IAS 2025

Conference report

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POZ
HEALTH, LIFE & HIV

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Contents

Acronyms and abbreviations

AHD	Advanced HIV disease
aHR	Adjusted hazard ratio
AI	Artificial intelligence
AIDS 2026	26th International AIDS Conference
AIN	Anal intraepithelial neoplasia
ART	Antiretroviral therapy
ARV	Antiretroviral
B/F/TAF	Bictegravir/emtricitabine/tenofovir alafenamide fumarate
BMI	Body mass index
bNAbs	Broadly neutralizing antibodies
CAB	Cabotegravir
CAB-LA	Cabotegravir long-acting
CAB/RPV	Cabotegravir/rilpivirine
DOR	Doravirine
DSD	Differentiated service delivery
DTG	Dolutegravir
F/TAF	Emtricitabine/tenofovir alafenamide fumarate
F/TDF	Emtricitabine/tenofovir disoproxil fumarate
FY	Fiscal year
HBV	Hepatitis B virus
HIVST	HIV self-testing
IAS	International AIDS Society
IAS 2023	12th IAS Conference on HIV Science
IAS 2025	13th IAS Conference on HIV Science
LEN	Lenacapavir
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PNR	PrEP-to-need ratio
POC	Point of care
PrEP	Pre-exposure prophylaxis
PYs	Person-years
Q1	Quarter 1
STI	Sexually transmitted infection
TAF	Tenofovir alafenamide fumarate
TB	Tuberculosis
TCA	Topical trichloroacetic acid
TDF	Tenofovir disoproxil fumarate
TLD	Tenofovir, lamivudine and dolutegravir
UNAIDS	Joint United Nations Programme on HIV/AIDS
U=U	Undetectable equals untransmittable
VMMC	Voluntary male medical circumcision
WHO	World Health Organization

Terminology

Key populations refers to gay men and other men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and their clients, and trans people.

Vulnerable populations refers to people living with HIV and groups outside of key populations who may be at increased vulnerability to acquiring HIV, for example, adolescents, Indigenous peoples, migrants, refugees, internally displaced persons, people with disabilities, people in prisons and other closed settings, people of advanced age, women and girls.

IAS 2025 at a glance

IAS 2025 had **3,986 participants** from **124 countries**.

46% of IAS participants came from central, eastern, southern and western Africa.

84% of IAS 2025 delegates attended in person.

IAS 2025 awarded 247 in-person and virtual scholarships to delegates from 56 countries; **62% of scholarship recipients** were from central, eastern, southern and western Africa.

59% of IAS 2025 participants were **under 46 years**.

Introduction

IAS 2025, the 13th International AIDS Society Conference on HIV Science, took place in Kigali, Rwanda, and virtually from 13 to 17 July 2025.

Despite challenges created by sudden funding cuts, almost 4,000 people came together in Kigali and virtually, showing the resilience that defines the HIV response and a commitment to protecting gains made in over 40 years of this pandemic.

IAS 2025 provided a forum for participants to review the early impact of US funding cuts and debate how the HIV response can adapt to shrinking donor support.

Scientific innovation in prevention was also at the forefront during IAS 2025, with the release of new World Health Organization (WHO) guidelines recommending the use of long-acting injectable lenacapavir as a pre-exposure prophylaxis (PrEP) option and the presentation of promising data on the experimental monthly PrEP agent, MK-8527.

"We have the tools and the knowledge to end AIDS as a public health problem. What we need now is bold implementation of these recommendations, grounded in equity and powered by communities."

Meg Doherty, WHO

IAS 2025 showcased the central role of African science in shaping the global HIV response. The conference also highlighted the host country's achievement in reaching the 95-95-95 targets for HIV diagnosis, treatment and viral suppression and its success in tackling a Marburg virus outbreak in 2024.

"Rwanda's experience in the HIV response over the past few decades – alongside our recent pandemic response – demonstrates what is possible when countries prioritize people-centred approaches and invest in strategic partnerships."

Sabin Nsanzimana, Minister of Health, Rwanda

A total of 5,257 abstracts were submitted to IAS 2025, and 2,016 were accepted, an acceptance rate of 38%. The conference featured 31 oral abstract sessions in five tracks and 30 invited-speaker sessions, including three plenaries, 22 symposia and two special sessions. Alongside these conference sessions, 36 satellites and seven pre-conferences offered delegates focused insights into a wide variety of topics.

The Kigali Declaration

At IAS 2025, scientists, academics, advocates, clinicians, programme implementers, elected officials and public health leaders signed the Kigali Declaration, asking governments, multilateral organizations, donors and civil society to recommit to HIV as a global priority. The declaration stresses the importance of country ownership of HIV programmes, backed by meaningful partnerships and robust investment. To continue the remarkable record of scientific innovation that has transformed HIV treatment and prevention, sustained funding is needed to develop regional centres of excellence and the next generation of researchers. Collaborative research with community input and open data sharing will speed the next wave of HIV prevention and treatment tools, vaccine development and, ultimately, a cure.

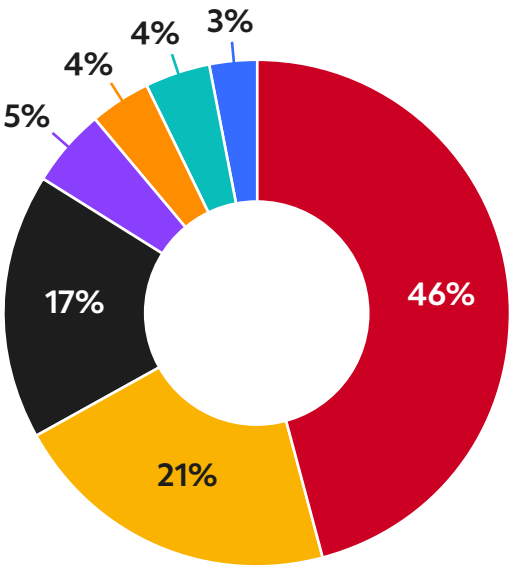
The Kigali Declaration also urges countries to accelerate the rollout of proven prevention tools while ensuring ongoing access to antiretroviral treatment. The declaration calls on countries to adopt a human rights-centred approach that removes legal barriers, ends discrimination and partners with affected communities in delivering services, rejecting the politicization of science. Every country should enable its public health agencies and scientists to act on data without fear, the declaration affirms, and science – not politics – must continue to guide public health decisions.

Who was there?

IAS 2025 had 3,986 participants; 6% of participants were scholarship recipients and 16% of participants had virtual registrations, allowing them to view live sessions, ask questions and network with other delegates online.

Country and region

Central, eastern, southern and western Africa had the highest representation at IAS 2025, making up 46% of delegates. North America contributed 21%, while 17% of delegates came from western and central Europe and 5% came from South and Southeast Asia.

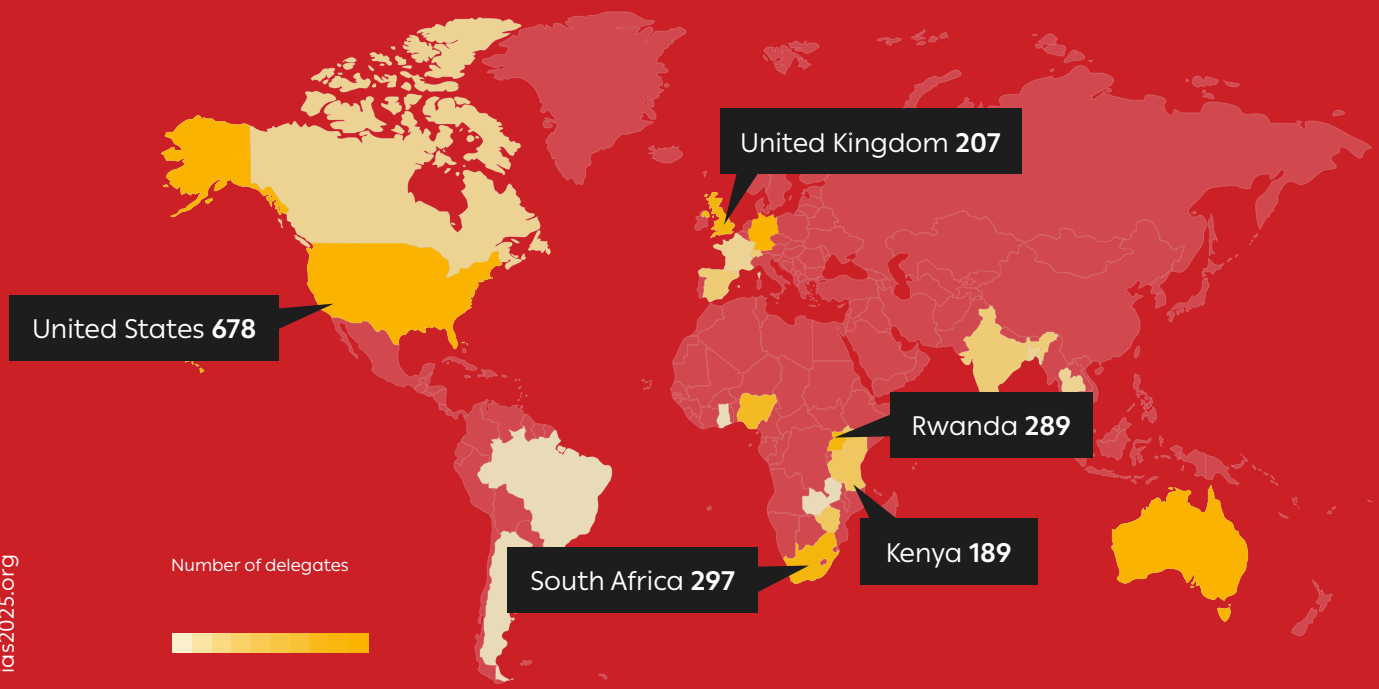


Delegates by region

- Central, eastern, southern & western Africa
- North America
- Western & central Europe
- South & southeast Asia
- Latin America
- East Asia & Oceania
- Other

A total of 124 countries were represented at IAS 2025. The United States (678 participants), South Africa (297), Rwanda (289) and the United Kingdom (207) had the largest representation at the conference .

