ITPC

Global Reference on HIV Literacy

An Adaptive Resource for Communities, Programmes, and Policymakers

About ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Intellectual property and access to medicines (#MakeMedicinesAffordable)
- Community-led monitoring and accountability (#WatchWhatMatters)
- Activism and capacity building (#BuildResilientCommunities)

To learn more about ITPC and our work, visit. itpcglobal.org.

About Build Resilient Communities (BRC):

The progress to date in access to HIV treatment and improvements in the quality of HIV services are based on communities self-organizing and demanding their right to health. ITPC understands the importance of creating meaningful partnerships within the movement to form broader coalitions to fight for social justice.

To learn more about Build Resilient Communities and our work, visit brc.itpcglobal.org.

Lead writers: *Momentum Strategies LLC*

Editing, technical support and coordination: Pragashnee Murugan and Nadia Rafif from ITPC Global, Gang Sung and Naira Sargsyan from UNAIDS

Copy-edit: Janette Bennett

Design: Nigel French

Thank you to the leadership and lived experience of people living with HIV, key populations, and community networks whose engagement and advocacy continue to shape more equitable, accountable, and people-centred HIV responses.

To download this report from the ITPC website, click here.

UNAIDS & ITPC (2026). Global Reference on HIV Literacy: Strengthening community-led, people-centred HIV responses through accessible, actionable knowledge.

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Abbreviations

3TC	Lamivudine ABC Abacavir
ADP-MENA	Activists Development Program, Middle East and North Africa
AHD	Advanced HIV disease
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CAB	Cabotegravir; also used for Community Advisory Board
CAB-LA	Cabotegravir long-acting
CBO	Community-based organization
CLO	Community-led organization
CML	Community-led monitoring
DSD	Differentiated service delivery
DTG	Dolutegravir
EMA	European Medicines Agency
FORRS	Focused and Relevant, Simple and Standardized
FTC	Emtricitabine
GBV	Gender-based violence
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IRIS	Immune reconstitution inflammatory syndrome
KAP	Knowledge-attitudes-practice
LA	Long-acting
LA-ARVs	Long-acting antiretrovirals
LMICs	Low- and middle-income countries
LEN	Lenacapavir
MENA	Middle East and North Africa
MMD	Multi-month dispensing
NCD	Non-communicable disease
NVP	Nevirapine
OAMT	Opioid agonist maintenance treatment
OI	Opportunistic infection
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PPPY	Per person per year
PrEP	Pre-exposure prophylaxis
RDTs	Rapid diagnostic tests
RIL	Rilpivirine
RIL-LA	Long-acting rilpivirine
RRP+	Rwanda Network of People Living with HIV
SRH	Sexual and reproductive health
TB	Tuberculosis
TDF	Tenofovir disproxil fumarate
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
US FDA	United States Food and Drug Agency
U=U	Undetectable = untransmittable
VL	Voluntary license
VMMC	Voluntary male medical circumcision
WHO	World Health Organization

Acknowledgements

The *Global Reference on HIV Literacy* was developed by the **ITPC** with financial support from **UNAIDS**, and with technical guidance from the HIV Testing and Treatment Team at UNAIDS. The Reference aims to support community-led, people-centred, and rights-based HIV responses by strengthening access to accurate, up-to-date, and context-relevant HIV literacy.

A **Global Community Technical Advisory Board (TAB)** was established to provide strategic guidance, technical input, and expert review throughout the development of the Global Reference. TAB members brought expertise grounded in lived experience, community leadership, advocacy, programme implementation, and technical work, ensuring that the content reflects the realities and priorities of people living with HIV, key populations, young people, and affected communities across regions.

The TAB also contributed to the integration of human rights–based, gender-responsive, and key population–informed perspectives, helping to ensure that the Reference addresses real-world challenges related to access, stigma and discrimination, confidentiality and privacy, gender-based violence, and the realization of the right to health.

The Global Technical Advisory Board included the following members:

Loon Gangte—DNP+, South Asia

Denis Godlevskiy—ITPC Eastern Europe and Central Asia (EEAC)

Sergio López—Somosgay - Latin America and the Caribbean (LAC)

Zakaria Bahtout—ITPC Middle East and North Africa (MENA)

Robinah Babiyre—International Community of Women Living with HIV (ICW), East Africa

Cindy Kelemi—Botswana Network on Ethics, Law and HIV/AIDS (BONELA), Botswana

Jeffrey Walimbwa—ISHTAR MSM, Kenya (men who have sex with men—key population)

Deo Mutambuka—Rwanda Network of People Living With HIV/AIDS-RRP+, Rwanda

Grace Nyarath—African Sex Workers Alliance-Aswa, Kenya

UNAIDS and ITPC extend their sincere appreciation to **Mohan Sundararaj**—*Momentum Strategies LLC*, who served as one of the Lead Technical Writer for the Global Reference. Their expertise were central to shaping the content, structure, and technical quality of the document.

Thank you to **Nadia Rafif** and **Pragashnee Murugan** of ITPC and **Gang Sun and Naira Sargsyan** from the Testing and Treatment Team in UNAIDS for their leadership, coordination, and strategic oversight throughout the development process.

UNAIDS and ITPC further express their gratitude to **relevant UNAIDS and World Health Organization (WHO) staff** for their technical review and guidance. Their contributions helped ensure alignment with the latest global evidence, normative guidance, and policy recommendations.

UNAIDS and ITPC particularly recognize the leadership and lived experience of people living with HIV, key populations, and community networks whose engagement and advocacy continue to shape more equitable, accountable, and people-centred HIV responses.

Foreword

Solange L. Baptiste
Executive Director, ITPC

Communities have long driven the global HIV response, turning science into real access, dignity and hope through leadership and lived experience. HIV literacy has been foundational to that progress: when people have clear, accurate and up-to-date information, they can prevent HIV, test early, start and stay on treatment and protect their long-term health. In a moment of accelerated innovation and heightened risk, the need for trusted, community-friendly literacy is even more urgent, especially as misinformation and social isolation distort what people believe and how they navigate care.

For ITPC, HIV literacy is not a “health education” add-on. It is part of power-building: knowledge that enables communities to claim the right to health, challenge stigma and discrimination, strengthen confidentiality and consent and demand quality, respectful care. This is the basis for community-led interventions across the response, from peer support and service navigation to community-led monitoring, implementation feedback, policy advocacy, research and access leadership. As this Global Reference makes clear, the objective is not only to improve access to information, but to strengthen community-led action and systems change, translating evidence into accountability and better outcomes for those being left behind.

This guide was developed by ITPC in collaboration with UNAIDS and with the support and guidance of a Global Community Technical Advisory Board (TAB) grounded in community expertise and lived experience—as a practical, adaptable resource for people living with HIV, key populations, young people and the community networks and partners who support them. It is designed to be used in real contexts to strengthen treatment literacy, generate demand for services, support adherence, inform monitoring and research and equip communities to identify barriers and drive solutions, including when systems are under strain.

I urge governments, donors, implementers and civil society to apply and adapt it locally, invest in community leadership and ensure HIV literacy remains a core pillar of resilient, people-centered responses.

Introduction

HIV literacy has long been a cornerstone of the global HIV response. By supporting people to understand HIV prevention options, treatment pathways, and approaches to care and support, HIV literacy has contributed significantly to improved individual health outcomes and sustained engagement in services. It has also played a critical role in generating demand for services, promoting adherence to life-saving interventions, and enabling communities to advocate for equitable, high-quality, and people-centred HIV responses—central to the global commitment to end AIDS as a public health threat.

At its core, HIV literacy is inseparable from **human rights and the right to health**. Access to accurate, timely, and understandable information is a prerequisite for people to exercise their rights, make informed decisions, and claim quality, respectful care. HIV literacy supports efforts to address stigma and discrimination, challenge harmful gender norms, and respond to gender-based violence, while reinforcing the importance of confidentiality, privacy, and informed consent across all aspects of HIV prevention, treatment, and care.

This imperative is particularly relevant for young people, who increasingly access HIV and health information through social media, informal digital networks, and peer-to-peer platforms. While these spaces can expand reach and engagement, they also expose young people—especially young people living with HIV and young members of key populations—to misinformation, fragmented narratives, and content that is not grounded in the latest evidence or normative guidance. Many reports limited access to trusted, youth-friendly, rights-affirming HIV literacy resources that reflect their lived realities and support informed decision-making.

> **“In the era of misinformation and social isolation, we must proactively and deliberately rebuild knowledge of health information in a community-friendly manner, delivered by trusted sources.”**
>
> **—Solange Baptiste, ITPC**

The context in which HIV literacy is produced, accessed, and applied has evolved considerably these past few years. Scientific advances in HIV prevention, treatment, and care have accelerated, increasing both opportunity and complexity within HIV responses. At the same time, HIV financing has largely stagnated, and health and community systems in many settings face increasing pressure. Recent global shocks—including public health emergencies, climate-related events, economic instability, humanitarian crises, and funding disruptions—have further underscored the vulnerability of HIV responses when communities lack access to clear, accurate, and up-to-date information and the capacity to advocate for their rights.

Despite expanded access to HIV-related information and the growing use of digital platforms, significant gaps persist in existing HIV literacy materials. Many resources are outdated, available in limited languages, or insufficiently adapted to the needs and realities of people living with HIV, key populations, and young people. In many cases, materials do not adequately reflect diverse geographical, cultural, legal, and gender contexts, nor do they sufficiently address issues such as stigma, discrimination, criminalization, gender-based violence, confidentiality, and privacy. These gaps are compounded by systemic challenges—such as medicine stockouts, weaknesses in service delivery and clinic management, gaps in provider capacity, and treatment-related side effects—which undermine trust in services and contribute to disengagement from care.

In response to these challenges, ITPC, in collaboration with UNAIDS, has developed this **Global Reference on HIV Literacy** as a next-generation resource. It is intended first and foremost for **people living with HIV**, **members of key populations**, **young people**, including adolescent girls and young women, and their **allies**, as well as the **communities, networks, and organizations** that support, represent, and deliver services with and for them. It is also designed as a practical resource for those who engage directly with communities—including **community-led and community-based organizations, programme managers, healthcare workers, clinicians, advocates, and policymakers**, including national Ministries of Health—who play a critical role in enabling community leadership, participation, and rights-based approaches.

The objective is not only to improve access to information, but to strengthen **community-led action and advocacy**. HIV literacy is positioned throughout this resource as a foundation for access, accountability, and systems change—supporting communities to identify barriers, advocate for improved services, influence policies, and advance the right to health in their contexts. Examples of advocacy strategies and successful campaigns are integrated across sections to illustrate how knowledge can be translated into action.

The content draws directly on findings from a global scoping assessment led by ITPC with support from UNAIDS. That assessment was informed by qualitative interviews, surveys, and desk reviews involving people living with HIV, representatives of key populations, young people, community educators, healthcare workers, programme managers, and donors across multiple regions. It examined existing HIV literacy materials related to prevention, testing, treatment, care, and support, with particular attention to low- and middle-income country contexts, alignment with WHO and national normative guidance, and the inclusion of gender-responsive, youth-informed, and key population-led perspectives. The priorities and recommendations identified through this process inform both the structure and focus of this resource.

This reference is designed as a **practical, adaptable tool**, rather than a prescriptive manual. It recognises that HIV policies, normative guidance, service delivery models, and technologies continue to evolve, and that some guidance remains under development. It does not replace national policies or clinical guidelines, nor does it prescribe a single model for HIV literacy implementation. Instead, it should be understood as a living resource that complements existing guidance and supports communities and their partners to interpret, adapt, and contribute to evolving HIV responses.

Development of this Global Reference was informed by extensive consultation with communities and civil society across regions, populations, genders, and age groups—including key populations and young people—and benefited from technical review by WHO and UNAIDS staff to ensure alignment with the most up-to-date evidence and normative guidance available at the time of publication.

Limitations and Scope

This Reference is designed as a practical and adaptive resource to support HIV literacy across diverse contexts. While every effort has been made to align data with the Global AIDS Update 2025, UNAIDS normative language, Global AIDS Strategy targets, and relevant WHO terminology, it does not aim to replicate normative guidance but to complement it through a community-centered lens.

Examples included are illustrative and not exhaustive. Some regions may be underrepresented due to limited availability of documented examples at the time of publication. References are drawn from established and trusted stakeholders and are listed in alphabetical order, not by importance. As external content and the broader HIV landscape continue to evolve — with new data and guidance regularly issued — users are encouraged to verify sources and update the Reference as needed. This document should therefore be understood as a living resource, intended to be adapted and strengthened over time.

How to Use This Guide

This resource is designed to be **flexible, practical, and easy to navigate**, recognising the diversity of contexts, capacities, and priorities across communities and stakeholders.

It does not need to be read sequentially. Readers are encouraged to **navigate directly to the sections most relevant to their needs or lived experience**, using the structure, hyperlinks, and references to explore topics in greater depth. Each section can function as a standalone reference while reinforcing cross-cutting themes of **human rights, access, advocacy, confidentiality, and privacy**.

Throughout the document, **practical boxes** are included to:

- highlight common barriers to access and quality care, including stigma, discrimination, and rights-related challenges;
- provide tips on how communities can overcome these barriers; and
- identify advocacy priorities and examples of successful community-led campaigns at local, national, and global levels.

The content can be used in multiple ways, including:

- as a **reference tool** for people living with HIV, key populations, young people, advocates, and community organizations;
- as a **training or discussion resource** for peer education, workshops, and capacity-building activities;
- as a **support for dialogue** between communities, service providers, and policymakers; and
- as a **foundation for locally adapted materials**, including translations, summaries, and context-specific tools.

Users are encouraged to **adapt, translate, and reuse** the content as appropriate. Not all sections will be relevant in every context, and materials should be selected and tailored based on local priorities, national guidance, legal and policy environments, available resources, and evolving guidance.

Given the dynamic nature of HIV policies, technologies, and service delivery models, readers are encouraged to consult the **hyperlinked references and normative guidance** included throughout and to use this resource alongside national and global guidance.

Background: Mapping the HIV Response in a Period of Crisis and Transition

The Global HIV Situation

According to the 2025 Global AIDS Update, an estimated **40.8 million** people were living with HIV at the end of 2024. In the same year, approximately 1.3 million people acquired HIV, a figure that remains more than three times higher than the 2025 global target of 370,000 new infections. Despite important gains over the past decade, the pace of progress is insufficient to end AIDS as a public health threat by 2030.

Across all regions, HIV incidence remains disproportionately high among **people from key populations and their sex partners**, as well as **adolescent girls and young women**. These trends reflect the continued impact of **criminalization, gender inequality, stigma and discrimination**, and uneven access to **people-centred, tailored HIV prevention and care services**.

While new HIV infections have declined significantly since 2010—particularly in parts of sub-Saharan Africa—these global gains mask widening disparities. Incidence has decreased markedly in Eastern and Southern Africa and in West and Central Africa, yet progress remains uneven within countries, especially among key populations and adolescent girls and young women.

In contrast, new infections have **remained stable in the Caribbean** and continue to **increase in parts of Asia and the Pacific, Eastern Europe and Central Asia, Latin America, and the Middle East and North Africa**, particularly among key populations and young people.

Across all regions, HIV incidence remains disproportionately high among **people from key populations and their sex partners**, as well as **adolescent girls and young women**. These persistent disparities reflect the continued impact of **criminalization, gender inequality, stigma and discrimination, punitive laws, and insufficient access to people-centred, community-led, and tailored HIV prevention and treatment services**.

Although treatment coverage has expanded—with approximately **77% of people living with HIV accessing antiretroviral therapy globally in 2024**—prevention efforts remain under-resourced and uneven. The epidemic increasingly reflects structural inequities rather than biomedical limitations. Without sustained political commitment, rights-based approaches, and scaled-up investment in prevention and community leadership, progress risks stalling—or reversing—in several regions.

Progress, Innovation, and Persistent Gaps

HIV literacy has been central to progress against the epidemic. It has enabled **people living with HIV and their allies** to understand scientific advances, demand access to services, mobilize resources, and hold institutions accountable. Community-led HIV literacy has contributed directly to treatment scale-up and access to affordable generic antiretroviral medicines for **more than 30 million people globally**.. Between Between **2015 and 2024**, knowledge of HIV status increased from **71% to 87%** among people living with HIV. Among those who knew their status, **antiretroviral therapy (ART) coverage rose from 47% to 89%**, and **viral suppression among people on treatment increased from 83% to 94%**. However, these aggregate gains mask deep inequities, with clear evidence of **who is being left behind**, including key populations, young people, migrants, and people living in fragile and humanitarian settings.

HIV literacy also plays a critical role in building demand for **innovation**. Advances such as **HIV self-testing** and **long-acting antiretroviral medicines** for prevention and treatment offer major opportunities to expand choice, improve adherence, and address concerns related to stigma, disclosure, and privacy. A growing pipeline of long-acting technologies holds promise—provided communities have access to accurate information and are meaningfully engaged in decisions about rollout and access.

Inequality, Health Systems, and the 2025 Funding Crisis

Scientific progress alone cannot end the epidemic. HIV continues to be shaped by **social, economic, racial, and gender inequalities**, alongside **punitive laws, restrictive policies, stigma, and discrimination**. HIV literacy is essential to addressing these structural drivers by enabling communities to understand their rights, challenge harmful practices, and advocate for equitable access to quality services.

These challenges have been sharply intensified by the **2025 global HIV funding crisis**. Funding cuts and freezes have led to widespread service disruptions, particularly affecting **people from key and priority populations** in many low- and middle-income countries. Community-based and community-led organizations—including women-led networks delivering tailored, rights-affirming services—have been forced to scale back or close programmes. Millions of people have lost access to **HIV prevention services**, many of which have historically been delivered by community-led organizations.

Beyond the **human right to health**, strong evidence demonstrates that HIV prevention is **cost-effective and cost-saving**, reinforcing advocacy efforts to protect and reinstate prevention programming.

Community Leadership and Accountability

Since the beginning of the epidemic, **communities have been at the forefront of the HIV response**, often delivering services with limited resources and developing innovative approaches for those most affected. People living with HIV, key populations, and their allies continue to advocate for access to **sexual and reproductive health services, gender-based violence response, psychosocial support, oral and injectable PrEP, PEP**, and **harm-reduction services**.

Community-led monitoring (CLM) remains a cornerstone of accountability. Led by people living with HIV and affected communities, CLM generates evidence on access to and quality of services and uses that evidence for advocacy to address gaps and uphold human rights. CLM has proven particularly critical in responding to service disruptions caused by **conflict, climate events, funding cuts, disease outbreaks, and pandemics**.

WHAT THE NEW GLOBAL AIDS STRATEGY (2026–2031) MEANS FOR COMMUNITIES

The **UNAIDS Global AIDS Strategy (2026–2031)**, approved in **December 2025**, marks a critical transition for the global HIV response. The Strategy places renewed emphasis on:

- **Community-led and people-centred responses**
- **Human rights, gender equality, and removal of structural barriers**
- **Sustainable financing and service resilience**
- **Equitable access to innovation**, including long-acting prevention and treatment
- **Accountability**, including expanded use of community-led monitoring

Communities, people living with HIV, and key populations are explicitly recognized as essential partners in achieving global targets and sustaining progress beyond 2030.

USING UNAIDS AND WHO GUIDANCE FOR ADVOCACY AND ACCOUNTABILITY

UNAIDS and WHO guidance—referenced throughout this Global Reference—are critical tools for community advocacy and accountability.

- **UNAIDS** provides strategic direction, sets global targets, documents progress, and supports advocacy on **human rights, stigma and discrimination, community engagement**, and equitable access to services.
- **WHO** develops evidence-based normative guidelines for **HIV prevention, testing, treatment, care, and service delivery**, including for key populations, informed by values, preferences, feasibility, and equity.

Together, these resources support communities to advocate for rights-based policies, monitor service quality, and advance people-centred, community-led HIV responses.

1

HIV Natural History

KEY POINTS

- Human immunodeficiency virus (HIV) is a virus that attacks the body’s immune system.
- Without treatment, HIV progresses over many years, gradually weakening the immune system and leaving people unable to fight infections.
- Tests, such as CD4 cell count and viral load, provide information about the health of the immune system and the likelihood of HIV progression.
- Acquired immunodeficiency syndrome (AIDS) occurs when HIV has damaged the immune system. “AIDS” is usually used in strategic documents and global public health goals and targets.
- Advanced HIV disease (AHD) refers to all children under age five years, as well as adolescents and adults living with HIV who have weakened immune systems (CD4 count of <200 cells/mm3) or certain serious illnesses. People with AHD are at high risk of illness and death; they need a special package of care, including HIV treatment, to restore their health (see “Opportunistic Infections and Co-Infections” for more information).

