

GLOBAL REPORT
UNDER EMBARGO
UNTIL 10.30 GMT
TUESDAY 23 NOVEMBER 2010



HIV INVESTMENTS

KEY FINDINGS

- A total of US\$ 15.9 billion was available for the AIDS response in 2009, US\$ 10 billion short of what is needed in 2010.
 - In low- and middle-income countries, domestic resources account for over half of all AIDS-related investments. In low-income countries, however, 88% of spending on AIDS comes from international funding.
 - The majority of international funding for AIDS comes from bilateral donors. The United States of America is the largest international donor.
 - Investment in treatment and care is increasing—but many countries depend on international assistance for their treatment and care programmes.
 - HIV prevention programmes largely rely on international funds.
 - One third of countries make the AIDS response a high budgetary priority, based on disease burden and national income.
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» Investing for AIDS is a shared responsibility

Investing for AIDS is a shared global responsibility that is paying clear dividends—it saves lives now, improves the quality of life of people living with HIV, and will lessen future burdens of cost and disease. In 2009, international donors and governments together provided US\$ 15.9 billion for the global AIDS response, more than half of which came from domestic sources in low- and middle-income countries.

As a result of this unprecedented health investment, HIV prevalence is falling due to programmes that reduce risk behaviour, more than 5 million people are receiving life-saving antiretroviral therapy, millions of orphans have received basic education and health care, and more tolerant and enabling social environments have been established in many countries through campaigns to reduce HIV-related stigma and discrimination. None of this would have been possible without the strong mobilization of the global community and the unprecedented levels of funding provided collectively by donors, governments, the private sector, philanthropic organizations and individuals to address HIV.

However, the gap between investment needs and resource availability is widening at a time of fiscal constraints. In 2009, there was a US\$ 10 billion gap as, for the first time, international assistance did not increase from 2008 levels.

In most countries, the AIDS response is funded by a complex interplay of domestic public spending, multilateral and bilateral aid, private-sector and philanthropic support and individual out-of-pocket spending. In many low- and middle-income countries, the largest source of HIV funding—52%—is domestic expenditure. Government donors provide an additional 42% and the international philanthropic sector 5% (1).

International investment levels have largely reflected the epidemic distribution. Donors' HIV-related spending is higher in countries with high HIV prevalence. The sharing of the responsibility has largely matched the financial capabilities of individual countries and the magnitude of national epidemics.

Middle-income countries contributed a far greater proportion of the resources to their national AIDS response. Low-income countries' share of investment for the national AIDS response was much smaller.

DOMESTIC INVESTMENT PRIORITY INDEX (DIPI)

A new UNAIDS Domestic Investment Priority Index attempts to measure the extent of investment priority given by governments to support their national AIDS response. The Index is calculated by dividing the percentage of government revenue each country directs to the AIDS response by the population HIV prevalence. A high value usually indicates a high level of priority.

$$\text{Domestic investment priority index} = \frac{\text{Public expenditure on AIDS response}}{\text{Government revenue}} \times \frac{\text{National population}}{\text{People living with HIV}}$$

On average, the percentage of government revenue allocated to the AIDS response was one fifth of the population HIV prevalence. Fifty-five countries allocated more than 0.5% of total government revenue. Data from 121 countries show that one third of all countries make investments at a level that is commensurate with their national income levels and share of the global epidemic burden. Among the 104 countries reporting, the median level of priority is 0.35. The Priority Index of a large majority of countries (70%), however, falls below this average—suggesting that many countries need to invest more in their AIDS responses.

Eight of 14 countries in West and Central Africa and six of 16 countries in east and southern Africa appear to be spending less on the AIDS response than might be expected given their disease burden and government resources. The Russian Federation and Ukraine, the two countries in Eastern Europe and Central Asia with the highest HIV prevalence, are spending at relatively low levels given their disease burden and ability to pay. The Domestic Investment Priority Index implies that both countries could contribute more domestic resources to the AIDS response (Figure 6.1). Figure 6.2 shows the distribution of funds to different elements of the epidemic response.

Figure 6.1

**Domestic Investment Priority
Index for countries with the
highest HIV prevalence**

	Year	DIPI	Median spending
Botswana	2008	0.31	●
Brazil	2008	0.80	●
Cameroon	2008	0.06	●
China	2009	0.69	●
Colombia	2009	0.52	●
Congo	2009	0.68	●
Côte d'Ivoire	2008	0.05	●
Democratic Republic of the Congo	2008	0.28	●
Ghana	2008	0.10	●
India	2009	0.07	●
Indonesia	2008	0.29	●
Kenya	2009	0.33	●
Lesotho	2008	0.33	●
Malawi	2009	0.03	●
Mozambique	2008	0.03	●
Nigeria	2008	0.13	●
Russian Federation	2008	0.19	●
South Africa	2009	0.18	●
Thailand	2009	0.37	●
Uganda	2008	0.72	●
Ukraine	2008	0.09	●
Viet Nam	2009	0.05	●
Zimbabwe	2009	0.04	●

