

OUTLOOK EXAMINES

**MAKING SENSE
OF THE MONEY**

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**WHERE DOES
THE MONEY
FOR AIDS GO?**

MAKING SENSE OF THE MONEY



*OUTLOOK makes the
case for the
necessities of life.*

IS HEALTH A NECESSITY OR A LUXURY?

Your gut reaction? A necessity.

People should have access to health care—right?

However, the answer, based on health-care spending behaviour, seems to indicate that people treat health care as a luxury. In most countries health spending increases at the same rate as the overall economy grows. In an economist's world, where necessity has an elasticity of 0 and luxury an elasticity of 1, health care has an income elasticity of close to 1 (see Elasticity box).

So how can your gut reaction be made to mirror reality?

OUTLOOK looks at the possibilities.

More health investment

In good economic times, health care investments rise. Since health care has an elasticity of close to 1, a per-capita income increase of 1% would lead to an equal increase in demand for health. And the world has seen this happen.

However, relying on a growing economy is unlikely to work across the board. Not all economies are big enough to be able to raise the resources required to meet and sustain health needs. If it had been left solely to market forces, few people would be on HIV treatment today.

Worldwide health investment will continue to be made up of a combination of international assistance and domestic investment. Today health investments in low- and middle-income countries have reached almost US\$ 700 billion.

It could be said that what's been good for the AIDS response has also been good for global health in general. Funding for the AIDS response has ensured that more money has gone into tuberculosis and malaria programmes.

Spending on HIV amounted to nearly US\$ 15.6 billion in 2008. In countries where data exist, approximately 70% of the spending in low- and middle-

income countries comes in the form of international assistance. The remainder is funded by national revenues and out-of-pocket spending by individuals and families.

Understand the limits of domestic spending on HIV

The Abuja Declaration recommended that countries' spending on health should be about 15% of the government budget. But what does this really mean on the ground?

In 2008, the Democratic Republic of the Congo passed landmark legislation, declaring it a state responsibility to provide or facilitate access to HIV prevention, treatment, care and support for all of its people. UNAIDS estimates that the total resource needs for the country—where between 300 000 and 400 000 people are living with HIV—for 2010 are about US\$ 330 million, about 3.8% of the total economy.

DRC's overall economy might not be as vulnerable to economic shocks as other countries, according to World Bank indicators. The country's economy is estimated to be US\$ 9 billion. Of this, the government's share of revenue is

about 13%, and of this it spends about US\$ 3.8 million, or 0.3%, on HIV.

UNAIDS estimates that governments should allocate between 0.5% and 3% of government revenue on HIV, depending on the HIV prevalence of the country.

If the Democratic Republic of the Congo were to increase its national contribution to 0.6%, appropriate to its HIV prevalence levels, it would merely spend another US\$ 2.9 million. The country would still fall short by US\$ 323 million. To meet its constitutional obligations, the country has to either tax its people more or rely on international assistance.

At the end of 2008, international assistance provided about US\$ 91 million, or 96%, of the total spending on HIV in the country. If this were to be reduced, the country would have to make very difficult choices, including stopping its current treatment programme.

In 2008, domestic HIV spending in Africa was six times higher than in other parts of the world. Botswana leads the world in domestic spending on HIV as a proportion of its government revenue—over 4%. It is able to do so because the government's share of the economy is about 35% and its relatively strong economy is less vulnerable to shocks.

And the results are real. There is more than 80% coverage for people in need of treatment and 94% of pregnant women have access to services to prevent HIV transmission to their babies. But now the question is whether Botswana will be able to sustain the current investment levels over time.

Countries such as Mozambique and Uganda spend about 1% of their government revenue on HIV, although their share of the economy is only about 13%. Both countries have a high rate of HIV prevalence and a large number of people living with HIV. And their economies are fragile. Malawi is in a similar situation, spending about 2.5% of its government revenue on HIV.

Swaziland spent around 1.7% of its revenue on its AIDS response in 2007—this is expected to rise to about 3% in the medium term. The fiscal impact of

this level of HIV investment in the long term is not regarded as sustainable by the World Bank. In fact, some economists suggest that the net present values of its HIV investment far exceed what is sustainable in the long term.

Is it fair to expect countries to spend more?

