HAS DONOR PRIORITIZATION OF HIV/AIDS CONTROL DISPLACED AID FOR OTHER HEALTH CAUSES?

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It is an unfortunate reality that budgeting procedures too often may mean that new funds for HIV and AIDS can draw resources away from other activities, either at country level, or at donor level. Therefore, all parties need to commit themselves to the principle that additional funding for HIV and AIDS is to be used for additional spending, otherwise displacement is inevitable to the detriment of overall development.

-- from 2004 UNAIDS Report[1]

Introduction

As attention by bilateral and multilateral donors to the prevention, control and treatment of HIV/AIDS increases, advocates for other health issues affecting the poor have expressed concern that this prioritization may have adversely affected funding for and attention to other health and population causes. Such concerns have been particularly prominent among reproductive health and population scholars and advocates,[2] although not limited to this group. Those involved with tobacco control, tuberculosis and child immunization, among other causes, have also expressed the same concern.[3] Even organizations dedicated to HIV/AIDS prevention and control have acknowledged a potential problem, as the excerpt above from a 2004 UNAIDS report indicates. A number of analysts have suggested that such competition and funding for scarce resources is counter-productive,[4] arguing that interventions to address HIV/AIDS such as condom promotion can serve a variety of health causes, champions of different issues ought to work collaboratively, and the deeper aim should be to build health systems capacities so that all major health problems of the poor can be addressed.[5] Collaboration has not been so easy to generate, however, as networks of advocates have mobilized around specific health causes that have competed for scarce donor funding, resources that have been allocated based not just on need but also on political considerations.

While many concerns have been raised, the precise effects of donor prioritization of HIV/AIDS prevention and control on donor funding for other health causes have not been examined. In this paper I consider funding for health and population from major bilateral and multilateral donors over the past decade in an initial attempt to investigate this issue. I take no normative position on *how* donor health and population resources should be allocated, save to note that there are very good reasons each of the causes discussed in this paper deserve significantly greater attention than they receive, including HIV/AIDS. This research, rather, has empirical rather than normative aims. Presumably, though, empirical conclusions from this paper and other research on donor funding may be useful for future policy decision-making.

Background

A number of dynamics may contribute to displacement. Donors have hard-budget constraints. If a donor chooses to augment funding for one cause, it must decrease funding for other causes unless it can secure additional resources.[6] Also, bandwagon effects may occur among donors. As influential donors prioritize a particular cause, others may follow, leading to the neglect of other issues.[7] In addition, national health systems must manage donor resources, diverting scarce capacity away from other causes.[8]

On the other hand, if some donors prioritize one cause, others may divert resources to additional issues. National authorities may do the same, a fungibility effect.[9] Also, funds provided for a particular cause may build national infrastructure that can support other causes, as advocates of global polio eradication have argued concerning vaccination for other diseases. In addition, global attention to a major health issue such as HIV/AIDS may have helped galvanize international support for the general issue of addressing the health causes of the poor, benefiting other health issues.

This paper considers only aggregate donor funding, so one must be cautious in drawing broad inferences on HIV/AIDS displacement effects from these data alone. I do not analyze national health funding so we can draw no conclusions about donor effects on country-level resources. Also, many factors besides HIV/AIDS prioritization influence funding levels for other health causes, including the burden of particular conditions and the advocacy effectiveness of their champions. A complete analysis of HIV/AIDS displacement effects requires controlling for these factors. In addition, the HIV/AIDS agenda may be influencing other health causes in ways not revealed by funding trends, for instance by diverting donor and national *human* resources toward HIV/AIDS and away from other issues. To investigate displacement fully we need studies of multiple kinds, including examination of the national and bureaucratic politics of aid provision in industrialized countries and of interactions among donors themselves.

