



Meeting the need

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The AIDS epidemic knows no bounds. It defies international borders and transcends socioeconomic, political, ethnic and other divides. It is a global threat that requires global action—not least in ensuring that sufficient resources reach those countries and communities most in need. At the moment, this is patently not the case.

As of mid-2002, aggregate spending for HIV/AIDS in 2002 was projected to approach US\$3 billion in low- and middle-income countries, much of it underwritten by international assistance. In the most heavily affected region (sub-Saharan Africa), international spending on HIV/AIDS has risen well above the US\$165 million figure documented in 1998—a trend projected to continue in 2002. In the past few years, domestic spending on HIV/AIDS has also increased significantly in many countries.

But much more needs to be done. The mismatch between need and funding is one of the biggest obstacles to controlling the epidemic. Most poor countries still struggle to

boost their spending, even to levels that fall far short of the need. If current budgetary trends continue, donor support in 2003 will still be much less than the bare minimum required for basic prevention and care programmes.

Despite the fact that millions of people living with AIDS are being impoverished even further by the epidemic (see ‘The mounting impact’ chapter), many of them have to pay for their own care. It is a virtual certainty that out-of-pocket spending (which, in 2000, represented 22% of total HIV/AIDS spending in the eight countries studied in the SIDALAC project) accounts for a considerable share of overall AIDS spending everywhere, especially among the poor. (Out-

Declaration of Commitment

By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between US\$7 billion and US\$10 billion in low- and middle-income countries and those countries experiencing, or at risk of experiencing, rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS [...] (paragraph 80).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

A picture of spending in Latin America and the Caribbean

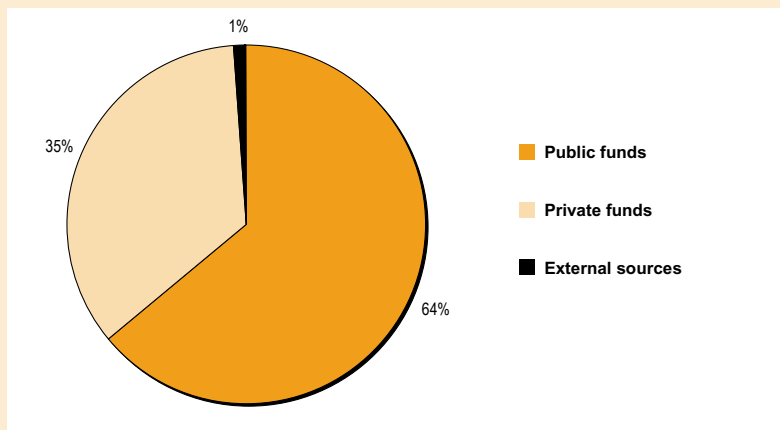
The SIDALAC project, with support from UNAIDS, the European Union and other donors, has compiled data on HIV/AIDS spending in eight countries in the Americas (Argentina, Bolivia, Brazil, Chile, Costa Rica, Mexico, Peru and Uruguay), which collectively account for 70% of the total population in Latin America and the Caribbean. In 2000, these countries spent a total of US\$1.8 billion on HIV/AIDS. If weighed against their total gross domestic product of US\$2759 billion, their HIV/AIDS spending amounted to less than 0.1% of total output.

Brazil, a country noted for its multisectoral public sector response to the epidemic, spent just under US\$3 per capita on antiretroviral therapy in 2000—slightly less than the US\$4–5 per capita that Argentina and Chile spent.

For the eight countries as a whole, spending on antiretroviral drugs accounted for just over half of total spending on HIV/AIDS; 30% went on other personal health services for people living with HIV/AIDS; and 17% was devoted to public health and prevention efforts. The latter figure may seem low, given the widely acknowledged benefits of prevention and public health, but it is of note that, for example, the United States Federal Government allocated only 7.8% of its total HIV/AIDS spending to prevention in 2000.

