Development Assistance Committee

Analysis of aid in support of HIV/AIDS control, 2000-2002

This report presents the results of a review of statistical data on aid to HIV/AIDS control, carried out by the DAC Secretariat in collaboration with members of the DAC Working Party on Statistics (WP-STAT) and Joint United Nations Programme on HIV/AIDS (UNAIDS) between February and May 2004.

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Key findings

In 2000-02 DAC members' total official development assistance (ODA) commitments for HIV/AIDS control were USD 2.2 billion per year. Bilateral aid to HIV/AIDS control amounted to USD 1.1 billion per year and allocations to the Global Fund to fight AIDS, tuberculosis and malaria to USD 0.5 billion per year. The remainder is DAC members' estimated aid to HIV/AIDS control through core funding to United Nations organisations and the World Bank. A clear trend towards rising HIV/AIDS-related expenditure was apparent over the triennium.

The United States accounted for over a third of total bilateral commitments; the United Kingdom was the second largest source of financing. Larger donors, especially multilaterals, are the main funders of treatment programmes, which require substantial funding and long-term commitments. Smaller donors tend to concentrate on HIV prevention, but also supported home-based care and social mitigation activities.

Sub-Saharan Africa was the main recipient region. The top three recipient countries were Nigeria, Kenya and Uganda.

Current data systems of the DAC allow robust estimates to be made but developing a more precise coding system would increase the usefulness of the data for analytical purposes.

I. Introduction

1. This report presents the results of a review of statistical data on aid to HIV/AIDS control, carried out by the DAC Secretariat in collaboration with members of the DAC Working Party on Statistics (WP-STAT) and Joint United Nations Programme on HIV/AIDS (UNAIDS) between February and May 2004. The objectives of this review were to:

- verify the data on aid to HIV/AIDS control reported to the CRS Aid Activity database for years 2000-02 and complete these so as to provide definitive statistics for the XV International AIDS Conference in Bangkok (11-17 July 2004);
- assess the extent to which the standard statistical methodology allowed the bulk of these flows to be identified; and
- make proposals for improving data collection in the future.

2. The report first recalls the background and rationale of the study (section II) and explains how it was carried out (section III). It then presents members' contributions in a summary form (section IV). The data are presented in a number of tables, but some descriptive information on members' HIV/AIDS activities is also given. (Data cover ODA only. Aid to HIV/AIDS control reported to the study for countries on Part 2 of the DAC List of Aid Recipients is excluded from the analysis but are included in the list of aid activities presented in Part 2 of this publication.) Further actions to improve the quality of statistics in this field are suggested in section V.

II. Background and rationale

3. The DAC Secretariat received an official request for a review of statistical data on donors' assistance to HIV/AIDS control from UNAIDS in January 2004. This follows several years of collaboration between the DAC Secretariat, UNAIDS and the United Nations Population Fund (UNFPA). But work on the study has also been stimulated by numerous requests for data on aid to HIV/AIDS control from aid agencies, NGOs and development research institutes. In donor countries HIV/AIDS is subject to parliamentary requests and debates between governments and NGOs. Data requests are also received from the governments of aid recipient countries. UNAIDS gets on the average five data requests each day. In 2005, UNAIDS will need data for its preliminary report on the review of progress made in relation to targets set out in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). (As regards resources, the Declaration of Commitment on HIV/AIDS for 2005 states 'Ensure financing of at least USD 7-10 billion for HIV/AIDS programmes in low and middle income countries'.)

4. HIV/AIDS remains one of the greatest development challenges of our day. It is the first disease mentioned in Millennium Development Goal 6.[1] [2] At the same time, measuring aid to combat HIV/AIDS presents special problems. In countries with high HIV prevalence, the effects of the disease reach far beyond individual misery, undermining social infrastructure and productive capacity. Thus activities in many fields remote from immediate prevention and treatment concerns can help mitigate the consequences of the epidemic.

5. In DAC statistics, aid to HIV/AIDS control is classified under the "population/reproductive health" sector. Activities are identified with the help of the purpose code "STD control including HIV/AIDS" (code 13040), defined as comprising ***"all activities related to sexually transmitted diseases and HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care"***. In discussions with data users, the Secretariat is frequently requested to address the following concerns:

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1 MDG6: Combat HIV/AIDS, malaria and other diseases. Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

2 Preventing the spread of HIV/AIDS was also recently rated by a panel of top international economists as having the highest priority among 17 possible uses of additional international funding See www.copenhagenconsensus.com.

- The data may not relate solely to HIV/AIDS control as all sexually transmitted diseases are covered by the same purpose code.

- In the DAC sector classification each purpose code covers only those activities that have the stated purpose as their main focus. Thus the HIV/AIDS code does not encompass relevant activities that are integrated into basic or reproductive health care programmes.

- HIV/AIDS control is not necessarily limited to interventions within the health sector.

- The classification does not distinguish between resources devoted to HIV/AIDS prevention, treatment and care.

6. Thus, in addition to providing data for the Bangkok Conference, the study aimed to determine the extent to which the standard statistical methodology (see Box 1) captured donors' assistance to HIV/AIDS control.

Box 1. Reporting on the purpose of aid in DAC statistics

In DAC statistics (and in most members' internal reporting systems) each activity can be assigned **only one purpose code**. This is to avoid double-counting when summing up activities in different ways. For activities cutting across several sectors (e.g. health and reproductive health), either a multisector code or the code corresponding to the largest component of the activity is used.

The method of assigning a single purpose code is usually taken to imply that DAC statistics underestimate aid allocated for a specific purpose. This is true if members generally use multisector codes for multisector projects. On the other hand, overestimation can occur in cases where the normal practice is to select the code of the largest component of the activity. To improve the accuracy of data on the sectoral breakdown of aid, some members have decided to report aid activities at the component level.

At present the method of assigning a single purpose code is the only practical means of standardising reporting on a basis that permits valid donor comparisons. The feasibility of collecting data through multiple purpose codes may be discussed at the WP-STAT in future. Four members have implemented such a "sector profiling" system internally and informed the Secretariat of both positive and negative experiences.

Purpose code based statistics are supplemented with data on the **policy objectives of aid**. The reporting is based on a marking system with three values: "principal objective", "significant objective", and "not targeted to the policy objective". Each activity can have more than one policy objective. At present the DAC has six policy markers [gender equality (including WID), environmental sustainability, participatory development/good governance and the three Rio Conventions]. Five members (Australia, Netherlands, Norway, Sweden, United Kingdom) have recently started to monitor HIV/AIDS spending in their internal systems through a policy marker.

Text search is another method to retrieve additional information on the purpose of aid in DAC statistics. From a methodological point of view, statistics based on text search could be considered as resembling those produced with the policy objective markers although they are of course less precise. (For HIV/AIDS, for example, the activities picked up through text search may not be entirely focused on HIV/AIDS control. However, since HIV/AIDS is mentioned in the project description, it is likely that they would not have been undertaken without this purpose, or without a major component of the activity being HIV/AIDS control.)

