



Joint United Nations Programme on HIV/AIDS

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FINANCING THE EXPANDED RESPONSE TO AIDS

July 2004



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Financing the expanded response for AIDS

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Financing the expanded response for AIDS

Executive summary

The 2001 United Nations Declaration of Commitment on HIV/AIDS calls for mobilizing massive new resources to mount an effective, comprehensive response to the epidemic. Accurate information on the magnitude and nature of resources available for AIDS programmes is essential to monitoring global success in meeting the targets in the Declaration of Commitment and ultimately the Millennium Development Goals for 2015. This information is also vital to sound strategic planning and programme scale-up in the low- and middle-income countries most affected by AIDS.

In recent years, UNAIDS and its partners have significantly increased global capacity to monitor resource flows for AIDS. This report summarizes the most recent data available on spending from all sources of AIDS programmes in low- and middle-income countries.

Financial needs for an effective response

In 2001, UNAIDS convened a panel of experts to project the level of financial resources required to respond effectively to the global epidemic. This process identified essential interventions to prevent new infections, provide care and treatment, and mitigate the epidemic's impact, assigning unit costs to each service and using available health service delivery information to estimate potential coverage for each intervention at country-level. After gauging optimal coverage levels in different regions for an effective global response, UNAIDS and its research partners estimated that US\$ 10.5 billion and US\$ 15 billion would be needed in 2005 and 2007, respectively, to finance the needed AIDS response.

Important developments since 2001 have prompted UNAIDS to revise its estimates of resource needs. Additional data have become available regarding the actual costs in different regions for key services, the global effort to expand access to antiretroviral therapy (ART) represents a new and important resource challenge, and it was determined that a comprehensive resource estimate required consideration of costs associated developing sufficient human capacity, which were not factored in the 2001 estimates.

To finance a comprehensive response to the epidemic, UNAIDS now estimates that US\$ 12 billion will be needed annually by 2005 – and US\$ 20 billion by 2007.

Resource trends for AIDS

Based on currently available information, UNAIDS projects that annual AIDS spending from all sources will increase from an estimated US\$ 4.7 billion in 2003 to US\$ 10 billion in 2007. Unless new resources are directed toward the global response,

the gap between the need and available resources will grow significantly in coming years.

Four funding streams support the financing of AIDS programmes: domestic spending, bilateral assistance, multilateral agencies (including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)), and the private sector. UNAIDS projects that bilateral assistance is likely to grow faster than other sources, primarily as a result of the scaling up in 15 priority countries of the United States government's five-year, US\$ 15 billion initiative known as the 'President's Emergency Plan for AIDS Relief' (PEPFAR). The second most significant source of new funds is anticipated to be the GFATM.

Domestic spending

Many countries have significantly increased their spending on AIDS, although public sectors in many countries have yet to prioritize AIDS in their budget allocations. Domestic spending includes both funds from the public sector as well as from individuals and families affected by HIV, termed "out-of-pocket" spending. UNAIDS estimates that in 2003 in-country sources accounted for US\$ 2.1 billion of the world's US\$ total of US\$ 4.7 billion in AIDS expenditure, US\$ 2.5 billion in 2004, reaching an estimated US\$3 billion in 2007.

In Latin American countries, the public sector accounted for the vast majority (84%) of AIDS expenditure in 2002, but this proportion was substantially lower in sub-Saharan Africa. The government of Rwanda finances 21% of general health spending, but only about 5% of public health funds are spent on AIDS.

In Kenya, the average HIV infected individual spends nine times more in out-of-pocket health care costs than the typical Kenyan spends on any other kind of health service. In these resource limited countries with generalized epidemics, payments by households represent a substantial share of total health expenditures on AIDS.

Bilateral funding

Bilateral AIDS assistance among leading donor countries increased by 64% between 2000 and 2002, and additional growth is anticipated. In 2004, UNAIDS estimates that bilateral spending will reach US\$ 1.3 billion, more than 20% of the projected global spending of US\$ 6.1 billion from all sources.

The United States remains the leading bilateral donor in terms of absolute dollars. The United Kingdom, the European Community, and Canada are also expected to play important roles in providing AIDS assistance in 2004 and beyond.

Key multilateral initiatives

Creation of the GFATM represented a major step forward in the global effort to mobilize additional resources to respond to AIDS. Based on current pledges to GFATM, contributions of nearly US\$ 1.5 billion are forecast for 2004. During the most recent round of grant awards (the fourth), GFATM recommended the funding of projects with a total five-year value of US\$ 2.9 billion. Evaluation results from projects in earlier rounds indicate that most recipient countries are effectively implementing the critical health programmes approved by GFATM. The organization

aims to reach a rather steady plateau by 2008 of roughly US\$ 3 billion annually in income and disbursements – approximately double current funding levels.

The UN system has significantly increased the level of financial and human resources devoted to AIDS. For example, AIDS expenditure by the World Food Programme (WFP) increased from US\$ 1 million in 2000 to US\$ 195 million two years later. Among UN system sources, the World Bank represents the largest source of AIDS funding for low-income countries. Through its Multi-Country AIDS Programme, the World Bank has approved US\$ 1 billion in multiyear grants or interest-free loans to support AIDS programmes in sub-Saharan Africa.

Private sector

Financial support from foundations increased from US\$ 7 million in 1997 to US\$ 260 million in 2002. The Bill & Melinda Gates Foundation is largely responsible for the sharp increase in philanthropic support for AIDS programmes in low- and middle-income countries, although many other foundations also provide significant financial support. However, there are indications that overall philanthropic support for AIDS activities may be declining.

Spending by international nongovernmental organizations (NGOs) has fluctuated in recent years, with estimated funding of US\$ 119 million in 2002. Meanwhile, corporations support an effective response through workplace programmes, and also provide financial support for AIDS initiatives. In 2002, eight United States corporations awarded more than US\$ 600,000 in AIDS grants.

Vaccines and microbicides

Evidence remains incomplete on the level of financing for the research and development of critical new AIDS technologies. It is estimated that global investment in AIDS vaccine research and development (R&D) amounted to range from US\$ 624 to US \$ 670 million in 2002, with the public sector accounting for 67% of such funding. In 2004, an estimated US\$ 143 million was spent worldwide on microbicide R&D, with the United States government representing the single largest source of such funding.

Translating funding into action

To help turn the tide against HIV/AIDS, available resources must be put to good use in a timely manner. Factors that impede HIV/AIDS resources from being optimally effective include failure to target programmes to those who need them the most, failure to implement interventions with proven scientific effectiveness, and bureaucratic obstacles to the rapid disbursement and use of available funds. Strong resource monitoring systems can help detect such problems and point the way toward possible policy responses to facilitate expedited use of available financial resources. Over the past three years, there has been an increasing refinement in tracking financial resources for the AIDS epidemic. Collecting this data is both feasible and affordable in all countries. Resource flow analysis should be integrated into all levels of resource disbursement and expenditure – from global ODA to district level spending – and should become a routine component of monitoring and evaluation systems

I. Introduction

As the AIDS epidemic has spread, funding for sexually transmitted diseases (STDs) and HIV and AIDS activities has also increased sharply over the last few years. Based on the best available information, UNAIDS estimates that spending on AIDS in low- and middle-income countries amounted to nearly US\$ 4.7 billion in 2003 – a 20% increase over 2002 (US\$ 3.9 billion) and an almost 15 fold increase over 1996 expenditures.

Along with the spread of the epidemic, political commitment to reverse the spread of AIDS has grown stronger, triggering greater international action to mobilize critical financial resources. At the Millennium Summit in 2000, world leaders pledged to halt and begin to reverse the spread of AIDS by 2015. In 2001, the United Nations General Assembly Special Session on HIV/AIDS unanimously adopted the Declaration of Commitment on HIV/AIDS, which provides a comprehensive framework for achieving the HIV-related vision of the Millennium Development Goals.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was launched in 2002 to increase resources to fight three of the world's most devastating diseases. Resolving to address the challenges of financing for development, world leaders adopted the Monterrey Consensus in 2002, pledging to mobilize and increase the effective use of financial resources to achieve internationally agreed development goals. On World AIDS Day 2003 WHO and UNAIDS released a detailed plan to reach the 3 by 5 target of providing antiretroviral treatment to three million people living with AIDS in developing countries and those in transition by the end of 2005. This is a vital step towards the ultimate goal of providing universal access to AIDS treatment to all those who need it. In 2003, the United States government launched the United States President's 'Emergency Plan for AIDS Relief' (PEPFAR). Just this year, the Copenhagen Consensus stated that AIDS is the leading priority for the international community. As a result of increased advocacy and mobilization efforts, spending on AIDS activities increased from US\$ 998 million in 2000, to US\$ 3.9 billion in 2002. It is estimated that global spending from all sources will reach US\$ 6.1 billion on AIDS activities in 2004.

It is important to note there are differences between budgeted funding, or commitments, and actual spending, or disbursements made by donor governments. Some donor governments disburse all committed funds within the same year in which they are obligated; others, such as the United States, may disburse funds committed in a single year over multiple years, reflecting the reservation of funds to fulfill multi-year contracts or the need for newly funded programmes to build to capacity. In this document, every attempt is made to use the same funding source definitions to allow comparison across different funding sources.

II. Estimated total resources needed

In 2001, UNAIDS and its partners performed the first estimation of resource needs to adequately respond to the AIDS crisis. This process identified a set of essential

prevention, treatment, care, support and mitigation interventions. For each essential intervention, the group calculated unit costs for service delivery and estimated potential country-level coverage, based on the assessment of existing health delivery capacity. UNAIDS and its partners had estimated resource requirements for 2005 to be US\$ 10.5 billion.

During the past three years, this methodology has been reviewed and refined. UNAIDS now estimates that US\$ 12 billion will need to be spent annually on AIDS interventions in low- and middle-income countries by 2005 – a figure that is expected to rise to US\$ 20 billion annually by 2007. Table 1 summarizes resource needs by main service components, while Table 2 provides details of total requirements in 2005 and 2007.

Table 1. Resource Requirements for HIV/AIDS Interventions, Principal Components, 2005 and 2007, US\$ billions.		
Intervention	2005	2007
Prevention	6	9.8
Care and Treatment	3.8	6.7
Orphans, Vulnerable Children	1.1	2.2
Admin, overheads	0.7	1.1
TOTAL	11.6	19.9

Source: UNAIDS

Table 2. Annual costs of scaling up HIV and AIDS activities (US\$ millions)		
	2005	2007
Prevention-related activities		
<i>General population interventions</i>		
Mass media	96	129
Voluntary counselling and testing	1,101	2,175
<i>Programs for key populations at high risk</i>		
AIDS education in schools	95	100
Outreach for out-of-school youth	633	1,100
Interventions focused on sex workers and their clients	384	718
Interventions focused on men who have sex with men	342	725
Harm reduction programs	124	241
Workplace prevention	505	901
Prevention programs for people living with HIV	34	112
Prevention for special populations (prisoners, migrants, truck drivers, etc.)	115	252
<i>Service delivery</i>		
Condom social marketing	147	198
Public and commercial sector condom provision	865	1,093
Improving management of sexually transmitted infections	660	783
Prevention of mother-to-child transmission	167	320
Blood safety	224	230
Post-exposure prophylaxis	1	1
Safe medical injections	93	94
Universal precautions	394	663
Other Prevention	18	53
Orphan support		
Orphanage support	509	1,051
Community support	364	722
School fees	204	406
Treatment and care		
Palliative care	271	231
Diagnostic testing	24	19
Treatment for opportunistic infections	349	482
Prophylaxis for opportunistic infections	114	320
Anti-retroviral therapy	2,875	5,183
Laboratory monitoring for anti-retroviral therapy	182	426
Policy, advocacy, administration and research	545	936
Program costs	155	192
Total	11,592	19,857

Source: UNAIDS

Several factors have led UNAIDS to increase its estimates for future resource needs. It is anticipated that care and treatment programmes will be rapidly expanded in 2005, in accordance with the global target of three million people on antiretroviral therapy (ART) by the end of 2005 (the '3 by 5' initiative), described in the box below.

In addition, more recent data obtained from UNAIDS-convened costing workshops in all regions have resulted in increases in the unit costs of specific interventions. In contrast to earlier UNAIDS analyses of resource needs, the latest estimates also include projected costs for certain key investments in human capacity. A more detailed analysis of estimated resource needs is available¹ on the UNAIDS website (www.unaids.org).

Based on these analyses, from an estimated 2003 level of spending of less than US\$ 5 billion, programmes will need to expand by more than 20% annually to reach the 2007 spending level.

World Health Organization (WHO) and UNAIDS set a target for treatment

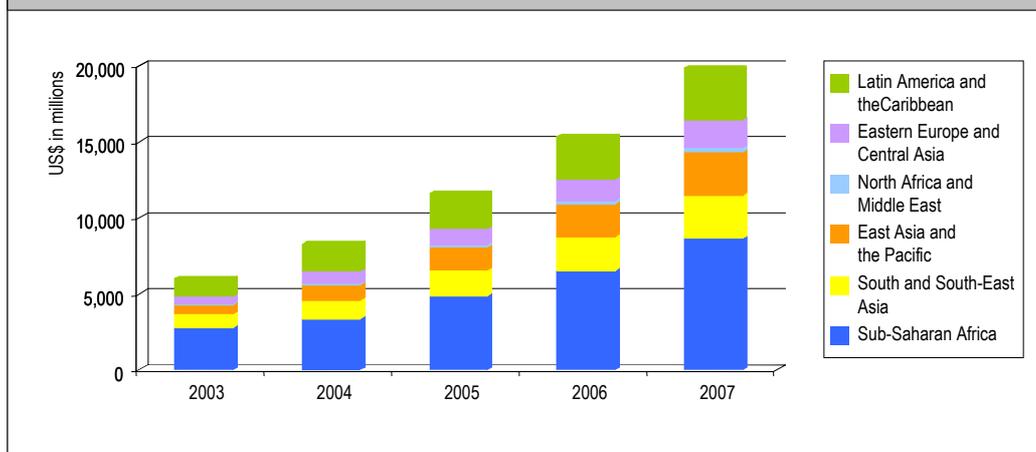
‘We must meet the challenge of expanding access to HIV treatment. This requires overcoming the formidable barrier of creating sufficient operational capacity – a key area where UNAIDS Cosponsor, WHO, must play a critical role’ (Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS (UNAIDS))

In 2003, the Director-General of WHO and the Executive Director of UNAIDS called for an international effort to provide antiretroviral therapy to 3 million people by the year 2005. The total two-year costs for 3 by 5 are estimated to range from US\$ 5.4 billion to US\$ 6.4 billion. The estimated range of costs reflects uncertainty about enrolment rates over the two years and drug prices. The costs include: providing ART, programmes of diagnostic HIV testing, palliative care, treatment of opportunistic infections, prophylactics for preventing opportunistic infections, universal precautions, post-exposure prophylaxis, preventing mother-to-child HIV transmission, and programme support costs. All cost estimates include traded goods (e.g., drugs) and local goods (i.e., goods for which foreign exchange is not necessary, such as labour).

