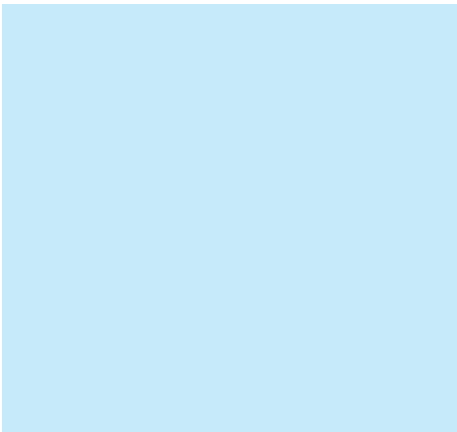
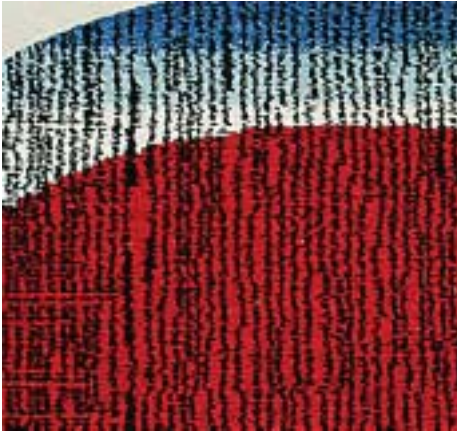


# Financing the response to AIDS 10



## Chapter 10



## FINANCING THE RESPONSE TO AIDS

From UNAIDS' launch in 1996 until 2005, available annual funding for the response to AIDS in low- and middle-income countries increased 28-fold, from US\$ 300 million to US\$ 8.3 billion. Existing pledges, commitments and trends suggest the rate of increase may be declining and that available funds will be US\$ 8.9 billion in 2006 and US\$ 10 billion in 2007.

Those amounts will be far short of meeting the estimated requirements of US\$ 14.9 billion in 2006, US\$ 18.1 billion in 2007 and US\$ 22.1 billion in 2008. Looking beyond 2007, an effective response will depend on sustained growth in annual funding until the epidemic is stopped and reversed (UNAIDS, 2005).

Global and national advocacy to boost and sustain political leadership and public support remain essential. Also essential is making far better use of funding flows that are available. That means streamlining the flow of financial resources to the front lines of the epidemic, putting it to optimal use and providing HIV-related prevention, treatment, care and support as quickly as possible to everyone in need.

### Current funding in perspective

The annual increases in funding have been impressive but, given the rapid

spread of the epidemic, the resulting amounts are disappointing. In 2005, the 148 countries classified as low- and middle-income by the World Bank (World Bank, 2005) were home to 5.5 billion people, or 85% of the world's population (United Nations, 2005). The estimated annual funding of US\$ 8.3 billion for the AIDS response that year included out-of-pocket spending by HIV-positive people and their households. In millions of cases, they were spending far beyond their capacity and being driven even deeper into poverty and debt but still not receiving antiretroviral therapy and other basic services.

The funding estimates also included everything spent within each country by the government, civil society organizations and private businesses, and everything donated by bilateral and multilateral donors and international civil society organizations, including philanthropic foundations. That same year, the 22 high-income countries that are the main

donors to development aid (and members of the Organisation for Economic Cooperation and Development's Development Assistance Committee) were home to 879 million people, or 13.6% of the world's population. The money spent from all sources on providing those 879 million people with the full range of health services came to more than US\$ 3 trillion (OECD, 2005). That was so even though these 22 countries carry nothing approaching the burden of HIV infection, tuberculosis, malaria, gastrointestinal infection and other poverty-related diseases carried by the 148 low- and middle-income countries.

In the United States, home to 298 million people (4.6% of the world's population), around 55% of annual health-care spending is private, while the remaining 45% is split between the federal and state governments. At the start of 2005, the federal government alone committed to spending US\$ 17.3 billion on the domestic response to AIDS that year (Henry J. Kaiser Family Foundation, 2005).

Comparatively speaking, US\$ 8.3 billion available for spending in low- and middle-income countries in 2005 was not sufficient. More importantly, it did not come close to meeting the actual requirements for that year and that was not just because of the obvious shortfall in the total amount available. It was also because

there was a mismatch between where the money was most needed and where it was actually spent.

## Estimated requirements

UNAIDS began estimating financial resource needs in 2001. In early 2005, three expert groups—the Global Resource Tracking Consortium, the UNAIDS Reference Group on Economics, and the UNAIDS Reference Group on Estimates, Modelling and Projections—began developing the current estimates of funding requirements. To help develop the estimates further, the High Level Meeting on the Global Response to AIDS, held in London in March 2005, established a Resource Needs Steering Committee representing donors, national governments, civil society, the private sector and technical partners (UNAIDS, 2005). Figure 10.1 summarizes the resulting estimates of the funding requirements from 2006 through 2008.

### PREVENTION

The severity of the epidemic, the current coverage and necessary target coverage of people in need of HIV prevention, and the costs of providing HIV prevention services were all taken into consideration, country by country, to estimate the total

US\$ billion	2006	2007	2008	2006–2008
Prevention	8.4	10.0	11.4	29.8
Care and treatment	3.0	4.0	5.3	12.3
Support for orphans & vulnerable children	1.6	2.1	2.7	6.4
Programme costs	1.5	1.4	1.8	4.6
Human resources	0.4	0.6	0.9	1.9
<b>Total</b>	<b>14.9</b>	<b>18.1</b>	<b>22.1</b>	<b>55.1</b>

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

funding requirements. Also taken into consideration were needs for HIV-specific health services, broader interventions in the health-care system (e.g. to ensure blood safety) and activities in non-health sectors (e.g. education). Figure 10.2 shows the resulting estimates of funding required for prevention activities in all low- and middle-income countries, while Figure 10.3 presents these estimated needs by region.

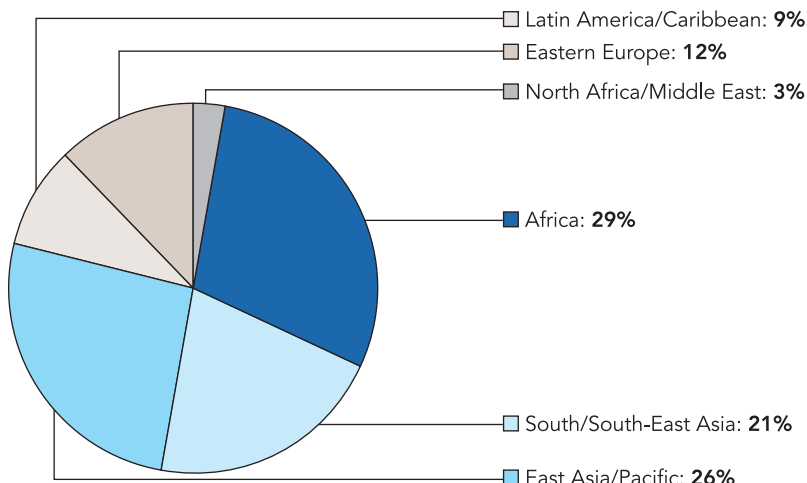
It is estimated that more than half the total required for the AIDS response each year

should go to prevention, due to the many elements that make up comprehensive prevention programmes and the large populations they must reach. Effective prevention activities create environments where people are knowledgeable about HIV, do not stigmatize or discriminate against HIV-positive people or those at greater risk of HIV exposure, and feel safe and comfortable when they take action to establish HIV-related services or seek access to services for themselves or others. In such environments, counselling, testing, treatment and care services will be more

<b>FIGURE 10.2</b>	<b>Funding required for prevention</b>			
<b>Prevention activities (US\$ million)</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2006–2008</b>
Mass media	91	100	109	299
Community mobilization	449	608	772	1830
Voluntary counselling and testing	451	569	690	1710
Youth in school	101	104	108	313
Youth out of school	768	945	1126	2838
Programmes focused on sex workers and their clients	429	552	682	1663
Programmes focused on men who have sex with men	312	407	499	1218
Harm reduction programmes for injecting drug users	114	149	180	443
Workplace	421	523	628	1573
Prevention programmes for people living with HIV	22	33	48	103
Special populations	151	252	252	654
Condom social marketing	159	175	190	525
Public and commercial sector condom provision	1381	1501	1625	4506
Improving management of sexually transmitted infections	672	718	764	2154
Prevention of mother-to-child transmission	206	264	324	794
Blood safety	226	228	231	685
Post-exposure prophylaxis (health-care setting, rape)	1	2	2	5
Safe medical injections	897	897	897	2690
Universal precautions	1590	1944	2303	5838
<b>Total</b>	<b>8441</b>	<b>9969</b>	<b>11 430</b>	<b>29 840</b>

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

**FIGURE 10.3** Distribution by region of the funding required for prevention



Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

effective as people become better informed, less fearful and more likely to take fuller advantage of them. Good prevention is a prerequisite and an essential companion to good treatment and care.