Methods

I calculated the amount of funding for major health and population causes in constant US dollars over the past decade from large bilateral and multilateral donors. I used the Credit Reporting System (CRS) database of the Development Assistance Committee (DAC), an organization that monitors and assesses aid from the world's major bilateral and multilateral donors. I analyzed the years 1992 to 2003 since my primary concern was recent rather than historical priorities, and since records for these but not earlier or later years were relatively comprehensive for each of the donors considered.

CRS categories 120 and 130 cover health and population funding, and include contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. These categories are divided into fifteen sub-categories. I grouped these sub-categories into six broad health agendas that historically have been prominent among donors: HIV/AIDS prevention and control, reproductive health and population, the control of infectious

diseases other than HIV/AIDS, basic healthcare, health sector capacity development, and nutrition.[10] I then examined annual funding figures, comparing HIV/AIDS trends with those of the other agendas.

CRS data have a number of well-known limitations. I therefore supplemented these data with information from other sources, including UNAIDS reports, U.S. government documents and independent research on donor funding. Among the limitations of the CRS database are that it is incomplete as donors do not report all grants and loans to the DAC; each grant is assigned to only one category according to its primary purpose, even if it includes funding for multiple causes; the CRS records commitments rather than disbursements; and the category for HIV/AIDS also includes funding for the control of other sexually-transmitted diseases. This being said, the CRS in recent years is relatively complete,[11] and there is no reason to believe that reporting omissions vary systematically by cause, so comparisons across causes may be reasonably valid. Also, other studies have concluded that nearly all funding in the STD/HIV category is for HIV/AIDS, and even funding geared toward the control of other sexually-transmitted diseases is likely to benefit HIV/AIDS prevention and control.[12]

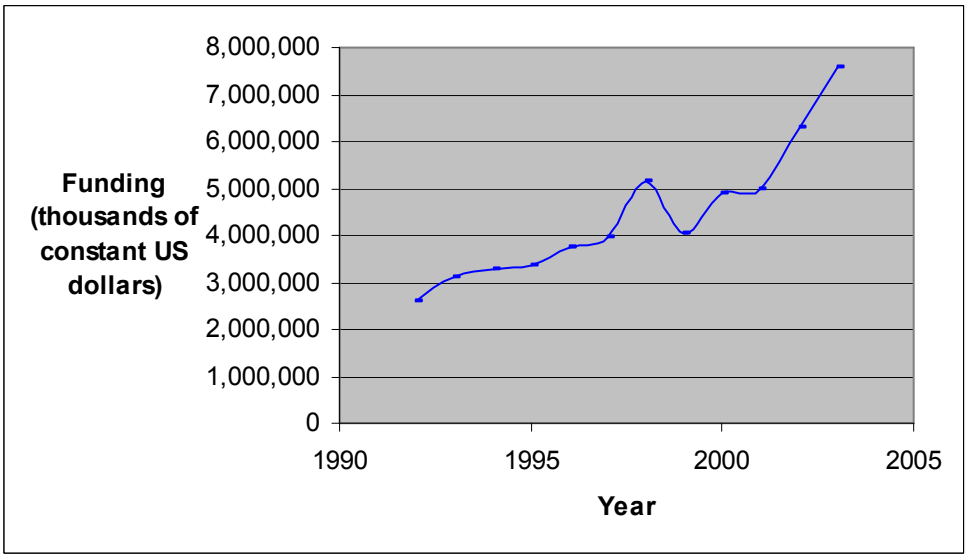
Results

Total donor funding for health and population

The health and population sector has fared well relative to other sectors in recent years. In the mid-1970s health made up approximately 6 percent of total overseas development assistance; by the turn of the millennium it constituted more than 10 percent.[13] Funding for health and population grew three percent per year over the period 1973 to 1998, a trend that continued even during a trough in total aid during the 1990s.[14]

In constant dollar terms, funding for health and population nearly tripled from 1992 to 2003, rising from $2.60 billion to $7.58 billion (figure 1).

Figure 1: Total donor funding for health and population in constant dollars



Source: CRS database.

