

Delivering the 2010 target

Financing universal access to HIV and AIDS treatment



act:onaid

Front cover image:

Ruth Nkuya is HIV positive (*pictured with her antiretroviral medication*).

Ruth works as a secretary for the National Association of People Living with HIV/AIDS (NAPHAM), an ActionAid partner and the first organisation to advocate for free antiretrovirals in Malawi.

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Executive summary

The G8's commitment to achieve universal access to HIV and AIDS treatment is destined to fail unless the UK and other donors bridge the funding gulf that currently exists between what is needed and what is actually spent on treating HIV and AIDS.

Globally, access to treatment for HIV and AIDS is increasing. Between 2003 and the end of 2005, the number of people receiving anti-retroviral treatment (ART) in low- and middle-income countries tripled to 1.3 million¹ – 300,000 more people every six months². This rate of increase continued in 2006. As a result, approximately 1.65 million people now receive treatment³. This progress demonstrates what can be achieved and should spur further, urgently needed action. Approximately 4.4 million (four in five) people in need of ART still lack access to it.

In 2005 the UK led the G8 negotiations on the Gleneagles Communiqué which made a commitment to 'develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010'. This commitment has since gained broader political support globally and has been the catalyst for national and global action.

The 2006 United Nations General Assembly Political Declaration on HIV and AIDS commits UN member states to set 'ambitious national targets [in 2006], including interim targets for 2008... that reflect... the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010...!.

As countries meet their commitment to deliver national 'roadmaps' to universal access, the UK and other donors must match their rhetoric with a greater financial commitment. They must fund in full each nationally agreed target.

Existing estimates of global resource needs give a limited indication of the global cost of a comprehensive response to HIV and AIDS, and highlight in particular an **AIDS funding gap of at least \$8.1 billion in 2007**. This is likely to be a significant underestimation.

A G8 funding plan is crucial to show intent on the part of donors to deliver sufficient funding and provide greater incentive for countries to develop national targets. Developing countries need to know when and how this money is going to appear so they can start to implement their national targets and guarantee access to treatment for all.

This funding plan should map out how donor countries intend to raise and channel additional funding to ensure that work to meet national targets and achieve universal access by 2010 is fully resourced. Crucially, the funding plan should recognise lessons learned in the past – for example, increased funding must be additional to existing aid commitments and not taken from other key requirements. The funding must also be predictable to

enable country governments to plan long-term investment. Funding must also be untied, aligned with national targets and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose. Furthermore, to ensure greater coherence and coordination, existing funding mechanisms must be scaled up and strengthened, not supplemented by several, small, uncoordinated initiatives.

The funding plan should also set realistic and ambitious funding targets for donor governments, particularly for overseas aid, and define how it will be used effectively, including, in particular, full funding of the Global Fund to fight AIDS, Tuberculosis and Malaria. In doing so, the funding plan need only focus upon the urgent delivery of existing promises. **If current financial commitments and spending promises were met, available funding would treble and the commitment to universal access would be within reach.**

The UK and others must not, however, simply focus on more money. In addition, the most must also be made of existing AIDS funding.

While the Department for International Development (DFID) must be congratulated for sponsoring the second largest bilateral HIV and AIDS programme in the world, ActionAid believes it is crucial for DFID to do more. It must demonstrate global leadership in the equitable allocation of funding, adequately measure the impact of its funding and ensure the rights and immediate treatment needs of people living with AIDS today are not forgotten.

At present, DFID's HIV and AIDS expenditure is still not accurately recorded, activities not specific to HIV and AIDS are still included in records of funding spent on HIV and AIDS, and data regarding impact is still not disaggregated. As a result, it is difficult to reach any firm conclusions about the effectiveness of UK efforts to tackle HIV and AIDS.

Of additional concern to ActionAid is DFID's programmatic focus. In 2006, an interim evaluation of its AIDS strategy, commissioned by DFID, found that only 3-5.3% of its programmes focused on treatment while 32% focused on prevention, for example. Further

research is needed to clarify DFID's comparative focus on treatment, but it is important that any imbalance in DFID's HIV and AIDS work is resolved.