**TREATMENT AND CARE**

The WHO/UNAIDS “3 by 5” initiative set a target of reaching three million people in need of treatment in low- and middle-income countries with antiretroviral therapy by the end of 2005. Although 1.3 million people were actually reached, this was by no means a failure. When the initiative was launched on World AIDS Day (December 1) 2003, there were only 400 000 people receiving

therapy; an additional 900 000 people started antiretroviral therapy during 2004 or 2005. Besides that significant achievement, the experience of trying to hit the “3 by 5” target taught WHO, UNAIDS and their many partners a great deal about where basic health-care infrastructure and human resources are lacking and where more money needs to be invested to accelerate access to treatment.

Figures 10.4 shows an estimate of the money required over the next three years to accelerate access to treatment at a rate that can achieve levels as close as possible to the most common definition of universal access for treatment by 2010. Figure

<b>FIGURE 10.4</b> Funding required for treatment and care, including antiretroviral therapy (ART), in order to achieve the coverage targets shown			
Year	People on ART (million)	ART coverage of urgent cases	Total funding (US\$ million)
2006	3.0	55%	2986
2007	4.8	67%	4029
2008	6.6	75%	5250
2009	8.3	79%	-
2010	9.8	80%	-

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

<b>FIGURE 10.5</b>		<b>Distribution by activity of the funding required for treatment and care</b>			
<b>Treatment and care activities (US\$ million)</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2006–2008</b>	
Palliative care	308	302	295	905	
Provider-initiated testing	66	79	109	254	
Opportunistic infections treatment	686	703	707	2096	
Opportunistic infections prophylaxis	287	403	510	1200	
Antiretroviral therapy, including nutritional support	1642	2482	3624	7748	
Laboratory testing	54	79	104	237	
<b>Total</b>	<b>3043</b>	<b>4048</b>	<b>5349</b>	<b>12 440</b>	

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

10.5 shows the distribution of funding requirements by activity, while Figure 10.6 shows the distribution by region. It should be noted that research and discussions to specify what “universal access” means in different countries are ongoing. Meanwhile, the working definition used for estimating resource needs is that “universal access” occurs when 80% of all people in urgent need of treatment are receiving it. This is based on the experi-

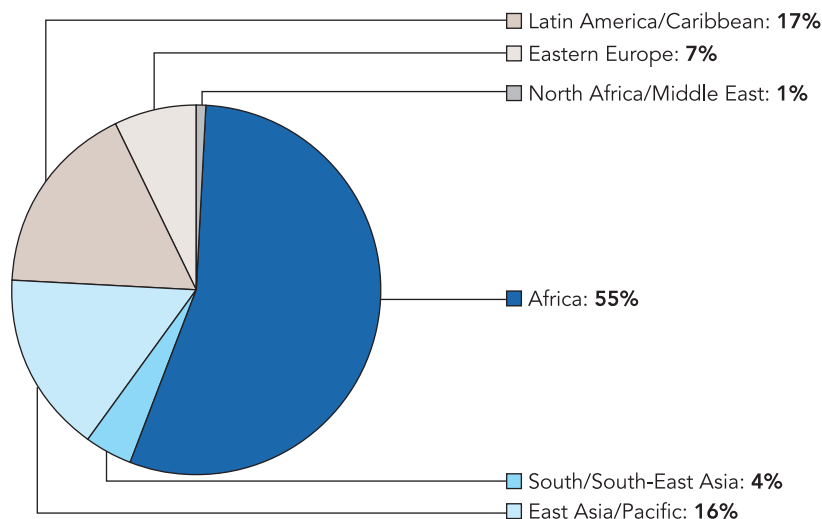
ence in high-income and some middle-income countries with well-developed health-care systems, where treatment coverage seldom exceeds 80% for a variety of reasons, including adverse reactions to drugs and personal choice.

**SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN**

Estimates of the funding required for activities supporting orphans and vulnerable

10

**FIGURE 10.6** Distribution by region of the funding required for treatment and care



Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

children take into account children living below national poverty lines who are double orphans (having lost both parents), single orphans (having lost one parent) and near orphans (likely to lose a parent within one year) due to their parents' HIV-related illness or death from AIDS. There was multi-agency agreement that, for the purpose of these estimates, UNICEF's estimates for all double, single and near orphans living below the poverty line in sub-Saharan Africa would be used, whatever the cause of their parents' death or illness. This was to reflect the high burden of HIV in the region (Stover et al., 2005). Figure 10.7 shows the funding required by activity. Of the total required from 2006–2008, 95% is required in sub-Saharan Africa.

#### PROGRAMME SUPPORT AND INFRASTRUCTURE

To deliver the services described above will require improvements to programme support and infrastructure. Estimates include the costs of developing and administering HIV policies, plans and programmes; undertaking monitoring and evaluation, as well as local and international technical assistance; and acquiring equipment, as well as constructing and upgrading health centres, hospitals and laboratories. They include only the costs of building on existing programmes and infrastructure, by increments, and do not include the direct costs incurred in the delivery of services by health and other

workers to the public. As shown in Figure 10.8, they fluctuate from year to year to account for the different stages, from planning to completion, of constructing 2700 new health centres by 2010 and upgrading 19 000 existing health centres and 800 hospitals.

#### HUMAN RESOURCES

Estimated costs for human resources (as outlined in Figure 9) include only the costs of training, retaining and attracting sufficient numbers of qualified nurses and physicians to support the AIDS response in low-income countries and two middle-income countries, Botswana and South Africa. They do not include the costs of training, retaining and attracting counsellors, clinical officers, adherence supporters, laboratory technicians, palliative care and community workers, or community coordinators. Those are part of the per-patient-visit costs taken into account in the estimates above for prevention, treatment and care, support for orphans and vulnerable children, and programme support. For example, training and honoraria for more than 316 000 community workers are covered under estimates for programme support. Assessing the need for a comprehensive package of human resources to support the scale-up of the AIDS response in each country will require further analysis but the estimates given here are based on the best information currently available.

<b>FIGURE 10.7</b>				
<b>Funding required for activities supporting orphans and vulnerable children</b>				
<b>Orphan support activities (US\$ million)</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2006–2008</b>
Education	193	287	443	923
Health-care support	145	174	200	519
Family/home support	971	1255	1604	3830
Community support	14	18	25	57
Organization costs	246	322	422	990
<b>Total</b>	<b>1569</b>	<b>2055</b>	<b>2694</b>	<b>6319</b>

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

<b>FIGURE 10.8 Funding required for programme support and infrastructure</b>				
<b>Programme activities (US\$ million)</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2006–2008</b>
Management	485	376	390	1251
Advocacy and communications	118	111	111	340
Monitoring and evaluation	148	138	146	432
Operations research	11	7	7	25
Training	72	136	231	439
Logistics and supply, including transportation	305	259	304	868
Supervision of personnel and patient tracking	97	68	92	257
Drug resistance surveillance	69	68	68	205
Construction of new health centres	60	23	167	250
Laboratory and other infrastructure upgrading	121	185	236	542
<b>Programme and infrastructure costs</b>	<b>1486</b>	<b>1371</b>	<b>1753</b>	<b>4610</b>

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

Included in the estimates are the costs of training an additional 5700 student nurses and 3070 student doctors every year between 2006 and 2008, so the first additional student nurses will graduate in 2009 and the additional first student doctors in 2012. (These numbers may seem low but reflect the estimated capacity of existing medical schools in the region.) Also included are the costs of wage supplements in low-income countries, where average annual wages are now US\$ 3200 for nurses and US\$ 5300 for doctors. The supplements will put

their wages midway between what they are now and what they might expect to earn if they accepted jobs in the United Kingdom. These supplements are urgently needed to retain the current drastically depleted supply of nurses and doctors and to add to the supply by retaining new graduates and attracting nurses and doctors from elsewhere.

#### LIMITATIONS OF THE ESTIMATES

The preceding numbers are estimates of the overall requirements for all low- and middle-income countries. Decisions

<b>FIGURE 10.9 Funding required for building human resource capacity</b>				
<b>US\$ million</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2006–2008</b>
Education	50	89	123	262
Nurses' wage supplements	153	261	370	784
Doctors' wage supplements	152	258	366	776
<b>Total</b>	<b>355</b>	<b>608</b>	<b>859</b>	<b>1822</b>

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.



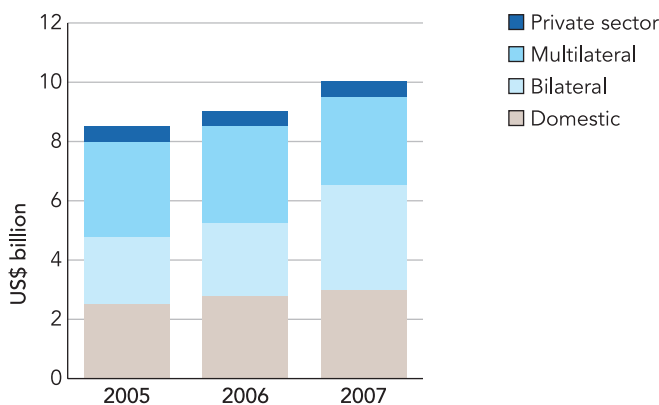
about resource allocations in any particular country should be based on assessments of that country’s unique circumstances and needs. For example, though the overall requirements suggest that 12% of all money should go towards supporting orphans and vulnerable children, over nine-tenths of that 12% is for sub-Saharan Africa. For countries outside of sub-Saharan Africa, the percentage of all HIV-related requirements assigned to supporting orphans and vulnerable children is likely to be considerably less than 12%. Spending decisions should be based on reliable evidence about the nature of each country’s particular epidemic, that is, concentrated among particular groups in urban areas or mainly in certain districts—or generalized and spreading into rural areas. Current efforts should also be reviewed in terms of their resources and programmes, their cost-effectiveness, where more effort might be focused, and whether or not stigma and discrimination are denying equal access to services for everyone in need.

