August2006.

REVIEW PAPER – Literature and Actors in the Field of Health Financing and HIV/AIDS

Guthrie, Teresa. 2006
The Centre for Economic Governance and AIDS in Africa

TABLE OF CONTENTS

1 INTRODUCTION 3
1.1 Purpose and Structure of this Paper 3
2 OVERVIEW OF THE ISSUES OF HEALTH FINANCING GENERALLY 4
2.1 Issues in development aid 4
2.2 Health financing in general 5
2.3 Health financing mechanisms 6
2.4 The Government's Role in Financing Health Care 7
2.5 External Aid / Donor Funds for Health 8
2.6 Out-of-Pocket Health Expenditure 9
2.7 Health Care Financing Reform – the increasing need for protection and risk pooling 9
2.8 Fiscal Space for Health Spending 10
2.9 Efficiency and Cost Effectiveness Measurements of Health Interventions 11
2.10 Tracking of Health Financing and Expenditure 11
2.11 Coordination of efforts 12
3 OVERVIEW OF ISSUES AND INITIATIVES REGARDING FINANCING FOR HIV/AIDS 13
3.1 Current sources and mechanisms for HIV/AIDS financing 13
3.2 Current expenditure for HIV/AIDS 14
3.2.1 Tracking donor funds for HIV/AIDS 14
3.2.2 Tracking public funds for HIV/AIDS 16
3.2.3 Tracking household expenditure on HIV/AIDS (OOPE) 17
3.3 Effectiveness of current expenditure on HIV/AIDS 18
3.4 Financial absorptive capacity 18
3.4.1 Social Sector Spending Limits Impede Absorptive Capacity 20
3.5 Resource needs for HIV/AIDS – costings and estimations of HIV/AIDS Targets 20
3.6 Innovative financing mechanisms – funding the gap 21
3.7 Co-ordination of Efforts in HIV/AIDS Financing ~ the Global Task Team Division on Labour 22
3.8 Key initiatives and actors in the field of financing for HIV/AIDS - International, regional and national 24
4 POTENTIAL CONTRIBUTION OF THE CENTRE FOR ECONOMIC GOVERNANCE AND AIDS IN AFRICA .... **Error! Bookmark not defined.**
4.1 The political and technical environment .... **Error! Bookmark not defined.**
4.2 Themes and issues to which CEGAA could make a valuable contribution .... **Error! Bookmark not defined.**
4.2.1 Health Systems Financing for HIV/AIDS .... **Error! Bookmark not defined.**
4.2.2 Innovative Financing Options .... **Error! Bookmark not defined.**
4.2.3 Household Level Analysis .... **Error! Bookmark not defined.**
4.2.4 HIV/AIDS Expenditure .... **Error! Bookmark not defined.**
4.2.5 Costings and Estimation of Resource Needs .... **Error! Bookmark not defined.**
4.2.6 Macroeconomic Analysis and Fiscal Space .... **Error! Bookmark not defined.**
4.2.7 Human Resources for HIV/AIDS and Health .... **Error! Bookmark not defined.**
4.2.8 HIV/AIDS Medicines and Commodities .... **Error! Bookmark not defined.**
5 CONCLUSION 27

1 INTRODUCTION

A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. As such, a health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction. It therefore needs to provide services that are responsive and financially fair, while treating people decently[1].

Health systems financing refers to the generation (or collection), pooling, management and spending of funds (purchasing/providing of services) for health systems. The purpose of health financing is to ensure that adequate funding is available and the right financial incentives are in place to guarantee that all individuals have access to needed preventive and personal health care.

"All countries need to be able to track how much is spent on health, who is spending the funds, on what funds are spent and who benefits. They also need to be able to identify which interventions contribute most to improving health and reducing inequalities in access to the available resources, to estimate how much it will cost to scale up coverage of health services and to monitor the impact of the system on financial catastrophe and impoverishment. A health financing information system is therefore a critical part of the overall health information system" [2].

In the context of HIV/AIDS, given its impact upon all levels of society, which is often catastrophic at household level, and the enormous resources required for a comprehensive response, the above statement applies critically. There have been rapidly increasing allocations of funds to HIV/AIDS at international and national levels, with mobilisation of efforts to respond effectively and efficiently to the demands, particularly in scaling up the delivery of treatment, however an important funding gap remains. Now the challenges of slow funding mechanisms, bottlenecks, strict conditionalities and reporting requirements, poor financial and information systems and management skills, and generally limited absorptive capacity, are becoming more apparent. Hence it is the strengthening of the health systems generally, and the financial aspects particularly, that has become a critical prerequisite for the successful expenditure and impact on HIV/AIDS.

This background paper seeks to provide some overview of the key issues with regard to the *financial* aspects of the response to HIV/AIDS, including the consideration of the urgent need for adequate, sustainable and equitable sources of finances for HIV/AIDS. The paper shall identify key literature, actors and activities in the field of financing for health generally and HIV/AIDS more specifically.

1.1 Purpose and Structure of this Paper

---

[1] WHO, 2006
[2] WHO, 2006

The paper first provides an overview of the key issues in health financing generally, as a means of introduction to the topic, and because these all apply to the issue of HIV/AIDS. However, since there is extensive literature in the field of health financing generally, this paper does not provide a comprehensive review of all the available health financing literature, but the key texts are listed in Appendix 1.

Rather, the paper seeks to focus on those aspects specific to HIV/AIDS, and so it then considers the key topics and themes of the literature in the field of financing for HIV/AIDS specifically. At the same time, the paper identifies the key players involved in each of the themes or topics discussed.

2 OVERVIEW OF THE ISSUES OF HEALTH FINANCING GENERALLY

This section seeks to highlight some of the key issues as relate to health financing generally, since these also apply to the situation of HIV/AIDS financing. This section does not provide a comprehensive review of all related literature, but references for the key texts can be found in Appendix 1.

2.1 Issues in development aid

There has been much focus on development aid in general, that has addressed the issues of sustainability, predictability, harmonization and accountability. In particular, the Overseas Development Institute (ODI) Forum on the Future of Aid is an online community dedicated to research and opinions about how the international aid system currently works and where it should go next. The ODI rep[3]orts that: "The lack of either a clear regulatory environment, or a market mechanism to force a more rational 'division of labour' among the various agencies involved generates a number of inefficiencies. These range from poor coordination to high transactions costs and stark inequalities between 'donor darlings' and 'donor orphans', often unrelated to the recipient country's track record" (de Renzio & Rogerson, 2005).

Since the late 1990s, explains Rocha Menocal & Mulley (2006), "a new paradigm of effective aid has emerged, that, at least in principle, is based on the concepts of country ownership, partnership, and mutual accountability". These principles are embraced in the Paris Declaration on Aid Effectiveness, which includes a series of commitments from both donor and recipient countries to improve the quality of international development assistance. Donors have come to recognise that recipient country ownership is essential to the effectiveness of aid and development efforts. "It has become increasingly evident that ownership of specific policy measures or programmes, and good governance in general, can only be achieved if recipient governments begin to take a more proactive role in determining how aid is allocated and managed" (Rocha Menocal & Mulley, 2006). They argue that country and regional initiatives, such as NEPAD, also provide opportunities for recipients to influence donor behaviour.

[3] http://www.futureofaid.net/

With regard to the improved absorption of development aid in general, Booth (2005) notes that the factors influencing aid effectiveness are not restricted to conventional "aid quality" issues and that they affect both sides of the aid relationship. "It is not the case either that all the faults lie on the donor side or that recipient-side failings are the only significant obstacle. For quantitative improvements in aid flows to become associated with enhanced effectiveness, the two types of limitation on quality would need to be tackled simultaneously and with equal vigour" (Booth, 2005). He suggests the following to improve the absorption of aid:
On the donor side:

- better value for money – a vigorous assault on tied aid and on the promotion of narrow donor interests;
- firmer commitments and more predictable financial flows, so that where countries have clear policies these are able be planned and implemented;
- greater efforts to deliver aid in ways that strengthen country institutions and the incentives for governments to make clear policies;
- better understanding of countries' social, political and administrative systems, so that fewer mistakes are made in channelling support;
- a more careful and coordinated selectivity in allocating aid, so that basic human needs are met whenever feasible but the changes in institutions that are needed for long-term development are effectively supported as well.

On the recipient side, quality means:

- better value for money again – an assault on waste, as well as leakages of all kinds, using methods that work in the context;
- more predictable funding flows to ministries and implementing agencies, implying a stronger commitment to good practices in public financial management;
- greater insistence on aid modalities that strengthen institutions and policies, and the defeat of the vested interests that surround the usual free-for-all in project funding;
- consistent, high-level support for the unpopular but essential reforms in administrative systems;
- a political project focused on state-building, in which the satisfaction of citizens' basic needs has a central place within a long-term vision of national development. (Booth, 2005).

All these points obviously apply in the improvement of efficiency of aid for HIV/AIDS, and it will be important to measure the success of HIV funds against the indicators for each of these aspects, as suggested by the Paris Conference on Innovative Financing for Development (2006).

2.2 Health financing in general

Health care financing refers to the "approaches to mobilise funds for health care" (Hsiao, 1998:4). It is considered a means to an end, or a tool to achieve certain societal goals.

There are three vital and interrelated functions of health system financing: revenue collection, pooling of resources, and purchasing or provision of interventions.

i. Revenue collection is the process through which a health system receives money from households and organizations or companies, as well as from donors.
ii. Pooling is the accumulation of funds through prepayment, and management of revenues in such a way as to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Pooling is traditionally known as the insurance function within a health system, and occurs when people subscribe to a scheme (compulsory or voluntary) or pay into the system through taxes.
iii. Purchasing is the process by which funds are used to provide services (preventive or curative) or pay providers to do so. Strategic purchasing involves a continuous search for the best ways to maximize health system performance, efficiency and equity by deciding which services and interventions should be purchased and how to buy them and from whom.[4]

Overall there is extensive literature regarding financing of the healthcare sector in general, including the analysis of financing mechanisms, costings and cost-effective analyses of health services, public-private partnerships (PPPs) and the financial aspects of human resources and procurement mechanisms. In addition, data availability on health budgets and expenditure has been greatly enhanced by the contribution of the National Health Accounts undertaken by the WHO, and by several civil society organisations which seek to monitor their governments' expenditure on health.

The health-financing literature issues have been broadly categorised under the following headings and the key points mentioned. This serves merely as an introduction, and does not provide an extensive review of all the literature nor an evaluation of particular financing mechanisms (refer to Appendix 1 for a list of key identified texts).

2.3 Health financing mechanisms

There are several methods for financing health care and each has its strengths and weaknesses. The financing methods chosen by a country will have consequences on the amount of funds raised, on the equity between different income groups and beneficiary groups, and can cause losses in production resulting from the economic distortions created by the financing approach (Schieber & Maeda, 1997). The health care financing policy will also have a significant impact on the structure and organisation of health care delivery.

The major sources of financing for health care include: government revenue (public, usually collected through taxation, and also includes those donor funds channelled through the national treasury i.e basket funding/ budget support); external/ donor funding (development aid and grants); social health insurances, community financing schemes, medical saving accounts, user fees, and private sources, which include private voluntary health insurances, business contributions, and out-of-pocket expenditure (OOPE) (that which households and individuals pay themselves for health services and medication).

[4] WHO, http://www.who.int/healthsystems/topics/financing/en/index.html

The country's choice of financing mechanisms will depend on a number of factors including the history of the country, the culture, the current institutions and the trade-offs in priorities that the state/ nation is willing to make. Importantly, no one mechanism provides the magic solution to the problems of health care in developing countries, and thus "explicitly or implicitly, trade-offs need to be made in choosing one method over the other or using different methods to different degrees" (Hsiao, 1998:17). Because of limited public resources for social spending in many developing countries, difficult decisions need to be made: which services should be included in a publicly financed package (and how comprehensive should they be); who should be eligible (limited universality); and what these services should cost (Hay, 2003:1). In the context of HIV/AIDS, these questions are pertinent.

"The health financing system needs to be developed within the particular macroeconomic, socio-cultural and political contact of each country. It should create balances incentives with regard to equity, efficiency, sustainability and quality of care"
Kampala Declaration on Fair and Sustainable Health Financing, 2005.

A useful framework for the analysis of any financing mechanism could include the following criteria against which the mechanism should be evaluated: the level of funding; efficiency; equity; viability; and its health impact. Each of the existing health-financing mechanisms should be evaluated along these criteria, while also bearing in mind the particular demands of the HIV/AIDS epidemic.

Regarding equitable financing mechanisms, "an equitable health system treats alike all those who face the same health need, and treats preferentially those with the greatest needs. Further, an equitable health financing system ensures that the healthy subsidize the sick and that the burden of financing is fairly shared by having the better-off subsidize the less well-off. These objectives generally require spending public funds in favour of the poor" (WHO website, 2006). However, little analysis has operationalised the concept of equitable health financing. WHO developed a "Fairness of Financing Index", which has not had widespread usage, as yet[5].

Let us consider briefly the key sources of financing for health: public, external and private ~ individual and household contributions are considered here, while businesses and private insurances are not examined.

2.4 The Government's Role in Financing Health Care

It is recognised that governments play an important role in the funding and provision of health services (Jones & Duncan, 1995:14). With regard to HIV/AIDS related services, this is also the case, and the sustainability of these services is linked with ability of countries to increase their own allocations to the response. Governments' role in financing public health care services will be influenced by the size of the economy and availability of resources, the growth prospects, the fiscal policy, and the government's health priorities (Hay, 2003:8). "Governments have been active players in the health sectors not only of sub-Saharan Africa but throughout the world, there are good reasons for this: economic, political and pragmatic

[5] Wagstaff, 2002

reasons" state Bennett & Ngalande-Banda (1994:4). Governments raise their own revenue, primarily through general taxes of individuals, businesses, goods, properties, and also through earmarked taxes and indirect taxes, charges and fees. Governments also raise loans (borrow) commercially or on concessionary terms (Hay, 2003:3), and may use inflation as an alternative source of revenue, by printing more money in order to finance the deficit (Hsiao, 1998:21).

Health care financing through local revenue has the advantages of being predictable, sustainable (assuming the tax revenue remains stable), and equitable (assuming a progressive taxation system). Alternatively, Hsiao (1998:18) argued that tax revenue may not be a stable source of finance for health care, due to factors such as low political prioritisation of health, the instability of the economies of developing countries, and the use of public expenditure as a tool of macro-economic policy. In situations of recession or a reducing tax base, the source of funds through general taxes would be limited. "This is exacerbated by the observation that health needs tend to grow during a recession when tax revenue decreases" (Jones & Duncan, 1995:19).

On the other hand, funds for health obtained from the state's own revenue, through taxes as opposed to those from donor funds, are more sustainable and allow for better forecasting, planning and management. Where the economy remains relatively stable and the tax base remains constant, then tax revenue may be considered more reliable and stable over time (Guthrie & Hickey, 2004). Earmarked taxes for a specific health issue may be considered even more reliable and are less likely to be influenced by political decisions, thus ensuring dedicated amounts of funding to a priority health issue.

The proportional share of the government's total expenditure that goes to health care may be used as a indicator of the *relative* adequacy of (or priority give to) health financing (as compared with other sectors/ priorities). Hay (2003:3) goes further and suggests an analysis of the government's expenditure as a share of the GDP (or GNP) should refer to the government's discretionary budget, because governments are often heavily tied in debt-servicing and have other statutory payments. Thus the "health share of the discretionary budget may be a better indicator of a government's commitment to publicly financed health services than its share of total government expenditure" (Hay, 2003:3). The Kampala Declaration on Fair and Sustainable Health Financing suggested that "donor financing needs gradually to be replaced with nationally mobilized resources in line with the Abuja Declaration to ensure sustainability and country ownership of the health development process".

A useful target for measuring adequacy could be that of the Abuja Declaration (April 2001) in which the member states of the Organisation of African Unity committed themselves to allocate 15% of their national budgets to health spending, with increased emphasis on HIV/AIDS programmes. It was not clearly indicated if the government's *discretionary* expenditure should be used, that is, without debt-servicing and statutory payments.

2.5 External Aid / Donor Funds for Health

External aid to health may be bilateral or multilateral aid, and may come in the form of general budget support, project-support or sector-wide approach (SWAp), or often flows directly between donors and the non-governmental service providers. The mix of different funding channels and mechanisms for external aid has been described as an 'unruly melange' (Buse & Walt, 1997).

It is generally accepted that in many less developed countries, the scenario of health expenditure being funding totally from local revenue is one that is a far way off, and rather there needs to be emphasis on better balance between donor and local funds. Thus, despite the pressure on governments to increase their allocations to health, it is recognised that external aid continues to be an important contribution to the total expenditure on health, and even more so with regard to HIV/AIDS. Further issues relating to donor funds are raised under the following section on HIV/AIDS financing.

2.6 Out-of-Pocket Health Expenditure

In many poor countries with weak health systems, the funds spent by persons themselves in protecting and maintaining their health, known as out-of-pocket expenditure (OOPE), often forms a substantial proportion of the total health expenditure.

It has generally been accepted that the occurrence of illness and the resulting costs, direct and indirect, have had catastrophic impact for those households with lower income levels, often pushing them further into impoverishment (Xu et al, 2003. McIntyre et al, 2006. Russell, 2005). This cycle is often referred to as the medical poverty trap (Whitehead et al. 2001). In light of this, more emphasis has been placed on the role of health insurance schemes which could protect against these impacts. As explained by Xu et al (2003:111): "People, particularly in poor households, can be protected from catastrophic health expenditures by reducing a health system's reliance on out-of-pocket payments and providing more financial risk protection". It is therefore important to examine household health expenditure, impacts and coping strategies, to inform policies that would better protect poor households.

The National Health Accounts measure the OOPE as a proportion of the total health expenditure. In addition, national demographic and health surveys and/or income and expenditure surveys capture what households are spending on their health, but with limited disaggregation. OOPE as it relates to HIV/AIDS is discussed in more detail below.

2.7 Health Care Financing Reform – the increasing need for protection and risk pooling

The sustainability of health care financing has gained importance in the face of uncertainty and cyclical fluctuations, with the decline in economies of developing nations, the impact of structural adjustment programmes, and declining donor assistance. This has lead to greater emphasis on financing systems which do not rely on external aid, and thus the interest in alternatives such as social and voluntary insurances, community cost-sharing schemes, pre-payment schemes, Bamako Initiative and user-fees (refer to Beattie *et al*, 1996, for country

case studies of these mechanisms). However, these 'cost-sharing mechanisms' have been criticised as placing the burden on the patients, and thus restricting the access of the poor to health care.

In addition, attention must be paid not only to innovative financing mechanisms, but also to enhance the efficiency of existing ones. For example, the state's health response would be greatly enhanced by improved management and co-ordination of donor funds[6]. Consideration of mandatory social health insurances might improve the quality of the public health services. In addition, greater efforts are required to reduce out-of-pocket expenditure, as this is usually borne disproportionately by the poor, since the wealthy have comprehensive private insurance schemes to cover all their health costs. "It therefore appears to be necessary to find an appropriate mix of public and private sector interventions with elements of cost-sharing for services and drugs, insurance schemes and more efficient use of available resources" (Korte, Richter, Merkle, Görgen. 2002).

