



Sustaining Financial Support for global HIV/AIDS

CSIS Issue Brief

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The following brief is intended as a background piece for discussion at the July 13, 2006, 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 will focus 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. Among the most fundamental of these challenges will be meeting rising global financial demands, driven significantly by expanding access to treatment as well as rising health infrastructure and workforce requirements. If these demands are to be met, the United States once again will need to take a leadership role, both in increasing its own funding for global HIV/AIDS and in galvanizing international partners to do the same.

INTRODUCTION

Global funding for HIV/AIDS has risen dramatically in the last five years, impelled by—and in turn reinforcing—a major shift among donor and recipient countries in norms and expectations of global responsibility and commitment. Resolutions at the 2005 United Nations General Assembly World Summit and the G-8 summit in Gleneagles calling for significant new resources and universal access to HIV/AIDS treatment by 2010 reflect the optimism and momentum of this change. In the United States, bipartisan congressional support and growing public awareness have fueled movement and greater support.

But continued momentum is not guaranteed. At the most recent UN General Assembly summit, members showed a marked reluctance to set firm targets, either in funding levels or in global HIV outcomes. Failure to reach previous ambitious targets—for example the World Health Organization’s 3x5 initiative, which promised to put 3 million people in low-income countries on antiretroviral therapy by 2005—may make donors wary of setting the bar too high. Refinements in country-level data collection by UNAIDS generated new, sometimes lower, estimates of HIV-prevalence rates in a number of acutely affected countries. Confusion around these new estimates, compounded by several widely circulated media reports that prevalence rates had been vastly exaggerated in several key African countries, may have added an additional layer of doubt and caution.

In the United States, there is a risk that fiscal realities and other global priorities may over time constrain attention and resources devoted to what will be a long and complex fight against HIV, where quick results will be ever more difficult to achieve. President Bush’s emergency plan gave a critical boost to global efforts, with its focus on rapid increase of new funds, concrete results,

and a renewed sense of urgency. However, maintaining a sense of urgency over the long hard years ahead may prove exceedingly difficult. As the first phase of the emergency plan comes to an end, demands for global health spending more broadly will likely be increasing as well, with new threats—e.g. avian flu, SARS—emerging, and health systems demands—e.g. for personnel, infrastructure—rising apace. U.S. policymakers will be challenged to balance competing health demands and craft a strategy that moves the U.S. toward an integrated, comprehensive, and sustainable long-term approach. Further, U.S. policymakers will likely demand growing and solid evidence of recipient countries stepping up their efforts: both only in financial flows and efficient and transparent use of funds, and in serious efforts to change behavior, for example protection of women and reaching high-risk groups.

As it looks toward the next phase of its global HIV/AIDS strategy, the United States has an opportunity to use its leadership to leverage step up its own financing efforts, to mobilize new partner institutions and donors, to encourage recipient countries to continue to increase their own commitments, and to strive for a comprehensive approach to HIV prevention, care, and treatment, and supporting health and social service requirements.

ACCOMPLISHMENTS

At the UN General Assembly Special Session (UNGASS) in 2001, the international community issued the Declaration of Commitment on HIV/AIDS, establishing programmatic goals for responding to the HIV/AIDS epidemic. To reach these goals, it set a financial target of \$7-10 billion for HIV/AIDS expenditures in developing countries by 2005.¹ This was later revised upwards to \$11.9 billion.² With spending estimated to have reached \$8.3 billion in 2005, growth has been significant, but the revised target has not been met.

Funding comes from a wide variety of sources with bilateral and multilateral aid making up the greatest share, and governmental domestic spending and household spending also contributing significantly. Private sector spending is a significant unknown, since there is little aggregate data on what businesses may be spending on their employees, families, and communities. Reported funding from the private sector comes largely from foundations, with the preponderance from the Bill and Melinda Gates Foundation. In nominal dollars, the U.S. government is by far the world's largest single bilateral funder. Since the 2001 goals were set, the U.S. has increased its annual global AIDS budget by more than 380 percent to reach \$3.2 billion in FY2006.³

With global financing falling short of the targeted 11.9 billion, UNGASS-set 2005 goals for prevention and treatment were not met, and in the June 2006 follow-up UNGASS meeting countries were reluctant to set new concrete targets. As a result, the world is moving into the next stage of fighting HIV/AIDS without a clear roadmap of what it hopes to accomplish, who

¹ This and all ensuing financial data, unless otherwise noted are from UNAIDS, *2006 Report on the global AIDS Epidemic*, 2006.