The public share of total HIV/AIDS spending varied widely between countries, from a low of only 2% in Bolivia, to much higher shares of 57% in Argentina, 68% in Costa Rica, 79% in Brazil, and 86% in Mexico. None the less, HIV/AIDS did not impose an impossibly large burden on the budgets of the health ministries of any of these countries. For Argentina and Brazil, HIV/AIDS used 2–3% of the public health budget. For the other countries, the burden on public health spending was 1.5% or less of the total.

Public, private and donor funding for HIV/AIDS, in selected Latin American and Caribbean countries*: 2000



* Argentina, Bolivia, Brazil, Chile, Costa Rica, Mexico, Peru and Uruguay

Source: FUNSALUD, SIDALAC, UNAIDS, 2001

Figure 37

of-pocket spending is the money individuals themselves spend on HIV/AIDS services.) Among the few prominent exceptions is Brazil, where out-of-pocket HIV/AIDS spending is a low 6%, thanks to strong public funding.

By contrast, private, out-of-pocket spending in Rwanda, for example, accounted for 93% of total HIV/AIDS spending in 1998–1999, and only 7% came from government and donors. Such high dependence on out-of-

pocket spending, particularly when it is the poor who are paying, is of grave concern. It is imperative that new ways be found to reduce the share of total AIDS spending by the poor. One way is to boost support to public health care and other social services, as part of broader, poverty-focused programming. This, in turn, reinforces the need for a fairer distribution of resources, not just nationally but globally.

Measuring the gap

A detailed calculation of the estimated total financial need in low- and middle-income countries for HIV/AIDS, done by an international team convened by the UNAIDS Secretariat, has shown that, in 2005, US\$9.2 billion will be required. That amount is several times greater than the spending projections for 2002 in low- and middle-income countries. A sustained increase therefore has to be achieved, with annual spending rising progressively to an annual total of US\$9.2 billion in 2005. Of that amount, US\$5.4 billion is required for countries with a gross domestic product of less than US\$2000 per person. This projected, staggered rise in spending assumes that many countries cannot immediately mount the entire range of activities

needed. Indeed, most countries would take several years to build up the human and infrastructural capacity to programme their expanded responses. These projections are based on conservative estimates of possible costs for each of the 18 prevention, treatment and care services used in the calculations of overall resource needs, and do not include costs for building up infrastructure.

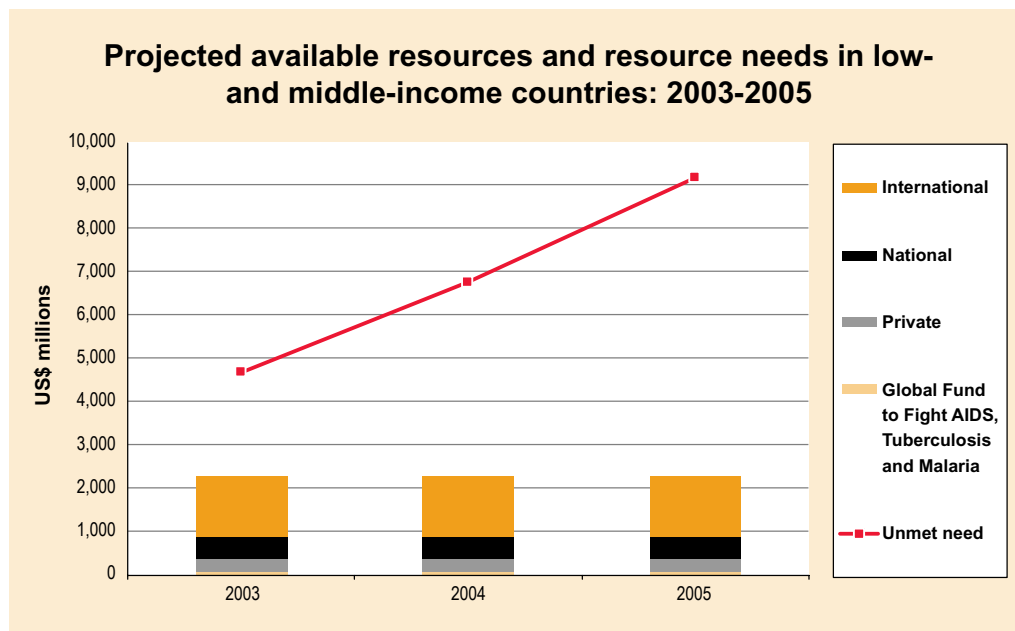
If expenditures on AIDS were to remain at current levels, the funding shortfall would grow to at least US\$7 billion by 2005 (see Figure 38), unless significant amounts of additional funding become available. (The respective contributions shown in this graph are based on current trends and pledges.)

