AHF AIDS HEALTHCARE FOUNDATION

GLOBAL QUALITY REPORT 2025

PREPARED BY GLOBAL QUALITY, HMIS & MEDICAL TEAMS

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List of Acronyms

ART	Anti-Retroviral Therapy
BoD	Board of Directors
C&T	Care and Treatment (HIV health facility)
CD4	CD4+ cell count (Lymphocytes T)
CME	Continued Medical Education
CSO	Civil Society Organization
CSS	Client Satisfaction Survey
GQR	Global Quality Report
GQT	Global Quality Team
GTPT	Global Testing and Prevention Team
HCW	Health Care Workers
HF	Health Facility
HFA	Health Facility Assessment
HMIS	Health Management and Information Systems
HTC	HIV Testing & Counseling
INH	Isoniazid
KVP	Key & Vulnerable Population (for HIV)
LAC	Latin America and the Caribbean Region
LTFU	Lost to Follow Up
LP	Late Presenter
MC	Medical Circumcision
M&E	Monitor and Evaluation
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NLIC	No Longer in Care
ORI	Optimize Retention Initiative
PITC	Provider Initiated Testing & Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PPR	Provider Productivity Report
PWID	People Who Inject Drugs
Q1	Quarter year (Q1 -Q2 -Q3 -Q4)
QBM	Quality Benchmark
QI	Quality Improvement
R&R	Recording and Reporting
RTP	Rapid Test Program
STI	Sexually Transmitted Infections
TG	Transgender persons
TIMS	Time In Motion Survey
TO	Transferred Out
TPT	Tuberculosis Preventive Treatment
VL	HIV Viral Load
VMMC	Voluntary Medical Male Circumcision
US	United States
WCG	Wellness Center Grant (AHF)
Yrs	Years old
YTD	Year to Date

01

Introduction

The AHF Global Quality Report (GQR) for 2025 documents the progress, consolidated results, and achievements of the Global Program across the HIV continuum of care, as well as associated quality initiatives and benchmarks for the year 2025. The report is further enriched with trend analyses covering the past five to ten years. Data presented originate at the facility level, are systematically collected through country offices and bureaus, and are submitted to the Global Health Management and Information Systems (HMIS) Team.

The GQR encompasses the Quarterly Feedback Reports and the Prevention and Enrollment Dashboard. It serves as a reference document for all Global Program staff to analyze performance and drive quality improvement (QI) by refining strategies and using routinely collected, analyzed, and reported data from facility staff and country and bureau teams.

Members of the Global Quality Team (GQT), together with their bureau, country, and facility-level teams, worked diligently to implement new and updated Global Program strategies, initiatives, and tools. Despite challenges, steady progress has been demonstrated. The report presents results from the overhauled web-based Recording and Reporting (R&R) system, which includes the Weekly and Quarterly Provider Productivity Report (PPR), the Quarterly Quality Benchmarks (QBM), and the Monthly HIV Testing and Condom Management Report.

These tools generate a wealth of quality data that are regularly presented through online dashboards, summary reports, and detailed feedback reports for immediate use, analysis, and action. The scale-up of the “Track-Positive” initiative documents the pathway from HIV-positive testing to effective linkage to care and has resulted in a significant increase in confirmed linkage.

The overall census of clients in care is approaching the three-million mark in 2025 and is expected to surpass this milestone in 2026, reflecting the collective efforts of AHF staff on the ground, supported by country and bureau teams.

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The number of Care and Treatment (C&T) facilities implementing the Optimize Retention Initiative (ORI) continued to grow, with facilities adopting new M&E tools for online recording and reporting. The annual Medical Record Audit, assessing client retention, baseline CD4 count, viral load (VL) coverage, VL suppression, and TB preventive treatment (TPT) across all supported C&T facilities, was completed. In addition, Health Facility Assessment 2025, Round IV, was completed for the vast majority of Global Program–supported C&T facilities, often in conjunction with the Medical Record Audit.

On the medical front, syphilis and other STIs received increased focus. STI courses offered through the CME eHealth Academy platform resulted in increased participation and a high number of certificates issued.

Retention remained a core focus in 2025, alongside STI control and implementation of the AHF Wellness Center model. Nearly all approved grant proposals were implemented, and new STI-focused AHF Wellness Centers across the four bureaus became fully operational, providing STI and HIV prevention services to growing numbers of clients, with monthly reporting to the Global Program.

Toward the end of the year, the biennial Global Quality Meeting was convened in São Paulo, Brazil, bringing together a broad cross-section of AHF's global quality leaders. This successful four-day event featured a robust and forward-looking agenda centered on its flagship theme, "Sustaining Quality 3.0: 2026 and Beyond." The key outcomes and strategic priorities emerging from the meeting are highlighted in the closing section of this 2025 Report.

All of this progress, together with numerous results and trends, is presented and discussed in this report reflecting the strong support and coordination provided by the Global Medical (GMT), Quality (GQT), HMIS, and Prevention and Testing (GPT) Teams, who invite readers to review and use these valuable data and remain open to feedback, suggestions, corrections, and ideas for continuous improvement.

Retention remained a core focus in 2025, alongside STI control and implementation of the AHF Wellness Center model.

The Global Quality data are accessible as an annually updated infographic presentation on the **AHF Website:** https://www.aidshealth.org/about/.

Figure 1.1: The HIV Testing and Prevention Snapshot, 2025

56,279,252

2025 CONDOM TARGETS

64,630,186

2025 CONDOMS DISTRIBUTED

CONDOMS DISTRIBUTED IN

46 COUNTRIES

INCLUDES US

115%

2025 Condoms Achievement

INCLUDES USA

126,588

NUMBER OF PEOPLE POSITIVE

2.6%

POSITIVITY RATIO

INCLUDES USA

4,909,543

NUMBER OF PEOPLE TESTED

111%

2025 HIV Testing Achievement

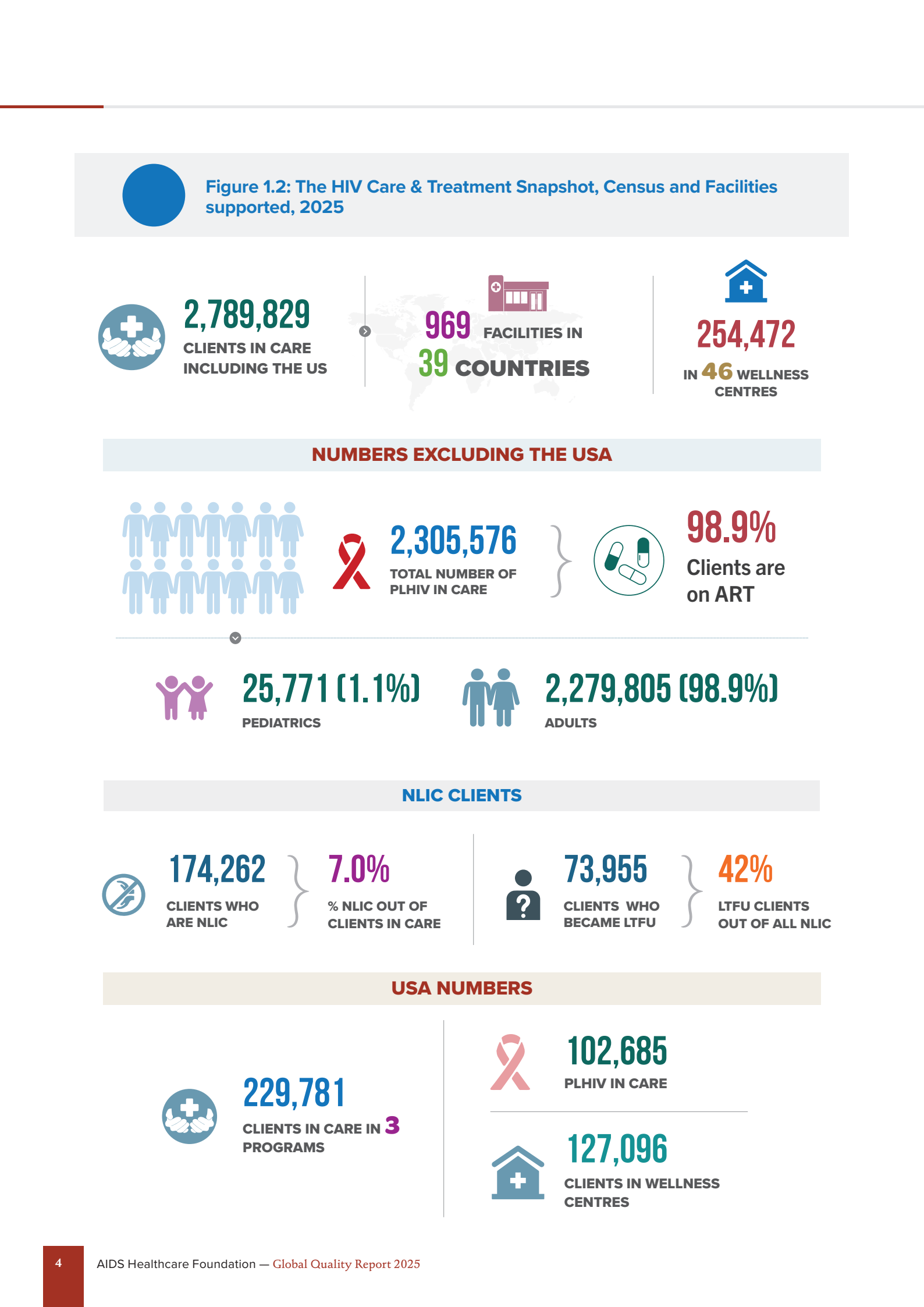
EXCLUDES USA

112,947

PEOPLE LINKED TO CARE

91% of People tested are Linked to care

Figure 1.2: The HIV Care & Treatment Snapshot, Census and Facilities supported, 2025



2.1 Condoms distribution

Globally, AHF contributes to HIV prevention through the distribution of over 60 million condoms annually, of which 34% are AHF branded condoms (Love and Icon). This effort is channeled through standalone AHF facilities, partnerships with governments and CBOs, and various outreach and prevention activities. Global program data shows a concerning decline in condom distribution since 2019, as observed in **Figure 2.1.1.**

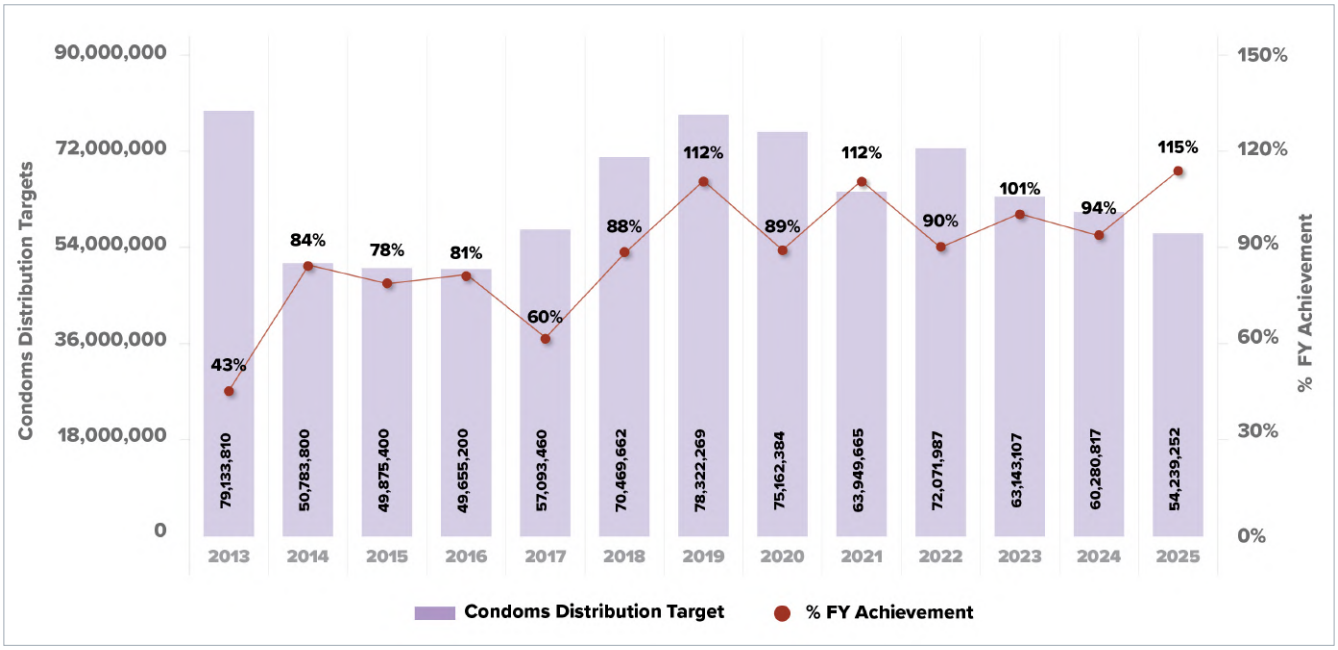
Condoms distribution targets were on a steady decline from 2019, decreasing from over 78 million to 55 million condoms by the end of 2025. This trend aligns with other publications indicating a worldwide drop following the COVID-19 pandemic, due to a syndemic of disruptions: pandemic logistics, behavioral changes, biomedical advancements, funding constraints, and enduring stigma.

For AHF as an organization, this underscores the need for a multi-pronged response:

- **Reinvestment in Dual-Messaging:** Promoting condoms as essential for comprehensive prevention (HIV, STIs, pregnancy) alongside, not opposed to, PrEP and ART.
- **Innovative Distribution:** Scaling up non-clinical access points (vending machines, peer networks, geosocial app integration) to complement facility-based distribution.
- **Advocacy:** Highlighting the cost-effectiveness and broad protection of condoms to safeguard them in global and national health budgets.

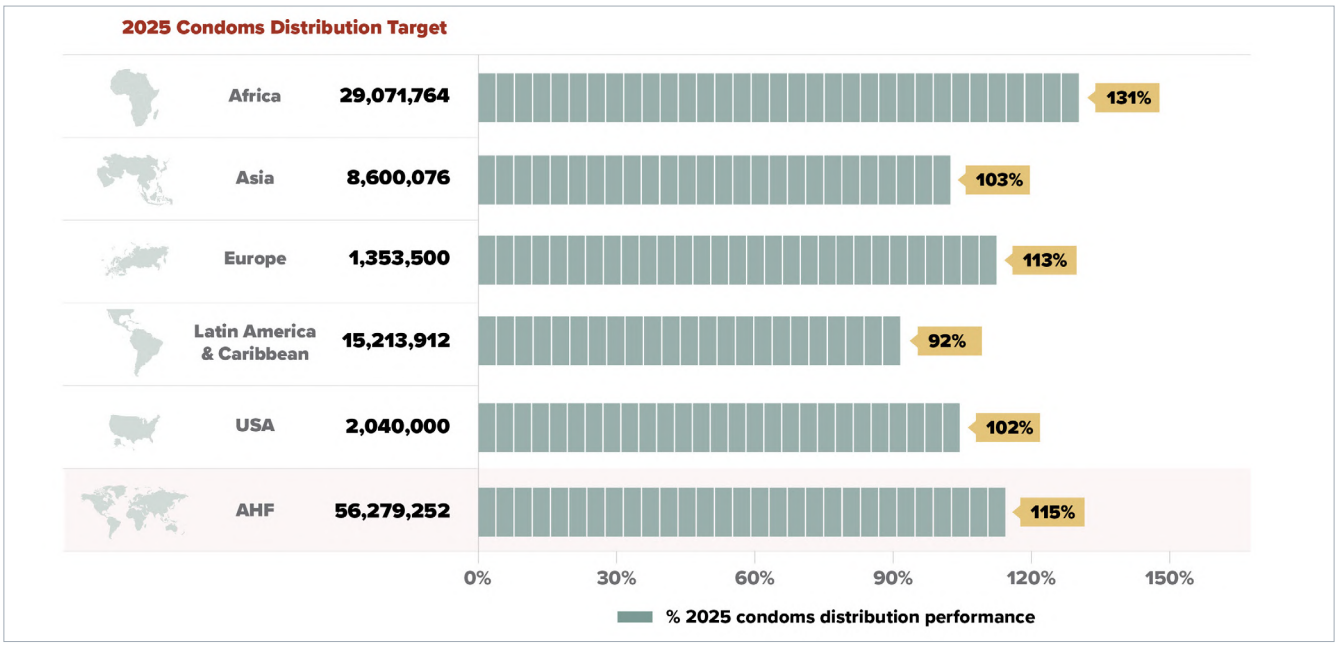
Figure 2.1.1 below shows condoms distribution against global program targets between 2013 and 2025. The set targets were on a steady decline from 2017, decreasing from over 78 million to 55 million condoms by the end of 2025. Overall, the trend reflects sustained capacity to exceed distribution targets in recent years.

Figure 2.1.1: AHF condoms distribution, 2025. Performance towards targets, by Bureau



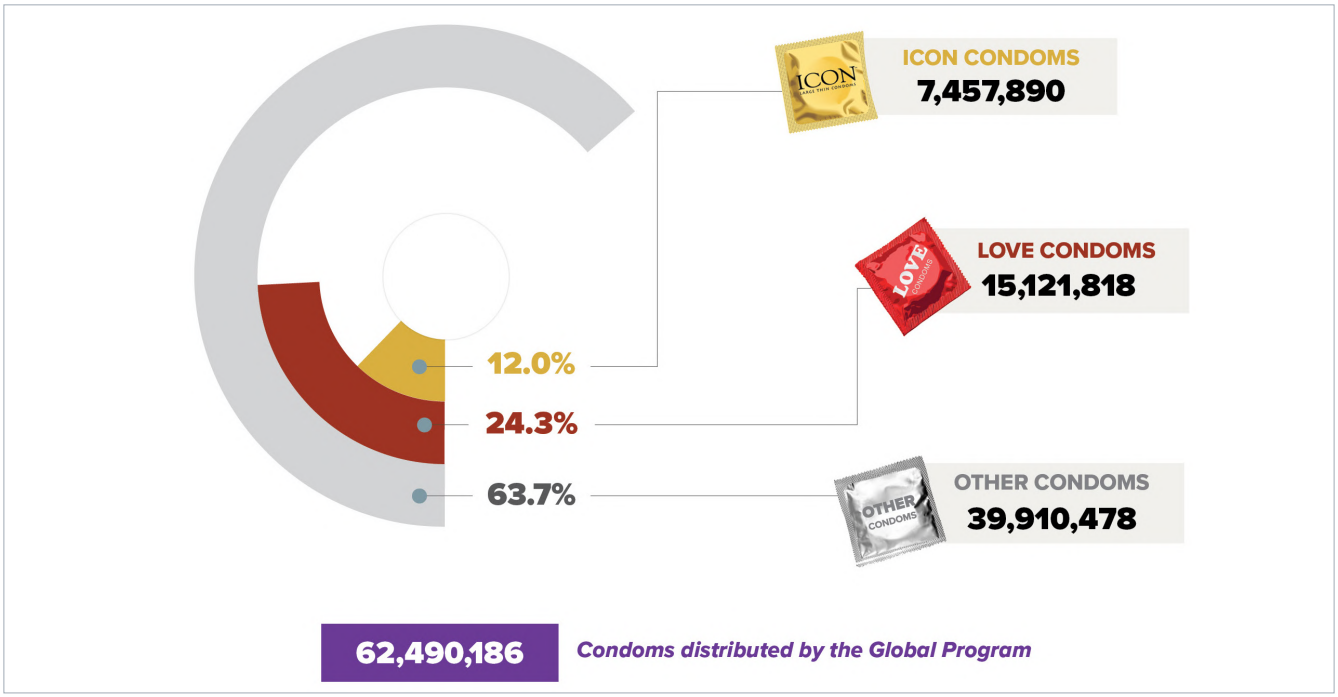
The year 2025 condom distribution against the set targets for the year, **figure 2.1.2 below,** shows improved performance, with the global program exceeding its target at 115%, driven primarily by Africa, achieving 131% of its target. Europe (113%), Asia (103%), and the USA (102%) surpassed their targets, indicating effective implementation and demand across regions. Latin America and the Caribbean reached 92% of the target.

Figure 2.1.2: AHF condoms- 2025. Performance towards set targets for number of condoms to be distributed, by Bureau



Figures 2.1.3 and 2.1.4 show that 64% of condoms distributed by the Global Program were non-AHF branded, largely comprising condoms donated by governments and partners, as well as non AHF-branded but AHF-procured condoms.

Figure 2.1.3: Global condom distribution achieved in 2025, by brand.



Africa, Europe, and the Latin America & Caribbean (LAC) Bureaus distributed at least 60% of their condoms as "Other" types (condoms purchased by the local government or other donors), whereas the Asia Bureau is dependable of AHF branded condoms (more than 70% of the totally distributed condoms), as are some countries in the Africa Bureau as well.

Figure 2.1.4: Global condom distribution by bureau, AHF brand (Love or Icon) or "Other", 2025

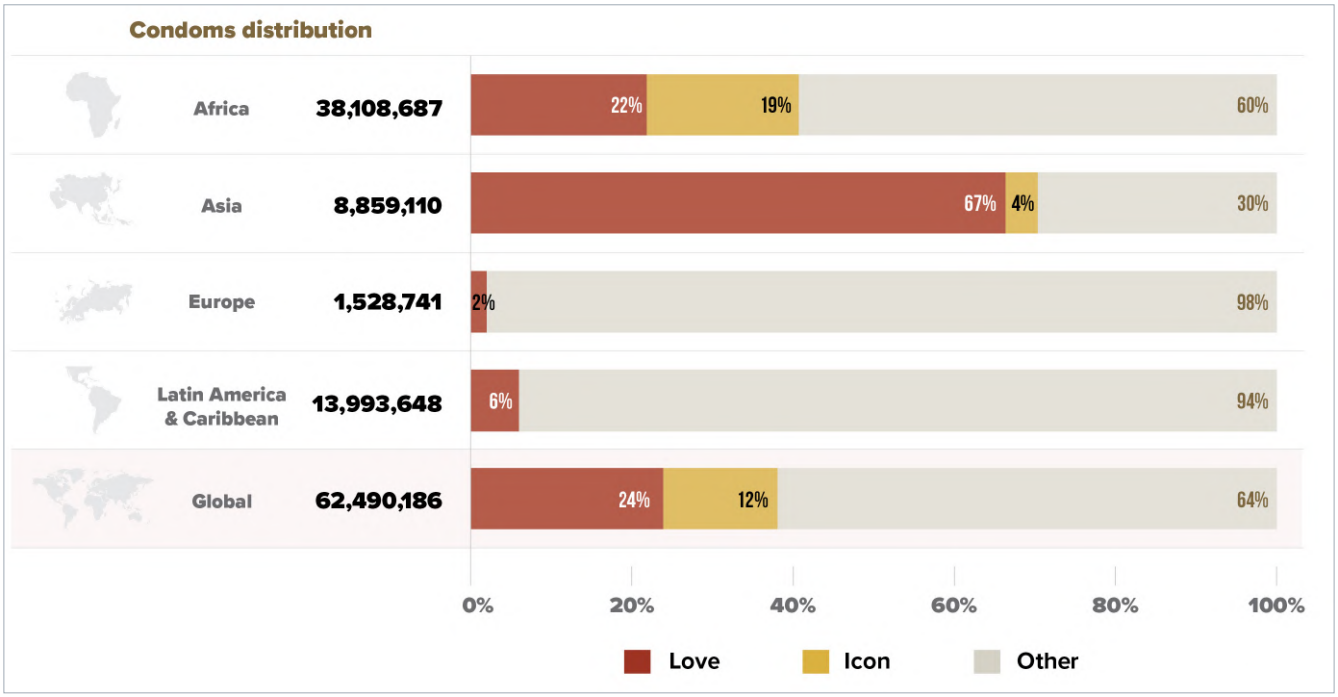


Figure 2.1.5 reveals a trend: whereas the distribution of "other" condoms has increased, the distribution of AHF-branded condoms (Love/Icon) has declined significantly over time. Though this shift could partly reflect positive strides in national ownership, the overall declining trend in condom access remains serious, suggesting that national systems are not yet fully compensating for the reduction in donor-supported supply. This situation underscores that AHF's role in ensuring consistent procurement, quality assurance, and targeted distribution will remain prominent, and may even become more essential, to sustain prevention gains in its supported countries.

Therefore, the shift in procurement source is not a problem itself. It necessitates a two-part analysis: First, reviewing total condom distribution volumes to ensure overall access is maintained or expanded. Second, investigating the underlying reasons—likely rooted in national ownership policies and sustainable financing—to confirm this trend aligns with the strategic goal of building independent, resilient national HIV prevention programs.

Figure 2.1.5: Six-year trend in condom distribution, AHF brand (Love or Icon) and Other condoms, 2020-2025

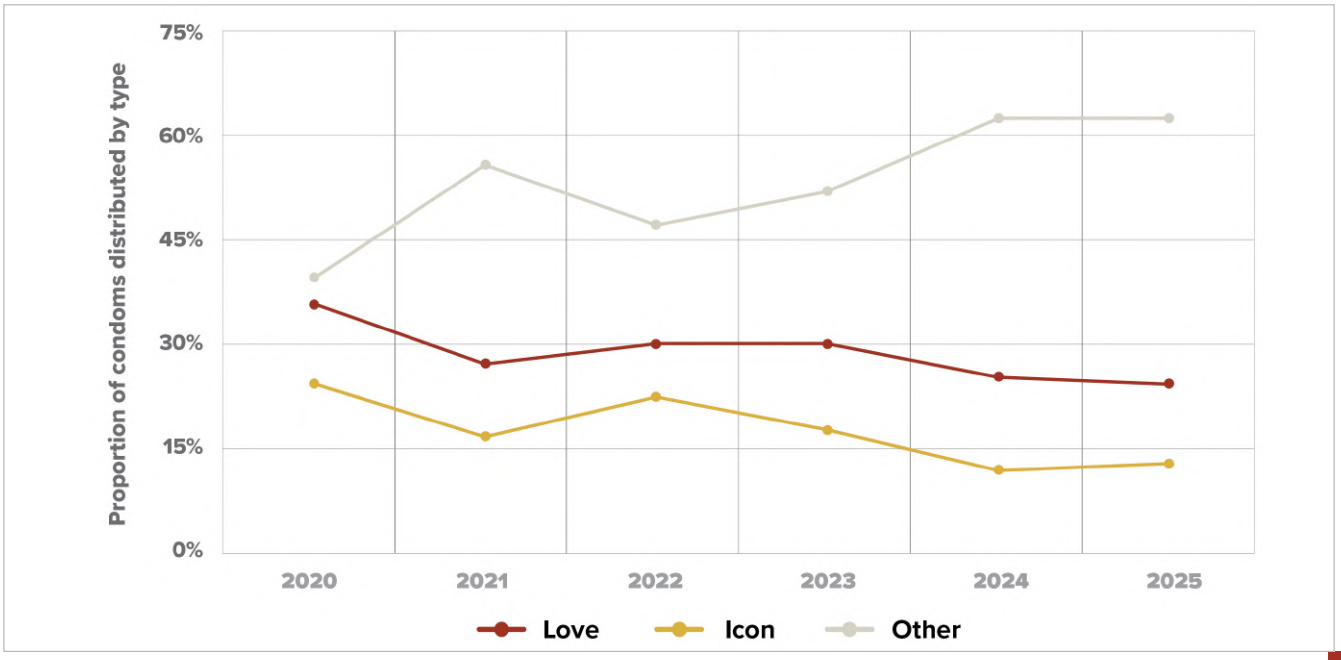
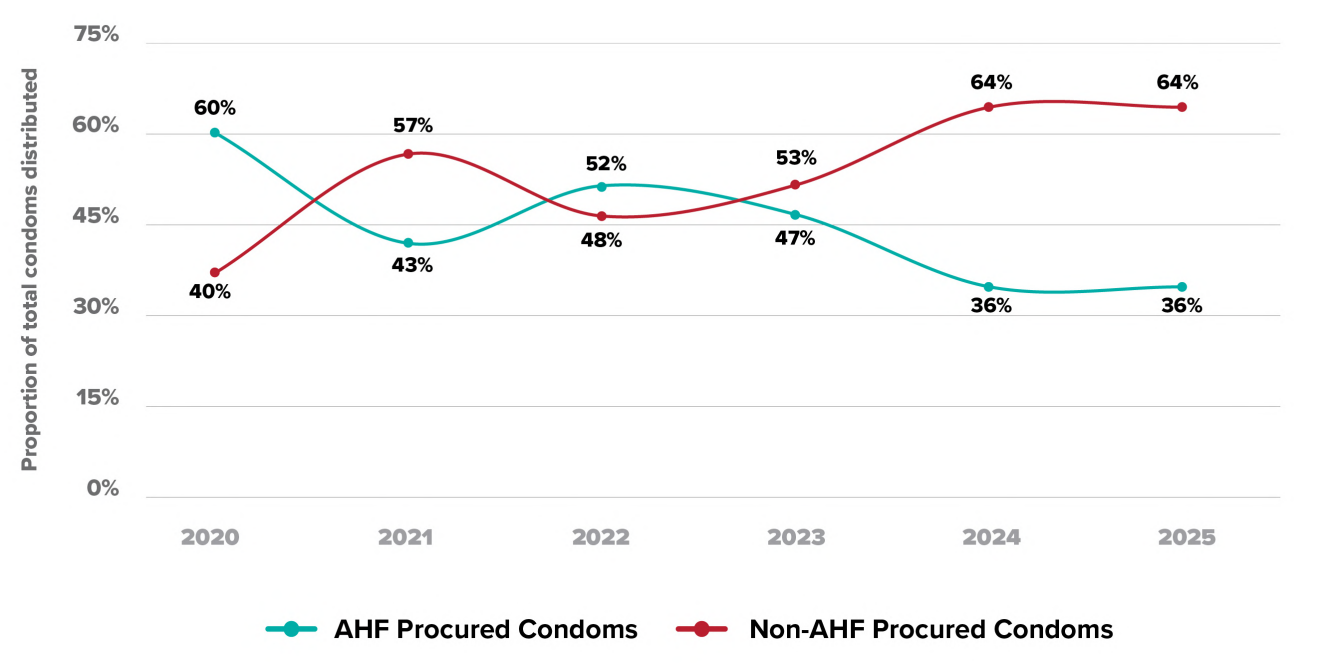


Figure 2.1.6 represents a six-year trend in condoms distributed by type – AHF procured or non-AHF procured – between 2020 and 2025. The chart illustrates a clear strategic shift from a primary reliance on AHF procurement in 2020 to a primary reliance on non-AHF sources by 2024-2025. The transition period spanned 2021 to 2023, after which the procurement mix stabilized with non-AHF sources accounting for a substantial and consistent majority.

Figure 2.1.6: Six-year trend in condom distribution, AHF procured and non-AHF procured. 2020-2025



03 HIV Testing

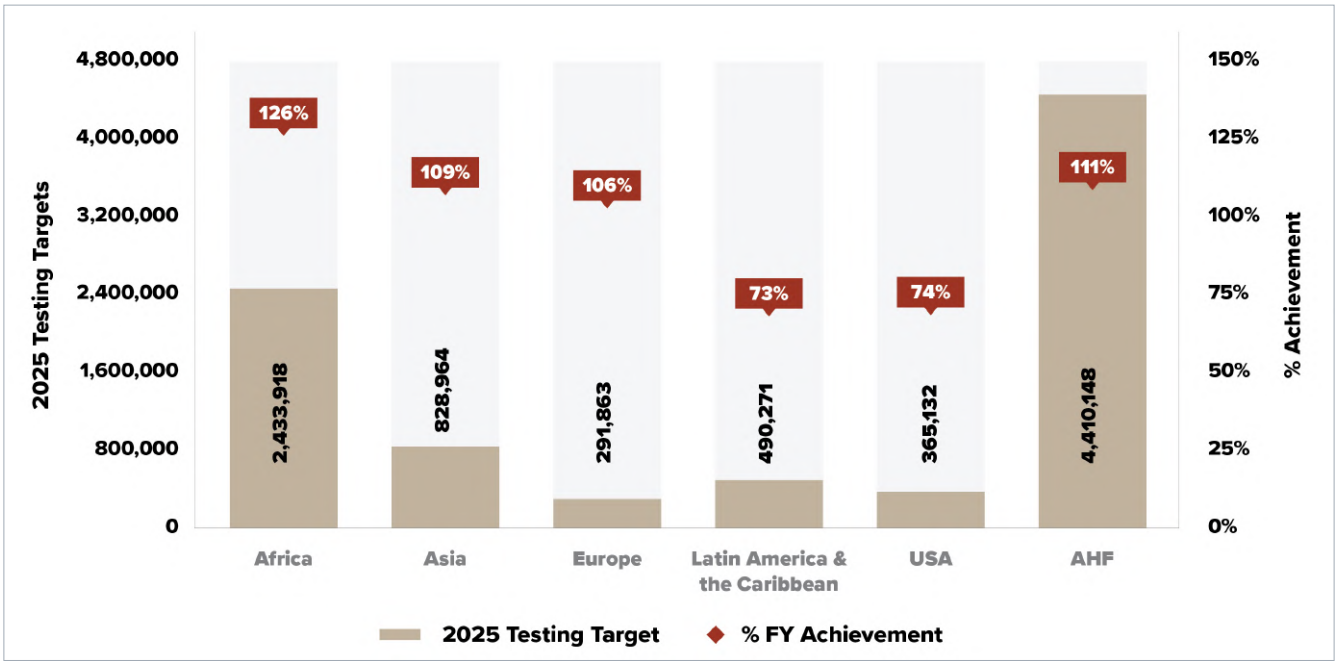
3.1 Test Program Performance

In 2025, 48 countries, including the United States, tested 4,909,543 people for HIV and identified 126,588 positive cases during the year, resulting in an overall positivity rate of 2.6%.

3.1.1 Test performance against annual AHF program targets for 2025

AHF exceeded the global 2025 testing target, reaching 111%, driven by Africa (126%), Asia (109%), and Europe (106%), with Latin America and the Caribbean (73%) and the USA (74%) lagging. This data reflects targets largely informed by prior-year achievements. The variations across bureaus indicate differences in implementation capacity and operating context.

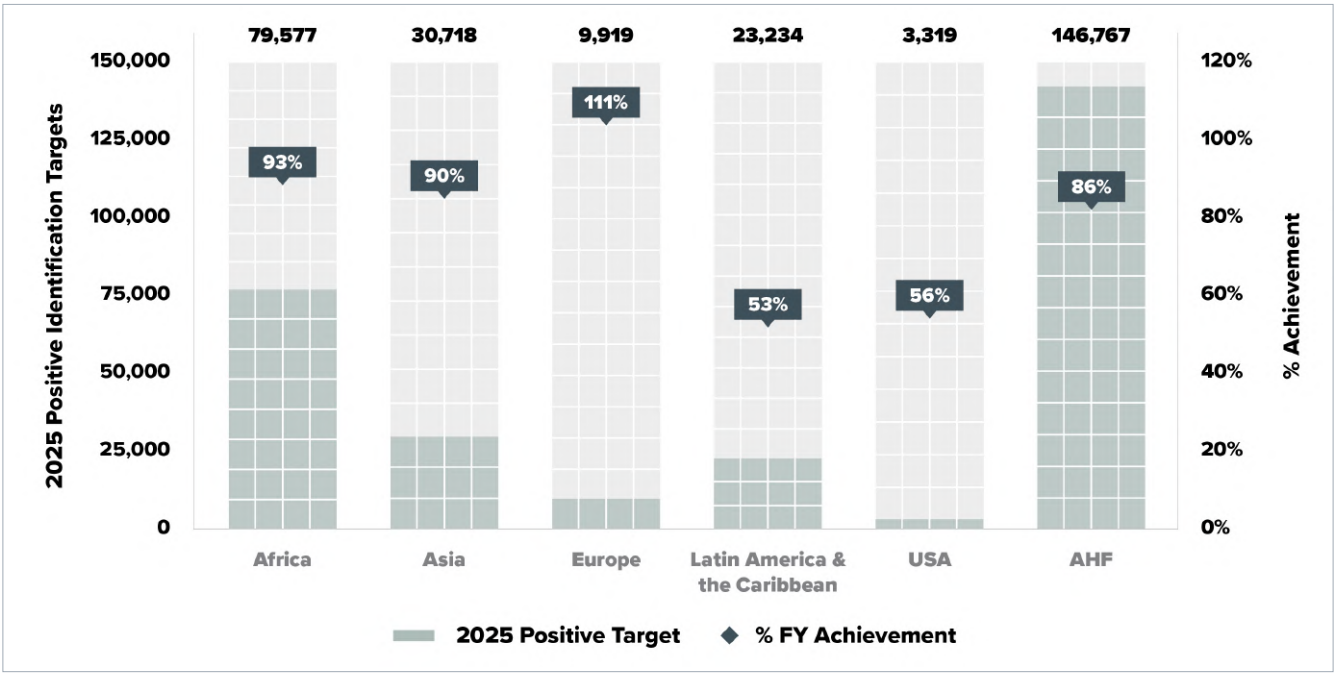
Figure 3.1.1: HIV testing targets and the achievement against set targets for number of people tested, 2025



3.1.2 Test positivity performance towards AHF program annual targets for 2025

Overall, 86% of the HIV positive's identification targets for the year 2025 were achieved. This is a 5% drop compared to 2024. Europe Bureau surpassed its annual targets for HIV positive client's identification by achieving 111% as shown in **figure 3.1.2 below.**

Figure 3.1.2: HIV positive identification targets and the annual achievement against the targets for 2025

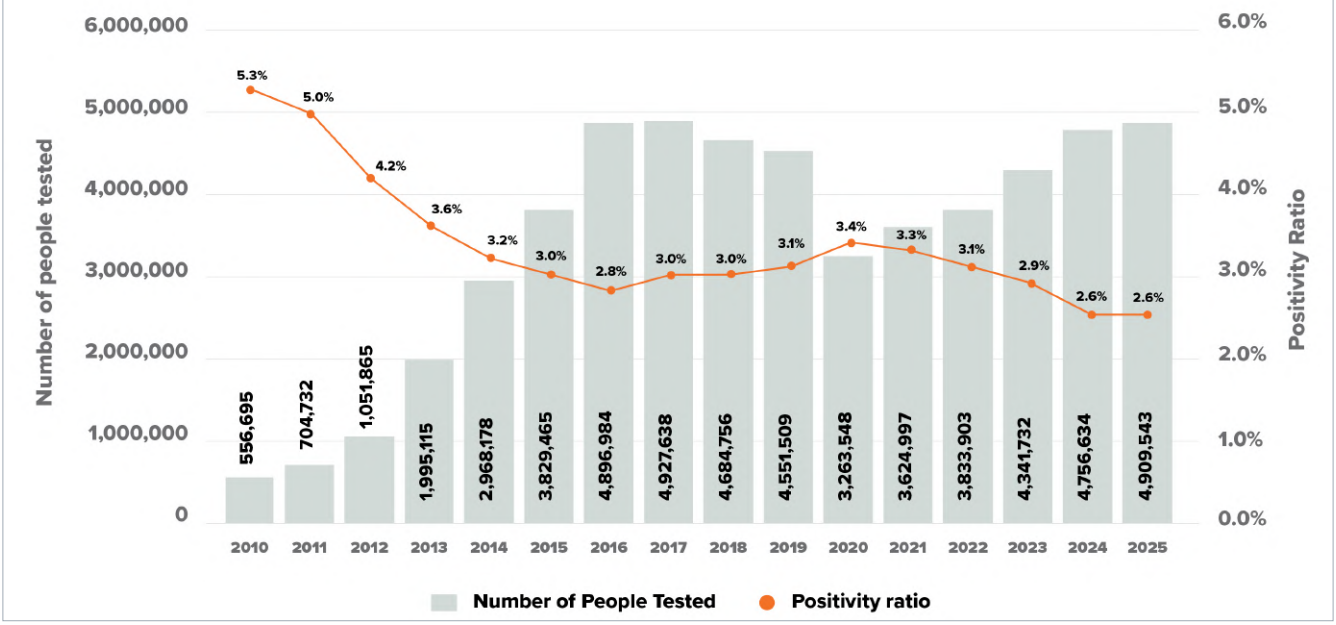


3.2 Testing outcome and identification of PLHIV

The HIV positivity ratio has shown a steady linear decline from 3.4% in 2020 to 2.6% out of the 4,909,543 tests that were conducted in 2025. This decline in the positivity ratio occurred alongside a significant increase in the number of clients tested, even though testing strategies became more targeted. This likely reflects two promising global trends: a documented decline in new HIV infections and a steady increase in the number of people living with HIV (PLHIV) who already know their status.

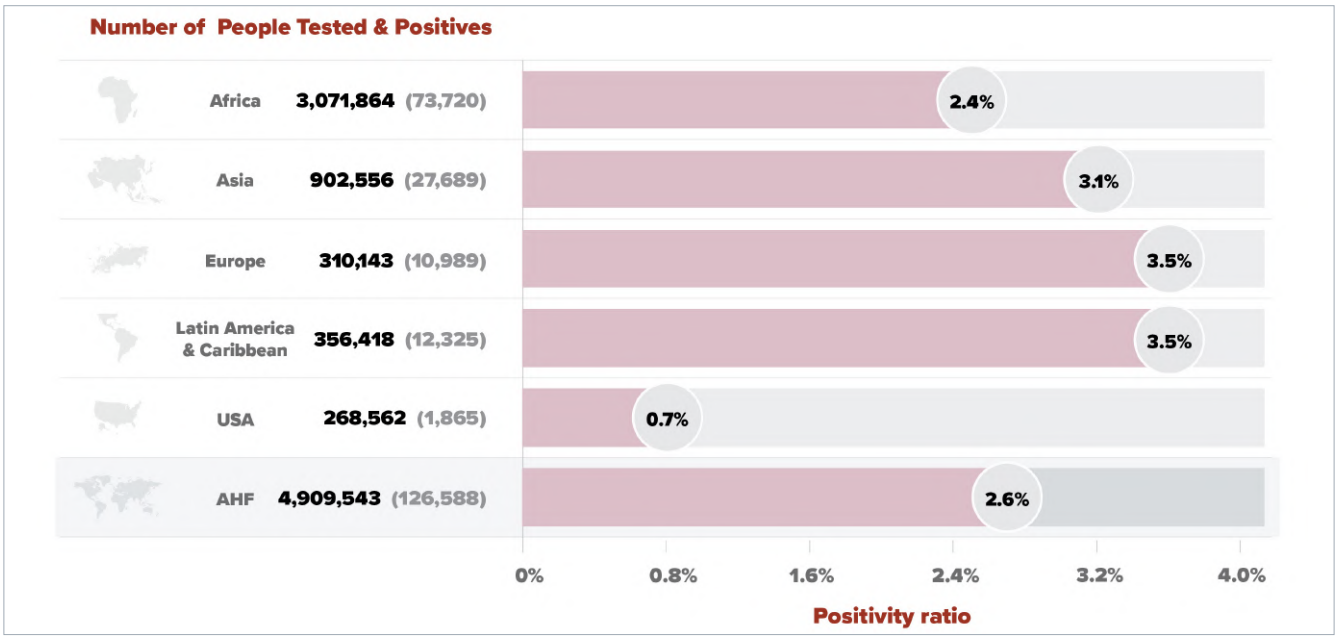
Yet to maintain program efficiency and impact, global program testing approaches are constantly evaluated based on granular data analysis, shifting toward investing in the highest-yield interventions, such as expanding Sexual Partner Testing and integrating HIV testing into open-door STI services, as exemplified by the Wellness Center Initiative.

