



Asia-Pacific  
Economic Cooperation

APEC Health Working Group

# APEC Action Plan to End the HIV Epidemic (2026–2031): **Six Policy Pillars for Action**

# APEC Action Plan to End the HIV Epidemic (2026–2031)

APEC economies have committed to ending HIV as a public health threat by 2030, aligned with the UNAIDS 95-95-95 targets and the UN goal of reducing new HIV infections by 90%. Despite major scientific progress, the region is not yet on track: infections are still rising in some economies, prevention coverage remains uneven, and gaps persist across testing, treatment, and long-term care. At the same time, new diagnostics, treatment options, and prevention tools mean the epidemic can be controlled if economies act with greater coordination and urgency.

This Action Plan provides a practical framework for action across six interdependent pillars. Together, these pillars address leadership, policy reform, prevention, testing, treatment, innovation, and financing. The message for the deck is simple: technical solutions exist, but stronger policy, better systems, and sustainable implementation are needed to turn them into population-level impact.

# Pillar 1: Foster Political Commitment, Multisectoral Collaboration & Sustainable Domestic Funding

## Context

Political deprioritization and limited stakeholder awareness and collaboration across sectors have weakened momentum toward the 2030 goals, leading to limited policy attention and constrained domestic funding. Core dimensions of this barrier include persistent perceptions that HIV is no longer a public health priority; insufficient awareness and coordination across non-health sectors, including finance, education, justice, and religious institutions; and declining support for community organizations, civil society, and networks of PLHIV. Stigma and discrimination compound these challenges by making political decision-making and resource allocation for HIV politically sensitive and less visible. At the same time, insufficient and unsustainable domestic HIV funding and dependence on external funds continue to undermine the long-term effectiveness and scalability of HIV responses. Many economies lack stable domestic financing mechanisms or dedicated budget lines for HIV, leaving prevention, testing, and community-based programs vulnerable to political and fiscal shifts. Over-reliance on international donors, especially for prevention services, creates structural fragility when external funding declines or transitions, as it has recently. Spending also remains misaligned with epidemiological realities, with insufficient allocation toward high-impact interventions such as HIV prevention (e.g., PrEP), treatment adherence support, and community outreach. Limited use of social contracting to fund NGOs further constrains program delivery. Underlying these issues is a persistent lack of awareness of the return on investment that well-targeted HIV funding delivers in terms of long-term cost savings, productivity, and health system resilience.

Target	Indicator
<p><b>Target 1.1:</b> By 2031, all APEC economies adopt and fund a domestic strategy to end the HIV epidemic, either standalone or within an integrated health strategy</p>	<p><b>Indicator 1.1.1:</b> Number of APEC economies with a current domestic HIV/AIDS strategy, aligned with UNAIDS and UNGA goals, that outlines strategic priorities and targets .</p>
<p><b>Target 1.2:</b> By 2031, APEC economies strengthen sustainable HIV financing and reduce reliance on external funding</p>	<p><b>Indicator 1.2.1:</b> Number of APEC economies where domestic public expenditure constitutes the majority of total HIV spending</p>

# Pillar 1: Foster Political Commitment, Multisectoral Collaboration & Sustainable Domestic Funding

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation.

1. Develop or update a multisectoral domestic HIV strategy endorsed at ministerial level, with participation from relevant ministries and agencies (including health, finance, labor, education, and social protection), with measurable and time-bound targets, and with transparent costing and articulation of expected health and economic returns.
2. Establish or strengthen domestic HIV coordination mechanisms (e.g., coordination councils or equivalent entities) to enable regular multisectoral and interministerial coordination and annual progress reviews, with meaningful engagement of civil society, youth, and high-risk populations, in accordance with economies' domestic practices and legislation.
3. Where appropriate, establish or strengthen enabling policy, legal, and procurement frameworks that allow domestic funding of NGOs and community-led service providers to deliver HIV prevention, testing, linkage, and treatment-support services (e.g., through social contracting or comparable mechanisms).
4. Invest in robust and sustainable HIV-related information systems, including standardized data collection and interoperable digital tools and forms, to support planning, service delivery, monitoring, and timely course correction.
5. Where appropriate and in accordance with economies' domestic practices and legislation:
  - Adopt program-based budgeting and performance monitoring for HIV, including periodic reviews of allocative efficiency to direct resources toward high-impact interventions aligned to epidemiology.
  - Establish and monitor spending benchmarks (including for services for high-risk populations and community-led services, where appropriate).
  - Report on the domestic share of HIV expenditure and allocation efficiency.
  - Implement budgeting safeguards (e.g., protected program codes or contingency lines) for essential commodities (ART, viral load reagents, PrEP, PEP) to reduce vulnerability to fiscal shocks and emergencies.
6. Where appropriate, explore matched private co-financing, development impact bonds, or outcomes-based payment models tied to verified prevention and viral suppression results, with public stewardship and value-for-money safeguards, in accordance with economies' domestic practices and legislation.