Advocacy Areas

Communities have had a central role in the global HIV response, not just as service implementers, but as advocates, monitors, and drivers of change. For decades, people living with HIV and their allies have engaged in successful advocacy campaigns, working with researchers, media, governments, and other stakeholders. These campaigns have led to many victories, including the global scale-up of HIV treatment and the development and adoption of strategies, goals, and targets for ending AIDS as a threat to global public health by 2030.

The 2025 funding cuts threaten access to HIV prevention, testing, care, treatment, and support services in many countries, particularly for people who are members of key and vulnerable populations; advocacy is needed for:

- Sustainable financing for the HIV response; community-led organizations should be funded directly to support HIV service delivery.
- Meaningful community engagement across the HIV response.
- Restoration of peer and community health workers and service delivery to people living with and affected by HIV, including members of key and vulnerable populations.
- Scale-up of all forms of HIV prevention.
- Increasing access to rapid, point-of care CD4 cell testing upon entry/re-entry into HIV care to identify people living with HIV who have AHD.
- Ensuring that all people living with HIV who have AHD receive a special package of care.

Overview of HIV Natural History

HIV treatment, called antiretroviral therapy (ART), is recommended by the World Health Organization (WHO) for all people living with HIV. ART can prevent HIV progression, improve health and quality of life, and enable a normal lifespan for people living with HIV

Natural history describes the progression of an untreated illness. Without ART, HIV gradually disables the immune system, leaving it too weak to fight off infections—leading to serious illness and death.

HIV Progression

The first phase of HIV is called primary or acute infection. When HIV enters the body, it is carried into the lymph nodes. They become full of HIV and burst, sending the virus into the bloodstream, where it destroys most of a person's CD4 cells, which coordinate the immune system's response to infections.. Some people fall ill with flu-like symptoms (which may include fever, headache, rash, and sore throat), while others have no symptoms. At this time, people have a very high viral load, making HIV transmission most likely to happen. Then, a person's immune system recognizes HIV and begins to fight it by making antibodies. A person's viral load begins to go down and their CD4 cell count will increase—but not to pre-infection levels.

The next stage of HIV infection is called chronic infection. Over years, the immune system continues to fight HIV. At the same time, HIV enters and infects CD4 cells, turning them into virus factories. Before they die, each CD4 cell can make hundreds of new copies of HIV. The immune system keeps making CD4 cells to fight HIV and other infections, but HIV continues to infect and destroy them until the immune system gets worn out.

Blood tests that look for the amount of HIV (called viral load) or the number of CD4 cells in a sample can provide information about how fast HIV is likely to progress (the higher the viral load, the more rapid HIV progression), and the health of the immune system (the lower the CD4 cell count is, the weaker the immune system).

Without treatment, a person's CD4 cell count will slowly decline as their viral load increases. People generally lose 100 CD4 cells/mm^3 per year, although this varies widely. It takes between two and 15 years for the immune system to become seriously weakened, depending on factors such as a person's age, general health and nutrition status, and genetics.

Advanced HIV Disease

Advanced HIV disease means that HIV has weakened a person's immune system (a CD4 cell count under 200 cells/mm^3 this also includes all children living with HIV under the age of five years and adults and adolescents with certain signs, symptoms, and illnesses). AHD makes people vulnerable to severe illness and death, often from infections that a healthy immune system prevents; these are called opportunistic infections (OIs).

The average time from AHD to death is 1.5 to three years. People with AHD have the most urgent need for HIV treatment, including a special package of care to prevent them from falling ill, as well as treatment of OIs as their immune system rebuilds.

References and Resources

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2

HIV Transmission

KEY POINTS

- HIV can be transmitted when certain body fluids (blood, pre-ejaculate, semen, vaginal and rectal fluids, and breast milk) from a person living with HIV directly enter another person’s body.
- HIV can be transmitted during pregnancy, childbirth, and breastfeeding; through vaginal and anal sex; and while injecting drugs with shared, unsterilized equipment. It can also be transmitted in healthcare settings when infection control procedures are not followed or via occupational exposure.
- The risk of HIV transmission depends on two things: whether an HIV-negative person is using HIV prevention; and the amount of the virus in the body fluids of a person living with HIV (called viral load). The higher the viral load, the greater the risk.
- HIV treatment, called antiretroviral therapy, can suppress the virus to levels so low that it cannot be found by a test (called undetectable) or transmitted during sex. ART also greatly reduces the risk of vertical transmission.
- The risk of HIV transmission from a person living with HIV who is taking ART as directed and has a suppressed viral load (≤1,000 copies/mL) is nearly zero.
- People living with HIV who have an undetectable viral load cannot transmit HIV to their sexual partners. This is called undetectable = untransmittable, or U=U.

Advocacy Areas

HIV activism is grounded in human rights and continues to address gender-based, legal, economic, social, structural, and other barriers to HIV prevention and other services and to fight for inclusion of peers across all HIV services.

People living with HIV, researchers, and their allies launched the U=U campaign in 2016 to share the scientific evidence that people living with HIV who have an undetectable viral load cannot transmit HIV to sex partners. Despite initial reluctance to embrace it, U=U has grown globally, with the endorsement of over 100 countries, reducing stigma and supporting demand for antiretroviral therapy and viral load monitoring. However, gaps in continuous HIV treatment, adherence support, and viral load monitoring are undermining U=U in some countries and contexts.

The examples below highlight possible areas for action and are not intended to be exhaustive.

- Ensure widespread access to clear, accurate information on HIV transmission, including U=U.
- Provide community-led education and empowerment, particularly for adolescents, women, and key populations, to reduce misinformation and stigma around HIV transmission.
- Advocate for uninterrupted access to WHO-recommended HIV treatment for all people living with HIV.
- Advocate for access to routine viral load testing for people living with HIV who are receiving ART and for appropriate follow-up and support for people with a detectable viral load.

Overview of HIV Transmission

When HIV is untreated or unsuppressed by treatment, it can be transmitted when body fluids from a person living with HIV directly enter another person's body. HIV is found in blood, pre-ejaculate, semen, vaginal and rectal fluids, and breast milk of people living with untreated or unsuppressed HIV.

HIV can enter a person's body via open cuts and sores in the skin, through mucous membranes (tissues in the lining of the rectum and sex organs), and by direct injection. It is not transmitted by kissing, hugging, or sharing food. HIV can be transmitted during pregnancy, childbirth, and breastfeeding; via vaginal or anal sex in the absence of consistent and correct use of HIV pre-exposure prophylaxis (PrEP), HIV post-exposure prophylaxis (PEP), condoms, or other forms of HIV prevention; by sharing unsterilized injection equipment in medical and non-medical settings; via needlestick injuries and other occupational exposures; and through inadequate infection control procedures in healthcare settings. More effective and universal testing for donors and donated blood has greatly reduced the risk from transfusions.

The risk of HIV transmission depends on two things: whether HIV prevention (condoms, pre- and post-exposure prophylaxis, needles and syringes that are not shared with other people; see "HIV Prevention" for more information) is used; and the amount of the virus in a person's body fluids (the higher the viral load, the greater the risk of transmission). The viral load is highest shortly after infection with HIV and among people who are not consistently receiving HIV treatment.

When taken as directed, ART reduces the amount of HIV in these body fluids to levels so low that a test cannot find them, which is called undetectable. People with an undetectable viral load who are taking ART as directed cannot transmit HIV to their sex partners (U=U). The risk of HIV transmission from a person living with HIV who is taking ART as directed and has a detectable viral load (≤1,000 copies/mL) is nearly zero.

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HIV Prevention

KEY POINTS

- WHO recommends an evidence-based, combination approach to HIV prevention, which should be adapted to individual needs and circumstances. This includes new long-acting (LA) antiretrovirals (ARVs), which are nearly 100% effective, harm reduction (including needles, syringes, opioid agonist maintenance treatment), condoms, HIV pre- and post-exposure prophylaxis, and voluntary medical male circumcision.
- Access to all forms of HIV prevention—especially LA methods—is limited and must be scaled up globally.
- HIV prevention services and commodities should be widely available in community- and peer-based settings, as well as healthcare facilities.
- Access to uninterrupted HIV treatment and viral load testing is essential because these can prevent HIV transmission during sex, pregnancy, childbirth, and breastfeeding.

Advocacy Areas

Communities have long advocated for the removal of harmful laws and policies that create barriers to health services and increase stigma, discrimination, criminalization, gender inequalities, and gender-based violence (GBV). They also advocate for increased access to all forms of HIV prevention. The examples below highlight possible areas for action and are not intended to be exhaustive.

- Advocate with policymakers, ministries of health and finance, and other key stakeholders to adopt and achieve the 2030 targets for ending AIDS as a threat to public health.
- Continue to fight for rights- and gender-based policies that enable the HIV response and removal of barriers that impede it.

Community Systems & Peer Networks

- Strengthen and continue support for HIV and peer networks.
- Train peer and community members to share information with their communities about long-acting HIV prevention methods to build demand—and increase access to all forms of HIV prevention.

Harm Reduction

- Increase access to and coverage of harm reduction needles, syringes, opioid agonist maintenance treatment, overdose prevention, and other services.

ADDRESSING FUNDING CUTS AND INCREASING THE RESILIENCE AND SUSTAINABILITY OF HEALTHCARE SYSTEMS

In response to the 2025 funding cuts on international funding for the HIV response in June 2025, WHO issued operational guidance for sustaining priority HIV, viral hepatitis, and STI services in a changing funding landscape.

The WHO operational guidance provides approaches, tools, and key steps to link normative guidance with practical implementation and bolster resilience of national health systems. It includes frameworks, procedures, and criteria to enable countries to make informed decisions; systemically monitor service disruptions, shifts in, and risks to health funding for national priority-setting; and adapt healthcare services and systems to reflect national contexts.

Source: World Health Organization: Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: Operational guidance. Available at: https://iris.who.int/server/api/core/bitstreams/c215245f-66b3-4cf8-9664-7489e8adbed5/content

The guidance emphasizes harnessing opportunities to integrate priority HIV, viral hepatitis, and sexually transmitted infection (STI) services into primary healthcare, ongoing community engagement, and people-centered services. It emphasizes maintaining human rights, transparency, and accountability, as well as accessible, appropriate services for key populations and their sex partners.

Planning and self-check questions

☐ Do leadership and coordination mechanisms ensure transparent priority-setting and the engagement of all relevant stakeholders and community groups?

☐ Are service disruptions and gaps being assessed across system functions, using both real-time and retrospective data?

☐ Has the full delivery and financing landscape been mapped out, including dependence on external funding and the alignment between donor support and domestic financing priorities?

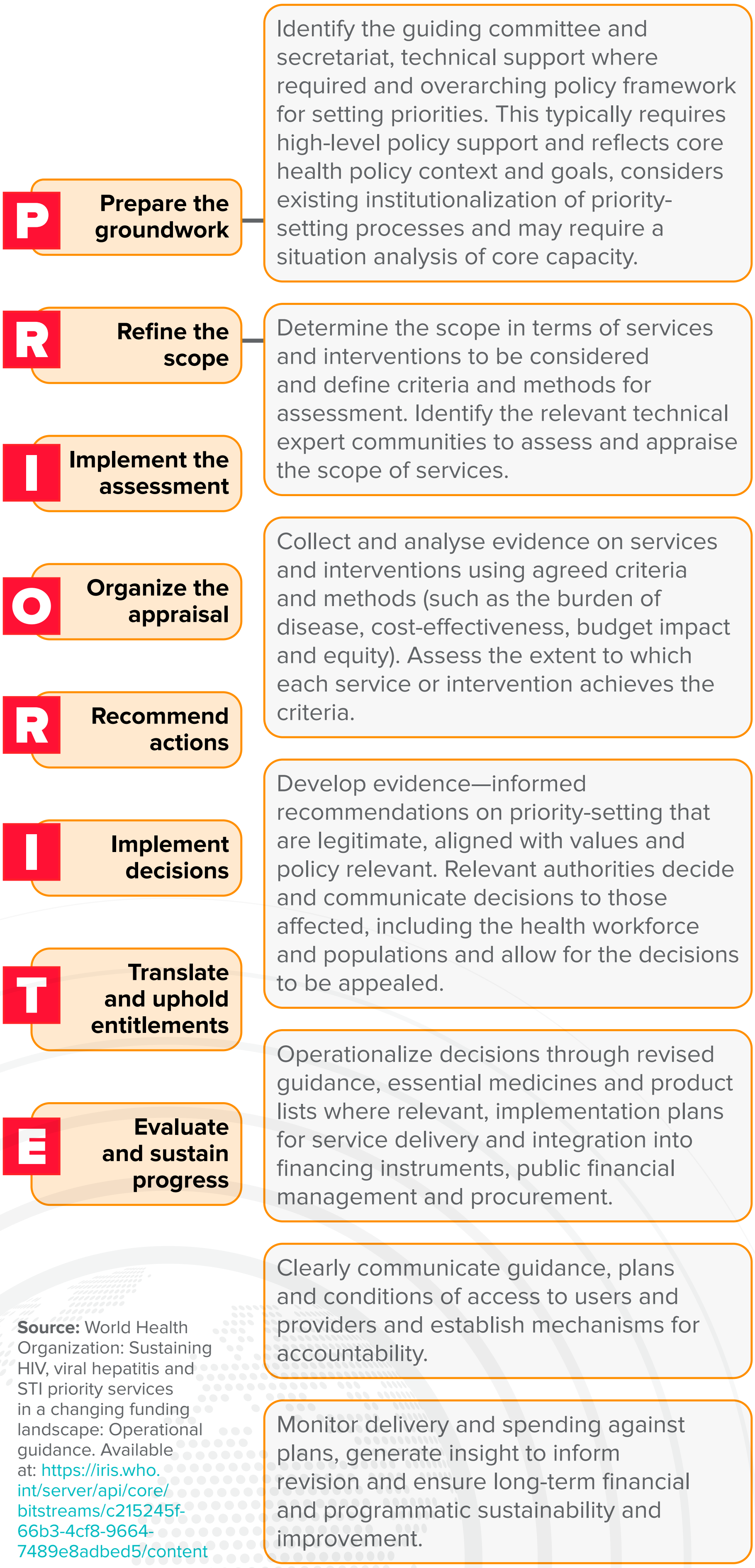
☐ Do the findings and assessments directly guide adaptive planning and inform priority-setting decisions?

Youth, Gender and Education

- Encourage integration of HIV education into schools, youth clubs, and community centers to reach young people early and consistently.
- Support youth-led innovation to empower adolescent girls and young women to design and deliver HIV prevention messages that resonate with peers.

Integrated and Community-led HIV Prevention

- Promote integration of HIV prevention into sexual and reproductive health services.
- Promote equitable access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) via community-led, peer-led prevention services adapted to the needs of people who are members of key and vulnerable populations and their sex partners.
- Provide information about and support for adherence to HIV PrEP.
- Prepare communities, healthcare systems, and healthcare workers for long-acting HIV prevention.
- Work to improve access to and affordability of long-acting HIV prevention.



P Prepare the groundwork

R Refine the scope

I Implement the assessment

O Organize the appraisal

R Recommend actions

I Implement decisions

T Translate and uphold entitlements

E Evaluate and sustain progress

Identify the guiding committee and secretariat, technical support where required and overarching policy framework for setting priorities. This typically requires high-level policy support and reflects core health policy context and goals, considers existing institutionalization of priority-setting processes and may require a situation analysis of core capacity.

Determine the scope in terms of services and interventions to be considered and define criteria and methods for assessment. Identify the relevant technical expert communities to assess and appraise the scope of services.

Collect and analyse evidence on services and interventions using agreed criteria and methods (such as the burden of disease, cost-effectiveness, budget impact and equity). Assess the extent to which each service or intervention achieves the criteria.

Develop evidence—informed recommendations on priority-setting that are legitimate, aligned with values and policy relevant. Relevant authorities decide and communicate decisions to those affected, including the health workforce and populations and allow for the decisions to be appealed.

Operationalize decisions through revised guidance, essential medicines and product lists where relevant, implementation plans for service delivery and integration into financing instruments, public financial management and procurement.

Clearly communicate guidance, plans and conditions of access to users and providers and establish mechanisms for accountability.

Monitor delivery and spending against plans, generate insight to inform revision and ensure long-term financial and programmatic sustainability and improvement.

Source: World Health Organization: Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: Operational guidance. Available at: https://iris.who.int/server/api/core/bitstreams/c215245f-66b3-4cf8-9664-7489e8adbed5/content

- Advocate for uninterrupted supplies of prevention commodities.

Treatment, Pregnancy & Vertical Transmission

- Underscore the importance of access to HIV treatment for improving quality of life and health, enabling a normal lifespan among people living with HIV, and preventing sexual and vertical transmission.
- Provide information about and access to HIV prevention during pregnancy.
- Promote male involvement in prevention of vertical transmission.

Overview of HIV Prevention

Because people may be exposed to HIV from sex and/or sharing needles and syringes or in healthcare settings via lack of infection control or occupational exposure, WHO recommends an evidence-based, combination approach to HIV prevention. This includes biomedical, behavioral and structural interventions, which can be adapted to individual needs and circumstances.

The Global HIV Prevention Coalition has created five main pillars for national HIV prevention responses:

① Combination prevention for key populations

② Combination prevention for adolescent girls and young women

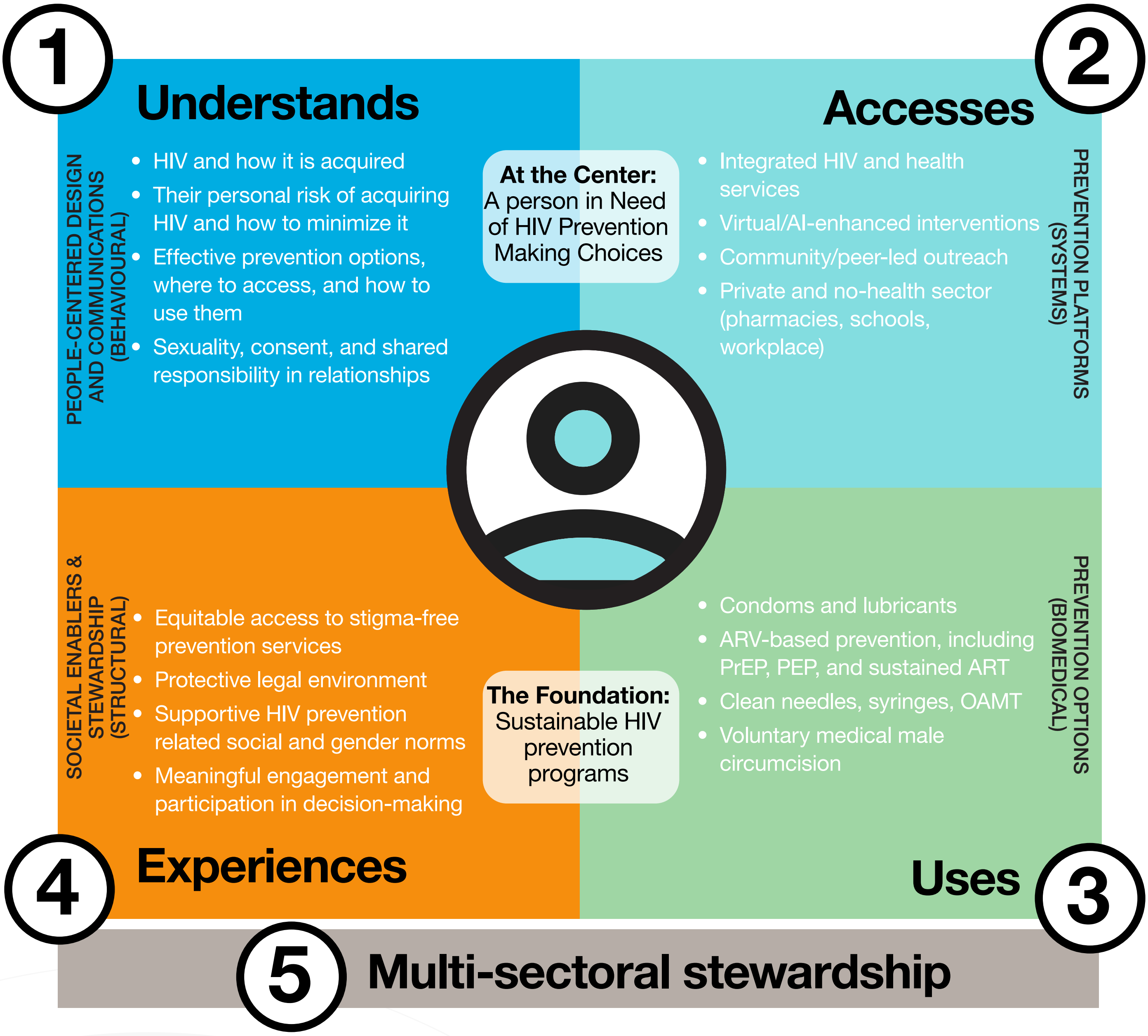
③ Combination prevention for men and adolescent boys in settings with high HIV incidence

④ Promotion and distribution of condoms and lubricant

⑤ Wider access to antiretroviral-based prevention

The Global HIV Prevention Coalition's Prevention 2030 Access Framework sets out a person-centred approach to access and choice, organised along a prevention access journey. National prevention plans should therefore focus on ensuring that people in need can:

- understand prevention options and their relevance;
- access the right methods and services through safe, non-stigmatising delivery points;
- use prevention effectively and consistently (with support to start, continue or switch methods);
- benefit from an enabling environment that protects rights and removes structural barriers.