The Fifty-eighth World Health Assembly (WHA) acknowledged that many Member States were pursuing health-financing reforms that might involve a mix of public and private approaches, including the introduction of social health insurance. The WHA urged Member States to:

(1) "to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment as a result of seeking care"…..

(3) "to ensure that external funds for specific health programmes or activities are managed and organised in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole"…..

(6) "to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organisation, under strong overall government stewardship". (WHA58.33. 2006:139).

2.8 Fiscal Space for Health Spending

Attention has recently been paid to the issue of fiscal space, that is "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position." (Heller in WHO, 2006f). It refers to those deliberate policy constraints on social sector spending, which are argued to be necessary to preserve macroeconomic stability, and in particular include limiting recruitment and salary costs. These measures are said to have caused a human resource crisis in the health sector, and this has specifically affected the scaled-up response to HIV/AIDS.

In order for donor policies to allow for sustainable fiscal space, WHO (2006f) suggests that donors should ensure: long term commitments to scale up aid; predictable and stable flows of financing; and coordinated and harmonized aid across donors to reduce recipient's transaction costs. With regard to the recipient countries, those policies and actions that

[6] The UNAIDS three-one principles are a good example promoting better co-ordination of external aid to HIV/AIDS activities by the national department.

would create conditions for sustained fiscal space are identified by WHO (2006f) are: affordable long-term investment and expenditure plans; increases in aid accompanied by stronger tax efforts; ability to finance any residual cash-flow variations; ability to manage donor aid; reallocation on budgets towards health sector; and, health systems that are efficient, effective and equitable. Some health economists argue that it is the degree to which these conditions are present that will determine whether fiscal space for health spending can be sustained (WHO, 2006f).

The WHO's 2006 World Health Report argues that negotiating fiscal space for the health workforce will require the international health development world to engage productively with ministries of finance, international finance institutions and major international stakeholders. Strengthened evidence on the health and economic returns on investment in the health workforce will assist in these negotiations (WHO, 2006f).

2.9 Efficiency and Cost Effectiveness Measurements of Health Interventions

There have been many studies which have attempted to measure the efficiency and cost-effectiveness of various health interventions. Most of these, by the nature of the methodology involved, are limited to specific intervention/programme situations, and are usually compared to similar programmes to ascertain the relative effectiveness. The development of a generalized cost-effectiveness analysis (GCEA) methodology by the WHO Health System Financing Department has contributed to maximizing the possibility of generalizing results from one setting to another (Tan-Torres Edejer *et al*, 2003. Hutubessy *et al*, 2003). Additionally, the WHO-CHOICE[7] has assembled regional databases on the costs, impact on population health and cost-effectiveness of key health interventions, as well as having developed standard tools and methods for undertaking cost-effectiveness analyses.

2.10 Tracking of Health Financing and Expenditure

The major contribution to the available data on health expenditure in many countries have been the National Health Accounts (NHAs), which use a methodology developed and promoted by the WHO Health Systems Financing Department. Partners for Health Reform*plus* have conducted NHAs and have produced many relevant policy-briefs to assist governments in planning their health systems (PHR+, 2004a).

"National health accounts (NHA) trace all the resources that flow through the health system over time and across countries. They are designed to capture the full range of information contained in these resource flows and to reflect the main functions of health care financing: resource mobilization and allocation, pooling and insurance, purchasing of care, and the distribution of benefits".[8]

[7] **CHO**osing **I**nterventions the are **C**ost-**E**ffective.
[8] WHO website, accessed July 2006.

The National Health Accounts (NHA) methodology provides a tool to allow countries to consistently, systematically and comprehensively monitor all the resource flows for health care activities in the country. This information greatly enhances the policy making process, as well as the decisions regarding allocation of resources. "NHA are used by policy-makers for monitoring health expenditure patterns; policy instruments to re-orientate the pattern can then be further introduced".[9]

NHAs are certainly a valuable source of information for national governments in their monitoring of health expenditure, and can assist with informed policy-making, planning and resource allocation decisions. They are also particularly useful for cross-country comparisons. Definitions and standardised categorisation of expenditures are critical to ensure that similar entities are being measured across countries, and measured in the same manner. The accuracy of the NHA data will be limited by the availability and accuracy of the data within the country. Where data is lacking, the NHA researchers will make use of estimation techniques, indicating their inherent assumptions and limitations. As Tangcharoensathien et al (1999:352) concluded in their evaluation of the Thailand NHA: "International comparisons through collaborative efforts in standardising definition and methodology will be a useful by-product when developing countries are able to sustain their NHA reports".

In terms of monitoring governmental health budgets, several efforts have been initiated by civil society groups, such as the International Budget Project (IBP), the Budget Information Service within Idasa, ActionAid International, and others (see Appendix XX for further similar activities).

2.11 Coordination of efforts

There have been calls for development partners (sources of external aid) to co-ordinate their funding efforts within countries. The key reasons for the need to coordinate donor funds in the health sector are summarized by Buse & Walt (1997):

Factors internal to the health sector:

- Increasing number and diversity of external agencies,
- Increasing volume and importance of health aid,
- Project proliferation and recipient institutional weakening,
- Shift from project to sector aid,
- Policy conditionality associated with sector reform and the need for leverage,
- Focus on efficiency, and
- Effectiveness and equity goals.

Factors exogenous to the health sector:

- Heightened scrutiny of developmental assistance,
- Increasing incidence of instability and massive relief and rehabilitation efforts, and
- Debate over UN agency mandates.

---

[9] Tangcharoensathien et al, 1999:342

Buse & Walt (1997:454) provide an overview of the key efforts to improve coordination of funds for the health sector, describing both recipient-managed and donor-driven coordination initiatives[10], and highlighting the strengths and weaknesses of each. Co-ordination of donor efforts should be the over-riding focus, coupled with the development of the public sector's capacity to co-ordinate and monitor allocations and expenditure. Improved financial management skills and systems, monitoring and evaluation systems, institutional and policy analysis skills, as well as synchronized (and more flexible) reporting procedures would greatly enhance government's ability to monitor and co-ordinate social sector spending (Guthrie, 2006).

3 OVERVIEW OF ISSUES AND INITIATIVES REGARDING FINANCING FOR HIV/AIDS

A number of critical articles relating to financing for HIV/AIDS were identified and are listed in Appendix 1. They are not reviewed in detail here, but an overview of the key content topics and issues were identified for this document. The key actors involved in these aspects are also identified here, and are listed more comprehensively in Appendix XX.

3.1 Current sources and mechanisms for HIV/AIDS financing

The current sources for HIV/AIDS are the same as for health generally, namely: *public funds* from local revenue usually raised through taxes and those funds through budget-support mechanisms from external sources[11]; the other forms of *external aid* – bilateral, multi-lateral, project-support, SWAp etc, and finally *private sources* – OOPE, businesses and private insurance schemes[12].

Significant levels of funding for HIV/AIDS programmes are available from a number of international sources including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the U.S. government's President's Emergency Plan for AIDS Relief (PEPFAR), , and the World Bank's Multi-Country HIV/AIDS Program (MAP).

The mix between these 3 sources (public, external and private) varies in each country, with many developing countries being heavily dependent upon external aid to fund their HIV/AIDS response, and with households often contributing a significant proportion.

The discussion above regarding health financing mechanisms applies here with regard to HIV/AIDS specifically, and thus any evaluation of HIV/AIDS-specific mechanisms would assess the mechanism along a number of criteria, namely: the adequacy of funds, efficiency,

---

[10] Such as geographical zoning, sub-sector specialization, donor consortia, project co-financing, sector aid, harmonization of procedures, donor agency reform, and inter-agency intelligence gathering.

[11] There has been some debate around whether budget-support funds should be classified as donor aid or as local revenue. Governments argue that these funds become their discretionary spending, and therefore anything they allocate to HIV/AIDS should be labelled as public funds. Of course the donors disagree.

[12] There has been some debate about whether insurance (either public or private) should be considered sources of funds. Strictly speaking it is the individuals, households, employers and governments which contribute the funds to the insurance scheme, which acts as an agent of funds.

equity, viability (sustainability), and its ultimate impact on the field in question (for example, health outcomes). Generally, there are strengths and limitations of all donor and domestic financing mechanisms. The key point is that there is a need and place for all types, and not to over-emphasize one at the expense of other mechanisms. A balance between donor-driven and recipient-managed systems is required, where both are equal partners in the collaborative effort for the most effective, efficient and equitable distribution and utilization of resources.

3.2 Current expenditure for HIV/AIDS

3.2.1 Tracking donor funds for HIV/AIDS

Regarding external sources of funds for HIV/AIDS, important research is being done at the global level by those concerned with measuring and mapping the **donor flows** for HIV/AIDS. The key sources of information for this information are multilateral organizations (including UNAIDS, UNFPA, OECD) which are attempting to compile global data on bilateral and multilateral HIV/AIDS donor flows, as well as research institutes and foundations collecting information on aid from private foundations (Hickey & Guthrie, 2005).

The 'Financial Resource Flows for Population and AIDS Activities' project (www.resourceflows.org) is conducted by UNAIDS, United Nations Population Fund (UNFPA), and the Netherlands Interdisciplinary Demographic Institute (NIDI). Their research tracks donor flows for population activities overall, which include HIV/AIDS as well as family planning services, basic reproductive health services and basic research. The Financial Resource Flows for Population Activities Report (FRFPAR) is the most comprehensive publication of the RF project and is published annually by UNFPA. The FRFPAR summarises all data on donor expenditure and domestic government expenditure made by national governments and NGOs in developing countries and countries in transition.

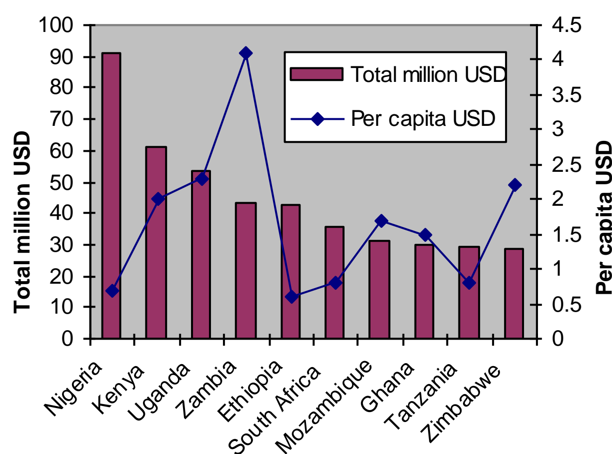
Although the Resource Flows project is geared towards assessing donor and domestic government spending on population activities overall, there is a fair degree of disaggregation of spending on HIV/AIDS. Data is available on AIDS expenditures and actual disbursements from international foundations, multilateral agencies and bilateral donors. Their on-line database also provides a breakdown of expenditure and actual disbursements from multilateral agencies and bilateral donors, by region and by country. They compile information on HIV/AIDS assistance from international foundations over time, and contributions from the prominent foundations, including Gates, Packard, Rockefeller, MacArthur, and Wellcome Trust.[13] However their data, which largely relies upon self-administered mail surveys, does not capture expenditure on AIDS research and excludes bilateral aid from donor countries outside of the Development Assistance Committee (DAC) (Hickey & Guthrie, 2005).

[13] Information quoted from UNFPA/UNAIDS/NIDI Project. "Financial Resource Flows for Population and AIDS Activities: AIDS Assistance Provided by International Foundations." Presentation at Cuernavaca, Mexico, 17/18 February 2005.

The OECD (Organisation for Economic Co-operation and Development) has conducted a special study of 2000-2002 Donor Assistance to HIV/AIDS control, using data from the OECD – DAC (Development Assistance Committee) CRS (Creditor Reporting System) Aid Activity database (www.oecd.org/dac/stats/crs/hivaids). The primary limitations of the special study are that it only looks at aid from the 22 DAC member countries, the EC and other international orgs (with data collected from aid agencies and government departments), and is restricted to HIV/AIDS activities within the health and reproductive health fields.

The Global Fund website is an excellent tool for HIV/AIDS resource tracking because it makes available monthly reports on approved proposals, grant agreements and disbursements, by region and by round. There is a wealth of easily accessible financial data, including summaries and detailed reports of disbursements by disease, expenditure target (e.g. drugs and commodities, human resources), region and income level of country (Hickey & Guthrie, 2005). The GFATM website also enables users to create detailed reports (in Microsoft Excel) by country, by region, by round, by disease, by status (e.g. approved, disbursed), and by principal recipient type (e.g. government, civil society). This allows monthly tracking of the status of every grant in any country.

OECD Special Study on Aid for HIV/AIDS Control
(average commitments 2002-2003)
Top ten recipient countries



Source: OECD-DAC UNAIDS. Aid Activities in Support of HIV/AIDS Control 2000-2002. Volume 2004/6. June 2004.

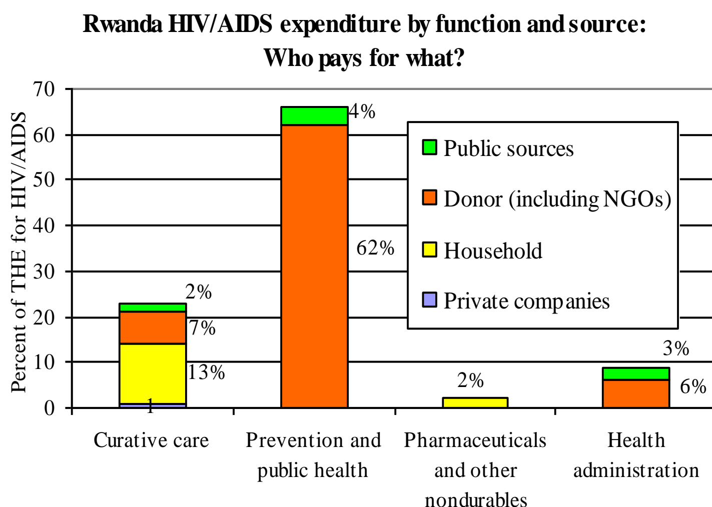
In addition to the above mentioned efforts at tracking donor funds, some key organisations in the United States are producing regular research and analysis on U.S. philanthropic contributions to HIV/AIDS, by private foundations and the U.S. government. They are Funders Concerned About AIDS in New York (www.fcaaids.org) and the Henry J. Kaiser Family Foundation (www.kff.org). The US-based organization DATA Debt, Trade, AIDS, Africa is an additional source of updated analysis and factsheets which track PEPFAR and U.S. government contributions to the Global Fund (www.data.org).

Focusing mostly on U.S. government spending, the Henry J. Kaiser Family Foundation in Washington DC produces excellent policy briefs and factsheets on American funding for HIV/AIDS domestically and in developing countries. They serve as a leading source of research and analysis on U.S. flows for HIV/AIDS globally, including PEPFAR (Henry J. Kaiser Family Foundation, 2006).

3.2.2 Tracking public funds for HIV/AIDS

The primary collection of data regarding country-level expenditure on HIV/AIDS is undertaken in-country with the support of the UNAIDS Resource Tracking and Projection (RTP) Unit (discussed in more detail below). UNAIDS has developed, promoted and supported the National AIDS Spending Assessment (NASA) methodology, which has contributed to the comprehensive, standardised collection of data regarding all spending on HIV/AIDS, both health and non-health expenditure, that is categorised according to the key components of national strategic plans and is thus very useful for national strategic planning. The RTP Unit was able to make a valuable contribution to the recent 2006 Global AIDS Report (UNAIDS 2006), where it reconstructed financial trends from 2001-2005 for 97 countries. In addition, the RTP also convenes a Consortium of Global Resource Tracking efforts, which brings together a number of organisations and persons, and which seeks to harmonise and standardise methods of resource tracking.

The HIV/AIDS sub-analysis within National Health Accounts has also contributed data to current expenditures, but has focused primarily on the health sector spending for HIV/AIDS, which is categorised according to the International Classification of Functioning, Disability and Health. The HIV/AIDS Subanalysis of NHA was conducted by Abt Associates, Inc. PHR+ in 3 African countries: Rwanda (1998, 2000, 2002), Zambia (2002) and Kenya (2002). The graph below shows some Rwandan NHA results.



Source: Republic of Rwanda, Ministry of Health. *Rwanda National Health Accounts 2002*. February 2005:52.

In addition, there has been some monitoring of governmental expenditure on HIV/AIDS from civil society monitoring and advocacy groups. The multi-country report (Guthrie & Hickey, 2004), co-ordinated by the AIDS Budget Unit of Idasa, presents data on budget allocations for HIV/AIDS, while the review by Hickey & Guthrie (2005) provides a valuable overview of African countries' efforts at achieving the Abuja Declaration targets. Action Aid International has been active in collecting data and presenting it in suitable formats for both

policy-makers and civil society, often contributing to important national, regional and international advocacy campaigns.

3.2.3 Tracking household expenditure on HIV/AIDS (OOPE)

HIV/AIDS has exacerbated the medical poverty trap discussed above as a result of catastrophic health expenditure, usually over extended periods as the illness progress, resulting in the death of the household breadwinners. Some of the NASAs conducted have confirmed that OOPE is forming a large proportion of the total expenditure on HIV/AIDS. For example, in Burkina Faso in 2003, households contributed 14% of the total expenditure on AIDS - primarily used for traditional healers (70%) and purchasing pharmaceuticals (29%) (according to the National AIDS Account, 2003). In Zambia, households contributed 29% of expenditures through OOPE (according to the NHA HIV/AIDS sub-analysis, 2002). In Rwanda in 2002, households contributed 16% of HIV/AIDS expenditures through out-of-pocket spending (NHA HIV/AIDS sub-analysis, 2002).

Improved understanding of the financial barriers to access, and the influence of user-fees on health-seeking behaviour, can only be obtained through household level analysis which would consider the OOPE on HIV/AIDS, its impact on the household including influencing their health-seeking options and behaviours, the household's coping strategies, and the challenges they face in accessing treatment.

However, the measurement of OOPE for HIV/AIDS-related services has proven particularly methodologically challenging, and limited information is available on the most appropriate measurement techniques (Guthrie, 2006a). Given the roll out of ARVs, which may not be provided free at-the-point of delivery and which may have other indirect costs, the measurement of OOPE on HIV/AIDS at the household level requires the development of appropriate methods. The information generated on the financial impact on households and their coping mechanisms, would be critical for the design and implementation of appropriate interventions and support for vulnerable households.