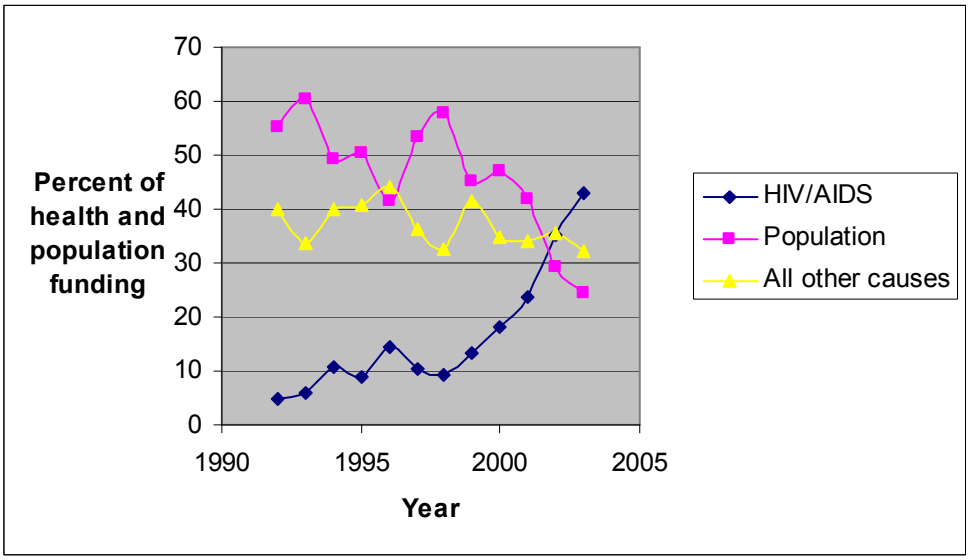
United States funding

The United States has been by far the largest donor for health and population among DAC countries over the past decade, providing approximately one-third of total bilateral aid.[15] Within US budgets the percentage for HIV/AIDS increased markedly from 1992 to 2003, from 4.8 to 43.1, overtaking all other categories (figure 2). Over the same period, the percentage for population dropped from 55.2 to 24.5. Funding for health sector capacity development nearly vanished, dropping from 37.0 percent to 1.1 percent. Total US government funding for HIV/AIDS reported in the CRS rose from $26 million in 1992 to $938 million in 2003 (figure 3). One reason for the steep rise may be the initiation of funding for anti-retroviral therapy which began only after 2000. Population funding has been stagnant at just over $500 million, while funding for all

other health causes rose, but at a slower pace than that for HIV/AIDS, from $219 million to $705 million.

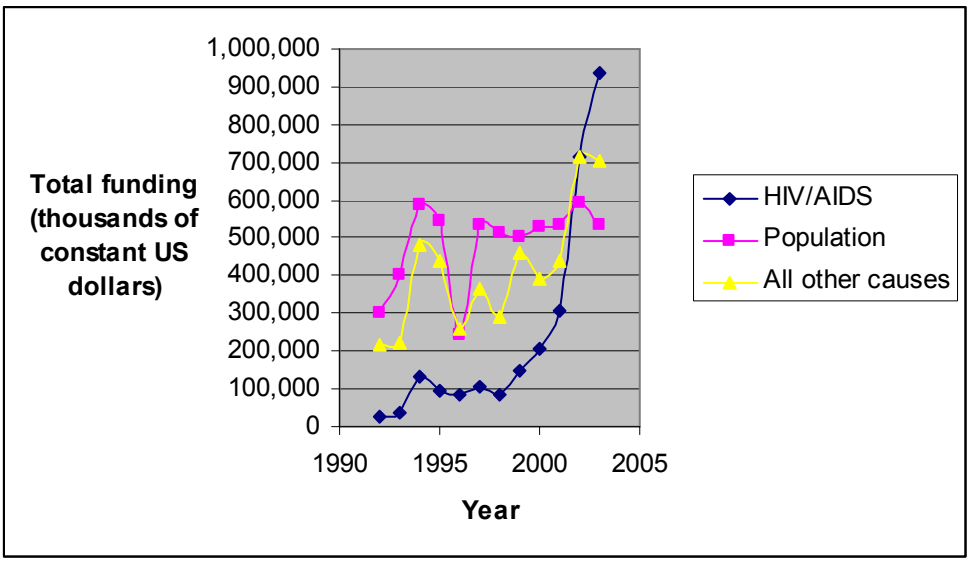
Covering funding only through 2003, these figures largely exclude the substantial increase for HIV/AIDS that has come from President Bush's Emergency Plan for AIDS Relief (PEPFAR), announced in his January 2003 State of the Union address, a five-year, $15 billion global initiative that includes an additional $9 billion above amounts already pledged. It is highly likely therefore that from 2004 on HIV/AIDS has taken on even greater prominence in US funding for health and population.

