



Western and central Europe and North America

2025 DATA

10% decrease in number of new HIV infections since 2010

39% decrease in number of AIDS-related deaths since 2010

People living with HIV: 2.4 million [2.1 million–2.7 million]

New HIV infections: 63 000 [52 000–75 000]

AIDS-related deaths: 9800 [7300–12 000]

Testing and treatment cascade (all ages):

People living with HIV who know their HIV status: 91% [71–>98%]

People living with HIV who are on treatment: 80% [62–91%]

People living with HIV who have a suppressed viral load: 77% [68–85%]

Financing of the HIV response:

Resource availability for HIV and 2030 target

The region is not on track for achieving 2030 targets

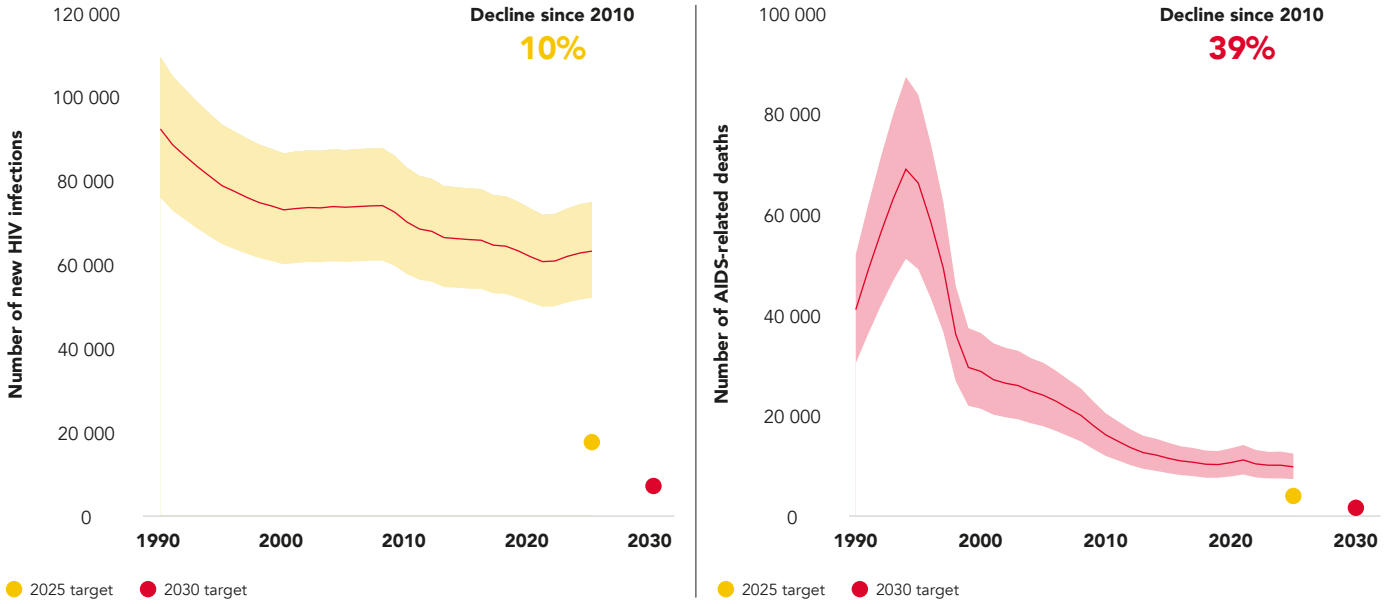
Annual numbers of new HIV infections and AIDS-related deaths in western and central Europe and North America decreased by 10% and 39%, respectively, between 2010 and 2025 (Figure 17.1). This slow reduction in incidence, in particular, is much lower than the 90% reduction target of ending AIDS by 2030.

Despite challenges for programmes and surveillance, several countries in the region markedly reduced numbers of new HIV infections between 2010 and 2025, including Estonia (72%), Ireland (41%), Latvia (70%), Norway (67%), Portugal (72%) and Switzerland (53%). A few countries estimated increases (e.g. Bulgaria, Malta). These countries all had relatively low annual numbers of new HIV infections by 2024–2025, making it difficult to estimate the magnitude of change precisely.

