

Results Report 2026: Annex

Updated 3 September 2026

The Global Fund Results Report 2026 includes selected programmatic results – such as people on antiretroviral therapy, people with TB treated and insecticide-treated mosquito nets distributed – delivered by Global Fund-supported programs in 2025.

Table 1 below provides a comparison of the aggregated results over 2021-2025.

Table 2 tracks absolute and relative changes in service delivery from 2024 to 2025.

Countries accounting for a large share of portfolio-level increases or drops over 2024-2025 are listed in **Table 3**.

Table 4 provides a qualitative explanation of the drivers of notable changes over 2024-2025 in selected countries.

Table 1: Selected programmatic results over 2021-2025 in countries where the Global Fund invests*

Services		2021	2022	2023	2024	2025
HIV	PEOPLE ON ANTIRETROVIRAL THERAPY FOR HIV	23.2M (98)	24.5M (97)	24.9M (97)	25.6M (99)	26.9M (101)
	HIV TESTS TAKEN BY PRIORITY AND KEY POPULATIONS ¹	12.7M (101)	12.5M (101)	13.1M (102)	11.7M (101)	12.1M (101)
	PREGNANT WOMEN RECEIVED MEDICINE TO PREVENT TRANSMITTING HIV TO THEIR BABIES	667.2K (50)	710.0K (48)	695.2K (48)	647.5K (57)	623.0K (56)
	PEOPLE REACHED WITH HIV PREVENTION PROGRAMS AND SERVICES	12.5M (102)	15.5M (101)	17.9M (102)	12.3M (100)	10.0M (101)
	• MEMBERS OF KEY POPULATIONS REACHED WITH HIV PREVENTION PROGRAMS	5.8M (100)	7.3M (100)	8.0M (101)	7.7M (99)	6.2M (97)
	• YOUNG PEOPLE REACHED WITH HIV PREVENTION PROGRAMS	6.1M (20)	7.4M (22)	8.5M (22)	3.0M (18)	2.7M (18)
	• ADOLESCENT GIRLS AND YOUNG WOMEN REACHED WITH HIV PREVENTION PROGRAMS	3.7M (18)	3.3M (18)	3.9M (18)	2.0M (18)	2.3M (18)
	PEOPLE WHO RECEIVED ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIS ²	97.3K (25)	177.4K (36)	321.6K (39)	1.4M (56)	1.1M (68)
TUBERCULOSIS	PEOPLE TREATED FOR TB	5.3M (92)	6.5M (88)	7.1M (85)	7.4M (88)	7.4M (88)
	HIV-POSITIVE TB PATIENTS ON ART DURING TB TREATMENT	286.9K (75)	344.5K (75)	353.0K (76)	316.7K (76)	302.3K (73)
	PEOPLE ON TREATMENT FOR DRUG-RESISTANT TB	109.4K (90)	120.5K (86)	123.8K (83)	120.1K (83)	115.5K (83)
	PEOPLE IN CONTACT WITH TB PATIENTS RECEIVED PREVENTIVE TREATMENT	0.4M (47)	1.5M (48)	2.0M (49)	3.4M (58)	3.5M (75)
	PEOPLE LIVING WITH HIV ON ART WHO INITIATED TB PREVENTIVE TREATMENT	3.2M (50)	2.8M (54)	2.0M (55)	2.2M (64)	1.5M (66)
MALARIA	INSECTICIDE-TREATED MOSQUITO NETS DISTRIBUTED ³	133.3M (60)	218.1M (62)	227.2M (59)	162.5M (58)	195.7M (61)
	PREGNANT WOMEN RECEIVED PREVENTIVE TREATMENT FOR MALARIA	11.3M (29)	14.6M (30)	15.5M (30)	17.8M (30)	19.9M (30)
	CHILDREN WHO RECEIVED SEASONAL MALARIA CHEMOPREVENTION	34.5M (10)	37.1M (10)	44.6M (12)	50.9M (12)	52.1M (15M)
	SUSPECTED CASES OF MALARIA TESTED	284.1M (67)	323.1M (67)	337.5M (65)	359.9M (65)	366.9 M (66)
	CASES OF MALARIA TREATED	147.5M (65)	163.9M (63)	171.2M (62)	173.0M (62)	166.8M (65)

* Numbers in parentheses represent the number of countries/multicountry grants that have contributed to the reported results, M indicates million; K indicates thousands.

1. Priority and key populations include people who experience a greater epidemiological vulnerability to HIV, TB and malaria, and may have reduced access to services due to a combination of biological and socioeconomic factors.

2. The results of people who received antiretroviral pre-exposure prophylaxis are not included in the total prevention results.

3. Country mass net distribution campaigns occur every three years and are not evenly distributed across the three-year implementation cycle, so year-on-year comparison has limited value in measuring progress and success of the national malaria programs.

Table 2: Trends in selected programmatic results over 2024-2025 in countries where the Global Fund invests