DIPI=Domestic Investment Priority Index

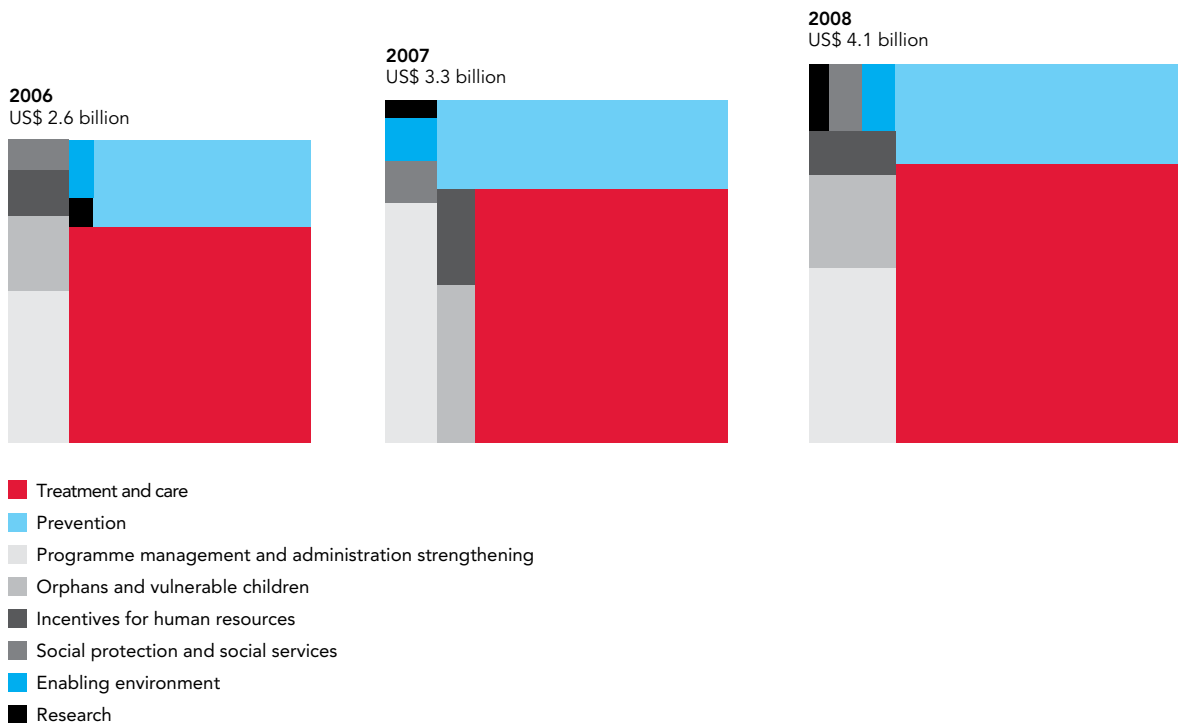
● Above median ● Below median

Figure 6.2

HIV spending in low- and middle-income countries

HIV spending in current US dollars by programmatic area in 43 low- and middle-income countries, 2006–2008.

Source: Country Progress Reports 2010.



Overall size of square is proportional to the total amount spent each year.

International investments are not increasing; donor fair share is not being met

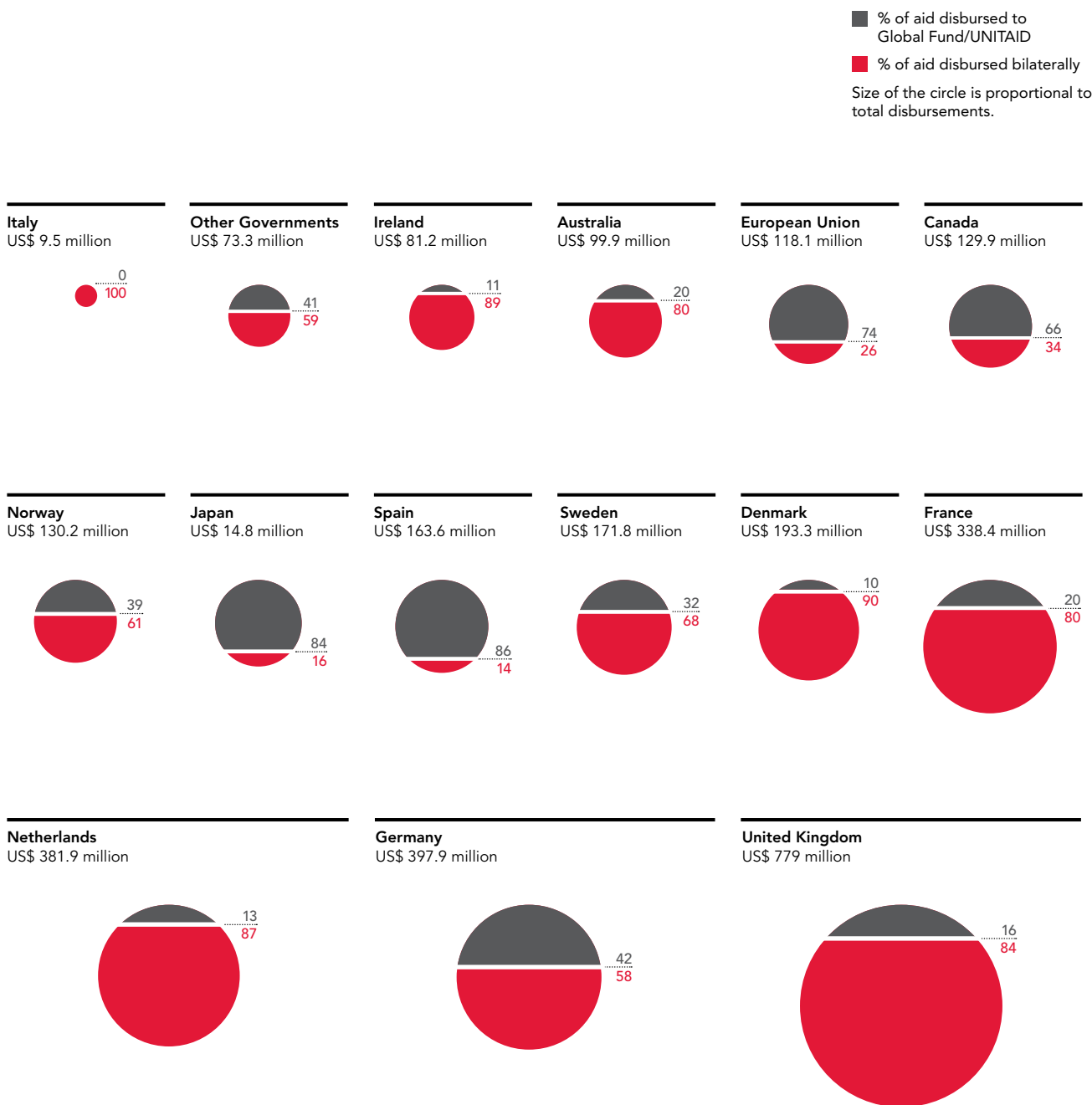
Donor governments' actual disbursements for the AIDS response in 2009 stood at US\$ 7.6 billion in 2009, a slight decrease from the US\$ 7.7 billion made available in 2008. These disbursements include both bilateral aid (funds disbursed directly from a donor country to a recipient country) and contributions to multilateral organizations (Figure 6.3). The majority of these resources went to the countries most affected by the epidemic. The top 20 recipients of aid account for 71% of the people living with HIV globally. Low-income countries received 78% of international funds, with another 14% going to lower-middle-income countries.

