Agenda item 9

UNAIDS/PCB (59)/26.31

BACKGROUND NOTE

Addressing the impact of funding cuts on people living with, affected by and at risk of HIV, and on the response to HIV and AIDS

UNAIDS

8–11 December 2026 |Geneva, Switzerland
UNAIDS Programme Coordinating Board Issue date: 25 November 2026

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Executive summary

1. The thematic segment of the 59th meeting of the Programme Coordinating Board (PCB) addresses the impact of funding constraints and shifts on people living with, affected by and at risk of HIV, and on the response to HIV and AIDS. It draws on financing and programme data, surveys, community reporting, modelling and country and community case studies. The analysis is organized around three pillars: the consequences of financing reductions for people and HIV response functions (Pillar 1); documented country and community adaptations and mitigation strategies (Pillar 2); and policy and financing approaches to sustain effective, equitable HIV responses (Pillar 3).

2. The financing contraction has disrupted workforce capacity, community networks and enabling systems, while treatment for people already receiving antiretroviral therapy has been relatively protected. These effects are unequal and shaped by existing social and structural inequalities. Women and girls, key and other marginalized populations, children and people facing poverty, displacement, stigma or discrimination confront overlapping barriers to services, support and protection, while community-led organizations face losses of funding and independent capacity. Gender inequalities further shape these impacts through unequal decision-making power, exposure to violence, economic insecurity, unpaid care responsibilities and barriers to sexual and reproductive health services. These financing reductions and shifts may therefore disproportionately affect women and girls, while also weakening services needed by men, boys and marginalized populations, whose access is affected in different ways by stigma, discrimination and criminalization.

3. The global HIV response is facing a sustained financing crisis that has developed over more than a decade and involving multiple donor governments, threatening hard-won gains in health, equity, human development, human rights and community participation. In 2025, United States (US) disbursements fell from US$6.7 billion to US$4.6 billion, while contributions from other donor governments had fallen by nearly half since 2011. United States bilateral contributions fell by 26% between 2024 and 2025, and contributions from other major donors and investors in the global HIV response had already been declining for more than a decade. Total donor-government HIV financing declined by 25%, from US$8.3 billion to US$6.2 billion, its lowest level since 2007. The Global Fund reduced existing Grant Cycle 7 allocations by US$1.43 billion, approximately 11%. Total HIV resources in low- and middle-income countries fell by 6% to US$17.6 billion in 2025, US$4.3 billion below the US$21.9 billion estimated to be needed annually by 2030. Domestic financing increased to 59% of available resources, and more than 55 countries have committed to increasing their contributions, although capacities remain uneven.

4. The January 2025 pause of US foreign assistance brought stop-work orders, programme terminations and selective waivers for resumption of essential HIV services. Waivers permitted specified HIV services designated as “life-saving” to continue, but largely did not protect the wider systems supporting the HIV response, or broader HIV prevention, community-led and rights-related programming. Much bilateral financing was channelled through implementing partners outside national budgets, and governments and communities faced difficulties identifying which personnel, services and supporting functions had been withdrawn. Subsequent America First bilateral health agreements are multi-disease, not HIV-specific, and their implications for HIV depend on implementation and the functions financed in specific agreements.

5. Prevention and community-led services and systems are often the last to be prioritized by external and domestic resources. Between 2010 and 2025, new HIV infections fell by 42% and AIDS-related deaths by 57%. Nevertheless, in 2025, approximately 1.2 million people acquired HIV, 570 000 died from AIDS-related causes and about 10.7 million people living with HIV were not virally suppressed. HIV prevention, key-population services, community-led functions, technical assistance and data systems have depended more heavily on external financing than treatment. In 2024, 66% of prevention funding was externally financed.

6. Antiretroviral therapy (ART) for many established patients was relatively protected, while testing, linkage to care, prevention responses, community-led responses and supporting systems experienced greater disruption. Across the US President's Emergency Plan for AIDS Relief (PEPFAR)-supported sites, annual HIV testing fell by 18%, pre-exposure prophylaxis (PrEP) initiations by 33% and the direct-service workforce by about 24%. PEPFAR prevention spending fell by 51%. Among people with HIV-associated tuberculosis (TB), ART coverage fell from 91% to 87%. Losses in testing, linkage to care, laboratory monitoring, adherence support and outreach may undermine viral suppression and related HIV prevention, even where medicines remain available. Yet the United States still provides more than 73% of donor government financing for HIV highlighting both its indispensable leadership and the risks of an increasingly concentrated financing architecture. Renewed solidarity from all donor governments, including European and other countries, will be critical to help close the financing gap and sustain the global commitment to end AIDS as a public health threat by 2030.

7. Since the US was the largest investor in community and key-population HIV services, people dependent on community and key-population services were particularly affected by shifts in US international financing. Among surveyed PEPFAR partners previously providing key-population services, 73% permanently ended at least one such service. The suspension of PEPFAR's Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) programme affected approximately two million adolescent girls and young women, as well as women-led organizations supporting the programme. Funding losses weakened peer support, safe spaces, community mobilization, community-led monitoring and participation in policy processes. These functions are not necessarily replaceable through clinical service transfer or short-term contracts. Recent changes to US funding policies restrict what financing permits organizations to do.

8. UNAIDS-supported sustainability roadmaps, data and in-country presence and assistance provided immediate support to countries and communities to mitigate the impact of the pause in external funding and ensure continuity of services. Community organizations mobilized emergency referrals, peer support and local resources, frequently preserving selected activities at reduced scale. Governments issued guidance focused on treatment access, absorbed previously donor-supported workers and approved emergency or supplementary budgets. The Global Fund's reprioritization protected the existing treatment cohort, prevention products, harm reduction, peer workers and existing community-led monitoring, although community systems strengthening allocations were reduced by 22% in the subset of grants with available revised budgets. Community engagement influenced some of these decisions, but participation in financing and transition decisions was limited and inconsistent.

9. Emergency adaptation rarely replaces predictable financing and can transfer costs to households and communities through user fees and unpaid work. Contracts for defined

services do not necessarily finance mobilization, advocacy or independent monitoring, and criminalization often exclude key-population organizations from public contracting. Community service continuity can coexist with weakened civic capacity, and transition must be assessed against equitable access and outcomes, not financing commitments alone.

10. Sustaining the HIV response requires protecting essential services and rights, adapting programmes through evidence-informed prioritization, and ensuring durable financing and accountable institutions that support independent community capacity. Immediate obligations include reliable ART, diagnosis and linkage to care, retention, laboratory monitoring and sustained viral suppression, alongside the prevention of vertical transmission and effective prevention for populations at greatest risk. Prioritization should be informed by local transmission dynamics, treatment gaps, coverage and patterns of vulnerability. It should consider the effectiveness, cost, reach and feasibility of established and emerging approaches, including treatment and viral suppression, behavioural interventions, condoms, harm reduction, voluntary medical male circumcision (VMMC), PrEP medications and structural responses. Epidemiological prioritization should recognize the complementary contributions of evidence-based biomedical, behavioural and structural interventions, community-led responses and enabling environments, while safeguarding equitable access to essential services.

11. Integration into primary health care and universal health coverage can improve continuity and efficiency when financing, workforce, products, referral pathways, confidentiality and accountability are adequate. Differentiated and tailored services should be retained where general facilities cannot offer comparable safety, trust or quality. Financing should be matched to function. Social contracting can support defined community-delivered services where contracts cover full costs, while independent advocacy, organizing, legal support and community-led research or monitoring require flexible, predictable financing. Debt burdens slow transitions, and predictable international solidarity remains necessary where domestic resources cannot sustain essential obligations.

12. The proposed priorities emphasize protecting essential functions, documenting continuing losses and making transparent, equitable decisions about resource allocation. HIV services should be integrated responsibly. Community functions should be financed according to what they do, including organizations and networks led by people living with HIV, women, young people and key populations.

13. Fiscal space and affordable health products should be secured, with sustained shared international responsibility through predictable, differentiated transitions. Rights should be protected as a condition of effective access to HIV services. Strategic information and accountability should be strengthened. Meaningful participation by organizations and networks led by people living with HIV, women, young people and key populations should be ensured in decisions on financing, priorities, programme adaptation and transition, with opportunities to influence decisions and hold institutions accountable.

14. Member States, in collaboration with civil society organizations and partners, could advance these findings by requesting regular reporting on essential functions and on HIV financing commitments, allocations and disbursements, including the share reaching community-led organizations as set out in the global 2030 targets in the 2026-2031 Global AIDS Strategy and the 2026 Political Declaration on HIV/AIDS.

Section 1. Introductory overview

1.1 An ongoing contraction and reconfiguration of HIV financing

15. The global HIV response is facing a sustained financing crisis accumulating over more than a decade that threatens hard-won gains in health, equity, human development, human rights and community participation. The suspension, reduction and reconfiguration of international assistance were particularly acute in 2025, disrupting HIV services as well as the workforce, community networks and enabling systems through which people living with, affected by and at risk of HIV obtain effective access to prevention, treatment, care and support. While treatment for many people already receiving antiretroviral therapy (ART) has been relatively protected, disruptions to testing, linkage to care, prevention, community-led responses and rights-related functions have exposed important vulnerabilities in the response.

16. Women and girls, including adolescent girls and young women, key populations, children and people facing poverty, displacement, stigma and discrimination may encounter overlapping barriers to services and protection. For women and girls, the effects extend beyond clinical coverage to sexual and reproductive health, protection from violence, livelihoods, unpaid care responsibilities, bodily autonomy and participation in decisions affecting their lives. Similar concerns extend to key and vulnerable populations. Community-led organizations have been central to identifying needs, maintaining access, mobilizing responses and defending rights, yet many face severe financial losses and restrictions on their ability to operate independently.

