

# Update on the Impact of the Economic Crisis

## HIV Prevention and Treatment Programmes



# **Update on the Impact of the Economic Crisis: HIV Prevention and Treatment Programmes**

**December 2009**



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The report draws on the following five sources of information:

- UNAIDS Country Coordinators
- Civil Society Organizations-members of the UNAIDS Programme Coordinating Board
- Fourteen country-case studies commissioned by the UNAIDS Secretariat
- UNAIDS co-sponsors' information on their work concerning the impact of the global crisis
- Interviews with the Global Fund and the five largest bilateral funders of HIV programs (accounting for over 85% of international AIDS flows).

This report owes much to the contribution of the UNAIDS Country Coordinators who have provided timely and extremely useful information that helped document the impact of the global crisis on HIV and AIDS programs worldwide.

## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AP	Asia and Pacific
ART	Antiretroviral treatment
ARV	Antiretroviral drugs
CBO	Community based organizations
CSO	Civil Society Organizations
ECA	Eastern Europe and Central Asia
ESAF	Eastern and Southern Africa
HIV	Human Immunodeficiency Virus
IDUs	Injecting drug users
IMF	International Monetary Fund
LAC	Latin America and Caribbean
MARP	Most-at-risk population
MDG	Millennium Development Goals
MENA	Middle-East and North Africa
MSM	Men who have sex with men
NGO	Non-governmental organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UCC	UNAIDS Country Coordinators
SSA	Sub-Saharan Africa
SW	Sex workers
WCA	Western and Central Africa
WHO	World Health Organization

## Executive Summary

The global economy is showing tentative signs of recovery, but the crisis impact, coinciding with growing attention to competing health and development priorities, risks eroding funding for HIV. This, with external shocks like drought in Africa, has the potential to overturn recent gains in HIV prevention and life expectancy.

To find out whether the risk to HIV responses was real, short surveys of the perceived impact of the crisis elicited rapid responses from a key informant in each of 71 countries in March 2009 and 63 countries in July/August 2009.<sup>1</sup> The July/August monitoring was expanded to include information from four other sources: (i) a survey of 457 Civil Society Organisations (CSOs) which provided a range of insights into the effects of the economic crisis; (ii) case studies of 14 countries; (iii) analysis of the impact of the crisis by other UNAIDS co-sponsors and (iv) interviews with the six largest funders of HIV and AIDS.

The information suggests that **the impact of the global crisis on HIV programs worsened during 2009**. Among the 50 countries for which there is information in both March 2009 and July/August 2009 surveys, the number where antiretroviral treatment was perceived to have been affected already rose from four to nine countries. There was a sharp increase between the two surveys in respondents saying they expected an impact in the country in the coming 12 months: from 26% in March to 46% in July/August for antiretroviral treatment, home to 1.9 million people on treatment. For HIV prevention programs, the rise in respondents who expected an impact rose from 48% in March to 56% in July/August 2009, when prevention programs in 19 countries (30%) were reported to have been affected already.

**Responses from CSOs surveyed in August/September 2009 depict a similar impact:**<sup>2</sup> 59% reported an impact on prevention and 53% on treatment. Nearly three-quarters said their capacity building and developmental efforts had been compromised, 65% that their outreach to key populations was affected.

**The global crisis is affecting many countries' plans for reaching universal access.**

**Prevention programs** are expected to be affected by reduced funding with strong repercussions for CSO activities. Concern is greatest for prevention programs for sex workers and men having sex with men, voluntary counseling and testing, and interventions to reduce stigma and empower young people.

**Treatment:** Respondents expect slower treatment scaling up or no increase in access in 27 countries. In three countries respondents worry that 26,000 people already on treatment may lose treatment access. In countries with large and growing numbers of people who need treatment, unanticipated shortfalls in funding are forcing difficult choices -- not enrolling any new patients, or starting treatment only for the most "critically ill" whose CD4 counts are below 150/mm<sup>3</sup> instead of the current guideline of 200/mm<sup>3</sup>, despite evidence that survival chances are better if treatment starts at much higher CD4 counts (the new WHO guideline is 350/mm<sup>3</sup>).

**The impact of the crisis varies greatly by region.** West and Central Africa is perceived to be particularly exposed through funding cuts, declining household incomes, and worsened food security. Eastern Europe and Central Asia has the largest percentage of countries said to be affected through sharp declines in GDP

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<sup>1</sup> A short survey on the impact of the economic crisis on country's HIV/AIDS programs (especially funding) was sent to UNAIDS Country Coordinators (as well WHO and World Bank staff in March). The March survey results were reported in "The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact". July 2009. UNAIDS and the World Bank.

<sup>2</sup> 457 CSOs responded to the survey organized by UNAIDS and 80 completed the survey in full. These CSOs represent a wide range of organizations in 75 countries.

growth and devaluations that have increased the cost of imported antiretroviral drugs. There is relatively little perceived or expected impact in Latin America and in the Asia and Pacific region, reflecting lower HIV prevalence, early economic recovery in Asia, and strong commitment of some governments to providing treatment.

**The perceived impact of the crisis occurs in several ways.** The decline in economic growth worldwide has cut employment, reducing household earnings and remittances and increasing poverty. This affects people's ability to remain on treatment by making it more difficult to afford health care and travel costs, or to eat enough to be able to take ART.

The crisis has affected the capacity of donor governments to provide external aid and of affected countries to fund HIV responses through domestic public spending. UNAIDS respondents in 21 countries report that cuts in external funding for 2010 have been announced (less than 10% in 4 countries, 10-25% in 14 countries and 26-50% in 3 countries). The five-year reauthorization of the U.S. PEPFAR program in 2008 and Global Fund replenishment in the same year have helped buffer HIV funding from these two main sources, but even this support is not entirely certain for the near future. Respondents noted substantial uncertainty in July/August about future funding levels: 66% of the 41 respondents who reported no cut in external aid yet viewed cuts as probable or highly probable, and 62% of the 50 respondents who reported no government budget cuts deemed them probable or highly probable in upcoming year.

**Governments are reported to be taking various actions to try to sustain HIV responses, including:**

- *Trying to mobilize additional funding* through advocacy with development partners, developing a national Trust Fund or Solidarity Fund for HIV/AIDS, and exploring more use of user fees and/or health insurance to pay for antiretroviral treatment
- *Cutting budgets and expenditures, and/or rationalizing interventions and reducing inefficiencies:*
  - Looking for technical efficiencies in the HIV and AIDS response
  - Merging agencies or other institutional reforms to reduce costs
  - Cutting spending in areas deemed unnecessary or ineffective and imposing stricter rules on operational spending
  - Creating a centralized national procurement system for antiretroviral drugs and prevention commodities and improving drug supply chain management
  - strengthening fiduciary systems
- *Rethinking strategic plans:*
  - Integrating HIV and AIDS in broader national planning
  - Developing a strategy for the health system that takes account of the impact of the crisis
  - Revising existing national AIDS strategies and annual action plans and their costs to take account of the impact of the crisis

#### **Perceived Needs for Assistance**

Respondents in 75% of the countries see a need for external technical assistance to help countries face the current crisis, in the following areas:

- **Strategic planning**, including developing better strategic plans for HIV and AIDS, prioritizing programs for scaling up, and strengthening management systems
- **Building strong monitoring and evaluation systems** to generate strategic evidence to inform policy making and program decisions

- **Improving resource allocation and efficiency of interventions**, prioritizing programs in the context of scarce resources, analyzing the cost-benefit of interventions, and defining efficient intervention packages for the most-at-risk groups
- **Assessing the impact of the global crisis and possible coping mechanisms. Mobilizing external assistance through renewed advocacy**
- **Strengthening the capacity of civil society** to deliver efficient services, especially organizations serving most-at-risk groups and networks of PLHIV
- **Strengthening social protection packages for poor households**
- **Strengthening the health sector**, including improving supply management of antiretroviral drugs

Overall, the results from the March and July/September monitoring of the impact of the global crisis on HIV funding and programs suggest that the HIV and AIDS response has reached a turning point. The challenge facing an increasing number of countries is how to sustain increased access to prevention and treatment in a context of greater resource scarcity. This suggests the need for the following actions:

- Countries affected by the HIV epidemic should: (i) conduct more rigorous evaluations to discover which investments in prevention generate results; (ii) improve the cost-effectiveness of interventions by focusing on reducing costs in the immediate future; (iii) improve the allocation of resources by ensuring that budget cuts do not affect predominantly prevention areas that are crucial for reversing the course of the epidemic; (iv) expand social safety nets to include people living with HIV and most affected by the epidemic; (v) actively engage with funders to clarify changes in funding; and (v) pursue options for ensuring that the HIV and AIDS response is sustainable over the long-term.
- External funders of the HIV and AIDS response should: (i) strengthen consultations among major funders to prevent unintended results from the combined effect of their individual decisions and actions in response to the crisis; (ii) ensure that funding policy changes do not leave essential areas unfunded; (iii) ensure that synergies between health and HIV programs in areas such as sexual and reproductive health and tuberculosis are fully realized; and (iv) support initiatives to systematically evaluate the impact of prevention interventions to fill the current knowledge gaps.