Figure 3.2.1: Trend - number of people tested and positivity ratio, 2010 to 2025 (Includes US)



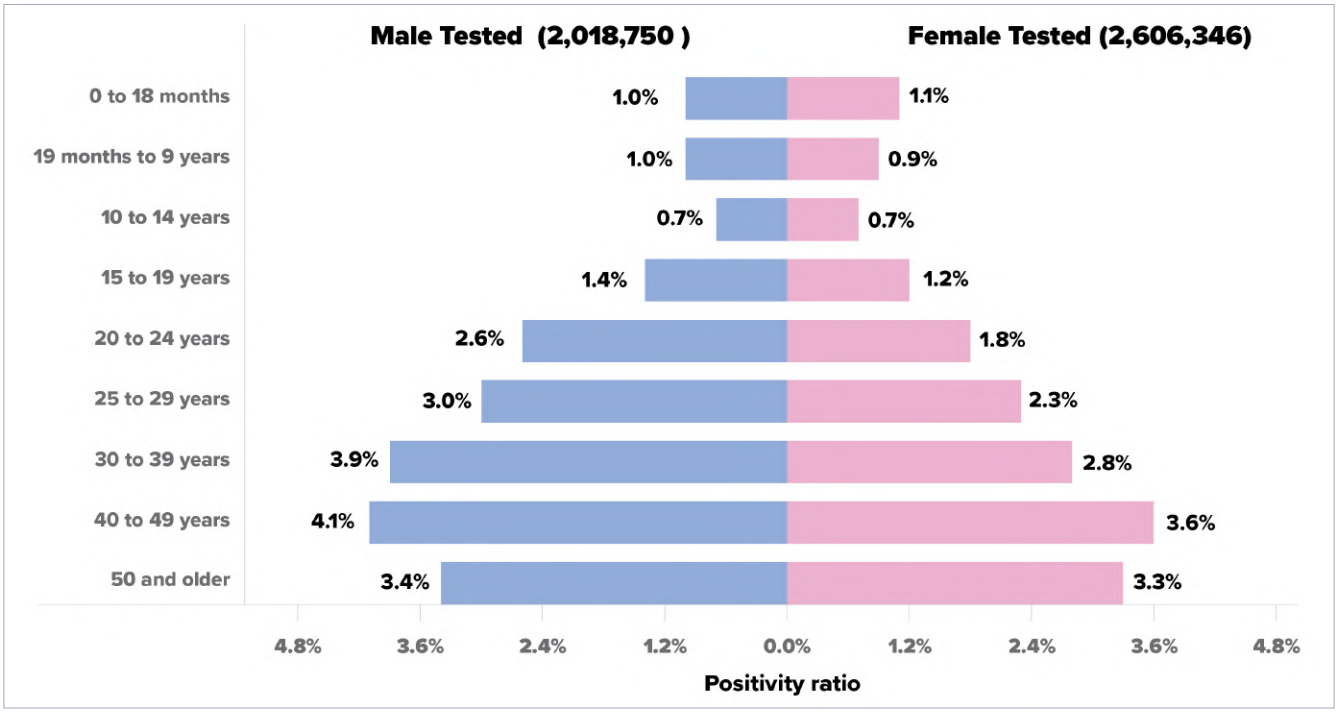
The average HIV positivity ratio stood at 2.6% (bureau range 0.7% to 3.5%), out of the 4,909,543 tests that were conducted as shown in **figure 3.2.2 below.** Europe and Latin America and the Caribbean Bureaus had the highest positivity ratio of 3.5%. Africa Bureau accounted for more than 60% of the number of clients tested in 2025.

Figure 3.2.2: Number of HIV-tested clients and positivity ratio by bureau - 2025



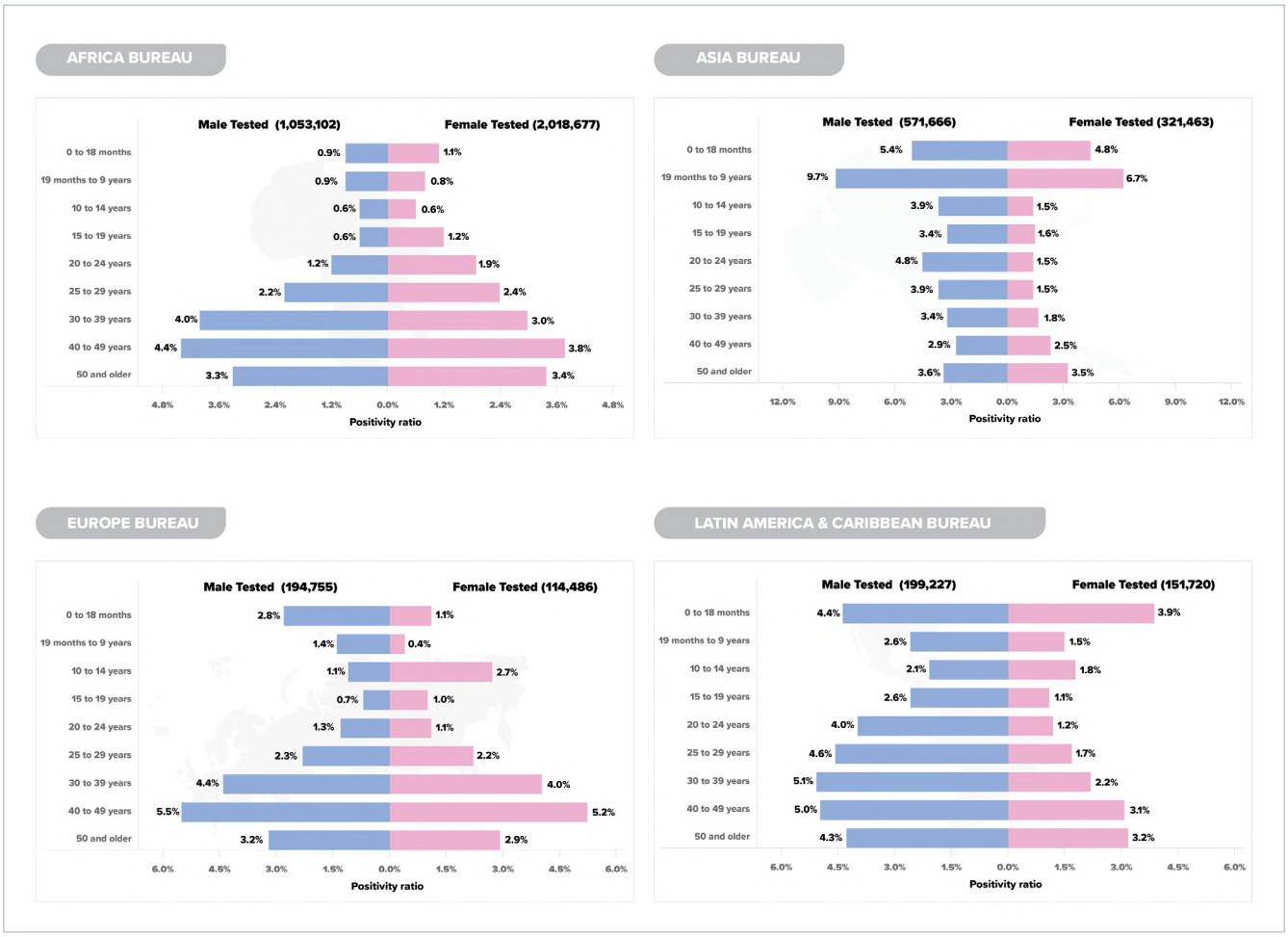
Globally, higher HIV positivity ratios for both sexes are observed within the 20-49 years age category, with positivity is distinctly higher among males. In all the age groups 15 years and above, positivity was consistently higher among males than female, though more females were tested in the age groups 10-39 years.

Figure 3.2.3: Total persons tested for HIV and positivity ratio, by gender and age category, Global – 2025



Looking at age and gender trends by bureau, age distribution differs markedly. Generally, in the age group 30 years and above, all bureaus had higher positivity among the males tested within the reporting period. Bureau variation is striking and mostly associated with test settings and target populations. The positivity among female (15 to 19 yrs) ranges between 1.0% and 1.6% while for male adolescents the positivity ranges between 0.6% and 3.4%. Further analysis of this pivotal data informs the global testing programs in strategizing and targeted testing. This is illustrated in **figures 3.2.4 below.**

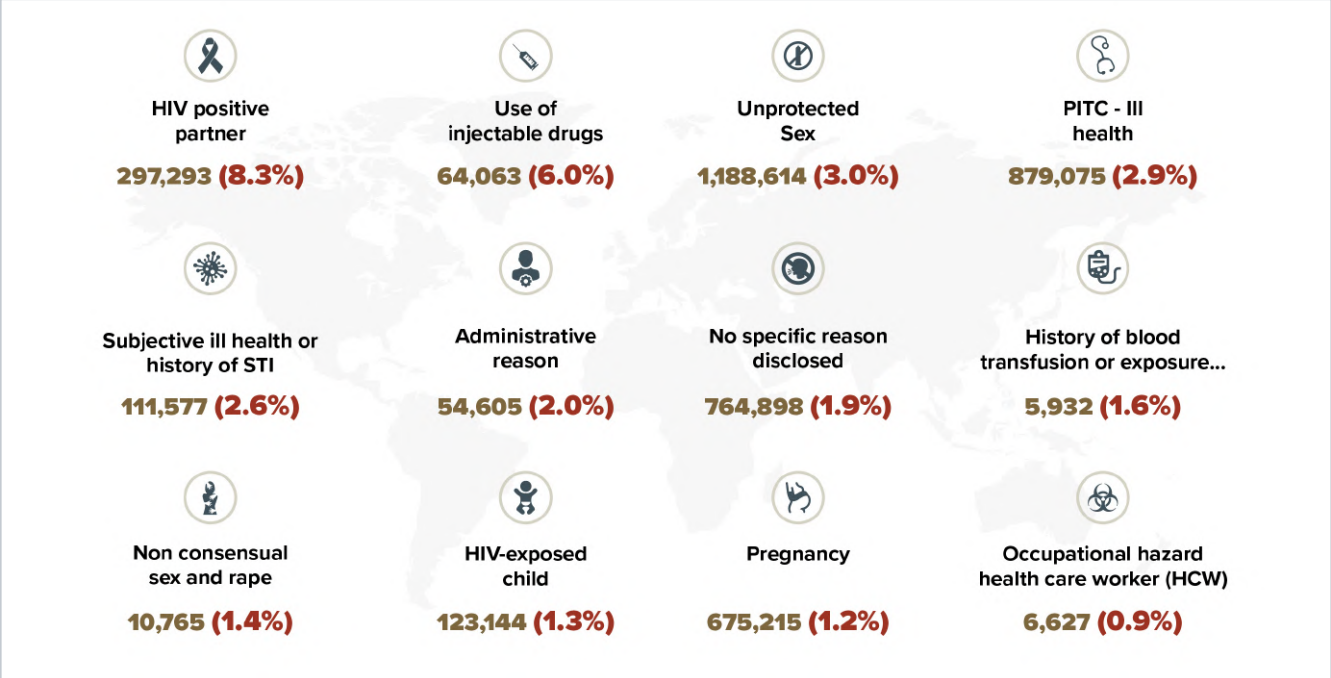
Figure 3.2.4: Total persons tested for HIV and positivity ratio, by gender and age category, Bureaus – 2025



3.2.1 Testing outcomes by main reason for HIV Test

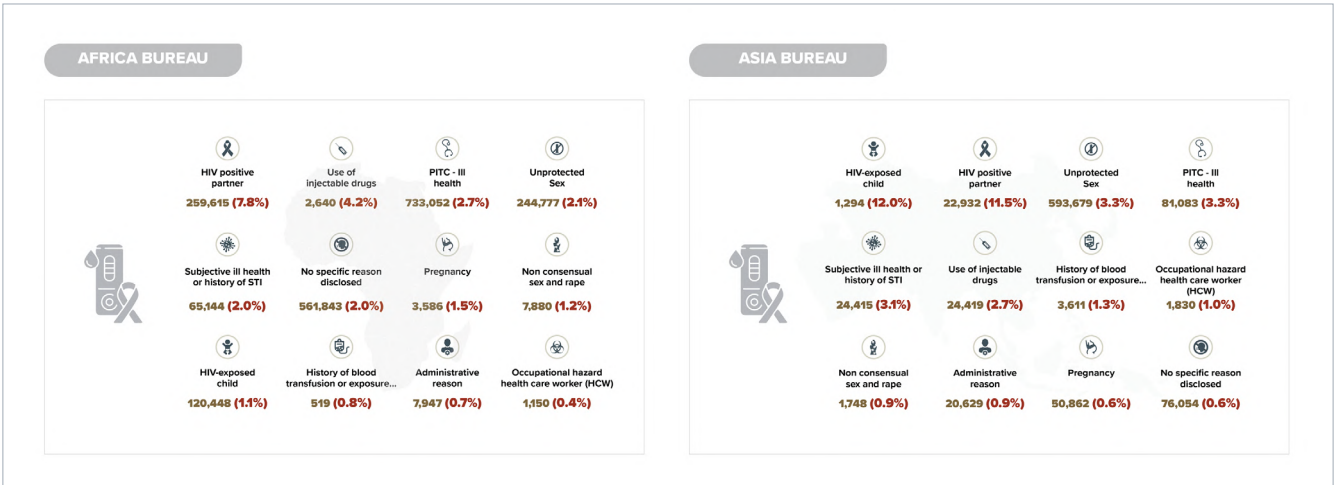
Figure 3.2.5 shows that clients who cited that they tested for HIV because their partners were HIV positive had the highest positivity ratio globally at 8.3%, followed by those who use injectable drugs (PWID) at 6.0%.

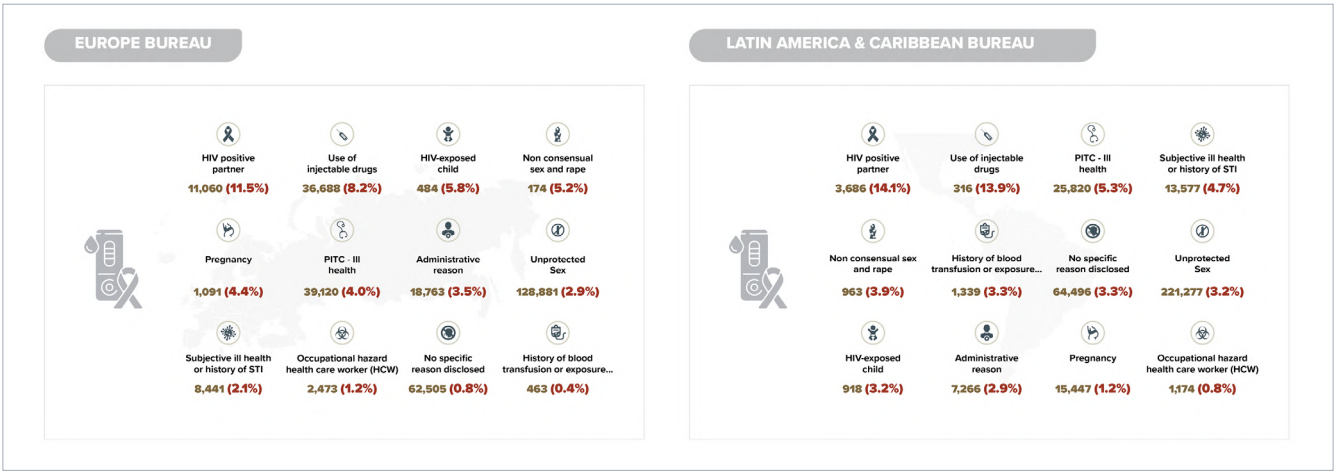
Figure 3.2.5: Positivity ratio by main reason for HIV-testing, Global Program – 2025



Africa, LAC and Europe Bureaus reported highest positivity among clients who cited HIV positive partners as reasons for testing while Asia Bureau reported highest positivity rates among HIV-exposed infants. Most clients tested in 2025 belonged to 3 categories: Unprotected sex, Provider Initiated Testing & Counseling (PITC) or III health, and pregnancy. Globally, in all the 3 groups the positivity ratio ranged from 1.9% - 3.0%. Testing of clients who cited being a partner of Persons Living with HIV (PLHIV, range 7.8% – 14.1%) and testing of people who use injectable drugs (PWID, range 2.7% – 13.9%) had the highest positivity in all 4 bureaus of the global program. A history of STI and/or ill health stands out in Latin America and Caribbean Bureau (4.7% and 5.3% respectively). This has been illustrated in **figure 3.2.7 below.**

Figure 3.2.7: Positivity ratio by main reason for HIV-testing, Africa Asia, Europe and LAC Bureaus – 2025

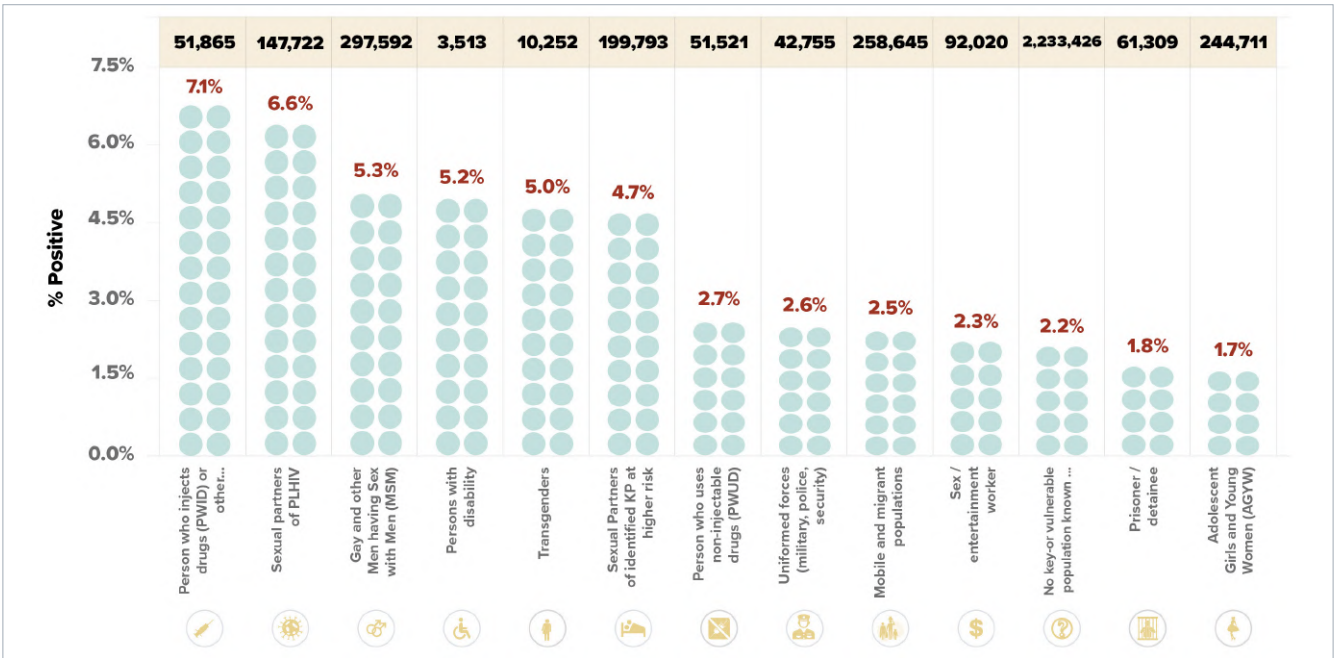




3.2.2 Testing outcomes by Key and Vulnerable Population (KVP)

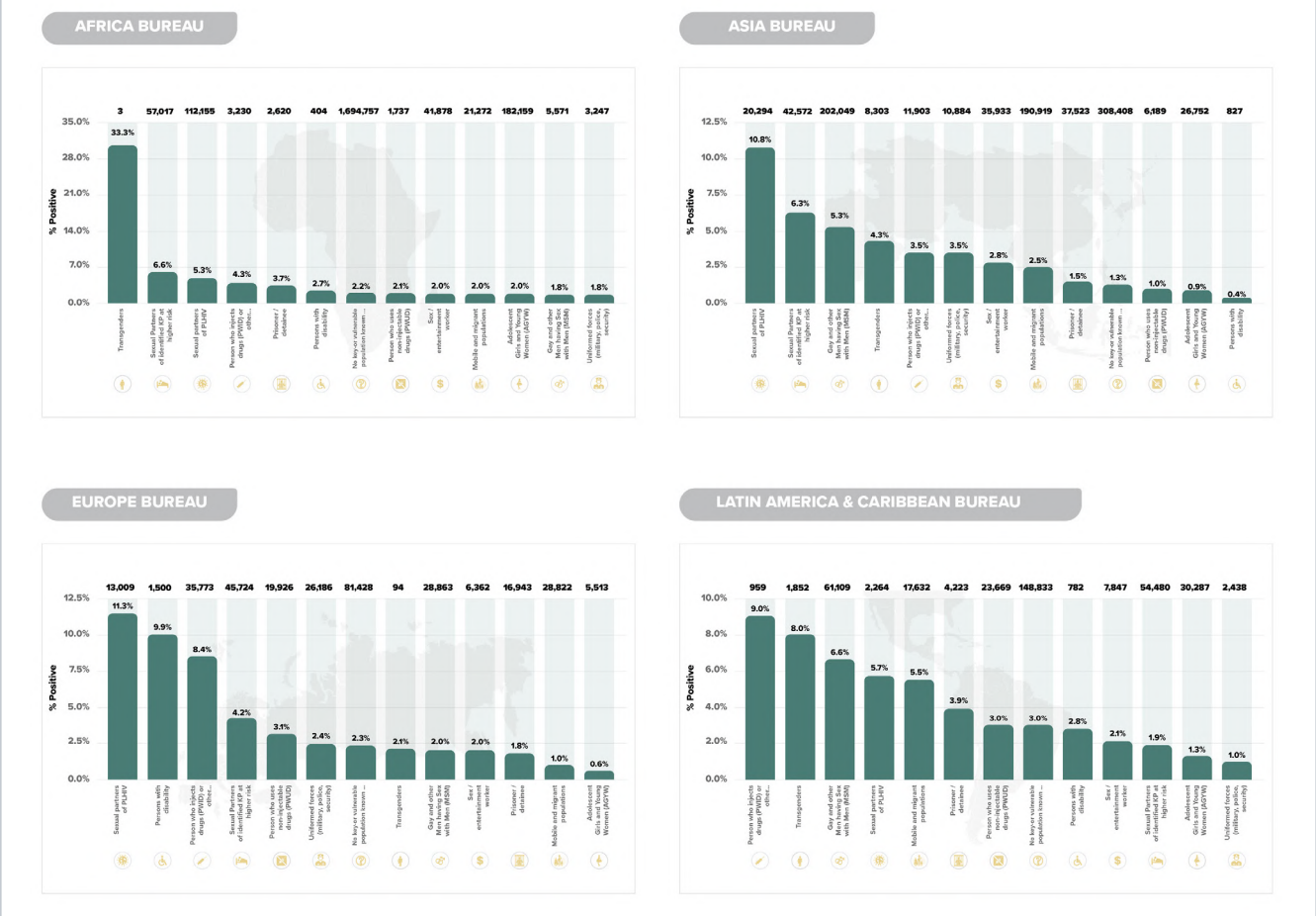
Global data for key and vulnerable populations collected indicates that positivity ratio was higher among Persons who Inject Drugs (PWID) at 7.1%, followed by sexual partners of PLHIV (6.6%) and persons with disability (5.3%) as shown in **figure 3.2.6 below.** This information is not always available for all clients tested, as for reasons of privacy, discriminatory legislation, or individual preferences, in many instances it is not possible to accurately identify this variable for clients. The clients could belong to more than one category, and staff are advised to ask about the one that seems to be the most important. In most countries this information, is not recorded and reported in the national HIV testing registers and reports and hence often not available for AHF reporting.

Figure 3.2.8: HIV-Positivity ratio by Key Population, Global Program – 2025



Latin America and Caribbean Bureau reported highest positivity ratio at 9.0% among Persons Who Inject Drugs (PWID) or other needle sharing, while Asia Bureau reported the highest positivity ratio (10.8%) among sexual partners of identified KP at higher risk. Africa (33.3%) and Europe (11.3%) Bureaus on the other hand reported high positivity among transgenders and sexual partners of PLHIV respectively as shown in **figure 3.2.9 below.**

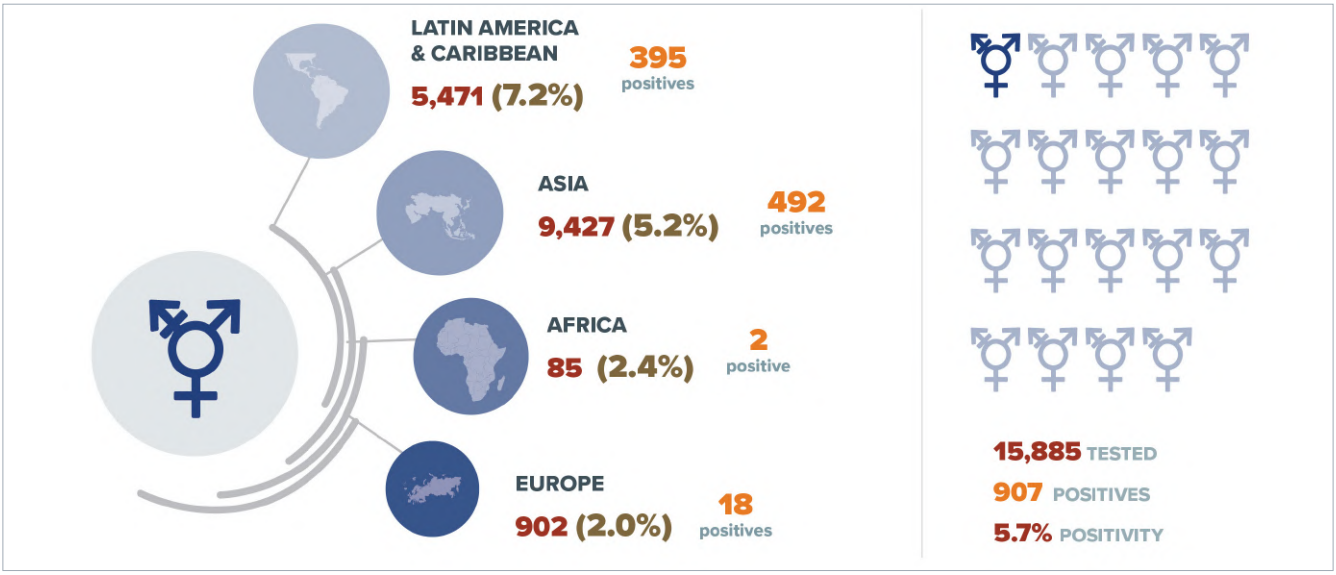
Figure 3.2.9: Positivity ratio by main reason for HIV-testing by Bureau, Q1-Q2 2025



3.2.3 Testing outcomes for Transgenders - 2025

Most transgenders were tested in Asia Bureau (n=9,427) with a positivity ratio of 5.2%, closely followed by Latin America and Caribbean with a total of 5,471 tests but with a higher positivity ratio of 7.2%. This has been illustrated in **Figure 3.2.10 below.**

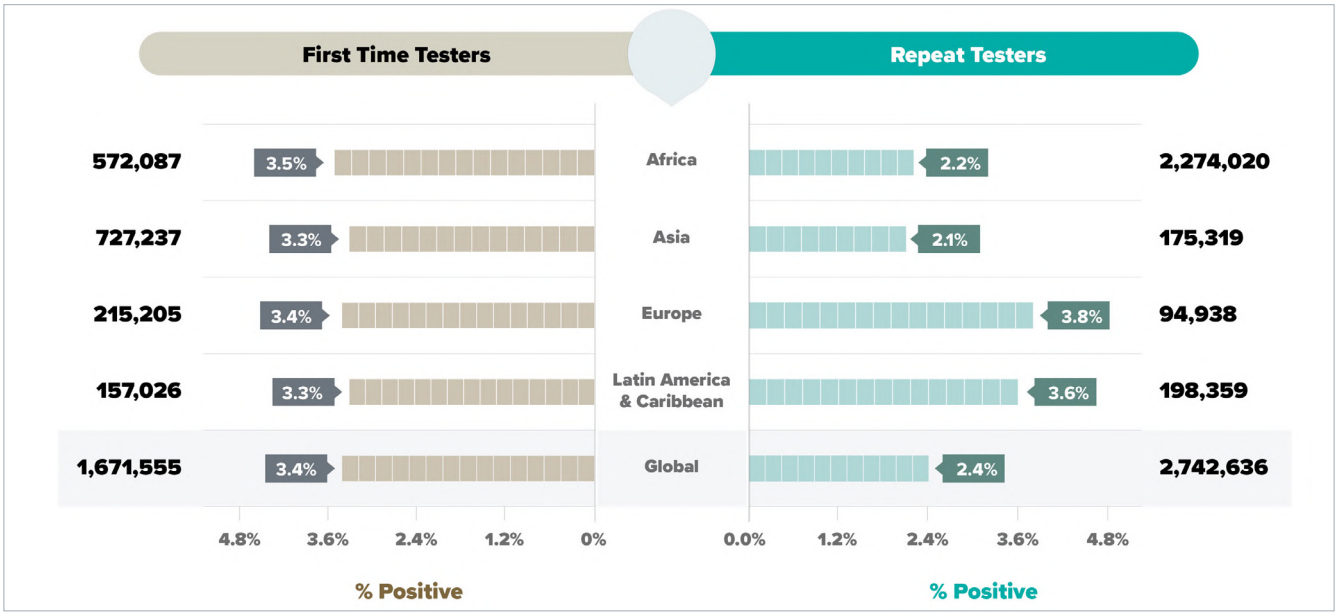
Figure 3.2.10: HIV-Positivity ratio for transgender persons, Bureaus, 2025



3.2.4 First-time testers versus repeat testers

Figure 3.2.11 below shows that by end of 2025, Africa Bureau reported the highest positivity among first time testers at 3.5% while Europe bureau recorded the highest positivity among clients who were repeat testers at 3.8%. Africa & Latin America and Caribbean Bureaus tested more repeat testers as compared to the clients who came for the first time. High positivity among repeat testers may be subject to bias, when known PLHIV clients are tested again for often unknown reasons. Between country variation in testing algorithms and number of tests required, may give rise to overreporting positive test results.

Figure 3.2.11: Numbers of positive tests by first or repeat testing and positivity ratio, Bureaus, 2025



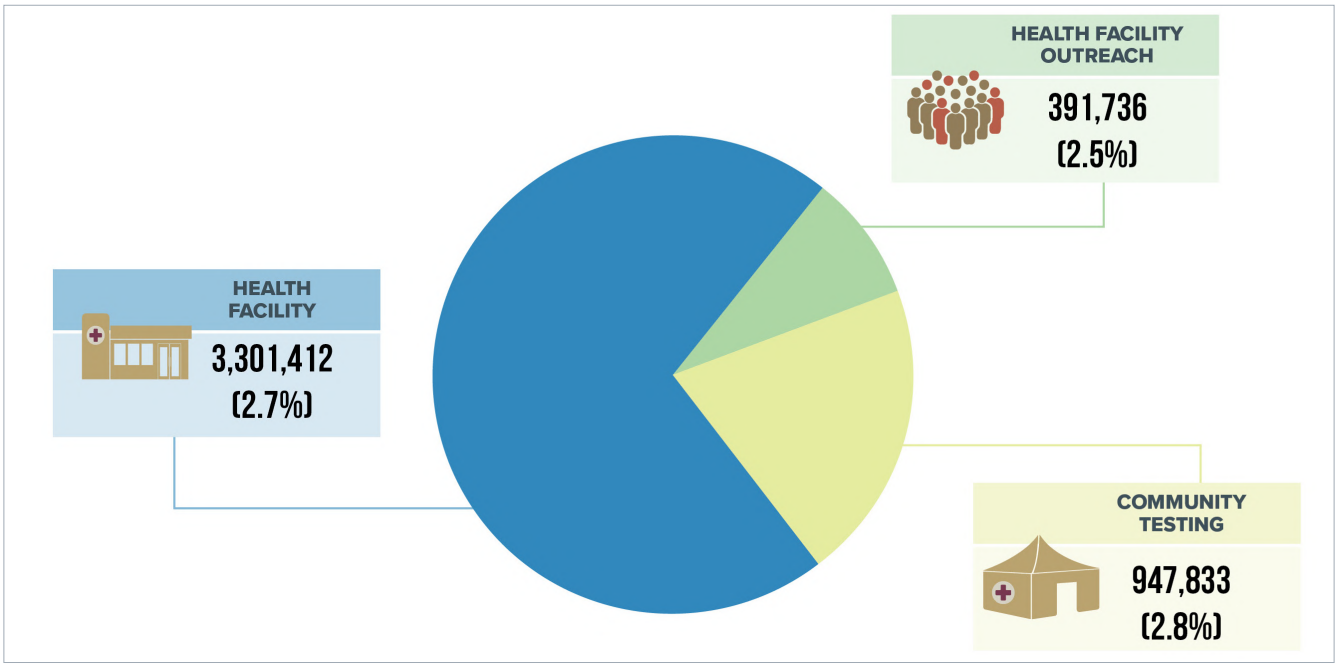
3.2.5 Facility based HIV testing versus Outreach/Community testing events

Global program data reveals that positivity is consistently higher among tests conducted in health facilities and dedicated community settings than in traditional health facility outreach programs. More than two-thirds of all HIV tests are now conducted within health facilities, underscoring the program's strategic shift toward facility-based populations made in the past years, but urging to critically reshape outreach activities to ensure they target the highest-yield populations and areas of greatest vulnerability.

Among others this requires:

- Mapping and targeting hotspots with precision.
- Re-evaluating traditional outreach methods to focus on high-risk networks (e.g., intensified partner testing).
- Doubling down on integrated, high-yield settings like the Wellness Center Initiative, which uses open-door STI services as an entry point and Sexual Partners Targeted Testing.

Figure 3.2.12: Numbers tested and positivity ratio by testing location, Global Program, 2025



All bureaus yielded a high positivity ratio among clients tested in health facilities as compared to the other settings apart from Africa Bureau that yielded the highest positivity ratio from clients tested in community settings as illustrated in **figure 3.2.13 below.**

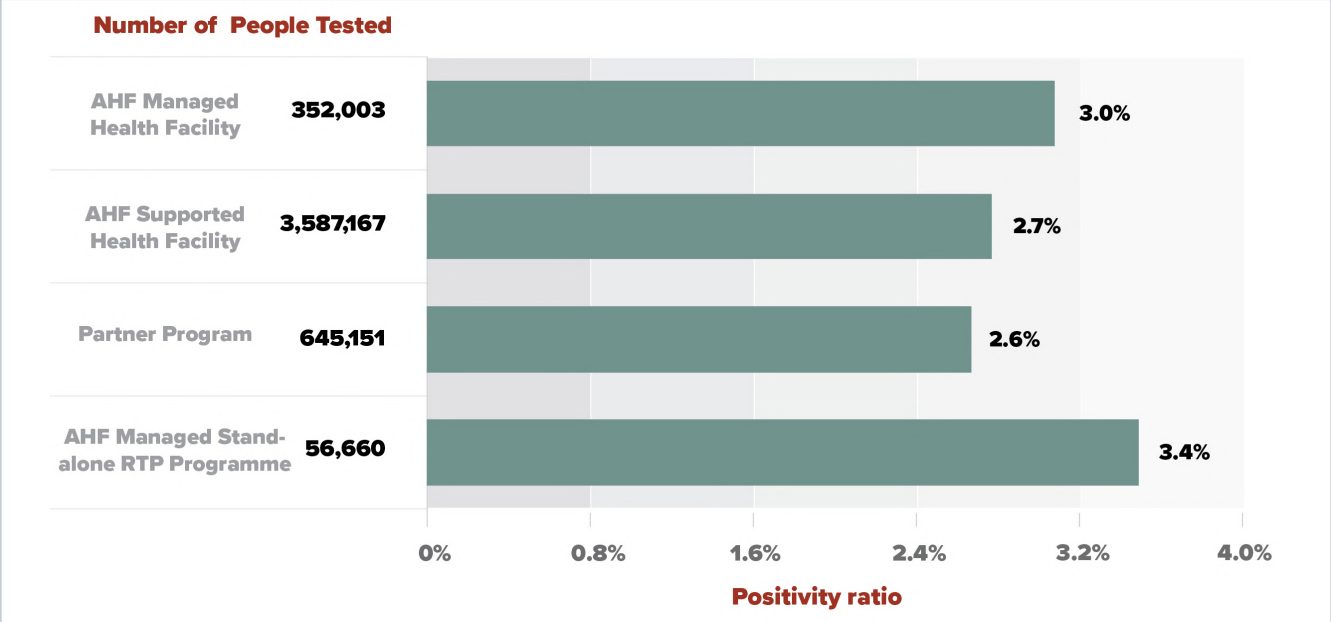
Figure 3.2.13: Numbers tested and positivity ratio by test location, Bureaus, 2025

Test Setting	HEALTH FACILITY		HEALTH FACILITY OUTREACH		COMMUNITY TESTING	
	Tested	% Positive	Tested	% Positive	Tested	% Positive
Africa	2,615,283	2.3%	150,173	1.9%	306,408	3.9%
Asia	359,303	4.8%	133,588	2.3%	409,665	1.8%
Europe	140,834	4.3%	23,527	2.6%	145,782	2.9%
Latin America & Caribbean	185,992	3.7%	84,448	3.7%	85,978	2.8%
Global Total	3,301,412	2.7%	391,736	2.5%	947,833	2.8%

3.2.6 HIV testing by Testing Program category. Global Program - 2025

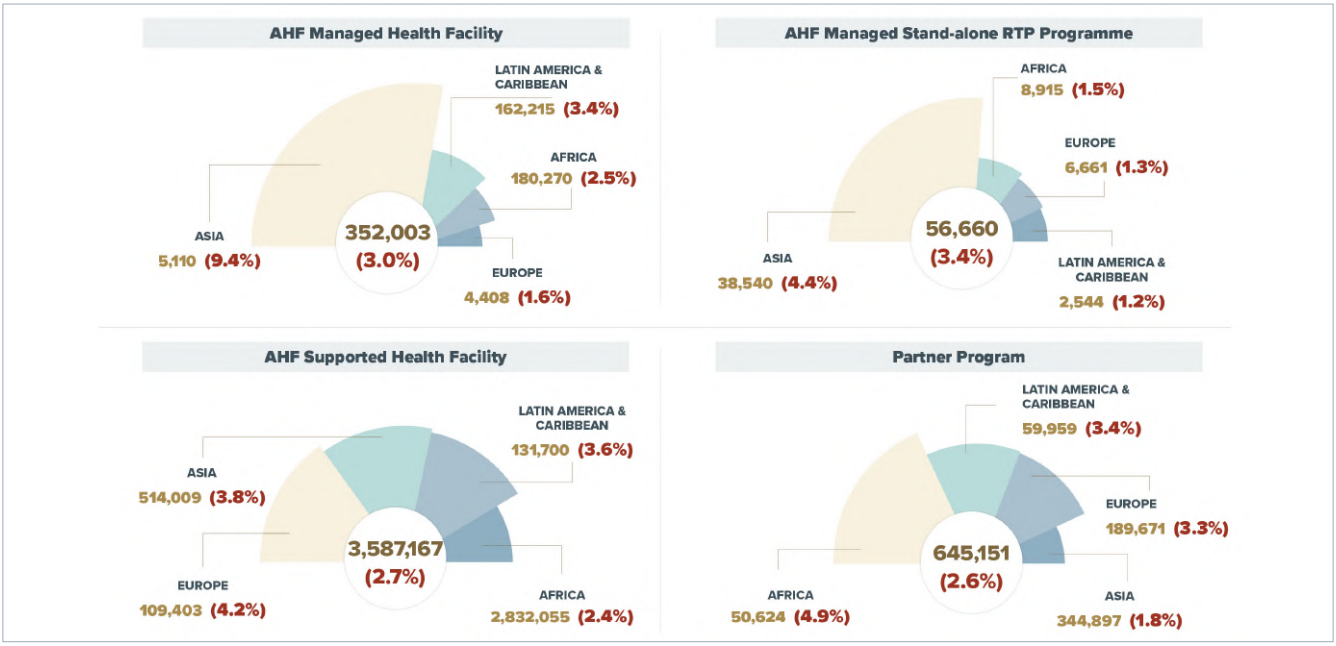
AHF testing data is reported from AHF-managed Rapid Test Programs (RTPs) at community level, facility-based testing (HTC and PITC) and test programs carried out by contracted NGOs/CSOs mostly active at community level (Partner Programs). **Figure 3.2.14 shows** the positivity by category of testing program. Globally, AHF Managed Stand-alone RTP Programs yielded the highest positivity. Most tests were conducted in AHF supported health facilities accounting for > 70% of all the tests conducted within the year.

Figure 3.2.14: Number of people tested and positivity ratio by test program category. Global Program, 2025



Asia Bureau had the highest positivity among clients tested in both AHF Managed health facilities and AHF Managed Stand-alone programs at 9.4% and 4.4% respectively. Europe Bureau (4.6%) had the highest positivity rate among clients tested in AHF-Supported health facilities while the Africa Bureau had the highest positivity rate of 4.9% among clients tested by partner programs.

Figure 3.2.15: Number of people tested and positivity ratio by test program category. Bureaus, 2025

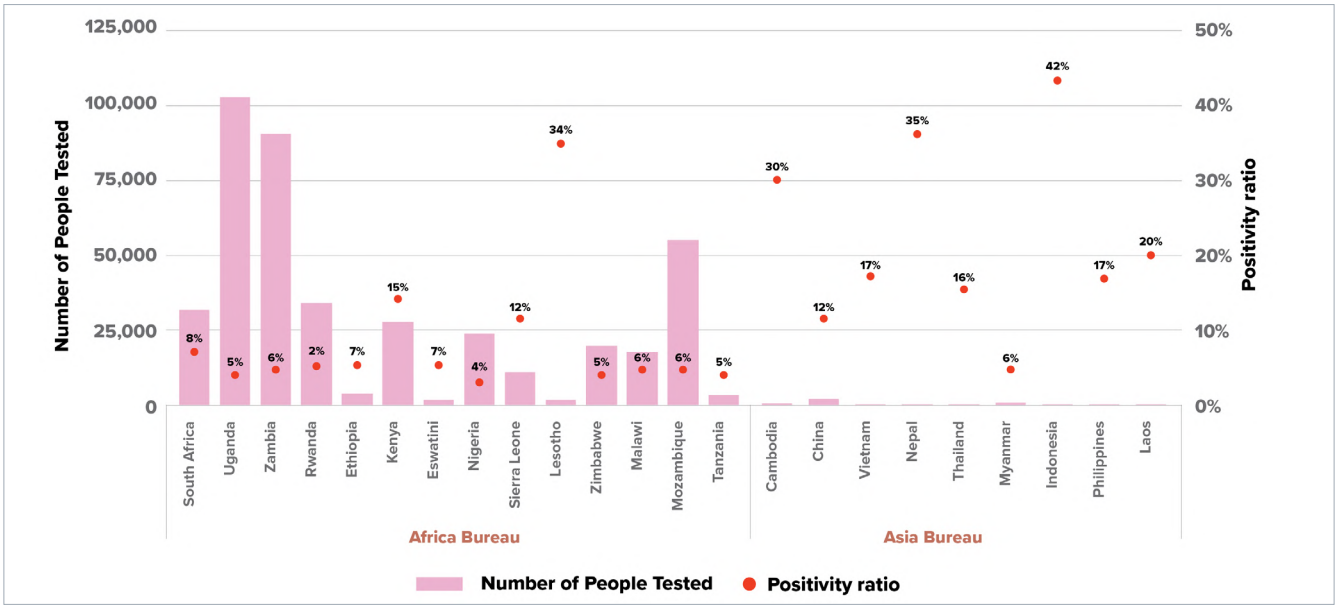


3.3 Sexual Partner Testing

Sexual partner testing is a targeted strategy implemented in AHF's Africa and Asia Bureaus to identify individuals at risk of HIV infection by focusing on the sexual and social networks of People Living with HIV (PLHIV). This approach involves voluntary partner notification, risk-based testing, and ethical practices to ensure confidentiality and informed consent. By leveraging trusted relationships, partner testing facilitates early identification, timely testing, and linkage to care for those who test positive while reinforcing prevention for those who test negative. Building on its success, AHF is expanding this strategy to the LAC Bureau to enhance HIV diagnosis and care outcomes across the region.

