Ending AIDS Starts With Access



UNAIDS GLOBAL AIDS UPDATE 2026

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Contents

Foreword 4

Executive summary 7

1. THE STATE OF THE HIV EPIDEMIC AND RESPONSE IS DRIVEN BY ACCESS TO HIV PREVENTION AND TREATMENT SERVICES 12

Numbers of new HIV infections are declining—but not quickly enough 15

Fewer people are dying from AIDS-related illnesses 21

HIV funding cuts are creating turmoil 26

References 34

2. IMPROVING ACCESS TO HIV SERVICES FOR ALL 35

Too many barriers are in the way 37

Treatment services are expanding, but slowly and unevenly 46

HIV prevention is under pressure 58

References 70

3. A FINANCING CRISIS AND THE WAY FORWARD FOR THE HIV RESPONSE 73

Funding shifts threaten country HIV programmes 74

Community leadership in the HIV response 85

Integration is an important and complex priority 93

Partnerships and innovations will get us to the last mile 103

References 108

Foreword

Winnie Byanyima
Executive Director, UNAIDS
United Nations Under-Secretary-General



When I reflect on how far we have come in the response to HIV, I feel both pride and deep concern—pride in what humanity has achieved through science, solidarity and struggle; but concern that, at the very moment when we have the tools to end AIDS as a public health threat, political choices and deepening inequalities threaten to put that goal beyond our reach.

I remember when an HIV diagnosis was effectively a death sentence. Today, 32.1 million people are receiving lifesaving treatment, with 29 million of those in developing countries. This extraordinary achievement did not happen by chance. It was reached through the courage and determination of people living with HIV, activists and communities who challenged pharmaceutical monopolies, confronted discrimination and demanded that lifesaving medicines be made accessible to all.

Science has now brought us to another turning point. Lenacapavir, an HIV prevention injection administered only twice a year, could transform our ability to prevent new infections. By October 2026, 175 000 people in nine sub-Saharan African countries had received it. From 2027, generic versions are expected to become available at just US$ 40 per person per year in eligible lower-income countries. Other long-acting prevention and treatment technologies are advancing rapidly.

These innovations offer extraordinary hope, particularly for adolescent girls and young women in Africa, who continue to face an unacceptable burden of new infections.

But I have learned one lesson from decades of fighting inequality: a scientific breakthrough is not a public health breakthrough until it reaches the people who need it.

This is why this year's World AIDS Day theme—Ending AIDS Starts With Access—is so important.

Access is not simply about the availability of medicines. It is about affordability. It is about whether a young woman has the power to protect herself. Whether a gay man can seek health care without fear of arrest. Whether a sex worker can enter a clinic without humiliation. Whether people living with HIV can receive treatment without stigma or discrimination.

Access is about power, rights and justice.

And today, all three are under attack.

The global response to HIV has been shaken by a financing crisis of historic proportions. International HIV assistance fell by 18% in 2025, disrupting essential services and threatening hard-won gains. Community-led organizations—often the only lifeline for the most marginalized people—have been among the first to lose funding.

We must be clear about what these cuts mean. They are not simply numbers in a budget. They mean people missing treatment, young women losing access to prevention, and communities being left without the services on which their lives depend.

At the same time, organized anti-rights movements are attacking gender equality, sexual and reproductive health and rights, and the rights of LGBTQIA+ people. Civic space is shrinking. Discriminatory laws and policies are driving people away from health services.

We cannot end AIDS while denying people their rights. And we cannot protect the gains of the AIDS response while dismantling the community organizations that made those gains possible.

The financing crisis has also forced an overdue conversation about the future of the HIV response. I welcome the growing determination of countries to strengthen national ownership, increase domestic investment and integrate HIV services into national health systems.

But national ownership cannot mean abandoning international solidarity. Nor can countries be expected to assume greater responsibility while crushing debt burdens and an unjust international financial architecture denies them the resources to invest in their people's health.

We need debt relief, fairer international financing rules and greater fiscal space for developing countries. We must also reform the rules governing intellectual property so that publicly supported scientific innovation serves the public good, rather than allowing monopolies and high prices to determine who lives and who dies.

These are political choices. Different choices are possible.

Thirty years ago, UNAIDS was created because the world recognized that defeating AIDS required something different—a joint effort bringing together governments, the United Nations, scientists and communities. This model of solidarity and shared leadership has helped transform the course of the HIV pandemic.

This year, the future of UNAIDS itself was called into question. Yet, in the face of enormous pressure, countries came together to adopt the ambitious new United Nations Political Declaration on HIV/AIDS and reaffirm the importance of a coordinated global response.

I draw strength from this commitment. And even more from the extraordinary resilience of communities.

Throughout my years leading UNAIDS, I have seen people living with HIV, women's movements, LGBTQIA+ activists and other community leaders refuse to surrender, even in the most hostile circumstances. They have defended rights, challenged injustice and kept services alive when institutions failed them.

They remind us that progress is never inevitable. It must be fought for, defended and renewed.

The new Political Declaration offers a pathway forward. If its commitments are fulfilled, an estimated 3.2 million new HIV infections and 1.3 million AIDS-related deaths could be averted by 2030.

As I approach the end of my tenure at UNAIDS, I remain convinced that ending AIDS as a public health threat is achievable. But it will not happen through science alone, nor through declarations that remain promises on paper.

It will take political courage: to invest in people, defend human rights, confront inequality and put the public good before private profit.

The communities most affected by HIV have shown this courage for decades. Now governments and the international community must match it.

We have the science. We know what works. We know what stands in our way.

The question is no longer whether we can end AIDS. It is whether we will make the choices necessary to do so.

We must not fail this generation.

Executive summary

The world has moved closer towards controlling the HIV pandemic, but changes in funding and resulting service disruptions jeopardize this progress.

The number of AIDS-related deaths has been reduced to its lowest level in more than two decades, testament to the extensive coverage and improved quality of treatment and care programmes. An estimated 32.1 million [28.2 million–33.4 million] people living with HIV (78%) were on lifesaving treatment in 2025, up from 500 000 [440 000–520 000] in 2000.[1]

Progress in the HIV response, but inequalities remain

Among the 41.0 million [35.3 million–47.5 million] people living with HIV worldwide, the proportion of people accessing antiretroviral therapy increased from 2% [1–2%] in 2000 to 78% [59–94%] in 2025. Despite this progress, HIV remains a major public health threat. Approximately 570 000 [430 000–780 000] people around the world lost their lives to AIDS in 2025, equivalent to almost 1600 deaths per day.

As more people living with HIV take antiretroviral medicines, the risk of HIV transmission is also decreasing *(1, 2)*. An estimated 1.2 million [950 000–1.7 million] people acquired HIV in 2025—42% less than in 2010. The steepest declines were among children aged 0–14 years in sub-Saharan Africa—a 69% drop since 2010.

Progress has been uneven, however. In sub-Saharan Africa, almost two-thirds (380 000 [270 000–540 000]) of new HIV infections in 2025 were among women. Outside sub-Saharan Africa, where an estimated 69% of new infections are among people from key populations and their sex partners,[2] the annual number of new HIV infections has changed little in the past five years. Children, men and people from key populations remain less likely to receive HIV treatment. Efforts to reduce these disparities have suffered setbacks over the past two years (see Chapter 1).

HIV programmes face multiple threats

Funding losses have destabilized HIV programmes worldwide, coinciding with a wider contraction in official development assistance over the years. The 23% drop in official development assistance in 2025 was the steepest year-on-year decline in history *(3)*, with HIV programmes experiencing an 18% decrease in international financing (see Chapter 3).

The United States Government remains the single largest source of international HIV funding, and is the source of more than 73% of all

1 All data presented in this report that are not sourced are available at https://aidsinfo.unaids.org/.
2 UNAIDS special analyses 2025.

donor government funding in the HIV response for low- and middle-income countries. United States bilateral contributions fell by 26%, however, between 2024 and 2025, and disbursements from the Global Fund to Fight AIDS, Tuberculosis and Malaria dropped by 13% in 2025 compared with 2024.[3] Contributions from other major donors had already declined by about 58% between 2010 and 2024. The impact of the United States Government funding cuts has been especially dramatic given the reliance of many countries on its support for core HIV programmes.

Total resources for the HIV response have fallen steeply as a result, with the three regions most heavily affected by HIV losing at least 12% of their HIV funding in 2025. Some of the largest funding reductions occurred in countries with high HIV burdens and limited fiscal space to increase funding for HIV.

Many low- and middle-income countries responded, with domestic HIV spending increasing slightly between 2024 and 2025 to account for approximately 59% of total HIV resources. This increase partly reflected the sharp decline in external resources, however, and was far from sufficient to compensate for the reductions in international funding.

Governments acted quickly to safeguard their HIV treatment programmes, but prevention services and community systems have been badly affected (see Chapter 2). Condom and voluntary medical male circumcision programmes have lost funding, the number of people using oral pre-exposure prophylaxis (PrEP) has fallen, and outreach and other support services for people from key populations and for adolescent girls and young women have been disrupted in several countries. There are also signs of increasing stress on testing and treatment programmes. Fewer HIV tests and viral load tests are being conducted, and the number of people starting HIV treatment for the first time has declined.

The effects of these disruptions are expected to spread unevenly across regions and populations, exacerbating existing health, gender and socioeconomic inequities. Much of the impact will be felt in sub-Saharan Africa, which continues to have the highest burden of HIV. It may take several years for the full consequences of service disruptions to emerge, by which point epidemic trajectories could already have changed substantially.

The setbacks have come at a time when an increasing number of countries are demonstrating that remarkable gains against HIV are achievable. Seven countries with high HIV burdens have reduced the number of people acquiring HIV per year by more than 78% since 2010, and 12 countries are providing at least 90% of people living with HIV with lifesaving antiretroviral medicines.

These accomplishments are not yet the norm. HIV infection can be prevented and treated, but millions of people still cannot access the services and tools that will keep them HIV-free or enable them to live long, healthy lives if they acquire HIV.

Access barriers are slowing progress

Persistent barriers continue to impede faster progress. They include health system deficiencies; unaffordable costs of health care; staffing and other shortages; stigma, discrimination and persecution; gender-based violence; and harmful norms and punitive laws that prevent access to HIV prevention and treatment services. Many

3 Note that 2025 marked the third year of the Global Fund grant cycle, at which point disbursements typically decline.

countries have sought to remove at least some of these barriers and make HIV services more accessible and user-friendly, but the efforts are not yet extensive enough and they are now experiencing major setbacks.

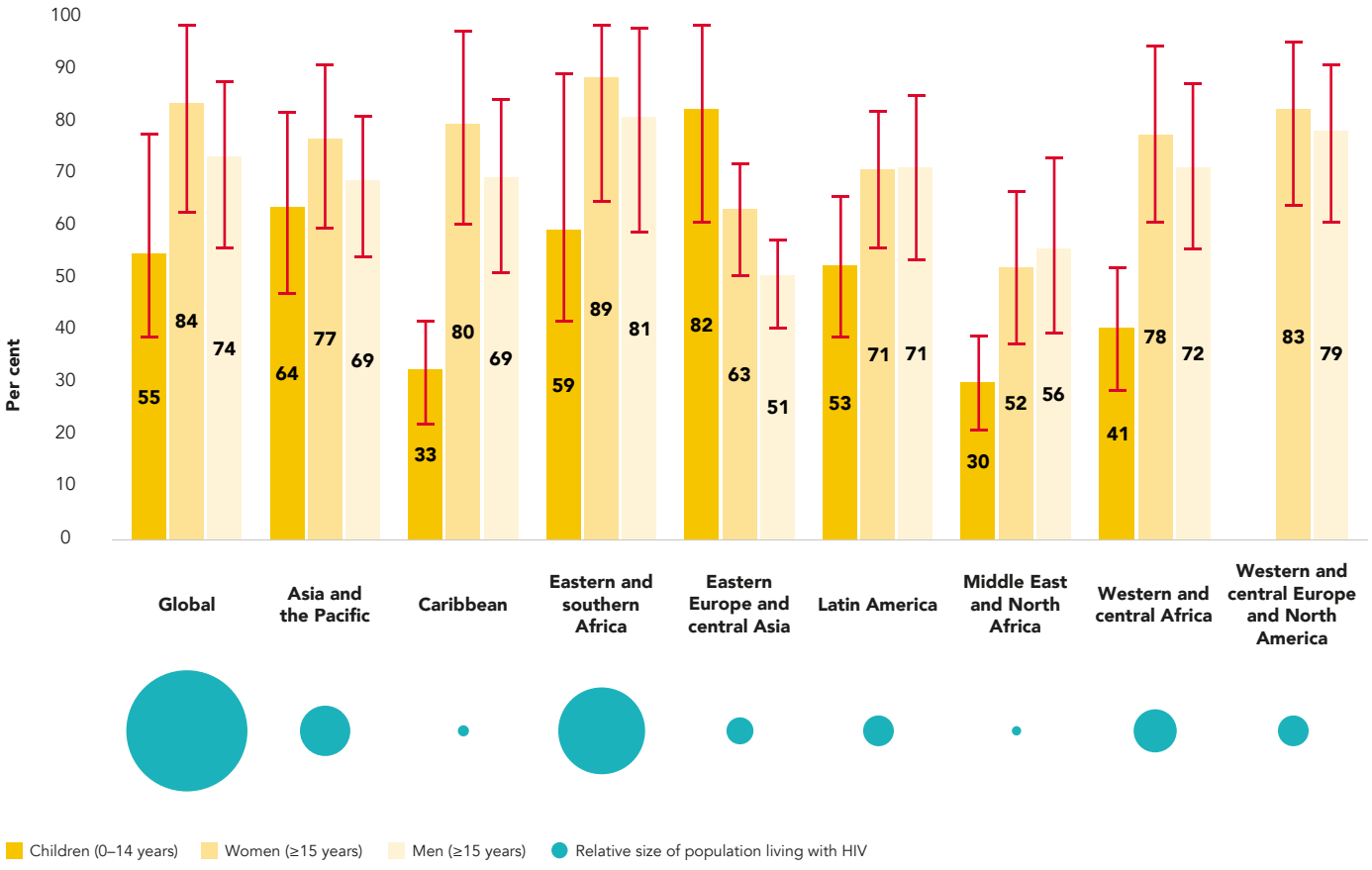
Primary HIV prevention programmes have experienced major funding disruptions, and community organizations have had to halt or cut back on outreach and peer support work, eroding HIV services. Data and procurement systems are under stress. In many places, this is happening amid orchestrated campaigns against human rights protections, with civic space becoming increasingly constrained *(4)*.

Paediatric HIV care remains a critical gap in the global HIV response. Of the estimated 1.3 million [1.0 million–1.7 million] children aged 0–14 years living with HIV in 2025, more than 80% were living in only 20 countries (mostly in sub-Saharan Africa). Bridging the gap in these countries would dramatically accelerate the efforts to end AIDS in children. Almost half of the children living with HIV (45% or 570 000) were not receiving HIV treatment.

Men living with HIV continue to be less likely than their female peers to be on HIV treatment in most regions (Figure 0.1). Even though treatment coverage is higher among women, considerably more women than men living with HIV were not receiving antiretroviral therapy in 2025 in sub-Saharan Africa (2.2 million women, 1.9 million men). This reflects the fact that there are more women than men living with HIV in sub-Saharan Africa.

HIV treatment coverage among people from key populations is lower than for

Figure 0.1. Percentage of people living with HIV receiving antiretroviral therapy, by age and sex, and by region, 2025



Source: UNAIDS estimates 2026.

the overall population of people living with HIV in most countries. Access to HIV and other health-care services for people from key populations continues to be restricted by hostile legal environments, harassment and violence, compounded by stigma, discrimination and gender inequalities.

Due to these barriers and gaps along the cascade of HIV testing and treatment services, 8.9 million people living with HIV were not receiving treatment in 2025, and 10.6 million did not have a suppressed viral load. Closing treatment gaps will protect the health and lives of people living with HIV, make it much easier for the rest of the population to stay HIV-free, and reduce additional treatment costs and strain on health systems in the future.

Notably, the people missing out on the benefits of HIV treatment are in a relatively small number of countries: about 60% of people who did not have a suppressed viral load in 2025 resided in only 20 countries. Reducing access barriers and achieving rapid improvements in testing and treatment programmes in the countries with the largest gaps will have a major impact on the evolution of the global HIV pandemic.

The full potential of primary prevention options is yet to be realized. Two years of funding cuts have made it more difficult to access these services and tools, but there are efforts to increase access to new HIV prevention options. Many prevention programmes designed for adolescent girls and young women in sub-Saharan Africa are being dismantled as funding levels decline. Wider access to PrEP could boost HIV prevention, but over 13% fewer people were using PrEP in 2025 than in 2024, with people from key populations being the most affected by this decline.

Programmatic rollout of lenacapavir began in late 2025 in the first of 24 early-adopter low- and middle-income countries. As of November 2026, there have been 175 000 new initiations across nine countries *(5)*.[4]

Condom programmes have been defunded steadily over recent years. The total number of condoms distributed fell from 3 billion to 2.7 billion between 2024 and 2025.[5] Accessing basic HIV prevention services remains particularly difficult for people from key populations. Harm reduction interventions are in crisis in many countries, and outreach activities are being cut back.

HIV funding must be diversified and protected

The effects of the funding losses show the fragility of the progress made against the HIV pandemic and underscore the urgent need to diversify and protect HIV financing. Countries are trying to adapt rapidly to these new conditions. Fifty-five countries have reported increases in their domestic public budgets for HIV since 2025, despite difficult fiscal environments and other challenges, but these emergency responses could not offset the large shortfalls caused by international support being withdrawn.

The funding shifts of the past two years reinforce an ongoing need for diversified and equitable financing strategies that can protect progress in the HIV response and other public health priorities. These financing transitions cannot proceed at the same pace in all countries: the field is uneven and the options available differ widely. There continues to be a focus on self-reliant and sustainable

4 Eswatini, Kenya, Lesotho, Mozambique, Nigeria, South Africa, Uganda, Zambia, Zimbabwe.

5 Reaching a targeted level of 80% condom use at last sex with non-regular partners and 95% condom use during paid sex among sex workers and clients requires that approximately 20 billion condoms are distributed or sold for HIV prevention per year (6 billion in Africa and 14 billion for people from key populations in other regions) *(6)*.

HIV responses, although transitions may be occurring at a pace that does not match country readiness. For the foreseeable future, many countries will require continued global solidarity to ensure responsible transition of their HIV responses, while preparing for phased increases in domestic contributions.

A path forward for the HIV response

The global effort to end a pandemic that has claimed an estimated 44.2 million [36.7 million–55.0 million] lives now has to regroup. The path ahead requires renewed global solidarity, stronger and equitable domestic investment, carefully sequenced transitions, and sharper allocation of funds to the programmes and populations where they can have the greatest impact.

Strengthening the HIV response through country-led sustainability efforts, with a focus on deeper integration of the HIV response with other health, community and social services and systems, and especially with primary health care, is increasingly seen as a prerequisite for ending AIDS as a public health threat. But special care is needed to ensure primary health-care systems preserve the people-centred and rights-based approaches that underscore the most successful HIV programmes.

Funding for community-led HIV services and support—which has never adequately reflected the vital importance of this work—has been withdrawn in the past two years. This support must be restored so that community-led organizations can continue to be the backbone of HIV responses, especially for marginalized populations.

Governments and affected communities have shown that when barriers are removed or sidestepped—and when the underlying health and community systems function well—more people can access, use and benefit from HIV services, and countries can move closer to controlling their HIV epidemics.

For decades, the HIV response has been powered by community activism, scientific knowledge and innovation, political will, adequate funding, well-functioning health systems and partnerships that draw these forces together.

The global upheavals and financial constrictions of the HIV response have been dramatic, and their effects will reverberate for some time. But the means to reinvigorate the global effort to end AIDS exist; and ending AIDS as a public health threat by 2030 is still possible.

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(All links accessed 10 November 2026.)



CHAPTER 1

The state of the HIV epidemic and response is driven by access to HIV prevention and treatment services

The world has moved closer towards controlling the HIV epidemic, but funding and service upheavals and competing demands on country systems threaten to derail this progress.

More people are receiving antiretroviral therapy and have a suppressed viral load than ever before, and AIDS-related deaths are at their lowest level since peaking in 2004.[1] Treatment rollout combined with primary prevention services has led to fewer people acquiring HIV in 2025 than at any point since the mid-1990s. But four years away from the 2030 deadline for reaching an ambitious set of targets agreed by United Nations Member States *(1)*, these achievements are under threat (Table 1.1).

Major shifts and constraints in the funding landscape have disrupted HIV programmes across the world. In addition, the conditions in which HIV programmes operate are deteriorating as unrelenting stigma, discrimination and anti-rights and anti-gender campaigns that prevent HIV services gain traction in many countries.

The global effort to end an epidemic that has claimed an estimated 44.2 million [36.7 million–55.0 million] lives now has to regroup. The stakes are high. Meeting the 2030 global targets could avert an estimated 1.3 million AIDS-related deaths and prevent 3.2 million people from acquiring HIV by 2030.[2]



1 The epidemiological estimates in this report are unchanged from those released by UNAIDS in July 2026. They are supplemented by additional analyses and data reported through Global AIDS Monitoring and other platforms.

2 UNAIDS epidemiological estimates 2025 and Goals modelled projections.

Table 1.1. Progress towards achieving the 2030 global AIDS targets for service coverage and supportive elements

Indicator	Target for 2030	End 2025 value
Ensure available, accessible, acceptable and high-quality HIV treatment and care for people living with HIV		
95% of people living with HIV know their HIV status	95–95–95	Total: 88–89–95; men: 86–86–95; women: 91–92–95; children: 65–84–85
95% of people who know their HIV-positive status are on treatment		
95% of people living with HIV who are on treatment have a suppressed viral load		
Scale up HIV prevention options that bring together biomedical, structural and behavioural interventions		
90% of people in need of prevention use prevention options, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis, condoms and harm reduction	90%	Declines in PrEP
Provide young people with comprehensive sexuality education (policy on inclusion within secondary education)	100%	83% of 143 reporting countries
Eliminate vertical transmission of HIV, syphilis and hepatitis B virus, and end paediatric AIDS	266	HIV specifically: 22 of 266 countries or territories All three conditions: 1 of 266 countries or territories
90% of people living with HIV have a suppressed viral load	95%	74%
End stigma and discrimination and uphold human rights and gender equality in the HIV response		
<10% of people living with, at risk of or affected by HIV face stigma and discrimination	<10%	15% of people living with HIV experienced discrimination in health-care settings (43 countries) Global medians of people who reported experiencing stigma and discrimination: 29% of sex workers; 16% of gay men and other men who have sex with men; 30% of people who inject drugs; 34% of transgender people
<10% of women, girls, and people living with, at risk of or affected by HIV experience gender inequality or violence (prevalence of recent intimate partner violence)	<10%	14% [12–17%] of adolescent girls and women aged 15–49 years
<10% of countries have punitive legal and policy environments that deny or limit access to services	<10%	Countries with punitive laws: HIV nondisclosure, exposure or transmission—133 countries; sex work—167 countries; possession of small amounts of drugs—152 countries; same-sex sexual acts—65 countries; transgender people—15 countries
Ensure community leadership in the HIV response		
30% of HIV testing and supportive services are delivered by community-led organizations	30%	Not currently measurable
80% of people-centred HIV prevention programmes for people from key populations are delivered by community-led organizations	80%	22% of needles and syringes distributed in the past 12 months by key population-led needle–syringe programmes (*n* = 25) <1% of people who inject drugs receive opioid agonist maintenance therapy at a specified date by key population-led organizations (*n* = 17)
60% of programmes for societal enablers are delivered by community-led organizations	60%	
Commit to an enabling civic space	198	39 of 193 countries have open civic space
Integrate HIV services with primary health care and other sectors		
95% of people receiving HIV prevention or treatment services also receive sexual and reproductive health services, including for sexually transmitted infections	95%	Not currently measured
95% of pregnant women living with HIV and newborns receive maternal and newborn care that integrates or links to HIV	95%	
All countries have access to equitable pricing for diagnostics and therapeutics	All	
Ensure sustainable financing for a person-centred national and global HIV response		
Reduce out-of-pocket expenses for HIV in line with universal health coverage	Baseline is being measured	
Countries commit to sustaining the HIV response by progressively increasing domestic funding	Low-income countries reach 30%; low- and middle-income countries reach 50%; and upper- and middle-income countries reach 95% of their total funding for HIV	59% domestic 4% increase from 2024
US$ 21.9 billion mobilized for HIV investments for low- and middle-income countries	US$ 21.9 billion	US$ 17.6 billion
End AIDS as a public health threat		
By 2030, reduce the number of new HIV infections by 90% from 2010	90%	42% reduction from 2010
Reduce the number of AIDS-related deaths by 90% from 2010	90%	57% reduction from 2010
Global numerical targets		
20 million people access antiretroviral medicine-based prevention	20 million	2.6 million
40 million people living with HIV are on HIV treatment	40 million	32.1 million
38 million people living with HIV have a suppressed viral load	38 million	30.4 million

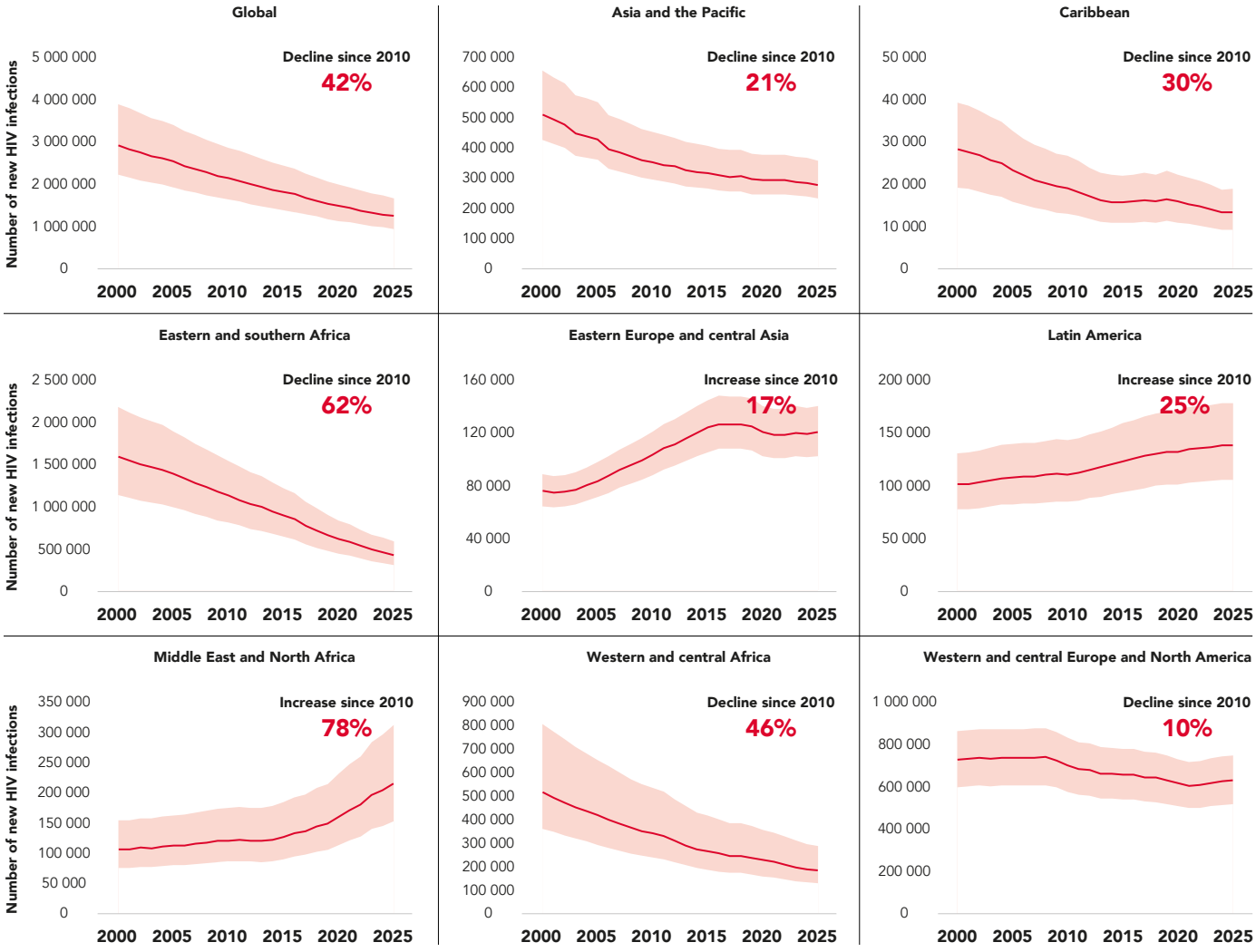
Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).
Note: ▢▢▢ reflects an overview of progress in that area.

Numbers of new HIV infections are declining—but not quickly enough

An estimated 1.2 million [950 000–1.7 million] people acquired HIV globally in 2025, indicating a 42% drop compared with 2010, with the steepest declines in sub-Saharan Africa. Numbers of new HIV infections fell by 62% in eastern and southern Africa and 46% in western and central Africa during this period (Figure 1.1).

The overall decline in new infections is driven largely by the massive rollout of treatment *(2, 3)*. Globally the average rate of decline in new HIV infections was around 13% for the period 2011–2015, 16% for the period 2016–2020 and 14% for the period 2021–2025, reflecting expanding treatment coverage in the 2016-2020 period.

Figure 1.1. Numbers of new infections (all ages) and percentage change 2010–2025, global and by region



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

Sustained progress in some countries, setbacks in others

Seven countries—Benin, Eswatini, Kenya, Lesotho, Nepal, Rwanda, Zimbabwe—have reduced their annual numbers of new HIV infections by at least 78% since 2010 and could potentially reach the target of a 90% reduction by 2030, if disruptions due to funding losses and other deficiencies can be resolved *(4)*. Another 20 countries,[3] mostly in sub-Saharan Africa, have reduced their annual numbers of new HIV infections by more than 60% since 2010, and have a chance of reaching the 2030 target.[4]

Recent trends in some countries show that when HIV programmes are neglected or misdirected, numbers of new infections can surge. Since 2020, the annual numbers of new infections have risen in Pakistan (from 30 000 to 44 000), the Philippines (from 18 000 to 34 000), Madagascar (from 13 000 to 26 000), the Bolivarian Republic of Venezuela (from 4800 to 7000), Egypt (from 4700 to 6300), Sudan (from 4000 to 5300) and Fiji (from 790 to 1700). Numbers of new infections are also rising in other countries, including some with small epidemics, such as Algeria and Lebanon.[5]

This is happening in the context of HIV funding upheavals, especially for HIV prevention services and community systems and support. People at high risk of HIV, including people from key populations and adolescent girls and young women, are seeing trusted service providers disappear or operations cut back, reducing access to essential HIV services.

The steepest reductions in new infections have been among men, especially young men, in sub-Saharan Africa. This is mainly due to the large proportion of women living with HIV who are on treatment and have a suppressed viral load and therefore do not transmit HIV to their sex partners. Despite the substantial decline, however, the scale of the HIV epidemic in sub-Saharan Africa is so large that 530 000 [370 000–770 000] people aged 15 years or older acquired HIV there in 2025, of whom almost two-thirds (64%) were female.

Outside sub-Saharan Africa, where an estimated 69% of new infections are among people from key populations and their sex partners,[6] the annual number of new HIV infections has remained largely constant over the past five years, with 630 000 [480 000–850 000] people acquiring HIV in 2025. In these regions, most people acquiring HIV are from key populations, who typically contend with punitive laws and law enforcement practices, and rampant stigma and discrimination that limits their access to HIV services. Similar inequities afflict their counterparts in sub-Saharan Africa, where an estimated 26% of new HIV infections among people aged 15–49 years are among people from key populations and their sex partners.[7]

In some regions complacency has set in, while in others a lack of services adds to the vulnerability of people from key populations (see Chapter 2). Notably, numbers of new infections have increased since 2010 in eastern Europe and central Asia, Latin America, and the Middle East and North Africa (Figure 1.1), which together accounted for more than 250 000 new HIV infections in 2025.

3 Australia, Botswana, Burkina Faso, Burundi, Central African Republic, Chad, Ethiopia, Guinea, Guinea-Bissau, Malawi, Namibia, Portugal, South Africa, South Sudan, Tajikistan, Thailand, Togo, Uganda, United Republic of Tanzania, Zambia.

4 This list includes only countries with more than 200 new HIV infections as of 2025, the threshold for being able to evaluate the trend.

5 See the regional HIV factsheets at https://www.unaids.org/sites/default/files/media_asset/2026-WAD-report.

6 UNAIDS special analysis 2025.

7 UNAIDS special analysis 2025.

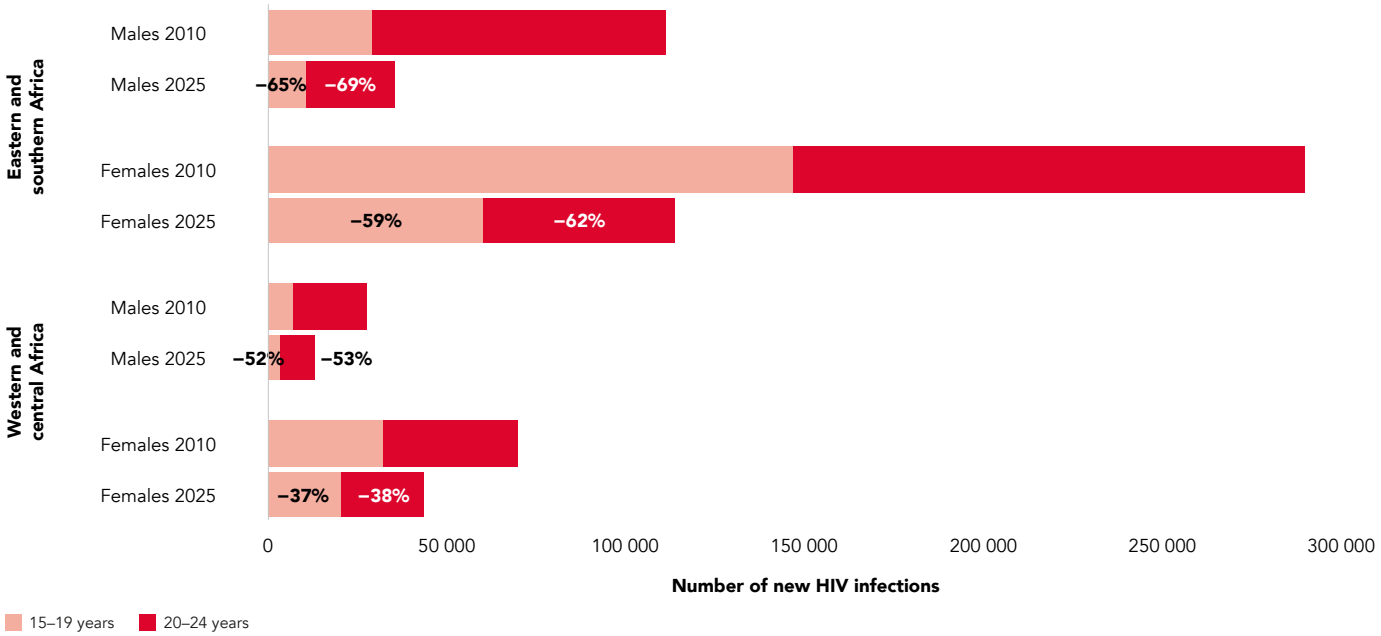
Women and adolescent girls are still at high risk

Of the estimated 500 000 [360 000–690 000] women aged 15 years or older who acquired HIV in 2025, 68% were living in sub-Saharan Africa. Although HIV incidence is declining among women and girls in sub-Saharan Africa, they continue to be adversely affected by gender-based and socioeconomic discrimination *(5)*, intimate partner violence *(6)*, inadequate access to tailored and respectful services, and biological and physiological vulnerabilities *(7, 8)*. HIV incidence among adolescent girls and young women aged 15–24 years is three times higher than among their male peers in sub-Saharan Africa (Figure 1.2). Very high HIV incidence has continued in localized settings in South Africa and elsewhere in eastern and southern Africa *(9, 10)*. Overall, more than three-quarters (80%) of the estimated 200 000 [130 000–280 000] adolescent girls and young women who acquired HIV in 2025 were living in sub-Saharan Africa.

The funding disruptions of the past two years could perpetuate these disparities. HIV prevention services funded by the United States President's Emergency Fund for AIDS Relief (PEPFAR) reached an estimated 2.3 million adolescent girls and young women across sub-Saharan Africa in 2024, but much of this programming has shifted or been suspended *(11, 12)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is planning to prioritize HIV services for adolescent girls and young women over the next few years *(13)*.

Dedicated prevention options need to reach more adolescent girls and young women in places with high HIV incidence. Pre-exposure prophylaxis (PrEP), especially long-acting injectable versions, must be made more readily accessible. Higher coverage of testing and treatment among men would also lessen the risk of women and girls acquiring HIV. These efforts are likely to be most effective if linked to actions that address the gender inequalities and other barriers that limit the ability of women and girls to access and use HIV services.

Figure 1.2. Number of new HIV infections among young people (aged 15–24 years) and percentage change over time, by sex, eastern and southern Africa and western and central Africa, 2010 and 2025



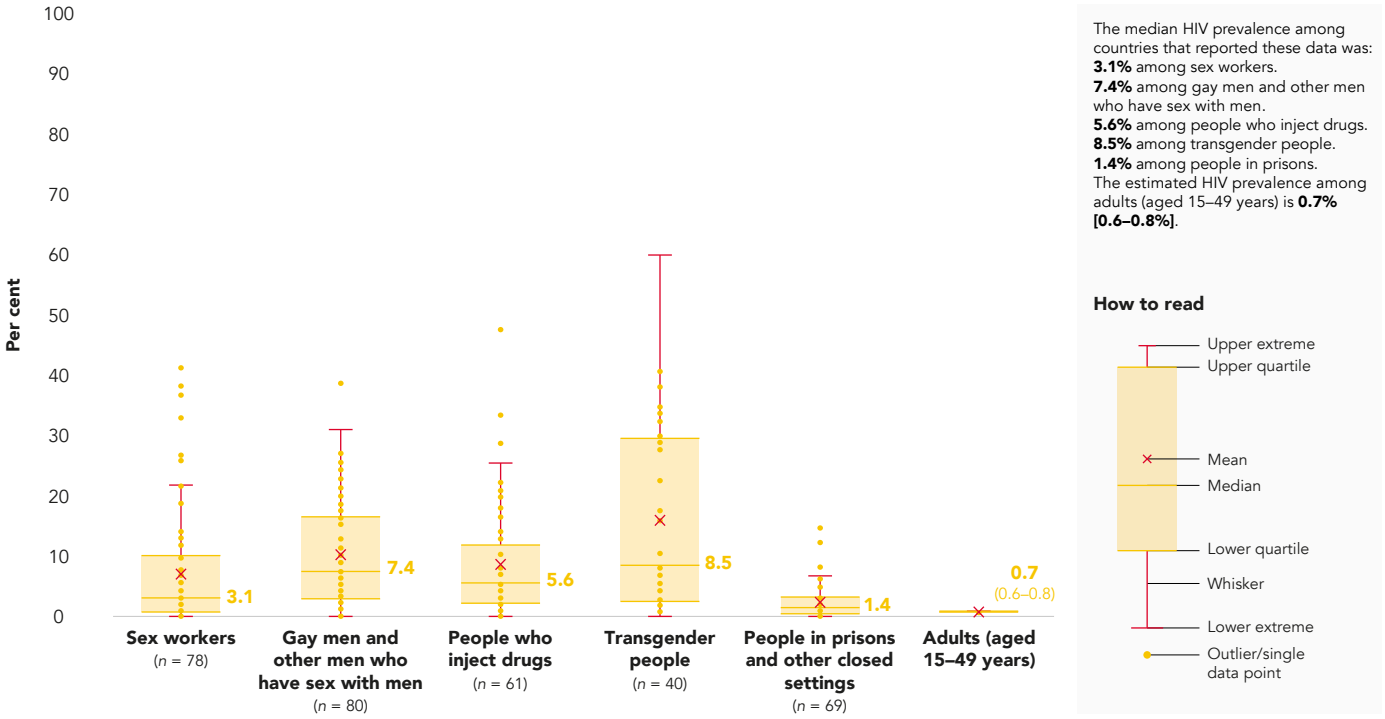
Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

People from key populations bear a disproportionate HIV burden

The HIV burden among people from key populations remains disproportionately high (Figure 1.3). Compared with adults overall, the relative risk of acquiring HIV among people from key populations has generally worsened since 2010, except for sex workers and their clients *(14)*.[8] Country-reported survey data show that HIV prevalence among people from key populations is still substantially higher than in the overall population of adults aged 15–49 years (Figure 1.3), with the following regional medians:

- Sex workers: 1% (Asia and the Pacific, Latin America) to 22% (eastern and southern Africa).
- Gay men and other men who have sex with men: 2–4% (Asia and the Pacific, western and central Europe and North America) to 14% (western and central Africa) and 20% (eastern and southern Africa).
- People who inject drugs: 3–5% (Latin America, western and central Africa, western and central Europe and North America) to 8% (Asia and the Pacific) and 11% (eastern and southern Africa).[9]
- Transgender people: 2–3% (Asia and the Pacific, eastern Europe and central Asia, western and central Europe and North America) to 32% (western and central Africa) and 35% (Caribbean).
- People in prisons and other closed settings: <1% (Asia and the Pacific, Latin America, Middle East and North Africa) to 5% (eastern and southern Africa).

