

EXECUTIVE SUMMARY

Funding for HIV/AIDS from U.S.- based philanthropies totaled \$459 million in 2010, a drop of \$33 million (7%) from 2009 funding.¹ New commitments (funding committed in a given year but not necessarily disbursed in that year) to HIV/AIDS in 2010 totaled \$206 million, and were also lower compared to 2009, decreasing by 44%. Funding continues to be highly concentrated among a small group of the top 10 funders, who alone represent 80% of total disbursements.

The key driver of the overall decrease in both disbursements and commitments was a drop in funding from the largest private HIV/AIDS funder, the Bill & Melinda Gates Foundation, although these decreases were largely due to the multi-year nature of their commitments and reflect that they were undergoing an HIV/AIDS strategy review process in 2010. The fight against HIV/AIDS remains a top priority for the Gates Foundation and they forecast increased commitments as part of a new strategy and grants cycle in 2011. While not a permanent decrease, its effect demonstrates the sector's dependency on the largest funder.

Funders other than the Gates Foundation also experienced a decrease from 2009 to 2010, although much more slight at 2%. One of the factors in this decrease is a continuing trend of funders exiting the field of HIV/AIDS-specific funding. The number of philanthropic organizations that gave \$300,000 or more to HIV/AIDS in 2010 was down by 30% (or 21 organizations) over the last three years, as long-time HIV/AIDS funders moved into areas such as sexual and reproductive health and health systems strengthening. Moreover, three of the top 10 funders forecast decreases in 2011 funding to HIV/AIDS due to a shift of funds to other related health areas.

Though now the field is experiencing a decline of numbers of funders, U.S. HIV/AIDS philanthropy has managed to increase from a mere \$216,000 in 1983 to \$459 million by 2010, in large part due to political will and funders' dedicated efforts to raise the level of response.

¹ Funding for HIV/AIDS to the Global Fund to Fight AIDS, Tuberculosis and Malaria from HIV/AIDS philanthropic funders—totaling \$6,217,761 from five funders in 2010, or about 1% of total HIV/AIDS philanthropic disbursements—was removed from all figures in the report, because it is increasingly difficult to track accurately. Funding to the Global Fund was also removed from previous year's figures, including 2009, in order to make accurate comparisons. Please see page 41 for more information.

Key Highlights for 2010

- » Total disbursements (funding expended) from U.S.-based philanthropies were \$459 million, a decrease of \$33 million, or 7% from \$492 million in 2009. Total commitments (funding committed in a given year but not necessarily disbursed in that year) also decreased, from \$367 million to \$206 million (or 44%).
- » Funding for HIV/AIDS from the philanthropic sector was highly concentrated among a relatively small number of funders, with the top 10 funders accounting for 80% of all HIV/AIDS-related disbursements in 2010. The Gates Foundation alone accounted for 47% of all disbursements.
- » Disbursements by the Gates Foundation for HIV/AIDS totaled \$215 million in 2010, \$29 million less than its comparable disbursements in 2009 (\$244 million). Total disbursements by all other funders also decreased but more slightly, by \$5 million (or about 2%) at \$244 million in 2010 compared with \$249 million in 2009.
- » The number of funders disbursing more than \$300,000 in 2010 (a total of 60 organizations) was the lowest on record since 2005 (when 81 total organizations gave more than \$300,000), as several long-time HIV/AIDS funders closed their HIV/AIDS-specific grant programs. This is a continuation of a recent trend in which some funders have begun to move away from HIV/AIDS-focused grantmaking, often towards related health areas, and new funders have not replaced them.
- » Corporate funders represented 24% (\$109 million) of total 2010 disbursements—a slight increase from 18% of total disbursements, or \$106 million, in 2009.
- » Most HIV/AIDS funding provided by U.S.-based philanthropies in 2010 (78% of all disbursements) was directed to addressing the international epidemic, as opposed to funding addressing the epidemic within the United States. The majority of funders (56% in 2010) devoted some or all of their giving to addressing the international epidemic, while a quarter did so exclusively.

Key International Findings

- » Funding for international initiatives was \$20 million lower in 2010 than in 2009 (a 5% decline).
- » Several geographic regions received less funding in 2010 compared to 2009, including Eastern and Southern Africa (\$148 million in 2010, which was \$10 million less than the previous year) and Eastern Europe and Central Asia (\$5 million in 2010 compared with \$12 million in 2009).
- » The biggest share (43%) of international funding went to research in 2010 (\$155 million), followed by prevention (\$65 million) and advocacy (\$45 million). In 2010, funding for nearly every category was less than 2009 amounts. Total funding amounts among funders other than the Gates Foundation for prevention and advocacy have risen since 2009, with \$29 million in 2010 for prevention compared with \$28 million in 2009, and \$26 million in 2010 for advocacy compared with \$23 million in 2009.

