

ADB/UNAIDS Study Series

Asia-Pacific's Opportunity:
Investing To Avert An HIV/AIDS Crisis

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Executive Summary

The countries of Asia and the Pacific are at a make-or-break point on HIV/AIDS.

Even at relatively low levels of infection compared with those in sub-Saharan Africa, the course of the epidemic in this region, home to over half the world's people, will determine the magnitude of the HIV/AIDS pandemic – as well as its toll – over the next decade.

Already, over 7 million people are living with HIV/AIDS in Asia-Pacific, with approximately 0.5 million deaths every year. The resulting economic losses totalled US\$7.3 billion in 2001 alone. Millions of people have been impoverished and the poorest rendered destitute.

Asia-Pacific's leaders must promptly invest in comprehensive, multi-sectoral responses to HIV/AIDS to avert severe epidemics and escalating economic losses.

Even in low-prevalence countries, socio-economic losses have mounted in areas suffering from advanced, localized epidemics.

Failure to immediately establish comprehensive and effective prevention, care and treatment programmes will result in an estimated 10 million adults and children in Asia-Pacific becoming newly infected between 2004 and 2010, the annual death toll rising to 0.76 million by 2010 and annual financial losses reaching US\$17.5 billion.

Poverty reduction efforts will be eroded. By current trends, every year between 2003 and 2015, an average of 5.6 million people will be impoverished by HIV/AIDS in Cambodia, India, Thailand and Viet Nam, alone.

But by establishing comprehensive responses today, cumulative new infections by 2010 can be reduced from 10 million to 4 million, deaths in 2010 to 0.76 million to 0.66 million and annual losses to US\$15.5 billion.

Resource needs are rising exponentially. In 2003, the countries of Asia-Pacific required more than US\$1.5 billion¹ to finance a comprehensive response but only US\$200 million was available from all sources combined, including the public sector. From 2007 until 2010, US\$5.1 billion will be required each year.

¹ The new UNAIDS global estimates published in July 2004 have revised the Asia Pacific estimate for 2007 to US\$5.9 billion instead of US\$5.1 billion. Since the figures presented in this report were derived jointly by government experts together with global and regional experts, based on the government's current capacity, the older estimates have been retained. The revisions will not make a material difference to the arguments being presented here. Details of the current estimate are available as an ADB/UNAIDS publication. For the new estimates, see the UNAIDS Global Report 2004.

When measured against the enormous human and economic losses that will be averted, these investments are modest. They will result in savings for the region of nearly US\$2 billion annually by 2010.

Moreover, the region as a whole can well afford these investments. Even the peak resource need of US\$5.1 billion annually for the years 2007-2010 is just 4 per cent of current regional health expenditure and 0.2 per cent of regional gross national income (2001).

A key constraint is that too little health spending is publicly financed. Without far greater investment of public resources, the response will remain inadequate and inefficient, key priorities will be neglected, and multisectoral efforts will not develop.

Based on current trends in donor support, public investments across the region must increase ten-fold by 2007. Larger and richer countries can afford to substantially increase public sector investments. In poorer countries, donors must cover funding shortfalls or, where necessary, even fully-fund national efforts.

Public resources should go to financing a large part of all prevention services, and to subsidizing health care and treatments for poor HIV/AIDS-affected households. It is vitally important that governments ensure full funding of prevention programmes for vulnerable populations where most new infections continue to occur, including sex workers and their clients, injecting drug users, men who have sex with men, migrant and mobile populations, and young people. The particular risks faced by women should be identified and addressed.

The widespread problem of limited programming and absorptive capacity must also be addressed urgently. Otherwise, increases in budget allocations will not have meaningful impacts.

At this critical juncture, only resolute action by national leaders can keep the HIV/AIDS epidemic in Asia-Pacific from worsening. Leadership and sustained commitment are crucial if this devastating epidemic is to be overcome. Leaders must:

- ⌘ Close resource gaps,
- ⌘ Back vital prevention programmes and antiretroviral treatment for low income households,
- ⌘ Enable multisectoral responses,
- ⌘ Address absorptive capacity constraints, and
- ⌘ Tackle advanced sub-national epidemics.

A Make-or-Break Period in Epidemic's Scale and Socio-Economic Impact

***The governments of Asia-Pacific and the donors can still
avert a massive increase in infections,
limit economic losses and save tens of millions of
men, women and children from crushing poverty
– if they act quickly.***

The countries of Asia and the Pacific are at a “make-or-break” point on HIV/AIDS. If they scale up their responses quickly to the epidemic and bridge the shortfall in financing for comprehensive prevention, care and treatment programmes, the benefits will be enormous. Millions of people will not become HIV positive, lives will be saved and impoverishment averted as well as the major economic losses that countries face from large numbers of infections.