It is also crucial to recognize that any estimate has its limitations, due to limited availability of data and inherent uncertainty about the future. However, given the considerable efforts made to solicit the latest available data, UNAIDS is confident that the preceding resource estimates constitute the best available estimates of overall requirements for low- and middle-income countries for the years 2006 through 2008. In concert with UNAIDS, many international and country-level partners are constantly at work improving and updating the data and analysis that go into making the most reliable estimates possible.

### The money available—estimates and trends

Based on UNAIDS projections done in mid-2004, in 2005 there was an estimated US\$ 8.3 billion available for the AIDS response in low- and middle-income countries. If recent trends

**FIGURE 10.10** Sources of the estimated and projected funding for the AIDS response from 2005 to 2007\*



\*Assuming there are no new commitments  
 Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

## GLOBAL RESOURCE TRACKING CONSORTIUM AND NATIONAL AIDS SPENDING ESTIMATES

The UNAIDS Global Resource Tracking Consortium provides the baseline data needed for estimating funding availability for future years, including data on existing sources and allocations of funding in all countries. It also assesses absorptive capacity (e.g. human resources and infrastructure to deliver treatment) and identifies bottlenecks (e.g. national drug licensing policies that slow importation of medicines) in countries.

Although the Consortium's members include a growing number of international and regional organizations, it depends on countries' resource tracking practitioners to provide the most comprehensive, reliable and up-to-date information possible. A problem with data from countries is that they usually come in the form of budgets, which are often higher than actual expenditures but also lack sufficient detail. For example, a budget may not count an expenditure on treatment and care of opportunistic infections as HIV-related and may not show that part of the expenditure is recovered from fees (i.e. out-of-pocket spending by patients and their families.) Also, the budgetary data provided by countries usually pertain only to the health sector, not to education or to other sectors.

In 2005, UNAIDS launched an initiative promoting National AIDS Spending Assessments (NASAs) and the establishment of country-wide systems for continually gathering, analysing and reporting data on HIV-related expenditures in all sectors, not just the health sector.

continue and donors honour their prior pledges and commitments, there will be US\$ 8.9 billion available in 2006 and US\$ 10 billion in 2007 (UNAIDS, 2005). Figure 10.10 shows the sources of that funding (note that 'Private sector' in these projections includes not only businesses but also charitable foundations and nongovernmental organizations).

### Domestic spending—by people and their governments

UNAIDS projects that funding from domestic sources within low- and middle-income countries will increase from US\$ 2.6 billion in 2005 to US\$ 2.8 billion in 2006 and then to US\$ 3 billion in 2007. Many governments have yet to make HIV a priority in their budget allo-

cations but, if governments and external donors do not spend more, affected individuals and families will have to spend more out of their own pockets.

### HOW MUCH AFFECTED INDIVIDUALS AND FAMILIES SPEND

The best available data on domestic spending come from Latin America and the Caribbean, thanks to pioneering work done by the Regional AIDS Initiative for Latin America and the Caribbean (SIDA-LAC and FUNSALUD, 2004). On average, out-of-pocket spending by households accounts for around 25% of all spending on HIV but the percentage varies widely from country to country. In some upper-middle-income countries, governments cover from 80% to 95% of HIV-related costs through their public health and social security programmes. In



*While domestic spending now accounts for around 30% of all spending on HIV in low- and middle-income countries, most of that 30% is accounted for by middle-income countries.*

some low- and lower-middle-income countries, governments and external donors together cover from 25% to 50% of costs. The balance is covered by out-of-pocket spending.

Where out-of-pocket spending accounts for a high percentage of all HIV spending it is because hospitals and other health-care providers are underfunded. Patients and their families often pay for their own medicines (e.g. antibiotics for the treatment of opportunistic infections) and also pay user fees to cover all or part of the costs of other essentials, such as bedding, meals and disposables.

A 2002 analysis of out-of-pocket spending in 13 Latin American countries found that out-of-pocket expenditure on HIV came to US\$ 73.9 million (around 25% of all HIV expenditure in those countries). Of this, people paid US\$ 18.9 million for clinical services, with half going to antiretroviral therapy. The remainder, US\$ 55 million, paid for condoms (UNAIDS Resource Tracking Consortium, unpublished).

Outside of Latin America and the Caribbean, only a handful of countries have

systematically collected information on out-of-pocket spending but, in sub-Saharan Africa, a series of studies have found that out-of-pocket spending accounts for a substantial share of total spending on HIV. For example, out-of-pocket spending in 2002 accounted for 45% of all HIV expenditure in Kenya, 9.4% in Ghana, and 30% in the Republic of Zambia, and in 2003 for 14% in Burkina Faso (Kates, 2005).

#### HOW MUCH GOVERNMENTS SPEND

While domestic spending now accounts for around 30% of all spending on HIV in low- and middle-income countries, most of that 30% is accounted for by middle-income countries. UNAIDS estimates that, over the next three years, the largest proportion of spending from all sources will be in sub-Saharan Africa but the largest proportion of domestic spending (around 57% of all domestic spending in low- and middle-income countries) will be in Latin America and the Caribbean (UNAIDS, 2004).

There are two reasons for the asymmetry. First, all but a few of the sub-Saharan African countries are low-income and heavily dependent on external funding

for their response to AIDS, whereas all but a few of the Latin American and Caribbean countries are middle-income and have well-developed health-care systems funded largely by domestic spending. Second, many governments in Asia, Central Europe and elsewhere should be spending more on HIV and could afford to do so but have yet to recognize HIV as an urgent problem requiring more attention. In fact, government spending in the majority of low- and middle-income countries in all regions has not kept pace with the need for expanded and comprehensive prevention, treatment, care and support services. This has been one of the chief constraints on countries' capacity to implement their national AIDS plans.

Spending patterns differ considerably from country to country. For example, Burkina Faso is one of the world's poorest countries. In 2003, the country's sources for total expenditure on HIV was external funding (78%); out-of-pocket spending (14.3%) and from government (7.7%). The World Bank, alone, accounted for 25.6% of its total expenditure and for 77% of all resources managed by public organizations. Around 74% of the country's spending went towards HIV prevention, including information, education and communication programmes and condom distribution. Only 26% went towards treatment and care, due largely to the fact that only 1200 people were being provided with antiretroviral therapy, even though many more were in urgent need. That year, the Global Fund to Fight AIDS, Tuberculosis and Malaria approved a grant which would expand treatment coverage to an additional 3500 people.

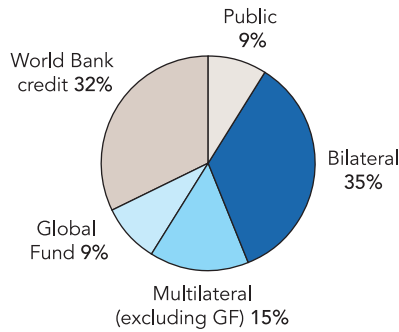
Until recently, HIV spending estimates for countries have covered only spending

in the health sector. In 2005, UNAIDS began advocating and supporting National AIDS Spending Assessments to help all international and national partners monitor financial flows from all sources into all sectors. Figure 10.11 shows early results, with 2004 HIV spending estimates from three countries broken down by source. The wealth of the three countries differed significantly: with Gross Domestic Product (GDP) per capita of US\$ 1174 in Burkina Faso, US\$ 2982 in India, and US\$ 9230 in the Russian Federation. Per capita spending on HIV also differed significantly, from US\$ 0.28 in the Russian Federation to US\$ 1.28 in Burkina Faso.

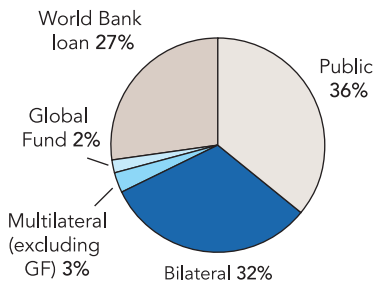
Figure 10.12 also shows early results from the new National AIDS Spending Assessments, with 2004 HIV spending estimates from four countries broken down by programmatic area of spending.

The spending estimates shown in Figure 10.11 and Figure 10.12 show no obvious relationship between countries' per capita spending on HIV and their per capita GDP or the nature of their HIV epidemics—whether their epidemics are low level, concentrated or high level and whether emerging or advanced. Clearly, to meet needs for an expanded and comprehensive response to AIDS, countries will have to increase their total spending on HIV and they will also have to do better jobs of targeting their spending, based on solid evidence of where interventions are most required. In particular, middle-income countries should give higher priority to spending on HIV from their own sources. All countries and donors need to give higher priority to reducing the burden placed on low-income households when they are obliged to pay for their own HIV-related services because no one else will pay.

