AIDS, CRISIS AND THE POWER TO TRANSFORM

UNAIDS GLOBAL AIDS UPDATE 2025

EXECUTIVE SUMMARY

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UNAIDS/JC3153E – Executive summary

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FOREWORD

The AIDS 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 AIDS 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 AIDS 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.

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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)*.

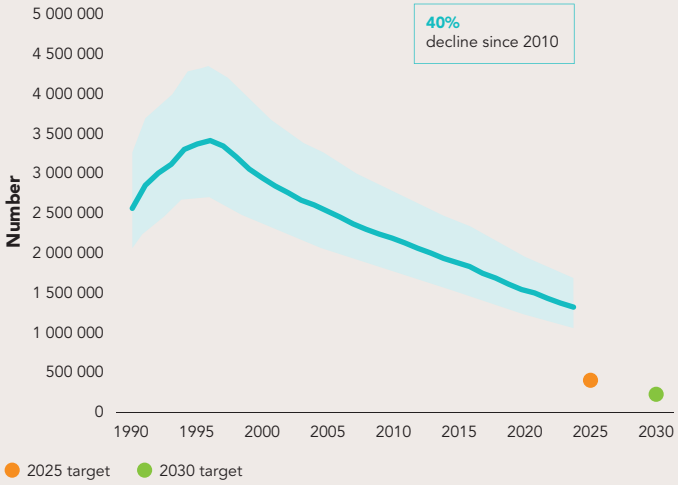
An estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2024—40% less than in 2010 (Figure 0.1).[1] An even steeper 56% decline in the number of new infections was achieved in sub-Saharan Africa, which is home to half of all people who acquired HIV globally in 2024. Five countries,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

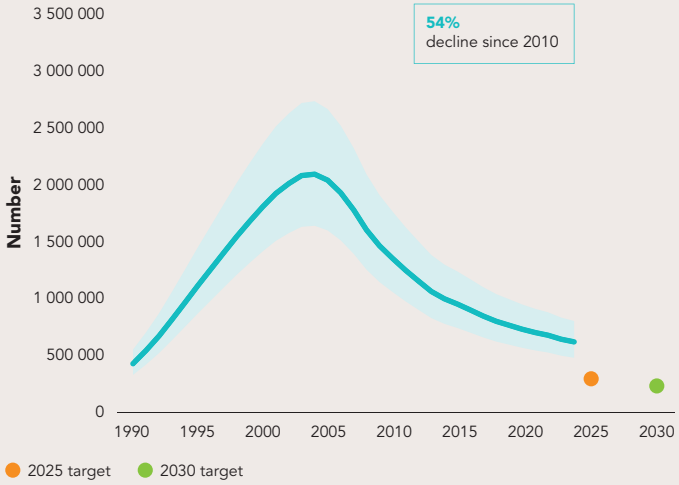
In 2024, the world had made significant progress in the response to HIV—but this is now in jeopardy

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/).

