SUSTAINABLE AND EQUITABLE FINANCING OF THE HIV RESPONSE
Countries everywhere are contending with higher demands for health and social spending, often in a context of depressed revenues and unstable public financing. Even before the COVID-19 pandemic and its associated economic disruptions, the resources available for HIV in low- and middle-income countries had been levelling off: despite rising in the previous decade, domestic HIV resources had begun to decline before 2020, and limited investment in key populations has been holding back an equitable HIV response. As a result, the US$ 21.4 billion (in constant 2019 US dollars) available for HIV in 2021 was well short of the US$ 29.3 billion needed in 2025 in order to end the AIDS epidemic by 2030.
The cascading effects of the COVID-19 crisis—and, most recently, the war in Ukraine—now present additional challenges. These crises are reshaping development financing decisions and threatening public investments in health, including HIV programmes.

Domestic investments have helped power the HIV response, but only a minority of countries with a high HIV burden are able to finance full-fledged HIV programmes from domestic coffers: among low- and middle-income countries, just 26% currently finance at least 70% or more of their HIV spending from domestic sources. Post-COVID-19 economic recoveries in many low- and middle-income countries have been uneven and economic growth is expected to slow in 2022 and 2023, according to International Monetary Fund (IMF) projections. Inequalities between countries are increasing as a result of their uneven vulnerability to these economic shocks, and the public finances of low- and middle-income countries are under massive pressure (1, 2).

Deepening the financing predicament of many low- and middle-income countries is the substantial decline in international resources available for HIV. Aside from the Government of the United States of America, development assistance for HIV from bilateral donors has decreased by 57% in the past decade. The large and relatively stable disbursements from the United States, however, have masked those trends.

Meanwhile, out-of-pocket spending remains a major source of health-care financing, despite its impoverishing effect on low-income households and the obstacle it presents to the use of HIV and other health-care services. The proportion of the global population spending at least 10% of their household expenditures on health care has risen by 40% since 2000 (3). Viable and fairer alternatives are available (see the Cameroon feature story in this Chapter).

COVID-19 continues to highlight the crucial importance of equitable and efficient public health systems.

COVID-19 continues to highlight the crucial importance of equitable and efficient public health systems, of adequate and well-protected health workforces, and of affordable health services and products everywhere. Seldom has the interconnectedness of societies across the world been clearer. There is a massive need to revive global solidarity.

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1 The IMF’s April 2022 projections anticipated economic growth in low- and middle-income countries slowing from 6.8% in 2021 to 3.8% in 2022 and 4.4% in 2023. See: World economic outlook, April 2022. Washington (DC): International Monetary Fund; 2022 (https://www.imf.org/-/media/Files/Publications/WEO/2022/April/English/text.ashx).

2 It rose from 9.4% in 2000 to 13.2% in 2017, according to the most recent World Health Organization (WHO) estimates (https://data.worldbank.org/indicator/SH.UHC.OOPC.10.ZS?view=chart).

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Elisabeth Emetini’s life changed nearly a year ago. In the past, she had to pay for check-ups, lab tests, and anything related to her medical condition. “The abolishing of user fees in Cameroon for HIV services has had a real positive effect on me,” she said. It’s not only less of a strain on her pocketbook but it’s also lifted a weight off her shoulders. “Now I am more motivated to take my HIV medicine because it’s not a hassle to get a prescription and I also have had my viral load tested for free as well as a tuberculosis test done,” the Yaoundé resident said. Cameroon, July 2022.
DOING AWAY WITH USER FEES IN CAMEROON

Charging user fees at public health facilities restricts people’s access to services and pushes already-impoverished households deeper into poverty (4). User fees and other out-of-pocket expenditures are the major causes of catastrophic health spending, which affects almost one billion people annually (5).¹ Free access to health-care services at public health facilities, in contrast, increases use and advances equitable access, it can improve health outcomes and boost progress toward achieving global HIV and health targets (6–9). Despite this, user fees are still being levied at clinics and hospitals in many countries, prompting calls and campaigns for the removal of user fees for HIV, tuberculosis and related services at public health facilities, including maternal care clinics.