ActionAid is consequently calling for the UK to galvanise sufficient funding from G8 members and improve its own funding to HIV and AIDS to ensure its commitment to universal access is achieved. In particular, ActionAid is calling for:

- Gordon Brown to push for international agreement on a funding plan at the G8 meetings in 2007 that will deliver sufficient funding to achieve their commitment to universal access. This funding plan should map out how donor countries plan to urgently increase revenue and channel much-needed additional money to fully fund all national targets.
- every nationally agreed target to be financed in full with predictable, untied funding, strictly aligned to national priorities and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose.
- the UK to increase its commitment to HIV and AIDS in the forthcoming Comprehensive Spending Review in 2007.
- the Global Fund to be funded in full according to global resource needs; and for the UK to contribute its fair share.
- DFID to improve the transparency of its bilateral funding. Its HIV and AIDS expenditure must be accurately recorded, activities not specific to HIV and AIDS should not be recorded as funding spent on HIV and AIDS and data regarding impact must be disaggregated to ensure marginalised groups are effectively targeted.
- DFID to prevent any imbalance in their programmatic interventions. As the second largest bilateral HIV and AIDS programme worldwide DFID must demonstrate leadership with a proportionate, comprehensive response to HIV and AIDS and ensure the rights and immediate treatment needs of people living with AIDS today are not forgotten.

Introduction

In 2005, the UK and other G8 leaders gave hope to millions of people for whom AIDS is still a potential death sentence. The G8 Finance Ministers' meeting in June that year, and then the Gleneagles Communiqué in July, built upon earlier efforts to expand HIV treatment. A commitment was made to 'develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010'.

This commitment has since gained broader political support. For example, world leaders reiterated the commitment at the World Summit in September 2005 and at the UN high level meeting on AIDS in 2006, where they pledged 'universal access to comprehensive prevention programmes, treatment, care and support by 2010'. The commitment has also been the catalyst for national and global action. The UNAIDS and DFID-led Global Steering Committee on universal access has coordinated efforts by UN agencies to help countries develop strategies to move towards universal access.

However, despite this growing momentum to comprehensively scale up the global response to HIV and AIDS, a number of barriers to universal access to treatment exist – including inadequate health systems, the high price of drugs and inadequate funding. A huge funding gap exists between what is currently available and what is needed for a comprehensive response to AIDS. The commitment made by the UK and others is at risk of failing for lack of sufficient funding. As a result, millions of people are still not receiving the information, services or treatment they need to curb the impact of HIV and AIDS. Of these, women and young people are particularly affected. In parts of Africa and the Caribbean for example, young women aged 15-24 are up to six times more likely to be HIV-infected than young men⁴.

ActionAid believes this must not continue. Instead, the UK and others must bridge this financial gulf and ensure universal access is made reality.

Throughout 2005, the UK demonstrated leadership on HIV and AIDS. In its 2005 election manifesto, the government agreed to 'press for an international agreement on universal access to AIDS treatment by 2010'. In Gleneagles, the UK led negotiations on the Communiqué and subsequently co-chaired the Global Steering Committee. Now, the UK must build upon this political leadership and ensure its commitment to universal access is matched by sufficient funding.

This paper looks at the current funding gap in the global comprehensive response to HIV and AIDS and calls on the UK to work with other G8 countries to galvanise sufficient funding from G8 members. In particular, it calls for Gordon Brown to build on the UK's political leadership in 2005 and push for G8 countries to agree an international funding plan which focuses upon the urgent delivery of existing financial commitments. It also calls on the UK to improve its own funding to HIV and AIDS. In doing so, this paper places particular emphasis upon treatment. A comprehensive approach to HIV and AIDS demands that prevention, treatment and care and support are seen as a mutually reinforcing continuum. Universal access must therefore proportionately address all three components. Yet, access to treatment provides a lens through which to view the broader AIDS-funding shortfall and is the clearest and most high-profile target set by the G8 and the UN system.

