

Western and central Africa

2025 DATA

46% decrease in number of new HIV infections since 2010

60% decrease in number of AIDS-related deaths since 2010

People living with HIV: 5.2 million [4.6 million–6.1 million]

New HIV infections: 190 000 [130 000–290 000]

AIDS-related deaths: 110 000 §[84 000–150 000]

Testing and treatment cascade (all ages):

People living with HIV who know their HIV status: 78% [61–96%]

People living with HIV who are on treatment: 74% [57–90%]

People living with HIV who have a suppressed viral load: 68% [60–80%]

Elimination of vertical transmission:

Antiretroviral therapy coverage among pregnant women living with HIV: 70% [58–86%]

Vertical transmission rate: 17% [14–21%]

Financing of the HIV response:

Resource availability for HIV: US$ 1.98 billion—it is critical to mobilize additional domestic resources, sustain and strategically align external support, and maximize efficiency in the use of all available resources.

Numbers of new HIV infections have fallen sharply, but progress remains fragile

Important gains have been achieved in the HIV response in western and central Africa, with the annual number of new HIV infections declining by 46%, from 340 000 [240 000–540 000] in 2010 to 190 000 [130 000–290 000] in 2025. The number of AIDS-related deaths decreased by 60% over the same period (Figure 16.1). The region accounts for 15% of annual new HIV infections globally. Sustaining this progress and closing persistent gaps in reaching adolescent girls, young women and people from key populations will require increased, sustainable financing, particularly as the region navigates a shifting donor landscape.[1] Most countries in the region recorded substantial reductions in numbers of new HIV infections, but increases were observed in Cabo Verde, Congo and Niger.

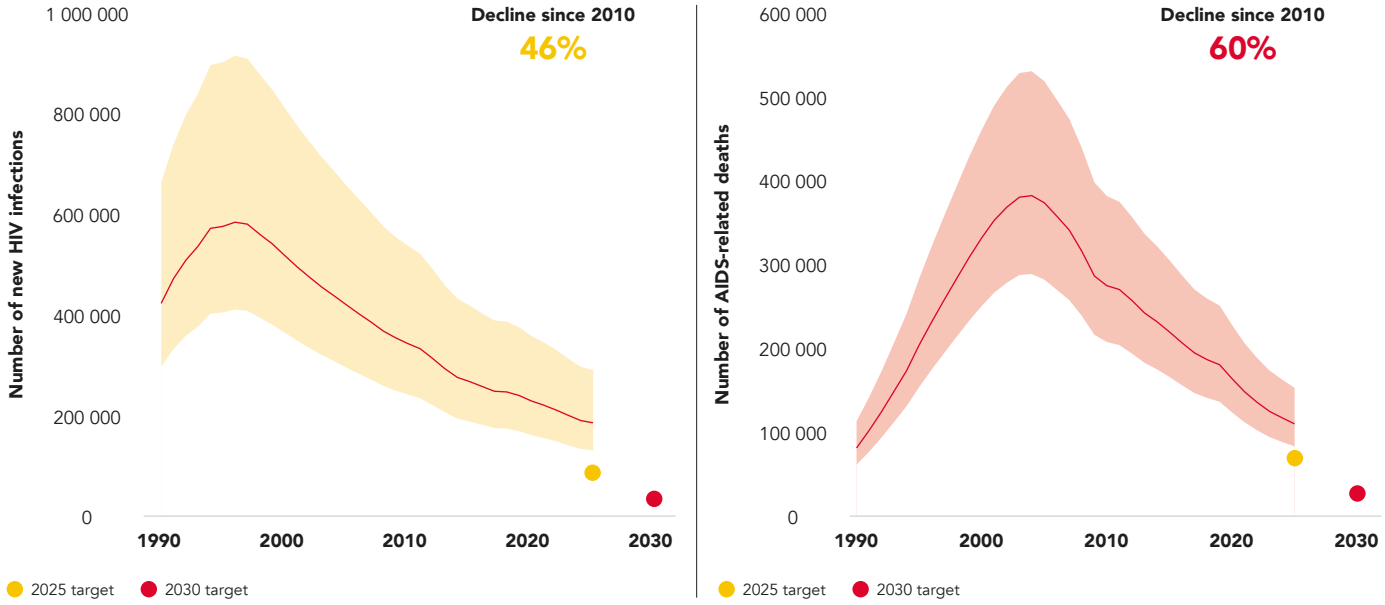
In the region in 2025, adolescent girls and young women aged 15–24 years accounted for 24% of all new HIV infections and were three times more likely to acquire HIV than their male counterparts, who accounted for 7% of all new infections.