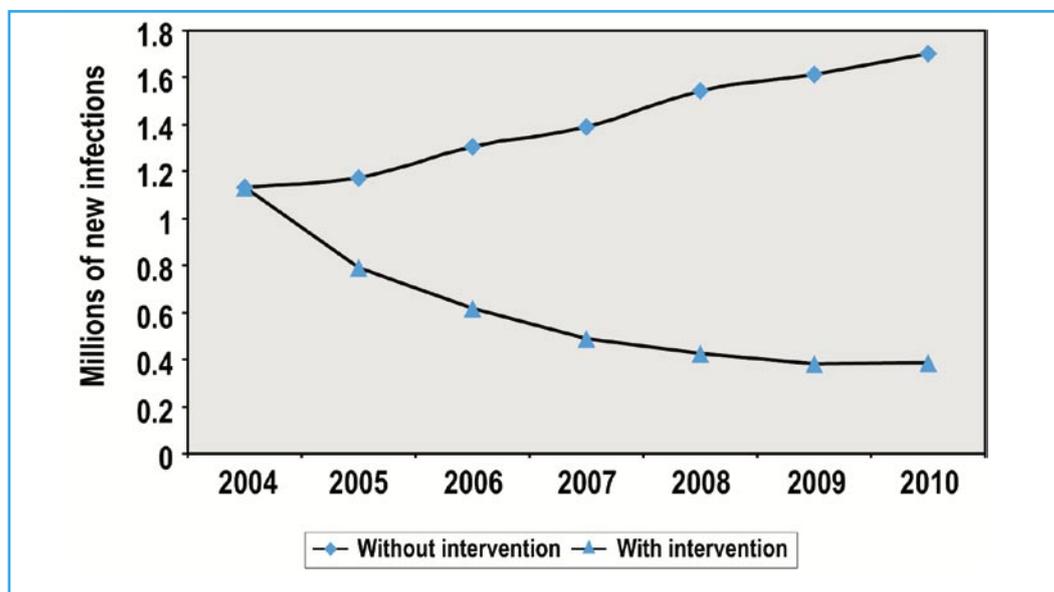
The levels of infection in this region remain low compared to sub-Saharan Africa, but its countries are home to much larger populations – well over half the world's people. Therefore, even at low levels of infection, the course of the epidemic in these populous countries will determine the magnitude of the global HIV/AIDS pandemic over the next decade, as well as its impact.

Already, over 7 million people are living with HIV/AIDS in the Asia-Pacific region; the annual death toll is 0.5 million. India is home to nearly as many people living with HIV/AIDS as South Africa, the country with the greatest number of people infected, even though adult prevalence in India is less than one-twentieth that of South Africa, there are nearly as many people living with HIV/AIDS in India as in South Africa. Similarly, Viet Nam, with an adult prevalence of 0.4 per cent, has 220,000 people living with HIV/AIDS, significantly more than Swaziland, where adult prevalence is over 38 per cent, and more than double the number in the Congo, where adult prevalence is about 5 per cent.

As a result, if prompt action is not taken to put in place an effective response, the number of adults becoming newly infected with HIV in Asia and the Pacific will be close to that of sub-Saharan Africa (Figure 1).² At this rate of increase, a total of 10 million adults and children will be newly infected in the region between 2004 and 2010, and the annual death toll will mount to 750,000 by 2010. In contrast, if comprehensive prevention, care and treatment programmes begin now, the number of people newly infected by 2010 can be contained at 4 million and the number of deaths in 2010 kept to approximately 660,000.

² Derived from Stover J., et. al. (2002), Can we reverse the HIV/AIDS pandemic with an expanded response?. The Lancet; 360: 73-77.

Figure 1: Two scenarios for the number of new infections in Asia-Pacific, 2004-2010



The stakes are just as high in terms of economic losses and the impact on poverty. According to a recent study by ADB/UNAIDS, if prevention, care and treatment efforts continue to be as inadequate as at present, by 2010 yearly losses to the region will equal US\$17.5 billion compared with the estimate of US\$7.3 billion lost in 2001.³ (Estimated losses in 2001 comprised over US\$7 billion in lost income and additional expenses borne by HIV/AIDS-affected households – overwhelmingly the result of the sickness and death of adults – as well as US\$250 million in government spending on HIV/AIDS prevention and care.)

Conversely, the study estimates that the establishment of a successful response today will hold the region's losses to US\$15.5 billion by 2010, implying a savings of nearly US\$2 billion in 2010 alone.⁴ These two scenarios are detailed in Table 1.

Failure to curb the epidemic now will force tens of millions of people into poverty and national efforts to achieve the Millennium Development Goal of poverty reduction will be set back. Studies detailing the poverty impact of HIV/AIDS in Cambodia, India, Thailand and Viet Nam show that significant numbers of households that are not poor are being pushed into poverty and households that are already poor are being rendered destitute, particularly in provinces and areas where the epidemics are more advanced.⁵

³ ADB/UNAIDS (2004), *Socio-Economic Impact of HIV/AIDS in Asia and the Pacific: Current and Future Scenario*. ADB/UNAIDS Study Series: Paper IV.

