Asia and the Pacific (12)	Caribbean (4)	Eastern and southern Africa (12)	Eastern Europe and central Asia (9)	Latin America (8)	Middle-East and North Africa (2)	Western and central Africa (8)
≤10%	Afghanistan	Costa Rica	Kenya	Belarus	Bolivia (Plurinational State of)	Algeria	Burkina Faso
	Bhutan	Cuba	Liberia	Georgia	Brazil	Egypt	Burundi
	India	Dominican Republic	Malawi	Kazakhstan	Chile		Central African Republic
	Indonesia	Saint Kitts and Nevis	Namibia	Kyrgyzstan	El Salvador		Nigeria
	Nepal		Rwanda	Mongolia	Honduras		
	Pakistan		Seychelles	Republic of Moldova	Nicaragua		
	Philippines		United Republic of Tanzania	Tajikistan	Peru		
	Thailand		Zambia	Uzbekistan			
	Timor-Leste		Zimbabwe				
	Viet Nam						
>10%	**Fiji**		**Angola**	**Azerbaijan**	**Ecuador**		**Mali**
	Lao People's Democratic Republic		**Ethiopia**				**Togo**
			Uganda				**Gambia**
							Côte d'Ivoire

Source: UNAIDS financial estimates 2026, preliminary Global AIDS Monitoring (https://aidsinfo.unaids.org/).

Brazil's leadership in the AIDS response

The Government of Brazil made a transformative commitment to the national HIV response through the launch of the Brasil Saudável (Healthy Brazil) Programme in 2024 *(57)*. This intersectoral initiative brings together 14 federal ministries to eliminate 14 socially determined diseases and infections as public health threats by 2030.

Closely aligned with the Global AIDS Strategy 2026–2031, the 2026 Political Declaration on HIV/AIDS and the Sustainable Development Goals, the programme focuses on conditions that disproportionately affect vulnerable populations, including HIV, vertical transmission of HIV, TB, leprosy, malaria, viral hepatitis and trypanosomiasis. Recognizing that health outcomes are shaped by broader social determinants, the initiative combines health interventions with actions to eradicate hunger, expand human rights, strengthen science and technology, and improve infrastructure and basic sanitation across the country.

The programme is already delivering measurable results. With about 1 million people living with HIV, Brazil has achieved two of the 95–95–95 targets required to eliminate AIDS as a public health threat—HIV testing and viral suppression. A further milestone was reached in December 2025, when the Pan American Health Organization certified Brazil for the elimination of vertical transmission of HIV, making it the first country with a population of more than 100 million people to attain this achievement.

In line with global HIV prevention targets, Brazil has significantly expanded access to PrEP. As of 30 June 2026, approximately 230 000 people were using PrEP nationwide, corresponding to 5.2 people using PrEP for every newly diagnosed HIV infection. Although this already surpasses the Ministry of Health target of three people using PrEP per new HIV infection, subnational data reveal important disparities across states. Addressing these gaps will be essential to ensuring equitable access to PrEP and maximizing the impact of Brazil's HIV prevention response.


3

Chapter 3

The 2026 United Nations Political Declaration on HIV/AIDS: accelerating progress towards ending AIDS

On 22–23 June 2026, United Nations Member States convened at the United Nations General Assembly High-level Meeting in New York to adopt the new Political Declaration on HIV/AIDS: United to End AIDS *(2)* The Declaration sets out the new global priorities, targets and actions that will guide the global HIV response over the next five years and accelerate progress towards ending AIDS as a public health threat by 2030.

Member States made strong new commitments under the 2026 Political Declaration on HIV/AIDS, including:

- Commit to two new global treatment and prevention scale-up milestones: reaching 40 million people living with HIV with life-saving HIV treatment—including 38 million people with a suppressed viral load—and 20 million people with antiretroviral medicine-based prevention by 2030.
- Reaffirm the 95–95–95 targets for HIV testing, treatment and viral suppression by 2030, disaggregated by all populations.