17. The HIV response entered 2025 with longstanding vulnerabilities in international financing arrangements. Combined contributions from donor governments other than the United States (US) had fallen by 50% since 2011, from US$3.2 billion to US$1.6 billion in 2024, increasing the US share of donor-government HIV financing from 59% to approximately 81%. This growing concentration reflected the substantial contraction of financing from other donors, rather than a comparable expansion of US contributions. In 2025, US disbursements fell from US$6.7 billion to US$4.6 billion, while contributions from other donor governments remained broadly unchanged. Total donor-government HIV financing consequently declined by 25%, from US$8.3 billion to US$6.2 billion, its lowest level since 2007.[1] Uncertainty over donor contributions also prompted the Global Fund to reduce existing Grant Cycle 7 (GC7) allocations by US$1.43 billion, approximately 11% across its three diseases, adding to pressures on country implementation.[2]

18. The January 2025 suspension of US foreign assistance initiated a period of disruption and reconfiguration, including stop-work orders, selective waivers, programme terminations and changes to implementation arrangements. US financing and health products, provided largely through PEPFAR, were delivered through international non-governmental and partner organizations primarily to local organizations and locally based international intermediaries, with limited direct government-to-government support. Waivers permitted the continuation or resumption of specified HIV services and supporting systems to enable “life-saving” services under US policy, but largely did not protect broad HIV prevention, community-led and rights-related programming. Suspended payments, workforce losses and uncertainty over permitted activities constrained implementation. Continued support for antiretroviral medicines and selected

clinical services did not necessarily sustain the full workforce, outreach, logistics, monitoring and community systems underpinning effective responses.[3] [4]

19. The America First Global Health Strategy, established in September 2025, provides a new framework for continuing US support through time-bound bilateral health agreements, increased domestic co-financing, and changed implementation responsibilities—largely to focus on national governments and local partners. Through these bilateral agreements and its contribution to the Global Fund, the United States still provides more than 73% of donor government financing for HIV. By October 2026, the US-based policy research organization, KFF, recorded agreements covering 36 countries, with announced commitments totalling US$26.7 billion for 2026–2030, approximately 60% from the US and 40% from participating countries.[5] Country commitments vary substantially, from more than three quarters of the agreement's total value in Botswana to nearly US$3 billion in Nigeria. These are multi-disease global health agreements, not HIV-specific allocations or evidence of disbursement. The extent to which country commitments represent additional domestic financing remains unclear. Their implications for HIV depend on implementation, the functions financed, country fiscal capacity and the participation of affected communities.

20. International institutions are also being reshaped within the global health ecosystem. The United Nations (UN) is transforming its Joint Programme on HIV/AIDS and operating model, with implications for country support, strategic information, sustainability, human rights and community engagement.[6] [7] The Global Fund's Eighth Replenishment subsequently secured US$12.64 billion in pledges, with US$10.78 billion approved for country allocations for 2026–2028. The new allocation framework places greater emphasis on countries with high disease burdens and limited economic capacity, alongside differentiated transition and co-financing arrangements.[8] [9] [10]

21. Total HIV resources in low- and middle-income countries fell by 6% to US$17.6 billion in 2025, US$4.3 billion below the US$21.9 billion estimated to be needed annually by 2030. Domestic financing increased, partially offsetting an 18% decline in international resources, and more than 55 countries have committed to increasing their contributions. Domestic resources accounted for 59% of available financing, although countries' capacities to sustain essential services and supporting systems remain uneven.[11]

22. The financial contraction extends beyond HIV, affecting broader health responses and the conditions for integration. Official development assistance (ODA) fell by 23.1% in real terms in 2025, with grants, humanitarian assistance, health programmes, civil society and core funding for UN organizations particularly affected. [12] Countries have taken steps to increase domestic financing for HIV. UNAIDS reports that domestic HIV spending increased in 2024 for the first time since the COVID-19 pandemic, and that more than 54 countries have committed to increasing their domestic contributions since 2025. Domestic HIV spending also increased slightly in 2025, although these gains have been insufficient to offset declining external assistance, particularly in low-income settings where fiscal space remains constrained. [13] Debt burdens add to these pressures, with 28 African countries spending more on debt servicing than on health. [14]

23. Initiated with UNAIDS support in 2024, country-led HIV sustainability roadmaps provide a framework for countries to assess long-term sustainability, identify national priorities and financing needs, plan changes to the organization and financing of their HIV responses, and guide continuity planning and financing transitions where financing is

uncertain (see Box 2). Their implementation now takes place amid accelerated financing reductions and institutional change. By October 2026, more than 30 countries had undertaken the development of sustainability roadmaps.[15]

24. Foundations and other multilateral entities together accounted for about 4% of HIV resources in low- and middle-income countries in 2024.[16] Philanthropic institutions, research funders and advocacy partnerships contribute to innovation, catalytic financing, market shaping and public mobilization. Their involvement can also influence research agendas, investment priorities and the selection of interventions. Unlike intergovernmental institutions, philanthropic organizations are not necessarily subject to public oversight or accountability to Member States. Transparency in funding relationships, disclosure of interests and independent assessment of comparative effectiveness, affordability and sustainability are therefore important to ensure that investment decisions reflect national priorities and the full range of effective treatment, prevention and community responses.[17]

1.2 Global HIV progress, continuing gaps and inequalities

25. The global HIV response has made substantial progress, although significant challenges and inequalities remain. Between 2010 and 2025, new HIV infections fell by 42% and AIDS-related deaths by 57%. Nevertheless, in 2025, approximately 1.2 million people acquired HIV and 570 000 died from AIDS-related causes. There were around 1 million more infections and 400 000 more deaths than if the world had been on track to meet global targets.[18]

26. In 2025, 32.1 million of an estimated 41.0 million people living with HIV received ART (78%), while approximately 10.7 million were not virally suppressed. Treatment coverage was lower among adult men (74%) than adult women (84%), and substantially lower among children (55%). Of the estimated 1.3 million children living with HIV, approximately 570 000 were not receiving treatment, and 670 000 were not virally suppressed. ART coverage among pregnant women living with HIV reached 87%, leaving continuing gaps in preventing vertical transmission. Closing gaps in diagnosis, treatment access, retention and viral suppression offers substantial opportunities to reduce HIV-related illness, deaths and transmission. In 2025, approximately 290 000 adult men and 220 000 adult women died from AIDS-related causes. Tuberculosis (TB) remains the leading cause of death among people living with HIV, accounting for an estimated 150 000 deaths in 2024.[19]

27. Expanded ART has increased survival and life expectancy among people living with HIV, creating growing needs for long-term, integrated care. The number of people living with HIV aged 50 years and older has risen from 3.6 million in 2010 to 11.3 million in 2025, now comprising 28% of all people living with HIV. Alongside continued prevention, diagnosis and treatment of tuberculosis, health systems must respond to ageing with HIV, noncommunicable diseases including cardiovascular disease, diabetes and mental health conditions, as well as cancers—particularly cervical cancer among women living with HIV. Sexually transmitted infections (STIs) also require sustained prevention, screening and treatment, both as health priorities in their own right and as part of comprehensive sexual and reproductive health services. These changing and overlapping needs reinforce the importance of strengthening integration into primary health care (PHC) and universal health coverage (UHC), while maintaining specialized

HIV expertise, continuity of treatment, equitable access and community-led support.[20] [21] [22]

28. New HIV infections remain unevenly distributed across regions and populations. In 2025, approximately half occurred in sub-Saharan Africa, where women and girls accounted for six in ten new infections. Between 2010 and 2025, new infections declined in Asia and the Pacific, the Caribbean, eastern and southern Africa, and western and central Africa, but increased in eastern Europe and central Asia (17%), Latin America (25%), and the Middle East and North Africa (78%). Among adolescent girls and young women aged 15–24 in sub-Saharan Africa, new infections declined by approximately 56% between 2010 and 2025, but an estimated 160 000 acquired HIV in 2025. HIV incidence among young women remains three to four times that among their male peers. [23]

29. Gender inequality, violence, unequal power in sexual relationships, economic insecurity, and discriminatory laws and practices continue to shape HIV exposure and access to services. In pooled survey data from sub-Saharan Africa, women who had recently experienced intimate partner violence were about three times as likely to have a recent HIV infection.[24] Severe food insecurity was associated with a two-fold higher risk of recent HIV infection among women, but not among men, across six countries.[25] Sustaining progress requires effective prevention, increased treatment coverage and viral suppression among men, social and behavioural approaches, and structural responses that address gender inequality and violence.[26] [27]

30. In 2024, key populations and their sexual partners accounted for approximately 26% of new HIV infections in sub-Saharan Africa and about two thirds elsewhere. HIV prevalence among sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and people in prisons and other closed settings remains substantially higher than in the general adult population in many settings. Prevention coverage is uneven, particularly for people who inject drugs. In countries with available data for 2020–2024, median reported experience of physical and/or sexual violence in the preceding 12 months was 22% among transgender women (21 reporting countries), 23% among people who inject drugs (18 countries), 20% among sex workers (40 countries), and 8% among gay men and other men who have sex with men (36 countries). These are medians across reporting countries, not global prevalence estimates.[28]

31. HIV treatment and prevention form a continuum. ART protects the health and survival of people living with HIV, while sustained viral suppression prevents onward sexual transmission. Diagnosis, linkage to care, retention and adherence support are therefore foundational to both treatment and prevention outcomes.[29] [30] Complementary prevention responses reduce new infections and future treatment needs through biomedical, behavioural, social, community-led and structural approaches that respond to patterns of transmission, exposure and vulnerability.[31]

1.3 Country and community leadership, equity and the enabling environment

32. Communities entered the financing contraction with strong policy recognition but uneven institutionalization, financing and legal protection. Since US financing supported a substantial share of community-led services and functions, abrupt reductions and shifts in external support have severely disrupted community-led responses, placing some service delivery, mobilization, advocacy and independent accountability functions at risk. The 2026-2031 Global AIDS Strategy and Political Declaration recognize the importance of community-led responses and domestic financing mechanisms, including social

contracting.[32 33] However, only 62 of 106 (or 58%) countries reporting in 2022–2025 had laws, regulations or policies on social contracting that enable communities to secure domestic funding for service delivery. In 12 countries with recent national AIDS spending assessments, international sources provided 99.4% of resources for community-led organizations. In 2024, organizations led by people living with HIV could legally register in more than 80% of reporting countries, compared with 45–60% for organizations led by other key populations.[34 35] These differences illustrate the gap between policy recognition and the financing and institutional conditions required for community-led responses to operate sustainably.