III. Scope and coverage of the study

7. The proposal for the special study on aid to HIV/AIDS control was prepared by the DAC Secretariat in consultation with UNAIDS. It was built on a first analysis of aid to HIV/AIDS control reported to the DAC (CRS Aid Activity database) and an examination of supplementary data provided by Canada and Norway.[3] Having obtained DAC members' support for the study, the Secretariat examined the CRS data for three years (2000-02) more thoroughly and prepared, for each member individually, a letter with a number of attachments for verification and completion. The questions had been developed around the following principles:

a) Activities classified as "STD control including HIV/AIDS" (purpose code 13040) were referred to as "HIV/AIDS control activities".

8. The first analysis of CRS data carried out to prepare the proposal for the study had indicated that the large majority of activities reported under purpose code "STD control including HIV/AIDS" related to HIV/AIDS.[4] Taken that the study was to cover commitments in 2000-02, the simplification was considered as fully legitimate. (General STD control programmes were common in the early 1990s. In recent years focus has inevitably been on HIV/AIDS.) Another justification for this approach was that it was difficult to imagine a STD control programme that would not contribute to HIV/AIDS control.

b) Data previously reported to the CRS were thoroughly examined.

9. HIV/AIDS activities incorporated in wider health, reproductive health or other programmes can be identified in the CRS through text searches if "HIV" or "AIDS" (or "VIH" or "SIDA") appear in the project title or description. While the results of text search need to be carefully verified [e.g. to avoid counting e.g. "navigation aids" or contributions to Spanish-language universities (universidad) as HIV/AIDS control], they do permit an easy selection of activities likely to include significant HIV/AIDS components.

c) The aim was to collect data that would give a reliable statistical estimate of the magnitude of DAC members' aid to HIV/AIDS control (as opposed to providing accurate accounting records) to be presented at the XV International AIDS Conference in Bangkok.

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3 Internal databases of Norway and Canada permit tracking HIV/AIDS activities in all sectors. Norway (NORAD) uses a policy marker. Canada (CIDA) has a system that permits an activity to be assigned multiple purpose codes and estimate the amount of aid allocated to each. Both include the supplementary data in their CRS reporting (using "free text fields").

4 For years 1999-2002, DAC members reported 2169 activities with purpose code 13040. Over 1800 activities (85%) mentioned HIV/AIDS explicitly in the project title or description.

10. Aid to HIV/AIDS control can straddle all sectors. Information, education and communication activities can be incorporated in basic education for young people and adults. Multisectoral social programmes can include HIV/AIDS components. Transport is frequently referred to as an important sector to fight against HIV/AIDS. It was nevertheless likely (and the cases of Canada and Norway provided some evidence for this) that the largest amounts of aid to HIV/AIDS control were allocated within the health sector.[5] As the time available to collect data for this study was approximately two months, the DAC Secretariat and UNAIDS recommended limiting supplementary data collection to health and reproductive health activities [purpose codes 12110 to 13081], including however certain types of multisector activities (activities classified under "multisector aid for basic social services" [purpose code 43020], small projects funds).

11. To reduce the administrative burden in refining the available CRS data, the Secretariat suggested that members limit their examination to activities above a certain threshold.[6] The threshold was set so that at least 80-90% of the total value of activities was covered. In practice, this meant USD 100 000, except for Greece and Ireland where USD 50 000 was used. No threshold was set for Luxembourg and New Zealand as these countries had not previously reported aid to health in the CRS. Members that already used some other system for tracking aid to HIV/AIDS for their internal purposes were allowed to report the readily available data. The Secretariat examined these and advised on whether they could be considered to be comparable with those of other donors.

12. Finally, statistics on DAC members' aid to HIV/AIDS control would not be complete without data on their multilateral aid. Data were therefore to be collected also on aid to HIV/AIDS control extended by United Nations organisations and international financial institutions. This part of the study was carried out in close collaboration with UNAIDS to benefit from its experience in identifying HIV/AIDS spending in the context of the UN System Strategic Plan on HIV/AIDS (UNSSP).

13. The UNSSP was developed by UNAIDS in collaboration with 29 UN agencies to guide the UN system response to the pandemic over the period 2001-2005. It identifies the partnerships and synergies necessary to support countries to achieve the UNGASS goals. It also addresses the functional competencies that characterise the "special contribution" of the UN System. The UNSSP encapsulates the HIV/AIDS related plans and strategies developed by the participating organisations. It provides an overview of each organisation's HIV/AIDS related mandate, spending and human resources. At present data on spending are available in divergent forms and with differing levels of detail. Data collection on multilateral aid to HIV/AIDS control for the study would also assist UNAIDS in further developing the UNSSP.

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5 The data for both Norway and Canada suggested that the HIV/AIDS purpose code covered most but by no means all bilateral aid for this purpose. In the case of Norway, the inclusion of activities marked as targeting HIV/AIDS control as principal objective increased the total amount by 50%. For Canada, the HIV/AIDS components identified through CIDA's "multiple purpose coding system" accounted for an additional 10%, but the analysis revealed that not all Canadian aid to HIV/AIDS control was financed by CIDA. The data also confirmed that HIV/AIDS activities were incorporated in various social sector and multisector projects and programmes. Within the social sectors, the majority were classified as aid to health. (For Norway, "social welfare and services" was also significant.) By contrast, very few activities were found within economic infrastructure, production or the "non-sector allocable" categories. Excluding them would not have a great impact on the total.

6 Applying a threshold of USD 100 000 to activities in the health and reproductive health sectors in 2000-2002, for example, reduced the number of activities donors had to examine from over 9000 to 4600.

IV. Members' responses

14. The Secretariat's letter requested members to:

a) Verify the correctness of the data reported under purpose code 13040[7];

b) Examine the HIV/AIDS related activities identified through text search and confirm whether or not these could be included in statistics on aid to HIV/AIDS control with their full amounts[8];

c) Examine other activities in health and reproductive health sectors and identify those related to HIV/AIDS (marking them "yes" or "no") and, if possible, report the amounts estimated to be spent on HIV/AIDS control;

d) Verify data on their contributions to UNAIDS and report contributions to any other organisations/funds that in their view ought to be included in statistics on aid to HIV/AIDS control.

15. All 23 members responded, and nearly all responded to all questions.[9] In addition, taking advantage of the Secretariat's visits to member countries in the context of other work, the questions were discussed also with HIV/AIDS specialists of eight aid agencies.[10]

16. This section presents the data collected in the study in tables and charts and summarises members' comments. Section IV.1 discusses members' bilateral aid to HIV/AIDS control and section IV.2 their contributions to the Global Fund to fight AIDS, tuberculosis and malaria. Section IV.3 deals with aid to HIV/AIDS control extended by multilateral organisations and the question as how to estimate, for each member, aid to HIV/AIDS control channelled through the multilateral system. DAC members' total aid to HIV/AIDS control is shown in section IV.4, and the geographical breakdown in section IV.5.