Regarding OOPE on user fees, WHO (2006) found that user fees are applied to antiretroviral therapy and care in many settings, even if treatment is subsidized. However, it has been shown that (i) user fees decrease adherence, thus undermining antiretroviral therapy sustainability; (ii) both collection of user fees based on the ability to pay and exemption mechanisms for the poor have proven inefficient, thus undermining uptake and equity of access; and (iii) user fees impoverish households. Therefore, countries implementing a public health approach to scale-up treatment are being advised to adopt a policy of free access at the point of service delivery to basic HIV services, including consultation fees, HIV testing and antiretroviral therapy. Faced with national budget constraints and lack of guaranteed long-term international funding, some highly-affected countries find it difficult to abolish user fees and have raised concerns related to the sustainability of free access policies. Assisting countries to resolve this dilemma by the development of alternative funding mechanisms is an urgent priority for international donors and technical agencies, in order to reduce the catastrophic impact of user fees and OOPE on households affected by HIV/AIDS.

3.3 *Effectiveness of current expenditure on HIV/AIDS*

Importantly there are increasing efforts to cost HIV/AIDS programmes, but as yet very limited cost-efficiency analyses of existing interventions (Cleary et al, 2OO4). Creese *et al* (2002) undertook a systematic review of the cost-effectiveness of HIV/AIDS interventions in Africa and found the evidence to be fragmentary and varying greatly between interventions. While there is growing attention to differing models of care for HIV–positive persons, there are as yet, few economic evaluations of their comparative efficiency.

A particularly useful cost-effectiveness analysis of different HIV/AIDS prevention activities was that undertaken by Hogan *et al* (2005), which compared the costs per disability adjusted life year (DALY) for mass media, education and treatment of STIs for female sex workers and for the general population, VCT, PMTCP, school-based education activities and various ART treatment strategies. Similarly, the WHO-CHOICE database provides a database of the Cost effectiveness results for health interventions, and particularly for HIV/AIDS interventions in the Africa region[14]. This data provides useful information for governments with limited resources, in trying to make difficult choices between interventions, and further such cost-effectiveness analyses would provide powerful evidence for effective policy-choices.

Of the other cost-effectiveness studies identified by Franklin (2001), most were from the service providers' perspective and thus limited to financial costs of the service provider, while economic cost-effectiveness analyses (including indirect costs to all role-players) were less available. In addition, most were single- as opposed to longitudinal studies, and thus failed to capture the frequency and aggregate cost of hospital visits over a period of time, since they focus only on the costs per single hospital visit, using post-hoc clinical notes and laboratory results (Guthrie, 2006). It is also important to measure the costs of non-HIV/AIDS specific care, such as TB, STDs and other opportunistic infections, because HIV has increased the prevalence of these diseases. The Cleary *et al* (2004) cost-effectiveness analysis of providing ART was an important study because it also costed the no-ART option, which included the treatment of OIs for those persons not receiving ART, and provided useful evidence to support the roll-out of ARVs.

Information on both allocative and technical efficiency of HIV/AIDS programmes is greatly needed, as well as country-specific costings. The development of databases of unit costs of HIV/AIDS programmes that are country and regional specific would contribute greatly to more accurate estimates of resource needs at country, regional and global levels (Izazola, 2006[15]).

3.4 *Financial absorptive capacity*

The complexity of the HIV/AIDS financing environment and the increased quantity of flows has sparked greater interest in the issue of absorption capacity. Absorption capacity

---

[14] http://www.who.int/choice/results/hiv_afre/en/index.html
[15] Izazola, J. A. 2006. Personal communiqué.

may be broadly defined as the ability of implementing agencies which receive funds to utilise those funds in the planned time period and for the purposes intended (Hickey, 2006).

Research into rates of spending, or **actual expenditure** vs. amounts allocated or disbursed, is often hampered by lack of timely and accurate actual expenditure data. However, where this research and analysis is possible, it provides important insight into causes of bottlenecks in spending, and limited absorptive capacity. Related to these issues of implementation are those of conditionalities and modalities of aid, specifically for HIV/AIDS. "While analysis of budget allocations sheds light on prioritisation of government's response, monitoring of actual expenditure against budgeted allocations provides a measure of the efficiency of funding channels used to deliver financial resources to the implementing government body." (Roberts, et al., forthcoming). Thus the collection of good actual expenditure data at country-level (through NASAs) is important to provide data to be used as an indicator of absorption capacity.

Funding channels and conditionalities can impact on absorption capacity, at both the levels of donor flows to developing countries as well at intergovernmental level transfers within a country (Hickey, 2006). In the first case, a wide body of literature has grown around the effectiveness of aid in general, and the usefulness of earmarking funds for a particular sector. The fungibility of aid refers to the reality that, despite earmarking of donor funds for particular purposes, receiving governments may simply re-direct national funds intended for the targeted sector towards a more neglected priority. The net result is that the sector or programme targeted by donor funds does not receive net additional resources.

The fungibility of aid applies in the context of HIV/AIDS particularly. Donors concentrate their resources on HIV/AIDS, thus permitting developing countries to reduce their own country commitment. Precisely to avoid this dynamic, the Global Fund pursues a principle of additionality, which requires that Global Fund monies do not replace the financial commitment of receiving governments to HIV/AIDS programmes. However a strong system of tracking HIV/AIDS allocations and expenditure from all sources is necessary in order to monitor displacement of funds. To this end, studies to assess the system-wide effects of Global Fund grants have been undertaken by the London School of Hygiene and Tropical Medicine, while the data generated by the NASAs will provide evidence which can test for additionality or at least provide a preliminary assessment.

At the country level, the efficiency of spending is also affected by types of funding channels and the conditions attached to transfers used to finance HIV/AIDS programmes.

Critically, the lack of human resources can further disrupt the efficient flow of funds for HIV/AIDS programmes, because of its impact on the efficient deliver of services. "Today the lack of human capacity has become one of the most significant obstacles to rapidly scaling up programmes. Resource analysis must now focus on identifying which factors (human skills, training needs, staffing numbers, financing, equipment, space in offices, clinics, and laboratories) actually limit programme expansion." (UNAIDS, 2005a:40).

Additional bottlenecks may include: limited liquidity of funding, unpredictable donor flows, and bureaucratic tendering, procurement and disbursement procedures (ActionAid International, 2005:5). Delays in funding flows from national to sub-national and district

level can stall implementation, as in the case of India where the delayed or reduced release of funds can lead to 'lumpy' spending[16]. Both highly centralised or highly decentralised budget systems can cause bottlenecks is they are not operating efficiently. The HIV/AIDS budget analysis conducted in Kenya, South Africa, Mozambique and Namibia (Guthrie & Hickey, 2004) provides analysis of the flow of funds from national to local level and the regulations and conditions for the transfer of funds. In Kenya for example, for the period April 2002 to May 2003, 60% of the total amount approved for community-based organisations (CBOs) by the National Aids Coordinating Council was disbursed. Of this amount, only 42% was actually spent (Kioko, in Guthrie & Hickey, 2004). This type of examination of actual expenditure, budget processes, budget control procedures, and transfer mechanisms is necessary to identify bottlenecks and implement appropriate reforms.

Great attention is required to the issues of limited absorptive capacity and bottlenecks in the funding flows, since these undermine the impact of expenditure on HIV/AIDS. Another factor limiting the impact of spending are the imposed limits on social sector spending.

3.4.1 Social Sector Spending Limits Impede Absorptive Capacity

Development experts including Jeffrey Sachs and Mark Malloch-Brown have argued that the IMF's insistence upon low-inflation policies in developing countries is at odds with the need to substantially boost expenditure in order to fight HIV/AIDS and achieve the Millennium Development goals. The imposed wage bill caps and social sector spending limits have severely curtailed the absorptive capacity of many governments.

"How can poor countries invest in the doctors, nurses, and teachers needed to meet the Millennium Development Goals (MDGs) when current International Monetary Fund (IMF) loan conditions limit the spending of recipient country governments?" asks Rowden (2005). There is a fundamental contradiction between the need to greatly scale-up social spending to fight HIV/AIDS and what can actually be spent under the IMF's current low-inflation monetary policy.

3.5 Resource needs for HIV/AIDS – costings and estimations of HIV/AIDS Targets

UNAIDS produces estimates of the total amount of financial resources needed globally to provide an adequate response to the HIV/AIDS epidemic. The 'resource gap', or net need, is understood as the total need subtracted from the resources already available via: bilateral and multilateral aid, domestic government spending, private household/out-of-pocket spending, NGOs and foundations. The UNAIDS estimates are based on models which use: figures from research on the costs of delivering HIV/AIDS interventions; estimates of demand for services; research on current coverage of services; and funds already secured. The aim is to determine total resources needed to achieve the Millennium Development Goals, the UNGASS targets, and the WHO Universal Access Targets.

[16] ActionAid International – India feasibility assessment, reported in Hickey & Guthrie, 2005.

The 2001 UNAIDS resource needs estimates were revised in 2005 and are being improved upon continuously as they are only as good as the hard data available and the accuracy of the assumptions on which they are based. According to the June 2005 figures, the estimated funding gap between resources needed and those available is estimated to be at least US$18 billion over the period 2005 to 2007.

UNAIDS Resource Needs Estimates, 29 June 2005

	2006	2007	2008	Total for 2006-08
Total AIDS resource needs for prevention, treatment and care, support for orphans and vulnerable children, and programme and human resource costs	US$14.9 billion	US$18.1 billion	US$22.1 billion	US$55.1 billion
Estimate/projections of resources available	US$8.9 billion	US$10 billion		
Funding gap from 2005 to 2007	At least US$18 billion			

Source: UNAIDS. 2005. *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries.*

WHO, UNAIDS and Futures are continuing to develop the tool to measure the resource needs. A valuable contribution has been the Cape Town model for costing ARV programmes developed by Boulle & Cleary (2005). UNAIDS is improving its support to countries to undertake their own costing of their national strategic plans and universal access targets. In addition, other specific costing studies have been undertaken, which contribute to the understanding of the scope of resources required for scaling up interventions, such as the costing of the WHO 3 by 5 goal by Gutierrez (2004) and the HIV/AIDS-specific MDG goals (Evans *et al*, 2005).

In addition, the UNAIDS RTP[17] Unit also attempts to project what resources will be available for HIV/AIDS over the coming years. There are many methodological challenges in the process, but using projections based on current trends, pledges and commitments, UNAIDS estimates that the resources available for AIDS will grow from an estimated US$4.7 billion in 2003 to US$10 billion in 2007 (UNAIDS, 2005).

Once resource needs are estimated, being based on more accurate costed programmes and modelled estimates of need, and with accurate tracking of actual expenditure, the required financing (or ‘gap’) can then be determined and the most effective financing mechanism, or mix thereof, can de designed to meet the gap.

3.6 Innovative financing mechanisms – funding the gap

Recognising the growing financial costs related to achieve the UNGASS and Universal Access Goals, and for an adequate response to HIV/AIDS, the inherent limits to local revenue funds especially in lower income countries, and the potential reduction of donor funding for HIV/AIDS (e.g. the recent uncertainty about the GFATM 5th round), there has

[17] Resource Tracking and Projections Unit.

been increasing debate on innovative financing mechanisms that are sustainable, equitable and adequate.

International support for this was advanced at a conference in Paris in March 2006, attended by 93 states as well as international and non-governmental organisations. Participants reviewed many different options for alternative sources of funds. Two proposed innovative mechanisms were:

- International Finance Facility (IFF): This aims to front-load funding by raising finance through bond markets. A pilot for immunisation is already underway, funded by six European countries whose 20-year commitment will result in a steady and predictable flow of financing for immunisation over the next ten years.
- The air ticket solidarity levy[18]: The objective of this new initiative of the international community is to create a long-term, guaranteed and predictable resource with solid perspectives for growth. Initiated by Brazil and France and adopted at the Paris Conference on Innovative Financing for Development early 2006, UNITAID airticket tax is set to be implemented in 14 countries and will be supported by multi-year budgetary assistance from other countries.

Other options for innovative funding mechanisms proposed and reviewed at the Paris conference were:

- Other solidarity levies;
- Taxing financial transactions and reducing tax evasion;
- Migrant remittances;
- A humanitarian lottery;
- Voluntary initiatives, such as 'Red', an initiative on the part of some global fashion leaders to raise sustainable funding for the Global Fund.
- A Leading Group on Solidarity Levies to fund development has been created which includes 38 donor and low-income countries. (WHO, 2006f).

Greater attention is required on these and other options. The inherent difficulty in any new financing mechanism is the length of time involved in conceptualisation, development, piloting, and monitoring of the impacts, before they can be rolled-out on a larger basis. The negative consequences of the 'user-fees', thought to be an excellent financing mechanism by the World Bank and other proponents, should be remembered before enforcing mechanisms which ultimately burden the poor, even in the case of options such pre-payment or 'voluntary' community insurance schemes.

3.7 Co-ordination of Efforts in HIV/AIDS Financing ~ the Global Task Team Division on Labour

With the increasing complexity of actors in the field of HIV/AIDS, and the increasing funding efforts, there is need for greater coordination of funding activities at national and

[18] http://www.unitaid.eu/EN-Inutaid-unis-pour-soigner.html

global level. Knack & Rahman (2006) discuss the donor fragmentation and bureaucratic quality in aid recipients. UNAIDS (2005b) claims that this has resulted in an implementation crisis—available resources are not being used, and the epidemic continues to outpace the response. There is growing international recognition of this crisis, and donors are expressing increasing interest in providing additional funding to the UN system to play a stronger and better coordinated technical support role.

In recognition of this urgent need, UNAIDS promoted the"3 Ones" strategy which aimed to improve coordination at the country level by encouraging one national strategic plan, one national co-ordinating body, and one monitoring and evaluation system. This in principle was an important commitment, but the achievement at country-level appears to have been limited, although no formal assessment of the progress of the "3 Ones" has been made.

The Global Task Team Division of Labour

More recent attempts to coordinate efforts involved the leaders from donor and developing country governments, civil society, UN agencies, and other multilateral and international institutions, who met in London on 9 March 2005. They agreed to form a Global Task Team (GTT) to develop a set of recommendations on improving the institutional architecture of the response to HIV and AIDS (UNAIDS, 2005a). The particular focus was on how the multilateral system can streamline, simplify and further harmonize procedures and practices to improve the effectiveness of country-led responses and reduce the burden placed on countries.

An interagency working group was convened to agree a division of labour. The group agreed on 17 broad areas of UNAIDS technical support and identified a 'Lead Organization' and 'Main Partners' in each of these areas. Each of the UNAIDS organizations leads in at least one technical area. This information is presented in a Technical Support Division of Labour matrix (see Table in Appendix XXX). The 17 technical support areas are grouped around three thematic headings:

1. Strategic planning, governance and financial management;
2. Scaling up interventions; and
3. M&E, strategic information, knowledge sharing and accountability.

The Lead Organization, who is primarily responsible for coordinating the provision and/or facilitation of the technical support, also plays a proactive leadership role by taking a lead in global policy discussions regarding the technical support area, establishing global and regional support mechanisms for the delivery of country-level support, identifying gaps in the provision of support at country level, advising country-level stakeholders, and stimulating demand. UNAIDS (2005b) stressed that the Lead Organization plays a brokering role, and should not be viewed as sole provider of UN technical support in its area. Similarly, the Lead Organization is not responsible for managing the financing for technical support provided by a Main Partner. In other words, the relationship between the Lead Organization and its Main Partners is not hierarchical and does not represent an additional layer of bureaucracy. The overarching goal is to improve the quality of UN technical support, requiring both the Lead Organization and its Main Partners to focus on

rapidly providing a service and achieving a concrete result, as opposed to focusing on the process as a vehicle to increase an individual agency's ability to leverage resources.

3.8 Key initiatives and actors in the field of financing for HIV/AIDS - International, regional and national

The HIV/AIDS field is characterised by many actors and activities, often fragmented and duplicative, not necessarily complimentary. Broadly they may be categorised into those that are sources of funds, those that are agents (or managers) of funds, and those that spend the funds in service delivery (the providers), and may also be classified according to their level of scope i.e. international/ global, regional or national. We have considered here only the key international agencies that influence or contribute to research or policy development in the field of financing for HIV/AIDS, and others are listed in Appendix XX.

The UNAIDS "3 Ones" strategy aimed to improve coordination at the country level by encouraging one national strategy plan, one national co-ordinating body, and one monitoring and evaluation system. This in principle was an important commitment, but the achievement at country-level appears to have been limited, although no formal assessment of the progress of the "3 Ones" has been made.

Also in an attempt to enhance the co-ordination between the players, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors presented the Division of Labour between UNAIDS, WHO and the World Bank (WB) (refer to UNAIDS 2005). UNAIDS is responsible for strategic information, under which falls their resource tracking and needs estimations activities. UNDP is interested in addressing HIV/AIDS as a development issue. The World Bank is responsible for strategic planning, and will focus attention on building the capacity of national bodies to plan and manage their HIV/AIDS response.

In light of the GTT division of labour, the World Bank developed its AIDS Strategic Action Plan (ASAP), a global technical assistance service, which responds to country requests for support in developing well-prioritized, evidence-based, results-focused, costed AIDS strategies and action plans. In addition the World Bank Multi-County AIDS Program in Africa (Africa MAP), launched in 2000, is one of many World Bank programs for HIV/AIDS assistance and specifically aims to provide long-term support (10-15 years) to combat HIV/AIDS and mitigate its impact in African countries.

Within UNAIDS, those efforts related to the financial aspects, are the Resource Needs Estimation (RNE) Team and the Resource Tracking and Projections (RTP) Unit. The RNE team focuses on estimating the total costs of a national HIV/AIDS programmes, consisting on the essential components and based on various estimations of uptake. An important initiative has been the development of the Resource Needs Model (RNM), developed by Futures Group and the University of Cape Town (and others) for the purpose of assisting countries to estimate their specific resource needs, especially with regard to their costing of their national strategic plans, and for their universal access targets.

The RTP Team was established relatively recently within the UNAIDS Executive Office, so as to be a cross-cutting function, and focuses on tracking global financial commitments to HIV/AIDS, tracking national public commitments to attain the UNGASS financial goals (using the NASA techniques), as well as attempting to project future commitments.

With regard to tracking of domestic expenditure on HIV/AIDS, the NASA methodology is the main tool being promoted by the UNAIDS RTP Unit, because it provides the framework for the reconstruction of all HIV-related financial transactions, and provides a well-developed classification of all sources, providers and functions. The NASA methodology is an advancement on the National AIDS Accounts and on the NHA – primarily because of the level of disaggregation by the types of functions provided in country – importantly capturing those outside of the health sector, and reflecting the key components of most national strategic plans.

In addition, the RTP Unit convenes a Global Consortium of Resource Tracking for HIV/AIDS. This group of experts involved in various resource tracking activities serves as a reference group, with sub-working groups addressing specific activities. At a recent meeting (August 2006) to discuss the NASA methodology, emphasis was placed on harmonizing the RNM with the NASA methods, and the complimentarity of the activities. Importantly, the UNAIDS is attempting to compare the estimates of global resource needs against the identified actual expenditure, so as to estimate the 'resource gap'.

The activities of the WHO in the HIV/AIDS field and health financing are discussed more in detail in the following section.

