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Issues Paper: Ending the HIV Epidemic in APEC Economies

(HWG/01/2025S)

APEC Health Working Group Self-Funded Project: "Accelerating Progress Toward the 95-95-95 HIV/AIDS Targets Across APEC Economies in Pursuit of Universal Health Coverage"

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Executive Summary

HIV remains a major public health challenge across APEC. An estimated 7 million people are living with HIV, and APEC economies account for about one-quarter of global new infections. Epidemics are concentrated among MSM, sex workers, PWID, and their partners, with young people disproportionately affected. All APEC governments endorse the 2030 goal of ending AIDS and the interim UNAIDS 95-95-95 and 10-10-10 targets, yet regional progress is off-track, with incidence declining too slowly and rising in some settings. Most economies have domestic plans and strategies aligned to 2030 goals, but implementation is uneven.

APEC economies face seven major barriers to progress toward the 2030 goals:

1. 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 widespread misconceptions that HIV is already under control; competition for attention and investment with other health priorities such as COVID-19 and NCDs; 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.

2. Restrictive laws and policies that conflict with public health evidence and objectives undermine the effectiveness of HIV responses across the region. These laws and policies discourage individuals, especially those from key populations, from seeking prevention, testing, or treatment services, and they weaken public trust in health institutions. The dimensions of this barrier include the criminalization of same-sex relations, sex work, and drug use; restrictive age-of-consent laws that limit access to HIV testing and PrEP for adolescents and young people; residency or identity requirements that exclude migrants and undocumented individuals from care; mandatory registration of HIV status or reporting of key populations to authorities; and prohibitions on NSPs, opioid substitution therapy, and community-based prevention.

3. Limited access to and underutilization of PrEP, harm reduction, and other HIV prevention tools continue to sustain HIV transmission across the region, particularly among key populations. This barrier is characterized by limited awareness and persistent stigma that suppress demand for PrEP among both clients and providers; inconsistent public-sector delivery and availability of PrEP services; and narrow or exclusionary eligibility criteria that restrict access based on gender, age, or partner status. At the same time, declining investment in condom promotion and behavioral interventions has eroded earlier gains in prevention, while coverage of harm reduction measures such as NSPs and opioid substitution therapy remains well below recommended levels.

4. Inadequate HIV testing coverage and weak linkage to care continue to delay diagnosis and disrupt the continuum of care, resulting in missed opportunities for early treatment initiation and viral suppression. Testing services are limited in number, geography, or hours of operation, and in some cases, fees remain a barrier to access. Stigma and fear of discrimination discourage individuals, particularly those from key populations, from seeking testing or returning for results. HIV self-testing and routine opt-out testing in healthcare settings remain underutilized, and confirmatory testing procedures are frequently cumbersome. Fragmented referral and intake systems, including inefficient registration and case management processes, further weaken linkage to care.

5. Delays in HIV treatment initiation and challenges to treatment retention continue to limit progress toward viral suppression and long-term treatment success. People newly diagnosed with HIV experience delays in beginning ART due to the absence of same-day or rapid-start protocols. Health workforce shortages, long wait times, and limited service hours or geographic coverage further reduce accessibility, particularly for people living in rural areas or without stable transportation. Stigma and fear of disclosure combined with inadequate peer support, psychosocial counseling, and community engagement discourage ongoing engagement in care.

Weak health information systems impede the ability to track missed appointments and proactively re-engage patients, while inconsistent access to routine viral load testing and drug resistance surveillance prevents timely identification of treatment failure.

6. 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 UHC and insurance schemes remains inconsistent.

7. 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 and key population services, creates structural fragility when external funding declines or transitions as it has been recently. Spending also remains misaligned with epidemiological realities, with insufficient allocation toward high-impact interventions such as PrEP, harm reduction, 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.

The analysis presented in this paper underscores that while APEC economies have made meaningful progress toward the global 2030 goals, these gains remain fragile and uneven. This Issues Paper provides the contextual foundation for the forthcoming *APEC Action Plan to End the HIV Epidemic*, which will translate these findings into practical, actionable recommendations for governments, industry, academia, civil society, and PLHIV. By working together through the APEC platform, economies can accelerate progress toward the 2030 goals and realize a shared vision of ending HIV as a public health threat by 2030.