Services		Absolute / Relative change over 2024-2025	Absolute / relative increase (# of countries showing an increase or newly reporting) over 2024-2025	Absolute / relative decrease (# of countries showing a decrease or no longer reporting ¹) over 2024-2025
HIV	PEOPLE ON ANTIRETROVIRAL THERAPY FOR HIV	1.3M / 5.0%	1.4M / 5.6% / (86)	-160K / -0.6% / (15)
	HIV TESTS TAKEN BY PRIORITY AND KEY POPULATIONS	436K / 3.7%	1,860K / 15.9% / (58)	-1,424K / -12.2% / (46)
	PREGNANT WOMEN RECEIVED MEDICINE TO PREVENT TRANSMITTING HIV TO THEIR BABIES	-25K / -3.8%	21K / 3.3% / (29)	-46K / -7.1% / (30)
	PEOPLE REACHED WITH HIV PREVENTION PROGRAMS AND SERVICES	-2.3M / -18.6%	1.2M / 9.9% / (50)	-3.5M / -28.5% / (52)
	• MEMBERS OF KEY POPULATIONS REACHED WITH HIV PREVENTION PROGRAMS	-1.5M / -20.0%	721K / 9.4% / (52)	-2.3M / -29.4% / (49)
	• YOUNG PEOPLE REACHED WITH HIV PREVENTION PROGRAMS	-330K / -11.0%	1.3MK / 42.9% / (10)	-1,6M / -53.9% / (9)
	• ADOLESCENT GIRLS AND YOUNG WOMEN REACHED WITH HIV PREVENTION PROGRAMS	333K / 16.6%	1.3M / 66.7% / (11)	-1.0M / -50.1% / (8)
	PEOPLE WHO RECEIVED ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIS	-238K / -17.4%	177K / 13.0% / (45)	-415K / -30.4% / (21)
TUBERCULOSIS	PEOPLE TREATED FOR TB	89K / 1.2%	175K / 2.4% / (50)	-86K / -1.2% / (40)
	HIV-POSITIVE TB PATIENTS ON ART DURING TB TREATMENT	-14K / -4.6%	11K / 3.6% / (35)	-26K / -8.2% / (40)
	PEOPLE ON TREATMENT FOR DRUG-RESISTANT TB	-5K / -3.8%	2K / 1.4% / (32)	-6K / -5.2% / (50)
	PEOPLE IN CONTACT WITH TB PATIENTS RECEIVED PREVENTIVE TREATMENT	159K / 4.7%	470K / 13.9% / (57)	-311K / -9.2% / (18)
	PEOPLE LIVING WITH HIV ON ART WHO INITIATED TB PREVENTIVE TREATMENT	-644K / -29.6%	236K / 10.8% / (36)	-881K / -40.4% / (35)
MALARIA	INSECTICIDE-TREATED MOSQUITO NETS DISTRIBUTED	33.3M / 20.5%	129.3M / 79.6% / (38)	-96.0M / -59.1% / (26)
	PREGNANT WOMEN RECEIVED PREVENTIVE TREATMENT FOR MALARIA	2.1M / 11.9%	2.4M / 13.6% / (24)	-306K / -1.7% / (6)
	CHILDREN WHO RECEIVED SEASONAL MALARIA CHEMOPREVENTION	1.2M / 2.3%	3.4M / 6.7% / (10)	-2.2M / -4.4% / (4)
	SUSPECTED CASES OF MALARIA TESTED	7.0M / 1.9%	29.5M / 8.2% / (39)	-22.5M / -6.3% / (27)
	CASES OF MALARIA TREATED	-6.2M / -3.6%	8.8M / 5.1% / (29)	-15.0M / -8.7% / (35)

¹ Note: Countries/multicountry grants that exited reporting for this service are included in both the absolute decrease and the decrease count. The total number of countries in Table 1 reflects only countries reporting results in 2025 and therefore excludes those that exited the reporting cohort.

Table 3: Top-5 countries driving portfolio-level trends in selected programmatic results over 2024-2025 in countries where the Global Fund invests

		Absolute / relative increase over 2024-2025 (% share of portfolio increase) ²	Absolute / relative decrease over 2024-2025 (% share of portfolio decrease) ²
HIV	PEOPLE ON ANTIRETROVIRAL THERAPY FOR HIV	South Africa 651K / 11.6% / (45.4%)	Zambia -39K / -2.9% / (24.2%)
		India 182K / 10.2% / (12.7%)	Congo (Democratic Republic) -32K / -7.4% / (20.1%)
		Nigeria 109K / 6.7% / (7.6%)	Thailand -28K / -5.6% / (17.4%)
		Uganda 50K / 3.4% / (3.5%)	Malawi -27K / -2.9% / (16.9%)
		Mozambique 39K / 1.9% / (2.7%)	Namibia -12K / -5.6% / (7.4%)
	HIV TESTS TAKEN BY PRIORITY AND KEY POPULATIONS	India 527K / 36.4% / (28.3%)	Nepal -387K / -54.1% / (27.2%)
		Mozambique 212K / 80.9% / (11.4%)	Zambia -264K / -31.9% / (18.6%)
		Kenya 181K / 69.5% / (9.8%)	Nigeria -176K / -17.5% / (12.4%)
		Thailand 117K / 24.9% / (6.3%)	Chad -98K / -98.5% / (6.9%)
		Indonesia 101K / 13.7% / (5.4%)	South Africa -77K / -13.5% / (5.4%)
	PREGNANT WOMEN RECEIVED MEDICINE TO PREVENT TRANSMITTING HIV TO THEIR BABIES	Congo (Democratic Republic) 5K / 53.2% / (22.6%)	Uganda -8K / -9.9% / (18.2%)
		Central African Republic 4K / 88.5% / (17.7%)	India -8K / -100.0% / (18.0%)
		Sierra Leone 2K / 36.0% / (8.8%)	Botswana -8K / -100.0% / (16.4%)
		Gabon 2K / country entered reporting / (8.6%)	Malawi -7K / -19.7% / (16.3%)
		Nigeria 1K / 4.8% / (5.9%)	Kenya -6K / -13.5% / (12.8%)
	PEOPLE REACHED WITH HIV PREVENTION PROGRAMS AND SERVICES	Mozambique 404K / 216.4% / (33.1%)	Malawi -594K / -87.1% / (16.9%)
		Tanzania 126K / 328.1% / (10.3%)	Nepal -488K / -54.1% / (13.9%)
		Zambia 69K / 56.4% / (5.6%)	Ethiopia -405K / -63.3% / (11.5%)
		Peru 56K / 44.8% / (4.6%)	Nigeria -305K / -20.0% / (8.7%)
		Burkina Faso 54K / country entered reporting / (4.4%)	Chad -258K / -91.8% / (7.4%)
	MEMBERS OF KEY POPULATIONS REACHED WITH HIV PREVENTION PROGRAMS	Kenya 64K / 46.2% / (8.8%)	Nigeria -1,045K / -77.8% / (46.1%)
		Peru 56K / 44.8% / (7.8%)	Dominican Republic -236K / -100.0% / (15.3%)
		Mozambique 53K / 100.5% / (7.3%)	Pakistan -100K / -28.3% / (6.5%)
		Burkina Faso 46K / country entered reporting / (6.4%)	Bangladesh -83K / -35.0% / (5.4%)
		Zambia 42K / 141.9% / (5.9%)	Sri Lanka -82K / -67.6% / (5.3%)
	YOUNG PEOPLE REACHED WITH HIV PREVENTION PROGRAMS	Nigeria 740K / 402.4% / (57.5%)	Malawi -622K / -92.8% / (38.5%)
		Mozambique 352K / 261.6% / (27.3%)	Kenya -284K / -87.9% / (17.6%)
		Tanzania 96K / country entered reporting / (7.5%)	Chad -250K / -100.0% / (15.5%)
		Ghana 41K / 5500% / (3.2%)	South Africa -127K / -19.4% / (7.8%)
		Zambia 26K / 28.6% / (2.0%)	Lesotho -111K / -76.3% / (6.9%)
HIV	PEOPLE WHO RECEIVED ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIS	Mozambique 20K / 7.2% / (11.4%)	Nigeria -237K / -75.1% / (57.2%)
		Sierra Leone 17K / 221.1% / (9.6%)	South Africa -60K / -60.3% / (14.4%)
		Ethiopia 17K / 166.5% / (9.6%)	Malawi -30K / -45.8% / (7.2%)
		Uganda 16K / 110.6% / (9.2%)	Zimbabwe -27K / -59.3% / (6.4%)
		Indonesia 14K / 46.6% / (7.7%)	Philippines -10K / -21.6% / (2.4%)