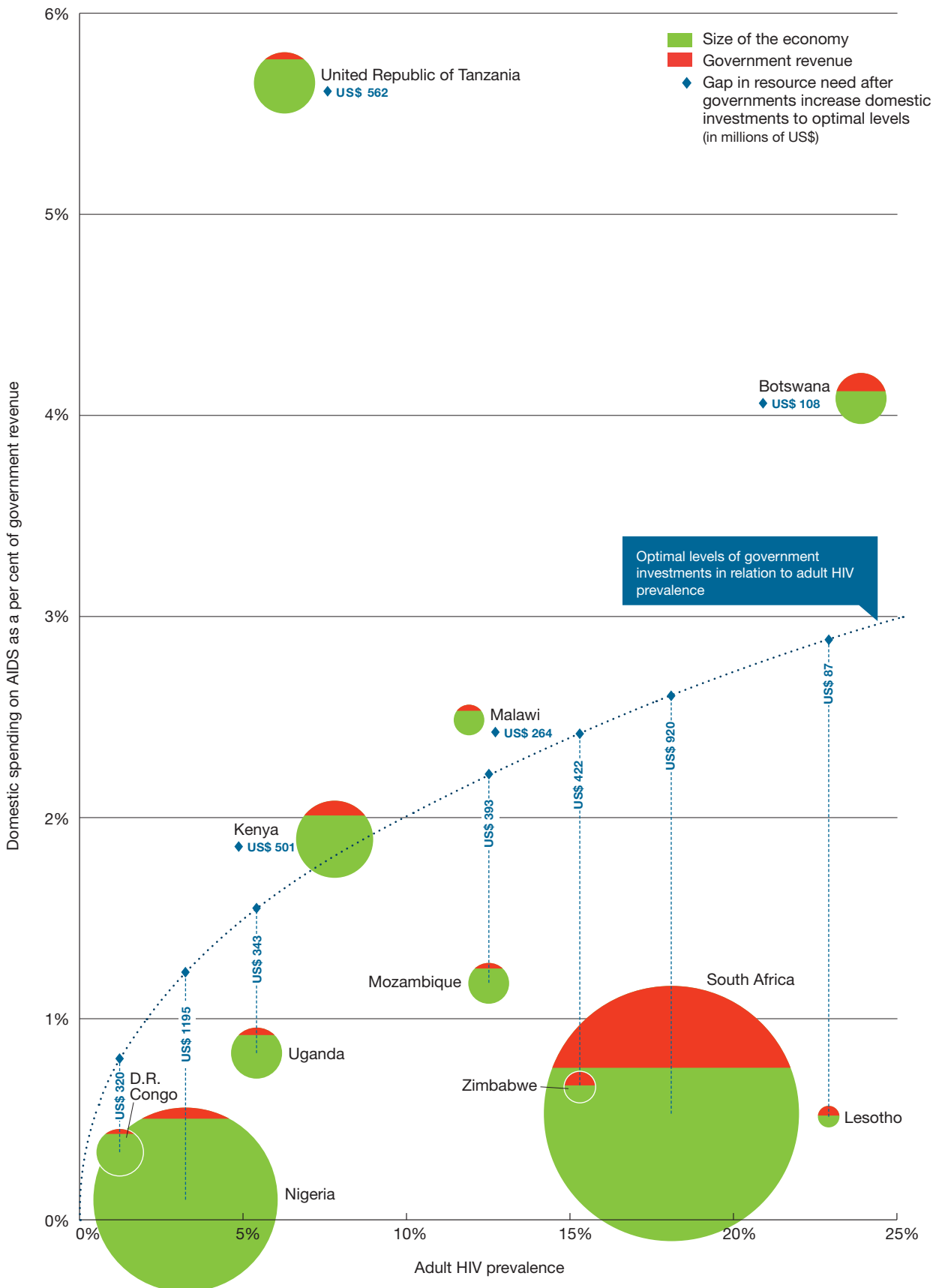
In some cases the answer is yes. Large emerging economies, such as those of China, India and South Africa, still have the ability to invest more. And in doing so could free up resources for countries that have greater needs and few avenues to raise resources domestically. Take the case of South Africa—the total resource needs for 2010 are about US\$ 3.2 billion, about 1.2% of its economy and 3.7% of its government revenue. In sheer size, the US\$ 1 billion investment by the country is the largest ever, but is still only one third of the total need, and less than the rate of spending in other countries with similar or lower prevalence levels. The good news is that its economy had been growing at a rate of about 5% until the recent global financial crisis. If growth returns to these levels, it will have the ability to expand its investments.

China and India currently receive over US\$ 245 million each year as official development assistance for HIV. Together, they account for 8% of the funds dispensed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). India has increased its health budget in recent years, riding on consistent economic growth. However, it still accesses international assistance for a significant part of its AIDS response.