Primary HIV prevention options include physical barriers (male and female condoms), harm reduction (distribution of sterile needles, syringes, and other injection equipment and opioid agonist maintenance therapy), antiretroviral medication, PrEP (including oral and long-acting injectable formulations and the the dapivirine vaginal ring), PEP, and voluntary medical male circumcision.

Effective HIV prevention services for people who are members of key and vulnerable populations need to be person-centered, stigma-free, confidential, respectful, and evidence-based. All HIV prevention services need to be integrated into primary healthcare, community-led, co-delivered by peer health workers, available in community-led settings and online, and tailored to people's needs and preferences.

Long-Acting Injectable Biomedical Prevention

WHO recommends two long-acting injectable ARVs for HIV prevention, long-acting injectable cabotegravir (CAB-LA) and lenacapavir (LEN), as additional options for combination HIV prevention. In clinical trials, CAB-LA and LEN were safe and more effective than oral PrEP containing tenofovir disoproxil fumarate (TDF), mainly due to poor adherence to the oral PrEP regimen.

HIV testing is recommended when starting, continuing, and discontinuing LA injectable PrEP. WHO recommends use of quality-assured HIV rapid diagnostic tests to enable long-acting injectable PrEP delivery.

Long-Acting Injectable Cabotegravir (CAB-LA)

CAB-LA is used as PrEP for HIV prevention and as part of HIV treatment. For PrEP, CAB-LA is given as an intramuscular injection, usually in the buttocks. The first two injections are one month apart and then every two months to prevent HIV. In clinical trials comparing CAB-LA with oral PrEP containing TDF, it was 79% more effective than oral PrEP. Notably, adherence to oral PrEP in these trials was poor – when taken as directed, oral PrEP is highly effective.

- It is important not to miss scheduled injections of CAB-LA (and to use other forms of HIV prevention if you do miss an injection). CAB-LA stays in the body for about 12 months after the last injection, but at levels that are too low to prevent HIV after the first one or two months (if the injection was the first or a subsequent injection respectively) -the pharmacokinetic tail.
- If a person has an undetected HIV infection and takes CAB-LA or acquires HIV in the tail period (when there are still low levels of CAB-LA in their bloodstream), they could develop resistance to CAB-LA (meaning that it will become ineffective) as well as other drugs in the same family, including dolutegravir (DTG), an ARV widely used for first line HIV treatment.
- CAB-LA can be used with oral hormonal contraception and gender-affirming hormones.
- CAB-LA cannot be used during tuberculosis (TB) treatment with rifampicin and some anti-seizure drugs.
- CAB-LA can be used safely during pregnancy and breastfeeding. A person should make their own decision to start, continue, or discontinue CAB-LA during pregnancy after a discussion of the risks and benefits with a healthcare provider.

Lenacapavir (LEN)

In clinical trials, LEN demonstrated >96% effectiveness compared with the background HIV incidence and >89% more effective than oral PrEP containing TDF, largely due to poorer adherence to oral PrEP. LEN becomes effective after people are given two 300mg tablets and two injections on day one, followed by two 300mg LEN tablets on day two. Thereafter, two injections of LEN are given every six months.

- As with CAB-LA, LEN remains in the body for about 12 months after the last injection, but at levels that are too low to prevent or treat HIV after 6 months.
- If a person has an undetected HIV infection and takes LEN or acquires HIV in the tail period (when there are still low levels of LEN in their bloodstream), they could develop resistance to LEN
- LEN can be used with oral hormonal contraception and gender-affirming hormones.
- Certain medications may interact with LEN and require a dose adjustment, including some drugs used for TB treatment such as rifampicin, rifabutin and rifapentine, some anticonvulsants, some illicit/recreational drugs (ketamine) and some erectile disfunction drugs.
- Available data support LEN use during pregnancy and breastfeeding. If someone becomes pregnant, they should make the choice to start, continue, or discontinue LEN, following discussion of the risks and benefits with a healthcare provider.

The United States Food and Drug Agency (US FDA) was the first regulatory agency to approve LEN for HIV prevention in June 2025; additional regulatory agency approvals have followed swiftly.

Table 2. **Dosing Schedules for CAB-LA and LEN PrEP**

Product	Administration	Schedule
CAB-LA HIV integrase inhibitor (which prevents HIV from making an enzyme that allows it to integrate its DNA into the DNA in CD4 cells, so it cannot replicate)	One intramuscular injection (into the gluteal muscle of the buttock or thigh)	The second injection is given one month after the first injection; thereafter, injections are given every two months.
LEN HIV capsid inhibitor (which blocks several steps of the HIV lifecycle, so it cannot replicate)	Two subcutaneous injections (into the abdomen) accompanied by an oral lead-in: **Day 1:** Two 300mg LEN tablets with two LEN injections **Day 2**: Two 300mg LEN tablets	Two subcutaneous Injections are given every six months thereafter.*

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*In July 2025, a Phase 3 trial of once-yearly LEN PrEP was launched, with results expected in 2028 (https://www.clinicaltrials.gov/study/NCT07047716?limit=100&rank=86).

Biomedical Methods

As PrEP and PEP should only be used by someone who is HIV negative, HIV testing is required to start, continue and discontinue PrEP and PEP. Rapid diagnostic tests or HIV self-testing may be used for oral PrEP, the DVR and PEP.

Oral PrEP containing TDF:

Oral PrEP (tenofovir disoproxil fumarate [TDF] with emtricitabine [FTC] or lamivudine [3TC]) can prevent HIV. When taken as directed, oral PrEP is at least 90% effective (and possibly up to 94-99% effective) at reducing the likelihood of sexually transmitted HIV

- Oral PrEP can be used with oral hormonal contraception and gender-affirming hormones and during pregnancy and breastfeeding.
- Dosing of oral PrEP varies by population. Some people may need seven days of PrEP before it reaches protective levels; they should be offered other methods of prevention during this time.

Table 3. **Oral PrEP Dosing**

Population	Dosing
Cisgender women	**For sexual and/or injecting exposure (for a short or long time):** ● Take one dose of oral PrEP for seven days before exposure to HIV; use alternative prevention methods during this time. ● Continue taking oral PrEP for as long as desired AND for at least seven days after the last potential exposure to HIV.
Transgender and gender-diverse people, assigned female at birth	
Transgender and gender-diverse people, assigned male at birth, taking estradiol-based hormones	
People using oral PrEP to prevent HIV acquisition from injecting practices	
Cisgender men with sexual exposure	**For sexual exposure only (a one-off exposure, a short time, or an extended time)**: ● Start by taking two doses of oral PrEP two to 24 hours before sex (ideally, taken closer to 24 hours before sex, to allow more time to absorb PrEP). ● Continue taking one dose of oral PrEP per day for as long as protection is desired AND for at least two days after the last potential sexual exposure.
People assigned male at birth with sexual exposure and not taking estradiol-based hormones	

Source: WHO implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection — provider module for oral and long-acting PrEP. Available at: https://iris.who.int/bitstream/handle/10665/378164/9789240097230-eng.pdf?sequence=1

Vaginal Ring

The dapivirine vaginal ring is an additional PrEP option for women. It is a flexible silicone ring inserted into the vagina, from where it slowly releases the ARV, dapivirine, to help reduce the risk of HIV, and it is designed to be used continuously and replaced regularly according to national guidance.

The ring may be a good option for women who want a discreet, long-acting prevention method that does not require taking pills every day and does not involve injections. It can be especially helpful for women who prefer a method they can manage themselves. In clinical trials, effectiveness of the ring ranged from 30% to over 50%.

Key considerations:

- The ring works best when it is used consistently and replaced on time (every 28 days).
- Users should receive clear counselling on correct insertion/removal, what to do if the ring comes out, and how to get a replacement quickly.
- Like other PrEP options, the ring requires ongoing HIV testing and follow-up according to national guidance.
- The ring does not protect against other STIs or unintended pregnancy, so condoms remain important where relevant.

HIV post-exposure prophylaxis

HIV post-exposure prophylaxis (PEP) relies on timely use of antiretroviral drugs to prevent HIV infection – ideally within 24 hours, and no later than 72 hours after a potential exposure to HIV. PEP is taken for 28-days. While a two drug regimen is effective for PEP, a three drug regimen is preferred. The PEP consists of a 28-day course of three ARVs (preferably DTG/ tenofovir [TDF] and 3TC or FTC).

Physical barriers

Condoms and lubricant (external condoms and internal condoms) are a core HIV prevention option and remain essential for combination prevention. When used correctly and consistently, they provide triple protection by helping prevent HIV, other STIs, and unintended pregnancy (when relevant). For best protection, condoms should be used from start to finish of sex and replaced if they tear or slip. Using water-based or silicone-based lubricant can reduce friction and help prevent condom breakage; oil-based products (petroleum jelly, body oils, some lotions) can damage latex condoms and increase breakage. Communities should be able to access condoms and lubricant easily, privately and without stigma through multiple channels, with no stock-outs, good-quality products (not expired, packaging intact, stored properly), and clear information that addresses common misconceptions (for example, using two condoms at once increases breakage).

Harm reduction

Needle and syringe programs, including low dead-space syringes and opioid agonist maintenance treatment (OAMT), are evidence-based approaches that reduce vulnerability to HIV and viral hepatitis among people who inject drugs. These interventions are part of a larger package of WHO-recommended enabling and health interventions for people who inject drugs.

Other interventions

Voluntary male medical circumcision (VMMC) is a simple and safe procedure during which a trained healthcare provider removes the foreskin from the penis. WHO has recommended VMMC since 2007 as a key part of combination HIV prevention for adolescent and adult men in high-burden settings. VMMC reduces the likelihood of sexually transmitted HIV among heterosexual adolescent and adult men by 60%—and indirectly reduces the likelihood among their female partners.

VMMC is always voluntary and based on informed consent (and for adolescents, appropriate assent/parental consent in line with national law and safeguarding standards), with privacy and respectful counselling. VMMC does not provide complete protection against HIV, so it should be combined with other prevention options. Services should include pain management and follow-up care (including wound-care guidance and advice to avoid sex until healing is complete), and include or link to HIV testing, STI services, condoms and lubricant, and other prevention and sexual and reproductive health services, with no coercion and no stigma.

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4

HIV Testing

KEY POINTS

- HIV testing empowers people by allowing them to take control over their health, including by starting HIV treatment.
- HIV testing should always be voluntary and confidential.
- HIV testing should always include the "5Cs": consent, confidentiality, counseling, correct test results, and connection (to HIV prevention, treatment, and care, as well as linkages to essential gender-based violence, psychosocial and peer support, sexual and reproductive healthcare, and mental healthcare).
- Annual and/or exposure-based HIV testing is recommended.
- Options include HIV self-testing and dual testing for syphilis and HIV. Reactive results should be confirmed at a healthcare facility.
- There are strategies for addressing gaps in access to and acceptability, accessibility, and appropriateness of HIV testing services for people who are being left behind, including peer delivery, and adapting them to people's health needs.

Advocacy Areas

Communities have fought to increase access to and improve methods of HIV testing and have worked to deliver HIV testing in settings where people and members of key populations feel comfortable and safe, have access to support and counseling, and can be linked to HIV services. The examples below highlight possible areas for action and are not intended to be exhaustive.

Rights, Legal and Ethical Standards in HIV Testing

- Fight to maintain "5Cs" in HIV testing services in the wake of funding cuts.
- Ensure that legal, structural, and other barriers to HIV testing for people who are members of key and vulnerable populations and their sexual partners are removed to enable access to confidential, voluntary HIV counseling and testing, with linkage to sexual and reproductive health (SRH), GBV, and psychosocial services.
- Eliminate restrictive national age of consent laws for HIV testing that create barriers for adolescents.

Community- and Peer-Led HIV Testing

- Ensure that peer and community health workers are trained and able to perform HIV testing.
- Advocate for local peer-led initiatives that deliver mobile and home-based, confidential HIV counseling and testing in rural areas.

HIV Self-Testing and Integrated Diagnostics

- Ensure access to affordable HIV self-tests and follow-up services.
- Scale up access to dual HIV/syphilis rapid tests and integrate them into SRH services.

Supply Chains and Diagnostic Access

- Ensure continuous access to all HIV diagnostics, including HIV self-tests, by advocating for an increased, uninterrupted supply of testing commodities.

Overview of HIV Testing

Testing is the first step to accessing HIV prevention, care, and treatment. It should always be voluntary and confidential.

There are many reasons why it is important for a person to know their HIV status. Testing empowers people and provides linkage to essential HIV prevention, care, treatment, and support services. There are different options for how, where, and by whom HIV testing is performed; access to these options depends on national guidelines.

HIV testing services should be provided in community-led settings and healthcare facilities and include pre- and post-test counseling and linkage to HIV prevention, treatment, and other support services.

The “5Cs” (consent, confidentiality, counseling, correct test results, and connection to HIV prevention, treatment, and care) are essential for HIV testing. HIV testing should always be voluntary; people have the right to opt out of HIV testing and must give informed consent to be tested. Testing must be confidential; counsellors should not disclose anything the person being tested has said. Pre-test counseling can be done via social media, videos, and other channels, with the opportunity to speak with a counsellor in a private setting; post-test counseling is based on the test result. Testing services should be quality-assured to ensure that people get correct results, and people should be linked to appropriate services. Because an HIV diagnosis may lead to intimate partner violence for girls and women, they should be offered linkage to GBV, peer support, and psychosocial services.

HIV testing looks for parts of HIV, called antigens, or antibodies to the virus, which a person’s immune system produces within 23-90 days of HIV entering their body–this is called the “window period.” WHO recommends using a combination of three rapid diagnostic tests and/or enzyme-linked immunoassays to diagnose HIV.

A negative or non-reactive result means that a person did not have HIV 23 to 90 days–during the “window period, when a person is still developing HIV antibodies–before taking the test; if they have been exposed to HIV more recently, retesting is recommended. A positive or reactive result, confirmed by three different types of tests, means that a person has HIV.

Annual and/or exposure-based HIV testing is recommended for people who are members of key and vulnerable populations, as well as men; pregnant, postpartum, and breastfeeding women; infants and children born to people living with HIV; adolescents; couples; and sexual and/or injecting partners of people living with HIV. This applies especially in settings with high HIV prevalence (>5%).

In the context of voluntary testing, social network-based testing involves sharing information about HIV testing or self-testing kits. It is recommended for people who are members of key populations and sexual and/or drug-injecting partners of people living with HIV. This approach also targets people with ongoing exposure to HIV.

Self-testing and Dual Testing

HIV self-testing, including mixed self-testing for syphilis and HIV enables people to collect a sample (either blood, via fingerstick, or saliva) and perform rapid testing privately, or in a community-led setting or a healthcare facility, and before starting PrEP.

People who self-test positive for HIV and/or syphilis should be linked to a healthcare facility for confirmatory testing, counseling, care, and treatment for HIV and /or syphilis.

Gaps in HIV Testing: Who is Being Left Behind and Strategies for Increasing Uptake

Infants and children born to people living with HIV, men, and people who are members of key and vulnerable populations are being left behind; they are not being reached by testing services, which can lead to worsened HIV outcomes. To effectively reach and engage people, quality HIV testing services must be available, accessible, and acceptable; barriers need to be removed, and strategies, such as using digital platforms to distribute self-testing kits, should be adopted.

EARLY INFANT DIAGNOSTICS

Interventions for infants must also provide maternal healthcare.

Diagnosing HIV in infants and children enables initiation of life-saving antiretroviral treatment. Without ART, mortality rates among infants and young children are high; 35% will die within a year, reaching 52% by two years.

HIV-exposed infants (born to, and/or breastfed by mothers living with HIV) can be tested at birth or within four to six weeks of birth. Since infants and children carry maternal antibodies until they reach 18 months of age, point-of-care nucleic acid testing (which looks for the virus rather than antibodies and delivers same-day results) should be used to diagnose HIV.

For adolescents most vulnerable to HIV, particularly those who are members of key populations, barriers to HIV testing services should be addressed, including criminalization, gender inequalities, stigma and discrimination, concerns about privacy and confidentiality, age of consent laws, and lack of youth-friendly, peer-delivered testing services.

Men face specific barriers, including harmful gender norms that discourage them from seeking care and health systems that may leave them to choose between seeking health services and earning a living. Strategies to improve uptake of HIV testing specifically for men include assessing their needs and designing services that meet them. Services offering HIV self-testing and peer counseling and support, should be person-centered, community-led, convenient, flexible, confidential, easy to access, stigma- and discrimination-free, and respectful.

To enhance engagement of people who are members of key and priority populations, community-led HIV testing services should engage people via social media, through their networks, in person, and through outreach, and offer confidential HIV self-testing. Services should be respectful, convenient, and peer-delivered, with linkage to prevention, care, treatment and support, and community members should be engaged in the design, implementation, delivery, and oversight of these services.

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5

HIV Treatment

KEY POINTS

- HIV treatment, called antiretroviral therapy (ART), is WHO-recommended for people living with HIV of all ages.
- The goal of ART is to suppress the virus to levels so low that a test cannot detect it, which improves health and quality of life and enables a normal lifespan for people living with HIV. It can prevent HIV transmission to sex partners and greatly lower the risk of vertical transmission. ART can control but not cure HIV because the virus hides in cells where treatment cannot reach it.
- Currently, ART is lifelong; most people take daily pills. ART needs to be taken as directed (this is called adherence), so that it improves health and quality of life and enables a normal lifespan for people living with HIV.
- Daily ART adherence can be challenging. To ease this burden, researchers have developed long-acting (LA) injectable antiretrovirals to prevent and treat HIV, but access to them is limited, especially in low- and middle-income countries (LMICs).
- Viral load testing is used to monitor response to HIV treatment. When HIV is detectable, people living with HIV may need individualized, enhanced adherence support, and in some cases, different ARVs.
- People living with HIV, including members of key and vulnerable populations, should have access to uninterrupted, stigma-free, peer- and community-led, welcoming, and high-quality HIV treatment and services.

Advocacy Areas

Global, grassroots-led movements of people living with HIV have urged governments to fund research, collaborated on design and implementation of HIV treatment trials, worked with regulators to expedite access to and approval of ART, fought for affordable generic treatment, and demanded and secured funding for the HIV response in LMICs.

Over decades, HIV activists and their allies have demonstrated, lobbied, worked with ministries of health and finance, used legal public health safeguards, and worked at all levels with multiple stakeholders to ensure health equity and the human right to health for people living with and vulnerable to HIV. As of 2024, nearly 31.6 million people were accessing HIV treatment; over 20 million of them were taking affordable generic ARVs.

The examples below highlight possible areas for action and are not intended to be exhaustive.

Treatment Policy, Guidelines and Global Commitments

- Advocate for implementation and maintenance of WHO-recommended HIV treatment and guidelines for service delivery.
- Join global, regional, and national movements to return all community-led HIV services and HIV treatment to pre-2025 levels.
- Advocate for inclusion of long-acting ARVs into national guidelines.

Community and Peer Workforce

- Ensure reinstatement of peer and community health workers.

Quality, Equity and Accountability in HIV Services

- Ensure that HIV services are stigma- and discrimination-free.
- Monitor and advocate for improvements in access to and quality of government-funded HIV services and treatment programs (see “CLM” in Part 2 of this Guide).

Treatment Access and Supply Chains

- Advocate for an uninterrupted supply of viral load testing commodities and treatment, including pediatric formulations.
- Advocate for access to affordable generic long-acting HIV treatment and training for communities and healthcare workers to support implementation.

RESOURCES FOR SUSTAINING NATIONAL HIV SERVICES

In June 2025, WHO released operational guidance for countries, titled *Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape.* The guidance highlights sustaining people-centered HIV prevention, testing, and treatment services and continuity of care adapted to national contexts to ensure that hard-won progress towards ending AIDS as a public health threat is maintained.

In 2024, UNAIDS developed the *HIV Response Sustainability Roadmap* and website, with technical guidance. It features the *HIV Response Sustainability Primer,* a *User Guide for Completing the HIV Response Sustainability Assessment*, and the *HIV Response Sustainability Assessment Tool*; these resources support countries and their partners to develop their own national sustainability roadmaps. In 2025, UNAIDS released a companion guide to Part B of the *HIV Response Sustainability Roadmap* to support its design and implementation.