Figure 1.3. HIV prevalence among people from key populations compared with people in the general population (aged 15–49 years), global, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/); UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).
Notes: *n* = number of countries. The adult prevalence uncertainty bounds define the range within which the true prevalence 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.

8 UNAIDS special analysis 2025.

9 HIV prevalence among people who inject drugs shows a marked gender disparity. In the 19 countries reporting sex-disaggregated data, global median prevalence is 15% among women who inject drugs and 9% among men who inject drugs (Global AIDS Monitoring 2026, https://aidsinfo.unaids.org/).

Prevention coverage for people from key populations continues to be uneven, with people who inject drugs especially underserved. Faced with punitive laws and policies and stigma and discrimination, people from key populations often struggle to access HIV prevention services at hospitals and clinics, and prefer outreach and other peer-led services. Funding cuts have degraded or entirely dismantled many of these services, exposing people to even higher risks of acquiring HIV.

Numbers of HIV infections in children are declining steeply

The steepest decline in the number of new HIV infections has been among children aged 0–14 years, with a 69% drop since 2010. This trend is due largely to the extensive reach of programmes to eliminate vertical transmission of HIV in eastern and southern Africa, where the annual number of children acquiring HIV fell by 76% between 2010 and 2025. Progress has been slower in western and central Africa (59% decline) and Asia and the Pacific (62% decline).

Twenty-two countries or territories[10] have eliminated vertical transmission of HIV. Botswana and Namibia are well on their way to matching these accomplishments *(15)*. Only Maldives has achieved triple elimination of HIV, syphilis and hepatitis B *(16)*. Globally, programmes for preventing vertical transmission of HIV averted an estimated 250 000 [170 000–380 000] new infections in children in 2025.[11]

Overall, however, the number of new HIV infections among children is not declining fast enough to reach the 2030 global target. An estimated 93 000 [63 000–140 000] children acquired HIV in 2025, most of them in eastern and southern Africa (46 000 [30 000–71 000]), western and central Africa (32 000 [21 000–47 000), and Asia and the Pacific (8200 [6300–12 000]). Globally, about 1 in 13 new HIV infections in 2025 was due to vertical transmission. The total number of children living with HIV in 2025 was estimated at 1.3 million [1.0 million–1.7 million], 87% of whom were in sub-Saharan Africa.

Fewer new HIV infections among women overall and wider access to antiretroviral therapy for pregnant and breastfeeding women living with HIV are the main factors driving the decrease in vertical transmission of HIV. Coverage of services to prevent vertical transmission has levelled off in recent years, however, with 88% [75–>98%] coverage globally in 2025, similar to the 86% [73–>98%] achieved in 2019. Coverage reached 95% [81–>98%] in eastern and southern Africa but was only 70% in Asia and the Pacific and western and central Africa, the two other regions with high burdens of HIV in children.

The main immediate factors contributing to child HIV infections differ in the two worst-affected regions (Figure 1.4). In eastern and southern Africa, around 32% of HIV infections in children occur when their mothers acquire HIV during pregnancy or the breastfeeding period. Even if they are promptly diagnosed and linked to treatment, vertical transmission could still occur. In addition, retention in care during and after pregnancy remains a concern in Africa and other regions *(17)*. In western and central Africa, about 57% of new HIV infections among children are due to their mothers not receiving antiretroviral therapy at all, a reminder that universal access to HIV treatment

10 Anguilla, Antigua and Barbuda, Armenia, Bahamas, Belarus, Belize, Bermuda, Brazil, Cayman Islands, Cuba, Denmark, Dominica, Jamaica, Malaysia, Maldives, Montserrat, Oman, Saint Kitts and Nevis, Saint Vincent and Grenadines, Sri Lanka, Thailand, Turks and Caicos.

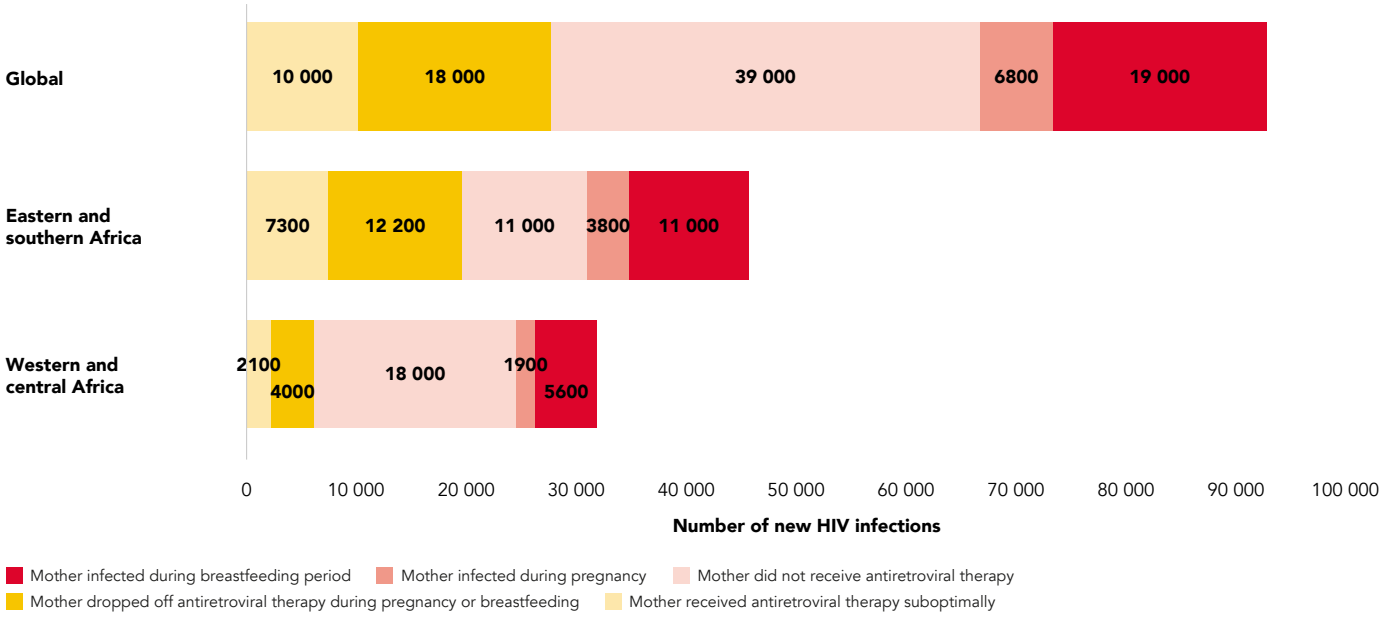
11 UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

remains a distant prospect for women living with HIV in this region. Studies from southern Africa show that service barriers and deficiencies also contribute to maternal mortality rates that are higher among women living with HIV than among their HIV-free peers *(18, 19)*.

Improvements in service coverage and quality and retention in care, including peer support for pregnant and breastfeeding women and new mothers, would accelerate further declines in new child infections. However, peer support and other community-based services have been cut back due to funding disruptions. In addition, underlying factors, including unequal burdens of care and intimate partner violence, can impact the ability of women to access and use HIV and other health services *(20)*.

Timely access to antenatal care that links with HIV testing and treatment services remains vitally important for women, including for sex workers and women in prisons and other closed settings. In a study in six low- and middle-income countries,[12] 86% of female sex workers were mothers, but only 28% of them reported using antenatal care services due to cost, stigma or other barriers *(21, 22)*. The introduction of injectable lenacapavir as PrEP could further reduce the number of HIV infections in children, given that a large share of new HIV infections in children occurs when their mothers acquire HIV during pregnancy or postpartum *(23)*.

Figure 1.4. Sources of new HIV infections in children, global, eastern and southern Africa, and western and central Africa, 2025



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

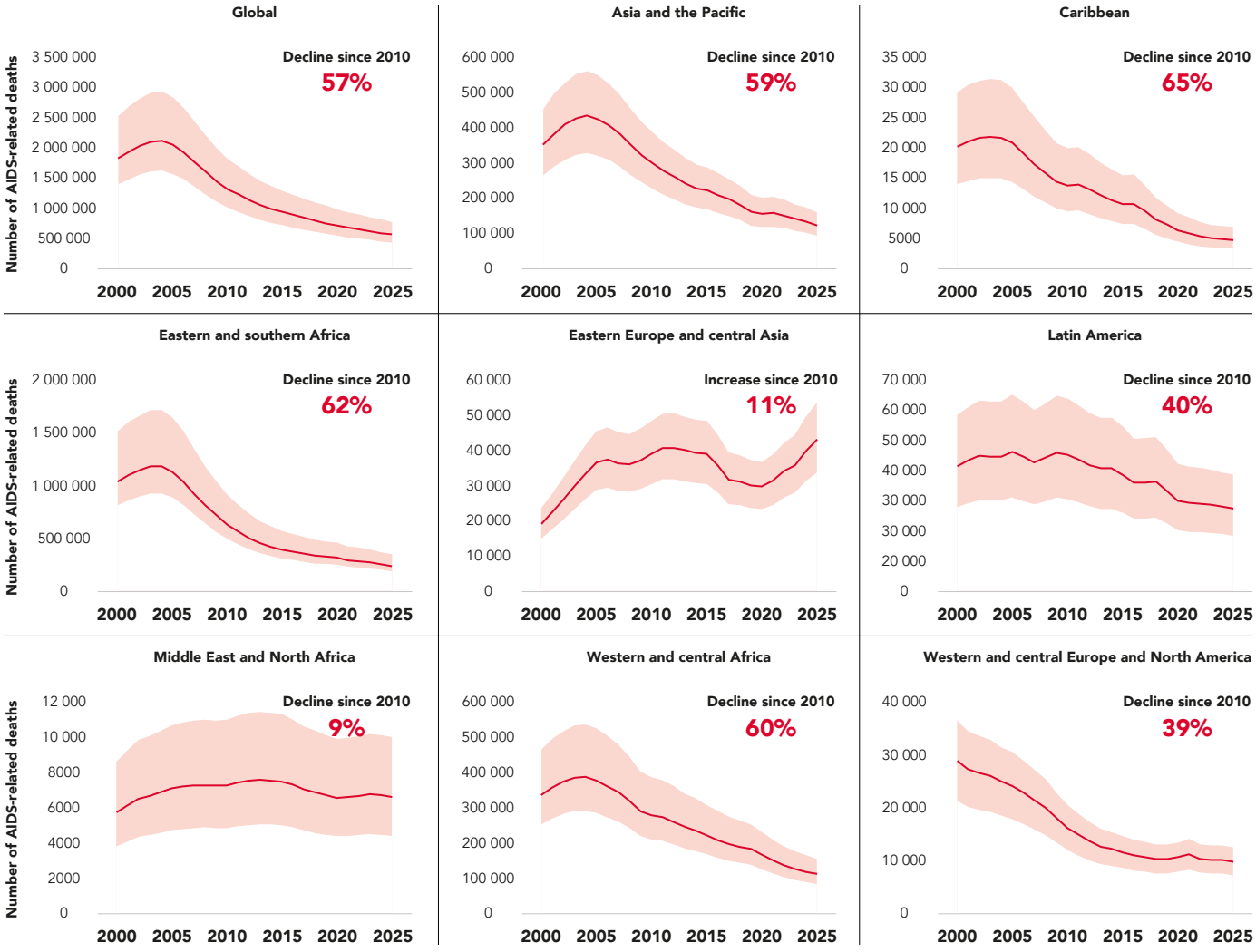
12 Democratic Republic of the Congo, India, Indonesia, Kenya, Nigeria, South Africa.

Fewer people are dying from AIDS-related illnesses

The HIV epidemic is claiming far fewer lives in the regions with the highest HIV burdens, compared with 2010. Numbers of AIDS-related deaths have declined by about 60% in Asia and the Pacific, the Caribbean and sub-Saharan Africa, and by about 40% in Latin America and western and central Europe and North America. This is testament to the extensive coverage and improved quality of treatment and care programmes in these regions. In eastern Europe and central Asia and the Middle East and North Africa, however, little progress has been made (Figure 1.5).

Approximately 570 000 [430 000–780 000] people around the world lost their lives to AIDS in 2025, including 61 000 [39 000–90 000] children aged 0–14 years—equivalent to almost

Figure 1.5. Numbers of AIDS-related deaths (all ages) and percentage change, 2010–2025, global and by region



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

1600 deaths per day. The world could still reach the target of reducing the number of AIDS-related deaths in 2030 by 90% compared with 2010—but doing so in the context of funding and service disruptions will require rapid recovery and adjustment.

More people than ever are receiving HIV treatment, but there are substantial gaps

Access to HIV testing, treatment and care services has increased dramatically since the start of the twenty-first century. Between 2000 and 2025, the number of people living with HIV accessing antiretroviral therapy worldwide increased from 500 000 [440 000–520 000] to 32.1 million [28.2 million–33.4 million], a remarkable public health achievement. In sub-Saharan Africa, home to almost two-thirds (64%) of the 41.0 million [35.3 million–47.5 million] people living with HIV worldwide, the percentage of people accessing life-saving antiretroviral therapy increased from less than 1% to 83% [61–>98%] over the same period. Eleven countries have reached all three of the 95–95–95 targets.[13,14]

The full potential impact of the treatment rollout is being constrained, however, by persistent access gaps. About 85% [62–>98%] of people living with HIV in eastern and southern Africa and 80% [62–91%] in western and central Europe and North America were receiving antiretroviral therapy in 2025, but coverage was lower in western and central Africa (74% [57–90%]), Asia and the Pacific (72% [56–84%]), Latin America (71% [55–84%]), eastern Europe and central Asia (56% [44–63%]) and the Middle East and North Africa (53% [38–70%]). The burden of HIV in sub-Saharan Africa is still so high, however, that it accounts for about half of all people living with HIV but not on treatment globally; a further quarter are in Asia and the Pacific.

Treatment coverage continues to be lower among men generally and among people from key populations, and is especially poor among children (see Chapter 2). In the three regions with the most people living with HIV (Asia and the Pacific, eastern and southern Africa, western and central Africa), adult women living with HIV are considerably more likely to be on antiretroviral therapy than their male counterparts. Of the 1.3 million [1.0 million–1.7 million] children living with HIV in 2025 globally, only 55% [39–78%] were receiving antiretroviral therapy; coverage was 59% [42–90%] in eastern and southern Africa and 41% [28–52%] in western and central Africa, the two regions with the largest populations of children living with HIV.[15]

Among key populations, treatment coverage continues to be lowest among transgender people and sex workers. In countries reporting survey data, coverage was higher among gay men and other men who have sex with men than among the overall adult population living with HIV (see Chapter 2).[16]

13 The 2030 global AIDS targets call for 95% of people living with HIV to know their HIV status, 95% of people who know their HIV-positive status to receive antiretroviral therapy, and 95% of people on treatment to have a suppressed viral load.

14 Botswana, Cambodia, Denmark, Eswatini, Lesotho, Namibia, Rwanda, Saudi Arabia, Sweden, Zambia, Zimbabwe.

15 There are wide uncertainty ranges for antiretroviral therapy coverage among children in several countries.

16 For more detailed information, see the thematic factsheets at https://www.unaids.org/sites/default/files/media_asset/2026-WAD-report.

Viral load suppression levels are high

Globally, in 2025, an estimated 95% [72–>98%] of people on antiretroviral therapy had a suppressed viral load, protecting them against AIDS-related illnesses and death *(24, 25)* and preventing onward transmission of HIV to their sex partners. Viral load suppression levels have risen in all regions and are very high in eastern and southern Africa and in the mostly high-income countries of western and central Europe and North America.

Among people on treatment, viral load suppression levels in 2025 were lowest in eastern Europe and central Asia (86% [68–98%]) and the Caribbean (89% [67–>98%]) but were at least 92% in each of the other regions, including in sub-Saharan Africa.

Due to gaps along the testing and treatment cascade, including in many high-performing countries, an estimated 10.6 million people living with HIV did not have a suppressed viral load in 2025 (see Chapter 2). Until these gaps are addressed, epidemic control will elude the world.



Protecting HIV prevention: keeping services within reach



Credit: UNAIDS Uganda

For a young woman receiving condoms, PrEP or a referral from a community-based provider, HIV prevention is a conversation with someone she trusts, a place where she can ask questions without shame, and a familiar face who understands her circumstances. For her, HIV prevention is not an abstract programme or budget line.

Across eastern and southern Africa, community organizations, outreach workers and drop-in centres make HIV prevention accessible, including for people who face stigma in health facilities *(26)*. When major funding shifts and reductions occurred in early 2025, prevention services were among the first to be impacted. Additionally prevention services are often not prioritized by countries themselves. Organizations lost funding, workers lost jobs, and centres closed or reduced their services, cutting off communities from trusted sources of prevention and support *(14)*.

The initial impact varied across the region. In Zambia between January and May 2025, 32 wellness centres providing prevention services to more than 20 000 people from key populations closed. DREAMS programmes supporting prevention services among adolescent girls and young women across 22 districts and 16 voluntary medical male circumcision (VMMC) centres for young men shut down. More than 11 500 health workers and community-based volunteers whose livelihoods depended on external funding were at risk of losing their jobs *(27)*.

In Malawi, 18 drop-in centres reduced operations, affecting around 7000 people accessing PrEP and 7600 people receiving treatment for HIV. In Eswatini, several community-led facilities ceased functioning. In Kenya, outreach, PrEP access and condom distribution were disrupted, and staffing constraints raised concerns about privacy *(28)*.

Condom distribution was also affected. Despite Malawi having around 12 months of national condom stocks, non-facility distribution stopped. In Zimbabwe, central stocks were estimated to last about 5.5 months in May 2025 *(29)*.

The disruption made clear that commodities in a warehouse cannot protect anyone unless those commodities reach the people who need them.

Different responses, important lessons

In Zambia, the number of people receiving PrEP at least once fell by 64% in 2025 compared with 2024, but the picture was not one of decline everywhere. Ethiopia and Uganda expanded access through domestic and other funding, while Kenya and Rwanda mobilized domestic resources to sustain priority programmes. Botswana and South Africa sought to maintain continuity of care by connecting clients from affected community organizations to government facilities.

Protecting prevention, together

Sustaining HIV prevention requires reliable domestic financing, resilient supply chains and stronger community systems.

"Condoms must remain at the heart of this effort," says Anne Githuku-Shongwe, UNAIDS Regional Director for Eastern and Southern Africa. "Having them in stock is only the beginning. They must reach people through effective distribution, demand creation, accessible dispensing points, and community organizations that make access and use possible and free from stigma."

Uganda addressed the disconnect between condom availability and access. Although national warehouses held more than three years' stock, community hotspots experienced stockouts. Through an alternative distribution mechanism using local storage hubs and boda boda riders, condoms are now delivered directly to mapped community hotspots *(30)*.

Through regional economic communities, countries can pool purchasing power, improve demand forecasting and explore regional production of essential commodities. For example, the Southern African Development Community (SADC), UNAIDS and partners are working with the Government of China to advance regional pharmaceutical manufacturing through technology transfer, skills development and investment, reducing reliance on imports and strengthening access to HIV prevention commodities and other essential health products.

"SADC is committed to advancing regional health sovereignty through collective procurement, stronger supply chains and regional manufacturing, ensuring sustainable, equitable and reliable access to essential HIV prevention commodities and other health products for all our people," says Dr Lamboly Kumbonecki, Head, Health and HIV Department, SADC Secretariat.

"Ultimately, HIV prevention depends not only on commodities and budgets, but on ensuring people can access services in places where they feel safe and through people they trust," says Lilian Mworeko, ICWEA. "Community organizations and peer workers are not an optional extra; they are the human connections that make prevention work."

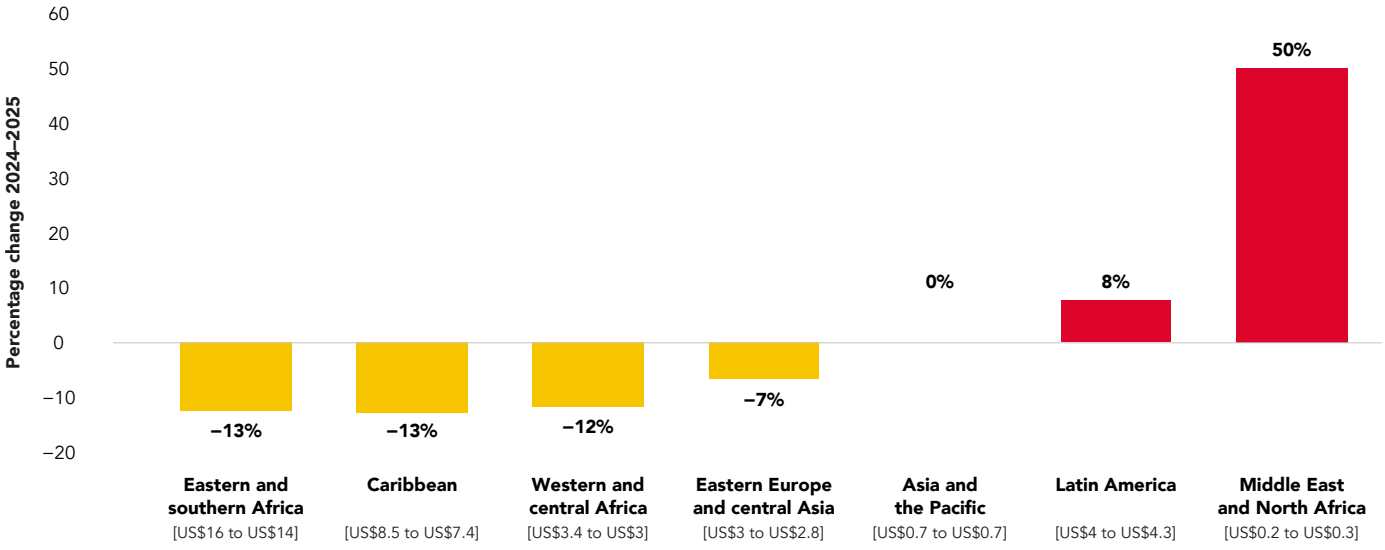
HIV funding cuts are creating turmoil

Funding losses have caused upheaval in HIV programmes across the world against a backdrop of a broad retreat on official development assistance. Over many years in global health and HIV Three regions with high burdens of HIV lost at least 12% of their HIV funding in 2025 (Figure 1.6) (see Chapter 3).

The steep funding losses of 2025 followed a decade-long decrease in external funding for HIV programmes in low- and middle-income countries (see Chapter 3). United States bilateral contributions fell by 26% between 2024 and 2025,[17] while contributions from other major donors and investors in the global HIV response had already been declining for more than a decade. The impact of the United States Government funding reductions has been especially acute, given the reliance of many countries on United States assistance for core HIV programmes *(31, 32)*. Despite these reductions, the United States still provides more than 73% of donor government financing for HIV, highlighting both its indispensable leadership and the risks of an increasingly concentrated financing architecture. Renewed solidarity from all donor governments, including European and other countries, will be critical to help close the financing gap and sustain the global commitment to end AIDS as a public health threat by 2030.

Although 55 countries reported increases in their domestic contributions, these emergency responses could not offset the large shortfalls caused by withdrawn international support. The decades-long push to end an epidemic that has claimed 44.2 million

Figure 1.6. Percentage change in per capita resources available for HIV programmes, by region, 2024–2025



Source: UNAIDS financial estimates 2026.

17 In constant 2025 US$. In nominal US$, there was a 28% reduction.

[36.7 million–55.0 million] lives now faces significant threats. The documented and projected effects of these funding losses show the fragility of the progress made against the HIV epidemic and underscore the urgent need to restore and protect HIV financing.

The effects of the funding cuts have been exacerbated by the high pre-existing reliance on United States foreign assistance through PEPFAR in many national HIV responses,[18] which has made it difficult to readily replace lost United States Government support with domestic or other external resources. Even after the 2025 reductions, approximately 22% of HIV resources available in low- and middle-income countries came from United States Government bilateral financing and around 12% from the Global Fund. The continued importance of these two funding sources highlights their central contributions and the vulnerability created by the concentration of international HIV financing among relatively few major donors. Self-reliance, country leadership and domestic financing of HIV responses are critical.

Domestic resources accounted for about 59% of total HIV spending in low- and middle-income countries in 2025. Emergency responses saw domestic spending increase by about 4% in 2024–2025, although the increase in the domestic share also partly reflected the sharp contraction in external resources. For many low- and middle-income countries, the fiscal space for making and sustaining increased domestic HIV resources is very limited and is being cramped further by rising energy and borrowing costs, the spreading impact of the super El Niño weather effect, and other adversities *(33)*. In some countries that have relied heavily on external funding for their HIV responses, debt servicing obligations already eclipse total government health spending.[19,20]

The effects of the funding losses are expected to spread unevenly across regions and populations, widening health, gender and socioeconomic inequities. Much of the impact will be felt in sub-Saharan Africa, which continues to have the highest burden of HIV. There and elsewhere, people at high risk of HIV are seeing trusted service providers disappear or cut back their operations (see Chapter 2) *(34–39)*.

Increasing evidence of the damage being done to HIV programmes

Data from more than 31 000 PEPFAR-supported health facilities and community service sites revealed declines in HIV testing, HIV diagnoses, treatment initiation, access to prevention services and PEPFAR-supported workforces after the United States Government funding freeze was announced in early 2025 *(11)*. Another survey of 166 PEPFAR-supported organizations in 46 countries between April 2025 and April 2026 found that funding reductions had led to the closure of 1714 services sites, including more than 1000 public health facilities and 126 drop-in centres. Between 20% and 23% of the organizations reported being unable to obtain condoms, laboratory commodities, PrEP or antiretroviral medicines, and almost 9 in 10 organizations reported staffing losses *(40)*. However, these surveys did not capture how many of these services were transferred to government or community providers.

18 In at least 15 PEPFAR-supported countries, United States Government bilateral financing accounted for more than half of total resources for HIV programmes. This reliance was especially high in the United Republic of Tanzania (94%), Côte d'Ivoire (90%), Haiti (87%), Nigeria (82%) and Zambia (70%).

19 In Angola, Eritrea, Gambia, Ghana, Nigeria and Uganda, debt-service payments exceed government health expenditure by more than threefold.

20 Global AIDS Monitoring and UNAIDS-supported national AIDS spending assessments 2019–2025.

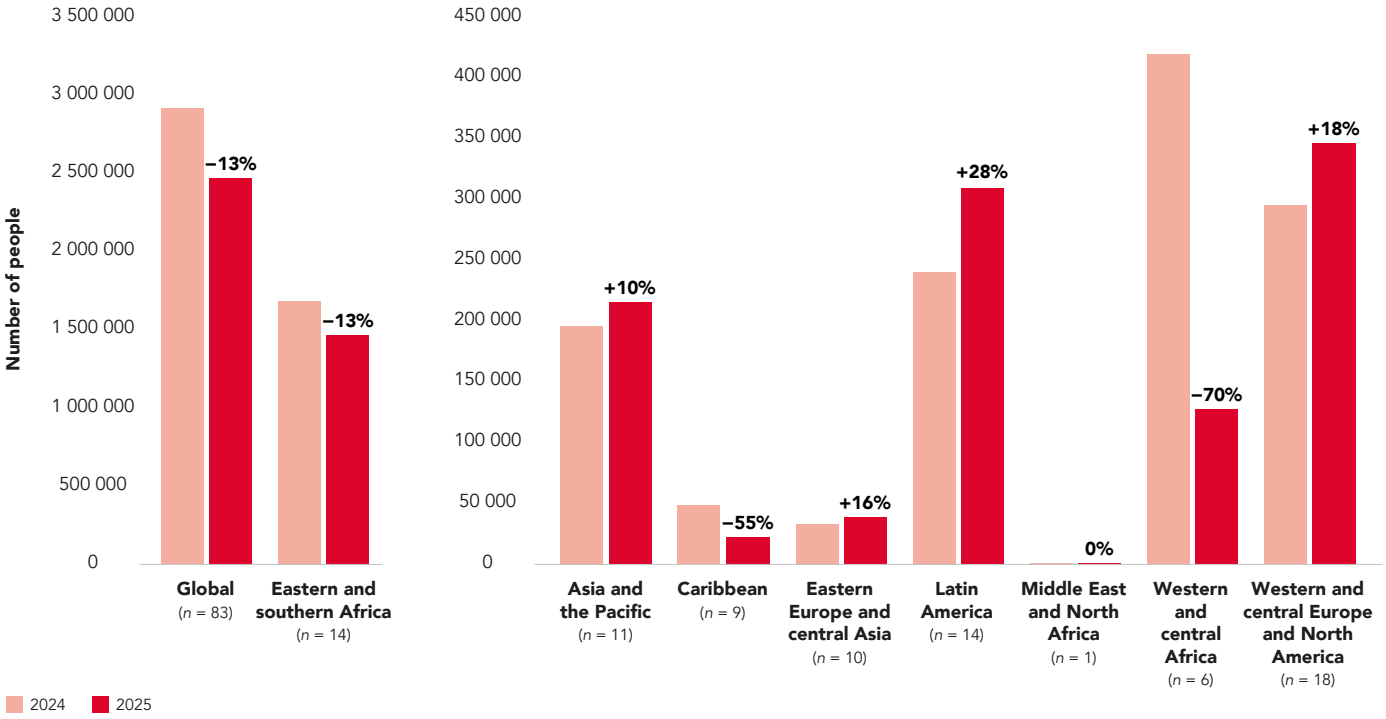
Programmes for prevention of vertical transmission of HIV were mostly shielded from the funding cuts, but other prevention services have been badly affected. Condom and VMMC programmes have been defunded, and outreach and other support services for people from key populations and adolescent girls and young women have been defunded in several countries. PEPFAR expenditure data show condom programming decreased by 93% and the number of health-care workers directly providing services decreased by more than 62 000 (24% decline) *(11)*.

A considerable number of PrEP initiations in 2024 were facilitated through PEPFAR funding *(41)*. The drop-off in this support saw the global number of people using PrEP fall for the first time between 2024 and 2025, with steep drops in the Caribbean and western and central Africa (Figure 1.7).[21]

Treatment programmes have been protected … for now

When funding disruptions started in early 2025, most governments in low- and middle-income countries acted quickly to safeguard their HIV treatment programmes *(42)*. National and provincial governments in South Africa introduced budgetary changes and transition planning to maintain existing programmes and prevent stockouts. To achieve service continuity, Zimbabwe transferred several functions to Ministry of Health district teams, and resources were redirected to support Government-led nurse recruitment, with the Ministry of Finance releasing frozen posts *(43)*. In some countries, such as Kenya, Nigeria and Rwanda, initial declines in testing and treatment coverage were mostly

Figure 1.7. Percentage change in the number of people receiving PrEP, global and by region, only countries reporting in both years, 2024–2025



Source: Global AIDS Monitoring 2026.
Note: *n* = number of countries reporting data. Data are not available for South Africa. See https://aidsinfo.unaids.org for country-specific data.

21 Preliminary Global AIDS Monitoring data 2026.

reversed in the second half of 2025. Countries with greater external funding reliance, however, such as Burundi, Cameroon and Uganda, experienced sustained service disruptions, with many indicators worsening *(44)*. The United States Government renewed its support for many services, especially treatment programmes.

Despite the mitigating steps taken, reports from countries show signs that the stress on testing and treatment programmes is increasing and service access and quality are being compromised (see Chapter 2). Fewer HIV tests are being conducted *(11)*, and the number of people starting HIV treatment for the first time has declined in several countries *(12)*.

Tracking the impact of funding losses on epidemic trends

Funding cuts tend to have a delayed impact on epidemic trends. Current national HIV estimates therefore do not yet show the impact of the 2025 funding disruptions because they do not account for the declines in the quality and uptake of services or localized programme failures.[22]

Estimates of treatment coverage and outcomes are not yet capturing the effects of missed appointments, treatment interruptions, reduced adherence support and community outreach, declines in viral load testing and laboratory monitoring, or service disruptions that especially disadvantage people from key populations and poorly served districts. In addition, national estimates can remain stable while specific populations, places and services experience disruptions.

The effects of service disruptions also take time to translate into new infections. Existing treatment programmes continue to provide protection in the short term, and reductions in testing, prevention, treatment uptake and retention must first reduce viral load suppression levels before HIV transmission increases. This process unfolds over years. The impact on HIV programmes can be immediate, but the full effect on numbers of new infections may become apparent only after several years, as the cumulative consequences of reduced prevention and treatment services take hold.

Also compromised are the services and community-led support that enable people to keep taking their antiretroviral medicines *(12, 30)*. There is already evidence of increasing numbers of people dropping out of treatment, within the context of service disruptions, antiretroviral medicine stockouts, increased user fees and other challenges *(11)*. There are also signs that efforts to increase the low coverage of antiretroviral therapy for children living with HIV are being affected *(43)*.

Community services are often a crucial entry point for accessing HIV treatment and prevention, especially for people from populations whose HIV-related needs tend to be neglected. Fewer community-led facilities and services force people from key populations to seek care at general clinics, where they may experience stigma and discrimination. In the PEPFAR-focused study mentioned above, two-thirds of the organizations providing outreach to key populations had been forced to close *(40)*. Other studies show the funding losses have already led to almost a quarter of surveyed civil society and women's rights organizations curbing or suspending their work to end violence against women *(45)*. Organizations working with women in humanitarian crises have also been badly affected *(46)*.

Concerns about degraded capacity and infrastructure

Evidence shows that funding losses are affecting the collection and management of HIV-related data, HIV testing and laboratory services (e.g. CD4 cell count, viral load testing), and the support services that treatment and care programme rely on. Disruptions

22 It is important to recognize that HIV estimates are derived from multiple years of surveillance and programme data and are not direct counts of new infections or deaths.



to laboratory services, patient tracing and maintenance of records ultimately affect clinical care. It will take several years for the full impact of this to become visible, but there are already signs that vital underlying capacities and systems of HIV programmes are being weakened.

The number of HIV tests taken fell from about 246 million in 2024 to 233 million in 2025, likely due to supply and service disruptions.[23,24] Fewer viral load tests were conducted in 2025 compared with 2024, with some declines occurring in countries with very large HIV treatment programmes in eastern and southern Africa *(12)*. Routine periodic viral load monitoring is essential to detect viral and clinical treatment failure (also a predictor of advanced HIV disease) and to adapt treatment regimens if needed.

The collection and analysis of timely, accurate and actionable data are essential for understanding evolving HIV epidemics and adjusting responses. The data guide the allocation of resources; reveal gaps, disparities and inefficiencies in programmes; help with problem-solving; and provide a basis for accountability. Demographic and Health Surveys and Integrated Biological and Behavioural Surveys have enabled a rich and nuanced understanding of HIV epidemics, the populations affected, and use of prevention and treatment programmes. In some countries, these have been the only nationally representative population-based health surveys, and they have been embedded within government statistical services. External funding shifts have not prioritized these valuable periodic surveys; without support they will be radically reduced or discontinued entirely.[25]

The funding losses are a major setback to the world's efforts to end AIDS as a public health threat by 2030. The available evidence already reveals major disruptions across HIV programmes, although the full impact will become evident only over time. Notably, if HIV prevention is undermined, more people will acquire HIV and the cost burden of treatment will rise. It could take several years for this outcome to show, at which point the trajectory of a country's epidemic would already have shifted decisively, with the effects weighing heaviest on people from key and vulnerable populations, including adolescent girls, women and children.

23 In the 91 countries with comparable data for 2024 and 2025.
24 Global AIDS Monitoring 2025 and 2026.
25 The Gates Foundation allocated an emergency grant to maintain the Demographic and Health Surveys website and complete a number of surveys that were in progress, but no future United States Government-funded surveys are envisaged *(47)*.

Table 1.2. The HIV epidemic and response at a glance, 2010–2025

Indicator (global)	2010	2015	2020	2024	2025	Percentage change 2010–2025
New HIV infections						
All ages	2.1 million [1.6 million–2.9 million]	1.8 million [1.4 million–2.4 million]	1.5 million [1.1 million–2.0 million]	1.3 million [980 000–1.7 million]	1.2 million [950 000–1.7 million]	–42%
Women ≥15 years	910 000 [670 000–1.3 million]	800 000 [580 000–1.1 million]	630 000 [460 000–880 000]	520 000 [380 000–720 000]	500 000 [360 000–690 000]	–45%
Men ≥15 years	920 000 [710 000–1.2 million]	820 000 [630 000–1.1 million]	700 000 [540 000–930 000]	660 000 [510 000–870 000]	650 000 [500 000–860 000]	–29%
Women 15–24 years	430 000 [280 000–600 000]	330 000 [220 000–470 000]	250 000 [170 000–360 000]	210 000 [140 000–290 000]	200 000 [130 000–280 000]	–54%
Men 15–24 years	270 000 [140 000–400 000]	210 000 [110 000–310 000]	170 000 [91 000–260 000]	160 000 [84 000–230 000]	150 000 [82 000–230 000]	–43%
Children 0–14 years	300 000 [200 000–450 000]	190 000 [130 000–290 000]	140 000 [92 000–210 000]	100 000 [70 000–160 000]	93 000 [63 000–140 000]	–69%
People living with HIV						
All ages	32.5 million [27.9 million–37.6 million]	35.9 million [30.8 million–41.5 million]	38.9 million [33.4 million–45.0 million]	40.7 million [35.0 million–47.1 million]	41.0 million [35.3 million–47.5 million]	+26%
Children 0–14 years	2.6 million [2.1 million–3.6 million]	2.2 million [1.8 million–3.0 million]	1.7 million [1.4 million–2.4 million]	1 400 000 [1 100 000–1 900 000]	1.3 million [1.0 million–1.7 million]	–52%
People receiving HIV treatment						
Women ≥15 years on antiretroviral therapy	3.9 million [3.4 million–4.0 million]	9.3 million [8.2 million–9.7 million]	14.6 million [12.8 million–15.1 million]	17.2 million [15.1 million–17.9 million]	17.6 million [15.5 million–18.3 million]	4.5x
Men ≥15 years on antiretroviral therapy	3.3 million [2.9 million–3.5 million]	6.7 million [5.9 million–7.0 million]	10.9 million [9.6 million–11.3 million]	13.2 million [11.7 million–13.8 million]	13.8 million [12.2 million–14.4 million]	4.2x
Children 0–14 years on antiretroviral therapy	440 000 [390 000–460 000]	830 000 [730 000–860 000]	870 000 [760 000–900 000]	730 000 [640 000–760 000]	690 000 [610 000–720 000]	+57%
AIDS-related deaths						
All ages	1.3 million [1.0 million–1.8 million]	940 000 [720 000–1.3 million]	720 000 [550 000–1.0 million]	600 000 [460 000–830 000]	570 000 [430 000–780 000]	–57%
Women ≥15 years	510 000 [380 000–730 000]	330 000 [250 000–480 000]	270 000 [200 000–380 000]	230 000 [170 000–330 000]	220 000 [160 000–310 000]	–57%
Men ≥15 years	590 000 [440 000–810 000]	480 000 [360 000–660 000	360 000 [270 000–500 000]	300 000 [230 000–410 000]	290 000 [220 000–390 000]	–51%
Children 0–14 years	230 000 [140 000–330 000]	130 000 [84 000–200 000]	89 000 [57 000–130 000]	67 000 [43 000–99 000]	61 000 [39 000–90 000]	–73%

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

Keeping HIV treatment alive in Sudan: rebuilding a response against the odds

In April 2023, armed conflict erupted in Sudan between the Sudanese Armed Forces and the Rapid Support Forces. What began as a power struggle has become one of the world's worst humanitarian disasters. The country is still in crisis. As for the HIV response, it is a slow uphill battle.

