

Funding for HIV and AIDS



KEY POINTS:

- To be on course to end AIDS as a public health threat by 2030, UNAIDS estimates that US\$26.2 billion will be required for the global HIV response in 2020 alone. This means the world must increase the amount of resources available for HIV by US\$1.5 billion each year between 2016 and 2020, a situation that is looking increasingly unlikely.
- In recent years, high-income countries have reduced funding for the HIV response in low- and middle-income countries, with a 7% decrease reported between 2015 and 2016. Philanthropic donations, on the other hand, have risen for the past three consecutive years.
- Domestic funding for the HIV response now exceeded funds provided by international donors, accounting for 57% of the global funding total in 2015. In the face of donor stagnation there is increasing emphasis on countries most affected by HIV to finance their own responses and find more efficient and cost-effective ways to do so.
- Despite the fact that between 40% and 50% of all new HIV infections among adults occur 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.

Explore this page to find out more about [sources of HIV and AIDS funding](#), [how international funding is allocated](#), [how funding could be spent more effectively](#) and [the future of funding for the HIV response](#).

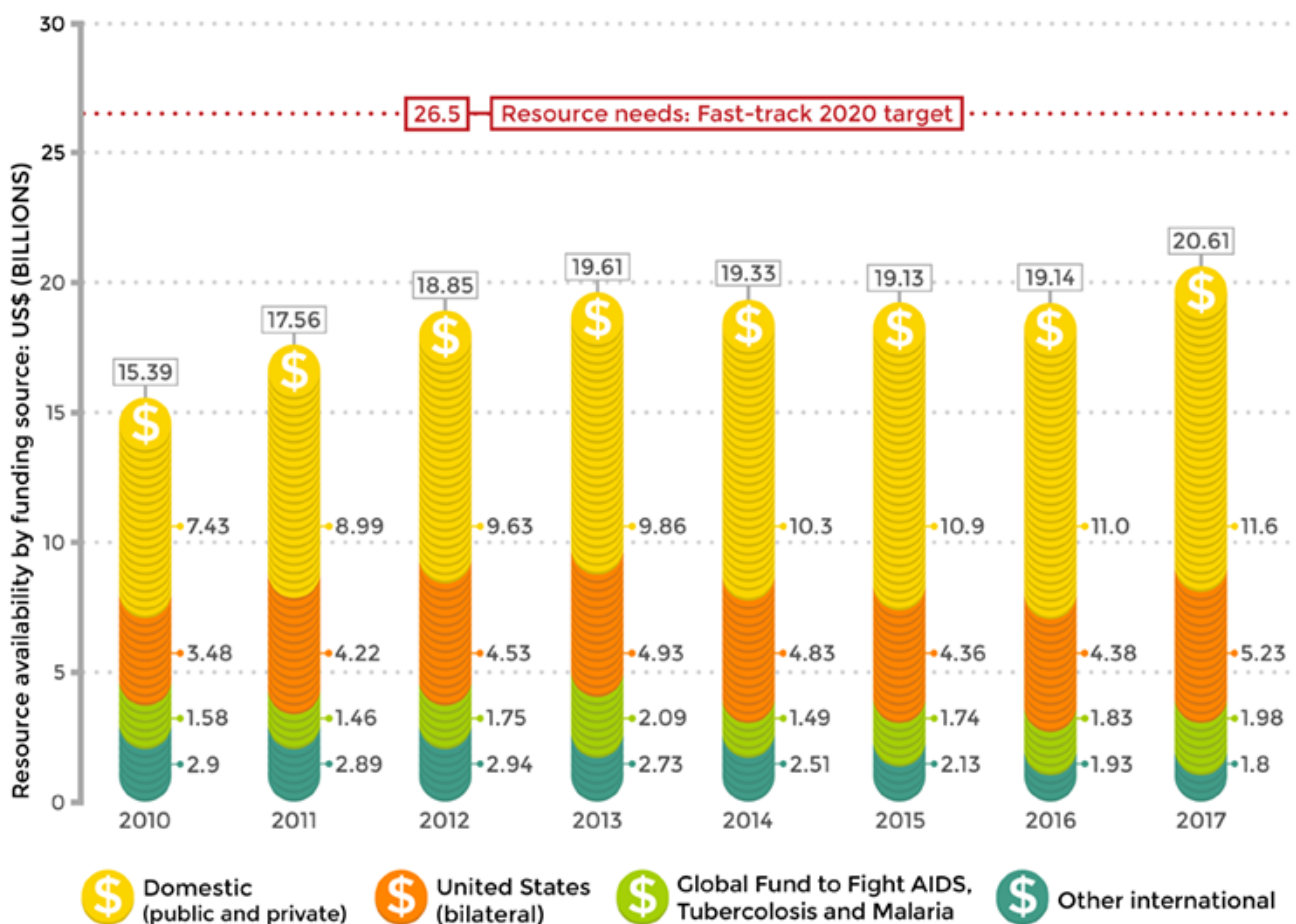
The huge mobilisation of resources for the global HIV and AIDS response over the course of the epidemic has been unprecedented in the history of public health. The challenge of funding HIV

