REPORT

Financing the Response to HIV in Low- and Middle-Income Countries:

International Assistance from Donor Governments in 2015

July 2016

Prepared by:

Jennifer Kates & Adam Wexler
Kaiser Family Foundation

and

Eric Lief
Consultant

Executive Summary

In advance of the 21st International AIDS Conference (IAC), to be held in Durban, South Africa July 18-22, this report provides the latest data on donor government funding to address the HIV epidemic in low- and middle-income countries. It is part of a more than decade-long partnership between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Kaiser Family Foundation (Kaiser) to track donor government funding on HIV, assessing both bilateral disbursements and multilateral contributions. The current report provides data for 2015, at the close of the Millennium Development Goals (MDG) era. It finds that funding from donor governments decreased in 2015, by more than US$1 billion, compared to 2014, with declines by 13 of 14 governments assessed. While some of this decrease is due to issues of timing and exchange rate fluctuations, including the significant appreciation of the U.S. dollar, overall spending in 2015 declined even after accounting for these factors. As such, it marks the first decline in donor government funding to address HIV in 5 years.[1]

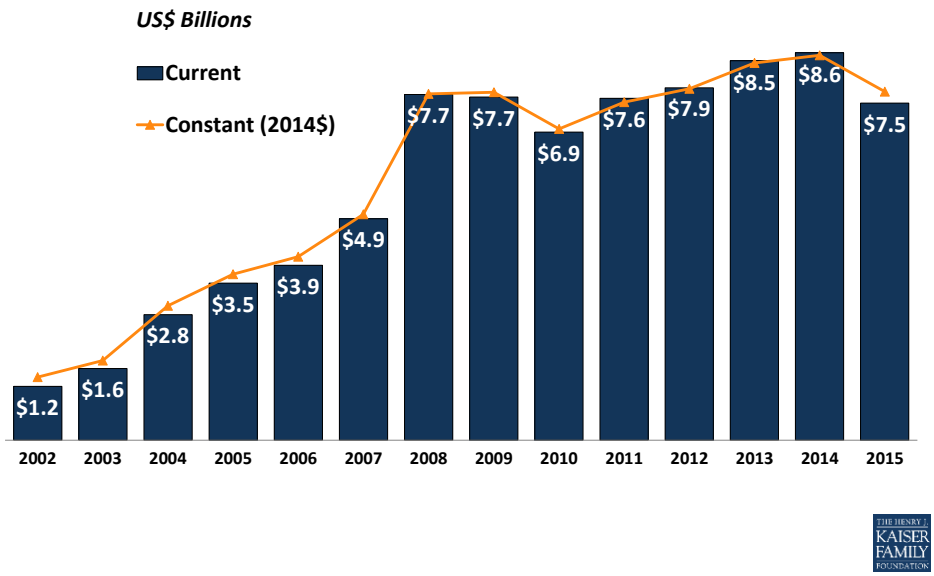
Key Findings Include:

- **Overall spending for HIV went down in 2015.** Donor government spending to address HIV in low and middle-income countries declined by more than $1 billion (US$7.53 billion in 2015 compared to US$8.62 billion in 2014), a 13% decline (see Figure 1). Spending declined for 13 of 14 donor governments assessed in the analysis, and declined even after adjusting for inflation.[2]
- **The decline is due to a complex set of factors**. These include the significant appreciation of the U.S. dollar, resulting in the depreciation of most other donor currencies. However, even in their currencies of origin, funding declined for 11 of 14 governments. Other factors include a delay in disbursements by the U.S. government and the front-loading of pledged contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria by some donors. Still, even after accounting for these factors, funding went down in 2015.
- **Bilateral spending declined for all 14 governments.** Bilateral spending declined by US$715 million, or 11%, between 2014 and 2015, declining for all 14 governments assessed (and 12 of 14 in currencies of origin). Funding from the U.S. government declined by US$411 million, accounting for 57% of the bilateral spending decline, but this was largely an issue of timing, as the U.S. implements new and expands existing programs and reallocates funding from several over-budgeted countries. Without counting the reduction in U.S. bilateral spending, most of which is expected to be disbursed in 2016, total funding from donors declined by 8 percent.
- **Multilateral contributions were down for 12 of 14 governments**. Contributions to the Global Fund were down by $305 million (after adjusting for an HIV share), declining for 11 of 14 governments assessed (and 8 in currencies of origin). Some of this decline was due to unique factors, including a subset of donors who front-loaded their contributions to the Global Fund in 2014 as part of a three-year, 2014-2016 pledge made during the Global Fund's last replenishment period, and to the U.S. government's pledge to match investments in the Global Fund by $1 for every $2 raised, resulting in a decline in 2015. Donor government contributions to UNITAID were also down.
- **Most HIV funding is bilateral**. In 2015, three quarters of HIV funding (74%) was provided bilaterally, primarily driven by the size of U.S. bilateral disbursements Seven donors provided most of their funding through bilateral channels - Australia, Denmark, Ireland, the Netherlands Norway, the United Kingdom and

the United States. Seven donors – Canada, France, Germany, Italy, Japan, Sweden, and the European Commission – provide most of their HIV funding through the Global Fund.

