UNAIDS June 2026

Global AIDS Brief

UNITED TO END AIDS

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Contents

Introduction

Renewing commitment to avoid reversing decades of progress

Progress made to date on the HIV response is real and fragile. Without renewed commitment and action, we risk a resurgence of the epidemic. In 2025, HIV responses around the world were disrupted by shifts in funding that threatened to stall years of progress in the HIV response. In 2025, external financing[1] for all development sectors fell by 23% 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, critical interventions addressing barriers to services, and 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 programmes re-emerge.

Gender equality, sexual and reproductive health and rights, and rights of LGBTQI+ people are under attack in many parts of the world. New or tightened laws against same-sex relations have been adopted in a number of countries. This risks undermining decades of progress and pushing the people who need services the most away from services. In addition, many of the community services that key populations rely on are disappearing due to the cuts in funding.

1 Official development assistance.

In this report, UNAIDS provides the latest global and regional data on the HIV epidemic and response as of the end of 2025.[2] Considerable progress has been achieved in the HIV response over the past four decades, with unprecedented scale-up of HIV treatment and understanding about what drives the epidemic and what can prevent onward transmission of HIV. It is critical to build on these achievements and sustain them through and beyond 2030.

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, 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[3] and to reach the goal of universal health coverage.

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.

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.

2 Country-level and final global and regional data will be available on the UNAIDS website ahead of the International AIDS Conference in late July 2026 and in the Global AIDS Update report in November 2026.

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

Summary numbers

	2010	2015	2020	2024	2025
People living with HIV	32.5 million [29.4 million –36.3 million]	35.9 million [32.5 million –40.1 million]	38.9 million [35.2 million –43.4 million]	40.6 million [36.8 million –45.4 million]	40.9 million [37.1 million –45.7 million]
New HIV infections	2.1 million [1.7 million –2.7 million]	1.8 million [1.5 million –2.3 million]	1.5 million [1.2 million –1.9 million]	1.3 million [1.0 million –1.6 million]	1.2 million [980 000 –1.6 million]
AIDS-related deaths	1.3 million [1.0 million –1.7 million]	940 000 [740 000 –1.2 million]	720 000 [560 000 –940 000]	600 000 [460 000 –770 000]	570 000 [440 000 –740 000]
Coverage of prevention of vertical transmission	49% [43–61%]	78% [68–97%]	84% [72–>98%]	85% [74–>98%]	87% [75–>98%]
Coverage of antiretroviral therapy	24% [19–28%]	47% [37–55%]	68% [54–78%]	77% [62–90%]	78% [62–90%]

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. But AIDS is not over. The world is not on track to achieve the 2030 goal of ending AIDS as a public health threat—but the goal remains within reach.

Since 2010, the estimated number of new HIV infections fell by 43% globally (Figure 1),[4] 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 94 000 [66 000–140 000] 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.

4 Unless otherwise indicated, all data cited in this report are based on UNAIDS data and will be available at https://aidsinfo.unaids.org on 28 July.

Despite progress, the world missed the 2025 targets

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

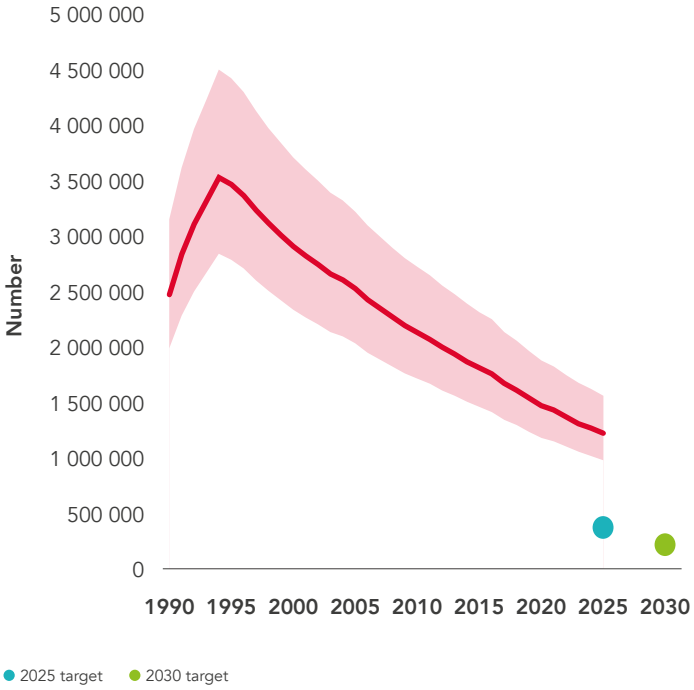
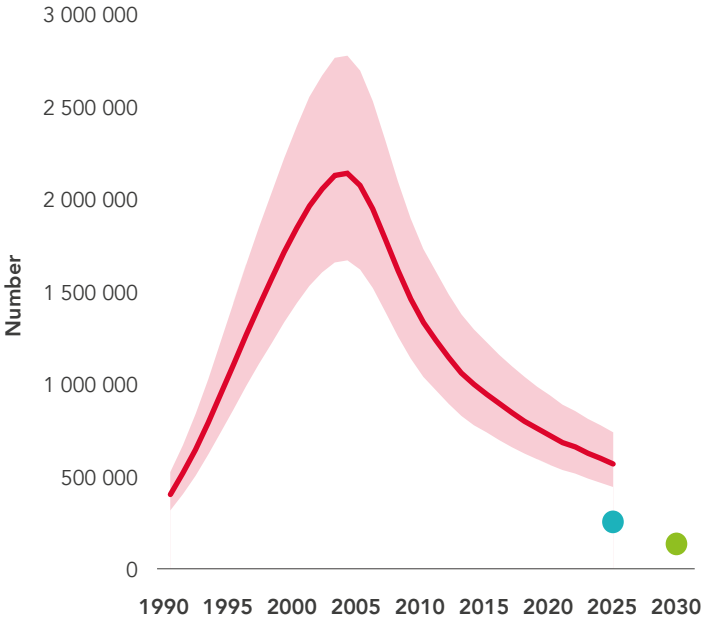


Figure 2
Number of AIDS-related deaths, global, 1990–2025 and 2030 target



Source: preliminary UNAIDS epidemiological estimates 2026.

The number of AIDS-related deaths in 2025 was 57% lower than in 2010 from 1.3 million [1.0 million–1.7 million] in 2010 to 570 000 [440 000–740 000] in 2025 (Figure 2), with a decline in deaths among adult women aged 15 years and older from 510 000 [390 000–690 000] to 220 000 [170 000–300 000] and among adult men from 590 000 [450 000–770 000] to 280 000 [220 000–370 000]. 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.[5]

These achievements were supported by a 20% increase in total HIV resources since 2010, with US$ 18.7 billion available for the HIV response in low- and middle-income countries in 2024 (before the funding reductions of 2025). This was already short of the estimated US$ 21.9 billion needed annually by 2030, a funding gap of nearly 15%. The unprecedented funding reductions in 2025 have made HIV programmes fragile in many low- and middle-income countries.

5 Data on TB and HIV are available only for 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 have declined drastically. Initial data from 62 countries show that the number of people receiving PrEP at least once in the reporting year declined by 38% between 2024 and 2025, including in countries heavily affected by HIV. In one bilateral donor programme, HIV testing declined by 22% in countries with a high level of HIV in 2025, between 2024 and 2025 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% *(2)*.[6]

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, 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.

An overall lack of domestic funding for prevention programmes and declines in donor HIV assistance have put HIV prevention services at risk.

