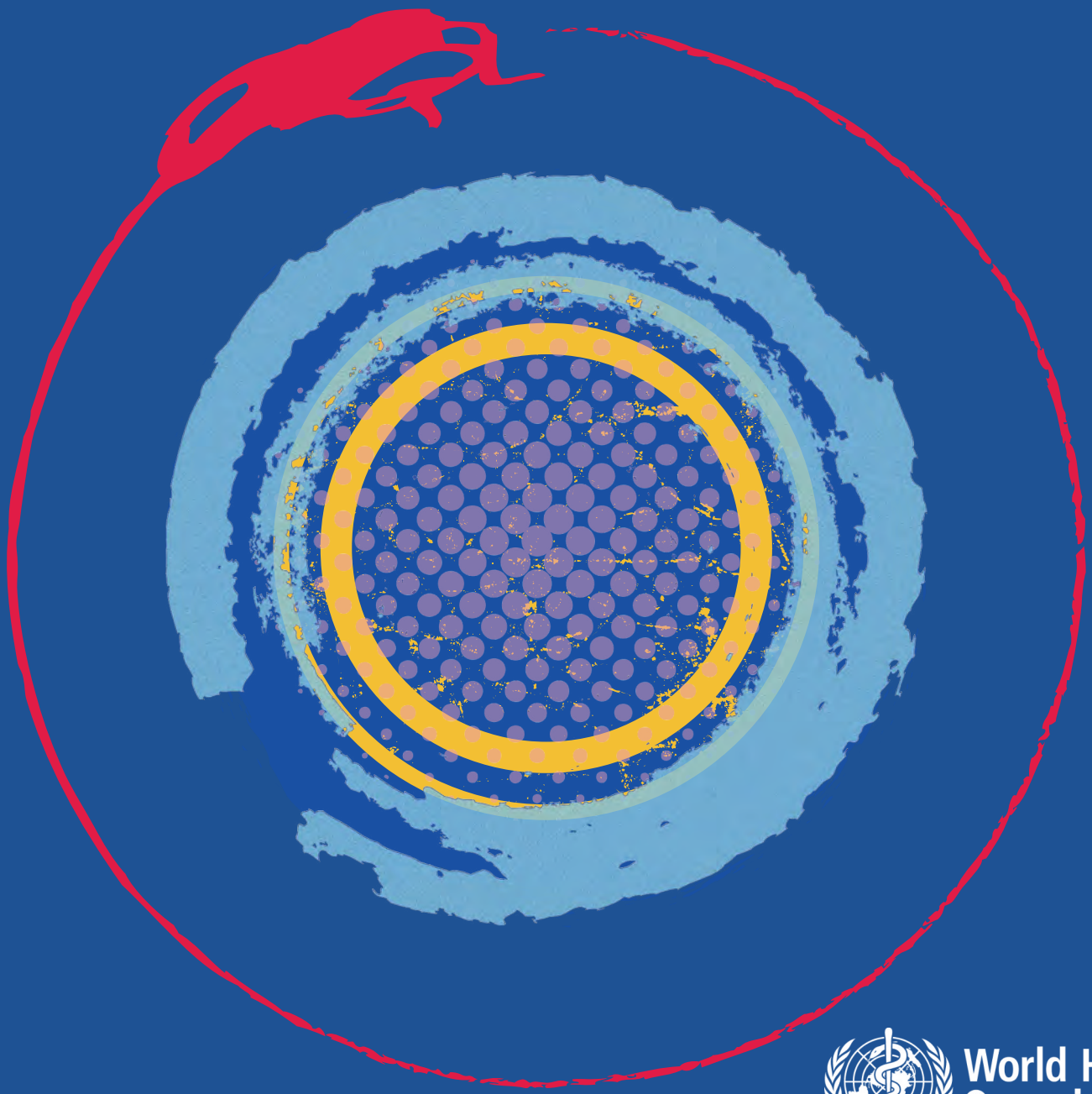
Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, 2022–2030

2026 mid-term progress report



World Health Organization

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Contents

Dr Tedros Adhanom Ghebreyesus
Director-General
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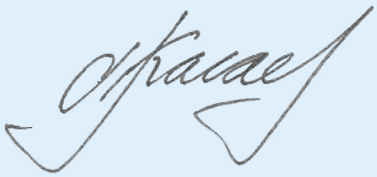
This report tells two stories. It demonstrates what is possible when countries invest in health, communities and science. But it also shows how quickly progress can be undone with funding disruptions, humanitarian emergencies and persistent inequalities. Over the next five years, we must build integrated, resilient health systems that reach those furthest behind and ensure HIV, hepatitis and STI services remain available in every setting.

Dr Tereza Kasaeva
Director
Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections

This assessment is more than a progress report – it is a practical guide for action for the second half of this strategy period. It highlights where countries are succeeding, where progress is stalling, and where investments can have the greatest impact. Together with our new consolidated HIV service delivery and HIV surveillance guidance, WHO is equipping countries with practical tools to strengthen programmes today and reach the people and communities who need them most.



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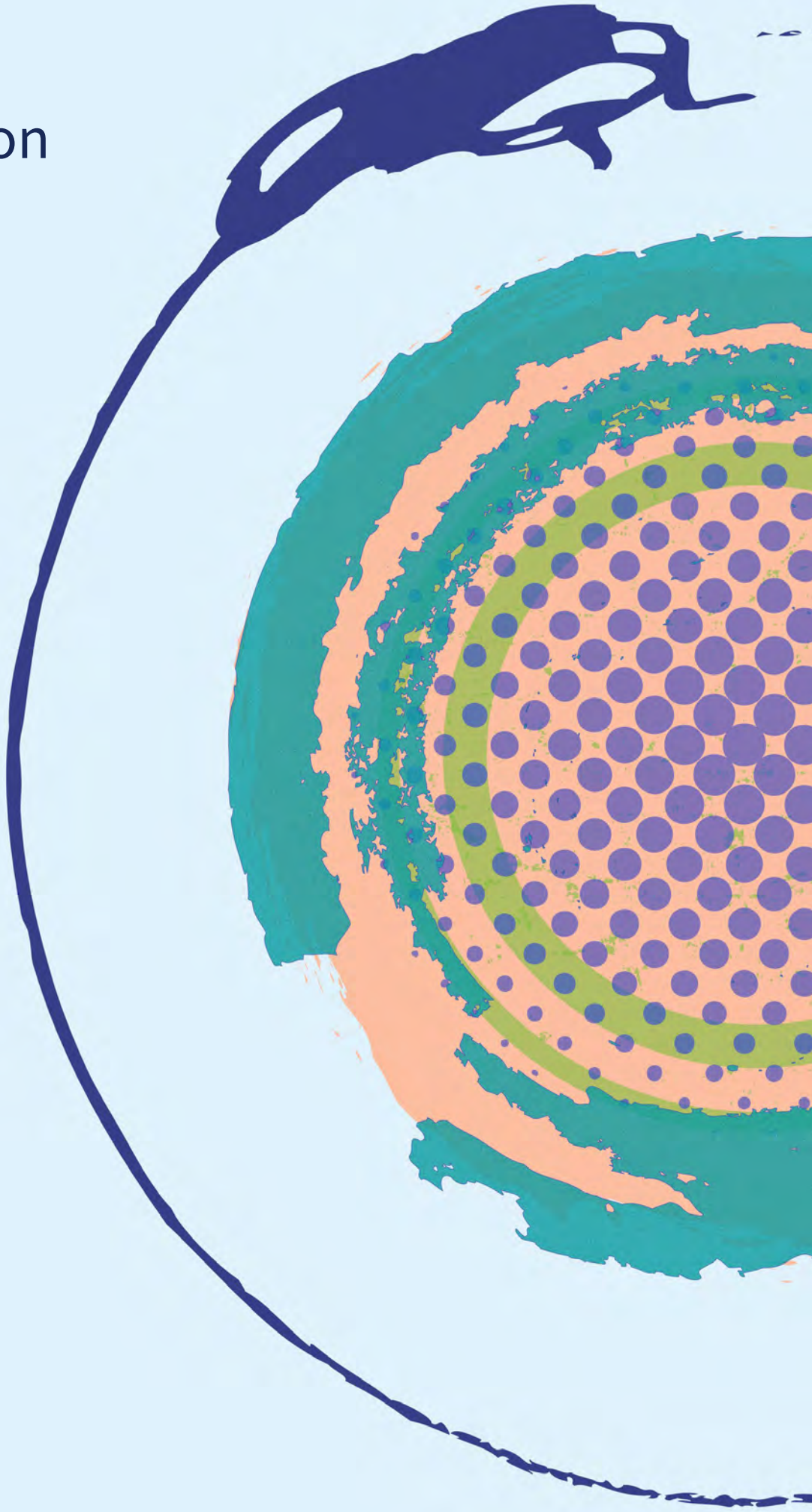
Abbreviations

AHD	advanced HIV disease
AI	artificial intelligence
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ART	antiretroviral therapy
ARV	antiretroviral
COVID-19	coronavirus disease 2019
DAA	direct-acting antiviral
DTG	dolutegravir
EASL	European Association for the Study of the Liver
EGASP	Expanded Gonococcal Antimicrobial Resistance Programme
EU	European Union
FTC	emtricitabine
GAM	Global AIDS Monitoring
GHSS	*Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030*
GNI	gross national income
HBV	hepatitis B virus
HCC	hepatocellular carcinoma
HCV	hepatitis C virus
HDV	hepatitis D virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV	herpes simplex virus
LMICs	low- and middle-income countries
MIC	minimum inhibitory concentration
NSP	national strategic plan
OAMT	opioid agonist maintenance treatment
ODA	official development assistance
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
R&D	research and development
SDG	Sustainable Development Goal
STI	sexually transmitted infection
TB	tuberculosis
TDF	tenofovir disoproxil fumarate
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1

Introduction



HIV, viral hepatitis and sexually transmitted infections (STIs) continue to impose a large burden on global health. Together, they are responsible for the deaths of about 2.3 million people each year,[1] alongside substantial morbidity and long-term disability. More than 1 million cases of four curable STIs[2] are estimated to occur each day, and about 3 million people acquire HIV, hepatitis B virus (HBV) or hepatitis C virus (HCV) annually. There are major overlaps in modes of transmission, as well as in the populations that are most affected and the health services that they need.

In 2015, all Member States of the United Nations (UN) committed to ending AIDS by 2030 as part of the Sustainable Development Goals (SDGs) *(1)*. This commitment has been embedded in successive global strategies developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) *(2–4)*, and reaffirmed in political declarations at UN high-level meetings on HIV *(5, 6)*.

All Member States of the World Health Organization (WHO) have committed to the goal of eliminating viral hepatitis as a public health threat by 2030, initially in a 2014 resolution at the World Health Assembly and subsequently through their adoption of the first global strategy on viral hepatitis, which was for 2016–2021 *(7, 8)*. The focus of this strategy was HBV and HCV, because they account for more than 95% of hepatitis-related deaths.

The WHO global health sector strategy on STIs for 2016–2021 had the long-term goal of ending STIs as a major public health concern, and it defined corresponding targets for 2030 *(9)*.

In 2021, WHO developed a new and consolidated set of strategies: the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (GHSS) *(10)*. The goal was defined as "End AIDS and the epidemics of viral hepatitis and sexually transmitted infections by 2030", and corresponding 2030 targets were set for reductions in disease burden and improvements in service coverage. WHO Member States noted these strategies with appreciation at the World Health Assembly in 2022 and requested progress reports in 2024, 2026, 2028 and 2031 *(11)*.

Following reporting in 2024 *(12)*, this 2026 report provides a mid-term assessment of progress.[3] The report is organized in five major chapters.

Chapter 2 provides an overview of the GHSS and highlights how a changed (and changing) wider context is affecting efforts to end the HIV, viral hepatitis and STI epidemics at global and national levels.

Chapter 3, **Chapter 4** and **Chapter 5** discuss the disease-specific strategy components: HIV, viral hepatitis and STIs, respectively. Each chapter covers the same topics:

- epidemic status and trends, with a focus on progress towards 2030 targets for reductions in disease burden;
- service coverage, with a focus on progress towards 2030 targets for improvements in access to prevention, diagnosis and treatment;
- WHO guidance and support for strategy implementation between 2022 and 2026; and
- critical issues and priorities for action in the years up to 2030.

Chapter 6 assesses progress in the shared approaches needed for a people-centred response. These approaches include sustaining services through primary health care, universal health coverage and integrated systems; strengthening services related to prevention; triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis; provision of harm reduction services; integrated surveillance, data systems and use of artificial intelligence (AI); and facilitating equitable access to vaccines, diagnostics and medicines.

The report is based on data reported to WHO by Member States in annual rounds of data collection; data gathered by the UNAIDS secretariat, WHO and the United Nations Children's Fund (UNICEF) through the Global AIDS Monitoring system; estimates of disease burden published by UNAIDS; data and estimates published in WHO's *Global hepatitis report 2026 (13)*; and data from the WHO Global Health Observatory.[4]

The report's main findings and messages are summarized in **Box 1.1**.

[1] This includes about 1.3 million deaths from viral hepatitis, about 0.6 million HIV-related deaths, and about 0.35 million STI-related deaths *(14,15)* resulting from human papillomavirus (HPV) and syphilis infections.

[2] These are syphilis, gonorrhoea, chlamydia and trichomoniasis.

[3] It expands on a report to the 79th World Health Assembly (A79/24).

[4] Further details about data sources are provided in **Annex 1**.

BOX 1.1.

Main report findings and messages

Background and context

- Ending the epidemics of HIV, viral hepatitis and STIs as global public health threats or concerns is achievable with available interventions for prevention, diagnosis and treatment, and the GHSS defined 2030 targets accordingly.
- Between 2022 and 2026, the midpoint of the strategy period, the wider context was reshaped. Changes (often interrelated) with major implications for efforts to end the HIV, viral hepatitis and STI epidemics include the following: shifting geopolitics; reductions in international donor funding; more emphasis on domestic funding for the health sector in low- and middle-income countries (LMICs), and integrated approaches to service delivery; more restrictive policies on gender, sexuality, reproductive rights and key populations in some countries; UN reform; scientific progress; and technological innovation.

Overarching findings

- Progress towards the 2030 targets is mixed, ranging from impressive gains to worsening trends.
- Globally, the best progress has been in reducing the number of HIV-related deaths and the number of people acquiring HIV, following the enormous scale-up of antiretroviral therapy (ART) for people living with HIV. There has also been a large reduction in the number of people acquiring chronic HBV infection, owing to substantial improvements in the coverage of hepatitis B vaccination (at birth and in infancy).
- The number of HBV-related deaths is increasing, while reductions in HCV-related deaths are relatively modest. Treatment coverage for people with HBV and HCV infection lags far behind ART coverage for people living with HIV. Available evidence suggests that the incidence of syphilis and gonorrhoea is rising.
- Reductions in international donor funding since 2025 present a severe challenge, especially to the HIV response.

HIV

- Globally in 2025, 1.2 million people (95% uncertainty interval [UI]: 0.95–1.7 million) acquired HIV. This was a 42% reduction compared with 2010 and almost halfway to the target of a 90% reduction by 2030.
- Close to half of new infections (and about 70% of infections outside sub-Saharan Africa) are among key populations and their partners. The key populations are men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings.
- Globally in 2025, 570 000 people (95% UI: 430 000–780 000) died from HIV-related causes. This was a large reduction of 57% compared with 2010, following impressive progress in the provision of ART to people living with HIV. To reach the 2030 target of a 90% reduction, the annual number of HIV-related deaths needs to be reduced to about 130 000.
- Globally in 2025, there were 41 million people (95% UI: 35–48 million) living with HIV, of whom 53% were women and girls and 64% were in the WHO African Region.
- In 2025, 88% of people living with HIV knew their status; among these people, 89% were on ART, and 95% of those on ART had a suppressed viral load, close to the "95–95–95 targets".
- A total of 32 million people (95% UI: 28–33 million) were on ART by the end of 2025, an increase from about 8 million in 2010. However, there were still 9 million people living with HIV (22% of all people living with HIV) who were not on ART.
- ART coverage is lower among men than among women, and lower among children than among adults.
- Achieving the 2030 global targets for reductions in the number of people acquiring HIV and HIV-related deaths requires closing gaps in ART coverage, and substantial strengthening of HIV prevention efforts (beyond treatment and viral suppression among those already living with HIV), especially among key populations. Prevention options include long-acting pre-exposure prophylaxis (PrEP).
- In 2024, global funding for the HIV response amounted to US$ 18.7 billion, of which 48% was international donor funding. In 2025, cuts to international donor funding had negative impacts on HIV prevention, HIV testing, ART initiation, laboratory testing, human resource capacity, community-based services and HIV data systems for monitoring.
- Domestic financing in high HIV burden countries is critical to sustain and strengthen the HIV response.
- A new global AIDS strategy is available to guide the HIV response in the period 2026–2031.

Viral hepatitis

- Almost all chronic HBV infections can be prevented through hepatitis B vaccination in infancy, and almost everyone with HCV infection can be cured with a short course of antiviral treatment. Nonetheless, viral hepatitis remains one of the few major communicable diseases for which mortality is increasing.
- In 2024, an estimated 1.3 million people died from the sequelae of chronic HBV and viraemic HCV infection (cirrhosis and hepatocellular carcinoma, HCC). This included 1.1 million (95% UI: 0.9–1.3 million) HBV-related deaths, an increase of 17% compared with 2015. The number of HCV-related deaths fell by 12% in the same period, to 240 000 (95% UI: 160 000–370 000) in 2024.
- In 2024, 240 million people (95% UI: 202–296 million) were living with chronic HBV infection and 47 million people (95% UI: 31–71 million) with viraemic HCV infection (2.9% and 0.6% of the global population, respectively).
- HBV- and HCV-related cirrhosis and HCC are the result of infections acquired 20–30 years earlier. The only way to achieve the 2030 targets of reducing both HBV- and HCV-

related deaths by 65% compared with levels in 2015 is to massively expand the provision of antiviral treatment (lifelong for chronic HBV infection and 12 weeks for HCV infection).

- Major gaps in diagnosis and treatment persist. By the end of 2024, only 27% of people living with chronic HBV infection and 36% of people living with viraemic HCV infection had been diagnosed. Treatment coverage in 2024 was 4.3% for people with chronic HBV infection and 20% for people with HCV infection.
- In the longer term, the best way to reduce the number of HBV- and HCV-related deaths is to reduce the number of people acquiring HBV and HCV infections. This is also necessary to achieve the 2030 targets for reductions in incidence and prevalence.
- Globally in 2024, 0.9 million people (95% UI: 0.7–1.2 million) acquired a chronic HBV infection; this was a decline of 32% from 2015, largely owing to improved coverage of hepatitis B infant vaccination (84% in 2024). The WHO African Region accounted for 68% of new infections in 2024.
- Most chronic HBV infections are acquired in the first 5 years of life, through mother-to-child transmission or person-to-person contact in the presence of open cuts and sores. The global prevalence of HBV infection in children aged under 5 years was 0.6% in 2024, a reduction from 0.8% in 2015 but still far from the 2030 target of 0.1%. The prevalence was much higher in the WHO African Region (1.4%). Worldwide, 85 countries have a prevalence of less than 0.1%.
- Achieving the 2030 global target of a 95% reduction in HBV incidence (compared with 2015) requires a large improvement in birth-dose coverage of the hepatitis B vaccine in the WHO African Region. Coverage was only 17% in 2024, and 20 of the 47 countries in the region were not yet implementing birth-dose vaccination.
- Globally in 2024, 0.9 million people (95% UI: 0.6–1.4 million) acquired HCV infection, a decline of 8% compared with 2015 and far from the target of an 80% reduction by 2030. Transmission is driven by injecting drug use and, in some settings, unsafe medical and nonmedical injections.
- Urgent action to improve the coverage of available interventions and reverse the current rise in HBV-related mortality is needed, especially in countries with the highest burden.

STIs

- Collecting reliable data about STIs is challenging. Infections are often asymptomatic, syndromic management does not yield etiological diagnoses, laboratory confirmation requires infrastructure that is not available in many settings and stigma drives underreporting. In LMICs, these challenges are compounded by limited diagnostic capacity, inadequate funding of STI programmes and fragmented health information systems.
- Even in high-income countries, surveillance of major STIs remains limited or absent. Infections are rarely notifiable and standardized reporting systems are lacking.
- These data challenges hinder assessment of progress towards targets for reductions in the incidence of STIs and improvements in the coverage of prevention, diagnostic and treatment services. The data that are available suggest that progress is mostly off track, with worsening trends for some indicators.
- In 2020, there were an estimated 374 million new cases of the four curable STIs (syphilis, gonorrhoea, chlamydia and trichomoniasis) in adults aged 15–49 years. WHO estimates for more recent years are not available, but systematic reviews and data from high-income countries indicate that the number of cases of syphilis and gonorrhoea is rising.
- Antimicrobial resistance (AMR) to *Neisseria gonorrhoeae* remains a critical threat: several countries, particularly in Asia, have reported increased resistance to ceftriaxone, the first-line treatment, at levels of 5% and above.
- There have been improvements in the coverage of screening for syphilis among pregnant women (75% in 2024) and in the provision of treatment for this population (85% of those testing positive).
- Globally, full coverage of human papillomavirus (HPV) vaccination among girls by the age of 15 years reached 18% in 2024. This was a modest improvement from 13% in 2020 but still far below the 2030 target of 90%. Single-dose coverage is better, at 31%.
- The global coverage of screening (at least once) for cervical cancer among women aged 30–49 years was 38% in 2022.
- In the past 5 years, 85% of countries have updated their STI guidelines.
- Priorities for action in the years up to 2030 are expanded access to people-centred STI prevention, testing and treatment services; massive expansion of HPV vaccination, including through single-dose schedules; rapid translation of innovations into practice; and strengthened surveillance to guide policy.
- A review of the STI indicators and accompanying targets used for global monitoring is required.

Shared and integrated approaches

- HIV services have helped to strengthen health services more broadly in many countries. These include services for people with hepatitis B and hepatitis C, which have been integrated into HIV service delivery platforms in many countries, although often not countrywide.
- In 2025, Maldives became the first country validated by WHO to have eliminated mother-to-child transmission of HIV, hepatitis B and syphilis. Other countries have been validated for elimination of mother-to-child transmission of HIV and syphilis (17 countries), HIV and

hepatitis B (one country), HIV only (three countries) and syphilis only (one country).

- At national level, there is growing emphasis on the importance of digital systems, on disease surveillance using systems that are digital and interoperable, and on ensuring that surveillance of specific diseases is done within one integrated system. AI has the potential to transform many aspects of health care.
- Generic versions of medicines and diagnostics have helped to expand access to treatment for HIV, hepatitis B and hepatitis C. However, concerns about inequity in access persist in middle-income countries, and for other commodities such as long-acting HIV PrEP, HPV vaccines and hepatitis diagnostics.

Conclusions

- The world is not yet on track to end HIV, viral hepatitis or STIs as public health threats or concerns by 2030.
- The period from 2026 to 2030 is an opportunity for course correction, based on progress to date, gaps that still exist, lessons learned, new opportunities and the evolving wider context. Achieving the 2030 goals and targets will require increases in domestic funding in LMICs and action on multiple fronts.
- Together, Member States, civil society, communities, WHO and partner agencies can accelerate progress towards the 2030 goals, while also laying the foundations for a healthier, more equitable and more sustainable future beyond 2030.

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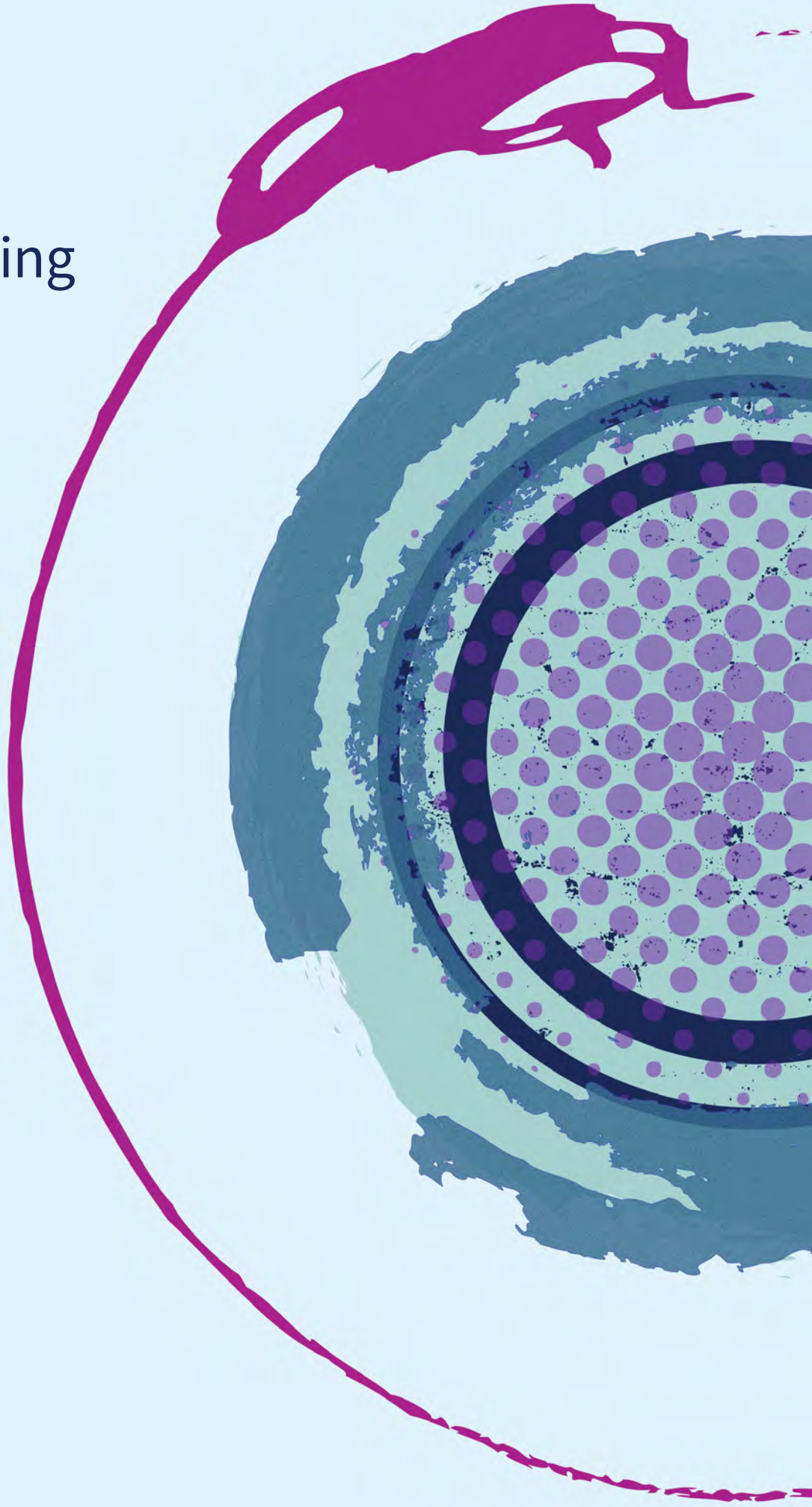
Chapter 2

Strategy overview and changing context



2.1 Strategy overview

The *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (GHSS) were developed throughout 2021 and noted with appreciation by the World Health Assembly in 2022 *(1)*.[1] The strategies have a common vision, disease-specific goals and shared strategic directions that include disease-specific actions (**Fig. 2.1**).

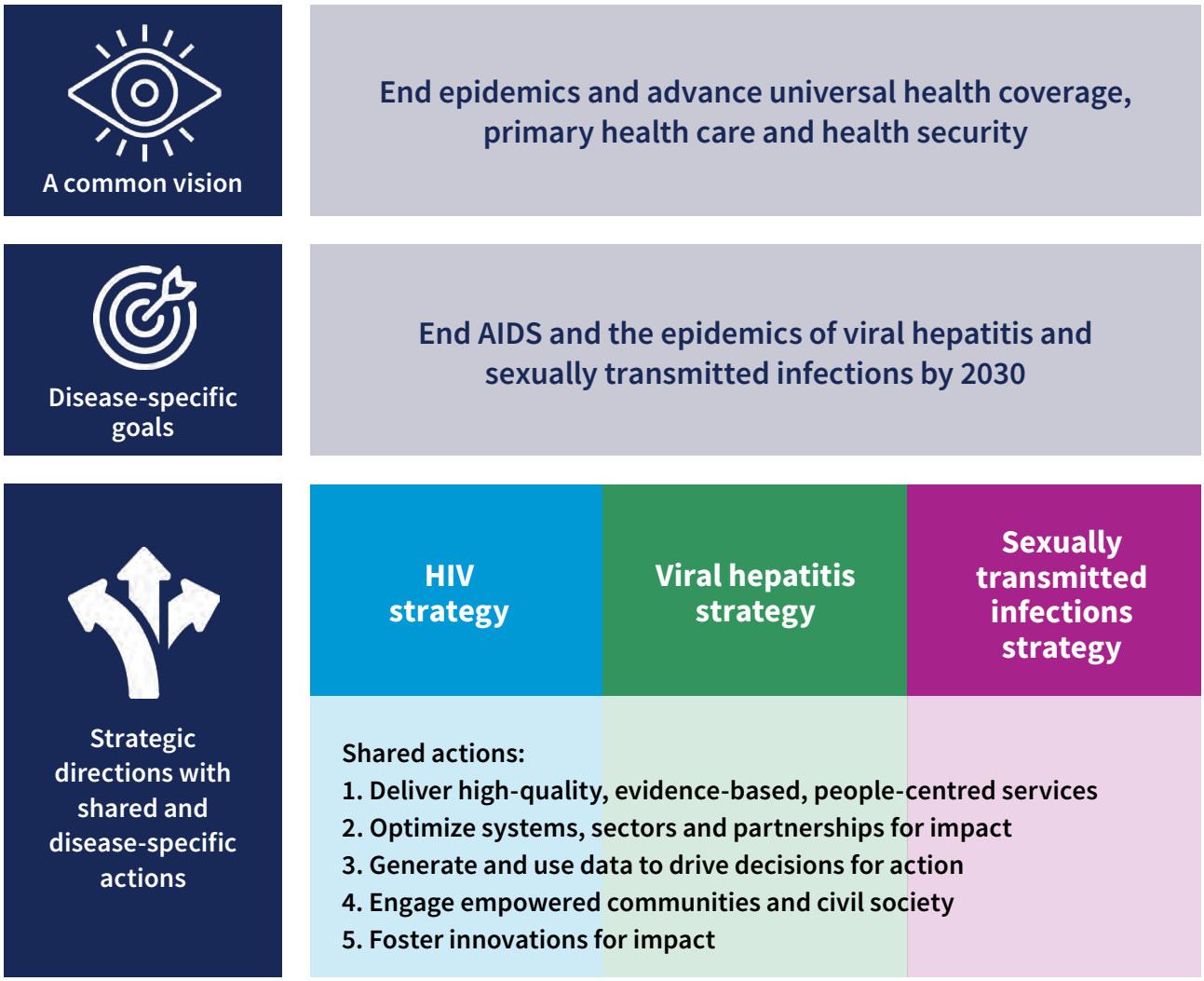
The common vision is to "end epidemics and advance universal health coverage, primary health care and health security". The disease-specific goals are to "end AIDS and the epidemics of viral hepatitis and sexually transmitted infections by 2030". These goals are aligned with the United Nations (UN) Sustainable Development Goals (SDGs) – in particular, Target 3.3 *(3)* – and contribute to broader SDG targets related to equity, gender equality and human rights.

The five strategic directions that provide the organizing framework for action are:

- delivery of high-quality, evidence-based, people-centred services;
- optimization of systems, sectors and partnerships for impact;
- generation and use of data to drive decisions for action;
- engagement of empowered communities and civil society; and
- fostering innovations for impact.

These strategic directions mark a deliberate transition from fragmented, disease-specific approaches towards integrated, system-based responses that are anchored in primary health care (PHC) and universal health coverage (UHC).

Fig. 2.1. The GHSS: a unified framework



AIDS: acquired immunodeficiency syndrome; GHSS: *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030*; HIV: human immunodeficiency virus.

Source: WHO 2022 *(1)*.

[1] The strategy development process from 2021 is documented elsewhere (*(2)* pp10).

The strategies are underpinned by a theory of change (Fig. 2.2), which emphasizes:

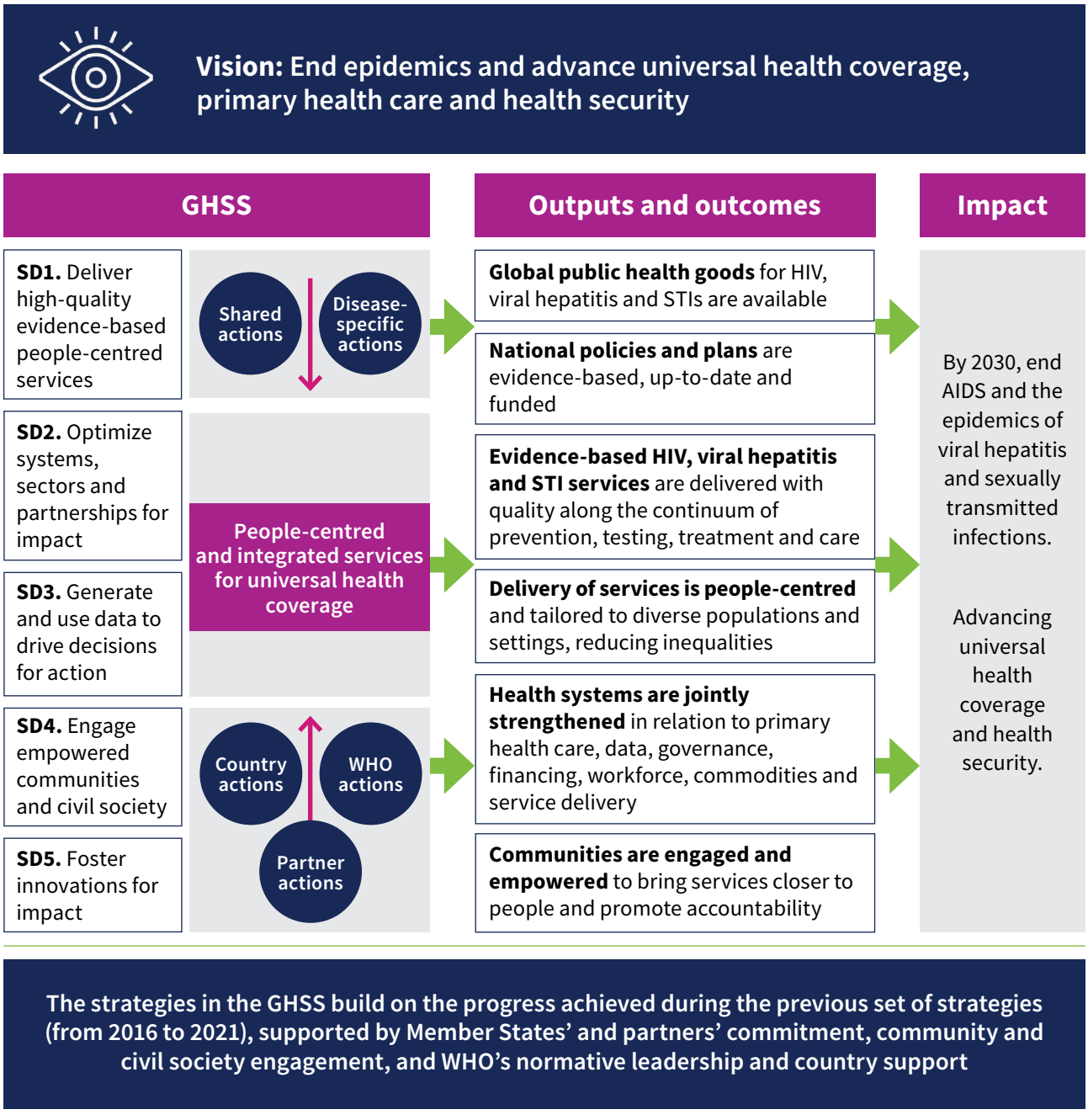
- integrated service delivery across prevention, testing, treatment and care;
- health system strengthening, including workforce, financing, governance and supply chains;
- community engagement and leadership, as central to access and accountability;
- data-driven decision-making, including person-centred and digital systems; and
- innovation, including new technologies and service delivery models.

This framework recognizes that disease-specific outcomes cannot be achieved or sustained without strong, resilient and equitable health systems.

The strategies include indicators and targets for:

- epidemiological impact; that is, reductions in incidence, prevalence and mortality;
- levels of service or intervention coverage, which are required to achieve the epidemiological targets; and
- policy uptake, planning and surveillance, which are required to support implementation of services and interventions, track progress and inform course correction.

Fig. 2.2. The GHSS: theory of change



AIDS: acquired immunodeficiency syndrome; GHSS: *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030*; HIV: human immunodeficiency virus; SD: strategic direction; STI: sexually transmitted infection; WHO: World Health Organization.

Source: WHO 2022 *(1)*.

They include both disease-specific indicators and indicators related to shared, integrated approaches that are common to HIV, viral hepatitis and sexually transmitted infections (STIs). The indicators, the targets and the latest data about the status of progress are discussed in detail in **Chapter 3** (HIV), **Chapter 4** (viral hepatitis), **Chapter 5** (STIs) and **Chapter 6** (shared approaches).

The strategies are closely aligned with broader global health and development frameworks, including:

- the World Health Organization's (WHO's) 14th General Programme of Work (GPW 14), which further reinforces country impact, resilience and equity *(4)*;[1]
- the 2030 Agenda for Sustainable Development, including cross-cutting goals (SDGs) and targets related to equity and leaving no one behind *(3)*;[5] and
- UN system reform and UN80[2] discussions, which emphasize efficiency, integration and country-level impact *(6)*.

The global health sector strategy on HIV was developed in alignment with the *Global AIDS strategy 2021–2026 (7)*.[3]

Together, these frameworks reinforce a common direction: integration, sustainability, equity, impact and country ownership.

The GHSS have been translated into regional frameworks in all six WHO regions (**Box 2.1**).

In accordance with its core functions, WHO's role in supporting GHSS implementation was defined as follows: strategic leadership and partnerships, public health advocacy and communication, norms and standards, innovation, technical support, and global monitoring and reporting.[4] WHO support for GHSS implementation is discussed in **Chapter 3**, **Chapter 4**, **Chapter 5** and **Chapter 6**;[5] additional details are provided in **Annex 2**.

BOX 2.1.

WHO regional frameworks to support strategy implementation

- WHO African Region: *Framework for an integrated multisectoral response to TB, HIV, STIs and hepatitis in the WHO African Region 2021–2030: report of the Secretariat (9)*
- WHO Region of the Americas: *Elimination Initiative 30+. Accelerating the elimination of communicable diseases in the Americas (10)*
- WHO South-East Asia Region: *Integrated regional action plan for viral hepatitis, HIV and sexually transmitted infections in South-East Asia; 2022–2026 (11)*
- WHO European Region: *Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030 (12)*
- WHO Eastern Mediterranean Region: *The regional action plan for the implementation of the global health sector strategies on HIV, hepatitis and sexually transmitted infections, 2022–2030 (13)*
- WHO Western Pacific Region: *Regional framework for reaching the unreached in the Western Pacific (2022–2030) (14)*; and *Regional framework for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis in Asia and the Pacific, 2018–2030 (15)*

2.2 Changing context

When the GHSS were considered by the WHO Member States in 2022, the world was emerging from the acute phase of the coronavirus disease (COVID-19) pandemic. Countries faced major disruptions to essential health services, widening inequalities, and health security and fiscal pressures, all of which set back progress towards the SDGs.

The COVID-19 pandemic was the biggest global shock to population health and health systems in generations *(16)*. Impacts on HIV, viral hepatitis and STI services included disruptions to HIV testing; diagnosis and treatment for people with hepatitis; harm reduction services; and STI screening and treatment services, particularly among vulnerable populations *(17, 18)*. Structural inequities within and between countries were also exposed (including unequal access to diagnostics, medicines and vaccines), highlighting the extent to which many public health systems, including those in high-income countries, are vulnerable to unexpected shocks.

The pandemic also accelerated important innovations and shifts in service delivery. Community-led responses expanded, models of differentiated service delivery[6] were scaled up, multi-month dispensing of medicines became more common, and the use of digital health approaches and real-time reporting became normalized. HIV programmes in particular demonstrated resilience and adaptability, with many countries maintaining treatment continuity despite severe disruptions to other health services *(20)*.

The COVID-19 pandemic and response efforts reinforced the importance of integrated, people-centred health systems; strong surveillance systems; local manufacturing capacity; a diversity of implementing partners; and sustained investments in preparedness and PHC.

[1] Previously, the strategies were also aligned with WHO's 13th Global Programme of Work (GPW 13) *(5)*.

[2] The UN80 Initiative – so called because it is now 80 years since the UN was founded – is about building a simpler, more effective and more coherent UN system that delivers better for people and the planet, at a time of shrinking resources and rising needs.

[3] The new Global AIDS Strategy, for the period 2026–2031, is discussed in **Chapter 3** *(8)*.

[4] See pp 92–94.

[5] There is a specific subsection on this topic in each chapter.

[6] Differentiated service delivery is an approach that simplifies and adapts HIV services to better serve the needs of people living with HIV and to optimize the available resources in health systems *(19)*.

In 2026, the mid-point of the GHSS, global and national responses to HIV, viral hepatitis and STIs are being further reshaped by geopolitical, financial, technological and societal change that has already been much more rapid and far-reaching than was anticipated in 2022.

The wider context is characterized by shifting geopolitical priorities and actions; reductions in funding for international development, including in the health sector; constraints on domestic funding for health; a growing emphasis on the importance of integrated delivery of health services and sustainability; changes in the global and national policy environment; reform of multilateral institutions, including or affecting those in the health sector; scientific advances; rapid technological innovation; and concerns about equity in access to commodities.

2.2.1 Geopolitics

Geopolitical developments have altered, and continue to change, the environment within which national and global responses to HIV, hepatitis and STIs are developed and implemented, with both direct and indirect impacts. The most obvious examples are changed priorities in countries that have been leading donors of funding for international development for decades, resulting in major reductions in bilateral and multilateral donor funding for health and other sectors (**Section 2.2.2**); and wars and conflicts that affect population health and health infrastructure.

2.2.2 International donor funding for health

Geopolitical developments have had a significant impact on official development assistance (ODA), including funding for the health sector. In 2025, global ODA amounted to US$ 174 billion, a 23% reduction from US$ 226 billion in 2024 *(21)*. Preliminary data indicate that ODA from the United States of America (USA) was reduced by 57% in 2025 compared with 2024, equivalent to about three quarters of the entire global reduction in ODA *(21)*. Other examples include a 23% cut to total ODA in France *(22)* and a cut in the share of gross national income (GNI) allocated for ODA in the United Kingdom of Great Britain and Northern Ireland (United Kingdom) (to 0.3% of GNI by 2027, down from about 0.5% in recent years) *(23)*.

Reductions in ODA are one of the most significant changes affecting the global and national responses to HIV, hepatitis and STIs since the GHSS were developed in 2022, with a particularly large impact on HIV *(24)*. At global level and in many countries with a high burden of HIV, the HIV response has relied substantially on financing from the United States President's Emergency Plan for AIDS Relief (PEPFAR, established in 2003) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund, established in 2002).

In the eighth replenishment of the Global Fund in 2025, donors pledged US$ 12.6 billion for 2026–2028, far short of the US$ 18 billion target (a shortfall of about US$ 5.4 billion) *(25–27)*. The pledges were about 20% lower than the US$ 15.7 billion raised in the previous cycle, reflecting a significant reduction in donor funding *(28)*. The United States government, which has historically contributed about one third of the contributions to the Global Fund, reduced its contributions, as did other leading donor countries.

Reduced and more uncertain financing threatens the continuity of services, causes workforce instability, weakens surveillance systems and risks reversing achievements to date. Cuts to funding threaten progress on diagnostics, vaccines, treatment access and outbreak surveillance for viral hepatitis and STIs, in addition to HIV. Reduced investment could lead to rising rates of infertility, pelvic inflammatory disease, cancers and antimicrobial-resistant gonorrhoea, while weakening capacity to detect and respond to future STI outbreaks *(29)*. For viral hepatitis, reductions in international donor funding risk destabilizing interconnected systems (e.g. harm reduction, screening, prophylaxis and treatment services) that have built on those developed for HIV *(30)*.

2.2.3 Domestic funding for health

Actions to mitigate the impact of the COVID-19 pandemic have had long-term economic consequences in some countries, including higher debt burdens. This has constrained domestic spending on health, including for scaled-up responses to HIV, hepatitis and STIs. Nonetheless, increased domestic funding for the HIV, hepatitis and STI response has become increasingly important in the context of reductions in international donor funding. In 2025, the United States government modified its global health assistance strategy to place greater emphasis on bilateral agreements, which require increased co-investment by recipient governments *(31, 32)*. The new Global AIDS Strategy 2026–2031, recently developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), includes an emphasis on domestic leadership and financing *(8)*.[1]

2.2.4 Integration and sustainability

Recent changes in the landscape of funding for health have underlined the importance of ensuring that countries do not become over-reliant on external funding and that services can be sustained as much as possible through domestic funding.

The changing funding environment presents obvious

[1] Further details are provided in **Chapter 3**.

challenges, but also creates opportunities for transformation. Countries are increasingly exploring more integrated and sustainable approaches that embed HIV, hepatitis and STI services alongside those for tuberculosis (TB) and other communicable diseases, within broader health systems and UHC frameworks.

Several countries have accelerated efforts to integrate HIV and viral hepatitis services into PHC, maternal and child health services, sexual and reproductive health programmes, mental health services and noncommunicable disease platforms. These shifts reflect a broader recognition that vertical disease responses alone will not be sustainable in the coming decade.

