

Eastern and southern Africa

2025 DATA

62% decrease in number of new HIV infections since 2010:

62% decrease in number of AIDS-related deaths since 2010:

People living with HIV: 21.1 million [17.5 million–24.8 million]

New HIV infections: 420 000 [300 000–580 000]

AIDS-related deaths: 240 000 [190 000–350 000]

Testing and treatment cascade (all ages):

People living with HIV who know their HIV status: 93% [68–>98%]

People living with HIV who are on treatment: 85% [62–>98%]

People living with HIV who have a suppressed viral load: 81% [67–95%]

Elimination of vertical transmission:

Antiretroviral therapy coverage among pregnant women living with HIV: 95% [81–>98%]

Vertical transmission rate: 6% [5–8%]

Financing of the HIV response:

Resource availability for HIV: US$ 8.4 billion (from the US$9.9 billion required to meet the 2030 target)..

Progress is at risk

Eastern and southern Africa is the region most affected by the HIV pandemic globally, accounting for 51% of people living with HIV globally—but there has been continued progress in the HIV response. This progress is now at risk of being reversed, with a 13% cut in funding between 2024 and 2025, mainly due to drops in external financing for the HIV response.

Significant progress has been made in preventing HIV transmission in the region, with numbers of new HIV infections declining by 62%, from 1.1 million [800 000–1.5 million] in 2010 to 420 000 [300 000–580 000] in 2025. The region accounted for 34% of all new HIV infections globally in 2025 (Figure 13.1).

Progress has not been consistent across the region. Countries with the highest HIV burdens have shown considerable declines in the number of new HIV infections—in 2025, Eswatini, Kenya, Lesotho, Rwanda and Zimbabwe achieved at least a 78% reduction in the number of new infections since 2010, placing them well on track towards the goal of a 90% reduction by 2030. Some smaller epidemics, however, especially in the Indian Ocean islands, including Comoros and Madagascar, have shown increases. The number of AIDS-related deaths in the region decreased by 62%, from 630 000 [500 000–920 000] in 2010 to 240 000 [190 000–350 000] in 2025 (Figure 13.1).

Despite the progress seen in most countries in the region, adolescent girls and young women aged 15–24 years accounted for 27% of all new HIV infections and were three times more likely to acquire HIV than their male counterparts. Studies have shown that incidence rates now peak among women aged 25–34 years in some countries.[1]

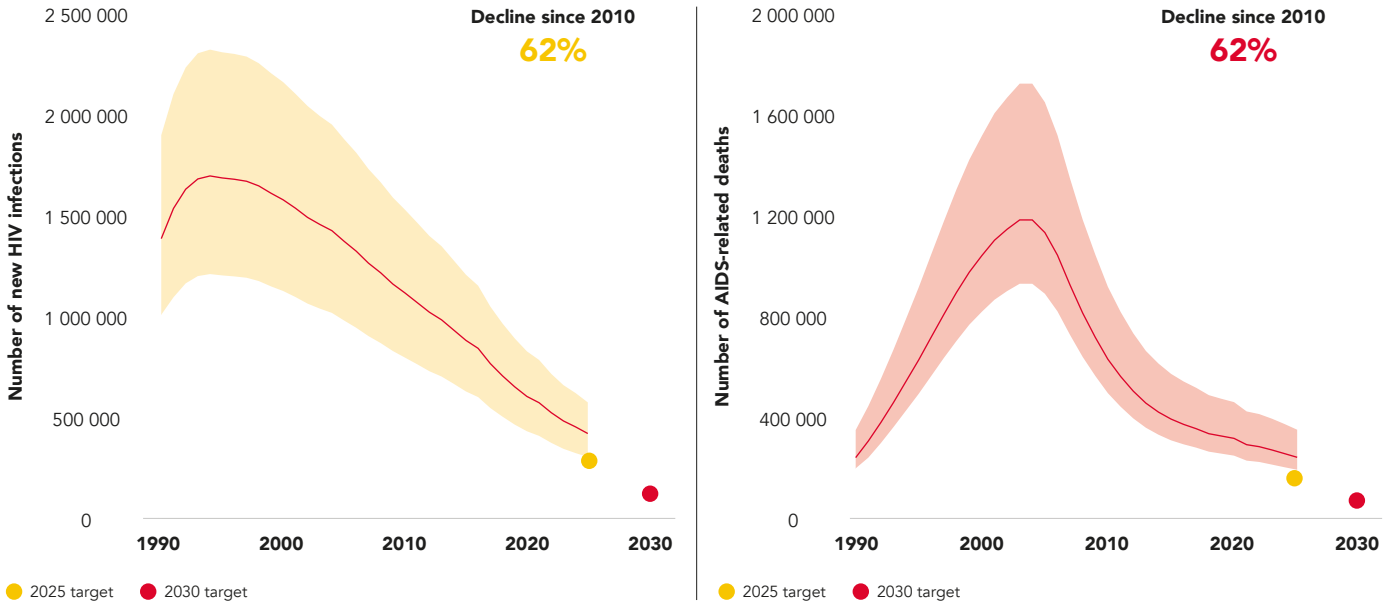
Several countries have achieved significant reductions in vertical HIV transmission. In eight countries, coverage of prevention of vertical transmission exceeds 95%, contributing substantially to the decline in vertical HIV transmission and moving closer to the goal of eliminating vertical transmission.[2]