Universal access to treatment: where are we now?

While ambitious, the commitment to achieve universal access builds upon previous initiatives and commitments. In particular, the WHO/UNAIDS '3 by 5 Initiative' successfully demonstrated that scaling-up access to treatment in developing countries is feasible. It increased the number of people receiving anti-retroviral treatment (ART) and helped light the way for further action. This section of the paper looks first at progress made to date by such initiatives in scaling-up access to treatment, and then at the need for fully funded national plans to build upon this success.

Scaling-up access to treatment

Globally, access to treatment for HIV and AIDS is increasing. Between 2003 and the end of 2005, the number of people receiving ART in low- and middle-income countries tripled to 1.3 million⁵, 300,000 more people every six months⁶. This rate of increase continued in 2006. As a result, approximately 1.65 million people now receive treatment⁷. This progress demonstrates what is achievable, but it is not enough. Approximately 4.4 million (four in five) people in urgent need of ART still lack access to it.

While useful, this global snapshot fails to highlight the regional and national disparities in access to treatment. Progress has been uneven. Regionally, for example, 68% of people in need of ART in Latin America and the Caribbean, and just 5% in North Africa and the Middle East, were actually receiving it as of the end of 2005. Notably, the number of people receiving treatment in sub-Saharan Africa increased eight-fold from 2003 to 2005 – for example, by the end of 2005, Botswana ensured that 75% or more of people in need of ART received it⁸. Namibia and Uganda achieved a coverage rate of 50% or more. This success demonstrates genuine political commitment from some of the poorest and most badly affected countries to tackle HIV and AIDS. Yet despite this success, five out of every six people in need of ART in sub-Saharan Africa continue to go without.

Nationally, urban residents typically have better access to treatment than rural residents and children routinely miss out on treatment, due in part to the lack of child-friendly drugs. Furthermore, while women and men equally lack access to treatment, fear of disclosure, as well as domestic and other forms of violence represent significant barriers to adherence to treatment programmes for many women, reinforcing in turn their vulnerability and existing gender discrimination.⁹

There are a number of reasons for this uneven and inadequate progress, including weak health systems, the high price of drugs and in particular, inadequate funding. Further efforts to scale up treatment and achieve universal access must therefore be tailored to country-specific disparities and priorities.

National targets and treatment plans

The 2006 United Nations General Assembly Political Declaration on HIV and AIDS commits UN member states to set 'ambitious national targets [in 2006], including interim targets for 2008... that reflect... the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010...'

Setting these national targets is intended to be a transparent and fully inclusive country-driven process, thereby ensuring it is based on evidence, truly reflective of need and accurately costed. UNAIDS has been

Universal access to treatment in Nigeria

The Nigerian government has provided ART to people living with HIV and AIDS since 2002 when 25 centres in various parts of the country were selected as part of a pilot treatment project. By mid-2004, this pilot project had successfully demonstrated the efficacy of providing ART. Approximately 13,500 people were receiving treatment from these centres and many more were on waiting lists.

The project highlighted several major barriers to further scaling up treatment in Nigeria. For example, the associated cost of access to treatment for patients, including out of pocket expenses for treatment for opportunistic infections and the cost of travelling to treatment facilities, was considerable. In addition, many health facilities were inaccessible to rural communities and had poor equipment. Now there are 160 centres in Nigeria with at least one in each state. While this represents considerable progress it is still not enough to meet treatment needs in full.

Despite these barriers, in 2005, the Federal Government of Nigeria agreed a *Plan to Scale up Anti-retroviral Treatment for HIV or AIDS in Nigeria 2005-2009* following consultations and consensus with all stakeholders. In it, the Nigerian government committed to "work towards ensuring that all persons in the country have access to quality healthcare that can adequately treat or manage their conditions,

including the provision of anti-retroviral medication (ARV)", and in particular to reach universal coverage of ART by 2009/2010.