Key U.S. Domestic Findings

- » Funding provided for the domestic epidemic was down nearly 10%, totaling \$101 million in 2010 compared with \$112 million in 2009.
- » As in previous years, the Northeast region of the United States received the largest share of domestic funding (46%) in 2010, a total of \$46 million compared with \$53 million the previous year.
- » The biggest share of domestic funding went to social services in 2010 (\$23 million), followed closely by research (\$23 million) and HIV prevention (\$20 million). Funding to support domestic-based research experienced the sharpest decline from 2009 to 2010 (from \$34 million in 2009). Funding for domestic prevention programs also fell slightly from 2009 to 2010 (from \$34 million to \$23 million).

2011 FORECAST:

Looking ahead, projections for 2011 suggest that total HIV/AIDS-related philanthropy funding levels may increase: 27% of the funders that answered this question forecast anticipated increases for 2011, including the top funder, the Gates Foundation. Forty-seven percent of funders expect their HIV/AIDS-related disbursements to remain approximately the same (including four of the top 10 funders).

Eleven percent of funders expect their funding to decrease in 2011, but that group includes three of the top 10 funders. Those three funders indicated that their funding will decrease because they plan to shift funding to other related health areas, such as sexual and reproductive health, neglected diseases, chronic hunger and malnutrition, and maternal and child health.

While these data suggest HIV/AIDS philanthropic funding will increase in 2011, it is important to note every dollar in any given year lost enables new HIV infections, results in fewer lives saved, and stalls progress against the global epidemic at every intervention level, from bio-medical science advances and behavioral prevention achievements, to progress on human rights issues. To seize current opportunities to end the epidemic, the philanthropic sector must strive to achieve maximum impact for every dollar spent, and mobilize increased and efficient funding for HIV/AIDS.

2011 AND THE ROAD AHEAD

This year, which marks three decades since the first reported AIDS case in the United States, may prove to be a game-changing moment in the history of the epidemic. Hard-won scientific advances in treatment and prevention offer new hope, bringing additional tools that can help halt HIV transmission. Current financial resources, however, are not enough, and have not been enough, at home and abroad, to end HIV/AIDS.

Resources for HIV/AIDS continue to tragically decrease as research reveals new options and the epidemic is stabilizing in some areas of the world. During an ongoing period of economic uncertainty, coupled with a growing focus on other health and development challenges, serious questions remain as to how to fully utilize new findings on HIV prevention and treatment, along with existing tools that have already demonstrated success. The emerging consensus is that resources will need to be allocated and used more efficiently, requiring greater demonstration of **evidence-based** and **results-oriented** programming, and shifting to more **methodical** and **sustainable long-term approaches**. Examples of these strategies are reflected in the examples of philanthropic innovation profiled within this report, from a new funding mechanism focused on key youth populations, to the scale-up of a new prevention intervention focused on MSM couples, to a non-cash technical assistance program empowering communities in Africa.

Though philanthropic giving represents only a small part of total resources for HIV/AIDS, it has changed the course of the epidemic in large part due to the sector's unique ability to be independent and flexible, and to address key focus areas such as advocacy and marginalized populations that are not covered by other sources of funding. As more philanthropic funders move away from HIV/AIDS than ever before, and resources become more dependent on the few funders at the top, how and where current funding is targeted must increasingly exemplify these principles to ensure impact.

The following sections provide a brief overview of current HIV/AIDS scientific progress, available resources, and potential funding gaps. As the sector evaluates the road ahead, this information is essential to understanding the future of the philanthropic response to HIV/AIDS: **where can private funding best innovate, strengthen, and advance the response?**

While perspectives differ, one simple truth emerges: we cannot break the arc of this epidemic—where five people were newly infected for every three starting treatment in 2010—if we adopt a 'business as usual' approach.

– **Michel Sidibé**, Executive Director, UNAIDS; *AIDS at 30: Nations at the Crossroads*

RECENT SCIENTIFIC ADVANCES

In addition to the existing tools for HIV prevention such as male circumcision, condoms, harm reduction strategies, prevention of vertical transmission, and behavior-change programs, the following interventions look promising as part of a combination approach to prevention.

The “treatment as prevention” concept has generated particular interest and excitement² as it appears likely to further break down the persistent dichotomy between treatment and prevention that has often pitted advocates and policymakers against each other in the scramble for resources.

Tool	Name of trial/product	Date of results	Population involved	Efficacy
Microbicide	CAPRISA 004/TDF gel	July 2010	Women	39%
Oral PrEP	iPrEx/TDF-FTC daily	November 2010	Men who have sex with men, transgender women	44%
Treatment as prevention	HPTN 052/ART for HIV-positive people	May 2011	Sero-discordant heterosexual couples	96%

According to *Capitalizing on Scientific Progress: Investment in HIV Prevention R&D in 2010*,³ a report by the HIV Vaccines & Microbicides Resource Tracking Group, the total global investment—including commercial, public and philanthropic support—in research and development reached \$1.9 billion for four key prevention options: preventive HIV vaccines, microbicides, oral pre-exposure prophylaxis (PrEP) using ARVs and operations research related to male circumcision.