Before the war, 42 health facilities delivered free HIV treatment. As fighting spread, health centres closed and 70% of hospitals in Khartoum shut their doors. The Central Depot, where antiretroviral medicines were stored, became inaccessible. Unsafe supply routes and shifting frontlines disrupted distribution, bringing Sudan at risk of stockout of HIV medicines.

Millions of people have been displaced multiple times within Sudan, and an estimated 4.7 million people fled to neighbouring countries. For people living with HIV, the consequences were immediate. Many left without their medicines, lost contact with health providers or struggled to find life-saving treatment.

"Before the civil war, around 11 304 people were on treatment in Sudan. After the war started, the national programme estimated that number temporarily fell to 4419," says Ali Elsheikh, UNAIDS Senior Coordinator, Sudan.

Keeping the HIV response alive

As the only UNAIDS staff member in Sudan, Mr Ali worked with the Ministry of Health and partners to mobilize support for the national response. Joint efforts helped secure Global Fund support for HIV programmes covering 2024–2026, followed by approximately US$ 20.8 million for the next three years.

"Maintaining the HIV response during the war required strong coordination, aligned partnerships and continued focus on national priorities," says Dr Sara Azhari, Director of the Disease Control Directorate, Ministry of Health, Sudan.

Fathelrahman Hassan agrees. "We risked our lives relocating medicine stocks from frontline hospitals to safer neighbourhoods," he says. As Chair of the Sudanese PLHIV Care Association, he says they repurchased and recovered looted medicines from the markets and redistributed them to people living with HIV. Alongside these efforts, community networks played a vital role in tracing people lost to follow-up, reconnecting patients to care, enrolling newly diagnosed people and keeping people connected to treatment.

"We persevered in delivering treatment directly to doorsteps and tracking displaced persons to ensure no person living with HIV suffered treatment interruption," says Mr Fathelrahman.

UNAIDS mobilized technical expertise to support the development of Sudan's 2027–2030 National HIV Strategic Plan and the country's 2026 HIV estimates, helping maintain essential planning and monitoring despite the disruption.

By September 2026, according to national programme data, 15 037 people were accessing HIV treatment, more than three times the low point reached during the conflict in 2023 and around 24% above pre-war levels at the end of 2022.

The treatment network had been largely restored, with 39 treatment centres and seven distribution points operating.

The work is far from over

Fighting continues, and an estimated 8.6 million people remain displaced. HIV prevention services have yet to recover, and preventing vertical transmission remains a growing concern. Against this backdrop, the wider epidemic remains under pressure.

Estimates suggest that the number of people living with HIV in Sudan rose from 44 000 in 2022 to 50 000 in 2025, and the number of new infections increased from 4600 to 5300. These estimates should be interpreted with caution, however, because the war severely disrupted data collection and surveillance.

"Until everyone, everywhere, can access the services they need, this progress remains fragile. History has shown us how quickly gains can be reversed," says Mr Ali.

Sudan has shown that even amidst war, an HIV treatment response can be rebuilt and sustained. Protecting these gains requires continued resources, partnerships and determination. The progress made cannot become another casualty of the war.



Credit: WHO / Lindsay Mackenzie

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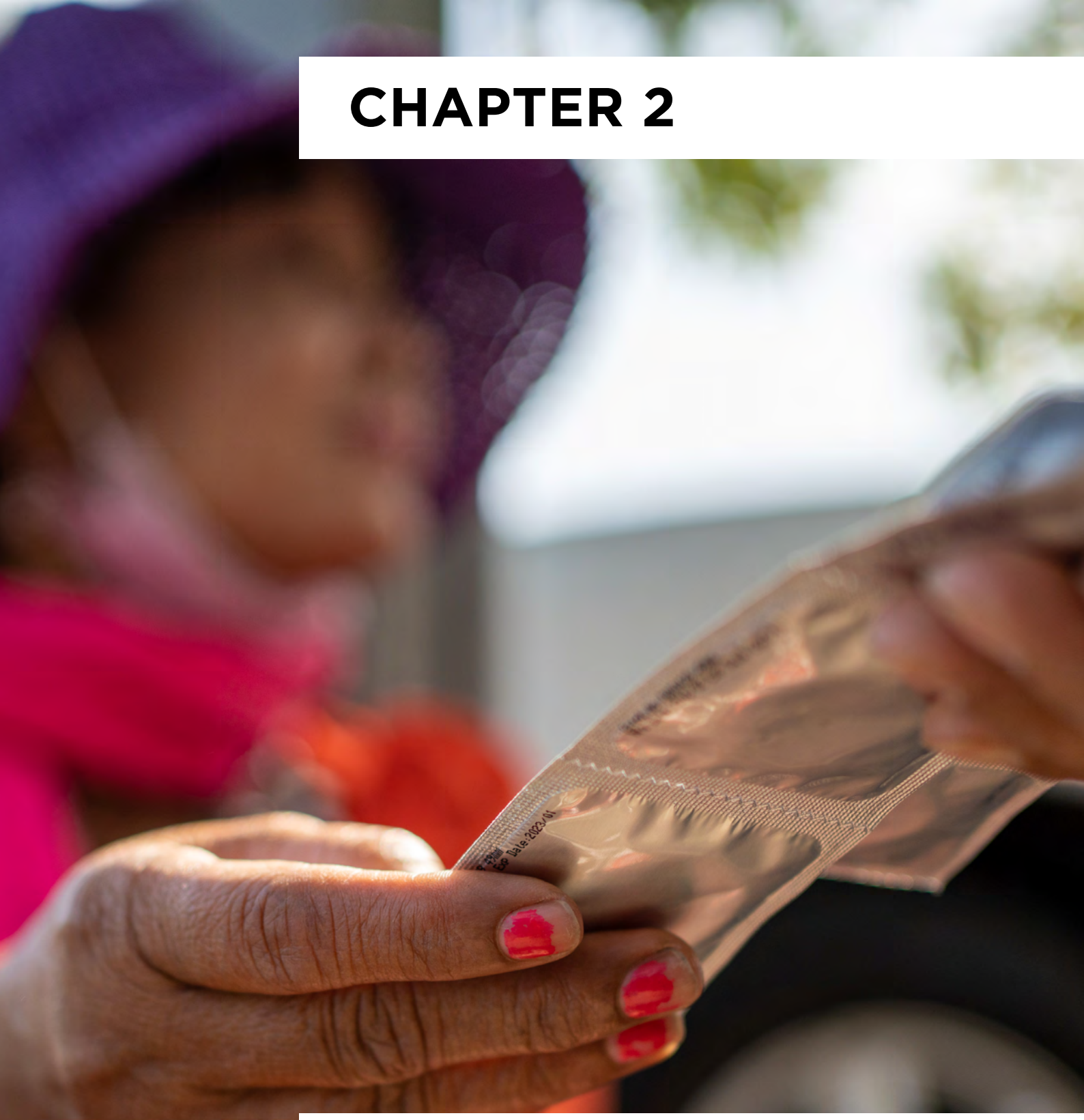
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CHAPTER 2

Improving access to HIV services for all

HIV is preventable and treatable. The science, technologies and services for controlling and eventually ending the HIV pandemic already exist, and the strategies and approaches for deploying these tools effectively are well understood.

A growing number of countries are reaping the rewards of this knowledge and experience. Seven countries with high burdens of HIV have reduced the annual number of people acquiring HIV by more than 78% since 2010; 12 countries are providing at least 90% of people living with HIV with lifesaving antiretroviral medicines; and 22 countries or territories have been validated for eliminating vertical transmission of HIV (Table 2.1).

This list of countries, however, should be much longer. Millions of people across the world still cannot access or struggle to use the services and tools that will keep them HIV-free or enable them to live long, healthy lives if they do acquire HIV. This constitutes a failure of universal health care, despite the huge accomplishments of the global HIV response.

Persistent barriers continue to impede progress. Most of the barriers blocking access are well understood. They include health system deficiencies, unaffordable costs of health care, staffing and other shortages, stigma, discrimination and persecution, and harmful norms and punitive laws that prevent access to HIV services. In addition, underlying gender and other forms of inequality deprive people of their autonomy and rights, while increasing their vulnerability to adverse health outcomes and exposing them to harm. In some cases, essential HIV services or commodities remain unavailable or in short supply, such as harm reduction services for people who use drugs.

Many countries have implemented changes to remove these barriers and make HIV services more accessible and user-friendly, but these efforts are not enough and countries are experiencing major setbacks.

Table 2.1. Progress towards HIV prevention, treatment and elimination of vertical transmission targets

Reduced number of new HIV infections by more than 78% since 2010	Provides at least 90% of people living with HIV with lifesaving antiretroviral medicines	Validated for eliminating vertical transmission of HIV (countries or territories)	
Benin	Botswana	Anguilla	Dominica
Eswatini	Cambodia	Antigua and Barbuda	Jamaica
Kenya	Eswatini	Armenia	Malaysia
Lesotho	Kenya	Bahamas	Maldives
Nepal	Lesotho	Belarus	Montserrat
Rwanda	Namibia	Belize	Oman
Zimbabwe	Rwanda	Bermuda	Saint Kitts and Nevis
	Sao Tome and Principe	Brazil	Saint Vincent and Grenadines
	Saudi Arabia	Cayman Islands	Sri Lanka
	Togo	Cuba	Thailand
	Zambia	Denmark	Turks and Caicos
	Zimbabwe		

Note: a 78% reduction from 2010 suggests countries are on track to reach a 90% reduction by 2030.

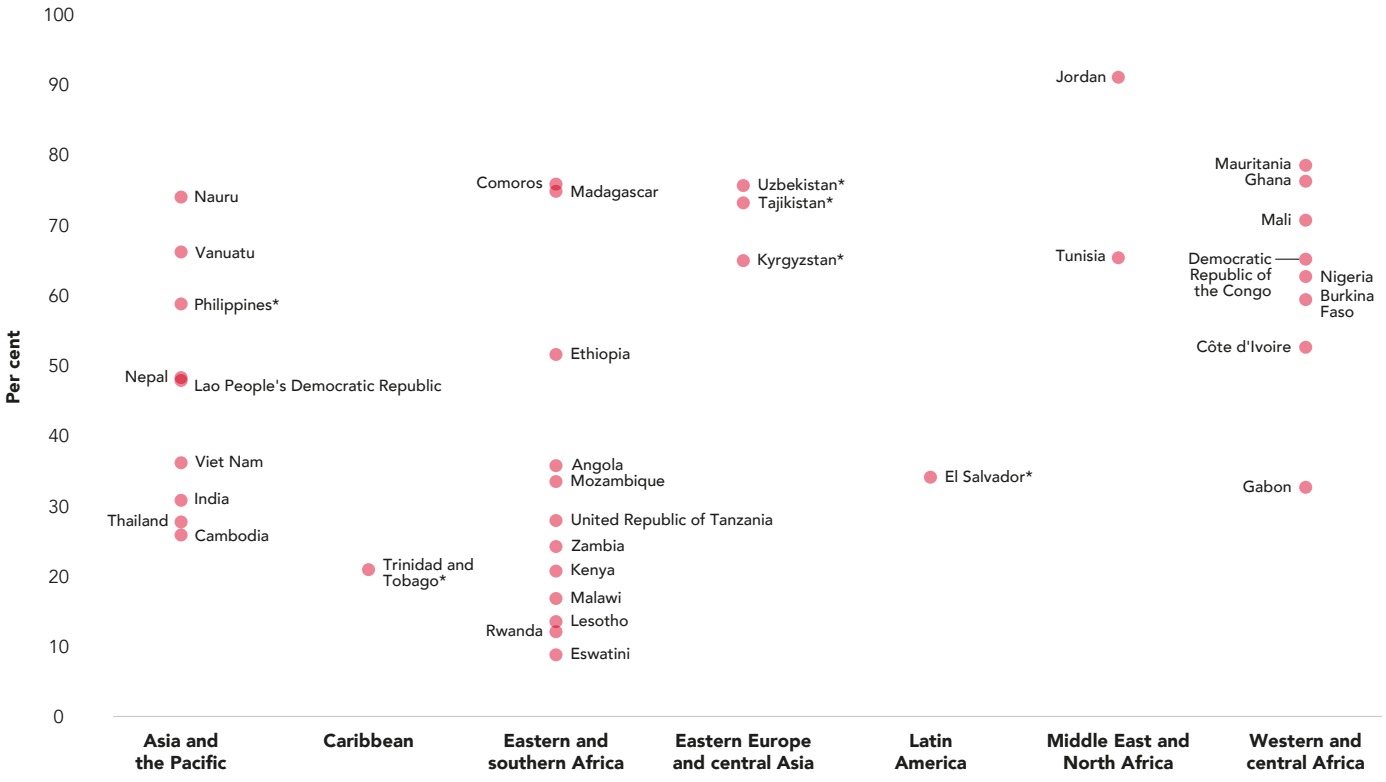
Too many barriers are in the way

After years of steady gains, the push to provide HIV services and establish conditions that will enable the world to end AIDS as a public health threat by 2030 is on the backfoot. The communities and governments committed to this goal are struggling to regroup.

Stigma and discrimination remain widespread

More than 40 years into the HIV pandemic, stigma and discrimination still undermine HIV prevention, treatment and care. In median, half of adults aged 15–49 years reported having discriminatory attitudes towards people living with HIV across 36 countries with recent data. The prevalence of these attitudes ranges widely (Figure 2.1) but appears to be especially high in western and central Africa. Analysis of data from 38 countries for 2000–2023 shows that discriminatory attitudes towards people living with HIV negatively affect HIV testing and their use of and adherence to HIV treatment *(1)*.

Figure 2.1. Percentage of women and men (aged 15–49 years) who report discriminatory attitudes towards people living with HIV, countries with available data, 2021–2025



Source: population-based surveys 2021–2025.
* Data for women only.
Note: 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 who are HIV-negative.

In only a few countries, including Eswatini, Lesotho and Rwanda, do less than 10% of people report discriminatory attitudes towards people living with HIV. These gains must be actively defended *(2)*. In several countries with data covering multiple years, earlier declines in the prevalence of discriminatory attitudes have either stalled or reversed. Stigma and discrimination in health-care settings continue to impede access to lifesaving medicines and services (see Chapter 3).

Experiences of stigma and discrimination remain very common among people from key populations (Figure 2.2). In countries with available data, at least 29% of sex workers, people who inject drugs and transgender people had experienced stigma and discrimination in the previous six months.

Feelings of shame, low esteem and self-blame associated with internalized stigma can isolate people from support and HIV services. A meta-analysis of studies from sub-Saharan Africa reported that over a third (36%) of people living with HIV experienced internalized stigma *(3)*.

Figure 2.2. Number of countries by reported levels of stigma and discrimination among people from key populations in the past six months, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/).
n = number of countries.
Note: the size of the bubble reflects the number of countries reaching each threshold. Median values are 29% for sex workers, 16% for gay men and other men who have sex with men, 30% for people who inject drugs and 34% for transgender people.

From shame to self-worth: young women living with HIV and female sex workers in Ghana reclaim confidence, self-agency and hope



At 7 o'clock each morning, the women began the day in silence.

They walked together before returning to sessions that asked them to confront some of life's hardest questions: What do I believe about myself? What am I afraid of? What do I want my future to look like?

For six days, 33 women, including 20 living with HIV, came together for MeSombo ("I am worth it"), adapted from Zimbabwe's Wakakosha programme. This residential programme created a safe space for women to confront feelings of shame and consider questions about their relationships, bodies, HIV treatment needs and futures, using meditation, music, dance, writing and stress reduction exercises to challenge deeply held negative beliefs. The programme is modelled on a community-led internal stigma reduction intervention developed by Beyond Stigma and Zvandiri *(4)*.

Initiated by UNAIDS Ghana and developed with networks of people living with HIV and community partners, MeSombo was a response to evidence of persistent internalized stigma, psychosocial distress and social exclusion, particularly among women facing intersecting vulnerabilities linked to HIV, sex work, gender-based violence and poverty.

The programme did not stop at emotional healing. Through a wider empowerment initiative, DAAKYE, participants received human rights education, vocational training, mentorship, start-up kits for income-earning activities, and referrals to mechanisms for seeking redress when their rights are violated. Early results suggest the programme has had an impact. At baseline, less than half of participating adolescent girls and young women expressed pride in themselves, and more than 60% reported guilt or worthlessness. By the end of the pilot, 80% reported improved self-esteem and confidence, and knowledge of where to report rights violations rose from less than 30% to 90%. There has also been an improvement in adherence to HIV treatment.

For Gifty Teye, the change was also about taking care of herself: "I realized that I love myself and that I had let myself down by not taking my medicine and eating on time. With MeSombo, I remind myself that I have to take time for myself and eat well."

The story did not end with the programme. In September 2025, participants from the first DAAKYE cohort returned for refresher and peer-advocacy training, and then took their learning into their communities. Over three days, they led outreach activities in health centres, markets and churches, reaching 345 people and strengthening links with health and faith institutions.

One of the participants, Patience, says: "After MeSombo, I've made up my mind that I won't waste even one minute of my life because I have a lot to achieve!"

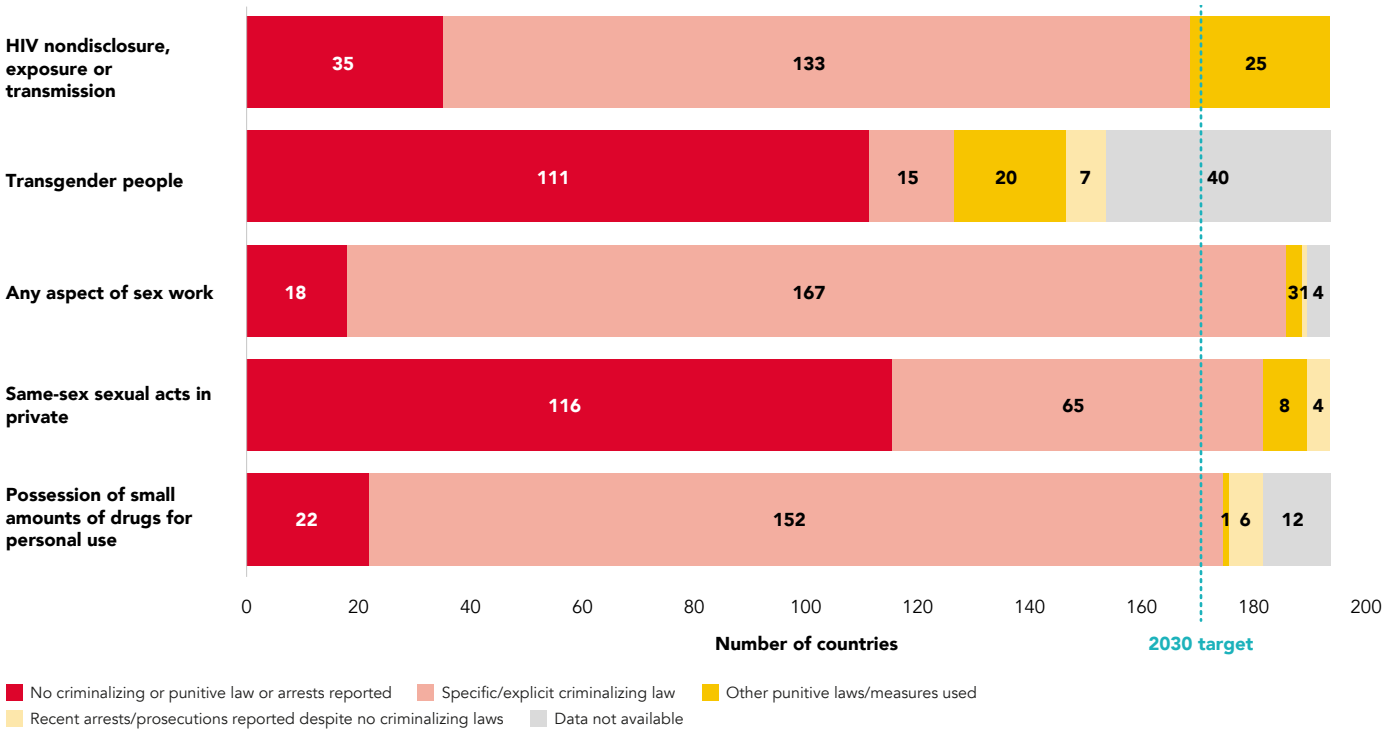
Punitive laws still prevent access to HIV services

Punitive laws that target people living with HIV and people from key populations remain in place in the majority of countries, even though multiple studies show they create enormous harm and undermine public health *(5–7)*. Only four countries do not have laws that criminalize HIV nondisclosure, exposure or transmission, sex work, same-sex sexual acts in private, transgender people, or possession of small amounts of drugs for personal use, or do not have prosecutions based on general criminal laws for HIV nondisclosure, exposure or transmission in the past 10 years. Often people from these populations are persecuted by authorities even in the absence of specific laws targeting them (Figure 2.3).

Such laws cause people to delay or avoid seeking HIV and other prevention, treatment and care services (see Chapter 3). In some countries, even routine interactions with health-care providers can expose people living with HIV to possible criminal investigations and prosecution *(8)*. Age-of-consent limitations for access to HIV prevention and treatment services can hinder access to HIV and other vital services, especially for adolescent girls and young women *(9)*.

Although some countries and jurisdictions have taken positive steps, the large majority still criminalize some aspect of sex work (167 countries) or possession of small amounts of drugs (152 countries). Many countries criminalize same-sex sexual relations (65 countries) or transgender people (15 countries). People at increased risk of HIV are often subject to multiple criminalizing laws that target their sexual orientation, gender identity, sex worker status or drug use.

Figure 2.3. Number of countries with discriminatory and punitive laws and approaches, 2026



Source: National Commitments and Policy Instrument 2017–2026, supplemented by additional sources (http://lawsandpolicies.unaids.org/).

Despite the growth of anti-rights campaigns in many countries, there has been some progress in repealing criminalizing laws that inhibit HIV responses. Sixteen countries[1] have decriminalized private, consensual same-sex intercourse in the past decade, including, most recently, Trinidad and Tobago *(10, 11)*. There have been setbacks, however, including in Burkina Faso and Niger, which have introduced laws criminalizing same-sex sexual acts and gender expression, and Senegal, which has increased penalties for sex between men, affecting their ability to access HIV prevention and treatment services.

In some settings criminalizing laws are enforced erratically or not at all, but in other countries arrests or prosecutions are being reported despite the existence of moratoria or absence of explicit criminalizing laws *(12)*. In addition to arrest and prosecution, criminalizing laws sanction everyday harassment and physical harm, often by the police *(13)*. Even without legislative changes, shifts in political and social discourse that normalize bigotry and victimization can increase people's exposure to violence, harassment, stigma and discrimination—and ultimately reduce access to HIV services.

Reforms to laws criminalizing HIV nondisclosure, exposure and transmission in several countries show that positive changes are possible. Legal actions to decriminalize HIV nondisclosure, exposure or transmission, transgender people, sex work, same-sex sexual acts and possession of small amounts of drugs for personal use were under way in about 23 countries in mid-2026 *(14)*.

Public health-focused engagement with law enforcement agencies, especially at local levels, can have positive outcomes. Training police officers to improve their knowledge of HIV and injecting drug use can benefit both law enforcement and communities, as shown in Tijuana, Mexico, and elsewhere *(15–17)*.

Protections and legal redress for rights violations

Most countries with available data report having legal protections[2] against discrimination based on HIV status. Very few countries, however, report having legal protections against discrimination based on involvement in sex work, drug use or possession, gender identity or sexual orientation (Figure 2.4), despite these protections being important for people to safely access HIV treatment and prevention services. In some countries, legal protections are offset by criminalizing laws, punitive law enforcement practices, and dismissive attitudes of public officials.

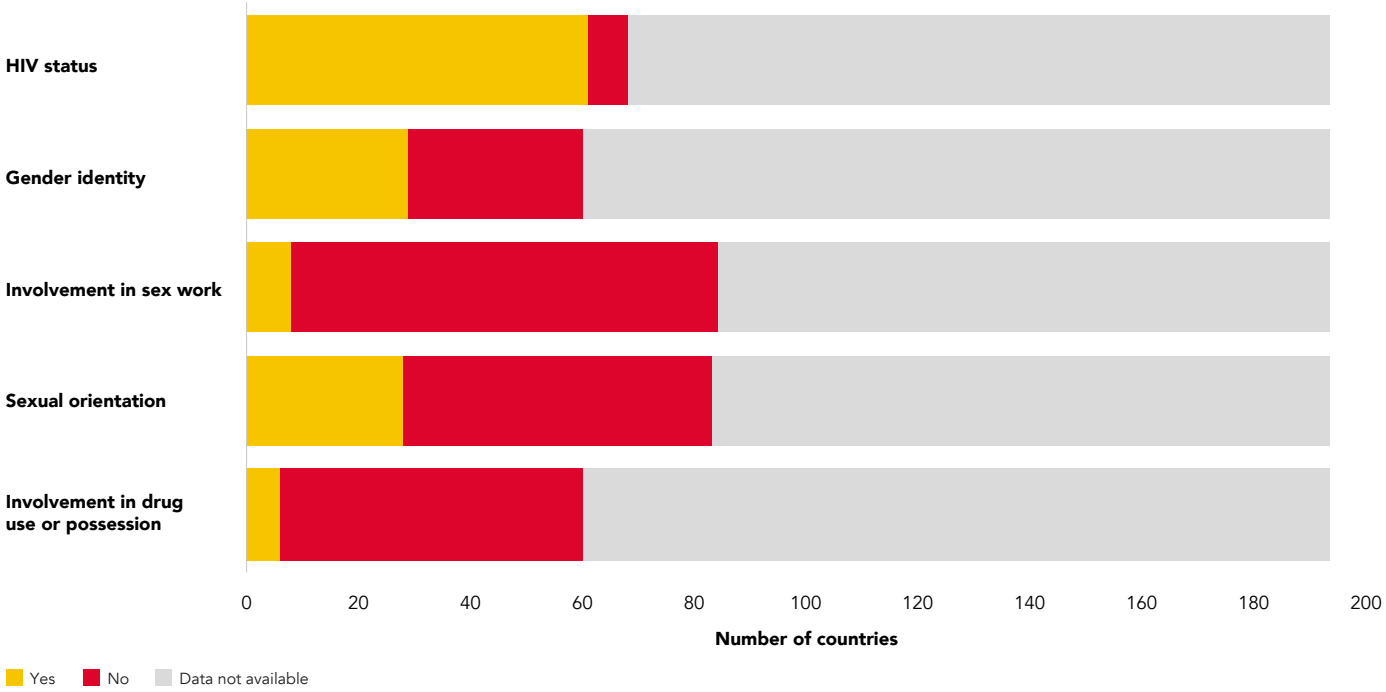
People from key populations can safely report violence or discrimination to law enforcement structures in only a minority of countries and to varying degrees *(18)*. Even where constitutional or legislative protections are nominally in place, it is still deemed unsafe or risky for people from key populations to report violence or discrimination to the authorities in a significant number of countries *(19)*.

Protective actions are possible. Even when there are no specific constitutional or legal protections in place for people from key populations, general legislative prohibitions of discrimination have

1 Angola, Antigua and Barbuda, Barbados, Belize, Bhutan, Botswana, Dominica, India, Mauritius, Namibia, Nauru, Saint Kitts and Nevis, Saint Lucia, Seychelles, Singapore, Trinidad and Tobago.

2 Legal protections refer to constitutional or legal protections specifying HIV status, gender identity or sexual orientation as a protected attribute; courts or government having legally recognized that HIV status, gender identity, sex work, sexual orientation or drug use or possession are protected under another attribute; or other legal protection.

Figure 2.4. Number of countries with legislative or legal protections against discrimination, by basis, global, 2017–2026



Source: National Commitments and Policy Instrument 2017–2026 (http://lawsandpolicies.unaids.org/).

been used successfully in the past two years to protect or advocate for their rights. This was done to protect people on the basis of their sexual orientation (37 countries) or to protect transgender people (36 countries), sex workers (35 countries) or people who use drugs (39 countries).[3]

More accessible and robust mechanisms for reporting and addressing discrimination are needed, along with affordable legal services to challenge rights violations. In 2026, 81 countries had mechanisms established by the government and 72 countries had mechanisms established by community or nongovernmental organizations to record and address HIV-related discrimination. Access to legal support was nominally available in 109 countries *(19)*.

Gender-based violence and inequalities persist

Gender-based violence occurs worldwide and is often perpetrated in situations of war and armed conflict *(20)*. An unsettling proportion of women and adolescent girls experience intimate partner violence.[4] Overall, an estimated 14% of ever-married or ever-partnered women aged 15–49 years experienced physical or sexual intimate partner violence at some point in the past 12 months *(21)*. More than one in five ever-married or ever-partnered adolescent girls aged 15–19 years (23%) are estimated to have experienced physical or sexual intimate partner violence at least once in their lifetime, and one in six (16%) have experienced such violence in the past 12 months *(21)*.

3 Against discrimination based on HIV status, gender identity, sexual orientation, involvement in sex work or involvement in drug use or possession.

4 Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.



Challenges faced by survivors of violence adapting to life in new countries in western Africa

Nadia (not her real name) was allegedly abducted from Burkina Faso and detained in a secret location for more than 50 days.

The 21-year-old transgender woman said the lights were continuously on and she nearly lost her eyesight. She reported being tortured, beaten and forced to reveal the password to her phone so she could identify all the LGBTQIA+ people in her contacts list, under threat of death.

She is living with HIV, but she did not disclose her status or request antiretroviral therapy.

After her release, one of her friends contacted Alternative Côte d'Ivoire, a nongovernmental organization focused on defending the rights of LGBTQIA+ people and HIV awareness. The Safe Horizon project provided funds to help Nadia leave the country and find refuge. Forty other people benefited from their help in 2025.

Many refugees to Côte d'Ivoire described trauma, loneliness and a sense of loss. After nearly three months, Nadia has shown progress, however, adapting well through a local support network and becoming increasingly involved in community activities in Abidjan, the capital city. "I am really happy to be in Abidjan, even though I left everything behind. At least here I feel safe. I miss my family, but here I have found another family at Alternative Côte d'Ivoire's shelter. I want to stay, rebuild my life, find work and become independent," says Nadia.

Several organizations in Côte d'Ivoire offer vocational and economic empowerment training for refugee women and transgender people. Other organizations, such as Ivoirian Human Rights Defenders and the West African Network of Human Rights Defenders, which are not LGBTQIA+ organizations, regularly refer cases to Alternative Côte d'Ivoire for relocation support while continuing to provide case management.

For people living with HIV, Espace Confiance, financed by the French nongovernmental organization Sidaction, and the Blockhaus Hospital provide health services and access to antiretroviral therapy. Arc en Ciel+ runs a drop-in centre for LGBTQIA+ people but has limited funds and cannot handle relocations.

Survivors of violence have expressed a desire to find employment or develop income-generating activities—often not possible where LGBTQIA+ people are criminalized in their country of origin. "For beneficiaries whose return is impossible in the short and medium term because of persistent risks of persecution, economic empowerment remains a key priority," says Umunyana Rugege, Director of the UNAIDS Communities and Human Rights team.

Psychological support also remains a central pillar of helping vulnerable people and people living with or at risk of HIV.

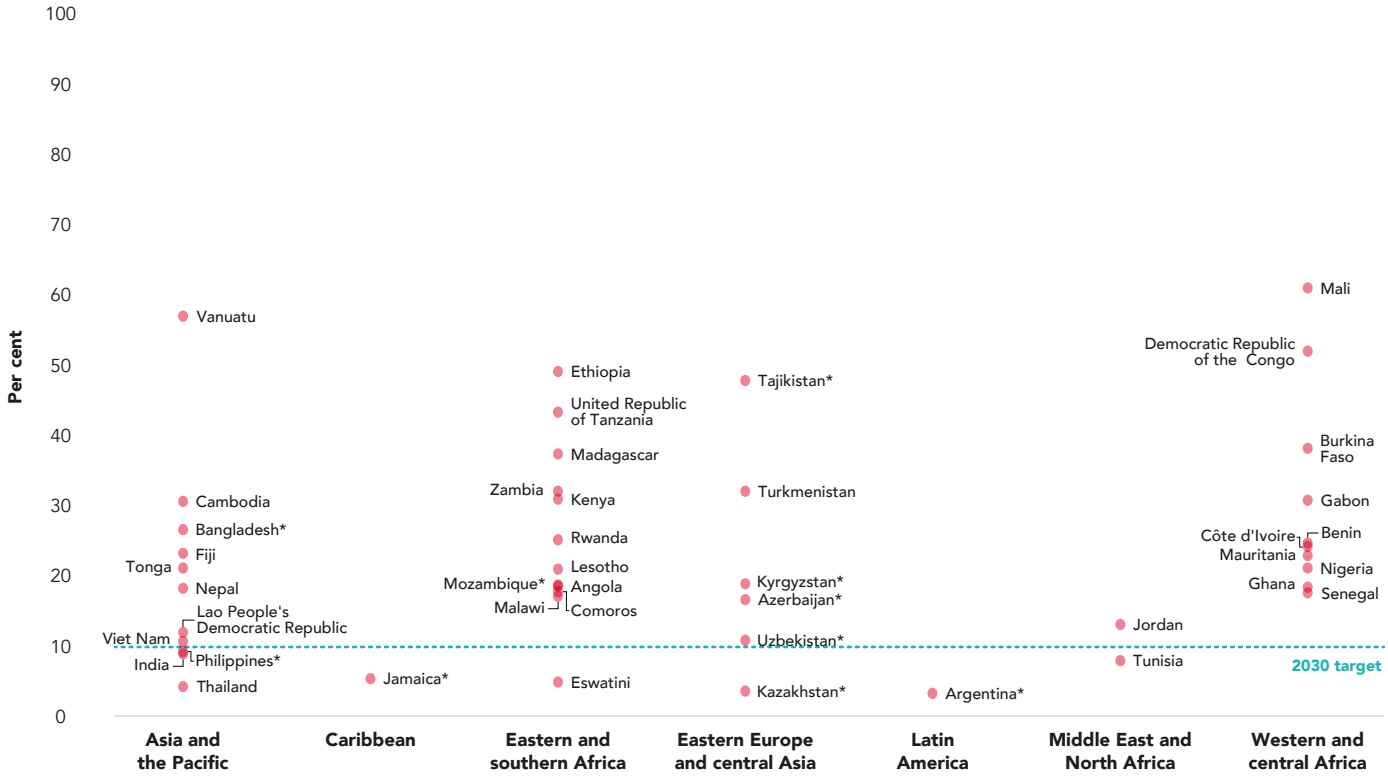
More pressing for nongovernmental organizations is helping people obtain refugee status in Côte d'Ivoire, especially with conflicts flaring up in neighbouring countries. Another concern is funding, because resources for the Safe Horizon project run out in April 2027. Community groups such as Alternative Côte d'Ivoire are critical for ensuring continuity of access to HIV services for people in challenging contexts.

An ongoing concern is the extent to which violence against women and girls is condoned in societies. Across 43 countries with available data, in median more than one in five adult men and women (21%) expressed accepting attitudes towards violence against women, ranging from 3.1% in Argentina to 61% in Mali (Figure 2.5) *(22)*.[5]

There is evidence that intimate partner violence is associated with increased risk of acquiring HIV in settings with a high burden of HIV, and that it dissuades women from accessing HIV prevention and care services *(23)*. The experience or fear of physical or sexual violence can deter women living with HIV from accessing treatment and care and continuing to take antiretroviral medicines *(24)*, increasing the risk of transmitting HIV to their children during pregnancy, delivery or breastfeeding.

Experiences of sexual or physical violence among people from key populations deter people from using HIV services and adhering to antiretroviral therapy *(25)*. Across countries with available data, a median of 22–23% of transgender people, people who inject drugs and sex workers, and 9% of gay men and other men who have sex with men had experienced recent sexual or physical violence (Figure 2.6).

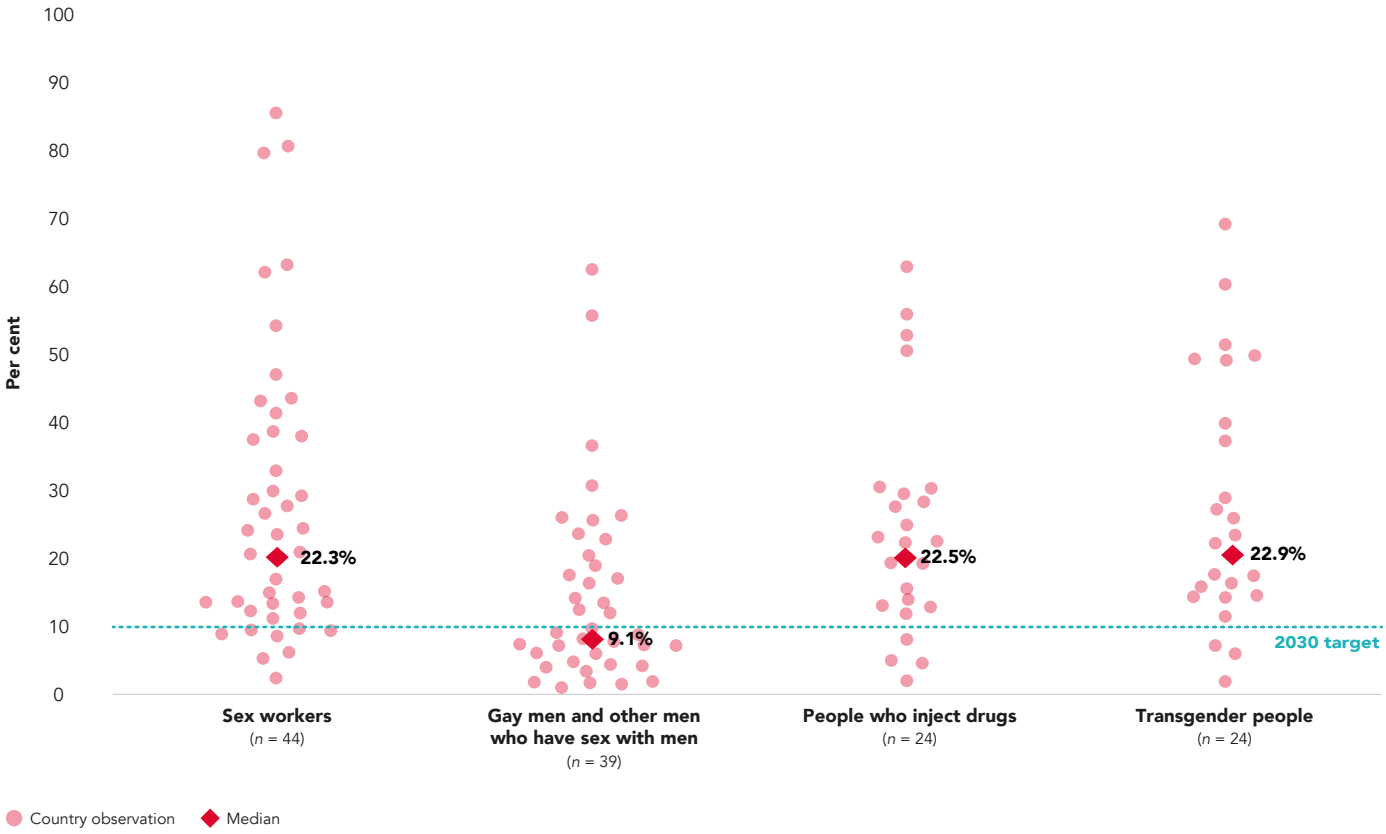
Figure 2.5. Percentage of women and men (aged 15–49 years) who report having accepting attitudes towards violence against women, countries with available data, 2021–2025



Source: population-based surveys 2021–2025.
*Data for women only.
Note: accepting attitudes towards violence are measured as agreement with five statements on whether a husband is "justified" in hitting or beating his wife in the following situations: goes out without telling him, neglects the children, argues with him, refuses to have sex with him, burns the food.

5 Accepting attitudes towards violence are measured as agreement with five statements on whether a husband is "justified" in hitting or beating his wife in the following situations: goes out without telling him, neglects the children, argues with him, refuses to have sex with him, burns the food.

Figure 2.6. Percentage of people from key populations with experience of sexual or physical violence in the past 12 months, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/).
Note: *n* = number of countries.