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

National governments in some low- and middle-income countries are now stepping up to fund their own responses, slowly filling some funding gaps and working towards a more sustainable response to HIV.²

HIV resource availability* in low- and middle-income countries by source of funding, 2010-2017 and 2020 target



*in constant 2016 US dollars

Source: UNAIDS Data 2018

In 2011, the United Nations’ 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 2015.³ At the same time, the 2011 UNAIDS Strategic Investment Framework encouraged countries to prioritise their spending on population groups most affected by

HIV in order for funding to have the highest, most efficient impact.⁴ However, a lack of investment in key population programmes remains a persistent issue.

The funding target set by the United Nations in 2011 was missed, with US\$19.1 billion made available for the HIV response in low- and middle-income countries by the end of 2016. Domestic spending constituted 57% of these resources.⁵

Since then, UNAIDS' ambitious Fast-Track approach —endorsed by the UN General Assembly in the 2016 Political Declaration on Ending AIDS—has committed to ending the global HIV epidemic as a public health threat by 2030. In order to achieve this, UNAIDS estimates that US\$26.2 billion will be required for the HIV response in 2020, steadily decreasing to \$23.9 billion by 2030.⁶

In order to reach the 2020 target, the world must increase the amount of resources available for the HIV response by US\$1.5 billion each year between 2016 and 2020. ⁷ 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. In 2018, the United States of America (USA), the largest contributor to the global response, proposed cuts of US\$1 billion.⁸

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, UNAIDS⁹

Sources of HIV and AIDS funding

Domestic resources

Domestic funding is HIV spending, by country governments in their national budgets. 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 finance their HIV response.

In 2015, domestic resources exceeded funds provided by donors and accounted for the majority of global HIV funding (57%), totalling US\$10.9 billion.¹⁰ Although domestic investments increased by an average of 11% a year from 2006 to 2016, the rate of that increase slowed to 5% between 2015 and 2016.¹¹

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Although challenging for low- and middle-income countries, shifting towards domestic funding has advantages. These include fostering ownership and accountability in the implementation of the national HIV response and increasing their sustainability.¹²

Some wealthier countries are progressively contributing more domestic resources to the HIV response. For example, India funds more than 80% of its national HIV programme, while [South Africa](#), pays for 77% of its response.¹³ However, the funding situation in South Africa is expected to become more challenging over the coming years following the government's commitment to fund lifelong treatment.¹⁴

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.¹⁵ In East and Southern Africa, the region worst affected by HIV in the world, eight of the 15 countries reporting data to UNAIDS in 2017 were dependent on donors for more than 80% of their HIV response.¹⁶

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Case study: Transitional funding in Vietnam

In 2015, spending on HIV in Vietnam was estimated at US\$137.5 million. The USA's President's Emergency Plan for AIDS Relief (PEPFAR) funded 36% of this, while the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) contributed 14%.¹⁷ As a result, the vast majority (94%) of people living with HIV received free antiretroviral treatment in 2015.¹⁸