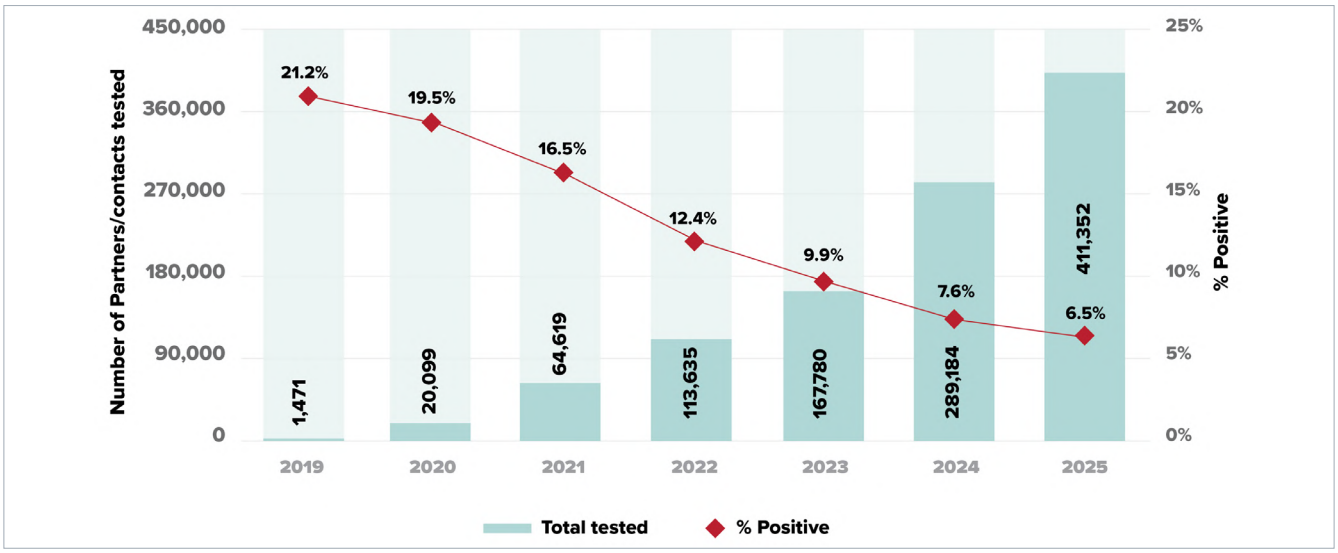
Lesotho, Cambodia, Indonesia, Laos, and Nepal had high positivity ratios of at least 20% among sexual partners of HIV positive clients who were tested in 2025. Uganda and Zambia had the highest number of client's sexual partners elicited who were tested for HIV. Today, this is the most effective AHF HIV strategy in terms of case detection, an interruption of transmission and strong emphasis is laid on its promotion and implementation in global program, expanding this strategy in all bureaus.

Figure 3.3.1 Sexual partner testing. Number of Tests and Positivity Ratio by Country, 2025



The uptake of thesexual partner testing initiative has significantly increased the number of total people reached and tested between 2019 and 2025 as seen on **figure 3.3.2 below.** However, the positivity ratio has been on a considerable decline from 21.2% to 6.5% within the same period, respectively.

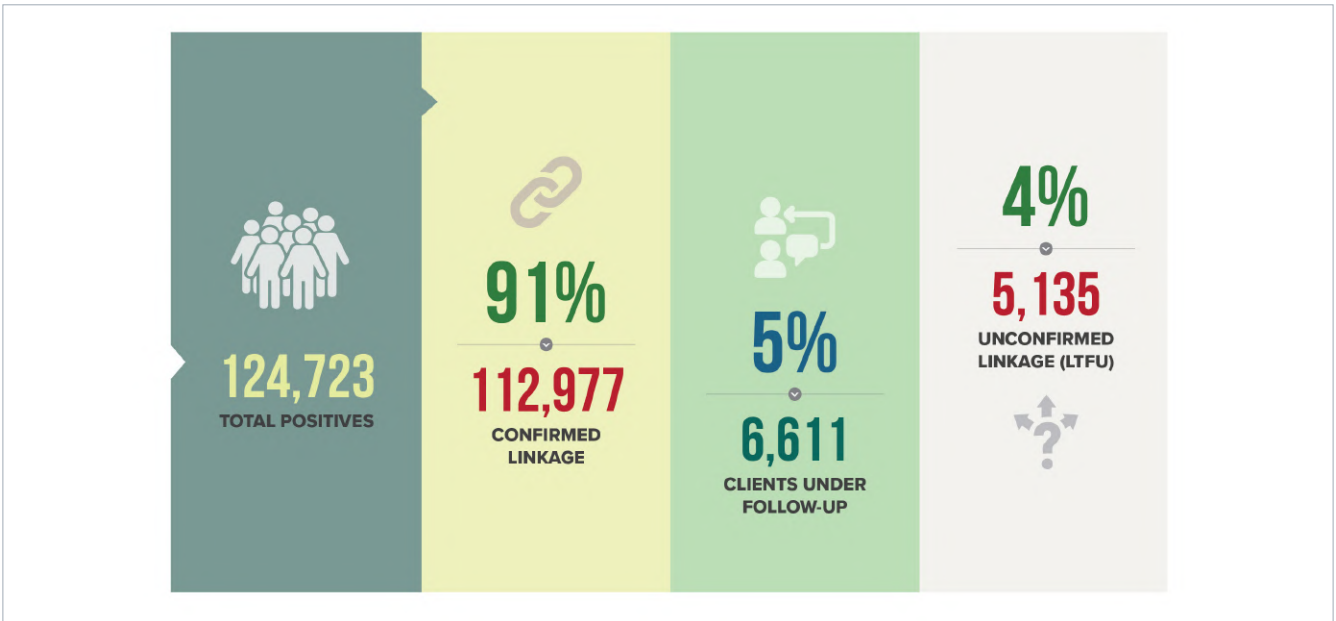
Figure 3.3.2 Sexual partner testing trend. Number of Tests and Positivity Ratio, 2019-2025



3.4 Linkage into Care and Treatment Service

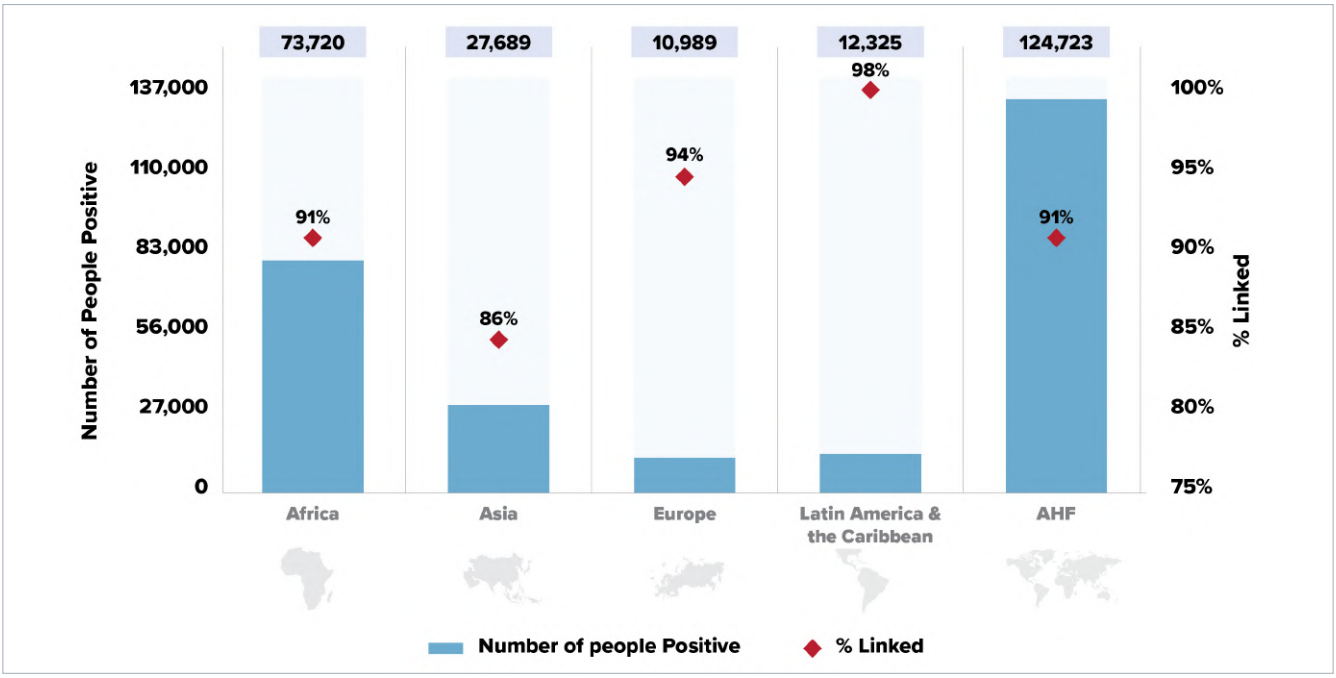
Out of 124,723 HIV positive clients identified in the Global Program in 2025, 91% were linked to the 3 categories of HIV care facilities - AHF Supported, non-AHF supported and AHF-managed facilities. Linkage is confirmed if a client has had 2 consecutive clinical visits to an HIV C&T facility and has been enrolled. Clients under follow-up are those who have been referred to a C&T facility, but confirmation of linkage is pending. 4% of the identified positive clients, linkage could not be confirmed, and follow-up was unsuccessful.

Figure 3.4.1: Linkage outcomes for PLHIV identified, Global Program, 2025



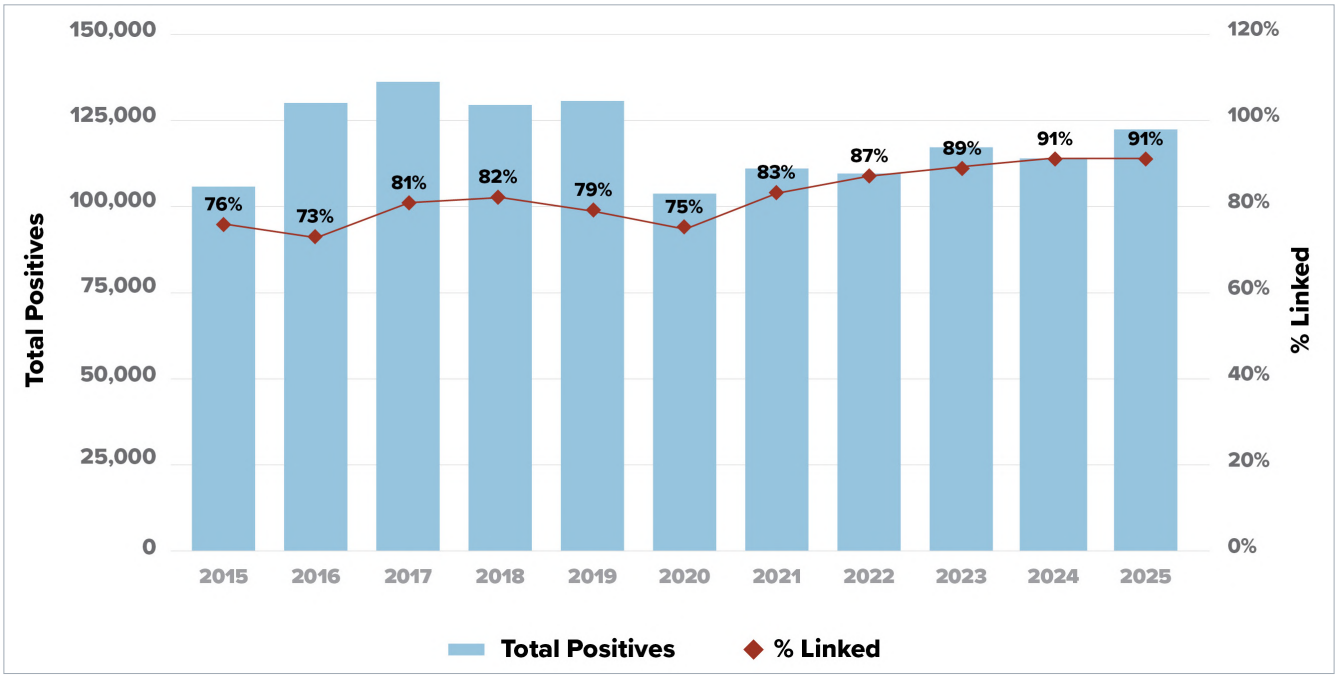
Latin America and the Caribbean Bureau had the highest linkage rate across the bureaus at 98% as shown in **figure 3.4.2 below,** while Asia Bureau recorded a lower linkage rate at 86% out of the 27,689 positive clients identified.

Figure 3.4.2: Proportion of clients linked by Bureau, 2025



The proportion of clients among all positives identified who were reported as linked to care fluctuated between 72% in 2015 and 91% in 2025, as displayed in **figure 3.4.3.** Linkage fell in 2020, concomitant with the Covid-19 pandemic unleashing, but rose to 91% in both 2024 and 2025. This marked improvement in linkage may well be attributed to Global Programs' efforts in optimizing retention and the implementation of the Track-Positive application.

Figure 3.4.3: Linkage trends over time, 2015-2025

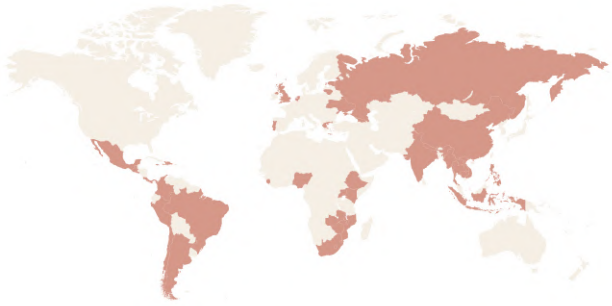


04 HIV Care, Enrollment and Census

4.1 Active AHF Supported Facilities

With 146 new facilities joining the AHF Global Program in 2025, the overall expansion of the HIV Care and Treatment program reached 1,042 facilities. These include 994 HIV Care & Treatment facilities and 48 AHF Wellness Centers in Africa, Asia, Latin America & the Caribbean and Europe Bureaus. The amount and regional distribution of active AHF managed and supported facilities is displayed in **figure 4.1.1.** Africa Bureau counted for more than half of all global program facilities by the end of 2025.

Figure 4.1.1: Growth of active AHF supported facilities - 2025

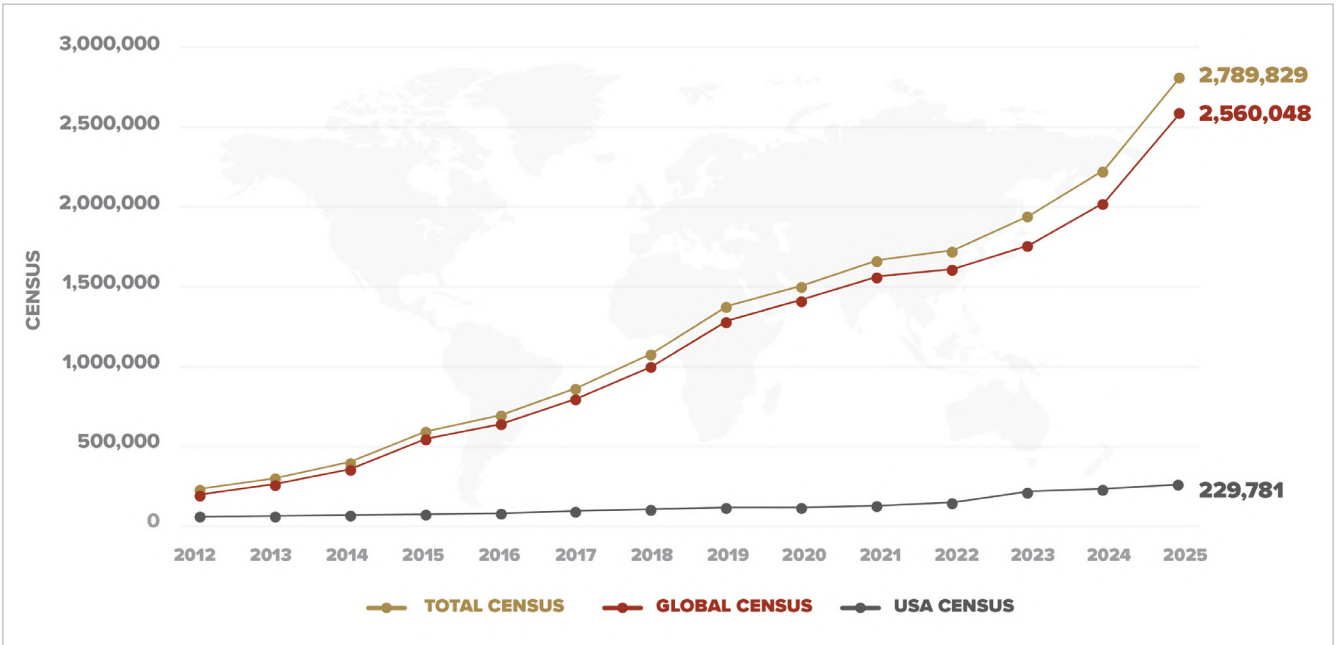


	AFRICA	ASIA	EUROPE	LATIN AMERICA & CARIBBEAN	GLOBAL
Number of Countries	14	10	3	12	39
HIV Care & Treatment facilities	538	252	52	127	969
Wellness Centres	15	10	3	18	46

4.2 Growth of total number of PLHIV in care

The number of clients in care in global programs grew over time and by the end of 2025, the total stood at 2,560,048. This number includes 254,472 clients from wellness centers in Africa, Asia, Europe and Latin America & Caribbean Bureaus but excludes the US census (229,781 clients). Combining numbers of clients in Global and US domestic programs, AHF had reached more than 2.79 million lives in care at the end of 2025.

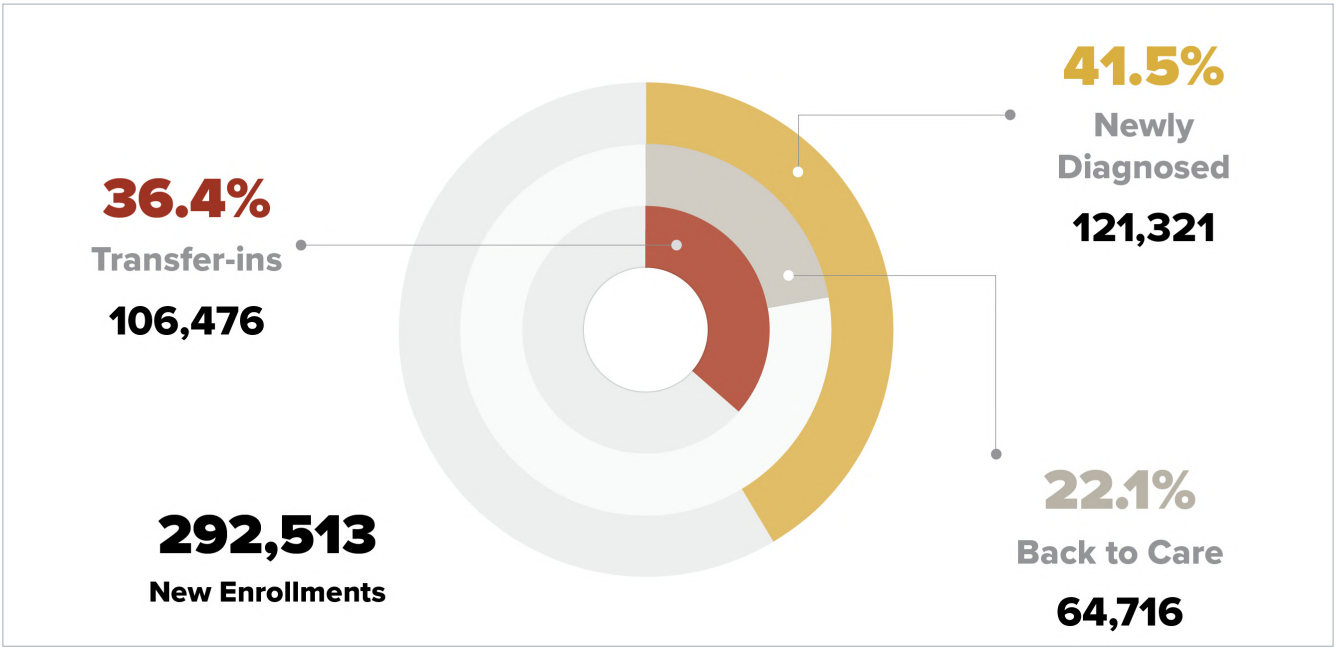
Figure 4.2.1: Census growth 2012-2025 (Global and US programs combined)



4.3 Newly enrolled clients in 2025

AHF had enrolled 292,513 clients by the end of 2025, accounting for 13% of active PLHIV clients in care. The majority were newly diagnosed clients representing 42% while transfer-ins comprised 36% of total enrolments. 22% of the new enrolments were clients who were restarted in care. These are clients who were previously enrolled in HIV care & treatment but had discontinued or interrupted their treatment and became lost to follow-up (LTFU). Newly diagnosed clients are individuals who have recently received a positive HIV test result and are enrolled into care and treatment services for the first time. Transfer-in (TI) are clients who were receiving HIV care and treatment at one healthcare facility but have now transferred their care to a different facility of their choice. They come with a transfer document, including their medical details and treatment history, to ensure continuity of care.

Figure 4.3.1: Origin of clients newly enrolled for care and treatment, 2025

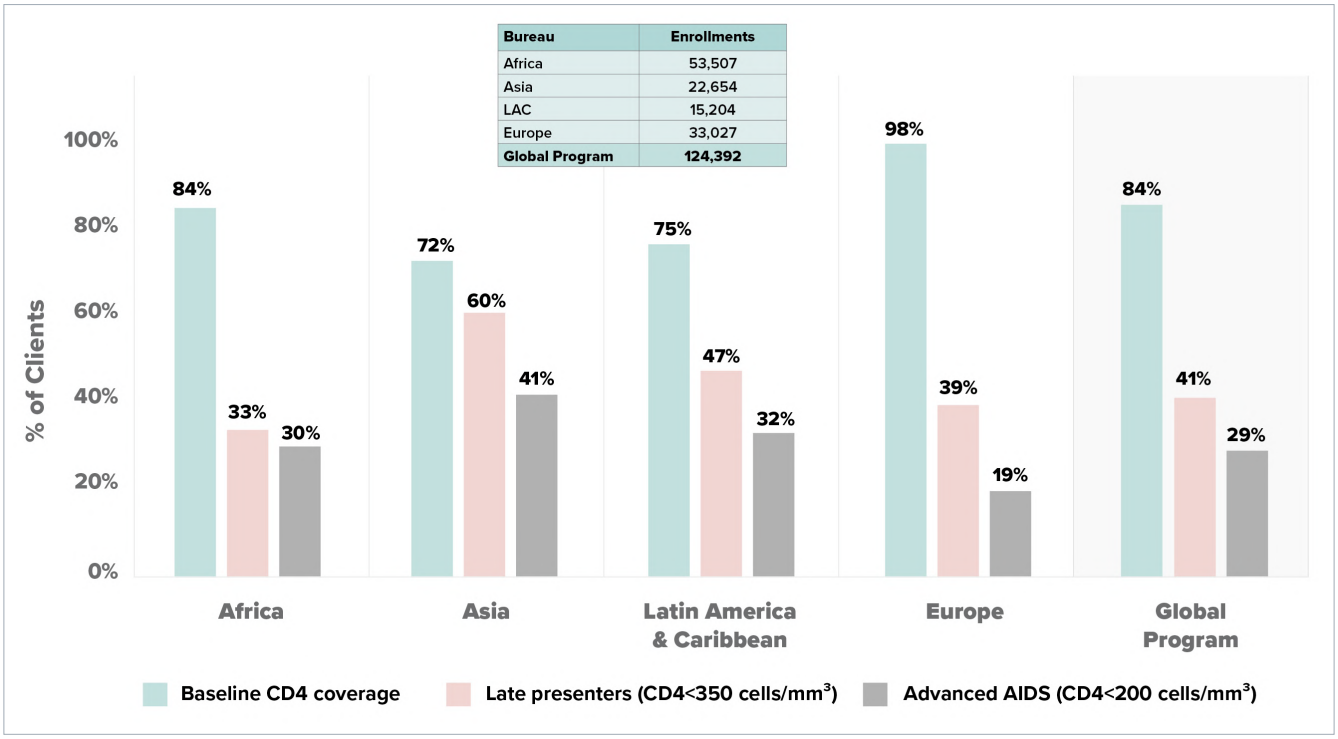


5.1 CD4 Cell count at Baseline

Baseline CD4 test is recommended for all newly enrolled clients initiating ART and constitutes AHF's Quality Benchmark (QBM) 5. Globally, 84% of clients newly enrolled in 2025, had a CD4 cell test result at baseline (CD4 cell test coverage). Asia and Latin America had less than 80% of their clients covered, while Africa and Europe Bureaus had more than 80% of their newly enrolled clients tested.

The results indicate that large numbers of clients are enrolled at a late stage, with CD4 cells already below 350 cells/µL (33% in Africa to a high of 60% in Asia Bureau). Asia and Latin America & the Caribbean Bureaus had the highest proportion of clients presenting with advanced AIDS (CD4 cell count <200 cells/µL) at enrolment, the global program average being 29% of total enrolments within the year.

Figure 5.1.1: CD4 Cell count for new enrolments at baseline - 2025

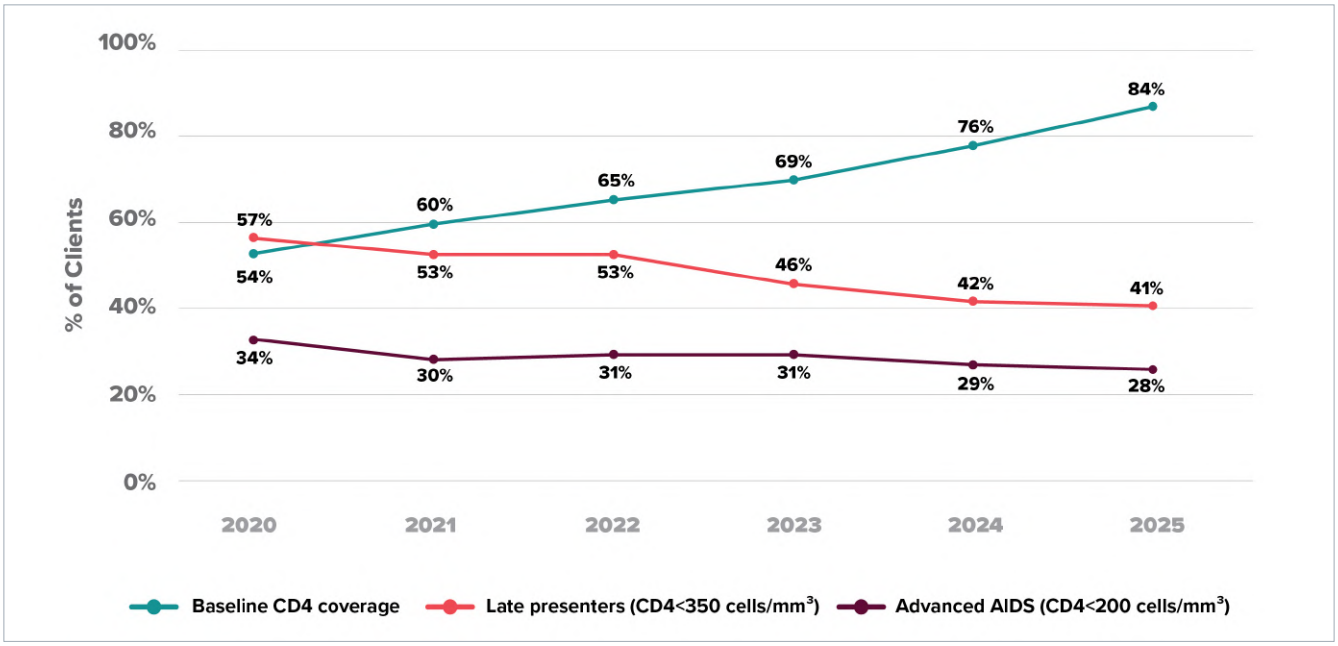


5.2 Anti-Retroviral Treatment (ART) Initiation

The most prominent trend in **figure 5.1.2 below** is the steady expansion of baseline CD4 coverage among newly enrolled clients, which grew by approximately 30 percent (from 54.3% to 84.2%) between 2020 and 2025. This increased monitoring capacity directly correlates with a healthier patient profile at entry; the proportion of Late Presenters (CD4<350) saw a significant decline from 56.6% to 40.5%.

While the percentage of patients presenting with Advanced AIDS (CD4<200) also decreased, the decline was more gradual, moving from 34.2% to 28.5% within the same period. This suggests that while general screening and early entry into care are improving rapidly, there remains a persistent challenge in reaching the most vulnerable or high-risk individuals before they reach advanced clinical stages.

Figure 5.1.2: Baseline CD4 coverage, late presenters and advanced AIDS among new enrolments, 2020-2025

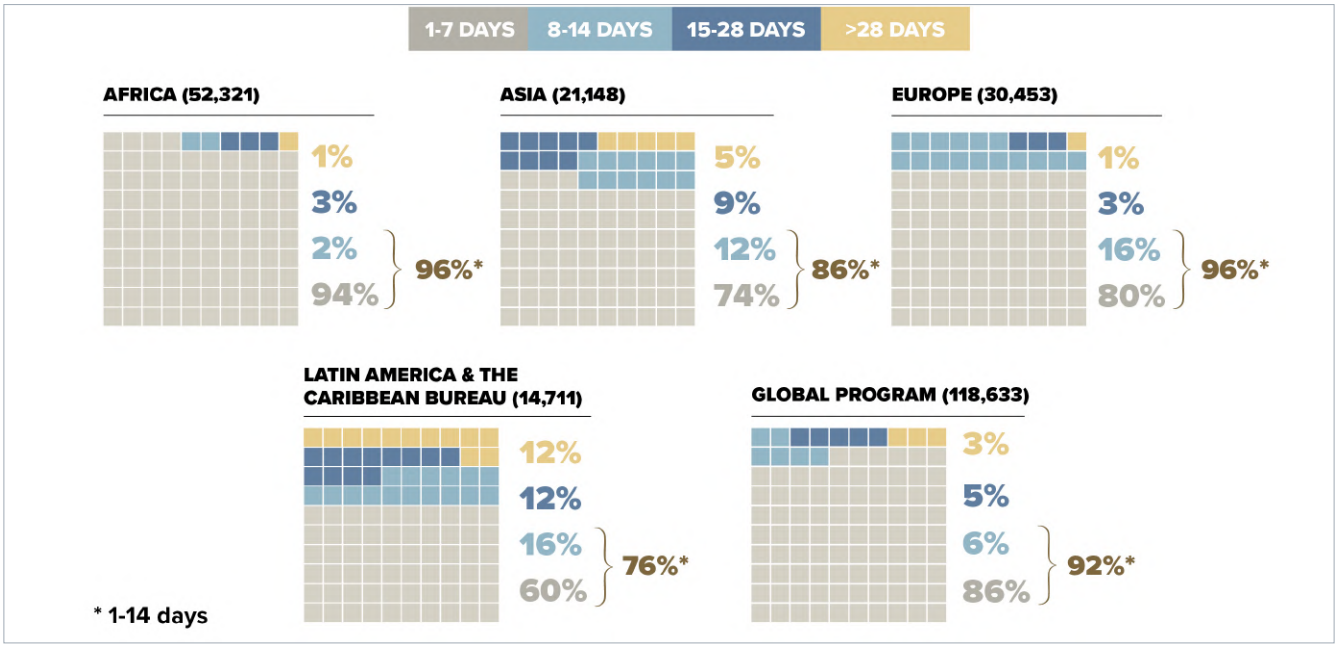


5.2 Anti-Retroviral Treatment (ART) Initiation

AHF advocates for "treatment for all" and considers every newly enrolled HIV-positive client as eligible for initiation on ART without undue delay. Treatment facilities monitor the median time between date of HIV-diagnosis and date of ART initiation for the reporting facility.

The AHF Quality Benchmark 4 (QBM) is defined as less than 2 weeks' time lag between HIV diagnosis and ART initiation. **Figure 5.2.1 below** calculates for each bureau the median time between date of HIV-diagnosis and date of ART initiation of facilities. The Global Program had more than 90% of total enrolled clients initiated on ART within the recommended 14 days. Asia and the Latin America & the Caribbean Bureaus, initiated ART in more than 10% of clients, who were enrolled in the past year, more than 14 days after the date of HIV diagnosis.

Figure 5.2.1: Median time between date of HIV-diagnosis and date of ART initiation for clients. Proportion of clients by bureau - 2025



06 Treatment, Outcome and Retention

6.1 Retention

AHF's HIV care and treatment program monitors clients that become No Longer in Care (NLIC) due to reasons such as transfer-out (TO) to other facilities, relocation, refusing HIV care and treatment services, death or Lost to Follow Up (LTFU). A total of 174,262 clients (7.0% of all clients in care) were reported as NLIC in 2025, with two categories comprising over 80% of all NLIC clients, namely: transferred out (44%) and LTFU (42%).

Figure 6.1.1: Distribution of reasons for becoming NLIC. Global Program - 2025

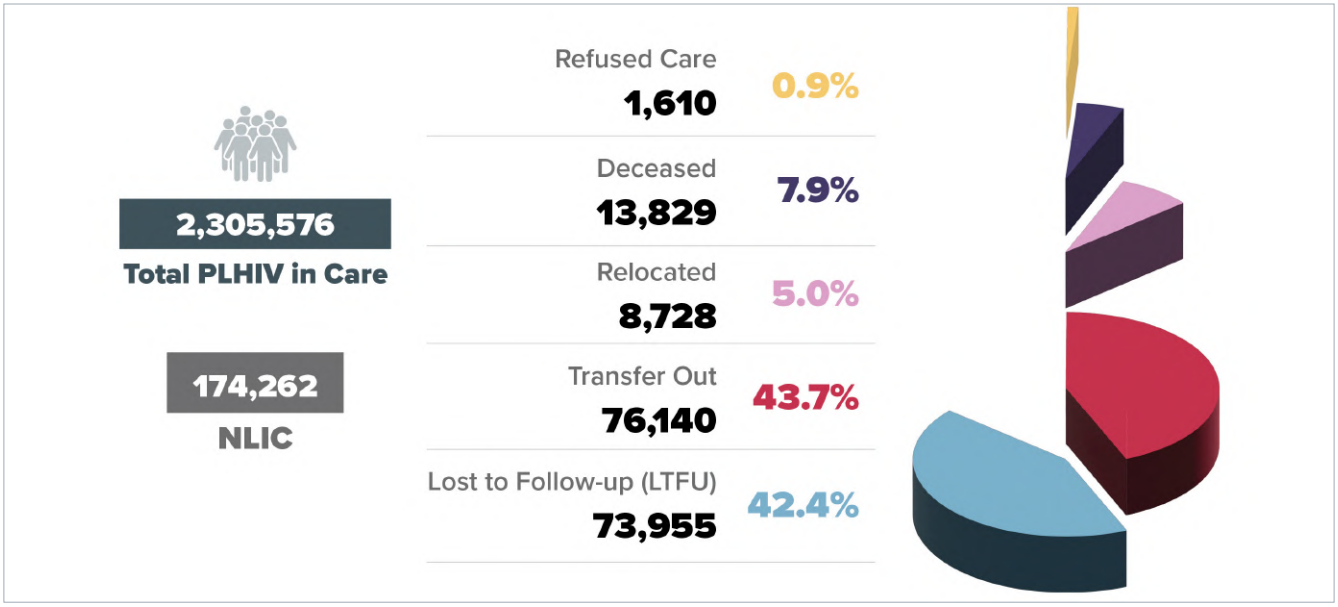


Figure 6.1.2 below displays the proportion of LTFU among all NLIC clients reported by the end of 2025. Africa and LAC Bureaus had more than 45% of all NLIC clients classified as LTFU. Europe Bureau reported the least proportion of LTFU clients among NLIC reported in 2025 at 7% of the 10,076 NLIC clients.

Figure 6.1.2: Clients who became NLIC and proportion LTFU among NLIC clients, Global – Bureaus - 2025

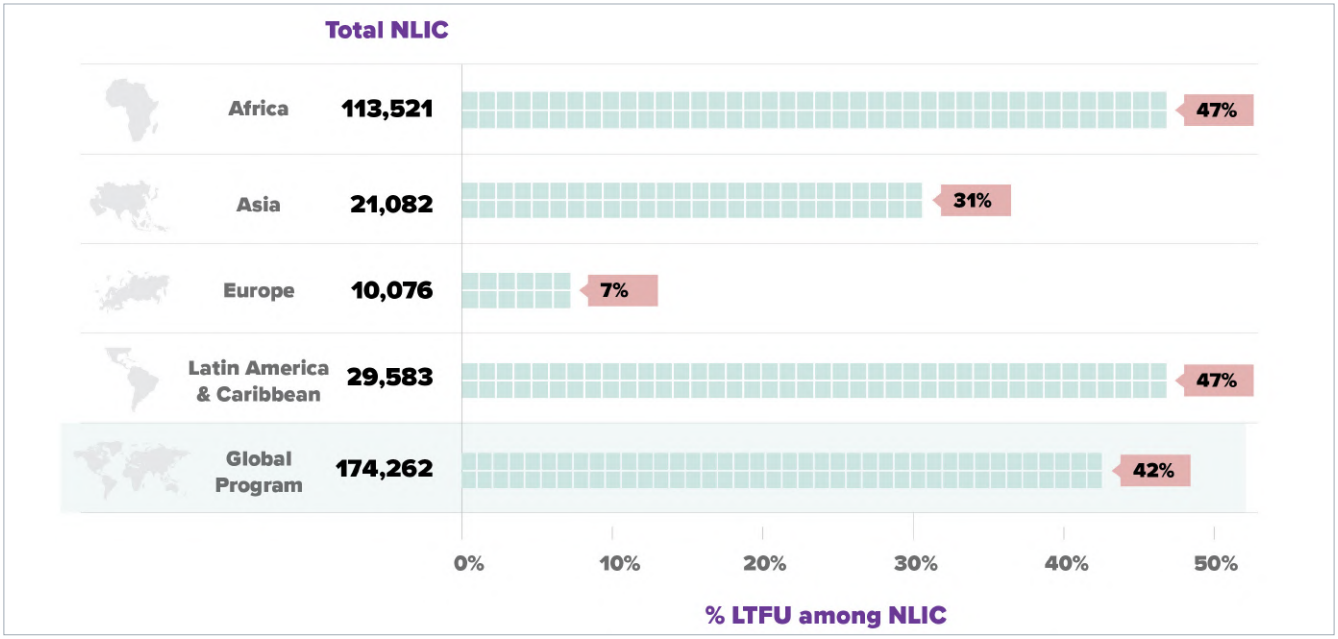
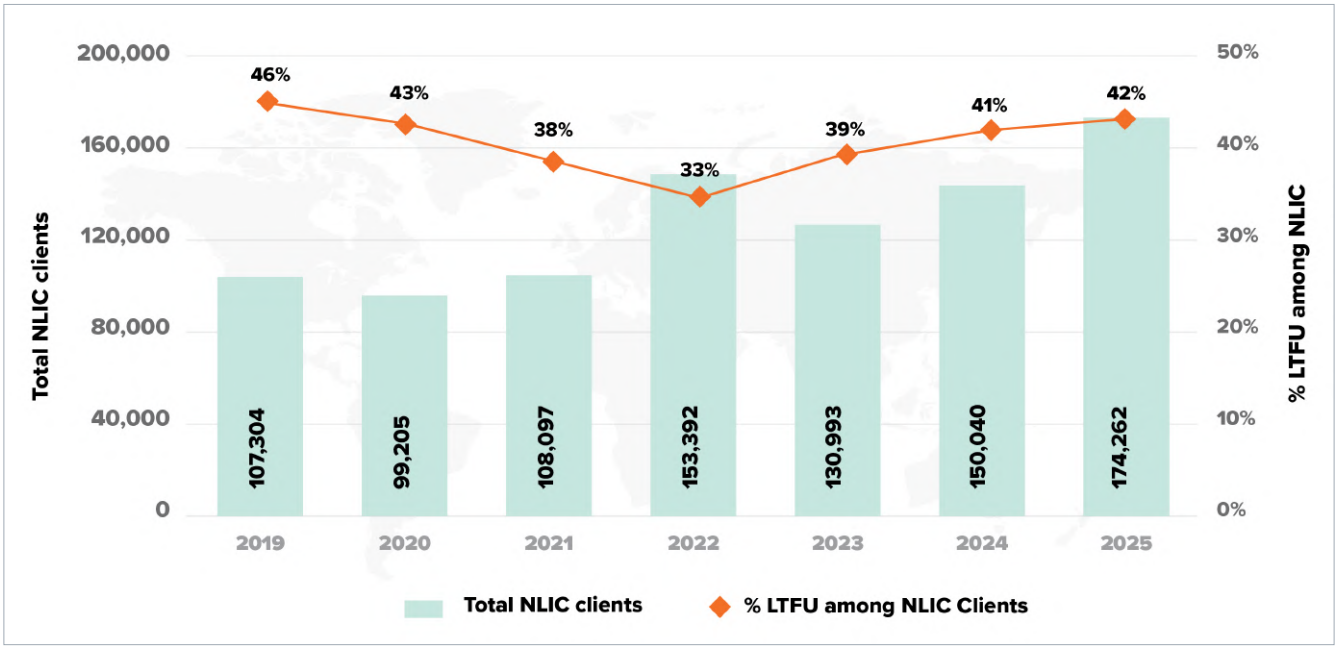


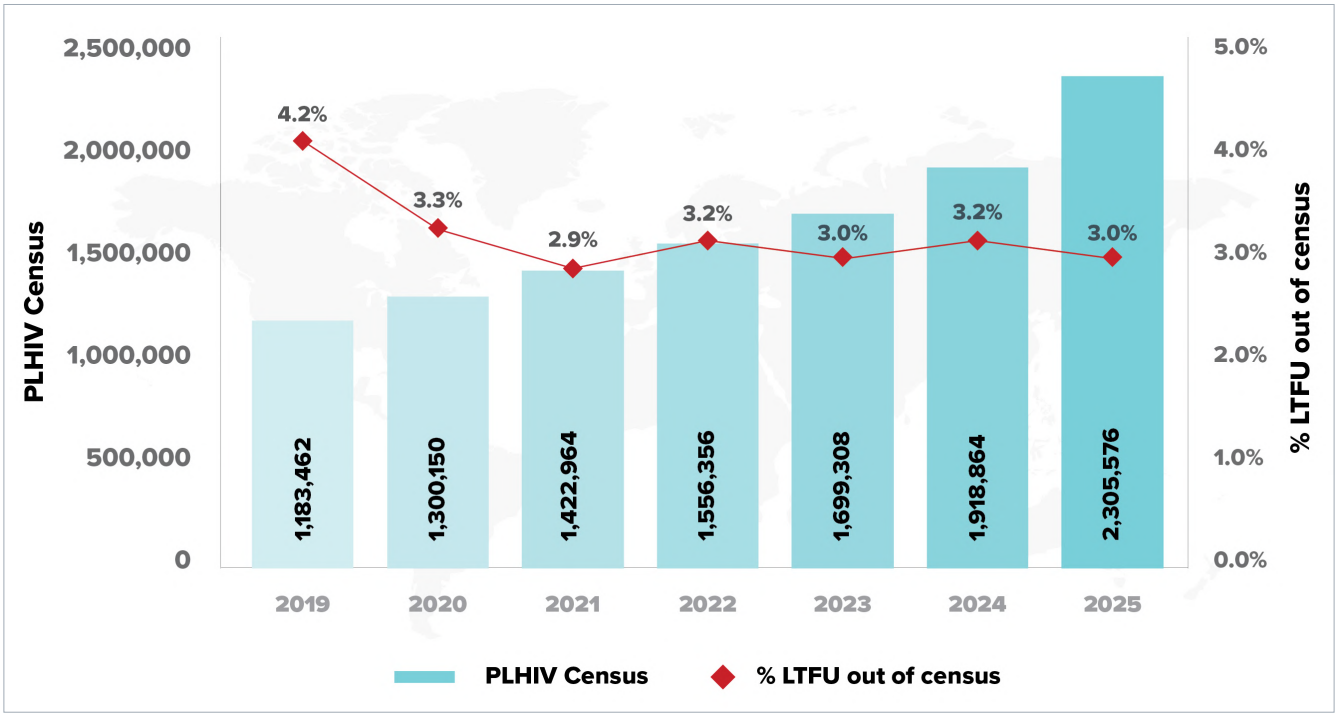
Figure 6.1.3 below illustrates the 6-year trend in proportion of LTFU clients among all NLIC clients reported in the years 2020 to 2025. The decline recorded between 2019 and 2022, reversed steadily up to 2025. conspicuous. The global program reported more than 40% clients LTFU among the total NLIC in both 2024 and 2025.