Violence takes many forms, including denying women the ability to make informed decisions about contraceptive use, sexual relations or their own health care, with only a little over half (56%) of adolescent girls and adult women aged 15–49 years saying they can do so *(26, 27)*. For example, barriers facing women from key populations can be especially daunting. Women who inject drugs experience intersecting forms of discrimination, high rates of gender-based violence, and other injustices that restrict their access to sexual and reproductive health care *(28, 29)*. Gender inequalities, discrimination and poverty limit economic autonomy and control of women and adolescent girls over their sexual and reproductive lives, increasing their vulnerability to HIV, especially in sub-Saharan Africa *(30, 31)*. Young women comprise nearly 61% of African youth not in employment, education or training, with about a quarter citing unpaid care obligations as the main reason *(32)*.

When barriers are removed or sidestepped—and when the underlying health and community systems function well—more people can access, use and benefit from HIV services, and countries move closer to controlling their HIV epidemics. Additional barriers are now in play, however. Funding disruptions have forced community organizations to shut their doors, halting outreach and peer support work, eroding HIV services, and chipping away at data and procurement systems. In many countries, this is happening amid ongoing campaigns aimed at depriving women and LGBTQIA+ people of their rights and liberties *(33, 34)*.

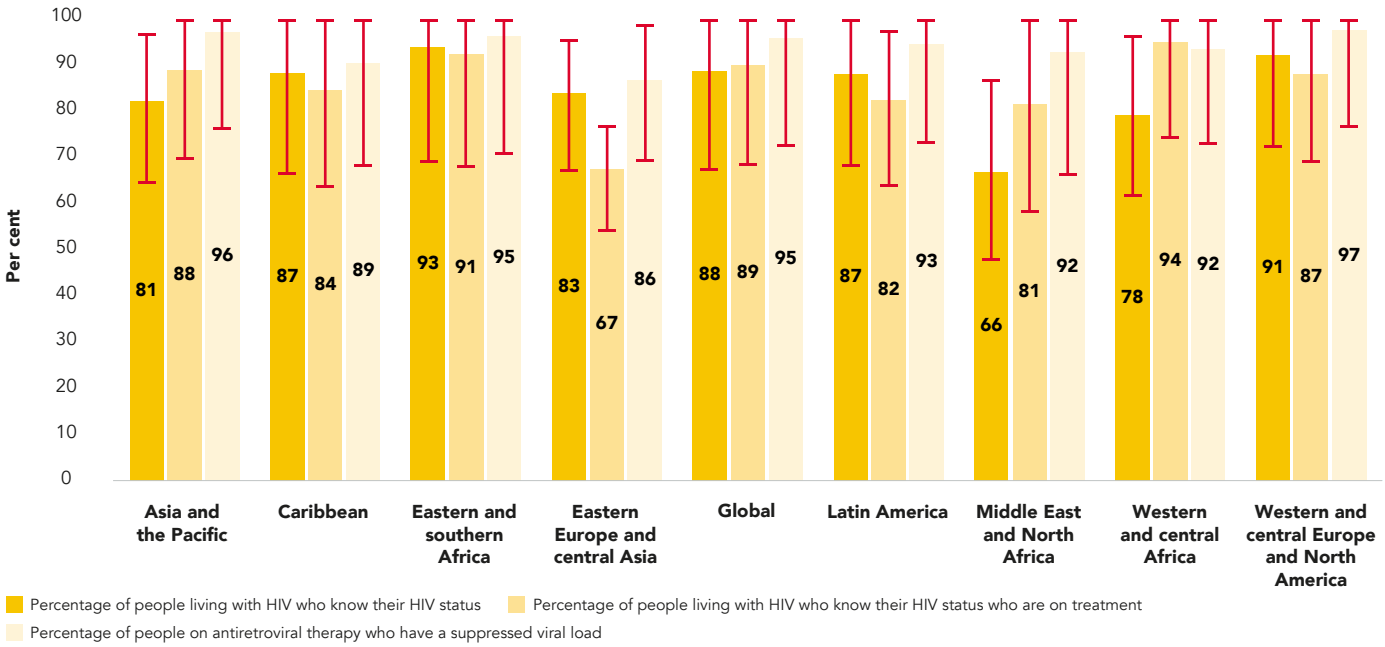
Treatment services are expanding, but slowly and unevenly

Despite many barriers, countries have edged closer to making HIV treatment and care accessible on a scale that can end AIDS as a public health threat. Globally in 2025, 88% [67–>98%] of people living with HIV knew their HIV status, 89% [67–>98%] of these were on antiretroviral therapy, and 95% [72–>98%] of people on treatment had a suppressed viral load—close to the 95–95–95 targets the world set out to achieve by 2030.

As in previous years, however, not everyone is benefiting equally. Children, adolescents, men and people from key populations are still much less likely to know their HIV status, be on treatment or have a suppressed viral load, as are people living with HIV in eastern Europe and central Asia and the Middle East and North Africa (Figure 2.7).

In some regions, large proportions of people living with HIV are not aware they have acquired HIV (34% in the Middle East and North Africa, 22% in western and central Africa, 19% in Asia and the Pacific in 2025). In other regions, linking people who test positive for HIV to treatment and care is the biggest weakness. In 2025, an estimated 33% of people diagnosed with HIV in eastern Europe and central Asia, 18% in Latin America and 16% in the Caribbean were not on antiretroviral therapy. Funding losses raise concerns that an equitable global rollout of HIV treatment may become increasingly difficult to achieve.

Figure 2.7. Progress towards the 95–95–95 testing, treatment and viral load suppression targets, global and by region, 2025

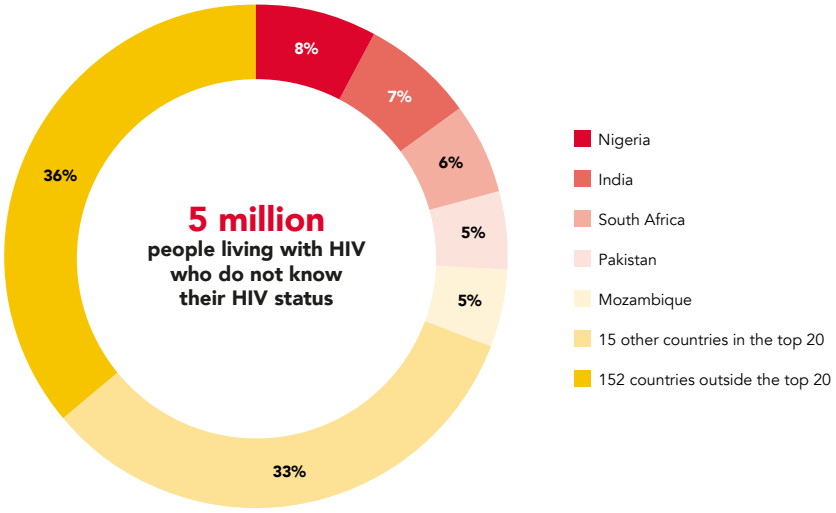


Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

Fewer people are taking HIV tests

HIV testing is the first step towards knowing one's HIV status and if necessary starting HIV treatment. Yet the number of HIV tests taken declined between 2024 and 2025 globally. Among 91 countries that reported on HIV testing in both 2024 and 2025, there was a drop of 13 million HIV tests (from 246 million in 2024 to 233 million in 2025).[6] The declines were notable in a majority of the 15 countries with the biggest HIV testing programmes and were especially steep in eastern and southern Africa. This trend appears to be related to disruptions in supplies and services caused by sudden funding losses in early 2025. If fewer HIV tests are done or tests are not available to people at increased risk of HIV, more cases remain undetected and untreated, exposing people to HIV-related illnesses and allowing continued transmission. In 2025, 5 million people across the world did not know they were living with HIV, with almost two-thirds of these (64%) living in only 20 countries (Figure 2.8).[7]

Figure 2.8. Percentage of people living with HIV who did not know their HIV status, 20 countries with large gaps, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/). This summary excludes countries for which UNAIDS estimates were not published.

Treatment coverage is improving—but gaps remain

Over the past three decades, the world has seen a remarkable increase in the number of people receiving lifesaving HIV treatment, a feat that has averted an estimated 28.5 million [21.8 million–39.5 million] deaths. Twenty years ago, 1.9 million [1.7 million–2.0 million] people were receiving antiretroviral therapy, mostly in high-income countries; in 2025, this number had risen to an estimated 32.1 million [28.2 million–33.4 million] people, most of whom were receiving free or subsidized treatment.

In 2025, treatment coverage in eastern and southern Africa (85% [62–>98%]) was comparable to that in many high-income countries in western and central Europe and North America (80% [62–91%]). In Asia and the Pacific, the Caribbean, Latin America, and western and central Africa, coverage has risen, but to lower levels (around 72–74%), but it languishes below 60% in eastern Europe and central Asia and the Middle East and North Africa.

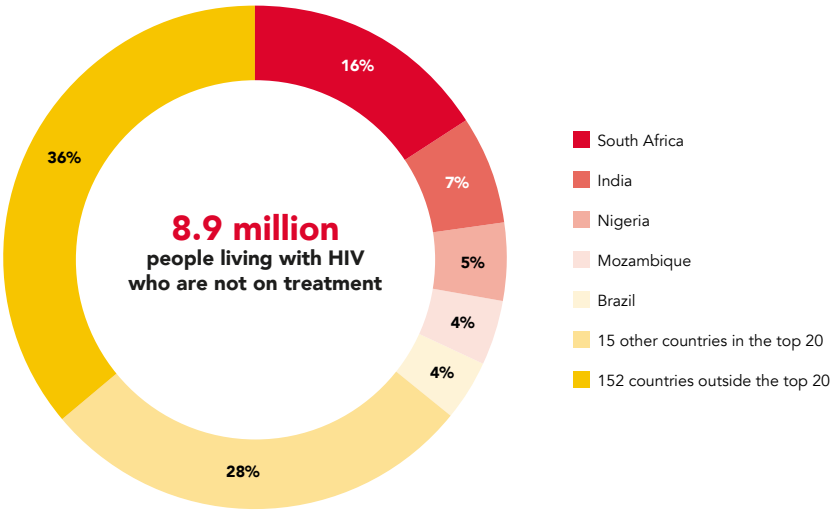
The rate of expansion in treatment coverage has been slowing since 2019–2020 in eastern and southern Africa and outside sub-Saharan Africa, and since about 2023 in western and central Africa. As treatment coverage expands, it becomes more difficult for programmes to reach the remaining people living with HIV, many of whom are from marginalized populations or do not routinely interact with the health-care system. In some instances, age-of-consent laws block access, or humanitarian crises such as climate change or armed conflict make it more difficult to maintain HIV treatment and care services *(36)*.

6 Numbers of HIV tests will fluctuate for multiple reasons, including due to funding constraints, testing policies, and testing campaign strategies *(35)*.

7 Additional countries in descending order include: Indonesia, Democratic Republic of the Congo, United Republic of Tanzania, Mexico, Madagascar, Angola, Kenya, Ghana, Uganda, Philippines, Brazil, Ethiopia, Côte d'Ivoire, Cameroon, Congo. This analysis excludes countries for which UNAIDS estimates were not published.

About half of the 8.9 million people living with HIV but not receiving antiretroviral therapy are in sub-Saharan Africa, a reminder of the scale of the HIV epidemic there. In eastern and southern Africa, 85% [62–>98%] of people living with HIV were on antiretroviral therapy in 2025, but this still meant 3.2 million people were not on treatment. A further quarter of all people not on HIV treatment were in Asia and the Pacific. Five countries accounted for more than a third of all people living with HIV who were not on antiretroviral therapy in 2025—Brazil, India, Mozambique, Nigeria and South Africa (Figure 2.9).

Figure 2.9. Percentage of people living with HIV who were not on antiretroviral therapy, 20 countries with large gaps, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/). This analysis excludes countries for which UNAIDS estimates were not published.



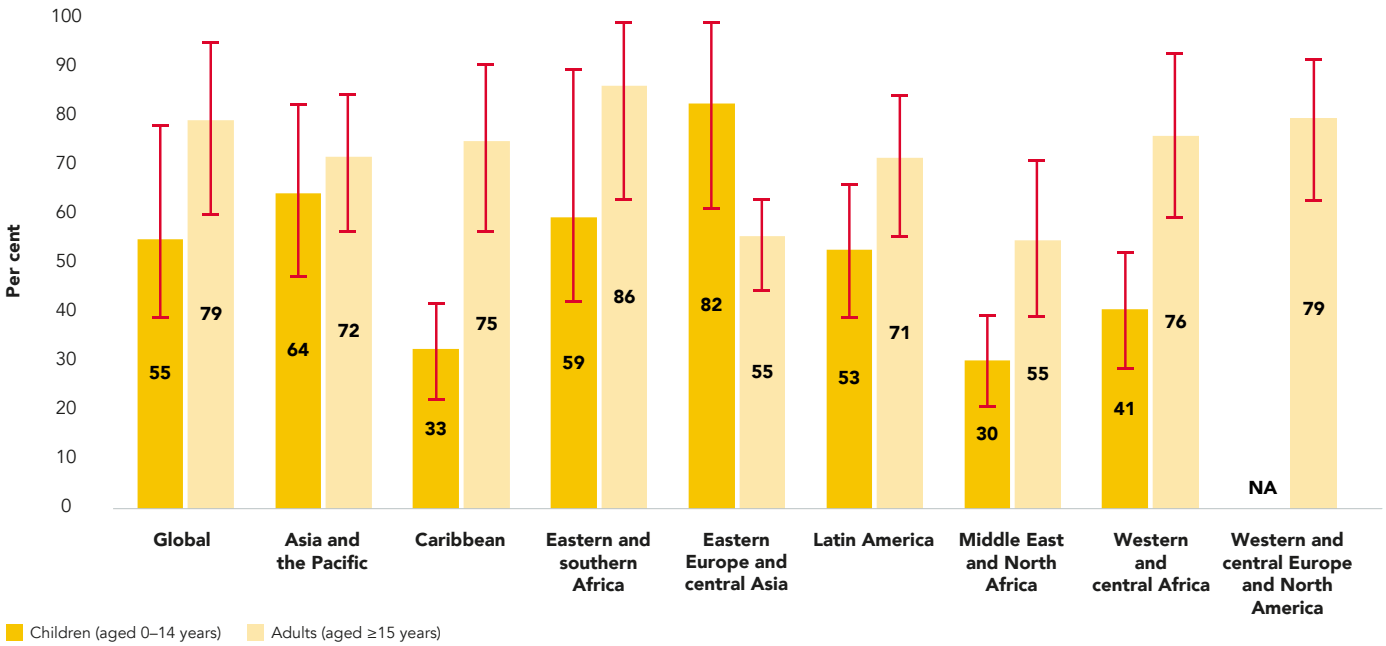
Only about half of children who need HIV treatment are receiving it

Paediatric HIV care remains a critical gap in the global HIV response (Figure 2.10). Of the estimated 1.3 million [1.0 million–1.7 million] children aged 0–14 years living with HIV in 2025, 690 000 [610 000–720 000] (55% [39–78%]) were receiving antiretroviral therapy. This means almost half (570 000) of all children living with HIV were not on HIV treatment. More than 80% of these children were in sub-Saharan Africa and were aged over 5 years. None of the 10 countries—all in sub-Saharan Africa—that account for two-thirds of all children living with HIV is close to reaching the 2030 target of 95% treatment coverage. Among adolescents aged 15–19 years, HIV treatment coverage was 63% globally and 71% in eastern and southern Africa.

Treatment services in some countries with large populations of children living with HIV were disrupted by the 2025 funding cuts. The number of children requiring and receiving HIV treatment has been falling, as fewer children acquire HIV and people living with HIV "age out" of the 0–14 years cohort. However some countries had declines in the percentage of children living with HIV receiving treatment between 2024 and 2025, including countries such as Kenya, Haiti and Lesotho. An analysis of high-burden countries found similar results *(37)*. This suggests children are being lost from treatment in some countries, although it should be noted that the analysis did not reflect subsequent recuperation of services that were taken over by governments or communities after PEPFAR programmes closed.

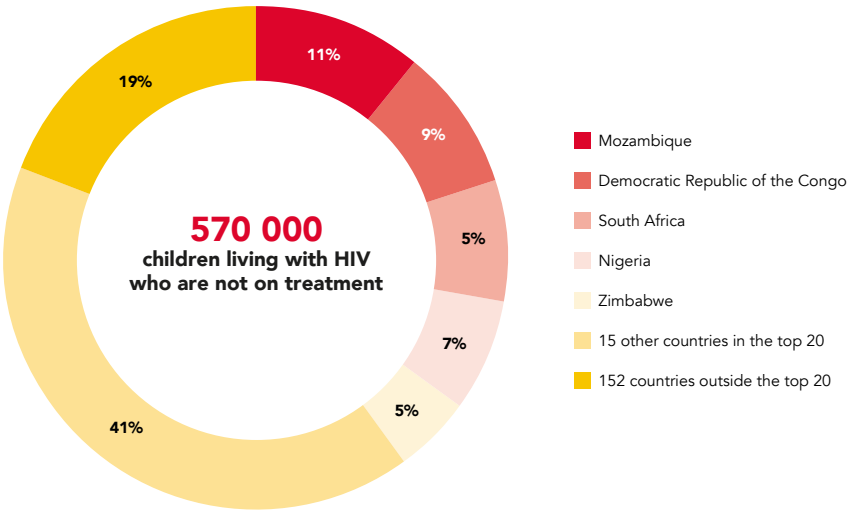
The treatment gap for children is concentrated within a small number of countries. More than 80% of children living with HIV but not on treatment in 2025 were in only 20 countries (Figure 2.11). Bridging the gap in these countries would dramatically accelerate the push to end AIDS in children.

Figure 2.10. Percentage of children (aged 0–14 years) living with HIV and adults (aged ≥15 years) receiving antiretroviral therapy, global and by region, 2025



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

Figure 2.11. Percentage of children (aged 0–14 years) living with HIV but not on antiretroviral therapy, 20 countries with largest treatment gaps, 2025



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

Despite progress, many people are still not receiving treatment in sub-Saharan Africa

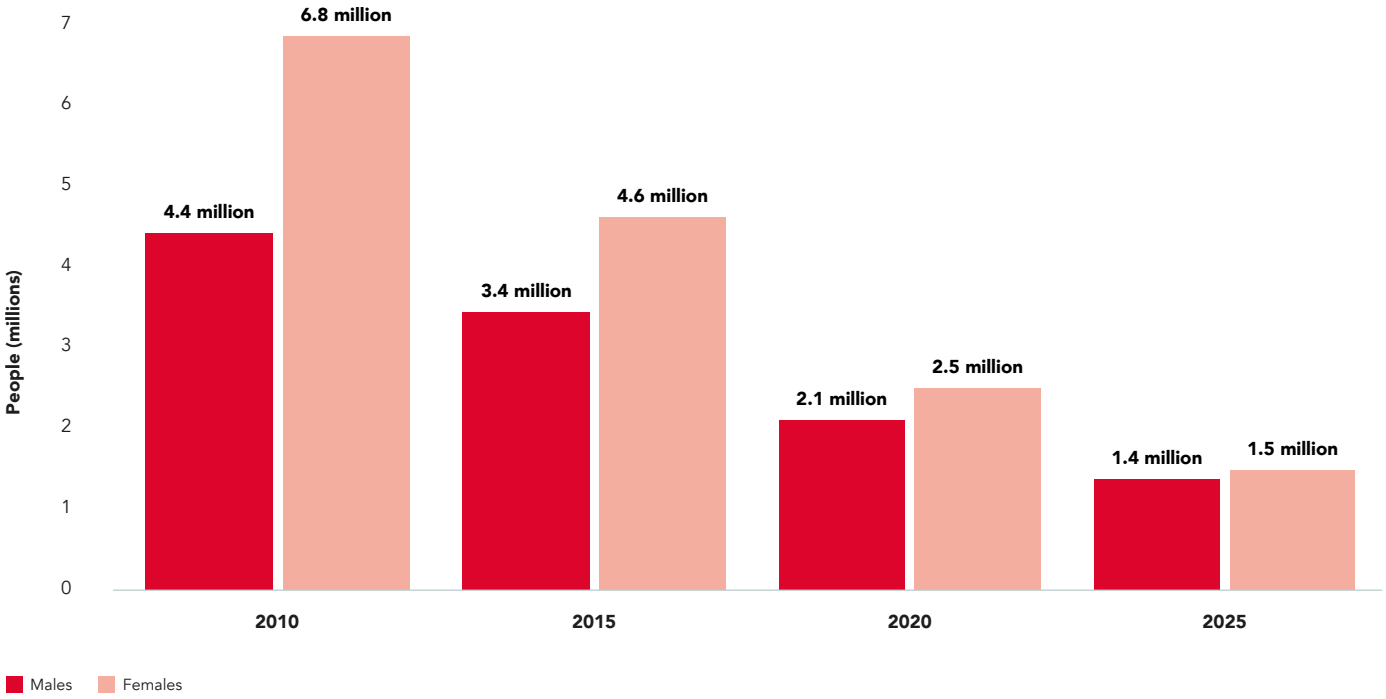
Men aged 15 years or older living with HIV continue to be less likely than their female peers to be on HIV treatment in most regions, including in the three regions with the largest numbers of people living with HIV (Asia and the Pacific, eastern and southern Africa, western and central Africa). The extent of these disparities varies across regions.[8]

Men's comparatively low engagement in HIV care stems from a variety of factors, all of which are amenable to change. These factors include gender norms that devalue health-seeking behaviours, low trust in formal health-care services, work-related mobility, and opportunity and other costs of accessing care *(38)*. For men from key populations, the prospect of humiliation, ridicule or arrest when attending public health facilities is an added deterrent.

Even though treatment coverage is higher among women, considerably more women than men were not receiving antiretroviral therapy in 2025 in eastern and southern Africa (1.5 million women versus 1.4 million men) and western and central Africa (710 000 women versus 470 000 men) (Figures 2.12 and 2.13). This reflects the fact that women outnumber men among people living with HIV in these two regions. In all other regions, more men than women living with HIV were not receiving antiretroviral therapy. Overall, however, the rate at which the treatment gap has been narrowing has slowed down for women and men in the past five years.

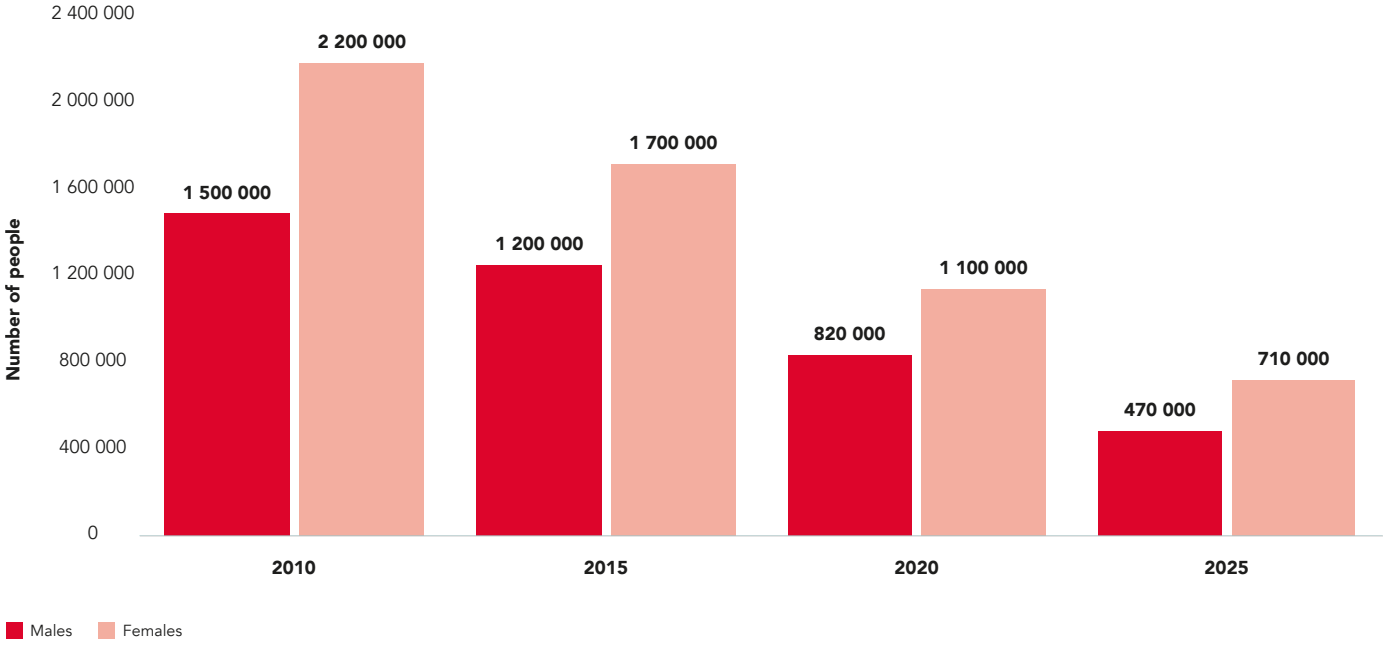
8 Large proportions of women accessing HIV testing and treatment services do so via antenatal care and other maternal, newborn and child health-care services.

Figure 2.12. Antiretroviral therapy gap, adult men and women (aged ≥15 years), eastern and southern Africa, 2010–2025



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

Figure 2.13. Antiretroviral therapy gap, adult men and women (aged ≥15 years), western and central Africa, 2010–2025



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

People from key populations are still being left behind

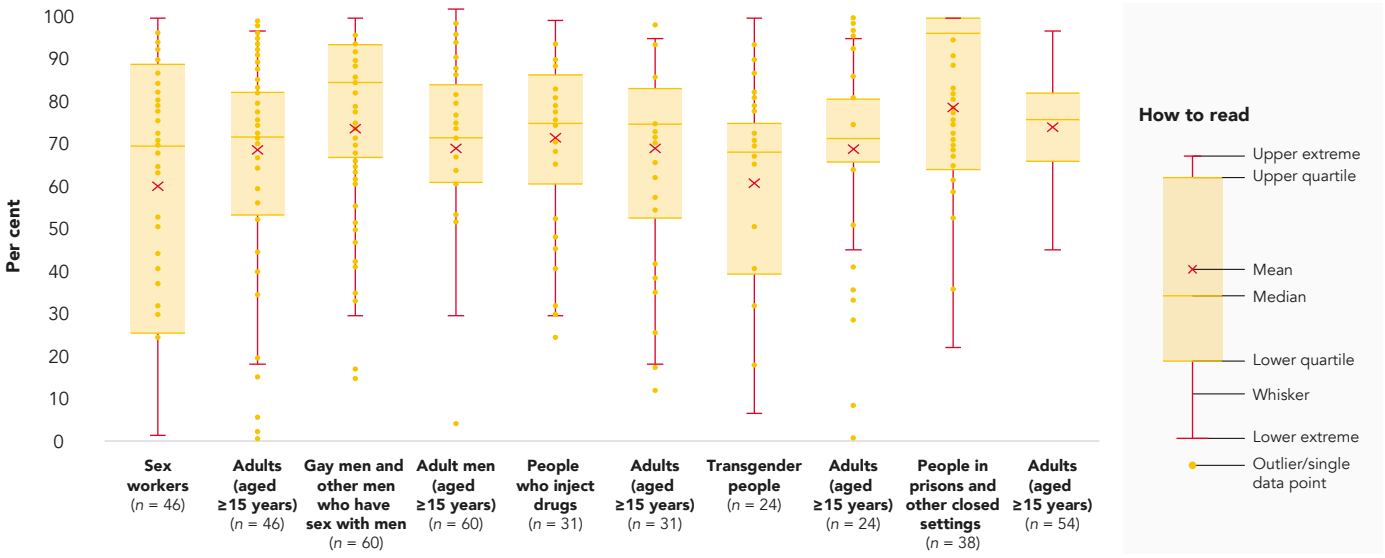
HIV testing and treatment coverage among people from key populations is typically lower than for the overall population of people living with HIV, but with wide variation, according to available data. The median percentages of sex workers (72 countries), gay men and other men who have sex with men (73 countries) and transgender people (36 countries) who had taken an HIV test in the past 12 months or knew their HIV positive status were roughly similar (78–80%), but the percentage was lower for people who inject drugs (68% across 49 countries) *(39)*.

Antiretroviral therapy coverage varied more widely (Figure 2.14), with coverage lowest among sex workers and transgender people in the limited number of countries reporting data. Coverage tended to be lower among female sex workers and females who inject drugs than among their male peers.

There is substantial variation in treatment coverage among people from key populations across countries. In South Africa *(40)* and Thailand *(39)*, around 80% or more of gay men and other men who have sex with men living with HIV were on treatment in 2025 and 2024 respectively, compared with only 15% of their peers in Burkina Faso in 2022 *(41)* and 38% in Mali *(42)* in 2024. Similar differences were seen among sex workers living with HIV.

Access to health care for people from key populations continues to be restricted by hostile legal environments, harassment and violence, compounded by intersecting forms of stigma, discrimination and gender inequality. A study conducted by community organizations among people who use drugs in 10 countries in Latin America found low levels of trust in public institutions, persistent experiences of stigma in health-care settings, and widespread exposure to

Figure 2.14. Treatment coverage among people from key populations and people in the general adult population, selected countries with available data, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/) and UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).
Note: *n* = number of countries. Treatment and testing estimates for key populations are derived largely from countries reporting the results of surveys, whereas estimates for the overall population are based on HIV programme data. Other data sources may imply different levels of coverage. For people in prisons and other closed settings, for example, a systematic review of studies reported that HIV treatment had been documented in all carceral facilities in only 22 countries and in one or more facilities in 79 countries. Antiretroviral therapy coverage was unclear. See Santo T Jr, Hickman M, Altice FL, Grebely J, Taylor S, Lynch M, et al. Global coverage of interventions for reduction of injecting drug use-related harm, HIV, viral hepatitis and tuberculosis in prisons and other carceral settings: a systematic review. Int J Drug Policy. 2026;150:105069 (https://doi.org/10.1016/j.drugpo.2025.105069).

punitive policing practices. Nonbinary and transgender people reported the highest levels of harassment and rights violations *(43)*.

For these reasons, people from key populations tend to depend on peer-led organizations for vital treatment and care services *(44)*, but such organizations have been severely affected by the sudden depletion of donor funding and lack of domestic funding for these targeted approaches. In Nigeria, after funding cuts to peer-led, safe service sites, retention in care levels among gay men and other men who have sex with men using community-led services fell by 26% *(45)*. A survey among organizations for people who use drugs showed widespread disruptions to HIV testing and linkage to HIV treatment, with women who use drugs especially affected *(46)*. In some contexts, Indigenous people might be seen as a key population affected by HIV (see Latin America regional profile) *(47)*. In Brazil, for example, absent or inadequate services contribute to rates of vertical transmission being more than twice as high among Indigenous people than among people in the general population (3.2% versus 1.3%) *(48)*.

A critical measure of progress: viral load suppression

National programmes are getting better at enabling people living with HIV to take their antiretroviral medicines as prescribed, so they have a suppressed viral load and good health outcomes. Globally, an estimated 74% [64–86%] of people living with HIV had a suppressed viral load in 2025, equivalent to about 30.4 million [22.5 million–40.8 million] people, up from 23.7 million [17.5 million–31.8 million] in 2020.

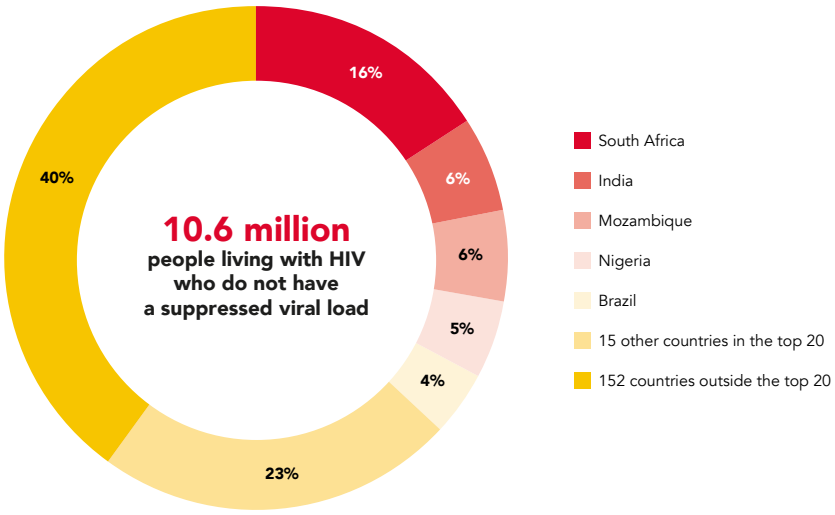
Successful HIV treatment brings numerous benefits, including improved health, quality of life and survival for people living with HIV; prevention of HIV-related illnesses; reduced HIV transmission and prevention of vertical transmission; and reduced HIV incidence at the population level. Substantial numbers of people who start HIV treatment, however, struggle to adhere to treatment and drop out of care, sometimes repeatedly. This is a challenge, especially for men, adolescents and young adults, people from key populations, and pregnant and postpartum women *(49)*, notably those who are not benefiting from community-led care models *(50–52)*. Interventions and support that enable people to stay or easily re-engage in treatment are vitally important *(53)*.

Overall, among the estimated 41.0 million [35.3 million–47.5 million] people living with HIV in 2025:

- 5.0 million people did not know their HIV status;
- 4.0 million people knew their HIV status but were not receiving antiretroviral therapy;
- 1.7 million people on treatment did not have a suppressed viral load.

This means there were 10.6 million people living with HIV with an unsuppressed viral load and therefore at risk of HIV-related illnesses and transmitting HIV to their sex partners in 2025. Even in eastern and southern Africa, the region with some of the most comprehensive treatment programmes in the world, an estimated 4.0 million people living with HIV did not have a suppressed viral load. Elsewhere, 2.2 million people living with HIV in Asia and the Pacific, 1.7 million in western and central Africa, 1.1 million in eastern Europe and central Asia, and 890 000 in Latin America did not have a suppressed viral load.

Figure 2.15. Percentage of people living with HIV who did not have a suppressed viral load, 20 countries with large gaps, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/). This summary excludes countries for which UNAIDS estimates were not published.

More women than men did not have a suppressed viral load in eastern and southern Africa (2.0 million versus 1.6 million) and in western and central Africa (910 000 versus 550 000). In all other regions, men outnumbered women among people aged 15 years and older who did not have a suppressed viral load.

Further analysis reveals that almost two-thirds (60%) of people with an unsuppressed viral load in 2025 resided in 20 countries (Figure 2.15).[9] A similar concentration of "missed" populations can be seen across the treatment cascade:

- Almost one-third (31%) of people who did not know they were living with HIV were in five countries (Figure 2.8).[10]
- More than half (51%) of people who knew they were living with HIV but were not on antiretroviral therapy were in six countries.[11]
- More than a third (34%) of people who were on treatment but did not have a suppressed viral load were in only three countries.[12]

Despite the remarkable gains made in HIV treatment and care, these gaps represent a failure of universal health care. Until the gaps are addressed, HIV epidemic control is not possible. Rapid improvements in testing and treatment programmes in the countries with the largest gaps will have a major impact on the evolution of the global HIV epidemic and response.

Several countries remain substantially exposed to volatile international HIV financing, notably Nigeria (external financing accounts for 98% of HIV resources), Mozambique (94%) and Uganda (80%). Kenya (48%), Indonesia (23%) and South Africa (22%) also have a considerable level of dependency on external financing. Given that these countries are home to about one-third

9 In descending order: South Africa, India, Mozambique, Nigeria, Brazil, Indonesia, Uganda, United Republic of Tanzania, Kenya, Cameroon, Ghana , Mexico, Philippines, Malawi, Ethiopia, Thailand, Zimbabwe, Zambia, Myanmar, Viet Nam. This summary excludes countries for which UNAIDS estimates were not published.

10 Including India, Mozambique, Nigeria, Pakistan and South Africa.

11 In descending order: South Africa, India, Brazil, Mozambique, Indonesia, Uganda.

12 In descending order: South Africa, Mozambique, Nigeria.

(34%) of all people living with HIV who do not have a suppressed viral load, sustained, adequate financing for HIV testing and treatment must remain a very high priority.

It is well established that peer counselling and support, treatment clubs, mentor mother programmes *(54)*, other community-led activities, treatment reminders, avoidance of antiretroviral medicine stockouts, and ready access to treatment and care services can improve treatment adherence *(55)*. The impact of digital health interventions on treatment adherence is still being established *(56–58)*.

Other barriers are more difficult to overcome, including stigma and discrimination, violence (especially intimate partner violence) *(24)*, punitive policing practices directed at people from key populations *(59, 60)*, unmet mental health needs *(61)*, and food, livelihood and water insecurity. A study from Kisumu county in Kenya found that adults on HIV treatment who experienced water insecurity had nearly four times the odds of poor treatment outcomes compared with their peers who were able to access water. Treatment adherence appeared to be their biggest HIV-related challenge *(62, 63)*. For women and girls, burdens linked to caregiving responsibilities can take precedence over personal health care and undermine treatment adherence *(64)*.

Governments reacted swiftly to the funding cuts in early 2025 by prioritizing their treatment programmes, which helped ensure people could continue taking their antiretroviral medicines *(65)*. There are indications, however, that the full impact on treatment programmes may not yet be apparent *(66)*. Reductions in HIV testing, peer and other community-led support, laboratory services and health workforce numbers will affect the quality of treatment and care.

South Africa had been funding most of its treatment and care programme with domestic resources, supported by contributions from the United States Government that were halted in early 2025. An assessment of the impact of these funding losses found that community-based HIV testing and prevention services had been reduced, the quality of clinic-based HIV services was deteriorating, treatment adherence support was being lost, and actionable programme data were less readily available *(67)*.

Weakened data systems make it more difficult to track patients, identify people who interrupt or halt treatment, and enable people on the move to maintain consistent access to treatment and care. Laboratory systems and access to CD4 tests and viral load testing are also affected, making it more difficult to prevent and manage advanced HIV disease and monitor treatment outcomes. For example, viral load testing coverage and reporting improved after 2015 in most regions, but this trend appears to have reversed in 2025.

A systematic review in 2025 of studies and reports shows that viral load testing fell by 16–68% in PEPFAR-supported treatment programmes *(68)*. Preliminary data from countries reported to UNAIDS reveal a similar trend, with declines especially evident in countries with large HIV treatment programmes in eastern and southern Africa, such as Malawi. Routine collection of viral load data is vital for monitoring treatment outcomes and detecting gaps and disparities so improvements can be made.

Advanced HIV disease: progress is at risk without CD4 testing

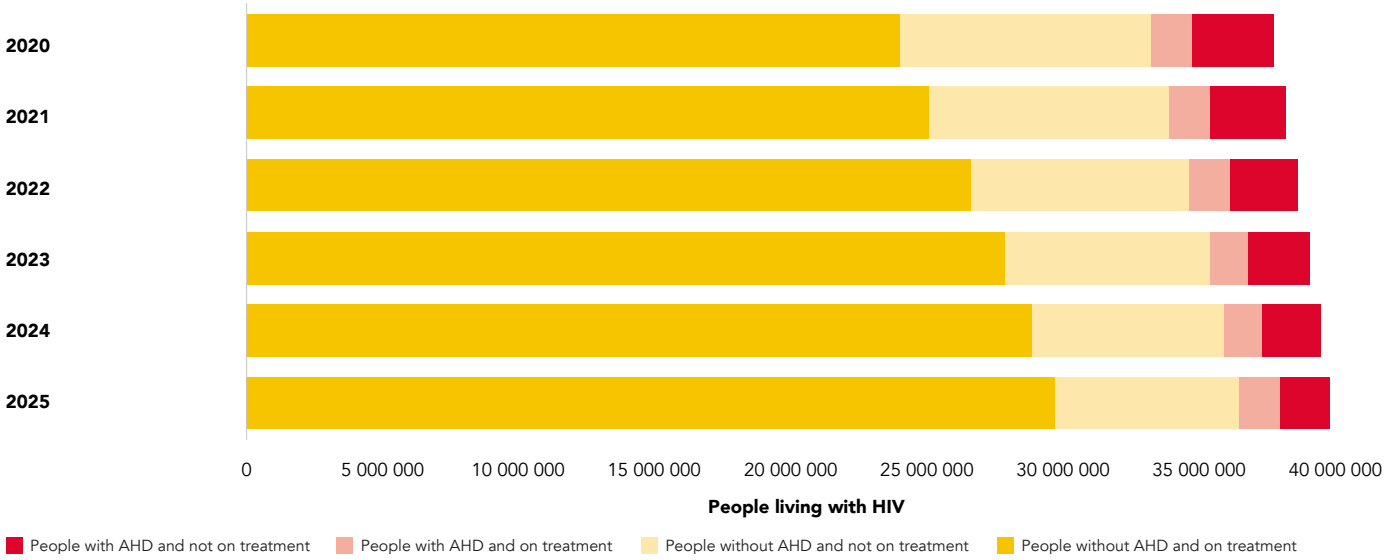
Globally in 2025, an estimated 3.4 million people had advanced HIV disease (AHD),[13] equivalent to 8% of all people living with HIV.[14] Although AHD is most common among adults living with HIV, AHD prevalence of 30% has been found at outpatient health facilities among children aged 5–14 years living with HIV *(69)*.

