EU R&I and Health Policy to
Tackle Global Challenges

Implications for the global HIV response

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SUMMARY

In 2024, an estimated 40 million people were living with HIV. While 77 % were being treated, nine million were not. Despite progress, the HIV response faces growing challenges due to shifting funding and political uncertainty.

The US, which provided about 80 % of HIV-related official development assistance in 2024, froze USD 4.3 billion of funding from the President's Emergency Plan for AIDS Relief (PEPFAR) in early 2025. Other donors, including the European Commission, have also scaled back. These cuts have led to staff layoffs, suspended prevention programmes and service disruptions. Weakening data systems further limit response capacity.

UNAIDS faces major financial constraints. Domestic financing is beginning to rise, with some countries pledging to increase domestic HIV spending by 2026. Still, many remain limited by debt, low growth and constrained budgets. HIV research has also been significantly impacted. USAID cuts have disrupted vaccine trials and in 2025, the US withdrew funding for mRNA vaccine funding, raising concerns for both HIV innovation and global health security.

The US State Department recently announced that some flagship HIV programme would continue, through six-month programmes, while negotiations for longer-term funding with national partners takes place. The recently released America First Global Health Strategy reaffirmed US support for global HIV targets but the path ahead remains unclear.

Together, these developments signal a critical moment for the global HIV response. Sudden funding cuts are straining health systems, threatening progress and exposing the fragility of global efforts. At the same time, they present an opportunity to rethink funding models, strengthen domestic leadership and protect gains made over decades of investment.

The Mind the Gap series was conceived as a platform to assess and reflect on the rapidly evolving global health landscape. It not only examines shifts in financing but also explores the impact on historically high investment areas such as HIV, malaria, tuberculosis, and sexual and reproductive health. As global stakeholders engage in conversations about how to reshape the global health ecosystem to meet current and future needs, it's critical to take stock of where we stand. Mind the Gap provides a timely snapshot of these shifts, combining data and anecdotal insights to highlight the real-world impact of a rapidly evolving funding landscape and provide solutions to build a more resilient, equitable and flexible architecture to tackle global health challenges.

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1. POLICY CONTEXT

The emergence of the HIV epidemic in the 1980s prompted the launch of a coordinated global health response. Since then, it has grown into one of the largest and most sustained global health efforts, with the United States historically serving as the largest donor, contributing about 80 % of HIV-related ODA in 2024. Funding rose significantly from the 1980s through the early 2010s but has since plateaued, remaining relatively stable despite growing needs.

In 2024, an estimated 40 million people were living with HIV, including 1.3 million newly diagnosed individuals, compared to 28 million in 2020. About 77 % of people living with HIV globally were receiving antiretroviral therapy (ART) in 2024. U.S. government support has been central, with the President's Emergency Plan for AIDS Relief (PEPFAR), established in 2003, which has become the largest commitment by any nation to a single disease, investing more than USD 100 billion, providing ART to over 20 million people, and saving more than 25 million lives. PEPFAR also accounts for the majority of HIV prevention efforts in sub-Saharan Africa, the Caribbean, and the Middle East and North Africa.

Alongside this, UNAIDS, founded in 1996, has served as a unifying platform for the HIV response, advancing advocacy, prevention, treatment, and fundraising through its joint programme of eleven UN agencies. UNAIDS estimates that between 1996 and 2023, its work supported the provision of treatment that helped avert 24.1 million AIDS-related deaths.

Established in 2002, the Global Fund to Fight AIDS, Tuberculosis, and Malaria pools resources from governments, civil society, technical agencies, and communities to combat these diseases. By June 2024, it had invested USD 26.6 billion in HIV programs and USD 5.5 billion in HIV/TB programs, providing 28 % of global HIV financing. Its efforts have cut AIDS-related deaths by 73 % and new infections by 61 % to date.

This brief examines the impact of 2025 funding cuts on the global HIV response. In early 2025, the US froze USD 4.3 billion in funding from PEPFAR. Further reductions are anticipated in the 2026 fiscal year, with projections indicating a decrease of approximately 40 % compared to 2025 funding levels. Beyond HIV treatment and prevention, the response has long been a multisectoral platform integrating sexual and reproductive health and rights (SRHR), tuberculosis, HPV prevention, as well as cervical cancer care, mental health, and maternal health services. The broader implications of these cuts for SRHR and TB/malaria are addressed in accompanying briefs.

