GPC
Global HIV
Prevention Coalition

HIV PREVENTION 2030

A Global Access Framework for Country-Led Responses

Contents

Introduction and context 2
The urgent need to accelerate progress

Objectives of the 2030 Access Framework 5
A renewed global HIV prevention push

Paradigm shift 10
A new era of HIV prevention

2030 Prevention Access Framework 11
A person-centred approach to access and choice

Prevention optimization 19
Enhanced prioritization in a resource constrained environment

Prevention financing and sustainability 23
Transformations to the prevention investment architecture

Conclusion 28
Call to action for country-led prevention

Annexes 31
Annex 1: Milestones, epidemiological and resource estimates, and other guidance
Annex 2: HIV prevention resources

References 42

Introduction and Context

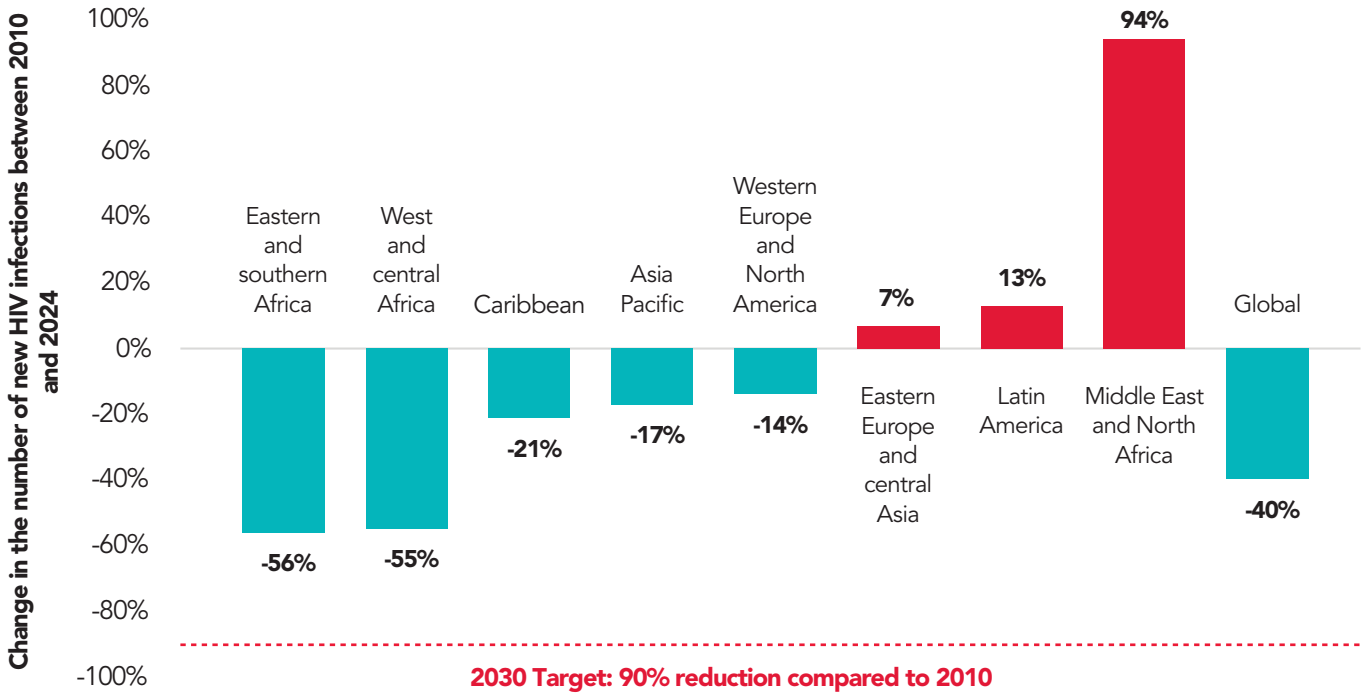
The urgent need to accelerate progress

The 2025 global HIV prevention targets were not achieved. By the end of 2024, annual new HIV acquisitions had reached their lowest level in more than three decades. But the decline was not steep enough to reach the 2025 target of an 80% reduction in new infections between 2010 and 2025. By the end of 2024, new infections globally had declined by about 40%.

Five countries—Lesotho, Malawi, Nepal, Rwanda and Zimbabwe—did achieve a 75% reduction between 2010 and 2024 *(1)*, demonstrating that the targets were achievable. Those advances were the result of strong political will, scale up of prevention and treatment, community leadership and global solidarity. However, globally the decline in new HIV acquisitions was much too slow to meet the 2025 and 2030 targets (fewer than 200 000 new HIV infections per year in 2030).

Overall, an estimated 1.3 million (1 million – 1.7 million) people newly acquired HIV in 2024. Even in settings with declining HIV incidence, some groups, in particular key populations, are being left behind. While new HIV infections are declining in Africa, they are stagnating and growing in other regions (Figure 1).

Figure 1. Percentage change in annual numbers of new HIV acquisitions between 2010 and 2024, by region and global



Source: UNAIDS epidemiological estimates 2025.

Key groups remain underserved. Reported median HIV prevention coverage in 2024 was only 38% for gay men and other men who have sex with men, 39% for people who inject drugs, 44% for transgender people and 47% for sex workers *(2)*, while an estimated 210 000 adolescent girls and young women acquired HIV in 2024, equal to 570 new acquisitions per day *(1)*.

For the first time since 2012, the number of countries criminalizing same-sex sexual activity and gender expression has increased, creating additional barriers to HIV prevention access and use *(3)*. Key populations and sexual and reproductive health and rights are increasingly subject to organized opposition, some of it fuelled by misinformation propagated in social media channels.

Effective treatment and wide access to primary prevention are the backbones of successful HIV prevention, and new technologies promise to accelerate prevention progress. Long-acting injectable antiretrovirals (ARVs) represent one of the biggest advances in HIV in many years *(4)*. Artificial intelligence (AI) could also help expand access to HIV-related information to support people in making informed prevention decisions and self-care *(5)*.

An unprecedented funding crisis

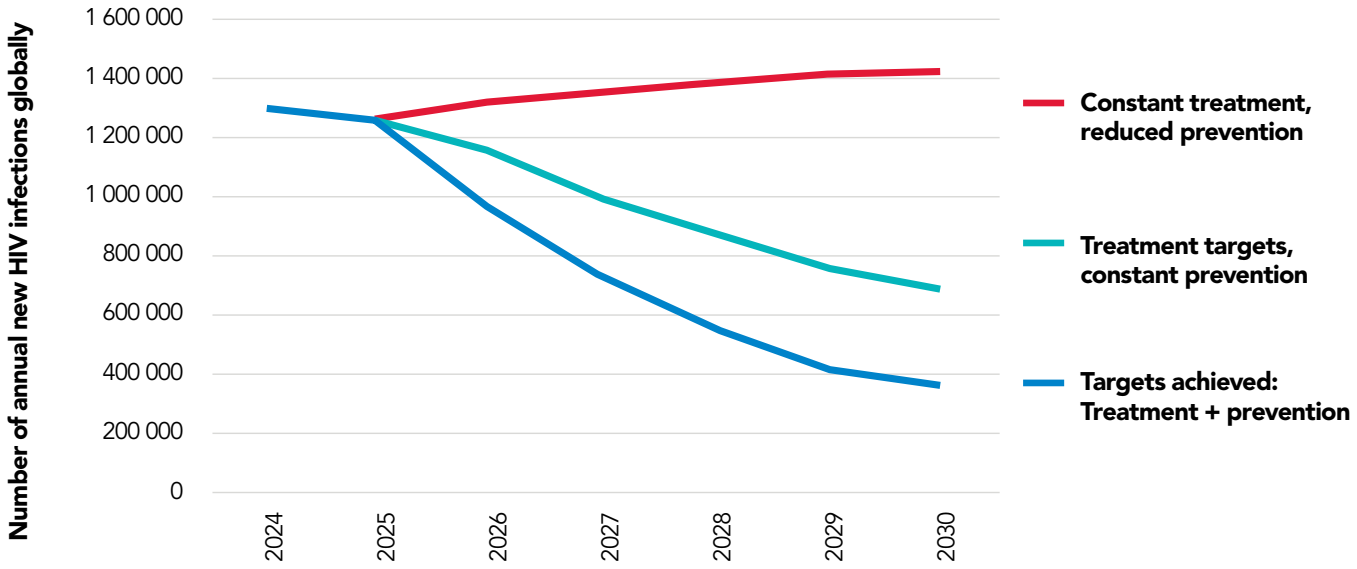
The year 2025 marked the beginning of the most severe funding crisis since the AIDS pandemic began. The United States of America significantly reduced bilateral HIV funding *(6, 7)*, while the Global Fund reduced its country allocations for Grant Cycle 7 (2023–2025) *(8)*; replenishment for Grant Cycle 8 remained substantially below the targeted amount and funds raised in the previous cycle. Several other donor countries, including France, Netherlands, and the United Kingdom, have also announced reductions in foreign aid of 40–70% in 2026 *(9)*.

The funding cuts hold drastic implications for HIV prevention, including for harm reduction for people who use drugs. As of May 2025, as many as 3.5 million people from key populations were no longer covered by specialized HIV prevention programmes which PEPFAR had funded, and an estimated 2.5 million people had lost access to PEPFAR-supported pre-exposure prophylaxis (PrEP) *(10)*. Prevention systems suffered.

Even before those funding cuts, HIV prevention investments were inadequate. Around US$ 1.7–2.1 billion was available for primary prevention in low and middle-income countries in 2024, which was about one third of the $5.3 billion required annually by 2030 *(11)*. Within existing funding envelopes, prevention is also underprioritized. Based on reporting from 88 countries, only 10–12% of total HIV spending was directed towards HIV prevention in 2024—about half of the average 24% that is needed to reach the 2030 goals *(12)*. In addition, countries were heavily reliant on external sources: 64 of 82 reporting countries relied on external sources for at least 75% of their prevention funding *(12)*.

Even if HIV treatment coverage is sustained at current levels (and only primary prevention is affected by funding cuts), new HIV infections are projected to rise from 2026 (Figure 2). A new path is needed to meet the 2030 targets in this changed environment.

Figure 2. Projected impact of reduced funding for prevention on new HIV infections, 2025–2030



Source: UNAIDS estimates and projections from Avenir Health, October 2025.
For more information please see: https://www.unaids.org/sites/default/files/2025-04/JC3144_Estimates_Funding_cuts_impact_En.pdf

Objectives of the 2030 Access Framework

A renewed global HIV prevention push

The overall 2030 goal is to reduce HIV incidence globally by 90% compared to 2010, as set out in the Global AIDS Strategy 2026–2031. All 16 top-line targets of the Global AIDS Strategy including those on prevention, treatment and enablers work in combination to reduce HIV incidence, AIDS-related deaths and HIV-related discrimination.

This 2030 Prevention Access Framework focuses on one of those top-line targets, which covers primary prevention and requires that **90% of people in need of HIV prevention are using effective prevention options by 2030**. This target is disaggregated into 15 second-line prevention targets for specific populations and programmes (see Table 3a for the logical flow of targets and Table 5 in Annex 1 for a full list).

The 2030 Prevention Access Framework presents in greater detail the milestones and actions for achieving these targets––all of which are grounded in the three priorities of the Global AIDS Strategy: country-led, resilient and sustainable HIV responses; people-focused services; and community leadership.

The Framework's numerical milestones include the 40+20 milestones, which call for 40 million people living with HIV to be accessing HIV treatment and having viral suppression, and for 20 million people to be accessing ARV-based HIV prevention options by 2030. These and other milestones are shown in Figure 3 and discussed further below.

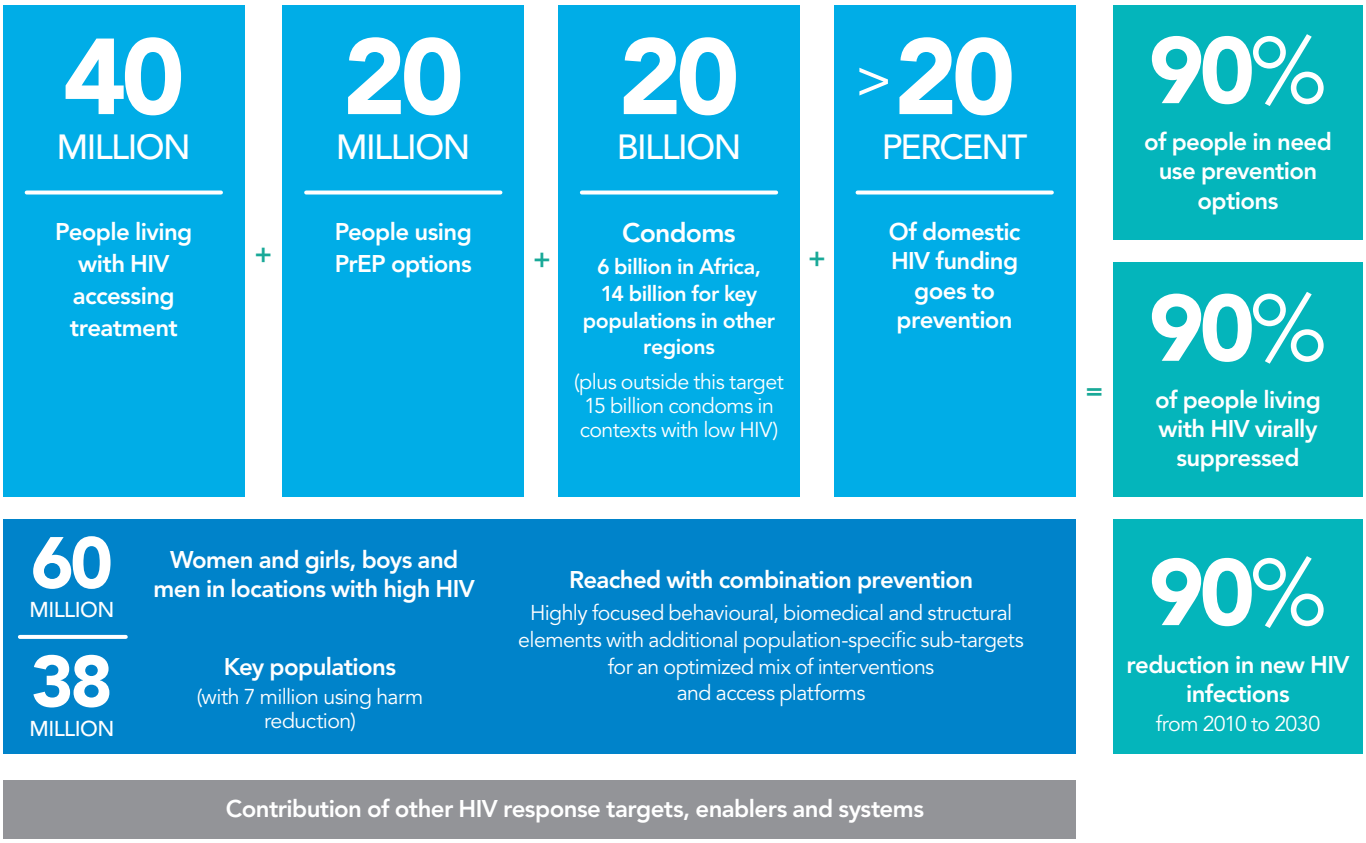
Overall, the 2030 HIV prevention access push seeks to accelerate the use of innovations, expand use of the most cost-effective interventions, and confront the sustainability challenges facing the HIV response.