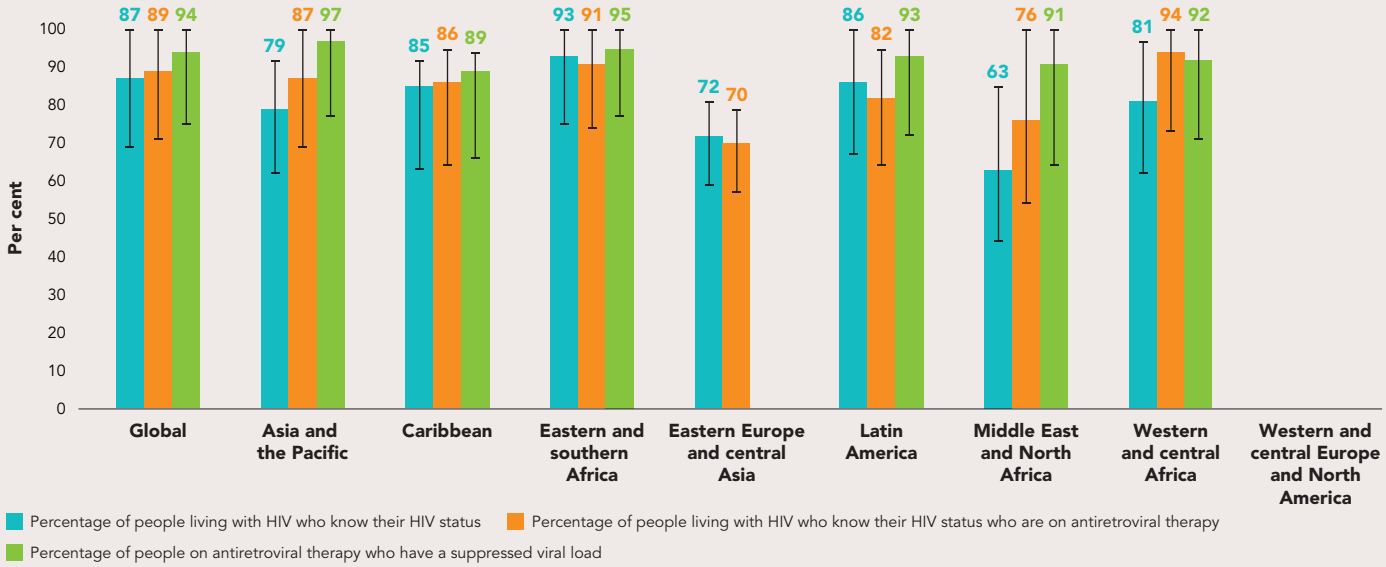
Countries have reduced the annual number of children acquiring HIV through vertical transmission to 120 000 [82 000–170 000], a 62% drop since 2010 and the lowest number since the 1980s. Overall, programmes to prevent the vertical transmission of HIV averted nearly 4.4 million new HIV acquisitions in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



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

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)*.

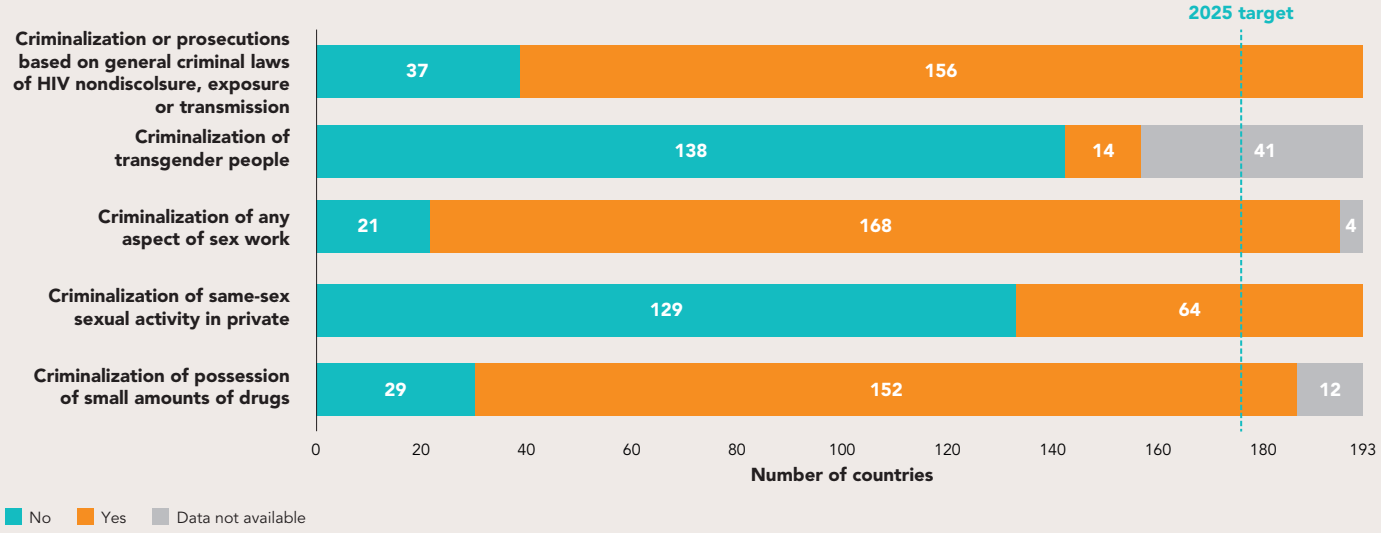
Many of the barriers and inequalities holding back sustainable progress against HIV have not been dislodged. Stigma, discrimination, punitive laws (Figure 0.4), gender inequalities and violence continue to sabotage people's attempts to stay HIV-free or to live safe and healthy lives if they acquire HIV. 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