About 43% of required resources [total amounts for all interventions in 2007] will be needed in sub-Saharan Africa, 28% in Asia, 17% in Latin America and the Caribbean, 9% in Eastern Europe, and 1% in North Africa and the Middle East (see Figure 1).

¹ C Hankins, JP Gutierrez, S Bertozzi, W McGreevey, L Bollinger, R Greener, John Stover. Increased resource needs for an expanded response to AIDS in low and middle income countries. June 2004. Submitted for publication.

Figure 1. Projected annual HIV and AIDS financing needs by region, 2003-2007 (in US\$ million)



Source: UNAIDS, 2004

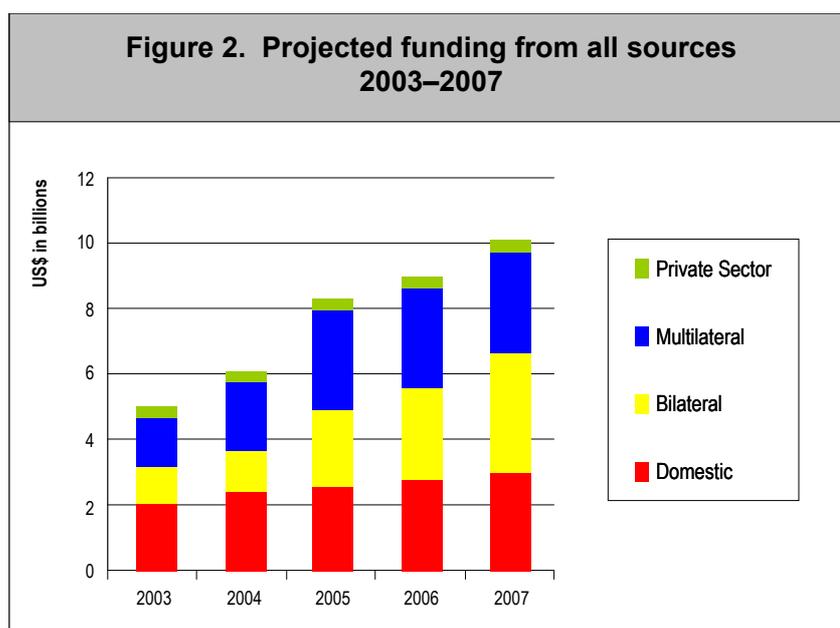
III. How to meet global resource needs

A. Estimating global resources

An effective response to AIDS requires mobilizing sufficient resources to implement prevention activities and to provide care and treatment for the people who need it most. Based on current trends and future pledges, the resources available for AIDS will increase from an estimated US\$ 4.7 billion in 2003 to US\$ 10 billion for 2007. The sources for these funds can be divided into four categories:

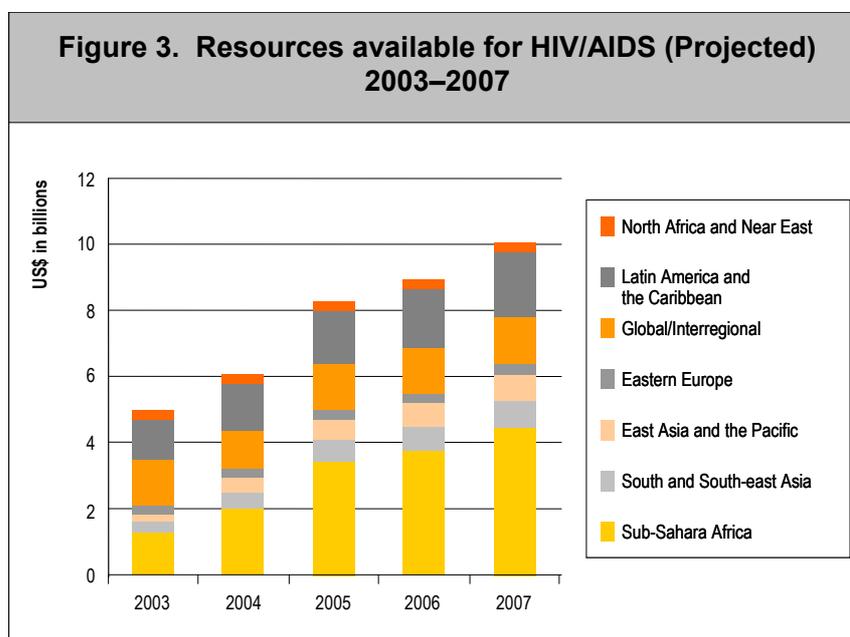
- Domestic spending (both from the public sector and those from individuals and families affected by HIV),
- Bilateral donors, including special initiatives such as PEPFAR,
- Multilateral agencies, including UN systems, the World Bank, and GFATM, and
- Private sector, including foundations, international NGOs, and the business community.

Figure 2 sets forth estimated amounts from each of these sources from 2003 to 2007, with more detailed analyses for each of these sources in the following section.



Source: UNAIDS

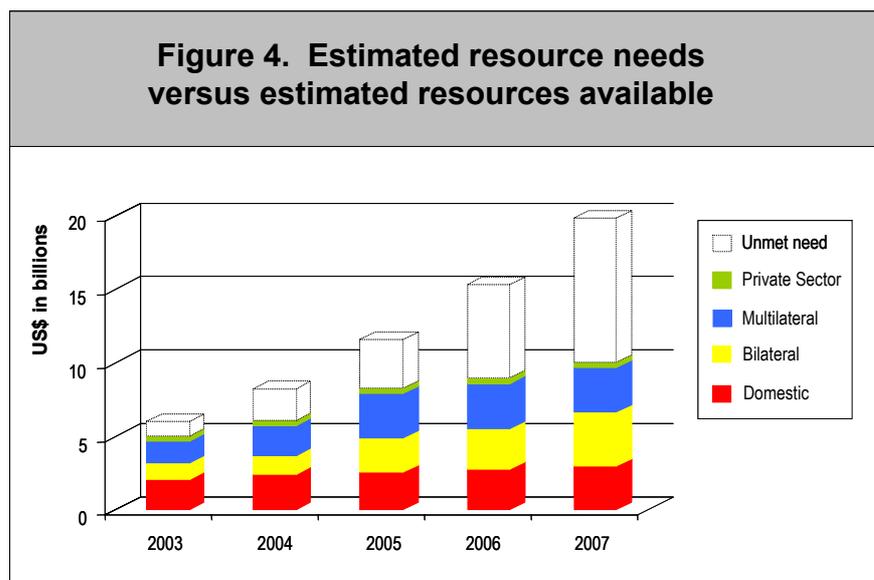
As presented in Figure 3, the most important increase will occur in the sub-Saharan African region, where the availability of resources is estimated to increase more than two-fold. Overall, UNAIDS estimates a 100% increase in total resource availability estimated for from 2003 to 2007.



Source: UNAIDS

While the largest proportion to total funds would be allocated to Sub-Saharan Africa, almost 57% of the domestic resources would be concentrated in the Latin America and Caribbean (LAC) region. To some extent this discrepancy can be attributed to the fact that a higher proportion of the countries in that region are middle-income countries than is the case for Sub-Saharan Africa or Asia. Also that far more information exists on HIV-related spending in the LAC region, stemming from the extensive work on National AIDS Accounts (NAA) conducted by SIDALAC (*Iniciativa Regional sobre SIDA para America Latina y el Caribe*).

Figure 4 shows the unmet need and the expected gap from 2003 to 2007. By 2007 49% of the expected need will have to be mobilized by the international community, assuming that the majority of these funds will need to come from external sources as most of the regions and countries with the largest need won't be able to commit these additional resources themselves.



Source: UNAIDS

Among funding sources, the largest increase would come from bilateral sources, mostly driven by the PEPFAR initiative which would provide 75% of the total bilateral funds estimated for 2007. The share of domestic resources would decrease as bilateral funding grows, but the absolute amount would be 46% more in 2007 than 2003. The second most significant source of new funds is anticipated to be the GFATM.

B. Funding streams

The four funding streams described in the previous section are essential to generating the resources needed to mount a comprehensive response to the epidemic in low- and middle-income countries. This section summarizes recent data on each of these funding streams. This section also presents the latest information on expenditures devoted to the research and development of HIV vaccines and microbicides.

The international community is expected to produce two-thirds of global funding for AIDS in 2005 and in subsequent years. Most of this money will finance programmes to meet the needs of the poorest and worst-affected countries of Asia and sub-Saharan Africa, which will rely on external donors to meet up to 80% of their needs. Elsewhere, domestic sources, including national governments, civil society, the business sector, and affected households, will account for the major share of AIDS resources.

1. Domestic spending

A number of countries have recently increased their own AIDS spending, in some cases dramatically. On the basis of data collected in selected low- and middle-income countries over the past three years, total domestic government spending on AIDS programmes in 2003 was about US\$ 2.1 billion).

Countries currently use one of two approaches to track AIDS resources at the national level: 1) National AIDS Accounts – which analyze AIDS financing and expenditures from both the public and private sector, and 2) AIDS Budget Analysis, which studies annual state budgets, health sector expenditure review, and financial reports of national governments.

Information derived from both approaches seeks to ensure long term financial sustainability with a view to improving the allocation of resources within countries, enhancing equity and the utilization of services, and increasing the international response for funding AIDS programmes. Sound expenditure estimates country efforts to design and implement strategic plans to confront the AIDS epidemic.

Total spending on health services

Previous analyses consistently demonstrated that governments in low-income countries spent health resources on hospital services usually available only to the upper-income groups. Inequities have long typified health spending in many resource-limited countries. Low-income-country governments finance only a quarter (26%) of total health spending in their countries, with the remainder paid for out of pocket².

For example, the proportion of national budgets dedicated to the health sector in Namibia, Kenya and South Africa remains below the Abuja Declaration commitment of 15%. Generally, AIDS-specific allocations are increasing in these countries, with South Africa being the leading example³.

African countries spend on average 4.8% of gross domestic product (GDP) on health, slightly higher than in South-Asia (4.4%) but below levels in Latin America and the Caribbean (7%). In contrast, health spending in countries of the Organization for Economic Cooperation and Development (OECD) represents approximately 9.7% of GDP. Wealthier countries also spend more per capita on health. Though many factors determine the health of a population, higher spending is generally correlated with better health outcomes.^{4,5}

Spending on AIDS Services

Latin America and Caribbean

The poorest countries in the LAC region – Honduras, Nicaragua, Guyana and Belize – dedicate more than 2% of overall health spending for AIDS. Nicaragua and Honduras invest 6% of health spending on AIDS programmes. Bolivia, another low-income country where HIV incidence is relatively low, spends 0.57% of the total health expenditures on AIDS.

The share of the AIDS expenditure in relation to total expenditure on health is increasing in Guyana and Belize, primarily because they are now actively implementing their National Strategic Plans, which include access to ARV.

² World Development Indicators 2004, p. 90

³ *Funding the Fight against HIV/AIDS in Southern Africa – a comparative budgetary analysis in Kenya, Namibia, Mozambique and South Africa - Guthrie, T., Kioko, U., Njeru, E., Sumbana, H., Lauriciano, G., Phororo, H., Endjala, R., Hickey, A., Ndlovu, N*

⁴ Poullier et al. 2002. "Patterns of Global Health Expenditures: Results for 191 Countries. WHO/EIP/HFS/FAR Discussion Paper No. 51.

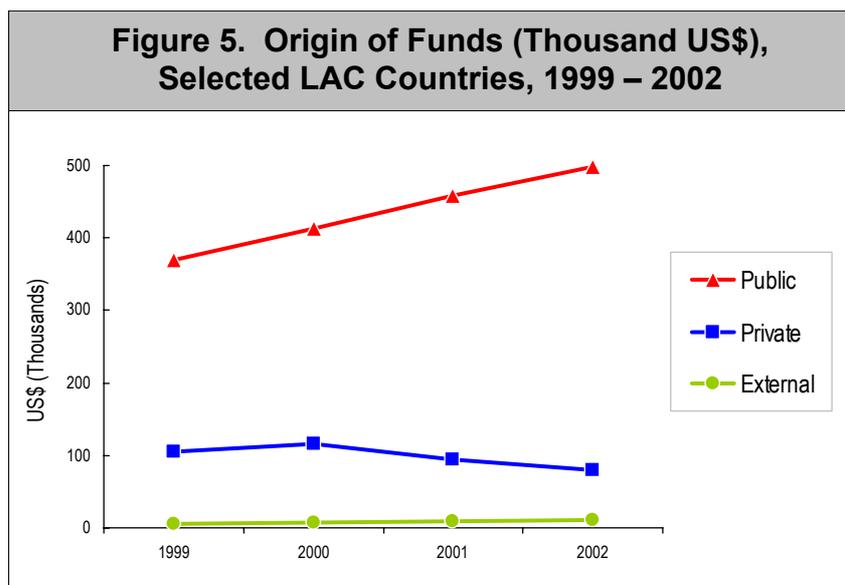
⁵ WHO. 2002. *The World Health Report 2002: Statistical Annex.*

National AIDS Accounts have been implemented in 18 Latin American countries. Table 3 shows expenditure for at least four years (1999-2002) in 13 of these countries.

