

International AIDS Assistance: “New” Money?

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The following brief was among background papers prepared to inform work of the conference “Sustaining U.S. Global Leadership on HIV/AIDS,” organized by the CSIS Task Force on HIV/AIDS and chaired by Senators Russell Feingold and Bill Frist. The conference focused on critical challenges that U.S. policymakers will confront in the next phase of U.S. global AIDS efforts, as PEPFAR’s first five-year phase comes to an end.

SUMMARY

All credible formulae for addressing HIV and AIDS in the developing world assume a rising tide of financing from many sources in partnership. These include governments and philanthropies of the developed world, multilateral organizations, developing-country governments, the business community, and in some cases, individuals themselves. Funding for HIV/AIDS has been on the rise during the last decade. The question of additionality – the uncertainty as to whether new international financing is genuinely adding to existing international assistance funding – has remained a key concern in the U.S. response to the pandemic. Additionality has also been defined in terms of whether international assistance supplements or supplants what developing countries can and should do for themselves. Seen in either of these ways, a preliminary analysis of newly-available data on HIV/AIDS financing in 13 representative developing countries provides encouraging evidence:

- In all 13 countries, international HIV/AIDS assistance has increased, and all 13 have simultaneously increased their own domestic HIV/AIDS public spending.
- In all but one of the 13, these increases were additive to both total international assistance and total domestic public spending; in other words, HIV/AIDS spending growth did not drive offsetting cuts in other spending overall.

BACKGROUND

A 2001 analysis produced under the leadership of the Joint U.N. Programme on HIV/AIDS (UNAIDS) set out the first global estimates of practical HIV/AIDS financing needs in the developing world, subsequently updated to \$11.7 billion by 2005, \$14.9 billion by 2006 and \$22.1 billion by 2008.¹ ² The original analysis also set out a framework for response, built on an assumption that one third of needed financing could and should derive from national sources in developing countries.

Since 2001, identified available financing for HIV/AIDS prevention, treatment, care and research in the developing world has more than quadrupled, to \$8.3 billion (range of the estimate: \$7.5-\$8.5 billion).³ There are multiple contributors to this reported growth. One recent analysis itemizes spending by developing-country governments totaling in excess of \$2.1 billion in 2004, almost twice totals previously reported, although a significant amount of this may derive from expanded reporting rather

¹ B. Schwartlander, et. al., “Resource Needs for HIV/AIDS,” *Science*, 29 June 2001, vol. 292.

² “Resource needs for an expanded response to AIDS in low- and middle-income countries,” UNAIDS, August 2005.