Figure 6.1.3: Proportion of LTFU among all NLIC clients, 2019 to 2025



PLHIV census has increased significantly between 2019 and 2025, from 1.18 million to 2.3 million clients in HIV care respectively. The proportion of LTFU clients among all PLHIV clients has been ranging from 2.9% to 3.2% over the past 5 years. The Global Program reported the highest LTFU rate in 2019 at 4.2% among all PLHIV clients in care.

Figure 6.1.3: Proportion of LTFU among all NLIC clients, 2019 to 2025



6.2 Treatment Monitoring and HIV Viral Load

Achieving HIV viral suppression is a sign of successful antiretroviral therapy (ART) among PLHIV clients. Viral Load (VL) testing is recommended to assess suppression, which is critical to improve health, prevent sexual transmission (U=U) and reduce vertical transmission. HIV Viral Load and TPT completion Quality Benchmarks are reported as part of the annual medical record/chart audits. In 2025, the Global Program recorded that out of clients active in care and who were longer than 3 months on ART, 78% had a viral load test result in the preceding year, (78% VL test coverage). Of those, 97% were suppressed (VLS 97%), as illustrated in **figure 6.2.1 below.**

Figure 6.2.1: Global Program - VL coverage and suppression rates, 2025

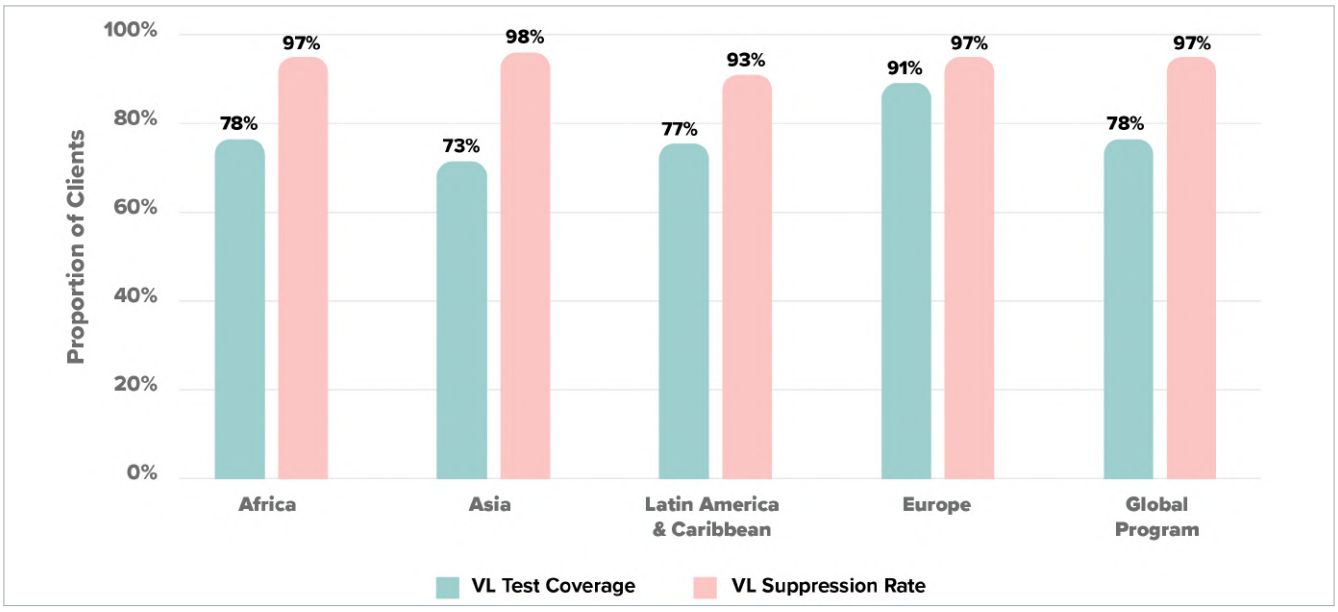
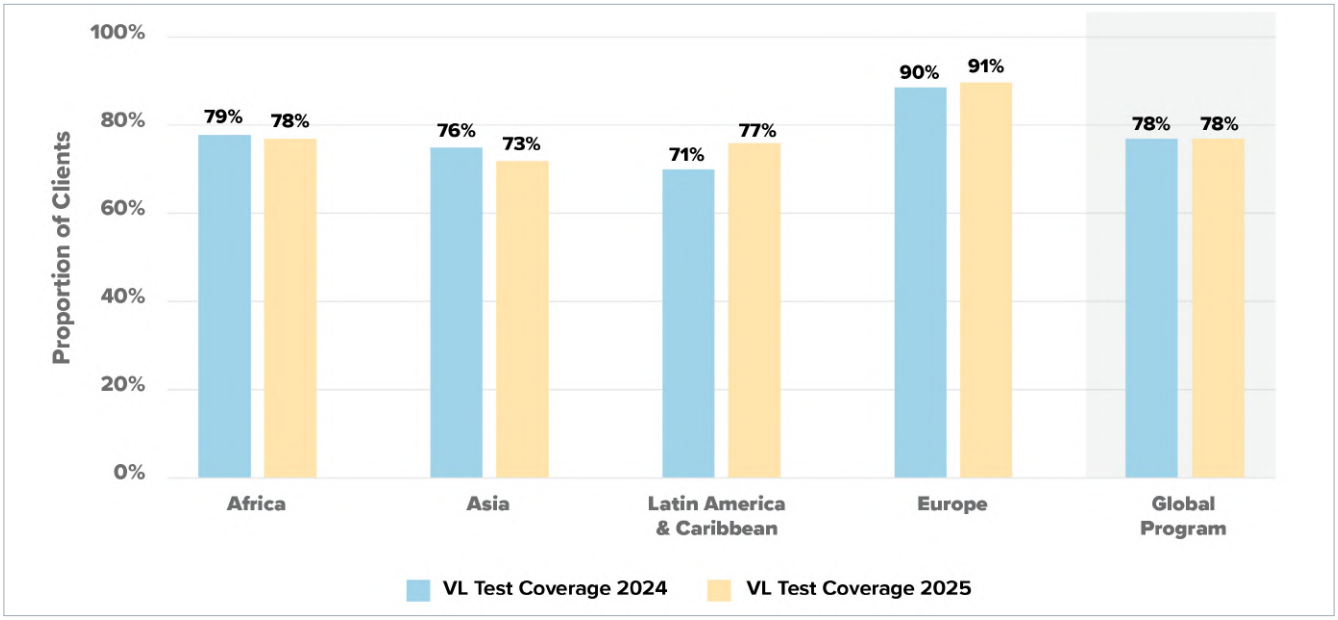


Figure 6.2.2 illustrates below the Viral Load (VL) test coverage across four regional bureaus and the overall global program for the years 2024 and 2025. Overall, global VL test coverage remained relatively stable at 78% in both 2024 and 2025. While the Europe Bureau maintains the highest coverage levels, the LAC Bureau was the only region to show significant growth over the two-year period.

Figure 6.2.2: Comparison of viral load coverage among bureaus, 2024-2025



As represented in **figure 6.2.3 below,** the Viral Load (VL) suppression rate across the bureaus and the global program for the years 2024 and 2025 was consistent. LAC Bureau was the only region with VL suppression rate below 95% over the two-year period.

Figure 6.2.3: Comparison of viral load suppression among bureaus, 2024-2025

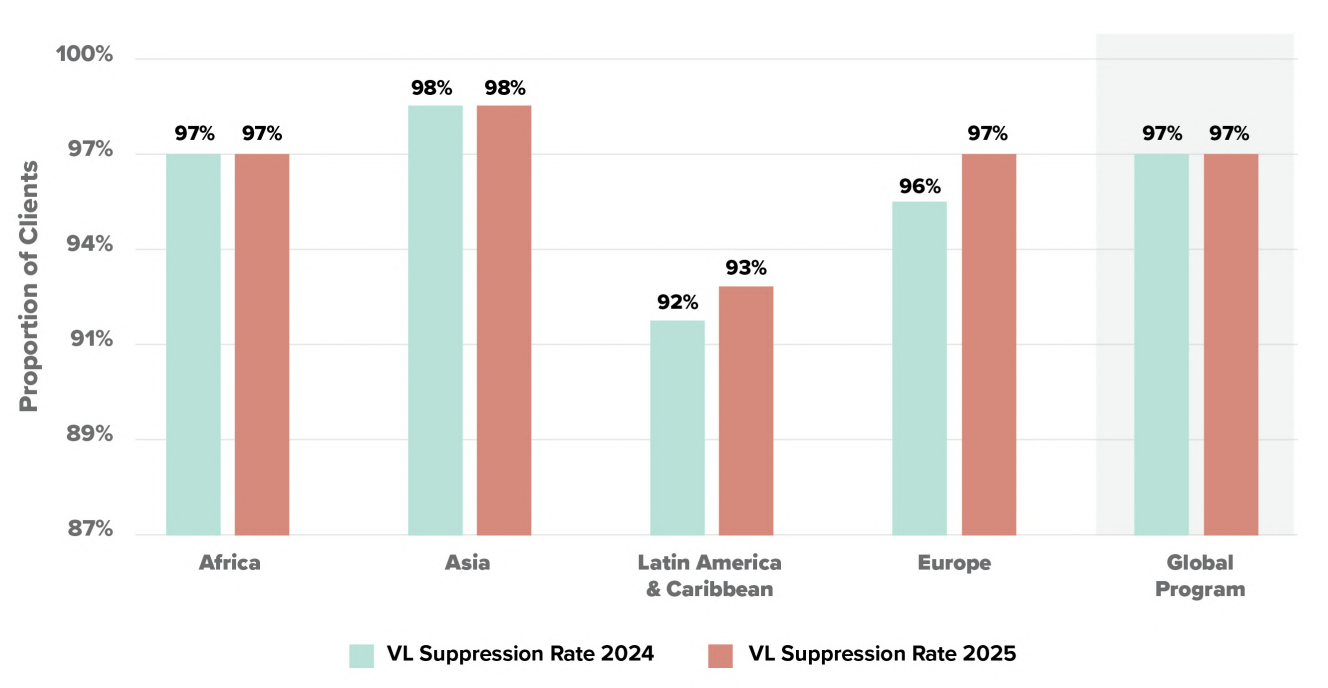
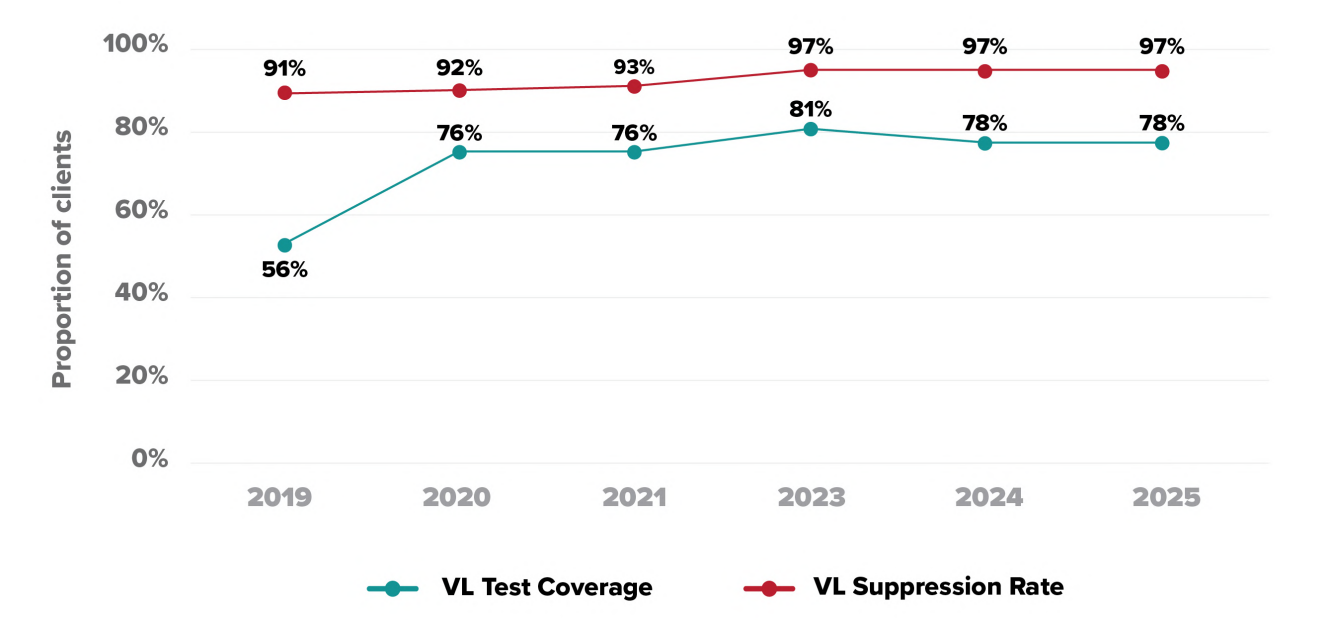


Figure 6.2.4 below shows a clear improvement over time in both viral load coverage and suppression among active PLHIV clients identified. Viral load (VL) test coverage increased substantially from 56% in 2019 to 76% in 2020 and 2021, peaked at 81% in 2023, and then declined slightly to 78% in 2024 and 2025, remaining well above 2019 levels. In contrast, the VL suppression rate demonstrated a steady and sustained upward trend, rising from 91% in 2019 to 93% in 2021, and reaching 97% by 2023, where it remained stable through 2025.

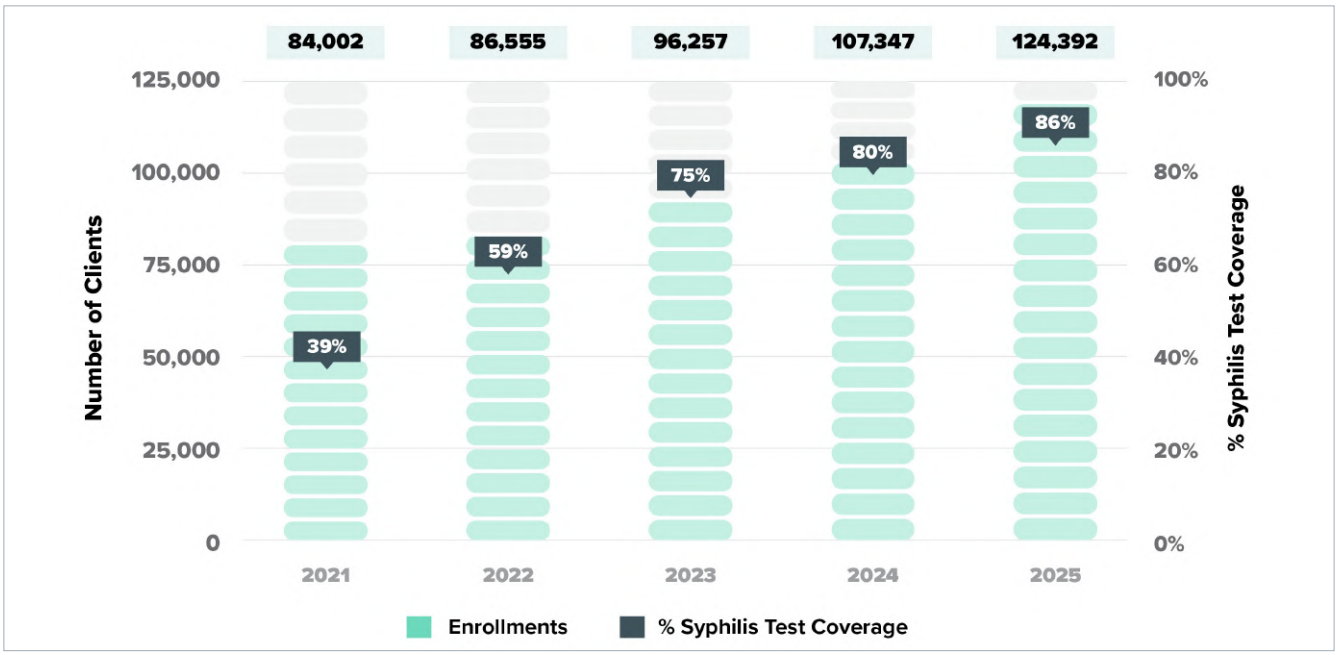
Figure 6.2.4: Global Program - VL coverage and suppression rates, 2019-2025



6.3. Syphilis Screening and STI management for newly enrolled HIV clients

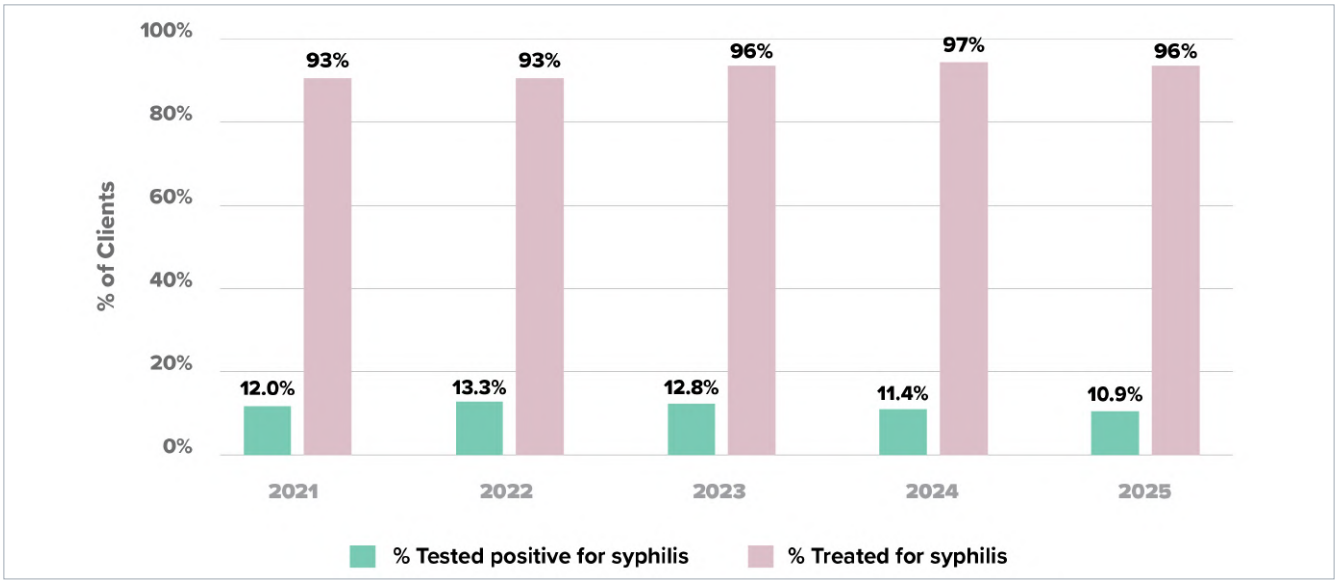
Syphilis screening and treatment completion among PLHIV enrolled in HIV care and treatment facilities is quarterly reported as AHFs Quality Benchmark 9. **Figure 6.3.1** illustrates a steady increase in both newly enrolled clients and syphilis test coverage from 2021 to 2025. Enrolments rose consistently over the period, increasing from 84,002 clients in 2021 to 124,392 in 2025. At the same time, syphilis test coverage in the Global Program among newly enrolled clients improved markedly, climbing from 39% in 2021 to 59% in 2022, reaching 75% in 2023, and continuing upward to 80% in 2024 and 86% in 2025.

Figure 6.3.1: Benchmark 9a: Proportion of newly enrolled HIV clients with baseline syphilis test, 2025



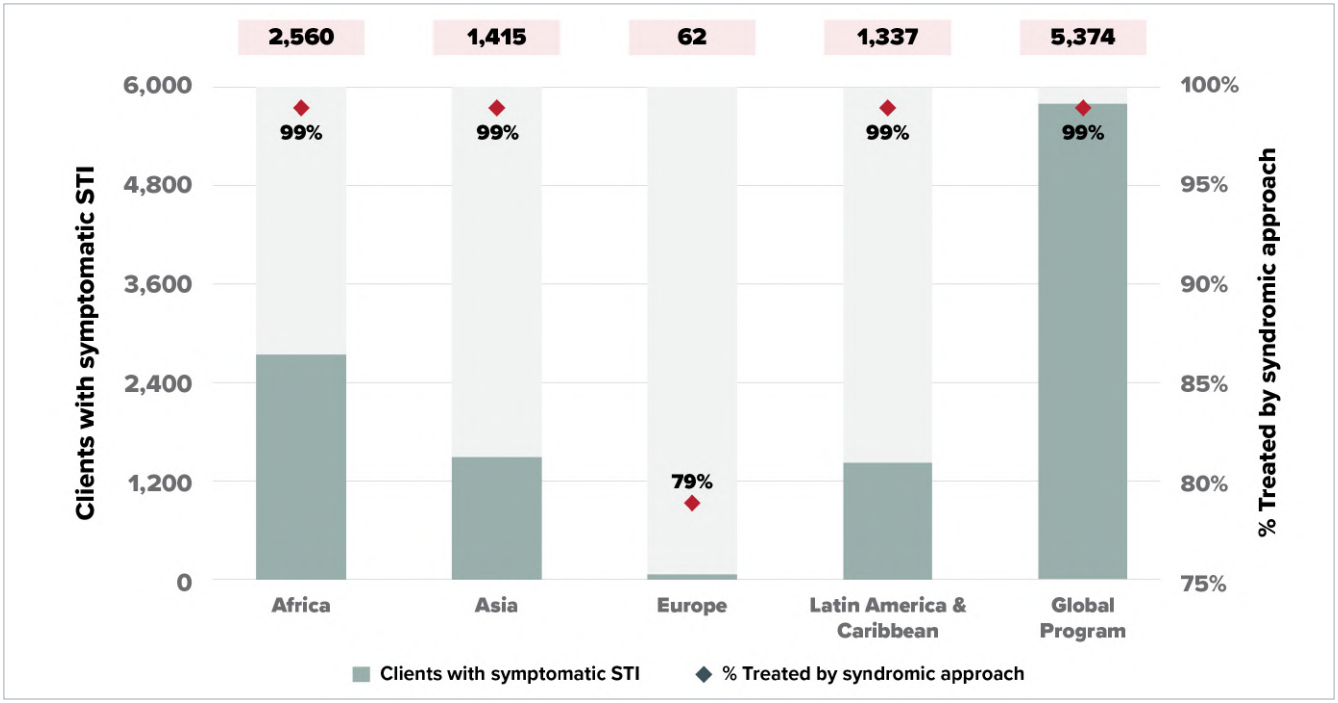
Global Programs average positivity rate for syphilis in 2025 was 10.9% among new enrolments in HIV care, as displayed in **figure 6.6.2.** The percentage of newly enrolled clients testing positive for syphilis has only slightly decreased steadily from a high of 13.3% in 2022 to 10.9% in 2025. The treatment rate for those who tested positive has remained consistently high and has improved over time, rising from 93% in 2021–2022 to a peak of 97% in 2024.

Figure 6.3.2: Benchmark 9b: Proportion of newly enrolled HIV clients tested positive for syphilis and treatment completion, 2021-2025



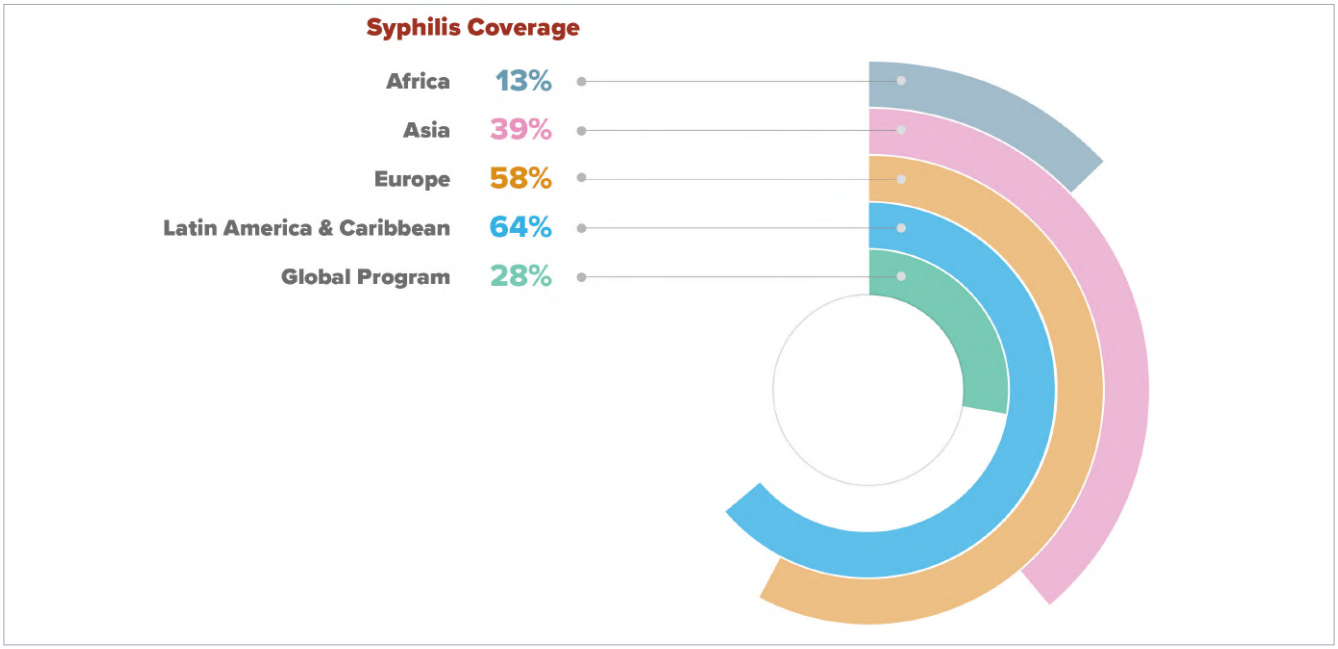
All bureaus reported symptomatic STIs (other than syphilis) among the newly enrolled clients. A total of 5,374 clients who had symptomatic STIs were identified and treated by syndromic approach, 99% of these clients having completed treatment within the reporting period, as shown in **figure 6.6.3.**

Figure 6.3.3: Number and proportion of HIV clients treated for symptomatic STI – 2025



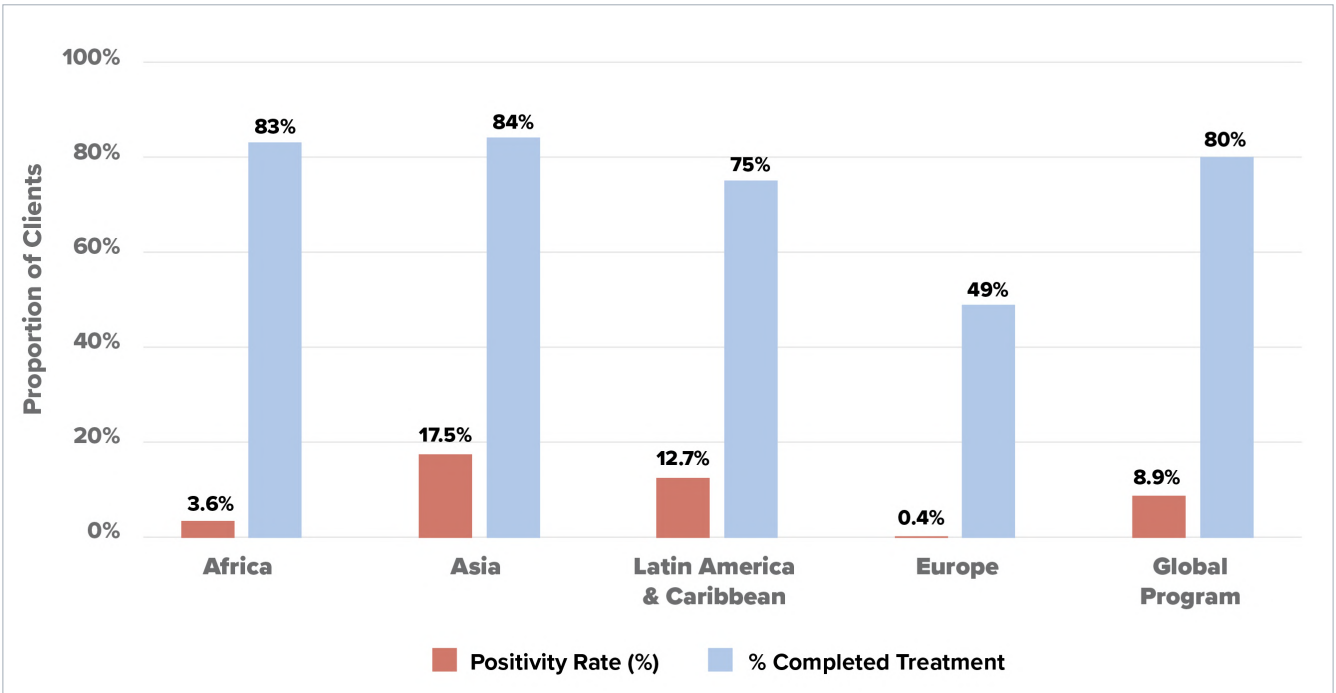
A review of data on syphilis testing among all active PLHIV clients in care is included for the first time in the 2025 Medical Records Audit (MRA). It coincides with AHFs standing recommendation to perform syphilis testing annually among clients active on ART. The review establishes for all clients in care, whether those longer than one year on ART since enrolment, have been re-tested in the year prior to the audit. Syphilis testing coverage varied widely, from as low as 13% in Africa Bureau to as high as 64% in Europe Bureau, with the Global Program achieving an overall coverage of 28% as shown on **figure 6.3.4 below.**

Figure 6.3.4: Global Program – Syphilis testing coverage, 2025



Among the clients with a syphilis test in the past 12 months within the Europe Bureau, 0.4% had a positive test result where 49% of them had completed treatment at the time of the 2025 medical chart audits, as illustrated on **figure 6.3.5.** The bureau reported the least positivity rate and the least treatment completion rate among the identified positive clients. The Global Program reported a positivity rate of 8.9%, where 80% of the identified positive clients had completed treatment.

Figure 6.3.5 Global Program – Syphilis positivity rate and treatment completion, 2025



6.4 Mortality

The increased availability of Anti-Retroviral Therapy (ART) has substantially reduced AIDS incidence and AIDS-related mortality among PLHIV clients. Despite the advancements in Anti-Retroviral Therapy (ART), mortality remains a critical concern among PLHIV clients, especially late presenters that start care at an advanced HIV clinical stage and in resource-limited settings. Figure 6.4.1 below displays mortality rates among clients in care, comparing crude (all causes), HIV-related and non-HIV-related mortality rates between 2019 and 2025. Crude mortality, HIV-related and non-HIV-related mortality rates (per 1,000 clients) for Global Programs have been on the decline since 2019. The reduction in overall (crude) mortality over the period appears to be driven primarily by sustained declines in HIV-related mortality, while non-HIV-related mortality showed modest fluctuations with a slight downward trend in the later years.

Figure 6.4.1: Crude, HIV-related and non-HIV-related mortality rate (per 1,000 clients), 2019 to 2025

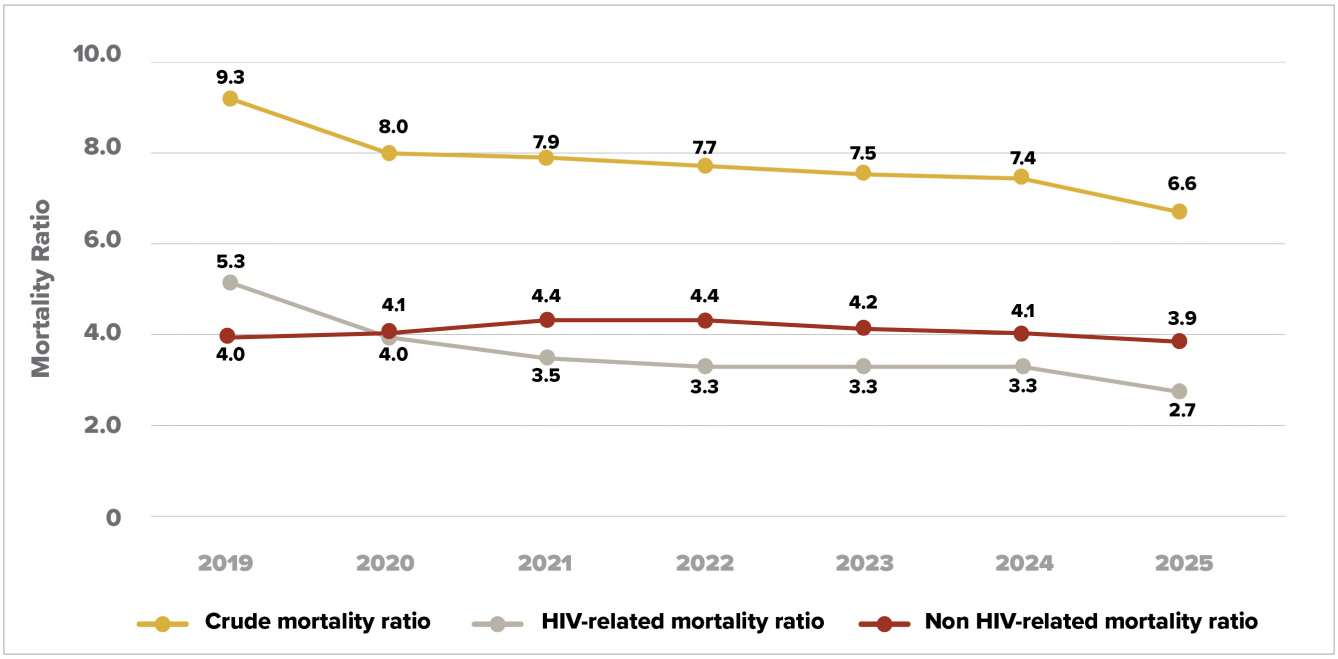
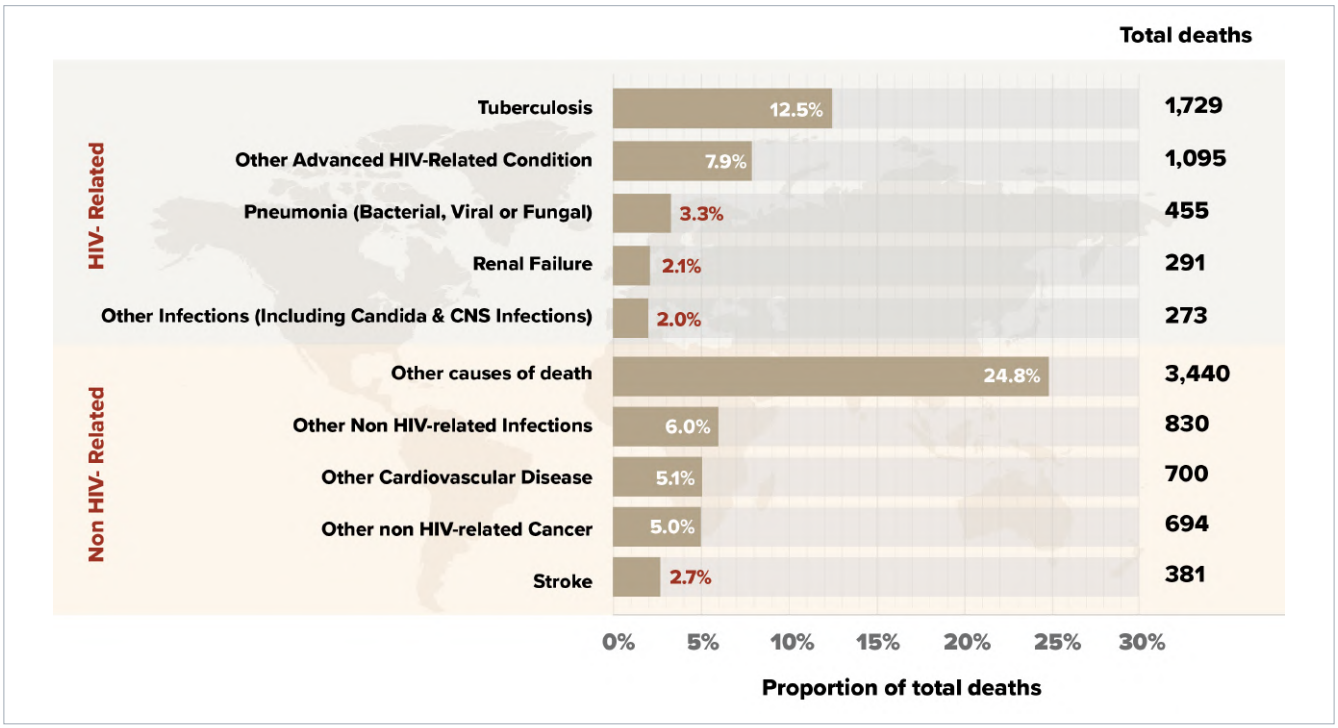


Figure 6.4.2 below shows the leading causes of deaths among PLHIV clients in care, disaggregated into HIV and non-HIV-related deaths reported by the end of 2025. TB is the leading cause of HIV-related deaths, at 12.5% of total deaths. Other causes of deaths accounted for 24.8% of the 13,859 deaths reported in the same period.

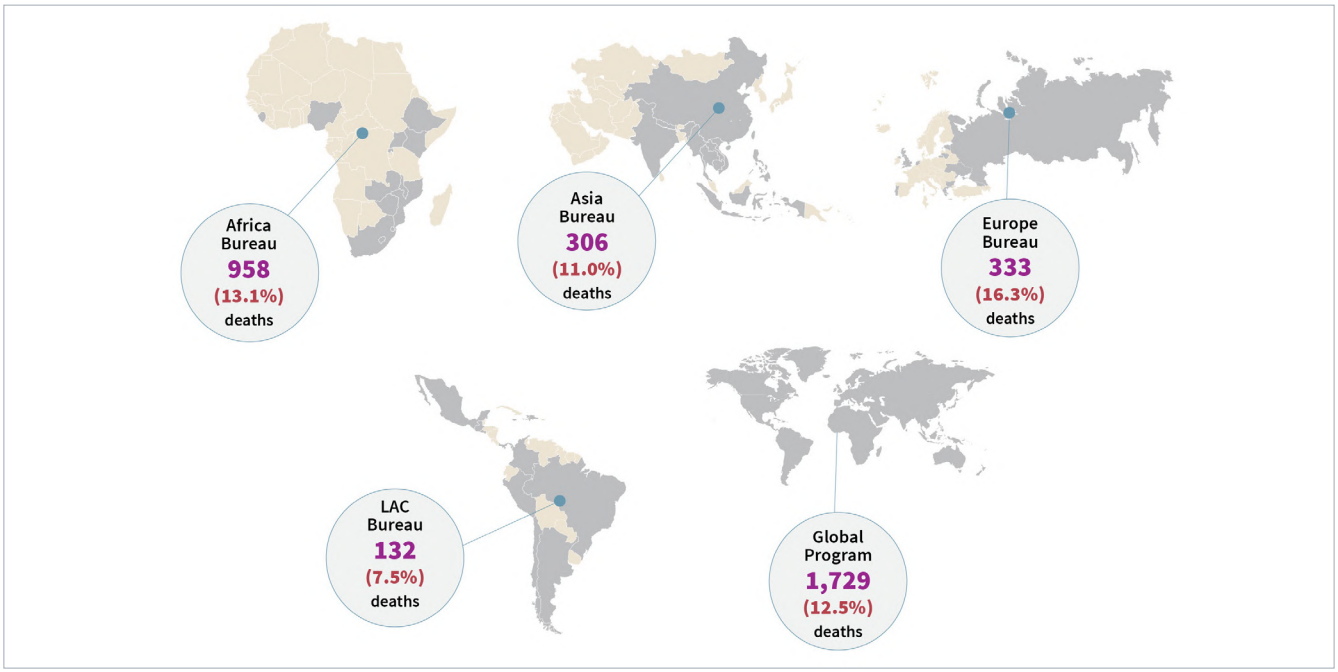
Figure 6.4.2: Leading causes of deaths among PLHIV clients, Global Program, 2025 (n=13,859)



6.4.1 TB Mortality

Tuberculosis (TB) was reported as the leading cause of HIV-related deaths among PLHIV clients by the Global Program and across other bureaus. **Figure 6.4.1 below** displays total deaths reported by the bureaus and the proportion of deaths due to TB among PLHIV clients in care by the end of 2025. All bureaus reported TB deaths at more than 9% out of all mortality within the reporting period.