2 AVAC. *We CAN End the AIDS Epidemic (statement)*. June 2011. Available at: www.avac.org/ht/d/sp/i/34301/pid/3430.1

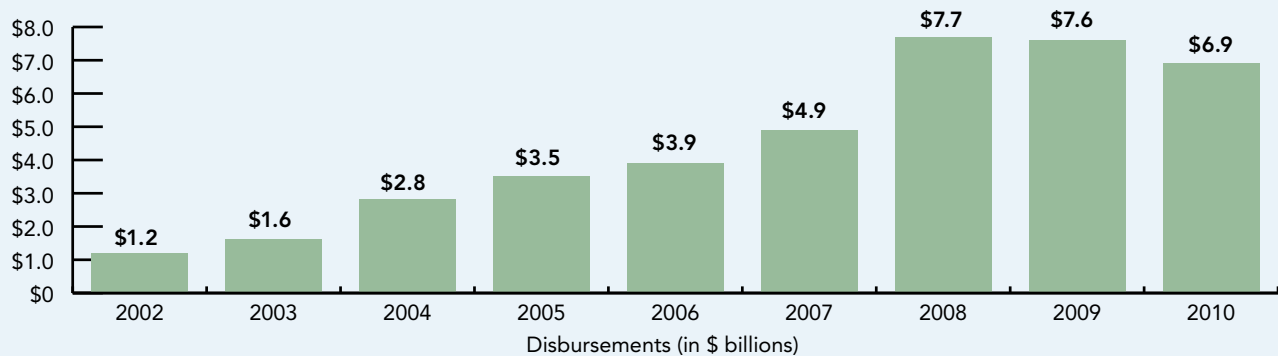
3 Available at: www.hivresourcetracking.org. The Working Group consists of AVAC: Global Advocacy for HIV Prevention, the International AIDS Vaccine Initiative (IAVI), the International Partnership for Microbicides (IPM) and the Joint United Nations Program on HIV/AIDS (UNAIDS).

Current Resources: Donor Governments & Private Philanthropy

HIV/AIDS-related private philanthropy continues to represent only a small part of the resources available to HIV/AIDS, both domestically (within the United States) and internationally, in comparison to funding from government sources.

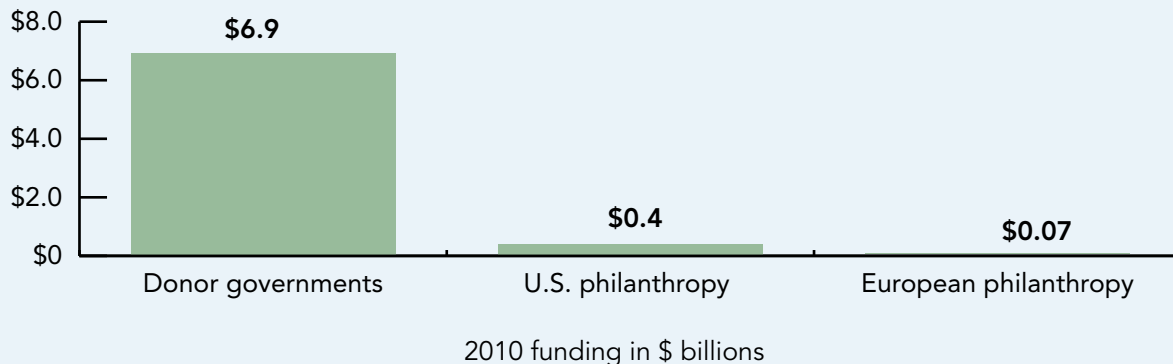
About half of all resources available for the HIV/AIDS response in low- and middle-income countries is provided by those countries for their own epidemics; the other half is provided in the form of international assistance from donor governments and non-governmental philanthropic sources. The UNAIDS and Henry J. Kaiser Family Foundation report on funding from donor governments found that disbursements for international AIDS assistance totaled \$6.9 billion in 2010, a decrease from 2009 by 10%, after years of steady growth from 2002-2008.^{4,5} According to the report, the decrease was due to a combination of three main factors: actual reductions in development assistance, currency exchange fluctuations, and a slowdown in the pace of U.S. disbursements, which was not a budget cut.

Chart A: International AIDS Assistance from Donor Governments



Source: UNAIDS and The Henry J. Kaiser Family Foundation. *Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2010*. August 2011.