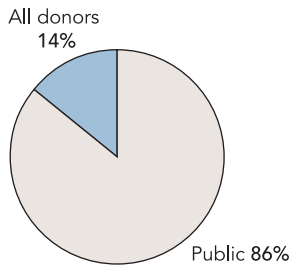
**FIGURE 10.11** Sources of HIV spending in three countries, 2004



**BURKINA FASO**  
HIV and AIDS spending per capita: US\$ 1.87



**INDIA**  
HIV and AIDS spending per capita: US\$ 0.59



**RUSSIAN FEDERATION**  
HIV and AIDS spending per capita: US\$ 0.28

Source: UNAIDS, based on National AIDS Spending Assessments.

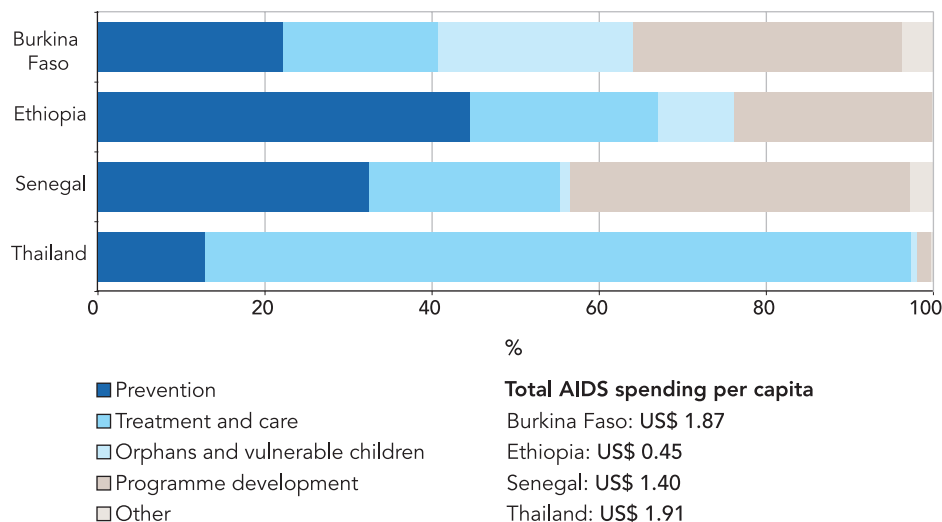
### Commitments of Official Development Assistance

Donor country governments provide the bulk of the development aid that flows from higher income countries to lower income countries. The main donor countries are the 22 member countries of the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) and they include the G7. Official Development

Assistance (widely known by its acronym, ODA) is the term for development aid from DAC members.

Thirty-seven years ago at the UN General Assembly, Development Assistance Committee members promised to spend 0.7% of their Gross National Income on official development assistance but, to date, only five have achieved this target. In 2005 Development Assistance Committee members renewed the promise

**FIGURE 10.12** HIV spending by programmatic area in four countries, 2004



Source: UNAIDS, National AIDS Spending Assessments.

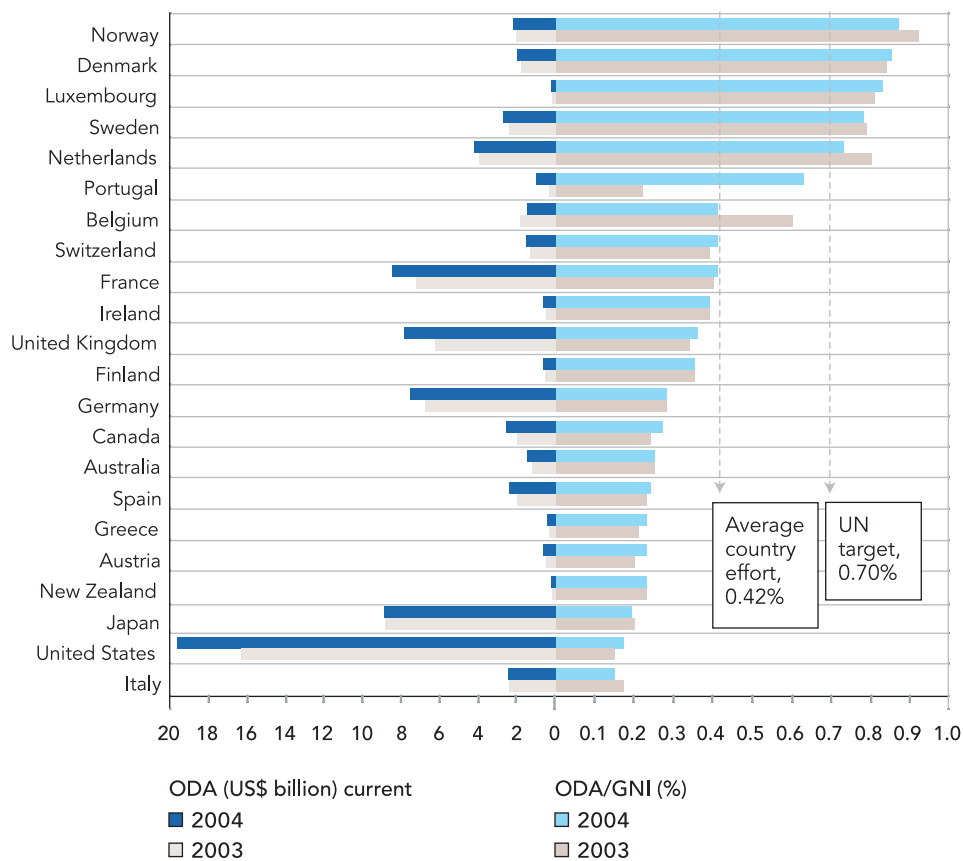
**THE MISMATCH BETWEEN GOVERNMENT SPENDING AND COUNTRIES’ REAL NEEDS**

Over the last few years, many countries have developed national AIDS plans to guide their responses but, in many cases, the plans have not been sufficiently strategic, evidence-based and targeted. Several reviews by the World Bank and others have found that many do not serve as genuine tools for guiding interventions, most are too general, few are followed by annual action plans, and few are informed by recent epidemiological information (Mullen, 2005). It is not surprising, then, that there is a substantial disconnection between what should be financed and what is actually financed at country level.

To illustrate, in one Asian country HIV infection levels in the general population remain low, as indicated by an HIV prevalence of less than 0.3% among pregnant women. By contrast, HIV prevalence among injecting drug users approaches 60% in the largest city and among sex workers it is 30% in selected areas. Data analyses from surveillance indicate that injecting drug use accounts for up to 75% of HIV transmission and that, together, injecting drug use and sex work account for more than 90% of all cases. Yet, despite these data, most of the country’s interventions are not directed towards these two groups. This example is not isolated. There are similar situations in many other countries.

Clearly, countries benefit from technical assistance that supports development of national AIDS plans and annual action plans that are strategic, prioritized and responsive to the epidemiological picture in the country. But such assistance has to avoid the all too common pattern of different donors and international aid agencies doing overlapping and uncoordinated studies.

**FIGURE 10.13** DAC members' Official Development Assistance in 2003 and 2004



Source: Organisation for Economic Co-operation and Development (2005).

at the G8 Summit at Gleneagles and elsewhere (G8, 2005). Greece is now committed to reaching the 0.7% target in 2007, France in 2012 and the United Kingdom in 2013. If all the 2005 commitments are met, including one to double aid to Africa, the amount will reach nearly US\$ 130 billion in 2010 (OECD, 2006).

Official Development Assistance increased by 5.9% from 2003 to 2004, to reach US\$ 79.5 billion. Their commitment to long-term programmes increased by 13.3%, which shows increasing support to sustained development. Figure 10.13

shows the contributions made by each Development Assistance Committee member country, in absolute terms and as a percentage of Gross National Income.

**BILATERAL AND MULTILATERAL FLOWS TO THE AIDS RESPONSE**

Official Development Assistance is spent in one of two ways, through bilateral or multilateral aid. Bilateral aid is direct assistance from one country (the bilateral donor) to another, in the form of financial, technical and other assistance to support development, including development of the AIDS response. Multilateral aid is indirect assistance, mostly originating

## COMMITMENTS VERSUS DISBURSEMENTS

In any discussion of aid flows, it is important to notice the difference between commitments and disbursements. Donors often commit money one year that may not be spent until the following year or that may be spent over a number of years. In the current environment, where funding for the AIDS response is increasing, the commitments tend to be more than disbursements each year. Depending on the source of information, available figures are often only for commitments or for disbursements but not for both.

with donor countries but some with philanthropic foundations. It goes, first, to multilateral organizations (World Bank, regional development banks, UN agencies and others, including the Global Fund to Fight AIDS, Tuberculosis and Malaria) and they, in turn, give it to recipient countries.

UNAIDS estimates that bilateral and multilateral flows accounted for US\$ 5.7 billion, or 68.8% of the US\$ 8.3 billion available for the AIDS response in 2005. Based on the original pledges, commitments and trends at the time estimates were made, bilateral and multilateral flows will account for US\$ 6.2 billion (70%) of the US\$ 8.9 billion available in 2006 and for US\$ 7.0 billion (70.0%) of the US\$ 10 billion in 2007 (UNAIDS, 2005).