IV.1 DAC members' bilateral aid to HIV/AIDS control

17. Table 1 below presents the data on DAC members' bilateral aid to HIV/AIDS control (excluding contributions to the Global Fund to fight AIDS, tuberculosis and malaria). It shows that in 2000-02 DAC members allocated on average USD 1.1 billion per year directly for this purpose. In addition, HIV/AIDS control activities were included in broader health and reproductive health programmes. This amount is unknown but does not, in any case, exceed USD 270 million per year.

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7 This code could be assigned to activities only partially targeting HIV/AIDS control. (See Box 1.)

8 To present the data along with those derived from purpose codes, it was thought necessary to estimate how large a share of each activity targeted HIV/AIDS control. (See Box 1.)

9 All members except the United States examined the data previously reported to the CRS. The United States provided a new data set and thus did not respond to questions b), c) and d).

10 These were Belgium, France, Germany, Italy, Netherlands, United States, World Bank and UNDP.

18. Chart 1 illustrates the trend. DAC members' total bilateral commitments increased by 64% between 2000 and 2002 (by 90% if growth is calculated on the basis of the upper limit). The chart also addresses the question as to what extent the DAC's standard reporting systems capture members' aid to HIV/AIDS control.

Chart 1. DAC members' bilateral aid to HIV/AIDS control captured in the DAC's standard statistical reporting systems

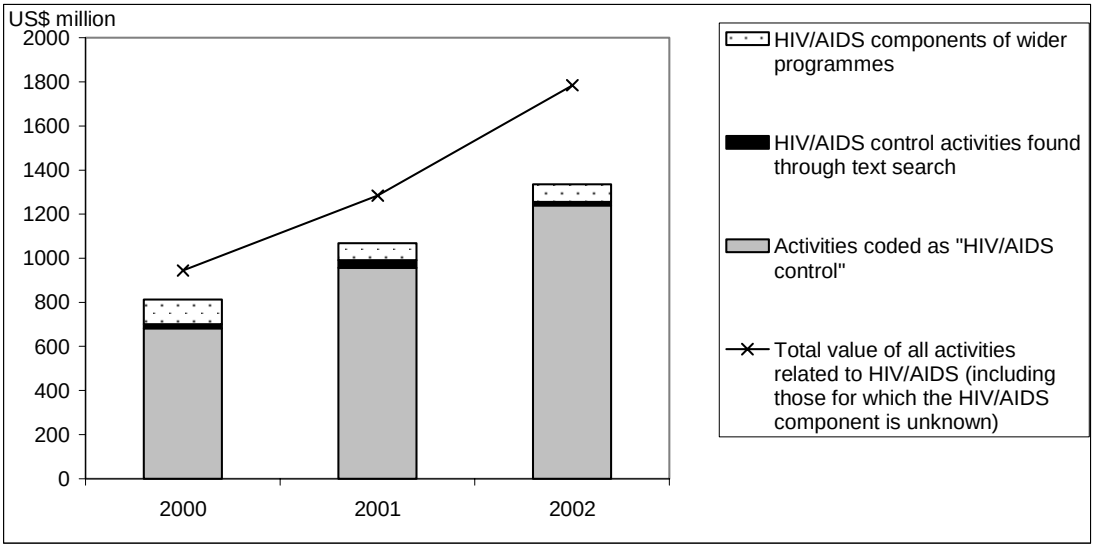

Table 1. DAC members' bilateral aid to HIV/AIDS control in 2000-02, commitments, millions of USD

	Activities coded as "HIV/AIDS control"				2000-02 average			
	2000	2001	2002	2000-02 average	Text search	Components	Total	Upper limit
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Australia	32.3	26.4	10.7	23.1	1.8	4.5	29.4	29.4
Austria	0.1	0.1	0.1	0.1	0.0	0.1	0.2	0.6
Belgium	7.9	2.6	13.2	7.9	0.0	0.4	8.3	8.3
Canada	43.8	36.6	50.9	43.8	0.1	3.8	47.6	47.6
Denmark	1.7	2.0	14.7	6.1	0.1	2.0	8.2	20.1
Finland	0.4	1.9	0.7	1.0	0.0	0.0	1.0	10.5
France	22.2	19.3	22.4	21.3	0.4	0.2	21.9	21.9
Germany	16.8	29.0	32.0	25.9	7.4	5.5	38.8	53.0
Greece	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Ireland	0.3	4.3	25.6	10.1	0.2	3.5	13.8	13.8
Italy	4.5	1.1	2.8	2.8	0.2	0.9	3.9	6.6
Japan	15.6	17.2	13.3	15.4	0.0	0.9	16.3	32.8
Luxembourg	0.0	0.9	8.5	3.1	0.0	0.0	3.1	5.1
Netherlands	33.1	48.7	78.9	53.5	1.0	7.7	62.2	115.5
New Zealand	0.1	0.3	0.5	0.3	0.0	0.0	0.3	0.3
Norway	26.5	44.8	16.1	29.1	7.0	5.1	41.2	99.4
Portugal	0.0	0.0	0.0	0.0	0.0	2.3	2.3	46.6
Spain	1.8	2.5	5.6	3.3	0.1	0.0	3.4	3.5
Sweden	9.2	14.3	35.7	19.7	1.7	0.2	21.6	21.6
Switzerland	0.7	0.2	0.8	0.5	0.0	3.1	3.6	3.6
United Kingdom	117.4	106.1	77.4	100.3	3.0	43.2	146.5	188.1
United States	329.3	582.7	787.8	566.6	0.0	0.0	566.6	566.6
EC	28.6	24.0	55.2	35.9	0.2	6.1	42.3	52.6
Total DAC	692.1	964.9	1253.0	**970.0**	23.3	89.6	**1082.9**	**1347.9**

Notes:

Denmark is finalising an internal study on aid to HIV/AIDS control, and may revise data presented in this report.

Norway reported data for years 2001-03.

For **Norway** and the **United Kingdom**, activities reported as having HIV/AIDS control as a significant objective are included in column 8.

Data for the **United States** consist of different government departments' budgetary allocations to HIV/AIDS control activities in aid recipient countries on a fiscal year basis. The figures include HIV/AIDS research by the National Institutes of Health (USD 490 million in 2000-02) and a part of activities of the Centers for Disease Control (USD 139 million) not previously reported to the CRS. Excluding these gives a total of USD 1.1 billion over 2000-02. Aid to HIV/AIDS control reported to standard CRS (commitments on a calendar year basis) amounts to USD 1.2 billion over 2000-02.