AHD significantly increases the risk of severe illness, hospitalization and death for people living with HIV, and yet it continues to be underreported and may become tougher to manage due to the impact of funding losses. A systematic review of 36 studies from 2016–2025 reported that one in eight (12%) antiretroviral therapy-naive people who presented with AHD died within one year, with most deaths occurring within three months *(70)*. In a cohort study involving almost 18 000 people in South Africa, people with AHD were 16 times more likely to die within six months compared with other people starting antiretroviral therapy *(71)*.

As treatment programmes mature, the prevalence of AHD is declining, both among people on antiretroviral therapy and people not yet on treatment (Figure 2.16)—but the service disruptions of 2025 threaten to stall or reverse this progress. Even though AHD prevalence is highest among people living with HIV who are not on antiretroviral therapy, the burden of AHD is slowly shifting towards people on antiretroviral therapy as treatment coverage increases.

UNAIDS analysis indicates that close to half of all people with AHD are currently on treatment (about 1.5 million people). It is increasingly apparent that many people move in and out of HIV care due to a range of factors and are susceptible to AHD *(72)*. This underscores the

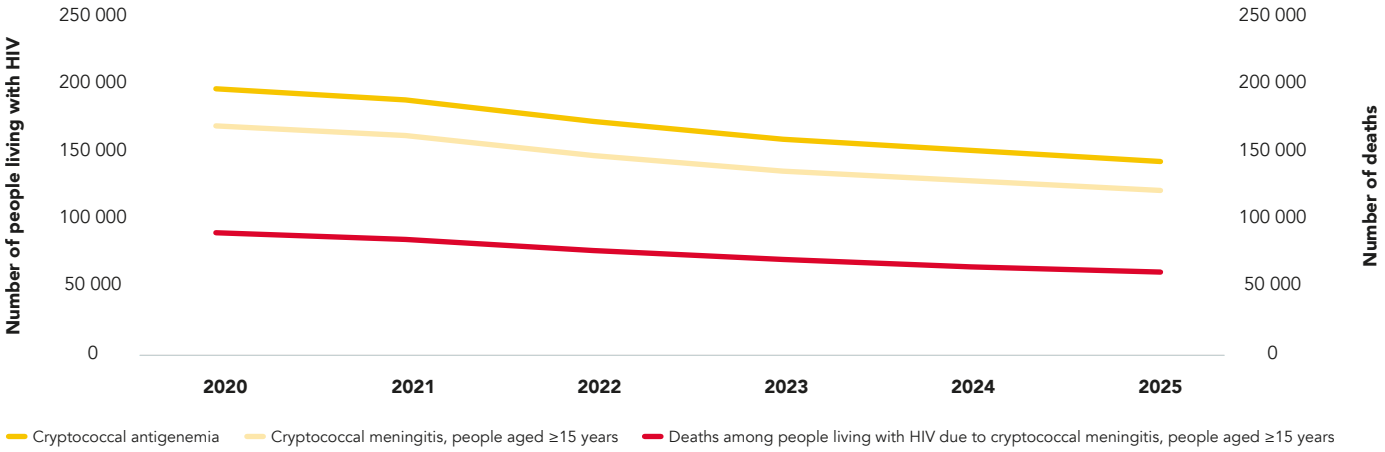
Figure 2.16. Estimated numbers of people with advanced HIV disease, on or not on antiretroviral therapy, 2020–2025



Source: UNAIDS special analysis of 2026 estimates.
Note: model estimates are shown covering all countries, each of which reflects the national trends in people living with HIV, antiretroviral therapy coverage and initiations, and CD4 cell count distributions and progression. These are independent from programme-reported CD4 testing results, with fluctuations influenced by HIV diagnostic access, antiretroviral therapy initiations and CD4 testing coverage, and are reported incompletely.

13 Defined as having a CD4 cell count below 200 cells/μL, or WHO clinical stage of 3 or 4 in adults and children aged 5 years or older.
14 UNAIDS special analyses of 2026 national epidemiological trend estimates, including CD4 cell count progression by age, sex and treatment status.

Figure 2.17. Estimated number of deaths due to cryptococcal meningitis among people living with HIV, 2020–2025



Note: these estimates are based on national epidemic Spectrum estimates and past global meta-analysis of risk factors for cryptococcal infection. See, for example, Rajasingham R, Govender NP, Jordan A, Loyse A, Shroufi A, Denning DW, et al. The global burden of HIV-associated cryptococcal infection in adults in 2020: a modelling analysis. Lancet Infect Dis. 2022;22(12):1748–1755 (https://doi.org/10.1016/S1473-3099(22)00499-6).

need for CD4 testing at diagnosis, at antiretroviral therapy initiation and at re-engagement in care, and for people with treatment failure *(73)*.

After tuberculosis (TB), the fungal infection cryptococcal meningitis is the most common cause of death among people living with HIV. UNAIDS estimates that the number of deaths attributable to cryptococcal meningitis among people living with HIV decreased from 89 000 in 2020 to 60 000 in 2025 (Figure 2.17). This decline is due to the effects of improved diagnosis, treatment and care and viral suppression *(74)*. Wider access to cryptococcal antigen screening with pre-emptive fluconazole and access to flucytosine and liposomal amphotericin B for treatment would further reduce the toll of cryptococcal meningitis. Funding losses now put this progress at risk.

AHD can be reduced by diagnosing and linking people to treatment promptly after acquisition of HIV, and by providing adherence and other support so they can stay on treatment. CD4 testing, as the entry point to the AHD package of care, is advisable at initial diagnosis and when initiating or restarting antiretroviral therapy.

For people who have already started treatment, targeted periodic CD4 testing among people presenting with viral or clinical failure can detect those with persistent or recurrent AHD and should be followed by the full World Health Organization (WHO) recommended package of care: screening for TB and cryptococcal antigen, preventive treatment for TB and cryptococcal meningitis, and rapid antiretroviral therapy initiation or optimization with dolutegravir-based regimens *(73)*.

Funding losses are now impeding these vital interventions. Community-led outreach services and drop-in centres are scaling back their work, peer-led treatment adherence support is waning, and CD4 testing was unevenly available in 2025. Among 132 countries reporting these data to UNAIDS, 117 countries (89%) stated that CD4 testing was available, but only 59 countries (45%) said it was available in more than 95% of HIV treatment clinics *(75)*. A study from six PEPFAR-supported countries found a 35% decline in CD4 tests run between 2024 and 2025 *(76)*. These service and reporting gaps must be remedied, and CD4 testing must be restored, as recommended by WHO.

HIV prevention is under pressure

The overall decline in new HIV infections has been driven largely by the success of treatment programmes in reaching more people living with HIV, supporting sustained treatment adherence, and suppressing viral loads. People with a suppressed viral load have a near-zero chance of transmitting HIV to their sex partners *(77)*. The most efficient way to reduce new HIV infections is to close the remaining service gaps, address the barriers that limit access to treatment, and ensure comprehensive HIV prevention options and services—including primary prevention—are readily available to everyone who needs them.

Primary HIV prevention is being neglected

Despite the critical role of antiretroviral therapy in reducing the number of new HIV infections, modelling indicates that treatment and care programmes alone will not achieve epidemic control *(78)*. A mix of primary prevention services and tools is also needed. People have the right to protect themselves against HIV infection and must be able to choose the prevention options that work best for them.

A great deal of unfinished business remains. The full potential of primary prevention options is yet to be realized, but two years of funding cuts have placed primary prevention services under increased pressure.

After expanding, many prevention programmes designed for adolescent girls and young women in sub-Saharan Africa are now being dismantled as funding dries up. Wider access to PrEP, especially the highly effective long-acting versions now available, could massively boost HIV prevention—but funds for purchasing and deploying these breakthrough tools have been withdrawn or redirected. Similarly, funding cuts stand in the way of reviving condom programmes and increasing the uptake of VMMC in priority countries in eastern and southern Africa. Accessing basic HIV prevention services remains particularly difficult for people from key populations. Harm reduction interventions are in crisis in many countries, and outreach activities are being scaled back. Overall, the coverage of primary prevention services, including among women and adolescent girls, is far below the 90% target set in the 2026 Global AIDS Strategy.

Underlying these challenges are persistent gender inequalities, punitive laws targeting marginalized populations, high levels of sexual or physical violence, and stigma and discrimination, all of which continue to obstruct access to and use of basic HIV prevention options and services.

Rollout of oral PrEP has stalled

The funding cuts of the past two years are reversing earlier progress in the use of PrEP to avoid HIV acquisition. The number of people receiving PrEP declined by 13% between 2024 and 2025 when comparing the same 83 countries (excluding South Africa) in both years. This is equivalent to 393 000 fewer people protected from acquiring HIV in 2025 than in 2024 in the reporting countries. The target is to

have more than 20 million PrEP users by 2030, but only 2.6 million people were on PrEP at the end of 2025.

The majority of PrEP users in 2025 were female (22% were adolescent girls and young women).[15] According to data reported from 39 countries, among people from key populations, PrEP use has fallen significantly since donor funding was cut (Figure 2.18) *(35)*.[16]

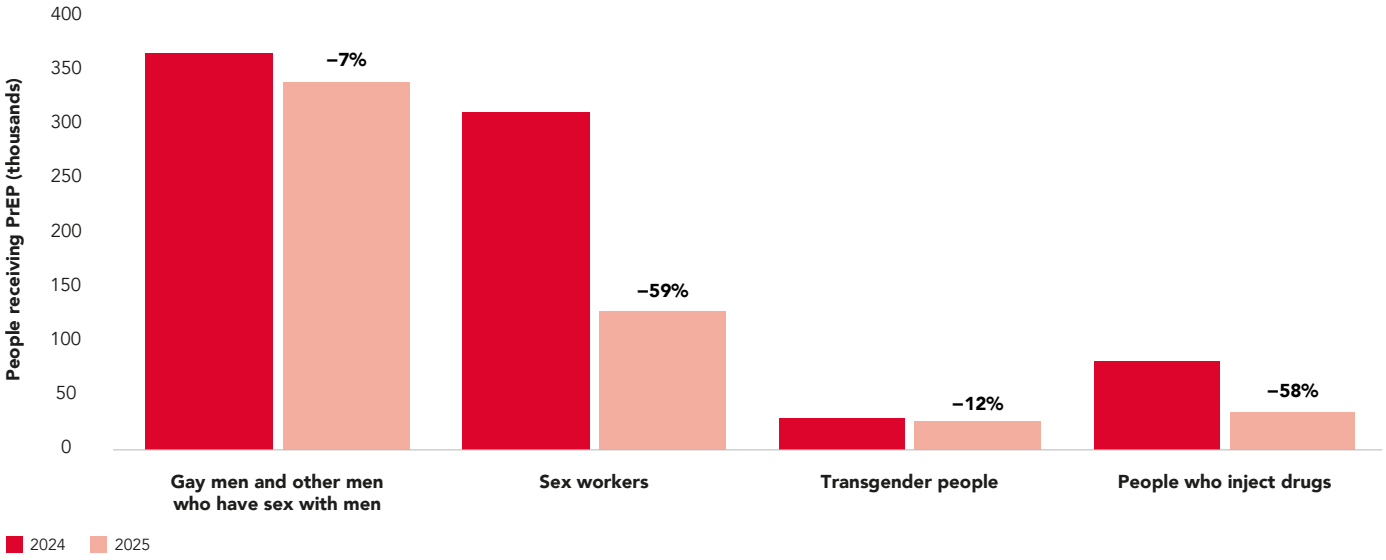
Figure 2.19 shows recent trends in the use of PrEP in 12 of the low- and middle-income countries with the largest PrEP programmes, most of which had relied on PEPFAR-funding. Half of these countries saw a steep drop in PrEP use, although a few, including Brazil, Uganda and the United Republic of Tanzania, achieved increases *(79)*. Programme data from Nigeria show PrEP initiations among people from key populations falling by more than 80% in the first half of 2025 *(80)*. As a result, there was a sharp decline in PrEP use among people from key populations, as reported to UNAIDS between January and April 2025. Viewed by region, the steepest drops in the number of PrEP



15 47% of PrEP users were men aged 15 years and older.

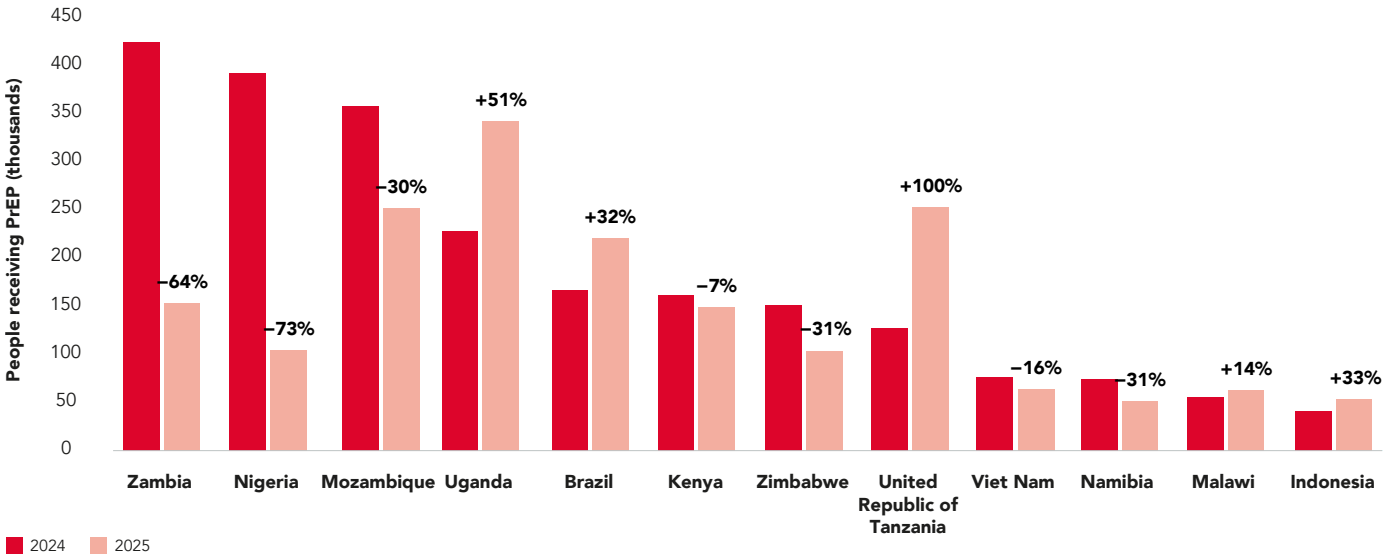
16 Data reported to the Global AIDS Monitoring system show a 59% decline in PrEP use in 2024–2025 among all sex workers, 58% among people who inject drugs, 12% among transgender people, and 7% among gay men and other men who have sex with men.

Figure 2.18. PrEP use among people from key populations, 2024–2025, countries reporting in both years



Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).
Note: data from South Africa, the largest national PrEP programme globally, were not available.

Figure 2.19. Percentage change in the number of people using PrEP at least once, 12 countries with large PrEP programmes, 2024–2025



Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).
Note: data from South Africa, the largest national PrEP programme globally, were not available.

users in 2024–2025 occurred in the Caribbean and western and central Africa (55–70% less users), with modest rises recorded in Asia and the Pacific, eastern Europe and central Asia, and Latin America (6–32% more users) *(79)*.

In addition, continuation of oral PrEP use has been low. One meta-analysis reported a probability of continuation of 77% at six months among gay men and other men who have sex with men and transgender people *(81)*, although this varied substantially. Another meta-analysis showed continuation at three months declining significantly among postpartum women *(82)*. This indicates that oral PrEP is not an ideal option for all potential users.

United States funding for PrEP is now largely focused on pregnant and breastfeeding women, potentially leaving PrEP for people from key populations underfunded in many countries *(83)*. In 2025, PEPFAR supported PrEP programmes in approximately 45 countries, with spending amounting to about US$ 82 million, compared with US$ 133 million in 2024 *(84)*. This was before the introduction of long-acting lenacapavir for PrEP in early-adopter countries, which largely commenced in 2026. Fifty per cent of total PrEP spending came from the United States Government, 18% from the Global Fund, and 32% from domestic resources.

Long-acting PrEP is beginning to reach countries

The development of highly efficacious long-acting PrEP has raised hopes that widescale access could deliver a breakthrough for HIV prevention. Although not a "magic bullet", long-acting options such as twice-yearly injectable lenacapavir can help users avoid the pill fatigue, adherence difficulties and stigma that may be associated with oral PrEP *(85)*. Study evidence suggests that as many as 75% of PrEP users may prefer injectables *(86)*. Modelling suggests that 5% coverage of lenacapavir among people at highest risk of infection in generalized epidemics could reduce HIV incidence by as much as 25–35% *(87)*.

Programmatic rollout of lenacapavir began in late 2025 in the first of 24 early-adopter low- and middle-income countries, supported by financing from the Global Fund and PEPFAR *(88)*. Gilead Sciences, the patent-holder for lenacapavir, has entered into voluntary licensing agreements with six generic manufacturers to broaden access in 120 low- and middle-income countries. The company has committed to serve as the supplier until generic lenacapavir becomes available, estimated for 2027. The first tentative approval of generic injectable lenacapavir was granted by the United States Food and Drug Administration to Dr Reddy's Laboratories in November 2026.

Concerns remain about the geographic limitations of the rollout, lack of clarity about which prospective users will have access to lenacapavir, and limited national control over pricing, volumes and timelines *(89)*. Scale and equity are needed to achieve the required impact. UNAIDS modelling estimated that 20 million people should be using PrEP, of whom 13 million would be on long-acting PrEP, to help reach the 2030 global AIDS target of a 90% reduction in the number of new HIV infections compared with 2010.

Condom programmes are being defunded

Condom programmes are badly affected by funding losses, with the total number of condoms distributed falling from 2.99 billion to 2.67 billion among comparable countries in 2024–2025.[17] A similar trend was observed in most of the 15 countries with the largest programmes (although India, Mozambique, Thailand and the United Republic of Tanzania managed to increase condom distribution) (Figure 2.20). Overall, the number of condoms distributed decreased by 26% in the Caribbean, more than 17% in eastern and southern Africa, and 14% in Latin America.

17 Reaching a targeted level of 80% condom use at last sex with non-regular partners and 95% condom use during paid sex among sex workers and clients requires that approximately 20 billion condoms are distributed or sold for HIV prevention per year (6 billion in Africa and 14 billion for people from key populations in other regions) *(90)*.

In Fiji, access to free PrEP starts with trust



Health-care staff from Medical Services Pacific, a nongovernmental health-care provider, and the Ministry of Health participate in training ahead of the introduction of PrEP services in Labasa, Fiji. Credit: UNAIDS Fiji.

When Momi, a transgender woman in her early thirties, heard that a clinic in Fiji's capital Suva was holding a community meeting about PrEP, she decided to go. Momi had already heard about PrEP through friends who had travelled to Australia. Now it was being offered in her country, free of charge.

"I was very relieved when I heard about PrEP becoming available," says Momi. "At the community meeting I not only got information about PrEP but I also got my first prescription, so I can stay HIV-free."

UNAIDS estimates that the number of new HIV infections in Fiji increased 12-fold between 2010 and 2025. In 2025, only 39% of people living with HIV knew their HIV status and only 22% were receiving antiretroviral therapy.

Free oral PrEP was rolled out nationally in May 2026 and is now available through HIV and sexually transmitted infection hubs and Medical Services Pacific clinics in the Central, Western and Northern divisions of Fiji.

"Free PrEP gives people in Fiji a new HIV prevention choice, but making it available is only part of the job," says Renata Ram, UNAIDS HIV Adviser in Fiji. "Trust matters. Community organizations and peer workers can answer questions, address concerns, and help people feel confident about accessing PrEP and other HIV services."

Communities, the Government and partners have been working together since September 2025 on a peer-led approach to reach the people most affected by HIV. Sixty-two peer outreach workers from six organizations were recruited and trained, including on PrEP. They help people locate testing, PrEP, treatment and other health services.

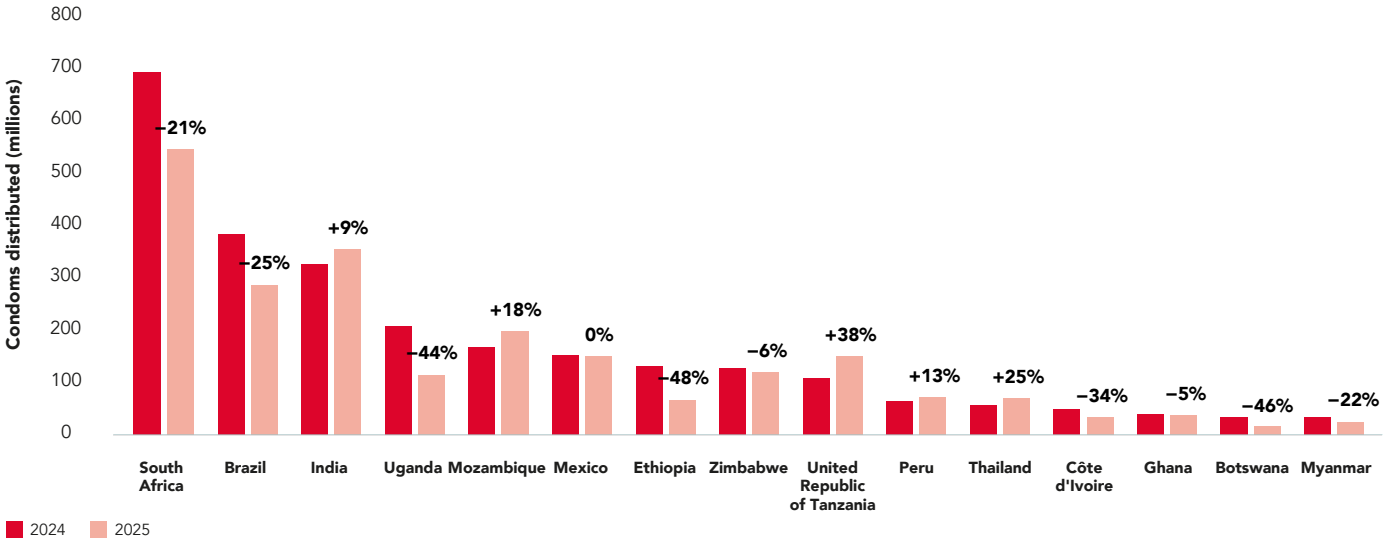
"When we began receiving calls and direct messages from people asking for guidance on where and how they could access PrEP, we were ready to respond," says Asaeli Sinusetaki, Interim CEO of Rainbow Pride Foundation.

For many people, this means starting with an organization they already know rather than having to navigate the health system alone. The same principle holds after an HIV diagnosis. Fiji Network Plus (FJN+), which is led by and for people living with HIV, provides counselling, treatment support, home visits and practical assistance. Executive Director Joeli Colati was diagnosed with HIV 19 years ago. At the time, he believed HIV spelt certain death for him. Through FJN+, he learned about treatment, self-care and living well. Today, he leads the organization that once supported him.

The Indo-Pacific HIV Partnership, funded by the Australian Government through the Department of Foreign Affairs and Trade and led by UNAIDS, with Health Equity Matters as a partner in Fiji, is helping to strengthen community leadership and access to HIV services.

In Fiji, access means more than having a service available. It means knowing where to go, feeling safe enough to go there, and having someone trusted to help open the door.

Figure 2.20. Numbers of condoms distributed in 15 countries with the largest condom programmes, 2024–2025



Source: Global AIDS Monitoring 2025–2026 (https://aidsinfo.unaids.org/).

Condoms continue to be an important primary HIV prevention option, including in prisons and other closed settings. In settings where HIV prevalence is high, condoms are usually cost-effective for preventing HIV infections. They are often also cost-saving and offer the added benefit of protecting against other sexually transmitted infections and unplanned pregnancy *(91)*. The prevention potential of condom use, however, is still underused in many countries with large HIV epidemics. Limited national survey data from 2010–2025 show condom use by men and women at last high-risk sex stagnating in several countries, although at relatively high levels in some countries *(92)*.

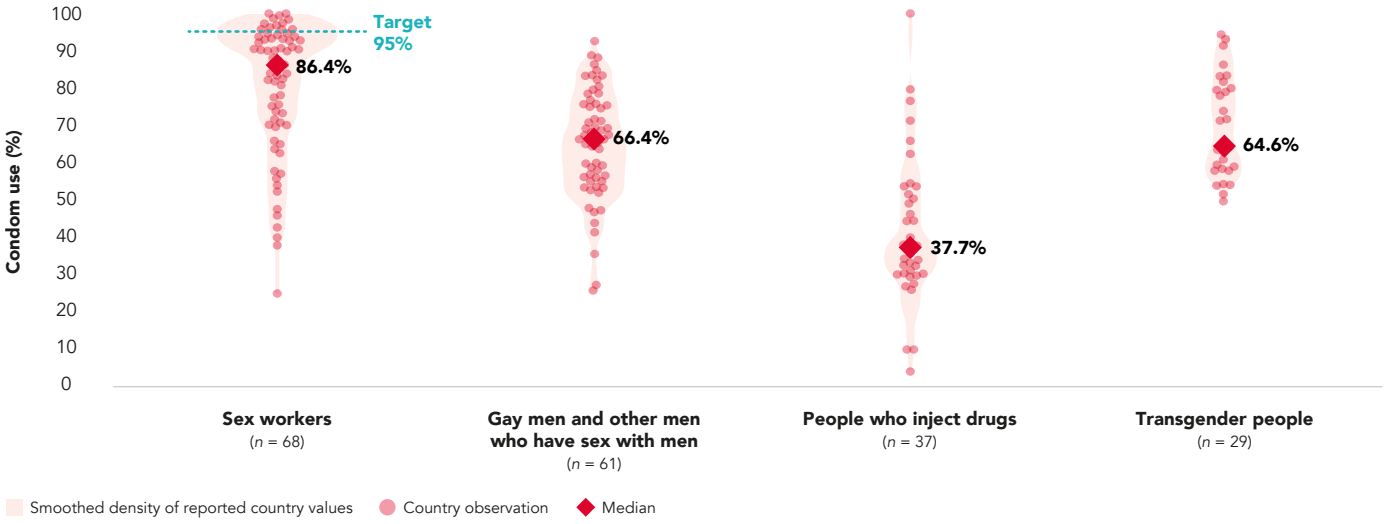
Among people from key populations, condom use at last sex varies widely, from a very low median of 38% among people who inject drugs to 65% among transgender people, 66% among gay men and other men who have sex with men, and 86% among sex workers (at last sex with a client) (Figure 2.21) *(39)*. The 2030 target calls for 95% condom use during paid sex between sex workers and clients. Between 2017 and 2026, 47 countries reported providing condoms and lubricants in prisons and other closed settings.

Countries have shown that achieving the 2030 target of 80% condom use with non-regular partners is possible and that the declining trends in use are not universal *(93)*. To close gaps in condom use, countries need to revive condom total market approaches with complementary roles for the public, social marketing and private sectors, and focus on generating demand among a generation of young people aged 15–29 years that has not been exposed to condom promotion *(90)*.

A new strategy is needed for VMMC

Voluntary medical male circumcision programmes have been affected badly by funding withdrawals. Rapid assessments indicate that 13 of 15 priority countries experienced severe programme disruptions following the withdrawal of external funding, with only South Africa and, to a lesser extent, Mozambique maintaining functional services *(94, 95)*. Most programmes lost trained workforces and experienced supply chain breakdowns, along with failing quality assurance and monitoring systems. The number of VMMC procedures performed in the 14

Figure 2.21. Condom use at last sex among people from key populations, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/).
Note: *n* = number of countries.

priority countries with national VMMC programmes fell by 53% in 2024–2025. Findings from five independent models, however, indicate that VMMC continuation remains cost-effective and is often cost-saving in most high-burden settings *(96, 97)*.

New approaches are needed for the rollout of VMMC, especially in countries (e.g. Malawi, Uganda and Zimbabwe) that could benefit considerably from robust VMMC programmes, but where the numbers of procedures conducted have fallen steeply. One option is to focus on subnational areas where HIV incidence is high and where VMMC would remain highly cost-effective, with an emphasis on boys and men aged over 15 years. Another option entails shifting from donor-dependent, vertical programming to integrated services embedded in national health systems, including national health insurance packages. Also worth considering is positioning VMMC within a broader men's health platform, where it can serve as an entry point for HIV testing and treatment, sexually transmitted infection screening and management, TB case-finding, noncommunicable disease screening, and sexual and reproductive health services *(95)*.

Stabilizing and rebuilding VMMC programmes will require sustained efforts over years. Changes will need to fit country contexts, capacities and readiness. South Africa is showing that domestic ownership and financing can maintain these programmes at scale, whereas Zimbabwe is using innovative financing to mobilize funding. Kenya offers proof that VMMC can be integrated in routine health services *(95)*.

Harm reduction services are in turmoil

More countries than ever—112 in 2025, up from 108 a year earlier—recognize harm reduction in national HIV or health policies, but policy shifts and the withdrawal of funding support are undermining the slow advances made in recent years. Most countries are failing to reach harm reduction targets, leaving people who use drugs at higher risk of harm and death *(98)*.

Services that enable safe injecting among people who inject drugs are a mainstay of harm reduction and have been shown to reduce rates of HIV and hepatitis C infection in this population. Ninety-three of the 112

countries with harm reduction policies in 2025 had at least one operational needle–syringe programme, although mostly with low coverage. Only one of 24 reporting countries (Kazakhstan) reported distribution of more than 100 needles and syringes per person who injects drugs per year by needle–syringe programmes. Safe injection facilities were operating in 19 countries but were under threat in some of these *(98)*. Although 95 countries had at least one operational opioid agonist maintenance therapy programme *(98)*, coverage was generally low in the 23 low- and middle-income countries reporting coverage data.

Drug use, including drug injecting, is a well-documented phenomenon in prisons and other closed settings *(99)*. Between 2017 and 2024, however, only nine countries reported that they had needle–syringe programmes and 29 that they offered opioid agonist maintenance therapy in prisons and other closed settings.

Even when these services are nominally available, access is hindered by the legal repercussions and stigma attached to drug use *(100)*. People who inject drugs may struggle to access and use harm reduction and other prevention options, with women especially affected. In the 24 countries

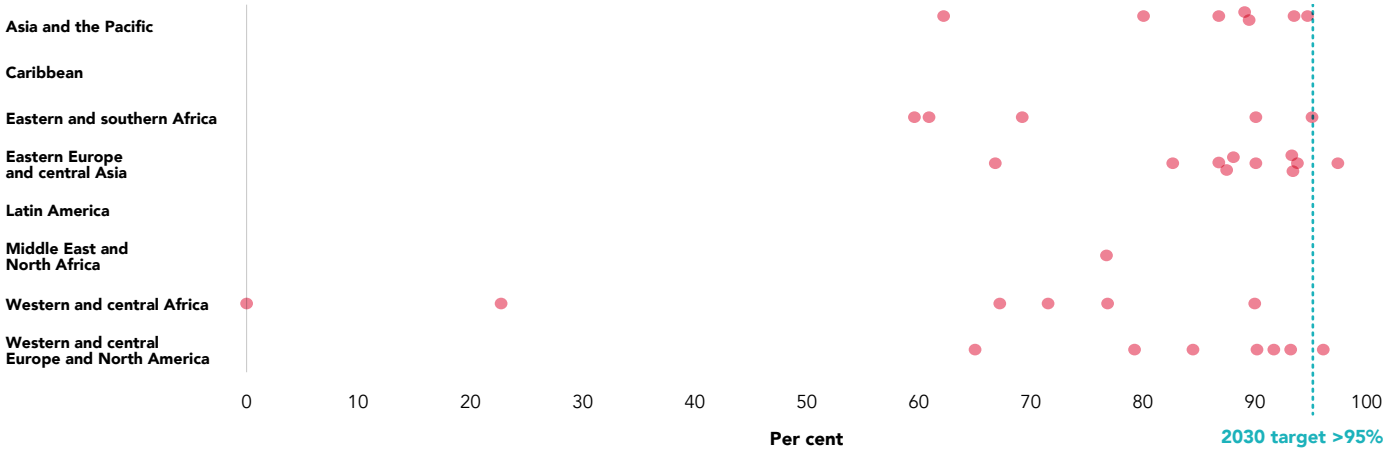
Harm reduction successes in Kenya and Malaysia

The provision of needle–syringe projects, opioid agonist maintenance therapy and direct-acting antiretroviral therapy in Kenya since the early 2010s has brought clear benefits. A survey of more than 3100 people who inject drugs (almost all males) estimated that HIV incidence decreased steeply in coastal areas (from 1.84 to 0.32 per 100 person-years) and the capital Nairobi (from 4.42 to 0.20 per 100 person-years) between 2015 and 2025. HIV prevalence also fell, from 18% to 10% in coastal areas, and from 12% to 8.5% in Nairobi. Hepatitis C incidence was reduced almost three-fold *(104)*. Ongoing advocacy, including from community leaders, culminated in the 2025 National Harm Reduction Bill, which sought to institutionalize harm reduction as a public health obligation. Recent funding cuts, which have resulted in closures of needle–syringe projects, now threaten these gains.

Malaysia introduced a harm reduction programme in 2005. Financed by the Government and implemented by private health-care providers and community organizations, the programme was expanded in 2011, after which the Government began replacing Global Fund support with national funding. Harm reduction was integrated into primary health care and the broader health system. A national harm reduction taskforce was set up, bringing together law enforcement agencies, correctional services, drug intervention services, civil society and development partners. This enabled Malaysia to expand opioid agonist maintenance therapy into some prisons and drug rehabilitation centres.

These interventions helped reduce new HIV diagnoses among people who inject drugs from more than 4000 per year in 2005 to 115 in 2017, with HIV prevalence in this population falling from 22% in 2009 to 13% in 2017 *(105, 106)*. A World Bank-supported analysis estimated that Malaysia's programmes prevented more than 12 600 HIV infections, generating more than US$ 11 million in direct health-care savings *(103)*.

Figure 2.22. Percentage of people who inject drugs who report using safe injecting practices by region, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/).

reporting these data, a median of 39 needles and syringes were distributed per person who injects drugs per year, and only 9% had access to opioid agonist maintenance therapy (23 countries) *(39)*.

The fact that 87% of people who inject drugs reported using a sterile syringe the last time they injected (36 countries) testifies to the efforts of community-led and other nongovernmental organizations (Figure 2.22) *(39)*. The funding losses since early 2025 threaten to derail this work, however. The United States was the second-largest donor (after the Global Fund) of harm reduction programmes, and was the largest contributor overall to the Global Fund, but its funding withdrawals are having a far-reaching, debilitating impact *(101)*.

A large survey among organizations for people who use drugs has documented widespread disruptions to outreach and peer-led harm reduction programmes, HIV testing and linkage to treatment, services for women who use drugs, and legal and human rights support. Nearly half of respondents (49%) reported shortages of essential commodities, and 30% observed increases in overdose events *(46)*. Many harm reduction service providers—including in Cambodia, Kenya, Mozambique, Nigeria, Tajikistan and the United Republic of Tanzania—have either ceased or drastically reduced their activities, with community-led services being hit the hardest *(98)*. Nearly half of respondents (49%) reported shortages of essential commodities, and 30% observed increases in overdose events *(46)*.

Services have been somewhat resilient in countries with established domestic funding for these interventions, including South Africa. Elsewhere, peer networks have sought to salvage faltering formal services, and community-led organizations have tried to regroup to maintain lifesaving services. These recoveries are not sustainable without replenished and consistent funding *(98)*. Other changes are also needed. The majority of harm reduction programmes are focused on adult men and tend to exclude women and young people *(102)*. Gender-responsive interventions that target women and address the overlap between drug use, sexual health risks and gender-based violence have been shown to have positive health outcomes *(103)*.

Estonia's harm reduction response always adapting as new drugs flood the market

Aljona Kurbatova can never rest on her laurels. As Head of the Center for the Promotion of Health and Well-being at the National Institute for Health Development (TAI), she oversees all of Estonia's harm reduction services.

"For us, we accomplish something and we begin to see positive trends but suddenly a new drug is on the market and we have to start again," she says.

Working jointly with people who inject drugs and the police, TAI identified a new synthetic opioid this year, even more powerful than the last. "Mainly due to good relationships, forensics now prioritizes samples given to them by harm reduction providers, allowing us to publish results in record time," says Ms Kurbatova. "This is a significant shift from when we started two decades ago."

Faced with one of the most severe HIV epidemics among people who inject drugs in Europe in the early 2000s, and one of the highest overdose mortality rates in 2010s, this small Baltic state had to expand its harm reduction programme that was started in 1997. It provided needles and syringes, and added health services and counselling. Key milestones included the introduction of a national take-home naloxone project in 2013 and drug policy reforms a year later.

For Ms Kurbatova, a turning point came in 2018 when community networks of people who used drugs and law enforcement trusted each other more. "Having people with lived experiences act as liaisons boosted prevention and outreach," she says. Currently, the Government of Estonia supports service providers led by people who use drugs and jobs for people with drug use experience in public clinics.

Over the years, the Government has progressively integrated the full range of harm reduction into broader health and social systems. "Before, people would use heroin two times a day—but now with synthetic opioids it can sometimes be up to 10 times a day, which means we have had to address a lot of other issues beyond health and HIV," Ms Kurbatova says. Homelessness, public security and unemployment had to be factored in to make an impact.

As of 2025, the HIV incidence rate in Estonia (0.05 per 1000 population, all ages) was much lower compared with surrounding countries in eastern Europe and central Asia (0.40) and similar to the rate in western and central Europe (0.05). The estimated annual number of new infections declined significantly by 72% between 2010 and 2025 in Estonia. During the same time, it declined by about 10% in the western and central European region and increased by 17% in the eastern European and central Asian region.

"It makes no sense to offer treatment if people have nowhere to live, so one has to see this as a total package," Ms Kurbatova says. "We keep repeating to everyone that harm reduction is health care for people who use drugs." Currently, around 7000 people benefit from harm reduction services, including needle–syringe programmes and opioid agonist therapy, with an estimated 9000 people who inject drugs in the country of 1.3 million people. Having been supported through the Global Fund in the early 2000s, services for people who use drugs in Estonia are now funded through a single state budget programme. A state certification system has been established for peer educators, enabling people who use drugs to be employed within public health institutions, including hospitals.

"Estonia's coordination between national health and drug control systems demonstrates its long-term commitment to sustaining harm reduction at scale," says Daria Ocheret, Human Rights Adviser at UNAIDS.

Ms Kurbatova prays some things do not change—and she hopes defense budgets will not overshadow domestic health priorities.