Meeting the need

It is estimated that, overall, between one-third and one-half of the required funding could come from domestic private and public sources. Certainly, national ownership and responsibility are vital ingredients for effective AIDS responses, and the list of countries that

devote significant funds towards combating the epidemic has grown considerably in recent years. In addition, the Abuja Declaration, adopted at the Organisation of African Unity's special summit on AIDS in 2001, included a pledge that 15% of national budgets would

Figure 38



Source: Adapted from joint WHO/UNAIDS presentation, 27 January 2002, Geneva

be allocated to health spending. As Figure 38 shows, this would require a significant increase in spending for several countries.

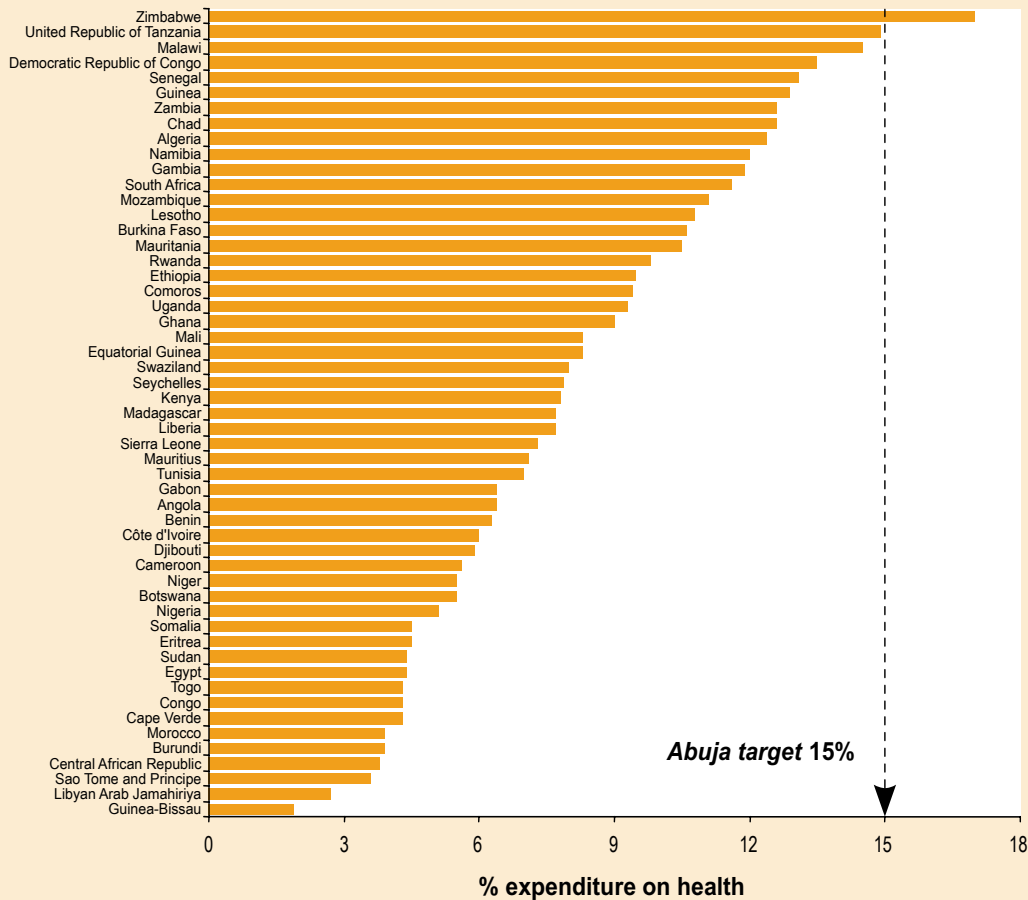
But many of the worst-affected countries rank among the poorest in the world, and are unable to finance their entire HIV/AIDS efforts domestically. National AIDS programme managers, health directors and health ministers from 14 sub-Saharan African countries in 2001 pinpointed the funding gaps their countries faced. In each of six of the countries (Kenya, Lesotho, Malawi, the United Republic of Tanzania, Uganda and Zimbabwe), the gaps ranged from US\$50 million to US\$200 million. Measured against the countries' limited tax bases and low income levels, the shortfalls highlight the need for greater donor assistance. Up to 80% of total resources needed in sub-Saharan Africa and

