A stitch in time could save nine

Vertical funding patterns for HIV in the Global South

Rohini Sahni, V. Kalyan Shankar

Abstract:

This paper, primarily dealing with vertical funding for HIV since the year 2000, opens with a comparison of two countries – Uganda and the USA. The comparison is between the death numbers, the prevalence rates and the estimated numbers of people who are HIV/AIDS positive. The text that follows goes on to compare the funding available in both these countries and focuses on the abysmal paucity of vertical funds that are available in the global South. Through statistical data and comparisons between nations within the context of infected population, the availability of funds domestically and internationally, and the estimates of funds available per affected individual, the researchers demonstrate the disparity in the availability and dependence of funding in the global South. Next, the paper goes on to illustrate that the funding available through the years since 2000 has not only been undersized, but also irregular. The authors bring in the evidence of un-kept promises of funding by the OECD countries during the period under study. Finally, the paper briefly spells out the implications of the inadequate and irregular funding for sustainable capacity building and strategies in combating HIV/AIDS in the global South.

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Rohini Sahni, V. Kalyan Shankar[1]

In Uganda, considered one of the success stories of intervention against HIV/AIDS, the estimated number of deaths due to AIDS was 94,000, 78,000 and 91,000 in 2001, 2003 and 2005 respectively (UNSTATS, UNAIDS/WHO HIV/AIDS Database). These numbers appear staggering by themselves. But with a 6.8% HIV prevalence rate in the population, and the estimated infection numbers of adults and children falling within a broad range of 0.85 - 1.2 million in 2005 (UNAIDS/WHO HIV/AIDS Database), the future mortality numbers would continue to be overwhelming. Not to mention of the estimated 1 million orphans alive in 2005 (UNAIDS/WHO HIV/AIDS Database), a phenomenon that has already sparked off “an increase of both street children and child headed families” (Ddimulira, 2002).

In the United States, the equivalent figures of estimated deaths due to HIV/AIDS were 14,000, 14,000 and 16,000 in 2001, 2003 and 2005 respectively (UNSTATS, UNAIDS/WHO HIV/AIDS Database). With a 0.6 % prevalence rate, the estimates for infected population fall in the range of 0.72 - 2 million for the year 2005.

In the above cases, while the infection numbers in both the countries broadly fall within a similar range, any meaningful comparison ends here. In case of the USA, the mortality figures for the infected people could be staggered over a longer time span. In Uganda on the other hand, with the current high levels of mortality, there is a distinct possibility that the infected population may not survive for long. Uganda is not a lone example, and the socio-demographic indicators for a number of African, Asian and Latin American countries reveal a similar situation.

Any reversal in the mortality trends would depend on the extent of social and medical support systems in place. This in turn would depend directly on the funds available. The above comparison between the two nations cannot be more startling than in the allocations of funds for HIV/AIDS activities. In the USA for instance, the domestic federal funding for HIV/AIDS activities was a massive 17.852 billion $ US in 2006[2],

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[2] This figure and later figures for the US include a very small component of research spending.

requested to be scaled up to 18.879 billion $ US for 2007 (HIV/AIDS Policy Fact Sheet, 2006). In Uganda on the other hand, the annual domestic HIV/AIDS budget allocation could muster only 18.8 million $ US in the year 2004 (Report on the Global AIDS Epidemic, 2006). In the same year, Uganda was the highest recipient of international funding for HIV/AIDS, 169.22 million $ US in all (OECD, 2006); the international component of funds outweighing the domestic component by some distance. As a consequence, any creation and sustainability of domestic support systems to counter HIV was dependant on international flows.

Pattern of fund flows: Too little *and* too irregular

In the year 2005, the total funding to counter the proliferation of HIV/AIDS that reached the global south was a mere 2.65 billion US $. Moreover, if we take the total funds within the six years spanning 2000-2005, to the entire Global south, it was 12.636 billion US dollars, a figure that does not match up to even the *annual* spending in the USA alone (USA spent 17.2 billion dollars in 2005 as part of the federal funding for HIV).

This already gives an idea of the abysmal paucity of funds being disbursed to the global south, where the majority of the HIV/ AIDS victims live (and die). Countries like Mozambique and Nigeria having estimated HIV/AIDS related deaths ranging between 1.4-2.2 million and 1.7-4.2 million (UNAIDS/WHO HIV/AIDS Database), received funds to the tune of 82.3 and 72.2 million respectively (OECD Database) in 2004 . Table I illustrates the distribution of international funds to the Global South.

