

Finance and implementation

The previous chapters have outlined the major elements of a comprehensive response to the AIDS epidemic: prevention of new infections, treatment and care, and support for orphans and vulnerable children. We have outlined a set of necessary services or interventions in each area and addressed some of the most important issues involved in implementing these measures. In this chapter we turn to topics that cut across the three elements of the response. First we consider the cost of mounting an effective response to the epidemic and review recent data from UNAIDS on current and projected resource availability. We then examine two issues that will have to be resolved if new funds for AIDS programs are to be spent effectively at the country level: poor donor coordination and limited absorptive capacity. Finally, we discuss how the United Nations system could do more to help countries combat the epidemic.

Estimating the cost

Estimating the cost of meeting the Millennium Development Goals is an important part of the UN Millennium Project's mandate. Fortunately, work on resource requirements for AIDS is relatively advanced. As a result, the Working Group on HIV/AIDS has been able to rely on existing work in this area.

UNAIDS estimates

The most comprehensive work on resource needs for HIV/AIDS in the developing world has been done by UNAIDS. Their most recent analysis, which extends and revises earlier work (Schwartlander and others 2001; UNAIDS 2002a), estimates that \$11.6 billion will be required in 2005 and \$19.9 billion in 2007 (UNAIDS 2004b). Of the 2007 total, prevention accounts for 50 percent, treatment and care for 34 percent, and support for orphans and vulnerable children for 11 percent. About 43 percent of these resources would be

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needed in Sub-Saharan Africa, 28 percent in Asia, 17 percent in Latin America and the Caribbean, 9 percent in Eastern Europe, and 1 percent in North Africa and the Middle East. These estimates result from gathering country-specific data on the unit costs of a set of essential services, estimating the number of people needing each service, and setting feasible targets for coverage of each service. A number of considerations should be kept in mind in interpreting the resulting estimates.

First, this method calculates average costs rather than marginal costs. In some cases, where large fixed costs have already been incurred or where there are increasing returns to scale, the incremental cost of expanding coverage from its current levels may be lower. In other cases, actual costs may rise, as capacity constraints become more binding (see below) or where people who do not have access to a service are more difficult and more expensive to reach. An alternative costing methodology, Marginal Budgeting for Bottlenecks, has been developed to shed light on marginal costs of expanding services and on the costs and benefits of addressing particular constraints to service delivery (Knippenberg and others n.d.). This tool may be a more useful guide to incremental costs over the short run than the average cost approach. The UNAIDS approach is probably the most appropriate for evaluating resource requirements over the longer term.

Second, costs in the UNAIDS model depend on the choice of coverage targets, which in turn reflect estimates of system capacity to deliver services. Thus, in a certain sense these are estimates of the total cost of reaching as many people as system capacity will permit, rather than the cost of providing basic services to all who require them. Capacity is assumed to grow between 2003 and 2007, at a rate that depends on a country's GDP and past performance, but remains a constraint on coverage in many cases. This consideration is particularly relevant to antiretroviral therapy, which places relatively high demands on health systems. The coverage targets for antiretroviral therapy in the costing analysis were revised to make them consistent with the 3 by 5 target (see below); by 2007 coverage corresponds to 52 percent of those in need (Hankins and others 2004). Coverage targets for this and other services cannot be directly compared with the targets set by the working group, which are for 2015, but since the UNAIDS targets are quite high this is not a major obstacle to our use of their estimates.

Third, while the model considers system capacity as a constraint on coverage levels, it does not explicitly consider the costs of expanding capacity, such as the cost of building new clinics, hospitals, or laboratories. Moreover, while the human resource costs of delivering particular interventions are included in the estimates whenever possible, the potentially large costs of relieving the shortage of skilled staff that currently limits coverage (by raising salaries, improving working conditions, or expanding nursing and medical schools) are not considered and would be difficult to assign to particular AIDS services.

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This is probably the largest category of costs that are not included in these otherwise comprehensive estimates.

Finally, the UNAIDS estimates extend only to 2007 and can thus serve only as a rough guide to costs between 2007 and 2015. Growth in the number of people requiring treatment will almost certainly cause the annual cost of treatment and care to increase substantially, although the extent of the increase will depend critically on the success of prevention in the intervening years, and some of the costs may be offset by further reductions in the price of antiretroviral drugs. Rapidly scaling up both prevention and treatment could also cut costs in later years by reducing the number of orphans and vulnerable children requiring support.

Other estimates

The only other major attempt to estimate the cost of providing a comprehensive set of prevention and treatment services in the developing world was that of WHO's Commission on Macroeconomics and Health (CMH). The CMH, using the same basic methodology as UNAIDS, calculated that expenditures on AIDS in a smaller number of mostly low-income countries would have to rise to \$14 billion per year over 2001 levels by 2007, and to \$22 billion annually by 2015 (Commission on Macroeconomics and Health 2001). This analysis did not include services for orphans and vulnerable children, but did attempt to incorporate the cost of expanding health system capacity. Given the enormous uncertainties involved in this kind of calculation, the degree of agreement between the CMH and UNAIDS estimates is remarkable and provides some assurance that these figures are at least in the right range.

Some other recent studies have used the UNAIDS analysis or its methodology to shed light on the costs of specific components of the response. WHO and UNAIDS estimated in early 2004 that achieving the target of treating 3 million people by 2005 would cost between \$4.9 and \$5.4 billion over 2004–05, depending on the path by which the target was reached and the price of drugs (Gutierrez and others 2004). This figure assumes a delivery model consistent with the WHO operational guidelines and includes not only antiretroviral therapy itself, but the recommended set of accompanying services (WHO/UNAIDS 2004b). This estimate reaches \$5.4 billion–6.4 billion in the recent UNAIDS costing report. In 2003 the Global HIV Prevention Working Group analyzed the funding gap for prevention, drawing on UNAIDS' work for estimates of resource needs (Global HIV Prevention Working Group 2003).