# Pillar 2: Address Legal & Policy Barriers to Access to HIV Services

## Context

Legal, policy, and administrative environments can influence access to HIV prevention, testing, and treatment services across APEC economies. In some contexts, certain regulatory or procedural requirements may affect individuals' willingness or ability to seek services, particularly among high-risk populations. These factors may include consent requirements, confidentiality provisions, service authorization rules, residency or documentation requirements, reporting obligations, and limitations on certain service delivery models. Where such factors reduce timely access to services or continuity of care, they can have implications for prevention effectiveness, testing uptake, treatment initiation and retention, and viral suppression. Addressing these issues involves voluntary, economy-led consideration of how existing frameworks interact with public health objectives and how access to HIV services can be strengthened in ways that are consistent with domestic legislation, governance, and contexts.

Target	Indicator
<b>Target 2.1:</b> By 2031, all APEC economies address legal or policy provisions that restrict access to HIV prevention, testing, or treatment services.	<b>Indicator 2.1.1:</b> Number of APEC economies with comprehensive, non-discrimination protections covering high-risk populations

# Pillar 2: Address Legal & Policy Barriers to Access to HIV Services

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation.

1. Encourage periodic, economy-led reviews of laws, policies, and administrative requirements that may affect access to HIV prevention, testing, or treatment services for high-risk populations, with a view to identifying opportunities to better align public health objectives and HIV outcomes, consistent with domestic legislation.
2. Where appropriate and consistent with domestic legislation and practices, consider clarifying or operationalizing age-related consent provisions to facilitate confidential access to HIV testing and prevention services (including PrEP), in accordance with public health objectives.
3. Where consistent with domestic regulatory frameworks, review and address policy or regulatory factors that may limit the implementation of evidence-based HIV service delivery models, including opt-out testing and expanded service delivery through primary care or community-based settings, particularly for remote or underserved populations.
4. Where feasible, establish or strengthen domestic mechanisms to monitor factors affecting access to HIV services, aligned with existing domestic frameworks and priorities, to support evidence-informed policy dialogue and peer learning.
5. Where epidemiologically relevant and consistent with economies' domestic frameworks and legislation, consider evidence-informed public health measures to reduce HIV transmission in the context of substance use disorder treatment services, as part of comprehensive HIV prevention strategies.

# Pillar 3: Expand Access to PrEP & Other HIV Prevention Tools

## Context

Limited access to and underutilization of HIV prevention tools such as PrEP within healthcare continue to sustain HIV transmission across the region, particularly among high-risk populations. Inconsistent delivery and availability of PrEP services, coupled with narrow eligibility criteria, restrict access for those at substantial risk. Inadequate access to timely STI diagnostic tools weakens prevention efforts and delays linkage to care. Declining investment in condom promotion and behavioral interventions has also eroded earlier gains in prevention. Gaps in access to prevention-relevant vaccines, including hepatitis B and monkeypox, particularly among high-risk populations, compound these challenges.

Target	Indicator
<b>Target 3.1:</b> By 2031, all APEC economies have $\geq 50\%$ of people at substantial risk of HIV infection using ARV-based pre-exposure prophylaxis (oral or long-acting) as part of a combination prevention package.	<b>Indicator 3.1.1:</b> Number of APEC economies with an adopted domestic policy recommending ARV-based PrEP for high-risk populations.

# Pillar 3: Expand Access to PrEP & Other HIV Prevention Tools

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation.

1. Establish or update domestic PrEP guidelines to expand evidence-based eligibility criteria and include recommendations for both oral and long-acting PrEP for people at substantial risk, regardless of sex, age, or serodiscordance (partner) status.
2. Strengthen provider capacity and scale PrEP and PEP delivery within approved settings, with integration into telehealth, primary care, health services for TB and hepatitis, and other healthcare settings.
3. Invest in condom and lubricant availability and associated education and outreach, particularly for high-risk populations where incidence is concentrated.
4. Implement targeted and mass-media educational campaigns (including via social media), endorsed by relevant authorities where feasible, to promote accurate, evidence-based information on HIV prevention and healthy behaviors; reduce stigma; and normalize HIV prevention tools among high-risk groups, including U=U messaging where appropriate, tailored to domestic epidemiology and contexts.
5. Introduce or expand differentiated prevention models in partnership with community-based organizations serving migrant and mobile populations, including rapid access to PEP and pathways to PrEP initiation and continuation, adapted to mobility patterns and service access barriers.
6. Reduce stigma and discriminatory practices in healthcare settings and strengthen provider competence for combination prevention by implementing routine training on non-discriminatory, person-centered care and culturally competent service delivery, especially but not only for high-risk populations, alongside mechanisms to identify and address discriminatory practices within healthcare.