Table 1: Distribution of international funds for HIV/AIDS control for the Global South:

Year	2000	2001	2002	2003	2004	2005
All	1027.79	1533.13	1818.32	2941.41	2665.59	2652.92
Africa	625.53	790.58	815.8	1620.32	1513.00	1588.31
Asia	132.12	136.09	228.3	364.77	295.41	475.62
S. America	9.97	13.5	17.51	184.64	54.32	36.31

(Source: CRS aid activities in support of HIV/AIDS control, OECD)

Would the requirement of funds be different depending upon whether the person is from a developed or developing country? Or irrespective of the country, would the requirement rather depend on whether the individual under consideration is HIV positive? This ought to be the next matter of introspection here.

Table 2: Funds available per affected individual in selected countries

Country	Estimates of individuals affected by HIV in 2005 (a)	Funds available in the year 2004 (in millions US $)			Funds available per affected individual (US $ per annum)
		Domestic funding (b)	International funding (c)	Total (b+c)=d	(d/a)
Africa					
Uganda	10,00,000	18.8	169.2	188.0	188
Tanzania	14,00,000	22.1	93.2	115.3	82
Zaire	10,00,000	3.6	151.9	155.5	155
South Africa	55,00,000	340.5	148.2	488.7	88.8

Mozambique	18,00,000	2.6	82.3	84.9	47
Nigeria	29,00,000	6.5	72.2	78.7	27
Benin	87,000	10.6	9.8	20.4	234
Asia					
India	57,00,000	73.3	204.7[3]	278.0	48
China	6,50,000	98.0	106.9	204.9	315
Indonesia	1,70,000	9.6	17.6	29.2	171
Thailand	5,80,000	92.8	1.2	94	162
South America					
Argentina	1,30,000	89.6	0.03	89.63	689
Brazil	6,20,000	401.7	6.13	407.83	657
USA	**12,00,000**	**16,300.0**	**------**	**16,300.0**	**13,583**

Source: The estimates of infected individuals has been taken from the UNAIDS /WHO Global HIV/AIDS Online Database. The domestic funding has been referred from the UNAIDS Report on the Global HIV/AIDS Epidemic, 2006. The international funding data has been derived from the OECD Online Database. The funds available per individual have been calculated by the authors.

Table 2 provides a comparison of the funds available (domestic and international) per HIV/AIDS affected individual across selected countries. It shows the extent of scarcity of funds that plague the developing and under-developed countries, allowing them little scope to counter HIV.

Considering the widespread proliferation of HIV/AIDS across the global South, it would be a tough task firstly to bring all the affected individuals under the blanket of medical and social care. But more importantly, the extent of funds available by itself reduces the scope for intervention. In cases like Tanzania, with 82 dollars of funds per affected individual per annum, or India with 48 dollars of funds, a further segregation of funds into medical care (ARV or otherwise), extension of prevention means, social security/housing would result in extremely paltry sums for these sub-categories.

In contrast, if we consider the case of USA, which has 13,600 $ per affected individual at its disposal, the federal budget gets channeled across the components of healthcare, prevention and cash/housing assistance. For the year 2007, the requested budgetary allocation was 22.8 billion US $, of which 13.2 billion US $ (58 %) for healthcare services, 0.96 billion US $ (4 %) for prevention activities and 2.1 billion US $ (9 %) for cash/housing assistance (HIV/AIDS Policy Fact Sheet, 2006). The requested funding for global HIV programs was 3.9 billion US $, a sizable 17 % of the total budget allocations; but a tricky figure considering that only a small fraction of it may be disbursed. If we consider the instance of the proposed and actual contributions to the Global Fund, the pivotal organization to counter HIV, it reveals a story of unfulfilled promises (see Table 3).

Table 3: The disparity between actual and proposed contribution to the Global Fund for selected countries

Country	Proposed Contribution to Fund (US million $)	Actual Contribution to Fund (US million $)	Actual contribution as % of Proposed Contribution
USA	4,039	500	12.4
Japan	2,040	200	9.8
Germany	784	131	16.7

[3] The figure for India is for the year 2005. The previous year's figure was markedly lower at 44.6 million US $.

UK	607	200	32.9
France	540	131	24.3
Australia	156	0	0.0
Switzerland	110	10	9.1
Across OECD	10,000	1,742	17

(Source: www.oxfam.org/en/files/ pp0206_false_hope_or_new_start.pdf)

The un-kept promises on part of the fund donors results in a lesser corpus of funds for disbursement to the very people who need it most. To exacerbate the situation further, there is a gross irregularity of the fund flows over the years of what little has been made available. The fluctuations in fund flows are common across both bilateral and multilateral sources, as the following tables (4 and 5) illustrate.