The UNAIDS costing may have to be significantly revised in the area of programs for orphans and vulnerable children, in large part because there is much less consensus on a set of essential services and on how (and to whom) they should be delivered. A UNICEF survey concluded that the cost of delivering basic services to children at the community level was considerably higher than anticipated and that providing this support to orphans and vulnerable

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children in households below the poverty line could cost as much as \$6 billion by 2010 in Sub-Saharan Africa alone (see chapter 4). This is considerably more than the \$2.2 billion estimated for 2007 by UNAIDS, even though the UNAIDS study included all countries with HIV prevalence above 1 percent. In another respect the UNAIDS study may have overestimated the cost of orphan support, since it assumes a large role for orphanages. Institutional care is considerably more expensive than care in families and communities (Desmond and Gow 2001; Prywes and others 2004).

The working group has not conducted its own costing analysis. The UN Millennium Project Secretariat, however, led an effort to estimate the cost of meeting the health Millennium Development Goals in a small number of case study countries, using a variety of approaches, including a modified version of the UNAIDS methodology (UN Millennium Project 2004). Coverage targets were set at or close to 100 percent for all services in 2015, with gradual scale-up from current coverage in intervening years. An important feature of this study was that it attempted to incorporate the costs of building health system capacity by including allocations for strengthened management, physical infrastructure, substantial increases in health workers' salaries, and other systemwide costs. The cost of salary increases alone constituted a substantial share of the estimated total cost of meeting the health Millennium Development Goals (encompassing AIDS, malaria, tuberculosis, and maternal and child health). Although these estimates should be considered very preliminary, they suggest that a serious attempt to resolve the crisis in human resources for health might add very substantially to the cost of a comprehensive response to HIV/AIDS.

In summary, there is substantial agreement that providing a set of basic HIV/AIDS services to all those who need them would cost well over \$10 billion and as much as \$20 billion a year. The most important gap in the existing estimates concerns health systems: lack of health system capacity currently limits expansion of some services, especially antiretroviral treatment, but relatively little is known about what it would cost to relieve this constraint. Filling this gap is an important priority, but good cost estimates will depend on better understanding of how to build stronger health systems in various settings.

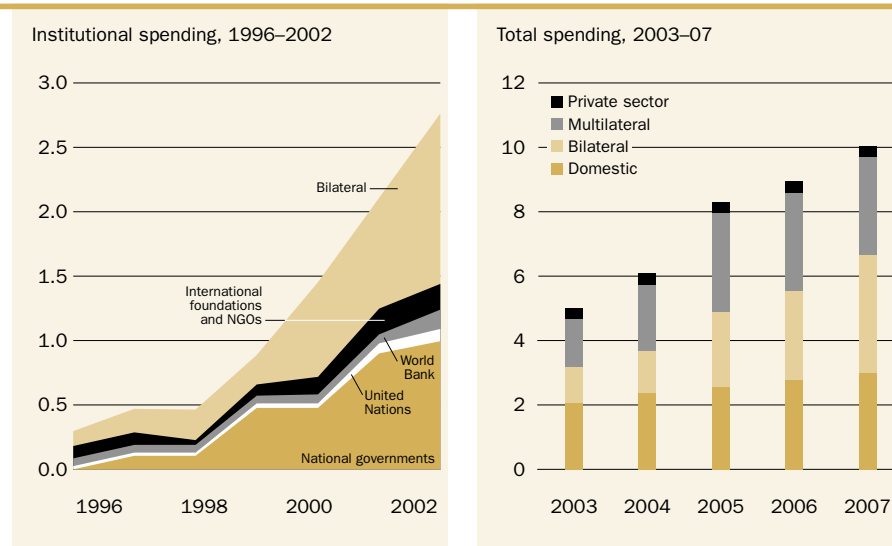
Current and projected resources

Global resources for AIDS in the developing world have grown enormously in recent years, but they remain insufficient. According to UNAIDS, institutional spending on HIV/AIDS (including funding by bilateral donors, multilateral organizations, and developing country governments) rose as much as ninefold between 1996 and 2002 to about \$2.7 billion (UNAIDS 2003b). Spending from these sources has continued to increase rapidly, and when contributions from households and the private sector are included, resources for AIDS are expected to exceed \$6 billion in 2004 (UNAIDS 2004b). Almost 40 percent of this total comes from domestic sources (national governments

Figure 5.1
Spending on HIV/AIDS
by governments
and international
organizations has
risen dramatically,
and spending from
all sources is likely
to continue to grow
Billions of dollars

Note: Bilateral spending includes funds from the European Community. Domestic spending includes national governments and households.

Source: UNAIDS 2004.



and households), while 21 percent comes from bilateral sources and 34 percent from multilateral channels, including the Global Fund, the World Bank, and the UN system. UNAIDS projects that available resources will rise to more than \$10 billion by 2007, with most of the increase coming from international sources (figure 5.1).

Among bilateral donors, the United States and the United Kingdom are by far the largest contributors to AIDS programs, accounting for 35.2 percent and 27.6 percent of bilateral aid, respectively, and the U.S. share is expected to grow as its AIDS initiative gets under way. It should be noted, however, that the United States currently ranks only sixth in its contribution relative to GDP, and last among OECD countries in development assistance overall as a share of national income (UNAIDS 2004b).

Despite these very substantial increases, resources available for AIDS in the developing world are still well below what will be required to bring the epidemic under control and to bring essential prevention, treatment, and support services to those who need them. In 2007, for example, the projected \$10 billion would constitute only a little more than half of UNAIDS' estimate of need in that year. Moreover, measurements and projections of expenditure refer to disbursements by donors or governments. Since there is often a considerable delay before these funds reach the project or grassroots level, the real funding gap is larger than these numbers suggest.