Select Abbreviations

AIDS: acquired immunodeficiency syndrome
APEC: Asia-Pacific Economic Cooperation
ART: antiretroviral therapy
COVID-19: coronavirus disease 2019
HIV: human immunodeficiency virus
HIVST: HIV self-testing
HWG: APEC Health Working Group
MSM: men who have sex with men
NGO: non-governmental organization
NSP: needle and syringe program (also known as needle exchange program)
PLHIV: people living with HIV
PrEP: pre-exposure prophylaxis
PWID: people who inject drugs
UHC: universal health coverage
UN: United Nations

Methodology

The Issues Paper was developed through a structured, multi-phase and multi-stakeholder process as part of the APEC Health Working Group (HWG) Self-Funded Project, "Accelerating Progress Toward the 95-95-95 HIV/AIDS Targets Across APEC Economies in Pursuit of UHC" (HWG/01/2025S), which is sponsored by Chile; co-sponsored by Japan, Peru, Singapore, Chinese Taipei, and Thailand; and overseen by Dr. Leonardo Chanqueo Cornejo (Ministry of Health, Chile) and Dr. Rafael Araos Bralic (Universidad del Desarrollo, Chile).

1. Desk research: From February to April 2025, a comprehensive review of epidemiological data, policy documents, and regional and global reports (including UNAIDS, WHO, and Georgetown University HIV Policy Lab data) was undertaken to map the HIV landscape across APEC economies and identify progress, gaps, and barriers to achieving the 95-95-95 and 90% incidence-reduction targets.

2. Expert consultations: From May to August 2025, written inputs were collected from members of the APEC HIV Experts Network including HWG-nominated policymakers, academics, clinicians, people living with HIV (PLHIV), industry leaders, civil society representatives from across APEC economies.

3. APEC engagement: Preliminary findings were presented for feedback at the 1st APEC Policy Dialogue to End the HIV Epidemic on 5 August 2025 in Incheon, Korea, and at the APEC HWG Meeting on 8 August 2025 in Incheon, Korea. Input from these engagements was incorporated into the paper.

4. Final drafting: From September to October 2025, the final draft was prepared in collaboration with the Project Overseers, incorporating input and feedback from all previous phases and from a diversity of stakeholders.

Note

Throughout this paper, data are drawn from both the APEC and UNAIDS Asia-Pacific regional groupings. While these regions overlap substantially, they are not identical. Where regional HIV data are cited, they reflect either the "Asia-Pacific region" (UNAIDS) or the APEC region. APEC regional data was compiled from individual economy data or extrapolated from UNAIDS Asia-Pacific regional data.

Introduction

All APEC member economies have committed to the United Nations (UN) Sustainable Development Goals (SDGs), which include ending Human Immunodeficiency Virus (HIV) as a public health threat by 2030. In support of the UN SDGs, UNAIDS set interim "95-95-95" targets for 2030: 95% of people living with HIV (PLHIV) know their status, 95% of those diagnosed receive antiretroviral therapy (ART), and 95% of those on ART achieve viral suppression. A fourth "95" target was later added to provide effective HIV combination prevention options to 95% of all people at risk of acquiring HIV. Complementary "10-10-10" targets call for addressing social barriers to ending the HIV epidemic: less than 10% of economies have punitive laws that limit access to services, less than 10% of people living with HIV experience stigma and discrimination, and less than 10% of women, girls, and other key populations experience gender inequality and violence. Achieving these targets would also put APEC economies on course to achieve the 2014 UN General Assembly goal of reducing HIV incidence by 90% by 2030. Modeling shows that reaching the 95-95-95 and related targets would reduce new infections and AIDS-related deaths and yield large social and economic returns. Every 10% increase in HIV prevalence may correspond to a 0.14% decrease in gross domestic product (GDP).[1]

Despite clear targets, the benefits of meeting them, and decades of progress, HIV remains a major public health challenge across APEC economies. The APEC region is home to an estimated 7 million PLHIV, constituting the largest epidemic outside sub-Saharan Africa.[2] APEC economies account for about 25% of new HIV infections globally.[3] Most new infections are concentrated among key populations, including men who have sex with men (MSM), transgender people, sex workers, people who inject drugs (PWID), and their partners, and particularly young people in these populations.[4] In fact, more than 25% of new diagnoses in APEC economies occur among those aged 15-24 years.[5] Many economies have reduced AIDS-related mortality, some by more than 50% since 2010, but overall incidence is falling too slowly and is rising in some settings.[6] Most APEC economies have seen only a modest decline in new infections since 2010, while some are experiencing rapidly growing epidemics.[7] In some economies, HIV has fallen off the political agenda, reducing existing resource allocation or limiting new investments that are needed. The COVID-19 pandemic further disrupted services and diverted attention. Recent global analyses indicate that even in higher-income economies the pace and scale of domestic responses remain insufficient to end HIV as a public health threat by 2030.[8] Without renewed political commitment, APEC economies risk a widespread resurgence of HIV and will fail to meet the 2030 goals[i]. Governments need to re-prioritize HIV now.