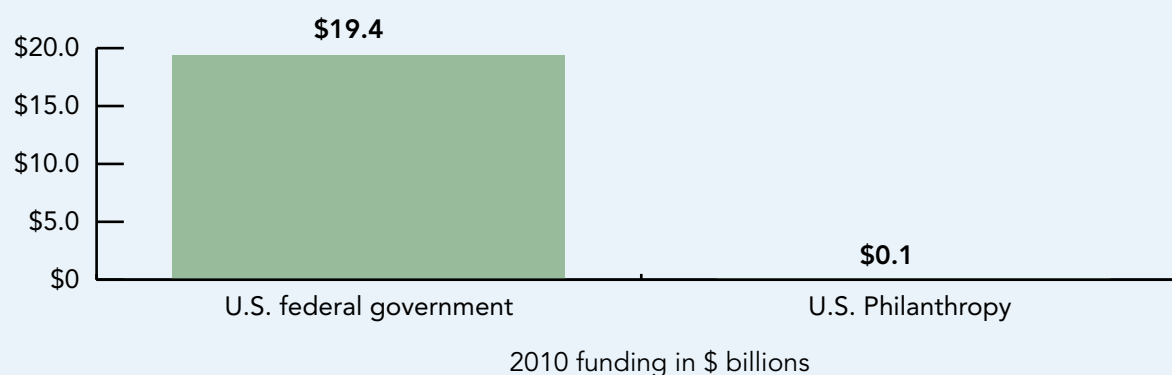
Chart B: International Assistance to HIV/AIDS in Low- and Middle-income Countries
(Donor governments, U.S. & European philanthropy comparison)



4 UNAIDS and The Henry J. Kaiser Family Foundation. *Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2010*. August 2011. Available at: www.kff.org/hivaids/upload/7347-07.pdf.

5 Funding from donor governments for international AIDS assistance was essentially flat from 2008-2009.

Chart C: U.S. Assistance for the Domestic U.S. HIV/AIDS Epidemic in 2010
(Federal government and U.S. philanthropy comparison)



Notes: Chart does not include funding for HIV/AIDS from state governments. U.S. government total is for FY2010 while U.S. philanthropy total is for calendar year 2010.

Source for U.S. government domestic giving: The Henry J. Kaiser Family Foundation. *HIV/AIDS Policy Fact Sheet: U.S. Federal Funding for HIV/AIDS: The President's FY 2012 Budget Request*. March 2011. Available at: www.kff.org/hivaids/upload/7029-07.pdf.

It is worth noting that although they provide the most resources by far as a group, many governments only support specific areas or priorities. In its funding for the domestic epidemic, the U.S. government focuses primarily on treatment, prevention and medical care. **Advocacy**—which can encompass a range of activities to change public opinion, community and institutional norms, government policy and outcomes⁶—is not a main focus area of the U.S. government's funding, even though it is well known as a tool that can maximize impact.

Also, some governments choose not to provide resources targeting or supporting certain **marginalized populations**, even if such populations are disproportionately affected by HIV. Such decisions often stem from lack of awareness about such populations; associated social, cultural, economic and political stigma; and restrictive legal regimes. Governments in many countries are unwilling or unable to fund programming specifically for MSM (even though HIV prevalence is nearly always higher in this community than among the general population). For example, 76 countries currently criminalize same-sex relations,⁷ which obstructs the ability of these individuals to access needed HIV treatment and prevention interventions.

6 As defined by Dose of Change, available at http://issuu.com/doseofchange/docs/advocacy_glossary

7 The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA). *State-sponsored Homophobia: A world survey of laws criminalizing same-sex sexual acts between consenting adults*. May 2011. Available at: old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2011.pdf

KNOW YOUR EPIDEMIC – FINDING THE GAPS

Throughout this report selected highlights of the latest data on the global and domestic U.S. epidemics are provided to contextualize the philanthropic response. Epidemics vary widely according to country context, which is why it is critical for public and private funders to “know” their epidemic in order to achieve maximum impact. Experience to date indicates, however, that responses do not often match with knowledge, especially in regards to marginalized populations. For example:

THE GLOBAL EPIDEMIC

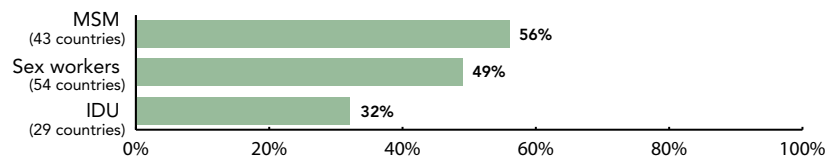
- » In Eastern Europe and Central Asia, a region of concentrated new infections in populations such as IDUs, sex workers, and MSM, only 11% of HIV prevention investments are focused on these higher-risk populations.
- » The proportion of HIV prevention funding for programs for sex workers, MSM, and IDUs was only 1.7% in Burkina Faso, 0.4% in Côte d’Ivoire and 0.24% in Ghana in 2008, yet the estimated percentage of new infections in those population

groups in 2010 was 30%, 28% and 43%, respectively.