Table 3. Total HIV/AIDS Expenditures in LAC countries (US\$ millions).				
Year	1999	2000	2001	2002
<u>Argentina</u> ⁴	178,627	182,750	153,155	169,813
Belize	715	768	1,085	1,119
Bolivia	2,548	3,146	3,741	3,802
Brazil	677,352	625,220	n/d	n/d
Chile	28,521	27,576	17,071	20,868
Colombia	49,928	45,462	44,342	43,507
Costa Rica	10,591	11,627	10,771	10,089
El Salvador	9,353	9,948	18,206	22,904
Guyana	505	853	1,517	1,977
Guatemala	10,189	14,137	n/d	n/d
Honduras	n/d	24,828	26,231	n/d
Mexico	143,375	179,675	212,663	226,050
Nicaragua	n/d	6,032	7,375	8,045
Panama	4,792	9,245	13,940	14,143
Paraguay	4,064	5,650	3,555	2,700
Peru	38,390	43,110	n/d	n/d
Uruguay	20,358	19,565	16,413	12,025
Venezuela	25,499	40,820	64,895	59,641

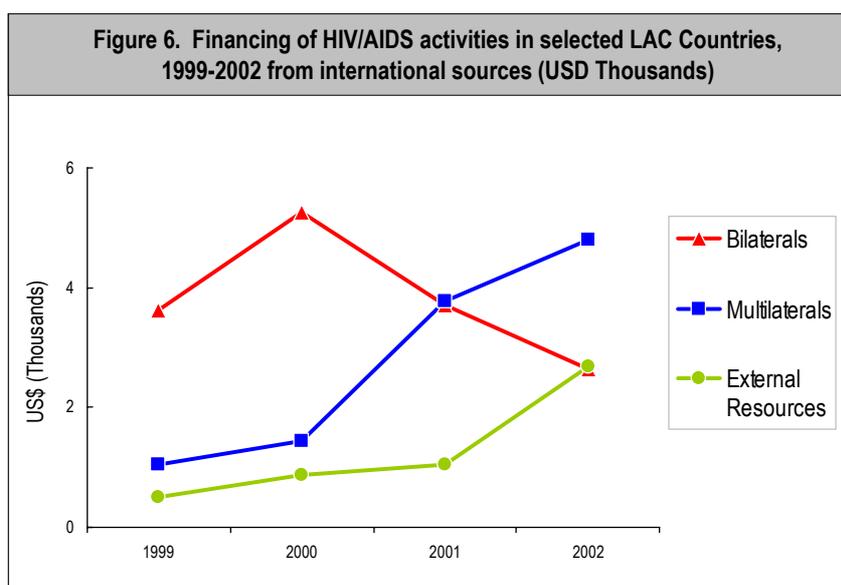
Source: National HIV/AIDS Accounts, FUNSALUD/SIDALAC 1999-2002.

In 2002, the expenditure in these 13 LAC countries (Argentina, Belize, Bolivia, Chile, Colombia, Costa Rica, El Salvador, Guyana, Mexico, Panama, Paraguay, Uruguay and Venezuela) increased by 22.9% over amounts spent in 1999. Public sectors accounted for the vast majority (84.6%) of AIDS expenditures in 2002 in the 13 countries, followed by the private sector (13.6%, almost exclusively in the form out-of-pocket spending) and external sources (1.7 %). (Figure 5).



Source: SIDALAC HIV/AIDS National Accounts 1999 to 2002

Bilateral spending in the LAC region decreased between 1999 and 2002 period, while multilateral and international private sources increased their expenditures (Figure 6).



Source: SIDALAC HIV/AIDS National Accounts 1999 to 2002

In the LAC region, AIDS spending focused on services delivered by a relatively narrow group of service providers (Table 4). In 2002, providers of personal health care services spent 94.1% of the total funds. Meanwhile, only 5.6% was disbursed by public health service providers, (STD/AIDS programmes spent 2.6% and the remaining promotion and prevention organizations, 3 %).

Table 4. Financial resources executed by service providers in selected LAC countries, 1999 – 2002. (US\$ thousands).								
User of the funds	1999		2000		2001		2002	
	US\$ (Thousands)	%						
Hospital	243,653	50.90	276,460	51.50	292,478	52.20	318,588	54.10
Ambulatory Center	71,791	15.00	83,867	15.60	84,052	15.00	91,274	15.50
Diagnosis Center	38,799	8.10	34,985	6.50	45,692	8.10	48,795	8.30
Pharmacies	75,187	15.70	92,101	17.20	88,605	15.80	85,710	14.60
Other Personal Health items	4,108	0.90	5,049	0.90	10,988	2.00	9,442	1.60
STD/HIV/AIDS	15,397	3.20	16,071	3.00	18,829	3.40	15,053	2.60
Promotion and Prevention Organisms	19,489	4.10	18,184	3.40	18,019	3.20	17,787	3.00
Insurance	10,453	2.20	10,211	1.90	2,114	0.40	2,082	0.40
TOTAL	478,877	100.00	536,929	100.00	560,778	100.00	588,730	100.00

Source: SIDALAC HIV/AIDS National Accounts 1999 to 2002

[The STD/HIV/AIDS National Programs executed between 3.2 % and 2.6% of the total expenditures in 1999-2002.]

Of total AIDS expenditures in 2002 in the 13 LAC countries, 75.2% is for providing personal services (i.e. care); 18.2% for public health and prevention (epidemiological surveillance, Information, Education and Communications (IEC) programmes, social marketing, and other direct prevention functions)⁶, 4.5% for administrative expenses, 0.2 % for infrastructure and equipment, and 1.8 % for non-health actions (Table 5).

Table 5. Total expenditures by function, US\$ thousands and percentage. Selected LAC countries.								
Functions	1999		2000		2001		2002	
	US\$ (Thousands)	%						
Personal Health	322,070	67.30%	368,279	68.60%	404,948	72.10%	442,794	75.20%
Public Health	127,520	26.60%	136,150	25.30%	119,335	21.30%	107,335	18.20%
Administration	23,459	4.90%	25,519	4.80%	27,059	4.80%	26,678	4.50%
Investment	1,842	0.40%	1,880	0.30%	1,990	0.40%	1,261	0.20%
Items of Memorandum (Health Related or Non health expenditure)	3,944	0.80%	5,255	1.00%	8,022	1.40%	10,570	1.80%
TOTAL EXPENDITURE	478,836	100%	537,083	100%	561,352	100%	588,639	100%

Source: SIDALAC HIV/AIDS National Accounts 1999 – 2002.

Research and development accounted for the most significant ‘non-health’ expenditure, representing US\$ 4 million, or 38 % of non-health spending (a significant increase over research and development (R&D) spending of US\$ 267,000 in 1999). Other non-health items include monetary benefits to PLWHA, US\$ 2.8 million (27%).

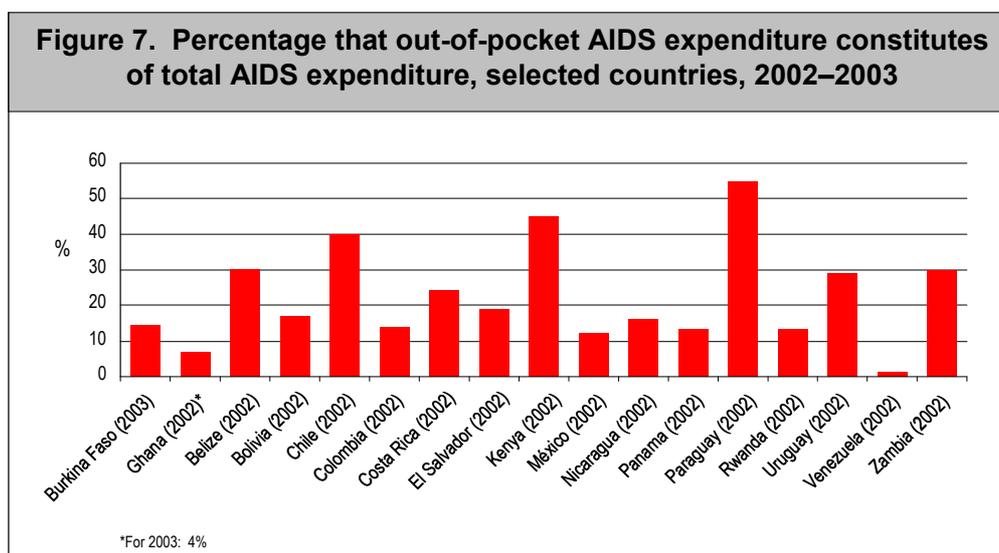
⁶ The diagnosis and treatment of sexually transmitted infections, particularly in sex workers, men who have sex with men, and even within the general population, are considered as prevention expenditures. The diagnosis and treatment of STIs are classified as personal health care services (according to the National Health Accounts), however, because of the positive externalities of treating STIs in reducing the probability of acquiring/transmitting HIV, a significant benefit for the broader society, for AIDS policy purposes they are classified as prevention activities.

In 2002, social security was the main mechanism for public sector spending on AIDS, accounting for US\$ 268.8 million, or 53.9% of public sector spending.⁷ Domestic governments are the second most important source for public spending, accounting for US\$ 196 million in costs, or 39.4% of the total public. Sub-national governments provide 6.7% of AIDS spending in the LAC region.

Between 1999 and 2002, AIDS spending by governments in the LAC region increased by 75%. Meanwhile, social security expenditures increased through 2001, then remained level in 2002. This flattening in social security spending may stem from recent reductions in the prices of ART drugs.

Only a handful of countries, mostly in Latin America, have systematically collected information on out-of-pocket expenditures (OOPE)⁸ on AIDS. Although this information offers only a glimpse of direct household costs associated with AIDS, it is apparent that People Living with HIV/AIDS (PLWHA) and their households are spending substantial sums for HIV-related care, even in some of the world's most economically vulnerable countries. This information comes from available data and special studies, such as limited household surveys.

In the LAC region, OOPE for AIDS amounted to US\$ 73.9 million in 2002 (Figure 7), in comparison to US\$ 89.6 million in OOPE in the 13 LAC countries where information was available⁹. Households' OOPE mainly supported public health functions (74% of total OOPE), such as the purchase of condoms, which accounted for roughly 90% of overall spending in the region on HIV-related public health services and for 91% of OOPE. Personal health services accounted for US\$ 18.9 million in OOPE in 2002, with ART purchases consuming more than half of out-of-pocket health care spending.



Source: SIDALAC & Abt Associates/PHRplus

⁷ Argentina, Belize, Bolivia, Chile, Colombia, Costa Rica, El Salvador, Guyana, Mexico, Panama, Paraguay, Uruguay and Venezuela.

⁸ Out-of-Pocket expenditures 'consist of expenditures paid for medical services, product and supplies net of any payment or reimbursement from health insurance plans, government or any other third-party payers.' US Department of Labor/Bureau of Labor Statistics. Consumer Expenditure Survey Anthology, 2003, p. 67-68

⁹ An estimate of these 13 countries in addition to Brazil, Honduras, Peru, Dominican Republic and Guatemala showed an expenditure of US\$ 232 million or 19% of the total expenditures of the 18 countries for 2000.

Sub-Saharan Africa

In Africa, AIDS is the single most important cause of morbidity and mortality. It accounts for nearly 19% of total years of life lost due to disability or premature mortality. So, it is not surprising that HIV-related spending absorbs a substantial share of total expenditures on health.

Five countries in sub-Saharan Africa — Rwanda, Kenya, and Zambia, Burkina Faso and Ghana — have collected information on out-of-pocket health spending on AIDS. In these resource-limited countries with generalized epidemics, payments by households represent a substantial share of total health expenditures on AIDS, ranging from 45% in Kenya (2002), to 13% in Rwanda (2002), Zambia 30% (2002), 9.4%, 7.2% in Ghana (2002, 2003 respectively), 14.3% in Burkina Faso (2003). These figures vividly illustrate the epidemic's alarming burden on HIV-affected households. In Kenya, the average HIV-positive individual spends nine times more in out-of-pocket health costs than the typical Kenyan spends on any kind of health service.

Although AIDS represents a substantial share of health spending in Africa, spending patterns for AIDS can often differ significantly from general health spending. For example, although the Government of Rwanda finances 21% of general health spending, only about 5% of public health funds are spent on AIDS. Conversely, donors that work in Rwanda allocate a third of their assistance to AIDS-related activities. While general health spending in Rwanda is US\$ 8 per capita (US\$ 51 PPP), AIDS expenditures represent US\$ 48 (US\$ 360 PPP) per person living with AIDS.

In Burkina Faso¹⁰, one of the world's poorest countries, the response to AIDS is highly dependent on external donors, which contribute 78% of total AIDS expenditures. Credits provided by the World Bank represent the large majority (77%) of publicly spent resources, or 25.6% of the total spending. In this economically vulnerable country, households contribute 14.3% of the total expenditure on AIDS, almost double the amount spent by the government, and 98.3% of private expenditure.

The relatively small share of spending which supports the delivery of personal health services in Burkina Faso (26%) stems from the low coverage (1,200 nationwide) for ART; a grant approved by the GFATM envisions covering 3,500 PLWHA with ART in coming years. Public health activities represent the largest share (34%) of AIDS expenditures, with virtually all such spending (98%) focusing on information/education/communication programmes. The vast majority (81%) of prevention spending is used to support purchasing condoms.

In Ghana, total AIDS expenditures in 2003 (estimated at US\$ 27.6 million or US\$ 11.90 PPP) represents a doubling of spending over 2002 when measured in the national currency. Spending levels in 2003 are comparable to average annual costs of implementing the country's National Strategic Framework for AIDS over five years, although the allocation of 2003 resources is markedly different from those set forth in the NSF.

