Funding Needs and Gaps of the HIV Response

Policy Paper

Interagency Coalition on AIDS and Development

Coalition interagence sida et développement

GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

1 WHAT IS THE ISSUE?

Millions of people around the world now need lifelong access to HIV treatment, diagnostics, health services, social services and supplies such as condoms to help prevent HIV transmission. These medicines, services, and supplies must be ordered, paid for, distributed and made available to be used properly. Money is required for all steps. UNAIDS regularly provides estimates about all of these costs, including currently and in the future if needs are to be met.

What is increasingly clear is that there is a large gap between the funding that is needed and the funding that is now made available. UNAIDS says that 116 low- and middle-income countries now need at least $26 billion for HIV, but the world is spending only $19.2 billion.[1,2] (This includes HIV funding from all sources—including national governments, corporations, households, and international assistance from wealthy governments and charitable foundations.[3]) These figures and trends show that insufficient funding is a major crisis in global HIV responses.

2 HOW THE FUNDING GAP AFFECTS PEOPLE LIVING WITH HIV

The gap between the HIV funding that is needed and the funding that is now made available has a big impact on the financial burden on people living with HIV, the cases of illness that people face when they postpone treatment and care, the likelihood of resistance to first-line antiretroviral treatment when supplies of medications are interrupted, and the inability to provide adequate HIV clinical care without CD4 and viral load testing equipment.

The funding gap has severe personal and public financial and health consequences. In every country of the world, people living with HIV and their families and communities spend a large amount of money on their health. They use their incomes, savings, or borrowed funds to pay for the fees and expenses related to medicines and health care. For HIV-related treatment and care, this spending by people living with HIV and their households can amount to 15%-45% of all HIV-related spending in the country, including funding by the government.[4,5] That means that people living with HIV, and their families and communities, are already the single largest 'HIV funder' in many countries around the world.

Governments, especially national governments, are also major funders of HIV-related treatment, services and care, mostly by spending money on clinic and hospital care. The level of that HIV-related funding affects the medicines and services that people living with HIV can access and afford. When government funding changes, the availability and cost of HIV treatment, preventive health services, and social services also change. Without sufficient financial resources, governments cannot ensure that all or even most of the promised health services are available regularly. Such shortcomings put the lives of millions of people at risk, especially those with limited personal economic resources.

UNAIDS says that if governments provided the needed funding, by 2030 the world could help an additional 28 million HIV-uninfected people to avoid getting infected by HIV and help an additional 21 million people living with HIV to stay healthy.

[1] All funding amounts in this paper are presented as US $.
[2] UNAIDS. Countries Adopt UNAIDS Fast-Track Strategy to Double Number of People on Life-saving Treatment by 2020. 24 November 2015. www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/november/20151124_LocationPopulation (accessed 27 October 2016).
[3] Of total global HIV funding for low- and middle-income countries, 57% of all funding comes from in-country sources—national and local governments, local corporations and charities, and households, according to the Report of the UN Secretary-General, On the Fast-Track to End the AIDS epidemic, 2016. Another 39% was contributed from high-income countries, with a quarter of that invested through multilateral funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and UNITAID, and three-quarters invested directly from government programmes such as U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the UK Department for International Development (DfID). (Source: Institute for Health Metrics and Evaluation, Financing Global Health 2014: Shifts in Funding as the MDG Era Closes, Seattle, WA: IHME, 2015.) The remaining 4% of total HIV funding for low- and middle-income countries came from the private sector, including philanthropic foundations, corporations, faith-based organisations, international non-government organisations (NGOs), and innovative financing schemes such as an airline ticket tax that helps to fund UNITAID.
[4] WHO. Health Financing Database. 2016. www.who.int/gho/health_financing/total_expenditure/en/ (accessed 27 October 2016).
[5] Estimates from Institute for Health Metrics and Evaluation. Financing Global Health 2014: Shifts in Funding as the MDG Era Closes. Seattle, WA: IHME, 2015.

3 BACKGROUND INFORMATION

Approximately 37 million people are now living with HIV, and millions more are members of key populations[6] and others at high risk of becoming infected with the virus. In addition to lifelong access to HIV treatment, many need a range of health services and social services to address issues such as sexual health, reproductive health, mental health and addiction, and issues of aging and economic hardship. They also need supplies that can help reduce transmission, such as condoms and clean syringes if they inject drugs.

