AIDS, CRISIS AND THE POWER TO TRANSFORM

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UNAIDS
GLOBAL
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UPDATE
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FOREWORD

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UNAIDS Executive Director

The HIV response may be in crisis, but we have the power to transform

This report shows that at the end of 2024, just before a sudden collapse in funding triggered a crisis in the global HIV response, the remarkable efforts of communities and governments had brought down the numbers of new HIV infections by 40% and of AIDS-related deaths by 56% since 2010. But it also shows that huge gaps in HIV prevention remained, with 1.3 million new infections in 2024—almost unchanged from the year before.

We started 2025 excited about a transformative opportunity to tackle HIV with lenacapavir, a new long-acting medicine that can prevent HIV infection with twice-a-year injections. This is just one of a suite of new long-acting medicines. Within the next few years, annual injections and monthly tablets to prevent HIV could be a reality. We could be on the verge of an HIV prevention revolution that reduces new infections towards epidemic control—if the world comes together again to overcome monopolies, drive down prices, and ensure everyone who could benefit has access to these new, highly effective prevention tools.

But the sudden withdrawal of the single biggest contributor to the global HIV response disrupted treatment and prevention programmes around the world in early 2025. International assistance accounts for 80% of prevention programmes in low- and middle-income countries. UNAIDS modelling shows that if the funding permanently disappears, there could be an additional 6 million HIV infections and an additional 4 million AIDS-related deaths by 2029. At the same time, the number of countries criminalizing the populations most at risk of HIV has risen for the first time since UNAIDS began reporting.

Communities, however, have been resilient. When formal systems broke down in Ethiopia, young volunteers formed WhatsApp groups to check on their peers, mothers banded together to support children's treatment, and youth collectives used community radio to share health information.

The consensus behind the old model of financing the HIV response may be coming to an end, but the international community is forging a new, more sustainable path. At the fourth International Conference on Financing for Development in Seville, Spain, nations embraced calls for debt relief, international tax cooperation and reform of international financial institutions—the first steps towards a new economic settlement that can give countries the fiscal space needed to invest in the global HIV response.

Twenty-five of the 60 low- and middle-income countries included in this report have found ways to increase HIV spending from domestic resources into 2026. This is the future of the HIV response—nationally owned and led, sustainable, inclusive and multisectoral.

This transformation cannot happen overnight, however. Global solidarity and renewed commitment from funding partners will be needed as countries plan and lead sustainable transitions towards self-financing.

The prize, if we get there, could be remarkable. The HIV response has already saved 26.9 million lives. With an HIV prevention revolution, we could end AIDS as a public health threat, saving many more lives. And it could be better value for money too: UNAIDS estimates that if the world embraces new technologies, efficiencies and approaches, the annual cost of the HIV response could fall by around US$ 7 billion.

The HIV response may be in crisis, but we have the power to transform. Communities, governments and the United Nations are rising to the challenge. Now, we must get to work.

EXECUTIVE SUMMARY

Decades of hard work and solidarity have reduced the annual numbers of people acquiring HIV and people dying from AIDS-related causes to their lowest levels in more than 30 years. At the end of 2024, the declines in numbers were not sufficient to end AIDS as a public health threat by 2030—but the means and the momentum for doing so existed. Examples of country successes were multiplying, and national governments were assuming greater responsibility for their HIV responses. New scientific breakthroughs continued to be made, including long-acting injectable antiretroviral medicines.

That was the situation at the end of 2024. Since then, however, HIV programmes in low- and middle-income countries have been rocked by sudden, major financial disruptions that threaten to reverse years of progress in the response to HIV. Wars and conflict, widening economic inequalities, geopolitical shifts and climate change shocks—the likes of which are unprecedented in the global HIV response—are stoking instability and straining multilateral cooperation.

UNAIDS projections show that a permanent discontinuation of support from the United States President's Emergency Plan for AIDS Relief (PEPFAR) for HIV treatment and prevention could lead to more than 4 million additional AIDS-related deaths and more than 6 million additional new HIV infections by 2030 *(1, 2)*.

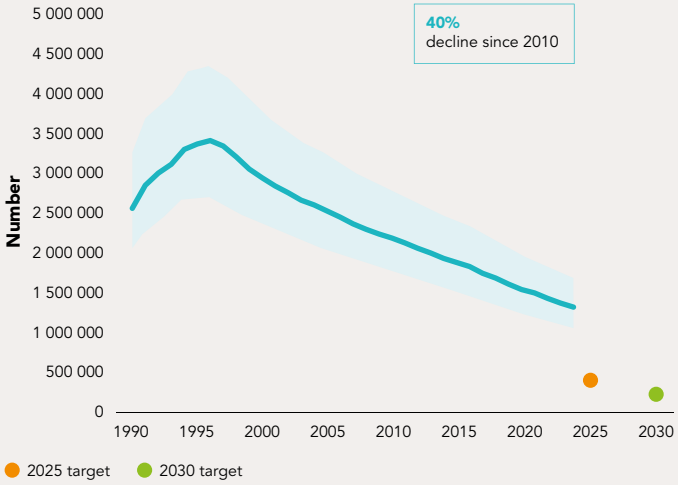
An estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2024—40% less than in 2010 (Figure 0.1).[1] An even steeper 56% decline in the number of new infections was achieved in sub-Saharan Africa, which is home to half of all people who acquired HIV globally in 2024. Five countries, mostly from sub-Saharan Africa, were on track to achieve a 90% decline in new infections by 2030 compared with 2010.[2]

In sub-Saharan Africa the provision of antiretroviral therapy, among other advances, has led to a rebound in life expectancy from 56.5 years in 2010 to 62.3 years in 2024.

1 For more information on UNAIDS data in this report, see Annex 1.
2 Lesotho, Malawi, Nepal, Rwanda, Zimbabwe.

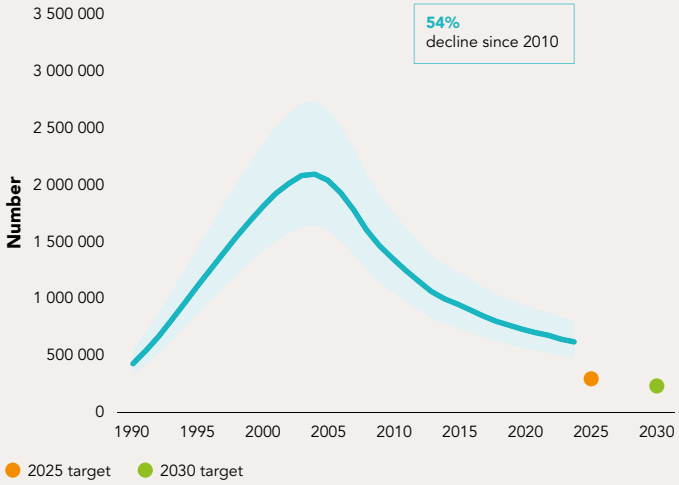
In 2024, the world had made significant progress in the response to HIV—but this is now in jeopardy

Figure 0.1. Number of new HIV infections, global, 1990–2024, 2025 and 2030 targets



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

Figure 0.2. Number of AIDS-related deaths, global, 1990–2024, 2025 and 2030 targets



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

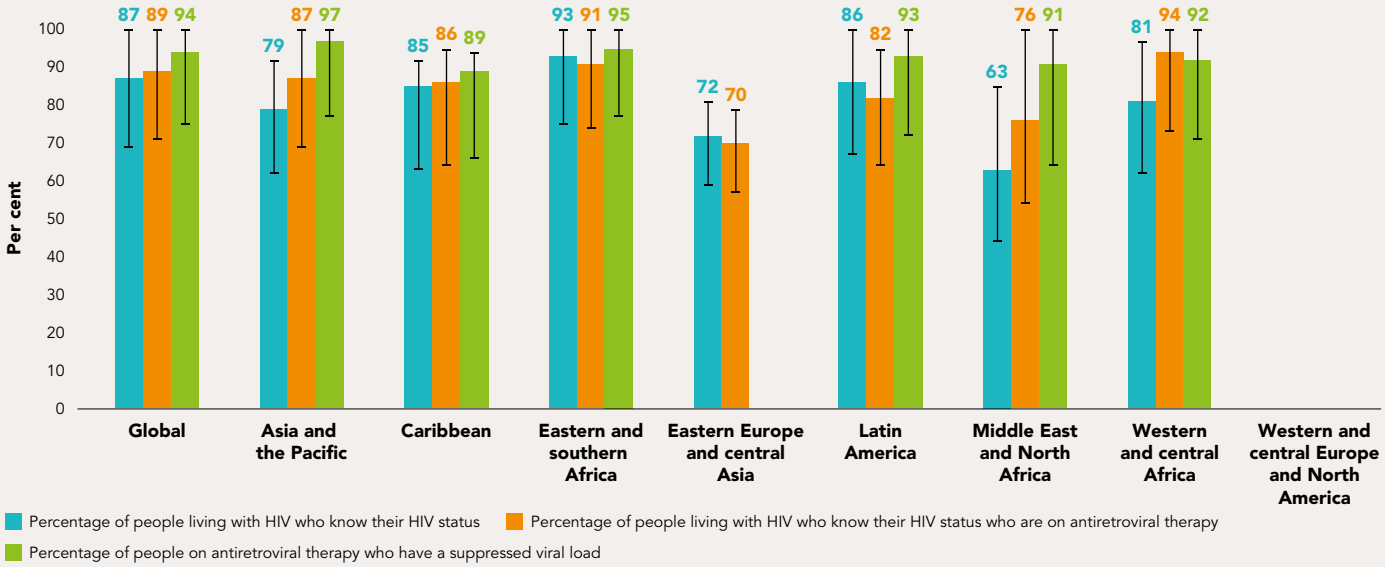
Countries have reduced the annual number of children acquiring HIV through vertical transmission to 120 000 [82 000–170 000], a 62% drop since 2010 and the lowest number since the 1980s. Overall, programmes to prevent the vertical transmission of HIV averted nearly 4.4 million new HIV acquisitions in children between 2000 and 2024.

The number of lives lost to AIDS-related causes in 2024—630 000 [490 000–820 000]—was unacceptably high, but it was 54% less than in 2010 (Figure 0.2), an achievement made possible by the large-scale provision of mostly free-of-charge HIV testing services and treatment. The number of AIDS-related deaths among children was reduced from 240 000 [160 000–340 000] in 2010 to 75 000 [50 000–110 000] in 2024.

Globally in 2024, about three-quarters of the 40.8 million [37.0 million–45.6 million] people living with HIV were receiving antiretroviral therapy (77% [62–90%]) and (73% [66–82%]) had suppressed viral loads—a huge public health achievement. In sub-Saharan Africa, which is home to more than 60% of all people living with HIV, the provision of antiretroviral therapy, among other advances, has led to a rebound in life expectancy from 56.5 years in 2010 to 62.3 years in 2024 *(3)*.

Some regions are very close to achieving the 95–95–95 targets

Figure 0.3. Progress towards the 95–95–95 testing, treatment and viral load suppression targets, by region, 2024



Note: for western and central Europe and North America, data on progress towards the 95–95–95 targets in 2024 were pending.
Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

Countries have committed to end AIDS as a public health threat by 2030, defined as achieving a 90% reduction in numbers of new HIV infections and AIDS-related deaths from a 2010 baseline. The world would be largely on track towards this goal if it reached the 95–95–95 targets for testing and treatment.[3] In 2024, the global HIV response was closer than ever to reaching these testing and treatment targets. Globally, an estimated 87% [69–>98%] of all people living with HIV knew their HIV status, 89% [71–>98%] of people who knew their HIV-positive status were receiving antiretroviral therapy, and 94% [75–>98%] of people on treatment had a suppressed viral load (Figure 0.3).

The inroads in the response to HIV have been impressive but uneven

Even before the funding losses, the gains against HIV were spread unevenly. HIV testing and treatment coverage and viral suppression levels among people living with HIV improved across all regions in 2024, but they still lagged considerably in eastern Europe and central Asia and the Middle East and North Africa, and more work was needed in Asia and the Pacific.

3 The targets call for 95% of all people living with HIV to know their HIV status, 95% of all people diagnosed with HIV to receive antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have a suppressed viral load by 2025.

Sub-Saharan Africa was home to half of the 9.2 million people globally in 2024 who needed but were not receiving HIV treatment. A further quarter of the total unmet need was in Asia and the Pacific. In the absence of a cure for HIV, millions of people will continue to need HIV treatment for many decades to come, but funding losses are destabilizing many treatment programmes and the efforts to make them more equitable.

A little over half of all children living with HIV (55% [40–73%]) were receiving antiretroviral therapy in 2024. This was an improvement on the coverage of 17% [12–22%] in 2010, but it still meant more than 620 000 of the estimated 1.4 million [1.1 million–1.8 million] children living with HIV were *not* receiving antiretroviral therapy in 2024. Globally, about 12% of all AIDS-related deaths in 2024 were among children, even though children accounted for only 3% of all people living with HIV.

Men living with HIV were still less likely than their female peers to be receiving antiretroviral therapy (73% [57–85%] versus 83% [66–97%]) or to have a suppressed viral load (69% [61–77%] versus 79% [71–88%]) in 2024. People from key populations were less likely to be receiving HIV treatment, even in places where treatment services were reaching the large majority of people living with HIV *(4)*.[4]

The estimated 210 000 [140 000–280 000] new HIV acquisitions among adolescent girls and young women (aged 15–24 years) in 2024 are the result of the disproportionately high HIV risk that still confronts them, particularly in sub-Saharan Africa. Prevention services for them and other young people are now being defunded *(5)*.

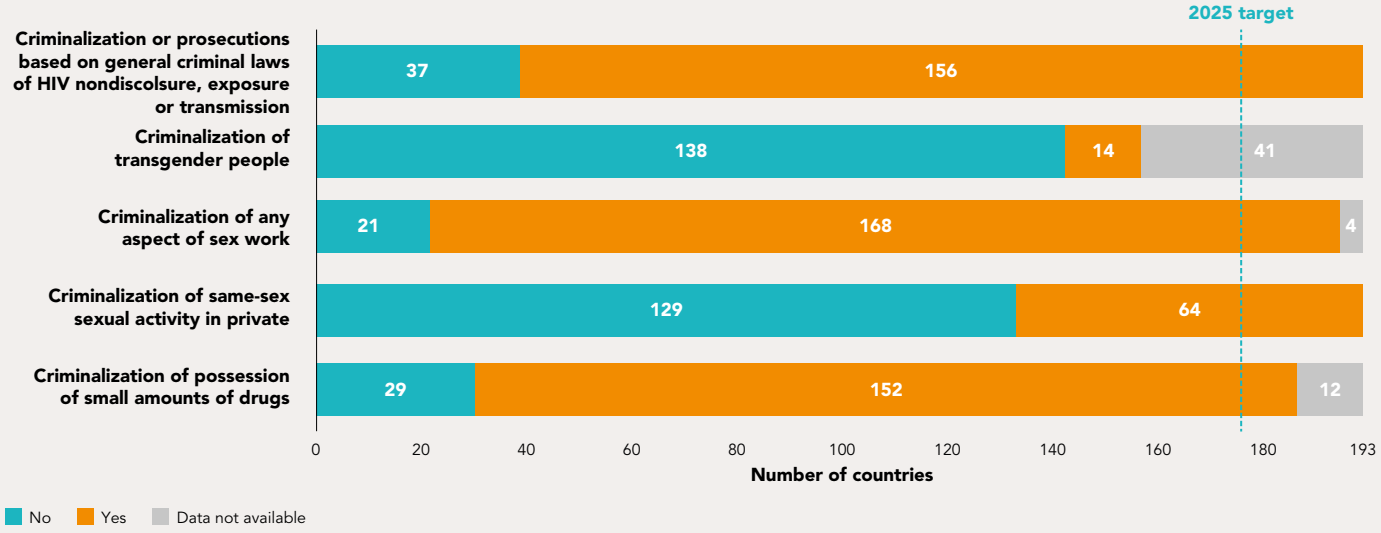
Many of the barriers and inequalities holding back sustainable progress against HIV have not been dislodged. Stigma, discrimination, punitive laws (Figure 0.4), gender inequalities and violence continue to sabotage people's attempts to stay HIV-free or to live safe and healthy lives if they acquire HIV. Far too many governments lack the political will to provide HIV-related services and protection for people from key and other vulnerable populations, including adolescent girls and young women, who are most at risk for acquiring HIV and experiencing HIV-related stigma, discrimination and violence.

9.2 million people living with HIV globally in 2024 were not receiving HIV treatment.

4 Key populations include sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and people in prisons and other closed settings.

The number of countries with criminalizing laws was rising in 2024

Figure 0.4. Number of countries with discriminatory and punitive laws, 2025



Note: this figure does not capture where key populations may be de facto criminalized through other laws, such as vagrancy or public morality laws, or the use of the above laws for different populations.
Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see references in regional factsheets and http://lawsandpolicies.unaids.org/).

The conditions that render people vulnerable to HIV are being reinforced in many countries. Campaigns are attacking HIV-related human rights, including for public health, with girls, women and people from key populations often the targets (see Chapter 1).

The number of new HIV infections decreased between 2010 and 2024 by 56% in sub-Saharan Africa, 21% in the Caribbean and 17% in Asia and the Pacific, but they increased by 94% in the Middle East and North Africa, 13% in Latin America and 7% in eastern Europe and central Asia. Numbers of new HIV infections have risen in at least 32 countries since 2010, and the world is off track to reach the 2025 target of 370 000 or fewer new infections by a wide margin (see Chapters 1 and 3).

Service gaps and deficiencies in HIV programmes and health and community systems meant that an estimated 120 000 [82 000–170 000] children acquired HIV in 2024. The vast majority of child HIV infections (about 83%) still occur in sub-Saharan Africa. Many HIV programmes continue to neglect people from key populations and their sex partners, who account for an estimated 80% of new HIV infections outside sub-Saharan Africa and about 25% in sub-Saharan Africa *(6)*. A majority of people from key populations were not being reached with basic HIV prevention services. Prevention services that did exist for people from key populations have relied heavily on external assistance, but a great deal of this support was halted in early 2025.

A systemic shock is rocking the HIV response

That was the situation at the end of 2024. Since then, HIV programmes in low- and middle-income countries have been rocked by a systemic shock, with sudden funding cuts and freezes putting hard-won progress in the response to HIV in jeopardy.

HIV programmes across the world are struggling from the sudden, drastic reductions in funding for the global HIV response announced by the United States Government in early 2025. PEPFAR had committed USD 4.3 billion in bilateral support in 2025 *(7)*. Those services were stopped overnight when the United States Government shifted its foreign assistance strategies. Disruptions are being felt across the HIV response and pose a huge risk of increased mortality, a surge of new HIV infections, and the development of resistance to the most commonly used treatment regimens. Urgent action and revived solidarity are needed to sustain the progress made and prevent a resurgence of HIV.

The current wave of funding losses has already destabilized supply chains, led to the closure of health facilities, left thousands of health clinics without staff, set back prevention programmes, disrupted HIV testing efforts, and forced many community organizations to reduce or halt their HIV activities, upending critical community systems *(9)*.

There is a fear that other major donor countries might retreat from the solidarity they have established with poorer countries to respond to one of the deadliest pandemics in modern history. If this happens, and the current cuts and freezes are maintained,[5] decades of progress in the HIV response could be reversed and the goal of ending AIDS as a public health threat could be in peril.

The PEPFAR programme has been a lifeline for countries with high HIV burdens *(7)*. PEPFAR supported HIV testing for 84.1 million people and HIV treatment for 20.6 million people, reached 2.3 million adolescent girls and young women with HIV prevention services, and directly supported more than 340 000 health workers in 2024 *(7, 8)*. This support has been severely cut back. The impact is rippling across dozens of countries and damaging vital parts of their HIV responses.

HIV prevention is especially at risk, since prevention funding in many countries has come from external sources and is often not prioritized by countries. External funding financed almost 80% of HIV prevention in sub-Saharan Africa, 66% in the Caribbean and 60% in the Middle East and North Africa *(10)*.

5 UNAIDS analysis shows there has been a gradual but persistent shift in development cooperation priorities among several major bilateral (~77% decline, excluding United States Government) and multilateral (24% decline, excluding Global Fund) donors since 2010. Changes in global official development assistance include the reprioritization of budgets towards national security, climate resilience and domestic infrastructure. This signals a continuing risk of further reductions in international health financing, including for HIV.

Condom procurement, distribution and use have declined over the past decade due in part to the defunding of condom programmes. Voluntary medical male circumcision programmes in some countries in eastern and southern Africa were still struggling to recover from setbacks as a result of the COVID-19 pandemic *(11)*. Highly effective prevention options such as pre-exposure prophylaxis (PrEP) reached about 3.9 million people in 2024, but this was far short of the 2025 target of 21.2 million people. In 2024, comprehensive prevention services for people from key populations were reaching less than half of the people who needed them.

The estimated 13.9 million [10.2 million–19.9 million] people who inject drugs around the world continue to be left behind in HIV programmes, with women who inject drugs especially neglected *(12)*. Only two of 32 reporting countries have achieved the 2025 United Nations-recommended levels of coverage for opioid agonist maintenance therapy, and only 13 of 35 countries have achieved the United Nations targets for needle and syringe distribution. No country has reported that it has met both of these targets.

The 2025 funding cuts are now pushing many prevention programmes into crisis. Countries are reporting limited availability of PrEP and reduced activities to prevent new HIV acquisitions, including among adolescent girls and young women (see Box in this section). Voluntary medical male circumcision activities have been reduced or paused in several PEPFAR-supported countries. Efforts to reduce stigma, discrimination and gender-based violence are being defunded. Prevention services for people from key populations have relied heavily on external assistance—but a great deal of this support was halted in early 2025.

Supply chains for HIV test kits and medicines, laboratory services and vital data information systems have been disrupted. Critical gaps in financing for frontline health workers and HIV testing services have appeared. These effects extend well beyond HIV and are straining health programmes more generally.

For more than 40 years, community-led organizations and networks have shaped and powered HIV programmes across the world, saving countless lives. The impact and cost-effectiveness of community-led interventions is evident in a growing body of research evidence *(13, 14)*. Community-led organizations, particularly in peer-supported services, have been shown to increase testing uptake, improve adherence to antiretroviral therapy, strengthen retention in care, achieve higher levels of viral load suppression, and reduce vertical transmission in multiple settings and countries *(15–18)*. Funding losses have now forced many ccommunity-led and other nongovernmental organizations to reduce or cease their HIV activities.

All this seriously jeopardizes the world's push to end AIDS as a public health threat by 2030, a goal that was within grasp before this disruption.

The bulk of HIV prevention funding in many countries has come from external funding.

Access to PrEP in Nigeria

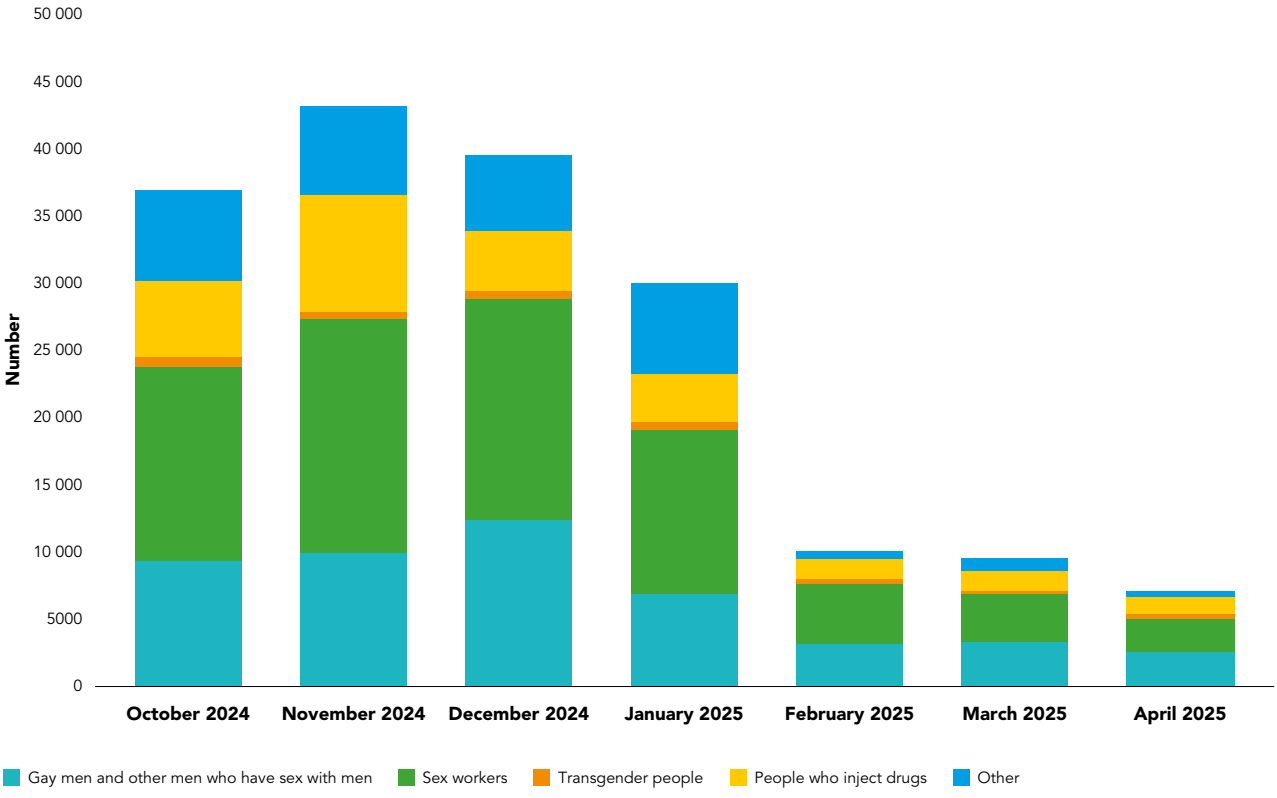
Nigeria is one of nine countries that have continued to report on monthly PrEP provision to UNAIDS in the context of the recent funding cuts. These data show a considerable decline in both the total number of people receiving PrEP and specifically the number of gay men and other men who have sex with men receiving this preventive medicine.

PrEP use remains highly concentrated, with 64% of all users globally coming from five African countries in 2023.[6] The reported number of people receiving PrEP in Nigeria in November 2024 was approximately 43 000. By April 2025, this number had fallen to below 6000.

PEPFAR contributed to more than 90% of PrEP initiations globally in 2024, making PrEP programmes particularly vulnerable to the United States funding cuts *(8)*. According to the latest data from the Nigerian national AIDS spending assessment, PEPFAR funded 99.9% (US$ 23.2 million) of Nigeria's PrEP programme in 2021. Approximately US$ 15 million of the PEPFAR budget for Nigeria in 2024 was allocated for PrEP. In the first months of 2025, the number of people receiving PrEP in Nigeria fell by over 85%.

Insufficient availability of PrEP may be linked to gaps in technical assistance for PrEP programmes, frozen funding or funding gaps for PrEP procurement, logistical challenges affecting delivery of shipments, and issues with accessing existing in-country stocks, especially for community-led service delivery. When interpreting these data, it is crucial to also highlight the impact of funding cuts on data systems, including the ability to monitor services and estimate the need for PrEP.

Figure 0.5. Number of people who receved PrEP at least once in the reporting period, by population, Nigeria, October 2024 to April 2025



Source: country-reported data through the monthly Global AIDS Monitoring platform (https://hivservicestracking.unaids.org/).

6 Kenya, Nigeria, South Africa, Uganda, Zambia.

No choice but to go forward together

Countries, governments, communities, civil society, donors and their partners must regroup rapidly. The immediate priorities are to prevent service disruptions, protect supply chains for antiretroviral medicines and other essential HIV products, and maintain the reach and preserve the quality of HIV services.

Programmatic, political and financial sustainability need to be built into HIV responses by countries, with the support of regional and multilateral organizations, by:

- building sustainable services for HIV testing, treatment and prevention, and leveraging primary health-care services, with differentiated services delivery for treatment and prevention, including services by community-led organizations;
- investing in systems strengthening (including data and surveillance), community systems and integration of HIV services with health and other relevant sectors;
- putting in place the mechanisms for communities to continue to play their critical roles in the HIV response within an inclusive, multisectoral, country-led and country-owned HIV response;
- targeting structural barriers that block access to prevention and treatment services, such as stigma, discrimination, gender inequalities and violence;
- addressing the harmful social norms that perpetuate gender-based violence, including inter-partner violence, unsafe and non-consensual sex, and behaviours that enhance risk of HIV.

There is an urgent need for diversified and durable financing mechanisms for HIV and other public health priorities. The funding losses have exposed the fragility of HIV programmes in many low- and middle-income countries. Yet, hidden in this unfolding crisis are opportunities to make HIV responses and entire health systems more resilient against future shocks, whether due to funding shifts, pandemics, climate change or conflicts.

Many countries have been rebalancing their HIV programmes by increasing domestic funding for HIV. Current indications are that 25 countries plan to increase their domestic budgets for HIV in 2026, despite the constrained financial context.[7]

Countries are developing strategies, with UNAIDS support, to manage the sudden funding losses. More than 30 countries are developing HIV sustainability roadmaps to increase domestic investments in their HIV programmes as part of strategies to build sustainable, inclusive, multisectoral, country-owned HIV responses by 2030 *(19)*.

7 Twenty-five of the 60 countries reporting to Global AIDS Monitoring on forecasted budget trends for 2026 have stated they expect to increase their domestic public HIV budgets: Bhutan, Bolivia (Plurinational State of), Brazil, Dominican Republic, Namibia, Pakistan, Republic of Moldova, Tajikistan, Timor-Leste (<5% increase); Algeria, Azerbaijan, Belarus, Central African Republic, Cuba, Egypt, Georgia, Kazakhstan, Kenya, Nigeria, Thailand, United Republic of Tanzania (5–10% increase); Democratic Republic of the Congo, Ethiopia, Mali, Niger (>10% increase).

The challenging funding situation for the HIV response, and for related health and societal investments, has made it clear that increasing the fiscal space for countries is essential. This can be done through tax reforms and debt reduction instruments and strategies. The response to HIV has historically relied on a combination of both domestic funding from taxes and donor grants. The latter remain essential, but a longer-term sustainable future requires a diversified approach, including the inclusion of HIV into health insurance packages, and the use of blended financing instruments combining resources from donors, development banks and even private actors.

It is important for donors to recognize that the option of increasing domestic HIV funding is not immediately or equally available to all countries. Combinations of debt distress, slow economic growth and underperforming tax systems leave many countries, notably in sub-Saharan Africa, with limited fiscal space to increase their domestic funding for HIV. It is vital that donors support their efforts to progressively expand domestic HIV financing by continuing to show the solidarity that is needed to avert a return to the early 2000s when AIDS was deadliest.

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Chapter 1

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WHERE ARE WE NOW?

1.1 Overview of the epidemic and response

When United Nations Member States adopted the 2030 Agenda for Sustainable Development in 2015, they also committed to end AIDS as a public health threat by 2030, a pledge they reaffirmed in the 2016 Political Declaration on HIV and AIDS *(1)*. This optimism was not misplaced. At a time when less than a fifth of the Sustainable Development Goals (SDGs) are currently on track, the global HIV response (SDG target 3.3) is a rare demonstration that results can be achieved, even if the ultimate goal is not yet reached.

By the end of 2024, the annual number of people newly acquiring HIV was at its lowest since the mid-1980s, and the annual number of people dying of AIDS-related causes had been reduced to levels last seen in the early 1990s. At least seven countries had achieved the 95–95–95 targets in 2024, and 18 countries and territories had eliminated the vertical transmission of HIV. Another 10 countries without available data for 2024 achieved 90% treatment coverage in 2022 or 2023. Average life expectancy had rebounded in the countries hit hardest by HIV.

The declines in numbers of new HIV infections and AIDS-related deaths were not yet sufficient to end AIDS as a public health threat by 2030—but the means and the momentum for doing so existed. Examples of country successes were multiplying, and national governments were assuming greater responsibility for their HIV responses. New scientific breakthroughs continued to be made, including long-acting injectable antiretroviral medicines that are almost 100% effective in preventing HIV infections but require precise targeting and demand-generation among the people at highest risk of HIV acquisition to be cost-effective *(2)*.

That was the situation at the end of 2024. Since then, HIV programmes in low- and middle-income countries have been rocked by sudden, major financial disruptions that threaten to reverse decades of hard-won progress against HIV. Wars and conflict, widening economic inequalities, geopolitical shifts and climate change shocks—the likes of which are unprecedented in the global HIV response—are stoking instability and straining multilateral cooperation. Urgent action and revived solidarity are needed to sustain the gains made and prevent a resurgence of HIV.

HIV programmes in low- and middle-income countries have been rocked by sudden, major financial disruptions that threaten to reverse decades of hard-won progress against HIV.

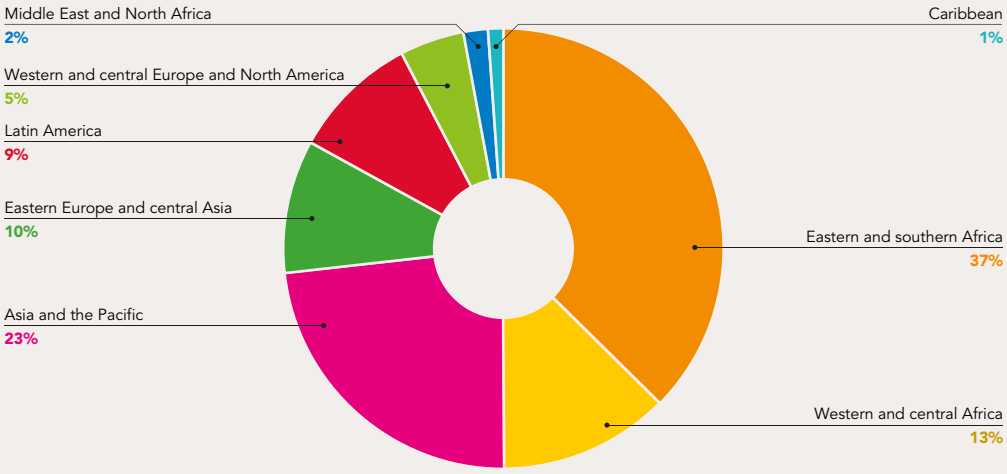
1.2 Even before the funding crisis, the rate of decline in new HIV infections was insufficient to reach the 2030 target

Globally in 2024, there were 40% fewer new HIV infections compared with 2010, but the rate of decline has been too slow to meet the target of 370 000 or fewer new HIV infections in 2025, let alone the target of 200 000 infections by 2030. An estimated 1.3 million [1.0 million–1.7 million] people newly acquired HIV in 2024—only slightly fewer than the estimated 1.4 million [1.1 million–1.7 million] new infections in 2023. Half of all people who acquired HIV in 2024 were living in sub-Saharan Africa (Figure 1.1).

Between 2010 and 2024, numbers of new HIV infections decreased by 56% in eastern and southern Africa, 55% in western and central Africa, 21% in the Caribbean and 17% in Asia and the Pacific—but they increased by 94% in the Middle East and North Africa, 13% in Latin America and 7% in eastern Europe and central Asia (Figure 1.2).

Half of all new HIV infections are in sub-Saharan Africa

Figure 1.1. Distribution of new HIV infections, by region, 2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

An estimated 1.3 million people newly acquired HIV in 2024.

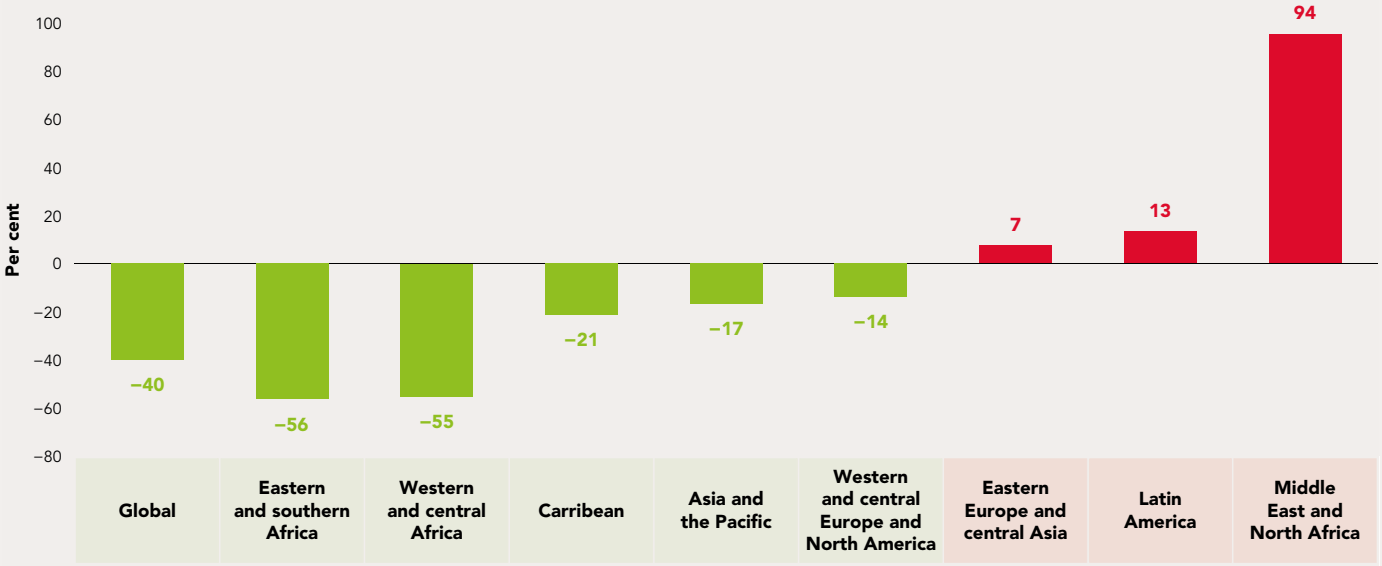
Efforts to achieve greater gender equality and uphold the rights of girls and women are as urgent as ever.

While many countries have made significant progress in reducing new HIV infections over the past two decades, five countries (Lesotho, Malawi, Nepal, Rwanda, Zimbabwe) had reduced their annual numbers of new HIV infections by at least 75% between 2010 and 2024 and were on track to reach the target of reducing the numbers of new HIV infections by 90% by 2030. Another two countries (Eswatini, Kenya) had reduced their annual numbers of new HIV infections by 70% since 2010. At least six high-income countries had reduced numbers of new infections by more than 50% since 2010, albeit from already low levels.

In sub-Saharan Africa, where this progress has been strongest, much unfinished work remains. Recent analysis shows the lifetime probability of acquiring HIV in sub-Saharan Africa has declined steeply from almost 22% [20.1–24.2%] in 1995, but it was still almost 9% [7.5–10.7%] in 2021 *(3)*.[1] The rate of decline in new infections has been steeper among men than women. Adolescent girls and young women aged 15–24 years are still at high risk of acquiring HIV (see Chapter 3). In 2024, 140 000 [88 000–180 000] adolescent girls and young women acquired HIV in eastern and southern Africa, and 31 000 [19 000–49 000] in western and central Africa. In eastern and southern Africa, adolescent girls and young women account for 28% of new infections among all age groups and 77% of new infections among young people aged 15–24 years. In addition, increasing proportions of new infections in sub-Saharan Africa are among women aged 25–49 years. Efforts to achieve greater gender equality and uphold the rights of girls and women are as urgent as ever.

Reductions in new HIV infections are uneven

Figure 1.2. Percentage change in annual numbers of new HIV infections between 2010 and 2024, global and by region

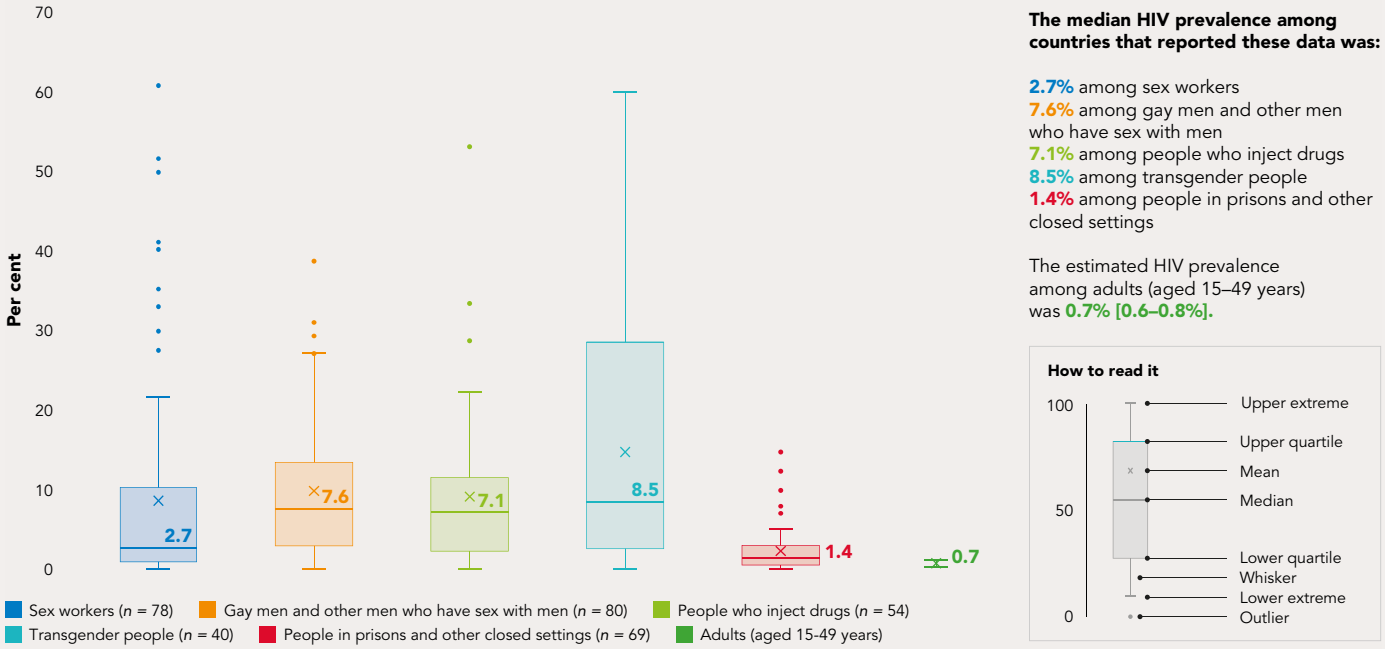


Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

1 As a comparison, this probability was well below 1% in most other regions.

Key populations continue to be more affected by HIV globally

Figure 1.3. HIV prevalence among people from key populations compared with adults (aged 15–49 years), global, 2020–2024



The median HIV prevalence among countries that reported these data was:

2.7% among sex workers
7.6% among gay men and other men who have sex with men
7.1% among people who inject drugs
8.5% among transgender people
1.4% among people in prisons and other closed settings

The estimated HIV prevalence among adults (aged 15–49 years) was **0.7% [0.6–0.8%].**

How to read it

Notes: *n* = number of countries.

Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/); UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

Progress in preventing HIV acquisitions was less evident among people from key populations and their sex partners, who accounted for an estimated 80% of new infections outside sub-Saharan Africa and about 25% in sub-Saharan Africa in 2022 *(4)*. These populations are still disproportionately affected by HIV, including in places where HIV is widely present (Figure 1.3).

