

commitment to
CARE

The role of donor countries and multilateral institutions
in financing HIV/AIDS programmes

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international

COMMITMENT TO CARE DISCUSSION PAPER, JUNE 2004

Who we are

ActionAid International's vision is a world without poverty in which every person can exercise their right to a life of dignity. We currently work with nine million people in 40 countries across Africa, Asia, Latin America and the Caribbean to obtain this goal.

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Summary

ActionAid International is campaigning for an urgent but holistic response to the HIV/AIDS epidemic. This must recognise the right of poor and marginalised people to receive HIV and AIDS-related care that goes beyond basic treatment to include their social, psychological, nutritional and economic needs. Such care must counteract the forces of stigma and discrimination to ensure that women, children and marginalised groups are given special access to care services.

In many African nations, HIV and AIDS is undermining and reversing development achievements and plunging people further into poverty. In Asia and the Pacific and in Latin America and the Caribbean there are clear indications that the number of infections is growing rapidly: in the Asia-Pacific region almost one million people acquired HIV in 2003.¹

Developing country governments and civil groups have a central role to play in tackling the pandemic. But, if this global emergency is to be dealt with successfully, the financial support of the rich industrialised nations, the World Bank and the International Monetary Fund (IMF) is crucial.

ActionAid International calls on developed country governments, especially members of the G8, as well as the World Bank and the International Monetary Fund to act now to combat the HIV/AIDS pandemic by:

- Providing increased, additional, sustainable, long-term funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Urgently reviewing debt relief mechanisms and considering debt cancellation in order to generate new funds at national level.

¹ UNAIDS and World Health Organisation, AIDS Epidemic Update 2003, Geneva

Introduction

HIV/AIDS, poverty and development

"Simply put, if we don't address the AIDS pandemic urgently, other international development efforts are certain to fail."

Canadian Prime Minister Paul Martin, reported in The Boston Globe, 10 May 2004

The HIV/AIDS crisis in developing countries is inextricably linked with poverty, social exclusion, discrimination and the denial of human rights. The work of ActionAid International in Africa, Asia and Latin America brings our staff and partners into daily contact with the social and economic devastation it causes. Our experience demonstrates that vulnerability to HIV/AIDS is exacerbated by poverty. It is poor communities who experience the greatest hardship in relation to HIV/AIDS, and within poor communities it is women and children who suffer most.

HIV/AIDS is rapidly reversing the hard-won development achievements of previous decades. It threatens economic growth because most deaths occur amongst young adults who are the mainstay of the workforce. It threatens social cohesion by scything through the parental generation leaving behind millions of orphans.

World Bank sponsored research, published in 2003,² found the long-term effects of HIV/AIDS could be much worse than originally predicted. The report warned that previous estimates of the impact of HIV/AIDS on GDP were too low. The study argued a country like South Africa could face economic collapse unless it aggressively increased its response to the epidemic.

ActionAid International believes that programmes designed to end the HIV/AIDS crisis must address the context in which the disease is thriving. Isolating HIV/AIDS within a narrow health perspective and failing to engage with the underlying issues of poverty and inequality will only lead to failure. As Stillwaggon points out: "Among all low- and middle-income countries, HIV prevalence is strongly correlated with falling protein consumption, falling calorie consumption, unequal distribution of national income and, to a lesser extent, labor migration. ... Poverty not only creates the biological conditions for greater susceptibility to infectious diseases, it also limits the options for treating disease."³

Securing the future: increasing international financing for HIV/AIDS

"More donor assistance is urgently needed to close the financing gap in health in the poorest countries of the world... Assistance from developed nations should increase from the current levels of about US\$ 6 billion per year globally to US\$ 27 billion by 2007 and US\$ 38 billion by 2015"

Commission on Macroeconomics and Health, WHO, 2003

If rich nations and the World Bank and IMF are genuinely determined to resolve the HIV/AIDS crisis, they need to act now to make the necessary funds available. The volume, quality and sustainability of international funding must improve significantly if real progress is to be made.

The World Health Organisation (WHO) estimates that US\$5.5 billion will be needed to fund the care and treatment outlined in its "3 by 5" initiative⁴ in 2004 and 2005 (see Table 1 and Figure 1). These costs include direct treatment costs, including provision of antiretrovirals (35% of the total), testing, counselling, condom distribution, prophylaxis for opportunistic infections and palliative care etc., as well as programme costs including training for health personnel and volunteers, purchase of equipment, improving the drug distribution system.