WHO (2025): Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: operational guidance https://www.who.int/publications/m/item/HQ-2025-00573

UNAIDS (2024): Technical Guidance: The HIV Response Sustainability Primer; Part A Companion Guide; User Guide for Completing the HIV Response Sustainability Assessment; The HIV Response Sustainability Assessment Tool; The Sustainability Toolkit. https://www.unaids.org/en/resources/documents/2024/20240117_HIV_response_sustainability

UNAIDS (2025): HIV Response Sustainability Roadmap Part B Companion Guide. https://sustainability.unaids.org/wp-content/uploads/2025/09/HIVRespSust_PartB.pdf

Overview of HIV Treatment

HIV treatment, or ART, can be started as soon as someone is diagnosed with HIV, even on the same day, is recommended for everyone living with HIV—infants, children, adolescents, and adults.

ART is a combination of drugs, usually one or more pills, that need to be taken daily. They work together to stop HIV from replicating, which allows a person’s immune system to recover and stay healthy.

Adherence to lifelong, daily oral treatment prevents drug resistance, which can stop antiretrovirals from working, but it can be challenging due to a combination of intersecting individual, community-led, structural, and interpersonal reasons. WHO recommends provision of adherence support interventions for all people living with HIV receiving ART. Effective interventions include counseling, reminders, support from peers, trained laypeople and healthcare workers, and education to support and improve ART adherence and outcomes.

Additionally, researchers have developed long-acting forms of HIV treatment to support adherence. Long-acting antiretrovirals (LA-ARVs) are slowly released into the bloodstream, lasting for weeks to months. They replace the need for daily pills. LA-ARV treatment is recommended for people who are virally suppressed, do not have hepatitis B virus (HBV), and are struggling with adherence.

As of 2025, there are three LA injectable ARVs. Many other oral and injectable formulations, given weekly, monthly, and even annually, are in development.

LONG-ACTING HIV TREATMENT

Current LA treatment is a combination of two ARVs: long-acting cabotegravir (CAB-LA) and rilpivirine (RPV)-LA. They are given as two injections, one of each ARV, in the buttocks, with the second dose one month after the first injections and every two months thereafter. It is important not to miss scheduled injections of CAB/RPV-LA because the drugs stay in the body for months to years at levels that are too low to treat HIV, but are still high enough for HIV to develop resistance to both drugs and other ARVs from the same families.

WHO recommends CAB/RPV-LA as an alternative switching option for virally suppressed adults and adolescents who do not have active hepatitis B infection, to support people living with HIV who face challenges with adherence to daily oral ARVs. This is because CAB/RPV-LA was developed in and approved only for people who were already taking oral ART and had an undetectable viral load. The people living with HIV in these clinical trials had no history of HIV treatment failure and no evidence of resistance to CAB or RPV—so this regimen is not for everyone. It is not used for initial treatment because it has not been studied that way, and it cannot be used in people who have had HIV treatment failure. Researchers are looking at ways that CAB/RPV-LA could be used in more people, such as by giving it once a month instead of once every two months.

In clinical trials, the most common side effects of LA-ARVs are injection site reactions, including pain, redness, swelling, and nodules (small hard lumps under the skin, which are not always visible but can be felt).

Implementation of and access to LA ARVs for HIV prevention and treatment are limited. Affordable generic versions of CAB-LA and LEN, available through voluntary licenses (VLs) in some countries, are not expected until 2027, and as of Q3 2025, there is no VL for RPV-LA. Many middle-income countries are not included in these VL agreements, allowing them to purchase generic CAB-LA or LEN. These countries face unaffordable prices for originator versions of CAB-LA and LEN. Communities and networks of people living with HIV, their allies, and many other stakeholders have an important role in sharing information about and advocating for widespread access to LA HIV prevention.

ART controls but does not cure HIV because the virus hides in cells where treatment cannot reach it. The goal of HIV treatment is to suppress the virus to an undetectable level. Viral suppression protects the immune system, enables improved health and quality of life and a normal lifespan for people living with HIV—and it prevents transmission to sex partners of people living with HIV (U=U).

WHO recommends that people start HIV treatment as soon as possible, ideally when they are diagnosed with HIV. At this time, people living with HIV should be given a CD4 cell count to assess their immune status. People with a CD4 cell count of <200 cells/mm^3 have advanced HIV disease (AHD), meaning that HIV has weakened their immune system; they need a special package of care and treatment.

Side Effects

All ARVs have side effects, but newer drugs are better and have fewer and milder side effects than older drugs, and many side effects are short-lived, improving after the first few weeks of taking ART. It is important for people living with HIV to have information about common side effects from ARVs and how they can be managed (see https://i-base.info/side-effects/).

Attending routine clinic visits for monitoring by a healthcare provider is important because ARVs can cause changes in cholesterol, triglycerides, blood sugar levels, and blood pressure. Monitoring ensures that side effects are addressed and managed.

> **“Peers like me, or healthcare providers, when we talk about adherence, we need to shift power and knowledge to the person who is taking medicine.”**
>
> **—Loon Gangte, Founder and President of the Delhi Network of Positive People (DNP+)**

The Importance of Adherence

Adherence literally means sticking to something. WHO defines adherence as the extent to which a person’s behaviour, such as taking medication, following a diet, and/or changing lifestyle, aligns with agreed-upon recommendations from a healthcare provider.

Adhering to HIV treatment means taking ARVs as directed and getting on-time injections of LA-ARVs. It is the most important thing a person living with HIV can do to stay healthy. When people miss too many doses, their treatment may stop working, putting them at risk of serious illness and death.

There are many reasons why this can be difficult, some of which are beyond a person’s control, such as drug stockouts and treatment disruptions. Other factors can make adherence challenging, such as stigma, shame, and depression; concerns about privacy and disclosure; experiencing side effects; pill burden; food restrictions; feeling that taking pills is a daily reminder of HIV; and simply forgetting to take ARVs. People living with HIV need to be provided with clear information about why adherence matters, and interventions to improve should be adapted to individual needs.

DISRUPTIONS TO ART ACCESS

Modeling the impact of HIV funding cuts in LMICs found that as many as 2.9 million to 4 million additional HIV-related deaths may occur by 2030 due to disruptions to HIV services and ARV access. To address this, WHO has outlined a framework, tools, checklists, and processes to enable national-level decision-making, prioritization, and accountability for HIV services, while upholding community engagement and people-centered services.

People living with HIV who have a high CD4 cell count (which indicates a strong immune system) are at lower risk of falling ill if ART is interrupted. Longer ART interruptions—lasting from months to years—allow HIV to weaken the immune system, putting people at risk of opportunistic infections and death.

It takes about two weeks for viral load to rebound after ART is interrupted. People living with HIV may experience flu-like symptoms, including fever, chills, fatigue, sore throat, headaches, muscle aches, and swollen lymph nodes, as their viral load rebounds and HIV becomes transmissible—meaning that U=U no longer applies.

ART dramatically reduces the risk of vertical transmission, so uninterrupted access to treatment is important for pregnant and breastfeeding women. In addition, infants and children under age five, people living with HIV who have a low CD4 cell count (<200 cells/mm^3) and/or are seriously ill, and people living with HIV on third-line treatment (see “First-, Second- and Third-Line ARV Treatment”) are at risk of severe illness and death when their ART is interrupted.

Resources have been developed to answer questions about what to do if treatment is interrupted:

HIV i-base (2025): How can I look after my health if I have to stop treatment? https://i-base.info/qa/25879

UNAIDS (2025): Q&A on the impact of interruption of treatment for people living with HIV https://www.unaids.org/sites/default/files/2025-05/20250520_QA-ART-Interruption_0.pdf

WHO (2025): Guidance on handling interruptions in antiretroviral treatment due to HIV service disruptions, drug shortages, or stockouts https://www.who.int/news-room/questions-and-answers/item/guidance-on-handling-interruptions-in-antiretroviral-treatment-due-to-hiv-service-disruptions—drug-shortages—or-stockouts

Initial and Subsequent ARV Treatment

The ARVs that people begin treatment with, called initial treatment (formerly known as first-line treatment), are highly effective, safe, convenient, and tolerable. WHO-recommended initial treatment is a fixed-dose combination of three ARVs in a once-daily single pill, taken with or without food. Initial treatment usually has mild side effects. If taken as directed, it will keep HIV undetectable for many years.

WHO recommends specific subsequent regimens for HIV treatment (formerly known as second-line and third-line treatment).

Monitoring for Response to HIV Treatment

A CD4 cell count is important for people who have just been diagnosed with HIV, people who are restarting ART, and people who have been taking ARVs that are not working.

A CD4 count identifies people with advanced HIV disease, who have a weakened immune system. They require a special package of care, which includes ART and screening, testing, and treatment for infections that they are vulnerable to.

Viral load testing is used to monitor response to ART; it is done at six and 12 months after treatment initiation and then every 12 months. An undetectable viral load means that ART is working—and that HIV cannot be transmitted to sex partners. If the viral load is <1,000 copies, the likelihood of sexual transmission remains negligible; it increases when the viral load is >1,000 copies.

For people with a viral load of >1,000 copies, WHO recommends enhanced adherence support, tailored to individual needs (including counseling and other adherence support interventions), and a repeat viral load test. Based on the results, people may need to switch their ARVs.

HIV Treatment Failure and Drug Resistance

ARVs should be taken daily to stay at a steady level, so they are effective. When people miss several doses of ARVs or stop taking them, HIV replicates, making millions of copies each day. Some copies have changes in their genetic structure, called mutations. Certain mutations—and especially, combinations of mutations—can stop ARVs from being effective, which is called drug resistance. People can become resistant to one or more ARVs, including drugs from different classes, which limits their treatment options.

Some people may have HIV drug resistance even though they have never taken ART. This happens because the HIV they acquired was already resistant to one or more ARVs (called transmitted drug resistance). Some people develop HIV drug resistance (called acquired drug resistance). Many different factors can lead to acquired HIV drug resistance; these include stockouts, life circumstances that make adherence difficult or impossible, poor drug absorption, and drug-drug interactions.

Drug resistance can prevent ART from working, leading to HIV treatment failure. People who experience HIV treatment failure are at risk of illness and death—and they need to switch their ARVs. If initial treatment has failed, a person needs to be switched to subsequent treatment (which is selected according to what initial treatment was). Subsequent treatment may have different side effects than initial treatment.

Retention in Care

Retention in care means that a person who is enrolled in HIV care routinely attends HIV services. It is associated with improved health and quality of life, viral suppression, and lower likelihood of HIV transmission. It enables people living with HIV and their families and caretakers to access a package of comprehensive care that should be people-centered, high-quality, stigma-free, non-judgmental, and welcoming. This includes HIV prevention, testing, care, and treatment during pregnancy and after childbirth; monitoring response to ART and immune status; psychosocial support; peer-delivered adherence counseling and support; side effects management; regimen switching; and diagnosis and treatment of opportunistic infections.

Communities play an important role in HIV services. Differentiated, community-led (including women-led, youth-led, and peer-based) ART delivery and outreach programs enable long-term retention in care and ART adherence and can be adjusted to people's health needs during ART initiation, re-engagement in care, and addressing treatment failure.

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6

HIV Prevention, Testing, Care and Treatment Services for Different Populations

KEY POINTS

- WHO recommends differentiated service delivery (DSD), a person-centered approach to simplifying and adapting HIV services to the preferences, expectations, and physical and mental health needs of infants, children, adolescents, and adults vulnerable to or living with HIV to improve their health, quality of life, and survival.
- People living with HIV need to be included in the design, delivery, and oversight of HIV services. These services should be available in diverse settings, including in their communities, and co-delivered by peers to increase trust, and improve retention in treatment, care, and health outcomes.
- HIV services must be low-threshold and adapted to specific contexts, needs, life stages, and vulnerabilities among different communities, including children, adolescents, key populations, men, women, and older people living with HIV.
- Multiple, intersecting stressors have led to a high prevalence of depression among people living with HIV, underscoring the need for expanded, culturally competent services for mental health and substance use conditions.

Advocacy Areas

People living with HIV and their allies, researchers, and other stakeholders have realized that human rights barriers, gender inequity, stigma, and discrimination prevent key and vulnerable populations from accessing health services and increase their vulnerability to HIV. This has led to the development of key population-led programs and services and work to identify and uphold critical enablers and remove harmful laws and policies. At the same time, the need for person-centric care for people living with HIV of all ages has led to development and implementation of DSD for infants, their parents and/or caregivers, children, adolescents, men, women, and older adults living with HIV.

Networks of people living with HIV, communities, and peer workers have played an essential role in the healthcare system by sharing information, delivering services, and providing support, often reaching people who have been left behind. Many have lost their jobs due to recent funding cuts.

The examples below highlight possible areas for action and are not intended to be exhaustive.

Sustainable Funding and Community Leadership

- Advocate for sustainable funding to enable networks of people living with HIV to continue providing community-led, essential information and services to people vulnerable to and living with HIV.
- Advocate for intersectional leadership centering people living with HIV who are members of key and vulnerable populations in design, delivery, and oversight of HIV services.

Children, Adolescents and Family-Centered HIV Care

- Improve health, quality of life, and survival among infants (under one year of age) and children (ages one to 10 years) who have been exposed to or are living with HIV by advocating for optimized HIV testing, treatment, care, and service delivery.
- Ensure that healthcare workers are trained to support people living with HIV who wish to have children, and during pregnancy and breastfeeding, to ensure that mothers and other caregivers and infants and children are retained in care.
- Increase access to family-centered, holistic HIV services for children living with HIV and their parents and caregivers, and advocate for uninterrupted access to pediatric ARV formulations.

DIFFERENTIATED SERVICE DELIVERY (DSD)

High-quality, stigma- and discrimination-free HIV services are essential for engagement and retention in HIV prevention, care, and treatment—and for maintaining quality of life, health, and survival among people living with HIV.

WHO has recommended DSD for a decade. DSD is a person-centered approach to simplify and adapt HIV services to reflect preferences, expectations, and needs of people who use all HIV services. DSD also reduces unnecessary burdens on the health system and decongests healthcare facilities.

Examples of HIV DSD include: multi-month ART dispensing at community distribution points; Community Adherence Groups and Adherence Clubs in community or facility-based settings (which offer co-management of diabetes, hypertension, and preventive therapy for tuberculosis); delivery of prevention, self-testing, information, and linkage to care at drop-in centers, community-led organizations and via outreach. Services should offer counseling and support for people who are re-engaging in HIV services, tailored services adapted to the needs of older people living with HIV; and social support and mental healthcare.

- Create opportunities for adolescent leadership and meaningful participation in the design, delivery, and oversight of their HIV services. These services need to reach, be adapted to, and engage adolescents in their diversity.

Equitable, Inclusive and Population-Responsive Services

- Improve access to and quality of HIV services for men, women, boys, girls, gender-diverse people, and all key and vulnerable populations.
- Ensure that people living with disabilities are involved in the design and delivery of inclusive, accessible HIV services, with integrated rehabilitation and social support services.
- Address the health and psychosocial needs of older individuals living with HIV, including gender-specific concerns.

Stigma-Free, Integrated, and Gender-Responsive Care

- Train and sensitize healthcare workers to provide stigma-free sexual and reproductive health services for women, girls, and gender-diverse people living with HIV.
- Provide stigma- and discrimination-free, community-led, peer-led HIV services for key and priority populations, including services provided by women's networks and services.
- Advocate for integration of HIV-specific, trauma-informed mental healthcare and GBV services into HIV programs.

Harm Reduction Workforce Capacity

- Train and sensitize healthcare workers on harm reduction services

HIV and Mental Health Care

WHO and UNAIDS recommend integration of mental health care (for depression, anxiety, and alcohol and/or substance use) into HIV services. Over two decades of research have found that people living with, vulnerable to, or affected by HIV have higher rates of mental health conditions than the general population. People living with HIV are twice as likely to become depressed as their HIV-negative counterparts, with higher rates among women living with HIV than men.

Many factors contribute to depression among people living with HIV, such as the shock and anxiety of dealing with a new diagnosis, fears of falling ill, experiencing discrimination, and/or multiple forms of stigma (including negative attitudes of healthcare providers and fear of disclosing HIV status to family, friends and partners), side effects from certain ARVs, and symptoms of other illnesses.

Lack of access to supportive services and care for mental health and substance use conditions for people who are living with HIV leads to poorer health outcomes. Mental health and other support services for people living with HIV should be person-centered, stigma- and discrimination-free, and relevant to the specific contexts of their users. As examples: people who are members of key populations may face additional burdens from criminalization, marginalization and violence; adolescents who are vulnerable to or living with HIV are also vulnerable to mental health and substance use conditions; and older people living with HIV may experience loneliness, social isolation, neurocognitive symptoms, and onset of age-related, non-communicable diseases.

Access to mental healthcare and support for substance use conditions can be expanded by training healthcare workers to recognize and manage common conditions in community-based and community-led settings and engaging peers, adherence counsellors, and community health workers to deliver support services.

ART and Pregnancy

People living with HIV who wish to have children can safely do so. Couples in serodifferent relationships (where one partner is living with HIV) can rely on ART to prevent HIV transmission to sex partners and infants, including during breastfeeding.

Some people know their HIV status and are already receiving HIV treatment when they become pregnant. Sometimes, an HIV diagnosis comes during pregnancy, adding to stress and uncertainty—underscoring the importance of information, support, and counseling. A comprehensive package of care includes: ART (HIV treatment is recommended during pregnancy—it is safe and it protects the health of women living with HIV and their babies); adherence counseling; infant ARV prophylaxis; infant diagnosis; co-trimoxazole prophylaxis; postnatal care and infant feeding in the context of HIV; and nurturing care.

It is important to start ART as soon as possible during pregnancy since maternal viral load significantly increases the risk of vertical transmission. An undetectable viral load—especially when giving birth—lowers the risk of vertical transmission during pregnancy and breastfeeding to less than 1%. Interventions can reduce the risk of vertical transmission for women diagnosed with HIV late in their pregnancy—and during childbirth.

Infant Feeding and HIV Prophylaxis

WHO recommends that in places where replacement feeding is recommended, mothers living with HIV who are receiving ART and are virally suppressed should be offered the choice to breastfeed and support for breastfeeding, and receive community- and family-based support interventions.

Table 4. **Infant Prophylaxis**

Risk level	Recommended regimen
Low (infants born to mothers living with HIV who were on ART for at least 4 weeks before delivery and a viral load of <1,000 copies/mL at delivery)	Six weeks of nevirapine (NVP) is the preferred option; dolutegravir (DTG) or lamivudine (3TC) are alternative options.
High (infants born to mothers with HIV who received less than four weeks of ART at delivery; born to women with HIV and a viral load >1,000 copies/mL in the four weeks before delivery; born to women who acquired HIV during pregnancy; or born to women with or without a prenatal negative HIV test result)	Six weeks of a three-drug regimen is recommended (the preferred option is abacavir [ABC], 3TC and DTG). After six weeks on a three-drug regimen, breastfeeding infants should receive single-drug prophylaxis (NVP is the preferred option; DTG or 3TC are alternative options) for the remainder of breastfeeding or until the mother achieves viral suppression.

Source: WHO: Comprehensive package of care for infants and young children exposed to HIV. Available at: https://www.who.int/publications/i/item/9789240040236

ART for Infants

WHO recommends ARV treatment initiation as soon as possible for newborns and infants living with HIV.

Holistic and community-based family care can improve health, quality of life, and survival among infants and young children living with HIV and their parents and caregivers. Retention in care among mothers and infants can be supported by promoting voluntary involvement of male partners, outreach and follow-up by peer workers and networks of women living with HIV, and text reminders.

ART for Children

Globally, 1.4 million children were living with HIV in 2024; they accounted for nearly 12% of AIDS-related deaths, and only 55% of them were receiving ART.

HIV treatment is recommended for all children living with HIV. Child-friendly ART formulations are available. Retention in HIV services for parents and caregivers of children living with HIV is enhanced by ART multi-month dispensing and community ART delivery; holistic, family-centered healthcare; weekend and outreach clinics; and virtual support. Support and age- and regimen-specific guidance for parents and caregivers on administering ART to children are important resources.

Because they are vulnerable to opportunistic infections, all children living with HIV and under age five are considered to have AHD. This means that they require a special package of care to prevent, diagnose, and treat certain serious illnesses that people with weakened immune systems are vulnerable to.

Disclosing HIV status to children is a complicated and personal decision. Benefits include giving children the opportunity to accept and openly discuss their HIV status, which enables them to seek peer support and may improve their ARV adherence. Parents and caretakers may want to rely on support from healthcare providers and peer counsellors around disclosing HIV status to children and consider a stepwise approach based on age.