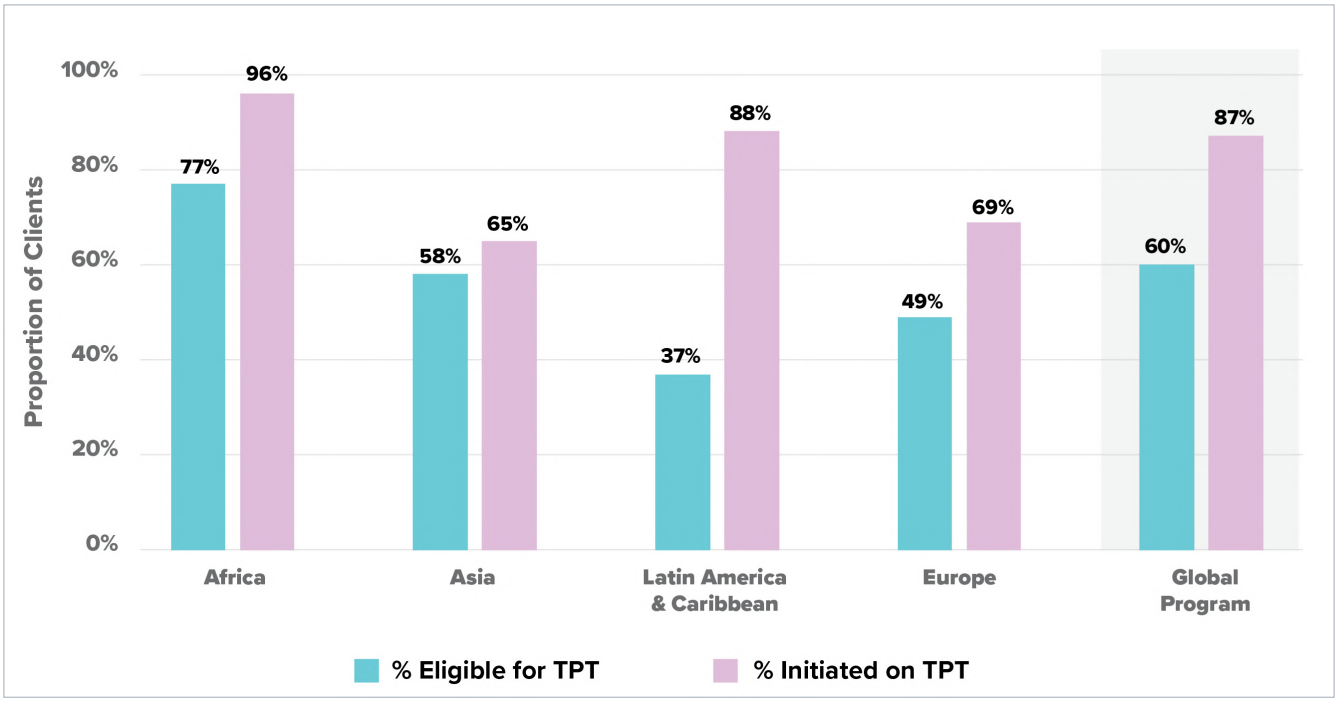
Figure 6.4.3: Proportion of TB deaths out of total deaths by bureau - 2025



6.5 TB Prevention

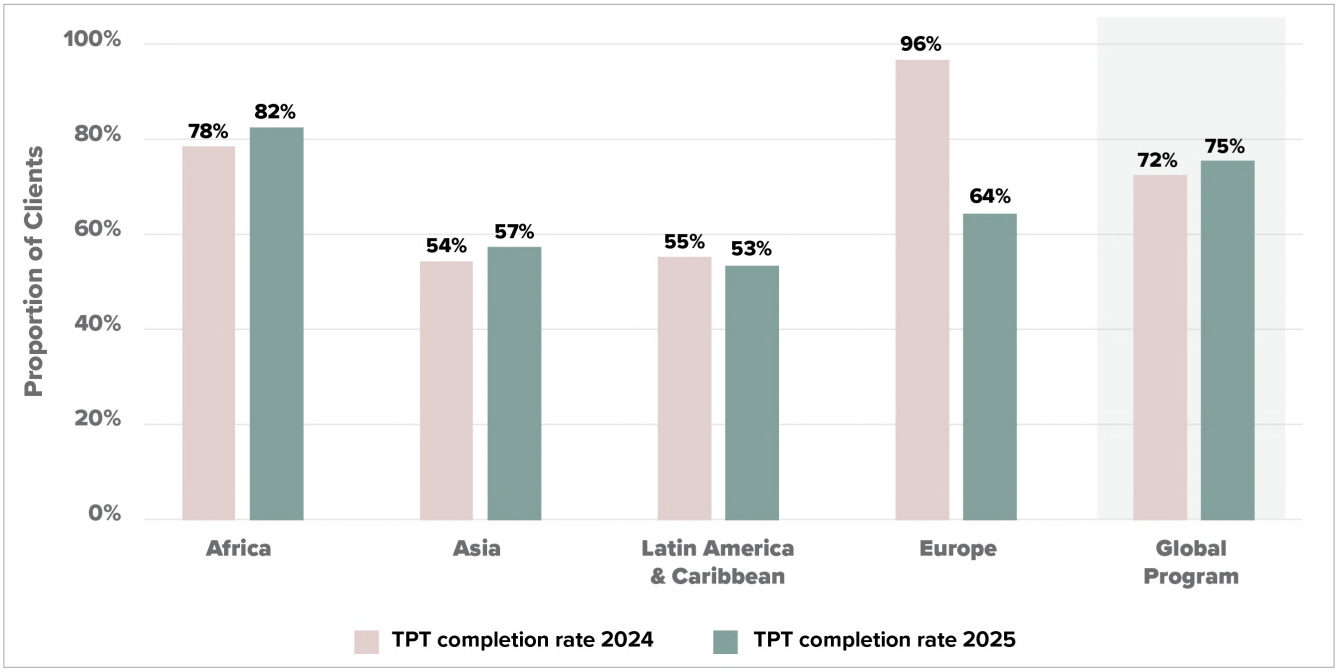
AHF Quality Benchmark 10, Tuberculosis Preventive Therapy (TPT) for all eligible PLHIV has been monitored in the countries where the TB prevalence dictates the intervention among PLHIV clients and is a standing recommendation in national guidelines. TPT Initiation is monitored at enrolment as part of the Quarterly QBM report. **Figures 6.5.1 below** displays TPT initiation rates at enrolment in Africa, Europe, Asia and LAC Bureaus. The Global Program initiated TB Preventive Therapy (TPT) to 87% of the more than 72,000 newly enrolled clients who were eligible for TPT within the year. TPT initiation rates were lowest in Asia and Latin America and the Caribbean Bureaus at less than 70%. TB is not endemic in Argentina, Jamaica, Chile, Colombia and Trinidad and Tobago hence not reported as part of the quality benchmarks.

Figure 6.5.1: TPT Initiation at enrolment in 2025, by Bureau



TPT completion is monitored as part of the annual medical record audit. Across 2024 and 2025, the Global Program saw a modest TPT completion increase from 73% to 75%. While the Africa Bureau demonstrated steady growth to 82%, Europe experienced a sharp decline from 96% to 64. Conversely, both the Asia and LAC bureaus struggled with lower completion levels, maintaining completion rates below 60% among active clients audited, as displayed in **figure 6.5.2.**

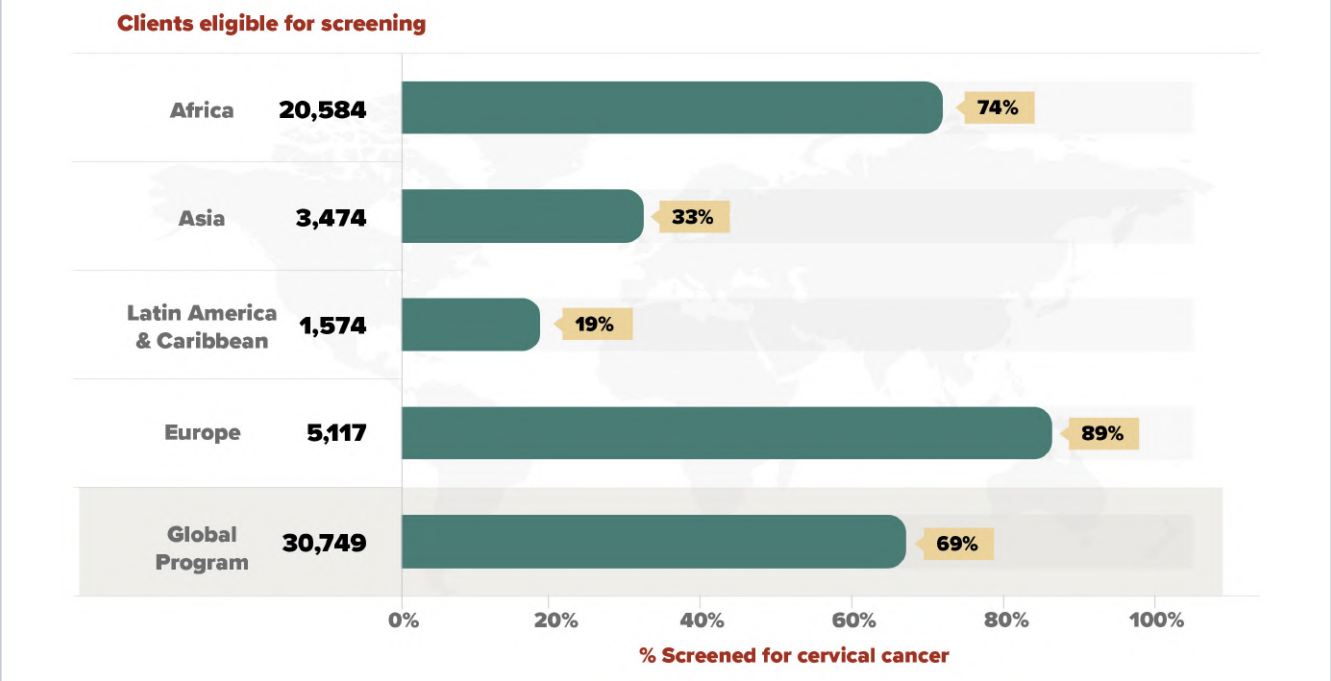
Figure 6.5.2: TPT completion rate by bureau, 2024-2025



6.6 Cervical Cancer Screening

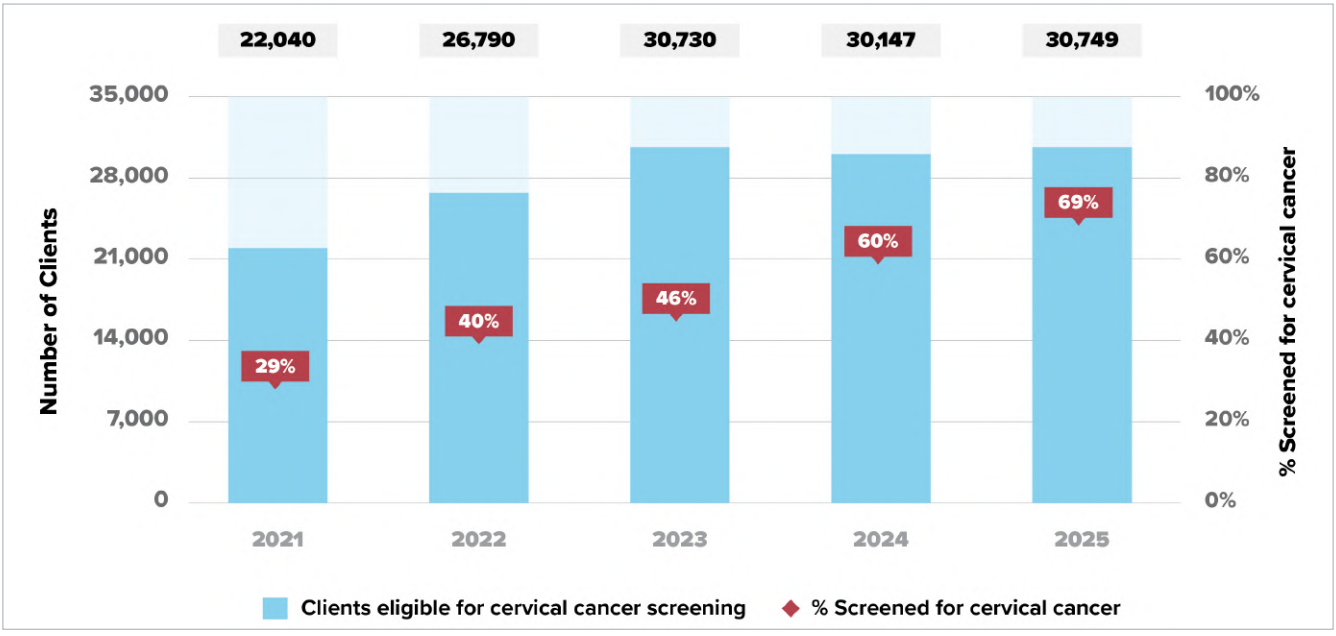
Figure 6.6.1 below displays the number of clients eligible, and proportion of clients screened for cervical cancer among the new enrolments reported in 2024. Globally, 50% of the clients who were eligible for cervical cancer screening were screened. Africa Bureau had the highest number of clients eligible for cervical cancer screening while Europe Bureau had the highest proportion of clients screened for the service within the reporting period.

Figure 6.6.1: Proportion of clients eligible and screened for cervical cancer, Bureaus - 2025



From 2021 to 2025, the program significantly expanded its reach, with the number of eligible clients growing from 22,040 to 30,749. During this same period, the cervical cancer screening rate more than doubled, rising steadily from 29% to 69%. This trend highlights a successful scaling of services, as the program managed to increase coverage despite a 40% increase in the eligible population.

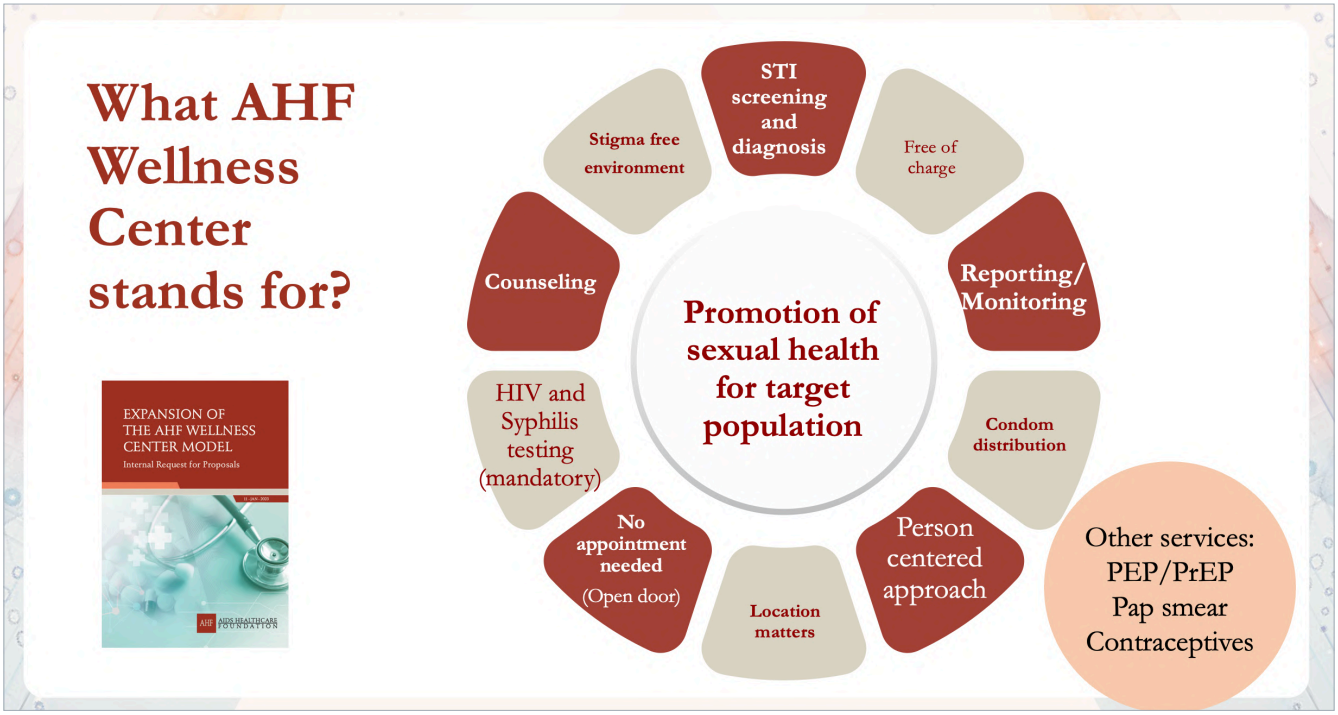
Figure 6.6.2: Global Program: Proportion of clients eligible and screened for cervical cancer, 2021-2025



07 Global Quality 2025 Core Activities

7.1 Wellness Center Program

Figure 7.1.1 The Wellness Center Model



Advancing the Wellness Center Strategy: A Year of Expansion and Impact in 2025

The year 2025 was defined by a major strategic investment in expanding AHF's STI response through the Wellness Center Initiative, as evidenced by the significant number of individuals diagnosed and treated.

Key achievements include:

- Over 7,500 HIV diagnoses, with a global positivity rate of 3.6% among all individuals tested.
- More than 22,500 syphilis diagnoses.
- Over 80,000 people provided with treatment for other STIs.

This success was made possible through the impressive work of the Bureaus and country teams, supported by the Global Quality Team (GQT), GAMPO, and senior management.

OVER
7,500
HIV DIAGNOSES

3.6%
POSITIVITY RATIO

More than
22,500
Syphilis diagnoses

Over
80,000
People provided with treatment for STIs

To ensure the quality and scalability of the initiative, the GQT implemented a robust monitoring framework:

1

Development of Monitoring Tools:

Created and deployed tools for the systematic collection of quality indicator data.

2

Structured Technical Visits:

Conducted on-site visits, providing immediate feedback through standardized reports and actionable recommendations.

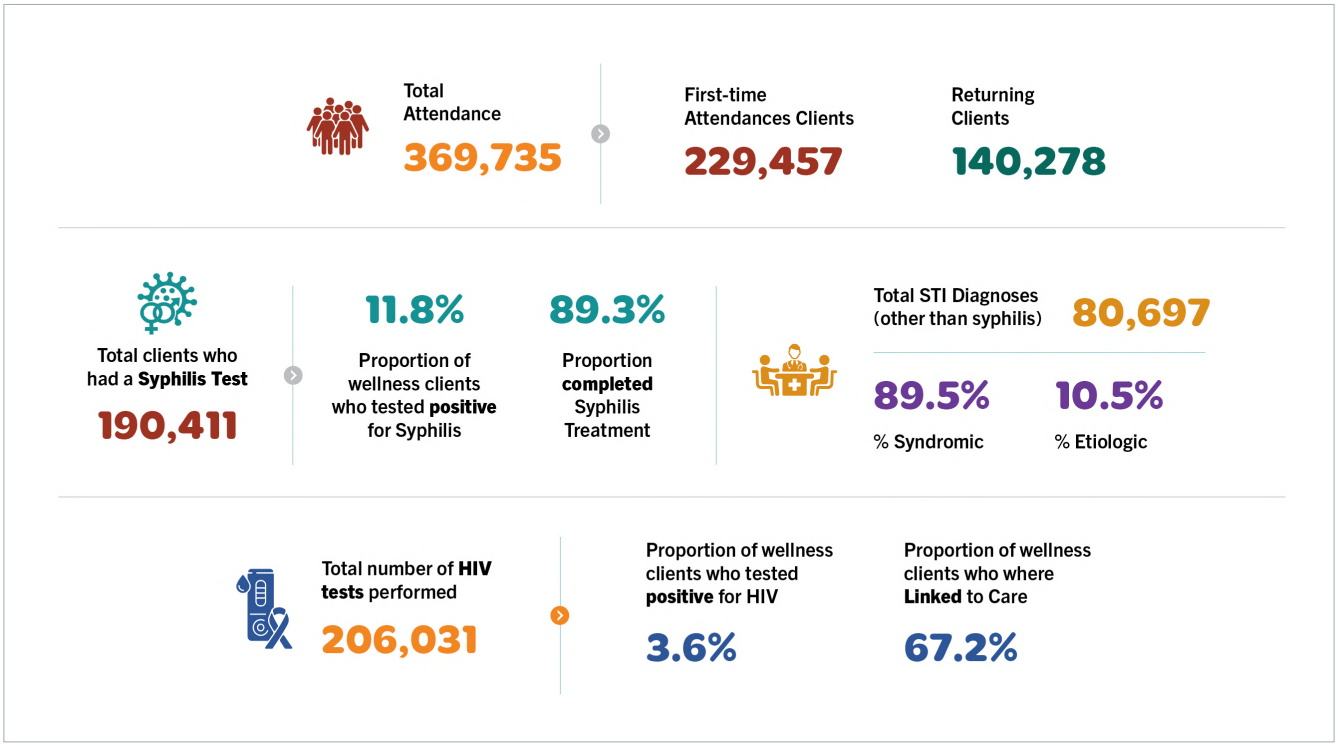
3

Collaborative Reviews:

Held a series of virtual meetings to review protocols, assess implementation progress and challenges, and provide feedback through joint analysis of performance indicators.

Looking ahead, we are continuously refining a performance matrix to benchmark clinic operations, guide the expansion of successful sites, and provide targeted support to centers that are not yet fully aligned with the AHF Wellness Center model.

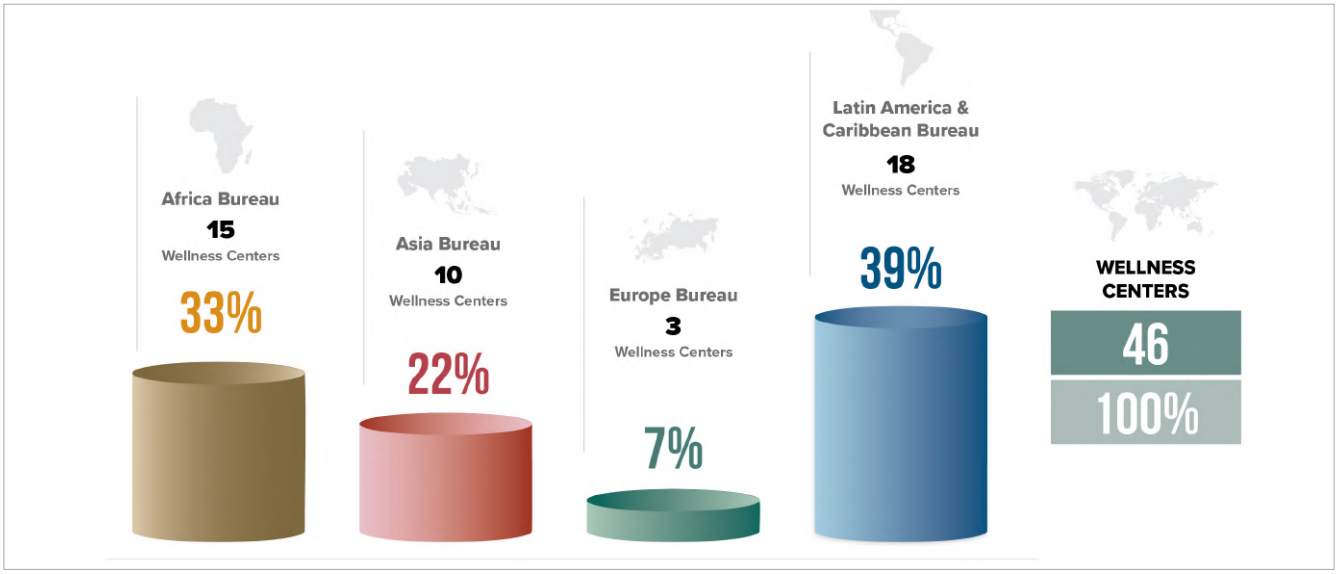
Figure 7.1.2: Snapshot Wellness Program 2025



7.1.3 Growth of the Global Program Network of Wellness Centers

By the end of 2025, the Global Program had 46 wellness centers operating in all four bureaus. The Europe Bureau has three wellness centers, or 7% of all wellness centers, while the LAC Bureau hosts the majority, with 39% (n=18).

Figure 7.1.3: Distribution of existing and new wellness centers by bureau, 2025



7.1.4 Evaluation of the new implemented AHF Wellness Centers productivity

Between 2024 and 2025, data were submitted to the AHF Wellness Web portal by 46 wellness centers, **Figure 7.1.3** illustrates first-time attendance for STI consultations and other (non-STI) services by bureau. Across the global program, wellness centers reported a total of 229,457 first-time attendances. The Latin America and Caribbean and Africa Bureaus recorded the highest numbers of first-time attendances, reporting 105,756 and 88,936 clients respectively during the 2024–2025 period.

Figure 7.1.4: First Attendance -KPI-1, by Bureau, 2025

	First-time Attendance	Total number of Returning Clients	Total Attendance
Africa	88,936	30,445	119,381
Asia	31,232	14,412	45,644
Latin America & Caribbean	105,756	92,239	197,995
Europe	3,533	3,182	6,715
Global Program	229,457	140,278	369,735

A total of 140,278 clients made return visits to the 46 wellness centers. Of these, 59.4% returned for new or recurrent STI consultations, while 40.6% sought prevention services. The Africa and Latin America and Caribbean Bureaus reported the highest proportions of returning clients who visited wellness centers for new or recurrent STI consultations, as illustrated in **Figure 7.1.5.**

Figure 7.1.5: Returning Clients for Follow-up consultations (STIs and other services) KPI-2, by Bureau, 2025

	Total number of Returning Clients	Returning Clients for a New or Recurrent STI consultation	Returning Clients for other services
Africa	30,445	15,713 (51.6%)	14,732 (48.4%)
Asia	14,412	13,043 (90.5%)	1,369 (9.4%)
Latin America & Caribbean	92,239	52,651 (57.1%)	39,588 (42.9%)
Europe	3,182	1,907 (59.9%)	1275 (40.1%)
Global Program	140,278	83,314 (59.4%)	56,964 (40.6%)

Between 2024 and 2025, a total of 190,411 Wellness Center clients were tested for syphilis, with the Africa and Latin America and Caribbean Bureaus contributing the largest numbers of clients tested. An overall high positivity rate of 11.8% was recorded from these tests. The Asia Bureau reported the highest positivity rate among all bureaus, at 29.3%, from the 35,395 syphilis tests conducted. These results are illustrated in **Figure 7.1.6.**

Figure 7.1.6: Total clients who had a Syphilis Test KPI-3, by Bureau, 2025

	Total number of Clients who had a Syphilis Test	Tested Positive and % Positive
Africa	50,435	4,192 (2.3%)
Asia	35,395	10,382 (29.3%)
Latin America & Caribbean	99,317	7,710 (7.8%)
Europe	5,264	239 (4.5%)
Global Program	190,411	22,523 (11.8%)

Figure 7.1.7 presents the distribution of STI diagnoses by bureau, disaggregated by syndromic and etiologic approaches. Across the global program, a total of 80,697 STI (excluding syphilis and HIV) diagnoses were reported, of which the majority (89.5%, n=72,252) were made using the syndromic approach, while 10.5% (n=8,445) were etiologic diagnoses.

Africa reported the highest number of STI diagnoses (38,150), with 88.6% diagnosed syndromically and 11.4% etiologically. Latin America and the Caribbean followed closely with 33,594 diagnoses, the highest proportion of syndromic diagnoses among all bureaus (94.1%). Asia reported 7,807 STI diagnoses, with 78.3% syndromic and 21.7% etiologic diagnoses. Although Europe reported the lowest total number of STI diagnoses (1,146), it had the highest proportion of etiologic diagnoses at 39.3%, compared to other bureaus.

Figure 7.1.7: Total STI Diagnoses (other than syphilis) KPI-4, by Bureau, 2025

	Total number of STI Diagnoses	Syndromic	Etiologic
Africa	38,150	33,815 (88.6%)	4,335 (11.4%)
Asia	7,807	6,115 (78.3%)	1,692 (21.7%)
Latin America & Caribbean	33,594	31,626 (94.1%)	1,968 (5.9%)
Europe	1,146	696 (60.7%)	450 (39.3%)
Global Program	80,697	72,252 (89.5%)	8,445 (10.5%)

Figure 7.1.8 below summarizes HIV testing outcomes across the bureaus. A total of 206,031 HIV tests were Latin America and the Caribbean conducted the highest number of HIV tests (121,396), reporting 3,906 positive results and a positivity rate of 3.2%. Africa followed with 58,631 tests performed, yielding 1,982 positive results (3.4%). Asia conducted 22,011 HIV tests and reported 1,532 positive cases, corresponding to the highest positivity ratio among all bureaus at 7.0%. Europe recorded the lowest testing volume at 3,993 tests, with 97 positive results and a positivity ratio of 2.4%.

Figure 7.1.8: Total number of HIV tests performed KPI-5 by Bureau, 2025

	Total number of HIV tests performed	Tested Positive and % Positive
Africa	58,631	1,982 (3.4%)
Asia	22,011	1,532 (7.0%)
Latin America & Caribbean	121,396	3,906 (3.2%)
Europe	3,993	97 (2.4%)
Global Program	206,031	7,517 (3.6%)

7.2 Medical Record/Chart Audit 2025

The annual medical record/chart audit (MRA) activity reconciles reported patient census and actual numbers of patients active in care as a means of enhancing recording and reporting capacity at site level and resulting data quality. It is an effective tool to bring clients LTFU back in care. This quality activity was conducted between March and November 2025. Key highlights are displayed in **figure 7.2.1 below.**

Figure 7.2.1: Medical Record/chart audit summary, 2025

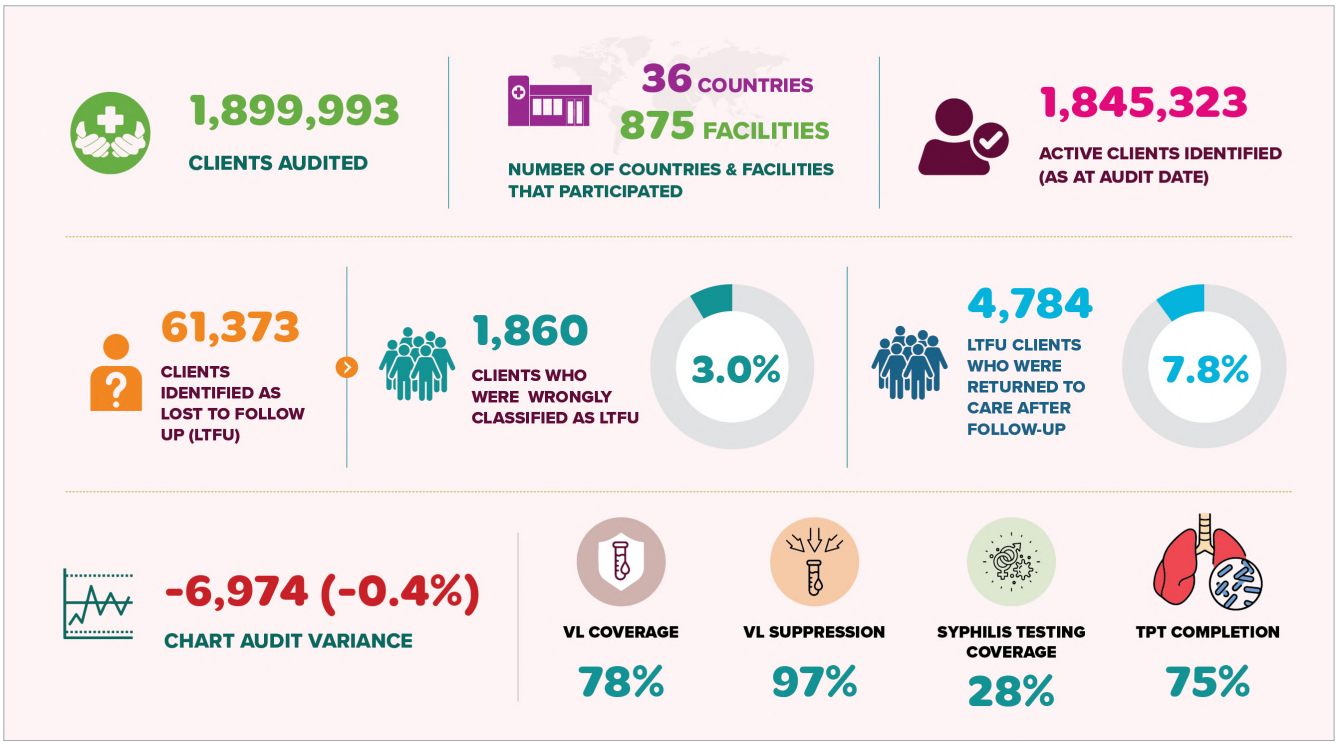


Figure 7.2.2 displays a summary of outcomes and comparison of medical record/chart audits conducted between 2021 and 2025. A total of 875 HIV C&T facilities (almost all global program C&T facilities) in 36 countries were audited, representing an 11% increase from 785 audited facilities in 2024. The number of active clients audited increased from 1.66 million to 1.85 million within the same period. The proportion of clients returned to care has been on a significant decline over past audits. 7.8% of the LTFU clients identified in Phase 1 of the audits were returned to care after follow-up in 2025, an increase from 6.8% in the previous year.

Figure 7.2.2: Medical reviews comparison summary, 2019 and 2025

	2019	2020	2021	2023	2024	2025
Number of HIV C&T facilities audited	561	648	682	760	785	875
Number of countries audited	36	37	38	36	36	36
Active clients identified (as at audit date)	970,373	1,206,628	1,242,945	1,469,873	1,663,227	1,845,323
LTFU clients identified	32,241	45,239	25,347	26,186	55,260	61,373
Clients wrongly classified as inactive	6,091	8,030	6,250	2,238	2,858	1,860
Proportion of clients wrongly classified among LTFU	18.9%	17.8%	24.7%	8.5%	5.2%	3.0%
Clients returned to care	3,581	4,247	3,064	2,571	3,781	4,784
Proportion of clients returned to care among LTFU	11.1%	9.4%	12.1%	9.8%	6.8%	7.8%

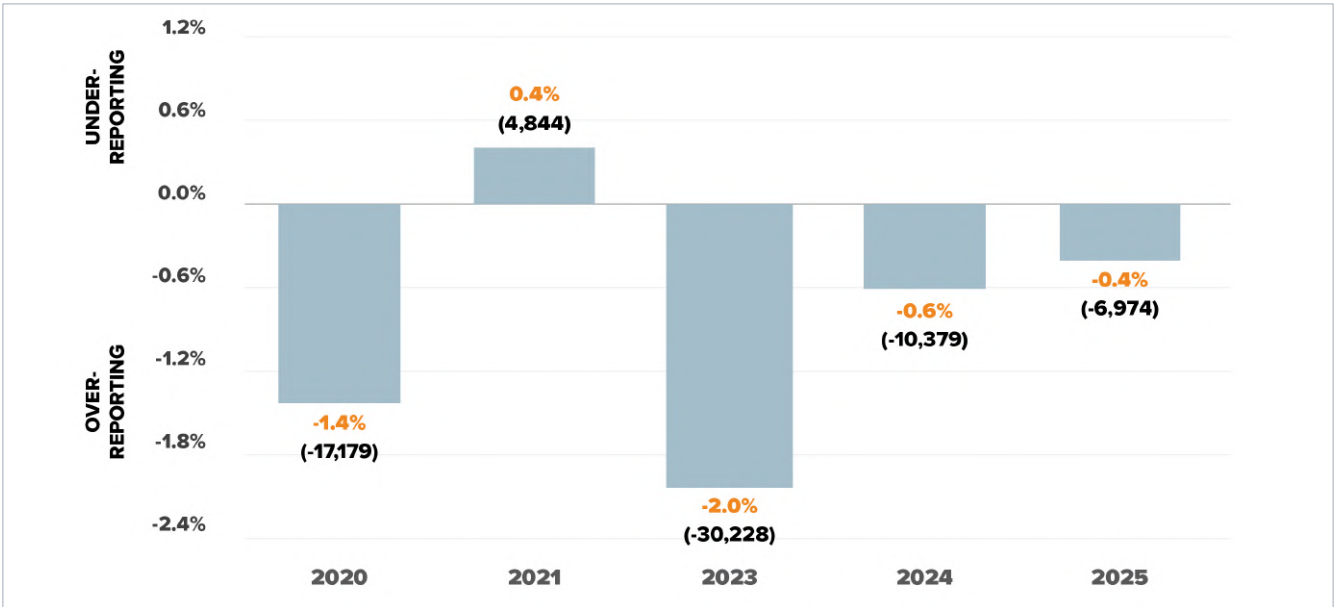
Figure 7.2.3 below presents the annual percentage variance between the WebPPR-reported census and medical audit outcomes for the Global Program over the period, 2018 to 2025. Overall, the variance was mostly negative, indicating that the WebPPR census over-reported on active clients in care compared to audit findings. The largest negative discrepancies were observed in the earlier years, with variances of –2.2% in 2018 and –2.5% in 2019, suggesting substantial misalignment between routine reporting on WebPPR and audited records during this period. The magnitude of variance declined in 2020 (–1.4%), indicating considerable improvement in data concordance.

In 2021, the variance shifted marginally positive (+0.4%), representing the only year in which the Global Program WebPPR census was slightly under-reported relative to audit outcomes. This reversal and reduced margin of variance suggest a temporary improvement in reporting accuracy or changes in data reconciliation practices.

Negative variance was observed again in 2023 (–2.0%), comparable to levels seen in the early years, implying a deterioration or disruption in data consistency. However, subsequent years show a marked reduction in discrepancies, with variances narrowing to –0.6% in 2024 and –0.4% in 2025. This downward trend in absolute variance indicates progressive alignment between WebPPR census data and audit results in the most recent period. The Global Program overreported the number of active clients in care in 2025, which led to a 6,974 client drop in the census after the chart audit reconciliation process.

In summary, the medical chart audits variance trend for the Global Program demonstrates a long-term improvement in data quality and concordance, with substantial discrepancies in the early years gradually giving way to minimal variance by 2024 to 2025, reflecting strengthened reporting systems, improved reconciliation processes, or enhanced audit-informed data corrections at the HIV C&T facilities.

Figure 7.2.3: Number of clients and percentage variance in census from chart audits, 2020-2025

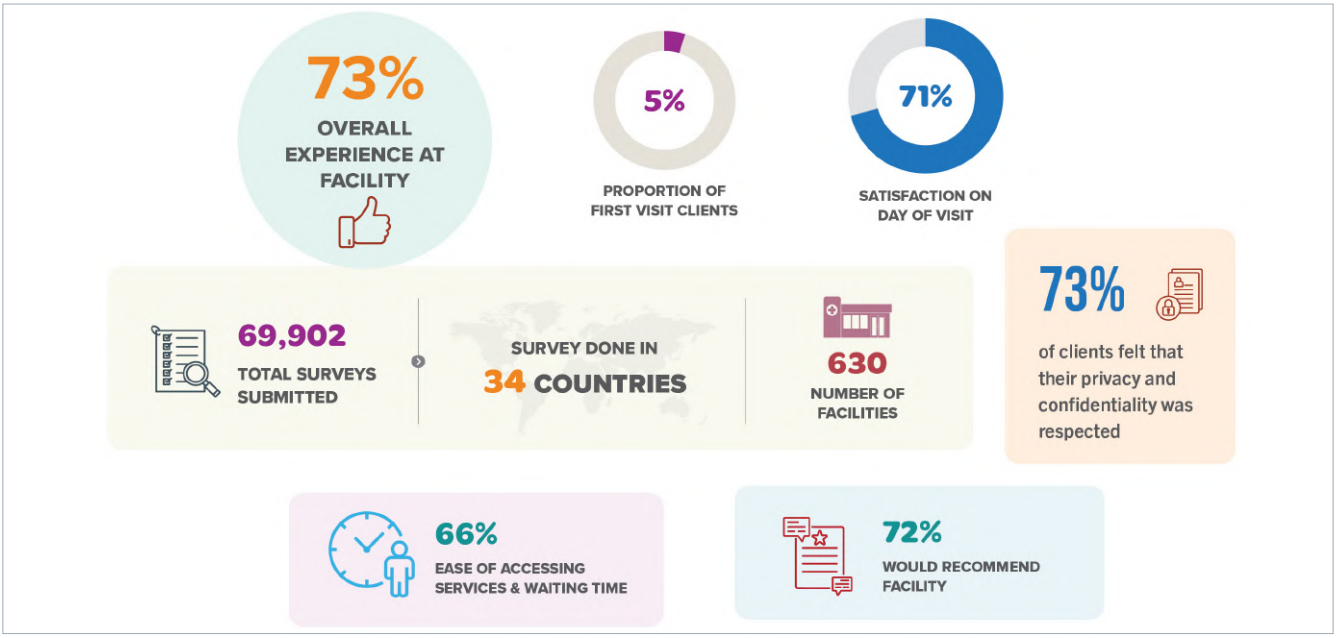


7.3 Client Satisfaction Survey (CSS) 2025

The measurement of clients' satisfaction is an attempt to capture elements of the quality of care against patient expectations. These elements include overall client experience, ease of access to services and waiting time, adherence to client privacy and confidentiality and likelihood of recommending the facility to friends and acquaintances. The survey improves the previous ones, based on the feedback received from countries and facilities. During the 2025 survey, clients registered at the facility would scan a Quick Response (QR) code on handheld devices such as tablets and smartphones from where they would submit their feedback to this round of CSS. The great response and manageable logistics ensures that the survey will be continuous throughout 2026.

69,902 clients in 630 HIV C&T facilities across 34 countries had responded to the 2025 Client Satisfaction Survey (CSS). Globally, 73% of the respondents were very satisfied with the overall experience at the facility while 66% expressed high satisfaction with the ease of accessing services and waiting time. 72% of the respondents reported that they would most likely recommend their facility to family and friends.

Figure 7.3.1: Summary findings from Client Satisfaction Survey (CSS), 2025



Nearly half of the respondents (48%) reported receiving care for longer than five years, indicating a substantial proportion of long-term HIV care at the reporting C&T facilities. A further 22% had been at the facility for 2–5 years, while 14% reported a duration of 1–2 years. Smaller proportions were newer to the facility, with 11% having attended for less than one year and 5% indicating that this was their first visit, as illustrated on **figure 7.3.2.**

Figure 7.3.2: Duration of care at facility, 2025

Across all bureaus, satisfaction levels were very high, with the majority of respondents reporting that they were either very satisfied or satisfied. From **figure 7.3.3,** the Europe Bureau recorded the highest proportion of very satisfied respondents (83.7%), followed by the Asia Bureau (79.2%), the Global Program (74.6%), the Africa Bureau (72.6%), and the LAC Bureau (69.1%). When combining very satisfied and satisfied responses, positive ratings exceeded 90% in all bureaus, highlighting consistently strong approval. Neutral responses were low across bureaus, ranging from 0.0% in the Europe Bureau to 3.4% in the Africa Bureau. Levels of dissatisfaction were minimal: unsatisfied and very unsatisfied responses together did not exceed 2.1% in any bureau and were effectively negligible in the Europe and LAC Bureaus.