International assistance is crucial to sustaining the AIDS response. Of the 132 countries reporting HIV spending by funding source, 70 countries (53%) rely on international funds to finance 50% or more of HIV spending. And for the majority of the low- and middle-income countries, increasing domestic investment priority to the optimum levels is not sufficient to meet the needs of the AIDS response. The United States of America was the largest international

Figure 6.3

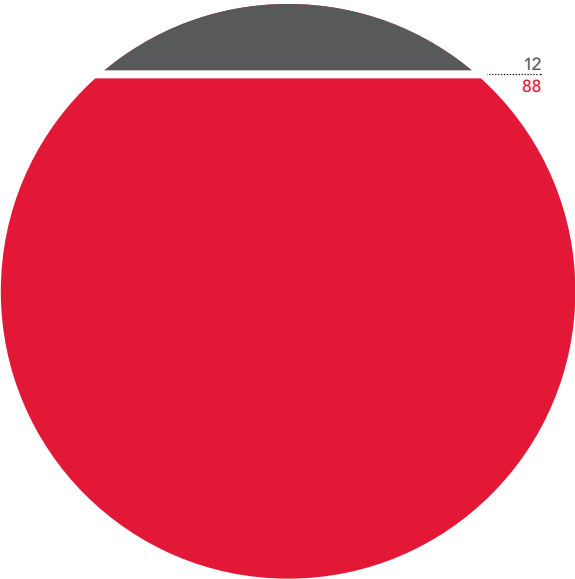
Channels used by major donor countries for disbursing international AIDS funding in 2009

Source: Kates et al. 2010.

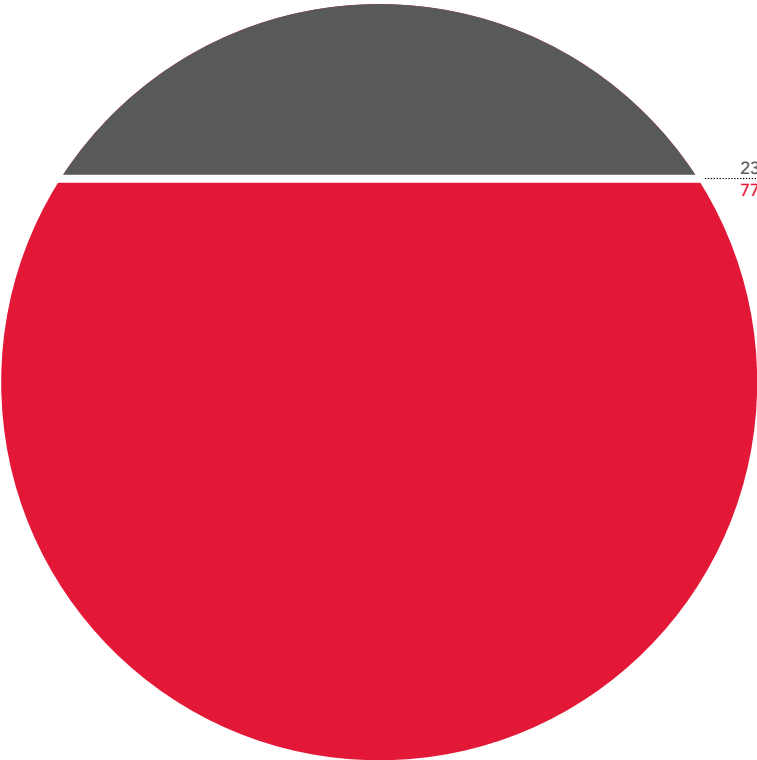


Bilateral funding includes HIV-earmarked multilateral funding; multilateral funding includes Global Fund contributions adjusted to represent the estimated HIV share based on Global Fund grant distribution by disease to date (61% for HIV) and UNITAID contributions adjusted to represent the estimated HIV share based on distribution by disease to date (49% for HIV).

United States
US\$ 4.4 billion



Total
US\$ 7.6 billion



donor, accounting for 58% of all donor-government disbursements for AIDS and for 27% of the funding available for AIDS from all sources (donor governments, multilateral institutions, domestic government spending, and private and individual out-of-pocket spending). The United Kingdom accounted for 10% of total donor government disbursements for AIDS, and Germany and the Netherlands accounted for 5% each.

International investment funding channels

Bilateral funding remains the principal source of international AIDS funds for low- and middle-income countries. Of the US\$ 7.6 billion donor governments made available for AIDS in 2009, US\$ 5.9 billion (77%) was provided as bilateral aid. The United States of America, the largest donor, provides a vast majority (88%) of its resources directly to countries.

However, a sizeable proportion (23%) of all international assistance is available through multilateral institutions such as the Global Fund to fight AIDS, Tuberculosis and Malaria and UNITAID. Canada, the European Union, France, Japan and Spain each provided more than two thirds of their HIV-related international assistance through the Global Fund and UNITAID in 2009. The Global Fund, which accounts for 72% of disbursements from multilateral sources, was the main source of AIDS funding in 52 of its 92 recipient countries.

Donor fair share of international investments for AIDS response is not being met

Comparing donor country funding for AIDS with their national gross domestic product (GDP) is one way of determining whether the contribution represents a fair share to the HIV response (Figure 6.4). Some donors give less in absolute terms than others but dedicate a greater share of their GDP to international assistance on AIDS. Most donor countries have the potential to provide substantially more resources than they are currently providing.

