THE HENRY J. KAISER FAMILY FOUNDATION

Financing the Response to HIV/AIDS in Low and Middle Income Countries: Funding for HIV/AIDS from the G7 and the European Commission

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INTRODUCTION

Financing the response to the global HIV/AIDS epidemic has emerged as one of the world's greatest challenges, and one that will be with us for the foreseeable future. Often, those countries most affected are also least resourced, increasing their vulnerability to HIV/AIDS and complicating their ability to respond, as is the case for many nations in sub-Saharan Africa. In addition, there is concern about a potential "next wave" of the epidemic in several of the world's most populous nations, particularly China, India, and Russia, which stand on the brink of generalized epidemics if more is not done now. Yet analyses indicate that if effective HIV prevention programs, coupled with treatment, were truly brought to global scale, and on a sustained basis, millions of future infections could be prevented and HIV-related mortality reduced.[1,2,3] Given the magnitude of the epidemic, the role of international donor assistance in low and middle income countries has been and continues to be critical.

Indeed, funding from international donors has risen significantly over the past several years, owing primarily to donor government assistance through bilateral aid and contributions to The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund).[4,5] The World Bank also provides substantial funding for HIV/AIDS,[6] as does the private sector (foundations, corporations, international non-governmental organizations, and individuals). Notably, many affected country governments allocate domestic resources to combat their epidemics, and households and individuals within these countries often shoulder at least some, if not much, of the financial burden. Taken together, it is estimated that resources made available from all of these funding streams rose from approximately $300 million in 1996 to $6.1 billion in 2004, and are expected to reach $8 billion in 2005.[7,8,9]

Despite increases in funding for HIV/AIDS, however, official estimates suggest that a considerable financing gap remains, one that will likely grow over time.[7,8,10] The Joint United Nations Programme on HIV/AIDS (UNAIDS) now estimates that $15 billion will be needed to effectively respond to the HIV/AIDS epidemic in low- and middle-income countries in 2006, rising to $22 billion in 2008. Ultimately, most of these resources will need to come from the international community.[7,11,12]

Within the international community, donor governments have an especially vital role to play in filling this gap. This is particularly true of the Group of 7 (G7) – Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States – and the European Commission (EC), some of the wealthiest donors in the world and major contributors of foreign development assistance. For example, in 2004, the G7 accounted for an estimated 72%[13] of total net official development assistance (ODA) provided by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD).[14,15]

This paper provides the latest available data on funding for HIV/AIDS in low and middle income countries by the G7 and the EC, including their bilateral aid and contributions to the Global Fund. Data are provided for 2004 (some of which are preliminary only). Included are both estimated funding commitments and disbursements As past studies have found, further corroborated by the current analysis, funding from the G7 and EC for HIV/AIDS represents a relatively complete picture of donor government efforts overall (87%) and therefore serves as an important gauge of international assistance for HIV/AIDS.[16] Such data also serve to inform multiple other efforts including:

- Resource mobilization;
- Monitoring of progress towards international development targets (e.g., Millennium Development Goals, United Nations General Assembly on HIV/AIDS, Monterrey Consensus, and others);
- Assessing additionality (that is, that net assistance for HIV/AIDS represents an increase over existing efforts for HIV/AIDS and development assistance more generally);
- Understanding "fair share" (the contributions of donors relative to their wealth and other factors);
- Facilitating transparency; and
- Providing a critical link in the larger HIVAIDS foreign aid equation of: where is assistance going, how quickly, for what, and to what effect.

I. METHODOLOGY

Data provided in this report, collected and analyzed as part of collaborative effort between UNAIDS and the Kaiser Family Foundation, were obtained from multiple sources. UNAIDS and the Kaiser Family Foundation conducted direct data collection from the governments of Canada, France, Germany, Italy, Japan, the United Kingdom, the United States and the European Commission during the first half of 2005. Data for the U.S. were also derived from Congressional appropriations legislation and other official documents. Other data sources include: the Global Fund's web-based databases; the OECD Creditor Reporting System (CRS); and the Netherlands Interdisciplinary Demographic Institute (NIDI) Resource Flows Project. There is currently no single or standardized mechanism for capturing complete data on HIV/AIDS funding from all donor countries, although such mechanisms are in development. Therefore, some of the data collected for this report should be considered preliminary only, and more research is underway to refine, standardize, and finalize data collection procedures and analysis over time.

This report provides both funding commitments and disbursements for HIV/AIDS in 2004. Commitments, or obligations, represent firm decisions that funding will be provided, regardless of the time at which actual outlays, or disbursements, occur.[17] For the United States, final enacted appropriations were considered the equivalent of commitments since the U.S. Congress sets specific new commitment authority numbers in legislation. The one exception to this was the adjustment of the U.S. Global Fund appropriation for 2004 to reflect carry-over of some of these funds to FY 2005, due to a legislative requirement that the total amount of U.S. contributions to the Global Fund cannot exceed 33% of the total amount of funds contributed to the Global Fund from all sources.[18]

Disbursements, which often lag commitments, are the actual expenditure or outlay of obligated funds. Disbursement figures were obtained directly from donors, from official donor documentation (e.g., for the U.S., disbursement rates were obtained from the Budget of the United States Government and the Office of Management and Budget[19,20]) or were estimated based on historical disbursement rates. Disbursements in any given year may include disbursements of funds committed in prior years.

Disbursements, not commitments, are considered to be "resources available" for purposes of assessing resources against estimated need. It is important to note, however, that a disbursement by a donor does not necessarily mean that these funds were provided to a country or other intended end-user. Rather, a disbursement is the "release of funds to, or the purchase of goods or services for a recipient. Disbursements record the actual international transfer of financial resources, or of goods or services valued at the cost of the donor". For example, contributions made by donors to the Global Fund in a given year are considered to be disbursed by donors in full, although these funds are not necessarily disbursed by the Global Fund to programs in that same year.

Both bilateral funding and Global Fund contributions were collected and analyzed. Data represent funding for HIV prevention, care, treatment and support activities, but do not include funding for international HIV/AIDS research. Included in bilateral funding were any HIV/AIDS commitments made by the donor other than to the Global Fund. All Global Fund contributions were adjusted to represent 60% of the total, reflecting the Global Fund's grant distribution through 2004 for HIV/AIDS as reported by the Global Fund.

Data represent fiscal year (FY) 2004, as defined by the donor, and fiscal years vary by donor. The U.S. FY runs from October 1-September 30. The fiscal years for Canada, Japan, and the UK are April 1-March 31. The EC, France, Germany, and Italy use the calendar year. Among the key multilateral institutions analyzed, the World Bank fiscal year is July 1-June 30. The other United Nations agencies use the calendar year and their budgets are biennial. The Global Fund's fiscal year is also the calendar year. In some cases, therefore, data obtained directly from donors on their FY 2004 contributions to the Global Fund may differ from amounts reported on the Global Fund's website by calendar year.