33. HIV financing reductions are occurring alongside shrinking civic space and growing opposition to gender equality and to the rights of women, girls, key and other marginalized populations. They intersect where funding policies restrict support for sexual and reproductive health, gender equality and key populations. In 2025, civic space was repressed or closed in 83 of 198 countries and territories.[36] Punitive laws remain widespread, including the criminalization of same-sex sexual relations in 64 countries and aspects of sex work in 168.[37] These restrictions can undermine the ability of community organizations to operate, access financing, advocate for affected populations and deliver essential services.

34. Stigma and discrimination compound these constraints. Across 34 countries, a weighted average of 39% of adults aged 15–49 years held discriminatory attitudes towards people living with HIV. In 25 countries with Stigma Index 2.0 data, 25% of people living with HIV reported experiencing stigma or discrimination when seeking non-HIV-related health care in the previous 12 months, compared with 13% when seeking HIV care. Services may remain available, yet fear, discrimination and violence undermine effective access.[38]

35. Government, sectoral and community leadership are complementary. National authority over priorities should be exercised through inclusive processes in which affected communities have real influence. Meaningful community participation requires influence over decisions and independent capacity for monitoring, advocacy and accountability. Where domestic mechanisms reimburse only specified services, mobilization, rights protection and independent monitoring may remain unfunded. Community organizations should not be treated as unpaid substitutes when financing is withdrawn.

1.4 A response built through shared responsibility, solidarity and community action

36. International and domestic investment, alongside community action, enabled major advances in HIV treatment and prevention. Global treatment coverage rose from 24% in 2010 to 78% in 2025, and in 2024 PEPFAR supported treatment for 20.6 million people and more than 340 000 health workers.[39]

37. PEPFAR's substantial investment in the HIV response, its programme priorities and implementation arrangements shaped both the consequences and visibility of recent funding reductions and shifts. Much bilateral financing was channelled through implementing partners outside national budgets, supporting health workers, laboratories, procurement, data systems and community-led services within and alongside public health systems. These arrangements expanded service capacity but also created dependencies that were not always fully documented within national planning and financing systems. Following the suspension and termination of awards, governments

and communities faced difficulties identifying which personnel, services and supporting functions had been withdrawn, compounded by interruptions to routine PEPFAR data reporting.[40 41 42]

38. Community organizations and networks have been integral to the HIV response since its earliest years, often emerging through mutual support, collective action and advocacy before large-scale donor financing. Their contribution extends beyond contracted service delivery to mobilization, rights protection and independent accountability. They enable people living with and affected by HIV to identify shared needs, organize collectively, influence decisions and pursue their own priorities.[43 44]

39. Dependence on external financing varies substantially across regions and countries. In 2024, domestic resources accounted for 52% of HIV financing in low- and middle-income countries overall, but only 33% in sub-Saharan Africa.[45] In eastern and southern Africa, international donors provided 61% of the US$9.8 billion available for HIV in 2022, with PEPFAR and the Global Fund together accounting for 52.5% of all international assistance. In western and central Africa, international sources financed around 60% of HIV resources in 2022.[46 47] Dependence on a single donor also varied. Before the 2025 reductions, PEPFAR financed more than 60% of HIV-related expenditure in Haiti, Mozambique, Nigeria, the United Republic of Tanzania and Zambia, and 30–60% in the Dominican Republic, Eswatini, Malawi, Rwanda and Ukraine, while Brazil, India, South Africa and Thailand had low dependence.[48] These differences expose the limitations of a financing architecture reliant on voluntary donor contributions and uneven national fiscal capacity.

40. HIV prevention, including dedicated programmes for adolescent girls and young women such as DREAMS, key-population services, community-led functions, technical assistance and data systems, has depended heavily on external financing, particularly from the United States.[49] In 2024, prevention accounted for 11% of HIV funding in low- and middle-income countries, and 66% of it was externally financed.[50]

1.5 Sustainability and transition under changing financing conditions

41. The current financing contraction is reshaping ongoing sustainability-focused transition and integration efforts by countries. The Global AIDS Strategy 2026–2031 and the 2026 Political Declaration emphasize country and government leadership, meaningful community leadership, appropriate integration into primary health care and universal health coverage, and shared domestic and international responsibility.[51 52] These priorities build on earlier sustainability discussions, including the 2024 Programme Coordinating Board (PCB) thematic segment on sustaining the gains of the HIV response, and existing sustainability roadmaps.[53]

42. Responsible transition should be predictable, transparent, jointly planned, differentiated, informed by epidemic needs, and assessed for equity. Communities and affected populations should participate meaningfully in decisions on priorities, financing, implementation and monitoring.[54] Transition may involve increased domestic financing and appropriate health-system integration, but continued international support will remain necessary where fiscal capacity, institutional readiness or political and legal conditions prevent essential functions from being sustained equitably—particularly for community-led responses. Responsible transitions also require costed, funded mitigation plans that identify populations and essential functions at risk, the measures needed to maintain effective access, the institutions responsible for implementation, and the financing and

timelines needed. These plans should be developed with affected communities and incorporate gender-responsive measures, including protection of sexual and reproductive health services, gender-based violence prevention and response, and community-led functions. Transition milestones should be linked to demonstrated service continuity, equitable access and meaningful participation, rather than solely being linked to increased domestic financing commitments or the transfer of financial responsibility.[55]

43. Analysis of household surveys in 15 countries found that HIV programmes achieved more equitable outcomes on selected measures than general health services, suggesting that wholesale absorption into broader health systems could put these gains at risk. A separate analysis of data from 182 countries found that integration of HIV with other health services was positively associated with equity across the HIV treatment cascade. However, discriminatory attitudes towards people living with HIV, gender inequality and homophobia were associated with diminished equity, while stronger civil society engagement was associated with more equitable HIV outcomes.[56]

44. Restrictive legal environments, humanitarian crises and displacement within and across countries further constrain transition. Continuity of HIV care in these settings depends on protection, food security and other essential services.[57]

45. Sustainability should be judged by the continuity, quality, equity and accountability of essential functions, rather than preserving every existing institution or programme. Immediate obligations to protect people and services must be distinguished from longer-term decisions about financing and delivery. Community and structural functions must also be sustained to protect access, equity, rights and accountability of the HIV response.

Pillar 1. Impact of funding cuts on people and services of the HIV response

46. The evidence compiled for this pillar comes from programme data, facility and partner surveys, community reporting and modelling. These sources are complementary but incomplete, and many surveys are not representative.

2.1 Effects on people living with, affected by and at risk of HIV

47. Funding cuts affected HIV response functions unevenly in 2025–2026. ART provision for many established patients was relatively protected, while testing, linkage, prevention, community-led responses and supporting systems experienced greater disruption.

48. Since the US was the largest investor in community and key-population HIV services, people dependent on community and key-population services were particularly affected. For example, a survey of 166 PEPFAR-funded prime implementing partners in 46 countries (November 2025–April 2026) found that 73% of surveyed partners previously providing key-population services reported permanently ending at least one such service. Around two-thirds permanently stopped key-population outreach, structural interventions or gender-based violence services.[58] In Nigeria, after one-stop shops for key populations were reconfigured into treatment-focused community service coordination centres, national programme data showed declines between the first and second quarters of 2025 of 51% in HIV prevention reach, 70% in HIV testing and 83% in pre-exposure prophylaxis (PrEP) initiation.[59]

49. Early programme data illustrate different patterns of disruption across HIV service functions. In 129 clinics across eight programmes in Kenya, Uganda and the United

Republic of Tanzania, completed visits remained broadly stable during the first five weeks after the January 2025 funding interruption, while new enrolments declined from 2 695 to 1 144 (58%) and viral load testing from 15 416 to 10 863, compared with the corresponding 2024 period.[60] In Johannesburg, South Africa, routine programme data showed 8.5% fewer HIV tests, 31% fewer diagnoses and 30% fewer ART initiations in the first quarter of 2025 than in the first quarter of 2024, following termination of activities funded by the US through the US Agency for International Development. The authors noted possible under-recording of testing.[61]

50. Women, girls and children faced overlapping losses in services and social support. For example, in 165 facilities funded by the US through the US Centers for Disease Control and Prevention across four countries, early infant diagnosis remained 12% lower in Angola and 18% lower in Zambia during the seven weeks following service resumption (12 February–31 March 2025), compared with the period before the stop-work orders, while HIV testing of pregnant women was 28% lower in the Democratic Republic of the Congo.[62] Full-year national data suggest that countries prioritized the resumption of services to prevent vertical transmission, which were among the services permitted under the January 2025 waiver.[63] Risks nonetheless remain. In eastern and southern Africa, about one third of new HIV infections among children follow maternal HIV acquisition during pregnancy or breastfeeding, a pathway that depends on prevention for women, postnatal retention and community support such as mentor mothers.[64] Children already living with HIV also depend on case-finding, paediatric treatment, viral load monitoring, retention and family and community support. Services for orphans and vulnerable children were excluded from the January 2025 waiver, exposing important caregiving and social support functions to disruption. The extent to which these functions were subsequently restored or replaced remains uncertain. Evidence on subsequent paediatric outcomes remains limited, although a review of donor funding disruptions found adverse effects on retention and loss to follow-up.[65] [66] [67] [68]

51. UNAIDS reported that the funding suspension halted PEPFAR's DREAMS activities, which combine HIV prevention with educational, economic and violence-prevention support for adolescent girls and young women, in ten countries in early 2025, affecting approximately two million adolescent girls and young women. Interruptions to routine PEPFAR data reporting reduced the information available to national authorities and implementing partners for identifying affected services and supporting functions. In a 2025 rapid assessment involving adolescent girls and young women across ten sub-Saharan African countries, 48% reported that their communities had experienced disruption in access to HIV prevention, treatment and sexual and reproductive health services.[69] [70] Additionally, in a 2026 survey conducted by UN Women of 855 women-led and women's rights organizations in humanitarian settings across 52 countries and contexts, not specific to HIV, 84% reported that access to services for women and girls had worsened since January 2025.[71]

52. Stigma, criminalization, displacement and poverty affect access to and use of services, and these effects are compounded by funding shifts. For example, in contexts where specialized or community sites closed, remaining public services were not always accessible or acceptable. In Malawi, former drop-in centre clients were reportedly turned away when seeking STI care. In South Africa, some clients had to travel further after community medicine delivery ended.[72]