Figure 3. Key targets and numerical milestones

a. 2030 primary prevention targets in the Global AIDS Strategy 2026–2031.

DENOMINATOR	COVERAGE	OUTCOME
People in need of HIV prevention	**95% of people in need of prevention reached with HIV prevention**	**90% of people in need of prevention use effective prevention options**
Young people and adults (in areas with elevated HIV) **Key populations** (sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, people in prisons and other closed settings)	Translated into: ■ 95% of people reached with person-centered prevention programmes ■ 95% of country distribution need met for condoms, PrEP, PEP, needles, syringes, OAMT ■ 90% of adolescents and young people receive comprehensive sexuality education ■ 80% of people-centred HIV prevention programmes for key populations delivered by community-led organizations	Translated into: ■ 80% condom use with non-regular partners ■ Up to 80% use of PrEP including long-acting products in line with epidemiology and people's choices Population-specific targets: ■ 90% of boys and men accessed VMMC in 15 priority countries ■ 95% of people who inject drugs use safe injecting equipment, 50% of people who inject opioids on OAMT • 95% condom use at paid sex among sex workers and clients

b. Numerical milestones for reducing HIV incidence under the Prevention Access Framework.



Note: OAMT: opioid agonist maintenance treatment; PEP: post-exposure prophylaxis; PrEP: pre-exposure prophylaxis; VMMC: voluntary medical male circumcision

c. Relationship between 2030 targets, milestones, baselines and underlying assumptions

Target	Numerical milestone[i]	Baseline[ii]	Notes and assumptions
90% of people living with HIV virally suppressed	**40 million people living with HIV** are sustained on effective HIV treatment	As of 2024, an estimated 31.6 million people living with HIV were receiving HIV treatment *(1)*	40 million is the rounded number representing 90% of people living with HIV in all countries globally in 2030.
Up to 80% use of PrEP including long-acting products in line with epidemiology and people's choices	**20 million people globally are effectively using PrEP** with an increasing share of long-acting PrEP options	As of 2024, an estimated 3.9 million people were using PrEP at least once in the year (translating into approximately 2 million person-years of PrEP use).	The target refers to 20 million person-years of PrEP. This is approximately double the 2025 target of 10.6 million person-years. 20 million person-years of PrEP use is the rounded estimate of global PrEP need in all countries. It is calculated based on a sliding scale. PrEP targets for sub-populations in countries vary based on HIV incidence and other criteria between 0 and 80% (see Table 6 in Annex 1).
95% of adolescent girls and young women, adult women, pregnant and breastfeeding women, and adolescent boys and men in settings with elevated HIV, effectively reached with people-centred HIV prevention programmes	**60 million women and girls and men and boys in settings with elevated HIV incidence** are accessing combination HIV prevention programmes	As of 2024, approximately one third of adolescent girls and young women in settings with elevated HIV were reached with dedicated programmes. Around half of the men and boys eligible for voluntary medical male circumcision (VMMC) was being reached with that intervention.	60 million people is the rounded number representing 95% of people in geographical areas and sub-populations (disaggregated by age, sex and regular/non-regular partners) with HIV incidence exceeding 0.2% in sub-Saharan Africa. In other regions HIV incidence of more than 0.2% is extremely rare outside key populations. The number does not include key populations, for which specific numerical milestones are set in the next row.
95% of key populations effectively reached with people-centred HIV prevention programmes	**38 million people from key populations** (sex workers, gay men and other men who have sex with men (MSM), people who inject drugs (PWID), and transgender people, prisoners) are accessing HIV prevention	As of 2024, in the countries reporting these data, 55% for sex workers, 30% for MSM, 40% PWID, 44% Transgender were reached with HIV prevention services and tools *(2)*.	38 million represents 95% of key populations that need to be reached with HIV prevention programmes in low and middle- income countries.

i Numerical milestones are based on UNAIDS special analyses for 2030 resource needs estimates (treatment, PrEP, key populations, harm reduction), the SHIPP tool (women and girls, boys and men) and Spectrum prevention needs estimates (condoms).

ii Unless indicated otherwise, all baseline values in this section are based on: Global HIV Prevention Scorecard. Special analysis. Geneva: Joint United Nations Programme on HIV/AIDS 2025; (https://hivpreventioncoalition.unaids.org/en/scorecards)

80% condom use at last sex with non-regular partners **95% condom use at paid sex** among sex workers and clients	**20 billion condoms distributed and sold** for HIV prevention per year. This would take the global condom market to an estimated 35 billion condoms in 2030.	Median condom use at last paid sex was 84% according to reporting by sex workers *(2)* and 74% according to reporting by men who paid for sex. Median condom use with non-regular partners was 63%, according to reporting by men, and 36%, according to reporting by women.	20 billion condoms represents the total condom need for HIV prevention, 6 billion in sub-Saharan Africa for all populations and 14 billion for key populations globally. The need is established by applying percentage targets to different sub-populations. The value of 35 billion condoms also includes condom use by couples not affected by HIV for contraceptive purposes.
95% of people who inject drugs use safe injecting equipment at last injection **50% of people who inject opioids on opioid agonist maintenance treatment**	**7 million people who inject drugs using harm reduction** including safe injecting equipment, opioid agonist maintenance treatment and overdose prevention	As of 2024, 4 in 10 people who inject drugs were reached with harm reduction services. Median use of safe injecting equipment across countries was 87% and median coverage of opioid agonist maintenance therapy was 9% *(2)*.	7 million represents 95% of people who inject drugs in low and middle-income countries.
At least **20% of domestic HIV funding** should be allocated to primary prevention	No global aggregated milestone available	In 2023 and 2024 (based on data from 48 countries), about 8% of domestic HIV funding went to prevention *(12)*.	The target is an indicative benchmark and based on a global average of 24% of HIV resource needs required for prevention. The exact need should be determined at country level.

Annual milestones for people and prevention options

For clarity and accountability, national and subnational governments are encouraged to define clear top-line annual numerical milestones, based on routine country needs estimations. The annual country milestones shown in Table 1 are presented by way of example. (Figure 5 in Annex 1 provides annual prevention milestones by region). Annual country and even subnational milestones can be formulated by using annual country needs estimation processes and tools. These have been integrated into the Spectrum model that countries use every year to produce their annual estimates and requested in the Global AIDS Monitoring process. Further support to produce and use these estimates will be provided by UNAIDS and the Global HIV Prevention Coalition.

Table 1. Illustrative country example for HIV prevention annual access milestones, 2026–2030

	2024 (baseline)	2026	2027	2028	2029	2030
Condoms	52 million	56	64	72	80	85 million
PrEP	70 000	100 000	220 000	270 000	350 000	350 000
PEP	TBC	TBC	TBC	TBC	TBC	TBC
VMMC	120 000	120 000	120 000	120 000	120 000	120 000
Women and girls in locations with elevated HIV incidence (>0.2%)	350 000	350 000	550 000	750 000	900 000	900 000
Men and boys in locations with elevated HIV incidence (>0.2%)	200 000	200 000	300 000	350 000	400 000	400 000
Sex Workers reached	23 000	25 000	35 000	40 000	45 000	45 000
MSM reached	20 000	24 000	32 000	40 000	50 000	60 000
TG people reached	1000	1500	2000	3000	3500	4000
PWID reached with needles and syringes	4000	6000	8000	9500	9500	9500
PWID receiving OAMT	500	1000	2000	3000	4000	4800
Prisoners reached	1000	2000	3000	5000	6000	6000

Note: This table presents the milestones for an illustrative country in sub-Saharan Africa.

Paradigm Shift

A new era for HIV prevention

The new context, challenges and opportunities amount to a new era for HIV prevention. The Prevention 2030 Global Access Framework provides a focused approach for achieving the global 2030 HIV goals in a financially constrained environment. With appropriate strategic shifts and investments (Figure 4), it is feasible for every person at risk of HIV to have access to a prevention option that suits their needs by 2030.

Figure 4. The paradigm shift for 'HIV prevention 2030'

FROM 2025	TO 2030
✖ Intervention-centred	+ Person-centred
✖ Few choices, most requiring daily adherence	+ More short- and long-term options
✖ Multilayered road maps (5 pillars, 10 actions)	+ Focused access framework
✖ Many aspirational long-term goals	+ Clear top-line annual numerical milestones
✖ Project-based activities	+ One national programme
✖ Mostly provider-initiated	+ Community-led and self-care models widely available
✖ High donor dependence	+ Country-led ownership and investment frameworks

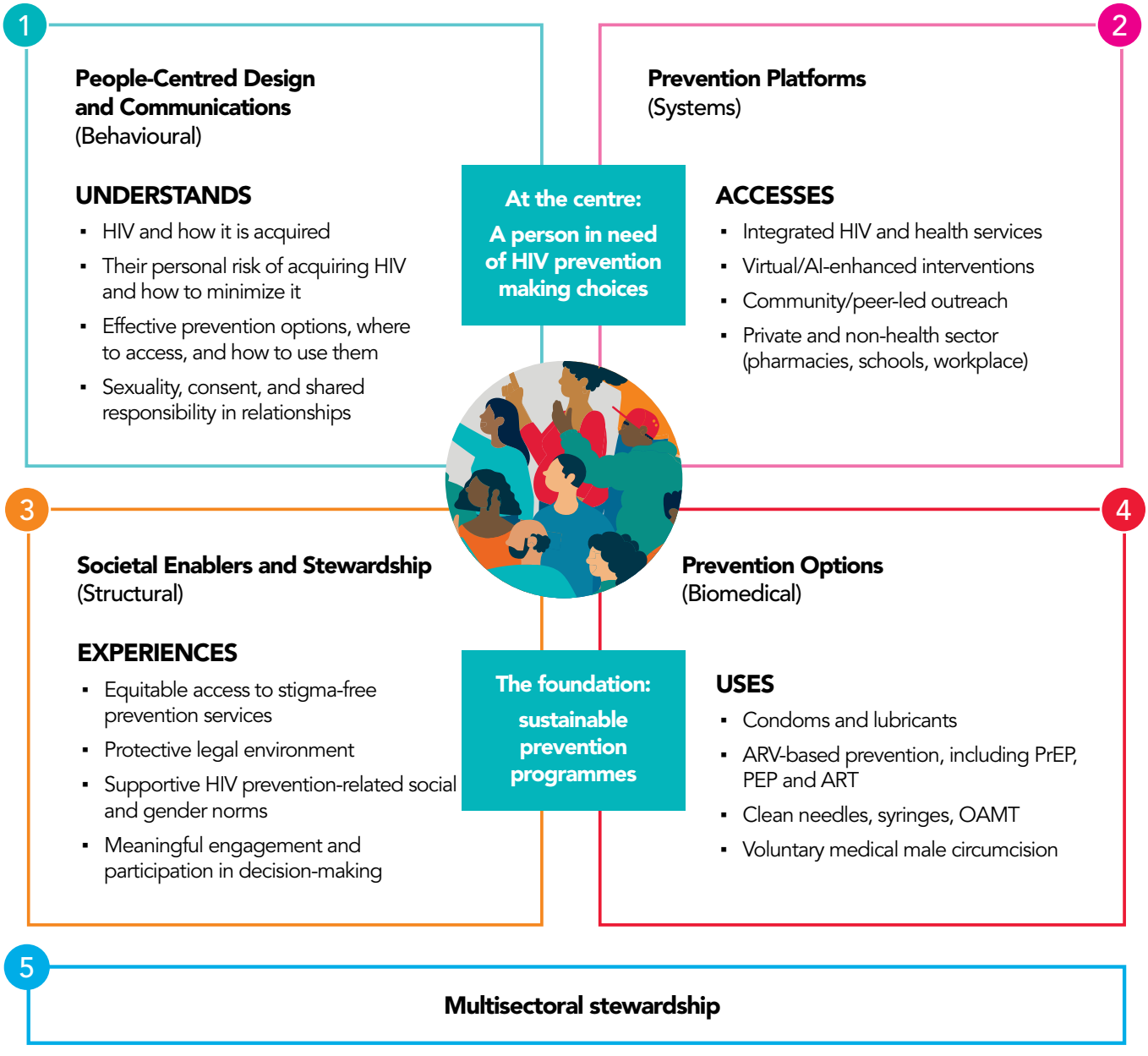
2030 Prevention Framework

A person-centred approach to access and choice

'HIV prevention 2030' is a focused access framework. It is structured around people's prevention "journeys" and reflects the fact that they need to: **1) understand** their prevention needs, options and benefits; **2) access** prevention services; **3) use** prevention options effectively; and **4) experience** an enabling environment (Figure 5).