1 Longitudinal population-level HIV epidemiologic and genomic surveillance highlights growing gender disparity of HIV transmission in Uganda. Nat Microbiol. 2024;9(1):35–54 (https://doi.org/10.1038/s41564-023-01530-8).

2 Countries with coverage of prevention of vertical transmission exceeding 95% include Botswana, Eswatini, Malawi, Namibia, South Africa, Uganda, the United Republic of Tanzania and Zambia.

Numbers of new HIV infections and AIDS-related deaths continue to decline

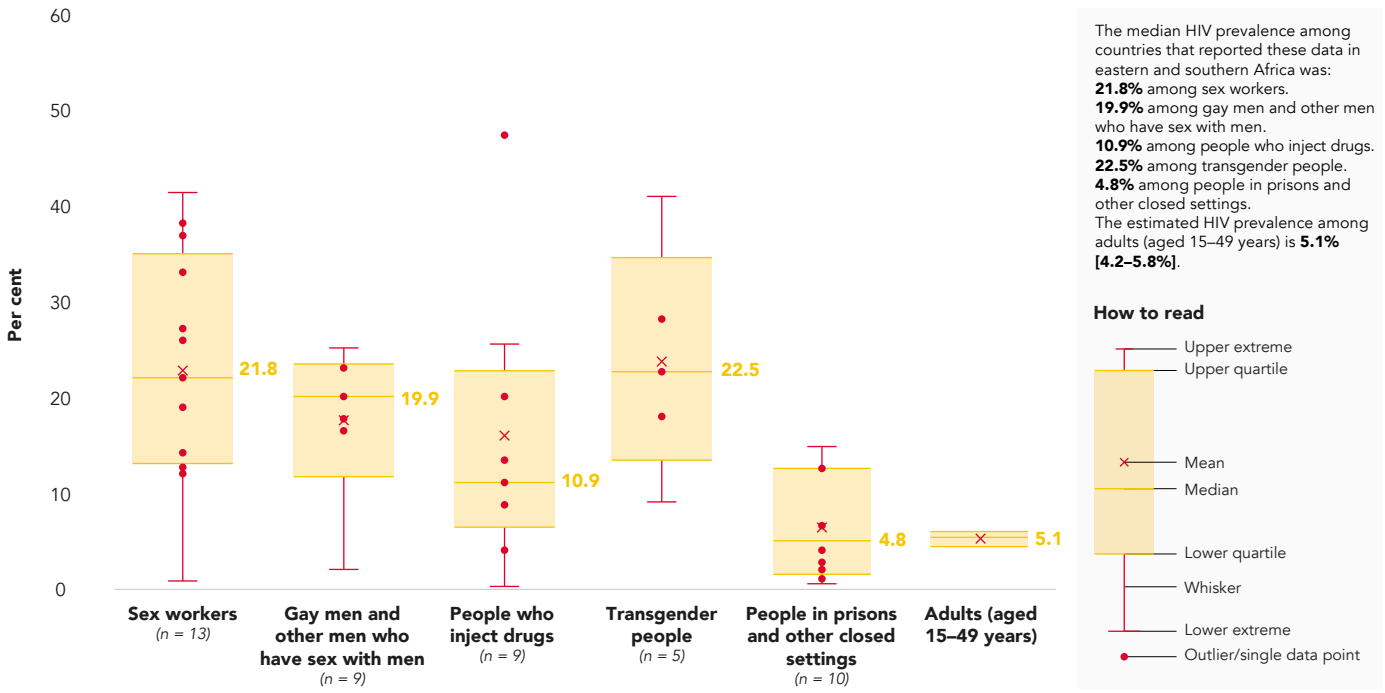
Figure 13.1. Numbers of new HIV infections and AIDS-related deaths, eastern and southern Africa, 1990–2025, 2025 and 2030 targets