⁴ ADB/UNAIDS (2004), *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region*. ADB/UNAIDS Study Series: Paper I.

⁵ ADB/UNAIDS (2004), *Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand and Viet Nam*. ADB/UNAIDS Study Series: Paper III.

Table 1: The cost of inaction: Burden of disease and direct and indirect financial costs of HIV/AIDS, 2001 and 2010

Asia and the Pacific	Current (2001) ^a	Baseline response 2010 Comprehensive response does not begin by 2010 ^b	Comprehensive response 2010 Comprehensive response begins in 2004 ^b	Difference 2010 Cost of inaction
Direct Health Costs (Public/Private)				
Prevention (US\$m)	218	3,338	3,180	158
Care (US\$m)	35	1,999	1,743	256
Sub total (US\$m)	253	5,336	4,923	413
Indirect Costs by Households				
Funeral, transport, etc. (US\$m)	171	272	238	34
Carer (lost income) (US\$m)	17	28	25	4
Sufferer (lost income) (US\$m)	6,907	11,869	10,352	1,517
Sub total (US\$m)	7,095	12,170	10,615	1,556
Total Cost (US\$m)	7,348	17,507	15,538	1,968
Cost per person with HIV (US\$)	1,129	1,513	2,511	-
Burden of Disease				
People living with HIV ('000)	6,510	11,570	6,189	5,381
DALYs ('000) ^c	13,660	24,201	19,854	4,347
Deaths ('000)	431	760	663	97

Source: ADB/UNAIDS Study Series: Paper IV.

Notes:

a) HIV prevalence taken from UNAIDS (2002)

b) Derived from Stover J., *et. al.* (2002), Can we reverse the HIV/AIDS pandemic with an expanded response?. The Lancet; 360: 73-77.

Baseline prevention assumes a comprehensive approach has not begun by the end of 2010, in contrast to the comprehensive scenario, in which an expanded approach is implemented from 2004.

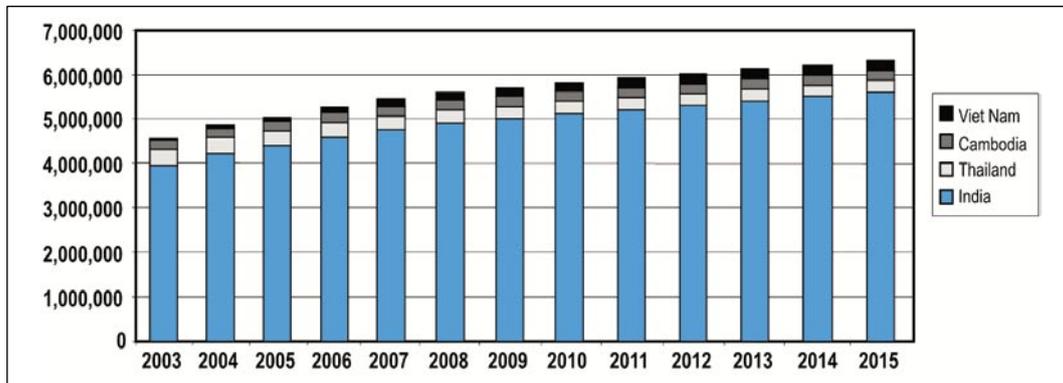
c) DALYs are Disability Adjusted Life Years, calculated by estimating the years of life lost to a specific disease or disease in aggregate.

The same studies estimate that, in every year from 2003 to 2015, an average of 5.6 million people in Cambodia, India, Thailand and Viet Nam will become poor or fall deeper into poverty if the epidemic is not checked now. As much as 88 per cent of the increase in poverty will occur in India. (Figure 2)

The scale of devastation wrought by HIV/AIDS on the countries of sub-Saharan Africa is already visible in the worst-hit areas of several Asian-Pacific countries: large numbers of young adults have died, many years have been shorn off the rate of life expectancy, and hospitals are filled with people sick or dying of HIV/AIDS-related illnesses.

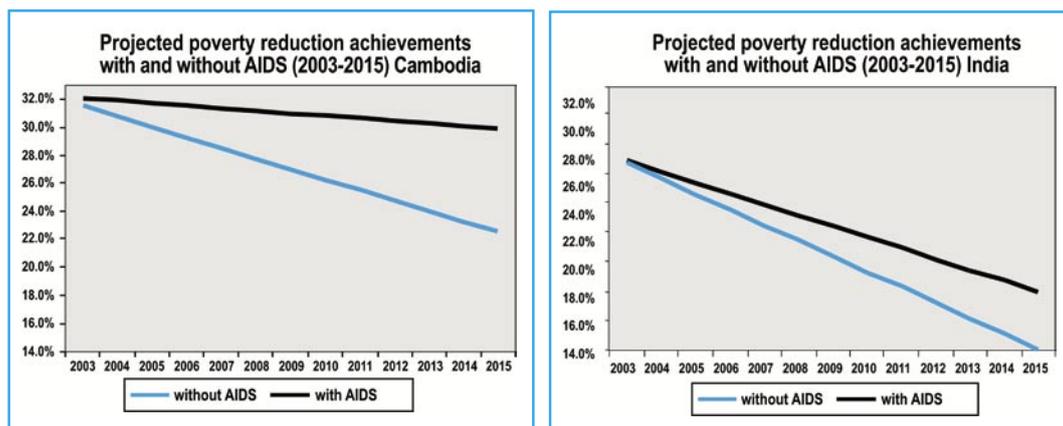
Note: Data on the estimated loss of income due to HIV-related illness and death are currently very limited in the Asia-Pacific region. Similarly, assumptions made in order to estimate poverty – for example, the pattern of income distribution of HIV infected people, coping mechanisms used within a household containing PLWHA, and the expenditures required in seeking treatment and buying medicines – are based on currently available data from the countries.