This work paid off in Cameroon, where the government has decided to remove user fees for HIV services and care in public health facilities countrywide. Antiretroviral medicines had been nominally free in Cameroon since 2007, but related expenditures—for medical consultations, laboratory tests, medicines for opportunistic infections and hospitalization—were not provided free of charge (10). In addition, many health-care providers demanded unofficial fee payments.²

Médecines Sans Frontières, community organizations, UNAIDS and the United States President’s Emergency Plan for AIDS Relief (PEPFAR) commissioned research documenting the effects of user fees on health use and outcomes, exploring pathways for removing them and identifying pitfalls that had to be avoided during their removal. Extensive advocacy and consultations encouraged a government decision to eliminate user fees for HIV services and care at public health facilities and affiliated community-based organizations nationwide, starting in January 2020. After the government’s decision to do away with user fees for HIV-related service and maternal care, technical assistance was arranged to estimate the budgetary requirements to offset lost revenues and to define the financial management mechanisms for addressing any shortfalls.

The removal of user fees had to be planned and implemented with care to avoid disruptions due to loss of revenues at the facility level (11).

This was challenging for Cameroon, where out-of-pocket health spending accounted for around 70% of total health expenditure due to low domestic government spending on health (the average for sub-Saharan Africa is 39%) (12).


² In a study of 76 public health facilities in 2016, Cameroon’s Treatment Action Watch found that more than one half required patients to pay more than the official prices for services. See: État de l’accès aux soins des PV-VIH au Cameroun. Yaoundé: Treatment Action Watch; 2016.
It was also important to ensure that replacement funds reach health facilities on time, especially those in remote areas, and to maintain or improve service quality.

Strong support at the highest level of government drove Cameroon’s decision. It also enabled the creation of a task force to manage the process and the introduction of vital reforms to replace lost revenues. A clear pathway for change was developed, with milestones aligned to the country’s budgetary system and to supportive, long-term technical assistance. Also central to the process were reforms that earmarked increased domestic public health spending to replace lost fee-based revenues. Technical assistance to enable timely disbursement and utilization also contributed to strengthening public financial management.

Despite reduced public revenues and other COVID-19-related challenges, the Government of Cameroon has remained committed to its decision, which followed on earlier reductions of user fees for some other health services (such as immunization, prevention and treatment of malaria for pregnant women and children, and chemotherapy for cancer patients). COVID-19 disruptions have made it difficult to assess the impact of the policy change thus far, but early evidence points to increased uptake of HIV services and continuing implementation of the decision to ensure free access at public health facilities.
INTERNATIONAL INVESTMENTS IN HIV ARE LEVELLING OFF

In 2021, only US$ 21.4 billion (in constant 2019 US dollars) was available for HIV programmes in low- and middle-income countries (see Figure 0.4 in Chapter 1). Furthermore, resource availability data compiled by UNAIDS show that both domestic and international funding for HIV in low- and middle-income countries were levelling off well before the COVID-19 pandemic.

International resources for HIV were about 6% lower in 2021 than in 2010, and they have declined steadily since 2012–2013. The overall reductions would have been much steeper were it not for sustained and high levels of funding from the United States Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), which have increased by about 36% and 56%, respectively, since 2010. Bilateral contributions from the United States Government currently account for almost one quarter (23%) of total annual resources available for HIV in low- and middle-income countries, while the Global Fund accounts for a little more than one tenth (12%). Other international funding for HIV in low- and middle-income countries, mainly from bilateral donors, has fallen steeply—by 82%—since 2008, although the trend varies for individual donors. It is notable, though, that the trend in overseas development assistance provided by bilateral donors to sectors other than HIV shows no such decrease (Figure 5.1).

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3 The Global Fund’s increase in disbursements in 2021 was mostly driven by the additional resources allocated to mitigate the impact of COVID-19 on HIV services. These additional disbursements are not expected to continue beyond 2021.