The high prevalence of HIV in people from key populations compared with adults in the general population (aged 15–49 years) (Figure 16.2) implies that more efforts are needed to reach these often-marginalized populations and calls for increased investment in primary prevention programmes. It is essential to prioritize increased investment in intensified, better targeted prevention efforts.

1 Global AIDS strategy for 2026–2031: united towards ending AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2026 (https://www.unaids.org/en/resources/documents/2026/2026-2031_Global-AIDS-Strategy).

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

Figure 16.1. Numbers of new HIV infections and AIDS-related deaths, western and central Africa, 1990–2025, 2025 and 2030 targets



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

Treatment coverage is improving, but critical gaps remain in prevention and paediatric care

Despite the funding disruptions of 2025, the percentage of people living with HIV in the region receiving antiretroviral therapy increased from 71% [55–87%] in 2024 to 74% [57–90%] in 2025. HIV treatment services overall have been maintained, with 78% [61–96%] of people living with HIV knowing their HIV status, 74% [57–90%] receiving antiretroviral therapy, and 68% [60–80%] having a suppressed viral load (Figure 16.3). The number of people aged 15 years and over receiving HIV treatment has more than doubled since 2015. Between 2010 and 2025, the number of AIDS-related deaths decreased by 60%. Funding disruptions underline the importance of sustainable financing and forward planning for essential HIV commodities, including antiretroviral medicines, diagnostics and prevention technologies. Better alignment between commodity forecasting, procurement planning and available financing is needed to prevent supply interruptions and protect continuity of services.[23]

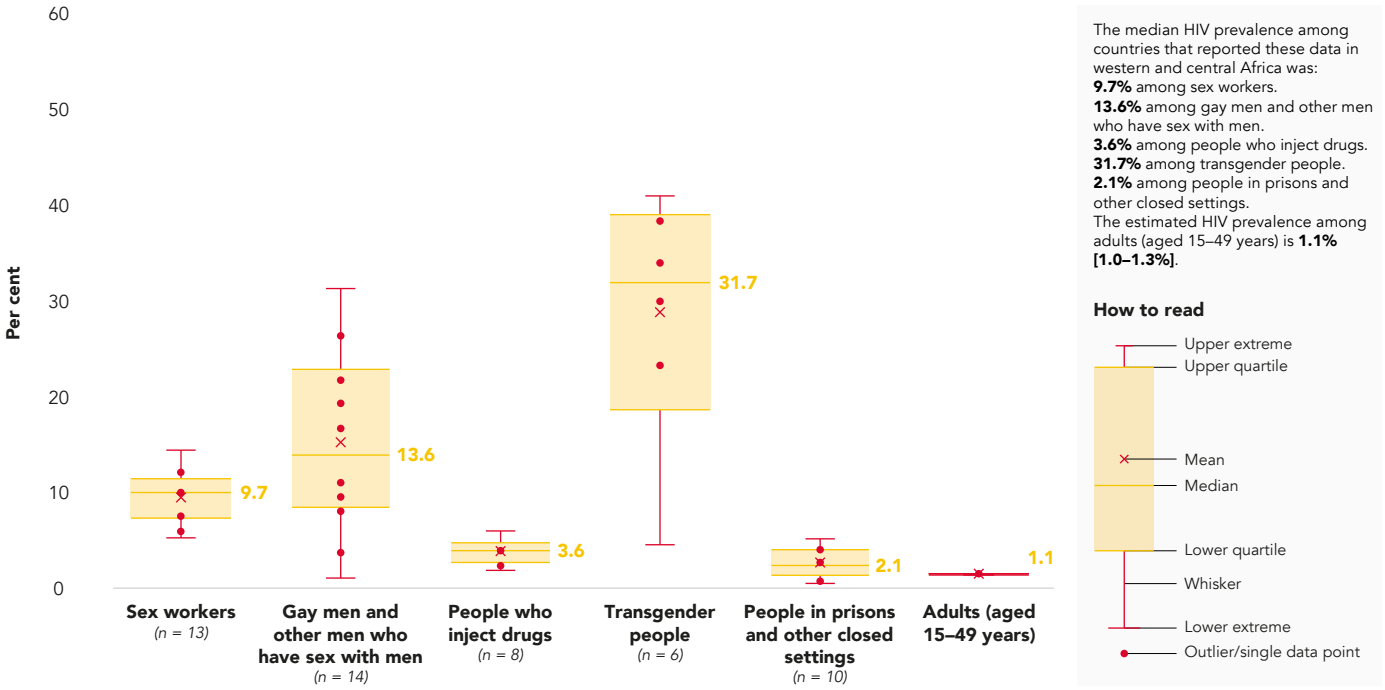
Western and central Africa is home to 18% of pregnant women living with HIV globally. In 2025, 70% [58–86%] of pregnant women living with HIV in the region received antiretroviral medicines to prevent vertical transmission. Treatment coverage among children living with HIV increased slightly, from 37% [26–48%] in 2024 to 41% [28–52%] in 2025, but less than half of children living with HIV were receiving antiretroviral therapy in 2025. With these low coverages, paediatric HIV is a top priority for countries in the region.