Adolescents

Adolescence (age 10-19) is a particularly important time for HIV services. According to UNICEF, in 2024, 145,000 adolescents ages 15-19 acquired HIV. There is a lack of available, affordable, appropriate, and acceptable services that uphold the human rights of teens, especially those who are members of key populations. Age of consent laws, lack of legal protection for gender-diverse youth, and criminalization of same-sex relationships, sex work, and drug use, are barriers to HIV and reproductive and sexual health services—and should be removed.

Adolescents need opportunities for leadership and meaningful participation in the design, delivery, and oversight of their HIV services. These services should reach, be adapted to, and engage adolescents in their diversity. These include adolescent girls and young women, who face negative attitudes from healthcare workers, gender inequality, stigma, and discrimination, and are not supported or empowered to make decisions about their sexual and reproductive healthcare, as well as young people who are members of key and vulnerable populations, who face stigma, discrimination, criminalization, marginalization, and violence.

Health facilities can reach and engage adolescents by providing teen-friendly spaces in health facilities; offering after-school and weekend services; peer mentoring and adherence support; integration of sexual and reproductive health, gender-based violence, and psychosocial support into HIV services; and information via mobile apps, infographics, and social media.

ART adherence is challenging for adolescents, whether they are initiating ART or have been receiving it for years. They face individual, structural, provider-, disease- and medication-related barriers to adherence, such as stigma, physical violence, depression, ARV side effects, lack of social and peer support, and lack of parental awareness of their HIV status. Adherence-enhancing services should address sexual and reproductive health, side effects management, and mental health, ideally while building family, peer, and caregiver support and, when available, offering long-acting HIV prevention and treatment to adolescents.

Switching from pediatric to adult care can be challenging for adolescents, since this transition is not always a smooth process.

Women

WHO recommends integration of sexual and reproductive healthcare and psychosocial support into HIV services. Women living with HIV should be offered prevention and treatment of STIs; screening for and treatment of cervical cancer; family planning counseling and services, including for infertility, pre-conception care, and maternal and perinatal healthcare; and menopause. Psychosocial care and support services should include addressing stigma, discrimination, and gender-based violence; providing mental health care; peer and family support; and information and education about HIV prevention, treatment, and adherence.

Men

Globally, men and boys aged 15 and over accounted for 55% of new HIV acquisitions in 2024. In Eastern and Southern Africa, where HIV is highly prevalent, men and boys are less likely to know their HIV status, less likely to access ART, and less likely to achieve viral suppression than girls and women in the same age range.

Boys and men living with HIV need prevention, care, and treatment of sexually transmitted infections, viral hepatitis, and tuberculosis, as well as peer support and counseling services.

Access to HIV services for men can be improved by ensuring that they are holistic, confidential, and anonymous; sensitizing peer and healthcare workers to their needs; offering them virtually and in the community; integrating them into outpatient and emergency care settings and during pregnancy care for partners; and providing them in convenient male-friendly spaces.

Older Adults

ART has improved health and quality of life and restored a normal lifespan to people living with HIV. Globally, an estimated 10.5 million people over age 50 were living with HIV in 2024 according to UNAIDS. That number continues to increase, as people living with HIV are living longer – and new HIV acquisitions are increasing among older people.

Longevity among people living with HIV comes with unique health challenges, including the need for many different medicines. Research has found that HIV can accelerate aging (although ART can stop and partially reverse it), possibly due to inflammation triggered by an overactive immune system. Non-communicable diseases (NCDs), such as Type 2 diabetes, hypertension, heart and kidney disease, stroke, certain cancers, anemia, weakened bones, and frailty may occur earlier in people living with HIV than in HIV-negative people—and certain antiretrovirals may increase cholesterol, triglycerides, blood pressure, weight gain, and damage to the bones or kidneys.

Older people living with HIV may need to treat multiple medical conditions—which means taking more medicines, with more side effects and an increased risk of drug interactions (which can lower efficacy or worsen side effects). In addition, age-related cognitive changes may make it difficult for people to remember medications.

Older people living with HIV should have the opportunity to discuss ARV side effects and have their cholesterol, blood pressure, kidney and liver function, and blood sugar monitored routinely as part of their healthcare visits. The same things that are good for HIV-negative people—regular exercise, a healthy diet, and stopping cigarette smoking—are even more important for people living with HIV, especially as they get older.

People Living with Disability

People living with disability may experience impairments in their sensory, musculoskeletal, cardiovascular, or mental function and limits to their activity, mobility, employment, and social life. Discrimination against, neglect, and exclusion of people living with disabilities—especially girls and women—increases the likelihood of poverty and vulnerability to HIV and limits their access to education and services, including for sexual and reproductive health, HIV, and gender-based violence.

People living with HIV and disability need to be included in leadership, design, delivery, and monitoring of their healthcare services, which should be comprehensive, inclusive, and rights-based. Person-centered disability and HIV services can be co-delivered by peers and healthcare providers trained in HIV and rehabilitation; these services need to be stigma- and discrimination-free, accessible, and community-led, offering sexuality education, sexual and reproductive healthcare, gender-based violence services, rehabilitation, mental health care, and other support services, as identified by people living with HIV and disability.

Sustaining HIV Services and Treatment for Key Populations

Key populations are communities that are disproportionately affected by HIV and face legal, structural, social, and economic barriers to health services, including high levels of stigma. The main key populations are the following, as well as their sex partners: gay, bisexual and other men who have sex with men; sex workers; transgender and gender-diverse people; people who inject drugs; and people in prison and other closed settings. As of 2022, HIV vulnerability was 23 times higher among gay, bisexual and other men who have sex with men than among the general population, 20 times higher among transgender women, 14 times higher among people who inject drugs, nine times higher among sex workers, and twice as high among people in prison and other closed settings.

People can be members of one or more key populations; they are especially vulnerable to HIV, often face violations of their human rights, and lack access to services due to stigma, discrimination, criminalization, and geographic and economic barriers. In addition, some groups of people can be vulnerable to HIV in certain circumstances or contexts; these include adolescent girls and young women, people with disabilities, and internally or externally displaced people.

HIV information and prevention, testing, care, and treatment services for people who are members of key and vulnerable populations, including women and their sexual partners must be available, accessible, appropriate, affordable, and acceptable. These services must be adapted to people's needs and co-delivered by peer workers in stigma-free, community-led programs. Community-led and peer-based services build trust, enhance retention in care, and improve health outcomes among people who are members of key populations.

As countries explore ways to maximize existing funding and address shortfalls, they may integrate services for HIV, viral hepatitis, sexual and reproductive healthcare, and psychosocial services, such as for mental health, into primary healthcare.

The 2025 WHO operational guidance, *Sustaining HIV, viral hepatitis and STI priority services*, calls for meaningful involvement of key populations and affected communities throughout decision-making and priority-setting processes; assessing access for people who are marginalized, stigmatized and/or in high-burden settings; and tracking the number of people living with HIV and key population members who avoid healthcare due to stigma, discrimination, and gender inequality.

Table 5. WHO Tiered Approach to Priority-Setting for Services and Interventions in the Context of Reduced Resources

Tier 1: Essential	Tier 2: Important	Tier 3: Expanded
Does the intervention score high on cost-effectiveness and equity?	Does the intervention score at least moderate on cost-effectiveness and equity?	
Must continue to fund	May not be able to fund at this time because of limited funding, but important to evaluate in the short term	**Not possible to continue to fund unless additional resources become available**

Adapted from: WHO: Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: operational guidance. Available at: https://www.who.int/publications/m/item/HQ-2025-00573

Gay, Bisexual, and Other Men Who Have Sex With Men

Gay, bisexual, and other men who have sex with men face criminalization, stigma, discrimination, and violence. In addition to prevention, testing, care, and treatment for HIV, services for gay, bisexual, and other men should include anal healthcare, STI testing, care, and treatment (including doxyPEP, a course of doxycycline taken after sex to prevent syphilis, chlamydia, and gonorrhea, and suppressive therapy for genital and anal herpes), harm reduction services, addressing chemsex, counseling, and support. These services should be co-delivered by peers and community- and facility-based providers who have been sensitized on their culture and issues.

People Who Inject Drugs

People who use and inject drugs often feel unwelcome and stigmatized at healthcare facilities. This underscores the need to scale up community- and peer-based programs that deliver HIV, primary care, and harm reduction services, such as OAMT, needle and syringe programs, overdose prevention, drug testing, vein care, and treatment for skin infections and abscesses. These programs also offer testing, care, and treatment for TB, viral hepatitis, and STIs, including doxyPEP and suppressive therapy for genital herpes. Additionally, information about interactions between ARVs, stimulants, opioids, and other drugs should be available, as well as spaces and services for women who use and inject drugs should be available.

Sex Workers

People who engage in sex work face criminalization, gender-based and other violence, stigma, and discrimination—all of which are barriers to accessing HIV services.

HIV services for sex workers should be community- and peer-based and adapted to their specific needs and contexts, such as providing services during evening hours, and offering SRH care, including testing for asymptomatic STIs, doxyPEP, suppressive therapy for genital herpes, and reproductive healthcare; information about interactions between hormonal contraception, ARVs, and other medicines, and harm reduction services.

Transgender People

Too often, transgender people go unrecognized by HIV programs and services, while stigma, transphobia, criminalization, and violence increase their vulnerability to HIV. In addition to HIV prevention, testing, care, and treatment for HIV, services for transgender people should be holistic, responsive to the specific vulnerabilities they experience, and delivered in peer- and community-led settings, in the context of gender-affirming care. Services should include PrEP and PEP, harm reduction, testing for and treatment of STIs, including doxyPEP and suppressive therapy for genital herpes and co-infections such as tuberculosis and viral hepatitis. They should also offer information about interactions between gender-affirming hormonal therapy and other medicines.

People in Prisons and Other Closed Settings

People in prisons and other closed settings lack equitable access to HIV prevention, testing, care, and treatment, especially women. They require access to the same HIV and support services as people outside of these settings.

Adolescent boys and girls, transgender and gender-diverse people, women, and men in prison and other closed settings are vulnerable to violence and sexual abuse. Prisons and other closed settings should protect people against gender-based violence and sexual assault. They should provide counseling and support, harm reduction services, peer-led education that increases HIV and health literacy, sexual and reproductive health services, maternity care and HIV prevention, testing, care, and treatment. Pre-release programming, with linkages to post-release HIV services, psychosocial services, and case management should be available to guide people living with HIV from incarceration into the community. Pre- and post-release programming should be informed by people with lived experience to ensure its relevance.

HIV TREATMENT IN HUMANITARIAN SETTING

Migrants, mobile populations, refugees, and people who are internally displaced due to conflicts, natural disasters, climate change, and other causes face multiple barriers to accessing HIV prevention, testing, care and treatment. Responses need to be adapted to the context and nature of and emergency, but should prioritize HIV prevention, continuous access to ART, mental health care and psychosocial support and services for survivors of intimate partner and gender-based violence.

WHO and UNAIDS have developed recommendations to address HIV in humanitarian settings, as follows:

1. Prepositioning ART Supplies
2. Decentralized Care Models
3. Community-based ART delivery (pharmacies, mobile clinics, peer-led
4. Task Shifting
5. Digital Health Tools (telemedicine, mobile adherence reminders, and electronic health records)

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The Well Project (2024): Aging and HIV https://www.thewellproject.org/hiv-information/aging-and-hiv

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UNICEF (undated): The Adolescent Kit for Expression and Innovation https://adolescentkit.org/index.html

UNICEF (undated): UPSHIFT—Unlocking the Potential of Youth as Global Social Innovators https://www.unicef.org/innovation/upshift

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7

HIV Co-infections and Opportunistic Infections

KEY POINTS

- People living with HIV may be vulnerable to certain illnesses, called opportunistic infections (OIs), which occur when the immune system is weak. These include tuberculosis, severe bacterial infections and fungal infections.
- Some people living with HIV, including children under the age of five and adults and adolescents who have weakened immune systems, are at risk of serious illness and death. This is called advanced HIV disease (AHD).
- CD4 cell testing at diagnosis and upon treatment failure or re-entry to care identifies people with AHD, who need a special package of care, including TB preventive treatment, and rapid diagnosis of and treatment for OIs.
- Some viral and bacterial infections (such as hepatitis B, hepatitis C, human papillomavirus and TB) are common among people living with HIV. These are called co-infections, because a person living with HIV may have two or more infections at the same time.
- HIV worsens co-infections, but they are treatable and most are curable.
- Untreated STIs increase vulnerability to HIV acquisition or transmission and have other medical consequences, highlighting the importance of routine sexual and reproductive healthcare.

Advocacy Areas

People living with HIV and their allies have fought to optimize research, care and treatment for opportunistic infections and HIV co-infection. The current funding freeze may lead to treatment disruptions. Access to a CD4 cell count is important for identifying people with AHD upon entry to or re-initiation of ART.

Overview of HIV Opportunistic Infections

Untreated HIV gradually weakens the immune system, eventually leaving people vulnerable to severe illness from certain viruses (cytomegalovirus, herpes simplex), bacteria (TB, salmonella, mycobacterium avium complex), fungi (oral or esophageal candidiasis, cryptococcus neoformans, histoplasmosis, pneumocystis jivoreci pneumonia), or parasites (cryptosporidiosis, toxoplasmosis). These are called opportunistic infections. These infections rarely cause illness in people with a healthy immune system, but they can lead to severe illness and death in immunocompromised people.

HIV treatment can prevent OIs by keeping the immune system strong. Sometimes people living with HIV, including children, take other medicines, called prophylaxis, to protect them against certain illnesses as their immune system recovers.

All people living with HIV who have latent tuberculosis should be treated for it to prevent them from falling ill with active TB. Adults who have a CD4 cell count of <350 cells/mm^3 and all children living with HIV should be given co-trimoxazole prophylaxis to protect them against malaria and severe bacterial infections if they live in an area where these are common.

- Join ongoing advocacy for rapid, point-of-care CD4 testing and treatment of common opportunistic infections (see https://oneill.law.georgetown.edu/projects/advanced-hiv-disease/).
- Advocate for uninterrupted supply of and access to ART and commodities to enable routinized screening, testing, prevention, and treatment for co-infections and OIs.

Advanced HIV Disease

Up to a third of people living with HIV are not tested and diagnosed until they have developed advanced HIV disease (AHD); HIV has weakened their immune system, which puts them at risk for severe illness and death. Globally, most HIV-related deaths occur in people with AHD.

WHO recommends CD4 cell testing as the preferred method for all people living with HIV who start or re-enter care to identify people with AHD. People with HIV should start treatment even if CD4 testing is unavailable. WHO recommends use of clinical staging to identify AHD in settings where CD4 testing is not available.

In adults and adolescents, AHD is diagnosed when the CD4 cell count is <200 cells/mm^3 or if they are seriously ill. All children living with HIV who are under the age of five have AHD, regardless of their CD4 cell count. People living with AHD need a special package of care to prevent illness and death from certain common OIs: TB, cryptococcal meningitis, and severe bacterial infections. The AHD package of care includes ART, enhanced adherence counseling and support, and screening, testing, prophylaxis, and/or treatment of OIs.

In addition, people who start ART with a low CD4 cell count may develop immune reconstitution inflammatory syndrome (IRIS), a condition in which a person falls ill, either from an existing illness that worsens or a previously undiagnosed disease. As part of the WHO-recommended package of care, people with AHD are monitored by a healthcare provider; symptoms of IRIS are treated and ART is continued.

As part of the package of care for AHD, WHO recommends:

- TB preventive treatment, which will stop people from falling ill with TB
- Systemic screening for TB, at every healthcare visit, by asking people about their symptoms and TB testing (via rapid molecular testing and rapid LF-LAM testing) and chest X-ray
- Treating active TB based on tests to see which drugs will be effective
- Screening for cryptococcal antigen (if screening is unavailable, WHO recommends primary prophylaxis with fluconazole to adults and adolescents living with HIV and a CD4 cell count of <100 cells/mm^3 until CD4 cell count reaches >200 cells/mm^3)
- Providing cryptococcal antigen-positive adults and adolescents living with HIV with a CD4 cell count of <100 cells/mm^3 with pre-emptive antifungal therapy to prevent invasive cryptococcal disease, before initiating or re-initiating ART (cryptococcal meningitis is treated with a single high dose of liposomal amphotericin B with 14 days of flucytosine)

- Interventions for people living with HIV who have been hospitalized with AHD, including pre-discharge goal setting, medication review, transitional care planning, telephone follow-up, and home visits by healthcare providers and/or peer supporters

HIV Co-infections

Some viral and bacterial infections are common among people living with HIV, regardless of their CD4 cell count, often due to overlapping transmission modes; these are known as *co-infections*. Some of the most common co-infections among people living with HIV are hepatitis B virus (HBV), hepatitis C virus (HCV), and human papillomavirus (HPV) and TB which is considered an OI and a co-infection. HIV can accelerate the progression of certain co-infections such as HBV, HCV, HPV, and TB, underscoring the importance of prevention of, and testing and treatment for co-infections

Table 6. HIV Co-infections: Prevalence, Prevention, their Impact on HIV, and Treatment

	Co-infection and prevalence	Prevention	Impact	Treatment
HBV	Globally, 7.4% of people living with HIV are also living with HBV.	A vaccine can prevent HBV.	**Impact on HIV:** HBV is more likely to become chronic and progress to cirrhosis, liver failure, and liver cancer more rapidly in people living with HIV. **Impact on HIV:** HBV does not worsen HIV.	Tenofovir, an ARV used to treat HIV, is also an effective treatment for HBV; currently, treatment is lifelong, although researchers are searching for a cure.
HCV	Global prevalence of HIV/HCV co-infection is highest among people who inject drugs (82.4%), including gay, bisexual and other men who have sex with men and inject drugs (30.2%), followed by gay, bisexual and other men who have sex with men (6.3%).	There is no HCV vaccine. Harm reduction programs offering needle/syringe opioid agonist maintenance therapy and other interventions, including for chemsex, can lower the risk of HCV transmission, as does expanding access to HCV treatment.	**Impact on HIV:** HCV is more likely to become chronic and progress to cirrhosis, liver failure and liver cancer more rapidly in people living with HIV. **Impact on HIV:** HCV does not worsen HIV.	HCV can usually be cured by 12 weeks of treatment with once-daily, oral direct-acting antiviral treatment.

	Co-infection and prevalence	Prevention	Impact	Treatment
HPV	Global prevalence of HPV is high; nearly all unvaccinated, sexually active people have acquired HPV. Often, the immune system clears HPV, but it may become persistent and cause oral or genital warts. Some types of HPV, called “high-risk”, are more likely to cause cancer.	A vaccine can prevent HPV.	**Impact of HIV:** HIV increases the risk of HPV and its persistence. People living with HIV have a greater likelihood of larger genital warts, pre-cancers, and certain HPV-related cancers (oropharyngeal [back of the throat], cervical, vaginal, vulval, penile, or anal). **Impact on HIV:** HPV does not worsen HIV.	People living with HIV should be screened for HPV-related anal and cervical cancer. Warts can be treated (ointments, gels, freezing, or surgery); pre-cancers can be removed. HPV-related cancers are treated according to their stage, with surgery, chemotherapy, and/or radiation.
TB	TB is the leading cause of death among people living with HIV. It is both an opportunistic infection and a co-infection of HIV. People living with HIV should undergo a four-symptom screening for TB at each visit to a healthcare facility; people who have one or more symptoms should have follow-up with a WHO-recommended rapid molecular test for TB. WHO strongly recommends LF-LAM testing in inpatient and outpatient settings.	A vaccine can prevent TB meningitis and disseminated TB in children, but it does not prevent TB infection or reactivation. WHO recommends TB preventive treatment with three months of rifapentine and isoniazid (3HP), with alternatives of six or nine months of isoniazid for eligible people living with HIV.	**Impact on HIV:** People living with HIV are 19 times more likely to develop active TB disease than HIV-negative people, and HIV increases the risk of extrapulmonary and disseminated TB. For these reasons, TB is also considered to be an OI. HIV makes TB more difficult to diagnose, especially among people with AHD. **Impact on HIV:** TB worsens HIV.	Inactive TB should be treated to prevent active TB disease in people living with HIV. This is called *TB preventive treatment*. People on ART who are diagnosed with TB can initiate WHO-recommended treatment for drug-susceptible or drug-resistant TB, based on results of drug susceptibility testing, with attention to potential drug interactions. People living with HIV diagnosed with TB who are not receiving ART and have a CD4 cell count of <50 cells/mm3 should take TB treatment for two weeks before ART initiation.