Review of data received

19. ***Activities reported as having HIV/AIDS control as their main purpose - code 13040*** *(see columns 1-4):* Members were requested to verify the accuracy of data for years 2000-02 for each reporting agency. Six members confirmed the figures. Nine members adjusted the data slightly upwards and three slightly downwards. Five members reported significantly larger amounts than before by providing for the purposes of this study data on the activities not included in their standard CRS reporting.[11]

20. ***Text search*** *(see column 5):* Through text search the Secretariat identified 232 activities not coded as 13040.[12] A few donors commented that the text search was a useful method to improve their purpose coding and revised their data shown in columns 1-3. Most other activities were considered as HIV/AIDS related but not necessarily for the full amount. The majority were social programmes for people living with HIV/AIDS (coded under sector 163) and a few HIV/AIDS related contributions reported as emergency aid. These are shown in column 5.

21. ***HIV/AIDS components in wider health and reproductive health programmes*** *(see column 6)*: Twenty members reported 1022 activities with HIV/AIDS components. The amount estimated to be spent on HIV/AIDS control was provided by 17 members for 623 activities. Three members reported it was not possible to estimate the HIV/AIDS amounts. Two members responded that they had examined the list of activities provided by the Secretariat but none of the activities included HIV/AIDS components. The total amount of aid to HIV/AIDS control identified through this method was USD 90 million per year, which represents a 30% increase (excluding the United States) over the amount identified solely through the purpose codes. If other activities including HIV/AIDS components (of unknown amounts) are taken into account, the upper limit of average annual bilateral aid to HIV/AIDS control in 2000-02 can be estimated at USD 1.3 billion per year (column 8).

22. Chart 2 presents, for reference, the share of HIV/AIDS commitments in the total for each health and reproductive health purpose code. [It shows, for example, that the total amount of infectious disease control activities with HIV/AIDS components was USD 100 million over 2000-02. Data on the amount specifically allocated to HIV/AIDS control were available for 50 activities (the total of which was USD 75 million). The HIV/AIDS components summed up to USD 40 million.] It is important to note that these are averages and that the variations were large. Two members [Belgium and Germany] examined all activities in health and reproductive health sectors and found HIV/AIDS components ranging from 10 to 90%.

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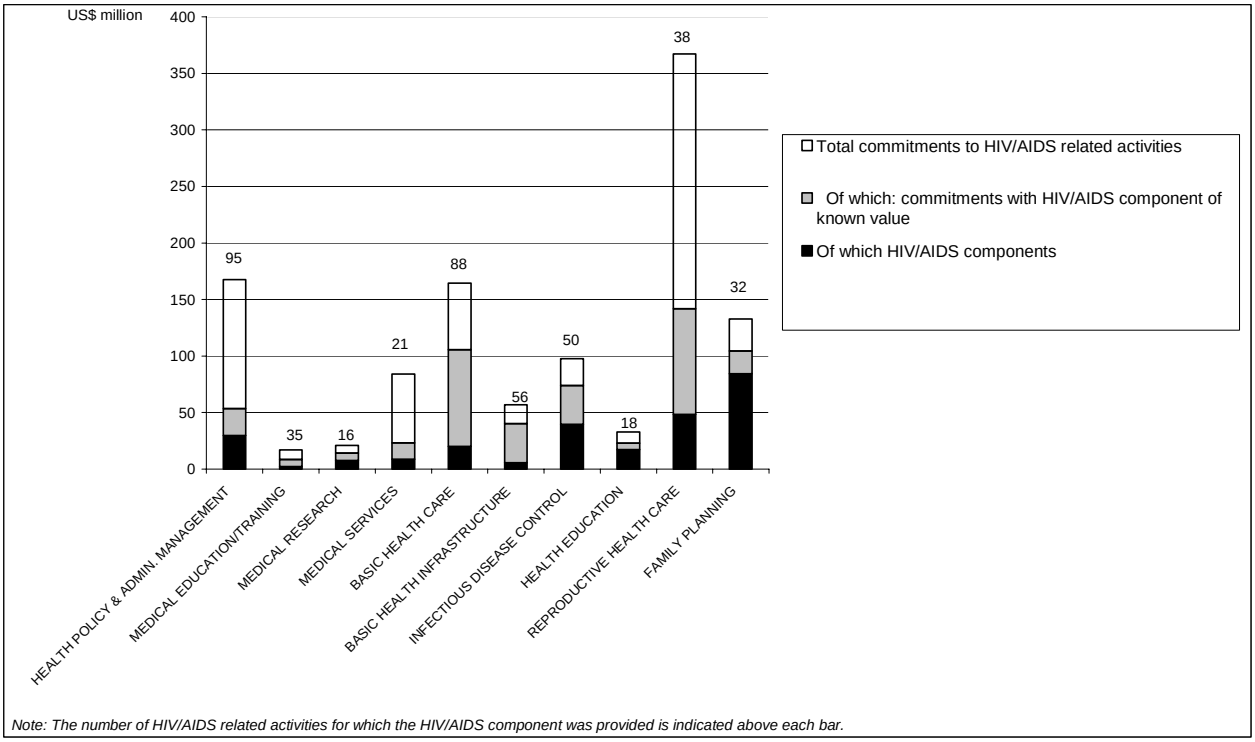
11 Technical co-operation for Japan, activities financed through the Commission budget for the EC, National Institutes for Health and Centers for Disease Control and Prevention for the United States. Luxembourg and New Zealand resumed regular CRS reporting in March-April 2004.

12 Excluding the United States.

Chart 2. HIV/AIDS components in health and reproductive health activities, totals for 2000-02



Note: The number of HIV/AIDS related activities for which the HIV/AIDS component was provided is indicated above each bar.

Summary of members' comments

23. In their responses members stated that the bulk of their HIV/AIDS activities had been reported under purpose code 13040, even if in some cases this had implied coding non-health sector activities (e.g. social programmes for HIV/AIDS orphans) under the health sector. This difficulty could be overcome by creating a second purpose code for HIV/AIDS under the category "other social infrastructure and services". Text search was generally not considered as a reliable way of collecting information, but was a useful method to verify purpose codes. It was highlighted that in the field of reproductive health text search was particularly difficult since for political reasons programmes were not always explicitly labelled.

24. Several members commented on difficulties in quantifying the HIV/AIDS components of wider programmes. Such information was not readily available in members' project management systems. Health (or HIV/AIDS) advisors did not possess this information. The data source was either the desk officer in charge of the activity (in the headquarters or on the field) or the project appraisal documents that include detailed budgets for each component. The statistician could access this information but in practice did not have time for such detailed research work.

25. Several members had discussed internally whether, in the absence of specific data, amounts allocated to HIV/AIDS control within reproductive and basic health care programmes could be estimated. All reproductive health programmes are likely to include some HIV/AIDS activities. Condom distribution programmes for family planning purposes contributed to HIV/AIDS control directly. Opportunistic infections due to HIV/AIDS were treated in district hospitals. In countries with high HIV prevalence rates all support to

health systems could be considered at least in part as aid to HIV/AIDS control. It could therefore be argued that a certain percentage of all reproductive (or basic) health care programmes should be counted as aid to HIV/AIDS control, though the percentage might perhaps vary depending on the stage of the epidemic in different countries.

