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The global fight against HIV/AIDS amid financial pressures and an uncertain future for UNAIDS

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Although the global fight against HIV/AIDS has achieved considerable epidemiological and medical progress, its political and financial foundations have suffered increasing pressure in 2026. Over the past two decades, both new HIV infections and AIDS-related deaths have fallen significantly. Antiretroviral therapy has fundamentally changed the outlook for people living with HIV, while new long-acting prevention options are creating additional opportunities to reduce transmission. The twice-yearly injectable *lenacapavir* is seen as particularly promising for reaching people for whom daily medication intake, stigma or limited access to health services have so far posed major barriers[1].

For decades, the global HIV/AIDS response has relied heavily on US-funded programmes such as PEPFAR. The abrupt freezing, reduction and political redirection of US assistance from January 2025 onwards coincided with a broader decline in international development financing. Additional expected cuts by other donors, together with mounting pressure on national health budgets, are forcing a reassessment of how the responsibility for the HIV response is shared globally. Countries with high HIV prevalence and limited fiscal space are especially vulnerable, as external funding has long helped sustain essential services ranging from prevention and testing to treatment. In parallel, UNAIDS, the Joint United Nations Programme on HIV/AIDS established in 1996, is itself under pressure to reform. Recent votes on the new Political Declaration on HIV and AIDS, as well as deliberations within the UNAIDS Programme Coordinating Board, show that the global response is being weakened not only by a funding crisis, but also by an increasingly fragmented normative consensus.

Current state of the global HIV response

UNAIDS estimates that around 40.9 million people were living with HIV worldwide in 2025, including approximately 39.7 million adults and 1.3 million children[2]. Women and girls accounted for 51 per cent of all people living with HIV. In the same year, around 1.2 million people acquired HIV and approximately 570,000 died from AIDS-related illnesses. This continues the long-term decline in the epidemic. New infections are now around 65 per cent below their 1995 peak and 43 per cent below 2010 levels, while AIDS-related deaths have fallen by roughly 57 per cent since 2010. Even so, progress remains too slow to end AIDS as a public health threat by 2030. One reason is the stark divergence between regions. While substantial gains have been made in parts of sub-Saharan Africa, new infections are rising or stagnating elsewhere, particularly in Eastern Europe and Central Asia, the Middle East and North Africa, and Latin America[3].

[1] https://www.who.int/news/item/14-07-2025-who-recommends-injectable-lenacapavir-for-hiv-prevention

[2] You can access the annual UNAIDS report via the following link: https://www.unaids.org/sites/default/files/2025-07/2025-global-aids-update-JC3153_en.pdf. Facts and figures are primarily taken from this report.

[3] For more facts and figures on the current status of the fight against HIV, please visit the following link: https://www.unaids.org/en/resources/fact-sheet

The so-called 95-95-95 targets serve as the central international benchmarks for the HIV response. They aim for 95 per cent of all people living with HIV to know their status, 95 per cent of those diagnosed to receive antiretroviral therapy, and 95 per cent of those on treatment to achieve viral suppression[4]. The latter means that treatment reduces the amount of virus in the blood to a level at which HIV causes far less harm to health and is effectively no longer sexually transmissible. According to UNAIDS estimates, 88 per cent of all people living with HIV knew their status in 2025. Of these, 89 per cent were receiving treatment, and 95 per cent of those on treatment had achieved viral suppression. Measured against all people living with HIV, however, this means that only 78 per cent had access to treatment and 74 per cent were virally suppressed. The gaps remain particularly pronounced among children, men and key populations, meaning groups that face a higher risk of HIV and greater barriers to accessing health services. Only 54 per cent of children living with HIV had access to treatment in 2025, while treatment coverage among men remained lower than among women. Stigma, discrimination and criminalisation continue to leave groups such as men who have sex with men, sex workers, people who inject drugs and people in prison at substantially higher risk of HIV.

HIV therefore remains a major global health challenge. Further progress will depend on stable financing, functioning health systems and reliable access to prevention, testing and treatment for the populations most at risk.