Top 20 countries represented at IAS 2025

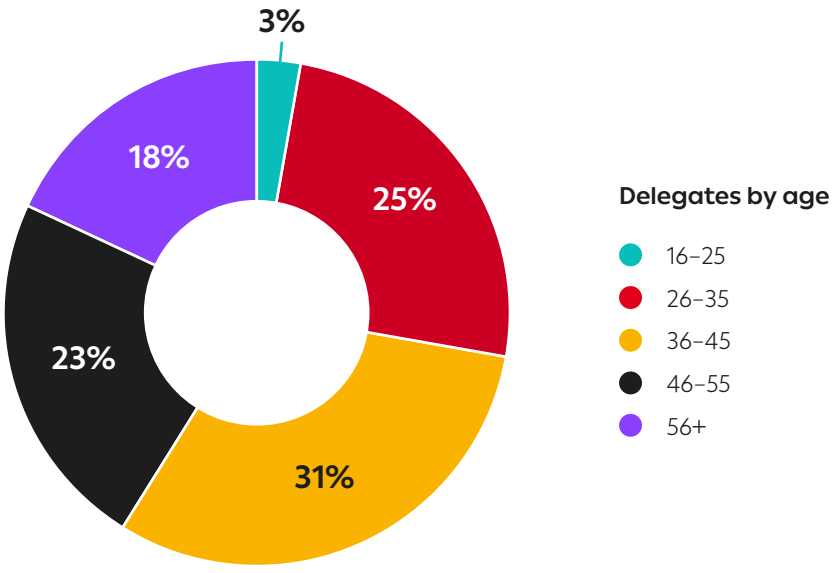


Gender

Overall, 50% of participants were female, 48% were male and 1% were non-binary or gender non-conforming; 1% of participants said their gender differed from sex assigned at birth and 1% did not specify their gender.

Delegates by age range

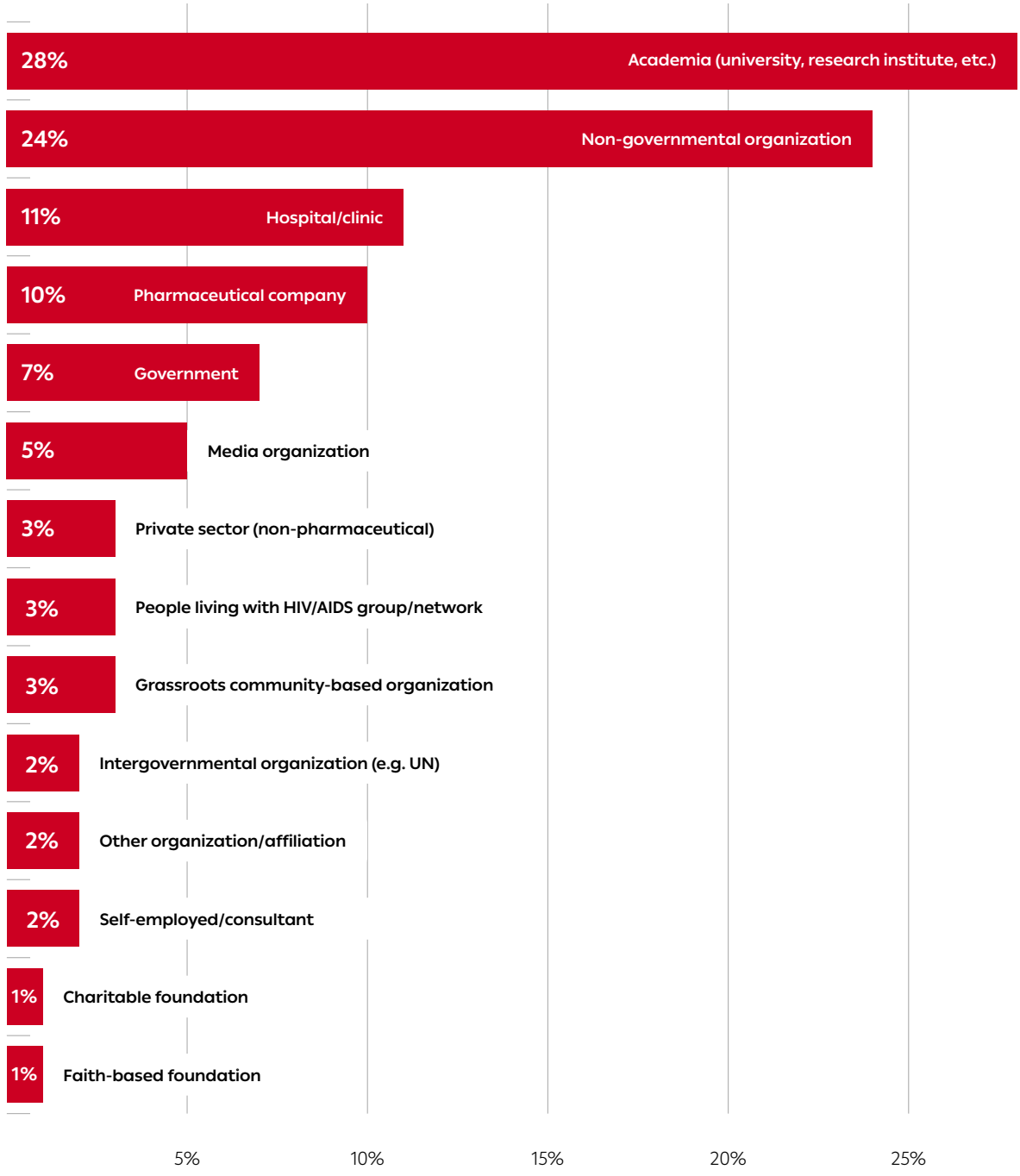
More than a quarter (28%) of IAS 2025 participants were between 16 and 35 years.



Affiliations and institutions

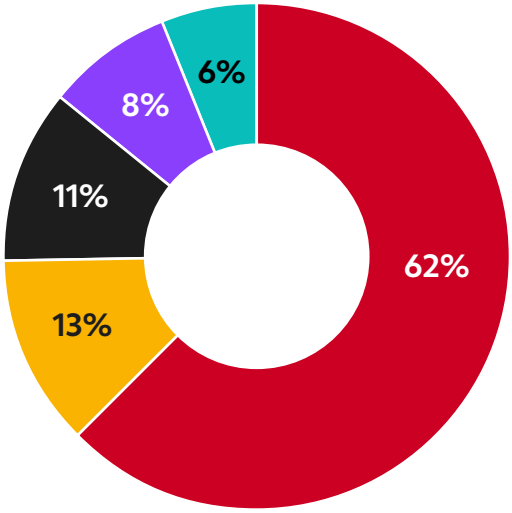
People working in academia (28%, 904 participants) and in non-governmental organizations (24%, 782 participants) made up the largest share of participants in IAS 2025.

Organizational affiliation



Scholarships awards

IAS 2025 awarded a total of 247 scholarships (226 in-person scholarships and 21 virtual scholarships) to delegates from 56 countries . Scholarship recipients were most commonly from central, eastern, southern and western Africa (62%), South and Southeast Asia (11%) and Latin America (8%).

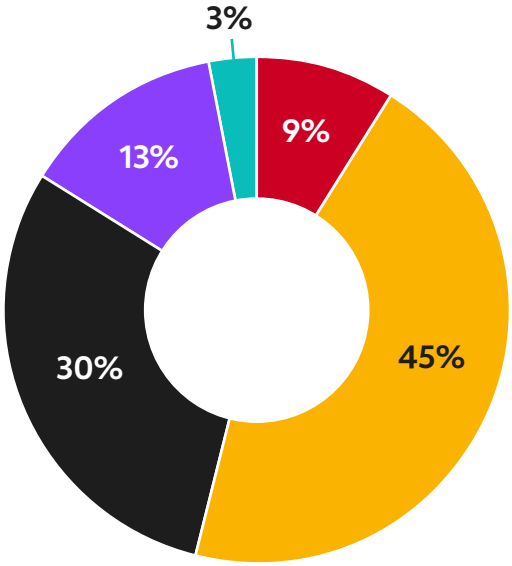


Scholarship recipients by region

- Central, eastern, southern & western Africa
- Other
- South & Southeast Asia
- Latin America
- North America

Overall, 57% of scholarship recipients were female, 40% were male, 3% were non-binary or gender non-conforming, and 4% identified with a different gender than their sex at birth.

Just over half of scholarship recipients (53%) were younger than 36 years.



Scholarship recipients by age

- Under 26
- 27–35
- 36–45
- 46–55
- 56+

Volunteers

Volunteers at IAS 2025 helped coordinate programme activities, greeted conference delegates, assisted with registration, acted as guides during the conference, staffed various activities, and performed other crucial tasks.

The conference enjoyed support from 157 volunteers, including 132 from the host country, Rwanda, 14 from other countries in central, eastern, southern and western Africa, four from North America and seven from Europe. A total of 89% of volunteers were under 36 years of age and 56% were under 26 years of age.

What was shared?

IAS 2025 took place as HIV programmes were adjusting to the abrupt halt in US government funding for a wide range of services in around 50 countries. As well as its usual focus on cutting-edge science, IAS 2025 provided a forum for review of the early impact of the funding cuts and the steps being taken to mitigate funding losses and re-engineer health systems.

Funding cuts

Cuts in funding led to immediate declines in HIV testing and treatment initiation. A comparison of service activity between 2024 and 2025 in Mozambique's national HIV programme showed a 14% decrease (-15,727) in treatment initiation in February-May 2025 from the same period in 2024[2]. Treatment interruptions, defined as delays in collecting medication of more than 59 days, increased by 39% (+10,392) in April-May 2025 from the same period in 2024. Viral load testing declined by 38% in adults and 44% in children, while viral suppression declined by 33% in adults and 43% in children in February-May 2025 from the same period in 2024. Modelling of the trends before and after February 2025 using the Optima epidemic model for Mozambique indicates that if the reductions in activity continue at the levels observed in the period of February-May 2025, an additional 83,000 people will acquire HIV between 2025 and 2030 (15% above trend) and an additional 14,000 HIV-related deaths will occur (10% above trend).

In South Africa's Johannesburg health district, where USAID APACE funding supported activities to improve rates of HIV testing, diagnosis and treatment initiation, APACE-funded activities halted in January 2025. An analysis compared service activity across Q1 2023 to 2025, finding that HIV testing decreased by 8.5% from Q1 2024 to Q1 2025, while HIV diagnoses fell by 31% and antiretroviral therapy (ART) initiation by 30%[3]. The declines in testing, HIV diagnoses and treatment initiation reflect the loss of healthcare workers, especially counsellors providing index and targeted community-based HIV testing to people most vulnerable to HIV acquisition, the researchers concluded.

Funding cuts have also affected access to prevention interventions. A retrospective comparison of service activity in Zambia's national HIV programme between Q1 2024 and Q1 2025 showed that whereas there was a marginal decline in the numbers of people beginning ART (-0.5%), the number of oral PrEP initiations declined from 71,608 in Q1 2024 to 28,230 in Q1 2025, a 60.6% decrease. This performance was 51% below the quarterly target of 58,120. Voluntary male medical circumcision (VMMC) services saw a similar drop, from 107,034 individuals in Q1 2024 to 60,546 in Q1 2025, a 43.4% decline, achieving just 49.5% of the quarterly target of 144,589[4].