Discriminatory attitudes, stigma, punitive laws, gender inequalities and violence continue to disrupt people's attempts to stay free of HIV or to live healthy lives if they acquire the virus. In many countries, there is a lack of political commitment to provide HIV-related services and ensure protection for people from key and other vulnerable populations (see Chapter 3). People from key populations have had to depend on the work of their own community-led groups and other nongovernmental organizations, many of which are now reeling from funding cuts. Also affected are HIV surveys and studies that provide vital information to guide programmes for people living with, at risk of or affected by HIV. Less information about these populations and the barriers they face will likely result in less funding for the requisite interventions.

People from key populations and their sex partners accounted for an estimated 80% of new infections outside sub-Saharan Africa and about 25% in sub-Saharan Africa in 2022.

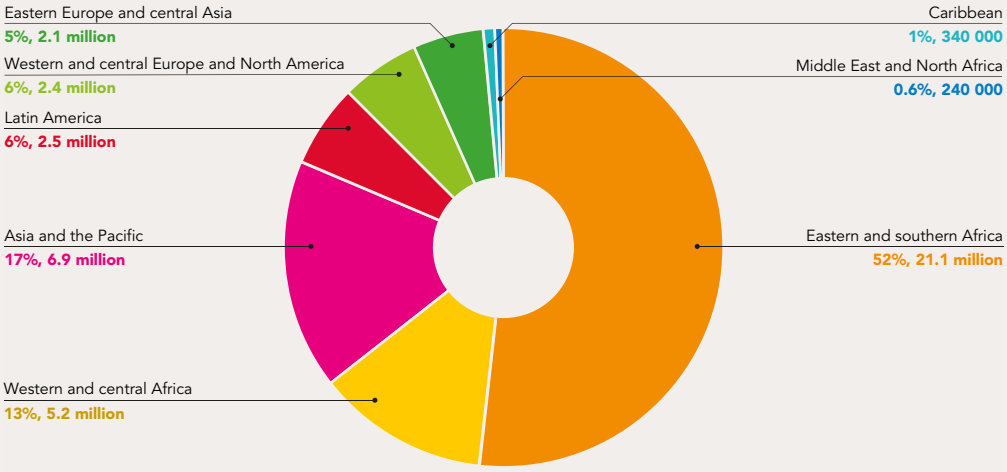
HIV programmes have reduced the annual number of children acquiring HIV through vertical transmission to 120 000 [82 000–170 000], a 62% drop since 2010 and the lowest number since the 1980s. Eighteen countries and territories[2] have been certified as having halted the vertical transmission of HIV.[3] Two countries with large epidemics have been certified as being on the path to elimination (Botswana, Namibia).

Overall, programmes to prevent the vertical transmission of HIV averted nearly 4.4 million [3.1 million–6.4 million] HIV acquisitions in children between 2000 and 2024. Much of this was due to accomplishments in eastern and southern Africa—achievements that are now jeopardized by funding cuts to HIV programmes. In western and central Africa, the rate of decline in paediatric HIV infections has slowed markedly since 2015, a trend that will be difficult to address if funding losses are not recovered.

Globally, approximately 40.8 million [37 million–45.6 million] people were living with HIV in 2024, the highest number ever. This increase is due to more people with HIV accessing lifesaving medicines and services and living longer. But the trend is not sustainable. Unless the world becomes much more successful at enabling people to stay HIV-free or a cure is developed *(5)*, the HIV epidemic and the need for treatment will keep growing. HIV prevention remains the biggest challenge.

Two-thirds of people living with HIV are in sub-Saharan Africa

Figure 1.4. Distribution of people living with HIV, by region, 2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

2 Anguilla (2017), Antigua and Barbuda (2017), Armenia (2016), Belarus (2016), Belize (2023), Bermuda (2017), Cayman Islands (2017), Cuba (2015), Dominica (2020), Jamaica (2024), Malaysia (2018), Maldives (2019), Montserrat (2017), Oman (2022), Saint Kitts and Nevis (2017), Saint Vincent and the Grenadines (2024), Sri Lanka (2019), Thailand (2016).

3 Defined as fewer than 50 new HIV infections in children per 100 000 births.

1.3 HIV treatment continues to reduce the number of AIDS-related deaths

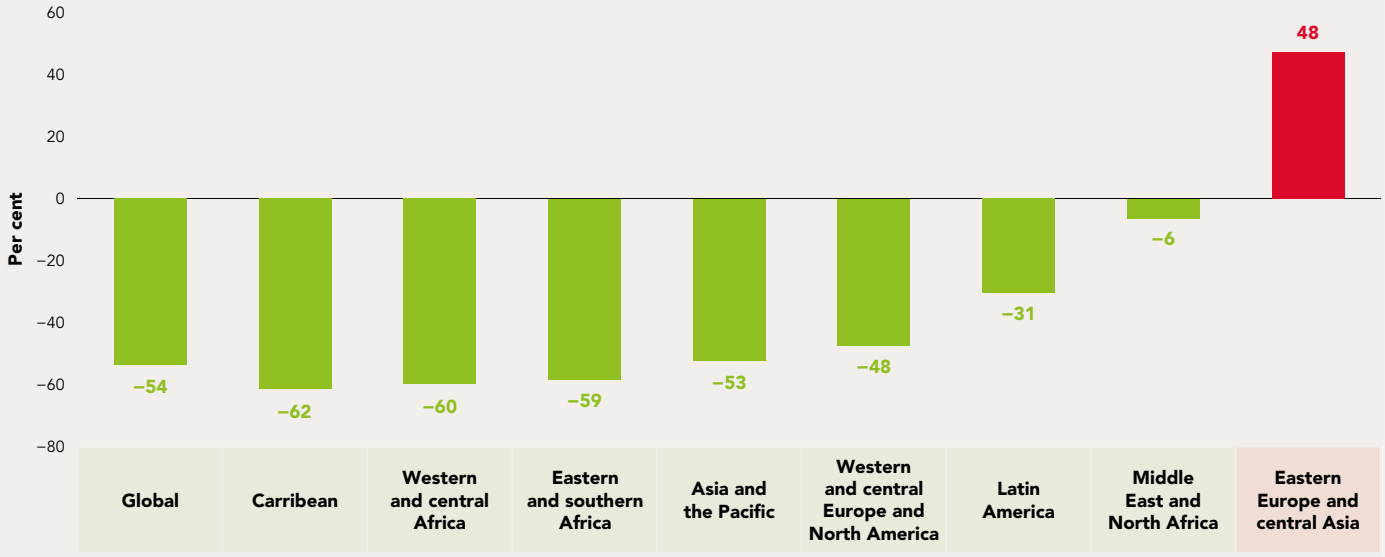
The number of deaths due to AIDS-related causes was reduced by more than half between 2010 and 2024 when AIDS claimed an estimated 630 000 [490 000–820 000] lives. Driving this decrease are widening access to effective antiretroviral therapy and rising levels of viral load suppression in Asia and the Pacific, the Caribbean and sub-Saharan Africa. Similar improvements are absent in eastern Europe and central Asia and the Middle East and North Africa, and numbers of AIDS-related deaths in eastern Europe and central Asia are still increasing (Figure 1.5)

Globally in 2024, approximately 31.6 million [27.8 million–32.9 million] people were receiving HIV treatment, equal to 77% [62–90%] of all people living with HIV. Some regions were close to achieving the 95–95–95 testing and treatment targets by 2025.[4] At least seven countries (Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia, Zimbabwe) had reached all three 95–95–95 targets by the end of 2024, and a further 12 countries had reached 90% for each of these three targets.

The continuous addition of new HIV infections and persistent gaps in testing and treatment programmes, however, meant that 9.2 million people living with HIV were *not* getting lifesaving medicines in 2024. Global treatment coverage increased only marginally between 2023 and 2024 (from 75% to 77%), before the current wave of funding cuts.

Numbers of AIDS-related deaths have decreased steeply in most regions

Figure 1.5. Percentage change in annual numbers of AIDS-related deaths between 2010 and 2024, global and by region



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

4 The targets call for 95% of all people living with HIV to know their HIV status, 95% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have viral suppression by 2025.

9.2 million people living with HIV were not getting lifesaving medicines in 2024.

Treatment coverage and viral load suppression levels continued to be lower among men generally and among people from key populations, and they were especially poor among children. Reasons for these disparities include stigma and discrimination, absent or insufficient services, and a lack of sufficient support for many people living with HIV. Although effective and palatable HIV treatment for children exists, AIDS-related causes claimed the lives of 75 000 [50 000–110 000] children in 2024, the vast majority of them in sub-Saharan Africa. Overall, an estimated 620 000 [490 000–800 000] children living with HIV were *not* receiving HIV treatment in 2024.

Taking antiretroviral medicines and having viral load suppression protects a person's own health and prevents onward HIV transmission. With almost one in four people living with HIV not on treatment, neither the full prevention nor the lifesaving impact of treatment and care programmes is being achieved.

The persistently large proportion (25–40%) of people who have advanced HIV disease (AIDS) at diagnosis or when starting treatment is concerning. This trend is evident across all regions and has changed little in the past decade—a reminder of the constant need to monitor, adjust and improve treatment programmes (see Chapter 2) *(6–8)*.

There was a 71% drop in tuberculosis (TB)-related deaths among people living with HIV between 2010 and 2023—from an estimated 560 000 [420 000–710 000] to 160 000 [130 000–190 000] deaths. The decline in numbers of TB-related deaths among people living with HIV in Asia and the Pacific (–78% between 2010 and 2023) and sub-Saharan Africa (–72%), where almost 90% of all TB-related deaths among people living with HIV occur, has slowed since 2021. Sudden rises in the numbers of TB-related deaths among people living with HIV after 2018 appear to be reversing in eastern Europe and central Asia and Latin America *(9)*.

With almost one in four people living with HIV not on treatment, neither the full prevention nor the lifesaving impact of treatment and care programmes is being achieved.

1.4 Recent funding cuts could undo decades of progress

The means for further and more equitable progress against HIV exist, and there are many country examples to illustrate this (see Chapters 2 and 3). This work now has to proceed in a world that seems to be shifting on its foundations. Many donor countries are retreating from the solidarity they once maintained with poorer countries to respond to one of the deadliest epidemics in modern history. Funding cuts and freezes imposed in 2025 place the global HIV response in jeopardy.

In the absence of a cure for HIV, millions of people will continue to need HIV treatment for many decades to come, but funding losses are destabilizing treatment programmes. Unless remedied rapidly, interruptions in treatment services (e.g. due to stockouts of antiretroviral and other medicines or staffing

The importance and strategic use of HIV epidemic estimates

Estimates and trends of the HIV epidemic at the country, regional and global levels have been published by UNAIDS annually using mathematical models. These include estimates in more than 170 countries of the number of people living with HIV, the number of people newly infected with HIV, the number of people who have died from AIDS-related causes, and the 95–95–95 testing and treatment indicators, among other estimates. Country-level models are developed by country teams using the best available demographic, epidemiological and programmatic data from multiple data sources. Model development is guided by the UNAIDS Reference Group on Estimates, Modelling and Projections.

Since 2001, UNAIDS has worked closely with countries and key partners to strengthen country capacity to produce and take ownership of national HIV estimates. Data and estimates are reviewed annually at the national and global levels to ensure consistent and reliable quality, and final estimates are approved by national authorities.

The estimates are used to understand the trajectory of the HIV epidemic at the national and, where available, geographical dispersion at subnational levels; monitor progress in the HIV response towards key targets; identify gaps and inequalities in the HIV response; and inform national strategic frameworks and donor agreements. The estimates and models are also used as a starting point to assess the impact of different scenarios on future epidemic trends in order to optimize HIV responses and estimate their cost.

At the regional and global levels, the estimates have been used by UNAIDS, other United Nations agencies and key partners to estimate the impact of the pandemic, track progress, report on United Nations political declaration commitments, and provide guidance for developing strategic and sustainable HIV responses. In high-burden epidemics, these estimates were strengthened and validated using population-based surveys. Those surveys were discontinued in many countries with the closing of the United States Agency for International Development and reduction in United States President's Emergency Plan for AIDS Relief (PEPFAR) funding, impeding the ability for countries to monitor HIV and other public health areas.

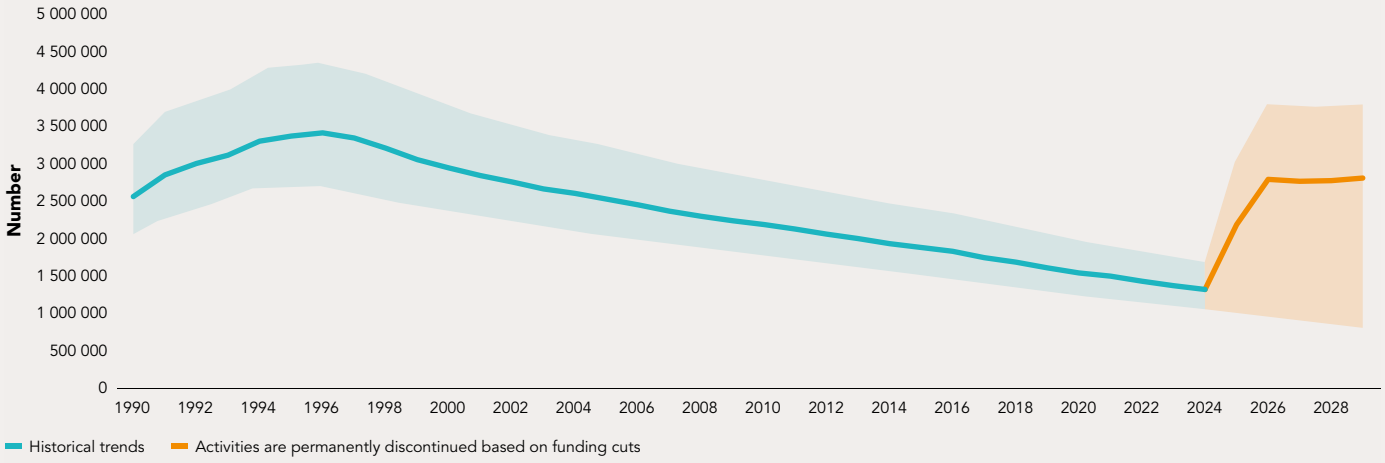
More information on the models is provided in Annex 1.

shortages) can damage health systems and degrade population health. When people must make repeated clinic visits to receive test results, start treatment or get antiretroviral medicine refills, it jeopardizes their health and increases the risk of transmitting HIV (and/or TB) to other people, which in turn puts further strain on health systems. A study based on data for Malawi, for example, showed that procurement and supply disruptions for HIV- and TB-related services could require an additional 14.3 million hours of client-facing time from health-care workers per year in an already highly constrained health system *(10)*.

The impact is likely to be severe. Treatment interruptions will contribute to an increase in HIV-related morbidity and mortality and numbers of new infections, resulting in long-term human and economic costs and consequences. UNAIDS modelling shows that if the programmes previously supported by PEPFAR are halted, there will be more than 4 million additional AIDS-related deaths and more than 6 million additional new HIV infections by 2030 (Figures 1.6 and 1.7).

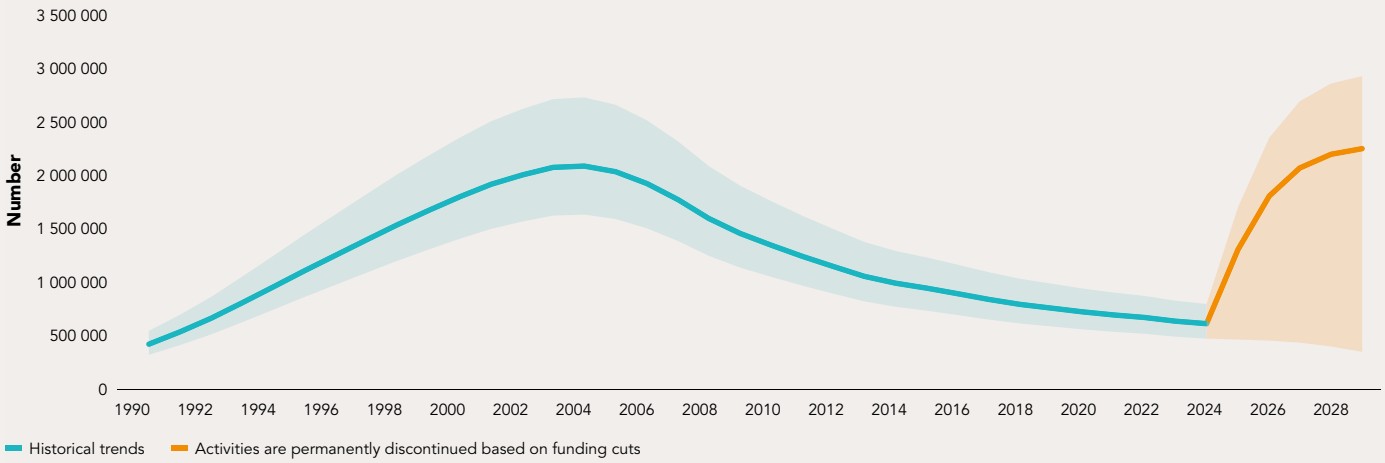
The recent funding restrictions could potentially put us back to levels not seen since the early 2000s

Figure 1.6. Number of new HIV infections, 1990–2024, and projections assuming cuts in HIV funding, 2025–2029, global



Source: UNAIDS 2025 estimates and projections from April 2025 using Avenir Health Goals Model.

Figure 1.7. Number of AIDS-related deaths, 1990–2024, and projections assuming cuts in HIV funding, 2025–2029, global



Source: UNAIDS 2025 estimates and projections from April 2025 using Avenir Health Goals Model.

Along with purchasing HIV medicines, diagnostics and other health products, and remunerating and training health staff, donor funding helps finance information systems, research, logistics, procurement, and the community programmes that make HIV responses effective, equitable and person-centred.

The full impact of the reductions in health-care staff for HIV and related services—especially testing and treatment linkage and adherence support—is yet to be fully assessed. PEPFAR, for example, was supporting remuneration for at least 340 000 health workers *(11)*, but it is not clear how many of these are still working. Also unclear is the full extent to which crucial services have been maintained or resumed, and their quality and reach. This is partly because the funding losses are also disrupting—and in some cases dismantling—data collection and management systems, which affects the capacity to track service interruptions and to respond appropriately.

Amid the widespread cuts to official development assistance spending, HIV community systems built over decades and instrumental to progress across HIV responses are now under threat. Without sustained investment, their abilities to complement and reinforce national health systems will erode. These organizations and networks have painstakingly earned the trust of the communities they serve. If they disappear, it could take years to rebuild the organized means to advocate for people's rights, connect them to services, and monitor the quality of the services.

The way forward is complex. The immediate priority is to protect and sustain HIV programmes in the face of drastic funding losses and human rights setbacks, and to use new opportunities such as long-acting prevention tools to the fullest extent possible in varying country contexts.

An increasingly hostile environment

The human rights environment for HIV responses is deteriorating and the anti-gender movement is gaining strength, to the detriment of public health and especially the populations most affected by HIV. Tied to these trends is the constricted civic space in many countries, making it more difficult for civil society and community-led organizations to operate, organize and serve the health and related needs of communities *(12)*.

This is occurring in the wider context of rampant widespread mis- and disinformation, including about public health and science more generally. Misrepresentations of scientific findings appear to be on the increase, and there is a growing perception that trust in scientific processes and health institutions has declined. This has implications for the HIV response.

It is important to note that these trends are not uniform. A recent large study found that in most of the 68 countries surveyed, the majority of people trusted scientists and felt scientists should engage more with society and in policy-making *(13)*. Nevertheless, even among a minority of people, a lack of trust in scientific processes, findings and guidance is a concern. It is also a reminder that people's knowledge of and perceived need to use HIV services cannot be taken for granted. Public information about HIV and campaigns to foster demand for effective services and tools remain essential.

Table 1.1 Summary of progress against the 2025 targets

COMBINATION HIV PREVENTION FOR ALL	TARGET	2024 STATUS
Reduce number of new HIV infections to under 370 000	370 000	1.3 million [1.0 million–1.7 million]
Reduce number of new HIV infections among adolescent girls and young women to below 50 000	50 000	210 000 [140 000–280 000]
95% of people at risk of HIV access effective combination prevention options	95%	38%/39%/44%/47% (medians) (gay men and other men who have sex with men/ people who inject drugs/transgender people/sex workers)
Pre-exposure prophylaxis (PrEP) for 10 million people at substantial risk of HIV (or 21.2 million who used PrEP at least once during the year)	21.2 million	3.9 million
50% opioid agonist maintenance therapy coverage among people who use opioids	50%	0 of 8 regions
90% sterile injecting equipment at last injection	90%	13 of 35 countries
90% of men aged 15 years and over in 15 priority countries have access to voluntary medical male circumcision	90%	67% (2023)
95–95–95 TARGETS FOR HIV TESTING AND TREATMENT	**TARGET**	**2024 STATUS**
Reduce annual number of AIDS-related deaths to under 250 000	250 000	630 000 [490 000–820 000]
34 million people on HIV treatment by 2025	34 million	31.6 million [27.8 million–32.9 million]
95–95–95 testing, treatment and viral suppression targets	95–95–95	All ages: 87–89–94 Women (15+ years): 92–91–95 Men (15+ years): 84–87–94 Children (0–14 years): 63–87–86
		Key population: unknown
90% of people living with HIV receive preventive treatment for TB by 2025	90%	35% of people newly enrolled in HIV treatment had started preventive treatment for TB (median for 2023)
Reduce number of TB-related deaths among people living with HIV by 80% by 2025 (compared with 2010 baseline)	80%	71%
PAEDIATRIC HIV	**TARGET**	**2024 STATUS**
86% of children living with HIV have a suppressed viral load by 2025	86%	47% [38–60%]
100% of pregnant and breastfeeding women living with HIV receive antiretroviral therapy, with 95% having a suppressed viral load before delivery and during breastfeeding by 2025	100%	84% [72–>98%]/not available
GENDER EQUALITY AND EMPOWERMENT OF GIRLS AND WOMEN	**TARGET**	**2024 STATUS**
Less than 10% of women and girls experience physical or sexual violence from a male intimate partner in the past 12 months by 2025	<10%	1.5–34.6% >10% in 22 of 58 countries
Less than 10% of people from key populations experience physical and/or sexual violence in the past 12 months by 2025	<10%	23%/22%/20%/8% (medians) (people who inject drugs/transgender people/sex workers/ gay men and other men who have sex with men)
Less than 10% of people support inequitable gender norms by 2025	<10%	19.2%/20.5% (medians) (women aged 15–49 years/men aged 15–49 years)
95% of girls and women aged 15–49 years have their HIV sexual and reproductive health-care service needs met	95%	Median of 63% of women currently married or in union make their own decisions regarding sexual relations, contraceptive use and their own health care
COMMUNITY LEADERSHIP	**TARGET**	**2024 STATUS**
Ensure community-led organizations deliver 30% of testing and treatment services, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy by 2025	30%	Community-led organizations can legally provide HIV testing in 84 countries and distribute antiretroviral medicines in 39 countries
Ensure community-led organizations deliver 80% of HIV prevention services for populations at high risk of HIV infection, including for women within these populations, by 2025	80%	Community-led organizations can legally distribute condoms in 92 countries, and provide naloxone in 15 countries
Ensure community-led organizations deliver 60% of programmes to support the achievement of societal enablers by 2025	60%	Community-led organizations can legally deliver legal services in 55 countries
REALIZE HUMAN RIGHTS AND ELIMINATE STIGMA AND DISCRIMINATION	**TARGET**	**2024 STATUS**
Less than 10% of countries criminalize ▪ sex work ▪ possession of small amounts of drugs ▪ same-sex sexual behaviour ▪ HIV transmission, exposure or nondisclosure	<10%	168 countries 152 countries 64 countries 156 countries
Less than 10% of countries lack mechanisms for people living with HIV and people from key populations to report abuse and discrimination and seek redress	<10%	48% of countries have mechanisms established by the government; 34% of countries have mechanisms established by communities
Less than 10% of people living with HIV and people from key populations lack access to legal services	<10%	61% of countries have mechanisms in place to ensure access affordable legal services
More than 90% of people living with HIV who experienced rights abuses have sought redress by 2025	>90%	31% of people living with HIV sought redress
Less than 10% of the general population report discriminatory attitudes towards people living with HIV	<10%	53% (median) >50% in 17 of the 33 countries reporting >75% in 7 countries
Less than 10% of people living with HIV report internalized stigma	<10%	38%
Less than 10% of people from key populations report experiencing stigma and discrimination	<10%	21%/28%/35%/35% (medians) (gay men and other men who have sex with men/sex workers/people who inject drugs/transgender people)
Less than 10% of people living with HIV experience stigma and discrimination in health-care and community settings	<10%	17% in health-care settings (median) 13% in community settings (median)
UNIVERSAL HEALTH COVERAGE AND INTEGRATION	**TARGET**	**2024 STATUS**
Systems for health and social protection that provide 90% of people living with, at risk of or affected by HIV with integrated HIV services	90%	
90% of people in humanitarian settings access integrated HIV services	90%	
45% of people living with, at risk of or affected by HIV have access to social protection benefits	45%	52% of the world's population is covered by at least one social protection benefit, an increase from 43% in 2015
INVESTMENTS AND RESOURCES	**TARGET**	**2024 STATUS**
Fully fund the HIV response by increasing annual HIV investments in low- and middle-income countries to US$ 29 billion	US$ 29.3 billion	In 2023, US$ 19.8 billion was available from all sources, an 18.8% increase since 2010 but well below the US$ 29.3 billion resource mobilization target for 2025

Progress is off track Moderate progress 2025 targets are within reach

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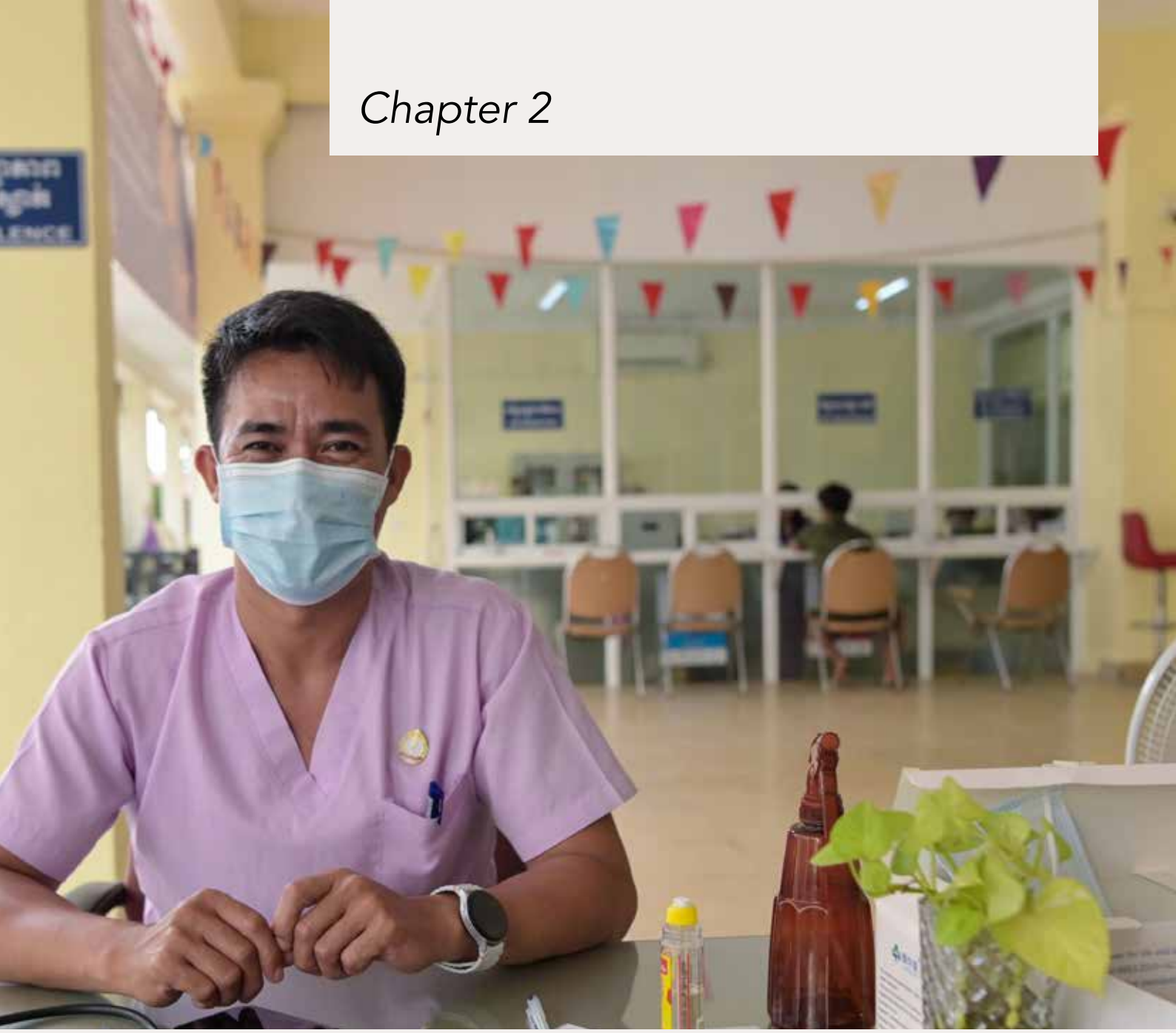
Chapter 2



SERVICES THAT SAVE THE LIVES OF PEOPLE LIVING WITH HIV

The number of people receiving antiretroviral therapy across the world rose to 31.6 million in 2024—equivalent to 77% of the estimated 40.8 million people living with HIV.

Globally in 2024, there were 54% fewer deaths due to AIDS than in 2010, an achievement made possible by widening access to HIV testing services and effective treatment (Figure 2.1). In sub-Saharan Africa, which is home to more than 60% of people living with HIV, the provision of antiretroviral therapy, among other advances, resulted in a rebound in life expectancy from 56.5 years in 2010 to 62.3 years in 2024 *(1)*.

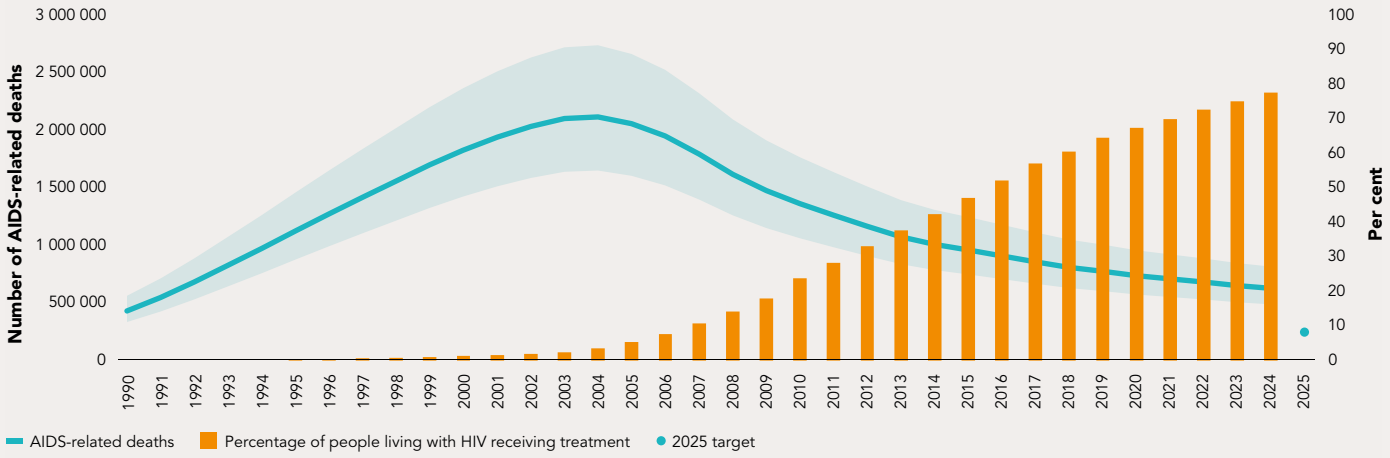
AIDS still claimed an estimated 630 000 [490 000–820 000] lives in 2024, however—far more than the global target of fewer than 250 000 AIDS-related deaths by 2025. Almost all these deaths were in low- and middle-income countries. Service gaps and other hindrances—now including sudden, steep 2025 funding losses—still limit the impact of global HIV treatment efforts.

The number of people receiving antiretroviral therapy across the world rose to 31.6 million in 2024—equivalent to 77% [62–90%] of the estimated 40.8 million [37.0 million–45.6 million] people living with HIV. Equally important is the growing proportion of people living with HIV who have viral load suppression, enabling them to live healthy lives and to have zero risk of onward transmission. Viral load suppression levels among all people living with HIV reached 73% [66–82%] in 2024, up from 53% [48–59%] in 2018.

HIV testing and treatment coverage and viral load suppression levels among people living with HIV improved globally in 2024 (Figure 2.2), although they still lag considerably in eastern Europe and central Asia and the Middle East and North Africa (see regional chapters). Eastern Europe and central Asia is the only region where the number of AIDS-related deaths has risen since 2010—by 48% (see Figure 1.5 in previous chapter).

Rising HIV treatment coverage has led to a steep decline in the number of AIDS-related deaths

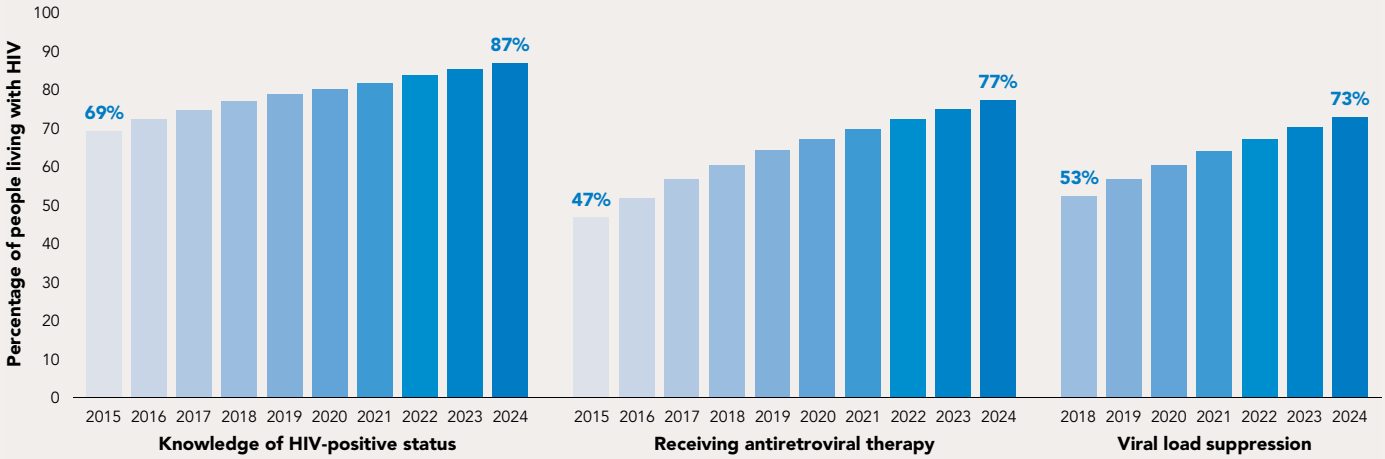
Figure 2.1. Numbers of people dying from AIDS-related causes and percentages of people living with HIV receiving antiretroviral therapy, global, 1990–2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

Testing and treatment coverage and viral load suppression levels among people living with HIV continued to rise in 2024

Figure 2.2. Percentages of people living with HIV who know their status, who are receiving antiretroviral therapy and have viral load suppression, global, 2015–2024



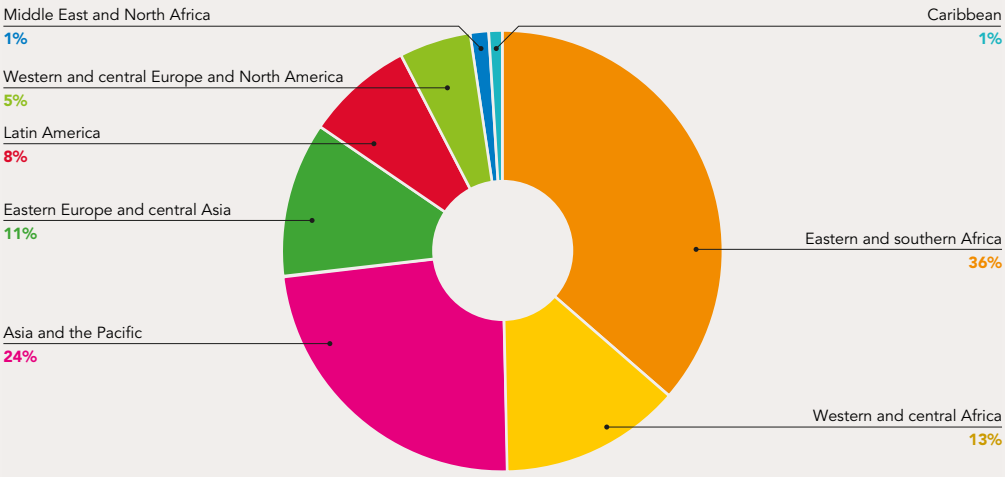
Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

The sheer scale of the HIV epidemic in sub-Saharan Africa means that in 2024 it was home to half of the 9.2 million [7.8 million–10.3 million] people globally who needed but were not getting HIV treatment (Figure 2.3). A further quarter of the total unmet need was in Asia and the Pacific. A total of 61% of all AIDS-related deaths in 2024 were in sub-Saharan Africa, most of them in eastern and southern Africa, where the epidemic claimed the lives of an estimated 260 000 [210 000–330 000] people in 2024.

Globally in 2024, an estimated 75 000 [50 000–110 000] children died from AIDS-related causes, compared with 240 000 [160 000–340 000] in 2010. The vast majority of these deaths (84%) were in sub-Saharan Africa. Globally, 12% of all AIDS-related deaths are among children, even though children account for only 3% of all people living with HIV. Child deaths should decline if HIV testing services do better at diagnosing children living with HIV and providing them with more palatable and efficacious paediatric antiretroviral medicine formulations.

More than half of the unmet HIV treatment need is in two regions

Figure 2.3. Distribution of unmet antiretroviral therapy need, by region, 2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

2.1 The 95–95–95 targets were within reach in 2024, but some countries are being hit hard by funding losses

HIV responses were getting closer to achieving the 95–95–95 targets in 2024.[1] Globally, an estimated 87% [69–>98%] of all people living with HIV knew their HIV status, 89% [71–>98%] of people who knew their HIV-positive status were receiving antiretroviral therapy, and 94% [75–>98%] of people on antiretroviral therapy had a suppressed viral load. These are huge improvements in a short space of time.

The three targets were almost achieved in eastern and southern Africa (having reached 93–91–95), where testing, treatment and viral load suppression levels—which were already high—continued to increase in 2024. Seven countries in this region[2]—each of which is contending with a large HIV epidemic—achieved all three "95" targets in 2024. Several high-income countries have achieved the "95" targets, including Denmark and Sweden *(2)*.[3]

Lesotho increased testing coverage by using index testing, outreach activities and peer-led interventions, with an emphasis on reaching younger people. Its success in meeting the other targets is due in part to a focus on person-centred care and psychosocial support, and the use of multimonth antiretroviral medicine refills to reduce the burden and cost of travelling to pharmacies or clinics *(3)*. Zimbabwe has applied similar approaches and focused HIV testing services and treatment facilities in areas with high HIV prevalence. As a result, people living with HIV who are unaware of their HIV status and/or not receiving antiretroviral therapy now tend to be concentrated in specific areas, including border regions *(4)*, allowing programme managers to focus limited testing resources in these areas.

A further 12 countries—eight of them in sub-Saharan Africa—have reached 90% on each of the three targets, suggesting they are in reach of the 95–95–95 targets. There is a real risk, however, that funding and HIV programme disruptions will reverse these achievements. Several other high-income countries are similarly close to achieving the 95–95–95 targets, including Australia, Belgium, France, Ireland, the Kingdom of the Netherlands, Saudi Arabia and Switzerland.

In Asia and the Pacific, the Caribbean, the Middle East and North Africa and western and central Africa, the biggest gap is around the first "95" target of diagnosing people living with HIV.

1 The targets call for 95% of all people living with HIV to know their HIV status, 95% of all people who know their HIV-positive status to receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have a suppressed viral load by 2025.
2 Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia, Zimbabwe.
3 Based on estimates for 2010 up to 2023 and 2022, respectively, since those countries do not have data yet for 2024.

Funding losses—some countries are being hit hard

The trends described in this report go up to the end of 2024 and do not reflect the impact of the reductions in donor support to HIV programmes in the first months of 2025. Severe reductions have been applied to the United States President's Emergency Plan for AIDS Relief (PEPFAR) programme, which has been a lifeline for countries with the highest HIV burdens, supporting HIV testing for 84.1 million people and HIV treatment for 20.6 million people in 55 countries in 2024 *(5)*.

If not addressed, these funding disruptions could lead to an alarming rise in numbers of new HIV infections and AIDS-related deaths, according to several modelling exercises (see Chapters 1 and 4). The loss of a quarter of external aid for HIV programmes and discontinued PEPFAR support could result in more than 4 million additional AIDS-related deaths by 2030. Even if funding for HIV treatment (but not prevention) is restored, a recent study found that cuts to prevention and supplementary services could result in an additional 1 million new HIV infections from 2025 to 2030 *(6)*.

Maintaining and distributing stocks of antiretroviral medicines to people living with HIV is essential, but it is only one of many elements needed for a successful HIV treatment programme. Testing services must be accessible beyond formal health facilities and should link effectively to treatment and care services. Community-led and other nongovernmental organizations must be able to perform their vital outreach work, assist in delivering services, help with referrals, and provide the peer and other support that enables people to keep taking their HIV medicines. These organizations should be able to monitor services and advise on improvements. Clinical and other researchers should assess the efficacy of different testing and treatment technologies and service delivery approaches. Information systems need to collect and synthesize complex programme data, which can then inform budget allocations and procurement and programming decisions. To varying degrees, all these components are now under threat *(7)*.

In South Africa, where more than 80% of the national HIV budget is funded from the domestic tax base,[4] the South African Government quickly stepped in to cushion the impact of the loss of United States Government funding. The South African Government manages the world's largest HIV treatment programme, with approximately 6 million of the 7.8 million [7.2 million–8.5 million] people living with HIV receiving antiretroviral therapy in 2024. The funding losses have damaged vital parts of the HIV response. Testing and data information systems were disrupted, with viral load testing reportedly decreasing by up to 21% in March and April 2025 *(8)*. Community-led and other nongovernmental organizations had to cease outreach and other vital activities serving key and other marginalized populations, along with the important tasks of bringing back into care people who had interrupted their treatment. Community-led monitoring of HIV services was stopped. Purchases of long-acting injectable pre-exposure prophylaxis (PrEP) were frozen. Clinical research was halted or put on hold, and HIV response staff were made redundant *(9, 10)*.

Other countries are being hit even harder. Of the 28 countries sharing monthly data with UNAIDS in sub-Saharan Africa (see Annex 1), only six have been able to report consistent monthly data on their HIV treatment programmes and five on their testing programmes since January 2025. Among countries reporting on testing, the numbers of people tested for HIV are generally declining. Rwanda is a rare example, where an initial decline in testing appears to have been reversed *(11)*.