Figure 7.3.3: Satisfaction with overall experience at facility by bureau, 2025

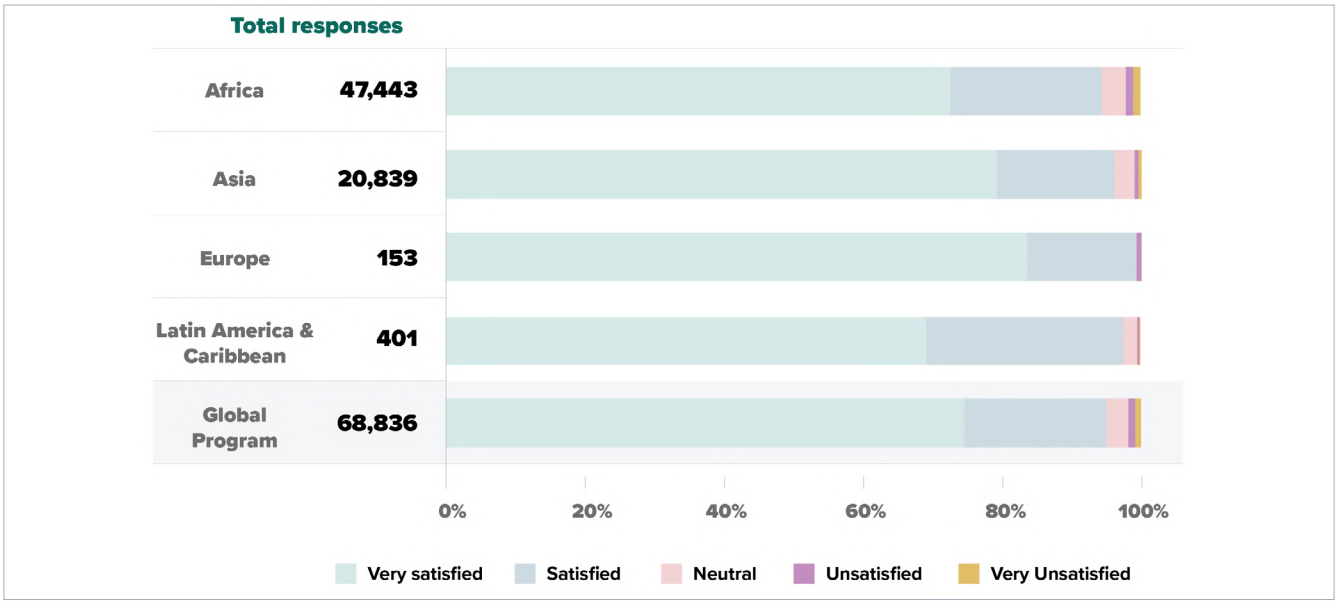


Figure 7.3.4 indicates consistently high levels of satisfaction across all bureaus, with most respondents reporting that they were either very satisfied or satisfied with their experience on the day of their visit. The Europe Bureau recorded the highest share of very satisfied respondents (84.2%), followed by the Asia Bureau (78.1%), the LAC Bureau (75.1%), the Global Program (71.9%), and the Africa Bureau (69.1%). Dissatisfaction remained minimal: combined unsatisfied and very unsatisfied responses did not exceed 2.8% in any bureau and were negligible in the Europe and LAC Bureaus.

Figure 7.3.4: Overall satisfaction on the day of visit by bureau, 2025

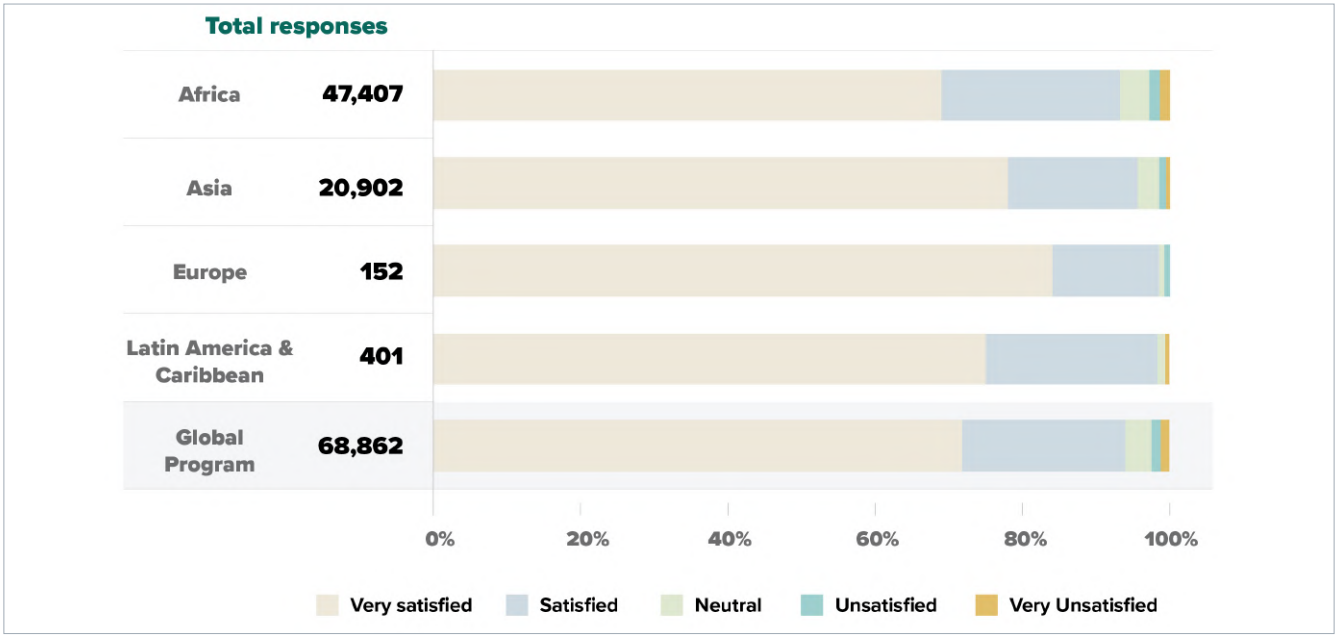
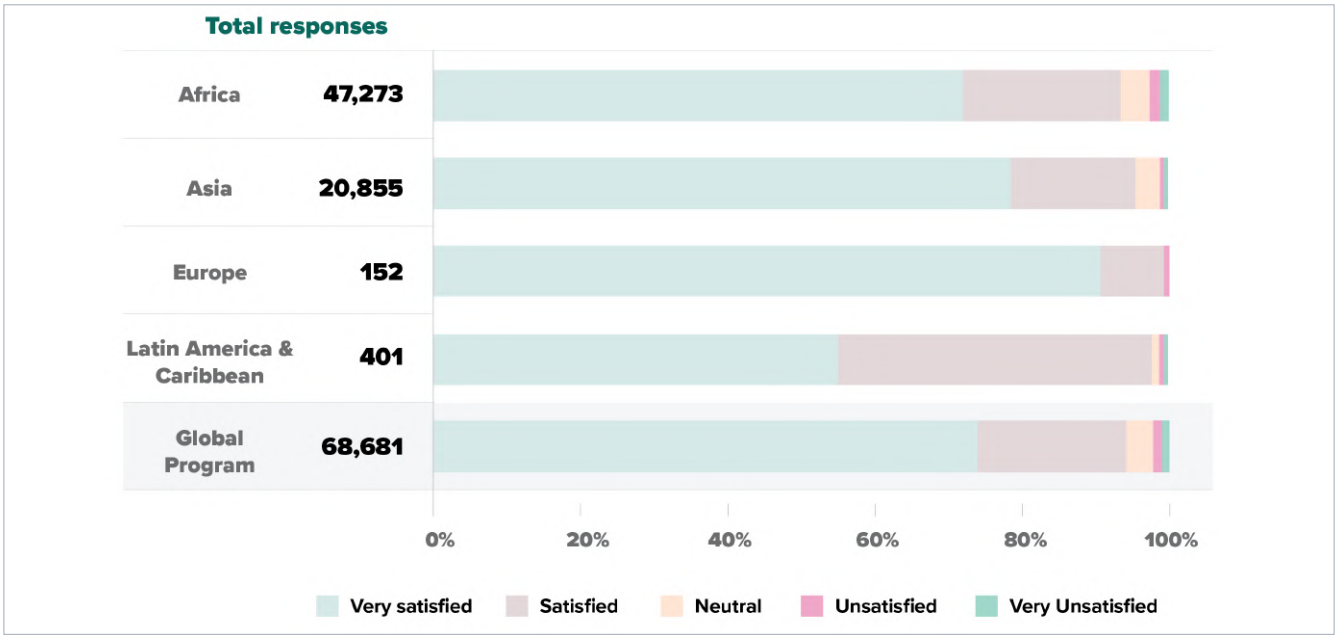


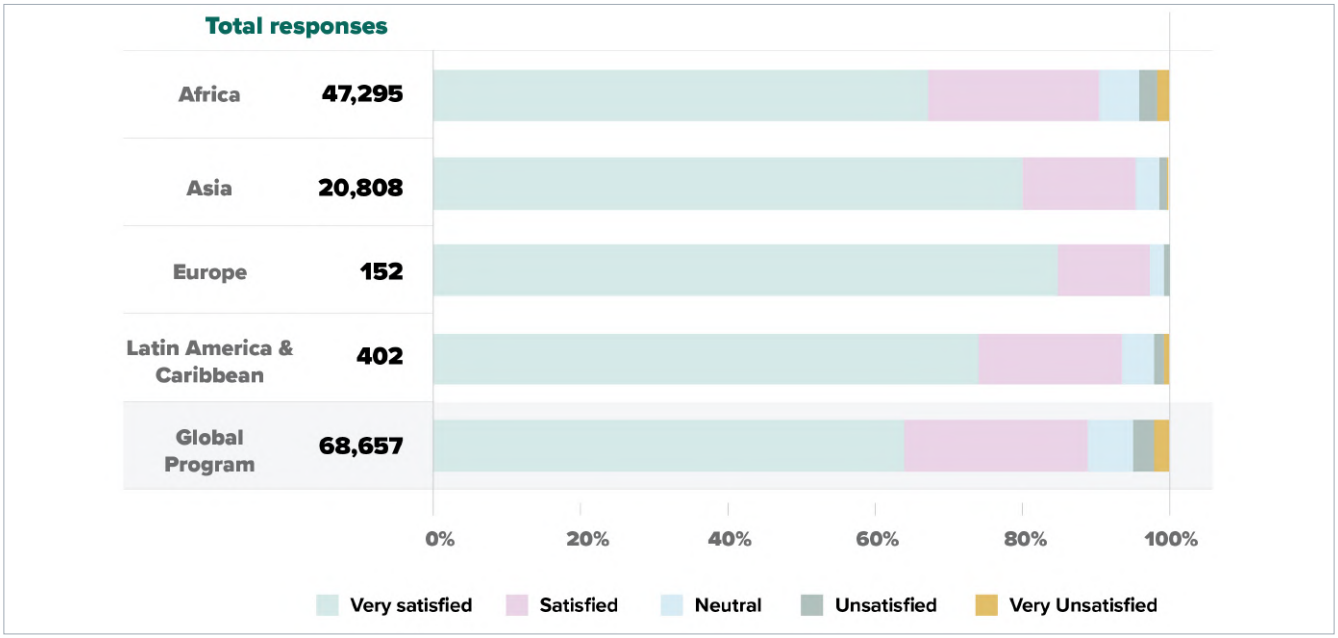
Figure 7.3.5 shows that the Global Program recorded high satisfaction with respect for clients' privacy and confidentiality, with 74.0% of clients being very satisfied and an additional 20.2% satisfied, indicating a combined positive rating of 94.2%. Only a small proportion expressed dissatisfaction. Variations exist in the distribution between the top two satisfaction categories, but overall dissatisfaction remains low.

Figure 7.3.5: Satisfaction with respect for clients' privacy and confidentiality by bureau, 2025



Africa Bureau, while still reflecting strong overall satisfaction (89.0% combined), showed the lowest "very satisfied" rate (64.1%) and the highest dissatisfaction rate (4.9%) among all bureaus. Europe Bureau had the highest satisfaction rate, with 97.4% combined positive feedback and no "very unsatisfied" responses, though only 152 responses had been submitted by the end of the year, as seen in **figure 7.3.6.**

Figure 7.3.6: Satisfaction with ease of accessing services and the waiting time by bureau, 2025



Overall, 73.6% of respondents globally were "very likely" to recommend the facility, and 20.3% were "likely," indicating a strong positive perception across the Global Program. Neutral and negative responses were minimal, each accounting for about 4% or less. The data indicate high satisfaction and strong willingness to recommend facilities across all bureaus, with particularly strong results in Europe and Asia, and broadly positive sentiment even in regions with more balanced response distributions such as LAC as displayed in **figure 7.3.7.**

Figure 7.3.7: Likelihood of recommending facility to family and friends by bureau, 2025

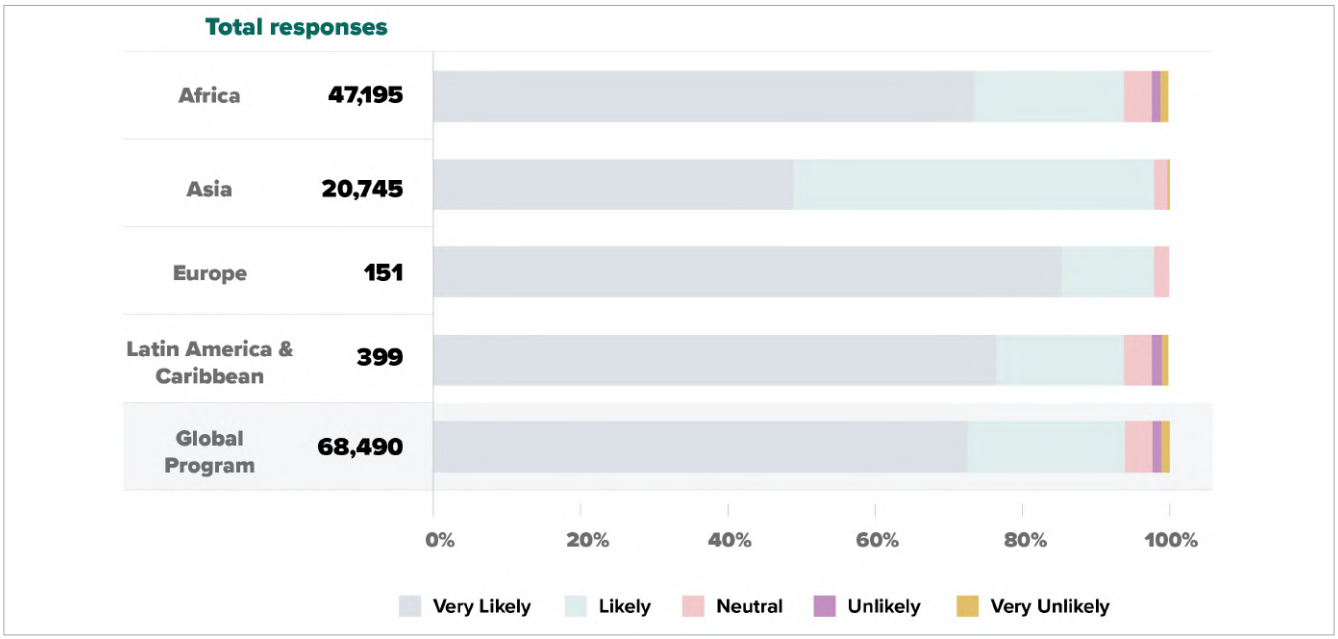


Figure 7.3.7: Key sentiments on suggestions for facility improvement from CSS, 2025

Aspect	Negative Sentiments		Neutral Sentiments		Positive Sentiments		Total Mentions
	Number	%	Number	%	Number	%	
Accessibility	206	18%	610	55%	298	27%	**1,114**
Availability & Hours	178	28%	398	63%	51	8%	**627**
Cost & Affordability	122	33%	170	45%	82	22%	**374**
Facilities & Cleanliness	593	23%	1,309	51%	665	26%	**2,567**
Service Quality	715	14%	1,587	30%	2,912	56%	**5,214**
Staff Behaviour	625	26%	1,143	48%	633	26%	**2,401**
Waiting Time	1,523	31%	2,799	57%	561	11%	**4,883**

Sentiment analysis was used for the qualitative question in the 2025 CSS. The table above highlights service quality and waiting time as the most frequently mentioned aspects in suggestions for facility improvement in 2025. Service quality attracted the highest number of mentions (5,214) and was viewed most positively, with 56% positive sentiments, indicating it is a key strength of facilities. In contrast, waiting time also had a high volume of feedback (4,883) but was predominantly neutral (57%) and had a relatively high share of negative sentiments (31%), signaling an important area for improvement.

Facilities and cleanliness and staff behaviour received mixed feedback, with neutral sentiments dominating but positive sentiments slightly outweighing negative ones, suggesting acceptable performance with room for enhancement. Accessibility, availability and hours, and cost and affordability were mentioned less frequently and were largely neutral, though cost and affordability recorded a comparatively higher proportion of negative sentiment (33%), pointing to affordability concerns among clients.

Overall, the findings suggest that while service quality is a major positive driver, waiting time and cost-related issues remain the most outstanding areas requiring targeted improvement efforts.

7.4 Health Facility Assessment Round IV

In 2025 AHF Global Quality saw the unfolding of the fourth Round of AHF's HF assessment process and its updated methodology and associated tools. HFA responds to the executive decision to carry out comprehensive biennial quality assessment of each global AHF supported HF, meant to provide well documented information that answers the question "Where does the AHF-supported- or managed health facility stand now?"

The Round IV HFA is not a one-off exercise, but part of a recurrent iterative and interactive QI process, providing a baseline inventory and monitoring report that is transformed, with the facility staff, in an improvement plan. The tools for HFAIV were updated and revised in 2024.

HFA Round IV (HFA IV) looked at a total of 883 Care & Treatment facilities active in 2025 in the Global Program, that were eligible to be assessed on their capacity in providing quality HIV services, prioritizing the facilities that were not assessed in previous rounds. Eventually 768 facilities were assessed and reports uploaded in the online HFAIV database being accessible for granular analysis by bureau and country level program staff using the global program Web Portal

Figure 7.4.1: Number of facilities assessed, and reports uploaded in HFA Round IV by 31 Dec 2025

Country	Eligible Facilities	Selected Facilities		Facilities Assessed
Africa Bureau				
South Africa	61	37	61%	37 (100%)
Uganda	69	42	61%	41 (98%)
Zambia	43	31	72%	31 (100%)
Rwanda	38	38	100%	38 (100%)
Ethiopia	18	16	89%	16 (100%)
Kenya	71	70	99%	70 (100%)
Eswatini	6	6	100%	6 (100%)
Nigeria	58	35	60%	35 (100%)
Sierra Leone	14	14	100%	14 (100%)
Lesotho	23	23	100%	23 (100%)
Zimbabwe	19	19	100%	19 (100%)
Malawi	28	23	82%	23 (100%)
Mozambique	22	22	100%	22 (100%)
Asia Bureau				
India	2	2	100%	2 (100%)
Cambodia	42	42	100%	42 (100%)
China	14	14	100%	14 (100%)
Vietnam	75	64	85%	64 (100%)
Nepal	19	19	100%	19 (100%)
Thailand	29	27	93%	27 (100%)
Myanmar	7	7	100%	7 (100%)
Indonesia	19	19	100%	19 (100%)
Philippines	18	18	100%	18 (100%)
Laos	7	7	100%	7 (100%)
Europe Bureau				
Ukraine	31	31	100%	31 (100%)
Russia	17	17	100%	17 (100%)
Estonia	1	1	100%	0 (0%)
Latin America and the Caribbean Bureau				
Mexico	6	6	100%	6 (100%)
Guatemala	11	11	100%	11 (100%)
Argentina	16	16	100%	16 (100%)
Dominican Republic	5	5	100%	5 (100%)
Peru	17	17	100%	17 (100%)
Haiti	12	12	100%	12 (100%)
Jamaica	17	17	100%	17 (100%)
Brazil	29	23	79%	23 (100%)
Chile	1	1	100%	1 (100%)
El Salvador	8	8	100%	8 (100%)
Colombia	4	4	100%	4 (100%)
Panama	5	5	100%	5 (100%)
Trinidad and Tobago	1	1	100%	1 (100%)
Global Program	**883**	**770**	**87%**	**768 (100%)**

	NUMBER OF COUNTRIES	NUMBER OF C&T FACILITIES	PROPORTION OF FACILITIES ASSESSED	OVERALL SCORE
	13	470	80%	90%
	10	232	94%	92%
	2	49	100%	94%
	13	123	96%	92%

7.4.1 Expected Outcomes of the assessment

- Determine the availability and quality of the service elements of the facility.
- Assess the current capacity of the health facility for provision of HIV prevention, Care and Treatment and Wellness/STI services.
- Provide meaningful feedback to facility staff and management by identifying areas for strengthening and improvement to upgrade the health facility in providing quality care and support to PLHIV.
- Establish a baseline for subsequent biennial re-assessments, to gage improvements made and design further steps to lift the facility to a higher quality level.

HFA Round IV assessed a total of 309 items in 42 Sections divided over 10 service Chapters

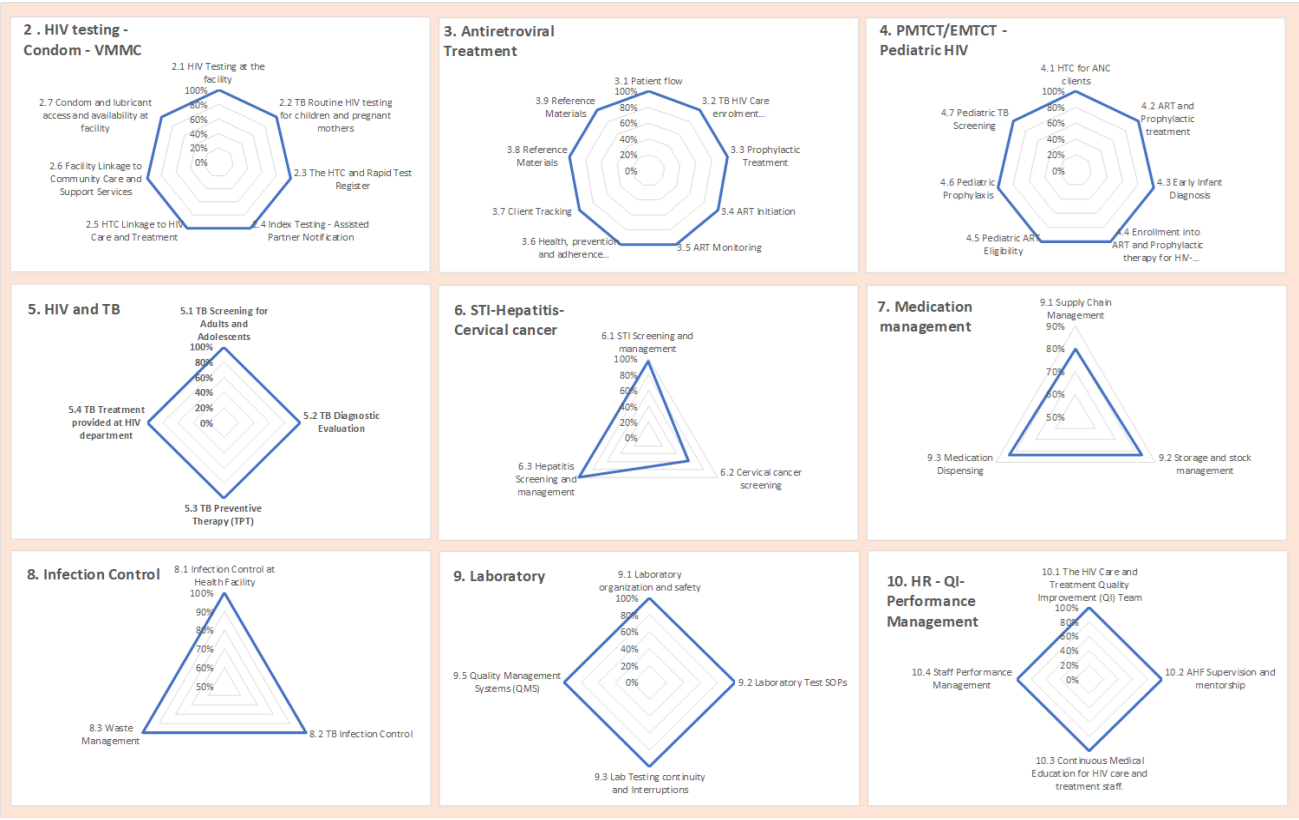


Figure 7.4.3: Mean Chapter Scores by bureau – 768 C&T facilities - HFA Round IV 2025