International funds for HIV programmes in Vietnam are decreasing as the country moves from low-income to a lower middle-income status. In response, the Vietnamese government has invested in finding more sustainable way to ensure HIV treatment and has committed to covering 70% of treatment needs by 2018 at a cost of US\$15-20 million for first-line antiretrovirals (ARVs).¹⁹

In order to fund this, the government's has centralised ARV procurement, and is funding costs through its Social Health Insurance (SHI) fund. SHI is a national insurance scheme that is compulsory for those in formal employment but voluntary for others. According to the Vietnam Authority of HIV/AIDS Control, people living with HIV are less likely to be covered under SHI. While 67% of the general Vietnamese population are covered, only 30 to 50% of people living with HIV are (depending on location). High costs not covered by SHI and difficulties signing up to the scheme with missing legal documents such as an identity card means that many people living with HIV miss out on having health insurance.²⁰ For example people who inject drugs make up 60% of all new HIV infections in Vietnam, yet many do not have the legal documentation to get health insurance, so many are left behind. ²¹

International funding

International HIV funding from donor governments is provided through both bilateral and multilateral channels. International investment in the HIV responses of these countries peaked in 2013 at nearly US\$10 billion; it has since declined to around US\$8.1 billion in 2016.²²

This decline was due to a number of factors including the depreciation of donor currencies, delays in funding from the [USA](#) (the biggest donor), and the decision taken by many to 'front-load' their contributions to the Global Fund – so that they give more earlier on.²³

The USA accounted for the majority of bilateral and multilateral funding from donor governments in 2016 (US\$4.9 billion). 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.²⁴

Bilateral assistance

In 2016, 74% of donor government funding was distributed bilaterally, which means it was sent directly from a donor country to recipient country. Although 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.²⁵

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

One source of bilateral funding is PEPFAR, which initially started in 2003 as a five year, US\$15 billion commitment by the USA government to tackle the global HIV and AIDS epidemic.²⁶

PEPFAR has continued to this date and has spent more than US\$70 billion on programmes globally to combat HIV and AIDS, tuberculosis, malaria and other opportunistic infections since 2003.²⁷ As of September 2017, PEPFAR was supporting antiretroviral treatment (ART) for more than 13.3 million people and had funded 85.5 million HIV tests in that year alone, including for more than 11.2 million pregnant women.²⁸ PEPFAR's 2017-2020 strategy narrowed its focus to 13 countries with high levels of HIV, although it operates programmes in more than 50 countries overall.²⁹

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 is a 22% decrease on 2015 levels (US\$1.9 billion), with most of the decrease due to the introduction of a U.S. law, limiting the country's contribution to one-third of total contributions to the Global Fund. However, much of this missing funding was provided later, in 2017.³⁰

Australia, Norway, France, Germany, Italy, Japan and Canada all provide the majority of their HIV funding through multilateral channels.³¹

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

Founded in 2002, the Global Fund is an international financing organisation that works in partnership between governments, civil society, the private sector and people affected by HIV, tuberculosis and

malaria.³² It provides more than 20% of all international financing for HIV programmes, and has disbursed more than US\$17 billion for HIV programmes in more than 100 countries between 2002 and 2016 (excluding TB/HIV programmes).³³

The Global Fund has three key criteria for allocating its funds, prioritising: countries with high disease burden, countries where the proportion of key populations is highest, and countries where national health systems lack capacity to respond to HIV. In 2017, it supported programmes providing ART to 11 million people and provided 579 million HIV tests.³⁴

The Global Fund has been instrumental in supporting key populations in a number of ways. It appoints key population representatives to sit on Country Co-ordinating Mechanisms (CCMs), national committees that submit requests for funding on behalf of the entire country and oversee implementation once the request has been granted. It has also been instrumental in funding a large majority of key population programmes in many countries.³⁵ For example, it is the world's largest investor in harm reduction programmes for people who inject drugs.³⁶

In September 2016, the Fifth Replenishment of the Global Fund saw governments and private sector donors commit US\$12.9 billion between 2017 and 2019. This was very close to the US\$13 billion target, and represented a nearly US\$1 billion increase on funds raised at the previous pledging conference in 2013.³⁷