Middle-income countries will need to shore up their domestic investments. Countries such as Brazil, China, India, Mexico, the Russian Federation, Ukraine and Viet Nam can fully finance their AIDS responses from domestic sources. Low-income countries too must increase their investments to levels proportionate to their revenue. Half of the global resource needs for low- and middle-income countries are in 68 countries that have a national need of less than 0.5%

UNAIDS ESTIMATES THAT GOVERNMENTS SHOULD ALLOCATE BETWEEN 0.5% AND 3% OF GOVERNMENT REVENUE ON HIV, DEPENDING ON THE HIV PREVALENCE OF THE COUNTRY.

Can governments meet the resource needs of the AIDS response from government revenue?



of their gross national income. These countries could fund a significant part of their national AIDS response.

But protection must be given to marginalized populations in programmes funded by domestic sources. AIDS programmes must work with sex workers, people who inject drugs, men who have sex with men and transgender people—the populations are most likely to be left out from accessing social and health services, even in countries with stronger economies. This is of particular concern in countries that do not qualify for international assistance based on economic indicators and that do not have a strong tradition of supporting civil society organizations and community groups.

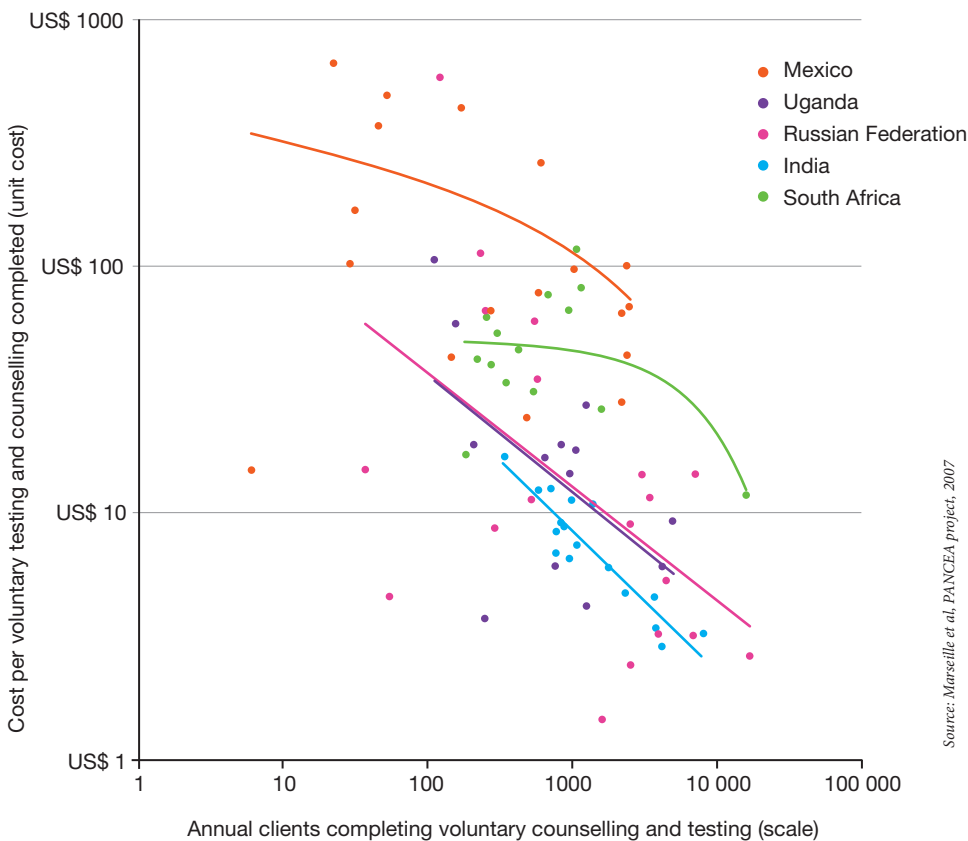
Innovation in health financing—reducing individual risk

Channelling out-of-pocket expenditures may be another option for increasing investments in health. Good data on how much people spend from their own incomes and savings is scarce, but various estimates place it globally at more than US\$ 1 billion. However, the high cost of health care can deter people from accessing it.

Out-of-pocket expenditures push the burden of health care onto individuals and families, which can in turn make it look more like a luxury than a necessity. A social health insurance programme that is equitable can soften the impact,

OUT-OF-POCKET EXPENDITURES PUSH THE BURDEN OF HEALTH CARE ONTO INDIVIDUALS AND FAMILIES, WHICH CAN IN TURN MAKE IT LOOK MORE LIKE A LUXURY THAN A NECESSITY. A SOCIAL HEALTH INSURANCE PROGRAMME THAT IS EQUITABLE CAN SOFTEN THE IMPACT, ESPECIALLY ON THE POOR.