Regional disparities persist

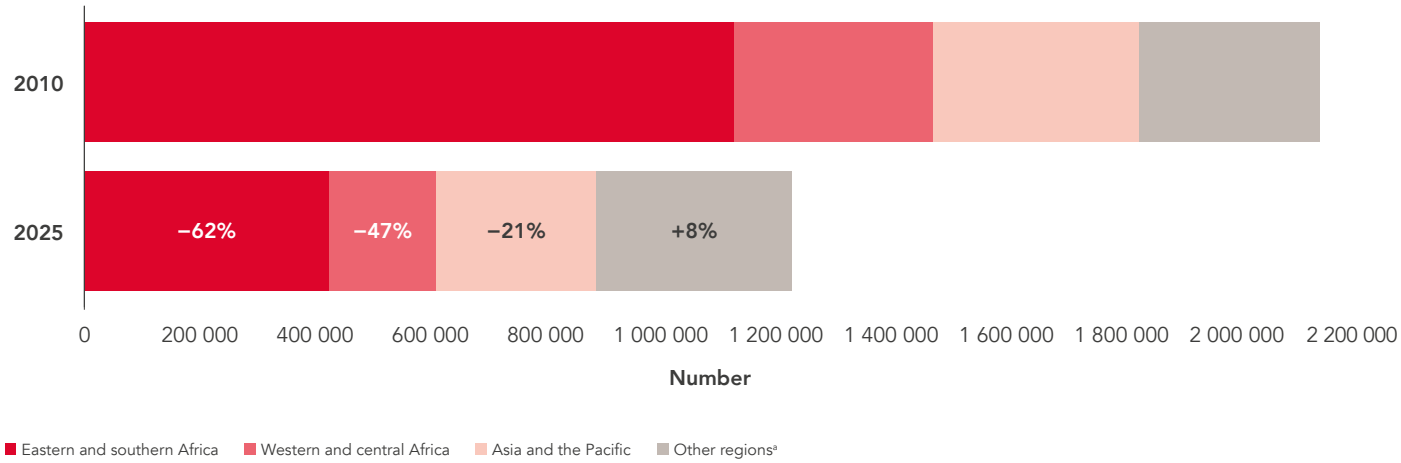
Between 2010 and 2025, numbers of new HIV infections continued to decline in some regions but increased in others. The full impact of the reductions in HIV prevention programmes due to funding shifts is not measurable yet because data systems cannot capture incidence in real time. Declines occurred overall 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.

6 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

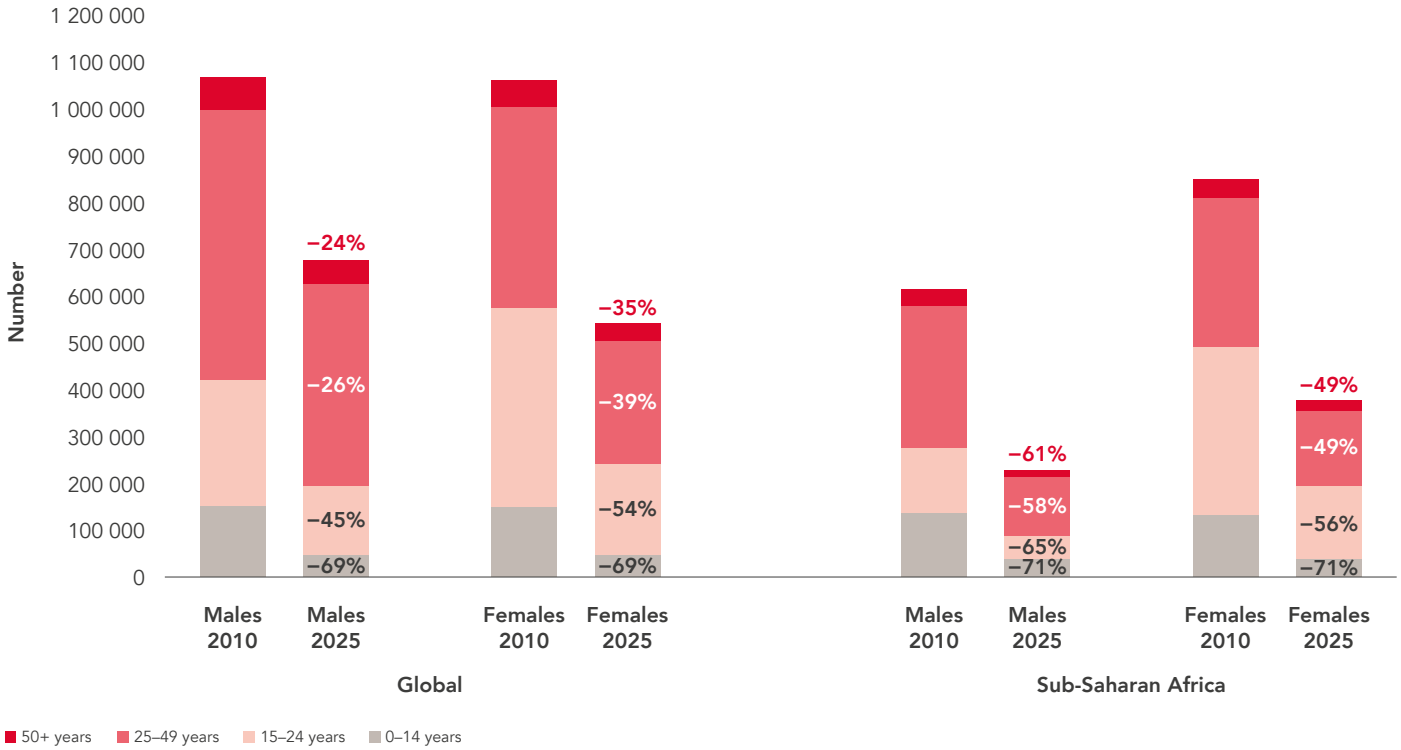


[a]*Other regions* combines regions with lower absolute numbers of new HIV infections than the regions shown separately. Trends within this group varied between 2010 and 2025: the number of new infections declined in the Caribbean (−30%) and western and central Europe and North America (−13%), but increased in eastern Europe and central Asia (+15%), Latin America (+13%) and the Middle East and North Africa (+77%).

Source: preliminary UNAIDS epidemiological estimates 2026.

Declines in numbers of new acquisitions are slowest among men outside of sub-Saharan Africa, while men within sub-Saharan Africa have faster declines than their female counterparts

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



Source: preliminary UNAIDS epidemiological estimates 2026.

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 faster among men than women.

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 [130 000–270 000] 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 94 000 [66 000–140 000] children acquiring HIV in 2025, with 84% of these in sub-Saharan Africa. In 2025, 87% [75–>98%] of women living with HIV who were pregnant were receiving treatment—a very slow increase from 84% [72–>98%] in 2020.