Funding cuts are creating vast gaps in service provision

According to UNAIDS, global development financing fell by 23 per cent in 2025, the steepest decline since records began[5]. This contraction is particularly serious for the HIV response because many countries with high HIV prevalence and limited fiscal space have so far been able to sustain core elements of their programmes only with the support of international donors. The impact extends well beyond the financing of medicines. It also affects essential functions such as prevention, testing, low-threshold counselling and care, data collection, patient follow-up and services for key populations. Partner countries are now under pressure to increase domestic financing more rapidly. In many high-burden settings, however, this expectation collides with limited public resources, already strained health systems and civil-society structures that are themselves heavily dependent on external support.

The International epidemiology Databases to Evaluate AIDS (IeDEA) research network surveyed HIV clinics and programmes in 32 countries across sub-Saharan Africa, Latin America and the Caribbean, and the Asia-Pacific region to assess the impact of changes in US policy and financing on HIV-related services[6]. Almost half of the surveyed sites reported disruptions to HIV services since January 2025. Counselling and testing, PrEP[7] provision, paediatric HIV services, programmes to prevent mother-to-child transmission, HIV treatment and tuberculosis-related services were particularly affected. Further constraints were reported in medicine availability, laboratory diagnostics and routine clinical operations.

Twenty-eight per cent of surveyed sites reported shortages or interruptions involving essential medicines, including 22 per cent that experienced disruptions to antiretroviral therapy. Thirty-four per cent reported limitations in laboratory services, including HIV testing, early infant diagnosis, viral load monitoring and resistance testing. Almost half experienced disruption to clinical operations, including staff shortages, salary cuts, interrupted patient follow-up, data-management problems and constraints in sample processing. These disruptions weaken specifically those parts of the response designed to prevent delayed diagnosis, loss to follow-up and the late detection of treatment failure. Prevention is therefore being undermined at the very moment when new long-acting tools are offering substantially better prospects for reducing new infections.

[4] https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf
[5] As was stated in the latest UNAIDS press release: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2026/july/20260702_PCB58_future
[6] Link to the study: https://pmc.ncbi.nlm.nih.gov/articles/PMC12925645/
[7] PrEP stands for pre-exposure prophylaxis, which refers to the preventive use of antiretroviral medications by HIV-negative people at increased risk of infection.

US HIV financing has been reduced and redirected

For decades, the United States was the world's largest bilateral donor to the global HIV response, primarily through PEPFAR. Launched in 2003, the President's Emergency Plan for AIDS Relief supports HIV prevention, testing, treatment, care and health systems in some of the countries most affected by the epidemic. The freezing, reduction and political redirection of US foreign assistance since January 2025 therefore has structural consequences that extend far beyond individual programmes. The approval in February 2026 of approximately US$5.88 billion in funding, including US$4.6 billion for bilateral HIV support under the *America First Global Health Strategy*, US$1.25 billion for the Global Fund and US$45 million for UNAIDS, indicates that the United States has not withdrawn entirely from global HIV financing[8]. The direction of support is nevertheless shifting towards bilateral agreements, greater national ownership by partner countries and closer alignment with US strategic priorities.

The case of South Africa demonstrates the consequences of this shift. The announced termination of US HIV and AIDS funding for the country is particularly consequential because South Africa suffers from the world's largest HIV epidemic, with more than 8 million people living with HIV, and remains central to the global AIDS response. Until 2025, the United States supported South Africa's HIV programmes through PEPFAR with an estimated US$400 million a year[9]. Although South Africa finances antiretroviral treatment largely from domestic resources and is not directly dependent on US funding for HIV medicines, US support most recently accounted for around 17 per cent of national HIV expenditure. Its contribution was disproportionately important for prevention, testing, paediatric diagnostics and programmes for key populations. The US Government has justified its abrupt withdrawal from HIV financing for South Africa by citing what it regards as Pretoria's inadequate response to Washington's political demands, including allegations concerning the treatment of the white Afrikaner minority, which South Africa rejects.