With regard to key funding mechanisms that have influenced the policy arena and functioning of programmes in the HIV/AIDS field, the largest structure developed is the Global Fund Against TB, AIDS and Malaria. In addition, and more recently, the Gates Foundation have contributed vast sums of money to the issue of health and HIV/AIDS.
Regarding those NGOs that have global or regional scope in their intervention (as relating specifically to financing aspects), Action Aid International has been active in training and supporting their civil society partners to monitor public spending on HIV/AIDS in a number of countries globally. Similarly, the Open Society Initiative and Soros Foundations have recently begun to support their Foundations to undertake health and HIV/AIDS budget and expenditure monitoring activities. The Centre for Economic Governance and AIDS in Africa (CEGAA) - aims to contribute to improved economic governance, fiscal policy and financial management and accountability, with specific attention to improving the response to HIV and AIDS in Africa. CEGAA undertakes economic and budget analysis research, training and advocacy activities in order to provide evidence of, and possible solutions to, the fiscal and administrative challenges that face so many African countries in their fight against HIV and Aids. Also importantly, the International Budget Project (IBP) trains and supports civil society groups to monitor and influence government budget processes, institutions and outcomes. The overarching aim of the project is to make budget systems more responsive to the needs of society and, accordingly, to make these systems more transparent and accountable to the public[19]. The IBP also considers health budgets specifically. The Health Economics Unit, University of Cape Town – undertakes health and HIV/AIDS service costings, modelling, economic evaluations, and operates a teaching unit.

[19] http://www.internationalbudget.org/

Importantly, the HEU supports and trains African health economists, a critical profession in the planning, implementation and monitoring of effective financing mechanisms required for the HIV/AIDS response.

There are many national levels activities in the HIV/AIDS financing arena, including both those public structures such as the National AIDS Commissions (NACs, or NACAs), and the many non-governmental organisations and academic institutions. Examples of the latter are the Nairobi University, Economic Department, which undertakes HIV/AIDS costing, resource tracking, budget monitoring and economic evaluations, and is establishing an HEU (health economics unit) school. Another is the Economic and Social Research Foundation (ESRF) in Tanzania which is undertaking a NASA.

Overall, there appears to be a balance between the different levels of activity; global, international and national (noting that all the activities at national level could not be captured). However, there could be more linkages between these levels, allowing the country experiences to influence the global policy and methodological development, while also facilitating the flow of the global policy concepts and methodologies to be applied at country level. Lack of capacity at national levels (down to district level) seriously hampers the effective implementation of best-practices and methodological tools. Those organizations actively seeking to build the capacity of National AIDS Commissions (NACs) are somewhat limited, although the World Bank will be focusing specifically on this aspect according to the GTT division of labour. There has been more attention by NGOs on the empowerment of civil society in monitoring their governments' response to HIV/AIDS. This is also an equally important focus, since it is through external pressure that government bodies often improve their functioning, effectiveness and accountability.

There appears to be a balance between the research-focused activities and the advocacy-oriented activities. It was found, generally, that an organization will either focus on one or the other aspect, and few try to combine the research skills with an advocacy emphasis[20]. These foci require different skills and often do not reside together in organizations or individuals. At the same time, the particular contributions of government agencies, research agencies and civil society (especially community) groups must be acknowledged and strengthened. Existing research agencies could contribute greatly to the content and knowledge base within CEGAA, while community level advocacy organizations could be an important outlet for CEGAA's potential technical and policy briefs. At the same time, it would be the national public agencies and policies that could potentially benefit greatly from the information, guidance and technical support offered by CEGAA. There would be far greater national acceptance of globally-initiated policies, targets and ideas, if these were well disseminated and explained at the local level, both within government and among civil society movements at grass-root level.

Linking this analysis to the resource needs estimation also being undertaken by the UNAIDS RTP Unit is important, with some input and support from CEGAA, and building the capacity of NAC officials in both methods, in conjunction with the work being done by the

[20] Note that most research organization do have developed dissemination strategies, but tend not to focus great effort on advanced advocacy campaigns. Similarly, the advocacy organizations do collect information and prepare statements etc, but tend to focus the majority of their efforts on advocacy campaigns that will increase awareness and bring about change at different levels.

UNAIDS RTP Unit and the Consortium on Global Resource Tracking, and the World Bank ASAP project.

In terms of costing and cost effectiveness analysis within the health field generally, the WHO Health Systems Financing (HSF) Department has taken the lead and contributed greatly to the development and standardisation of methods, as well as developing a database of the unit costs of all interventions. Their focus on HIV/AIDS specific interventions has been somewhat limited.

There are many, many other key players who might have been discussed here, but some of which are listed in the appendix XX.

4 CONCLUSION

Globally, increasing external aid and donor funds for HIV/AIDS have been and are being made available to many developing countries (such as those from the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Presidential Emergency Plan for AIDS Relief (PEPFAR). In addition to the financial resources, large allocations of human and infrastructural resources have also been invested in the fight against HIV/AIDS, yet the evidence indicates that further resources, both financial and human are required, with better management of these.

The response to HIV/AIDS has demanded improvements in the health care system, integrated policies, improved procurement systems, and has required enhanced financial, implementation and monitoring systems. However, despite scaled-up efforts and resources to deal with the epidemic, there are increasing reports of poor co-ordination among donors, duplication and complex reporting mechanisms. In addition, there is evidence of limited absorptive capacity, the under-utilisation and misspending of funds, with limited efficacy and efficiency of spending. Countries are reporting bottlenecks in the financing mechanisms and strict donor conditionalities and reporting requirements, which undermine absorptive capacity and technical efficiency of spending (Guthrie, 2006b).

This paper first provided a brief overview of the key issues in health financing generally, as a means of introduction to the topic, and because these all apply to the issue of HIV/AIDS. Thereafter attention was paid to those aspects specific to HIV/AIDS financing, as identified in the literature and through discussions with key players in the field.

General Health Financing Issues
This overview of existing literature found that there is extensive literature regarding financing of the healthcare sector in general, including the analysis of financing mechanisms, costings and cost-effective analyses of health services, public-private partnerships (PPPs) and the financial aspects of human resources and procurement mechanisms. In addition, data availability on health budgets and expenditure has been greatly enhanced by the contribution of the National Health Accounts undertaken by the WHO, and by several civil society organisations which seek to monitor their governments' expenditure on health.

Health systems financing refers to the generation (or collection), pooling, management and spending of funds (purchasing/providing of services) for health systems. There are several methods for financing health care and each has its strengths and weaknesses, and will have differing consequences on the amount of funds raised, on the equity between different income groups and beneficiary groups, and in terms of its unintended consequences (Schieber & Maeda, 1997). The key point is that there is a need and place for all types, and not to over-emphasize one at the expense of other mechanisms. A balance between donor-driven and recipient-managed systems is required, where both are equal partners in the collaborative effort for the most effective, efficient and equitable distribution and utilization of resources.

The sustainability of health care financing has gained importance in the face of uncertainty and cyclical fluctuations, with the decline in economies of developing nations, the impact of structural adjustment programmes, and declining donor assistance. This has lead to greater emphasis on financing systems which do not rely on external aid, and thus the interest in alternatives.

HIV/AIDS Financing Issues

Large amounts of financial resources have been mobilised for the response to HIV/AIDS, both at the global and national levels. Yet there remains a funding gap for the achievement of free access to treatment. In addition, additional challenges within the financing mechanisms are becoming apparent. Slow funding mechanisms, bottlenecks, strict conditionalities and reporting requirements, poor financial and information systems and management skills, and generally limited absorptive capacity are undermining the effectiveness and impact of the response. Hence it is the strengthening of the health systems generally, and the financial aspects particularly, that has become a critical prerequisite for the successful expenditure and impact on HIV/AIDS.

In particular, the contribution of individuals and poor household to the total expenditure on HIV/AIDS has been acknowledged, and its potentially catastrophic effects highlighted (Xu et al, 2003. McIntyre et al, 2006. Russell, 2005). “People, particularly in poor households, can be protected from catastrophic health expenditures by reducing a health system’s reliance on out-of-pocket payments and providing more financial risk protection” (Xu et al, 2003:111). It is therefore important to examine household health expenditure particularly as it relates to HIV/AIDS, it impact and household coping strategies, to inform policies that would better protect poor households. The negative impact of user-fees on poor households has been identified, however, faced with national budget constraints and lack of guaranteed long-term international funding, some highly-affected countries find it difficult to abolish user fees and have raised concerns related to the sustainability of free access policies. Assisting countries to resolve this dilemma by the development of alternative funding mechanisms is an urgent priority for international donors and technical agencies, in order to reduce the catastrophic impact of user fees and OOPE on households affected by HIV/AIDS.

With regard to the absorptive capacity of recipients of aid, great attention is required to address the issues of limited absorptive capacity and bottlenecks in the funding flows, since these undermine the impact of expenditure on HIV/AIDS. Another factor limiting the

impact of spending are the imposed limits on social sector spending, since these curtail the human resources capacity, which is critical for the scaling-up of HIV/AIDS programmes.

Improved financial management skills and systems, monitoring and evaluation systems, institutional and policy analysis skills, as well as synchronized (and more flexible) reporting procedures would greatly enhance government's ability to monitor and co-ordinate social sector spending (Guthrie, 2006). Funding channels and conditionalities can impact on absorption capacity, at both the levels of donor flows to developing countries as well at intergovernmental level transfers within a country (Hickey, 2006).

This paper has identified that there are sufficient efforts exist at tracking actually expenditure on HIV/AIDS from both global and national levels (UNAIDS, PHR+, CEGAA). However, there is limited attention to the effectiveness and impact of the expenditure. Information on both allocative and technical efficiency of HIV/AIDS programmes is greatly needed, as well as country-specific costings. The development of databases of unit costs of HIV/AIDS programmes that are country and regional specific would contribute greatly to more accurate estimates of resource needs at country, regional and global levels.

With improved data on the country-level costs of interventions, the resource needs can be better estimated, using modelled estimates of need. This meant the the required financing (or 'gap') can then be determined and the most effective financing mechanism, or mix thereof, can de designed to meet the gap. In this regard, the work of the UNAIDS RTP, the WHO CE, and the Futures RNM, are all important contributions.

These efforts have contributed to more accurate estimations of the resources required to achieve the UNGASS and Universal Access Goals. These findings have highlighted the limits to local revenue funds especially in lower income countries, and the potential reduction of donor funding for HIV/AIDS (e.g. the recent uncertainty about the GFATM 5th round). Thus there has been increasing debate on innovative financing mechanisms that are sustainable, equitable and adequate.

Existing Initiatives and Actors

With the increasing complexity of actors in the field of HIV/AIDS, and the increasing funding efforts, there is need for greater coordination of funding activities at national and global level. The UNAIDS '3 Ones' and the Global Task Team Division of Labour were important efforts in this regard (refer to UNAIDS 2005).

Broadly the key actors may be categorised into those that are sources of funds, those that are agents (or managers) of funds, and those that spend the funds in service delivery (the providers), and may also be classified according to their level of scope i.e. international/ global, regional or national. This paper considered only those key international agencies that influence or contribute to research or policy development in the field of financing for HIV/AIDS. Overall, the review found there to be a balance between the different levels of activity; global, international and national (noting that all the activities at national level could not be captured), as well as a balance between the research-focused activities and the advocacy-oriented activities.

At the same time, it would be the national public agencies and policies that could potentially benefit greatly from the information, guidance and technical support. There would be far greater national acceptance of globally-initiated policies, targets and ideas, if these were well disseminated and explained at the local level, both within government and among civil society movements at grass-root level.

APPENDIX I - LITERATURE IDENTIFIED

1. GENERAL DEVELOPMENT AID ISSUES/ ARCHITECTURE

Birdsall, N., Williamson, J., Deese, B. 2002. Delivering on Debt Relief: From IMF Gold to a New Aid Architecture.. Centre for Global Development. [Online]. Available: http://bookstore.iie/merchant.mvc [2006, Aug 1].

Booth, D. 2005. Aid to Africa: More doesn't have to mean worse. ODI Opinion Paper. [Online]. Available: http://www.odi.org.uk/publications/opinions/43_aid_to_africa_june05.pdf [2006, Aug 29].

de Renzio, P., Rogerson, A. 2005. Power to Consumers? A Bottom-up Approach to Aid Reform. ODI Opinion Paper. [Online]. Available: http://www.odi.org.uk/publications/opinions/40_aid_reform_may05.pdf [2006, Aug 29].

Foster, M., Killick, T. 2006. What Would Doubling Aid do for Macroeconomic Management in Africa? ODI working paper 264. [Online]. Available: http://www.odi.org.uk/publications/working_papers/wp264.pdf [2006, Aug 29].

Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors Final Report. (no date). [Online]. Available: http://data.unaids.org/publications [2006, Aug 29].

Knack, S., Rahman, A. Donor fragmentation and bureaucratic quality in aid recipients. *Journal of Development Economics. (in press).* [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBV-4JDN6JD-1-5&_cdi=5936&_user=635696&_orig=search&_coverDate=03%2F06%2F2006&_sk=999999999&view=c&wchp=dGLbVtz-zSkzk&md5=85a5ba094f7a1ddaf77a97f7eda0b49d&ie=/sdarticle.pdf [2006, July 24].

Interfund. 2004. From disaster to development: HIV and AIDS in Southern Africa. [Online]. Available: http://www.sarpn.org.za/documents/d0001195/index.php [2006, Aug 29].

National Action Committee, Government of Zimbabwe, 2003. Zimbabwe water and sanitation sector HIV/AIDS response: programme, strategies and guidelines. UNICEF. http://www.sarpn.org.za/documents/d0001030/index.php

ODI. 2005. SCALING UP *versus* ABSORPTIVE CAPACITY: CHALLENGES AND OPPORTUNITIES FOR REACHING THE MDGS IN AFRICA. ODI Briefing Paper. [Online]. Available: http://www.odi.org.uk/publications/briefing/bp_may05_absorptive_capacity.pdf [2006, Aug 29].

ODI. 2006. Aid architecture: A blueprint for the future. [Online]. Available: http://www.odi.org.uk/annual_report/ar2006/air_architecture_spread_web.pdf [2006, Aug 29].

Rocha Menocal, A., Mulley, S. 2006. Learning from experience? A review of recipient government efforts to manage donor relations and improve the quality of aid. ODI working paper 268. [Online]. Available: http://www.odi.org.uk/publications/working_papers/wp268.pdf [2006, Aug 29].

Rocha Menocal, A., Rogerson, A. 2006. Which Way the Future of Aid? Southern Civil Society Perspectives on Current Debates on Reform to the International Aid System. ODI Working Paper 259. [Online]. Available: http://www.odi.org.uk/publications/working_papers/wp259.pdf [2006, Aug 29].

Paris Declaration. 2005. Paris Declaration on AID Effectiveness.

van Donk, M. 2004. UNDP Development planning and HIV/AIDS in sub-Saharan Africa. Regional Project on HIV & Development. [Online]. Available: http://www.sarpn.org.za/documents/d0001371/index.php. [2006, Aug 29].

2. HEALTH

2.1. Health financing general

Abel-Smith, B. 1985. Global perspective on health service financing. *Social Science & Medicine*. 21(9):957-963. [Online]. Available: http://www.sciencedirect.com/science?_ob=ArticleURL&_aset=V-WA-A-W-CW-MsSAYZA-UUW-U-AABUWVBAAY-AAWDYWBEAY-BZAWCUVDD-CW-U&_rdoc=52&_fmt=summary&_udi=B6VBF-4692PH8-32&_coverDate=12%2F31%2F1985&_cdi=5925&_orig=search&_st=13&_sort=d&view=c&_acct=C000033878&_version=1&_urlVersion=0&_userid=635696&md5=946e49f680bd68daf72fabc889fe9c21 [2005, September 25].

Aedondo, A., Orozco, E., De Icaza, E. 2005. Evidences on weaknesses and strengths from health financing after decentralization: lessons from Latin American countries. *Int J Health Plann Manage*. Vol. 20 (2), pp. 181-204. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15991461 [2006, July 24].

African Union (AU). 2006. HEALTH FINANCING IN AFRICA. [Online]. Available: http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/SP_PRC_ATM5_Financial_factors.pdf [2006, July 24].

Ball DE. 2005. Health in Africa: it's time for good guidelines on health financing practice. BMJ (Clinical Research Ed.) [BMJ] 2005 Oct 15; Vol. 331 (7521), pp. 904-5. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=16223829 [2006, July 24].

Beattie, A. *et al.* 1996. Sustainable Health Care Financing in Southern Africa. World Bank.

Burke, M.A., de Francisco, A. 2006. Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers. Global Forum for Health Research.

De Allegri, M., Pokhrel, S., Sauerborn, R. Health financing and access to services. Lancet; 2/12/2005, Vol. 365 Issue 9459, p569-570, 2p, 1c . [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=aph&an=16070571 [2006, July 24].

Doherty,J., Thomas,S., Muirhead,D. 2002. *Health Financing and Expenditure in Post-Apartheid South Africa, 1996/97 - 1998/99*. The National Health Accounts Project. Centre for Health Policy, University of the Witwatersrand and Health Economics Unit, University of Cape Town.

Eldis. Health financing: designing and implementing pro-poor policies. [Online]. Available: http://www.eldis.org/static/DOC10299.htm [2006, July 24].

Frenkel, M. 1995. Health financing policy after the 1994 Clinton plan experience. *J Health Care Finance*. Vol. 21 (3), pp. 68-71. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=7600241 [2006, July 24].

Hay, R. 2003. The 'Fiscal Space' for Publicly Financed Health Care. Oxford Policy Brief No.4. [Online]. Available: http://www.opi.org.uk/index.php?p=publications&opisid=eab643448321038ac57073f4c983555e [2005, September 25].

Hsiao,W. 1998. Health Care Financing in Developing National: a background paper. Harvard University, Scholl of Public Health. (Hard copy available in the resource centre of the Health Economics Unit, UCT.)

Kampala Declaration on Fair and Sustainable Health Financing, 2005. [Online]. Available: http://www.who.int/health_financing/countries/kampala.pdf [2006, July 24].

Korte, R., Richter, H., Merkle, F., Görgen, H. 2002. Financing health services in Sub-Saharan Africa: Options for decision makers during adjustment. *Social Science & Medicine*.34(1):1-9.

Kutzin, J. 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*, 56(3):171-204.

Lee, K., Walt, G., Haines, A. 2004. The challenge to improve global health: financing the Millennium Development Goals. *JAMA*. Vol. 291 (21), pp. 2636-8. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15173157 [2006, July 24].

Leighton, C. 1996. Strategies for achieving health financing reform in Africa. *World Development;* Vol. 24 Issue 9, p1511, 15p, 5 charts. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=hlh&an=9703114872 [2006, July 24].

McIntyre, D. 2005. Financing for Health. Macro-economic lecture notes for M.PH – Health Economics (UCT).

Palmer, N., Mueller, D., Gilson, L., Mills, A., Haines, A. 2005. Health financing and access to services. *Lancet*; Vol. 365 Issue 9459, p570-570, 1/3p. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=aph&an=16070578 [2006, July 24].