Approximately 600,000 people in Nigeria currently require ART. By the end of the period covered by this plan (2009), the number of Nigerians who require ART is projected to increase to 1,200,000. The sustained cost of treatment, the level of investment and the increased spending on HIV and AIDS needed to achieve universal access in Nigeria is therefore considerable.

As of September 2006, the treatment plan was still being costed. However, the Nigerian government had already begun to commit funding to treatment. In 2006, N2.1 billion (approximately \$15 million) was allocated to purchase anti-retroviral drugs. This followed N500 million (approximately \$3.7million) allocated in April 2001, and N1.5 billion (approximately \$11 million) in 2004.

The Nigerian government is committed to increasing its financial support of HIV and AIDS treatment, but funding support from development partners is required to augment this. Section 4.9 of the treatment plan clearly states that other sources of financing must be pursued from all stakeholders, including national and international communities. In addition support for technical capacity development and provision of equipment is required.

tasked with supporting countries by ensuring the participation of civil society, people living with HIV, women and most-at-risk populations, and setting standard indicators and guidance for this process.

As countries meet their commitment to deliver national 'roadmaps' to universal access, the UK and other donors must match their rhetoric with a greater financial commitment. Each nationally agreed target, like that agreed by the Nigerian government (see box), must be funded in full. This additional funding must be predictable, untied, strictly aligned to national priorities and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose.

Funding national plans: global cost and funding gaps

The cost of funding each national target will differ from country to country. Until all national targets are agreed it is difficult to authoritatively say what the total global cost will be. However, existing estimates of global resource needs give a limited indication of cost, and highlight in particular an **AIDS funding gap of at least \$8.1 billion in 2007.**

According to UNAIDS, global AIDS expenditure must reach \$15 billion in 2006, \$18.1 billion in 2007 and \$22.1 billion in 2008. Of this, UNAIDS estimates that

\$3-\$5 billion (22% of total funding needed for a comprehensive response to AIDS in low- and middle-income countries) is needed per year, between 2006 and 2008, to work towards universal access to treatment by 2010. This estimate, however, significantly underestimates the full cost of universal access to treatment. For example, the definition of universal access used by UNAIDS to reach this estimate – 80% coverage of people who would die within a year without treatment – is very narrow. **If instead, like the '3 x 5 initiative', all those who have begun to develop AIDS-related symptoms were given ART, just 68% of people in need of treatment would receive it by 2010 under this UNAIDS model.**¹⁰

An alternative global cost of universal access to treatment

A recent study¹¹ by the British Columbia Centre for Excellence in HIV/AIDS suggests the cost of universal access to treatment is much higher than estimates by UNAIDS suggest. It argues that more than \$15 billion is needed to provide ART to everyone in the world infected with HIV but that this cost would decrease as the numbers of newly infected individuals shrank. The study argues universal access to treatment would average \$7 billion per year. The model assumes that instead of treating only those with AIDS-related symptoms, all HIV-positive people would receive treatment from the time of diagnosis and that treatment would cost \$365 a year, rising by 3% a year. It also assumes little or no transmission would occur from people on anti-retroviral treatment and does not include, for example, costs for the wider healthcare system or price variation for second-line drugs.

More significantly, these global estimates show that existing and projected AIDS funding is dwarfed by global resource needs and that countries are destined to fail to meet their commitment to universal access unless more money is urgently made available. In 2004, an estimated \$6.1 billion from all sources was spent on the three components of a comprehensive response to HIV and AIDS – prevention, treatment and care and support. UNAIDS projections based on past trends and existing pledges and commitments indicate that in 2006 and 2007 there will be a funding gap of \$6 billion and \$8.1 billion respectively¹². It is important to note though that the funding gap may actually be greater than these estimates suggest, both because UNAIDS may be underestimating need and because donor reports may be unreliable, as highlighted below.