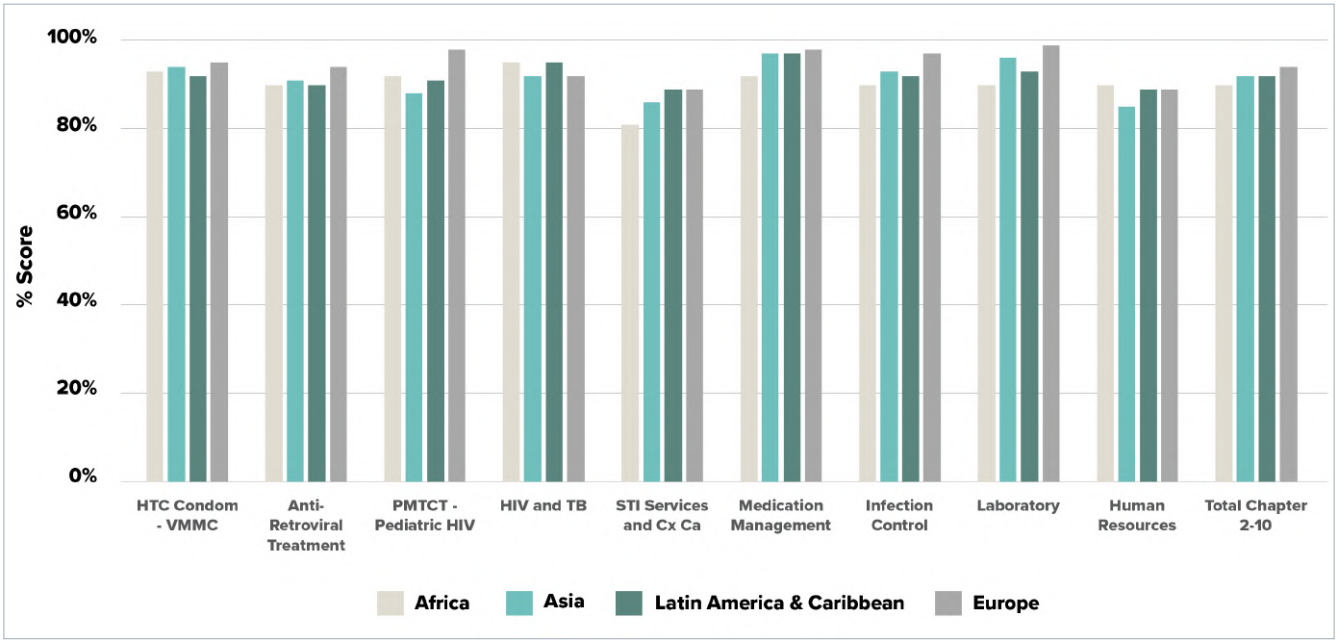


Figure 7.4.4: Chapter 2: HIV Testing & Counseling (HTC) - Condom Management

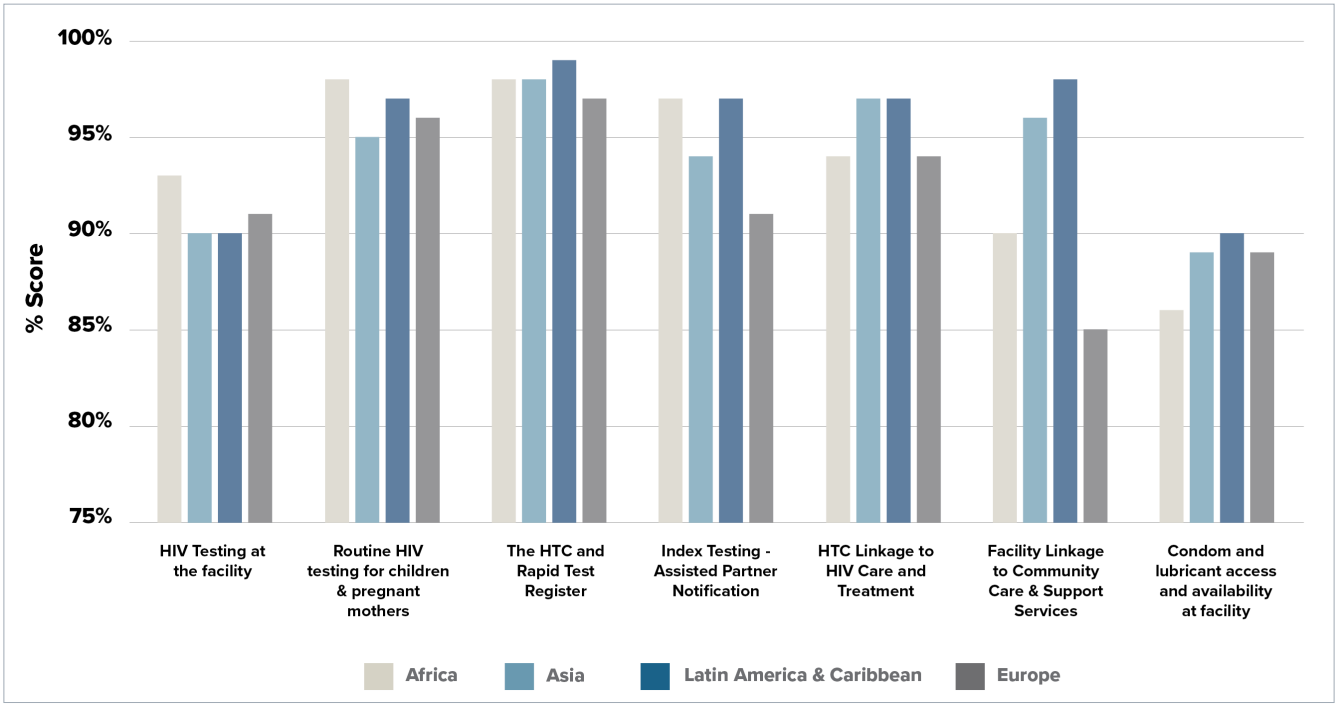


Figure 7.4.5 Chapter 3: Adult Treatment

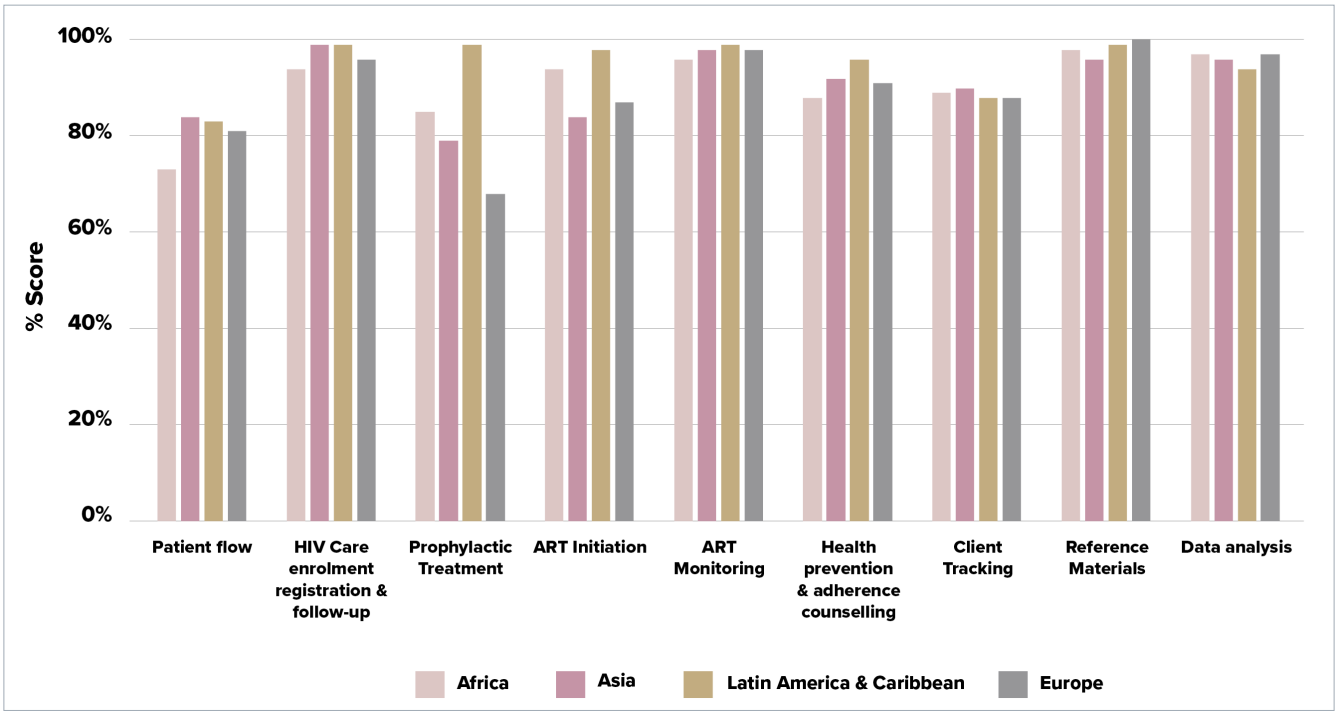


Figure 7.4.6 Chapter 4: PMTCT – Pediatric HIV

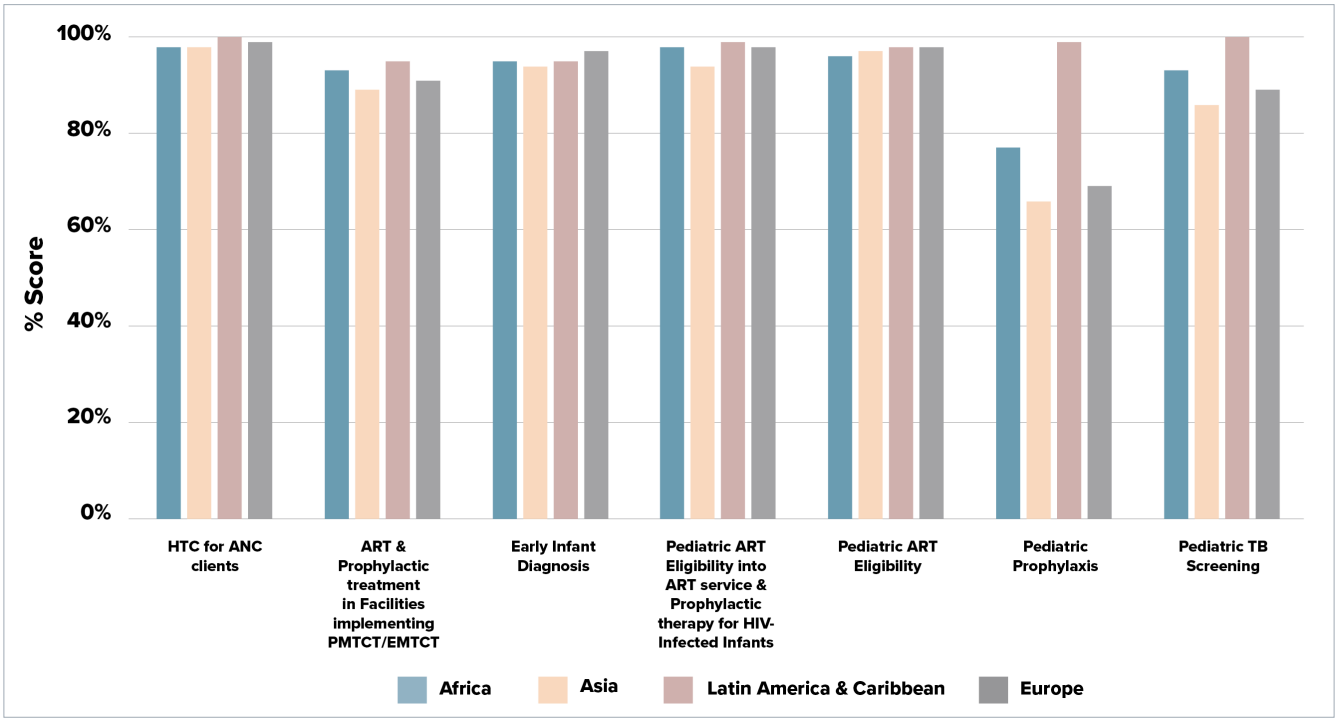


Figure 7.4.7 Chapter 5: HIV and TB

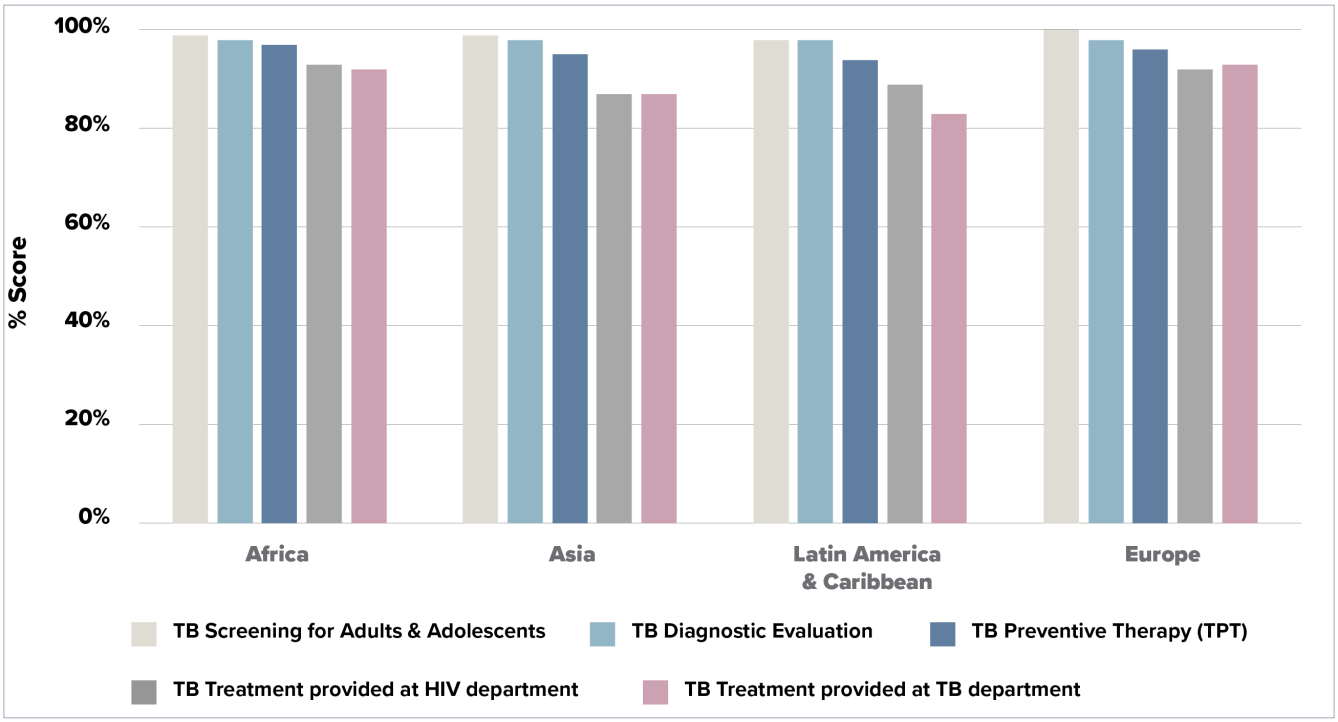


Figure 7.4.8 Chapter 6: STI Services and Cervical Cancer Screening

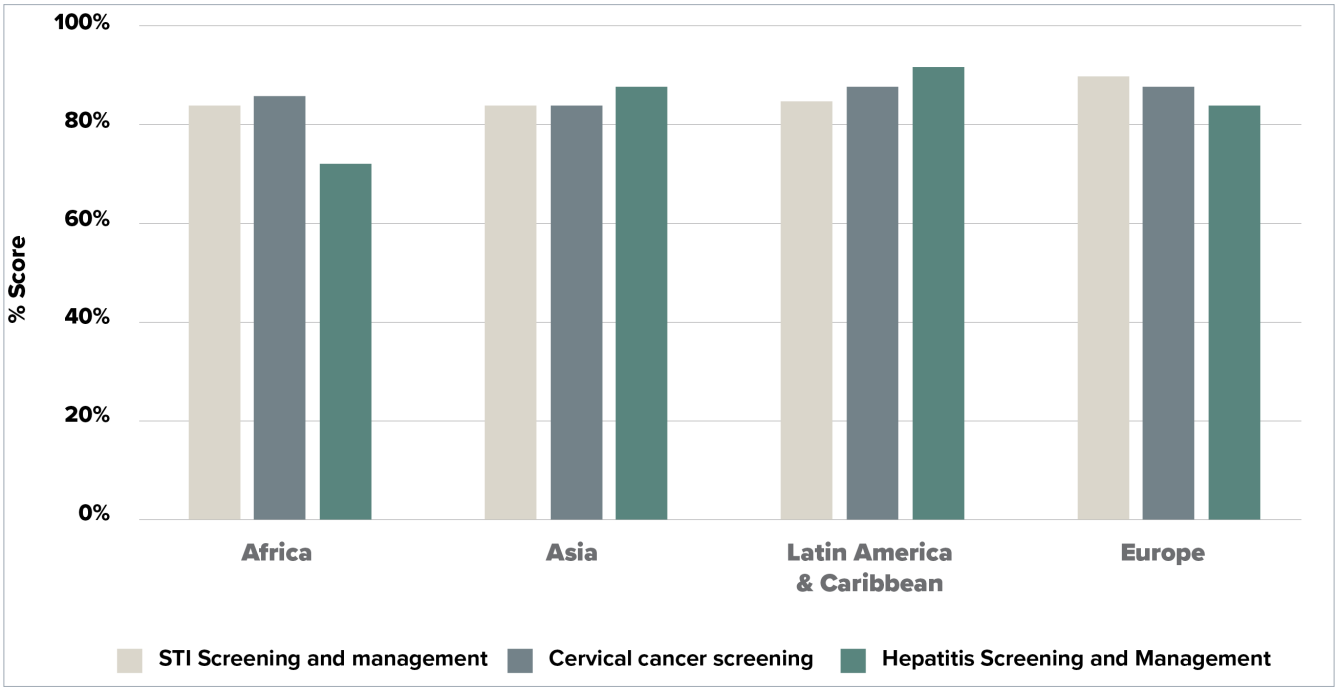


Figure 7.4.9 Chapter 7: Medication Management

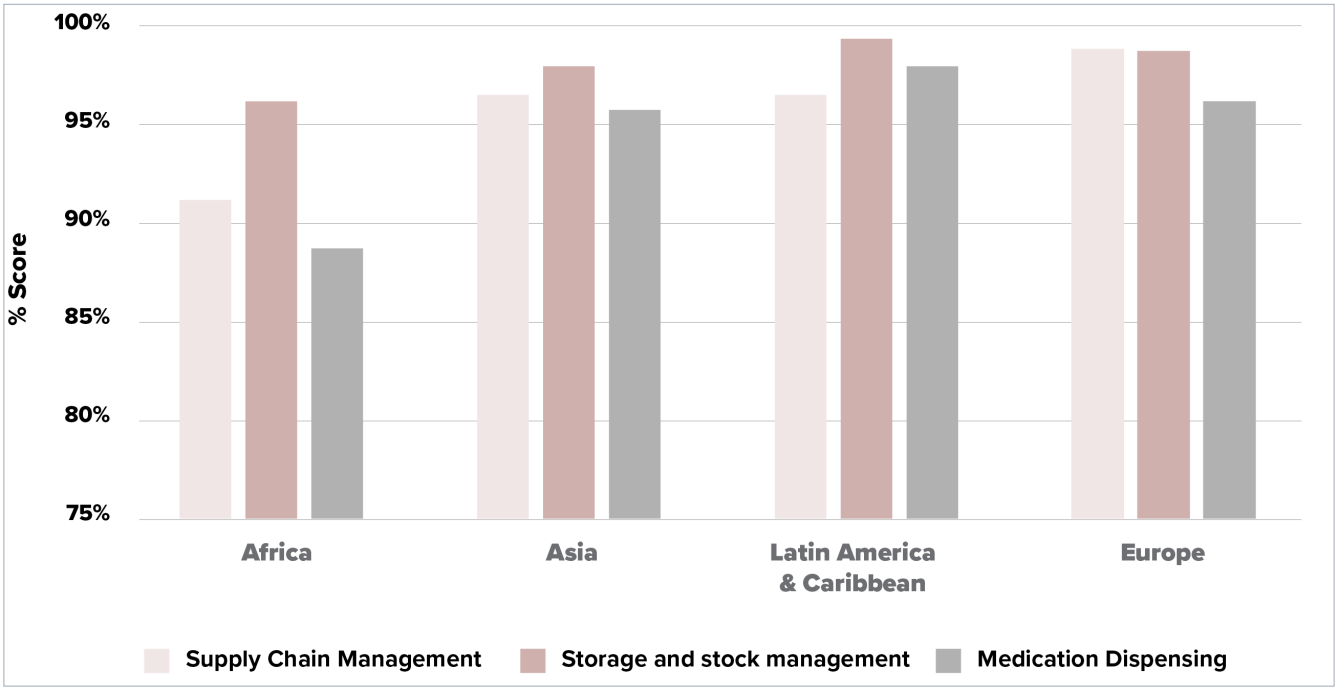


Figure 7.4.10 Chapter 8: Infection Control

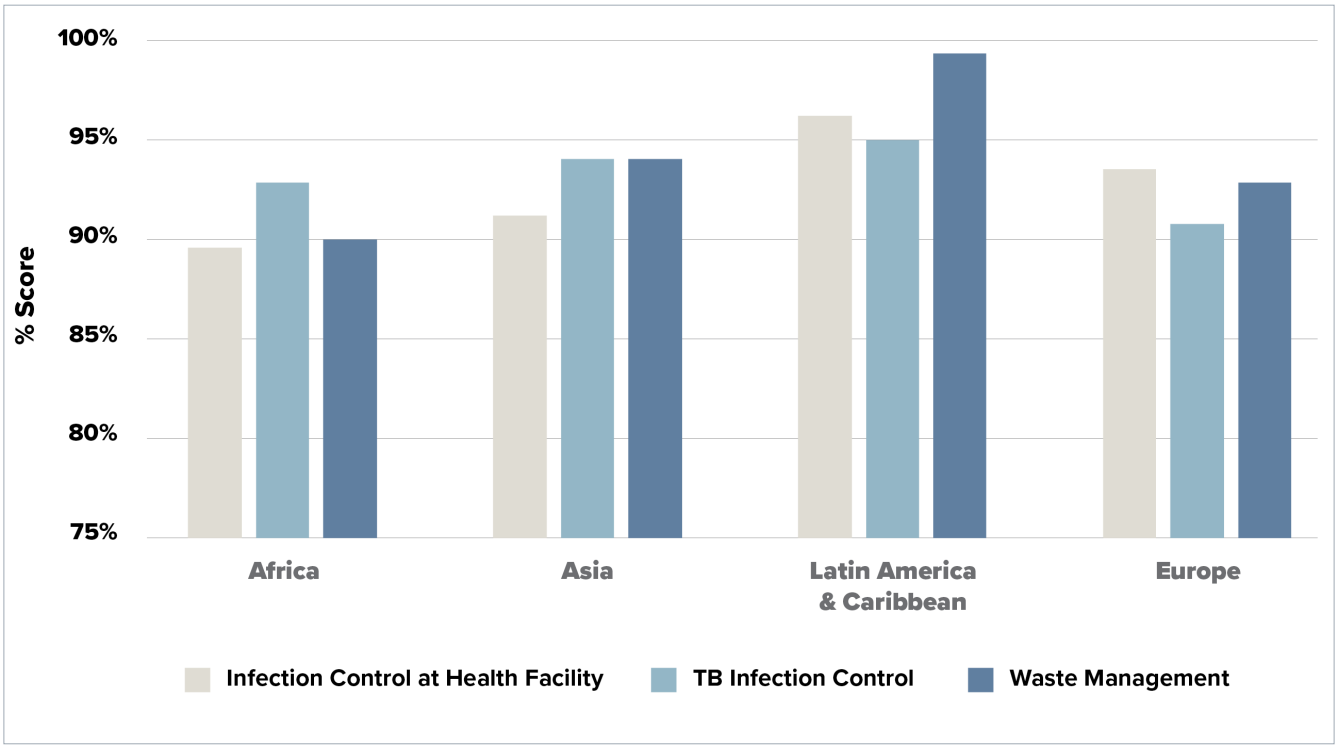


Figure 7.4.11: Chapter 9: Laboratory

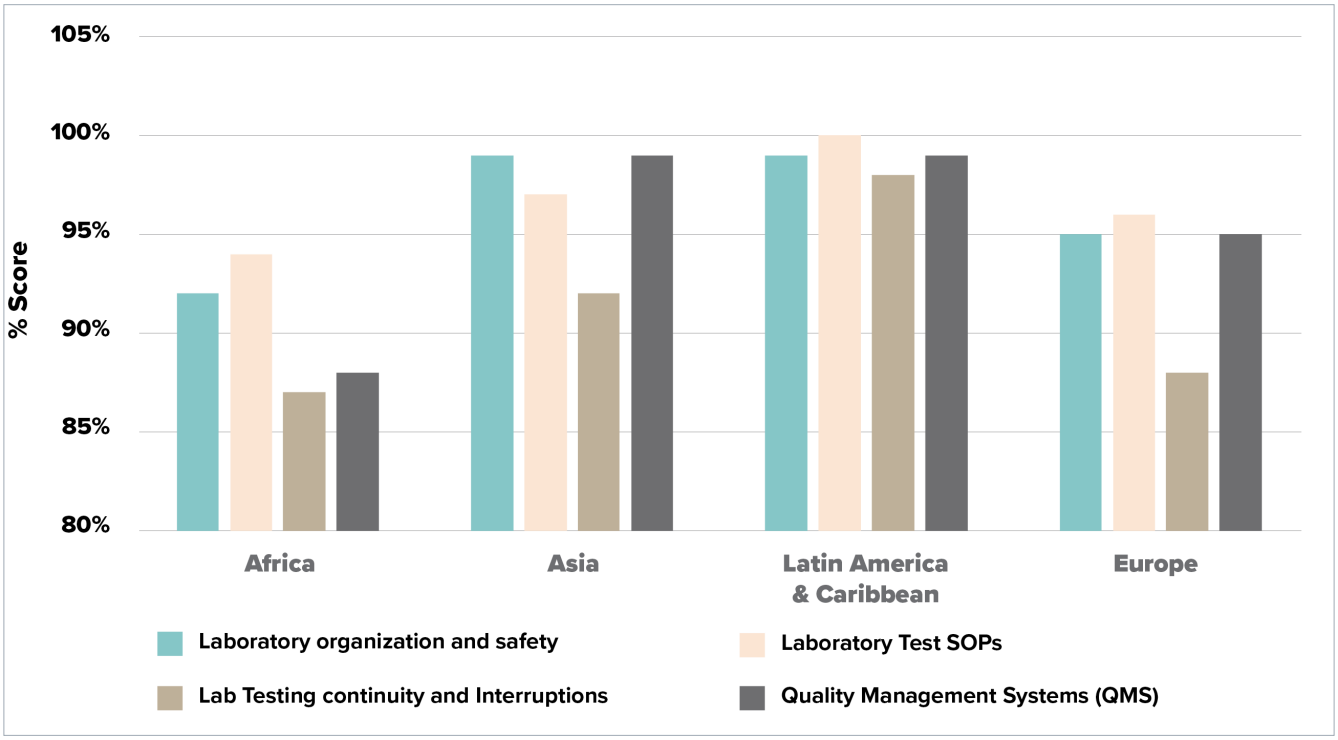
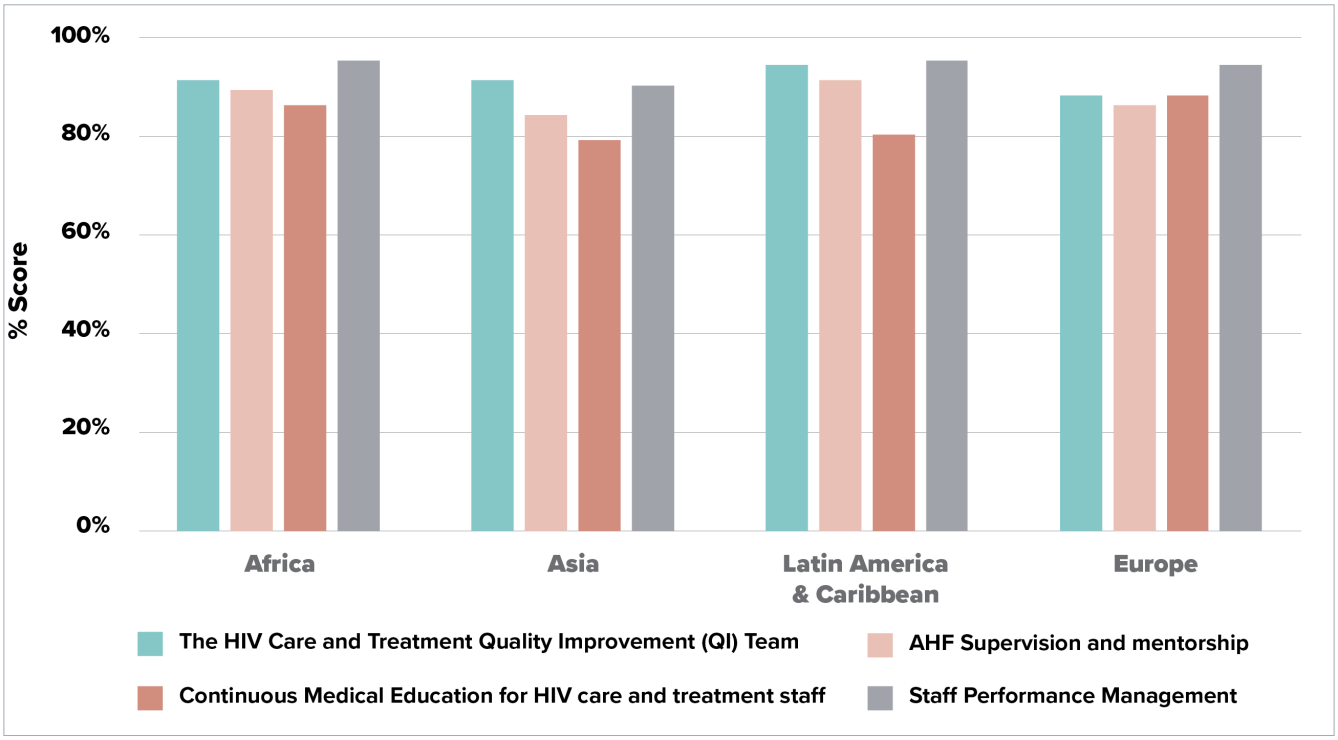


Figure 7.4.12: Chapter 10: Human Resources



7.5 CME for clinical care providers

7.5.1 Overview of the Bureau achievements of AHF HCWs in e-learning - 2025

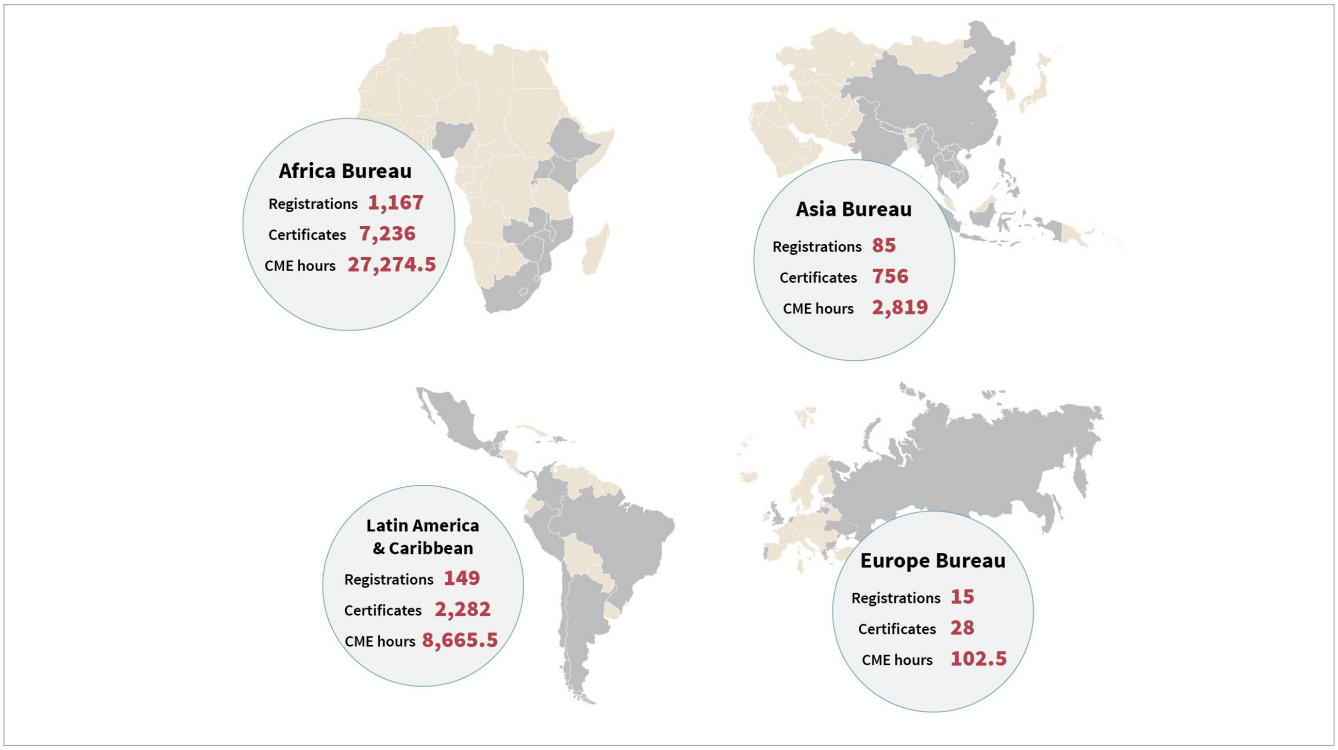
In the year 2025, the AHF CME platform “Ehealthacademy” saw increased activity, with development and launch of 9 new courses, and more registrations of health care professionals joining in. The number of certificates issued rose by a new record number of more than 3000 in one year when compared to the end of 2024, a remarkable achievement, most certificates were achieved for the intensive course “Introduction to biomedical research methods” with more than 600 English and Spanish certificates combined. Another important course launched incorporated important news from the IAS Kigali conference including new WHO guidelines also enjoyed good attendance that will stretch into 2026.

STIs remained a high priority in the context of the Wellness Center Expansion, new clinical STI cases were added and STI courses were translated to Chinese and Ukrainian language and successfully launched. Unfortunately, in China we encounter repeated technical problems, we were blocked twice due to firewall issues and are resolving with a new hosting. A new intensive STI update course including news presented at the STI&HIV conference in Montreal is far in progress and will be launched in early 2026. The monthly Clinical Case Discussions for the Africa, Asia and Latin America Bureaus continued enjoying high attendance and remain well appreciated by the participants.

7.5.2 New Courses launched in 2025

- Curso de retención (Spanish) for AHF staff and for External non-AHF partner physicians.
- Introduction to biomedical research methods for AHF staff and External non-AHF partner physicians.
- Introducción a los métodos de investigación biomédica for AHF staff and non-AHF partner physicians.
- STI Clinical Cases 4-6 for AHF staff and for External non-AHF partner physicians.
- Casos clínicos de ITS 4-6 for AHF staff.
- Management of STIs part 1 in Chinese 性□播感染（STIs）第一部分 for AHF staff.
- Management of Sexual Transmitted Infections (STIs) part 1 in Ukrainian Лікування інфекцій, що передаються статевим шляхом (ІПСШ) –оновлення 2023, частина 1 for AHF staff.
- News IAS conference Kigali 2025 for AHF staff and for External non-AHF partner physicians.
- Noticias de la Conferencia de la IAS en Kigali 2025 for AHF staff.

Figure 7.5.1 Overview of the Bureau achievements in CME e-learning - 2024



7.5.3 Cumulative registrations and certificates of AHF HCWs by the end of 2025

- Total registrations grew from 1,274 to 1,417
- Total certificates issued increased from) 7,175 to 10,311
- Total CME hours increased from 26,740.5 to 38,861.5

Non- AHF external partner colleagues:

- Total registrations grew from 407 to 491
- Total certificates issued grew from 591 to 831
- Total CME hours grew from 2,148 to 2,974.5

7.5.4 Clinical case discussions

Africa:

We continued with combined monthly virtual meetings (Teams) for doctors, nurses, pharmacists from both African regions, being dubbed as the “journal club group”.

In total, we had 11 meetings, 8 different countries presented excellent, challenging cases, in the remaining 2 meetings Dr. Nduduzo Dube presented the topic of Pediatric AIDS in Africa, and I presented important news from the IAS conference Kigali. Dr. Vivian Avelino-Silva convened an educative practical session on basic epidemiology and how to design a research project. All these sessions were highly appreciated and were followed by 100 – 160 participants in each meeting.

Asia:

11 virtual clinical case discussion meetings were held including presentation by myself of news from the IAS Kigali conference and an educative practical session on basic epidemiology convened by Dr. Vivian-Avelino Silva. All of these sessions were excellently prepared and chaired by Dr. Pagnaroat.

Latin America:

10 well attended virtual Clinical Case Meetings were held, organized and chaired by Dr. Miguel Pedrola with 60 participants on average from various countries.

7.6 Retention – ORI

7.6.1 Introduction

Optimizing client retention and uninterrupted anti-retroviral treatment are major strategies in achieving Viral Load Suppression (VLS) and optimal client and program outcomes. Retention is prioritized in Global Program since VLS has a direct impact on individual health as well as on the transmission chain in the community. Retention of PLHIV is a sustained key priority for AHF.

The Optimize Retention Initiative (ORI) supports healthcare providers to enhance and strengthen sustainable interventions aimed at improving quality of HIV Care and Treatment through evidence-based interventions: Stigma free services; Individual-centered approach; Actions to be taken in day-by-day clinic work and Teamwork. Country and facility teams design and implement ORI in their own service environment, recognizing the main gaps and needs for retention, supported by the Bureau and Global Quality Team (GQT).

7.6.2 ORI M&E

The ORI M&E approach documents the impact of the ORI interventions based on data generated and strengthens the routine monitoring and follow-up initiatives at service and intervention levels. The ORI Monitoring and Reporting Tool, developed by the HMIS and launched in 2023, is the first AHF quality tool bringing together in one online tool the client's information on core clinical and care parameters and an elaborate appointment system with documentation on contact attempts and active searches for clients who missed clinical appointments, medication pick-ups or laboratory tests.

This tool gives real time and client-based information on retention and summarizes data on actions to prevent loss to follow up (LTFU) and to bring clients back to care. The ORI Portal enables health services to follow a cohort of newly enrolled clients with the possibility to have in one tool HIV information, lab test, appointment schedules and outcomes of monitoring the clients who missed appointments being at risk to become lost to follow up.

7.6.3 ORI in 2025

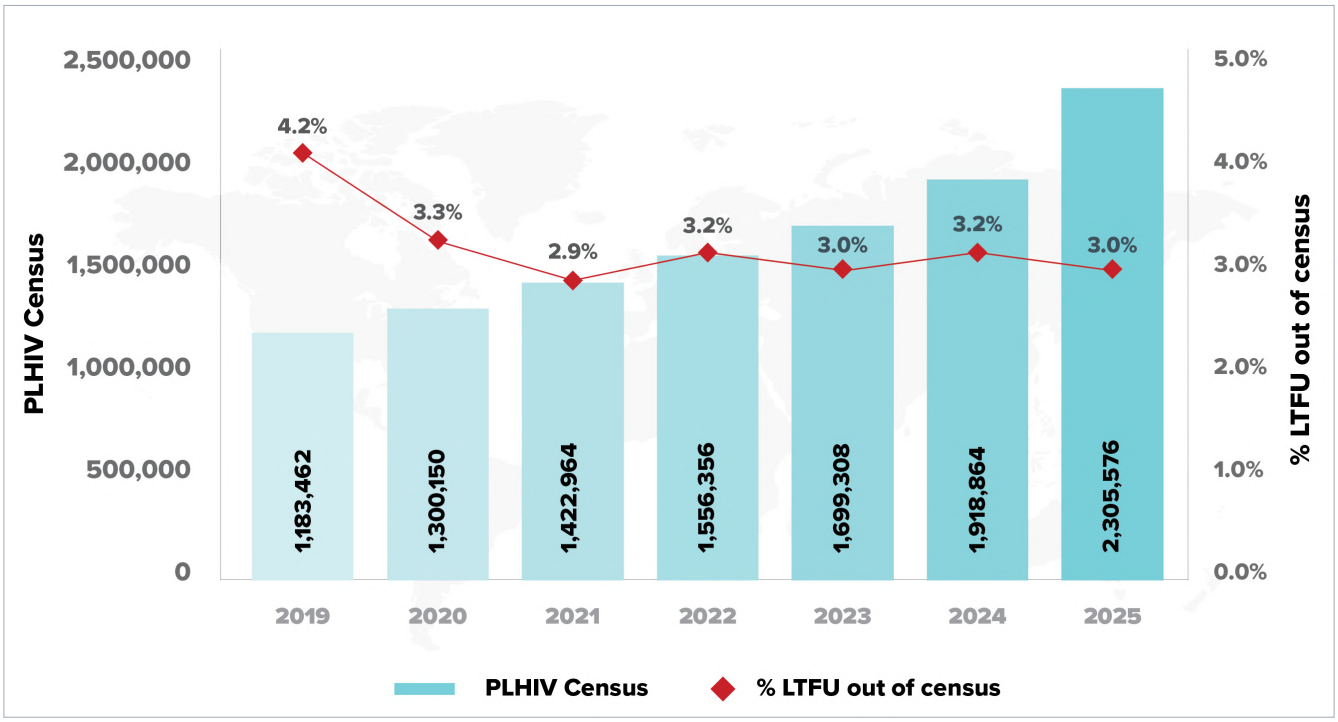
The Optimizing Retention Initiative (ORI), launched initially as a pilot in 2020, is now a global AHF priority in the Bureaus and Countries and drives client retention, improving the service quality, monitoring and tracking clients who missed appointments and are at risk of becoming LTFU. During the pilot phase of the ORI on-line tool, many countries faced unsurmountable barriers in implementing this client-based monitoring tool.

The need for an offline version of the tool became evident and in 2024 such tool has been made available for those facilities that cannot use online client-based data entry. Even though aggregated data will impose limitations to the monitoring, analyzing and reporting of retention, it still can provide a proxy of the impact of ORI in retaining more clients in care and avoiding loss to follow up.

7.6.4 Preliminary Results from ORI Implementation

The Optimized Retention Initiative (ORI) was implemented across all AHF-supported facilities globally, reflecting concerted efforts by facility teams to strengthen retention of clients in HIV care. Through systematic tracing and re-engagement of clients who had interrupted treatment, the initiative contributed to a reduction in loss to follow-up (LTFU) and improved continuity of care. Over the past five years, the proportion of LTFU clients has remained low and stable, ranging between 2.9% and 3.2% of all PLHIV in care. Notably, the highest LTFU rate was reported in 2019 at 4.2%, with subsequent years reflecting improved retention performance under ORI implementation.

Figure 7.6.4.1 Trend in Proportion of LTFU among all clients in care, 2019 - 2025



7.6.5 Resolutions from GQT Meeting in Sao Paulo, Brazil

The Global Quality Team held the biennial meeting in Sao Paulo, Brazil, in November 2025 where the following action items were suggested and approved by the Bureau teams:

- The ORI App will be scaled down to a minimal, non–client-level data model to reduce data sensitivity and complexity.
- Continued use of ORI will be reinforced in current countries, while actively expanding adoption to additional countries.
- ORI App will be prioritized for countries without EMR systems while in countries with EMRs, the initiative would be selectively used to complement EMRs, especially for functions not currently covered and to reduce duplication with paper-based systems.
- ORI will be used strategically as an appointment tracking and follow-up system alongside existing EMRs.
- Client classification will be simplified, shifting from NLIC to “disengaged from care,” with deceased, transfer-outs, and relocations tracked separately. LTFU and clients who refused HIV care will be grouped for active follow-up purposes.

08 Global Scientific Committee – Publications - Abstracts 2025

8.1 Global Scientific Committee

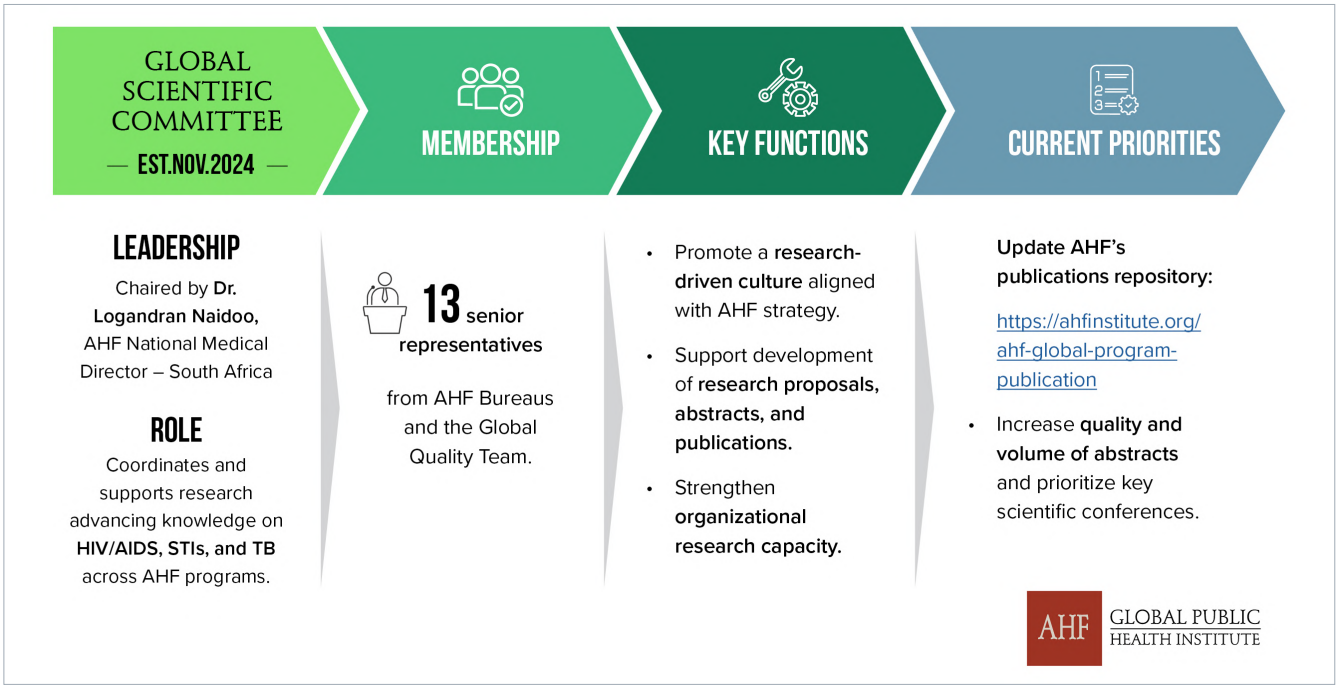
AHF's Global Scientific Committee (GSC) convened its inaugural meeting in November 2024. Since then, it has evolved into a fully operational forum that guides the organization's pursuit of advancing scientific knowledge and discovery. Chaired by Dr. Logandran Naidoo, AHF's National Medical Director in South Africa, the GSC is dedicated to coordinating, promoting, and supporting research initiatives that expand understanding and advance new knowledge on HIV/AIDS, sexually transmitted infections (STIs), and tuberculosis (TB), within AHF's global scope of work.

The committee comprises 13 senior representatives drawn from AHF's Bureaus and the Global Quality Team, collectively responsible for managing and overseeing research-related activities across the organization.

Core functions of the GSC include:

1. Fostering a research-driven environment within AHF to advance research that inform evidence-based practices and policies;
2. Identifying key research priorities aligned with AHF's mission and strategic objectives; (
3. Supporting and advising on the development of high-quality research proposals, projects, abstracts, and scientific publications; and
4. Strengthening research capacity by providing guidance, support and advice.

The GSC is presently engaged in updating the AHF scientific publications repository (https://ahfinstitute.org/ahf-global-program-publication); building organizational capacity to enhance the quality and volume of abstracts; and identifying and prioritizing key scientific conferences for abstract submissions. The GSC encourages all country programs to actively support its mission, thereby advancing cutting-edge medicine, advocacy, and scientific discovery in the global fight against HIV/AIDS, STIs, and TB.



8.2 Publications, Conference Presentations and Posters 2025

Community-based HIV testing in The Netherlands: experiences of lay providers and end users at a rapid HIV test checkpoint. Nori Krabbenborg, Ralph Spijker, Anna Maria Żakowicz, Milo de Moraes, Titia Heijman & Eline Op de Coul. December 23, 2025. AHF INSTITUTE.

Factors associated with loss to follow-up among people living with HIV at public health facilities in Manaus, Brazil: a multicentric study. Zeca Manuel Salimo, Elizangela Farias da Silva, Michael Nosano Yakubu, Yamile Alves Silva Vilela, Raquel Maria Navarro, Paulo Afonso Nogueira & Adele Schwartz Benzaken. December 12, 2025. The Lancet.

Alternatives to the three-test strategy for HIV diagnosis. Adele Benzaken, Fernanda Fonseca, Penninah Iutung, Marcus Lacerda and Michael Weinstein. December 11, 2025.

Viral suppression and associated factors after enhanced adherence counseling among people living with HIV with unsuppressed viral loads at tertiary and first-level health facilities in Zambia: A retrospective cohort study. Chitalu Chanda, Webster C. Chewe, Benson M. Hamooya, Lukundo Siame, Matenge Mutalange, Aliness Dombola, Nyuma Mbewe, Chisha Sinyangwe, Melvin Mwansa & Duncan Chanda. November 5, 2025. PLOS.

Advancing Women's Access to Menstrual-Friendly Toilets towards Ending Period Poverty: A Public Health Imperative in the Philippines. Jerico B. Ogaya, Ryan C. Guinaran, Catherine P. Alesna, John Don Opina, Shaila A. Pilo, Vic Arthur R. Masliyan, Christian Joseph Ong, Pearl Irish V. De Paz, Carina Joane V. Barroso, Rheajane A. Rosales, Analyn C. Españo & Don Eliseo Lucero-Prisno III. June 30, 2025. RECOLETOS MULTIDISCIPLINARY RESEARCH JOURNAL.

Performance of the VISITECT® CD4 Test for Rapid Identification of Advanced HIV Disease at AHF-Supported Sites in Zambia: A Diagnostic Accuracy Analysis in a Zambian Population. Eric Mpoyi Mulumba, Mazinga F. Kayembe, Webster C. Chewe, Chitalu Chanda, Nduduzo Dube, Clifford Chituta, Benson M. Hamooya, Freddy T. Kasweka, Martin Matabishi & Muyungila Bob Assani. January 7, 2025, MEDRXIV.

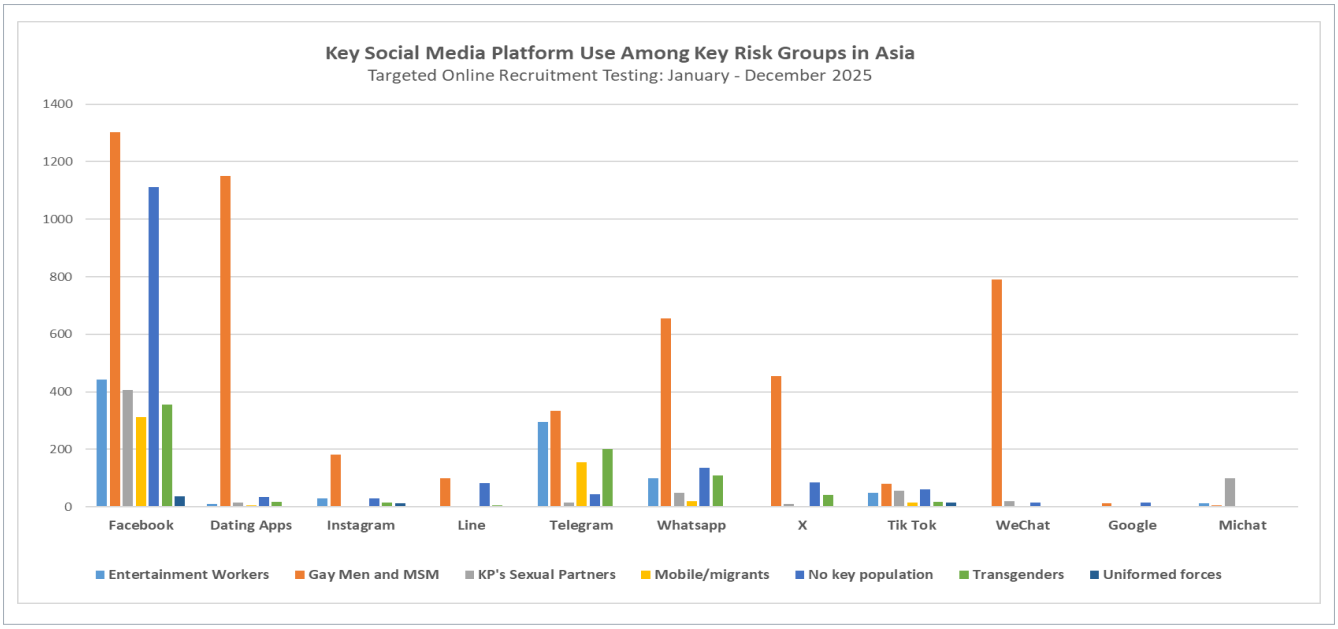
9.1 Asia Bureau

9.1.1 Targeted Online Recruitment Testing Strategy in Asia

Background: Reaching populations at heightened risk of HIV and other sexually transmitted infections (STIs) remains a persistent challenge across Asia, particularly among gay men, transgender people, and their sexual partners. To address this gap, innovative testing approaches have been implemented across the region, including Targeted Online Recruitment Testing. This strategy was first piloted in Thailand in the third quarter of 2022 across six sites and expanded to ten sites in 2023. In September 2024, the first regional scale-up training was conducted for Cambodia, Indonesia, Nepal, and Laos, followed by implementation in these countries by the end of the year. In 2025, the number of participating sites in these countries increased, and a second regional training held in June in Ho Chi Minh City expanded the approach to China, Vietnam, the Philippines, and Myanmar. By December 2025, the strategy was active at 48 sites across Asia.

Program Description: The multi-platform digital outreach strategy promotes HIV and syphilis testing through targeted engagement on social media and dating applications to increase testing uptake and identify undiagnosed infections among key populations. Outreach activities included tailored HIV testing and prevention messages disseminated via platforms such as Facebook, Telegram, Instagram, YouTube, WeChat, Google, X, and WhatsApp, as well as dating applications including Grindr, Tinder, Hornet, and Heesay. Individuals who engaged with these messages were followed up by trained peer educators and referred to health facilities or community-based testing sites for HIV and syphilis testing.

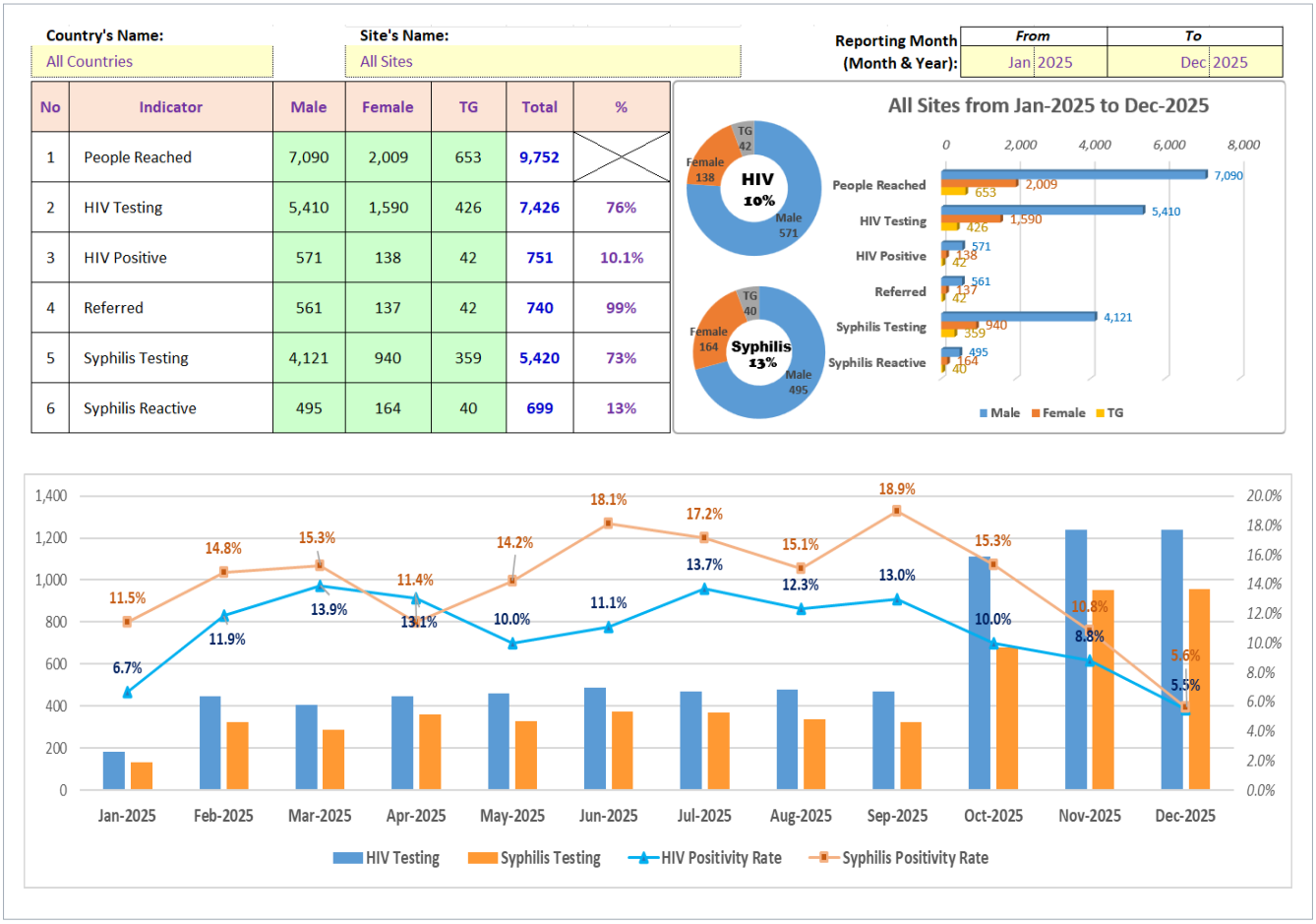
Figure 8.1.1 Key Social Media Platform Use Among Key Risk Groups in Asia: January – December 2025



9.1.2 Digital outreach for HIV and syphilis case finding among key populations in Asia: Evidence from a multi-platform testing strategy, 2024–2025. Lessons Learned

The strategy demonstrated consistent effectiveness in both 2024 and 2025 in reaching populations at elevated risk of HIV and syphilis. In late 2024, 44% of individuals engaged through digital outreach accessed HIV and syphilis testing, with overall positivity rates of 10% for HIV and 12% for syphilis. In 2025, outreach and testing volumes increased substantially, with 9,752 individuals reached through social media platforms. Of these, 7,426 underwent HIV testing, yielding a 10% positivity rate, while 5,420 received syphilis testing with a 13% positivity rate. Gay men consistently represented the largest group tested and continued to show high positivity rates (11% for HIV and 12% for syphilis). Notably, positivity among transgender people increased in 2025, reaching 9% for HIV and 10% for syphilis. Dating applications were particularly effective, accounting for 13% of all individuals engaged through digital platforms.

Figure 9.1.2 HIV and Syphilis Positivity Through Targeted Online Recruitment Testing Strategy. Jan-Dec 2025



No	Indicator	Male	Female	TG	Total	%
1	People Reached	7,090	2,009	653	9,752	
2	HIV Testing	5,410	1,590	426	7,426	76%
3	HIV Positive	571	138	42	751	10.1%
4	Referred	561	137	42	740	99%
5	Syphilis Testing	4,121	940	359	5,420	73%
6	Syphilis Reactive	495	164	40	699	13%

Conclusion: The implementation of a multi-platform digital outreach strategy resulted in substantial increases in HIV and syphilis testing among key populations across Asia and successfully identified high-yield positivity rates. HIV positivity of 10–12% and syphilis positivity of 12–14% indicate that digital outreach effectively reached individuals at high risk of infection. The strong performance of dating applications, particularly in engaging gay men, underscores the critical role of digital tools in contemporary HIV testing programs. Building on these results, the AHF Asia Bureau plans to double the scale of this approach in 2026 by expanding to additional sites across the region, with the goal of further improving equitable access to HIV and syphilis testing for gay men, transgender people, and their sexual partners throughout Asia.

The First Scaling Up Training Conducted in Bangkok City, Thailand in August 2024 and the Second Scaling Up Training Conducted in Ho Chi Minh City, Vietnam in June 2025

9.2 Latin America and Caribbean Bureau

9.2.1 Census Growth

The number of people living with HIV (PLHIV) increased from 270,641 (GPR, January 4, 2025) to 274,782 at year-end, representing a 1.5% increase, despite the completion of operations in El Salvador in September, which resulted in the loss of 8,455 patients. Throughout the year, Latin America and the Caribbean (LAC) countries implemented multiple strategies to increase enrollment, strengthen linkage to care, and improve retention.

9.2.2 Country Highlights

Mexico strengthened and expanded existing collaborations, including the incorporation of CAPASITS Chetumal as a satellite of CAPASITS Cancún. In cities where AHF Mexico operates Wellness Centers or Testing Points (Mexico City, Nezahualcóyotl, Oaxaca, and Mérida), these sites facilitate linkage to care, promote early treatment initiation, and reduce delays in access to services.

Panama strengthened its rapid testing program within Wellness Centers and, through the Linkage to Care program, successfully referred patients to partner clinics. With support from allied organizations, the Index/Contact Tracing strategy was reinforced, offering HIV testing to partners of PLHIV with high acceptance rates. HIV testing promotion was also initiated within primary healthcare services.

Colombia increases the census, memoranda of understanding were designed and implemented with strategic partners. In coordination with community-based organizations such as *Fundación Conciencia por la Vida,* access to early diagnosis and HIV treatment was ensured for vulnerable populations, particularly irregular Venezuelan migrants in Cúcuta, benefiting 336 patients and strengthening retention. Through partnerships with healthcare providers (IPS), including Mediser in Riohacha, and within the framework of the *Support to the National Response and Care for People Living with HIV project,* 457 new patients were enrolled. Additionally, collaboration with EUDES, supported by AHF Global Fund resources, provided housing, food, and transportation support to 69 patients referred in Bogotá, Cartagena, and Cúcuta, improving retention. Continuous technical assistance to teams in six cities, with a focus on quality of care, differential approaches, and retention, resulted in significant outcomes, including zero deaths in the last quarter of 2025.

Peru, 60% NLIC patients were attributable to the decentralization process. The primary challenge moving forward is the development of strategies to strengthen coordination between hospitals providing first-level care and primary healthcare centers.

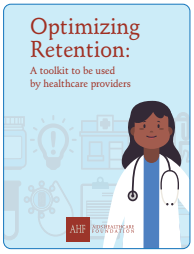
Argentina, Community Sexual Health Center (CCSS) achieved a 7% year-on-year increase in the population census in CABA. Monitoring of first-time consultations demonstrated active enrollment of new users, while tracking individuals accessing two or more services confirmed continuity of use and user engagement. Follow-up indicators for STI and PrEP pathways demonstrated continuity of care, while monitoring patients without CD4 determination served as a quality indicator for clinical staging. Annual retention measures confirmed population stability over time.