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

HIV prevalence remains markedly higher among key populations in eastern and southern Africa

Figure 13.3. HIV prevalence among people from key populations compared with adults in the general population (aged 15–49 years), reporting countries in eastern and southern Africa, 2021–2025



Source: UNAIDS Global AIDS Monitoring, 2022–2026; UNAIDS epidemiological estimates, 2026 (https://aidsinfo.unaids.org/).
Note: n = number of countries. Total number of reporting countries = 21. The adult prevalence uncertainty bounds define the range within which the true value lies (if it can be measured). Narrow bounds indicate that countries reported similar prevalence, while wide bounds indicate greater disparity in the reported prevalence.

Nevertheless, the region accounted for 49% of new HIV infections among children globally in 2025. Of all new HIV infections among children in the region, 51% occurred as a result of mothers not receiving antiretroviral treatment or not having a suppressed viral load during pregnancy or breastfeeding, and 32% because of mothers acquiring HIV during pregnancy or breastfeeding.

Key populations continue to have disproportionately high HIV prevalence—22.5% among transgender people, 21.8% among sex workers and 19.9% among gay men and other men who have sex with men, compared with 5.1% [4.2–5.8%] among adults in the general population (aged 15–49 years) (Figure 13.3). This highlights the need to scale up evidence-based combination prevention services, including expanded access to pre-exposure prophylaxis (PrEP), post-exposure prophylaxis, harm reduction, community-led outreach and people-centred service delivery.

Treatment has been maintained, but HIV prevention services are declining

HIV prevention efforts in the region face growing challenges amidst funding disruptions. Between 2024 and 2025, HIV testing declined by 13%, condom distribution fell by 17%, and PrEP uptake decreased by 8% (with 2.3 million people receiving PrEP in 2025). Voluntary male medical circumcision numbers fell substantially across the region, from 3.1 million in 2024 to 1.5 million in 2025 across 13 of 15 countries; only Mozambique and South Africa demonstrated some resilience, with numbers going up in 2025.

HIV treatment coverage continues to expand. Seven countries in the region achieved all three 95 targets (Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia, Zimbabwe). Substantial challenges remain in achieving equitable access to HIV services, with progress towards testing, treatment and viral load suppression targets varying across countries and populations. In 2025, an estimated 1.5 million people living with HIV did not know their HIV status, more than 1.7 million people who knew their status were not receiving antiretroviral therapy, and children continued to experience poorer treatment outcomes than adults (Figure 13.4).

