

## **INTERNATIONAL ASSISTANCE FOR HIV/AIDS IN THE DEVELOPING WORLD: TAKING STOCK OF THE G8, OTHER DONOR GOVERNMENTS, AND THE EUROPEAN COMMISSION**

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### **SUMMARY**

As world leaders meet in Saint Petersburg, Russia for this year's G8 Summit, it is important to take stock of international efforts to finance the response to the global HIV/AIDS epidemic. This paper provides the latest available data on international assistance for HIV/AIDS in low- and middle- income countries with a focus on the G7, the European Commission (EC), and other donor governments, including their bilateral aid and contributions to the Global Fund. In 2005, donor governments provided an estimated \$4.3 billion in commitments to HIV/AIDS, an increase over 2004 commitments of \$3.6 billion. Most funding (85%) was provided by the G7 and EC, and primarily through bilateral channels. Despite increases in funding for HIV/AIDS, however, official estimates suggest that a considerable financing gap remains, one that will likely grow over time. Marshaling needed resources from all sources – donor governments, multilateral organizations, the private sector, and governments of affected countries – and for the long haul, is one of the world's greatest challenges moving forward.

## INTRODUCTION

As the Group of Eight (G8) world leaders meet in Saint Petersburg, Russia for this year's G8 Summit, it is important to take stock of international efforts to finance the response to the global HIV/AIDS epidemic. Financing a sufficient and sustained response to the epidemic has emerged as one of the world's greatest challenges, and one that will be with us for the foreseeable future. Often, those countries most affected are also least able to respond, increasing their vulnerability to HIV/AIDS and complicating their ability to respond, as is the case for many nations in sub-Saharan Africa. In addition, concerns have been raised about "second wave" nations, particularly China, India, and Russia, which stand on the brink of generalized epidemics if more is not done now. Yet analyses indicate that if effective HIV prevention programs, coupled with treatment, were truly brought to global scale, and on a sustained basis, millions of future infections could be prevented and HIV-related mortality reduced.<sup>1,2,3</sup> Given the magnitude of the epidemic, the role of international assistance in low and middle income countries has been and continues to be critical.

Indeed, international funding from has risen significantly over the past several years, primarily in the form of bilateral Official Development Assistance (ODA), Official Aid (OA) and contributions to The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund).<sup>4,5</sup> The World Bank also provides substantial funding for HIV/AIDS,<sup>6</sup> as does the private sector (foundations, corporations, international non-governmental organizations, and individuals). Domestic spending by many affected-country governments to combat their epidemics has also grown, and households and individuals within these countries often shoulder at least some, if not much, of the financial burden. Taken together, it is estimated that resources made available from all of these funding streams rose from approximately \$1.6 billion in 2001 to \$6.1 billion in 2004, and are estimated to have reached approximately \$8.3 billion in 2005.<sup>4</sup>

Despite increases in funding for HIV/AIDS, however, official estimates suggest that a considerable financing gap remains, one that will likely grow over time. The Joint United Nations Programme on HIV/AIDS (UNAIDS) now estimates that \$15 billion will be needed to effectively respond to the HIV/AIDS epidemic in low- and middle-income countries in 2006, rising to \$22 billion in 2008.<sup>4,5</sup> Ultimately, most of the remaining resources will need to come from the international community.<sup>5</sup>

Within the international community, donor governments, through bilateral and multilateral assistance, have an especially important role to play in filling this gap. This is particularly true of the G8 which, in addition to providing significant resources, has shown a unique, collective ability to lead international action on HIV/AIDS and other infectious diseases.<sup>7,8</sup> In 2005, G8 members - Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States (the "G7") - together provided an estimated 75%<sup>9</sup> of total net official development assistance (ODA) reported by members of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD).<sup>10,11</sup> Russia, also a member of the G8, is currently a net recipient of international assistance for HIV/AIDS, but does provide contributions to the Global Fund. In addition to the G8, other donor governments, particularly the Netherlands and Sweden, provide significant amounts of international assistance overall and for HIV/AIDS specifically.

This paper provides the latest available data on international assistance for HIV/AIDS in low- and middle-income countries with a focus on the G7, the European Commission (EC), and other donor governments, including their bilateral aid and contributions to the Global Fund. Both commitments and disbursements are provided. Data are from 2005, except where noted, and some data are still considered preliminary (see detailed methodology in Annex 1).

As past studies have found, further corroborated by the current analysis, funding from the G7 and other major donors for HIV/AIDS represents the bulk of such international assistance efforts overall, and therefore serves as an important gauge of the response to the epidemic. Such data also serve to inform multiple other efforts including:

- Resource mobilization;
- Monitoring progress towards international development targets;

- Assessing additionality (that is, that net assistance for HIV/AIDS represents an increase over existing efforts for HIV/AIDS and development assistance more generally);
- Understanding “fair share” (the contributions of donors relative to capacity and other factors);
- Facilitating transparency; and
- Providing a critical link in the larger HIV/AIDS foreign aid equation of: where is assistance going, how quickly, for what, and to what effect.

## I. HOW IS THE RESPONSE FINANCED TODAY?

### a. Forms of Foreign Assistance for HIV/AIDS

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

- *Official Development Assistance (ODA)*: grants or loans provided by official agencies to countries and territories with the promotion of economic development and welfare as their main objective and provided at concessional financial terms (if a loan, having a grant element of at least 25 percent).<sup>12</sup> ODA is assistance provided to nations categorized by the OECD DAC as “developing countries and territories”, such as those in sub-Saharan Africa; many in Latin America and the Caribbean, including Guyana and Haiti; and many in Asia, including India, China, and Vietnam.<sup>13</sup>
- *Official Aid (OA)*: official assistance is the same as ODA except that its recipients are “Countries and Territories in Transition”, such as those in Central and Eastern Europe and the Newly Independent States of the former Soviet Union.<sup>13</sup>

Assistance encompasses many activities: “projects and programmes, cash transfers, deliveries of goods, training courses, research projects, debt relief operations and contributions to non-governmental organisations.”<sup>14</sup> Specific forms of assistance used by donors are as follows:<sup>12,15,16,17,18</sup>

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

Research activities are generally not included as part of assessments of the magnitude of foreign assistance, although research is an important part of the response to HIV/AIDS and some donors provide a significant amount of support for international research in this area. The United States, for example, provides a greater amount of funding for international HIV/AIDS research on an annual basis than total funding for HIV/AIDS by some other donor nations. U.S. funding for international HIV research was estimated at \$384 million in 2005, approximately 10 percent of which was provided directly to non-U.S. based organizations.<sup>19</sup> In addition to this amount, the U.S. provides annual funding to the International AIDS Vaccine Initiative (IAVI) and to the International Partnership for Microbicides (and related microbicide research) through its non-research bilateral assistance accounts (close to \$60 million in 2005<sup>20</sup>). Other donor nations also provide funding for HIV research including France, which provided an estimated \$31.1 million for field research activities in 2005 and Canada, which provided \$1.4 million.