### Bilateral flows to the AIDS response

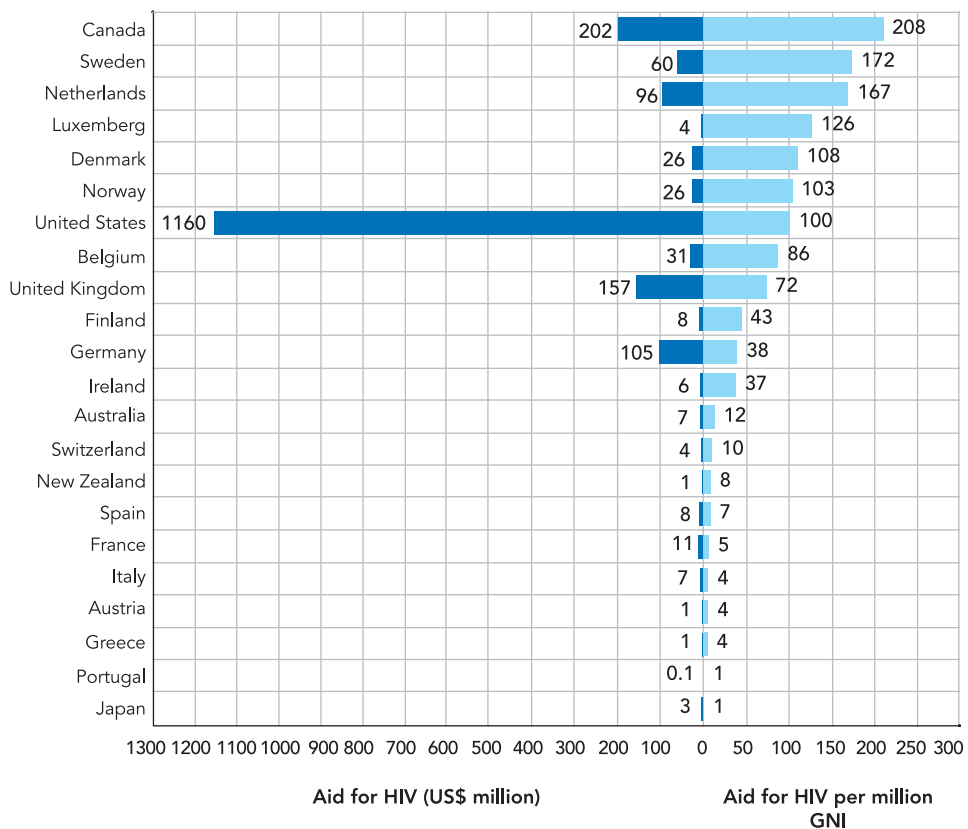
UNAIDS estimates that bilateral support of the AIDS response will grow faster than support from any other source, rising to US\$ 3.7 billion in 2007 (UNAIDS, 2005). The sharp rise will be due mainly to increases in support from the United States President's Emergency Plan for AIDS Relief (PEPFAR), which could be providing about 75% of all bilateral support in 2007. A 2004 study of

bilateral support from 2000 to 2002 found that large donors tend to focus on treatment programmes, which require substantial funding and long-term commitments. Smaller donors tend to focus on HIV prevention but also support home-based care and some mitigation activities. Figure 10.14 shows how much Development Assistance the member countries committed to the response to HIV, in absolute terms and as a percentage of Gross National Income, for 2004.

The amounts shown in Figure 10.14 are derived from an analysis of Official Development Assistance figures reported to the Organisation for Economic Co-operation and Development, where reports break down commitments by category. For a variety of reasons, a significant amount of spending on HIV is hidden in the official reports (for example, because it is an unidentified part of a larger category of spending on health, education, etc.) An earlier analysis, based on interviews with high ranking officers from Development Assistance Committee member countries, suggests that their actual commitments to HIV spending came to a total of just over US\$ 2.7 billion in 2004 and their disbursement totalled just over US\$ 1.9 billion. Figure 10.15 shows the percentages of the total committed by particular members (Kates, 2005).

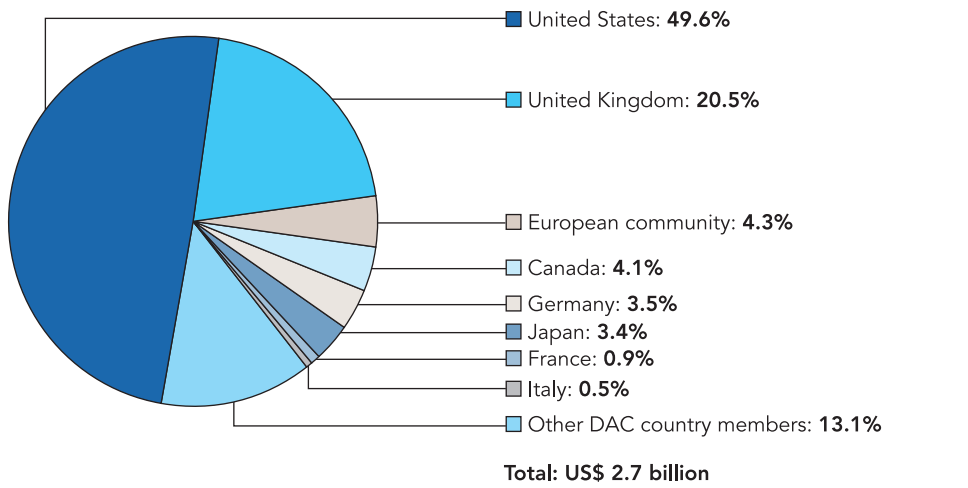


**FIGURE 10.14** DAC members' Official Development Assistance committed to HIV in 2004



Source: UNAIDS, based on data from DAC members' reports to OECD.

**FIGURE 10.15** DAC members' bilateral commitments to HIV-related programmes in 2004



Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

### THE UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

In January 2003, the United States President announced a commitment of US\$ 15 billion over five years for the global response to AIDS, to be channelled through the United States President's Emergency Plan for AIDS Relief (PEPFAR). Most is channelled bilaterally rather than through multilateral mechanisms and, of that, two thirds is going to 15 focus countries—12 in Africa, 2 in the Caribbean and 1 in Asia—heavily burdened by HIV. The first PEPFAR annual report shows that PEPFAR disbursed US\$ 570.2 million to the AIDS response in those 15 countries in 2004 and was committed to an additional US\$ 915.6 million in 2005 (Office of the United States Global AIDS Coordinator, 2005).

PEPFAR's policy to distribute bilateral funding across HIV-related programmes is as follows:

- 55% for treatment of people with HIV, with 75% of that to be spent on the purchase and distribution of antiretroviral drugs in 2006 and 2007;
- 15% for palliative care of people experiencing HIV-related end-stage illness;
- 20% for HIV prevention, with at least 33% of that to be spent on abstinence-based programmes; and
- 10% for support services for orphans and vulnerable children.

Recognizing that tuberculosis is the leading cause of death among people with HIV, PEPFAR committed US\$ 20 million to HIV-Tuberculosis programmes in 2005 and promised a significant increase in funding for such programmes in 2006.

### Multilateral flows to the AIDS response

UNAIDS estimates that multilateral aid accounted for US\$ 3.0 billion, or 36% of the US\$ 8.3 billion available for the AIDS response in 2005. It is likely to remain constant at around US\$ 3.0 billion and account for only 30% of the US\$ 10 billion available in 2007 (UNAIDS, 2005). The Global Fund to Fight AIDS, Tuberculosis and Malaria is the largest source of multilateral financial aid to countries, followed by the World Bank Group, which includes a number of regional development banks. The UNAIDS Secretariat and the other nine UN agency Cosponsors of UNAIDS (besides the World Bank) are sources of multilateral aid but, while some of it comes in the form of funding or co-funding of

country-level programmes, most of it comes in the form of advocacy, information, facilitation, mediation and technical assistance.

#### THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Declaration of Commitment on HIV/AIDS called for “a global HIV/AIDS and health fund” and “a worldwide fund-raising campaign aimed at the general public as well as the private sector” to contribute to the fund. Six months later, in January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established. Since its launch, the Global Fund has been guided by the “additionality” principle, meaning that its grants should in no way have negative impacts on national



*The UNAIDS Secretariat and Cosponsors as well as the World Bank are sources of multi-lateral aid. While some of it comes in the form of funding or co-funding of country level programmes, most of it comes in the form of advocacy, information, facilitation, mediation and technical assistance.*

governments' or other partners' commitments to support programmes to address the three diseases.

By the end of December 2005, the Global Fund had received US\$ 4.7 billion in contributions and also pledges that would bring the cumulative total to US\$ 8.6 billion by the end of 2008. It had approved five rounds of grants—in April 2002, January 2003, October 2003, June 2004, and September 2005—for a total of 350 grants to governments and other recipients in 128 countries. Proposals considered by the Fund are divided into two phases, phase 1 covering the first two years and phase 2 usually covering three but sometimes only one or two additional years. The total of all phase 1 and 2 grants approved by the end of 2005 was US\$ 4.8 billion. The total of all proposals approved by the end of 2005 will be US\$ 9.6 billion, assuming all phase 2 grants are approved.

The Global Fund monitors and evaluates implementation of all programmes it funds and disburses funds when programmes are ready to receive them (see 'National responses' chapter). It began making

disbursements in 2003 and total disbursements had come to US\$ 1.9 billion by the end of December 2005, with US\$ 1.1 billion disbursed in 2005 alone. Based on an analysis of actual funding from both phases of all proposals approved in the first five rounds, annual disbursements are distributed as shown in the box below.