This estimate of funding needs relates only to the 3 by 5 strategy and only those preventative activities required to support it directly. It does not include scaling up other interventions nor major changes to the health infrastructure – although these will be an absolute necessity in many developing countries affected by HIV/AIDS. As seen in the quote above, the WHO's Commission on Macroeconomics and Health believes that by 2007 funding levels will need to increase to US\$27 billion if developing country health systems are to operate effectively, a basic prerequisite for the long term roll out of HIV/AIDS care services.

Coverage assumptions:

- 1) 10% of the target is met in 2004, and 90% in 2005.
- 2) 25% of the target is met in 2004, and 75% in 2005.

Drug cost assumptions:

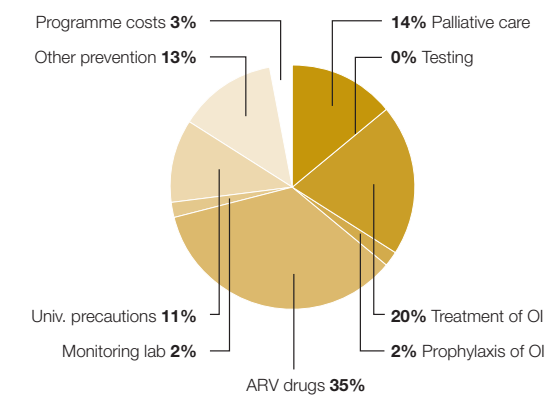
- A) "Higher cost" – unit cost of drugs as currently available with best prices provided by the WHO Essential Drugs and Medicines.
- B) "Lower cost" – as negotiated by the Clinton Foundation applied to all countries.

Table 1. Estimated cost of 3 by 5, 2004-2005 (US\$billion)

Scenario	Costs in 2004*	Costs in 2005*	Total 2004-2005
1A: 10%/90% with higher drug costs	\$2.20	\$3.20	\$5.40
1B: 10%/90% with lower drug costs	\$2.20	\$2.80	\$4.90
2A: 25%/75% with higher drug costs	\$2.34	\$3.20	\$5.50
2B: 25%/75% with lower drug costs	\$2.20	\$2.70	\$4.90

* costs rounded up to two decimal points

Figure 1. Total costs of 3 by 5 (scenario 2A)



Source: WHO/UNAIDS, Estimated cost to reach the target of three million with access to antiretroviral therapy by 2005 ("3 by 5"), Geneva

At present the Group of Eight countries (G8)⁵ are responsible for 80% of all HIV/AIDS funding.⁶ In their summit in 2000 they made a series of commitments to tackle the epidemic and have re-affirmed these each year since. However, as demonstrated in the box below, progress has been slow.

Support from G8 countries takes the form of both bilateral (country-to-country) funding and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

G8 commitments and achievements to date

Commitments in 2000

- To reduce the number of young people infected by HIV or AIDS by 25% by 2010.
- To support the Global Fund to fight AIDS, Tuberculosis, and Malaria (Global Fund).
- To develop an integrated approach to facilitate the fair, efficient and sustainable availability of discounted medicines for the poorest.
- To establish a multilateral solution to the restrictions on access to medicines in developing countries caused by the WTO's Trade Related Intellectual Property Right rules (TRIPS).

Progress by the end of 2003

- Seven hundred thousand young people have been infected by HIV and AIDS since 2002, bringing the total of infected children under fifteen to 2.5 million.
- The individual strategies of G8 members are undermining GFATM financially and politically. G8 donors pledged US \$1.5 billion in support to the Global Fund but almost US\$1 billion has yet to be paid. In 2005, The Global Fund will require US\$3,500 millions to fund its new round of grants and extensions on existing projects.
- Despite the fact that the cost of treatment has been reduced to US \$140 per person per year, five and a half million people are still denied access to treatment and the World Health Organisation's initiative to treat three million people by 2005 is under-funded.
- The proposed solution to the problems caused by the rules of the World Trade Organisation's Trade Related Intellectual Property Rights agreement, which are intended to permit the production, export and import of cheap, generic drugs to developing countries, is wholly unsatisfactory and involves such complicated procedures that it is likely to deter producers and importers alike.