- **The U.S. remains the largest donor to HIV.** In 2015, the U.S. accounted for two-thirds (66.4%) of donor government disbursements for HIV. The U.K. was the second largest donor (13.0%) followed by France (3.5%), Germany (2.7%), and the Netherlands (2.3%).
- **In 2015, several donor governments provided a greater share of funding to HIV than their share of the world's GDP.** This includes the U.S., the U.K., Norway, and Denmark. However, when standardized by the size of their economies (GDP per US$1 million), Denmark ranks first followed by the U.K., the U.S., Norway, and the Netherlands.

Figure 1: International HIV Assistance from Donor Governments: Disbursements, 2002-2015



Introduction

In advance of AIDS2016, the 21st International AIDS Conference (IAC) which will be held in Durban, South Africa, July 18-22, this report provides the latest data on donor government funding to address the HIV epidemic in low and middle-income countries. It is part of a more than decade-long partnership between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Kaiser Family Foundation (Kaiser) to track donor government funding on HIV, assessing both bilateral spending and multilateral contributions. These data from 2015 mark the end of the Millennium Development Goals (MDG) era, and the return of the IAC to Durban after 16 years. At that time, there were approximately 3.2 million new HIV infections globally[3], less than 100,000 people on antiretroviral therapy (ARVs) in Sub-Saharan Africa,[4] and donor government funding for HIV had just topped US$700 million[5]. Today, new infections have fallen by more than a third, to 2.1 million, there are more than 10 million people in Sub-Saharan Africa on ARVs – and 17 million on ARVs in low and middle income countries overall – and donor government spending is in the billions. Still, UNAIDS estimates that resources to address the epidemic will need to rise in low- and middle-income countries from US$19 billion in 2015 to US$26.2 billion in 2020 to reach global "Fast Track Targets" and put the world on a trajectory to end AIDS by 2030.[6] A key component of these resources is funding from donor governments. The report provides these data for 2015, the latest available.

Box 1: Other Sources of Funding for HIV in Low- & Middle-Income Countries:

While this report focuses on donor governments, there are three other major funding streams for HIV assistance: multilateral organizations, the private sector, and domestic resources.

Multilateral Organizations: Provide assistance for HIV using pooled funds from member contributions and other means. Contributions are usually made by governments, but can be provided by private organizations and individuals, as in the case of the Global Fund. Some multilateral organizations are specifically designed to address HIV (such as the Global Fund, which also finances TB and malaria efforts, and UNITAID); donor government contributions to the Global Fund and UNITAID are counted as part of the donor government's financing effort in this analysis. Donor government contributions to multilateral organizations that are not specifically designed to address HIV, but may include HIV activities within their broader portfolio (such as the World Bank), are not included in this analysis.

Private Sector: Including foundations (charitable and corporate philanthropic organizations), corporations, faith-based organizations, international NGOs, and individuals. It is estimated that philanthropies provided US$618 million in 2014 to HIV activities internationally.[7] Among foundations, the Bill and Melinda Gates Foundation is the leading philanthropic funder of international HIV efforts. Corporations and businesses also support HIV programs in low- and middle-income countries through non-cash mechanisms such as price reductions for HIV medicines; in-kind support; commodity donations; employee and community prevention, care, and treatment programs; and co-investment strategies with government and other sectors.

Domestic Resources: Including both spending by low and middle-income country governments that also receive international assistance for HIV and by households/individuals within these countries, represent a significant and critical part of the response. UNAIDS estimates that domestic spending continues to surpass that provided by donors; it accounted for an estimated US$10.9 billion or 57% of total resources available for HIV for in-country services in 2015.[8]

Findings

Overview

Donor government spending to address HIV in low and middle-income countries, which includes multiple types of assistance (see Box 2), declined by more than $1 billion in 2015 (US$7.53 billion in 2015 compared to US$8.62 billion in 2014), a 13% decline. Spending declined for 13 of 14 donor governments assessed in the analysis, and declined even after adjusting for inflation.[9] These declines are due to a complex set of factors, including the significant appreciation of the U.S. dollar, resulting in the depreciation of most other donor currencies. However, even in their currencies of origin, funding declined for 11 of 14 governments. Other factors include a delay in bilateral disbursements by the U.S. government and the front-loading of pledged contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria by some donors. Still, spending declined even after accounting for these factors. As such, it marks the first decline in donor government funding to address HIV in 5 years.