4 PEPFAR contributed 18% (about US$ 460 million) of South Africa's annual HIV budget (US$ 2.56 billion) in 2022.

Changes in the total numbers of people receiving antiretroviral therapy are difficult to quantify because of delays in data being transferred from clinics to national programme managers, and in some cases people have already received their medicines for up to six months. Most countries have maintained antiretroviral medicine stocks of at least three to six months but are still at risk of stockouts *(12)*. A more sensitive indicator of the state of treatment programmes is the number of people initiating or restarting antiretroviral therapy. These numbers were reported to be declining in six countries (Botswana, Kenya, Nigeria Rwanda, Togo, Zimbabwe). Most of these countries also reported recent drops in the number of people having viral load tests *(11)*.

STORY

A lifeline interrupted in Uganda—why community health systems matter

In early 2025, 22-year-old Jokpee Emmanuel arrived at Reach Out Mbuya in Kampala, Uganda, expecting to attend the Friends Forum—a safe space for young people to gather, share and support each other. Instead, he was met with a sign on the gate: "Due to the suspension of United States funding, Reach Out Mbuya will be closed for 90 days. We regret the inconvenience caused."

The Reach Out Mbuya community health initiative is not just a health facility. It is a lifeline. For years, it served Uganda's most vulnerable communities, offering care that goes far beyond medicine. For Jokpee, who was born with HIV, Reach Out provided access to antiretroviral therapy, emotional support, school tuition and dignity. "Reach Out was like a second home," he says. "They did not just give me medicines. They cared for me and reminded me that I am more than my diagnosis. I could live a full life."

The closure followed a suspension of United States funding through PEPFAR, which had long supported community-led HIV responses in Uganda. The impact was immediate and severe. Community-led and community-based centres such as Reach Out Mbuya are central to public health in many low-resource settings. They offer holistic, person-centred services catered to local realities. They respond to the social, emotional and economic realities of people's lives. These systems have been essential to the global HIV response, driving down infections and improving quality of services and life, especially among marginalized groups.

Jokpee was forced to seek care at an overcrowded Government facility. He waited six hours, only to be told antiretroviral medicines were out of stock and to return the following week. "A week without antiretroviral medicines! That is how resistance develops. That is how people die," he says.

He eventually received a one-month supply of medicines, but the fear of another stockout remained. Although the Government of Uganda worked to fill the gap through national health facilities, it could not match the reach or personal connection of community-based programmes.

In the weeks that followed, Reach Out Mbuya managed to reopen, with support from a PEPFAR-funded programme called Kampala HIV Project. Most staff returned, restoring most of the centre's core services. The number of clients accessing the centre is slowly increasing but is still below previous levels.

Jokpee's story is a warning. When community-led and -based systems lose support, people fall through the cracks. If it were not for places like Reach Out Mbuya, Jokpee and his peers would be at risk of being left behind in the HIV response.

Sustained investment in community-led responses is the only way forward if we are to end AIDS as a public health threat by 2030.

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STORY

Funding cuts undermine community-led innovations in the Philippines

"We will focus on treatment!" This is the reassurance HIV advocates say they have received from the Government of the Philippines in the aftermath of United States funding cuts to the Philippines HIV response.

These commitments are critical to scale up treatment access for the 60% of people living with HIV in the Philippines who are not currently receiving antiretroviral therapy. But far more is needed to achieve epidemic control in a country that has seen a six-fold increase in new infections since 2010.

In 2024, three to four people were infected with HIV every hour in the Philippines. Of particular concern is that almost half of them are young people aged 15–24 years. Programmes to reach young key populations, especially young gay men and other men who have sex with men, are urgently needed.

"We are seeing a trend where younger and younger people are getting infected," says Russell Elloso of Network Plus Philippines, the umbrella organization of people living with HIV. "And we are not seeing a plateau—the number of cases is still increasing. That means the current approaches are not working."

Through PEPFAR, the United States invested primarily in supporting HIV prevention strategies and community-led work to ensure services reached people most in need.

One of the programmes that has been cancelled as a consequence of the funding cuts is the EpiC-supported Free to be YOUTH HUB. This innovative think tank developed culturally resonant HIV prevention and treatment support approaches specifically for young people. It ran 12 projects, including an academy for social media influencers, an innovative approach to HIV education, and a peer-led project to re-enrol youth who had stopped HIV treatment.

"We have a progressive HIV policy in the Philippines and a comprehensive sexual and reproductive health policy, but they are not youth-focused and youth-centred," explains Aaron James Villapando, Co-chair of Free to be YOUTH. "The value of this initiative was having an advisory board focused on promoting a youth-led response. Young people can lead, and we need to be at the frontlines of the HIV response for it to be effective."

In the aftermath of the funding freeze, the organization has ramped up efforts to engage the private sector and foundations. A key priority has been to work with local government and local youth councils to secure more decentralized and sustainable funding for HIV programmes in the respective provinces. But activists are finding it particularly difficult to secure support for interventions for young key populations.

"Our Secretary of Health has assured the public that they will scale their current initiatives with a goal of not being so dependent on international funding. But the reality is that some of the community-led projects that are most needed are not priorities," Mr Villapando says.

Stakeholders are lobbying the Department of Health to expand modern prevention methods and community-led service delivery, which were traditionally funded by external donors. These donor investments specifically addressed critical programmatic gaps, including youth programming and increasing access to modern testing and prevention options.

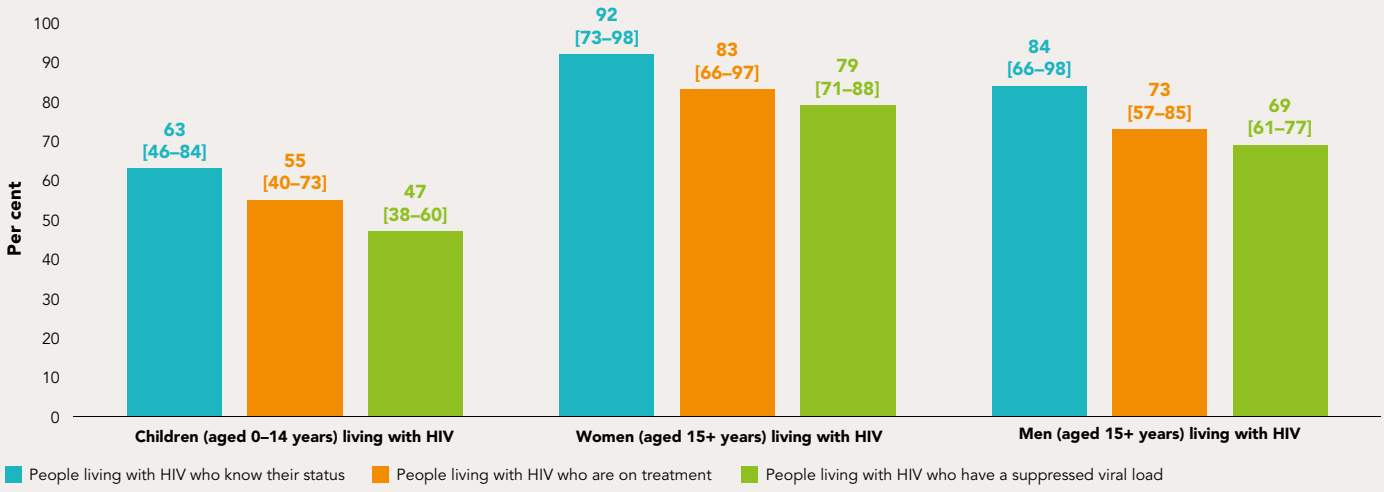
Despite the Government procuring almost all HIV commodities, including PrEP, challenges remain around funding and systems for community-led responses, and the introduction of novel interventions such as long-acting PrEP, the dapivirine vaginal ring and self-testing. Advocates are lobbying policy-makers to develop and implement a social contracting mechanism so the community can continue to provide services without support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and PEPFAR.

2.2 Not everyone is benefiting equally from treatment rollout

Despite the progress in testing and treatment programmes, there are still major disparities across regions and between age groups, men and women and different key populations.

Many children and men living with HIV are being missed along the treatment cascade

Figure 2.4. Testing and treatment cascade among children, women and men, global, 2024



Source: UNAIDS epidemiological estimates, 2025 (https://aidsinfo.unaids.org/).

Many people from key populations and men are still not accessing treatment services

When people living with HIV have high rates of viral load suppression, it protects their own health and reduces HIV transmission to their sex partners. On average, men aged 15 years and over living with HIV are less likely (73% [57–85%]) to be receiving antiretroviral therapy than their female peers and less likely to have viral load suppression (Figure 2.4). This has implications for men's health and for onward HIV transmission. The largest gaps are in diagnosing men living with HIV and linking them to treatment and care. Men from key populations are especially affected. Programme and other data suggest that once men receive antiretroviral therapy, their viral load suppression rates tend to be similar to those of women (about 94%).

These disparities can be addressed by reducing HIV-related stigma, reshaping norms of masculinity that associate seeking health services with weakness and vulnerability, and making health services more convenient and less intimidating for men *(13–15)*.

Antiretroviral therapy coverage and treatment outcomes among people from key populations are difficult to determine because of challenges in confidentially collecting information about modes of HIV transmission within health data systems. The most comprehensive analysis of HIV data among key populations in sub-Saharan Africa has shown that antiretroviral therapy coverage was correlated with, but lower than, antiretroviral therapy coverage for the total population. As in the rest of the world, coverage levels varied widely. Yet even in countries with high treatment coverage in the general population (80%), estimated coverage tended to be significantly lower among key populations—25% less for people who inject drugs, 19% less for gay men and other men who have sex with men, 13% less for transgender women and 11% less for female sex workers *(16)*.

Globally, data indicate that median coverage of antiretroviral therapy in recent years was 77% among gay men and other men who have sex with men (44 reporting countries), 74% among people who inject drugs (21 countries), 69% among sex workers (36 countries) and 61% among transgender people (22 countries). Evidence from Kenya and Uganda, for example, shows that differentiated testing and treatment services can achieve very high coverage among people from key populations *(17, 18)*.

Harassment and violence can prevent access to HIV testing and treatment services for people from key populations and undermine the collection of data needed to advocate and budget for these services. More routine HIV-related surveillance could lay the basis for more equitable service provision and access *(16)*, but the current funding disruptions make such improvements unlikely in the short term.

Some countries have been pursuing differentiated service delivery approaches to make HIV testing and treatment more available, accessible and suited for different populations. One such initiative is the multicountry HIV Coverage, Quality and Impact Network (CQUIN), which draws together 21 African countries. Using a self-assessment tool, each country has been gauging its service capacity for effective HIV testing and treatment, with the results informing specific action plans. The exercises are led by national ministries of health, with broad participation by the main stakeholders. The assessments are repeated annually to track progress and share lessons through the South to South Learning Network *(19)*.

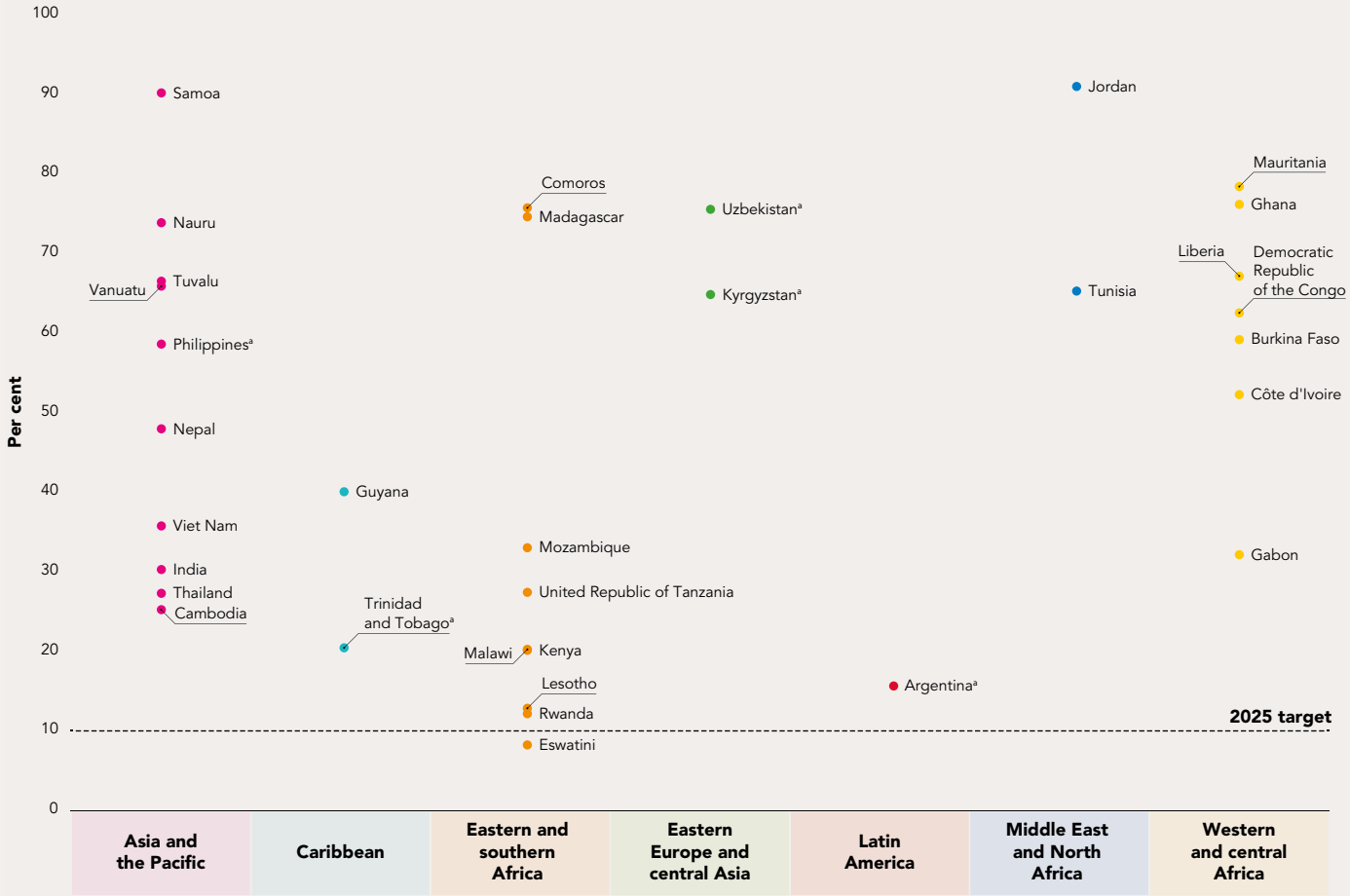
Data from surveys indicate that adolescent girls and young women face specific barriers when accessing HIV testing and treatment, including health services that are not adapted to their needs, stigmatizing behaviour of health-care staff, and policies or laws that require parental consent to seek services. Differentiated testing and treatment services could address this. More youth-friendly testing approaches, more compassionate attitudes among health-care workers, removal of obstructive age-of-consent requirements, and peer-led and other forms of trusted support can help make it easier for young people to know their HIV status, access treatment and keep taking their antiretroviral medicines *(20–22)*.

Stigma, discrimination and violence continue to obstruct service access

Discriminatory attitudes towards people living with HIV are widespread in many countries (Figure 2.5), although population-based surveys show that some countries—notably Argentina, Eswatini and Rwanda—are approaching or have reached the target of less than 10% in the general population. In the 33 countries with available data, a median of 53% of men and women aged 15–49 years held discriminatory attitudes towards people living with HIV *(23)*.[5] In addition, these attitudes are often openly expressed. Data compiled through the HIV Stigma Index 2.0 surveys show that in 21 of 35 countries with such data, at least one in 10 people living with HIV experienced stigma or discrimination in their communities, with this proportion exceeding 30% in several countries *(24)*.

HIV-related stigma and discrimination are still unacceptably high

Figure 2.5. Percentage of women and men (aged 15–49 years) who report experiencing discriminatory attitudes towards people living with HIV, countries with available data, 2020–2024



[a] 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 with children who are HIV-negative.

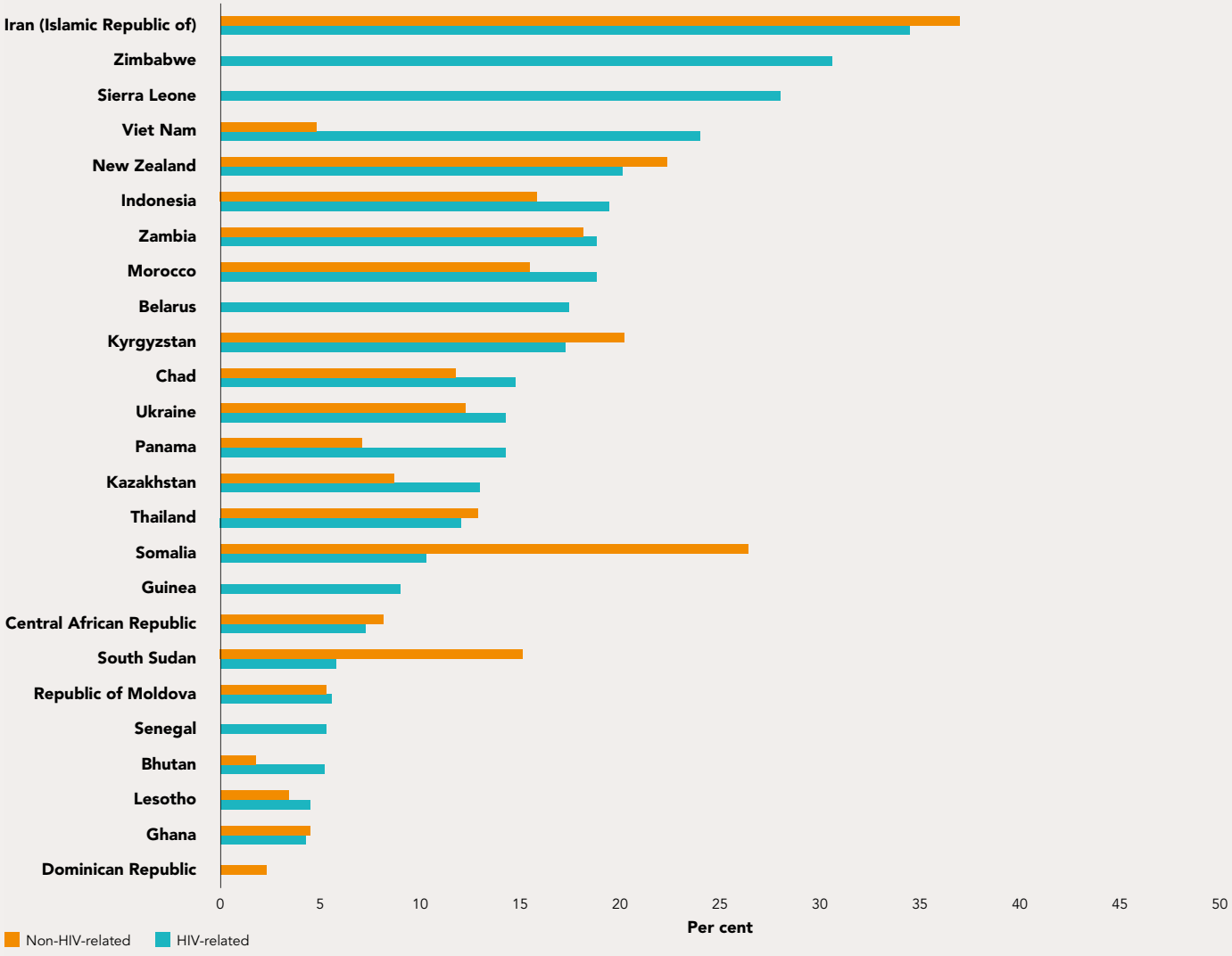
Source: population-based surveys, 2020–2024.

5 Discriminatory attitudes towards people living with HIV are measured as disagreement with two statements on whether the respondent would buy fresh vegetables from a shopkeeper if they knew the person was living with HIV and whether children living with HIV should be allowed to attend school with children who are HIV-negative.

Survey and other data also show that many people living with HIV experience stigma and discrimination when seeking health services (Figure 2.6), including in high-income countries *(25)*. These experiences are associated with lower uptake of HIV testing and antiretroviral therapy and lower levels of viral load suppression, as shown by analysis of data from population-based surveys in sub-Saharan African countries *(26)*. According to People Living with HIV Stigma Index 2.0 surveys done in 25 countries, a third (34%) of people who experienced stigma and discrimination when seeking HIV care went on to interrupt or entirely stop their HIV treatment at some point (compared with 25% for people who did not report such experiences) *(27)*.

People living with HIV are routinely exposed to stigma and discrimination

Figure 2.6. Percentage of people living with HIV who experienced stigma and discrimination due to their HIV status when seeking HIV or other health-care services in the previous 12 months, countries with available data, 2020–2024



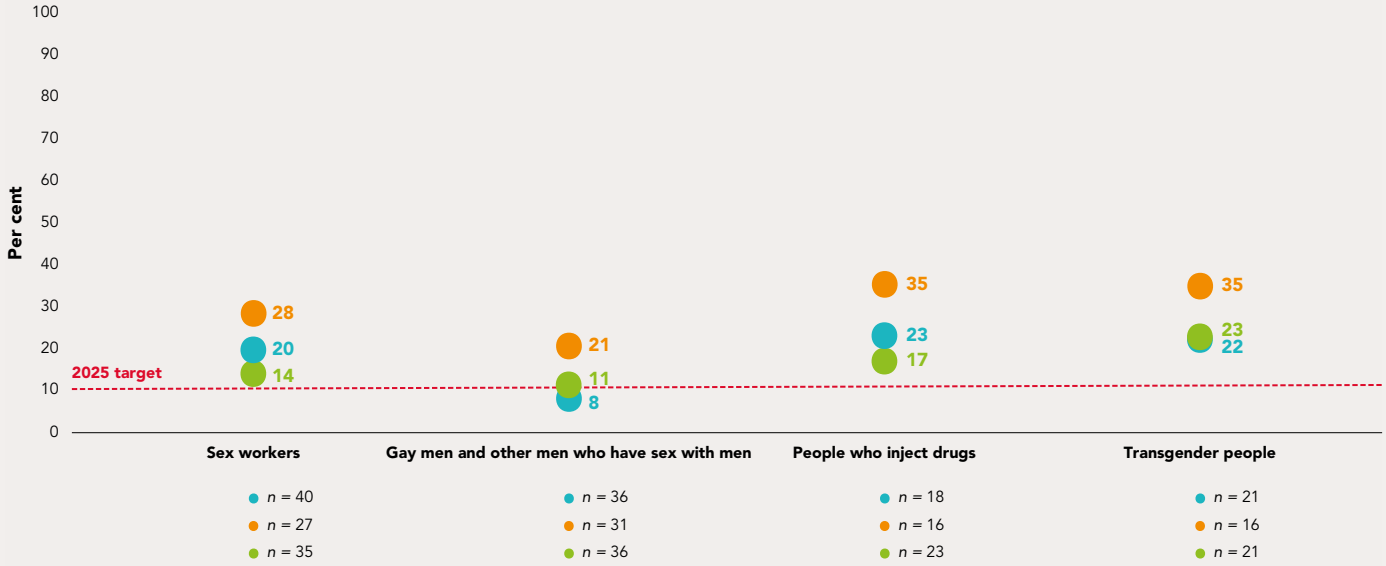
Source: People living with HIV Stigma Index 2.0, 2020–2024.

People living with HIV were also likely to experience stigma and discrimination when seeking non-HIV health services—one in four reported such experiences *(27)*. Efforts to integrate HIV services into broader health-care provision will need to address these realities.

Internalized stigma remains common and is a frequently cited reason for missing health-care visits. An analysis of Stigma Index 2.0 studies from 25 countries found that almost 40% of people living with HIV said they felt ashamed to be living with HIV, and one in five said the fear of revealing their HIV status had led to them missing doses of antiretroviral medicines *(27)*.

People from key populations often experience intersectional stigma, discrimination or violence, which, in addition to doing other harm, deters many of them from using health services. A median of 23% of people who inject drugs (18 reporting countries), 22% of transgender women (21 countries), 20% of sex workers (40 countries) and 8% of gay men and other men who have sex with men (36 countries) reported experiencing physical and/or sexual violence in the previous 12 months (Figure 2.7).

Figure 2.7. Median percentages of people experiencing sexual and/or physical violence, stigma and discrimination, and avoidance of health services among people from key populations, global, 2020–2024



Note: *n* = number of countries.

The 2025 target is to ensure these experiences occur in less than 10% of the population.

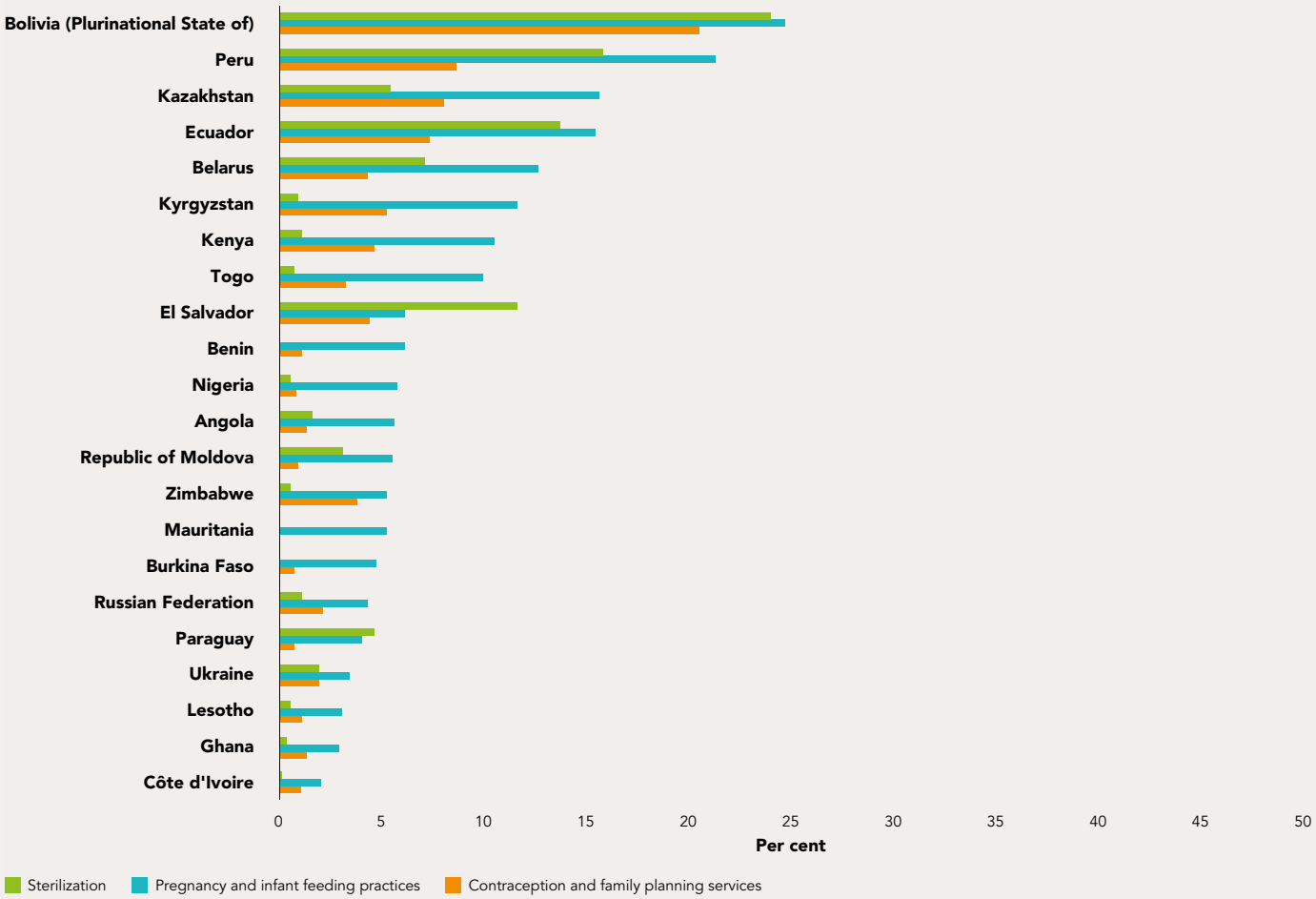
Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/).

Violence must be addressed

Violence against women living with HIV prevents many women from accessing and benefiting from HIV treatment (Figure 2.8). Women who experienced physical intimate partner violence in the previous year were on average 9% less likely to have viral load suppression compared with women who had not experienced such violence, based on analysis of data from seven surveys in sub-Saharan Africa *(28)*. Increasing evidence supports the integration of violence prevention in health-care settings, including adolescent HIV services *(29)*. Recent studies have shown continued high levels of coercion, mistreatment and abuse of women living with HIV when using sexual and reproductive health services, notably in eastern Europe and Latin America *(30)*. According to a study in four Latin American countries, more than 70% of women living with HIV in Latin America report experiencing some form of violence related to their gender and HIV status *(31)*.

Women living with HIV still experience abuse and mistreatment when using sexual and reproductive health services

Figure 2.8. Percentages of women experiencing coercion, mistreatment or abuse when accessing sexual and reproductive health services, by country, 2020–2023



Note: coercion related to contraception and family planning refers to advice or pressure not to have children and incentives to use contraception, including long-lasting forms; coercion related to pregnancy, childbirth and infant feeding refers to pressure to terminate a pregnancy, pressure to have a caesarean section and pressure to use infant formula; coercion related to sterilization refers to pressure to be permanently sterilized.

Source: People Living with HIV Stigma Index 2.0 studies 2020–2023; Confronting coercion: a global scan of coercion, mistreatment and abuse experienced by women living with HIV in reproductive and sexual health services. International Community of Women Living with HIV; 2024.

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STORY

Power to earn and live—overcoming inequalities and supporting women living with HIV in Tajikistan

The day for Safargul begins at 04:00 and rarely ends before midnight. She juggles the demands of raising four children, tending a vegetable garden and managing the household in the small city of Kulyab in Tajikistan. Twice a week, she works at the local AIDS centre as a peer consultant. She supports women newly diagnosed with HIV, helping them understand the importance of starting treatment and not giving up hope.

Safargul has been living with HIV since 2006. No one in her community knows her HIV-positive status. "It would mean the end of normal life," she says. "People would exclude me from gatherings, from everyday conversations."

Her husband and eldest son were migrant workers abroad—just like the husbands of many of the women she now supports. "I see young women infected by their husbands and refusing treatment because they fear someone in the family might find out. They do not know enough, and they have no power to protect themselves," she says.

Safargul is worried that most of these women are economically dependent on their husbands and their families. In Tajikistan, one of the poorest countries in central Asia, nearly 30% of gross domestic product comes from remittances, with many men migrating to Kazakhstan or the Russian Federation for work. According to the National AIDS Center, in 2015 one in eight new HIV cases was linked to male labour migration, but that figure rose to one in three by 2023. As a result, the risk of HIV infection among women—especially in rural communities—has crept up.

Takhmina Haidarova knows this risk firsthand. She was raised in a traditional household and then married a man who worked abroad and rarely came home. After the loss of their child, she hoped another pregnancy would ease the pain—but during a routine check-up, she learned she was living with HIV.

"I did not even know HIV existed in Tajikistan," she recalls. Her husband rejected her, and his family blamed her after he died of an AIDS-related illness. "I had no knowledge, no support, and no one to turn to."

Takhmina now leads the Tajikistan Network of Women Living with HIV. With support from UNAIDS, and together with a local team of researchers, the Network conducted a time-use survey in 2024, which revealed the systemic inequalities facing women living with HIV. Nearly 80% are homemakers and spend more than eight hours a day on unpaid labour. Most need permission from their husbands to visit a health facility. For many women, autonomy over health decisions comes only after divorce or widowhood. Tragically, 97% of women living with HIV in Tajikistan hide their HIV-positive status, even from family members.

"My mother-in-law knows her son infected me," one woman says, "but still she will not accept a cup of tea from me."

For Zarina from Tursunzade, change began with business skills training and a small grant from UNAIDS and UN Women. After leaving an abusive marriage and becoming a single mother, she built a sewing business that now employs women living with HIV. She also teaches women affected by HIV—including those in remote rural areas—how to start their own small sewing businesses.

"Thanks to this support, I became independent—and I can help others who were abandoned like I was," she says.

UNAIDS Country Director in Tajikistan, Aziza Hamidova, refers to the recent gender assessment study led by UNAIDS, which concluded that restrictive gender norms, entrenched practices, stigma, discrimination and gender-based violence hinder timely access to health services, including for HIV. "The HIV response must reflect the real lives of women," she says. "It must support their right to grow, earn and live with dignity."

Progress in supporting HIV services for women is fragile. Funding cuts as small as 10–20% could reverse years of gains. More than 60% of the HIV response in Tajikistan is funded by the Global Fund and PEPFAR with the United States Government, and only 37% is funded domestically. UNAIDS and partners are worried that funding cuts may deepen deprivation and perpetuate stigma, leaving women living with HIV to bear the burden of survival and exclusion. "Investing in women's health, safety and economic power is not just smart—it is urgent," Aziza says.

People must be able to report, challenge and seek redress for discrimination, harassment and violence. As of 2024, less than half of 92 reporting countries (48%) had mechanisms established by the government and a third (34%) had mechanisms established by community or nongovernmental organizations to assist people to register complaints and seek redress for discrimination related to their HIV status or for being a member of a key population *(32)*.

These mechanisms should be publicized and accessible to the people who need them. Data reported by community and civil society representatives from 117 countries show that such awareness remains limited. Affordability constraints were reported in 66 of these countries and the mechanisms were reportedly not functioning in 47 countries *(32)*.

Preventing and treating cervical cancer

Cervical cancer is the fourth most frequent cancer in women and the most common cancer among women living with HIV *(33)*—and yet it is preventable and curable. Estimated coverage of first-dose human papillomavirus (HPV) vaccination in 2023 in countries that have introduced HPV into the routine immunization system was about 71% in the World Health Organization (WHO) African Region *(35)*.

2.3 HIV treatment coverage among pregnant women has risen unevenly, leaving children at risk of HIV

HIV acquisitions among children have been reduced to their lowest levels since the early years of the epidemic. This decrease is due mainly to two impressive achievements: far fewer women of reproductive age are acquiring HIV, and women living with HIV are more likely to receive and continue taking their antiretroviral medicines. HIV treatment coverage among pregnant women living with HIV is 84% [72–>98%] globally and was 93% [81–>98%] in eastern and southern Africa in 2024. There has, however, been very little increase in this coverage over the past decade.

In addition, the gains are spread unevenly. Gaps and deficiencies in HIV programmes and health systems meant that an estimated 120 000 [82 000–170 000] children still acquired HIV in 2024, the vast majority (83%) of whom were in sub-Saharan Africa. New infections among children in eastern and southern Africa have decreased substantially (by 71% from 2010), but the decline in western and central Africa has been much less pronounced (by 53% from 2010) (Figure 2.9). As a result, 36% of all child HIV infections now occur in western and central Africa. Most of these infections are attributable to mothers living with HIV not receiving or not being able to keep

taking their antiretroviral medicines (Figure 2.10). Only about 56% [47–71%] of pregnant women living with HIV in this region were receiving antiretroviral medicines to prevent vertical transmission of HIV in 2024.

Greater access to antenatal care and integration of antenatal services with HIV testing and treatment will improve health outcomes for mothers and their children. Following the funding cuts of early 2025, however, the number of pregnant women tested for HIV or known to be living with HIV has declined generally, including in Nigeria and Rwanda *(36)*.

In eastern and southern Africa, almost a third of new acquisitions in children (32%) are attributable to women acquiring HIV during pregnancy or in the postnatal period. This can also be remedied—for example, by making it much easier for pregnant or breastfeeding women to access and use long-acting versions of PrEP. Other steps include encouraging their male partners to test for HIV so that appropriate precautions can be taken *(37)*. In addition, studies show that communities of women living with HIV, such as Mentor Mothers, can make a substantial difference to rates of vertical transmission *(38)*.

About a quarter of all pregnant women or mothers living with HIV are aged 15–24 years.

More can be done to support young mothers living with HIV

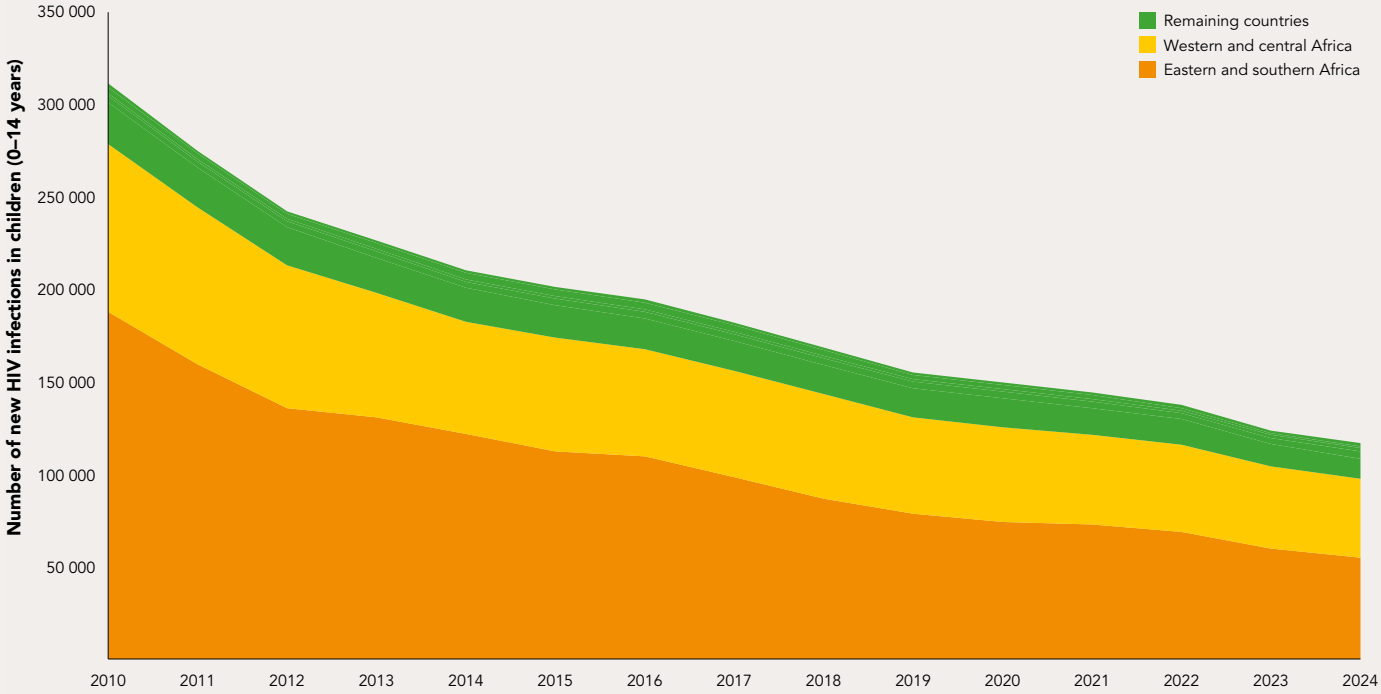
Young mothers living with HIV are especially in need of greater support. About a quarter of all pregnant women or mothers living with HIV are aged 15–24 years. Many of these women face major challenges that call for age-differentiated pregnancy and postpartum care.

Improvements include antenatal care services that address the special concerns and needs of young mothers living with HIV, easier access to sexual and reproductive health services, and stronger engagement of male partners as part of antenatal care. Also important are differentiated HIV treatment and adherence support services, including community-led activities that assist marginalized adolescents and young women.

Mentor mother programmes in several African countries are supporting adolescents who are pregnant or parenting with skills and assistance to access services for HIV, sexually transmitted infections, sexual and reproductive health and rights, mental health and nutrition. Mothers2Mothers, for example, harnesses the skills and experience of young mothers living with HIV to help peers access and stay on HIV treatment and to offer parenting guidance and support (see Chapter 4).

The largest decline in pediatric HIV infections has been in eastern and southern Africa

Figure 2.9. Trends in numbers of HIV acquisitions in children (0–14 years), by region, 2010–2024

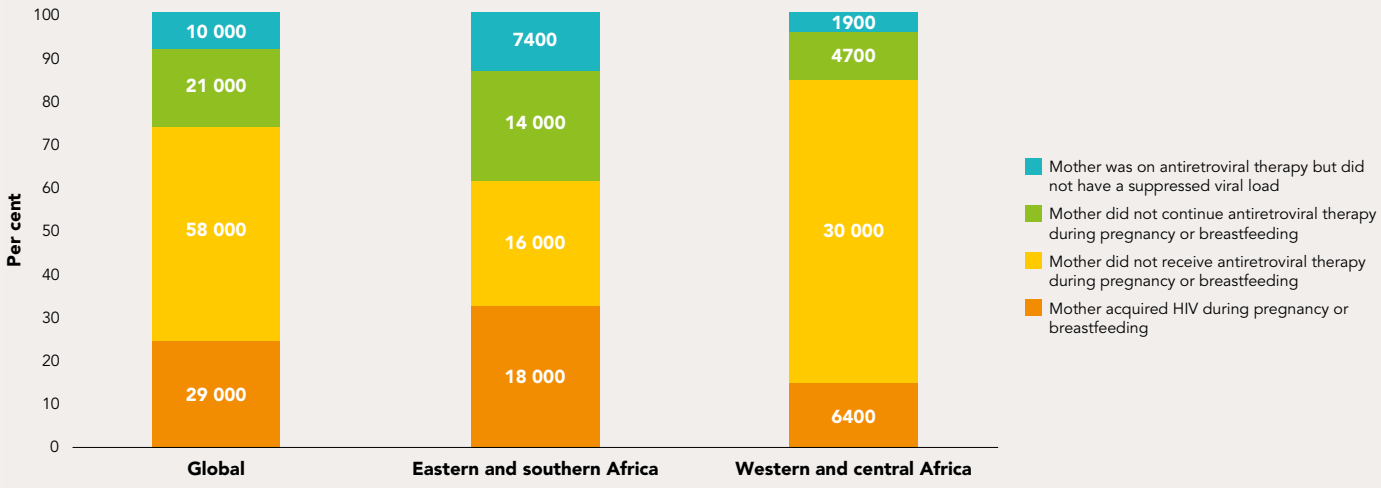


Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

In eastern and southern Africa, almost a third of new acquisitions in children are attributable to women acquiring HIV during pregnancy or in the postnatal period.