² World Bank, The Long-run Economic Costs of AIDS: Theory and an Application to South Africa, July 2003, Washington

³ Eileen Stillwaggon, AIDS and the Poverty in Africa, The Nation Magazine, May 3 2001

⁴ 3 by 5 refers to the WHO and UNAIDS cosponsored initiative which aims to treat three million of the six million people who currently require antiretroviral therapy by the end of 2005. WHO and UNAIDS, Treating 3 million by 2005: Making it happen, 2003, Geneva. For a commentary on 3 by 5 see ActionAid International, 3 by 5: ensuring HIV/AIDS care for all?, June 2004

⁵ The G8 countries are Canada, France, Germany, Italy, Japan, Russia, United Kingdom and United States

⁶ Kaiser Family Foundation, Global HIV/AIDS Support from G8 Countries, May 2003

Bilateral aid

Table 2. 2002 Bilateral AIDS Support from Selected Countries (in US\$ millions)

G8	US\$ millions
US	629
UK	313
Japan	90
Germany	70
Canada	39
France	31
Italy	> 25
G8 total	1,198
Other governments	
Netherlands	67
Norway	35
EC	28
Other	171
Other govts total	301
Total bilateral aid	1,498

Source: Kaiser Family Foundation, Global HIV/AIDS Support from G8 Countries, May 2003

Bilateral support for AIDS programmes from the G8 totalled just under US\$1.2 billion in 2002 with an additional US\$300 million coming from other governments (see Table 2).

This figure is set to rise with President Bush's initiative calling for the US to provide US\$ 15 billion over five years. The US\$15 billion includes both existing spending levels as well as the President's new proposal, and thus amounts to US\$ 10 billion in new money. While new money for HIV/AIDS programmes is welcomed, the President's Emergency Plan for AIDS Relief suffers from many of the problems of bilateral aid. It is guided by the priorities and strategic interests of the donor, includes elements of tied procurement from the host country and carries high transaction costs in terms of reporting requirements. In addition, there is no guarantee that the recipient country will continue to receive a predictable level of support – funding is entirely at the discretion of the donor and may be ended at any time.

Problems with bilateral aid initiatives
The proliferation of uncoordinated bilateral initiatives risks undermining the effectiveness of HIV and AIDS efforts in Southern countries. The main effects of proliferation of bilateral initiatives are that these:
<ul style="list-style-type: none"> • result in donor-driven approaches, rather than bottom-up solutions. • increase the administrative burdens of recipient countries. • hamper the development of coherent national strategies on HIV and AIDS. • drain resources away from existing, experienced, multilateral initiatives. • result in lack of transparency.
The recently approved "three ones" framework ⁷ is a step in the right direction, but its strategic framework does not mention the involvement of people living with HIV/AIDS and gives insufficient emphasis to issues of stigma and discrimination.
ActionAid International calls on all international aid donors to support current multilateral initiatives, untie financial contributions, and harmonise and improve the reporting on their bilateral HIV and AIDS work.
* Agreed on 25 April 2004, the "three ones" principles aim to achieve the most effective and efficient use of resources, as well as rapid action and results-based management. The "three ones" are an agreement to have: one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system. For further information see: UNAIDS, www.unaids.org/en/other/functionalities/ViewDocument.asp?href=http://gva-doc-owl/WEBcontent/Documents/pub/UNA-docs/Three-Ones_KeyPrinciples_en.pdf

Multilateral aid

ActionAid International supports the principles adopted by the Global Fund to fight AIDS, Tuberculosis and Malaria, which has succeeded in mobilising massive resources for HIV/AIDS. The participatory approach of the Global Fund has fostered high levels of ownership and commitment amongst developing country governments and affected communities. By providing a central point for funding it also avoids the difficulties experienced by developing countries in dealing with the competing requirements of bilateral donors and enables them to better coordinate spending within an overall national strategy. In addition, the work of the Global Fund is based on the understanding that any effective response to HIV/AIDS requires action beyond the health sector that can involve all society, something that ActionAid International fully endorses.

The support of G8 governments to the Global Fund is welcomed but financial contributions will need to increase substantially over the years ahead in order to address the scale of the HIV and AIDS epidemic. G8 leaders also need to resolve the continuing problems caused by slow disbursement of the money they have pledged.

At present, the Global Fund has sufficient resources only to support its existing work and to begin funding a new round of projects in 2004. It estimates that it will need US\$3.5 billion in 2005.⁷ Existing pledges would leave it with a shortfall of some US\$2.65 billion. Table 3 below shows the amount of existing pledges to the Global Fund for 2004 and future years. Given that US legislation authorising funding for HIV/AIDS work internationally includes a clause that will limit the US share of Global Fund contributions to 33% or less of the total contributed, it is now vital that the European Union and G8 donors act to increase their contributions without further delay.