Such changes are captured in a recent commentary *(6)*:

> *Global health priorities and approaches are undergoing significant shifts: from globally-driven to country-led and regionally-supported programmes; from disease-specific interventions to integrated, primary healthcare approaches to universal health coverage; from infectious diseases and maternal and child health to inclusion of noncommunicable diseases, mental health, ageing and the One Health approach; from centralized to local and regional manufacturing of essential health products; and to aligned, predictable and sustainable domestic financing in support of national health plans.*

2.2.5 Global and national policy environment

Key populations – including men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons – are particularly vulnerable to persistent stigma, discrimination and criminalization.

In some countries and regions, national policies related to gender, sexuality, reproductive rights and key populations are directly affecting the health services that are provided, how they are provided and whether they can be accessed. Legislative restrictions that affect civil society organizations, LGBTQ+ communities and harm reduction programmes have increased in some settings.

Changes in government policy have also affected the scope of support available through international donor funding *(32)*.

Stigma, discrimination and punitive laws remain among the greatest barriers to ending the AIDS epidemic *(8, 33)*.

2.2.6 Global health architecture and UN reform

The broader global health architecture is undergoing substantial transition *(6)*.

Since 2022, debates around the future of multilateralism, pandemic preparedness, governance reform and institutional mandates have intensified and are likely to continue to do so in the period up to 2030 and beyond. Discussions linked to UN reform processes, including the UN80 Initiative and wider system transformation efforts, will influence the future positioning of disease-specific programmes and partnerships. Questions regarding the future role, structure and financing of UNAIDS have become increasingly prominent as countries and partners consider how HIV responses should evolve within a changing UN, country and development landscape.

These discussions reflect broader shifts in global and country health governance. The distinctions between global health security, disease-specific programmes and health systems strengthening have become increasingly blurred. Pandemic preparedness and response capacities are now recognized as intrinsically linked to resilient health systems, surveillance infrastructure, laboratory networks and community trust. Disease-specific programmes, which have built extensive systems for surveillance, procurement, laboratory monitoring and community engagement, provide important lessons and platforms for broader health system resilience. National governments and Ministries of Health are taking a central role yet also require health diplomacy support to now convene diverse partners.

Climate change, migration, conflict and humanitarian emergencies increasingly shape health priorities. Digital technologies and commercial actors are exerting growing influence over health information ecosystems, service delivery and pharmaceutical innovation. This diversification creates opportunities for partnership and innovation but also risks fragmentation, duplication and weakened accountability.

2.2.7 Scientific advances and technological innovation

Scientific advances are transforming possibilities for prevention, diagnosis and treatment. For HIV, these include long-acting antiretrovirals that can be used for both prevention and treatment. An example is lenacapavir, which has been recommended by WHO for HIV prevention since 2025 *(34)*. For hepatitis, new treatment options are in clinical trials; they include bepirovirsen, which is being tested as a functional cure of hepatitis B. For HIV, hepatitis and STIs, advances in molecular diagnostics and genomic surveillance are enhancing capacity for earlier diagnosis and outbreak detection. Innovations and platforms related to diagnostics, digital health, data and service delivery are also being shared across all three strategy areas.

Artificial intelligence (AI) is rapidly emerging and could transform many aspects of health care. For example, AI-supported analytics could help to improve disease surveillance, forecasting, clinical decision-making, supply chain management and programme optimization.

Digital health platforms are increasingly being deployed to support differentiated service delivery, remote consultations, adherence support and integrated patient management systems.

These innovations come with risks and concerns; for example, about safety, privacy, algorithmic bias, misuse of health data, inequities in access and the concentration of technological capacity within a small number of commercial actors. In the context of HIV and sexual health, there are specific concerns about confidentiality and stigma.

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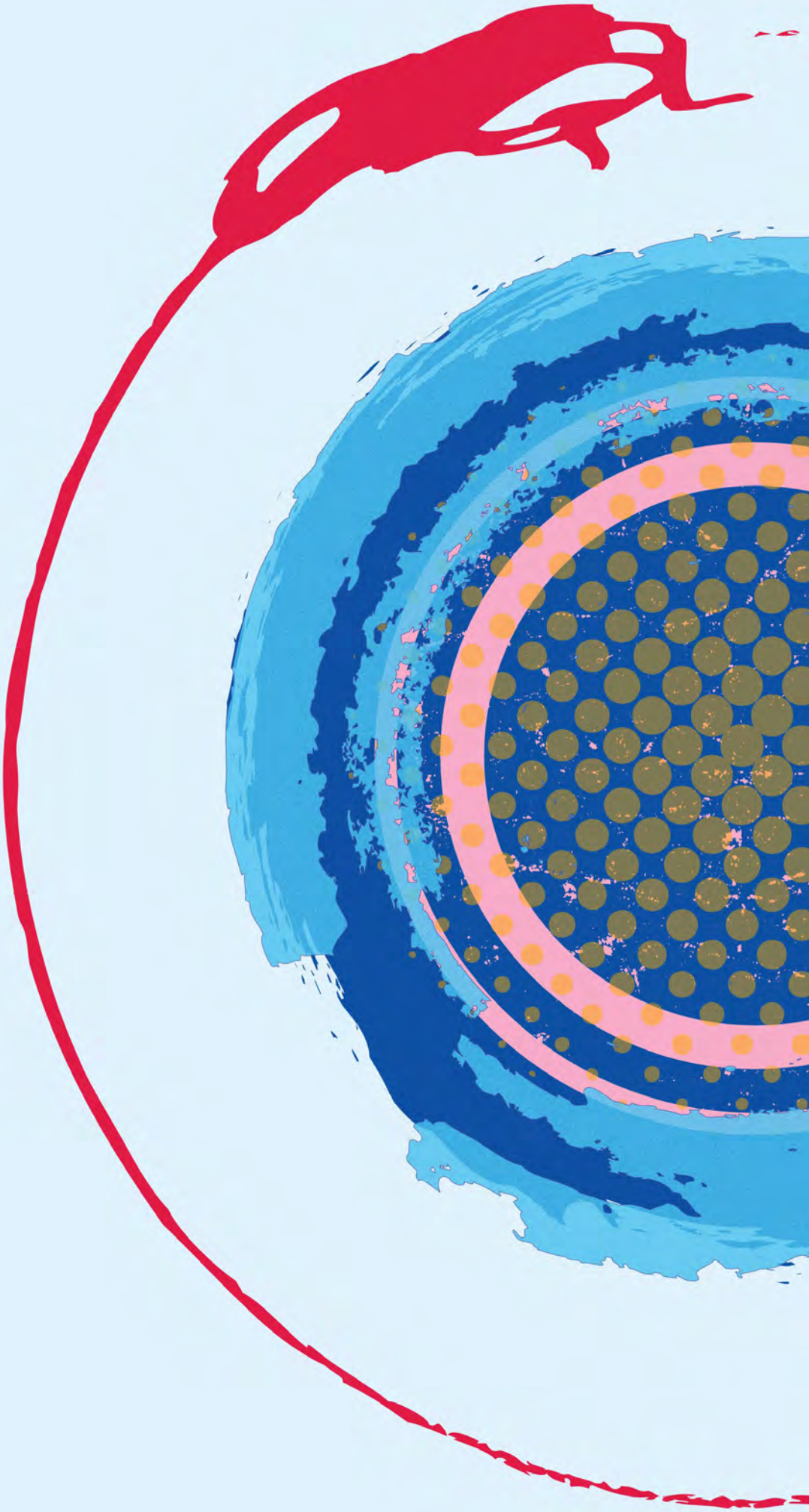
Chapter 3

HIV



Over the past 2 decades, enormous progress has been made in expanding access to antiretroviral therapy (ART) for people living with HIV, preventing millions of deaths and supporting people living with HIV to live long and healthy lives. Nonetheless, HIV remains a major global public health challenge. In 2025, there were 570 000 (95% uncertainty interval [UI]: 430 000–780 000) HIV-related deaths and 1.2 million people (95% UI: 0.95–1.7 million) acquired HIV *(1)*.

In 2015, all Member States of the United Nations (UN) committed to ending AIDS by 2030, as part of the Sustainable Development Goals (SDGs) *(2)*. This commitment has been reaffirmed in political declarations at UN high-level meetings on HIV *(3–5)* and embedded in successive global strategies developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) *(6–8)* and the World Health Organization (WHO) *(9, 10)*. The WHO *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (GHSS) *(9)* were developed in alignment with the *Global AIDS strategy 2021–2026 (7)*.

The goal of ending AIDS as a public health threat is defined by targets set for 2030, which are to reduce the number of new HIV infections and HIV-related deaths by 90% compared with levels in 2010. There are accompanying targets for improving the coverage of prevention, testing and treatment services, including the "95–95–95" cascade-of-care targets. These 95–95–95 targets are that 95% of people living with HIV know their HIV status, 95% of people who know their HIV-positive status are on ART, and 95% of people on ART have a suppressed viral load. People living with HIV with an undetectable viral load have zero risk of transmitting HIV to their sex partners, and people with a suppressed viral load have a near-zero risk of doing so *(11)*.

This chapter provides a mid-term assessment of progress towards the GHSS targets set for 2030, organized according to four topics:

- epidemic status and trends;
- service coverage;
- WHO guidance and support for strategy implementation, 2022–2026; and
- critical issues and priorities for action in the years up to 2030.

It uses the latest data and estimates available from UNAIDS (up to 2025), including data reported through the Global AIDS Monitoring (GAM) system managed by UNAIDS, WHO and the United Nations Children's Fund (UNICEF); HIV-related data reported by Member States to WHO in 2025; and the published literature.[1]

The key findings and messages are provided in **Box 3.1**, followed by an illustrative overview of progress towards the 2030 targets (**Fig. 3.1**).

[1] Further details are provided in **Annex 1**.

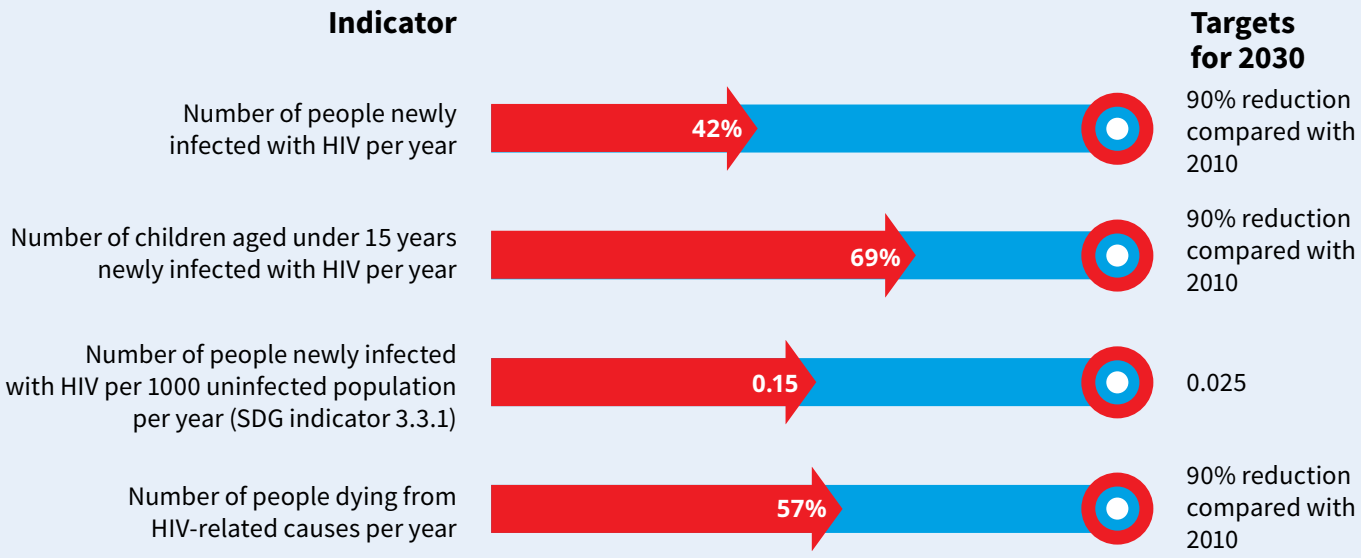
BOX 3.1.

Chapter summary: key findings and messages

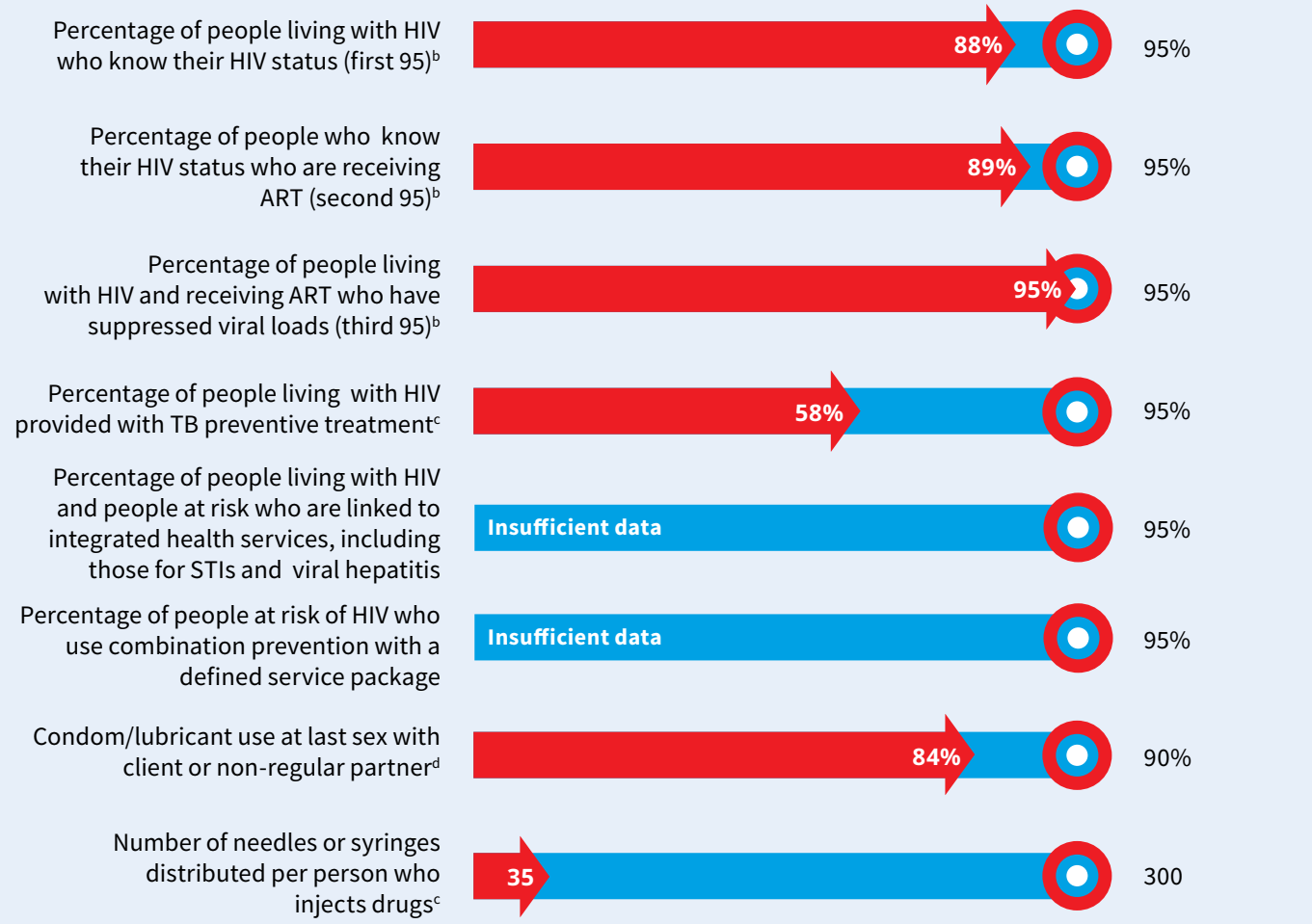
- There has been substantial global progress in reducing the annual numbers of people acquiring HIV and HIV-related deaths. Intensified efforts are required to reach the global targets set for 2030.
- Globally in 2025, 1.2 million people (95% UI: 0.95–1.7 million) acquired HIV. This was a 42% reduction compared with 2010 and almost halfway to the target of a 90% reduction by 2030.
- Close to half of new infections (and about 70% outside sub-Saharan Africa) are among key populations and their partners. The key populations are men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings.
- Globally in 2025, 570 000 people (95% UI: 430 000–780 000) died from HIV-related causes. This was a large reduction of 57% compared with 2010. To reach the 2030 target of a 90% reduction, the annual number of HIV-related deaths needs to be reduced to about 130 000.
- Globally in 2025, there were 41 million people (95% UI: 35–48 million) living with HIV, of whom 53% were women and girls and 64% were in the WHO African Region.
- In 2025, 88% of people living with HIV knew their status, 89% of those who knew their status were on ART and 95% of those on ART had a suppressed viral load, close to the 95–95–95 targets set for 2030.
- There were 32 million people (95% UI: 28–33 million) on ART by the end of 2025, up from about 8 million in 2010. However, there were still 9 million people living with HIV (22% of all people living with HIV) who were not on ART.
- ART coverage is lower among men than among women, and lower among children than among adults.
- Achieving the 2030 global targets for reductions in the number of people acquiring HIV and HIV-related deaths requires closing gaps in ART coverage and substantial improvements in HIV prevention efforts (beyond treatment and viral suppression among those already living with HIV), especially among key populations. Prevention options include long-acting pre-exposure prophylaxis (PrEP) for people at elevated risk of acquiring HIV.
- Reductions in international donor funding for the HIV response since 2025 present a severe challenge. In 2025, there were negative impacts on HIV prevention, HIV testing, ART initiation, laboratory testing, human resource capacity and HIV data systems for monitoring.
- Domestic financing in high HIV burden countries is critical to sustain and strengthen the HIV response.
- A new global AIDS strategy is available to guide the HIV response in the period 2026–2031 *(8)*.

Fig. 3.1. Global targets for HIV: latest status of progress[a]

a) Impact targets



b) Service coverage targets



ART: antiretroviral therapy; SDG: Sustainable Development Goal; STIs: sexually transmitted infections; TB: tuberculosis.

[a] This is 2025 for all indicators unless otherwise stated.

[b] This represents one of the three 95-95-95 testing and treatment indicators as defined in the Global AIDS Strategy 2021–2026.

[c] Data are for 2024.

[d] Data are for 2020–2024 and for condom use among sex workers.

3.1 Epidemic status and trends

A global overview of the latest status of the HIV epidemic is provided in **Fig. 3.2**.

3.1.1 Number of people living with HIV

Globally in 2025, an estimated 1.2 million people acquired HIV, bringing the total number of people living with HIV to 41 million (95% UI: 35–48 million) (**Fig. 3.2**, **Fig. 3.3**). Of these, 64% were in the WHO African Region (**Fig. 3.3**). The number has been steadily growing both globally and in most WHO regions; however, in recent years, numbers have plateaued in the WHO African and South-East Asia regions.

Globally, the age distribution of people living with HIV is similar for both the male and female population (**Fig. 3.4**). In 2025, 62% of people living with HIV were aged 25–49 years and 28% were aged 50 years or more. Overall, 53% of people living with HIV were female and 47% were male.

3.1.2 Annual number of people acquiring HIV

Globally, 1.2 million people (95% UI: 0.95–1.7 million) acquired HIV in 2025 (**Fig. 3.5**). This was a 42% reduction compared with 2010 and about halfway to the target of a 90% reduction by 2030, which is equivalent to about 200 000 people per year.

Regional patterns vary (**Fig. 3.5**). Since 2010, there have been large reductions in the annual number of people acquiring HIV in the WHO African and South-East Asia regions. Numbers have remained relatively stable in the WHO Region of the Americas, the European Region and the Western Pacific Region. The most concerning trend is in the WHO Eastern Mediterranean Region, where the annual number of people acquiring HIV has more than doubled since 2010.

At global level, the annual numbers of people acquiring HIV were similar in the male and female populations until about 2016, after which there was a faster decline among women and girls (**Fig. 3.6**). In 2025, 56% of people who acquired HIV were men and boys. The WHO African Region is the only part of the world where the annual number of people acquiring HIV is higher in the female population.

The annual number of children aged under 15 years who acquired HIV fell by 69% between 2010 and 2025, following substantial progress in reducing vertical transmission (mother-to-child transmission) through provision of ART among pregnant women. In 2025, 88% of pregnant women living with HIV had access to antiretroviral (ARV) medicines to prevent transmission of HIV to their child.

In sub-Saharan Africa, there are particularly pronounced sex disparities. Adolescent girls and young women aged 15–24 years account for much higher numbers of new infections than males of the same age (**Fig. 3.7**).

3.1.3 HIV acquisition among key populations

The risk of acquiring HIV is much higher among key populations and their partners. Key populations include men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings.

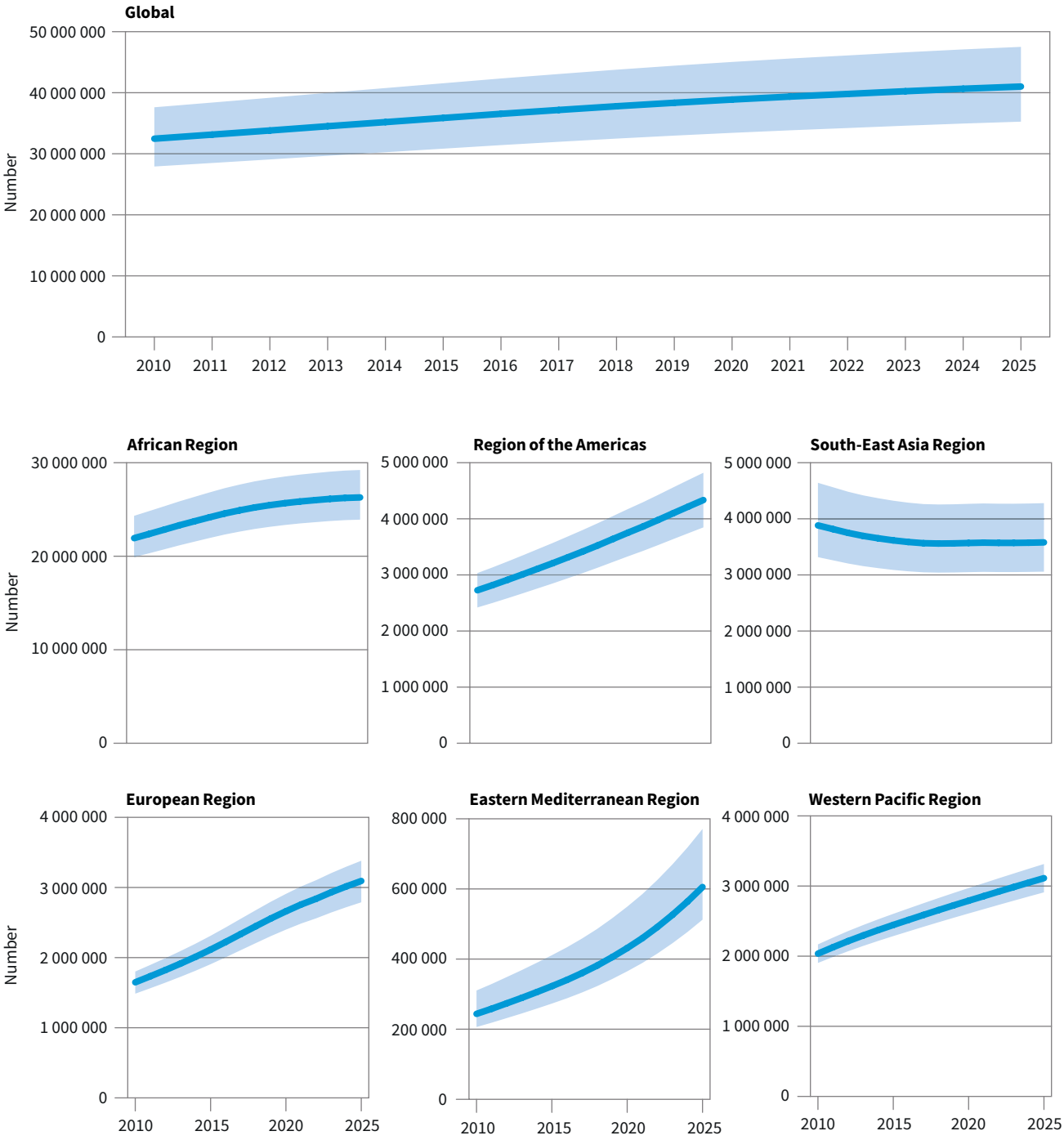
Fig. 3.2. Estimated global numbers of adults and children living with HIV, acquiring HIV and dying from HIV-related causes in 2025[a]

	People living with HIV	People acquiring HIV	People dying from HIV-related causes
Total	**41.0 million (35.3–47.5 million)**	**1.2 million (0.95–1.7 million)**	**570 000 (430 000–780 000)**
Adults (≥15 years)	**39.7 million (34.1–46.0 million)**	**1.1 million (0.87–1.5 million)**	**510 000 (390 000–700 000)**
Females (≥15 years)	21.0 million (17.8–24.5 million)	500 000 (360 000–690 000)	220 000 (160 000–310 000)
Males (≥15 years)	18.8 million (16.2–21.6 million)	650 000 (500 000–860 000)	290 000 (220 000–390 000)
Children (0–14 years)	**1.3 million (1.0–1.7 million)**	**93 000 (63 000–140 000)**	**61 000 (39 000–90 000)**

[a] 95% uncertainty interval in parentheses.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org

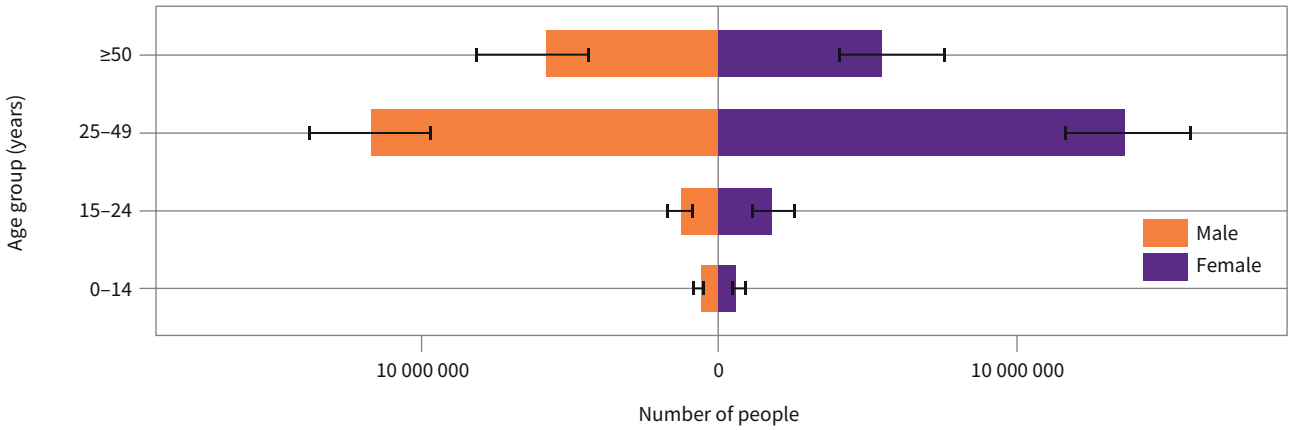
Fig. 3.3. Estimated numbers of people living with HIV, globally and for WHO regions, 2010–2025[a]



[a] Shaded areas represent 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.4. Global number of people living with HIV in 2025, disaggregated by age group and sex[a]



[a] Error bars show 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

In 2024, key populations and their partners accounted for about half of the global number of people who acquired HIV; outside sub-Saharan Africa, the share was 70% (**Fig. 3.8**).[1] Within sub-Saharan Africa in 2024, about a quarter of the people who acquired HIV were among key populations and their partners; this share has been falling since 2010.

In some parts of the world, the prevalence of HIV among young men who have sex with men has been increasing. For example, it more than doubled in Indonesia and almost tripled in Malaysia and Viet Nam between 2011 and 2022 *(12)*.

Fiji is an example of a country where an escalating HIV epidemic among key populations, particularly people who inject drugs, is being addressed with urgency (**Box 3.2**).

3.1.4 HIV-related deaths

Globally, the annual number of HIV-related deaths has been falling for many years (**Fig. 3.9**), owing to the enormous scale-up of access to ART for people living with HIV (**Section 3.2**). The annual number of HIV-related deaths fell from 1.3 million (95% UI: 1.0–1.8 million) in 2010 to 570 000 (95% UI: 430 000–780 000) in 2025, a 57% reduction. Much more remains to be done to achieve the global target of a 90% reduction, which is equivalent to an annual total of about 130 000 deaths.

Trends among WHO regions vary (**Fig. 3.9**). In absolute terms, the biggest

[1] At the time of report publication, estimates for 2025 were not available.

BOX 3.2

Responding to an HIV outbreak among key populations in Fiji

Fiji is experiencing one of the world's fastest-growing HIV epidemics. The number of new cases rose from 415 in 2023 to over 1500 in 2024, and more than 1200 cases were reported in the first half of 2025. Among people starting HIV treatment in 2024, 48% were people who inject drugs, highlighting injecting drug use as a probable route of transmission. The increase is linked to a boom in the availability of methamphetamines *(14)*.

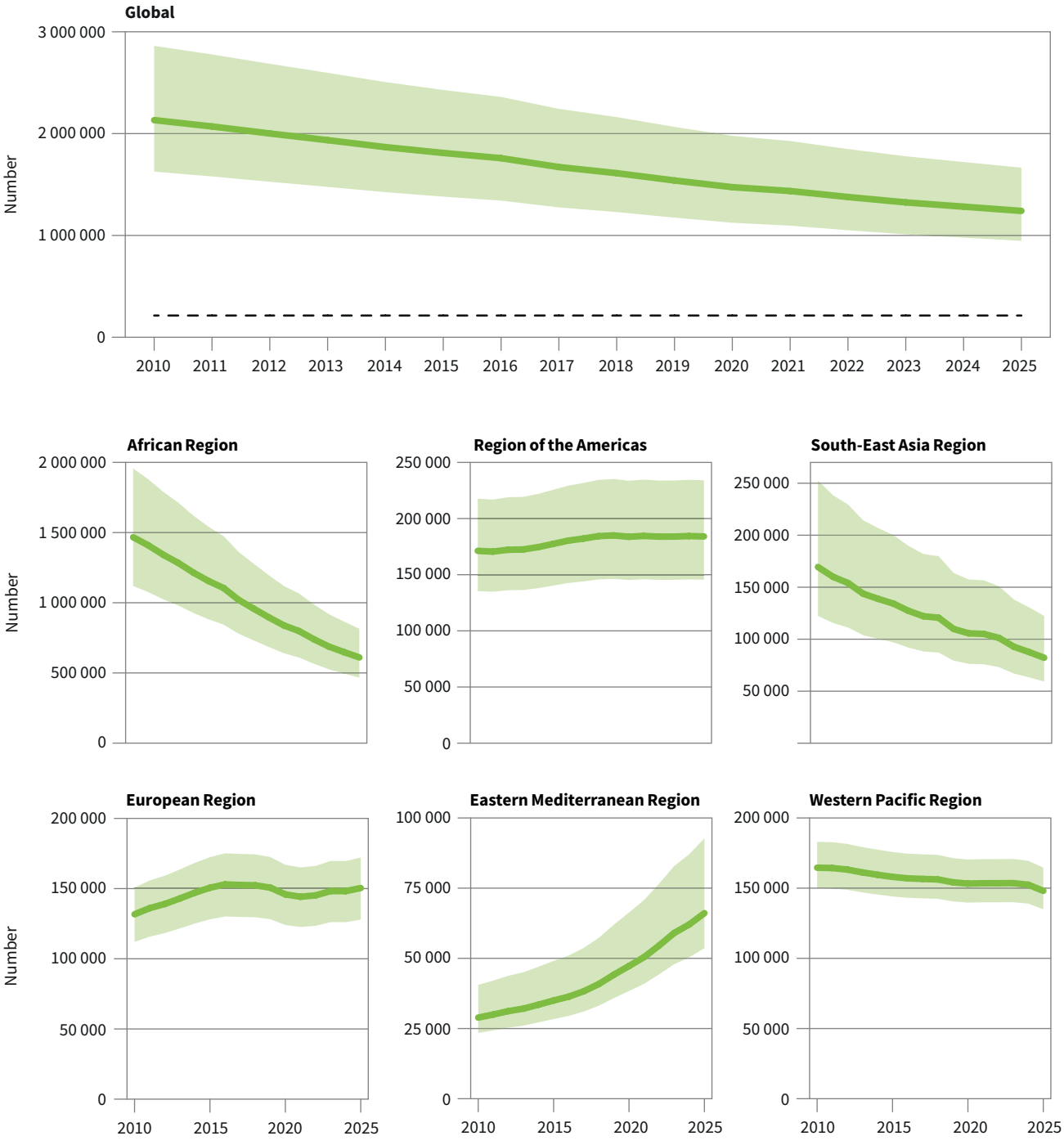
A joint rapid assessment was commissioned by WHO and the UN Development Programme (UNDP), with funding from The Global Fund. It was conducted by the Kirby Institute, Fiji National University and the Australian Injecting and Illicit Drug Users League. The assessment found that many people who inject drugs in Suva, the capital city, lacked access to needle and syringe programmes and commodities, and feared discrimination when seeking health services. The findings highlighted an urgent need for harm reduction services – particularly needle and syringe programmes – as part of a comprehensive public health response.

Following the assessment, Fiji's Ministry of Health and Medical Services is implementing a comprehensive HIV Surge Strategy (2024–2027) and a national HIV Outbreak Response Plan, in collaboration with WHO, UNAIDS, UNDP, the UN Population Fund (UNFPA) and other partners. The response includes efforts to expand comprehensive HIV testing and treatment, strengthen outreach to key populations, and accelerate the introduction of evidence-based harm reduction interventions, including needle and syringe programmes.

As implementation progresses, factors critical to expanding harm reduction services as part of a comprehensive HIV response are sustained political commitment, coordinated action across sectors, a good understanding of transmission dynamics across populations and meaningful community engagement.

WHO published an operational guide on needle and syringe programmes in early 2026 *(15)*. Fiji's experience demonstrates the relevance and timeliness of such global guidance in supporting locally led, context-specific HIV responses across diverse settings.

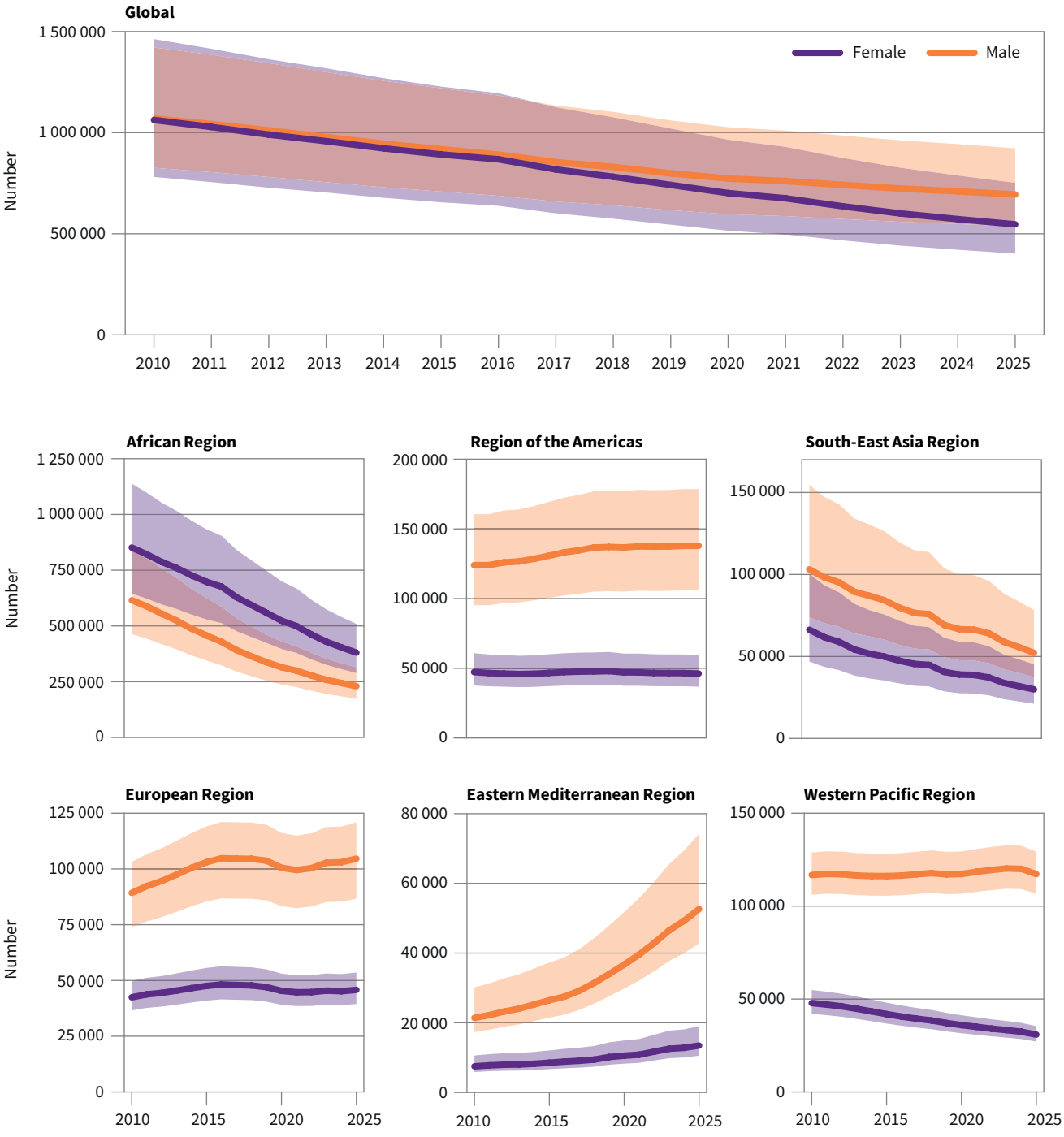
Fig. 3.5. Estimated number of people acquiring HIV, globally and for WHO regions, 2010–2025[a]



[a] Shaded areas represent 95% uncertainty intervals. The horizontal dashed line represents the global target of a 90% reduction by 2030, compared with 2010.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

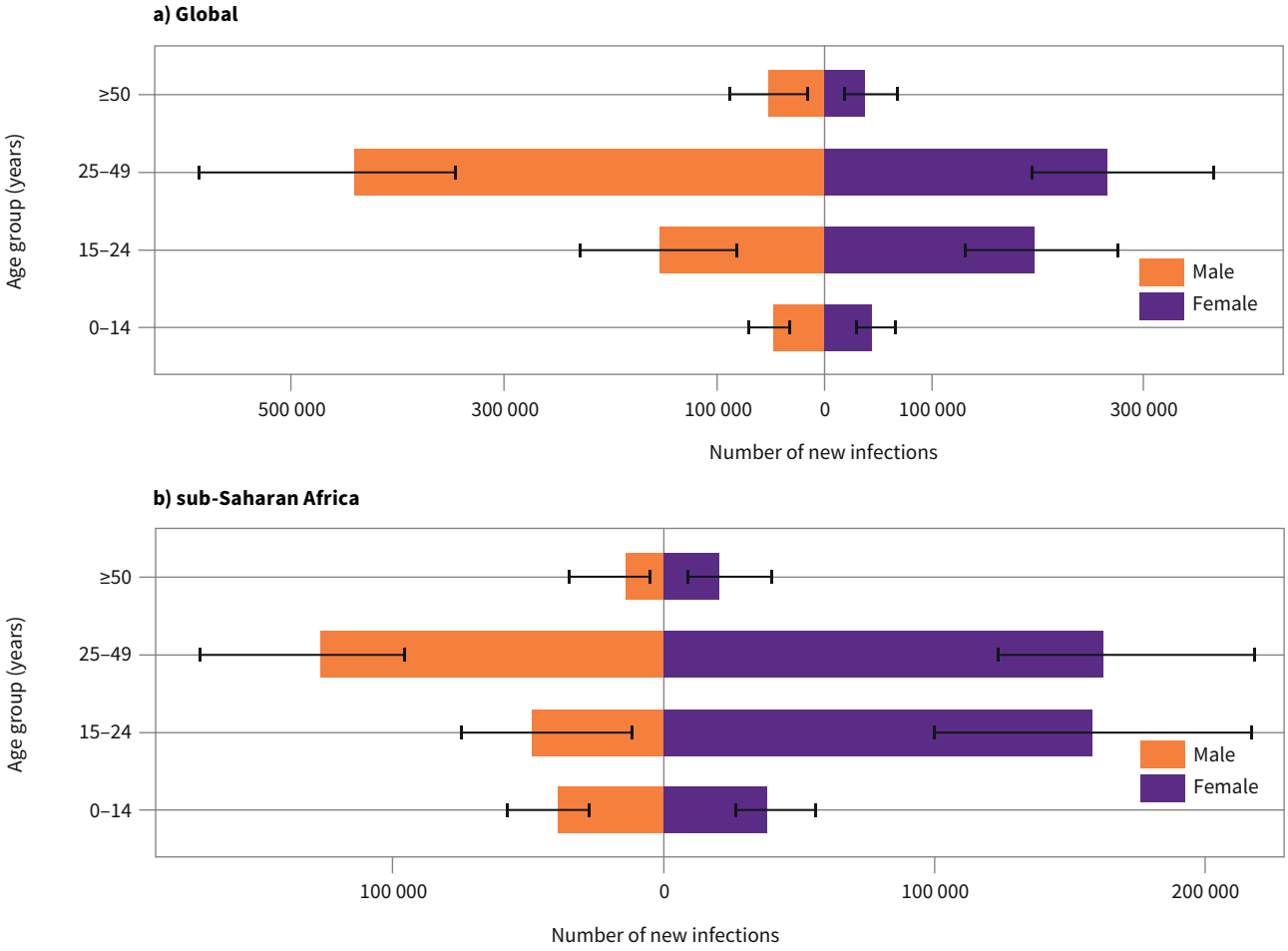
Fig. 3.6. Estimated number of people acquiring HIV disaggregated by sex, globally and for WHO regions, 2010–2025[a]



[a] Shaded areas represent 95% uncertainty intervals.

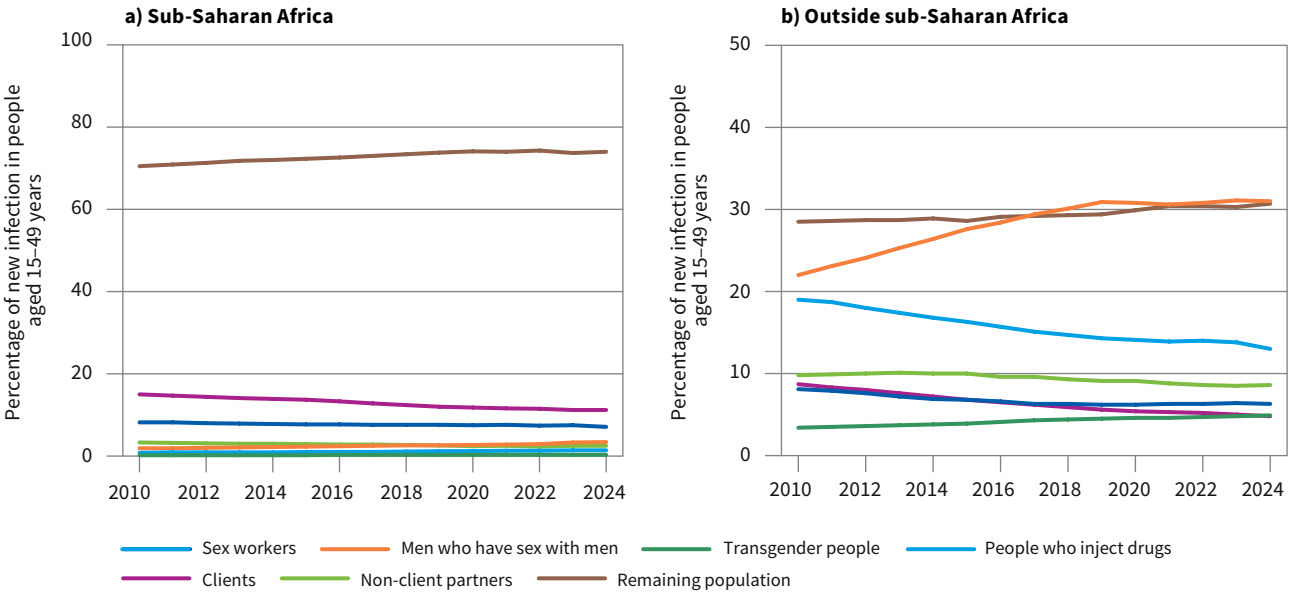
Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.7. Estimated number of people acquiring HIV by age group and sex, a) globally and b) in sub-Saharan Africa, 2025



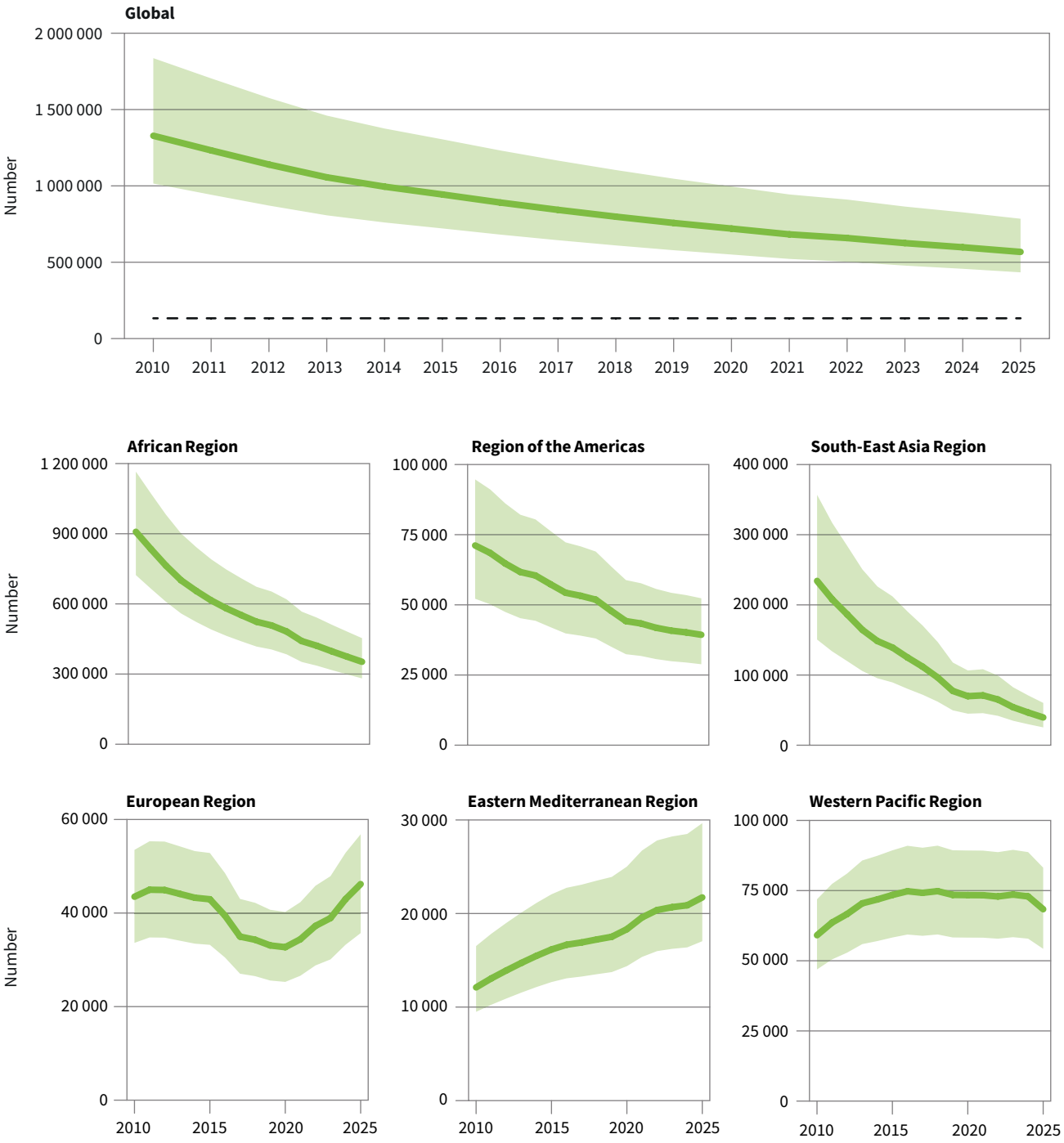
[a] Error bars show 95% uncertainty intervals.
Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.8. Distribution of new infections among key populations, their partners and the remaining population, 2010–2024[a]



[a] At the time of report publication, estimates were not available for 2025.
Source: UNAIDS special analysis 2025 *(13)*.