Improving cost-effectiveness can help bridge the resource gap

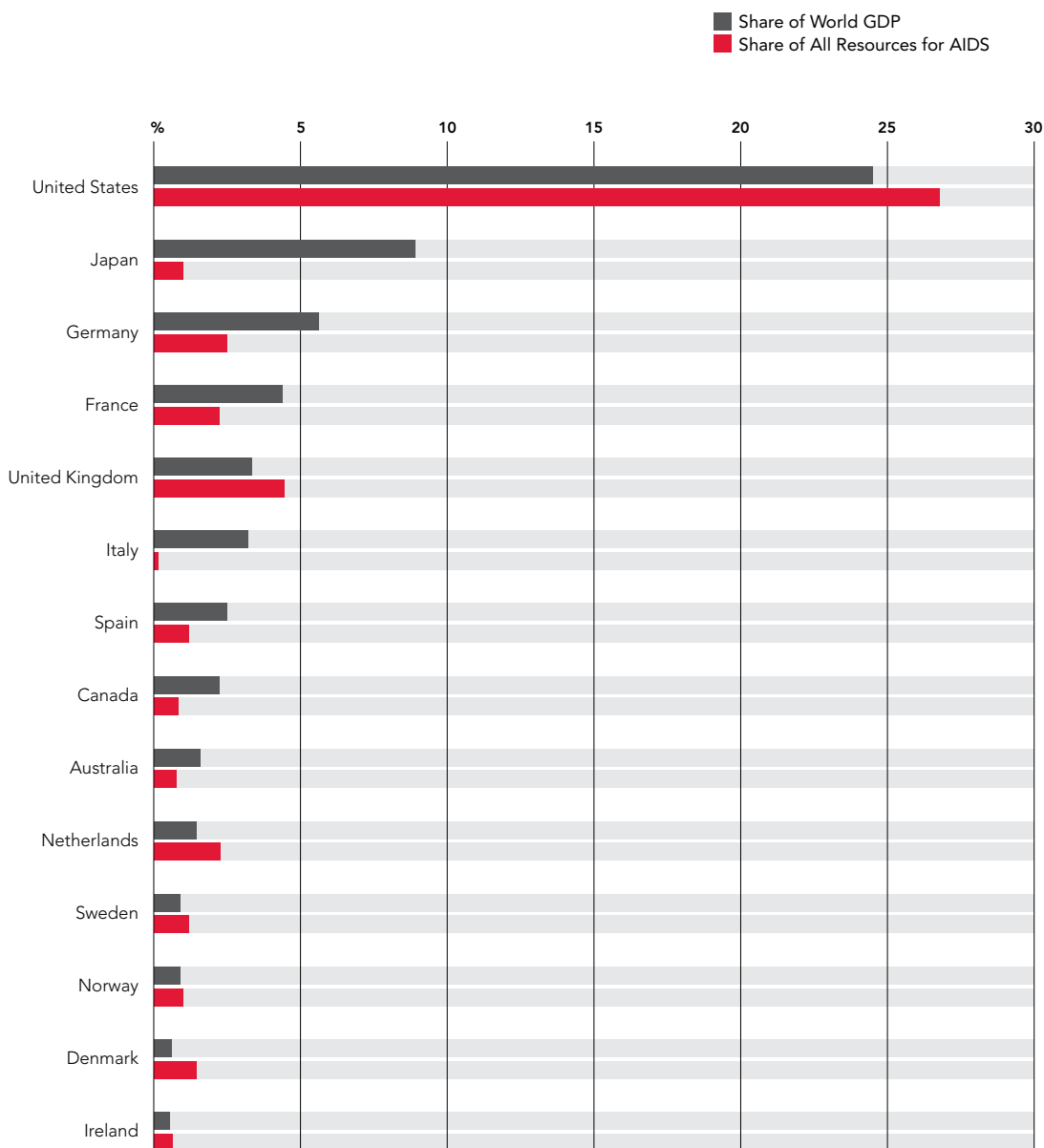
The resource availability for the AIDS response has always fallen short of what is needed. National programmes have had to ensure that programme choices are effective and efficient to have the maximum impact in averting new HIV infections and AIDS-related deaths. Countries have seen best results when resources are tailored to epidemic patterns and have followed evidence: for example, treatment programmes that use the most effective combination of drugs and male circumcision as a priority component of prevention in generalized epidemics. In many countries, programmes promoting abstinence received far more resources than efforts to increase condom use or reduce multiple partners. Evidence from Zambia shows that, without the right mix of behavioural interventions, gains are minimal.

The use of antiretroviral drugs for preventing mother-to-child HIV transmission has been reported with costs of US\$ 34 per disability-adjusted life-year

Figure 6.4

Donor share of the world GDP and all resources available for AIDS, 2009

Source: Kates J et al. 2010.



GDP = gross domestic product. Bilateral funding includes HIV-earmarked multilateral funding. Bilateral funding includes multilateral funding earmarked for HIV but does not include the Global Fund or UNAIDS. Global Fund contributions are adjusted to represent the estimated HIV share based on Global Fund grant distribution by disease to date (61% for HIV). UNAIDS contributions are adjusted to represent the estimated HIV share based on distributions by disease to date (49% for HIV). The resources available are estimated and represent disbursements from all sources.

Figure 6.5

Price trends for commonly used antiretroviral therapy regimens

Price trends for some of the most commonly used antiretroviral therapy regimens for adult patients in low-income countries, 2008-2010.

Source: World Health Organization. Transaction prices for Antiretroviral Medicines and HIV Diagnostics from 2008 to March 2010. A summary report from the Global Price Reporting Mechanism. Geneva May, 2010.

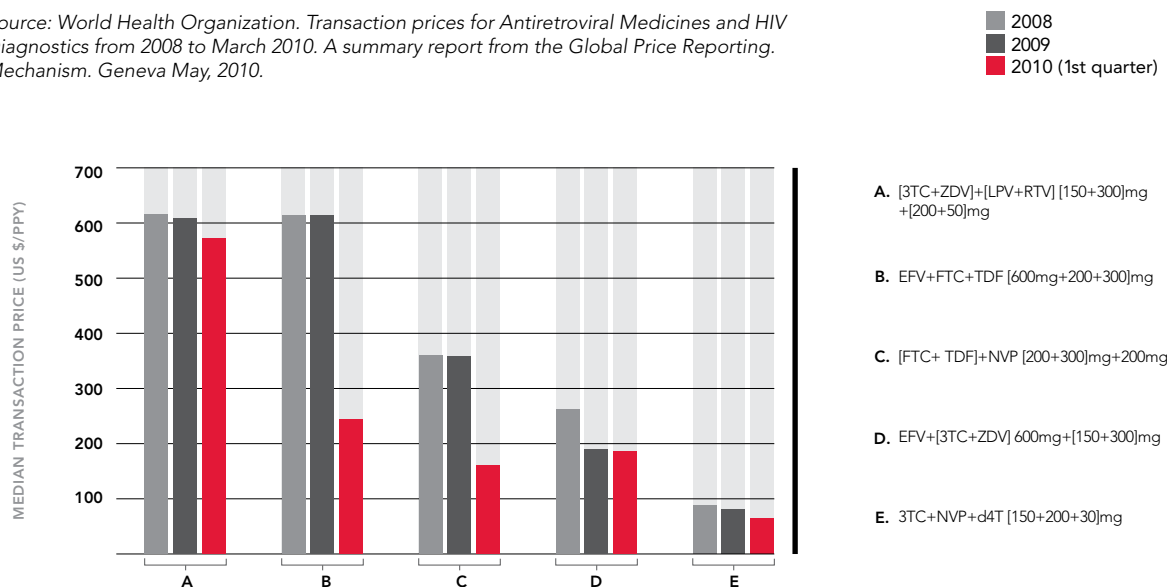
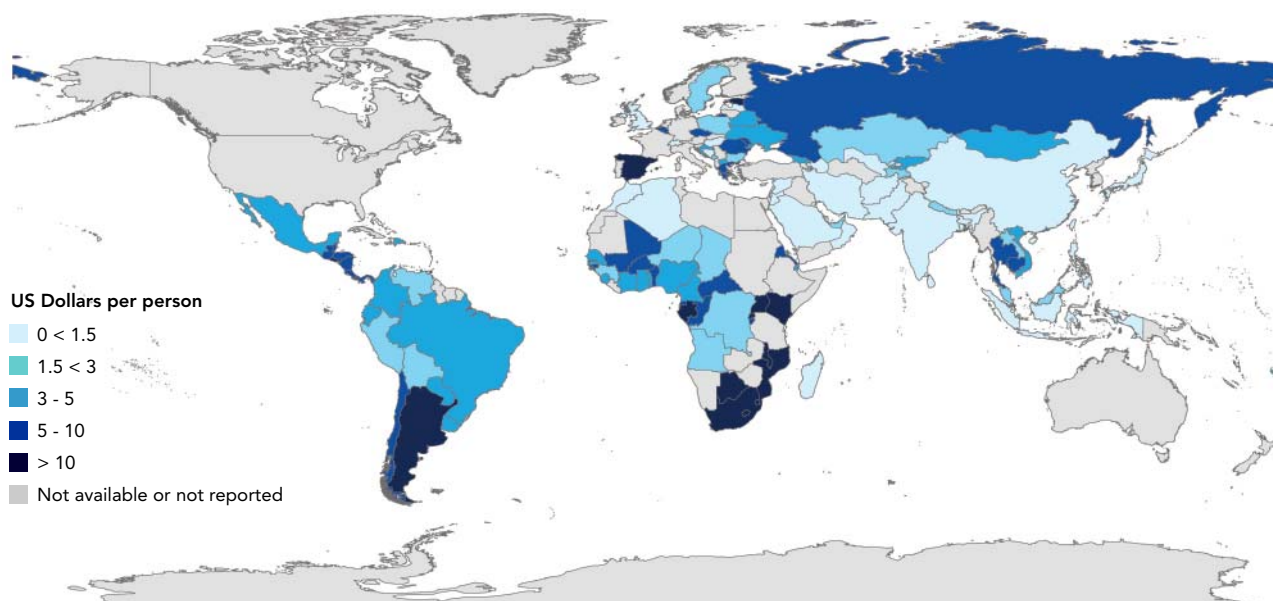