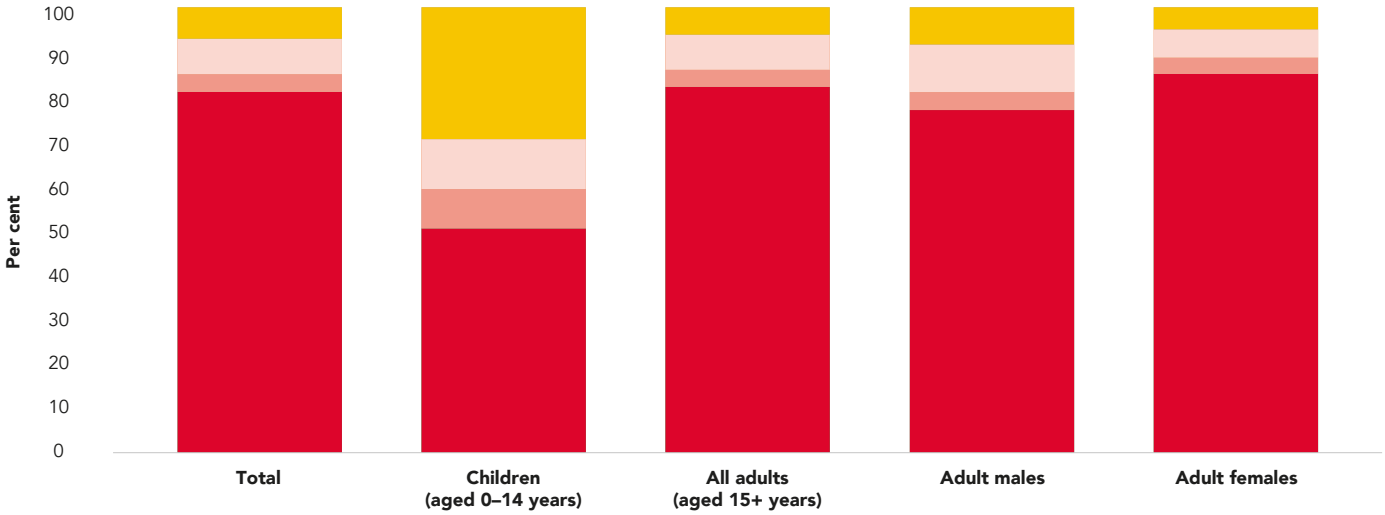
Reported median antiretroviral therapy coverage was 100% among people in prisons and other closed settings (seven countries), 95% among gay men and other men who have sex with men (nine countries), 89% among sex workers (12 countries), 79% among people who inject drugs (six countries) and 69% among transgender people (four countries).

HIV services, including treatment access, have been disrupted by conflict, climate shocks and displacement across the region. In 2023–2024, the region hosted more than 28.9 million internally displaced people and 6.4 million refugees. Health systems in Ethiopia are under strain from droughts, landslides and conflict, limiting care for people living with HIV.[3] An effective HIV response in humanitarian settings must address these barriers through integrated, gender-responsive approaches.

3 Ethiopia—situation report, 13 December 2024. New York: United Nations Office for the Coordination of Humanitarian Affairs; 2024 (https://www.unocha.org/publications/report/ethiopia/ethiopia-situation-report-13-december-2024).

HIV testing and treatment cascade, by age and sex, eastern and southern Africa, 2025

Figure 13.4. HIV testing and treatment cascade, by age and sex, eastern and southern Africa, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

Societal barriers need urgent attention

Structural barriers, including gender inequalities, persist in the region. This heightens vulnerability to HIV, particularly for girls, women and people from key populations, and prevents access to services.[4] Girls and women, particularly those facing economic hardship, such as in humanitarian crises, may engage in intergenerational and transactional sex as a survival strategy, which increases their exposure to violence and HIV.[5, 6] A rise in anti-gender and anti-LGBTQIA+ rhetoric is putting sexual and reproductive health, HIV and other vital services at risk for girls, women and people from key populations.[7] The expansion of community-centred initiatives under the DREAMS partnership, which empowered adolescent girls and young women through economic programmes, school interventions and comprehensive sexuality education, had reduced the number of sexual partners and HIV incidence in some contexts.[8] Most of these programmes, however, were suspended following United States funding cuts in 2025.[9]

Data from reporting countries in 2021–2025 highlight the impact of stigma and discrimination on people from key populations (Figure 13.5). Fifty-four per cent of people who inject drugs (five countries), 50% of sex workers (eight

4 Badejo O, Wouters E, Van Belle S, Buve A, Smekens T, Jwanle P, et al. Latent class analysis of barriers to HIV testing services and associations with sexual behaviour and HIV status among adolescents and young adults in Nigeria. PloS One. 2024;19(4):e0300220 (https://doi.org/10.1371/journal.pone.0300220).