While other countries concluded new bilateral agreements under the *America First Global Health Strategy*, South Africa was excluded from support amid diplomatic tensions. Earlier cuts had already produced tangible effects. Between 2024 and 2025, HIV-related spending in South Africa fell by 43 per cent as a result of the changes in US financing[10]. Reports from frontline services point to reductions in counselling staff, longer waiting times, greater difficulty initiating PrEP and weakened data systems. In a country where almost 1,000 adolescent girls and young women acquire HIV each week, these developments affect not merely administrative programme structures but core prevention capacity. The South African case shows that redistributing global responsibility depends not only on whether national governments are willing to assume a greater share of financing, but also on whether external donors manage such transitions in a predictable and politically responsible manner.

Vote on the new Political Declaration on HIV/AIDS

The UN High-Level Meeting on the new United Nations Political Declaration on HIV/AIDS, held on 22 and 23 June, took place in a context of severe cuts to international health financing and growing uncertainty over the future global HIV architecture. Even so, the Political Declaration reaffirmed its goal of ending AIDS as a public health threat by 2030 and identified financing gaps, the weakening of prevention programmes and access to new tools such as long-acting PrEP as central issues for the next phase of the response[11]. The Declaration was adopted by 149 votes in favour, 8 against and 14 abstentions[12]. This broad majority suggests that HIV/AIDS continues to be recognised as a global challenge and shared responsibility, and that the multilateral 2030 target still commands substantial support.

Only the United States, Russia, Israel, the Democratic People's Republic of Korea, Burkina Faso, Burundi, Niger and Senegal voted against the Declaration. The United States objected to what it regarded as divisive and non-consensual language, as well as to provisions on trade, technology transfer and intellectual property. Russia rejected language it

[8] https://news.un.org/en/story/2026/02/1166897
[9] https://www.bbc.co.uk/news/articles/cdr457lxr71o
[10] https://phr.org/our-work/resources/wasted-investments-looming-crisis-the-impact-of-u-s-global-health-funding-cuts-on-hiv-in-south-africa/

[11] Click here to access the political declaration: https://docs.un.org/en/A/80/L.79
[12] Health Policy Watch reported on this: https://healthpolicy-watch.news/us-russia-oppose-un-political-declaration-on-hiv/

viewed as interference in national jurisdiction, criticised references to gender and opposed rights-based approaches such as *Harm Reduction* in the context of drug use. In the HIV context, *Harm Reduction* includes measures such as sterile injecting equipment, opioid substitution therapy, counselling and testing services. These measures are intended to reduce infection risks among people who inject drugs and to reach those who are often excluded from mainstream health services as a result of criminalisation or stigma.

Language on key populations, sexual and reproductive health, gender-based violence and technology transfer was also contested. In this context, technology transfer refers to the sharing of knowledge, licences and production capacity for medicines, diagnostics and other health technologies. The European Union supported the Declaration despite significant reservations about the paragraph on technology transfer, recognising the political importance of maintaining a common framework for the years ahead. The EU also criticised the text for falling short of the 2021 Declaration and for weakening the human rights-based approach in problematic ways[13]. In its view, vulnerable groups, key populations, young women and girls, civil society and community-led organisations must remain at the centre of an effective HIV response. The EU distanced itself from unconditional language on technology transfer and reaffirmed that such transfers should be voluntary and take place on mutually agreed terms.

The vote showed that the normative consensus underpinning the HIV response is increasingly contested. The Declaration therefore amounts to a political minimum consensus reached under difficult circumstances. Its impact will depend largely on whether Member States back the 2030 objective with reliable financing, protected civic space, credible transition strategies and access to new prevention tools.

The future of UNAIDS and global cooperation

Only a few days after the adoption of the new Political Declaration, the UNAIDS Programme Coordinating Board (PCB) met in Geneva from 30 June to 2 July to consider the future structure of the Joint Programme[14]. The PCB comprises 22 regionally balanced out Member States[15] with voting rights, the UNAIDS Cosponsors[16] and five non-governmental organisations without voting rights.