### b. Bilateral and Multilateral Channels for Assistance

Assistance is provided by donor governments through both bilateral and multilateral channels, and some mix of the two. Decisions about how much assistance to provide through these different channels (what

“mix” to use) are dependent on several factors, such as: the desired level of control over the use of funds by donors; varying approaches to cooperation and coordination; donors’ own internal capabilities and field staff capacity for carrying out programs; and recipient country governance status and structures, as well as capacities. These different channels can be described as follows:<sup>12,15,16,18</sup>

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

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

In addition to aid channel, donor strategies for and approaches to financing HIV/AIDS (as well as foreign assistance more generally) vary across several other key dimensions that are important for understanding the broader context of the response; each of these dimensions has implications for the way in which aid flows to recipients. These dimensions include:<sup>21,22,23,24,25,26,27</sup>

- Funding cycle, with most donor governments budgeting funds on an annual, biennial, or other short-term basis;
- The period over which a government’s appropriation of funding must be committed/obligated (e.g., single-year, multiple years, or both; for example, in the United States, different accounts used to fund HIV/AIDS and other efforts have different such requirements);
- Disbursement rate of commitments, reflecting differences in donor requirements about when funds must be spent; program start-up; grant and contracting rules; reservation of funds to fulfill multi-year contracts; and assessment of absorptive capacity, governance, and program performance at the country recipient level;
- Whether funding for HIV/AIDS is part of HIV/AIDS-specific project support, sector wide approaches (SWAPs) or basket funding, or general budget support;
- Whether there is a country or regional focus for assistance efforts. For example, the U.S. is directing the far majority of its bilateral assistance for HIV/AIDS to 15 focus countries (12 in Africa, 2 in the Caribbean, and 1 in Asia), France focuses heavily on Francophone Africa, Italy on the Horn of Africa, and Japan on Asia;
- Whether the primary recipient of funds is a government, an NGO/intermediary (including both international and indigenous NGOs), or both; and
- Whether any earmarks are specified or conditions/limitations attached to the receipt of aid (e.g., the U.S. has specific earmarks for the allocation of global HIV/AIDS funds to prevention, care, treatment, and orphan support<sup>28</sup> and limits the types of interventions that can be funded<sup>29</sup>).

At the recipient country level, the variation in these dimensions across donors often results in duplicative and/or multiple administrative processes, receipt of funds at varied and unpredictable intervals, and numerous monitoring and evaluation systems, all of which present challenges for both recipients and donors. In recognition of these challenges, several recent donor harmonization initiatives and agreements have been launched to address aid effectiveness more generally (e.g., The Rome

Declaration on Harmonization, 2003<sup>30</sup>; The Paris Declaration on Aid Effectiveness, 2005<sup>30</sup>) and for HIV/AIDS specifically (The “Three Ones” Principles, 2004<sup>31</sup>).

## II. WHO FINANCES THE RESPONSE? DONORS GOVERNMENTS AND OTHER FUNDING STREAMS FOR HIV/AIDS

### a. Donor Governments

Donor governments fund virtually all of the world’s development assistance through both bilateral aid and contributions to multilateral organizations. Among donor governments, most development assistance is provided by the G7 (75% of net ODA in 2005) (see Table 1).<sup>9</sup> These same nations, as well as the Netherlands and Sweden, also provide the bulk of international assistance for HIV/AIDS. Most other members of the DAC also provide HIV/AIDS assistance. Within some of these governments, multiple agencies and programs are used to provide, administer, and/or manage international assistance for HIV/AIDS (see Table 2).

Several donor governments have launched significant HIV/AIDS related initiatives, perhaps most notably, because of its magnitude, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), announced by President Bush in 2003. PEPFAR is a 5-year, \$15 billion initiative to address HIV/AIDS, TB, and malaria through prevention, care, treatment, and research<sup>32,33</sup> (see Box 1). PEPFAR has resulted in a significant increase in global funding for HIV/AIDS, and represents a growing share of overall U.S. foreign assistance.<sup>34</sup>

Other recent initiatives include the U.K.’s International Finance Facility (IFF) proposal;<sup>35</sup> the French “solidarity” levy on airline tickets, which took effect on July 1 of this year and seeks to raise funds for the International Drug Purchase Facility, or UNITAID, for the purchase of bulk medicines for HIV, TB, and malaria;<sup>36</sup> proposals to create Advance Market Purchase Commitments for vaccines and other technologies;<sup>37</sup> and Japan’s announcement in 2005 of a new “Health and Development Initiative” which provide \$5 billion over five years to help developing nations fight infectious diseases, including HIV/AIDS (a successor to Japan’s Okinawa Infectious Diseases Initiative that ran from 2000-2005).<sup>38</sup>

### b. Other Funding Streams<sup>4,5</sup>

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

Country	US\$M	Percent of Total
		ODA
Australia	1,666	2%
Austria	1,552	1%
Belgium	1,975	2%
<b>Canada</b>	3,731	4%
Denmark	2,107	2%
Finland	897	1%
<b>France</b>	10,059	9%
<b>Germany</b>	9,915	9%
Greece	535	1%
Ireland	692	1%
<b>Italy</b>	5,053	5%
<b>Japan</b>	13,101	12%
Luxembourg	264	0%
Netherlands	5,131	5%
New Zealand	274	0%
Norway	2,775	3%
Portugal	367	0%
Spain	3,123	3%
Sweden	3,280	3%
Switzerland	1,771	2%
<b>United Kingdom</b>	10,754	10%
<b>United States</b>	27,457	26%
<b>TOTAL DAC</b>	<b>\$ 106,477</b>	<b>100%</b>
<b>G7</b>	<b>\$ 80,068</b>	<b>75%</b>

Source: OECD, 30 March 2006; preliminary data.

