Funding for HIV and AIDS

The huge mobilisation of resources for the global HIV and AIDS response over the course of the epidemic has been unprecedented in the history of public health. The challenge of funding HIV treatment, prevention and care in middle- and low-income countries has been characterised by vocal advocacy, unique and innovative funding mechanisms, previously unseen levels of bilateral (direct government to country) aid, and philanthropic donations whose scale have rivalled those of donor governments and multilateral institutions.

However, recent years have seen a regression. Donor funding for the HIV response in low- and middle-income countries declined by 7% between 2015 and 2016. This continuing trend of disinvestment towards the global HIV response follows several years of flat-line funding since the economic crisis hit in 2008 and global aid budgets began to constrain.1

Competing funding demands such as humanitarian emergencies and refugee crises combined with ongoing fiscal austerity in many countries has meant a reduction in funds made available for the global HIV response. This has led to funding gaps that threaten to derail the response. National governments in some low- and middle-income countries are now stepping up to fund their own responses, slowly filling some gaps and working towards a more sustainable response to HIV.

In 2011, the Political Declaration on HIV and AIDS called on the international community to mobilise between US$ 22 billion and US$ 24 billion for the global HIV response in low- and middle-income countries by 2015.2 In 2016, an estimated US$ 19.1 billion was made available.3

UNAIDS’ new and ambitious Fast-Track approach commits to ending the global HIV epidemic as a public health threat by 2030. In order to achieve this, an estimated US$ 26.2 billion will be required for the HIV response in 2020, steadily decreasing to $22.3 billion by 2030.4 As a result,
there is a lot more emphasis on countries most affected by the HIV epidemic to finance their own responses and find more efficient and cost-effective ways to do so.

Despite these rising financial commitments, the future outlook of global funding for the HIV response remains uncertain. Most recently the United States of America (USA), which remains the largest contributor to the global response, has proposed cuts of almost 20% amidst competing demands on donor budgets more generally.5

In order to make significant progress, the investments to reach the end of AIDS as a global public health threat by 2030 need to be increased and front-loaded during the next four years or we will drown with increasing costs.

– Jose Izazola, Chief, Evaluation and Economics, UNAIDS6

Sources of HIV and AIDS funding

Domestic resources

Domestic funding is HIV spending allocated by country governments in their national budgets. This represents an increasingly significant and essential means of funding the global HIV and AIDS response. Historically, the HIV response has been largely funded by international donors and governments, but low- and middle-income countries are now beginning to lead on efforts to tackle the HIV epidemic.

In 2015, domestic resources exceeded funds provided by donors and accounted for the majority of global HIV funding (57%), totalling $10.9 billion.7 Although challenging for low- and middle-income countries, shifting the funding paradigm towards domestic funding has advantages. These include fostering ownership and accountability in the implementation of the national HIV response and increasing its sustainability.8

In sub-Saharan Africa, countries such as Kenya, South Africa, Togo and Zambia have dramatically increased their domestic HIV spending in recent years.9 South Africa mostly funds its own response and spent over $1.5 billion on its HIV and AIDS programmes in 2014. However, this is likely to become a challenge over the coming years following the government’s recent commitment to funding lifelong treatment.10

Despite this progress, many low- and middle- income countries remain heavily dependent upon international donors to finance their HIV response. In 2014, 44 countries had 75% or more of their HIV financing needs provided by external sources.11 96% of Mozambique’s and 86% of Zimbabwe’s HIV response was financed by international assistance.12

Case study: Financing HIV treatment costs in Vietnam

In Vietnam, funding from the USA’s President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), has enabled the government to cover 95% of the cost of antiretroviral drugs (ARVs), equating to US$ 21.2 million in 2014. For the first time, the government is spending more than $3.5 million of its
own money to treat people living with HIV. This is the first step towards ensuring sustainable resources for the country’s HIV response.

With international donor funds expected to decrease in the coming years, the Vietnamese government will have to find a more sustainable way to ensure treatment coverage. Recently, the government committed to covering 70% of treatment needs by 2018 and has allocated $15-20 million to buy first-line ARVs.13

People who inject drugs (sometimes referred to as PWID) are particularly affected by the HIV epidemic in Vietnam. Nearly 60% of all HIV cases are among this group and people who inject drugs have an estimated HIV prevalence of 30%. To be effective, Vietnam will have to ensure its national HIV response includes programmes targeting people who inject drugs and other key populations such as sex workers. These key groups have sometimes been left behind when international funding has been withdrawn in other middle-income countries.14

**International HIV funding**

International HIV funding from donor governments is provided through both bilateral and multilateral channels. In 2016, donor governments provided US$ 7 billion for HIV – a 7% decline on 2015 levels (US$ 7.53 billion).15