## Introduction

As the severity of the global crisis became apparent, there was growing concern about its potential impact on HIV and AIDS responses around the world. In 2008 and 2009, economic growth and trade declined, unemployment rose, and earnings and remittances declined. The results are felt worldwide. They affect the ability of households to afford health care, exacerbated in some countries by external shocks such as drought or floods which worsened food security and access to adequate nutrition – a key component of antiretroviral treatment. Lower government revenues and higher deficits raise the possibility of declining government expenditures on health and HIV and AIDS, and of reduced external support from by high income countries for HIV prevention and AIDS treatment. This would reverse the tremendous gains attained worldwide in scaling up the HIV and AIDS response.

These considerations prompted the World Bank and UNAIDS Secretariat to monitor the impact of the global crisis on developing countries affected by HIV and AIDS. In March 2009, UNAIDS, the World Bank and WHO carried out a survey of their in-country staff.<sup>3</sup> This was followed in July/September 2009 by expanded monitoring covering UNAIDS Country Coordinators, civil society organizations, key donors, and UNAIDS co-sponsors. The results from this monitoring effort are discussed in this report.

### Structure of the report

**Section I** summarizes briefly how the economic crisis had affected the developing and emerging economies by late 2009.

**Section II** describes the perceived impact of the crisis on the HIV and AIDS response in late 2009. It discusses which components are viewed by respondents to be most at risk and the channels through which the global crisis affects HIV and AIDS responses.

**Section III** assesses how the reduction in funding is likely to affect HIV and AIDS programs in regions and summarizes the implications for universal access.

**Section IV** summarizes how countries and the international community are attempting to adjust to the crisis.

**Annex 1** compares the March and July UNAIDS Country Coordinators' surveys.

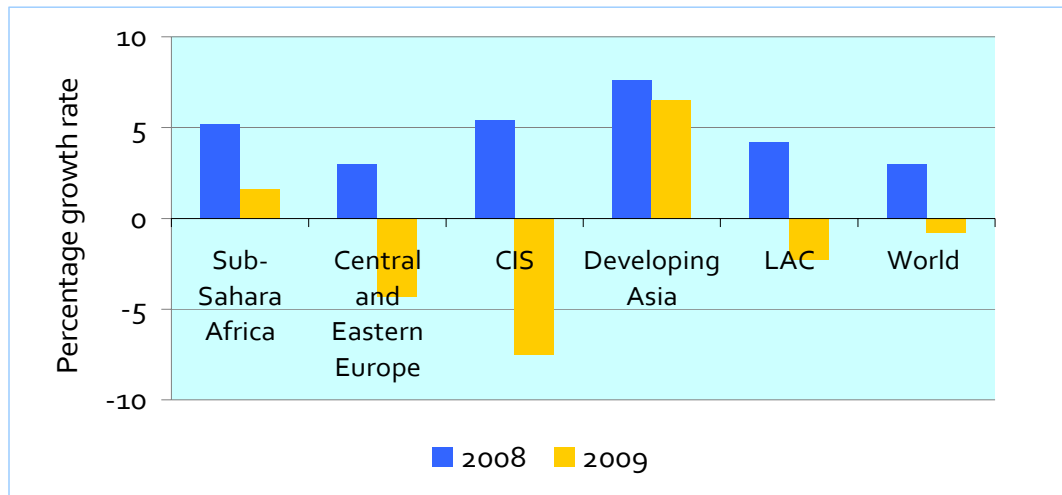
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<sup>3</sup> See: "The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact". World Bank and UNAIDS. July 2009.

## 1. The Global Economic Crisis

The financial crisis that began in 2008 spread across the world as a broad economic crisis. In Sub-Saharan African countries, declines in exports and lower tourism earnings and worker remittances reduced GDP growth to well below 2% in 2009 (Figure 1.1), resulting in a fall in GDP per capita for the first time in a decade. The economies of Central and Eastern Europe and the Commonwealth of Independent States were especially hard hit by the crisis with their GDP contracting sharply in 2009. GDP also declined in Latin America and the Caribbean in 2009 (IMF World Economic Outlook 2010).

**Figure 1.1: Overview of world and regional GDP growth (Annual percentage change in real terms)**



Source: IMF World Economic Outlook. January 2010

Note: CIS= Commonwealth of Independent States; LAC = Latin America and Caribbean

**Although global recovery is better than earlier projections, it is variable across regions and countries are still fragile.**<sup>4</sup> There are concerns that the economic recovery is highly dependent on stimulus packages, that real output in high income countries will take several years to recover to pre-crisis levels,<sup>5</sup> and that uncertainty and weak access to credit in the private sector will deter new hiring. These factors would tend to depress international trade, external aid and remittances – important factors affecting households' standards of living in low and middle-income countries.

**The current crisis could have long-term effects on human development and the HIV epidemic.** Especially in Sub-Saharan Africa where large portions of populations are clustered around the poverty line, output and employment losses can have a big impact on poverty. When households are pushed into poverty, health conditions deteriorate. These effects may be short-term if the economic recovery accelerates, but the specific characteristics of HIV raise concerns about long-term impacts.

**Reduced prevention efforts and treatment interruptions are likely to have a permanent impact.** Reduced prevention efforts in the short-term may increase new infections and HIV prevalence. Given the long-term nature of the HIV epidemic, the impact will be felt for many years to come. Reduced access to antiretroviral treatment may boost HIV transmission and will worsen survival rates of adults with HIV -- adversely impacting their children's long-term welfare. Both consequences indicate that

<sup>4</sup> The latest (higher than earlier) IMF projected 2010 global GDP growth is 3.9%, 2% in advanced economies, 6% in emerging and developing economies. IMF World Economic Outlook. January 2010.

<sup>5</sup> An IMF analysis of 88 banking crises over the past four decades found substantial lost growth: on average, seven years after the onset of a crisis, output was almost 10% below the level where it would have been without the crisis. IMF World Economic Outlook. October 2009.

without corrective interventions, the achievements of recent years will be lost with potentially severe consequences for economic and social development in low and middle-income countries over the long-term.

How real are these risks? To find out, monitoring of the impact of the global crisis on the HIV and AIDS response in low and middle-income countries was initiated in March 2009 and continued in July-September 2009. The findings are discussed in the following section.

## 2. Perceived impact on HIV and AIDS response

The objective of the monitoring started in March 2009 was to gather information on the potential risks to HIV and AIDS programs of the global economic crisis. The initial effort was modest: a short survey asked in-country staff of UNAIDS, the World Bank and WHO whether and how the global crisis had already affected prevention and treatment programs in the country in which they worked, and whether they expected an impact over the next 12 months.

A follow-up monitoring survey in July/August 2009 elicited responses from 63 UCCs in countries where two-thirds of the people with HIV globally live. Survey questions were added on the government budget, external aid, to obtain information to corroborate UCCs' perceptions and four additional information sources were also used to assess the impact of the crisis.

- (i). A survey of 670 Civil Society Organizations (CSO) undertaken in August-September 2009. A total of 457 CSOs answered the questionnaire and 80 completed it fully.
- (ii). Case studies of 14 countries: Ethiopia, Burkina Faso, Senegal, and Tanzania in Africa; Indonesia and Philippines in Asia; Dominican Republic and Trinidad and Tobago in the Caribbean; Argentina, Brazil and Mexico in Latin America; and Belarus, Romania and Moldova in Eastern Europe.<sup>6</sup>
- (iii). Analysis of the impact of the crisis done by other UNAIDS co-sponsors.
- (iv). Interviews in September 2009 with the Global Fund and five other largest bilateral funders of HIV and AIDS programs (together accounting for 83% of international assistance for HIV).

Results presented in this document are mainly derived from the July/August 2009 survey of UNAIDS Country Coordinators (UCC). Data from other sources of information are used to crosscheck as much as possible UCC responses and complement the information they provided. The resulting analysis is still subject to possible bias as the information collected represents the opinions of the surveyed correspondents. Thereby the survey results should be interpreted with caution. Nevertheless, as will become more evident in the following sections, the UCC responses are largely consistent with other sources of information and press reports. Overall, the information provided by the surveyed respondents provides a rich basis for assessing the impact of the crisis on HIV and AIDS programs.

Another limitation of the rapid assessment survey data is that they show the number of countries where respondents report or expect an impact, but no indication of the severity of the impact. It would be useful to complement the survey results with more detailed country-specific analysis of the impact of reported budget cuts on new infections and AIDS-related mortality.

### Comparison of the March and July/August 2009 surveys

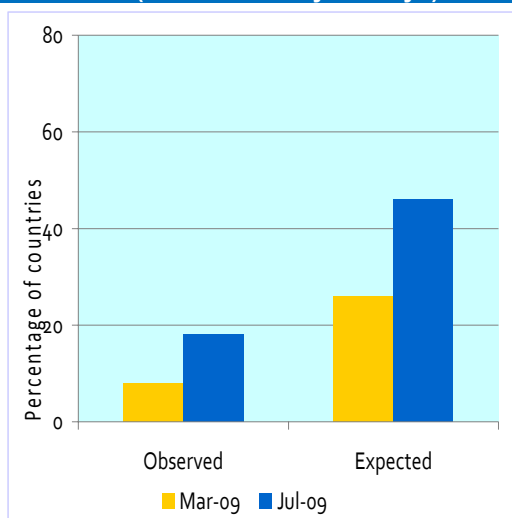
The March 2009 survey elicited responses from UNAIDS Country Coordinators (UCCs) and WHO health officers in 71 countries.<sup>7</sup> In the July/August survey, UNAIDS UCCs in 63 countries responded. Looking only at the 50 countries for which there are responses in both surveys (see Annex 1), Figures 2.1 and 2.2 show the significant increase in the percentage of countries where impact is reported or expected within 12 months.

