

METHODOLOGY

This year's report assesses the current sources of global AIDS financing as well as the status and potential trajectories of the epidemic. This section provides an overview of how ONE made various calculations and what assumptions we used to derive the figures presented in the report.



MEASURING PROGRESS TOWARDS THE TIPPING POINT

ONE defines the achievement of the beginning of the end of AIDS – “a tipping point” – as the point at which the number of people newly added onto treatment in a given year equals the number of people newly infected with HIV in the same year. On a graph, it is the point where these two curves intersect.

ONE used the data for new HIV infections and individuals newly added to treatment from UNAIDS' July 2015 report, “How AIDS Changed Everything”, the factsheet corresponding to the report and the UNAIDS online database, AIDSInfo. In order to calculate the number of people newly added to treatment, we subtracted the number of people on treatment in 2013 from the number of people on treatment in 2014.

MEASURING DONOR FINANCING

ONE utilises a combination of publicly available information and donor government reporting to understand countries' AIDS financing. The five main sources of financing data are:

- **Official development assistance (ODA):** Organisation for Economic Co-operation and Development (OECD) DAC preliminary data for 2014,ⁱ accessed through the OECD Database;
- **Development assistance for health (DAH):** Data and analysis from the Institute for Health Metrics and Evaluation (IHME)'s 2015 report “Financing for Global Health 2014: Shifts in Funding as the MDG Era Closes” and also the IHME's online database for donor financing for global health;

- **Financial assistance for HIV/AIDS:** Data and analysis from the Henry J. Kaiser Family Foundation (KFF) report, “Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2014”;
- Published donor contributions on the websites of UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria; and
- Publicly available information on donor government websites, including strategy documents, press releases, foreign ministry pages and budget reports.

Official Development Assistance (ODA)

Using the “Total Flows by Donor” DAC1 spreadsheet under the “Development” selection of the OECD database, ONE pulled Official Development Assistance (1A + 1B) and Debt Relief (1A6) for the 14 profiled countries, selecting Official Development Assistance as our “Flow,” Net disbursements as our “Fund flow,” and Constant prices as our “Amount type”. We then subtracted “Debt Relief” from “Official Development Assistance” to arrive at the ODA value included in the donor profile tables.ⁱⁱ

As OECD ODA is only provided in USD 2013 constant prices, we used the country deflators published by the DAC to convert the generated values to USD 2014 constant prices.

Development Assistance for Health (DAH)

ONE used IHME's definition of development assistance for health (DAH): “the financial and in-kind contributions provided by global health channels to improve health in developing countries”. While ONE had access to OECD donor flows for health, ONE deemed the IHME figures for DAH to be the preferable source for health-specific donor spending.ⁱⁱⁱ The IHME figures for DAH encompass grants in addition to concessionary loans, disbursed with no interest or at a rate markedly lower than the current market rate. To develop DAH estimates, IHME collected

data from organisations that offered funding for health projects in developing countries from 1990 through 2014. In cases where 2013 and 2014 data are not available, IHME used statistical methods which relied on previous trends in spending and budget data to produce preliminary estimates. All numbers in the IHME report were reported in USD 2014 constant prices.

Total Financial Assistance for HIV/AIDS

ONE defines total financial AIDS assistance as the sum of a donor government's bilateral and multilateral AIDS contributions. These funding amounts were collected from KFF reports from 2013, 2014 and 2015 and corroborated by ONE country directors and other contacts from donor countries.

Bilateral Assistance for HIV/AIDS

ONE considers the KFF report to be the most current and reliable source for bilateral AIDS assistance due to its official consultation process, in which the funding totals for each country are authenticated by the appropriate donor government representatives, and the cooperation and involvement of UNAIDS.

To obtain data for 2014, the KFF 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. For these core countries, communicating with governments directly is preferable to using the latest official statistics on international HIV-specific assistance from the OECD's Creditor Reporting System (CRS), which dates from 2013 and does not include all forms of international assistance (i.e. 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 NGOs.

Data for all other member governments of the OECD DAC were acquired from the OECD CRS database and UNAIDS records of core contributions.

Numbers for bilateral HIV/AIDS assistance were taken directly from KFF's reports from 2013 to 2015. The data from 2012 and 2013 (which KFF presents in current prices) were converted to USD 2014 constant prices using the DAC deflators.

Neither the KFF reports nor ONE's report measure or analyse donors' spending on other health interventions that are complementary to HIV/AIDS programmes (i.e. investments in sexual and reproductive health, tuberculosis or nutrition), though ONE recognises the importance and relevance of these investments.

In addition, the donor profiles do not evaluate countries' contributions to HIV/AIDS research and development (R&D). Financing for R&D has played an instrumental role in the development of current tools that have accelerated progress, and it will continue to be a major catalyst for the improvement of HIV treatment and prevention efforts. Nevertheless, this report is focused on core funding for current implementation efforts and supporting interventions rather than on R&D.