- » In both Kenya and Mozambique, an estimated one quarter to one third of new HIV infections occur among IDUs, MSM and sex workers. Yet total spending directed to HIV prevention among these key populations in 2008 was 0.35% in Kenya and 0.25% in Mozambique, and almost all from international sources.

Source: UNAIDS Report on the Global Epidemic, 2010. Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.

Chart D: Median Coverage of HIV Prevention Programs for Selected Population Groups, 2010



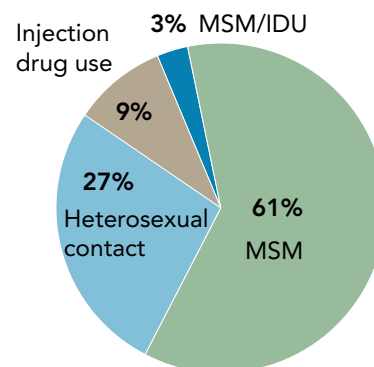
Source: UNAIDS Report on the Global Epidemic, 2010. Available at: www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.

THE DOMESTIC U.S. EPIDEMIC

Some 50,000 new infections occur in the United States each year, the majority of which occur among MSM. African-American males had the highest rate of new HIV infections of any ethnic and gender group from 2006–2009. The majority of new infections were also among young people aged 13–29.⁸ New infections in young African-American MSM increased 48% from 2006–2009.

In terms of geographic distribution, about half (45%) of all new AIDS diagnoses were in the South, which continues to have the greatest number of people estimated to be living with HIV and AIDS of all the regions (Northeast, South, Midwest, West and U.S. Territories). More than 80% of AIDS diagnoses are found in large U.S. metropolitan areas, and the state/dependent area with the highest AIDS diagnosis rate per 100,000 in 2009 was also a city: Washington, DC.^{9,10}

Chart E: New Infections in the U.S. in 2009 by Transmission Category



Source: Centers for Disease Control and Prevention. Fact Sheet: Estimates of New HIV Infections in the United States, 2006–2009. August 2011. Available at: www.cdc.gov/nchstp/newsroom/docs/HIV-Infections-2006-2009.pdf

8 Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. 2011. Estimated HIV Incidence in the United States, 2006–2009. PLoS ONE 6(8):e17502. doi:10.1371/journal.pone.0017502. Available at: www.plosone.org/article/info:doi/10.1371/journal.pone.0017502.

9 The Henry J. Kaiser Family Foundation. The HIV/AIDS Epidemic in the United States. August 2011. Available at: www.kff.org/hiv/aids/upload/3029-12.pdf.

10 For further state-specific details about epidemic demographics and funding, see the AIDS United State Fact Sheets: www.aidsunited.org/policy-advocacy/state-fact-sheet/

Global Resource Gap

At the UN General Assembly High Level Meeting on AIDS in June 2011, commitments were made to achieve new targets by 2015, such as eliminating vertical transmission, halving sexual transmission of HIV, and getting 15 million people on treatment. Commitments were also made to reach the UNAIDS estimate of what is needed to achieve universal access to HIV prevention, treatment, care and support by 2015 in low- and middle-income countries—at least **\$22 billion annually**—and to close the \$7 billion annual gap between the estimated total resources allocated to HIV/AIDS and what is needed.¹¹ While philanthropy cannot fill the resource gap alone, philanthropic organizations and corporations can use their visibility to influence policymakers, other funders, media and the public. Philanthropic organizations can also build coalitions that share resources and increase leveraging power. Coordinated actions across the field could serve as a catalyst that inspires new and existing donors to rally for increased funding and better use of funds, and could make a huge impact.

Such a rally is imperative, as the resource gap appears likely to grow wider because, in the current economic climate, many donors—philanthropic, government, and others—are allocating fewer resources to HIV/AIDS. The U.S. government, the world's largest funder in terms of absolute resources, may face difficulty in reaching its goals given the current fiscal challenges. Recently, for example, the Obama administration requested \$9.8 billion for FY2012 for the **Global Health Initiative (GHI)**,¹² the U.S. government strategy through which international HIV/AIDS assistance now flows, but that amount is subject to reductions in a time of stringent budget cuts to foreign assistance, and the U.S. economy is not likely to dramatically improve in the immediate future.

At the same time, the **Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)**—the second largest source of international HIV/AIDS assistance—is currently underfunded. During its most recent replenishment drive, donor governments from 40 countries pledged a total of \$11.7 billion for the years 2011-2013. That amount was about \$1.3 billion less than what the Global Fund itself considered minimal to meet its current commitments and continue to make grants to countries in need moving forward.¹³

Few stakeholders or observers dispute the argument that HIV/AIDS can only be fully addressed with more resources. A growing number are making the case, however, that spending more money now is the cost-effective approach over the long run. Most notably, an **investment framework**¹⁴ developed under UNAIDS auspices proposes a comprehensive, longer-term approach to the global HIV/AIDS epidemic based on three program areas: basic programming (mostly treatment but also prevention tools such as prevention of vertical transmission, male circumcision, condom promotion, and programs for key populations such as injecting drug users, MSM and sex workers); “critical enablers” to help maximize impact of resources and programming (such as community mobilization); and synergies with development sectors (such as health-systems improvement and HIV education in schools and workplaces).