The adequacy of AIDS funding depends on many factors beyond the total quantity of funds from all sources. First, it matters a great deal where the money comes from: while some developing country governments have increased funding on AIDS substantially, a disturbingly large share of domestic expenditure comes from households themselves, especially in the poorest countries. Data on AIDS-specific spending are scarce, but so-called out-of-pocket expenditures (formal or informal user fees to public health services or payments to

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quantity**

private providers) are estimated to account for almost three quarters of health spending in low-income countries (World Development Indicators 2004, cited in UNAIDS 2004b). Although it makes sense for people who can afford to contribute to the cost of their care to do so, in the absence of public or private insurance or free public health services for those who need them, the burden of paying for AIDS treatment and care can be catastrophic and contribute in an important way to the impoverishment of families and communities. In addition, little is known about the quality of services purchased from private providers.

Second, the quality of donor financing matters as much as its quantity. Development assistance for AIDS will be more effective if it responds to recipient rather than donor priorities, if fewer conditions are attached to its use, if it is longer-term and predictable, and if the burden of paperwork and reporting imposed on recipients is kept to a minimum. These issues, which apply to all sectors, are considered at greater length in the UN Millennium Project's synthesis report (UN Millennium Project 2005a); see also the discussion of donor coordination below.

Finally, of course, the money must be spent well. Funds must go the right programs—misplaced priorities or inequitable allocation will diminish the impact of AIDS spending—and these programs must be implemented effectively. To the extent that AIDS programs are not well designed or monitored or that the funds allocated to them never reach the clinics, hospitals, or community organizations where they are to be used, more spending will not translate into fewer infections or more people in treatment. Thus, while reaching the goal of bringing the epidemic under control by 2015 will require further increases in resources, and these funds will have to come mostly from the donor nations, equal effort must be devoted to overcoming the barriers to spending these new resources as effectively as possible (see below).

The Global Fund

While all financing channels have a role to play, the working group believes that it is vital to strengthen and ensure the survival of the Global Fund to Fight AIDS, Tuberculosis and Malaria, while continuing to improve its performance. The Global Fund is a multilateral institution designed to rapidly channel money to country-owned and country-implemented initiatives against these three diseases. In its first three years, it has established an innovative grant evaluation and funding process, approved 297 proposals from 128 countries requesting over \$3 billion, and disbursed more than \$633 million (as of October 2004).

The Global Fund differs from more traditional channels for development assistance in several ways (Radelet 2004). First, it does not implement or oversee funded programs; it is by design a financing mechanism only. In theory, this gives it the potential to be an unusually agile financing vehicle, well suited

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to funding rapid scaling up of the AIDS response, although this feature introduces problems of its own (see below). Second, it funds country-initiated and country-designed programs and thus responds to country rather than donor priorities. Moreover, as a multilateral funding mechanism, it pools the contributions of donors in these program areas, in theory reducing the multiplicity of donor projects and administrative demands on recipients. Finally, the Global Fund works at the country level through a novel institution, the Country Coordinating Mechanism (CCM), that brings together donors, civil society, and government. The CCMs endorse and harmonize all grant proposals and are responsible for overseeing implementation by recipients and ensuring transparency and accountability. Although both the performance and inclusiveness of CCMs have varied considerably, in many countries they seem to have opened new channels of communication and enabled broader participation in setting priorities and designing programs.

Ultimately, of course, the Global Fund must be judged by results: by how rapidly it can channel funds to programs against the three diseases and by whether these programs meet their objectives. It is too early to reach definitive conclusions, but early results are promising. The Global Fund's own evaluation of 25 grants that were at least a year old by April 2004 found that 12 had met or exceeded targets, 8 had made good progress but fallen somewhat short of targets, while 5 were doing poorly (GFATM 2004b). Across the set of 25 grants recipients reached an average of 80 percent of one-year performance targets; 6 of 9 HIV/AIDS grants were judged to be on track. Nonetheless, the early experience of the Global Fund suggests several challenges and areas for improvement.

First, disbursement of funds for approved proposals has been disappointingly slow and a source of frustration for some recipients. The main delays have been at the start: on average, it takes six months before a grant is signed, and one or two more months for a first disbursement to be received (GFATM 2004a). While these delays have been decreasing, the process could be accelerated by increasing the fund's unusually small staff of portfolio managers, by reinforcing the role of private recipients for civil society grants, and by offering centralized options for pooled product procurement.

Second, and more seriously, the current proposal process neither requires countries to consider implementation challenges seriously enough nor does it enable the Global Fund itself to adequately evaluate implementation capacity during the approval process. The interests of neither the Global Fund nor recipient countries are served by approving proposals, including those for ambitious AIDS treatment programs, that do not include realistic consideration of human resources or other health system challenges and do not lay out a plausible plan of implementation. This is not to suggest that the Global Fund should reject all proposals from countries where health personnel or critical infrastructure are in short supply—these are just the countries it was designed to serve. But the pro-

The potential harm to health systems can be minimized by interpreting the Global Fund's mandate broadly

cess must be designed to encourage systematic planning by countries themselves for overcoming these obstacles. Three changes or shifts in emphasis might help:

- The proposal form itself should explicitly require applicants to explain how human resource needs will be met. How many health workers of which kinds will be needed to deliver the planned services, and how will they be recruited and trained? Is there a national human resources strategy for the health sector, and how does the proposal fit within it?
- Applicants should be required to review performance on past Global Fund grants, as well as related grants from other international donors. They should be asked explain how they will address any shortcomings that emerged, including those highlighted by the fund's own two-year evaluations, if available. Countries that have not done well in the past should not be automatically denied new grants, but should present a coherent plan for overcoming previous problems. A recent analysis of the fund went a step further and recommended that past performance become an explicit criterion in evaluating proposals (Radelet 2004).
- Although the Fund does not assist countries with implementation, it should encourage countries to request funds for technical assistance where necessary. Moreover, it should help recipients to find qualified partners: difficulty in identifying appropriate partners has slowed the use of funds allocated for this purpose to date.