One of the problems with current funding support is that it fails to recognise that a commitment to fund HIV/AIDS treatment must be a lifetime commitment. Once a person begins antiretroviral treatment they must adhere to it for life. Interruptions in treatment are dangerous to the patient and have the potential to allow resistance to drugs to develop. As developing nations gear up to provide antiretroviral treatment to large numbers of their citizens, the implications for international funding are clear. This can no longer be left to the uncertainties involved in year on year pledges. Instead, funding mechanisms must change in order to guarantee a lifetime of financial support.

ActionAid International believes that an Aidspan proposal to secure increased long term funding by using an Equitable Contributions Framework⁸ for determining rich countries' contributions to the Global Fund is worthy of support. Using this Framework, the amounts contributed to the Global Fund by each of the thirty seven richest nations (those with Gross Domestic Products (GDP) of at least US\$5 billion in 2002) would be set according to their percentage share of Global GDP. Thus, if the Global Fund's overall requirements for 2005 are US\$3.5 billion, the UK with a 4.8 percent share of global GDP would be required to contribute US\$168 million. Spain on the other hand, with a 2 percent share of global GDP would be required to contribute US\$ 70 million.⁹ As well as being predictable, donations would also be equitable, reflecting the relative wealth of contributors.

⁷ http://www.theglobalfund.org/en/files/factsheets/resource_needs.pdf

⁸ The Equitable Contributions Framework analysis was first developed by Tim France, Gorik Ooms and Bernard Rivers in "The Global Fund: Which Countries Owe How Much?", 21 April 2002. See www.aidspace.org/gfo/docs/gfo15.htm.

⁹ Figures extrapolated from http://www.fundthefund.org/documents/AIDSPAN_equitable_contribution.doc

Table 3. Pledges to the Global Fund by the year due (in USD)

	2001 - 2002	2003	2004	2005	2006	2007	2008	Pledge Period to be confirmed
G8 donors								
Canada	25,000,000	25,000,000	25,000,000	25,000,000	51,094,891			
France	57,835,853	60,620,853	177,725,118	177,725,118	177,725,118			
Germany	11,995,200	37,427,325	46,806,985	85,308,057	85,308,057	87,085,308		
Italy	100,000,000	100,000,000	118,483,412	118,483,412				
Japan	80,000,000	79,993,443	100,000,000					
Russia	1,000,000	4,000,000	5,000,000	5,000,000	5,000,000			
United Kingdom	78,215,278	40,032,750	53,097,345	58,407,080	40,000,000	40,000,000		
United States	300,000,000	322,725,000	546,755,000	200,000,000	200,000,000	200,000,000	200,000,000	
Total G8	654,046,331	669,799,371	1,072,867,861	721,018,558	508,033,175	327,085,308	200,000,000	
Other major donors								
European Commission	137,064,385	49,763,033	262,761,950	50,947,867	50,947,867			
Belgium	12,207,409	7,229,938	11,129,320					
Greece								296,209
Ireland	9,835,000	11,161,430	12,147,671					
Netherlands	8,087,400	43,590,360	47,393,365	60,426,540				
Norway	17,962,003	17,709,581	18,195,051					
Spain		35,000,000	15,000,000	25,000,000	25,000,000			
Gates Foundation	50,000,000	50,000,000						
Total	235,156,197	214,454,342	366,627,357	136,374,408	75,947,867			296,209
Grand total G8 and other major donors	889,202,528	884,253,713	1,439,495,218	857,392,965	583,981,043	327,085,308.1	200,000,000	296,209
Total from all sources	946,361,297	927,222,091	1,515,030,303	866,674,627	593,262,705	330,285,308	200,200,000	3,971,209

The US contribution cannot exceed 33% of all contributions for 2004

Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria: Pledges and Contributions, May 2004 available at www.theglobalfund.org/en/files/pledges&contributions.xls

Increasing resources in developing countries: addressing the debt crisis

The vast amount that developing countries have to spend on servicing their national debts undermines their ability to contribute significantly to the cost of tackling HIV/AIDS.