26. While the Secretariat has discussed the issue with only a small number of statisticians and HIV/AIDS experts of the agencies mentioned in footnote 10, the general view seems to be that pure estimates should be avoided. Some countries have taken a clear decision (at the management level) not to include estimates in their databases. Both the statisticians and the HIV/AIDS experts were of the view that it was preferable to report too little rather than too much and at least to be able to justify and explain the figures. More importantly, they felt that statistics on aid to HIV/AIDS control should by definition include only those activities that were primarily designed for this purpose.

27. Only one member made "pure estimates" for the study. These, however, were determined as percentages of the total commitments made to two specific areas of activity.[13] First, health sector programmes were considered likely to include significant HIV/AIDS components, at least in Africa.[14] Secondly, a part of aid to NGOs was considered to be used for HIV/AIDS control activities. While for this latter activity the estimates on the percentage allocated to HIV/AIDS control were relatively arbitrary, including NGOs in statistics could be important for promoting support for HIV/AIDS control in donor countries.

28. For most members, data presented in Table 1 do not include HIV/AIDS research. Since it was difficult to distinguish between research targeted to developing countries and more general medical research on the disease, they preferred not to report these activities. However, France and Belgium had carried out a thorough exercise to identify HIV/AIDS research projects that were undertaken for the benefit of developing countries. France thus reported a number of research activities by its Development Research Institute (*Institut de recherche pour le développement*) and the National Research Agency for HIV/AIDS and Hepatitis (*Agence nationale de recherche sur le sida et les hépatites*), but did not include any HIV/AIDS research by the Pasteur Institute. Belgium reported activities of its Institute for Tropical Medicine (*Institut de médecine tropicale*).

29. Finally, members highlighted that HIV/AIDS activities could be financed through debt relief. The "contrat de désendettement et de développement" of France is an example of a new instrument for financing projects in the social sectors through debt for development swaps. It is planned that a share of these will be for HIV/AIDS control.[15] Other contributions are being made in kind (e.g. supply of drugs or diagnostic equipment).

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13 These did not include estimates for reproductive health, as the member considered these too arbitrary.

14 In the course of the study the Secretariat examined a few appraisal reports for health sector programmes and noted that HIV/AIDS control was typically identified as a separate component with its own budget. It also noted that several members had reported health sector programmes in the CRS for the last few years. By contrast, no sector-wide approaches were identified.

15 The projects financed so far (on the average €3.2 million per year in 2001-2003) are included in Table 1.

Some descriptive information on HIV/AIDS prevention, treatment and care

30. An issue that was not addressed in the letters sent to members was whether their aid to HIV/AIDS control focused on prevention, treatment or care.[16] It was raised in the discussions with the HIV/AIDS experts. Of the six bilateral donors interviewed, only the United States monitored aid to HIV/AIDS control by type of activity. Others stated that they mainly financed HIV/AIDS prevention activities, noting, however, that prevention could be efficient only if treatment was in place. [Offering HIV/AIDS infected persons treatment that prolonged their lives was an incentive for them to not spread the disease. Voluntary counselling and testing (VCT) programmes were being transformed to testing, counselling and treatment (TCT) programmes.] A few said prevention activities were better suited for bilateral financing since treatment required larger amounts of money and programming over several years (even decades). Through their regular contacts with the recipient governments, bilateral donors had good opportunities to do advocacy work.

31. Bilateral donors did, however, finance HIV/AIDS care (home-based care) and "social mitigation" activities i.e. special programmes to address the social consequences of HIV/AIDS. Provision of social and legal services for people living with HIV/AIDS or support to HIV/AIDS orphans are examples of such programmes. These activities took place outside the health sector. Furthermore, HIV/AIDS was increasingly considered as an important cross-sectoral development issue that needed to be taken into account when planning aid programmes. Prevention and mitigation measures could be incorporated in aid activities in all sectors (education, agriculture, rural development, commerce, etc.)

32. It should also be noted that part of DAC members' HIV/AIDS activities are not included in standard reports to the DAC. Box 2 below describes a multicountry programme for twinning arrangements with hospitals.

Box 2. ESTHER

ESTHER (a French acronym meaning Group for a Network of Solidarity in Hospital Care) was created in 2001 to help improve access to treatment for HIV-infected patients and provide better-quality global care. Today, the network is composed of eight countries of the European Union: Austria, Belgium, France, Germany, Luxembourg, Italy, Portugal and Spain. WHO and UNAIDS are also partners of ESTHER and members of its International Advisory Committee. More than 20 countries in Africa, Asia, and Latin America are involved in this initiative. A Public Interest Grouping (GIP), created by the French ministries of Health, Finance, and Foreign Affairs, located in Paris, serves as the secretariat. Each member country finances and implements partnership projects with the collaborating countries[17].

ESTHER aims to
-- facilitate twinnings of hospitals, health structures and associations, and to share experience and know-how;
-- provide technical support and equipment to developing countries to improve care for persons living with HIV/AIDS;
-- improve the continuity of care;
-- support relevant non-government and community initiatives, and facilitate links between hospitals and families;
-- develop joint approaches with European and international organisations to increase the coherence and coverage of interventions.

For more details, see www.esther.fr (English window).

16 UNAIDS had requested data on the breakdown but the Secretariat advised it was not possible to compile statistics at this detailed level.

17 Contributions by France, for example, were € 9 million in 2002.

IV.2 Contributions to the Global Fund to fight AIDS, tuberculosis and malaria

33. Table 2 below presents data on members' contributions to the Global Fund to fight AIDS, tuberculosis and malaria (hereafter referred to as the Global Fund). By the end of 2002, DAC members' contributions to the Global Fund had reached a total of USD 917 million. Some members made their first contribution only in 2003. The average contributions shown in Table 2 have been derived as follows:

- for members that made contributions both in 2001 and 2002 the figure represents the 2-year average;
- for members that have made only one contribution, in any of the years 2001 to 2003, that figure is used as the average.

Table 2. DAC members' average contributions to the Global Fund, commitments, millions of USD

	Average contribution	60% of average contribution
Austria	0.9	0.6
Belgium	5.4	3.3
Canada	51.0	30.6
Denmark	14.0	8.4
France	47.1	28.3
Germany	42.0	25.2
Ireland	9.2	5.5
Italy	75.2	45.1
Japan	80.0	48.0
Luxembourg	0.9	0.6
Netherlands	43.6	26.2
New Zealand	0.7	0.4
Norway	5.6	3.3
Portugal	0.4	0.2
Spain	35.0	21.0
Sweden	20.6	12.3
Switzerland	11.0	6.6
United Kingdom	210.3	126.2
United States	137.5	82.5
EC	53.7	32.2
Total DAC	**844.0**	**506.4**

Notes

Australia made its first contribution to the Global Fund in 2004: AUSD 25 million for three years.

According to the French authorities' pledges made in Evian, **France**'s contribution to the Global Fund should reach € 150 million in 2004, 2005, 2006.