Table 1: International HIV Assistance from Donor Governments (USD), 2015

Government	Bilateral Disbursement	Global Fund		UNITAID		Total Disbursement
		Total (100%)	Adjusted (55%)	Total (100%)	Adjusted (49%)	
Australia	$ 71.4	$ 49.7	$ 27.3			$ 98.7
Canada	$ 16.2	$ 169.4	$ 93.2			$ 109.3
Denmark	$ 122.1	$ 14.9	$ 8.2			$ 130.2
France	$ 25.0	$ 335.1	$ 184.3	$ 109.7	$ 53.8	$ 263.1
Germany	$ 72.8	$ 233.0	$ 128.2			$ 200.9
Ireland	$ 29.7	$ 12.2	$ 6.7			$ 36.4
Italy	$ 1.3	$ 33.3	$ 18.3			$ 19.7
Japan	$ 13.3	$ 190.2	$ 104.6			$ 117.9
Netherlands	$ 145.6	$ 53.0	$ 29.2			$ 174.7
Norway	$ 64.7	$ 74.4	$ 40.9	$ 5.5	$ 2.7	$ 108.3
Sweden	$ 53.8	$ 100.8	$ 55.4			$ 109.2
United Kingdom	$ 627.4	$ 580.6	$ 319.3	$ 67.2	$ 33.0	$ 979.7
United States	$ 4,307.8	$ 1,267.0	$ 696.9			$ 5,004.6
European Commission	$ 7.2	$ 155.3	$ 85.4			$ 92.7
Other DAC	$ 46.6	$ 47.2	$ 26.0	$ 4.0	$ 2.0	$ 74.5
Other Non-DAC	$ -	$ 20.8	$ 11.4	$ 2.0	$ 1.0	$ 12.4
TOTAL	$ 5,604.7	$ 3,336.8	$ 1,835.3	$ 188.5	$ 92.4	$ 7,532.4

Box 2: Types of Donor Government Assistance for HIV

Donor governments provide multiple types of financial and other assistance to address HIV in low- and middle-income countries, which together are included in the definition of bilateral disbursements, as follows:

Grants: Transfers made in cash, goods or services for which no repayment is required and no legal debt is incurred by the recipient. Grants may be made from a grantor to a grantee, or to an intermediary organization on a grantee's behalf. Grants can be unconditional or conditional.

Loans: Transfers for which the recipient incurs a legal debt and repayment is required in convertible currencies or in-kind.

Concessional loans: Loans that are made at or below market interest rates (including at zero interest), and typically are given a much longer grace period and maturity than other forms of financing. To be considered part of official development assistance (ODA) as defined by the Organisation for Economic Co-operation and Development (OECD), a loan must have a grant element (a grant "equivalent") of at least 25%.

Commodities: Materials, supplies, and equipment, such as medicines and diagnostics.

Technical assistance/co-operation: Transfer of knowledge through training, staff, and other services.

Bilateral/Multilateral Funding

Assistance is provided by donor governments through both bilateral and multilateral channels, and some mix of the two (see Box 3). Decisions about how much assistance to provide through these different channels (what "mix" to use) are dependent on several factors, such as: the desired level of control over the use of funds by donors; varying approaches to cooperation and coordination; a donor's own internal capabilities and field staff capacity for carrying out programs; and recipient country governance and capacity.

Box 3: Defining Bilateral and Multilateral Channels for Assistance

The different channels for delivery of international assistance can be described as follows:

Bilateral assistance: Direct assistance from one government to, or for the benefit of, one or more other countries. Bilateral assistance generally consists of projects and programs, the content and direction of which is decided by the donor, providing more direct control over decisions about how and where funding is targeted (e.g., donors can stipulate countries, conditions, etc.).

Multilateral assistance: Indirect assistance, in that it is provided by donor governments (usually unconditionally) to multilateral organizations that also receive funding from many other donors and in turn provide assistance to, or on behalf of, one or more countries. Multilateral assistance generally consists of projects and programs, the content and direction of which is decided by the multilateral organization, using pooled funding from multiple donors. Multilateral aid may enable donors to satisfy other goals, such as leveraging support from other donors, financing the response through alternative vehicles, reaching more or different countries and regions, and/or accessing different capacities. For example, a donor without a large field presence may choose to provide more of its aid through a multilateral mechanism.

Multi-bi assistance (multilateral-bilateral): Assistance provided by a donor to a multilateral organization for specific activities, as defined by the donor, and for which the multilateral organization acts as an implementing agent.

The majority of donor government assistance for HIV is provided bilaterally, including 74% (US$5.6 billion) in 2015, although in recent years there has been a shift towards greater use of multilateral channels (see Figures 2 & 3). As with overall funding, bilateral funding fell in 2015, by US$715 million, or 11%, compared to 2014, declining for all 14 governments assessed (and 12 of 14 in currencies of origin; the Netherlands and Norway increased bilateral funding in their currencies of origin).