This decline was due to a number of factors including the depreciation of donor currencies, delays in bilateral disbursements by the United States of America (USA) (the biggest donor), and the front-loading of pledged contributions to the Global Fund. However, even accounting for these, donor government spending has continued to fall consecutively since 2014.16

Although the USA accounted for the majority of bilateral and multilateral funding from donor governments in 2016, governments in 2016 (US$ 4.9 billion), where standardised by the size of its economy the country ranked third. Contributions by the USA were followed by the United Kingdom (UK) (US$ 645.6 million), France (US$ 242.4 million), the Netherlands (US$ 214.2 million) and Germany (US$ 182 million). Since 2006, these five countries have accounted for roughly 80% of all HIV funding from donor governments.17

**Bilateral assistance**

The majority of donor government funding was distributed directly to recipient countries in 2016 (74%). Although ‘bilateral’ funding fell by US$ 108 million in 2016 compared to the previous years, this was offset by disbursements of US$ 69 million from the USA governments.18

*The President’s Emergency Plan for AIDS Relief (PEPFAR), USA*

One source of bilateral funding is the President’s Emergency Plan for AIDS Relief (PEPFAR) which started as a five year (2003-2008), US$ 15 billion commitment by the USA government to tackle the global HIV and AIDS epidemic.19

Since 2003, PEPFAR has spent US$ 70 billion on programmes globally to combat HIV and AIDS, tuberculosis, malaria and other opportunistic infections. PEPFAR is the largest healthcare initiative to be launched by one country to address one disease.20 PEPFAR currently funds ART treatment for nearly 11.5 million people, up from the 50,000 individuals who were receiving ART in sub-Saharan Africa before it was set up.21

**Multilateral assistance**

In 2016, a total of US$ 1.5 billion international HIV assistance was provided through multilateral
organisations such as the Global Fund, UNITAID and other United Nations agencies. This was a significant 22% decrease on 2015 levels (US$ 1.9 billion) with most of this due to legislative limitations on Global Fund contributions – although much of this missing funding was later disbursed in 2017.22

Seven donors provided the majority of their HIV funding through multilateral channels (Australia, Norway, France, Germany, Italy, Japan and Canada).23

*The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)*

Founded in 2002, the Global Fund is an international financing organisation that aims to ‘attract and disburse additional resources to prevent and treat HIV and AIDS, tuberculosis and malaria.’24 The Global Fund currently supports programmes providing ART to 10 million people.25

In September 2016, the Fifth Replenishment of the Global Fund saw governments and private sector donors commit $12.9 billion to fight HIV and AIDS, tuberculosis and malaria between 2017 and 2019. This was almost exactly the $13 billion target, and represented a nearly $1 billion increase on funds raised at the previous pledging conference in 2013.26

The Global Fund is the world’s largest financier of HIV and AIDS, TB and malaria programmes. In 2015, 55% of its total disbursements went towards HIV and AIDS programmes. The USA was the largest donor to the Global Fund followed by the UK, France, Germany and Japan.27

*Other sources of funding*

Private philanthropic organisations provided US$ 618 million for global HIV and AIDS programmes in 2014 – an 8% increase on 2013 levels. However, this is still down 8% on the high mark in 2008 ($674 million).28

Private philanthropies include foundations, corporations, faith-based organisations, non-government organisations and individuals. As well as providing funding for the global HIV response, many of these organisations provide other non-financial support such as price reductions for HIV treatment.29

*The Bill & Melinda Gates Foundation*

The Bill & Melinda Gates Foundation is the leading philanthropic funder of international HIV efforts. In fact, it is one of the largest private foundations in the world and aims primarily to enhance healthcare and reduce extreme poverty. In 2014, the foundation provided 34% of all HIV-related philanthropic giving.30

To date, the foundation has committed more than $3 billion in HIV grants to organisations around the world and has given an additional $1.6 billion to the Global Fund. The foundation concentrates its spending in places where existing funds are scarce and will therefore have the greatest impact.31

*Innovative funding mechanisms*

The global HIV response has inspired a number of innovative funding models. One example is UNITAID which, in the last five years, has raised over half of its funds through the ‘air ticket levy’. 
Ten countries have so far implemented the air ticket levy, an additional tax on plane tickets which individual countries can set and control.\textsuperscript{32}

Another example is the Global Fund’s Debt2Health programme launched in 2007 to generate additional domestic resources for health financing through debt swaps. Under this programme developing countries can forgo repayment of a portion of their sovereign debt on the condition that they invest an agreed amount in their health system through the Global Fund. By the end of 2013, a total of US$ 212.5 million had been written off in swap agreements under this scheme.\textsuperscript{33}

**How is international HIV and AIDS funding allocated?**

International HIV and AIDS funding is allocated in a number of ways and has changed over time. In recent years, funders of the HIV response have been exploring ways to increase the impact and efficiency of HIV and AIDS programmes with many starting to aim resources at key affected populations most at risk of HIV.