Sexually Transmitted Infections (STIs)

The most common STIs are: syphilis, gonorrhea, chlamydia, and trichomoniasis, which are curable, although gonorrhea is becoming increasingly drug-resistant; HBV and HPV, for which there are vaccines and treatment; and herpes simplex virus, which can be treated. Untreated STIs can cause ectopic pregnancy, infertility, stillbirth, certain cancers, and neurological and cardiovascular damage. In addition, STIs can increase vulnerability to HIV through genital, oral, and anal sores and tears in the skin, which make it easier for HIV to enter the body.

Most STIs are asymptomatic, underscoring the importance of STI prevention, routine testing, and treatment for all sexually active people. WHO recommends STI screening for asymptomatic pregnant women; gay, bisexual, and other men who have sex with men; sex workers; and sexually active adolescents and young adults in high-prevalence settings.

WHO TRIPLE ELIMINATION TARGETS:

The global triple elimination initiative aims to address vertical transmission of syphilis, HBV, and HIV by expanding and integrating delivery of healthcare services. For more information, see: https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b.

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8

HIV and Non-Communicable Diseases (NCDs)

KEY POINTS

- People living with HIV are at increased risk of NCDs, such as diabetes, heart disease and high blood pressure, especially as they age.
- Healthcare providers should be trained to include screening for and prevention and treatment of NCDs in HIV services.

Advocacy Areas

People living with HIV have highlighted and shared information about adverse events from ART, including metabolic and body shape changes, weight gain, and elevated risk of cervical cancer from HPV. They have pressed for research on HIV and aging, ARV-related adverse events and long-term toxicities, and NCDs and for integration of strategies to screen, prevent, and manage them into clinical care. People living with HIV and their allies have launched campaigns for HPV vaccination and screening for and treatment of cervical cancer.

- Ensure that healthcare workers are trained to address NCDs among people living with HIV.
- Advocate for comprehensive service packages for HIV and aging, including peer support.

Overview of HIV and NCDs

Many countries have high burdens of HIV and NCDs. ART has increased longevity among people living with HIV, but they are at increased risk of NCDs, such as diabetes, heart disease, depression, and certain cancers. HIV-related inflammation, toxicity from ARVs, and aging, as well as hereditary and lifestyle factors, contribute. WHO recommends integration of care for NCDs into HIV services. Prevention, diagnosis, care, and treatment of chronic diseases are important for all people living with HIV, especially as they age, and these services should include routine blood tests to track levels of cholesterol, triglycerides, blood sugar, blood pressure, and liver and kidney function tests.

Healthcare providers, peer workers, and family can have important roles in helping people living with HIV identify and manage modifiable risks (for example, smoking cessation, exercise, healthy diet, and lowering alcohol intake). HIV healthcare workers need training to integrate screening and treatment for NCDs and by referrals to peer support and counseling. On the national level, countries can provide funding for campaigns to raise awareness of NCD risks and to train HIV and other healthcare workers to prevent, screen for, and treat them.

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9

HIV Research

KEY POINTS

- HIV research has led to breakthroughs, including what HIV is, what it does, how to prevent it, how to test for it, and how to treat it.
- People living with HIV have played a key role in shaping research priorities since the beginning of the epidemic. They help ensure that studies address real-world challenges and unmet needs; provide feedback on study design, recruitment strategies, and ethical considerations; identify and address implementation barriers; disseminate results in accessible formats, local languages and contexts; and advocate for funding.
- Ongoing research is focused on improving HIV prevention and treatment and ways to cure HIV.
- HIV research must be inclusive of LMICs and adequate numbers of women and people who are members of key populations to generate statistically significant, relevant, and applicable results.
- Funding for HIV research is essential.

Advocacy Areas

In the early days of the epidemic, AIDS activists successfully fought for the opportunity to oversee government-funded research, including design and analysis of clinical trials. Since then, they have been involved in research funded by governments and pharmaceutical companies, forming and participating in Community Advisory Boards and as members of protocol review teams.

People living with HIV and their allies have advocated for inclusive, relevant global research to inform and optimize HIV prevention, treatment, and care services, as well as to find a cure, improve service delivery, and inform policies (such as harm reduction) by generating a supportive evidence base.

Activists have fought for inclusion of women, including during pregnancy, and gender-diverse people in research to ensure its relevance to all people living with HIV.

- Join people living with HIV and researchers to fight funding cuts to US-funded research.
- Continue to push for meaningful involvement of people living with HIV, including women and gender-diverse people, in research globally.

Overview of HIV Research

Decades of research have changed the prognosis for HIV, from a mysterious, usually fatal illness to a chronic, manageable disease. Along the way, researchers discovered the human immunodeficiency virus, characterized its effects on the immune system, and developed and optimized eight classes of life-saving antiretroviral treatments and effective prevention strategies. Researchers are working on an HIV vaccine and have discovered pathways towards a cure. People living with HIV have been involved in multiple areas and steps of this research, including identifying and advocating for exploration of key areas and concepts, contributing to the design, oversight, and analysis of clinical trials—and participating in them.

HIV CURE RESEARCH

Up to 10 people living with HIV have been treated for their cancer with stem cell transplants, some from donors who are genetically resistant to HIV. All 10 stem cell recipients have remained virus-free, with no replication-competent HIV found in their bodies, for months to years—without ART. This groundbreaking research is proof of concept for an HIV cure, although stem cell transplants are not feasible for widespread use due to the complexity of the procedure and the potential for life-threatening adverse events. Researchers are examining these results closely to find clues. They are exploring different strategies for curing HIV, such as:

- Driving latent HIV out from where it is hiding and activating it, so the immune system can recognize and kill infected cells
- Boosting the immune system with broadly neutralizing antibodies and other immune-based therapies, so it can control HIV by itself
- Pushing latent HIV into deeper hiding, where it will remain dormant after ART is stopped
- Cell and Gene Therapy that would like stem cell Treatment clear the virus (including from reservoirs) from the body.

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10

Access to HIV Medical Products

KEY POINTS

- Intellectual property barriers prevent access to affordable generic medical products to prevent and treat HIV—and other illnesses—in low- and middle-income countries.
- Legal public health safeguards, called Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities, have been used by people living with HIV, civil society, and governments to remove these barriers and enable access to affordable generic medicines.

Advocacy Areas

Patents keep antiretroviral prices high by allowing pharmaceutical companies exclusive rights to produce and sell their ARVs for 20 years or more at unaffordable prices. People living with HIV and their allies fought for access to affordable generic ARVs in low- and middle-income countries (LMICs), dropping the price for a year of first-line HIV treatment from USD 10,000 to USD 100 in less than a decade.

Activists have fought for voluntary licensing (VL) agreements, which allow companies to produce and sell generic versions of these drugs, but many middle-income countries are excluded from these agreements and must pay whatever pharmaceutical companies charge. Activists and governments in middle-income countries that are excluded from VLs have successfully pursued various legal strategies, such as opposing patents and urging their governments to issue a compulsory license to improve access to and affordability of treatment for HIV, hepatitis C, tuberculosis, and other illnesses. For example, Egypt rejected the patent on sofosbuvir, an HCV treatment, which enabled it to produce generic versions and treat millions of people affordably.

The examples below highlight possible areas for action and are not intended to be exhaustive.

- Advocate for dissemination of information on and strategies for implementing legal measures that increase access to affordable generic versions of patented medical products.
- Engage communities of people living with HIV and civil society groups to monitor and report on access to and pricing of HIV health products, and advocate for affordability and widespread access to these products.
- Work with others (people living with HIV organizations and networks, other civil society groups, public interest lawyers, and national patent offices) to ensure that local populations benefit from TRIPS flexibilities and generic drug production.
- Advocate for increased access to affordable medicines.

Overview of Access to HIV Medical Products

The 2001 Doha Declaration enables governments to use TRIPS flexibilities for public health. These flexibilities include exemptions to patents for least-developed countries. This allows a country to authorize production of generic and biosimilar products without the patent holder's consent, called compulsory licensing, and challenge unmerited patents by filing pre- and post-grant oppositions. People living with HIV and their allies can also work with national patent offices to strengthen the criteria for obtaining a patent.

Intellectual property rights create monopolies by allowing a pharmaceutical company to patent their products. This means the company has exclusive rights to produce and sell a medicine for at least 20 years, at prices that are unaffordable for LMICs. These monopolies also limit supply, as with COVID-19 and mpox vaccines and other medical products, and prevent countries from developing the capacity for local production. Voluntary licenses enable access to generic ARVs and other medicines, but pharmaceutical companies dictate their terms, including where and by whom generic versions of their products can be sold. Middle-income countries are often excluded from VLs, and the licenses may include access-limiting provisions, such as restricting production of generic drugs—not selling them domestically.

Long-acting, injectable and ARV formulations have been developed to prevent and treat HIV and many more conditions. These include once-weekly oral regimens, which are in the pipeline. Access to affordable generic versions of current and pipeline LA-ARVS in LMICs, especially those excluded from voluntary licenses, is limited and should be expanded through use of TRIPS flexibilities.

Table 7. Approval and Access Status of LA-ARVs

	Approval status (Q4, 2025)	Access
CAB-LA Long-acting, injectable HIV prevention	Argentina, Australia, Botswana, Brazil, Canada, Chile, China, Colombia, European Medicines Agency, Ivory Coast, Kenya, Lesotho, Malawi, Malaysia, Mexico, Myanmar, Mozambique, Namibia, Nigeria, Peru, Philippines, Rwanda, South Africa, Taiwan, Tanzania, Thailand, Uganda, Ukraine, United Kingdom, United States, Zambia, Zimbabwe SUBMITTED: Chile, Colombia, Mexico, Rwanda, Taiwan, Vietnam	In the US, CAB-LA is priced at USD 22,200 per person per year (PPPY). ViiV Healthcare has issued a voluntary license and is offering a "not-for-profit" price of USD 240 PPPY (which does not include distribution costs and healthcare delivery), only for low-income, least-developed, and sub-Saharan countries. ViiV has not disclosed its price for middle-income countries. Generic versions are anticipated in 2027. Researchers estimate CAB-LA could be produced generically for USD 60-119 per person, per year. A formulation that is dosed every four months (versus every two months) is currently in development.
CAB/RPV-LA Long-acting, injectable HIV treatment	High-income countries	In July 2025, ViiV and the Medicines Patent Pool announced that the voluntary license agreement for CAB-LA was expanded to include use of CAB-LA as part of LA treatment. There is no VL for RPV-LA as of Q3 2025.
Lenacapavir Part of treatment for multi-drug resistant HIV	Approved in Canada, the EU, and the US	Priced at USD 42,250 PPPY in the US for treatment
LEN Long-acting HIV prevention	As of February 2026, LEN PrEP has been approved in Botswana, Eswatini, the EU, Kenya, Malawai, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, the US, Zambia, and Zimbabwe.. Dossiers were submitted to regulatory agencies in Thailand and Vietnam in December 2025, in Peru in January 2026, and in the Philippines in February 2026. In 2025, WHO released guidelines recommending LEN as an option for PrEP (available at: https://iris.who.int/server/api/core/bitstreams/30ec1404-5338-4459-a6f0-a187c85f3ff1/content) hA once-yearly formulation is in development and will enter Phase III trials in 2025.	Priced at USD 28,218 PPPY in the US for prevention. Gilead has not announced its "no-profit" price for LEN. It has offered a voluntary license for LEN in low- and lower-middle-countries. A generic version could be profitably mass produced for USD 100 PPPY. In July 2025, the Global Fund to Fight AIDS, Tuberculosis and Malaria, with partners (WHO, UNAIDS, the Gates Foundation, Unitaid, the Elton John AIDS Foundation, AVAC, and CIFF), announced that it had signed an agreement with Gilead that will enable LEN access for up to two million people in LMICs, supported by the Global Fund. Early access will be prioritized based on HIV epidemiology, national prevention strategies, and available resources, starting at the end of 2025. In September 2025, an agreement was announced between Dr. Reddy's Laboratories and Unitaid, the Clinton Health Access Initiative, and Wits RHI. Starting in 2027, affordable generic lenacapavir to the 120 LMICs in Gilead's voluntary license will be available for USD 40 per person, per year. Pricing for lenacapavir in LMICs not included in Gilead's voluntary license remains unknown.

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11

Structural Determinants and Policy Enablers

Stigma and Discrimination

KEY POINTS

- Stigma, including self-stigma, and discrimination remain among the most significant barriers to HIV prevention, testing, treatment, and care.
- Stigma manifests at multiple levels: internalized, anticipated, enacted, institutional, and intersectional.
- Legal and policy environments, including criminalization of same-sex relationships, sex work, drug use, HIV non-disclosure and exposure, and gender-diverse and gender non-conforming identities, are major structural determinants of access to HIV services.
- Discrimination, unlike stigma, often has legal remedies available through national laws and human rights mechanisms.
- Stigma and discrimination intersect with gender inequalities and harmful gender norms, particularly for women, girls, and gender-diverse people living with and affected by HIV.
- Addressing stigma requires multi-level action:
  - Individual level: Empowerment and education; peer support groups and networks; counselling and psychosocial support
  - Community level: Awareness campaigns; peer involvement; normalizing HIV testing and treatment; engaging traditional, cultural, and religious leaders
  - Healthcare level: Training health workers; recipient of care rights and accountability systems; integration of HIV services
  - Structural and legal level: Anti-discrimination laws and legal protections; decriminalization of HIV-related behaviors; policy advocacy and reforms
  - Systems level: Regular measurement of HIV-related stigma and discrimination; operational research; community feedback through participatory monitoring and community-led monitoring (CLM)

Advocacy Areas

Communities play a critical role in dismantling HIV-related stigma and discrimination, which remain major barriers to access, quality, and equity in HIV services. Through rights-based language, community leadership, accountability mechanisms, and health-system reform, stigma-reduction efforts can transform attitudes, improve service experiences, and strengthen health outcomes. The examples below highlight possible areas for action and are not intended to be exhaustive.

Overview of Stigma and Discrimination

Discrimination and stigma remain among the most pervasive and damaging barriers to an effective HIV response. They deter people from seeking testing and care, disclosing their status, or remaining in treatment due to fear of judgment, ostracization, violence, or loss of livelihood. People living with HIV and those perceived to be more vulnerable to HIV—such as gay and bisexual men, transgender people, sex workers, people who use drugs, women and girls, migrants, and incarcerated people—often face multiple, overlapping forms of exclusion.

Discrimination refers to unfair or unjust treatment based on actual or perceived HIV status, sexual orientation, gender identity, occupation, drug use, race, gender, disability, or other characteristics. It may be:

- Institutional: Embedded in laws, policies, and practices in healthcare, employment, education, justice, and social protection
- Interpersonal: Expressed through exclusion, harassment, denial of services, or abuse

Unlike stigma, discrimination often has legal remedies. National constitutions, anti-discrimination laws, and international human rights treaties provide avenues for redress when individuals are denied services, employment, or fair treatment. Courts, tribunals, ombudspersons, national human rights institutions, and equality bodies are key mechanisms for accountability. However, in many settings, the law itself legitimizes and reinforces stigma, for example, through the criminalization of HIV non-disclosure and exposure (even where no transmission occurs), same-sex relationships, diverse gender identities, drug use and possession for personal use, and sex work.

Rights-Based Language, Norms & Public Education

- Promote inclusive, affirmative, people-first language in healthcare, media, education, and community settings that upholds the human rights and dignity of people affected by HIV.
- Push for sustained investment in public education campaigns, healthcare worker training and accountability, and participatory approaches that dismantle bias, stereotypes, and harmful gender norms.
- Promote knowledge and communication of the U=U principle to support awareness-raising, treatment adherence, and stigma reduction.

Community Leadership & Accountability

- Ensure that stigma-reduction programs are community-led and meaningfully involve people living with HIV and key populations in design, implementation, and evaluation.
- Advocate for sustained community-led monitoring and quality-improvement mechanisms in health facilities to routinely identify and address stigma and discrimination.

Stigma manifests in multiple forms:

- Internalized stigma: Feelings of shame, guilt and worthlessness and fear of rejection among people living with HIV
- Anticipated stigma: Expectations of discrimination, denigration, or violence that deter people from accessing health services or disclosing their status
- Enacted stigma: Actual experiences of prejudice, exclusion, or discriminatory behavior in families, communities, workplaces, health facilities, or other institutions
- Institutional stigma: Policies, practices, and structures—including within health systems, schools, workplaces, social services, and the legal system—that restrict access to services and rights
- Intersectional stigma: Overlapping and compounding stigma experienced at the intersection of HIV status and other marginalized identities—such as gender, age, sexuality, race, class, poverty, disability, migration status, and incarceration—which together intensify exclusion and reduce access to care and justice

Stigma, including self-stigma, and discrimination significantly undermine HIV prevention and treatment efforts. Fear of negative judgment or violence leads people to avoid or delay HIV testing, disengage from care, or interrupt treatment, resulting in worse health outcomes and increased transmission. Stigmatizing attitudes and practices in healthcare settings lead to breaches of confidentiality, denial or delay of services, substandard treatment, and sometimes direct abuse. Research consistently shows that stigma is associated with higher levels of depression, anxiety, and substance use, further complicating HIV management and quality of life.

Healthcare settings are, therefore, critical spaces where stigma can be either perpetuated or dismantled. Stigma in facilities contributes to late diagnosis, attrition from care, and mistrust in health systems. Gender inequalities and harmful gender norms often compound these dynamics: women, girls, and gender-diverse people living with HIV may face judgmental attitudes, coercion, or neglect in sexual and reproductive health services, including violations of bodily autonomy and informed consent.

Several global and community initiatives demonstrate effective approaches to reducing HIV-related stigma and discrimination. These include:

- Establish two-way reporting mechanisms between recipients of care/ communities and health system managers to report, track, an address cases of stigma, discrimination, and abuse.

Health Systems Integration & Workforce Capacity

- Integrate stigma-reduction as a critical enabler within national HIV strategies, budgets, and universal health coverage (UHC) frameworks.
- Integrate HIV stigma-free service provision practices into mandatory and regular continuing education and in-service training for healthcare workers.

Financing, Data & Institutionalization

- Allocate dedicated budgets for community-led initiatives and networks focused on reducing stigma and discrimination, including those led by women, young people, and key populations.
- Institutionalize stigma-reduction indicators in national monitoring and evaluation frameworks and routine health information systems.

- Community education, awareness, and peer support: Campaigns (for example, for Zero HIV Stigma Day) and community-driven initiatives led by people living with HIV, key populations, and traditional and religious leaders can challenge harmful beliefs and create more supportive environments. Networks of people living with HIV often provide safe spaces for mutual support and are a foundation for broader advocacy and movement-building.
- Healthcare provider training: Co-developed training on implicit bias, cultural competence, human rights, and recipient of care-centered communication, grounded in lived experience, can reduce prejudice and build trust-based, affirming care.
- Policy and legal reforms: UNAIDS and partners call for the decriminalization of HIV transmission, non-disclosure and exposure, same-sex relationships, sex work, and drug use and possession for personal use, alongside strong anti-discrimination protections and access to justice.
- Participatory approaches: Toolkits developed by networks of people living with HIV and key populations emphasize meaningful involvement in designing, implementing, and evaluating programs, ensuring that interventions are relevant, culturally grounded, and effective.
- Measurement and feedback: Regular measurement of HIV-related stigma and discrimination, combined with community feedback and CLM, helps identify priorities, track progress, and inform accountability.

This aligns with the Global Partnership on Ending Stigma and Discrimination initiative and ongoing global efforts to remove legal, policy, and structural barriers that prevent communities from accessing HIV prevention, treatment, and care.

Programs that combine these strategies have demonstrated measurable impact. Facilities that implement participatory, stigma-reduction training report improved trust between recipients of care and providers, higher satisfaction, and better health outcomes. Community-led initiatives have shifted social norms, reduced fear-based narratives, and built stronger constituencies for rights-based HIV responses.

YOUTH-LED CAMPAIGN TO CHALLENGE STIGMA

The Y+ Beauty Pageant, led by the Uganda Network of Young People Living with HIV (UNYPA), is a vibrant, youth-driven campaign that uses fashion, performance, and creative expression to challenge HIV-related stigma and discrimination.

Each year, young people living with HIV take the stage as leaders and role models, showcasing confidence, talent, and pride. Through music, dance, and storytelling, participants reclaim their narratives, promote accurate information about HIV, and demonstrate that HIV does not define their identity or limit their aspirations.

The pageant has become a powerful platform for empowerment, visibility, and community dialogue, helping shift public attitudes and reducing internalized stigma among young people. It also builds a cohort of young HIV advocates who continue championing human rights and inclusion beyond the event.

https://rrpplus.org/progress-assesment-on-the-implementation-of-stigma-index-2-0-recommendations-in-rwanda/

The Rwanda Network of People Living with HIV (RRP+) has played a central role in reducing HIV-related stigma and discrimination in Rwanda by empowering people living with HIV (PLHIV) and engaging them actively in the national HIV response.