The main reasons for vertical transmission of HIV differ between regions

Figure 2.10. Stack-bar analysis of reasons for new HIV acquisitions among children, 2024



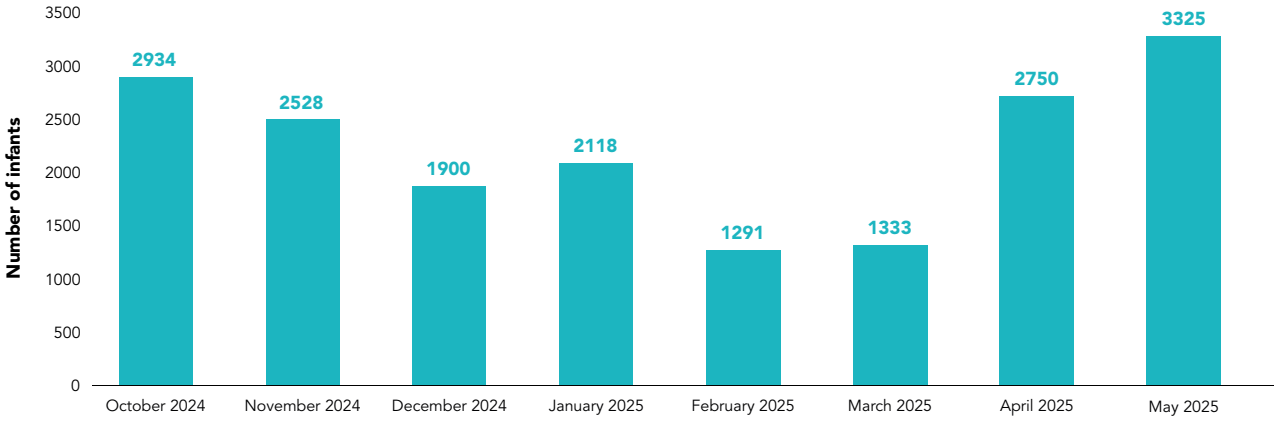
Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

How to diagnose more children who have acquired HIV

The missed or delayed diagnosis of HIV in infants and children is a major reason for the low treatment coverage and high mortality among those living with HIV. This can be addressed through wider availability and use of early infant diagnosis within the first two months after birth for babies exposed to HIV. In 2024, coverage of early infant diagnosis among children in eastern and southern Africa reached 74% (and exceeded 80% in some countries), but it was only 30% in western and central Africa (with coverage exceeding 50% in very few countries). Following the funding cuts to the PEPFAR programme in early 2025, access to early infant diagnosis declined markedly in Botswana, Burundi and Kenya *(39)*. Data from more recent data suggest that the Government is mitigating the impact in Kenya (Figure 2.11).

Early infant diagnosis alone is not enough to close the treatment gap for children. Eighty-nine per cent of children living with HIV are aged two years or over, and many of them are undiagnosed. Identifying these children and linking them to lifesaving HIV treatment and care require the greater use of differentiated HIV testing methods, including integration with maternal and child health programmes, outpatient testing (e.g. linked to vaccination programmes), family-based testing and index testing (e.g. of parents who are living with HIV and enrolled in care) and self-testing.

Figure 2.11. Number of infants who received an HIV test within two months of birth, Kenya, October 2024 to May 2025



Source: country-reported data through the monthly Global AIDS Monitoring platform (https://hivservicestracking.unaids.org/).

The gap in treatment for children living with HIV is unacceptable

Testing and treatment services are still missing large numbers of children living with HIV. A little over half of all children living with HIV globally (55% [40–73%]) were receiving antiretroviral therapy in 2024, up from 17% [12–22%] in 2010. But this was still much lower than the 78% [62–91%] coverage among adults living with HIV.

About 620 000 [490 000–800 000] of the estimated 1.4 million [1.1 million–1.8 million] children living with HIV were *not* receiving antiretroviral therapy in 2024. Of these children, about 40% were aged under five years. Without effective antiretroviral therapy, children with HIV face alarmingly high mortality rates: 50% of children infected perinatally die by age two years, and 80% die by age five years *(40)*.

Gaps at each stage of the testing and treatment cascade are undermining efforts to reach all children living with HIV with lifesaving treatment. In addition, there continue to be significant gaps in the care for children with advanced HIV disease, responding to second-line treatment failure, and treatment management for adolescents living with HIV *(41)*. Early diagnosis, rapid linkage to care, prompt initiation on effective antiretroviral therapy for children living with HIV, and re-engagement with antiretroviral therapy for children who drop out of care remain major priorities *(40)*.

The challenge of treatment interruption among children and adolescents

Interruptions in HIV treatment among young children living with HIV are associated with high mortality rates. Between 14% and 19% of children aged under one year living with HIV who experienced an interruption in treatment in 2024 had died, according to a review of more than half a million children receiving HIV treatment through PEPFAR programmes *(42)*. An earlier cohort study in southern Africa found that treatment interruption during the first six months of antiretroviral therapy increased the risk of death in children living with HIV by 52% *(43)*.

Wider access to child-friendly dolutegravir-based antiretroviral therapy is expected to improve treatment adherence and outcomes for children *(44)*. More than 90 countries were procuring this WHO-recommended regimen by the end of 2023 (up from 33 countries at the end of 2021) *(45)*. Studies show that rates of viral suppression in children and adolescents increased in the two years following the transition to dolutegravir *(46)*. Consolidating these benefits also requires routine viral load testing, regular treatment monitoring and patient tracking to reduce treatment interruptions and allow counter-measures to be taken quickly *(47, 48)*.

Treatment adherence can be difficult for adolescents living with HIV, who are also contending with transitions to adulthood and other adversities such as stigma and discrimination, lack of social support, and the perceived distrust of health workers.

Interventions that emphasize treatment literacy, provide counselling and social support, and guard privacy and confidentiality appear to be acceptable and effective for improving treatment adherence among adolescents *(49)*. Interventions that plan and deliver services according to the situations and needs of individuals are associated with improved antiretroviral therapy retention and viral suppression, according to a recent systematic review of studies *(50)*. There are indications that economic incentives and cash transfers may help improve retention in care *(51, 52)*, although the overall evidence is mixed *(52)*.

2.4 Linked HIV and TB services are saving millions of lives

The linking or integration of HIV and tuberculosis (TB) services is having a significant impact on the health of people living with HIV and TB. Antiretroviral therapy and TB treatment for people living with both HIV and TB averted an estimated 6.8 million [5.9 million–7.7 million] deaths between 2010 and 2023 *(53)*.

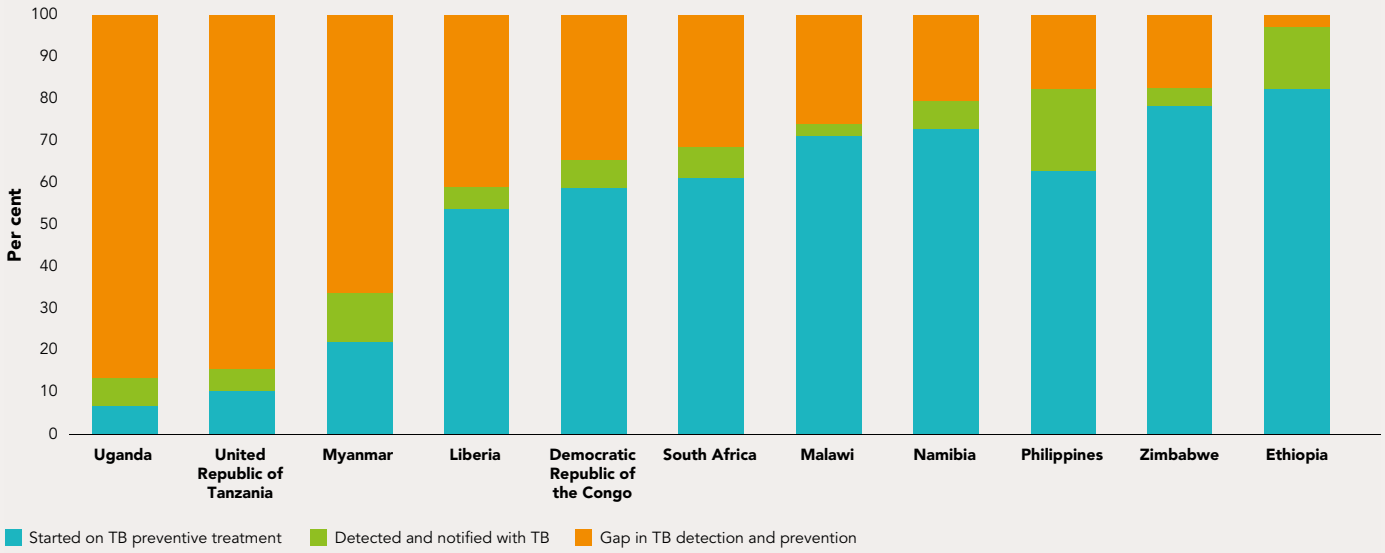
The global coverage of antiretroviral therapy for people living with HIV who were newly diagnosed with TB remained at 89% in 2022 and 88% in 2023. Compared with the total estimated number of people living with HIV who developed TB in 2023, however, coverage was much lower, at 58% (which was slightly higher than the 56% coverage in 2022). These treatment coverage levels are markedly lower than for all people living with HIV (75% in 2023). The main reason for the disparity was the big gap between the estimated number of people living with HIV who developed TB in 2023 (a best estimate of 662 000 [589 000–739 000]) and the reported number of people living with HIV who were diagnosed with TB in 2023 (approximately 437 000).

Since people living with HIV are especially susceptible to other infectious diseases, it is important that they also receive TB preventive therapy. These services have grown exponentially in the past two decades. The global number of people receiving both HIV treatment and TB preventive therapy increased from fewer than 30 000 in 2005 to 3.0 million in 2019, but the number then decreased to 2.4 million in 2020, 2.2 million in 2021 and 1.9 million in 2022, followed by a small increase to 1.96 million in 2023. Possible reasons for the reductions include disruptions to health services caused by the COVID-19 pandemic and a drop in the number of countries reporting these data during that pandemic.

There continue to be opportunities to further integrate and improve these services. Some countries with high burdens of both HIV and TB are still struggling to detect TB or provide TB preventive therapy for people newly enrolled on antiretroviral therapy (Figure 2.12). Overall, the median gap in TB detection and prevention was 50% in 2023 across 48 countries reporting these data. Closing this gap through further integration requires some basic health system improvements, including for procurement and distribution of medical supplies, observance of treatment guidelines and protocols, and reduction of HIV- and TB-related stigma among health-care staff.

Some countries have opportunities to close gaps in preventing or detecting TB among people living with HIV

Figure 2.12. Gaps in TB detection and prevention among people newly enrolled on antiretroviral therapy, high TB/HIV burden countries with available data,[a] 2023



[a]Countries included in this figure are in the WHO global list of high-burden countries for HIV-associated TB and had available data. For more information on the list of high-burden countries, see Annex 3 of the WHO Global tuberculosis report 2024.

Source: Global AIDS Monitoring 2024; Global tuberculosis report 2024. Geneva: World Health Organization; 2024.

2.5 HIV testing and viral load suppression levels are high—but not everywhere

Globally, about 35.5 million [28.3 million–41.2 million] of the estimated 40.8 million [37.0 million–45.6 million] people living with HIV (87% [69–>98%]) in 2024 knew their HIV status. Testing programmes were performing especially well in eastern and southern Africa and in the mostly high-income countries in western and central Europe and North America: 93% [75–>98%] of people living with HIV in eastern and southern Africa knew their HIV status in 2024, and 89% [69–>98%] of people living with HIV in central Europe and North America.[6] Even then, this left about one in seven people living with HIV globally not knowing they had acquired HIV, not receiving lifesaving treatment, and at risk of unwittingly transmitting HIV to other people. Hostile social environments and punitive laws deter many people from key populations from using testing services, while misconceptions about the risk of acquiring HIV stigma, criminalization of HIV transmission, and a fear of discovering that one is living with HIV also discourage many people from taking an HIV test *(54)*.

6 The latest region-wide estimate for western and central Europe and North America dates to 2022.

HIV self-testing offers perhaps the most promising way to diagnose more people living with HIV.

Data reported to UNAIDS indicate that in 2024, a median of 81% of gay men and other men who have sex with men (71 reporting countries), 80% of transgender people (36 countries), 79% of sex workers (67 countries) and 70% of people who inject drugs (47 countries) had taken an HIV test and received the results in the previous 12 months or had previously tested positive for HIV.

Systematic reviews of studies from Africa point to community-based testing approaches (e.g. at mobile units, community venues or homes) as effective ways to increase testing uptake, including among men, due to the greater convenience they offer *(14, 55)*. Also successful are social network-based approaches (which encourage people to motivate sexual partners and members of their social networks to test for HIV), as shown in a systematic review of studies that focused mostly on transgender women and gay men and other men who have sex with men *(56)*. HIV self-testing offers perhaps the most promising way forward to diagnose more people living with HIV, including young people, men and people from key populations.

HIV self-testing holds great promise

HIV self-testing is a highly promising and affordable strategy. It offers more privacy and convenience and can be integrated easily into community-led testing efforts. Recently analysed data from a self-testing programme in Côte d'Ivoire, Mali and Senegal show that community-led distribution of HIV self-testing kits can increase HIV status awareness, reduce numbers of HIV acquisitions and deaths, and improve the efficiency of resource allocation. Over three years, female sex workers and gay men and other men who have sex with men distributed 380 000 test kits to peers, who then further distributed the kits to their partners and clients *(57)*.

Linkage to confirmatory testing and antiretroviral therapy initiation after self-testing is generally high, particularly when assisted testing is available or when people obtain their test kits through a social network-based approach, according to a large review of studies, most of them focused on key populations in Africa *(58)*. A global systematic review of 15 studies found that HIV self-testing improved linkage to care among female sex workers (compared with standard testing approaches) *(59)*.

HIV self-testing appears to be highly acceptable among men *(60)*, especially when the test kits are available at low cost or free of charge. Linkage to care, however, may be challenging, with factors including travel and opportunity costs to attend clinics, long waiting hours at clinics, apprehension about stigma and discrimination, and privacy concerns *(61)*.

Viral suppression levels have risen, but treatment interruption remains a concern

When people living with HIV are able to adhere to their antiretroviral therapy regimens and have viral suppression, their HIV infection no longer threatens their health and they cannot transmit HIV to other people. Globally in 2024, an estimated 73% [66–82%] of people living with HIV had a suppressed viral load—a huge public health achievement. Some people, however, struggle to remain in HIV care and keep taking their antiretroviral medicines. Viral suppression levels among men (69% [61–77%]) and children (47% [38–60%]) living with HIV are much lower than among women living with HIV (79% [71–88%]).

Interrupting or halting antiretroviral therapy can result in viral rebound, increased susceptibility to HIV-related and other diseases, increased drug resistance, and a higher chance of AIDS-related death. There is increasing evidence, including from Europe and North America, of higher mortality among people living with HIV who interrupt their care—even when they subsequently restart treatment and care *(62)*. Analysis of data from South Africa has also revealed increased mortality among people resuming their HIV treatment after interruptions, compared with people with no interruption *(63)*.

Common reasons for interrupting antiretroviral therapy include treatment side-effects, difficulties taking daily pills, migration and mobility, not being able to attend routine clinics appointments, and the debilitating effects of HIV-related stigma *(63)*. Feelings of shame and loss of dignity appear to be major barriers to men's continued engagement in care. Imprisonment or detention can also lead to treatment interruption *(64)*.

Some of the underlying causes of treatment interruption can be tackled by reducing waiting times at clinics, improving treatment literacy, reducing stigma from health-care workers, avoiding antiretroviral medicine stockouts, and making it easier for people to transfer between facilities *(65)*. Peer and psychosocial support can make it easier for people to remain in care *(66–68)*, although studies note that these interventions need to be tailored also for men *(69)*. There is now the added risk that service disruptions and potential stockouts due to funding losses will make it more difficult for people to adhere to HIV treatment and have viral load tests so they can receive the most appropriate antiretroviral regimens. This would harm their health and set back efforts to further reduce numbers of new HIV infections.

Interrupting or halting antiretroviral therapy can result in viral rebound, increased susceptibility to HIV-related and other diseases, increased drug resistance, and a higher chance of AIDS-related death.

Staying on treatment can be a challenge—and funding cuts are not helping

Supporting people living with HIV so they can adhere to treatment and quickly tracing and re-engaging people who interrupt their treatment is of paramount importance to save more lives and avert more new HIV infections.

When people stop taking their antiretroviral medicines, even people with previously suppressed HIV can experience a rapid increase in viral load, often reaching detectable levels within days to a few weeks *(70)*. This viral load rebound elevates the risk of HIV transmission, rendering people infectious shortly after stopping antiretroviral therapy *(71)*. The higher the viral load, the higher the infectiousness, particularly impacting sexual and vertical transmission.

Drug resistance can develop within several weeks of stopping treatment. Studies from low- and middle-income countries in recent years have found rates of resistance to dolutegravir-based antiretroviral regimens of between 4% and 20% *(72)*. If more people interrupt their treatment, drug resistance can be expected to increase. This will make HIV treatment more complicated and costly at a time when funding support is being cut back, and it will increase the risk of new HIV transmissions.

Well-functioning health information systems and person-centred approaches are vital to avoid treatment interruptions and re-engage people who drop out of care. People encountering friendlier, more supportive attitudes from health-care workers are more likely to return to care, as shown in a recent study carried out at 24 clinics in Zambia. The improvements were achieved through training and coaching, feedback from clients, and facility-level incentives such as recognition for staff performance *(73)*. Peer support groups help people adhere to their treatment and return to care, as the Men's Forum has shown in Johannesburg, South Africa *(74)*. Low-cost counselling provided by lay counsellors and tailored for dealing with the issues and concerns men face can help re-engage more men in HIV care *(75)*. Telehealth interventions appear to improve adherence to treatment *(76)* and help reduce depressive symptoms among people living with HIV *(77)*.

Advanced HIV disease poses a continuing challenge

Over the past decade and across regions, a persistent 25–40% of people living with HIV have had advanced HIV disease (CD4 count <200 cells/mm^3) when diagnosed or initiating antiretroviral therapy, according to several large datasets.[7] There is no evidence that this has changed in recent years *(78)*. People with advanced HIV disease have increased risk of death, most commonly due to TB, cryptococcal meningitis or severe bacterial infections *(79, 80)*.

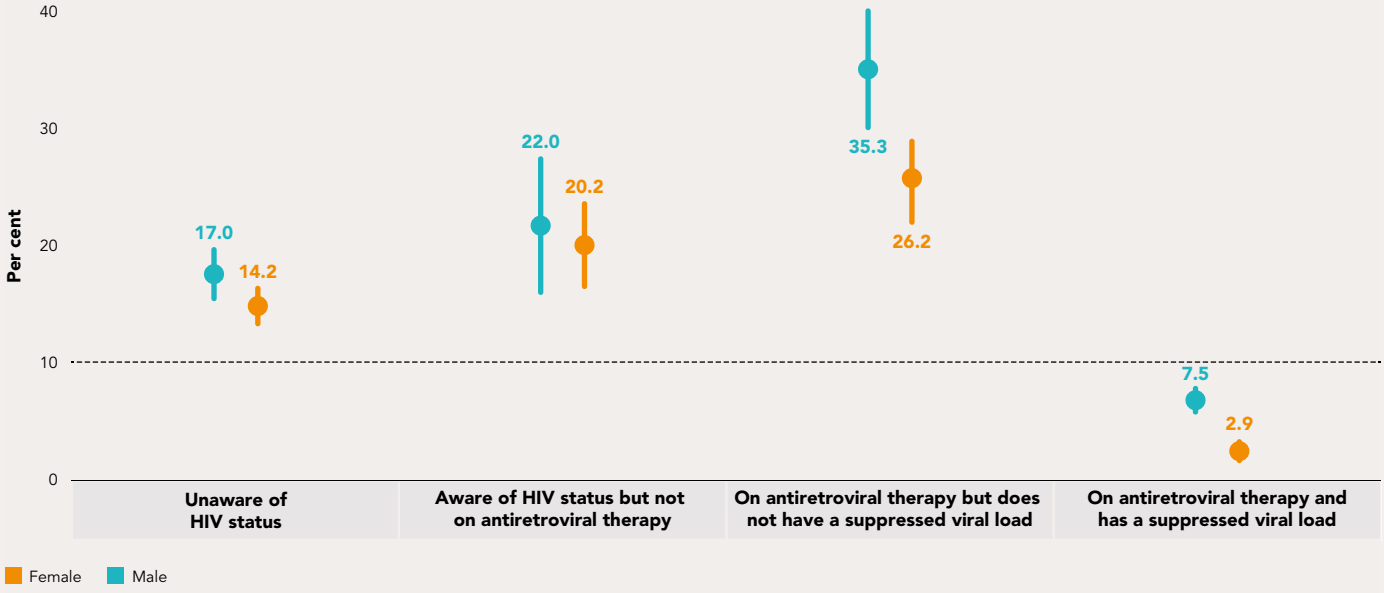
7 A CD4 count below 500 cells/mm^3 indicates a weakened immune system. A count below 200 cells/mm^3 indicates advanced HIV disease, or AIDS.

People living with HIV who have never received treatment, start treatment late, receive suboptimal treatment or stop treatment are prone to advanced HIV disease. Analysis of data from 13 major surveys in sub-Saharan Africa conducted between 2016 and 2021 found that men were almost twice as likely as women to have advanced HIV disease—13% of men and 8% of women had a CD4 count below 200 cells/mm^3 *(81)*. Confirming other studies, the analysis also found that the prevalence of advanced HIV disease was highest among people who were receiving HIV treatment but did not have viral suppression (Figure 2.13).This does not suggest that antiretroviral therapy is not working. Many of these people may have started antiretroviral therapy late, with very severely compromised immune systems that take longer to repair; others may have intermittently interrupted their treatment. The overall trend highlights an ongoing need for early diagnosis and rapid antiretroviral therapy initiations for people living with HIV; screening, treatment and prophylaxis for major opportunistic infections; and intensified adherence support interventions.

Of additional concern is the decline in CD4 testing in most regions, most notably in eastern, central and southern Africa *(82)*. Routine CD4 testing is important for managing HIV treatment, including screening for advanced HIV disease and early detection of treatment complications. Specific diagnostic tests for commonly fatal advanced HIV disease conditions such as TB and cryptococcal meningitis are not widely available, especially in primary care settings. There is a major risk that the funding losses for HIV programmes will further weaken country capacities to maintain this vital component of successful HIV treatment efforts.

The prevalence of advanced HIV disease is surprisingly high among people on antiretroviral therapy, and especially among men

Figure 2.13. Percentages of people living with HIV with advanced HIV disease at different stages of the testing and treatment cascade, 13 sub-Saharan African countries, 2015–2021



Source: Stelzle D, Rangaraj A, Jarvis JN, et al. Prevalence of advanced HIV disease in sub-Saharan Africa: a multi-country analysis of nationally representative household surveys. Lancet Glob Health. 2025;13(3):e437–e446 (https://doi.org/10.1016/S2214-109X(24)00538-2).

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Chapter 3

HIV PREVENTION IS IN JEOPARDY

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3.1 HIV prevention is having an impact

Decades of hard work and innovation by communities, governments and scientists have reduced the number of people acquiring HIV to its lowest point in almost three decades. An estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2024—40% less than in 2010, but still more than three times the 2025 target of 370 000 or fewer new infections.

These prevention gains are uneven, and they are advancing too slowly to end AIDS as a public health threat by 2030 (Figure 3.1). Far too many people who are most at risk of acquiring HIV are still not able to make use of the tools and services that can protect them against the virus. HIV prevention programmes have long been underresourced and are now being hit hard by funding losses. Countries, communities and their partners must regroup rapidly to stop the HIV response from derailing.

There has been a 56% drop in the number of new infections since 2010 in sub-Saharan Africa, which was home to about half of all people who acquired HIV globally in 2024. Fewer adolescent girls and women are acquiring HIV, but they continue to face a disproportionately high risk of HIV in much of sub-Saharan Africa.

Numbers of new HIV infections are still increasing in the Middle East and North Africa. In Latin America and eastern Europe and central Asia, numbers of new HIV infections have increased in recent years but are starting to level off. In Asia and the Pacific, the Caribbean, and western and central Europe and North America, numbers of new HIV infections are decreasing slowly. Asia and the Pacific accounts for about 23% of all new infections globally.

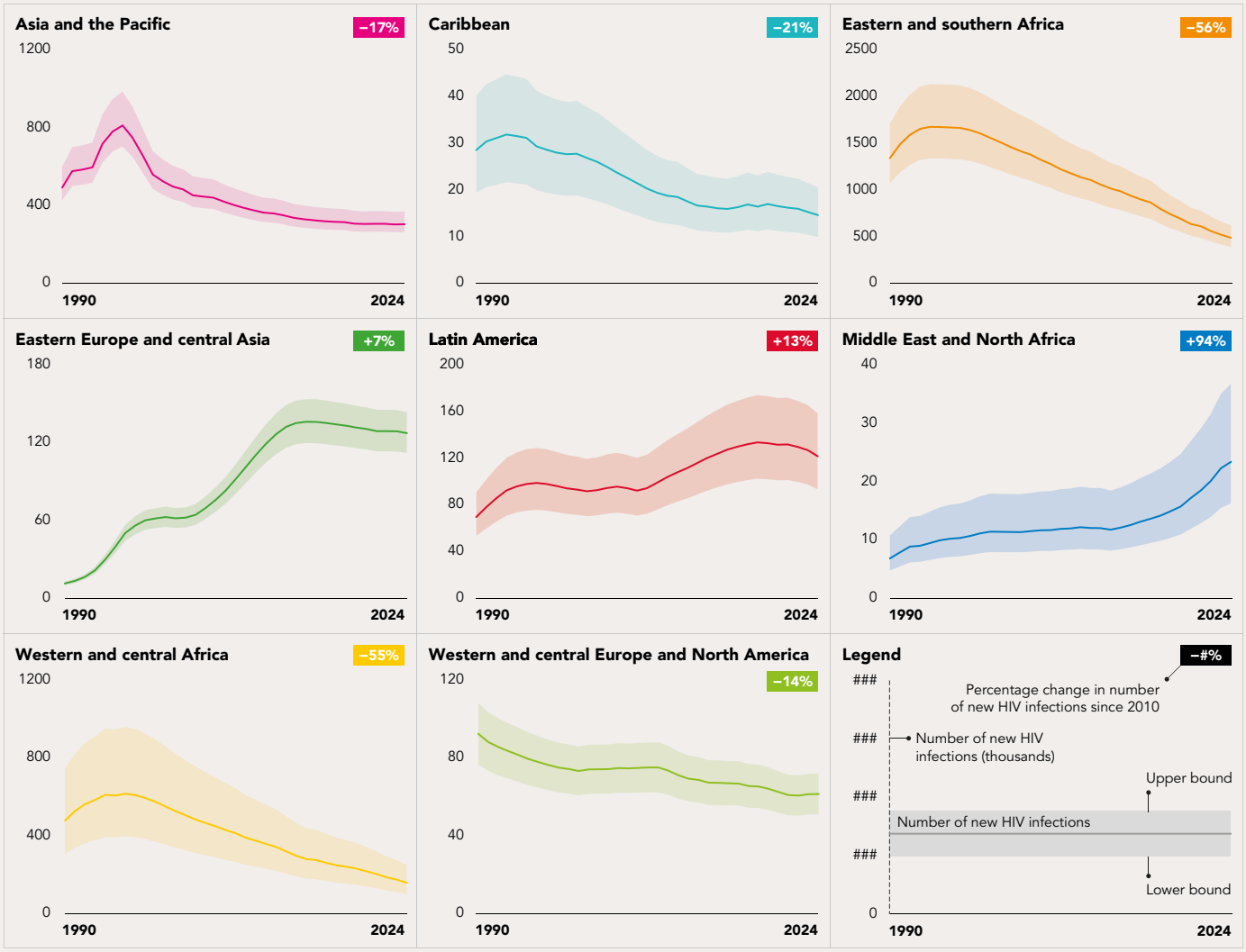
Over 50% of new HIV acquisitions are among people from key populations and their sex partners *(1)*. People from key populations and their sex partners continue to be neglected in HIV programmes, even in places where the epidemic affects them the most.

Spending patterns remain misaligned to the needs and realities of the epidemic. In recent reporting to Global AIDS Monitoring, only 10–12% of total HIV spending (among 88 countries reporting on expenditures) was directed towards HIV prevention, which was half of the average 24% share of spending needed across low- and middle-income countries to reach the 2030 prevention targets. Only 2.6% of total HIV funding was spent on programmes for key populations, despite their disproportionately high share of new infections.

These trends are not sustainable. At the current rate of increase of new HIV infections, the number of people living with HIV and requiring lifelong treatment will keep growing. Even if the HIV response stays on the course it was on before the recent funding cuts, about 46 million people will be living with HIV in 2050 *(2)*.

The impact of HIV prevention on reducing new HIV infections is mixed

Figure 3.1. Numbers of new HIV infections (thousands), by region, 1990–2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

Primary prevention implemented at scale and, after 2010, widening access to HIV treatment are the main reasons for the drop in the number of new HIV infections. People with an undetectable viral load have zero risk of transmitting HIV to their sex partners, and people with a suppressed viral load have a near-zero risk of doing so *(3, 4)*.[1] Treatment alone, however, is not enough. Mathematical modelling using data for eastern and southern Africa, for example, shows that reaching the 95–95–95 targets (while maintaining current prevention coverage) will not achieve the 2030 prevention target *(5)*.[2]

1 A person's viral load is undetectable when it is so low that a polymerase chain reaction test cannot measure it. A suppressed viral load is defined as equal to or less than 1000 copies/mL.

2 This target calls for reducing the number of new HIV infections in 2030 by 90% compared with 2010.

There are obvious areas for improvement:

- Condom and voluntary medical male circumcision (VMMC) programmes are faltering in countries with some of the largest HIV epidemics, and breakthrough prevention options such as long-acting pre-exposure prophylaxis (PrEP) are available to only a small fraction of the people who can benefit from them.
- In many regions, comprehensive prevention services for people from key populations are reaching less than half the people who need them, and almost no country is meeting the global harm reduction targets.
- New generations of young people are missing out on prevention interventions and services that can help protect them against HIV.
- Harmful gender norms, stigma, discrimination, criminalization, violence and socioeconomic inequalities continue to be barriers to HIV prevention, especially for adolescent girls and young women.

The world has the knowledge and proven tools to drastically reduce new HIV infections everywhere to the levels that will end AIDS as a public health threat. A growing number of countries are using these resources to huge effect, but many other countries are not showing the same resolve. The deep cuts applied to international development assistance for HIV now threaten to impede further progress.

For every person who received prevention services in 2024, three others were left unprotected.

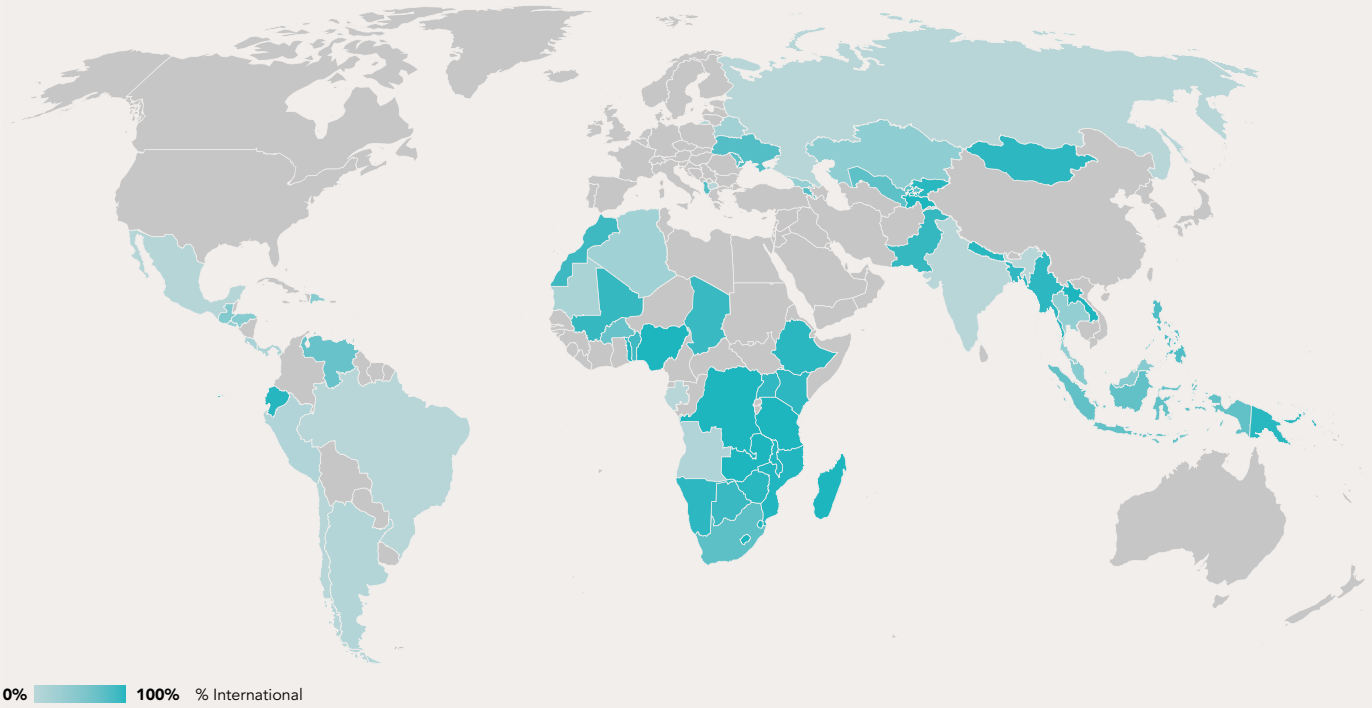
Effects of the funding cuts on HIV prevention

Primary HIV prevention programmes have been underfunded in all regions. An estimated US$ 1.7 billion–2.1 billion was available for primary prevention programmes in low- and middle-income countries in 2024 *(6)*, which is about a third of the estimated annual need of US$ 5.3 billion in 2030. This means that for every person who received prevention services in 2024, three others were left unprotected.

The bulk of HIV prevention funding in many countries has come from external sources (79% in western and central Africa, 78% in eastern and southern Africa, 66% in the Caribbean, and 60% in the Middle East and North Africa). Only 18 of the 82 countries reporting these data financed more than a quarter of their HIV prevention programmes with domestic funds (Figure 3.2). The abrupt HIV funding freezes and cuts imposed in early 2025 are now pushing many of the donor-reliant programmes into crisis.

HIV prevention in many countries has relied heavily on donor funding

Figure 3.2. Proportions of HIV prevention funding coming from international sources, 2025



Source: UNAIDS financial estimates using latest available prevention funding data from global AIDS Monitoring, national AIDS spending assessments, PEPFAR Panaroma Spotlight, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Loss of funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR) for HIV prevention in particular is a major concern. In addition to strengthening health systems, helping to establish supply chains for HIV commodities and supporting societal enabler programmes, PEPFAR greatly supported the provision of effective biomedical and behavioural prevention services, including community-led services, in more than 50 countries. It reached 2.3 million adolescent girls and young women with comprehensive HIV prevention services; enabled 2.5 million people to use HIV PrEP; provided almost 84 million people with HIV testing services; and directly supported more than 340 000 health workers. PEPFAR also expanded access to highly effective services to prevent vertical transmission of HIV, averting an estimated 7.8 million HIV acquisitions in babies *(7)*.

The wave of funding losses has already disrupted supply chains, led to the closure of health facilities, left thousands of community health workers jobless, set back PrEP programmes, and forced numerous community organizations to reduce or halt their HIV activities *(8)*. The losses might also compel countries to reallocate funding from prevention and testing services to purchasing antiretroviral medicines, which would further degrade primary prevention activities *(9)*.

Already marginalized, people from key populations are especially vulnerable to these setbacks. Prevention services for people from key populations have relied heavily on external assistance and were already underfunded, but a great deal of this support was halted in early 2025. Prevention services for young people, especially adolescent girls and young women in sub-Saharan Africa, are also being defunded *(10)*. Funding cuts to societal enabler interventions will make it even more difficult to overcome the structural barriers that hold back HIV prevention.

The full impact is still accumulating (see Chapter 1). Unless addressed, this massive and sudden withdrawal of financing support could trigger a return to the early 2000s, when well over 2 million people acquired HIV each year. Permanent termination of HIV programmes receiving external funding could result in over 6.6 million additional new HIV infections globally between 2025 and 2029 *(11, 12)*, with other studies presenting similarly dire forecasts (see Chapter 1) *(9)*.

Key populations are still being left behind

Efforts to protect key populations from HIV continue to be irregular and inadequate. Key populations and their sex partners bear the burden of about 25% of new HIV acquisitions in sub-Saharan Africa and 80% of new acquisitions in the rest of the world *(1)*. HIV programmes and investments do not yet reflect this reality. Across most regions, more than half of people from key populations are not being reached with basic HIV prevention services (Figure 3.3).

A median of only 38% of gay men and other men who have sex with men (27 reporting countries) and 39% of people who inject drugs (22 countries) accessed at least two prevention services in the previous three months. The coverage and use of combination HIV prevention among sex workers is also low, with a reported median of only 47% receiving at least two prevention services in the previous three months (33 countries). Corresponding median coverage among transgender people was 44% (15 countries). People in prisons and other closed settings are still routinely neglected in HIV prevention programmes.

Permanent termination of HIV programmes receiving external funding could result in over 6.6 million additional new HIV infections globally between 2025 and 2029.

STORY

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As HIV infections soar due to injecting drug use, harm reduction should be a priority in Fiji

Kalesi Volatabu, founder of Drug-Free World Fiji, breaks the ice at drug awareness sessions by sharing her shocking story.

When she was 13, her parents sent her to relatives in Sydney for what she thought was a vacation. In fact, they expected her to stay there, work and send money back to them in Fiji. She ended up on her own with no passport, no schooling and no care. She spent three years on the streets. Boyfriends abused her. She was raped twice. She attempted suicide three times. By the age of 17, she was a mother.

"Marijuana did nothing for me," she says. "My drug of choice was meth. I needed to go to the hardest drug to numb the pain I was going through ... to fill the void. When I share this in Fiji today in villages, schools and churches, it gives people the power to say, 'This is what happened to me.' It is a healing journey."

Kalesi leads the one community organization exclusively committed to addressing the drug use fuelling Fiji's ballooning HIV epidemic.

Since 2014, number of new HIV infections in Fiji has risen by an alarming 10-fold. UNAIDS estimates that in 2014, there were fewer than 500 people living with HIV in Fiji. Just 10 years later, that number was 5900 [4500–8900]. In 2024, only 36% [27–54%] of people living with HIV in Fiji were aware of their HIV status, and only 24% [18–36%] were receiving treatment.

Preliminary data for 2024 from the Ministry of Health show that among people newly diagnosed with HIV who are currently receiving antiretroviral therapy, half contracted HIV through sharing needles.

Responding to the sharp increase in new diagnoses, the Government of Fiji declared an HIV outbreak in January 2025. The HIV Outbreak Response Plan and the previously announced Counter Narcotics and HIV Surge strategies call for the introduction of harm reduction programmes for people who inject drugs. Currently there are none.

Although there is agreement in principle with the introduction of needle–syringe programmes, moving towards implementation has been more challenging. "We still need to raise awareness," says Kalesi. "It is not just about giving out needles. It is about education. But there are so many myths and misconceptions. We have to educate the leaders first. When the indigenous chiefs call, people will follow. Then there are the churches. Last but not least, the Government."

Medical Services in the Pacific (MSP) Fiji is prepared to implement a needle–syringe programme. The non-profit-making organization provides a broad range of sexual and reproductive health services. It is already supporting the scale-up of much needed HIV prevention, testing and linkages to care. Beyond its clinics in Labasa, Lautoka and Suva, it deploys an outreach team of clinicians and counsellors to the field. A mobile clinic goes to hotspot areas to provide a package of HIV and noncommunicable disease services in areas with high levels of injecting drug use.

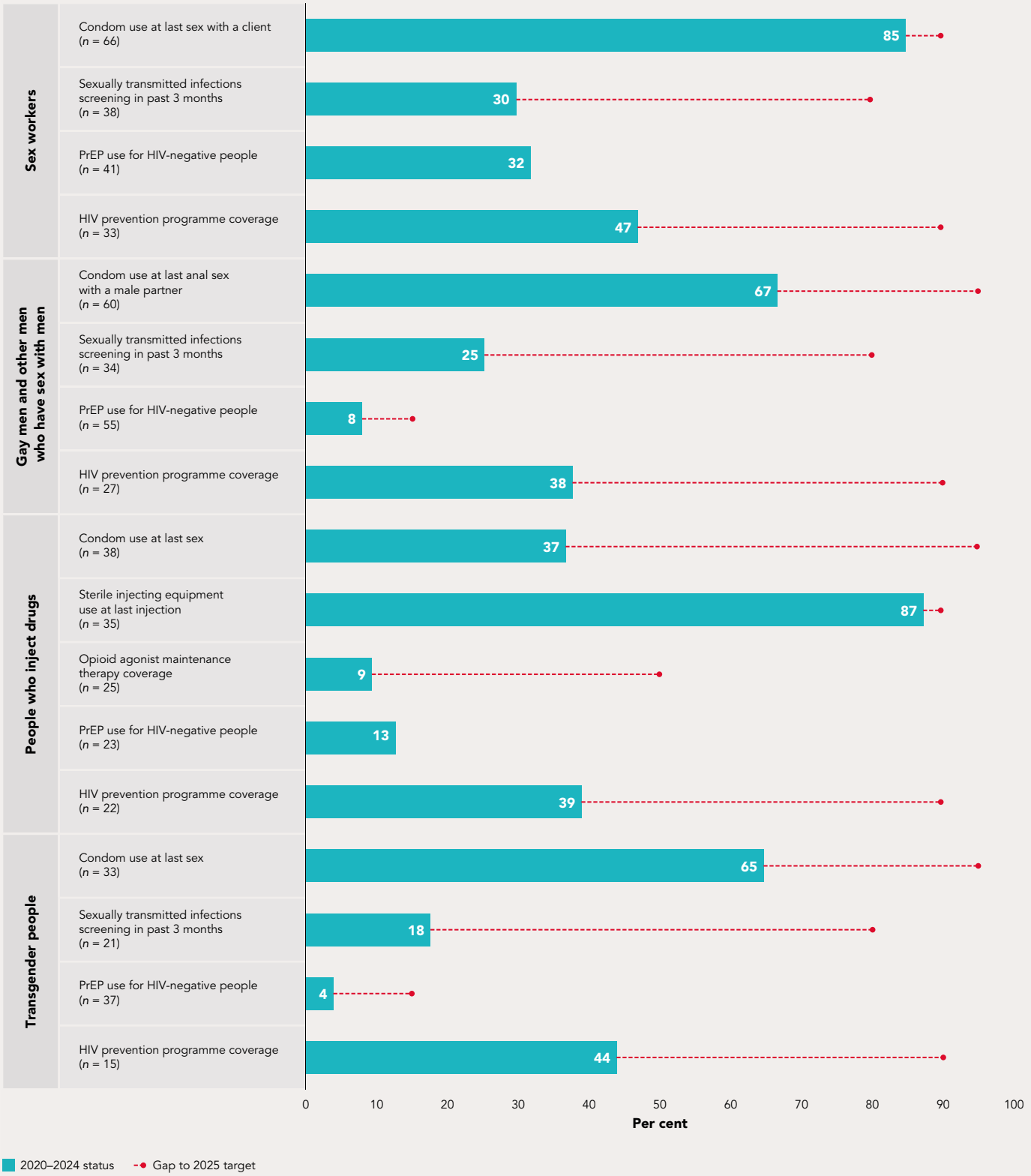
"Since we started providing point-of-care (rapid) screening last year, the numbers have continued to escalate," says MSP Fiji Country Director, Railala Nakabea. "It is not only in the cities and towns. We are also seeing positive cases in rural communities. Most of the cases we detect are among people who inject drugs."