Tuberculosis is the leading cause of death among people with HIV infection. Besides supporting tuberculosis-specific programmes, the Global Fund supports programmes that have both HIV and tuberculosis components. As of the end of December 2005, programmes supported by the Global Fund had:

- provided 2.5 million people with counselling and HIV testing;
- put 384 000 people on antiretroviral therapy for HIV and were expected to reach a total of 1.8 million people by the end of their five-year grants;
- reached 600 000 people with treatment for tuberculosis, many of them co-infected with HIV, and were expected to reach a total of 3.5 million people;
- provided 397 000 orphans and vulnerable children with social, medical and educational support; and

### DISTRIBUTION OF ALL GLOBAL FUND COMMITMENTS TO THE END OF 2005

- 56% to HIV, 26% to malaria, 17% to tuberculosis, and 1% to health-system strengthening;
- 67% to low-income countries, 25% to lower-middle income and 8% to upper-middle income countries;
- 60% to sub-Saharan Africa; 12% to East Asia and Pacific; 10% to Latin America and Caribbean; 9% to Eastern Europe and Central Asia; 8% to South Asia, Middle East and North Africa;
- 47% to drugs and commodities; 20% to human resources and training; 12% to physical infrastructure; 8% to administration; 6% to monitoring and evaluation; 7% to other; and
- 61% to government, 16% to multilateral organizations, 15% to nongovernmental and community-based organizations, 4% to faith-based organizations, 3% to private sector, 1% to other (based on rounds 2–5 only).

(Note that this breakdown only shows disbursements to Principal Recipients, not to the many civil society organizations that are registered as Sub-Recipients.)

- trained 304 000 additional people to work on HIV, tuberculosis or malaria (Global Fund, 2005).

Set up as a charitable foundation under the laws of Switzerland, the Global Fund is required to be financially prudent. It

only approves a phase 1 or 2 grant if it has sufficient assets to cover all years of that phase. To date, donors have all followed through on the pledges they have made, so the Global Fund is confident it will be able to provide phase 2 grants in a timely manner to all proposals

### THE GLOBAL FUND'S VOLUNTARY REPLENISHMENT MECHANISM

Until 2004, the Global Fund to Fight AIDS, Tuberculosis and Malaria depended on ad hoc contributions from more than 45 countries, and also from philanthropic foundations, corporations and individuals. To make its resources more sustainable and predictable, it established the Voluntary Replenishment Mechanism with UN Secretary General Kofi Anan as Chair and regular replenishment meetings attended by representatives of all stakeholder groups. These meetings give them opportunities to review results achieved, comment on the Fund's operations and effectiveness and make pledges based on mutually agreed targets and contributions.

In 2005, there were three replenishment meetings. At the last of these, held in London in September, 29 international donors pledged a total of US\$ 3.7 billion for 2006 and 2007, which was more than half of the Fund's estimated need of US\$ 7 billion for the two-year period. The next meeting, scheduled for July 2006, will seek additional pledges to meet the total need.



*International nongovernmental organizations make substantial contributions to the AIDS response in low- and middle-income countries.*

approved. Efforts to secure future pledges include a mid-year replenishment conference in 2006, a strategic plan to increase contributions from the private sector and the mobilization of new donors.

#### **WORLD BANK**

The World Bank is one of UNAIDS' ten Cosponsors and has the largest HIV-related budget of any UN agency, making it the second largest multilateral donor to the AIDS response in low- and middle-income countries, after the Global Fund to Fight AIDS, Tuberculosis and Malaria. The World Bank has been providing grants, interest-free credits and low-interest loans to support HIV projects in low- and middle-income countries since 1988. It began sharply increasing support in 2000.

By the end of December 2005, the World Bank had committed a cumulative total of more than US\$ 2.5 billion to HIV projects, including HIV components of broader projects. As of December 2005, 79 active projects, approved since 2001, had disbursed US\$ 893 million and were expected to disburse more than one billion more. These commitments, projects and disbursements were as follows.

- Through the World Bank's Multi-Country HIV/AIDS Programme for Africa, US\$ 1.15 billion was committed to 3 subregional projects and 33 projects in 33 different countries in sub-Saharan Africa; US\$ 545 million has been disbursed.
- Through the World Bank's Multi-Country HIV/AIDS Programme for the Caribbean, US\$ 118 million was committed to one regional project and nine projects in nine different countries; US\$ 25 million has been disbursed.
- Through other development programmes, US\$ 706 million was committed to 2 regional projects and 31 country-based projects in 26 different countries (10 in sub-Saharan Africa); US\$ 322 million has been disbursed.

As a major provider of development aid, the World Bank has always been the object of close scrutiny and sharp criticism. It admits to past mistakes and is stepping up efforts to monitor and evaluate its own performance as well as the performance of all projects it funds. In 2005, it published *The World Bank's Global HIV/AIDS Program of Action*, showing

### WORLD BANK'S EVOLVING HIV PROGRAMMING

Launched in 2000, the World Bank's Multi-Country HIV/AIDS Programme (MAP) has introduced a number of innovations to donor practices, including funding the operating and recurring costs of multisectoral programmes; instituting simplified procedures for approval and disbursement of funds; and directly funding civil society programming at the national, district and community levels. MAP was designed to meet the challenge of responding to AIDS in Africa. Lessons learnt while trying to meet that challenge have led to redesign so that it now accommodates a far wider scope and complexity of activity than traditional World Bank funding was able to accommodate. It was anticipated, at the outset, that this would be the case and recognized that programme implementation would require intense supervision and technical assistance and, also, constant learning and alteration of the design. Such was the success of the programme in Africa that one for the Caribbean was established.

Aside from MAP, the World Bank has developed new ways of supporting cross-country interventions that cannot be supported through individual country programmes. These include subregional AIDS programmes in the Caribbean, Central America, Central Asia and Africa. The World Bank has also integrated HIV programming into development projects (e.g. construction of transportation corridors or pipelines) by requiring safeguards against HIV infection where there is risk of HIV transmission.

how it intends to proceed over the next few years (World Bank, 2005).

#### OTHER UNAIDS COSPONSORS AND THE UNAIDS SECRETARIAT

All agencies in the United Nations system are responsible for mainstreaming HIV strategies and activities into their policies and programmes, and that includes providing HIV-related services to their own employees and their families. The main agencies contributing to the global response to AIDS, however, are the UNAIDS Secretariat and their 10 Cosponsors.

Every two years, the UNAIDS Programme Coordinating Board approves a UNAIDS Unified Budget and Workplan (UBW) allocating funds for specific activities and identifying which agency or agencies will be responsible for each activity. Under this budget, activities of the

UNAIDS Secretariat and the Cosponsors are guided by the UNAIDS' Strategic Framework for Action (UNAIDS, 2003). It sets five main objectives and one cross-cutting objective: to build human resource capacity for responding to AIDS in countries. The five main objectives are:

1. To empower leadership for the country response to AIDS.
2. To mobilize and empower public, private and civil society partnerships.
3. To promote and strengthen management of strategic information.
4. To build capacities to plan, track, monitor and evaluate country responses.
5. To facilitate access to technical and financial resources.

In addition, each of the Cosponsors engages in HIV-related activities that are

consistent with its general mandate. In 2005, for example, the Office of the United Nations High Commissioner for Refugees (UNHCR) carried out activities aimed at ensuring that HIV-related prevention, treatment, care and support were provided to the approximately 20 million refugees, asylum seekers, returnees and other persons of concern for which it has a mandated responsibility.

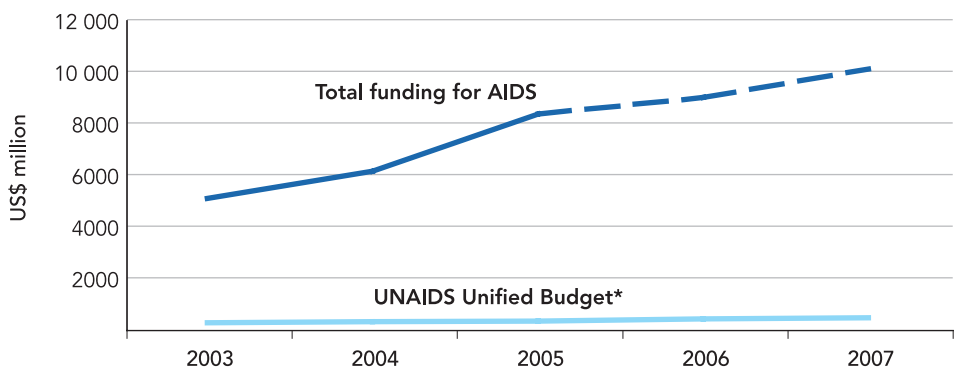
The Unified Budget for 2004 and 2005 was US\$ 522 million, an average of US\$ 261 million per year. The Cosponsors' HIV-related country-level budgets brought the total to US\$ 1.34 billion, an average of US\$ 667 million per year (UNAIDS, 2003). The UNAIDS Unified Budget for 2006 and 2007 is US\$ 797 million, an average of US\$ 398.5 million per year, up by 52.7% from the 2004–2005 average. The Cosponsors' country-level budgets for HIV-related activities bring the total to US\$ 2.56 billion, an average of US\$ 1.28 billion per year, up by 91.0% from the 2004–2005 yearly average (UNAIDS, 2005). Figure 10.16 compares increases in the Unified Budget to increases to the total amount available for the response to

AIDS in low- and middle-income countries.