² Note: Portfolio increase includes countries entering the cohort in 2025, while portfolio decrease includes countries that reported this service in 2024 but did not report it in 2025.

Services		Absolute / relative increase over 2024-2025 (% share of portfolio increase)	Absolute / relative decrease over 2024-2025 (% share of portfolio decrease)
TUBERCULOSIS	PEOPLE TREATED FOR TB	Nigeria 57K / 14.1% / (32.3%)	Pakistan -14K / -2.8% / (16.4%)
		India 33K / 1.3% / (18.9%)	Uzbekistan -14K / -100.0% / (16.2%)
		South Africa 16K / 8.7% / (9.2%)	Thailand -7K / -8.2% / (7.6%)
		Bangladesh 10K / 3.0% / (5.5%)	Uganda -6K / -7.2% / (7.4%)
		Sudan 9K / 64.4% / (5.3%)	Kenya -5K / -5.2% / (5.9%)
	HIV-POSITIVE TB PATIENTS ON ART DURING TB TREATMENT	Indonesia 2K / 21.8% / (17.0%)	India -9K / -100% / (32.9%)
		Malawi 1K / 19.0% / (13.0%)	Angola -4K / -78.1% / (13.7%)
		Sierra Leone 1K / 80.3% / (10.8%)	Uganda -3K / -11.8% / (13.0%)
		Lesotho 1K / 48.4% / (10.3%)	Congo (Democratic Republic) -2K / -19.8% / (8.5%)
		Zimbabwe 1K / 12.7% / (9.5%)	Nigeria -2K / -12.9% / (8.4%)
	PEOPLE ON TREATMENT FOR DRUG-RESISTANT TB	Angola 1K / 52.1% / (34.4%)	India -2K / -3.6% / (30.0%)
		Philippines 0K / 2.7% / (12.6%)	Congo (Democratic Republic) -1K / -34.7% / (10.4%)
		Kenya 0K / 13.3% / (6.0%)	South Africa -1K / -9.2% / (9.7%)
		Pakistan 0K / 2.2% / (5.5%)	Kazakhstan -1K / -12.4% / (8.4%)
		South Sudan 0K / 30.6% / (5.5%)	Ukraine 0K / -12.5% / (7.0%)
	PEOPLE IN CONTACT WITH TB PATIENTS RECEIVED PREVENTIVE TREATMENT	Indonesia 157K / 199.3% / (33.5%)	India -207K / -12.5% / (66.6%)
		Nigeria 65K / 15.3% / (13.8%)	Uganda -70K / -26.2% / (22.6%)
		Philippines 41K / 45.4% / (8.7%)	Tanzania (United Republic) -7K / -35.2% / (2.3%)
		Pakistan 33K / 55.6% / (7.0%)	Congo (Democratic Republic) -7K / -8.7% / (2.1%)
		Bangladesh 32K / 18.0% / (6.9%)	Ghana -5K / -12.8% / (1.5%)
	PEOPLE LIVING WITH HIV ON ART WHO INITIATED TB PREVENTIVE TREATMENT	Nigeria 71K / 48.6% / (29.8%)	Eswatini -188K / -96.5% / (21.3%)
		Ghana 36K / 260.5% / (15.2%)	Rwanda -106K / -100% / (12.0%)
		Sierra Leone 26K / 265.9% / (10.8%)	Zambia -102K / -43.9% / (11.5%)
		Guinea 16K / 80.5% / (6.6%)	South Africa -101K / -37.4% / (11.5%)
		Cameroon 15K / 99.2% / (6.3%)	Uganda -71K / -68.1% / (8.1%)