The HIV Leadership Forum, representing Director Generals of 40 national AIDS commissions, conducted a 24-country survey to assess HIV service continuity, systems resilience and available transition assets after the halt in US government funding[5]. Findings from 14 African countries were presented at IAS 2025, showing substantial impacts on services. All countries continued to issue ART, and services for the prevention of vertical transmission remained resilient due to integration with maternal healthcare. However, prevention services delivered by community non-governmental organizations (NGOs) were highly vulnerable to disruption; respondents estimated that 75% of standalone NGO sites were either disrupted or closed after January 2025. The funding halt disrupted the collection of monitoring and supply chain data in all 24 countries, especially prevention indicators. All the countries experienced some degree of supply chain disruption; HIV prevention supply chains managed by NGOs were most affected, and only 44% of countries reported having six to nine months of stock of antiretrovirals (ARVs) for prevention, compared with 68% reporting six to nine months of stock of ARVs for treatment.

The survey estimated that 123,668 healthcare workers were lost from the formal and informal health systems as a result of the halt order; approximately 60% were nurses, clinical officers and other frontline staff. The researchers concluded that although governments had been able to adapt rapidly to the loss of funding, public facilities are struggling to absorb sudden influxes of ART clients from other services, and the long-term impact of healthcare worker attrition is unclear. The loss of funding has had severe impacts on HIV prevention systems, and rebuilding the data, surveillance, supply chain and outreach systems to reach populations will prove a major challenge for national programmes.

Moving forward, the HIV Leadership Forum advocates for an end to parallel systems and the incorporation and financing of HIV services within universal healthcare or social insurance packages, as well as the development of task-shifting models that integrate community-led services within the national community health infrastructure.

Two modelling studies projected the impact of loss of treatment and prevention funding on achievement of the 2030 targets for HIV incidence and HIV-related mortality. Using the UNAIDS Optima epidemic modelling tool, one research group selected 26 countries with recently updated models that account for between 43% and 50% of all people living with HIV globally[6]. The 26 countries received 49% of all global HIV funding and 54% of the President's Emergency Plan for AIDS Relief (PEPFAR) funding prior to 2025. The modelling compared three scenarios: a continuation of funding at 2024 levels; prevention and community testing funding cut by 24% by 2026, but treatment and health facility testing sustained by domestic funding; and prevention and testing funding cut by 24% and immediate discontinuation of PEPFAR funding.

Compared with the steady-state scenario, the second scenario would result in somewhere between 71,500 and 1.7 million new HIV acquisitions between 2025 and 2030 and 5,000-61,000 extra deaths, depending on the impact of mitigation measures. In the third scenario, between 4.4 million and 10.8 million new HIV acquisitions and 770,000 to 2.9 million additional deaths would occur between 2026 and 2030, depending on the impact of mitigation measures. Key populations and children would be disproportionately affected by funding cuts. HIV acquisitions would be 30% to 60% higher in key populations than in other populations outside Africa. If PEPFAR funding were discontinued, 880,000 children would acquire HIV and 120,000 children would die of HIV-related causes in low- and middle-income countries between 2025 and 2030[7].

A second research group assessed the impact of the withdrawal of funding for PrEP by developing an HIV transmission model that incorporated PEPFAR reporting on the numbers of key population recipients of PrEP in 28 PEPFAR-supported countries in Africa in Q3 2024[8]. The model calculated the impact of PrEP removal on HIV acquisition over one year. It estimated that stopping PEPFAR's provision of PrEP could lead to 6,671 additional new HIV acquisitions over one year: 2,909 (1,802-3,709) among men who have sex with men; 2,006 (1,232-3,014) among female sex workers; 526 (293-844) among trans women; and 214 (73-314) among people who inject drugs. This corresponds to relative increases in new HIV acquisitions of between 0.8% among people who inject drugs to 2.9% among female sex workers; country-level increases are estimated to exceed 5% in eight countries for men who have sex with men, two countries for people who inject drugs, five countries for trans women and six countries for female sex workers.

HIV cure and remission

A conference plenary reviewed the state of "deep latency" in elite controllers of HIV and its implications for cure strategies[9]. Studies of elite controllers show that immune selection leads to the accumulation of intact proviruses in non-genic or heterochromatic regions that are less able to reactivate. This "deep latency" is a model for highly effective immune control and is also seen to increase over time in people on long-term suppressive ART. In participants with over 20 years of ART suppression, deep latency signatures increased over time on ART and were accelerated with earlier ART initiation. Patterns of deep latency were also greater in women, who had more functional innate immunity but no differences in CD4 or CD8 T-cell responses. Together, these findings suggest mechanisms and biomarkers of effective immune control that shape the HIV reservoir and could be valuable in assessment of cure-directed strategies.

Several conference sessions explored aspects of the HIV reservoir, including interventions to reduce the size of the reservoir and the effects of the reservoir on co-morbidities. These studies identified promising approaches and new challenges in reservoir reduction. A study in humanized mice showed that ex vivo transduced HLA-E-restricted CD8+ T-cells persisted and expanded in the mice after acute HIV infection and were associated with reduced virus replication. In ART-treated mice, the HLA-E-transduced cells were associated with lower levels of intact proviral HIV DNA, implying that HLA-E-restricted CD8+ T-cells had reduced the HIV reservoir size[10].

A prospective, interventional study in 25 people living with HIV showed that psychological stress tests induced significant changes in acute stress responses that were associated with the induction of unspliced cell-associated HIV RNA but not HIV DNA, suggesting a role for environmental factors on reservoir modulation[11]. An in vitro study showed that defective HIV proviruses with large, complementary deletions can recombine to produce replication-competent viruses[12]. This study provides proof of concept that, in a permissive environment, some defective proviruses can recombine and support reservoir maintenance. A sub-study of the Early Pediatric Initiation of cART, Canada Child Cure Cohort Study examined the relationship between inducible HIV RNA as a marker of reservoir size and biomarkers of cardiovascular inflammation in 121 children (median age 13 years). It found a significant association between higher inducible RNA levels and serum levels of CRP (p=0.009), IL-6 (p=0.04), IL-1ß (p=0.002) and IL-18 (p=0.014)[13]. The findings emphasize the importance of achieving early viral suppression in children living with HIV to minimize cardiovascular risk.

A plenary presentation emphasized the ongoing need for an HIV vaccine in on the African continent, as well as key barriers and enabling technologies for HIV vaccine development in the region[14]. Major research gaps include the lack of knowledge of HIV sequence diversity and host genetic diversity in Africa. Current challenges in vaccine research include the identification of immunogens that expand B-cell precursors and the polishing and shaping of these immunogens to encourage early B-cells to mature into broadly neutralizing antibodies (bNAbs). A conference session explored a range of applications for bNAbs in cure and remission studies. A Phase 1b study evaluated viral suppression and rebound during analytic treatment interruption in 28 people with suppressed HIV who received single infusions of two long-acting bNAbs (3BNC117-LS and 10-1074-LS) at treatment interruption, followed by up to eight subcutaneous injections of the IL-15 superagonist N-803 (6 mcg/kg) three weeks apart[15]. ART was resumed if HIV RNA remained above 1,000 copies/ml for four weeks; 42% of participants did not experience viral rebound >200 copies/ml by week 24, 58% remained off ART at week 24, and 29% remained off ART at week 48. There was no correlation between baseline bNAb sensitivity and loss of virologic control.

HIV treatment

WHO released updated treatment guidelines for HIV at IAS 2025, recommending long-acting injectable cabotegravir/rilpivirine (CAB/RPV) as an alternative switching option for ART for adults who have achieved full viral suppression on oral ART and do not have active hepatitis B infection. A conference plenary presentation reviewed the need for long-acting ART in low- and middle-income countries, as well as the challenges associated with introduction[16]. A high prevalence of resistance to non-nucleoside reverse transcriptase inhibitors and the need for cold-chain storage make rilpivirine a less attractive long-acting agent in low- and middle-income settings, so trials of alternative regimens are needed to inform the use of long-acting treatment in these settings.

Long-acting treatment CAB/RPV is currently recommended as a switch option for people with suppressed HIV; there are limited data on the use of this regimen in people with suboptimal suppression of HIV. At IAS 2025, the IMPALA trial reported that CAB/RPV was effective in maintaining viral suppression in people with suboptimal viral control in Africa. The study findings offer a promising option for supporting people with HIV who have adherence challenges. The multi-country randomized study compared CAB/RPV to a three-drug, dolutegravir-based regimen in 540 people with suboptimal viral control, defined as either a viral load measurement above 1,000 copies/ml in the past two years, a history of being lost to follow up for at least four weeks or unlinked to care for at least three months after HIV diagnosis[17]. Participants were randomized after maintaining a viral load <200 copies/ml for 12 weeks.

At week 48 of follow up, injectable CAB/RPV was associated with non-inferior viral suppression (91.4% vs. 89.2% with HIV RNA <50 copies/ml, risk difference [RD]: 2.3%, 95% confidence interval [CI] -2.7% to 7.2%). Virologic failure (two viral loads >200 copies/ml or one >1,000 copies/ml) occurred in five CBV/RPV recipients; four developed high-level resistance to CBV and three to RPV. All resuppressed HIV RNA on an oral regimen. IMPALA excluded people with active hepatitis B (hepatitis B surface antigen positive) or prior HBV acquisition without immunity. An analysis of hepatitis B acquisition and reactivation in IMPALA participants found that 7.8% of randomized participants had evidence of vaccine-induced immunity; ALT elevations >3x ULN were observed in 2.6% in the TLD arm and 0.7% in the CAB/RPV arm[18]. One participant in the CAB/RPV arm acquired hepatitis B during the study, diagnosed after a significant liver enzyme elevation (1,229 IU/L) was detected at month 12.

An analysis of 42 pregnancies in women exposed to cabotegravir and reported to the Antiretroviral Pregnancy Registry showed no significant concerns regarding adverse birth outcomes, although the number of births reported warrants caution[19]. Of the 42 pregnancies, 39 were in women who had been exposed to CAB prior to conception but not at the time of conception, and three in women who initiated CAB during pregnancy. A total of one stillbirth and three spontaneous abortions were observed, along with four induced abortions. Among 35 live births, one birth defect of congenital ptosis was reported, and among 33 singleton live births, five were preterm, three had low birth weight and three had very low birth weight.