The broad political commitment and national momentum behind universal access is welcome. Yet this is worthless to the 4.4 million people still without access to treatment if it does not result in positive change. The funding gap must be bridged and national targets must be funded in full. The cost of failure to communities and individuals is immeasurable.

In Mwanza, southern Malawi, for example, no-one has access to life saving ART. “We have heard all about them, but never seen them,” says Dismus Nkhoma. Dismus works for the Mwanza AIDS Support Organisation, which in collaboration with the local district hospital provides counselling and testing to members of the community. He continues, “It would be good to have free provision of these medicines so that I can afford to send my nephews to school and stop them from becoming child labourers.”

Bridging the financial gulf

Global AIDS expenditure has increased almost threefold since 2002¹³ as a result of civil society pressure and increased political will. Yet while genuine progress has been made, more is needed; immediate need continues to exceed available funding. The UK and other donors must act to ensure this disparity does not continue. The UK in particular must build upon its political leadership on universal access in 2005 and seek agreement among other donor countries on an HIV and AIDS funding plan to plug the \$8.1 billion funding gap.

This section focuses on the need for a G8 funding plan. It identifies some of the broader issues the funding plan should address and suggests how current need could be met through increased overseas aid and scaling up the Global Fund. In doing so, it highlights that the funding plan need only focus upon the urgent delivery of existing promises. **If existing financial commitments and current spending promises were met, available funding would treble and the commitment to universal access championed in 2005 would be within reach.** Finally, this section also looks at the importance of improving current spending on HIV and AIDS, focussing in particular on the Department for International Development (DFID).

Developing a funding plan to finance universal access to treatment

A funding plan is crucial to the delivery of a comprehensive response to HIV and AIDS. It would show genuine intent on the part of donors to deliver sufficient funding for the commitments they have made, and would provide greater incentive for countries to develop national targets. Developing countries need to know when and how this money is going to appear so they can start to implement their national targets and guarantee access to treatment for all.

This funding plan should map out how donor countries plan to urgently increase revenue and channel much-needed additional funding to fully

fund all national targets and achieve their commitment to universal access by 2010. Crucially, the funding plan should recognise lessons learnt in the past and provide funding accordingly. For example, the increased funding must be additional to existing aid commitments and not taken from other key requirements. The funding must also be predictable to enable country governments to plan long-term investment. Funding must also be untied, aligned with national targets and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose. **Furthermore, to ensure greater coherence and coordination, existing funding mechanisms must be scaled up and strengthened, not supplemented by several small, uncoordinated initiatives.**

The funding plan should also set realistic and ambitious funding targets for donor governments, particularly for overseas aid, and define how it will be used effectively, including, in particular, the full funding of the Global Fund.

Overseas aid

In 2004 the G7 countries spent approximately \$2.9 billion (7%) of approximately \$39.6 billion in bilateral aid to developing countries¹⁴ on HIV and AIDS¹⁵. Similarly, in 2004/05, the UK allocated just over 7% of its total bilateral aid expenditure (approximately \$590 million¹⁶) to HIV and AIDS. This does not include multilateral aid, for example the \$36 million the UK contributed to the

Global Fund for HIV in 2004. The total amount of bilateral funding for HIV and AIDS can and must increase, but not at the expense of other priority aid expenditure. Scaling up funding for the treatment target must therefore be approached in the wider context of increases in aid budgets, in line with the commitments made in 2005 by G8 countries.

If all G8 countries met their commitment to give 0.7% of gross national income (GNI) in aid and maintained the existing 7% proportion for HIV and AIDS, an additional \$11 billion would be available to HIV and AIDS which alone would bridge the funding gap in 2007¹⁷. But today, only five of the world's richest countries are fulfilling their promise to give 0.7% of their GNI to overseas aid – Denmark, Norway, the Netherlands, Luxembourg and Sweden. Of the G8 countries, the US, Japan, Russia and Canada have still not set a timetable to reach this target. France and the UK have committed to reach this target by 2012 and 2013 respectively, while Germany and Italy have committed to reach the target by 2015. France, Italy Germany and the UK have set interim targets for aid levels. However, this planned increase is too slow to help significantly bridge the HIV and AIDS financing gap in the next two to three years.