Figure 2: International HIV Assistance: Funding Channels for Donor Government Disbursements (USD), 2015

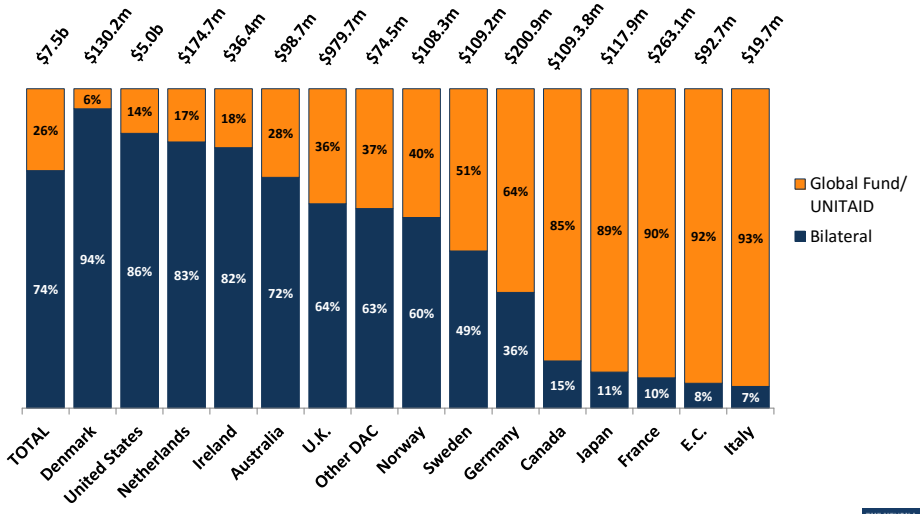
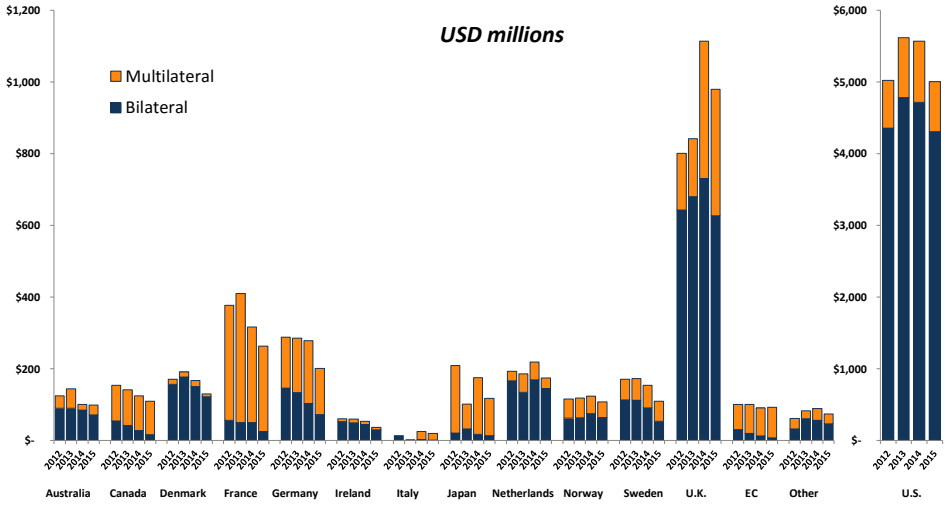


Figure 3: Trends in International HIV Assistance from Donor Governments: Multilateral & Bilateral Funding, 2011-2015



A significant driver of this decrease was the U.S. government, whose bilateral funding declined by US$411 million in 2015, accounting for 57% of the bilateral spending decline. However, this decline was largely an issue of timing, as the U.S. reports[10] that it pushed much of this funding into 2016 to account for (a) the start-up of the new DREAMS program, a $385 million partnership, including $330 million from PEPFAR, aimed to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries; (b) the expansion of voluntary medical male circumcision services in 14 Eastern and Southern African countries ($90 million) and (c) planned reductions in funding in a subset of countries that were over-funded relative to the size of their epidemics. Without counting the reduction in U.S. bilateral spending, most of which is expected to be disbursed in 2016, total funding from donors declined by 8 percent.

Multilateral assistance, which accounted for 26% of funding for HIV in 2015, totaled US$1.9 billion, a decline of 15% (US$330 million) compared to 2014. Contributions to the Global Fund were down by $305 million (after adjusting for an HIV share), declining for 11 of 14 governments assessed (and 8 in currencies of origin). Some of this decline was due to unique factors, including a subset of donors who front-loaded their contributions to the Global Fund in 2014 as part of a three-year, 2014-2016 pledge made during the Global Fund's last replenishment period, and to the U.S. government's pledge to match investments in the Global Fund by $1 for every $2 raised, resulting in a decline in 2015. Contributions to UNITAID were down by $25 million (adjusted for an HIV share).