Intermittent treatment schedules, such as weekends off pill taking, have been proposed as a temporary means of preserving antiretroviral drug supplies in circumstances where funding cuts threaten continuity of supply. A systematic review and meta-analysis presented at IAS 2025 identified eight randomized trials, which compared continuous treatment with a variety of intermittent treatment schedules (up to a maximum of four days off treatment per week)[20]. The pooled analysis of 1,346 participants in eight studies found no significant difference in rates of viral rebound above 50 copies/ml or virologic suppression below 50 copies/ml at week 48. In three studies that measured treatment-emergent resistance, the rates of emergence were similar for intermittent and continuous treatment (1.9% vs. 2.1%).

But a randomized study of intermittent treatment in adolescents found that a weekend-off treatment strategy was inferior to continuous treatment. BREATHER Plus randomized 470 adolescents with suppressed viral load to continue their existing regimen of continuous tenofovir disoproxil fumarate (TDF), lamivudine and dolutegravir (TLD) or switch to taking TLD five days on, two days off[21]. Participants had a median age of 16.5 years and had been taking ART for a median of 11.8 years. A total of 10% of participants in the semi-continuous treatment arm and 5% in the continuous treatment arm experienced viral rebound above 50 copies/ml during the study, a risk difference of 5.1% (95% CI 0.5, 9.9) (p=0.034). In a Kaplan-Meier analysis of the proportions with HIV RNA >50 copies/ml by week 96, participants in the semi-continuous treatment arm had twice the risk of viral rebound (HR 2.1, 95% CI 1.0-4.4). The study investigators concluded that semi-continuous treatment cannot be recommended as a treatment strategy for adolescents with HIV taking TLD and receiving viral load tests every six to 12 months.

IAS 2025 saw the presentation of early data on a potential once-weekly oral antiretroviral combination. A Phase 2b randomized study compared three alternative doses of ulonivirine (MK-8507) (100mg, 200mg or 400mg once weekly), an investigational non-nucleoside reverse transcriptase inhibitor, in combination with islatravir (20mg once weekly), with once-daily dosing of bictegravir/emtricitabine/tenofovir alafenamide (B/F/TAF), in participants virally suppressed for at least six months on B/F/TAF[22].The trial was halted due to decreases in total and CD4 lymphocyte counts in islatravir recipients in investigational studies; before the halt in islatravir/ulonivirine dosing, 113 of 161 randomized participants had reached 24 weeks of follow up. All participants evaluable at week 24 maintained HIV RNA suppression. Rates of drug-related adverse events (17.4% vs. 10.0%) and adverse events leading to study discontinuation (2.5% vs. 0.0%) were similar between the study arms. Development of the once-weekly combination of ulonivirine 200mg/islatravir 2mg is ongoing.

An analysis of predictors of virological failure in the ODYSSEY trial showed that in children starting antiretroviral treatment with a dolutegravir-based or standard-of-care regimen in Africa, Europe or Thailand, treatment failure by week 96 was associated with WHO stage 3/4 disease or treatment at a site on the African continent[23]. The study recruited 381 children with a median age of 10.5 years; 19% had ongoing WHO stage 3/4 events at baseline. In a multivariable model, dolutegravir treatment, as well as higher age, higher body mass index (BMI)-for-age and higher CD4 percentage, were associated with lower risks of treatment failure; an ongoing WHO stage 3/4 event was associated with a higher risk of treatment failure when a higher threshold for virological failure was used (>1,000 copies/ml).

Co-morbidities and co-infections

A retrospective study of changes in weight in people virally suppressed on ART for at least six months found that over three years of follow up, weight gain of greater than 10% was associated with demographic factors, baseline BMI or a history of immunosuppression but not current antiretroviral exposure[24]. The study evaluated changes in weight and BMI in 10,413 adults living with HIV in the United States who remained virally suppressed (<200 copies/ml) after three years of treatment; 41% lost weight or did not gain weight, 26% gained <5% in weight and 12% gained >10% in weight and shifted to a higher BMI category. In logistic regression analysis, being Black, female, age 18-29, having a normal baseline BMI, CD4 <200 cells/mm3 and no TAF/TDF exposure 12 months pre-baseline were associated with 10% gain and shift to a higher BMI category.

A randomized Phase IV open-label study demonstrated that in people living with HIV and obesity, switching from TAF/emtricitabine plus an integrase inhibitor to either doravirine/F/TAF or doravirine/F/TDF did not result in substantial weight change after 48 weeks[25].
The study randomized 145 virally suppressed participants in the United States in equal proportions to continue their existing regimen or switch to either doravirine/F/TAF or doravirine/F/TDF. After 48 weeks of follow up, the mean change in weight was -1.84% (-3.37, -0.30) for continued INSTI+TAF/FTC, -0.47% (95% CI -2.09, 1.14) for DOR/F/TAF and -2.73% (-4.22, -1.23) for DOR/F/TDF. The estimated mean difference between doravirine and INSTI-based treatment (both with F/TAF) was +1.36% (p=0.23), while the estimated mean difference between doravirine/F/TDF and INSTI/F/TAF was -0.89% (p=0.41). Subgroup analyses showed no effect of race, sex, gender, age, integrase inhibitor type and history of weight gain on treatment differences.

People living with HIV are more likely to develop anal cancer than the general population[26]. Screening for and treatment of anal intraepithelial neoplasia (AIN) has been shown to reduce progression to anal cancer, but treatment options have not been compared in a randomized study[27]. The TECAIN study randomized 257 people living with HIV with AIN in Germany to treatment with either topical trichloroacetic acid (TCA) or electrocautery[28]. Participants received up to four rounds of treatment during the 12-week treatment period. The primary endpoint of therapeutic success was defined as a combination of complete clinical response evaluated by high-resolution anoscopy and histological resolution/regression of AIN four weeks after the end of treatment. TCA did not meet the non-inferiority threshold of 12% after four weeks of follow up, but at week 12, 50.8% of TCA recipients and 48.7% of electrocautery recipients had reached the therapeutic success endpoint (difference 2.2, 95% CI -10-7, 15), showing that TCA was non-inferior to electrocautery. Intraoperative pain and local anaesthetic use were significantly lower in the TCA group. TCA has the potential to broaden access to AIN treatment as it does not require specialist equipment or training to administer and can be provided by any qualified healthcare provider.

Undiagnosed tuberculosis (TB) is common among people newly diagnosed with HIV. Uncertainty persists about the impact on outcomes and retention in care of same-day ART initiation in people with potential symptoms of TB. The SaDAPT trial randomized 590 people living with HIV in Lesotho and Malawi and presenting for HIV care with at least one TB symptom to same-day ART initiation or ART initiation after TB diagnostic testing ("TB-results-first")[29]. The study found no significant differences in retention in care or viral suppression 22-30 weeks after treatment initiation. Rates of TB diagnosis, hospitalization or death from TB and tuberculosis-immune reconstitution inflammatory syndrome did not differ between the study arms. This led the investigators to conclude that in a public health setting, same-day ART initiation is non-inferior to TB-results-first management, supporting current WHO guidance.

Prevention

New PrEP recommendation

At IAS 2025, WHO released new guidelines recommending the use of injectable lenacapavir (LEN) twice a year as an additional PrEP option for HIV prevention[30]. 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 2 million people over three years[31]. The agreement is intended to meet demand until generic versions of LEN manufactured under voluntary licensing agreements become available in eligible countries. The Global Fund and voluntary licensing agreements cover 120 high-HIV-incidence, low- and middle-income countries.

PrEP uptake

An analysis of the relationship between policy adoption and PrEP uptake in 139 countries revealed that while certain individual policies correlate with PrEP uptake, policies act in concert with one another, emphasizing the importance of a supportive policy environment rather than a single policy change. Individual-level regression analysis showed that of 54 policies analysed, eight policies were significantly associated with PrEP uptake: task shifting to permit nurses and other non-physicians to prescribe PrEP (one policy); decriminalizing same-sex sex (three policies); decriminalizing HIV exposure (three policies); and HIV self-testing (one policy)[32]. Multiple regression showed that only one policy on task shifting was significantly associated with PrEP uptake.

In an analysis restricted to 33 countries in Africa, four policies were significantly associated with PrEP uptake in individual regressions: decriminalizing HIV exposure (two policies); prohibiting compulsory HIV testing (one policy); and loosening age restrictions on testing and treatment (one policy). While no single policy was significantly associated with PrEP uptake in multiple regression, correlation analyses showed that at least four pairs of policies were highly correlated in enabling PrEP uptake. The researchers concluded that although the impact of individual policies diminished when multiple policies were considered together, each policy still influenced PrEP uptake both independently and in concert with other policies.

An analysis of progress in PrEP implementation between 2018 and 2023 calculated the PrEP-to-need ratio (PNR) (ratio of PrEP initiations to incident HIV cases) for 11 countries with more than 50,000 PrEP initiations in 2023 or more than 100,000 PrEP initiations ever, classifying countries as leading (PNR >5), growing (PNR 1-4.99) or emerging (PNR <1)[33]. Six countries were classified as leading (Kenya, Lesotho, Malawi, Uganda, Zambia and Zimbabwe) and five as growing (Brazil, Mozambique, Nigeria, South Africa and Tanzania); none were classified as emerging. The average time to transition from an "emerging" to "growing" PNR was 3.8 years and from a "growing" to "leading" PNR, 4.4 years.

HIV testing before long-acting cabotegravir initiation

In its 2025 guidelines, WHO recommends that injectable cabotegravir may be initiated after rapid HIV antibody testing and that confirmatory HIV RNA testing is unnecessary. The recommendation is intended to encourage uptake of CAB-LA by removing a diagnostic barrier. Research in 180 adolescents in Brazil who chose to initiate CAB-LA in the PrEP15-19 Choices study found that the HIV Detect oral fluid self-test and Determine HIV Early Detect rapid antibody test showed high sensitivity and specificity (>99.9%, p=0.006) in study participants[34].

PrEP during pregnancy and breastfeeding

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 need to be discontinued during pregnancy or breastfeeding in women who could be exposed to HIV. The choice to start, continue or discontinue PrEP when becoming pregnant should be made by the individual following discussion of the risks and benefits with a healthcare provider[35].

Safety data on the use of long-acting cabotegravir (CAB-LA) and lenacapavir were presented at IAS 2025, providing reassurance on safety and underlining the importance of designing PrEP studies that include pregnant and lactating participants. At AIDS 2024, the 25th International AIDS Conference, the HPTN 084 open-label extension study reported no significant difference in composite poor pregnancy outcomes between those exposed to CAB during pregnancy or prior to pregnancy or those with unexposed pregnancies[36]. Updated findings from the open-label study, including 433 pregnancies recorded to June 2024, confirmed no increased risk of adverse maternal or pregnancy outcomes in women exposed to cabotegravir during or prior to pregnancy when compared with unexposed women who had opted for oral PrEP[37].