MSP Fiji Medical Officer, Kesa Tuidraki, reiterates the importance of harm reduction alongside longer-term and more widely accepted plans for the construction of a drug rehabilitation facility. "It is not only HIV," she says. "We also have increasing hepatitis C infection, which is even more easily spread through sharing injecting equipment. We need to have harm reduction programmes in place as soon as possible. Rehabilitation does not address the immediate public health emergency." She acknowledges the importance of partnering with an organization of people with lived experience to more effectively serve the community of people who use drugs.

For Kalesi Volatabu, it is critical that stakeholders work together to design a tailored approach. "We definitely need harm minimization strategies, but we have to contextualize the programmes. What would work in the western context will not work in Fiji. You need to speak the language of your audience. It must be driven by the people and owned by the people."

Combination prevention services are not reaching the most vulnerable people

Figure 3.3. Gap to achieve combination prevention targets among key populations, by intervention, global, 2020–2024



Note: the methods used are described in the section "Calculation of pre-exposure prophylaxis (PrEP) coverage for HIV-negative people" in Annex 1 (available online). PrEP targets were calculated based on the number of people who would most benefit from PrEP use, i.e. people with greatest vulnerability to HIV exposure within each key population. Reported numbers of users of PrEP include all users, regardless of vulnerability. The graph shows median coverage among countries reporting, except for PrEP use. Coverage of interventions can be underestimated due to the lack of reporting from some countries. HIV prevention programme coverage refers to people from key populations who reported receiving at least two prevention services in the past three months. Possible prevention services received include condoms and lubricants, counselling on condom use and safer sex, testing for sexually transmitted infections and sterile injecting equipment. Condom use at last higher-risk sex does not take into account people taking PrEP and therefore might not accurately indicate risk to HIV acquisition.

Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/); UNAIDS special analysis 2025.

Community-led organizations, especially those led by young people, women and people from key populations, are uniquely positioned to reach the people who are most at risk for HIV and are crucial providers of prevention services in spaces that are free of stigma and discrimination (Figure 3.4). Their ability to keep doing so hangs in the balance in many countries, as official development assistance for HIV continues to decline.

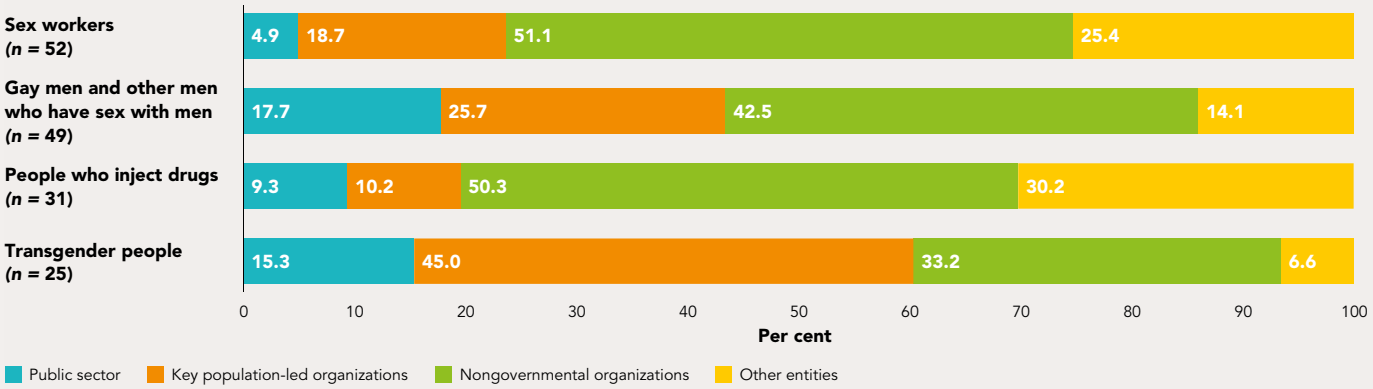
The underlying conditions that render people from key populations so vulnerable to HIV are being allowed to persist. In some places, they are being reinforced, aggravating the harm done. Campaigns are attacking rights-based approaches, including for public health, with women and people from marginalized populations often the targets.

For the first time since UNAIDS started reporting on punitive laws, the numbers of countries criminalizing same-sex sexual activity and gender expression have increased. In the past year, Mali and Trinidad and Tobago have criminalized same-sex relations, Uganda's Anti-Homosexuality Act has intensified the proscription of same-sex relations *(13)*, and Ghana has moved in a similar direction, with the Parliament reintroducing the Human Sexual Rights and Family Values Bill in 2025. Mali has also criminalized transgender people.

In 2025, only eight of 193 countries did not criminalize same-sex sexual acts in private, transgender people, sex work, possession of small amounts of drugs (Figure 3.5a,b,c) or HIV nondisclosure, exposure or transmission *(14)*.[3,4] A large majority of countries criminalize some aspect of sex work (168 countries) or the possession of small amounts of drugs (152 countries); a third criminalize same-sex sexual relations (64 countries); and 14 countries criminalize transgender people. Laws that criminalize same-sex sexual relations, and other laws, are sometimes used to criminalize transgender people. HIV nondisclosure, exposure or transmission remains a potential criminal offence in 156 countries, despite an absence of evidence that they contribute to slowing the epidemic.

People from key populations depend on community-led and other nongovernmental organizations for HIV prevention services that are free of stigma and discrimination

Figure 3.4. Distribution of the reported numbers of people from key populations reached with HIV prevention interventions by type of provider, 2020–2024

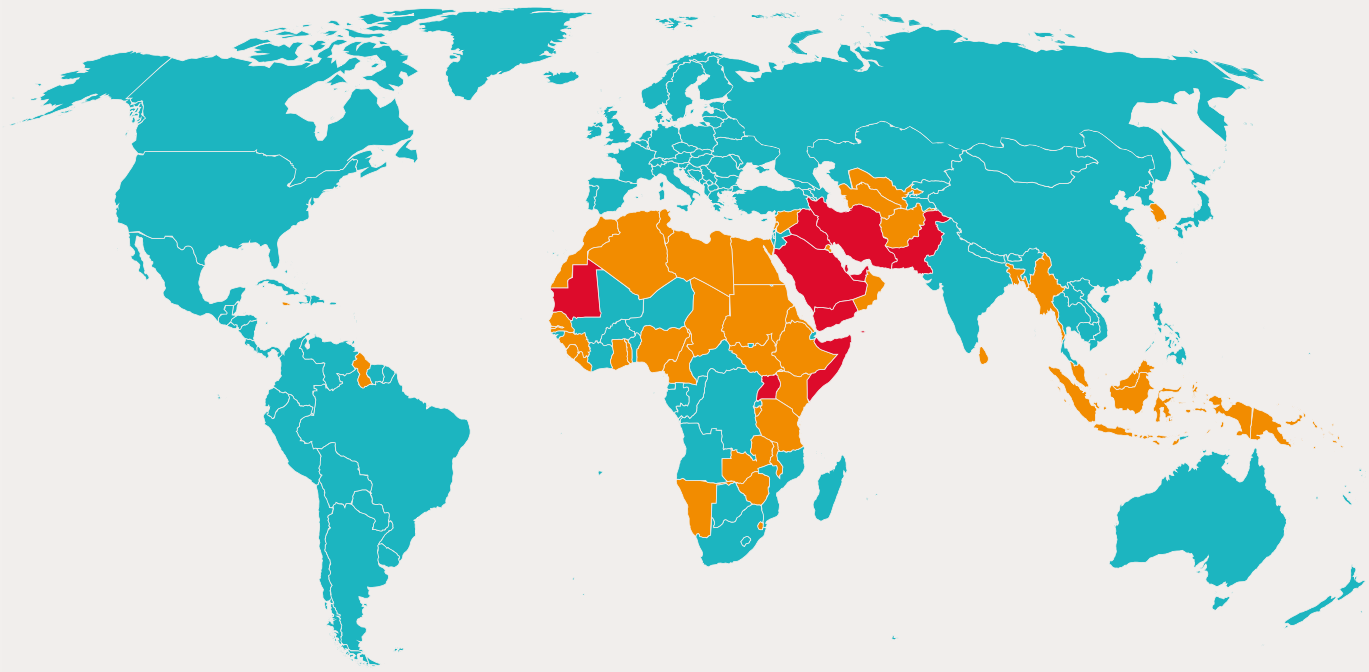


Note: *n* = number of countries.
Source: Global AIDS Monitoring 2021–2025 (https://aidsinfo.unaids.org/).

3 Chile, Colombia, Netherlands (Kingdom of the), Paraguay, Slovenia, Switzerland, Uruguay, Venezuela (Bolivarian Republic of).
4 Slovenia and Switzerland, however, have reported prosecutions related to HIV nondisclosure, exposure or transmission in the past 10 years.

Almost all countries have punitive laws that criminalize at least one key population

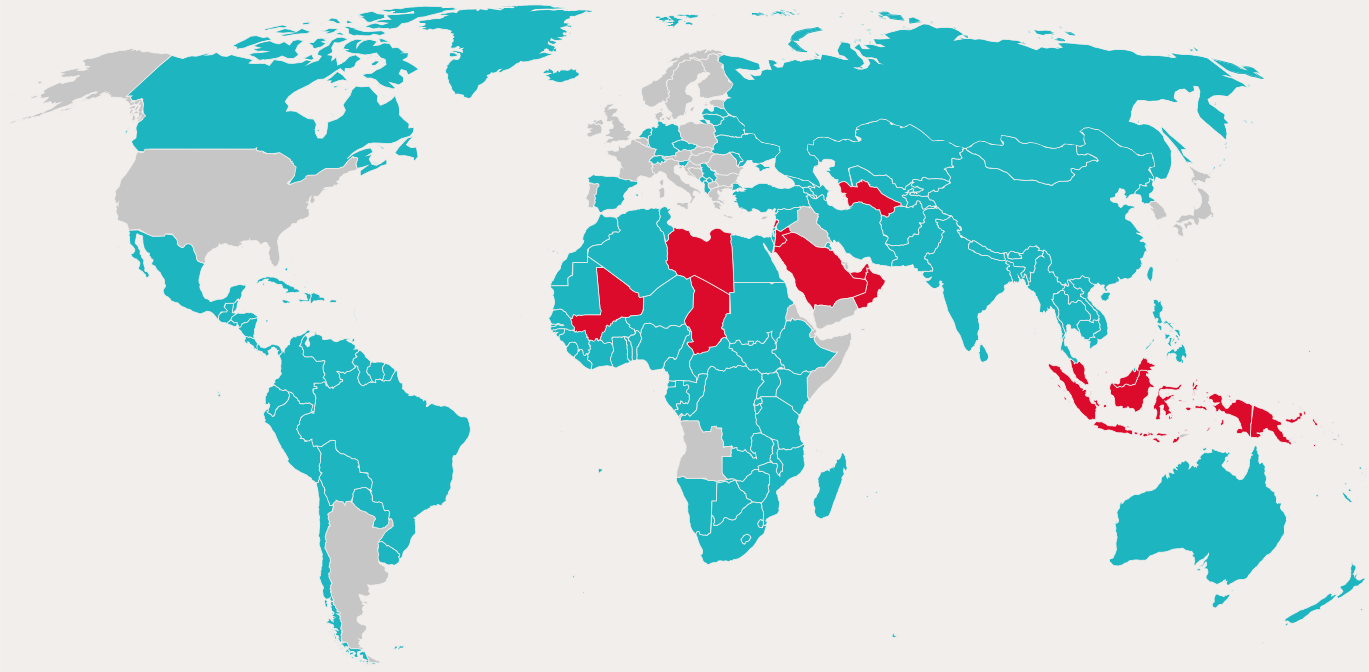
Figure 3.5a. Countries with laws criminalizing same-sex sexual acts in private, global, 2025



Death penalty
Imprisonment (14 years–life, up to 14 years) or no penalty specified
Laws penalizing same-sex sexual acts have been decriminalized or never existed, or no specific legislation

Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see references in http://lawsandpolicies.unaids.org/).

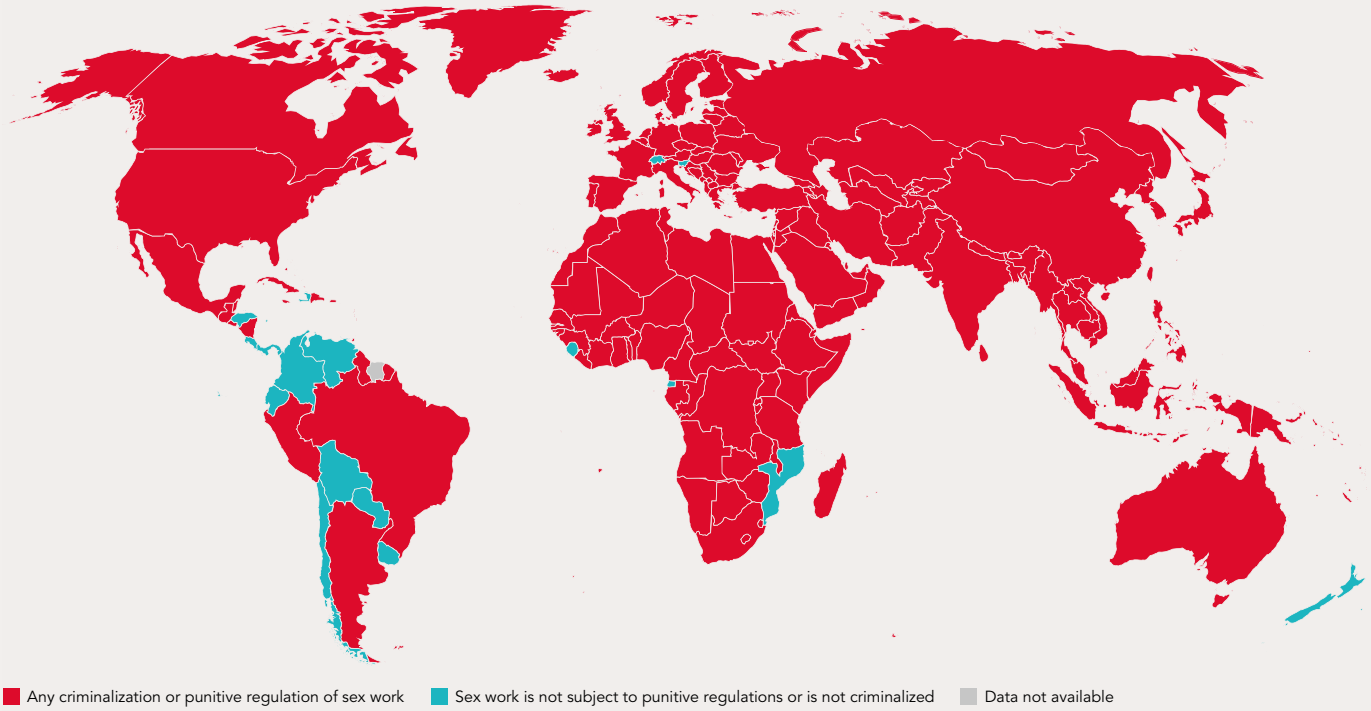
Figure 3.5b. Countries with laws criminalizing transgender people, global, 2025



Criminalizing law
No criminalizing law
No data available

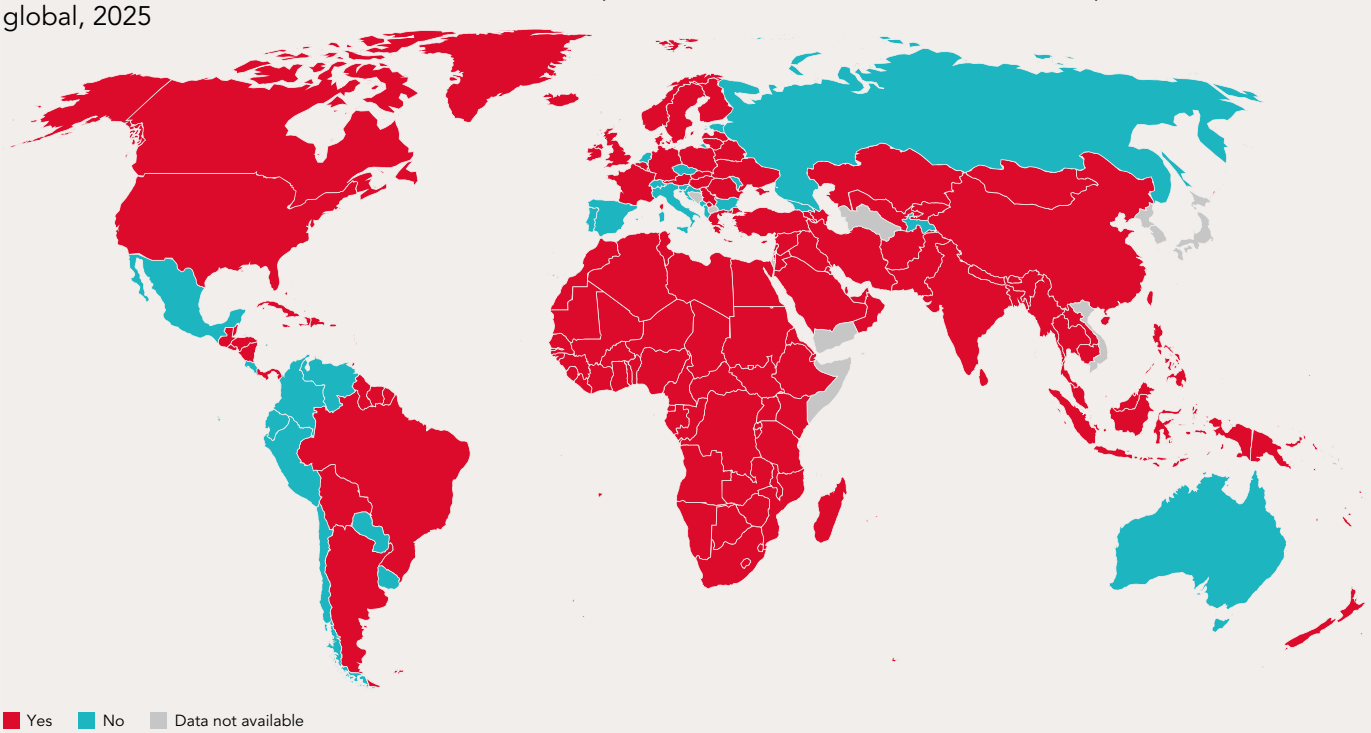
Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see references in http://lawsandpolicies.unaids.org/).

Figure 3.5c. Countries with laws criminalizing any aspect of sex work, global, 2025



Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see references in http://lawsandpolicies.unaids.org/).

Figure 3.5d. Countries with laws criminalizing the possession of small amounts of drugs for personal use, global, 2025



Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/), supplemented by additional sources (see references in http://lawsandpolicies.unaids.org/).

Criminalization and repressive policing expose people from key populations to a disproportionate risk of acquiring HIV and other life-threatening infections such as hepatitis C. This is true also in settings where HIV is widely prevalent in the overall population, as in much of sub-Saharan Africa *(15)*. Globally in 2022, the risk of acquiring HIV was up to 23 times higher for gay men and other men who have sex with men, 20 times higher for transgender women, 14 times higher for people who inject drugs (and even higher for young people and women who inject drugs) *(16)*, and nine times higher for sex workers than for adults (aged 15–49 years) overall *(1)*. Ideally, these punitive laws should be removed, as recommended by the Global Commission on HIV and the Law *(17)*. At the very least, the enforcement of punitive laws and policies that undermine HIV responses should be suspended or relaxed. People must also be able to report, challenge and seek redress for the discrimination, harassment and violence that these kinds of laws sanction.

HIV data for key populations are becoming sparser

Accurate size estimates and HIV-related data for key populations are generally scarce, with criminalization and widespread discrimination among the obstacles. Until recently, the 30 to 40 integrated biobehavioural surveys conducted annually provided vital insights to guide HIV and other programmes for programmes for key populations. But fewer of these surveys are being done—a trend that the cuts in donor support will almost certainly intensify. The funding uncertainty has consequences: many key population survey activities are being delayed or are at risk of cancellation due to funding freezes. Fewer sources of good-quality data will render these key and other neglected populations even less visible to policy-makers and programme planners and will undermine evidence-based prevention activities *(18)*.

In Africa, HIV remains a major threat to girls and women—greater gender equality would change this

The total number of adolescent girls and young women (aged 15–24 years) acquiring HIV has been reduced by half globally since 2010, and by a similar margin (51%) in both eastern and southern Africa and western and central Africa. These declines generally track with levels of access to effective HIV treatment programmes and the extent to which girls and young women can access and use combination prevention options that fit their lived realities. Economic empowerment, access to comprehensive sexuality education, transformation of harmful social norms, and completion of secondary education create enabling environments where girls and young women can make informed decisions, access HIV prevention and care services, and exercise control over their sexual and reproductive health, ultimately reducing their vulnerability to HIV. This progress is the result of focused, sustained investment in HIV prevention for adolescent girls and young women and highlights the importance of continuing and scaling up these efforts *(19)*.

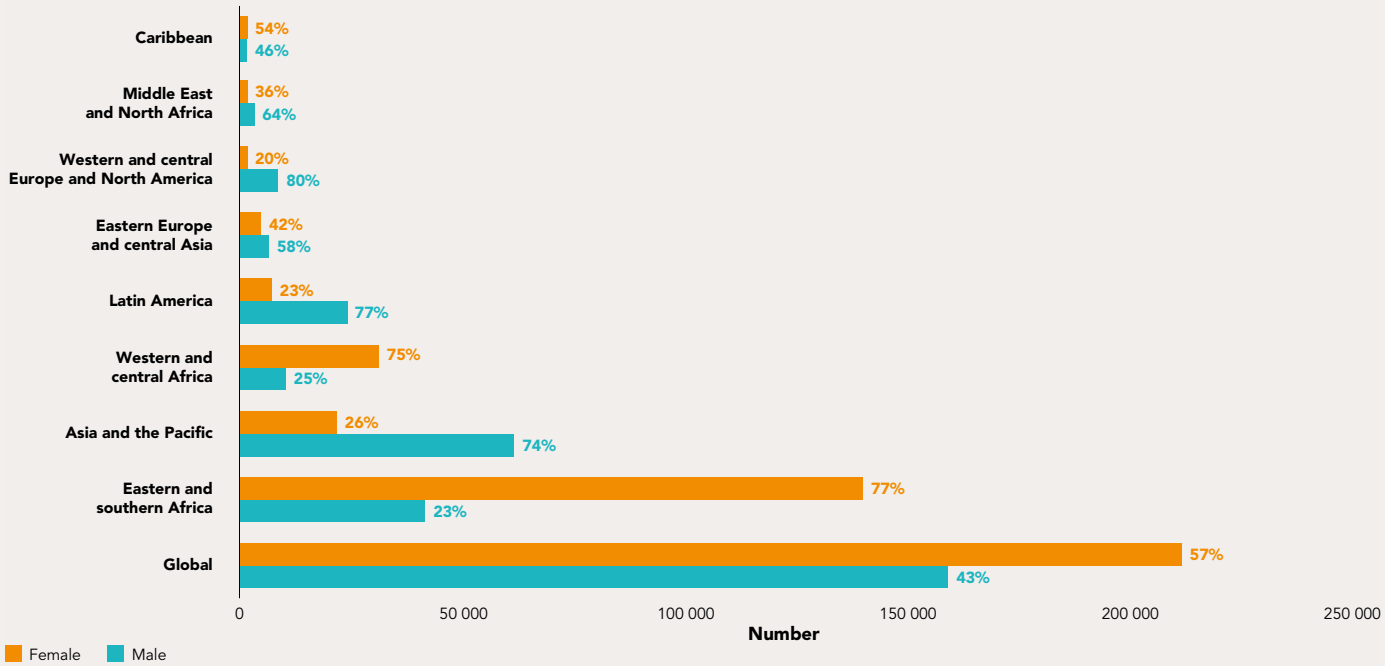
But gender inequalities, violence and gaps in basic HIV prevention programmes put adolescent girls and young women at much higher risk of acquiring HIV than their male peers in sub-Saharan Africa (Figure 3.6). HIV incidence among adolescent girls and young women continues to be exceptionally high in much of eastern and southern Africa and in specific areas in western and central Africa. In 2023, less than half (46%) of

the areas with high or moderately high HIV incidence[5] in sub-Saharan Africa were being served by a prevention programme focused on adolescent girls and young women. Levels of condom use with non-regular partners and access to PrEP are too low for adequate protection against HIV. Consequently, an estimated 210 000 adolescent girls and young women globally acquired HIV in 2024—equal to 570 new infections among adolescent girls and young women per day. Moreover, recent reviews and studies continue to show that adolescent girls and young women aged under 25 years remain disproportionately vulnerable to HIV due to structural and behavioural drivers, including limited access to services, low socioeconomic status and gender inequalities *(20, 21)*.

The HIV epidemic among girls and women is also evolving. Empirical data from community cohorts in four countries in eastern and southern Africa6 show that HIV incidence has been declining faster among young women and men aged 15–24 years than among people aged 25 years and over. Due to these changing patterns in HIV incidence, the largest proportion of new HIV infections in these countries is now among people aged 25–49 years. This shift is especially evident among women *(22, 23)* and is also a consequence of successful interventions targeting younger age groups. Rather than indicating reduced importance of prevention for adolescent girls and young women, this should be seen as a call to consolidate gains and intensify efforts to further reduce HIV incidence in this high-risk age group, even as prevention services expand to older age groups. HIV prevention services in eastern and southern Africa need to adjust to this trend and do better at reaching both women and men aged over 25 years alongside efforts to target adolescent girls and young women. For instance, across eight African countries, modelling shows that increasing secondary school enrollment by 70–100% can avert up to 84 000 new infections by 2030 (Education Plus Initiative, 2025). In addition to the health gains, these investments are projected to generate significant economic benefits, improve educational outcomes, and contribute to reductions in gender-based violence, early pregnancies, and child marriages, illustrating the broader impact of HIV prevention for adolescent girls and young women.

Adolescent girls and young women are still at much higher risk of acquiring HIV in sub-Saharan Africa, but adolescent boys and young men are at higher risk elsewhere

Figure 3.6. Estimated numbers of new HIV infections among young people aged 15–24 years, by sex, global and regional, 2024



Source: UNAIDS epidemiological estimates 2025 (https://aidsinfo.unaids.org/).

5 High HIV incidence denotes one or more new infections per 100 person-years. Moderately high incidence denotes 0.3–0.99 new infections per 100 person-years.

6 Kenya, South Africa, Uganda, Zimbabwe.

STORY

Reducing stigma in health-care settings and reforming the law: a double hurdle in western and central Africa

In seven countries in western and central Africa surveyed in 2023, more than 12% of people living with HIV aged 18–24 years reported avoiding health centres for care because of their HIV status (24).

Whether it is a refusal of care, humiliating comments or disclosure of their status, many people described feeling alienated. Last year, with funds from Expertise France and the help of UNAIDS and partners, a pilot was launched to raise awareness of stigma in Cameroon, Côte d'Ivoire, Senegal and Togo.

Training in the Looking In, Looking Out (LILO)[7] approach raised awareness among 150 health professionals in Senegal and 97 in Togo about sexual diversity, gender-based violence and respect for human rights. In Kara, northern Togo, a visual digital tool (named "image boxes") has been designed with communities to raise awareness of health and HIV.

When individuals and communities know their rights, they are empowered to take control of their own health and to hold service providers accountable. This is one of the key messages of this tool used by the Network of People Living with HIV (RAS+ Togo). A total of 300 young people attended educational health sessions in the Central African Republic. In Benin and the Central African Republic, the project focused on legal reform, with the involvement of parliamentarians, including members of the women's caucus in both countries. Legal texts, a draft decree and a decree have been drafted in the Central African Republic. In Benin, the work also focused on advocacy for the adoption of the new HIV bill.

"We must make the link between HIV and gender-based violence. The law must protect women in all spheres, especially including health," said Huguette Bokpe Gnacadja, President of the National Institute for Women in Benin.

The year-long partnership has enabled action to be taken at the individual level (rights literacy), organizational level (paralegals in community organizations, training for community actors), interorganizational level and national level (legal reform).

In the next year, UNAIDS wants to further improve access to inclusive human rights-based HIV services for people from key populations, adolescents, girls and young women in the region.

"The fight against HIV will not be won in laboratories, but in the power relations between caregivers and those receiving care, between the state and its citizens," said Fatou Sy, a UNAIDS focal point in the region who oversaw the projects in the six countries. "We have more work to do."

When individuals and communities know their rights, they are empowered to take control of their own health and to hold service providers accountable.

7 Looking In, Looking Out (LILO) refers to a process of internal and external reflection aimed at improving understanding of key populations and their access to health services. The approach seeks to strengthen the knowledge of intermediaries in the response to stigma surrounding key populations, with a view to encouraging their involvement in creating a supportive environment.

Countries must do more to curb gender-based violence

In addition to the harm and trauma caused, violence and the fear of violence can deter people from using services and tools that can prevent or manage HIV infection *(25)*. For girls and women, intimate partner violence is an unnervingly common experience, which heightens their risk of acquiring HIV in settings where HIV prevalence is high (Figure 3.7) *(26)*.

Among adolescent girls and women aged 15–49 years, data from population-based surveys in 2020–2024 show a median 18% had recently experienced physical and/or sexual violence by an intimate partner in eastern and southern Africa (eight countries) and 14% in western and central Africa (nine countries), compared with 10% in Asia and the Pacific (eight countries) and 5% in western and central Europe and North America (30 countries). Young women are especially at risk: data from 18 countries show one in six women aged 15–24 years experienced physical and/or sexual violence by an intimate partner at some point in the past 12 months *(27)*.

In 2020–2024, a median 20% of sex workers (40 reporting countries) and 22% of transgender people (21 reporting countries) said they had experienced physical and/or sexual violence in the past 12 months.

Transgender people and women from key populations are particularly vulnerable, with women who engage in sex work facing high risks of violence from intimate partners, clients and police. One review of studies from eastern and southern Africa found that 21–82% of female sex workers had been attacked at some point in their lives *(28)*. An earlier review of studies from across the world reported a lifetime prevalence of violence of 45–75% *(29)*. Experiences of physical and/or sexual violence are strongly associated with higher rates of HIV infection among female sex workers *(30)*.

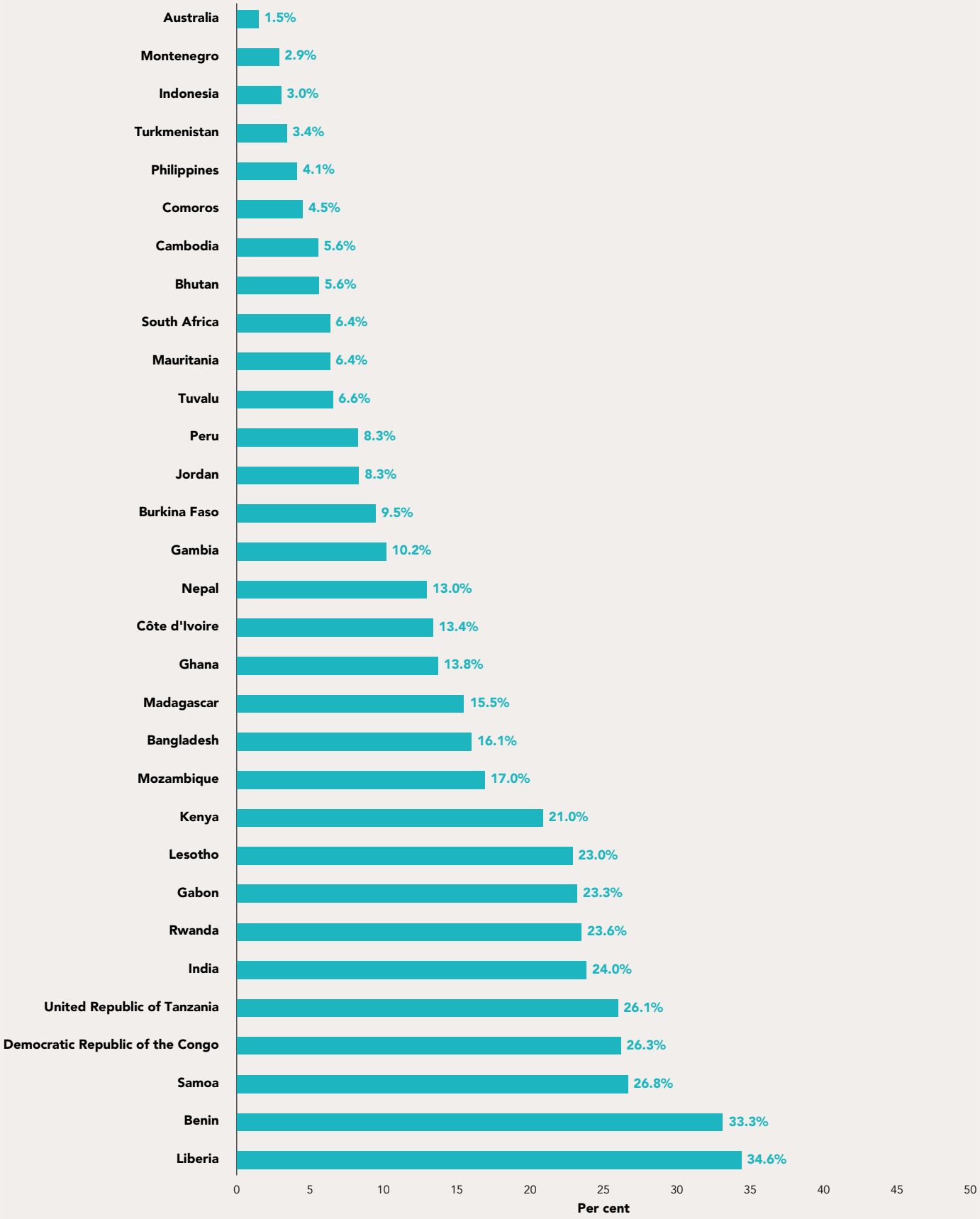
In many countries, large proportions of men and women endorse or tolerate violence against women. Across 38 countries with available data, a median 19% of adult women and men aged 15–49 years reported accepting attitudes towards violence against women *(31)*.

Strong evidence supports the integration of violence prevention in health-care settings such as antenatal care and sexual and reproductive health services, and in HIV services within and beyond the health-care sector (see Chapter 4) *(32, 33)*. Implementation of violence prevention strategies is sparse, however, in part due to health system weaknesses *(34)*.

For girls and women, intimate partner violence is an unnervingly common experience, which heightens their risk of acquiring HIV in settings where HIV prevalence is high.

Intimate partner violence is very common in some countries

Figure 3.7. Prevalence of intimate partner violence in the past 12 months among ever-married or partnered women aged 15–49 years, countries with available data, 2020–2024



Source: population-based surveys, 2020–2024; 2021–2024 EU survey on gender-based violence against women and other forms of inter-personal violence (EU-GBV).

Young people lack the means to protect their sexual health

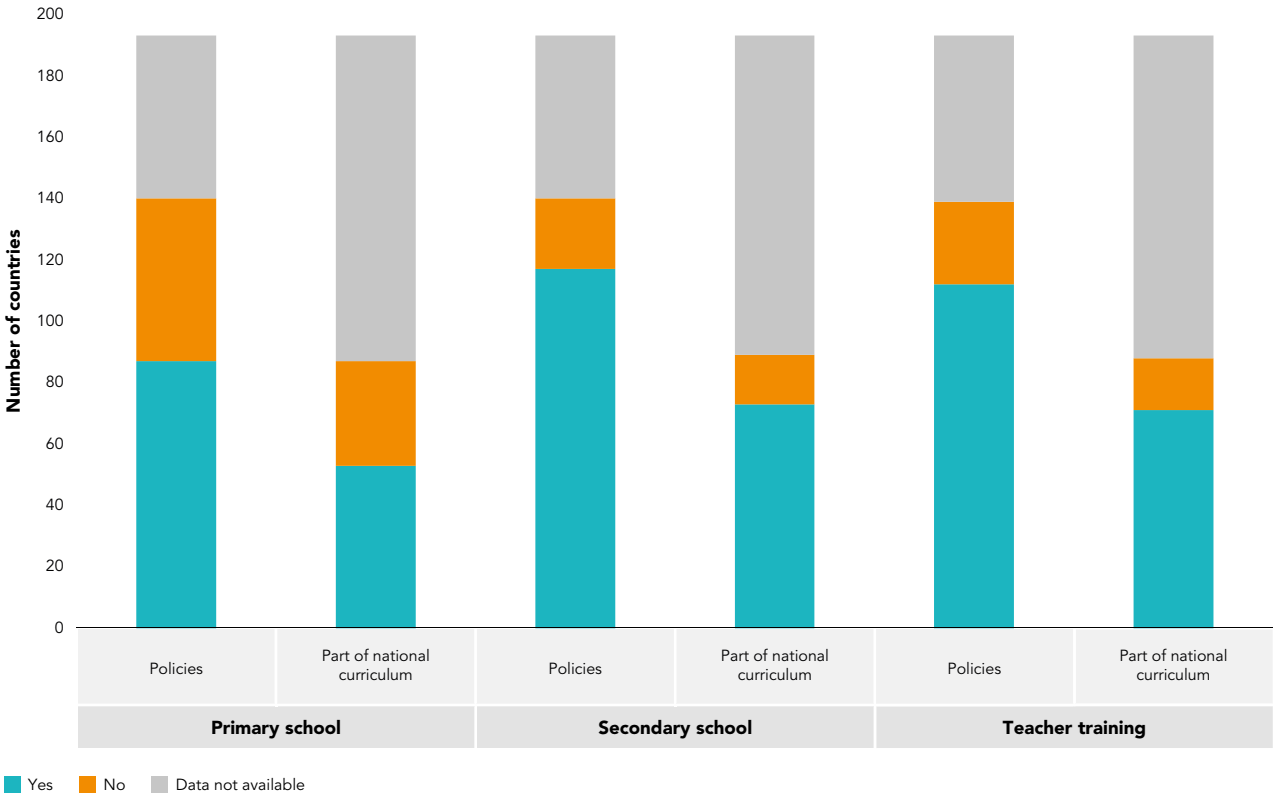
For girls and women, staying HIV-free depends on their ability to control their sexual lives and protect their sexual health, neither of which is easy when gender inequalities and discrimination persist. The uneven availability and quality of comprehensive sexuality education puts them and their male peers at an early disadvantage (Figure 3.8). Even when comprehensive sexuality education is part of the national curriculum, it is often taught incompletely, if at all, in classrooms *(35, 36)*.

Access to sexual and reproductive health information and services, including family planning, is compromised and incomplete. This is the case especially for women in rural areas and for young and marginalized women. Punitive laws, stigma and discrimination push these services even further from the reach of women from key populations *(37, 38)*. These realities are not improving: some jurisdictions are actively depriving girls and women of their sexual and reproductive health rights, and campaigns aimed at extending such restrictions are gaining momentum.

A little over half of women and girls aged 15–49 years are able to make their own decisions regarding sexual relations, contraceptive use and use of health care (Figure 3.9) *(39)*. Adolescent girls and young women tend to have the least decision-making control related to sexual relations, contraceptive use and health care; age-of-consent laws are an additional restriction in some countries *(40)*. These barriers must be removed, and girls and women must be able to claim their sexual and reproductive health and rights.

Inclusion of sexuality education in national curricula is alarmingly low

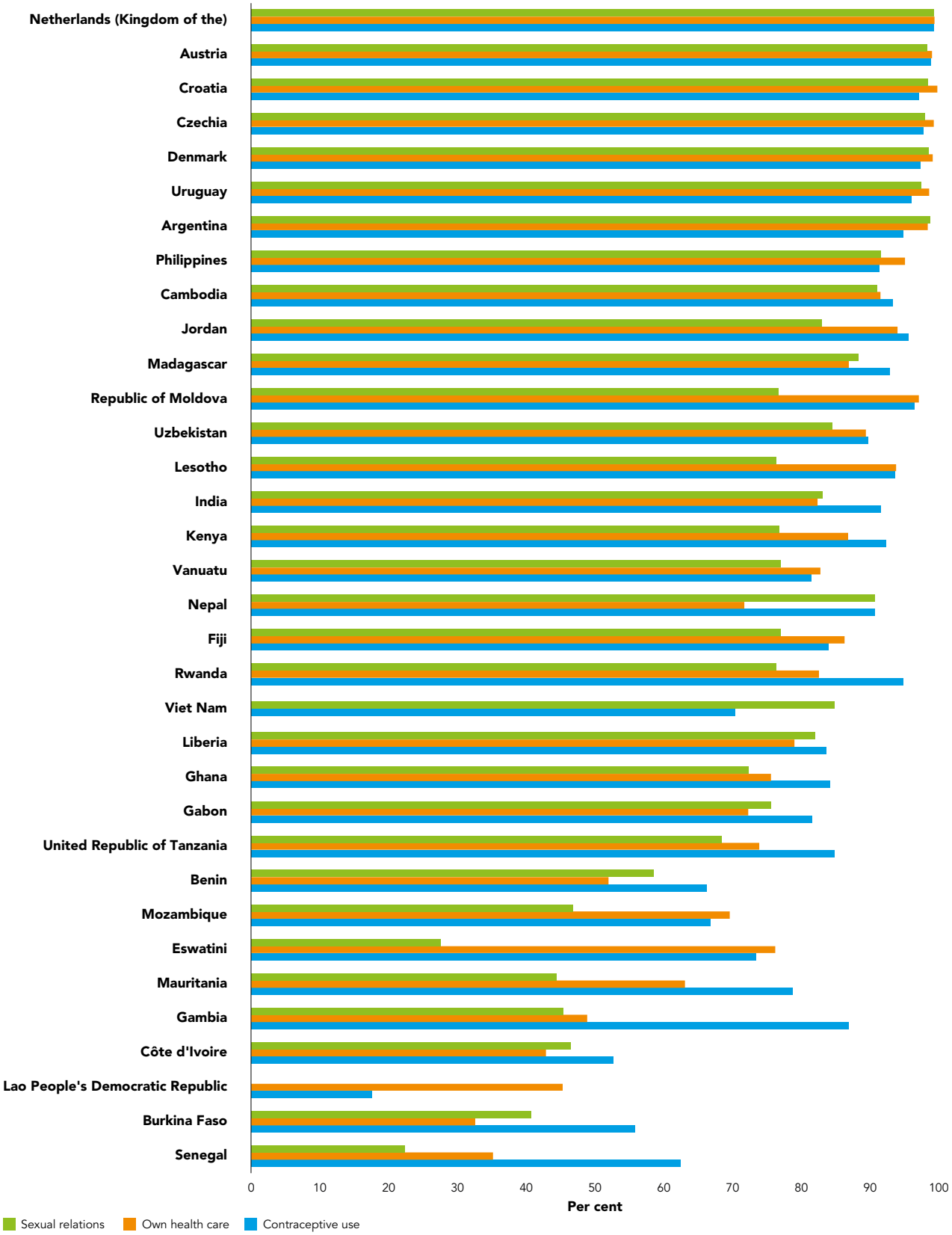
Figure 3.8. Countries with policies and curricula on life skills-based HIV and sexuality education, by education level, global, 2017–2024



Source: National Commitments and Policy Instrument, 2017–2024 (http://lawsandpolicies.unaids.org/).