4 Measured as a proportion of their gross national income (GNI).
Past trends show that economic shocks have had a disproportionately negative impact on overseas development assistance for HIV (Figure 5.2). Year-on-year declines in total international resources available for HIV were strongly correlated with the 2008 global financial crisis and the 2014 European debt crisis, for example. Changes in spending priorities associated with the COVID-19 pandemic—and the war in Ukraine—therefore might further depress overseas development assistance support for HIV programmes and restrict efforts to fill the HIV funding gap.

**FIGURE 5.2** Year-to-year change in resource availability for HIV from domestic and international sources, low- and middle-income countries, 2001–2021


Note: International resources include all multilateral funding (e.g., the Global Fund and various UN agencies and programmes), all bilateral funding (including from the United States Government) and funding from philanthropic sources.
DOMESTIC INVESTMENT IN HIV UNDER THREAT

Domestic resources for HIV declined by 2% in 2021 compared with 2020, following a similar drop in the previous year. This funding source has been the main driver of the growth in available HIV resources in low- and middle-income countries over the past decade: domestic funding had been increasing since the early 2000s and had continued to do so even after the 2008 global financial crisis. Importantly, this funding compensated for the steep reductions in HIV funding from international sources after that crisis and again in 2013–2014 (Figure 5.2). However, the increases became smaller from the mid-2010s onward and then halted in 2018. These are ominous developments, because domestic investments in HIV account for about 60% of total resources available for the HIV pandemic.

The economic shocks experienced in low- and middle-income countries during the COVID-19 crisis—and the ripple effects of the war in Ukraine—may further depress domestic resources for HIV. A recent UNAIDS analysis found that the key predictors of domestic government spending on HIV were the national economic output of countries (measured as gross domestic product), human development index performance, HIV prevalence and the share of general government expenditure on health (13). Several of those indicators are under threat. The World Bank has warned that per capita government spending is expected to drop and remain below pre-COVID-19 levels until at least 2026 in 52 mostly low- and middle-income countries, several of which have large HIV epidemics. Unless stronger priority is given to health, the World Bank also expects per capita government health spending to remain below 2019 levels—and possibly fall—in many of those countries (1). Reduced economic output (and fiscal revenues) and less emphasis on health in government budgets will likely affect domestic HIV spending.

The war in Ukraine may also affect the situation more directly across eastern Europe and central Asia, a region where HIV incidence has increased in the past decade.
WHERE ARE THE BIGGEST FUNDING GAPS?

Resource allocations for HIV vary by region, with particularly large funding gaps in eastern Europe and central Asia, the Middle East and North Africa, and Asia and the Pacific. Generally, the largest gap in funding for HIV (about US$ 3.5 billion) is in lower-middle-income countries: resources available in those countries for 2021 fell 55% short of the projected needs for 2025 (Figure 5.3). The economic impact of the COVID-19 pandemic in some of those countries is also likely to be severe, making it even more difficult for them to close their funding gaps with domestic resources alone.

FIGURE 5.3 Resources for HIV, 2021, and estimated resource needs, 2025, by country income classification


Note: The resource estimates are presented in constant 2019 US dollars. The countries included are those that were classified by the World Bank in 2020 as being low- and middle-income.
Donor commitments for HIV prevention have improved in recent years, but there continue to be large gaps in funding for HIV prevention programmes across country income groups (Figure 5.4). Additional resources are needed to reach the US$ 9.5 billion that will be required for HIV prevention in 2025 in order to put countries on track to end the AIDS epidemic by the end of the decade. Data reported by 86 low-and middle-income countries show that an average of 8% of total HIV spending was being allocated to prevention programmes in 2021. That share of HIV spending will need to rise to 33% by 2025.

**Additional resources are needed to reach the US$ 9.5 billion that will be required for HIV prevention in 2025 in order to put countries on track to end the AIDS epidemic by the end of the decade.**

**FIGURE 5.4** Percentage share of total HIV spending for prevention, 2021, and estimated share needed for prevention in 2025, low- and middle-income countries


Note: Figure contains data from 86 countries that reported their latest expenditures on prevention interventions.
Overall, low- and middle-income countries fund about 72% of their HIV treatment and care programmes with domestic resources, but only 42% of their prevention programmes (14). Some low-income countries continue to rely almost exclusively on external funding for their HIV prevention programmes. Funding for HIV prevention among key populations still comprises very small proportions of total HIV spending in low- and middle-income countries, even in regions where the vast majority of new HIV infections are occurring in these populations (Figure 5.5). The bulk of that funding—at least two thirds—comes from international sources, with interventions for prisoners and detainees being the only exception. This reliance exposes prevention programmes for key populations to potential further cuts in international funding.