Pregnancy and breastfeeding were not excluded in the PURPOSE 1 randomized study comparing injectable lenacapavir and oral PrEP (F/TAF or F/TDF)[38]. Among 2,140 women receiving LEN, there were 193 pregnancies compared with 218 in those receiving F/TAF (2,135 women) and 98 in those on F/TDF (1,070 women). Pregnancy outcomes were balanced across study arms, and rates were similar to those expected in the background population. Lenacapavir trough drug concentrations were similar in pregnant and non-pregnant participants and between trimesters in pregnant participants. LEN was detectable in breastmilk, but concentrations in breastfed infant plasma were very low (breastfed infant to mother plasma ratio=0.02 [IQR 0.01-0.05]).

The Tshireletso PK sub-study recruited 27 lactating women and their breastfeeding infants and evaluated maternal plasma, infant plasma and maternal breastmilk concentrations of cabotegravir initiated within 14 days of delivery[39]. Drug concentrations were measured before and one week after the month 1 and month 5 injections; CAB reached protective concentrations within one week of dosing, and 74% of maternal CAB concentrations were at least four times greater than the protein-adjusted IC90, but infant plasma CAB concentrations exceeded the PA-IC90 in only 14% of samples.

PrEP choice

A plenary session at IAS 2025 encouraged implementers to think of PrEP implementation beyond scale up and to consider "scale out" and "scale deep"[40]. "Scale out" takes a proven innovation and starts to deliver it to new populations in new ways, while "scale deep" requires deeper insight into the end user to understand their barriers to use and their preferences. "Scale out" requires the demedicalization of PrEP through task shifting, self-testing, multi-month dispensing, decentralized services and the delivery of PrEP outside traditional medical facilities. Scaling deep requires a greater focus on providing PrEP choices that fit the lifestyles of users, as well as awareness of the requirements of different types of PrEP clients, from independent, self-sufficient users happy to use self-testing and non-medical distribution points to PrEP clients who require more support and affirmation for PrEP use through services such as Youth PrEP clubs and mobile clinics.

A conference symposium highlighted approaches to implementing PrEP choice in practice[41]. PrEP choice has been central to Zimbabwe's national combination prevention strategy, from the adoption of WHO guidance on oral PrEP in 2016 to approval of the dapivirine ring in 2021 and CAB-LA in 2022. Zimbabwe had initiated a cumulative total of 149,667 people on oral PrEP by the end of 2024. CAB-LA was introduced in April 2024, and 3,504 people had been initiated on CAB-LA by December 2024. PrEP choice in Zimbabwe depends on strong governance and leadership, budgeting and supply chain management, as well as delivery through differentiated service delivery, community engagement and demand creation activities[42].

PEPFAR supported the introduction of CAB-LA in five countries in fiscal year (FY) 2024; PEPFAR quarterly monitoring data for Eswatini, Malawi, Ukraine, Zambia and Zimbabwe were used to assess the number of additional PrEP starts and returns attributable to the introduction of injectable CAB-LA in FY 2024[43]. In FY 2024, 441,269 individuals initiated PrEP and, on average, 127,292 returned for PrEP when both oral PrEP and CAB-LA options were available. Overall, 900 individuals switched from oral PrEP to CAB-LA and 3,772 PrEP-naive individuals initiated CAB-LA in the first quarter of CAB-LA introduction. Compared with the same quarters in FY 2023, CAB-LA introduction correlated with a 25% increase in PrEP initiations and a 33% increase in PrEP return. PrEP uptake among those who were PrEP naïve more than doubled (+111%) in Eswatini from FY 2023 to FY 2024 after the introduction of CAB-LA and increased in all countries apart from Ukraine.

Studies also examined PrEP preferences among various populations. The PrEPared to Choose implementation study is evaluating PrEP persistence and switching between products in 1,164 adolescents and young people aged 15-29 in South Africa. A total of 74% chose CAB-LA after PrEP choice counselling, 25% chose oral PrEP and 1% chose the dapivirine ring. An analysis of the early product switching pattern between initiation and the second follow-up visit showed that 7.5% switched product by the second follow-up visit, with the majority switching from oral PrEP to CAB-LA[44].

In Zambia, a qualitative study of PrEP preferences was conducted among 17 adolescent girls and young women who had recently initiated CAB-LA through DREAMS programme centres. Participants viewed CAB-LA as discreet and non-stigmatizing and appreciated the control it gave them over HIV prevention[45]. Participants in the PURPOSE 2 trial of lenacapavir versus oral PrEP were asked to complete an electronic questionnaire on PrEP preferences; 2,918 took part at baseline and 1,126 at week 52. Some 78% of participants preferred twice-yearly injections at baseline and 81% at week 52 (52% expressed a strong preference for injections) compared with 14% and 11% who preferred pills at baseline and week 52, respectively[46].

PrEP implementation

A symposium reviewed the challenges involved in scaling up long-acting PrEP, highlighting the research gaps that must be addressed to achieve high levels of uptake and persistent use[47]. Evidence of the most effective behavioural methods of promoting individual uptake and keeping people on PrEP remains sparse. As funding for prevention shrinks or remains static, it will be critical to determine whether implementation research should prioritize volume (the number who initiate) or persistence (the number who remain protected)[48].

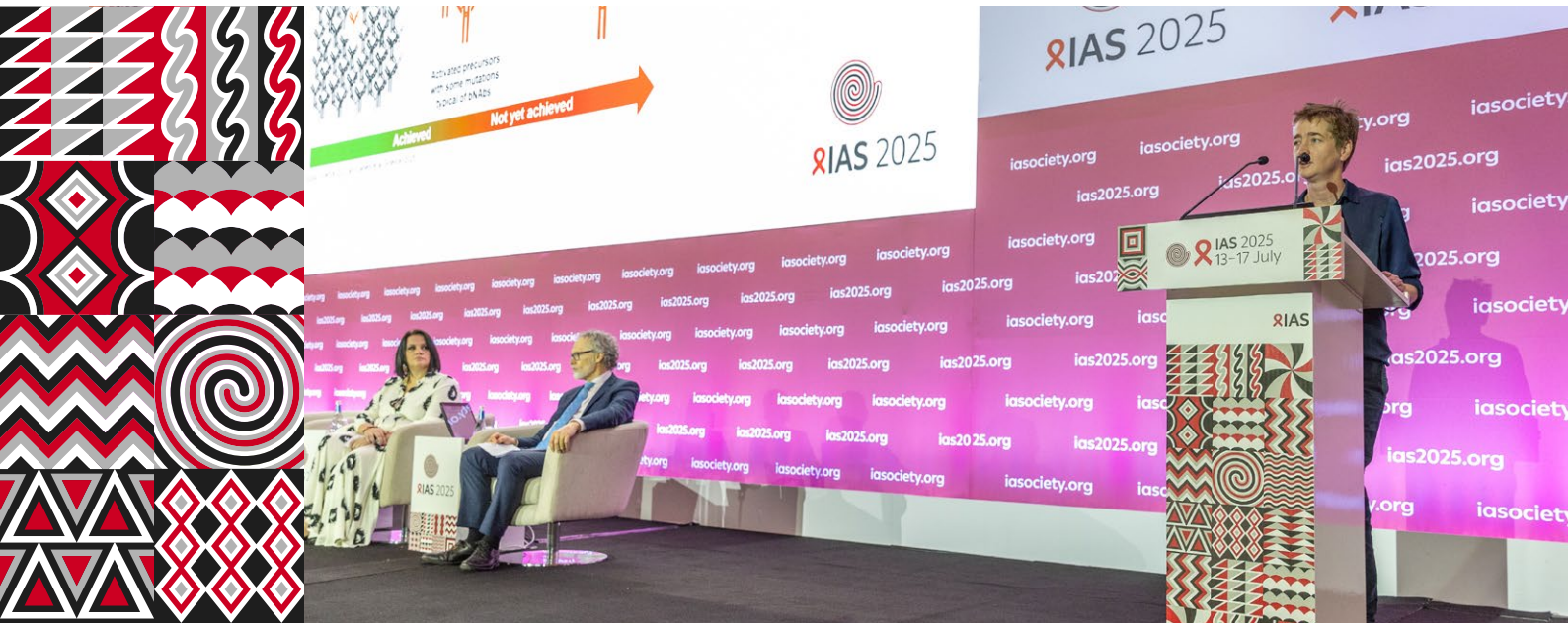
Successful scale up hinges on enhancing individual motivation to initiate and continue long-acting prevention. This can be achieved through diverse strategies like peer case management, financial incentives, community-based pickup points, extended clinic hours, improved provider-client communication and web chats to counter misinformation. A promising solution lies in artificial intelligence (AI) systems that build trust and personalize support, connecting people to stigma-free care. One such platform, tested over three months, addresses the limitations of existing resources by offering counselling, clarifying misconceptions, providing self-test options, evaluating PrEP eligibility and scheduling appointments for initial medication[49].

Programmatic evidence from the Zimbabwe CAB-LA implementation programme shows that user concerns about injection site reactions, continuity of supply and drug resistance remain barriers to the adoption of long-acting PrEP, as do provider concerns about the management of discontinuation, testing for acute HIV and the management of inconclusive results[50]. Healthcare regulations on who can inject and in which settings pose barriers to innovative community delivery strategies, while the limited supply of CAB-LA and lenacapavir does not match the size of the population with high HIV incidence. Maintaining service quality during the rollout of innovative delivery models also poses a concern as funding pressures lead to reductions in staff.

Potential new monthly PrEP agent

Phase 2 study results presented at IAS 2025 showed that MK-8527, a nucleoside reverse transcriptase translocation inhibitor, has potential for use as a monthly oral PrEP agent. The study evaluated the pharmacokinetics and safety of three doses of MK-8527 (3mg, 6mg or 12mg) or placebo given every four weeks for up to six months[51]. The study recruited 350 adults with low likelihood of HIV exposure (58.3% female; median age 28 years; 51.4% White; 41.4% Black/African American; 2.3% Asian). MK-8527 plasma levels were measured at days 1 and 2, week 20 and follow-up day.

At all doses, MK-8527 achieved protective levels within 24 hours and concentrations were maintained above the protective level for at least one month after the last dose; drug concentrations were dose proportional. The incidence of drug-related adverse events was similar across all dosing groups (14.9-20.2%); one serious adverse event (miscarriage) was considered related to the study drug. There was no significant difference in CD4 lymphocyte or total lymphocyte decreases between the study drug and placebo groups. Phase 3 efficacy studies of MK-8527 as monthly PrEP are due to begin enrolment in the second half of 2025.