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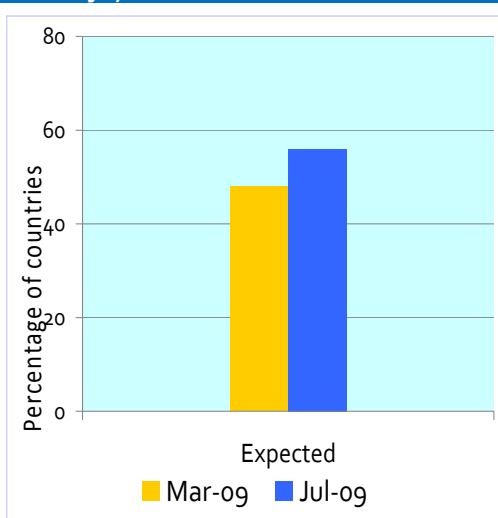
<sup>6</sup> The executive summaries of the country case-studies can be consulted on the UNAIDS webpage on the Impact of the Global Economic Crisis on HIV Prevention and Treatment Programmes [http://www.unaids.org/en/PolicyAndPractice/Global\\_economic\\_crisis\\_impact\\_AIDS\\_response.asp](http://www.unaids.org/en/PolicyAndPractice/Global_economic_crisis_impact_AIDS_response.asp)

<sup>7</sup> The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact. UNAIDS and World Bank, 2009.

**Figure 2.1: Comparison of the reported and expected impact on antiretroviral treatment (March and July Surveys)**



**Figure 2.2: Comparison of the expected impact on prevention (March and July surveys)**



Source: UNAIDS Country Coordinators' Survey, March and July/August 2009; including only 50 countries that provided responses in both surveys.

*Note: The March survey does not provide information on the observed impact on prevention which would allow a comparison with the July survey.*

**Respondents in far more countries report an impact on antiretroviral treatment and expect an impact in the coming 12 months (Figure 2.1).** The percentage of countries where treatment programs were perceived to be already affected rose from 8% in March to 18% in July 2009. Most of the increase was in Sub-Saharan Africa, consistent with the spread of the economic crisis in that region (Annex 1). The percentage of countries where respondents expected an impact on treatment in the next 12 months rose from 26% in March to 46% in July 2009.

**More respondents are worried about prevention (Figure 2.2).** The percentage of countries where respondents expect prevention programs to be affected during the next 12 months increased from 48% in March to 56% in July 2009.<sup>8</sup>

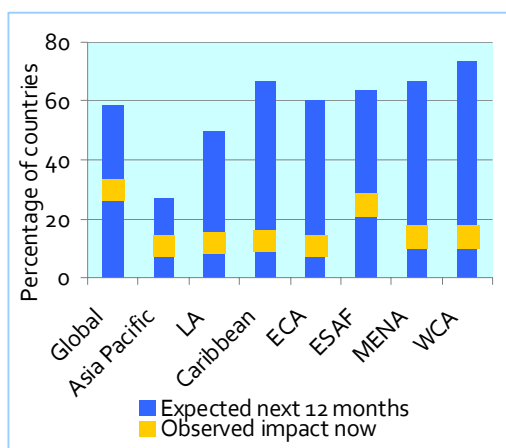
### Expected Impact on HIV and AIDS Programs, July/August Survey

The July/August UCC survey included additional questions probing the basis for respondents' perceptions of impact. In particular, they were asked whether government budgets and external aid had been cut and if yes, by how much. Open-ended questions were also added on how governments were responding to the crisis and what type of technical assistance might be needed.

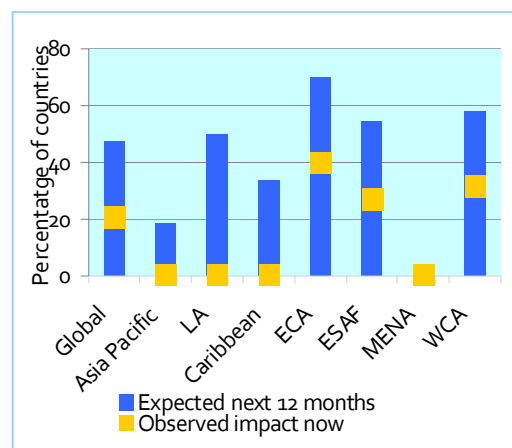
**Impact on prevention.** Respondents in 30% of the countries reported that there had already been an impact on prevention, and nearly twice as many -- 59% -- expected an impact over the next 12 months (Figure 2.3). These 37 countries are home to 75% of people living with HIV globally. Asia and Pacific is the only region where relatively few respondents expected an impact (respondents in 27% of countries).

<sup>8</sup> The March survey did not ask whether prevention had already been impacted, thereby no comparison with responses to this question in the July/August 2009 survey is possible.

**Figure 2.3: Percentage of countries in each region where impact on prevention is reported, and expected in next 12 months**



**Figure 2.4: Percentage of countries in each region where impact on treatment is reported, and expected in next 12 months**



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: LA= Latin America; ECA = Eastern Europe and Central Asia; ESAF= Eastern and Southern Africa; WCA=Western and Central Africa; MENA = Middle-East and North Africa.

**Impact on treatment.** In 21% of countries – all in sub-Saharan Africa – respondents said there had been an impact on antiretroviral treatment already. More than twice as many (48%) expected an adverse impact during the next 12 months (Figure 2.4).

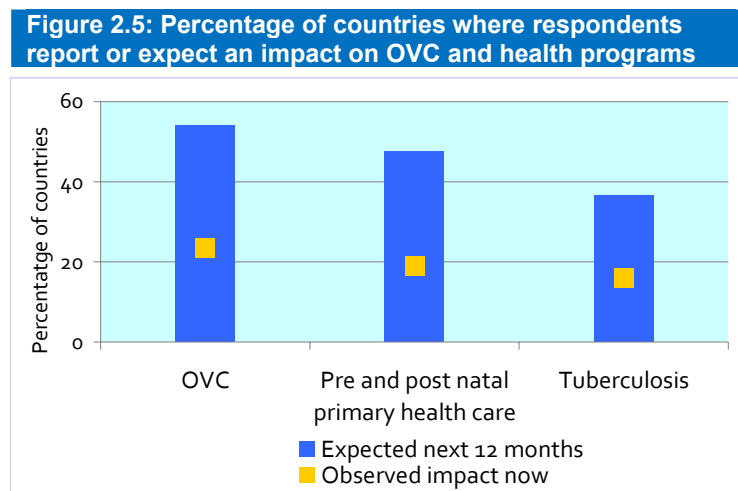
**Concern about antiretroviral programs varies greatly among regions.** Concern is non-existent in North Africa and the Middle-East, largely because there are few people on treatment allowing the government budget to continue to fund their treatment. Concern is extremely high in ECA where 70% of the countries are expected to be affected. A factor explaining such a high percentage is the severity of the economic recession in these countries (Figure 1.1). In total, over 1.9 million people on treatment live in the 30 countries which respondents expect to be affected during the next twelve months (Table 2.1).

**Table 2.1: Numbers of countries and people on treatment where impact is expected on antiretroviral treatment**

	Number of countries expected to be affected	Number of people on treatment
Asia and Pacific	2	172,000
Caribbean	1	12,000
Eastern and Southern Africa	6	1,407,500
Eastern Europe and Central Asia	7	76,000
Latin America	3	46,500
North Africa and Middle-East	0	0
Western and Central Africa	11	225,200
Total	30	1,939,200

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

**Impact on mitigation and health programs.** Respondents reported an impact on programs for orphans and vulnerable children in 24% of the countries and expected an impact within 12 months in 54% of countries. Figure 2.5 also shows perceptions about pre- and post-natal primary health care and tuberculosis programs.



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Expected impact varies across regions (Table 2.2):

- The only region where no effect was reported and none expected was North Africa and the Middle East.
- Concerns about OVC were highest in Eastern and Southern Africa, followed by Western and Central Africa, reflecting the impact of the AIDS epidemic on parental deaths in these regions.
- Pre- and post-natal primary health care programs are of great concern in Eastern Europe and Central Asia as well as in Western and Central Africa.
- Concerns about tuberculosis are predominant in Latin America and Eastern Europe and Central Asia.

**Table 2.2: Percentage of countries in each region where OVC, natal care and tuberculosis are expected to be affected<sup>1/</sup>**

	Asia and Pacific	Caribbean	ESAF	ECA	LA	MENA	WCA
OVC	27%	67%	82%	40%	33%	0%	74%
Pre and post natal care	9%	33%	55%	70%	33%	0%	68%
Tuberculosis	9%	33%	46%	50%	50%	0%	42%

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Notes: 1/ ECA = Eastern Europe and Central Asia; ESAF = Eastern and Southern Africa; LA = Latin America; MENA = Middle-East and North Africa; WCA = Western and Central Africa.