Figure 6.6

Domestic and international HIV spending per person

Domestic and international HIV spending in international US dollars (purchasing power parity) per person by country, 2009 or last available year.

Source: Country Progress Reports 2010.



saved; however, providing full treatment to the pregnant woman saves the life of the mother and protects an infant from HIV infection and orphanhood. There is also scope for innovation in promoting cost-effectiveness. Malawi is considering providing all pregnant women living with HIV with full anti-retroviral therapy (for their own health and for stopping the mother-to-child transmission of HIV). Although this is potentially expensive at the beginning, the cumulative benefits over the long term are better mother-to-child outcomes, reduced maternal mortality, reduced orphanhood, and increased school retention rates.

Reducing the unit cost of procurement as well as delivery of services is one way to improve value for money. Antiretroviral therapy costs today are in many cases a fraction of what they used to be, due in large part to efficiency gained in service delivery and reduction in commodities prices (Figure 6.5). The median price of the most commonly prescribed regimen for adults has dropped to around US\$ 0.17 per day. Prevention costs have also declined. Stopping a single case of infection among infants now costs a mere US\$ 5 compared with thousands of dollars a few years ago. The cost of condoms has also declined to as low as US\$ 0.04 per unit.

Investment for the AIDS response must be predictable and sustainable

As resource availability for HIV increased over the last decade, spending on HIV prevention, treatment, care and support have increased. Overall investments for the AIDS response grew by 82% between 2006 and 2008. Treatment and care programmes received 56% and HIV prevention programmes received 20% of the total resources available. Nearly 71 countries depend on international sources for funding more than 50% of their prevention activities. In contrast, the cost of treatment and care programmes on average appears to be shared equally between domestic sources and international sources. However, 26 countries reported that nearly 77% or more of their treatment and care expenditure relies on external sources (Figure 6.6, Figure 6.7 and Figure 6.8).

At a time when demand for universal access for prevention and treatment is growing, lack of additional resources is slowing down the pace of achieving results for people. As countries strive to increase their investments for the AIDS response, attention is needed to make long-term resource availability predictable. ■

Figure 6.7

Annual HIV domestic and international spending

Annual HIV domestic public and international spending in current US dollars, total and per person living with HIV, among the 15 low- and middle-income countries with the highest spending, 2009 or last available year, international dollars (purchasing power parity).