These four dimensions encompass the behavioural, biomedical, structural and systems-related considerations that can support country-led planning and investment over the next five years.

Figure 5. A person-centred HIV prevention framework



1. People-centred design and communications (behavioural)

The impact of HIV prevention options depends on people's willingness to use them. It is therefore critical to address the key factors that shape those decisions, including: people's knowledge about HIV prevention *(13)* and where to access services; their understandings of their personal risk; and their ability to make empowered decisions. There is extensive evidence on what behavioural interventions can achieve and on their limitations *(14)*.

Although early HIV incidence declines were linked in part to changes in sexual behaviour change like reductions in multiple partnerships, those changes were not sustained. The evidence indicates that behavioural interventions can contribute to building the knowledge, motivation, demand and skills people need to make informed prevention choices and use prevention options effectively. But as stand-alone interventions they are not expected to reduce HIV incidence on their own. Accordingly, HIV counselling and information for key populations should not be aimed at changing underlying behaviours, but they can be leveraged for engagement and should be provided in a non-judgemental manner, alongside other prevention interventions *(15)*.

New guidance outlines the key principles of person-centred design and communication *(16)*. To enhance responses countries can:

Apply person-centred design to develop one consolidated but differentiated prevention communication plan. Past HIV prevention communication was often product- and project-specific––and therefore fragmented. HIV prevention communication can now cover different prevention options and their benefits, rather than just specific products. Similarly, an overall communication approach should be designed for all the targeted audiences, rather than for specific groups, though it still should be differentiated enough for specific key and priority populations. Messages based on person-centred design are beneficial, while untargeted mass media campaigns are discouraged *(17)*. As a good example, Zimbabwe's HIV Communications Strategy identifies the best influencers and information channels for reaching different populations *(18)*.

- **Develop and implement an optimized mix of prevention communication.** HIV prevention communication requires a mix of scaled media communication for larger target populations and, in addition, more intensive interpersonal outreach approaches (e.g. for key populations, or very young people in settings with high HIV incidence). AI-enhanced HIV prevention messaging can be applied for different populations and purposes, and at scale. It has been shown to improve PrEP uptake *(19),* increase condom use *(20)* and reduce behaviours that can result in the acquisition of HIV in vulnerable groups *(21)*. Comprehensive sexuality education (CSE) can lay an important foundation for young people to receive prevention- related information and build knowledge and skills that protect their sexual health. CSE should be integrated into education curricula globally and should not depend primarily on HIV programming and funding.
- **Assign leadership of prevention communications to one multisectoral public health entity.** To make the best use of limited resources, an institution with multisectoral reach is needed to coordinate communications. It should do so in close collaboration with communities, implementers and other sectors, including by harnessing private sector communications expertise.

2. Prevention platforms (systems)

Sustainable HIV prevention requires a well-defined, country-led system that provides access through different health and non-health platforms. People in need of HIV prevention should be able to choose from a defined range of service delivery platforms that cater to the needs of different subpopulations (Figure 6).

In the past, access sometimes has been through fragmented, time-bound projects. The new 2030 Framework applies a systems approach. It considers feasibility, reach, preferences, and the barriers that affect

different populations. For example, countries use different models to reach key populations at scale *(22)*. Additional guidance on sustainable, scaled HIV programmes with key populations is available *(23)*; it applies a differentiated model for trusted access platforms for key populations (see Figure 3 in Annex 1). Guidance on a differentiated model to reach adolescent girls and young women is also available *(24)*.

Taking into account their contexts, countries can:

- **Determine the most appropriate mix of access points.** A government-led, multistakeholder process can define the access points for all relevant populations and prevention options, including public, private and community-led services. The suite of available platforms will be resource-dependent and should be evidence-informed and scalable. Countries should map out prevention access by population and by platform, while considering relevance, feasibility, privacy, safety and accessibility (which vary for different subpopulations). Collaboration across sectors—including education (schools), labour (workplaces) etc.—is critical for expanding HIV prevention delivery platforms.

- **Identify opportunities for integration to improve access.** Integrating HIV prevention into primary care and sexual and reproductive health (SRH) services is a recommended sustainability approach, particularly in settings with elevated HIV incidence in the general population where women and men are routinely reached through these services *(25)*. For example, in several high-burden countries, large numbers of sexually active women access contraception, yet there continue to be gaps in integrating HIV into contraceptive services. Those can be addressed using existing operational guidance *(26)*. Integration opportunities include: provider-initiated HIV prevention counselling; testing; routine condom offers; and access to PrEP as part of contraceptive services. Conversely, SRH services—including contraception—can be integrated into HIV testing and treatment programmes. Government leadership (around policy, financing accountability) is a critical enabler for integration *(27)*.

- **Develop differentiated models to improve access for key populations.** For key populations, there is a need for differentiated approaches in most settings. A good example of integration is Malaysia's 'KK model' and the 'Differentiated HIV services for key populations' approach, in which government and communities share various roles *(26)*. Other successful models offer key population-led HIV prevention services which operate in public facilities with designated community engagement spaces *(27)*. However, such models only work if stigma and discrimination of key populations in services is minimized. Where safety, confidentiality and stigma-free services cannot be guaranteed, community- and peer-led service delivery, especially through sustainable and integrated trusted access platforms, is essential to reach key populations *(28)*. According to one multi-country analysis, an estimated 10–45% of key populations access prevention from peer-led organizations and a further 33–51% do so from nongovernmental organizations (NGOs) *(29)*.

- **Expand use of innovative virtual and telehealth access platforms.** Effective virtual platforms were developed and/or scaled up during COVID-19 and should be maintained and further expanded *(30)*. Virtual platforms can enhance outreach, including for peer-led programmes. Telehealth options are cost-efficient, can help engage hard-to-reach populations, reduce stigma and create more accessible prevention access platforms *(31)*.

- **Enable self-care approaches to HIV prevention.** Self-care for HIV prevention, when combined with strong community support, can improve access and outcomes, and potentially reduce costs. Self-care includes, for example, free self-testing and PrEP access from pharmacies, as well as the use of dispensers to access self-care products. Through chatbots, virtual check-ins and personalized digital reminders, AI-enabled tools can support self-care prevention models *(32)*. If expanded, such self-care models can shift HIV prevention away from mostly provider-initiated services, although providers would still be involved in supporting and complementing self-care.

- **Develop a consolidated country-owned prevention data system.** Strong, country-owned data and surveillance systems are needed for prevention. Countries need to have prevention data systems that provide key coverage and outcome data for their contexts. Also important is the capacity for data analysis and use, including community generated data. Countries can use model-based annual prevention needs estimates as a denominator for annual tracking. That can be done more regularly and at lower cost than population-based surveys, which, although expensive, remain relevant for impact measurement, but are not required annually. Lighter outcome measurement tools to complement such surveys are available.
- **Ensure steady supply of prevention commodities through all relevant access platforms.** Procurement and supply chain considerations are key to ensure that prevention commodities are available at the various outlets. To maximize coverage and reach, countries should minimize costs, for example by using high-volume international procurement platforms for prevention commodities, regardless of the funding source *(33)*. At country level, existing health logistics systems and private sector retail networks can be leveraged.

Figure 6. Diverse HIV prevention delivery platforms to maximize choice and access

Choose and prioritize prevention platforms based on country context and the preferences of key and priority populations

3. Prevention options (biomedical)

People must be able to choose between different HIV prevention methods and delivery options. That includes 'treatment as prevention', given that people with undetectable viral loads cannot transmit HIV to others (the U=U, or 'undetectable = untransmissable' effect of HIV treatment) *(34, 35)*.

With more short- and long-term prevention options now available, a systematic approach is required for offering the different options. The concept of choice and optimal mix of prevention methods for HIV differs partially from other fields of public health such as contraception. Different subpopulations have different prevention preferences. In addition, low-cost, multi-purpose tools like condoms and clean needles are widely relevant even where HIV incidence is low, while the benefits of PrEP are most relevant in settings with substantial HIV incidence (as outlined further below).

In line with those considerations, countries can:

- **Offer people a structured choice of prevention products.** Access to relevant options, choice and the opportunity to change products over time not only increase prevention coverage, but are also likely to be cost-effective *(36)*. Ultimately, the key aim is to have high prevention coverage among the people who are most at risk of acquiring HIV. PrEP would be a priority option for some key populations, but a complementary one for others. For example, sustained, high levels of condom use is priority for sex workers, while harm reduction remains a top priority for people who inject drugs.

- **Estimate the need for various prevention options per population.** Needs estimates for specific methods are useful for planning and should be calculated with an optimal mix in mind. The aim is to increase prevention uptake overall, not just for one product. (See Table 1 for an example of a country method mix table that can be adapted for planning purposes.)

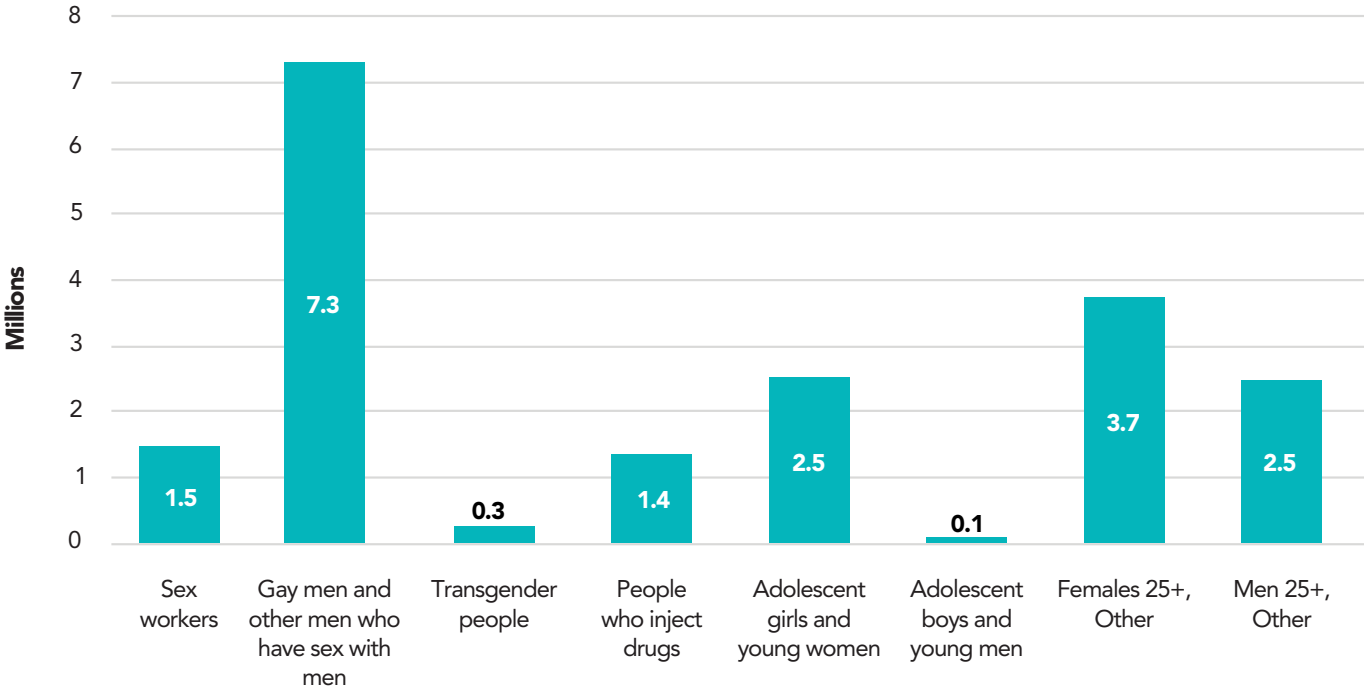
- **Rapidly introduce ARV-based and other long-acting prevention technologies.** People with the greatest need must be able choose from existing and new prevention technologies. This includes long-acting injectable PrEP formulations, the dapivirine vaginal ring, and oral PrEP containing tenofovir. As other options, such as once-monthly oral PrEP (MK-8527), progress through clinical trials and are approved by regulatory bodies, their access must also be prioritized. Updating PrEP guidelines and accelerating regulatory approval therefore are top priorities. Globally, a key milestone is to ensure at least 20 million people are using various PrEP options by the year 2030, broken down by population (Figure 7).

- **Sustain scaled and equitable access to condoms for triple protection.** Condoms remain the only tool that simultaneously protects people from HIV, other sexually transmitted infections (STIs) and unintended pregnancy. They also remain the primary contraceptive choice of adolescents globally. However, distribution and promotion of condoms have received reduced attention after 2010, leading to declining condom use and rising sexually transmitted infections in several settings. Countries in different regions have shown that achieving 80% condom use with non-regular partners is possible; the declining trends in use are not universal. *(37)*

  To close condom use gaps, countries need to reinvigorate condom total market approaches with complementary roles for public, social marketing and private sectors. The total global need for triple protection is estimated at 35 billion condoms annually. A programmatic focus on condom promotion is needed in sub-Saharan Africa to achieve an estimated target of six billion condoms distributed and sold annually by 2030 (see Figure 3). The estimated need for condoms among key populations globally is about 14 billion per year, which can be met also through a total market approach, private sector models playing a bigger role in countries with higher incomes.