South and South-East Asia will have to come from international sources. This funding shortfall cannot be met from a single source. Several distinct sectors are involved in responding to AIDS, each of which has its own comparative advantages.

International donors account for approximately two-thirds of budgeted HIV/AIDS spending in 2002 in low- and middle-income countries, the bulk of it in the form of Official Development Assistance. In addition to providing funding, many donor countries can also draw on domestic technical resources and help build solidarity directly between their own communities at home and those in the recipient countries (e.g., through the networks of non-profit organizations). Figure 40 summarizes budgeted 2002 HIV/AIDS spending from a variety of international sources.

Figure 39

Public expenditure on health as percentage of general government expenditure in African countries: 1998



Source: WHO (2001) *World Health Report*

Multilateral organizations represent another important channel of assistance. They are well placed to ensure that internationally accepted scientific and technical standards are applied, to help promote consensus on the effective approaches, and to help AIDS

programmes achieve longer-term financial sustainability. Agencies such as UNDP, UNFPA and UNICEF, for example, are also important channels for deploying funding from bilateral donors in countries where they lack programming capacity.

Figure 40

A range of major international foundations have substantially increased their support for population activities—from US\$99.3 million in 1995 to an estimated US\$539 million in 2000. Many of the activities relate to sexual education, condom provision and other HIV/AIDS-related programmes. The Bill and Melinda Gates, Rockefeller, Ford, Marie Stopes, Kaiser, and United Nations Foundations, among others, are all active in international HIV/AIDS programming.

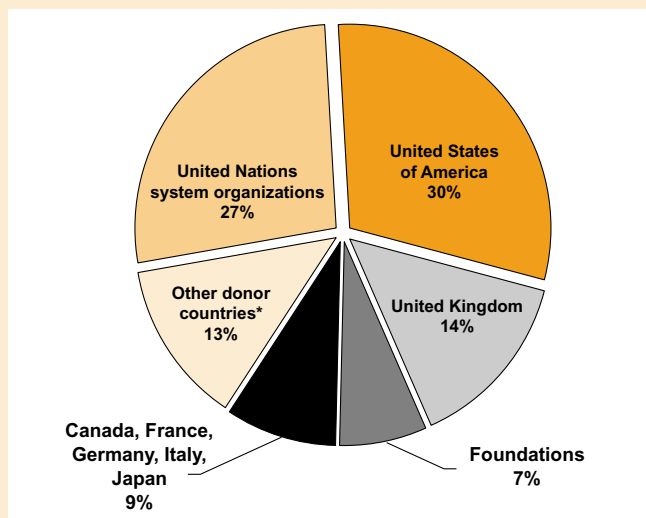
The newest funding channel is the Global Fund to Fight AIDS, Tuberculosis and Malaria. Its comparative advantage is the ability to rapidly direct new resources towards programmes that hold the best chances of success, in the countries with the greatest need.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Operating since January 2002, the Global Fund to fight AIDS, Tuberculosis and Malaria was set up as a financial instrument to complement existing funding for programmes addressing HIV/AIDS, tuberculosis and malaria. The Fund concentrates on generating additional resources and making them available at the community and country levels.