The Global Fund

Since its creation in 2001 the Global Fund has grown to play a key role in the international response to HIV and AIDS. But despite its importance, the Global Fund has been consistently short-changed by the G8. Four years ago, donors refused to accept a predictable funding mechanism, opting instead for voluntary donations. Since then, donors' will has failed and the Global Fund regularly faces funding crises.

The continued success of the Global Fund is central to achieving universal access and the Millennium Development Goals. As global resource needs in relation to HIV and AIDS, malaria and tuberculosis are met, the Global Fund's resources should also increase. Current estimates indicate that the Global Fund provides two-thirds of global funding for malaria and tuberculosis and 20% of funding for HIV and AIDS. Simply maintaining this share of international funding means that the Global Fund will need to receive \$5.9 billion in 2007, increasing each year to \$8.3 billion in

2010. The funding plan must find a way to resolve this shortfall and ensure the Global Fund receives the predictable funding it should – in full.

Other sources of funding

Additional sources of funding exist, including:

- Innovative finance mechanisms
- Domestic spending
- Foundations
- Multilateral donors

Whilst it is important the funding plan considers these, it must first and foremost address the current inadequacy of aid expenditure. The funding plan must not set unsustainable, arbitrary funding requirements on alternative sources of funding or privatise the response to HIV and AIDS. Primary responsibility to respond to HIV and AIDS must rest with donor governments.

Innovative financing mechanisms like UNITAID, for example, can play a role in the global response to HIV and AIDS but they must not substitute or divert attention from scaling up and strengthening existing AIDS mechanisms.

France, Brazil, Chile, Norway and the UK launched UNITAID, the International Drug Purchase Facility, in September 2006. This new facility aims to scale up access to treatment for HIV and AIDS, malaria and tuberculosis for the poorest people in developing countries by lowering the price of quality drugs and diagnostics, and accelerating the pace at which they are made available. It will do so by using long-term and predictable financing – approximately \$380 million per year (just 4.7% of the \$8.1 billion funding gap) – partly raised by a levy on air tickets. It will also support the use of compulsory licenses by developing countries to drive down the price of treatment.

In 2006, domestic spending on HIV and AIDS in low- and middle-income countries was estimated to total \$2.8 billion (almost a third of total AIDS funding)¹⁸. This is expected to increase to \$3 billion in 2007¹⁹. Middle-

income countries with strong economic growth and a stable political situation are under particular pressure to increase domestic investment in HIV and AIDS. Any increase in domestic spending must be government-led and eliminate the need for out-of-pocket expenses that are currently met by people affected by HIV and AIDS. For many people, these expenses cannot be considered disposable funding. In fact, they often involve last-minute, urgent interventions many can ill afford.

Improving existing DFID funding for HIV and AIDS

The UK has committed £1.5 billion (approximately \$2.8 billion) to HIV and AIDS for 2005 through to 2008. Its HIV and AIDS expenditure is expected to rise to £500 million in 2006/07 and then to £550 million in 2007/08. DFID is therefore sponsoring the second largest bilateral HIV and AIDS programme worldwide. ActionAid welcomes this but believes it is crucial for DFID to demonstrate global leadership in the equitable allocation and impact of funding. However, ActionAid's analysis of UK AIDS funding has in the past identified a lack of transparency and clarity over the allocation of UK aid in this area, and its impact²⁰.

In 2006, DFID commissioned an interim evaluation of its AIDS strategy, the initial findings of which were published in a working paper in June²¹. While it emphasised that tracking was still being revised to address concerns expressed by ActionAid and others, it is clear that little has changed. HIV and AIDS expenditure is still not accurately recorded, the cost of activities not specific to HIV and AIDS are still recorded as expenditure on HIV and AIDS, and data regarding impact is still not disaggregated.