34. The Global Fund has informed the Secretariat that 60% of its outflows have been for HIV/AIDS control. Consequently, only 60% of DAC members' contributions to the Fund should be included in aid to HIV/AIDS control. Table 2 shows the amounts per donor.

IV.3 Aid to HIV/AIDS control through multilateral organisations

35. This section relates to HIV/AIDS activities financed through the multilateral organisations' core budgets. Funds allocated to specific projects (extra-budgetary funds) are recorded as bilateral aid and not discussed here.

36. DAC members finance HIV/AIDS control activities through UNAIDS, UNICEF, UNFPA, the UNDP, the World Bank, regional development banks and other UN agencies. EU members also finance HIV/AIDS control through the EDF and the Commission budget.

37. All core support to **UNAIDS** should fully count as aid to HIV/AIDS control. For the other agencies, it is first necessary to establish the share of aid to HIV/AIDS control in their core budget expenditure and, following the example of the Global Fund, apply this percentage to each member's contribution to the organisation. Table 3 below presents the data collected from the main multilateral organisations and Table 4 the amounts to be imputed for each bilateral donor.

Table 3. Aid to HIV/AIDS control: outflows from multilateral organisations in 2000-02, millions of USD

	2000	2001	2002	Avg 00-02	HIV/AIDS as % of total outflows
	USD million				
EC - Commission	32.9	54.2	59.5	48.9	1.6
EC - EDF	9.8	2.7	0.1	4.2	0.2
UNAIDS	64.1	95.5	105.2	88.2	100.0
UNFPA	..	13.4	23.4	18.4	7.8
UNICEF	..	38.9	48.8	43.9	12.2
IDA	207.5	281.3	222.8	237.2	3.4
AfDF	0.0	8.9	0.0	3.0	0.3
Total	**314.3**	**494.9**	**459.8**	**443.7**	**3.1**
Memo					
IBRD	3.0	59.8	54.1	39.0	0.4

Notes:

For ***EC***, data include contributions to the Global Fund.

UNICEF reports to the CRS at the project level, but in its internal system monitors spending on HIV/AIDS control (one of its five priorities) at the activity level regardless of the sector used for the project. The figures in the table relate to all activities and are therefore larger than totals in the CRS for code 13040.

UNFPA data are derived from its project management system where desk officers indicate for each activity the percentage of funds estimated to be spent on reproductive health, family planning, HIV/AIDS and basic research.

The HIV/AIDS department of the ***UNDP*** has provided a rough estimate on the share of its total outflows spent on HIV/AIDS. This estimate (11%) was not taken into account in table 4 on multilateral imputed amounts. The new project management system should allow improved reporting from 2004 onwards.

Data for ***WHO*** were received too late to be included in this report.

World Bank: Includes IDA grants for multisectoral AIDS programmes (MAP). Excludes HIV/AIDS Trust Funds (maximum USD 13 million per year).

Table 4. DAC members' aid to HIV/AIDS control through multilateral organisations, average 2000-02,

millions of USD

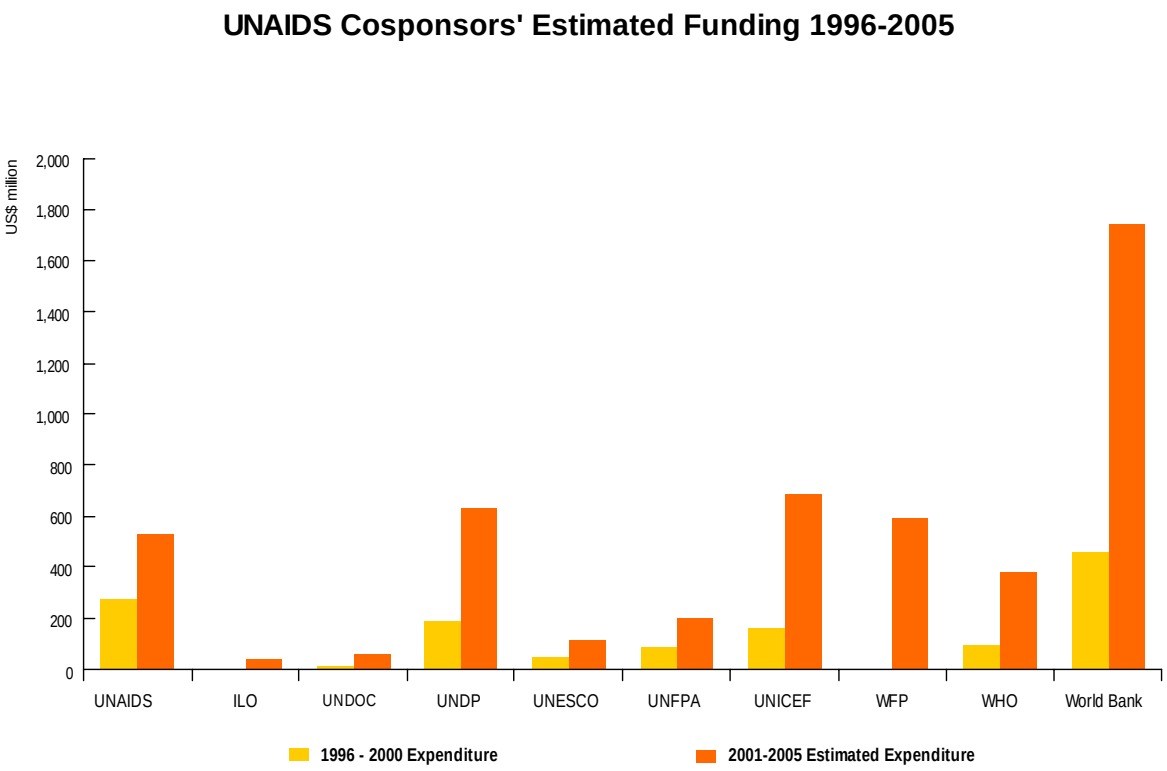
	Through EC	Through UNFPA	Through UNICEF	Through IDA	Through Reg. Banks	Imputed Multilaterals	UNAIDS	Total
Australia		0.1	0.5	5.4		6.0	1.1	7.1
Austria	3.2	0.0	0.2	3.1	0.1	6.6		6.6
Belgium	5.1	0.4	0.4	4.7	0.2	10.9	2.6	13.4
Canada		0.6	4.7	11.3		16.6	2.6	19.2
Denmark	1.5	2.4	5.5	5.7	0.2	15.3	3.1	18.4
Finland	1.8	1.3	1.8	1.9	0.0	6.8	3.3	10.1
France	20.9	0.1	1.2	23.5	0.5	46.3	0.3	46.6
Germany	28.0	1.4	0.7	31.9	0.5	62.5	1.3	63.8
Greece	3.2	0.0	0.0	0.3		3.5		3.5
Ireland	1.6	0.2	0.7	0.6		3.1	2.0	5.1
Italy	16.7	0.3	2.5	13.9	0.2	33.5	1.8	35.3
Japan		4.6	14.6	70.7	0.5	90.4	6.5	96.9
Luxembourg	0.3	0.0	0.1	0.3		0.7	0.5	1.3
Netherlands	5.1	6.4	8.5	9.1	0.0	29.1	17.7	46.7
New Zealand		0.1	0.2	0.4		0.7		0.7
Norway		2.7	6.2	4.2	0.2	13.3	11.0	24.3
Portugal	1.8	0.0	0.0	0.7	0.0	2.5	0.2	2.7
Spain	9.7	0.1	0.3	4.4		14.4	0.4	14.8
Sweden	2.4	1.8	4.9	11.8	0.2	21.2	5.3	26.5
Switzerland		0.8	1.8	6.8	0.2	9.6	2.1	11.7
United Kingdom	21.2	4.1	4.9	29.4	0.3	59.9	4.6	64.4
United States		1.1	21.7	98.2	0.7	121.7	21.9	143.6
Total DAC countries	**122.6**	**28.7**	**81.3**	**338.4**	**3.7**	**574.7**	**88.2**	**662.9**
EC				*20.4*		*20.4*		*20.4*