Figure 2: Projected impact of HIV/AIDS on poverty headcount in Cambodia, India, Thailand and Viet Nam, 2003-2015



Source: ADB/UNAIDS Study Series: Paper III.

Figure 3: Projected poverty reduction achievements with and without AIDS, Cambodia and India, 2003-2015



Source: ADB/UNAIDS Study Series: Paper III.

The studies estimate that in Cambodia, poverty reduction will be slowed by up to 60 per cent every year between 2003 and 2015; in Thailand, by 38 per cent annually; and in India, by 23 per cent annually (Figure 3).⁶

As the HIV/AIDS epidemic is likely to affect poverty in a similar way in other Asia-Pacific countries, the grim scenario of millions of people in the region being impoverished within a decade is all too possible.

Policymakers in the Asia Pacific region have not recognized the level of the devastation, assuming that the epidemic only has a serious impact when it is a large scale, nationwide HIV/AIDS epidemic, not when national HIV prevalence is relatively low.

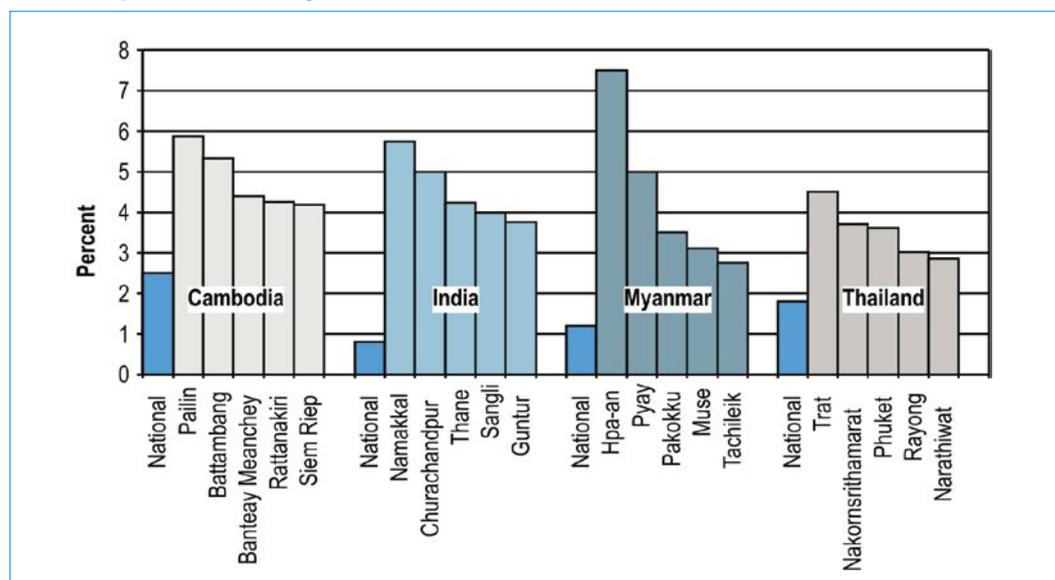
⁶ Ibid.

Country studies by ADB and UNAIDS show this assumption to be false: aggregate losses are found to be severe in provinces/states and areas with higher than average prevalence figures, even in countries where the generalized national epidemic has not yet reached over 1 per cent of adults infected nationally.

The studies cover two countries with generalized epidemics – Cambodia (2.6 per cent adult prevalence) and Thailand (1.5 per cent) – and two with concentrated epidemics, India (0.9 per cent) and Viet Nam (0.4 per cent).⁷ The findings underline the importance of focusing on sub-national epidemiological and socio-economic trends in populous countries (Figure 4). Thus:

- ⌘ In Thailand's Chiangmai province, at the epidemic's peak in 1993, HIV prevalence amongst adults reached 8-10 per cent, three- to four-fold higher than national prevalence in the same year. Some surveys indicate that as many as 15 per cent of the men aged 18-50 have died in the villages of this region.⁸ On several other fronts, the impact in Chiangmai has been far more severe than national indicators would suggest. Life expectancy at birth has fallen by nearly five years, in contrast to a two year reduction nationally. Death rates for young adults have risen 120 per cent in the province compared with 90 per cent nationally. The proportion of children orphaned by AIDS is three times

Figure 4: HIV prevalence among antenatal women at national and selected sub-national provinces in Myanmar, Cambodia, Thailand and India



⁷ ADB/UNAIDS (2004) *Comparison of Impact of HIV/AIDS at National and Selected Sub-national Provinces Level in Cambodia, India, Thailand and Viet Nam*. ADB/UNAIDS Study Series: Paper II.