- Reach 90 per cent of people in need of prevention using effective HIV prevention options, including PrEP, PEP, male and female condoms and harm reduction; and provide adolescent girls and boys, young women and young men, with comprehensive education on sexual and reproductive health and HIV prevention, in and out of school.

- Secure sustainable financing with a new global financing commitment of US$ 21.9 billion annually by 2030, backed by explicit pledges to sustain domestic and international funding and minimize out-of-pocket health expenditure and to fully fund HIV prevention, societal enablers and communities.

- Fulfil the human rights of people living with, at risk of or affected by HIV, including people from key populations, ensuring gender equality and the empowerment of all women and girls, and ending HIV-related stigma, discrimination and violence: reach the 10–10–10 targets on HIV-related stigma and discrimination, gender inequality and violence, and legal and policy frameworks that deny or limit access to HIV services.

- Leverage universal health coverage and strengthen integration of HIV services with primary health care and broader health systems: ensure 95% of people receiving HIV prevention or treatment services also receive sexual and reproductive health services, 95% of pregnant women living with HIV and their children receive maternal and newborn care, and 95% of people living with HIV receive preventive treatment for TB.

- Strengthen community leadership: reach 30–80–60 targets for community-led service delivery and accountability, including by securing an enabling civic space for communities of people living with, affected by or at risk of HIV.

- Achieve the 2030 targets defined as benchmarks for ending AIDS: a 90% reduction in the number of new HIV infections and AIDS-related deaths by 2030, compared to 2010 levels—the agreed definition for ending AIDS as a public health threat—after which countries can move from mitigating the HIV epidemic to managing HIV as a chronic disease.

The 2026–2031 Global AIDS Strategy: a bold blueprint to end AIDS

The foundation for the 2026 Political Declaration adopted at the 2026 High level meeting on AIDS was the Global AIDS Strategy 2026–2031 *(2)* which was developed through broad multistakeholder discussion and consultation. It considers the impact of rapid changes in the HIV, global health and development ecosystem, and sets out a path for collective action over the next five years and beyond.

The Strategy aims to ensure that by 2030, 40 million people living with HIV are on HIV treatment, of whom 38 million have a suppressed viral load; 20 million people are accessing antiretroviral-based HIV prevention options; and all people can access discrimination-free HIV-related services.

Three priorities to end AIDS as a public health threat by 2030

The Global AIDS Strategy 2026–2031 reinforces a shift towards person-centred approaches, while deepening expectations that national HIV responses are led by countries, communities and civil society within a framework of shared responsibility. In doing so, the Strategy consolidates and accelerates an ongoing transition in the HIV response—from an emergency-oriented, externally financed model towards a sustainable, nationally led, rights-based, gender-transformative and integrated approach embedded in resilient systems. It emphasizes long-term domestic financing; integration of HIV within universal health coverage, primary health care and other platforms; and formalization of mechanisms to support community-led responses.

Within the Strategy, three core priorities and eight results areas have been identified, along with measurable targets that countries can monitor (Figure 21):

- Priority 1 emphasizes domestic leadership towards a sustainable HIV response, through diversified financing and integration of HIV into universal health coverage systems. It calls for fiscal innovation, multisectoral collaboration, integration into primary health care, and strengthened country data systems, including governance grounded in equity and privacy.

- Priority 2 focuses on integrated, differentiated and people-focused HIV services that ensure access to HIV prevention, testing, treatment and care for people living with, at risk of or affected by HIV, including in humanitarian crises, by combining biomedical tools, structural interventions and societal and behaviour change, and by pursuing equitable access to medicines and other health products.

- Priority 3 champions community-led governance. Legal reform, resourcing community-led organizations and safeguarding are key.

Taken together, these priorities constitute a costed, measurable and focused agenda for ending AIDS by 2030 and sustaining multisectoral, inclusive national HIV responses into the future. At a time of global upheaval and uncertainty, the priorities lay out an ambitious but attainable path towards an historic public health achievement: ending AIDS as a public health threat by 2030.