### Flows from business, foundations and nongovernmental organizations

The UNAIDS projections of HIV-spending conducted in mid-2004 and illustrated in Figure 10.10 used the term “private sector” very broadly, to include private businesses, foundations and nongovernmental organizations and particularly those with an international reach, rather than ones based in countries. (The projections do not include in-kind contributions made by private businesses through their AIDS-in-the-workplace programmes or through extending those programmes out into surrounding communities.) The 2001 Declaration of Commitment called for a worldwide fund-raising campaign aimed at this sector but, so far, the results have been disappointing. Given the trends, UNAIDS projects that contributions from these sources will remain constant at around US\$ 400 million for 2006, 2007 and 2008 and three-quarters of that amount

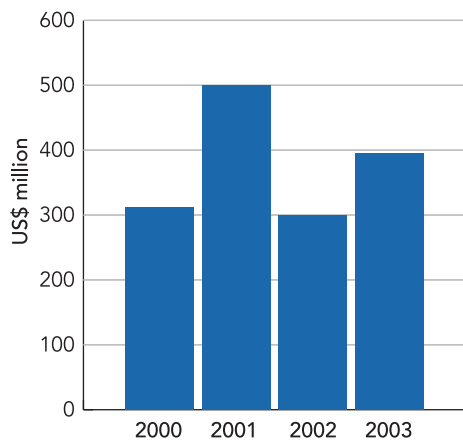
**FIGURE 10.16** UNAIDS Unified Budget compared to resources available for HIV in low- and middle-income countries



\*UNAIDS Unified Budget includes core, supplemental and agency own resources. It does not include estimates of country-level spending by Cosponsors. Source: UNAIDS (2005). UNAIDS Unified Budget and Workplan 2006–2007.

FIGURE 10.17

Commitments by foundations based in the United States to domestic and global HIV projects, 2000–2003



Source: Funders Concerned About AIDS (2005).

will come from foundations based in the United States (UNAIDS, 2005).

**FOUNDATIONS**

Independent bodies in both the United States and Europe have attempted to quantify the contribution of charitable foundations to HIV funding in recent years. As shown in Figure 10.17, a study by Funders Concerned about AIDS found that 2003 was the fourth consecutive year in which US-based foundations (including the charitable arms of corporations) committed more than US\$ 300 million to the domestic and global AIDS response (Funders Concerned about AIDS, 2005). Of the US\$ 394.5 million committed in 2003, US\$ 308.2 million was for projects that would benefit low- and middle-income countries and, of that, two thirds was committed by the Bill and Melinda Gates Foundation. The amount for projects benefiting low- and middle-income countries was distributed as follows:

- 75% to organizations based in North America or Western Europe which would use it for global projects or re-
- granting to projects in low- and middle-income countries;
- 14% to Africa and Middle East;
- 8% to Asia and Pacific;
- 2% to Eastern Europe and Central Asia; and
- 1% to Latin America and Caribbean.

In Europe, a 2005 study by the European HIV/AIDS Funders Group found that, in 2003, foundations based in Europe disbursed the equivalent of US\$ 33.6 million to HIV-related projects that would benefit low- and middle-income countries (European HIV/AIDS Funders, 2005). The study noted that traditions and laws in the United States support a level of private philanthropic activity found in few other countries. It also noted the advantages that private grant-makers have over public ones, including the ability to innovate and take risks.

**INTERNATIONAL NONGOVERNMENTAL ORGANIZATIONS**

International nongovernmental organizations make substantial contributions to the AIDS response in low- and middle-income countries. It is sometimes

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assumed that they derive all of their revenue from members of the public who respond to their fund-raising campaigns but, in fact, they usually derive most of their revenue from bilateral and multilateral donors and foundations. There are hundreds of international nongovernmental organizations, large and small, engaged in international development work and putting at least some of their effort into the response to AIDS. Currently, however, there are insufficient data on which to base even approximate estimates of the financial value of their collective contributions to the AIDS response and to avoid double-counting of contributions made by others.

### Funding for HIV vaccine and microbicide research

HIV vaccines and microbicides will benefit people in all countries, from the richest to the poorest. For that reason, expenditures and requirements for research and development of these products are not factored into any of the estimates provided elsewhere in this chapter. Though there is increasing scientific confidence that it will be possible to develop safe and effective preventive HIV vaccines and microbicides, there are many challenges that will require the investment of significantly more resources than have been available so far.

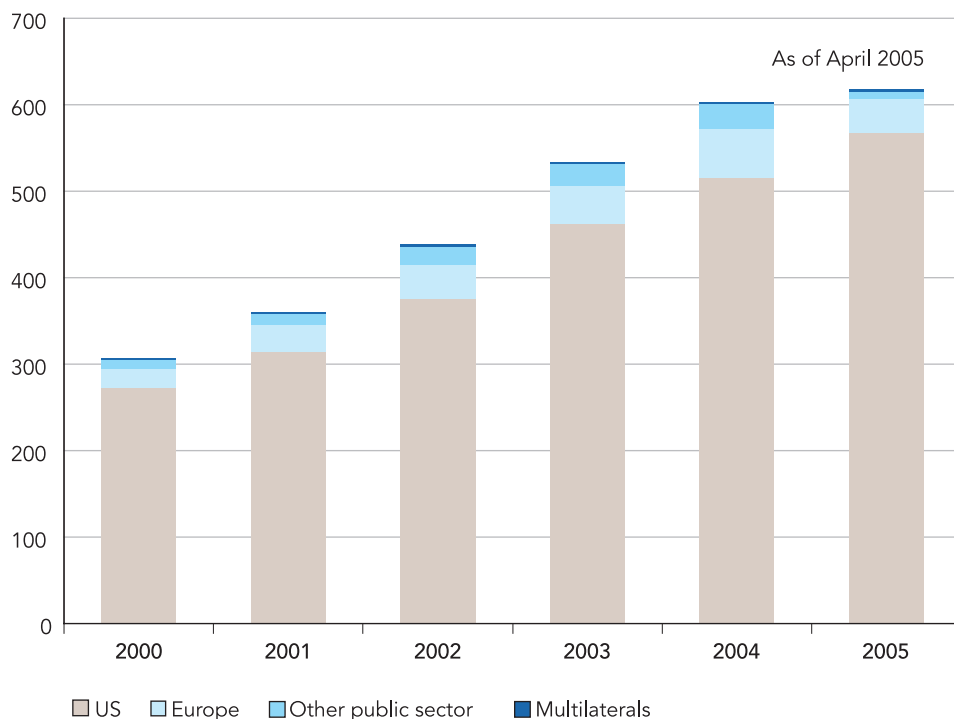
The Coordinating Committee of the Global HIV Vaccine Enterprise estimates that disbursements of US\$ 1.2 billion per year are required to accelerate the search for a safe and effective HIV vaccine. There was approximately US\$ 682 million available in 2004, of which 88% was from the public sector

(governments and universities), 10% from industry and 2% from private philanthropy. Since 2000, there has been a slight decline in funding from industry. Though pharmaceutical and biotechnology companies invest heavily in developing many other health-care products, they have invested little in developing an HIV vaccine. By contrast, public-sector financing has increased considerably, as shown in Figure 10.18. (For 2005, actual disbursements and firm commitments made as of April 2005 are taken into account (HIV Vaccines and Microbicides Resource Tracking Working Group, 2005).)

The International Partnership for Microbicides and the Alliance for Microbicide Development estimate that over the next five years, US\$ 280 million per year will be required to accelerate the search for safe and effective microbicides. Figure 10.19 shows that total non-commercial investment increased from US\$ 65.1 million in 2000 to US\$ 163.4 million in 2005, still far short of the amount required. As in the case of the search for an HIV vaccine, pharmaceutical and biotechnology companies have shown little interest in this work. They have developed a number of microbicide candidates for testing but, in 2004, their own investments were estimated to be less than US\$ 6 million (HIV Vaccines and Microbicides Resource Tracking Working Group, 2005).

Funding is only one component of the significant contribution the public sector makes to HIV vaccine and microbicide research. The public sector in low- and middle-income countries provides essential in-kind support. In countries where trials of candidate vaccines and microbicides

**FIGURE 10.18** Annual public-sector investment in preventive HIV vaccine research and development between 2000 and 2005 by region



Source: HIV Vaccines and Microbicides Resource Tracking Working Group (2005).