RRP+ has undertaken community awareness and education campaigns, training peer educators and media professionals to challenge myths and misconceptions about HIV and promote respectful reporting that reduces stigma. These efforts include mobilizing journalists to report responsibly on HIV, and training youth ambassadors and women leaders to use social media to share positive narratives and fight discrimination.

https://rrpplus.org/rwanda-people-living-with-hiv-index-2-0-survey-report-2020/

the علاجي (MY TREATMENT) INITIATIVE

Launched by ITPC-MENA, the علاجي initiative is a digital community campaign designed to empower people living with HIV in the Middle East and North Africa (MENA), where stigma and discrimination remain significant barriers to care and social inclusion. Through a dedicated Facebook page and private messaging groups, علاجي offers a safe and anonymous digital space for community engagement. It focuses on three main pillars:

- Peer education: Sharing accurate, accessible information on HIV treatment, rights of recipients of care, and managing side effects
- Psychosocial support: Providing peer-to-peer encouragement to break isolation, strengthen self-esteem, and reduce internalized stigma
- Practical assistance: Guiding people living with HIV to appropriate health services, addressing medicine stockouts, and referring individuals to legal or social support

The علاجي campaign has built a vibrant online community of several hundred active members. It has contributed to improved treatment. It has also strengthened people’s ability to advocate for their rights and report discrimination for follow-up and redress. علاجي illustrates how simple, low-cost, community-led digital tools can create supportive environments for people living with HIV and play a vital role in combating stigma across the MENA region.

1 Human Rights and Gender Barriers

KEY POINTS

- Human rights violations and gender inequities limit access to HIV services and worsen health outcomes.
- Criminalization of HIV non-disclosure, exposure and transmission, same-sex relationships, gender identity, drug use and possession for personal use, and sex work creates structural barriers.
- Gender-based violence, unequal access to resources, and harmful gender norms disproportionately affect women, adolescent girls, and key populations.
- Removing these barriers is essential for an effective, equitable HIV response.

Advocacy Areas

The following advocacy areas highlight priority actions to advance legal reform, integrated services, and accountability, ensuring that the HIV response upholds dignity, safety, and rights for all.

Legal Reform & Protection from Violence

- Advocate for legal and policy reform to decriminalize HIV non-disclosure, exposure and transmission, same-sex relationships, gender identity, drug use and possession for personal use, and sex work.
- Advocate for reform to protect all people from discrimination and violence.
- Demand accountability from governments and institutions to uphold human rights protections, including for gender equality, through laws, funding mechanisms, community advocacy capacity, and to safeguard human rights defenders.

Integrated, Gender-Responsive Services

- Push for integration of HIV, gender-based violence, psychosocial, peer support, and sexual and reproductive health services to meet the needs of women and gender-diverse people.

Gender Equality & Movement Building

- Promote gender-transformative programming that addresses harmful norms and empowers women, girls, and LGBTQ+ people. Support their networks and movements.

Overview of Human Rights and Gender Barriers

HIV is both a health and a human rights issue. Discrimination in law and policy amplifies vulnerability to HIV, while gender inequities also increase vulnerability and limit access to services. Women, girls, gay and bisexual men, transgender people, sex workers, and people who use drugs often face intersecting barriers that result in poorer health outcomes.

Gender-based violence and harmful social norms discourage women from accessing and benefiting from services, while punitive laws criminalizing HIV non-disclosure, exposure and transmission, and/or behaviors linked to key populations and gender identity exacerbate stigma and deter engagement with health systems. As of 2025, only eight out of 193 countries have no punitive laws related to HIV status, LGBTQ+ people, drug use, or sex work, highlighting that the vast majority of countries still criminalize key populations or HIV exposure. This widespread criminalization must be urgently overturned to enable an effective HIV response.

Global agencies, including UNAIDS and UNDP, have called for removing legal barriers, strengthening gender equality, and integrating HIV services within broader health and rights frameworks. Ensuring legal protections and gender-sensitive, gender-transformative programming is not only a moral imperative but also a proven way to improve HIV outcomes.

GENDER AND HUMAN RIGHTS ADVOCACY IN RWANDA

The Rwanda Network of People Living with HIV (RRP+) strengthens the protection of women, adolescents, and key populations living with HIV by leading sustained advocacy and dialogue with policymakers and national human rights institutions. Through community consultations, evidence gathering, and targeted engagements, RRP+ brings forward the lived experiences of those most affected by inequality and stigma. Its work helps influence policies, improve accountability, and ensure that gender and human rights considerations remain central to Rwanda's HIV response. RRP+ Photos\Photo 3.jpg RRP+ Photos\campaign.jpg. *For more information, see: the "Gender Assessment of Rwanda's National HIV Response" by the* Rwanda Biomedical Center *and RRP+ Rwanda's own "Gender Policy" document, which outlines its institutional commitment to empowering people living with HIV through a gender- and rights-based lens* (rrpplus.org)*.*

BUILDING A HUMAN RIGHTS MOVEMENT IN MENA

In the MENA region, where human rights defenders and community advocates for people living with HIV and key populations often face isolation, repression, and a lack of formal training, there is a critical need to build a resilient and skilled movement. ITPC-MENA designed the innovative pilot fellowship Activists Development Program (ADP-MENA). It identifies emerging advocates and provides them with an intensive, structured curriculum in:

- Human rights frameworks: Understanding national, regional, and international mechanisms for protection
- Strategic advocacy and campaigning: Developing targeted advocacy plans to address issues such as decriminalization, stigma, and access to treatment
- Media and strategic communication: Learning how to safely and effectively frame messages and engage with the media
- Community mobilization and leadership: Strengthening skills to build and lead community networks.

The ADP-MENA cohort has evolved into a powerful network of cross-country advocates. Graduates have successfully led national campaigns against medicine stockouts, documented rights violations for shadow reports to international bodies, and provided crucial legal and psychosocial support to peers in crisis. The program demonstrates that strategic investment in the leadership and rights-based capacity of community activists is a fundamental pillar for sustaining an effective, resilient, and truly community-led HIV response in challenging environments.

LIGHTHOUSE SOCIAL ENTERPRISE – “BREAKING STIGMA, ENDING HIV” INITIATIVE IN VIETNAM

Implemented by Lighthouse Social Enterprise Vietnam with support from ViiV Healthcare Positive Action, the *Breaking Stigma, Ending HIV (BSEH)* initiative reduces HIV-related stigma to improve equitable access to prevention, treatment, and care in Viet Nam. The programme is community-led, positioning people living with and affected by HIV as agents of change.

At its core are *Community Taskforces for Anti-Stigma and Quality Improvement (CTAQ)*, which:

- Lead stigma-reduction campaigns, dialogues, and peer education
- Document lived experiences to inform advocacy and training
- Amplify community voices through the *Live+Love* podcast
- Pilot the *Community–Provider Collaboration for Quality Improvement (CPQI)* model, enabling joint community–provider action on service improvements
- Advocate for policy reforms to address systemic stigma and protect health rights

By combining community leadership, storytelling, advocacy, and structured collaboration with health facilities, BSEH demonstrates how community-led models can strengthen accountability, transform attitudes, and create a more enabling environment to end HIV in Viet Nam.

EDUCATION PLUS INITIATIVE—ADVANCING GIRLS' EDUCATION TO END AIDS

The **Education Plus Initiative**, launched in 2021 by UNAIDS and partners, is a high-level, multi-sectoral effort to prevent HIV infections among adolescent girls and young women in sub-Saharan Africa by keeping them in school and addressing structural inequalities.

Adolescent girls and young women remain disproportionately affected by HIV, particularly in Eastern and Southern Africa. Education Plus recognizes that HIV vulnerability is shaped not only by access to health services, but also by gender inequality, poverty, gender-based violence, and limited access to secondary education.

The initiative focuses on five core pillars:

- **Keeping girls in secondary school** through policy reform and financial support.
- **Comprehensive sexuality education (CSE)** and life-skills training.
- **Sexual and reproductive health and rights (SRHR)** access, including HIV prevention.
- **Prevention of gender-based violence (GBV)**.
- **Economic empowerment and social protection** for adolescent girls and young women.

By aligning education, health, gender equality, and social protection policies, Education Plus promotes a structural, rights-based approach to HIV prevention—recognizing that biomedical tools alone are insufficient without addressing the social determinants of risk.

Community-led Monitoring (CLM)

KEY POINTS

- Community-led Monitoring empowers communities to systematically identify gaps and propose solutions related to access to, and quality of, HIV services.
- CLM generates evidence in the form of empirical data on service gaps and rights violations, which is used for advocacy and accountability.
- CLM is especially critical during service disruptions caused by funding cuts, crises, humanitarian settings, or other emergencies.
- CLM strengthens communication, trust, and partnership between healthcare workers and communities-led/community-based organizations (CBOs).
- Programs are most effective when they are participatory, rights-based, and led by affected populations.
- Global initiatives, such as ITPC's CLM Toolkit and CLM Hub, provide practical guidance for community implementation, and donors, including Expertise France, PEPFAR, and the Global Fund, have long invested in CLM. This demonstrates strong and sustained support for community-generated data within country programs.

Advocacy Areas

- Advocate for sustained funding and institutionalization of CLM at national and global levels.
- Promote the integration of CLM findings into national and local health planning, budgeting, and decision-making.
- Support capacity-building for networks of people living with HIV and key and vulnerable populations, including women- and girls-led networks, to lead monitoring initiatives, including in humanitarian settings and challenging environments.
- Use CLM evidence to push for improved quality, accessibility, and equity of HIV services.

Overview of Community-led monitoring

Community-led monitoring is a process by which communities gather and analyze evidence on the accessibility, quality, and acceptability of HIV services. Rooted in the principle of “nothing about us without us,” CLM ensures accountability and strengthens trust between communities, health systems, and other duty bearers.

CLM has proven effective in identifying service delivery failures, including stockouts, stigma in healthcare settings, and barriers linked to punitive laws. During political instability, pandemics, or funding crises, CLM is often the first process to detect service disruptions and suggest immediate solutions.

CLM is not only about data; it is also a tool for empowerment. By involving communities in the design, collection, and use of data, CLM builds local ownership and advocacy power. Evidence from CLM has influenced national HIV policies, improved service delivery, and shaped donor strategies. Increasingly, governments are recognizing the added value of CLM and, in some countries, are already co-financing CLM work through social contracting and similar arrangements.

CLM IN PRACTICE WITH ITPC-MENA

In the MENA region, where data collection can be challenging due to stigma, legal barriers, and limited resources, there was a critical need for a CLM model that was both effective and adaptable.

ITPC-MENA championed the Focused and Relevant, Simple and Standardized (FORSS) approach to CLM. This methodology is:

- Focused and relevant: It selects a limited number of high-impact indicators (such as ARV stockouts, user fees, and experiences of stigma) that directly reflect community priorities and can be acted upon.
- Simple and standardized: It uses streamlined data collection tools (short surveys, simple forms) that are easy for community members to use and ensure that data are comparable across sites and over time.

By training networks of people living with HIV and key populations on the FORSS approach, ITPC-MENA enabled communities to systematically generate credible evidence on service gaps. This evidence has been instrumental for targeted advocacy, leading to concrete outcomes, such as resolving chronic medicine stockouts in specific clinics and prompting policy dialogue on reducing user fees and combating stigma within national health systems. The FORSS model demonstrates that CLM does not need to be complex to be powerful; it needs to be strategic, community-owned, and directly linked to advocacy.

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Programme Implementation and Innovation

Differentiated Service Delivery (DSD)

KEY POINTS

- DSD is a recipient of care-centered, evidence-based approach that adapts the *who, what, where,* and *when* of HIV services to better meet people's needs.
- Core models include multi-month dispensing (MMD), community ART groups, fast-track refills, telehealth, and integration with non-communicable disease care.
- Evidence shows that DSD improves retention, viral suppression, and health system efficiency while reducing the burden on recipients of care.
- DSD was critical during COVID-19, ensuring continuity of HIV treatment amid widespread disruptions.

Advocacy Areas

Differentiated service delivery (DSD) is essential to sustaining HIV services, improving quality of care, and strengthening health-system resilience—especially in contexts of constrained financing and growing service demands. By adapting services to people’s needs and shifting care closer to communities, DSD can expand access, reduce burdens on health systems, and improve health outcomes. The following advocacy actions highlight priorities to institutionalize, finance, and scale effective DSD models.

Policy & Systems Integration

- Advocate for the institutionalization of DSD within national HIV guidelines and essential health benefit packages.
- Promote integration of HIV with NCD care, gender-based violence services, sexual and reproductive health, and psychosocial support within DSD models to strengthen health-system resilience.

Financing & Community-led Response

- Call for increased financing to scale up MMD and community ART distribution, including support for community and peer treatment advocates.
- Advocate for sustained funding for high-impact community interventions, including rapid/auto-testing, expanded access to PrEP, PEP, and ART, and community safe spaces for key populations, such as gay and bisexual men and transgender women.

Digital & Innovation Enablers

- Push for investment in digital systems and telemedicine as key DSD enablers.

Overview of DSD

Differentiated service delivery has become a cornerstone of HIV treatment innovation. It shifts HIV care from rigid, facility-based models to flexible, person-centered approaches that optimize outcomes for both clients and health systems.

Key DSD model categories include:

- Multi-month dispensing: WHO recommends three- to six-month ART refills for clinically stable clients. Evidence from multiple African countries shows that MMD improves retention and reduces loss to follow-up by up to 30%.
- Community ART groups: Peer-supported groups reduce clinic congestion and enhance adherence. Programs in Mozambique and Uganda show improved viral suppression and reduced costs.
- Fast-track refills: Streamlined pharmacy-only visits minimize time spent at facilities while maintaining adherence support and viral load monitoring.
- Integration with NCD care: Bundling HIV with care for hypertension, diabetes, and aging-related conditions increases efficiency and supports the long-term health of people living with HIV.
- Telehealth and home-based care: The expansion of telemedicine during COVID-19 allowed uninterrupted care through remote consultations and decentralized medication delivery.
- Differentiated PrEP delivery: WHO recommends simplified and community-led PrEP models. MMD and community-led PrEP distribution are emerging as effective approaches to increase prevention access alongside treatment DSD.

Overall, DSD strengthens equity and resilience, ensuring that services reach people who are underserved or excluded by traditional facility-based systems.

2 Key Population Toolkits

KEY POINTS

- Global implementation toolkits (MSMIT, IDUIT, SWIT, TRANSIT, MENA Rosa, and the SRHR Guidelines for Women Living with HIV) provide practical, evidence-informed guidance for designing, adapting, and scaling programmes for key populations and women and girls living with HIV.
- These toolkits were developed jointly by WHO, UN agencies, technical experts, and networks of key populations and women living with HIV to operationalize earlier WHO normative guidance, particularly the 2014 Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations.
- Since then, the normative framework has evolved. The WHO (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations constitute the current global normative standard. The implementation toolkits should therefore be understood as complementary operational resources and applied in alignment with the 2022 guidance.
- Effective implementation requires adaptation to local cultural, legal, and epidemiological contexts, and meaningful leadership of affected communities.

Advocacy Areas

- Advocate for alignment of national HIV strategies, policies, and Global Fund funding requests with the WHO 2022 Consolidated Guidelines, while drawing on relevant operational elements of existing toolkits.
- Promote training and capacity-building so that community-led organizations and health workers can effectively implement updated, rights-based approaches, including in local languages.
- Encourage investment in implementation research to assess adaptation processes, impact, and scale-up in line with evolving normative standards.
- Support institutionalized participatory programme design where key populations and women and girls living with and affected by HIV meaningfully engage and co-lead interventions.

Overview of Key Population Toolkits

Implementation toolkits translate global guidance into practical steps for governments, planners, and communities. While developed to support implementation of earlier WHO recommendations, many of their operational tools remain relevant when aligned with updated normative standards.

The WHO 2022 Consolidated Guidelines introduce important updates compared to the 2014 framework. They expand integration across HIV, viral hepatitis, and sexually transmitted infections; reinforce differentiated and person-centred service delivery models; and update recommendations on HIV prevention (including newer prevention options), testing strategies, treatment initiation and monitoring, and harm reduction. The 2022 guidance also strengthens emphasis on enabling legal and policy environments, community-led services, integration of mental health and broader health needs, and removal of structural barriers affecting key populations. As such, while the implementation toolkits continue to offer valuable operational guidance, they should be used in conjunction with — and aligned to — the 2022 WHO normative framework.

Key toolkits include:

- MSMIT (Men Who Have Sex with Men Implementation Tool) — programme guidance for gay and bisexual men, emphasizing peer-led outreach, HIV testing, linkage to care, and structural interventions to reduce stigma and discrimination.
- IDUIT (Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs) — guidance grounded in evidence for harm reduction, including needle and syringe programmes, opioid agonist therapy, and integrated HIV/HCV services.

- SWIT (Sex Worker Implementation Tool) — consolidates biomedical, structural, and rights-based interventions, including peer outreach, legal empowerment, and community-led service models.
- TRANSIT (Implementation Tool for Transgender People) — addresses the needs of transgender communities, including gender-affirming care, stigma reduction, and integrated service delivery.
- MENA Rosa Treatment Literacy Toolkit — developed by and for women living with HIV in the MENA region to strengthen peer education and treatment literacy.
- WHO SRHR Guidelines for Women Living with HIV — developed with global women's networks, addressing stigma, rights violations, and comprehensive sexual and reproductive health and rights services.

Collectively, these tools advance a rights-based, people-centered, and evidence-informed approach aligned with WHO and UNAIDS guidance. They are widely used in Global Fund country proposals and national HIV strategies to support programs that meaningfully engage and are co-led by key populations and women living with HIV.

TAP4S: TESTING FOR STATUS, PREP FOR SAFE SEX, ART FOR SOUND HEALTH (VIET NAM)

Implemented in 2024–2025 by Lighthouse Social Enterprise Vietnam in Hà Nội, Ho Chi Minh City, and Bình Dương, with support from the Elton John AIDS Foundation, the *TAP4S* initiative aims to curb rising HIV infections among LGBTIQ+ communities and contribute to Viet Nam's 95–95–95 targets.

Responding to increasing incidence, misinformation, and gaps in affirming services, TAP4S uses tramxacauvong.com—a community-designed digital platform run by peer educators—to link LGBTIQ+ people, including chemsex users, to HIV testing (including self-testing), PrEP, ART, mental-health care, and harm-reduction services. The platform offers trusted information, a map of LGBTIQ+-friendly providers, peer counselling via chatbot and live support, and free prevention commodities.

Results (Jan 2024–Sept 2025):

- 70,000+ people reached and 26,000+ online counselling interactions
- 5,000+ HIV self-test kits distributed and 12,000+ facility-based tests
- 2,440 people linked to PrEP and 585 initiated on ART

TAP4S shows how community-led, digitally enabled, differentiated service delivery can expand access for highly stigmatised communities and strengthen engagement across the HIV prevention and treatment cascades.

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3 Innovative Delivery Approaches for HIV Literacy

KEY POINTS

- Digital health interventions (telemedicine, apps, SMS, appointment systems, and AI tools) are transforming HIV-related service delivery by reducing interruptions, supporting decentralized ART delivery, and enabling differentiated service delivery models.
- Peer-led education and navigation remain among the most effective approaches for improving HIV literacy, HIV testing uptake, adherence, and retention, especially for key and vulnerable populations facing stigma and criminalization.
- Visual, interactive, and gamified formats (infographics, animation, comics, quizzes, digital storytelling, virtual reality, and chatbots) enhance comprehension, especially among young people and people with low literacy or limited formal education.
- Digital platforms extend peer reach, enabling interactive Q&A, real-time myth-busting, and psychosocial support while requiring strong safeguarding measures to address gender-based violence and other risks.
- Adaptation and localization of digital and print materials to local languages, literacy levels, disability needs, and cultural contexts are essential to promote equality, rights, and inclusion and to ensure that messages resonate with communities.
- Print materials remain critical in low-connectivity settings and continue to complement digital formats, particularly in rural, humanitarian, and marginalized contexts.

Advocacy Areas

HIV literacy is a cornerstone of effective prevention, treatment, and community empowerment—particularly as services become more digital and differentiated. Peer-led and digitally enabled literacy approaches can counter misinformation, strengthen informed decision-making, and expand reach to underserved communities. The following advocacy priorities focus on embedding HIV literacy within national systems, financing peer leadership, and ensuring inclusive, ethical, and sustainable innovation.

Policy Integration & System Alignment

- Advocate for inclusion of digital and peer-led HIV literacy approaches in national HIV strategic plans, universal health coverage frameworks, and national eHealth strategies.

Financing & Institutionalization of Peer-Led Models

- Push for institutional funding of peer-led models (Global Fund and domestic programs, for example), including training, certification, remuneration, and safeguarding protocols to protect both peers and clients.