³ *Ibid.*

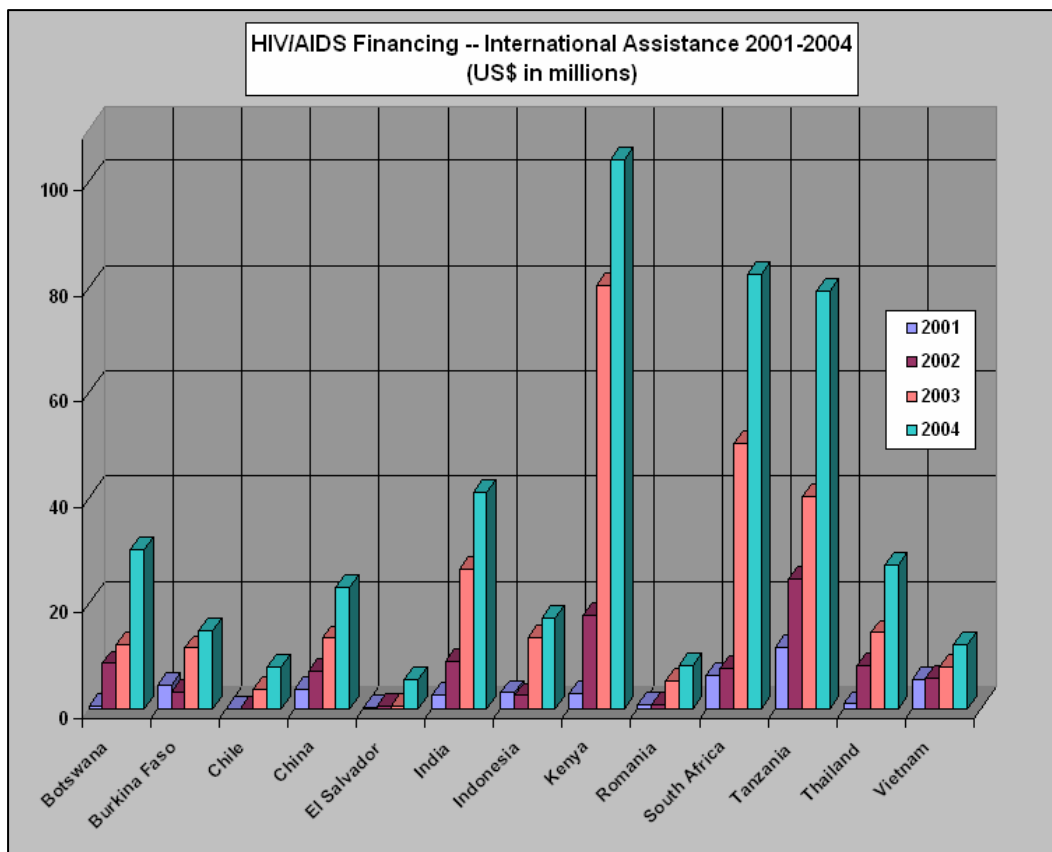
than real growth.⁴ An earlier UNAIDS report projected simultaneous household spending of \$1.3 billion in middle-income developing countries, also a legitimate part of the response.⁵

Early concerns that increases in international HIV/AIDS assistance spending might occur at the expense of other major assistance efforts have not been substantiated at the global level. Depending on the analysis cited, international official HIV/AIDS financing has grown post-2001 by anywhere from \$2.2-\$3.5 billion.⁶ Measured narrowly, total assistance reported to the OECD Development Assistance Committee (DAC) increased in real terms during the 2001-2004 quadrennium by more than enough to accommodate this growth in HIV/AIDS assistance. This is true even with overall growth attributable to exceptional requirements such as Iraq, Afghanistan, humanitarian emergencies and debt relief factored out of the equation.⁷

In the context of health assistance, however, there is some evidence to suggest funding constraints in several health subsectors simultaneous with growth in HIV and AIDS and other infectious disease financing.⁸

Country-level Additionality – A case study

An examination of data for 13 representative developing countries shows growth in international assistance financing for HIV/AIDS during the period 2001-2004 totaling over \$568 million. The following chart illustrates this trend:^{9,10}



⁴ “2006 Report on the Global AIDS Epidemic,” UNAIDS, New York, June 2006, Annex 3.

⁵ “Report on the State of HIV/AIDS Financing,” submitted by UNAIDS to its Programme Coordinating Board, June 2003.

⁶ UNAIDS, op. cit. (see note 4), Chapter 10.

⁷ “Aid Rising Sharply, According to Latest OECD Figures,” OECD, Paris, December 13, 2005.

⁸ OECD/DAC, Creditor Reporting System (CRS) database, online queries, February-April 2006.