⁸ UNESCO, Bangkok: (unpublished) Survey data collected as part of National Rural Development Committee (NRD2C) survey of villages in northern Thailand (Zone 10), 1999.

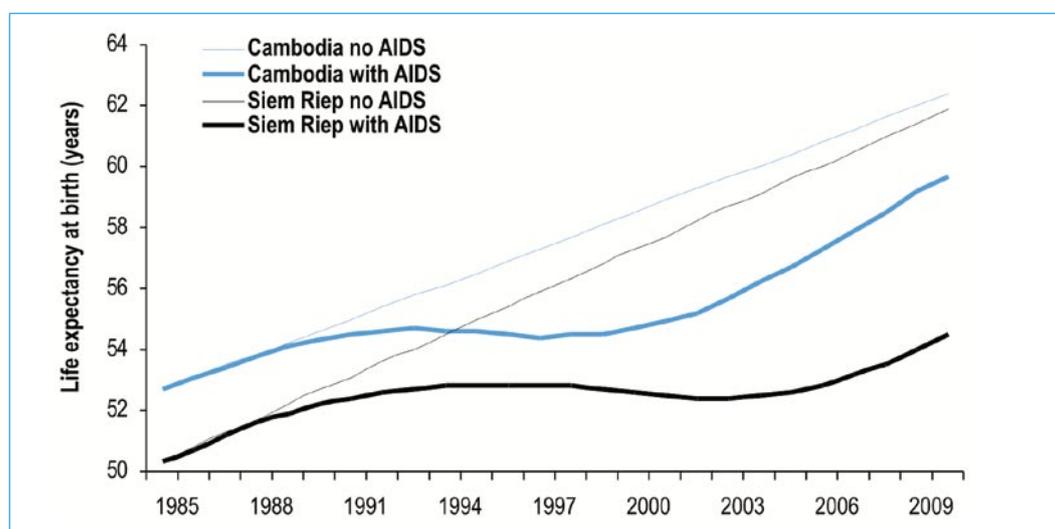
higher in Changmai than the national average, as is the rate of increase in tuberculosis cases.

- ✂ In Cambodia's Siem Riep province, HIV prevalence is nearly double the national average. The ADB/UNAIDS country study estimates that life expectancy in Siem Riep in 2007 will be 7.3 years lower because of HIV/AIDS than it would otherwise have been, whereas national life expectancy will be 2.3 years lower (Figure 5). This reduction in life expectancy in Siem Riep is as severe as that experienced by some sub-Saharan Africa countries – for example in Ethiopia and Nigeria, which have far higher national prevalence rates than Cambodia (6.4 per cent and 5.8 per cent, respectively, at the end of 2001).
- ✂ Adult prevalence in India's Andhra Pradesh state is close to 2 per cent, more than double the national rate. By 2004, one in eight hospital beds in the province will be needed for people sick with HIV/AIDS-related illness – nearly five times the national average.

The impact of HIV/AIDS is already so severe in these areas that it could be argued that they need special programmes of emergency assistance. These programmes should, at the very least, include scaled-up prevention, care and treatment programmes as well as multisectoral efforts to mitigate the impact on households and communities through, for example, subsidized schooling, establishing programmes to support and care for orphans, female and child-headed households, and expanding income-generation projects.

Finally, the evidence from India and Viet Nam indicates that localized HIV/AIDS epidemics are probably also taking a severe toll in seriously affected areas of other Asia-Pacific countries with relatively low national prevalence. These would include: People's Republic of China, Indonesia, Lao PDR, Nepal, Pakistan and Papua New Guinea.

Figure 5: Cambodia's life expectancy trends with and without AIDS, national figures compared to one province (Siem Riep)