HIV prevalence among people from key populations remains significantly higher than among the general adult population—4.8% among people who inject drugs (16 reporting countries), 2.4% among transgender people (4 countries), 2.3% among gay men and other men who have sex with men (13 countries), 2.2% among people in prisons and other closed settings (10 countries), and 1.5% among sex workers (seven countries) (Figure 17.2).

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

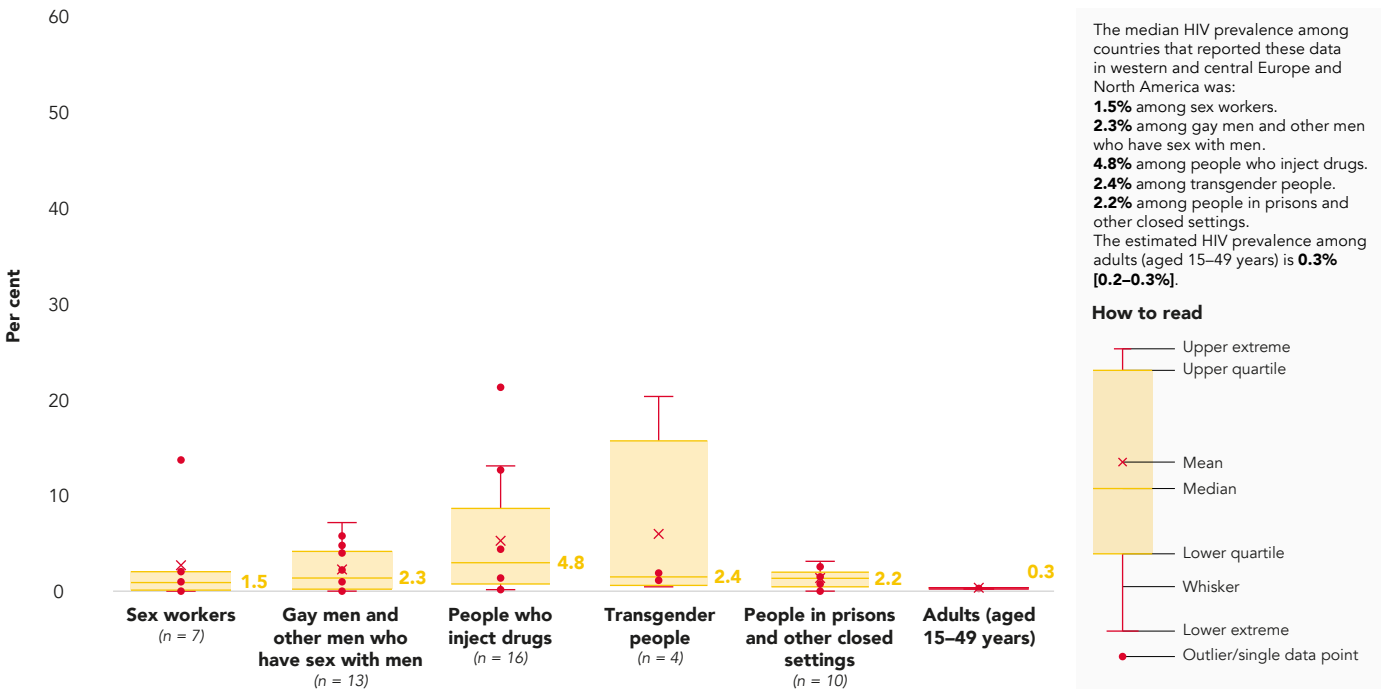
Figure 17.1. Numbers of new HIV infections and AIDS-related deaths, western and central Europe and North America, 1990–2025, 2025 and 2030 targets



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

Key populations remain most affected by HIV

Figure 17.2. HIV prevalence among people from key populations compared with adults in the general population (aged 15–49 years), reporting countries in western and central Europe and North America, 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 = 40. Data presented are from fewer than five reporting countries: transgender people (Canada, Italy, Netherlands and Romania). 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.