² UNAIDS, *Resource Needs for an Expanded Response to AIDS in low- and middle-income Countries*, 2005.

³ U.S. Office of the Global AIDS Coordinator, *Action Today, a Foundation for Tomorrow: the President's Emergency Plan for AIDS Relief. Second Annual Report to Congress*, Feb. 2006.
<http://www.state.gov/s/gac/rl/c16742.htm>

will lead the way, or how the response will be funded. UNAIDS sets out an ambitious set of anticipated achievements⁴, if the international community is able to increase its spending to meet the expected need from 2006 to 2008 and can more effectively track and coordinate the distribution of these funds. But many observers are concerned that these targets may not adequately account for the critical underlying infrastructure that will need to be in place to achieve these goals.

CHALLENGES

Although the international community has increased its funding for HIV/AIDS exponentially in the last 10 years, the epidemic has grown and the world has been unable to meet its goals in prevention and treatment (see Figure 5). In 2005 there were 4.1 million people newly infected with HIV, and services to those already infected remained limited. Only 20 to 30 percent of young adults have been successfully reached by prevention programs, 9 percent of HIV-positive pregnant women are receiving antiretrovirals, 20 percent of the general HIV-positive population are receiving antiretrovirals, just 6 countries have reduced the numbers of infected citizens by 25 percent, and only 11 countries have reduced the number of babies born with HIV by 20 percent. Moreover, the expected cost to improve performance and meet the 2001 goals keeps growing.

According to UNAIDS, by 2008 \$22.1 billion a year will be needed to comprehensively respond to the disease. Approximately half of the available money is needed for prevention and a quarter for treatment and care. The remainder of funds would be needed to meet the needs of children orphaned or otherwise deprived because of the disease, programmatic costs associated with the local and international response, and human resource expenses for training and retaining nurses and doctors (see Figure 2). In order to meet these needs, spending will have to nearly triple over the next few years.

Recent trends do not indicate that donor countries are on target to fill the financing gap. At the same time, development aid in general has grown, but much of the increase has been dedicated to purposes other than HIV/AIDS. If current financing patterns continue, UNAIDS predicts that there will be only \$10 billion in 2007 to meet the needs of all low- and middle-income countries—creating a shortfall of \$8.1 billion.⁵

In addition to logistical challenges, political and cultural motivations have also kept funding from reaching some areas where it is most needed. In many cases, at-risk populations, such as sex workers and men who have sex with men, are not receiving the services needed to stem the epidemic. The sensitivity of addressing the epidemic in these communities is evident in the political statement that came out of UNGASS+5 in June 2006 in which countries gathered to review progress since 2001 and renew their pledge to stop the spread of the disease. Mention of these target populations who are most at risk was avoided altogether in the Political Declaration, after the United States and several Islamic countries strongly objected to their inclusion. Nonetheless, to stop the spread of the disease, it is important to create country plans for funding distribution that accurately reflect the character of the epidemic in that country.

⁴ UNAIDS, *Resource Needs*, op. cit., page 4.

⁵ UNAIDS, *Resource Needs*, op. cit.

FUNDING SOURCES

Any U.S. strategy to cover the global HIV/AIDS financing gap will require increasing U.S. bilateral flows and domestic spending by developing countries themselves, leveraging substantial additional funding from multilateral institutions and international partners, and encouraging and partnering with private sector entities.

Bilateral Aid: In 2004 global HIV/AIDS bilateral assistance commitments were approximately \$2.7 billion⁶ The United States, United Kingdom, Netherlands, Sweden, Canada, and Germany were leading bilateral funders. For 2005, 1.9 billion in bilateral HIV/AIDS assistance funding was appropriated for PEPFAR, and U.S. bilateral disbursements are expected to have exceeded \$1 billion. An additional \$384 million was appropriated for research.⁷ President Bush has requested almost \$4 billion for global HIV/AIDS for 2007.⁸

Developing Country Spending: In 2004, HIV/AIDS spending by developing country governments exceeded \$2 billion. Such spending has been, and remains, an anticipated component of the global response, and its projected growth is a needed contribution to global funding. Acutely affected countries will likely come under greater pressure for a more strategic approach to domestic HIV/AIDS spending in meeting treatment and prevention goals and in targeting high-risk populations and using resources efficiently. In addition, there is likely to be much greater scrutiny of HIV/AIDS flows, and affected countries and their international partners will need to guard against diversion and misuse of rising resource levels, by increasing financial management capacity, domestic oversight mechanisms, and safeguarding against corruption and mismanagement.