Biomedical innovation has driven much of the progress to date. Advances in diagnostics, simplified ART regimens and long-acting formulations, and prevention tools such as pre-exposure prophylaxis (PrEP) have transformed HIV from a fatal disease to a manageable chronic condition and made epidemic control increasingly achievable. Scientific progress alone, however, is insufficient. Timely and equitable access across all APEC economies remains essential. Gaps in access to new technologies and sub-optimal service delivery hinder progress toward better outcomes, particularly among key populations and in resource-constrained settings. Policy, regulatory, and financing strategies that support research and innovation and expand access to testing, prevention, treatment, and long-term care have not been prioritized even though they are critical to realizing the full potential of biomedical advances and to accelerating progress toward the 2030 goals.

This ***APEC Issues Paper to End the HIV Epidemic*** summarizes the regional HIV landscape, including epidemiological trends, key populations, domestic strategies, and past progress in APEC economies. It then analyzes major barriers to meeting the 2030 goals and ending HIV as a public health threat, including gaps in stakeholder awareness and political prioritization, public policy and legal barriers, prevention, testing and linkage to care, access to innovation, treatment initiation, and retention, and financing and sustainability. The paper is intended to inform and complement the *APEC Action Plan to End the HIV Epidemic* (forthcoming).

[i] "2030 goals" is used throughout the paper to refer to the UN SDG for HIV, UNAIDS 95-95-95-95 and 10-10-10 targets, and 2014 UN General Assembly goal collectively.

Landscape of HIV in APEC

Epidemiological Trends

The HIV epidemics across APEC economies are heterogeneous, spanning mature epidemics in some parts of the Americas and Asia and concentrated outbreaks in other parts of Asia.[9] The UNAIDS Asia-Pacific region recorded about 300,000 new HIV infections in 2023, a level that approaches the UNAIDS target of fewer than 370,000 new infections *globally* by 2025 and underscores how far the region remains from reduction goals.[10] Regional trends show a slow overall decline, with wide variation by economy and population. Since 2010, the Asia-Pacific region achieved only a 13% reduction in annual new infections, and several APEC economies are facing stagnating or rising HIV incidence.[11] For example, epidemics are expanding in Papua New Guinea[12] and the Philippines,[13] particularly among MSM and partners of key populations. According to local modelling, Mexico may have more than 18,000 new infections in 2024, with 30% of new diagnoses occurring at the AIDS stage.[14] On the other hand, Canada[15] and New Zealand[16] have expanded treatment coverage to over 80% of PLHIV and reduced AIDS-related mortality, and Chinese Taipei[17] reported 91-96-96 against the 95-95-95 targets in 2023. While not an exhaustive accounting of trends, each of the 21 APEC economies has unique HIV epidemiology with a wide margin between the bottom and top performers.

Key Affected Populations

Across most APEC economies, HIV is concentrated in specific populations rather than the general population. UNAIDS estimates that 79% of new infections in the Asia-Pacific region occur among key populations (i.e., MSM, transgender people, sex workers, and PWID, and their partners).[18] In most economies, MSM and PWID account for most new infections.[19] MSM are a primary risk group in many urban settings.[20] PWID also face high risk, with median HIV prevalence around 7.5% in UNAIDS Asia-Pacific economies reporting data (versus 0.2% in the general adult population).[21] Young people within key populations are also increasingly affected: more than 25% of new infections in the region are among those aged 15-24, mostly young MSM or transgender youth.[22] Adolescent girls and young women account for a smaller but notable share of new infections in some economies, typically linked to transactional sex or intimate partner transmission.[23] Migrant workers face heightened vulnerability due to structural, legal, and social barriers that limit access to prevention, testing, and treatment and disrupt continuity of care.[24] The challenge is not identifying who is most affected, but rather consistently reaching these groups with effective services.

Domestic HIV Strategies

Most APEC economies have recently updated HIV strategies and plans to align with the 2030 goals and have embraced and committed to the UNAIDS targets to scale up prevention, testing, and treatment (*see Table 1 on page 6*). Still, a few economies have a strategy, though targets are not yet fully aligned with 2030 goals. Regional collaborations, such as ASEAN's 2021 Declaration to Ending AIDS, reinforce these economy-level commitments.[25] Common themes in domestic plans and strategies in APEC economies include a focus on key populations, service integration (e.g., tuberculosis or sexually transmitted infection services), and stigma and social barriers.[26] At the same time, the plans and strategies vary widely in specificity and maturity of implementation. While they are critical tools, they have not fully translated into full or consistent implementation or positive results for many economies.