Of additional concern to ActionAid is DFID's programmatic focus. Of 1,424 programmes classified as prevention, family planning and reproductive health services, research, treatment, care and support and mitigation, just 3% focused on treatment. This includes all DFID-funded programmes that related to ARVs and other HIV-specific treatment, such as treatment of opportunistic infections, and traditional healers treating AIDS. In comparison, 72 further programmes focused on research, including vaccine development and microbicides. While investment and research into new technologies is essential for the long term, such expenditure must be balanced by adequate expenditure on existing medicines with a proven track record.

The same working paper tried an alternative approach following feedback from within DFID in which only programmes that focused upon HIV prevention, care and support for people affected by HIV and AIDS and/or treatment were considered. Of 376 AIDS-specific programmes, 32% focused on prevention, 23% focused on care and support and just 5.3% focused on treatment (62% either cut across these categories or did not specify).

The evaluation does not specify the comparative cost of these programmes or how many were agreed before and after the commitment to universal access. Furthermore, this evaluation does not include money given to the Global Fund, for example, which could be used for treatment and the large number of cross-cutting projects may also include treatment. As a result, further research is needed to clarify DFID's comparative focus on treatment. However, one year on from the G8 commitment to universal access to treatment it is important that any imbalance is resolved. DFID must demonstrate leadership in a comprehensive response to HIV and AIDS and ensure the rights and immediate treatment needs of people living with AIDS today are not forgotten.

Conclusion

Prevention, treatment, care and support must be seen as a mutually reinforcing continuum. Each component must therefore be proportionately addressed for the international response to HIV and AIDS to be comprehensive and effective.

In July 2005, the UK achieved its election manifesto promise and led G8 leaders in committing to 'develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010'. The UK helped lead discussions to coordinate efforts by UN agencies to help countries develop strategies to move towards universal access. One year on, further leadership is required from the UK to ensure their commitment receives adequate funding.

Existing global estimates indicate that the funding gap for a comprehensive response to HIV and AIDS is at least \$8.1 billion in 2007. This is likely to be a significant underestimation. Definitions of universal access to treatment used to reach this estimate are flawed – the added cost of wider healthcare system needs or price variations for second line drugs were not considered, and a difference often exists between donor pledges and what is actually disbursed or spent. One thing is certain though. If this financial gulf is not bridged national targets may go unfunded and countries will fail to achieve universal access.

As well as bridging this financial gulf, the most must also be made of existing HIV and AIDS spending. ActionAid is calling for:

- Gordon Brown to push for international agreement on a funding plan at the G8 meetings in 2007 that will deliver sufficient funding to achieve their commitment to universal access. This funding plan should map out how donor countries plan to urgently increase revenue and channel much-needed additional money to fully fund all national targets.
- every nationally agreed target to be financed in full with predictable, untied funding, strictly aligned to national priorities and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose.
- the UK to increase its commitment to HIV and AIDS in the forthcoming Comprehensive Spending Review in 2007.
- the Global Fund to be funded in full according to global resource needs, and for the UK to contribute its fair share.
- DFID to improve the transparency of its bilateral funding. Its HIV and AIDS expenditure must be accurately recorded, activities not specific to HIV and AIDS should not be recorded as funding spent on HIV and AIDS and data regarding impact must be disaggregated to ensure marginalised groups are effectively targeted.
- DFID to prevent any imbalance in their programmatic interventions. As the second largest bilateral HIV and AIDS programme worldwide DFID must demonstrate leadership with a proportionate, comprehensive response to HIV and AIDS and ensure the rights and immediate treatment needs of people living with AIDS today are not forgotten.

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Acknowledgements:

Fionnuala Murphy, Simon Wright, Patrick Watt, Carmen Sepulveda Zelaya, Jessica Woodroffe, Aditi Sharma, Iacopo Viciani, Angela Burton



ActionAid is a unique partnership of people who are fighting for a better world - a world without poverty.

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