2 Impact of the US funding cuts: a snapshot on HIV commodity availability and management risks. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/resources/documents/2025/UNAIDS_focused-analysis_HIV-commodities).

3 2025 HIV market impact memo. Boston, MA: Clinton Health Access Initiative; 2025 (https://www.clintonhealthaccess.org/report/2025-hiv-market-impact-memo-clinton-health-access-initiative/).

Key populations continue to bear a disproportionate burden of HIV in western and central Africa

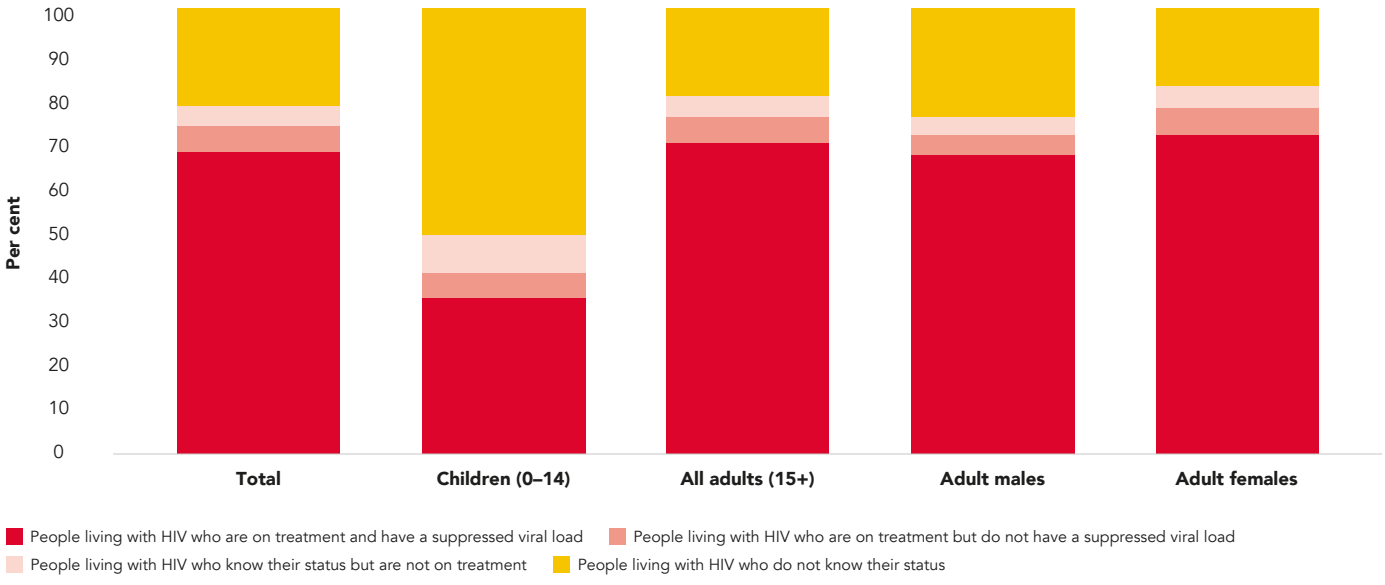
Figure 16.2. HIV prevalence among people from key populations compared with adults (aged 15–49 years), reporting countries in western and central Africa, 2021–2025



Source: UNAIDS Global AIDS Monitoring, 2022–2026; UNAIDS epidemiological estimates, 2026 (https://aidsinfo.unaids.org/).
Notes: n = number of countries. Total number of reporting countries = 25. 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.