# Pillar 4: Improve HIV Testing Coverage & Strengthen Linkage to Care

## Context

Late diagnosis and weak linkage systems continue to undermine progress toward the 2030 goals across the region. Access to testing remains uneven due to limited service availability, user fees, regulatory barriers, and persistent stigma, including stigmatizing attitudes and discriminatory practices within healthcare settings, especially but not only for high-risk populations. HIV self-testing, community testing, and opt-out testing in routine healthcare settings remain underused despite strong evidence of impact, in part because services are not consistently perceived as confidential, safe, and free of stigma. Fragmented referral systems, long wait times, and limited digital tools contribute to loss to follow-up between diagnosis and treatment. Strengthening policies, integrating testing into routine care, expanding differentiated testing models, and establishing rapid, simplified linkage pathways, including same-day ART, are essential to reducing missed diagnoses and achieving improved outcomes across the region, even in economies with high viral load suppression or linkage rates.

Target	Indicator
<b>Target 4.1:</b> By 2031, all APEC economies have $\geq 95\%$ of people living with HIV know their HIV status.	<b>Indicator 4.1.1:</b> Number of APEC economies with a domestic policy permitting HIV self-testing or community-based testing as part of a domestic testing strategy
<b>Target 4.2:</b> By 2031, all APEC economies ensure that $\geq 95\%$ of people with HIV are diagnosed and $\geq 95\%$ are successfully linked to care and HIV treatment.	<b>Indicator 4.2.1:</b> Number of APEC economies with a domestic policy or strategy that establishes formal linkage mechanisms between HIV testing, counselling, and enrollment in care

# Pillar 4: Improve HIV Testing Coverage & Strengthen Linkage to Care

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation

1. Support and scale community- and lay-provider testing models, including mobile outreach, workplace testing, and peer-led approaches (including mobile brigades), and facilitate HIV self-testing with distribution through public procurement, pharmacies, and NGOs, ensuring clear and rapid linkage-to-care pathways for reactive results, particularly for high-risk populations and underserved areas.
2. Integrate opt-out, opportunistic HIV testing into routine clinical settings, especially in higher-prevalence areas and high-yield services (e.g., emergency departments, inpatient admissions, STI services, and TB services), consistent with domestic policies permitting or normalizing opt-out testing in healthcare facilities.
3. Leverage electronic medical records and other digital tools to automate testing prompts, capture results, and enable timely referrals and follow-up (including electronic referrals, SMS follow-up, or app-based navigation), with appropriate confidentiality and data protection safeguards, to reduce missed testing opportunities and loss to follow-up.
4. Introduce or expand case managers and/or peer navigators to guide newly diagnosed individuals into care and support early retention, particularly for youth and mobile populations.
5. Integrate HIV testing into antenatal care (including repeat testing later in pregnancy and postpartum where epidemiologically indicated, and partner testing and linkage as appropriate) and establish linkage-to-care and treatment navigation in prisons and other closed settings, including continuity during transfers and pre-release linkage to community HIV services.

# Pillar 5: Enable Prompt HIV Treatment Initiation, Retention & Minimize Resistance

## Context

Delays initiating HIV treatment and gaps in long-term retention continue to hinder progress toward viral suppression across the region. Many people newly diagnosed with HIV do not begin ART promptly because same-day or rapid-start protocols, defined as treatment initiation within seven days of diagnosis, are not consistently implemented. Limited clinic hours, long wait times, health worker shortages, and transportation barriers further restrict access, particularly for people living in rural or underserved areas. Stigma, fear of disclosure, and insufficient psychosocial and peer support also discourage individuals from returning for follow-up care. Weak health information systems reduce the ability to track missed appointments and re-engage people who fall out of care, and inconsistent access to routine viral load testing and drug-resistance surveillance delays the identification of treatment failure. Genotypic resistance testing is recommended in certain clinical situations, such as acute infection, pregnancy, or suspected resistance, but treatment should still begin immediately, without waiting for test results, when a person is ready to start ART. Strengthening treatment outcomes, therefore, requires expanding differentiated service delivery and patient-centered care models that address quality of life, ageing with HIV, and the needs of disproportionately affected communities. Widening the range of service delivery platforms, including community-based settings, alongside enhanced psychosocial support, can help improve retention and continuity of care across populations.

