



HIV prevention at a crossroads: Breakthrough tools meet a funding crisis

Major advances in HIV prevention could be within reach for low- and lower-middle-income African countries as a result of innovative funding agreements, IAS 2025, the 13th IAS Conference on HIV Science, held in July 2025. These advances could prevent millions of people from acquiring HIV over the next decade.

But global HIV services face serious challenges of sustainability and equity after donor funding cuts and attacks on human rights. These challenges threaten decades of progress in the HIV response and jeopardize our opportunity to take full advantage of the recent scientific breakthroughs in HIV prevention.

This briefing reviews the latest evidence on threats and opportunities for HIV prevention shared at IAS 2025, and highlights the ways that new scientific findings can improve our understanding of how to accelerate the adoption of highly effective HIV prevention methods.

A sudden halt to HIV funding

In January 2025, the US government issued a stop-work order halting all foreign aid, including President's Emergency Plan for AIDS Relief (PEPFAR) and US Agency for International Development (USAID) funding for HIV programmes. This affected programmes across central, eastern, southern and western Africa, with waivers granted only for HIV treatment and prevention of vertical transmission. HIV services were disrupted, including access to pre-exposure prophylaxis (PrEP), HIV testing, treatment initiation and viral load monitoring.

Multiple studies presented at IAS 2025 documented the immediate impact and projected the long-term consequences of funding cuts.

- In [Mozambique](#), treatment initiation fell by 14%, viral load testing by 38% and viral suppression by 33% in the three months after the funding halt compared with the same period in 2024. If this trend continues, modelling indicates that an additional 83,000 people will acquire HIV between 2025 and 2030, 15% above the previous trend¹.
- In [South Africa's Johannesburg health district](#), where USAID funding supported activities to improve rates of HIV testing, diagnosis and treatment initiation, HIV testing decreased by 8.5% from Q1 2024 to Q1 2025, while HIV diagnoses fell by 31% and ART initiation by 30%².
- In [Zambia](#), the number of people starting oral PrEP was 60% lower in the first three months of 2025 than in the same period in 2024. Voluntary male medical circumcision services saw a 43% decline in activity³.

A survey of 14 African countries found that 75% of NGO-run HIV service sites faced interruption or closure when US funding stopped. The survey estimated that the formal and informal health systems lost around 120,000 healthcare workers because of the halt order; approximately 60% were nurses, clinical officers and other frontline staff involved in the delivery of testing, treatment, counselling and PrEP support⁴.

A modelling study projected the impact of loss of treatment and prevention funding on achievement of the 2030 target for reducing HIV incidence. The model incorporated 26 countries that account for approximately half of all people living with HIV worldwide⁵.

Immediate discontinuation of PEPFAR funding and a planned 24% reduction in other donor funding for prevention and testing would result in between 4.4 million and 10.8 million new HIV acquisitions between 2026 and 2030, depending on the impact of mitigation measures. Funding cuts would have a disproportionate impact on key populations and children.

The anti-rights movement

Advances in prevention science are occurring in the context of a coordinated, well-funded international movement to target programmes and policies that defend bodily autonomy, gender equality, harm reduction and LGBTQ inclusion. Politically driven funding cuts to PEPFAR and USAID are dismantling HIV programmes, especially those focused on key populations. In many countries, civil society organizations face reduced funding and growing legal and political constraints. This will increase vulnerability to HIV, particularly for adolescent girls and young women, gay men and other men who have sex with men, trans people, sex workers, migrants, and people who inject drugs.

An effective response requires alliances across silos – the same groups that are attacking HIV programmes also oppose abortion, gender equality and racial justice. At IAS 2025, civil society groups highlighted concerns about the threats to key population programmes as funding is withdrawn. HIV incidence is highest among key populations, so an effective HIV response must meet the needs of key populations.

Long-acting prevention options are growing; now we need implementation at pace

At IAS 2025, the World Health Organization (WHO) released new guidelines recommending the use of injectable lenacapavir (LEN) twice a year as an additional PrEP option for HIV prevention⁶. Lenacapavir is the latest long-acting PrEP option, joining injectable cabotegravir (CAB-LA) and the dapivirine vaginal ring. LEN injections may be suitable for people who do not want to take daily pills or visit a clinic frequently. WHO encouraged countries to begin integrating lenacapavir PrEP into national prevention programmes as soon as possible.

Just before the conference, Gilead Sciences [announced an agreement](#) with the Global Fund to Fight AIDS, Tuberculosis and Malaria to supply enough doses of LEN at no profit to provide PrEP for up to two million people over three years⁷. The agreement aims to meet demand until generic versions of LEN manufactured under voluntary licensing agreements become available in eligible countries. Agreements between [Unitaid](#), [the Clinton Health Access Initiative](#),

[Wits RHI](#), the [Gates Foundation](#) and generic manufacturers will make LEN for HIV prevention available to eligible countries at around USD 40 a year^{8,9}. The Global Fund and voluntary licensing agreements cover 120 high-HIV-incidence, low- and middle-income countries. However, middle-income countries in Latin America, Asia and the Caribbean are not eligible, raising the prospect that they will not benefit from large-scale implementation of LEN for HIV prevention.

In 2024, 1.3 million people acquired HIV, but only 18% of people who could benefit from PrEP had access to it. Providing LEN to 4% of the population in countries with a high burden of HIV could avert up to 18% of HIV acquisition over 10 years, [a modelling study concluded](#)¹⁰. These findings emphasize the importance of incorporating LEN into national prevention programmes rapidly to achieve substantial reductions in HIV incidence.