Source: Country Progress Reports 2010

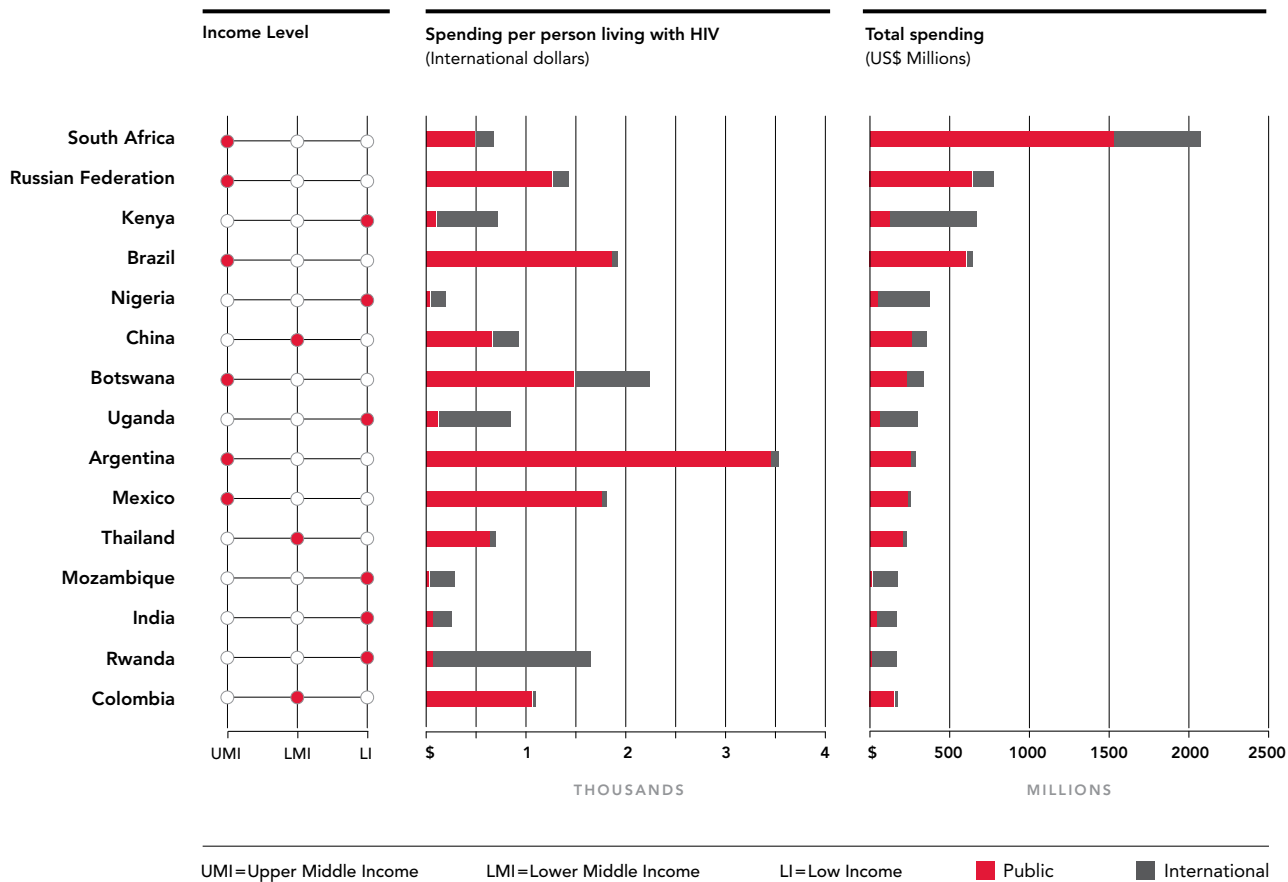
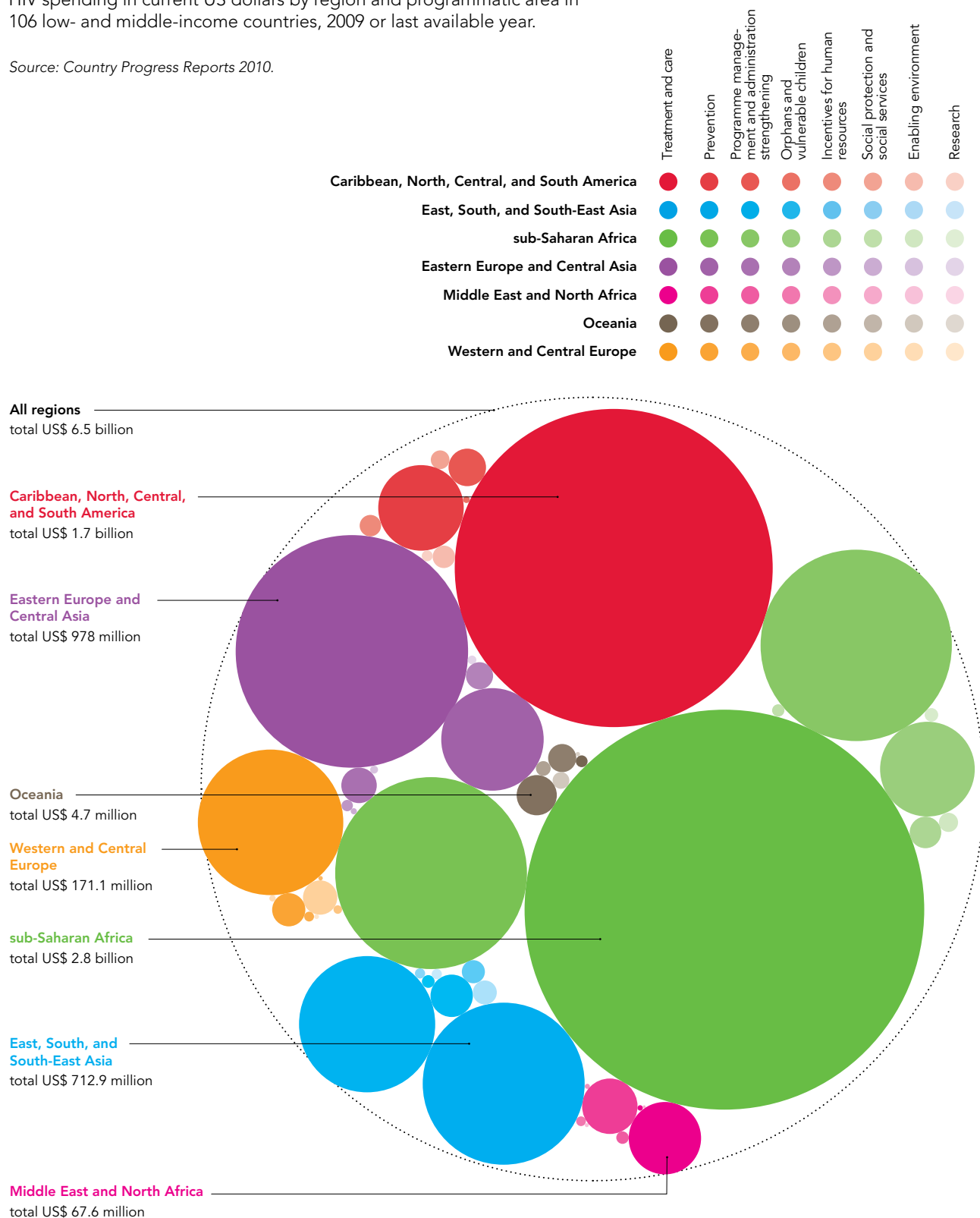


Figure 6.8

Regional HIV spending in low- and middle-income countries

HIV spending in current US dollars by region and programmatic area in 106 low- and middle-income countries, 2009 or last available year.

Source: Country Progress Reports 2010.