Target	Indicator
<b>Target 5.1:</b> By 2031, all APEC economies have at least 95% of people living with HIV on ART and achieving viral suppression, supported by timely initiation and effective retention in care	<b>Indicator 5.1.1:</b> Number of APEC economies in which at least 95% of people living with HIV are receiving ART
	<b>Indicator 5.1.2:</b> Number of APEC economies in which at least 95% of people living with HIV have suppressed viral loads
	<b>Indicator 5.1.3:</b> Number of APEC economies that have adopted guidelines on rapid initiation of ART within 7 days of diagnosis

# Pillar 5: Enable Prompt HIV Treatment Initiation, Retention & Minimize Resistance

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation.

1. Adopt and implement Treat All policies, including same-day or rapid ART initiation, and update treatment readiness criteria to remove unnecessary clinical or administrative delays (e.g., reliance on CD4 thresholds), while supporting initiation based on individual readiness and capacity for adherence.
2. Optimize ART delivery through differentiated, integrated, and decentralized care:
  - Expand ART provision through differentiated service delivery models, including primary care, community-based, and home delivery.
  - Advance universal access to simplified ART regimens with high resistance barriers and multi-month dispensing for stable patients.
  - Integrate ART services with TB, STI, viral hepatitis, vaccination, mental health, and NCD care.
  - Deploy decentralized or point-of-care diagnostic and clinical protocols to reduce delays from diagnosis to treatment, particularly in high-prevalence or underserved areas.
3. Ensure all people on ART have access to routine viral load monitoring without financial or administrative barriers and establish or strengthen HIV drug resistance monitoring systems to guide clinical decision-making and protect long-term treatment efficacy.
4. Strengthen adherence and retention through combined patient-support approaches, including peer navigators and lay health workers, psychosocial and mental health support, education for people and providers on U=U and treatment durability, and use of digital tools (e.g., SMS reminders, mobile applications, electronic patient records) to track continuity of care and re-engage individuals lost to follow-up.
5. Build provider capacity and improve quality of care through advanced training on stigma reduction, patient-centered, and differentiated service delivery, and through implementation of youth-friendly, and migrant-sensitive care models, adapted to domestic contexts.

# Pillar 6: Strengthen Regulatory & Reimbursement Pathways for Long-Acting HIV Prevention, Testing & Treatment Innovation

## Context

Regulatory & reimbursement barriers for long-acting HIV prevention, testing, and treatment innovation continue to delay or restrict access to innovative HIV tools. While new technologies offer substantial potential to transform the HIV response, they often face slow and fragmented approval pathways. Many economies make limited use of fast-track regulatory mechanisms, reliance models, or regional joint review processes, resulting in duplicative and lengthy reviews. Even after approval, delays in coverage and reimbursement decisions persist, particularly where HTA capacity is limited or narrowly focused on short-term cost rather than long-term public health impact. Inclusion of new products in domestic formularies and procurement systems is often slow or incomplete, and integration into insurance schemes remains inconsistent.

Target	Indicator
<b>Target 6.1:</b> By 2031, all APEC economies include HIV medicines and essential diagnostics within public insurance and benefit packages so that financial barriers do not limit access to innovation	<b>Indicator 6.1.1:</b> Number of APEC economies where HIV medicines (including long-acting PrEP) have been granted market entry approval by economy-level regulatory authorities
	<b>Indicator 6.1.2:</b> Number of APEC economies where HIV medicines, including oral and long-acting PrEP, are covered under public insurance schemes

# Pillar 6: Strengthen Regulatory & Reimbursement Pathways for Long-Acting HIV Prevention, Testing & Treatment Innovation

## Recommended actions:

Customize actions to local context, system capacity, and in accordance with economies' domestic legislation.

1. Streamline regulatory approval processes for long-acting and other innovative HIV prevention, testing, and treatment technologies:
  - Adopt or align with international regulatory standards.
  - Strengthen regional regulatory reliance, recognition, and information- and work-sharing mechanisms.
  - Implement accelerated or adaptive approval pathways for priority HIV innovations.
  - Where appropriate, support pilot or demonstration programs (e.g., for PrEP) to generate local evidence on feasibility, acceptability, and impact to inform regulatory and policy decisions.
2. Strengthen collaboration and information exchange between regulatory, HTA, reimbursement, and payer authorities to reduce delays between market authorization and coverage decisions, including through coordinated review processes and fast-track reimbursement pathways for priority HIV products.
3. Strengthen public and/or private coverage and payment alignment for HIV services:
  - Where appropriate, ensure that essential HIV services are explicitly covered under public insurance or other benefit packages, with out-of-pocket costs minimized.
  - Align HIV budget execution with public and private payment mechanisms.
  - Remove patient fees for essential laboratory services.
4. Develop or update domestic value assessment and pricing frameworks to incorporate broader value considerations (e.g., through multi-criteria decision analysis) and ensure timely inclusion of digital health tools and diagnostic innovations in essential diagnostics lists, procurement systems, and service delivery plans.