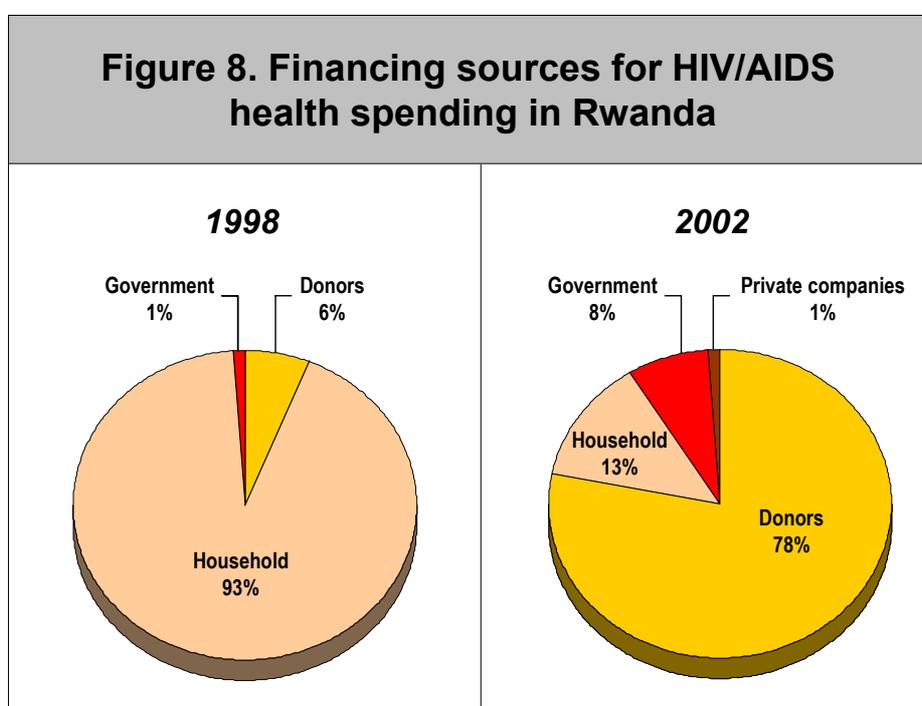
¹⁰ 2003

Excluding a World Bank loan, public sector spending on AIDS in Ghana remains extremely low. In 2002, external sources accounted for about three quarters of total AIDS expenditures (excluding the World Bank loan, which by 2003 represented 30% of all AIDS spending in Ghana). The first year of implementation of the GFATM-funded project was not associated with a decrease in financial commitments from other sources, suggesting that GFATM support is additional to resources already available from other sources.

In 2003, overall, AIDS spending represented approximately 30% of total health expenditures in Ghana. Households finance 38% of these expenditures through out-of-pocket spending – nearly four times the amount provided by the national government¹¹.

An update to the Rwanda 1998 NAA (Figure 8) study shows the significant changes in the relative contributions of different financing sources to AIDS health spending between 1998 and 2002. In particular, donor contributions have risen sharply, from approximately 6% in 1998 to 78% in 2002. It should be noted that the first NHA exercise was conducted at the height of the donor reconstruction effort following the war in 1994. Since that time, donor funding for health care in general has decreased sharply, by approximately 50%. Despite this drop in overall donor financing for health, the findings show a steep increase in donor funding for AIDS activities.

Increased donor financing has helped to remove part of the burden from HIV-affected households in Rwanda. However, household spending for AIDS remains much higher than government contribution; this is consistent with the low overall financing for health services as a share of total government spending (4% of the executed government budget)¹².



Source: ABT Associates/PHRplus

¹¹ National Spending for HIV/AIDS, 2004, UNAIDS pre-publication

¹² National Spending for HIV/AIDS, 2004, UNAIDS pre-publication

A comparison of three countries in Southern Africa using HIV/AIDS budget analysis illustrates the many approaches to AIDS financing and the diversity of national epidemics.

Namibia. In Namibia's Development Budget, AIDS specific spending – primarily stemming from donor contributions – increased by 467% from 10,781,000 Namibian Dollars in 2002/03 to N\$61,097,000 in 2003/4, although inflation during the period increased at an annual rate of 97%. These figures underestimate actual AIDS spending.

*Mozambique*¹³. In Mozambique, AIDS allocations increased from US\$ 7.85 million in 2001 to US\$ 10.62 million in 2002 (Moz, MoH-DPC, 2003), a nominal increase of 35%. Between 2001 and 2002, AIDS-related activities absorbed US\$ 7.85 million in government expenditures and US\$ 10.62 million in donor financing. These figures only include spending by the Ministry of Health and do not include contributions by NGOs or the private sector.

With respect to the overall health budget as a percentage of the total budget (between 2000/01 and 2005/06), the share devoted to health services has increased significantly, from 9.9% in 2000/01 to 15.4% in 2003/04. The AIDS share of the total budget, however, declined from 0.5% in 2000/01 to 0.4% in 2005/06. Treatment services account for approximately 60% of AIDS spending in Mozambique, while prevention services constitute roughly 40%.¹⁴ To date, there is limited information available on the financial breakdown between various programmes or sub-components of government's AIDS response.

AIDS expenditures in Mozambique are extremely low, representing 0.2% of GDP in 2000/01 and a projected 0.1% in 2005/06. These figures underscore the need for additional government and donor allocations to ensure treatment for those who are infected and to prevent the epidemic from spreading.

South Africa. In November 2003, the Government of South Africa, the country believed to have the largest number of people living with AIDS, announced a plan to provide ART free of charge through the public sector. The 2004/5 national budget allocates R 373 million (US\$ 57.4 million) for the first-year roll-out of the national ART programme.

The total allocation of R 1.439 billion (US\$ 68 million) for programmes and services in 2004/5 allocated in the national budget is nearly seven times the amount allocated in AIDS in 2000/1 but less than 0.37 % of consolidated national and provincial spending. Health expenditures remain at a steady 11% of consolidated national and provincial spending, with 2.8% of the consolidated health budget set aside for AIDS (a percentage that is set to rise to 4.0% in 2006/7¹⁵).

¹³ Sumbana, H. and Lauriciano, G. (2004). "Funding the Fight against HIV/AIDS". Mozambique Country Report. In Guthrie, T., Hickey, A. 2004. **Budgeting for HIV/AIDS in Developing Countries ~ State Commitments In Africa And Latin America.** Idasa, Cape Town.

¹⁴ Rough estimates from interviews with NAC.

¹⁵ 2004/5 'South African national budget, with a focus on new allocations for ARV treatment programmes', Idasa 31 May 2004.

The comparison of these three countries in Southern Africa indicates that some heavily affected countries are spending a relatively small proportion of their national budgets on AIDS, even though the epidemic represents the region's single greatest development challenge. However, there is evidence that some governments are increasing their AIDS allocations.

To date, one NAA has been conducted in Asia Pacific – in Thailand. Preliminary estimates show that in 2003, Thailand spent approximately THB 2,894 million¹⁶ (US\$ 70 million) on AIDS activities, equivalent to US\$ 116 per PLWHA per annum. The NAA revealed that treating opportunistic infections (51%) and providing ART (28%) were the two major components of national AIDS spending.¹⁷

2. Bilateral funding for AIDS

In May 2004, the Secretariat of the Development Assistance Committee (DAC) of the OECD reviewed statistical data on AIDS assistance in collaboration with members of the DAC Working Party on Statistics and UNAIDS, issuing a new report, '*Aid Activities in Support of HIV/AIDS Control, 2000-2002*'. This report presents the first comprehensive overview of aid allocations to AIDS activities by donor and recipient countries.

One of the key objectives of this undertaking was to assess the extent to which the standard statistical methodology allowed the bulk of these resource flows to be identified and to estimate, in particular, the order of magnitude of AIDS activities integrated into basic or reproductive health care programmes. The main findings and conclusions of the study indicate that total bilateral commitments of DAC members for AIDS activities increased by 64% between 2000 and 2002.

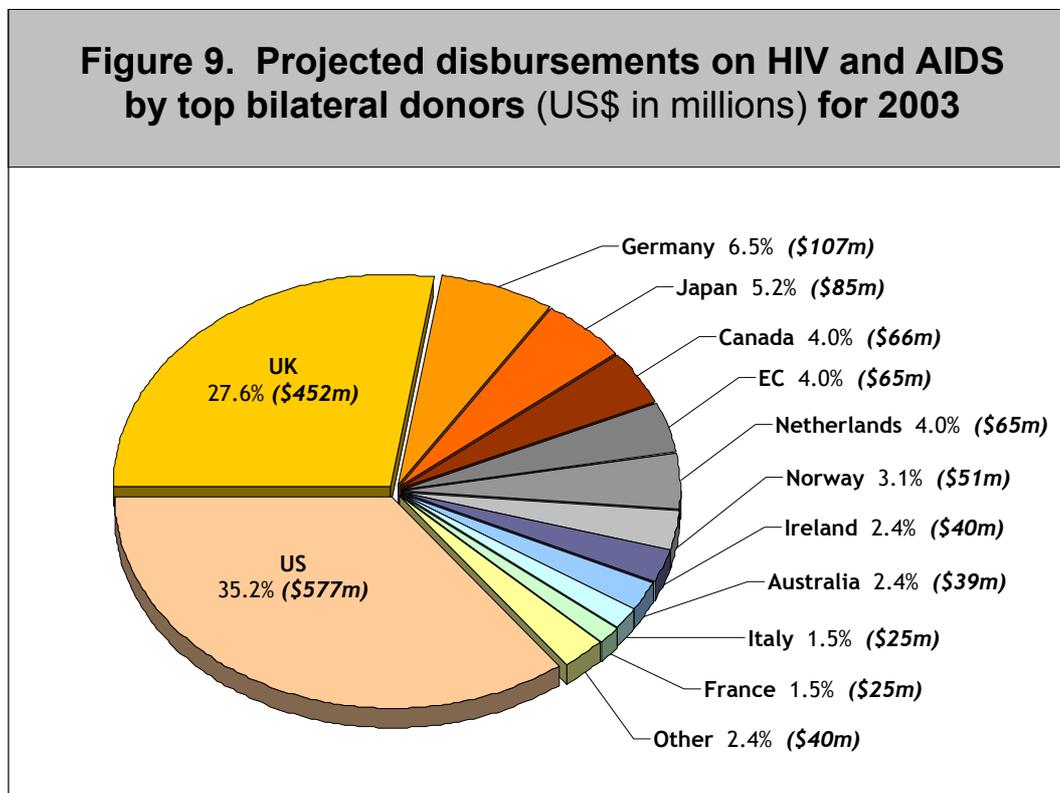
In 2000-02 DAC members' total official development assistance (ODA) commitments for AIDS control were US\$ 2.2 billion per year. Bilateral aid to AIDS control amounted to US\$ 1.1 billion per year and allocations to the GFATM to US\$ 500 million per year. The remainder of AIDS financing flows through core funding to United Nations organizations and from the World Bank.

During this three-year period, there was a clear trend towards increasing levels of AIDS assistance, with the United States accounting for more than one-third of total bilateral commitments, followed by the United Kingdom. Larger donors are likely to be the primary funders of treatment programmes, which require substantial funding and long-term commitments. Smaller donors tend to concentrate on HIV prevention, but also support home-based care and social mitigation activities. Sub-Saharan Africa was the primary recipient region, with Nigeria, Kenya and Uganda accounting for the largest amount of support from external donors. This study will influence on how DAC members will report their AIDS ODA in the future.

¹⁶ Preliminary figures only account for AIDS expenditure within the health sector

¹⁷ Preliminary estimates taken from National Spending for HIV/AIDS 2004', UNAIDS Pre-Publication

UNAIDS projects that in 2004 global expenditure on AIDS will amount to US\$ 6.1 billion, of which bilateral spending will be an estimated US\$ 1.3 billion. The top bilateral donors for 2004 will be the United States, the United Kingdom, the European Community, and Canada (see Figure 9).



Source: UNAIDS, 2003

United States President's Emergency Plan for AIDS Relief

In January 2003, the United States government announced a new 'President's Emergency Plan for AIDS Relief' (PEPFAR), asking the United States Congress to commit US\$ 15 billion over 5 years to international AIDS, tuberculosis, and malaria efforts. PEPFAR aims to provide treatment to 2 million people with AIDS, prevent 7 million new HIV infections, and provide care to 10 million people infected and affected by HIV and AIDS, including orphans and vulnerable children. Plans envision that PEPFAR will support international efforts on AIDS through existing through bilateral and multilateral channels. Of the US\$ 15 billion planned for PEPFAR:

- Almost US\$ 9 billion would represent new funding, focused primarily in 15 priority countries;
- US\$ 5 billion would support ongoing funding for existing bilateral efforts; and
- Up to US\$ 1 billion to support contributions to the GFATM.

This initiative initially selected 14 priority countries (that collectively account for 50% of the world's PLWHA), and the United States government recently announced that Viet Nam would also become eligible for PEPFAR assistance.¹⁸ Funding for PEPFAR began in fiscal year (FY) 2004 and will extend through FY 2008. FY 2004 funding is expected to total US\$ 2.4 billion for AIDS, Tuberculosis, and malaria prevention, care, treatment and research efforts; of this, US\$ 2.3 billion will be for AIDS.¹⁹

In February 2004, the United States government released US\$ 350 million for PEPFAR activities to scale up programmes that provide ART treatment; abstinence-based prevention programmes, including those targeted at youth; safe medical practices initiatives; and programmes to provide care for orphans and vulnerable children.²⁰ For FY 2005, currently under consideration by the United States Congress, President Bush requested US\$ 2.7 billion for global AIDS activities (\$2.3 billion excluding international research). Proposed amounts include a contribution of US\$ 200 million for the GFATM.²¹

¹⁸ 12 in Africa (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia) and 2 in the Caribbean (Guyana, Haiti).

¹⁹ Kates, J., Summers, T, U.S. Government Funding for Global HIV/AIDS, Through FY 2005, Kaiser Family Foundation, June 2004.

United States Department of State, The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy, February 2004.

United States Department of State, Fact Sheet: The President's Fiscal Year 2005 Budget for the Emergency Plan for AIDS Relief, February 2004.

United States Department of State, Fact Sheet: The President's Emergency Plan for AIDS Relief: Five-Year Strategy, February 2004.

United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (PL 108-25).

United States Office of Management and Budget, Analytical Perspectives, Budget of the United States Government (Fiscal Year 2005).

White House, Fact Sheet: The President's Emergency Plan for AIDS Relief, January 2004.

²⁰ <http://usinfo.state.gov/gi/Archive/2004/Apri/12-11076>

²¹ Global Fund to Fight AIDS, Tuberculosis, and Malaria, Pledges and Contributions in 2003.

Kates, J., Summers, T, U.S. Government Funding for Global HIV/AIDS, Through FY 2005, Kaiser Family Foundation, June 2004.