> Despite the overall decline in the number of new HIV infections, the region's share of new child HIV infections globally has risen, from 26% in 2010 to 34% in 2025—second only to eastern and southern Africa—demonstrating that progress on paediatric HIV has not kept pace with the region's broader epidemic decline.

Figure 16.3. HIV testing and treatment cascade, by age and sex, western and central Africa, 2025



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

The number of people in the region receiving pre-exposure prophylaxis fell by 70% between 2024 and 2025—the steepest decline in any region globally—highlighting the vulnerability of HIV prevention programmes to funding disruptions. The number of condoms distributed and HIV testing volume increased by a marginal 3% and 1%, respectively, between 2024 and 2025.

Stigma, legal barriers and gender inequality continue to limit access to services

Many countries in the region retain punitive and criminalizing laws related to HIV and people from key populations. Progress towards reaching the 10–10–10 societal enablers targets remains slow. Of 25 countries, twenty-one countries criminalize HIV non-disclosure, exposure or transmission, in three countries HIV non-disclosure, exposure or transmission is a crime under a law that covers a broader range of communicable diseases but does not specifically refer to HIV and two countries do not have laws criminalizing HIV non-disclosure, exposure or transmission but the general law has been used to prosecute cases in the past 10 years. Two criminalize transgender people and 22 have laws criminalizing some aspect of sex work. Fifteen countries criminalize same-sex sexual acts between consenting adults in private (one with the death penalty, one with imprisonment of 14 years to life, 12 with imprisonment of up to 14 years, and one with the penalty not specified), and ten have either never criminalized these acts or have decriminalized them. All 25 countries criminalize possession of small amounts of drugs for personal use. Five countries require mandatory HIV testing for marriage, work or residence permits, or for people from certain groups.

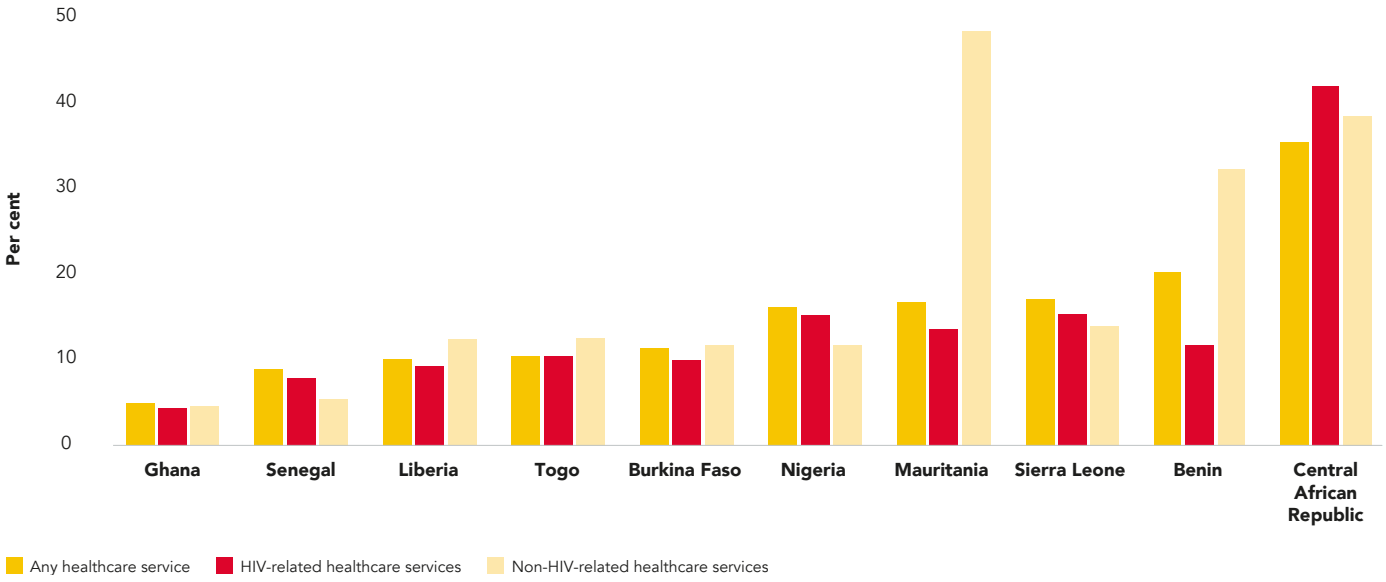
The situation has worsened in recent years. Two countries that had previously never criminalized same-sex relations have now done so—Mali, whose new penal code came into force in December 2024, and Burkina Faso, whose law was adopted in September 2025. In March 2026, Senegal, which already criminalized same-sex acts, doubled the maximum prison sentence to 10 years. Each new law makes it harder for people to seek HIV testing, treatment and prevention without fear of arrest, violence or exposure. Health workers and community organizations become afraid to reach the people most at risk, which weakens the whole HIV response and puts the 10–10–10 targets further out of reach.