38. In the study, DAC members were requested to report contributions to any other organisations/funds that in their view ought to be included in the statistics on aid to HIV/AIDS control. These included the International Planned Parenthood Federation (IPPF) and the International AIDS Vaccine Initiative. As their total amount was small, the contributions are not shown separately but have been included in the totals for bilateral aid (Table 1).

39. Data in the UNSSP (see paragraph 13) offer an overview of multilateral organisations' HIV/AIDS-related resources. Chart 3 below shows, for reference, UNSSP data for a number of organisations for some of which data could not be collected for this study.[18] It shows that most organisations have considerably increased their resources to benefit the fight against AIDS. The descriptive information received indicates that UN Agencies are increasingly mainstreaming their HIV/AIDS related in activities such as life skills education, rural development, reproductive health services, food security, tuberculosis treatment and intravenous drug use prevention.

[18] The main objective of the data collection within the UNSSP was to ascertain progress in the UN System's response to the HIV/AIDS epidemic over a five year period (2001-2005).

Chart 3. HIV/AIDS related expenditure by multilateral organisations (Source: UNAIDS)



IV.4 Total aid to HIV/AIDS control

40. Table 5 below summarises the bilateral and multilateral components of DAC members' aid to HIV/AIDS control discussed above. In 2000-02, DAC members allocated on average between USD 2.2-2.4 billion of aid per year to HIV/AIDS control. The United States is by far the largest donor contributing over a third of total bilateral commitments. It is followed by the United Kingdom, the Netherlands and Norway whose contributions together represent another 30% of the bilateral total. Relatively, Australia and Ireland are also large donors of aid to HIV/AIDS control. (The share of aid to HIV/AIDS control in their total bilateral ODA was 4.5% and 5.2% respectively.) If imputed multilateral aid to HIV/AIDS is taken into account, Germany and Japan are added to this list.

Table 5. DAC members' bilateral and multilateral aid to HIV/AIDS control, average commitments 2000-02, millions of USD

	Bilateral (1)	Possible additional bil. HIV/AIDS related amounts (2)	Global Fund (3)	Imputed Multilaterals (4)	UNAIDS (5)	Total HIV/AIDS lower limit (1)+(3)+(4)+(5)	Total HIV/AIDS upper limit (1)+(2)+(3)+(4)+(5)
Australia	29.4	0.0	0.0	6.0	1.1	36.6	36.6
Austria	0.2	0.4	0.6	6.6	0.0	7.3	7.7
Belgium	8.3	0.0	3.3	10.9	2.6	25.0	25.0
Canada	47.6	0.0	30.6	16.6	2.6	97.4	97.4
Denmark	8.2	11.9	8.4	15.3	3.1	35.0	46.9
Finland	1.0	9.5	0.0	6.8	3.3	11.1	20.6
France	21.9	0.0	28.3	46.3	0.3	96.8	96.8
Germany	38.8	14.2	25.2	62.5	1.3	127.8	142.0
Greece	0.0	0.0	0.0	3.5	0.0	3.6	3.6
Ireland	13.8	0.0	5.5	3.1	2.0	24.5	24.5
Italy	3.9	2.7	45.1	33.5	1.8	84.4	87.0
Japan	16.3	16.5	48.0	90.4	6.5	161.2	177.7
Luxembourg	3.1	1.9	0.6	0.7	0.5	5.0	6.9
Netherlands	62.2	53.3	26.2	29.1	17.7	135.1	188.4
New Zealand	0.3	0.0	0.4	0.7	0.0	1.5	1.5
Norway	41.2	58.2	3.3	13.3	11.0	68.9	127.1
Portugal	2.3	44.3	0.2	2.5	0.2	5.2	49.6
Spain	3.4	0.2	21.0	14.4	0.4	39.2	39.4
Sweden	21.6	0.0	12.3	21.2	5.3	60.5	60.5
Switzerland	3.6	0.0	6.6	9.6	2.1	21.9	21.9
United Kingdom	146.5	41.6	126.2	59.9	4.6	337.1	378.7
United States	566.6	0.0	82.5	121.7	21.9	792.7	792.7
Total DAC countries	**1040.6**	**254.7**	**474.2**	**574.7**	**88.2**	**2177.7**	**2432.4**
EC	*42.3*	*10.3*	*32.2*	*20.4*	*0.0*	*95.0*	*105.3*

IV.5 Recipient breakdown of aid to HIV/AIDS control

41. Charts 4 and 5 below show a breakdown of aid to HIV/AIDS control by region and by income group. Three quarters of total aid to HIV/AIDS control (excluding contributions not allocated by recipient) was extended to Africa. Half of total aid targeted the Least Developed Countries; the share was 85% for the group of Low Income Countries in its entirety.