Other than contributions provided by donor governments to the Global Fund, UNAIDS, or to a UN agency for an HIV/AIDS specific purpose (e.g., The 3x5 Initiative), general contributions to UN entities, most of which are membership contributions set by treaty or other formal agreement (e.g., the World Bank's International Development Association or UN country membership assessments), are not counted as part of a donor government's HIV/AIDS assistance even if the multilateral organization in turn directs some of

these funds to HIV/AIDS. Rather, they are counted as HIV/AIDS funding provided by the multilateral organization, as in the case of the World Bank's efforts.

Data for 2004 were available from all G7 and EC governments except Japan. Because Japan's fiscal year recently ended, data on 2004 bilateral commitments were incomplete at the time of reporting; data used in this analysis for Japan are from 2003 and should be considered preliminary estimates only. Although obtained directly, data from France and the U.K. for 2004 are also preliminary. U.K. policy is not to disaggregate resources for HIV/AIDS from sexual and reproductive health activities; these activities were reviewed and included if there was a substantial portion focused on HIV/AIDS, but further analysis is being conducted.

Data from other members of the DAC for 2004 were collected where available or estimated based on 2003 data. Data from 2004 were reported directly to UNAIDS by Australia, Finland, Ireland, Sweden and Switzerland. Data for Austria, Belgium, Denmark, Greece, Luxembourg, Netherlands, New Zealand, Norway, Portugal and Spain were estimated based on 2003 data provided either to UNAIDS[21] or to the OECD CRS.

All 2004 figures for the G7 and EC were adjusted by average exchange rates for each donor's fiscal year to obtain the US$ equivalent, based on foreign exchange rate historical data available from the U.S. Federal Reserve.[22]

II. How is the Response Financed Today?

a. Forms of Foreign Assistance for HIV/AIDS

Donor governments provide multiple types of financial and other assistance to address HIV/AIDS in low and middle income countries, categorized as *official development assistance* (ODA) and *official aid* (OA), and defined by the OECD as:

- *Official Development Assistance (ODA)*: grants or loans provided by official agencies to countries and territories with the promotion of economic development and welfare as their main objective and provided at concessional financial terms (if a loan, having a grant element of at least 25 percent)". ODA is assistance provided to nations categorized by the OECD DAC as "developing countries and territories", such as those in sub-Saharan Africa; many in Latin America and the Caribbean, including Guyana and Haiti; and many in Asia, including India, China, and Vietnam.[23]
- *Official Assistance (OA)*: official assistance is the same as ODA except that its recipients are "Countries and Territories in Transition", such as those in Central and Eastern Europe and the Newly Independent States of the former Soviet Union.

Foreign assistance encompasses many activities: "projects and programmes, cash transfers, deliveries of goods, training courses, research projects, debt relief operations and contributions to non-governmental organisations."[24] Specific forms of assistance used by donors are as follows:[17,25,26,27,28]

- *Grants:* Transfers made in cash, goods or services for which no repayment is required and no legal debt is incurred by the recipient. Grants may be made from a grantor to a grantee, or to an intermediary organization on a grantee's behalf. Grants can be unconditional or conditional.
- *Loans*: Transfers for which the recipient incurs a legal debt and repayment is required in convertible currencies or in-kind.
- *Concessional loans:* loans that are made at or below market interest rates (including at zero interest), and typically are given a much longer grace period and maturity than other forms of financing. To be considered part of ODA, a loan must have a grant element (a grant "equivalent") of at least 25 percent.
- *Commodities*: Materials, supplies, and equipment, such as medicines and diagnostics.
- *Technical assistance/co-operation*: Transfer of knowledge through training, staff, and other services.

Research activities are generally not included as part of assessments of the magnitude of foreign assistance, although research is an important part of the response to HIV/AIDS and some donors provide

a significant amount of support for international research in this area. The United States, for example, provides a greater amount of funding for international HIV/AIDS research on an annual basis than the total commitments for HIV/AIDS of some other donor nations (U.S. funding for international HIV research was estimated at $328.2 million in 2004 and $343.3 million in 2005;[29,30] it is important to note that not all of this funding is for research activities in the field). Other donor nations also provide funding for HIV research including the European Commission ($55 million in 2004) and France ($31 million in 2004).[31]

b. Bilateral and Multilateral Channels for Assistance

Assistance is provided by donor governments through both bilateral and multilateral channels, and some mix of the two. Decisions about how much assistance to provide through these different channels (what "mix" to use) are dependent on several factors, such as: the desired level of control over the use of funds by donors; varying approaches to cooperation and coordination; donors' own internal capabilities and field staff capacity for carrying out programs; and recipient country governance status and structures, as well as capacities. These different channels can be described as follows:[17,25,26,28]

- *Bilateral assistance:* direct assistance from one government to, or on behalf of, one or more other countries. Bilateral assistance generally consists of projects and programs the content and direction of which is decided by the donor, who has more direct control over decisions about how and where funding is targeted (e.g., donors can stipulate countries, conditions, etc).
- *Multilateral assistance:* indirect assistance, in that it is provided by donor governments (usually unconditionally) to multilateral organizations that also receive funding from many other donors and in turn provide assistance to, or on behalf of, one or more countries. Multilateral assistance generally consists of projects and programs the content and direction of which is decided by the multilateral organization, using pooled funding from multiple donors. Multilateral aid may enable donors to satisfy other goals, such as leveraging support from other donors, financing the response through alternative vehicles, reaching more or different countries and regions, and/or accessing different capacities. For example, a donor without a large field presence may choose to provide more of its aid through a multilateral mechanism.
- *Multi-bi assistance (multilateral-bilateral)*: assistance provided by a donor to a multilateral organization for specific activities, as defined by the donor, and for which the multilateral organization acts as an implementing agent.

c. Other Key Dimensions of Donor Government Foreign Assistance for HIV/AIDS

In addition to aid channel, donor strategies for and approaches to financing HIV/AIDS (as well as foreign assistance more generally) vary across several other key dimensions that are important for understanding the broader context of the response; each of these dimensions has implications for the way in which aid flows to recipients. These dimensions include:[4,32, 33,34,35,36,37,38]