<b>Table 2: G7 &amp; EC Departments/Agencies for HIV/AIDS Assistance</b> <sup>22,39</sup>	
<b>Government</b>	<b>Departments/Agencies</b>
Canada	Canadian International Development Agency (CIDA); Department of Finance; Department of Foreign Affairs and International Trade; Health Canada; International Development Research Center (IDRC)
European Commission	EuropeAid; Tacis (Eastern Europe and Central Asia); CARDS (Balkans); European Development Fund (EDF) for Africa, the Caribbean, and Pacific; ALA for Asia and Latin America; MEDA for the Mediterranean and Middle East; ECHO (Humanitarian worldwide)
France	International Interministerial Cooperation and Development Committee; Ministry of Foreign Affairs; Ministry of Economic Affairs, Finance, and Industry; Priority Solidarity Fund; French Development Agency
Germany	Federal Ministry for Economic Cooperation and Development (BMZ); German Bank for Reconstruction (KfW); Agency for Technical Cooperation (GTZ); Ministry of Health
Italy	Ministry of Foreign Affairs; Ministry of Economy and Finance
Japan	Japan International Cooperation Agency (JICA); Ministry of Foreign Affairs (MOFA); Ministry of Health; Ministry of Finance; Japan Bank for International Cooperation (JBIC); Japan International Corporation of Welfare Services (JICWELS)
U.K.	Department for International Development (DFID); Foreign and Commonwealth Office; The Treasury
U.S.	State Department; U.S. Agency for International Development (USAID); Centers for Disease Control and Prevention (CDC); Department of Defense (DoD); Department of Labor (DoL); Department of Agriculture (USDA); National Institutes of Health (NIH)

The private sector, including foundations (charitable and corporate philanthropic organizations), corporations, international NGOs, and individuals, also represents an important funding stream for HIV/AIDS, often acting to pilot new and innovative strategies, leverage existing ones, and develop partnerships with the public sector. It is estimated that U.S.-based philanthropies committed \$395 million in 2003 to HIV/AIDS activities in both the United States and internationally (this figure includes some commitments that are multi-year).<sup>40</sup> Among foundations, the Bill and Melinda Gates Foundation is the leading philanthropic funder of international HIV/AIDS efforts.<sup>40</sup> A survey of European foundations estimated 2003 spending on HIV/AIDS in the developing world at \$32.2 million<sup>41</sup>; 2005 estimates, due to be published shortly, are expected to show significant growth.<sup>42</sup> Corporations and businesses also support HIV/AIDS programs in low and middle income countries through non-cash mechanisms such as price reductions for HIV/AIDS medicines, in-kind support, commodity donations, employee and community prevention, care, and treatment programs, and co-investment strategies with government and other sectors.<sup>34,40</sup>

### Box 1: PEPFAR<sup>32,33</sup>

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

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

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

Of the \$15 billion authorized:

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

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

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

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

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

Total U.S. bilateral and Global Fund commitments for HIV/AIDS in FY 2005 were \$2.1 billion. In FY 2006, commitments are expected to total \$2.6 billion. [Note: These figures do not include funding for HIV/AIDS research. Global Fund contributions are adjusted to reflect an estimated HIV/AIDS share in each year (57% of the contribution in 2005), as well as carry-over of some FY 2004 funds that were obligated in FY 2005 (see methodology)]

Domestic resources, both spending by affected country governments and by households/individuals within these countries, represent a significant and critical part of the response. UNAIDS estimates that domestic spending was approximately \$2.1 billion in 2005.<sup>43</sup> The extent to which affected-country governments provide resources for HIV/AIDS varies due to numerous factors including country income, debt, availability of external resources, and political commitment. In 2002, for example, Latin American country governments were estimated to have accounted for more than 80% of the region's overall HIV/AIDS expenditures, a much greater proportion than countries in sub-Saharan Africa, reflecting in large part income differentials between the regions.<sup>44</sup> Similarly, individuals in some countries pay substantial amounts in out-of-pocket (OOP) expenditures for HIV/AIDS care as a proportion of overall AIDS expenditures, with some studies indicating that OOP for HIV/AIDS represented an estimated 45% of total AIDS expenditures in Kenya (2002), 40% in Chile (2002), 30% in Zambia (2002), 14% in Burkina Faso (2003), and about 14% in Colombia (2002).<sup>44</sup>

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

**The Global Fund:** Formally launched in June 2001, the Global Fund is an independent, public-private partnership. Its primary objectives are to raise new resources to fight HIV/AIDS, tuberculosis, and malaria and to issue grants to support prevention, care, and treatment programs to countries with the greatest need.<sup>45</sup> The creation of the Global Fund has served to mobilize new resources for all three diseases. The Global Fund receives its funding through public and private contributions. As of July 2006, almost \$9 billion has been pledged to the Global Fund from all sources, of which \$5.4 billion has been contributed. Almost all contributions to the Global Fund have come from governments (97%), primarily the G7 and EC (83% of contributions from all sources; 86% of all government contributions).<sup>46</sup> To date, the Global Fund has committed \$5.4 billion in 131 countries for HIV/AIDS, TB, and malaria efforts. The Global Fund reports that 57% of grant approvals to date are for HIV/AIDS projects.<sup>47</sup> Because donors provide contributions to the Global Fund specifically for HIV/AIDS, TB, and malaria, these contributions are counted as part of donor commitments, a portion of which is considered to be for HIV/AIDS.