2. TRACKING FUNDING CHANGES IN THE GLOBAL HIV RESPONSE

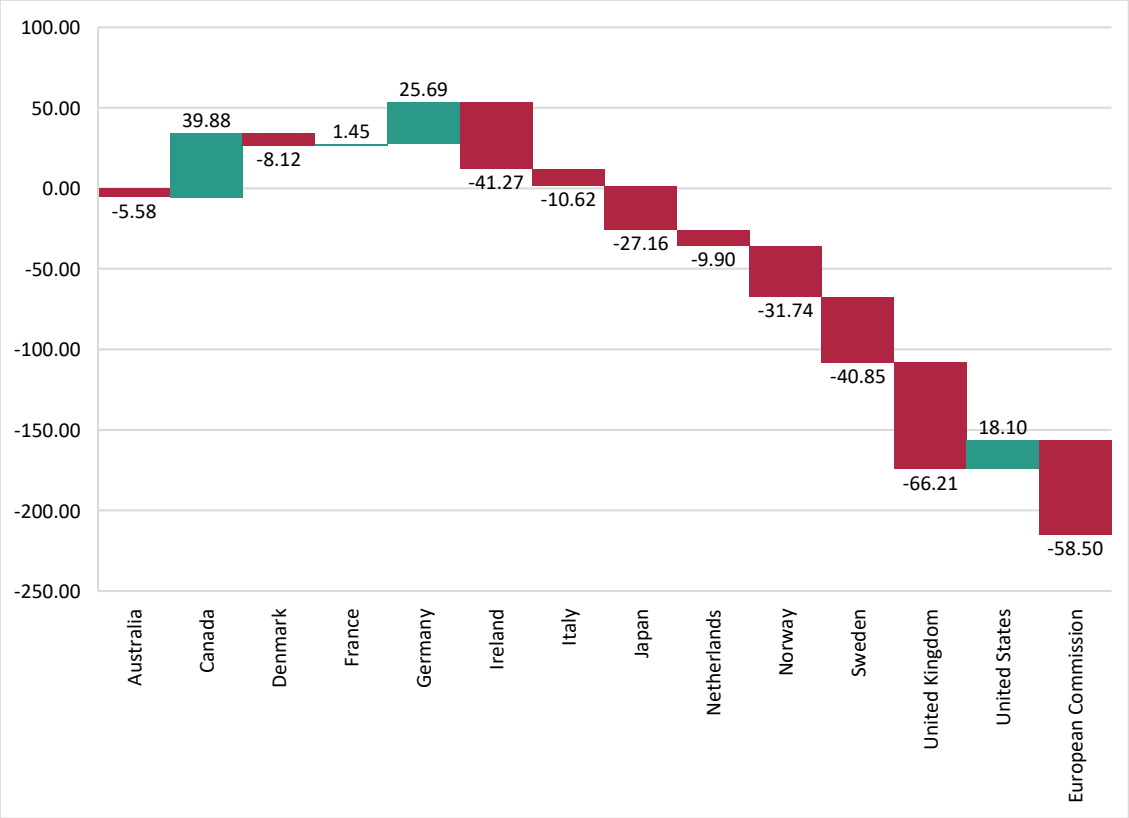
In 2024, the global HIV response was supported by an estimated USD 18.7 billion in donor ODA to low- and middle-income countries (LMICs), only 83 % of the USD 21.9 billion estimated to be required to end HIV/AIDS as a global health threat by 2030. Domestic resources accounted for 52 % of total funding, marking a modest 2.2 % increase compared to 2023.

Among donors, the US has consistently been the largest contributor (80 %), followed by France (4 %), Germany (3 %), the United Kingdom (3 %), and the Netherlands (2 %) in 2024. Donor governments collectively provided around USD 8 billion to LMICs that year through both bilateral and multilateral channels, with Development Assistance Committee (DAC) countries maintaining relatively stable contributions between 2011 and 2024. DAC countries are members of the OECD's Development Assistance Committee, primarily high-income countries, that coordinate and report on official development assistance and help set global aid standards.

In 2025, the freeze and uncertainty around PEPFAR's USD 4.3 billion bilateral funding sent shockwaves through the global HIV community. Without a return to 2024 funding levels, the current 17 % funding gap could widen further, threatening progress toward the 2030 targets. The entrenchment of the US global health aid in high burden HIV countries primarily in Africa, has created a significant dependency on US financing that has long provided critical support for individuals living with or at risk of acquiring HIV. For example, in Uganda, PEPFAR provided antiretroviral therapy for 1.4 million people living with HIV. In Mozambique 82 % of people living with HIV rely on PEPFAR-supported health facilities for their care and services.

Other donors have also begun reducing their contributions. Between 2019 and 2024, several donor governments showed downward trends in HIV allocations, with the European Commission cutting its support by 59 % from USD 76 million in 2019 to USD 35.2 million in 2024. Figure 1 illustrates the percentage change in funding allocation among selected donor governments for HIV between 2019 (pre COVID-19) and 2024, showing a downward trend. Spain is an outlier and is not shown in the figure; it increased its contributions by over 73 % from USD 15 million in 2011 to USD 26 million in 2024. According to UNAIDS' 2025 report, there are growing concerns that other donors may also retreat from the solidarity built with LMICs over the past decades.