Key populations still not benefiting from the science

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

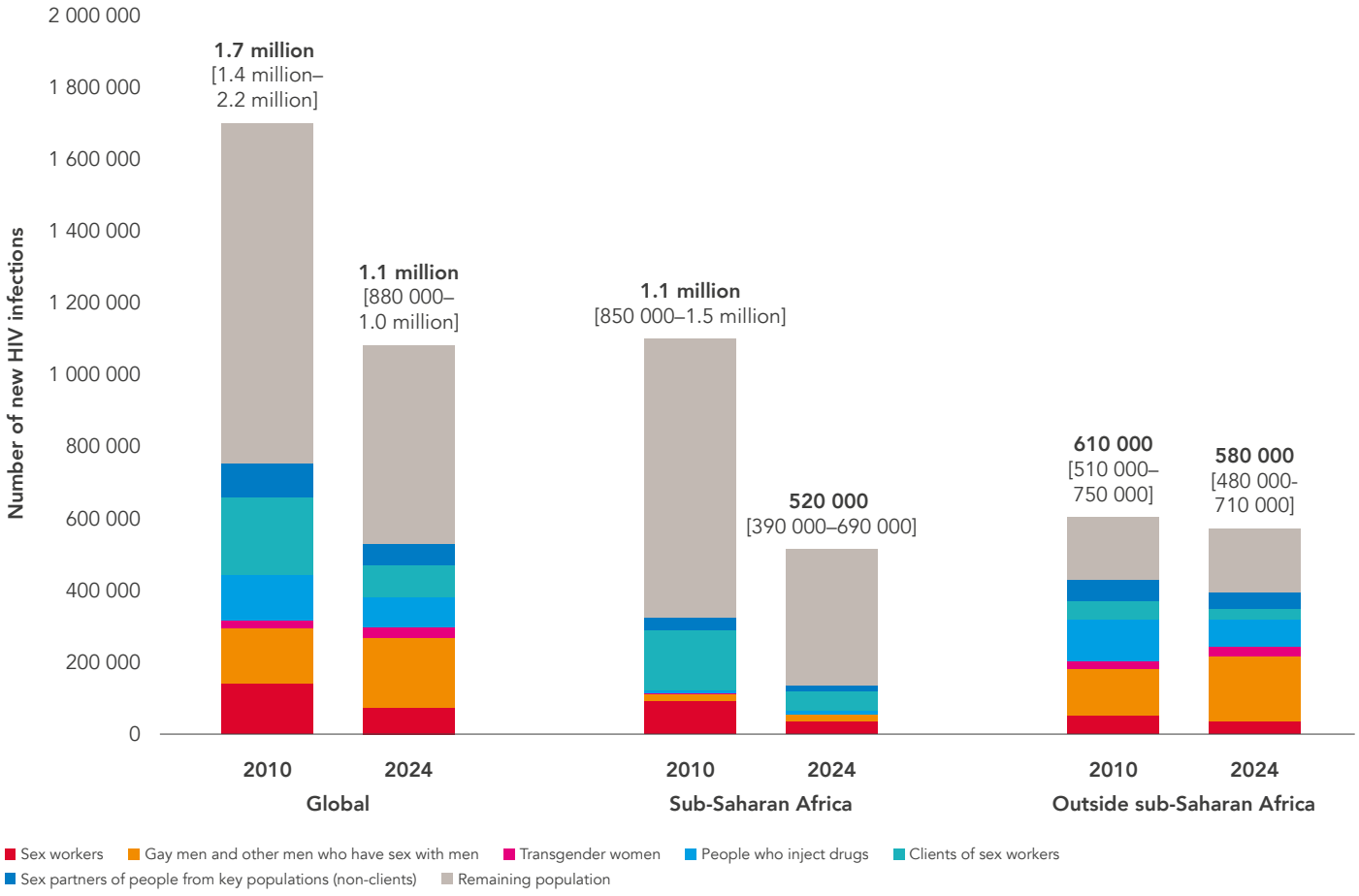
People from key populations face a considerably higher risk of HIV acquisition. Globally in 2024, the risk of HIV acquisition compared with the adult population (aged 15–49 years) was estimated to be 34 times higher among people who inject drugs, 18 times higher among gay men and other men who have sex with men, 17 times higher among sex workers, and 17 times higher among transgender women.[9]

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

7 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.
8 Data on new HIV infections among people from key populations are available only for 2024.
9 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.

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. 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.

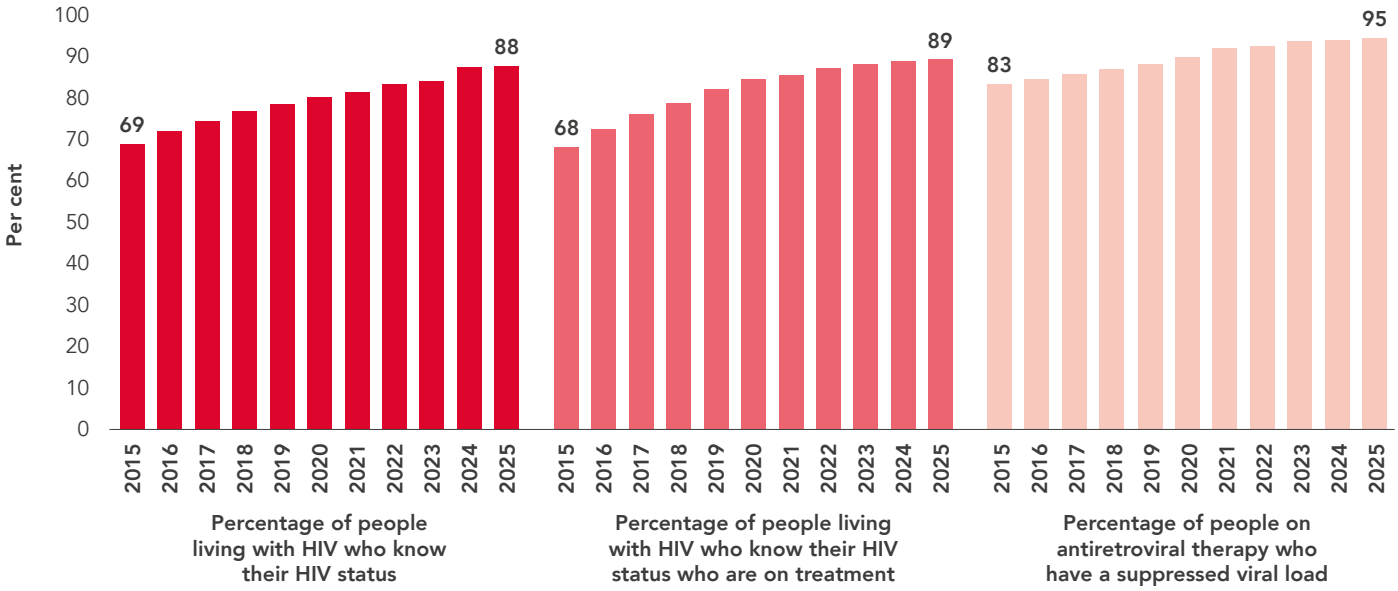
Progress on treatment has been maintained—but for how long?

Globally, at the end of 2025, 88% [70–>98%] of people living with HIV knew their HIV status, 89% [71–>98%] of people who knew their HIV status were on treatment, and 95% [76–>98%] of people on treatment had viral suppression[10] (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 2.7% 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: preliminary UNAIDS epidemiological estimates 2026.

10 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% [67–83%] of all people living with HIV had a suppressed viral load and 95% [76–>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 *(3)*.

Community-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.[11]

In 2025, just over half of children living with HIV were on antiretroviral therapy (54%), up from 17% in 2010.

Treatment gaps are substantial among some populations

In 2025, just over half of children living with HIV were on antiretroviral therapy (54% [40–73%]), up from 17% in 2010—leaving more than 580 000 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 cohort.