Progress Toward 2030 HIV Goals

APEC's progress toward the 2030 goals is mixed and off-track overall. In the UNAIDS Asia-Pacific region in 2024, an estimated 79% of PLHIV knew their status, 69% were on ART, and 66% had suppressed viral load.[27] Some economies are near the targets, while others lag substantially. In at least eight APEC economies, fewer than half of PLHIV are on treatment, reflecting gaps in diagnosis and retention.[28] Viral suppression is especially low where second-line ART and routine viral load testing are limited. The scale up of prevention tools and

services is also lagging with regional PrEP coverage below 3% and with only 195,000 people in the UNAIDS Asia-Pacific region ever having used PrEP in 2023, against a target of 8.2 million by 2025.[29] Condom use trends vary, and needle and syringe programs (NSPs) reach a minority of PWID in many settings.[30] For the APEC region, it seems gains in treatment coverage have been offset by persistent or widening gaps in testing, prevention, and service quality.

Table 1. Domestic HIV strategies and plans in APEC economies

APEC Economy	Plan	Years
Australia	9th National HIV Strategy[31]	2024-2030
Brunei Darussalam	-	-
Canada	HIV/AIDS and STBBI Strategic Plan[32]	2022-2027
Chile	National Plan for the Prevention & Control of HIV/AIDS & STIs[33]	2021-2022
P.R. China	Plan for the Prevention & Control of HIV/AIDS[34]	2024-2030
Hong Kong, China	Recommended HIV/AIDS Strategies[35]	2022-2027
Indonesia	National Action Plan for Prevention & Control of HIV/AIDS & STIs[36]	2020-2024
Japan	-	-
Republic of Korea	2nd National Action Plan on HIV/AIDS Prevention & Control[37]	2024-2028
Malaysia	National Strategic Plan for Ending AIDS[38]	2016-2030
Mexico	Specific Action Plan for HIV & Other STIs[39]	2020-2024
New Zealand	National HIV Action Plan[40]	2023-2030
Papua New Guinea	National STI & HIV Strategy	2024-2028
Peru	Strategic Plan for Prevention & Control of STIs, HIV & Viral Hepatitis[41]	2021-2024
The Philippines	7th AIDS Medium Term Plan[42]	2023-2028
Russia	State Strategy to Combat the Spread of HIV	2016-2020
Singapore	-	-
Chinese Taipei	HIV/AIDS Elimination by 2030 Project, Phase 1[43]	2022-2026
Thailand	National Strategy to End AIDS[44]	2017-2030
The United States	National HIV/AIDS Strategy[45]	2022-2025
Viet Nam	National Strategy to End the AIDS Epidemic by 2030[46]	2020-2030

Barriers to Progress in Ending the HIV Epidemic in APEC

Political deprioritization & limited stakeholder awareness & collaboration across sectors

Inconsistent and insufficient political will to prioritize HIV amid competing health demands is a critical cross-cutting barrier to progress in APEC economies. In several economies, HIV has fallen off the agenda as case counts have stabilized or as other priorities have emerged like COVID-19 and non-communicable diseases. HIV is increasingly viewed by many political leaders and health policymakers as a manageable chronic condition due in large part to recent biomedical innovation. But this misconception that HIV is "under control" has made it difficult to sustain high-level commitment to HIV as a public health problem, leading to flat budgets and stalled policy momentum. In some settings, leadership turnover and the restructuring of HIV programs into broader communicable disease-focused programs have also diluted focus and attention. Stakeholder awareness beyond the health sector is also limited. Senior policymakers, legislators, and the public may lack up-to-date information on HIV biology or epidemiology, so they do not know the extent of the problem and therefore do not support or advocate for action.[47] In addition, stigma and discrimination of key populations in some economies, sometimes on a moralistic or religious basis, have reduced public interest in responding to HIV and complicated political decisions around new HIV policies and investments.

Where high-level commitment is sustained, new infections and deaths have declined.[48] Conversely, in economies where HIV has had a lower public and political profile, policies have been delayed, budgets reduced or flattened, and epidemics have emerged.[49] To realign with the 2030 goals, APEC leaders must visibly re-prioritize HIV by championing HIV publicly, embedding HIV goals in development agendas, and empowering health ministries and their departments. Engagement of PLHIV, civil society, and non-health-related stakeholders is also essential, as is engagement with religious institutions as Malaysia and Indonesia have done to develop faith-aligned messaging. Community-led organizations, which deliver frontline prevention and support, remain underutilized and underfunded. Too few programs and policies in APEC economies bring together and foster collaboration between the finance, education, justice, and religious sectors, together with health ministries and experts, that are required to address such a multi-faceted issue as HIV.