Third, the Global Fund's basic design might inadvertently promote vertical, disease-specific programs. Thus, it could endanger other disease priorities—and health systems—by underwriting the diversion of staff and other limited resources and the establishment of separate management and logistical systems (Bennett and Fairbank 2003). To some extent this is unavoidable, given the focus on the three diseases and the need to show rapid results in combating them. But the potential harm to health systems can be minimized (and the collateral benefits maximized) by interpreting the Global Fund's mandate broadly to include strengthening of health systems required for delivery of AIDS, tuberculosis, and malaria interventions and by considering the likely impact of proposed programs on health systems.

Thus, an AIDS treatment proposal that would set up a stand-alone network of treatment sites with its own drug distribution, laboratory, and management systems should be viewed less favorably than one that would work through and strengthen existing systems. Precedents for such broad programs exist within the current grant portfolio of the Global Fund—for example, the AIDS grant to Haiti includes funds for building and refurbishing healthcare centers, stocking centers with essential medicines, and staff training—but this approach should be more vigorously encouraged. Moreover, the Global Fund has shown considerable flexibility in harmonizing with other donors: financing from the fund has contributed to sectorwide approaches in Ghana, Mozambique, and Zambia.

Current donor initiatives too often result in a patchwork of poorly coordinated programs

The “integrated” proposal option that the Global Fund introduced in the fourth round of proposals offers a promising way for the fund to support health systems. This option allows countries to propose programs that develop cross-cutting health system capacity, including human resources and infrastructure, and thereby relieve some of the bottlenecks constraining implementation of AIDS, tuberculosis, and malaria programs. However, the Global Fund needs to promote this option more vigorously and provide more specific guidelines for integrated proposals. The lack of clarity and awareness among countries resulted in only six integrated proposals being submitted. None were accepted.

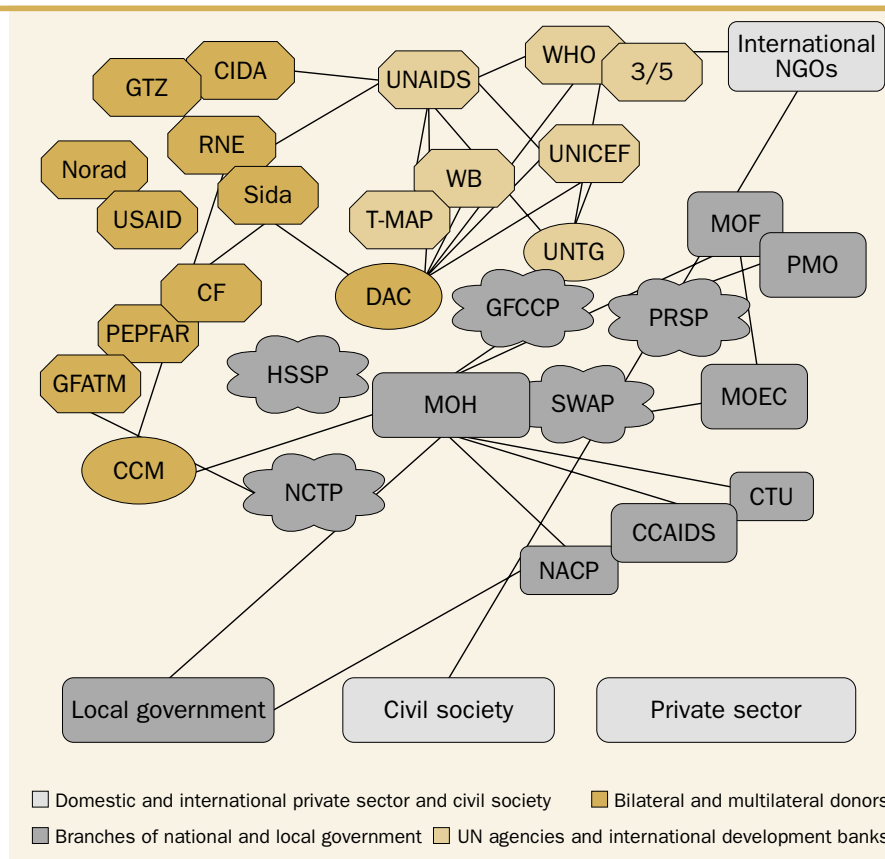
Although the Global Fund can improve its procedures and performance (and has demonstrated a strong commitment to continued innovation), the greatest challenge it faces is a looming shortage of funds. Already it has had to put off a fifth proposal round until 2005. The Global Fund estimates that it will require \$2.3 billion in 2005, but has received only \$1.0 billion in pledges. In 2006, it will require \$2.7 billion simply to renew existing grants, with another \$1 billion needed for a new round of grants. The United States is currently the largest donor to the Global Fund, and Secretary of Health and Human Services Tommy Thompson chairs its board. But the majority of U.S. AIDS funding is now channeled through its new bilateral initiative, the President’s Emergency Plan for AIDS Relief, with only a maximum of \$547 million out of \$2.4 billion going to the Global Fund in the 2004 AIDS budget. Other donors share the blame, however, and the United States is currently threatening to reduce its contribution unless others do more. The Global Fund is too important, as a funding channel and as a promising new approach to development assistance, to be allowed to fail for lack of funds. The working group strongly urges that all donor nations increase their contributions to permit the Global Fund to meet its existing commitments and launch new rounds of proposals that correspond to country demand.

Donor coordination

The growth in donor interest and funding for AIDS programs in developing countries, while welcome and long overdue, has in some places exacerbated confusion and inefficiency on the ground, as a growing number of donors, international agencies, and nongovernmental organizations pursue separate agendas. Current donor initiatives too often result in a patchwork of poorly coordinated programs, burdening health personnel and managers with multiple reporting requirements, discouraging integration of services, and impeding rational planning. Better coordination among donors and between donors and national governments will be critical to making good use of new resources for AIDS. The problem of donor coordination is closely linked to the challenge of building national ownership of and control over the AIDS response while ensuring efficiency and accountability.

Figure 5.2
As the case of Tanzania shows, developing a coherent response to AIDS at the country level requires coordinating the activities of many players

Note: Lines represent important institutional links.
 Source: Molin 2004.