**How does the Global Fund allocate its resources?**

Between 2002 and 2011, the Global Fund allocated its HIV and AIDS resources by demand and country requests and disbursed its resources on a first come, first served basis. Under this system, the most ambitious proposals tended to receive grants regardless of the effectiveness of the chosen intervention, its cost-effectiveness or efficiency.\textsuperscript{34}

From 2012 to 2016, the Global Fund based the distribution of HIV funds on country need and more specific objectives to control the epidemic. The allocation methodology was based on criteria such as HIV prevalence and a recipient country's ability to finance its own response.\textsuperscript{35}

In April 2016, the Global Fund approved a new allocation methodology for 2017 to 2019. The new method gives greater priority to low-income/high burden countries. However, while low-income countries will receive 44.3% of Global Fund investment over this period compared to 41.9% between 2014 and 2016, lower-middle income countries and upper-middle income countries will receive slightly less.\textsuperscript{36}

There has been some criticism of this new funding allocation. Various NGOs have raised concerns that key affected populations - such as men who have sex with men, sex workers and people who inject drugs - who bear the greatest burden of HIV in many middle-income countries may be left behind because they are socially excluded and stigmatised.\textsuperscript{37}

**Case study: Romania’s spike in new HIV infections**

The Global Fund withdrew from Romania in 2010 as the country gained middle income status. The resulting gap in funding has led to a drastic increase in HIV cases, specifically in key populations. Among people who inject drugs, new HIV infections rose from 3% in 2010 to 29% in 2013. Much of this increase is linked to the lack of funds to provide targeted prevention interventions for people who inject drugs.\textsuperscript{38}

While the Global Fund directly allocates the vast majority of its funding (85%), the remaining 15% is distributed via 'counterpart financing'.\textsuperscript{39}

To be eligible for this funding, a country (or ‘counterpart’) has to commit a minimum level of funds...
towards its national HIV programmes as a share of government and Global Fund investments. The counterpart financing threshold is currently set at 5% for low-income countries, 20% for ‘lower’ low- and middle-income countries, 40% for ‘upper’ low- and middle-income countries and 60% for upper-middle income countries.40

Some have argued that counterpart financing, in conjunction with the Global Fund’s country allocations, constrain a country’s HIV budget by setting both a lower and upper limit. There is also currently no guidance for what happens to allocations when a country moves into a different income category.41

**How does PEPFAR allocate its resources?**

The majority of PEPFAR’s resources are have been dedicated to focus-country programmes. “Focus countries” (which were mainly high prevalence, high population countries in sub-Saharan Africa) accounted for 90% of PEPFAR’s bilateral funding between 2004 and 2011. In 2013, an Institute of Medicine report said that PEPFAR’s funding priorities did not completely reflect the global HIV burden -- defined by the number of HIV cases and HIV prevalence. For example, three focus countries -- Rwanda, Haiti and Guyana -- received a disproportionate share of PEPFAR funding considering their small populations and number of HIV cases. By comparison, Swaziland, which has the highest HIV prevalence in the world, received the least amount of money among PEPFAR focus countries. Between 2004 and 2011, PEPFAR spent $635 million in Rwanda compared to just $126 million in Swaziland.42

A number of studies have more fundamental concerns about estimations of HIV prevalence, particularly in regions like sub-Saharan Africa where there are varying levels of participation in Demographic Health Surveys.43 These surveys are often the only representation of national HIV prevalence, and if they are not accurate, it makes measuring and targeting subnational populations even more difficult.44

**How do other funders allocate their resources?**

UNITAID is a global health initiative which aims to increase access to affordable treatment and prevention of HIV and AIDS, malaria and tuberculosis. The organisation intervenes to stimulate otherwise niche health markets in order to expand supply, improve quality, stimulate development of new and better projects, and bring prices down. In 2010, UNITAID established the Medicines Patent Pool (MPP) to hold patents of antiretroviral and other medication. This allows the MPP to manufacture these drugs more cheaply for distribution in low- and middle-income countries.45

The World Bank, as well as financing HIV prevention, treatment and care programmes, supports countries to do ‘better for less’. Specifically, it provides technical assistance to increase the efficiency, effectiveness and sustainability of national responses to the epidemic.46