- **Expand access to harm reduction for people who use drugs.** Evidence-informed packages of harm reduction, including clean needles and syringes, OAMT and overdose prevention (naloxone) remain highly effective prevention options but are under-used. Scaled country- and community-led harm reduction approaches can dramatically increase access and reduce HIV transmission.

Figure 7. Need for HIV PrEP by 2030, per population, in low and middle-income countries



Source: UNAIDS HIV prevention needs estimates, Geneva: Joint United Nations Programme on HIV/AIDS; 2025.

4. Societal enablers (structural)

Stigma and discrimination, punitive laws, harmful gender norms and inequalities create barriers to HIV prevention services, reduce viral suppression and increase HIV incidence *(38, 39, 40, 41)*. Globally, the legal environment for HIV prevention and key populations improved moderately since the 1980s, but overall progress has stalled in recent years and it has been reversed in some countries. These barriers have to be addressed. Civic space for affected communities also has to be protected.

To achieve that, countries can:

- **Identify the key barriers in access to HIV services and influencing HIV outcomes for different populations.** Addressing human rights, gender-related and other social barriers requires political commitment, collaborative strategies and long-term investment. The barriers can be identified as part of developing national HIV plans and strategies, as outlined in the Global AIDS Strategy 2026–2031. This framework focuses on the prevention-related dimensions.

- **Define partners' roles and comparative advantages in addressing barriers. Some barriers can be addressed by the health, justice and education sectors, for example, and by HIV advocacy groups engaging with those sectors, parliamentarians and other stakeholders. Those activities will vary by country but can include, the following:** [iii]

  - Advocacy for reducing the age of consent and removing third-party consent (parental and spousal) requirements for accessing HIV prevention methods, testing, sexual and reproductive health services and related information.
  - Decriminalization of LGBTQI+ people and behaviours, sex work, drug use and HIV transmission.
  - Supporting the legal registration of community-led organizations that provide HIV prevention services and ensuring they can access funding.
  - Expanding the prevention of gender-based violence, and access to gender-based violence services within health service delivery, with strong linkages to HIV services—including timely PEP for survivors of sexual violence.
  - Promoting gender equity and women's empowerment.

- **Decide on implementable actions to address structural barriers that hold back prevention programmes.** HIV prevention efforts may also need to tackle or find ways around structural barriers that directly affect people's access to and use of prevention options. That can include:

  - Integrating messaging on supportive gender norms into HIV prevention communications (e.g. shared responsibility for protection; encouraging men to seek health services).
  - Sensitizing and supporting healthcare workers to provide respectful, equitable and non-discriminatory HIV prevention services, especially for key populations and/or sexually active young people, including through community-led monitoring.
  - Considering safety, security and confidentiality issues in the design of outreach, virtual and facility-based services for key populations.
  - Strengthening referral and redress pathways for legal support to uphold the rights of key populations (e.g. in cases of violence and discrimination).
  - Analysing and addressing inequalities in prevention access and use (e.g. by income, gender, age or other factors), including in relation to service availability, acceptability and affordability.

- **Apply a human rights-based approach to HIV prevention.** This includes the decriminalization of key populations, since punitive laws deter criminalized populations from seeking from health and HIV services, with negative consequences that ripple across societies. Also relevant are third-party consent requirements. Sustainable access to HIV prevention requires applying human rights standards to HIV services *(42)*. It also entails creating enabling legal, policy and institutional environments that respect, protect and uphold the rights of people living with HIV and key populations—particularly in HIV contexts of criminalization and shrinking civic space. And it calls for the meaningful participation of people living with HIV and other affected populations in the design, implementation and monitoring of prevention programmes. These policy changes are low-cost options for improving the operating environment for HIV prevention.

Governments, political leaders and programme managers need to recognize the challenges posed by the rise of organized campaigns against certain populations and of HIV-relevant misinformation that circulates on social media and elsewhere. HIV prevention needs to be popularized through evidence- and rights-based narratives that emphasize the public health benefits of successful HIV programmes.

iii Also see the Global AIDS strategy for 2026–2031. Geneva: UNAIDS; 2026 (https://www.unaids.org/sites/default/files/2026-02/2026%E2%80%932031_Global-AIDS-Strategy_en.pdf).

5. Multisectoral stewardship (cross-cutting)

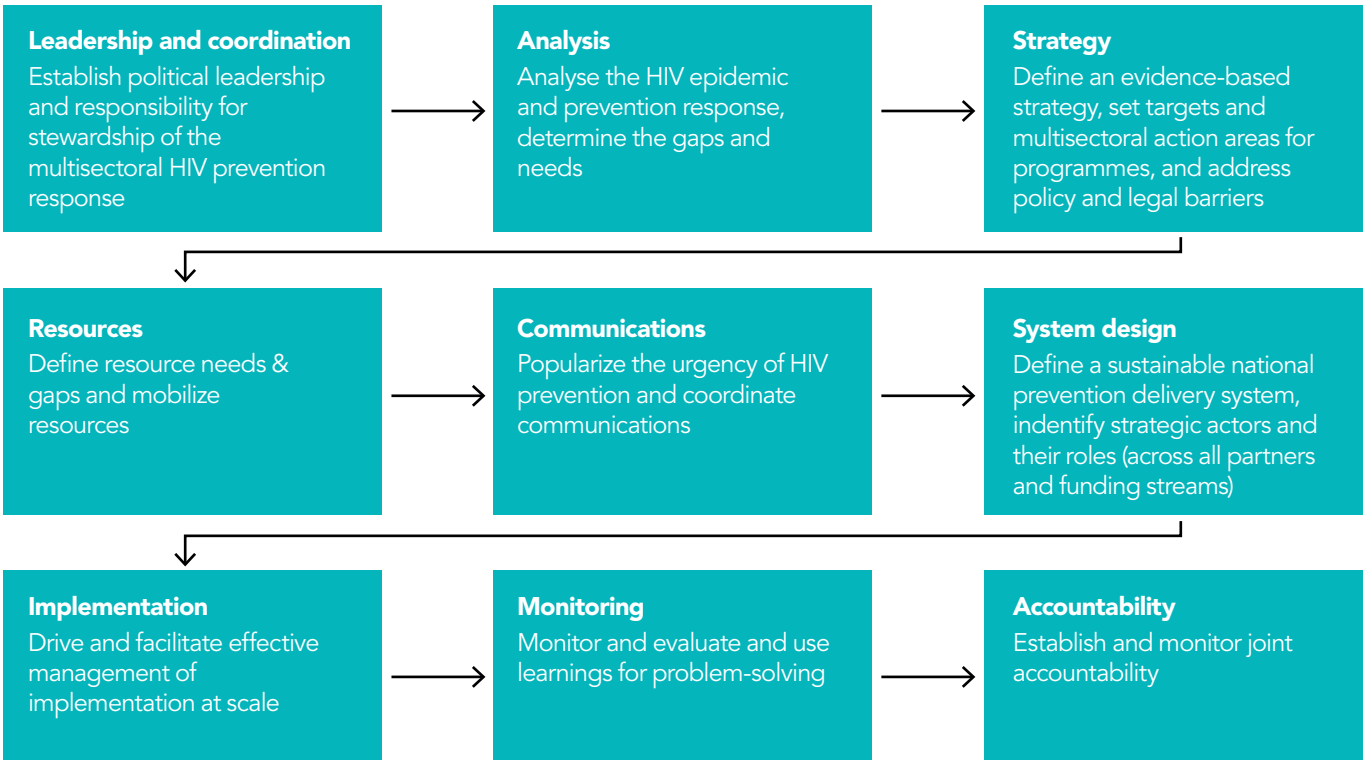
Strong leadership and stewardship in HIV prevention is crucial. By building and sustaining core capacities for HIV prevention within systems for health—including those led by affected communities—countries can place prevention at the forefront of their HIV responses *(43)*.

The complexities of HIV prevention call for a dedicated management mechanism that can draw on skilled human resources.

Strong government commitment and stewardship is essential to move from project-based activities to a coordinated, national HIV prevention programme. Alongside governments, the leadership of affected communities will contribute to sustainable prevention systems.

Multisectoral HIV management structures are important assets for the response, but need to be fit for purpose. In Botswana, for example, the National AIDS Coordinating Agency was transformed into the National Health Promotion Agency in 2019, which was placed in the Office of the Presidency and issued with an expanded mandate to include the prevention of noncommunicable diseases such as cancer and diabetes, in addition to HIV *(44)*. Figure 8 describes nine key multisectoral stewardship functions and steps (which are also elaborated in additional guidance) *(42)*.

Figure 8. Key multisectoral stewardship functions for HIV prevention



Source: HIV Leadership Forum. Global HIV Prevention Coalition. Stewarding multisectoral HIV prevention at the country level. Geneva: Joint United Nations Programme on HIV/AIDS (to be published).

Prevention Optimization

Enhanced prioritization in a resource constrained environment

To achieve the 2030 goals in a challenging environment, national HIV responses need to reconfigure the focus and modalities of HIV prevention. With reduced external resources, limited fiscal space and many competing priorities, it is not easy for governments to sustain their HIV responses. But by using existing HIV resources smartly and efficiently, it is still possible to substantially reduce new HIV acquisitions by 2030 *(45)*.

Prioritization is essential. HIV prevention is most effective when tailored prevention packages are accessible to the people who need them the most and in settings with the highest HIV burdens; when those packages are provided through effective delivery platforms; and when they are affordable.

Large numbers of people who are at moderate risk of HIV also need to be reached with scaled, lower-cost interventions. More detailed prevention prioritization guidance is available from UNAIDS, WHO, the Global Fund and others *(46, 47, 48)*. Figure 9 illustrates how countries can expand prevention packages for populations with higher HIV incidence without rigidly excluding individuals from other populations who seek access to HIV prevention.

Figure 9. Prioritization considerations based on the level of HIV incidence

HIV incidence rate in the sub-population (by age, sex, geography *and* behaviour)	**Interventions to be delivered at scale for the specific sub-populations** (with the respective HIV incidence rates)
Low (less than 0.2%)	+ HIV testing services and condoms available + PEP available + ART (all people living with HIV)
Moderate (between 0.2% and 0.5%)	+ Demand generation for essential combination prevention above (virtual/ media) + PrEP available
High (between 0.5% and 2%)	+ Interpersonal (face-to-face) outreach (demand and services) + PrEP available with active promotion
Very high (more than 2%)	+ Highest PrEP targets with universal offer

The 'Five P' HIV prevention prioritization matrix shown in Figure 10 provides a framework for more achieving more targeted planning and investments for prevention.

Figure 10. The 'Five P' HIV prevention prioritization matrix

PEOPLE: Focus on key and priority populations who need prevention most

Focusing HIV prevention efforts on key populations and their partners remains a highly effective way to reduce population-level HIV transmission—including in generalized epidemics *(1, 49)*. One model established that in three African settings, 60–80% of all new infections occurring in 2013–2033 could be prevented through stronger HIV programmes among sex workers. Targeting subsets of priority populations can further improve cost-effectiveness. For example, in an analysis in Kenya's Siaya district, only only 14 000 of the almost 100 000 adolescent girls and young women were found to need intensified HIV prevention *(46)*. Countries can use the latest estimation tools to revise their estimates of the populations that are most in need of HIV prevention (Table 7 in Annex 1).

People-centred precision in prevention means using data to design programmes so that the right people can access the most suitable prevention options

Changing epidemic dynamics should also be considered. While gay men and other men who have sex with men accounted for 9% of new adult HIV acquisitions in 2010 globally, they comprised 18% in 2024 *(50, 47)*. Similarly, increasing proportions of new HIV acquisitions in sub-Saharan Africa are now occurring among women aged 25–49 years *(1)*. If resources for empirical size estimation methods are unavailable, countries may consider cheaper alternatives such as the Delphi method, wisdom of the crowds, internet search trend analysis, or regional benchmarking, although the use case for estimated derived from such methods is more limited *(51, 52)*.

PLACE: Precision targeting of the highest HIV incidence locations

In many settings, location is the primary factor determining the lifetime probability of acquiring HIV. In Kenya, for example, just 10 (of 47) counties accounted for 57% of new HIV acquisitions in 2021. In Myanmar, people who inject drugs located in borderland areas had 67% higher HIV incidence in 2014–2021 *(53)*.

A precision focus on locations does not always mean picking a few areas and only focusing on them. It can also call for adjusting the intensity of actions in all relevant places to fit their levels of HIV incidence.

Precision targeting of subnational locations implies that prevention packages should be different where there are large differences in HIV incidence. Importantly, this approach does not mean concentrating on a few areas only but varying the intensity of actions. Also, if differences in HIV incidence are small, for example less than two-fold, then the cost for managing separate packages might exceed the benefits. Finally, it should be noted that subnational HIV incidence estimates are often subject to substantial uncertainties. A good example of precision targeting is Mozambique's HIV Prevention Roadmap 2022–2025, which defines different HIV prevention packages based on district-level HIV incidence *(54)*. Several countries have used the **Sub-National HIV Incidence Estimates for Priority Populations (SHIPP)** for differentiating national HIV prevention programmes and Global Fund proposals from 2022 onwards.

PLATFORM: Delivering information and services in the best way

The reach and suitability of various prevention access platforms for different populations should be considered in planning. Key population-led HIV prevention models can be more cost-effective than public services in some contexts, for example in Thailand *(55)*. In Mali and Nepal, online outreach improved cost-effectiveness of HIV testing outcomes compared to all in-person services *(56)*. Differentiated service delivery for HIV prevention can yield further efficiencies. Six-month oral PrEP dispensing with HIV self-testing can help increase access and minimize delivery and pick-up costs without compromising quality *(57)*.

Depending on resource availability, countries may plan to 'stack' different delivery models for priority groups (Figure 3 in Annex 1). It is important to explore ways to reduce fragmentation, while retaining necessary differentiation of delivery and standardizing human resources.