**Figure 5.5** Percentage of total HIV spending for prevention and societal enabler programmes for key populations, 2021, and estimated total share needed, 2025, in low- and middle-income countries and by region


Note: Data are from 61 countries that reported their latest expenditures on prevention and societal enabler interventions. Testing and treatment services are not included.
MIXED PROGRESS AMID UNEVEN HIV INVESTMENTS

Levels of investment per person living with HIV vary significantly across countries and regions. Due to high prices of products such as antiretroviral medicines and the costs of service delivery and certain prevention interventions, investments needed by 2025 can be as high as US$ 4750 per person per year (constant 2019 US dollars) in the Middle East and North Africa, US$ 2034 in eastern Europe and central Asia, US$ 1741 in Latin America and US$ 1574 in Asia and the Pacific. The corresponding amounts are US$ 725 per person per year in the Caribbean, US$ 400 in eastern and southern Africa, and US$ 539 in western and central Africa. If we compare the resources available for HIV in 2021 against those required to meet the 2025 targets, the funding gaps also vary widely. In some regions, the 2021 resources are close to the total amounts needed in 2025, but in others, the gaps are quite large: they range from a 13% gap in western and central Africa and a 57% gap in the Asia and the Pacific and eastern Europe and central Asia regions, to 82% in the Middle East and North Africa (Figure 5.6). Importantly, all regions need to use these resources with greater efficiency.

If we compare the resources available for HIV in 2021 against those required to meet the 2025 targets, the funding gaps also vary widely.

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5 To make the amounts comparable, the investments have been converted into constant 2019 US dollars and adjusted for inflation. The total amounts are also adjusted by population size and HIV prevalence. The resulting measure is the total HIV expenditure per person living with HIV, and it includes testing, treatment, prevention and investments for improving societal enablers. As shown in Figure 5.05, the level of adjusted investments can be correlated to impact measurements such as HIV incidence and AIDS-related mortality rates per 1000 population in order to assess the sufficiency and efficiency of the resources.
FIGURE 5.6 Total HIV resource availability per person living with HIV, HIV incidence and AIDS-related mortality rates in low- and middle-income countries, by region, 2010–2021, and 2025 targets

**EASTERN AND SOUTHERN AFRICA**

- **HIV RESOURCES PER PERSON LIVING WITH HIV (US$)**
  - 2010: 600
  - 2025: 0

- **INCIDENCE AND MORTALITY RATES PER 1000 POPULATION**
  - 2010: 6
  - 2025: 0

**WESTERN AND CENTRAL AFRICA**

- **HIV RESOURCES PER PERSON LIVING WITH HIV (US$)**
  - 2010: 600
  - 2025: 0

- **INCIDENCE AND MORTALITY RATES PER 1000 POPULATION**
  - 2010: 6
  - 2025: 0

**ASIA AND THE PACIFIC**

- **HIV RESOURCES PER PERSON LIVING WITH HIV (US$)**
  - 2010: 2000
  - 2025: 0

- **INCIDENCE AND MORTALITY RATES PER 1000 POPULATION**
  - 2010: 1
  - 2025: 0

**CARIBBEAN**

- **HIV RESOURCES PER PERSON LIVING WITH HIV (US$)**
  - 2010: 1500
  - 2025: 0

- **INCIDENCE AND MORTALITY RATES PER 1000 POPULATION**
  - 2010: 1
  - 2025: 0

**Legend:**
- **Resource Availability per Person Living with HIV**
- **Resource Needs per Person Living with HIV (2025)**
- **Incidence per 1000 Population**
- **2025 Incidence Target**
- **Mortality per 1000 Population**
- **2025 Mortality Target**
Source: Analysis based on UNAIDS epidemiological and financial estimates and projections, 2022.
When evaluating the achievements of HIV responses, the role of price reductions and cost-efficiency gains is sometimes overlooked. Activism and advocacy have driven down unit costs, especially for antiretroviral medicines, and service delivery innovations have made HIV funds go further. Price reductions for HIV products have also freed funds to further expand programmes and upgrade high-impact interventions (such as new antiretroviral formulations and pre-exposure prophylaxis, or PrEP). Declining treatment costs per person have enabled many low- and middle-income countries to massively widen their HIV treatment programmes in the past decade.