Fig. 3.9. The number of HIV-related deaths, globally and for WHO regions, 2010–2025[a]



[a] Shaded areas represent 95% uncertainty intervals. The horizontal dashed line represents the global target of a 90% reduction by 2030, compared with 2010.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

reductions in HIV-related deaths have been achieved in the WHO African Region. There has also been a large reduction in the WHO South-East Asia Region and a steady decline in the Region of the Americas. In the WHO Western Pacific Region, the annual number of HIV-related deaths has been relatively stable. The most concerning trends are in the WHO Eastern Mediterranean and European regions, with marked increases in recent years, particularly among men (**Fig. 3.10**).

Overall, there are more HIV-related deaths among the male population (**Fig. 3.10**, **Fig. 3.11**). Among both the male and female population, most deaths are among people aged 25–49 years (**Fig. 3.11**).

3.2 Service coverage

An overview of progress towards the GHSS 2030 targets for the coverage of services and interventions related to HIV treatment and prevention is provided in **Table 3.1**.

3.2.1 The 95–95–95 cascade-of-care targets

Globally in 2025, an estimated 88% of people living with HIV knew their status, 89% of those who knew their status were on ART and 95% of those on ART had a suppressed viral load; these values were close to the 95–95–95 targets set for 2030 (**Fig. 3.12**). Among WHO regions, the highest percentages were in the African Region (90–92–95). The lowest percentages (41–76–79) were in the WHO Eastern Mediterranean Region, where there is a particularly concerning upward trend in HIV incidence.

In 2025, seven countries in eastern and southern Africa with the world's highest HIV burden achieved the 95–95–95 targets: Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia and Zimbabwe.

Globally, knowledge of HIV status, ART coverage and levels of viral suppression have steadily improved year on year (**Fig. 3.13**).

A total of 32 million people (95% UI: 28–33 million) were on ART by the end of 2025, an increase from about 8 million in 2010.

The global HIV treatment cascade shows continuing disparities by age and sex (**Fig. 3.14**).

Among adults living with HIV in 2025, men were less likely than women to know their HIV status (86% versus 91%) and to be on ART (86% versus 92%, among those who knew their HIV status). Levels of viral suppression among men and women on ART were the same (95%).

Compared with adults, children were less likely to know their HIV status (65% versus 89%), be on ART (84% versus 89%, among those who knew their status) and to have viral suppression on ART (85% versus 95%) (**Fig. 3.14**). In addition, men living with HIV were more likely than women to present with advanced HIV disease (AHD) *(16)*.

3.2.2 ART coverage and viral suppression among all people living with HIV

The 95–95–95 targets assess ART coverage among people who know their HIV status, and viral suppression among those on ART. Global progress in ART coverage and the outcomes of treatment, and remaining gaps, can also be assessed by comparing the numbers of people on ART and the numbers who are virally suppressed

Table 3.1. Global status of progress towards GHSS 2030 targets for HIV service coverage

Indicator	2025 progress	2030 target
Percentage of people living with HIV who know their HIV status (first 95 of 95–95–95)	88% (67 to >98%)[b]	95%
Percentage of people who know their HIV status who are receiving ART (second 95 of 95–95–95)	89% (67 to >98%)[b]	95%
Percentage of people living with HIV and receiving ART who have suppressed viral loads (third 95 of 95–95–95)	95% (72 to >98%)[b]	95%
Percentage of people living with HIV provided with TB preventive treatment	58%[c]	95%
Percentage of people living with HIV and people at risk who are linked to integrated health services, including those for STIs and viral hepatitis	Insufficient data	95%
Percentage of people at risk of HIV who use combination prevention with a defined service package	Insufficient data	95%
Condom/lubricant use at last sex with client or non-regular partner[a]	84%	90%
Number of needles or syringes distributed per person who injects drugs (as part of comprehensive harm reduction services)	35[c]	300

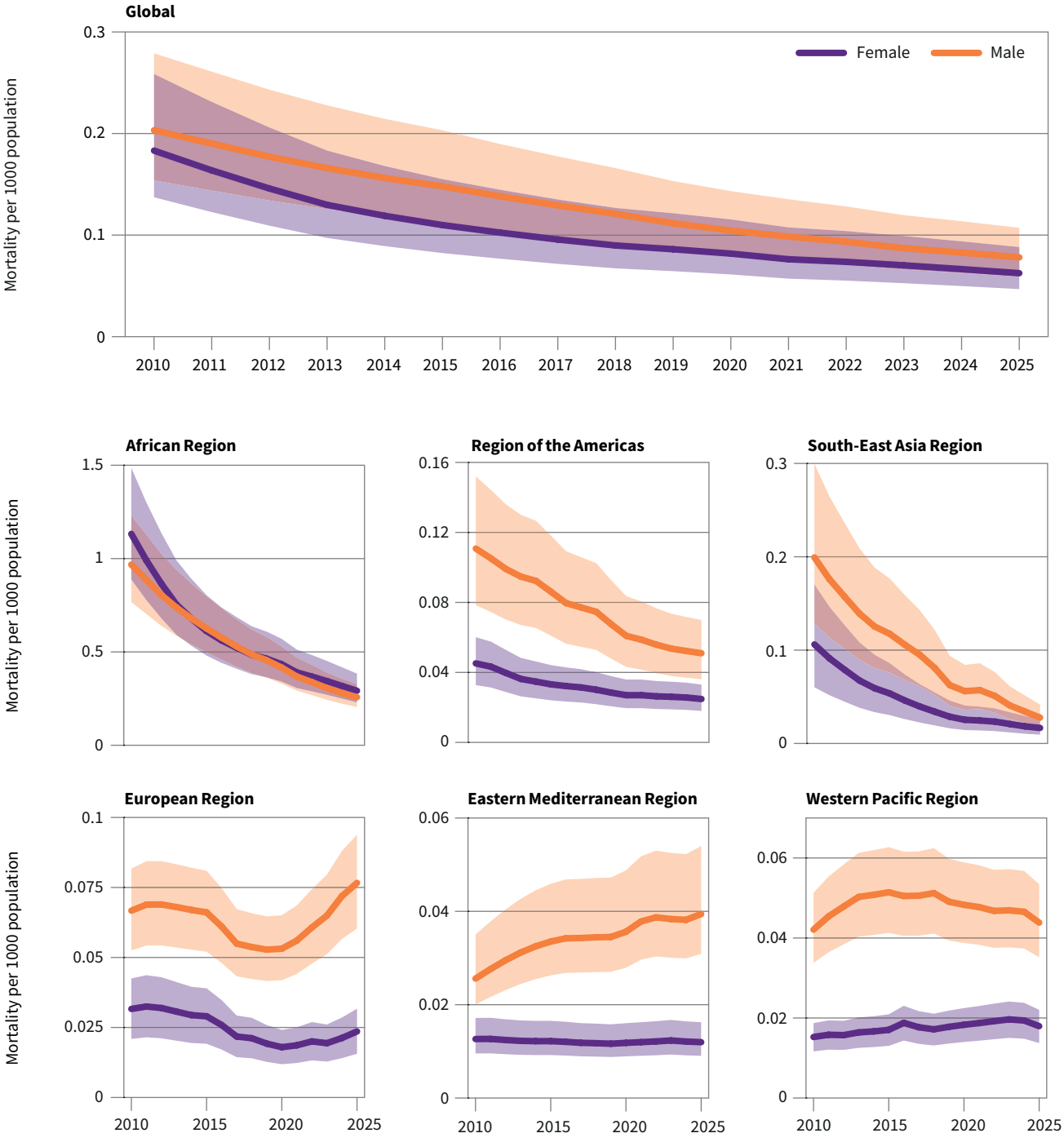
ART: antiretroviral therapy; GHSS: *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030*; STI: sexually transmitted infection; TB: tuberculosis.

[a] Data are for 2020–2024 and for condom use among sex workers.

[b] Ranges shown are 95% uncertainty intervals.

[c] Data are for 2024.

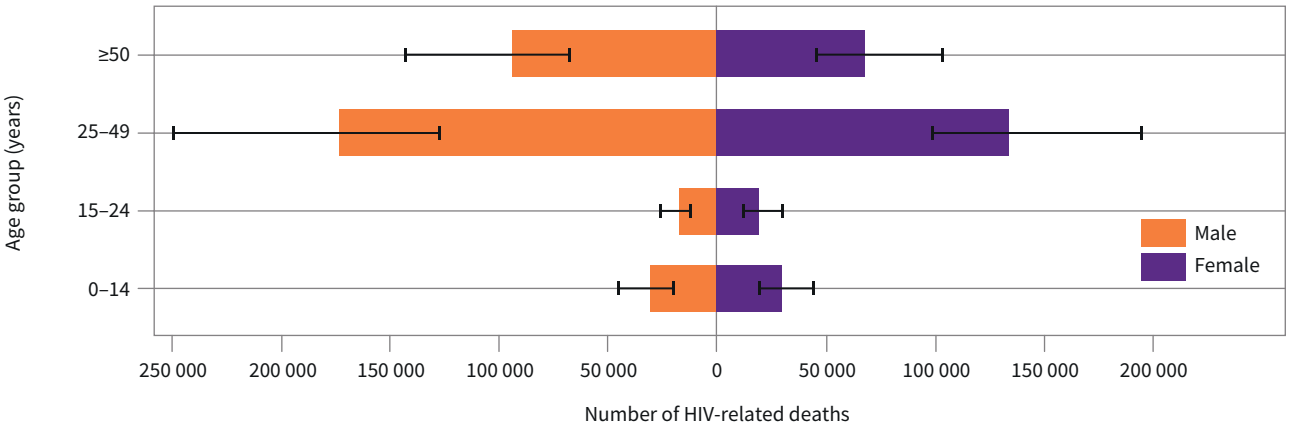
Fig. 3.10. HIV-related deaths per 1000 population, globally and for WHO regions, by sex, 2010–2024[a]



[a] Shaded areas represent 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.11. Global number of HIV-related deaths in 2025, disaggregated by age group and sex[a]



[a] Error bars show 95% uncertainty intervals.
Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

with the total estimated number of people living with HIV (**Fig. 3.15**).

Among WHO regions, the relative gaps between the number of people living with HIV and the numbers of people on ART and with viral suppression are particularly large in the Eastern Mediterranean Region. The WHO African Region is the only one in which over 80% of people living with HIV are estimated to be on ART.

3.2.3 HIV prevention

The available data for the GHSS targets related to HIV prevention (**Table 3.1**) show that service coverage is inadequate among key populations:

- based on data reported for 2020–2024, condom use among sex workers was 84%; and
- the average number of needles and syringes distributed per person who injects drugs was only 35 in 2024, far less than the 2030 target of 300 per year.

WHO first recommended oral pre-exposure prophylaxis (PrEP) in 2015. As of 2026, WHO-recommended options include the dapivirine vaginal ring, long-acting injectable cabotegravir and twice-yearly injectable lenacapavir. As the first PrEP option that is given only twice per year, lenacapavir has the potential to address adherence challenges associated with uptake of other prevention options (**Box 3.3**).

Globally, the reported number of people who received PrEP at least once per year increased from low levels in a few countries in 2018 to 3.5 million in all regions by 2024 (**Fig. 3.16**). However, the number of PrEP recipients remains far below the global target included in the Global AIDS Strategy for 2026–2031, which is to reach 20 million people by 2030 *(8)*.

In 2024, among women, those aged 25–49 years accounted for 41% of PrEP recipients, followed by those aged 20–24 years (29%) and 15–19 years (19%). Similarly, among men, those aged 25–49 years accounted for the largest share of PrEP recipients (56%), followed by those aged 20–24 years (21%) and 15–19 years (8%). Among key populations, men who have sex with men accounted for 49% of PrEP recipients, followed by sex workers (37%), people who inject drugs (9%), transgender people (3%), and people in prisons and other closed settings (2%).

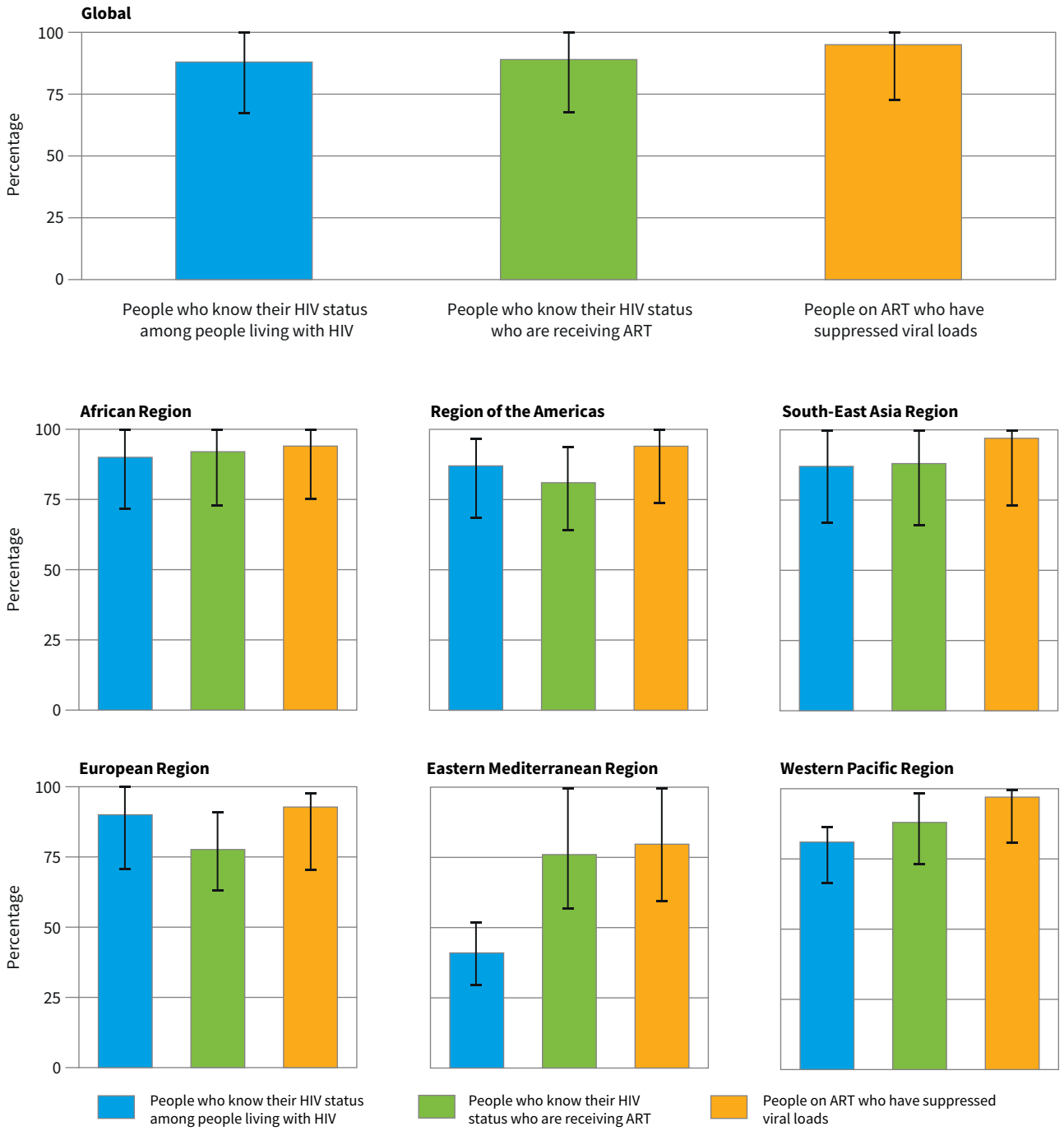
Cuts in international donor funding in 2025 (**Chapter 2** and **Section 3.4** below) have affected prevention services, including provision of PrEP. Preliminary data (reported in 2026 as part of GAM) suggest a substantial reduction in the number of people using PrEP in some countries; in others, national governments have responded to fill gaps and the number of people provided with PrEP has increased.

3.2.4 Disruptions to HIV services in 2025

In 2025, there were reductions in international donor funding for the HIV response and changes to the modalities used to provide external support (**Chapter 2**).

A WHO survey of impacts on HIV services and mitigation measures put in place in 2025 found that treatment services were prioritized and disruptions to ART were limited, while prevention and testing services were more negatively impacted (**Box 3.4**). A separate analysis of programmatic data showed substantial reductions in funding provided through the United States President's Emergency Plan for AIDS Relief (PEPFAR) for about 2 million people on ART in 26 countries *(19)*. Alongside the WHO survey results, this suggests that ministries of health and others stepped in to fill funding gaps for treatment, at least in the short term.

Fig. 3.12. Progress towards the 95-95-95 targets, globally and for WHO regions,[a] 2025

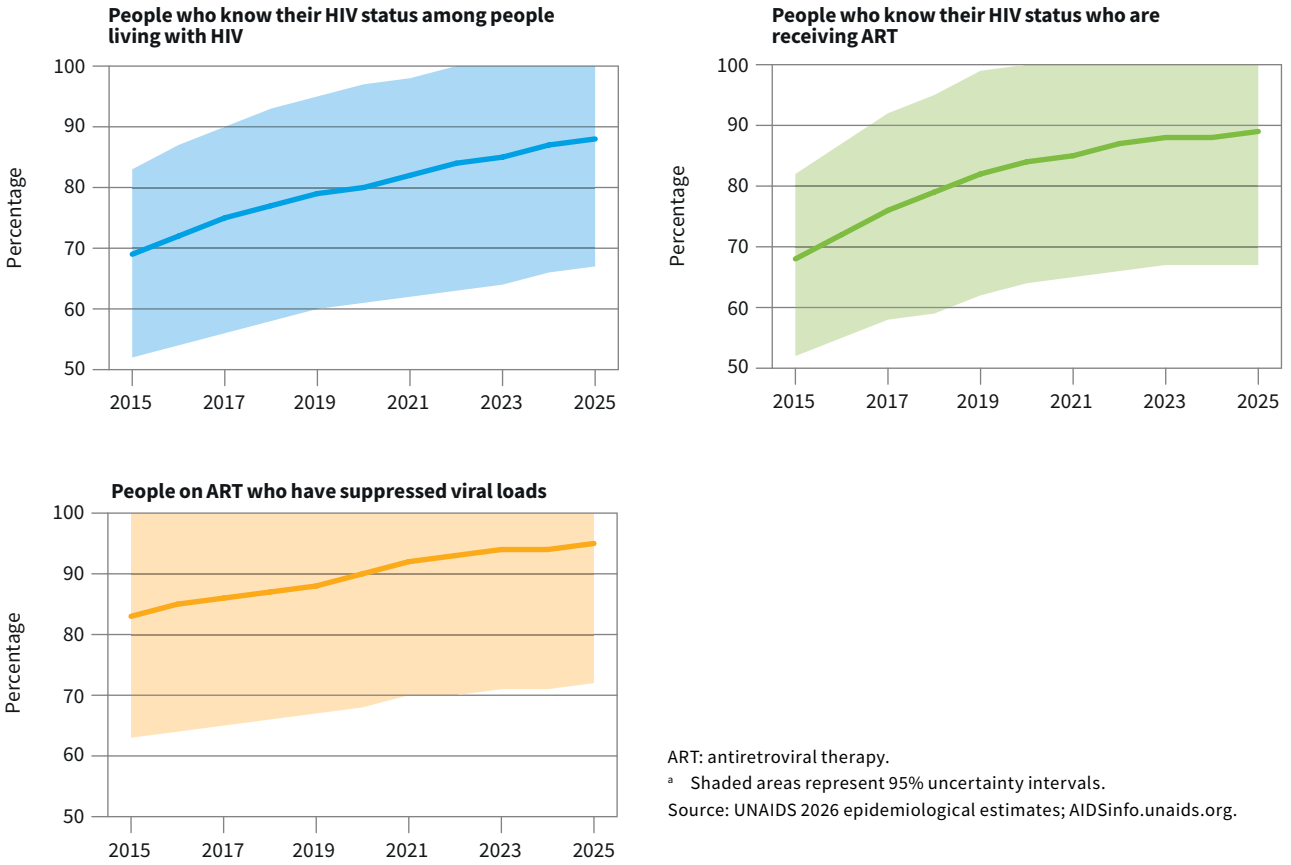


ART: antiretroviral therapy; HIV: human immunodeficiency virus.

[a] Error bars show 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.13. Global trends in knowledge of HIV status, ART coverage and viral suppression among people living with HIV,[a] 2010–2025



ART: antiretroviral therapy.

[a] Shaded areas represent 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

BOX 3.3.

Lenacapavir and the expansion of HIV prevention choice

In July 2025, WHO released new guidelines recommending twice-yearly injectable lenacapavir as an additional option for HIV prevention, as part of combination prevention approaches *(17)*.

Lenacapavir is a highly effective, long-acting alternative to oral pills and other prevention options. With just two doses per year, it has the potential to expand prevention options for people at elevated risk of acquiring HIV – particularly those who face challenges with daily adherence, stigma or access to health care.

Rollout has already begun. Between December 2025 and July 2026, ten African countries introduced lenacapavir for PrEP: Eswatini, Kenya, Lesotho, Malawi, Mozambique, Nigeria, South Africa, Uganda, Zambia and Zimbabwe. By mid-July 2026, more than 40 000 people had received lenacapavir in these countries (*18*).

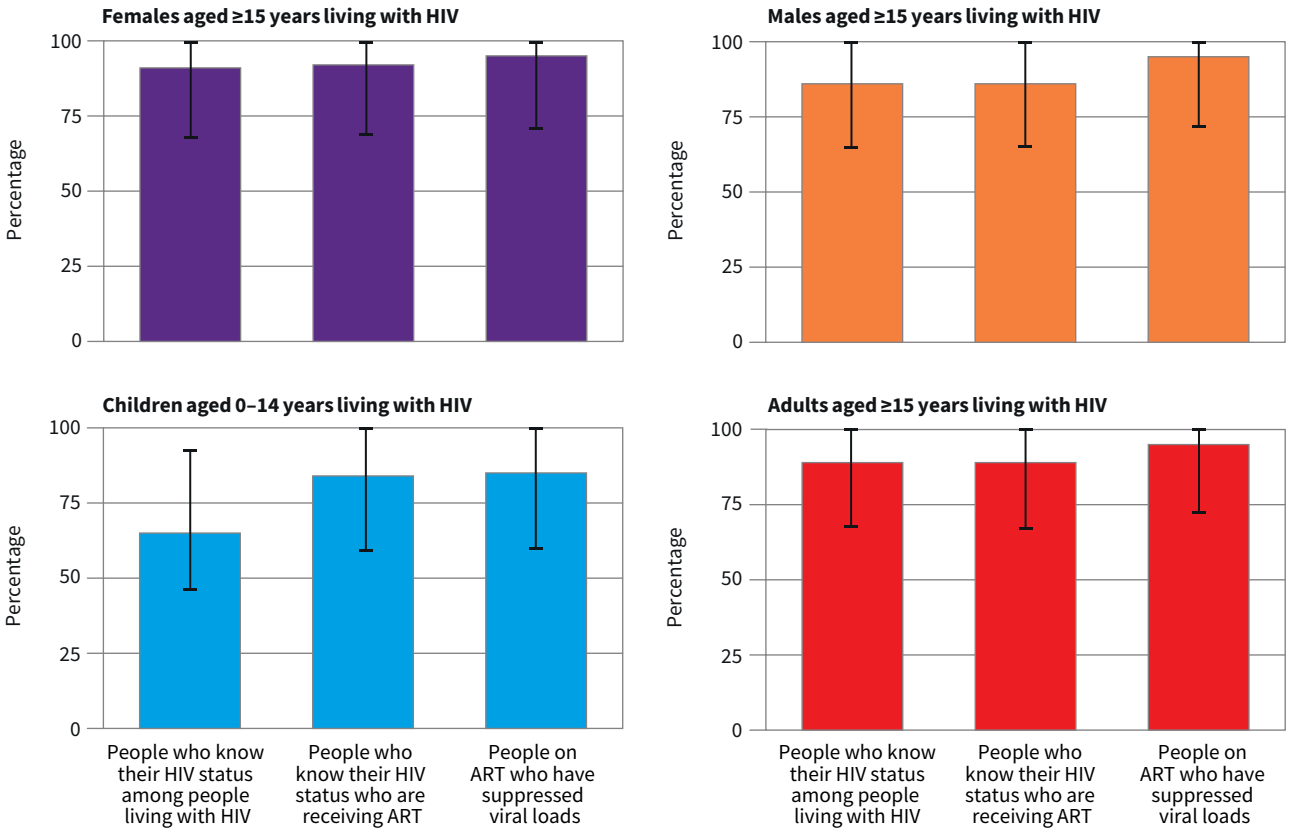
The Global Fund and the United States government have expanded support for the introduction of lenacapavir to 14 additional countries: Benin, Botswana, the Dominican Republic, Fiji, Georgia, Haiti, Honduras, Indonesia, Morocco, Papua New Guinea, the Philippines, Rwanda, Thailand and Ukraine.

Although these early findings are encouraging, increased supplies and lower costs will be needed to expand access and achieve high levels of coverage.

As of mid-2026, there were six generic manufacturers supporting production of low-cost lenacapavir for 120 LMICs. Additional partnerships and local manufacturing could help to accelerate the availability of supplies at prices that could make large-scale public health use more feasible.

The public health impact of lenacapavir and other promising prevention tools will depend on how quickly an affordable product becomes available, how effectively countries can deliver and sustain services, and whether rollout continues to prioritize equitable access for populations at risk of acquiring HIV infection.

Fig. 3.14. Progress towards the 95–95–95 targets, disaggregated by sex and age group,[a] 2025

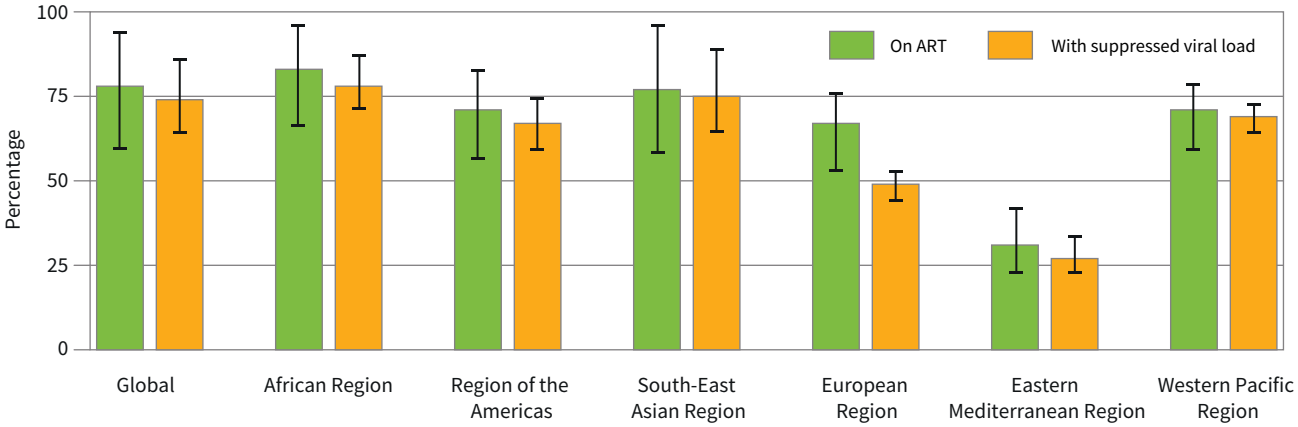


ART: antiretroviral therapy.

[a] Error bars show 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.15. ART coverage and viral suppression among all people living with HIV, globally and by WHO region,[a] 2025

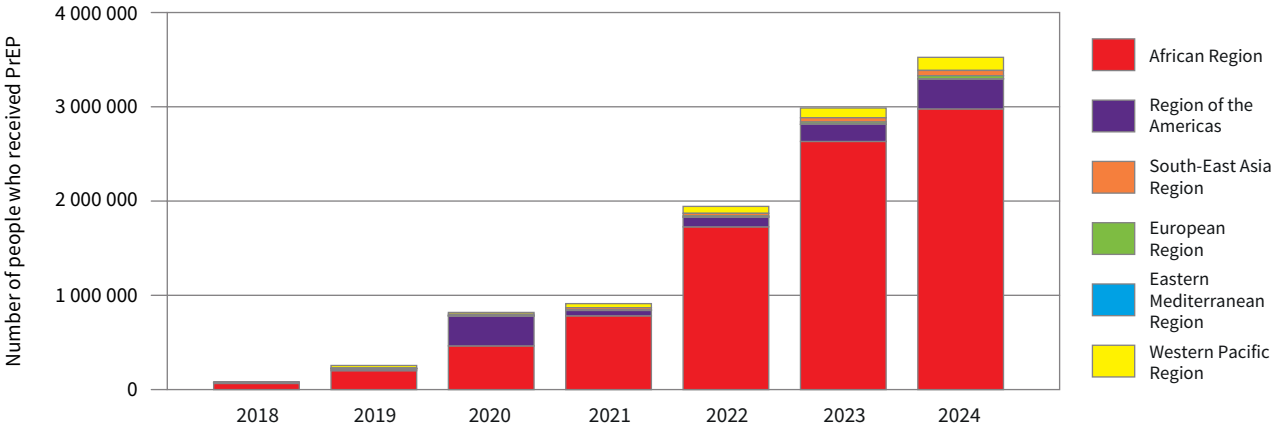


ART: antiretroviral therapy.

[a] Error bars show 95% uncertainty intervals.

Source: UNAIDS 2026 epidemiological estimates; AIDSinfo.unaids.org.

Fig. 3.16. Global number of people who used PrEP at least once per year disaggregated by WHO region, 2018–2024[a]



PrEP: Pre-exposure prophylaxis.

[a] Data for 2025 were not available as of 13 July 2026.

BOX 3.4

HIV service disruptions linked to reductions in international donor funding, July–September 2025: results from a WHO survey

WHO conducted a survey among Member States of how HIV services were being affected by reductions in international donor funding in the period July–September 2025. Of 107 responding countries, 47 reported some disruption to HIV services, including 23 countries in the WHO African Region.

Governments took immediate action to manage the effects of funding disruptions, particularly by prioritizing continuity of treatment and other essential services. Eleven countries reported disruptions to either adult or paediatric ART services, and three reported stock-outs of major ART regimens. Nine countries reported having less than 6 months of stocks available for major regimens.

Compared with treatment services, HIV testing and prevention services were more frequently affected by funding disruptions. Twelve countries reported disruptions to HIV testing and 13 reported disruptions to PrEP services. Such disruptions risk delays to diagnosis and ART initiation, and reductions in uptake of services among people at elevated risk of acquiring HIV. If sustained, such disruptions could increase HIV incidence, lead to higher proportions of people with AHD at diagnosis, place additional pressure on treatment programmes and make the 2030 targets harder to reach.

Data and health information systems were also affected. Among 92 reporting countries, 26 experienced disruptions to HIV data functions; these disruptions most commonly affected data entry, access to health information systems, server operations, data analysis, data cleaning and forecasting for commodities and supplies. Most of these disruptions were reported at subnational and service delivery levels. A total of 29 countries reported disruptions to human resources, including programme managers, data entry staff, data analysts, laboratory technicians, information technology and infrastructure maintenance staff, and community health workers. Although these disruptions may be less visible than service interruptions, over time they can weaken programme monitoring, planning, accountability and commodity security.

Among 25 countries that reported on mitigation actions, approaches taken included sustaining service continuity by partnering with nongovernmental and civil society organizations, integrating HIV services into routine services, and reallocating or referring patients to other care sites where services remained available. Despite these efforts, gaps remained across HIV services in 20 countries; these gaps particularly affected HIV prevention, treatment, health workforce and overall HIV programme financing.

Overall, the survey suggested that action by national governments helped to cushion the immediate effects of funding reductions, but that underinvestment in testing, prevention, treatment access, the health workforce and data systems could have serious long-term consequences if disruptions persist.

Similar findings have been reported by UNAIDS *(20)*. For example, while provision of ART was sustained in 2025, there were reductions in provision of HIV testing and PrEP, and large reductions in funding for condom programming and programmes that ensure people can reach prevention services (e.g. supportive laws, regulations and policy environments).

Data compiled by the Clinton Health Access Initiative from 14 countries in Africa and Asia showed negative impacts on most key HIV service indicators in 2025, with little to no recovery to date *(21)*. Compared with 2024:

- the number of people initiated on PrEP decreased by 42% in 10 reporting countries;
- the number of HIV tests decreased by 12% in eight reporting countries;
- the number of new HIV-positive diagnoses decreased by 28% in seven reporting countries; and
- the number of adults started on ART fell by 9% and the number of children started on ART fell by 15%, in eight reporting countries.

Risks to ARV supply chains were also highlighted – a major concern given the necessity of avoiding interruptions to treatment.

If funding shortfalls affect treatment continuation in the long term, impacts on HIV incidence and mortality could be substantial *(22)*.

3.3 WHO guidance and support for strategy implementation, 2022–2026

Since the development of the GHSS in 2021 and its publication in 2022, WHO has provided guidance and support for strategy implementation.

3.3.1 WHO guidelines and implementation tools

Between 2022 and 2026, WHO developed and published guidance and digital tools covering the spectrum of HIV prevention, testing, treatment, monitoring and surveillance based on the latest available evidence (**Fig. 3.17**, **Fig. 3.18**). These resources include new and

Fig. 3.17. WHO normative guidance and implementation tools on HIV prevention, diagnosis, treatment and care, 2022–2026

Fig. 3.18. WHO guidance and tools[a] on HIV surveillance and strategic information, 2022–2026

[a] Accompanying digital products include a machine-readable guidelines for HIV *(30)*, a DHIS2 HIV case surveillance tracker *(31)*, and a DHIS2 HIV prevention tracker *(32)*.

updated clinical recommendations for HIV testing, service delivery, AHD and PrEP; recommendations on the prioritization of services following funding disruptions; guidance on strategic information and surveillance; specific guidance on key and vulnerable populations; and digital tools for strengthening routine national HIV data systems *(15, 17, 23–45)*.

Updated HIV clinical management recommendations published in 2025 introduced changes to ARV regimens, tuberculosis (TB) preventive treatment and infant postnatal prophylaxis, with the aim of simplifying care and improving outcomes. Guidelines on the management of AHD emphasized the importance of CD4 cell count testing *(27)*, and new service delivery guidelines recommended integrated service delivery for noncommunicable diseases and mental health *(26)*.

WHO has increasingly complemented normative guidance with the development of digital products to support the implementation of recommendations within HIV surveillance systems (**Fig. 3.18**). The 2022 WHO strategic information guidelines *(28)* support the strengthening of routine national HIV surveillance systems. Building on those guidelines, the HIV digital adaptation kit (2nd edition) *(29)* and the development of machine-readable guidelines *(30)* enable countries to more rapidly and consistently translate these recommendations into digital health information systems and service delivery platforms. Together, these advances are strengthening the ability of health systems to translate guidance into practice at country level, and to use data more effectively to improve HIV programme performance.

Guideline development included close collaboration with the main global networks representing key populations, and engagement with people living with HIV and other affected communities.

Throughout 2022–2026, WHO collaborated closely with global and regional community-led and civil society organizations, including Harm Reduction International, International Network of People who Use Drugs, Global Network of People Living with HIV (GNP+), MPact Global Action for Gay Men's Health and Rights, Global Action for Trans Equality and Global Network of Sex Work Projects. The aim was to promote community-led responses, and to inform WHO guidance and the policy documents and statements of partners. For example, in 2025, WHO supported GNP+ to develop minimum requirements for people living with HIV on integrating HIV into primary health care and community systems *(46)*.

3.3.2 Policy uptake and monitoring

WHO has supported countries to adopt and implement guidance on prevention, testing and treatment at scale; also, WHO monitors uptake for all key areas including PrEP, HIV self-testing, use of dual tests, ARV regimens and viral load monitoring *(47)*. The rapid and wide uptake of WHO recommendations demonstrates their

relevance, feasibility and alignment with country needs. For example, in 2025 *(47)*:

- 91% of reporting countries had adopted WHO PrEP recommendations (**Fig. 3.19**);
- 109 countries had HIV self-testing policies;
- 95 countries had adopted dual HIV/syphilis rapid tests; and
- 90 countries reported routine implementation of self-testing.

WHO has continued to promote the global scale-up of simplified PrEP and post-exposure prophylaxis (PEP) delivery, with a focus on reducing the need for frequent facility visits, including through streamlining HIV testing requirements. HIV testing returned to pre-pandemic levels globally for the first time in 2022.

In 2025, WHO prequalified lenacapavir for HIV prevention and supported the first 14 countries to accelerate rollout (**Box 3.3**).

In 2025, 125 countries (92% of 136 reporting countries) had adopted dolutegravir (DTG) as part of the preferred first-line ARV regimen for adults and adolescents (**Fig. 3.20**), an increase from 60 countries in 2020.[1] The preferred regimen comprises DTG combined with tenofovir disoproxil fumarate (TDF) and lamivudine (3TC) or emtricitabine (FTC).

3.4 Critical issues and priorities for action up to 2030

To drive progress towards the 2030 targets, critical issues that need to be addressed include:

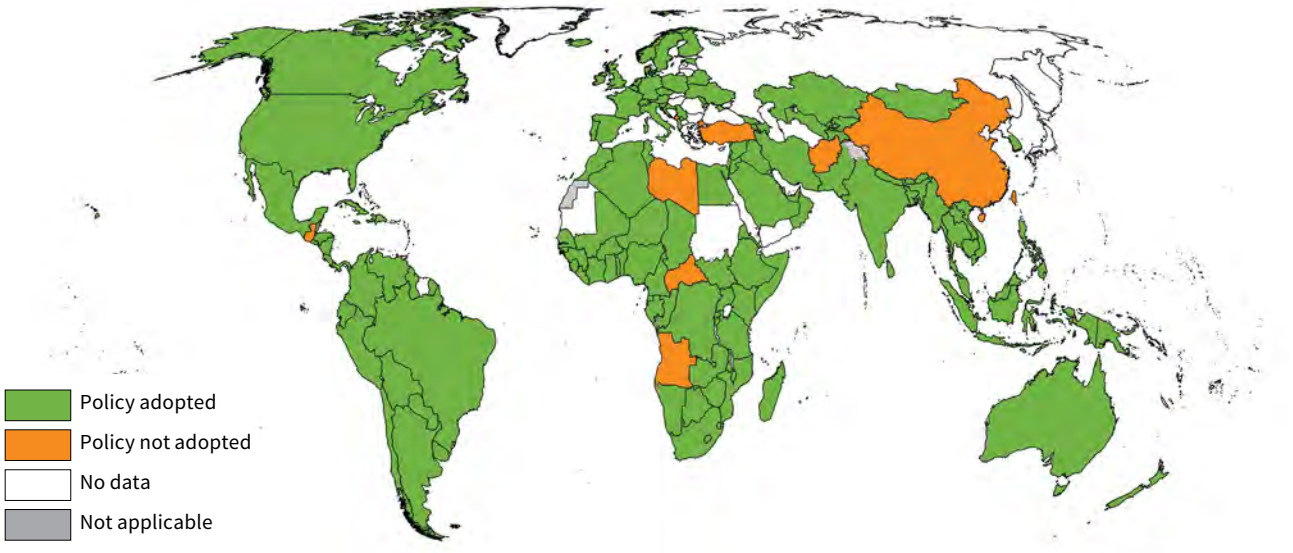
- remaining gaps in provision of ART to people living with HIV and management of AHD;
- slow progress in reducing the number of people acquiring HIV each year;
- how to sustain and further build on progress made in the past 2 decades, in the context of major changes to international donor funding for the HIV response; and
- inequities in access to the benefits of innovation.

Priorities for action in the years up to 2030 include:

- closing gaps in access to ART and sustained care for people living with HIV, with an emphasis on people-centred and integrated services;
- substantial improvements in HIV prevention, including through wider access to new long-acting injectables and primary prevention;
- strengthening domestic leadership and financing; and
- alignment with the new Global AIDS Strategy for 2026–2031 *(8)*.

At a global level, the HIV response is also evolving and adapting in the context of wider UN reform (**Chapter 2**).

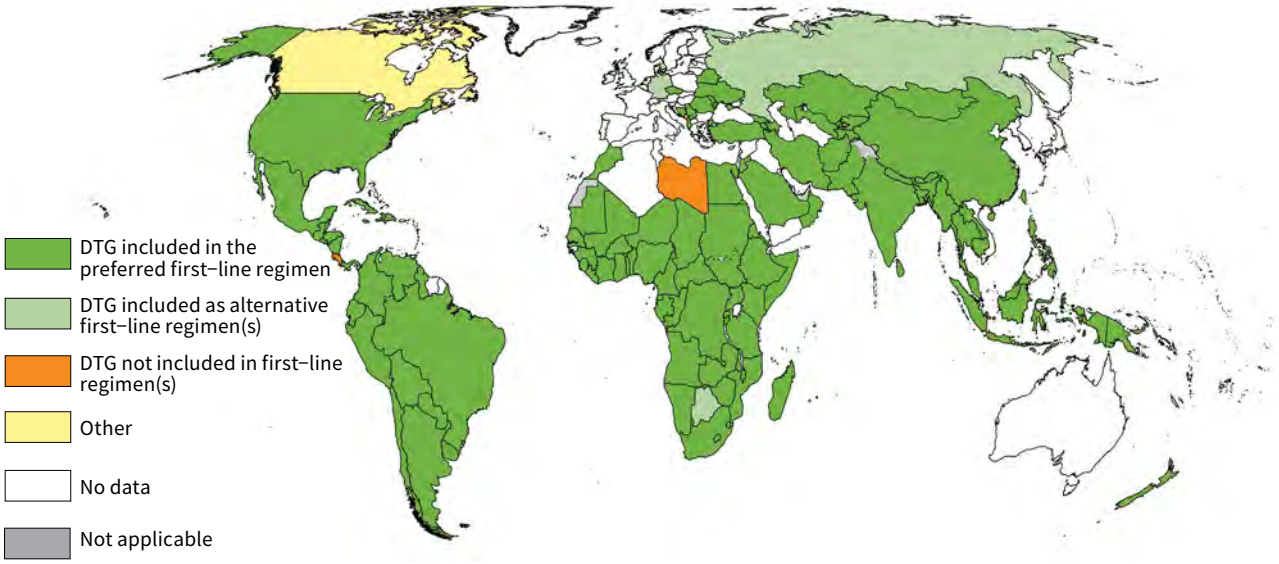
Fig. 3.19. Adoption of WHO policies on PrEP in national guidelines, 2025



PrEP: pre-exposure prophylaxis.

[1] This is the first year for which data on use of DTG in first-line regimens are available.

Fig. 3.20. Adoption of TDF + 3TC (or FTC) + DTG as the preferred first-line ARV combination for treatment initiation in national guidelines for adults and adolescents living with HIV, 2025



3TC: lamivudine; ARV: antiretroviral; DTG: dolutegravir; FTC: emtricitabine; TDF: tenofovir disoproxil fumarate.

3.4.1 Closing gaps in access to ART for people living with HIV

Global investments over the past 2 decades, particularly through PEPFAR and the Global Fund, have driven one of the most significant public health achievements in history: the rapid expansion of access to ART for people living with HIV, globally and in sub-Saharan Africa in particular. Nevertheless, gaps in access and continuity of care remain, reflecting ongoing structural, social and health system challenges that require sustained attention.