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are tested, hospitals and clinics and their regular salaried staff play crucial roles in conducting and supporting the trials. National regulatory authorities and ethics committees work to ensure that candidate products are safe and trials are conducted

in an acceptable manner. In sub-Saharan Africa, for example, the African AIDS Vaccine Programme supports countries to develop national HIV vaccine plans and works with local partners to devise methods to recruit and retain volunteers for

**FIGURE 10.19** Annual public- and philanthropic-sector investment in microbicide research and development between 2000 and 2005 (US\$ million)

	2000	2001	2002	2003	2004	2005
<b>PUBLIC SECTOR</b>						
United States	34.6	61.3	75.3	78.8	92.0	99.3
Europe	0.7	0.4	5.1	10.6	29.9	37.8
Other	0.3	<0.1	0.2	0.9	2.0	5.0
Multilaterals	<0.1	0.3	0.4	<0.1	0.2	0.2
<b>Total public</b>	<b>35.7</b>	<b>62.0</b>	<b>81.0</b>	<b>90.2</b>	<b>124.2</b>	<b>142.3</b>
<b>PHILANTHROPIC SECTOR</b>						
<b>Total philanthropic</b>	<b>29.4</b>	<b>3.4</b>	<b>24.8</b>	<b>16.9</b>	<b>18.1</b>	<b>21.1</b>
<b>NON-COMMERCIAL (Public &amp; Philanthropic)</b>						
<b>Total non-commercial</b>	<b>65.1</b>	<b>65.4</b>	<b>105.8</b>	<b>107.1</b>	<b>142.3</b>	<b>163.4</b>

Source: HIV Vaccines and Microbicides Resource Tracking Working Group (2005).

## THE MISMATCH BETWEEN DONORS' AID AND COUNTRIES' REAL NEEDS

The summary of estimated funding requirements is based on estimates of the amount of money needed for specific HIV prevention, treatment and other activities in all low- and middle-income countries. Few countries have produced comparable estimates, based on sound evidence of where spending is needed, and few have mechanisms through which all stakeholders agree on estimates and priorities and allocate resources accordingly. In addition, donor countries have their own priorities and these often do not coincide with recipient countries' priorities. As a result, there is a significant mismatch between spending and actual needs.

In recent years, donors have increased their aid in response to the need to build countries' capacity to respond to the HIV epidemic. A question now being asked is, "Why does capacity building seem to be lagging so far behind the increase in aid?" The answer is complex but two factors stand out. First, donors' policies often limit the scope for using their aid. If it comes in the form of money it is frequently tied to conditions that require currency exchange and purchase of imported goods (e.g. drugs, equipment and supplies). If it comes in another form, it usually consists of foreign technical assistance or foreign-managed construction of health facilities. Second, countries' needs are mostly for core budget expenditures that are mainly local (e.g. wages for nurses, doctors and other personnel) and are recurring.

There is general consensus that current methods of managing aid are inefficient and ineffective (see 'National responses' chapter). The long-term nature of the epidemic means that countries need sustained and predictable funding that increases over time. Given the predominantly local and recurring nature of countries' real financial needs, donor aid should be in the form of ongoing support for general budgets or specific parts of budgets. In countries that meet public expenditure management standards, aid flows through government budgets can improve harmonization and help strengthen governance, minimizing the need for disbursement through parallel systems outside of government.

the trials and ensure that they are properly informed and protected.

### Measuring the gap: available versus required funding

According to the estimates described above (see Figure 10.1), funding needed for the AIDS response in low- and middle-income countries will be US\$ 14.9 billion in 2006 and US\$ 18.1 billion in 2007 but only US\$ 8.9 billion and US\$ 10 billion will be available. It is

tempting to do the arithmetic and conclude that there is urgent need for additional commitments of US\$ 6 billion and US\$ 8.1 billion. However, measuring the gap between what may be available and what will be required is not so simple.

### Closing the gap

To meet the funding requirements, there must be action on two fronts. First, more money must be raised. There is

*Rising levels of funding and ongoing efforts to improve the management of financial resources provide grounds for cautious optimism about support for national responses to AIDS.*



considerable potential for several of the current sources of funding, including governments of middle-income countries, to commit more to the AIDS response. There is also potential for the main donor countries to raise money in new ways by, for example, adding an AIDS tax to air fares or income tax and by issuing bonds. It is clear, however, that enough funding to meet the requirements can be achieved only if the main donor countries fulfil the promises they made, first, at the G8 Summit at Gleneagles, Scotland, in July 2005 (G8, 2005) and then at the 2005 World Summit in New York in September. At the latter, a UN General Assembly resolution reaffirmed Member States' commitments to the Millennium Declaration (2000) and Declaration of Commitment on HIV/AIDS (2001) and stated a new commitment to "developing and implementing a package for HIV-prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it" (United Nations, 2005).

Second, the national and international partners in the response to AIDS must stay on course and accelerate efforts to

build countries' capacity to respond to AIDS and make better use of whatever money may be available. The following chapter discusses the challenges faced in scaling up national responses and how the partners are meeting them, guided by the "Three Ones" principles. However, two issues regarding funding should be emphasized here: absorptive capacity and the importance of resource tracking.

#### **ABSORPTIVE CAPACITY**

As well as being the most heavily burdened by HIV, the countries of sub-Saharan Africa also have weak health-care systems. This has raised concerns that implementing agencies in those countries may not be able to translate rapidly increasing financial support into programme spending in a timely manner.

Evidence from South Africa shows that, after initial delays while establishing new programmes or enhancing existing ones, the country's government agencies were able to rapidly increase their spending on HIV-related programmes. The South African Government launched the National Integrated Plan for HIV/AIDS in 2000, and it involved conditional grants from

three ministries to their nine provincial counterparts in health, education and social development. During the first year (fiscal year 2000–2001) the provincial authorities were able to spend only 36.5% of the funds made available to them that year. During the second year, they were able to spend 74.5% of the funds and, by the third year, they had reached a spending rate of 85%. A 2003 study concluded:

*The massive improvement in spending over the next two years suggests that the problem initially was not the CG [conditional grant] mechanism, itself, but the mammoth administration and financial management challenges to be expected in the first year of a national programme. Getting the NIP [National Integrated Plan for HIV/AIDS] programmes up and running required setting up management structures and employing coordinators in the provinces, developing financial transfer and monitoring systems and establishing programme standards, plans and materials (Hickey et al., 2003).*

A 2005 study found, however, that South Africa is still hampered by its weak health-care system and insufficient government capacity to absorb funds. It concluded:

*“Increased government and donor allocations for HIV and AIDS, without improved capacity to spend, challenge the overall strength of the health system. . . . Absorptive capacity is increasingly becoming the issue for HIV and AIDS spending in South Africa, rather than availability of resources. For this reason the donor community should . . . invest in capacity building in the government system to ensure that the resources they inject into the government are utilised effectively and efficiently” (Ndlovu, 2005).*

Another study found that the design of a country’s own funding mechanisms can

improve absorption of nationally sourced funds but that bilateral donors’ funds are more problematic. This is due, in large part, to conditions bilateral donors attach to their funds. Evidence from South Africa and Mozambique indicates that, while “ring-fenced” funding (i.e. funding that restricts spending to certain activities) can help ensure that new and critical projects are supported, such funding may clash with national priorities. This decreases flexibility for programme managers as they try to manage the flow of funds so that they serve countries’ own priorities (NACC, 2004).

Accurate analysis of expenditures of bilateral funding for HIV is rendered largely unfeasible because of the tendency of bilateral donors to report only on the amounts they have committed, rather than on amounts actually disbursed. However, government officials in Africa estimate that actual disbursement rates from bilateral donors may be below 50% (Ndlovu, 2005).

#### RESOURCE TRACKING

One of the most serious obstacles to proper use of funds comes in the form of “bottlenecks”—bureaucratic procedures or regulations that stop or slow down the flow of financial resources from the original source (e.g. a national government or donor) to final destination (e.g. a service provider on the front lines of the epidemic). Because typically there are several intermediaries between source and destination, it is important to map all of these elements (sources, intermediaries and destinations) and track the flow of money so problems can be identified. The greater the number of intermediaries, the more likely fund transfers will be delayed and some of the original amounts lost or stopped along the way.

AIDS budget analyses conducted in Kenya, Mozambique, Namibia and South Africa show the value of resource tracking monitoring whether disbursed funding is actually being spent. For example, in Kenya from April 2002 to May 2003, only 60% of the money approved by the National AIDS Coordinating Council for community-based organizations was actually disbursed to the organizations. Of the 60% that reached them, only 42% was actually spent. This meant that only 25% of the funding approved for community-based organizations over that period was actually spent during that period (NACC, 2004).

### Ensuring that prevention, treatment and care are properly funded

Rising levels of funding and ongoing efforts to improve the management of financial resources provide grounds for cautious optimism about support for national responses to AIDS. There are three significant *ifs*, however. *If* the funding requirements for 2006–2008 (shown in Figure 10.1) can be met, *if* adequate funding can be sustained beyond 2008 and *if* the national and international partners can meet the challenges outlined

above, the following could be achieved by 2010:

- Comprehensive HIV prevention, based on the characteristics of the epidemic in each country, including programmes to reduce risk behaviours by those at greatest risk of exposure to HIV, as well as all adults and youth; to prevent mother-to-child transmission; and to ensure safe blood supplies and injections.
- Treatment and care for 9.8 million people, including 80% of those in urgent need.
- Adequate support for all orphans and vulnerable children, including home support, schooling, health care and community support.
- Sufficient programme capacity (planning, administration, staff, etc.) and infrastructure (hospitals, health centres, laboratories, etc.) to support the interventions shown.
- Sufficient numbers of appropriately trained nurses, doctors and other personnel to support the above (UNAIDS, 2005).

Those achievements would constitute the “package for HIV-prevention, treatment and care” by 2010 called for by the UN General Assembly at the 2005 World Summit (United Nations, 2005).