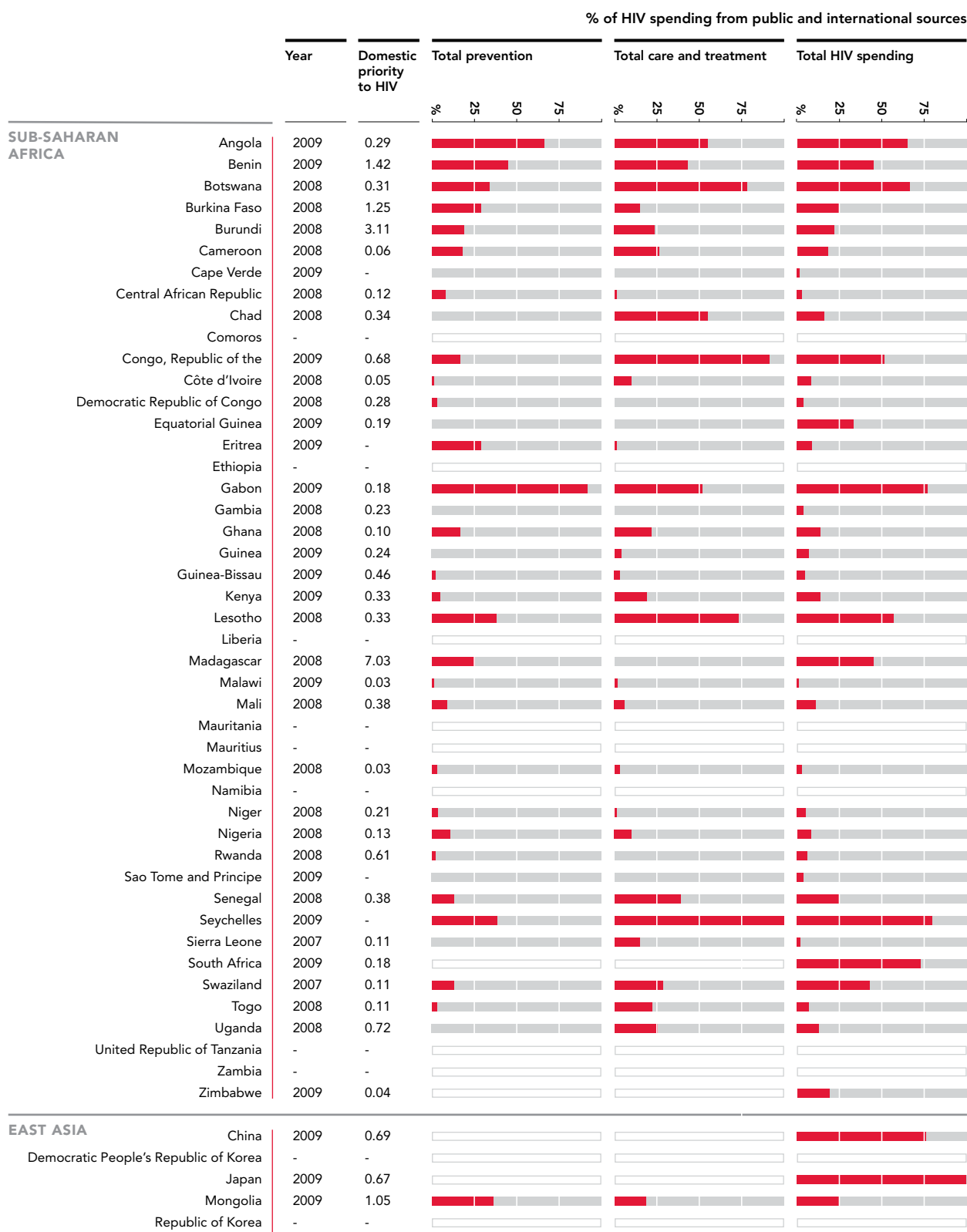


ACTION ITEMS

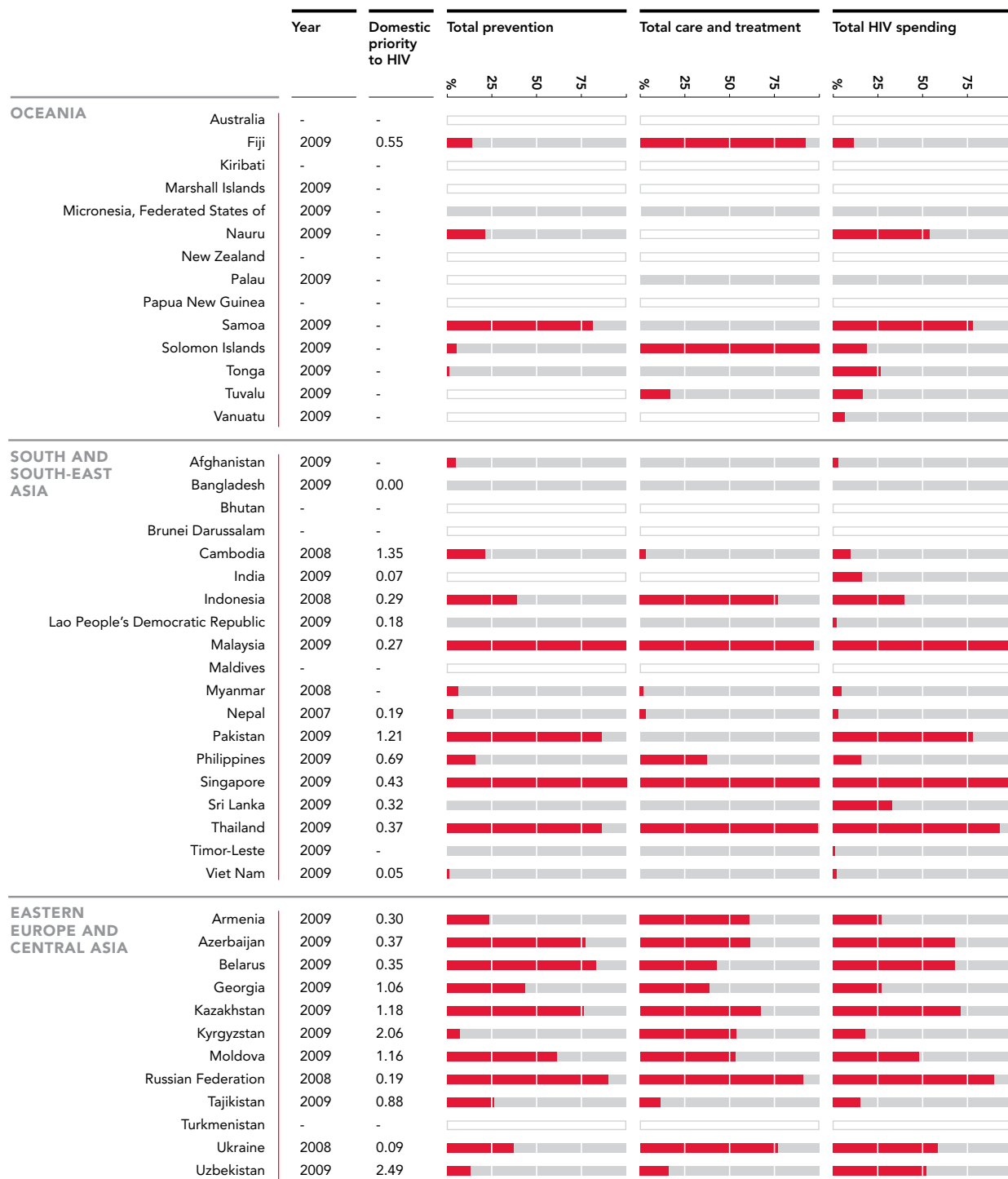
- The AIDS response must be fully funded. This is a shared responsibility between governments, donor countries, civil society and the private sector.
- Donor countries must continue to increase their allocations to the AIDS response.
- Countries that have the potential to increase domestic investments must do so to accelerate progress towards universal access to HIV prevention, treatment, care, and support.
- Resources for AIDS programmes must be predictable. National strategic plans must be realistic.
- Each national programme should set priorities to ensure that available resources are invested appropriately in cost-effective programmes.
- Donor investments must match country priorities.
- Investments must be evidence informed and reach populations most in need first so that the returns are maximized and meet human rights standards.
- HIV treatment programmes should be expanded urgently and utilize optimal combinations of high-quality and less-toxic drugs that reduce mortality over the long term.
- HIV prevention investments are cost-effective when they include combination approaches that maximize synergies rather than isolated interventions.