Schieber, G., Maeda, A. 1997. "A curmudgeon's guide to financing health care in developing countries". Quoted in Schieber, G. (ed). 1997. Innovations in health care financing: Proceedings of a World Bank Conference, March 1997. Washington D.C: World Bank Discussion Paper No.365.

Sekwat, A. 2003. Health financing reform in sub-Saharan Africa: major constraints, goals, and strategies. *J Health Care Finance*. Vol. 29 (3), pp. 67-78. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=12635996 [2006, July 24].

WHA. 2006. The Fifty-eighth World Health Assembly. Sustainable health financing, universal coverage and social health insurance. [Online]. Available: http://www.who.int/health_financing/HF%20Resolution%20en.pdf [2006, July 24].

World Bank. Health Financing Revisited: A Practitioner's Guide. [Online]. Available: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20200211~menuPK:376811~pagePK:148956~piPK:216618~theSitePK:376793,00.html [2006, July 24].

World Health Organization. 2000. The World Health Report 2000. Health Systems: Improving Performance. Geneva, WHO.

WHO, 2005a. Achieving Universal Health Coverage: Developing the Health Financing System. [Online]. Available: http://www.who.int/health_financing/ [2006, July 24].

WHO. 2005b. Paris Declaration on AID Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability. Workshop on harmonization and alignment of development assistance towards health and development in Uganda.

WHO Health Systems Unit. 2006. What is a Health System? http://www.who.int/healthsystems/en/

2.2. Financing Mechanisms

Arredondo A; Orozco E; De Icaza E. Evidences on weaknesses and strengths from health financing after decentralization: lessons from Latin American countries. The International Journal Of Health Planning And Management [Int J Health Plann Manage] 2005 Apr-Jun; Vol. 20 (2), pp. 181-204. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15991461 [2006, July 24].

Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). *Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.

Bennett, S., McPake, B., Mills, A. 1997. 'The public-private mix debate in health care' in Bennett, S., McPake, B., Mills, A. (eds). 1997. *Private Health Providers in Developing Countries: Serving public interest?* London: Zed Books.

Bennett, S., Nagalande-Banda, E. 1994. *Public and Private Roles in Health: a review and analysis of experience in sub-Saharan Africa.* Geneva: WHO.

Bird RM, Smart M. 2002. Intergovernmental Fiscal Transfers: International lessons for developing countries. *World Development*. 30(6): 899-912.

Bitran R, Giedion U. 2002. *Waivers and exemptions for health services in developing countries*. Washington: World Bank.

Buse, K., Walt, G. 1997. An unruly mélange? Coordinating external resources to the health sector: a review. *Soc.Sci.Med.* 45(3):449-463.

Carrin G. 2004. Towards advanced risk-sharing in health care financing: with a focus on the potential of social health insurance in developing countries. Verhandelingen - Koninklijke Academie Voor Geneeskunde Van België [Verh K Acad Geneeskd Belg] Vol. 66 (3), pp. 215-34; discussion 234-6. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15315121 [2006, July 24].

Cassels A. 1997. A Guide to Sector-Wide Approaches for Health Development: Concepts, Issues and Working Arrangements. Geneva: World Health Organization.

Cassels A, Janovsky K. 1998. Better health in developing countries: are sector-wide approaches the way of the future? *The Lancet*. 352: 1777-1779.

Cissé, B., Luchini, S., Moatti, JP. 2006. Progressivity and horizontal equity in health care finance and delivery: What about Africa? *Health Policy, In Press, Corrected Proof, Available online 3 April 2006.* [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6V8X-4JMM5JC-1-R&_cdi=5882&_user=635696&_orig=search&_coverDate=04%2F03%2F2006&_sk=999999999&view=c&wchp=dGLbVzb-zSkzS&md5=0c5f4d003ca239f2b41c0ef61ce6a1b1&ie=/sdarticle.pdf [2006, July 24].

Doherty, J., Thomas, S., Muirhead, D., McIntyre, D. 2003. South African Health Review 2002: Health Care Financing and Expenditure. HST.

Foster, M., Brown, A., Conway, T. (no date). Sector-Wide Approaches for Health Development: a review of experience. WHO.

Gilson L; Doherty J; Lake S; McIntyre D; Mwikisa C; Thomas S. 2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy Plan*. Vol. 18 (1), pp. 31-46. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=12582106. [2006, July 24].

Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H, Ouendo M. 2001. Strategies for promoting equity: experience with community financing in three African countries. *Health Policy* 58: 37-67.

Gilson L. 1998. The lessons of user fee experience in Africa. *In*: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). *Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.

Guthrie, T. 2006. Donor Funding for Social Sector Spending ~ Comments on sector-wide approach, general budget support and project-specific funding. (Internal document prepared for the use of SIDA).

Hay, R 2003. The 'fiscal space' for publicly financed health care. *Oxford Policy Institute Brief*. 4: 1-8.

Kalumba, K., Musowe, V. 1996. Effective Coordination and Use of Donor Funding in Zambia. In Beattie *et al.* 1996:159-165.

Jones, A., Duncan,A. 1995. Hypothecated Health Taxes: a recent evaluation of recent proposals. Office of Health Economics. London: BSC Print.

Knack, S. Rahman, A. 2006. Donor fragmentation and bureaucratic quality in aid recipients. *Journal of Development Economics*. [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBV-4JDN6JD-1-5&_cdi=5936&_user=635696&_orig=search&_coverDate=03%2F06%2F2006&_sk=999999999&view=c&wchp=dGLbVtz-zSkzk&md5=85a5ba094f7a1ddaf77a97f7eda0b49d&ie=/sdarticle.pdf [2006, July 24].

Komuhangi, L. 2000. "Impact of Health Sector Ceilings on HIV/AIDS Expenditure in Uganda." Report prepared for Justice Africa UK. November 2000.

Korte, R., Richter, H., Merkle, F., Görgen, H. 2002. Financing health services in Sub-Saharan Africa: Options for decision makers during adjustment. *Social Science & Medicine*.34(1):1-9. [Online]. Available: http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-465D3F0-B&_user=635696&_handle=V-WA-A-W-AZ-MsSAYWA-UUA-U-AABUWVYBAZ-AAWDYWEAAZ-BZAWYDZAB-AZ-U&_fmt=summary&_coverDate=01%2F31%2F1992&_rdoc=1&_orig=browse&_srch=%23toc%235925%231992%23999659998%23322771!&_cdi=5925&view=c&_acct=C000033878&_version=1&_urlVersion=0&_userid=635696&md5=79aa66e2a4e0545ad4a33b53ec504492

Kutzin J. 1998. Health Insurance for the formal sector in Africa: Yes, but … *In*: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). *Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.

Kutzin J. 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy* 56: 171-203.

Lambo E. 1998. Aims and performance of prepayment schemes. *In*: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). *Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.

Mayhew, S.H. Donor Dealings: Impact of International Donor Air on Sexual and Reproductive Health Services. *Journal of* International Planning Perspectives.

Musgrove P, Zeramdini R, Carrin G (2002). Basic patterns in national health expenditure *Bulletin of the World Health Organization,* 80 (2): 134-142.

OECD-DAC UNAIDS. 2004. Aid Activities in Support of HIV/AIDS Control 2000-2002. Volume 2004/6. June 2004.

Palma, A. 2001a. "Absorptive Capacity for Government and Donor Funding: Assessing the DOH Case." Philippine Institute for Development Studies Policy Notes, December 2001. Available at www.pids.gov.ph

Palma, A. 2001b. "Assessment of the Absorptive Capacity for Government and Donor Funding: The Case of the DOH." Discussion Paper Series No. 2001-04. Philippine Institute for Development Studies. February 2001. Available at www.pids.gov.ph

Palmer N, Mueller D, Gilson L, Mills A, Haines A. 2004. Health financing to promote access in low income settings – how much do we know? *The Lancet*. 364: 365-370.

Wagstaff A. 2002. Measuring equity in health care financing: reflections on and alternatives to WHO's fairness of financing index. *Health Economics* 11: 103-115

Wagstaff A, van Doorslaer E. 1992. Equity in the finance of health care: Some international comparisons. *Journal of Health Economics* 11: 361-388.

WHO. 2005a. Achieving Universal Health Coverage: Developing the Health Financing System. [Online]. Available: http://www.who.int/health_financing/pb_1.pdf [2006, July 24].

WHO. 2005b. Designing Health Financing Systems to Reduce Catastrophic Health Expenditure. Technical brief. [Online]. Available: http://www.who.int/health_financing/en/ [2006, July 24].

WHO (no date). WHO's Health Financing Policy. [Online]. Available:
http://www.who.int/health_financing/HF%20Resolution%20en.pdf [2006, July 24].

2.3. Household Level Analysis

Asenso-Okyere, W. & Dzator, J. 1997, 'Household cost of seeking malaria care. A retrospective study of two districts in Ghana', *Social Science and Medicine*, vol. 45, pp. 659-667.

Martins, J. 2006. Household Budgets as a social indicator of Poverty and Inequality in South Africa. Presentation made at the 7th Annual conference of the International Society for Quality Of Life Studies. Rhodes University, 17-20 July 2006.

McIntyre, D, Thiede, M., Dahlgren, G., Whitehead, M. 2005. "What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?". *Social Science & Medicine, Volume 62, Issue 4, February 2006, Pages 858-865.* [Online]. Available:
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-4GWC27Y-2-3&_cdi=5925&_user=635696&_orig=search&_coverDate=08%2F15%2F2005&_sk=999999999&view=c&wchp=dGLbVlz-zSkzV&md5=1a9312fc77f7f3f4c08d12eef196069a&ie=/sdarticle.pdf [2006, July 24].

Nieftagodien, S. 2006. Exploring Consumption Patterns and Living Standards of Black Households in South Africa. Paper delivered at the 7th Conference of the International Society for Quality of Life Studies (ISQOLS), Rhodes University, Grahamstown, 17-20 July 2006.

Russell, S. 2005, 'Illuminating cases: understanding the economic burden of illness through case study household research', *Health Policy and Planning* (in print).

Sauerborn, R., Adams, A. & Hien, M. 1996. 'Household Strategies to cope with the economic costs of illness', *Social Science and Medicine*, vol. 43, pp. 291-301.

Xu, K., Klavus, J., Aguilar-Rivera, A.M., Carrin, G., Zeramdini, R., Murray, C. (no date). Summary Measures of the Distribution of Household Financial Contributions to Health. In Health Systems Performance Assessment.

Xu, K., Evans, D.B., Kawabata, K., Zeramdini, R. Klavus, J., Murray, C. 2003. Household catastrophic health expenditure: a multicountry analysis. *The Lancet*. (362): 111-117. Available [online]: www.thelancet.com [August 11, 2006].

Xu, K., Evans, D.B., Kadama, P., Nabyonga, J., Ogwang Ogwal, P., Nabukhonzo, P., Aguilar, A.M. 2006. Understanding the impact of eliminating user fees: Utilization and catastrophic health expenditures in Uganda. *Social Science & Medicine.* 62: 866–876. [Online]. Available: www.elsevier.com/locate/socscimed [2006, July 24].

Xu, K. 2005. Distribution of health payments and catastrophic expenditures: Methodology. WHO.

2.4. Health Care Financing Reform

Bennett S, McPake B, Mills A. 1997. Private health providers in developing countries: Serving the public interest? London: Zed Books.

Frenkel M. Health financing policy after the 1994 Clinton plan experience. 1995. *Journal Of Health Care Finance*. Vol. 21 (3), pp. 68-71. [Online]. Available:
http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=7600241
[2006, July 24].

Fuchs, V. 1996. 'Economics, values, and health care reform', *American Economic Review*, vol. 86, pp. 1-24.

Gilson, L. 1995. Management and Health Care Reform in Sub-Saharan Africa. *Soc.Sci. Med.* 40 (5): 695-710. [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-47GYK49-F-1&_cdi=5925&_user=635696&_orig=search&_coverDate=03%2F31%2F1995&_sk=999599994&view=c&wchp=dGLbVlz-zSkzV&md5=ddb2a5b98d0c42da28de272ad804736d&ie=/sdarticle.pdf [2005, September 25].

Gilson L; Doherty J; Lake S; McIntyre D; Mwikisa C; Thomas S. 2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy And Planning.* Vol. 18 (1), pp. 31-46. [Online]. Available:
http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=12582106
[2006, July 24].

Leighton, C. 1996. Strategies for achieving health financing reform in Africa. World Development; Vol. 24 Issue 9, p1511. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=hlh&an=9703114872
[2006, July 24].

Liu, X., Mills, A. 2002. Financing reforms of public health services in China: lessons for other nations. *Social Science & Medicine*. 54(11):1691(8). [Online]. Available:
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-44CN141-7-1&_cdi=5925&_user=635696&_orig=search&_coverDate=06%2F30%2F2002&_sk=999459988&view=c&wchp=dGLbVlz-zSkzV&md5=80b1f7f7d28ebb89f6554987bf48d7a3&ie=/sdarticle.pdf [2005, September 25].

Peabody, J.W. (1996). Economic Reform and Health Sector Policy: Lessons from Structural Adjustment Programs, *Social Science and Medicine,* Vol. 43, No. 5, pp. 823-835.

Sekwat A. 2003. Health financing reform in sub-Saharan Africa: major constraints, goals, and strategies. *Journal Of Health Care Finance.* Vol. 29 (3), pp. 67-78. [Online]. Available:
http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=12635996 [2006, July 24].

Sharma DC. 2000. WHO to support health reforms in South East Asian region. Lancet; Vol. 356 (9232), pp. 839. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=11022941 [2006, July 24].

Travis P, Egger D, Davies P, Mechbal A. 2002. Towards better stewardship: concepts and critical issues. Geneva: Evidence and Information for Policy, World Health Organisation.

Whitehead, M., Dahlgren, G. & Evans, T. 2001, 'Equity and health sector reforms: can low income countries escape the medical poverty trap?', *Lancet*, vol. 138, pp. 833-836.

2.5. Efficiency and Cost Effectiveness Issues

Baltussen, R. 2005. Priority setting of public spending in developing countries: Do not try to do everything for everybody. *Health Policy*, http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6V8X-4HM7RRB-1-1&_cdi=5882&_user=635696&_orig=search&_coverDate=11%2F21%2F2005&_sk=999999999&view=c&wchp=dGLbVtb-zSkWW&md5=322f41d32d7db7f43fcc77745049a2d3&ie=/sdarticle.pdf

Birch, S., Gafni, A. 2003, 'Economics and the evaluation of health care programmes: generalisability of methods and implications for generalisability of results', *Health Policy*, vol. 64, pp. 207-219.

Evans, D.B., Lim, S.S., Adam, T., Tan-Torres Edejar, T. & WHO CHOICE MDG Team. 2005. Evaluation of current strategies and future priorities for improving health in developing countries. *BMJ*. 331;1457-1461. [Online]. Available: http://bmj.com/cgi/content/full/331/7530/1457 [2006, Aug 29]

Evans, D.B., Tan-Torres Edejer, T., Adam, T., Lim, S.S. and the WHO Choosing Interventions that are Cost Effective (CHOICE) and Millennium Development Goals Team. 2005. Methods to assess the costs and health effects of interventions for improving health in developing countries. *BMJ*. 331;1137-1140

Hutubessy, R., Chisholm, D., Tan-Torres Edejer, T. and WHOCHOICE. 2003. Generalized cost-effectiveness analysis for national-level priority-setting in the health sector. [Online]. Available: http://www.resource-allocation.com/content/1/1/8 [2006, July 24].

Levy, A. *et al.* 2006. The direct costs of HIV/AIDS care. *The Lancet Infectious Diseases,* 6 (3):171-177. [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6W8X-4J9WSCX-10-1&_cdi=6666&_user=635696&_orig=search&_coverDate=03%2F31%2F2006&_sk=999939996&view=c&wchp=dGLbVtb-zSkWW&md5=c9e994514b3bfe7f3c03333b49ab0473&ie=/sdarticle.pdf [2006, July 24].

Mays GP; McHugh MC; Shim K; Lenaway D; Halverson PK; Moonesinghe R; Honoré P. 2004. Getting what you pay for: public health spending and the performance of essential public health services. *Journal Of Public Health Management And Practice.* Vol. 10 (5), pp. 435-43. [Online]. Available:
http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15552769
[2006, July 24].

McIntyre D and Gilson L. 2002. Putting equity in health back onto the social policy agenda: experience from South Africa. *Social Science and Medicine* **54**: 1637-1656.

Murray, C., Evans, D., Acharya, A., Baltussen, R. 2000. Development of WHO Guidelines on Generalized Cost-Effectiveness Analysis. *Health Econ*. 9: 235–251.

Pearson M. 2002. Benefit incidence analysis: how can it contribute to our understanding of health systems performance. London: DFID.

Tan-Torres Edejer, T., *et al.* (eds). 2003. Making Choices in Health: WHO Guide to Cost-Effectiveness Analysis. Geneva: WHO.

Wagstaff A, van Doorslaer E. 1992. Equity in the finance of health care: Some international comparisons. *Journal of Health Economics* **11**: 361-388.

Wagstaff A. 2002. Measuring equity in health care financing: reflections on and alternatives to WHO's fairness of financing index. *Health Economics* **11**: 103-115.

2.6. Tracking of Health Financing and Expenditure

Fofack, H. Ngong, R. Obidegwa, C. (2003). *Public Expenditure Performance in Rwanda: Evidence from a Public Expenditure Tracking Study in the Health and Education Sectors.* March 2003.

Getzen, T. 2000, 'Health care is an individual necessity and a national luxury: applying multilevel decision models to the analysis of health care expenditures', *Journal of Health Economics*, vol. 19, pp. 259-270.

Govindaraj, R., Chellaraj, G., Murray, C. 1997. Health Expenditures in Latin America and the Caribbean. *Soc. Sci. Med.* 44 (2):157-169. [Online]. Available:
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-3SWT27W-3-2&_cdi=5925&_user=635696&_orig=search&_coverDate=01%2F31%2F1997&_sk=999559997&view=c&wchp=dGLbVlz-zSkzV&md5=c61b905ca5b9a0e15324e926f104f3de&ie=/sdarticle.pdf [2005, September 25].

Lee K; Walt G; Haines A. 2004. The challenge to improve global health: financing the Millennium Development Goals. JAMA: *The Journal Of The American Medical Association.* Vol. 291 (21), pp. 2636-8. [Online]. Available: http://search.epnet.com/login.aspx?direct=true&db=cmedm&an=15173157 [2006, July 24].

Musgrove P, Zeramdini R, Carrin G. 2002. Basic patterns in national health expenditure. Bulletin of the World Health Organization, 80 (2): 134-142.

Nandakumar, A.K., Bhawalkar, M., Tien , M, Ramos, M. and Susna De. 2004. *Synthesis of Findings from NHA Studies in Twenty-Six Countries*. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

Oxford Policy Management. 2005. *Global Financing for HIV/AIDS – A Conceptual Framework. For ActionAid International UK.*

Partners for Health Reform*plus*. 2004. *Using the National Health Accounts Subanalysis to Track Resource Flows for HIV/AIDS*. June 2004.