At a glance: five pillars of success for the 2026 Political Declaration

The new commitments made by Member States in the 2026 Political Declaration fall under five pillars (Figure 21). Taken together, the five pillars recognize that ending AIDS requires more than biomedical tools. The five pillars call for sustained political commitment, domestic investment, community leadership, equitable access to innovation and strong international cooperation.

Figure 21
An ambitious 2026 Political Declaration across five pillars of success

Ending AIDS as a public health threat by 2030

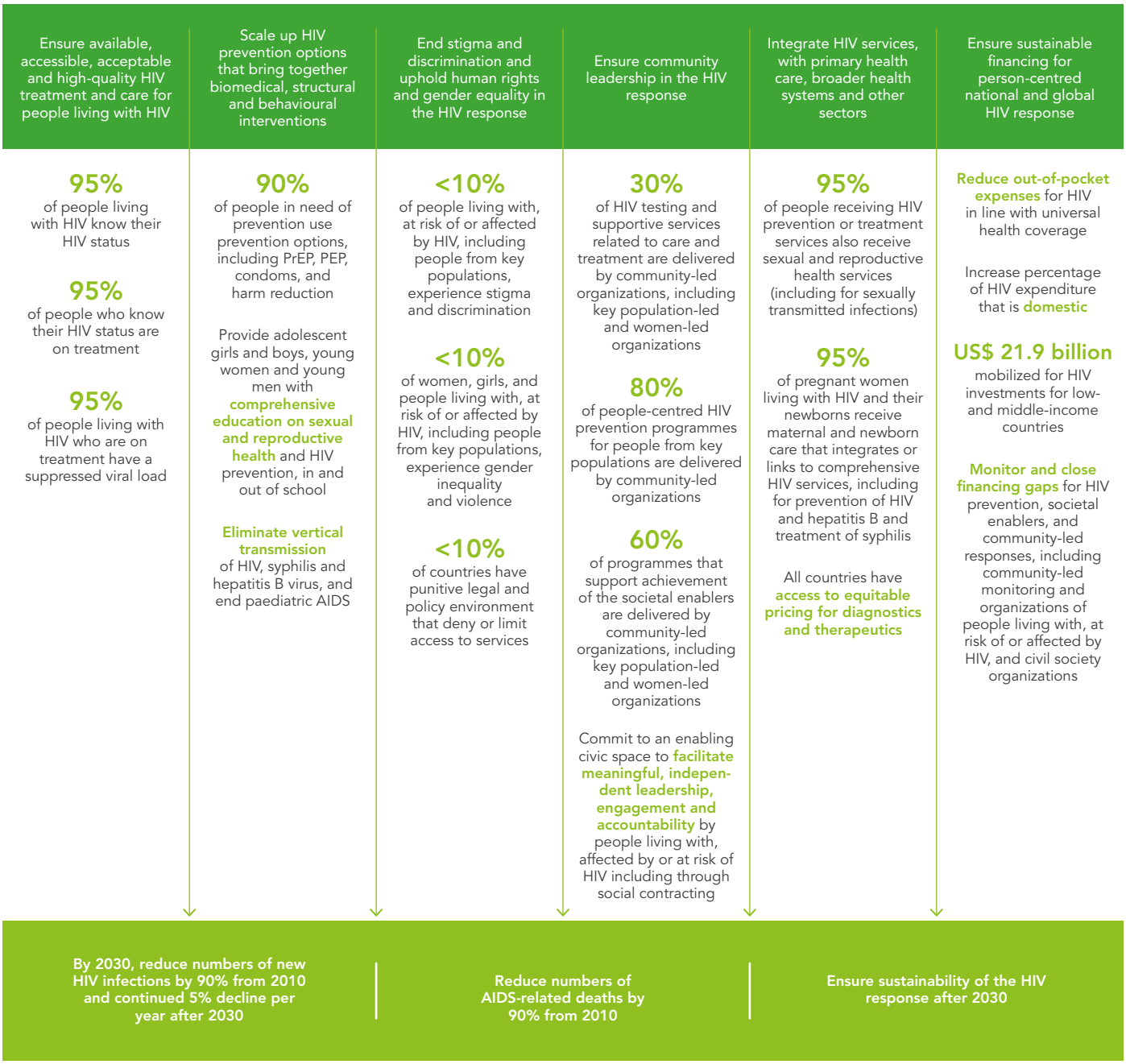
1. Advancing person-centred HIV prevention and treatment for people living with, affected by or at risk of HIV	2. Community leadership, equity and rights	3. Access to medicines, integration and accountability	4. Financing the future of the HIV response	5. Renewed support for multilateralism
Comprehensive prevention	Reinforce community-led responses	Access to medicines	US$ 21.9 billion annually by 2030 for HIV in low- and middle-income countries	Coordination and technical cooperation
Reaching the 95 targets across all populations	Social contracting	Technology transfer	Finance HIV prevention and societal enablers	Annual progress reporting
Explicit focus on key populations	Community-led monitoring supported by increased funding	Integrate HIV services into maternal, child, sexual and reproductive health, and TB services	Strengthen domestic investment	Reconvene at the 2031 High-level Meeting
Gender equality, empowering women and girls and fulfilling their human rights, including SRHR	30–80–60 targets	Commitment to research	Shift towards domestic funding without disrupting services, with reduction of out-of-pocket expenditure	
Eliminate vertical transmission, end paediatric AIDS, and ensure comprehensive care for women and children living with HIV	Enable a civic space for civil society	Strengthen disaggregated data and accountability systems at country level		
	10–10–10 targets			