PACKAGE: Defining the best mix of interventions

The prevention needs estimates based on the UNAIDS Spectrum model, which informed the 2030 HIV prevention targets, represent a prioritized mix of prevention options. Cost-effectiveness and optimization analysis using models such as Goals, Optima *(58)*, the AIDS Epidemic Model (AEM) and others can be used for further prioritization *(59)*. Three factors are especially important for prioritization and establishing the right mix of interventions based on cost-effectiveness:

- The HIV incidence rate in the subpopulation (national estimates are available via tools like Spectrum and subnational estimates are available via tools like **NAOMI** and SHIPP),
- Cost per person reached per year, and
- Assumed effectiveness of the intervention.

Defining the best mix of HIV prevention interventions should balance allocative efficiency modelling with the needs and social contexts of various communities. Decision-making should consider user preferences.

PRICE: Maximizing value for money and sustainability

Ensuring the best possible prices for high quality prevention medicines, commodities and services is more crucial than ever. Access to generic versions and increased competition have significantly reduced the prices of PrEP and OAMT in recent years. Other cost considerations are discussed in the section on prevention financing and sustainability.

In settings with great dependence on external funding, the largest efficiency gains for prevention can often be achieved by transitioning from donor-driven costs to sustainable country government costing practices. Such transitions are being implemented in several countries. For example, India transitioned its national key population programme with a large-scale community system towards domestic financing. Costs were reduced while essential service packages, community implementation and social contracting were sustained. For prevention programmes, savings can often be made in three main areas:

- **Reduce the fragmentation of service delivery** by streamlining projects and cadres into one national programme.
- **Move to sustainable and more standardized salary and remuneration scales** for human resources in line with country practice rather than donor practice.
- **Use high-volume (international) procurement platforms** for commodities.

Distributional cost-effectiveness analysis is useful to evaluate how HIV outcomes and costs of prevention are distributed across different population groups. This may require accepting higher per capita costs to reach criminalized and stigmatized populations who have higher HIV incidence, because reaching them promise major benefits for the populations themselves and the HIV response overall.

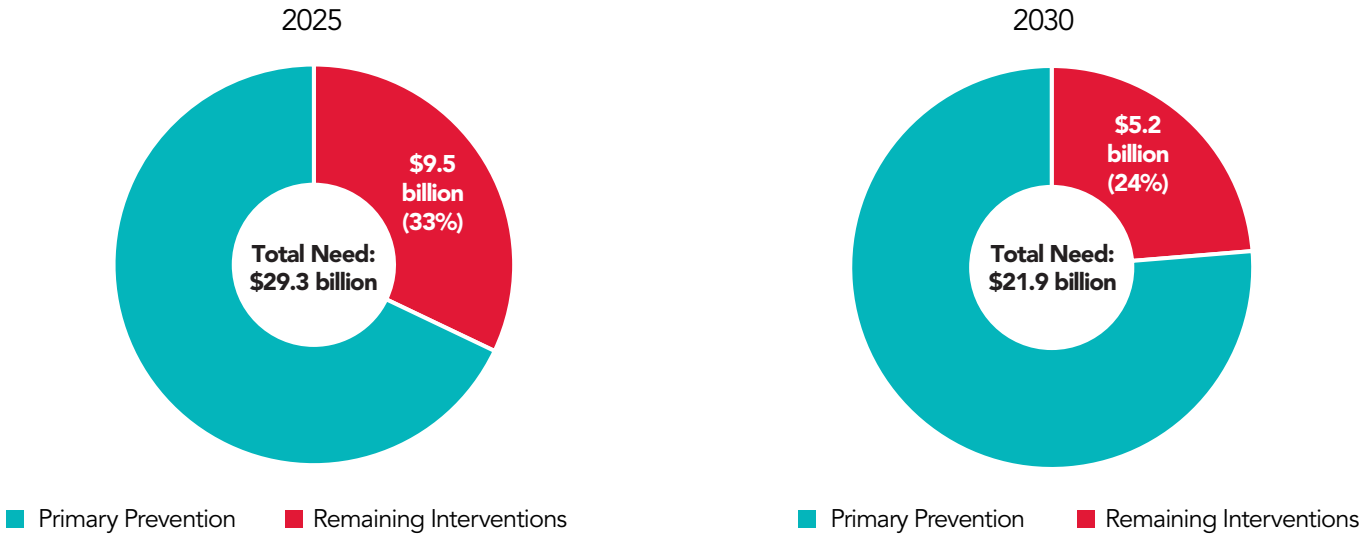
Prevention financing and sustainability

Transformations in the prevention investment architecture

In the 2026–2030 period, HIV prevention financing needs to transition from emergency and project-financing to sustainable financing of prevention, in line with country systems.

By 2030, reaching the global HIV prevention goals will require US$ 5.2 billion annually in low- and middle-income countries, equivalent to 24% of total HIV resource needs (US$ 21.9 billion). These resource needs estimates are lower than previous ones because of major cost efficiencies *(11)* and enhanced prioritization. The latter include a reduction in the average price of oral PrEP from about US $109–134 per person per year in 2019 to less than US$ 40 in 2025 *(60, 61)*, and significant reductions in OAMT unit costs (Figure 11).

Figure 11. Adjusted resource needs estimates for HIV prevention, 2025 versus 2030



Source: UNAIDS financial estimates, July 2025

With constrained resources, it is essential to translate prevention targets into implementable country-owned investment plans.

The funding need for primary prevention varies by region, from 12% of total HIV resources in western and central Africa to 38% in Eastern Europe and central Asia (Figure 11).

To contextualize the global targets and investment needs, it is important to understand that more than half of total HIV primary prevention funding is needed in just eight countries—South Africa (12%), India (10%), China (6%), Brazil (6%), Pakistan (5%), Russian Federation (5%), Indonesia (4%), and the Philippines (4%) (*62*).

In line with their economic and epidemic contexts, country governments can:

- **Fundamentally reorganize prevention financing around country-led investment plans.** Country-owned prevention investment plans should become the central planning instrument in all countries. In middle-income countries, international partners will retain roles in the provision of granular epidemiological and programming tools for estimating needs and setting country targets as a basis for primarily domestically funded prevention responses. In low-income and lower-middle-income countries with high HIV burdens, international partners will need to continue providing support, based on redefined country-owned plans and cost structures, including the efficiencies outlined in the previous section.

- **Apply a total market approach to HIV prevention.** While not traditionally considered domestic funding, a total market approach can help address the limited scale and sustainability of HIV prevention. The prevention of HIV is an essential health service that should be included in (universal) health coverage benefit packages. It should be free at the point of use for people at highest risk of HIV and those facing structural barriers. The total market approach can complement that by expanding the choice of access platforms and products. It recognizes that populations with higher income can buy prevention products out of pocket, while government subsidies can focus on lower-income groups who cannot afford private sector prices.

  Social marketing and social enterprise models offer access to affordable products outside health facilities. In some contexts, commercial models can also be a source of sustainable income for community-led service providers. Table 2 shows a systematic approach towards shared financing for prevention. Rather than donors financing their own donor-led projects, the systematic approach invites them to fund parts of country-led programmes.

Table 2. Example of segmentation in a total market approach and systematic approach to shared financing (illustrative assumptions are for a lower-income country context and can be adapted)

Prevention options	Target (illustrative)	Programme/market segments (percentage share of products and populations to be reached)			Funding source for free and subsidized (percentage share of cost)	
		Free (public)	Subsidized (social marketing)	Sold (private/out of pocket)	Government	Donors
Condoms	85 million	50%	30%	20%	50%	30%
PrEP	120 000	80%	10%	10%	30%	60%
PrEP (long-acting)	230 000	100%	—	—	10%	90%
PEP	TBC	60%	20%	20%	50%	20%
VMMC	120 000	90%	—	10%	50%	50%
Needles and syringes	2.5 million	80%	—	20%	40%	20%
OAMT	4 800	100%	—	—	80%	20%
People-centred programmes and access platforms	**Target** (illustrative)	**Facility**	**Outreach**	**Virtual**	**Government**	**Donors**
Women and girls in locations with elevated HIV incidence (>0.2%)	900 000	40%	10%	50%	80%	20%
Men and boys in locations with elevated HIV incidence (>0.2%)	400 000	10%	10%	80%	80%	20%
Sex workers reached	45 000	40%	40%	20%	50%	50%
Gay men and other men who have sex with men reached	60 000	20%	10%	70%	50%	50%
Transgender people reached	4000	20%	30%	50%	50%	50%
People who inject drugs reached	10 000	40%	40%	20%	50%	50%
Prisoners	8000	80%	—	20%	90%	10%

- **Increase domestic funding for primary prevention and allocate at least 20% of domestic HIV spending to prevention.** Domestic financing will determine the success of the global response from 2026 to 2030 and beyond. Based on an analysis done in 22 countries with data from 2019 to 2024, nearly 80% of HIV primary prevention programmes are financed externally, compared to 55% of care and treatment *(63)*. Such reliance puts primary prevention at risk.
- Primary prevention also requires greater prioritization overall, especially in domestic spending. As a benchmark, and considering the country context, UNAIDS advises that at least 20% of domestic HIV spending should go to primary prevention by 2030 *(64)*. Table 3 provides baseline values at regional level.

Table 3. Proportion of HIV resources spent on prevention (data from 57 countries, 2023–2024)

Region	Percentage of total HIV resources spent on prevention	Percentage of domestic HIV resources spent on prevention
Asia–Pacific	8	7
Eastern and southern Africa	10	5
Eastern Europe and central Asia	21	15
Latin America and the Caribbean	16	15
Middle East and North Africa	5	0
Western and central Africa	9	3
Global	**11**	**8**

Source: Special analysis from the Global AIDS monitoring dataset. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://hivfinancial.unaids.org/hivfinancialdashboards.html).

- **Explore innovative domestic financing modalities for HIV responses including prevention.** There are several viable strategies to increase domestic funding for HIV prevention:
  - Include HIV prevention in the benefits package for ***social health insurance*** *(65)*. Brazil and Thailand have included PrEP in their social health insurance packages since 2017 and 2021, respectively *(66, 67)*. It is also important to ensure cover for people in need of HIV prevention. In 2023, Cambodia expanded the Health Equity Fund eligibility criteria to include female sex workers *(68)*.
  - ***Social contracting*** of community-led organizations is important to facilitate access to prevention at community level and thereby increase uptake of HIV prevention methods *(69)*. The scale up of these financing mechanisms has been slow, but there are promising examples. Jamaica has socially contracted HIV prevention for gay men and other men who have sex with men and transgender people since 2021 *(70)*, while Viet Nam began social contracting of harm reduction services in 2023 *(71)*. Meaningful involvement of communities is critical when developing these mechanisms *(72)*.

- **Special levies and taxes** have been used to fund HIV prevention in several countries, including the Philippines, South Africa, Uganda and Zimbabwe *(73, 74)*.
- To increase the likelihood of governments absorbing externally funded HIV prevention programmes, ***strengthening public financial management (PFM) systems*** is key. On-budgeting HIV prevention funding from external sources—such that it runs through the PFM system regardless of who implements it—contributes to successful donor transitions *(75)*.

- **Provide adequate funding to ensure that key populations can access prevention.** In 2024, only 2.6% *(76)* of total HIV funding was spent on programmes for key populations, even though they accounted for an estimated 69% of new HIV infections outside sub-Saharan Africa and about 26% in sub-Saharan Africa in that year *(77)*. By 2030, spending on HIV prevention direct services (except PrEP) for key populations will require 13% of total funding *(78)*. It is very important to increase domestic funding for HIV prevention among key populations, while sustaining international financing until in-country provisions are in place for adequate budget allocations, social contracting modalities, quality and safety standards.
- **Ensure that new prevention technologies are available, accessible, affordable and acceptable.** These new technologies should be provided alongside existing effective options, including oral PrEP, to ensure meaningful choice. In addition to affordability, timely regulatory approval, inclusion in national guidelines and Universal Health Coverage benefit packages and access to quality assured generic products through voluntary licences or other legal and policy measures will be critical for scale-up.

  Some countries have already generated cost-effectiveness thresholds for long-acting PrEP, including Kenya, South Africa and Zimbabwe *(79, 80)*. Access to Lenacapavir at a price of US$ 40 for two injections per year has been confirmed for 120 low- and middle-income countries *(81)*. However, an affordability gap remains for several middle-income countries that account for a substantial proportion of need for this prevention technology. Long-acting PrEP can remain cost-effective at prices slightly higher than for oral PrEP, but not at substantially higher prices. Countries can determine the thresholds at which products will improve the overall impact of the prevention response and use them in pricing advocacy and negotiations.

Economic analysis—including resource tracking, costing norms and cost-effectiveness—is essential to monitor progress on these transformations. National AIDS spending assessments and other resource tracking methods remain critical tools for understanding granular expenditure on HIV prevention, including domestic spending and spending on key populations.

Conclusion and Commitments

Call to action for country-led prevention

Achieving the vision for 2030—where every person at risk of HIV will have access to a prevention option that suits their needs—is only possible with a transformed HIV prevention response. The Prevention 2030 Global Access Framework provides countries with a new and focused approach to achieve their goals in a constrained environment.

To operationalize Prevention 2030, countries are encouraged to develop a **concise action plan**, outlining the prevention transformations that will increase access at country level. The action plan may be an addendum to existing HIV prevention roadmaps, strategies or national plans.

It is proposed that countries seek to complete their HIV prevention action plans by end-2026. The checklist in Table 4 can be used to guide that process.