Enormous average cost variation for voluntary counselling and testing service delivery across multiple cities within countries



Elasticity

The income elasticity of demand for any good is a measure of the relationship between a percentage change in income and the percentage change in the demand for that good. A high value for the elasticity means that demand is sensitive to income; a low value means that it is not.

An income elasticity of less than 1 will mean that demand will change by less than the percentage change of income. This is normally associated with necessities, which people will try to consume regardless of their income. Poorer people will therefore spend a larger proportion of their income on necessities than more wealthy people do.

An income elasticity greater than 1 will mean that demand will change by more than the percentage change of income. This is normally associated with luxuries, for which poorer people will tend to use a smaller proportion of their income on than more wealthy people do.

An income elasticity of 1 for health means that the percentage change in demand for health will be the same as the percentage change of income in the country concerned. On average, populations will spend a fixed proportion of their income on health, averaging around 5% in low- and middle-income countries (including public as well as private spending).

especially on the poor. By distributing risk equitably across the population, the resources generated can meet the needs of those who need it most. This is particularly attractive in countries where the government's share of the economy is not substantial.

Where the poor cannot pay for their share, the state can step in by providing coverage, either from its own resources or through international assistance. Rwanda has initiated such a scheme. Resources from the Global Fund were utilized to pay for premiums for the very poorest and for people living with HIV. Health outcomes were positive, not just for AIDS, tuberculosis and malaria, but across all health areas. Similar approaches have been attempted in Burkina Faso and Ghana.

Taxing luxury for social good

In recent years, several innovative schemes have been proposed to raise resources for HIV from indirect taxes. The MassiveGood project aims to raise money from the travel industry, while UNITAID gathers valuable funds from taxing airline passengers. There is talk of taxing high-value bank transactions, cell phone usage and money exchange.

Taxing petrol consumption has helped to build bridges and mass rapid transit systems. But while effective in raising money, in the end the capacity for such initiatives to succeed depends on long-term economic growth. There are limits to what society can expect to take from the economy and sustain it over time before public interest wanes.

Making the money work further

As international resources to respond to the AIDS epidemic grew in the early part of the last decade, there was a call to make the money work. In 2010, this has given way to a slightly modified call: make the money work further, better and smarter.

There are two ways to do this—by increasing the efficiency and the ef-

fectiveness of the HIV programmes. This means doing it better—knowing what to do, directing resources in the right direction and not wasting them, bringing down prices and containing costs.

A study conducted by the PANCEA project found that the unit cost of HIV testing varied sharply from one facility to another, even within the same country, in some countries more than ten-fold. The cost of the delivery of services often differs, depending upon the source of the money. In India, for example, the basic unit cost associated with a programme for sex workers has been set by the government. Yet many organizations spend far above the set limit—these expenditures are often underwritten by external sources, whose predictability of sustaining the funding in the long term is uncertain.

Realizing that it spent more on purchasing antiretroviral drugs locally than abroad, South Africa recently changed its policies. Lowering costs is one piece of the African health-care puzzle.