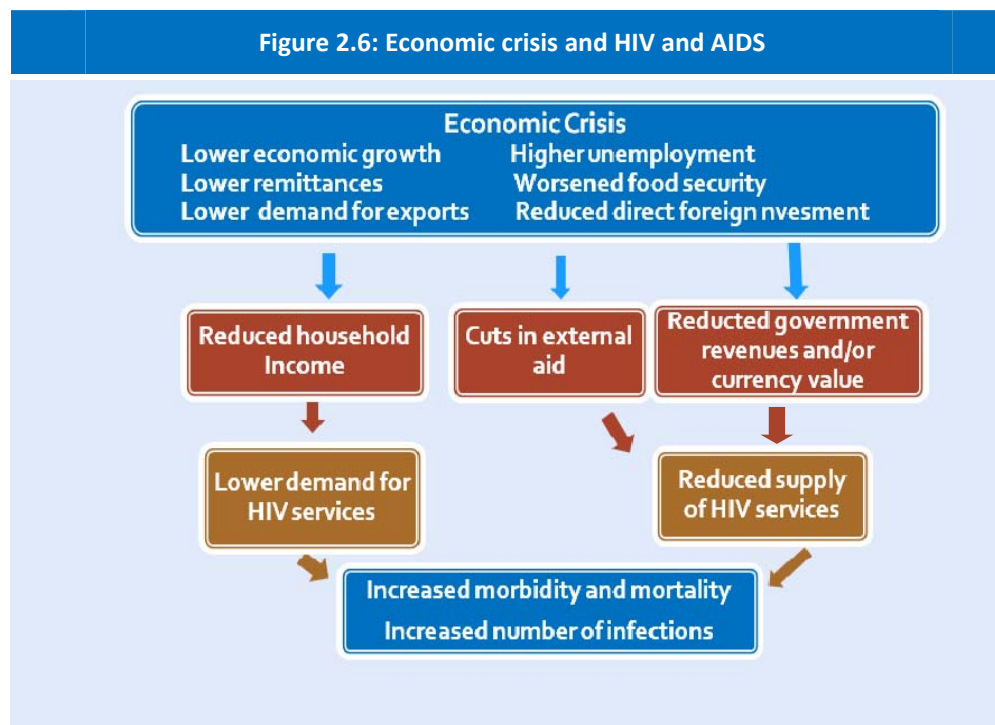
It is worrying that respondents expected an adverse impact on prevention in so many countries, which are home to 75% of the total number of people living with HIV and 59% of the people receiving treatment in the 63 countries surveyed. Does the high percentage reflect respondent bias, or spreading or intensified impact of the global crisis? A partial answer to this question is provided by the analysis of the factors perceived to affect the HIV and AIDS response.

## Key Factors Affecting the HIV and AIDS Response

In poor countries, previous economic recessions generally have been found to worsen education and health outcomes.<sup>9</sup> In the current crisis, there have been unprecedented efforts to protect health and education, but the global extent of this crisis poses an additional risk for HIV and AIDS responses, which are heavily aid-dependent. The crisis and resulting need to finance large stimulus packages has reduced financial capacity of high income countries to provide developing countries with increased financial assistance to cushion the crisis impact.

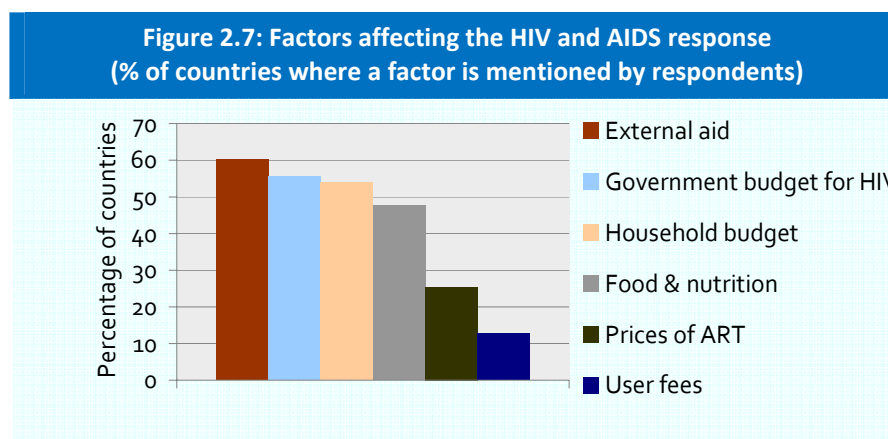
The impact is amplified by other trends which would have taken place even in the absence of the global economic recession. These include a slowing (and perhaps reversal) in the increase in external aid for HIV and AIDS, new concerns such as the H1N1 epidemic, and changing priorities that affect the way aid for health is allocated. The effect of the crisis was also magnified by other external shocks such as a severe drought in some African countries which worsened food security, making it more difficult for people on antiretroviral treatment to take their medications, which must be taken with food.

It is not possible to disentangle the effect of the crisis on HIV prevention and treatment from the other factors occurring at the same time, which needs to be kept in mind. The pathways through which economic crisis can affect prevention and treatment are summarized in Figure 2.6 and discussed in the following paragraphs.



<sup>9</sup> See Ferreira and Schady 2008. By contrast, some studies found improvements in richer countries; for instance, high school graduation rates rose in the United States during the great economic depression (Goldin 1999).

**Decline in external aid** is the factor most cited by respondents (60%) followed by lower government budget for HIV and AIDS (56%), reduced household income (54%) and worsened food and nutrition (48%). Higher prices for ART and related supplies (as a result of exchange rate devaluations) and increased user fees are listed by relatively few respondents (Figure 2.7).



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

**The factors perceived to affect countries vary greatly across regions (Table 2.3):**

- Reduced **household income** is mentioned most frequently in the Caribbean, Latin America, Western and Central Africa and Eastern and Southern Africa. The private health sector is a major supplier of services in these regions, making household income an important determinant of health care access.<sup>10</sup>
- **Nutrition** is the most frequent concern in Eastern and Southern Africa and in the Caribbean. In parts of Africa, droughts are adversely affecting access to food, which is essential for taking antiretroviral treatment. Press reports document examples of patients discontinuing treatment either temporarily or permanently because of hunger.<sup>11</sup>

**In the words of one Civil Society respondent:** *“We work at the rural area for the rural women. Each time we have HIV programs, the people do not heed any form of invitation because of high level of hunger arising from poverty. We are always told: “we want to eat first before a disease kills us”*

<sup>10</sup> The importance of household and government spending is highlighted by recent data. In 2008 disbursements from bilaterals and multilaterals reached \$7.7 billion and funding from households and local governments amounted to an estimated \$6.1 billion (46% of total). UNAIDS, 2008.

<sup>11</sup> “Uganda: hungry HIV-positive patients abandon ARVs.” IRIN Plus News. August 18 2009.

**Table 2.3: Factors causing or expected to affect the HIV and AIDS response (% of affected countries in each region where factor is listed by respondents )**

Regions <sup>1/2/</sup>	AP	Caribbean	ESAF	ECA	LA	MENA	WCA
Household income	27%	100%	55%	50%	50%	33%	69%
Food and nutrition	18%	100%	64%	30%	33%	0%	68%
External Aid	18%	67%	55%	70%	50%	67%	84%
Government budget	27%	67%	64%	60%	50%	33%	68%
Prices for ART	0%	67%	18%	50%	17%	0%	32%
User fees	9%	67%	0%	20%	0%	0%	16%
Private sector provision of services	0%	67%	27%	30%	0%	33%	58%

The ranking of each factor mentioned by the highest percentage of respondents in a region (and by at least 50% of respondents).
  The ranking of each factor mentioned the second most frequent by respondents in a region (and by at least 25% of respondents).

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Notes: 1/ AP = Asia and Pacific; ECA = Eastern Europe and Central Asia; ESAF = Eastern and Southern Africa; LA = Latin America; MENA = Middle-East and North Africa; WCA = Western and Central Africa.

- Concern about external aid** is a major factor in every region except Asia and the Pacific that show less strain. In ECA and Latin America respondents fear that cuts in external support affecting drug users and other high risk groups may not be replaced by government funding because of weak political support for these groups. In Western and Central Africa, a general concern is that governments will be fiscally unable to offset reduced external aid.
- Government funding** is the most frequently mentioned factor in Eastern and Southern Africa, where HIV and AIDS programs account for a substantial share of government health expenditures and there is a fear that the government budget will be cut in response to lower government revenues.
- Concern about the cost of AIDS drugs is high among respondents in Eastern Europe and Central Asia and the Caribbean.** Exchange rate devaluations and higher inflation have resulted in higher domestic prices for imported antiretroviral drugs and other supplies, an important factor in Eastern Europe and Central Asia where private health expenditures accounted for 40% of total health expenditures in 2006.<sup>12</sup> In some countries, the increased cost creates a risk that health insurance funds will run out of money.
- Most respondents in Asia and Pacific are slightly concerned about the impact of the crisis,** consistent with early signs of economic recovery in Asia. However, respondents in two countries express concern about government budgets and falling household incomes.

<sup>12</sup> World Health Organization Statistical Information System

### Box 2.1: Country specific examples

In one **Eastern African country**, staple food prices rose 300% in 2008, and a drought struck in 2009. Several development partners have said that their AIDS funding in 2010 will remain at the 2009 level. Increasing demand for antiretroviral treatment and flat budgets are resulting in drug shortages. Only 17.5% of facilities surveyed by a large NGO between January and April 2009 had antiretrovirals and cotrimaxazole in stock.

In the **Caribbean**, one country reported that HIV programs were affected by rising food prices and reduced government expenditure across the board, including HIV. As a result, no new programs in prevention and support to NGOs had been initiated.