Table 4. Prevention 2030 planner—country checklist

	Due Date
Needs estimates: Revise prevention denominators for those in need of targeted services	April 2026
Method mix tables: Set annual numerical access targets per population and intervention	April 2026
Monitoring and evaluation tools: Update tools to include tracking of overall HIV prevention use (i.e. any method at last exposure)	June 2026
Access platforms: Map prevention use by population and product across delivery models	June 2026
Total market approach: Analyse viability of increased self-care and social enterprise	August 2026
Resource needs: Estimate domestic and external funding required to meet access targets	October 2026
Planning: Develop national Prevention 2030 Action Plan	December 2026
Monitoring: Update Prevention 2030 country scorecards	Annually
Resource tracking: Assess prevention spending; focus on domestic and key population expenditure	Annually
Management: Conduct annual peer review of performance with subnational and multisectoral entities	Annually

A call to action

COUNTRY GOVERNMENTS WILL:

- Set national and subnational programme, finance and impact **targets** based on granular needs estimates and in accordance with the 2026 UN Political Declaration, the Global AIDS Strategy 2026–2031 and this access framework.
- Develop truly country-led and well-prioritized, sustainable HIV prevention **plans** that advance prevention responses from fragmented projects to integrated, nationally owned programmes.
- Designate a national **multisectoral leadership entity** for HIV prevention and build its capacity to lead the prevention response.
- **Lead and coordinate** integrated health sector and multisectoral HIV prevention, including actions in government sectors, private sector and communities.
- Ensure adequate **domestic prevention financing,** including integration into social health insurance schemes and multisectoral budgets.
- Develop a country systems approach to prevention **access platforms** with differentiated platforms for different populations (but *not* separate project approaches).
- Develop and implement a support mechanism for **community systems,** including social contracting of civil society and community-led organizations reaching key and priority populations.
- Lead a prevention push campaign and coordinate people-centred HIV **prevention communication,** including in virtual spaces and by promoting prevention-related knowledge, norms and skills;
- Facilitate a rapid regulatory process for introducing and ensuring access to **long-acting prevention** products, while seeking to make maximum use of limited resources and catering to people's different preferences and needs.
- Sustain investments in condoms, needles, self-tests and other **self-care products,** applying a 'total market approach' with complementary roles for the public, social marketing and private sectors.
- Accelerate the necessary reforms to the legal and **policy environments** so the people who are most affected can access HIV prevention; and adopt law enforcement practices that facilitate, rather than obstruct, access to prevention.

FUNDING PARTNERS WILL:

- In their own interests, **sustain investment** in HIV prevention in low and middle-income countries, recognizing that a pandemic cannot be ended unless transmission is reduced in all countries.
- Support a **phased transition** to sustainability that will maintain access and use of prevention options, rather than abrupt defunding of HIV programmes.
- Engage **additional funders,** including high- and upper-middle-income countries, and foundations, to fund prevention with a systematic focus on lower-income countries that have high HIV incidence and highly vulnerable populations.
- **Align** their contributions to sustainable national prevention plans rather than donor-specific projects; support existing country health and community systems; and adhere to sustainable country cost guidelines.
- Continue supporting **access** to basic prevention options such as condoms, clean needles and oral PrEP;
- Support country efforts to achieve **affordable and rapid access** to innovative long-acting prevention technologies.

COMMUNITY-LED AND OTHER CIVIL SOCIETY ORGANIZATIONS WILL:

- Identify gaps and **advocate** for equitable access to all suitable HIV prevention options for all key and priority populations (including but not limited to women, men and young people in locations with high HIV, sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and prisoners).
- Lead in the development of **trusted access** programmes for key populations, young people, women and men, including people living with HIV, and work to remove barriers to access, including punitive laws and obstructive age of access requirements.
- Strengthen **community systems**, including community-led monitoring and surveillance, to improve the quality of prevention services and of data, progress tracking and reporting.
- Hold governments and other actors **accountable** for progress towards prevention targets through constructive advocacy; and develop structures for feedback, communication and problem solving between community and government systems.
- Develop and implement interventions to **reduce HIV-related stigma and discrimination** across health, community, justice, workplace, education and humanitarian settings.

TECHNICAL PARTNERS WILL:

- Provide global leadership and stimulate **political momentum** for HIV prevention in line with the mandate from the 2026 UN Political Declaration.
- Support granular data collection and analysis to develop **prevention needs estimates**, an optimal mix of prevention options, and guidance for most effectively using international HIV prevention financing.
- Provide **guidance, tools** and technical support to develop programmes; build demand; and use new delivery strategies to achieve sustained access to prevention options.
- Work with governments, industry and communities to ensure affordability, licensing and rapid regulatory approval in countries, as well as the inclusion of **new prevention options** as part of universal health coverage.

PRIVATE SECTOR WILL:

- Avail the use of **private sector access platforms** for HIV prevention, including through pharmacies, retail networks, supply chain systems, marketing, collaboration with social enterprises and online marketplaces.
- Advance HIV prevention in **virtual spaces** through generative AI platforms and the integration of HIV prevention in dating apps and other social media platforms.
- Develop and introduce **innovative prevention products** and work with low- and middle-income country governments and international technical and funding partners to ensure equitable access and affordability.

Annexes

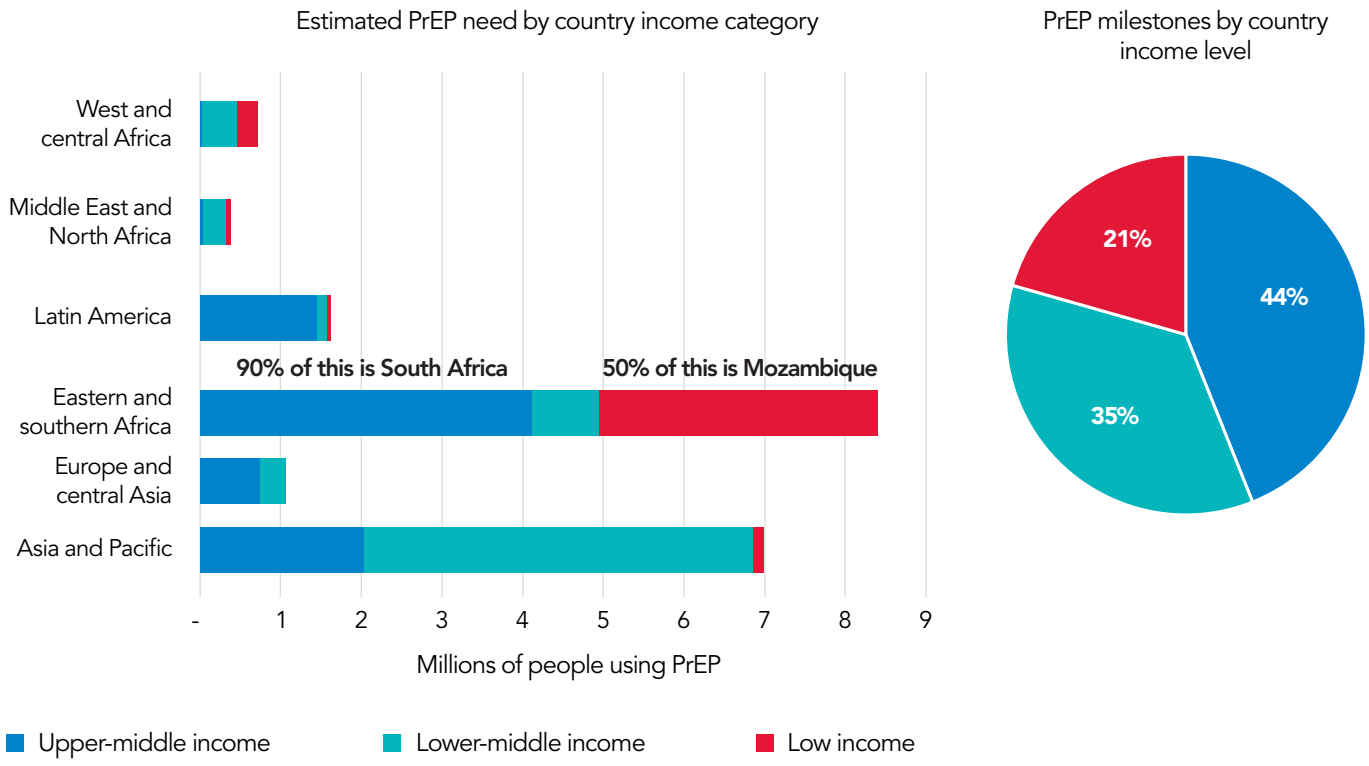
Annex 1: Milestones, epidemiological and resource estimates, and other guidance

Table 1. Detailed 2030 HIV prevention targets

	Target	Data source	Status
1	90% of people in need of prevention use appropriate, prioritized, person-centred and effective prevention options (PrEP, PEP, condoms, needle/syringe programmes, OAMT).	Population-based surveys	2025 target
2	80% of people use a condom at last sex with a non-regular partner.	Population-based surveys. (Global AIDS Monitoring (GAM) 1.14.)	New
3	50% of people at high risk of acquiring HIV (including key populations) use effective, ARV based, prevention options: oral PrEP, long-acting PrEP, PEP (target levels in line with epidemiology and people's choices).	Programme records.	New
4	95% of sex workers and their clients used a condom at last paid sex.	Integrated biological and behavioural surveillance (IBBS), population-based surveys.	New
5	95% of people who inject drugs used safe injecting equipment during their last injection.	IBBS. (GAM 1.8.)	New
6	50% use of OAMT among people who inject opioids.	Programme data, IBBS. (GAM 1.10.)	2025 target
7	95% of adolescent girls and young women, adult women, pregnant and breastfeeding women, and adolescent boys and men in settings with elevated HIV, effectively reached with people-centred HIV prevention programmes (HIV prevention-related contact with health services, (including SRH services, community outreach, virtual interventions, schools and other providers).	Population-based surveys or programme data.	New
8	90% of schools provide life skills-based HIV and sexuality education.	Annual school census questionnaire or the UNESCO Institute for Statistics (UIS) Annual Survey of Formal Education questionnaire.	2025 target
9	95% of key populations effectively reached with people-centred HIV prevention programmes.	Programme data, IBBS. (GAM 1.6, 1.7.)	2025 target
10	95% of the estimated need for condoms is available and distributed.	Programme data versus needs estimates.	New

11	95% of the estimated need for PrEP is available and distributed.	Programme data versus needs estimates.	New
12	95% of the estimated need for PEP is available and distributed.	Programme data versus needs estimates.	New
13	95% of the estimated need for sterile syringes is available and distributed.	Programme data versus needs estimates.	New
14	80% of people-centred HIV prevention programmes for key populations to be delivered by community-led organizations.	Work is ongoing on measurement sources and methods. Policy data on the operating environment for community-led service delivery are being used as proxy measures.	2025 target
15	90% of all people living with HIV are virally suppressed by 2030, increasing to 95% by 2040.	Programme data plus epidemiological estimates. (GAM 2.3.)	New

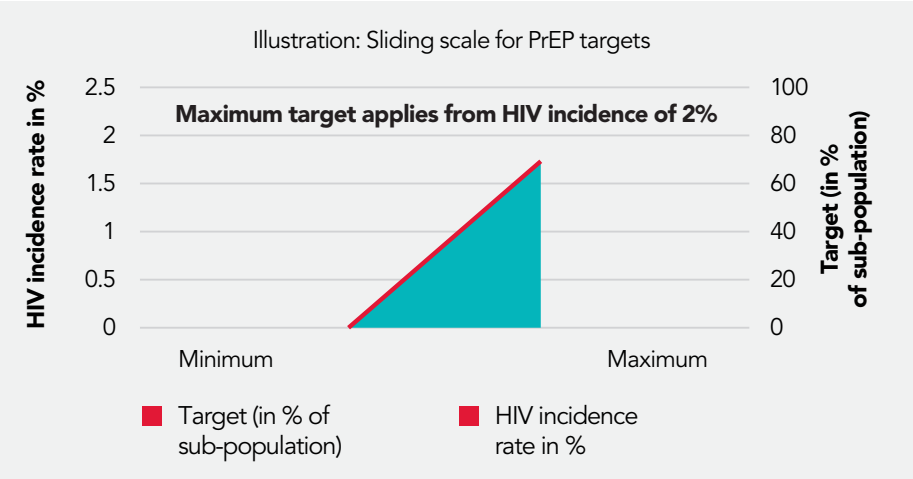
Figure 1. PrEP milestones by region and income level (2030)



Source: UNAIDS Special analysis based on needs estimates in line with 2030 global targets

Table 2. Assumptions underpinning the PrEP milestones

General rationale: the level of HIV incidence in specific sub-populations and their population sizes predict need for PrEP