Figure 1. Percent change of select donor government funding for HIV (bilateral & multilateral- between 2019 and 2024 (USD)

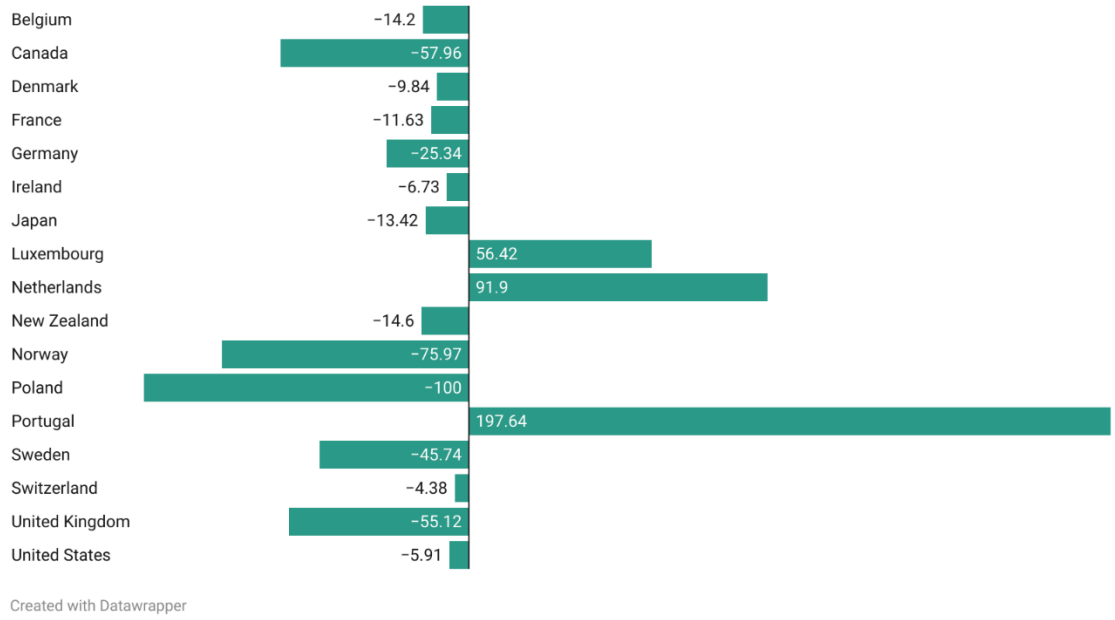


Source: KFF

Looking ahead, PEPFAR's funding outlook remains uncertain. The 2026 US budget is expected to include a further USD 1.9 billion reduction, with ongoing political debate over the extent of these cuts. While Congress has partially mitigated these reductions by maintaining USD 400 million in 2025 that otherwise would have been cut, these funds will not restore prevention services, which remain restricted under current US policy to support prevention only for pregnant and breastfeeding women. Notably, of the 770 global health awards cut in 2025, roughly half related to HIV/AIDS programming, underscoring the scale of disruption the response is facing.

In 2025, UNAIDS has faced severe financial constraints due to major reductions in multilateral contributions, particularly from the United States. Figure 2 shows the change in funding distribution among DAC countries between 2019 and 2023, showcasing a trend of reductions among 15 out of 18 countries (83 %). Available funding at the end of the year is projected at around USD 27 million, well below the board's designated 22 % budget threshold needed to sustain operations into the following year. This leaves a projected shortfall of USD 8.7 million by 2026. To address this, the UNAIDS Secretariat has requested board authorisation to draw up to USD 15 million from reserves.

Figure 2. Percent change of DAC country distributions to UNAIDS between 2019 and 2023



Source: OECD Data Explorer

2.1. DOMESTIC HIV FINANCING CHANGES

While the international funding landscape has shifted, so too has domestic financing for HIV. With reductions in bilateral aid and smaller budgets for multilateral support, LMICs are placing greater emphasis on domestic financing options. At the 2025 International Conference on Financing for Development, 26 of 61 countries reported plans to increase domestic contributions to the HIV response by 2026, with a mean increase of 8 %, equivalent to about USD 180 million in additional resources. This reflects growing national leadership and commitment, though not all countries are in a position to expand contributions due to debt distress, low economic growth, competing priorities, and limited fiscal space. A 2019 analysis found that the top five recipients of external HIV funding in Africa (Zimbabwe, Ethiopia, Mozambique, Uganda, and Tanzania) would be unable to cover even half of the gap should donors withdraw. Although often portrayed as dependent on external support, domestic government health spending per capita has in fact been higher in countries supported by PEPFAR than in those without such support, and between 2004 and 2021 it increased by 356 % and 201%, respectively. Despite this encouraging trend, domestic funding efforts remain insufficient to address the gap left by international donors that have withdrawn or significantly reduced their contributions.