Yet international HIV funding is decreasing at the same time that more people eligible for antiretroviral therapy (ART) and want and need access to other vital HIV prevention and treatment services. The total international HIV assistance from the world's wealthiest countries was $7.5 billion in 2015, down from $8.6 billion in the previous year.[7] This decrease was driven largely by national politics and economics in the countries that provide 95% of international HIV assistance: the United States, the United Kingdom, and several other countries in Western Europe. This trend is especially dangerous for people living with HIV in countries that depend on international aid, including countries in sub-Saharan Africa, South Asia and the Caribbean.[8,9]

Wealthy countries are also withdrawing support from middle-income countries because they believe those nations can and should be able to spend more of their own funds on HIV.[10] But because of large populations in several of these countries, many have a long struggle ahead of them to provide adequate health care and social services to everyone in need. Despite the term 'middle-income',[11] countries in this category are home to more than half of the world's people living on less than $2 per day and a full 70% of the world's people living with HIV.

The withdrawal of international HIV funding from middle-income countries threatens the continuity and coverage of health services, especially for politically and socially marginalized populations—such as people who use drugs, sex workers, gay men and other men who have sex with men (MSM), and transgender people—that are not well served by national and local health services and legal systems. Evidence in countries such as Mexico and Romania has shown that HIV rates have increased after international funding for HIV commodities such as condoms and syringes ended.[12]

4 THE GOOD AND THE BAD: OPPORTUNITIES AND CHALLENGES FOR PEOPLE LIVING WITH HIV

Fortunately, there are **opportunities** for people living with HIV to influence funding for HIV.

- Within high-income countries of Europe, North America, and elsewhere, many activist coalitions are working to push for sustained and increased spending for international aid.[13,14] These coalitions actively need to partner with people living with HIV around to world and amplify their voices and stories to underscore the importance and impact of investing in international assistance.

[6] The term 'key populations' refers to people and communities with higher-than-average rates of HIV and greater risk for becoming infected with the virus. Men who have sex with men (MSM), sex workers and people who inject drugs are key populations in nearly every country. Other people and communities are considered key populations in some countries, including migrants, prisoners and adolescent girls. In most countries and regions, members of key populations are less likely on average to be get HIV prevention and treatment services due to stigma, discrimination and many legal, social and cultural barriers.

[7] Kaiser Family Foundation. Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015. July 2016. http://kff.org/global-health-policy/report/financing-the-response-to-hiv-in-low-and-middle-income-countries-international-assistance-from-donor-governments-in-2015/ (accessed 27 October 2016).

[8] Muchiri S et al. HIV/AIDS Expenditures in Sub-Saharan Africa: Observations from Kenya, Rwanda and Zambia. July 2013.

[9] Institute for Health Metrics and Evaluation. Financing Global Health 2014: Shifts in Funding as the MDG Era Closes. Seattle, WA: IHME, 2015.

[10] For example, the United States government, through its HIV programme called PEPFAR, requires the governments of countries receiving HIV assistance to match at least 25% of costs. The Global Fund also requires matching investment by countries, ranging from 5% to 60% depending on the income level of the country.

[11] Many countries, particularly in Latin America and the Caribbean, Eastern Europe, and the Middle East, but also in Africa and Asia, have growing economies and are thus rising into 'middle-income' status. The World Bank currently classifies 108 countries as middle-income, meaning that their populations have an average annual per capita income of between $1,026 and $12,475. Countries currently in this broad classification include populous ones such as Brazil, China, India, Indonesia, Mexico, Nigeria, Pakistan, and South Africa.

[12] Open Society Foundations. Undermining the Global Fight: The Disconnect Between the Global Fund's Strategy and the Real-life Implications of the New Funding Model. November 2014. Available at www.opensocietyfoundations.org/sites/default/files/undermining-global-fight-20141201.pdf. Also: Aran-Matero D, et al. Levels of Spending and Resource Allocation to HIV Programs and Services in Latin America and the Caribbean. PLoS One. 2011; 6(7): e22373.