High HIV treatment coverage is an important achievement, despite data gaps on migrants

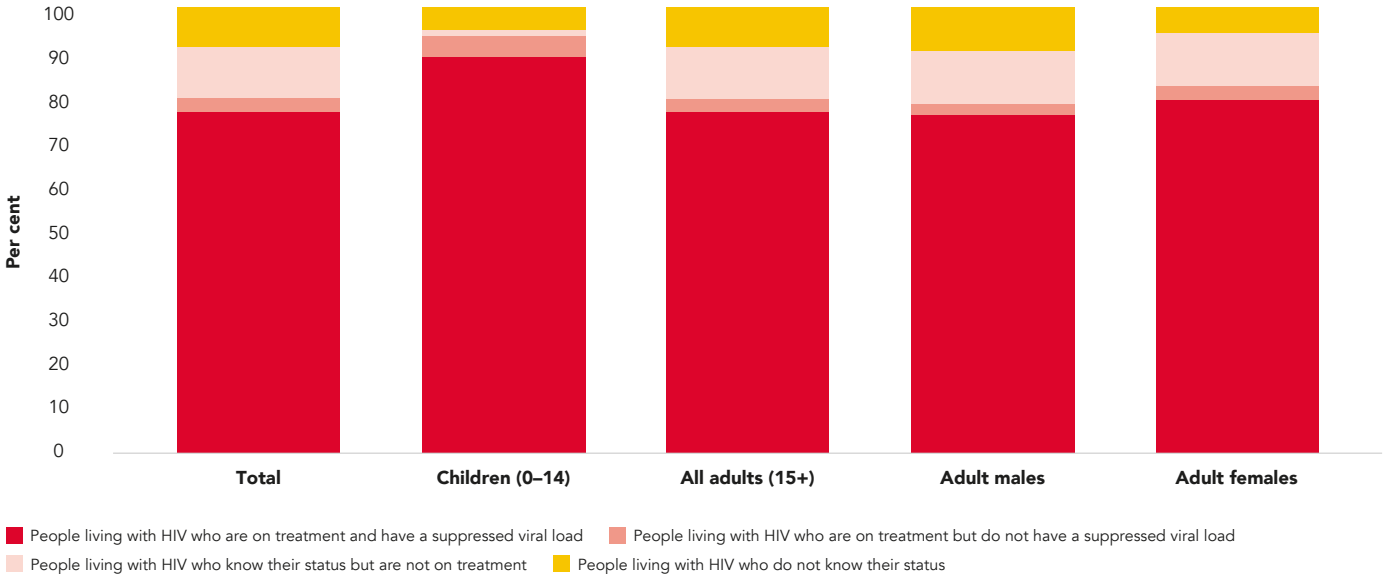
Tracking epidemic trends and progress in HIV testing and treatment in Europe is increasingly complex due to population movements within and beyond the region. Significant gaps remain in HIV burden measurement and access to care among migrants, especially those in vulnerable situations or with irregular status.[1] Harmonizing and integrating programme monitoring and surveillance systems across countries in the region is critical. Programmatically, efforts to re-engage people who have dropped out of care, sometimes starting from a re-diagnosis of HIV, are increasingly important to reach and maintain high treatment coverage.[2]

In this context, maintaining high coverage of HIV testing and treatment services is a real achievement. In 2025 in the region, approximately 91% [71–>98%] of people living with HIV knew their HIV status, 80% [62–91%] were on antiretroviral therapy, and 77% [68–85%] had a suppressed viral load (Figure 17.3).

Of the 1.9 million people on antiretroviral therapy in the region in 2025, an estimated 96 000 (5%) had advanced HIV disease (CD4 cell count below 200/mL[3])—mainly among people who did not have or maintain a suppressed viral load. Of the 490 000 people living with HIV but not on antiretroviral therapy, 126 000 (26%) had advanced HIV disease

HIV testing and treatment cascade, by age and sex, western and central Europe and North America, 2025

Figure 17.3. HIV testing and treatment cascade, by age and sex, western and central Europe and North America, 2025



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

1 Nöstlinger C, Cosaert T, Van Landeghem E, et al. HIV among migrants in precarious circumstances in the EU and European Economic Area. Lancet HIV. 2022;9(6):e428–e437 (https://doi.org/10.1016/S2352–3018(22)00032–7).