2.2. Domestic funding changes and priorities announced in light of global donor transitions in the HIV response:

South Africa

South Africa currently finances 77 % of its HIV response. Its 2025 budget outlines a planned annual increase of 5.9 % in health expenditure in the next three years including funding for HIV and tuberculosis programming to grow by 3.3 % annually. The government intends to invest in health system strengthening, including the development of a patient information system, a centralised chronic medicine dispensing and distribution mechanism, and a facility-level medicine stock surveillance system.

Democratic Republic of the Congo (DRC)

The DRC has launched the Presidential Initiative to End Pediatric AIDS, backed by USD 18 million in national funds over five years. Announced by President Félix Tshisekedi, the initiative renews efforts to tackle continued challenges in pediatric HIV treatment, with only 44 % currently receiving treatment, a figure stagnant for over a decade. The plan focuses on four priorities: early detection and treatment for children, adolescents and pregnant women; preventing new infections; ensuring immediate treatment for all diagnosed; and addressing structural barriers to access.

3. GLOBAL IMPLICATIONS ON HIV AND HEALTH OUTCOMES: MODELLING RESULTS

The implications of funding on HIV programming and outcomes can be difficult to predict at short and long term intervals. Several modelling efforts have been undertaken to estimate the impact of the funding cuts on HIV outcomes globally as well as in PEPFAR supported regions. Although depending on assumptions, modelling estimates can provide a valuable sense of the scope and scare of potential impact. Based on available studies, funding cuts are projected to vastly affect the number of new infections and AIDS-related deaths (Table 1).

Table 1. Modelling studies of projected impacts

	Workbook model	Goal model from Avenir Health (UNAIDS estimates)	Avenir Health	Optimal model from Burnet Institute	HIV modelling consortium	JIAS publication	STDSIM	Impact Counter	Lancet
Modelling period included	2025-2029	2025-2029	2025-2030	2025-2030	2025-2040	90-day pause	90-day pause	1 year	2025-2030
Countries included	55 countries supported by PEPFAR	55 countries supported by PEPFAR	55 countries supported by PEPFAR	26 countries (14 PEPFAR)	55 countries for Goals, 13 for Opitma,1-4 countries for the other models	PEPFAR-supported countries	7 countries in sub-Saharan Africa: Ethiopia, Kenya, Malawi, South Africa, Tanzania,	Sub-Saharan Africa	133 countries and territories

							Zambia, and Zimbabwe		
Projected new HIV infections	8.7 million	6.6 million	7.5 million	4.4-10.7 million	26.2 million	-	35 000- 103 000	-	-
Projects additional AIDS-related deaths	6.3 million	4.2 million	4.1 million	0.8-2.9 million	15.2 million	109 552	60 000- 74 000	159 272 (adults) 16 954 (infants)	25.5 million
Assumption on changes	Cessation of all PEPFAR activities Calculation used the number of people reached with services to determine impact	Cessation of all PEPFAR activities Relies on epidemiological and programme funding data for each country Reliance on self-reports for most data on	Compared projections assuming status quo with estimates assuming complete elimination of US funding in each country. Some consider some cuts or reallocation	Discontinued PEPFAR support and anticipated international aid declines Pre-calibrated national data from 2022–2024 was used for the model	Cessation of all PEPFAR activities Projections compare "status quo" (constant 2024 US funding) with complete elimination of US funding. Assumes no other donor	A 90-day disruption of HIV treatment and care programmes Model assumed discontinuation of ART to 50 % of people leads to a median increase of 1.36 times	For the full 90 day pause, defaulted patients will restart treatment within 6 months, while new treatment initiations resume 6 months after funding is restored.	Full suspension of PEPFAR would cause 47 % of projected deaths, ~159 000, in one year if ART is interrupted for an average of three months.	Assumes USAID funding lowers mortality and can be shown with past global data Assumes no other external or domestic funding will

		behaviours, the use of intervention effect sizes from published studies that may overstate intervention impacts outside of controlled study settings, and the use of proxy countries to estimate the impact in countries with fewer than 4 000 annual HIV infections	of funds over time		or domestic resources fill the gap Funding cuts reduce service availability	the number of HIV-related deaths over a 1-year period Limited calculation of excess HIV-related deaths to only those resulting from interruption of treatment for 90 days, i.e., a 90-day treatment interruption and assumption that ART would be re-initiated immediately at the end of the 90-day period	After the 4- and 8-week pauses in the Waiver scenario, new treatment starts resume at 25 % of pre-Executive Order levels, reflecting uncertainty. They return to full levels after 90 days.	An estimated 10 % of infants born during the 90-day gap could die without PEPFAR-funded ART, leading to ~ 4 230 deaths	fully replace USAID cuts