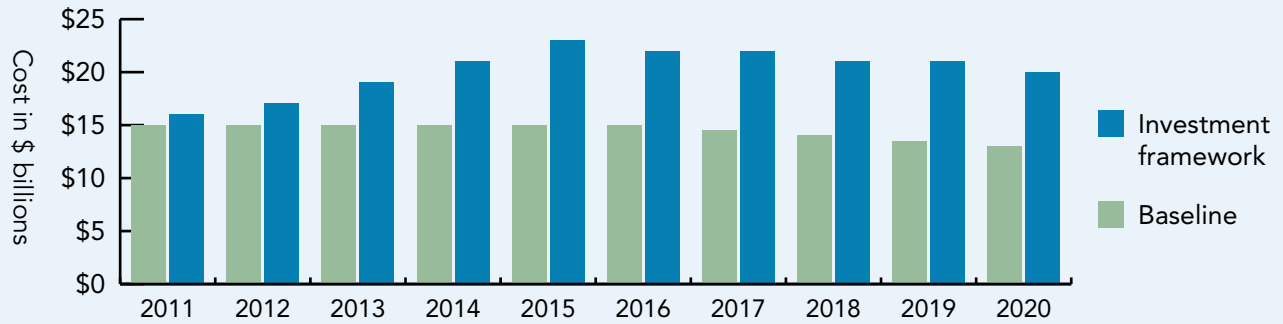
11 UN General Assembly. *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*. A/RES/65/277. June 2011. Available at: www.un.org/ga/search/view_doc.asp?symbol=A/65/L.77

12 The Henry J. Kaiser Family Foundation. *U.S. Funding for the Global Health Initiative (GHI): The President's FY 2012 Budget Request*. March 2011. Available at: www.kff.org/globalhealth/upload/8160.pdf.

13 Global Fund to Fight AIDS, Tuberculosis and Malaria. *Making a difference: Global Fund Results Report 2011*. Available at: www.theglobalfund.org/documents/publications/progress_reports/Publication_2011Results_Report_en/.

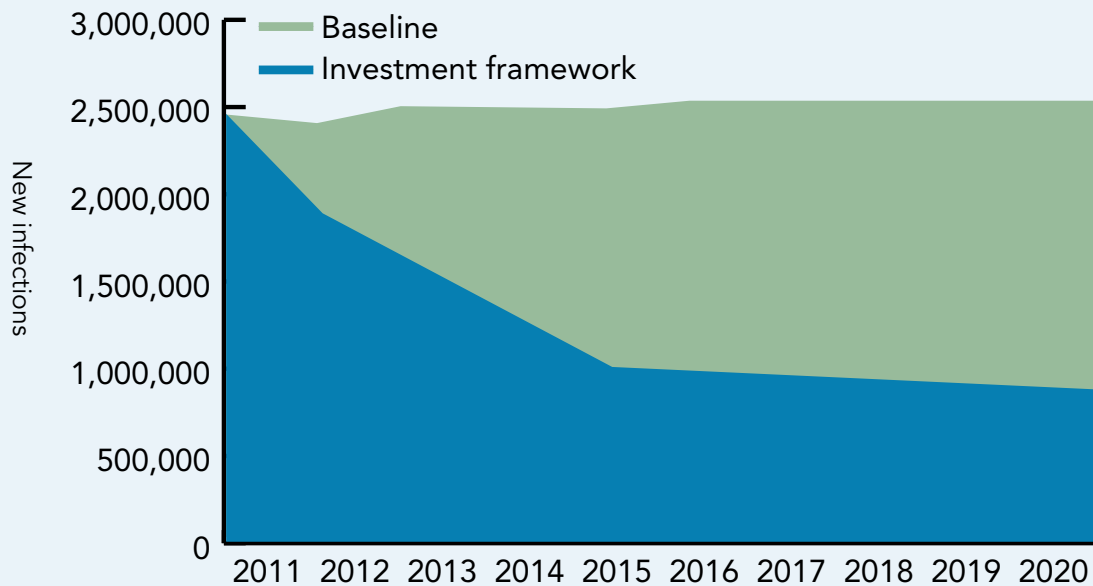
14 Schwartländer et al. “Towards an improved investment approach for an effective response to HIV/AIDS.” *The Lancet*. 3 June 2011, 2031–41.

Chart F: Cost in Low- and Middle-income Countries



Source: Schwartländer et al. "Towards an improved investment approach for an effective response to HIV/AIDS." *The Lancet*. 3 June 2011, 2031-41.