Summers, T, Kates, J., *Global Funding for HIV/AIDS in Resource Poor Settings*, Kaiser Family Foundation, December 2003.

The concept of 'fair share'

As funders, providers and advocates work to enhance the global AIDS response and mobilize sufficient resources, many have sought to determine the 'fair share' for various donors. To determine appropriate national shares, several different approaches are possible. UNAIDS and the WHO's Commission on Macroeconomics and Health have identified potential sources of funding to meet their estimates of total need and have also proposed goals for various funding sectors, such as donor governments, multilateral institutions, and affected governments.

In other cases, the 'fair share' calculations are done within one of these sectors, typically to compare support provided by donor governments through various bilateral and multilateral channels.

Assessing the 'fair share' of donor contributions to respond to AIDS, however, is quite complex. No single, agreed formula exists for making such assessments, and several questions must be answered in order to proceed, including:

- What is the 'total' against which individual contributions are assessed? Is it estimated total need to combat AIDS? Estimates of total funding by donor governments? Should that total include just AIDS costs or be broadened to include critical infrastructure and capacity deficits?
- Who should be included in a fair share calculation? G7 governments only? All OECD members? Private sector contributors? Affected country governments? Donations by individuals?
- How should differences in relative wealth be taken into account?
- Should other factors, such as AIDS burden, poverty, and debt service, be incorporated into fair share assessments in some fashion?

Related to these questions is the choice of methodology for assessing national contributions and each country's fair share. Various assessment methodologies are available, including:

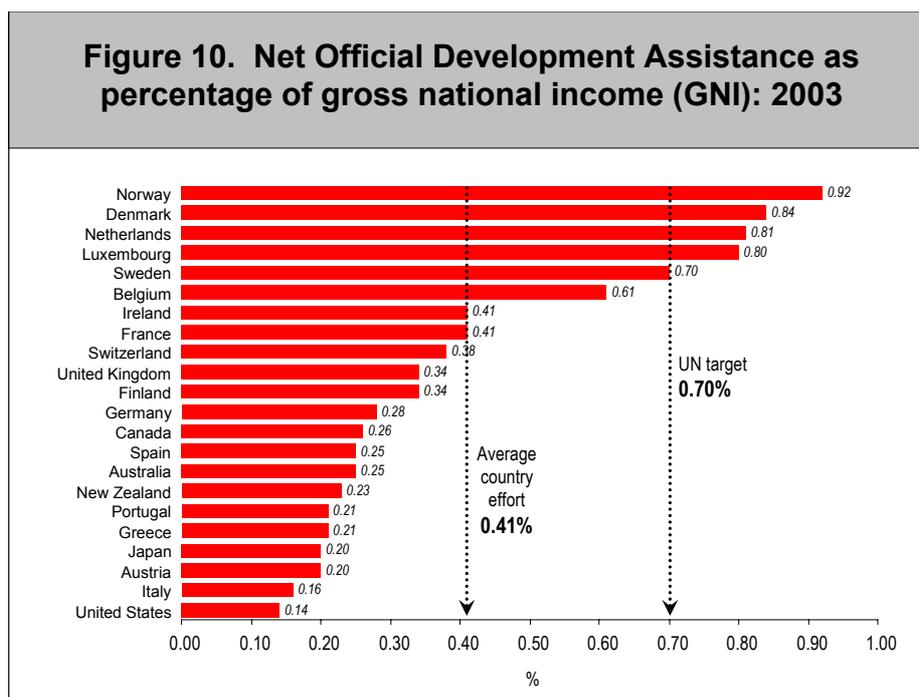
- total dollar amount of commitment
- total dollar amount of commitment compared with gross domestic product (GDP) or gross national income (GNI), two standard measures of relative wealth
- share of total compared to the cost-sharing distribution negotiated for United Nations Member State support of particular UN functions
- share of total compared to the cost-sharing distribution negotiated for WHO Member State support to the WHO budget.

Each of these methods yields different results. For example, while the United States government made the highest dollar commitment to global AIDS in 2003, it ranked 6th when its commitment is adjusted based upon its GDP (standardized per million GDP). Yet this calculation does not take into consideration other factors that some consider important, such as how much funding the United States government provides to the World Bank, WHO, UNAIDS, the United Nations Children's Fund (UNICEF), and similar organizations that ultimately make major financial and technical contributions to AIDS programmes in low- and middle-income countries.

This analysis also does not factor in United States tax subsidies provided to support charitable giving for AIDS by individuals, foundation, and corporations. Similarly,

many European nations provide substantial support to countries affected by AIDS through mechanisms that allow decisions about allocations to be made by the affected countries rather than by the donors (such as sector-wide approaches or ‘basket’ financing).

Comparing ‘fair share’ can be useful in approximating the relative generosity of various funders to the overall effort on AIDS, but it should be understood that the calculations are extremely rough and take into account only some of the ways in which donors provide support.^{22 23} (Figure 10)



Source: Organisation for Economic Co-operation and Development, 2004 (OECD), 2004

3. Key Multilateral Initiatives

UN Systems

During 2000 and 2001, 29 UN system organizations participated in the development of the UN System Strategic Plan on HIV/AIDS (UNSSP), covering the years 2001–2005. Developed within the overall context of the Global Strategy on HIV/AIDS, the UNSSP seeks to clarify roles and responsibilities on AIDS in the UN system, promote system-wide coherence and strategic effectiveness, and improve coordination and communication among diverse UN system organizations. The UNSSP articulates system-wide objectives in nine areas of work and identifies the responsibilities of individual UN entities in achieving these objectives.

Over the period of 2001-2003, the level of financial resources devoted to AIDS work by the UN system increased significantly. For example, UNICEF increased

²² Summers, T, Kates, J Global Funding for HIV/AIDS in Resource Poor Settings, Kaiser Family Foundation, December 2003

expenditure on AIDS from US\$ 67 million in 2001 to US\$ 95 million in 2002 and to US\$ 111 million in 2003. The World Food Programme (WFP) expenditure in 2000 for AIDS amounted to US\$ 1 million, while in 2002 the programme reported actual expenditure of US\$ 195 million. Total AIDS expenditure by the Food and Agriculture Organization (FAO) over the periods 1996-2000 to 2001-2005 increased more than tenfold.

World Bank

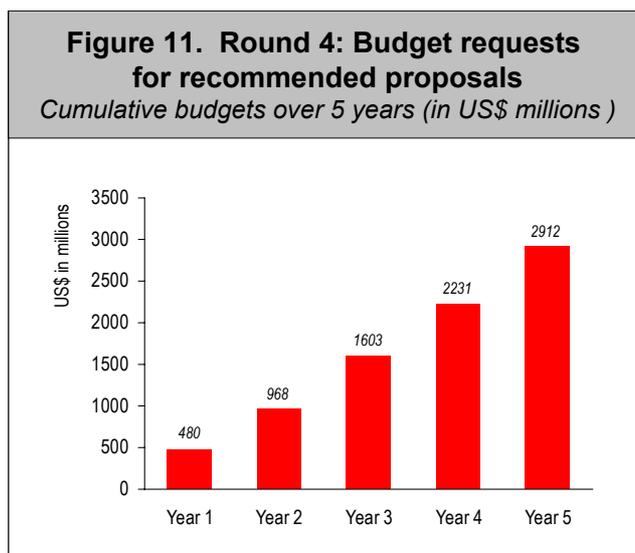
Among UN system funding sources, the World Bank represents the largest source of AIDS funding for low-income countries. World Bank loans for AIDS can be considerable, as in the cases of Brazil and India. They are considered to be domestic resources, since countries must repay them. Through its Multi-Country AIDS Programme (MAP), the World Bank has approved US\$ 1 billion in grants or interest-free loans to support AIDS programmes in sub-Saharan Africa. As of May 3, 2004, the Bank has committed US\$ 985.9 million to MAP programmes in Africa, and the implementing national AIDS commissions had disbursed US\$ 224.2 million of that. The Programme has committed a further US\$ 16.6 million to sub-regional and cross-border projects.

Global Fund to Fight AIDS, Tuberculosis, and Malaria

In January 2002, the GFATM was established to act as a financing mechanism to efficiently commit and disburse funds to approved programmes.

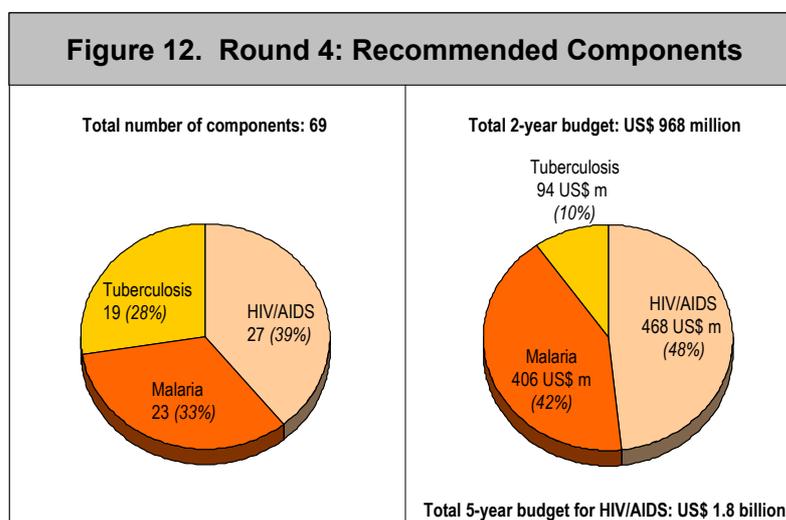
In June 2004, cumulative disbursements for the three previous rounds of grant awards had reached US\$ 400 million, equaling 89% of the target of US\$ 450 million disbursed. The most recent Round 4 is the largest yet, at \$968 million, 67% of the forecasted pledges and contributions (US\$ 1.5 billion) for 2004. This round primarily focuses on rolling out treatment programmes.

In Round 4 the Global Fund received and screened 134 proposals (containing 217 service components) from 82 countries. Of the submitted proposals, 173 service components were reviewed by the Technical Review Panel, and 69 components involving programmes in 50 countries were recommended for funding, with a total value of US\$2.9 billion over the full 5 years and US\$ 968 million over the first two years (Figure 11).



Source: GFATM Eighth Board Meeting: 28-30 June 2004

Based on current pledges, contributions are forecast at US\$ 1.472 billion for 2004. To date, 67%, or US\$ 986 million of this amount, derives from non-United States sources, while the United States has contributed 33%, or \$486 million. However, the forecast amount of US\$ 1.5 billion falls short of maximizing the potential 2004 United States contribution to the Global Fund by \$61 million. (The United States contribution is limited by law to 33% of total contributions.) Maximizing the United States pledge, which would require non-United States pledges of US\$ 1.1 billion, would yield total pledges of US\$ 1.7 billion (Figure 12).



Source: GFATM Eighth Board Meeting: 28-30 June 2004

Impact of Global Fund to date

Data has been collected on progress made on 25 grants in operation for over a year. In all, 25 grants in 15 countries had a total commitment of US\$ 158 million. Of these, nine were for AIDS (US\$ 68 million), eight for tuberculosis (US\$ 57 million), and eight for malaria (US\$ 33 million). The regional breakdown was as follows: nine grants to six countries in sub-Saharan Africa, eight grants to four countries in Asia, seven grants to four countries in Latin America and the Caribbean, and one grant in North Africa.

Overall, the results are encouraging, with more than 80% of agreed targets reached across the 25 programmes. Nearly half (12) are on track or overachieving against targets agreed for the first year. In Honduras, nearly twice as many people as targeted were put on ART treatment, while in Haiti, ART targets were exceeded by 25%.

Other programmes that have reached the one-year mark have exceeded targets for some of their activities but are behind on others. Ghana's AIDS programme, for example, has reached only half of the 1,200 people targeted for treatment in its first year of operation. But the programme has trained two and a half times as many personnel to provide home care services than originally planned and has gone well beyond the number of health centers envisaged to offer prevention of mother-to-child transmission of HIV.

It has also exceeded its targets for the number of people receiving voluntary counseling and testing. Ghana, therefore, is well positioned to drastically scale up the numbers of people receiving ARV treatment over the coming year and may well end up exceeding all its targets.

Five grants are substantially underachieving against agreed targets. Unless they rapidly accelerate their implementation, these grants are unlikely to be approved for Phase 2 funding. These five grants, and others that show weak implementation, are now the subject of special measures being led by the GFATM's newly formed Operational Partnerships and Country Support Team.

The GFATM has introduced a performance-based disbursement system. Based on this system, one year into implementation, the 12 grants overachieving or on track received a median 91% of targeted disbursements. The 8 grants that are somewhat behind received a median 58% of their targeted disbursements, and the 5 grants substantially underachieving received a median 21% of their targets. Overall, the anniversary grants achieved a median 70% of the disbursements expected after one year. At the one year cut off, a total of \$55 million of the expected US\$ 92 million had been disbursed.

For a number of these grants, additional disbursements have been made since then. As of June 18, 2004 the median percentage of expected disbursements received by all anniversary grants increased to 73%. In dollar amounts, this translates into an actual disbursement of US\$ 74 million against an expected US\$ 115 million. As of this date, the 25 anniversary grants represent 19% of the Global Fund's total disbursement of US\$ 400 million.

Future challenges

To fund only renewals from the first three Rounds, the GFATM needs roughly \$1.3 billion in additional financing. Based on the experience with Round 4, it can be assumed that future rounds will produce high-quality proposals with a total two-year value of around US\$ 1 billion. Based on the GFATM's current practice of issuing a call for proposals every 8-9 months, two new rounds may be conducted before the end of 2005, resulting in a total estimated need of US\$ 3.3 billion. In July 2004, the GFATM received pledges for 2005 amounting to US\$ 886 million.

Beginning in 2000, UN Secretary-General Kofi Annan and others called for a Global Fund that would mobilize at least US\$ 10 billion per year. The GFATM envisions what it has referred to as a 'cruising altitude' consisting of US\$ 7-8 billion per year in income and disbursements. Projecting likely or optimal growth of a new institution such as the GFATM is challenging, requiring assumptions regarding future demand, availability of finance and the role of the institution in the broader development finance landscape. In June 2004, the GFATM presented to its Board Members projections that the organization will achieve a steady rate of financing of approximately US\$ 3 billion annually by year 2008 – double the current level of income and disbursement.