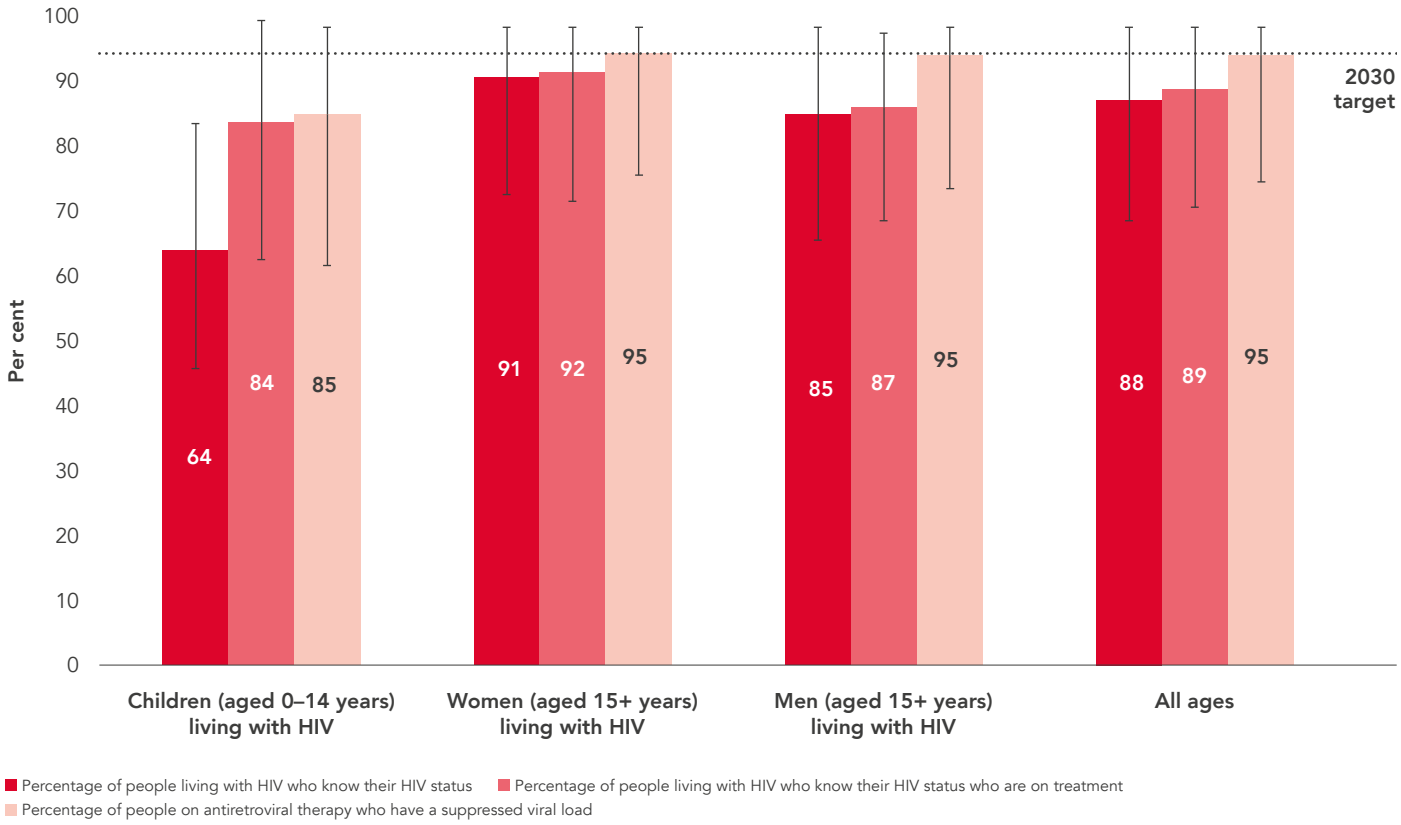
Globally, men living with HIV had lower treatment coverage than women (74% [57–85%] vs 84% [66–97%]) in 2025 (Figure 7). Regional and country variations exist, however: in Latin America and the Middle East and North Africa, women living with HIV had lower treatment coverage than men living with HIV.

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 *(4)*.

11 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: preliminary UNAIDS epidemiological estimates 2026.

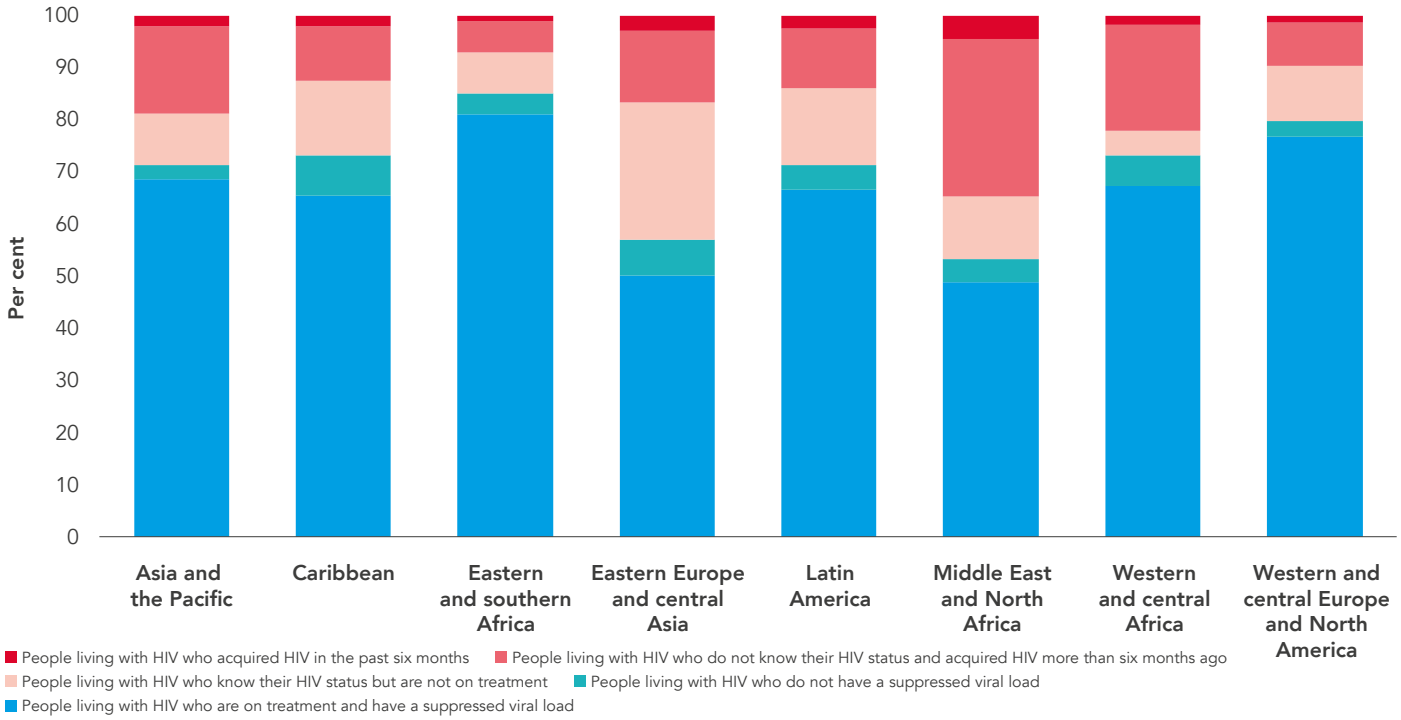
More effort is needed to reach viral suppression across regions

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: preliminary 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 8.8 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 *(5)*. 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[12] *(6, 7)*.

12 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.

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 *(8)*. 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.

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.[13]

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% *(9)*. The study showed an 85% reduction in services for gay men and other men 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 *(10)*.

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

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 national systems as these strengthen;
- 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 *(11)*, 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 *(12, 13)*.

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 9).[14,15] 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 *(14)*.

Programmes to address discriminatory attitudes need to be maintained over time because evidence shows these attitudes can rise again after initially declining, with data available from at least six countries reflecting a decline followed by an increase in discriminatory attitudes.[16]

Rights-based 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 *(15)*.

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 *(16)*. 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.