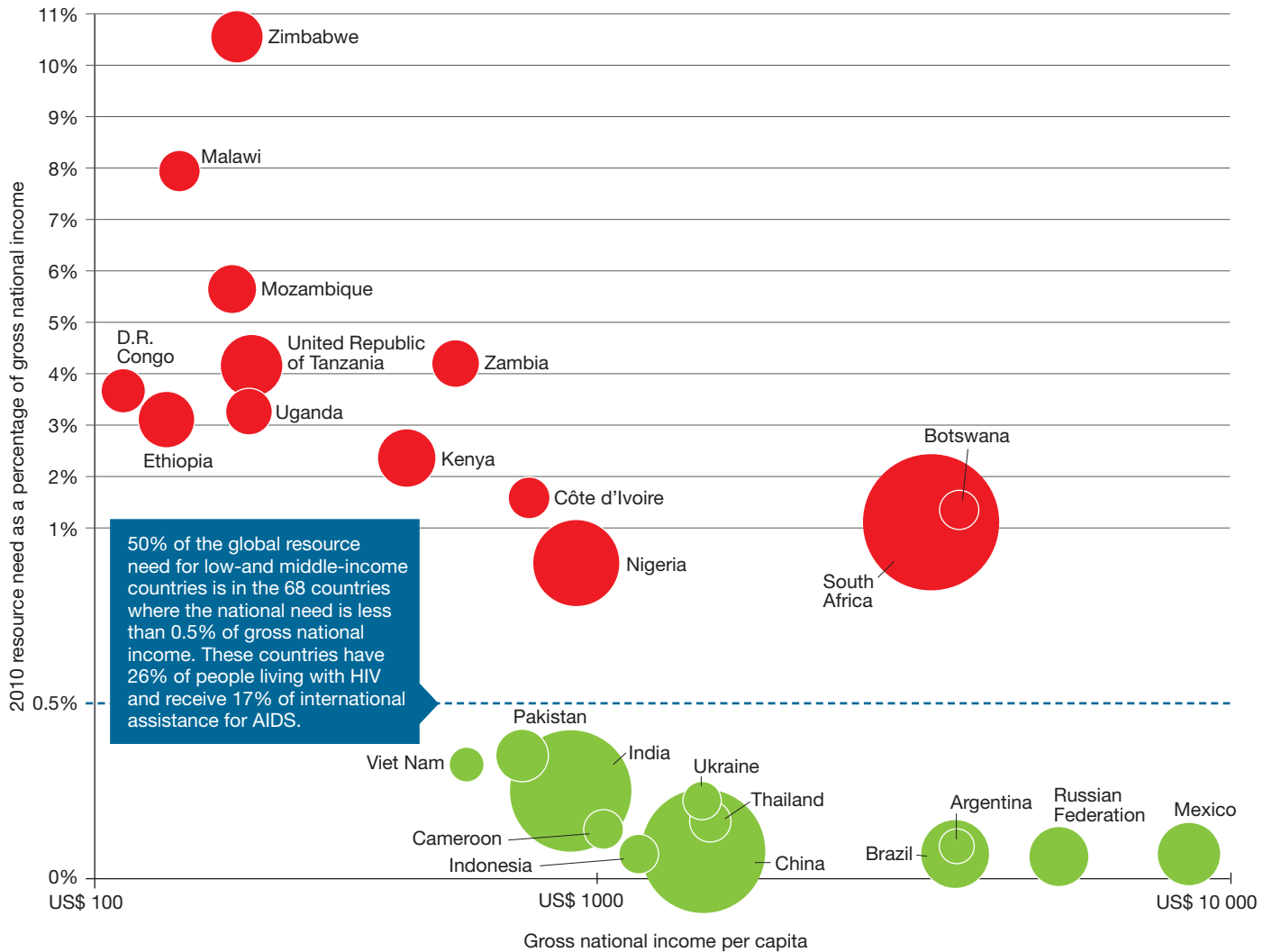
And Africa cannot afford fragmented health regulatory authorities—a single pharmaceutical plan, currently being discussed by the African Union, can simplify the access and delivery of life-saving medicines for the continent as a whole. Pooling patents could help to bring to market more effective and cheaper medicines.

Many countries have utilized the flexibilities allowed under TRIPS to access less-expensive HIV medicines. However, in recent years there has been a trend to sign trade agreements that limit their ability to do, especially with the newer generation of drugs.

Many countries have conducted assessments to identify where the last 1000 infections occurred and triangulated them with investment patterns to ascertain if the money was directed at the right places. As a result the programme priorities are shifting. A modes of transmission study in Benin found that more than 30% of all new infections occur through sex work. Yet the resources that went towards sex work programmes

Who can bear the resource burden of the AIDS response?

The 25 countries represented in this figure require 75% of the total resources needed for the AIDS response. Around 85% of people living with HIV reside in these countries. Together these countries generate 70% of the global gross national income in low- and middle-income countries.



- Countries that can meet a substantial proportions of their resource needs from domestic resources (public and private).
- Countries that cannot meet their resource needs from domestic resources (public and private) only.

The size of a country's circle represents their total resource need for the AIDS response in 2010 (UNAIDS estimates).

were only 3.5% of the total prevention spending. A similar pattern has for long been observed in Ghana. In many countries with low and concentrated epidemics, it is much easier to find resources to reach the general population or young people than for sex workers or adolescents at higher risk. Bangladesh has now found a healthy balance. The split between resources allocated to young people and populations at higher risk is nearly the same—around 40%.

Young people are not homogenous. In Asia it is estimated that 95% of infections among young people occur among adolescents at higher risk. But less than 10% of the resources spent on young people are directed towards this subset of the population.

In sub-Saharan Africa few programmes reach men and women in long-term relationships—they are perceived to be at low risk, even though a majority of infections occur in this group.

Is this acceptable? Can resources be directed more efficiently?

Another complex and much debated step is to review the efficiencies of the different programme approaches. Are HIV programmes evidence informed and the accountability for results clear?

Health-care delivery costs can be brought down through integration of tuberculosis and HIV services, bringing all mother and child care services under one roof, task shifting. Outreach to young people can become smarter and cheaper if we use social networking and SMS rather than the labour-intensive methods currently being used.