In 2025, 22% of people living with HIV were not on ART and 26% of people living with HIV did not have suppressed viral loads (**Fig. 3.15**), equivalent to about 9 million and 11 million people, respectively. Overall, levels of ART coverage were lower among men compared with women, and lower in children compared with adults (**Fig. 3.14**).

These gaps in ART coverage and viral suppression help to explain why the annual number of HIV-related deaths remains far above the 2030 target level (570 000 in 2025 compared with the target level of about 130 000). Other factors include interruptions to treatment and late diagnosis. Discontinuation of care can be followed by reengagement in care, including in repeated cycles, which has a significant impact on immune recovery.

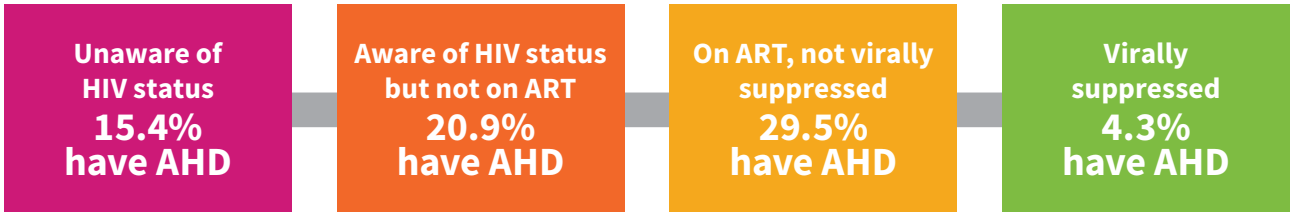
People who interrupt or discontinue ART, or whose access to care after acquiring HIV is very delayed, are more likely to develop AHD (**Fig. 3.21**). People with AHD have significantly higher rates of life-threatening AIDS-related complications, including TB, cryptococcal meningitis, histoplasmosis and severe bacterial infections. Hospitalizations for AIDS-related illness remain a significant challenge *(48)*.

The following are examples of approaches that could help to close gaps in access to ART and continuity of care:

- Expanded use of people-centred service delivery models, including differentiated service delivery for ART.[1] This includes engagement of affected communities in implementing community-based models of care, with adequate compensation for community service delivery providers, and strengthening of links between health services and communities to understand and address causes of disengagement from care.
- More effective communication of the HIV prevention benefits of viral suppression, including under the umbrella of messaging that “Undetectable = Untransmittable”.
- Innovations in service delivery to reach populations that continue to face treatment access barriers. These could include development and use of targeted strategies along the life-course – including for people aged 50 years and older and for children living with HIV – and enhanced efforts to overcome the HIV-related stigma and discrimination that impedes access to ART and treatment continuation.

[1] Differentiated service delivery is an approach that simplifies and adapts HIV services to better serve the needs of people living with HIV and to optimize the available resources in health systems *(26)*.

Fig. 3.21. Distribution of AHD among people living with HIV in sub-Saharan African countries



AHD: advanced HIV disease; ART: antiretroviral therapy.
Source: Stelzle et al. (2025) *(16)*.

- Generation and use of more granular data on treatment coverage and retention, to guide efforts to improve access to and delivery of services.[1]
- Investment to rebuild capacity to diagnose AHD. The WHO-recommended package of care for AHD includes screening, diagnosis (including use of CD4 testing), prophylaxis and enhanced adherence counselling for all individuals. Delivery of this package has been constrained by a sharp decline in CD4 testing in recent years *(49)* and the withdrawal of several test manufacturers from the market.
- Rapid uptake of innovations (including those in service delivery) and the equitable adoption of long-acting treatment options as they become available.
- Widespread uptake of WHO recommendations on testing and service delivery, including the package of care for AHD and better tolerated paediatric ARV formulations.

With millions of people being on ART for many years, there is a need to consider living with HIV as people age *(50)*. About 11 million people aged 50 years and older are living with HIV (**Fig. 3.4**). This group experiences higher levels of multimorbidity than their counterparts without HIV, including a higher incidence of noncommunicable diseases *(51)*. Health systems must support healthy ageing with HIV through people-centred models of care, including primary care–based approaches that address both physical and psychosocial well-being.

3.4.2 Revitalization and expansion of HIV prevention efforts

Globally, the number of people acquiring HIV each year fell by 42% between 2010 and 2025 (**Fig. 3.5**). However, there were still 1.2 million people who acquired HIV in 2025, far above the 2030 target of a 90% reduction by 2030, which would see numbers fall to about 200 000 per year.

Drivers of continuing high HIV incidence include inadequate funding and delivery of primary prevention interventions; gaps in ART coverage; reduced funding for HIV responses that are community-based and led; and ongoing social and structural barriers that hinder access to prevention, testing and treatment services, including HIV-related stigma and discrimination.

There are opportunities for health systems and communities to achieve greater reductions in HIV incidence across different settings and populations by facilitating more widespread uptake of condoms, PrEP, PEP, harm reduction services and improved STI/HIV prevention services.[2]

Wider access to new PrEP options requires not only supply, but also accessibility and affordability, including through generic production in low and lower-middle-income countries (**Box 3.3**).

The Global AIDS Strategy for 2026–2031 includes targets that 90% of people in need of prevention use prevention options; these are defined as PrEP, PEP, condoms, needle-syringe programmes and opioid agonist maintenance treatment *(8)*.

Several high-income countries are already considering the feasibility of striving for the elimination of sexual HIV transmission, based on available interventions such as PrEP and condoms.

3.4.3 Domestic financing in high HIV burden countries

Closing existing gaps in the provision of ART to people living with HIV and substantial improvements in HIV prevention will require sufficient and sustained funding.

Since the early 2000s, a large share of funding for the HIV response, at both country and global levels, has been from international donor funding – primarily through PEPFAR and the Global Fund. In 2024, global funding for the HIV response amounted to US$ 18.7 billion, with international donor funding accounting for 48% of the total *(8)*.

Since 2025, official development assistance (ODA), including funding for the health sector and for the HIV response specifically, has declined (**Chapter 2**):

- globally, the total amount of ODA fell by 23% in 2025, from US$ 226 billion to US$ 174 billion *(52)*;

[1] Alongside the generation and use of more granular data, confidentiality and data security need to be protected.

[2] This is also discussed in **Chapter 5** and **Chapter 6**.

- preliminary data indicate that ODA from the United States fell by 57% in 2025 compared with 2024, a reduction that accounted for about three quarters of the global decline in ODA in 2025; and
- in the Global Fund's eighth replenishment in late 2025, donors pledged US$ 12.6 billion for 2026–2028, far short of the US$ 18 billion target *(53–55)*. The pledges were about 20% lower than the US$ 15.7 billion raised in the previous cycle.

The United States government has also modified its global health assistance strategy to place greater emphasis on bilateral agreements, which require increased co-investment by recipient governments *(56, 57)*.

In this context, sustaining and strengthening the HIV response in LMICs will increasingly depend on domestic financing. The Global AIDS Strategy for 2026–2031 envisages that, by 2030, upper-middle-income countries will account for 46% of the annual resources needed for the HIV response, with the remainder needed in lower-middle-income countries (34%) and low-income countries (20%) *(8)*. It also envisages that upper-middle-income countries will finance almost the entirety of their responses, lower-middle-income countries about two thirds and low-income countries about one third.

Strong data systems are fundamental to understanding and addressing the remaining and persistent gaps in the HIV response. Continued strengthening of national data and surveillance systems will be important in this rapidly changing global context. The integration of HIV surveillance systems and functions into wider national health information system architectures will help to ensure the long-term sustainability of monitoring and inform responsive, data-driven decision-making.

3.4.4 Alignment with the new Global AIDS strategy

The Global AIDS Strategy for 2026–2031 is organized around three priorities *(8)*:

- Priority 1 focuses on domestic leadership, diversified financing, integration of HIV into universal health coverage and primary health care, multisectoral collaboration and equitable data governance.
- Priority 2 promotes integrated, differentiated and people-centred HIV services, combining prevention, testing, treatment and care with social and behavioural interventions, while supporting local manufacturing of health commodities.
- Priority 3 advances rights-based and gender-responsive approaches through legal reform, community-led governance, adequate resourcing of community organizations and safeguarding.

Sustainability is a central theme of the strategy, which calls for durable financing and service delivery systems that provide accessible, quality HIV services; reduce out-of-pocket costs; strengthen community responses; and address structural inequalities. Strategic investments in national and local capacity, supported by flexible financing and cross-sectoral collaboration, are seen as essential to sustaining gains and strengthening resilience against HIV and other health threats.

The strategy recognizes the importance of key populations, including people living with HIV, men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients. The engagement of these populations is critical to an effective HIV response.

The strategy retains the 2030 targets of reducing the number of new HIV infections and the number of AIDS-related deaths by 90% compared with 2010, as well as the 95–95–95 targets. There are also new targets, including that:

- by 2030, 40 million people living with HIV are on ART and 38 million are virally suppressed;
- by 2030, 20 million people have access to ARV-based HIV prevention;
- by 2030, 90% of people in need of prevention use prevention options (defined as PrEP, PEP, condoms, needle-syringe programmes and opioid agonist maintenance treatment); and
- all people have access to HIV services free from stigma and discrimination.

These targets (and others included in the strategy) reinforce the three pillars of the HIV response: treatment, prevention and equitable access to services.

The GHSS remains well aligned with the Global AIDS Strategy for 2026–2031 *(8)* and the political declaration of the 2026 high-level meeting on HIV/AIDS (**Box 3.5**) *(5)*.

BOX 3.5.

The 2026 UN high-level meeting on HIV/AIDS

The UN General Assembly held its sixth high-level meeting on HIV/AIDS on 22–23 June 2026, following previous high-level meetings in 2001, 2006, 2011, 2016 and 2021. The outcome was a political declaration, which was adopted by 149 Member States.

Through the declaration, Member States:

- reaffirmed the global commitment to end AIDS as a public health threat by 2030, while acknowledging that progress towards 2030 targets is off track;
- highlighted a challenging operating environment, including declining HIV financing, widening inequalities, humanitarian crises, conflict and pressures on multilateralism that threaten progress;
- called for stronger integration of HIV services within primary health care, universal health coverage and broader health systems, including linkages with services for TB, viral hepatitis, STIs, sexual and reproductive health, mental health and noncommunicable diseases;
- reaffirmed the central role of human rights, gender equality, community leadership and the meaningful involvement of people living with HIV, or at risk of and affected by HIV, as essential enablers of progress;
- committed to accelerating access to evidence-based HIV prevention, testing, treatment and care, including scaling up long-acting technologies, achieving the 95–95–95 targets and eliminating vertical transmission of HIV;
- recognized the importance of innovation, data, accountability and continued multilateral coordination, including through the future institutional arrangement that will evolve from UNAIDS, to sustain progress beyond 2030.

Recognizing the importance of sustained accountability beyond the 2030 deadline, Member States agreed to convene a seventh UN high-level meeting on HIV/AIDS in 2031, to review progress, identify remaining gaps and chart the future course of the global response.

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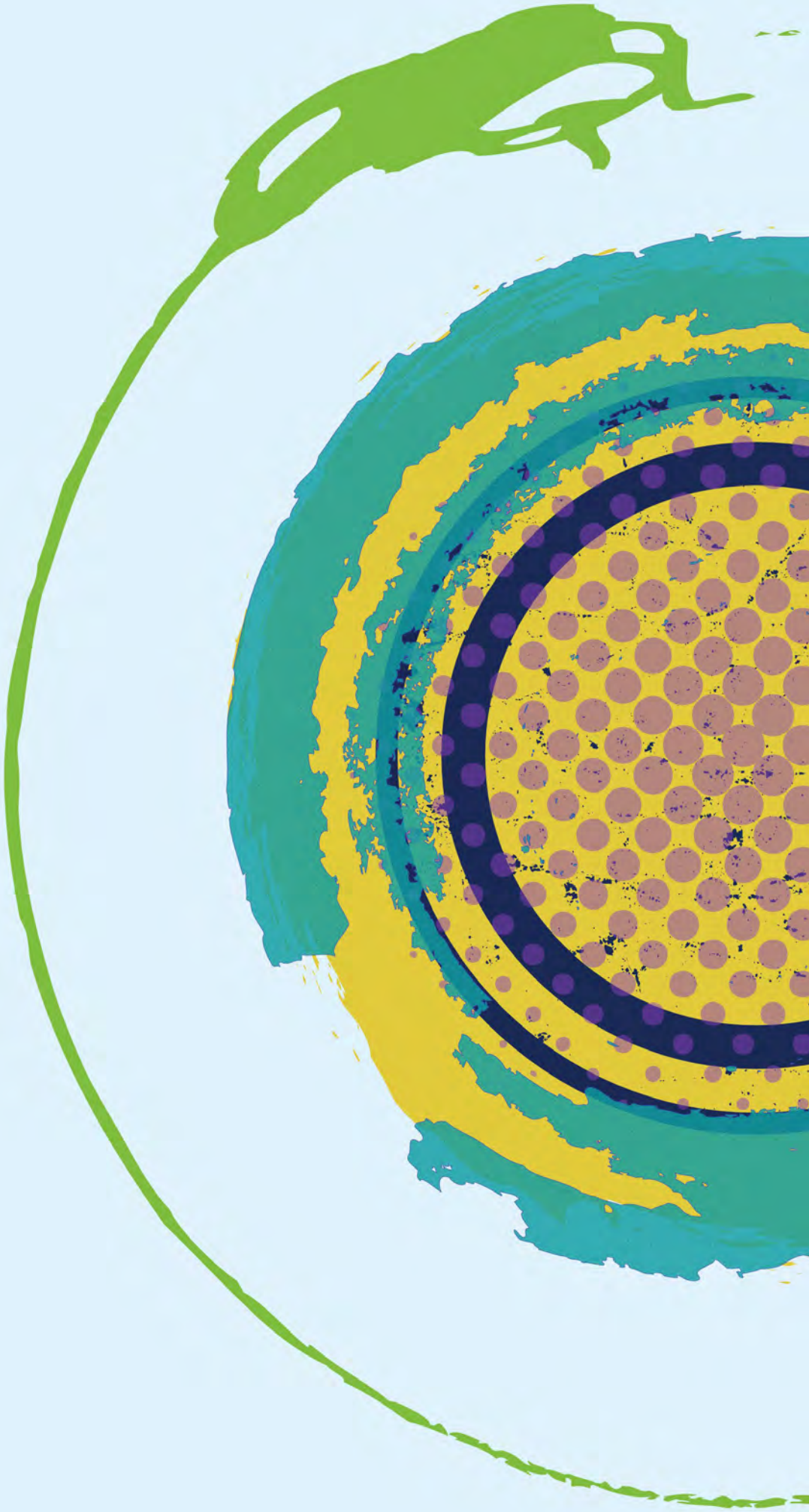
Chapter 4

Viral hepatitis



Viral hepatitis is one of the leading infectious causes of death worldwide *(1)*. This is despite the existence of interventions to prevent and treat infections of hepatitis B virus (HBV) and hepatitis C virus (HCV), which in combination account for more than 95% of viral hepatitis–related mortality.[1] Hepatitis B vaccines with very high efficacy have been available for four decades, and there are effective treatments to manage chronic HBV infection. Most people with HCV infection can be cured with safe and highly tolerable treatment regimens.

All Member States of the World Health Organization (WHO) have committed to the goal of eliminating viral hepatitis as a public health threat by 2030, initially in a World Health Assembly resolution in 2014 *(2)* and subsequently through adoption of the first global strategy on viral hepatitis in 2016 *(3)*. Aligned with this commitment, the WHO global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (GHSS) include 2030 targets for substantial reductions in new HBV and HCV infections, the prevalence of chronic HBV infection, and HBV-related and HCV-related deaths, as well as accompanying targets for improvements in the coverage of prevention, diagnostic and treatment services *(4)*.

This chapter provides a mid-term assessment of progress towards the 2030 targets, organized according to four topics:

- epidemic status and trends;
- service coverage;
- WHO guidance and support for strategy implementation, 2022–2026; and
- critical issues and priorities for action in the years up to 2030.

The chapter is based on the latest available data published in WHO's *Global hepatitis report 2026 (1)*. The key findings and messages are provided in **Box 4.1**, followed by an illustrative overview of progress towards the 2030 targets for epidemic impact and service coverage (**Fig. 4.1**).

BOX 4.1.

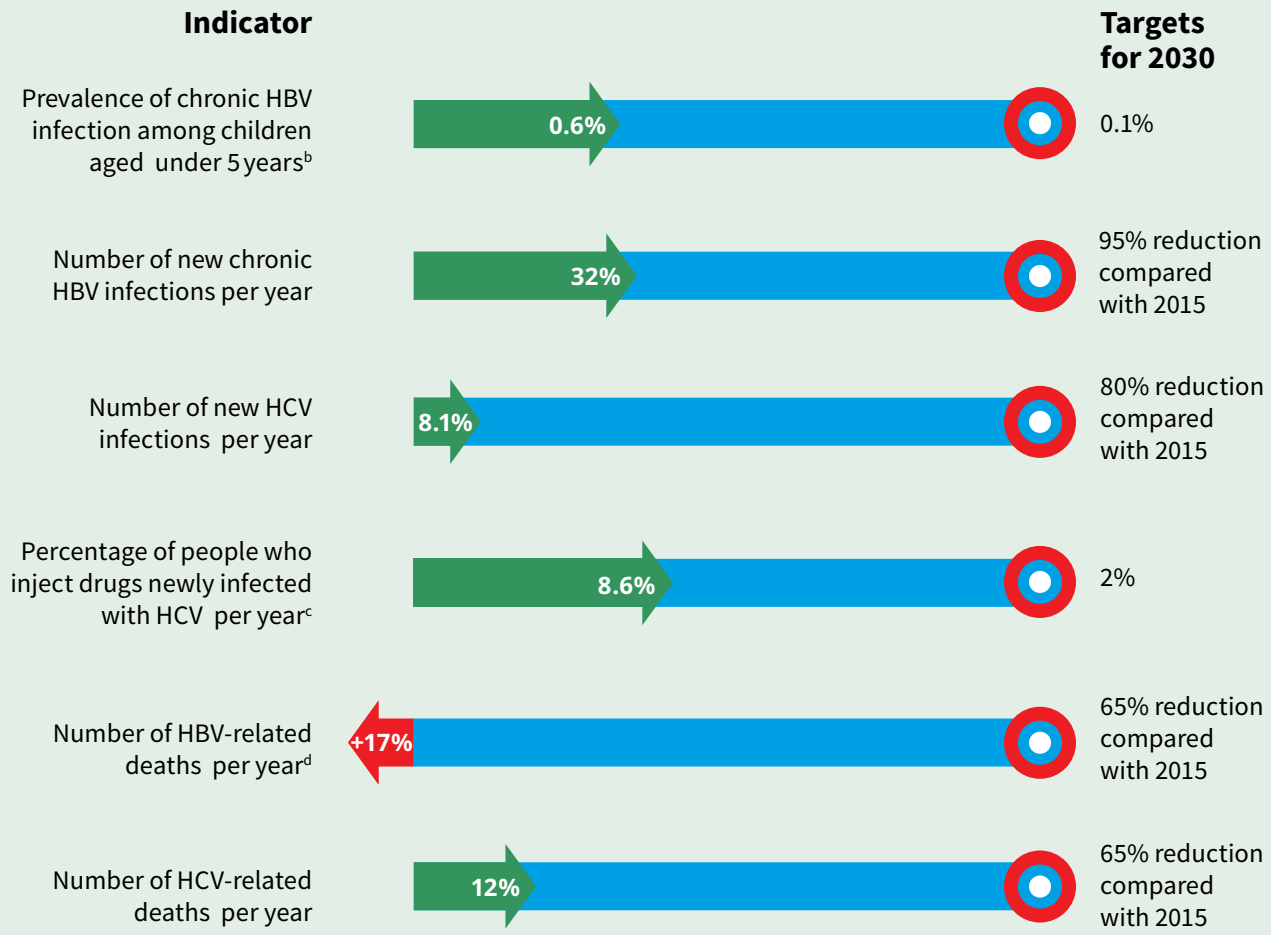
Chapter summary: key findings and messages

- Substantial progress has been achieved in some countries and WHO regions, particularly in reducing HBV incidence through childhood vaccination and expanding access to curative treatment for HCV infection. However, the current global pace of progress is not sufficient to achieve the 2030 elimination targets.
- Viral hepatitis remains one of the few major communicable diseases for which mortality is increasing.
- In 2024, 1.3 million people died from the sequelae of chronic HBV and viraemic HCV infection (cirrhosis and hepatocellular carcinoma, HCC). This included 1.1 million (95% uncertainty interval [UI]: 0.9–1.3 million) HBV-related deaths, an increase of 17% compared with 2015. The number of HCV-related deaths fell by 12% in the same period, to 240 000 (95% UI: 160 000–370 000) in 2024.
- In 2024, 240 million people (95% UI: 202–296 million) were living with chronic HBV infection and 47 million people (95% UI: 31–71 million) with viraemic HCV infection (2.9% and 0.6% of the global population, respectively).
- HBV- and HCV-related cirrhosis and HCC are the result of infections acquired 20–30 years earlier. The only way to achieve the 2030 targets of reducing both HBV- and HCV-related deaths by 65% compared with levels in 2015 is to massively expand the provision of antiviral treatment.
- Major gaps in diagnosis and treatment persist. By the end of 2024, only 27% of people living with chronic HBV infection and 36% of people living with viraemic HCV infection had been diagnosed. Treatment coverage in 2024 was 4.3% for people with chronic HBV infection and 20% for people with HCV infection.
- In the longer term, the best way to reduce the number of HBV- and HCV-related deaths is to reduce the number of people acquiring HBV and HCV infections. This is also necessary to achieve the 2030 targets for reductions in incidence and prevalence.
- Globally in 2024, 0.9 million people (95% UI: 0.7–1.2 million) acquired a chronic HBV infection; this was a decline of 32% compared with 2015, largely owing to improved coverage of hepatitis B infant vaccination (84% in 2024). The WHO African Region accounted for 68% of new infections in 2024.
- Most chronic HBV infections are acquired in the first 5 years of life, through mother-to-child transmission or person-to-person contact in the presence of open cuts and sores. The global prevalence of HBV infection in children aged under 5 years was 0.6% in 2024, a reduction from 0.8% in 2015 but still far from the 2030 target of 0.1%. It was much higher in the WHO African Region (1.4%). Worldwide, 85 countries have a prevalence of less than 0.1%.
- Achieving the 2030 global target of a 95% reduction in HBV incidence (compared with 2015) requires a large improvement in birth-dose coverage of the hepatitis B vaccine in the WHO African Region. Coverage was only 17% in 2024, and 20 of the 47 countries in the region were not yet implementing birth-dose vaccination.
- Globally in 2024, 0.9 million people (95% UI: 0.6–1.4 million) acquired HCV infection, a decline of 8% compared with 2015 and far from the target of an 80% reduction by 2030. Transmission is driven by injecting drug use and, in some settings, unsafe medical injections.
- Urgent action to improve the coverage of available interventions is needed, especially in countries with the highest burden.

[1] The remainder is caused by hepatitis A, D and E.

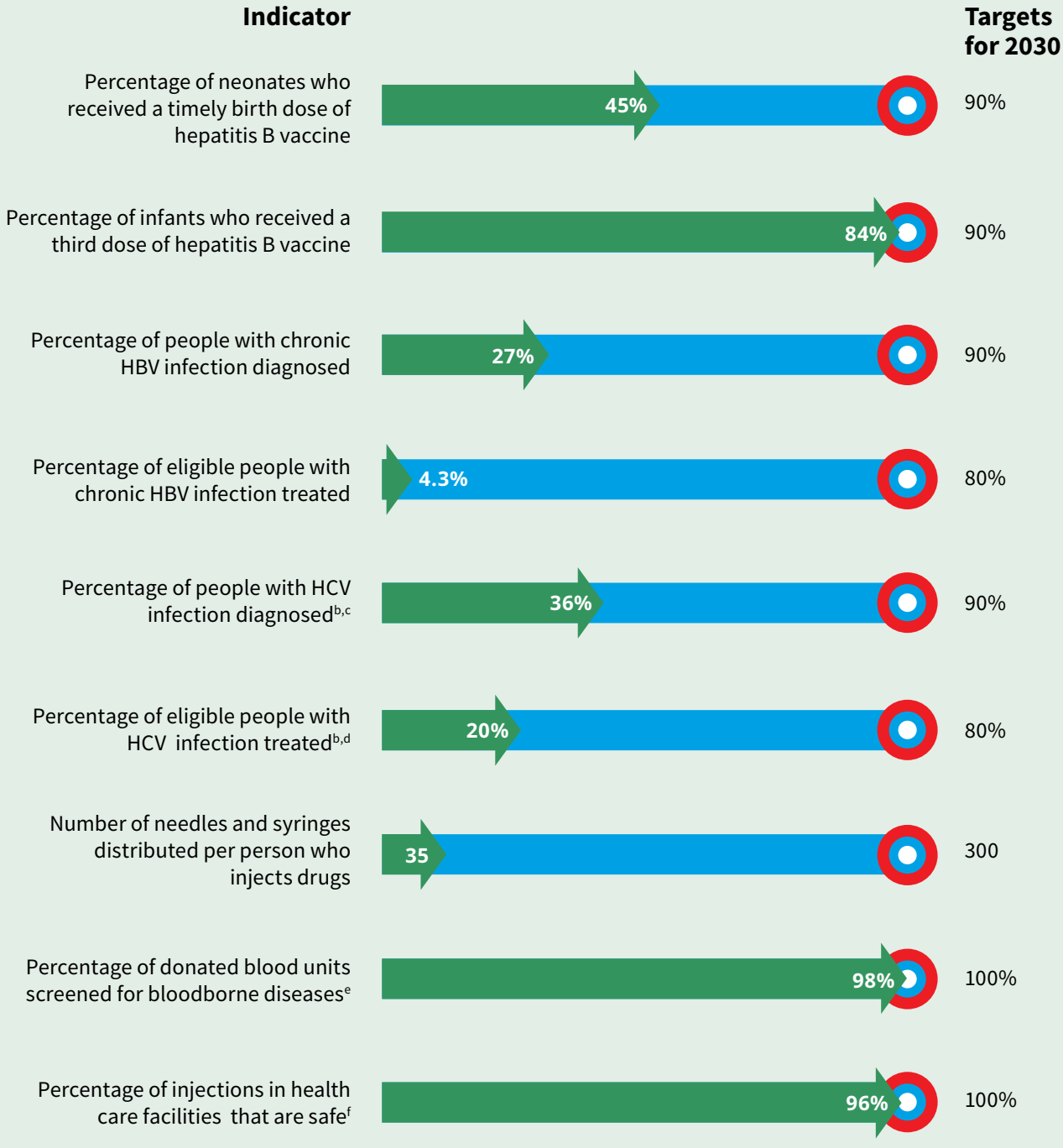
Fig. 4.1. Global targets for viral hepatitis: latest status of progress[a]

a) Impact targets



[a] This is 2024 for all indicators unless otherwise stated.
[b] The baseline estimate for 2015 is 0.8%.
[c] Data are for 2021.
[d] There was a 17% increase in HBV-related deaths between 2015 and 2024.

b) Service coverage targets



HBV: hepatitis B virus; HCV: hepatitis C virus.

[a] This is 2024 for all indicators unless otherwise stated.

[b] The denominator is the cumulative number of people with an HCV infection at any time in the period 2015–2024.

[c] The numerator is the cumulative number of people diagnosed with HCV infection in the period 2015–2024.

[d] The numerator is the cumulative number of people with HCV infection who were treated in the period 2015–2024.

[e] Data are for 2018.

[f] Data are for between 2011 and 2015.

4.1 Epidemic status and trends

People can be infected with HBV and HCV through exposure to infected blood (HBV and HCV) or other bodily fluids (HBV). In highly endemic areas, most chronic HBV infections occur in children aged under 5 years, either through mother-to-child transmission at birth or horizontal transmission through person-to-person contact in the presence of open cuts and sores. People can also be infected with HBV through exposure to infected blood via needle-stick injuries, tattooing, piercing, sexual contact, and sharing of contaminated needles or sharp instruments in health care settings or among people who inject drugs. The most common routes of HCV transmission are unsafe medical injections and procedures, unscreened blood transfusions, and sharing of needles and syringes among people who inject drugs.

People with a new infection are typically asymptomatic, although occasionally a new infection can cause acute hepatitis. In some people, infection becomes chronic, persisting silently (i.e. without symptoms) for many years. Over a period of about 3 decades following initial infection, chronic infection can advance to severe sequelae such as cirrhosis and hepatocellular carcinoma (HCC), which drive hepatitis-related morbidity and mortality *(5, 6)*. Cirrhosis is an advanced stage of liver disease characterized by extensive hepatic fibrosis, nodularity of the liver, alteration of liver architecture and disrupted hepatic circulation. Both HBV and HCV are established carcinogens that can cause HCC, a primary cancer of the liver arising from the hepatocytes.

People infected with HBV in infancy or early childhood (before reaching the age of 5 years) are at highest risk (about 95%) of developing a chronic infection, while the risk of developing a chronic HBV infection is below 5% for people infected in adulthood *(7, 8)*. HCV infection becomes chronic in about 55–85% of infected individuals (across all age groups), with the remainder clearing the virus spontaneously *(6)*.

Incidence is defined as the number or rate (per 100 000 population) of new chronic HBV infections or viraemic HCV infections (including reinfections for HCV) in a year; it reflects the ongoing risk of transmission.

Prevalence is defined as the number or percentage of people in a population that are infected at a given point in time. A chronic HBV infection is defined as the persistence of hepatitis B surface antigen (HBsAg) for 6 months or more after acute infection. Viraemic HCV infection is defined as the presence of HCV virus in the blood (HCV RNA or HCV core antigen [HCVcAg]) and is often referred to as active, ongoing or current infection.

Mortality is defined as deaths resulting from the sequelae of chronic HBV or HCV infection, including cirrhosis and HCC.

An overview of progress towards the six 2030 targets for epidemic impact (reductions in incidence, prevalence and mortality) included in the GHSS *(4)* is provided in **Table 4.1**.

4.1.1 Global burden of chronic infection and hepatitis-related mortality

Worldwide in 2024, there were an estimated 240 million people living with a chronic HBV infection (95% UI: 202–296 million), equivalent to 2.9% of the global population, and 47 million people were living with viraemic HCV infection (95% UI: 31–71 million) (**Fig. 4.2**). The number of people with a chronic HBV infection has been declining very slowly, while the number of people with HCV infection has fallen by 20% since 2015.

The burden of HBV infection in 2024 was concentrated in two WHO regions (**Table 4.2**): the WHO Western Pacific Region, where 102 million people were living with a chronic HBV infection (95% UI: 92–117 million), equivalent to 4.6% of the general population (95% UI: 4.1–5.2%); and the African Region, where 64 million people were living with a chronic HBV infection (95% UI: 53–81 million), equivalent to 5.1% of the general popu-

Table 4.1. Global status of progress towards GHSS 2030 impact targets for viral hepatitis

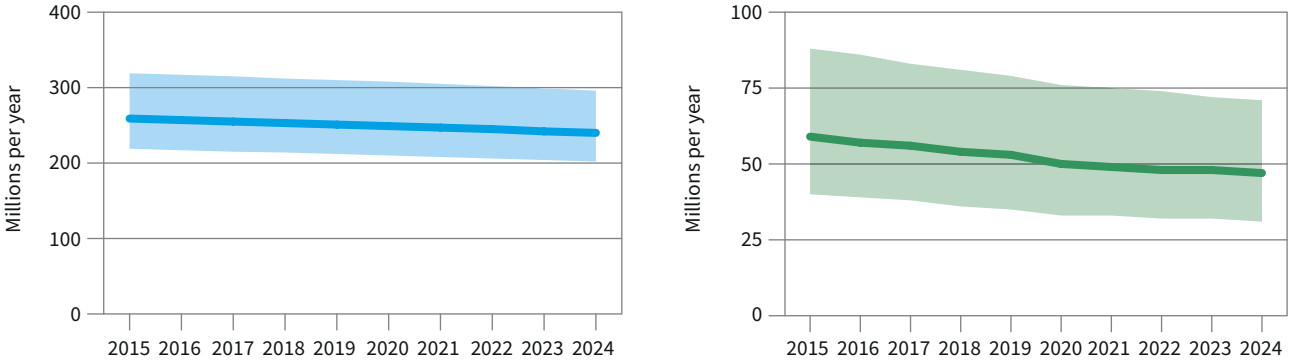
Indicator	2024 progress (%)	2030 target (%)
Incidence		
Reduction in the annual number of new HBV infections, compared with 2015	32	95
Reduction in the annual number of new HCV infections, compared with 2015	8.1	80
Percentage of people who inject drugs who acquire a new HCV infection each year	8.6	2
Prevalence of chronic HBV infection among children aged under 5 years[a]	0.6	0.1
Mortality		
Reduction in the annual number of HBV-related deaths	+17[b]	65
Reduction in the annual number of HCV-related deaths	12	65

GHSS: global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030; HBV: hepatitis B virus; HCV: hepatitis C virus.

[a] Serves as a proxy for the cumulated incidence (past or present infection) in children aged under 5 years.

[b] There was a 17% increase in HBV-related deaths between 2015 and 2024.

Fig. 4.2. Global numbers of people living with chronic HBV infection (left) or HCV infection (right), 2015–2024[a]



HBV: hepatitis B virus; HCV: hepatitis C virus.

[a] Shaded areas represent 95% uncertainty intervals.

Table 4.2. Prevalence of HBV and HCV infections, globally and for WHO regions, 2024

WHO region	Prevalence in the general population (%) (95% UI)		Total number (all ages) of people infected (millions) (95% UI)	
	Chronic HBV infection	HCV infection	Chronic HBV infection	HCV infection
African Region	5.1 (4.1–6.3)	0.7 (0.4–1.1)	64 (53–81)	8.8 (4.9–14)
Region of the Americas	0.5 (0.3–0.8)	0.5 (0.4–0.7)	5.0 (3.2–8.1)	5.3 (3.7–7.5)
South-East Asia Region	2.3 (2.0–2.7)	0.4 (0.3–0.8)	43 (36–50)	8.1 (5.0–15)
European Region	1.0 (0.7–1.3)	0.6 (0.4–0.8)	9.7 (6.5–13)	5.6 (3.8–7.1)
Eastern Mediterranean Region	1.9 (1.4–3.5)	1.4 (1.1–2.0)	16 (11–29)	12 (8.8–16)
Western Pacific Region	4.6 (4.1–5.2)	0.3 (0.2–0.5)	102 (92–117)	7.0 (4.6–11)
Global	**2.9 (2.5–3.6)**	**0.6 (0.4–0.9)**	**240 (202–296)**	**47 (31–71)**

lation (95% UI: 4.1–6.3%). Together, these two regions accounted for 70% of the global number of people living with a chronic HBV infection in 2024.

For HCV, the WHO Eastern Mediterranean Region accounted for a disproportionate share (relative to population size) of infections: 12 million people (95% UI: 8.8–16 million) were infected in 2024, equivalent to 25% of the global total. This was the only region in which more than 1% of the general population was infected (Table 4.2).

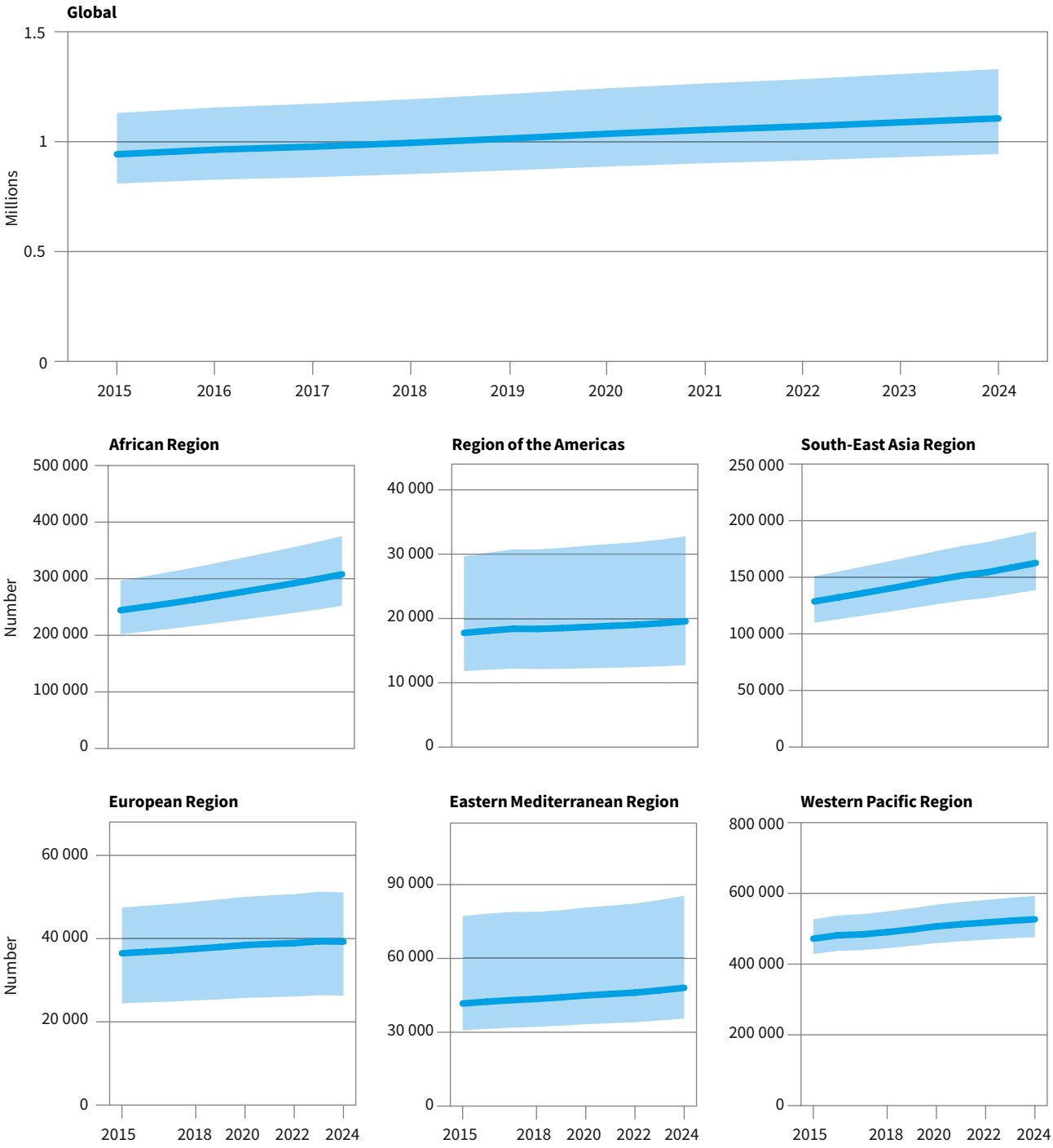
Globally in 2024, an estimated 1.1 million people (95% UI: 0.9–1.3 million) died from HBV-related cirrhosis and HCC, representing a 17% increase compared with 2015 (Fig. 4.3). There were an additional 240 000 (95% UI: 160 000–370 000) deaths attributable to HCV-related cirrhosis and HCC, corresponding to a 12% reduction since 2015 (Fig. 4.4). These divergent trends reflect the scale-up of curative treatment for HCV infection and the slow progress in expanding the coverage of lifelong treatment for people with chronic HBV infection, particularly in high-burden settings.

The absolute number of HBV-related deaths increased in all WHO regions between 2015 and 2024, although to varying degrees (Fig. 4.3). The largest absolute increases were in the WHO African and South-East Asia regions (both 26%), followed by the Eastern Mediterranean Region (15%), the Western Pacific Region (12%), the Region of the Americas (10%) and the European Region (8%).

The absolute number of HCV-related deaths decreased between 2015 and 2024 in four WHO regions (Fig. 4.4): the Eastern Mediterranean Region (33%), the European Region (31%), the Region of the Americas (21%) and the Western Pacific Region (12%). The absolute number of deaths increased by 24% in the WHO African Region and by 34% in the South-East Asia Region.

HBV-related mortality is highly concentrated geographically (Fig. 4.5). In 2024, 75% of HBV-related deaths occurred in the WHO African and Western Pacific regions, which also had the highest mortality rates. Ten countries accounted for 69% of global HBV-related deaths: Bangladesh, China, Ethiopia, Ghana, India, Indonesia, Nigeria, the Philippines, South Africa and Viet Nam. Many of these countries have a large cohort of adults with long-standing chronic infection acquired early in life, and limited access to diagnosis and treatment.

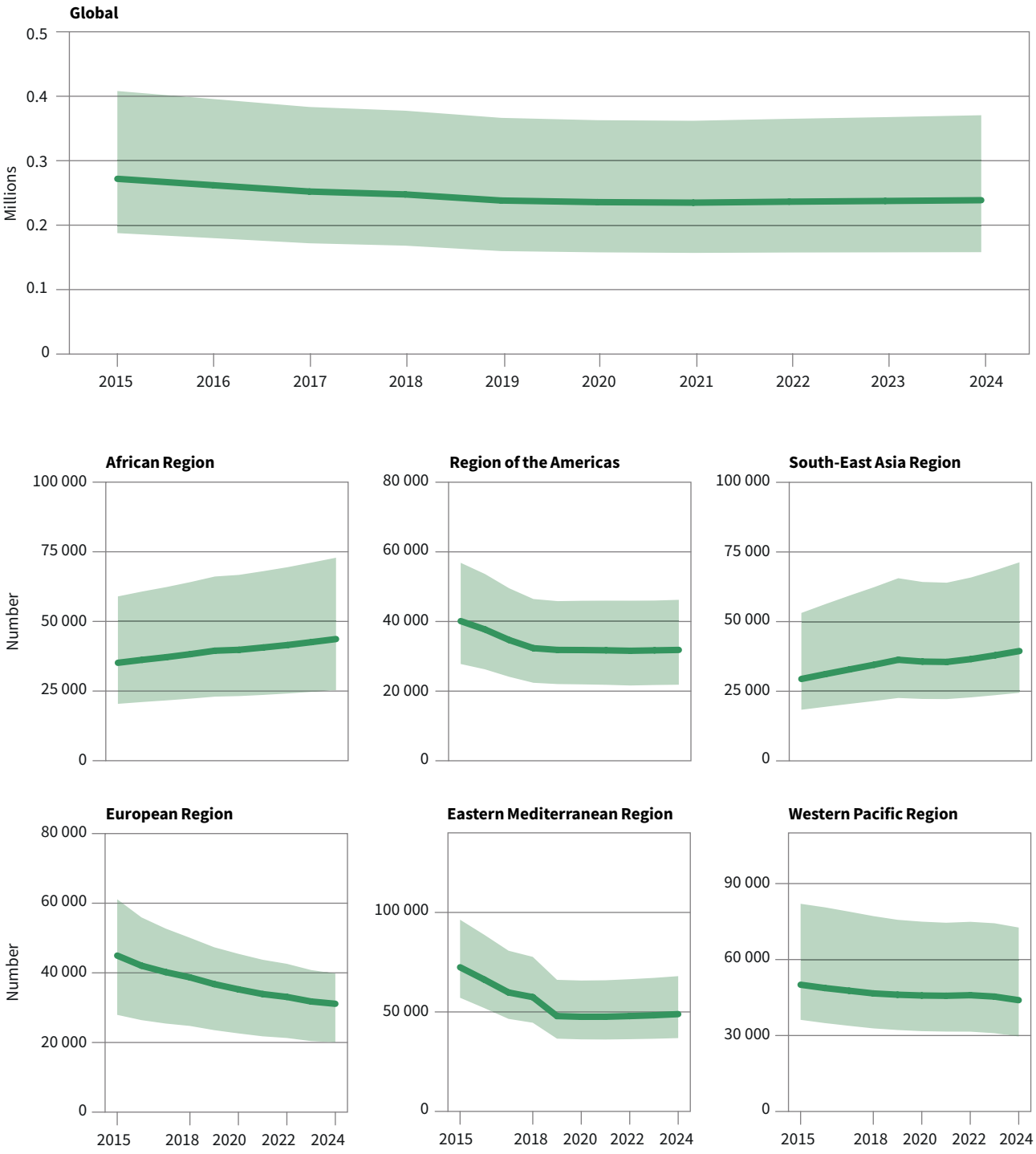
Fig. 4.3. Number of HBV-related deaths, globally and for WHO regions, 2015–2024[a]



HBV: hepatitis B virus.

[a] Shaded areas represent 95% uncertainty intervals.

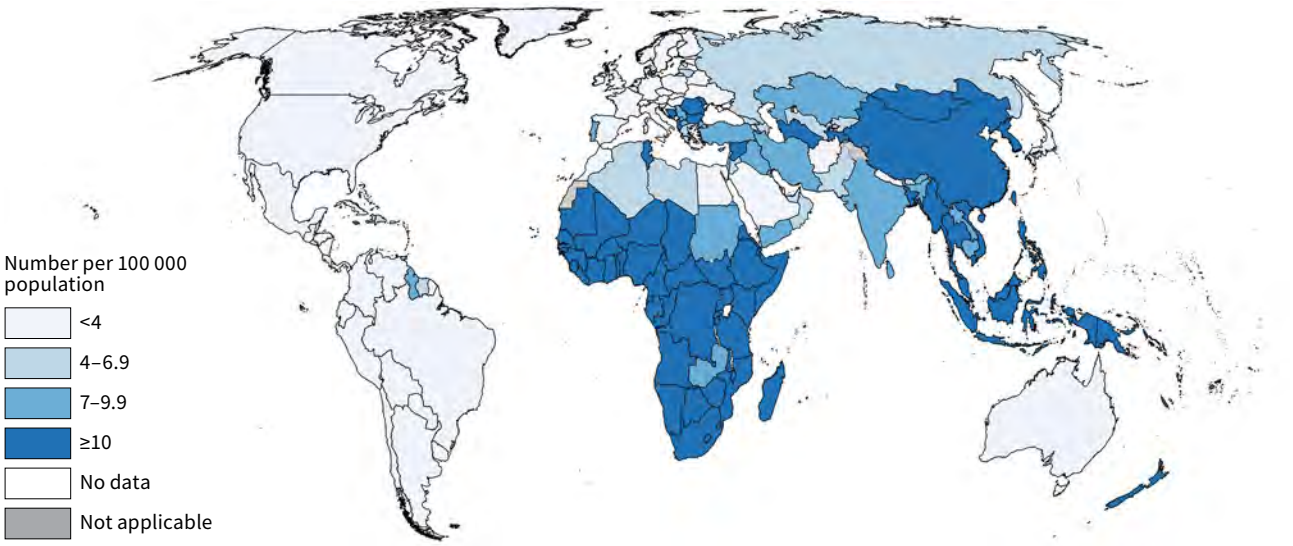
Fig. 4.4. Number of HCV-related deaths, globally and for WHO regions, 2015–2024[a]



HBV: hepatitis B virus.