At the PCB meeting, Member States, affected communities and partner organisations broadly agreed that UNAIDS must evolve in response to declining resources, shifting donor priorities and the wider reform agenda across the United Nations system. At the same time, they stressed that the global HIV response will continue to require political leadership, multisectoral coordination, accountability and the meaningful participation of people living with HIV and affected communities. These are functions to which UNAIDS has so far made a distinctive contribution.

The Decision adopted at the 58th meeting of the UNAIDS PCB defined a reform process that is now expected to be translated into a more concrete decision-making framework[17]. A working group mandated to examine the further transition and integration of UNAIDS into the United Nations system presented an interim report that clearly rejects the rapid closure of the Programme by the end of 2026[18]. Instead, it advocates a phased transformation that preserves core coordination, data and participation functions. At country level, the report recommends differentiated models tailored to HIV burden, national capacities and the political environment. The financing question, however, remains unresolved. The report merely cautions against distributing functions and funding streams across several organisations, warning that this could weaken coordination, increase transaction costs and make accountability more difficult.

[13] The EU Statement: https://www.eeas.europa.eu/delegations/un-new-york/eu-explanation-vote-un-general-assembly-2026-political-declaration-hivaids-united-end-aids-2030_en?s=63

[14] https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2026/july/20260702_PCB58_future

[15] These member states currently include: Belgium, Brazil, Burundi, Cambodia, Canada, China, Denmark, Germany, Haiti, India, Iran, Kenya (Rapporteur), Lesotho, Mexico, the Netherlands (Chair), Nigeria, the Philippines (Vice-Chair), Poland, Senegal, Ukraine, the United Kingdom, and the United States of America.

[16] UNHCR, UN Women, UNICEF, ILO, WFP, UNESCO, UNDP, WHO, UNFPA, World Bank, UNODC.

[17] https://www.unaids.org/sites/default/files/2026-07/PCB58_Decisions_Final_EN.pdf

[18] You can find the full interim report here: PCB58_Interim_Report_PCB_Working_Group_1.pdf

The Board took note of the Working Group's interim report and requested that it present concrete options ahead of the next multistakeholder consultation. By the Board's special session on 26 October 2026, an implementable and financially sustainable plan for the future structure and governance of UNAIDS is expected to be in place. A previously discussed rapid phase-out of the Programme before 2030 has therefore not been agreed. Instead, attention is shifting towards an orderly transition process that will need to determine which functions UNAIDS should continue to perform itself, which could be anchored elsewhere in the United Nations system and how the necessary financing can be secured.

The key question is which functions UNAIDS will retain in this process. These currently include data analysis, target monitoring, coordination across the United Nations system, support for national HIV strategies, human rights-based advocacy and the formal participation of civil society and affected communities. In the HIV context, this participation is not an optional addition but a prerequisite for effective prevention. Many services for key populations are delivered through community structures, peer networks and low-threshold services, including mobile testing, support with treatment initiation and trust-building among groups that often approach public authorities with caution. The Board reaffirmed this approach in relation to long-acting antiretroviral prevention and treatment, access to national programmes and monitoring systems, and community-led monitoring mechanisms.

For the global HIV response, the UNAIDS process represents a major institutional turning point. A leaner and better integrated structure could be beneficial if it reduces duplication, clarifies responsibilities and improves the division of labour across the United Nations system. A transition would be problematic, however, if it shifted coordination, accountability and community functions onto organisations that are already under considerable strain. At a time of declining financing and growing political tension, UNAIDS' added value lies specifically in its ability to bring together prevention, human rights, data and multilateral coordination while engaging communities in a targeted and meaningful way. The October session will therefore show whether the reform process makes UNAIDS more focused and operationally effective or instead weakens the very functions that remain most important for the final stretch towards 2030.

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