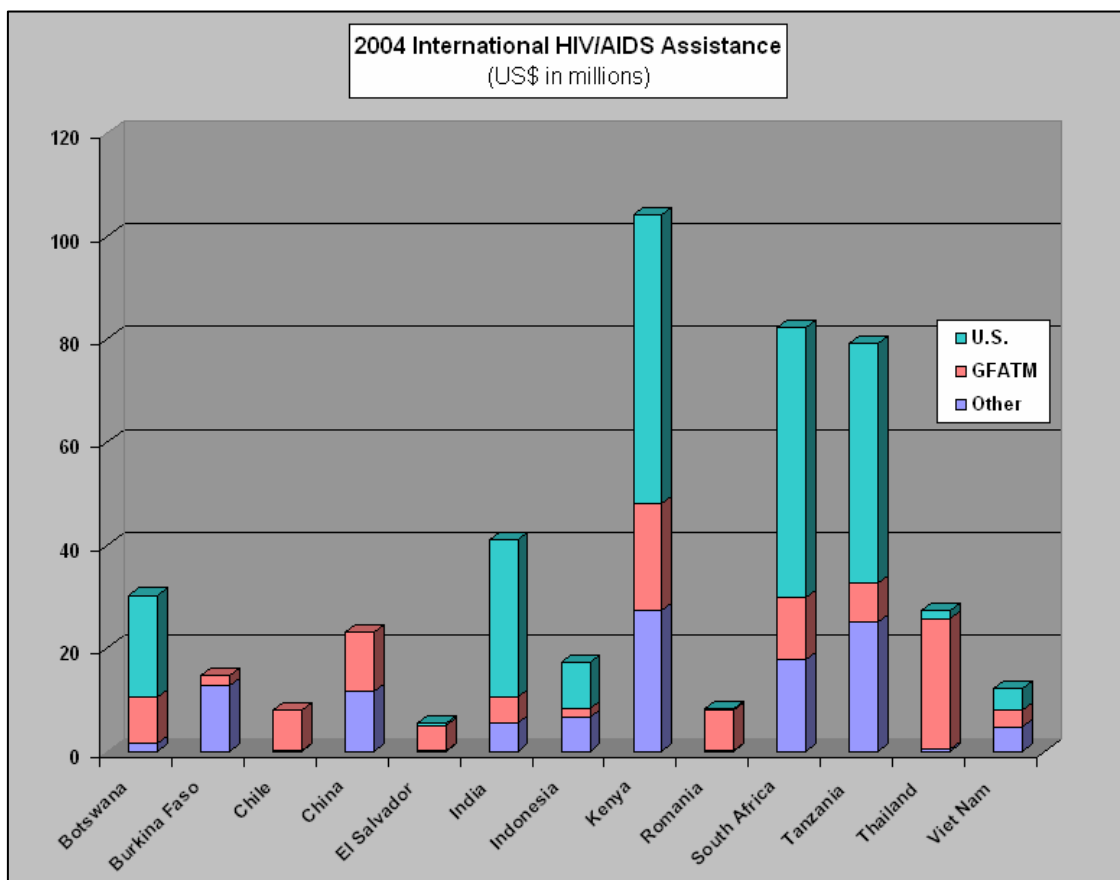
⁹ *Ibid.*

¹⁰ “The President’s Emergency Plan for AIDS Relief: Second Annual Report to Congress,” Appendix 3, Office of the U.S. Global AIDS Coordinator, Washington, DC, February 8, 2006.

During the same timeframe, all but one (Indonesia) of the 13 examined countries also were reported to have experienced significant growth in total international economic assistance;¹¹ HIV/AIDS assistance increases, in other words, did not generally come at the expense of sustained assistance funding for other sectors. Five of the 13 were in fact among the top beneficiaries of overall assistance growth.

In terms of health sector assistance growth, however, the situation shows some symptoms of the global constraints referred to previously: Overall, international health assistance among the 13 examined countries more than tripled during the timeframe under review. However, nearly two-thirds of the increase was HIV/AIDS-related. In seven of the 13, HIV/AIDS demands were reported to have consumed a predominant share of health assistance growth, although known limitations to the DAC data analyzed – acknowledged by the OECD and others – detract from its validity in support of findings this detailed.¹²