Services		Absolute / relative increase over 2024-2025 (% share of portfolio increase)	Absolute / relative decrease over 2024-2025 (% share of portfolio decrease)
MALARIA	INSECTICIDE-TREATED MOSQUITO NETS DISTRIBUTED	Nigeria 24.2M / 198.6% / (18.7%)	Niger -14.9M / -90.1% / (15.5%)
		Burkina Faso 14.9M / 1097% / (11.5%)	India -14.7M / -100.0% / (15.3%)
		Sudan 12.8M / country entered reporting / (9.9%)	Madagascar -14.8M / -95.8% / (15.3%)
		Congo (Democratic Republic) 11.2M / 128.1% / (8.7%)	Côte d'Ivoire -13.7M / -89.7% / (14.3%)
		Cameroon 9.2M / 1037% / (7.1%)	Ghana -8.1M / -55.9% / (8.5%)
	PREGNANT WOMEN RECEIVED PREVENTIVE TREATMENT FOR MALARIA	Nigeria 605K / 29.7% / (25.0%)	Madagascar -112K / -23.9% / (36.7%)
		Tanzania (United Republic) 266K / 13.4% / (11.0%)	Angola -102K / -51.9% / (33.5%)
		Uganda 237K / 19.3% / (9.8%)	Burundi -47K / -17.0% / (15.3%)
		Central African Republic 190K / 102.7% / (7.9%)	Congo (Democratic Republic) -27K / -0.7% / (8.8%)
		Malawi 189K / 98.2% / (7.8%)	Zimbabwe -9K / -9.3% / (3.0%)
	CHILDREN WHO RECEIVED SEASONAL MALARIA CHEMOPREVENTION	Chad 1.3M / country entered reporting / (39.0%)	Nigeria -2.0M / -5.8% / (89.3%)
		Togo 630K / 138.8% / (18.4%)	Guinea-Bissau -120K / -52.0% / (5.3%)
		Niger 438K / 9.7% / (12.8%)	Ghana -106K / -6.9% / (4.7%)
		Mozambique 321K / country entered reporting / (9.4%)	Mauritania -14K / -18.1% / (0.6%)
		Côte d'Ivoire 221K / country entered reporting / (6.4%)	
	SUSPECTED CASES OF MALARIA TESTED	Nigeria 4.3M / 12.8% / (14.5%)	Malawi -6.1M / -34.0% / (27.3%)
		Sudan 4.0M / 820.7% / (13.5%)	Congo (Democratic Republic) -4.2M / -9.7% / (18.8%)
		Indonesia 3.3M / 58.6% / (11.3%)	Burkina Faso -2.7M / -15.7% / (12.1%)
		Zambia 2.9M / 16.5% / (9.8%)	Madagascar -2.7M / -35.2% / (11.9%)
		Ethiopia 2.6M / 11.0% / (8.7%)	Burundi -1.9M / -18.2% / (8.4%)
	CASES OF MALARIA TREATED	Nigeria 2.2M / 9.0% / (25.3%)	Malawi -4.6M / -50.2% / (30.6%)
		Zambia 1.9M / 21.1% / (21.6%)	Burkina Faso -3.1M / -30.8% / (20.9%)
		Mozambique 1.2M / 10.4% / (13.7%)	Madagascar -1.9M / -52.9% / (12.4%)
		Guinea 690K / 35.9% / (7.9%)	Congo (Democratic Republic) -1.5M / -5.7% / (9.8%)
		Chad 659K / 44.9% / (7.5%)	Burundi -1.1M / -20.2% / (7.3%)

Table 4: Notes on notable changes over 2024-2025 in selected countries where the Global Fund invests

Services		Notes
HIV	PEOPLE ON ANTIRETROVIRAL THERAPY FOR HIV	General note: Overall, the number of people living with HIV receiving HIV treatment increased, driven by expanded treatment enrollment, stronger retention efforts, and enhanced service delivery models in several high-burden countries. The largest gains were associated with treatment scale-up initiatives, and community-based approaches. Reported declines were primarily linked to data quality and reporting issues often linked to international funding cuts, or data revisions and methodological changes. Country-specific notes: • South Africa: The increase was driven primarily by the government's "Closing the HIV Treatment Gap" campaign, along with expanded service delivery models of care in 2025. Improved reporting from the private sector also contributed to the increase. • India: The country increased its ambition for 2025 with the aim of finding more missing HIV-positive cases. The improved performance of the service is a strong indication that the country is succeeding in finding the missing cases. • Nigeria: The increase was driven by expanded testing strategies, same-day treatment initiation, and scale-up of treatment sites. However, UNAIDS has notably revised the estimated number of people on HIV treatment downward based on new survey results that do not figure in the Global Fund reported value. • Uganda: The increase was driven by a focus on retention, particularly through the implementation of direct service delivery models including community-based approaches. • Congo (Democratic Republic): The decline was driven by stock-outs of testing commodities, as well as data completeness issues following the introduction of a new data collection tool. • Malawi: The decline reflects an adjustment to correct for previous over-reporting, following a 2024 Data Quality Assessment. Actual performance remained broadly stable compared to the previous year. • Namibia: The decline is largely attributed to the absence of data clerks in two regions related to international funding cuts, which affected data capturing and reporting. Fifty-five facilities in total remained uncovered as of December 2025.
	HIV TESTS TAKEN BY PRIORITY AND KEY POPULATIONS	General note: The number of HIV tests taken by priority and key populations increased on net in 2025, driven by expanded testing outreach and testing intensity, broader screening coverage, and strengthened community services in several countries. The largest increases were observed among adolescents and youth, people in prisons, and men who have sex with men. Reported declines were primarily linked to international funding cuts, operational disruptions, grant transitions resulting in partial-year reporting, and reduced reporting availability. Country-specific notes: • India: Prison-based HIV testing expanded significantly due to broader screening coverage among inmates, routine testing of new admissions, improved commodity availability, and enhanced follow-up systems. • Mozambique: The increase was driven by substantial growth in HIV testing in adolescents and youth. Growth was also observed among priority and key populations. The increased HIV tests reported for priority populations was attributed to testing campaigns, which the country undertook with support from the Global Fund. • Kenya: The increase was driven by expanded HIV testing services across key and priority populations. The Principal Recipient reported an upward trend across all key populations, with the largest increases among adolescents and youth. • Thailand: The increase was driven mainly by people in prison and men who have sex with men, together accounting for over 80% of the growth. Migrant testing also more than doubled due to strengthened community outreach. • Indonesia: HIV testing among men who have sex with men increased due to expanded outreach, community-based screening, expansion of self-testing, and improved linkage to services. Improvements were noted across all other key populations and partners of people living with HIV. • Nigeria: The overall decline was driven by international funding cuts that impacted service delivery and data reporting. These affected sex workers, people who use drugs, people in prisons, and men who have sex with men. • Chad: In 2025, only early infant diagnosis was reported, while in 2024 HIV testing was also reported among adolescents and youth, men who have sex with men, and sex workers.