Table 4: CRS funding for South America:

Value		Years					
Donor	Donor (level 03)	2000	2001	2002	2003	2004	2005
Bilateral	Austria			0.01			0.01
	Belgium					0.12	0.16
	Canada	0.08	0.1	1.7	0.05		0.04
	Finland				0.71		
	France	0.08	0.12				
	Germany	0.47	0.69	0.01	0.09	0.03	0.19
	Ireland		0.09	0.06			0.17
	Italy			0.02		0.19	
	Japan	0.43	0.31	0.18	0.03	0.06	
	Netherlands	0.33					0.23
	Norway		0	0.06			
	Spain		0.05	0.45		0.1	0.57
	Sweden				3.1		0.47
	United Kingdom	3.72					
	United States	3.5	7.58	10.04	16.31	17.67	13.13
Multilateral		1.36	4.56	4.98	164.35	36.15	21.34
Grand Total		9.97	13.5	17.51	184.64	54.32	36.31

(Source: CRS aid activities in support of HIV/AIDS control, OECD)

Table 5: CRS Funding for Africa:

Value		Year					
Donor	Donor (level 03)	2000	2001	2002	2003	2004	2005
Bilateral	United States	148.66	244.68	297.26	444.31	695.11	732.6
	United Kingdom	166.81	92.74	58.15	166.66	68.54	81.83
	Switzerland	4.02	0.52	2.3	1.37	7.32	4.03
	Sweden	8.83	11.2	18.81	19.05	42.23	59.13
	Spain	0.9	2.04	3.43	4.3	6.37	10.41
	Portugal	1.59	3.25	2.07		0.05	0.13
	Norway	11.72	9.83	45	12.01	7.5	28.75
	New Zealand	0.06	0.25	0.09	0.4	0.32	1.78
	Netherlands	6.66	32.07	43.68	13.67	41.99	128.74

	Luxembourg		0.51	5.5	0.11	3.55	1.1
	Japan	2.54	6.46	5.65	8.62	2.82	2.78
	Italy	5.84	2.15	2.8	3.14	2.23	
	Ireland	3.13	4.97	10.92	9.15	5.77	20.46
	Greece				0.41	0.52	0.38
	Germany	8.99	30.54	24.62	31.85	14.48	43.51
	France	8.42	9.98	2.79	4.47	5.98	0.08
	Finland	0.37	1	0.39	1.44	3.8	0.61
	Denmark	1.68	1.66	14.69	6.09	8.85	14.07
	Canada	31.93	13.56	36.33	39.16	45.02	12.14
	Belgium				8.48	11.71	14.06
	Austria			0.09	0.11	1.2	0.36
	Australia	5.09	0.36	0.25	16.7	0.41	0.03
Multilateral		208.29	322.81	240.98	828.82	537.23	431.33
Grand Total		625.53	790.58	815.8	1620.32	1513	1588.31

(Source: CRS aid activities in support of HIV/AIDS control, OECD)

At a continental level, funding for Africa has been more consistent. This has not been the case with either Asia or South America. But analyzing further, individual donor countries in Africa do show a wide range of fluctuations in the funding made available.

Table 6: Funds received in aid of support for HIV/AIDS control:

Years	2000	2001	2002	2003	2004	2005
Angola	1.76	2.27	9.86	6.67	19.46	35.53
Argentina	0.01	0.36	0.32	9.42	0.03	17.39
Barbados	15.2	-----	-----	-----	-----	0.05
Benin	1.27	5.52	26.01	19.57	9.82	0.22
Cameroon	4.59	50.79	2.94	1.49	27.66	0.86
Zaire	2.01	5.47	8.88	7.81	151.91	6.61
Ethiopia	72.98	23.97	29.67	88.53	72.06	107.73
Kenya	108.47	23.76	51.41	110.88	86.52	118.91
Nigeria	130.36	110.96	30.88	103.87	72.27	87.94
Tanzania	18.56	33.15	36.51	115.68	93.27	254.48
Uganda	19.92	85.42	53.74	81.56	169.22	64.68
Zambia	20.32	27.57	78.83	163.75	62.42	88.23
Brazil	3.54	6.1	6.88	108.96	6.13	1.1
Bolivia	4.14	0.81	0.82	4.1	7	0.18

(Source: CRS aid activities in support of HIV/AIDS control, OECD)

This paucity and irregularity of funds poses the following challenges for the recipient nations in terms of strategizing to counter HIV:

a. There is no guaranteed roll-over of commitments to funding projects, resulting in a continuous need to keep scouting for alternative sources of funding by the recipient countries.
b. Even if we consider a situation where the funds are untied, as a result of the short term nature of funding, the scope of projects to be undertaken gets restricted.

The sustainability of funds is as important as the quantum of funds received. This has a direct impact on the grass-root strategies that can be pursued. Unless there is an increase in the quantum of funds, as also a more regular flow, any sustainable capacity building in the HIV affected nations in the global South would continue to remain elusive.

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