4. IMPLICATIONS OF GLOBAL FUNDING CHANGES ON THE HIV RESPONSE

Shifts in global HIV financing in early 2025 underscore their far-reaching impact on services, programmes, and health systems in low- and middle-income countries (LMICs). Sudden and substantial funding cuts, particularly from the United States, have triggered widespread disruption, including reductions in frontline health workers, the suspension of prevention initiatives, and serious risks to the continuity of treatment.

Even before these changes, an estimated nine million people living with HIV were not accessing antiretroviral therapy in 2024. Current disruptions are expected to widen this gap, undermining timely prevention, diagnosis, and treatment, as well as the management of co-infections such as tuberculosis and malaria. The risk of late identification and progression to advanced HIV disease is also rising.

A March 2025 market evaluation of PEPFAR countries further found disruptions in HIV testing across 10 countries, risks of antiretroviral stock-outs in eight countries, and shortages of oral Pre-exposure prophylaxis (PrEP – a preventive medication taken before HIV exposure) in four countries. Even when commodities were available, pauses in PEPFAR funding have often created logistical barriers to transporting supplies to clinics and clients.

A June 2025 analysis by the Clinton Health Access Initiative covering 13 countries in sub-Saharan Africa and Southeast Asia reported severe disruptions between late 2024 and early 2025. These included a 2-22 % reduction in treatment initiations, a 3-64 % decline in CD4 testing for advanced disease, a 28-65 % reduction in oral PrEP initiations, and a 16-68 % fall in viral load monitoring across programmes. Such interruptions not only increase HIV-related morbidity and mortality but also heighten the risk of drug resistance, with long-term human and economic consequences. Deaths linked to these service disruptions are already being reported in Uganda and Sudan.

A WHO survey of global country offices found that 48 % reported disruptions to HIV services, including prevention of mother-to-child transmission, while 36 % observed moderate reductions in the availability of HIV commodities. Following the U.S. funding freeze, more than 60 % of women-led HIV organisations surveyed either lost funding or were forced to cease operations. This is particularly concerning as women account for 53 % of people living with HIV globally, with over 77 % of new infections in sub-Saharan Africa occurring among adolescent girls and young women.

Data systems and availability has also been affected. In Malawi for example, funding cuts have significantly affected HIV data management. During an assessment in February

2025, 20 % of electronic health record systems were found to be nonfunctional at supported facilities. The weakening of data systems, coupled with the loss of key data personnel, has made it increasingly difficult to support informed decision making and evidence-based planning.

Institutional impacts have also been significant. UNAIDS has reduced by more than 50 %, from 608 to approximately 280 positions, and scaled back its country presence from 75 to 36 offices. At the local level, funding retractions have caused major human resource losses; in Mozambique alone, over 30 000 health personnel, including nearly 20 000 community health workers vital to HIV care and broader health delivery, have lost their jobs.

The US recently published its updated national global health strategy - the America First Global Health Strategy – reaffirming its commitment to UNAIDS global HIV targets. The strategy does not include specific priorities for key populations, including LGBTQI communities. The strategy also reiterates a State Department announcement of a partnership with Gilead Sciences (a US based company) to provide 2 million people with Lenacapavir by 2028. Questions remain about how this will be implemented particularly in light of the funding cuts and institutional changes earlier this year.