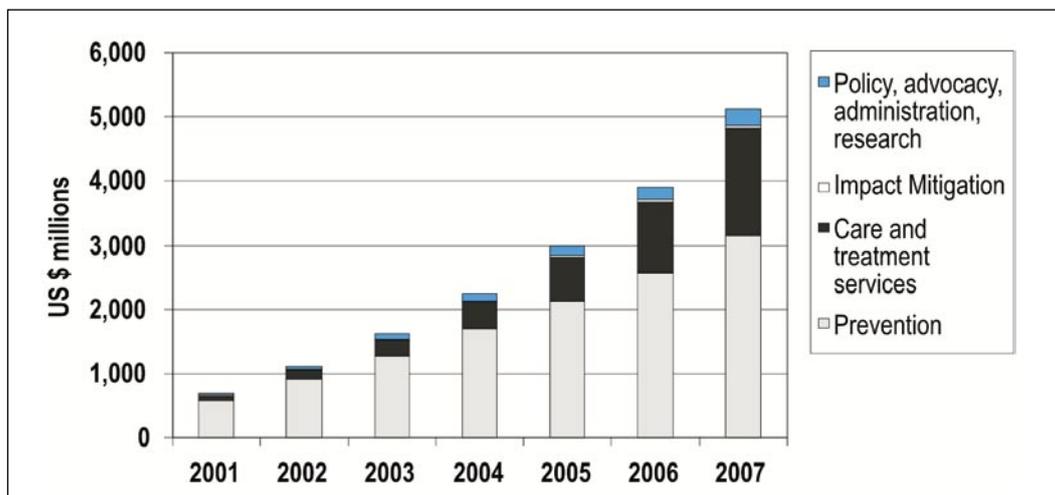
Success Hinges on Ending Resource Shortfalls: Asia-Pacific Can Close the Resource Gaps

A core message of the ADB/UNAIDS studies is that if the leaders of the Asia-Pacific are to succeed in curbing the HIV/AIDS epidemic in the region, they must first tackle the enormous shortfall in the finances needed to establish comprehensive prevention, care and treatment responses in every country.

Comprehensive prevention, care and treatment responses include, as a minimum, programmes for vulnerable groups and young people, treatment of sexually transmitted infections, condom promotion, the use of disposable syringes and the provision of highly-active antiretroviral therapy. The particular risks faced by women must be identified and addressed, and all programmes must safeguard and promote human rights. In both principles and practices, for example, combating stigma and discrimination against people living with HIV/AIDS.

In 2003, the countries of Asia-Pacific needed more than US\$1.5 billion¹¹ to finance a comprehensive response to the epidemic, but only US\$200 million was available from the public sector, donors and government combined. This funding gap is likely to be even greater in coming years, because of the backlog in providing for prevention, care and treatment needs.¹² By 2007, regional resource needs for HIV/AIDS prevention, care and treatment will rise to US\$5.1 billion¹³ – about US\$2.00 per capita (Figure 6).¹⁴

Figure 6: Resources required to fight HIV/AIDS in Asia and the Pacific will triple by 2007



Source: ADB/UNAIDS Study Series: Paper I.

Mitigation of impact include programs for orphans and other activities for affected families

¹¹ ADB/UNAIDS (2004), *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region*. ADB/UNAIDS Study Series: Paper I.

¹² The studies use conservative estimates of resource needs. For instance, the costs of expanding or strengthening infrastructure so that services can be provided broadly, or for the capacity building required to scale up from small to national-level programmes, are not included.

¹³ This figure has been recently revised to US\$5.9 billion (UNAIDS Global Report, 2004).

¹⁴ Ibid.

Rapidly increasing resource needs are a fundamental characteristic of HIV/AIDS epidemics. Both the numbers of people contracting HIV and the numbers falling sick from HIV/AIDS increase exponentially each year, particularly when epidemics reach the generalized stage, as do the costs of providing comprehensive prevention, care and treatment programmes. The escalation in resource needs also reflects the fact that care and treatment – particularly antiretroviral therapy – are more expensive than prevention. Such considerations make it all the more essential that governments and donors in the Asia-Pacific region finance and facilitate comprehensive responses while HIV prevalence is still relatively low in their countries. In many cases, public health budgets are disproportionately skewed towards secondary and tertiary care ignoring the need for home based care, outreach for treatment and VCT services.

The resources needed are considerable. But, when viewed from the perspective of the savings that result – nearly US\$2 billion annually by 2010, as shown in Table I – they are modest and fully justified investments.¹⁵

Moreover, the region as a whole can well afford to close this large shortfall in financial needs, now and for the rest of the decade. Even the peak resource needs of US\$5.1 billion annually for the years 2007-2010, amount to only 4.4 per cent of present regional health expenditure (2001) and 0.2 per cent of the region's US\$2 trillion gross national income of 2001.

Rather than affordability, the main constraint in Asia-Pacific is that too little health spending is publicly financed and provided.¹⁶ Between 1997 and 2000, about three-quarters of total health spending in the region involved private payments to private providers of healthcare, with the public sector financing just one-quarter of health services.¹⁷ Households bear large out-of-pocket costs which, as a proportion of household income, are among the highest in the world.¹⁸ (Thailand is the exception in the region, with a large proportion of healthcare costs borne by the government through tax, insurance or other prepayment mechanisms.)¹⁹ In the case of HIV/AIDS-related care and treatment, this pattern is especially inequitable as persons living with HIV/AIDS, and their families, are often the least able to bear large additional expenses.

¹⁵ ADB/UNAIDS (2004), *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region*. ADB/UNAIDS Study Series: Paper I.

¹⁶ *Ibid.*

¹⁷ ADB/UNAIDS (2004), *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region*. ADB/UNAIDS Study Series: Paper I, citing World Bank 2003.