Efforts to bring about legal reforms and combat stigmatization and discrimination are under way in several countries, despite increasing hostile narratives against key populations and human rights. The percentage of people living with HIV who have reported experiencing stigma and discrimination in healthcare settings range from 5% in Ghana to 36% in Central African Republic. (Figure 16.4).[4] Adolescents and young people face barriers to HIV testing: twenty countries require parental or guardian consent for HIV testing for young people aged under 18 years. Women face numerous barriers in accessing sexual and reproductive health services, reflected in the low proportion of women who report being able to make their own decisions regarding sexual relations, contraceptive use and health care: only 8% in Senegal, 19% in Côte d'Ivoire, 25% in Mauritania and 52% in Ghana.[5]

4 People Living with HIV Stigma Index 2.0 studies, 2021-2025

5 SDG indicator 5.6.1: women's decision-making on sexual and reproductive health. New York: United Nations Population Fund (https://www.unfpa.org/data/sdg/5.6.1).

Figure 16.4. Percentage of people living with HIV who experienced stigma and discrimination in health-care settings in the past 12 months, countries with available data, western and central Africa, 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.

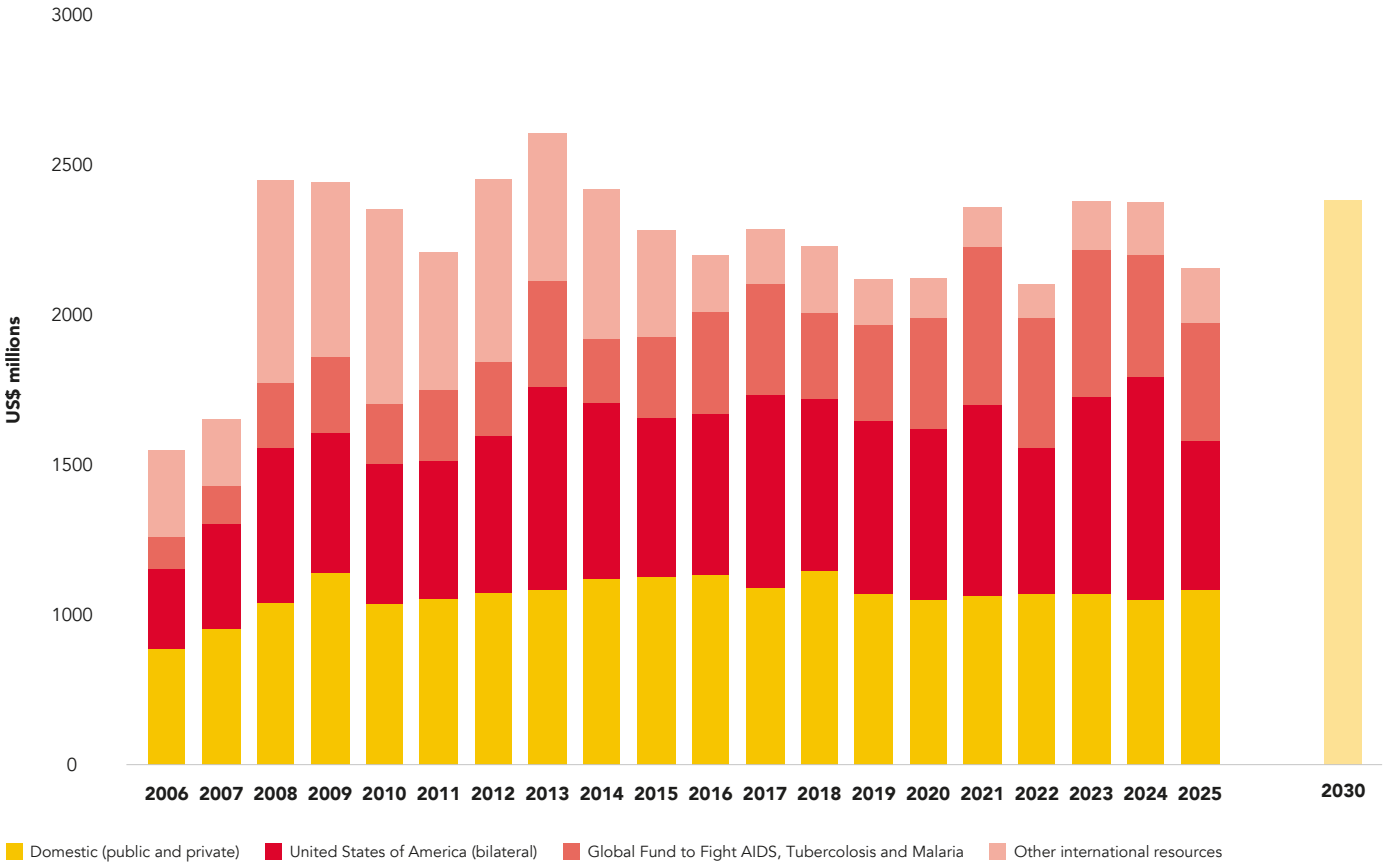