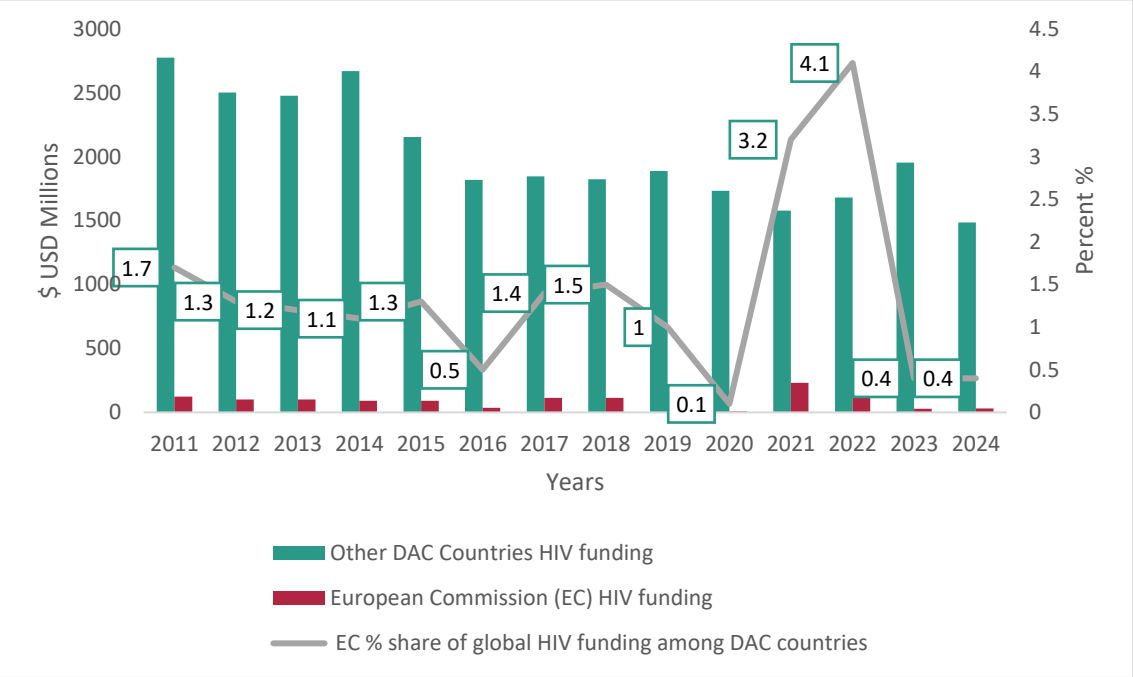
In fall of 2025, the US State Department announced the continuation of select flagship HIV programs. While widely seen as a positive development, these initiatives will first be implemented as six-month projects, during which negotiations with national partners will take place to secure longer-term funding. Observers have described this approach as "ambitious but high risk," given the complexity of the negotiations and unresolved issues such as the total funding amount and the potential reinstatement of personnel whose roles were previously eliminated.

4.1. SPOTLIGHT ON THE EUROPEAN COMMISSION'S CONTRIBUTION TO THE HIV RESPONSE

The European Union and its Member States have consistently reaffirmed their commitment to ending AIDS as a public health threat by 2030, supporting the UN Political Declarations on HIV/AIDS and investing in research, prevention, and health systems. The EU has been a consistent contributor to the Global HIV response with allocations among DAC between 2011 and 2024 ranging between 0.1 % and 4.1 % (Figure 3). Since 2002, the European Commission has disbursed EUR 3.5 billion to the Global Fund, making the EU one of its largest donors alongside substantial Member State contributions. Reflecting the priorities of the EU Global Health Strategy, the Commission has steadily increased its pledges over recent replenishments, rising from EUR 550 million for 2020–2022 (a 16 %

increase from the previous cycle) to EUR 715 million for 2023–2025. The official commitment for the upcoming replenishment covering 2026–2028 remains pending.