2 Progress towards reaching the Sustainable Development Goals related to HIV in the European Union and European Economic Area: monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia—2023 progress report. Stockholm: European Centre for Disease Prevention and Control; 2024 (https://www.ecdc.europa.eu/sites/ default/files/documents/hiv–evidence–brief–progress–towards–sustainable%20development–goals–2023_03.pdf

(Figure 17.4). In both groups, the prevalence of advanced HIV disease is falling slowly, thanks to the impact of expanding early diagnosis and treatment.

Late diagnosis is a risk factor and component of advanced HIV disease. According to European Centre for Disease Prevention and Control and World Health Organization (WHO) surveillance data for 2024, 48% of HIV diagnoses in the European Union and European Economic Area and 54% across the wider region were made at a late stage (CD4 cell count below 350/mm ^{3}). Rates were highest among older adults, reaching 61% (and up to 66% among people aged 50 years or over). Proportions of low CD4 cell counts in programme data are contingent on patterns in diagnoses and case reporting. These data confirm the persistence of advanced HIV disease among people initiating or re-initiating treatment and highlight the need for targeted testing strategies for older adults.[4]

The number of people receiving pre-exposure prophylaxis (PrEP) in the region increased by 18% between 2024 and 2025 (18 reporting countries), reflecting continued investment in HIV prevention. Harm-reduction coverage for people who inject drugs is comparatively strong where reported, with 90% reporting using sterile injecting equipment the last time they injected drugs (seven countries).

The population of people living with HIV in the region is ageing rapidly: 52% were aged 50 years or over in 2025 (52% of men, 53% of women), up from 28% in 2010. This reflects the success of antiretroviral therapy in extending life expectancy but also raises new challenges for integrating HIV care with services for age-related comorbidities and noncommunicable diseases.[5] The high and rising share of older adults in the region places it ahead of the global curve and underscores the urgency of age-appropriate prevention, testing and integrated care models.

Stigma, discriminatory laws and racial disparities continue to limit access to HIV services

HIV-related stigma and discrimination remain barriers to accessing HIV services across western and central Europe[6] and North America.[7]

In the United States of America, people from African American and Hispanic or Latino communities remain disproportionately affected by HIV. In 2024, Black or African American people accounted for 39% of new HIV diagnoses, despite representing only about 12–13% of the population, with a diagnosis rate more than eight times higher than that among White people (approximately 42 versus 5 per 100 000). Hispanic or Latino people

3 HIV/AIDS surveillance in Europe 2025 – 2024 data. Stockholm/Copenhagen: European Centre for Disease Prevention and Control/WHO Regional Office for Europe; 2025

4 UNAIDS special analyses of 2026 national epidemiological trend estimates

5 European standards of HIV prevention and care: Module on HIV and co-morbidities https://www.ecdc.europa.eu/sites/default/files/documents/ECDC-EACS-standards-of-care-HIV-comorbidities.pdf

6 HIV stigma in the healthcare setting: monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia. Stockholm: European Centre for Disease Prevention and Control; 2024 (https://www.ecdc.europa.eu/en/publications–data/hiv–stigma–healthcare–setting–monitoring–implementation–dublin–declaration).

7 Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2017–2021: national profile. HIV Surv Suppl Rep. 2023;28(3).

accounted for about a third of new HIV diagnoses, with a diagnosis rate nearly five times higher than that among White people. These persistent disparities, which are especially pronounced among young Black men and in the southern United States, continue to be driven by structural and social determinants of health.[8]

In Canada, people from Black and Indigenous communities continue to be disproportionately represented among new HIV diagnoses. Among first-time diagnoses in 2024 for which race or ethnicity data were reported, 31.6% were among Black people, 25.4% among White people and 7.1% among Indigenous Peoples (First Nations, Inuit or Métis). Race and ethnicity data are incomplete, however, and available for only 38.1% of diagnoses.[9]

Discriminatory laws that target people from key populations at risk of HIV in the region—such as criminalization of sex work, same-sex relations or possession of small amounts of drugs for personal use—continue to limit access to services. 33 countries in the region have laws criminalizing some aspect of sex work; at least 27 countries have laws criminalizing possession of small amounts of drugs; 22 countries have laws criminalizing HIV non-disclosure, exposure or transmission and 13 countries have used the general criminal law to prosecute cases in the past 10 years.[10] No countries in the region criminalize same-sex sexual acts.