Restrictive laws & policies that conflict with public health evidence & objectives

Punitive laws and policies in many APEC economies hinder efforts to end the HIV epidemic, especially where HIV is concentrated among stigmatized groups. At least nine economies criminalize consensual same-sex sexual activity, and many criminalize sex work and drug use. These laws and policies increase stigma and discrimination and prevent access to prevention, testing, and treatment because they deter people at risk from seeking services due to fear of legal or social repercussions or harassment. Outreach workers report that MSM and transgender women are less likely to test or disclose risk in settings with anti-LGBT laws.[50] Where anti-drug enforcement is strict (including compulsory detention or imprisonment), PWID avoid NSPs and opioid substitution therapy, contributing to low coverage of these harm-reduction services. UNAIDS reports that median needle distribution in the UNAIDS Asia-Pacific region is only 21% of recommended levels and only 9% of opioid users receive substitution therapy.[51]

Age-of-consent and other restrictive policies also impede services, particularly for adolescents. In several APEC economies, parental consent is required for those under 18 years to receive HIV testing or prevention tools. Until 2018, one economy mandated parental consent for minors, but a legal amendment now allows people aged 15-17 years to test without parental approval in response to rising infections among youth.[52] In Chile, individuals aged 14-18 years can test without parental consent. But many economies still set high thresholds or maintain ambiguous rules that effectively exclude adolescents from confidential testing, PrEP, or sexual health education. Beyond age-of-consent rules, policies in some settings restrict which facilities can initiate ART, or they impose residency and identity requirements that deter migrant or undocumented populations from care. Some economies still impose mandatory reporting or registration laws and policies requiring registration of HIV status or reporting of key populations to authorities. Other economies prohibit the community-based distribution of prevention tools including condoms and PrEP for religious or moral reasons.

Policies that limit decentralized care and in effect prevent community-based organizations or primary-care clinics from dispensing PrEP, providing tests, or managing ART force patients in remote or underserved areas to rely on centralized facilities far from home.

Limited access to & underutilization of PrEP, harm reduction & other HIV prevention tools

Limited access to and underutilization of HIV prevention tools, especially for key populations, continues to undermine epidemic control and progress toward the 2030 goals in APEC economies. Despite the availability of biomedical and behavioral interventions, HIV prevention programs remain fragmented, underfunded, and often inaccessible to those at highest risk. PrEP uptake in the APEC region remains under 10%.[53] Structural and social barriers, particularly stigma, misconceptions about risk, and lacking outreach to key populations, further limit demand and uptake. Awareness of and demand for PrEP remain low in many settings and among key populations, even where PrEP is technically available, in part due to stigma toward users and providers and a lack of tailored public education campaigns. Among MSM, transgender people, and sex workers, PrEP is sometimes viewed with caution or mistrust, especially where provider attitudes are stigmatizing, or services are not offered in trusted, private, and community-based settings. In several economies, providers themselves are reluctant to discuss or recommend PrEP due to limited training or concern about reinforcing stigma.

Although WHO recommended PrEP nearly a decade ago, public-sector delivery of PrEP remains inconsistent across the APEC region. In some economies, PrEP is formally included in public insurance but is not available at the facility or sub-national level due to inadequate scale-up. In Chile, PrEP is financed by public funds, but two of the 16 regions still do not yet provide access to PrEP services. In some economies like Hong Kong, China, PrEP is not provided in the public sector, so users pay out-of-pocket.[54] In other economies, PrEP is provided through select public clinics, but scale-up remains limited.[55] In Singapore, PrEP is technically available via private providers, but many at-risk individuals purchase generic versions online without medical supervision or routine testing.[56] Thailand made PrEP free under its Universal Health Coverage Scheme in 2020, but as of 2024, only 41% of the domestic PrEP uptake target was achieved.[57] In other economies, narrow or exclusionary eligibility criteria restrict access to PrEP based on HIV status, gender, age, or whether an individual is a sexual partner of someone living with HIV.[58] Age-of-consent laws and other restrictive laws and policies intersect with eligibility criteria and further limit access for adolescents, young adults, migrants, and other key populations, even in economies with high incidence among youth.