Figure 3. European Commission HIV funding among DAC between 2011-24



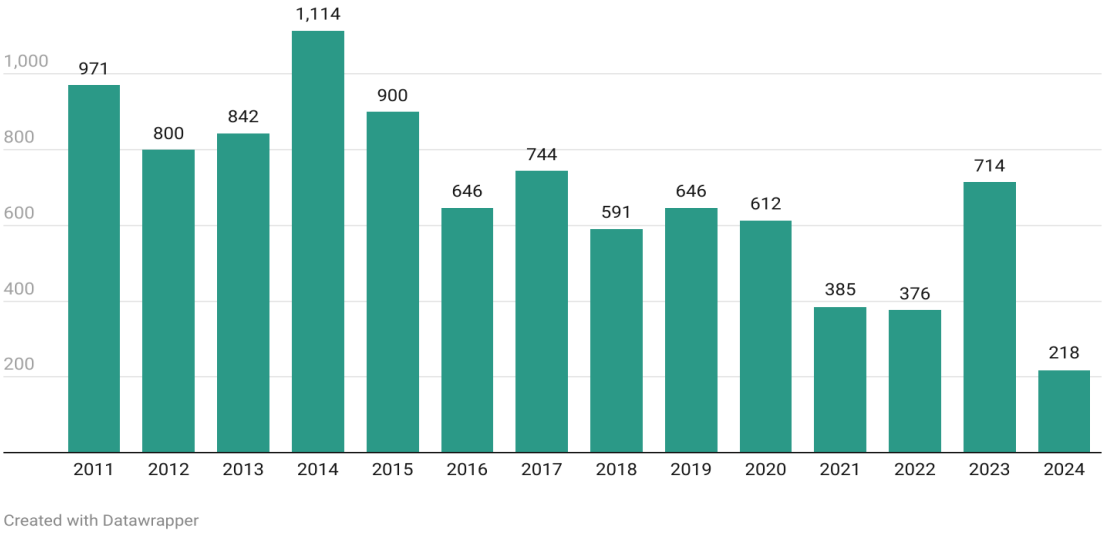
Source: KFF, UNAIDS

4.2. SPOTLIGHT ON UK CUTS

The UK is a founding member of the Global Fund and its third largest donor, having contributed GBP 5.5 billion to date. For the seventh replenishment, the UK pledged GBP 1 billion for 2023–2025, and it is co-hosting the eighth replenishment this year alongside South Africa. However, recent shifts in UK priorities and reductions in official development assistance are affecting global HIV/AIDS funding. Bilateral HIV funding from the UK has declined since 2021, and cuts are now also impacting multilateral organisations central to the response, including UNAIDS, UNFPA, and Unitaid. Between 2019 and 2023, UK contributions to UNAIDS fell by 55 % (Figure 4).

The UK is a founding member of Unitaid, which accelerates access to innovative treatments for HIV, malaria, and tuberculosis, contributing over GBP 588 million to date from a GBP 1.1 billion commitment for 2007–2026. In 2021, UK funding to Unitaid dropped from an expected GBP 77 million to GBP 6 million, including a deferred GBP 33 million contribution from 2020. Despite these cuts, UK investment in Unitaid has been widely acknowledged for advancing science and innovation in low- and middle-income countries. Contributions to both Unitaid and the Global Fund are expected to continue, though commitments for the next replenishment remain unconfirmed.

Figure 4. UK bilateral and multilateral HIV funding between 2011-24 (USD in millions)



Source: KFF, UNAIDS

Analysis by the Guttmacher Institute highlights the potential consequences of reduced UK funding, predicting significant impacts on lives, access to antiretroviral therapy, testing and counselling, and prevention of mother-to-child transmission. These findings underscore the critical importance of sustained investment to protect global HIV progress.

Figure 5. How UK investments in the Global Fund to Fight AIDS, Tuberculosis and Malaria could impact health outcomes

	UK INVESTMENT	PEOPLE PROVIDED ANTIRETROVIRAL THERAPY	MOTHERS TREATED TO PREVENT HIV TRANSMISSION TO THEIR BABIES	PEOPLE RECEIVING HIV COUNSELING AND TESTING	MEMBERS OF KEY POPULATIONS REACHED WITH HIV PREVENTION PROGRAMS	LIVES SAVED
Annual investment	£333 MILLION	626K	50K	37.6M	1.6M	492K
For a £10 million decrease in funding		-19K	-2K	-1.1M	-47K	-15K
For a £100 million decrease in funding		-188K	-15K	-11.3K	-466K	-148K

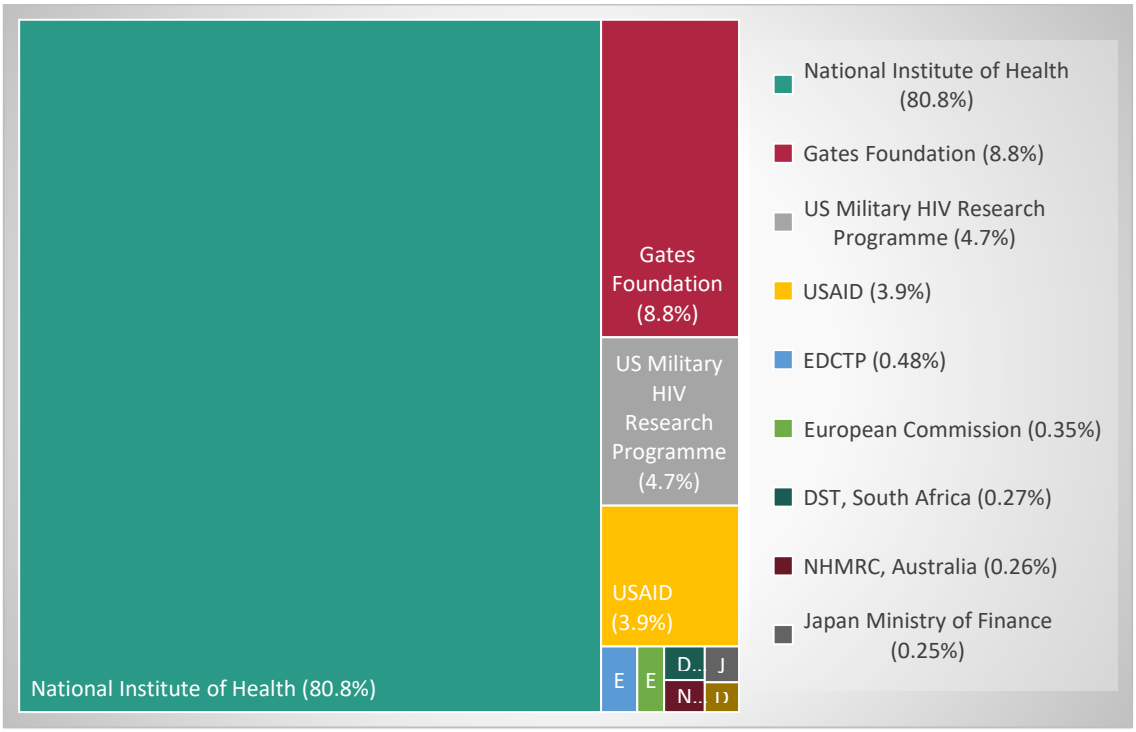
Notes: Impacts estimated using data from the Global Fund to Fight AIDS, Tuberculosis and Malaria, *Eighth Replenishment Investment Case*, 2025, https://www.theglobalfund.org/en/investment-case. Scenarios of funding cuts do not add up due to rounding. M=million. K=thousand.