In some countries, the number of international entities—donor agencies and their contractors, UN agencies and international development banks, the Global Fund, international nongovernmental organizations and foundations—involved in funding, implementing, or overseeing AIDS programs or advising national governments can reach into the dozens. Organizations, initiatives, and the relationships among them form a bewildering tangle, as illustrated in considerably simplified form for Tanzania in figure 5.2.

Lack of coordination can harm the AIDS response in a number of ways:

- Uneven distribution of services. In the absence of a rational division of effort, donors, government, and nongovernmental organizations often provide overlapping services, leaving other needs unmet or other populations unserved.
- Destructive competition. Donors, under pressure to disperse funds and achieve results quickly, compete for scarce personnel, government support, and infrastructure.
- Multiple systems and standards. Separate programs establish wasteful separate systems for supply, monitoring and evaluation, and training rather than working together to strengthen existing systems. Clinical guidelines, training requirements, and so on are not harmonized.

**Multisectoral
national AIDS
coordinating
authorities
should be
responsible
for setting
national
priorities**

- Excessive demands on government capacity. Multiple donor requirements place unnecessary demands on limited government administrative capacity.
- Lack of national ownership. Dependence on donors with their own agendas makes it difficult for governments to formulate and implement a coherent national vision.

Besides the inevitable challenges of ensuring that so many entities work together efficiently, the problem of donor coordination has at its heart a basic diversion of interests. National governments understandably want to maintain authority over the national response and control the activities of donors and other international entities on their soil, while donors have a legitimate interest in ensuring that the programs they fund achieve results and remain consistent with their own priorities. Even with good will on all sides, any solution will require compromise on these basic objectives.

Existing mechanisms for coordination

A number of institutions already exist to address issues of donor coordination. Within the UN system, UNAIDS theme groups bring together the different agencies working on AIDS, and in some cases, representatives of government, donors, and civil society. While theme groups are useful forums for sharing information, they lack the authority to impose solutions on the separate agencies, whose budgets they do not control, let alone on donors, and thus have limited impact (UNAIDS 2002b). The agencies also prepare Integrated UN Work Plans at the country level, but these documents have been criticized as mere repackaging of agency programs. More broadly, UN country programs are meant to adhere to jointly developed United Nations Development Assistance Frameworks.

Poverty reduction strategies, which in theory result from broad participatory processes, should provide a unified framework for considering the full spectrum of development priorities and for rational allocation of resources. But the treatment of the health sector in these strategies has often been cursory, with little budgetary detail and insufficient assignment of roles and responsibilities (Dodd and others 2004; Soucat and Yazbeck n.d.; Walford 2002).

In principle, multisectoral national AIDS coordinating authorities should be responsible for setting national priorities and for overseeing the activities of the various arms of government, as well as development partners working on AIDS (see below). But in practice, many national AIDS coordinating authorities lack the capacity to remain well informed on donor activities, let alone to impose order on them. In some countries, AIDS coordination within government has been hampered by an unclear division of responsibilities between coordinating authorities and AIDS units within Ministries of Health (SARA 2002).

In addition, donors have often tried to minimize duplication through informal agreements among themselves, sometimes by taking responsibilities for different geographic regions. Although this approach may reduce overlap,

Sectorwide approaches reduce or eliminate the problem of uncoordinated donor programs

it does nothing to enhance government ownership or uniformity of standards and practices. At the global level, the Development Assistance Committee of the OECD has published a set of guidelines on donor coordination, reflecting growing appreciation of the importance of this issue (OECD 2003).

The sectorwide approach

The most comprehensive approach to donor coordination in health is the so-called sectorwide approach, under which donors agree to provide some or all of their funding in a particular sector as direct budgetary support to the relevant government ministry in return for a greater voice in the development and implementation of government strategy (Moore 2003). In principle, sectorwide approaches reduce or eliminate the problem of uncoordinated donor programs, while requiring donors and governments to work together to achieve common aims, embodied in mutually agreed strategies and plans. This arrangement also counters the tendency of donors to avoid funding salaries or other recurrent expenditures. An additional advantage of sectorwide approaches is that they give donors a strong incentive to work to improve government systems rather than bypassing them (Ssengooba and others 2004). In exchange for these benefits, national governments accept a greater degree of donor oversight. Sectorwide approaches in health cannot resolve all coordination issues around AIDS, of course, since a comprehensive response must involve other sectors.

The UN Millennium Project as a whole strongly favors sectorwide approaches and “basket funding” over program funding as a vehicle for donor assistance in meeting the Millennium Development Goals, as outlined in the project’s synthesis report (UN Millennium Project 2005a). Sectorwide approaches will not make sense, however, nor will donors agree to them, unless national governments and ministries of health are perceived to meet minimum standards of effectiveness and transparency. If donors believe their money cannot be well spent by national governments or if they cannot come to agreement on priorities and strategies, they will continue to fund their own programs and establish parallel systems to implement them. Conversely, governments will not welcome sectorwide approaches if they are required to cede too much autonomy to a cabal of donors. In general, the working group believes that the long-term aim of combating AIDS while building national capacity is best served by moving toward sectorwide approaches wherever possible. Donors should be willing to sacrifice short-term performance in some cases in return for the benefits of sustainability and national ownership of AIDS programs.

The Three Ones

On April 25 2004, donors, under the leadership of UNAIDS, the United Kingdom, and the United States, agreed to three core principles—the Three Ones—with which to coordinate national AIDS responses.

Box 5.1
HIV/AIDS
indicators for
monitoring the
UN General
Assembly Special
Session targets

Source: UNAIDS 2002c.

Global commitment and action

1. Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition.
2. Amount of public funds available for research and development of vaccines and microbicides.
3. Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programs.
4. Percentage of international organizations that have HIV/AIDS workplace policies and programs.
5. Assessment of HIV/AIDS advocacy efforts.