Figure 2: US funding for HIV/AIDS, population and all other causes as a percentage of total US health and population funding



Source: CRS database.

Figure 3: US funding for HIV/AIDS, population and all other causes in constant dollars



Source: CRS database.

Other sources also point to the increasing prominence of HIV/AIDS in US health and population budgets. The United States Agency for International Development (USAID) reported an increase in its annual budget for HIV/AIDS from $95.7 million in 1992 to $795.0 million in 2003.[16] In 1997 HIV/AIDS constituted only 13 percent of USAID's health and population budget and population 40 percent.[17] By fiscal year 2002 HIV/AIDS comprised 30 percent of the budget, surpassing population's share, which had dropped to 27 percent.[18] A Kaiser Foundation analysis calculated US government commitments of $1,490 million for HIV/AIDS for resource-poor settings in fiscal year 2003, an increase from $1,196 million in 2002.[19] It estimated commitments of $2,253 million for 2004, channelled primarily through USAID and the National Institutes for Health.

Funding from all donors

While HIV/AIDS has been ascendant in US budgets, it never exceeded more than 21.7 percent of total health and population funding from the rest of the world's major donors over the period 1992 to 2003, and in half these years made up less than seven percent (table 1). Population funding also has been less significant among other donors than the United States, making up less than twenty percent every year except 1992 and 2003. Health sector capacity development has been central for other donors, exceeding 30 percent of total funding every year except one, and in 2003 standing at 36.9 percent.

Table 1: Percentage of health and population funding for six causes from all donors other than the United States reporting to the CRS

Year	HIV/AIDS	Population	Basic Health care	Health sector capacity	Infectious disease control	Nutrition	Total
1992	6.98	24.14	23.33	38.85	5.25	1.44	100
1993	1.53	13.89	25.04	42.87	4.11	12.56	100
1994	14.54	19.42	11.23	45.58	8.42	0.82	100
1995	6.84	14.28	33.64	36.84	3.04	5.35	100
1996	2.30	8.08	38.65	40.77	8.69	1.51	100
1997	2.65	19.71	11.77	46.85	16.87	1.06	99*
1998	6.71	13.63	11.39	40.53	4.44	23.30	100
1999	11.66	6.85	17.95	48.33	3.18	12.04	100
2000	13.10	8.68	28.96	34.67	10.14	3.89	99*
2001	21.68	12.81	24.39	32.82	7.48	0.71	100
2002	15.24	17.23	22.10	29.17	15.05	1.21	100
2003	16.00	22.55	12.22	36.89	11.03	1.30	100

Source: CRS database.