- Funding cycle, with most donor governments committing funds on an annual, biennial, or other short-term basis;
- The period over which a government's appropriation of funding must be committed/obligated (e.g., single-year, multiple years, or both; for example, in the United States, different accounts used to fund HIV/AIDS and other efforts have different such requirements);
- Disbursement rate of commitments, reflecting differences in donor requirements about when funds must be spent; program start-up; grant and contracting rules; reservation of funds to fulfill multi-year contracts; and assessment of absorptive capacity, governance, and program performance at the country recipient level;
- Whether funding for HIV/AIDS is part of HIV/AIDS-specific project support, sector wide approaches (SWAps) or basket funding, or general budget support;
- Whether there is a country or regional focus for donor efforts. For example, the U.S. is directing the far majority of its bilateral assistance for HIV/AIDS to 15 focus countries (12 in Africa, 2 in the Caribbean, and 1 in Asia), France focuses heavily on Francophone Africa, Italy on the Horn of Africa, and Japan on Asia;

- How much aid is "tied", that is, can only be used by the recipient to purchase goods and services (e.g., medications, supplies) procured from the donor country;
- Whether the primary recipient of funds is a government, an NGO/intermediary (including both international and indigenous NGOs), or both; and
- Whether any earmarks are specified or conditions/limitations attached to the receipt of aid (e.g., the U.S. has specific earmarks for the allocation of global HIV/AIDS funds to prevention, care, treatment, and orphan support[39] and limits the types of interventions that can be funded[40]).

At the recipient country level, the variation in these dimensions across donors often results in duplicative and/or multiple administrative processes, receipt of funds at varied and unpredictable intervals, and numerous monitoring and evaluation systems, all of which present challenges for both recipients and donors. In recognition of these challenges, several recent donor harmonization initiatives and agreements have been launched to address aid effectiveness more generally (e.g., The Rome Declaration on Harmonization, 2003[41]. The Paris Declaration on Aid Effectiveness, 2005[41]) and for HIV/AIDS specifically (The "Three Ones" Principles, 2004[42]).

III. Who Finances the Response? Donors Governments and Other Funding Streams for HIV/AIDS

a. Donor Governments

Donor governments provide virtually all of the world's development assistance through both bilateral aid and contributions to multilateral organizations. Among donor governments, most development assistance is provided by the G7 (72% of net ODA in 2004; see Table 1)[13,15] These same nations provide the bulk of donor government funding for HIV/AIDS. The other 15 members of the DAC also provide HIV/AIDS assistance, including some at significant levels, such as the Netherlands and Sweden.[16] Within each donor government, numerous departments and agencies are used to provide, administer, and/or manage foreign assistance for HIV/AIDS (see Table 2).

Several members of the G7 and the EC have launched significant HIV/AIDS related initiatives, perhaps most notably, because of its magnitude, is the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), announced by President Bush in 2003. PEPFAR is a 5-year, $15 billion initiative to address HIV/AIDS, TB, and malaria through prevention, care, treatment, and research[43,44] (see Box 1). PEPFAR has resulted in a significant increase in global funding for HIV/AIDS, and represents a growing share of overall U.S. foreign assistance.[45]

Table 1: DAC Members: Net Official Development Assistance (ODA), 2004, (preliminary data)

Country		US$M	ODA/GNI*	Percent of Total ODA
Australia		1,465	0.25	2%
Austria		691	0.24	1%
Belgium		1,452	0.41	2%
Canada		2,537	0.26	3%
Denmark		2,025	0.84	3%
Finland		655	0.35	1%
France		8,475	0.42	11%
Germany		7,497	0.28	10%
Greece		464	0.23	1%
Ireland		586	0.39	1%
Italy		2,484	0.15	3%
Japan		8,859	0.19	11%
Luxembourg		241	0.85	0%
Netherlands		4,235	0.74	5%
New Zealand		210	0.23	0%
Norway		2,200	0.87	3%
Portugal		1,028	0.63	1%
Spain		2,547	0.26	3%
Sweden		2,704	0.77	3%
Switzerland		1,379	0.37	2%
United Kingdom		7,836	0.36	10%
United States		18,999	0.16	24%
TOTAL DAC	**$**	**78,568**	**0.25**	**100%**
G7	**$**	**56,686**	**0.22**	**72%**

GNI: Gross National Income

Source: OECD, April 2005.

Table 2: G7 & EC Departments/Agencies for HIV/AIDS Assistance[32,46]	
Government	**Departments/Agencies**
Canada	Canadian International Development Agency (CIDA); Department of Finance; Department of Foreign Affairs and International Trade; Health Canada; International Development Research Center (IDRC)
European Commission	EuropeAid; Tacis (Eastern Europe and Central Asia); CARDS (Balkans); European Development Fund (EDF) for Africa, the Caribbean, and Pacific; ALA for Asia and Latin America; MEDA for the Mediterranean and Middle East; ECHO (Humanitarian worldwide); PHARE (Pre-accession assistance); SAPARD (Pre-accession agricultural support)
France	International Interministerial Cooperation and Development Committee; Ministry of Foreign Affairs; Ministry of Economic Affairs, Finance, and Industry; Priority Solidarity Fund; French Development Agency
Germany	Federal Ministry for Economic Cooperation and Development (BMZ); German Bank for Reconstruction (KFW); Agency for Technical Cooperation (GTZ); Ministry of Health
Italy	Ministry of Foreign Affairs; Ministry of Economy and Finance
Japan	Japan International Cooperation Agency (JICA); Ministry of Foreign Affairs (MOFA); Ministry of Health; Ministry of Finance; Japan Bank for International Cooperation (JBIC)
U.K.	Department for International Development (DFID); Foreign and Commonwealth Office; The Treasury
U.S.	State Department; U.S. Agency for International Development (USAID); Centers for Disease Control and Prevention (CDC); Department of Defense (DoD); Department of Labor (DoL); Department of Agriculture (USDA); Peace Corps; National Institutes of Health (NIH)

b. Other Funding Streams

In addition to the G7, EC, and the other members of the DAC, there are three other major funding streams for HIV/AIDS: multilateral organizations, the private sector, and domestic resources. Multilateral organizations provide assistance for HIV/AIDS using pooled funds from member contributions and other means. Contributions are usually made by countries, but can be provided by private organizations and individuals, as in the case of the Global Fund. The main multilateral organizations providing HIV/AIDS assistance are: the Global Fund; the World Bank; and different entities within the UN system (see Box 2). Other international development banks, including the Inter-American Development Bank, the Asian Development Bank, and the African Development Bank also finance HIV/AIDS efforts.