Other sources of funding

Private philanthropic organisations provided US\$680 million for global HIV and AIDS programmes in 2016. This is a 2% increase from 2015, the third consecutive year of growth, and US\$8 million more than the previous record year of 2008, when philanthropic donations totalled US\$674 million.³⁸

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.³⁹

The top 20 funders account for 87% of 2016 philanthropic resources, with the two largest funders — The Bill and Melinda Gates Foundation and Gilead Sciences representing over half of all philanthropic funding in 2016. The annual rise was driven by significant increases from ViiV Healthcare, Aidsfonds, and Elton John AIDS Foundation, and in particular a US\$41 million increase from the Bill and Melinda Gates Foundation. However, among all other private funders, giving to the HIV response decreased by 5%.⁴⁰

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Funding to low- and middle-income countries from private funders increased by 11% between 2015 to 2016. East and Southern Africa is the region to receive the greatest share of private funds. The top intended use for funding from philanthropic donations was research (which, at US\$249 million, increased 13% from 2015) followed by prevention (a 26% increase at US\$169 million).⁴¹

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 2016, the foundation provided 35% of all HIV-related philanthropic giving.⁴²

To date, the foundation has committed more than US\$3 billion in HIV grants to organisations around the world and has given an additional US\$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.⁴³

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 an 'air ticket levy', an additional tax on plane tickets which individual countries can set and control. Ten countries have so far implemented the air ticket levy. ⁴⁴

Another example is the Global Fund's Debt2Health programme, which 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 they invest an agreed amount in their health system through the Global Fund. To date, debts swapped under Debt2Health agreements total around US\$212 million, involving Australia and Germany on the creditor side; Côte d'Ivoire, Egypt, Ethiopia, Indonesia and Pakistan on the beneficiary side.⁴⁵

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 [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 on the basis of 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.⁴⁶

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.⁴⁷

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.⁴⁸

Once a country reaches upper-middle-income status, it is no longer eligible for Global Fund grants unless its disease burden continues to be classified as high. These countries will go through a process known as 'transitional funding', as they shift from Global Fund grants toward full domestic funding for health programmes. Between 2017 and 2019, 18 disease programmes from 14 countries will go through transition.[49](#)

Concerns have been raised regarding the effect transition may have on the HIV response. The Global Fund Advocates' Network argues that using a country's income level as a measure of its ability to sustain a public health response does not factor in that country's willingness and ability to absorb programmes into its domestic funding and operational structures. Additionally, while many governments have shown a strong willingness to fund HIV treatment, very few have stated their commitment to continuing and expanding community-based prevention programmes aimed at key populations, the people who are most affected by HIV.[50](#)

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[51](#), however, the rate of new infections began to slow between 2014 and 2015.[52](#)

Much of the rise in new HIV infections is linked to the lack of funds to provide targeted prevention interventions for people who inject drugs.[53](#)

While the Global Fund directly allocates the vast majority of its funding (85%), the remaining 15% is distributed via 'co-financing'.[54](#)

To be eligible for this funding, a country has to commit a minimum level of funds towards its national HIV programmes as a share of government and Global Fund investments. The co-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.[55](#) Some have argued that co-financing, in conjunction with the Global Fund's country allocations, constrain a country's HIV budget by setting both a lower and upper limit.[56](#)

How does PEPFAR allocate its resources?

PEPFAR funds and operates programmes in more than 50 countries. However, between 2017 and 2020, PEPFAR will focus its funds on 13 high burden countries, all of whom have the systems in place to help them gain control of their epidemics by 2020. PEPFAR hasn't specified what percentage of its funds will go to these 13 countries or by how much the budget for other PEPFAR countries will be reduced.[57](#)

In 2013, an Institute of Medicine report found that PEPFAR's funding priorities did not completely reflect the global HIV burden -- defined by the number of new HIV cases and HIV prevalence. For example, in the 2018 financial year, PEPFAR's budget requests for Rwanda and Haiti are both greater than its request for [eSwatini](#), which has the highest HIV prevalence in the world.[58](#)

How do other funders allocate their resources?