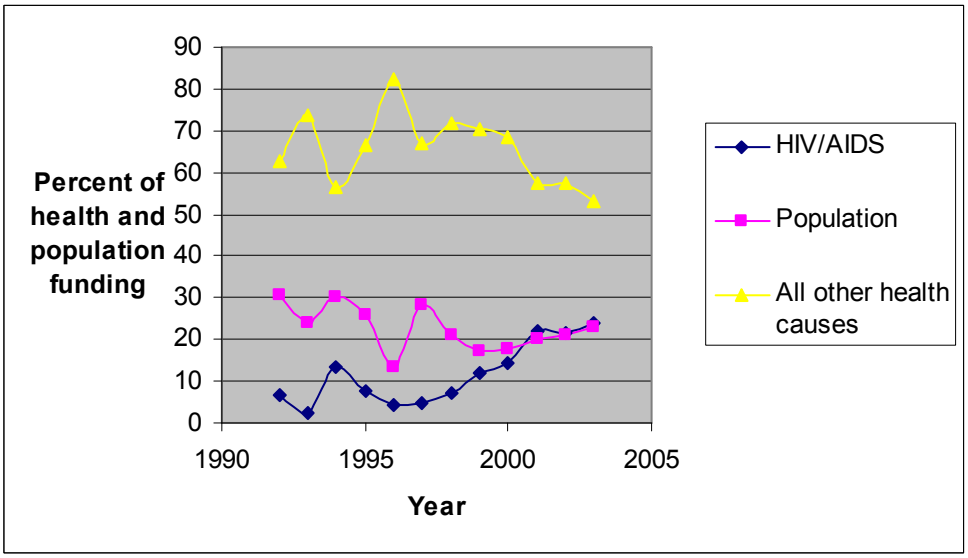
* A small number of grants reported in the CRS for 1997 and 2000 were not classified in any of the sub-categories that constitute the six health causes reported here; therefore the totals are slightly less than 100 percent.

When we consider all donors including the United States, the HIV/AIDS and population agendas are less prominent than when the United States is considered alone (figure 4). HIV/AIDS has grown in percentage of funding across time, but still only comprises 23.8 percent of the total, very close to population's share at 23.1 percent. All other causes constitute 53.1 percent of the total, down from 62.8 percent in 1992 but still more than half the total. Among the six agendas, health sector capacity development receives the greatest share at 26.6 percent.

In terms of aggregate amounts in constant dollars (figure 5), all three categories showed significant increases over the years 1992 to 2003. Funding for all other health causes increased 146 percent to $4.03 billion. Funding for population rose 119 percent to $1.75 billion, other donors compensating for the declining share for population in US budgets. HIV/AIDS showed the sharpest rise at 961 percent to $1.80 billion. A UNAIDS analysis also reported a dramatic rise in HIV/AIDS funding (although noting

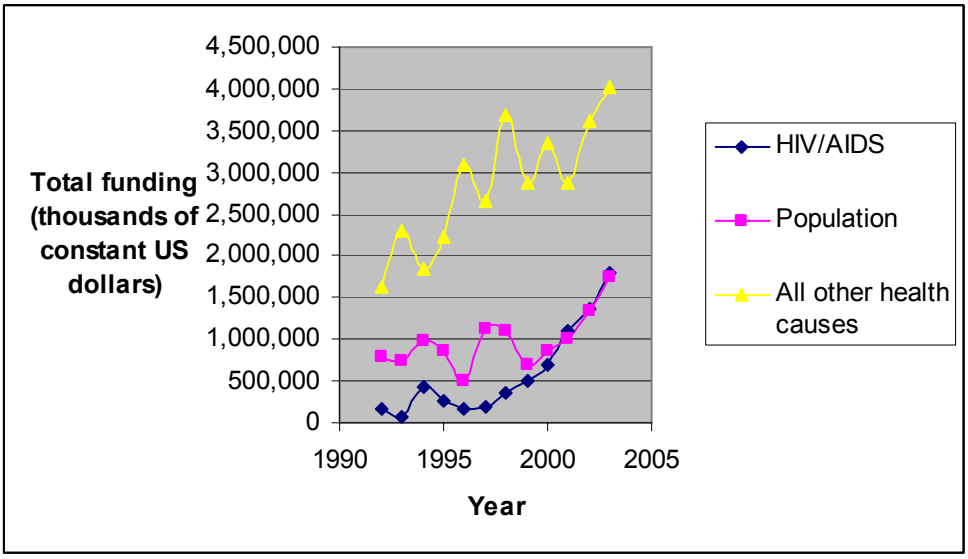
that amounts remain far from adequate) from $300 million in 1996 to $1.7 billion in 2002.[20]

Figure 4: Funding from all donors for HIV/AIDS, population and all other causes as a percentage of total donor health and population funding



Source: CRS database.