2026 High-level Meeting: renewed commitments and country-focused targets

As a result of the 2026 High-level Meeting, Member States adopted 20 top-line targets, including the 16 targets of the Global AIDS Strategy. These structure the global response into distinct, manageable sections and serve to simplify accountability while addressing evolving challenges (Figure 22) *(58)*. Some targets are maintained from the 2021 Political Declaration because they have not yet been achieved by all countries and remain crucial.
If achieved in full, the commitments would avert an additional 3.2 million new HIV infections and 1.3 million AIDS-related deaths by 2030 (Figure 23).

Figure 22

20 targets to end AIDS as a public health threat by 2030 and ensure sustainability of the HIV response after 2030

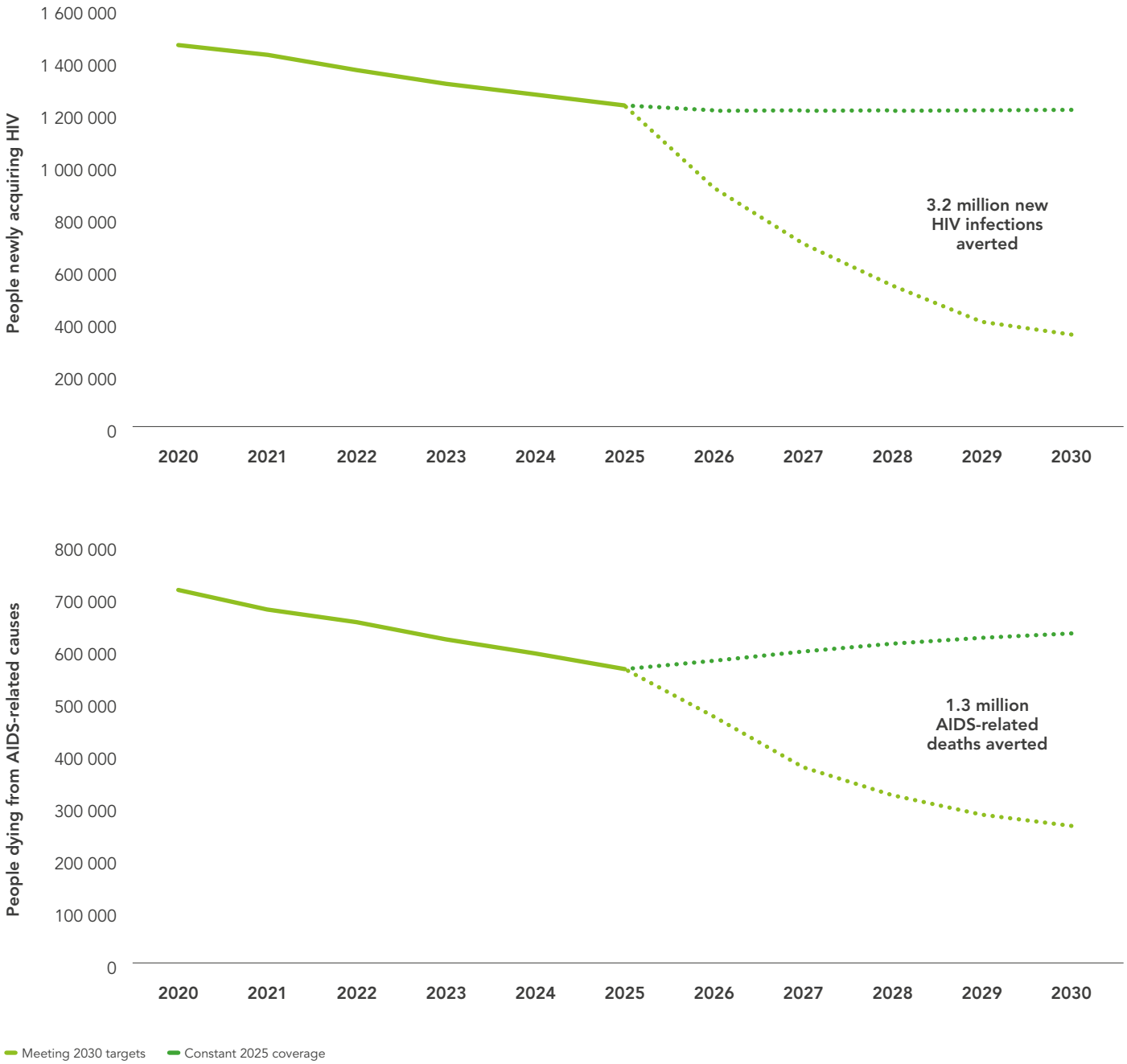


PEP: post-exposure prophylaxis.

All targets should be disaggregated as appropriate by gender, age and key population.

Figure 23

Potential new HIV infections and AIDS-related deaths averted if 2030 HIV targets are met, global 2020–2025 estimates and 2026–2030 projections



Source: UNAIDS epidemiological estimates 2026 and Goals projections.

References