Data from reporting countries highlight the impact of stigma and discrimination on people from key populations. A median of 31% of transgender people (five countries), 30% of people who inject drugs (four countries), 23% of sex workers (11 countries) and 18% of gay men and other men who have sex with men (10 countries) reported experiencing stigma and discrimination in the past six months. A median of 15% of people who inject drugs (six countries), 13% of gay men and other men who have sex with men (10 countries), 11% of transgender people (five countries) and 10% of sex workers (eight countries) reported having avoided health-care services in the past 12 months due to stigma and discrimination.

People from key populations experience high levels of violence. In the region, a median of 28% of people who inject drugs (seven countries), 27% of sex workers (13 countries), 20% of transgender people (six countries) and 9% of gay men and other men who have sex with men (11 countries) reported experiencing physical and/or sexual violence in the past 12 months. Stigma, discrimination and violence push people away from health services, which weakens HIV prevention and treatment results.

Heavy donor dependency leaves the HIV response vulnerable to funding shocks

The region remains highly dependent on external donors for funding the HIV response, which is a key challenge in ensuring the sustainability of efforts (Figure 16.5). Total HIV resources in the region declined by 12% between 2024 and 2025, including a 19.3% reduction in international resources, underscoring the region's continued vulnerability to external financing shocks. Strengthening routine HIV expenditure tracking, including through national AIDS spending assessments and integrated health

Figure 16.5. HIV resource availability in western and central Africa, 2006-2025, and estimated needs for 2030