Phiri, F., Tien, M., Ministry of Health/Abt Associates. 2004. Zambia national health accounts 2002: Main findings. http://www.sarpn.org.za/documents/d0001232/index.php

Republic of Kenya, Ministry of Health. 2002. *Kenya National Health Accounts 2001/2*.

Republic of Rwanda, Ministry of Health. 2005. *Rwanda National Health Accounts 2002*.

Tangcharoensathien, V. et al. 1999. National Health Accounts development: lessons from Thailand. Health and Policy Planning. 14(4):342-353. [Online]. Available: http://heapol.oxfordjournals.org/cgi/reprint/14/4/342 [2005, September 25].

WHO. (Multiple yeas). National Health Accounts. www.who.org

World Health Organisation. 2003. Guide to producing national health accounts: with special applications for low-income and middle-income countries. Geneva: WHO, World Bank, USAID.

2.7. Human Resources

Blaauw D, Gilson L, Penn-Kekana L, et al. (no date) Organisational relationships and the 'software" of health sector reform. Background paper. Disease Control Priorities Project. [Online]. Available: http://www.dcp2.org/page/main/ViewPublications.html. [2006, August 1].

Bryce J, el Arifeen S, Pariyo G, et al. 2003. Multi-country evaluation of IMCI Study Group. Reducing child mortality: can public health deliver? *Lancet*. 362:159–64.

Chen L, Evans T, Anand S, et al. 2004. Human resources for health: overcoming the crisis. *Lancet*. 364:1984–90.

Dovlo D. 2004. Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review. *Human Resources for Health*;2:7. [Online]. Available: http://www.humanresources-health.com [2006, July 24].

Hongoro C, McPake B. 2003. Human resources in health: putting the right agenda back to front [Editorial]. *Tropical Medicine and International Health*. 8:965–6.

Saunders DM, Chopra M. 2005. Confronting Africa's health crisis: more of the same will not be enough [Education and Debate]. BMJ 2005;331:755–8.

Kabene, S.M., Orchard, C., Howard, J.M., Soriano, M.A., Leduc, R. 2006. The importance of human resources management in health care: a global context. *Human Resources for Health*. 4:20. [Online]. Available: http://www.human-resources-health.com/ [2006, July 24].

Kurowski C, Wyss K, Abdulla S, et al. 2004. Human resources for health: requirements and availability in the context of scaling-up priority interventions in low-income countries. Case studies from Tanzania and Chad. Report to the Department for International Development. London: LSHTM, IDRC.

Liese B, Blanchet N, Dussault G. 2003. The Human Resource Crisis in Health Services in Sub-Saharan Africa. Background paper. Washington DC: World Bank.

Marchal B, Kegels G. 2003. Health workforce imbalance in terms of globalization: brain drain or professional mobility. *International Journal of Health Planning and Management*. 18(Suppl.1):S89–S101.

Nunn P, Harries A, Godfrey-Fausset P, et al. 2002.The research agenda for improving health policy, systems performance and service delivery for tuberculosis control: a WHO perspective. Bulletin of World Health Organization; 80: 471–76.

Padarath A, Ntuli A, Burthiaume L. Human resources. 2004. n: Ijumab PI, Day C, Ntuli A, editors. South African Health Review 2003-04. Durban: Health Systems Trust.

Padarath A, Chamberlain C, McCoy D, et al. (no date). Health personnel in southern Africa: confronting maldistribution and brain drain. Equinet Discussion Paper No.3. Zimbabwe: Equinet, Health Systems Trust, MEDACT.

Stilwell B, Diallo K, Zurn P, et al. 2003. Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges. *Human Resources for Health.* 1(1):8. [Online]. Available: http://www.human-resources-health.com [2006, July 24].

USAID. 2003. The Health Sector Human Resource Crisis in Africa: An Issues Paper.Washington DC7 USAID, AED, SARA.

Van Lerberghe W, Conceic¸ao C, Van Damme W, Ferrinho P. 2002. When staff is underpaid: dealing with the individual coping strategies of health personnel. Bulletin of World Health Organization.80(7): 581–84.

Wendo, C. 2002. Uganda stands firm on health spending freeze. *Lancet*. Vol. 360 Issue 9348, p1847.

2.8. Drug Production, Patents , Pricing, Pharmaceuticals and Trade Policies

Abbott, T. 1995, 'Price regulation in the pharmaceutical industry: prescription or placebo?', *Journal of Health Economics*, vol. 14, pp. 551-565.

Drager, N. and Fidler, D.P. (2004) GATS and Health Related Services. WHO, Geneva.

DiMasi, J., Hansen, R., Grabowski, H. & Lasagna, L. 1991, 'Cost of innovation in the pharmaceutical industry', *Journal of Health Economics*, vol. 10, pp. 107-142.

DiMasi, J., Hansen, R. & Grabowski, H. 2003, 'The price of innovation: new estimates of drug development costs', *Journal of Health Economics,* vol. 22, pp. 151-185.

Foster, S. 1991. Supply and use of essential drugs in sub-Saharan Africa: Some issues and possible solutions. *Social Science & Medicine, Volume 32, Issue 11, Pages 1201-1218.*

Lu, J. & Comanor, W. 1998, 'Strategic pricing of new pharmaceuticals', Review of Economics and Statistics, vol 80, pp. 108-117.

Pollock, A.M. and Price, D. 2000. "Rewriting the regulations: how the World Trade Organisation could accelerate privatisation in health-care systems". *Lancet,* 356, 1995-2000.

WHO Policy Perspectives on Medicines. 2001. Globalization, TRIPS and access to pharmaceuticals. No. 3, WHO Geneva.

WTO. 2001. TRIPS and Pharmaceutical patents Fact Sheet.

3. HIV/AIDS related

Note that CADRE has developed a database of South African HIV/AIDS literature, which includes some financing articles as well as those relating to HIV/AIDS services. Contact: karen@cadre.org.za

3.1. HIV/AIDS Financing Mechanisms

England, R. 2006. Coordinating HIV control efforts: what to do with the national AIDS commissions *The Lancet,* Vol 367, Issue 9524: 1786-1789. [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6T1B-4K3716K-15-1&_cdi=4886&_user=635696&_orig=search&_coverDate=06%2F02%2F2006&_sk=996320475&view=c&wchp=dGLbVtb-zSkWW&md5=f0be6feec7312b05a3c92477c5704cc8&ie=/sdarticle.pdf [2006, July 24].

Department for International Development (DFID). 2003. HIV/AIDS Mainstreaming: a definition, some experiences and strategies. [Online]. Available: http://www.sarpn.org.za/documents/d0000271/index.php [2006, July 24].

Guthrie, T. 2006b. Situational Analysis - Strategic Framework for the Centre for Economic Governance and AIDS in Africa.

Nordstrom, A. 2006. "Medicines, money and motivated health workers are key to universal access to HIV/AIDS prevention, treatment care and support". Closing Speech made to the XVIth International AIDS Conference. 18 August 2006, Toronto. [Online]. Available: http://www.who.int/mediacentre/news/releases/2006/pr43/en/index.html [2006, July 24].

UNAIDS. 2002. HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding the Response.

UNAIDS, 2005a. Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Geneva.

UNAIDS, 2005b. UNAIDS Technical Support Division of Labour: Summary & Rationale. Geneva.

UNAIDS, 2005c. UNAIDS Guidelines on construction of core indicators. [Online]. Available: http://www.sarpn.org.za/documents/d0001605/index.php [2006, July 24].

UNAIDS. 2005d. The "Three Ones" in action: where we are and where we go from here. [Online]. Available: http://data.unaids.org/publications/irc-pub06/jc935-3onesinaction_en.pdf [2006, July 24].

UNAIDS. 2005e. Making the Money Work through greater UN support for AIDS responses. [Online]. Available: http://data.unaids.org/publications/irc-pub06/JC1158-MakingMoneyWork_en.pdf [2006, July 24].

UNAIDS. 2006. Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on Construction of Core Indicators. [Online]. Available: http://data.unaids.org/publications [2006, July 24].

WHO, 2003. Global Health Sector Strategy for HIV/AIDS 2003 - 2007. [Online]. Available: http://www.sarpn.org.za/documents/d0000380/index.php [2006, July 24].

World Bank. 1997. Confronting AIDS. Online: www.worldbank.org

World Bank, 2005. The World Bank's Global HIV/AIDS Program of Action. www.worldbank.org

3.2. HIV/AIDS Expenditure and Sources of Funds

Barnett, Courtney, Bhawalkar, Manjiri, Nandakumar, A.K., and Schneider, Pia. (2001). *The Application of the National Health Accounts Framework to HIV/AIDS in Rwanda.* Special Initiatives Report No. 31. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.February 2001.

Guthrie, T., Hickey, A. (eds) 2004. Funding the Fight: budgeting for HIV/AIDS in developing countries. Cape Town: Idasa. [Online]. Available: www.idasa.org.za [2005, February 25].

Hickey, A., Guthrie, T., and Ndlovu, N. 2003. Budgeting for HIV/AIDS in South Africa: Report on Intergovernmental Funding Flows for an Integrated Response in the Social Sector. Cape Town: Idasa AIDS Budget Unit. November 2003.

Hickey, A. 2004. *New allocations for ARV treatment: An analysis of 2004/5 national budget from an HIV/AIDS perspective*. Occasional Paper. 31 May 2004. Idasa AIDS Budget Unit.

Hickey, A., Guthrie, T. 2005. Review of HIV/AIDS Budget Tracking Research. AIDS Budget Unit, Idasa. Available: www.idasa.org.za [2005, August 25].

Hickey, A. 2006. Financial Absorptive Capacity – the South African example. AIDS Budget Unit, Idasa.

Kates, J. 2005. Financing the response to HIV/AIDS in low and middle income countries: Funding for HIV/AIDS from the G7 and the European Commission. The Henry J Kaiser Family Foundation. http://www.sarpn.org.za/documents/d0001507/index.php

Komuhangi, L. 2000. "Impact of Health Sector Ceilings on HIV/AIDS Expenditure in Uganda." Report prepared for Justice Africa UK. November 2000.

Lamourelle, G., Harrison, P. Rowley, J., Warren, M. 2006. "New prevention technologies: trends in resource flows for HIV vaccines and microbicides" in Burke, M.A., de Francisco, A. 2006. Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers. Global Forum for Health Research.

Martin, G. (2003). *A Comparative Analysis of the Financing of HIV/AIDS Programmes in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe.* Cape Town: Human Sciences Research Council. October 2003.

Ndlovu, N. 2005. Budget allocations for HIV and AIDS in 2005/6 provincial social sector budgets: Implications for improved spending. IDASA. [Online]. Available: http://www.sarpn.org.za/documents/d0001511/index.php [2006, July 24].

Ndlovu, N. 2006. A Glimpse at HIV and AIDS Funding in Budget 2006. Factsheet. AIDS Budget Unit, Idasa. [Online]. Available: www.idasa.org.za [2006, Feb 28].

Roberts, R.A., Hickey, A., Rosner, Z. 2006. "The Role of Community Involvement." Chapter in Beck EJ, Mays N, Whiteside A, Zuniga eds. The HIV Pandemic: Global Implications. Oxford: Oxford University Press. (in press).

Schneider, P., Bhatt, P. 2004. *Linking Indicators from National Health Accounts and the NHA HIV/AIDS Subanalysis to Health Policy Goals.* Bethesda, MD: The Partners in Health Reform*plus* Project, Abt Associates Inc. November 2004.

Streak, J. 2005. Government's social development response to children made vulnerable by HIV/AIDS: Identifying gaps in policy and budgeting, IDASA. [Online]. Available: http://www.sarpn.org.za/documents/d0001589/index.php [2006, July 24].

Summers, T. and Kates, J. 2003a. *Global Funding for HIV/AIDS in Resource Poor Settings*. Henry J. Kaiser Family Foundation. December 2003. Available at www.kff.org

Summers, T. and Kates, J. 2003b. *U.S. Government Funding for HIV/AIDS in Resource Poor Settings*. Henry J. Kaiser Family Foundation. December 2003. Available at www.kff.org

UNAIDS, 2006. 2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition. Appendix 3 – Financial Expenditure and Commitments to HIV/AIDS in 97 countries. [Online]. Available: www.unaids.org. [2006, July 24].

UNAIDS. 2005. Resource needs for an expanded response to AIDS in low- and middle-income countries. [Online]. Available: http://data.unaids.org/publications/irc-pub06/resource [2006, July 24].

UNAIDS. 2006. Financing the Response to AIDS. [Online]. Available: http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH10_en.pdf [2006, July 24].

UNAIDS Global Consortium on Resource Tracking. 2005. *National Spending for AIDS 2004.* Prepublication Draft. February 2005.

UNAIDS. 2003. *Report on the State of HIV/AIDS Financing.* Revised/Updated March 2003. [Online]. Available: www.unaids.org [2006, July 24].

U.S. Department of State. 2005a. "The President's Emergency Plan for AIDS Relief: Five-Year Strategy." Fact Sheet, Bureau of Public Affairs, Washington DC. 10 June 2005. [Online]. Available: http://www.state.gove/s/gac/rl/fs/2004/29706.htm [2006, July 24].

U.S. Department of State. 2005b. "U.S. Efforts to Combat the HIV/AIDS Pandemic in Africa." Special Briefing by Randall Tobias, U.S. Global AIDS Coordinator. Washington DC, 13 June 2005. [Online]. Available: http://www.state.gov/s/gac/rl/rm/47810.htm [2006, July 24].

U.S. Department of State. 2004. "Combating HIV/AIDS: The U.S. Global Strategy." Testimony by Ambassador Randall L. Tobias, U.S. Global AIDS Coordinator before the Committee on Appropriations, Subcommitee on Foreign Operations, Export Financing and Related Programs, U.S. House of Representatives. Washington, DC. 18 March 2004. [Online]. Available: http://www.state.gov/s/gac/rl/rm/2004/30564.htm [2006, July 24].

3.2.1. External Aid / Donor Funds for HIV/AIDS

Several donors have conducted their own resource mapping projects. Some of these are available through their websites.

Brugha, R. *et al.* 2004. The Global Fund: managing great expectations. *The Lancet,* Volume 364, Issue 9428, Pages 95-100.

Harinder, J. 2003. *UK AIDS Aid: An Analysis of DFID HIV/AIDS Expenditure*. ActionAid UK. 28 November 2003.

IMF. The IMF's Role in the Fight Against HIV/AIDS. [Online]. Available: http://www.imf.org/external/np/exr/facts/hivaids.htm [2006, July 24].

Kaiser Family Foundation. 2006. Reports on American funding for HIV/AIDS. www.kff.org

Lewis ,M. 2005 . Finance and Development Magazine of the IMF: A War Chest for Fighting HIV/AIDS. [Online]. Available: http://www.imf.org/external/pubs/ft/fandd/2005/12/lewis.htm
[2006, July 24].

Ndlovu, N. 2005. An Exploratory Analysis of HIV and AIDS Donor Funding in South Africa. Budget Brief No. 155. Cape Town: Idasa AIDS Budget Unit.

Oomman, N. (no date). An Overview of the World Bank's Response to the HIV/AIDS Epidemic in Africa, with a Focus on the Multi-Country HIV/AIDS Program (MAP). [Online]. Available: http://www.cgdev.org/doc/HIVAIDSMonitor/OverviewWorldBankMAP.pdf
[2006, July 24].

Schocken, C. Overview of the Global Fund to Fight AIDS, Tuberculosis and Malaria. [Online]. Available: http://www.cgdev.org/doc/HIVAIDSMonitor/OverviewGlobalFund.pdf
[2006, July 24].

Sessions ,M. Overview of the President's Emergency Plan for AIDS Relief (PEPFAR). [Online]. Available: http://www.cgdev.org/doc/HIVAIDSMonitor/OverviewPEPFAR.pdf
[2006, July 24].

USAID. 2004. USAID Southern Africa HIV/AIDS strategic plan fy 2004-2008. [Online]. Available: http://www.sarpn.org.za/documents/d0001278/index.php [2006, July 24].

World Bank. 2004. Interim review of the multi-country HIV/AIDS program for Africa MAP programme. [Online]. Available: http://www.sarpn.org.za/documents/d0001201/index.php [2006, July 24].

3.2.2. Household Expenditure and Impact of HIV/AIDS

Akintola, O. 2004. A gendered analysis of the burden of care on family and volunteer caregivers in Uganda and South Africa. HEARD. [Online]. Available: http://www.sarpn.org.za/documents/d0001119/index.php. [2006, Aug 29]

Baylies, C. 2002. The Impact of AIDS on Rural Households in Africa: A Shock Like Any Other? *Development and Change*. v. 33, iss. 4, pp. 611-32.

Bhorat, H., Shaikh, N. 2005. Poverty and labour market markers of HIV+ households: an exploratory methodological analysis. Development Policy Research Unit, University of Cape Town & Provincial Administration of the Western Cape. [Online]. Available: http://www.sarpn.org.za/documents/d0001490/index.php [2006, Aug 29]

Booysen, F., Bachman, M., Matebesi, Z., Meyer, J. 2004. The socio-economic impact of HIV/AIDS on households in South Africa: pilot study of Welkom and Qwaqwa, Free State Province. University of the Free State, and Centre for Health Systems Research and Development. [Online]. Available: http://www.sarpn.org.za/documents/d0001489/index.php
[2006, Aug 29]

Drimie, S. 2002. The Impact of HIV/AIDS on Rural Households and Land Issues in Southern and Eastern Africa. A Background Paper prepared for the Food and Agricultural Organization, Sub-Regional Office for Southern and Eastern Africa. [Online]. Available: http://www.sarpn.org.za/documents/d0000152/index.php [2006, Aug 29]

Ngalula, J., Urassa, M., Mwaluko, G., Isingo, R., Boerma, JT. 2002. "Health service use and household expenditure during terminal illness due to AIDS in rural Tanzania" in *Tropical Medicine & International Health.* 7(100:873-877.

O'Donnell, M. 2004. Food security, livelihoods and HIV/AIDS: a guide to the linkages, measurement and programming implications. Save the Children. [Online]. Available: http://www.sarpn.org.za/documents/d0000898/index.php [2006, Aug 29]

Petty, C., Selvester, K., Seaman, J., Acidri, J. 2005. Mozambique Assessment: The impact of HIV/AIDS on household economy. Save the Children. [Online]. Available: http://www.sarpn.org.za/documents/d0001546/index.php [2006, Aug 29]

Seaman, J., Petty, C., Acidri, J. 2005. Malawi Assessment: The impact of HIV/AIDS on household economy in two villages in Salima district. Save the Children. [Online]. Available: http://www.sarpn.org.za/documents/d0001545/index.php [2006, Aug 29]

Seaman, J., Petty, C., Narangui, H. 2005. Swaziland Assessment: HIV/AIDS and household economy in a Highveld Swaziland community. Save the Children. [Online]. Available: http://www.sarpn.org.za/documents/d0001549/index.php [2006, Aug 29]

Walker, L., Mhambi, K., Izumi, K. 2004. Women, HIV/AIDS, property rights and livelihoods in Zimbabwe. Institute for Development Studies. [Online]. Available: http://www.sarpn.org.za/documents/d0000868/index.php [2006, Aug 29].