Monthly oral PrEP

Another potential option for long-acting PrEP is using a new oral antiretroviral, MK-8527. A Phase II study, which compares doses before larger efficacy trials, reported that [MK-8527 has potential for use](#) as a monthly oral PrEP agent and showed no serious drug-related side effects¹¹. Monthly oral PrEP may appeal to those who prefer pills to injections. Dispensing one pill a month would also require less clinic and healthcare worker time than giving injections. Two large studies now underway are comparing monthly PrEP with daily oral PrEP outcomes in diverse populations. This potential new PrEP option increases the likelihood that people will find a form of PrEP that suits them.

Expanding PrEP options to meet user preferences improves uptake

Making long-acting PrEP available increases the total uptake of PrEP, enabling countries to make faster progress in reducing HIV incidence. PEPFAR supported the [introduction of CAB-LA](#) in Eswatini, Malawi, Ukraine, Zambia and Zimbabwe in 2023 and 2024¹². Overall, 441,269 people started PrEP and, on average, 127,292 returned for PrEP when both oral PrEP and CAB-LA options were available. In the year after CAB-LA was introduced, the number of people who started PrEP increased by 25% and the number who returned for repeat prescriptions increased by 33%.

Other studies showed that when offered the option, many people strongly prefer long-acting PrEP. [A focus group study in Zambia](#) found that adolescent girls and young women who had recently started using

long-acting cabotegravir PrEP viewed CAB-LA as discreet and non-stigmatizing and appreciated the control it gave them over HIV prevention¹³. [A study in 1,164 adolescents and young people in South Africa](#) found that after counselling, 74% chose CAB-LA, 25% chose oral PrEP, and 1% chose the dapivirine ring¹⁴. In the [PURPOSE-2 trial](#), which compared lenacapavir injections with oral PrEP, 78% of all participants preferred twice-yearly injections at the beginning of the study, while 14% preferred pills¹⁵.

Long-acting PrEP is safe to use during pregnancy

Women have a [higher likelihood of acquiring HIV](#) during pregnancy and in the months after giving birth¹⁶. At IAS 2025, WHO [presented updated guidelines](#) on the use of antiretrovirals for prevention and treatment during pregnancy and breastfeeding, including a recommendation that none of the available PrEP products have to be discontinued during pregnancy or breastfeeding in women with a risk of exposure to HIV. Pregnant women should decide on PrEP use after discussing risks and benefits with a healthcare provider¹⁷.

Safety data on the use of long-acting cabotegravir and lenacapavir during pregnancy and breastfeeding at IAS 2025 provided reassurance on safety and underlined the importance of designing PrEP studies that include pregnant and breastfeeding participants. One study showed that [women who received cabotegravir](#) during or before pregnancy did not have a higher likelihood of adverse maternal or pregnancy outcomes than women who had opted for oral PrEP¹⁸. Similarly, there was no difference in pregnancy outcomes between women taking LEN or oral PrEP [in a second study](#)¹⁹.

Accelerating the pace of implementation

A supportive policy environment plays a significant role in setting the pace of PrEP implementation. [An analysis of 139 countries](#) showed that certain policies worked together to promote uptake: task shifting to permit nurses and other non-physicians to prescribe PrEP; decriminalizing same-sex sex; decriminalizing non-intentional HIV exposure; approval of HIV self-testing; prohibition of compulsory HIV testing; and relaxing age restrictions on HIV testing and treatment²⁰.

Community-led monitoring can accelerate PrEP implementation by identifying service gaps and enabling redesign. A study comparing [monitored and unmonitored](#) health facilities in Malawi and South Africa (November 2020–October 2024) found 32% higher PrEP initiation at monitored sites²¹. In [Chiang Mai, Thailand, community monitoring revealed](#) low PrEP availability in 2022; subsequent advocacy expanded access to 24 hospitals by 2024²².

Helping people start – and stay on – PrEP

People can be helped to start PrEP by reducing barriers and addressing user concerns. A review of the [Zimbabwe CAB-LA implementation programme](#) showed that user concerns about injection site reactions, continuity of supply and drug resistance remain barriers to the adoption of long-acting PrEP. Other barriers are provider concerns about the management of discontinuation, testing for acute HIV and the management of inconclusive test results²³. Healthcare regulations defining who is qualified to inject long-acting PrEP and in which settings, combined with limited capacity to train an already overstretched workforce, pose barriers to innovative community delivery strategies, while the limited supply of CAB-LA and LEN does not match the size of the population with high HIV incidence.

A promising path to reduce strain on health systems lies in AI tools that can personalize support and connect people to stigma-free care. [One such platform](#), evaluated over three months, offers counselling to clarify misconceptions, provide self-test options, evaluate PrEP eligibility and schedule appointments for initial medication²⁴.

In its 2025 guidelines, WHO recommends that people start injectable cabotegravir after rapid HIV antibody testing and that confirmatory HIV RNA testing is unnecessary. This recommendation will enable people to start CAB-LA after a point-of-care test, instead of waiting for a laboratory test result, and will allow more sites to provide CAB-LA PrEP. A study of [180 adolescents starting CAB-LA in Brazil](#) found that the combined use of an oral fluid self-test and rapid antibody test produced equivalent results to HIV RNA testing²⁵.

Conclusion

There are major opportunities and challenges for HIV prevention as long-acting PrEP begins to become available in some – but not all – regions at a time when funding cuts place new pressures on HIV programmes, especially those serving key populations. As HIV programmes are challenged to reconfigure, scientific breakthroughs in biomedical prevention technologies, combined with accelerated access pathways, offer real potential to expand available PrEP options.

Data presented at IAS 2025 show the importance of supportive policy environments for PrEP implementation and uptake. Delivering on the promise of new and existing technologies will require robust policy frameworks, sustained political commitment, and the integration of PrEP into national health strategies to ensure equitable and timely access.

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