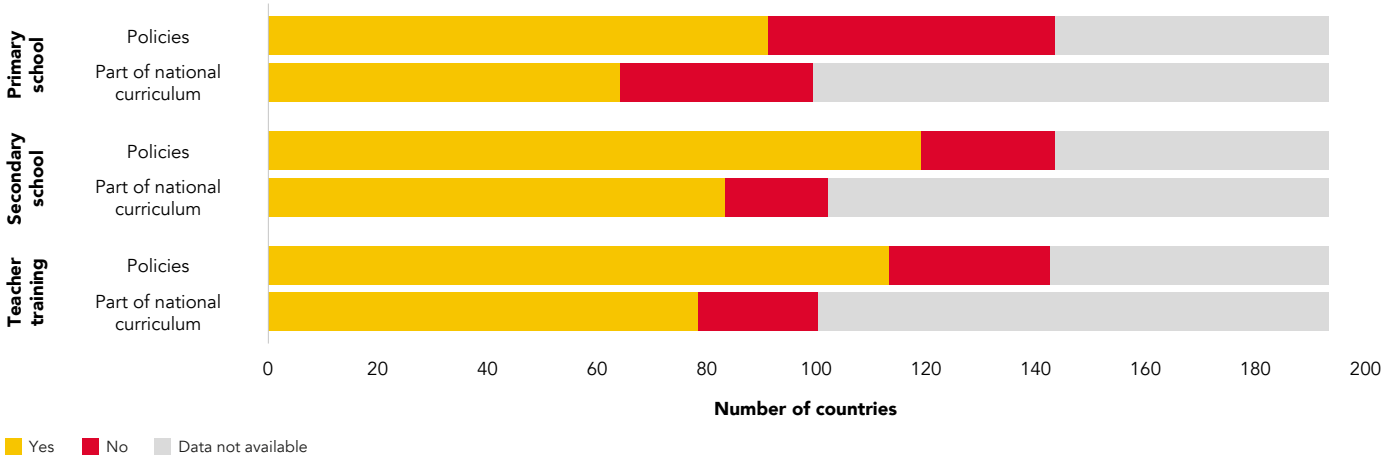
The 40+20 global targets

The 40+20 HIV targets are aimed at ensuring that by 2030, 40 million people globally are on HIV treatment, 20 million people are using antiretroviral-based prevention *(107)*. In addition the Global Prevention Coalition has additional milestones to ensure countries reach these targets. These include 20 billion condoms are distributed, and more than 20% of domestic funding goes to HIV prevention. These numerical milestones can be reached if the 16 targets of the 2026 Political Declaration on HIV/AIDS, adopted in June 2026 at the United Nations General Assembly, are achieved *(108)*. This accomplishment would see the world achieve three crucial overarching targets: 90% of people in need would be using prevention options, 90% of people living with HIV would have a suppressed viral load, and the number of new HIV infections would be reduced by 90% compared with 2010.[18]

Comprehensive sexuality education matters

Since comprehensive sexuality education is important for ensuring people have the knowledge to access HIV prevention and treatment services, it should be universally integrated into school curricula. It currently features in the curricula of a majority of reporting countries (Figure 2.23), but it is often taught unevenly and erratically in classrooms *(109)*. Assessments in 100 countries show that only one in five countries were monitoring the implementation of sexuality education through their education management information systems, and only one in four countries were evaluating learning through student assessments *(110)*. This is despite strong evidence

Figure 2.23. Countries with policies and curricula on life skills-based HIV and sexuality education, by education level, global, 2017–2026



Source: National Commitments and Policy Instrument 2017–2026 (http://lawsandpolicies.unaids.org/).

18 Global HIV Prevention Coalition Plus (GPC+) is supporting this prevention push by building on the strengths and partnerships of the evolving Global HIV Prevention Coalition and the Long-acting PrEP Coalition.

that adolescents and young people express high needs for school-based sexuality education related to HIV prevention *(111)*.

Implementation of comprehensive sexuality education has been shaped by the availability of training resources, skilled teachers, political will and financing *(112)*. Partly as a result, comprehensive knowledge of HIV prevention among young people aged 15–24 years is still very low. Across countries with available data, a weighted average of 25% of adolescent girls and young women (38 countries) and 29% of their male peers (33 countries) had correct comprehensive knowledge of HIV prevention, according to population-based surveys from 2021–2025. HIV knowledge is a little more widespread in eastern and southern Africa (35% among young women, 36% among young men), but it was very low in western and central Africa (27% and 25%, respectively) *(22)*. In addition to specific sexuality education, there is strong evidence of the protective effect of education on HIV outcomes, especially for girls and women *(113)*.



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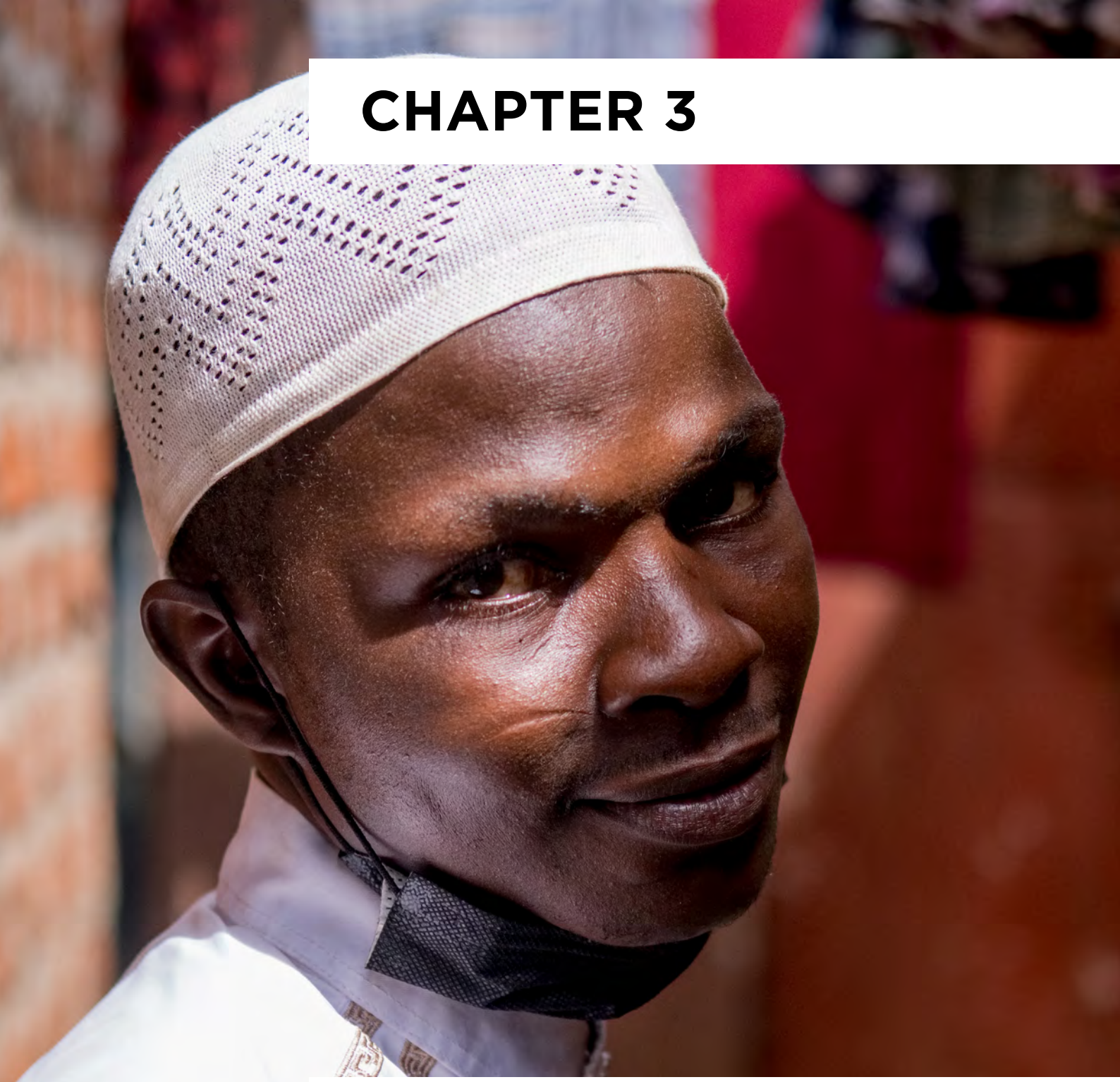
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CHAPTER 3

A financing crisis and the way forward for the HIV response

Funding shifts threaten country HIV programmes

The shifting funding landscape and constraints across the HIV, health, development and humanitarian sectors have continued to destabilize efforts to end AIDS as a public health threat. Total resources for HIV have fallen steeply, with some of the biggest funding losses occurring in countries with the highest HIV burdens and limited fiscal space to replace lost funding from domestic sources.

The 23% drop in official development assistance in 2025 was the steepest year-on-year decline in history *(1)*, with HIV programmes experiencing an 18% decrease in international financing (Figure 3.1). High reliance on donor resources for HIV—averaging above 60% in low-income and lower-middle-income countries in sub-Saharan Africa—is accentuating the impact of the funding losses.[1] Countries are being forced to adapt rapidly to these highly challenging conditions.

Fifty-five countries have reported increases in domestic public budgets for HIV since 2025, despite difficult fiscal environments and other economic challenges, including high debt-service obligation costs, rising fuel prices and low economic growth prospects. It is still to be seen whether these efforts will consolidate into stable growth of domestic resources for HIV and efficiency gains.

In 2025, United States bilateral funding fell by 26% and disbursements from the Global Fund dropped by 13% compared with 2024.[2] This reduced the resources available for HIV programmes in low- and middle-income countries in 2025 by more than US$ 1 billion to US$ 17.6 billion. This is US$ 4.3 billion short of the US$ 21.9 billion needed annually by low- and middle-income countries to achieve the 2030 global AIDS targets and put them on track to end AIDS as a public health threat *(2)*.

Despite these funding cuts, the United States Government remains the single largest source of international HIV funding for low- and middle-income countries, accounting for more than 73% of donor government funding in the HIV response. HIV financing from other bilateral donors declined by about 58% between 2010 and 2024. As a result, the United States share of total external HIV funding grew over this period, which partly explains the enormous disruption when the United States Government suddenly paused its foreign assistance for HIV programmes in 2025.

Many countries responded by increasing their domestic budgets for HIV, although mainly as part of emergency responses to try to safeguard HIV treatment programmes. The share of domestic resources allocated to HIV programmes reached 59% in 2025, compared with 48% in 2010.

This increased domestic share does not tell the whole story, however. Domestic HIV spending fell by 14% from its 2017 peak to a low in 2023, before increasing by about 5%. This partial recovery still left domestic spending below the earlier peak (Figure 3.2). At the same time, declining external financing has magnified the domestic share of resources available for HIV.

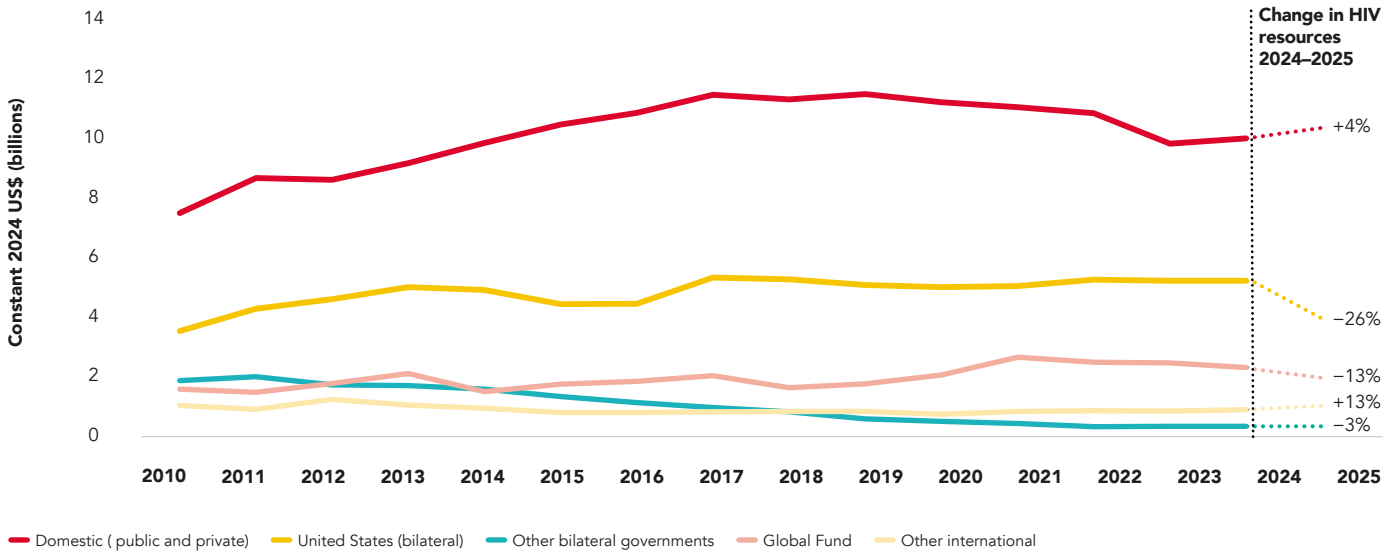
1 UNAIDS HIV financial estimates 2026.

2 Note that 2025 marked the third year of the Global Fund grant cycle, at which point disbursements typically decline.

The policy challenge is therefore not simply to shift a greater share of financing to domestic sources, but to increase the overall volume and sustainability of domestic investment where fiscal space allows, while maintaining international support where large financing gaps remain. This places special pressure on the need to achieve efficiencies and effective integration.

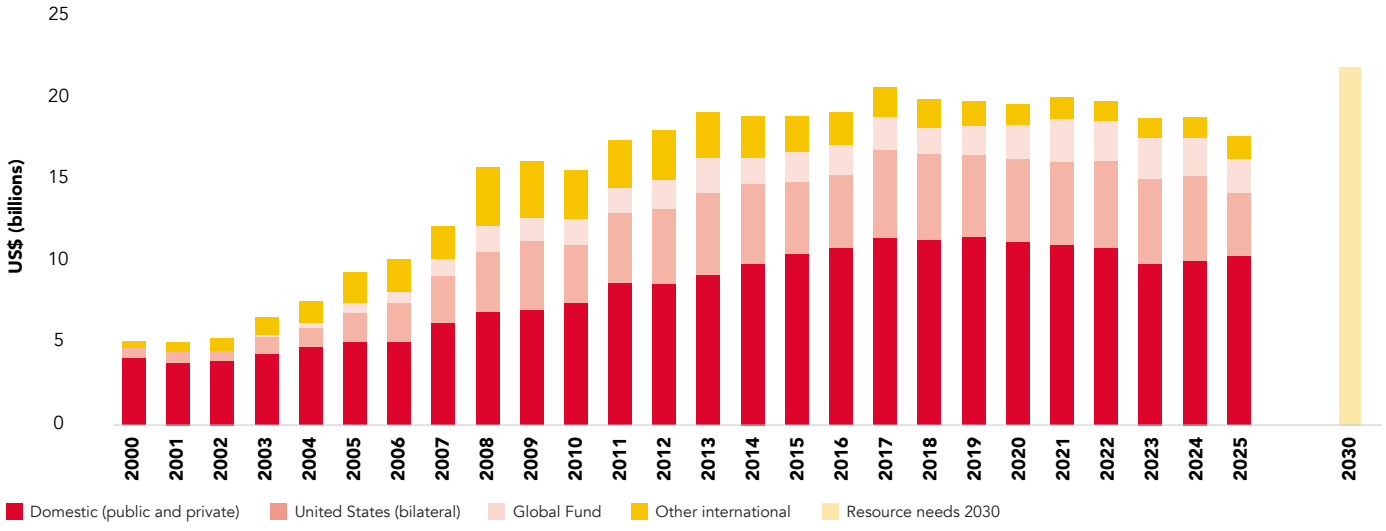
Per capita HIV resources are a useful lens for assessing how financing levels for the HIV response change as populations grow and epidemic patterns and programme priorities evolve. In 2025, per capita resources available for HIV globally were at their lowest level since 2010, at US$ 2.50—this was 22% below the 2017 peak of US$ 3.20 per capita (Figure 3.3). The extent of the decline varied

Figure 3.1. Percentage change in financial resources for HIV, by source of funding, 2010–2025



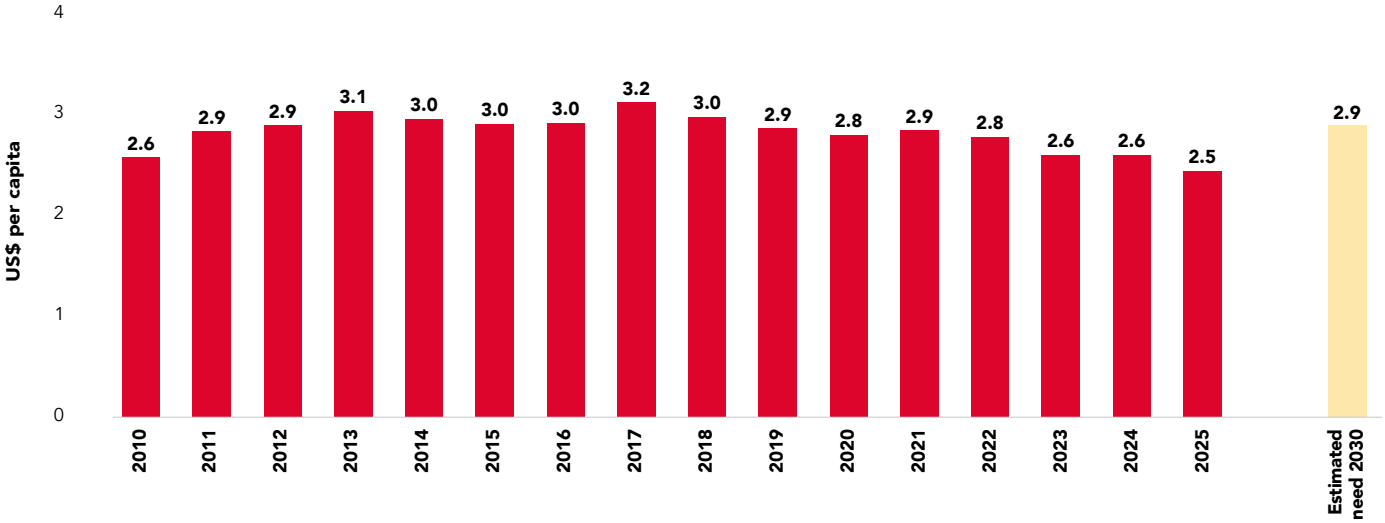
Source: UNAIDS HIV financial estimates 2026
Note: the shift by donor governments other than the United States from bilateral funding to the Global Fund has not offset the overall decline in their HIV financing, which fell by 50%, from US$3.2 billion in 2011 to US$1.6 billion in 2025.

Figure 3.2. Total HIV resource availability in low- and middle-income countries, by source, 2010–2025, and estimated resource needs in 2030



Source: UNAIDS HIV financial estimates, constant 2024 US$.

Figure 3.3. Total per capita HIV resource availability, low- and middle-income countries, 2010–2025 (US$), and estimated need in 2030



Source: UNAIDS HIV financial estimates 2026.

across regions. Per capita resources decreased by 12–13% in the Caribbean and eastern and southern Africa between 2024 and 2025, and by 7% in eastern Europe and central Asia. Eastern and southern Africa remained the region with the highest level of HIV resources per capita, but resources have fallen from US$ 22.3 per capita at their 2017 peak to US$ 14.0 in 2025.

These trends are important because HIV financing must continue to sustain lifelong antiretroviral therapy, while supporting prevention and addressing inequalities and changing programme priorities. At the global level, estimated resource needs for 2030 are US$ 2.90 per capita—about US$ 0.40 per capita more than the US$ 2.50 available in 2025.

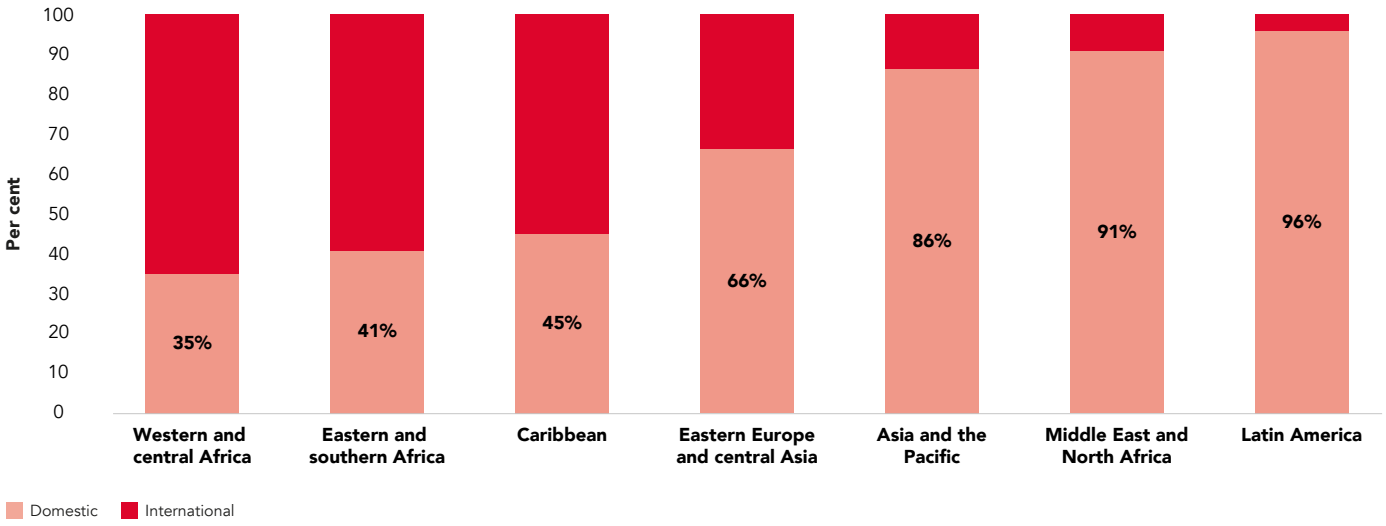
HIV prevention programmes are at risk as external funding declines

Country reliance on external funding for HIV differs considerably by region. International sources financed more than 65% of the HIV response in western and central Africa, compared with 59% in eastern and southern Africa, 55% in the Caribbean and 34% in eastern Europe and central Asia. Other regions have been funding more than 85–90% of their HIV programmes from domestic sources (Figure 3.4).

These regional averages mask substantial variation between countries. In eastern and southern Africa, external financing accounts for 90% or more of total HIV spending in Ethiopia, Malawi, Mozambique and Zambia, whereas Namibia funds 90%, South Africa 78% and Kenya 52% of total HIV spending from domestic sources. Eastern Europe and central Asia includes countries where international financing exceeds 60%, such as Armenia and Tajikistan, alongside countries where domestic resources finance close to 90% or more of their HIV responses, such as Belarus and Kazakhstan *(3)*.[3] Wide differences are also evident in the Caribbean and Latin America: international financing accounts for more than 95% of HIV resources in Haiti and 74% in the Bolivarian Republic of Venezuela, compared with 37% in Ecuador and 35% in Jamaica. By contrast, domestic resources finance 90% of the HIV response in Peru, 96% in Colombia, and almost the entire responses in Brazil and Chile.

3 Recently completed national AIDS spending assessments.

Figure 3.4. Domestic and international shares of HIV financing in low- and middle-income countries, by region, 2025



Source: UNAIDS 2026 HIV financial estimates.

Prevention programmes are particularly exposed to abrupt reductions in external financing. The effects of reduced antiretroviral medicine procurement may be mitigated initially if countries have adequate buffer stocks, although any sustained reduction would ultimately threaten treatment continuity. By contrast, reductions in financing for testing and prevention activities can translate more quickly into fewer outreach activities, interrupted community-led services, reduced access to prevention commodities and fewer tests.

The latest available country expenditure data suggest that prevention is often more dependent on external sources than the overall HIV response,[4] a pattern that is especially evident in sub-Saharan Africa. In eastern and southern Africa, international financing accounts for all reported prevention spending in Eritrea and Zambia, 94% in Mozambique and Namibia, 93% in Ethiopia, 88% in Uganda and 86% in Malawi. Even countries with strong domestic financing of their overall HIV responses can be dependent on external funding for prevention. International sources finance about 48% of total HIV spending in Kenya and 22% in South Africa, but they are responsible for much larger shares of prevention spending—67% in Kenya and 51% in South Africa.

In western and central Africa, reliance on international financing extends across the overall response and prevention programmes. International sources finance all reported prevention spending in the Central African Republic, the Democratic Republic of the Congo, Guinea and Sierra Leone, and 98% in Nigeria. Similar vulnerabilities are visible outside sub-Saharan Africa. In eastern Europe and central Asia, international sources finance 92% of prevention spending in Azerbaijan, despite accounting for only 17% of its total HIV spending; the corresponding shares are 77% versus 61% in Tajikistan and 72% versus 63% in Armenia. This suggests that increasing domestic financing of the overall HIV response does not necessarily translate into comparable domestic ownership of prevention.

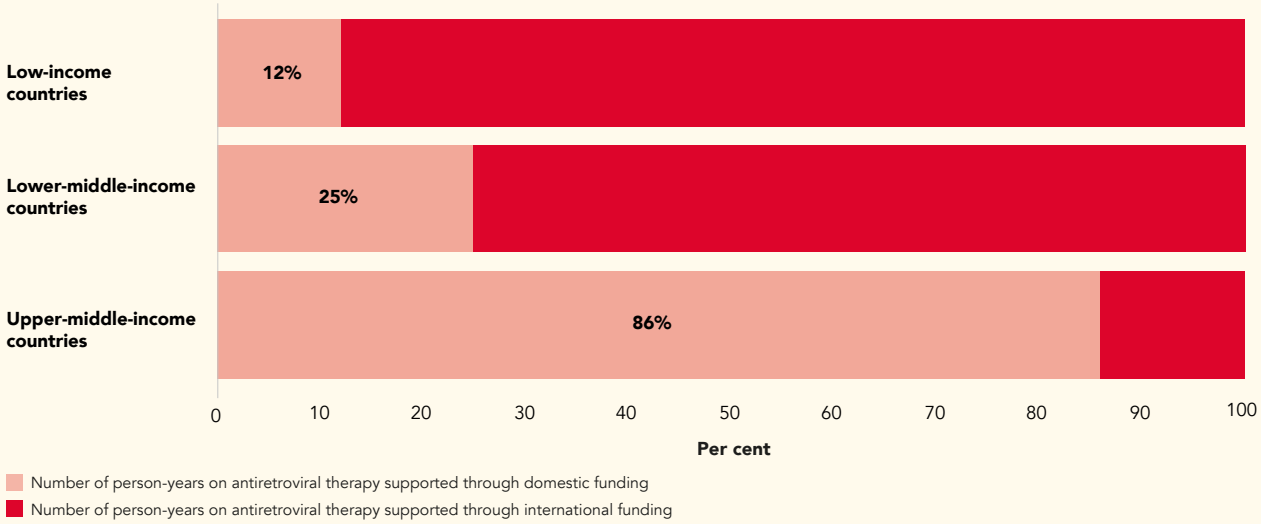
4 Note that reporting years vary by country across 2021–2025, and therefore the figures should not be interpreted as a uniform 2025 snapshot or as a direct reflection of the 2025 funding cuts.

Antiretroviral therapy costs are still highly uneven

Antiretroviral therapy represents the largest component of HIV spending across all low- and middle-income countries. Between 2010 and 2025, the price of antiretroviral therapy commodities for first-line regimens in sub-Saharan Africa, the lead cost of the HIV response, was reduced from approximately US$ 210 to US$ 37 per year.[5] However, data from 64 countries (with total HIV spending of US$ 10 billion in 2025) show that treatment programmes still absorbed about 35% of total spending, of which about 60% was for purchasing antiretroviral medicines *(3)*.[6] Across these countries, 11.4% of total HIV spending went towards prevention, 9.0% to HIV testing, 3.5% to programmes for adolescent girls and young women, 2.1% to key population programmes, and 1.8% to PrEP. Based on reported procurement volumes from these countries, an estimated 19.1 million person-years of antiretroviral medicines were procured in 2025, of which about 61% were financed by international sources (Figure 3.5) *(4)*.

This dependency is highest in low-income and lower-middle-income countries. Even in upper-middle-income countries such as South Africa, where treatment programmes rely only partially on external funding, the sheer scale of the programmes means sudden losses of donor support are highly destabilizing. The risk is therefore shaped not only by the share of treatment expenditure that is funded externally, but also by the absolute size of the treatment programme and the speed with which a government can assume responsibility for costs that previously had donor financing.

Figure 3.5. Percentage of person-years of antiretroviral therapy funded from international and domestic sources of funding, by country income category, 2025



Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).

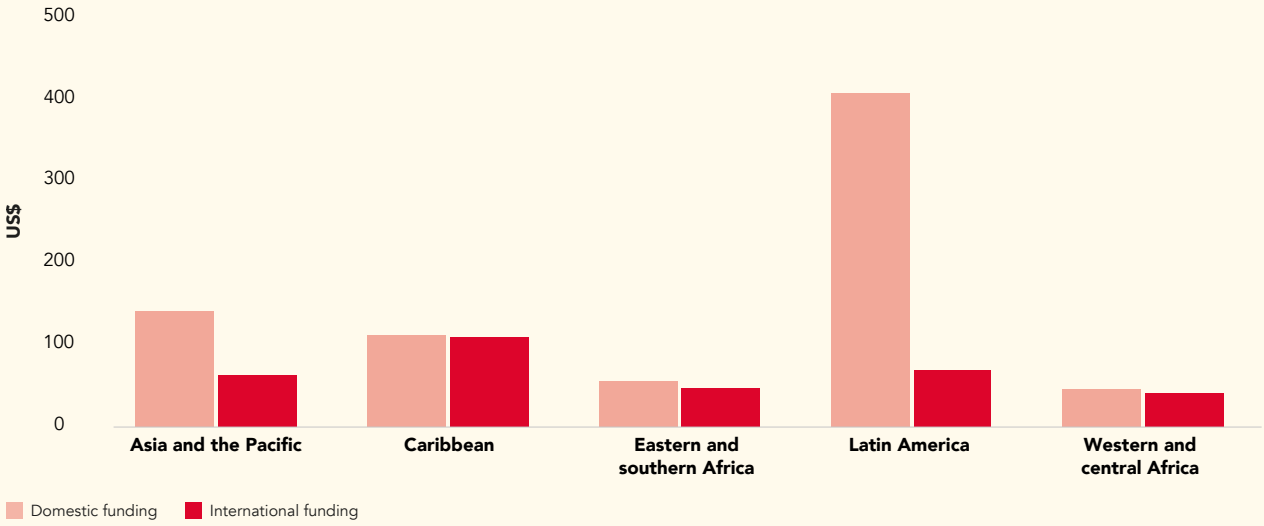
The prices of HIV products, especially antiretroviral medicines, affect the ability of countries to finance their HIV responses. Given the scale of treatment needs, small price disparities can have a substantial effect on treatment spending. As countries take on more of the antiretroviral financing burden, they will need strategies and efficient practices for procuring antiretroviral medicines at the most affordable prices possible.

5 UNAIDS estimates. This is the average for tenofovir/lamivudine-based first-line regimens for low-income and lower-middle-income countries.
6 UNAIDS national AIDS spending assessments.

Procurement prices of antiretroviral medicines vary widely. In Asia and the Pacific, the Caribbean, Latin America and western and central Africa, domestically procured antiretroviral medicines cost significantly more than those procured internationally procured (Figure 3.6). This could be due to procurement inefficiencies and price variations across different product mixes and pack sizes. Generally, prices for antiretroviral medicines purchased through pooled procurement or internationally financed procurement (e.g. the large volumes procured by the Global Fund) tend to be lower than prices for medicines procured domestically.

Prices for antiretroviral medicines and other medical technologies, especially newly introduced products, offered to middle-income and upper-middle-income countries can be considerably higher than prices for low-income and lower-middle-income countries. Market-shaping strategies, greater price transparency and more efficient procurement can help achieve more affordable prices. As countries assume a greater share of HIV financing, this will be increasingly important to sustain treatment for growing numbers of people living with HIV and to enable resources to be directed to other essential parts of the HIV response.

Figure 3.6. Antiretroviral regimen cost per person-year (weighted-average), by funding source (US$)



Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).

The diversification of manufacturing of medicines and other health products, including expanded production capacity in Africa and other regions, continues to gain momentum. This offers important opportunities to strengthen supply security, expand regional manufacturing capacity, support technology transfer and economic development, and improve the resilience of health systems. Local manufacturing of antiretroviral medicines for treatment and prevention, for example, is expected to facilitate affordable access for many countries.

Realizing the full benefits of expanded and diversified manufacturing will require supportive market conditions that enable products to be supplied sustainably and at competitive prices. Production scale, input costs, supply chains, product mix and procurement arrangements can all influence final prices, particularly as new manufacturing capacity develops. Regional and multicountry pooled procurement, demand aggregation and other market-shaping approaches can complement expanded local manufacturing by creating more predictable demand and supporting economies of scale.

Funding cuts are weakening the systems and programmes that sustain HIV services

Expenditure data show growing pressure on HIV programmes as financing tightens.[7] Data from 29 countries point to widespread spending reductions across prevention-related programmes. These 29 countries account for 44% of total numbers of people living with HIV in lower- and middle-income countries. More than 60% of these countries (17 of 29) reported lower prevention spending in 2025. Among countries reporting expenditure for specific interventions, 70% (14 of 20) reported reduced spending on PrEP, 68% (15 of 22) on programmes for key populations, and 65% (15 of 23) on HIV testing. The breadth of these reductions raises concerns about the continuity and scale of services critical to preventing new HIV infections and reaching the people and communities most affected by HIV *(3)*.

The United States Government has been the largest source of international financing for HIV, and the decline in its support is having a profound impact on financing for prevention and other key programming areas.

Risks of accelerated financing transitions

The funding upheavals have obliged countries to rapidly address their HIV financing shortfalls—especially in sub-Saharan Africa, where reliance on external support has been high. Some countries have sought to increase domestic investments, including by tapping into alternative financing sources, while other countries are reallocating resources across their HIV programmes or accelerating integration efforts in search of greater cost-efficiencies. These adjustments are crucial, because the current levels and distribution of HIV funding will make it very hard to sustain and accelerate the progress achieved in the global HIV response.

The accelerated pace at which countries are being required to transition, without assurance of their readiness, is a major concern. Many countries that receive Global Fund support have been informed that the pending funding cycle will be their final or penultimate opportunity to access significant Global Fund financing support. Global Fund allocations for HIV are down by 18% compared with the previous three-year funding cycle across 13 sub-Saharan African countries. The Global Fund is phasing out grants to 35 countries in its eighth cycle of grant-making, with another 12 countries due to follow in the ninth cycle *(5)*. Other major donors are also cutting back on support for HIV programmes, in some cases very rapidly.

Meanwhile, countries are committing to accelerated financing transition timelines of three to five years, based on rapid increases in co-financing as a condition for external support, according to analysis of 28 publicly announced bilateral agreements with the United States Government *(6)*.[8]

Most of the affected countries have little fiscal manoeuvring space due to high levels of economic uncertainty and tightening financial conditions. They face several risks, including service disruptions, particularly in prevention

7 Some countries reported only aggregate prevention expenditure, while others provided more granular expenditure data for specific interventions. Thirty-seven lower- and middle-income countries reported these data; the nine countries with overwhelmingly domestically financed HIV responses were excluded from this analysis. The remaining 29 countries account for 44% of all people living with HIV in low- and middle-income countries.

8 In seven of 11 countries analysed, combined co-financing requirements in memoranda of understanding (MOUs) and Global Fund transitions exceed domestic health spending. Countries that miss the MOU co-financing targets risk a one-to-one funding match or requirement or full withdrawal of support *(5)*.

and community-led programmes, and potential reversals in their bids to achieve disease control *(6)*. In nearly half (17 of 35) of the countries analysed, public spending on debt-interest payments is more than twice as high as government spending on health, rising to over three times in 11 countries. These debt-servicing pressures severely constrain the fiscal space available to rapidly replace external HIV financing with domestic resources.[9]

Financing of community systems and services remains fragile

Community-led and other civil society organizations are especially vulnerable to shifts in external financing. National AIDS spending assessments supported by UNAIDS in 30 countries show that civil society engagement in the HIV response has relied heavily on two main sources of funding: the United States Government (74% of reported civil society organizations' expenditure before the 2025 PEPFAR reductions) and the Global Fund (15%). Only about 4% came from domestic public sources (government budgets or social health insurance), another 4% from domestic private sources (mainly donations from local businesses or individuals), and 3% from other international sources.[10] Few of the new United States Government bilateral agreements currently include clear mechanisms for sustaining funding support to civil society organizations, including community-led organizations *(6)*.

The world is far from meeting its commitment to community leadership in the HIV response. The latest available data collected between 2019 and 2025 from 30 countries show an average of 22% of total HIV expenditure passed through civil society organizations, although the share varied substantially by programme area. Expenditure channelled through these organizations accounted for 38% of spending on prevention, 39% of spending on social enablers, and 25% of spending on testing and counselling expenditures (Figure 3.7).

Countries face major HIV financing challenges

The funding upheavals of the past two years reinforce an ongoing need for diversified and resilient financing strategies that can protect progress on HIV and other public health priorities. The path to 2030 requires renewed international solidarity, stronger and equitable domestic investment, carefully sequenced transitions, and sharper allocation of funds to the programmes and populations where they can have the greatest impact.

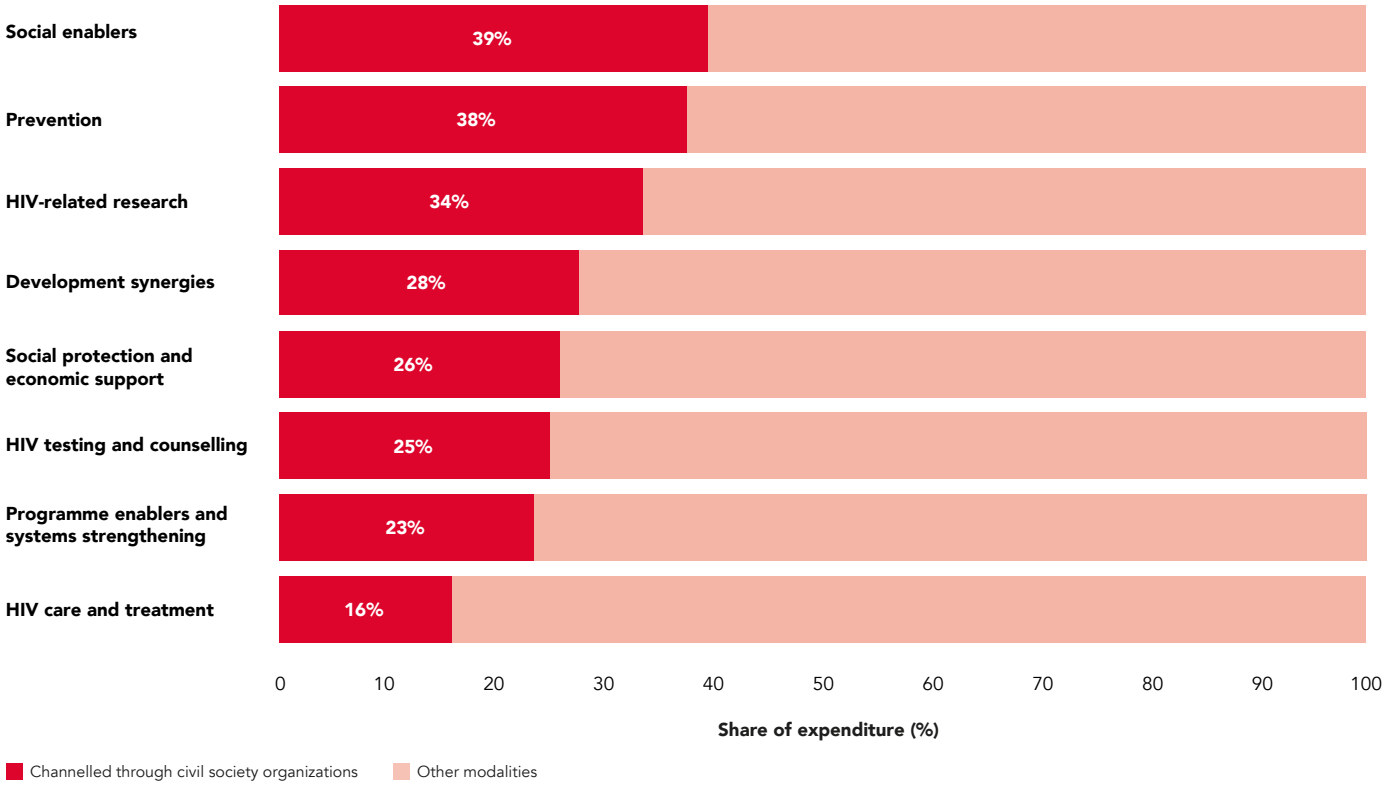
The initial priority of countries was to avert service disruptions, safeguard supply chains for antiretroviral medicines and other essential HIV products, and preserve access to HIV services. Some of this was done by reallocating existing resources or adding to staff workloads—but these approaches may not be sustainable.

The immediate challenge is to stabilize HIV financing while proceeding with realistic financing transitions that do no further harm to HIV responses. Countries are trying to adapt in a variety of ways. Several countries have negotiated new agreements with major donors (notably with the United

9 UNAIDS financial estimates 2025.

10 Data from recent national AIDS spending assessments in 30 countries in Asia and the Pacific and sub-Saharan Africa, mostly for 2024 and 2025, with information on spending through civil society or nongovernmental organization service providers (see https://hivfinancial.unaids.org/hivfinancialdashboards.html).