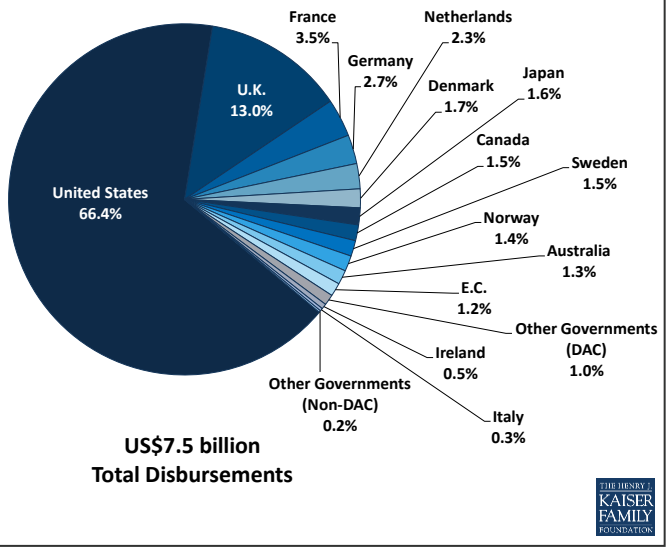
In 2015, 7 donors provided most of their funding through bilateral channels, particularly Denmark (94%), followed by the U.S. (86%), the Netherlands (83%) and Ireland (82%). Still, 7 donor governments (Canada, France, Germany, Italy, Japan, Sweden and the European Commission) provide most of their HIV funding through the Global Fund. While HIV funding provided by all donor governments through multilateral channels totaled 26% in 2015, without the U.S., which provides most of its funding bilaterally, the share rose to 49%.

Not all governments provide multilateral contributions. In 2015, for example, 7 members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) did not contribute to the Global Fund. In addition, only four DAC members contributed to UNITAID.[11]

The Largest Donors

The majority of international assistance for HIV has historically been provided by a subset of donors (France, Germany, the Netherlands, the U.K., and the U.S.), with the U.S. consistently being the single largest (in both bilateral disbursements and contributions to the Global Fund). Since 2006, these five donors have accounted for approximately 80% or more of total assistance for HIV. In 2015, the U.S. continued to be the largest donor in the world, accounting for two-thirds (66.4%) of HIV disbursements by donor governments (See Table 1 and Figure 4). The U.K. was the second largest donor (13.0%), followed by France (3.5%), Germany (2.7%), and the Netherlands (2.3%). The U.S. was also the largest donor to the Global Fund followed by the U.K., France, Germany, and Japan. France was the largest donor to UNITAID followed by the U.K. and Norway.

Figure 4: International HIV Assistance: Donor Governments as a Share of Total Donor Government Disbursements, 2015



Assessing Fair Share

One question that often arises is what constitutes each government's "fair share" of international HIV assistance efforts. Yet, such assessments are complex and there is no single, agreed-upon methodology for making them, and several questions must be considered, including:

- What is the "total" against which individual contributions are assessed? Estimated total funding by donor governments? Should that total include just direct HIV-related costs or be broadened to include critical infrastructure and capacity deficits?
- Which funders should be included in a fair share calculation? DAC governments only, or private sector, recipient government and out-of-pocket spending by individuals?
- To what extent should the efficiency of donor assistance be taken into account (e.g., how much is "tied" aid)?
- How should differences in relative wealth between donors be taken into account?
- Should factors other than funding (e.g. differences in country tax subsidy policies for charitable giving for HIV by individuals, foundations, and corporations; patent policies) be taken into account?

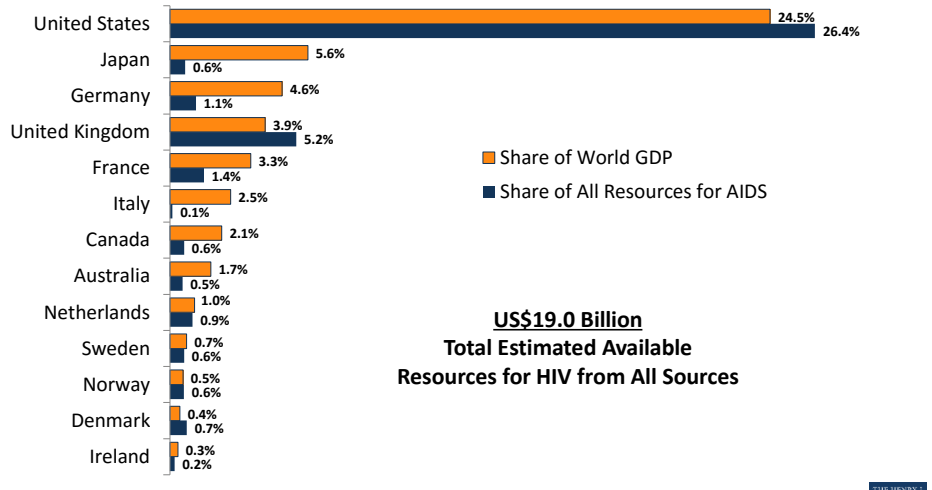
These questions have implications for the methodology chosen to assess fair share and there are inherent limits in using any one methodology for doing so. For example, a rank by total funding does not capture the relative wealth of a nation. Yet a standardized measure including wealth does not take into account certain other donor policies that may inhibit or facilitate the amount of assistance such as tax subsidies for charitable giving. Table 2 provides several different comparative measures that could be used to assess fair share:

Table 2: Assessing Fair Share Across Donors				
Government	Share of World GDP	Share of Total Donor Government Funding for HIV	Share of Global Resources Available for HIV	Total HIV Funding Per $1 Million GDP
Australia	1.7%	1.3%	0.5%	$ 80.6
Canada	2.1%	1.5%	0.6%	$ 70.4
Denmark	0.4%	1.7%	0.7%	$ 441.6
France	3.3%	3.5%	1.4%	$ 108.7
Germany	4.6%	2.7%	1.1%	$ 59.8
Ireland	0.3%	0.5%	0.2%	$ 153.0
Italy	2.5%	0.3%	0.1%	$ 10.8
Japan	5.6%	1.6%	0.6%	$ 28.6
Netherlands	1.0%	2.3%	0.9%	$ 236.6
Norway	0.5%	1.4%	0.6%	$ 278.0
Sweden	0.7%	1.5%	0.6%	$ 221.8
United Kingdom	3.9%	13.0%	5.2%	$ 343.8
United States	24.5%	66.4%	26.4%	$ 278.9
European Commission	-	1.2%	0.5%	-
Other DAC	-	1.0%	0.4%	-
Other Non-DAC*	-	0.2%	0.1%	-
*Represents Non-DAC member contributions to the Global Fund and UNITAID. Bilateral HIV funding from these donor governments is not currently available.				

- **Rank by share of total donor government funding for HIV**: By this measure, the U.S. ranked first in 2015, followed by the U.K., France, Germany and the Netherlands (see Table 2 and Figure 4).

- **Rank by share of total resources available for HIV compared to share of the global economy** (as measured by GDP): In 2015, UNAIDS estimates that US$19 billion was made available for HIV from all sources (donor governments, multilaterals, the private sector, and domestic sources) for HIV. Of this the U.S. provided 26%, the largest share of any donor and just above its share of the world's economy as measured by gross domestic product or GDP (25% in 2015). Denmark, Norway, and the U.K. also provided greater shares of total HIV resources than their shares of GDP (see Table 2 and Figure 5).

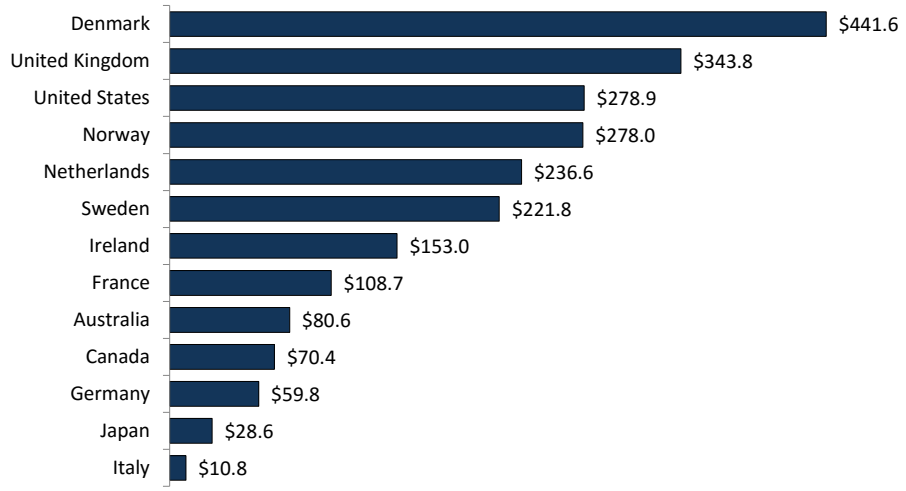
Figure 5: Assessing Fair Share 1: Donor Share of World GDP* Compared to Donor Share of All Resources Available for HIV, 2015



*GDP = gross domestic product.
NOTE: UNAIDS estimate of resources available for HIV/AIDS from all sources, June 2016. This estimate includes domestic expenditures (public and private) for all l middle- income countries, including countries that transitioned into high income level, according to World Bank 2013 country classification of income status.

- **Rank by funding for HIV per US$1 million GDP**: When donor government disbursements are standardized by the size of their economies (GDP per US$1 million), donors rank quite differently than when measured by actual disbursement amounts. Whereas Denmark ranked sixth in actual disbursements provided for HIV in 2015, it ranked number one when standardized by GDP. The U.K. ranked second by this measure, followed by the U.S., Norway, and the Netherlands (see Table 2 and Figure 6).

Figure 6: Assessing Fair Share 2: Donor Rank by Disbursements for HIV per US$1 Million GDP*, 2015



*GDP = gross domestic product.