The Bill & Melinda Gates Foundation concentrates its spending via grant-making in places where existing funds are scarce and will therefore have the greatest impact.47

**Case study: A new focus on key populations**

Targeting specific populations at risk of HIV transmission (such as men who have sex with men and people who inject drugs) has proved highly effective and efficient in a number of countries.48 49 50 To reflect this evidence and in the context of stagnating donor funding, donors have been establishing new funding frameworks and mechanisms that aim to finance efforts that focus on key populations.
Since 2011, the UNAIDS Strategic Investment Framework has encouraged countries to prioritize their spending on country epidemiology (where HIV affects certain groups) to produce 'substantial and lasting effects on the HIV/AIDS epidemic'. It is hoped that implementing the framework will avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020.51

In 2016, PEPFAR launched a $100 million Key Populations Investment Fund to expand HIV prevention and treatment access for key populations. The fund aims to identify, measure and tackle the factors driving stigma and discrimination that prevent access to tailored HIV services.52

However, targeting these groups is particularly challenging for a number of reasons. High levels of stigma and discrimination create barriers and disincentives for them to access services, and more broadly sow distrust and drive key populations underground and to the margins of society. Organisations such as UNAIDS also remain almost completely reliant upon individual countries to provide data on these groups, with large variations in data collection.53

We will only end the AIDS epidemic by 2030 if no one is left behind [...] It is unacceptable that key populations still face stigma, discrimination, and violence, which impede their ability to access quality HIV services.

– Deborah Birx, US Global AIDS Coordinator Ambassador

**How could funding be spent more effectively?**

While funding for the HIV response has generally increased over time, the rapid increase in spending on HIV treatment has led to a decline in the percentage of resources spent on prevention services. In recent years, spending on prevention services has been reduced to about 20% of all HIV spending. In 2016, a new Political Declaration on HIV and AIDS saw member states committing to spend 25% of all spending on prevention, highlighting the current gap in funding for this area of the HIV response.54 55

Despite between 40% and 50% of all new HIV infections among adults occurring among key populations and their partners, just 2% of all HIV funding and around 9% of resources allocated specifically for prevention are spent on these groups.56 57

Moreover, the majority of funding for key populations is from external sources, such as PEPFAR's Key Populations Investment Fund. While these efforts help to fill the funding gap, they do not address the need for sustainable interventions driven by the domestic resources of affected countries.58
Despite between 40% and 50% of all new HIV infections among adults occurring among key populations and their partners, just 2% of all HIV funding is spent on these groups.

One study of four countries in different regions with different epidemics found that funding for primary prevention programmes (that aim to halt new infections), accounted for a disproportionately low level of HIV spending- 6% in Brazil, 4% in Cameroon, 15% in Myanmar and 10% in South Africa. Investments must be rebalanced to ensure an effective response.

Funding for HIV prevention research and development has increased in some areas but has fallen in others. While funding for research into vaccines, pre-exposure prophylaxis (PrEP), female condoms and the prevention of mother-to-child transmission (PMTCT) increased in 2014, investments towards microbicides, treatment as prevention and medical male circumcision decreased. Between 2013 and 2014, funding for all HIV prevention research and development fell by 1% to $1.25 billion.

Closing the HIV resources gap

UNAIDS' Fast-Track approach requires a rapid increase in funding for HIV over the next few years to have a decisive impact on the epidemic and ensure the long-term sustainability of the HIV response. From an estimated $19 billion made available in 2015 for HIV programmes in low- and middle-income countries, investments will need to increase by roughly one third to $26.2 billion by 2020.

A number of factors have influenced the estimated funding needed. These include the 2015 World Health Organization treatment guidelines that recommend that all people living with HIV start treatment regardless of CD4 count. UNAIDS’s initial funding projections were actually higher but reductions in antiretroviral drug prices and a more streamlined approach to care and support services for people living with HIV are driving costs down.

The stagnation of donor funding is also demanding that interventions are cost-effective and efficient. The African Union’s ‘Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa’ emphasises country ownership, efficiency and sustainable financing of the HIV response and is one example reflecting increasing political commitment to these principals. Likewise, the ‘Arab Strategic Framework for the Response to HIV and AIDS (2014–2020)’ aims to increase reliance on domestic sources for the HIV response in all Arab countries by 80% by 2020.

A number of countries have already used a range of strategies to increase the efficiency and sustainability of their HIV and AIDS programmes. For example, Cambodia has re-allocated its existing resources to high-impact, targeted interventions. In South Africa, billions of Rands have been saved by dramatically improving the antiretroviral drug tendering process. Kenya and Kazakhstan have set up their future HIV funding mechanisms in anticipation of receiving fewer
external funds from donors in the coming years.68

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