4. Private sector including foundations, NGOs, and the business community

Foundations

Foundations are an important source of funding for AIDS activities. Resources contributed to AIDS from foundations have grown steadily, from US\$ 7 million in 1997 to US\$ 260 million in 2002. The Bill & Melinda Gates Foundation largely accounted for the major jump in foundation support for AIDS during this period, reporting AIDS spending of almost US\$ 230 million in 2002. Other foundations reporting large AIDS expenditure in 2002 include the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development (US\$ 14 million), the Packard Foundation (almost US\$ 6 million), the United Nations Foundation (US\$ 5 million) and the Wellcome Trust (US\$ 4 million).

A 2002 survey of top United States grant-providers by Funders Concerned about AIDS affords a snapshot of foundation commitments. The figures include donations to domestic and international programmes, but roughly 63% of the money from the top 10 foundations is spent abroad. Available data suggest the 2002 commitment is significantly less than in 2001, the year that saw the highest-ever commitment from international foundations. But donations are frequently intended to cover several years, making it difficult to compare fluctuations from year to year (Table 6).

Table 6. Focus by U.S. Grantmakers on U.S. and International HIV/AIDS, 2001	
Tier of Grantmakers	Estimated % of grantmaker commitments focused on HIV/AIDS outside of U.S.
Top 10 U.S. HIV/AIDS Grantmakers	63%
Next 15 HIV/AIDS Grantmakers	48%
Next 25 HIV/AIDS Grantmakers	22%

Source: HIV/AIDS Foundation Grantmaking, Funders Concerned About AIDS June 18, 2004

International NGOs

Expenditure for HIV/AIDS by international NGOs, which receive most of their funding from donor countries or foundations, have fluctuated over the years from US\$ 62 million in 2000, to US\$ 48 million in ___ and US\$ 119 million in 2002. Among the NGOs reporting the highest expenditures for AIDS activities in 2002 are Population Services International (almost US\$ 38 million), International HIV/AIDS Alliance (US\$ 12 million), the Population Council (US\$ 11 million), DKT International (almost US\$ 10 million), and John Snow, Incorporated (US\$ 7 million).

Business Community

Despite the challenging economic climate of the last few years, corporations continued to provide significant funding for AIDS, especially in the international arena. In 2001 and 2002, eight United States corporations were major AIDS grantmakers, awarding more than US\$ 600,000 in AIDS-related grants in each year (Table 7).

Table 7. U.S. Corporate Grantmakers with the Largest HIV/AIDS Grantmaking, 2001-2002		
<i>(listed in order of total combined 2001-02 grant making)</i>		
	HIV/AIDS Grant Commitments	
	2001	2002
Bristol-Myers Squibb Foundation (NY)	14,500,000	16,900,000
Merck Company Foundation, The (NJ)	11,400,000	11,400,000
Abbott Laboratories Fund (IL)	6,200,000	6,950,000
M×A×C AIDS Fund (NY)	2,946,505	5,607,152
Levi Strauss Foundation (CA)	2,720,245	2,600,000
Pfizer Foundation, The (NY)	1,550,000	2,500,000
Latria Group, Inc. (NY)	1,800,000	1,800,000
Burroughs Wellcome Fund (NC)	750,000	603,000

Source: HIV/AIDS Foundation Grantmaking, Funders Concerned About AIDS June 18, 2004

More than fifteen additional United States corporations made AIDS grants totaling \$100,000 or more in 2001 and 2002 (see Table 8).

Table 8. U.S. Corporate Grantmakers with Significant HIV/AIDS Grantmaking 2001-2002 <i>(listed in order of total combined 2001-02 grantmaking)</i>		
	HIV/AIDS Grant Commitments	
	2001	2002
Prudential Foundation, The (NJ)	885,000	N/A
Federated Department Stores Foundation (OH)	441,858	183,000
Wells Fargo Foundation (CA)	532,000	N/A
Coca Cola / Coca Cola Africa Foundations (GA)	350,000	135,000
SBC Foundation (TX)	435,000	N/A
American Express Foundation (NY)	183,000	234,300
MetLife Foundation (NY)	200,000	200,000
Citigroup Foundation (NY)	105,000	287,000
Gap Foundation, The (CA)	320,000	5,000
Fannie Mae Foundation (DC)	181,100	110,000
Alcoa Foundation (PA)	196,323	10,000
Vivendi Universal Foundation, Inc. (NY)	185,000	N/A
J.P. Morgan Chase Foundation (NY)	168,500	N/A
Northwestern Mutual Foundation (WI)	150,000	N/A
Avon Foundation (NY)	100,000	N/A

Source: HIV/AIDS Foundation Grantmaking, Funders Concerned About AIDS June 18, 2004

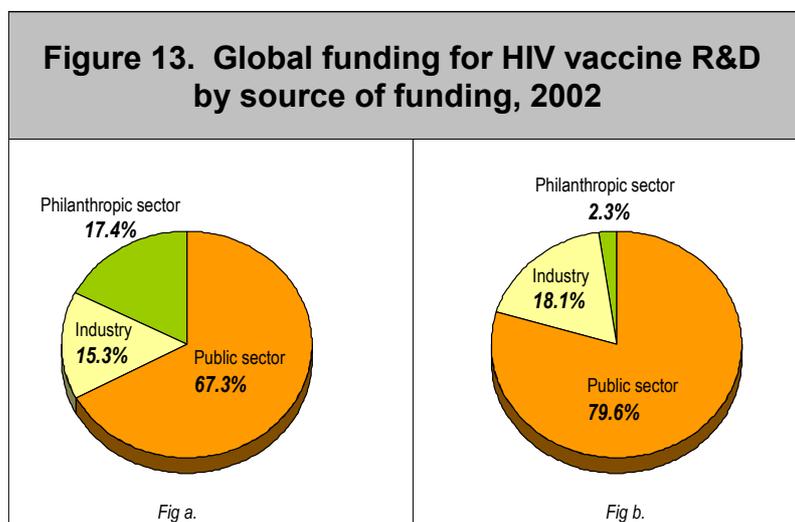
Beyond direct financial grants from either corporate foundations or giving programmes, the corporate sector also contributes to AIDS through various in-kind donations, including communications and marketing, logistics and distribution, human resource and application of information technology.

The corporate sector also contributes to AIDS through essential workplace programmes. Companies, particularly those with large workforces in heavily affected regions, commit resources to fight AIDS in the workplace through comprehensive programmes including non-discriminatory policies, awareness and prevention (including distribution of condoms), and – very importantly – access to care, support and treatment.

5. Resources for vaccine and microbicide research and development

Accelerating the development and widespread use of preventive HIV vaccines throughout the world will require the active engagement of governments, international agencies, the private sector, and community based organizations. Significant progress has been made in HIV vaccine development, but it will likely be several more years before licensed preventive vaccines begin to emerge. Increased and sustained political will and action, however, could significantly shorten the time needed to generate an HIV/AIDS vaccine. Currently, information on global expenditure on preventive HIV vaccine research and development is quite limited.

In 2002, global investment in HIV vaccine research were estimated to be US\$ 646 million (range US\$ 624 million to US\$ 670 million). The public sector (including multilateral agencies) accounted for 67.2% of these funds, industry for 15.3%, and the philanthropic sector for 17.4% (see Figure 13 and Table 9).



Note: Figure (a) shows the breakdown of total 2002 investment and figure (b) shows the breakdown for the total excluding the Bill and Melinda Gates Foundation challenge grant to IAVI.
Source: Public Policy Department, IAVI, "Global Investment and Expenditures on Preventive HIV Vaccines: Methods and Results for 2002, Working Draft – July 1, 2004"

Table 9. Global funding for HIV vaccine R&D in 2002 by funding source – mid range estimates

Public Sector	Amount	
	(US\$ millions)	Percentage
• US Public Sector	382.00	59.10%
• Europe Public Sector	41.30	6.40%
• Other Public Sector	9.60	1.50%
• Multilaterals	1.90	0.30%
Industry	Amount	
	(US\$ millions)	Percentage
• Pharmaceutical companies	57.00	8.80%
• Biotechnology companies	42.00	6.50%
Philanthropic sector	Amount	
	(US\$ millions)	Percentage
• Foundations	110.00	17.00%
• Corporate donations & private individuals	2.70	0.40%
TOTAL	646.00	100.00%

Source: IAVI, 2004

If one excludes the Bill and Melinda Gates Foundation challenge grant of US\$ 100 million, total investment in 2002 was US\$ 549 million (range US\$ 533 to US\$ 567

million), of which the public sector accounted for 79.6%, industry for 18.1% and the philanthropic sector for 2.3%. Of the funds spent in 2002 43.2% went towards pre-clinical research, 28.2% to clinical trial support, 20.7% to basic research and just under 8% to activities linked to cohort development, vaccine preparedness, advocacy and policy development (Table 10).

Table 10. Global expenditures on HIV vaccine R&D in 2002 by product development stage		
	Amount	
	(millions US\$)	Percentage
Basic research	114.00	20.70%
Pre-clinical research	237.00	43.20%
Clinical trials	155.00	28.20%
Cohort development/ vaccine preparedness	35.50	6.50%
Advocacy and policy development	7.60	1.40%
TOTAL	549.10	100.00%

Source: IAVI, 2004

Between FY1997 and the end of 2003, public sector and philanthropic pledges toward microbicide R&D totaled US\$ 532.2 million. Of that amount, US\$ 334.4 million, roughly 68%, came from the United States government through three agencies of the Department of Health and Human Services (DHHS): the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and Agency for International Development (USAID).

NIH investment predominated, accounting for 77% of all United States government support for microbicide R&D between 1997 and 2003, with NIH support doubling from US\$ 24.7 million in FY1997 to US\$ 60.9 million in FY2003. Support from USAID grew nine-fold, from US\$ 2.1 million in 1997 to almost US\$ 18 million in FY2003. CDC support for the field fluctuated, with an expenditure peak of \$4.5 million in FY2002.

As for the public sector in other countries, no significant investments were made until FY 2002 when the Department for International Development (DFID) of the United Kingdom provided approximately US\$ 23 million to the United Kingdom Medical Research Council primarily for advancement of its lead microbicide candidate, and the French Government provided support for microbicide research at the National Agency for AIDS Research (ANRS). Establishment of the International Partnership for Microbicides (IPM) catalyzed support for its product development programme from the governments of Denmark, Ireland, the Netherlands, Norway, and the UK, as well as modest contributions from the United Nations Population Fund (UNFPA) and the World Bank.

Philanthropic agencies increased their level of resources for microbicide R&D in 2000, with the Bill & Melinda Gates Foundation providing a US\$ 26 million grant to the Global Microbicide Project (GMP), a US\$ 20 million grant to the Population

Council in 2001, a US\$ 12 million grant to the GMP in 2002, and a five-year commitment of \$60 million to the IPM in 2003. In 2002, the Rockefeller Foundation also raised the level of its commitment with a \$15 million phased grant to the IPM.

In sum, overall investment in microbicide R&D has grown considerably, and further increases are expected. Estimates for FY2004 for United States public-sector investment through DHHS and USAID are US\$ 66.8 million and US\$ 22.0 million, respectively, an increase of US\$ 10 million over FY2003. Adding out-year commitments by other public sectors and foundations, total public- and private-sector investment in microbicide R&D is estimated at US\$ 143 million in FY2004.

New commitments by other European governments and the European Union (EU) may further increase support for the field in 2005 and 2006, but those levels are still undetermined. Experts in the field advise that an effective microbicide R&D programme will require a US\$ 300 million annual investment by 2007. The hope also persists that ways will be found to evoke support from large biopharmaceutical companies, which have not yet invested in microbicides. Realistically, however, any support from that source is likely to be largely in kind, with future potential dependent on obtaining proof that a microbicidal product would actually be an effective technology to reduce HIV transmissions (Table 11).

Table 11. Funding for Microbicide Research and Development, FY1997-2003 (in US\$)			
SOURCE	2002 (actual)	2003 (actual)	Cumulative* ('97-'03)
United States	75.3	78.8	334.4
International	67.4	4.8	72.6
Philanthropic	3.0	63.0	125.2
TOTAL	145.7	146.6	532.2

** Reflects figures for 1997 to 2001 which are not shown in the table*

SOURCE: Lamphear TL. Funding for Microbicides: An Overview. Silver Spring, MD: Alliance for Microbicide Development, 2004.

IV. Translating funding into action

A government's commitment to respond to AIDS can be measured by how well it ensures that sufficient financial resources are available. Once the resources are allocated to specific AIDS priority areas, they must immediately be put to sound use. To get ahead of the epidemic, resources should be delivered where they are most needed, and they must be used in a 'smarter' fashion – more efficiently and effectively.

Keeping systematic records of financial in- and out-flows is vitally important for planning purposes. Unfortunately, tracking AIDS resources is currently a low priority in most-affected areas, and is poorly developed, if performed at all.

As an essential part of resource flows analysis, reliable and ongoing information is needed on certain fundamental questions:

1. **Equity:** Is the money paying for services for the most affected and vulnerable populations? For example, if the leading mode of HIV transmission in a country is injecting drug use, are sufficient funds being allocated to programmes serving injecting drug users, or are the resources being used for general media campaigns that may be less controversial but substantially less effective?
2. **Allocative Effectiveness:** Are funds supporting interventions proving effective in preventing new infections, providing appropriate care and treatment, or mitigating the epidemic's socioeconomic impact? For instance, funding for antiretroviral treatment that does not use the appropriate combined drug regimens is not only ineffective, but also can be dangerous, facilitating the development of drug resistance in the individual patient and in the community at large.
3. **Additionality:** One of the guiding precepts for the creation of the GFATM was that the funds would not supplant, but would instead be additional to, those coming from other sources. However, tracking additionality, both at the donor level and within national financial systems has proven to be enormously challenging.
4. **Bottlenecks:** Even when funding is strategically allocated, there are many reasons why money cannot be spent in a timely way. Understanding these bottlenecks can help resolve bureaucratic and programming capacity problems.
5. **Misallocation/corruption:** Proper auditing of AIDS resource flows serves to reassure donors and governments that money is not being channeled to non-AIDS-related activities, or, even worse, to further personal financial gain.