Figure 3.7. Share of total HIV expenditure channelled through civil society organizations, by programme area, selected countries



Source: UNAIDS national AIDS spending assessments 2019–2025.
Note: *n* = 30 reporting countries. Given that these data are from 2019–2025, they do not necessarily reflect the situation after the 2025 funding cuts.

States Government) or reprioritized budget allocations to HIV programmes. Other countries are accelerating the integration of HIV services into their wider health systems or planning to increase domestic resources to HIV.

Ultimately, domestic financing will have to be the bedrock of sustainable HIV responses in the future. This will require embedding and safeguarding HIV financing within national health budgets and national health insurance arrangements. Twenty-eight countries have developed HIV sustainability roadmaps and transition plans, with UNAIDS supporting 25 roadmaps and work currently ongoing in at least five others. The roadmaps are helping countries react to the funding shocks and plan for and implement accelerated, well-managed transitions *(7)*. These financing decisions should be informed by data disaggregated by sex, age and population group, and should safeguard services that address gender inequalities and human rights.

The transitions cannot proceed at the same pace in all countries, however. The field is uneven and the options available to countries differ widely. Countries with currently large domestic HIV contributions can seek further price reductions for health commodities and efficiency savings. Countries with a relatively balanced mix of domestic and external financing are best placed to diversify their funding sources, such as through enhanced tax systems (including health taxes), integration of blended financing, and by preventing expansion of out-of-pocket expenditure. Countries with heavy reliance on external support, many of them with high HIV burdens, are in a very difficult predicament, with potential transitions to self-reliance that are unrealistically quick.

For the foreseeable future, these countries require continued global solidarity to prevent further structural damage to their HIV responses, while readying phased increases in domestic contributions. Donors should extend emergency support, including through debt relief interventions, to countries with HIV programmes that are in fiscal distress. Donors can ringfence their HIV financing support and use it to underwrite country-led transition strategies that emphasize equity and sustainability; commit investments while tying phased retreats to realistic, country-specific strategies for progressing towards greater domestic financing of HIV responses; and bring forward future support to underwrite these strategies.

It is often noted that very few countries have met their commitments on health financing, including the pledges made in the 2001 Abuja Declaration, which called for African countries to allocate at least 15% of national budgets to health. By the same token, in 2025 only four high-income countries honoured the United Nations target to allocate the equivalent of at least 0.7% of their gross national income to official development assistance for low- and middle-income countries.[11] There is an undeniable need for continued international solidarity, tied to realistic financing transition strategies, if a reversal of the progress made against AIDS is to be avoided.



11 Only Norway (1.03%), Luxembourg (0.99%), Sweden (0.85%) and Denmark (0.72%) met the target in 2025, according to data from the Organisation for Economic Co-operation and Development. Several other countries (Australia, Canada, France, Italy, Japan, United Kingdom of Great Britain and Northern Ireland, United States) contributed 0.4% or less of gross national income to foreign aid.



COIN Comprehensive Health Center, through its Red Golondrinas project, provides HIV prevention information and services to migrants.

Women community health promoters in the Dominican Republic open up new opportunities for HIV prevention

Mariluz Martínez has worked with the Center for Comprehensive Guidance and Research (COIN) for 22 years and currently serves as its community coordinator. For her, community health promoters are a trusted link between communities and health services. "They are the ones who know where to find the people we need to reach and who open doors for us," she says.

Ms Martinez highlights the example of Carmen Lorenzo, who has worked as a community health promoter for more than 35 years. After completing her education, she became a lawyer and established herself as a trusted figure giving legal advice to people living with HIV.

International HIV funding in the Caribbean fell by 18% in 2025. In response, the Dominican Republic reallocated budget resources to ensure continuity of antiretroviral treatment. "Despite the funding cuts, there were no stockouts of antiretroviral medicines," said Melvin Brioso, Technical Manager at CONAVIHSIDA (the National Council for HIV and AIDS).

Ms Martinez warns that the growing emphasis on identifying new HIV diagnoses and linking people to health services, however, has limited educational and prevention activities. "Prevention takes time," she says, emphasizing the need for sustained funding for community outreach and community health worker training.

In the Dominican Republic, 88 000 people are living with HIV. There were 4500 new infections and 1300 AIDS-related deaths in 2025.

Since 2010, the number of AIDS-related deaths has declined by 63%, but the number of new infections has decreased by only 7%, a reminder of persistent prevention challenges. The most recent data show HIV prevalence of 7% among gay men and other men who have sex with men and 28% among transgender women, compared with about 1% in the general adult population.

The Dominican Republic is developing its National HIV Response Sustainability Plan, led by the Ministry of Public Health and CONAVIHSIDA, with support from the Global Fund and UNAIDS. The country has begun to integrate HIV services into its national health system and is working more closely with community organizations as service providers to use funds more efficiently.

Dr Fernando Díaz, Clinical Manager at COIN, believes that one of the greatest achievements in HIV prevention has been the leading role of communities, with people sharing information and recommending PrEP through trusted networks. "PrEP users are the driving force behind its promotion," he says. His reflection reminds us that a sustainable HIV response also means investing in people and the opportunities they create to transform lives.

"HIV and AIDS will not be defeated through one final push, but through a sustained commitment to protect, consolidate and expand the progress we have achieved," said Víctor Atallah, Minister of Public Health of the Dominican Republic, at the United Nations General Assembly High-level Meeting on HIV/AIDS in June 2026.

Community leadership in the HIV response

Community-led organizations and networks have been the backbone of the HIV response for decades. Their activism and advocacy are decisive for shaping policies and programmes, and for upholding human rights and the rights of all people living with, affected by or at risk of HIV. The services and support they provide serve as a lifeline, especially for people from key populations and people living with HIV. The 30–80–60 global AIDS targets highlight the importance of community-led action in the HIV response.[12,13]

Although recognition of the vital role of these organizations has grown, funding support has not reflected their outsized contributions to HIV programmes. A great deal of this support has been withdrawn in the past two years, forcing many organizations to cut back or halt their HIV work. These setbacks are aggravated by the ongoing encroachment on civic space and the increasing use by some countries of legal and bureaucratic controls that make it difficult and sometimes dangerous for community-led and other civil society organizations to function.

Despite the adversities, community organizations, especially those led by affected communities, have persevered by publicizing rights violations and raising awareness of rights and services, supporting survivors, challenging restrictions in the courts, adopting new income-raising strategies, and shifting their ways of working *(8)*. The outcomes of these attempts at recovery will depend in large part on whether more hospitable financing, legal and regulatory environments can be achieved.

Operating environments are complicated and varied

The ability to register as a legal entity is a basic requirement for civil society organizations. Although almost all 105 reporting countries stated that organizations led by people living with HIV were able to legally register, only 60–70 reported that organizations led by gay men and other men who have sex with men, transgender people or sex workers were allowed to do so. Organizations led by people who inject drugs were least likely to be afforded such legal dispensations. About two-thirds (68%) of 108 reporting countries indicated there were no restrictions on the registration or operation of community-led organizations, although a minority acknowledged that complex or costly registration requirements, cumbersome reporting and other obligations presented barriers *(9)*.

Access to predictable funding is arguably the most pressing challenge for community-led organizations, but not all countries grant community-led organizations even the legal authority to solicit, receive and use funding.

12 The 30–80–60 targets include that by 2030, 30% of HIV testing and supportive services related to care and treatment are delivered by community-led organizations, including key population-led and women-led organizations; 80% of people-centred HIV prevention programmes for people from key populations are delivered by community-led organizations; and 60% of programmes that support achievement of the societal enablers are delivered by community-led organizations, including key population-led and women-led organizations.

13 Existing HIV monitoring systems do not yet systematically track the proportion of services and programmes delivered by community-led organizations. A set of policy questions assessing the enabling and operating environment, including financing, for community-led service delivery was developed and integrated into the Global AIDS Monitoring framework to serve as proxy measures for monitoring progress towards the 30–80–60 targets.

Community-led organizations are permitted to receive funding from international donors in 84 of 110 reporting countries or through social contracting mechanisms in 64 countries. Community representatives from a minority of countries reported that other laws, regulations or restrictions hinder access to funding *(10)*.

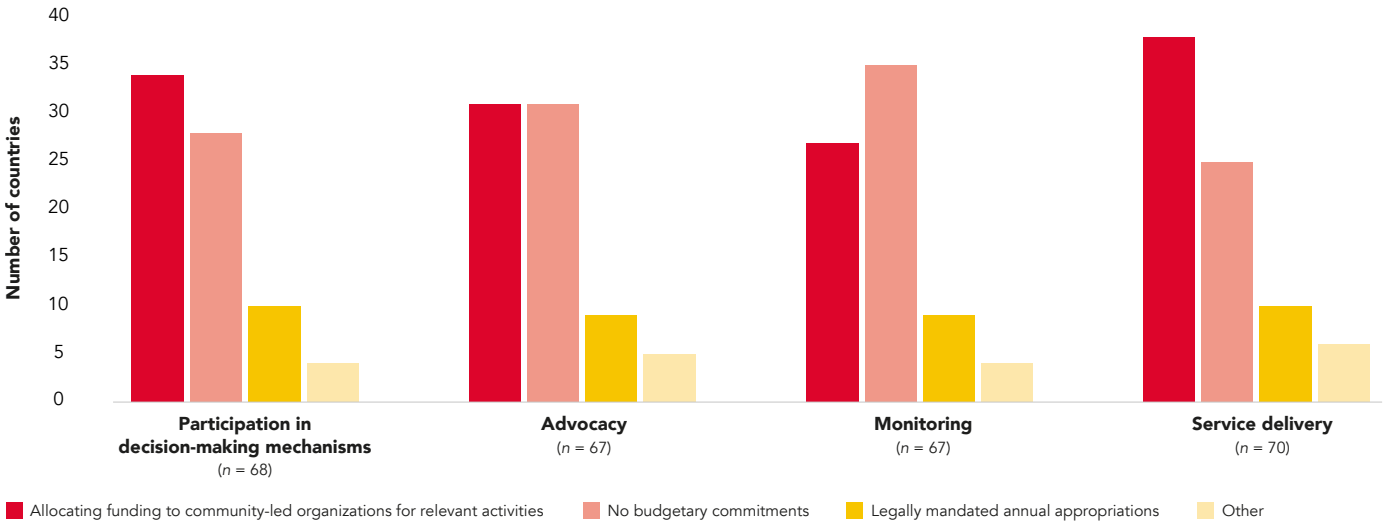
More positively, close to half of 70 reporting countries stated that at least some domestic public funds were allocated for various forms of community engagement in the HIV response in 2026, although very few countries did this through a permanent annual budget line (Figure 3.8).

Almost two-thirds (65%) of 52 reporting countries stated that their national policies specified processes for accrediting community-led organizations to deliver clinical services. Specific roles were reported to have been defined in national plans or strategies in 57 countries. Most reporting countries indicated that community-led organizations can legally distribute condoms and lubricants and provide HIV testing, treatment linkage, adherence and retention services (Figure 3.9).

Fewer countries reported that these organizations were allowed to distribute naloxone, needles and syringes or antiretroviral medicines, which are important for preventing or treating HIV.

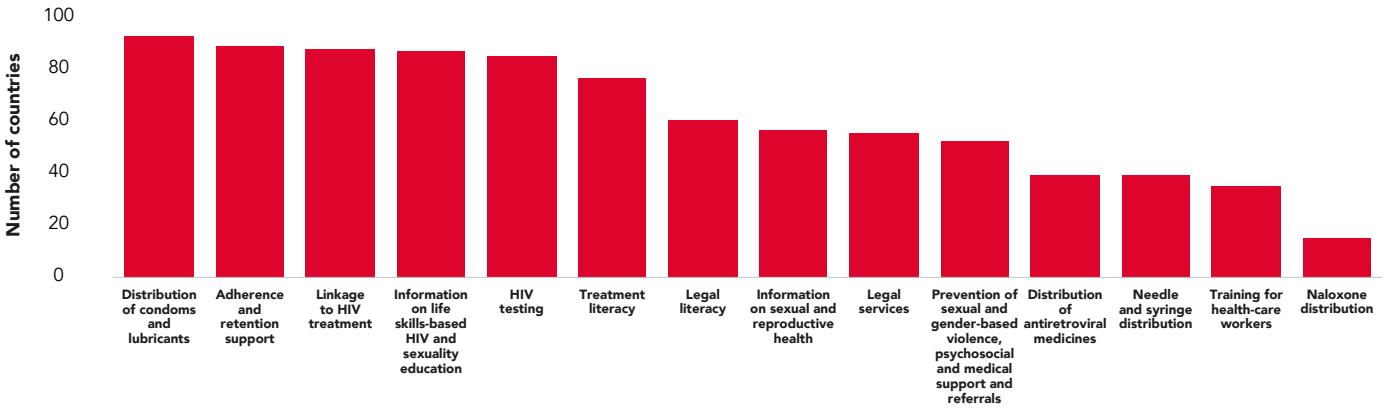
In addition to specific legal and regulatory constraints, community-led organizations in many countries operate under restrictive political and legal strictures. In some parts of Africa and in eastern Europe and central Asia, for example, anti-LGBTQIA+ laws and other restrictions are deterring engagement in health, especially HIV, services and inhibiting community-led advocacy *(11, 12)*. CIVICUS has documented this worsening trend, while noting that civil society organizations continue to show remarkable resilience and are achieving noteworthy victories in safeguarding civic freedoms. Overall, CIVICUS rated 83 of 193 countries and territories as having repressed or closed civic space in 2025, and only 39 countries as having open civic space. CIVICUS has noted recent improvements in three countries and deteriorations in 15 countries *(13)*. Almost 60% of people living with HIV globally reside in countries considered to be repressive or closed.

Figure 3.8. Numbers of countries allocating domestic public funds to community engagement in the HIV response, global, 2026



Source: National Commitments and Policy Instrument 2026 (http://lawsandpolicies.unaids.org/).
n = number of reporting countries

Figure 3.9. Numbers of countries where community-led organizations can legally provide HIV-related services, global, 2024–2026



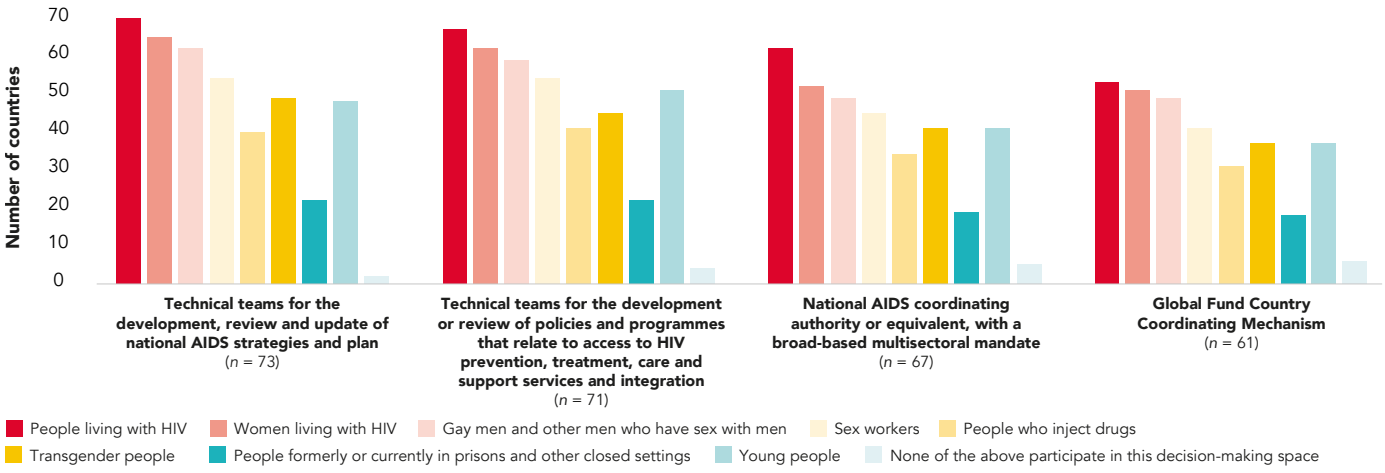
Source: UNAIDS National Commitments and Policy Instrument 2024–2026 (http://lawsandpolicies.unaids.org/).

Participation in decision-making is uneven

More than 90% of reporting countries indicated that people living with HIV are able to participate in the development of national policies, guidelines and strategies related to their health. Participation is lower for women living with HIV (83%), gay men and other men who have sex with men (78%), young people (72%), sex workers (69%), transgender people (62%), people who inject drugs (51%), and people in prisons and other closed settings (27%)—a reminder of the extent to which people from these populations are not only stigmatized but actively ostracized.[14] People from these populations participate to varying degrees in technical teams for the development of national AIDS strategies and service delivery programmes (Figure 3.10).

Fewer countries reported participation in more institutionalized decision-making spaces, such as national AIDS commissions and Global Fund Country Coordinating Mechanisms. Typically, people who inject drugs and people

Figure 3.10. Participation in decision-making spaces by people from key and other priority populations, global, 2026



Source: National Commitments and Policy Instrument 2026 (http://lawsandpolicies.unaids.org/).

14 It is noteworthy that participation rates reported by national authorities and civil society organizations are very similar.

formerly or currently in prisons or other closed settings were least likely to participate in decision-making spaces.

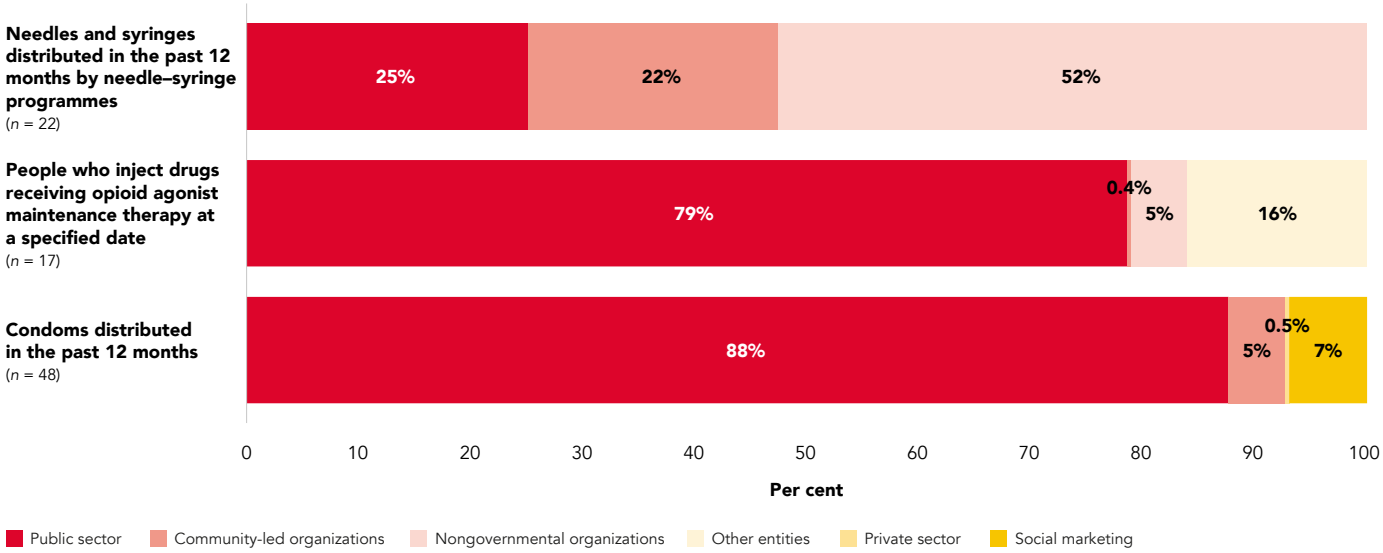
Service delivery by community-led organizations

The important contributions of community-led organizations in the delivery of prevention, treatment and care services are evident. Data reported from 22 countries show that in 2025, nongovernmental organizations distributed about half (52%) and key population-led organizations a further 22% of all needles and syringes in the previous 12 months (Figure 3.11) *(3)*.

Community-led monitoring is an increasingly salient source of information and analysis for HIV and other health programmes. Its impact is seen in Lesotho, for example, where reductions in service-related stigma and health commodity stockouts and shortened waiting times have been documented at 96 public health facilities after monitoring projects publicized a range of service delivery deficiencies *(14)*.

Erratic and inadequate funding has been a common challenge for community-led monitoring projects. Although funding cuts have compounded this, community-led monitoring projects continue to provide valuable insights into the quality and suitability of HIV services and the experiences of people seeking to use them. Information reported through Global AIDS Monitoring in 2026 reveals a range of recurring concerns, including user fee charges for accessing antenatal clinics; stockouts of medicines and HIV prevention products; personal insecurity at some health facilities; long waiting times at clinics and for laboratory results; limited facility opening hours; accessibility problems for people with disabilities; limited access to sexual and reproductive health services; breaches of confidentiality; and disrespectful behaviour of health-care staff.[15] Also highlighted are reductions in stigmatizing experiences in some settings following feedback from community-led and other programme monitoring.

Figure 3.11. Distribution of reported services, by type of provider, 2025



Source: Global AIDS Monitoring 2026 (https://aidsinfo.unaids.org/).
Notes: *n* = number of countries. Community-led organizations for needles and syringes distributed and people who inject drugs receiving opioid agonist maintenance therapy refer specifically to key population-led organizations. Private-sector and social marketing categories are included only for condoms distributed.

15 Data reported through Global AIDS Monitoring.

Insufficient funding for community-led HIV work

Opening new possibilities for trans organizations

Established in 2020, the African Trans Network (ATN) coordinates grassroots trans movements to advocate for the rights, safety and health care of transgender and gender-diverse people across Africa. Its restricted legal status limited the support it could provide, but registering as an independent legal entity in 2025 has enabled it to take its work to new levels.

ATN can now open a bank account, directly employ staff, independently enter into contracts with funders and partners, and transform from a coordinating network into one that resources the trans movement in Africa. Receiving earmarked funding for trans-specific activities is opening new possibilities for organizations such as ATN that work in difficult political, legal and social conditions to advance trans rights, protect trans communities, and improve their access to health services *(15)*.

Funding available for community-led HIV services and support has never adequately reflected the vital importance of this work. A little over a fifth (about 22%) of total international funding destined for HIV services has been going to civil society service providers,[16] of which a very small share (about 2% in the 15 countries with disaggregated data[17]) has gone to community-led organizations.

The majority of funding received by community-led organizations in high-burden contexts has been from international sources, and primarily from the United States government.[18] The funding losses experienced by community-led and other civil society organizations in the past two years have dealt a grave blow to these organizations and to the communities they serve. According to Frontline AIDS, more than three-quarters of surveyed civil society organizations reported service disruptions, with more than 80% operating at less than half their capacity by the end of 2025. Essential support services, including for mental health, legal aid, gender-based violence, peer education, outreach and counselling, were being reduced or discontinued. Ten per cent of services for transgender people and people who use drugs had been halted entirely. Services for sex workers and gay men and other men who have sex with men had also been reduced, leaving these communities increasingly exposed to HIV and other threats *(16)*.

These cuts are not limited to HIV-related organizations. According to a European Union Supporting and Enabling Environment CIVICUS survey across 195 civil society organizations in 68 countries, one in three civil society groups say funding cuts threaten their survival. The organizations most affected by cuts are those working on human rights, democracy and protection of marginalized groups *(17)*.

By May 2026, according to follow-up research by the International Network of People who Use Drugs, a third of 149 harm reduction organizations across eight regions had lost half or more of their annual budgets. A small minority (about a fifth) had managed to partially replace lost funding. Community-led organizations have been hit the hardest, and only one in 10 surveyed organizations were able to continue operating as normal. More than a third (36%) had halted services entirely, more than half (56%) had stopped outreach activities, and between a third and a half had reduced service hours and laid off staff *(18)*. Projects led by sex workers have reported similar turmoil, including staff lay-offs, shortages of condoms and PrEP, and disrupted access to antiretroviral therapy *(19)*.

16 Organisation for Economic Co-operation and Development creditor reporting system, accessed July 2026.

17 Bangladesh (2023), Belize (2023), Benin (2024), Burundi (2023), Côte d'Ivoire (2023), Indonesia (2025), Mozambique (2022), Namibia (2023), Nepal (2023), Nigeria (2021), Pakistan (2022), Papua New Guinea (2023), Togo (2022), Philippines (2025), Zimbabwe (2025).

18 Financial estimates based on UNAIDS supported national AIDS spending assessments in 29 countries.

In Nigeria, the abrupt funding cuts upended services for people from key populations. Within a few months, coverage of prevention services fell by 50%, HIV testing uptake by 70%, and PrEP initiations by 83% *(20)*. Many gay men and other men who have sex with men in Nigeria had relied on donor-funded, peer-led safe spaces for HIV care, but shifts in funding and lack of domestic funding for these organizations forced many centres to close *(21)*. In Uganda, access to services has declined, and harassment and violence have increased in the context of worsening persecution against gay men and other men who have sex with men *(22)*.

Reduced official development assistance has affected women's rights organizations, with consequences extending beyond service delivery to community leadership, peer support, advocacy and rights protection. After increasing between 2020 and 2024, funding to end violence against women and girls was projected to decline by 17–20% in 2025. Post-exposure prophylaxis for survivors of sexual violence has become harder to obtain in the Democratic Republic of Congo, and in Ethiopia it now requires the payment of user fees *(23)*.

Financing for HIV programmes for adolescent girls and young women and for women-led organizations is decreasing. A rapid assessment conducted by the International Community of Women Living with HIV in early 2025 found that more than 60% of surveyed women-led HIV organizations had lost financing or been forced to suspend essential programmes *(24)*. Substantial cuts of up to 54% were also expected in support for sexual and reproductive health programmes between 2024 and 2026 *(23, 25)*.

At the same time, however, many affected organizations have responded with determination and creativity. Despite ongoing armed conflict, community-led organizations serving people from key populations in Mandalay and Yangon in Myanmar offered advanced training to peer educators and shifted to using mobile clinics and home delivery services, multimonth dispensing, and digital platforms for appointment tracking, adherence counselling and symptom screening *(26)*.

Hit by funding cuts, Reach All Uganda, a key population-led outreach organization, launched a farming enterprise to cover its operating costs and transformed itself into a Government-recognized, independent clinic that continues to provide rights-based services *(27)*.

In the Kigoma region in the United Republic of Tanzania, Dare, a community-led organization, retrained its cadre of young peer educators and integrated them into existing council structures. They have continued to provide HIV prevention and testing education and support via public health facilities *(28)*.

To keep lifesaving HIV services operating, many women's organizations are relying on voluntary, unpaid work, amid reports of higher rates of burnout among staff *(25)*. The Mothers2Mothersprogramme launched the campaign Can't Stop, Won't Stop to mobilize continued support as it sought to preserve the jobs of hundreds of community health workers *(29)*. Youth-led organizations have also mobilized community-led support in Eswatini, Mozambique and Zimbabwe *(30)*.

These adaptations can only go so far in future-proofing community-led organizations. Flexible emergency funding is needed urgently so these organizations can reopen clinics, shelters and critical services. Beyond this, access to predictable and dedicated funding is essential, including dedicated financing for women- and key population-led organizations. Along with reviving direct donor support, embedding funding for community-led services in national health insurance systems and through multiyear social contracting, with strong accountability and governance safeguards, offer ways forward *(16)*.



Keeping HIV care alive during the Ebola outbreak in the Democratic Republic of the Congo

For people living with HIV in Ituri in the Democratic Republic of the Congo, a province already facing a protracted humanitarian crisis marked by conflict and displacement, the Ebola outbreak declared in May 2026 created an emergency within the emergency—the risk of losing access to lifesaving HIV treatment. Fear of infection, insecurity and overstretched health facilities kept many people away from clinics, putting their treatment for HIV at risk.

Community-led organizations stepped in within weeks. UCOP+, the national network of people living with HIV, and ANORS, the national alliance of civil society organizations engaged in the HIV response, mobilized relays to find people who had stopped seeking and receiving HIV services.

UNOP+ and ANORS delivered lifesaving medicine and offered counselling and psychosocial support. Between July and September 2026, after UNAIDS repurposed funding from Luxembourg to support the HIV response during the Ebola outbreak, 52 relay-people in Bunia, Mongbwalu and Rwampara visited 724 people living with HIV and provided 287 with antiretroviral medicines and cotrimoxazole.

Esther Nyamungu, a community worker at the Bunia distribution point who contracted Ebola and recovered, says "I am a survivor." For Ms Nyamungu, going to the Ebola treatment centre made all the difference. "I advise people living with HIV to go to the centre as soon as the first symptoms appear. It is thanks to the early treatment I received there that I am still alive, and thanks to my long adherence to antiretroviral therapy that I survived Ebola," she explains.

Relay-people raised awareness about Ebola and supported referrals while infection prevention was reinforced at Bunia's community antiretroviral distribution point. These efforts helped identify 106 people with suspected Ebola, 43 of whom were admitted to Ebola treatment centres.

An estimated 570 000 people are living with HIV in the Democratic Republic of the Congo, and about 30% of these are in provinces currently affected by Ebola. Maintaining HIV services during this health emergency is therefore a priority. National systems are adapting. Authorities have adopted an HIV/TB mitigation plan and standard operating procedures for HIV and TB services during the Ebola outbreak, and staff in affected areas are being trained to apply them. People living with HIV who contract Ebola need integrated care, including early HIV assessment and testing during Ebola treatment, and putting these procedures into practice can help prevent avoidable deaths.

"HIV cannot be treated as a secondary concern during an Ebola emergency," says UNAIDS Country Director Margaret Molnar, who travelled to Ituri. "Time and time again, when an emergency strikes, what saves people living with HIV is integrated care and strong community-led services."

Building on these efforts will be essential as the Ebola epidemic continues to evolve and grow. Community networks have shown what they can achieve, but they still reach only a fraction of the people in need. Sustained investment in their work and closer collaboration between HIV services and Ebola treatment centres is key, as well as continued leadership of regional organizations such as the Africa Centres for Disease Control and Prevention and multilateral partners such as UNAIDS.



“No patent is worth more than a life”—Duda Salabert’s fight to make HIV innovation accessible

For Brazilian Congresswoman Duda Salabert, the fight for dignity is inseparable from the fight for health and human rights. Re-elected to Congress in October 2026 as the third most-voted federal deputy from Minas Gerais, she has become a leading voice in efforts to expand access to long-acting HIV prevention. “Studies show that around 40% of trans women in Brazil are living with HIV. This is a consequence of the extreme vulnerability faced by this population in Brazil and Latin America,” she said at AIDS 2026, pointing to the discrimination, violence and barriers to health services that continue to place transgender communities at higher risk of HIV.

Ms Salabert is at the centre of the debate in Brazil over long-acting HIV prevention. Lenacapavir provides protection through two injections a year and has shown close to 100% efficacy in preventing HIV. Brazil participated in research that demonstrated the effectiveness of lenacapavir but was among the Latin American countries excluded from the voluntary licensing agreement for generic production.

Ms Salabert’s advocacy builds on broader political mobilization in Brazil. The Joint Parliamentary Front on STI/HIV/AIDS and Viral Hepatitis, coordinated by Congresswoman Erika Kokay, brings together parliamentarians from both chambers of Congress around the HIV response. In August 2025, Ms Kokay, together with Congresswomen Ana Pimentel and Daiana Santos, proposed a joint public hearing on access to long-acting medicines, bringing health science and human rights perspectives into the same debate. High prices emerged as a key barrier to equitable access.

Ms Salabert took the issue further. In February 2026, she introduced Bill 418/2026 to declare access to lenacapavir a matter of public interest and create pathways for its inclusion in Brazil’s Unified Health System. Two months later, she brought the Government, civil society, academia and UNAIDS back to Congress for discussions focused specifically on access to lenacapavir.

Civil society has also been central. The Brazilian Interdisciplinary AIDS Association, including its Working Group on Intellectual Property, has worked with UNAIDS to convene communities, researchers, the Government and other partners around long-acting medicines. Through digital mobilization, they have connected scientific innovation with questions of affordability, intellectual property and equitable access, drawing on Brazil’s history of using public-interest measures to expand access to HIV medicines.

“Lives are at stake, and we need to ensure that the country is not left behind and that prices do not make access unfeasible for those who need it most,” notes Veriano Terto Jr, Director and Vice President of the Brazilian Interdisciplinary AIDS Association.

In Brazil, this debate is rooted in the constitutional principle that health is a right of everyone and a duty of the State.

For long-acting HIV prevention, scientific progress has sharpened a political question: who will be able to benefit from it?

“If we have a medicine that can slow the spread of the global epidemic, but at an absurd price that prevents this medicine from reaching the population, the problem is not with science, it is not with the patent, it is with the price,” says Ms Salabert. “The dialogue is not moving forward. And if the dialogue does not move forward, all that is left for us is the social struggle.”

Integration is an important and complex priority

Deeper integration of the HIV response with other health, community and social services and systems, and especially with primary health care, is increasingly seen as a prerequisite for ending AIDS as a public health threat and sustaining this accomplishment. Integration is expected to boost the efficiency and impact of programmes and relieve some of the strain caused by funding pressures.

There is persuasive evidence supporting these expectations. The linked delivery of HIV and TB services has contributed to a 77% decline in TB-related deaths among people living with HIV between 2010 and 2025 *(31)*. According to a large meta-analysis focused mostly on sub-Saharan Africa, HIV and other health outcomes can be better within integrated services than in isolated services, and the uptake of non-HIV services tends to improve *(32)*. Many country studies have similar findings *(33–38)*. An integrated approach for eliminating vertical transmission of HIV, syphilis and hepatitis B has been shown to be cost-effective *(39)*, as has the integration of HIV with infectious and noncommunicable disease screening *(40)*.

The funding losses of the past two years have added impetus to integration efforts, amid growing confidence that primary health care is well positioned to absorb HIV services. Several countries have responded to the funding crisis by mandating deeper integration *(41)*. HIV treatment and care are widely seen as well positioned for further integration, since primary care services in many countries are designed to serve people with chronic noncommunicable conditions, which are frequently also experienced by people living with HIV. HIV care is already integrated with primary care in many high-burden settings *(42)*, but less so with hypertension and diabetes services *(43)*.

Although there are positive examples of service integration progressing and delivering, it is clear that integration into broader health systems can be challenging. When integration leads to increased service demands in already overburdened health systems, for example, it is unlikely to improve health outcomes *(32, 42)*. Effective and sustainable integration requires the readiness and alignment of the financing, workforce, information, procurement and distribution, monitoring and evaluation, and community systems that underpin and enable health systems to function smoothly and equitably. These systems must be robust enough to take on additional HIV functions without compromising outcomes.

HIV and sexual and reproductive health services should be integrated further

Studies investigating the integration of HIV and TB, sexual and reproductive health, mother and child health, noncommunicable diseases (including diabetes) and mental health services have found generally positive but variable results, with contextual factors weighing heavily on the outcomes *(42, 44–47)*.

The integration of HIV and sexual and reproductive health and rights services is progressing, notably in eastern and southern Africa, where initiatives such as 2gether 4SRHR are under way. This programme, which operates in 10 countries, links HIV and sexual and reproductive health and rights services, peer and mentor models, youth leadership, and peer-led action to change harmful social and gender norms.[19] It has led to improved prenatal care attendance, HIV prevention uptake, and prevention of vertical transmission among supported young mothers. In Malawi, for example, all participating adolescent mothers attended safe motherhood clinics; in Zimbabwe, 93% of young mothers living with HIV are still in care two years after childbirth *(48)*.

Meanwhile, women's and girls' access to high-quality sexual and reproductive health information and services, including family planning, is far from ideal, due to social and cultural norms, structural challenges, inadequate health infrastructure, inequitable access, and restrictive laws and policies *(49, 50)*. An analysis of data from Stigma Index 2.0 studies highlights that across 48 countries, the percentage of women living with HIV who reported experiencing any form of reproductive coercion in the year before the study ranged from 2.5% in Côte d'Ivoire to as high as 32.6% in Pakistan and 37.1% in Bolivia *(51)*.

When women are empowered in decision-making, they are more likely to negotiate safer sex, have stronger HIV-related knowledge and use condoms. Over half (56%) of adolescent girls and adult women aged 15–49 years who are currently married say they can make their own informed decisions regarding their own sexual relations, contraceptive use and health care (Figure 3.12).[20]

Integrated TB and HIV services are saving thousands of lives

Improvements in the integrated delivery of HIV and TB services have contributed to a steep drop in TB-related deaths among people living with HIV, from an estimated 605 000 [461 000–768 000] in 2010 to 137 000 [109 000–168 000] in 2025 *(31)*.[21] This decline has been maintained across all regions, except for Latin America, although the rate of decline has slowed in the past three years (Figures 3.13 and 3.14). Nonetheless, TB remains the leading cause of death among people living with HIV, with the burden concentrated in eastern and southern Africa (54% of deaths among people living with HIV in 2025), Asia and the Pacific (19%) and western and central Africa (18%).

WHO recommends that TB preventive therapy (TPT) be provided to all people newly enrolled on antiretroviral therapy. Globally, the annual number of people on antiretroviral therapy who received TPT increased from fewer than 30 000 in 2005 to 3.0 million in 2019, but numbers have since fallen to 1.46 million in 2025. Possible reasons for this reduction include disruptions to health services caused by the COVID-19 pandemic and changes in data collection. Nine countries accounted for about three-quarters (76%) of all people living with HIV on TPT in 2025.[22] Among these countries, TPT coverage for people newly enrolled on antiretroviral

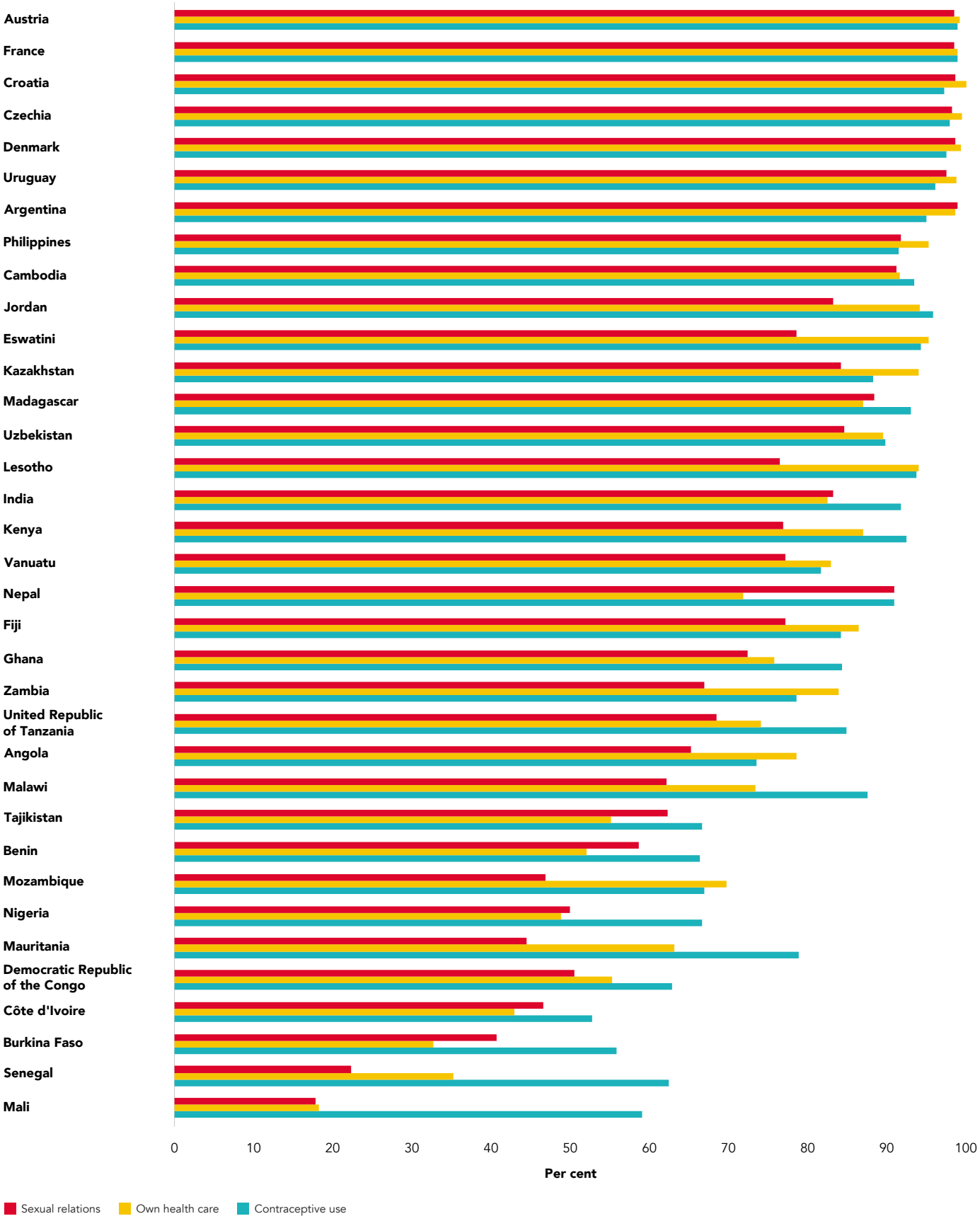
19 Botswana, Eswatini, Kenya, Lesotho, Malawi, Namibia, South Africa, Uganda, Zambia, Zimbabwe (see https://www.2gether4srhr.org).