Price reductions, however, have been uneven. Prices for commodities for HIV and other health issues vary significantly between regions and country income groups. Upper-middle-income countries pay highly elevated prices for antiretrovirals (Figure 5.7), especially second- and third-line antiretroviral regimens. In all regions, second-line antiretroviral therapy is still much more expensive than first-line regimens (Figure 5.8).

**FIGURE 5.7** Average price (US$) per person-year for different regimens of antiretroviral therapy, by country income group, 2021


Note: Data are for 89 countries that reported to UNAIDS Global AIDS Monitoring 2022.

Note: TDF = tenofovir disoproxil fumarate; 3TC = lamivudine; DTG = dolutegravir; EFV = efavirenz; AZT = azidothymidine; NVP = nevirapine; and FTC = emtricitabine.
The technical efficiency of HIV investments has also improved over time, enabling more people to benefit from HIV programmes. A new study covering 78 mostly low- and middle-income countries has found that the same amount of HIV spending was used almost twice as efficiently in 2018.\(^6\)

These price reductions and cost efficiencies should be sustained, and they can be extended more broadly across products and countries. PrEP—especially the new, long-acting injectable versions—is an important candidate for steep price reductions (see Chapter 2). Each dollar saved potentially increases access to life-saving services and products, but while savings and efficiency gains can help expand budgetary space for HIV, they are not enough to close the funding gaps that hold back HIV responses. New interventions at the international level are needed.

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\(^6\) The study considered prevention of mother-to-child HIV transmission and antiretroviral therapy programmes as the main outputs.
SAFEGUARDING HIV AND HEALTH SPENDING

While the COVID-19 pandemic has restricted economic growth and imposed huge additional costs around the world, it is also reinforcing the need to reform health financing and release low- and middle-income countries from endless cycles of crippling debt.

COVID-19 shifted fiscal policy in many high- and some middle-income countries. Countries with strong sovereign currencies were able to partially finance additional support for businesses and households through record levels of borrowing and bond issuances. Most low- and middle-income countries, however, lack those options and are experiencing major deteriorations in public financing. Many have resorted to taking on additional debt and reallocating funds from other sectors, including education and infrastructure (16, 17).

On average, government debt in low- and middle-income countries rose from 58% to 65% of gross domestic product between 2019 and 2021, equivalent to a staggering US$ 2.3 trillion (18). The United Nations Department of Economic Social Affairs has estimated that low-income countries on average were paying about 14% of national revenue in debt interest alone in 2021, almost four times higher than upper-middle- and high-income countries (19). High debt burdens tend to have a direct impact on health and HIV budgets.

There is a danger that fiscal austerity could be mainstreamed in many low- and middle-income countries in the coming period, with some 140 countries expected to introduce public expenditure cuts (see the Zambia feature story in Chapter 3) (20, 21). It is vital to avoid such responses, which typically harm the most vulnerable sections of society. Existing options must be activated and fast tracked: debt cancellation and relief is needed, along with additional, highly concessional financing and a purposeful reallocation of unused Special Drawing Rights issued in 2021. Country eligibility for concessional financing (i.e., lower costs of borrowing) should be relaxed against clear criteria that serve the public interest (22). As a result of the combined impacts of COVID-19 and the war in Ukraine, plans to transition away from concessional funding, including grant support for HIV, must be reconsidered.
Instead of requiring lower income countries to cut their public service budgets and workforces, lending mechanisms should enable them to strengthen their health systems and other pillars of socioeconomic development (19, 20, 23). Greater global solidarity is called for: high-income countries must meet their overseas development assistance commitments. Both low- and middle-income countries require donor funding to narrow their funding gaps for HIV prevention programmes, particularly for key populations. Reducing the prices of HIV products, especially in Latin America and eastern Europe and central Asia, will also be critical.