Adolescent girls and young women in many countries lack autonomy over their sexual lives and health

Figure 3.9. Percentage of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care, countries with available data, 2020–2024



Source: population-based surveys, 2020–2024; SDG indicator database. New York: United Nations (https://unstats.un.org/sdgs/dataportal/database).

© Tibu Africa: Training session on gender and HIV for young beneficiaries of Tibu Africa

STORY

Using sports to combat gender stereotypes and learn about HIV

Marouane Abouzid grew up in Casablanca, Morocco, where many boys act like bullies and sex is taboo. That changed when he joined the project Sport Is Your Protection, where he gained knowledge about gender equality and health. "The training on HIV awareness led by UNAIDS and Tibu Africa was a transformative experience in the sense that I saw how sports can be an effective way to get a message out," the 25-year-old says. "It also gave me essential skills like communicating clearly and active listening."

He enjoyed the project so much that he trained to lead sports activities and participate in other sessions. "I talk openly about what I have learned. I encourage my friends to get tested for HIV and encourage people to respect others," he says, excited about becoming a role model for his peers.

Marouane describes the activities as a safe space to discuss all sorts of issues that young people face in Morocco, such as poverty, unemployment and a patriarchal system.

Marouane is not alone. Assia Ezzahraoui, a participant in the Tibu Africa sports vocational school programme, joined the week-long sexual education awareness meeting. "The informative sessions gave me new insights into symptoms, prevention methods and available treatments," she says. Assia feels more secure about how to protect herself and her friends.

Tibu Africa was founded in 2011 and aims to bring the programme across different cities in Morocco. UNAIDS joined with Tibu Africa in 2024. "This first partnership with UNAIDS Morocco mobilized young people around issues to transcend barriers and create opportunities for dialogue and awareness," says Mohamed Amine Zariat, President of Tibu Africa. "We hope this first step will serve as a springboard for future, even more ambitious initiatives."

An estimated 24 000 [21 000–26 000] people are living with HIV in Morocco, and nearly 40% of these are women. Although the prevalence of HIV is relatively low in Morocco, vulnerable populations such as sex workers, gay men and other men who have sex with men and people who inject drugs are particularly at risk. Moroccan youth represent more than 30% of the total population, but a quarter of people aged 15–24 years have no job and lack education and training—young women are particularly hard hit.

Houssine El Rhilani, UNAIDS Country Director in Morocco, is aware of this. He believes the collaboration with Tibu Africa combining sport, education and awareness-raising can empower young people. "We were able to reach young people not only with information, but also through experience, providing them with concrete tools to become prevention ambassadors in their own communities," he says. "We cannot end AIDS without prioritizing future generations."

We cannot end AIDS without prioritizing future generations.

3.2 Using the many opportunities to get more out of HIV prevention

HIV prevention has come a long way in the past three decades. Highly effective prevention tools and methods exist, not least of which is antiretroviral therapy. Exciting new technologies such as long-acting injectable PrEP are emerging. Community systems have been built to serve and support key and other vulnerable populations—but funding losses now have the prevention response hanging in the balance.

Ways to get more out of treatment as prevention

Expanded HIV treatment coverage and rising levels of viral load suppression are a major reason for the drop in numbers of new HIV infections in recent years, along with the impact of primary prevention efforts such as condom programmes *(3, 4, 41, 42)*. Maintaining and further enhancing these programmes—including generating public awareness and promoting strong demand for them—are clear priorities everywhere *(43)*.

People living with HIV who receive effective antiretroviral therapy and have undetectable viral loads have zero risk of transmission to their sexual partners (the so-called U=U, or undetectable = untransmissible, effect of HIV treatment). Universal access to HIV testing and treatment and high levels of viral suppression are crucial for any successful HIV prevention strategy. This means doing away with the deficiencies and disparities that still riddle some testing and treatment programmes (see Chapter 2).

The impact of treatment as prevention can be boosted further by diagnosing more people living with HIV; starting them promptly on antiretroviral therapy; enabling people who initiate treatment to keep taking their antiretroviral medicines so they have a suppressed viral load; and rapidly re-engaging in care people who interrupt their treatment. As treatment programmes mature, the latter two elements are becoming increasingly important. Analysis from South Africa, for example, indicates that the single biggest share of new HIV acquisitions involves people living with HIV who were diagnosed and started antiretroviral therapy but then interrupted their treatment at some stage *(44)*.

It is estimated that about a quarter of all people living with HIV globally in 2024 were aged over 50 years.

It is crucial that the improvements also reach people from key populations and their sex partners who are living with HIV. In addition, if the disparities in treatment access and outcomes between men and women in sub-Saharan Africa can be removed, fewer women will acquire HIV. Analysis based on data from Uganda has shown, for example, that closing the disparities in viral suppression rates between women and men could have reduced new HIV acquisitions in women by half within three years *(23)*.

Strategies for treatment as prevention must also adapt to the growing population of older people living with HIV, which itself is a testament to the success of treatment programmes. The median age of people living with HIV in eastern and southern Africa, for example, will be about 46 years in 2030 and will keep rising. It is estimated that about a quarter (26%) of all people living with HIV globally in 2024 were aged over 50 years. If they do not have suppressed viral loads, they are at risk of transmitting HIV to their sex partners. Prevention services need to be tailored to these demographic shifts.

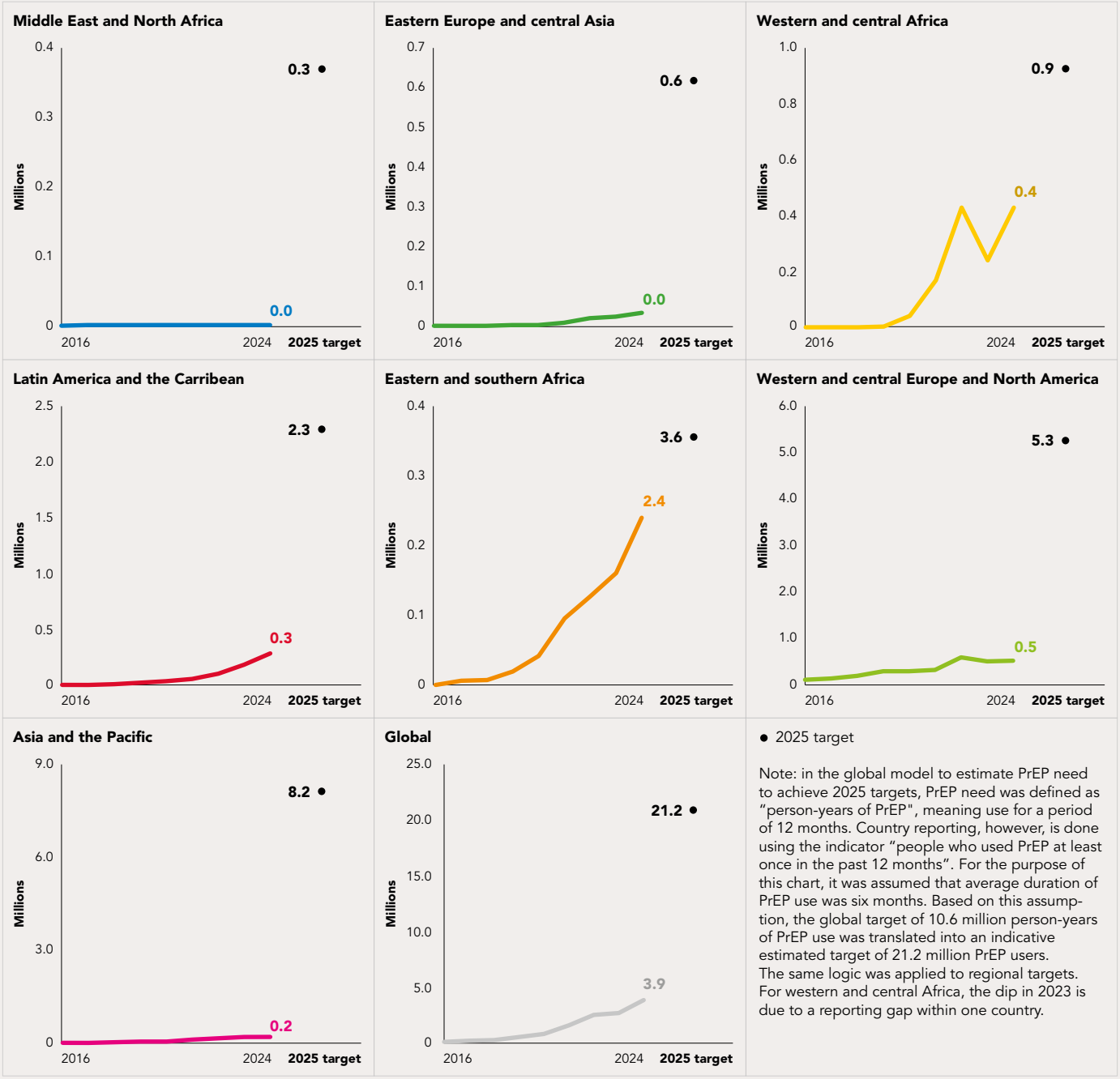
Pre- and post-exposure prophylaxis are not available to the people who need them most

PrEP and post-exposure prophylaxis (PEP) are important but underused prevention options for people from key populations and their sex partners, and for adolescent girls and women in settings where HIV incidence is high. When used as prescribed, oral or long-acting injectable PrEP can reduce HIV acquisition by more than 90%. Access to these prevention options has increased but is still well short of the levels needed (Figure 3.10). Oral PrEP was used by about 3.9 million people in 2024, far short of the 2025 target of 21.2 million people.

When used as prescribed, oral or long-acting injectable PrEP can reduce HIV acquisition by more than 90%.

The prevention potential of PrEP is not being used to the full

Figure 3.10. Numbers of people who received PrEP at least once during the reporting period in 2024, relative to 2025 targets



Note: in the global model to estimate PrEP need to achieve 2025 targets, PrEP need was defined as "person-years of PrEP", meaning use for a period of 12 months. Country reporting, however, is done using the indicator "people who used PrEP at least once in the past 12 months". For the purpose of this chart, it was assumed that average duration of PrEP use was six months. Based on this assumption, the global target of 10.6 million person-years of PrEP use was translated into an indicative estimated target of 21.2 million PrEP users. The same logic was applied to regional targets. For western and central Africa, the dip in 2023 is due to a reporting gap within one country.

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

Long-acting PrEP—such as the injectable antiretroviral medicines cabotegravir and lenacapavir, and the dapivirine vaginal ring—is an exciting addition to HIV prevention. For women who struggle to negotiate condom use with male partners, LGBTQIA+ people who face stigma and discrimination, female sex workers, and people who find it difficult to adhere to oral PrEP, the option of replacing several doses of oral PrEP a week with much less frequent injections could make it easier to avoid acquiring HIV *(45, 46)*.

An unprecedented opportunity for HIV prevention: an innovation to reach the people who need it most

Long-acting lenacapavir is one of the most promising new HIV prevention tools that has emerged in the HIV response *(47)*. Injections of lenacapavir every six months are exceptionally effective at preventing HIV acquisition, with 100% efficacy among adolescent girls and young women in the PURPOSE 1 trial in South Africa and Uganda *(48)* and 96% efficacy among cisgender men and transgender men and women in the PURPOSE 2 trial in Argentina, Brazil, Mexico, Peru, South Africa, Thailand and the United States of America *(46)*. This long-acting PrEP option is safe and well-tolerated, including during pregnancy. By providing six months of continuous HIV protection, it can address many of the adherence and continuation challenges associated with oral PrEP. A once-a-year version is being trialled.[8]

Increasing volume could help drive lower costs. If made available at affordable prices to the people who need them most and the rollout is fully financed, tools such as lenacapavir can be a valuable addition to HIV prevention options. Affordable pricing can be achieved. The current price for lenacapavir in France, Norway, Spain and the United States in late 2024 exceeded US$ 28 000 per person per year, but it is estimated that it can be manufactured profitably for about US$ 40 per person per year *(50, 51)*.[9] Feasible growth in demand (to 5 million–10 million people) could lower the price to about US$ 25 per person per year *(51)*.

Gilead Sciences, the manufacturer, has licensed six generic manufacturers[10] to supply the medicine in 120 resource-limited countries (primarily low- and lower-middle-income countries, with several Latin American countries excluded) *(52)*.[11] It has also pledged to supply the medicine at "no profit" until generic versions are available (scheduled for 2028), although no price has been established *(52, 53)*.

Early modelling suggests that lenacapavir could be cost-efficient compared with treatment costs if priced at approximately US$ 40–60 per person per year and if it reaches and is used by people from populations with high HIV incidence (more than 1%). Focused targeting at subnational levels where transmission is highest is critical. For example, in an epidemic with high HIV prevalence in the overall population, such as South Africa, providing lenacapavir to about 5% of the adult population (approximately 1.8 million people) would avert 25–35% of new HIV infections. A bigger impact could be achieved by reaching a larger share of the population, but cost efficiency would then decline (Figure 3.11). In an epidemic concentrated among key populations, such as in the Philippines, providing lenacapavir to about 58% of people most at risk of HIV infection (about 1.1 million people) could avert approximately 45% of new HIV infections *(54)*. Impact will require focus in the places where there is the highest risk of transmission and among the people most at risk, such as adolescent girls and young women and people from key populations.

It bears noting that long-acting PrEP alone will not rescue deficient prevention efforts. They will be successful only when introduced into well-functioning programmes, and they must reach the populations that need them most. This can be challenging because these populations are often marginalized and might face additional stigma in the context of targeted services. Strong demand-creation efforts will be vital *(55)*. Long-acting PrEP is best used as one of several options for people to choose from, including oral PrEP and lower-cost short-term options such as condoms, VMMC in priority countries and harm reduction services. Such a comprehensive approach will help countries get the most out of limited resources while catering to different people's preferences and needs *(56)*.

8 The manufacturer, Gilead Sciences, released the encouraging results of the pharmacokinetics and safety of a phase I trial of the 12-month lenacapavir formulation for prevention (administered intramuscularly) in March 2025 *(49)*.

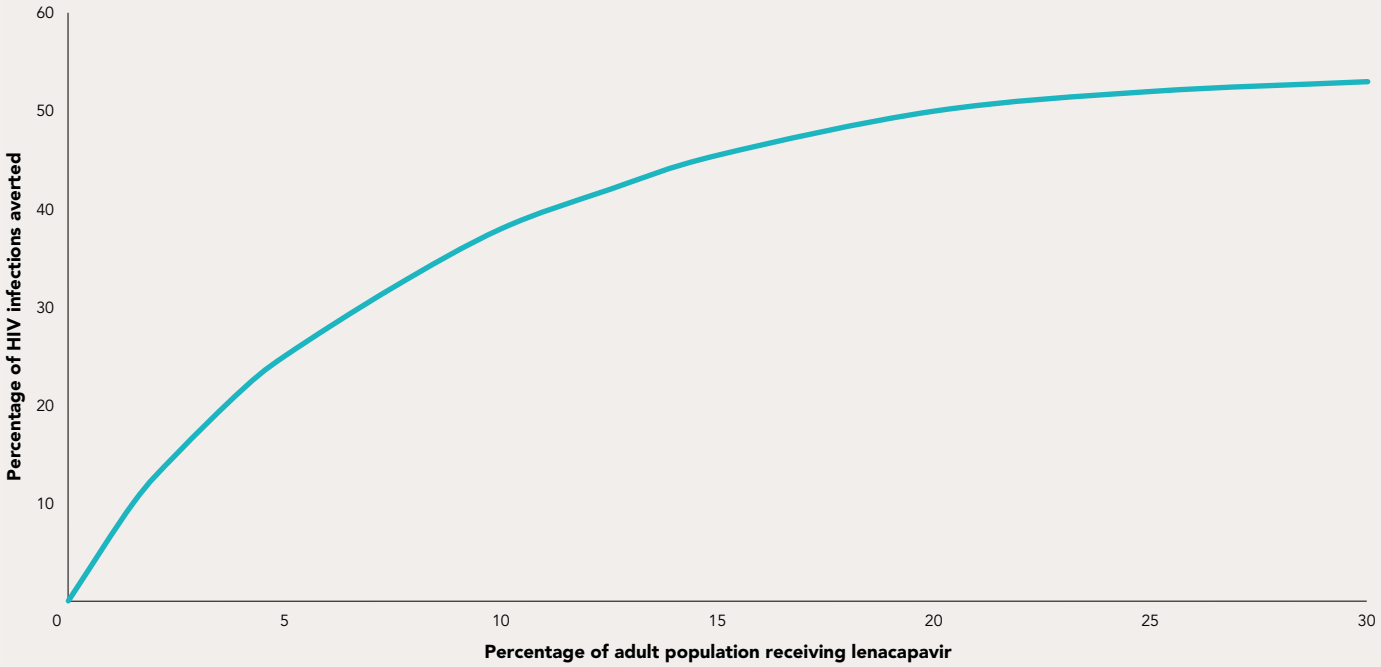
9 In a context of voluntary licensing and multiple suppliers.

10 Dr. Reddy's Laboratories (India), Emcure (India), EVA Pharma (Egypt), Ferozsons Laboratories (Pakistan), Hetero (India), Mylan, a subsidiary of Viatris (India).

11 Gilead Sciences is prioritizing registration in 18 countries: Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Philippines, Rwanda, South Africa, Thailand, Uganda, United Republic of Tanzania, Viet Nam, Zambia, Zimbabwe.

If well-targeted, long-acting PrEP can be cost efficient

Figure 3.11. Representation of the expected number of HIV infections averted with increasing population coverage of long-acting PrEP in a high-burden epidemic



Source: Summary of the consultation on the projected impact and cost-effectiveness of lenacapavir as pre-exposure prophylaxis (PrEP). London: Joint United Nations Programme on HIV/AIDS and Gates Foundation 2025. Figure based on analysis by Wu L, Kaftan D, Wittenauer R, et al. Health impact, budget impact, and price threshold for cost-effectiveness of lenacapavir for HIV pre-exposure prophylaxis in eastern and southern Africa: a modelling analysis. Lancet HIV. 2024;11(11):e765–e773 (https://doi.org/10.1016/S2352-3018(24)00239-X).

Choice matters

No single prevention option is suitable or preferable for everybody. People should have a range of options, along with information and counselling that enable them to weigh the advantages and disadvantages of each *(57)*. Studies show that offering people a choice of HIV biomedical prevention options, such as oral or long-acting injectable PrEP and PEP, can increase uptake of PrEP *(58)* and prevention coverage generally, and reduce the number of new HIV infections *(56)*.

The potential role of PEP, especially for people with varying perceptions or realities of HIV risk, continues to be neglected in prevention programmes. The use of antiretroviral medicines soon after possible exposure to HIV (ideally within 24 hours) is a highly effective prevention option if taken continuously for 28 days. PEP is underutilized, however, due to lack of awareness, fear of stigma and health system barriers, including overly restrictive protocols and judgemental attitudes of health workers.

Data-driven technologies, including machine learning and generative artificial intelligence tools, have shown promising possibilities in connecting people to the needed services and in supporting service delivery itself. Although these innovations are mostly still in nascent pilots, their responsible integration in plans for service delivery should be considered. As digital technologies become more integral to health-care delivery and community engagement, the protection of privacy, confidentially and other digital rights must be a central concern in HIV programming *(59)*.

Condom programmes must be reinvigorated

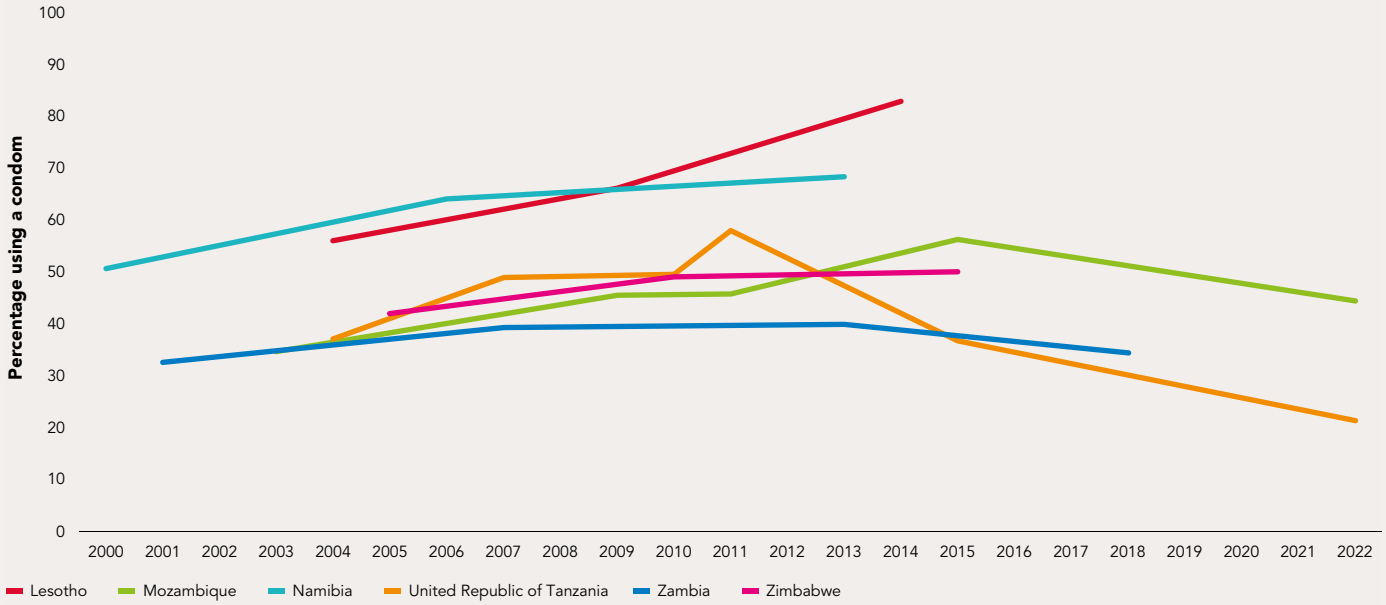
Male and female condoms continue to be among the most effective and cheapest prevention options available. They still have a major role to play in slowing the spread of HIV, including among key populations *(5, 42)*. In addition, they are the only prevention method that protects against HIV, other sexually transmitted infections and unintended pregnancy. Condom procurement, distribution and use, however, are far below the levels of need *(60)*.

In 17 of 24 sub-Saharan African countries with recent data, less than 50% of women aged 15–49 years reported using a condom the last time they had sex with a non-regular partner (median 35% across all 24 countries) *(61)*. Condom use is becoming less frequent among sexually active young women in several countries with recent data (Figure 3.12)—a sign that the concerted condom campaigns of the past no longer feature in the lives of younger people *(62)*.

The decline in condom use coincides with the defunding of condom programmes, a reduction of almost 30% in international condom procurement in 2016–2022 compared with 2010–2016, and drastically reduced demand generation campaigns following a cut of almost 50% in social marketing initiatives in low- and middle-income countries since 2010.[12]

Condom use is decreasing among young women in some countries with high HIV prevalence

Figure 3.12. Percentage of young, never married women aged 15–24 years who used a condom at last sex, of all young, single sexually active women surveyed, 2000–2022



Source: Demographic and Health Surveys.

12 Donors include the Global Fund, the United Nations Population Fund (including third-party procurement) and the United States Agency for International Development. Data for donors reflect global procurement; condoms may have been distributed in the same fiscal year. Data for social marketing organizations reflect the reported distribution as part of the DKT social marketing statistics report *(63)*. The data for South Africa reflect procurement through domestic resources. Other domestic procurement is not reflected.

Scarce recent data show divergent levels and trends in condom use among people from key populations, which appear to be correlated with the existence of criminalizing laws and the extent of prosecution experienced by people from these populations *(64, 65)*.

In recent years, a median 84% of sex workers said they used a condom the last time they had sex with a client (66 reporting countries), and a median 67% of gay men and other men who have sex with men reported using a condom the last time they had anal sex with a male partner (60 countries). A median 65% of transgender people reported using a condom at last sexual intercourse (33 reporting countries), but a median of only 37% of people who inject drugs reported using a condom the last time they had sexual intercourse (38 countries).

Among 121 countries reporting on HIV services in prisons and other closed settings between 2017 and 2024, 53 stated that condoms and lubricants were available in at least some prisons. Countries in Latin America and eastern Europe and central Asia were most likely to provide condoms and lubricants.

More generally, in population-based surveys in 18 countries, a median of 59% of women said they felt able to ask their husbands to use a condom (ranging from 20% in Senegal to 91% in Lesotho) *(66)*.

The impact of consistent condom use on HIV transmission among people from key populations can be seen in countries with sizeable HIV epidemics. In western and central Africa, for example, the combination of HIV treatment and condom use may have averted 81–88% of potential new HIV infections during 2012–2021 in Côte d'Ivoire, Mali and Senegal, according to a recent study. Condom use among gay men and other men who have sex with men and clients of female sex workers was a major factor. All three countries have progressively integrated their HIV prevention programmes, including condom distribution, among key populations. Significantly, sex work is legal in all three countries. In Senegal, HIV prevalence among female sex workers has decreased sharply, partly due to successful condom promotion. Sex between men, on the other hand, is criminalized and punished in Senegal. The available data show HIV prevalence among gay men and other men who have sex with men reached very high levels of 28% in 2018, compared with 0.4% among adult men in the same year *(67)*.

Voluntary medical male circumcision is still cost-effective

VMMC programmes have boosted HIV prevention in the 15 countries in eastern and southern Africa where they have been prioritized since 2007. VMMC programmes continue to be a cost-effective way to prevent new HIV infections *(68)*.[13] Modelling based on data from 13 of these priority countries shows that almost 890 000 new HIV infections were averted by the 37.5 million VMMCs conducted between 2008 and 2023—equivalent to one infection averted for every 42 procedures performed. Through 2030, the number of infections averted from VMMCs already conducted will rise to 1.4 million—and this impact will keep growing into the future *(69)*.[14]

13 VMMC lowers a man's risk of acquiring HIV during heterosexual intercourse by about 60%.

14 The results are based on applying the Goals HIV model in Botswana, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. The projection for each country is based on VMMCs conducted through 2023 and assumes no more VMMCs are conducted after 2023. The counterfactual scenario assumes that no VMMC programme ever existed. Both scenarios assume antiretroviral therapy coverage through 2023 and the same constant antiretroviral therapy coverage after 2030.

Across eastern and southern Africa as a whole, male circumcision prevalence increased from 40% during 2010–2015 to 56% in 2016–2023, and it now exceeds 80% in Ethiopia, Kenya and the United Republic of Tanzania *(70)*. Overall prevalence of male circumcision is on average much lower in southern Africa (33%) than in eastern Africa (70%) and still far from the 90% target set for 2025.

Recent trends in the uptake of VMMC have been mixed, with some programmes struggling to recover from setbacks during the COVID-19 pandemic *(71)*. The impact of funding losses on these programmes is still unfolding, although initial country reports indicate that VMMC activities have been reduced or paused in several PEPFAR-supported countries. Along with replacing lost funding, VMMC activities will need to become more thoroughly integrated with other prevention programmes.

Harm reduction services work but remain scarce and difficult to access

The use of punitive laws against people who inject drugs and the scarcity of harm reduction services continues to expose these people to a very high risk of acquiring HIV. In 2025, only 29 of 181 countries with available data did not criminalize the possession of small amounts of drugs *(18)*. The risk of acquiring HIV drops sharply when drug use and possession for personal use are decriminalized and when people can access effective harm reduction services *(72, 73)*.[15] This is evident in the Kingdom of the Netherlands and Switzerland, for example, where fewer than 10 people in each country acquired HIV through injecting drug use annually in 2013–2022 *(75)*.

Generally, however, the estimated 13.9 million [10.2 million–19.9 million] people who inject drugs around the world continue to be left behind in HIV programmes, with women who inject drugs especially neglected *(76)*. Globally in 2024, a median of only 39% of people who inject drugs received at least two prevention services in the past three months (22 reporting countries). Women who inject drugs find it particularly difficult to access harm reduction services *(76)*, due to stigma, gender-based violence, and generalized fear, shame and exclusion *(77)*.

Only two of 25 reporting countries have achieved the 2025 United Nations recommended levels of coverage for opioid agonist maintenance therapy, and only two of 32 countries have achieved the United Nations targets for needle and syringe distribution. No country has reported to have met both of these targets (Figure 3.13). Of 35 reporting countries, 13 have reached the safe injecting targets (90% using sterile equipment at last injection).[16]

15 Harm reduction services include needle–syringe programmes, opioid agonist maintenance therapy, HIV testing and treatment services, condom programmes, and viral hepatitis and tuberculosis services *(74)*.

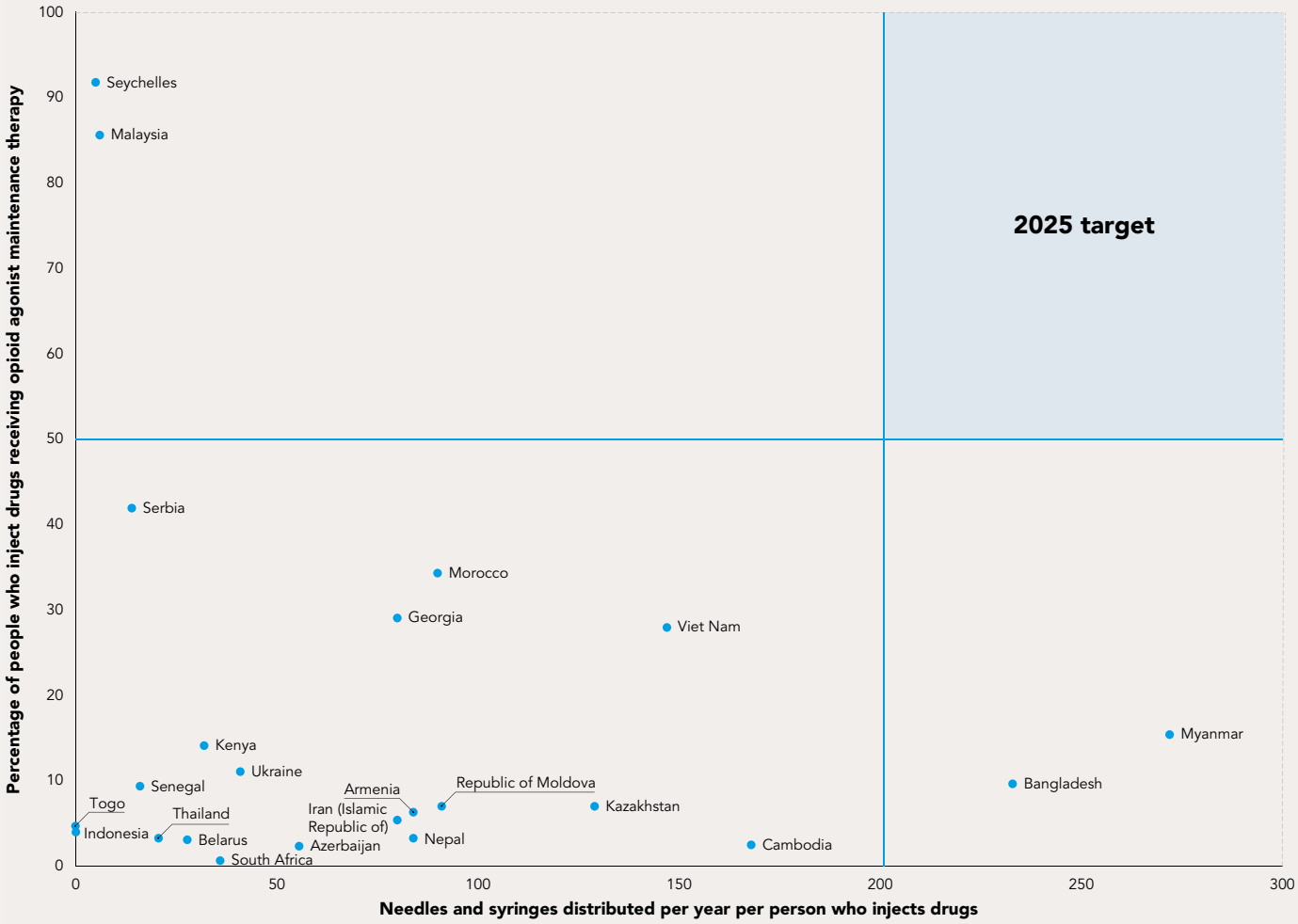
16 Armenia, Bangladesh, Belarus, Canada, Czechia, Germany, Greece, India, Montenegro, Nepal, Republic of Moldova, Ukraine, Viet Nam.

These harm reduction programmes are even rarer for people in prisons and other closed settings, despite ample evidence of injecting drug use in such settings. Between 2017 and 2024, nine of 133 countries reported that needle–syringe programmes in prisons were operational in the country and 28 of 132 countries reported opioid agonist maintenance therapy programmes operated in at least one prison.

With more than three-quarters of funding for harm reduction coming from international donors, these few services are in danger of closing down—for example, PEPFAR supported opioid agonist maintenance therapy for 27 000 people in seven countries and harm reduction programmes in three countries. These programmes are highly vulnerable to donor funding cuts, since host countries often lack the political will to finance harm reduction services from national budgets.

Very few countries are on track to reach the main 2025 harm reduction targets

Figure 3.13. Coverage of needle–syringe programmes and opioid agonist maintenance therapy among people who inject drugs, countries with available data, 2020–2024



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

3.3 The last mile is the toughest

As fewer people acquire HIV, it can be increasingly difficult to reach the people who are at increased risk of HIV but are missing out on existing prevention services. It is crucial to know where and among which populations HIV infection rates are highest and then focus the most effective interventions there.

In all regions, people from key populations continue to be at high risk of acquiring HIV—and more investments are needed in HIV prevention programmes that reach and service them. In places with large HIV epidemics, the precise targeting of interventions can be very difficult.

Analysis of granular HIV data from sub-Saharan Africa indicates that about three-quarters of new HIV infections occur in districts that contain about a quarter of the total population. This can guide more focused prevention efforts. In eastern and southern Africa, for example, the relative HIV risks of different demographic groups (e.g. defined by sex or age) can be determined. But beyond that, it is very difficult to zero in on the individuals who are most at risk and to steer prevention services towards them.

This is because the epidemic in this region is not concentrated among small clusters of people. As shown in recent studies, HIV still circulates among large numbers of people, a significant minority of whom eventually acquire the virus *(78)*. Programmes still need to reach a relatively large share of the population with prevention services to maintain or speed up the reduction of new infections *(79)*.

Some prevention tools, such as PrEP and harm reduction services, can and should be deployed in a highly targeted manner. But in countries where HIV is widely present in the general population, large-scale interventions, including low-cost primary prevention, such as condom programmes, are still needed to reduce numbers of new infections to levels that make epidemic control feasible. Leveraging community systems along with integrating HIV prevention into broader health services will be vital.

In all regions, people from key populations continue to be at high risk of acquiring HIV—and more investments are needed in HIV prevention programmes that reach and service them.

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Chapter 4

COMMUNITIES, FINANCING AND THE WAY FORWARD

4.1 Community spotlight

Community-led organizations perform lifesaving work

Community-led organizations and networks are the heart of the HIV response. For more than 40 years, their activism, knowledge and inventiveness have shaped and powered HIV programmes across the world, saving countless lives.

Community-led services and support are often lifelines for people neglected by standard health systems, reaching them with information, services and other support they need to stay HIV-free or live healthily with HIV. From advocacy to peer-led services, monitoring and research, these community-led interventions continue to fill service gaps, monitor and register deficiencies, identify solutions and help ensure HIV responses are grounded in human rights. Advocacy by women-led networks,[1] for example, has focused attention on the links between HIV and gender-based violence, the many ways in which gender inequalities shape HIV epidemics and responses, and the ongoing challenges of uneven and inadequate access to sexual and reproductive health and rights.

In recognition of these vital roles, the 2021 Political Declaration on HIV and AIDS committed countries to increase the proportion of HIV services delivered by community-led organizations to 30% for HIV testing and treatment services, 80% for HIV prevention services, and 60% for programmes supporting the achievement of societal enablers by 2025 *(1)*. In support, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and several other major donors pledged to invest in community-led, community-based and other civil society organizations *(2)*.

HIV services do better when community-led organizations are involved

The impact and cost-effectiveness of community-led interventions are evident in a growing body of research evidence *(3, 4)*. A recent review of studies from southern Africa, for example, reported that peer support projects, treatment adherence clubs and community-led HIV testing led to increased uptake of testing, improved adherence to antiretroviral therapy, stronger retention in care, reduced vertical transmission, and higher levels of viral load suppression in multiple settings and countries *(5)*.

1 Examples of these networks include the ATHENA Network, the Eurasian Women's Network on AIDS, the Indonesia Network of Women Living with HIV, the International Community of Women Living with HIV, Kuyakana, MENA Rosa, 4M Mentor Mothers and Positive Young Women Voices, Kenya.

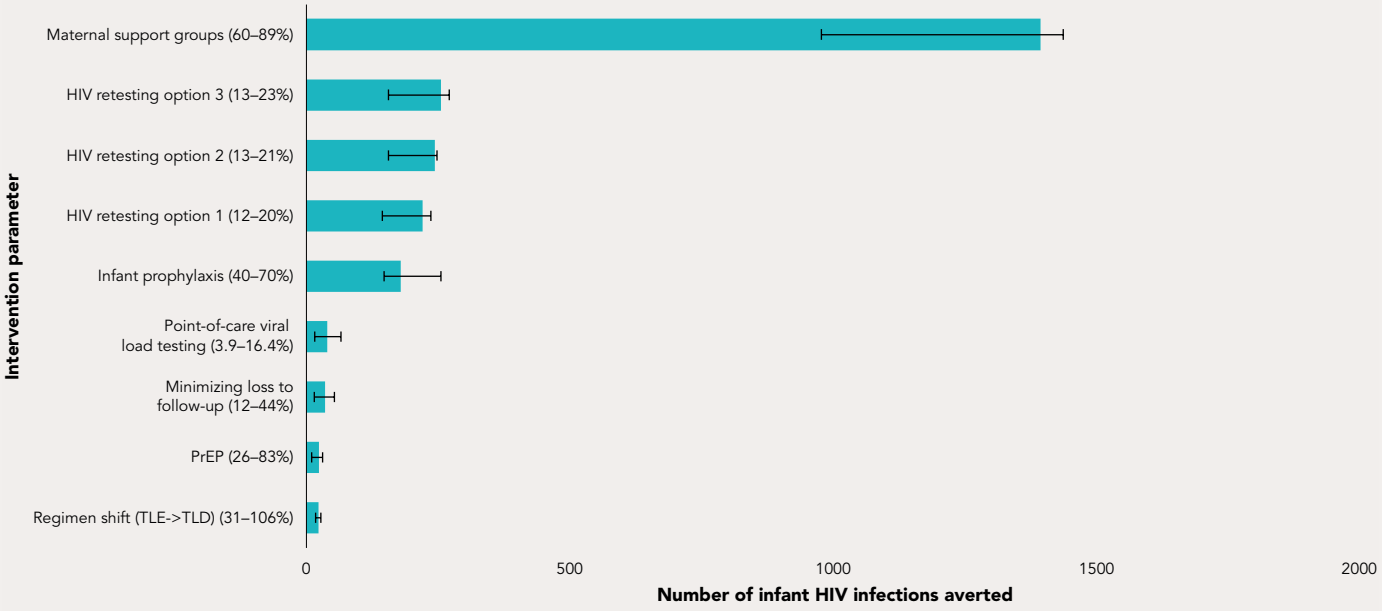
Community-led monitoring and research efforts complement other HIV surveillance systems by generating context-specific data that may otherwise go unnoticed and that can be used to improve services *(4, 6)*. Other activities of community-led organizations, such as legal aid, violence prevention, and access to sexual and reproductive health services, are often associated with improved uptake of HIV services *(7, 8)*.

Mentor Mothers programmes are highly valued *(9, 10)*. They increase women's retention in HIV treatment and care *(11)* and enhance the health and well-being of women and infants. In a trial in Uganda, peer support increased linkage to care rates from 86% in 2016–2017 to almost 100% in 2022 and halved treatment interruption rates among mothers living with HIV *(12)*. In Zambia, modelled estimates show that reaching 60–90% of pregnant women with maternal peer support could reduce the number of HIV acquisitions in children by 35%, making it the most effective vertical transmission intervention assessed in a recent study (Figure 4.1) *(13)*. Such programmes also improve women's health and well-being *(14)*.

For people from key populations, community-led person-centred HIV services help circumvent barriers that put such services out of reach *(14)*. Peer-led services and support among female sex workers have boosted HIV prevention efforts in Africa, Asia and South America *(8)*. In the AMETHIST trial in Zimbabwe, peer-led interventions for female sex workers significantly improved service uptake and outcomes, with intervention sites experiencing increased HIV testing, increased initiation of antiretroviral therapy and pre-exposure prophylaxis (PrEP), and higher rates of viral load suppression, compared with sites offering standard services *(15)*.

Peer-led maternal support programmes are highly effective

Figure 4.1. Projected effectiveness of interventions to reduce vertical transmission after one year



Note: this is a univariate sensitivity analysis of intervention effectiveness measure parameters representing the expected number of infant HIV infections averted after one year. The range for each parameter estimate is shown in parentheses. TLD=tenofovir, lamivudine and dolutegravir. TLE=tenofovir, lamivudine and efavirenz. HIV retesting option 1: HIV retesting during late antenatal care, during delivery or six weeks postpartum. Option 2: HIV retesting during late antenatal care, during delivery or six weeks postpartum, with an additional test at 14 weeks postpartum. Option 3: HIV retesting during late antenatal care, during delivery or six weeks postpartum and additional retesting every three months during breastfeeding.

Source: Chevalier JM, Hansen MA, Coskun E, et al. Cost-effectiveness of intervention combinations towards the elimination of vertical transmission of HIV in limited-resource settings: a mathematical modelling study. Lancet Glob Health. 2024;12(3):e457–e466 (https://doi.org/10.1016/S2214-109X(23)00588-0).

In Pakistan, tailored interventions led by a national network of people living with HIV successfully re-engaged almost half the 696 people who had dropped out of care *(16)*. In the Trans Amigas pilot in Brazil, transgender women who were assisted by peers were 40% more likely to be retained in HIV care at the end of the nine-month intervention *(17)*.