5 Ntimani JM, Mokoena-de Beer AG, Phetlhu DR. Delivery models of HIV pre-exposure prophylaxis and their influence on uptake in South Africa: an integrative review. South Afr J HIV Med. 2025;26(1):1684 (https://doi.org/10.4102/sajhivmed.v26i1.1684).

6 Trickey A, Johnson LF, Bonifacio R, Kiragga A, Howard G, Biraro S, et al. Investigating the associations between drought, poverty, high-risk sexual behaviours, and HIV incidence in sub-Saharan Africa: a cross-sectional study. AIDS Behav. 2024;28(5):1752–1765 (https://doi.org/10.1007/s10461-024-04280-8).

7 Shaw A. The global assault on LGBTQ rights undermines democracy. London: Chatham House; 2023 (https://www.chathamhouse.org/publications/the-world-today/2023-06/global-assault-lgbtq-rights-undermines-democracy).

8 Lavoie MC, Blanco N, Lascko T, Baumhart C, Verbeek J, Stoebenau K, et al. The effects of the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program on HIV incidence and other health-related outcomes among adolescent girls and young women: a systematic review and meta-analysis. EClinicalMedicine. 2025;82:103176 (https://doi.org/10.1016/j.eclinm.2025.103176).

9 Impact of PEPFAR stop work orders on PrEP. New York: AIDS Vaccine Advocacy Coalition; 2026 (https://www.prepwatch.org/wp-content/uploads/2026/04/ImpactOfStopWorkOrder_april2026.pdf).

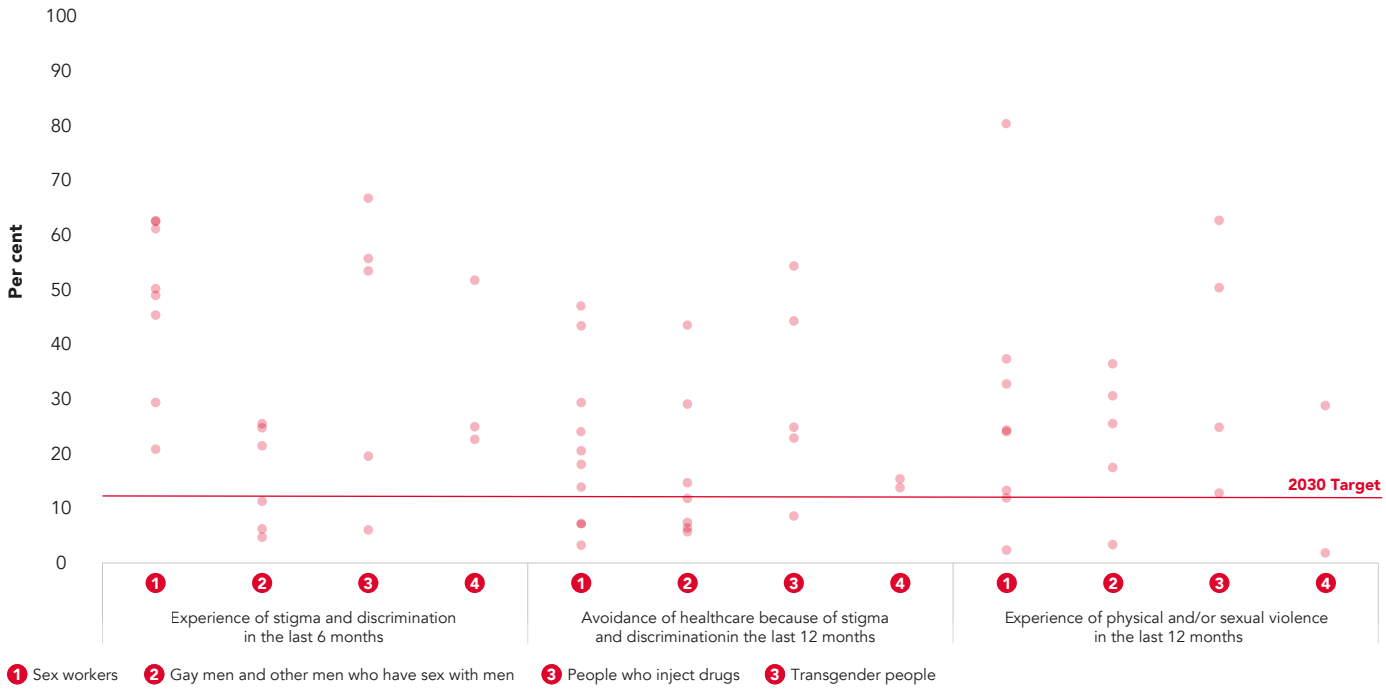
countries), 25% of transgender people (three countries) and 17% of gay men and other men who have sex with men (six countries) reported experiencing stigma and discrimination in the past six months. Twenty-five per cent of people who inject drugs (five countries), 20% of sex workers (10 countries), 15% of transgender people (two countries) and 12% of gay men and other men who have sex with men (seven countries) reported avoiding accessing health-care services in the past 12 months due to stigma and discrimination.