Apart from PrEP, condom promotion and behavioral interventions have seen declining investment in recent years. In several economies, community-based condom distribution, often led by civil society or peer networks, has lost funding or political support. Among young people and key populations, regular condom use remains low in many economies. In major cities, fewer than 50% of MSM report consistent condom use, and some local surveillance systems show stagnation or decline in condom uptake among high-incidence groups.[59] In addition to PrEP and condoms, harm reduction services such as NSPs and opioid substitution therapy also remain underutilized across the APEC region. Median NSP coverage across the Asia-Pacific is only ~21% of recommended levels, and only 9% of people who use opioids receive substitution therapy.[60] Punitive drug policies, criminalization, and law enforcement practices deter PWID from accessing harm reduction services, and still in several economies these services are provided primarily by NGOs with limited geographic reach and unstable funding.

Inadequate HIV testing coverage & weak linkage to care

Gaps in HIV testing and in linkage care (diagnosis to treatment) are major breakpoints in the HIV care continuum across APEC. Inadequate testing coverage still leaves a substantial share of PLHIV in many economies unaware of their status. In many rural areas and smaller cities, testing sites are few, hours are inconvenient, and out-of-pocket fees deter use. Even where services are more accessible, stigma and lacking understanding of risk suppresses demand, especially among key populations who may avoid public clinics due to confidentiality concerns or prior mistreatment. In 2023, approximately 15% of sex workers and 19% of transgender people avoided healthcare in the past year due to stigma or discrimination.[61] Within facilities,

judgmental attitudes or privacy breaches quickly drive people away, resulting in late diagnoses. HIV self-testing (HIVST) is effective for reaching people reluctant to use facility-based services, but it is part of domestic policy in only a few APEC economies (e.g., Chile, Peru, Viet Nam) and remains under-scaled. Community-based testing by lay providers, including peer-led models for key populations, is also an effective approach for addressing stigma and fear, but it is not authorized or funded widely across the APEC region. Routine opt-out testing in other high-throughput settings like emergency departments, maternal and tuberculosis clinics, and prisons can also help reach people at risk who do not otherwise engage as proactively with providers or facilities. Yet this practice is also not used widely among APEC economies.

Linkage to care is the process of connecting an individual who has tested positive for HIV to an HIV care provider or clinical setting where they can be assessed and prepared for treatment as soon as possible. But this process is weak and inefficient in many APEC economies, leaving people newly diagnosed with HIV waiting too long for or disconnected entirely from treatment and support. The first point of weakness in the linkage-to-care process for many economies is a historical reliance on centralized confirmatory testing, where a positive screening result is followed by a Western blot, PCR, or RNA test at a central facility to confirm the screening result and rule out a false positive. Confirmatory testing processes can require additional visits, time off work, transportation, paperwork, and opportunities for stigmatizing interactions. Some economies have begun to implement rapid diagnostic algorithms to accelerate this process, but these process improvements are not yet ubiquitous across APEC. HIVST is particularly prone to challenges with confirmatory testing and subsequent steps in the linkage to care due to a lack of standardized protocols for follow-up after self-testing compared to provider-initiated or facility-based testing.

The second point of weakness in the linkage-to-care process for many economies is fragmented referral and intake systems. Some testing providers, especially community-based organizations, private clinics, and mobile or peer-led services, are often not integrated sufficiently with public treatment centers and thus not able to make efficient or consistent referrals for newly diagnosed individuals with providers. Many economies also lack proper case management systems, services to support patients in navigating the process, or robust health information systems to help track individuals in the linkage-to-care process and prevent dropouts and delays. Even after successful referral, policies and processes for registration, scheduling, or intake at treatment centers are often not equipped or designed for transient or key populations, leading to further delay and disengagement.

Delays in HIV treatment initiation and challenges to treatment retention

APEC economies continue to face delays in initiating HIV treatment promptly after diagnosis and, after initiation, face challenges retaining people on lifelong treatment. Although WHO recommends same-day or rapid (within 3 days) start of ART, not every economy has domestic policies, plans, or programs that ensure this best practice is implemented consistently and widely for all PLHIV. As of 2023, some economies report that fewer than 60% of diagnosed people are promptly started on ART.[62] Weak linkage to care (*see previous section*) is a significant source of delays in treatment initiation. Where same-day or rapid-start protocols exist, they sometimes remain in a "pilot stage" for longer than necessary and available at only select facilities or for certain key populations. Some economies also continue to use outdated "readiness" criteria, which delays the start of HIV treatment until a patient has demonstrated the commitment and capacity for high adherence, out of concern for drug resistance and treatment failure from poor adherence. While this was a widespread and recommended practice historically, current international guidelines from WHO and other organizations no longer recommend delaying ART based on readiness criteria alone. Similarly, until recently, several economies recommended starting ART based on CD4 thresholds rather than at diagnosis, contrary to WHO guidance.