PREGNANT WOMEN RECEIVED MEDICINE TO PREVENT TRANSMITTING HIV TO THEIR BABIES	General note: Overall, the number of HIV-positive pregnant women receiving treatment to prevent transmission of HIV declined slightly in 2025. Gains in several countries were driven by expanded service availability, strengthened links between antenatal care and HIV treatment, improvements in data completeness, and reporting system enhancements. Reported declines were primarily linked to international funding cuts and reduced coverage of antenatal care services limiting the potential number of women who could be reached with HIV treatment. Country-specific notes: • Congo (Democratic Republic): The increase in HIV-positive pregnant women on treatment can be attributed to corrections made in the reporting system and data management tools, which better identified women who were already known to be receiving HIV treatment when they attended antenatal care services. • Central African Republic: The increase reflects significant expansion of sites providing HIV treatment to pregnant women, improved data completeness, and strengthened commodity tracking. • Sierra Leone: Growth was driven by expanded HIV testing among pregnant women, rapid treatment initiation under revised national guidelines, and strengthened training, supervision and partner support. • Nigeria: The increase was driven by expanded community platforms and strengthened linkages between antenatal care and HIV treatment. • Uganda: The decline is linked to international funding cuts, with reduced service coverage following termination of some implementing partners. • Kenya: The decline is attributed to low uptake of antenatal care services among pregnant women, missed HIV testing opportunities, and antiretroviral treatment coverage declining at the national level. • Cameroon: The decrease is primarily due to reduced access to antenatal care and enrollment in services for pregnant women, rather than treatment gaps. In addition to low coverage of women attending antenatal care, weak community engagement and referral systems, regional disparities, supply chain disruptions, and data reporting gaps contributed to the decline. • Mozambique: The decline reflects changes in the total number of HIV-positive pregnant women rather than service deterioration.
PEOPLE REACHED WITH HIV PREVENTION PROGRAMS AND SERVICES	General note: In 2025, reporting changes contributed to the overall decline. The indicator “Young people aged 10–24 years reached by comprehensive sexuality education and/or life skills-based HIV education” was discontinued, with 6 of the 7 countries no longer reporting in 2025. In addition, at least 11 countries changed the definitions of prevention indicators to become more restrictive. Further reported declines were primarily linked to international funding cuts. Improvements in some countries were driven primarily by expansion of prevention programs, strengthened community outreach and geographic scale-up. Country-specific notes: • Mozambique: The increase was primarily driven by the scale-up of services for adolescent girls and young women, alongside strong gains among sex workers and men who have sex with men. Performance improvements were supported by acceleration plans, expanded outreach and improved follow-up mechanisms. • Tanzania: The increase reflects resumption of prevention services to female sex workers and men who have sex with men through one of the grant’s Principal Recipients. • Zambia: The increase was driven by substantial expansion of services for sex workers, adolescent girls and young women, and men who have sex with men. Improvement was driven by strengthened peer educator networks, expanded community outreach, hotspot mapping and improved service delivery models. • Peru: The increase was driven by an improvement across priority and key populations. Performance was supported by expanded mobile outreach services, PrEP integration, and targeted interventions for key populations. • Ghana: Prevention program coverage was expanded to 11 regions in 2025, across an increased number of districts for each key population. As a result of the geographic expansion, more individuals were reached with HIV prevention services in 2025. • Malawi: The decline was driven by the discontinuation of the comprehensive sexuality education indicator, which was not reported in 2025. Notably, other prevention services for key populations expanded in 2025. • Nigeria: The decline largely reflects international funding cuts, which disrupted key population services at Community Services Coordination Centres (CSCCs) in 33 states. A rise in services to adolescent girls and young women partly offset the decline.