20 United Nations Population Fund analysis 2025 (https://unstats.un.org/sdgs/dataportal/database).

21 Overall, more than half (52%) of TB-related deaths among people living with HIV were in adult men, 47% in adult women, and the remainder in children. Almost 60% of TB-related deaths in 2025 occurred (in descending order) in South Africa, Kenya, the Democratic Republic of the Congo, Uganda, Indonesia, Mozambique, the United Republic of Tanzania, India, Zambia and Myanmar.

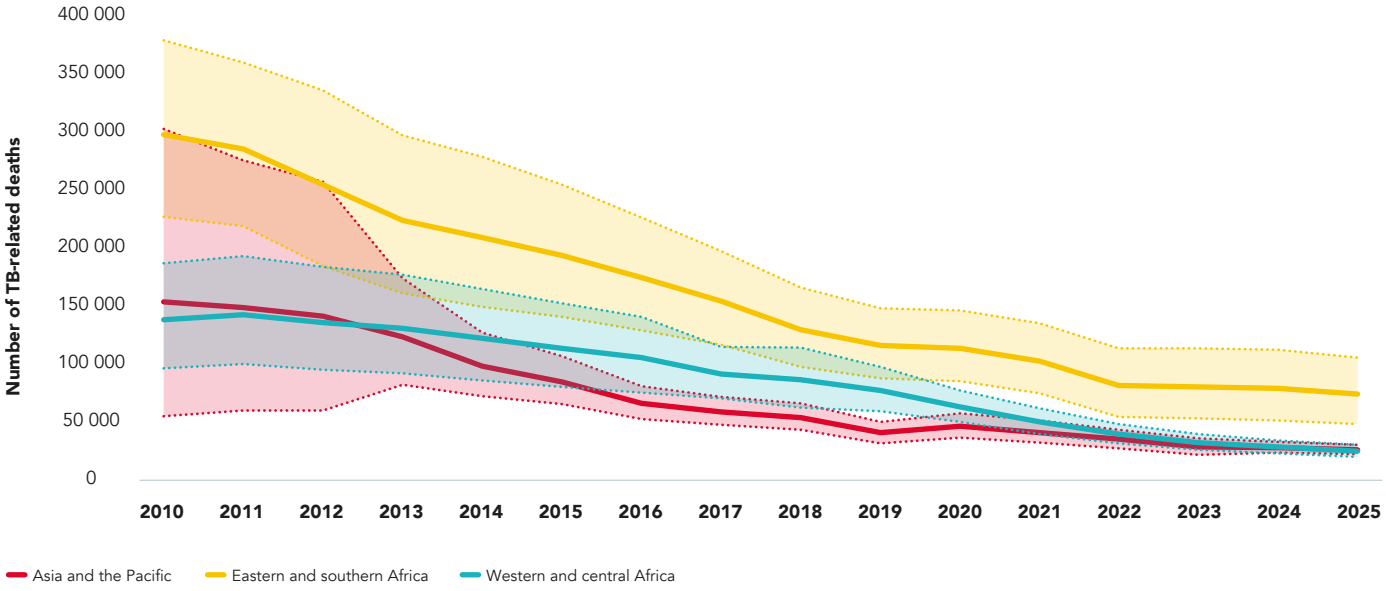
22 Mozambique (16%), India (15%), Zambia (14%), South Africa (12%), United Republic of Tanzania (7%), Uganda (5%), Zimbabwe (4%), Ghana (2%), Ethiopia (2%).

Figure 3.12. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and own health care, countries with available data, 2021–2024



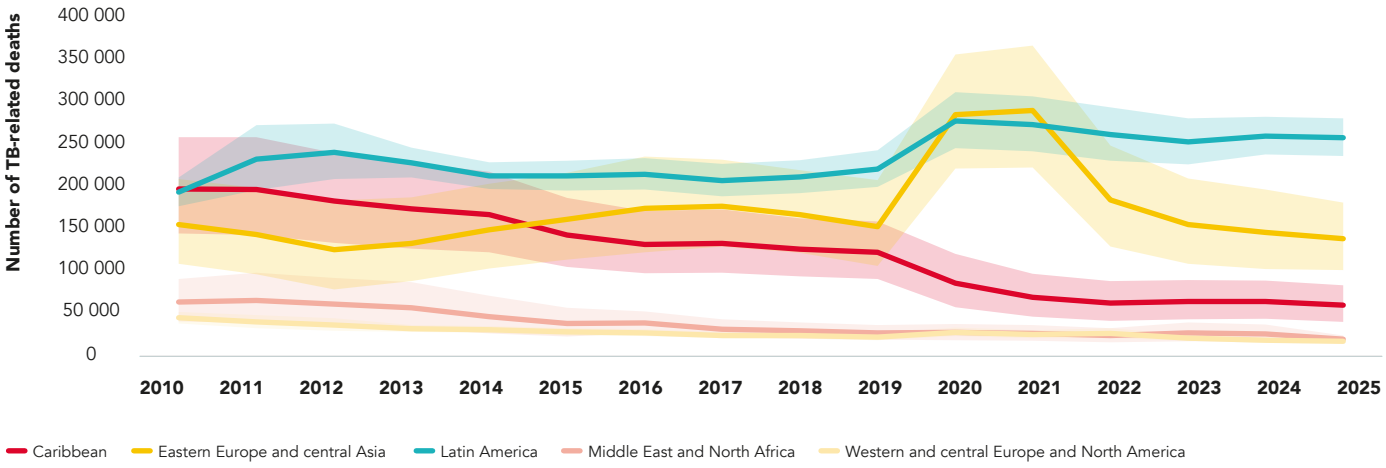
Source: population-based surveys 2021–2024 (https://unstats.un.org/sdgs/dataportal/database).

Figure 3.13. Estimated number of TB-related deaths among people living with HIV in Asia and the Pacific, eastern and southern Africa, and western and central Africa, 2010–2025



Source: Global tuberculosis report 2026. Geneva: World Health Organization; 2026.

Figure 3.14. Estimated number of TB-related deaths among people living with HIV in the Caribbean, eastern Europe and central Asia, Latin America, the Middle East and North Africa, and western and central Europe and North America, 2010–2025

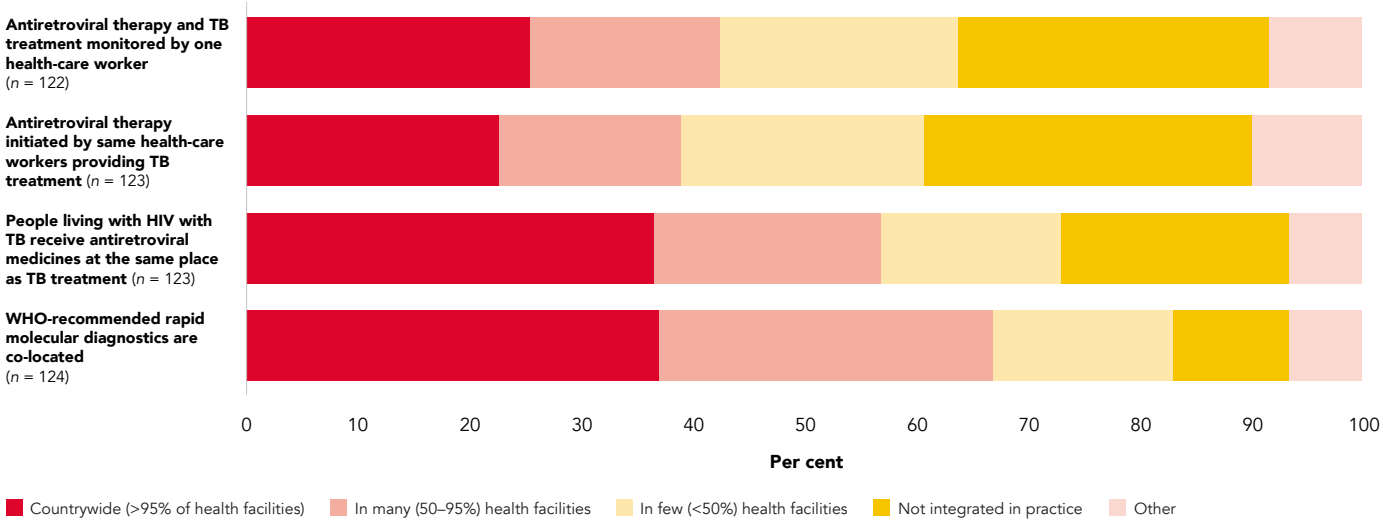


Source: Global tuberculosis report 2026. Geneva: World Health Organization; 2026.

therapy was 80% or higher in Ethiopia, Mozambique, South Africa, the United Republic of Tanzania and Zambia, but only 50% in Zimbabwe, and less than 10% in Ghana and Uganda *(3)*. TPT coverage among all people newly enrolled on antiretroviral therapy was 38% in 2025.

Among people diagnosed with TB, the combination of TB treatment and antiretroviral therapy is estimated to have averted 7.0 million deaths between 2010 and 2024 *(31)*. However, the full potential of integrated HIV and TB services is yet to be realized. More than 40% of countries reported that HIV and TB treatment was being monitored by a single health-care worker in at least half of health facilities, according to data spanning 2020–2026 (Figure 3.15) *(52)*.

Figure 3.15. Status of integration of HIV and TB services, countries with available data, 2020–2026



Source: National Commitments and Policy Instrument 2020–2026 (http://lawsandpolicies.unaids.org/).
n = number of reporting countries

Integrated services must be safe and convenient for everybody

Studies have highlighted the benefits of integration and the need to safeguard the people-centred and rights-based principles that underpin successful HIV programmes. When the Ugandan Government introduced an intensive strategy to integrate noncommunicable disease services with antiretroviral therapy, case detection of diabetes mellitus increased steeply and HIV outcomes were preserved *(53)*.[23] Similarly, the South African Department of Health responded to United States Government funding reductions by speeding up the integration of HIV services into primary health-care platforms, while continuing to promote differentiated service delivery. One of the early lessons learned appears to be that health facilities may struggle to achieve integration if rising workloads are not addressed and if vertical funding and monitoring structures continue to operate at higher programming levels *(54)*.

The importance of anti-stigma training and incorporating community-led outreach elements into integration efforts is highlighted in an evaluation from Kenya of the early impact of integrating drop-in HIV services for sex workers and gay men and other men who have sex with men. The study found that core HIV treatment services were largely preserved, but prevention services (including testing), PrEP initiation, and access to condoms and lubricants were negatively affected *(55)*. Research from Uganda indicates that although integration promises efficiency and expanded coverage, there is a risk of it undermining equitable access and continuity of care in adolescents and young people if implemented without safeguards *(56)*.

These findings underscore concerns that primary health-care systems are not yet designed or structured to fully serve the broader health needs of people from key and other marginalized populations, who often are exposed to stigma and violence and experience high burdens of noncommunicable diseases and mental health conditions *(57)*. It is well established that criminalization,

23 The number of screenings for diabetes mellitus among people living with HIV increased from 327 to 927 000 and the number of people newly diagnosed with diabetes increased from 19 to 8172. HIV outcomes were preserved, with viral load suppression levels staying very high, at 95%.

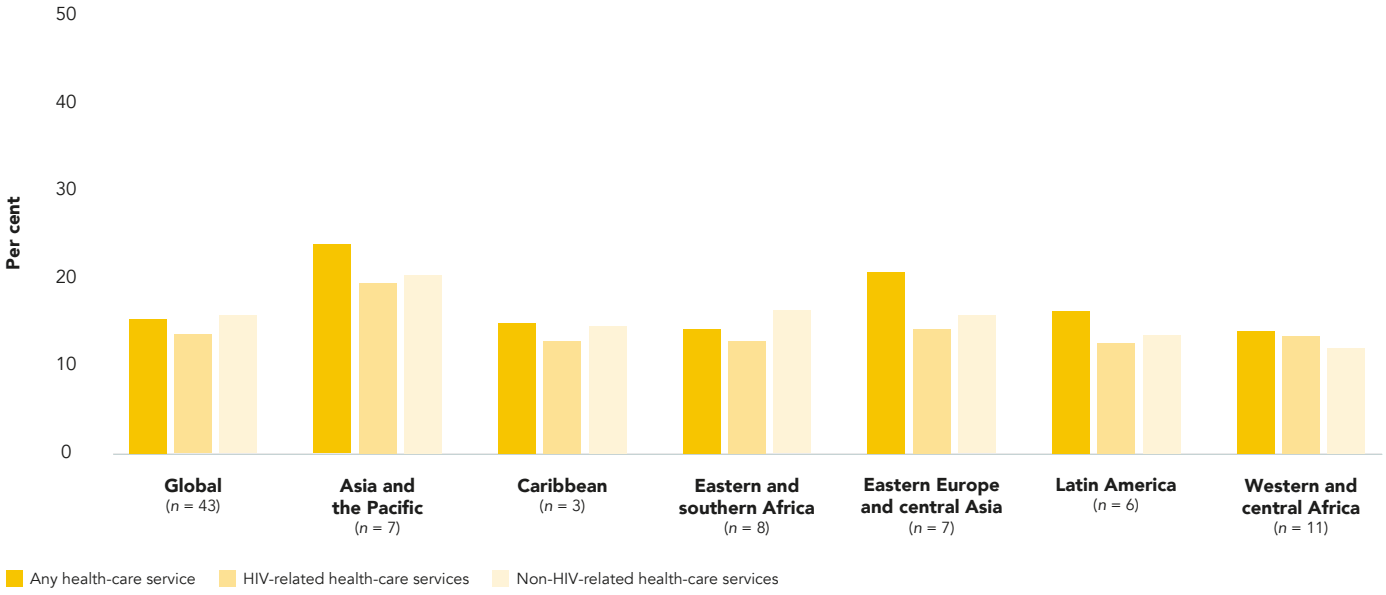
stigma and discrimination discourage people from seeking or remaining in care at public health facilities (see Chapter 2). The cited experiences also suggest that integration requires well-informed decisions about the service elements to be combined, the extent of the integration being sought, and the readiness of underlying systems. This is evident in community-led monitoring data reported to the Global AIDS Monitoring system, which have highlighted concerns about confidentiality, discriminatory attitudes of staff and long waiting times *(3)*. Community-led analysis of the Global Fund Grant Cycle 7 noted that poorly defined and rushed integration created uncertainty and risk, particularly in criminalized and politically hostile settings, where reliance on government-run services undermined access and trust *(58)*.

Across 43 countries reporting these data in 2021–2025, a weighted average of 15% of people living with HIV reported experiencing stigma and discrimination when seeking health care in the previous 12 months. The prevalence of such experiences ranged from 2% in Botswana, to 5% in Ghana and Lesotho, to more than 40% in Bolivia, the Islamic Republic of Iran and Pakistan. Although people may experience stigma and discrimination in HIV-related health-care facilities, these behaviours tend to be most common in general health-care settings (Figure 3.16).[24]

People from key populations are especially affected: 11–14% of sex workers (40 countries), transgender people (23 countries) and gay men and other men who have sex with men (40 countries), and 23% of people who inject drugs (25 countries) say they avoided seeking health care in the previous 12 months due to stigma and discrimination *(59)*.

Models for providing a wide range of integrated health services for people

Figure 3.16. Percentage of people living with HIV who experienced stigma and discrimination when seeking health-care services in the past 12 months, global and by regions, 2021–2026



Source: People Living with HIV Stigma Index 2.0 studies 2021–2025.
Note: experience of stigma and discrimination in health-care settings included experiencing at least one of the following behaviours due to 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, sharing of HIV status without consent. Data coverage of regional aggregates: global (43 countries, representing 48% of the 2023 population of people living with HIV; Asia and the Pacific (7 countries, 26%); Caribbean (3 countries, 15%); eastern and southern Africa (8 countries, 60%); eastern Europe and central Asia (7 countries, 17%); Latin America (6 countries, 51%); western and central Africa (11 countries, 65%). Aggregates for the Middle East and North Africa and western and central Europe and North America are not shown due to a paucity of data.

24 People Living with HIV Stigma Index 2.0 studies 2021–2025.

from key populations are being developed and are yielding important insights, among them the need to include structural interventions while incorporating peer outreach and support. In Eswatini, Nigeria and Viet Nam, key HIV services tailored to key population needs have been provided alongside mental health, sexual and reproductive health, gender-based violence, noncommunicable disease screening and TB services. Different models were used—community drop-in centres in Eswatini, and one-stop shops connected to community clinics in Nigeria or as standalone or public facilities in Viet Nam. Crucially, these efforts all included structural and community-based interventions such as peer support, stigma reduction and economic empowerment, and the services were delivered in safe, trusted spaces by multidisciplinary teams *(57)*.

Important links between cervical cancer and HIV

Cervical cancer is the most common cancer among women living with HIV and the fourth most common cancer among women overall.[25] Integrating cervical cancer services with services for HIV, sexual and reproductive health, sexually transmitted infections, and maternal and child health increases opportunities to prevent and manage cervical cancer. However, resource constraints (especially for laboratory services), workload burdens of health-care staff, long waiting times and limited availability of screening and treatment services are holding back the integration of services *(61–63)*. Conditions must be conducive to delivering integrated services effectively and in non-coercive, stigma-free and respectful ways. Income and education inequalities are undermining awareness uptake of services such as cervical cancer screening, according to analysis of data from 11 countries in Africa *(64)*.

A highly effective vaccine has been developed against the human papilloma virus (HPV), the primary cause of cervical cancer. The global cervical cancer elimination targets for 2030 call for vaccinating 90% of girls with the HPV vaccine by the age of 15 years; screening 70% of age-eligible women using a high-performance test; and treating 90% of women with identified cervical pre-cancer or invasive cancer by 2030 *(65)*.

As of mid-2026, 166 countries and territories included the HPV vaccine in their national immunization programmes, with school-based vaccination the most common approach. Globally, about a third (33%) of girls had received at least one dose of the vaccine, with coverage reaching 54% in Africa and 71% in Latin America and the Caribbean, but less than 25% in the WHO regions of South-East Asia and the Western Pacific *(66)*.

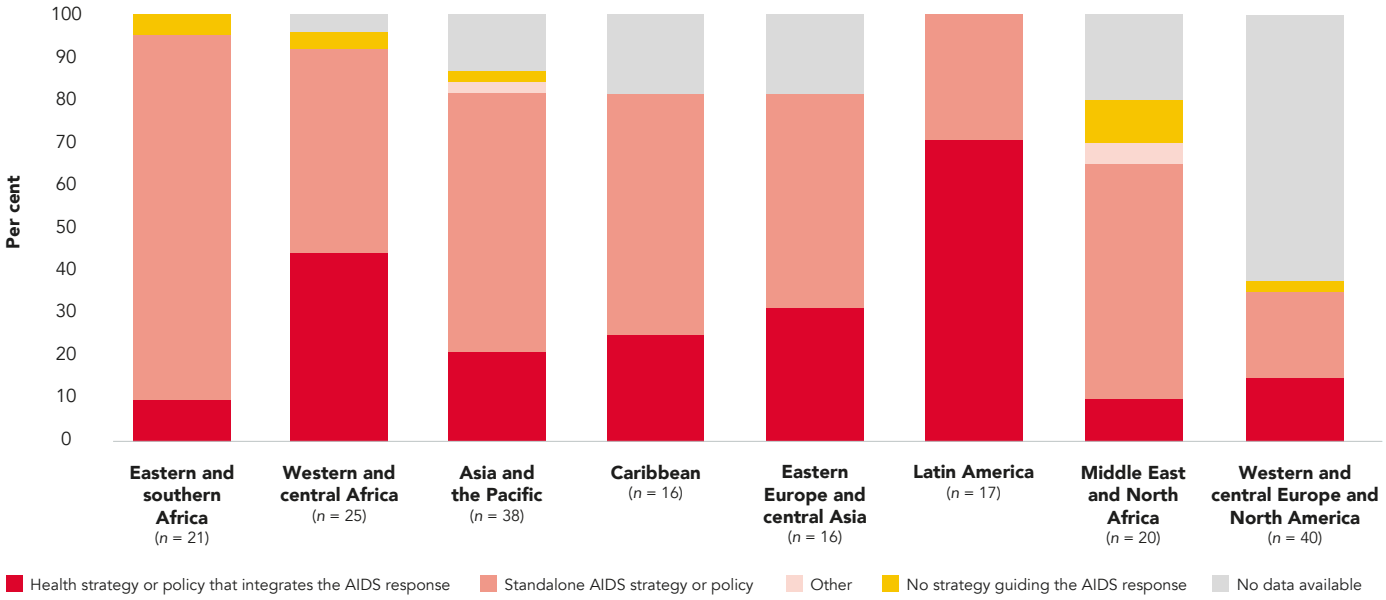
HIV within national health strategies

The integration of HIV with national health plans and strategies varies and tends to be more common in countries with high burdens of HIV. A third (50 of 151) of countries with available data reported that their HIV strategies were integrated in their national health strategies or policies (Figure 3.17). Another 94 countries reported having a standalone AIDS strategy or policy *(67)*.

The evidence around the integration of HIV with wider health systems

25 Women living with HIV have a six-fold higher risk of developing invasive cervical cancer compared with women who are HIV-free *(60)*.

Figure 3.17. Percentage of countries with HIV strategies integrated in national health strategies or policies, by region, 2017–2026



Source: National Commitments and Policy Instrument 2017–2026 (http://lawsandpolicies.unaids.org/).

underscores the importance of adopting phased approaches, ensuring readiness, and upholding principles of "do no harm". Where readiness conditions do not exist, dedicated HIV functions may need to be retained while systems are strengthened before safe and effective integration can be achieved.

HIV responses in humanitarian contexts are under pressure

The humanitarian sector has experienced deep funding cuts (37% in 2024–2025), which has led to the discontinuation of many HIV programmes in humanitarian settings *(68)*. National fiscal capacity to expand HIV funding is extremely constrained under such circumstances, because limited domestic resources tend to prioritize the immediate demands arising from armed conflict and natural disasters.

The consequences of deprioritizing HIV are severe: in conflict-affected settings, stockouts of antiretroviral medicines and damage to health-care facilities disrupt treatment and substantially increase loss to follow-up, threatening hard-won progress in the HIV response *(69)*.

In southern Africa, several countries with a high burden of HIV face a complex mix of natural and human-induced disasters, including droughts, floods, cyclones and extreme weather events. These intersect with transboundary and socioeconomic crises, which are often intensified by recurring El Niño cycles. The interplay between HIV, food insecurity, displacement and climate shocks affects entire HIV responses *(70)*. The United Nations Refugee Agency (UNHCR) estimates that about 1.1 million people are internally displaced in southern Africa due to natural disasters and climate change, underscoring the requirement for multisectoral approaches that can meet people's health and other needs, especially for women, girls and other people from populations at risk.

In 2025, UNHCR reported that the number of refugees supported with HIV tests fell from almost 574 000 to a little over 366 000 between 2024 and 2025, while the number of people receiving antiretroviral therapy through UNHCR support declined from about 24 000 to a little under 21 000 *(71)*. At the same time, displacement, food insecurity and climate-related shocks continue to increase vulnerabilities and create barriers to accessing HIV prevention, testing, treatment and care services. These challenges highlight the need for integrated and resilient health responses that ensure continuity of HIV services within broader primary health care and humanitarian programmes, with particular attention to populations at heightened risk.

Across the world, HIV organizations, many of them community-led, are increasingly responding when crises strike, including by delivering mobile health care to people on the frontline of war in Ukraine (see story), supporting networks of people living with HIV in Sudan (see story), keeping people living with HIV on treatment during the Ebola outbreak in the Democratic Republic of the Congo (see story), responding to severe flooding in Malawi and Mozambique, and providing safe spaces for migrants in Guatemala *(72)*.





A Ukrainian war veteran's journey from surviving to helping others

Hours after the Russian Federation launched its invasion of Ukraine in February 2022, Vadym volunteered for military service.

"When the invasion began, I had no doubts about what I had to do. Defending my country was the only choice I could make," he says.

Concerned that living with HIV would prevent him from serving, he said nothing about his status.

He learned he was living with HIV in his youth, a period when he began injecting drugs. After a long struggle with addiction, Vadym was no longer using drugs.

He spent nearly three years on active duty, first defending the Kyiv region with territorial defence forces and later serving as a mortar operator on the frontline in the north-eastern Kharkiv region. Throughout his service, he took his antiretroviral therapy.

Then in the cold winter months, he became seriously ill with TB while deployed. On the battlefield, his access to essential medical treatment had been severely limited.

After his discharge, he was wounded while leaving the frontline. He lost the use of one eye and suffered a blast-related brain injury.

He described physical and psychological pain. To cope, he started using drugs again. After physical rehabilitation in Kharkiv, he returned to Kyiv. Vadym sought psychological support from Return to Peaceful Life, a Ukrainian community organization supported by UNAIDS that works with veterans and their families. The support he received helped him quit drugs and move forward. He later joined the organization to help other people facing similar challenges. Today, he supports veterans with substance use problems, conducts HIV testing, and participates in outreach activities.

Yevhen Skliarenko, a former soldier and co-founder of Return to Peaceful Life, understands these challenges firsthand: "Some veterans come home severely injured, some with amputated limbs; others struggle with post-traumatic stress or drug use; and for those who are living with HIV, there are additional challenges," he says.

As more Ukrainians return from military service, ensuring they can access the care and support they need remains a major challenge for the country.

Through a joint humanitarian emergency programme funded by more than US$ 6 million from the Government of the Netherlands, UNAIDS and the United Nations Office on Drugs and Crime are supporting community-based organizations to help people living with or affected by HIV maintain access to essential health services during the war, including veterans and their families.

Working through 13 organizations across 11 regions, the programme aims to provide humanitarian assistance to 60 000 people, help 40 000 people maintain or regain access to essential HIV services, and reach 20 000 people with mental health and psychosocial support.

"For people living with HIV, the consequences of war go far beyond the immediate danger of attacks. Interrupted treatment, trauma, displacement and stigma can put their health and lives at risk," says Gabriela Ionașcu, UNAIDS Country Director in Ukraine. "By supporting trusted community organizations, we can help people stay connected to essential care, while addressing the wider challenges they face. Vadym's story shows why this support matters, and how it can help people not only rebuild their own lives but also support others."

Partnerships and innovations will get us to the last mile

For decades, the HIV response has been driven by community activism, scientific knowledge and innovation, political will, and partnerships that draw these forces together. Guiding it all has been the understanding that the epidemic thrives and HIV programmes falter when inequities are permitted, human rights are not upheld, bigotry prevails and public systems fail.

The upheavals of the past two years are dramatic, and their shockwaves will continue for some time. But the knowledge and tools for recuperating the global effort against AIDS exist—the linked obstacles of wavering political commitment and insufficient resources must be overcome. Together, goal-driven partnerships, rights-based policies and public-minded innovation can steer the world's bid to put the HIV response back on track.

A rich array of partnerships shows what is possible

Alongside the pressures brought to bear by organized activism, market-shaping interventions such as pooled procurement have played a formative role in reducing the prices of antiretroviral medicines and other health commodities to levels that made widescale provision possible.

Looking ahead, expanded joint procurement, public health-oriented management of intellectual property rights, unimpeded use of agreed TRIPS flexibilities, technology transfers, and local or regional manufacturing could further reduce prices and increase access. Several promising arrangements are in place or being developed.

A pooled African medicines procurement mechanism was established by the Africa Centres for Disease Control and Prevention in 2024 to help consolidate predictable demand for African manufacturers. The initiative, managed in collaboration with continental and global partners, holds huge promise. By some estimates, the African market size for medicines and vaccines runs to approximately US$ 50 billion per year *(73)*.

Backing this is the African Medicines Agency, which is helping to create a more unified regulatory market, essential for pooled procurement.[26] The Agency is a treaty-based entity built around national African regulators. It is also tasked with making medicines regulation quicker and less fragmented across the continent. The focus of this work is on vaccines and other products of public health importance *(74)*.

Meanwhile, the Medicines Patent Pool, a United Nations-based structure founded by Unitaid in 2010, continues to negotiate voluntary licences with patent-holders to allow for the manufacturing of pharmaceutical products in specified countries, with low or no royalty payments required. The purpose is to broaden access and reduce prices. The Medicines Patent Pool achieves this by stewarding agreements between patent-holders, generic manufacturers, procurement

26 As of July 2026, 33 of the 55 African Union Member States had ratified the treaty establishing the African Medicines Agency.

agencies, funders, governments, civil society, and communities of people affected by HIV and other diseases.

The Medicines Patent Pool has overseen the licensing of health products to 93 generic manufacturers, including the antiretroviral regimen tenofovir disoproxil fumarate, lamivudine and dolutegravir—the most widely used HIV regimen globally—across 100 countries, including India, Nigeria and South Africa *(75)*. At least 148 countries have benefited from Medicines Patent Pool-brokered licensing agreements, which have helped avert approximately 2.2 million deaths and 21 million virological failures, while saving countries an estimated US$ 2.6 billion *(76)*.

Similarly, the Pan American Health Organization joint purchasing system has taken a first step towards enabling 14 Latin American countries[27] to procure long-acting lenacapavir for PrEP at more affordable prices, after they had been bypassed in initial generic licensing agreements. In an initial deal brokered in 2024 by the Clinton Health Initiative, Unitaid and Wits Reproductive Health and HIV Institute, the originating manufacturer granted six generic manufacturers royalty-free licenses to produce and supply the medicine in 120 low- and middle-income countries *(77)*.

Especially in Africa, the political foundations for accelerating progress on HIV and other health priorities are being fortified. Issued in 2025, the Kigali Call to Action urges governments, multilateral organizations, donors, civil society and the for-profit sector to commit to five core principles that can help revive the HIV response and restore global solidarity. Highlighted are partnerships that uphold international solidarity, promote scientific collaboration, safeguard data sovereignty and strengthen local ownership, along with support for global HIV research. Emphasizing the protection of human rights, the Call to Action also rejected the politicization of science, insisting that science must drive HIV programmes *(78)*.

The Call to Action aligns closely with the Accra Reset call for health sovereignty, local leadership and mutually beneficial partnerships *(78)*. Launched in 2025, the Accra Reset aims to bolster countries' commitments and capacities to pursue their health and development priorities and reject arrangements that conflict with national interests. The priorities include national regulatory oversight of external health financing; strengthened capacity to negotiate the terms of external financing; alignment of donor partnerships with nationally agreed health priorities; and linking of health reforms to financial adjustments that increase domestic fiscal space and protect essential health services. Also highlighted is the need for countries and communities to control and benefit from their health-related data that shape their health futures *(79, 80)*.

There are also inspiring examples of how goal-driven partnerships can have a bigger impact on societal barriers than individual entities acting on their own:

- The Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination shows how political commitment can unlock resources and drive measurable change. Over four years, 25 countries reported tangible progress on policy reform, legal reform and improved access to justice *(81)*.
- Supported by Frontline AIDS, national coalitions of community organizations have boosted their

27 Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Uruguay, Venezuela (Bolivarian Republic of).

Global Fund: traversing a complicated landscape

Countries preparing funding requests under the Global Fund Grant Cycle 8 face an increasingly challenging landscape. Reduced funding, transforming global health architecture, and growing pressures for sustainability and integration are forcing difficult choices about how to protect HIV gains and sustain essential services, particularly for the people and communities most at risk of being left behind.

The Global Fund, which finances country-led responses to HIV, TB and malaria in more than 100 countries, is operating with lower allocations than in previous cycles. At the same time, many countries are aligning Global Fund investments with the new United States Government bilateral health agreements, increasing the importance of coordination and complementarity across funding streams.

The eighth Global Fund cycle requires countries to make strategic choices about how to use increasingly constrained resources to protect gains, sustain essential HIV services, and ensure the needs of people living with HIV and populations most at risk stay central.

An evolving UNAIDS country support model

UNAIDS is adapting its approach to delivering timely, coordinated and high-quality partnership with countries seeking Global Fund support in this rapidly changing environment. At the heart of this approach is the Virtual Support Team, which brings together experts from across the UNAIDS Secretariat, Cosponsors and other sources of expertise. Working closely with country and regional teams, the Team helps countries access technical assistance, quality assurance, peer review and practical support to navigate complex funding decisions and develop strong, evidence-informed funding requests. The Team also helps identify common challenges, connect countries with relevant expertise, and facilitate coordinated responses with partners, including the Global Fund.

Early results are encouraging. Across the first three Global Fund Technical Review Panel windows, the vast majority of funding requests supported through the Team successfully passed review, demonstrating the value of coordinated, multidisciplinary support to countries.

The Team has supported or is mobilizing support for 28 countries across four regions, representing approximately US$ 6.2 billion in Global Fund country allocations.

Over the coming years, countries will continue to face difficult decisions about how to sustain HIV programmes with fewer resources. Through the Team and its broader country support model, UNAIDS will continue to mobilize the collective expertise of the UNAIDS Joint Programme to support country-led priorities, protect essential HIV services and community-led responses, and help sustain progress towards ending AIDS as a public health threat.

The Global HIV Prevention Coalition

Since 2017, the Global HIV Prevention Coalition has served as a global platform to strengthen and sustain political commitment to primary HIV prevention, which is critical to curbing the number of new HIV infections alongside treatment. The Coalition was co-convened by UNAIDS and the United Nations Population Fund and advocated for continued focus on prevention in the HIV response. Global Fund allocations to primary prevention declined before 2017 but increased between 2018 and 2025. Earlier this year, the Coalition launched the HIV prevention 2030 Global Access Framework to ensure countries and partners continue to focus on prevention. The Framework aligns with global HIV targets to ensure 40 million people living with HIV access treatment, 20 million people use some form of PrEP, 20 billion condoms are used, and at least 20% of HIV domestic budget is allocated to prevention.

The Coalition has evolved into the Global HIV Prevention Coalition Plus (GPC+), a coordination mechanism driven and led by countries and communities. GPC+ builds on the strengths of the Global HIV Prevention Coalition and the Coalition to Accelerate Access to Long-Acting PrEP. It focuses on an integrated and holistic prevention approach, particularly for accelerating access to new long-acting technologies for prevention. The aim is to effectively support countries and communities in delivering on the Global AIDS Strategy 40+20 HIV global targets by strengthening multisectoral stewardship for countries and communities, applying a person-centred approach to prevention, and prioritizing limited resources by using the "Ps of prioritization"—people, places, packages, platforms and price.

roles in national decision-making, pushed their governments to allocate more resources to HIV programmes, and helped advance social contracting arrangements in Malawi, Uganda and the United Republic of Tanzania *(82)*.

- Across 10 countries in eastern and southern Africa, the 2gether 4SRHR partnership has combined the resources of community-based organizations, United Nations agencies and donors to strengthen integrated HIV and sexual and reproductive health services (see Integration section above) *(83)*.

Investing in and making innovations accessible

New antiretroviral therapy regimens that do not require taking daily pills can make it much easier for people to adhere to treatment. Especially promising are long-acting antiretroviral medicines and injectable versions. Also emerging are simplified regimens for people on complex treatment.

Experimental injectable antiretroviral medicines that may require injections only twice a year are in development. If these are used in combination with broadly neutralizing antibodies or other long-acting medicines, treatment could be compressed into two or three clinic visits per year. Three experimental injectable antiretroviral medicines are in development *(84–86)*. Once-weekly oral HIV treatment has moved a step closer to reality, with phase 3 trial results showing that islatravir/lenacapavir is effective and tolerated well in people with a suppressed viral load *(87)*. Also on the horizon is a once-daily combination pill containing bictegravir and lenacapavir, which could simplify treatment for people currently on complex, arduous regimens *(88)*.

Treatment adherence for children often becomes tougher as they enter adolescence: long-acting injectable antiretroviral therapy regimens could benefit them considerably. Twice-monthly injectable cabotegravir and rilpivirine appears to be superior to daily oral tenofovir/lamivudine/dolutegravir for maintaining a suppressed viral load among adolescents *(89)*, with studies reporting high rates of retention after almost two years *(90)*.

Further promising PrEP innovations are in the pipeline. A trial for a longer-acting version of injectable cabotegravir, administered three times

a year, is under way *(91)*. Phase 3 trials for a once-monthly oral form of PrEP, alimatravir, are fully enrolled, with results expected in late 2027 *(92)*. A once-yearly version of lenacapavir is also being trialled, with results expected in 2028 *(93)*.

Additional biomedical breakthroughs are needed urgently across the HIV response *(93)*. Even in the most optimistic scenarios, tens of millions of people will need to take lifelong antiretroviral therapy. The search for a functional cure for HIV must proceed with urgency, as should the quest for an affordable, safe HIV vaccine. Ongoing innovation will provide new medicines and commodities that can support epidemic control.

Equally valuable are the regulatory and other arrangements that can streamline the rapid introduction of proven new technologies and approaches. This can be done by using expedited review processes such as WHO prequalification and the European Medicines Agency EU-M4all procedure, which bypass lengthy standalone national reviews. The accelerated passage of biomedical innovations through regulatory checkpoints saw lenacapavir for PrEP achieve its first regulatory approval within a year after efficacy results had been reported, and its first introduction into projects within another year. By way of comparison, it took more than six years for oral tenofovir and emtricitabine PrEP to reach these milestones *(93)*.

As always, it will take additional effort and commitment to bring about affordable and sustainable access for the countries and communities most affected by HIV. The core principle of equitable access to such public goods must be upheld. This will require expanding licensing agreements, achieving favourable pricing schemes, and acceding to the use of TRIPS flexibilities when necessary.

Underpinning all this are the foundations of a successful HIV response: health systems, including their strategic information components, that even-handedly serve the needs of people; community systems that reach and empower marginalized populations and command their trust; and policies and laws that enable these systems to link and function effectively.

Building community systems

Novel approaches that foster and harness community networks and support are equally as important as biomedical breakthroughs. The mentor mothers model, for example, helps women initiate and adhere to lifesaving HIV treatment and achieve better health outcomes for themselves and their babies. Mentors relieve the burden on staff at health facilities; serve as links between communities and clinical care; and refer new mothers to social protection, sexual and reproductive health, gender-based violence, education and income-generating services.

Over recent years, thousands of mentor mothers and peer supporters have been recruited and trained, creating cadres of skilled community health workers *(94)*. When the Ministry of Health in the United Republic of Tanzania adopted the model, it resulted in almost 100% HIV testing coverage among adolescent girls and young women in antenatal care. In South Africa, 73% of high-risk adolescent and young mothers began using PrEP, compared with none in non-supported sites. In Zimbabwe, the vertical HIV transmission rate among young pregnant women accessing peer support was only 1%, compared with the national rate of 6.7% *(48)*. Unfortunately, a strong track record did not shield these programmes from funding cuts *(29)*.

Multilateral and multisectoral action

Three decades since it began operating, UNAIDS stands as an example of the value and impact of multilateral action in the global HIV response. Global coordination across United Nations agencies helps establish shared goals, clear agendas and an effective distribution of activities across the many dimensions of the HIV response. A multilateral response also facilitates target-setting and provides for global mechanisms of accountability, as shown in the Political Declaration on HIV/AIDS, which United Nations Member States adopted in June 2026. This declaration includes a comprehensive set of targets *(95)*. The adoption of these targets was the result of sustained political commitment and the activism of organizations led by people living with HIV, women, young people, people from key populations, Indigenous people and many others *(95, 96)*.

The current crisis in the HIV response is foreboding. Over previous decades, however, the response has prevailed when political denial was rampant, funding scarce, functional treatments absent or rationed, rights violated, and community networks disparaged. Each time, as has been noted, "the global HIV response found its footing again—anchored by science, grounded in communities and powered by a coalition that refuses to give up" *(97)*. Those strengths and assets are being put to the test again.

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