DoxyPEP

At AIDS 2022, the 24th International AIDS Conference, results of the DoxyPEP study showed that oral doxycycline post-exposure prophylaxis (PEP) in HIV-negative PrEP users and people with HIV reduced the chance of acquiring a bacterial sexually transmitted infection by 66%[52]. But DoxyPEP proved less effective against gonorrhoea in the DOXYVAC study in HIV-negative PrEP users[53] and ineffective in reducing the chance of acquiring bacterial STIs compared to placebo in cisgender women due to non-adherence[54].

A conference symposium reviewed experience and evidence gaps in the implementation of DoxyPEP. Implementation of DoxyPEP remains limited due to concerns about antibiotic resistance; the DOXYVAC study suggests it may be prudent to limit DoxyPEP use to no more than one dose a week and avoid concurrent use of doxycycline to treat infections in DoxyPEP users[55]. In young cisgender women, directly observed weekly dosing of doxycycline is being tested to evaluate acceptability within an adherence-support programme; further research is needed in this population to define the optimal dosing regimens and testing strategies[56].

HIV self-testing

Research presented at IAS 2025 highlighted the contribution of HIV self-testing (HIVST) to increasing diagnoses and linkage to care when integrated into national programmes and peer-led initiatives. An analysis of national programme data in Kenya showed that 1.4 million HIV self-tests were distributed and 26.2 million facility-based tests were carried out through 7,126 health facilities from 2019 to 2023[57]. After adjusting for county-level HIV prevalence and testing volume, the analysis found that for every 100 self-tests distributed, six people were diagnosed with HIV and seven initiated ART per facility. Levels of diagnosis and ART initiation were higher in women over 25 years than in men over 25 and higher in people over 25 than in younger people.

In South Africa, on the other hand, self-test distribution led to a greater increase in HIV diagnoses among men. An analysis of South African national programme data assessed the impact of HIV self-test distribution on facility-based HIV diagnoses from 2020 to 2023. It found an additional 2.9 HIV diagnoses per 100 self-tests distributed, and new diagnoses as a result of self-testing were significantly higher in men than in women[58].

Peer-driven self-test distribution among key populations in Uganda significantly improved linkage to care. The scheme enrolled trusted peer supporters to distribute self-tests and escort clients with reactive self-test results to health facilities and trained supervisors at health facilities to guide clients through confirmatory testing and care. Peer supporters and supervisors received stigma reduction training, and peer supporters used social media networks to reach key populations. The scheme distributed 203,377 self-tests, 51.5% to members of key populations; of those testing positive, 84% of those in key populations were linked to care compared with a national average of 79%, and 99% were linked to ART compared with a national average of 95%[59].

Social, behavioural and structural issues

Social determinants of health

A symposium reviewed how social and structural determinants of health create barriers to HIV prevention, care and adherence, especially in marginalized populations, and how responses to these social and structural factors can be integrated into HIV programmes[60]. The session emphasized the importance of developing HIV epidemic models that incorporate structural and social determinants, as well as multi-level interventions that address government, the justice system and civil society. Sessions in Track D identified mental health and climate change as prominent social determinants.

Mental health

Mental health conditions are common among people living with HIV and key and vulnerable populations, but remain widely unaddressed in settings with limited resources[61]. Studies presented at IAS 2025 demonstrated the links between mental health conditions and heightened vulnerability to HIV.

A national mental health survey of LGBTQ+ young people in Peru (n=4,643) found that young people who reported a history of depression were less likely to have accessed condoms (aOR 0.75, 95% CI 0.60-0.95), while a history of suicidal ideation was associated with a lower likelihood of accessing PrEP (aOR 0.57 95% CI 0.39-0.83])[62]. A cross-sectional survey of 1,026 young mothers and young pregnant women in South Africa found that 34% reported prolonged sadness and 10% suicidal ideation in the past year, with each associated with higher prevalence rates of HIV-associated risk behaviours in the past year[63]. Among young people with HIV in Lusaka, Zambia, the prevalence of suicidal behaviour was high (30.5%) and was associated with female gender, depression, anxiety, feeling stigmatized because of having HIV or having stigmatizing attitudes towards people living with HIV[64].

Despite clear evidence that mental health integration improves HIV outcomes, many health systems continue to treat them separately, limiting the impact of both[65]. A symposium on the integration of mental health into HIV prevention and care reviewed examples of integration, demonstrating that locally adapted tools, task sharing and community involvement are feasible and effective in achieving integration in resource-constrained settings. However, efforts remain fragmented and progress is slowed by underfunding, workforce shortages and lack of political prioritization. Integration must go beyond screening to include long-term psychosocial

support and sustained follow up. Meaningful scale up will depend on national commitment, adequate investment and a shift toward inclusive, rights-based models that reflect the realities and needs of affected communities[66].

A randomized trial in Zimbabwe compared the effects on adherence, retention and depression of a six-session motivational and problem-solving intervention by lay counsellors with an enhanced standard care in 280 adults with non-suppressed HIV on antiretroviral treatment[67]. Depression scores were significantly lower and self-reported adherence significantly higher in the intervention arm at four and 12 months, and participants in the intervention arm had a 70% lower probability of being prescribed second-line treatment after 12 months (OR 0.3; 95% CI 0.1, 0.7, p<0.01).

Climate change

A systematic review of six qualitative and 14 quantitative studies examining weather and climate variables and HIV-related measures on the African continent confirmed links between extreme weather events, such as droughts or heavy rainfalls, and HIV outcomes, engendering, in particular, food insecurity, reduced healthcare access and migration[68]. Drought was the most commonly studied variable; the longitudinal effects of other factors, such as extreme temperatures, require further study.

A study of 896 people receiving HIV care across 15 districts of Zimbabwe found that just over half (n=497/896) had experienced care disruptions due to climate stressors, most often adherence challenges due to lack of food (87%, n=432/497), insufficient water access (63%) or inability to store medication due to high temperatures (26%, n=129/497). Qualitative research among the cohort highlighted the need for social protection measures to mitigate the impact of climate change[69]. Discussants agreed that HIV programmes must integrate climate resilience – addressing healthcare access, mobility and socioeconomic factors. Embedding HIV services within broader systems, like food security, transportation and climate adaptation strategies, is vital to protect health in the face of worsening environmental instability.

Implementation science

Community-led research and monitoring

Conference sessions examined the role of communities in research and monitoring, highlighting promising models of community-led interventions to address stigma and service linkage. In Ghana, a community-led policy initiative developed in rural districts addressed stigma and service access, resulting in a 45% increase in HIV testing, with 98% of people diagnosed starting treatment within 30 days, alongside a 70% reduction in reported stigma[70]. In Kenya's informal settlements, 150 peer-led workshops reached approximately 3,000 young people with a programme of storytelling, dialogue and music to counter stigma, leading to a 30% decrease in self-reported stigma. Community health worker training was associated with a 25% increase in adherence to HIV treatment[71]. Further work is needed to bring these interventions to scale and ensure sustainable resourcing.

Community-led monitoring also has the potential to improve health outcomes. A comparative analysis looked at health outcomes at 33 facilities that implemented community-led monitoring and at neighbouring unmonitored facilities in Malawi and South Africa between November 2020 and October 2024 in the International Treatment Preparedness Coalition Citizen Science programme. It found a 32% higher likelihood of initiating PrEP at sites implementing community monitoring, while pregnant women living with HIV were twice as likely to deliver at these sites compared to unmonitored sites[72]. In Malawi, people receiving ART at sites with a differentiated service delivery (DSD) model informed by community-led monitoring were six times more likely to be in DSD care and twice as likely to be virally suppressed compared with sites without DSD strengthened by community-led monitoring.

Community-led monitoring led to improvements in outcomes through a cycle of data collection, qualitative research, community consultation and engagement with policy makers to address shortcomings in services. In Chiang Mai, Thailand, community-led monitoring of HIV-related services identified key barriers to HIV prevention and treatment[73]. In 2022, community-led monitoring identified low PrEP availability as a problem; advocacy in partnership with the provincial Public Health Office led to the expansion of PrEP availability to 24 hospitals by 2024. Community-led monitoring also identified that only 50% of ART recipients received multi-month dispensing in 2023, leading to an enhanced provincial target for multi-month dispensing. By 2024, 68% of ART clients received more than three months of drug supply at each visit. Community-led monitoring in six provinces in Thailand will be used to inform national policy development.

Implementation science and economics

With HIV receding from the global political agenda and major donors significantly reducing their commitments, sustainable domestic responses are crucial. An analysis of domestic resource mobilization in seven African countries with a high burden of HIV showed that all seven countries fall short of the Abuja Declaration's 15% health budget commitment; only one contributed over 60% of its HIV funding from internal sources in FY 2024, while others contributed between 1% and 15%[74].

A review of innovative funding instruments for domestic resource mobilization between 2015 and 2024 highlighted Zimbabwe's AIDS Trust Fund, which generated USD 52.7 million through tax mechanisms, Botswana's debt conversion instrument, which generated USD 20 million, and Côte d'Ivoire's Debt2Health agreement, which generated USD 27 million[75]. The review concluded that successful transitions from donor to domestic financing are often characterized by strong political commitment, effective stakeholder engagement, and the adoption of innovative financing strategies that leverage local resources.

Advanced HIV disease (AHD) remains a challenge for health systems; delayed HIV diagnosis, disengagement from care and lack of diagnostic capacity create barriers for timely identification and management of AHD. A study in Lesotho and South Africa evaluated the burden of AHD and implementation of an AHD care package of antiretroviral treatment initiation, cotrimoxazole prophylaxis and TB preventative treatment[76]. Door-to-door TB screening of 20,024 people took place between 2022 and 2024. Of those screened, 4,536 people were living with HIV and were offered point-of-care (POC) CD4 testing; 42.3% of people living with HIV received POC CD4 test results and 2.6% had CD4 counts below 200. The study showed that community implementation of the AHD care package is feasible if POC CD4 tests are available, though prophylactic treatment uptake needs improvement.

In Malawi, transitioning from partner-supported differentiated service delivery to Ministry of Health-led DSD for HIV care led to a slight increase in retention (70.2% to 71%) and a decrease in mortality (9.4% to 5.5%)[77]. Building capacity within the Ministry of Health before the transition, partner mentoring after transition, and adoption of a hub-and-spoke model of diagnosis and care supported successful transition.

Artificial intelligence is being incorporated into many areas of health system delivery. A conference session explored the use of a range of AI utilities to enhance HIV care quality, supply chains, data integrity and service delivery. Blockchain technology, a distributed and encrypted ledger, can ensure data security and improve the efficiency and accuracy of health records. Pilot studies in Kenya and the United States show that when medical and pharmacy records move to the blockchain, adherence improves (25%) and administrative errors in prescribing are reduced (40%), while commodity stockouts were reduced by 25% in Malawi and HIV test kit delivery delays were reduced by 50% in Ghana[78]. In Nigeria, AI-assisted mobile chest X-rays deployed at primary health centres significantly improved TB detection among people living with HIV through a combination of bacteriological scoring and electronic comparison of radiographic imaging. AI-assisted screening was associated with higher diagnostic yield than traditional methods (23% yield compared with 8%), demonstrating the value of AI for integrated TB/HIV care[79].