Chart G: Number of New HIV Infections per Year



Source: Schwartländer et al. "Towards an improved investment approach for an effective response to HIV/AIDS." *The Lancet*. 3 June 2011, 2031-41.

According to the framework, resources required under this comprehensive approach would peak at \$22 billion in 2015 and then decline from 2015-2020 because of gains in efficiency, decreases in new infections, and reduced need for services for PLWHA over time. The authors also conclude that adopting and sustaining the model to the fullest possible extent would mean an additional **7.4 million lives would be saved, 29.4 million life-years would be gained, and 12.2 million new infections would be averted** from 2011 to 2020.

U.S. Domestic Resource Gap

Federal funding for the U.S. domestic epidemic was 4.8% higher in the 2011 fiscal year than in 2010, and the FY2012 budget request represents a 4.7% increase over FY2010 levels.¹⁵ However, those increases have not been sufficient to counter the effects of many states' fiscal crises and to meet increased demand in the U.S. for treatment and care due to unemployment and other economic challenges, high drug costs, and new HIV treatment guidelines calling for earlier initiation. The challenges are most notable in terms of access to HIV medicines through the AIDS Drug Assistance Program (ADAP), which is co-funded and administered at state level.

Status of AIDS Drug Assistance Program (ADAP) as of August 25, 2011

Waiting lists	Alabama, Arkansas, Florida, Georgia, Idaho, Louisiana, Montana, North Carolina, Ohio, South Carolina, Utah, Virginia	9,141 people (up from approximately 3,500 people in September 2009)
Lowered financial eligibility	Arkansas, Illinois, North Dakota, Ohio, South Carolina, Utah	445 disenrolled
Other cost-containment measures (reduced formulary, capped enrollment, implemented medical criteria, etc.)	Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Illinois, Kentucky, Louisiana, North Carolina, North Dakota, Ohio, Puerto Rico, Utah, Virginia, Washington, Wyoming	

Source: National Alliance of State and Territorial AIDS Directors (NASTAD). *ADAP Watch*. August 26, 2011. Available at: www.nastad.org/Docs/015910_ADAP%20Watch%20update%20-%208.26.11.pdf

Though the FY2012 budget request for the domestic epidemic represents an increase over FY2011, the appropriations process could mean big cuts for programs such as health care for low-income PLWHA, ADAP, prevention, and housing assistance. Such cuts would make it difficult to fully roll out and meet the commitments of the **National HIV/AIDS Strategy (NHAS)**. Unveiled in July 2010, the NHAS aims to allocate resources where they are needed most, and among its targets are increasing the proportion of all HIV-positive gay and bisexual men, African-Americans, and Latinos with undetectable viral load by 20% by 2015. Perhaps the greatest challenge to the success of the NHAS will be the cost of implementing and sustaining the plan. It is estimated that an investment of \$15.175 billion¹⁶ will be required over a five-year period for the NHAS to meet its goals (see below). It is also estimated that the strategy could pay for itself with over \$17 billion in healthcare savings over the same five-year period if all its prevention goals are met.

U.S. National HIV/AIDS Strategy (NHAS)

THE NHAS HAS THREE PRIMARY GOALS:

- » Reducing HIV incidence
- » Increasing access to care and optimizing health outcomes
- » Reducing HIV-related health disparities

TARGETS SET FOR 2015 INCLUDE:

- » Lowering the annual number of new infections by 25%
- » Increasing the percentage of people living with HIV who know their serostatus to 90%
- » Increasing the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis 85%

15 The Henry J. Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: The FY 2012 Budget Request*. October 2011. www.kff.org/hivaids/upload/7029-07.pdf

16 Holtgrave, David R. "On the Epidemiologic and Economic Importance of the National AIDS Strategy for the United States." *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 11 August 2010. Published ahead of print as PDF at: http://journals.lww.com/jaids/Abstract/publishahead/The_Prevalence_and_Clinical_Course_of.99049.aspx

At the launch of the strategy, President Barack Obama reminded the country that partnership remains key to its successful implementation. A number of domestic private funders have since started to evaluate how their grantmaking can help advance the goals of the NHAS,¹⁷ such as supporting grantees whose programmatic outcomes demonstrate evidence of alignment with the strategy. As just one example, in July 2010, **AIDS United** was awarded a \$3.6 million Social Innovation Fund grant to expand its Access to Care (A2C) initiative to “ensure that PLWHA have access to primary medical care and HIV-specific care, improve individual health outcomes for PLWHA, and strengthen local services systems.” See the profile on page 53 to learn how the A2C initiative supports the principal goals of the NHAS.