Resources Available Compared to Need

UNAIDS estimates that US$19 billion was available to address HIV in low- and middle-income countries in 2015, but US$26.2 billion is needed by 2020 to meet global HIV targets to end AIDS as a global public health threat by 2030.[12] This leaves a more than US$7 billion gap to be filled over the next five years. While funding from donor governments remains significant – accounting for approximately 40% of total resources for HIV in 2015 – findings from this year's report, as well as prior trends showing donor government funding flattening, suggest that, at current rates of spending, it is unlikely to completely fill the gap. As such, global HIV targets may not be met unless other sources, including domestic public funding and the private sector, increase.

Conclusion

In 2015, funding disbursed by donor governments for HIV declined by more than US$1 billion, or 13%, compared to 2014. While the decline is due to a complex set of factors, including issues of timing and exchange rate fluctuations, donor spending declined even after accounting for these factors. As such, it marks the first decline in 5 years. Whether this decline remains a single year event or a harbinger of more to come remains to be seen, although donor governments are facing many competing funding demands, including humanitarian emergencies and the refugee crisis, all against a backdrop of fiscal austerity in a number of countries. With UNAIDS estimating that in- country resources for HIV, including from donor governments, will need to increase by at least US$7.2 billion by 2020 to put the world on a trajectory to end AIDS by 2030, it will be critical to monitor donor government spending going forward.

Annex: Methodology

This project represents a collaboration between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Kaiser Family Foundation. Data provided in this report were collected and analyzed by UNAIDS and the Kaiser Family Foundation.

Bilateral and multilateral data on donor government assistance for HIV in low- and middle-income countries were collected from multiple sources. The research team solicited bilateral assistance data directly, from the governments of Australia, Canada, Denmark, France, Germany, Ireland, Japan, the Netherlands, Norway, Sweden, the United Kingdom, and the United States during the first half of 2015, representing the fiscal year 2014 period. Direct data collection from these donors was desirable because the latest official statistics on international HIV specific assistance – from the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System (CRS) (see: http://www.oecd.org/dac/stats/data) – are from 2013 and do not include all forms of international assistance (e.g., funding to countries such as Russia and the Baltic States that are no longer included in the CRS database). In addition, the CRS data may not include certain funding streams provided by donors, such as HIV components of mixed grants to non-governmental organizations. The research team therefore undertook direct data collection from the donors who provide significant shares for international HIV assistance through bilateral channels.

Where donor governments were members of the European Union (EU), the research team ensured that no double-counting of funds occurred between EU Member State reported amounts and EC reported amounts for international HIV assistance. Figures obtained directly using this approach should be considered as the upper bound estimation of financial flows in support of HIV-related activities. Although the Russian Federation is a Member of the G8 and has contributed to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), it has also been a net recipient of HIV assistance, and therefore is not included in the donor analysis.

Data for all other member governments of the OECD Development Assistance Committee (DAC) – Austria, Belgium, the Czech Republic, the European Commission, Finland, Greece, Iceland, Korea, Luxembourg, New Zealand, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Switzerland – were obtained from the OECD CRS database and UNAIDS records of core contributions. The CRS data are from calendar year 2013, and therefore, do not necessarily reflect 2014 calendar year amounts. However, collectively, these governments have accounted for less than 5 percent of bilateral disbursements in each of the past several years. UNAIDS core contributions reflect 2014 amounts.

Data included in this report represent funding assistance for HIV prevention, care, treatment and support activities, but do not include funding for international HIV research conducted in donor countries (which is not considered in estimates of resource needs for service delivery of HIV-related activities).

Bilateral funding is defined as any earmarked (HIV-designated) amount, including earmarked ("multi-bi") contributions to multilateral organizations, such as UNAIDS. In some cases, donors use policy markers to attribute portions of mixed-purpose projects to HIV. This is done, for example, by the Netherlands, Norway, Denmark, and the U.K. Germany also programs its HIV response in this way, and in 2014, was among top donor countries in the area of health. Apart from its targeted HIV/AIDS programs, bilateral health programs mainly focusing on health systems strengthening are also designed to contribute to the HIV response in partner countries. Global Fund contributions from all governments correspond to amounts received by the Fund

during the 2014 calendar year, regardless of which contributor's fiscal year such disbursements pertain to. Data from the U.K., Canada, Australia, Denmark, France, Norway and Germany should be considered preliminary estimates.

Bilateral assistance data were collected for disbursements. A disbursement is the actual release of funds to, or the purchase of goods or services for, a recipient. Disbursements in any given year may include disbursements of funds committed in prior years and in some cases, not all funds committed during a government fiscal year are disbursed in that year. In addition, a disbursement by a government does not necessarily mean that the funds were provided to a country or other intended end-user.