The private sector, including foundations (charitable and corporate philanthropic organizations), corporations, international NGOs, and individuals, also represents an important funding stream for HIV/AIDS, often acting to pilot new and innovative strategies, leverage existing ones, and develop partnerships with the public sector. It is estimated that U.S.-based philanthropies committed $395 million in 2003 to HIV/AIDS activities in both the United States and internationally (this figure includes some commitments that are multi-year).[47] Among foundations, the Bill and Melinda Gates Foundation provides the bulk of philanthropic funding for international HIV/AIDS efforts. Corporations and businesses also support HIV/AIDS programs in low and middle income countries through non-cash mechanisms such as price reductions for HIV/AIDS medicines, in-kind support, commodity donations, and co-investment strategies with government and other sectors.[45,47]

Domestic resources, both spending by affected country governments and by households/individuals within these countries, represent a significant part of the response. UNAIDS estimates that domestic spending was approximately $2 billion in 2004.[48] The extent to which domestic governments provide

Box 1: PEPFAR*[5,43,44]

In January 2003, United States President George W. Bush announced the "President's Emergency Plan for AIDS Relief" (PEPFAR), asking the U.S. Congress to commit $15 billion over 5 years (U.S. fiscal years 2004 – 2008) to international HIV/AIDS, tuberculosis, and malaria efforts. Congress passed legislation authorizing this initiative, *The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*, in May 2003. PEPFAR established a new U.S. Global AIDS Coordinator, at the rank of Ambassador, to oversee all U.S. international HIV/AIDS funding and activities. PEPFAR's goals are to:

- Provide treatment to 2 million people with HIV/AIDS
- Prevent 7 million new HIV infections
- Provide care to 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children

PEPFAR includes international prevention, care, treatment, and research efforts for HIV/AIDS, TB, and malaria through bilateral and multilateral channels, and funding is largely concentrated in 15 focus countries: 12 in Africa (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia), 2 in the Caribbean (Guyana, Haiti), and 1 in Asia (Vietnam).

Of the $15 billion authorized:

- Almost $9 billion would represent new funding, targeted primarily to the 15 focus countries;
- $5 billion would represent ongoing bilateral funding of existing efforts in other countries; and
- Up to $1 billion would be for the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).

Actual commitments for PEPFAR over the 5 year period are determined annually by the U.S. Congress, in response to the President's annual budget request.

U.S. legislation authorizing PEPFAR specifies that its funds be allocated as follows:

- treatment (55%)
- prevention (20%)
- palliative care (15%)
- care for orphaned and vulnerable children (10%)

These allocations are recommendations for the first two years of PEPFAR; beginning in FY 2006, they are mandated by U.S. law.

Total U.S. bilateral and Global Fund commitments for HIV/AIDS in FY 2004 were $1.6 billion. In FY 2005, commitments are expected to total $2.2 billion. [Note: These figures do not include funding for HIV/AIDS research. Global Fund contributions are adjusted to reflect an estimated HIV/AIDS share in each year (60% of the contribution in 2004 and 56% of the contribution in 2005), as well as carry-over of some FY 2004 funds that were obligated in FY 2005 (see methodology)].

**This is an adaptation of a similar overview prepared by the Kaiser Family Foundation for: UNAIDS, Global Resource Tracking Consortium for AIDS, Financing the Response to AIDS, Prepublication, July 2004.*

resources for HIV/AIDS varies due to numerous factors including country income, debt, availability of external resources, and political commitment. In 2002, for example, Latin American country governments were estimated to have accounted for more than 80% of the region's overall HIV/AIDS expenditures, a much greater proportion than countries in sub-Saharan Africa, reflecting in large part income differentials between the regions. Similarly, individuals in some countries pay substantial amounts in out-of-pocket (OOP) expenditures for HIV/AIDS care as a proportion of overall AIDS expenditures, with some studies indicating that OOP for HIV/AIDS represented an estimated 45% of total AIDS expenditures in Kenya (2002), 40% in Chile (2002), 30% in Zambia (2002), 14% in Burkina Faso (2003), and about 14% in Columbia (2002).

Box 2: Key Multilateral Institutions Involved in HIV/AIDS Efforts

The Global Fund: Formally launched in June 2001, the Global Fund is an independent, public-private partnership. Its primary objectives are to raise new resources to fight HIV/AIDS, tuberculosis, and malaria and to issue grants to support prevention, care, and treatment programs to countries with the greatest need.[49] The creation of the Global Fund has served to mobilize new resources for all three diseases. The Global Fund receives its funding through public and private contributions. As of June 2005, a total of $6.1 billion has been pledged to the Global Fund from all sources, of which $3.9 billion has been contributed. Almost all contributions to the Global Fund have come from governments (96%), primarily the G7 and EC (81% of contributions from all sources; 85% of all government contributions).[50] To date, the Global Fund has committed $3 billion in 128 countries for HIV/AIDS, TB, and malaria efforts. The Global Fund estimates that 56% of funding distributed over all four funding rounds was for HIV/AIDS grants; the percentage was slightly higher (60%) prior to the last round of funding.[51] Because donors provide contributions to the Global Fund specifically for HIV/AIDS, TB, and malaria, these contributions are counted as part of donor commitments, a portion of which is considered to be for HIV/AIDS.

***The World Bank*.** The World Bank has been supporting HIV/AIDS efforts since 1986. The major World Bank efforts are its Multi-Country AIDS Programs (MAP) in Africa (launched in 2000)[52] and the Caribbean (launched in 2001)[53]. The World Bank provides assistance for HIV/AIDS through the International Development Association (IDA), which provides grants and interest-free loans (credits) to the world's poorest countries, and the International Bank for Reconstruction and Development (IBRD), which provides loans at commercial rates (non-concessional loans) to higher income countries (as non-concessional loans, these are not counted as part of ODA). IDA funds are derived primarily from member country contributions provided through a replenishment process every four years, borrower repayments, and investment income. The G7 provided approximately 70% of member country contributions to IDA at the time of 13th replenishment.[54] As of April 2005, the World Bank had committed a total of $3.5 billion to HIV/AIDS, including $2.6 billion in IDA and $829 million in IDRB loans. In 2004, the World Bank committed $380 million in IDA for HIV/AIDS.[55] Because countries provide general, not HIV-specific, contributions to the World Bank, World Bank funding of HIV/AIDS efforts is attributed to the World Bank as donor.