[a] Shaded areas represent 95% uncertainty intervals.

Fig. 4.5. HBV-related mortality rate (number of deaths per 100 000 population) at country level, 2024



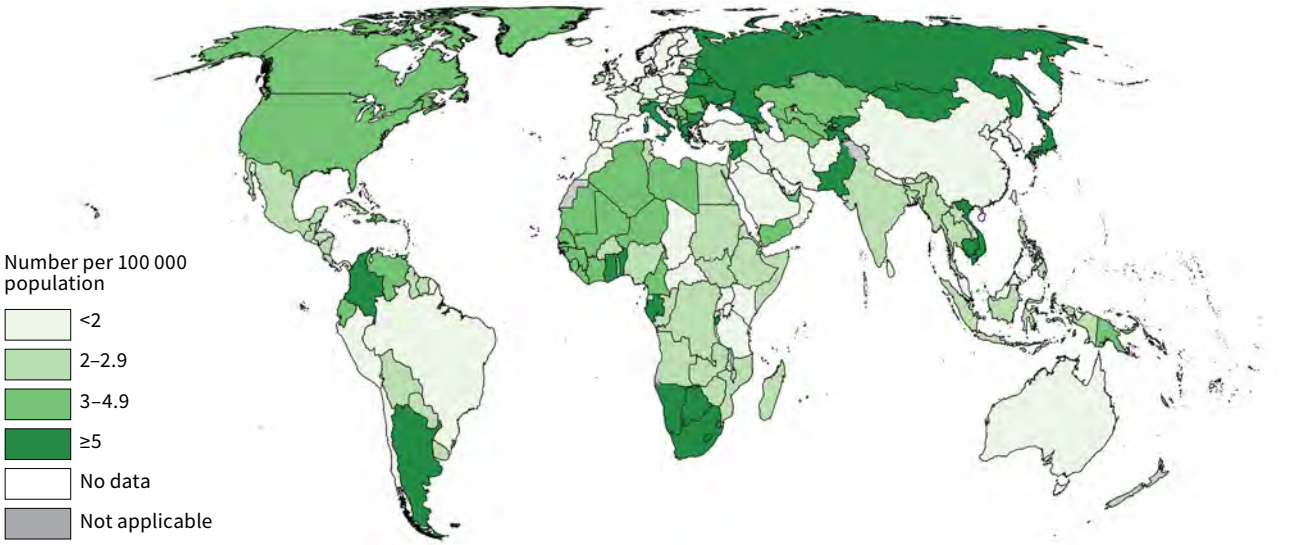
HBV: hepatitis B virus.

The geographic distribution of HCV-related mortality is more dispersed (**Fig. 4.6**). This reflects a mix of historical transmission patterns and causes, ageing cohorts of people with chronic infection and heterogeneous access to curative treatment.

In 2024, the 10 countries with the largest absolute number of HCV-related deaths were China, India, Indonesia, Japan, Nigeria, Pakistan, the Russian Federation, South Africa, the United States of America (USA) and Viet Nam. Collectively, they accounted for 58% of global HCV-related deaths.

To achieve the 2030 global target of a 65% reduction in hepatitis-related mortality compared with 2015, treatment coverage for both HBV and HCV infection will need to expand rapidly, particularly in countries that account for the largest share of deaths. China has the largest number of people living with chronic HBV infection (about 30% of the global total) and Pakistan has the largest number of people living with viraemic HCV infection (almost 20% of the global total); both countries have ambitious plans to scale up treatment in the years up to 2030 *(1)*.

Fig. 4.6. HCV-related mortality rate (number of deaths per 100 000 population) at country level, 2024



HCV: hepatitis C virus.

4.1.2 Incidence of chronic HBV infection and HCV infection

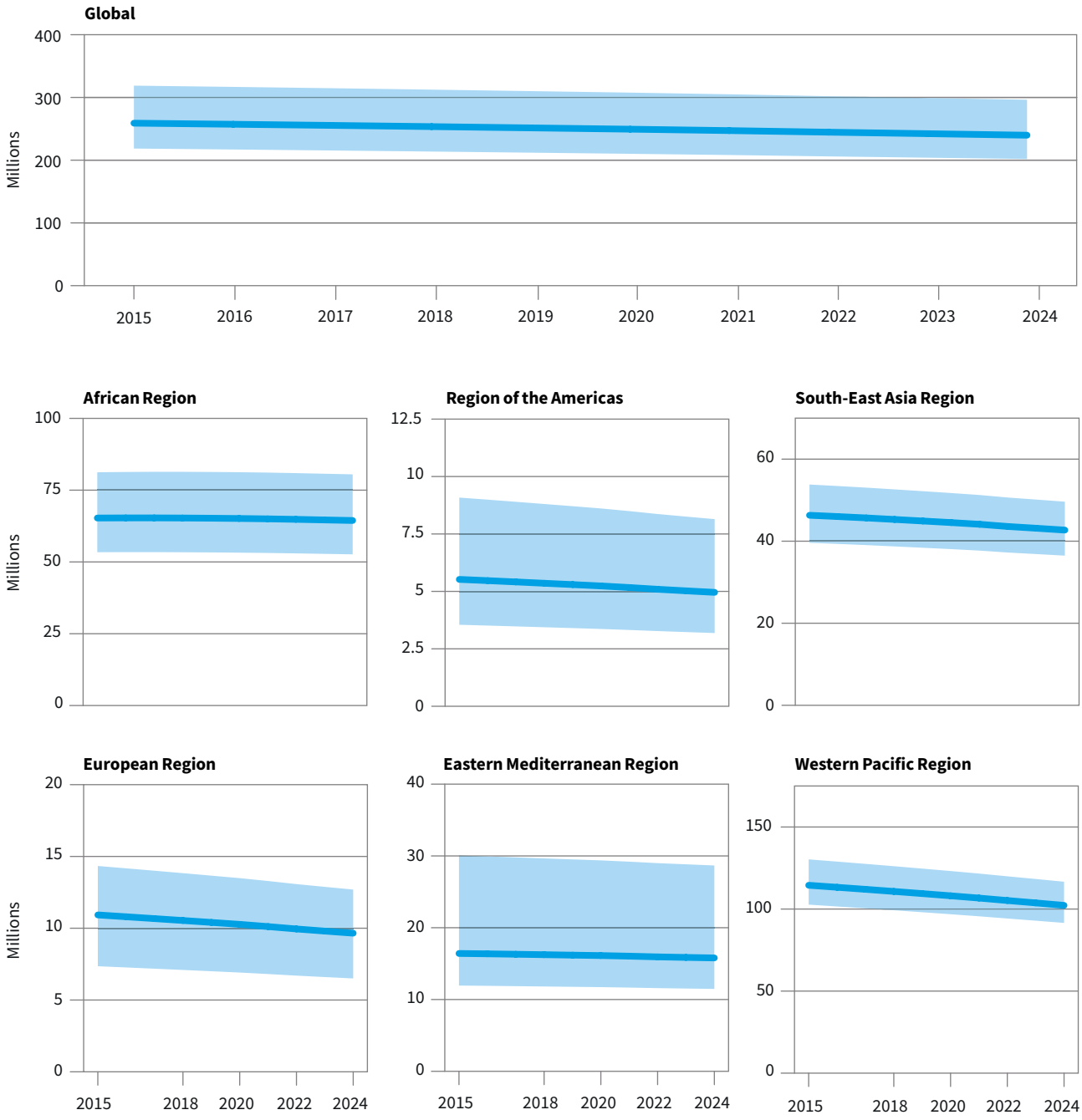
Globally in 2024, 0.9 million people (95% UI: 0.7–1.2 million) acquired a chronic HBV infection, a 32% decline compared with 2015 (**Table 4.1**; **Fig. 4.7**, **Fig. 4.8**). This decline represents considerable progress, but accelerated efforts are required to reach the target of a 95% reduction by 2030.

Progress in reducing the incidence of chronic HBV infections has been driven largely by expanded coverage of hepatitis B vaccination among infants (**Section 4.2**).

The WHO African Region accounted for 68% of new HBV infections in 2024, reflecting persistently low coverage of timely birth-dose vaccination and limited access to antiviral prophylaxis to prevent mother-to-child transmission (**Section 4.2**).

Between 2015 and 2024, there were impressive declines (of about 50%) in the number of new HBV infections in the WHO European, South-East Asia and Western Pacific regions (54%, 54% and 49% respectively). There were also large reductions in the WHO Region of the Americas (43%) and the African Region (25%). The

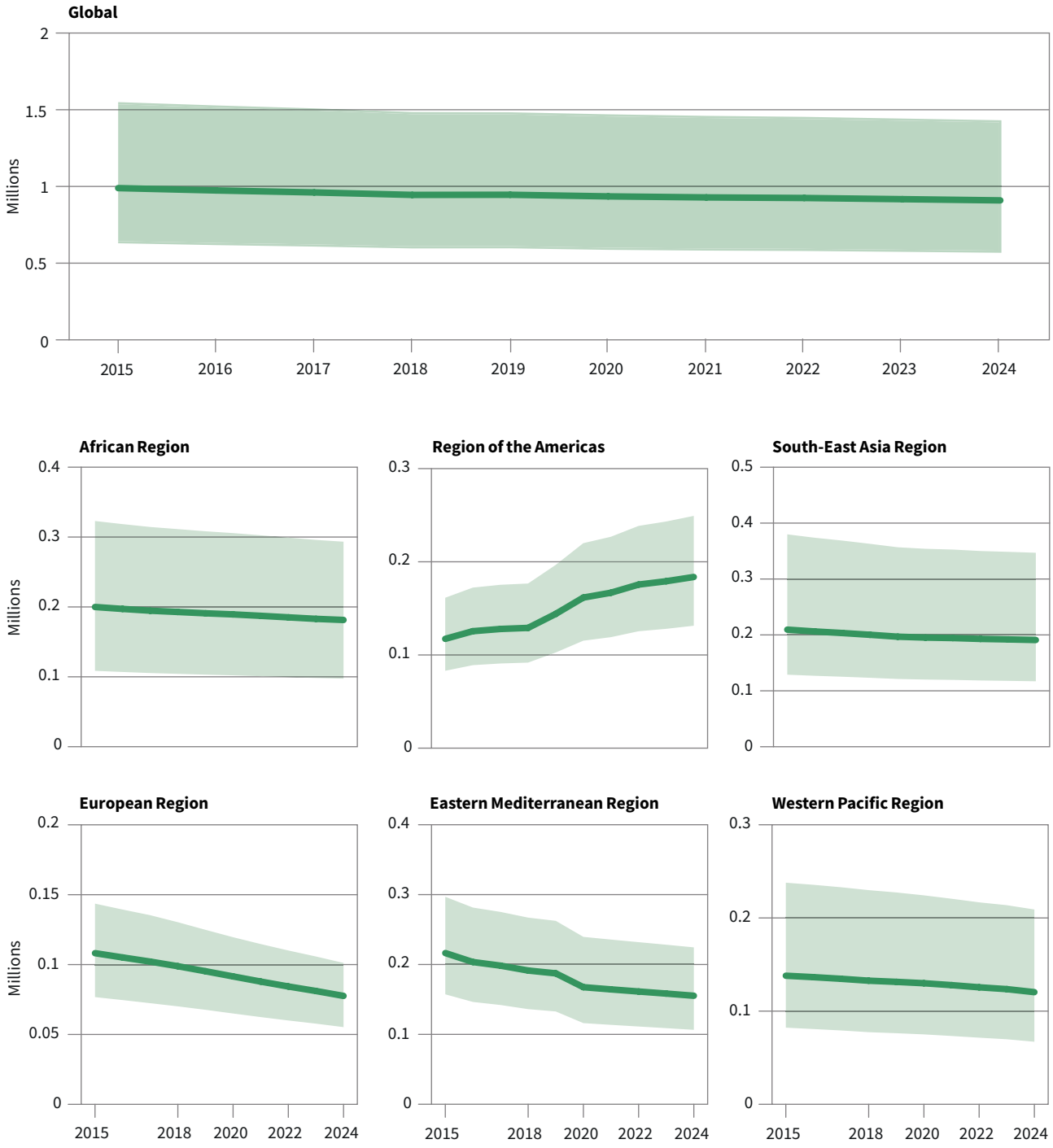
Fig. 4.7. Trends in the incidence of chronic HBV infections, globally and for WHO regions, 2015–2024[a]



HBV: hepatitis B virus.

[a] Shaded areas represent 95% uncertainty intervals.

Fig. 4.8. Trends in the incidence of viraemic HCV infections, globally and for WHO regions, 2015–2024[a]



HCV: hepatitis C virus.

[a] Shaded areas represent 95% uncertainty intervals.

smallest net reduction was in the WHO Eastern Mediterranean Region (17%), with a concerning upward trend emerging after 2022. Overall, the declines largely reflect sustained improvements in childhood vaccination coverage over the past decade.

In 2024, the global number of new HCV infections was 0.9 million (95% UI: 0.6–1.4 million), a decline of only 8.1% compared with 2015 and far short of the 2030 target of an 80% reduction (**Table 4.1**; **Fig. 4.8**). This slow progress reflects ongoing transmission in key populations and insufficient scale-up of preventive interventions. The largest declines in new HCV infections between 2015 and 2024 were in the WHO Eastern Mediterranean and European regions (both 28%). Three other WHO regions also achieved declines: the African, South-East Asia and Western Pacific regions. At the other extreme, there was an estimated 57% increase in HCV infections in the WHO Region of the Americas, highlighting an urgent need for expanded prevention and harm-reduction interventions in this part of the world, particularly in the USA.

At present, non-medical injection practices and injecting drug use are the dominant contributors to new infections. People who inject drugs account for an estimated 44% of new HCV infections globally and the coverage of harm-reduction services is far below the levels required to interrupt transmission (**Section 4.2.4**). Coverage is particularly low in regions with growing HCV epidemics among people who inject drugs, including parts of eastern Europe, central Asia and south-east Asia.

Historically, unsafe medical injections have been a major driver of HCV transmission. Globally, injection safety in health care facilities is now high, approaching universal use of safe injection practices (**Section 4.2**). However, there are important exceptions at country level, including among countries with a high prevalence of HCV infection in the general population.

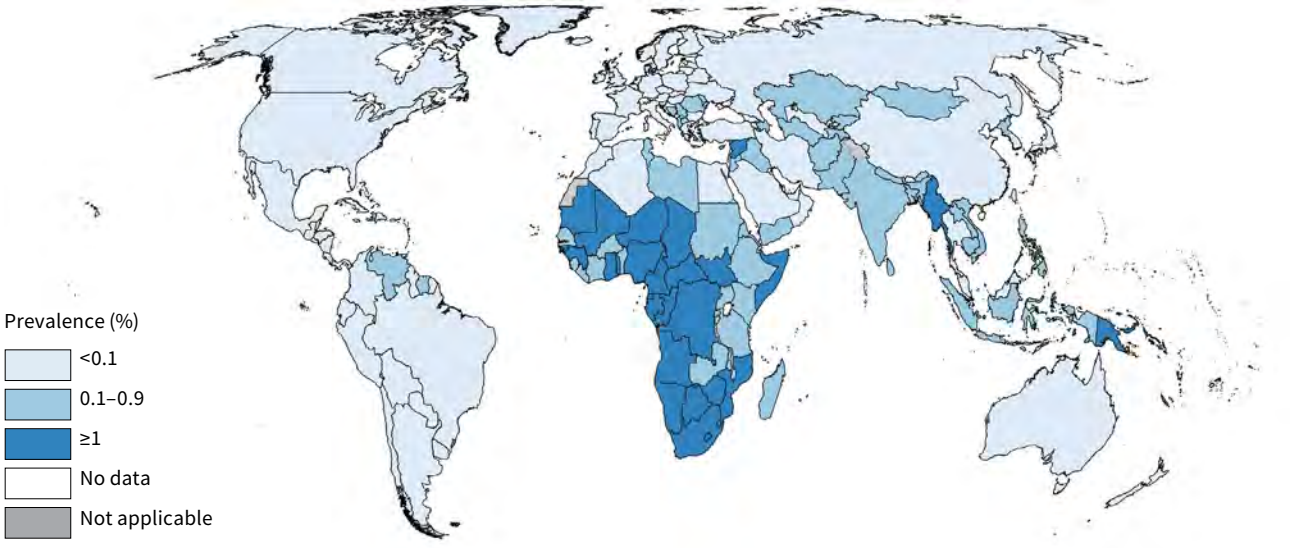
4.1.3 Prevalence of chronic HBV infection in children aged under 5 years

In 2024, the global prevalence of chronic HBV infection among children aged under 5 years was 0.6% (equivalent to about 3.8 million children), down from 0.8% in 2015 but still far above the 2030 target of 0.1% (**Table 4.1**).

The highest burden was in the WHO African Region (**Fig. 4.9**), where prevalence was 1.4% overall (equivalent to about 2.6 million children).[1] Prevalence exceeded 1% in most countries and reached levels of 2–5% in several countries. In contrast, 85 countries have a prevalence of less than 0.1%.

Achieving the 2030 global target of a 95% reduction in HBV incidence (compared with 2015) requires a large improvement in birth-dose coverage of the hepatitis B vaccine in the WHO African Region (**Section 4.2.1**) and expanded provision of antiviral prophylaxis to prevent mother-to-child transmission of HBV infection (**Section 4.3**).

Fig. 4.9. Prevalence of chronic HBV infection among children aged under 5 years at country level, 2024



HBV: hepatitis B virus.

[1] This is 69% of the global total of 3.8 million.

4.2 Service coverage

An overview of progress towards the 2030 targets for service coverage of interventions for prevention, diagnosis and treatment is provided in **Table 4.3**.

4.2.1 Hepatitis B vaccination – birth dose and third dose

Since 2009, WHO has recommended that all infants receive their first hepatitis B vaccine dose within 24 hours of birth. By December 2025, 61% (118 of 194) of Member States had adopted universal birth-dose vaccination, and an additional 13% (25 countries) offered targeted vaccination for infants born to HBV-positive

Table 4.3. Global status of progress towards GHSS 2030 targets for hepatitis service coverage

Indicator	2024 progress[a]	2030 target
Hepatitis B vaccination		
Percentage of neonates who received a timely birth dose of hepatitis B vaccine	45%	90%
Percentage of infants who received a third dose of hepatitis B vaccine	84%	90%
Diagnosis and treatment of people with chronic HBV and active HCV infection		
Percentage of people with chronic HBV infection diagnosed	27%	90%
Percentage of eligible people with chronic HBV infection treated	4.3%	80%
Percentage of people with HCV infection diagnosed[b,c]	36%	90%
Percentage of eligible people with HCV infection treated[b,d]	20%	80%
Harm-reduction services		
Number of needles and syringes distributed per person who injects drugs	35	300
Safety of blood and injections in health care facilities		
Percentage of donated blood units screened for bloodborne diseases[e]	98%	100%
Percentage of health care injections that are safe[f]	96%	100%

GHSS: global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030; HBV: hepatitis B virus; HCV: hepatitis C virus.

[a] Unless otherwise stated.

[b] The denominator is the cumulative number of people with HCV infection at any time in 2015–2024.

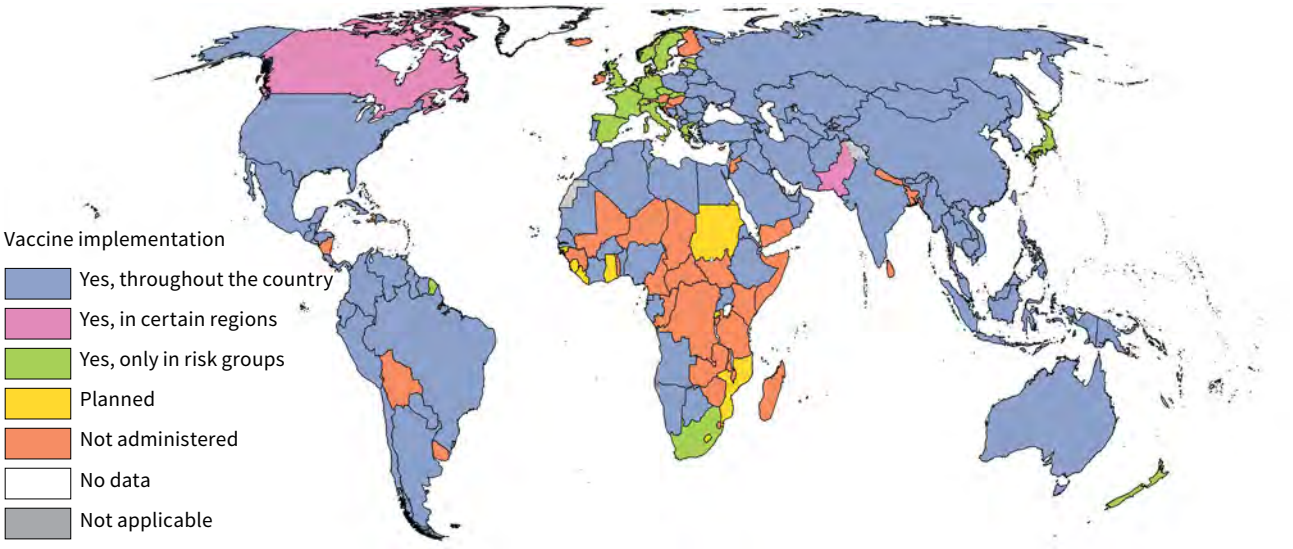
[c] The numerator is the cumulative number of people diagnosed with HCV infection in 2015–2024.

[d] The numerator is the cumulative number of people with HCV infection who were treated in 2015–2024.

[e] Data are for 2018.

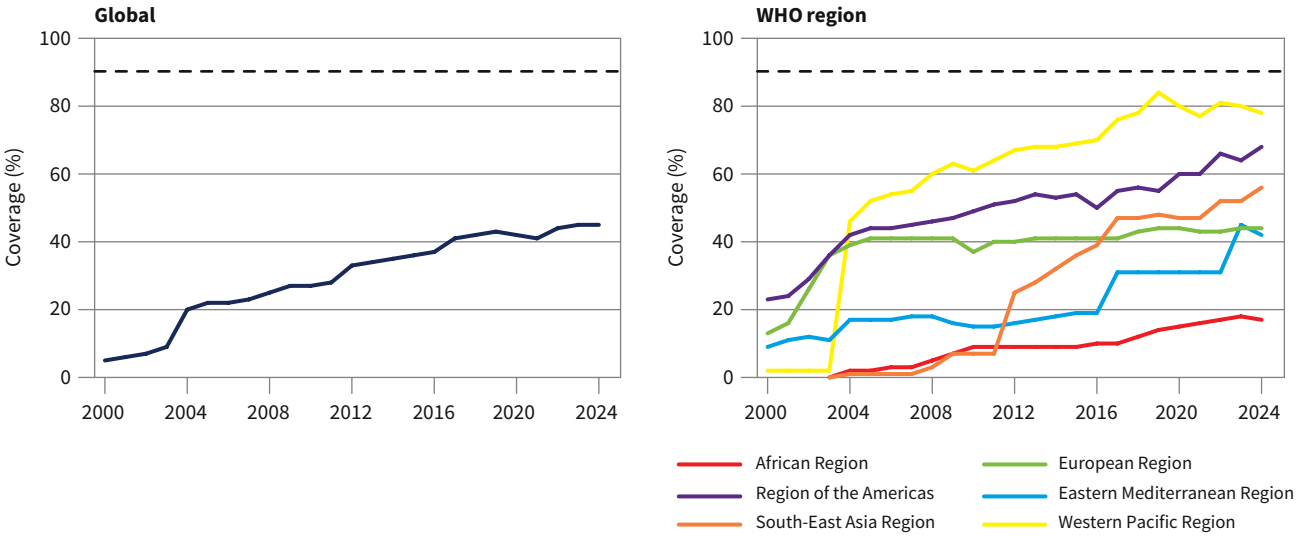
[f] Data are for 2011–2015.

Fig. 4.10. Implementation status of hepatitis B birth-dose vaccination at country level, 2025[a]



[a] Source: WHO Immunizations, Vaccines and Biologicals (IVB) database (https://immunizationdata.who.int/global/wiise-detail-page/introduction-of-hepb-birth-dose?ISO_3_CODE=&YEAR=), December 2025.

Fig. 4.11. Coverage of timely birth-dose hepatitis B vaccination, globally and by WHO region, 2000–2024[a]



[a] The horizontal dashed line marks the 2030 target of 90%.

mothers. Eight countries plan to introduce universal birth-dose vaccination before 2030 (**Fig. 4.10**).

Global coverage of birth-dose vaccination reached 45% in 2024, a big improvement from 5% in 2000 but still far below the 2030 target of 90% (**Fig. 4.11**).

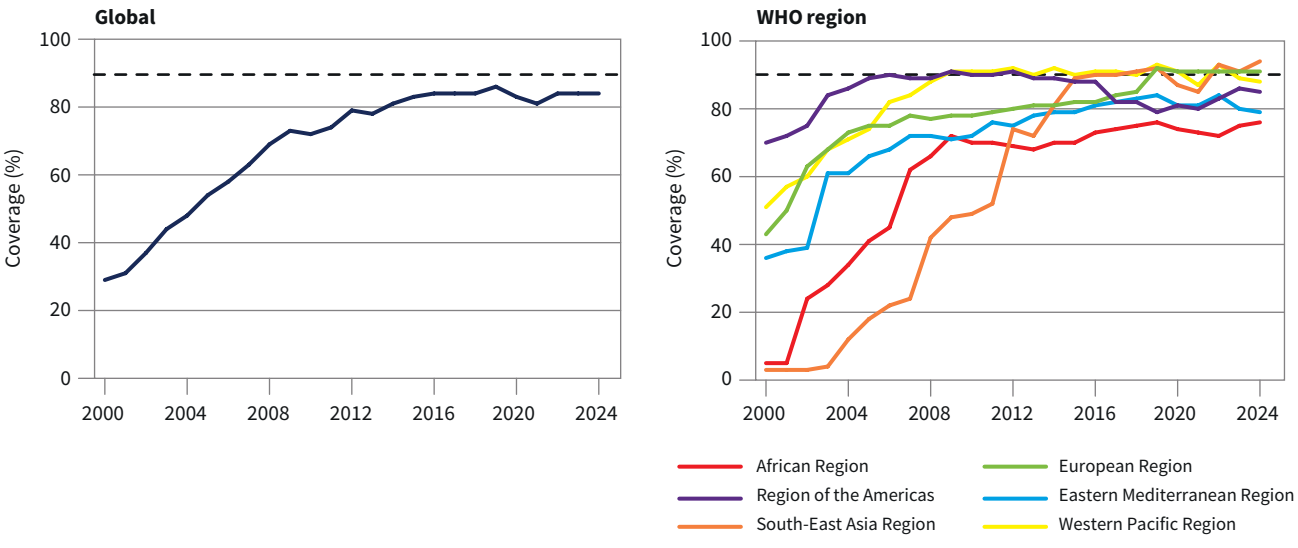
At regional level, progress has been uneven, largely influenced by updates to national policies and the expansion of birth-dose delivery platforms.

The region with the highest coverage is the WHO Western Pacific Region, which achieved a coverage of 78% in 2024.

The WHO African Region has the lowest levels of birth-dose coverage, despite experiencing the most severe burden of HBV infection globally (**Section 4.1**), as measured by incidence, prevalence and deaths per 100 000 population. In 2024, coverage reached only 17%, reflecting the substantial number of countries (20 of 47) that have not yet implemented a hepatitis B vaccination birth-dose policy (**Fig. 4.10**) as well as ongoing structural challenges, a comparatively low percentage of deliveries in health facilities and issues with timely vaccine availability.

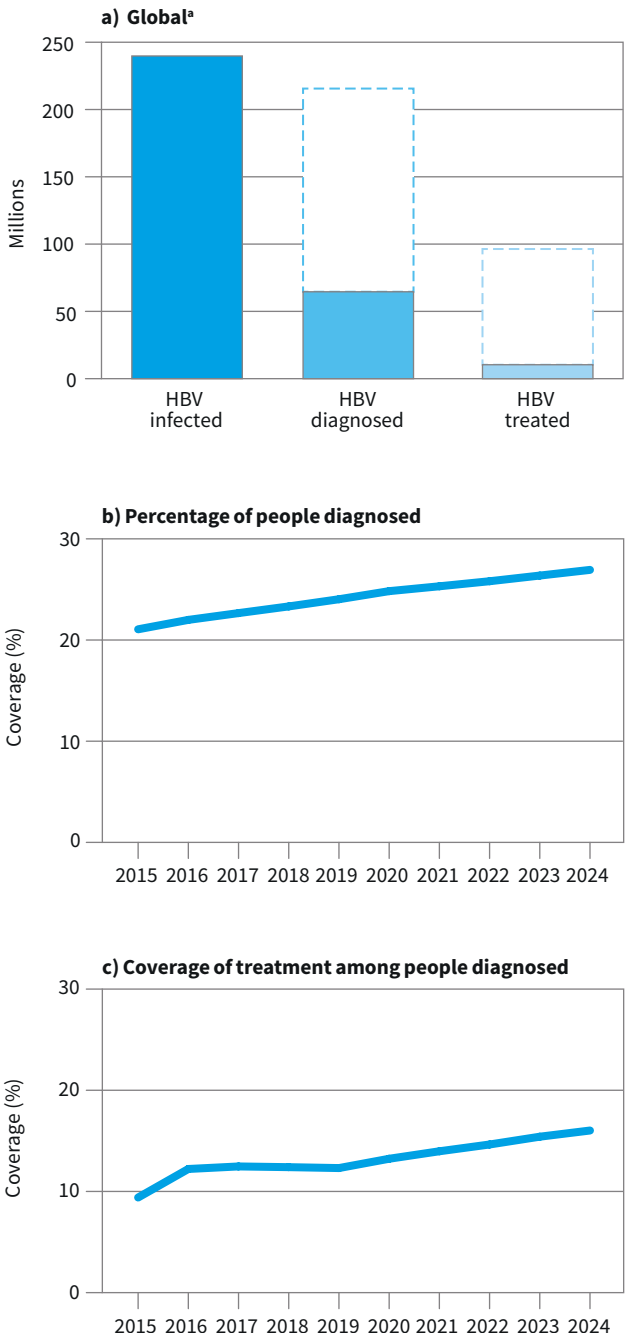
WHO recommends that timely birth-dose vaccination should be followed by two or three additional doses *(9)*, with infants completing the full primary vaccination series by the age of 6 months. As of 2025, most countries

Fig. 4.12. Coverage of third-dose hepatitis B vaccination, globally and for WHO regions, 2000–2024[a]



[a] The horizontal dashed line marks the 2030 target of 90%.

Fig. 4.13. Global cascade of care for people with a chronic HBV infection, 2015–2024



HBV: hepatitis B virus.

[a] The dashed lines show the global gap between the numbers of people diagnosed and on treatment by the end of 2024 and the numbers that equate to the 2030 coverage targets:

- for diagnosis, the target is that 90% of people with a chronic HBV infection have been diagnosed; and
- for treatment, the target is that 80% of people who have been diagnosed with an HBV infection and assessed as eligible for treatment are on treatment; globally, it has been estimated that about 50% of those diagnosed will meet the treatment eligibility criteria defined in the latest WHO guidelines.

had included universal hepatitis B infant vaccine in their national immunization plans. In 2024, global coverage of the third dose of the hepatitis B vaccine was 84%, close to the 90% target *(4)* (**Table 4.3**; **Fig. 4.12**). High levels of coverage, now sustained for more than a decade, have driven a substantial decline in the prevalence of chronic HBV infection among children aged under 5 years.

4.2.2 Diagnosis and treatment of chronic HBV infection

WHO has provided recommendations related to testing for chronic HBV infection and treatment options for people found to be infected *(10)*. The 2030 targets are that 90% of people living with chronic HBV infection are diagnosed and that treatment is being provided to 80% of those who meet treatment eligibility criteria. The 2024 WHO guidelines introduced expanded and simplified eligibility criteria for adults and adolescents *(10)*, prioritizing evidence of liver disease over biochemical and virologic thresholds,[1] and reducing reliance on specialist diagnostic tests. These updates expand treatment eligibility to an estimated 50% of people diagnosed with chronic HBV infection and support decentralization of care to primary health services. The 2024 guidelines are still relatively new, and there has been limited time for uptake and implementation.

The latest data on diagnostic and treatment coverage are for 2024. Of the 240 million people (95% UI: 202–296 million) living with chronic HBV infection globally in 2024, 65 million (27%) had been diagnosed and 10 million (4.3%) were on antiviral treatment (**Fig. 4.13**). To reach the 2030 targets, about 86 million people (36% of the 240 million people living with chronic HBV infection) should be on antiviral treatment by 2030.

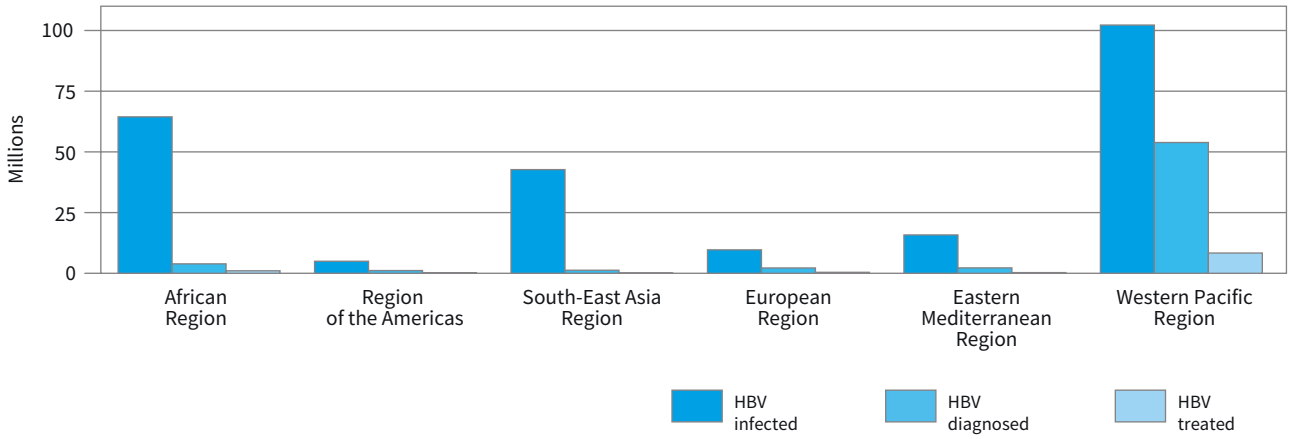
The current very low level of global coverage highlights the need for rapid expansion of HBV testing and treatment services, particularly in regions with large untreated populations and rising HBV-related mortality. In terms of absolute numbers, the biggest gaps in diagnosis and treatment in 2024 were in the WHO Western Pacific and African regions (**Fig. 4.14**).

4.2.3 Diagnosis and treatment of HCV infection

Since 2015, a short-course (12-week) oral treatment with direct-acting antivirals (DAAs) has been available for treatment of HCV infection; it is highly tolerable and has a cure rate of about 95% *(11)*. DAAs have rev-

[1] This includes treatment initiation for individuals with ≥F2 fibrosis identified using simple non-invasive tests and the removal of mandatory alanine aminotransferase (ALT) and HBV DNA cut-offs. In settings without DNA testing for HBV, persistently elevated ALT levels can be used to guide treatment initiation. The recommendation applies to adults and adolescents aged 12 years or more. Treatment eligibility was also expanded to include pregnant women.

Fig. 4.14. Cascade of care for people with a chronic HBV infection by WHO region, 2024[a]



HBV: hepatitis B virus.

[a] Region-specific estimates of the percentage of people with a chronic HBV infection who are eligible for treatment are not available.

olutionized treatment for people with HCV infection; the treatment was previously much less effective and caused side-effects that were often difficult to tolerate. The use of DAAs has enabled substantial progress in some countries, although global scale-up remains insufficient.

Between 2015 and the end of 2024, 24 million people (95% UI: 18–35 million) were diagnosed with viraemic HCV infection, representing 36% of the cumulative total of 68 million people estimated to have been living with HCV during this period. Of those diagnosed, 13 million people (95% UI: 12–20 million) – 20% of the total number of people with HCV infection – were treated (**Fig. 4.15**).

As of 2024, about 11 million people who had been diagnosed with HCV infection and were alive had not yet been treated, reflecting persistent gaps in linkages to care and treatment delivery.

The best levels of diagnostic and treatment coverage for HCV infection have been achieved in the WHO Eastern Mediterranean Region (**Fig. 4.16**). However, owing to the high levels of infection, this is still the region with the biggest gap (in absolute terms) between the number of people with HCV infection and the number of people treated.

4.2.4 Harm-reduction services

The population in need of harm-reduction services remains large. In 2023, an estimated 14 million people worldwide, representing 0.3% of the global population aged 15–64 years, were injecting drugs *(12)*. Among this population, an estimated 39% (95% confidence interval: 31–47%) were infected with HCV *(13)*, compared with an HCV prevalence of 0.6% in the general population.

Despite this high burden, coverage of harm-reduction services remains far below recommended levels globally: of every 100 people who inject drugs, only 18 have access to opioid agonist maintenance treatment (OAMT), and an average of just 35 sterile needles and syringes are distributed per person per year *(14)*, well below the 2030 target of 300. Coverage is particularly low in regions with growing HCV epidemics among people who inject drugs, including parts of eastern Europe, central Asia and south-east Asia.

The combination of a large population of people who inject drugs and persistently low coverage of harm-reduction services continues to drive HCV transmission in many countries, underscoring the urgent need to scale up the provision of needle and syringe programmes and OAMT. Policies that address stigma, discrimination and criminalization are also necessary to reduce new infections.

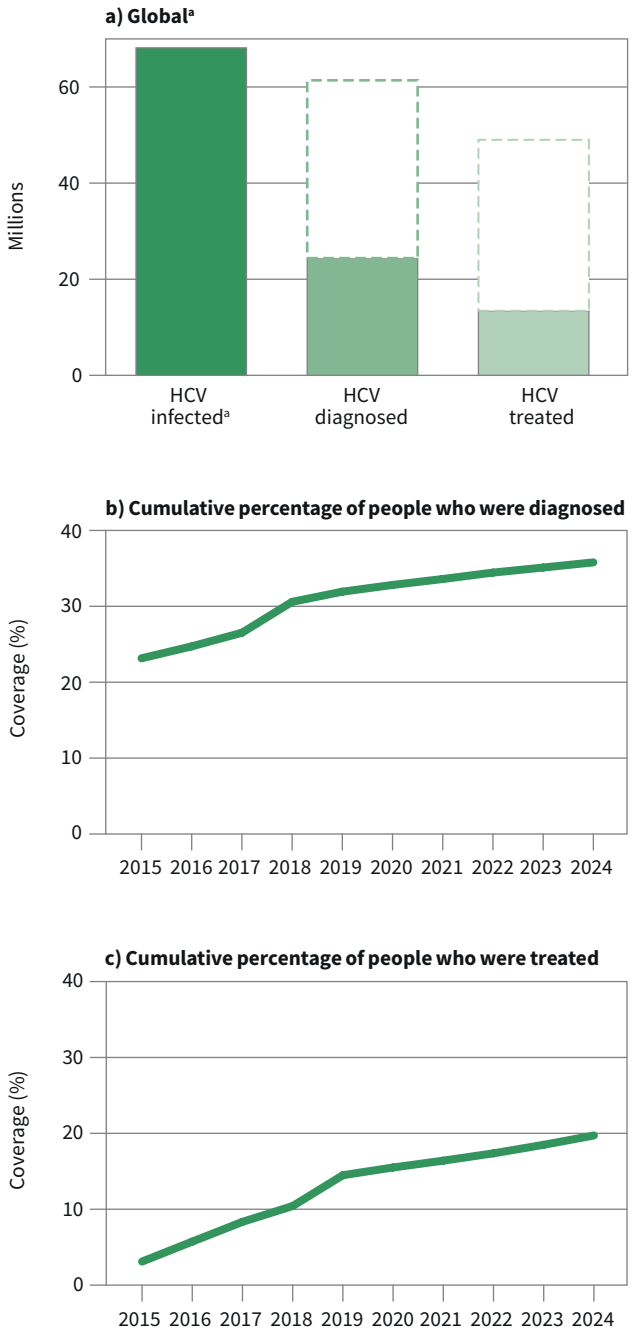
4.2.5 Safety of blood services and injections in health care facilities

WHO recommends that all blood donations are screened for infections before use. Screening for HIV, HBV, HCV and syphilis should be mandatory *(15, 16)*.

In 2018, among the 107 countries that reported on this indicator to the Global Database on Blood Safety, 98% were screening all blood donations for the four transfusion-transmissible infections using basic quality procedures *(17)*.[1] However, this aggregated estimate is likely to overstate global performance, because countries with weaker quality systems are less likely to report data. When disaggregated by income level, 99.8% of donations in high-income countries and 99.9% in upper-middle-income countries were screened following basic quality procedures, compared with only 83% in lower-middle-income countries and 76% in low-income countries, highlighting persistent inequities in blood safety systems.

[1] As of July 2026, the latest year for which data are available is 2018. Data are now being compiled in 2026.

Fig. 4.15. Global cascade of care for people with an HCV infection, 2015–2024



HCV: hepatitis C virus.

[a] The first bar is the cumulative number of people with an HCV infection at any time in the period 2015–2024. The dashed lines show the gap between the cumulative numbers of people diagnosed and treated between 2015 and 2024, and the cumulative numbers of people that equate to the 2030 coverage targets:

— for diagnosis, the target is that 90% of people with a viremic HCV infection have been diagnosed; and

– for treatment, the target is that 80% of people diagnosed with an HCV infection have been treated.

WHO recommends that health care workers use a new sterile needle and syringe for every injection and, when delivering injectable medications (intramuscular, subcutaneous or intradermal), that they use syringes with sharps injury protection and reuseprevention features *(18, 19)*. Available WHO estimates indicate that 96% of health care injections globally were administered using a new, unopened syringe and needle, corresponding to about 3.9% of injections being unsafe *(20)*. These estimates were based on demographic and health survey data from 40 countries conducted between 2011 and 2015.

4.3 WHO guidance and support for strategy implementation, 2022–2026

Since 2022, WHO has helped countries to translate the GHSS into national-level action on viral hepatitis by:

- developing guidelines *(10, 21–28)* that provide clear recommendations about prevention, diagnosis and treatment (**Fig. 4.17**);
- approving technologies; and
- supporting Member States to develop policies, and to introduce or expand recommended interventions and services.

The guidelines include approaches that facilitate more equitable access to services, such as decentralization, task shifting and the use of point-of-care diagnostics. WHO has also reinforced accountability by defining standardized indicators, cascade-of-care metrics, and clear benchmarks for monitoring progress and validating elimination at country level.

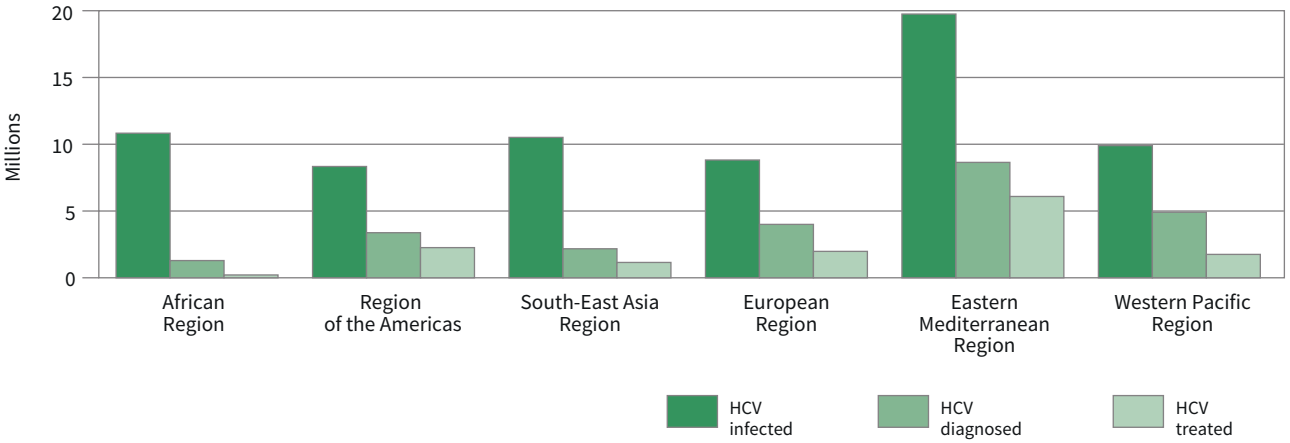
This section summarizes the status of progress in adoption and implementation of WHO recommendations issued between 2022 and 2026.

4.3.1 National strategic plans for viral hepatitis

WHO recommends that all countries develop and implement costed national strategic plans (NSPs) for viral hepatitis that are aligned with the GHSS. Such plans provide a framework for a coordinated and multisectoral hepatitis response, resource mobilization and accountability for progress towards elimination targets at country level *(23)*. NSPs are expected to be integrated within broader national health and development frameworks, and to guide implementation at scale. Countries are increasingly developing NSPs and have adopted WHO policies and guidelines for scaling up viral hepatitis testing and diagnosis in the public sector; however, subsequent implementation is variable, and often lags behind what is required to reach global targets.