As a public-private partnership, the Fund's Board includes official country representatives (from North and South), as well as representation from the business sector, non-

Documented available international resources for HIV/AIDS: 2002



*Members of the Development Assistance Committee of the OECD

Source: UNAIDS, 2002

governmental organizations and communities directly affected by the epidemic. The UNAIDS Secretariat, together with two of its Cosponsors (WHO and the World Bank), are nonvoting members of the Board. The Fund coordinates its activities with governments, civil society, nongovernmental organizations, UNAIDS, the private sector, and donor agencies.

Total pledges to the Fund stood at just under US\$2 billion in April 2002. Most of the pledged funds came from the Official Development Assistance budgets of donor countries, and from the endowments of major philanthropic organizations. Figure 41 summarizes donor pledges to the Fund, as of April 2002. In its first grants, announced in the same month, the Fund committed more than US\$616 million over two years to support programmes in over 30 countries to combat AIDS,

tuberculosis and malaria. Around 60% of these funds will support HIV/AIDS prevention and treatment programmes, and most of these grants specifically include funding to purchase antiretroviral treatment. A further 15% of funds will go to programmes to fight AIDS, together with malaria and/or tuberculosis.

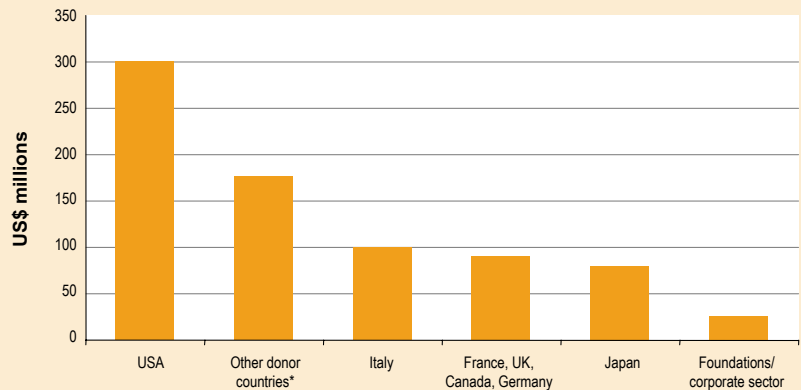
The Multi-Country HIV/AIDS Program for Africa

Managed by the World Bank, the Multi-Country HIV/AIDS Program for Africa came into effect in 2001. The Program takes the form of large, zero-interest loans to support governments over several years—loans that are largely channelled as grants to communities and civil society organizations. The emphasis is on increasing access to HIV/AIDS prevention, care, support and treatment programmes (with an emphasis on vulnerable groups), as well as mitigating the impact of the epidemic. Financed to the tune of US\$500 million, the first stage was approved by the World Bank in September 2001, and is now supporting 13 countries in sub-Saharan Africa. In February 2002, the Bank provided US\$500 million more, which is expected to support another 12–15 countries. In addition to country programmes, it is intended to support subregional and cross-border initiatives—for example, those targeting major transport routes such as the Abidjan-Lagos Corridor (see ‘Focus: AIDS and mobile populations’).

A similar initiative is now also under way in the Caribbean. Totalling US\$155 million, the Multi-Country HIV/AIDS Prevention and

Figure 41

Identified available resources for the Global Fund to Fight AIDS, Tuberculosis and Malaria, by source, as of April 2002



* Other member countries of the Development Assistance Committee of the Organisation for Economic Cooperation and Development and the European Union

Source: Joint WHO/UNAIDS presentation, 27 January 2002, Geneva

Control Project for the Caribbean works as a five-year loan programme that allows countries to obtain separate loans or credits to finance their national HIV/AIDS prevention and control projects. By April 2002, about US\$40 million had been allocated to projects in Barbados and the Dominican Republic.