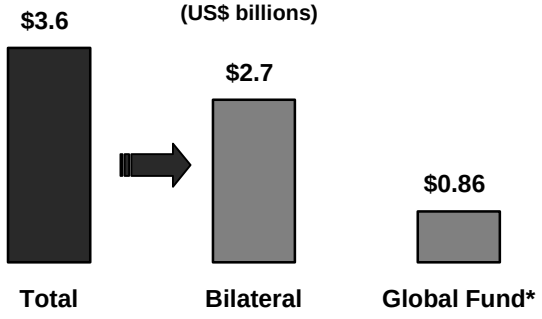
The United Nations*:* Numerous entities within the United Nations system carry out HIV/AIDS activities, coordinated by UNAIDS through a central Secretariat.[56] There are ten official co-sponsors of UNAIDS: Office of the United Nations High Commissioner for Refugees (UNHCR); UN Children's Fund (UNICEF); UN Development Program (UNDP); UN Population Fund (UNFPA); UN Educational, Scientific, and Cultural Organization (UNESCO); UN Drug Control Program (UNDCP); World Health Organization (WHO); World Bank; International Labor Organization (ILO); and the World Food Program (WFP). Each provides varying levels of project assistance to countries and a significant amount of technical assistance. The World Bank, as described above, provides the majority of direct project support. The WFP provides direct food assistance to those affected by HIV/AIDS. Technical assistance in the fight against HIV/AIDS is a main activity of the UN. For example, the WHO, with UNAIDS, oversees the global effort to greatly expand access to antiretroviral medications, 3 x 5, serving to provide leadership and coordination as well as standardized tools and guidelines. UNICEF's Supply Division helps governments, NGOs, and others to procure antiretrovirals. Funding used by UN entities to support HIV/AIDS activities comes both from specific HIV-related donor contributions (e.g., funding for UNAIDS or funding for the 3x5 Initiative) and from general contributions by member countries (and in some cases, through capital raised through other means). Funding provided by donors specifically for HIV/AIDS are attributed to donor government HIV/AIDS efforts; general funding provided by donors to the UN that may ultimately be used for HIV/AIDS is attributed to the UN. The biennial (2004-2005) budget for UNAIDS and eight of its co-sponsors for HIV/AIDS activities was $1.3 billion[57] (UNHCR and WFP not included; in 2002, WFP reported that it committed $195 million to food assistance for those affected by HIV/AIDS[58]). The biennial budget for 2006-2007, including all 10 co-sponsors, is expected to reach $2.6 billion.[59]

IV. FINDINGS: G7 AND EC COMMITMENTS AND DISBURSEMENTS FOR HIV/AIDS

Analysis of data from the G7, the EC, and other members of the DAC indicates that their combined financial commitments for HIV/AIDS in low and middle income countries reached an estimated $3.6 billion in 2004. Most was provided through bilateral channels ($2.7 billion or 76%); the remainder was provided through contributions to the Global Fund ($856.2 million or 24%; amount adjusted to represent an estimated HIV/AIDS share) (see Figure 1).[60] The G7 and EC accounted for 87% of all funds committed for HIV/AIDS by the DAC (see Table 3), a greater share than their share of the DAC's ODA overall. Certain other members of the DAC also provided substantial HIV/AIDS commitments in 2004, particularly the Netherlands and Sweden (funding for other DAC donors not disaggregated below).

The United States committed the highest amount of funding ($1.6 billion or 45%) to HIV/AIDS in 2004, including the highest bilateral commitment ($1.4 or 50% of bilateral commitments made by the DAC) and highest contribution to the Global Fund ($275 million or 32% of Global Fund contributions by the DAC, adjusted by 60%). The United Kingdom committed the second highest amount in 2004 ($596 million or 17%). Table 3 provides data by donor. Figure 2 provides commitments by donor as a share of total commitments from all DAC governments. Similar breakdowns are provided for bilateral commitments (Figure 3) and Global Fund contributions (Figure 4).

Figure 1: G7/EC & DAC HIV/AIDS Commitments (Bilateral & Global Fund), 2004
(US$ billions)



Sources: UNAIDS/KFF Analysis, June 2005; Global Fund (*adjusted).

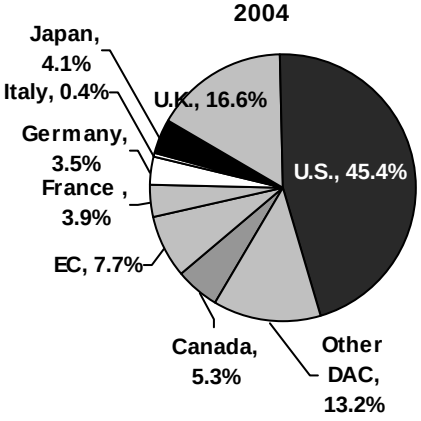
Estimated disbursements of bilateral assistance from the DAC were $1.9 billion in 2004, or 71% of the $2.7 billion committed in that year, with the G7 and EC accounting for 85% of DAC bilateral disbursements. The U.S. and U.K. also provided the two highest amounts in bilateral disbursements in 2004 (see Table 4). Disbursement rates varied by donor: Canada disbursed virtually all of its commitments; the U.S. disbursed the lowest proportion. As such, donors accounted for different shares of 2004 disbursements compared to commitments. The U.S., for example, accounted for 40% of estimated bilateral disbursements by DAC governments in 2004 compared to 50% of DAC commitments (see Figures 3 & 5). As mentioned above, disbursement rates are a function of differences in donor requirements about when funds must be committed, grant and contracting rules, program start-up factors, and assessments of recipient country absorptive capacity and program performance. The U.S. disbursement rate, for example, is expected to increase over time as the PEPFAR initiative matures.

Table 3: G7 and European Commission: HIV/AIDS Funding Commitments, 2004 (*US$ millions)*

	Total HIV/AIDS Commitment		Bilateral HIV/AIDS Commitment		Global Fund Contribution*	
	$	%	$	%	$	%
Canada	$189.2	5.3%	$111.3	4.1%	$77.9	9.1%
EC	$277.2	7.7%	$118.6	4.3%	$158.6	18.5%
France	$138.7	3.9%	$25.8	0.9%	$112.9	13.2%
Germany	$124.4	3.5%	$96.9	3.5%	$27.5	3.2%
Italy	$13.6	0.4%	$13.6	0.5%	$0.0	0.0%
Japan	$146.7	4.1%	$95.0	3.5%	$51.7	6.0%
U.K.	$596.1	16.6%	$560.0	20.5%	$36.2	4.2%
U.S.	$1,630.1	45.4%	$1,354.8	49.6%	$275.3	32.2%
Other DAC	$472.9	13.2%	$356.8	13.1%	$116.0	13.6%
Total	**$3,589.0**	**100.0%**	**$2,732.8**	**100.0%**	**$856.2**	**100.0%**
G7/EC	**$3,116.2**	**86.8%**	**$2,376.0**	**86.9%**	**$740.2**	**86.4%**