Making resource availability predictable

The most important lesson that the AIDS response has learnt in the current economic crisis is the issue of predictability. Countries cannot respond effectively to the epidemic on a fiscal-year basis. Efforts to finance AIDS programmes need to consider what is needed now

and what is needed over the longer term. The foundations for a comprehensive AIDS response must be strong enough to meet the needs not just in the next 12 months but over the next 10, 20 and 30 years.

In the past 12 months several countries have reported critical stock-outs of HIV medicines due to a lack of resources and managerial inefficiencies. Clinics are turning back people who need to start treatment because they have to focus on keeping existing programmes afloat. Most countries depend on external sources to meet their treatment bill. The Global Fund alone financed half of the 4 million people on treatment in 2008, while the US Government is another major source of investments in treatment programmes. If the Global Fund is not fully funded and the donor community does not fulfil its pledges or shifts its aid policies, the lifeline of millions could be in jeopardy.

The demand for access to HIV prevention, treatment, care and support has increased manifold in recent years. In the coming years, this is expected to further increase. This has to be converted into an opportunity to increase resources for global health. Strong economic growth requires a healthy and 'fit to work' population. To achieve this, health must become a necessity, not a luxury. ●

A skewed system

South Africa spends about 8% of its gross domestic product on health, which is slightly less than Sweden's 8.9%.

But the spending occurs in an unequal, two-tier system. Most of it is channelled into the private sector, which is where the bulk of resources are concentrated. The country was spending about 3.5% of its gross domestic product on its public health system in the mid-2000s—a smaller proportion than in considerably poorer countries, such as Honduras (4%), Lesotho (5.5%) or Colombia (6.7%).

Almost 60% of the health spend each year pays for the health care of about 7 million people, typically wealthier South Africans who belong to private medical schemes and who use the well-resourced, for-profit private health system.

Consequently, more than 23 million South Africans rely entirely on an overburdened and understaffed health system, while about 10 million people use the public sector, but occasionally pay out of their own pockets to use the private sector.

Some in South Africa are looking to a proposed national health insurance scheme as a quick way to improve health outcomes. The Health Minister believes that this has to go hand in hand with an overhaul of the public health system itself. A more equitable funding arrangement could help to speed up improvements.



WHERE DOES THE MONEY FOR AIDS GO?

Continued international investments for AIDS needed

International assistance to the global AIDS response has helped countries to scale up access to HIV prevention, treatment, care and support programmes in most parts of the world. This international assistance has been instrumental in catalysing and sustaining the AIDS response in many countries.

The funding cycle patterns of donors to some extent insulated HIV investments in 2009. However, it is critical that investment decisions being

made today are based on future needs. Many developed countries are beginning to emerge from the economic crisis and it is increasingly important to meet the investment of US\$ 25 billion required to reach the 2010 country targets for universal access.

“The economic crisis should not become an excuse to stop investing in the AIDS response” said Michel Sidibé, Executive Director of UNAIDS. “We cannot afford to let the economic crisis paralyse us. Not when the AIDS response is showing results.”

Investing in the AIDS response

In 2008, investments for AIDS reached a record high of US\$ 15.6 billion. This represented a 39% increase from 2007. Out of this, around US\$ 8.2 billion came in the form of international assistance. The share of international assistance is around 55% of the global resources available.

The biggest contribution was made by the Government of the United States of America, whose contribution of US\$ 3.5 billion accounted for 61% of bilateral official development assistance

2008 international disbursements

Country	Bilaterals	Multilateral	Total*
United States	87.5%	12.5%	3,953.5
UNITED KINGDOM	91.2	8.8	976.3
France	12.4	87.6	538.7
NETHERLANDS	86.1	13.9	500.8
GERMANY	60.139.9	477.7	
SWEDEN	50.9	49.1	171.5
NORWAY	64.6	35.4	159.8
CANADA	42.757.3	137.6	
JAPAN	15.5	84.5	135.8
ITALY	7.0	93.0	123.6
IRELAND	79.820.2	112.5	
AUSTRALIA	78.1	21.9	109.2
SPAIN	18.681.4	102.4	
Denmark	46.0	54.0	48.2
BELGIUM	72.627.4	35.4	
LUXEMBOURG	38.5	61.5	15.2
Austria	29.1	70.9	7.5
Switzerland	36.8	63.2	6.5
GREECE	86.4	13.6	6.1
Finland	55.0	45.0	5.3
NEW ZEALAND	61.8	38.2	5.1
Portugal	1.7	98.3	2.0

*US dollars in millions.

Source: OECD/DAC, *Measuring Aid to HIV/AIDS Control*, April 2009.