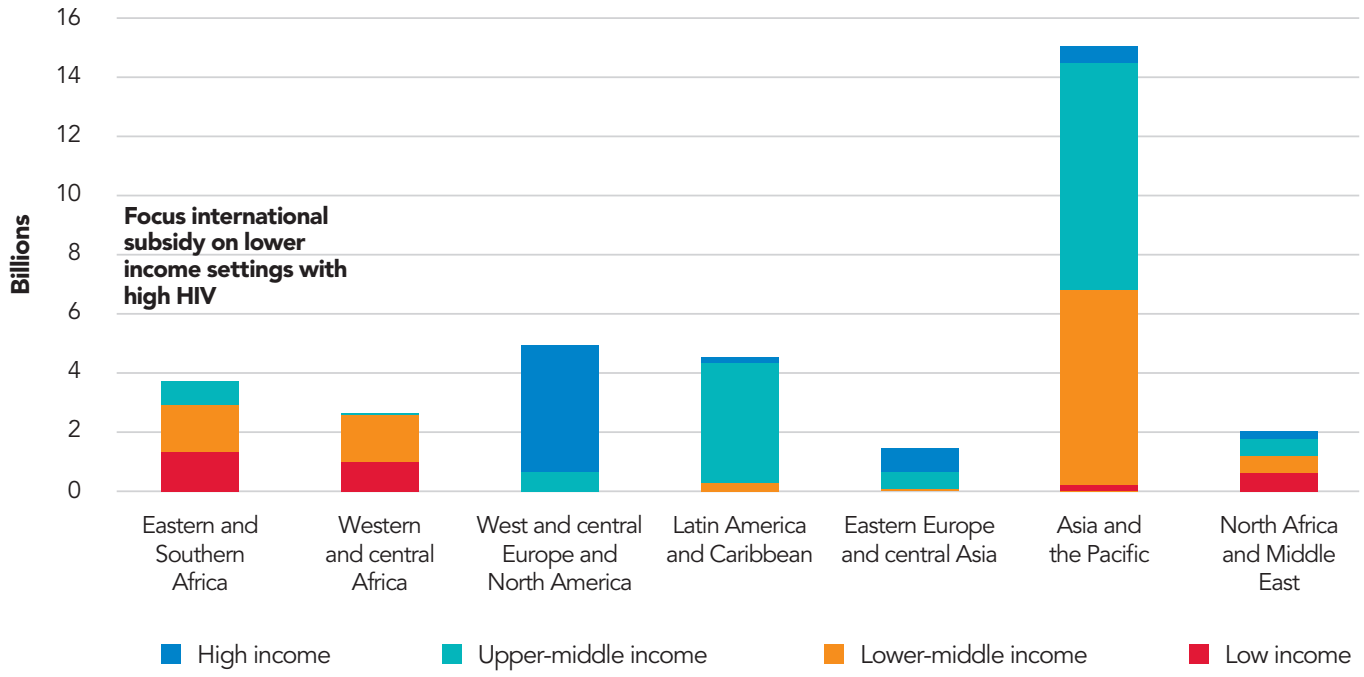


Description		Young people and adults in settings with elevated HIV	Key populations		
			Female sex workers	Men who have sex with men, transgender women	People who inject drugs, prisoners
Maximum target		80%	80%	80%	50%
HIV incidence rate thresholds (apply 2024 HIV baseline incidence rate up to 2030)	**Maximum target applies from**	2%			
	Sliding scale for targets starts at	0.2%	0%		
Other considerations for specific populations		Recommended to apply target based on HIV incidence rates in sub-categories of the sexually active population (people with non-regular and regular partners)		Apply minimum target of 20% of population size (including for male and transgender sex workers)	In most countries more than half of people who inject drugs use safe injecting equipment, therefore a maximum target of 50% in most settings
Overall minimum threshold*		5 persons on PrEP per estimated new HIV infection in a country			

* The overall minimum threshold corrects for uncertainty in sub-population assumptions, in particular population size and HIV incidence rates.

Source: Prepared by authors based on: Draft recommendations - Global Task Team for Setting 2030 HIV Targets (https://hivpreventioncoalition.unaids.org/en/resources/global-hiv-target-setting-2030-global-task-2030-targets-recommendations)

Figure 2. Condom milestones by region and country income group



Source: UNAIDS Special analysis based on Spectrum Prevention Needs Estimates for 2030

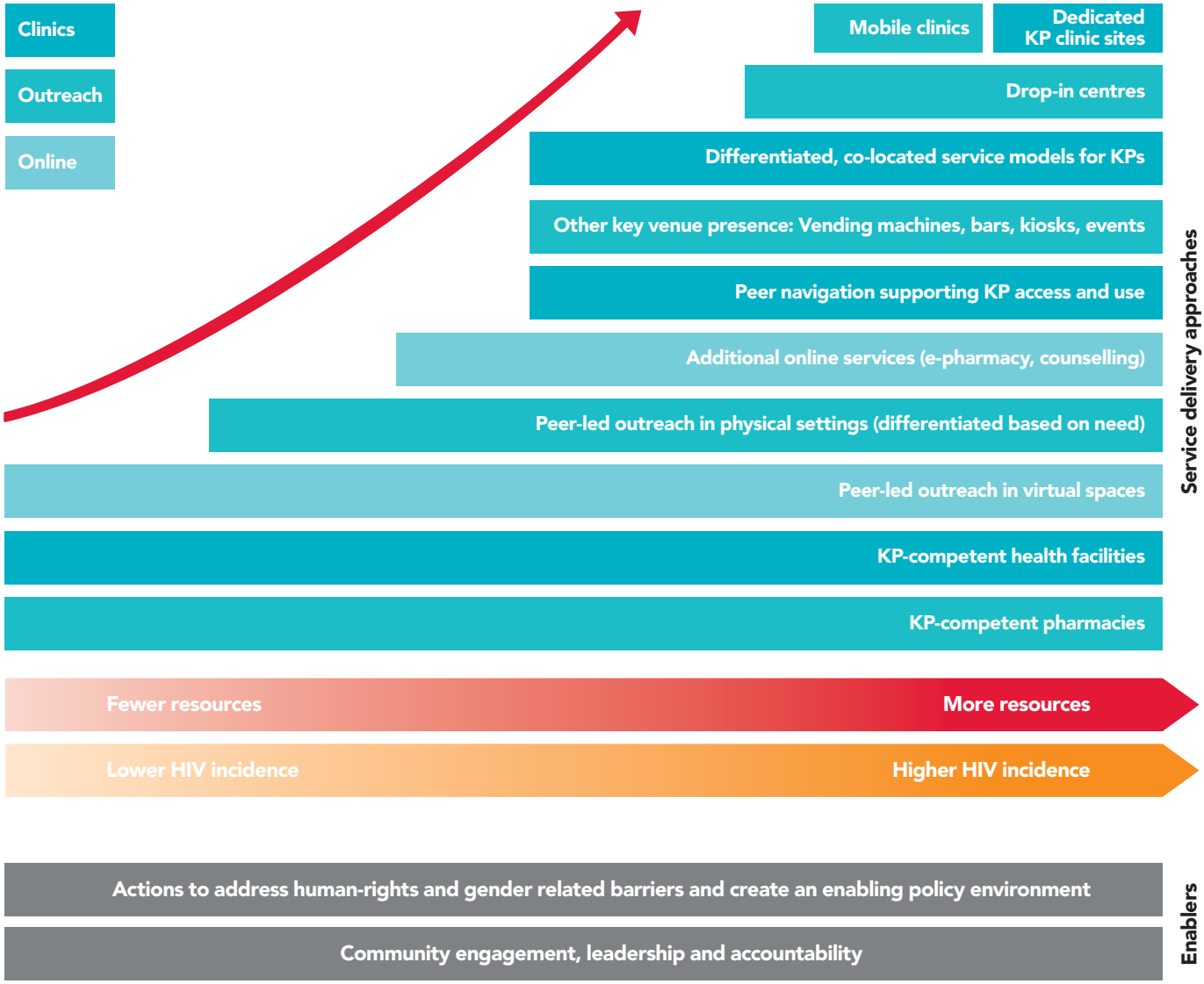
Table 3. Estimated regional median key population sizes

Population	Sex workers			Gay men and other men who have sex with men			Transgender women			People who inject drugs		
Region	**Median**	**Q1**	**Q3**	**Median**	**Q1**	**Q3**	**Median**	**Q1**	**Q3**	**Median**	**Q1**	**Q3**
Asia and Pacific	**0.28%**	0.21%	0.57%	**0.91%**	0.78%	1.60%	**0.18%**	0.07%	0.37%	**0.14%**	0.03%	0.31%
Caribbean	**1.63%**	1.58%	1.69%	**1.67%**	1.63%	1.82%	**0.06%**	0.05%	0.15%	As Latin America		
Eastern Europe and central Asia	**0.39%**	0.26%	0.42%	**0.81%**	0.64%	0.97%	**0.08%**	0.08%	0.08%	**1.06%**	0.70%	1.69%
East and southern Africa	**0.79%**	0.52%	0.93%	**0.73%**	0.58%	0.86%	**0.21%**	0.12%	0.25%	**0.20%**	0.11%	0.66%
Latin America	**0.53%**	0.33%	0.83%	**1.73%**	1.23%	1.80%	**0.10%**	0.10%	0.18%	**0.21%**	0.21%*	0.21%**
Middle East and North Africa	**0.37%**	0.31%	0.60%	**0.68%**	0.49%	0.79%	**0.13%**			**0.23%**	0.12%	0.34%
West and central Africa	**0.55%**	0.49%	0.70%	**0.38%**	0.15%	0.39%	**0.04%**	0.03%	0.07%	**0.16%**	0.09%	0.23%
North America	Same as western and central Europe			**2.68%**	2.59%	2.77%	**0.61%**	0.60%	0.63%	**0.57%**	0.57%*	0.57%**
Western and central Europe	**0.29%**	0.26%	0.53%	**2.06%**	1.46%	2.52%	**0.26%**	0.26% *	0.26% **	**0.51%**	0.46%	0.63%

Source: Special analysis, 2026 UNAIDS Guide for updating Spectrum HIV estimates.

Note: Q1 and Q3 stand for quartile ranges. They describe the range within which population sizes in half of the countries in the region were found.

Figure 3. Step-wise decision-making tool for key population delivery models



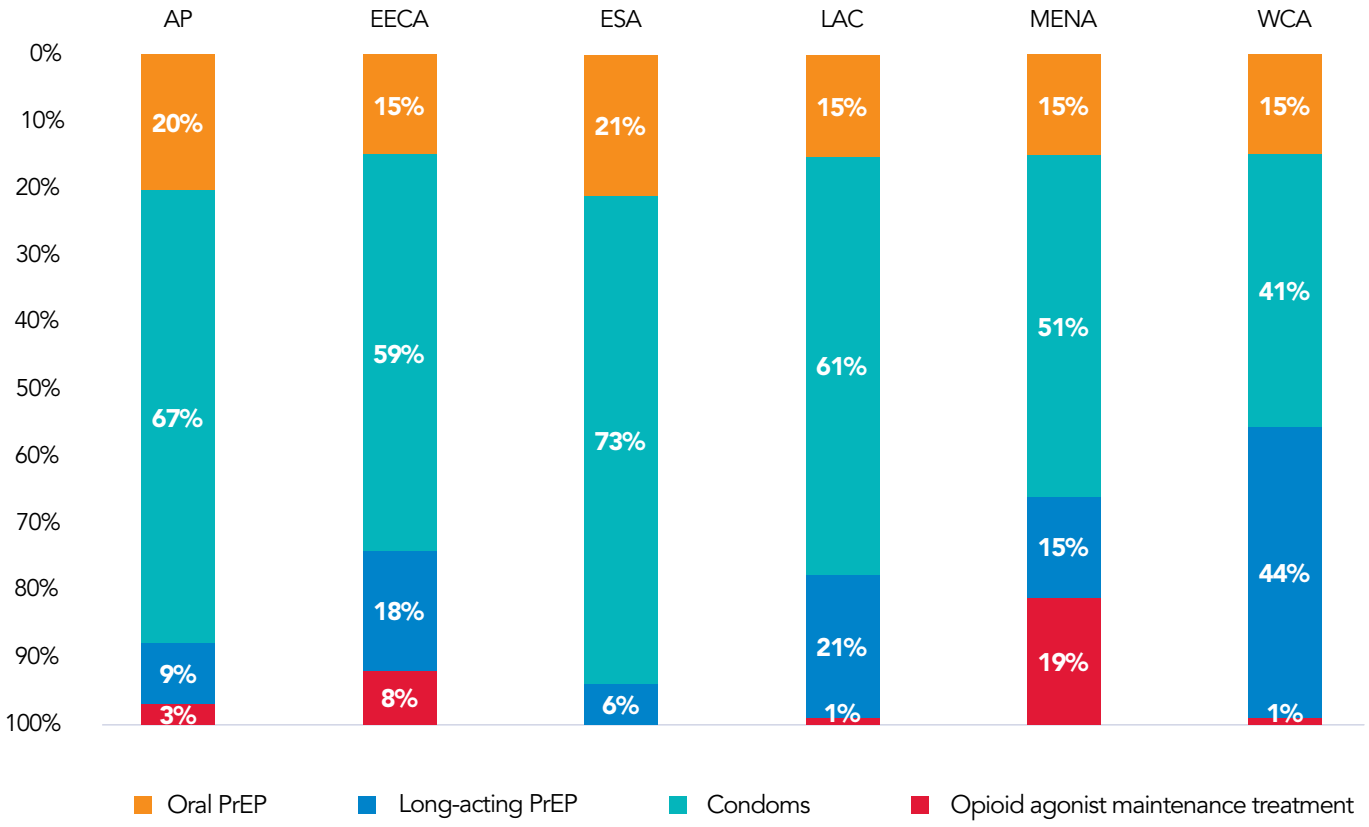
Enablers are a foundation that entail some actions that do not require extensive resources and others that do. The specific needs should be considered based on the country's legal and policy environment and resource availability .