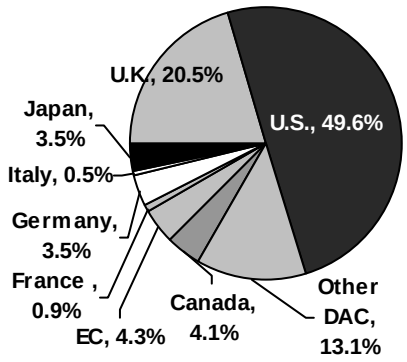
Notes: Funding for international HIV research not included; Global Fund contributions adjusted to represent estimated HIV/AIDS share of Global Fund* grant distribution by disease through 2004 (60% of total contribution); Canada's Global Fund contribution was provided in Canadian FY 2004 but outside of Global Fund FY 2004 and is counted here as part of Canada's 2004 funding for HIV/AIDS; Data from Japan, U.K., France, and certain other DAC are preliminary estimates only (see detailed methodology).
Sources: UNAIDS/KFF Analysis, June 2005; OECD CRS, June 2005; NIDI, RFP; UNAIDS/PCB(14)/03, Conference Paper 2a, June 2003; UNAIDS/PCB(14)/03.3, April 29, 2003; The Global Fund to Fight AIDS, Tuberculosis and Malaria; The World Bank; U.S. Department of State, Office of the Global AIDS Coordinator; U.S. Department of Health and Human Services; U.S. Congressional Appropriations Legislation and Conference Reports.

Figure 2: G7/EC as Share of Total HIV/AIDS Commitments by Donor Governments, 2004



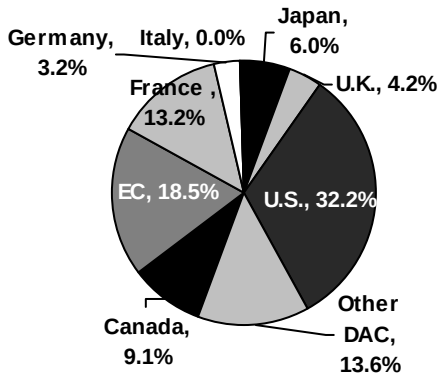
Sources: UNAIDS/KFF Analysis, June 2005; Global Fund* (adjusted).

Figure 3: G7/EC as Share of Bilateral Commitments, 2004



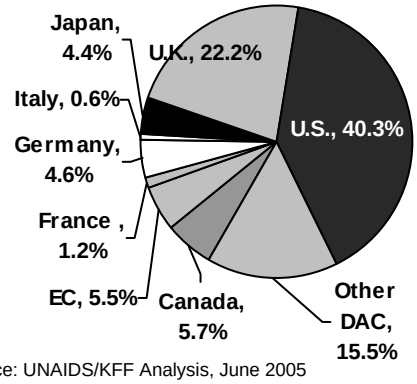
Sources: UNAIDS/KFF Analysis, June 2005

Figure 4: G7/EC as Share of Global Fund* HIV/AIDS Contributions by the DAC, 2004



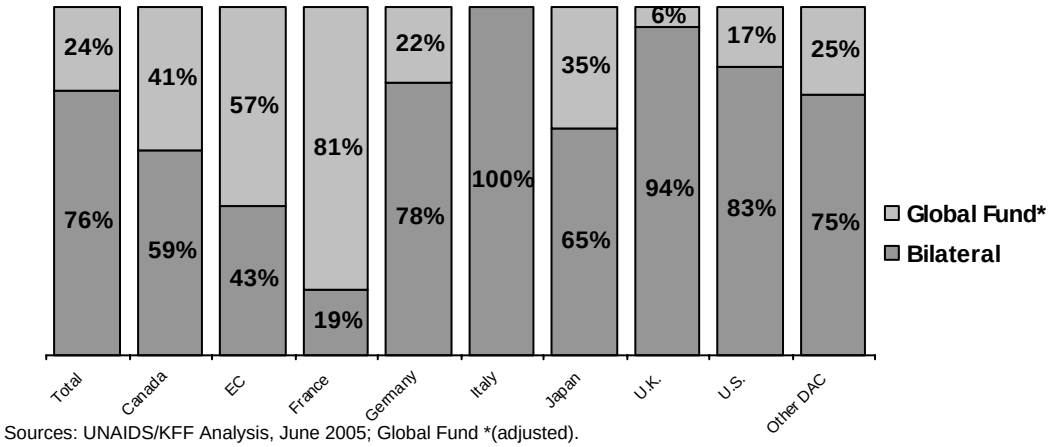
Sources: UNAIDS/KFF Analysis, June 2005; Global Fund* (adjusted).

Figure 5: G7/EC as Share of Bilateral Disbursements, 2004



Source: UNAIDS/KFF Analysis, June 2005

Figure 6: G7/EC Funding Channels for HIV/AIDS Commitments, 2004 (Global Fund Adjusted to Represent Estimated HIV/AIDS Share)



Sources: UNAIDS/KFF Analysis, June 2005; Global Fund *(adjusted).

Table 4: G7 and European Commission HIV/AIDS Bilateral Funding Commitments and Disbursements, 2004 (*US$ millions)*

	Commitments		Disbursements	
	$	%	$	%
Canada	$111.3	4.1%	$110.7	5.7%
EC	$118.6	4.3%	$105.7	5.5%
France	$25.8	0.9%	$22.7	1.2%
Germany	$96.9	3.5%	$90.0	4.6%
Italy	$13.6	0.5%	$12.4	0.6%
Japan	$95.0	3.5%	$85.0	4.4%
U.K.	$560.0	20.5%	$431.2	22.2%
U.S.	$1,354.8	49.6%	$781.2	40.3%
Other DAC	$356.8	13.1%	$300.0	15.5%
Total	**$2,732.8**	**100.0%**	**$1,938.9**	**100.0%**
G7/EC	**$2,376.0**	**86.9%**	**$1,638.9**	**84.5%**

Notes: Funding for international HIV research not included; Global Fund contributions adjusted to represent estimated HIV/AIDS share of Global Fund grant distribution by disease through 2004 (60% of total contribution); Canada's Global Fund contribution was provided in Canadian FY 2004 but outside of Global Fund FY 2004 and is counted here as part of Canada's 2004 funding for HIV/AIDS; Data from Japan, U.K., France, and certain other DAC are preliminary estimates only (see detailed methodology).

Sources: UNAIDS/KFF Analysis, June 2005; OECD CRS, June 2005; NIDI RFP; UNAIDS/PCB(14)/03, Conference Paper 2a, June 2003; U.S. Department of State, Office of the Global AIDS Coordinator; U.S. Department of Health and Human Services; U.S. Congressional Appropriations Legislation and Conference Reports; U.S. OMB, Budget of the United States Government, Fiscal Year 2006; U.S.OMB, SF 133 Reports.