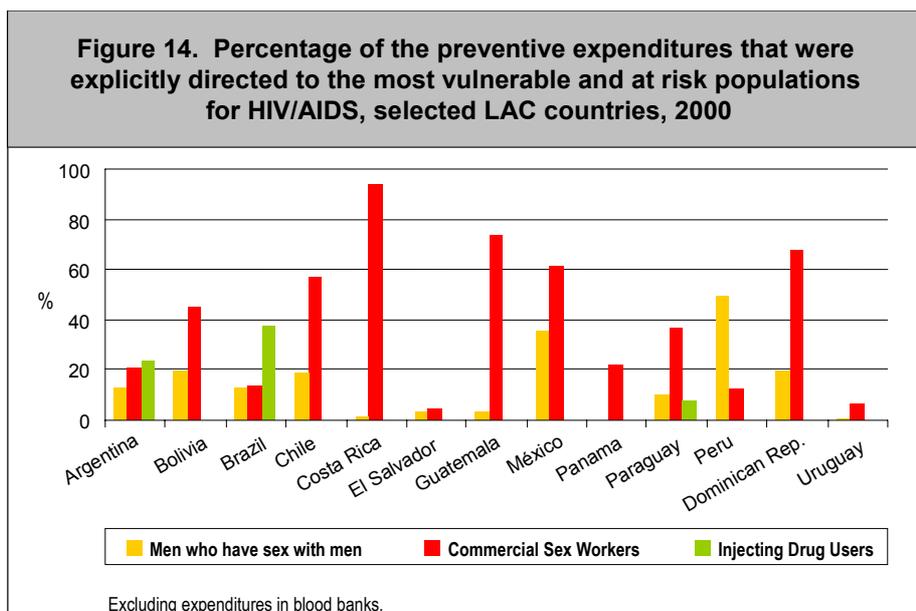
Brief examples of how these types of data can identify problems and challenges are highlighted below, except with respect to allocative effectiveness and misallocation/corruption, where public documentation is difficult to obtain.

Equity

The World Health Report 2000 (WHO) provides information on health financing and expenditure in 191 countries, documenting the inequity within countries, across regions, and around the world²⁴. In the case of AIDS, the work of SIDALAC on NAAs in the LAC region has shown that there is a similar uneven financial distribution of AIDS expenditure.

Most LAC countries have concentrated epidemics, with vulnerability to HIV typically concentrated among men who have sex with men, sex workers (female and male) and injecting drug users. Figure 14, dramatically depicts where funding has been focused in the recent past.

¹ Health System Performance assessment, debates, methods and empirism". Christopher Murray, WHO.



Source: SIDALAC HIV/AIDS National Accounts 1999 to 2002

Using the Allocation by Cost-effectiveness (ABC) Model in Honduras, Panama and Guatemala, several projects led by the World Bank have identified how AIDS expenditure will maximize the number of infections averted if they focus on the following activities: i) “condom social marketing, ii) free condom distribution targeted to high risk groups, iii) information, education and communication for high-risk groups including men who have sex with men, sex workers and prisoners, and iv) voluntary counseling and testing”.²⁵

However, as the graph above illustrates, most prevention spending (excluding blood banks) in these LAC countries supports non-targeted activities, with only a minor fraction of funding explicitly directed to men who have sex with men, sex workers and injecting drug users.

In Africa, similar inequities exist. In the absence of a financial support system that facilitates a patient’s fair access to care, an individual’s socioeconomic background will determine his or her access to vital treatment services.

Additionality

The Global Fund insists that its resources be ‘additional’ to other funds available for AIDS, tuberculosis and malaria programmes. If a government reduces its own commitments to these areas as GFATM funds are spent, the Fund’s grants may generate no net gain in service delivery. A sound and comprehensive resource tracking system is vital to efforts to monitor displacement and additionality. Consensus agreement among diverse stakeholders on the precise meaning of additionality will be required to develop an appropriate tracking system.

Where the National AIDS Account approach has been implemented, it is possible to obtain at least a preliminary assessment of additionality. Ghana was one of the first countries to receive GFATM funds. A recent retrospective estimation of National

²⁵ “HIV/AIDS in Central America: An overview of the epidemic and Priorities for Prevention”. Latin America and Caribbean Region. Global HIV/AIDS Program. World Bank, September 2003.

AIDS Accounts for 2002 and 2003 shows that the GFATM funds were indeed additional to all previously planned budgets from international agencies, programmes, and governmental organizations (Table 12).

Table 12. Total expenditures in HIV/AIDS, Ghana 2002-2003, in US Dollars.			
	2002	2003	Difference 2003-2002
Ministry of Health	\$1,116,490	\$960,036	(\$156,454)
Other Central Government	\$1,369,553	\$8,309,319	\$6,939,766
Non-profit Organizations	\$41,233	\$45,050	\$3,816
Households	\$1,446,364	\$1,983,509	\$537,146
Multilateral Agencies	\$181,042	\$4,191,236	\$4,010,193
Bilateral Agencies	\$9,409,389	\$10,937,889	\$1,528,500
Non-profit International Organizations	\$1,835,928	\$1,172,961	(\$662,967)
Total	\$15,400,000	\$27,600,000	\$12,200,000

Source: SIDALAC

By contrast, in Belize there was a reduction in the 2003 budgets from governmental sources and from some bilateral organizations with the expectation that the proposal developed for the GFATM would be approved and resources available for 2003.

Bottlenecks

Before 2004, financial flows could be regarded as the most important constraint on progress in responding to AIDS. Today the lack of human capacity has become one of the most significant obstacles to rapidly scaling up programmes. Resource analysis must now focus on identifying which factors (human skills, training needs, staffing numbers, financing, equipment, space in offices, clinics, and laboratories) actually limit programme expansion.

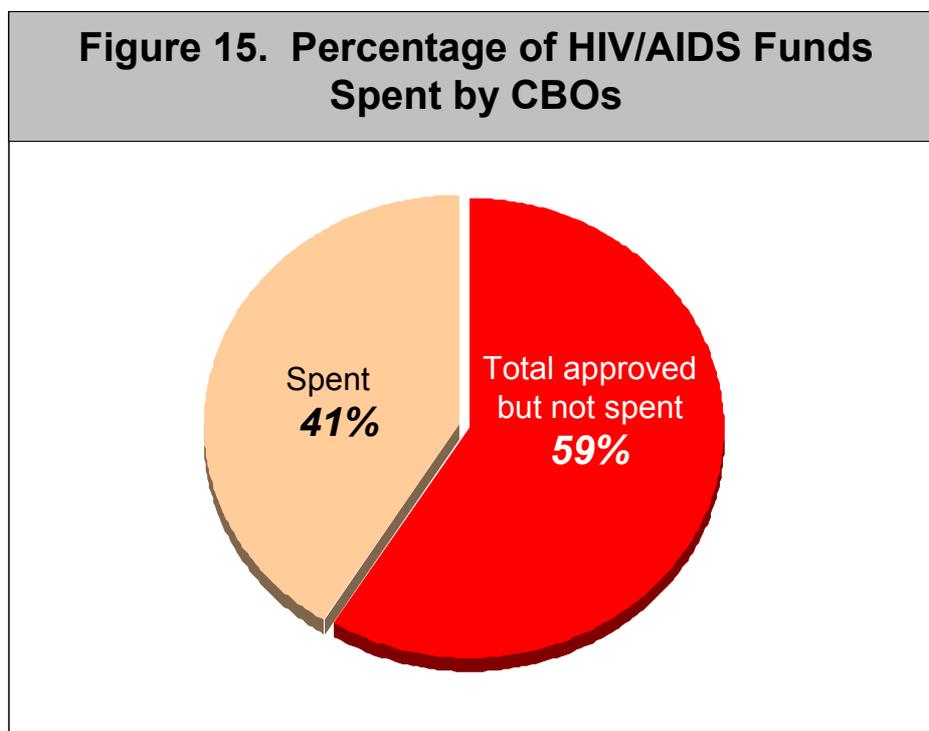
In Mozambique, as in many other countries, multiple bottlenecks to effective and efficient spending have been recognized, including limited liquidity and the unpredictability of foreign financing. The country's highly bureaucratic disbursement process is made worse by the decentralized nature of the Mozambican budget. Non-wage recurrent resources (*bens e serviços*) comprise only a small proportion of district budgets.

Still, this component of spending is important for service delivery, and there are both anecdotal and documented weaknesses in the budget execution system, specifically relating to delays in resources flowing from central to district level. The ways in which resource delays affect districts depend on a range of factors.

However, ultimately, the shortage of financial resources may be reflected in shortages in real resources, with attendant problems in terms of service delivery. Regardless of where the problems lie, such delays are likely to result in low levels of budget execution (Lindelov and Dehn 2001:4) In response to these difficulties, new monitoring and evaluation processes, as well as reforms to budget control systems, are being put in place. The government is also creating a centralized financial management system.

In Kenya, an analysis of the AIDS budget has been undertaken to determine whether implementing agencies are able to use available funds to produce the greatest output.

Between April 2002 and May 2003, a total of Kshs 43,298,785 was disbursed to various community-based organisations in Eastern Province. However, by the end of May 2003, only Kshs 18,318,504 had been spent, representing 41% (Figure 15).



Source: Idasa

Out of the total Kshs 72,035,564 approved for disbursement, only Kshs 43,298,785 had been disbursed. Between May 2003 and March 2004, the National AIDS control programme managed to disburse 82.7% of the total funds approved to various implementing organizations. Recent changes in government policy are expected to significantly improve efficiency in disbursing and spending funds.

Summary

Over the past three years, there has been an increasing refinement in tracking financial resources for the AIDS epidemic. Collecting this data is both feasible and affordable in all countries. This information is invaluable to donors, national governments, programme managers, and the public at large. It promotes accountability, ensures effective and appropriate use of funds, and allows equitable distribution of resources. Resource flow analysis should be integrated into all levels of resource disbursement and expenditure – from global ODA to district level spending – and should become a routine component of monitoring and evaluation systems.

ANNEX 1

RESOURCE AVAILABILITY FOR HIV/AIDS AND FUNDING GAP

Data was used from the resource tracking unit at UNAIDS²⁶ in order to estimate trends in HIV/AIDS funding for the past 7 years. This dataset includes information on bilateral, NGO, foundations and domestic sources of funding devoted to HIV/AIDS interventions by country (donor and receiver), and year.

These data were aggregated by region and subsequent estimates of the total resources available by region and year were calculated. Additional data related to current expenditures and future commitments were collected from the Kaiser Family Foundation, the GFATM²⁷, and the Regional AIDS Initiative for Latin America and the Caribbean (SIDALAC).

For the SSA and LAC regions, it was assumed that the resources committed by the PEPFAR initiative would represent the majority of the bilateral funding and there would be no increase in funding by other bilateral donors. For the other regions, based on data from previous years, a 33% yearly increase in bilateral funding was assumed on the assumption that other donors would concentrate their new funding on countries not supported by PEPFAR and the GFATM.

GFATM resources were estimated using data based on approved grants and expected disbursements by region.

Multilateral funds (primarily the World Bank with additional funds made available through the UNAIDS joint fundraising) were assumed to remain constant.

For NGOs and Private Foundations, it was assumed that the amounts per region would remain constant through 2007. This assumption was based on the fact that most of the new money already committed would be managed either through the GFATM or PEPFAR.

Finally, domestic funding are limited with the exception of the SIDALAC data for Latin America. The under-reporting proportion revealed by the SIDALAC studies was assumed to apply worldwide, as was the growth rate in domestic spending for HIV/AIDS. This is likely to be a conservative.

Based on the resource needs estimates, a calculation of the gap between need and availability was done to estimate the net need, defined as the amount of resources that have to be mobilized, in addition to the resources already committed, in order to present an adequate response to the HIV/AIDS epidemic. The gap provides a crude estimated of the resources that remain to be mobilized (in addition to those already committed), if an adequate response to the HIV/AIDS epidemic is to be made.

²⁶ Based on UNFPA/UNAIDS/NIDI Resource Flows for Population activities and AIDS

²⁷ amount in the grants the GF have signed with countries

ANNEX 2

METHODS USED TO ESTIMATE HIV/AIDS VACCINE R&D²⁸

This annex describes the methods used to estimate:

1. annual global investment in HIV vaccine R&D,
2. annual global expenditures on HIV vaccine R&D, and
3. the breakdown of annual expenditures by stage of product development.

Estimates of annual investments and expenditures were based on the total funds made available for HIV vaccine R&D in a particular year from the public, private and philanthropic sectors. In estimating investment and expenditure levels we have excluded:

- R&D for vaccines with primarily therapeutic applications
- Research not directed primarily at preventive HIV vaccines but that may have benefits or links to preventive HIV vaccines (e.g., platform technologies)

2.1. Estimating annual investment

Estimates of annual investment were based on a four step process:

- Step 1 A list of all organizations involved in funding preventive HIV vaccine research was drawn up based on the funders reported in the previous expenditure estimates and a list of IAVI's funders. This list was supplemented based on discussions with key individuals working in the HIV vaccine field and an extensive internet search. As new funders were identified they were added to the list.
- Step 2 For each of the funders identified the publicly available information was reviewed for any data on annual investment in HIV vaccine R&D. Information sources consulted included: government reports, annual reports, SEC filings, published studies and articles, scientific presentations and website postings.
- Step 3 For those funders where information was available:
- The data were reviewed and an annual estimate was generated.
- For those funders where there was limited or no information:
- Individuals were identified in each organization and interviewed (either in person or by phone) or contacted by email.
 - Based on the information collected an annual estimate was generated.

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Step 4 All of the estimates were reviewed for consistency to make sure that similar definitions were used and to eliminate double counting.

In estimating investments we have taken the perspective of the funder. In other words, if a funder made a sum of money available in a particular year for expenditure in that year or in future years, we have allocated that funding to the year in which the funds were made available. For example, in 2002 the Bill and Melinda Gates Foundation awarded IAVI a challenge grant of US\$ 100 million. All of the funds were transferred from the foundation to IAVI in 2002 and hence this was treated as a 2002 investment of US\$ 100 million although the funds were not spent during that year.