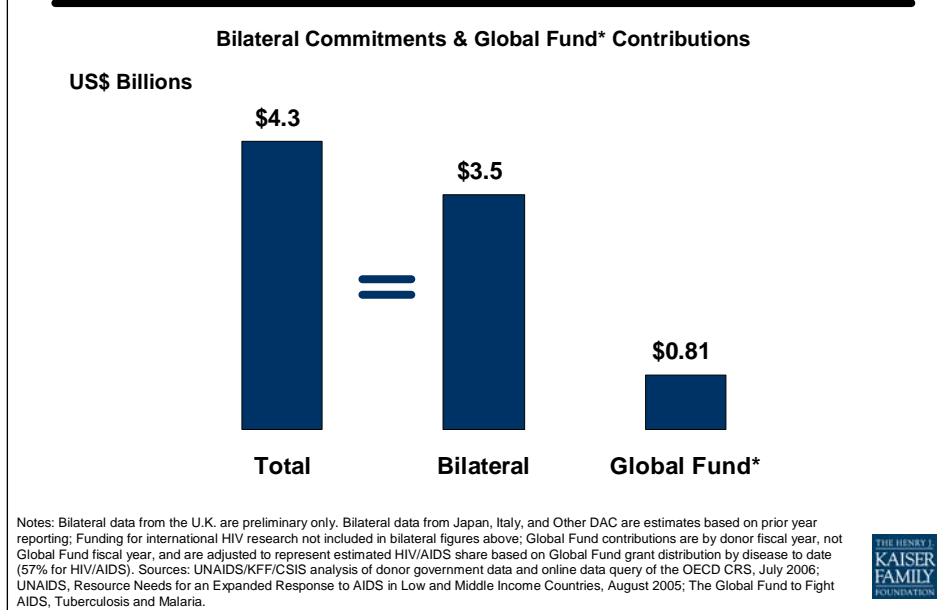
**The World Bank.** The World Bank has been supporting HIV/AIDS efforts since 1986. The major World Bank efforts are its Multi-Country AIDS Programs (MAP) in Africa (launched in 2000)<sup>48</sup> and the Caribbean (launched in 2001)<sup>49</sup>. The World Bank provides assistance for HIV/AIDS through the International Development Association (IDA), which provides grants and interest-free loans (credits) to the world's poorest countries, and the International Bank for Reconstruction and Development (IBRD), which provides loans at commercial rates (non-concessional loans) to higher income countries (as non-concessional loans, these are not counted as part of ODA). IDA funds are derived primarily from member country contributions provided through a replenishment process every four years, borrower repayments, and investment income. The G7 provided approximately 60% of member country contributions to IDA at the time of 14th replenishment.<sup>50</sup> As of April 2006, the World Bank had committed a total of \$2.6 billion to HIV/AIDS including past and current projects, approximately \$1.9 billion of which was for IDA grants and credits.<sup>51</sup> Because countries provide general, not HIV-specific, contributions to the World Bank, World Bank funding of HIV/AIDS efforts is attributed to the World Bank as donor.

**The United Nations:** Numerous entities within the United Nations system carry out HIV/AIDS activities, coordinated by UNAIDS through a central Secretariat.<sup>52</sup> There are ten official co-sponsors of UNAIDS: Office of the United Nations High Commissioner for Refugees (UNHCR); UN Children's Fund (UNICEF); UN Development Program (UNDP); UN Population Fund (UNFPA); UN Educational, Scientific, and Cultural Organization (UNESCO); UN Drug Control Program (UNDCP); World Health Organization (WHO); World Bank; International Labor Organization (ILO); and the World Food Program (WFP). Each provides varying levels of project assistance to countries and a significant amount of technical assistance. The World Bank, as described above, provides the majority of direct project support. The WFP provides direct food assistance to those affected by HIV/AIDS. Technical assistance in the fight against HIV/AIDS is one of the main activities of the UN. Funding used by UN entities to support HIV/AIDS activities comes both from specific HIV-related donor contributions (e.g., funding for UNAIDS) and from general contributions by member countries (and in some cases, through capital raised through other means). Funding provided by donors specifically for HIV/AIDS are attributed to donor government HIV/AIDS efforts; general funding provided by donors to the UN that may ultimately be used for HIV/AIDS is attributed to the UN. The biennial (2004-2005) budget for UNAIDS and eight of its co-sponsors for HIV/AIDS activities was \$1.3 billion<sup>53</sup> (UNHCR and WFP not included; in 2002, WFP reported that it committed \$195 million to food assistance for those affected by HIV/AIDS<sup>54</sup>). The biennial budget for 2006-2007, including all 10 co-sponsors, is \$2.6 billion.<sup>55</sup>

### III. FINDINGS: G7, OTHER DAC, AND EUROPEAN COMMISSION COMMITMENTS AND DISBURSEMENTS FOR HIV/AIDS

Analysis of data from the G7 and other members of the DAC indicates that their combined financial commitments for HIV/AIDS in low and middle income countries, including Global Fund contributions, reached an estimated \$4.3 billion in 2005, compared to \$3.6 billion in 2004. Most was provided through bilateral channels (\$3.5 billion or 81%); the remainder was provided through contributions to the Global Fund (\$813.6 million or 19%; amount adjusted to represent an estimated HIV/AIDS share) (see Figure 1).<sup>56</sup> The G7 accounted for 85% of all funds committed for HIV/AIDS by members of the DAC (see Table 3), a greater share than their share of the DAC's ODA overall. Certain other members of the DAC also provided substantial HIV/AIDS commitments in 2005, particularly the Netherlands and Sweden. Ireland's international HIV/AIDS effort was unusually high among smaller assistance funders.

**Figure 1: Total G7/EC and Other Donor Government Commitments for HIV/AIDS, 2005**



The United States committed the highest amount of funding (\$2.1 billion or 49%) to HIV/AIDS in 2005, including the highest bilateral commitment (\$1.9 or 55% of bilateral commitments made by the DAC) and highest contribution to the Global Fund (\$198 million or 24% of Global Fund contributions by the DAC, adjusted by 57%). The United Kingdom committed the second highest amount in 2005 (\$688 million or 16%). Table 3 provides data by donor. Figure 2 provides commitments by donor as a share of total commitments from all DAC governments. Similar breakdowns are provided for bilateral commitments (Figure 3) and Global Fund contributions (Figure 4).

Russia, also a member of the G8, is a net recipient of international assistance overall and for HIV/AIDS specifically. However, Russia has provided funding to the Global Fund, including \$10 in 2005, and \$25 million cumulatively (figures not adjusted to represent an estimated AIDS share). In addition, Russia recently announced its intention to significantly step up funding for its domestic HIV/AIDS effort in 2006.<sup>57</sup>

Estimated disbursements of bilateral assistance from the DAC were \$2.7 billion in 2005, or 77% of the \$3.5 billion committed in that year, with the G7 accounting for 81% of DAC bilateral disbursements. As with commitments, the U.S. and U.K. also provided the two highest amounts in bilateral disbursements in 2005 (see Table 4). Disbursement rates varied by donor, with some donors disbursing more in 2005 than committed, since disbursements in any given year represent a combination of current and prior year commitments. Some donors disbursed less than their share of commitments. The U.S., for example, accounted for 41% of estimated bilateral disbursements by DAC governments in 2005 compared to 55% of DAC commitments (see Figure 3). As mentioned above, disbursement rates are a function of differences in donor requirements about when funds must be committed, grant and contracting rules, program start-up factors, and assessments of recipient country absorptive capacity and program performance. The U.S. disbursement rate for PEPFAR, for example, has been increasing over the course of its implementation, as planned.

When bilateral disbursements are combined with Global Fund contributions, an estimated \$3.5 billion was made available by the DAC in 2005 (compared to \$4.3 billion in commitments).