Chart 4. Aid to HIV/AIDS control by region, total bilateral and multilateral commitments in 2000-02

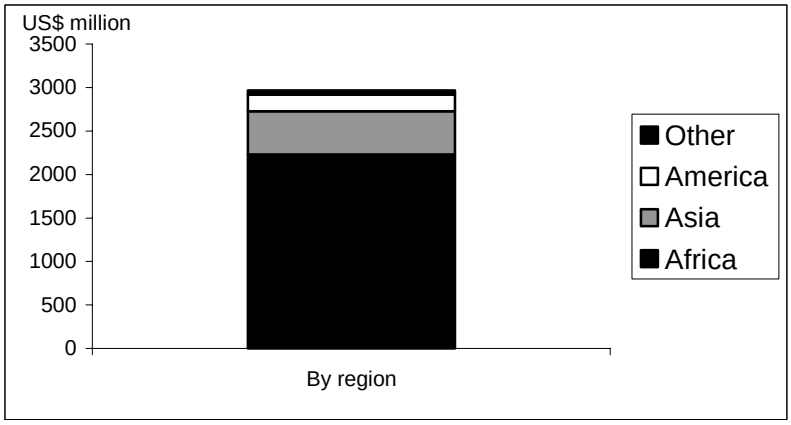
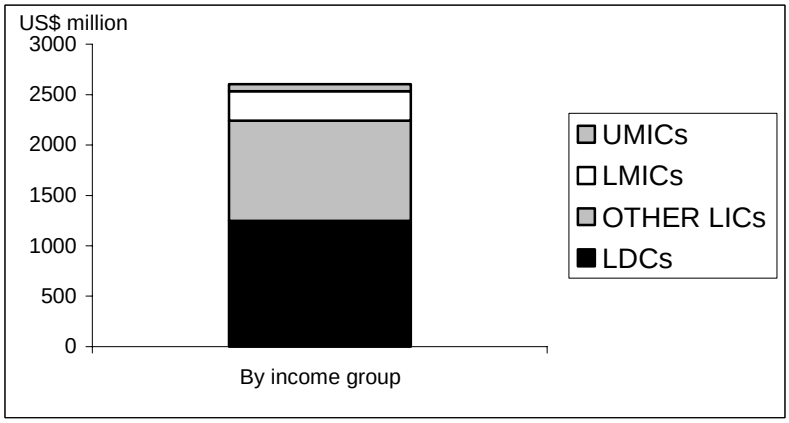


Chart 5. Aid to HIV/AIDS control by income group, total bilateral and multilateral commitments in 2000-02



42. Tables 6.a, 6.b and 6.c. below show the top recipient countries of aid to HIV/AIDS control according to various criteria.

Table 6. Top ten recipients of aid to HIV/AIDS control, average commitments 2000-02

Table 6.a. Top ten recipients, total aid commitments

		Aid to HIV/AIDS control, average commitments 2000-02			
		Total *Million USD*	Per capita *USD*	% of Aid to All Recipients	% of Total Aid to Recipient
1	Nigeria	**91.2**	0.7	**5.6%**	12.5%
2	Kenya	**61.3**	2.0	**3.8%**	10.7%
3	Uganda	**53.4**	2.3	**3.3%**	5.6%
4	Zambia	**43.2**	4.1	**2.7%**	6.6%
5	Ethiopia	**42.5**	0.6	**2.6%**	4.2%
6	South Africa	**35.6**	0.8	**2.2%**	7.7%
7	Mozambique	**31.3**	1.7	**1.9%**	2.1%
8	Ghana	**29.9**	1.5	**1.9%**	4.4%
9	Tanzania	**29.2**	0.8	**1.8%**	2.1%
10	Zimbabwe	**28.6**	2.2	**1.8%**	18.0%
	Other	***1169.6***		***72%***	*1.7%*
	Total	**1615.7**		**100%**	**2.1%**

During the period 2000-02, donors undertook HIV/AIDS control activities in 140 aid recipient countries. However, larger projects concentrated on 25 recipient countries which thus received 72 % of total geographically allocated contributions. The top ten recipients were from Sub-Saharan Africa. Nigeria is the largest recipient, with USD 91.2 million per year, with most of the projects being financed by the United Kingdom, the World Bank, and the United States.

Table 6.b. Top ten recipients, per capita aid commitments

		Aid to HIV/AIDS control, average commitments 2000-02			
		Total *Million USD*	Per capita *USD*	% of Aid to All Recipients	% of Total Aid to Recipient
1	Grenada	2.0	**19.8**	0.1%	14.2%
2	Barbados	5.1	**18.8**	0.3%	23.3%
3	Sao Tome & Principe	1.9	**12.3**	0.1%	5.9%
4	Cape Verde	3.7	**8.0**	0.2%	3.9%
5	Botswana	8.6	**5.0**	0.5%	21.5%
6	Jamaica	10.8	**4.1**	0.7%	2.7%
7	Zambia	43.2	**4.1**	2.7%	6.6%
8	Namibia	7.2	**4.0**	0.4%	6.0%
9	Gambia	5.1	**3.7**	0.3%	10.9%
10	Uganda	53.4	**2.3**	3.3%	5.6%
	Other	*1474.8*		*91%*	*2.0%*
	Total	**1615.7**		**100%**	**2.1%**

On a per capita basis, aid to HIV/AIDS control appears to concentrate on countries with small populations like Grenada and Barbados. Nigeria is only 39th on this ranking, with USD 0.7 per capita.

As regards the share of aid to HIV/AIDS control in total commitments by recipient, Kenya, Nigeria, South Africa and Zimbabwe were again topping the list at 11%, 13%, 8% and 18% respectively.

Table 6.c. Top ten recipients, share in total recipient aid commitments

		Aid to HIV/AIDS control, average commitments 2000-02			
		Total *Million USD*	Per capita *USD*	% of Aid to All Recipients	% of Total Aid to Recipient
1	Barbados	5.1	18.8	0.3%	**23.3%**
2	Botswana	8.6	5.0	0.5%	**21.5%**
3	Zimbabwe	28.6	2.2	1.8%	**18.0%**
4	Grenada	2.0	19.8	0.1%	**14.2%**
5	Nigeria	91.2	0.7	5.6%	**12.5%**
6	Gambia	5.1	3.7	0.3%	**10.9%**
7	Kenya	61.3	2.0	3.8%	**10.7%**
8	Burundi	14.5	2.1	0.9%	**8.9%**
9	Central African Rep.	6.3	1.6	0.4%	**7.7%**
10	South Africa	35.6	0.8	2.2%	**7.7%**
	Other	*1357.5*		*84%*	*1.8%*
	Total	**1615.7**		**100%**	**2.1%**

The countries with the highest adult rates of HIV prevalence according to UNAIDS 2001 statistics are the following: Botswana (39%), Zimbabwe (34%), Swaziland (33%), Lesotho (31%), Namibia (23%), Zambia (22%), South Africa (20%), Kenya (15%), Malawi (15%) and Mozambique (13%). All of them appear in one of the three lists of top ten aid recipients presented here except Swaziland (15th on the per capita ranking), and Lesotho (ranks much lower with USD 2.1 million of aid to HIV/AIDS per year in 2000-02).

V. Conclusions

43. Following this special study on aid to HIV/AIDS control, the DAC statistical methodology for reporting on HIV/AIDS control is being reviewed to improve the quality of data collection in this field. In particular, the study showed that the majority of HIV/AIDS control activities take place within the health sector, but that bilateral aid also finances social mitigation. The creation of a new purpose code which would separately capture these social mitigation programmes is under examination.

44. Even the most careful analysis, however, will not permit an accurate accounting of every expenditure related to HIV/AIDS. In severely affected countries, the pandemic has an impact on practically every social and productive sector. This means that aid activities in a wide variety of sectors will for the foreseeable future have to take account of both the consequences of the disease and of all feasible opportunities for incorporating measures to mitigate its effects.