Debt relief

Reducing the debt burdens of poor countries also has the potential of boosting the AIDS response where it is most needed. The debts of the 38 highly indebted poor countries (HIPC) (33 of them in Africa) amount, on average, to more than four times their annual export earnings. These debt burdens mean that annual debt-servicing obligations can undermine countries' social spending, including that required for their HIV/AIDS and orphans responses. In 16 African countries in 2001, governments were still spending more on servicing debts than on the health of their citizens. The HIPC debt initiative, devised by

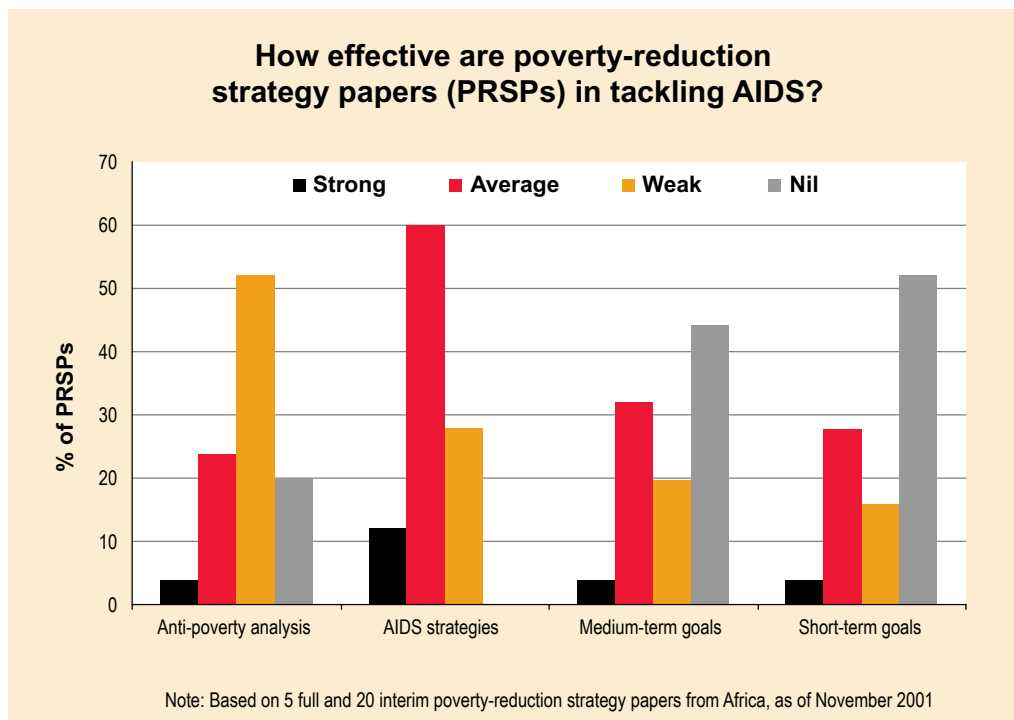
the World Bank and International Monetary Fund, is one attempt to relax those constraints and enable countries to allocate more resources to social development. Under the initiative, eligible countries qualify for debt relief if they meet certain conditions, including the adoption of economic adjustments and the drafting of poverty-reduction strategies in which social spending is given priority. Applicant countries are encouraged to include HIV/AIDS programmes in these strategies. UNAIDS and its Cosponsors are working to provide technical and other support to help countries integrate HIV/AIDS into poverty-reduction strategies.

Although only a few countries had completed the entire HIPC process by early 2002, 24

countries had reached the first of the two stages in this debt-relief process (the so-called 'decision point'), putting them in line for debt reduction. In those cases, debt relief could free significant sums of money for spending on public health care.