In **Eastern Europe and Central Asia**, one respondent reported that the country's exchange rate devalued in March 2009 causing an increase in imported drug prices of between 20 and 30%. In one country, a 10% cut in the government budget for 2010 budget was reported, which was expected to affect the provision of medical services. Many respondents in this region noted uncertainty about future levels of external aid which is a major source of funds for HIV prevention programs targeting most-at-risk groups.

In **Western and Central Africa**, in one country that exports oil and other minerals, budgetary cuts, including for HIV were reported, and difficulty accessing aid given the country's high middle-income status. In other low income countries, reduced household incomes due to declining remittances (50% reported for one country) and lower economic activity levels were perceived as key factors, with limited scope for increasing budgetary revenues, these countries are reported not to have the budgetary resources to offset any shortfalls in external aid for HIV and AIDS.

- **Reduced job security and social protection.** The ILO staff survey conducted in 2009 confirmed that the global economic crisis negatively affected workplace HIV prevention, treatment and care programmes. The jobs crisis affects some economic sectors disproportionately than others with job losses, increasing job informalization, and reduced job security seen as increasing risks of HIV transmission. Nearly all countries recognize the need for strengthening livelihood support for HIV prevention and treatment, and social protection to mitigate the impact of the crisis on HIV affected households across all regions.

### Box 2.2 The Global Jobs Pact Initiative

Adopted by the International Labour Conference in 2009, "Global Jobs Pact" calls on governments and organizations representing workers and employers to work together to collectively tackle the global jobs crisis through policies in line with the ILO's Decent Work Agenda. The pact was adopted against a backdrop of a recent report by the ILO showing an unprecedented increase in unemployment globally and a persistence of very high levels of poverty.

The Global Jobs Pact sets forth a comprehensive set of crisis response measures based on tested policies aimed at stimulating economic recovery, generating jobs, and providing security for working people. It specifically recognizes that workplace programmes on HIV/AIDS are a key area in responses to the crisis. One central objective of the Global Jobs Pact is to shorten the 4-5 year time-lag that is likely to occur between economic recovery and employment recovery. By the same token, implementing the Pact is an important strategy to avoid major setbacks on the way to achieving the internationally agreed development goals, including the MDGs, in particular on poverty reduction.

## Impact on the supply and demand for prevention and treatment

Are prevention and treatment affected by the same pathways? A preliminary answer is provided by the July/August survey questions on countries' prevention and treatment programs and some factors affecting the supply and demand of services.

Income, availability of food, cost of antiretroviral and user fees are some of the most important factors affecting the demand for treatment. Information on the factors affecting the supply side is limited to the answers concerning the availability of financial resources from external aid, user fees and the supply of services provided by civil society.

Information on prevention is more limited. On the demand side, the only information concerns the perceived role of household income. For supply, available funding and the capacity of Community-Based Organizations and Faith-Based Organizations are the two factors covered in the survey.

Table 2.4 shows the pattern of supply and demand factors listed by respondents, in countries where prevention and treatment programs are perceived to be already affected. **Treatment is seen to have been affected more by factors that impact demand.**<sup>13</sup> This suggests that lower income, worsened nutrition and rising costs need attention, in addition to sustaining funding for the supply of treatment. **The impact on prevention is through factors that affect both supply and demand,** with supply factors (reduced funding and capacity of CBOs and FBOs) noted by more respondents as affecting prevention more than treatment. These policy implications are discussed in more detail in Section IV.

Table 2.4: Factors affecting the supply and the demand for prevention and treatment <sup>1/</sup>				
	Prevention 1/		Treatment1/	
	Demand factors	Supply factors	Demand factors	Supply factors
Reductions in household income	74%		92%	
Worsened food security and nutrition			62%	
Cost of antiretroviral drugs			38%	
User fees <sup>2/</sup>			15%	15%
Cut in funding		68%		38%
Community- and Faith-Based Organizations		84%		77%

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Notes: 1/ Percentages refer to countries where programs are reported to be affected already.

2/ User fees affect both the demand and the supply of treatment.

<sup>13</sup> This is consistent with a study in Tanzania that found that supplementary food costs, transportation and fear of stigma inhibit people with HIV from accessing ART (Mshana et al 2006).

### 3. Funding and HIV and AIDS Programs

The July/August survey is based on the answers of UCC respondents which were asked whether in their opinion the global crisis was affecting the HIV and AIDS response and whether they expected an effect over the next 12 months. The answers to such questions are inherently subjective and are open to the risk that they reflect the perceptions of respondents rather than firm evidence. To address this, respondents were asked whether government and external aid funding had been cut and by how much, whether they expected a reduction in the near future and how this would affect prevention and treatment.

#### Perceived severity and uncertainty of funding

Reduction in resources for 2010 is mentioned in 27 countries (43% of all surveyed countries). As shown by Table 3.1, a cut in external aid is the most frequently mentioned factor affecting 21 countries (either as the sole factor or in conjunction with lower government funding). Reduced government funding is reported in 6 countries and in 3 more in conjunction with lower external aid.

Table 3.1: Reported reductions in resources for HIV and AIDS for 2010			
Range of reduction	Budgetary resources only	External resources only	External and budgetary resources <sup>1/</sup>
<10%	1	4	
10-25%	4	9	3
26-50%		3	
>50%	1	2	
No. of countries	<b>6</b>	<b>18</b>	<b>3</b>

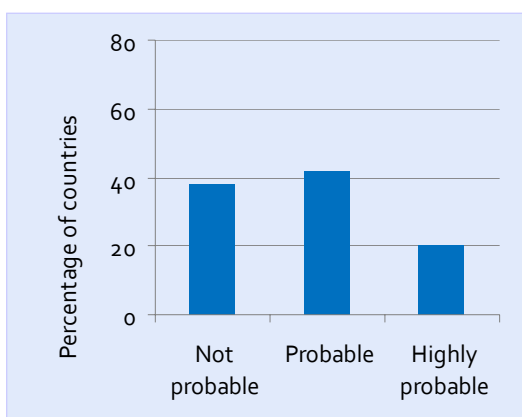
Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: 1/ Countries for which the decline in budgetary resources is the same as for external resources

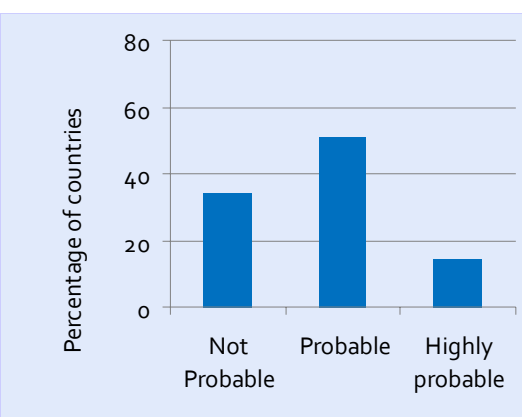
**Uncertainty about funding is high.** In 41 countries where respondents are not aware of any announced reduction in external aid for 2010, 66% judge cuts probable or extremely probable.<sup>14</sup> Similarly, in 50 countries where respondents did not report budgetary cuts, 62% viewed them as probable or highly probable (Figures 3.1, 3.2).

<sup>14</sup> Respondents who indicated that they were not aware of any reduction in funding were asked to rate the probability of funding cuts during the next 12 months.

**Figure 3.1: Perceived probability of cuts in 2010 budgetary funding for HIV and AIDS**



**Figure 3.2: Perceived probability of cuts in 2010 external aid for HIV and AIDS**



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: Respondents who were not aware of any reduction in funding for 2010 were asked to rate the probability of a reduction within the next 12 months.

### Regional impact on prevention funding

Many of the prevention programs perceived to be at risk of being cut are those that matter the most for reversing the course of the epidemic, especially in countries with concentrated epidemics. These are the programs that serve population groups most at risk of HIV infection (in the red cells in Table 3.2). Programs mentioned by respondents include:

- **Asia and Pacific (5 countries):** programs for sex workers
- **Caribbean (3 countries):** programs for MSMs, SWs, human rights and advocacy, and interventions to reduce stigma and discrimination, and violence against women
- **North Africa and Middle-East (2 countries):** programs for condom distribution, IDUs, MSMs and SWs
- **Latin America (3 countries):** programs for MSMs, human rights and advocacy and the reduction of stigma and discrimination
- **Eastern Europe and Central Asia (6 countries):** IDUs programs
- **Western and Central Africa (9 countries):** programs for sex workers
- **Eastern and Southern Africa (4 countries):** programs for sex workers

**Table 3.2: Percent of countries in each region where funding reduction is expected to affect prevention** <sup>1/ 2/</sup>

	AP	Caribbean	ESAF	ECA	LA	MENA	WCA
VCT	18%	67%	36%	20%	33%	67%	25%
Condoms	18%	67%	27%	50%	33%	67%	23%
AIDS education	18%	67%	27%	30%	33%	0%	19%
IDUs programs	18%	33%	9%	60.0	17%	67%	17%
MSM programs	36%	100%	18%	30%	50%	67%	24%
SW programs	46%	100%	36%	30%	33%	67%	28%
Human rights and advocacy	18%	100%	18%	30%	50%	33%	24%
Reduction of stigma and discrimination	27%	100%	18%	50%	50%	0%	27%
Violence against women	18%	100%	9%	20%	17%	0%	15%
Empowerment of young people	36%	67%	27%	40%	17%	33%	26%

■ The most frequently mentioned intervention in the region

■ The second most frequently mentioned intervention in each region.