People from key populations experience high levels of violence. In 2021–2025, 38% of people who inject drugs (four countries), 26% of gay men and other men who have sex with men (five countries), 25% of sex workers (eight countries) and 16% of transgender people (two countries) reported experiencing physical and/or sexual violence in the past 12 months.

Across the region, 11 of 21 countries continue to criminalize same-sex sexual relations, 19 have laws criminalizing some aspect of sex work, and all criminalize drug use. Fourteen countries criminalize HIV, either directly or under broader communicable disease laws. Most countries do not legally recognize the gender identity of transgender people. Discriminatory attitudes towards people living with HIV have reduced in some countries, such as Eswatini, Malawi and the United Republic of Tanzania. Initial declines have been followed by increases in Kenya and Mozambique, reflecting the importance of continuing to address discriminatory attitudes over time. Such attitudes remain widespread in other countries, such as Comoros and Madagascar.[10]

People from key populations experience high levels of stigma and discrimination

Figure 13.5. Experience of stigma and discrimination, avoidance of health care and sexual and/or physical violence among people from key populations, reporting countries, 2021–2025



Source: People Living with HIV Stigma Index 2.0 studies, 2021–2025.
Note: Experiences of stigma and discrimination in healthcare settings are measured as having experienced at least one of the following because of HIV status in the previous 12 months: denial of care, advised not to have sex, being the subject of gossip or negative talk, verbal abuse, physical abuse, avoidance of physical contact, and sharing of HIV status without consent.

10 Population-based surveys, 2021–2025.

High dependency on external funding

In 2025, total resources allocated to the HIV response in the region amounted to US$ 8.4 billion, reflecting a 15% decline since 2020 (Figure 13.6). The funding situation deteriorated sharply between 2024 and 2025, with total HIV resources falling by 10%, driven by an almost 20% reduction in external financing.