In developing these estimates we have differentiated between funders and intermediary organizations. Intermediary organizations are those who receive resources from funders and use them to fund others as well as their own work. For example, IAVI and SAAVI (South African AIDS Vaccine Initiative) were classified as intermediary organizations. In order to avoid double counting intermediary organizations were not treated as funders.

All funders of HIV vaccine R&D were allocated to one of three categories (see Table 2.1).

Classification of different funder types	
Public sector	<ul style="list-style-type: none"> · National governments (including government research bodies, international development assistance agencies, and other government funding agencies) · European Union · Multilateral agencies
Industry	<ul style="list-style-type: none"> · Pharmaceutical companies · Biotechnology companies
Philanthropic sector	<ul style="list-style-type: none"> · Foundations · Trusts · Individual bequests · Corporate donations · Non-governmental organizations

Investments made in currencies other than US dollars to non-US based organizations were translated into US dollars using the US Dollar 2002 annualized exchange rate from the CIA World Factbook 2003²⁹. For US based organizations, the rate of exchange at the time of the funds' transfer was used where such information was available. Otherwise the CIA World Factbook US\$ 2002 exchange rate was used.

In future iterations of data collection (i.e. for the year 2003) individuals contacted about the current level of funding for a particular organization will also be asked to comment on the estimates for previous years.

²⁹ These exchange rates are available at: <http://www.bartleby.com/151/fields/99.html>.

2.1.1 Specific issues: public sector and philanthropic estimates

Many public sector and philanthropic funders do not track HIV vaccine R&D funding separately from overall HIV/AIDS funding. As a result, the information provided is often based on the knowledge of the individual contacted and/or a key word search of the projects funded. The latter can lead to the identification of a number of projects where only a portion of each grant is directly related to vaccines. In these cases, we reviewed the description of the project and apportioned a percentage of the overall grant to HIV vaccines.

Information on the level of funding from the main US government funders (NIH, CDC, USAID and WRAIR) are based on self-reported figures. We have chosen to accept these numbers as reported. Obtaining a more precise estimate of spending on preventive HIV vaccine R&D (which excludes therapeutic vaccines or other related research) by the US NIH alone would require the auditing of more than 500 individual grants.

2.1.2 Specific issues: industry estimates

Company estimates, with the exception of VaxGen Inc and AlphaVax, were based on information about the companies' research pipelines collated from published data and presentations, and from information assembled during phone or in-person interviews and email exchanges with company representatives and other experts in the field. As most companies were very reluctant to provide any information on their actual expenditures, we attempted to generate a cost model for estimating company expenditures but were unable to develop credible estimates due to a lack of critical information on specific key cost components, e.g. the number of full time employees, and the extent of their investments in process development or preclinical research³⁰. As a result, the company estimates presented are based on information collected on the scope of their research programme and on estimates of grants and contracts they received from other organizations. These figures were then used to generate our best guess, high and low estimates for net industry investment and discussed with colleagues at IAVI and a few other key informants.

³⁰ To generate our cost model we surveyed various experts to get their estimates of key cost components of HIV vaccine R&D. We then interviewed people in companies with significant HIV vaccine programmes about the extent and associated costs of: staffing (staff size, time allocation); clinical trials (number and phase of ongoing trials, number of individuals enrolled); animal studies (number and size of monkey and other animal studies); process development (extent of work on each candidate); and other preclinical and basic research activities. Companies, however, were reluctant to provide the type of detailed information needed to develop useful cost models and cost estimates we received from experts varied widely. This highlights the need for a concerted effort to look more systematically at the critical cost components of HIV vaccine R&D.

2.1.3 Specific issues: double counting

As much as possible, we have tried to identify and eliminate double counting. For example, a number of the pharmaceutical and biotechnology companies active in HIV vaccine R&D receive grants or contracts from the US NIH to support their work. Funds from the NIH were accounted for under the US Public Sector – NIH line item and not under private companies. In other words, company estimates only include funds invested from their own sources and not grants or contracts provided by other organizations.

2.1.4 Specific issues: missing figures

Despite our best efforts we are conscious that all of the organizations funding HIV vaccine research and development may not have been identified. For example,

- We focused on national level funding and not on funds made available at the sub-national level (such as regions, states or provinces).
- We did not specifically contact universities to identify projects or staff being funded from sources not included in our funder list.
- Some organizations we contacted did not respond to our enquiries.

To address the potential problem of undercounting, we used our best judgement to estimate an “add-on coefficient” for each funding source category. The level of funds assigned to this category was based on a fixed percentage of the funds identified for each particular type of funder. Table 2.2 records the values used to generate the 2002 estimates.

Handling of missing figures in 2002 for each type of funder			
Percentage of funds allocated to “other”:	Low Estimate	Mid-point Estimate	High Estimate
Public Sector			
• US Public Sector	1.25%	2.50%	3.75%
• Europe Public Sector	2.50%	5.00%	7.50%
• Other Public Sector	2.50%	5.00%	7.50%
• Multilaterals	2.50%	5.00%	7.50%
Industry			
• Pharmaceutical companies	0.00%	0.00%	0.00%
• Biotechnology companies	5.00%	10.00%	15.00%
Philanthropic sector			
• Foundations *	5.00%	10.00%	15.00%
• Corporate & individual donations	5.00%	10.00%	15.00%

*Note: the US\$ 100 million Bill and Melinda Gates Foundation challenge grant to IAVI was excluded from the total identified foundation funds when the missing figure was calculated for foundations.

2.2 Estimating annual expenditures

The total level of funding made available in a particular year and the level of funds actually spent in that year do not always match. For example, a funder may provide a large sum of money in one year for use in future years, or the initiation of a research programme may be delayed.

In order to estimate annual expenditures, we identified the specific organizations funded and the amounts given by each funder where possible. From this information, we identified organizations for which we had both detailed revenue and expenditure data³¹. For those organizations where this information was available, annual expenditures on HIV vaccine R&D were estimated by subtracting the difference between revenue and expenditures from the total annual investment.. As we did not have detailed information on expenditures and revenues for all key players in the HIV vaccine field our expenditure estimate is likely to be on the high side.

2.3 Estimating the breakdown of expenditures by product development stage

Annual expenditures were allocated into one of five categories:

- (i) basic research
- (ii) pre-clinical research
- (iii) clinical trials
- (iv) cohort development and clinical trial infrastructure
- (v) vaccine education, advocacy and policy development

Definitions of the first four categories are based on those used by the US NIH to classify their HIV vaccine R&D funding (see Table 2.3). In addition, NIH lists a “paediatric vaccines” category. Funding classified as “paediatric” by NIH or other funders was allocated to one of the other five categories³². Other funders and intermediary organizations, however, use different definitions for breaking down their expenditures by stage of development (if they do so at all). As reclassifying the NIH data would have involved a major exercise beyond the scope of this project we opted instead to review the information available for each of the other organizations and to allocate their expenditures into one of the five categories based on the scope and stage of their R&D programme.

The category vaccine education, advocacy and policy development includes both country-level and global expenditures on policy development, vaccine education (including associated communications costs), and advocacy activities.

³¹ In 2002 the following organizations met these criteria: IAVI, SAAVI, AVAC, WHO-UNAIDS

³² In generating the 2002 estimates 50% of paediatric funding was allocated to pre-clinical research and 50% to clinical research based on information provided by Bonnie Mathieson, Chair of the Office of AIDS Research, HIV/AIDS Vaccine Coordinating Committee, NIH.

Prepublication Draft
July 2004

NIH HIV Vaccine expenditure categories	
<u>Basic research</u>	Research directed at increasing scientific knowledge of protective immune responses and host defences against HIV to facilitate the development of vaccines and other biomedical intervention strategies that prevent and/or control HIV infection.
<u>Pre-clinical research</u>	Research and development efforts directed at improving vaccine design (e.g. antigens, adjuvants, immunomodulators, delivery) and testing for safety; improving and supporting laboratory studies and animal models; and fostering collaboration for novel vaccine designs between government, academia, NGOs, and industry.
<u>Clinical trials</u>	Support for Phase I, II, III trials for safety, immunogenicity, and efficacy with suitable vaccine candidates or concepts in domestic and international settings.
<u>Cohort development</u>	Support to develop strategies, infrastructure and collaboration with researchers, communities, other US government agencies, other governments, international and domestic NGOs, and industry to identify trial sites and ensure adequate performance of trials and prevention needs of at-risk populations. Also included in this category are studies defining seroincidence and viral subtypes to determine and optimize feasibility of studies in appropriate cohorts.

Source: National Institutes of Health (2000). *National Institutes of Health Fiscal Year 2002 Plan for HIV-Related Research*. Washington, DC.

ANNEX 3

MONITORING FINANCIAL EXPENDITURE FLOWS FOR POPULATION AND AIDS

The core instrument of the UNFPA/UNAIDS/NIDI Resource Flows project to collect and monitor financial flows³³ for population and AIDS activities³⁴ at a world-wide level consists of an annual mail survey. The survey distinguishes between donors and recipients, each having sub-groups that receive tailored, partly pre-filled questionnaires.

Donor categories include:

1. primary donors: donor-country governments of OECD/DAC members³⁵ and international foundations of independent means;
2. intermediate donors: multilateral organizations, international NGOs, and universities and research institutes, which receive most of their income from primary donors or from other intermediate donors.
3. international and regional development banks.

Recipient categories include:

1. government departments of developing countries and countries-in-transition;
2. national NGOs in developing countries and countries-in-transition.

Inclusion of both primary and intermediate donors, combined with data collection at the project level, allows tracing financial flows from primary donors through various channels to final recipients and identifying and correcting double counts in expenditures.

Resource tracking aims at global coverage, but for efficiency reasons data collection is restricted to a selection of donors and recipient countries. With respect to donors, all DAC countries are included, as well as organizations that annually spend at least US\$ 1,000,000 on population activities and additionally organizations that are of strategic concern to UNAIDS. Recipient countries for which data are collected include a core set that meet the criteria of covering 80% of the combined population and 90% of total domestic funds for population activities reported in the three most recent survey rounds. In addition, countries are included that are of specific interest to UNAIDS. Remaining countries are surveyed on a rotating basis in a three-year cycle.

Besides reporting on expenditures in closed fiscal years (t-2), real-time (t) estimates for both donor categories and recipient countries by region are produced.

Limitations to data

Data are based on responses obtained from Governments and institutions surveyed. Although every effort is made to include all major organizations that contribute funds

³³ Financial flows consistently refer to expenditures or funds that have actually been disbursed, rather than to allocated funds.

³⁴ Data on HIV/AIDS activities distinguish four categories: STD activities, HIV/AIDS prevention activities, HIV/AIDS clinical care and treatment, and HIV/AIDS support and social mitigation.

³⁵ Increasingly, information about DAC members is retrieved from the OECD Creditor Reporting System (CRS) instead of through a direct Resource Flows questionnaire.

to STD/HIV/AIDS activities, it is not always possible to include every institution that provides financial assistance. Although outright refusal to provide information is extremely rare, non-response occurs for a variety of reasons. Therefore, all figures should be treated as best available estimates.

- **Variation in data availability and quality** – due in part to the lack of a uniform reporting system, data vary in availability and quality across and within sectors. For example, data collection efforts designed to assess affected country government resources and out of pocket spending have only recently begun and are much more complex than efforts to track donor government funding. The growing trend towards integration of services and the increasing use of sector-wide approaches (SWAs), particularly in health and education, make it increasingly difficult to track the level of funding going to STD/HIV/AIDS activities. The realities of data recording systems are such that some respondents are not able to provide expenditures for STD/HIV/AIDS activities because they are part of integrated health projects.
- **“Budgets/commitments” vs. “Spending/Disbursements”** – There are important differences between budgeted funding, or commitments, and actual spending, or disbursements, and distinguishing between them is difficult and subject to interpretation, particularly when funds flow through multiple entities before reaching direct service providers or beneficiaries. In addition, different funders may define commitments and disbursements in alternate ways. For example, countries making contributions to the Global Fund transmit their funds to its trustee (the World Bank), which transfers monies to grantees—that are then used to fund sub grantees. Donors consider their funds expended when sent to the Global Fund’s accounts, the Global Fund considers funds expended when transferred to grantees, and front-line providers may not see these funds for months. While both commitments and disbursements are clearly important, not all resource tracking efforts collect both and donors may not always report both commitments and disbursements. There is typically a difference between budgeted funding levels and the actual amounts disbursed, particularly with large donors. The variances can reflect delays in spending by donors as newly funded programs build to capacity or the reservation of funds to fulfill multi-year contracts. These variances can be significant. For example, UNAIDS has estimated that actual disbursements from U.S. bilateral HIV/AIDS programs in 2003 were approximately 30 percent less than budgeted amounts.
- **Time lag:** there is often a significant lag in data availability, making it difficult to provide timely information for current policymaking purposes; There are trade-offs in trying to achieve a favorable balance between getting timely, complete and reliable data, and generally a time-lag of two years occurs before data are published. Because donors do not release the data until the “books are closed” which is well into the following fiscal year. Donors do not release their data until their ‘books are closed’. Data on future commitments are not always complete because not all donors supply the requested information. Some respondents provide a very rough estimate. Most respondents are not able to disaggregate future commitments by category of HIV/AIDS activity, i.e., whether HIV/AIDS prevention or treatment and care

- **Need for technical assistance** – tracking resources is a complex undertaking and there is often a need to invest in technical assistance, particularly at the country-level. This investment also aids in the ability of affected countries and others to build capacity to track resources over time.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together nine UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its nine cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

To strategically plan for an effective response to the AIDS pandemic, resource tracking estimates for HIV/AIDS are required. Efficient allocation of international assistance and national resources for HIV/AIDS is based on transparent information about sources and uses of funds. Data is needed on both public and private resource allocations, estimation of the scope of potential resource needs, and ongoing analyses of the availability of resources.

The purpose of this Report is to identify the magnitude of global resources available relative to the estimated resource needs. The Report also reviews and compares the methodological approaches used to track HIV/AIDS expenditure at global and national levels, and identify gaps in HIV/AIDS financial information and present ways they can be addressed.



Joint United Nations Programme on HIV/AIDS

UNAIDS

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