Trends in Broader Philanthropy

The annual publication *Giving USA*, which tracks charitable contributions in all areas, reported in June 2011 that grantmaking by private, community and operating foundations totaled about \$41 billion, a decrease of 1.8% from the amount reported in 2010. Corporate giving, including both in-kind and cash donations, totaled \$15.3 billion, an 8.8% increase over the previous year’s amount.¹⁸ In July 2011, however, the *Chronicle of Philanthropy* reported that corporate funding was likely to remain flat in 2011 after the 2010 upswing as the U.S. economy remains unstable.¹⁹ The report concluded that it may take until at least 2013 for many corporate funders to return to pre-recession level giving. On the positive side, these circumstances have forced many grantmakers to make changes to get the most impact out of limited resources.

17 Visit FCAA’s Funders Toolkit for the National HIV/AIDS Strategy at www.fcaaid.org for more examples and resources on funder alignment with the NHAS.

18 Hall, Holly and Joslyn, Heather. “Giving Rose by 2.1% Last Year, New Estimate Shows.” *Chronicle of Philanthropy*. June 19, 2011. Available at: <http://philanthropy.com/article/Giving-Rose-by-21-Last-Year/127948/>

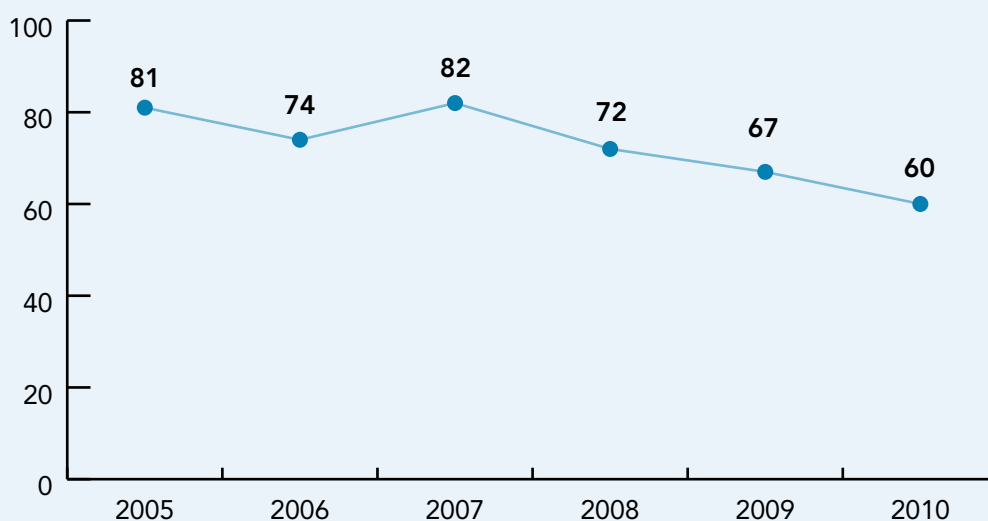
19 Frazier, Eric and López-Rivera, Marisa. “Corporate Giving Slow to Recover as Economy Remains Shaky.” *Chronicle of Philanthropy*. July 24, 2011. Available at: <http://philanthropy.com/article/Big-Businesses-Won-t/128327/>

What Can HIV/AIDS Philanthropy Do?

In the changing landscape of HIV/AIDS and the global economy, the longstanding “business as usual” approach seems increasingly unworkable and ineffective. Amidst the overall decline in resources for HIV/AIDS in 2010, philanthropic HIV/AIDS funders must consider the larger context of resources needed and available for HIV/AIDS, as well as the evidence of what works, and develop new strategies to best take advantage of the exciting opportunities in prevention, treatment scale-up, advocacy and support for marginalized populations.

The number of HIV/AIDS “top” funders—those giving \$300,000 and above to HIV/AIDS—has decreased by 21 organizations since 2005, as funders such as the Rockefeller Foundation, Rockefeller Brothers Foundation, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the Evelyn and Walter Haas Jr. Fund have moved away from HIV/AIDS-specific funding to focus on related health areas. Importantly, no new funders have replaced the financial support and leadership of these organizations within the sector. Given the trend of narrowing numbers of funders, today’s HIV/AIDS philanthropic leaders must use their position to inspire and influence others, and build new coalitions and coordinated efforts, as well as carefully considering how to make best use of the existing resources.

Chart H: Number of U.S. Philanthropic Funders Giving Over \$300,000 per Year
(by percentage of total expenditures)



To maximize its effectiveness, the philanthropic sector needs to continue to reprioritize and support strategically smarter, better coordinated, and more efficient interventions that target the needs of communities most impacted by the epidemic (whether in the United States or abroad). Such steps are particularly important as new policies and paradigms are developed to respond to promising new findings, and existing tools and efforts are examined. Though now the field is experiencing a decline of numbers of funders, U.S. HIV/AIDS philanthropy has managed to increase from a mere \$216,000 in 1983 to \$459 million by 2010, in large part due to political will and funders’ dedicated efforts to raise the level of response. The philanthropic sector must continue to provide a catalytic and strategic piece of the global response to HIV/AIDS.