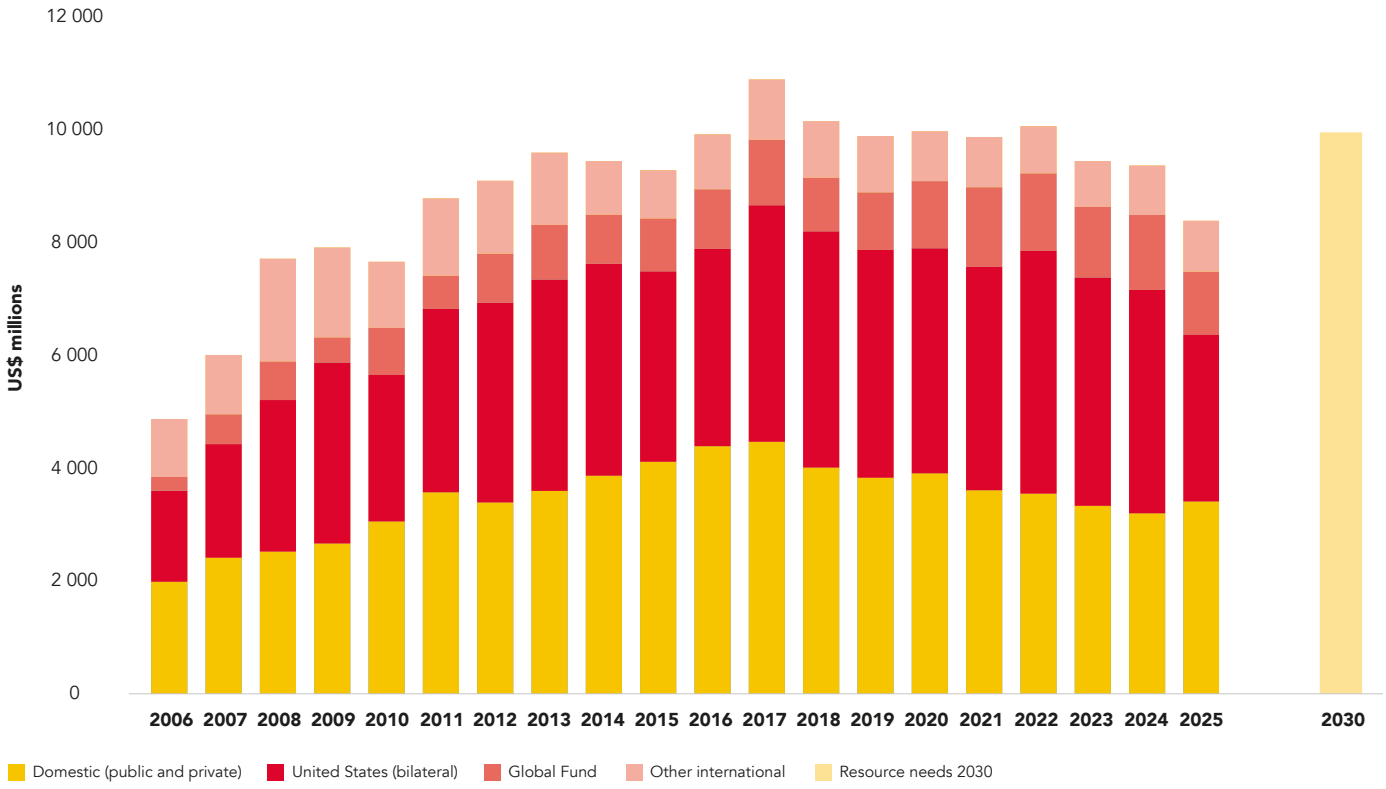
Approximately 40.7% of funding in 2025 was sourced domestically, but this proportion falls to only 20% if South Africa is excluded, underscoring the region's continued reliance on external donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief.

HIV treatment remains relatively well funded, but investment in HIV prevention is low, with only 8% of HIV funding allocated to prevention in Kenya, 10% in Namibia and South Africa, and 12% in Uganda. Although 12 countries in the region have increased domestic HIV budget allocations since 2025, these increases often represent emergency measures to address shortfalls in external financing and may not offset declines in donor funding.

The region continues to depend heavily on external financing for key HIV interventions, including prevention (76%), HIV testing among key populations (81%), paediatric treatment (66%) and strategic information

Funding for HIV in the region has overall been falling since 2016

Figure 13.7. Resource availability by funding source (2006–2025), and 2030 needs, eastern and southern Africa region