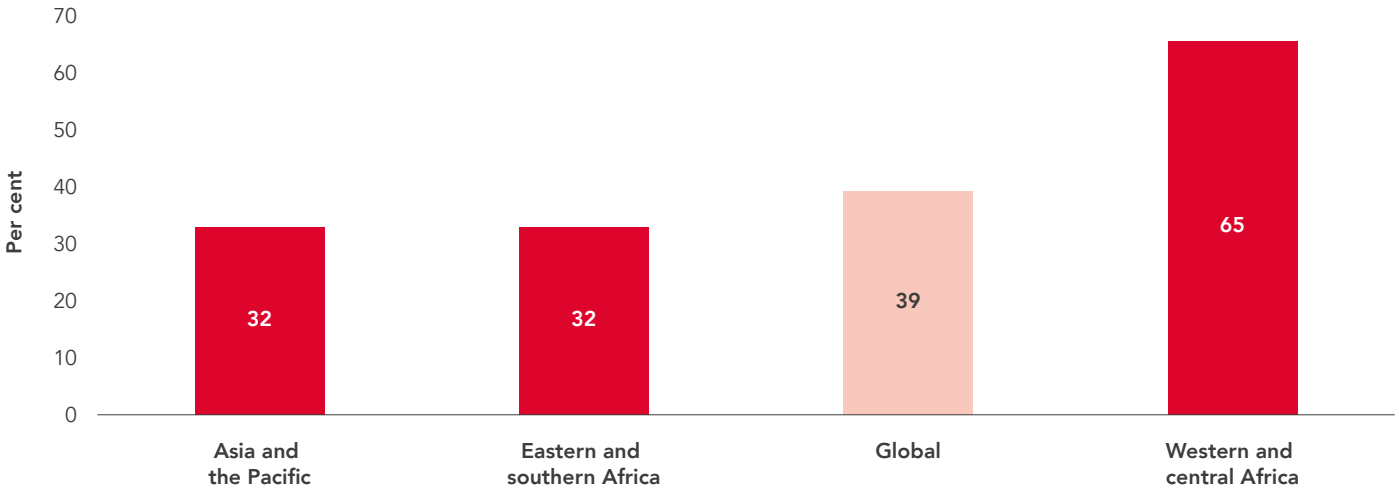
Programmes to address discriminatory attitudes need to be maintained over time.

14 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.
15 Population-based surveys 2021–2024.
16 Population-based surveys 2000–2024.

Discriminatory attitudes continue to exist in different regions

Figure 9

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



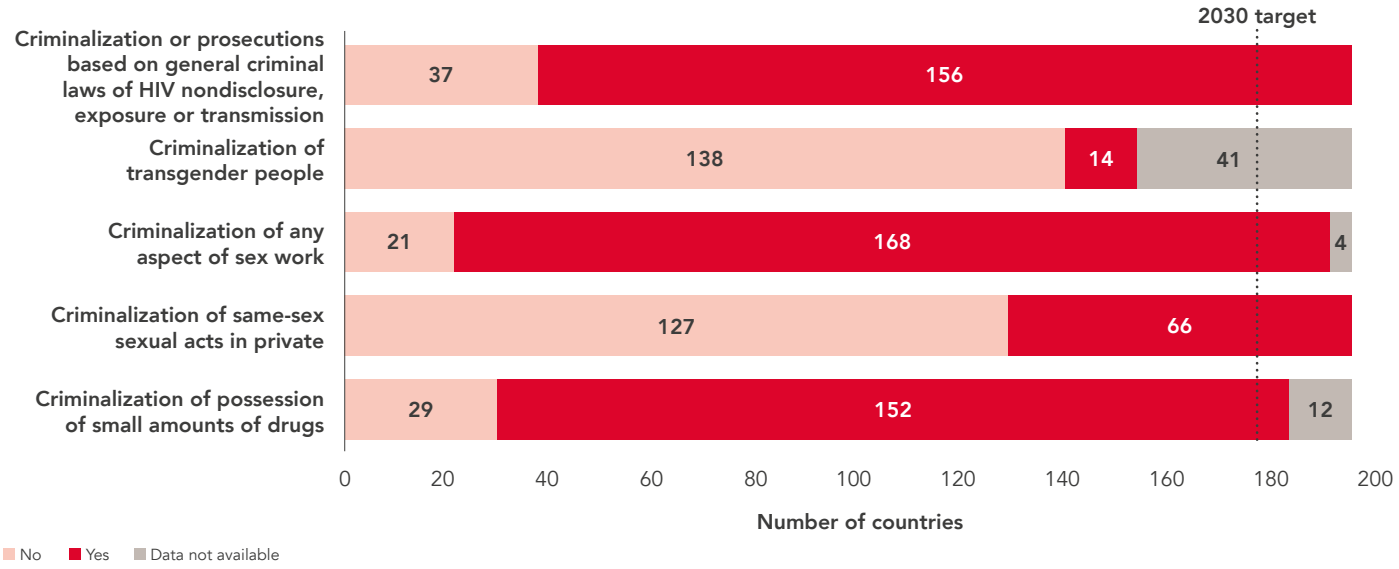
Note: data coverage of regional aggregates: global—34 countries, 33% of 2022 (the midpoint of this analysis) population; Asia and the Pacific—9 countries, 42% of 2022 population; eastern and southern Africa—10 countries, 49% of 2022 population; western and central Africa—8 countries, 73% of 2022 population. Aggregates for the Caribbean, Latin America, eastern Europe and central Asia, the Middle East and North Africa and western and central Europe and North America 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 10

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 introduced criminalization related to same-sex sexual activity and gender expression in 2025, and one country increased penalties for same-sex sexual activity in 2026 (Figure 10).

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.[17] 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.

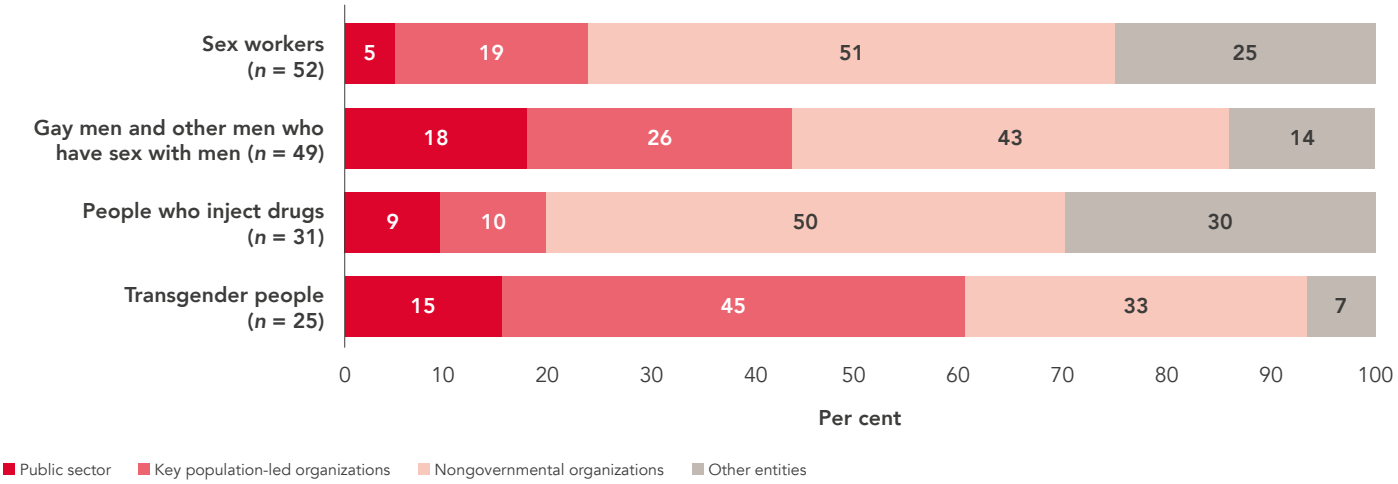
Community-led organizations deliver essential services

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 *(8)*. 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 11). 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.

