Ending AIDS Starts With Access



Executive summary

UNAIDS GLOBAL AIDS UPDATE 2026

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Foreword

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

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

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

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

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

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

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

Access is about power, rights and justice.

And today, all three are under attack.

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

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

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

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

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

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

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

These are political choices. Different choices are possible.

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

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

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

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

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

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

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

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

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

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

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

We must not fail this generation.

Executive summary

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

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

Progress in the HIV response, but inequalities remain

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

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

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

HIV programmes face multiple threats

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

The United States Government remains the single largest source of international HIV funding, and is

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

the source of more than 73% of all donor government funding in the HIV response for low- and middle-income countries. United States bilateral contributions fell by 26%, however, between 2024 and 2025, and disbursements from the Global Fund to Fight AIDS, Tuberculosis and Malaria dropped by 13% in 2025 compared with 2024.[3] Contributions from other major donors had already declined by about 58% between 2010 and 2024. The impact of the United States Government funding cuts has been especially dramatic given the reliance of many countries on its support for core HIV programmes.

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

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

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

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

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

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

Access barriers are slowing progress

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

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

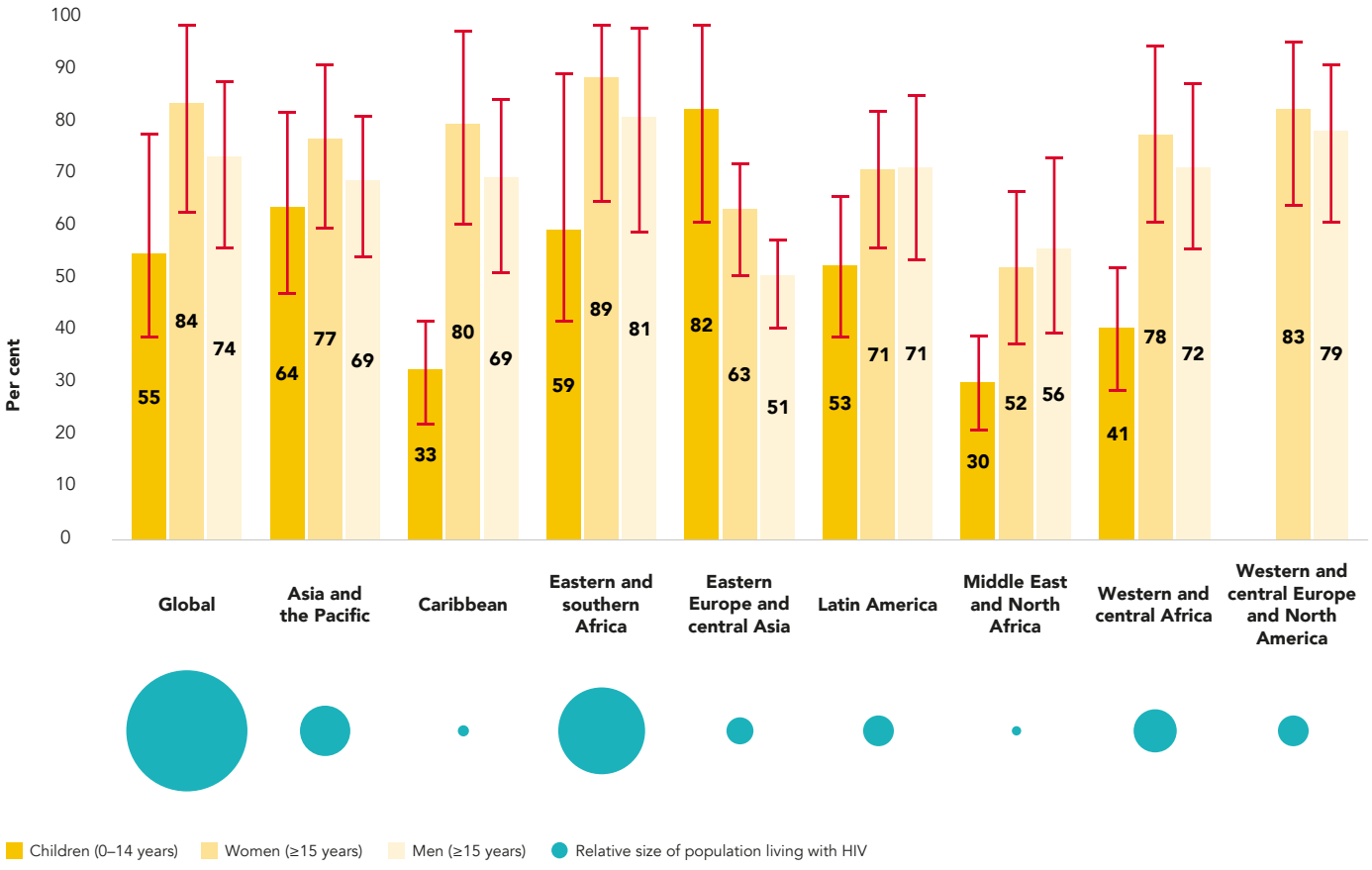
and treatment services. Many countries have sought to remove at least some of these barriers and make HIV services more accessible and user-friendly, but the efforts are not yet extensive enough and they are now experiencing major setbacks.

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

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

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

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



Source: UNAIDS estimates 2026.

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

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

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

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

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

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

HIV funding must be diversified and protected

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

The funding shifts of the past two years reinforce an ongoing need for diversified and equitable financing strategies that can protect progress in the HIV response and other public health priorities. These financing transitions cannot proceed at

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

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

the same pace in all countries: the field is uneven and the options available differ widely. There continues to be a focus on self-reliant and sustainable HIV responses, although transitions may be occurring at a pace that does not match country readiness. For the foreseeable future, many countries will require continued global solidarity to ensure responsible transition of their HIV responses, while preparing for phased increases in domestic contributions.

A path forward for the HIV response

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

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

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

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

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

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

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(All links accessed 10 November 2026.)

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