HIV-related stigma and discrimination remain major barriers to accessing HIV services for people living with HIV in the region. Health-care workers responding to a European Centre for Disease Prevention and Control survey in 2023 reported observing multiple forms of stigma and discrimination against people living with HIV within their place of work over the past 12 months. Of those surveyed, 30% had witnessed discriminatory remarks or derogatory comments, 22% unwillingness to provide care, 19% nonconsensual disclosure of HIV status, and 18% poorer quality of care (Figure 17.5).

Migrants accounted for 46.8% of new HIV diagnoses in the European Union and European Economic Area in 2024,[11] underscoring the need for HIV prevention services targeting the most vulnerable people. A substantial proportion of HIV acquisitions among migrants are acquired post-migration (pooled estimate 30% across European studies)[12] and linked to structural barriers to care and vulnerabilities related to sexual health, legal status, stigma and limited access to prevention tools such as PrEP.[13, 14]

8 CDC. HIV Diagnoses, Deaths, and Prevalence of HIV in the United States and 7 Territories and Freely Associated States, 2024 (or the 2024 National HIV Surveillance data release, May 2026). https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-prevalence.html

9 Public Health Agency of Canada. HIV in Canada, Surveillance Report to December 31, 2024: Executive summary. Ottawa: PHAC; 2025.

10 National Commitments and Policy Instrument, 2017-2026 supplemented by additional sources (see https://lawsandpolicies.unaids.org/).

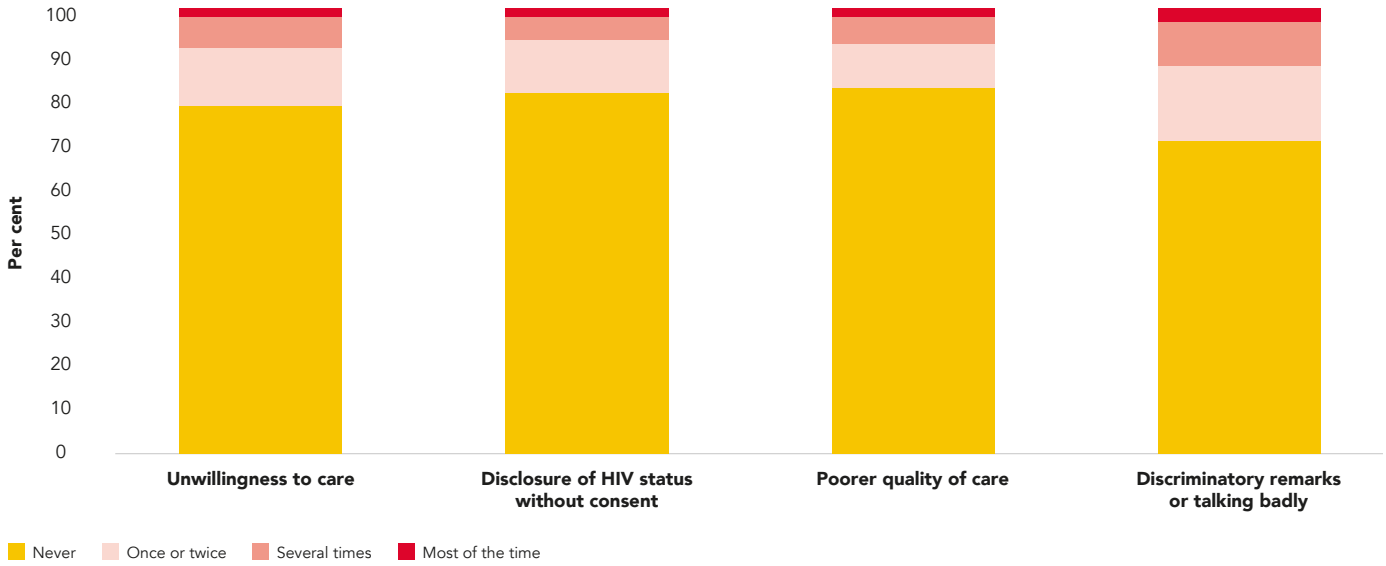
11 HIV/AIDS surveillance in Europe 2025 – 2024 data. Stockholm/Copenhagen: European Centre for Disease Prevention and Control/WHO Regional Office for Europe; 2025