Figure 5: Funding from all donors for HIV/AIDS, population and all other causes in constant dollars



Source: CRS database.

Discussion

HIV/AIDS prioritization by the United States government, the largest bilateral donor for health and population, may have displaced its own funding for other causes in this sector. CRS data indicate that as of 2003 HIV/AIDS comprised nearly half of all U.S. government funding for health and population, and because of PEPFAR, as of 2006 likely constitutes much more than that. Meanwhile, population dropped markedly in percentage terms and stagnated in aggregate amounts over the past decade, while funding for health sector capacity development, a cause formerly prominent among U.S. priorities, nearly vanished.

When all donors reporting to the Development Assistance Committee are considered, however, HIV/AIDS' possible displacement effects are less apparent. One reason is that health is presently a favored sector for foreign aid, donor resources for health and population having increased significantly in recent years, benefitting most of the health agendas considered in this paper. Also, HIV/AIDS has never figured as prominently in the agendas of other donors as it has in the U.S. agenda. Overall HIV/AIDS occupies a large but not dominant position when all donor aid is considered.

This being said, discerning HIV/AIDS displacement effects is a complex and under-researched issue, and considerable additional investigation will be necessary to explore this issue in full. Donor funding is only one among many indicators of priority, and examining this question requires research beyond analysis of aid providers alone, including inquiries into the politics of health in developing countries. In particular, there is a need to examine the issue at the country level, where flows of donor funding for HIV/AIDS prevention and control may be overwhelming health systems targeted by bilateral and multilateral donors. This effect may be even stronger in recent years as

several new well-financed global programs focused on HIV/AIDS have emerged, including PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria. A study of aggregate donor funding for health and population reveals broad trends, but is only one dimension of a much larger question concerning displacement effects in the health and population sector.

Endnotes

[1] UNAIDS, *2004 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2004).

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[9] C. Waddington, "Does earmarked donor funding make it more or less likely that developing countries will allocate their resources towards programmes that yield the greatest health benefits?" *Bulletin of the World Health Organization* 82 (2004): 703-708; S. Devarajan and V. Swaroop, *The Implications of Foreign Aid Fungibility for Development Assistance* (Washington, DC: World Bank, 1998).

[10] HIV/AIDS is purpose code 13040 (STD control including HIV/AIDS); reproductive health and population are purpose codes 13010 (population policy and administrative management), 13020 (reproductive health care), 13030 (family planning) and 13081 (personnel development for population and reproductive health); infectious diseases is purpose code 12250 (infectious disease control); basic health care is purpose codes 12220 (basic health care), 12230 (basic health infrastructure), 12261 (health education) and 12281 (health personnel development); health sector capacity development is purpose codes 12110 (health policy and administrative management), 12181 (medical education/training), 12182 (medical research) and 12191 (medical servces); and nutrition is purpose code 12240 (basic nutrition).

[11] Development Assistance Committee, *Comparison of Amounts Reported to the CRS and to the DAC by Sector, Year 2002* (Paris: Development Assistance Committee, 2002).

[12] OECD and UNAIDS, *Analysis of AID in Support of HIV/AIDS Control, 2000-2002* (OECD and UNAIDS, 2004); A. Attaran, A and J. Sachs, "Defining and refining international donor support for combating the AIDS pandemic," *Lancet*, 357 (2001): 57-61.

[13] Development Assistance Committee data file on aid to health. Available at http://www.oecd.org/dataoecd/24/10/25474231.xls.

[14] OECD, *Recent Trends in Offical Development Assistance to Health* (Paris: OECD, 2000).

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