Among the 110 countries that reported in WHO's 2025 round of global hepatitis data collection, progress in NSP development and implementation remained uneven

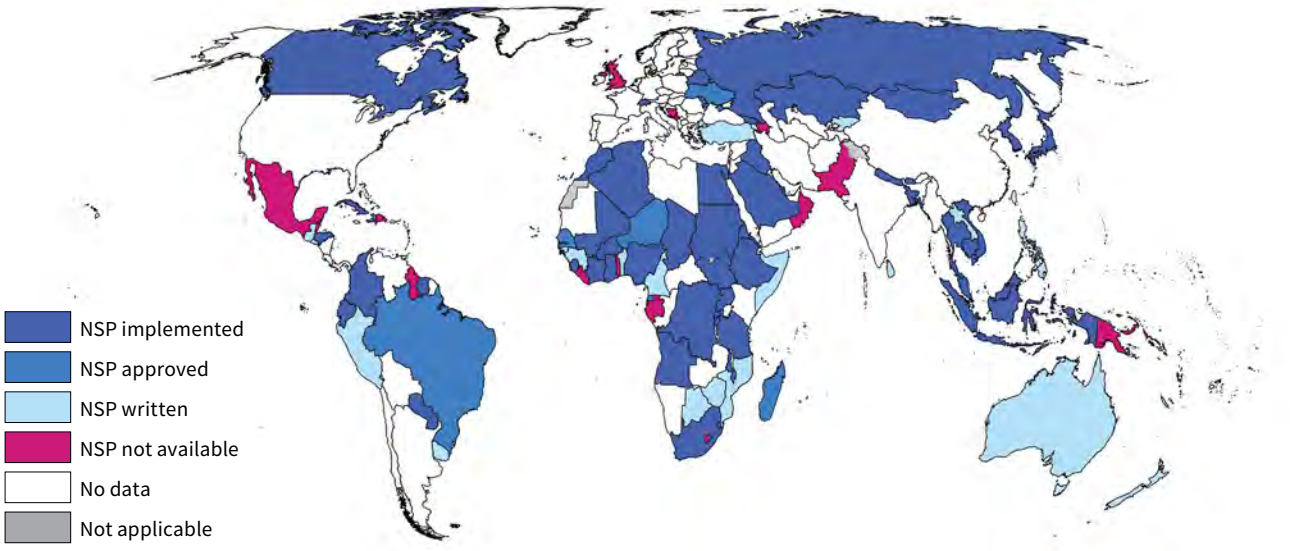
Fig. 4.16. Cascade of care for people with an HCV infection by WHO region, 2024



HCV: hepatitis C virus.

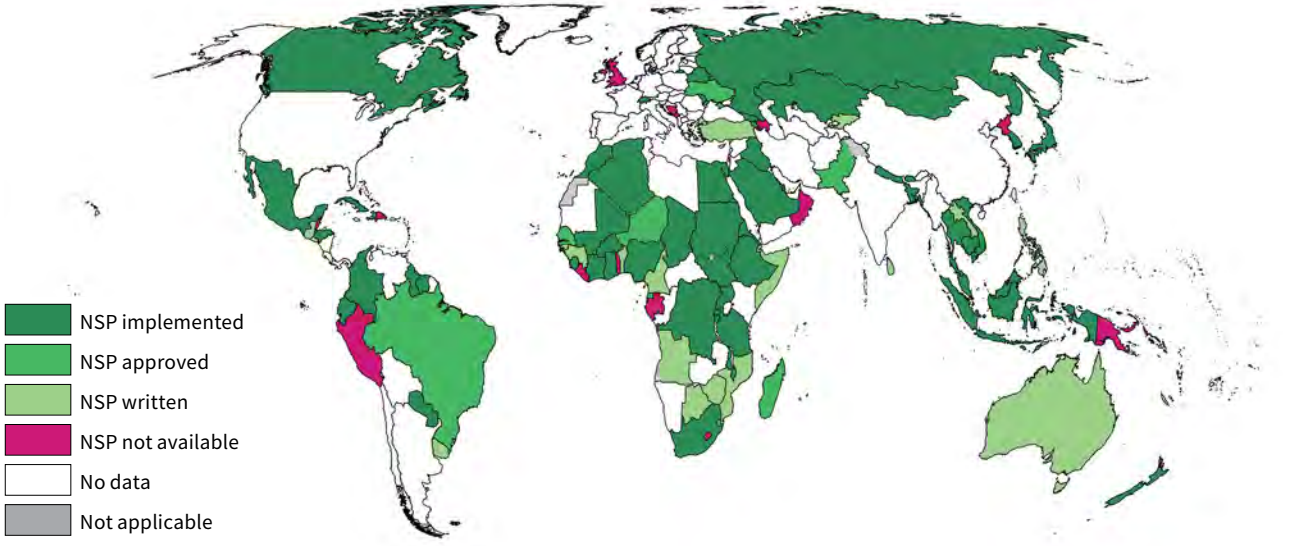
Fig. 4.17. WHO normative guidance and implementation tools for viral hepatitis, 2022–2026

Fig. 4.18. Status of national strategic plans for hepatitis B, 2025



NSP: national strategic plan.

Fig. 4.19. Status of national strategic plans for hepatitis C, 2025



NSP: national strategic plan.

(Fig. 4.18, Fig. 4.19). As of December 2025, 54 countries had started implementation of NSPs addressing HBV or HCV (or both). A further 31 countries had developed or formally approved NSPs but had not yet begun implementation, while 25 countries had no NSP for hepatitis.

The widespread development of NSPs reflects increasing political commitment to elimination of viral hepatitis. However, the large number of countries where plans remain unimplemented or absent highlights persistent gaps in national preparedness and the need for sustained technical support, financing and accountability to translate policy commitments into effective action. These findings mirror experience from HIV and tuberculosis (TB) programmes, where the existence of a formal strategy does not always translate into effective implementation *(29)*.

4.3.2 WHO guidelines for antiviral prophylaxis to prevent mother-to-child transmission of HBV and status of policy adoption as part of triple elimination

In 2020, WHO developed the first guidelines for prevention of mother-to-child transmission (PMTCT) of HBV and established HBV DNA thresholds at which provision of antiviral prophylaxis to pregnant women was recommended *(30)*.

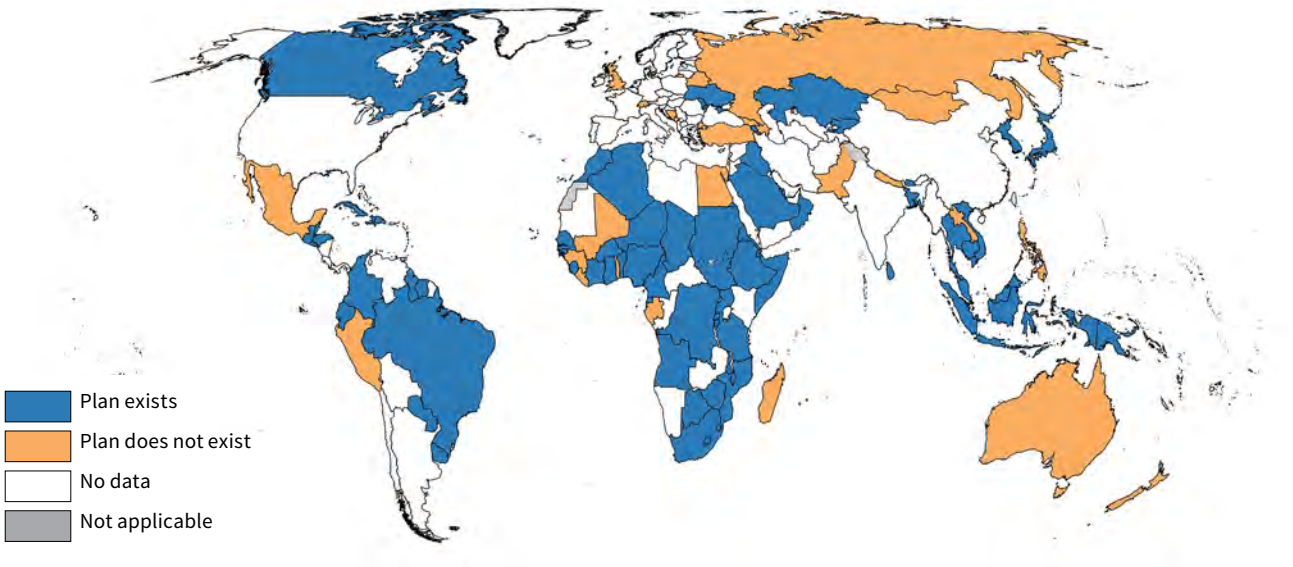
The guidelines were updated in 2024 *(10)*, with a focus on simplification to address major challenges in providing HBV DNA testing and testing for hepatitis B e antigen (HBeAg) among pregnant women who tested positive for hepatitis B surface antigen (HBsAg) in low- and middle-income countries (LMICs), particularly those in sub-Saharan Africa. The guidelines also aimed to facilitate PMTCT of HBV as part of triple elimination of HBV, HIV and syphilis through antenatal, childbirth and postnatal services.

Key elements of the 2024 guidelines are universal screening of pregnant women for HBV infection (HBsAg testing), assessment of women with chronic HBV infection, initiation of antiviral prophylaxis during pregnancy, provision of hepatitis B birth-dose vaccination – with or without hepatitis B immunoglobulin (HBIG) where indicated – and appropriate follow-up of exposed infants.

In WHO's 2025 round of global hepatitis data collection, 76 of 110 (69%) countries had a plan to eliminate vertical transmission of HBV within their broader triple-elimination strategies (Fig. 4.20). These commitments indicate growing alignment of PMTCT of HBV with existing maternal and child health, and HIV or syphilis service platforms.

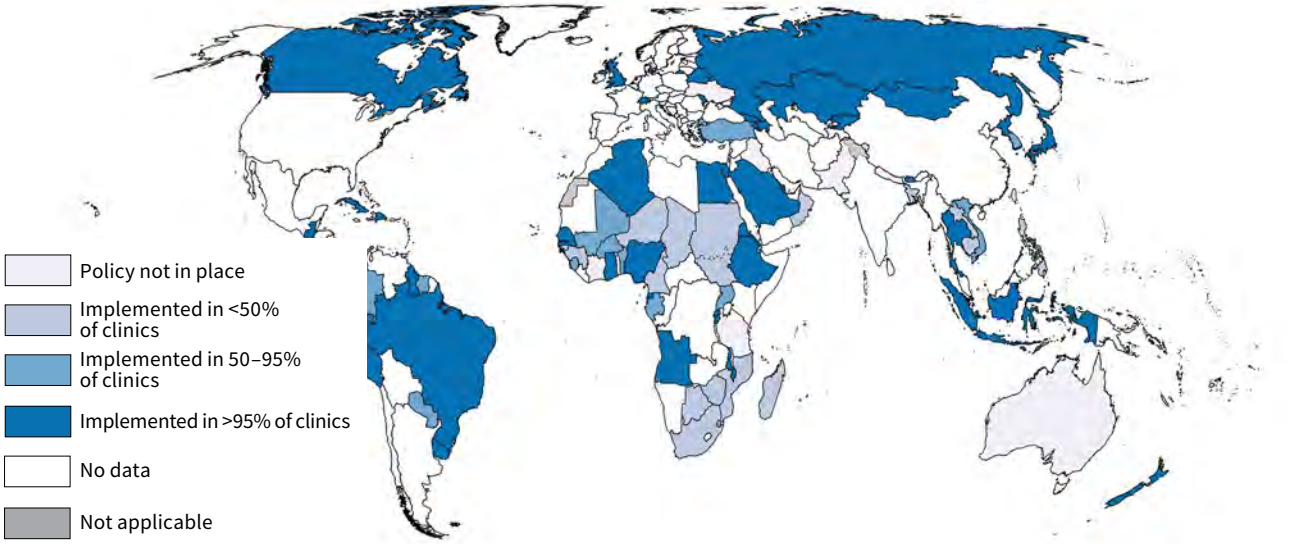
As of 2025, most countries had adopted national policies broadly aligned with WHO recommendations. Universal antenatal screening for HBV infection was the most widely adopted policy, reported by 128 of 130 countries (98%). However, implementation lagged behind policy adoption. In 2025, only 51 countries were implementing universal screening nationwide (Fig. 4.21). Only 80 of the 130 countries (62%) were providing antiviral prophylaxis during pregnancy, and 61

Fig. 4.20. Existence of a national plan for the elimination of mother-to-child transmission of HBV as part of triple elimination of HBV, HIV and syphilis, by country, 2025



HBV, hepatitis B virus.

Fig. 4.21. The status of implementation of a national policy for universal testing for HBV infection during pregnancy in public antenatal clinics, by country, 2025



HBV, hepatitis B virus.

(47%) were providing HBIG[1] to infants exposed to HBV. Implementation is frequently constrained by limited access to diagnostics, access to antiviral medicines and programmatic guidance for service delivery at scale.

Experience from efforts to eliminate mother-to-child transmission of HIV and syphilis shows that policy adoption, without nationwide implementation, is insufficient to achieve impact *(29)*. Strengthening PMTCT of HBV requires moving beyond formal endorsement to ensure sustained financing, clear operational guidance, health worker training, reliable access to diagnostics and medicines, and robust monitoring and accountability mechanisms at national and subnational levels. Accelerated and equitable implementation of policies for PMTCT of HBV that are aligned with those for HIV and syphilis will be essential to achieve triple elimination (**Chapter 6**).

4.3.3 Updates to WHO guidelines on diagnosis and treatment for people with HBV or HCV infection

Between 2022 and 2026, WHO published a comprehensive suite of updated normative products for the diagnosis and treatment of people with HBV and HCV infection. Updates included recommendations on the use of point-of-care molecular testing and reflex testing strategies; treating everyone diagnosed with HCV infection; and both expanded and simplified eligibility criteria for the treatment of people with chronic HBV infection (including for adolescents and pregnant women) *(10, 21, 28)*.[2] According to the latest criteria, it is estimated that about 50% of people with a chronic HBV infection are eligible for treatment.

The WHO guidelines also recommend simplified approaches to service delivery. These enable decentralization (beyond specialist care), task shifting and integration of services within broader health system platforms (e.g. primary health care, HIV services, maternal and child health programmes, prison health services and harm-reduction services), and associated improvements to efficiency, coverage and equity *(22, 28, 29)*. Delivering services closer to communities most affected by hepatitis is particularly important in high-burden and resource-constrained settings.

In 2025, 138 countries reported having national HBV treatment guidelines aligned with the 2024 WHO recommendations or similar guidance (e.g. the guidance published by the European Association for the Study of the Liver [EASL] *(31)*), incorporating expanded treatment eligibility criteria. This includes 78 countries that initiate treatment for individuals with HBV DNA of more than 2000 international units (IU)/mL and ALT levels above the upper limit of normal, and 72 countries that initiate treatment in patients with fibrosis of F2 or more, or an AST to platelet ratio index (APRI) score of more than 0.5, regardless of HBV DNA or ALT levels. In addition, 26 countries reported that patients

[1] HBIG contains antibodies against HBsAg (anti-HBs) and provides immediate, short-term passive protection against HBV. It is used for post-exposure prophylaxis among exposed infants born to HBsAg-positive mothers, especially those with high levels of HBV DNA. It should always be administered in combination with the hepatitis B birth-dose vaccination.

[2] The 2024 HBV guidelines prioritize early diagnosis and treatment to stop progression to advanced liver disease and liver cancer, including by removing complex biochemical and virologic thresholds for initiation of treatment. The latter reduces the previous dependence on specialist diagnostics and care.

with persistently abnormal ALT levels are initiated on treatment where HBV DNA testing is not available; and 21 countries reported that patients with extrahepatic manifestations are initiated on treatment, irrespective of APRI score, HBV DNA or ALT levels, in line with WHO recommendations.

Provision of decentralized treatment for people with chronic HBV infection remains limited, constraining expansion of treatment coverage (**Section 4.2**). Among 110 countries that reported data for 2025, 69 countries had decentralized HBV testing to primary health care centres across most parts of the country; HBV treatment was reported to have been decentralized in only 25 countries.

Countries have increasingly adopted policies to treat all individuals diagnosed with HCV infection. In 2025, 134 countries reported that they had either national HCV treatment guidelines aligned with the 2022 WHO guidelines or that they were using international guidelines published by EASL, both of which recommend treatment for all people with HCV infection. At the end of 2025, 55 countries reported that screening had been decentralized; only 22 reported that testing has been decentralized and 20 reported that treatment had been decentralized.

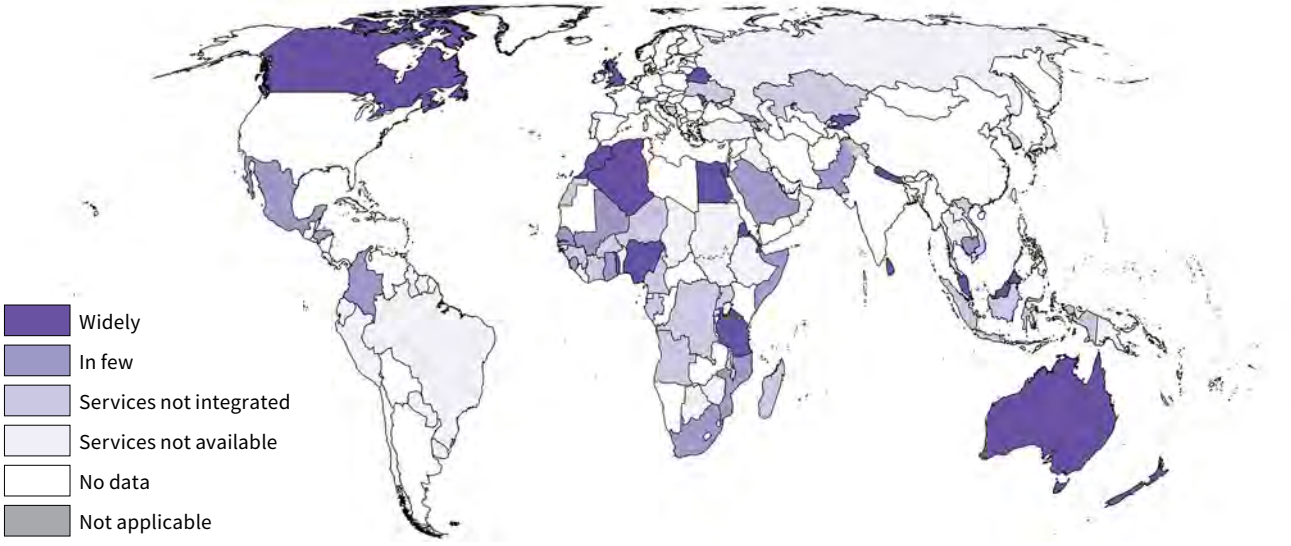
Integration of hepatitis services within HIV platforms has been reported by many countries, but coverage remains uneven across the cascade of care. Among 110 countries that reported data for 2025, 71 had integrated HBV testing services into HIV service delivery platforms that were available in most parts of the country, including HIV prevention centres, clinics providing pre-exposure prophylaxis (PrEP) and clinics providing antiretroviral therapy (ART). However, only 50 countries had integrated HBV treatment services with HIV services that were available in most parts of the country. For HCV, 58 countries reported that testing services had been integrated with HIV services that were available in most parts of the country. HCV treatment services were available within these platforms in only 44 countries, indicating more limited integration of treatment compared with screening and testing services.

Integration of hepatitis services within harm-reduction services is especially critical to address HCV transmission among people who inject drugs. In 2025, out of 110 countries that reported data, 35 were providing HCV testing and treatment as part of harm-reduction services, and 25 countries were providing them as part of OAMT programmes in prisons (**Fig. 4.22**, **Fig. 4.23**). These approaches take advantage of opportunities for diagnosis, improve linkages to care and promote more peoplecentred delivery of services. Legal, policy and regulatory barriers continue to impede the scale-up of harm-reduction services for people who inject drugs, despite their central role in preventing HCV transmission.

Globally, integration remains uneven. In many settings, hepatitis services continue to be delivered through fragmented or pilot-level initiatives, limiting their population impact.

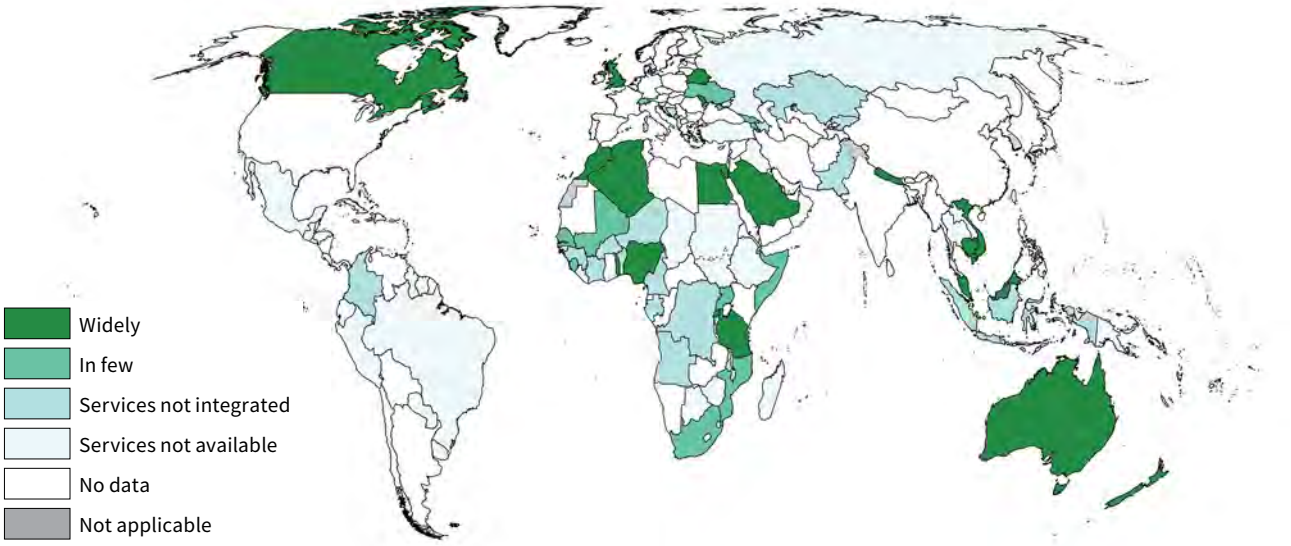
WHO operational guidance *(28)* has been developed to provide practical approaches to implementation, which are expected to further support Member States to scale up national hepatitis services, including through primary health care.

Fig. 4.22. Status of HBV and HCV service integration with needle and syringe programmes, by country, 2025



HBV, hepatitis B virus; HCV, hepatitis C virus.

Fig. 4.23. Status of HBV and HCV service integration with opioid agonist maintenance treatment, by country, 2025



HBV, hepatitis B virus; HCV, hepatitis C virus.

4.3.4 Development of guidance on validation of hepatitis elimination and the path to elimination

In 2023, WHO developed global guidance and a framework for countries and other stakeholders seeking to validate the elimination of viral hepatitis as a public health problem in the general population, with a specific focus on HBV and HCV. The guidance established indicators, targets and processes for the validation of elimination of HBV and HCV as public health threats, and monitoring of progress along the path to elimination (enabling recognition of progress before elimination, through bronze, silver and gold tiers), based on pilot work on the feasibility of elimination in seven countries *(24)* and on experience in several other countries. The guidance also includes recommendations on the surveillance of HBV- and HCV-related liver cirrhosis and cancer, to promote enhanced reporting and estimation of hepatitis-related mortality.

Countries are encouraged to pursue elimination of both viral hepatitis B and C as public health threats, but may choose to apply for one of the four certification options in a phased approach to be officially recognized by WHO for the elimination of mother-to-child transmission of HBV, the elimination of HBV or HCV (or both) as a public health threat, or progress along the path to elimination.

Several countries have achieved targets for hepatitis B benchmarks along the path to elimination of mother-to-child transmission of HBV (as part of triple elimination); examples include Maldives, and Turks and Caicos. Egypt became the first country to receive "gold tier" status for progress towards HCV elimination from WHO. As of June 2026, several other countries had initiated a process to apply for validation of elimination.

4.3.5 New tools

The pipeline of new tools to support elimination of viral hepatitis includes self-tests for HCV infection *(32)*, HCV core antigen (HCVcAg) tests, and improved treatments for HBV and hepatitis D virus (HDV) infection.

Clinical trials for several new products to treat HBV and HDV infection have been recently completed or are in their final stages *(33–35)*. They include a new treatment for HDV infection (bulevirtide) and a treatment to achieve functional cure of chronic HBV infection, for which WHO is monitoring results. Also in development are point-of-care and low-cost diagnostic tests for chronic HBV infection, and triple tests for HIV, HBV and syphilis.

As new products advance to implementation, WHO will support countries with timely registration, procurement facilitation and normative guidance. Ensuring equitable access for LMICs is essential, including support for in-country manufacturing capacity.

4.4 Critical issues and priorities for action up to 2030

To accelerate progress towards the 2030 elimination targets, there are five major priorities for global and regional action:

- scaling up treatment for people with HBV infection, especially in the WHO African and Western Pacific regions;

- scaling up treatment for people with HCV infection, especially in the WHO Eastern Mediterranean Region;
- improving the coverage of hepatitis B birth-dose vaccination, especially in the WHO African Region;
- improving the coverage of antiviral prophylaxis for PMTCT of HBV infection, especially in the WHO African Region; and
- improving the safety of nonmedical injections, in particular through harm-reduction services for people who inject drugs.

4.4.1 Scaling up treatment for people with HBV infection

Reducing HBV-related deaths from HCC and cirrhosis requires provision of antiviral treatment to people who already have a chronic HBV infection. Diagnosis and treatment for people living with chronic HBV infection must be rapidly expanded, particularly in the regions with the highest burden.

Of the estimated 240 million people living with a chronic HBV infection in 2024, about 102 million (43%) were in the WHO Western Pacific Region and 64 million (27%) were in the African Region. Scaling up HBV diagnosis and treatment is of particular importance in these two parts of the world.

Improving treatment coverage requires adoption of simplified treatment criteria, decentralization of care and sustained access to affordable medicines.

4.4.2 Scaling up treatment for people with HCV infection

Provision of antiviral treatment for people with HCV infection is necessary to prevent HCV-related morbidity and mortality, and to halt onward transmission.

The most immediate priority is to provide treatment for the estimated 11 million people who have been diagnosed with HCV infection but remained alive and untreated as of 2024. Of these people, 3.1 million were in the WHO Eastern Mediterranean Region and 2.6 million were in the Western Pacific Region. Of the estimated 47 million people living with HCV infection in 2024, about one quarter were in the WHO Eastern Mediterranean Region.

4.4.3 Improving the coverage of hepatitis B birth-dose vaccination

The only way to eliminate HBV as a public health threat in areas where it is currently endemic is to protect neonates and children aged under 5 years from infection. This can be done by ensuring high coverage of hepatitis B vaccination.

In 2024, the most severe burden of HBV infection in children aged under 5 years was in the WHO African Region (**Fig. 4.9**). In most countries in the region, more than 1% of children in this age group were infected, and in several countries the figure was much worse, at 2–5%. The regional average was 1.4%. Of the estimated 0.9 million new HBV infections in 2024, 68% were in the WHO African Region.

To prevent new HBV infections, the coverage of birth-dose hepatitis B vaccination needs to be greatly improved. This is most urgent in the WHO African Region, where coverage was only 17% in 2024 (**Fig. 4.11**).

4.4.4 Improving the coverage of antiviral prophylaxis for PMTCT of HBV infection

In addition to hepatitis B birth-dose vaccination, provision of antiviral prophylaxis to pregnant women with HBV infection helps to prevent mother-to-child transmission (**Section 4.3.2**). Multiplex tests for hepatitis, HIV and syphilis are increasingly becoming available, and provision of antiviral prophylaxis to any pregnant woman who tests positive for HBsAg is recommended, even in the absence of HBV DNA or HBeAg *(10, 28)*. Expanding testing and prophylaxis could have a major impact on the incidence of chronic HBV infections, especially in countries where hepatitis B birth dose vaccination is not yet implemented (**Fig. 4.10**) and where improving vaccination coverage is challenging.

Expanded coverage of HBV testing and provision of antiviral prophylaxis is particularly important in the WHO African Region, where the burden of HBV infection in the general population is most severe and coverage of hepatitis B birth-dose vaccination remains low (**Table 4.2**, **Fig. 4.11**).

Expanding HBV testing among pregnant women and the provision of antiviral prophylaxis and treatment to those who test positive or are eligible could facilitate broader scale-up of HBV treatment. For example, their antenatal care may provide an entry point for testing and treatment for other household or family members.

4.4.5 Improving harm-reduction services for people who inject drugs

The risk of HCV infection through the use of shared needles is between five and 10 times higher than the risk for HIV, and high rates of new infection and reinfection occur, regardless of age.

Following widespread scaling up of measures to ensure that medical injections and blood transfusion services are safe, a high priority for reducing new HCV infections is to ensure the safety of nonmedical injections – especially for people who inject drugs. This requires needle and syringe programmes and harm-reduction services.

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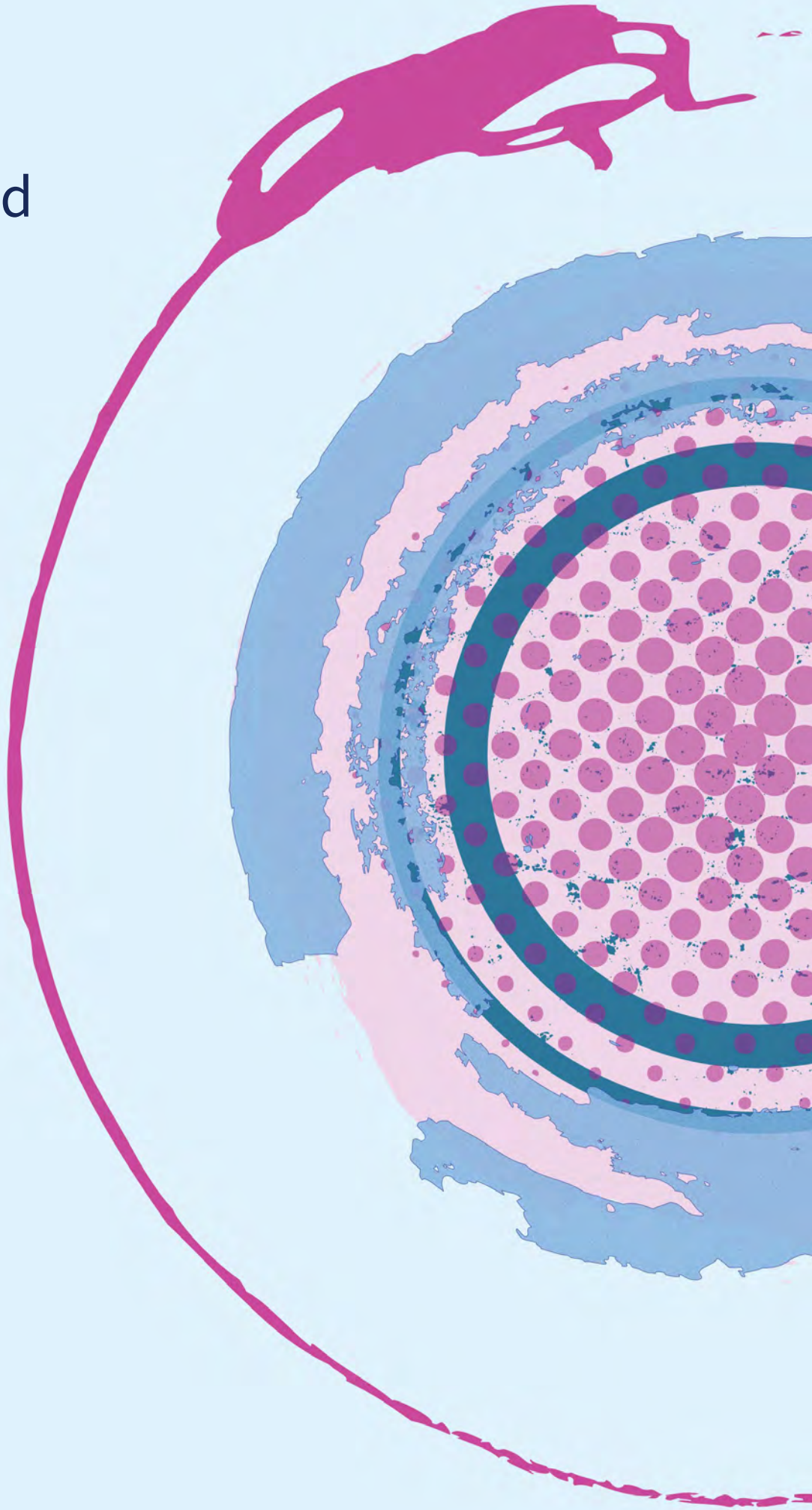
Chapter 5

Sexually transmitted infections



Every day, more than 1 million adults aged 15–49 years are estimated to acquire one of four curable sexually transmitted infections (STIs): *Treponema pallidum* (syphilis), *Neisseria gonorrhoeae* (gonorrhoea), Chlamydia trachomatis (chlamydia) and *Trichomonas vaginalis* (trichomoniasis) *(1)*. Other important infections that can be transmitted sexually include human immunodeficiency virus (HIV), human papillomavirus (HPV), herpes simplex virus (HSV) and hepatitis B virus (HBV).

The global health sector strategies on HIV, hepatitis and STIs for the period 2022–2030 (GHSS) *(2)* set the ambitious goal of ending STIs as a public health concern by 2030. The GHSS also set accompanying targets for reductions in the number of new infections and the coverage of interventions related to prevention, screening and treatment *(2)*. Achieving the targets requires overcoming political, structural and sociocultural barriers to delivering people-centred services and reducing the stigma that impedes access to them.

This chapter provides a mid-term assessment of progress, organized according to four topics:

- epidemic status and trends;
- service coverage;
- WHO guidance and support for strategy implementation, 2022–2026; and
- critical issues and priorities for action in the years up to 2030.

It uses the latest available data from a 2025 round of STI data collection from Member States by the World Health Organization (WHO); data reported through the Global AIDS Monitoring (GAM) system, which is managed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), WHO and the United Nations Children's Fund (UNICEF); data reported through other WHO platforms; and the published literature.[1,2]

The key findings and messages are provided in **Box 5.1**, and an illustrative overview of progress towards service coverage targets is shown in **Fig. 5.1**.

BOX 5.1.

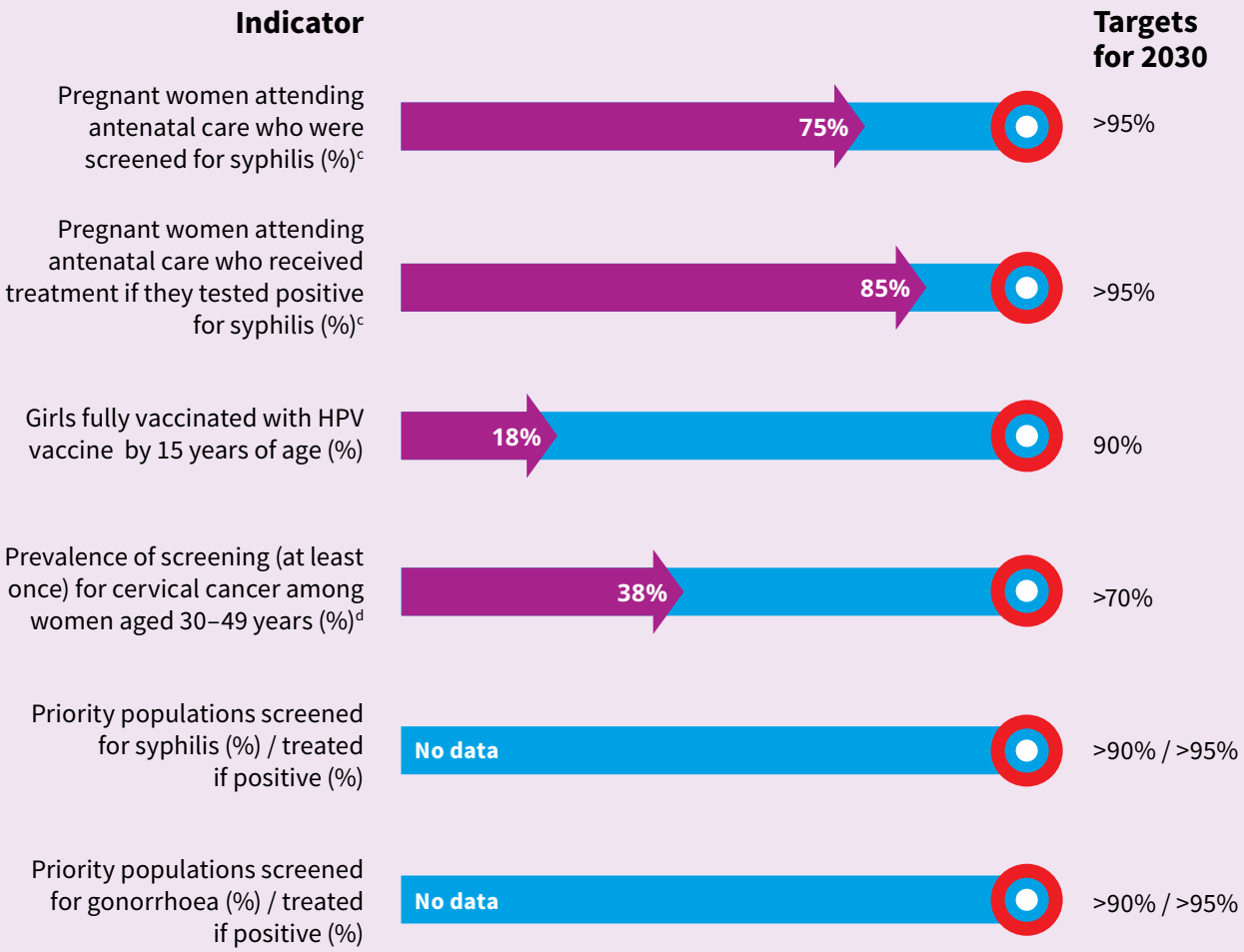
Chapter summary: key findings and messages

- Collecting reliable data about STIs is challenging. Infections are often asymptomatic, syndromic management does not yield etiological diagnoses, laboratory confirmation requires infrastructure that is not available in many settings and stigma drives underreporting. In low- and middle-income countries (LMICs), these challenges are compounded by limited diagnostic capacity, inadequate funding of STI programmes and fragmented health information systems.
- Even in high-income countries, surveillance of major STIs remains limited or absent. Infections are rarely notifiable and standardized reporting systems are lacking.
- These data challenges hinder assessment of progress towards targets for reductions in incidence and improvements in the coverage of prevention, diagnostic and treatment services. The data that are available suggest that progress is mostly off track, with worsening trends for some indicators.
- In 2020, there were an estimated 374 million new cases of the four curable STIs (syphilis, gonorrhoea, chlamydia and trichomoniasis) in adults aged 15–49 years. WHO estimates for later years are not available, but systematic reviews and data from high-income countries indicate that the number of cases of syphilis and gonorrhoea is rising.
- Antimicrobial resistance (AMR) to *N. gonorrhoeae* remains a critical threat: several countries, particularly in Asia, have reported increased resistance to ceftriaxone, the first-line treatment, at levels of 5% and above.
- There were an estimated 846 million people aged 15–49 years living with genital herpes (HSV1 and HSV2) in 2020; slightly more than one third had symptoms of genital herpes at least once in that year.
- An estimated one in three men are infected with at least one type of genital HPV.
- There have been improvements in the coverage of screening for syphilis among pregnant women (75% in 2024) and in the provision of treatment (85% of those testing positive).
- Globally, full coverage of HPV vaccination among girls by the age of 15 years was 18% in 2024. This was a modest improvement from 13% in 2020 but still far below the 2030 target of 90%. Single-dose coverage is better, at 31%.
- The global coverage of screening (at least once) for cervical cancer among women aged 30–49 years was 38% in 2022.
- In the past 5 years, 70% of countries have updated their national STI plans and in the past 3 years, 85% have updated their STI guidelines.
- Priorities for action in the years up to 2030 are: expanded access to people-centred STI prevention, testing and treatment services; massive expansion of HPV vaccination, including through single-dose schedules; rapid translation of innovations into practice; and strengthened surveillance to guide policy.
- A review of the STI indicators and accompanying targets used for global monitoring is required.

[1] Further details are provided in **Annex 1**.

[2] In some instances, data sourced from national reports or peer-reviewed publications do not represent official WHO statistics and should be interpreted within the context of the reporting country's health system and surveillance capabilities.

Fig. 5.1. Global targets for STIs: latest status of progress towards service coverage targets[a,b]



HPV: human papillomavirus.

[a] There are insufficient data available to assess progress towards targets for reductions in incidence.

[b] This is 2024 for all indicators except screening for cervical cancer, for which data are for 2022.

[c] Data are for 62 countries that reported on both indicators.

[d] This indicator is used in replacement of the original GHSS indicator.

5.1 Epidemic status and trends

Collecting reliable data about the incidence and prevalence of STIs is challenging. Infections are often asymptomatic, syndromic management does not yield etiological diagnoses, laboratory confirmation requires infrastructure that is not available in many settings and stigma drives underreporting. In low- and middle-income countries (LMICs), these challenges are compounded by limited diagnostic capacity, inadequate funding of STI programmes and fragmented health information systems. Even in high-income countries, surveillance of major STIs remains limited or absent. Infections are rarely notifiable and standardized reporting systems are lacking.

These data challenges hinder assessment of progress towards global targets for reductions in the combined incidence of the four curable STIs, the incidence of syphilis and gonorrhoea among people aged 15–49 years, and the incidence of congenital syphilis (**Table 5.1**). These challenges have been exacerbated by recent changes in the landscape of global health, including reductions in funding for global health agencies and deprioritization of STIs among international donor agencies and at country level, which have further constrained capacity to generate updated estimates based on strengthened collection and reporting of programmatic data.

5.1.1 Overall incidence of the four curable STIs

Globally in 2020, there were an estimated 374 million new cases of the four curable STIs (syphilis, gonorrhoea, chlamydia and trichomoniasis) in adults aged 15–49 years (**Table 5.1**) *(1)*. An updated global estimate for 2022 is available for syphilis, but not for the other three infections.

5.1.2 Incidence of gonorrhoea and syphilis among adults

The most recent WHO global estimates of the number of new gonorrhoea and syphilis cases in people aged 15–49 years date from 2020 and 2022, respectively; they were based on modelled data rather than direct measurement *(1)*.[1]

Gonorrhoea

There were an estimated 82.3 million new cases of gonorrhoea among people aged 15–49 years in 2020 (**Table 5.1**). Updated WHO estimates are not available; however, data from the WHO European Region show worrying upward trends *(3)*. Gonorrhoea incidence has increased substantially in countries that are part of the European Union (EU), with notification rates rising by over 303% since 2015 *(3)*. Men who have sex with men remain the most disproportionately affected group, accounting for more than half (62%) of the reported cases in 2024 *(4)*.

Importantly, data from WHO's Enhanced Gonococcal Antimicrobial Surveillance Programme (EGASP), which is being implemented in 14 countries, indicate that increasing antimicrobial resistance (AMR) is likely to complicate control efforts. Between 2022 and 2024, resistance to first-line cephalosporins (ceftriaxone and cefixime) increased markedly, alongside persistently high resistance to other antibiotics, signalling a growing risk of treatment failure and sustained transmission (**Section 5.3.4**) *(5)*.

Syphilis

Based on available estimates for 2022, the number of new syphilis cases among people aged 15–49 years increased by about 13% in 2 years, from 7.1 million in 2020 to 8.0 million in 2022 *(1)*. This trajectory is the opposite of what is required to reach the ambitious 2030 target of a 90% reduction compared with 2020.

In the absence of updated global figures, national surveillance data from high-income countries provide

Table 5.1. STI indicators for which global targets for reductions in incidence have been set: 2020 baselines and 2030 targets

Indicator	2020 baseline	2030 target
Global number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis among people aged 15–49 years per year	374 million	<150 million
Global number of new cases of gonorrhoea among people aged 15–49 years per year	82.3 million	8.23 million
Global number of new cases of syphilis among people aged 15–49 years per year	7.1 million	0.71 million
Global number of congenital syphilis cases per 100 000 live births per year	425	<50

Note: Indicators and targets are those presented in Annex 2 of the GHSS *(2)*.

[1] The GHSS did not include targets specific to chlamydia and trichomoniasis, and estimates only exist for 2020. Trends in the incidence of these two STIs are not discussed for these reasons.

the clearest signal that syphilis incidence is not only rising but is doing so at an accelerated rate.[1]

Examples include:

- countries in the EU and European Economic Area, where, between 2015 and 2024, syphilis notification rates more than doubled, reaching the highest levels observed during the past decade *(3)*;
- England, where diagnoses of infectious syphilis reached their highest level since the 1940s, with over 9500 cases in 2024 *(8)*;
- Japan, where the number of cases in 2024 (14 829) was almost 18 times higher than the number reported in 2011 (827) *(9)*;
- Australia, where syphilis has been declared a communicable disease incident of national significance, with the number of cases in 2024 more than double those in 2014 *(10)*.

The persistence of a high incidence of syphilis can be attributed to multiple factors, including *(11)*:

- declining condom use and changing sexual behaviour patterns;
- insufficient coverage of syphilis testing outside of antenatal care settings;
- lack of access to benzathine penicillin G in several high-burden countries owing to recurrent global supply shortages;
- incomplete partner notification and treatment; and
- the concentration of new infections among key populations, including men who have sex with men, sex workers and transgender people, who face structural barriers to accessing services *(11)*.