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Notes: 1/ AP = Asia and Pacific; ECA = Eastern Europe and Central Asia; ESAF = Eastern and Southern Africa; LA = Latin America; MENA = Middle-East and North Africa; WCA = Western and Central Africa.

### Expected impact on treatment, care and support

UNAIDS respondents fear that antiretroviral programs in 13 countries would be affected by reductions in funding. Concerns are not limited to antiretroviral treatment but affect the broader health system. Across regions, the most frequently mentioned concerns are the following (Table 3.3):

- **Treatment** in ECA, Latin America, WCA and ESAF, and treatment for the most-at-risk groups in Asia and the Caribbean;
- **Sexual and reproductive health** in the Caribbean and North Africa;
- **PMTCT** in MENA and WCA countries; and,
- **Support to network of PLHIV** in the Caribbean and ECA.

**Table 3.3: Percentage of countries in each region where funding reduction is expected to affect treatment, care and support**

	AP	Caribbean	ESAF	ECA	LA	MENA	WCAF
ART	18%	33%	55%	70%	50%	0	58%
Other care and treatment	27%	33%	36%	60%	17%	33%	37%
Treatment for most-at-risk groups	27%	67%	27%	50%	17%	0	42%
PMTCT	9.1	33%	27%	20.0	33.3	67%	58%
Sexual and reproductive health	18.2	67%	27%	40%	17%	67%	47%
Support to PLHIV networks	9.1	67%	46%	60%	17%	0	42%

■ The most frequently mentioned concern to be impacted by funding reduction.

■ The second most frequently mentioned concern to be impacted by funding reduction.

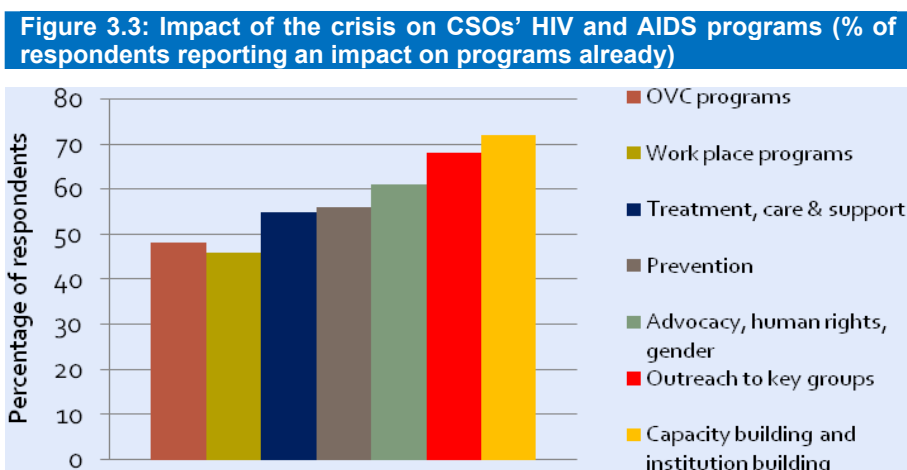
Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Notes: 1/ AP= Asia and Pacific ECA = Eastern Europe and Central Asia; ESAF = Eastern and Southern Africa; LA = Latin America; MENA = Middle-East and North Africa; WCAF = Western and Central Africa.

**Impact on civil society organizations.** In many countries, civil society organizations (CSOs) provide essential prevention and support services, especially to groups that government agencies cannot easily reach. CSOs are the expression of a dynamic response to HIV by civil society. Yet, the civil society response is often perceived to be “less essential” than the government response, making it extremely vulnerable to cuts in funding.

UNAIDS respondents expect CSOs to be affected in 62% of the countries. This result is echoed by the survey of CSOs carried out in August/September 2009. Of the 457 respondents, 80 completed the survey in full. These CSOs represent a wide range of organizations in 75 countries, whose work includes provision of ART, nutrition support, palliative care and targeted programs for high risk groups. Reduced funding is reported by 76% of CSO respondents and lower government resources by 58%. In addition, CSOs report that prevention programs funded by private enterprises are being terminated and that private donations are decreasing.

**CSO prevention and treatment programs are perceived to be nearly equally affected by the global crisis.** 59% report an impact on prevention and 53% on treatment (Figure 3.3). These percentages are much higher than the 30% of UCC survey respondents who perceive prevention to be affected or the 21% who indicate an impact on treatment. **The most affected programs** are capacity and institution building (mentioned by 72% of the respondents), outreach to key population groups, and advocacy, human rights and gender programs. In comparison, CSO programs seem more affected than other national programs.<sup>15</sup>



Source: UNAIDS survey of civil society organizations

### Universal Access

Both UCC and CSO survey respondents expect the global crisis to affect an increasing number of prevention and treatment programs over the next twelve months. This has important consequences for the goal of providing universal access to prevention and treatment services: UNAIDS respondents in 19 countries report that they are on track for reaching universal access, but they expect 32 countries to experience either a decline or a much slower scaling-up than envisaged (Table 3.4).

<sup>15</sup> For instance, the percentage of UCCs that expect programs for IDUs, MSM and sex workers to be affected vary from 27% to 44%, whereas 68% of CSOs expect outreach programs to key populations to be affected. Percentages for human rights and advocacy are 61% for CSO respondents and 38% for UNAIDS respondents.

Table 3.4: UNAIDS respondents' perceived impact of the global crisis on scaling up antiretroviral treatment programs during the next 12 months		
	Number of countries	Percentage
Declining access	6	10%
Slower scaling up	26 countries	41%
On track	19	30%
No data available	12	19%

Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

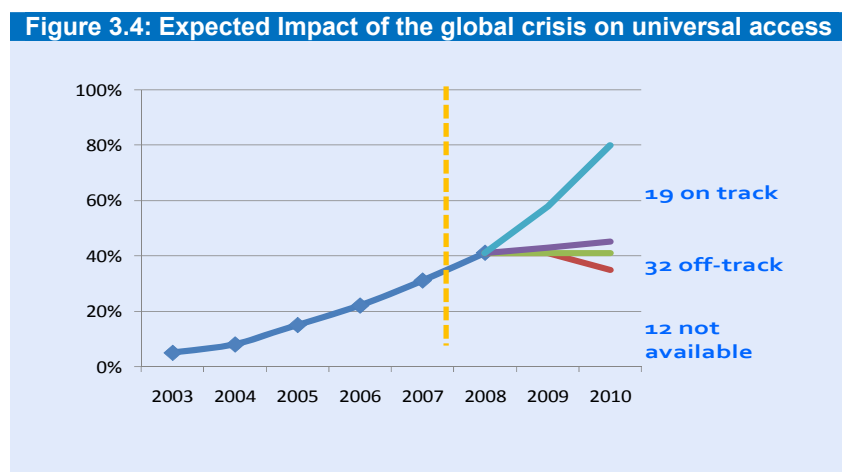
This is echoed in the CSO survey. Of the 120 CSOs that responded to this part of the survey, 14% expect to reduce their antiretroviral treatment and 42% expect either no increase in numbers of patients on treatment or slower scaling up (Table 3.5).

Table 3.5: Percentage of CSO respondents expecting an impact during the next 12 months <sup>1/</sup>		
	Prevention	Treatment
Reduction in number of clients	39%	14%
Maintenance of numbers, no scaling up	n.a.	21%
Slower scaling up	n.a.	21%

Source: UNAIDS survey of CSOs

Note: 1/ The number of responses varied between 112 and 126.

**Taken together, the results from the two surveys indicate that the universal access goal of providing treatment to 80% of those in need is under threat.** From 2002 to 2008 treatment coverage increased very rapidly and was on trend to reach universal coverage in the medium-term.<sup>16</sup> This now seems extremely unlikely for many countries (Figure 3.4). Nor does this take account of the December 2009 change in WHO-suggested criteria to start ART when CD4 cell count falls to 350 cells/ml<sup>3</sup> rather than 200.<sup>17</sup> Respondents in 38% of the countries, home to 45% of the people currently on treatment, view the feasibility of implementing these changes as improbable (Figure 3.5).



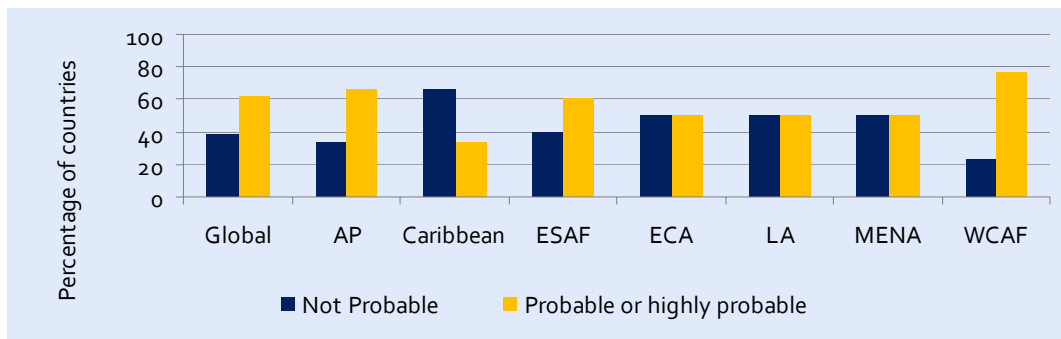
Source: WHO report "towards universal access" for 2003-2008.

Note: Projections after 2008 are illustrative only as the data do not allow projections of access to prevention and treatment services.

<sup>16</sup> Coverage is defined as the percentage of people in need of therapy who have access to antiretroviral treatment.