While most funding for HIV/AIDS by DAC governments in 2004 was provided through bilateral channels (76%), versus the Global Fund (24%), the mix varied by donor (see Figure 6). France provided the far majority of its funding through the Global Fund (81%), followed by the EC (57%). The remaining donors were more likely to provide HIV/AIDS assistance through bilateral channels. As indicated, Italy provided 100% of its 2004 commitments through bilateral channels (no funding to the Global Fund); however, this is due to the timing of Italy's contribution to the Global Fund, and is not reflective of how Italy generally provides funding for HIV/AIDS, which is primarily through the Global Fund. It is also important to note that these distributions reflect an adjusted Global Fund contribution by donors (60% to represent an estimated AIDS share). If donors' full contribution were used, including funding used by the Global Fund for TB and malaria programs, the proportion of funding channeled through the Global Fund, relative to bilateral funding, would be greater.

In addition, because the Global Fund is a new financing vehicle and because of the timing of Global Fund contributions, a one-year snapshot may not necessarily reflect the relative contributions of donors over time. Table 5 provides cumulative Global Fund pledges, pledge periods, and contributions to date for the G7 and EC (for multiple years and as of June 2005; not adjusted to represent an HIV/AIDS share). As demonstrated, when using cumulative pledges and contributions, the share represented by each G7/EC donor changes. Italy, for example, represents 9% of G7/EC pledges and 7% of contributions to date (compared to 0% in 2004).

Table 5: G7/EC Global Fund Cumulative Pledges and Contributions to Date (Full Amounts, Not Adjusted for HIV/AIDS Share)					
	Pledge (USD Equivalent)	Pledge as Percent of G7/EC Total	Pledge Period	Total Contribution To Date (USD Equivalent)	Contribution as Percent of G7/EC Total
Canada	210,262,267	4.0%	2002-2005	210,267,796	6.6%
EC	559,115,251	10.7%	2001-2006	451,837,961	14.3%
France	687,403,065	13.2%	2002-2006	499,197,293	15.8%
Germany	383,597,975	7.4%	2002-2007	201,038,376	6.4%
Italy	450,941,029	8.7%	2002-2005	215,160,273	6.8%
Japan	341,193,443	6.6%	2002-2005	327,720,013	10.4%
United Kingdom	453,952,006	8.7%	2001-2007	178,581,238	5.6%
United States	2,116,606,279	40.7%	2001-2008	1,081,606,279	34.2%
TOTAL	**$5,203,071,314**	**100.0%**	**2001-2008**	**$3,165,409,230**	**100.0%**
Source: Global Fund to Fight AIDS, Tuberculosis and Malaria, data as of June 11, 2005.					

V. ASSESSING FAIR SHARE*

(**Note - This section was adapted from a similar section prepared by the Kaiser Family Foundation for: UNAIDS, Global Resource Tracking Consortium for AIDS, Financing the Response to AIDS, Prepublication, July 2004*)

Assessing "fair share" in the context of HIV/AIDS funding is an important but complex task. There is no single, agreed upon formula for making fair share assessments, and several questions must be considered, including:

- What is the "total" against which individual contributions are assessed? Is it estimated total need to combat HIV/AIDS? Estimates of total funding by donor governments? Should that total include just HIV/AIDS costs or be broadened to include critical infrastructure and capacity deficits?
- Who should be included in a fair share calculation? G7 governments and the EC only? All members of the DAC? Private sector contributors? Affected country governments? Out-of-pocket spending by individuals?
- How should differences in relative wealth be taken into account?
- Should other factors, such has HIV/AIDS burden, poverty, and debt service, be incorporated into fair share assessments?
- Should some share of general (non-HIV specific) funding provided by donors to the World Bank, WHO, UNICEF and other parts of the UN system that is ultimately used for HIV/AIDS be incorporated into donors' share?
- Should differences in country tax subsidy policies for charitable giving for HIV/AIDS by individuals, foundations, and corporations be taken into account?
- Should the quality of assistance be taken into account (e.g., how much is tied aid)?

These questions have implications for the methodology chosen to assess fair share and various assessment methodologies have been proposed, each of which yields different results. Some of these include:

- Rank by total commitments (amount or percent of total)
- Rank by share of commitment compared to share of the global economy (gross domestic product, GDP) or share of developed country GDP;
- Rank by value of commitment compared with standardized measure of relative wealth, such as commitment per $1 million GDP or gross national income (GNI).
- Share of total compared to the cost-sharing distribution negotiated for United Nations Member States (or specific entity within the UN such as the WHO).

Table 6 (columns A-C) provides HIV/AIDS funding data from the G7 and EC according to several different methodologies for assessing fair share:

- Column A provides G7 and EC total commitments (bilateral and Global Fund contributions) as a share of all donor government funding for HIV/AIDS in 2004;
- Column B provides G7 and EC total commitments (bilateral and Global Fund contributions) standardized per $1 million of the GNI of each donor in 2004;
- Column C provides G7 and EC resources made available in 2004 (bilateral disbursements and Global Fund contributions) as share of total resources made available from all sources. This share is compared both to the donor share of world GDP and the donor share of advanced economy GDP.

As demonstrated, each provides a different result. For example, the U.S. ranks as the top donor in terms of share of donor government funding commitments for HIV/AIDS in 2004 but ranks as third when commitments are standardized according to GNI. The U.K. ranks the highest when commitments are standardized by GNI, followed by Canada. When looking at funding compared to share of the global economy as measured by GDP, some donors provide a greater share for HIV/AIDS, others provide less.

It is important to underscore that there are limits inherent in using any one of these methodologies for assessing fair share, and none should be used on its own to rank donor support for HIV/AIDS. For example, a rank by total commitments does not capture the relative wealth of a nation. Yet the standardized GNI measure also does not take in account certain differences in the economies of countries. Outside of the HIV/AIDS field, other methodologies have been proposed or developed that are designed to capture multiple dimensions of foreign assistance through composite indexes. For example, the Center for Global Development has developed an index for assessing donor development assistance that takes into account both the amount and the quality of aid by incorporating three elements: the quantity of donor development assistance; the amount of donor assistance that comes back to donors as debt payments; and the amount of aid that is tied.