Source: Guttmacher

5. GLOBAL IMPLICATIONS OF FUNDING CHANGES ON RESEARCH AND INNOVATION

Early 2025 reports highlight the profound impact of recent shifts in global HIV research funding on innovation, prevention, and vaccine development. The dismantling of USAID support has disrupted several international HIV vaccine initiatives, putting clinical trials on hold and undermining global collaboration. In 2022, the U.S. accounted for nearly 90 % of the USD 731 million allocated to HIV vaccine research globally (Figure 6). The European Commission accounted for 0.35 % while EDCTP accounted for 0.48 %. By the end of fiscal 2025, nearly 500 of 836 USAID awards transferred to the State Department are expected to have expired, creating uncertainty for ongoing research. NIH's decision to halt foreign subawards, which previously enabled collaboration with overseas researchers, further threatens the global HIV research ecosystem, with knock-on effects for TB, malaria, and HPV innovation.

Figure 6. Global Donors Funding HIV Research in 2022



Source: AVAC

Cuts are not limited to the U.S. The UK's funding for HIV-related R&D has fallen by nearly two-thirds over the past decade, with HIV vaccine research funding dropping from approximately GBP 5 million per year to zero. These long-term policy reductions, coupled with COVID-19 disruptions and shifting policy priorities, have slowed the pace of discovery and narrowed the global innovation pipeline. Planned clinical trials to explore

broadly neutralising antibodies against HIV, including those under the BRILLIANT HIV Vaccine Consortium, were suspended following major funding withdrawals, forcing researchers to scale back trials and delay progress.

South Africa illustrates both the challenge and the opportunity of global HIV research. As the largest recipient of NIH funding outside the U.S., the country has received nearly USD2 billion over two decades, supporting up to 70 % of its HIV and TB research portfolio and building world-class clinical trial infrastructure. This capacity enabled rapid pivoting during the COVID-19 pandemic, with global implications for vaccine testing and pandemic preparedness. Funding cuts now place at least 27 HIV and 20 TB trials at risk, with institutions such as Wits University facing billions in lost research income, widespread staff reductions, and disrupted trials. Beyond the scientific setback, these losses threaten local health innovation ecosystems and erode community trust built over decades. In response, the South African government committed 400 million Rand (USD 23 million) over three years, supplemented by 200 million Rand from the Gates Foundation and Wellcome Trust, creating a 600 million Rand package to sustain critical programs in HIV, TB, mental health, and maternal and child health.

In the U.S., additional setbacks emerged in August 2025 when USD 500 million in mRNA vaccine funding was retracted, reflecting misinformation about vaccine efficacy. Given the centrality of mRNA technology to HIV vaccine development and future pandemic response, these cuts carry global repercussions for health security.

Europe continues cautious progress, with early-phase clinical trials using candidates such as HIVconsvX and germline-targeting strategies at institutions including the University of Amsterdam. The EU recently authorised the use of lenocapavir in the EU-27, Iceland, Norway and Liechtenstein. Partnerships between the Global Fund, Gilead Sciences, and the Children's Investment Fund Foundation aim to accelerate access in low- and middle-income countries. However, slow regulatory processes and fragmented approval systems risk slowing the rollout of these transformative interventions.

These developments underscore both the promise of scientific breakthroughs and the vulnerability of global HIV research. Sustained, predictable investment, paired with streamlined regulatory processes and harmonised regulatory pathways, is essential to ensure that lifesaving innovations reach the populations that need them most.

Looking ahead, protecting the HIV innovation ecosystem will require renewed donor commitments, diversification of funding sources, and stronger regional research capacity, particularly in Africa and Asia. Expanding philanthropic and private sector engagement and aligning global regulatory systems could safeguard progress and preserve momentum toward an effective HIV vaccine and broader pandemic preparedness.

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