Trinidad & Tobago targeted Test and Treat (T&T) strategies improved timely enrollment and retention in HIV care. Patient tracers followed newly diagnosed clients to ensure prompt linkage and address care barriers. Peer advocates supported ART delivery, accompanied clients to appointments, located hard-to-reach individuals, and facilitated community referrals and partner notification. As a result, 89 clients returned to care and 175 new clients were successfully enrolled in HIV treatment.

Jamaica, AHF HIV health center achieved a 13% increase in active census, growing from 436 clients in 2024 to 493 by the end of 2025, while maintaining an 88% linkage-to-care rate for newly diagnosed individuals. A dedicated case management team—comprising a case manager and social worker—enabled personalized care, continuity, and rapid response to client needs. Additional best practices included strong referral systems, partnerships with private consultants, mental health services addressing HIV-related stigma, medication drop-off services, travel stipends, and gift vouchers to eliminate transportation and economic barriers to care.

Haiti emphasized the Index/Contact Tracing strategy to increase census figures. New and existing patients were encouraged to voluntarily share partner information, allowing case managers and social workers to offer free medical consultations and HIV/syphilis testing. Significant efforts were also made to re-engage patients classified as lost to follow-up (LTFU) through systematic phone calls and home visits, improving retention and increasing census numbers.

9.2.3 Best Practices: ORI Program



The interventions implemented under the ORI Program contributed to improved adherence, enhanced patient experience, and reduced structural barriers to continuity of treatment.

Colombia, Key practices included ORI WEB implementation in 100% of operating cities, continuous technical support to teams, and early identification of loss-to-follow-up risk factors. Improvement plans focused on retention, integration of psychology services alongside social work, and continuous monitoring of ORI indicators enabled timely, data-driven decision-making.

Mexico, implemented systematic appointment follow-up strategies, including preventive reminder calls or messages, post–missed appointment follow-up, home visits in selected cases, advance medication delivery, transportation support, food assistance, and mobile unit services in Oaxaca for remote and underserved communities.

Panama, all patients who missed appointments received follow-up calls. Where available, social workers conducted home visits after 90 days of absence. Adherence counseling was reinforced at every visit, and medications were dispensed every three months to reduce transportation barriers.

Peru, Growth groups and case clinical discussion meetings were implemented in AHF clinics, significantly contributing to patient adherence.

Argentina

CABA and Rosario achieved a 95% annual retention rate through multi-channel appointment reminders, missed-appointment recovery protocols (up to three contact attempts), and integrated follow-up across HIV, STI, PrEP, pharmacy, and laboratory services. These practices were embedded into institutional dashboards and planning processes.

Trinidad & Tobago (T&T), Missed appointment tracking, follow-up calls, patient tracing after 28 days of absence, and home visits after 91 days were implemented. Medication delivery services ensured uninterrupted ART access for clients unable to attend clinics.

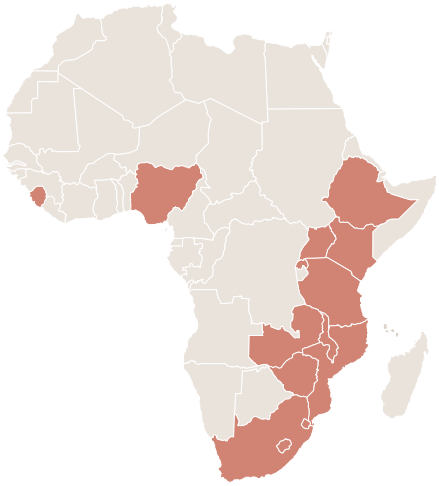
Jamaica, ORI performance showed a 100% contact rate in AHF HIV clinic. Best practices included EMR-based tracking systems, dual appointment reminders, same-day outreach for missed visits, and rapid escalation to case managers and home visits to re-engage clients.

Haiti, a structured monitoring system was implemented across all sites, including monthly appointment planning, weekly reviews, preventive reminder calls, follow-up calls, home visits, and advance medication supplies. These strategies significantly improved appointment adherence and retention.

Guatemala, development growth groups in two clinics, including strategies and clinical case discussions; supplies were provided to support patients. Immediate follow-up for patients who missed appointments was conducted via phone calls and home visits, with support from clinic staff and social work. Weekly follow-up reports, supplemented with additional data, were reviewed to identify patients who missed appointments. Monthly reports were produced documenting patients who missed appointments and the weekly follow-up provided.

ORI groups in Guatemala (Retalhuleu/Xela)

9.3 Africa Bureau



Quality Management Highlights for Africa Bureau 2025

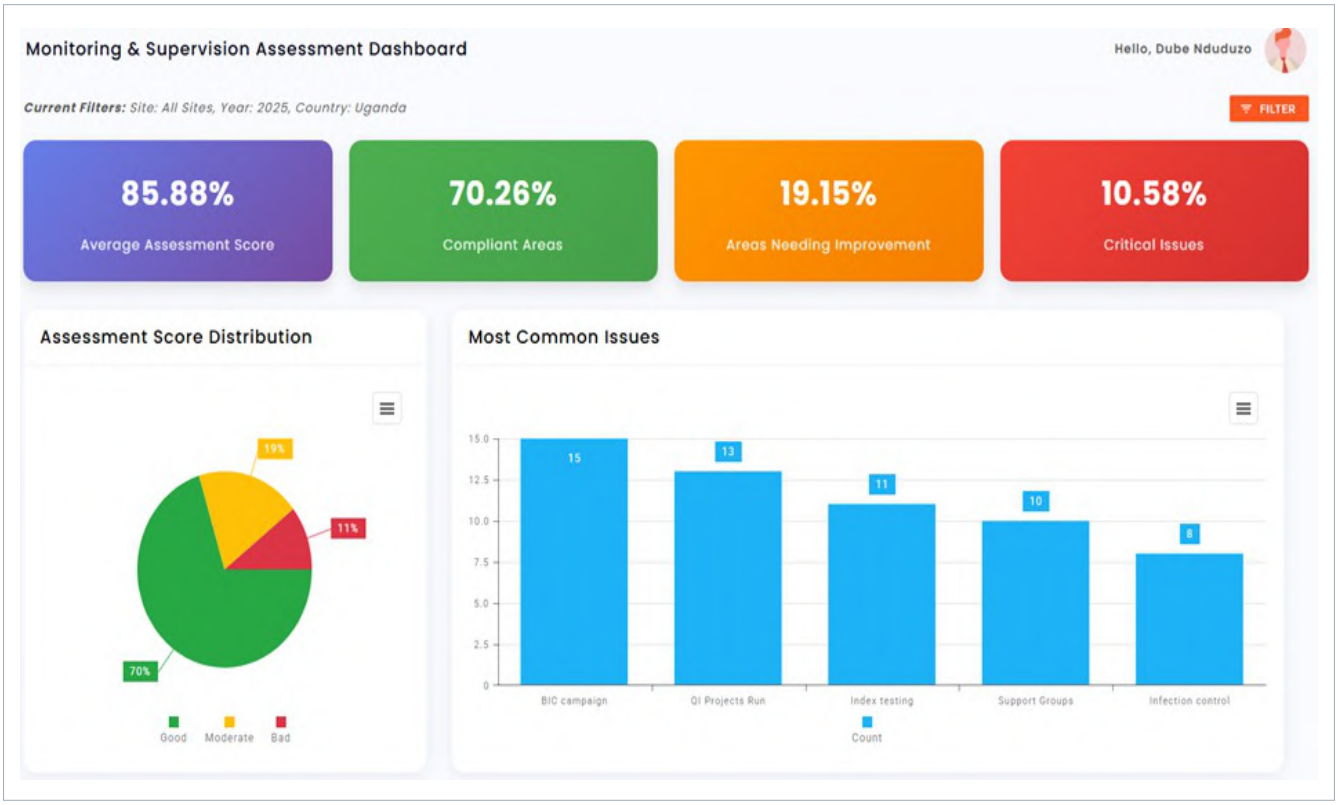
9.3.1 Embracing the 4th Industrial Revolution (Digitalizing Quality Management)

The Africa Bureau has taken a lead in trying to digitalize most of our systems to allow for easier monitoring and evaluation of interventions that focus on improving the Quality of care in our facilities. Digital capturing of data with centralized data bases allows the technical teams to monitor performance real time and evaluate impact periodically. This is very key in Quality management as it allows us to keep track of all the gaps that are discovered during Quality Measurement interventions like HFA, TIMS and CSS. Below are the 3 Quality Management Interventions that have been digitalized over the past 2 years.

9.3.2 Mentoring and Supervision Digital Reporting Portal

Mentoring and Supervision is very key in Quality management as it allows the country teams to keep the finger on the pulse all the time and come up with relevant Quality improvement interventions that would ensure Quality benchmarks are maintained. Previously since inception in 2020 mentoring and Supervision of facilities was done and reported manually in country and it was difficult for the Bureau Technical team to confirm if it was happening and if the findings are being utilized to keep improving Quality.

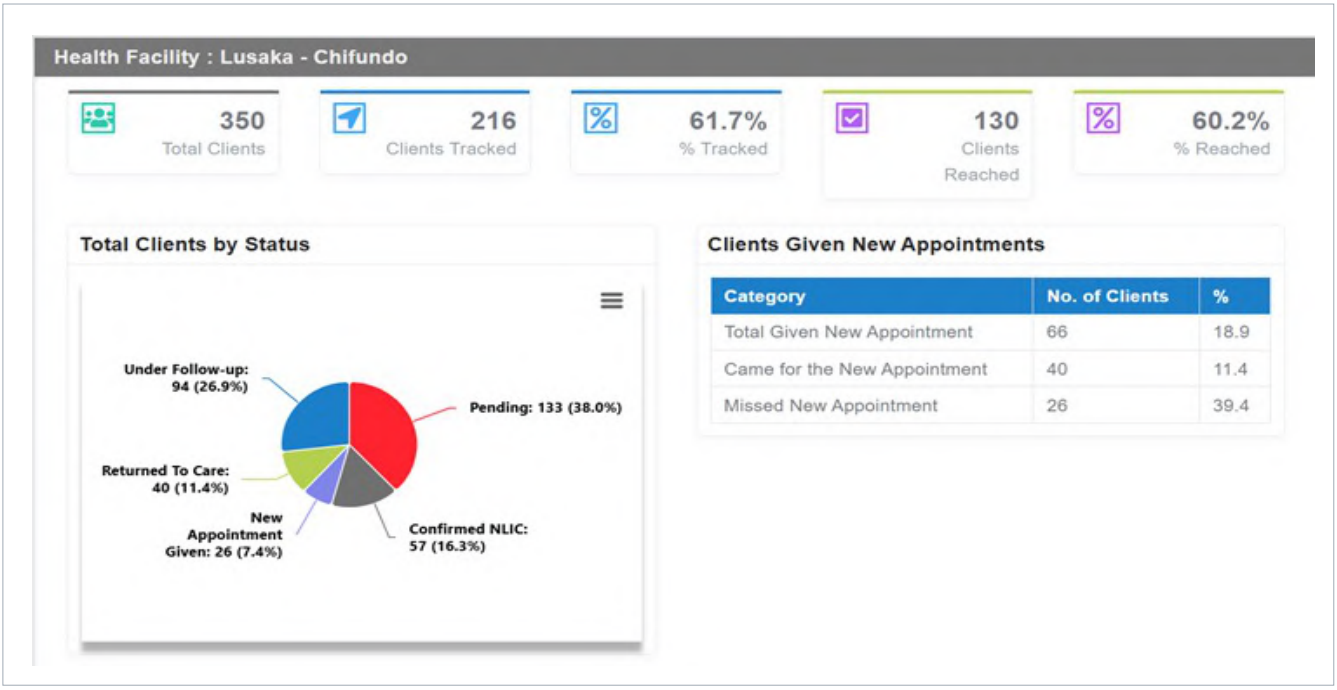
Due to the number of facilities and number of visits the information could not be consolidated into any meaningful data at both country and Bureau Level as it was accumulating hard copies in files in different offices. The hard copies did not allow the country leadership to track the Gaps found and the interventions taken to cover the gaps. With digitalization any Quality Measurement whether it is HFA TIMs or CSS the results are captured and the gaps or under performance is captured and displayed in the dashboard. The proposed interventions and timelines are also captured and as the corrective measures are implemented and gaps are resolved the database allows the teams to update. This allows the country leadership and Bureau technical teams to have an idea what Quality gaps are common in certain Regions or facilities and at the same time be able to know if they are being resolved.



9.3.3 Back in Care Digital Reporting Portal

The Africa Bureau adopted the Back in care Initiative in 2023 as response to high rates of attrition that happened during Covid 19 era and the period after. The initiative was meant to re track all patients that were LTFU to see if they could be found and brought back into care. Reporting this exercise and tracing staff productivity was very challenging as patients could be tracked twice and some missed or tracking of one patient captured twice.

As the bureau we then decided to create a reporting portal where all patients recorded as LTFU in a certain period would be entered using unique identifiers and whenever tracked they tracking was captured under the unique identifiers. Other than helping us ensure accurate reporting, since the database is centralized it also helps us keep track of the BIC activities on a real-time basis. This has helped us keep track of staff productivity and improve accountability in terms of tracking resources and workload at facility level.



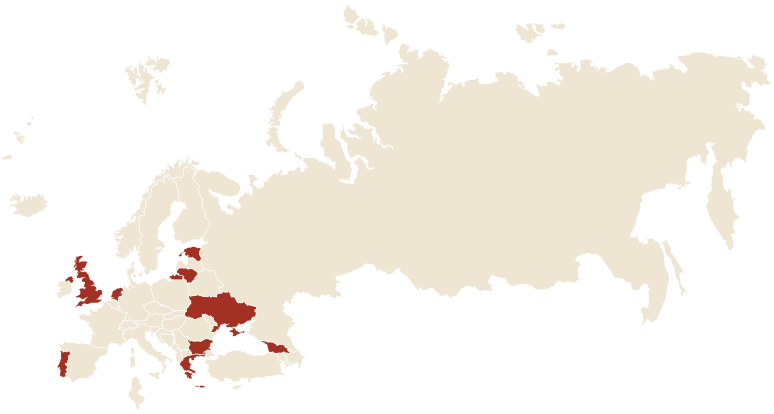
9.3.4 Staffing Matrix Digital Data Base

As a way of improving accountability and staff productivity the Africa Bureau has also developed a staffing Matrix that is meant to capture all the Human resources available in all the facilities we support and match them with the workload or productivity derived from the daily PPR reports uploaded to Global HMIS. The database is meant to be programmed to highlight immediately if the staff are underutilized or overworked. The database will not only capture AHF staff, but other MOH and partner staff deployed to the AHF supported Health facility. The database will automatically be linked to the Weekly and Quarterly PPR hence the workload measurement or computation will be based on real time figures not historical figures. This innovation is meant to allow in country leadership, mentoring and supervision teams to have a clear picture of how their human resources are being utilized daily, while HR and Finance will be able to budget and allocate Human resources fairly and effectively without depending on the in-country teams self-reported assessments.

9.3.5 Operational Research (Improving AHF visibility in Global Health Fraternity)

AHF Africa Bureau was well represented in 3 major Public Health Conferences in Africa namely IAS in Rwanda, 12th South African AIDS Conference and ICASA. At the IAS in Rwanda AHF Africa had 2 oral presentations and more than 10 Poster presentations. In the SA AIDS conference 3 papers were accepted for oral presentation while 6 were accepted for poster presentation. Operational research helps in the form of Quality improvement projects and helps us improve service delivery. Appearance and presentation of scientific research papers at these high-level conferences help increase AHF visibility and act as a valuable platform for advocacy at global health policy level.

9.4 Europe Bureau



9.4.1 The impact of Integrating Multiplex Testing in HIV Service Delivery

In 2025, the AHF Ukraine program aimed to improve early diagnosis of Bloodborne Viruses (BBVs) and Sexually Transmitted Infections (STIs), specifically hepatitis B virus (HBV), hepatitis C virus (HCV), and syphilis, by expanding multiplex diagnostic testing.

As defined by the World Health Organization (WHO), multiplex testing is a process that uses one sample and a single assay or platform to detect multiple infections at the same time. WHO announces the development of guidelines on multiplex testing, 2025.

This intervention addresses long-standing structural barriers to diagnosis and healthcare delivery in Ukraine, including fragmented testing pathways, additional referrals, and an increase in loss to follow-up (LTFU). These challenges were further exacerbated by war-related population mobility and disruption of healthcare infrastructure.

In Ukraine, in settings where multiplex testing is not available, individuals seeking testing must undergo separate diagnostic procedures for HIV, HBV, HCV, and syphilis. This model requires additional referrals and longer waiting periods, resulting in high attrition between initial testing and confirmatory diagnosis, delays in treatment initiation, undiagnosed co-infections, and inefficient use of limited healthcare resources.

In addition, most clients are not willing to be tested for HIV infection, as the associated stigma, to suggest HIV testing may be unacceptable and potentially offensive to many potential clients.

To overcome this barrier, offering multiplex testing enables AHF Ukraine to reach individuals for HIV and in some cases, Syphilis - who would otherwise refuse to be tested. Therefore, screening for four infections from a single finger prick allows testing some hard-to-reach population despite prevailing stigma.

The AHF Ukraine implemented multiplex testing as a core programmatic strategy on the 49 testing sites, enabling the simultaneous screening for HIV, HBV, HCV, and syphilis.

In 2025, a total of 119, 228 individuals received multiplex testing (Table 1).

Infection	Total Tested	Positive Results Identified	Positivity Rate
HIV	119,228	4,699	3.9%
Hepatitis B	119,228	2,006	1.7%
Hepatitis C	119,228	8,632	7.2%
Syphilis	119,228	1,417	1.2%

Overall, more than 16,700 reactive results on markers of infections were identified through a single integrated testing modality.

The high hepatitis C positivity rate (7.2%) confirms that large numbers of infections would likely have remained undiagnosed under a single testing model. Thousands of individuals received earlier diagnosis of co-infections, enabling faster referral and treatment initiation. These findings confirm that multiplex testing substantially improves diagnostic yield compared to fragmented testing strategies.

Multiplex testing results were systematically integrated into the state electronic medical information systems (MIS-VIL) and AHF Ukraine's anonymized internal database. This dual system supported: improved diagnostic data quality assurance, enhanced monitoring of testing outcomes and case detection trends, improved continuity of care amid internal migration.

Geographic Coverage

In 2025, multiplex testing was implemented in 22 regions on 49 testing sites of Ukraine supported by 41 formal partnership agreements with healthcare institutions and community-based organizations.

Public Health Significance

Since 2023, AHF Ukraine has actively advocated for multiplex testing as a best-practice approach to integrate diagnostics. This approach is now reflected in the initiation of World Health Organization (WHO) guideline development on multiplex diagnostics, positioning the organization as an early adopter and evidence generator for an emerging global standard.

The 2025 results demonstrate that multiplex testing is a sustainable, scalable, and high impact public health intervention. It should remain a cornerstone of AHF Ukraine's HIV, viral hepatitis, and STI testing strategy, supporting improved population-level health outcomes and a more resilient public health system in the years ahead.

ONEPRICK4RESULTS

9.4.2 Integration of Multiplex Testing in Europe Bureau

The AHF Europe Bureau utilizes multiplex testing in AHF countries and partner countries. To enhance monitoring, a dedicated separate system for reporting multiplex testing data was launched in October 2025. A unified quarterly process for collecting, validating, analyzing aggregated multiplex testing data that informs program monitoring, planning, and dissemination of outcomes.

For 2026, plans are in place to strengthen this monitoring framework and enhance the tracking of co-infections.

10 Sustaining Quality 3.0: 2026 and Beyond

2025 AHF Biennial Global Quality Meeting - Sustaining Quality 3.0

Date: November 3 to 6

Venue: Melia Paulista - Sao Paulo Brazil

Summary of recommendations and actions emerging from the meeting.

Meeting Overview and top 5 strategic themes.

Goal: Align global quality initiatives with AHF's mission to scale and sustain impact.

Focus Areas: Prevention, Testing, Wellness Centers, Retention, Data Systems, Finance, & Crisis Response.

Output: Actionable roadmap for 2026 with clear ownership and timelines.

- Prevention – Revise tools, define condom strategy, re-think Girls Act.
- Testing & Treatment Integration – Expand syphilis testing, scale successful models.
- Wellness Centers as Hubs – Entry points for STI/HIV testing, PrEP and care.
- Data-Driven Decisions – Enhance dashboards, retention tracking, and audits.
- Sustainability in Crisis – Protect staff & services in conflict settings.

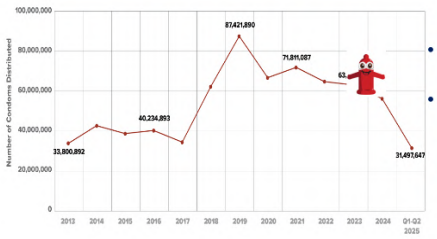
DEVELOP A COMPREHENSIVE PACKAGE FOR AN AHF YOUTH PROGRAM

Girls ActMinimun Package:

- Access to sexual reproductive health,
- Comprehensive sex education,
- Skills empowerment
- Developing social networks.

Task force comprising specific bureau focal persons to discuss Girls Act program implementation, develop measurement indicators, expected outcomes and establish reporting timelines within the implementation plan.

DEVELOP AHF GLOBAL CONDOM GUIDANCE



- Reinvigorate Condoms Committee
- Revise distribution tool
- Set targets based on client needs– not on procurement delays.

HIV TESTING:

COUNTRIES TO FOCUS AND DIRECT RESOURCE ALLOCATION TOWARDS HIGH-YIELD POPULATION CATEGORIES AND INTERVENTIONS INFORMED BY EPIDEMIOLOGICAL DATA AND TRENDS

Include syphilis in HIV testing reports

Scale-up and replication of successful testing models (e.g. online testing and partner testing) across bureaus.

- **Track Positive** is AHF's model for tracking HIV-positive clients from the point of diagnosis to linkage into care and implemented in Asia and Africa across all facilities.
- It supports **Benchmark 4 – Time to ART Initiation**, which aims to minimize the delay between diagnosis and start of treatment.
- **Test & Treat** emphasizes same-day ART initiation; however, this depends on successful linkage.

WELLNESS CENTERS

Serve as entry points for testing, treatment, PrEP/ PEP, cancer screening, and other prevention activities

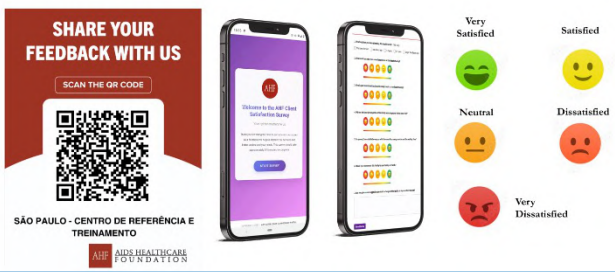
RETENTION & DATA SYSTEMS

ORI App: Scale-up for retention tracking in non-EMR countries; complement EMR systems.

Dashboard: Finalize validation, launch user guides

Client Definitions: Harmonize definition of "active client" and "NLIC" across global/domestic programs.

CLIENT SATISFACTION SURVEY
Revised Methodology



FINANCE & EFFICIENCY

- **Site Performance**: Identify bottom 10–20% underperforming sites for review/closure.
- **Budget 2026**: Include funds for supervision visits and emergency reserves (non-operational).
- **Variance Reports**: CPMs to review monthly; attend quarterly finance meetings.

CME & RESEARCH

- The scientific committee to work to resolve global ethical approval issues for publications
- Explore creating a publication repository for AHF Global – join AHF web page or AHF Public Health Institute.
- Discussed the challenges of getting courses accredited and the potential for collaboration with public health institutions to address this.
- To strengthen the guidance that every abstract and articles submitted to conferences/ journals should go through the scientific committee.

CRISIS PREPAREDNESS

Conflict Settings: Ukraine, Jamaica, Haiti need sustained funding & operational flexibility.

Emergency Budget: Treat separately– preserve for crises, don't absorb into operations

TB HIV INTEGRATION

TB/HIV - Scale up at C&T facilities:

TPT - Short Course,

GenXpert, and

TB-LAM diagnostics.

THANK YOU!

List of participants

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Renato Chuster
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Summary of recommendations and actions emerging from the meeting

	Main Session & Topics	Recommendations and action points
1 1.1	**HIV Prevention** Benchmark 1 Combination Prevention	Revision of **Principle 1 and QBM 1** shall include HIV and STI testing, and condom distribution as a primary measure of HIV prevention in the combination prevention QBM.
1.2	Girls Act	Build a comprehensive package for an **AHF Youth Program** as a bigger umbrella that will also have Gils Act but also looking at youth in general. Formation of a task force comprising specific bureau focal persons to discuss Girls Act program implementation, develop measurement indicators, expected outcomes and establish reporting timelines within the implementation plan. Minimum package for the Girls Act program defined as: access to sexual reproductive health, comprehensive sex education, skills empowerment, developing social networks. Current enrolment tool to be revised and shortened (5-page document)
1.3	Condoms	Prioritize Condoms for Wellness Centers, HF, Testing Programs and outreach activities, before distributing to partners. Avoid program rationing (for the fear of stock outs)! *Should we Define a minimum number of condoms per client and make a pilot distribution tool?* Define guidance for condom distribution during events to avoid waste. Reinstate the Condoms Committee Targets based on what is left in stock based on the end of the previous year (not on procured condoms on previous year, as there are many delays until the condom arrival at facility level). Formulate global, bureau and county-level targets based on client needs. Revise the condom tool to have facility based and end user data to have better condom distribution data.
1.4	Proposed position: Director of Global Prevention).	Need to define the position Responsible for Prevention at AHF Global level (e.g. **Director of Global Prevention & Testing).**
2.	**HIV Testing** What testing in a C&T facility is to be included in our reporting? Partner Testing, HIV and syphilis testing in Wellness Centers, Novel testing strategy Track positive and linkage BM 4: Time to ART Initiation	Countries to focus and direct resource allocation towards high-yield population categories and interventions informed by epidemiological data and trends. Revise the **monthly HIV testing report** to include an additional section on Syphilis testing and its outcomes. GQT to revisit the definition of 1st and 2nd visit for clients linked to HIV care in alignment with the ongoing discussion with Domestic Program. Scale-up and replication of successful testing models (e.g. **online testing and partner testing**) across bureaus. Revision of the Track-Positive module to **include date of ART initiation** for Africa and Asia Bureaus and accelerate program adoption in Europe and LAC Bureaus.

3.	**Wellness Centers** Applying the Wellness Center Model for Global Program, Advocacy Marketing & Branding, Recording and reporting wellness centers, Monitoring wellness centers implementation and performance	Wellness Centers in hybrid facilities shall be entry points for HIV/syphilis testing. Wellness Centers shall be entry point for HIV treatment (start and link to care), and for PrEP (when available by MoH). **Other services** to be offered and reported at wellness centers are: PrEP/PEP, Hepatitis B/C testing and cervical cancer screening. Strengthen service provision at the wellness centers through outreach activities, peer networks, tailored approaches based on regional contexts and localized marketing strategies with clear branding that services are free of charge. Capitalize on the use of available wellness tools for performance tracking and decision making. Implement medical records audit (MRA) at the wellness centers, using a customized MRA-Tool The Global Quality Team to develop a scoring system for wellness centers that considers factors beyond just patient numbers.
4.	**HIV Care & Treatment** CD4 cell test at baseline Viral Load (VL) test Syphilis Screening in PLHIV (BM 9)	Expand CD4 and viral load testing coverage through EMR integration and client reminders. (BM 5) & (BM6) Advocacy and collaboration with government to include STI and syphilis testing in national HIV care frameworks for increased syphilis testing uptake among PLHIV clients at the facilities. Recommend annual syphilis testing for all PLHIV, focusing on high-risk groups monitoring, and adapting to local testing capacity.
5.	**Retention** Optimize Retention Initiative (ORI), Measuring retention through facility based MRA analysis What is under ORI umbrella? Merging retention initiatives under the ORI umbrella, No-Longer in Care (NLIC), Transfer-out (TO)	**ORI as an initiative** should be strengthened and continued. Scale **ORI App** down to bare minimum to avoid client level data. ORI can replace weekly PPR if ORI App is fully scaled up. Reinforce the continuity of the ORI app for the countries already using it and get more countries on board. ORI App should be used on countries without EMR systems – it gives good tracking and follow-up information on appointments. Many countries with EMR are doing duplicated job with paper-based monitoring. Could use ORI App for certain aspects that are not covered by current EMR. Use of ORI as an appointment system to complement existing EMRs. Enhance patient retention monitoring with weekly reports, simplified reporting categories, and stronger follow-up systems. Follow-up meeting to be scheduled to discuss retention measurement and reporting before the end of 2025. Simplify client classification from NLIC to disengaged from care, with deceased clients, transfer outs and relocations reported independently. LTFU and clients who refused HIV care will be grouped together for active follow-up and tracking by the facilities. Finalize the discussion with the Domestic Program to harmonize definition of active clients at the HIV C&T facilities and wellness centers. Develop a summary of countries and facilities actively using ORI by next week.

6.	**HFA** Methodology and reporting the results, Feedback to facility and improvement planning	Convert assessment findings into actionable Quality Improvement Projects (QIPs) and correlating them with the medical record audit outcomes and the quality benchmarks. Safeguard objectivity when local teams conduct assessments versus external evaluators. Improve feedback from the assessments.to facilities Adjust assessment tool to better highlight critical indicators and improve scoring accuracy. Include a specific focus area in each consecutive HFA round (suggested was a focus on retention during the upcoming round). AHF Fund (referred to as potentially being renamed the "AHF Strategic Fund") being used to address infrastructure issues identified during facility assessments.
7.	**Client Satisfaction Survey 2025-2026** The new approach aims to improve objectivity and provide real-time feedback.	Support countries with localized server solutions for the Client Satisfaction Survey (CSS) due to stringent data protection and privacy laws. Implement the revised client satisfaction survey methodology, which has transitioned from paper-based to digital collection using QR codes. Consider introducing CSS at the integrated/hybrid wellness centers. Increase participation on the CSS through marketing, client education and sensitization, and display of survey results at the facilities. Consider the procurement of tablets for facilities with low smartphone coverage among clients in care.
8.	**Medical Records Audit** The medical records audit process, which examines patient records to verify active clients and assess documentation quality.	Timely dissemination of findings from the medical records audit for decision making processes and budgeting for bureaus and countries. The 2025 audit covered 1.9 million clients across 835 facilities in 77 countries. Extend auditing process to wellness centers with adjusted tools. Advocate for automation and EMR implementation by countries to reduce variances Encourage involvement of clinical staff and local Ministry of Health teams in the audit process to improve data accuracy and ownership.
9.	**Dashboard Demonstration** **Data Analytics** A dashboard system for AHF data visualization showcasing real-time data on client care, HIV testing, and wellness centers at global, bureau, country, site levels.	Finalize the data validation process for dashboard Develop dashboard user guides and an orientation plan for dissemination to bureaus and countries. Keep modifications minimal for now. The dashboard features interactive charts, customizable filters, and the ability to drill down for detailed analysis, with options to download data in various formats
10.	**Global Patient Report and Census Data Harmonization** Discussions with the domestic program led by Claudia are working toward alignment	Harmonizing definitions between global and domestic programs, particularly around what constitutes an "active client" and standardizing reporting periods. Standardize definition of "active client" across care and treatment facilities and wellness centers. Improve dissemination process of Global Quality Reports through multiple channels beyond placing as a resource on the web portal.

11.	**CME & Research** The meeting focused on updates and challenges related to the eHealth Academy and research activities across different regions.	Asia Bureau to address language barriers through translation to increase uptake of courses on the eHealth Academy. The scientific committee to work to resolve global ethical approval issues for publications Explore creating a publication repository for AHF Global – join AHF web page or AHF Public Health Institute. Discussed the challenges of getting courses accredited and the potential for collaboration with public health institutions to address this. To strengthen the guidance that every abstract and articles submitted to conferences/ journals should go through the scientific committee.
12.	**Finance -** The meeting focused on target setting and cost per test/patient tracking.	Bureau chiefs to submit a list of the bottom 10-20% underperforming sites (testing programs, C&T facilities, and Wellness Centers) for potential closure within 1.5 weeks (to James Cuccia). Bureau chiefs to ensure Country Program Managers (CPMs) review monthly variance reports and attend quarterly financial review meetings. Teams to budget for monitoring and supervision visits within countries in the 2026 budget.
13.	HIV & TB	Capitalize on TB Prevention at HIV C&T Facilities TPT implementation and support to short course regimens and tight monitoring of TPT eligibility. TPT completion and explore the need for repeat TPT over time. TB infection control at facility; standard contact tracing (TB screening) for PLHIVs newly diagnosed with TB. Strengthen TB diagnostic capacity at HIV C&T level through scale up of GenXpert platform and TB- Lam. Advocate and create capacity for TB treatment at HIV C&T level in applicable settings. Analyze TPT completion at facility level and explore correlation with facility MRA and respective TB/HIV HFA scores and mortality data.
14.	**Conflict –** Sustaining AHF work and AHF staff during conflict settings.	Preparedness ahead is key. Ukraine, Jamaica and Haiti need continued support and more funding. Emergency budget should not be treated the same as operational budget – meaning the emergency budget should not be spent most times but should still be available for the next year.

AIDS HEALTHCARE FOUNDATION

Countries of Operation

AHF

AHF Quality Benchmarks Highlights

2

2.6%

Benchmark 2

Proportion of all newly HIV tested clients, who have a confirmed positive test result.

91%

Benchmark 3

Proportion of all newly tested HIV-positive clients, who are linked to HIV care services.

3

4

92%

Benchmark 4b

Proportion of enrolled clients initiated on ART within 2 weeks after enrolment.

84% **Benchmark 5a**

28% **Benchmark 5b**

5

Benchmark 5a

Proportion of all newly enrolled HIV-positive clients who had a baseline CD4 cell count.

Benchmark 5b

Proportion of newly enrolled HIV-positive clients with a baseline CD4 cell test result, who had a CD4 cell count of less than 200.

78% **Benchmark 6a**

97% **Benchmark 6b**

6

Benchmark 6a

Proportion of clients (> 6 months on ART) who had a VL test result in the last 12 months.

Benchmark 6b

Proportion of clients (> 6 months on ART) with a VL test result in the last 12 months, who were suppressed (< 1000 copies/ml).

AHF Quality Benchmarks Highlights

7

2.7

Benchmark 7

Proportion of HIV-related mortality ratio (per 1,000 clients in care).

8

3.7%

Benchmark 8

Proportion of clients who became LTFU (among all clients).

9

86% **Benchmark 9a**

96% **Benchmark 9b**

Benchmark 9a

Proportion of newly enrolled HIV-positive clients, who were tested for syphilis.

Benchmark 9b

Proportion of newly enrolled HIV-positive clients, who tested positive for syphilis and completed treatment.

10

87%

Benchmark 10a

Proportion of Eligible HIV-positive clients who initiated a standard course of TB preventive therapy.

75%

Benchmark 10b

Proportion of HIV-positive clients that completed a standard course of TB preventive therapy.

AHF Quality Benchmarks 2025

Bureau Name	Country Name	Benchmark 2: Proportion of all newly HIV tested clients, who have a confirmed positive test result	Benchmark 3: Proportion of all newly tested HIV-positive clients, who are linked to HIV care services	Benchmark 4a: Median time period between date of HIV-diagnosis and date of ART initiation	Benchmark 4b: Proportion of clients initiated on ART, who were initiated within 14 days after HIV diagnosis	Benchmark 5a: Proportion of newly enrolled clients who had a baseline CD4 cell count	Benchmark 5b: Proportion of newly enrolled clients with a baseline CD4 cell test result, who had a CD4 cell count <200	Benchmark 5b: Proportion of newly enrolled clients with a baseline CD4 cell test result, who had a CD4 cell count <350
Africa	South Africa	1.9%	91%	1	96%	96%	57%	33%
	Uganda	2.1%	91%	1	95%	94%	60%	29%
	Zambia	2.6%	95%	1	98%	95%	56%	29%
	Rwanda	1.1%	93%	2	97%	100%	35%	15%
	Ethiopia	1.1%	75%	1	89%	68%	68%	46%
	Kenya	4.0%	89%	1	91%	85%	64%	39%
	Eswatini	2.2%	91%	1	92%	100%	65%	37%
	Nigeria	2.7%	98%	1	98%	100%	N/A	23%
	Sierra Leone	4.6%	98%	1	98%	98%	59%	22%
	Lesotho	8.4%	78%	1	98%	72%	63%	42%
	Zimbabwe	4.0%	81%	1	91%	98%	55%	41%
	Malawi	2.1%	79%	1	100%	81%	50%	24%
	Mozambique	2.5%	94%	1	99%	38%	50%	27%
	Tanzania	1.4%	93%	1	99%	100%	51%	17%
Asia	India	1.7%	88%	2	94%	96%	52%	17%
	Cambodia	7.4%	91%	1	97%	58%	67%	45%
	China	1.8%	91%	6	83%	98%	68%	36%
	Vietnam	3.7%	81%	6	82%	49%	74%	46%
	Nepal	6.5%	89%	4	87%	71%	66%	45%
	Thailand	4.0%	86%	7	74%	91%	64%	39%
	Myanmar	6.0%	90%	5	70%	99%	30%	16%
	Indonesia	5.3%	86%	1	87%	81%	78%	50%
	Philippines	2.8%	78%	1	87%	80%	75%	47%
	Laos	3.5%	84%	1	87%	37%	100%	50%
Latin America & the Caribbean	Mexico	2.7%	91%	9	63%	92%	71%	52%
	Guatemala	3.9%	95%	1	95%	98%	70%	42%
	Argentina	3.6%	100%	8	88%	100%	44%	19%
	Dominican Republic	3.9%	92%	1	95%	68%	57%	38%
	Peru	5.6%	94%	10	63%	74%	65%	40%
	Haiti	4.0%	98%	1	99%	11%	N/A	42%
	Jamaica	0.9%	94%	5	81%	50%	46%	19%
	Brazil	2.9%	104%	8	69%	95%	46%	25%
	Chile	2.2%	102%	N/A	N/A	100%	40%	15%
	Colombia	5.4%	98%	1	98%	96%	N/A	19%
	Panama	2.5%	101%	7	76%	78%	N/A	58%
	Trinidad and Tobago	N/A	N/A	4	82%	0%	N/A	N/A
Europe	Ukraine	3.9%	97%	1	93%	89%	65%	40%
	Russia	5.4%	93%	5	97%	100%	47%	24%
	Estonia	0.3%	100%	No data	No data	No data	No data	No data

AHF AIDS HEALTHCARE FOUNDATION

AHF Quality Benchmarks 2025

Bureau Name	Country Name	Benchmark 6a: Proportion of clients (>6 months on ART) who had a VL test result in the last 12 months	Benchmark 6b: Proportion of clients (>6 months on ART) with a VL test result in the last 12 months, who were suppressed	Benchmark 7: HIV-related mortality ratio (per 1,000 clients)	Benchmark 8: Proportion of clients who became LTFU (among all clients)	Benchmark 9a: Proportion of New HIV-Positive Clients, who were Tested for Syphilis	Benchmark 9b: Proportion of New HIV-Positive Clients, who Tested Positive for Syphilis and Completed Treatment	Benchmark 10a: Proportion of Eligible HIV-Positive Clients that Initiated a Standard Course of TB Preventive Therapy	Benchmark 10b: Proportion of HIV-Positive Clients that Completed a Standard Course of TB Preventive Therapy	Proportion of newly enrolled clients, treated by syndromic approach for symptomatic STI	Proportion of newly enrolled HIV-positive women in child-bearing age, who were screened for cervical cancer
Africa	South Africa	78%	97%	1.4	8.1%	94%	91%	100%	48%	100%	82%
	Uganda	87%	96%	2.3	2.7%	83%	100%	79%	95%	100%	68%
	Zambia	79%	98%	1.4	3.9%	85%	99%	98%	91%	99%	88%
	Rwanda	97%	99%	1.2	1.1%	99%	100%	100%	98%	100%	98%
	Ethiopia	88%	99%	2.4	2.1%	81%	100%	98%	95%	100%	65%
	Kenya	77%	98%	3.6	3.4%	72%	100%	95%	95%	100%	78%
	Eswatini	97%	99%	1.7	1.3%	100%	100%	92%	95%	100%	95%
	Nigeria	81%	94%	1.4	3.0%	100%	100%	100%	94%	100%	77%
	Sierra Leone	27%	89%	2.1	2.9%	99%	99%	100%	93%	100%	42%
	Lesotho	72%	99%	0.9	3.1%	70%	100%	98%	96%	100%	51%
	Zimbabwe	91%	98%	5.5	2.7%	99%	96%	92%	92%	97%	90%
	Malawi	59%	95%	2.5	13.5%	88%	98%	99%	54%	100%	71%
	Mozambique	58%	97%	1.4	3.0%	27%	74%	100%	91%	100%	70%
	Tanzania	N/A	N/A	1.6	2.6%	27%	N/A	99%	N/A	0%	50%
Asia	India	93%	98%	1.0	2.2%	100%	100%	100%	93%	0%	0%
	Cambodia	88%	98%	6.7	3.3%	97%	100%	64%	90%	100%	30%
	China	91%	98%	0.6	1.3%	98%	97%	100%	18%	80%	13%
	Vietnam	67%	99%	3.4	1.3%	41%	100%	75%	94%	100%	0%
	Nepal	87%	98%	4.2	1.7%	96%	93%	27%	50%	100%	72%
	Thailand	54%	98%	2.9	0.1%	93%	98%	9%	0%	100%	2%
	Myanmar	95%	97%	4.4	0.5%	100%	100%	92%	99%	100%	40%
	Indonesia	53%	97%	15.9	3.5%	94%	94%	41%	9%	100%	36%
	Philippines	41%	97%	6.7	5.1%	90%	95%	96%	65%	100%	18%
	Laos	78%	98%	14.2	3.9%	69%	100%	99%	99%	100%	68%
Latin America & the Caribbean	Mexico	93%	97%	1.1	2.0%	86%	93%	100%	0%	100%	10%
	Guatemala	96%	95%	7.2	3.5%	100%	100%	100%	94%	100%	100%
	Argentina	88%	96%	1.1	0.8%	76%	100%	100%	4%	100%	0%
	Dominican Republic	71%	87%	3.5	15.8%	100%	100%	100%	60%	100%	N/A
	Peru	60%	94%	3.5	5.9%	92%	100%	65%	18%	50%	2%
	Haiti	54%	86%	3.3	2.2%	74%	100%	100%	98%	0%	N/A
	Jamaica	91%	91%	2.9	9.5%	95%	100%	N/A	N/A	100%	20%
	Brazil	77%	94%	2.3	7.4%	88%	92%	33%	27%	98%	25%
	Chile	85%	92%	0.0	0.2%	96%	100%	N/A	100%	100%	N/A
	Colombia	87%	91%	2.6	16.8%	96%	100%	N/A	97%	100%	93%
	Panama	76%	92%	12.3	10.4%	44%	100%	100%	32%	100%	N/A
	Trinidad and Tobago	97%	93%	7.6	5.4%	100%	100%	N/A	N/A	0%	N/A
Europe	Ukraine	85%	96%	5.1	0.5%	100%	64%	87%	62%	81%	78%
	Russia	97%	97%	4.7	0.3%	100%	100%	98%	85%	0%	98%
	Estonia	No data	No data	2.1	8.9%	No data	No data	N/A	No data	N/A	N/A

AHF AIDS HEALTHCARE FOUNDATION

Global Medical, Quality and HMIS Teams Core Objective

To be assured, through data and evidence, that every AHF patient is receiving an excellent standard of care

For more information, email:
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