In 11 of the target countries, increases in international HIV/AIDS assistance was reported as predominantly attributable to financing by the Global Fund to Fight AIDS, TB and Malaria, and to the U.S. Government. The following chart sets out a 2004 breakdown of HIV/AIDS assistance financing for each of the thirteen, illustrating this predominance:¹³

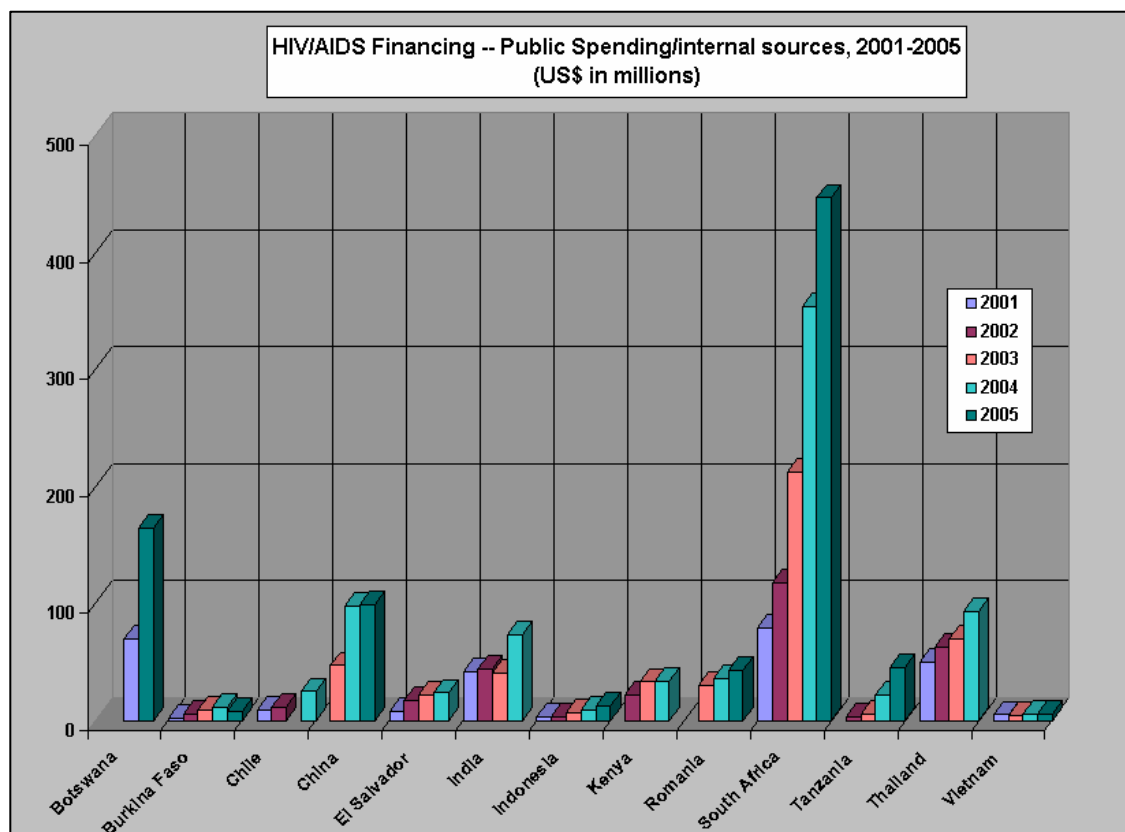


¹¹ OECD/DAC, *op. cit.* (see note 8).

¹² "Priorities in Global Assistance for Health, AIDS and Population," OECD Development Center, Working Paper no. 244, June 2005, p. 9, re limitations of the DAC/CRS database.