Initial indications are that, on average, HIPCs will spend about 25% of their annual interim debt relief on health care. As for AIDS, data from 10 low-income African countries from this group (Benin, Burkina Faso, Cameroon, Madagascar, Mali, Mauritania, Mozambique, Uganda, the United Republic of Tanzania, and Zambia) suggest that, together, they were budgeting some US\$32 million for AIDS activities, or about 5% of their HIPC savings, in 2001.

Figure 42



Source: Hecht R et al. (2002) Making AIDS Part of the Global Development Agenda, *Finance and Development*

The UNAIDS Secretariat has reviewed the first generation of 25 full and interim Poverty-Reduction Strategy Papers prepared by sub-Saharan African countries to gauge how well they were dealing with HIV/AIDS (see Figure 42). The review was based on four criteria:

- analysis of the relationship between AIDS and poverty has been carried out;
- the main strategies from the country's national AIDS plan feature in the poverty-reduction strategy papers;
- medium-term AIDS prevention and care goals and indicators for monitoring poverty are used; and
- short-term initiatives to fight HIV/AIDS (that can be monitored) have been incorporated.

In some other HIPC countries, however, little or no money from debt-relief proceeds has been specifically allocated to HIV/AIDS. In addition, this source of funding is not available to several low- and middle-income countries that are experiencing severe HIV/AIDS epidemics. Currently ineligible for debt relief under the HIPC Initiative are 16 countries where adult HIV prevalence exceeded 1.5%

in 2001. They include several sub-Saharan African countries where HIV prevalence was above 20%.

The business sector

The business sector also has an important role to play in funding an expanded response. Approximately 7% of the total resource need is for workplace prevention programmes, which private enterprises can fund. The scale and range of business involvement in the fight against AIDS are growing, but they are still only a fraction of their potential. Showing the way, meanwhile, are AIDS-related business initiatives that capitalize on key business strengths. For example, UNAIDS is working with MTV to help bring awareness to teenagers around the world. In Asia, the Thai Business Council has teamed up with the Thai Red Cross and other partners to integrate HIV/AIDS into the standard curricula taught to merchant sailors in maritime colleges. Debswana, in Botswana, has introduced prevention, treatment and care services for its employees and their spouses, effectively reducing HIV incidence, especially among its youngest workers (see 'Focus: AIDS and the world of work').

The bigger picture

Such innovations are helping countries significantly enhance their AIDS responses. But their longer-term impact is likely to be limited if the global distribution of resources and economic opportunities remains as unequal as it is today.

Unfortunately, resource transfers to low- and middle-income countries from both public and private sources are still declining. Much

stronger aid flows are essential for poorer countries to build and sustain comprehensive AIDS responses. Yet, levels of Official Development Assistance are at their lowest point in two decades. In 2000, only four high-income countries were living up to the 1970 commitment to raise these development aid levels to 0.7% of gross national product. Levels for most of the wealthiest countries were under 0.3%, drop-

Declaration of Commitment

Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS [...] (paragraph 84).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

ping as low as 0.1% in one case, as Figure 43 illustrates. Assistance to Africa as a whole has fallen dramatically, from US\$36 per person in 1990 to just US\$20 in 1999. According to UNDP estimates, assistance to the 28 countries most seriously affected by AIDS (countries with adult HIV prevalence exceeding 4%) fell by one-third between 1992 and 2000. The World Bank estimates that an additional US\$40–60 billion in foreign aid is needed annually, along with policy and institutional improvements, if countries are to reach the socioeconomic targets outlined in the Millennium Development Goals by 2015.