¹⁸ ADB/UNAIDS (2004), *Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand and Viet Nam*. ADB/UNAIDS Study Series: Paper II, citing World Bank 2003.

¹⁹ ADB/UNAIDS (2004), *Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand and Viet Nam*. ADB/UNAIDS Study Series: Paper III.

Sharing resources fairly, and focusing public resources on well-targeted programmes that offer general rather than patient-specific benefits, will ensure that comprehensive prevention and care programmes can be successfully expanded.²⁰

The ADB/UNAIDS studies describe the likely scenario as sharing of financing between governments, donors, insurance and households, assuming that financing from donors and the Global Fund to Fight AIDS, Tuberculosis, and Malaria does not increase. Table 2 details this for 2007, based on the US\$5.1 billion needed for that year.

Table 2. Likely share of funding for HIV/AIDS programmes in Asia-Pacific, 2007

Source	US\$ millions	Percentage Distribution
National and Local Governments	2,000	39
Donor Assistance	500	10
Global Fund AIDS, TB, Malaria	100	2
Private out-of-pocket spending, private insurance and social insurance	2,500	49
TOTAL	5,100	100

Source: ADB/UNAIDS Study Series: Paper I.

National and local governments have an important role to play in financing comprehensive HIV/AIDS programmes. It is a role that can certainly be fulfilled by the governments of the larger or better-off countries of Asia-Pacific. Without far greater investment of public resources and rationalization in the use of current budgets, the region's response to the epidemic will

remain inadequate and inefficient. Key priorities will remain neglected. Nor will a genuinely multisectoral response develop, as this hinges on a broad range of line ministries allocating – or receiving – funds for HIV/AIDS efforts. Thus, the ADB/UNAIDS studies indicate that public sector investments should increase ten-fold from 2003 levels to, at least, US\$2 billion in 2007 to meet the unmet needs.

These sums should contribute both to financing a large part of all prevention services and – crucially important in terms of blunting the poverty impact of HIV/AIDS – to subsidizing and expanding health care, including antiretroviral therapy, for poor and low-income households. Poorer households are the least able to afford care and treatment and are most severely affected by the loss of income resulting from HIV/AIDS-related sickness and death.²¹ Even with adequate resources, countries are likely to increase their poverty head count unless a pro-poor programme is implemented for treatment, care and alleviation of impact. Governments must ensure that sufficient public funds are available for effective prevention programmes for vulnerable populations, particularly sex workers and their clients, injecting drug users, men who have sex with men, young people and migrant and mobile populations. (Possible exceptions may be found in the Pacific Islands, where the epidemic type reflects those of Africa in nature.) The critical overall goal for governments is to ensure wide and equitable access to prevention and care.

²⁰ ADB/UNAIDS, *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and Pacific Region*. ADB/UNAIDS Study Series: Paper I.

²¹ ADB/UNAIDS (2004) *Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand and Viet Nam*. ADB/UNAIDS Study Series: Paper III.

International assistance must also increase. Resources from the GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria), for example, are likely to be in the order of US\$100 million annually, although the total grants, which cover periods of up to five years, are substantially larger. There are also substantial official bilateral and private assistance operations already in place that can be expected to increase.

International assistance cannot substitute for government financing in the region because of the massive scale of resources needed. Studies emphasize that in the poorer countries, donors may have to take on the responsibility for covering funding shortfalls or even fully funding national efforts. The need for significant international and donor support is especially relevant to the Pacific Island States, many of which are burdened by severe budgetary constraints and infrastructures too weak to serve their dispersed populations.

Together, private out-of-pocket payments, private insurance and social insurance will be required to cover half of the spending on HIV/AIDS prevention and care in 2007. Governments can effectively promote private and social insurance coverage for HIV/AIDS care and treatment through policy and legislative changes, for instance, by requiring insurance policies to cover treatment and care for HIV/AIDS or sexually-transmitted infections. And, although the remaining burden on households appears enormous, they will have been spared significant additional costs. Without the increase in public sector financing of comprehensive HIV/AIDS programmes, households would have been burdened with another US\$1.5 billion annually in lost income and additional expenses. (This sum is the difference between the burden on households in the “baseline” and “comprehensive” response scenarios portrayed in Figure 1.)

Box 1. National approaches to resource mobilization: some examples

Governments in Asia-Pacific have used a variety of approaches to address resource mobilization needs.

Thailand established itself as a leader in committing public funds to its HIV/AIDS response. Public financing was key to building a genuinely multisectoral response, with a broad range of line ministries allocating funds for HIV/AIDS efforts. Sustained public financing for HIV/AIDS dates back to the early 1990s, when the government initiated a high-profile campaign to control HIV and, by 1996, reversed the ratio of 90 per cent external funding to 5 per cent.²² In spite of substantial reductions (more than a third) in national funding, Thailand continues to spend approximately US\$0.63 cents annually per person on prevention and treatment, over nine-tenths of it from public sector funds.