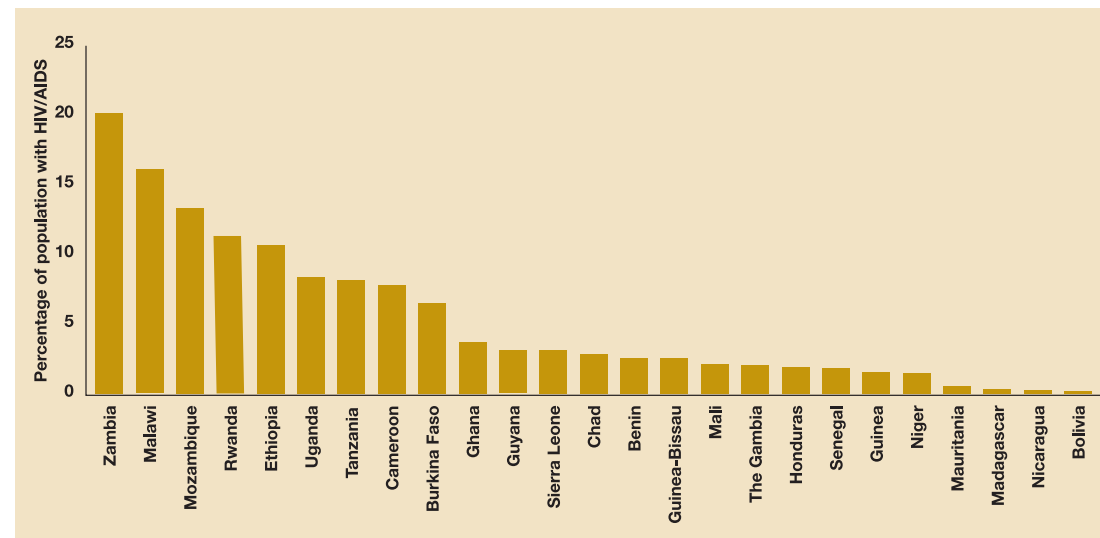
"Unsustainable debt represents a huge barrier to progress in the fight against HIV/AIDS. Repayments to creditors by some of the poorest countries in the world are diverting the resources needed to respond to current suffering and protect future generations."

Kevin Watkins, Oxfam¹⁰

According to UNAIDS and WHO estimates, over US\$10.5 billion a year will be needed in 2005 for a "barebones" package of prevention, treatment, care and support programmes in low- and middle-income countries. By 2007, almost US\$15 billion will be needed.¹¹ Currently Sub-Saharan Africa alone pays out almost US\$15 billion each year in debt service to foreign creditors. Donor countries should recognise that their best efforts to increase aid to fight HIV/AIDS are being sabotaged by the lingering debt crisis in the world's poorest countries. For ActionAid International it makes little sense to give with one hand while taking back with the other.

Thirtyfour of the heavily indebted poor countries (HIPC) that qualify for debt relief are in Africa. In 2002, 26 countries were receiving debt relief. These 26 countries are home to more than 10 million people living with HIV/AIDS. (Figure 3 below provides information on the HIV/AIDS prevalence rates in these countries.) If the remaining eligible countries plus Nigeria (which should qualify for HIPC but is currently excluded) were taken into account, the total number of PLWHAs living in heavily indebted countries would rise to 13.4 million.¹²

Figure 2. Percentage of population with HIV/AIDS: selected heavily indebted countries (2001/02)



Source: Oxfam, Debt Relief and the HIV Crisis in Africa: Does the Heavily Indebted Poor Countries (HIPC) Initiative go far enough?, Briefing Paper No 25, June 2002

¹⁰ Oxfam, Debt Relief and the HIV Crisis in Africa: Does the Heavily Indebted Poor Countries (HIPC) Initiative go far enough?, Briefing Paper No 25, June 2002

¹¹ UNAIDS, Press Release No. 108, "Despite substantial increases, AIDS funding is still only half of what will be needed by 2005", 26 June 2003, Geneva

¹² Oxfam, Debt Relief and the HIV Crisis in Africa: Does the Heavily Indebted Poor Countries (HIPC) Initiative go far enough?, Briefing Paper No 25, June 2002

World Bank and International Monetary Fund Policies and the Epidemic

Elsewhere,* ActionAid International has argued that during the 1990s, instead of focusing on HIV/AIDS, the World Bank through its Structural Adjustment Programmes sought 'improvements' in the way goods and services were provided. The emphasis was on health sector reforms, such as introducing user fees, privatisation, decentralisation and integration of services. These reforms frequently had the unintended effect of reducing access to effective health care, including services aimed at the prevention and control of HIV/AIDS, because the costs of accessing care rose beyond the reach of many ordinary people. In addition, these policies reduced the safety of health systems themselves, and allowed health services to become a source of HIV infection.**

The World Bank and International Monetary Fund (IMF) policies of the 1980s and 1990s failed poor people. They failed to protect social spending during its structural adjustment operations and this led to the deterioration of basic services – including those needed for the prevention and control of HIV/AIDS. They failed to consider the impact of their policies on poor people, already vulnerable to HIV, who have less access to safe-sex information, are less likely to use condoms and have fewer STI/HIV services.