Other approaches can boost the global AIDS response and help redress the kinds of conditions that leave people vulnerable to the epidemic and its effects. Commercial creditors, including multilateral lenders, can for-

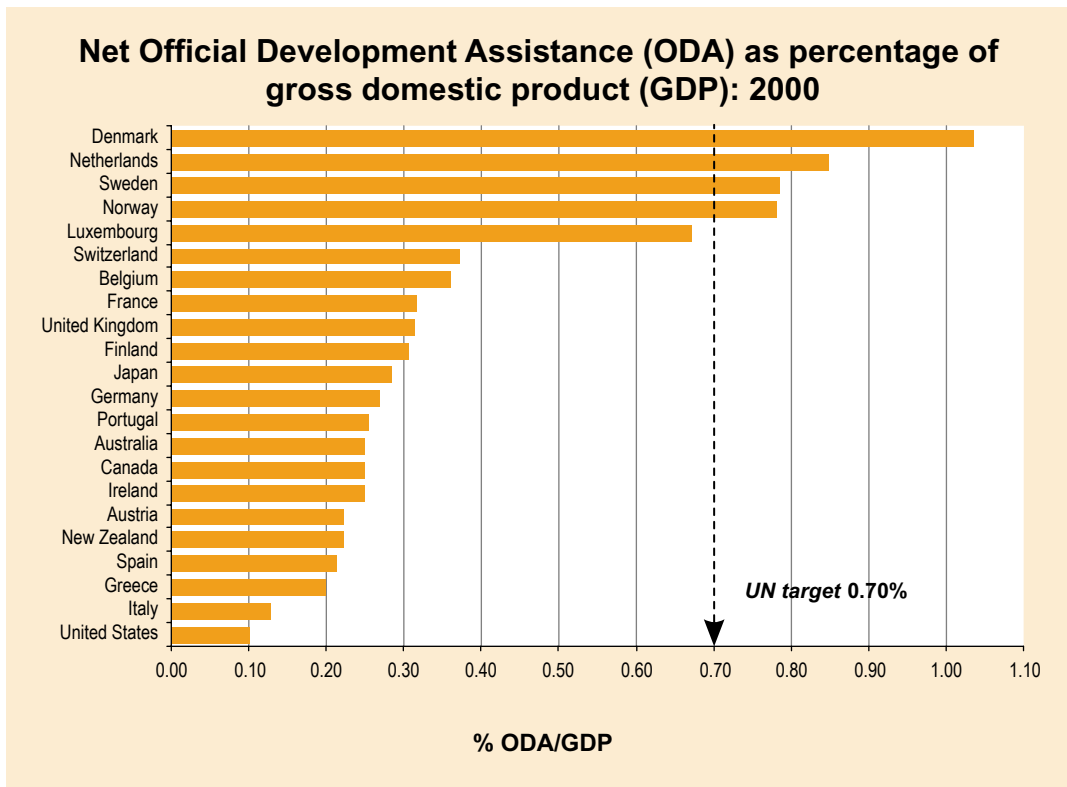
give much larger shares of debts owed by poor countries, many of which have already paid back amounts that far surpass the original principal borrowed. Positive changes to multilateral regulatory systems can help establish fairer global trade relations, and win greater market access for goods and services produced in low- and middle-income countries. Measures that encourage fairer and less volatile capital flows, too, can assist countries' efforts to boost their economies and improve socioeconomic conditions. For example, the inflow of foreign direct investment to all of sub-Saharan Africa in 2000 represented a mere 0.4% of the global total (down from 0.6% in 1999). Ample scope exists, therefore, for helping and enabling countries to pursue sustainable development strategies that reflect citizens' essential needs.

Making it count

The majority of low- and middle-income countries now have detailed plans for dealing with AIDS, and almost all of them have costed those plans. In order to ensure success, increased financial investment will have to be matched with investment in

human resource and institutional capacities. Improved governance and efficiency of resource transfer mechanisms will be required for AIDS spending to flow efficiently to the levels where it is most needed (see 'National responses' chapter).

Figure 43



Sources: For GDP data, OECD, *National Accounts of OECD Countries*, Volume 1, for ODA data, OECD

Countless communities are ready to take action. The new funding innovations being devised remind us that the world's capacity to rise to the HIV/AIDS challenge is far from

exhausted. But, set against the colossal needs, these types of efforts will need to be multiplied many times over if the world is to close the resource gap. 