How was it covered?

IAS 2025 saw a two-fold increase in top-tier media coverage, with 32 top-tier publications compared with 16 for IAS 2023, the 12th IAS Conference on HIV Science. In addition, our media fellows produced 25 articles. Examples of top-tier coverage included:

AP

"The UN warns millions will die by 2029 if US funding for HIV programs isn't replaced"

Associated Press

CNN

"WHO recommends twice-a-year HIV prevention shot as concern looms over funding for global HIV fight"

CNN

The Economist

"Rethinking the war on AIDS"

The Economist

Forbes

"Are We Getting Closer To A Broader Cure For HIV?"

Forbes

POLITICO

"Filling the void left by PEPFAR"

Politico

REUTERS

"WHO recommends Gilead's twice-yearly injection for HIV prevention"

Reuters

The official press programme at IAS 2025 included an embargoed media briefing for key reporters prior to the conference, a scientific highlights press conference, a press conference on the future of HIV innovation and a media roundtable on the future of HIV science. Media representatives attended site visits to Rwanda's Health Development Initiative. A conference session featured media representatives discussing the future of global health reporting.

The IAS official press programme drove most of the conference media coverage. The topics that attracted the greatest media attention were new WHO guidelines (44 stories), the UNAIDS Global AIDS Update report (36 stories), the Gilead/Global Fund announcement on no-profit supply of lenacapavir (31 stories) and Rwanda Minister of Health Sabin Nsanzimana on how Rwanda achieved the 95-95-95 targets for diagnosis, treatment and viral suppression (21 stories).

Overall, IAS 2025, compared with IAS 2023, saw similar or increased engagement and reach across most digital channels, including social media, website and email campaigns.

Over 6 million people viewed IAS 2025-related social posts (almost 2 million more than IAS 2023)

Over 49,000 social engagements on IAS accounts (8% more than IAS 2023)

Nearly **2 million individuals** viewed IAS Instagram collaborations

Over **40,000 website sessions** (82% increase on IAS 2023)

77% increase in click rate for Daily Digest emails compared to IAS 2023

How did it go?

Fourteen stakeholders (including conference co-chairs, track chairs, sponsors, partners, community members and other civil society representatives) provided in-depth feedback on the scientific content of the conference, organization, expected outcomes and recommendations for maximizing impact.

Online delegate survey

Of the 10,646 participants, 1,989 (18%) responded to an online survey on 20 topics. The quotations presented here are all drawn from the survey and key informant interviews. The quotations have been minimally edited for clarity and brevity where needed.

- A total of 44% were female, 44% were male, 2% were non-binary or gender non-conforming and 10% did not share their gender.

- A total of 51% of respondents were healthcare workers or social service providers, 20% were researchers, 10% had policy or administrative roles, 4% were advocates or activists, 7% were students and 3% were media representatives.

- A total of 27% of respondents identified as belonging to at least one key population.

- The survey response rate (29%) was higher than response rates for delegate surveys conducted after IAS 2023 (15%) or IAS 2021 (24%).

- The regional distribution of survey respondents and conference participants was similar.

What did people get out of it?

We will not go back!

Echoing Linda-Gail Bekker's opening plenary presentation, the most common take-home message from IAS 2025 was a single phrase – "We will not go back!" – cited by 13% of survey respondents. IAS 2025 provided a venue for the HIV field to take stock of the service disruption caused by recent donor funding cuts and forge a resolve to move forward, protecting the gains brought by recent innovations in treatment and prevention and service delivery, while reimagining how HIV services can be delivered in an era of shrinking donor support.

Survey respondents frequently mentioned the importance of country ownership, local leadership and community involvement in the reconfiguration of services when sharing their take-home messages from the conference.

"African countries must start to own their HIV programmes, and the recent financial turmoil serves as an opportunity to look within for local solutions to a continental problem."

Survey respondent

"We have come a long way with the fight against HIV/AIDS, and although threatened, we will not go back. Africa has shown great resilience in this fight and will continue to through prioritization and integration of services, and ensuring it is at the forefront of all work done in it."

Survey respondent

"Investments in national health systems, rather than parallel, fragmented and uncoordinated programmes, are vital for sustaining progress in the HIV response."

Survey respondent

"We are in a new era in the HIV response where, excitingly, the science and innovation are progressing rapidly but, sadly, implementation, access and hard-won gains over the years are being threatened by the funding squeeze. However, we will never go back. We are resilient, and with the community leading the response, we will sustain the gains, strengthen health systems and achieve epidemic control. We can do it and we will never give up!"

Survey respondent

"My take-home message from IAS 2025 is that the HIV response must now focus on practical and sustainable ways of working that are fully part of the national health system. We can't rely on short-term solutions or standalone programmes anymore. We need to build on what already exists, train local people, and make sure HIV services are delivered together with other health and social services, especially in communities."

Survey respondent

Innovation in prevention

Survey respondents frequently cited new evidence and discussions on the implementation of long-acting injectable PrEP as a key take-home message from IAS 2025, and 58% of survey respondents said they gained a lot of information about new prevention products and approaches at the conference.

Most key informants drew attention to new research on a potential monthly PrEP product as a noteworthy scientific advance – if the product proves effective in Phase 3 trials, it has the potential to further expand PrEP options and overcome workforce capacity and supply chain challenges associated with injectable long-acting PrEP.

Many survey respondents and key informants noted the importance of the new WHO guidance on the use of lenacapavir as long-acting injectable PrEP released at IAS 2025. They also noted the 9 July announcement that Gilead Sciences will supply enough doses of LEN for PrEP to reach up to 2 million people over three years in countries supported by the Global Fund, at no profit to Gilead. Survey respondents and key informants commented that these announcements had created a clear framework for discussions about PrEP implementation at the conference, enabling delegates to think realistically about what is needed to accelerate access and develop services to deliver long-acting injectable PrEP in their settings.

> **"I think there was a good space for people to not just talk about all these amazing new tools, but to talk about the real challenges that are going to be there in their implementation."**
>
> **Key informant, track chair**

Key informants and survey respondents recognized that IAS 2025 had also enabled delegates to learn about the practical implementation of PrEP choice and the benefits of choice for uptake and persistent use.

> **"It was really useful to hear data about how PrEP choice can help with PrEP coverage and persistence because it helps us in other parts of the world that don't currently have PrEP choice to advocate [for it]."**
>
> **Key informant, track chair**

"IAS 2025 painted a compelling picture: user-centred, choice-based and community-integrated approaches are central to unlocking the full potential of PrEP, especially long-acting options for epidemic control. Accelerating product availability, enabling differentiated delivery, strengthening provider-client communication, and supporting real-world continuation (which includes other prevention methods, such as condoms) will be critical. Failure to act with urgency risks undermining the promise of these powerful new tools."

Survey respondent

But some key informants drew attention to the lack of PrEP choice and low PrEP coverage outside Africa. Key informants highlighted the unaffordability of injectable PrEP in middle- and higher-income countries as an obstacle to PrEP choice.

A positive moment in challenging times

Many key informants and survey respondents said they came to Kigali uncertain of what mood to expect – would delegates be despondent about the future of the HIV response? But universally, those who commented said they were relieved and uplifted by the mood of the conference and the positive resolve that ran through conference sessions and hallway discussions. Key informants also noted the positive atmosphere amid the uncertainty generated by funding cuts and the value of the space provided for discussion of how to move forward with prevention innovations.

Key informants and sponsors acknowledged that IAS – the International AIDS Society – had faced significant challenges in staging this year's HIV science conference and appreciated the extraordinary efforts of the host country and the IAS Secretariat to ensure a successful conference. Several key informants emphasized the importance of maintaining an international space for science at a time when science and the language used to discuss the HIV response are becoming increasingly politicized.

"A well-organized and timely conference – and importantly – it brought the community of researchers, clinicians and activists together at a critical moment in the response to the pandemic – we need the solidarity in these unsettling times. I left energized!"

Survey respondent

"The incredible resilience, resourcefulness and determination of the individuals and organizations at the forefront of HIV work, as showcased at IAS 2025, serves as a powerful reminder that change is possible when we stand together."

Survey respondent

"I do think that science has to keep holding the line and we have to resist the politicization. Call out what the science says in the most honest and truthful way. I think the biggest issue we are going to be facing is the future of truth and information. How does one interpret the research on key populations and therefore inform interventions? I think we have to hold a space still for pure science."

Key informant

Will it make a difference?

Impact on participants' work

Overall, 99% of survey respondents agreed that attending IAS 2025 would enable them to take at least one action in their work or advocacy. Almost three-quarters (72%) expected to use knowledge gained at IAS 2025 to contribute to the development of HIV science, while 61% planned to identify new options for partnerships or strengthen existing partnerships. Similarly, 58% agreed that IAS 2025 would improve their ability to engage in the HIV response, and 55% expected to adapt their practices to the latest evidence.

Survey respondents anticipated that the conference would support their work in several ways. For example, 64% expected to share information gained at IAS 2025 with colleagues, peers and networks, whether through presentations or the development of materials, and 35% would build capacity in their organizations, through training or the development or updating of guidelines or procedures. In all, 41% said that attending IAS 2025 would improve their ability to engage with communities living with or affected by HIV in their work.

More than one in three (37%) anticipated developing new projects or research or scaling up existing projects or programmes as a result of taking part in the conference. One in five (22%) expected that, as a result of attending IAS 2025, the work focus of their organization would change.

Impact on policy and programming

Key informants anticipated four major impacts of IAS 2025 on policy and programming. They agreed that IAS 2025 had generated a strong message that a rapid transition to domestic financing of national HIV programmes is an imperative for all countries to ensure future service continuity and preserve progress towards treatment and prevention targets. Key informants expected to see more comprehensive assessments of the impact of withdrawal of donor funding on testing, treatment and prevention outcomes at AIDS 2026, the 26th International AIDS Conference, as well as more detailed discussions about how a transition to domestic financing can be accomplished, especially for those countries that have suffered the greatest proportionate loss in donor funding.

Key informants observed that the conference had signalled a clear shift in thinking about the vulnerabilities inherent in parallel programmes at country level. They expected to see rapid moves to integrate standalone HIV programmes and services outside the public sector into national HIV programmes to protect service continuity and ensure country ownership of supply chains, data and monitoring systems, and technical support.