Multilateral Assistance for HIV/AIDS

For multilateral contributions, ONE reported contributions to the Global Fund and UNITAID, using the numbers reported in KFF's reports from 2013, 2014, and 2015. While ONE acknowledges that multilateral contributions may go through other channels, for the purposes of this report it considers only these two mechanisms as the principal multilateral mechanisms involved in HIV/AIDS. In order to determine the specific fraction of each country's contribution that went toward HIV/AIDS, ONE multiplied each country's full contribution by the percentage of the Global Fund's or UNITAID's total funding that was used for AIDS in that particular year.

This percentage was 55% for the Global Fund and 51% for UNITAID in 2014; 57% for the Global Fund and 51% for UNITAID in 2013; and 55% for the Global Fund and 51% for UNITAID in 2012.

Global Fund pledges and contributions were collected for each of the G7 countries and the European Commission for the period 2002–13, and are current up to spring 2015. Whereas the Global Fund attributes funds received to the years in which they were pledged, KFF attributes funds to the years of actual receipt.

Global Fund contributions from all governments correspond to amounts received by the Fund during the 2014 calendar year, regardless of contributors' fiscal years. As a result, Global Fund totals presented in the KFF report may differ from those currently available on the Global Fund's website. Due to discrepancies in regard to contributors' fiscal years, data from the UK, Canada, Australia, Denmark, France, Norway and Germany should also be considered preliminary estimates.

MEASURING AFRICAN DOMESTIC RESOURCE MOBILISATION FOR HEALTH

Abuja Commitment

In 2001, sub-Saharan African countries made the commitment at the Abuja Summit to Address the Exceptional Challenges of HIV, Tuberculosis and other Infectious Diseases to spend 15% or more of their domestic budgets on health programmes. The portion of their budgets that governments allocate to health was sourced from the World Health Organization (WHO)'s Global Health Expenditures Database. In particular, ONE used the selection "General Government Health Expenditure as a % of General Government Expenditure" as an indicator of the portion of country budgets that were spent on health. USD 2013 current prices were the best available selection on the Expenditure Database, so we left the prices as they were.

Per capita health spending was also sourced directly from the Database. ONE used the selection "General Government Health Expenditure Per Capita". The results are compared to the \$86 per capita target, taken from the Chatham House Centre on Global Health Security Working Group on Health Financing. This is an update from the Taskforce on Innovative International Financing for Health Systems (HLTF) figures, which projected the annual cost required to scale up a set of essential services in 49 low-income countries to be around \$54 per capita between 2009 and 2015 (expressed in 2005 US dollar terms). The Chatham House figure simply reflects changes in inflation and exchange rates since 2005. As with the Abuja numbers, ONE left the prices in USD 2013 current form.

Emerging Donors

On page 34-35 of the report, we write the BRICS countries (Brazil, Russia, India, China and South Africa) have a combined annual aid budget of \$10.3 billion, with the largest contributions coming from China (\$7.1 billion), India (\$1.6 billion) and Brazil (\$730 million). This \$10.3 billion sum is based on data from the most recent year available (in current prices) for each country: 2010 for Brazil, 2013 for Russia, 2015 for India, 2013 for China, and 2013 for South Africa.

Constant vs. Current Pricing

For ODA, DAH and assistance for HIV/AIDS, ONE used constant prices (real terms) rather than current prices (nominal terms) to account for inflation and national currency devaluations and to assess change over time more accurately. To calculate constant prices, ONE applied the country deflators published by the OECD. For historical pledges and commitments, current prices (nominal figures) were maintained in order to better reflect the way in which these pledges and commitments were expressed at the time that they were made. This rule of thumb holds true unless otherwise noted, as with the graphs in the section on domestic resource mobilisation for health, in which we believed USD 2013 current prices to be the best available selection on the WHO's Global Health Expenditures Database. Deflator rates moreover are not available for countries in sub-Saharan Africa. Current to constant conversions could not be made for emerging economies, as deflator rates are not available for those countries.

Currency Conversions

Where data were reported in a currency other than US dollars (USD), the annual exchange rate was used to adjust the figure to a USD equivalent. Currency conversions for past pledges and contributions were made using the OECD's year-specific exchange rates per national US dollar. Currency conversions for commitments pertaining to 2015 and beyond (including the Global Fund pledge asks for this upcoming June) were made using the OANDA online tool on 14 October 2015.

- ⁱ These preliminary data provide only a basic breakdown and are subject to revision in the final figures, which are released in December and include a detailed breakdown.
- ⁱⁱ When examining ODA, ONE excludes bilateral debt relief in order to examine whether countries' reported ODA flows represent new, increased resource flows. While debt relief is important and useful, the rules on counting bilateral debt cancellation as ODA over-emphasise the value of the debt relief, and ONE believes that it should be additional to ODA, as agreed in the 2002 Monterrey Consensus.
- ⁱⁱⁱ As of fall 2015, the OECD's multilateral health spending estimates did not incorporate the full suite of purpose codes (120, 130 and 16064) ONE uses in order to produce a comprehensive picture of bilateral health spending. Therefore, OECD multilateral and bilateral health spending figures were not comparable and could not be added to yield a complete health-specific ODA figure, leading ONE to use the IHME figures for development assistance for health (DAH).