Treatment retention in many APEC economies is complicated by health system limitations. Health workforce shortages, geographic inaccessibility, and limited hours of operation at treatment centers, especially those outside major cities, contribute to long wait times, missed visits, product stock-outs, and weak follow-up for PLHIV trying to adhere to their treatment plans. In some economies, newly diagnosed PLHIV do not receive sufficient and consistent education, most notably that "U=U" (i.e., an undetectable viral load means HIV is untransmittable), which can help motivate adherence by emphasizing the prevention benefits of viral

suppression. Stigma, discrimination, and privacy concerns also deter PLHIV from follow-up and adherence. Decentralized models such as community-based ART distribution, home delivery, primary-care integration, and multi-month dispensing can alleviate many of these systems limitations while addressing some social barriers, but only a few economies have started to consider such models as a matter of policy and still fewer have piloted and scaled them. Many treatment programs in many economies also lack peer support, psychosocial counseling, and integration with services for mental health and comorbidities like tuberculosis despite their demonstrated benefits for retention. In addition, as in the case of linkage to care, weak health information systems fail to track missed appointments and facilitate rapid re-engagement.

Inconsistent adherence raises the risk of drug resistance, treatment failure, and continued HIV transmission, yet routine drug-resistance testing and viral-load monitoring remain limited in many economies in part due to a lack of policy, laboratory capacity, or the associated costs. Where viral-load monitoring or drug-resistance testing is available, it may not be free or affordable to PLHIV.

Regulatory and reimbursement barriers for new HIV prevention, testing, and treatment

New technologies ranging from long-acting and next-generation PrEP, PEP, and ART to point-of-care diagnostics, self-testing kits, viral load testing, and drug resistance diagnostics have the potential to transform the HIV response by improving prevention and adherence, expanding reach, and reducing transmission and drug resistance. However, systemic inefficiencies in regulatory, reimbursement, and financing processes frequently delay or restrict access and uptake to WHO-recommended or globally available HIV innovations. For one, there remains limited use of facilitated regulatory pathways and regional regulatory collaboration. Many APEC economies do not use reliance pathways that would allow them to accelerate approval of WHO-prequalified or Stringent Regulatory Authority (SRA)-approved HIV products; and in some economies, redundant or duplicative domestic procedures require full local dossiers. Joint review mechanisms or work-sharing initiatives such as the ASEAN Joint Assessment Procedure or ACCESS Consortium remain underutilized for HIV products.

After products are approved, delays in coverage and reimbursement decisions also limit access to new HIV technologies. Health technology assessment (HTA) processes, especially where in use by APEC economies as a formal part of reimbursement decisions, are often under-resourced. HTA processes in some economies lack the tools and expertise in methodologies such as multi-criteria decision analysis to accurately evaluate long-term public health impact, equity benefits, or cost offsets of HIV innovations, such as long-acting PrEP for certain key populations or in the context of comorbidity. As a result, reimbursement may be delayed or limited to narrower indications. In some economies, formularies, “national essential medicines lists” (NEMLs), and procurement catalogs are slow to include newly recommended technologies, or economies do not procure or distribute them widely and efficiently. Such delays or restrictions in coverage or incomplete inclusion in formularies or procurement systems lead to access gaps in the public sector, leaving only private channels, donor-funded programs, or limited public pilot sites available for access, which are often concentrated in urban areas or for certain populations. In several economies, where PrEP is not covered under public insurance or universal health coverage (UHC) schemes, individuals must pay out-of-pocket, which further limits access.

Insufficient and unsustainable domestic HIV funding and dependence on external funds

Sufficient and sustainable domestic funding underpins an effective HIV response, yet many APEC economies face significant resource gaps and vulnerabilities. The UNAIDS Asia-Pacific region had $3.3 billion available for HIV in 2023, about one-third of the funding needed to meet 2030 goals.[63] Nearly every APEC economy reports HIV funding shortfalls. Many economies face structural budget constraints more broadly, worsened by COVID-19 and macroeconomic pressures. Where domestic funding is insufficient, economies depend heavily on external sources, particularly international organizations (e.g., UNAIDS, Global Fund, Gates Foundation) and other governments (e.g., Australia, P.R. China, Japan, United States). But these external contributions have declined sharply over the past decade; and a lack of awareness and prioritization of HIV by political and finance leaders (*see page 8*) does little to help sustain, let alone increase, domestic funding,

especially where there is already little fiscal space left in health and broader public budgets to maneuver. This issue is especially acute for prevention: at least 12 APEC economies reportedly rely on external sources for over half of their HIV prevention funding.[64]