2.2 Effects on the essential HIV service package

53. While the essential ART provision for established patients was relatively protected, entry into care and supporting functions weakened. Globally, 32.1 million people received ART at the end of 2025, approximately 3% more than in 2024. However, across PEPFAR-supported sites, annual HIV testing fell by 18%, PrEP initiations by 33%, and the direct-service workforce by approximately 62 500 (24%).[73 74]

54. HIV testing and linkage to treatment and care declined markedly where delivery relied on community health workers. Among surveyed PEPFAR partners offering community testing, 82% reduced or halted the service, while spending on community testing fell by 30%, compared with 16% for facility-based testing.[75] Across PEPFAR-supported community service sites, HIV tests fell by 42% and new diagnoses by 36% between 2024 and 2025.[76] More than 90% of surveyed partners reported disrupted outreach and peer education, while 88% and 85% respectively reported disruption to community adherence clubs and community return-to-care services.[77] These disruptions threaten treatment continuity even where antiretroviral medicines remain available. A rapid survey of 76 clinics and programmes in the International epidemiology Databases to Evaluate AIDS (IeDEA) consortium across 32 countries in mid-2025 found that patient tracing was suspended in 33% and adherence support in 29%, weakening the systems needed to maintain retention in care and sustained viral suppression.[78]

55. US financing has been a major source of support for HIV prevention programmes. Recent reductions have therefore been consequential, with PEPFAR spending falling by 51% between fiscal years 2024 and 2025. Oral PrEP provision was also interrupted and support for condom programming declined.[79] In an interrupted time-series study of four non-governmental organizations serving mainly key populations in Uganda and Zimbabwe affected by stop-work orders and sustained funding reductions, prevention services in February 2025 were 37–63% below average 2024 levels, PrEP 43–72%, treatment 22–32% and testing 59–64%, depending on the model. Services remained well below 2024 levels through March 2026.[80]

56. Broader HIV prevention responses also experienced major reductions. Among surveyed PEPFAR partners, 92% reported disruptions to violence-prevention and response services, while spending on socioeconomic support fell by 63%. Of partners previously providing key-population outreach, 97% reported disruption.[81] Community outreach is itself a prevention intervention and a route to prevention services, prevention products, discussions about safer behaviours and practices, norm shifts and support. Disruptions to peer outreach, behavioural interventions, harm reduction, safe spaces and programmes addressing violence and economic vulnerability may weaken complementary pathways through which people reduce exposure and use prevention services. [82 83]

57. Clinical and community services are interdependent. Protecting medicines and facilities is essential, but effective coverage also depends on diagnosis, confidential and acceptable access, practical prevention options, continuity of care and social support.

58. Integrated TB/HIV services also show emerging pressures. Among people diagnosed with TB and living with HIV, ART coverage declined from 91% in 2024 to 87% in 2025. The number of people living with HIV initiating TB preventive treatment also fell from approximately 1.8 million to 1.5 million, although coverage among those newly enrolled

on ART increased. WHO identifies reduced international HIV financing as a possible contributor to these trends, but the extent of its influence remains uncertain.[84]

Box 1. Treatment and prevention as a continuum: protecting viral suppression and preventing new infections

Effective antiretroviral treatment prevents HIV-related illness and premature death, while sustained viral suppression prevents sexual transmission of HIV.[85] [86] These benefits depend on timely diagnosis, linkage to treatment, retention and re-engagement in care, adherence support and appropriate laboratory monitoring. Maintaining treatment continuity is therefore fundamental to both individual health and HIV prevention.

Funding reductions have affected functions that support treatment effectiveness. In the IeDEA survey, 24% of responding sites reported disruptions to viral load testing.[87] In an East African IeDEA analysis, viral load testing declined by approximately 30% during the initial five-week comparison period, although visits by established patients remained broadly stable. Viral suppression among those tested declined from 91% to 88%, although changes in testing coverage may affect interpretation.[88] Across PEPFAR-supported sites, viral load testing declined by 10% between 2024 and 2025, with larger reductions at intermittently reporting sites.[89] These findings raise concerns about the capacity to identify treatment failure and support sustained viral suppression, particularly where entry into care, retention or community-based support is weakened.

The consequences extend beyond monitoring. Late diagnosis and treatment interruption increase the risk of advanced HIV disease and HIV-related mortality. Before the funding reductions, an estimated 25–40% of people already had advanced HIV disease when diagnosed or initiating treatment in the settings examined. Globally, approximately 74% of people living with HIV were virally suppressed in 2025, underscoring the importance of closing remaining treatment gaps.[90]

HIV prevention operates through interacting pathways. Sustained viral suppression reduces infectiousness; condoms, harm reduction and changes in sexual behaviour and relationships reduce exposure; and voluntary medical male circumcision and pre-exposure prophylaxis (PrEP) reduce susceptibility. Prevention of vertical transmission requires sustained maternal treatment alongside comprehensive antenatal, postnatal and reproductive health services. Community mobilization and action to address gender inequality, violence, stigma, discrimination and criminalization help reduce vulnerability and support access to prevention and treatment. Effective combination prevention brings these approaches together according to local epidemiology and population needs.[91]

The clinical efficacy of prevention products does not automatically translate into population-level impact. Effectiveness depends on awareness, access, acceptability, uptake and sustained use, as illustrated by discontinuation of oral PrEP.[92] Similarly, the effects of reduced prevention financing may emerge gradually, depending on the services and supporting functions withdrawn.

Protecting treatment continuity and viral suppression is essential, but insufficient on its own. Sustaining equitable, effective combination prevention—including community, behavioural and structural responses—is equally important to preventing new infections and maintaining the long-term effectiveness of the HIV response.

2.3 Effects on community capacity, community-led functions and civic space

59. Funding losses have weakened community capacity beyond the disruption of individual service contracts. Networks of people living with HIV and key-population, youth-led and

women-led organizations reported reductions in peer support, treatment literacy, safe spaces, community mobilization and participation in policy processes.[93] [94] [95] Beyond delivering services, these organizations enable collective action, representation, mutual support, rights advocacy and independent accountability. Losses of financing, personnel and organizational infrastructure can weaken these functions even where some services continue through other providers. Capacities involving community relationships, institutional knowledge and association do not transfer to other formats of support or delivery.

60. Community-level accountability mechanisms have been disrupted or halted. Among surveyed PEPFAR partners, 62% (23 of 37) of those that had supported community-led monitoring (CLM) reported permanently stopping it.[96] South Africa's Ritshidze community-led monitoring initiative, through which people living with HIV and affected communities assess the accessibility and quality of public HIV and tuberculosis services, experienced reductions in financing.[97] [98] An analysis of 210 Global Fund grants across 93 countries, representing 91% of the value of funding reductions identified in the 2025 reprioritization exercise, found reductions relative to previously approved budgets of 22% for community systems strengthening and, at the international (multi-country) level, 71% for community-led advocacy and monitoring of domestic resource mobilization.[99]

61. Women-led HIV organizations have experienced particularly severe losses, with consequences extending beyond service delivery to community leadership, peer support, advocacy and rights protection. A rapid assessment conducted by the International Community of Women Living with HIV in early 2025 found that more than 60% of surveyed women-led HIV organizations had lost financing or been forced to suspend essential programmes. These losses can weaken access to trusted support for women living with HIV while reducing their capacity to organize, represent their interests and participate in policy and financing decisions.[100] In a survey by UN Women, the most affected areas of work were capacity development on gender in the context of HIV (27%), gender-based violence support services (27%), sexual and reproductive health services (24%), and HIV testing and prevention services (22%).[101]

62. In a voluntary survey conducted by UN Women of women-led and women's rights organizations working in humanitarian settings, 77% had lost staff, 45% had lost specialist expertise that could not be easily replaced, 33% reported losing institutional knowledge and community relationships, and 65% relied on unpaid or substantially voluntary work.[102] Community-based workers were also affected. Across PEPFAR-supported sites, ancillary direct-service workers (community staff, community-based social workers and community case managers) fell by 34% between 2024 and 2025.[103] The loss of trust, leadership and community connections may persist even if financing later resumes.

63. Broader humanitarian-sector evidence illustrates related losses in gender-based violence and protection services, although it is not specific to HIV programmes. In a 2026 UN Women assessment, 62% of surveyed organizations reported that safe spaces and women's centres were unavailable or significantly reduced, while 61% reported comparable reductions in gender-based violence case management services. These findings underscore the importance of assessing whether financing changes maintain access not only to HIV services but also to related protection, psychosocial and referral functions.

64. Financing reductions have coincided with changes to funding policies and heightened legal and political restrictions affecting some key populations and civil-society organizations. Criminalization and restrictions on freedom of association predate recent financing changes in many settings. Surveyed PEPFAR implementing partners reported changes in award conditions and programme eligibility requirements affecting the scope of supported activities, including some gender equality and rights-related responses. [104] These reported changes suggest that the consequences for community organizations may extend beyond reductions in resources to restrictions on the activities they can support. The precise scope and implications of individual restrictions require verification against the relevant US funding-policy instruments and award conditions.

2.4 Effects on the systems that support the HIV response

65. Funding cuts affected the infrastructure supporting HIV services. External financing helped sustain health workers, laboratories, procurement and logistics, data systems, and management capacity. In May 2025, South Africa's Minister of Health reported that 8 061 of 15 539 PEPFAR-funded workers across 27 districts had lost their jobs, while 7 478 remained employed at that point.[105] These figures reflect PEPFAR-funded employment losses at that date, not exclusively frontline clinical posts. In Johannesburg, programme investigators linked reductions in diagnosis and treatment initiation, in part, to the loss of counsellors and data capturers.[106] Such losses can impair publicly delivered services even when facilities and medicine supplies remain in place.

66. Disruptions to health product supply, laboratory services and programme operations varied across settings. In the IeDEA survey, 28% of responding sites reported reduced medication availability, including antiretroviral stockouts or shortages in 22%, and 34% reported laboratory disruptions, including to early infant diagnosis (24%), HIV diagnosis or confirmatory testing (18%) and drug-resistance testing (14%); disruptions to service delivery and clinic operations were more common, at 47% each.[107] Almost half (47%) of PEPFAR implementing partners delivering services directly also reported difficulties obtaining health products and supplies, including condoms, laboratory supplies, PrEP and HIV treatment, and 64% of partners that had provided HIV laboratory services reduced or stopped them.[108] Laboratory capacity underpins diagnosis, treatment monitoring and the detection of treatment failure and drug resistance, so its erosion affects both treatment outcomes and prevention. The consequences depended on existing stocks, procurement arrangements and national capacity to absorb previously donor-financed functions.