Note: KP = key population

Source: Planning and managing HIV programmes with key populations, Global HIV Prevention Coalition, Geneva: Joint United Nations Programme on HIV/AIDS; 2025. (https://hivpreventioncoalition.unaids.org/en/resources/planning-and-managing-hiv-programmes-key-populations)

Figure 4. HIV prevention resource needs

a. Share of resource needs (in percentage of US dollars) in 2030 for HIV prevention commodities, by UNAIDS region



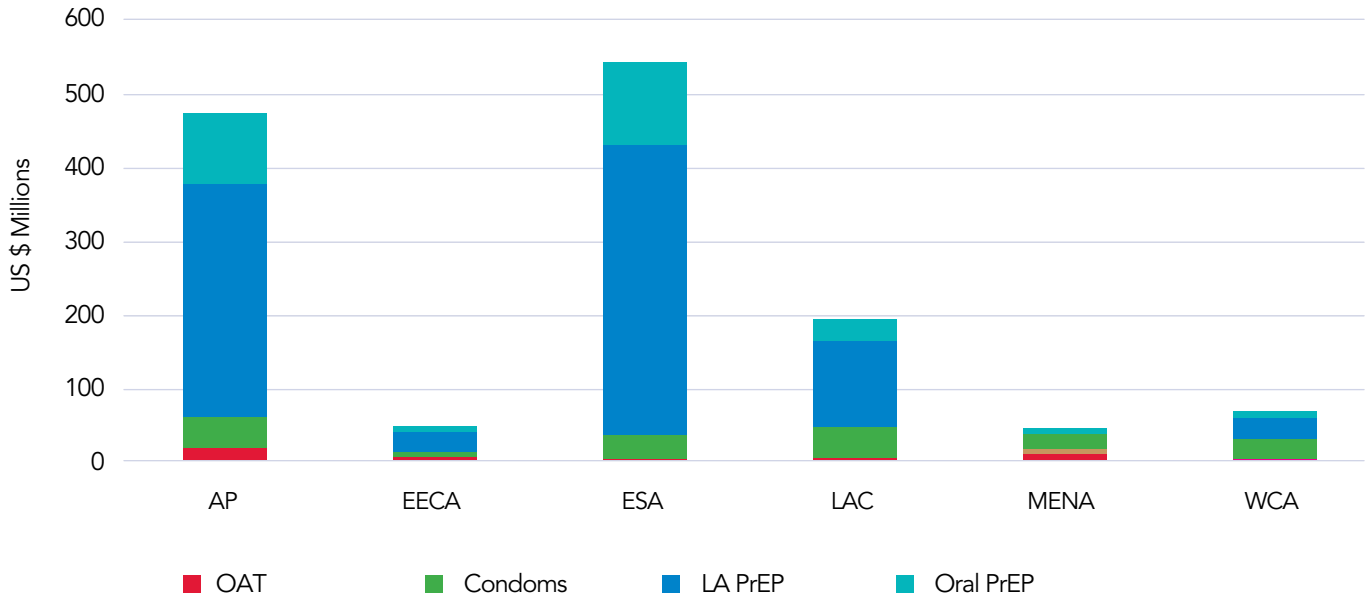
Notes: Long-Acting Pre-exposure prophylaxis = LA PrEP; OAMT = opioid agonist maintenance therapy.

AP = Asia–Pacific; EECA = Eastern Europe and central Asia; ESA = Eastern and southern Africa; LAC: = Latin America and Caribbean; MENA = Middle East and North Africa; WCA = Western and central Africa.

The disaggregation by method is only indicative, due to assumptions used to estimate cost, which differs for different products. The exact share of each method, in particular new long-acting products, cannot be predicted precisely since that will depend on user preferences, evolving prices and potentially new products on the market.

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

b. Resource needs (in US dollars) in 2030 for HIV prevention commodities by UNAIDS region

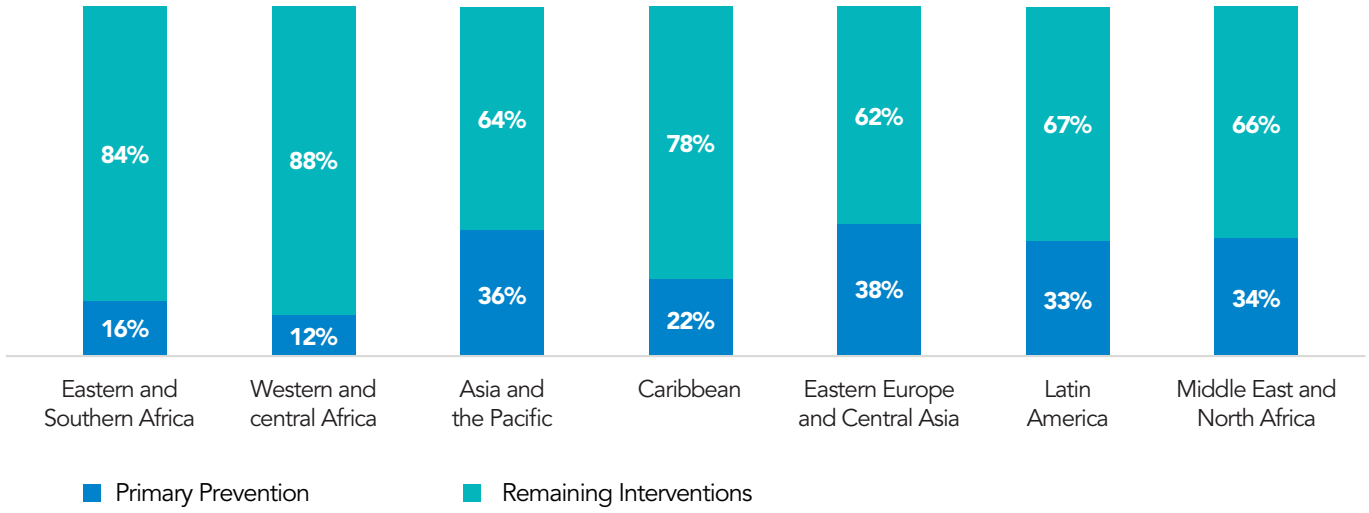


Notes: Long-acting pre-exposure prophylaxis = LA PrEP; OAT = opioid agonist therapy.

AP =: Asia–Pacific; EECA = Eastern Europe and central Asia; ESA = Eastern and southern Africa; LAC = Latin America and Caribbean; MENA = Middle East and North Africa; WCA = Western and central Africa.

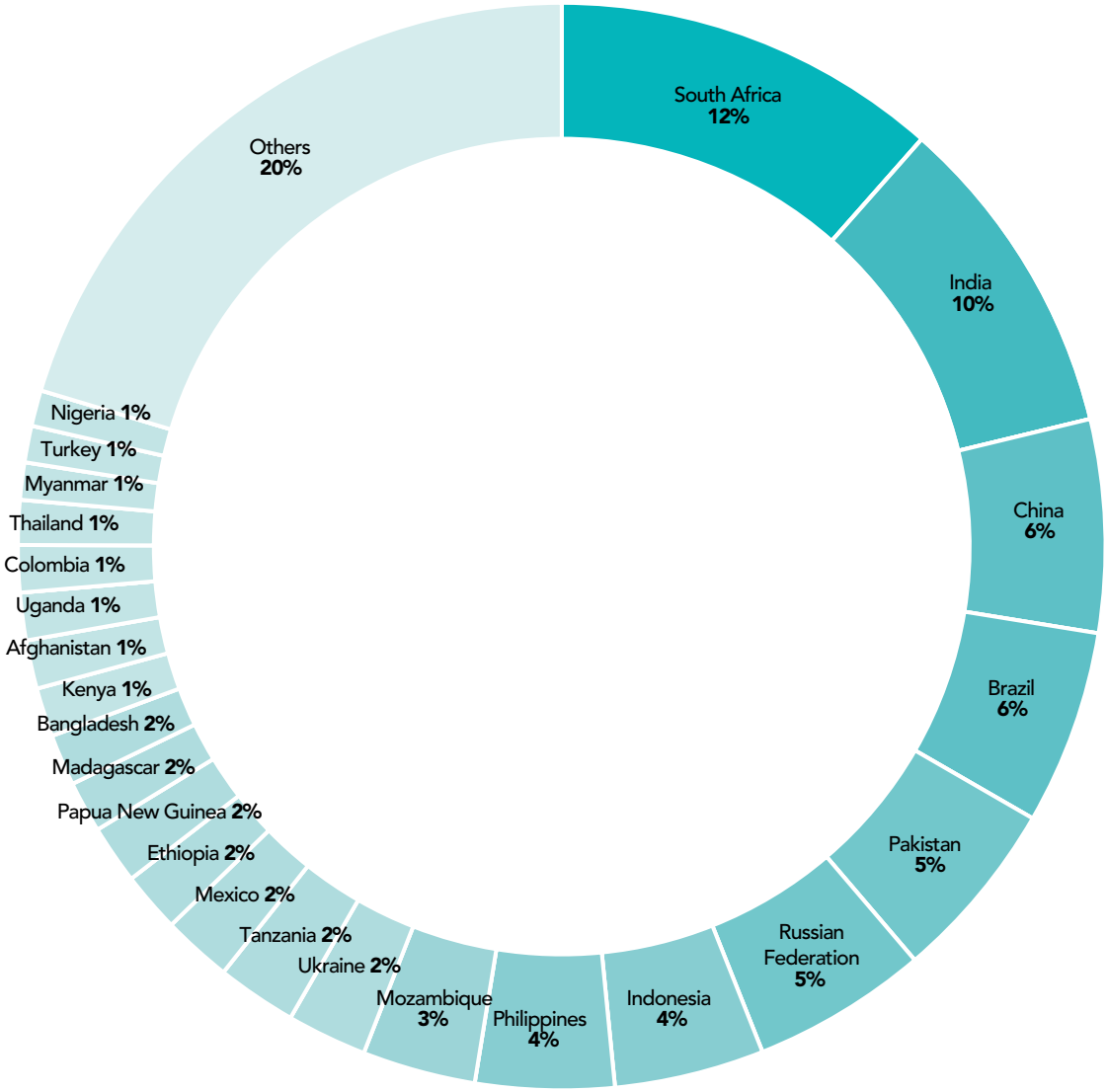
Source: UNAIDS financial estimates and projection of resource needs for 2026–2030, July 2025.

c. Distribution of 2030 HIV resource needs for primary prevention, by region



Source: AIDS, crisis and the power to transform: UNAIDS Global AIDS Update 2025. Geneva: Joint United Nations Programme on HIV/AIDS; 2025. page 114

d. Proportion of resource needs for HIV primary prevention by 2030 in low- and middle-income countries



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

Table 4. Proportion of HIV resources spent on prevention, selected countries

Country	Year	Percentage of total HIV resources spent on prevention	Percentage of domestic HIV resources spent on prevention
Afghanistan	2024	49	0
Angola	2024	10	9
Antigua and Barbuda	2023	9	9
Armenia	2024	35	18
Azerbaijan	2024	29	28
Bangladesh	2023	39	21
Belize	2023	8	3
Benin	2024	35	18
Bhutan	2024	45	0
Brazil	2024	7	7
Burkina Faso	2024	4	6
Central African Republic	2024	3	0
Chile	2024	28	28
Costa Rica	2024	5	5
Dominica	2023	50	50
Dominican Republic	2024	20	23
El Salvador	2024	18	19
Ethiopia	2023	10	12
Georgia	2024	50	47
Ghana	2023	8	1
Guatemala	2024	37	29
Guinea	2024	4	0
Honduras	2024	33	32
India	2024	27	27
Kazakhstan	2024	8	6

Kenya	2024	8	5
Kyrgyzstan	2024	13	1
Lao PDR	2024	30	23
Malawi	2024	15	0
Malaysia	2024	14	10
Mali	2024	38	38
Nepal	2024	21	1
Panama	2024	20	23
Papua New Guinea	2023	14	4
Peru	2024	43	44
Philippines	2024	6	6
Republic of Moldova	2024	34	28
Rwanda	2024	9	0
Seychelles	2024	39	39
Singapore	2024	6	6
South Africa	2024	9	5
Tajikistan	2023	32	13
Thailand	2023	15	12
Timor-Leste	2024	49	57
Togo	2024	11	6
Uzbekistan	2023	20	12
Zimbabwe	2023	21	0
TOTAL	**2023/2024**	**11**	**8**

Source: Special analysis from the Global AIDS monitoring dataset. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://hivfinancial.unaids.org/hivfinancialdashboards.html).

Note: Ten additional countries (Burundi, Chad, China, Egypt, Gambia, Saint Kitts and Nevis, Saint Lucia, Senegal, Sri Lanka and United Arab Emirates) reported 0% for both indicators and are therefore not displayed in this table.

Annex 2: HIV prevention resources

Prevention planning tools

- UNAIDS HIV estimates training materials (online here)
- HIV prevention needs estimation training materials (online here)
- UNAIDS The key populations atlas (online here)
- UNAIDS HIV financial dashboard (online here)
- UNAIDS Condom needs assessment tool (online here)
- Naomi HIV subnational estimates viewer (online here)
- Subnational HIV Estimates in Priority Populations (SHIPP) (online here)
- PrEP-It implementation planning, monitoring and evaluation tool (online here)
- FHI360 Toolkit to design social media campaigns that promote condom use (online here)
- WHO Implementation tool for PrEP of HIV infection (online here)
- GPC Five HIV prevention self-assessment tools (PSATs) (online here)

Technical guidance on HIV prevention

- WHO Differentiated and simplified PrEP for HIV prevention (online here)
- WHO Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis (online here)
- WHO Preventing HIV through safe VMMC for adolescent boys and men in generalized HIV epidemics (online here)
- WHO Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations (online here)
- Developing effective condom programmes: technical brief (online here)
- People-centred HIV prevention communication: Consolidated approaches for the demand generation and behavioural aspects of HIV prevention (online here)
- Planning and managing HIV programmes with key populations (online here)
- Needle and syringe programmes for people who inject drugs. WHO operational guide (online here)
- Budgeting and resource planning guidance for implementing virtual interventions as part of HIV responses (online here)
- Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis: policy brief (online here)
- Virtual HIV Interventions: A Budgeting and Programming Aid. (online here)

Prevention sustainability

- HIV Leadership Forum: Implementing social contracting for HIV prevention (online here)
- GPC Social contracting: Concepts and examples (online here, or here)
- GPC Supporting prioritization in the context of HIV funding cuts (online here)
- Strengthening national leadership for sustainable HIV (Prevention) programs: a policy brief for government leaders (online here)

HIV prevention progress reports

- Global HIV Prevention Coalition scorecards (online here)
- UNAIDS 2025 Global AIDS Update (online here)

Other resources on HIV prevention

- South-to-South Learning Network on HIV prevention (online here)
- New directions in measuring combination HIV prevention (online here)
- PrEP Watch (online here)

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