Table 6 (A-C): Assessing Fair Share

A		B		C				
G7 & EC: as Share of Donor Government Funding for HIV/AIDS, 2004 (of Combined Bilateral Commitment & Global Fund* Contribution)		G7 & EC: HIV/AIDS Funding per $1 million Gross National Income (GNI), 2004 (of Combined Bilateral Commitment & Global Fund* Contribution)		G7 & EC: Estimated Resources Available for HIV/AIDS Compared to Share of Gross Domestic Product (GDP), 2004 (of Combined Bilateral Disbursement and Global Fund* Contribution				
					Share of World GDP	Share of Global Resources for HIV/AIDS (all sources)	Share of Advanced Economies GDP	Share of Donor Government Resources for HIV/AIDS
U.S.	45.4%	U.K.	$274	U.S.	28.9%	17.4%	36.4%	37.8%
U.K.	16.6%	Canada	$194	Japan	11.5%	2.3%	14.5%	4.9%
EC	7.7%	U.S.	$137	Germany	6.7%	1.9%	8.4%	4.2%
Canada	5.3%	France	$69	U.K.	5.2%	7.7%	6.6%	16.7%
Japan	4.1%	Germany	$46	France	5.0%	2.2%	6.3%	4.9%
France	3.9%	Japan	$33	Italy	4.1%	0.2%	5.2%	0.4%
Germany	3.5%	Italy	$8	Canada	2.4%	3.1%	3.1%	6.7%
Italy	0.4%	EC	n/a	EC	n/a	n/a	n/a	n/a
Other DAC	13.2%	Other DAC	n/a	Other DAC	n/a	n/a	n/a	n/a

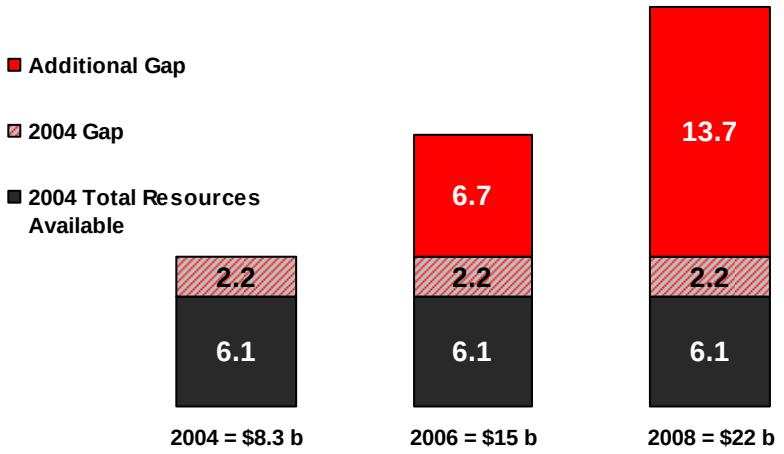
Notes: Funding for international HIV research not included; Global Fund* contributions adjusted to represent estimated HIV/AIDS share of Global Fund grant distribution by disease through 2004 (60% of total contribution); Canada's Global Fund contribution was provided in Canadian FY 2004 but outside of Global Fund FY 2004 and is counted here as part of Canada's 2004 funding for HIV/AIDS; Data from Japan, U.K., France, and certain other DAC are preliminary estimates only. Disbursements based on government reports and on historical disbursement rate data.
(see detailed methodology).
Sources: UNAIDS/KFF Analysis, June 2005; OECD CRS, June 2005; UNAIDS/PCB(14)/03, Conference Paper 2a, June 2003; UNAIDS/PCB(14)/03.3, April 29, 2003; The Global Fund to Fight AIDS, Tuberculosis and Malaria; The World Bank; U.S. Department of State, Office of the Global AIDS Coordinator; U.S. Department of Health and Human Services; U.S. Congressional Appropriations Legislation and Conference Reports; U.S. OMB, Budget of the United States Government, Fiscal Year 2006; U.S.OMB, SF 133 Reports.
GNI data imputed from: OECD, April 11, 2005 (http://www.oecd.org/dataoecd/59/51/34700392.pdf). Japan adjusted to represent average 2003-2004 GNI.
GDP data from: International Monetary Fund, World Economic Outlook Database, April 2005.

VI. Resources Available Compared to Need

Estimates of resources made available (funding commitments disbursed) for HIV/AIDS compared to need suggest that there is a significant global financing gap in the addressing HIV/AIDS and a risk that the gap could be growing. In 2004, an estimated $6.1 billion was made available for HIV/AIDS from all sources (two thirds of which was from international donors; about 39% was provided by the G7 and EC).[7,8,16] UNAIDS has estimated that $8.3 billion was needed to address HIV/AIDS in low and middle income countries in that same year, resulting in a financing gap of at least $2.2 billion (this $8.3 billion need figure should be considered a lower-bound estimate, since it did not include infrastructure costs and costs for all interventions). New figures from UNAIDS project that need will rise to $15 billion in 2006 and $22 billion in 2008.

To both fill the gap in 2004 and further meet these projected needs, an additional $8.9 billion ($2.2 + $6.7) would have to be made available by 2006, rising to $15.9 billion ($2.2 + $13.7) in 2008. Even if available funding from all sources were to double over its 2004 level by 2006, reaching $12.2 billion, it would still fall short of estimated need (see Figure 7).

Figure 7: The Funding Gap: Resources Available for HIV/AIDS Compared to Estimated Need, 2004 - 2008 (US$ billions)



Sources: UNAIDS/KFF Analysis; UNAIDS, 2004 Report on the Global AIDS Epidemic, July 2004; UNAIDS, Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries, PCB17 Conference Paper, June 27-29, 2005.

VII. Conclusion

As this paper has demonstrated, funding for HIV/AIDS from the G7 and EC represents the bulk of donor government funding for addressing the epidemic in low and middle income countries, and a significant share of overall global HIV/AIDS funding. Funding for HIV/AIDS has risen over time and indications are that it will likely continue to do so. However, the latest estimates from UNAIDS suggest that a significant financing gap remains, one which could grow over time; with each year of funding lag, more people will become infected with HIV and treatment needs will grow. Yet current funding decision frameworks by donors and others generally operate within compressed time frames, often defined by annual, biennial, or otherwise short-term funding cycles. Even the newer financing mechanism offered by the Global Fund is similarly dependent on contributions from donors that operate within these same, generally limited financing time frames. Moreover, even if current resources were to double over the next 2-3 years, a financing gap would remain. Given that the crisis of HIV/AIDS is of nearly unprecedented magnitude, and requires both a short-term and long-term response to make a sustained difference, there is a need for innovative thinking about ways to leverage and enhance donor assistance. In some cases, this could mean the modification of existing aid mechanisms; in others, there may be new mechanisms that could better sustain and build upon the response. Regardless, this is an endeavor that no one donor, or aid recipient, can achieve on their own.

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[58] UNAIDS, *Press Release, WFP Becomes Ninth Cosponsor of UNAIDS*, October 16, 2003.
[59] UNAIDS, *Unified Budget and Workplan 2006–2007*, UNAIDS/PCB(17)/05.4, June 27-29, 2005.
[60] After adjustment by 60% to represent an HIV/AIDS share of Global Fund grant distribution.

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