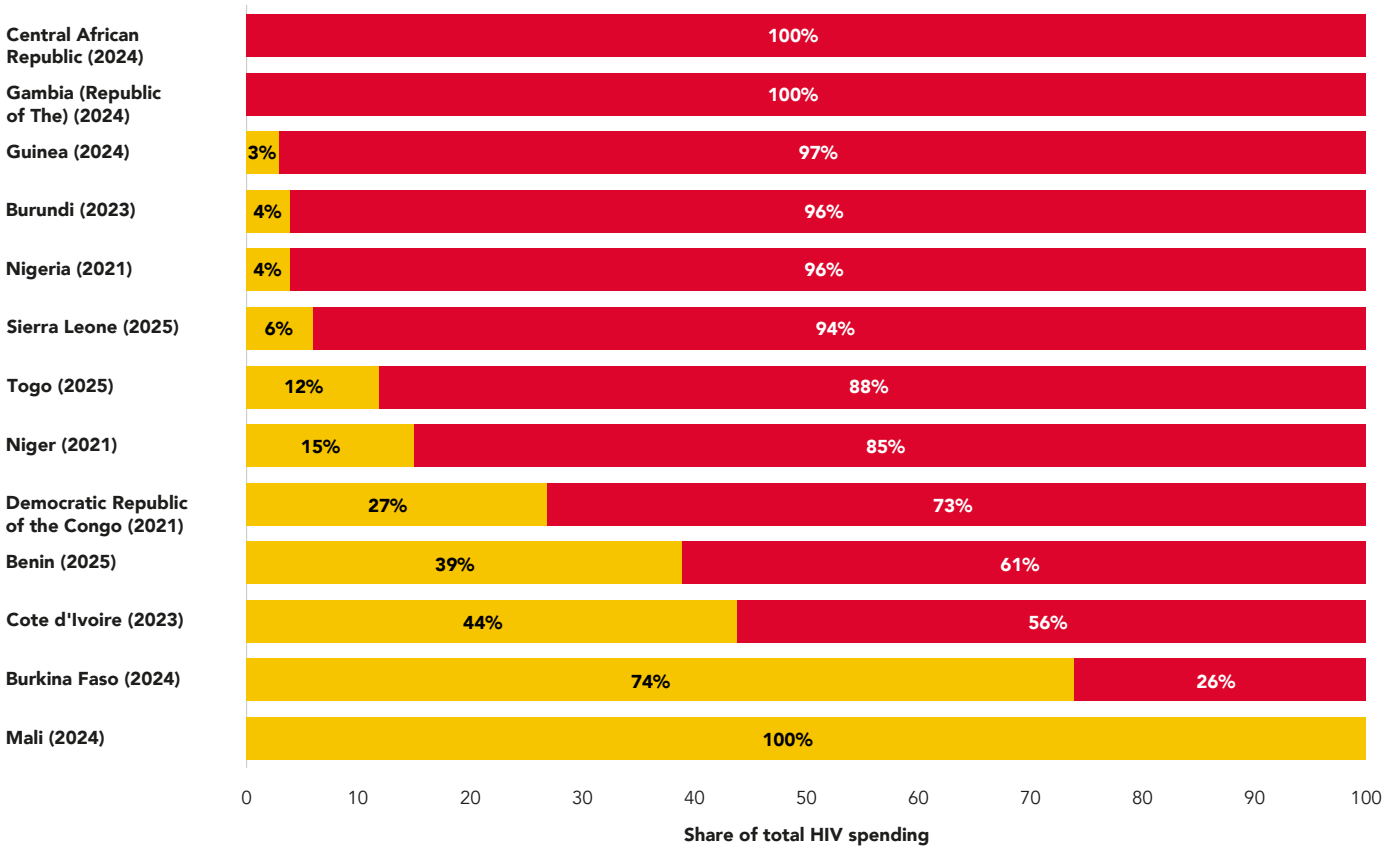
accounts, is critical to improve financing transparency, identify funding gaps, and monitor domestic and external contributions.[6]

Domestic resources account for only 35% of total HIV resources in the region, highlighting a persistent dependence on external support (Figure 16.6). Domestic HIV resources increased by approximately 6% in 2025, demonstrating continued government commitment despite fiscal pressures, but domestic investment remains around 10% below its 2018 peak. Encouragingly, several countries have reported increases in domestic HIV budgets since 2025, including Burkina Faso, Burundi, the Central African Republic, Côte d'Ivoire, Gambia, Mali, Nigeria and Togo. Particularly notable are Côte d'Ivoire, Gambia, Mali and Togo, all of which recorded increases of more than 10%, demonstrating that stronger domestic ownership remains possible even in a constrained fiscal environment. Strengthening domestic co-financing commitments and their effective implementation are increasingly important, particularly in the context of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Grant Cycle 8 and evolving bilateral financing arrangements. Countries need stronger mechanisms to track government commitments, budget allocations and expenditures.[7]

6 Guidelines for conducting a national AIDS spending assessment (NASA). Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/resources/documents/2025/20251114_NASA-guide).

7 Transition and co-financing: technical brief—Grant Cycle 8. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2026 (https://resources.theglobalfund.org/media/3z0njdq2/cr_gc8-transition-and-cofinancing_technical-brief_en.pdf).