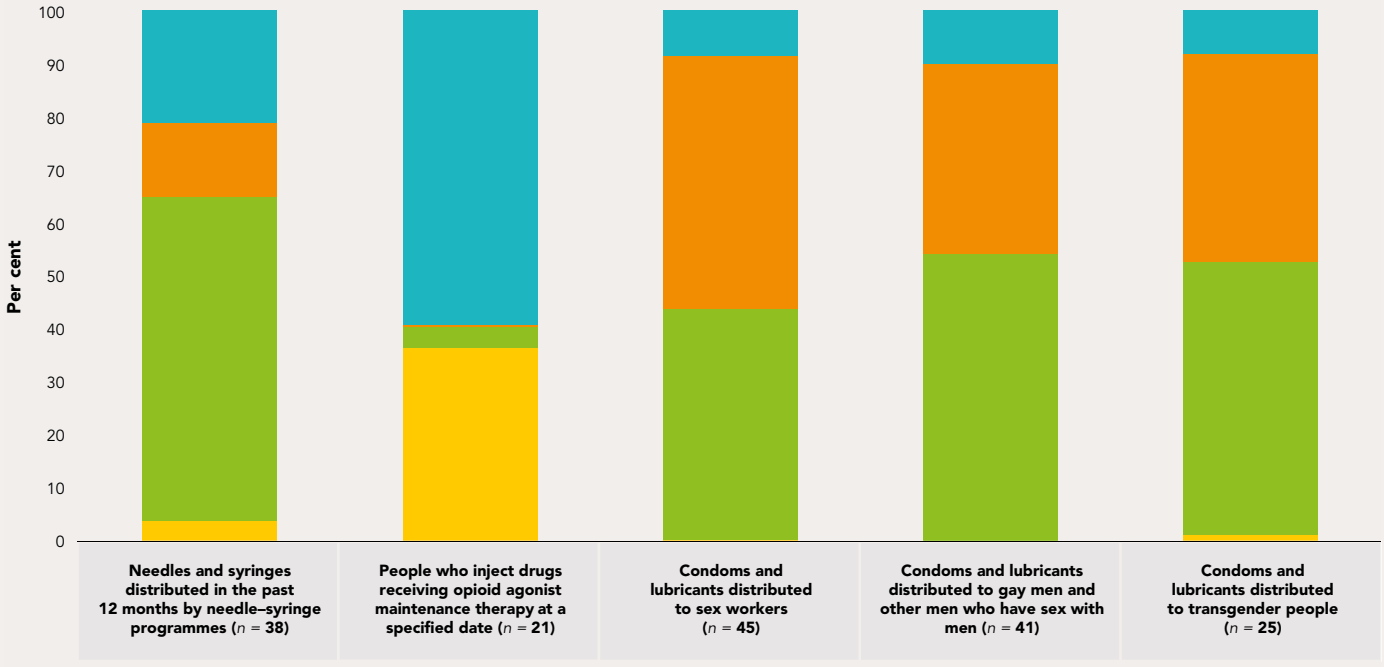
People from key populations depend on community systems

In some countries, people from key populations are almost entirely reliant on community-led organizations for vital HIV services and support. According to data recently reported to UNAIDS, 10–45% of people from key populations reached with tailored HIV prevention services were receiving these services from key population-led organizations. A further 33–51% relied on other nongovernmental organizations for the services.

In countries reporting these data to UNAIDS, more than 80% of sex workers, gay men and other men who have sex with men, and transgender people relied on nongovernmental organizations, including those led by people from key populations, for condoms and lubricants. For people who inject drugs, the public sector was a minor source of needles and syringes but the largest provider of opioid agonist maintenance therapy (Figure 4.2).

Key populations rely on nongovernmental organizations, including those run by people from key populations, for differentiated HIV prevention services

Figure 4.2. Distribution of reported services for people from key populations by type of provider, 2020–2024



Note: *n* = number of countries.

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

Keeping people's realities and needs at the centre of HIV responses

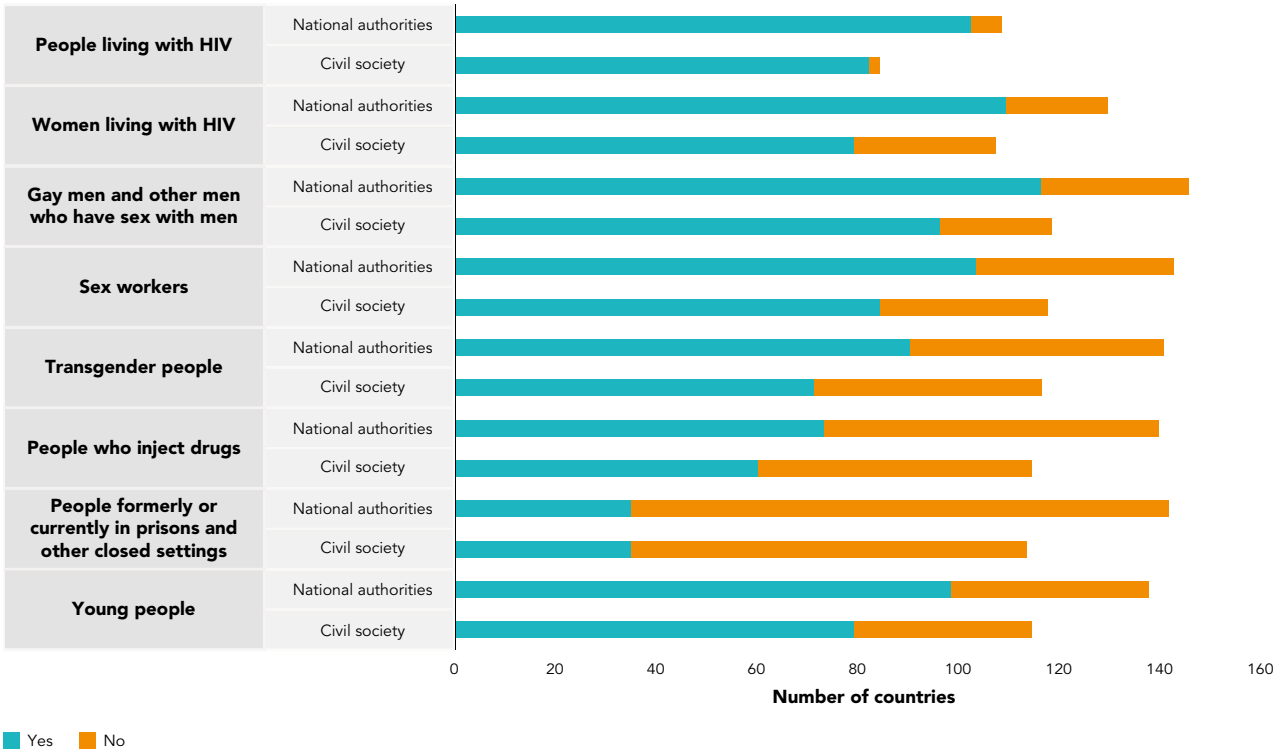
Meaningful engagement of communities in HIV policies and strategies has been a foundation for much of the progress made in the response to HIV. In the face of financial constraints, it is more important than ever that communities have a seat at the table for making policies, taking funding decisions and designing programmes.

In a majority of reporting countries, people living with HIV, people from key populations and young people are participating in the development of policies or strategies related to their health needs—with the exception of people who inject drugs and people in prisons and other closed settings (Figure 4.3). The reported extent of participation differs, however, depending on the source of the information—with civil society organizations, reporting lower participation than national authorities. Dwindling funding and other support and increasingly hostile regulatory and political environments cast doubt on whether these levels of participation will continue in the years ahead.

Community-led monitoring and research efforts improve the quality of services. For example, the work of Ritshidze, a community-led monitoring initiative in South Africa, has led to tangible improvements in service quality at clinics. Issues such as antiretroviral medicine stockouts, staff shortages and long waiting times were documented and addressed, resulting in improved antiretroviral therapy access and adherence *(19)*.

Participation in HIV policy-making varies widely across key populations

Figure 4.3. Participation of people living with HIV, people from key populations and young people in the development of policies, guidelines or strategies related to their health, global, 2017–2025



Note: participation of women living with HIV refers specifically to development of policies, guidelines or strategies related to prevention of vertical transmission.

Source: National Commitments and Policy Instrument, 2017–2025 (http://lawsandpolicies.unaids.org/).

Funding sources for communities are drying up

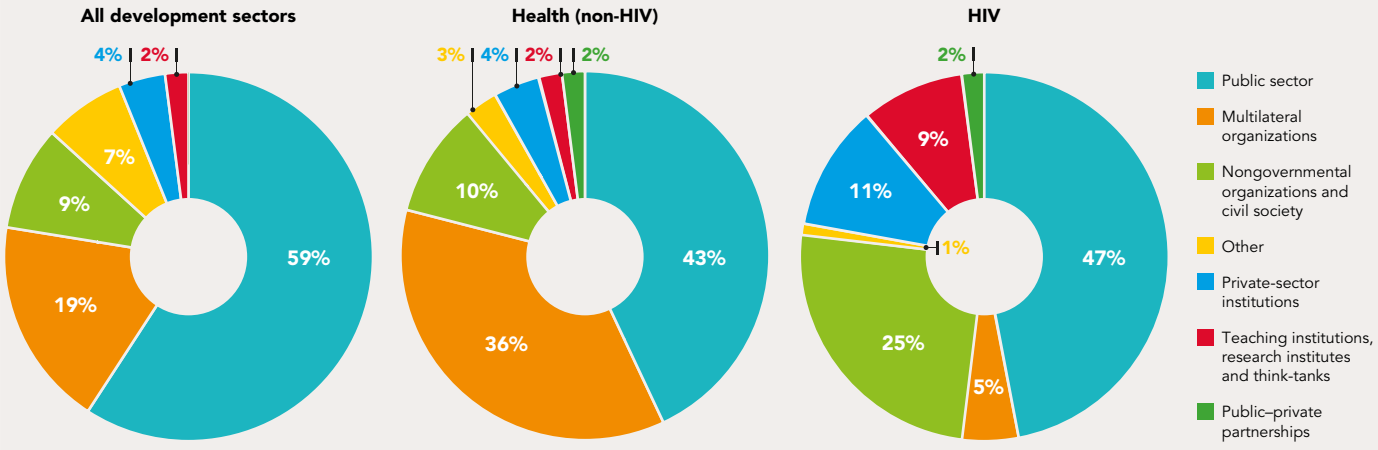
A quarter of donor funding for HIV programmes in 2023 went to civil society organizations and community networks, compared with only 10% through similar channels in non-HIV public health programmes (Figure 4.4). Disruptions to this architecture for HIV risk undermining essential HIV services.

Analysis of 22 recent national AIDS spending assessments covering the period 2019–2024 (see Section 4.2) showed that the share of HIV spending on "community services" was as high as 18–20% in some countries in the Caribbean, eastern Europe and central Asia, eastern and southern Africa and Latin America, although the share of spending specifically for community-led organizations was not easy to determine.

The funding cuts announced in early 2025 are having a huge impact on community-led and other nongovernmental organizations and the services they provide. The United States President's Emergency Plan for AIDS Relief (PEPFAR), for example, funded more than 113 000 community-based staff in direct service delivery in many countries in 2024, including community health workers, community mobilizers, DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe programme) mentors, peer educators, lay counsellors and mentor mothers. Around 20% acted as "expert clients" and peer navigators supporting treatment linkage and adherence *(20)*. Much of the PEPFAR funding for these posts is now frozen or under threat (Figure 4.5).

Civil society organizations were receiving a significant share of official development assistance for HIV

Figure 4.4. Comparison of distribution of official development assistance by service delivery channel provider, for HIV, health (non-HIV) and all other sectors, global, 2023



Source: UNAIDS financial estimates using data frm the OECD creditor reporting system.

The funding cuts announced in early 2025 are having a huge impact on community-led and other nongovernmental organizations and the services they provide.

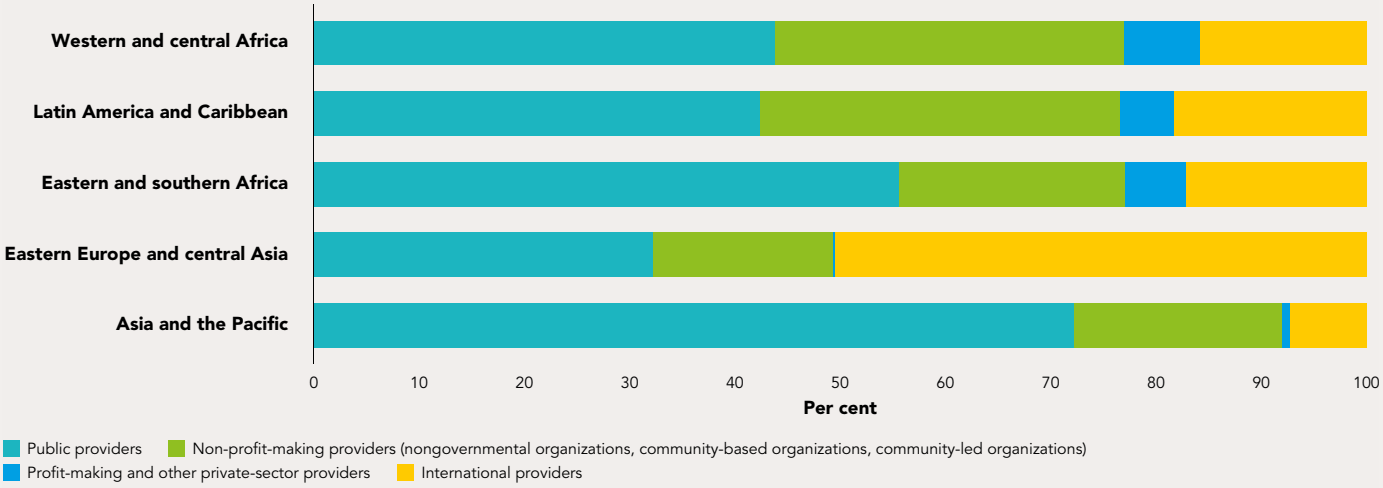
Research by Aidsfonds, the Global Network of People Living with HIV and the Robert Carr Fund found that one in five organizations serving people from key populations were stopping or reducing services and experiencing staff shortages as early as February 2025 *(21)*. A rapid assessment by the International Community of Women Living with HIV in February 2025 found that more than 60% of surveyed women-led HIV organizations had lost funding or been forced to suspend essential HIV services *(22)*. Frontline AIDS reported that almost half its community partners (45%) had been directly affected by funding cuts, losing up to 90% of their operating budgets and forced to lay off staff *(23)*. In another survey, 60% of reporting organizations said their capacity to deliver HIV prevention, treatment, care and support to young people had been badly affected *(24)*.

When surveyed by the International Network of People Who Use Drugs in March 2025, a total of 76 organizations serving people who inject drugs had already reported disruptions in outreach and peer-led harm reduction (38%), HIV testing (37%), legal support services (34%) and needle–syringe programmes (24%). Almost half of the surveyed organizations said they lacked harm reduction supplies or were relying on underground supply networks, and more than half reported experiencing increased stigma and discrimination *(25)*.

If these organizations, especially those that are community-led, disappear, it will take years to re-establish the capacities that have enabled them to serve the HIV-related needs of key and other affected populations.

Nongovernmental organizations are highly vulnerable to funding cuts

Figure 4.5. HIV spending by service provider types, by region, in 22 countries with recent national AIDS spending assessments, 2019–2024



Source: UNAIDS-supported national AIDS spending assessments, covering the period 2019–2024.

© NAPAD Amhara Region

STORY

Community workers at the heart of a resilient HIV response in Ethiopia

Amhara in northern Ethiopia is a region with a rich cultural history. The birthplace of the national language, Amharic, it is home to ancient churches such as the UNESCO World Heritage Site of Lalibela. In April 2023, the region was plunged into crisis when internal armed conflict erupted.

The consequences were devastating. Thousands of people were displaced, gender-based violence surged, essential services such as health and education were disrupted, and travel between cities became almost impossible.

As formal systems broke down, local community-based organizations and drop-in centres in urban areas such as the regional capital Bahir Dar continued to monitor the situation on the ground and provide vital services. These organizations became lifelines for people living with HIV, people from key populations and young people.

This changed in February 2025. Cuts in United States funding disrupted essential services. Many community-run organizations that relied on those funds were forced to close. Outreach workers who had built trust with people on their doorsteps were suddenly laid off. Peer support groups vanished. Fear took hold.

"I often find myself overwhelmed with stress," says a member of one women-led association of people living with HIV. "If medicine and other services stop, where will I go? I simply do not have the means to afford the treatment I need."

The data collected by the association paint a stark picture. For two months, no new clients have been enrolled in PrEP. "One of my biggest concerns is not having access to condoms," says a case manager. "Without them, HIV will spread much more easily."

She adds, "Without a financial budget, our members are left without the basics, no food, medical care, transportation, no hope. They have families. They rely heavily on this support. It would make a huge difference if members could access free medical treatment and hospital services. Many cannot even afford one meal a day. Their health is deteriorating. Their children are suffering. What they need most is dignity, food and a fighting chance."

Yet even when faced with collapse, communities refused to give up. Young volunteers formed informal networks and WhatsApp groups to check on peers and stay connected. Mothers banded together to support children's treatment. Youth collectives used community radio and shared airtime to spread critical health information.

Where formal systems failed, communities built their own safety nets.

The situation in Bahir Dar was a wake-up call. It exposed the fragility of systems dependent on a single funding source.

This crisis shows that resilience must be built into HIV responses from the start. Community-led and youth-driven responses must be recognized, resourced and scaled up. UNAIDS is providing support to community organizations to access funding support from local government authorities and private foundations to empower them to continue this important work of community outreach to the most vulnerable populations.

The conflict in the region has shown once again that HIV must feature in humanitarian, development and recovery agendas. The intertwined challenges of conflict, displacement, gender-based violence and HIV demand integrated, person-centred solutions. This will not happen if HIV is treated as an afterthought or is equated only with clinical care and if community-engagement is not recognized and supported.

New funding mechanisms are needed urgently

More than ever, access to funding is the single-biggest challenge facing community-led organizations. Yet, investments in community systems boost the reach and accountability of vital HIV and other health services. There are huge untapped opportunities to enhance health systems by partnering with communities to deliver cost-effective, person-centred services. Emergency funding mechanisms such as the Eurasian Coalition on Health, Rights, Gender and Sexual Diversity Emergency Support Fund and the Frontline AIDS Rapid Response Fund have been crucial lifelines, delivering grants to organizations facing unforeseen challenges and human rights crises. These are short-term in nature, however, and more flexible, longer-term funding is needed to support core costs and sustainability, such as that provided by the Robert Carr Fund.

Social contracting—whereby governments contract civil society organizations to provide certain services—is an underused but potentially important source of funding, and a basis to functionally link community systems with public health systems. Sixty-two of 104 countries with available data report having laws, regulations or policies on social contracting that allow for funding of service delivery by communities from domestic funding *(26)*.

Social enterprises can also help diversify revenue sources. In India, the Mist LGBTQ Foundation runs an online platform that markets merchandise and offers HIV self-testing and PrEP consultations free of charge or at a subsidized rate. Also in India, the Network of Maharashtra People Living with HIV TAAL+ Pharmacy runs a community pharmacy that sells antiretroviral and other medicines at subsidized rates negotiated through corporate social responsibility partnerships. In Thailand, M Plus operates a fee-based service for HIV and sexually transmitted infection medicines. The Chhouk Sar Association in Cambodia runs a clinic that offers HIV and sexually transmitted infection services free of charge alongside other fee-based elective services *(27)*.

Political and legal environments need to adapt

Community-led organizations need legal and regulatory arrangements that allow them to operate *(28)*. These conditions vary widely across regions. Country reporting in 2024–2025 indicates that organizations led by people living with HIV were legally allowed to register in more than 80% of reporting countries, but those led by other people from key populations could register in only 45–60% of countries.

The ability to legally register does not necessarily shield organizations from other forms of interference or harassment. Anti-rights and anti-gender campaigns and widening removals of democratic protections are making it increasingly difficult or even perilous for community-led and other civil society organizations to advocate and function. According to Civicus, in 2024 almost three-quarters of the world's population (72%) lived in 81 countries where civic space is either entirely closed or heavily repressed *(29)*.[2] By forcing many community-led organizations to drastically scale back or even shut down their activities, the wave of funding losses is having a similarly restrictive impact.

2 Civic space was obstructed in another 40 countries. According to the Civicus analysis, 118 of 198 countries and territories were experiencing severe restrictions in fundamental freedoms.

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STORY

Colombian Afro-descendant women are shaping the HIV response in their own terms

In Colombia, Afro-descendant women are taking the HIV response into their own hands. Faced with racism, inequality and violence—factors that make them more vulnerable to HIV—they are organizing themselves, speaking out, and demanding better access to health care, protection and rights.

In the Caribbean and Pacific coastal regions of Colombia, women represent half of all people diagnosed with HIV, compared with only a fifth at the national level. This gap is tied closely to gender inequality and other structural barriers such as violence and poor access to basic health services, including HIV testing and treatment. In addition, stigma—worsened by racism and sexism—makes it harder for many women to get an education, find work or receive proper medical care, leaving them more exposed to the risks of HIV.

Armed conflict and forced displacement have affected communities, exacerbating poverty and exposure to violence, including sexual violence.

UNAIDS, through the help of key donors, supports various organizations leading the HIV response in Afro-Colombian, Indigenous and rural communities. The Fundación Afro Mata 'e Pelo works to improve access to information on sexual and reproductive health in the Caribbean region of Colombia, where myths, stigma, discrimination and gaps in training among health workers remain common challenges.

In the Valle del Cauca department, located along the Pacific coast and within the Andean region, Fundación RedLujo supports transgender women, sex workers and nonbinary people by using artistic and pedagogical strategies to raise awareness about HIV and advocate for inclusive public policies that guarantee access to HIV prevention and care.

These organizations are bringing change to their communities, taking the lead in the response to HIV and pushing for fair, respectful access to health care. They work with Colombian Government institutions to make sure HIV prevention and care policies reflect local realities and include the voices and needs of communities.

"It is a challenge to make women visible, especially in the contexts and territories where Black and Indigenous women live," says Yaneth Valencia, HIV activist and founder of the Asociación Lila Mujer, a community-based organization focusing on women in southwestern Colombia. Through their sessions, women learn about HIV prevention and share their experiences. The organization advocates for better access to services and promotes the participation of women as agents of change in their territories.

"These spaces of sisterhood—of comadreo, as we call them in the communities—allow us to talk with our comadres. These can be self-help groups or peer advisors with whom we can talk and trust. It is also about recovering all that ancestry that allows us to reconnect and resist because we not only exist—we resist in a macho, racist, classist and very white context."

Afro-descendant women are leading community efforts in Colombia to respond to HIV with a focus on human rights. They are ensuring the response meets the real needs of their communities. Their work gives a voice to people often left out of HIV efforts and defends their right to health and dignity.

4.2 A financing shock—and ways to sustain and boost HIV responses

HIV programmes across the world have been rocked from the sudden major reductions in official development assistance for HIV announced by the United States Government in early 2025. Further anticipated cuts to assistance from other major donors would aggravate this financing crisis,[3] which is jeopardizing decades of hard-won progress against the AIDS pandemic.

The steep reductions in international funding for HIV have exposed the fragility of HIV programmes in many low- and middle-income countries and a reliance in some countries on limited funding sources. There is an urgent need for diversified and durable financing mechanisms for HIV and other public health priorities.

Countries have no choice but to adjust to this highly constrained funding environment. However, a combination of debt distress, slow economic growth and underperforming tax systems, especially in sub-Saharan Africa with fiscal space constraints, are limiting their ability to rapidly increase domestic HIV funding.

The immediate priority is to secure increased domestic investments and continued global solidarity to avert rising AIDS-related mortality and a surge in HIV new infections.

Hidden in this unfolding crisis are opportunities to make HIV responses and entire health systems more resilient against future shocks, whether due to funding shifts, pandemics, climate change or conflicts.

The steep reductions in international funding for HIV have exposed the fragility of HIV programmes in many low- and middle-income countries.

3 UNAIDS analysis shows there has been a gradual but persistent shift in development cooperation priorities among several major bilateral (80% decline since 2010) and multilateral (24% decline since 2010) donors. Changes in global official development assistance flows include the reprioritization of budgets towards national security, climate resilience and domestic infrastructure. This signals a continuing risk of further reductions in international health financing, including for HIV.

Funding losses threaten decades of progress in the response to HIV

The impact of the funding losses is rippling across HIV programmes in dozens of countries.

Countries are reporting stockouts of HIV medicines and test kits and faltering laboratory services. Funding shortages are limiting the availability of PrEP and other interventions to prevent new HIV infections.

Community-led services for people from vulnerable populations, projects focused on reducing stigma and discrimination and gender inequalities, and efforts to improve sexual and reproductive health, address gender-based violence and provide psychosocial support are being scaled back. Critical gaps in financing for frontline health workers and HIV testing services have appeared. The effects extend beyond HIV and add strain to health programmes that depend on integrated service delivery and infrastructure that has been built as part of the HIV response.

In 2024, domestic HIV resources accounted for 52% of resources available for HIV programmes in low- and middle-income countries.

Almost a quarter of 56 countries surveyed in late April 2025 reported having less than six months of stocks of condoms or PrEP, and almost half reported having supply chain management difficulties *(30)*. The PEPFAR "stop work order" in early 2025 rapidly affected thousands of health workers, especially in eastern and southern Africa. In Mozambique, more than 30 000 health staff—including nearly 20 000 community-based personnel—were impacted. At the time of writing this report, it was not clear how many of the more than 340 000 PEPFAR-supported health workers across several dozen countries have been able to continue working *(31)*.

Countries have been increasing their domestic HIV financing

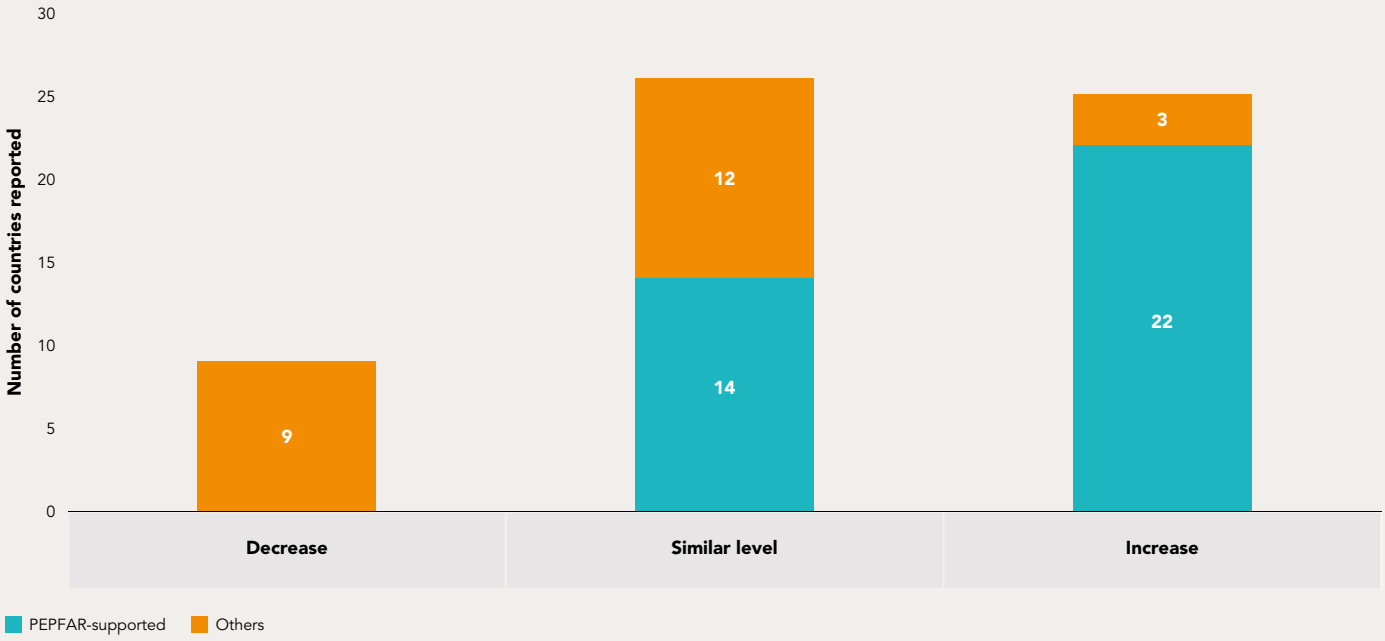
Many countries have been rebalancing their HIV programmes towards more sustainable models by increasing domestic funding for HIV. Even though domestic resource mobilization for HIV has been under strain since the beginning of the COVID-19 pandemic, more than half of reporting countries[4] have increased their domestic HIV spending in the past five years. In 2024, domestic HIV resources accounted for 52% of the resources available for HIV programmes in low- and middle-income countries.[5]

4 Including Cambodia, Costa Rica, the Democratic Republic of the Congo, Ghana, Indonesia, Kazakhstan, Lesotho and Malawi.

5 These latest estimates now exclude formerly upper-middle-income countries that the World Bank has reclassified as high-income countries, including Bulgaria, the Russian Federation and Uruguay.

Many countries intend to keep increasing their domestic funding for HIV

Figure 4.6. Forecasted trends in domestic public budgets for HIV for 2026 in 60 countries



Source: data reported by national governments to indicator 8.3 on 2026 trends in Domestic public budget for HIV, Global AIDS Monitoring July 2025.

Current indications are that many countries plan to to increase their domestic budgets for HIV. Twenty-five of 60 countries reporting to Global AIDS Monitoring[6] on forecasted budget trends for 2026 stated that they expect to increase their domestic public HIV budgets; the majority of these are PEPFAR-supported countries (Figure 4.6). This is also a unique opportunity to continue strengthening the centrality of community systems and community-led responses through innovative and underused financial mechanisms, such as social contracting, health taxes and corporate responsibility. This trend reflects growing national ownership and strong commitment to sustain the HIV response. But domestic resources alone will not be sufficient to fill the gaps in PEPFAR-supported countries. Those gaps may particularly impact programmes that were more dependent on international funding, such as for key populations.

Twenty-five of the 60 countries reporting to Global AIDS Monitoring on forecasted budget trends for 2026 stated that they expect to increase their domestic public HIV budgets.

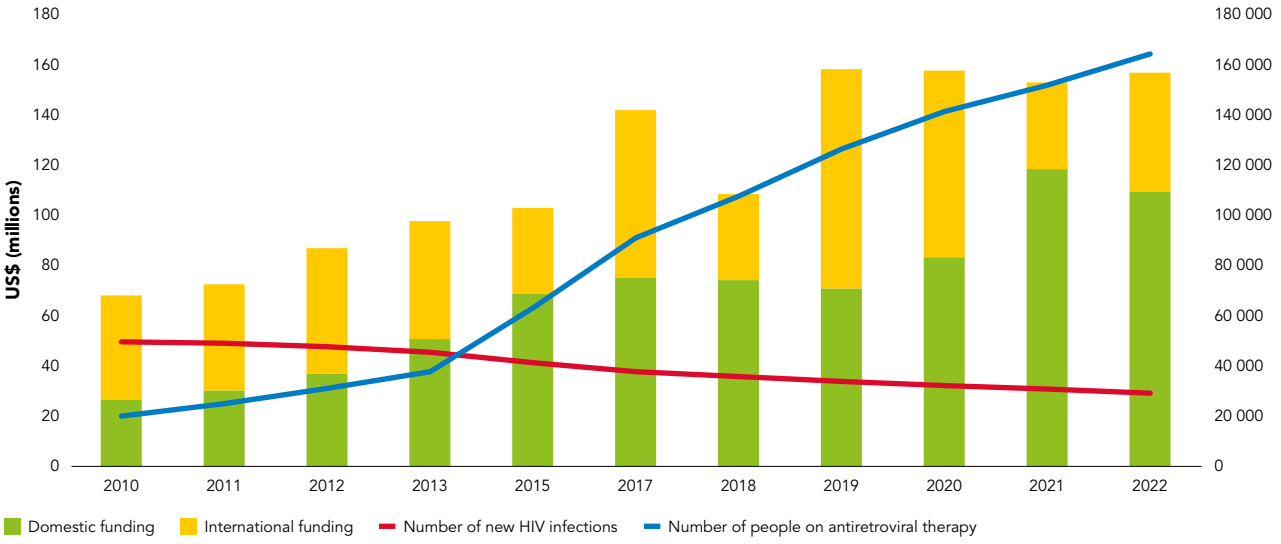
6 Bhutan, Bolivia (Plurinational State of), Brazil, Dominican Republic, Namibia, Pakistan, Republic of Moldova, Tajikistan, Timor-Leste (<5% increase); Algeria, Azerbaijan, Belarus, Central African Republic, Cuba, Egypt, Georgia, Kazakhstan, Kenya, Nigeria, Thailand (data under validation), United Republic of Tanzania (5–10% increase); Democratic Republic of the Congo, Ethiopia, Mali, Niger (>10% increase).

Increasing domestic financing in Indonesia

Indonesia has made significant progress in scaling up its HIV response through increased domestic investments. Based on its UNAIDS-supported national AIDS spending assessments, domestic HIV spending grew by more than fourfold between 2010 and 2022—from US$ 26.7 million to over US$ 109 million—while the share of international support gradually declined (Figure 4.7). Despite fluctuations, this shift towards greater domestic ownership has yielded tangible results, with the number of people on antiretroviral therapy increasing eightfold, from approximately 20 000 in 2010 to 230 000 in 2024. During the same period, the number of new HIV infections decreased by about 40%, from about 49 000 [44 000–54 000] to fewer than 25 000 [23 000–28 000] annually. Indonesia's experience highlights how sustained domestic financing, paired with strategic monitoring of resources and accountability, is essential for building a resilient, country-owned HIV response that delivers measurable impact.

Indonesia is making steady progress in domestic financing for its HIV response

Figure 4.7. Indonesian historical HIV spending data by funding source, 2010–2022



Source: Indonesian national AIDS spending assessments (UNAIDS-supported), 2010–2022.

Domestic HIV financing trends have not been uniform. Since the COVID-19 pandemic, domestic funding has generally increased in low- and lower-middle-income countries—which is significant, given their limited fiscal space. But there has been an opposite trend since 2020 in upper-middle-income countries, where HIV spending has fallen by 24%. This marks a reversal from the period of 2010–2019, when lower-middle-income and upper-middle-income countries increased their own HIV contributions by 39% and 57%, respectively.

These recent reductions do not necessarily reflect reduced political commitment or programming. They may be explained partly by cost savings such as reduced negotiated prices for antiretroviral medicines and more efficient supply chain and distribution systems. Nevertheless, efficiency-driven savings do not fully account for the magnitude of the net reductions in domestic HIV investments in upper-middle-income countries.

Many of the HIV activities supported by PEPFAR and other donors require durable financial commitment, trained workforces and well-functioning procurement and distribution systems. It is difficult for countries to instantly replace financing for these vital underpinnings. Many countries contend with forbidding fiscal challenges, including strained tax systems and high debt repayments in a context of slow economic growth. For example, Angola, Nigeria and Uganda spend almost five times more on servicing their public debts than on public health expenditure, and Gambia, Ghana and Zambia spend almost three times more on debt payments *(32)*.

Countries are working towards increasing sustainability

With UNAIDS support, countries are developing strategies to manage the sudden funding losses. Malawi, for example, has used the UNAIDS Rapid AIDS Financing Tool to draft a successful budget request to its Cabinet for additional domestic funds to bridge its sudden financing gap and increase domestic HIV financing in the 2026–2027 budget. Other countries are using the Rapid AIDS Financing Tool to calculate the domestic HIV investments that will be needed as they transition towards greater country ownership of their HIV programmes.

The 2025 South African budget review includes a 5.9% annual increase in health expenditure over the next three years, including a 3.3% annual increase for HIV and tuberculosis programmes. The Government intends to finance the development of a patient information system, a centralized chronic medicine dispensing and distribution system, and a facility medicine stock surveillance system *(33)*.

In Uganda the HIV response sustainability roadmap has been used to secure Government commitment of US$ 8.8 million for April and June 2025 and US$ 165.4 million for the fiscal year 2025–2026 to manage the impact of the United States funding cuts on its national HIV response. Uganda is also developing a two-year transition and sustainability plan to facilitate increased domestic HIV financing in its 2026–2027 national budget and to coordinate donor funding.[7]

More than 30 other countries are developing HIV sustainability roadmaps to increase domestic investments in their HIV programmes *(34)*. Of these, 16 have already completed the first phase of this exercise, whereby they identify the key transformations that will adapt their HIV responses to their evolving epidemics and shifting financial, political and social environments. Along with highlighting the importance of top-level political commitment, the roadmaps are prioritizing cost-saving service delivery models, the empowerment of affected communities, and new ways to unlock further efficiencies. Countries need to meet the challenge of addressing human rights and gender-related barriers to HIV services and to support accountability and transparency to communities throughout the Sustainability Roadmap process, including their implementation and monitoring.

Countries are pledging to increase domestic financing and progressively reduce reliance on international assistance. Botswana, for example, has introduced domestic funding targets for the HIV response for 2026 and 2030 as part of a wider commitment to increase health-care financing to 15% of the total Government budget by 2030 *(35)*. The United Republic of Tanzania has committed to raise more than half of its multisectoral HIV response funding from domestic resources, including the private sector *(36)*. Togo's roadmap traces a path to increase domestic HIV financing from 15% to 50% by 2030 *(37)*.

Several countries are already working on the second part of these sustainability roadmaps, laying out the specific changes that will be introduced in the next two to four years. Domestic HIV financing options include the use of blended finance and social impact bonds, social contracting, further integration of HIV services with broader health systems, and pooled procurement. Of the 16 countries that have finalized the first part of their HIV response sustainability roadmaps, 12 have committed to establish social contracting arrangements and three already have social contracting in place.

7 Unpublished communication, 10 April 2025.

Donor solidarity is still crucial

Donor solidarity—especially the support channelled via PEPFAR—has enabled huge progress in the past two decades. More than 90% of official development assistance for HIV in 2023 came from five countries, with the United States the largest contributor *(39)*. Many donor countries have been contributing in line with a "fair share" measurement (i.e. relative to the size of their economies) *(38)*. However, if United States funding of HIV were to end entirely, international assistance for HIV responses in low- and middle-income countries from donor governments would fall by 80%.

The HIV funding cuts in 2025 have arrived on the back of an almost 6% decline in official development assistance for HIV since its peak in 2013. This has been an anomalous trend: the share of official development assistance going to public health held steady between 2010 and 2022, but the share going to HIV programmes almost halved, from 6% to 3.4%.

Low- and middle-income countries have responded to this trend with increases in domestic HIV investments—but donor solidarity remains indispensable for HIV responses in many countries, particularly low-income countries. This is not a matter of simple overreliance. Although some countries are highly exposed to official development assistance reductions, others finance their HIV responses with a more balanced mix of resources or predominantly with domestic resources. The speed at which they can transition to greater country ownership, however, differs.

PEPFAR investments have contributed to impressive results, including a 76% reduction in the number of AIDS-related deaths and a 62% reduction in the number of new HIV infections in PEPFAR-supported countries between 2003 (when PEPFAR was initiated) and 2024. Many PEPFAR-supported countries in sub-Saharan Africa have progressively increased the domestic financing of their health systems. A 52% rise in financial contributions from PEPFAR between 2010 and 2024 was accompanied by a 62% growth in domestic resources for HIV in PEPFAR-supported countries (Figure 4.8). The increase in domestic HIV investments signifies the commitment of governments in PEPFAR-supported countries to strengthen national ownership and sustainability of their HIV responses *(40)*.

PEPFAR investments have contributed to impressive results, including a 76% reduction in the number of AIDS-related deaths and a 62% reduction in the number of new HIV infections.

STORY

Empowering young women in Cité Soleil: a model for reducing vulnerability to violence in Haiti

Gang violence in Haiti is contributing to a dire humanitarian crisis in a country where 5.7 million people face acute food insecurity and more than a million people are internally displaced, half of them children. In the country's capital of Port-au-Prince, only 50% of health-care facilities are operational, and access to essential health services, including HIV treatment, is severely limited. Amidst the escalating insecurity, ruthless sexual violence, including gang rape, is rampant, exacerbated by restricted or suspended gender-based violence services.

More than 6500 incidents of gender-based violence were reported in 2024, although this number is likely to be significantly underreported. Nearly two-thirds of these incidents involved rape or sexual assault. Between 2023 and 2024, there was a shocking 1000% increase in sexual violence against children.

"I was a victim of gang rape in 2021," says 29-year-old Laguerre Myrline. "This happened when we had to abandon our home to flee the attacks of armed men. At the southern entrance of Port-au-Prince, I was assaulted by several men. They abused me one after the other. Traumatized, I didn't even go to the hospital."

Women and children remain particularly at risk in this crisis. The Organization for Development and Poverty Reduction (ODELPA), a civil society organization supported by UNAIDS and the United Nations High Commissioner for Refugees (UNHCR), is implementing a transformative initiative aimed at reducing sexual and gender-based violence and other systematic violence in Cité Soleil, an impoverished and densely populated commune in Port-au-Prince.

The initiative includes capacity-building and economic empowerment via training on HIV prevention, prevention of gender-based violence and mental health support for girls, young women and men. Through these efforts, 180 beneficiaries have received startup funds to launch income-generating activities and businesses, helping them to break the cycle of financial dependence and offering a sustainable pathway to resilience and autonomy.

The programme has been so successful that the training sessions have been replicated for more than 1000 members of grassroots community organizations. In addition, ODELPA launched a multimedia communication campaign to raise awareness and provide education on prevention of gender-based violence.

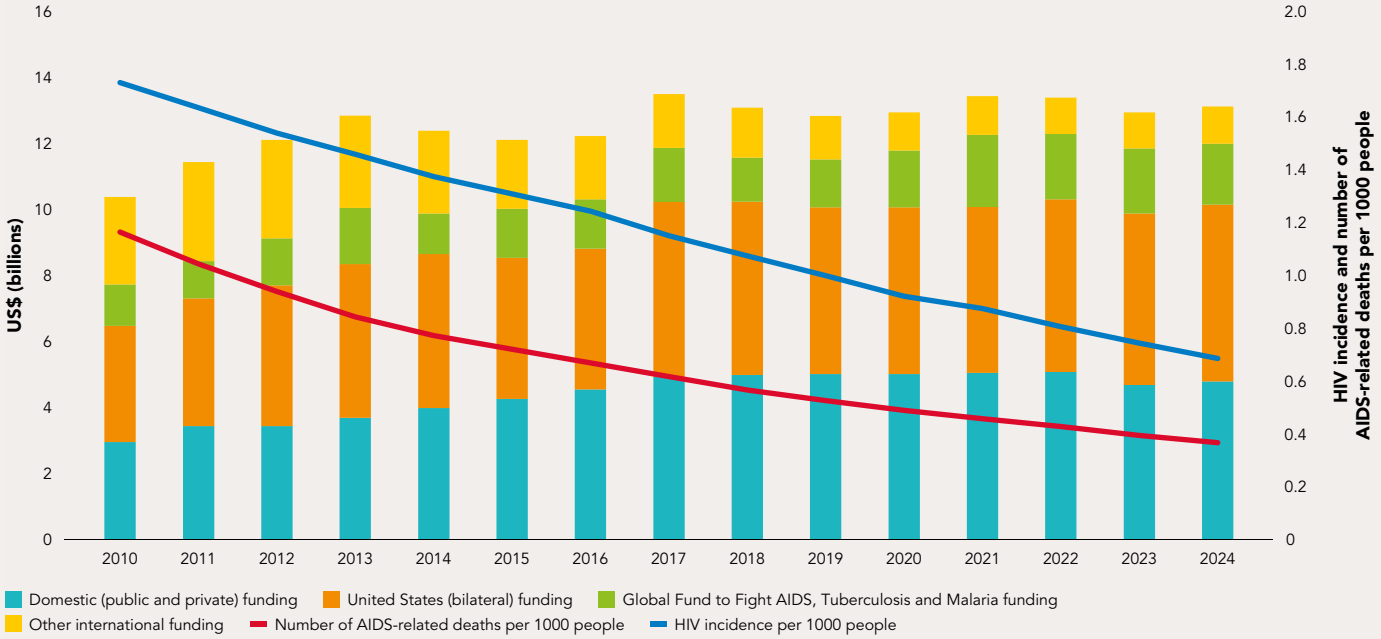
The campaign reached more than 1.5 million people across Haiti and the Haitian diaspora through four radio programmes. The project applies a holistic approach that combines education, economic empowerment and community-driven solutions as key elements to breaking cycles of violence and inequality and ensuring girls and young women can reclaim their rights and dignity and their future.