67. Strategic information and oversight capacities were also reduced. Losses of data staff, community-led monitoring and surveys weakened the ability to identify who was no longer being reached, particularly people outside facilities and populations facing exclusion.[109] [110] Within the 210 Global Fund grants across 93 countries analysed following the 2025 reprioritization exercise, representing 91% of the total value of reprioritization reductions, revised budgets reflected reductions of 23% for monitoring and evaluation systems and US$65 million for human resources for health, relative to previously approved budgets.[111] Reporting delays, changing reporting-site coverage and reduced data capacity further complicate interpretation of service trends.[112]

68. Constrained public budgets, displacement and humanitarian crises have compounded the consequences of financing reductions. In fragile and conflict-affected settings, HIV service continuity depends not only on antiretroviral medicines but also on functioning

health systems, security, food assistance, protection and access to services for displaced populations. By July 2026, UNHCR had received only 32% of its annual funding requirements, illustrating the wider contraction in humanitarian resources.[113] Reductions in humanitarian health and protection services increase risks for people living with and vulnerable to HIV, particularly where displacement, food insecurity and disrupted public institutions already constrain access.

2.5 Why impacts differed between populations and settings

69. A relatively small donor contribution can sustain otherwise unfunded services. In Ghana, the 2025 pause affected activities at more than 120 health-care sites across two regions and 10 civil-society organizations, including specialized key-population and rights-related functions.[114]

70. Replacement financing depends on fiscal capacity, institutional arrangements and political willingness to fund specific populations and functions. Reforms also require time, political leadership and alignment across financing, regulatory and service delivery systems, which may not be achievable within the limits imposed by abrupt funding reductions. Domestic budgets may protect access to medicines or clinical visits without replacing peer outreach, legal assistance, community mobilization or independent monitoring. Restrictive laws and stigma may prevent organizations from registering or receiving funds and deter clients from using integrated public services. Weak systems, humanitarian emergencies and displacement exacerbate the consequences of even relatively limited losses.

71. Geographic impacts vary. Reports from eastern Europe and central Asia describe threats to community outreach and support for people who use drugs and other key populations, alongside restrictive operating environments.[115] In Asia and the Pacific, regional networks report interruptions to outreach, PrEP demand generation, and community monitoring, as well as difficulty accessing domestic funding.[116] [117] In the Middle East and North Africa, longstanding resource gaps and conflict, including in Sudan, heighten vulnerability.[118]

72. As implementation of the new US Government bilateral health agreements progresses, the extent to which they will sustain essential HIV services and supporting functions disrupted in 2025–2026 remains uncertain. Continued monitoring of HIV-specific commitments, allocations and disbursements, implementation arrangements, and coverage of prevention, treatment and community-led services will be important in assessing continuity and equitable access.

2.6 Synthesis: what was maintained, what was lost and what remains uncertain

73. ART for many established patients was relatively protected, while HIV testing, entry into care, prevention, community-led responses and supporting systems were disrupted. The pattern varied between populations and settings. Community financing losses also affected trusted relationships, collective action, advocacy and independent accountability, functions that cannot necessarily be replaced through clinical service transfer or short-term contracts.

74. Losses in testing, linkage to care, laboratory monitoring, adherence support and outreach may undermine viral suppression and prevention even where medicines remain available.

75. Evidence is concentrated in PEPFAR-supported settings, particularly sub-Saharan Africa. Implementing-partner and community surveys are not nationally representative. Independently measured continuity, equity and outcomes remain limited.

Pillar 2. Country and community responses, adaptation and building forward

76. Governments, communities and partners responded through emergency measures, reprioritization and changes in financing and delivery.

3.1 Community emergency responses

77. Community organizations mobilized emergency referrals, peer support and local resources. These responses frequently preserved selected activities at reduced scale. Among 149 organizations serving people who use drugs, 44% prioritized core services, 40% increased volunteer or peer-led work, and 37% referred clients elsewhere; 52% had not replaced lost funding.[119] A survey of 79 organizations in 47 countries found that 63% reported direct operational effects, while allowances for 2 275 peer educators and community health workers had been suspended or reduced.[120]

78. Clinics adjusted delivery arrangements. For example, among 76 HIV clinics and programmes in 32 countries, 21% expanded multimonth dispensing, 11% formed new partnerships and 5% introduced telemedicine.[121] A study of 24 South African primary health-care facilities found ART provision broadly maintained despite partner-funded staffing reductions, while prevention services remained below baseline.[122]

79. Earlier shocks illustrate both the potential and limits of rapid adaptation. Following Uganda's 2023 Anti-Homosexuality Act, some drop-in centres introduced virtual service delivery and drew on local and international partnerships to sustain services, although substantial barriers to access persisted.[123] By March 2026, four key-population organizations in Uganda and Zimbabwe affected by the 2025 cuts had not restored their previous service levels.[124]

80. Community case studies submitted to the PCB in November 2026, illustrate diverse impacts and responses. In Georgia, where funding cuts coincided with tighter controls on foreign-funded organizations, the Eurasian Women's Network on AIDS moved self-help groups for women living with HIV online. This preserved some peer contact but did not replace paid staff, accessible meeting spaces or in-person support (Case study 4). Community-led research continued, but leaders worked unpaid, and online groups excluded women without reliable access or privacy (Case study 4). Other community organizations reported similar trade-offs between continuity and reduced reach. In West Africa, peer-supported linkage to testing and PrEP for gay men and transgender people was discontinued and had not resumed; volunteers could not replace trained peer educators (Case study 9).

3.2 Community monitoring, access and influence

81. CLM and community-led responses (CLR) enable affected people to identify service barriers and influence decisions. CLM often focuses on access and quality. CLR can examine wider social, structural and rights questions. Both require community authority over priorities, methods and findings.[125]

82. Ritshidze previously monitored more than 400 South African primary health-care facilities quarterly. Following the loss of US funding, the initiative continued through a scaled-down monitoring operation implemented by the Treatment Action Campaign, an established partner in Ritshidze. Between April and June 2025, monitoring covered 326 facilities across six provinces. Findings indicated reduced capacity in 48% of monitored clinics. [126] [127]

83. REDCA+ dismissed staff conducting US-funded CLM across four Central American countries in January 2025. It continued advocacy using earlier findings, but systematic monitoring ceased (Case study 3). In the Latin American survey, 57% of organizations had suspended and 30% had reduced CLM (Case study 11). In Central America and the Dominican Republic, CLM, stigma-index studies and human-rights work were among the functions least likely to receive replacement funding (Case study 10).

84. In South Africa, government instructions to provide same-day ART and accept transfers without referral letters did not eliminate access barriers. For example, community monitoring found patients turned away from chronic medicine collection. In Malawi, people from key populations reported being refused treatment for STIs at public clinics after drop-in centres closed.[128]

85. Available survey evidence indicates uneven community participation in financing, reprioritization and transition decisions, with particularly limited involvement reported by some affected populations. In a global survey of organizations serving people who use drugs, only 11% reported consistent and meaningful involvement in funding, reprioritization or transition decisions, while 47% reported no involvement with their Country Coordinating Mechanism.[129] Community engagement nevertheless influenced some Global Fund reprioritization decisions. Frontline AIDS reported the reinstatement of more than €1.9 million in Chad and approval of a redesigned €194 311 CLM budget in Niger. In Uganda, priority prevention programmes and additional support for five community drop-in centres were retained. Partners in Kenya reported protecting key-population services despite grant reductions.[130] There is less evidence on whether young people, including adolescent girls and young women and youth-led networks, have been able to influence financing and transition decisions.

86. Examples of programmes being retained following community engagement do not necessarily demonstrate meaningful participation by the populations concerned. Nevertheless, these examples demonstrate that community engagement can influence financing and reprioritization decisions. Assessments should distinguish consultation from meaningful participation by examining who was represented and whether affected communities demonstrably influenced priorities, resource allocation, implementation and accountability.

87. Existing monitoring frameworks capture community-led services and policy commitments only partially, and rarely measure organizational independence or influence.[131] [132] [133] Evidence on CLM outcomes remains limited, while community data require safeguards against surveillance of criminalized populations.[134] [135]

88. Participation mechanisms should assess who is represented and who influences decisions. The presence of civil society representatives does not necessarily ensure meaningful participation by women living with HIV, adolescent girls and young women, women from key populations, marginalized populations, or youth-led and women-led

organizations. Participation should include timely access to information, representation in priority-setting bodies, influence over resource allocation and mechanisms to hold decision-makers accountable.

3.3 Adapting to a changed funding environment

89. Organizations formed coalitions, shared infrastructure, reduced costs and sought alternative resources. These measures sometimes preserved activities but could reduce organizational autonomy and capacity.[136] Wider surveys document organizational restructuring and efforts to diversify financing, although evidence of sustained results remains limited.[137] [138]

90. Some countries entered the financing contraction with established mechanisms for domestic financing of community-led services. Social contracting can support specified functions through public purchasing, although legal, administrative and political conditions affect feasibility. This requires consideration in relation to laws, regulations or policies permitting domestic financing of community service delivery. Such provisions do not establish that organizations receive adequate financing or that independent mobilization, advocacy and accountability are sustained.[139] [140]

91. Brazil's HIV response has been funded almost entirely through the national Unified Health System since 1996, underpinned by a legal entitlement to free ART, centralized procurement and price negotiation, and public production of medicines. Routine national data indicate that ART, testing, PrEP and post-exposure prophylaxis continued without interruption in 2025–2026. Some externally financed civil society activities were affected, but this was not necessarily a wider disruption (Case studies 6–8). Where ministries already provide HIV care that is free of charge, as reported in Central America and the Dominican Republic, social contracting for community-delivered services has been difficult to establish (Case study 10). In a multi-country study, only 26% of Global Fund Country Coordinating Mechanism members reported that the State already paid community organizations (Msingi study, cited in case study 5).