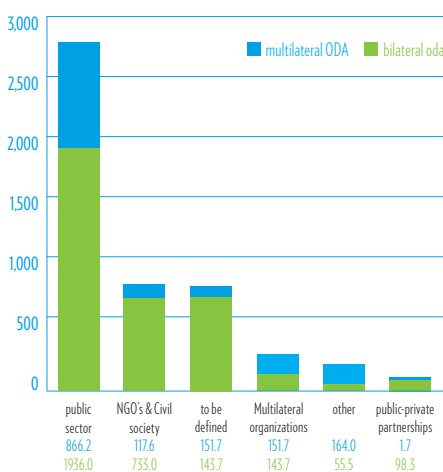
ranked second in terms of absolute value, received only US\$ 2.9 per capita.

Domestic investments for AIDS have increased over the past decade, but most countries still depend on international assistance to finance their programmes. In countries such as Ghana, Haiti, Indonesia, Mozambique and Rwanda, more than 70% of AIDS-related expenditures in 2006 came from international sources.

If international funding were to be reduced and not matched by an increase in domestic funding, it is likely that the AIDS response in over 100 countries would be in jeopardy.

The public sector is the major recipient of international assistance.

Allocation of official development assistance for HIV to implementing bodies, 2007



Source: UNAIDS analysis based on OECD/DAC CRS online database (last visited 25 May 2009).

An estimated 55% of the resources available in 2007 were channelled to government-led initiatives. Civil society organizations, on the other hand, received only about 17%, while 6% went to multilateral organizations and 2% to public-private partnerships.

The role of multilateral organizations in aid delivery

Most multilateral organizations traditionally disburse resources received from governments, foundations and individual donations from the general public. Many countries favour channelling a major proportion of their resources through these channels.

For example, Austria, Finland, France, Italy, Japan, Portugal and Switzerland disbursed more than 80% of their international assistance to multilateral organizations. The major multilateral organizations receiving these investments are the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID. In 2007, contributions disbursed to the Global Fund exceeded US\$ 1 billion for the first time, reaching US\$ 1.72 billion in 2008. However, multilateral organizations only represent 25% of all international investments for AIDS.

However, most importantly, more than 70 countries receive more than 75% of the international assistance for AIDS from multilateral organizations. Another 30 countries receive between 50% and 75% in a similar way. The Global Fund has disbursed around US\$ 1.03 billion to 136 low- and middle-income countries. UNITAID has provided US\$ 265 million for the AIDS response, generated out of a special airline ticket tax levied by around 20 countries in 2007.

By mid-2009, nearly 2.3 million people living with HIV were receiving antiretroviral therapy from programmes supported by the Global Fund. UNITAID support is currently providing treatment for more than 170 000 children, with a goal of reaching nearly 400 000 children by the end of 2010. Thanks to UNITAID and its partners, 11 paediatric formulations are now available in developing countries, and the price of quality AIDS medicines for children has fallen by 60% since 2006.

The UN system's assistance to the AIDS response is largely in the area of technical support. However, it also provides support to implementation. For example, the World Food Programme was one of the first agencies to provide food to expand access to antiretroviral

therapy in resource-poor settings. Providing nutrition and food security are critical components of care and support for many people living with HIV, particularly in sub-Saharan Africa.

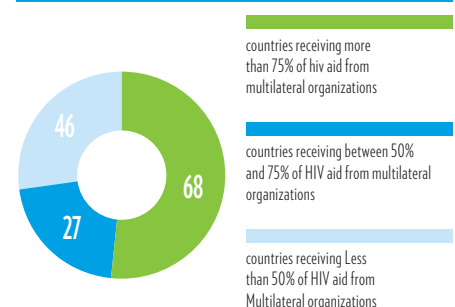
The World Food Programme implements AIDS programmes in over 50 countries, addressing treatment, care and support, and impact mitigation for people affected by the epidemic. In Lesotho, for example, nearly one third of people on antiretroviral therapy, along with their family members, receive nutritional support from the food body. "HIV has robbed families of bread-winners and added financial burden to poor households" says Bhim Udas, Country Director of the World Food Programme in Lesotho. "The pervasive food insecurity in Lesotho makes it difficult for people on antiretroviral therapy to meet their nutritional requirements".

Increasing AID effectiveness—doing more with less

Most of the international assistance to AIDS is channelled through bilateral channels, from one government to another. An estimated 69% of funding came as bilateral assistance from countries that are members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development. Another 23% was disbursed through multilateral agencies. Private funding from the philanthropic sector accounted for 7% of the international assistance.

This increase in resources and a corresponding increase in the number of actors at the country level often overwhelms national efforts to coordinate an inclusive and multisectoral response based on national priorities. The result is vertical and piecemeal actions against AIDS that are often duplicative and rarely sustainable. This poses significant challenges to the

Source of international assistance to countries



UNAIDS analysis based on OECD/DAC CRS online database (last visited 25 May 2009).

recipient country, which often has to juggle with the requirements of multiple donors.