**Table 3: Funding by The G7, Other DAC, and European Commission for HIV/AIDS: Total Commitments, Bilateral Commitments, and Global Fund Contributions, 2005 (US\$ millions)**

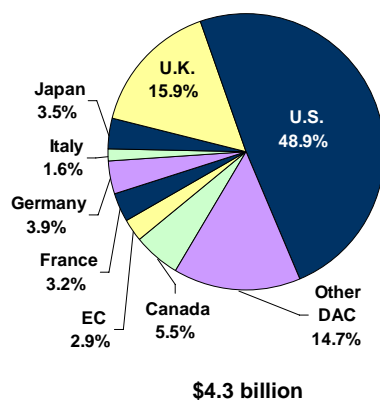
Government	Total HIV/AIDS Commitment		Bilateral HIV/AIDS Commitment		Global Fund Contribution	
	\$	%	\$	%	\$	%
Canada	\$236.6	5.5%	\$108.2	3.1%	\$128.4	15.8%
EC	\$126.4	2.9%	\$86.7	2.5%	\$39.7	4.9%
France	\$136.7	3.2%	\$33.6	1.0%	\$103.1	12.7%
Germany	\$169.9	3.9%	\$111.2	3.2%	\$58.7	7.2%
Italy	\$68.8	1.6%	\$13.6	0.4%	\$55.2	6.8%
Japan	\$152.0	3.5%	\$95.0	2.7%	\$57.0	7.0%
U.K.	\$688.1	15.9%	\$637.1	18.1%	\$51.0	6.3%
U.S.	\$2,116.6	48.9%	\$1,918.7	54.5%	\$197.9	24.3%
Ireland	\$59.7	1.4%	\$50.0	1.4%	\$9.7	1.2%
Netherlands	\$264.8	6.1%	\$232.8	6.6%	\$32.0	3.9%
Sweden	\$139.4	3.2%	\$111.2	3.2%	\$28.2	3.5%
Other DAC	\$172.8	4.0%	\$120.0	3.4%	\$52.8	6.5%
<b>Total</b>	<b>\$4,331.8</b>	<b>100.0%</b>	<b>\$3,518.1</b>	<b>100.0%</b>	<b>\$813.6</b>	<b>100.0%</b>
<b>G7</b>	<b>\$3,695.0</b>	<b>85.3%</b>	<b>\$3,004.1</b>	<b>85.4%</b>	<b>\$690.9</b>	<b>84.9%</b>

Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above; Global Fund contributions are by donor fiscal year, not Global Fund fiscal year, and are adjusted to represent estimated HIV/AIDS share based on Global Fund grant distribution by disease to date (57% for HIV/AIDS).

Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of the OECD CRS, July 2006; UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries*, August 2005; The Global Fund to Fight AIDS, Tuberculosis and Malaria.

**Figure 2: G7/EC as Share of Total HIV/AIDS Commitments by Donor Governments, 2005**

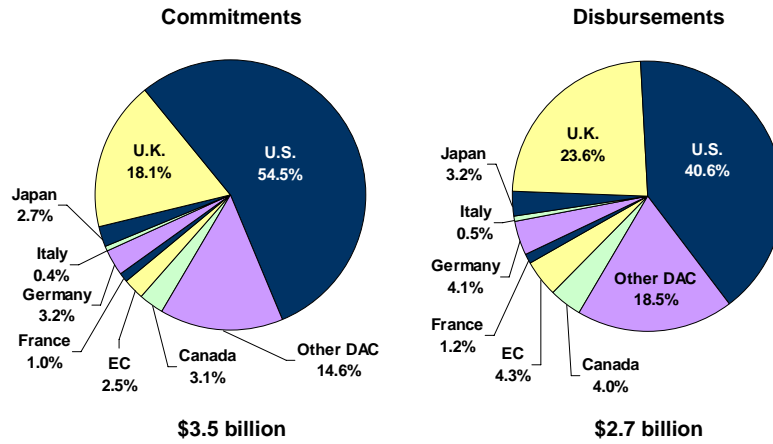
**Bilateral Commitments & Global Fund\* Contributions**



Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above; Global Fund contributions are by donor fiscal year, not Global Fund fiscal year, and are adjusted to represent estimated HIV/AIDS share based on Global Fund grant distribution by disease to date (57% for HIV/AIDS). Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of the OECD CRS, July 2006; UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries*, August 2005; The Global Fund to Fight AIDS, Tuberculosis and Malaria.



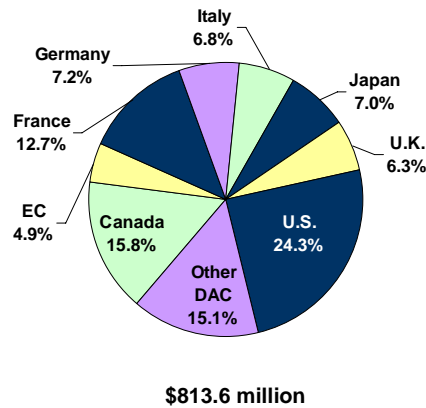
**Figure 3: G7/EC as Share of Bilateral Commitments and Disbursements for HIV/AIDS, by Donor, 2005**



Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above. Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of the OECD CRS, July 2006; UNAIDS, Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries, August 2005.



**Figure 4: G7/EC as Share of Global Fund\* HIV/AIDS Contributions by Donor Governments, 2005**



Notes: Global Fund contributions are by donor fiscal year, not Global Fund fiscal year, and are adjusted to represent estimated HIV/AIDS share based on Global Fund grant distribution by disease to date (57% for HIV/AIDS). Sources: UNAIDS/KFF/CSIS analysis of donor government data; The Global Fund to Fight AIDS, Tuberculosis and Malaria.



<b>Table 4: Funding by The G7, Other DAC, and European Commission for HIV/AIDS: Bilateral Commitments and Disbursements, 2005 (US\$ millions)</b>					
<b>Government</b>	<b>Commitments</b>		<b>Disbursements</b>		<b>Disbursement Rate</b>
	<b>\$</b>	<b>%</b>	<b>\$</b>	<b>%</b>	<b>%</b>
Canada	108.2	3.1%	107.7	4.0%	99.5%
EC	86.7	2.5%	114.7	4.3%	132.2%
France	33.6	1.0%	32.5	1.2%	96.7%
Germany	111.2	3.2%	110.6	4.1%	99.5%
Italy	13.6	0.4%	12.4	0.5%	91.2%
Japan	95.0	2.7%	85.0	3.2%	89.5%
U.K.	637.1	18.1%	637.1	23.6%	100.0%
U.S.	1918.7	54.5%	1095.0	40.6%	57.1%
Ireland	50.0	1.4%	49.8	1.8%	99.6%
Netherlands	232.8	6.6%	214.6	8.0%	92.2%
Sweden	111.2	3.2%	112.0	4.2%	100.7%
Other DAC	120.0	3.4%	122.8	4.6%	102.3%
<b>Total</b>	<b>\$ 3,518.1</b>	<b>100.0%</b>	<b>\$ 2,694.2</b>	<b>100.0%</b>	<b>76.6%</b>
<b>G7</b>	<b>\$ 3,004.1</b>	<b>85.4%</b>	<b>\$ 2,195.0</b>	<b>81.5%</b>	<b>73.1%</b>

Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above.