12 Mann S, Mougammadou Z, Wohlfahrt J, Elmahdi R. Post-migration HIV acquisition: a systematic review and meta-analysis. Epidemiol Infect. 2024;152:e49. doi: 10.1017/S0950268824000372.

13 European Centre for Disease Prevention and Control. Prevention, testing and treatment services for migrant populations in relation to HIV, tuberculosis, viral hepatitis and sexually transmitted infections. Stockholm: ECDC; 2026 (https://www.ecdc.europa.eu/en/publications-data/prevention-testing-and-treatment-services-migrant-populations-relation-hiv). See also the companion report: From evidence to practice – successful models for improved testing, linkage to and retention in care for migrant populations… Stockholm: ECDC; 2026.

14 S. Fernandez-Castelao, I. Armenteros, E. Orviz, Post-migration HIV acquisition and structural barriers among migrants newly diagnosed with HIV in a monographic STI clinic in Madrid, Spain, Conference Abstract, July 2026, International AIDS Conference, Rio de Janeiro.

Figure 17.5. Proportion of health-care workers surveyed who have observed different forms of stigma and discrimination towards people living with HIV at their place of work during the past 12 months, Europe and central Asia, 2023



Source: European Centre for Disease Prevention and Control. HIV stigma in the healthcare setting. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia. Stockholm: ECDC; 2024.

In France, 62% of migrant gay men and other men who have sex with men living with HIV acquired their HIV infection within the first year of arrival in the country.[15] Similar patterns are observed in Canada: among Black females diagnosed as living with HIV in Ontario, 54% of diagnoses occurred in the year of arrival and 89% within five years of arrival.[16] Contextual factors (e.g. legal status of same-sex sexual activity in the country of birth) and individual factors (e.g. social disadvantage and sexual behavioural risks) contribute to a relatively high risk of HIV acquisition soon after migration in Sweden[17] and the United Kingdom of Great Britain and Northern Ireland.[18]

15 Palich R, Arias–Rodríguez A, Duracinsky M, et al. High proportion of post–migration HIV acquisition in migrant men who have sexwith men receiving HIV care in the Paris region, and associations with social disadvantage and sexual behaviours: results of the ANRS–MIE GANYMEDE study, France, 2021 to 2022. Euro Surveill. 2024;29(11):2300445 (https://doi.org/10.2807/1560–7917. ES.2024.29.11.2300445).

16 New Ontario/Canada: Kroch A et al. The evolving HIV epidemic in Ontario, Canada: A retrospective analysis of new HIV diagnoses to identify subpopulations with persistent risk of HIV transmission. Canadian Journal of Public Health. 2025. Link: https://link.springer.com/article/10.17269/s41997-025-00997-8

17 Brännström J, Sönnerborg A, Svedhem V, et al. A high rate of HIV–1 acquisition post immigration among migrants in Sweden determined by a CD4 T–cell decline trajectory model. HIV Med. 2017;18(9):677–684 (https://doi.org/10.1111/hiv.12509).

18 Stirrup O, Tostevin A, Ragonnet–Cronin M, et al. Diagnosis delays in the UK according to pre or postmigration acquisition of HIV. AIDS. 2022;36(3):41522 (https://doi.org/10.1097/QAD.0000000000003110).