“Our ability to keep up with this is going to be especially challenging in this economic downturn. We’d be foolish not to open up a strategy to try and bring in other bilateral and multilateral resources. We need to be smarter about how we think as funders. We can’t just go in with parallel systems of intervention. It is probably the biggest issue on my plate, thinking about how to deal with that expanding need, and how to continue the medical, clinical and ethical commitment we’ve made to the patients already on drugs. We’re looking for efficiencies by moving to a more country-based delivery system. We also need an aggressive new dialog with our global partners, who have resources that can converge on this” said Eric Goosby, Global AIDS Coordinator and Ambassador-at-Large, in an interview to the Science Insider Magazine.

In this context it is important that countries have a framework to

accountability mechanisms for each partner. The 2009 national strategic plan forms the basis for overall mobilization of resources from donors.

Implications for the future

The economic crisis in 2009 has affected the AIDS response in many ways. Although it is unclear whether a lack of resources or faulty planning was responsible, many countries experienced funding cuts for treatment and prevention services.

To a large extent a rapid response mechanism set in place by UNAIDS, its Cosponsors and partners helped to avert stock-outs and shortages; however, the scaling up of programmes has been interrupted in many countries. As we look ahead to 2010, it is important to ensure that the more than 4 million on treatment continue to receive their medicines without interruption.

The global landscape is changing. The G8 has given way to the G20. This is an opportunity for many emerging economies to redefine their role in the

At the same time as domestic investments increase in developed and emerging economies, as well as middle-income countries, it is important that systems are in place to ensure that civil society organizations continue to receive funding for their activities.

Many governments are reluctant to fund civil society organizations or invest in programmes reaching marginalized populations. International organizations are often their only source of funding.

“It is widely accepted that civil society is an important actor in the sphere of HIV prevention. But funding from international organizations to civil society for HIV prevention among injectors is coming to an end soon. Given the lack of the government’s support for harm reduction programmes for injecting drug users, we are extremely worried about how to keep our programmes running,” says Pavel Aksenov, Executive Director of the Russian Harm Reduction Network.

Fully funding multilateral agencies, including the Global Fund, is critical in 2010. These channels represent a key lifeline to HIV prevention and treatment programmes in over 137 countries around the world. The nearly 50:50 split between domestic and international investments in the AIDS response will be put under strain in 2010.

Although there are signs of economic recovery in many of the main donor countries, they are not uniform. Will this change the pattern of investments? Who will bridge the gap? These questions are not easy to answer, but we must look at options. The 0.7% target on international aid and the Abuja target of 15% for health must not be buried, even in these tough economic times.

Universal access targets can be reached if governments commit 0.5% of their GDP to international aid and maintain the current proportion of investments for AIDS. It is important that the landmark commitment by the USA to provide US\$ 48 billion between 2009 and 2013 is fully met. As the largest single donor, any cut in its share is likely to have a direct impact on the lives of millions.

The considerations for the many economic stimulus package and bail-out plans approved by governments hold true for AIDS, health and development—helping people. The AIDS response needs a stimulus package now, as this can push forward the gains and in time make them irreversible. ●

Principles for the coordination of national AIDS responses.

Three Ones principles aim to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

One agreed AIDS Action Framework that provides the basis for coordinating the work of all partners.

One National AIDS Coordinating Authority, with a broad-based multisectoral mandate.

One agreed country-level Monitoring and Evaluation System.

optimally utilize the resources towards one common goal. The “Three Ones” principles of UNAIDS have served as a good model in many countries to increase aid effectiveness. Take, for example, Malawi. The country has developed a strategic management framework, revised in 2009, which provides a common understanding of the expected results, outputs, impacts, performance measurement and reporting mechanisms to be followed by all key stakeholders involved in the AIDS response in Malawi. A number of donors have for many years pooled their funds in support of Malawi’s national AIDS strategy and have signed a memorandum of understanding that outlines the responsibilities and

global response to AIDS. More than 16% of all international assistance available for AIDS went to G20 members. The lion’s share was taken by three countries: South Africa, India and China.

The Global Fund investments in China and India total more than US\$ 461 million, representing 6% of the investments for AIDS in 2008. Increasing domestic expenditures on AIDS in these countries will significantly free resources for other countries. Brazil is a good example. The majority of the resources for its AIDS response are funded domestically. While South Africa, India and China are ranked 1, 7 and 12, respectively, in top aid recipients for the AIDS response, Brazil stands at number 56.

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