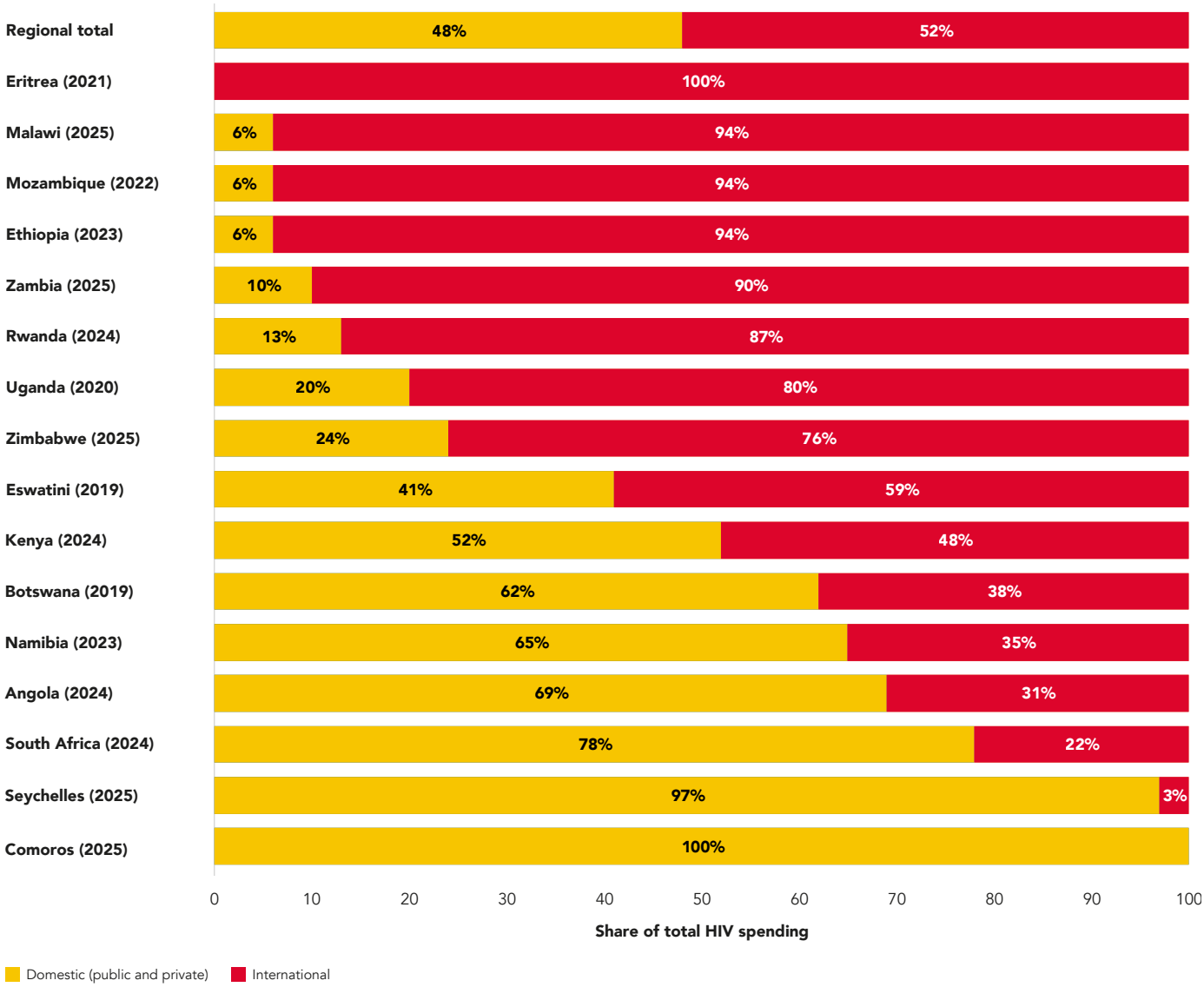
Source: UNAIDS financial estimates.

systems (88%). Meanwhile, high debt-service burdens in countries such as Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe limit fiscal space for health spending, challenging efforts to sustain and expand domestic financing for the HIV response and exposing the fragility of external donor dependence. This evolving financial landscape places critical areas of the response at risk—particularly prevention, social enablers and community-led services—demanding urgent shifts towards domestic ownership, innovative financing and long-term sustainability planning.

Several countries have developed HIV response sustainability roadmaps at the time of production of this report. These plans emphasize national ownership, HIV integration into broader health systems, and increased domestic resource mobilization.

Countries in the region have high levels of dependency on external funding

Figure 13.8. Domestic versus international share of total HIV spending, 2019–2025



Source: Global AIDS Monitoring, National AIDS spending assessments.