PEOPLE WHO RECEIVED ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIS	General note: The overall decline in individuals receiving pre-exposure prophylaxis (PrEP) was driven by declines in Nigeria, driven primarily by international funding cuts and related impacts to service delivery platforms. Declines in other countries were also linked to international funding cuts and challenges related to PrEP access, uptake and retention. The largest country-level improvements were driven by expanded outreach, stronger demand for PrEP services, and the scale-up of community-based prevention programs in several countries. Country-specific notes: • Mozambique: The increase was mainly driven by stronger uptake among adolescent girls and young women and other priority and key populations. The main driver was higher-than-expected demand for PrEP, attributed to the expansion of HIV testing campaigns. • Sierra Leone: The increase was driven by new PrEP initiations among key populations, supported by peer-led community interventions, service integration, drop-in center upgrades, provider capacity building and increased walk-in clients. • Indonesia: The increase was primarily driven by growth among sex workers and men who have sex with men. This was supported by the expansion of service delivery sites and enhanced community-based PrEP promotion through outreach activities. • Uganda: Uganda's PrEP growth was supported by expanded health worker training, community-based service delivery, active engagement of key population organizations, awareness campaigns and improved access through updated PrEP guidelines. • Nigeria: The decline in people receiving PrEP was driven by reductions among sex workers, men who have sex with men, and people who use drugs, largely due to service disruptions at Community Services Coordination Centers (CSCCs) in 33 states related to international funding cuts, which negatively impacted donor-supported service delivery platforms. • Malawi: The decline was primarily attributed to international funding cuts, which disrupted PrEP service delivery and whose effects continued through 2025. Performance was further constrained by limited uptake of key population programming in public health facilities, partly due to persistent stigma and insufficient provider capacity. • Zimbabwe: The decline in people receiving PrEP was driven primarily by substantial reductions among sex workers and men who have sex with men related to international funding cuts, which resulted in the suspension of previously implemented key population programs. Following this disruption, significant numbers of districts were no longer supported. • Philippines: The decline in people receiving PrEP was driven by lower PrEP coverage and uptake among men who have sex with men. The decrease reflects challenges related to PrEP awareness, access, and continuation rates, staffing shortages affecting enrollment, follow-up, and data entry, as well as a shift from daily PrEP to event-driven dosing.
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TB	PEOPLE TREATED FOR TB	General note: 2025 was broadly stable compared to 2024. Growth in many countries was supported by expanded case-finding, diagnostics, outreach and private sector engagement. Declines in many countries reflected international funding cuts, stock-outs, equipment and workforce constraints, or reporting methodology changes. Country-specific notes: • Nigeria: Strong improvement indicating sustained improvements in case detection. This growth reflects the continued expansion of TB services through private sector engagement, which contributed 34% of notifications, and community referrals, which accounted for 40% of cases. • Bangladesh: Stable performance in 2025, maintaining consistent case detection rates with incremental improvements in notification systems. • Sudan: TB case notifications increased in 2025 following conflict-related disruptions to services at the onset of the war in mid-2023. The increase was driven by the restoration and expansion of TB services, improved reporting completeness, deployment of GeneXpert and TrueNat diagnostic platforms, expansion of mobile active case-finding services, and the gradual resumption of health services across the country by the end of 2024. • Pakistan: The decline is primarily due to a drop-off in performance in Punjab, which is the largest province, accounting for over 55% of the total TB notifications in the country. The province has implemented a different service delivery model, privatizing Basic Management Units. Operationalization of the new model has encountered some onboarding challenges, with an impact on TB case finding. • Thailand: Case-finding among migrants was low due to low screening tool sensitivity, legal/administrative access barriers, staffing vacancies, and the Thailand-Cambodia border conflict causing mass migrant returns. • Uganda: Service declined primarily due to the budget-related termination of implementing partners supporting Community Awareness, Screening, Testing, Prevention and Treatment (CAST) TB campaigns, sample referral networks and facility-level mentorship activities. • Kenya: The slight decline is due to international funding cuts. Despite these impacts, sustained achievements are due to healthy stocks of TB commodities available, a well-capacitated health workforce and well-strengthened active TB case-finding approaches due to scale-up in deployment of AI-assisted X-rays and intensified outreach. • Philippines: The decrease was primarily driven by shortages and delayed delivery of first-line TB drugs, which resulted in reduced screening by health staff and delayed treatment initiation.
	HIV-POSITIVE TB PATIENTS ON ANTIRETROVIRAL THERAPY DURING TB TREATMENT	General note: In many countries, the decline in the number of HIV-positive TB patients on antiretroviral therapy (ART) for HIV reflects fewer TB/HIV co-infected patients being detected rather than a deterioration in ART coverage. Declines in other countries were linked to international funding cuts, diagnostic commodity stock-outs, conflict-related service interruptions, weak coordination and referrals between TB and HIV programs, delayed ART initiation, patient migration, patients lost to follow-up, and incomplete documentation. Improvements in some countries were driven by stronger TB/HIV integration and one-stop services, expanded HIV testing within TB programs, better linkage to ART services, reliable antiretroviral supplies, staff training and supervision, and broader community or decentralized service coverage. Country-specific notes: • Indonesia: Significant improvement between 2024 and 2025. Further improvement can be made by addressing clinician delays in treatment initiation, education to address patient concerns about combined medication side effects, and interoperability gaps between TB and HIV information systems. • Malawi: Performance improved, maintaining >99% HIV treatment uptake rate for TB/HIV co-infected patients. The improvement was due to service expansion, reliable supply of treatment drugs, regular supervision, improved monitoring & evaluation systems, and staff training in TB/HIV collaboration. • Zimbabwe: Performance improvements were driven primarily by the implementation of integrated HIV testing within TB services. • Uganda: Service declined, reflecting operational challenges and reduced partner support following international funding cuts affecting community-level TB/HIV services. • Congo (Democratic Republic): The decline in the number of TB/HIV co-infected patients initiated on ART was primarily driven by stock-outs of HIV testing commodities at the health facility level. • Nigeria: The decline reflects reduced TB/HIV co-infection identification rather than treatment gaps. • Kenya: The number of TB/HIV co-infected patients, with the “test and treat policy” adopted by the country since 2015, has been declining. This decline compared to 2024 reflects this trend, indicating that patients are now being initiated on HIV treatment early enough before they develop TB.

PEOPLE ON
TREATMENT
FOR DRUG-
RESISTANT TB

General note: Improvements in many countries were driven by intensified active case-finding and community outreach, expanded use of GeneXpert and other rapid diagnostics, stronger private-sector and community referrals, and the geographic scale-up of TB services. Reported declines were mainly linked to international funding cuts, conflict and insecurity, diagnostic commodity stock-outs and equipment failures, workforce or health-system disruptions, and weaker access to screening and notification services.

Country-specific notes:

- **Philippines:** Modest improvement with a high treatment initiation rate at 95%. Key barriers: treatment completion challenges, adverse events management, and lost-to-follow-up requiring continued attention to patient retention strategies.
- **Kenya:** Performance improved, maintaining 100% treatment initiation rate for all notified cases. Strong programmatic performance demonstrates effective linkage between DR-TB diagnosis and treatment services.
- **South Sudan:** A treatment initiation rate of 100% was maintained across four consecutive semesters. Key drivers of strong performance included commodity availability and strong linkage between diagnosis and treatment for DR-TB.
- **Pakistan:** Improvement in diagnosed patients starting second-line treatment reflects growing (though still inadequate) DR-TB care capacity and improved linkage to treatment following diagnosis.
- **Congo (Democratic Republic):** International funding cuts interrupted the supply of GeneXpert cartridges and second-line TB drugs, resulting in under-detection of DR-TB cases and reduced treatment initiation. Delays in transmitting laboratory results to TB diagnostic and treatment centers further contributed to the decline.
- **Kazakhstan:** The number of TB notifications is consistent with the estimated incidence, which has been declining since 2015 as a result of the successful implementation of Kazakhstan's National TB Program.
- **Ukraine:** The decline is proportional to reduced case notifications rather than treatment access failure. Substantial population movements caused by the ongoing large-scale war have significantly affected the country's disease burden.

PEOPLE IN CONTACT
WITH TB PATIENTS
RECEIVED
PREVENTIVE
THERAPY

General note: The increase in this indicator was driven primarily by intensified household contact investigation and community outreach, broader eligibility and geographic scale-up, improved coordination between community workers and health facilities, and greater use of shorter preventive regimens. Declines in some countries were mainly linked to international funding cuts, preventive treatment stock-outs, weaker contact investigation and community activities, and fewer eligible contacts in some settings.