92. Contracts for defined services do not necessarily finance mobilization, advocacy, independent monitoring or core organizational capacity. Criminalization can also exclude organizations serving key populations from public contracting.[141] Financing arrangements should therefore distinguish contracted service functions from independent civic and accountability roles.

93. Adaptation can transfer costs to households and communities. For example, patient cost-sharing was reported at 14% of surveyed sites in Central Africa and Asia and the Pacific.[142] Greater reliance on unpaid work shifted costs and responsibilities to community workers and organizations. In the wider humanitarian sector, 65% of women-led organizations relied on unpaid or substantially voluntary labour, and 48% reported increasing burnout among remaining staff.[143] Facilities that lost partner-funded staff relied on task shifting and temporary staffing.[144]

94. In Kenya, some facilities introduced fees for laboratory tests, and Coalition PLUS reported that viral load testing costs had shifted to patients or the State in 40% of cases (case studies 1 and 5). Greater reliance on volunteers and unpaid peer workers can maintain limited activities in the short term while weakening reach, quality, organizational resilience and longer-term sustainability.

3.4 Government responses

95. Domestic financing already provides the largest share of resources for HIV responses in low- and middle-income countries. UNAIDS estimates that domestic resources accounted for 59% of the US$17.6 billion available for HIV responses in 2025. Domestic financing increased by approximately 4% in 2025, partially offsetting an 18% decline in international resources, showing the commitment of many governments to sustaining HIV services.[145] However, national financing capacity varies considerably, and increased domestic expenditure has not fully compensated for declining international resources, particularly in countries with constrained fiscal space.

96. UNAIDS and the Joint Programme have supported countries in responding to these financing challenges through strategic information, financing analysis, technical assistance and country-led HIV sustainability roadmaps. These processes support national priority-setting, the identification of essential functions, domestic resource mobilization and planning for sustainable financing and institutional arrangements, while recognizing the importance of community leadership and continued international solidarity. [146]

97. Across Asia and the Pacific, domestic financing has become a major source of support for HIV responses. In 2024, approximately 82% of regional HIV financing came from domestic resources, although this proportion falls to 49% when China, India and Thailand are excluded.[147] WHO and UNAIDS report that China, India, Malaysia, Singapore and Thailand finance more than 90% of their HIV responses domestically, while 12 additional countries have reported plans to increase domestic funding since 2025. Fiji allocated an additional US$4.5 million to its urgent HIV response amid a rapidly expanding epidemic, while Papua New Guinea allocated US$13.5 million in emergency funding for HIV, tuberculosis and malaria.[148]

98. Governments responded through emergency coordination, service guidance, budget measures, workforce absorption and delivery changes. More than 55 countries reported plans to increase domestic HIV financing after the 2025 reductions, but commitments and implementation must be distinguished.[149]

99. Emergency measures focused on treatment access. For example, Malawi issued facility guidance and Nigeria convened a technical working group on AIDS, tuberculosis and malaria to coordinate responses.[150] [151] [152]

100. Financing and workforce measures were announced on different terms and at different stages of implementation. In Nigeria, a national gaps assessment informed approval of a supplementary budget of approximately US$200 million, without establishing subsequent expenditure or service restoration.[153] [154] Guatemala's Ministry of Health assumed the salaries of 81 staff in HIV comprehensive care units and replaced financing lost by a PrEP provider, although gaps persisted in prevention for key populations.[155] In Central America and the Dominican Republic, PEPFAR implementers suspended some services in late January 2025 across a network that had included 110 care and treatment sites, with gradual resumption from March. Ministries reorganized comprehensive care, reassigned staff to activities previously supported by PEPFAR, revised antiretroviral and PrEP requirements and worked with civil society to re-engage people who had interrupted treatment (Case study 10).

101. In July 2025, the South African Minister of Health announced R753.5 million in emergency funding. The allocation was intended to help maintain services affected by donor funding reductions, including patient-facing workforce capacity.[156] [157] In December 2025, National Treasury acknowledged that the allocation was insufficient to address what it described as an approximately R7 billion loss in PEPFAR funding, although some support subsequently continued through a six-month bridge arrangement.

102. Service transfers sometimes maintained access, but many changes reflected rapid reallocations under financial pressure rather than planned, fully resourced integration.

3.5 Responses by the Joint Programme, the Global Fund and other partners

103. The Joint Programme supported countries in tracking the impacts of funding reductions, identifying priorities, coordinating responses and maintaining continuity of essential HIV services. Its broader resource tracking, costing and financing analysis supported national planning and prioritization, including sustainability roadmaps, Global Fund funding requests and assessments of emerging financing gaps. In the six months to June 2026, through its GC8 Virtual Support Team, the Joint Programme provided direct technical support to 18 countries, covering approximately US$4.3 billion in Global Fund allocations and US$1.8 billion in investments under the new US Government bilateral health agreements (MOUs). This support focused on evidence-based prioritization, protecting essential HIV services and community systems, and strengthening complementarity across funding sources to maximize the impact of available resources.[158] An independent evaluation identified risks to community responses and key populations arising from institutional restructuring.[159]

104. In response to a more constrained resource envelope, the Global Fund undertook a mid-cycle reprioritization of GC7 grants in 2025, resulting in reductions of approximately US$1.43 billion (11%) across the three diseases. Its guidance emphasized protecting treatment continuity and other essential interventions, including prevention commodities, harm reduction, peer workers and existing CLM. [160] [161] Country-led reprioritization processes sought to maximize impact within available resources. At the same time, analysis of a subset of revised grant budgets identified a 22% reduction in community systems strengthening allocations relative to previously approved budgets. At the international multicountry level, allocations for community-led advocacy and monitoring of domestic resource mobilization were reduced by 71%.[162] These reductions raise questions about the extent to which essential community functions can be sustained and their implications for service continuity and equitable access.

105. A November 2025 survey of 38 HIV grantmakers found that 34% reduced reporting burdens, and 21% made rapid-response grants. [163] Other partners provided targeted support, including the partial resumption of CLM in Malawi, but flexible funding directly available to community organizations remained limited. Case studies record a 10.5% reduction in one eastern European and central Asian grant and a reduction in GC7 support in Central America and the Dominican Republic from US$106.2 million to US$90.0 million (about 15%).[164] [165] Several respondents reported that disruptions were concentrated in US-funded clinics and districts, while Global Fund-supported programmes continued in some cities (case studies 2, 5 and 10).[166][167]

3.6 Sustainability, transition and integration

106. National HIV sustainability roadmaps provide a framework for managing programmatic, financing and institutional transitions. Developed before the 2025 financing reductions, they have acquired greater urgency as countries seek to protect essential functions and develop sustainable financing arrangements (Box 2).[168] [169]

Box 2. Country-led HIV sustainability roadmaps

In 2024, UNAIDS introduced a country-led approach to HIV sustainability through national sustainability roadmaps. The approach addresses political leadership and commitment to a sustainable HIV response, including assessing enabling laws and policies, sustainable and equitable financing, effective HIV services and systems. The framework emphasizes that sustainability does not mean preserving existing programmes unchanged, but transforming responses to sustain their impact, equity and effectiveness beyond 2030. Part A identifies national priorities and transformations, while Part B translates these into implementation plans. [170] [171]The roadmaps also provide a country-owned framework for aligning external financing, co-financing commitments and planned transitions with national priorities.

The roadmaps recognize community-led responses as essential to sustainability, including community service delivery, monitoring, advocacy, and participation. Country approaches illustrate different pathways. Kenya proposes increased national and county financing, integration with UHC and social contracting for community-led initiatives.[172] Tanzania's roadmap prioritizes sustainable financing, stronger community leadership and organizational capacity, and proposes social contracting and community-led monitoring as mechanisms for sustaining community responses.[173] Eswatini emphasizes community systems, human rights and the integration of HIV services into broader health systems.[174] Thailand has also developed a Community-Led Response Sustainability Roadmap aimed at institutionalizing community-led responses and securing more predictable domestic financing.

Botswana's sustainability assessment addresses community and HIV prevention functions during financing transitions. Spending assessments indicated that international partners financed approximately 90% of social enablers and 59% of prevention, while government financing covered 74% of care and treatment.[175] The roadmap identifies risks to community-led services, particularly for key populations, and proposes strengthened social contracting, financing transitions and organizational capacity development.

The 2025 financing disruptions shifted attention to immediate gaps. Rapid AIDS Response Financing Tools (RAFTs) were developed for 32 countries, alongside regional versions, to support assessments of financing losses and the prioritization of essential services, commodities and workforce needs. Their application in national planning and financing decisions varied across countries.[176] In Malawi, the Government allocated approximately US$11 million in its 2025/26 budget to recruit 6,000 health workers previously supported by US funding, with plans to absorb them into the public payroll.[177] Other countries are advancing domestic financing commitments. Côte d'Ivoire has committed to increasing annual domestic HIV financing from US$60-65 million in 2025 to US$80–85 million from 2026. Such measures illustrate immediate efforts to protect service continuity, but do not resolve the longer-term sustainability of the wider HIV response.

The roadmaps provide a framework for sustaining community-led responses, but commitments do not establish that services and capacities have been protected. Many were developed before the 2025 financing reductions and require reassessment against changing resources and priorities. Social contracting and integration into health systems may sustain essential services, but do not necessarily protect independent community advocacy, mobilization, monitoring and the organizational capacities needed to address stigma, discrimination and structural inequalities.

Sustainability roadmaps establish commitments and pathways for transition. Progress should be assessed against the financing and implementation of agreed priorities, continuity and quality of treatment and prevention, equitable access, and the preservation of community-led functions, independent advocacy and accountability.

3.7 What can be learned from country and community responses

107. Five lessons emerge from country and community responses: emergency adaptation rarely replaces predictable financing; domestic absorption and integration need resources and safeguards; community service continuity can coexist with weakened civic capacity; participation matters when it influences decisions; and transition must be assessed against equitable access and outcomes, not financing commitments alone.

108. Country submissions and organizational surveys describe adaptations, but independently measured continuity, quality and outcomes are often unavailable.