Additional concessional financing and overseas development are not enough on their own, though: interventions are needed to ensure that the added resources are used to sustain or rebuild public services rather than to pay back creditors in times of high fiscal stress. The health sector had been especially vulnerable to rising debt repayment obligations in the run-up to the COVID-19 crisis. In 2019, for instance, 64 countries were spending more on servicing their external debts than on their public health systems (measured as a share of government revenue). Less expenditure on health care weakens capacity to respond to HIV and other pandemics (20). Ambitious actions to achieve debt relief, including outright cancellation, are needed (19, 23).

Instead of requiring lower-income countries to cut their public service budgets and workforces, international financing mechanisms should enable them to strengthen their health systems and other pillars of socioeconomic development.
COVID-19 AND AUSTERITY MEASURES THREATEN ZAMBIA’S AIDS RESPONSE

Zambia’s response to HIV is confronting a moment of truth. While Zambia has seen new HIV infections fall by 47% since 2010, which is on par with eastern and southern Africa as a whole (with a 44% decline), AIDS-related deaths fell only 40% (compared to 58% for the region overall), and the number of people needing lifelong treatment continues to grow. The national HIV response also remains heavily dependent on external sources, with international donors covering more than 95% of the country’s HIV-related spending. Since Zambia has graduated to middle-income status, however, the country’s future prospects for mobilizing international assistance to get the national AIDS response on track are uncertain.

Increasing domestic spending on AIDS, health, education and the other key pillars of a strong HIV response is an urgent national priority. However, hopes for achieving these needed increases in domestic spending are jeopardized by the country’s macroeconomic situation and debt crisis. After strong economic growth prior to the COVID-19 pandemic, the economy contracted by 2.8% in 2020 as a result of lockdowns and other effects of COVID-19 (24). In a 2021 population-based survey, eight in 10 households in Zambia reported that their business or employment was affected by COVID-19, with one in three reporting reduced income or loss of jobs during the pandemic (25).

Although the Zambian economy has since partially bounced back, its ability to leverage the recovery to fund health and human services has been undermined by the country’s debt situation: after using debt to finance expanded public investments, Zambia’s public debt now exceeds 100% of gross domestic product and is unsustainable (26). In 2020, Zambia became the first sovereign state since the emergence of COVID-19 to default on its national debt (27). Nearly half (46%) of Zambia’s debt is owed to private lenders: 22% to China, 8% to other governments and 18% to multilateral institutions. The primacy of private lenders makes it difficult to restructure Zambia’s debt, as private lenders are typically less willing than governmental or multilateral lenders to forgive or discount the amounts owed.
To address the debt crisis, the government has reached an agreement with the IMF. In return for economic support, the country has pledged to make major reductions in government spending. Under this agreement, government spending in 2026 (as a share of gross domestic product) will be roughly half of spending in 2020 (Figure 5.9).

**FIGURE 5.9** Government primary expenditure (as a share of gross domestic product), Zambia, 2016–2026


Fiscal austerity is a common, but often destructive, response to debt crises. The fiscal austerity that is implicitly called for under this agreement imperils Zambia’s ability to make essential domestic public investments in HIV and health, or to invest in other sectors that affect HIV vulnerability and service uptake, such as education and social protection.

Urgent actions are needed to prevent potentially severe reductions in government spending on health and social protection and to enable the kinds of people-centred investments that are needed to end the AIDS epidemic as a public health threat. International action is needed to mitigate the country’s debt burden, with particular attention to persuading private lenders to participate in debt relief. IMF Special Drawing Rights, which are interest-bearing reserve assets allocated among IMF Member States, should be reallocated to enable increased liquidity in Zambia. Domestically, the country should move towards a progressive taxation system, coupled with institutional reforms to ensure the country’s ability to collect the taxes due.
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