1 UNAIDS and KFF. Donor Government Funding for HIV in Low- and Middle-Income Countries in 2025. (https://www.kff.org/global-health-policy/donor-government-funding-for-hiv-in-low-and-middle-income-countries-in-2025/#35dcbca0-eb3f-45f6-8840-071d94f772ac).

2 Political Declaration on HIV/AIDS: united to end AIDS by 2030. New York: United Nations General Assembly; 2026 (https://digitallibrary.un.org/record/4120538/files/A_RES_80_268-EN.pdf).

3 PEPFAR Panorama Spotlight. Washington, DC: United States President's Emergency Plan for AIDS Relief; 2026 (https://data.pepfar.gov/).

4 Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/342899, accessed 30 June 2022).

5 Stevens O, Sabin K, Anderson RL, Garcia SA, Willis K, Rao A, et al. Population size, HIV prevalence, and antiretroviral therapy coverage among key populations in sub-Saharan Africa: collation and synthesis of survey data. Lancet Glob Health. 2024;12*(9)*:e1400–e1412 (https://pubmed.ncbi.nlm.nih.gov/39151976/).

6 Boyd AT, Oboho I, Paulin H, Ali H, Godfrey C, Date A, et al. Addressing advanced HIV disease and mortality in global HIV programming. AIDS Res Ther. 2020;17*(1)*:40 (https://doi.org/10.1186/s12981-020-00296-x).