<sup>17</sup> Starting treatment earlier improves survival; see Kitahata et al 2009; Sterne et al. 2006

**Figure 3.5: Probability of implementing new treatment guidelines (CD4 below 350) (% of countries in each region)**



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: 1/ % is of the 50 countries for which an answer was obtained

2/ AP= Asia and Pacific ECA = Eastern Europe and Central Asia; ESAF = Eastern and Southern Africa; LA = Latin America; MENA = Middle-East and North Africa; WCAF = Western and Central Africa.

#### 4. Responses to the Crisis

Most countries have been able to maintain social expenditures and cushion the impact of the economic crisis, acting on widespread consensus on the need to avoid the spending cuts made during previous crises, and using the greater fiscal space provided by the fiscal discipline followed during the last decade. With uncertain future availability of external funding, some countries are reported to have started exploring other local financing possibilities and ways to reduce inefficiencies and reduce costs by integrating HIV services into other services and processes and strengthening governance. The specific country responses listed by respondents are as follows:

##### **Generating additional financing** through:

- Establishing a Trust Fund or National Solidarity Fund for HIV/AIDS (one country)
- Mobilizing local resources (two countries)
- Advocating for sustained funding with regional financial institutions and United Nations agencies (five countries)
- Exploring long term ways to finance antiretroviral treatment such as cost sharing with patients and engaging more with private sector (one country)

##### **Rationalizing interventions and reducing inefficiencies:**

- Choosing low cost models for some AIDS interventions (one country)
- Assessing technical efficiencies in the HIV and AIDS response
- Merging institutions
- Cutting back spending in areas deemed unnecessary and imposing stricter rules on operational spending (e.g. travel, workshops, consultancies, etc.)
- Creating a centralized national procurement system for antiretroviral drugs and prevention commodities (four countries)
- Building fiduciary systems and improving the supply chain management of antiretroviral drugs

##### **Revising strategic plans** (six countries):

- Integrating HIV into broader national plans (one country)
- Developing a strategy for the health system that takes account of the global crisis (two countries)
- Implementing crisis measures to stimulate economic recovery, generate jobs, and provide security for working people and their families.
- Integrating crisis mitigation efforts into the United Development Assistance Framework (UNDAF) and country plans of UN agencies
- Revising existing national AIDS strategies and cost estimates for annual action plans to take account of the impact of the crisis
- **Cutting budgetary expenditures** (countries in Eastern Europe)

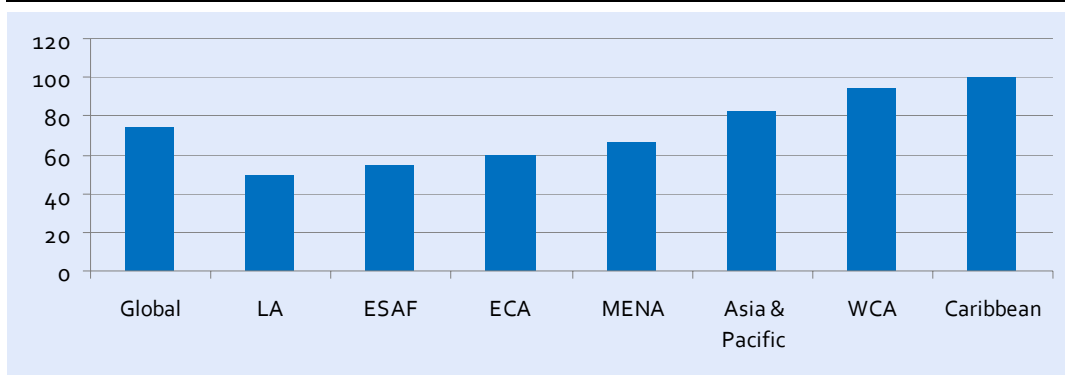
**Rationing access to antiretroviral treatment.** In countries where the number of people who need treatment is large and growing, unanticipated shortfalls in funding are forcing difficult choices:

- No longer enrolling new HIV patients
- Signing up only those “critically ill” i.e. those whose CD4 counts have dropped to 150/mm<sup>3</sup>

## Perceived Needs for Assistance

Respondents see the need for technical assistance in 47 countries (75% of the total; Figure 4.1). In Eastern and Southern Africa, only 52% of respondents report a need for technical support, possibly reflecting the strong donor support already being provided to many of these countries. Despite the relatively limited impact of the global crisis in Asia, 82% of respondents express a need for technical assistance. This is an important characteristic of the perceived demand for technical assistance: it is less for mobilizing additional resources than for improving the efficiency of the HIV and AIDS response and building systems to enable countries to manage the HIV and AIDS response within their national planning procedures (Table 4.1).

**Figure 4.1: Percent of respondents expressing a need for technical assistance**



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: LA = Latin America and Caribbean; MENA = North Africa and Middle-East; ECA= Eastern Europe and Central Asia; ESAF: Eastern and Southern Africa; WCA= Western and Central Africa

**Table 4.1: Expressed technical assistance needs by UCC respondents in 47 countries**

Areas of technical assistance	Number
<b>Strategic planning</b>	<b>20</b>
Developing a strategic plan with operational plan;	12
Prioritization of programs for scaling up the HIV and AIDS response	1
Strengthening planning and management	5
Strengthening health systems	2
<b>Evidence building; monitoring and evaluation</b>	<b>9</b>
Produce better estimates of MARP	
Improve tracking, monitoring and evaluation of impact	
Generate strategic evidence to inform policy making	
<b>Economic analysis of the impact of the global crisis</b>	<b>8</b>
Assess potential impact of the crisis	
Assess country coping mechanisms for meeting universal access targets	
<b>Resource allocation and efficiency</b>	<b>8</b>
Developing effective prevention model for MARP	2
Cost benefit analysis of interventions	1
Improving supply management of drugs	2
Guiding the development of effective social and behavioral change communication programs for HIV prevention	3
<b>Resource mobilization</b>	<b>9</b>
Advocacy for external resource mobilization	7
Domestic resource mobilization	2
<b>Capacity building</b>	<b>6</b>
Capacity building of CSOs, especially for MARP and networks of PLWHA	
Capacity building of NGOs and CBOs	
Building capacity of human resources	
<b>Social protection packages</b>	<b>1</b>
Additional protection for vulnerable groups including poor AIDS households	
<b>Advocacy</b>	<b>2</b>
High level advocacy for prevention and treatment of IDUs and harm reduction	
Advocacy directed at affected MARP	
<b>Total number of TA needs identified 1/</b>	<b>61</b>
<b>Total number of countries</b>	<b>47</b>

Source: UNAIDS Country Coordinators' Survey, July/August 2009 *Note: 1/This number exceeds the number of countries as there are several needs per country.*

**Strategic planning** is the most frequently listed area for technical assistance (20 respondents). The needs identified include development of HIV strategic plans, prioritization of programs for scaling up, strengthening planning and management systems and the health sector which in some countries is viewed as a bottleneck to scaling up the HIV and AIDS response.

**Improving monitoring and evaluation** is the second most frequently mentioned technical assistance need (9 respondents), in particular to obtain better estimates of the size of most-at-risk populations (MARPs), strengthen monitoring and generate strategic evidence to inform policy and program decisions.

**Technical assistance to improve resource allocation and efficiency of interventions** is listed by 8 respondents. This is related to strategic planning -- it includes prioritizing programs in the context of scarce resources, analyzing the cost-benefit of interventions, and defining interventions for MARPs. Also listed are guiding the development of effective behavioral and social change communication programs and improving supply management of antiretroviral drugs.

Eight respondents see a need for assistance to analyze the **economic impact of the global crisis** in countries where its impact is not yet fully visible but expected to be significant. Understanding better the channels through which the crisis could affect the HIV and AIDS response is viewed as essential for informing policy makers.

Seven respondents see the need for technical assistance for **mobilizing external funding**, fewer than might have been expected given how many report or expect cuts in funding.

**Building capacity** is identified as an area of needed technical assistance in 6 countries. This applies to CSOs, but especially for MARP and networks of PLHIV, which is consistent with many respondents' perception that the programs for MARP and networks of PLHIV are at great risk as a result of the crisis. Other areas for technical assistance include strengthening of social protection packages and specific advocacy for MARP and IDU programs.

### International Community

Donors and international financial institutions are struggling to maintain financial support. Interviews with the six major financial donors for HIV and AIDS (including the Global Fund) suggest that HIV funding is unlikely to rise in 2010. The longer term outlook remains uncertain and not very optimistic for HIV both because of the financial cost of the crisis for high income countries, and because of shifting priorities towards building health systems, funding other disease programs and non-health programs especially needs arising from climate change.

Faced with increased scarcity of funds for HIV relative to needs, donors are shifting their financial support towards countries with lower incomes and higher prevalence. The lower financial support for middle and upper middle income countries with low prevalence is forcing these countries to develop a transition strategy to enable the government to take over the programs previously funded by external aid, or to cut program budgets.

An important shift in funding decisions is the desire to concentrate on programs that achieve results. While this shift is certainly welcome, it creates a risk that prevention programs will be cut. It is fairly easy to measure and demonstrate the impact of treatment, but prevention results are much more difficult to achieve, quantify and evaluate. This may explain why CSOs – which are mainly involved in prevention – report such a large impact of the global crisis on their programs.