[13] MSF Access Campaign. See www.msfaccess.org/

[14] Health Gap. Myths and Facts about Donor Funding for the Global AIDS Response. 2016. www.healthgap.org (accessed 27 October 2016).

- At an international level, there is an active dialogue underway about the withdrawal of international HIV funding from middle-income countries. Networks of people living with HIV are at the centre of these discussions and have an important voice and role in explaining the real life impact on decisions that are made and determining policy directions and advocacy strategies.
- Furthermore, there are important advances being made in reducing the costs of HIV medicines, commodities and services. These advances are driven by successful efforts to increase the supply of low-cost medicines, equipment and supplies and also to improve the efficiency and effectiveness of the delivery of these vital materials to people in need.

The HIV effort will also need to continue to work to overcome key **challenges** in the funding landscape. These include:

- The need to build coalitions and communications in high-income countries to maintain support for international assistance and support for health in low- and middle-income countries.
- The need to combat local and national contexts of persistent discrimination and criminalization of people living with HIV and key populations who are living with HIV or at risk of HIV. This discrimination and criminalization influences governmental funding decisions for HIV and health, and also fuels related disparities in access to employment, education, housing, and health services, and consequent exposure to poverty, violence and incarceration.

5 HOW TO BE INVOLVED: SUGGESTED ACTION AREAS FOR PEOPLE LIVING WITH HIV

People living with HIV, key population groups and community organisations can and should be involved in increasing funding levels and commitments for HIV responses in their countries and globally. The following are examples of suggested activities and actions:

- **Advocate for wealthy countries to spend more on international assistance for HIV and health.** For HIV, only seven countries spend more than 20 cents for every $1,000 of their gross national income: the Nordic countries (Denmark, Norway and Sweden), the Netherlands, the United States, the United Kingdom, and Ireland.[15] The largest economies not meeting this threshold are Japan, Germany, France, Italy, Canada, Spain, and Australia. A spending level for HIV of 20 cents for every $1,000 of gross national income would help ensure universal access to HIV treatment and have significant positive influence toward ending the global HIV epidemic.

- **Advocate for international HIV funding to be targeted to people living with HIV in all countries.** A full 70% of people living with HIV live in middle-income countries. Many of them are facing desperate futures due to international and domestic funding constraints. International HIV funding should be targeted to where people living with HIV are in need.

- **Advocate for your own country to spend more on health, since basic health services are essential for people living with HIV.** A total of 135 countries include the right or commitment to health in their national constitutions. Of those, 95 countries state that people have the right to access health facilities, goods, and services and 111 countries mandate the right to equal treatment or freedom from discrimination.[16] Those national governments therefore have a constitutional and legal obligation to fulfil the right to health and to protect their populations from illness.

- **Advocate for your own country to spend efficiently and effectively.** Now that HIV programmes are scaling up and gaining experience in most countries, governments and community organisations are able to enrol and support additional people with increasing efficiency and effectiveness. Advocates can push governments to ensure availability of the most effective medicines, adequate staffing of health services, and an end to loss of funds, supplies, and equipment through poor management, corruption and theft.[17,18] Advocacy can improve management of programmes and their use of funding to achieve greater quality for every amount of funding spent.

[15] UNAIDS and Kaiser Family Foundation. Financing the Response to HIV in Low- and Middle-income Countries. 2013. http://files.unaids.org/en/media/unaids/contentassets/documents/document/2013/09/20130923_KFF_UNAIDS_Financing.pdf (accessed 27 October 2016).
[16] Perehudoff, S. K., R. O. Laing, and H. V. Hogerzeil. 2010. Access to Essential Medicines in National Consti¬tutions. *Bulletin of the World Health Organization* 88(11):800.
[17] World Health Organisation. The World Health Report: Health Systems Financing: The Path of Universal Coverage. Geneva: 2010. www.who.int/whr/2010/en/ (accessed 27 October 2016).
[18] Zeng W, Shepard DS, Chilingerian J, Avila-Figueroa C. 2012. How Much Can We Gain from Improved Efficiency? An Examination of Performance of National HIV/AIDS Programmes and its Determinants in Low- and Middle-income Countries. *BMC Health Serv Res* 12: 74.

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