7 Ford N, Kassanjee R, Stelzle D, Jarvis JN, Sued O, Perrin G, et al. Global prevalence of advanced HIV disease in healthcare settings: a rapid review. J Int AIDS Soc. 2025;28*(2)*:e26415 (https://doi.org/10.1002/jia2.26415).

8 Ford N, Ehrenkranz P, Jarvis J. Advanced HIV as a neglected disease. N Engl J Med. 2024;390*(6)*:487–489 (https://doi.org/10.1056/NEJMp2313777).

9 Ayala G, Sprague L, van der Merwe LL, Thomas RM, Chang J, Arreola S, et al. Peer- and community-led responses to HIV: a scoping review. PLoS One. 2021;16*(12)*:e0260555 (https://doi.org/10.1371/journal.pone.0260555).

10 Under pressure: study. Paris: Coalition Plus, FrontlineAIDS, Sidaction, Aidsfonds; 2026 (https://www.coalitionplus.org/wp-content/uploads/2026/01/Enquete_CoalitionPLUS_VEN-Copie.pdf).

11 Overcoming disruption: transforming the AIDS response. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/sites/default/files/2025-11/2025-WAD-report_en.pdf).

12 New HIV response sustainability approach [website]. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://sustainability.unaids.org/).

13 Sia D, Tchouaket ÉN, Hajizadeh M, Karemere H, Onadja Y, Nandi A. The effect of gender inequality on HIV incidence in sub-Saharan Africa. Publ Health. 2020;182:56–63 (https://doi.org/10.1016/j.puhe.2020.01.014).

14 Lyons CE, Rwema JOT, Makofane K, Diouf D, Njindam IM, Ba I, et al. Associations between punitive policies and legal barriers to consensual same-sex sexual acts and HIV among gay men and other men who have sex with men in sub-Saharan Africa: a multicountry, respondent-driven sampling survey. Lancet HIV. 2023;10*(3)*:e186–e194 (https://doi.org/10.1016/S2352-3018*(22)*00336-8).

15 People Living with HIV Stigma Index 2.0, 2020–2024 [website]. Amsterdam: Global Network of People living with HIV; 2026 (https://www.stigmaindex.org/).

16 People Living with HIV Stigma Index 2.0: global report 2023. Hear us out: community measuring HIV-related stigma and discrimination. Amsterdam: Global Network of People living with HIV; 2023 (https://development.stigmaindex.org/wp-content/uploads/2023/11/PLHIV-Stigma-Index-Global-Report-2023-3.pdf).

17 Reports reveal global HIV response at "critical turning point". Brighton: Frontline AIDS; 2025 (https://frontlineaids.org/global-hiv-response-critical-turning-point/).

18 Monitor [website]. Johannesburg: CIVICUS (https://monitor.civicus.org/data/).

19 National commitments and policy instrument. Geneva: Joint United Nations Programme on HIV/AIDS; 2022–2025 (https://lawsandpolicies.unaids.org/).

20 Kuchukhidze S, Panagiotoglou D, Boily MC, Diabaté S, Eaton JW, Mbofana F, et al. The effects of intimate partner violence on women's risk of HIV acquisition and engagement in the HIV treatment and care cascade: a pooled analysis of nationally representative surveys in sub-Saharan Africa. Lancet HIV. 2023;10*(2)*:e107–e117 (https://doi.org/10.1016/S2352-3018*(22)*00305-8).

21 Best practices: models of integration of SRHR, HIV and GBV services from four countries. New York: United Nations Population Fund; 2022 (https://esaro.unfpa.org/en/publications/best-practices-models-integration-srhr-hiv-and-gbv-services-four-countries).

22 Confronting coercion: a global scan of coercion, mistreatment and abuse experienced by women living with HIV in reproductive and sexual health services. International Community of Women Living with HIV; 2024 (https://www.wlhiv.org/reproductivejustice).

23 SDG indicators database [website]. New York: United Nations; 2023 (https://unstats.un.org/sdgs/dataportal/database).

24 Mayer, K, Kotze P, Lombaard, J, Caraco Y, Peer A, Poovan N, et al. Safety and pharmacokinetics of MK-8527 oral once-monthly: a phase 2 study in adults at low risk of HIV-1 exposure. Abstract. Presented at the International AIDS Society Conference, July 2025 (https://programme.ias2025.org/Abstract/Abstract/?abstractid=6515).