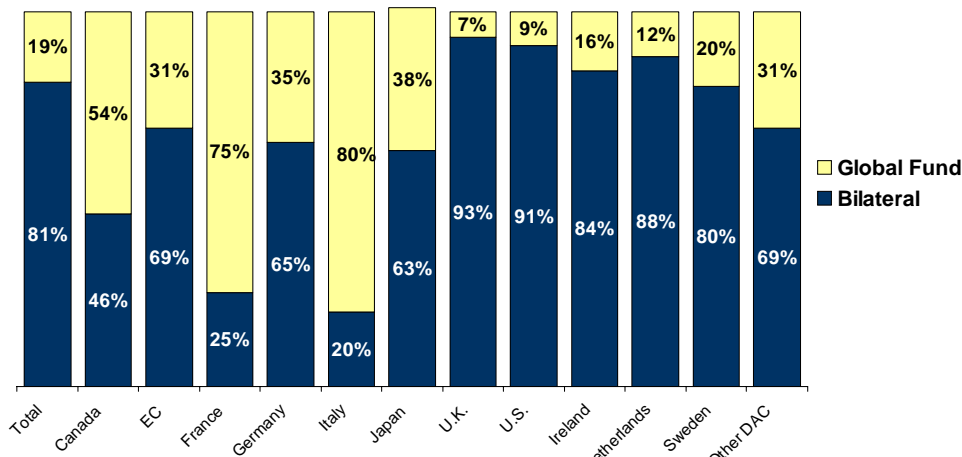
Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of the OECD CRS, July 2006; UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries*, August 2005.

While most funding for HIV/AIDS by DAC governments in 2005 was provided through bilateral channels (81%), versus the Global Fund (19%), the mix varied by donor (see Figure 5). Italy, France, and Canada provided the majority of their funding through the Global Fund. The remaining donors were more likely to provide HIV/AIDS assistance through bilateral channels, particularly the U.S. and the U.K. These distributions reflect an adjusted Global Fund contribution by donors (57% to represent an estimated AIDS share). If donors' full contribution were used, including funding used by the Global Fund for TB and malaria programs, the proportion of funding channeled through the Global Fund, relative to bilateral funding, would be greater.

In addition, because the Global Fund is a new financing vehicle and because of the timing of Global Fund contributions, a one-year snapshot may not necessarily reflect the relative contributions of donors over time. Table 5 provides cumulative Global Fund pledges, pledge periods, and contributions to date by the G7 and other DAC members (for multiple years and as of July 6 2006; not adjusted to represent an HIV/AIDS share). As demonstrated, when using cumulative pledges and contributions, the share represented by each donor changes compared to their share of contributions in a given year.

**Figure 5: G7/EC Funding Channels for HIV/AIDS Commitments, by Donor, 2005**

Global Fund Adjusted to Represent Estimated HIV/AIDS Share



Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above; Global Fund contributions are by donor fiscal year, not Global Fund fiscal year, and are adjusted to represent estimated HIV/AIDS share based on Global Fund grant distribution by disease to date (57% for HIV/AIDS). Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of the OECD CRS, July 2006; UNAIDS, Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries, August 2005; The Global Fund to Fight AIDS, Tuberculosis and Malaria.



**Table 5: The G7, Other DAC, and European Commission:  
Global Fund Pledges and Contributions to Date  
(Totals, Not Adjusted for HIV/AIDS Share)**

	Pledge (USD Equivalent)	Pledge as Percent of G7/EC Total	Pledge Period	Total Contribution To Date (USD Equivalent)	Contribution as Percent of DAC Total
Canada	433,476,552	4.3%	2002-2007	325,205,530	5.7%
EC	634,459,788	6.3%	2001-2006	521,394,461	9.1%
France	1,145,370,439	11.3%	2002-2007	754,352,851	13.1%
Germany	401,912,123	4.0%	2002-2007	241,108,103	4.2%
Italy	769,594,794	7.6%	2002-2007	432,996,273	7.5%
Japan	846,119,676	8.3%	2002-2007	476,668,241	8.3%
United Kingdom	632,056,306	6.2%	2001-2007	267,934,258	4.7%
United States	2,540,117,529	25.0%	2001-2008	1,495,617,529	26.0%
Ireland	94,623,920	0.9%	2002-2007	64,473,167	1.1%
Netherlands	275,154,866	2.7%	2002-2007	162,089,539	2.8%
Sweden	256,091,101	2.5%	2002-2007	213,546,433	3.7%
Other DAC	2,116,606,279	20.9%	2001-2007	786,745,975	13.7%
<b>TOTAL</b>	<b>\$10,145,583,371</b>	<b>100.0%</b>	<b>2001-2008</b>	<b>\$5,742,132,359</b>	<b>100.0%</b>
<b>G7</b>	<b>\$7,403,107,206</b>	<b>73.0%</b>		<b>\$4,515,277,245</b>	<b>78.6%</b>

Source: Global Fund to Fight AIDS, Tuberculosis and Malaria, data as of July 6, 2006.

#### IV. ASSESSING FAIR SHARE<sup>44</sup>

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

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

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

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

Table 6 provides HIV/AIDS funding data from the G7 and other donor governments according to several different methodologies that have been used for assessing fair share, with a comparison to their share of total commitments (bilateral donor commitments and Global Fund contributions). Included are the following examples:

- Total HIV/AIDS commitments (bilateral and Global Fund contributions) standardized per \$1 million of the GNI of each donor in 2005;
- Donor share of global resources available for HIV/AIDS (donor bilateral disbursements and Global Fund contributions) compared to their share of the World GDP
- G7 share of global resources available for HIV/AIDS (donor bilateral disbursements and Global Fund contributions) from the G7 compared to their share of G7 GDP

As demonstrated, each provides a different result. For example, the U.S. ranks as the top donor in terms of share of donor government funding commitments for HIV/AIDS in 2005 but ranks as 6th across donor governments when commitments are standardized according to GNI. The Netherlands ranks highest when commitments are standardized by GNI, followed by Sweden; among the G7, the U.K. is highest followed by Canada and then the U.S. When looking at funding compared to share of the global economy as measured by GDP, some donors provide a greater share for HIV/AIDS, others provide less; 5 of the G7 provide less for HIV/AIDS than their share of world GDP. Among the G7, the U.S. provides a slightly greater share of HIV/AIDS resources than its share of the G7 GDP; the U.K. and Canada provide greater shares.