Whiteside, A., Erskine, S. 2002. The impact of HIV/AIDS on Southern Africa`s Children: Poverty of planning and planning of poverty. [Online]. Available: http://www.sarpn.org.za/documents/d0000020/index.php. [2006, Aug 29].

3.3. Cost Effectiveness, Efficiency and Equity Issues in HIV/AIDS Financing

ActionAid International. 2005. Out of Reach: Why money for HIV&AIDS related care is still not reaching those who need it most. [Online]. Available: www.actionaid.org [2005, Sept 22].

Bennett,S., Boerma, JT., Brugha.R. Scaling up HIV/AIDS evaluation. *The Lancet, Volume 367, Issue 9504, 7 January 2006-13 January 2006, Pages 79-82.* [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6T1B-4HYWFTJ-15-1&_cdi=4886&_user=635696&_orig=search&_coverDate=01%2F13%2F2006&_sk=996320495&view=c&wchp=dGLbVtb-zSkWW&md5=0bac4675fed8bebc6a7691a830254e70&ie=/sdarticle.pdf [2006, July 24].

Cleary, S., Boulle, A., McIntyre, D., Coetzee, D. 2004. Cost-Effectiveness of Antiretroviral Treatment for HIV-Positive Adults in a South African Township. Durban: Health Systems Trust. [Online]. Available: http://www.heu.uct.ac.za/. [2005, April 25].

Creese.A. *et al.(*2002). "Cost-effectiveness of HIV/AIDS Interventions in Africa: a systematic review of the evidence". *Lancet*. 359 (9318):1635-43. Available: http://www.sciencedirect.com/science. [2005, May 3].

Gilks, C.F. *et al.* 2006. The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings. *Lancet*. Vol. 368 Issue 9534, p505-510.

Walker, D. 2003. "Cost and Cost-Effectiveness of HIV/AIDS Prevention Strategies in Developing Countries: is there an Evidence Base?" *Health Policy and Planning.* 18(1):4-17. [Online]. Available: http://heapol.oupjournals.org/cgi/content/abstract/18/1/4?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1115219900445_239&stored_search=&FIRSTINDEX=0&sortspec=relevance&volume=18&firstpage=4&journalcode=heapol [2005, May 4].

3.4. Costings of HIV/AIDS interventions – Resource Needs Estimation

Boulle, A. *et al.* (2002). "Exploring the costs of a limited public sector ART programme in South Africa." *South African Medical Journal.* 92 (10):811-817.

Evans, D.B., Lim, S.S., Adam, T., Tan-Torres Edejar, T. & WHO CHOICE MDG Team. 2005. Evaluation of current strategies and future priorities for improving health in developing countries. *BMJ*. 331;1457-1461. [Online]. Available: http://bmj.com/cgi/content/full/331/7530/1457 [2006, Aug 29]

Franklin, L., Desmond, C., Manning, R. 2001.The Costs of HIV/AIDS Care in South Africa: a literature review. Health Economics and AIDS Research Division, University of Natal, Durban. [Online]. Available: http://www.ukzn.ac.za/heard/

Gilks, C. 2000. Costing the Demands for HIV/AIDS Care and Managing Interventions. Paper presented at Kaiser Family Foundation AIDS Forum, KwaZulu-Natal.

Guiness, L., Arthur, G., Bhatt, SM., Achiya, G., Kariuki, S., Gilks, CF. 2002. "Costs of hospital care for HIV-positive and HIV-negative patients at Kenyatta National Hospital, Nairobi, Kenya" in *AIDS*. 16(6):901-8

Guthrie, T. 2006a. "Identifying and measuring costs for HIV+ persons in accessing ARVs and in maintaining their health." University of Cape Town M.P.H (Health Economics). Thesis. (pending).

Guthrie, T. 2006b. Household Health Care Decision Making. Draft paper prepared for M.PH, UCT.

Gutierrez, J.P. *et al.* 2004. Achieving the WHO/UNAIDS antiretroviral treatment 3 by 5 goal : what will it cost? Research Letter. *Lancet*. Vol364:63-64.

Hansen, K., Woelk, G., Jackson, J. *et al.* 1998. "The cost of home-based care for HIV/AIDS patients in Zimbabwe" in *AIDS Care*. 19:751-9. [Online]. Available: http://weblinks1.epnet.com/citation.asp [2005, May 3].

Hansen, K., Chapman, G., Chitsike, I., Kailo, O., Mwaluko, G. 2000. "The costs of HIV/AIDS care at government hospitals in Zimbabwe" in *Health Policy & Planning*. 15(4):432-440.

Haile, B. (2000). "Affordability of Home-based Care for HIV/AIDS" in *South African Medical Journal*. 90(7):690-691.

Haile,B. 2000b. The Costs of Adult Inpatient Care for HIV Diseases at GF Jooste Hospital. Health Economic Unit, UCT. [Online]. Available: http://www.heu.uct.ac.za/ [2005, April 29].

Johnson, S. *et al*. 2001. "Home-based Care for People with HIV/AIDS in South Africa – What will it cost?" Centre for Health Policy, Dept of Community Health, University of Witwatersrand.

Karstaedt, A., Lee, T., Kinghorn, A., Schneider, H. (1998). *Care for HIV-infected Adults at Baragwanath Hospital, Soweto.* "Part III: Management and Costs of Inpatients."

Kinghorn, A., Lee,T., Karstaedt, A., Khuonane, B. Schneider,H. (1996). "Care for HIV-Infected Adults at Baragwanath Hospital, Soweto". *South African Medical Journal.* 86(11):1490-4.

Levy, A., James, D., Johnston, K.M., Hogg, R.S., Harrigan, P.R., Harrigan, B., Sobolev, B., Montaner, J.S. The direct costs of HIV/AIDS care . *The Lancet Infectious Diseases, Volume 6, Issue 3, March 2006, Pages 171-177.* [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6W8X-4J9WSCX-10-1&_cdi=6666&_user=635696&_orig=search&_coverDate=03%2F31%2F2006&_sk=999939996&view=c&wchp=dGLbVtb-zSkWW&md5=c9e994514b3bfe7f3c03333b49ab0473&ie=/sdarticle.pdf [2006, July 24].

Nandakumar, A.K,. Schneider, P., Butera, D. (2000). *Use of and Expenditures on Outpatient Health Care by a Group of HIV Positive Individuals in Rwanda.* Bethesda, MD: Partnerships in Health Reform Project, Abt Associates Inc. July 2000.

Nelson, EAS., Weikert, M., Phillips, JA. 1995. "Paediatric Treatment Costs and the HIV epidemic" in *Central African Journal of Medicine.* 41:139-44.

UNAIDS, 2004. Costing Guidelines for HIV/AIDS Intervention Strategies. [Online]. Available: http://data.unaids.org/publications [2006, July 24].

Vassall, A., Compernolle,P. Estimating the resource needs of scaling-up HIV/AIDS and tuberculosis interventions in sub-Saharan Africa: A systematic review for national policy makers and planners. *Health Policy, In Press, Corrected Proof, Available online 4 January 2006.* [Online]. Available: http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6V8X-4HYN4YB-2-1&_cdi=5882&_user=635696&_orig=search&_coverDate=01%2F04%2F2006&_sk=999999999&view=c&wchp=dGLbVtb-zSkWW&md5=6999f0bf70548a09dc6517a426a88c10&ie=/sdarticle.pdf [2006, July 24].

3.5. HIV/AIDS Socio-Economic and Macro-Economic Impact Assessments

ActionAid International USA. (2005). *Square Peg, Round Holes, and Why You Can't Fight HIV/AIDS with Monetarism.* An issue briefing by Rick Rowden, ActionAid International USA. March 2005.

Barnett, T. & Whiteside, A. 2006. AIDS in the Twenty-First Century (*Fully revised and updated version).* [Online]. Available: http://www.ukzn.ac.za/heard/publications/publicationsBooks.htm [2006, August 7].

Bollinger, L., Stover, J. 1999. The Economic Impact of AIDS in South Africa. The Policy Project.

Bureau for Economic Research (BER). 2005. The Impact of HIV/AIDS on Selected Business Sectors in South Africa.

BER, 2006. The Macro-economic impact of HIV/Aids under alternative intervention scenarios (with specific reference to ART) on the South African economy. [Online]. Available: http://www.ber.sun.ac.za/downloads/2006/aids/Final%20Aids%20Report_Jun06.pdf [2006, August 1].

de Waal, A. 2003 Macro-Economic Implications of HIV/AIDS. [Online]. Available: http://www.sarpn.org.za/documents/d0000362/index.php [2006, Aug 29]

Feeley, R., Rosen, S., Fox, M., Macwan'gi, M., Mazimba, A. 2004. The costs of HIV/AIDS among professional staff in the Zambian public health sector. Central Board of Health. [Online]. Available: http://www.sarpn.org.za/documents/d0001271/index.php [2006, Aug 29]

Fourie, P., Schönteich, M. 2001. DIE, the beloved countries: Human security and HIV/AIDS in Africa. [Online]. Available: http://www.sarpn.org.za/documents/d0000177/index.php [2006, Aug 29]

Haacker, M. 2002. The Economic Consequences of HIV/AIDS in Southern Africa. IMF Working paper.

Haacker,M. 2004 . The Macroeconomics of HIV/AIDS. [Online]. Available: http://www.imf.org/external/pubs/ft/AIDS/eng/index.htm [2006, July 24].

Jayne, T.S. 2004. Measuring Impacts of HIV/Aids on African Rural Economies. [Online]. Available: http://www.sarpn.org.za/documents/d0000861/index.php [2006, Aug 29]

Lewis, M. (2005). "Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues." Centre for Global Development, Working Paper Number 58. 26 April 2005.

Lowenson, R., Whiteside, A. 1997. "Social and Economic Issues of HIV/AIDS in Southern Africa". SAfAIDS Occasional paper Series 2. Harare.

Marais, H. 2005. Buckling - The impact of AIDS in South Africa. Centre for the Study of AIDS, University of Pretoria. [Online]. Available: http://www.sarpn.org.za/documents/d0001789/index.php [2006, Aug 29].

Mhone, G. 2002. "The economic impact of HIV/AIDS in Africa" in USAID. HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response.

Mutangadura, G.B. 2005. Gender, HIV/AIDS and rural livelihoods in Southern Africa: Addressing the challenges. *A Journal of Culture and African Women Studies*. [Online]. Available: http://www.sarpn.org.za/documents/d0002034/index.php [2006, Aug 29]

Ojo, K., Delaney, M. 1997. "Economic and demographic consequences of AIDS in Namibia: rapid assessment of the costs" in *Int.J.Health Planning & Management*. 12(4):315-26.

Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA). 2005. Developing regional guidelines on HIV/AIDS in the informal cross-border trade sector in the SADC region [Online]. Available: http://www.sarpn.org.za/documents/d0001636/index.php [2006, Aug 29]

Thirumurthy, H., Graff Zivin, J., Goldstein, M. (no date). The economic impact of AIDS Treatment: Labor supply in Western Kenya. [Online]. Available: http://www.sarpn.org.za/documents/d0001904/index.php [2006, Aug 29]

UNAIDS. 2000. Socio-Economic Impact of HIV/AIDS in Africa. [Online]. Available: www.unaids.org [2006, Aug 29]

UNAIDS. 2002. HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response. [Online]. Available: www.unaids.org [2005, May 3].

Veenstra, N. & Whiteside, A. 2005. 'Economic Impact of HIV' *in Best Practice & Research Clinical Obstetrics and Gynaecology*, 19 (2): 197-210.

Whiteside, A. 2005. 'The economic impact of AIDS' in: Karim, A. & Karim, Q.A. (eds), HIV/AIDS in Africa, Cape Town: Cambridge University Press, p. 367 – 380. [Online]. Available: http://www.ukzn.ac.za/heard/publications/publicationsBooks.htm#Global_Health_and_Governance [2006, August 7].

Whiteside, A. & Barnett, T. 2002. Chapter 11, Poverty and HIV/AIDS: Impact, Coping and Mitigation Policy in Cornia, G.A. AIDS, Public Policy and Child Well-being, (UNICEF). [Online]. Available http://www.ukzn.ac.za/heard/publications/publicationsBooks.htm#Global_Health_and_Governance [2006, August 7].

3.6. Human Resources – capacity, brain drain etc

Chen L. 2005. HIV/ AIDS and human resources [Editorial]. Bulletin of World Health Organization 2005;83(4): 243–44.

Chen, L. *et al*. 2004. Human resources for health: overcoming the crisis. . *Lancet*. Vol. 364 Issue 9449, p1984-1990.

Lincoln, C., Hanvoravongchai, P. 2005. HIV/AIDS and human resources. *Bulletin of the World Health Organization*. Vol. 83 Issue 4, p243-243.

Kober K, van Damme W. 2004. Scaling up access to antiretroviral treatment in southern Africa: who will do the job? *Lancet*. 364(9428):103–07.

Marchal, B,. De Brouwere, V., Kegels, G. 2005. Viewpoint: HIV/AIDS and the health workforce crisis: What are the next steps? *Tropical Medicine & International Health*. Vol. 10 Issue 4, p300-304.

Shisana O, Hall E, Maluleke KR, et al. 2002. The Impact of HIV/AIDS on the Health Sector: National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities. Pretoria. Human Sciences Research Council, Medical University of South Africa, Medical Research Council, 2002.

Tawfik L, Kinoti S. 2002. The Impact of HIV/AIDS on the Health Sector in Sub-Saharan Africa: the Issue of Human Resources. Washington DC: SARA, AED, USAID.

WHO, 2006a. Treat , Train, Retain: The AIDS and Health Workforce Plan. Report on the Consultation on AIDS and Human Resources for Health. Geneva, 11-12 May, 2006.

WHO, 2006b. 'Treat, Train, Retain': The AIDS and health workforce initiative. DISCUSSION PAPER.

WHO, 2006c. 'Treat, Train, Retain': The elements of "Treat". Discussion paper.

WHO, 2006d. 'Treat, Train, Retain': The elements of "Train". Discussion paper.

WHO, 2006e. 'Treat, Train, Retain': The elements of "Retain". Discussion paper.

WHO, 2006f. 'Treat, Train, Retain': Financing issues.

WHO, 2006h. 'Treat, Train, Retain': At a glance. SUMMARY PAPER.

3.7. HIV/AIDS Drug Production, Patents , Pricing, Pharmaceuticals

Borrell, J.R. 2005. Patents and the Faster Introduction of New Drugs in Developing Countries *Applied Economics Letters*. v. 12, iss. 6, pp. 379-82.

Gray, R., Habiyambere, V., Renaud-Thery, F. 1998. Ensuring access to AIDS drugs. World Health, Vol. 51 Issue 6.

Kapp, C. 2002. Drug firms' representatives express concern over WHO's AIDS drug list. . *Lancet*. Vol. 359 Issue 9312, p1134.

Vasan, A. *et al.* 2006. The pricing and procurement of antiretroviral drugs: an observational study of data from the Global Fund. Bulletin of the World Health Organization. Vol. 84 Issue 5, p393-398,

WHO Drug Information, 2005. Improving medicines quality through prequalification. Vol. 19 Issue 1, p35-36.

WHO Drug Information, 2004. Procurement of medicines in HIV. Vol. 18 Issue 4, p297-297.

WHO Drug Information, 2002. Pilot Procurement Project for Quality and Sourcing (Pre-qualification) of HIV/AIDS drugs. Vol. 16 Issue 1, p31.

WHO Drug Information, 2002. Current status of the project. Vol. 16 Issue 1, p31.

APPENDIX 2 ~ KEY PLAYERS IN THE FIELD OF HIV/AIDS FINANCING - OVERVIEW OF EXISTING ACTIVITIES

The HIV/AIDS field is characterised by many actors and activities, often fragmented and duplicative, not necessarily complimentary. Broadly they may be categorised into those that are sources of funds, those that are agents (or managers) of funds, and those that spend the funds in service delivery (the providers). Often an organisation or body may fulfil more than one of these functions, and may be all three. In an attempt to enhance the co-ordination between the players, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors presented the Division of Labour between UNAIDS, WHO and the World Bank (WB) (refer to UNAIDS 2005).

Research and policy development activities in the field of health and HIV/AIDS financing may be broadly categorised by the level of their scope. These are listed below, and then the activities of the key ones are discussed further. Note that the sources of funds are not all listed here, but only in so for as they influence or promote research and policies with regard to financing for HIV/AIDS.

Note that the government structures are also not listed here, but it is acknowledged that the National AIDS Commissions (NACs) and the National AIDS Control Programmes (NACPs - usually situated in the Ministries of Health) are the critical players in terms of the planning, coordination and monitoring of the national responses to HIV/AIDS.

Agencies/Organisations with international scope and focus in HIV/AIDS financing research or policy development

- WHO Evidence and Information for Policy (EIP) cluster - Health Systems Financing Unit (Costs, Effectiveness, Expenditure and Priority Setting)
- UNAIDS Resource Tracking Unit
- UNAIDS NASA initiatives
- UNAIDS Resource Needs Estimations Unit
- Futures Institute – costings and resource needs model development
- World Bank AIDS Strategic Action (ASA) Plan
- GFATM
- Gates Foundation
- IDPF / UNITAID
- PHR*plus* assists national governments to undertake National Health Accounts and have recently begun HIV/AIDS sub-analyses.
- UNDP is interested in addressing HIV/AIDS as a development issue.
- UNFPA/UNAIDS/NIDI Resource Flows Project – measuring aid for reproductive rights, including HIV/AIDS.
- Economica y Politicas de la Salud Instituto Nacional de Salud Publica, Mexico. – economic analyses of HIV/AIDS impact, costings and estimations of the resource gap.

- Action Aid International supports their civil society partners to monitor public spending on HIV/AIDS.
- Open Society Initiative and Soros Foundations have recently begun to support their Foundations to undertake health and HIV/AIDS budget and expenditure monitoring activities.
- The International Budget Project (IBP) trains and supports civil society groups to monitor and influence government budget processes, institutions and outcomes. The overarching aim of the project is to make budget systems more responsive to the needs of society and, accordingly, to make these systems more transparent and accountable to the public. The IBP also considers health budgets specifically. (http://www.internationalbudget.org/)
- Medicine Sans Fronteirs (MSF) – an international humanitarian aid organisation that provides emergency medical assistance to populations in danger in more than 70 countries (http://www.msf.org). MSF is also a provider of ARV treatment services in several countries, and has produced several articles and reports on the challenges of scaling up treatment services.
- London School of Hygiene and Tropical Medicine – Britain's national school of public health undertakes health financing research in a number of countries.