National commitment and action

1. Amount of national funds spent by governments on HIV/AIDS.
2. National Composite Policy Index.

National program and behavior

1. Percentage of schools with teachers who have been trained in life skills-based HIV/AIDS education and who taught it during the last academic year.
2. Percentage of large enterprises or companies that have HIV/AIDS workplace policies and programs.
3. Percentage of patients with sexually transmitted infections at healthcare facilities who are appropriately diagnosed, treated, and counseled.
4. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.
5. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.
6. Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV.
7. Percentage of young people ages 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
8. Percentage of young people ages 15–24 reporting the use of a condom during sexual intercourse with a nonregular sexual partner.
9. Ratio of current school attendance among orphans to that among nonorphans ages 10–14.

Impact

1. Percentage of young people ages 15–24 who are HIV-infected.
2. Percentage of HIV-infected infants born to HIV-infected mothers.

The Three Ones are:

- **One** agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- **One** national AIDS coordinating authority, with a broad-based multi-sectoral mandate.
- **One** agreed country-level monitoring and evaluation system.

The agreed action framework would set out clear priorities for resource allocation, establish systems for joint review and consultation, and outline the

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links to poverty reduction strategies and other development agreements. The national authority would be responsible for developing and coordinating implementation of the action framework in a participatory manner, while leaving actual implementation to line ministries and other partners. These ideas are not new, but the attention that the Three Ones has attracted may help to reinvigorate efforts to make these institutions function more effectively.

The “Third One” offers the most concrete suggestion for practical progress, since multiple monitoring and evaluation frameworks have imposed unnecessary reporting burdens on managers at all levels and hampered the use of monitoring and evaluation to develop and improve policies. Donors should commit to aligning their monitoring and evaluation requirements at the global level and agree on core elements of country-level systems. Development partners should also invest in developing national capacity to implement these systems.

Country-level monitoring and evaluation and information systems should be linked to, but not limited by the 18 indicators developed by UNAIDS to monitor the UNGASS Declaration of Commitment (UNAIDS 2002c). The core UNGASS indicators fall into several classes, illustrating the basic types of data required for comprehensive monitoring (box 5.1). Some are epidemiological measures (for example, the percentage of young people who are HIV-infected). Other indicators attempt to measure aspects of behavior relevant to disease transmission (for example, the use of condoms). A third set, such as the fraction of people with advanced infection receiving antiretroviral treatment, address how many people are reached by particular services. Finally, the list includes measures of national or international commitment and action, including estimates of spending on HIV/AIDS and indexes of policy or advocacy. The UNGASS monitoring plan calls for information on these variables to be assembled by national governments using standard procedures and submitted to UNAIDS, and for all countries to begin reporting by 2004. The first progress report based on these data was published in September 2003 (UNAIDS 2003b).

These 18 UNGASS indicators are, of course, only a small subset of the kinds of information that would be useful to AIDS planning, which could include more specific behavioral and epidemiological data and better information on service delivery and expenditures. A particularly important innovation in epidemiological surveillance involves linking behavioral and demographic data to HIV serostatus in large, representative samples, such as the Demographic and Health Surveys already conducted in many countries. Surveys of this kind have been carried out in the Dominican Republic and at least seven countries in Africa (Ghana Statistical Service and others 2004; MAP 2002; Shisana and others 2002). Surveys of this kind are expensive and thus cannot replace regular sentinel surveillance for monitoring epidemic trends. Moreover, general population surveys are not useful where epidemics are concentrated in particular populations.

It is likely that continued support for the Global Fund will depend on obtaining concrete results quite soon

The acceptance by the donors of the Three Ones represents an important manifestation of commitment to better donor coordination. This first step will have to be followed, however, by concrete action on the ground in these three areas and by progress toward the “Fourth One” of unified funding mechanisms.

Overcoming capacity constraints

Although there is substantial agreement that providing AIDS services to all those who urgently need them would cost well in excess of \$10 billion a year, well more than is currently available, there will be no point in raising these additional resources if they cannot be spent effectively. It is often asserted that many developing countries lack the capacity to “absorb” such large infusions of new money and that some countries are having trouble spending the funds they have already received from the Global Fund, the World Bank, or other sources. These concerns cannot be dismissed, and there is no doubt that capacity issues pose a real challenge to successfully scaling up the response to AIDS, especially in the poorest countries.

One way to get a sense of the scale of capacity constraints, at least in the short term, is to consider the rate at which committed funds are actually disbursed or spent. Both the World Bank’s Multicountry HIV/AIDS Program (MAP) and the Global Fund initially encountered difficulties disbursing funds. At the country level, the 2003 Kenya Public Expenditure Review reported that the Kenyan Ministry of Health spent only 24–58 percent of its approved development budget in the three financial years from 1999 to 2001, although these figures may not accurately account for donor resources (Government of Kenya 2003). A bigger test will come soon, as the Global Fund and other donors provide large grants for ambitious treatment programs.

Addressing and resolving the most binding capacity constraints in the next few years will be critical for two related reasons. Unless these obstacles are overcome services cannot be scaled up, and prevention and treatment goals will not be met no matter how much funding is available. In addition, however, failure to break down the barriers impeding the productive use of already committed funds will surely make raising additional resources much more difficult. In fact, it is likely that continued support for the Global Fund, as well as for ambitious bilateral programs such as the U.S. AIDS initiative, will depend on obtaining concrete results quite soon with the substantial resources that some countries have recently received.

Before considering possible solutions, it is worth examining more closely the nature of capacity constraints, since the term is often used—and invoked as an argument against greater donor assistance—in a rather vague way that sometimes conflates quite distinct phenomena. At least three broad categories of obstacles to effective and timely use of funds can be distinguished; we focus primarily on two: relatively short-term administrative bottlenecks and longer

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term shortages of human or physical infrastructure. Although these two types of constraints interact in important ways, both the nature and timescale of the solutions they require are quite different. Another category of constraint, which arises from limited utilization of available services, is mentioned briefly below. We note as well that the term *absorptive capacity* is also sometimes applied in relation to possible macroeconomic consequences of large infusions of foreign aid, especially inflation and exchange-rate appreciation (“Dutch disease”). These issues are beyond the scope of our report.