5.1.3 Incidence of congenital syphilis per 100 000 live births

Between 2023 and 2024, 100 countries that accounted for about 30% of the global number of live births reported data on the number of cases of congenital syphilis per 100 000 live births through GAM. This level of reporting is not sufficient to allow reliable assessment of progress towards the global target of fewer than 50 cases per 100 000 live births by 2030. In particular, only a small number of countries in the WHO South-East Asia and Eastern Mediterranean regions reported data (**Fig. 5.2**).

Among the 100 countries that reported data in 2023 or 2024, 10 reported more than 400 cases per 100 000 live births, six reported numbers of cases in the range 200–399, 15 reported 50–199 and 69 reported fewer than 50. The highest case rates were in countries in eastern, central and southern Africa, and countries in the WHO Region of the Americas (**Fig. 5.2**).

The lowest case rates were predominantly in countries in the WHO European Region. However, these low rates mask an alarming increase in reported cases in this region; between 2023 and 2024, the number of cases almost doubled *(3)*.

In relation to syphilis in pregnant women, there is still much to be accomplished, given the observed seroprevalence of syphilis in this group, the still-incomplete testing and treatment cascade for antenatal care (**Section 5.2.1**), and the absence of any comparable acceleration in benzathine penicillin G supply or coverage. The 2030 global target of fewer than 50 cases per 100 000 live births remains distant.

5.1.4 Prevalence of other STIs

Although genital HPV is not an indicator for which a global target has been set, an estimated one in three men are infected with at least one type of genital HPV *(12)*.

There were an estimated 846 million people aged 15–49 years living with genital herpes (HSV1 and HSV2) in 2020, including 520 million people with genital HSV2 infection; slightly more than one third had symptoms of genital herpes at least once in that year *(13)*.

5.2 Service coverage

An overview of the status of progress towards targets for service coverage is provided in **Fig. 5.1** and **Table 5.2**. Coverage is improving, especially for syphilis screening and treatment as part of antenatal care, but it remains far short of targets for HPV vaccination and screening for cervical cancer.

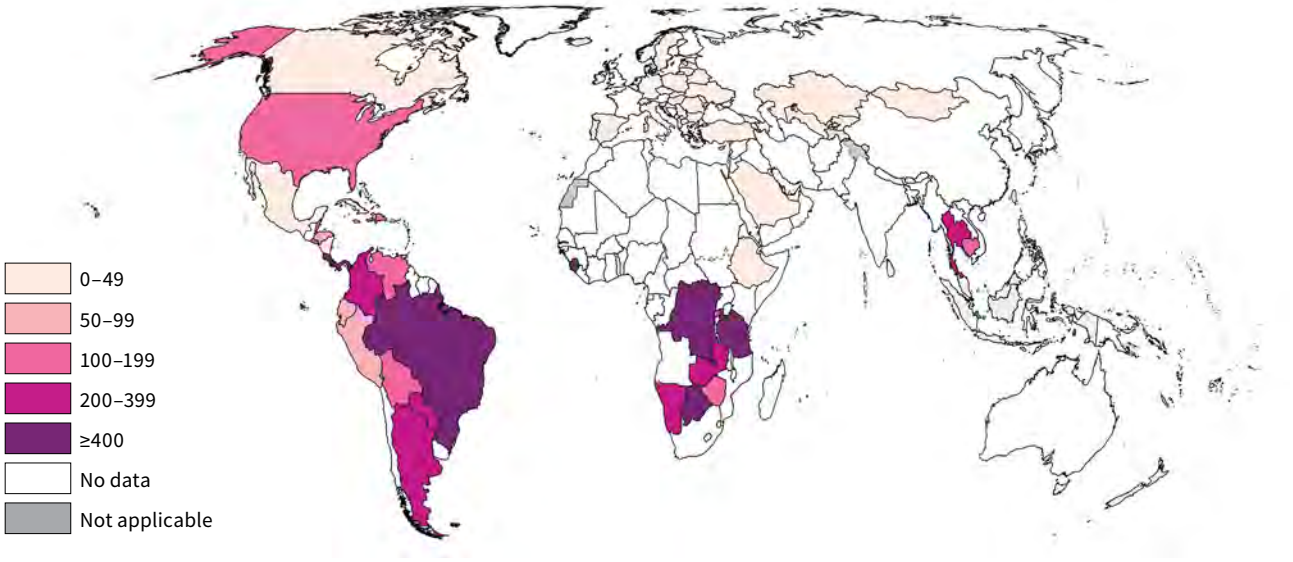
5.2.1 Antenatal screening and treatment for syphilis

Since 2020, there have been improvements in the coverage of screening and treatment for syphilis as part of antenatal care. Based on 62 countries that reported data on screening for syphilis and treatment for those screening positive,[2] the percentage of pregnant women attending antenatal care who were screened for syphilis increased from 66% in 2020 to 75% in 2024 (**Table 5.2**; **Fig. 5.3**) *(14)*. This 9-percentage-point increase reflects the cumulative impact of several factors: expanded deployment of dual HIV/syphilis rapid diagnostic tests (**Section 5.2.4**); strengthened integration of syphilis testing within antenatal care platforms; and increased policy emphasis on maternal syphilis screening as part of the agenda for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis (**Chapter 6**).

[1] Estimates published elsewhere also suggest increasing trends for syphilis and other STIs *(6, 7)*.

[2] These countries accounted for 52% of the global number of live births in 2024.

Fig. 5.2. Incidence of congenital syphilis (new cases per 100 000 live births per year), by country, 2023 or 2024[a]



[a] Data from both years were used, to maximize the number of countries for which recent data are shown. Data for at least one of these years were reported by 100 countries (**Annex 1**). If a country reported data for both 2023 and 2024, the data for 2024 were used.

Table 5.2. Global status of progress towards GHSS 2030 targets for STI service coverage

Indicator	2024 progress, unless stated otherwise	2030 target
Percentage of pregnant women attending antenatal care who were screened for syphilis	75%	>95%
Percentage of pregnant women attending antenatal care who received treatment if they tested positive for syphilis	85%	>95%
Percentage of girls fully vaccinated with HPV vaccine by age 15 years	18%	90%
Prevalence of screening (at least once) for cervical cancer among women aged 30–49 years (%)[a]	38%[b]	>70%
Percentage of priority populations screened for syphilis / treated if positive	No data	>90% / >95%
Percentage of priority populations screened for gonorrhoea / treated if positive	No data	>90% / >95%

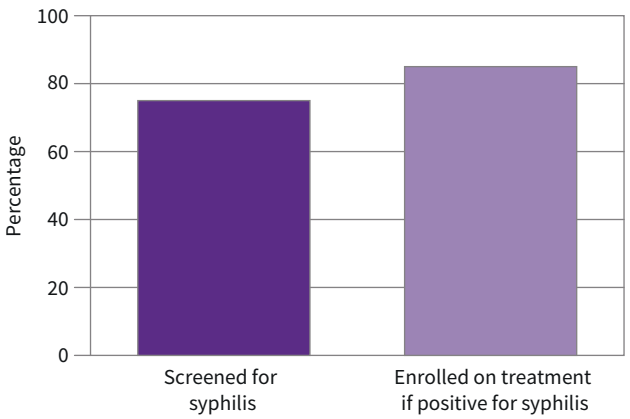
GHSS: global health sector strategies on HIV, hepatitis and STIs 2022–2030; HPV: human papillomavirus.

Note: Indicators and targets are those presented in Annex 2 of the GHSS *(2)* (see **Annex 1** for data sources).

[a] This indicator is used in replacement of the original GHSS indicator.

[b] The estimate is for 2022.

Fig. 5.3. Percentage of pregnant women attending antenatal care who were screened for syphilis and the percentage who were treated if positive in 2024, based on data reported by 62 countries[a]



[a] These countries reported data on both screening for syphilis and treatment for those testing positive.

Treatment bottlenecks remain. Among women testing positive, 85% were enrolled on treatment in 2024 (**Fig. 5.3**), still below the 2030 target of 95% (**Fig. 5.1**, **Table 5.2**). Health system barriers – including stockouts of benzathine penicillin G, weak referral systems and loss to follow-up – continue to affect or preclude timely treatment.

Data on screening for syphilis (and also gonorrhoea) among other priority populations (in addition to women attending antenatal care) are not available (**Table 5.2**).

5.2.2 HPV vaccination

HPV infection in women can lead to cervical cancer, which is the fourth most common cancer among women globally *(15)*. HIV increases susceptibility to HPV, reduces viral clearance, and accelerates progression from persistent infection to high-grade lesions and invasive cervical cancer *(16–18)*, resulting in a six-fold higher risk of cervical cancer among women and girls living with HIV *(19)*. Mortality rates are highest in sub-Saharan Africa, the part of the world with the highest prevalence of HIV among women and girls *(15)*. Expanding HPV vaccination is an essential component of the global strategy for cervical cancer elimination *(20)*.

There was a small improvement in the global coverage of full vaccination for HPV among girls by the age of 15 years, from 13% in 2020 to 18% (+5 percentage points) in 2024 (**Table 5.2**) *(21)*. This is still far from the 2030 target of 90%. There is considerable variation in coverage at country level (**Fig. 5.4**).

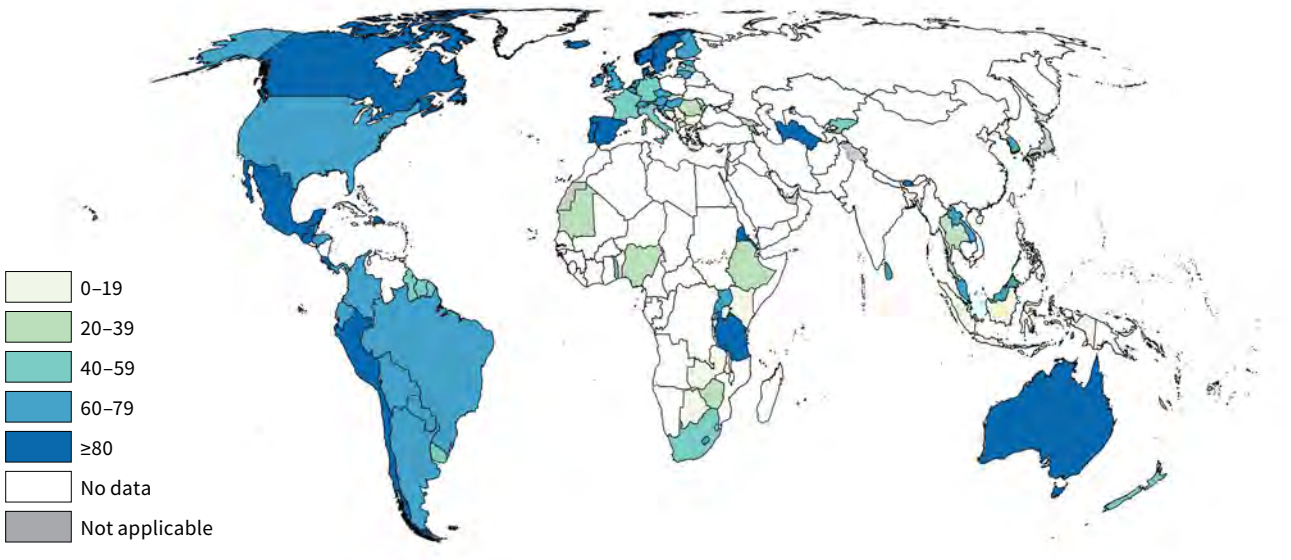
The slow pace of progress in improving vaccination coverage reflects persistent challenges in programme introduction and scale-up, particularly in LMICs.

In 2022, WHO recommended that a single dose of HPV vaccination confers protection that is comparable to that provided by two or three doses in individuals who are not immunocompromised *(22)*. In response to this recommendation, several countries have shifted to a single-dose HPV schedule. The coverage of at least one dose of HPV vaccination has reached 31% globally *(23)*, closer to the 2030 target.

For immunocompromised individuals, including women and girls living with HIV, provision of two to three HPV vaccine doses regardless of age or antiretroviral therapy (ART) status is still recommended *(22)*. This is required to achieve durable protection, given that antibody levels wane more rapidly in people living with HIV (particularly with the quadrivalent vaccine), and lower CD4 counts and detectable HIV viral load correlate with lower antibody titres *(24, 25)*.

The requirement for a multidose schedule for people living with HIV complicates service delivery: HPV vaccination is provided through school-based programmes, whereas provision of additional doses requires integration within HIV services, such as clinics providing ART. Provision is also constrained by financing, since the major donors (such as Gavi, the Vaccine Alliance) do not provide funding for second and third doses for women and girls living with HIV older than the routine eligible age cohort, which is typically 9–14 years. This challenge has become even more severe following overall reductions in international development assistance, particularly for HIV, since 2025 (**Chapter 2**, **Chapter 3**).

Fig. 5.4. Percentage of girls fully vaccinated with HPV vaccine by 15 years of age, by country, 2023 or 2024[a]



HPV: human papillomavirus.

[a] Data from both years were used, to maximize the number of countries for which recent data are shown. Data for at least one of these years were reported by 115 countries (**Annex 1**).

Addressing these challenges will require strengthened collaboration between immunization and HIV programmes to ensure delivery of the full vaccination schedule.

5.2.3 Cervical cancer screening and treatment

Screening is a critical pillar of cervical cancer elimination, enabling early identification of women with pre-cancerous lesions and invasive disease. Timely treatment of pre-cancer is essential to prevent progression and mortality, alongside effective management of invasive disease.

In 2022, the global prevalence of screening (at least once) among women aged 30–49 years was 38% (95% uncertainty interval [UI]: 33–43%) (**Table 5.2**) *(26)*. Estimates for later years are not currently available.

For women living with HIV, cervical cancer screening and treatment has expanded with support from the United States President's Emergency Plan for AIDS Relief (PEPFAR) and The Global Fund. PEPFAR-supported programmes screened over 7 million women between 2018 and 2022 across more than 20 countries *(27)*. WHO estimates of the coverage of screening and treatment for women living with HIV are currently in development.

Improving screening coverage both for women in the general population and for women living with HIV will be critical in the coming years to close gaps and advance towards elimination of cervical cancer.

5.2.4 Integration with primary health care, sexual and reproductive health, and HIV services

Ensuring access to high-quality, patient-centred STI services is essential.

More focus is needed on the implementation of the most effective and efficient interventions, especially the supply and distribution of male and female condoms. Although condoms are unique in simultaneously preventing STI transmission, HIV acquisition and unintended pregnancy, their distribution has stagnated and access remains inadequate in many settings. Revitalization of condom promotion and ensuring reliable supplies is essential, and should be combined with comprehensive primary prevention and sex education; vaccination for HPV, hepatitis B and mpox; timely management of STI signs and symptoms; partner services; and population-focused screening and treatment *(28–33)*.

Access to STI services could be expanded by integrating STI services into HIV, primary health care, sexual and reproductive health, and adolescent health services. Innovative service delivery models – such as peer and outreach services, mobile clinics and telehealth – could help to reach underserved populations.

Dual HIV/syphilis testing, self-testing for syphilis and self-care interventions also provide opportunities to improve access to STI prevention, diagnosis and care, particularly among key populations. The availability and deployment of rapid diagnostic tests that can simultaneously test for HIV and syphilis has been an important development, enabling screening for both infections within a single visit to a health facility, and improving the efficiency of diagnosis and treatment in antenatal care and other settings *(34)*. Other new tools are in the pipeline *(35)* and target product profiles are guiding the development of point-of-care tests *(36)*.

As part of the triple-elimination agenda (**Chapter 6**), integrated testing for HIV, syphilis and hepatitis B within antenatal care represents a high-impact platform that several countries are expanding.

5.3 WHO guidance and support for strategy implementation, 2022–2026

Since 2022, WHO has developed and disseminated new guidelines for several STIs, and has supported their uptake (e.g. through the development of national strategic plans); facilitated the development and implementation of new tools; improved global surveillance of gonococcal AMR; and developed a global STI database.

An overview of progress related to indicators for planning, policy uptake and surveillance for which GHSS targets were set is provided in **Table 5.3**.

Table 5.3. Global STI indicators for which targets for improvements in planning, policy and surveillance have been set: 2030 targets and (if available) status of progress[a]

Indicator	2025 progress, unless stated otherwise	2030 target
Percentage of countries with national STI plans updated within the past 5 years	70%	>90%
Percentage of countries with national STI case management guidelines updated within the past 3 years	85%	>90%
Percentage of countries reporting AMR in *N. gonorrhoeae* to the WHO Gonococcal Antimicrobial Surveillance Programme	36%[b]	>70%
Percentage of countries with strong STI surveillance systems	No data	>90%

AMR: antimicrobial resistance; *N. gonorrhoeae*: *Neisseria gonorrhoeae*.

[a] Indicators and targets are those presented in Annex 2 of the GHSS *(2)* (see **Annex 1** for data sources).

[b] Progress as of 29 June 2026, for either 2023 or 2024.

Fig. 5.5. WHO normative guidance and implementation tools for STIs, 2021–2026

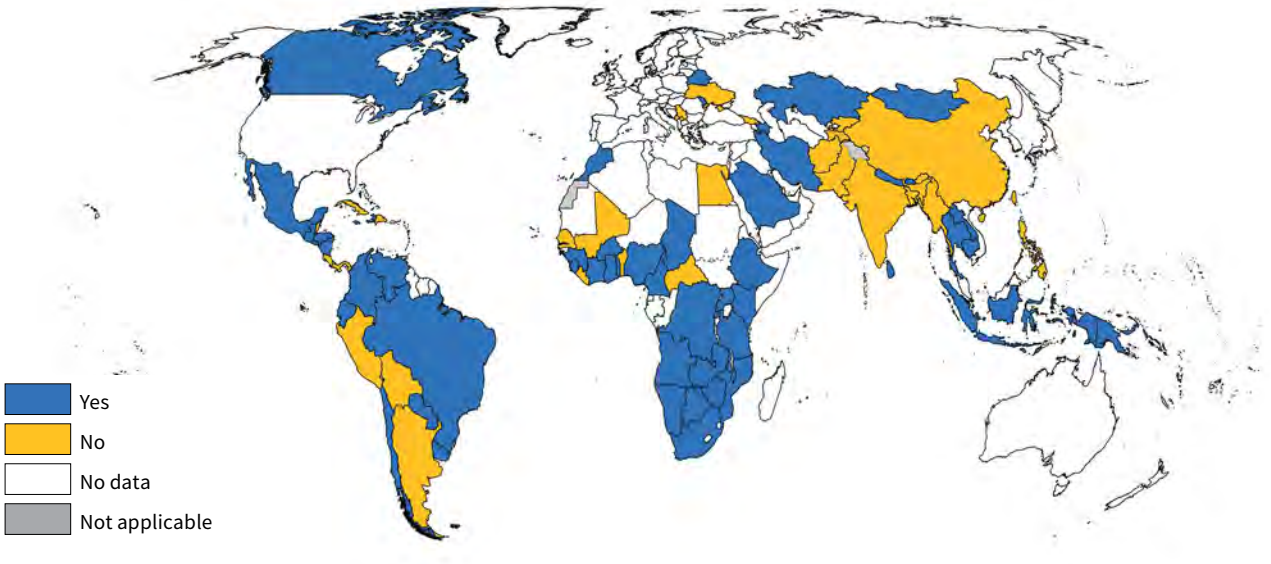
5.3.1 WHO guidelines and implementation tools

Between 2021 and 2026, WHO published a comprehensive suite of updated normative products for STIs, covering treatment, diagnostics, service delivery and programme management *(28–33, 37)*. These publications include updated treatment recommendations *(28–30)*, diagnostic guidance *(30)*, service delivery recommendations *(31)*, and guidelines for the management of both asymptomatic *(32)* and symptomatic *(33)* STIs (**Fig. 5.5**). They have informed national policy development in WHO Member States and have contributed to the reported increase in the number of countries with updated national plans and treatment guidelines related to STIs (**Fig. 5.6**, **Fig. 5.7**).

The consolidated operational handbook on STIs *(37)*, which translates these guidelines into practical implementation guidance, is expected to further support Member States to scale up national STI services.

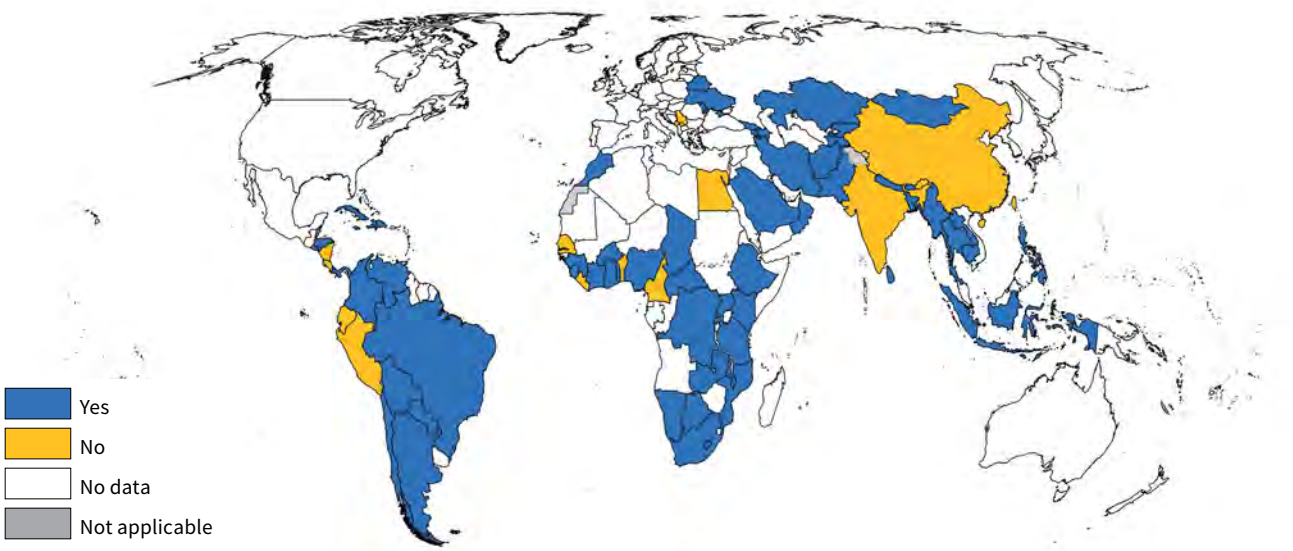
WHO has recently finalized guidelines on the use of doxycycline for post-exposure prophylaxis (doxyPEP), a strategy that has been shown to reduce the incidence of

Fig. 5.6. Countries with national STI plans that were updated within the past 5 years, 2025[a]



[a] Data for 2025 were reported by 98 countries.

Fig. 5.7. Countries with national STI case management guidelines that were updated within the past 3 years, 2025[a]



[a] Data for 2025 were reported by 92 countries.

syphilis and chlamydia in clinical trials among men who have sex with men and transgender women *(38, 39)*.

In 2021, WHO released updated clinical guidance to help countries make faster progress, more equitably, on the screening and treatment of cervical cancer *(40)*. It included some important shifts in WHO's recommended approaches to cervical screening and treatment, and had specific recommendations for the general population of women and (separately) for women living with HIV. WHO has been monitoring adoption of these guidelines; by 2024, 122 countries reported updating their national policy documents to align with WHO's recommendations for women living with HIV.

In 2026, WHO updated guidelines on screening and treatment of cervical cancer *(40, 41)*. The recommendations are primarily for the general population, owing to the paucity of data for women living with HIV; this highlights the need for better evidence for this population.

5.3.2 National STI plans and updating of treatment guidelines

Indicators related to policy uptake are encouraging (**Table 5.3**).

In 2025, the percentage of countries with national STI plans that were updated within the past 5 years was 70% (**Table 5.3**; **Fig. 5.6**), nearly meeting the 2025 milestone of more than 70% *(2)*. The percentage of countries with national STI case management guidelines that were updated within the past 3 years increased from 62% in 2020 to 85% in 2025 (**Table 5.3**; **Fig. 5.7**), exceeding the 2025 milestone of more than 70% *(2)*. This increase reflects the uptake and use of WHO guidelines for STIs published in 2021–2024 (**Section 5.3.1**).

5.3.3 Facilitation of innovation

WHO has worked with partners to facilitate the development of new tools for STIs. Clinical trials for several new products for preventing, diagnosing and treating STIs have been recently completed or are in their final stages *(35, 36)*. These products include new STI vaccines for which WHO is monitoring trial results; low-cost point-of-care diagnostics for chlamydia, gonorrhoea and trichomoniasis; new treatments for multidrug-resistant gonorrhoea and syphilis; and new self-testing products for syphilis and other STIs *(28)*.

As evidence related to new products becomes available, WHO will update normative guidance, provide support for registration and facilitate procurement, as appropriate. Ensuring equitable access to new products for LMICs will be essential, including through the expansion of in-country manufacturing capacity.

5.3.4 Enhanced gonococcal AMR surveillance

AMR in *N. gonorrhoeae* is one of the most critical threats to the STI response because it has the potential to render gonorrhoea untreatable. National surveillance has expanded, with 69 countries now reporting data to the WHO Gonococcal Antimicrobial Surveillance Programme (WHO-GASP) *(42)*.

Several countries have reported resistance to ceftriaxone at levels of 5% and above *(5, 43–46)*, a threshold that is particularly alarming given that ceftriaxone is the recommended first-line treatment for gonorrhoea and effective therapeutic alternatives are severely limited.

In response to these threats, WHO is coordinating the implementation of EGASP in 14 countries (at least one in

each of the six WHO regions). The aim is to strengthen gonococcal AMR surveillance and stewardship (**Box 5.2**), and efforts are guided by standardized protocols *(43, 45)* and documented through regular surveillance reports *(5, 43–46)*.

BOX 5.2.

Institutionalizing gonococcal AMR surveillance in India

In 2024, India began implementing EGASP under its National AIDS and STD Control Programme. Following a series of stakeholder consultations on etiological diagnosis of STIs and reproductive tract infections, 24 regional and state-level laboratories were identified for immediate implementation, to ensure national representativeness. Two regional hands-on training sessions were conducted for laboratory and clinic staff, followed by site-specific implementation planning.

Sites began reporting in January 2025. In the first two quarters, 167 patients with urethral discharge were enrolled, of whom 116 (69%) were culture-positive for *N. gonorrhoeae*, with antimicrobial susceptibility testing completed for 114 isolates. Early results showed high-alert minimum inhibitory concentration (MIC) values for cefixime (3.5%), azithromycin (3.5%) and ceftriaxone (0.8%). Ciprofloxacin resistance was 82.5%. No increased MIC values for gentamicin were detected *(5)*.

These findings represent a critical step by the Government of India, in coordination with the WHO Country Office, towards institutionalizing AMR surveillance for gonorrhoea. Expansion to remaining sites is planned for 2026.

Regular collection of susceptibility data, identification of resistance shifts and genomic characterization of circulating strains allows timely updates to treatment guidelines. It also informs the strategic positioning of new treatments and point-of-care tests for antibiotic stewardship.

5.3.5 Global STI prevalence database

STIs are often asymptomatic and hence not identified through passive case-finding surveillance activities. Laboratory confirmation requires infrastructure that is not available in many settings, while data linkages that connect epidemiological with laboratory data are weak. These realities mean that generating reliable global estimates of the incidence of the four curable STIs is challenging.

To help address persistent data gaps, WHO initiated the development of a global STI prevalence database in 2023, and made it publicly available (open access) in 2026 *(47)*. The database is a first-of-its-kind global resource that brings together data on STIs from LMICs for the period 2010 onwards. It addresses long-standing gaps in standardized, quality-assured data (by country and for specific populations) by consolidating published and unpublished data from diverse sources.

The database includes prevalence data from studies that report clearly defined population groups with sufficient methodological detail, and from studies with a sample size of at least 100 in which most samples were collected in 2010 or later. It includes data from household-based surveys, surveys conducted in specific populations (e.g. pregnant women, adolescents, key populations, sex workers or STI clinic attendees), and baseline data from intervention and case–control studies.

The current focus of the database is on five STIs: chlamydia, gonorrhoea, HSV2, syphilis and trichomoniasis. However, the database is a dynamic resource and will be updated to reflect the latest evidence as new studies are published and reviewed, and further infections are added.

The database has been developed for use by policy makers, researchers, industry, community organizations, and funding agencies that are interested in understanding the burden of STIs in particular settings and populations. The database will also be a resource for generating regional and global estimates of the burden of STIs and their time trends.

5.4 Critical issues and priorities for action up to 2030

To drive progress towards the 2030 targets, there are critical issues that need to be addressed through prioritized action at country, regional and global levels.

5.4.1 Critical issues

STI services are particularly vulnerable to disruptions. Unlike HIV treatment, which benefits from established care platforms, STI services are often deprioritized during crises.

The coronavirus disease (COVID-19) pandemic exposed these vulnerabilities acutely, as clinic closures and supply chain interruptions led to measurable declines in STI testing and treatment. More recently, armed conflicts, major changes in the landscape of funding for global health in 2025 and economic downturns in many parts of the world have disrupted laboratory capacity and commodity supply chains, particularly among displaced populations. In fragile settings, STI services are often the first to collapse and the last to be restored. Funding for STI products applicable to LMICs, which had been increasing in recent years, is estimated to have declined sharply since 2025 and remains poorly aligned with public health needs.

Building resilience requires investment in decentralized delivery, community-led approaches and strategic stockpiling of commodities. Countries with integrated HIV/STI platforms before disruptions demonstrated greater capacity to maintain service continuity, providing a model for resilience that should be systematically replicated.

5.4.2 Priorities for action up to 2030

There are four priorities for action at country level, and one priority for action at global level.

Country level

1. Scaling up quality prevention, testing and treatment services, including through strengthened collaboration with affected populations, and with particular attention to gaps in syphilis treatment and building resilience to disruptions

Expanding and facilitating access to services in both the public and private sectors is essential; for example, by integrating STI services into HIV, sexual and reproductive health and adolescent health services within primary health care, and decentralizing services so that care is widely available (beyond specialized services). This will also help STI services to withstand disruptions and external shocks. In addition, STI service platforms, particularly for key populations, offer infrastructure and community trust that can be leveraged to close gaps in HIV prevention and testing.

Strengthened collaboration is required to help to overcome stigma, discrimination and other barriers that impede access to services. This includes meaningful engagement with affected populations; community-led service delivery approaches; and empowerment of people to address their needs through a broader range of prevention, diagnostic and treatment options.

Closing gaps in the provision of treatment for syphilis is of particular importance, given the disparity between improved syphilis screening coverage and stagnant treatment completion rates. This requires securing supplies (including strategic reserves) of benzathine penicillin G, health worker training, strengthening of referral systems and development of user-friendly diagnostic tools tailored to the natural history of *T. pallidum* that go beyond current rapid diagnostic tests.

2. Accelerating HPV vaccination, including through single-dose schedules and innovative delivery platforms

A massive acceleration in the coverage of HPV vaccination is required, based on the foundation of sustained domestic financing and political commitment. To facilitate scale-up, the use of single-dose schedules and innovative delivery platforms are also important, particularly in the WHO African and South-East Asia regions.

3. Rapid translation of technological innovations

New diagnostics, treatments and vaccines must be moved from trials to implementation, with equitable access ensured through regulatory support and procurement facilitation.

4. Strengthening surveillance and AMR monitoring

Expanded case-based surveillance, including participation in WHO-GASP and enhanced genomic surveillance for gonococcal AMR, are essential to guide treatment policy.

Global level

1. Simplifying and refocusing global indicators and targets

The current GHSS target framework includes STI indicators for which no reliable and up-to-date data exist. Data generation was difficult even when the funding environment was more favourable. Within the current, more constrained context, a review of global indicators and associated targets is warranted, with a focus on defining a key set of indicators for which it will be feasible to monitor progress.

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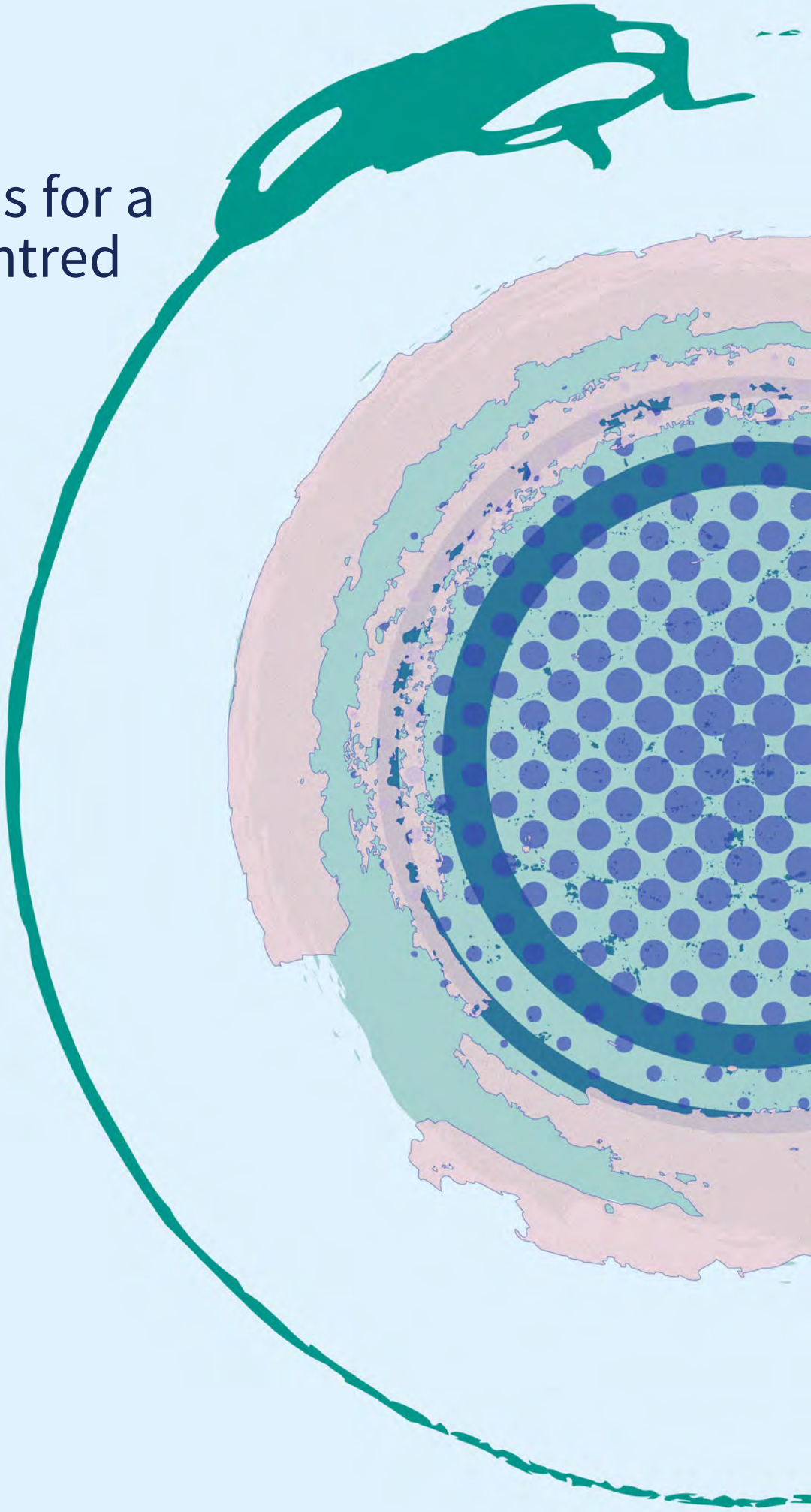
Chapter 6

Shared approaches for a people-centred response



HIV, viral hepatitis and sexually transmitted infections (STIs) share common modes of transmission, and there are overlaps among the most-affected populations and the health services that they need. The World Health Organization (WHO) *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (GHSS) included six shared approaches that contribute to the GHSS goal of ending AIDS and the epidemics of viral hepatitis and STIs by 2030 *(1)*. This chapter discusses each of these approaches in turn, illustrated with global data or country examples of progress. It then provides an overview of how WHO has provided guidance and support for the shared approaches, and highlights critical issues and priorities for action in the years up to 2030.

6.1 Shared approaches

The six shared approaches are:

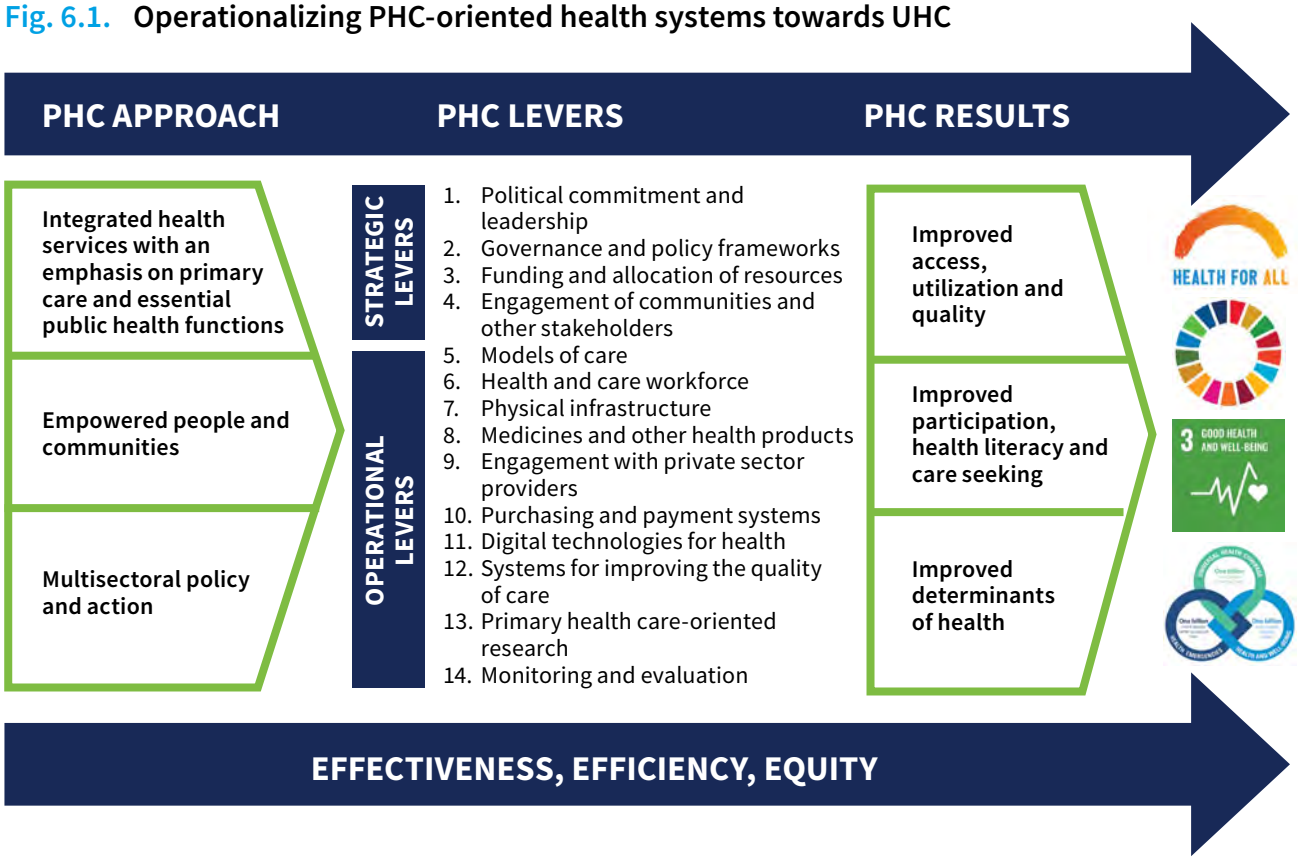
- sustaining services through primary health care (PHC), universal health coverage (UHC) and integrated systems;
- strengthening prevention services;
- eliminating mother-to-child transmission of HIV, hepatitis B and syphilis (i.e. triple elimination);
- providing harm reduction services;
- integrating surveillance, data systems and use of artificial intelligence (AI); and
- facilitating equitable access to commodities, diagnostics and medicines.

6.1.1 Sustaining services through PHC, UHC and integrated systems

Countries are increasingly integrating HIV, hepatitis and STI services into broader PHC and UHC agendas (**Fig. 6.1**) led by ministries of health.[1] Efforts have intensified amid growing concerns about sustainability and service continuity in the context of a changed financing environment and evolving global health architecture (**Chapter 2**). For example, in 2025 and 2026, HIV services were disrupted in countries that previously benefited from substantial external funding (**Chapter 3**). Integration extends beyond HIV, hepatitis and STI services, and includes those for maternal and child health, sexual and reproductive health, tuberculosis (TB), noncommunicable diseases and mental health.

Integration of hepatitis services within HIV platforms has been reported by many countries (**Chapter 4**), although coverage remains uneven. For example, among 110 countries that reported data for 2025, 71 had

Fig. 6.1. Operationalizing PHC-oriented health systems towards UHC



PHC: primary health care; UHC: universal health coverage.
Source: WHO (2023) *(4)*.

[1] UHC means that everyone can access the health services that they need, without suffering financial hardship *(2)*. Coverage of antiretroviral therapy (ART) among people living with HIV is one of the tracer indicators that WHO uses to track progress towards UHC *(3)*.

integrated testing services for hepatitis B virus (HBV) into HIV service delivery platforms that were available in most parts of the country. However, in only 50 countries were treatment services for people with chronic HBV infection integrated with treatment services for people living with HIV in most parts of the country. For hepatitis C virus (HCV), 58 countries reported that testing services had been integrated with HIV services in most parts of the country, whereas only 44 countries had treatment services for people with HCV infection available within these platforms.

Country examples of progress in integrating HIV, hepatitis and STI services include the following:

- Angola, Botswana, Brazil, Ethiopia, Indonesia, Kenya, Pakistan, Rwanda, Viet Nam and Zambia, where integration of HIV, hepatitis and STI services with PHC-oriented health systems has helped to achieve improved health outcomes *(5)*.
- Australia, where human papillomavirus (HPV) vaccination and cervical cancer elimination initiatives are linked to sexual health programmes *(6)*.
- Brazil, where access to pre-exposure prophylaxis (PrEP) for HIV has been expanded through public sector digital enrolment systems and community clinics *(5)*.
- Eswatini, Nigeria and Viet Nam, where differentiated and community-led HIV service delivery models for key populations[1] have been used within broader PHC, leading to improved access, engagement and health outcomes across a range of services *(5)*.
- Maldives, where HIV and STI services have been integrated into broader sexual and reproductive health platforms and digital health systems, supporting continuity of care despite the country's geographically dispersed island health system. In antenatal care, which is accessed by more than 95% of pregnant women, there is universal testing for HIV, syphilis and HBV. Immunization services are also strong, and over 95% of neonates have full vaccine coverage including a timely birth dose of the hepatitis B vaccine. Such levels of care are based on free antenatal care, vaccines and diagnostic services for all residents, including migrants, and are supported by strong policies and investment of over 10% of gross domestic product in health *(7)*.
- Rwanda, where integration of hepatitis services within HIV service platforms has contributed to increased access to hepatitis diagnosis and treatment *(5)*.
- Zimbabwe, where integrated HIV and sexual and reproductive health services for adolescent girls and young women have been expanded through community-based platforms *(8)*.

[1] For further discussion of key populations, see **Chapter 3** (**Section 3.1.3**).

More generally, HIV investments have helped to support broader laboratory and procurement systems, community delivery platforms and surveillance systems. Differentiated service delivery and community-based approaches developed for the HIV response are also helping to strengthen PHC-oriented models. More specifically, during a multicountry mpox outbreak in 2022, existing HIV services and systems were leveraged to support testing, surveillance and outreach activities *(9)*.

Access to STI services could be expanded by integrating STI services into services for HIV, sexual and reproductive health, and adolescent health (**Chapter 5**). Innovative service delivery models – such as peer and outreach services, mobile clinics and telehealth – could help to reach underserved populations.

Overall, implementation of integrated services remains uneven. Fragmentation of financing and reporting structures continues to be a challenge in many settings; in such situations, the central coordinating role of the ministry of health needs to be strengthened.

6.1.2 Strengthening prevention services

Interventions to prevent acquisition of HIV, viral hepatitis and STIs include vaccination, condoms, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), harm reduction services for people who inject drugs (e.g. needle and syringe programmes, and opioid agonist maintenance therapy [OAMT]), measures to ensure the safety of blood services, and prevention of mother-to-child transmission of HIV, HBV and syphilis through antenatal screening combined with treatment for those testing positive.

Globally, the coverage of most preventive interventions falls far short of the 2030 targets (**Chapter 3**, **Chapter 4**, **Chapter 5**).[2] Exceptions include the coverage of hepatitis B third-dose vaccination in infants and blood safety (**Chapter 4**).

More focus is needed on the implementation of the most effective and efficient interventions, especially the supply and distribution of male and female condoms (**Chapter 5**). Although condoms are unique in simultaneously preventing unintended pregnancy and the transmission of STIs including HIV, their distribution has stagnated and access remains inadequate in many settings.

Countries that have achieved or made substantial progress towards triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis are discussed in the next subsection.

[2] Condom promotion and distribution, and PEP, are discussed in **Chapter 3** and **Chapter 5**; hepatitis B vaccination, antiviral prophylaxis to prevent mother-to-child transmission of HBV, harm reduction services in the context of HCV, and measures to ensure blood safety (for the four transfusion-transmittable infections, HIV, HBV, HCV and syphilis) are discussed in **Chapter 4**; and HPV vaccination is discussed in **Chapter 5**.

Harm reduction services are discussed in **Section 6.1.4**.

6.1.3 Eliminating mother-to-child transmission of HIV, HBV and syphilis

Elimination of mother-to-child transmission of HIV, HBV and syphilis (triple elimination) is feasible when there is high coverage of antenatal care combined with routine screening for HIV, HBV and syphilis infection, and treatment for pregnant women who test positive. Screening has been facilitated by the availability of rapid diagnostic tests that simultaneously test for HIV and syphilis.[1]

In 2025, Maldives was validated by WHO as the first country to achieve triple elimination. This followed validation that transmission of HBV had been eliminated, after previous validation of the elimination of mother-to-child transmission of HIV and syphilis.