Country-specific notes:

- **Indonesia:** Strong performance was linked to a community-based household contact screening program innovation. This was achieved through intensified contact investigation, rigorous data validation, strong coordination between community health cadres and health facilities, and targeted advocacy and counseling.
- **Nigeria:** Strong improvement was linked to a large increase of initiations on shorter regimens, driving higher prevention treatment uptake. In addition, the National Childhood TB/HIV Testing Week contributed to accelerated enrollment.
- **Philippines:** Significant improvement was driven by the deployment of community volunteers to high-burden sites, nationwide online TB preventive treatment capacity building, standardized service delivery, and TB preventive treatment micro-planning at the local government level.
- **Pakistan:** The increase is associated with expanded contact screening efforts, including chest camps and greater use of X-ray services, as well as higher TB preventive treatment initiations in Punjab, Khyber Pakhtunkhwa and Balochistan.
- **Bangladesh:** Consistent performance improvement indicates a successful expansion of TB preventive treatment coverage among eligible populations, with community health workers contributing to the uptake of TB preventive treatment. Performance demonstrates steady progress in contact investigation and preventive treatment initiation.
- **India:** In 2024, India performed a National TB case-finding campaign that contributed to finding more contact cases that could receive TB preventive treatment. The 2024 value was therefore high relative to the 2025 value.
- **Uganda:** The decline was driven by international funding cuts that paused Community Awareness, Screening, Testing, Prevention and Treatment (CAST) TB campaigns and led to drug stock-outs, and the loss of human resources support in partner districts.
- **Tanzania:** The decline was driven by limited coverage of contact investigation. Only 27.6% of bacteriologically confirmed TB patient contacts were investigated, meaning a high proportion of eligible contacts were not reached.
- **Congo (Democratic Republic):** The decline was driven by weak community activities in the first half of 2025 due international funding cuts and reduced contact investigation in provinces previously supported by partners. There were also stock-outs of commodities noted in 2025.
- **Ghana:** The program faced new bottlenecks in contact tracing and enrollment in 2025, primarily due to reduced effectiveness of household contact tracing, challenges in identifying and screening eligible contacts, and delays in linking identified contacts to preventive treatment services.

Malaria	INSECTICIDE-TREATED MOSQUITO NETS DISTRIBUTED	General note: This service includes insecticide-treated mosquito nets distributed through both mass and continuous campaigns. Given the nature of mass campaigns, year-on-year trends are largely driven by shifts in the timing of mass campaigns at the country level. Large increases between 2024 and 2025 were usually driven by a 2025 mass campaign, while large declines were usually driven by a 2024 mass campaign followed by distribution through continuous modalities in 2025. Country-specific notes: • Nigeria: The increase in 2025 reflects campaigns in a total of nine states, compared to four states in 2024. This is in addition to the routine distribution of 3.5 million insecticide-treated nets (ITNs) distributed nationally. • Burkina Faso: Mass ITN campaign rolled out in 2025, whereas 2024 had only routine distribution. • Congo (Democratic Republic): The significant increase in the number of ITNs distributed in 2025 compared to 2024 is primarily due to delays in the implementation of five campaigns originally planned in 2024. Campaign implementation delays in five provinces were negatively affected by delayed reimbursements, delays in international logistics, coordination challenges, and armed conflict disrupting local transport in remote provinces. • Cameroon: Mass campaign rolled out in 2025 at the national level, which successfully reached the intended households, ensuring broad population coverage. This strong performance was supported by effective coordination and collaboration among the government, partners and regional stakeholders. Routine ITN distribution was maintained. • Malawi: Improvement was driven by a digitized mass ITN campaign in 2025. The use of the digital platform enabled real-time data tracking, improved coordination, and informed decision-making, supporting effective campaign implementation. • Niger: 2024 featured a mass ITN campaign, whereas 2025 included only routine distribution activities. • Madagascar: 2024 featured a mass ITN campaign, whereas 2025 included only routine distribution activities. In addition, delivery delays were noted in the first half of the year due to rationing. • Côte d'Ivoire: 2024 featured a mass ITN campaign, whereas 2025 included only routine distribution activities. In addition, challenges included delayed ordering of nets and non-adherence to distribution plans by central medical stores. • Ghana: 2024 featured a mass ITN campaign, whereas 2025 included only routine distribution activities.
	PREGNANT WOMEN RECEIVED PREVENTIVE TREATMENT FOR MALARIA	General note: The increase was driven primarily by improved availability of preventive treatment medicines, stronger integration with antenatal care services, earlier and more frequent antenatal attendance in many countries, expanded community outreach and engagement, improved provider adherence and monitoring, and broader reporting coverage. Declines in some countries were primarily linked to stock-outs of preventive treatment medicines, low antenatal care attendance, protocol non-compliance, and challenges integrating preventive malaria treatment into routine maternal health services. Country-specific notes: • Nigeria: Improvement in 2025 was related to increased antenatal care attendance among pregnant women. However, challenges with uptake were noted, related to stock-out issues of preventive treatment medicines. • Tanzania: Improvement was related to availability of preventive treatment medicines, early antenatal care service booking promotions, enhanced facility-level data reporting, and improved supervision. • Uganda: Service improvements were driven by enhanced health facility capacity contributing to improved treatment outcomes. • Central African Republic: Improvement was driven by strengthened integration of preventive malaria treatment to antenatal care services, improved availability of preventive treatment medicines, enhanced provider adherence, community engagement, and expanded antenatal care access points. • Malawi: Significant improvement compared to 2024, though notably coverage remains low due to limitations in early antenatal care coverage and uptake of prevention treatment. • Madagascar: The declines were primarily related to protocol non-compliance, supply chain stock-outs, geographic and sociocultural barriers, and weak coverage in remote geographical districts. • Angola: Protracted low antenatal care attendance remains an important barrier to increasing coverage of preventive malaria treatment for pregnant women. • Burundi: The declines in nearly all districts were related to stock-outs of prevention medications, drug quality concerns, and challenges integrating preventive malaria treatment services into routine maternal health services. Late attendance of pregnant women at