Short-term administrative bottlenecks. Administrative bottlenecks arise from weakness in management systems, especially systems for handling funds, purchasing commodities, contracting for services, reporting to donors or governments, and ensuring transparency. These deficiencies slow the flow of money, either from donor agencies to developing country governments or from primary recipients in capital cities to implementing partners, and slow the rate at which it can be spent on goods or services. Particularly common types of bottlenecks involve moving funds from ministries of health to the districts (especially when responsibility for health service delivery has been decentralized), contracting with local nongovernmental organizations and community-based organizations for delivery of services at the community level, and drug procurement (Ssenooba and others 2004). It is likely that problems of this kind account for most of the initial disbursement delays encountered by the Global Fund and other donors.

These problems in financial management need not involve corruption or deliberate mismanagement, although the perceived danger of diversion may cause donors or central governments to impose more onerous accounting and reporting procedures and thus exacerbate delays. Where corruption is pervasive and political will to tackle it lacking, donors may be obliged to bypass government systems altogether. This should be a last resort, however, since the long-term goal must be to strengthen public administration.

How can these constraints be alleviated? The most important first step, of course, is a good diagnosis identifying the most binding bottlenecks to financial flows and disbursement, which can take the form a “tracking” study following the flow of funds. Once the problems are identified, solutions are likely to take four forms.

- *Simplification and harmonization of donor requirements and procedures.* Where management capacity is limited, bottlenecks can be expected to arise in proportion to the complexity of the required procedures. Donors should strive to simplify their requirements to the greatest extent consistent with effective monitoring and should harmonize their procedures with those of other donors and, where possible, with those of recipient governments. In this way the problems of donor coordination and absorptive capacity are linked.
- *Policy changes at the country level.* More efficient management will often require reforms to improve accountability, simplify procedures, and

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introduce incentives for better performance. Policies restricting flexibility in the deployment of health personnel should also be reviewed (see below). Many of these necessary reforms can be thought of as part of broader civil service reform. Implementing these changes will require political will.

- *Technical assistance focused on management.* Technical assistance, especially when it is relatively long term, can help ministries of health, national AIDS commissions, district health teams, and other entities involved in running AIDS programs at the country level to improve management systems and train staff. Donors should be ready to fund this kind of assistance, as well as assistance with technical aspects of service delivery. Lack of capacity among local nongovernmental and community organizations—to write proposals, to manage and account for funds, to monitor programs—can also slow implementation of AIDS programs, and assistance should be made available to these organizations as well.
- *Investments in management infrastructure.* In many cases, bottlenecks can be reduced by investing in information systems, especially computerization. In some cases it may also make sense to hire additional administrative staff or to redeploy staff to the most overwhelmed parts of the system.

Thus, relieving management bottlenecks will require both policy changes and further investment to build capacity. Although improving public administration is a long-term process, there is reason to believe that targeted measures based on good diagnoses can improve the flow of funds quite rapidly.

Long-term shortages of infrastructure. The second class of capacity constraints involves deeper problems in the systems required for delivering AIDS services. Although prevention programs in other sectors also encounter capacity constraints, the most serious difficulties are likely to arise in delivering relatively complex interventions, especially antiretroviral therapy, in the health system. As discussed in chapter 3, insufficient or decrepit clinics and hospitals, lack of laboratory facilities, unreliable drug supply systems, and, most important, lack of skilled healthcare workers will pose formidable challenges to expanding treatment in some countries. These deficiencies, which will also hinder delivery of voluntary counseling and testing, treatment of sexually transmitted infections, and services to prevent mother-to-child transmission of HIV, can be considered capacity constraints in that they will limit the expansion of services—and the disbursement of committed funds—even when money is available to buy drugs, train existing staff, and cover other program-specific expenses. Over the longer term, however, many of these constraints can be “bought out” through investments in health systems. Physical infrastructure can be built and refurbished, and equipment can be purchased. The shortage of doctors, nurses, pharmacists, and other health personnel can also be relieved, through a combination of the following strategies.

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- *Reassignment of staff roles.* Healthcare workers should be given new roles to make the most of existing staff, for example, by allowing nurses to prescribe antiretroviral drugs in some circumstances and giving community health workers responsibility for supporting adherence. This may require revising regulations. Incentives can also be introduced to encourage staff to move to where they are most needed. This strategy will be particularly important in the short run, when the overall number of healthcare workers cannot easily be increased.
- *Improvements in salaries and working conditions.* In many developing countries higher salaries, along with better working conditions and more supportive management, will be essential for retaining staff and slowing brain drain. In some settings, where there are substantial numbers of already trained healthcare workers who have left the public sector, higher salaries may attract personnel back into the system. There seem to be few studies, however, that explore how much “spare capacity” of this kind really exists in particular countries or how much salaries would have to be increased to have a significant effect on retention or recruitment. It is important that salaries be increased as part of a comprehensive health sector plan, not as a way of luring scarce staff into AIDS programs from other parts of the health system. Donors should be prepared to contribute to salary increases; this is best done through sectorwide approaches. In some countries, expenditure ceilings or public sector hiring freezes may have to be lifted.
- *Expansion of preservice training.* In some cases, it may be necessary to increase the capacity of universities and other institutions to train new doctors, nurses, and other cadres of healthcare workers. This will only make sense where steps have been taken to limit the loss of trained staff to other countries and other professions. Moreover, building new or larger medical and nursing schools in every country may not be the best way to scale up training: regional solutions may be more efficient. These types of investment will take many years to have an impact on service delivery, illustrating the importance of a long-term human resources strategy and longer-term and more predictable donor commitments.