Multilateral Aid: Multilateral assistance has represented a significant source of aid dollars in 2005. The largest multilateral donor organization, the Global Fund to Fight AIDS, TB, and malaria, has approved \$5.49 billion in grants for HIV/AIDS, TB, and malaria combined since its establishment in 2002, of which \$2.34 billion has been disbursed. The U.S. has provided approximately one third of Global Fund dollars every year and in 2005 gave \$347 million.⁹

In 2004, the European Commission provided nearly \$300 million in international HIV/AIDS assistance¹⁰, including—uniquely among multilateral organizations—

⁶ Jennifer Kates, *Financing the Response to HIV/AIDS in Low and Middle Income Countries: Funding for HIV/AIDS from the G7 and the European Commission*, Kaiser Family Foundation, July 2005.

<http://www.kff.org/hivaids/7344.cfm>

⁷ This includes \$370 million from the National Institutes of Health and \$14 million from the Centers for Disease Control and Prevention. See NIH *Office of AIDS Research FY2007 Congressional Budget Justification* at: <http://www.oar.nih.gov/public/pubs/fy2007/fy07oarcj.pdf>. See also OGAC, *Action Today*, *op. cit.*

⁸ *Ibid.*

⁹ Friends of the Global Fight, “Financing the Global Fund to Fight AIDS, TB, and Malaria in 2007,” May 2006. http://theglobalfight.org/downloads/Fact_Sheets/FY07_Financing_Global_Fund.pdf

¹⁰ Kates, *Financing the Response*, *op. cit.*

contributions to the Global Fund. EC cumulative contributions to the Fund total over \$450 million¹¹, making the EC the second-largest contributor after the United States.

The World Bank is the second major source of multilateral aid and has approved a total of \$2.5 billion in HIV/AIDS-targeted loans and grants as of the end of 2005 (check this). World Bank programs have been a strong complement to U.S. efforts, with a strong competitive advantage in strengthening long-term health capacities, management systems, infrastructure, and training of health professionals. The United States would do well to strengthen its partnership and coordination with the World Bank and support a greater role for the World Bank in fighting global HIV.

The UN is another source of multilateral aid, although its principal strength is less in financial contributions than in coordinating global efforts and giving technical advice and facilitation. In 2004-2005, UN spending averaged \$667 million per year spread across its various programs.

Private Sector Spending: In 2004 HIV/AIDS funding from private and philanthropic sources totaled approximately \$400 million.

The largest contributors in this group are foundations, with two-thirds of foundation spending comes from the Bill and Melinda Gates Foundation alone. Since its inception in 2000, the Bill and Melinda Gates Foundation has given nearly \$1.5 billion towards HIV/AIDS.¹² Annual spending by the foundation overall is currently more than \$1.5 billion. The recent bequest of \$37 billion from Warren Buffet to the Gates Foundation is expected to double this outlay, and could create significant new resource flows to HIV efforts.

Spending by for-profit corporations is largely unknown, but there is growing awareness of the impact HIV/AIDS has on the economy and the workforce. At the recent UN gathering, the Global Business Coalition on HIV/AIDS (GBC) presented survey results that indicate that a significant number of companies are now providing their employees with HIV/AIDS services.¹³