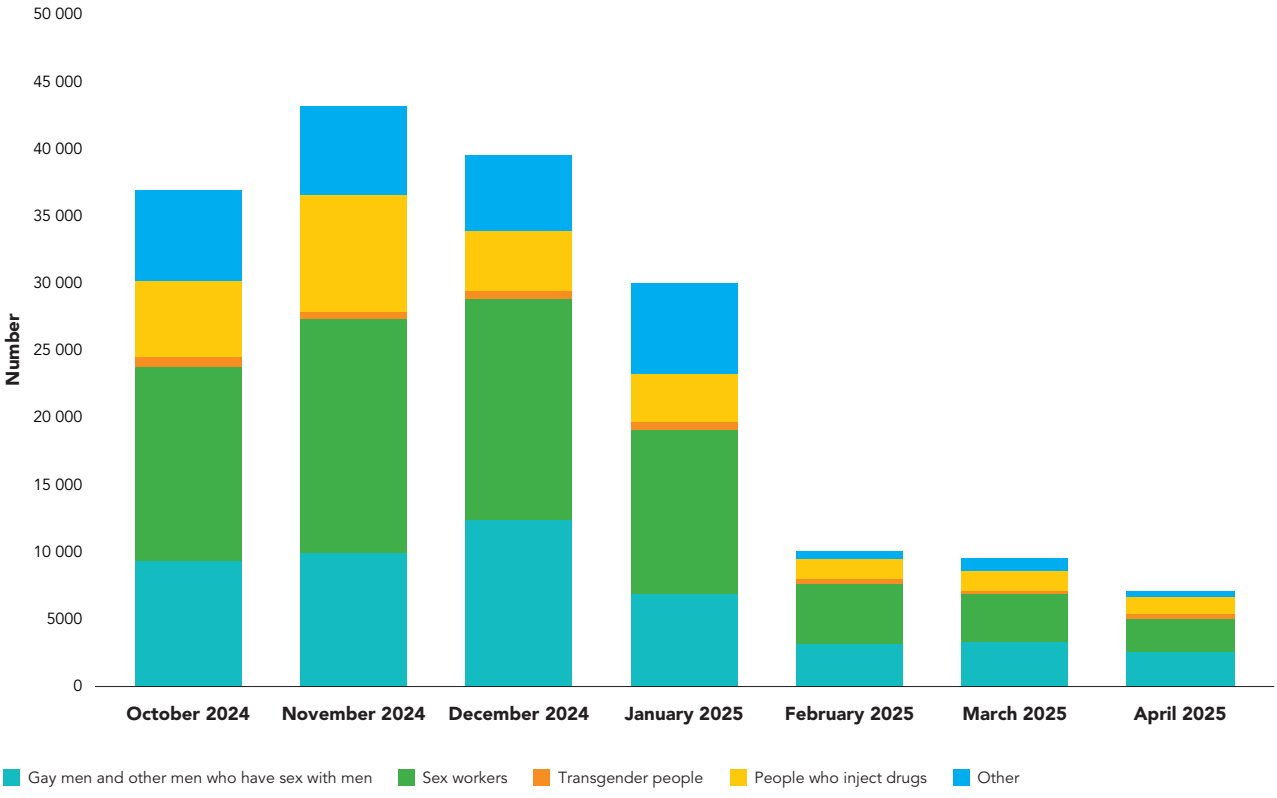
Nigeria is one of nine countries that have continued to report on monthly PrEP provision to UNAIDS in the context of the recent funding cuts. These data show a considerable decline in both the total number of people receiving PrEP and specifically the number of gay men and other men who have sex with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