Included in multilateral funding were contributions to the Global Fund (see: http://www.theglobalfund.org/en/) and UNITAID (see: http://www.unitaid.eu/). All Global Fund contributions were adjusted to represent 55% of the donor's total contribution, reflecting the Fund's reported grant approvals for HIV-related projects to date and includes HIV/TB and Health System Strengthening (HSS) funding. The Global Fund attributes funds received to the years that they were pledged rather than the year of actual receipt. As a result, Global Fund totals presented in this report may differ from those currently available on the Global Fund website. UNITAID contributions were adjusted to represent 49% of the donor's total contribution, reflecting UNITAID's reported attribution for HIV-related projects to date. The entire French contribution to UNITAID as well as a significant part of the French contribution to the Global Fund was derived from air ticket and financial transaction taxes; 5% of total French Global Fund contributions in 2014 was provided in the form of technical assistance supporting implementation of Global Fund grants.

Other than contributions provided by governments to the Global Fund and UNITAID, un-earmarked general contributions to United Nations entities, most of which are membership contributions set by treaty or other formal agreement (e.g., the World Bank's International Development Association or United Nations country membership assessments), are not identified as part of a donor government's HIV assistance even if the multilateral organization in turn directs some of these funds to HIV. Rather, these would be considered as HIV funding provided by the multilateral organization, as in the case of the World Bank's efforts, and are not considered for purposes of this report.

Data collected directly from the Australian, Canadian, Japanese, U.K., and U.S. governments reflect the fiscal year (FY) period as defined by the donor, which varies by country. The U.S. fiscal year runs from October 1-September 30. The fiscal years for Canada, Japan, and the U.K. are April 1-March 31. The Australian fiscal year runs from July 1-June 30. The European Commission, Denmark, France, Germany, Italy, Ireland, the Netherlands, Norway, and Sweden use the calendar year. The OECD uses the calendar year, so data collected from the CRS for other donor governments reflect January 1-December 31. Most UN agencies use the calendar year and their budgets are biennial. The Global Fund's fiscal year is also the calendar year.

All data are expressed in current US dollars (USD), unless otherwise noted. Where data were provided by governments in their currencies, they were adjusted by average daily exchange rates to obtain a USD equivalent, based on foreign exchange rate historical data available from the U.S. Federal Reserve (see: http://www.federalreserve.gov/) or the OECD. Data obtained from UNITAID were already adjusted by each to represent a USD equivalent based on date of receipts. Data on gross domestic product (GDP) were obtained from the International Monetary Fund's World Economic Outlook Database and represent current price data

for 2014 (see: http://www.imf.org/external/pubs/ft/weo/2014/01/weodata/index.aspx). Where data are expressed in constant USD, they were based on analysis of data from the OECD DAC, and account for both inflation and exchange rate differences.

Endnotes

[1] This analysis counts donor government contributions to multilateral organizations as part of donor government disbursements (in addition to their bilateral disbursements to countries). But donor contributions to multilateral organizations are not necessarily disbursed to countries in the same year. A separate analysis by UNAIDS (UNAIDS: PREVENTION GAP REPORT, Geneva, 2016.), which assesses funding disbursed to countries (including multilateral disbursements), finds that such funding fell for the second year in a row. This is due to the fact that in 2014, the Global Fund showed a one-time decrease in disbursements to countries, attributable to the roll out of a new funding model and in 2015, funding fell due to decreases in bilateral disbursements by donor governments.

[2] See, World Development Indicator database, http://data.worldbank.org/indicator/FP.CPI.TOTL.ZG. Inflation in 2015 in high-income countries was 0.3%.

[3] UNAIDS AIDSInfo, 2016.

[4] WHO, Antiretroviral therapy (ART) coverage among all age groups, Accessed July 2016, http://www.who.int/gho/hiv/epidemic_response/ART_text/en/.

[5] UNAIDS, Report on the State of HIV/AIDS Financing, UNAIDS/PCB(14)/03, Conference Paper 2a, 25 June 2003.

[6] Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD, et al. (2016) What Is Required to End the AIDS Epidemic as a Public Health Threat by 2030? The Cost and Impact of the Fast-Track Approach. PLoS ONE 11(5): e0154893. available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0154893.

[7] FCAA estimates of Philanthropic support in 2013 to address HIV/AIDS in Low-and-Middle-Income countries, Sep 2014.

[8] UNAIDS, personal communication, July 2016.

[9] See, World Development Indicator database, http://data.worldbank.org/indicator/FP.CPI.TOTL.ZG. Inflation in 2015 in high-income countries was 0.3%.

[10] Personal communication with the U.S. Office of the Global AIDS Coordinator, June 30, 2016.

[11] Based on analysis of the Global Fund's Pledges and Contributions database and UNITAID's 2015 Annual Report. The four DAC members that contributed to UNITAID in 2015 include: France, Norway, the Republic of Korea, and the U.K.

[12] These "Fast Track" targets, if reached, would put the world on track to end the AIDS epidemic by 2030. See, Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD, et al. (2016) What Is Required to End the AIDS Epidemic as a Public Health Threat by 2030? The Cost and Impact of the Fast-Track Approach. PLoS ONE 11(5): e0154893. available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0154893.

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This publication (#7347-12) is available on the Kaiser Family Foundation's website at www.kff.org.

Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*