¹³ OECD/DAC, *op. cit.*

Simultaneous with the above, newly-available data shows growth in internal public financing for HIV/AIDS during the period 2001-2005 totaling over \$706 million among the same 13 countries, with an average growth rate of 155 per cent.¹⁴ The following chart illustrates these trends:¹⁵



These internally-financed increases in HIV/AIDS spending took place in a context of an average near-doubling of overall public expenditure growth among the 13 during the 2001-2005 timeframe. In all thirteen countries, total public spending was reported to have increased by more than enough to support identified HIV/AIDS spending. In none of the 13 did HIV/AIDS demands force nominal reductions in aggregate internal-source financing for other programs.¹⁶ In none of the 13 were increases in international budget support sufficient to have altered this reality: All 13 countries spent more of their own money on HIV/AIDS, and all boosted their own overall public spending by amounts more than equivalent to their HIV/AIDS increases.

As a component of this, public health spending among the thirteen was also reported to have grown sufficiently to support identified increases in HIV/AIDS programming.¹⁷ It is unclear, however, whether needs for financing growth in some specific health subsectors may have been crowded out by demands related to HIV/AIDS and other infectious diseases.

¹⁴ The figures for the domestic public expenditure in South Africa are estimates/projections. For the remaining countries, the average rate of increase is 94%.

¹⁵ Data source: UNAIDS, *op. cit.* (see note 4), Annex 3.

¹⁶ OECD/DAC, *op. cit.* (see note 8), and World Factbook, Central Intelligence Agency, Washington DC, 2001 & 2006.

¹⁷ World Development Indicators, World Bank, Washington DC, 2002-2006.