It is important to underscore that there are limits inherent in using any one of these methodologies for assessing fair share, and none should be used on its own to rank donor support for HIV/AIDS. For example, a rank by total commitments does not capture the relative wealth of a nation. Yet the standardized GNI measure also does not take in account certain differences in the economies of countries. Outside of the HIV/AIDS field, other methodologies have been proposed or developed that are designed to capture multiple dimensions of foreign assistance through composite indexes. For example, the Center for Global Development has developed an index for assessing donor development assistance that takes into account both the amount and the quality of aid by incorporating three elements: the quantity of donor development assistance; the amount of donor assistance that comes back to donors as debt payments; and the amount of aid that is tied.<sup>21</sup>

**Table 6: Assessing Fair Share Across Donors**

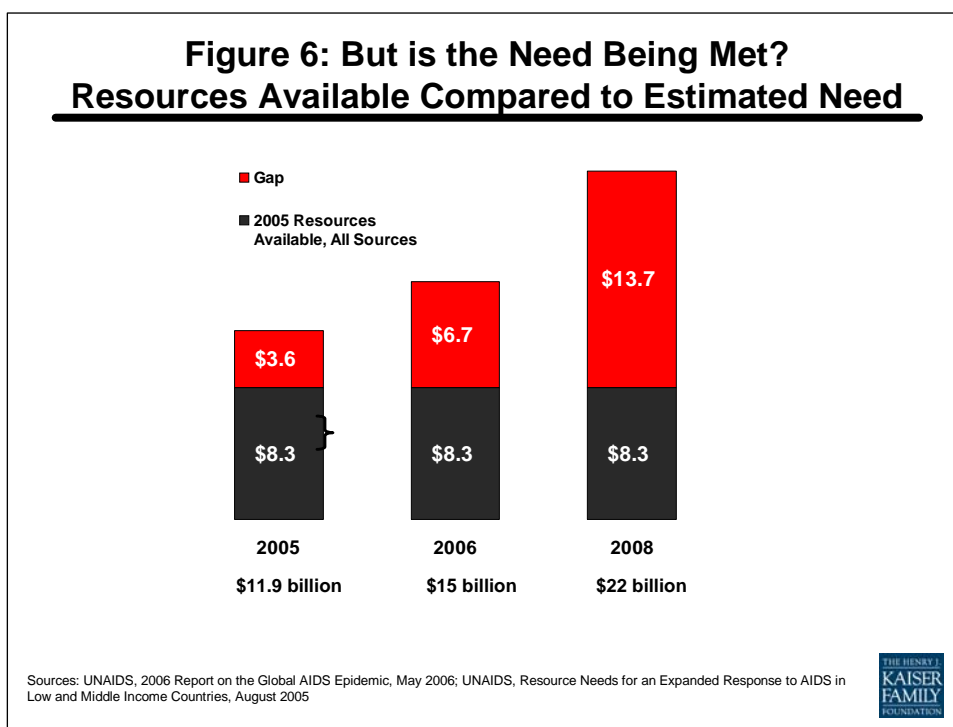
Share of Donor Government Funding Total Commitments for HIV/AIDS		Total HIV/AIDS Funding Commitment Per \$1 Million GNI		Government	Share of World GDP	Share of Global Resources Available for HIV/AIDS	Share of G7 GDP	Share of Resources Available for HIV/AIDS from the G7
Canada	5.5%	Canada	\$ 224.9	Canada	2.5%	2.8%	4.2%	8.6%
EC	2.9%	EC	\$ 12.8	EC	NA	1.9%	NA	NA
France	3.2%	France	\$ 62.8	France	4.7%	1.6%	7.8%	5.0%
Germany	3.9%	Germany	\$ 59.6	Germany	6.3%	2.0%	10.3%	6.2%
Italy	1.6%	Italy	\$ 39.9	Italy	4.0%	0.8%	6.5%	2.5%
Japan	3.5%	Japan	\$ 30.5	Japan	10.3%	1.7%	16.9%	5.2%
U.K.	15.9%	U.K.	\$ 303.9	U.K.	5.0%	8.3%	8.1%	25.2%
U.S.	48.9%	U.S.	\$ 163.2	U.S.	28.1%	15.6%	46.1%	47.3%
Ireland	1.4%	Ireland	\$ 358.5	Ireland	0.4%	0.7%	NA	NA
Netherlands	6.1%	Netherlands	\$ 442.8	Netherlands	1.4%	3.0%	NA	NA
Sweden	3.2%	Sweden	\$ 376.2	Sweden	0.8%	1.7%	NA	NA
Other DAC	4.0%	Other DAC	\$ 4.5	Other DAC	9.4%	2.1%	NA	NA

Notes: Bilateral data from the U.K. are preliminary only. Bilateral data from Japan, Italy, and Other DAC are estimates based on prior year reporting; Funding for international HIV research not included in bilateral figures above; Global Fund contributions are by donor fiscal year, not Global Fund fiscal year, and are adjusted to represent estimated HIV/AIDS share based on Global Fund grant distribution by disease to date (57% for HIV/AIDS); Russia not included in G8 totals. In 2005, Russia contributed \$10 million to the Global Fund of which \$5.7 million (57%) is an estimated AIDS share; Resources available are based on donor bilateral disbursements and Global Fund contributions.

Sources: UNAIDS/KFF/CSIS analysis of donor government data and online data query of OECD CRS, July 2006; UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries*, August 2005; The Global Fund to Fight AIDS, Tuberculosis and Malaria; World Bank, World Development Indicators database, July 1 2006; IMF, World Economic Outlook Database, April 2006.