But the conference also raised concerns from communities regarding the appropriate configuration of services for key populations. Donor funding has been particularly important for establishing prevention services for key populations, and discussions at IAS 2025 highlighted the potential loss of focus on the needs of key populations if services are integrated into larger national programmes. Key informants anticipated that finding the appropriate balance between integration and specialization will prove challenging and that community monitoring and leadership will be essential for successful transition to country ownership of key population programming. IAS conferences will provide an important space for these evolving discussions and the sharing of experiences and outcomes of integration, key informants agreed.

Despite the challenges of funding withdrawal, key informants agreed that IAS 2025 had provided further impetus towards the adoption of long-acting PrEP through funding announcements, the release of new prevention guidance on the use of lenacapavir as long-acting PrEP and the presentation of further data on long-acting PrEP.

A total of 34% of survey respondents expected that participation in IAS 2025 would strengthen their advocacy or policy work. A similar proportion (33%) expected that they would use what they learnt at the conference to raise awareness among communities, policy makers and scientific leaders, and 22% would advocate for changes in government behaviour.

Have we achieved our objectives?

Objective 1: Highlight the latest advancements in HIV science, with a particular focus on showcasing the significant contributions of African scientists in addressing the epidemic on the continent most affected by HIV.

A total of 93% of conference delegates agreed that they learnt about HIV research designed and conducted on the African continent at IAS 2025; 68% agreed to a great extent and 25% to a moderate extent. Key informants drew attention to the wide range of research designed and carried out in Africa by African researchers and presented at IAS 2025, from HIV cure research to clinical trials and implementation studies. Survey respondents also commented on the importance of the conference for bringing together African research networks and fostering South-to-South collaboration. Respondents often commented that IAS 2025 stimulated their awareness of the need to build research capacity on the continent.

Key informants also highlighted the importance of new evidence provided by studies conducted in Africa for expanding potential treatment options for people with HIV on the continent, notably studies of long-acting injectable CAB/RPV in people with adherence challenges and a study comparing two-drug maintenance treatment with the standard of care for virally suppressed people with HIV.

"My take-home message is the emphasis on the need to strengthen African-led scientific innovations, clinical trials and infrastructure for HIV vaccine research and development."

Survey respondent

"HIV cure research is key and thriving in Africa, hence [the need] to explore areas to improve HIV cure research in my country."

Survey respondent

"There is high need to engage African researchers for ongoing research in an African context if aiming for a cure owing to the high genetic diversity of HIV in Africa."

Survey respondent

Objective 2: Establish a legacy of research, ranging from basic science to implementation science, that is responsive to the priorities of affected communities and led by those most impacted.

Overall, 89% of delegates agreed that this objective had been met; 89% of delegates reported increased knowledge of the research priorities of affected communities and 90% reported increased knowledge of the role of communities in leading research, including 60% who reported increased knowledge to a great extent.

Key informants and survey respondents were especially likely to highlight the role of communities in setting research priorities and carrying out research as a key feature of IAS 2025. Community concerns and messages were more visible at IAS 2025 than at previous conferences, several key informants commented. They also noted greater acknowledgement by researchers and programme implementers of the importance of the community in sustaining and leading the HIV response, a perception amply reflected in qualitative comments from delegate survey respondents.

Key informants working in research and policy roles valued the opportunity to hear from community members in discussions about the future of HIV services, especially regarding their concerns about the integration of key population services into national programmes and the impact of the politicization of gender and sexual identities on funding and service delivery. Integrating these perspectives into future research that assesses the impact of funding cuts and service reconfiguration on key populations will be critical for ensuring an equitable and efficient HIV response, key informants suggested.

"The solutions to shifting priorities remain at the community level. The power for advocacy and success will come from the grassroots. We have the tools for prevention that can end the epidemic but must ensure access to all regions occur. Attention to the African continent is critical as [it is] the region with the highest burden."

Survey respondent

"Having attended IAS 2023, you could clearly see that there was a difference. There was more of a community feel. The community really took up the space at this conference. At this IAS [conference], the sessions we had were sufficient for the community members to share and learn from one another and have their voices heard."

Key informant, community

"IAS 2025 made one thing clear: we are not going back to the 1990s. The days of silence, stigma and top-down approaches must remain in the past. Communities have proven time and again that they hold the key to ending the HIV/AIDS pandemic – through peer-led models, grassroots advocacy and trusted service delivery. But communities cannot do it alone. Governments must put communities at the centre – not just in words, but in action and funding. When we invest in community-led responses, we invest in equity, resilience and real impact. The fight against HIV will be won from the ground up."

Survey respondent

"Communities are important in the HIV response, and going forward, the implementation of science research or policy change should always prioritize them. I also believe strongly in the call to not erase whole communities like trans or gay men from the conversation and processes for the success of the HIV response."

Survey respondent

Objective 3: Accelerate innovation in basic and clinical science for person-centred precision medicine for HIV, encompassing research on reducing transmission, developing vaccines, understanding pathogenesis, managing co-infections and co-morbidities, addressing ageing-related issues, and advancing toward an HIV cure.

Overall, 91% of delegates agreed that this objective had been met. At IAS 2025, 90% of delegates reported that they obtained new knowledge about gaps in HIV cure or remission and vaccine research, while 93% of delegates reported that they obtained new knowledge about client-centred approaches to prevention, treatment and care, co-infections and co-morbidities (63% to a great extent).

Key informants drew attention to research presented at IAS 2025 on: the use of -omics in HIV cure research; the characterization of host and viral diversity in Africa for vaccine research; a potential weekly treatment regimen; easily scalable treatment for anal pre-cancer; and a potential monthly PrEP regimen for advancing person-centred treatment and prevention.

"Regardless of the field we are working in, we are all challenged to ask: How are we making our work more person-centred, more sustainable, and more responsive to the realities on the ground? If we take even a few of these lessons forward, we move closer to health equity – and we do so together."

Survey respondent

"No matter how good the drugs are, reaching clients is the priority. Finding ways to demedicalize prevention and treatment is the only way we will sustain the response. With increasing pressure on facilities, and repeated evidence showing that clients don't want to go to facilities, decentralized care for stable [clients] is critical to both HIV and other service areas."

Survey respondent

Objective 4: Strengthen HIV prevention research to optimize cost-effective biomedical, behavioural and structural interventions, with a focus on identifying and overcoming implementation challenges, dismantling system barriers, and scaling successful prevention strategies in practice.

A total of 91% of survey respondents agreed that this objective had been met, including 92% of delegates who reported an increased understanding of implementation challenges and systems barriers for HIV prevention (63% to a great extent, 29% to a moderate extent); 88% reported that they obtained new knowledge about conditions for successful replication of HIV prevention interventions (49% to a great extent, 39% to a moderate extent) and 88% reported that they obtained new knowledge about gaps in biomedical, behavioural and structural HIV prevention interventions (48% to a great extent, 40% to a moderate extent).

A majority (58%) of survey respondents reported that they gained a lot of information about new prevention products and approaches at IAS 2025, while 49% said they gained a lot of information about prevention programme implementation and 44% said they gained a lot of information about structural barriers (including criminalization, legal barriers, policy, human rights, gender inequality and gender-based violence).

"The successful introduction of new products requires meaningful community engagement in programme design, implementation and monitoring. Product innovation must be matched by innovative and differentiated delivery models."

Survey respondent

"My take-home message from IAS 2025 is that ending the HIV epidemic requires more than innovation – it demands equity, resilience and community leadership. Scientific breakthroughs like lenacapavir and CAB-LA are promising, but without inclusive systems, sustainable funding and meaningful engagement of people living with HIV, progress will stall. We must act differently – implement locally, invest in systems, and centre the voices of communities most affected."

Survey respondent

Objective 5: Promote interdisciplinary collaboration across biomedical, clinical, social and implementation sciences to improve HIV outcomes across all life stages, with a strong focus on translating research findings into actionable policies and practices.

Overall, 73% of survey respondents agreed that this objective had been met; 82% reported that they obtained new knowledge about how to translate research outcomes into policy and practice for low- and middle-income countries and key populations (42% to a great extent, 40% to a moderate extent). A total of 65% of delegates attending the conference reported that they were satisfied with opportunities provided to network (33% strongly agree, 32% agree), and 61% planned to identify new options for partnerships or strengthen existing partnerships.

Key informants highlighted several research presentations at IAS 2025 that have the potential to affect policy and practice. The IMPALA study showed that long-acting injectable CAB/RPV is an effective regimen for people with adherence challenges on the African continent; these findings should encourage review of treatment guidelines, key informants agreed. Further data on the safety of cabotegravir in pregnancy should provide reassurance on its use in treatment and prevention.

"My take-home message from IAS 2025 is the urgent need for inclusive, youth-centred and community-driven approaches in the HIV response. Innovation, equity and collaboration are key to ending the AIDS pandemic. Meaningful involvement of affected populations, especially young people, must be prioritized in research, policy and programme design to ensure sustainable impact and lasting change."

Survey respondent

"IAS 2025 has not only enriched my knowledge but reignited my purpose to bring evidence into meaningful action. [...] Most importantly, it has made me ready to forge new partnerships and deepen existing ones because real impact is not inherently individualistic but collective, and change begins when knowledge moves in scalable way."

Survey respondent

"All the work we're doing is for the community – if our research doesn't get translated into real world actions – becomes useless."

Survey respondent

"Progress in the HIV response cannot happen in isolation. It demands true collaboration – between community activists, researchers, healthcare workers, affected individuals and policy makers – toward one shared goal: improving the quality of life for all people living with HIV and ending HIV transmission and AIDS-related deaths. While 2025 has tested our resolve, we will not move backward. Our commitment remains firm: to advance work that is rooted in social justice and led by the communities most impacted."

Survey respondent

How can we do better next time?

Greater focus on U=U

Some survey respondents and key informants felt that the message, "undetectable=untransmittable" (U=U), had not been given sufficient prominence at IAS 2025 and appealed for a higher profile at future conferences.

"My take-home message from IAS 2025 is that without U=U on the mainstage, we are not telling the full story. This science must be at the heart of every conversation about HIV testing, treatment and prevention. Community made sure U=U showed up in Kigali, but institutional leadership did not. As we look to AIDS 2026 and the 10-year anniversary of U=U, the call is clear. U=U is not optional. It is essential."

Survey respondent

Ageing and HIV

Delegates would like to see greater attention at future IAS conferences to person-centred care in older people living with HIV. Survey respondents identified a broad range of topics related to ageing with HIV that they wanted to learn more about, including menopause, management of cardiovascular disease and metabolic syndrome, and optimizing geriatric care. Delegates also wanted to learn more about neurocognitive disorders in older people living with HIV and future models of care.

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