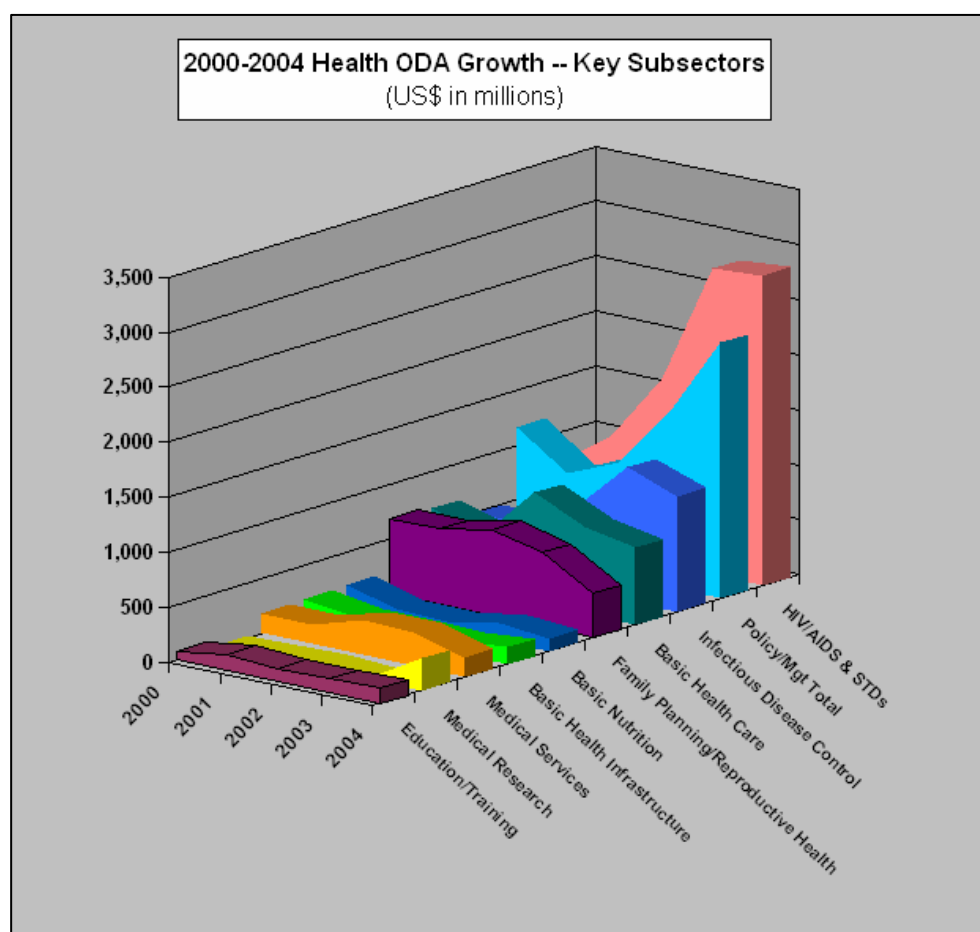
ISSUES

- ***HIV/AIDS Additionality defined?***

The concept of additionality is most often discussed in the context of debt relief, in terms of a number of alternative definitions.¹⁸ As applied to HIV/AIDS, additionality is most often defined in one of two ways:

1. New HIV/AIDS assistance financing is not offset by reductions in other assistance sectors or subsectors in a particular country or set of countries, or;
2. New HIV/AIDS assistance financing is additive not only to assistance financing, but to internal financing as well.

Neither of these definitions takes into account the reality that offsets can, alternatively, take the form of lower spending growth in other sectors and subsectors. Both globally and locally, as indicated previously, there is evidence suggestive of such a trend in international assistance spending. The following chart illustrates global trends:¹⁹



As can be seen, international HIV/AIDS and other infectious disease assistance spending jumped decisively during the 2001-2004 timeframe, while spending in most other health subsectors remained flat, grew negligibly, or even went down slightly.

¹⁸ “*Debt Relief, Additionality and Aid Allocation in Low-Income Countries*,” Robert Powell, Working Paper 03/175, International Monetary Fund, Washington DC, November 2003.

¹⁹ OECD/DAC, *op. cit.* (see note 8).

- ***Financial Inputs as Measurements of Global Success or Failure?***

The estimates of global HIV/AIDS financing demands cited earlier were constructed on a clear basis: that of the projected costs of specific activities in developing countries. It is unclear to what extent the “river” of new HIV/AIDS financing is flowing to these activities deemed in 2001 and 2005 to constitute priority needs. Management information systems worldwide are neither structured to answer this question nor, at the country level, are they generally technically sufficient to the task.

Against this backdrop, the fact of financial additionality can come to be seen as evidence of unqualified success, and of evidence that HIV/AIDS demands do not threaten overall development financing. However, additionality in and of itself does not mean that increased HIV/AIDS funding is flowing to an appropriate menu of activities, only that it is flowing.

- ***Innovative Financing Mechanisms -- Key to Sustainable Additionality -- have yet to Become Widespread***

As discussed previously, the \$8.3 billion in reported 2005 HIV/AIDS financing falls short of identified practical need (let alone total need) in the developing world. Additionality, such as it is, appears to mean that HIV/AIDS spending has been rising in the developing world without forcing spending cuts (although possibly constraining growth) in other sectors or subsectors. Looking ahead, it does not mean that this situation can continue if traditional grant assistance financing and internal public expenditure continue to be seen as predominant mechanisms of choice for funding growth.

In the 2001-2003 period, in the follow-up to the U.N. General Assembly Special Session (UNGASS) on HIV/AIDS and during the lead-up to establishment of the Global Fund, there was considerable discussion of the potential use of innovative financing mechanisms, such as non-discretionary means (e.g. tax incentives) to stimulate private financing, and interest-rate buydowns to facilitate expanded concessional lending by multilateral development banks. The Global Fund was specifically structured to permit such innovation. Five years after the fact, however, innovation in HIV/AIDS financing remains the exception rather than the rule. Most international HIV/AIDS assistance in the developing world still takes the form of traditional grants, as a consequence competing for grant funding with other demands in other sectors. Recent-vintage alternatives, such as the U.S.-supported Advance Market Commitment, the U.K.-proposed International Finance Facility and the French-enacted airline ticket tax, represent significant experiments in largely-unexplored territory, which the international community must expand into if the unprecedented financing demands driven by HIV/AIDS are to be met.