25 Expanding prevention choice: Early lessons from twice-yearly Lenacapavir introduction, 26th International AIDS Conference, 27 July 2026.

26 Cousins S. HIV community welcomes lenacapavir deal. Lancet. 2025;406*(10511)*:1455 (https://doi.org/10.1016/S0140-6736*(25)*02006-9).

27 Nyagah W, Segal K, Feltham J, Ash A, Major J, Masani M. How might we motivate uptake of the dual prevention pill? Findings from human-centered design research with potential end users, male partners, and healthcare providers. Front Reprod Health. 2023;5:1254953 (https://doi.org/10.3389/frph.2023.1254953). Erratum in: Front Reprod Health. 2023;5:1341771 (https://doi.org/10.3389/frph.2023.1341771).

28 Country documents [website]. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://sustainability.unaids.org/country-profiles/).

29 Global tuberculosis report 2025. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/383364).

30 Eswatini national HIV strategic framework (NSF) 2024–2028. Mbabane: National Emergency Response Council on HIV and AIDS; 2024 (https://www.nercha.org.sz/national-hiv-strategic-framework/).

31 Tajikistan. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/regionscountries/countries/tajikistan).

32 Uganda: testing and surveillance for epidemic preparedness and response. Exemplars in Global Health; 2022.

33 Su J, Stover J, Pretorius C, Winskill P, Sweeney S, Hallett TB, et al. The benefits of investments to combat HIV, tuberculosis and malaria for primary healthcare from 2000–2023: an economic modeling analysis. PLoS Med. 2026;23*(4)*:e1005036 (https://doi.org/10.1371/journal.pmed.1005036).

34 Zhang L, Tao Y, Woodring J, Rattana K, Sovannarith S, Rathavy T, et al. Integrated approach for triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis is highly effective and cost-effective: an economic evaluation. Int J Epidemiol. 2019;48:1327–1339 (https://doi.org/10.1093/ije/dyz037).

35 Kasaie P, Weir B, Schnure M, Dun C, Pennington J, Teng Y, et al. Integrated screening and treatment services for HIV, hypertension and diabetes in Kenya: assessing the epidemiological impact and cost-effectiveness from a national and regional perspective. J Int AIDS Soc. 2020;23(Suppl 1):e25499 (https://doi.org/10.1002/jia2.25499).

36 Rinaldi G, Kiadaliri AA, Haghparast-Bidgoli H. Cost effectiveness of HIV and sexual reproductive health interventions targeting sex workers: a systematic review. Cost Eff Resour Alloc. 2018;16:63 (https://doi.org/10.1186/s12962-018-0165-0).

37 Chang D, Esber AL, Dear NF, Iroezindu M, Bahemana E, Kibuuka E, et al. Non-communicable diseases by age strata in people living with and without HIV in four African countries. J Int AIDS Soc. 2022;25(Suppl 4):e25985 (https://doi.org/10.1002/jia2.25985).

38 Whitehead S. People with HIV are aging, and the challenges are piling up. NPR, 15 June 2024 (https://www.npr.org/sections/shots-healthnews/2024/06/15/nx-s1-4990795/hiv-aids-aging-health-risks-).

39 Filiatreau LM, Musiellob F, Dela Tsagli D,·Chibi B,·Mukwekwerere ED, Essack Z, et al. PEPFAR interrupted: real-world consequences of U.S. foreign aid instability for HIV service delivery in South Africa. Lancet Reg Health Afr. 2026 (https://doi.org/10.1016/j.lanafr.2026.100039).

40 Zakumumpa H, Adolf A, Kiplagat J, Cherop F, Bosire V, Buregyeya E. Early impacts of PEPFAR funding freeze on HIV service delivery in mid-Western Uganda. BMC Health Serv Res. 2026;*26(1)*:368 (https://doi.org/10.1186/s12913-026-14165-2).