Figure 16.8. Domestic versus international share of total HIV spending, 2021–2025



Source: National AIDS Spending Assessments (NASAs)

The recent funding crisis has highlighted the fragility of gains, particularly in key countries with high levels of dependency on external funding, such as Nigeria (96%), Senegal (83%) and Mali (75%). There is a need for an increased focus on domestic resource mobilization to reduce this dependency and strengthen long-term sustainability. Many countries in the region continue to face high debt-servicing obligations, limited fiscal space, and significant dependence on development assistance, making it difficult to sustain and expand HIV programmes through domestic resources alone. Beyond increasing domestic resources, countries need costed HIV sustainability and transition plans with clear financing responsibilities, milestones and accountability mechanisms, progressively embedding HIV financing in national budgets, health financing mechanisms and public financial management systems, while safeguarding essential services, community-led responses, and key and vulnerable populations.[89]

HIV prevention programmes and societal enabler programmes require increases in domestic spending. In 2024, almost a third of new HIV infections occur among people from key populations, their clients and other sex partners,[10] but only about 1% of total HIV resources goes towards prevention interventions for people from these populations.[11]

8 Progress update on sustainability in the HIV response. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/sites/default/files/2025-11/PCB57_Sustainability_Update_EN.pdf).

9 UNAIDS rallies African leaders to remain united to end AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2026 (https://unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2026/february/20260217_au).

10 UNAIDS special analyses, 2025.

11 UNAIDS financial estimates, 2024. Geneva: Joint United Nations Programme on HIV/AIDS; 2024.

In an increasingly constrained financing environment, improving allocative and technical efficiency is essential to protect HIV outcomes. Stronger evidence on programme costs, resource needs, financing gaps and returns on investment can inform prioritization and preserve high-impact interventions, particularly prevention, paediatric HIV services and community-led responses.[12,13]

The region's HIV response is affected by escalating conflict and displacement in the Sahel. In Burkina Faso, attacks have shut down 20% of health facilities, leaving 3.8 million people without access to care.[14,15] Global Fund support of US$ 244 million for 2024–2026 has helped sustain the national HIV response in Burkina Faso, including the transition of all eligible people living with HIV to dolutegravir-based antiretroviral therapy and the rollout of multimonth antiretroviral therapy dispensing to maintain continuity of care despite insecurity.[16] Given limited fiscal space and competing development priorities, countries will also need to explore diversified and innovative financing approaches, including strategic partnerships with the private sector, solidarity-based financing mechanisms, and opportunities to leverage broader health financing reforms to complement, rather than replace, predictable public financing and sustained international solidarity.[9,17]

Substantial gains in the region since 2010 remain fragile in the face of funding volatility, low domestic investment, and persistent gaps in reaching people from key populations, adolescent girls and children. Sustaining and accelerating progress will require countries to strengthen domestic resource mobilization, close the paediatric treatment gap, and remove the legal and social barriers that continue to limit access to HIV services for the people most at risk.

12 Stuart RM, Grobicki L, Haghparast-Bidgoli H, Panovska-Griffiths J, Skordis J, Keiser O, et al. How should HIV resources be allocated? Lessons learnt from applying Optima HIV in 23 countries. J Int AIDS Soc. 2018;21(4):e25097 (https://doi.org/10.1002/jia2.25097).

13 A case study on how allocative efficiency analysis supported by mathematical modelling changed HIV investment in Sudan. Washington, DC: World Bank; 2016 (http://hdl.handle.net/10986/24989).

14 World Bank data on Burkina Faso health facility closures. Geneva: Ecofin Agency; 2025.

15 Burkina Faso to get $250 mln from Global Fund for disease response. Geneva: Ecofin Agency; 2025 (https://www.ecofinagency.com/news/0909-48525-burkina-faso-to-get-250-mln-from-global-fund-for-disease-response).

16 UNAIDS 2026 results and transparency portal: Burkina Faso [website]. Geneva: Joint United Nations Programme on HIV/AIDS; 2026 (https://open.unaids.org/countries/burkina-faso).

17 Africa's health financing in a new era. Addis Ababa: Africa Centres for Disease Control and Prevention; 2025 (https://africacdc.org/news-item/africas-health-financing-in-a-new-era-april-2025/).