UNITAID is a global health initiative that aims to increase access to affordable treatment and prevention of HIV and AIDS, malaria and tuberculosis. The organisation intervenes to open up new health markets in order to expand supply, improve quality, stimulate development of new and better projects, while bringing prices down. In 2010, UNITAID established the Medicines Patent Pool (MPP) to hold patents of ARV and other medication. This allows the MPP to manufacture these drugs more cheaply for distribution in low- and middle-income countries.⁵⁹

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.⁶⁰

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.^{61 62 63} To reflect this evidence, and in the context of stagnating donor funding, donors have been establishing new funding frameworks and mechanisms to finance efforts that focus on key populations.

For example, since 2011, the UNAIDS Strategic Investment Framework has encouraged countries to prioritise their spending on groups most affected by HIV.⁶⁴ Similarly, in 2016, PEPFAR launched a US\$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.⁶⁵

The Global Fund launched a Key Populations Action Plan in July 2014, to run to 2017.⁶⁶ This has helped to inform the Global Fund's 2017-2019 criteria for allocating funding, which specifically requires countries to address HIV epidemics among key populations.⁶⁷ In addition, the Global Fund has made a further US\$800 million available for 'catalytic investments'. These are investments designed to support specific interventions that might not be adequately provided for in individual countries budgets. For example, the Global Fund may offer to match funding provided by a country, for programmes aimed at key populations, in order to encourage greater provision for this more at risk group. ⁶⁸

Targeting key populations is particularly challenging for a number of reasons. High levels of [stigma and discrimination](#) create barriers and disincentives for key populations to access services, and drive people 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, and countries vary widely in how well they do this. ⁶⁹

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 - in the era of 'treatment as prevention' - has led to a decline in funding for other prevention services. In recent years, spending on these prevention services has been reduced to about 20% of all HIV spending. The 2016 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.^{70 71}

Increasing funding for interventions aimed at key populations could also improve the efficiency of HIV financing. Currently just 2% of all HIV funding, and around 9% of resources allocated specifically for prevention, are spent on these groups, despite the fact that between 40% and 50% of all new HIV infections in adults occur among key populations and their partners.^{72 73} As mentioned above, the majority of funding for key populations comes from international donors. 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.⁷⁴

Human rights work plays a vital role in protecting populations most affected by HIV. However, only US\$137 million is spent annually on the global human rights response to HIV, accounting for just 0.13% of all HIV spending in low- and middle-income countries.⁷⁵ Funding for [harm reduction programmes](#) that target drug users also remains far below estimated need and is in decline, dropping 7% between 2015 and 2016.⁷⁶

In 2016, overall funding for HIV prevention research and development decreased by 3% (US\$35 million) from the previous year, falling to US\$1.17 billion, the lowest level in ten years.⁷⁷

The future of funding for the HIV response

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.⁷⁸

A number of factors have influenced the estimated funding needed. These include the 2015 World Health Organization treatment guidelines, which recommend all people living with HIV start treatment regardless of CD4 count.⁷⁹

The stagnation of donor funding is also demanding that interventions are cost-effective and efficient. In 2012, the African Union (AU) endorsed the 'Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa', which emphasises country ownership, efficiency and sustainable financing of the HIV response and reflects increasing political commitment to these principals.⁸⁰ An evolution of the Roadmap has since been endorsed by the AU in the 2013 Abuja + 12 Declaration, and again in 2015.⁸¹ 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

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by 80% by 2020.⁸²

Despite these commitments, and numerous low – and middle income countries deploying a range of strategies to increase the efficiency and sustainability of their HIV and AIDS programmes, it is unlikely many, particularly low-income countries, will be able to shoulder the financial burden for tackling the HIV epidemic in the near future. For example, in April 2001 the AU pledged to allocate at least 15% of their annual budget to the health sector. In 2016, only four countries—Ethiopia, The Gambia, Malawi and eSwatini—had met this target.⁸³ This signals that current funding gaps will remain, and may increase in future years.

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Next full review:

24 May 2018