In Haiti, the recent funding cuts have had a huge effect on the national HIV response, which was almost 100% funded externally and almost entirely reliant on PEPFAR (which provided about 90% of HIV funding) and the Global Fund (which contributed the remaining 10% of funding). Civil society organizations have been significantly impacted by the funding cuts, particularly those that provide services for people from key, priority and vulnerable populations. This has increased vulnerability to stigma, discrimination and gender inequality, and weakened responses to sexual and gender-based violence.

The youth project implemented by ODELPA and supported by UNAIDS and UNHCR is a small beacon of hope. Sustainable funding will be required to support the response to HIV in Haiti, including urgent renewed global solidarity.

Domestic HIV financing has increased in countries receiving PEPFAR support

Figure 4.8. Distribution of HIV resources in PEPFAR-supported countries, and trends in HIV incidence and AIDS-related mortality, 2010–2024



Source: UNAIDS-supported national AIDS spending assessments, 2010–2022.

Despite the increase in domestic HIV funding, the responses of some countries have remained highly reliant on external support. Based on data from the past five years, the United States Government, the Global Fund and other development entities collectively financed more than 90% of HIV responses in at least nine countries.[8] For these countries, the sudden funding cuts are a major blow.

Upper-middle-income countries are showing varying levels of resilience: many may be able to absorb reductions in donor support due to stronger domestic financing capacity, but several of them may still struggle to fill gaps in critical areas such as HIV prevention and societal enablers, where domestic investment has historically been limited.

Low- and lower-middle-income countries on the other hand remain highly vulnerable. HIV programmes in many of them are highly dependent on external financing and they are unlikely to withstand unplanned or rapid reductions in donor funding. This could lead to disruptions in essential services and weaken the overall HIV response.

The United States Government, the Global Fund and other development entities collectively financed more than 90% of HIV responses in at least nine countries in 2024.

8 Ethiopia, Haiti, Liberia, Malawi, Mozambique, Nigeria, South Sudan, United Republic of Tanzania, Zimbabwe.

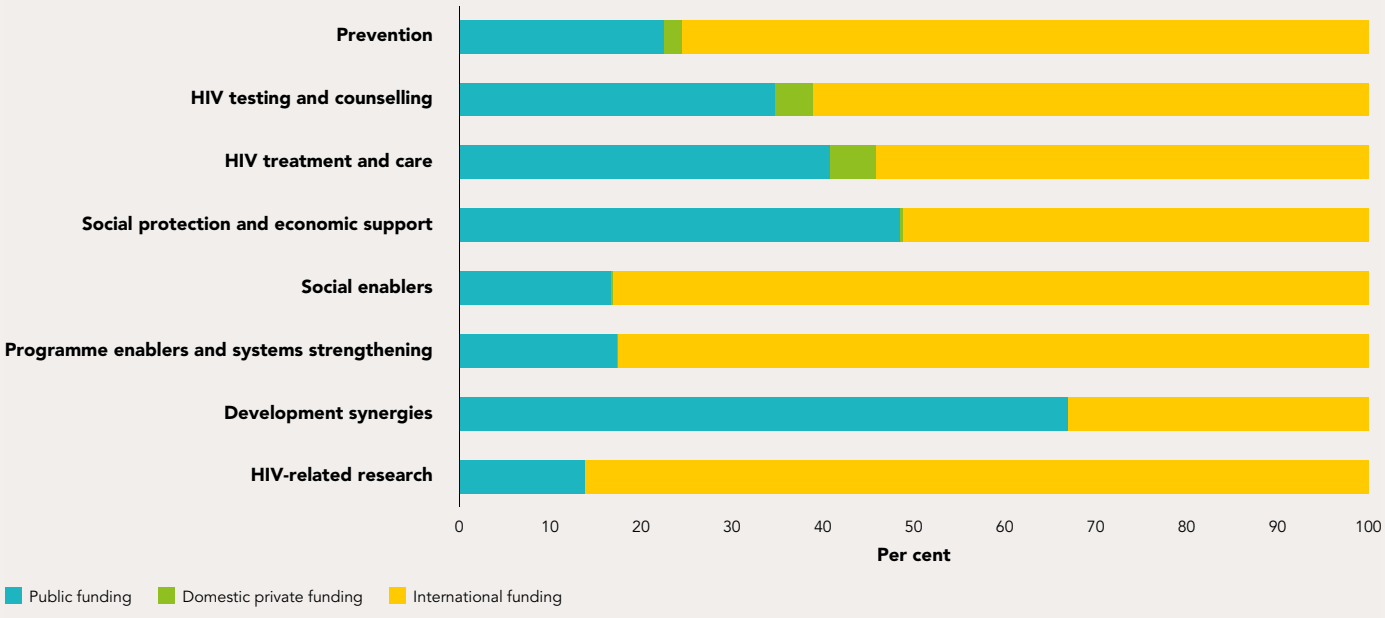
Countries can be grouped by their level of dependency on PEPFAR funding:

- In high-dependency countries, such as Haiti, Mozambique, Nigeria, the United Republic of Tanzania and Zambia, PEPFAR covered more than 60% of HIV-related expenditure. These countries face a high risk of immediate service disruption if United States Government support declines or ends, given their limited domestic or alternative donor resources.
- Countries such as the Dominican Republic, Eswatini, Malawi, Rwanda and Ukraine were moderately dependent on PEPFAR support (30–60% of HIV-related spending). Mixed financing models provide them with some buffer, but substantial gaps could still emerge if the support declines or ends.
- Low-dependency countries, such as Brazil, India, South Africa and Thailand, benefit from robust domestic HIV investments, which promises greater sustainability. Continued global solidarity remains crucial, however, to maintain momentum and achieve greater equity in their HIV programmes.

A more detailed picture of the importance of external support emerges from an analysis of recent national AIDS spending assessments in 22 low- and middle-income countries (2019–2024).[9] This shows that about 60% of HIV testing programmes, almost 80% of prevention programmes, more than 80% of societal enabler activities, and almost 90% of HIV-related research were financed externally (Figure 4.9). Diminishing official development assistance for HIV is a major risk for community-led and other nongovernmental organizations that are active in HIV responses.

HIV prevention, system strengthening and societal enabler programmes have relied heavily on external funding

Figure 4.9. Main sources of funding for HIV programme areas in 22 countries with recent national AIDS spending assessments, 2019–2024



Source: UNAIDS-supported national AIDS spending assessments, 2019–2024.

9 Benin (2024), Botswana (2019), Cambodia (2022), Democratic Republic of the Congo (2020), Eswatini (2019), Ethiopia (2023), Ghana (2022), Indonesia (2022), Jamaica (2020), Kenya (2019), Kyrgyzstan (2020), Malawi (2022), Mongolia (2021), Mozambique (2022), Nigeria (2021), Pakistan (2022), Papua New Guinea (2023), South Africa (2019), Tajikistan (2020), Uganda (2020), Zambia (2021), Zimbabwe (2020).

It is important for donors to recognize that the option of increasing domestic HIV funding is not immediately or equally available to all countries. Saddled with their highest debt burdens in decades, many of the world's poorest countries are not able to rapidly compensate for the sudden funding gaps in their HIV responses. Their efforts to expand domestic financing should be supported, including through debt relief, debt pauses or debt swaps, and blended financing mechanisms. Donors and philanthropic organizations can consider bringing future spending forward to support accelerated sustainability strategies. This is also an opportunity for emerging economic powers to contribute more actively to global health and HIV financing, in line with their growing economic capacities.

How can countries manage the funding shocks and sustain their HIV responses?

HIV financing has rested mainly on two pillars—external funding and domestic revenues. The current major reductions in external support call for shifting to a three-pillar system comprising increased HIV funding from domestic revenues, relatively smaller official development assistance funding, and diversified and blended financing instruments and mechanisms. The latter may include grants to leverage additional resources from development banks and other entities.

The immediate priority is to stabilize HIV programmes and funding:

- Countries that are heavily reliant on external funding need to take immediate budgetary steps to avoid or remedy service disruptions, along with accelerated transition planning backed by emergency and coordinated donor support.
- Countries with a more balanced mix of domestic and external financing can focus on strengthening co-financing models and on building resilience by further diversifying their funding sources. Stronger national stewardship, improved efficiencies, and a clearly established and aligned division of labour among financing partners are key in these countries.
- For countries with large domestic HIV contributions, the focus should be on improving budget execution, achieving continued efficiencies (including in supply chains) and pursuing further price reductions for HIV commodities.

An overhaul of both domestic and external HIV financing is needed

Most countries have no choice but to adjust to the sudden declines in external support for their HIV programmes. Their immediate challenge is to prevent service disruptions, shore up supply chains for antiretroviral medicines and other essential HIV products, and preserve the quality of HIV services. Ultimately, domestic financing is the bedrock of a sustainable HIV response. More effort and support will need to go towards safeguarding and institutionalizing HIV financing within national health budgets.

Evidence-based prioritization will be more vital than ever, with countries carefully allocating resources to programmes based on their epidemiological impact. The rebalanced allocations can then be compared with existing and past expenditures to determine new budgeting and spending recommendations. This approach can guide the reweighting of allocations between different programmes or interventions and the modalities through which services are delivered. Deciding on the most effective ways to deliver services can be as important as correctly selecting priority services and interventions *(41)*.

Ultimately, increased domestic funding is imperative. Countries will need to honour their commitments on health financing, including for HIV. Very few African countries, for example, have realized the commitments made in the 2001 Abuja Declaration, which called for allocating at least 15% of national budgets to health *(42)*.

Increased domestic financing for health and HIV can be sourced from enhanced domestic revenue collection (including through restructured corporate and/or personal income tax rates, wealth taxes, sin taxes, reforms of preferential tax regimes, and measures to combat tax evasion and avoidance), through improvements in tax administration systems, and by ringfencing budget lines for health. These adaptations will take time. Diversified financing includes blended finance models that leverage both public and private capital are another option for sustaining HIV investments *(43, 44)*.

In the meantime, the sudden funding losses risk forcing low- and middle-income countries into unrealistically quick transitions to "self-reliance", including potentially self-defeating trade-offs between different health priorities in a context of very limited domestic resources *(44)*. Continued solidarity from donors will be crucial, but external HIV financing strategies that follow a declining trajectory will need to adapt by prioritizing:

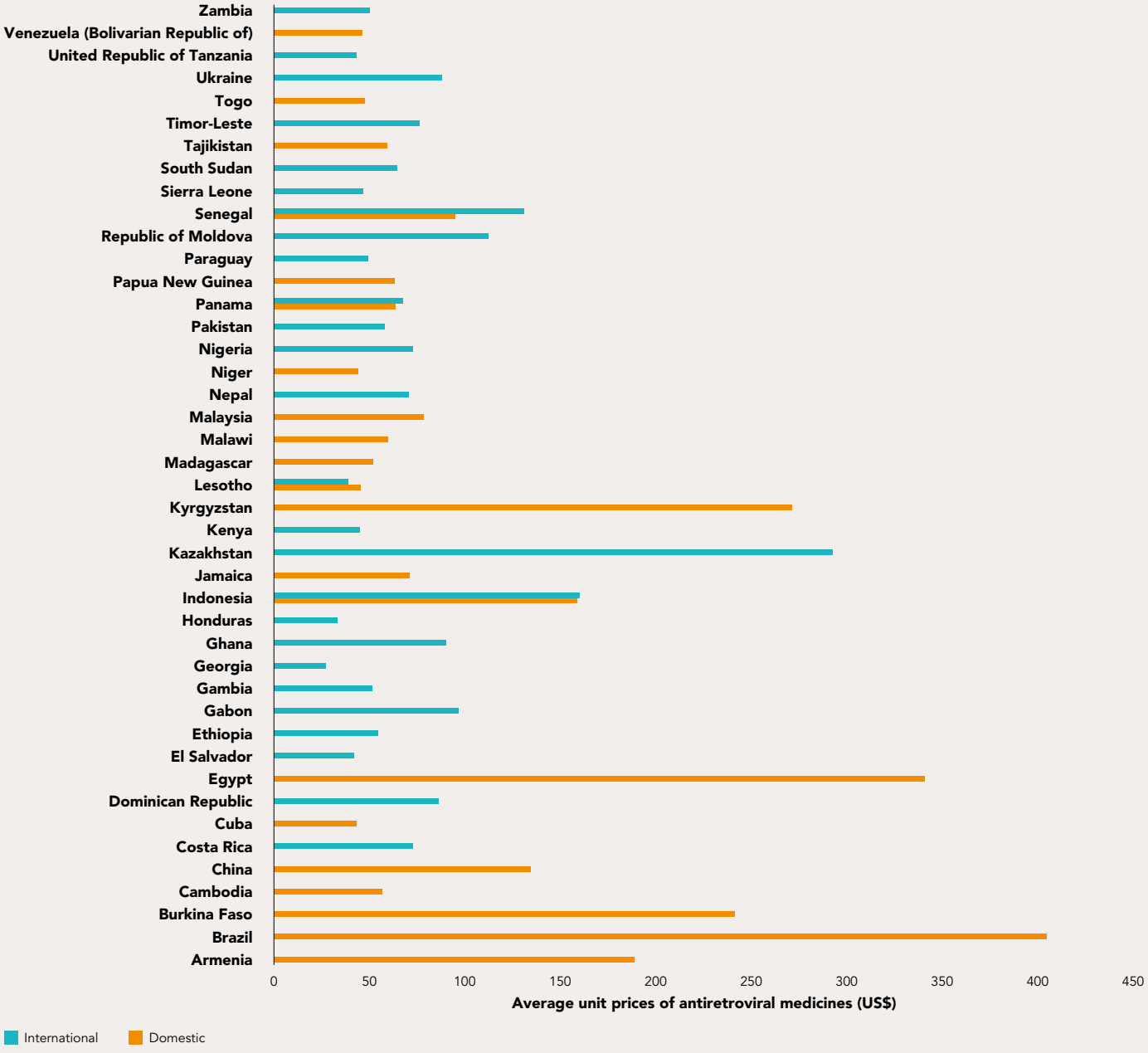
- emergency targeted support for HIV programmes (including HIV testing, treatment, prevention, communities and addressing human rights and gender-related barriers to services) in countries that are hobbled by debt and fiscal constraints and that lack immediate capacity;
- sustained investments in low-income and some lower-middle-income countries to build platforms for their transitions to stronger country systems and greater financial ownership of their HIV responses in the medium to long term;
- incentives and support for domestic resource mobilization strategies and for the development and implementation of diversified financing mechanisms across all country income groups.

Further price reductions can be achieved

The prices of key HIV products, especially antiretroviral medicines, are an important factor in a country's ability to finance its HIV response. Based on recent data reported to Global AIDS Monitoring and UNAIDS financial estimates in July 2024, HIV commodities account for almost 30% of total annual HIV spending in low- and middle-income countries and up to 40% in upper-middle-income countries.

There are large variations in procurement prices for antiretroviral medicines

Figure 4.10. Weighted average cost of first-line antiretroviral medicines (US$)



Note: the data reported to Global AIDS Monitoring 2025 on procurement prices are awaiting final validation.

Source: latest data reported to Global AIDS Monitoring 2024.

Price reductions for antiretroviral medicines and other HIV commodities—achieved through activism, generic production and market-shaping interventions such as pooled procurement—have enabled low- and middle-income countries to massively expand their HIV treatment programmes. The need for HIV treatment is so great, however, that these countries spent approximately US$ 3 billion on antiretroviral medicines annually in 2020–2022, according to procurement data from 110 countries. Approximately US$ 2 billion of annual spending went on purchasing generic antiretroviral medicines.

Procurement prices for antiretroviral medicines vary drastically across regions and country income groups. Middle- and upper-middle-income countries, especially in eastern Europe and Latin America, generally pay higher prices for antiretroviral medicines and other medical technologies, and in particular for innovative products (Figure 4.10). This is particularly relevant for their ability to use new long-acting treatment and prevention products, such as cabotegravir and lenacapavir. Standalone domestic procurement prices for antiretroviral medicines tend to be higher than for pooled and internationally financed procurement. Market-shaping strategies have the potential to lower these commodity costs.

Procurement prices for antiretroviral medicines vary drastically across regions and country income groups.

Untapped opportunities for integration

A strong consensus has emerged around the need for further integration of HIV with broader health systems, including primary health care. More extensive integration is expected to boost the use, efficiency and sustainability of HIV services, thereby improving both HIV and broader health outcomes and making health systems more resilient *(45)*. It is also seen as a way to overcome HIV funding gaps and advance towards universal health coverage and other relevant Sustainable Development Goals *(46)*.

Among the 152 countries with available data, about a quarter have integrated their HIV responses with broader health strategies. Integration at the point of care can make it easier and less costly for people to access multiple health services. Integration is also expected to generate savings for service providers, if more versatile service platforms increase coverage and reduce costs. Integration of systems (e.g. supply chains, laboratories, human resources, information systems, financing channels, programme management) has the potential to boost efficiencies, generate cost savings and smoothen the overall functioning of health systems.

There is good evidence supporting many of these expectations. A meta-analysis of 114 studies, mostly in sub-Saharan Africa, reported that both HIV and other health outcomes were better in integrated services than in separated services and the uptake of non-HIV services tended to rise *(45)*. Country studies report increased rates of HIV testing *(47)*, improved hypertension control among people living with HIV *(48)*, high acceptability of cervical cancer screening *(49)*, and increased uptake of sexual and reproductive health services *(50)*. Improvements in the linked delivery of HIV and tuberculosis (TB) services have led to a decline of more than 70% in the number of TB-related deaths among people living with HIV between 2010 and 2023 (see Chapter 2) *(51)*. Integration of HIV with screening for infectious and noncommunicable diseases has been found to be cost-effective in different settings *(52, 53)*, as has the integration of HIV services with family planning and other sexual and reproductive health interventions *(54)*.

Realizing the full potential of integration is not straightforward, however. The underlying systems need to function smoothly, including information, procurement and logistics systems. Supportive policies, integrated programme management and operational frameworks must be in place. Sufficient staff, budgets, equipment and health products must be available. Integrated service delivery systems must be of good quality and be non-stigmatizing and consensual, particularly towards people living with HIV and people from key populations. The risk of increased workload for health staff and the need to ensure staff competencies across various health conditions must be addressed *(45, 55–59)*.

Care is needed to ensure integrated services preserve person-centred approaches, protect human rights and gender equality, and advance equity. These approaches are critical to sustain the demand and coverage of services, which make them essential for sustainable HIV responses. This is particularly important for people from key populations and for people living with HIV (especially women), who are exposed to heightened stigma and discrimination when seeking health services (see Chapter 2) *(60)*. A balance must be struck between greater integration and preserving the community-driven accountability and engagement engagement that make HIV programmes successful, including community-led monitoring, community-led research and advocacy, community engagement in decision-making and community-led service delivery.

Social protection and HIV

If they are extensive enough, social protection programmes can improve people's health and well-being. In 2023, about 52% of the global population was covered by at least one social protection benefit, although coverage was much lower in many countries with a high burden of HIV, especially in sub-Saharan Africa *(68)*. It is widely assumed that cash transfer programmes can positively influence the use of health services and improve health outcomes, among many other benefits *(69–74)*—but studies researching the impact on HIV have mixed findings *(75)*. Social protection schemes must be inclusive and free from discrimination, ensuring equitable access for people from key populations and people living with HIV.

An evaluation of the effects of unconditional cash transfer programmes covering more than 5% of impoverished populations in 42 countries found a higher probability of recent HIV testing among recipients and slightly reduced odds of numbers of new HIV infections and AIDS-related deaths *(76)*. A systematic review of "cash plus" or "bundled" programmes[10] (mostly in eastern and southern Africa) found strong effects for HIV knowledge and testing uptake, but there was

Integrated service delivery systems must be of good quality and be non-stigmatizing and consensual, particularly towards people living with HIV and people from key populations.

10 Bundled interventions include cash plus health information, vocational training, mentoring and life skills.

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STORY

Displacement and HIV: doubly vulnerable in Ukraine

In early 2022, shortly after the full-scale invasion of eastern Ukraine, Kateryna was pregnant and caring for her young son and daughter.

"We lived under constant shelling in Pokrovsk. For the sake of my children, I had to flee to give birth," she says. She is originally from the Donetsk region in Ukraine, which by 2024 became the scene of intense fighting.

Today, her hometown of Pokrovsk lies in ruins. With three children and no home to return to, Kateryna is trying to rebuild her life from scratch.

Kateryna has found refuge in the city of Dnipro at a shelter run by the nongovernmental organization 100% Life was established by UNAIDS with donor support. The shelter provides a safe environment for women living with HIV, including those with children. It is one of four such shelters in the Dnipropetrovsk region, offering vital humanitarian assistance and connections to HIV care for people who have lost everything.

Since the beginning of the war, nearly 3.7 million people have been displaced within Ukraine. As the violence has escalated and people are forced to flee repeatedly, many people are living in areas of active fighting or under occupation. In this context, any reliable assessment of the rate of HIV among displaced people is impossible.

Despite this, the health system in Ukraine, supported by humanitarian organizations and international donors, has made extraordinary efforts to ensure continued access to HIV treatment. From the first days of the invasion, the Public Health Center quickly distributed antiretroviral medicines to central and western regions, where most internally displaced people fled. Emergency stocks were concentrated in leading health facilities and, with the help of nongovernmental organizations, volunteers and partners, supply chains were rapidly restored.

"In the early days of the war, hospitals in Lviv were overcrowded," says Olenka Pavlyshyn, an infectious diseases specialist at the Center for Integrated Medical and Social Services. "But even then, there were no interruptions in antiretroviral therapy." People received three- or six-month supplies of medicines, and treatment was provided based on medical need rather than documents or place of residence.

The response also reached people who fled abroad. A total of 6.4 million Ukrainians have left the country, and many face barriers to health care in host countries. "In some European countries, our citizens still cannot get health insurance, so they have no access to medical care," says Olenka. "Others are not ready to disclose their HIV status in a new environment, so these people come back to Ukraine every six months—and we give them the medicines they need for continued treatment while living abroad."

As the health system in Ukraine adapts to the demands of a displaced population inside the country and beyond its borders, pressure is growing.

Ukraine was once a regional leader in transitioning from donor to domestic funding for health services, but its HIV resources are extremely constrained due to the war. The country now relies heavily on international assistance to sustain essential medical care, including HIV services. Although antiretroviral therapy has been secured, HIV services may be at risk due to cuts in United States funding.

New HIV infections and AIDS-related deaths could rebound globally if the funding cuts are not recovered. Continued international support is critical to sustain the HIV response and ensure countless people caught in a war, like Kateryna, are not left behind.

less impact on sexual risk behaviours and HIV incidence or prevalence. A recent evaluation of economic strengthening interventions in South Africa reported insufficient impact on risk behaviours to reduce HIV and sexually transmitted infections significantly at the population level *(77)*. It is likely that the size of the cash transfers and the duration of the programmes were insufficient to achieve changes in socioeconomic status and influence the power and other imbalances that shape people's behaviours and decision-making *(78, 79)*.

Further evidence comes from an assessment of Brazil's Bolsa Familia cash transfer programme, which reported that HIV incidence was 41% lower and HIV-related mortality 39% lower in households receiving the payment. The effects were strongest among people in the poorest households—a crucial finding, given other evidence that cash transfer programmes do not necessarily reach the most impoverished sections of society *(80, 81)*. Access to the Bolsa Familia scheme is conditional on school attendance and immunization for children and antenatal monitoring for pregnant women *(82)*.

HIV services are being integrated in humanitarian emergency responses

Globally in 2024, there were more than 122 million forcibly displaced people, among whom more than half were internally displaced *(61)*. Twenty of the countries with the highest HIV burdens are included among the 50 countries considered to be "fragile states" due to the simultaneous impact of armed conflicts, economic malaise and extreme climate conditions *(62)*.[11] Disrupted or inaccessible health-care and other essential services are among the many challenges confronting displaced populations.

More than ever, HIV needs to be part of emergency preparedness and humanitarian responses. In 2024, HIV was reflected in about two-thirds of humanitarian response plans (14 of 24 countries[12]) but this needs to be translated into programmes for the people who are affected by HIV.

Of the 24 countries, 19 reported providing HIV counselling and testing, 18 provided HV treatment, 17 provided services for survivors of gender-based violence and 16 provided services for key populations *(63)*. According to UNHCR, more than 90% of 49 reporting countries were applying national HIV test-and-treat policies and integrating prevention-of-vertical transmission services with primary health care as part of refugee operations *(64)*.

Community-led organizations *(64, 65)* and other civil society organizations *(66)* are also becoming an integral part of humanitarian response and planning. There continue to be opportunities for integrating services for sexual and reproductive health *(67)* and for preventing gender-based violence *(68)*.

11 Angola, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, Haiti, Kenya, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, Uganda, Ukraine, Zambia, Zimbabwe.

12 Burkina Faso, Cameroon, Central African Republic, Democratic Republic of the Congo, El Salvador, Ethiopia, Guatemala, Haiti, Honduras, Mali, Mozambique, Myanmar, Ukraine, Venezuela (Bolivarian Republic of).

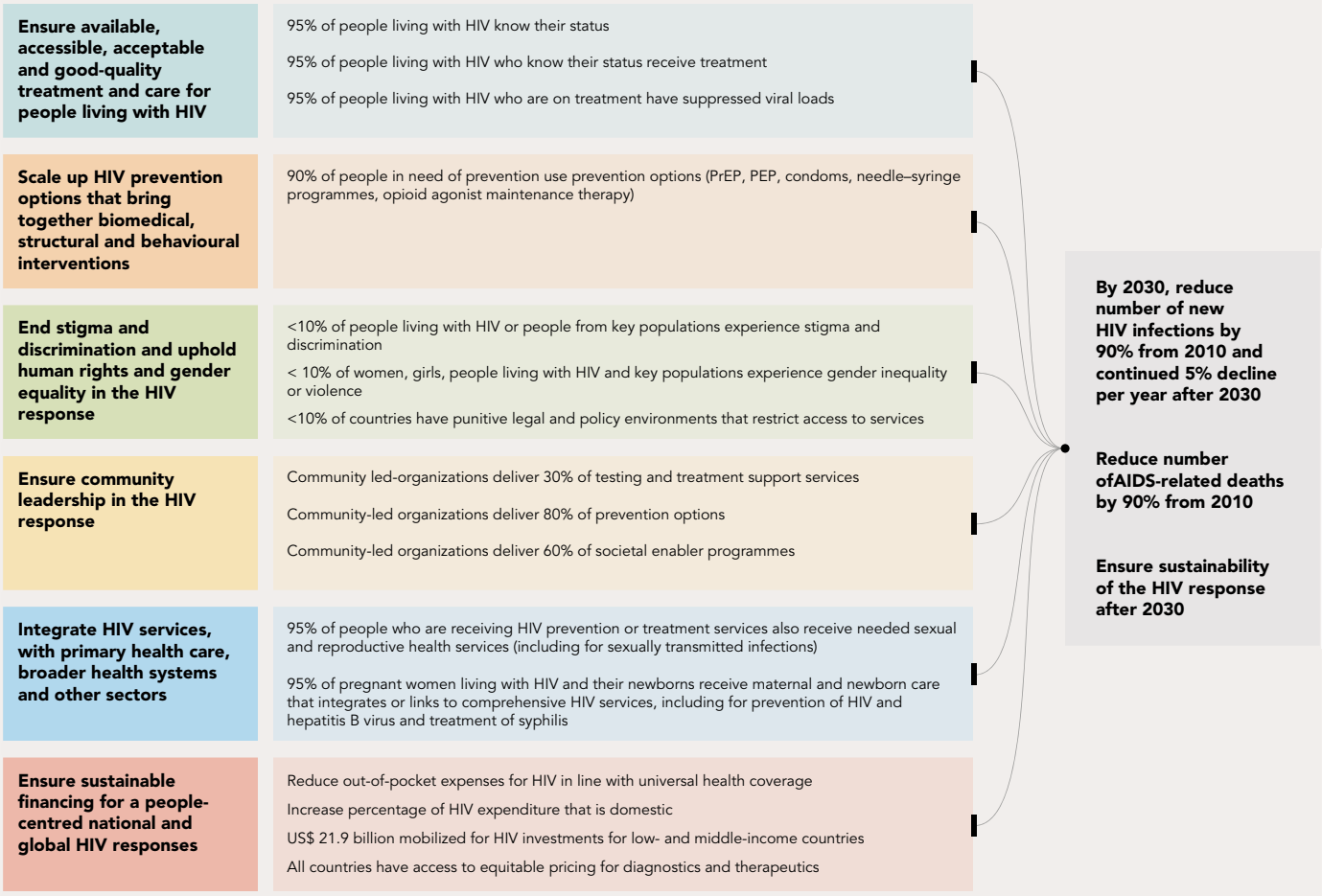
New global AIDS targets and resources needed to end AIDS by 2030

The global HIV response faces ongoing challenges, but the world is closer than ever to achieving a goal once thought impossible—ending AIDS as a public health threat.

Global AIDS targets are set every five years, and the 2025 targets are approaching their deadline. A high-level task team of HIV experts was convened by UNAIDS to develop a set of evidence-informed targets for 2030. These targets are intended to galvanize countries to drastically reduce numbers of new HIV infections and AIDS-related deaths by 2030; estimate the global resource needs for doing so across the period of 2026–2030; and build sustainable HIV responses beyond 2030.[13]

16 targets to end AIDS as a pubic health threat by 2030

Figure 4.11. The 16 topline targets to end AIDS as a public health threat by 2030 and ensure the sustainability of the response post-2030[a]

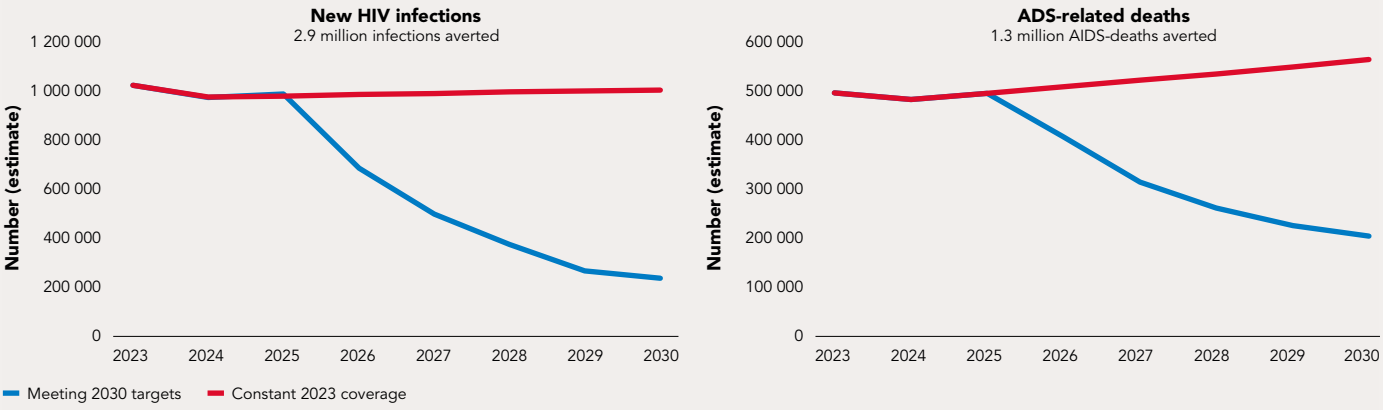


[a] The targets will be disaggregated as appropriate by gender, age and key population.

13 The Global Task Team on 2030 HIV Targets was composed of experts from governments, civil society, networks of people living with or affected by HIV, public health experts, and multilateral or bilateral donors. The team began its work in March 2024 and completed its mandate in February 2025 *(83)*.

Reaching the 2030 targets will save millions of lives

Figure 4.12. Projected numbers of new HIV infections and AIDS-related deaths averted between 2025 and 2030 by achieving the 2030 targets, global



Source: UNAIDS 2025 estimates and projections from April 2025 using Avenir Health Goals Model.

The Global Task Team on 2030 HIV Targets recommended 16 top-line global targets and 50 second-tier targets (Figure 4.11). The targets aim to simplify accountability while addressing evolving challenges *(85)*. A number of the targets that were in the 2021–2026 Global AIDS Strategy are proposed to be extended to 2030 because they have not yet been achieved by all countries and remain critical for ending AIDS as a public health threat by 2030; they include the 95–95–95 targets *(84)*. The targets will provide the framework for the forthcoming Global AIDS Strategy 2026–2031, which is currently being developed *(86)*.

Achieving the targets would bridge the gap in services and enabling environments and avert 2.9 million new HIV infections and 1.3 million AIDS-related deaths between 2025 and 2030 (Figure 4.12). This would be tantamount to reaching the 2030 goal of ending AIDS as a public health threat—or "ending AIDS". This goal is defined as a 90% reduction against the 2010 benchmark in both the number of people newly acquiring HIV and the number of people dying from AIDS-related causes *(87)*. This achievement will require reaching 40 million people with antiretroviral therapy and 20 million people with antiretroviral-based prevention, and ensuring all people have access to discrimination-free services.

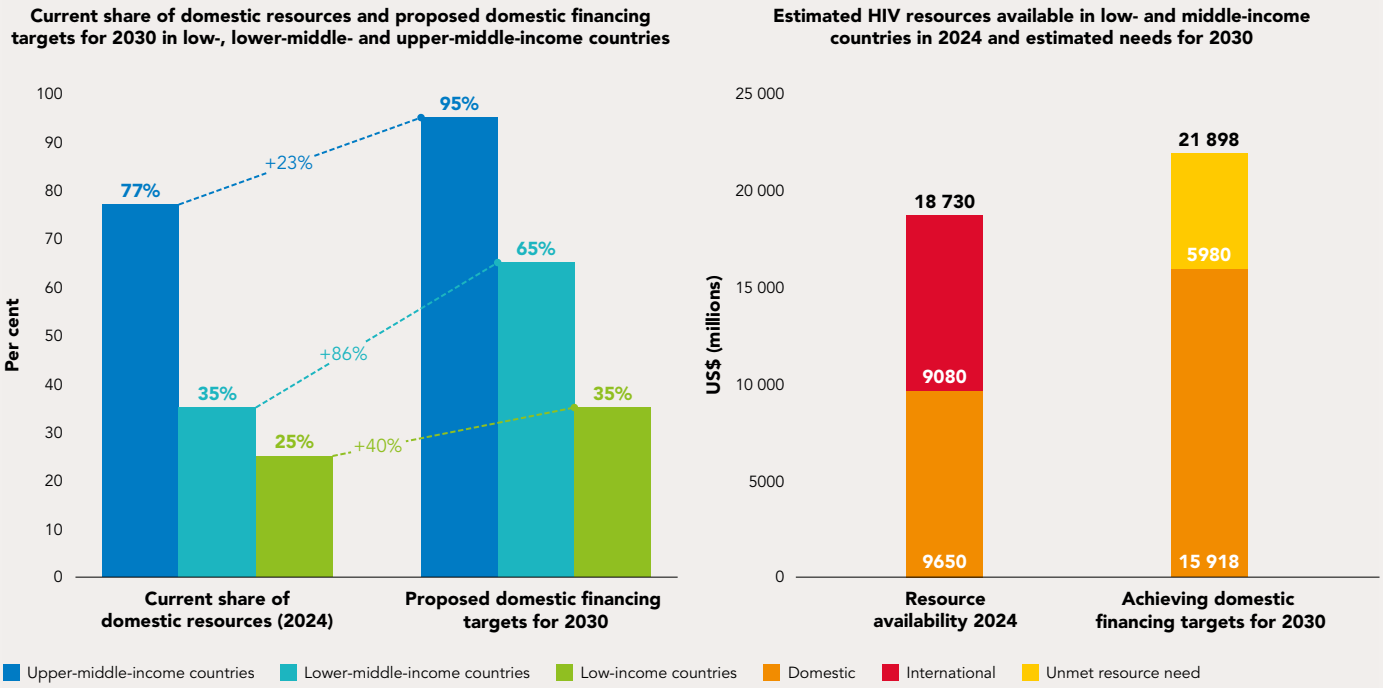
What will it cost to end AIDS as a public health threat?

Preliminary estimates from UNAIDS indicate that achieving the global targets will require annual resources in 2030 of US$ 21.9 billion in low- and middle-income countries, down from the previously estimated US$ 29.3 billion (Figure 4.13). These new estimates are lower than those published in 2021 due to major cost efficiencies that have been achieved across the HIV response. For example, there have been significant price reductions for antiretroviral medicines and for products used in opioid agonist maintenance therapy. In addition, the new estimates reflect more efficient and targeted service delivery and a strong emphasis on prioritized approaches based on HIV risk.[14]

14 The new estimates exclude countries that the World Bank reclassified from upper-middle-income to high-income countries in 2024.

Domestic HIV funding will need to increase

Figure 4.13. Estimated HIV resources available in low- and middle-income countries in 2024, estimated resource needs in 2030, and scenario in which domestic HIV financing targets are met



Note: the domestic financing targets reflect the average share of domestic resources across different income groups by 2030. Within each group—particularly among lower-middle-income and low-income countries—there is significant variation in disease burden and fiscal capacity across countries. These targets aim to encourage greater domestic ownership at the national level for a collective increase across each of the income groups.

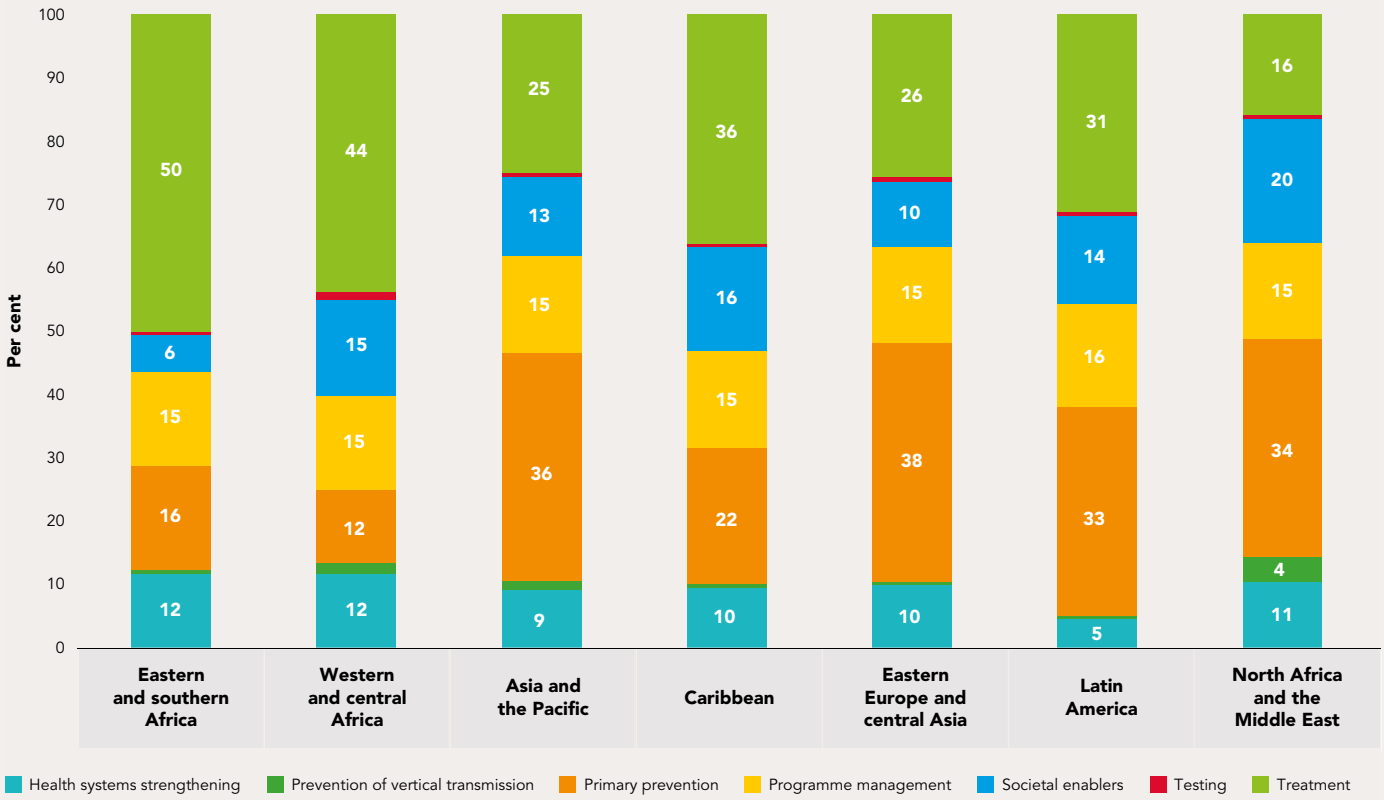
Source: UNAIDS financial estimates, July 2025.

Excluding countries that were reclassified as high-income countries by the World Bank in 2024, the domestic share of HIV funding stood at 52% of the global HIV response in 2024 (Figure 4.13). If countries meet the proposed domestic financing targets, it is estimated that the domestic share could increase to approximately two-thirds of total HIV resource needs by 2030. This would leave a funding gap of about a third, which would need to be filled by continued global solidarity.

Of the total annual HIV resource needs in 2030, approximately 20% would be required for low-income countries, 34% for lower-middle-income countries and 46% for upper-middle-income countries. Among all low- and middle-income countries, the preliminary estimated resource needs for HIV in 2030 are expected to be distributed programmatically, with 40% for testing and antiretroviral therapy, 24% for prevention and 10% for societal enablers, representing the programme areas requiring the largest share of resources, with the remaining resources going to prevention of vertical transmission, health systems strengthening and programme management (Figure 4.14).

UNAIDS estimates show that achieving the global targets will require annual resources in 2030 of US$ 21.9 billion in low- and middle-income countries.

Figure 4.14. Distribution of estimated annual resource needs by intervention and by region by 2030



Source: UNAIDS financial estimates and projection of resource needs for 2026–2030, July 2025.

The gap between current HIV resources and the new target can be bridged, but this will have to be done in a complicated donor financing environment. Total resources available for HIV in 2024 amounted to approximately US$ 18.7 billion. The biggest funding gap (19%) was in lower-middle-income countries, which would need to mobilize an additional US$ 1.4 billion from domestic and external sources to reach the annual targets for 2030. This is a challenging prospect, but delays in achieving fully financed HIV responses will multiply future costs and add significant strain to health systems, as the numbers of people living with HIV increase and their treatment and care needs become more complicated.

Sustained and accountable financing, from domestic sources supported by global solidarity, anchored in strong national leadership and supported by timely, transparent financial tracking, will make it possible to close the funding gap and ensure a resilient and effective HIV response to achieve the goal of ending AIDS as a public health threat by 2030.

The changing environment calls for leadership from many stakeholders at global, national and subnational levels, including the private sector, foundations, faith-based organizations, city-specific programmes, regional institutions, communities, countries and multilateral partners. The challenges of the HIV pandemic today require a response at all levels, including global and multilateral support. No community or country can end AIDS alone: we must stand together.

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