Other countries have been validated for elimination of mother-to-child transmission of HIV and syphilis (17 countries), HIV and HBV (1 country), HIV only (3 countries) or syphilis only (1 country) (**Table 6.1**).[2]

6.1.4 Providing harm reduction services

About 44% of new HCV infections are among people who inject drugs (**Chapter 4**) – one of the key populations at higher risk of acquiring HIV (**Chapter 3**). WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) recommend comprehensive harm reduction services, including measures to prevent the transmission of HIV and HCV. These services include needle and syringe programmes, OAMT and naloxone distribution for overdose management.

Globally, the coverage of services remains far below recommended levels. For example, the annual average number of needles and syringes distributed per person who injects drugs was estimated at 35 in 2024, far short of the GHSS 2030 target of 300 (**Chapter 3**, **Chapter 4**). In 2025, among the 110 countries that reported data, only 35 provided testing and treatment for HCV infection as part of harm reduction services, and only 25 provided them as part of OAMT programmes in prisons (**Chapter 4**).

Table 6.1. Countries that have received WHO validation for the elimination of mother-to-child transmission of HIV, syphilis or hepatitis B

Elimination category	Countries validated by WHO
Triple elimination: HIV, HBV and syphilis	Maldives
HIV and syphilis	Anguilla, Antigua and Barbuda, Belarus, Belize, Bermuda, Cayman Islands, Cuba, Denmark, Dominica, Jamaica, Malaysia, Montserrat, Oman, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Sri Lanka and Thailand
HIV and HBV	Turks and Caicos
HIV only	Armenia, the Bahamas and Brazil
Syphilis only	Republic of Moldova

Elsewhere, major gaps persist. These include insufficient coverage of hepatitis B birth-dose vaccination, especially in the WHO African Region, where it was 17% in 2024 (**Chapter 4**).

Based on lessons from triple elimination of mother-to-child transmission, WHO and partners are exploring other multi-disease elimination approaches for HIV, hepatitis and STIs (including cervical cancer elimination initiatives).

Constraints on service provision include national laws and policies, which are also becoming more restrictive in some countries (**Chapter 2**).

Examples of countries that have reduced HCV or HIV infections among people who inject drugs include Australia, Georgia, Italy, Portugal and the United Kingdom of Great Britain and Northern Ireland *(7, 10, 11)*.

Prevention efforts also need to evolve as risk behaviours change. For example, there is evidence of psychoactive substance use (e.g. methamphetamine, mephedrone, gamma-hydroxybutyrate [GHB] and gamma-butyrolactone [GBL]) in sexualized contexts (often referred to as chemsex) contributing to higher rates of HIV and STI transmission and other negative health outcomes in sexual networks, particularly among men who have sex with men *(12–15)*.

[1] These are referred to as multiplex rapid diagnostic tests.

[2] WHO also recognizes countries that have made considerable progress on the "path to elimination". Two countries have been recognized in this way: Botswana (for progress towards elimination of mother-to-child transmission of HIV) and Namibia (for progress towards elimination of mother-to-child transmission of HIV and HBV).

6.1.5 Integrating surveillance, data systems and use of AI

In several settings, investments in electronic medical records, laboratory connectivity and case-based surveillance systems are helping to improve programme monitoring and service delivery *(16)*. WHO has also developed digital adaptation kits to support the adoption and implementation of WHO normative guidance *(17)*.

At the national level, there is a growing emphasis on the importance of digital systems on undertaking disease surveillance using interoperable digital systems, and on ensuring that surveillance of specific diseases is done within a single system. Several countries have sought to reduce the use of parallel donor reporting systems, and to improve integration across HIV, hepatitis and STI surveillance platforms.

Community-led monitoring has expanded, particularly within HIV programmes. Increasingly, countries and partners recognize community-generated data as an essential component of accountability and people-centred responses.

AI has the potential to transform many aspects of health care. For example, AI-supported analytics could help to improve disease surveillance and forecasting, clinical decision-making, supply chain management and programme optimization. This use needs to be accompanied by safeguards related to privacy and data confidentiality (**Chapter 2**) *(18)*.

6.1.6 Facilitating equitable access to commodities

Equitable access is a central theme of the GHSS. Reductions in prices, and associated uptake within services, have supported remarkable progress in access to diagnostics and treatments. For example, generic antiretroviral (ARV) medicines for HIV and generic direct-acting antivirals (DAAs) for treatment of HCV infection have transformed access to treatment in many countries.

Nonetheless, in 2026, there are still major concerns about inequities in access to commodities for the prevention and treatment of HIV, viral hepatitis and STIs (**Table 6.2**).

Examples of inequity in access to commodities for the prevention and treatment of HIV, viral hepatitis and STIs include the following:

- Many middle-income countries are still excluded from voluntary licensing agreements and pooled procurement arrangements for generic ARVs for the treatment of HIV and DAAs for the treatment of HCV infection; hence, those countries still pay significantly higher prices *(19)*. Some low-income countries still have challenges in realizing access prices, owing to fragmented demand, registration and supply chain issues.
- The high prices of long-acting ARV medicines for HIV prevention and treatment, coupled with restrictive licensing arrangements, risk delaying access for populations that have the greatest public health need for those medicines *(20–22)*.
- In many countries, the prices of HPV vaccines and hepatitis diagnostics remain prohibitively high.

WHO, UNAIDS and the Independent Panel for Pandemic Preparedness and Response have all highlighted that market concentration, intellectual property barriers and manufacturing limitations contribute significantly to these inequities *(23, 24)*.

The rapid development of vaccines, diagnostics and therapeutics during the coronavirus disease (COVID-19) pandemic demonstrated the critical importance of investment in research and development (R&D), including partnerships between governments, academia, civil society and the private sector. However, the pandemic also intensified debate about how public investment in innovation should translate into equitable public access. Increasingly, governments and civil society organizations are calling for stronger use of TRIPS[1] flexibilities, voluntary licensing, patent pooling and technology transfer arrangements to balance incentives for innovation with public health imperatives *(24, 25)*.

National and regional manufacturing initiatives are helping to diversify production capacity. Examples include:

- India being a major global producer of affordable medicines for treatment of HIV and viral hepatitis;
- South Africa advancing regional manufacturing initiatives for vaccines and diagnostics; and
- Nigeria and the United Republic of Tanzania developing regional manufacturing for diagnostics.

Both the African Union and WHO have emphasized the importance of strengthening local production of vaccines, diagnostics and therapeutics to reduce dependence on a small number of global suppliers and to improve preparedness for future health emergencies *(24, 25)*.

Ensuring equitable access to current and future vaccines, diagnostics, medicines and digital health technologies remains central to achieving the 2030 targets for HIV, viral hepatitis and STIs, and to advancing UHC more broadly.

[1] TRIPS refers to the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights.

Table 6.2. Inequities in access to commodities for HIV, viral hepatitis and STIs: status in 2026

Commodity	Examples	Reasons	Potential solutions
ARV medicines	Variable access to newer regimens, with older regimens still used in some countries Variable access to paediatric regimens	Fragmented procurement Dependence on international donor funding	Expansion of regional manufacturing and domestic financing
BPG for treatment for syphilis	Variable access to BPG of suitable quality and at affordable prices	Insufficient manufacturing capacity The BPG market landscape is complex and often leads to sole sourcing[a] by countries	Strengthening of demand forecasting, country procurement and monitoring of national stock levels
Dual HIV/syphilis tests	Variable use in antenatal care and community screening	Availability of funding Delays in regulatory approval	Implementation of strategies to eliminate mother-to-child transmission of HIV and syphilis
Sterile injecting equipment and OAMT	Severely inadequate provision in many countries	Criminalization and stigma related to injecting drug use	A human-rights based approach to financing and service provision
HBV diagnostics and treatment	Limited availability within PHC in many countries	Limited integration of services for viral hepatitis within PHC Inadequate supplies	Integration of services for viral hepatitis into PHC Inclusion of HBV diagnostics and treatment in UHC benefit packages
HCV DAAs	Price varies, from less than US$ 100 per person to several thousands of US dollars per person	Patent restrictions Procurement inefficiencies	Use of TRIPS flexibilities and generic versions
HPV vaccines	Large disparities in coverage; low coverage in countries with high burden of infection and cervical cancer	High prices Limited supplies	Expansion of affordable supply and delivery systems
Long-acting HIV prevention or treatment	Injectable PrEP and ART are mostly available in high-income countries, with slower rollout in LMICs	Patents, pricing and limited licensing	Technology transfer Equitable licensing Use of pooled procurement
Mpox vaccines and diagnostics	During outbreaks, supplies were limited in African countries	Concentration of manufacturing capacity	Expansion of manufacturing capacity at regional level
STI diagnostics	Reliance on syndromic management of STIs in many settings, rather than diagnostic testing	Fragmented demand Weak R&D incentives to develop better diagnostics	Expanding the availability of affordable rapid tests

ART: antiretroviral therapy; ARV: antiretroviral; BPG: benzathine penicillin G; DAA: direct-acting antiviral; HBV: hepatitis B virus; HCV: hepatitis C virus; HPV: human papillomavirus; LMICs: low- and middle-income countries; OAMT: opioid agonist maintenance treatment; PHC: primary health care; PrEP: pre-exposure prophylaxis; R&D: research and development; TRIPS: Trade-Related Aspects of Intellectual Property Rights; STI: sexually transmitted infection; UHC: universal health coverage.

[a] Sole sourcing refers to a situation where only one supplier is available for the required product or service that a country or organization needs.

6.2 WHO guidance and support for shared approaches, 2022–2026

WHO has provided guidance and support for the six shared approaches through:

- the development and wide dissemination of normative guidelines and tools (**Fig. 6.2**) *(4, 26–32)*;
- the inclusion of HIV, viral hepatitis and STIs in the WHO UHC compendium *(33)*;
- engagement in partnerships that support local manufacturing of medicines and diagnostics;
- validation of the elimination of mother-to-child transmission in 23 countries (**Table 6.1**);
- facilitation of the R&D pipelines for commodities that enable integrated care (e.g. dual HIV/syphilis diagnostic tests); and
- country missions covering cross-cutting topics.

Further details are provided in **Annex 2**.

Fig. 6.2. WHO normative guidance and implementation tools related to the six shared approaches, 2022–2026

6.3 Critical issues and priorities for action up to 2030

The changing context for GHSS implementation (**Chapter 2**) has reinforced the importance of the shared approaches. Key examples of changes are:

- reductions in international donor funding for health (in particular, for the HIV response);
- the accelerated pace of technological change, especially AI; and
- a new preventive treatment for HIV, for which supply and price barriers need to be addressed to improve access.

Priorities for action in the years up to 2030 include:

- improving the resilience and sustainability of services related to HIV, viral hepatitis and STIs, including through increases in domestic financing in LMICs, further integration of service delivery within primary health care, and ensuring that services related to HIV, viral hepatitis and STIs are an integral part of national efforts to achieve UHC;
- revitalized efforts to improve the availability and uptake of common approaches to prevention of transmission;
- expanding efforts to eliminate mother-to-child transmission of HIV, HBV and syphilis;
- strengthening disease surveillance and use of data, including through integrated approaches;
- harnessing digital innovation;
- improving equitable access to diagnostics, medicines and vaccines; and
- protecting human rights and related access to services through legislative and policy frameworks.

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Annex 1

Data sources and methodological notes

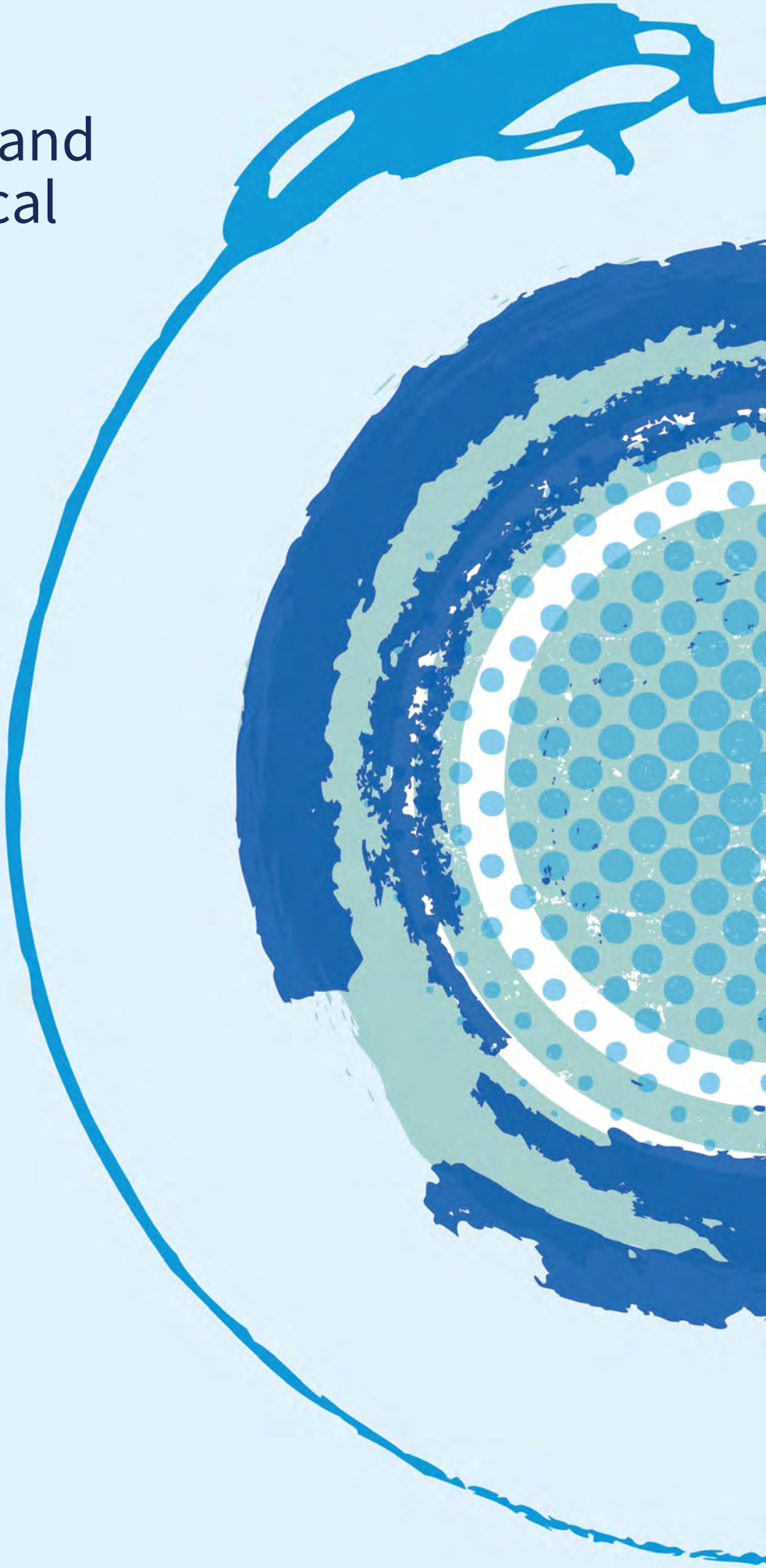

Table A.1.1 provides an overview of data sources for the tables and figures presented in two chapters of this report: **Chapter 3** (which covers HIV) and **Chapter 5** (which covers sexually transmitted infections [STIs]). A detailed explanation of the methods related to **Chapter 4** (which covers viral hepatitis) is available elsewhere *(1)*.

Table A.1.1. Overview of data sources for tables and figures in Chapter 3 (HIV) and Chapter 5 (STIs)

Disease area	Indicator	Reference (table or figure)	Source	Years presented	Number of countries with data for the most recent year	Summary methods as relevant
HIV	Number of people newly infected with HIV per year (people acquiring HIV)	**Fig. 3.1, 3.2, 3.5, 3.6, 3.7**	UNAIDS estimates	2025 (Fig. 3.1, 3.2, 3.7); 2010–2025 (Fig. 3.5, 3.6)	169	UNAIDS modelled estimates with uncertainty bounds (the term used by UNAIDS for uncertainty intervals) *(2)*
	Number of children younger than 15 years newly infected with HIV per year	**Fig. 3.1, 3.2, 3.7**	UNAIDS estimates	2025	110	
	Number of people newly infected with HIV per 1000 uninfected population per year (SDG Indicator 3.3.1)	**Fig. 3.1**	UNAIDS estimates	2025	169	
	Number of people dying from HIV-related causes per year (HIV-related deaths)	**Fig. 3.1, 3.2, 3.9, 3.11**	UNAIDS estimates	2025 (Fig. 3.1, 3.2, 3.11); 2010–2025 (Fig. 3.9)	168	
	People living with HIV	**Fig. 3.2, 3.3, 3.4**	UNAIDS estimates	2025 (Fig. 3.2, 3.4); 2010–2025 (Fig.3.3)	171	
	HIV-related deaths per 1000 population	**Fig. 3.10**	UNAIDS estimates	2010–2025 (Fig. 3.10)	168	
	Percentage of people living with HIV who know their HIV status (first 95 of 95–95–95)	**Table 3.1; Fig. 3.1, 3.12, 3.13, 3.14**	UNAIDS estimates	2025 (Table 3.1; Fig. 3.1, 3.12, 3.14); 2015–2025 (Fig. 3.13)	138	
	Percentage of people who know their HIV status who are receiving ART (second 95 of 95–95–95)	**Table 3.1; Fig. 3.1, 3.12, 3.13, 3.14**	UNAIDS estimates	2025 (Table 3.1; Fig. 3.1, 3.12, 3.14); 2015–2025 (Fig. 3.13)	131	
	Percentage of people living with HIV and receiving ART who have suppressed viral loads (third 95 of 95–95–95)	**Table 3.1; Fig. 3.1, 3.12, 3.13, 3.14**	UNAIDS estimates	2025 (Table 3.1; Fig. 3.1, 3.12); 2015–2025 (Fig. 3.13)	103	
	ART coverage among all people living with HIV	**Fig. 3.15**	UNAIDS estimates	2025	142	
	Viral suppression among all people living with HIV	**Fig. 3.15**	UNAIDS estimates	2025	103	
	New infections among key populations, their partners and the remaining population	**Fig. 3.8**	UNAIDS special analysis, 2025	2010–2024	172	Estimates derived from UNAIDS modelled HIV incidence data with additional disaggregation by population group *(3, 4)*

Disease area	Indicator	Reference (table or figure)	Source	Years presented	Number of countries with data for the most recent year	Summary methods as relevant
	Percentage of people living with HIV provided with TB preventive treatment	**Fig. 3.1; Table 3.1**	GAM	2024	73	Analysis and methods presented in *Global tuberculosis report 2025 (5)*
	Condom/lubricant use at last sex with client or non-regular partner	**Fig. 3.1; Table 3.1**	GAM	Data are for 2020–2024 and for condom use among sex workers	66	Median value across the reporting countries
	Number of needles or syringes distributed per person who injects drugs	**Fig. 3.1; Table 3.1**	*Global hepatitis report 2026 (1)*, drawing on the 2023 systematic review of harm reduction intervention coverage among people who inject drugs by Colledge-Frisby et al. *(6)*	2024	84 (according to supporting materials for Colledge-Frisby et al.) *(6)*	Colledge-Frisby et al. *(6)*
	Number of people who used PrEP at least once per year	**Fig. 3.16**	GAM	2018–2024	77	Country reported data
	Adoption of WHO policies on PrEP in national guidelines	**Fig. 3.19**	NCPI component of the GAM	2025	165	Country reported data through a two-part questionnaire. Part A is completed by national authorities and Part B is completed by civil society, communities and nongovernmental partners *(7)*
	Adoption of TDF + 3TC (or FTC) + DTG as the preferred first-line ARV combination for treatment initiation in national guidelines for adults and adolescents living with HIV	**Fig. 3.20**	NCPI component of the GAM	2025	136	
STIs	Percentage of pregnant women attending antenatal care who were screened for syphilis/ treated if positive	**Fig. 5.1, 5.3; Table 5.2**	GHO based on GAM *(8, 9)*	2024	62 – 15 countries (representing 3% of total world live births) indicated that data are not representative: ▶ in 12 of these 15 countries, data represented public sector only ▶ in the other 3 countries (Jamaica, Timor-Leste and Vanuatu) data were from the public and private sectors	Global coverage estimated as the weighted sum of national estimates of coverage using live births by country from the UN Population Division's World Population Prospects *(10)*, as a proxy for number of pregnancies

Disease area	Indicator	Reference (table or figure)	Source	Years presented	Number of countries with data for the most recent year	Summary methods as relevant
	Percentage of girls fully vaccinated with HPV vaccine by age 15 years	**Fig. 5.1, 5.4; Table 5.2**	WHO/UNICEF joint reporting form *(11)*	2023 or 2024 (latest available)	122	Global coverage, presented in **Table 5.2** and **Fig. 5.3**, estimated as the weighted sum of WHO HPV estimates of national coverage using the number of girls aged 15 years from the UN Population Division's World Population Prospects *(10)*
	Prevalence of screening (at least once) for cervical cancer among women aged 30–49 years (%)[a]	**Fig. 5.1; Table 5.2**	WHO, reported in Serano et al. *in press (12)*		179	Global estimate derived from country-reported screening data from 179 of 202 countries, with statistical modelling and imputation applied to generate comparable coverage estimates for all countries
	Incidence of congenital syphilis (new cases per 100 000 live births per year), by country	**Fig. 5.2**	GHO based on GAM *(13)*	2023 or 2024 (latest available)	100	Country reported data
	Percentage of countries reporting AMR in *Neisseria gonorrhoeae* to the WHO Gonococcal Antimicrobial Surveillance Programme	**Table 5.3**	WHO GASP, EGASP and GLASS	2023 or 2024 (latest available)	69[b]	Methods and validation as previously published, where countries with results for <5 isolates in 1 year have been excluded *(14)*
	Percentage of countries with national STI plans updated within the past 5 years	**Table 5.3; Fig. 5.6**	NCPI component of the GAM	2025	98	Country reported data
	Percentage of countries with national STI case management guidelines updated within the past 3 years	**Table 5.3; Fig. 5.7**	NCPI component of the GAM	2025	92	Country reported data

AIDS: acquired immunodeficiency syndrome; AMR: antimicrobial resistance; ART: antiretroviral therapy; EGASP: Enhanced Gonococcal Antimicrobial Surveillance Programme; GAM: Global AIDS Monitoring; GHO: Global Health Observatory; GLASS: Global Antimicrobial Resistance and Use Surveillance System; HIV: human immunodeficiency virus; HPV: human papillomavirus; NCPI: National Commitments and Policy Instrument; SDG: Sustainable Development Goal; STI: sexually transmitted infection; TB: tuberculosis; UN: United Nations; UNAIDS: Joint United Nations Programme on HIV/AIDS; UNICEF: United Nations Children's Fund; WHO: World Health Organization; WHO GASP: WHO Gonococcal Antimicrobial Surveillance Programme.

Note: Countries are defined as Member States of WHO. Data sources for UNAIDS estimates and indicators are as reported in GAM *(15)*.

[a] This indicator replaces the previous indicator in the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (16)*.

[b] Progress as of 29 June 2026.

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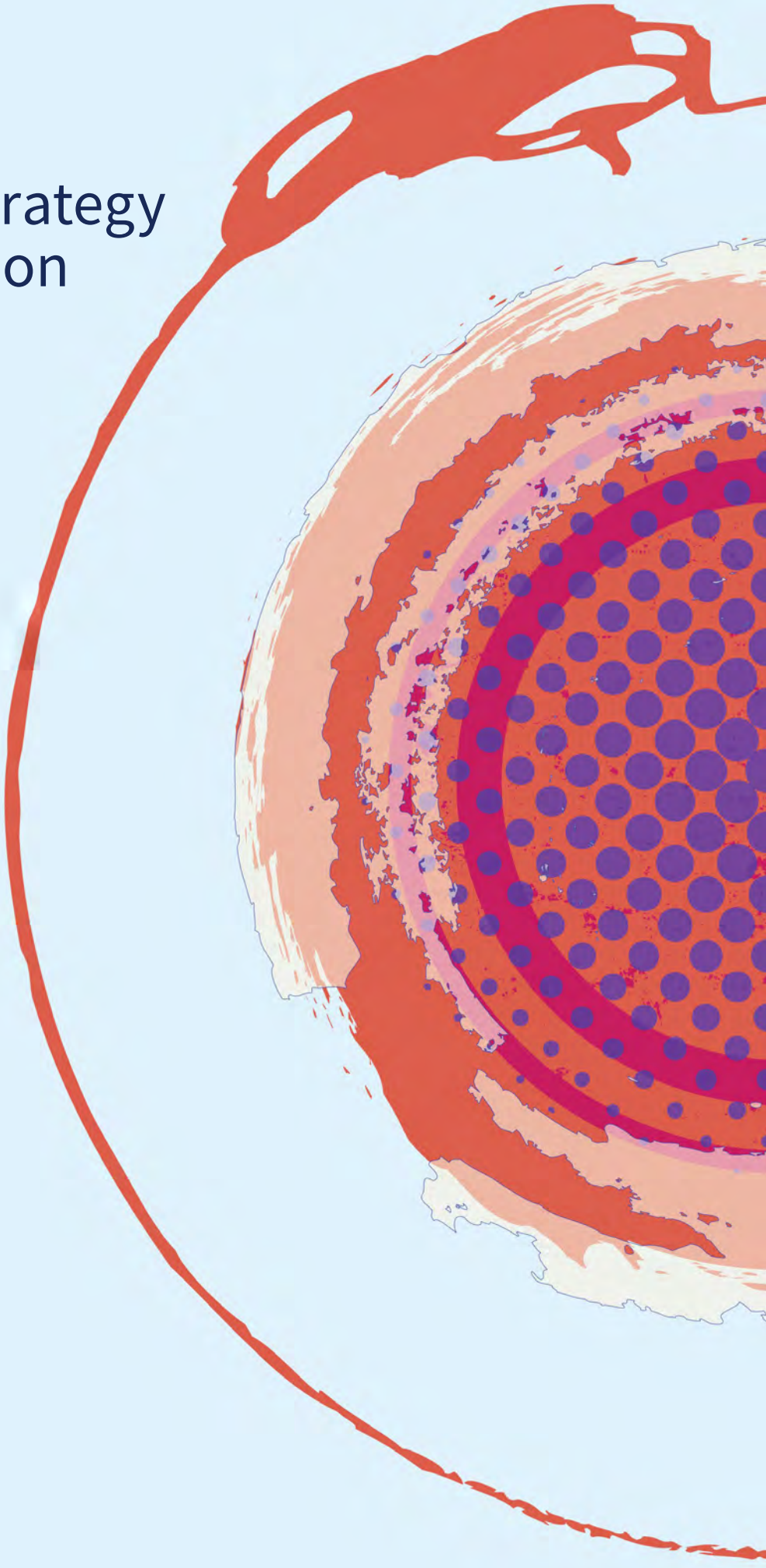
Annex 2

WHO's role in supporting strategy implementation



This annex provides examples of key actions by the World Health Organization (WHO) in support of Member States and partners in implementing the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections 2022–2030* (GHSS) *(1)*.

WHO's actions are guided by the Fourteenth General Programme of Work (GPW 14), 2025–2028 *(2)*, which places countries at the centre of WHO's work and emphasizes impact, equity, resilience and country ownership. As the global health financing landscape changes, WHO has further strengthened its stewardship role by supporting ministries of health to prioritize investments, sustain essential services, integrate programmes within broader health systems and strengthen national capacity for planning, implementation and accountability.

The GHSS identifies six complementary areas through which WHO supports implementation: strategic leadership and partnerships, public health advocacy and communication, norms and standards, innovation, technical support, and global monitoring and reporting.

Table A2.1 provides examples of WHO headquarters' actions in each of these areas, and additional actions by WHO regional offices are summarized in **Table A2.2**. WHO's actions are also described throughout this report.

Table A2.1. Examples of WHO headquarters' actions in supporting countries to implement the GHSS, 2022–2026

Strategic leadership and partnerships
▶ WHO provided technical guidance to over 185 countries covering strategic information, resource allocation and funding scenarios, while partnering with the Medicines Patent Pool and others to expand access to medicines and diagnostics.
▶ Manufacturing capacity was expanded for new HIV prevention technologies (cabotegravir and lenacapavir) and hepatitis diagnostics, alongside intensified support to countries navigating unprecedented external financing cuts in 2025–2026.
▶ Major elimination milestones were validated, including Maldives' triple elimination of mother-to-child HIV, syphilis and hepatitis B transmission (2025), Botswana's HIV pathway certification (2025) and Egypt's "gold tier" hepatitis C status (2023).
Public health advocacy and communication
▶ WHO digital platforms and campaigns reached over 60 million users annually, with mpox outbreak communications generating about 535 000 social media engagements and 5.6 million video views.
▶ Flagship campaigns (World AIDS Day and World Hepatitis Day) and partnerships such as the Global Alliance to End AIDS in Children by 2030 helped to sustain political commitment and translate guidance into national advocacy.
▶ Cross-disease advocacy advanced through webinars and conference sessions in collaboration with the WHO Special Programme on Primary Health Care and key community and civil society partners including through an STI Partners Forum, which promoted integrated approaches and community engagement.
▶ The WHO Strategic and Technical Advisory Group on HIV, viral hepatitis, and sexually transmitted infections (STIs) gave clear guidance on managing the balance between maintaining disease specificity, where it makes sense, and leveraging opportunities for strengthening integration.
Norms and standards
▶ WHO published extensive updated guidelines for HIV (differentiated service delivery, advanced disease management and long-acting prevention), viral hepatitis (simplified testing/treatment pathways) and STIs (drug-resistant gonorrhoea treatment).
▶ WHO monitored country policy adoption, which revealed high uptake for "Treat All" (95%) and dolutegravir first-line therapy (91%), but lower uptake for HIV self-testing (62%) and updated STI guidelines (43%). This monitoring enables targeted three-level support to ensure all countries are given optimal opportunities to adopt global guidance.
▶ New tools were developed, including the *Integrated drug resistance action framework for HIV, hepatitis B and C, and sexually transmitted infections (2026–2030) (3)* and machine-readable SMART Guidelines for HIV.
Innovation
▶ WHO advanced point-of-care and multiplex diagnostics, long-acting antiretroviral formulations and digital health platforms (e.g. SMART guidelines).
▶ Emerging areas monitored included HIV vaccine and cure research, hepatitis B functional cure approaches (antisense oligonucleotides and siRNA) and STI innovations (e.g. doxycycline post-exposure prophylaxis).
▶ WHO worked with partners on regulatory collaboration, market shaping and local manufacturing to ensure equitable access to new technologies.
Technical support
▶ Between 2022 and mid-2026, WHO delivered more than 500 technical support actions (303 for HIV, 56 for viral hepatitis and 45 for STIs), helping countries to build sustainable systems for planning, implementation, monitoring and quality improvement. About 90% of support was provided remotely owing to resource constraints.

- Among the technical support activities delivered, 215 addressed integrated programme areas across HIV, tuberculosis (TB), viral hepatitis and STIs, including joint strategic planning, triple elimination, integrated service delivery and person-centred strategic information systems. These efforts contributed to stronger national governance, coordination, workforce capacity and programme sustainability.
- In 2025, WHO coordinated rapid support across more than 50 countries facing major financing reductions that threatened services for over 30 million people.

Global monitoring and reporting

- WHO maintained an online accountability dashboard and published this GHSS mid-term report (2026) alongside the *Global hepatitis report 2026 (4)*.
- Hepatitis surveillance expanded to 187 countries (2024 and 2026), while 74 countries reported to the Gonococcal Antimicrobial Surveillance Programme.
- WHO strengthened person-centred strategic information systems and supported countries in translating monitoring data into national strategic plans and Global Fund requests.
- WHO conducted 17 peer reviews of funding requests for HIV, TB and Resilient and Sustainable Systems for Health for the Global Fund, submitted under the first 2026 funding cycle window, helping to strengthen the requests' technical quality and alignment with WHO recommendations.

Table A2.2. Examples of WHO regional offices' actions in supporting countries to implement the GHSS, 2022–2026

WHO African Region

- The *Framework for an integrated multisectoral response to TB, HIV, STIs and hepatitis in the WHO African Region 2021–2030 (5)* was implemented, with the first regional progress review presented by WHO to the Regional Committee in 2024 to guide country-level implementation and priority setting.
- The region continued to lead the Global Alliance to End AIDS in Children by 2030 through hubs in Eastern/Southern Africa and Western/Central Africa, supporting country acceleration plans, paediatric treatment scale-up and elimination of vertical transmission in partnership with the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund and the United States of America's President's Emergency Plan for AIDS Relief (PEPFAR).
- WHO delivered technical support for the adoption of updated HIV guidelines, including differentiated service delivery, advanced HIV disease management, pre-exposure prophylaxis (PrEP), testing strategies and TB/HIV collaboration, alongside guideline adaptation and capacity strengthening across Member States.
- Regional laboratory and surveillance capacity was strengthened through the *Regional framework for integrated laboratory systems*, expanded HIV drug resistance surveillance and continued support from the WHO Collaborating Centre at Botswana's National HIV Reference Laboratory.
- Elimination progress accelerated; notably, in 2024, Namibia became the first African and first high-burden country globally to achieve WHO validation for hepatitis B triple elimination, and in 2025, Botswana advanced from the "silver" to the "gold tier" for HIV.
- WHO worked closely with countries on developing national strategic plans, investment cases, programme reviews and the integration of HIV, viral hepatitis and STI services within primary health care (PHC) and universal health coverage (UHC) across the region.
- The Hepatitis Community of Practice (HepCOP), established in 2025, strengthened country elimination efforts through advocacy for hepatitis B birth-dose vaccination, decentralized testing and treatment, and laboratory capacity-building.
- WHO facilitated African countries in strengthening regional manufacturing and regulatory capacity; and promoting WHO-prequalified African manufacturers to improve supply security, affordability and health sovereignty, while also supporting country preparedness for long-acting HIV prevention technologies, including lenacapavir.

WHO Region of the Americas

- The region continued to implement the Disease Elimination Initiative *(6)*, with the Pan American Health Organization (PAHO) supporting countries to accelerate elimination of more than 30 communicable diseases through integrated approaches based in PHC.
- The EMTCT Plus Strategy expanded; the strategy integrates elimination of mother-to-child transmission (EMTCT) of HIV, syphilis, hepatitis B and Chagas disease within maternal and child health services, validation processes and strengthened surveillance.
- Elimination validation continued across the region: Belize, Jamaica and Saint Vincent and the Grenadines achieved validation in 2024, and Brazil achieved it in 2025, for elimination of HIV vertical transmission, reinforcing regional leadership on triple elimination.
- WHO conducted ongoing HIV programme reviews and technical assistance to strengthen national strategic plans, testing, differentiated service delivery, PrEP implementation, antiretroviral therapy (ART) optimization, advanced HIV disease diagnostics and treatment, and strategic information systems.
- Technical support helped countries to forecast needs and costs for HIV commodities, and to strengthen procurement and equitable access through the PAHO Strategic Fund and Revolving Fund.

- The region launched the *Best buys to accelerate disease elimination in the Americas package (7)*, offering evidence-based interventions and implementation guidance for HIV, hepatitis B, syphilis and other communicable diseases.
- A regional project was launched to strengthen EMTCT Plus in the Caribbean; the project supports laboratory systems, surveillance, and maternal and child health services across CARICOM (Caribbean Community) countries.
- Regional support for innovative HIV prevention technologies expanded; the expansion included long-acting PrEP, self-testing and combination prevention, alongside publication of *Health in the Americas: accelerating disease elimination (8)*, which documents progress and gaps.
- PAHO established the Alliance for the Elimination of HIV in the Americas to strengthen political leadership, country collaboration and coordinated action towards ending HIV as a public health problem by 2030.

WHO South-East Asia Region

- The *Integrated regional action plan for viral hepatitis, HIV and sexually transmitted infections in South-East Asia; 2022–2026 (9)* (also referred to as I-RAP) continued to guide country and WHO actions. In addition, in April 2025, WHO launched the *Regional roadmap for elimination of mother-to-child transmission of HIV, syphilis and hepatitis in the Asia and Pacific Region for 2024–2030 (10)*, which was developed jointly by the WHO South-East Asia Regional Office, the WHO Regional Office for the Western Pacific, UNICEF and UNAIDS.
- The region established and renewed the Regional Validation Committee for EMTCT and the Regional Strategic Technical Advisory Group for viral hepatitis, HIV and STIs.
- Annual national programme managers' meetings were continued through 2024, with regional technical discussions and cross-regional webinars introduced after the meetings, in response to funding constraints.
- The Indian Council of Medical Research – National Institute of Translational Virology and AIDS Research in Pune was designated as the Regional Reference Laboratory for HIV drug resistance (designation in progress, 2026).
- Maldives became the first country globally certified for triple elimination (2025), while Sri Lanka and Thailand maintained dual elimination status.
- Viral hepatitis, HIV and STI programme reviews were conducted in 10 countries to inform national strategic plans and Global Fund funding requests, alongside targeted technical support for the viral hepatitis outbreak response among Rohingya refugees in Cox's Bazar, Bangladesh.
- Regional landscape reviews informed the I-RAP mid-term review, covering STIs, HIV self-testing, digital health and artificial intelligence (AI), virtual interventions, hepatitis C mother-to-child transmission, liver cancer and cirrhosis risk factors, and access to penicillin for syphilis and rheumatic heart disease.
- WHO developed regional technical guidance on prevention of mother-to-child transmission of hepatitis C in 2026, and sustained regional advocacy through World AIDS Day and World Hepatitis Day webinars with communities and partner agencies.

WHO European Region

- The *Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030 (11)* continued to guide country and WHO actions, in the context of a challenging epidemiological situation; the plans strengthen service integration within PHC and UHC.
- Regional surveillance and strategic information systems were strengthened through annual reporting, harmonized collaboration with the European Centre for Disease Prevention and Control, improved HIV cascade methodologies, and innovative digital tools such as QUANTPrEP.
- Technical support reached more than 15 high-burden countries on HIV prevention, testing, treatment, EMTCT and TB/HIV collaboration; WHO also supported all Global Fund HIV funding applications in eligible countries, contributing to US$ 337 million in approved investments.
- HIV prevention advanced through expanded PrEP implementation, preparedness for long-acting prevention (including lenacapavir), strengthened testing strategies, and integrated community- and primary-care-based service delivery.
- Political leadership was reinforced through ministerial meetings, engagement with the European Parliament, advocacy on HIV-related stigma and human rights, and annual awareness campaigns.
- Denmark became the first European Union Member State validated for the elimination of HIV and syphilis mother-to-child transmission, while the Triple Elimination Initiative was launched in central Asia.
- National viral hepatitis programmes were strengthened through updated strategies, programme reviews, investment cases, expanded hepatitis B vaccination, elimination demonstration platforms, and decentralized community-based testing and treatment.
- STI progress was maintained despite limited resources, with strengthened surveillance, integrated STI/HIV prevention services, congenital syphilis elimination support, improved laboratory quality, response to benzathine penicillin G shortages and integration of mpox into routine sexual health services.
- The region responded to emerging challenges, including the humanitarian consequences of the war in Ukraine, migration-related vulnerabilities and shrinking civic space, while advocating for equitable, rights-based approaches.
- Despite 2025 funding reductions that cut WHO/Europe's technical capacity by nearly 70%, essential regional leadership, surveillance and technical support were maintained through organizational restructuring and prioritization of core functions.

WHO Eastern Mediterranean Region

- WHO and countries in the region continued to implement the *Regional action plan for the implementation of the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections 2022–2030 (12)*, with WHO working closely with Member States to accelerate progress through integrated, people-centred services.
- Technical support expanded for the development of national strategic plans, guideline adaptation, programme reviews, strategic information systems, and integration within PHC and UHC.
- Elimination initiatives accelerated, including Egypt's "gold tier" validation for hepatitis C elimination; support for Pakistan's Prime Minister's Initiative on hepatitis C elimination; and EMTCT support for HIV, syphilis and hepatitis B elimination in Oman, undertaken jointly with UNICEF.
- HIV testing and service delivery strengthened through regional guidance on optimized testing strategies, self-testing, differentiated service delivery and community-based approaches, with a particular focus on key populations and humanitarian settings.
- Regional capacity was strengthened through policy dialogues, technical consultations and country support on surveillance, laboratory systems and monitoring, including scaled-up testing across the region.
- WHO launched the World AIDS Day 2025 regional campaign, *Overcoming Disruption, Transforming the AIDS Response*, which highlighted service integration, PrEP and self-testing expansion, community engagement and digital surveillance innovations.
- Technical support sustained essential HIV, viral hepatitis and STI services for populations affected by humanitarian emergencies, including refugees and migrants.
- The region produced its first report on the epidemiological landscape of STIs to guide national strategic directions, alongside continued support for the development of Global Fund grant proposals.
- WHO strengthened coordination with regional and national community organizations to improve equitable access to services for key populations. At the same time, it advanced cross-cutting efficiency gains through integration with TB and the broader region-wide communicable disease elimination strategy.

WHO Western Pacific Region

- WHO published the *Regional framework for reaching the unreached in the Western Pacific (2022–2030) (13)*, advancing equity-centred communicable disease control.
- The *Regional framework on the future of primary health care in the Western Pacific* (2022) *(14)* reinforced PHC as the cornerstone of UHC.
- Implementation advanced on the Western Pacific regional framework to end TB: 2021–2030 *(15)*, alongside continued operation of a regional stockpile of second-line TB medicines, to address supply gaps in Pacific Island and resource-limited countries, delivered in collaboration with the Global Fund, the Global Drug Facility and national governments.
- The *Regional framework for triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis in Asia and the Pacific, 2018–2030 (16)* progressed further, with establishment of the Regional Validation Advisory Group on EMTCT of HIV, Syphilis and Hepatitis B, and Accelerated Control of Viral Hepatitis in the Western Pacific Region in 2024.
- In April 2025, WHO (through the South-East Asia Regional Office and the Western Pacific Regional Office), UNICEF and UNAIDS jointly launched the *Regional roadmap for the triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B in Asia and the Pacific Region for 2024–2030 (17)*. Malaysia maintained its dual elimination status of HIV and EMTCT of syphilis, with certifications confirmed in both 2023 and 2026.
- WHO sustained technical support for joint programme reviews and strategic planning across HIV, TB, viral hepatitis and STIs.
- Resource mobilization efforts continued, including support for Global Fund funding requests and broader fundraising, while advancing cross-programmatic efficiency through integrated service delivery models for HIV, TB, viral hepatitis and STIs within PHC.
- A dedicated regional committee session addressed HIV and substance use during the 2025 WHO Western Pacific regional meeting, followed by an urgent response to the HIV outbreak in Fiji.
- Regional advocacy and knowledge exchange continued through World AIDS Day and World Hepatitis Day webinars, in partnership with communities and partner agencies.

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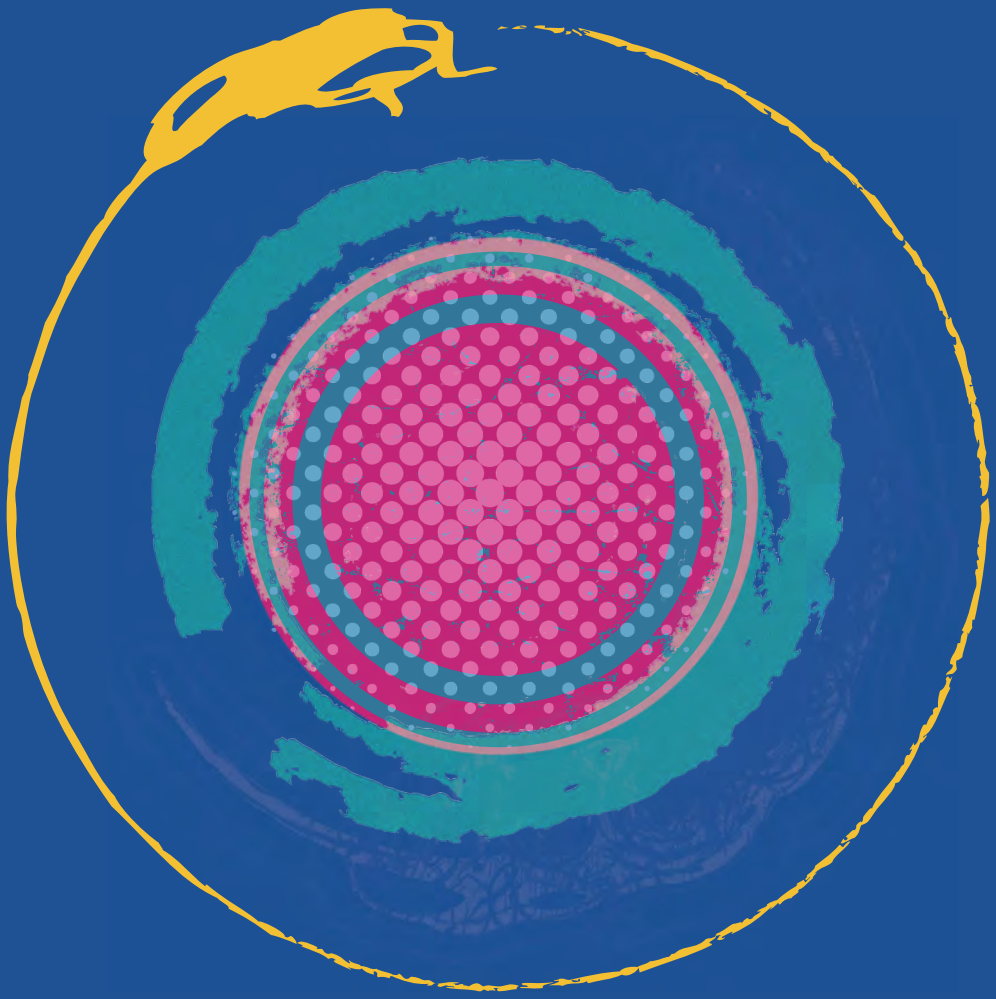

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