		antenatal care and drop-off of pregnant women receiving the doses posed additional challenges. • Congo (Democratic Republic): The decline was related primarily to limited availability of preventive treatment medications at the health facility level, especially in geographical areas related international funding cuts, as well as ongoing antenatal care attendance patterns including late initiation of antenatal care. • Zimbabwe: Performance declined driven by widespread regressions at the provincial and district levels. The deterioration observed across multiple geographic areas was related to international funding cuts.
	CHILDREN WHO RECEIVED SEASONAL MALARIA CHEMOPREVENTION (SMC)	General note: The increase was driven primarily by several high-volume countries newly reporting this indicator in 2025. Other country-level increases came from wider campaign coverage and improved delivery across additional districts and eligible populations. Declines in many countries were linked primarily to narrower campaign scope or eligible age group as well as data collection constraints. Country-specific notes: • Togo: Performance improved significantly with seasonal malaria chemoprevention scale-up successfully reaching targeted children in transmission areas, due primarily to improved facility reporting, strong staff training and community volunteer engagement. • Niger: The increase was driven by the nationwide implementation of SMC, expanding coverage from 67 districts in 2024 to all 72 districts in 2025. This expansion, together with population growth and improved data reporting quality, increased the number of children reached. • Uganda: Improvements were driven by the door-to-door delivery strategy and strong community mobilization particularly in the Karamoja region. Coverage extended to children across nine districts, reached via Village Health Teams. • Nigeria: Performance was constrained due to differences in reporting from states not supported by the Global Fund. Additionally, population movements in border states or conflict zones affected reporting. • Guinea-Bissau: The decline in the number of children covered was driven by the prioritization exercise conducted during the first half of 2025, the revision of the target population to children under 5 years of age, instead of the initially proposed target of children under 10, and the prioritization of high-burden areas. • Ghana: The slight decline can largely be attributed to security challenges affecting access to some communities and a reduced time period for registering and providing doses to children in SMC Cycle 1, resulting in a lower cohort. This contributed to SMC coverage improving from 96% to 99% in 2025. • Mauritania: The decline is attributable to data collection tool issues as well as the refugee influx at the Mali border.
	SUSPECTED CASES TESTED FOR MALARIA	General note: The increase was driven primarily by expanded testing through public, private and community channels, improved availability of rapid diagnostic tests, strengthened laboratory services and adherence to test-before-treat policies, and broader reporting coverage. Declines in some countries were primarily linked to lower malaria caseloads. In other countries, diagnostic stock-outs and supply disruptions, reduced community testing related to international funding cuts, protocol non-compliance, and reporting or data-quality limitations drove declining performance. Country-specific notes: • Nigeria: The absolute number of suspected cases of malaria tested at both the facility and community level increased between 2024 and 2025 with more cases being tested at both levels. It is hard to determine whether this could indicate an increase in cases, better access, and/or improved quality of care. • Indonesia: The improvement is related to additional cadres conducting tests in 2025. There was particular improvement in public sector testing and community-based testing. • Zambia: Zambia experienced an increase in rainfall following the droughts of 2023/24, leading to relatively increased transmission of malaria. Furthermore, improvement in testing was driven by improved availability of rapid diagnostic tests, strengthened laboratory services, and enhanced test-before-treat policy adherence across health facilities. • Malawi: Testing coverage remained near-universal. The year-on-year decline in the number of tests conducted reflects a reduced malaria case burden rather than any deterioration in program performance, likely attributable in part to the impact of the 2025 mosquito net mass distribution campaign, which contributed to lowering malaria transmission and reducing the demand for testing. • Congo (Democratic Republic): Testing coverage remained low in both public health facilities and the community. The decline in performance was mainly driven by stock-outs of rapid diagnostic tests and supply chain disruptions, mainly in areas supported by partners, and delays in the transport and distribution of commodities.

	• Burkina Faso: The decline reflects reduced malaria burden and caseload (epidemiological trend); parasitological testing coverage remains high. • Madagascar: The decline reflects protocol non-compliance in certain geographical areas, as well as stock-outs, issues with staff training, and low hospital report completeness. International funding cuts impacted community testing. Burundi: The decline was driven by testing at the community level, highlighting ongoing challenges in community-based malaria testing coverage and data quality. In contrast, testing at facilities maintained strong performance in 2025.
CASES OF MALARIA TREATED	General note: The decline was primarily driven by two distinct trends. In some countries, lower malaria caseloads led to fewer cases treated. In other countries, there were fewer proportional cases treated, driven by antimalarial stock-outs, supply-chain constraints, protocol non-compliance, workforce turnover, international funding cuts, and reporting issues limiting treatment. Improvements in some countries were driven by better availability of antimalarial medicines, strengthened facility and community case management, greater community health worker engagement, and improved monitoring. Country-specific notes: • Zambia: Zambia experienced increased rainfall following the droughts of 2023/24, leading to relatively increased transmission of malaria. Strong improvement driven by improved availability of first-line malaria treatment medications, enhanced case management capacity, and increased community health worker engagement in malaria control activities. • Nigeria: There was an increase in the absolute number of suspected cases tested in 2025 compared to 2024, alongside an increase in the test positivity rate at community and facility levels. This led to an increase in confirmed cases. • Guinea: Treatment rates at public, community and private facility levels were high. Community treatment in particular improved following a Ministry of Health and Public Hygiene directive to strengthen the supply of community health workers, together with improved monitoring. • Malawi: Treatment coverage remained high in 2025, with gaps due to stock-outs of first-line antimalarial medications in some facilities and patients purchasing from private pharmacies. The decline in 2025 reflects changes in reported malaria cases rather than a declining treatment coverage rate. • Burkina Faso: The decline is primarily due to a reduced malaria caseload, as the treatment coverage rate among confirmed cases remains at 100%. This indicates strong case management despite lower absolute values. • Madagascar: The decline in 2025 was related primarily to protocol non-compliance, input stock-outs, staff turnover, and international funding cuts. • Congo (Democratic Republic): The slight decline in malaria cases treated was correlated with reduced testing capacity and first-line antimalarial medical availability challenges. However, the treatment-to-testing ratio remains high, indicating effective case management when commodities are available. Burundi: Treatment coverage remained high in 2025, supported by availability of antimalarial medications and adherence to treatment guidelines. The decline reflects the lower number of reported confirmed cases, while some data quality gaps persist across districts.