41 Global tuberculosis report 2025. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/383364).

42 Global data [website]. Washington, DC: Fragile States Index (https://fragilestatesindex.org/global-data/).

43 Holding the line: communities as first responders to COVID-19 and emerging health threats. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/holding-the-line-communities-first-responders_en.pdf).

44 Gillespie AM, Obregon R, El Asawi R, Richey C, Manoncourt E, Joshi K, et al. Social mobilization and community engagement central to the Ebola response in west Africa: lessons for future public health emergencies. Glob Health Sci Pract. 2016;4*(4)*:626–646 (https://doi.org/10.9745/GHSP-D-16-00226).

45 La lutte contre la Mpox au sein des populations clés en République Démocratique du Congo : pourquoi l'intégration des services VIH aux maladies émergentes est importante. Ministry of Public Health, Hygiene and Prevention of the Democratic Republic of the Congo, Programme d'Accès aux Soins de Santé des Communautés, Réseau National des ONG de Défense des Droits de l'Enfant et de la Femme, Joint United Nations Programme on HIV/AIDS and World Health Organization; 2025.

46 Eighth replenishment: stop at nothing. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2025 (https://www.theglobalfund.org/en/replenishment/eighth-replenishment/).

47 America First Global Health Strategy. Washington, DC: United States Department of State; 2025 (https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf).

48 Transition timelines. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2026 (https://www.theglobalfund.org/media/hvkncr4j/cr_gc8-transition-timelines_list_en.pdf).

49 KFF tracker: America First MOU bilateral global health agreements. Washington, DC: KFF; 2026 (https://www.kff.org/global-health-policy/kff-tracker-america-first-mou-bilateral-global-health-agreements/).

50 People's Republic of China unveils US$ 3.49 million HIV prevention support for South Africa, facilitated by UNAIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2025/november/20251121_China_prevention_SA).

51 Global Fund partners demonstrate unity and resolve to sustain progress and strengthen global health security. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2026 (https://www.theglobalfund.org/en/news/2025/2025-11-21-global-fund-partners-demonstrate-unity-resolve-sustain-progress-strengthen-global-health-security/).

52 African Union (AU) roadmap to 2030 and beyond: sustaining the AIDS response, ensuring systems strengthening and health security for the development of Africa. Addis Ababa: African Union; 2025 (https://au.int/sites/default/files/documents/44542-doc-AU_Roadmap_to_2030._EN.pdf).

53 Africa's health financing in a new era. Addis Ababa: Africa Centres for Disease Control and Prevention; 2025 (https://khub.africacdc.org/records/resource?id=5).

54 Jerving S. The "Accra reset": time's up for the legacy aid system. Devex, 1 October 2025 (https://www.devex.com/news/the-accra-reset-time-s-up-for-the-legacy-aid-system-110845).

55 Nakola S. New Africa CDC platform boosts regional health manufacturing. China Daily, 14 October 2025 (https://www.chinadaily.com.cn/a/202510/14/WS68ee3e6ca310f735438b4f32.html).

56 Alliance for the Elimination of HIV in the Americas. Washington, DC: Pan American Health Organization; 2026 (https://iris.paho.org/server/api/core/bitstreams/afce0ef0-7885-49c1-baa6-c7cec4832f5c/content).

57 Diretrizes Nacionais do Programa Brasil Saudável - Unir para Cuidar [National guidelines of the Healthy Brazil programme: Unite to Care] . Brasilia: Ministry of Health; 2024 (https://www.gov.br/participamaisbrasil/diretrizes-nacionais-do-programa-brasil-saudavel) (in Portuguese).

58 Global task team on 2030 HIV targets writing group. Global HIV targets: a roadmap to 2030 and beyond. Lancet. 2025:S0140-6736*(25)*01449-7 (https://doi.org/10.1016/S0140-6736*(25)*01449-7).

UNAIDS
Joint United Nations Programme
on HIV/AIDS

20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 595 59 92

unaids.org