Organisations / Networks operating in Africa with HIV/AIDS focus[21]

- The Centre for Economic Governance and AIDS in Africa (CEGAA) - aims to contribute to improved economic governance, fiscal policy and financial management and accountability, with specific attention to improving the response to HIV and AIDS in Africa. CEGAA undertakes economic and budget analysis research, training and advocacy activities in order to provide evidence of, and possible solutions to, the fiscal and administrative challenges that face so many African countries in their fight against HIV and Aids.
- Health Economics Unit, University of Cape Town – health and HIV/AIDS service costings, modelling, economic evaluations, teaching unit. Importantly, the HEU supports and trains African health economists, a critical profession in the planning, implementation and monitoring of effective financing mechanisms required for the HIV/AIDS response.
- East African Treatment Access Movement (EATAM) – monitors public HIV/AIDS spending.
- Kenyan Treatment Access Movement (KTAM) – monitors public HIV/AIDS spending.
- Nairobi University, Economic Department – undertakes HIV/AIDS costing, resource tracking, budget monitoring and economic evaluations.
- Economic and Social Research Foundation (ESRF), Tanzania – undertakes HIV/AIDS resource tracking.

[21] Note that all the activities at national level could not be captured. It is acknowledged that several other national initiatives may exist in other African countries.

- Institute for Development Research, University of Addis Ababa, Ethiopia – undertakes HIV/AIDS resource tracking.
- Civil Society Network on HIV/AIDS in Nigeria (CiSNHAN) – general monitoring of HIV/AIDS activities and budgets.
- Malawi Economic Justice Network (MEJN) – undertakes HIV/AIDS resource tracking.
- Institute for Economic and Social Research (INESOR), Zambia – undertakes HIV/AIDS resource tracking.
- Treatment Access Campaign (TAC) – monitors the roll-out of the public ARV programme, systems monitoring, access to information.
- AIDS Budget Unit, Idasa – undertakes HIV/AIDS budget monitoring and supports other agencies in the same.
- SADC Secretariat – HIV/AIDS resource monitoring as part of its Strategic Plan.
- Health Economics and AIDS Research Division (HEARD) –conducts research on the socio-economic aspects of public health, especially the HIV/AIDS pandemic. While HEARD is based in South Africa at the University of KwaZulu-Natal, its operations are international in scope. It undertakes a range of socio-economic impact assessments and related research. Importantly HEARD offers management and other skills development for civil servants and others. (http://www.ukzn.ac.za/heard)
- Centre for Social Science Research (CSSR), University of Cape Town – economic impact assessment of HIV/AIDS in South Africa.
- University of Free State – household impact analysis – health and HIV/AIDS.
- Joint Civil Society Monitoring Forum (JCSMF) - monitors the roll-out of the public ARV programme, systems monitoring, access to information.
- Centre for AIDS Development, Research and Evaluation (CADRE), Rhodes University
- Bureau for Economic Research (BER) – HIV/AIDS impact economic analysis in South Africa.

Health financing or social sector/development spending focus

- Ugandan Debt Network – undertakes public budget monitoring, including health spending.
- Regional Network on Equity in Health in Southern Africa (EQUINET)
- Civil Society Poverty Reduction (Zambia) - undertakes public social sector expenditure monitoring.
- Centre for Budget Advocacy, ISODEC, Ghana - undertakes public budget monitoring.
- Catholic Commission for Justice, Development and Peace (CCJDP, Zambia) - undertakes public budget monitoring.
- Poverty Action Network Ethiopia (PANE) - undertakes public budget monitoring.

Other Regional Organisations

- Economic Literacy and Budget Analysis Group (ELBAG), India - undertakes public budget monitoring.
- SIDALAC (Latin American organisation) – undertakes HIV/AIDS resource tracking.
- FUNDAR (Mexican based) - undertakes public budget monitoring.

Specific details on the following key players:

World Bank

The Global Task Team (GTT) sub-committee on strategy and financing noted that: "poor planning will inevitably result in a lack of priority setting and the ineffective use of funds available. Well-elaborated national AIDS action frameworks (strategies) and annual AIDS priority action plans are therefore prerequisite for successful implementation of (national) programs and projects". In addition, countries requested assistance in improving strategies and preparing annual action plans in order to facilitate their desire to move from project to program funding (World Bank website, 2006).

The UN Technical Support Division of Labor designated the World Bank as lead organization in supporting strategic, prioritized, costed national plans, with the ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF and WHO as the main partners. In addition, at their first coordination meeting in January 2006, the Global Fund to fight AIDS, Tuberculosis, and Malaria, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) established a working group of the three donors to coordinate with the AIDS Strategy and Action Plan (ASAP).

AIDS Strategy & Action Plan (ASAP)

A global technical assistance service, the AIDS Strategy & Action Plan, or ASAP, responds to country requests for support in developing well-prioritized, evidence-based, results-focused, costed AIDS strategies and action plans. ASAP is hosted by the World Bank on behalf of UNAIDS.

AIDS specialists from UNAIDS organizations, non-UN institutions and local and international consultants undertake country and regional-level technical support activities on demand. Countries at any level of national HIV/AIDS strategy planning can request assistance, as well as peer reviews from ASAP. ASAP has also developed a scorecard-style tool (with guidelines) that countries can use themselves to assess their strategies (World Bank website, 2006).

At the "The Global Response to AIDS: 'Making the Money Work', The Three Ones in Action" meeting, held in London on 9 March 2005, leaders from donor and developing country governments, civil society, UN agencies and other multilateral and international institutions met in London, and agreed to form:

- A Global Task Team on improving coordination among multilateral institutions and international donors to further strengthen the AIDS response in countries.

The particular focus is on how the multilateral system can streamline, simplify and further harmonize procedures and practices to improve the effectiveness of country-led responses and reduce the burden placed on countries.

World Bank MAP Program

The World Bank Multi-County AIDS Program in Africa (Africa MAP), launched in 2000, is one of many World Bank programs for HIV/AIDS assistance and specifically aims to provide long-term support (10-15 years) to combat HIV/AIDS and mitigate its impact in African countries. Designed to be demand-driven, multi-sectoral and often community oriented, the Africa MAP is clearly different from traditional World Bank lending, although projects are intended to fit within the country's development strategy and the Bank's strategy for overall lending in that country. (Oomman, no date).

The Africa MAP initiative is dedicated to financing the HIV/AIDS strategies of recipient countries. Although the World Bank headquarters does provide general guidance for different activities for concentrated and generalized epidemics, there is no attempt centrally to prioritize activities or objectives in implementation. Instead, program priorities are determined by the World Bank country project team in conjunction with the recipient-country governments and generally align with the country's existing strategic documents, including the National AIDS Strategy, the Poverty Reduction Strategy Paper and the World Bank Country Assistance Strategy. Generally, World Bank funding is disbursed to the National AIDS Councils, although it may then be obligated to ministries, civil society organizations, private sector entities, in line with the agreement.

Global HIV/AIDS Program

Founded in 2002, the Global HIV/AIDS Program sits within the Human Development Network of the World Bank and is responsible for supporting the cross-sectoral nature of programming in this area. Although separate from the regional HIV/AIDS initiatives, the Global HIV/AIDS Program supports Work Bank-wide programs by facilitating shared lessons and improved implementation practices, including monitoring and evaluation. In addition, the Global HIV/AIDS Program supports the World Bank in its efforts to mainstream HIV/AIDS into all sectors such as education, transport, urban development and water supply and sanitation projects. (Oomman, no date).

The World Bank's Global HIV/AIDS Program of Action emphasizes five priority action areas, in keeping with our commitment to the "Three Ones" principles of one national strategic plan, one national coordinating authority and one national monitoring and evaluation system in each country. The interrelated action areas are:

1. support for strengthening national HIV/AIDS strategies to be more prioritized and evidence-driven, and better integrated with national planning processes;
2. sustained funding for national and regional HIV/AIDS programs and for strengthening health systems;
3. accelerating implementation of national program plans;

4. strengthening country monitoring and evaluation systems and capacity to collect, analyze and use data; and
5. generating and sharing knowledge, through evaluations and other analytic work to deepen the impact of programs.

Source: World Bank (2005).

Team Leaders (TTLs) are responsible for specific country HIV/AIDS projects, regional teams such as the ActAfrica team are directly responsible for the overall coordination and implementation of regional programs such as the Africa MAP. Although ActAfrica works with the country-teams on specific country implementation and support for strategy development, it serves as the region's focal point and clearinghouse of HIV/AIDS information, including providing information to countries in the region. (Oomman, no date).

WHO Health Systems Financing Department

The Health Systems Financing (HSF) Department seeks to contribute knowledge to the improvement of financing mechanisms for health systems generally. Health systems strengthening falls under the Evidence and Information for Policy (EIP) cluster, which collaborates closely with other key clusters and their departments and WHO's six Regional Offices. The HSF Department began its work in 2003, and has focused on five broad areas:

- Health financing policy
- Access, financial catastrophe and impoverishment
- Priority setting
- Costs of scaling up interventions, and
- Current availability and use of resources.

The HSF department has two units: Costs, Effectiveness, Expenditure and Priority Setting (CEP) and Health Financing Policy (HFP).

The CEP unit has undertaken extensive costing and cost-efficiency studies of health interventions and has developed the CHOICE database of unit costs and outcomes of health interventions in the different regions, and their effectiveness. The database incorporates interactions in costs and effects when interventions are undertaken concurrently, and at varying levels of coverage. The standardised methods enhance comparability across countries and regions (Evans *et al*, 2005). With regard to HIV/AIDS-specific interventions analysis, the Unit has done some cost-effectiveness analysis which allows for important comparisons between interventions. Also important is the contribution to the data on actual health expenditure in-country through the National Health Accounts which provide comprehensive data on public, private and external sources for health expenditure. More recently, sub-analyses on HIV/AIDS expenditure have been conducted. These are valuable, but primarily focus on those expenditures within the health sector. Non-health sector spending on HIV/AIDS is poorly categorized.

The HFP unit produces Technical Briefs for policy-makers. "Technical briefs for policy are succinct summaries of key policy issues, explaining what the issue is, why it is important, and how policymakers can address the issue". Importantly the unit considers catastrophic health expenditure, which often forces poor households further into impoverishment, and which critically applies in the case of HIV/AIDS due to the prolonged nature of the illness, and the long-term burden on households.

Overall, the HSF articles can be categorized under the following topics: Health financing mechanisms, Out of pocket payments, National Health Accounts (more recently including HIV/AIDS sub-analyses), Choosing Interventions that are Cost-Effective (CHOICE), Costs and Cost Analysis, Contracting, and Health Insurance.

The HIV/AIDS Department within the WHO

The HIV/AIDS Department within the HIV, TB and Malaria cluster of WHO, provides evidence-based, technical support to WHO Member States to help them scale up treatment, care and prevention services as well as drugs and diagnostics supply to ensure a comprehensive and sustainable response to HIV/AIDS (http://www.who.int/hiv/en/). The units within the HIV Department are: Prevention in the Health Sector, ART and HIV Care, Regional & Country Coordination, Strategic Information, and the new Health Systems Strengthening .

The HIV Department, in conjunction with UNAIDS produces Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, which collate the most recent country-specific data on HIV surveillance, monitoring, prevention and treatment as well as related maps and graphics.

UNAIDS Resource Needs Estimation Team

This unit within UNAIDS focuses on estimating the total costs of a national HIV/AIDS programmes, consisting on the essential components and based on various estimations of uptake. The global estimation collected the unit costs in differing countries in different regions, aggregated these to a global level and reported that "The revised estimates indicate global resource requirements amount to US$ 15 billion in 2006, US$ 18 billion in 2007 and US$ 22 billion in 2008 for prevention, treatment and care, support for orphans and vulnerable children (OVC), as well as programme and human resource costs. The financial requirements for human resources and programme costs are preliminary, and will form the basis for future refinement and improvement of the estimates" (UNAIDS, 2005:3).

An important initiative has been the development of the Resource Needs Model (RNM), developed by Futures and the University of Cape Town (and others) for the purpose of assisting countries to estimate their specific resource needs, especially with regard to their costing of their national strategic plans, and for their universal access targets.

UNAIDS Resource Tracking and Projections Team[22]

The Resource Tracking and Projection (RTP) was established relatively recently within the UNAIDS Executive Office, so as to be a cross-cutting function. The RTP unit sits within the Evaluation department, which has three units:

- monitoring operations research and evaluation (MnE),
- CHRIS (a data collection tool for country indicators to track progress towards the UNGASS goals), and the
- RTP unit.

The RTP focuses on tracking global financial commitments to HIV/AIDS, tracking national public commitments to attain the UNGASS financial goals (using the NASA techniques), as well as attempting to project future commitments. Recently, the activity of estimating resource needs was added to the Unit's responsibilities (using the resource needs model). With regard to the GGT division of labour, the responsibility of UNAIDS is the generation of strategic information, under which the activities of the RTP Unit are seen as falling.

The Unit is constantly being asked to produce figures on what is being spent, but the process faces many challenges. Often the donor reports do not match the reports from countries. It is also difficult to reconstruct multi- and bi-lateral agency commitments. Often the definitions used for donor commitments or disbursements are not in line with any existing methodologies eg OECD's or NASA's. While it is easier to incorporate the multi- and bi-lateral and some larger international commitments, it is most difficult to estimate the domestic (national) commitments, and actual expenditures. At this level, data is limited, weak and different methods are being used. The Unit plans to revise its 2004 projections in 2007, with improved data sources. The RTP Unit is trying to harmonise the definitions and methods to allow for greater global comparisons. The Unit has been collaborating with OECD and NIDI to track global commitments, and with 2 USA organisations to track the disbursements from philanthropic and international NGOs for HIV/AIDS.

With regard to tracking of domestic expenditure on HIV/AIDS, the NASA methodology is the main tool being promoted by UNAIDS, which provides the framework for the reconstruction of all HIV-related financial transactions, and provides a well-developed classification of all sources, providers and functions.

Recently, it was decided that the Evaluation Department should take on the global resources needs estimation, which is to be merged with the resource tracking efforts. These estimations have been undertaken by UNAIDS on 6 occasions, however, initially their efforts did not collect country-level data, and their estimations were not accepted as accurate[23]. They are now placing more effort on the country-specific unit costs of interventions. There is now some pressure to produce figures early in 2007, for actual expenditures, projected commitments, and for global resource needs. This will be

[22] The information presented here was kindly provided by Jose Antonio Izazola in an interview, Sept, 2006.
[23] Interview with Robert Greener, Economic Advisor for UNAIDS. Sept, 2006.

challenging. With regard to estimating resource needs, it relies upon some agreement at country level of the acceptable universal targets. The question is whether the RTP Unit should cost the 'ideal' package of global universal coverage, or should countries select their more realistic targets and these be costed?

In addition, the RTP Unit convenes a Global Consortium of Resource Tracking for HIV/AIDS. This group of experts involved in various resource tracking activities serves as a reference group, with sub-working groups addressing specific activities (such as resources for vaccines, preventative medicine and microbicides). The Consortium was established in 2004, and has produced 3 publications. These have included papers on OOPE, absorptive capacity and bottlenecks, but it was recognised that further analysis could be undertaken using the data produced by NASAs in-country. The RTP also made a valuable contribution to the 2006 Global AIDS Report (UNAIDS 2006, appendix 3), where it reconstructed financial trends from 2001-2005 for 97 countries.

At a recent meeting (August 2006) to discuss the NASA methodology, emphasis was placed on harmonizing the RNM with the NASA methods, and the complimentarity of the activities. Importantly, the UNAIDS is attempting to compare the estimates of global resource needs against the identified actual expenditure, so as to estimate the 'resource gap'. This is calculated according to the key programmatic components of a national response (e.g. prevention, treatment, care and support, etc.), so as to identify those areas requiring greater financial commitment.

UNAIDS also convenes a Economic reference group (one of many), which was intended to contribute to the coordination of all efforts, but the group has not met for almost 2 years. World Bank is involved and is co-funding the group[24]. However, the status of this group is now unclear with the GTT division of labour.

[24] *Ibid.*

APPENDIX 3: GTT DIVISION OF LABOUR (UNAIDS, 2005b)

The Global Task Team indicated 2 technical support areas that are linked with health financing, in which WHO are the Main Partners. These are shown in the table below:

Technical support areas	Lead organization	Main partners
1. STRATEGIC PLANNING, GOVERNANCE AND FINANCIAL MANAGEMENT		
HIV/AIDS, development, governance and mainstreaming, including instruments such as PRSPs, and enabling legislation, human rights and gender	UNDP	ILO, UNAIDS Secretariat, UNESCO, UNICEF, WHO, World Bank, UNFPA, UNHCR
Support to strategic, prioritized and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work.	World Bank	ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF, WHO

Technical support areas	Lead Organizations	Main Partners
1. STRATEGIC PLANNING, GOVERNANCE AND FINANCIAL MANAGEMENT		
HIV/AIDS, development, governance and mainstreaming, including instruments such as PRSPs, and enabling legislation, human rights and gender	UNDP	ILO, UNAIDS Secretariat, UNESCO, UNICEF, WHO, World Bank, UNFPA; UNHCR
Support to strategic, prioritized and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work	World Bank	ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF, WHO
Procurement and supply management, including training	UNICEF	UNDP, UNFPA, WHO, World Bank
HIV/AIDS workplace policy and programmes, private-sector mobilization	ILO	UNESCO, UNDP
2. SCALING UP INTERVENTIONS		
Prevention		
Prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually-transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services	WHO	UNICEF, UNFPA, ILO
Provision of information and education, condom programming, prevention for young people outside schools and prevention efforts targeting vulnerable groups (except injecting drug users, prisoners and refugee populations)	UNFPA	ILO, UNAIDS Secretariat, UNESCO, UNICEF, UNODC, WHO
Prevention of mother-to-child transmission (PMTCT)	UNICEF, WHO	UNFPA, WFP
Prevention for young people in education institutions	UNESCO	ILO, UNFPA, UNICEF, WHO, WFP
Prevention of transmission of HIV among injecting drug users and in prisons	UNODC	UNDP, UNICEF, WHO, ILO
Overall policy, monitoring and coordination on prevention	UNAIDS Secretariat	All Cosponsors
Treatment, care and support		
Antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections (adults and children)	WHO	UNICEF
Care and support for people living with HIV, orphans and vulnerable children, and affected households.	UNICEF	WFP, WHO, ILO
Dietary/nutrition support	WFP	UNESCO, UNICEF, WHO
Addressing HIV in emergency, reconstruction and security settings		
Strengthening HIV/AIDS response in context of security, uniformed services and humanitarian crises	UNAIDS Secretariat	UNHCR, UNICEF, WFP, WHO, UNFPA
Addressing HIV among displaced populations (refugees and IDPs)	UNHCR	UNESCO, UNFPA, UNICEF, WFP, WHO, UNDP
3. MONITORING AND EVALUATION, STRATEGIC INFORMATION, KNOWLEDGE SHARING AND ACCOUNTABILITY		
Strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy, and monitoring and evaluation, including estimation of national prevalence and projection of demographic impact	UNAIDS Secretariat	ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO, World Bank
Establishment and implementation of surveillance for HIV, through sentinel/population-based surveys	WHO	UNAIDS Secretariat