To help close funding shortfalls for key priorities, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has recently approved substantial funding for Thailand's efforts.

The Government of the People's Republic of China has allocated US\$1.2 billion to HIV/AIDS prevention, treatment and care for 2003-2004. For the fiscal year 2004, this is expected to represent a four-fold increase in funding.

In Nepal, the Government developed a five-year multisectoral national framework on HIV/AIDS for which it successfully sought donor participation. The framework and resource targets are predicated on ensuring that at least 60 per cent of all vulnerable populations are covered by comprehensive prevention and care programmes. Participating donors include AusAID, DFID and USAID. The UN system is providing technical assistance and the mechanism for fund disbursement .

In Myanmar, UNAIDS has helped to organise a special fund to tackle the epidemic over the next three years. The fund advances joint programming as well as donor coordination. Finance is received from donors based on agreed priority and a common plan of action, and distributed between the public sector, non-governmental organizations and UN agencies.

²² World Bank 1997; *Confronting AIDS: Public Priorities in a Global Epidemic*, page 276.

Box 2: Programming and absorptive capacity constraints must be addressed in tandem with resource mobilization

With few exceptions, the countries of the Asia Pacific region (like many around the world) are hampered in their response to HIV/AIDS not just by resource shortfalls but also by insufficient capacity to effectively use what funds are available.

An exploratory study of the situation in several countries in the region highlighted the nature of some of these constraints and the implications for HIV/AIDS related programming. In many cases, the physical and human resources of health systems are insufficient to utilize major new programmes. In addition, effective HIV/AIDS programme responses require innovative multisectoral public and private engagement, and the administrative and organization capacity needed to enact such partnerships is not available.

An outcome of this situation is that funds are not disbursed as planned and needed. For example, several countries in the region have received large World Bank IDA credits for HIV/AIDS programme responses but been unable to disburse these funds at an acceptable rate. This is despite long experience with implementing health and nutrition programmes and the availability of many capable non-government organizations. In some cases, the systems established for HIV/AIDS donor funds remain centrally controlled and encumbered by requirements for complex disbursement procedures. As a result, credit lines have been reduced while programme needs continue to increase.

Reforms and innovative management procedures are possible and have been enacted. Decentralization of funds administration and de-linking management bodies from the regular government administrative procedures can greatly expedite funds disbursement.

Human resources are critical for the enhancing and scaling up the success of programmes. Managers at national and provincial or state levels need training and the capacities of non-government organizations need to be enhanced and expanded. Given the key role of health systems in achieving priority goals, specific attention to strengthening the health care workforce is also required. For most countries, it will take several years to build up the human, organizational and infrastructure capacity to deliver expanded responses. This, therefore, must be an early priority of new and expanded programmes.

Political Leaders Are Critical to Resource Mobilization and Action

At this crucial juncture, only resolute action by all leaders can keep the HIV/AIDS epidemic in the countries of Asia-Pacific from worsening. National leaders must:

- (1) Close the resource gaps: There is simply no substitute for political leadership on this front. Only national leaders in each country – with the support of regional and global donors and partners – have the power to end the resource shortfalls. Far greater investments in the public sector are needed both to strengthen the health sector and to expand coverage with comprehensive HIV/AIDS prevention and care programmes.
- (2) Guarantee political backing for vital programmes: Governments must ensure full funding for effective prevention programmes for vulnerable populations, including sex workers and their clients, injecting drug users, men who have sex with men, young people, and migrant and mobile populations. Political support for research and evidence-based policies is crucial. In addition, governments should consider using legislation and policy to expand private and social insurance coverage of HIV/AIDS and STI care and treatment. Antiretroviral programs for poor and low income households must be financed by the public sector.
- (3) Enable a multisectoral response: Sustained and adequate public sector investments are essential to build a genuinely multisectoral response to HIV/AIDS. A broad range of line ministries, including the uniformed services, education, labour and transport ministries, must have their own budgets and targets for prevention, care and mitigation efforts. Political leadership is essential to encouraging and enabling a multisectoral response that includes gender responsive, anti-discriminatory and pro-poor institutional, policy and legal frameworks.
- (4) Address programming and absorptive capacity: Leaders must draw attention to and address the governance, human, organizational, and infrastructural constraints in current procedures and regulations that impede the receipt of funds and effective utilization of resources, in the health sector as well as non-health sectors.
- (5) Respond to sub-national epidemics: National leaders must identify, acknowledge and address the localized epidemics that are taking a significant human and socio-economic toll even in low-prevalence nations. Leaders should focus attention on sub-national epidemiological and impact data, and fund HIV/AIDS-focused “disaster relief” programmes for these areas, including scaled-up prevention, care, treatment and impact-mitigation efforts.

The ADB/UNAIDS Studies Series

The reports featured in this paper are part of an effort by the Asian Development Bank and UNAIDS to improve understanding of the scale of financial resource requirements to successfully respond to HIV/AIDS in the Asia-Pacific and the implications of failure to achieve these resource needs.

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