Expanding access to lenacapavir in low-income and middle-income countries

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Lenacapavir has created a rare opportunity in HIV prevention. As a twice-yearly pre-exposure prophylaxis (PrEP) option, lenacapavir could overcome some of the adherence, stigma, and service-delivery barriers that have constrained daily oral PrEP, although injectable delivery also introduces new operational challenges for health systems. In the PURPOSE 1 trial,[1] no incident HIV infections occurred among cisgender women receiving lenacapavir. In PURPOSE 2,[2] lenacapavir also demonstrated very high efficacy among cisgender men and gender-diverse people.[1,2] WHO now recommends injectable lenacapavir as an additional HIV prevention option within combination prevention.[3] These advances come at a time when global progress in HIV prevention remains slow, with an estimated 1·3 million new HIV infections in 2024.[4]

The immediate challenge is not whether lenacapavir is effective, but whether access on a global scale will be organised equitably enough to change the epidemic. On April 14, 2026, the Global Fund and the US government expanded their partnership to reach 3 million people with lenacapavir for HIV prevention by 2028, with its rollout already underway in nine African countries and support extended to 12 additional countries.[5,6] Peter Sands—the executive director of the Global Fund—has called for the expansion of access to "go bigger", reflecting the scale of lenacapavir's opportunity and its risks. A breakthrough prevention medicine will have little population-level effect if access remains concentrated in donor-funded programmes rather than integrated into national health systems.[4,5]

First, lenacapavir scale-up should be incorporated into ministry-led HIV prevention systems. The next phase of lenacapavir scale-up should be built around ministerial partnerships in low-income and middle-income countries (LMICs) rather than the drug's introduction alone. Through these partnerships, lenacapavir can be better integrated into national HIV prevention strategies, procurement systems, delivery platforms, and monitoring frameworks. These partnerships should also address delivery constraints specific to injectable PrEP, including injection workforce capacity, repeat clinic visits, and acceptability concerns related to injection-site reactions.[7] As WHO guidance is directed towards implementation by its member states, programme managers, and policy makers, lenacapavir should be understood not simply as a clinical endorsement but as a tool to be embedded within public health systems.[3] Additionally, the Global Fund has stressed its alignment with national strategies and the role of community-led organisations in lenacapavir's rollout.[5] In this context, lenacapavir's biomedical efficacy alone will not be enough: ministries of health should also be active partners in designing its equitable delivery.

Second, local and regional research, development, and implementation should guide lenacapavir scale-up. Historically, many global health innovations have been developed outside LMICs, introduced through donor channels, and only later adapted to local health systems. In this case, lenacapavir development and rollout should be integrated into health systems and led locally from the outset, with ministries, researchers, and community-led organisations shaping the implementation of its scale-up. If countries are expected to sustain equitable access, they should also help generate the evidence needed to guide successful scale-up. This need is reflected in WHO's decision to issue its recommendation alongside updated testing guidance for long-acting PrEP, underscoring that innovation should be matched by delivery evidence and programme adaptation.[3]

Third, international financing and governance must prevent access gaps from widening. Gilead Sciences has signed royalty-free voluntary licensing agreements with six generic manufacturers to supply 120 countries, mainly in LMICs.[8,9] Even so, large-scale generic rollout is not expected until 2027, and many middle-income countries outside the licensing territory might still rely on tiered pricing or slower negotiations,[8,9] which might preserve inconsistent access across countries and populations despite lenacapavir's broader rollout.

Equity should also extend beyond geography. UNAIDS has noted that rollout has already reached priority populations, including adolescent girls and young women, pregnant women, and key populations such as sex workers and men who have sex with men.[10] A lenacapavir agenda that prioritises populations facing

fewer political barriers or countries better able to secure financing would risk increasing existing inequities rather than reducing them. Notably, UNAIDS has warned that international assistance accounts for 80% of prevention programmes in LMICs and that permanent funding losses could lead to an additional 6 million HIV infections and 4 million AIDS-related deaths by 2029.[4]

Lenacapavir could mark a turning point in HIV prevention. However, its effect will not be determined by efficacy alone, but by whether access is advanced as a shared global health priority: led by ministries in LMICs, supported by local research and development, and financed and governed through an equity-oriented public health approach. Without equity-driven governance, lenacapavir can risk becoming another fragmented innovation rather than a transformative HIV prevention tool.

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Low-level viraemia in children living with HIV

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The global response to the HIV epidemic has made remarkable strides. Antiretroviral therapy (ART) has successfully reduced the viral load in many children (age 0–14 years) to undetectable levels, significantly improving long-term survival and quality of life.[1] However, low-level viraemia (LLV)—generally defined as persistent, detectable HIV RNA at 50–999 copies per mL despite ART—remains a concerning condition.[2] LLV poses potential risks for disease progression, drug resistance, and viral reservoir maintenance.[3] Clemente and colleagues recently published a scoping review of literature and developed international consensus recommendations on the management of persistent LLV, but their paper excluded studies in children (age 0–14 years) living with HIV.[4]

We provide some considerations for the study of LLV in children living with HIV. Understanding the clinical significance of LLV is crucial for optimising long-term health outcomes and informing future treatment strategies.

LLV is not an uncommon occurrence among children living with HIV; however, it often goes underappreciated in clinical practice. In 2025, McKenzie and colleagues[5] reported an LLV prevalence of 40·5% in 2618 children living with HIV (81·9% were on first-line dolutegravir-based regimens), with 7364 person-years of follow-up. Using a cut off of 1000 copies per mL to define virological failure, the authors found that children living with HIV with viral