SCORECARD: HIV INVESTMENTS

Public
International
Data not available

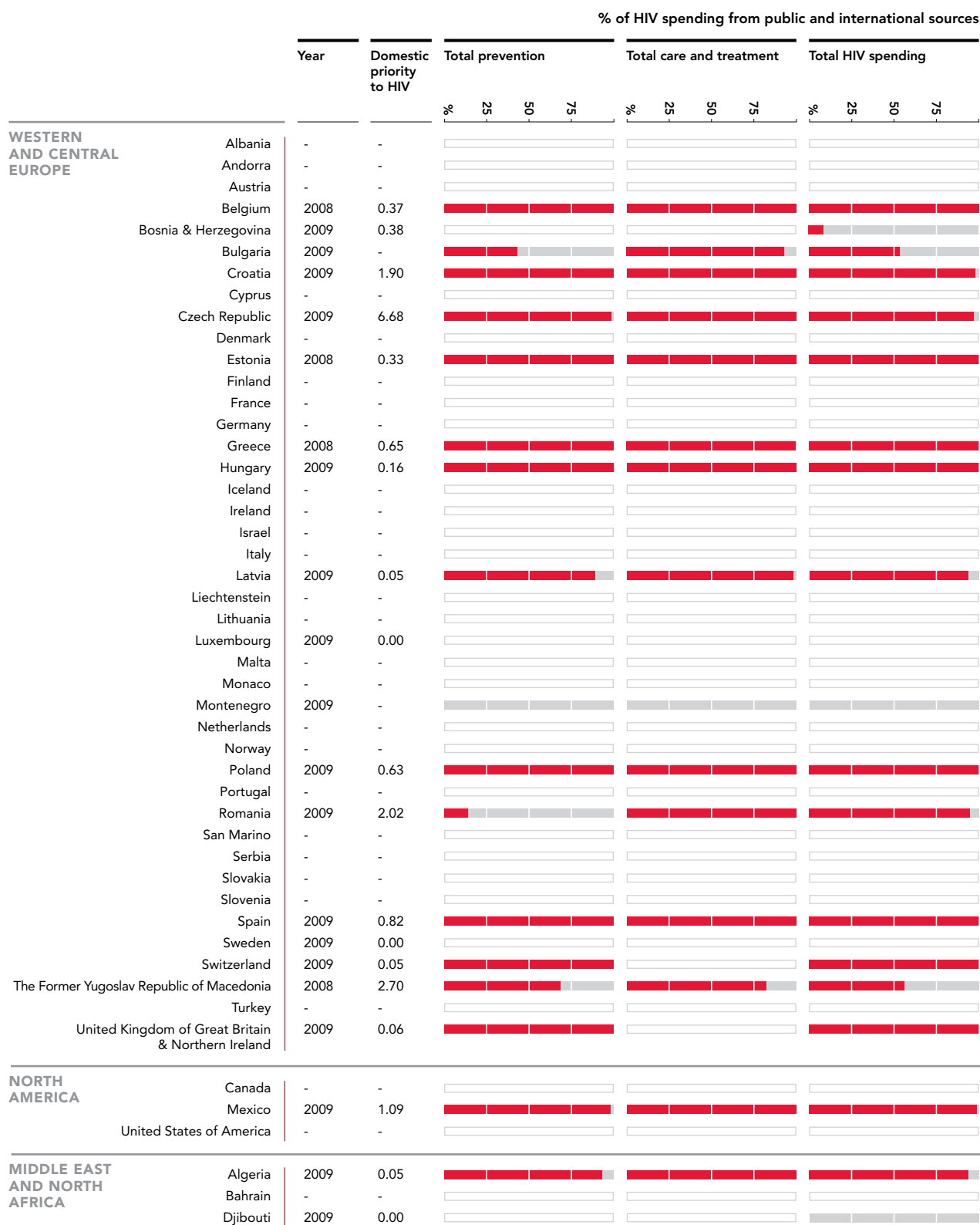


% of HIV spending from public and international sources



SCORECARD: HIV INVESTMENTS

Public
International
Data not available



% of HIV spending from public and international sources

		Year	Domestic priority to HIV	Total prevention			Total care and treatment			Total HIV spending		
				%	25	50	75	%	25	50	75	
MIDDLE EAST AND NORTH AFRICA <i>Continued</i>	Egypt	2008	0.74									
	Iran, Islamic Republic of	2008	-									
	Iraq	-	-									
	Jordan	2009	1.14									
	Kuwait	2009	0.23									
	Lebanon	-	-									
	Libyan Arab Jamahiriya	-	-									
	Morocco	2008	0.26									
	Oman	2009	-									
	Qatar	-	-									
	Saudi Arabia	2009	-									
	Somalia	2009	-									
	Sudan	-	-									
	Syrian Arab Republic	2009	-									
	Tunisia	-	-									
	United Arab Emirates	2009	-									
	Yemen	2009	-									
CARIBBEAN	Antigua & Barbuda	2009	-									
	Bahamas	2009	-									
	Barbados	2009	0.61									
	Cuba	2009	-									
	Dominica	2009	-									
	Dominican Republic	2008	0.21									
	Grenada	2009	-									
	Haiti	-	-									
	Jamaica	-	-									
	Saint Kitts & Nevis	2009	-									
	Saint Lucia	-	-									
	Saint Vincent & the Grenadines	2009	-									
	Trinidad & Tobago	2009	0.20									
CENTRAL AND SOUTH AMERICA	Argentina	2008	1.06									
	Belize	2009	0.19									
	Bolivia	2009	0.31									
	Brazil	2008	0.80									
	Chile	2008	1.07									
	Colombia	2009	0.52									
	Costa Rica	2008	1.16									
	Ecuador	2009	0.00									
	El Salvador	2008	1.22									
	Guatemala	2008	0.00									
	Guyana	-	-									
	Honduras	2008	0.84									
	Nicaragua	2008	3.96									
	Panama	2008	0.83									
	Paraguay	2009	0.68									
	Peru	2009	0.35									
	Suriname	-	-									
	Uruguay	2007	0.36									
	Venezuela	2009	0.21									