17 Chile, Colombia, the Netherlands (Kingdom of), Paraguay, Slovenia, Uruguay, Venezuela (Bolivarian Republic of) Chile, Paraguay and Slovenia 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 11
Distribution of the reported numbers of people from key populations reached with HIV prevention interventions, by type of provider, 2020–2024



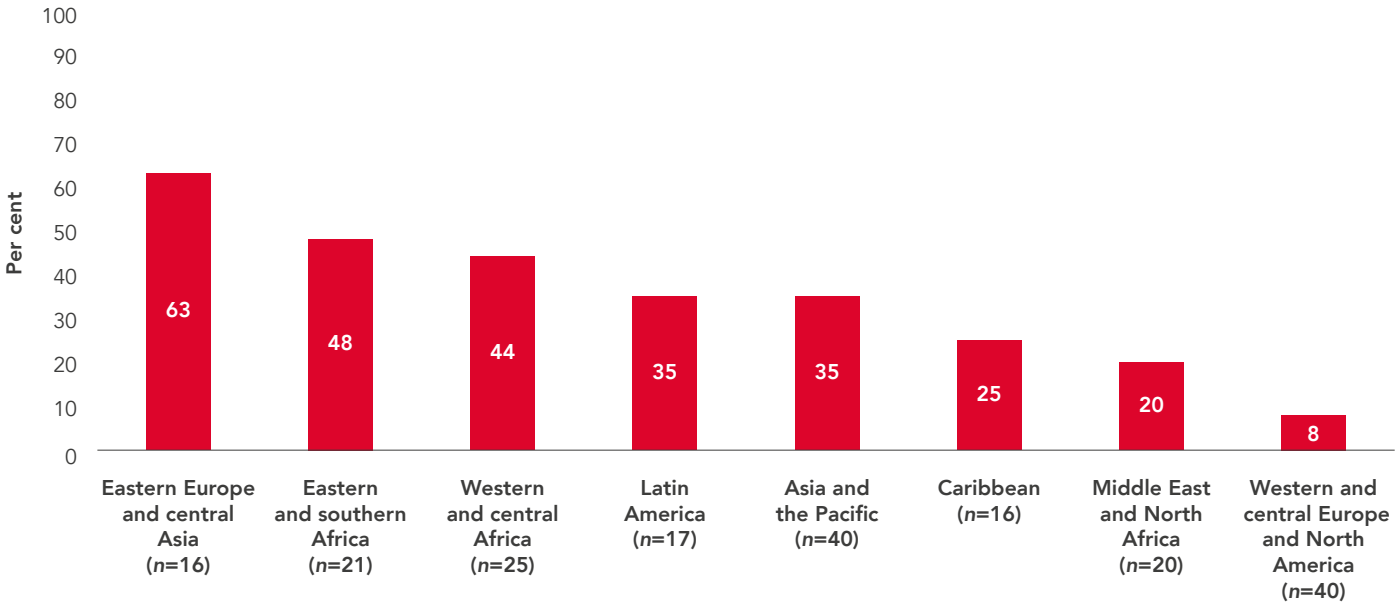
Note: n = number of countries.
Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/).

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 *(17)*. 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 12) *(18)*.

Efforts to put in place social contracting mechanisms must be continued

Figure 12
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

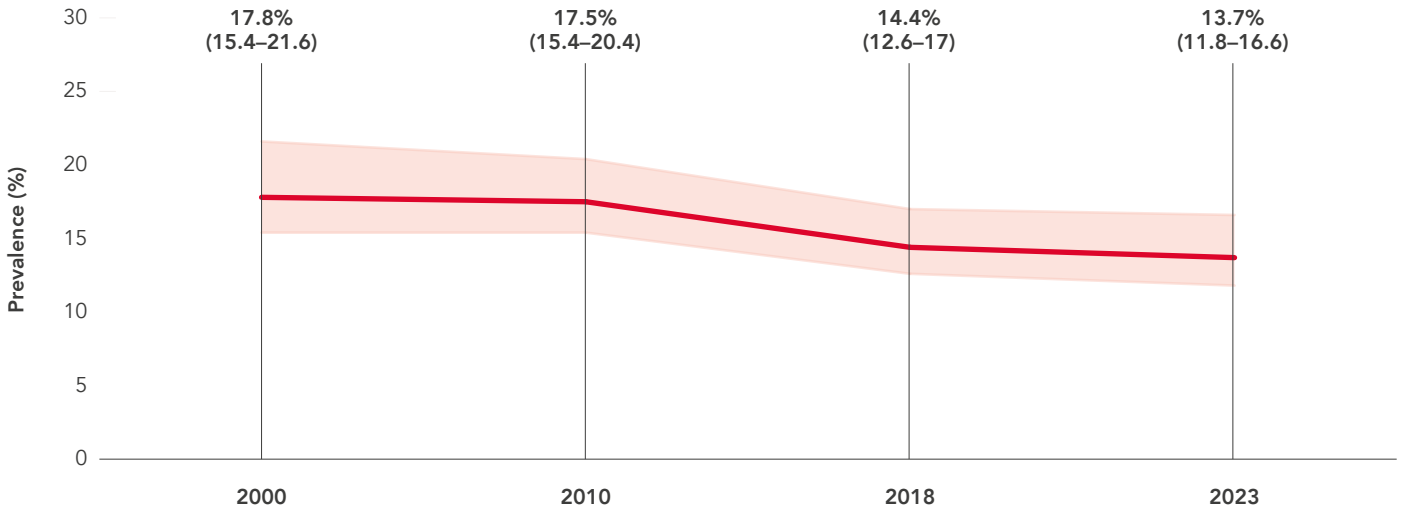
Violence against people living with HIV reduces access to—and the benefits of—HIV treatment. Women living with HIV who have experienced physical intimate partner violence are about 9% less likely to have viral suppression, based on seven surveys in sub-Saharan Africa *(19)*. Evidence supports integrating violence prevention into health care, including adolescent HIV services *(20)*. Global progress in reducing intimate partner violence is far too slow (Figure 13): 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.[18]

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 *(21)*. A little over half of women and adolescent girls (aged 15–49 years) can make their own decisions regarding sexual relations, contraceptive use and use of health care *(22)*.

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

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

Figure 13
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 reduce 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 *(23)*—has brought new urgency and reinvigorated partnership for HIV prevention. By the end of March 2026, over 6000 people were receiving lenacapavir in five countries in sub-Saharan Africa (Eswatini, Kenya, Nigeria, Zambia, Zimbabwe) *(24)*. The majority of these people were women aged over 25 years who received the injection 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 *(25)*. 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 *(26)*, ensuring they reach the people who need them most.