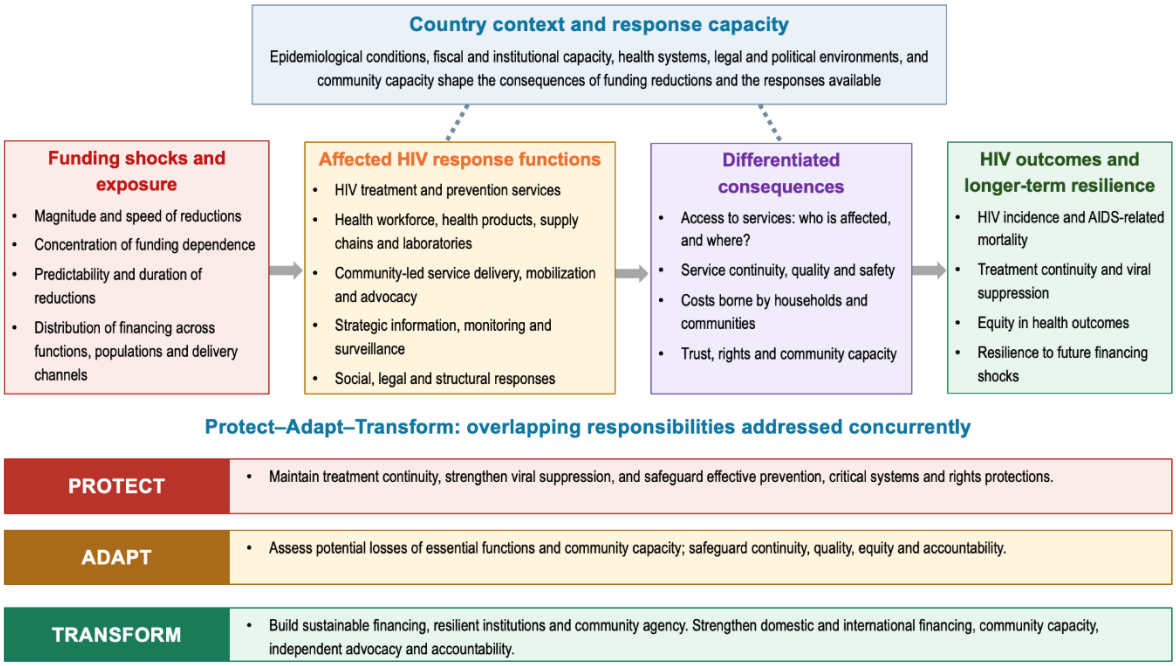
Pillar 3. Priorities for sustaining an effective and equitable HIV response

4.1 Protect, adapt and transform

109. The contraction and reconfiguration of HIV financing requires more than replacing lost resources or preserving established programmes. Responses should be differentiated by epidemic characteristics, financing exposure, fiscal capacity and the needs of affected populations.[178 179]

110. There are three overlapping responsibilities that need to be pursued concurrently: **protecting** essential functions, **adapting** programmes and delivery arrangements, and **transforming** financing and institutional systems for longer-term sustainability. Their relative emphasis will differ according to country circumstances, while specific measures may require sequencing and safeguards.

Figure 1. How funding shocks affect the HIV response, and concurrent policy responses



111. Exposure reflects the magnitude, speed, concentration, predictability and duration of financing reductions, and the distribution of financing across functions, populations and delivery channels. Reductions affect HIV treatment and prevention services; the health workforce, health products, supply chains and laboratories; community-led service delivery, mobilization and advocacy; strategic information, monitoring and surveillance; and social, legal and structural responses. Consequences for access, service continuity, quality and safety, household and community costs, rights and community capacity differ between populations and settings, depending on epidemiological conditions, fiscal and institutional capacity, health systems, legal and political environments, and community capacity. These consequences may affect HIV incidence, AIDS-related mortality, treatment continuity and viral suppression, equity in health outcomes, and resilience to future financing shocks.

4.2 Protect essential obligations and prioritize explicitly

112. Immediate obligations include reliable antiretroviral treatment, diagnosis and linkage, retention, laboratory monitoring and sustained viral suppression, alongside prevention of vertical transmission and effective prevention for populations at greatest risk. Sustained viral suppression is both a health outcome and a central prevention pathway. Protecting medicines without the systems supporting effective treatment is insufficient.

113. Prioritization should begin with local transmission dynamics, treatment gaps and patterns of exposure and vulnerability, rather than a predetermined list of interventions. It should assess the incremental contribution, cost, reach and feasibility of strengthened treatment and viral suppression, condoms, behavioural and structural responses, community responses, harm reduction, VMMC, oral and long-acting PrEP. Behavioural and structural approaches should be assessed for their potential contributions to HIV outcomes in their own right, as well as their interactions with biomedical interventions. Limitations in routine indicators should not alone determine their exclusion. Evidence of the relevance of

behavioural pathways should be distinguished from evidence of the effectiveness or cost-effectiveness of particular programmes. [180] [181] [182]

114. Choices should be transparent, revisable and informed by affected communities, balancing effectiveness, affordability, equity and rights. Epidemiological prioritization must not justify exclusion from essential care or rights protections.[183]

4.3 Integrate and consolidate responsibly

115. Integration into PHC and UHC can improve continuity and efficiency when financing, workforce, health products, referral pathways, confidentiality and accountability are adequate. Integration can benefit selected services, but this does not mean that all HIV functions can be effectively absorbed into general health systems. Readiness and outcomes should guide the pace and form of integration, including linkages with sexual and reproductive health, prevention of and responses to gender-based violence, and psychosocial services.[184] [185] Integration must also preserve linked functions, including TB screening, diagnosis and preventive treatment for people living with HIV, alongside continuity of ART, laboratory monitoring and community support.

116. Countries should retain differentiated or specialized services where general facilities cannot provide comparable safety, trust, access or quality, including for criminalized and stigmatized populations. Independent community mobilization, representation, advocacy and monitoring should remain connected to health systems without being subordinated to clinical service structures. Transition costs and the risks of interruption must be explicitly financed and monitored. Integration also requires explicit financing for community health workers, peer workers and community-based treatment and prevention support, including appropriate contracting or reimbursement arrangements. These functions should not be assumed to continue without dedicated resources.

4.4 Sustain community capacity through appropriate financing

117. In Asia and the Pacific, only 35% of 39 reporting countries had laws, regulations or policies permitting domestic financing of community-led service delivery, according to WHO and UNAIDS. Legal permission is a prerequisite in some settings, but neither legislation nor a service contract alone secures adequate funding for independent community organizing, advocacy and accountability.[186]

118. Community organizations, groups and networks sustain functions extending beyond service delivery, including mutual support, collective organization, advocacy, rights protection and independent accountability.[187] Financing should be matched to function, as different functions require different financing and institutional arrangements (Table 1). Public purchasing and social contracting may sustain defined services, while flexible core financing can support community organizing, mutual assistance and institutional capacity. Independent advocacy, rights protection and accountability require financing arrangements that safeguard organizational autonomy and protect against political interference.

Table 1. Community functions, evidence of disruption and potential financing arrangements

Community function	Examples of disruption, 2025–2026	Potential financing and institutional arrangements
Service delivery and outreach: community testing, key-population outreach, drop-in centres	82% of surveyed partners offering community testing reduced or halted services. Community-site HIV testing fell by 42%.	Public purchasing and social contracting covering full costs. Differentiated community provision where public services are inaccessible or unacceptable.
Treatment and prevention support: adherence clubs, return to care, patient tracing	88% of surveyed partners reported disruption to adherence clubs. Patient tracing was suspended at 33% of surveyed IeDEA sites.	Funded community cadres and support functions within PHC/UHC arrangements, including appropriate contracting and reimbursement.
Social and structural responses: violence prevention, socioeconomic support, safe spaces	92% of surveyed partners reported disruption to violence-prevention and response services; spending on socioeconomic support fell by 63%.	Multisectoral financing across health, social protection, gender, education and justice, complemented by flexible community grants.
Community mobilization and organization: networks, mutual support, people living with HIV, women-led, youth-led and key population-led organizations	More than 60% of surveyed women-led HIV organizations lost funding or suspended programmes.	Predictable, flexible core financing, including pooled or intermediary funds that accommodate smaller and informal organizations.
Leadership, rights and accountability: advocacy, community-led monitoring and research	62% of surveyed partners supporting community-led monitoring stopped providing it.	Independent financing for advocacy, rights protection and accountability, with safeguards against political interference.

Note: Findings are drawn from different surveys and programme reporting systems and are not directly comparable. Financing arrangements are illustrative options requiring adaptation to national circumstances. Sources: as cited in sections 2.2 and 2.3.

119. UNAIDS has published technical guidance on costing and budgeting community-led responses, which provides an operational resource for assessing the financing requirements of these functions. The choice between public contracting and direct or pooled financing should reflect legal eligibility, fiduciary readiness, community safety and organizational independence.[188] [189]

120. Smaller and informal groups need accessible financing arrangements that do not impose disproportionate registration, reporting or pre-financing burdens. Social enterprise, cooperatives, earned income and philanthropy may provide complementary resources and strengthen organizational resilience, where viable. However, commercially oriented financing can create tensions with social missions and cannot be assumed to replace sustained public and international support, particularly in settings of poverty and exclusion.[190] [191]

4.5 Financing and fiscal space

121. Financing strategies need to address immediate funding obligations, improve the use of existing resources and expand fiscal space over the longer term. More efficient

procurement, pricing, budget execution and service delivery can release resources, but savings should be demonstrated rather than assumed.

122. Domestic revenue mobilization, progressive taxation, health taxes, insurance or solidarity mechanisms, debt measures and concessional finance may contribute in different settings, but their scale, timing, equity and additionality require assessment.[192] Experience with Uganda's HIV/AIDS Trust Fund illustrates the political and institutional challenges of establishing dedicated domestic financing mechanisms. A 2019 analysis found that political considerations were central to the fund's establishment, while the earmarked tax revenues were estimated to cover only 0.5% of annual HIV resource requirements. The experience highlights the importance of assessing the revenue-generating potential, political feasibility and institutional arrangements of proposed financing mechanisms, rather than assuming that their establishment will substantially improve financial sustainability.[193]

123. Debt burdens and limited fiscal space constrain the speed of transition. Emergency bridge funding cannot be presented as a permanent financing solution, and costs should not be shifted to households.