Digital Infrastructure, Standards & Sustainability

- Call for investment in scalable, sustainable digital platforms (rather than fragmented pilots), with clear standards for data security, ethics, and equity across age groups, genders, key populations, and humanitarian settings.

Innovation, Co-Creation & Cultural Relevance

- Promote funding for innovative, participatory formats (visual, interactive, gamified, and arts-based approaches, such as music and storytelling) within HIV literacy strategies and donor-supported programs.

Overview of Delivery Approaches for HIV Literacy

Innovative delivery approaches—combining digital health technologies, peer-led models, visual and interactive formats, and adapted digital/print materials—are reshaping how HIV literacy is achieved and sustained.

Digital health interventions, such as telemedicine, SMS reminders, appointment booking apps, digital adherence tools, and AI-driven decision support, are now core components of HIV service delivery. The COVID-19 pandemic accelerated their adoption: telehealth was used extensively in countries such as South Africa, the United States, and Vietnam, to maintain ART continuity and specialist consultations, including in rural areas. In the Philippines, appointment booking apps reduced missed visits by over 20% and improved the flow of recipients of care. In East Africa, AI-based tools are being piloted to optimize ART regimens and identify recipients of care at risk of treatment interruption. Digital case-management systems coordinate home delivery, pharmacy pick-ups, automatic dispensing, and mobile clinic schedules, supporting decentralized ART delivery and DSD models.

Peer-led approaches have consistently been validated as high-impact strategies in HIV programs. Systematic reviews show peer-led outreach can increase HIV testing uptake among gay and bisexual men and sex workers by 30-50%. Peer navigators improve ART adherence, viral suppression, and retention, particularly among adolescents and marginalized groups. Because peers share lived experiences, they can help reduce internalized and anticipated stigma and build trust in settings where confidence in institutions is low. Increasingly, digital peer support (such as WhatsApp, Facebook groups, and moderated chats) allows real-time engagement and myth-busting, with safeguarding protocols to address gender-based violence and privacy risks.

PEER-LED DIGITAL MODEL IN MENA

The علاجي (My Treatment) initiative (ITPC-MENA) is a community-born platform that uses Facebook and private messaging groups to create a safe, anonymous space. Trained peer educators provide real-time, informal support, answer questions about adherence, and help debunk myths, demonstrating a significant increase in beneficiaries’ confidence and engagement in their care journey through direct human connection.

To complement direct peer interaction, ITPC-MENA led the cultural and linguistic adaptation of the global Life4me+ app into Arabic. This structured mobile application serves as a comprehensive digital companion for people living with HIV and key populations. It empowers users to self-manage their health, with features for pill reminders, lab result tracking, and a directory of friendly services. By localizing this tool, peer educators have a reliable, scalable resource to refer community members to, extending their reach and providing 24/7 support. The combination of informal peer groups and a formal, adapted app creates a robust digital ecosystem for treatment literacy and support.

- Advocate for co-creation and pre-testing of HIV literacy materials with key populations, including women from key populations and women and girls living with and affected by HIV, to ensure cultural relevance and resonance.

Accessibility, Inclusion & Local Adaptation

- Push for multilingual, disability-accessible materials (Braille, large-print, tactile graphics, audio, sign language, and captioned video) and for donor investment in locally adapted, context-specific materials, not only global resources.

Capacity Strengthening & Technical Support

- Support technical assistance and mentorship for community-led organizations to select, adapt, and maximize use of digital tools and innovative formats in ways that are safe, inclusive, and sustainable.

Visual and interactive resources are critical for translating complex medical information into accessible, relatable content. Infographics and animations help simplify ART regimens and prevention options. Gamification and quizzes increase engagement and retention, especially among adolescents. Digital storytelling enables people living with HIV to share their experiences, build empathy, and normalize treatment. Comics and illustrated booklets have improved prevention knowledge among young gay, bisexual, and other men who have sex with men in sub-Saharan Africa. Emerging tools, such as virtual reality and chatbots, offer personalized, confidential HIV education, especially for young people and hidden populations.

None of these innovations is effective without adaptation and accessibility. HIV literacy materials must be co-created and validated with communities and adapted to local languages, literacy levels, and cultural norms, while intentionally promoting equality, rights, and inclusion. Digital content must be mobile-friendly and, where possible, available offline to address connectivity gaps. Disability inclusion—through large print, Braille, tactile graphics, and audio—is essential to ensure that no one is left behind. Despite rapid digital advances, print materials remain indispensable, particularly in rural, humanitarian, and under-resourced settings and should be used in synergy with digital formats.

Taken together, these innovative approaches show that HIV literacy is strongest when digital tools, peer leadership, visual/interactive formats, and adapted materials are combined in ways that are community-led, rights-based, and tailored to local contexts.

Monitoring HIV Literacy Programs

KEY POINTS

- Monitoring HIV literacy is a scientific and participatory process that measures what communities know, understand, and believe about HIV and how this shapes service uptake and outcomes.
- Effective measurement combines quantitative tools (such as surveys, knowledge-attitudes-practice [KAP] studies and digital analytics) with qualitative and participatory approaches (peer-led research, community listening, and storytelling).
- Evidence from multiple settings shows that HIV literacy is directly correlated with ART adherence, prevention uptake (PrEP, condoms, and HIV self-testing), and reductions in HIV-related stigma, gender inequalities, and human rights barriers.
- Monitoring should be linked to community-led monitoring (see “Community-led Monitoring” for more information) to ensure that findings drive accountability, advocacy, and improvements in service quality.
- Monitoring tools must be able to capture intersectional experiences, including those based on gender, age, key population status, disability, and other inequalities.

Advocacy Areas

- Advocate for HIV literacy indicators to be integrated into national monitoring and evaluation frameworks, Global Fund reporting systems, and other major HIV accountability mechanisms.
- Push donors and governments to fund community-led HIV literacy assessments as a routine part of program design, implementation, and review.
- Promote investments in digital platforms (apps, SMS, in-app polls, and chatbots) that enable real-time monitoring of community knowledge, perceptions, and information needs.
- Call for peer-led evaluation mechanisms and advisory boards to ensure trust, accuracy, and accountability in how HIV literacy data are collected, interpreted, and used.
- Advocate for gender- and age-disaggregated data and a rights-based approach that captures human rights barriers and gender inequalities and assesses their impact on access, outcomes, and meaningful participation.

Overview of Monitoring HIV Literacy Programs

HIV outcomes are shaped not only by the availability of services, but also by HIV literacy—the ability of individuals and communities to access, understand, and apply information on HIV prevention, treatment, and rights. Monitoring HIV literacy is, therefore, essential for responsive, evidence-based programming.

A range of measurement approaches can be used:

- Quantitative instruments, such as population-based surveys, KAP assessments, and psychometrically validated HIV literacy scales (for example, the Mozambique HIV Literacy Test), provide population-level indicators of knowledge, misconceptions, and information gaps.
- Digital analytics (web traffic, app engagement, SMS responses, social media metrics, and chatbot interactions) offer real-time insights into which messages are being accessed and by whom and where gaps remain.
- Qualitative methods, including community dialogues, storytelling, participatory workshops, and ethnographic research, uncover lived experiences, structural barriers, stigma, and gender inequalities that shape literacy and behavior.
- Participatory approaches, such as peer-led data collection, community advisory boards, and co-designed monitoring tools, strengthen trust, ownership, and the relevance of findings.

Feedback loops are crucial. SMS surveys, WhatsApp groups, and in-app polling allow for rapid adjustments to content and delivery strategies. Social network analysis can help identify trusted messengers and information pathways, supporting the amplification of credible information and countering misinformation.

Monitoring HIV literacy complements the “Community-led Monitoring” chapter. While CLM documents rights violations, service quality issues, and systemic barriers, HIV literacy monitoring provides behavioral and knowledge-level evidence. Together, they form a cycle of evidence-to-advocacy, ensuring that HIV services are accountable, rights-based, and responsive to community needs and priorities.

13

Sustainability and Scalability of Efforts to Improve HIV Literacy

Critical Community Leadership

KEY POINTS

- Community engagement is central to the effectiveness, legitimacy, and long-term sustainability of HIV literacy programs.
- Engagement is a participatory process through which communities share power with health systems to improve outcomes.
- Social networks and digital platforms amplify community voices and extend program reach.
- Youth-led and intersectional approaches strengthen sustainability, inclusivity, and responsiveness to diverse needs.

Advocacy Areas

Community leadership is a cornerstone of an effective, accountable, and sustainable HIV response. When communities are formally recognized, resourced, and meaningfully included in decision-making, HIV programs are more responsive, equitable, and impactful. The following advocacy priorities focus on institutionalizing community leadership, strengthening participation, and ensuring sustained investment in community-led action.

Policy Recognition & Institutionalization

- Advocate for the formal recognition and integration of community leadership as a core pillar of the HIV response within national strategies, budgets, and contracting frameworks, ensuring sustained support for community-led organizations.

Participation & Shared Decision-Making

- Push for institutionalized community consultation mechanisms (for example, advisory boards, participatory budgeting, community councils, community consultative groups, and Key Populations Platforms).
- Demand meaningful inclusion of young people, women, gay and bisexual men, transgender people, people who use drugs, sex workers, people in closed settings, and other key, vulnerable and affected populations in all decision-making processes.

Overview of community leadership

Community engagement is not optional; it is a core determinant of program success. When communities lead, programs become more culturally relevant, trusted, and effective and their sustainability increases. Community-led approaches strengthen accountability, expand reach, and promote rights-based, inclusive responses.

Key elements include:

- Social networks: Trusted peers provide channels for accurate information, emotional support, and risk reduction.
- Community-based and community-led organizations: These organizations bridge gaps between marginalized communities and formal health systems, delivering tailored services and advocating for structural change.
- Grassroots advocacy: Community mobilization drives legal reforms, including decriminalization and the strengthening of anti-discrimination protections.
- Digital engagement: Platforms such as WhatsApp and Facebook extend peer education, psychosocial support, and rights advocacy.
- Intersectional approaches: Effective HIV responses must address overlapping inequities related to gender, sexual orientation, race, class, disability, and migration status.
- Youth leadership: Youth-led organizations are essential to sustaining HIV literacy and advocacy for future generations, including LGBTQ+ youth, young people living with HIV, adolescent and young women, sex workers, and young people who use drugs.

Financing & Accountability

- Promote financing models that allocate resources directly to communities and CBOs and/or community-led organizations (CLOs), strengthening program ownership and accountability.

Capacity Strengthening & Sustainability

- Support ongoing capacity-building for peer educators and community leaders to sustain HIV literacy and advocacy.

Capacity Building in HIV Literacy for CBOs and CLOs

KEY POINTS

- CBOs/CLOs play a pivotal role in delivering HIV literacy programs adapted to cultural, linguistic, and community-specific needs.
- Capacity-building enables CBOs to sustain high-quality, evidence-based programming.
- Peer educators within CBOs provide trusted, relatable communication and strengthen program reach and engagement.

Advocacy Areas

- Advocate for sustained donor investment in CBO and CLO capacity-building, including technical assistance, leadership development, and long-term institutional strengthening.
- Promote development of toolkits, resource libraries, and training-of-trainers models to institutionalize knowledge and ensure continuity.
- Call for the integration of CBOs and CLOs into national health planning, monitoring, and evaluation structures.
- Push for equitable funding mechanisms that enable smaller community-led groups to access resources directly.
- Encourage peer-led mentorship and exchange programs between CBOs/CLOs to share lessons, innovations, and best practices.

Overview of Capacity Building for CBOs and CLOs

CBOs and CLOs are critical to ensuring that HIV literacy interventions are grounded in local realities. However, many operate with limited resources and require targeted investments to sustain their impact.

Effective capacity-building strategies include:

- Training in program design, implementation, monitoring, evaluation, and advocacy
- Access to shared resource libraries, digital learning platforms, and operational tools
- Training-of-trainers models that support continuous skill transfer
- Financial management and grant-writing support to strengthen resource mobilization

Evidence shows that well-supported community-led organizations not only expand the reach of HIV services but also improve trust, accountability, and policy influence. Investment in CBOs and CLOs is, therefore, both a sustainability strategy and a rights-based imperative.

Expanding and Scaling Pilot Programs

KEY POINTS

- Pilot programs must be rigorously evaluated before scale-up to ensure effectiveness, efficiency, and community acceptability and appropriateness
- Scaling requires strong partnerships among governments, donors, and CBOs/CLOs, with mechanisms to ensure that smaller grassroots organizations remain engaged during expansion.
- Standardization of core components allows consistency while preserving flexibility for local adaptation.
- Digital platforms and e-learning accelerate replication, training, and dissemination of best practices.

Advocacy Areas

- Advocate for pilot programs to include robust evaluation frameworks, cost-effectiveness analyses, and participatory methods that involve community stakeholders.
- Advocate for phased national roll-out of proven models from the outset—securing government commitment, integration into national policies and budgets, and sustainable financing to ensure pilots transition into long-term, institutionalized services rather than ending when project funding stops.
- Push for government and donor investment in scaling proven community-led HIV literacy pilots.
- Promote integration of successful pilot models into national HIV strategies and health systems to ensure sustainability beyond project cycles.
- Call for digital platforms and e-learning tools to facilitate scalable training, knowledge transfer, and program dissemination.
- Encourage inclusion of peer and youth networks in monitoring, adaptation, and advocacy during scale-up.

Overview of Expanding and Scaling Pilot Programs

Pilot programs are essential for innovation but must be strategically transitioned into national and regional programs to achieve sustained impact.

Core elements of successful scale-up include:

- Rigorous evaluation: Pilots should include baseline, midline, and endline assessments, mixed-method evaluations, and cost-benefit analyses.
- Government partnership: Scale-up is most successful when pilots are embedded in national HIV strategies, budgets, and implementation plans.
- Standardization and adaptation: While core interventions must be standardized, delivery should be adaptable to cultural, legal, and epidemiological contexts.
- Digital scale-up: Virtual training, e-learning platforms, and digital communities of practice facilitate rapid replication and capacity-building across diverse settings

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14 Future Challenges and Resilience

Climate Change, Humanitarian Settings, Pandemics, and HIV Resilience

KEY POINTS

- Climate change, pandemics, and humanitarian crises intensify vulnerabilities for people living with and affected by HIV, heightening stigma, discrimination, social exclusion, gender-based violence, and social disruption.
- Crises trigger service interruptions, displacement, food insecurity, and increased vulnerability to opportunistic infections and other illnesses; shifts in survival strategies (such as transactional sex) heighten HIV transmission risks.
- HIV programs that integrate resilience planning, such as supply chain security, digital tools, decentralized services, and task shifting, are better able to withstand shocks.
- Community-based and community-led organizations play a frontline role in crisis adaptation, stigma reduction, and equitable response.

Advocacy Areas

- Advocate for integrating climate, pandemic and emergency resilience into national programs and strategies, including for HIV
- Ensure that HIV is included in humanitarian analysis, planning, and prioritization during humanitarian reset processes.
- Push donors to fund preparedness, response, and recovery efforts, including supply-chain fortification, decentralized care, community interventions, and climate- and emergency-smart health facilities.
- Call for global mechanisms to monitor and mitigate health inequities intensified by climate change and pandemics.
- Elevate community voices in climate, humanitarian, and emergency health policymaking, recognizing their essential role in resilience.

Overview of HIV Resilience

Climate change and pandemics act as multipliers of HIV vulnerability. Extreme weather events displace communities, disrupt supply chains, and worsen malnutrition, increasing susceptibility to HIV transmission and disease progression. Pandemics, such as COVID-19, destabilize health systems, redirect funding, and reduce access to essential services.

Evidence shows that resilient HIV programs:

- Deploy decentralized and differentiated service delivery to protect ART continuity.
- Use digital tools, including telemedicine and mHealth, for uninterrupted care.
- Integrate HIV into disaster preparedness, climate adaptation, and humanitarian response plans.
- Support community networks and CBOs and CLOs as first responders, ensuring continuity of treatment literacy, linkage, and CLM even during crises.

Without proactive resilience planning, hard-won gains in prevention and treatment are at risk. Strengthening community-led organizations—often the only actors able to maintain services during emergencies—is essential for future-proofing the HIV response.

Resource Mobilization and the Current Funding Landscape

KEY POINTS

- Global HIV funding has declined dramatically, creating significant resource gaps that jeopardize program sustainability.
- Donor fatigue and competing global priorities, including pandemics, climate change, and geopolitical crises, further threaten HIV investments.
- Community-led organizations, despite their central role, are disproportionately harmed by funding instability.
- Innovative and diversified financing models are urgently needed to sustain progress.

Advocacy Areas

- Push for earmarked domestic resources for community-led responses within national HIV budgets.
- Promote innovative and diversified financing mechanisms (for example, social impact bonds, blended finance, and private sector engagement).
- Call for transparency and accountability in donor allocations to ensure equitable distribution of resources.
- Ensure sustainable transition strategies when funding shifts occur, including required impact assessments and accountability for reductions.
- Use community-led monitoring evidence to advocate for equitable funding and resource allocation.

Overview of Resource Mobilization and Funding

Global HIV funding has plateaued, with a persistent annual shortfall of more than USD 8 billion needed to meet the 2025 global targets. Meanwhile, program costs are rising due to expanded treatment needs, new prevention technologies, and climate- and pandemic-related service adaptations. The UNAIDS Global AIDS Strategy called for at least 30% of HIV services to be community-led by 2025, yet progress remains far behind this target.

Funding cuts in early 2025 forced over 60% of surveyed women-led HIV organizations to reduce or suspend services. Across 14 countries, rapid assessments show major declines in community treatment literacy, interrupting activities, such as viral-load demand creation, PrEP/CAB-LA counselling, and advanced HIV disease literacy. Several CLM platforms across Africa, Latin America and the Caribbean, and Eastern Europe and Central Asia lost core operational funding, weakening early-warning systems for stockouts of ARVs and laboratory commodities. These disruptions demonstrate how cuts to community-led programming directly undermine service uptake, treatment continuity, and navigation of an increasingly complex HIV landscape.

Persistent donor fatigue, shifting global priorities, continued dependence on a small number of major funders, and limited domestic resource mobilization remain major challenges for sustaining HIV responses. Yet, there are promising opportunities: countries are gradually expanding domestic financing through UHC reforms and broadening fiscal space for health; private sector partnerships and workplace HIV programs are strengthening; innovative financing tools, such as social impact bonds and catalytic funds, are beginning to emerge; and program efficiencies are increasingly achievable through innovation and science, service integration, optimized supply chains, and task shifting. Still, without renewed and diversified financing, progress on HIV literacy, innovation, and rights-based community programming is stalling.

Principles for Collaboration and Advocacy

KEY POINTS

- Sustained progress requires multisectoral collaboration that places communities at the center.
- Partnerships across governments, donors, civil society, and communities must be grounded in equity, trust, transparency, and accountability.
- Advocacy must prioritize human rights, gender equality, community leadership, evidence-based practice, and resilience planning.

Advocacy Areas

- Advocate for “communities at the center” as a global standard for HIV and broader health system strengthening.
- Push for stronger cross-sector alliances (health, education, labor, environment, justice, social protection) to address structural determinants, including human rights, gender equality, and social protection.
- Demand robust accountability mechanisms that track commitments to human rights, gender equality, community leadership, stigma reduction, and equitable funding.

Overview of Collaboration and Advocacy

The HIV response has shown that progress is possible when collaboration is community-led, rights-based, and rooted in evidence. The next phase must integrate HIV within broader global health, climate, development, and humanitarian agendas, while protecting the unique needs of key populations and people living with HIV.

Core principles for success include:

- Equity: Prioritizing marginalized communities in policy, program design, and funding
- Evidence: Aligning with WHO, UNAIDS, and the latest scientific guidance
- Human rights: Removing punitive laws and addressing discrimination and gender inequalities
- Resilience: Building HIV programs that can withstand climate, pandemic, economic, and political shocks

Conclusion

The HIV epidemic remains one of the most urgent public health and human rights challenges of our time. It is also one of the clearest examples of what is possible when communities, governments, and global partners act collectively.

The evidence is clear:

- Communities must remain at the center. Networks of people living with HIV and key and affected populations, including women, girls, and gender-diverse people, are essential designers, innovators, implementers, and advocates.
- HIV literacy is foundational. Empowered communities can access, understand, and apply information to drive prevention, testing, treatment, and resilience.
- Resilience is essential. Climate change, pandemics, and political instability require programs that can adapt and sustain gains.
- Sustainable financing is urgent. Without renewed and diversified investment, global HIV targets will remain out of reach.

The path forward is not only about sustaining progress, but about reimagining resilience, equity, and justice in the HIV response. Achieving the end of AIDS as a public health threat requires bold advocacy, smarter investment, and unwavering commitment to communities.

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✉ admin@itpcglobal.org

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@itpc.bsky.social