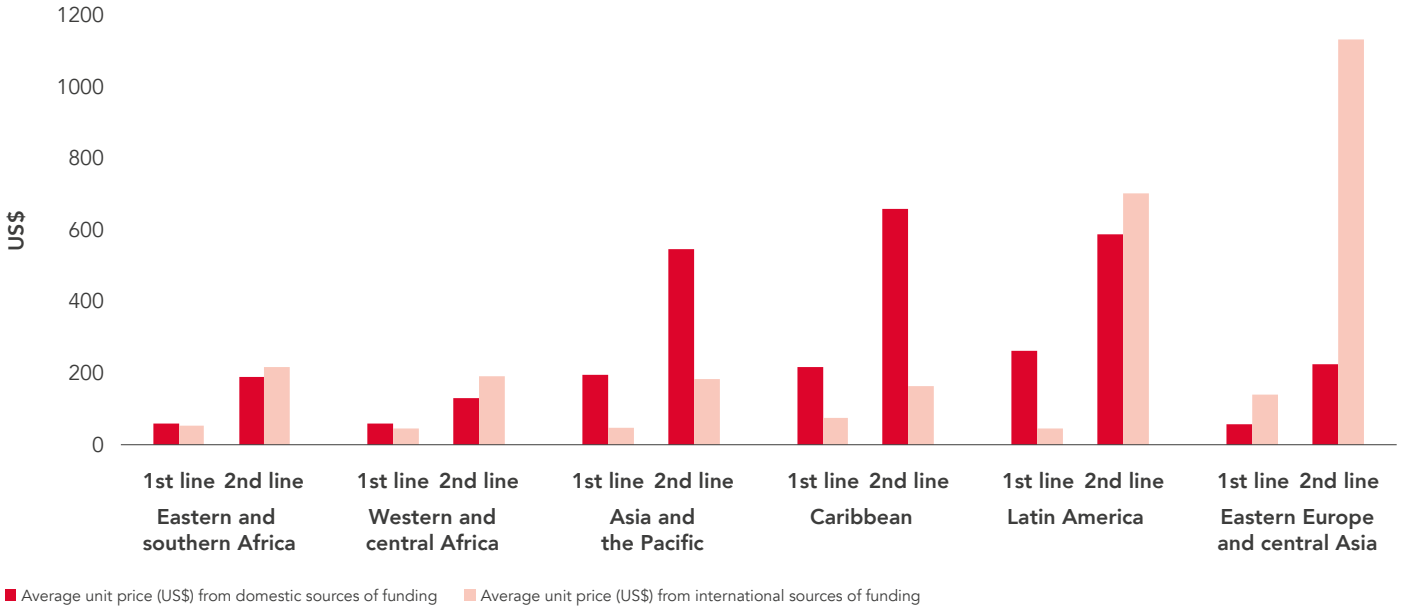
Equitable pricing and market access

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 every 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 (Figure 14). Consolidated evidence reveals considerable price variation across countries, particularly for second-line regimens, where prices increase significantly with income level *(27)*.[19] 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 14
Average procurement prices of antiretroviral medicines, by region and source of funding



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

19 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)*. 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 *(34–36)*. 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 *(39–41)*.

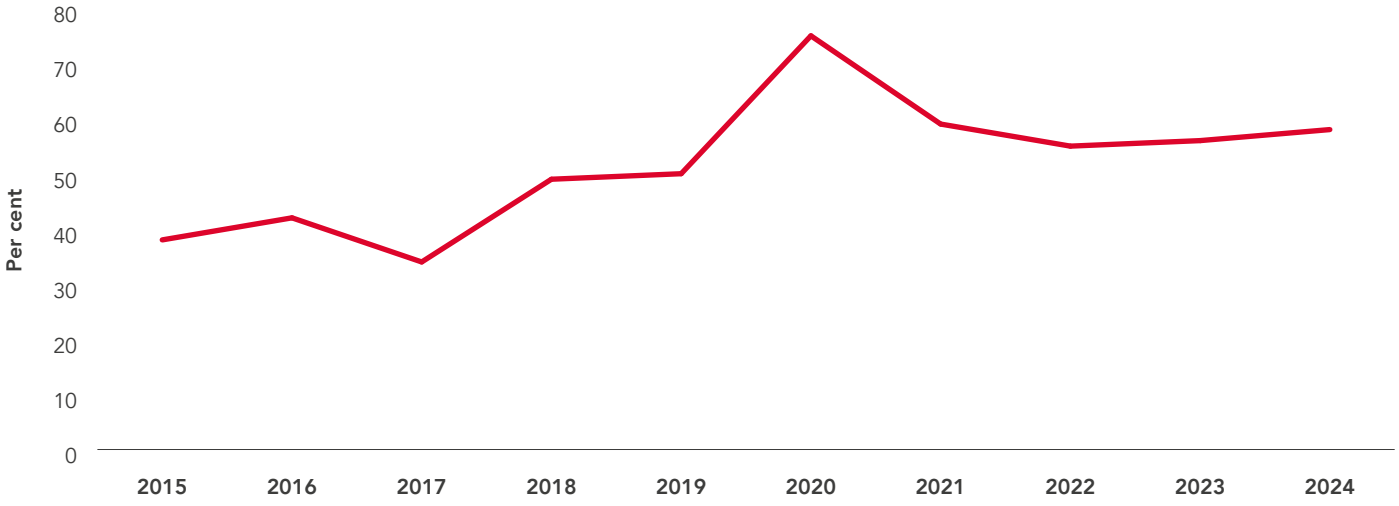
Integration of HIV and TB services is progressing

Among people living with HIV who were diagnosed with TB in 2024, the coverage of antiretroviral therapy was 91%—up from 46% in 2010 *(27)*.[20] 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.[21]

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 15).[22] 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 15
Percentage of people newly enrolled on antiretroviral therapy who started TB preventive treatment, global, 2015–2024



Source: Global AIDS Monitoring 2016–2025.

20 Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).
21 Global AIDS Monitoring 2025 (https://aidsinfo.unaids.org/).
22 Global AIDS Monitoring (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.[23] 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) *(15)*.

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)*. Community-led organizations are critical to the HIV response and beyond, for country and global resilience in the face of new and emerging epidemics.

23 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—only slightly more than the US$ 18.7 billion available in 2024. However, 2025 marked a profound shock to global health financing, with abrupt reductions in international assistance destabilizing HIV responses across many countries.

In 2024, international funding supported 42% of the HIV response in low- and middle-income countries, around 66% of HIV prevention and societal enabler programmes. 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.

HIV funding architecture is evolving

The global landscape of external financing for HIV in 2025 is marked by growing uncertainty and increasing funding pressures. In 2024, donor government contributions to HIV totalled US$ 8.37 billion. Of the estimated US$ 18.7 billion in HIV resources available in low- and middle-income countries, domestic resources accounted for 52%, donor governments for 44%, and foundations and other multilateral entities for the remaining 4%. Although the latest 2025 data on HIV-specific official development assistance are not available yet, broader Organisation for Economic Co-operation and Development data indicate a 23% decline in overall official development assistance across all development sectors, including reductions in bilateral (26%) and multilateral (13%) assistance *(1)*. The Global Fund and the United States Government continue to be the largest sources of external financing in the global HIV response, despite both moving to support more self-reliant and country-owned responses.

The global landscape of external financing for HIV in 2025 is marked by growing uncertainty and increasing funding pressures.

These recent donor commitments, including through the 2025 Global Fund Eighth Replenishment *(46)* and the United States America First Global Health Strategy *(47)*, also 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 with meeting co-financing commitments and progress towards the 95–95–95 targets.

Emerging economies and south–south cooperation are contributing to HIV financing at limited scale. 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, despite broader collaboration through south–south collaboration platforms.