124. KFF estimates that announced US commitments under the America First bilateral health agreements are 34% lower than previous US global health funding to the same countries over a comparable period (excluding Bolivia, Panama and the Philippines). This comparison concerns overall global health financing rather than HIV-specific funding, and compares announced commitments with previous funding levels. Financing arrangements should therefore be assessed against verifiable HIV-specific commitments, allocations and expenditure, the additionality and feasibility of domestic co-financing, the functions covered, and their effects on country authority, communities and rights. Predictable international solidarity remains necessary where domestic resources cannot sustain essential obligations. [194]

4.6 Societal enablers

125. Gender inequality, violence, stigma, discriminatory laws, criminalization, economic insecurity and restrictions on civic space shape both HIV exposure and effective access to services. Social protection, legal assistance and community mobilization are therefore integral to equitable sustainability.[195] Financing these functions requires responsibilities that extend beyond health ministries, including social protection, education, gender and justice sectors. Coordinated public financing, complemented where appropriate by flexible grants to community organizations, could support locally responsive action on social and structural determinants.

126. Equitable sustainability requires action to remove social and structural barriers, uphold the rights of women and girls and other affected populations, reform discriminatory laws and practices, and strengthen social protection, legal assistance and community-led mobilization.

127. Criminalization, discrimination and restrictions on freedom of association can further constrain organizations representing key and other marginalized populations. Sustaining community capacity therefore requires enabling legal and policy environments, protection of civic space and organizational autonomy, and the ability to advocate without political interference.[196] [197]

4.7 Governance, accountability and shared responsibility

128. The growing emphasis on health sovereignty, reflected in initiatives such as the Accra Reset, reinforces the need to align greater domestic financing responsibility with stronger country authority over priority-setting, financing negotiations and implementation. This includes strengthening national systems to manage and implement both domestic and international financing, alongside regional cooperation on pooled procurement, resilient supply chains and local or regional production of essential health products where economically and technically feasible. Meaningful participation by organizations and networks led by people living with HIV, women, young people and key populations is essential to equitable and sustainable responses. This requires opportunities to influence national priority-setting, financing allocations, programme design and transition decisions, supported by access to relevant information and independent capacity for advocacy and accountability.[198]

129. Sustaining the HIV response requires national systems that can monitor not only financing commitments and expenditure, but also access, service quality, equity, viral suppression, prevention reach, community participation and rights. Supporting the integration of accountability functions, capacities and mechanisms into national systems can strengthen long-term sustainability, while preserving independent community monitoring and accessible mechanisms for corrective action. External partners, including bilateral donors, philanthropies and advocacy partnerships, should be transparent about their funding priorities, objectives and decision-making processes, and align their support with inclusive, country-led decision-making without compromising independent community voice. These principles should extend to the development and review of bilateral financing agreements, national sustainability roadmaps and domestic resource allocation processes, ensuring that affected communities can influence decisions with consequences for service access, equity and rights.

4.8 Priorities for a sustainable transition

130. Immediate priorities are to protect treatment and prevention continuity, bridge critical gaps in community and supporting systems, safeguard strategic information, and clarify the terms of replacement financing. Medium-term priorities include costed and accountable transitions, readiness-based integration, fair financing of community services and independent functions, and transparent epidemiological prioritization.

131. Longer-term reforms should strengthen fiscal capacity, affordable procurement, rights protections, country authority and resilient community institutions. The measure of sustainability is not the completion of financing transitions or the survival of particular programmes, but the continuing capacity of countries and communities to sustain effective, equitable and accountable response functions.

5. Way forward and recommendations

132. While treatment has continued for many people already receiving care, funding reductions have disrupted other essential functions, including access to treatment, prevention, community support, rights protection and accountability. The following recommendations are framed around essential functions rather than particular programmes, and are directed to the actors best placed to act. Actions are grouped as immediate (within the next 12 months), medium-term (2027–2028) and longer-term (to

2030 and beyond). The recommendations align with the Global AIDS Strategy 2026–2031 and the 2026 Political Declaration, and should be adapted to each country's epidemic, fiscal and legal context.

133. **Protect essential functions and keep losses visible.** Governments and international partners should protect the full treatment and prevention continuum set out in section 4.2. Prevention of vertical transmission and treating HIV among children, and prevention for the populations and places with the highest incidence or vulnerability (including where incidence data are lacking, as for transgender people in many settings) remain priorities. Protection should extend through pregnancy and breastfeeding and to paediatric case-finding, treatment, retention and viral suppression. Family and community support for children affected by HIV, including orphans and vulnerable children must be addressed. TB screening, diagnosis and preventive treatment for people living with HIV requires close attention in the context of high HIV/TB mortality. Community-led responses, including outreach, peer support and CLM, should also be protected. Bridge financing should be monitored in relation to the functions it supports.

134. **Prioritize explicitly, transparently and equitably.** National priority-setting should be guided by local epidemiological evidence, treatment and prevention needs, patterns of exposure and vulnerability, and the effectiveness, cost and feasibility of available approaches. This requires assessing how to sustain and strengthen treatment and viral suppression alongside other prevention pathways, community-led responses and action on social and structural determinants. Established interventions and newer technologies should be assessed against available evidence, their incremental contribution, affordability and delivery requirements. Decisions should be public, open to review and shaped from the outset through meaningful participation by organizations and networks led by people living with HIV, women, young people and key populations. This participation should extend to financing allocations and decisions about which functions to protect, redesign, integrate or discontinue. Existing externally funded activities should not automatically be restored unchanged.

135. **Integrate HIV services responsibly.** Integration of appropriate HIV clinical and related services into PHC and UHC should proceed where continuity, quality, confidentiality and equitable access can be maintained. Integrating HIV services into general health systems does not, by itself, sustain independent community advocacy, monitoring, mobilization or accountability, which require appropriate institutional arrangements and financing. Recurrent and transition costs require financing. HIV-related needs should be defined in benefit packages including linkages with sexual and reproductive health, prevention of and responses to gender-based violence, and mental health services, and with community-led networks. Differentiated and community-led provision should be retained where general services cannot yet offer equivalent access. Data systems should include safeguards against use of health information for enforcement.[199]

136. **Finance community functions according to their roles and responsibilities.** Governments should consider extending social contracting and public procurement to community-delivered services, with financing that reflects the full costs of delivery, including organizational costs. International partners and philanthropies can complement domestic financing by supporting community organizing and representation, advocacy, rights protection and CLM, including through flexible and independent funding arrangements consistent with their respective mandates, policies and eligibility requirements. Where appropriate, intermediary arrangements may facilitate access to

financing for smaller community organizations within established governance and accountability frameworks. Countries and financing partners should explore dedicated budget lines, appropriate accreditation and reimbursement arrangements that enable community-led providers—including organizations and networks led by people living with HIV, women, young people, gender-diverse people and key populations—to participate in public purchasing and insurance mechanisms. Financing and co-financing arrangements should take account of the resources required to sustain essential community-led functions. Unpaid labour should not be considered a substitute for sustainable financing.

137. **Expand fiscal space and secure affordable health products.** Ministries of finance and health should set realistic domestic financing pathways, improve budget execution and funding release, and appraise levies, insurance and blended finance for additionality and equity. International partners and financial institutions should consider debt relief and restructuring, where appropriate, to create room for health spending. Governments and partners should strengthen equitable and affordable access to essential HIV health products through transparent pricing, pooled procurement, resilient supply chains and, where feasible, local and regional production.

138. **Sustain shared international responsibility through predictable, differentiated transitions.** Donor governments, the Global Fund and other partners should support predictable financing aligned with national sustainability roadmaps and budget cycles, consistent with their respective mandates, policies and governance arrangements and the principles of the Lusaka Agenda. Renewed solidarity from a broader group of donor governments, institutions and multilateral organizations is needed to diversify financing sources and strengthen the resilience of national HIV responses. Bilateral and co-financing arrangements should be transparent and take account of national fiscal capacity and the implications for prevention, key-population and rights functions. International support should continue where fiscal capacity or legal and institutional barriers prevent essential functions from being sustained equitably, through jointly agreed and context-appropriate transition arrangements.

139. **Protect rights as a condition of effective access.** Governments should uphold non-discrimination, privacy and freedom of association for people living with HIV and key populations, and review legal and policy barriers to effective access, including decriminalization in line with international guidance. They should provide enforceable safeguards, legal aid, rapid responses to violence and arrest, and protection of civic space. Responsibilities for violence prevention, education and social protection should be assigned to sectors with the budgets and capacity to deliver them, with eligibility that reaches migrants and criminalized populations.

140. **Strengthen accountability, strategic information and evidence.** Governments, the Joint Programme and partners should monitor effective access and essential functions as well as domestic financing shares. It is important to distinguish commitments, allocations and disbursements, and to report progress against the 30–80–60 and 10–10–10 targets, including the share of HIV financing that reaches organizations led by people living with HIV, women, young people and key populations. This includes clarifying how these targets can effectively be measured and monitored. Additionally, monitoring should assess whether community-led organizations participate meaningfully in financing, priority-setting and transition decisions, including their access to information, representation in decision-making processes and ability to influence outcomes.

141. **Community-generated data must be protected with appropriate safeguards.** Existing reporting commitments should be distinguished from new monitoring proposals and approaches still requiring evaluation. Priority evidence gaps include understanding the longer-term outcomes after the cuts. This includes understanding the implications for community-led and rights-related functions, responses in humanitarian settings, and the results of integration and social contracting.

142. **Global Solidarity**. The United States continues to provide more than 73% of donor-government financing for HIV, underscoring both its indispensable contribution and leadership, and the risks of concentrated donor dependence. Renewed solidarity from all donor governments, including European and other countries, alongside increased domestic financing, is essential to sustaining the HIV response and achieving the goal of ending AIDS as a public health threat by 2030.

5.1 Discussion questions for the thematic segment

1. What do available data and evidence show about the impact of funding cuts on people living with HIV and key and vulnerable populations, and on services and systems across the HIV response? Which essential functions have been maintained, reduced or lost, for whom, and what remains unknown?

2. How have communities, civil society, governments and partners responded to the funding shifts? Which responses have protected effective access and community capacity, what conditions are needed to sustain them, what costs have communities borne, and how are communities building on this experience?

3. What further actions and new approaches, including approaches not yet widely used in the HIV response, are needed to sustain an effective and equitable response—and how should responsibilities for financing, delivery and accountability be shared among countries, communities and international partners?

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