## V. RESOURCES AVAILABLE COMPARED TO NEED

Estimates of resources made available (funding commitments disbursed) for HIV/AIDS compared to need suggest that there is a significant global financing gap in the addressing HIV/AIDS and a risk that the gap could be growing. In 2005, an estimated \$8.3 billion<sup>4,5</sup> was made available for HIV/AIDS from all sources, compared to \$11.9 in estimated need, yielding a gap of \$3.6 billion. UNAIDS estimates that \$15 billion will be needed in 2006, representing a gap of almost \$7 billion to be filled. UNAIDS projects \$22 billion will be needed in 2008, which would mean that funding from all sources would need to almost triple from current levels to fill this gap (see Figure 6).



## VI. CONCLUSION

As this paper has demonstrated, funding for HIV/AIDS from the G7 and EC represents the bulk of international assistance funding for addressing the epidemic in low and middle income countries. Funding for HIV/AIDS has risen over time and indications are that it will likely continue to do so. However, the latest estimates from UNAIDS suggest that a significant financing gap remains, one which could grow over time; with each year of funding lag, more people will become infected with HIV and treatment needs will grow. Yet current funding decision frameworks by donors and others generally operate within compressed time frames, often defined by annual, biennial, or otherwise short-term funding cycles. Even the newer financing mechanism offered by the Global Fund is similarly dependent on contributions from donors that operate within these same, generally limited financing time frames. Moreover, even if current resources were to double over the next 2-3 years, a financing gap would remain. Given that the crisis of HIV/AIDS is of nearly unprecedented magnitude, and requires both a short-term and long-term response to make a sustained difference, there is a need for innovative thinking about ways to leverage and enhance donor assistance. In some cases, this could mean the modification of existing aid mechanisms; in others, there may be new mechanisms that could better sustain and build upon the response. Regardless, this is obviously an endeavor that no one donor, or aid recipient, can achieve alone, and will warrant attention at this year's G8 Summit and those to follow.

## ANNEX 1: METHODOLOGY

Data provided in this report were collected and analyzed as part of collaborative effort among UNAIDS the Kaiser Family Foundation and CSIS. Data were collected from multiple sources. The research team obtained bilateral assistance data directly, using standard protocols, from the governments of Canada, France, Germany, Ireland, the Netherlands, Sweden, the United Kingdom, the United States, and from the European Commission during the first half of 2006. Data for the U.S. were also derived from Congressional appropriations legislation and other official documents. While data from the U.K. were obtained directly from the U.K government, the U.K. bilateral figure is still considered a preliminary estimate only. In addition, it is important to note that U.K. policy is not to disaggregate resources for HIV/AIDS from sexual and reproductive health activities; these activities were reviewed and included if there was a substantial portion focused on HIV/AIDS, but further analysis is being conducted.

Bilateral data for all other members of the DAC, including Italy and Japan, were estimated based on 2004 data provided to UNAIDS<sup>5</sup> or to the OECD Creditor Reporting System (CRS).<sup>58</sup> Data on UNAIDS contributions were collected directly from donors and from UNAIDS. Data on Global Fund contributions were collected directly from donors and from the Global Fund's web-based databases.

Included in bilateral funding were any earmarked (HIV designated) multilateral amounts, such as donor contributions to UNAIDS. Data represent funding for HIV prevention, care, treatment and support activities, but do not include funding for international HIV/AIDS research, which are discussed above and presented separately where available. All Global Fund contributions were adjusted to represent 57% of the total, reflecting the Fund's reported grant approvals for HIV/AIDS to date.

Data are provided for both funding commitments and disbursements. Commitments, or obligations, represent firm decisions that funding will be provided, regardless of the time at which actual outlays, or disbursements, occur.<sup>12</sup> For the United States, final enacted appropriations were considered the equivalent of commitments since the U.S. Congress sets specific new HIV/AIDS obligation authority numbers in legislation. The one exception to this was the adjustment of the U.S. Global Fund appropriation for 2005 to reflect carry-over of some 2004 funds, due to a legislative requirement that the total amount of U.S. contributions to the Global Fund cannot exceed 33% of the total amount of funds contributed to the Global Fund from all sources.<sup>59</sup>

Disbursements are actual expenditures or outlays of obligated funds. Disbursement figures were obtained directly from donors, from official donor documentation (e.g., for the U.S., disbursement rates were obtained from the Budget of the United States Government and the Office of Management and Budget<sup>60,61</sup>) or were estimated based on historical disbursement rates. Disbursements in any given year may include disbursements of funds committed in prior years.

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

Data are by the fiscal year (FY) period, as defined by the donor, and fiscal years vary by donor. The U.S. FY runs from October 1-September 30. The fiscal years for Canada, Japan, and the UK are April 1-March 31. The EC, France, Germany, and Italy use the calendar year. Among the key multilateral institutions analyzed, the World Bank fiscal year is July 1-June 30. Most United Nations agencies use the calendar year and their budgets are biennial. The Global Fund's fiscal year is also the calendar year. In some cases, therefore, data obtained directly from donors on their FY 2005 contributions to the Global Fund may differ from amounts reported on the Global Fund's website, which are by calendar year.

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

All data are expressed in US dollars (USD). Where data were provided by donors in their currencies, they were adjusted by average exchange rates to obtain a USD equivalent, based on foreign exchange rate historical data available from the U.S. Federal Reserve.<sup>62</sup> Data obtained from the Global Fund were already adjusted by the Global Fund to represent a USD equivalent.

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- <sup>8</sup> Kirton J and Sunderland L, *The G8 Summit Communiqués on Health, 1975-2005*. The G8 Research Group, November 2005.
- <sup>9</sup> This figure includes aid provided to the European Union by the four G7 members who are also part of the EU (France, Germany, Italy and the United Kingdom).
- <sup>10</sup> Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States, European Commission.
- <sup>11</sup> OECD, March 30, 2006 (available at: [www.oecd.org/dataoecd/34/27/36418598.pdf](http://www.oecd.org/dataoecd/34/27/36418598.pdf)).
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- <sup>13</sup> See: *DAC List of Aid Recipients*, [www.oecd.org/document/45/0,2340,en\\_2649\\_33721\\_2093101\\_1\\_1\\_1\\_1.00.html](http://www.oecd.org/document/45/0,2340,en_2649_33721_2093101_1_1_1_1.00.html). ODA is assistance provided to countries on Part I of the DAC List. OA is assistance provided to countries on Part II of the DAC List. Effective in 2006, the OECD will no longer collect data on aid flows for OA.
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- <sup>29</sup> See, for example: USAID, Acquisition & Assistance Policy Directive (AAPD) 05-04, "Implementation of the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 – Eligibility Limitation on the Use of Funds and Opposition to Prostitution and Sex Trafficking", June 9, 2005.
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