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

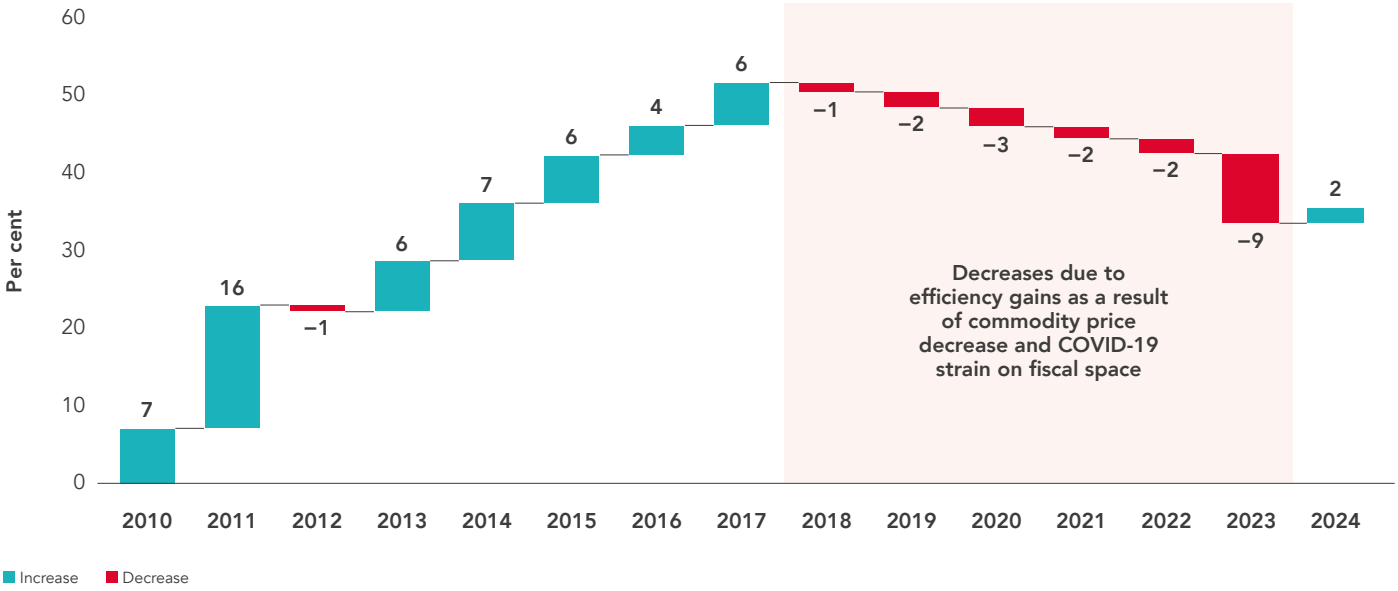
In 2024, domestic financing represented 52% of total funding for the HIV response. From 2010 to 2024, domestic HIV financing in low- and middle-income countries increased by 28% (Figure 16), although that growth stalled and there were decreases attributed to efficiency improvements as a result of commodity price decreases, and sharper decreases due to COVID-19 and fiscal strain in 2020–2023, before increasing again in 2024 by 2.2%.

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.[24] Twenty-eight African countries spend more on debt than on health. In western and central Africa, for example, public debt service is on average in some countries 5.5 times greater than public health allocations, crowding out fiscal space for HIV investment.[25] 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 54 countries have committed to increase their domestic contributions (Table 2), including establishing mixed financing instruments to increase and sustain domestic resources for the HIV response, as reported through Global AIDS Monitoring *(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. However, fiscal constraints limit how far domestic funding can substitute for external support.

Domestic spending on HIV grew in 2024 for the first time since the COVID-19 pandemic

Figure 16
Annual change (%) in domestic spending on HIV in low- and middle-income countries, 2010–2024



Source: UNAIDS financial estimates 2025.

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

Over 54 countries reported planned increases in domestic funding for HIV since 2025

Table 2
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 (7)
≤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**

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


3

Chapter 3

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

The Global AIDS Strategy 2026–2031, developed through broad multistakeholder discussion and consultation, provides the foundation for the recommendations laid out in this report. 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 and 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 17):

- 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.

Renewed commitments and country-focused targets

Sixteen top-line targets are proposed that structure the global response into distinct, manageable sections and serve to simplify accountability while addressing evolving challenges (Figure 17) *(57)*. Some targets are maintained from the 2021 Political Declaration because they have not yet been achieved by all countries and remain crucial. A new focus of the targets is on sustainability and integration.

Achievement of the 16 targets is expected to avert 3.2 million new HIV infections and 1.2 million AIDS-related deaths between 2025 and 2030, effectively meeting the 2030 goal of ending AIDS, with a 90% reduction in numbers of new HIV infections and AIDS-related deaths compared with 2010 (Figure 18). A further 5% reduction in numbers of new infections per year after 2030 would ensure the sustainability of longer-term progress in countries and communities after 2030 *(55)*.

This goal can be achieved if people are able to consistently access HIV treatment to live healthy lives and reduce onward transmission; if people can access other effective prevention options; if stigma and discrimination are reduced; and if policies, laws and structural barriers that prevent people from accessing services are removed.

Figure 17

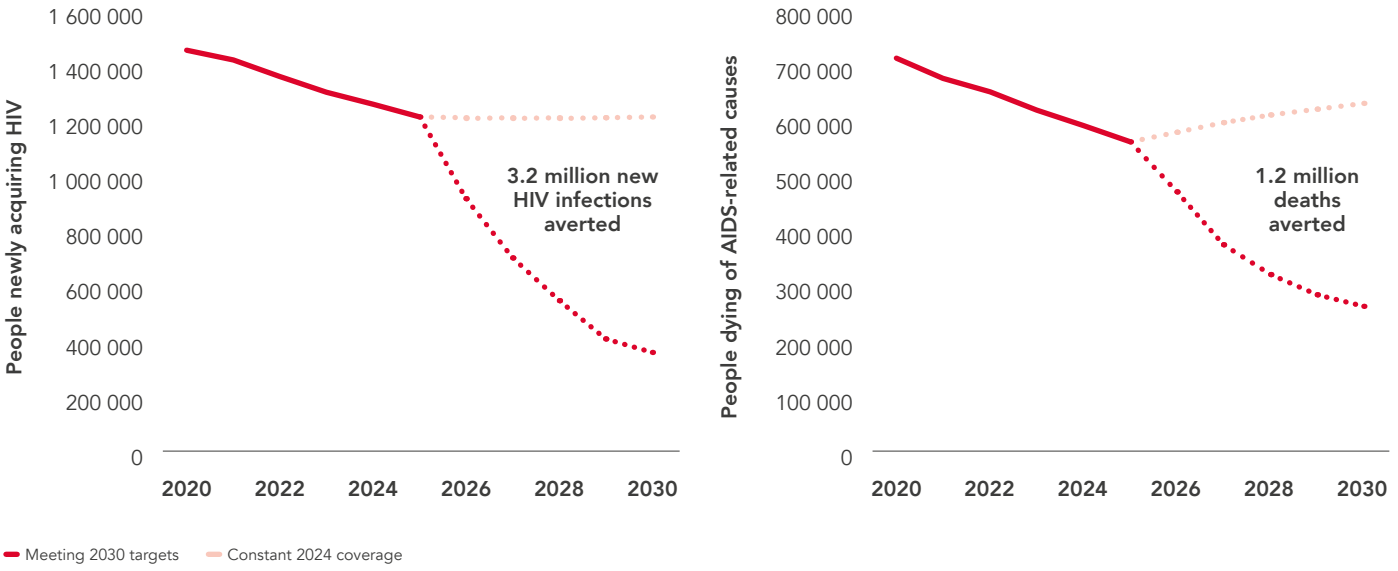
16 targets to end AIDS as a public health threat by 2030 and ensure sustainability of the HIV response after 2030

PEP: post-exposure prophylaxis.

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

Figure 18

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



Source: preliminary 2026 UNAIDS epidemiological estimates and Goals projections.

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