A widespread lack of data and dependence on external funds in many APEC economies both contribute to a misalignment between resource allocation and epidemiological need. For example, in the UNAIDS Asia-Pacific region, less than 15% of HIV-related expenditure is allocated to programs for key populations and partners even though 79% of new infections occur among them.[65] Prevention and diagnostics tend to be underfunded relative to treatment in many APEC economies, making it harder to finance new long-acting PrEP technologies, self-testing kits, or drug resistance surveillance. Anti-stigma initiatives and psychosocial support for PLHIV are also generally underfunded despite evidence of their potential to raise program effectiveness. Sustainability of domestic funding and efficient, evidence-informed allocation are also curtailed in some economies by restricted or underutilized social contracting between government and NGOs. Dedicated budget lines for community-led services are not yet institutionalized in many settings, and some government entities are not allowed or incentivized to purchase products or services from NGOs which would enable more effective community-based interventions. As a result, frontline organizations operate on short, project-based grants with limited stability. In one economy, for example, elimination of federal NGO budget lines in 2018 led to significant disruptions in HIV diagnosis and linkage to care.

Like many health issues, HIV remains framed as a cost center rather than a productive investment in human capital, health system resilience, and economic development. In every APEC economy, there is still room to improve awareness among health, finance, and political officials that underinvestment in HIV now leads to higher economic and societal costs in the long term, and that there is a clear and quantifiable return on investment to increasing and improving domestic expenditure on HIV, especially on HIV prevention. Studies estimate that every $1 invested in the HIV response yields a return of as much as $12 in health and economic benefits, including averted healthcare costs associated with new infections and HIV-related illnesses, preserved workforce productivity, and reduced burden on social systems.[66] Every 10% increase in HIV prevalence corresponds to a 0.14% decrease in GDP.[67] Despite this evidence, investments in prevention and long-term cost avoidance rarely yield immediate, politically visible returns, making them less attractive to decision-makers. Moreover, many economies lack localized evidence of return on investment and rely instead on global or regional studies like those cited here, making it difficult for them to see the domestic fiscal and economic implications of investing in HIV.

Conclusion

The analysis presented in this paper underscores that while APEC economies have made meaningful progress toward the global 2030 goals, these gains remain fragile and uneven. Achieving epidemic control across such a diverse region will require not only sustained political commitment but also the removal of the structural, legal, and systemic barriers that continue to impede equitable access to prevention, testing, treatment, and innovation. The seven barriers outlined in this paper, spanning political prioritization, restrictive laws, prevention gaps, testing and linkage challenges, treatment initiation and retention issues, regulatory and reimbursement bottlenecks, and funding shortfalls, represent interconnected dimensions of the same challenge. Each barrier reinforces the others, collectively slowing progress toward the 2030 goals. But evidence from within and beyond the APEC region demonstrates that these barriers are surmountable. This Issues Paper provides the contextual foundation for the forthcoming *APEC Action Plan to End the HIV Epidemic*, which will translate these findings into practical, actionable recommendations for governments, industry, academia, civil society, and PLHIV. By working together through the APEC platform, economies can accelerate progress toward the 2030 goals and realize a shared vision of ending HIV as a public health threat by 2030.

Appendix

Table 2. Overall HIV policy adoption in select APEC economies (HIV Policy Lab, Georgetown University)

APEC Economy	Very Few (0-19% of policies)	Few (20-39%)	Some (40-59%)	Many (60-79%)	Most (80%+)
Australia				✓	
Brunei Darussalam		✓			
Canada			✓		
Chile				✓	
P.R. China			✓		
Indonesia			✓		
Japan			✓		
Republic of Korea				✓	
Malaysia			✓		
Mexico				✓	
New Zealand			✓		
Papua New Guinea			✓		
Peru				✓	
The Philippines				✓	
Russia			✓		
Singapore			✓		
Thailand				✓	
The United States			✓		
Viet Nam			✓		

Note: The HIV Policy Lab rigorously tracks HIV-related law and policy in 194 economies (only WHO member states). The dataset quantitatively represents the HIV-related law and policy environment in each economy for multiple years. Currently, HIV Policy Lab tracks 33 key areas of HIV-related law and policy. Sixteen of these policies are comprised of two or more sub-policies, for a total of 50 policies being tracked. Policies are benchmarked against global norms from WHO and other international bodies and classified accordingly. The scale in the table above is calculated for each economy based on the percent of policies for which data are available that have a score of "adopted".

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