This section has emphasized factors that constrain the delivery of prevention and treatment services. Factors that prevent or discourage people from making use of services (“demand-side constraints”) can also be important in limiting the effective reach and impact of AIDS programs. Stigma, lack of awareness, and misinformation are some of the most important factors that might decrease the use of services even when they are available and affordable. (Obviously, user fees can be another critical barrier to uptake.) Community outreach, education, and involvement, exemplified by the concept of community “treatment preparedness,” along with campaigns to reduce stigma, are thus essential elements

The United Nations should be bolder in holding to account member nations

of AIDS programs (*International HIV Treatment Preparedness Summit, Final Report* 2003).

As this brief overview shows, while capacity constraints can limit the amount of money that can be spent effectively in the short run, overcoming them will require additional investments in management systems and in health systems. Building capacity while scaling up service delivery will also require good diagnosis, long-range planning, and policy reform. Capacity constraints and strategies for overcoming them are also discussed in the UN Millennium Project's synthesis report.

Roles for the United Nations

The UN system has played a critical role in shaping a global AIDS agenda in the first two decades of the pandemic. Through UNAIDS and the programs of its cosponsors, much progress has been made in formulating standards for care, treatment, and prevention. Furthermore, the United Nations has pushed hard—and successfully—to place AIDS at the top of the international agenda and has contributed in important ways to the mobilization of additional international resources for HIV/AIDS. Yet, the United Nations could do more at the international level. Most important, the working group believes that the United Nations should be bolder in holding to account member nations, in the rich and developing worlds alike, which have failed to honor their commitments to fighting AIDS. Particularly in the nations threatened by the next wave of the pandemic, the United Nations can play a critical role in drawing attention to failures in leadership and gaps in financing that continue to stymie a comprehensive response.

The UN's response to the epidemic, however, has been weaker at the country level. The United Nations must begin to focus on providing far more useful and appropriate technical and management assistance. This may represent a departure from its traditional role. But the United Nations, with its established presence on the ground, its neutrality, its broad legitimacy, and its ties to civil society, is uniquely placed to assist national governments to plan and implement comprehensive responses to the epidemic, as well as to raise funds and coordinate donors and other partners. The United Nations should increase its efforts in the following areas:

- Aiding in the development of strategic plans, new initiatives, and funding proposals.
- Advising on the most effective approaches to prevention and treatment.
- Assisting ministries of health and other line ministries to prepare detailed budgets that more accurately reflect country needs.
- Facilitating the mobilization of additional resources from international and national sources.
- Helping national governments to coordinate donors, nongovernmental organizations, and other partners.

The United Nations is well positioned to offer technical support

- Providing technical and management assistance in implementing funded programs.

The United Nations has already accepted many of these roles, but its record in fulfilling them has been mixed. The fundamental problem has been a shortage of personnel on the ground with the necessary skills to support countries in these areas.

One of the most important challenges facing many of the most affected countries is insufficient management capacity, particularly a lack of skilled staff at the central and regional level to design and implement new programs. While nongovernmental organizations and donor partners have filled in here and there, a more comprehensive effort must begin to build capacity to meet this increasing demand. The United Nations is well positioned to offer technical support to ministries of health, planning, and finance in coordinating country plans. In many cases, however, the UN presence is simply too small to help governments take even these initial steps. WHO, UNICEF, UNDP, and the UNAIDS secretariat should rapidly expand the workforce available for technical assistance in the strategic management of AIDS activities. As countries are called on to scale up their initiatives, the United Nations must follow suit and scale up its own presence at the national level, by mobilizing additional resources or reallocating personnel. WHO has taken significant steps in this direction as part of its 3 by 5 strategy and expects to do more now that more resources are available. But the need for technical assistance is not limited to treatment scale-up: WHO or other parts of the UN system must be ready to help governments develop and implement programs in other areas, including prevention and orphan support. WHO in particular must not abandon its commitment to a comprehensive response to the epidemic and must back this commitment with resources and personnel.

Many of these broad findings were also the main conclusions of an extensive external evaluation of UNAIDS conducted in 2002 (UNAIDS 2002b). According to this report, UNAIDS has met many of its objectives at the global level, including collecting and disseminating technical expertise, monitoring the epidemic, and building international consensus for an expanded response. The evaluation found, however, that UNAIDS has been much less successful in strengthening the UN work on HIV/AIDS at the country level. In part, this is the result of remaining problems in UNAIDS' structure: although the UNAIDS cosponsors have a unified budget for international work, each agency retains control of its budget at the country level. Thus, the UNAIDS Secretariat has little leverage to impose greater coordination, although the recent change in the status of the UNAIDS Country Coordinator is a move in the right direction.

The more prominent issues are probably quantity and quality of staff on the ground. Remedying this shortcoming will require more resources and perhaps also changes in the categories of personnel provided at the country

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level. UNAIDS, as part of its response to the external evaluation, is working to enhance country support and address many of these issues. For example, monitoring and evaluation support officers have recently been placed in priority countries.

Recommendations

- Donors and developing country governments must continue to increase their financial commitments to the health sector as well as to AIDS programs in order to bring essential services to those who need them and to relieve the burden on impoverished households. UNAIDS estimates that more than \$11 billion will be required for AIDS in 2005 and more than \$19 billion by 2007. Donor funding must be more predictable and less encumbered by restrictions on its use.
- Donor funding should be guided by a long-term perspective, with a substantial share of resources going to building health system capacity, including human resources and management. These investments will in turn enable recipient countries to spend aid money more effectively.
- Donors and recipients should put greater emphasis on measurable results and on monitoring progress toward well defined targets.
- The working group urges donors and national governments to move toward basket funding and sector-wide approaches in the health sector whenever possible to ensure coordinated support for nationally owned AIDS and health strategies. The Three Ones initiative is an important first step toward improved donor coordination.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria must receive the support it needs to survive, evolve, and grow. The donor nations, led by the United States, must provide at least \$2.3 billion in 2005 to allow the Global Fund to meet its obligations and plan for future rounds of grants. The Global Fund in turn should confront implementation challenges more directly, by requiring applicants to address problems encountered with earlier grants and by more strongly encouraging investments in health systems.