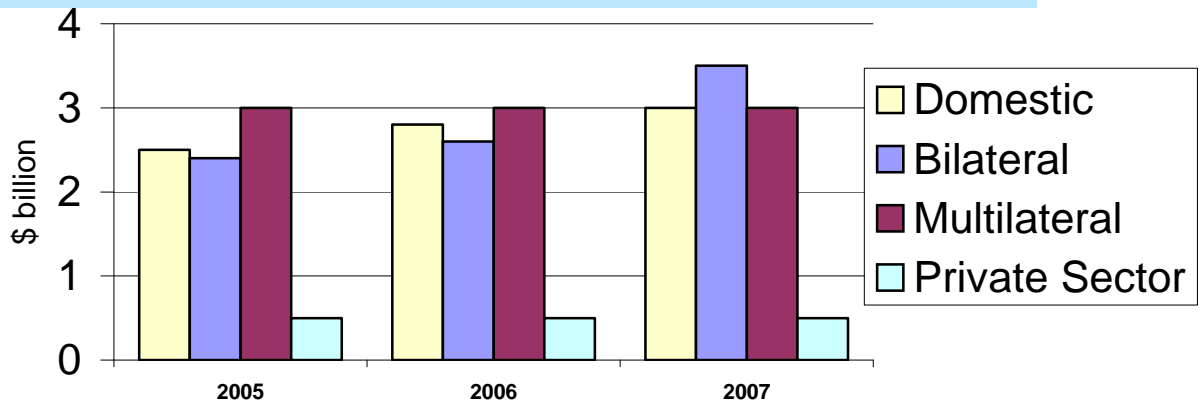
¹¹ Global Fund Web site: Global Fund website, <http://www.theglobalfund.org/en/files/pledges&contributions.xls>,

¹² Bill and Melinda Gates Foundation, Global Health, April 2006.

<<http://www.gatesfoundation.org/GlobalHealth/Grants/default.htm?showYear=2006>>

¹³ "First-Ever Baseline Report of Best Practices Shows Private Sector is Moving Toward Universal Access to HIV Treatment." *Business Wire*, May 31, 2006.

Figure 1: Sources of Estimated and Projected Funding for the AIDS Response from 2005 to 2007*



*Assuming there are no new commitments

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

Figure 2: UNAIDS Predicted Funding Requirements for Low- and Middle-Income Countries

\$ Billions	2006	2007	2008	2006-2008
Prevention	8.4	10	11.4	29.8
Care and Treatment	3	4	5.3	12.3
Support for Orphans & Vulnerable Children	1.6	2.1	2.7	6.4
Program Costs	1.5	1.4	1.8	4.6
Human Resources	0.4	0.6	0.9	1.9
Total	14.9	18.1	22.1	55.1

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

Figure 5: 2005 Country progress towards 2001 Declaration of Commitment on HIV/AIDS—Global targets (low- and middle-income countries)

GLOBAL RESULTS 2005	GLOBAL TARGETS 2005
Total annual expenditure*	
US\$ 8 297 000 000 Estimated range: US\$ 7.5 billion-US\$ 8.5 billion	US\$ 7.0 billion-US\$ 10.0 billion <i>Global target achieved</i>
Percentage of youth aged 15–24 who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission**	
MALE: 33 percent (Country range: 7 percent-50 percent coverage), (n=16) FEMALE: 20 percent (Country range: 8 percent-44 percent coverage), (n=17)	90 percent coverage <i>No country achieved this</i>
Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis***	
9 percent (Country range: 1 percent-59 percent coverage), (n=41)	80 percent coverage <i>No country achieved this</i>
Percentage of people with advanced HIV infection receiving antiretroviral therapy****	
20 percent (Country range: 1 percent-100 percent coverage), (n=116) 1 300 000 people on treatment	50 percent coverage (3 million people on treatment) <i>21 countries achieved this</i> <i>Global target not achieved</i>
Percentage of young males and females, aged 15–24, who are HIV infected*****	
MALES: 1.4 percent (Measure of uncertainty: 1.1 percent-1.8 percent), (n=54) FEMALES: 3.8 percent (Measure of uncertainty: 3.0 percent-4.7 percent), (n=54) No comparable global data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries.	25 percent reduction in most affected countries <i>6 of the most affected countries achieved this</i>
Estimated percentage of infants born to HIV-infected mothers who are infected in 2005*****	
26 percent of infants born to HIV-infected mothers were also infected (n=33 most affected countries) In 2001, approximately 30 percent of infants were infected. There has been an estimated 10 percent reduction in HIV transmission between 2001 and 2005.	20 percent reduction <i>11 of the most affected countries achieved this</i>

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