Added to the difficult global economic environment, uncertainty about funding makes program planning even more difficult. A key finding from the first monitoring survey emerges even more strongly from the second survey, 14 case studies, donor interviews and survey of CSOs: improving the efficiency of programs and the careful allocation and targeting of prevention efforts to achieve much greater results has never been more important.

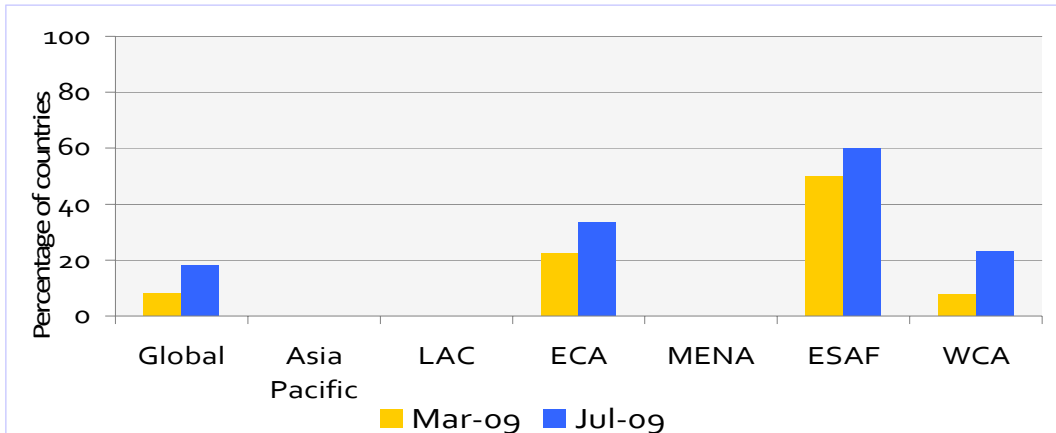
## Annex 1: Details on the March and July/August 2009 Surveys

The March survey was carried out jointly by the World Bank, UNAIDS and WHO. Responses were received from respondents (UNAIDS Country Coordinators and WHO health officers and World Bank Team Leaders) in 71 countries. The July/August survey was sent to UNAIDS Country Coordinators only and responses were obtained from respondents in 63 countries. There were 50 countries for which information was provided in both surveys (Table A1). This gives a sufficient number of countries in each region to compare across surveys except in the Caribbean, and in the Middle East and North Africa, where only two countries are included in both surveys.

Table A1: Respondents' Countries , March and July 2009 Surveys			
Region	Countries in both surveys	March 2009 Survey only	July 2009 Survey only
Asia and Pacific	9 Bangladesh, Cambodia, China, Fiji, Nepal, Papua New Guinea, Sri Lanka, Thailand, Viet Nam	12 Lao People's Democratic Republic, Malaysia, Myanmar	11 India, Philippines
Latin America	5 Argentina, Brazil, El Salvador, Honduras, Peru	10 Chile, Ecuador, Panama, Paraguay, Uruguay	6 Bolivia
Caribbean	2 Dominican Republic, Haiti	5 Bahamas, Guyana, Jamaica	3 Trinidad and Tobago
Eastern and Southern Africa	10 Botswana, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, South Africa, Tanzania	16 Comoros, Mauritius, Swaziland, Uganda, Zambia, Zimbabwe	11 Namibia
Western and Central Africa	13 Benin, Burkina Faso, Burundi, Cameroon, CAR, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Niger, Nigeria	13	19 Guinea, Liberia, Mali, Mauritania, Senegal, Togo
Middle-East	2 Egypt, Morocco,	4 Iran, Sudan	3 Yemen
Eastern Europe & Central Asia	9 Armenia, Belarus, Kazakhstan, Republic of Moldova, Romania, Russian Federation, Tajikistan, Ukraine, Uzbekistan	11 Bosnia and Herzegovina, Georgia	10 Kyrgyzstan
Total	50	71	63

The reported **impact on antiretroviral treatment worsened** substantially from March to July 2009 (Figure A1). In March 2009 respondents in 4 countries said there was already an impact (8% of total). In July 2009, impact was reported in 9 countries (18% of total). The **12-month outlook for treatment also worsened** substantially. The number of countries that respondents expected to be affected during the next 12 months increased from 13 (26%) in March 2009 to 23 (46%) in July 2009. As shown by Figure A2, expectations worsened in most regions.

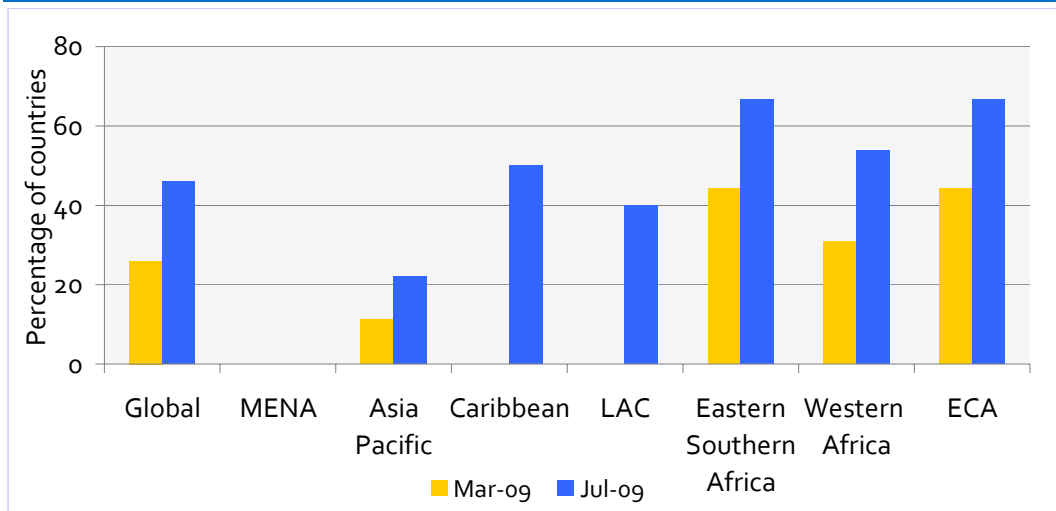
**Figure A1: Percent of respondents reporting impact on treatment (March and July 2009 Surveys)**



Source: UNAIDS/World Bank surveys

Note: LAC = Latin America and Caribbean; MENA = North Africa and Middle-East; ECA= Eastern Europe and Central Asia

**Figure A2: Percent of countries in each region where an adverse impact on antiretroviral treatment is expected during the next twelve months (March and July 2009 surveys)**

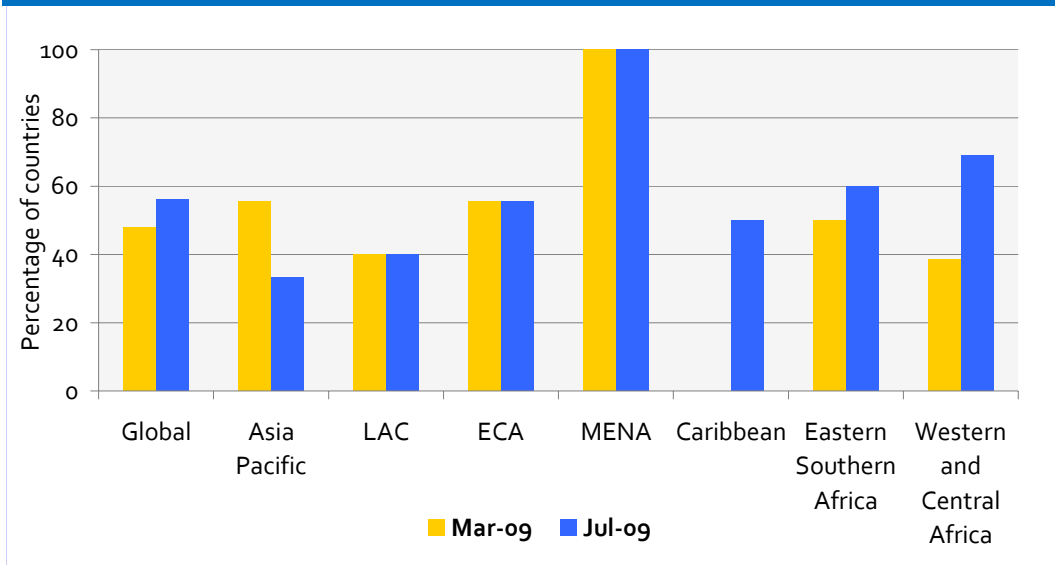


Source: UNAIDS/World Bank Surveys

Note: ECA = Eastern Europe and Central Asia; MENA = Middle-East and North Africa; LA = Latin America.

**Impact on prevention.** As the March survey did not ask respondents whether an impact on prevention was already noticeable, it is not possible to compare how the reported impact changed between March and July 2009. However, both surveys asked respondents how they expected programs to be affected during the next twelve months. Overall, the percentage of respondents expecting an impact increased from 28% in March to 56% in July (Figure A3). The increase is particularly noticeable in Western and Central Africa. The decrease in Asia is consistent with the economic recovery taking place in some countries. As in the March survey, respondents view prevention programs as more susceptible to being cut than antiretroviral treatment.

**Figure A3: Percentage of respondents in each region expecting an adverse impact on prevention (comparison of March and July 2009 surveys)**



Source: UNAIDS Country Coordinators' Survey, July/August 2009 (63 countries)

Note: ECA = Eastern Europe and Central Asia; MENA = Middle-East and North Africa; LAC = Latin America.

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