Over the last three years, the World Bank has dramatically improved its approach to the HIV/AIDS crisis: increasing resources available; putting emphasis on a multisectoral approach; working extensively at the community level with local organisations; building up institutional capacity; and developing partnerships with government, community groups and financing partners. Nevertheless, preliminary evaluation of the Bank's US\$500 million Multi-Country HIV/AIDS Programme (MAP) for Africa shows that the institutional weaknesses persist, and may take years to correct.***

* **ActionAid International, Low Credit: a report on the World Bank's response to HIV/AIDS in developing countries, 2004, London, paper prepared by Chris Simms**

** **An accepted view is that in the poorest countries, particularly at the periphery where health spending cutbacks have led to deterioration in supervision, monitoring, training and logistics and unsafe medical practices are an important source of HIV transmission. See, for example, Simonsen, L. et al, Unsafe injection in the developing world and transmission of bloodborne pathogens: a review, The Bulletin of the World Health Organisation, 1999**

*** **World Bank OED, Toward Country-Led Development: A Multi-partner Evaluation of CDF, Synthesis Report, 2003, Washington**

As of the April 2004 Spring meeting of the World Bank and International Monetary Fund, 27 countries (of 42 total original HIPC) have already reached the first phase of the HIPC process, the "decision point", and have had their annual debt payments reduced.¹³ Only ten of these countries have moved onto the "completion point" when they have their overall debt stock reduced. This leaves seventeen countries at the "interim" stage. Of these seventeen countries, eleven are still "on-track" with the HIPC process but have not yet completed it¹⁴ and six are "off-track" because they are not implementing structural adjustment programmes at a pace that is satisfactory to the International Monetary Fund.¹⁵ The fact that one of those countries "off track" is Zambia, a country with one of the highest rates of HIV/AIDS in the world, raises the question of whether current IMF criteria for debt relief should be changed where countries are experiencing a severe HIV/AIDS crisis.

Debt sustainability analysis must take into account the developmental impact of HIV/AIDS, as well as the resource requirements for responding to the epidemic. The United Nations Development Programme has suggested that a new measure of "debt-sustainability" should be introduced, based on the estimated costs of halving and reversing the trends of the pandemic by 2015. For many countries this would require full debt cancellation. Drop the Debt campaign has estimated that if the G7 countries were to fund the write off of the World Bank and IMF's debts from HIPCs, it would effectively cost each of their citizens only one dollar per year.¹⁶

Debt swaps

UNAIDS has explored the option of debt swaps for financing HIV/AIDS programmes and finds that quantitatively speaking the HIPC and various bilateral debt relief schemes at present represent much larger amounts of savings than current debt-conversion schemes. Despite noting that the qualitative aspects of debt-for-AIDS swaps may be considerable, UNAIDS concludes that swaps offer no universal remedy, only an additional instrument that certain countries, in collaboration with creditors, international organisations and bilateral donors, can use as part of their overall debt and AIDS strategies.

UNAIDS (Joint United Nations Programme on HIV/AIDS), Are debt swaps the answer for financing HIV/AIDS programmes?, 2004

Where the HIPC debt relief programme for poor countries has offered a limited amount of relief, allowing developing countries to use their resources in a more constructive way than paying foreign creditors, this has shown to be very helpful in the fight against HIV/AIDS.

While there are some issues that need to be resolved to ensure that the funds generated by debt relief are targeted at the linked issues of poverty reduction and HIV/AIDS, evidence from those countries that have HIPC debt relief indicate that spending on social sectors has increased as a result. The World Bank estimates that around 40% of total savings have been directed to education and 25% to health care, including HIV/AIDS programmes.¹⁷

Again, according to a report by the International Development Association and the IMF, poverty-focused spending in HIPC countries is increasing both in relation to GDP and total spending. "When compared to 1999, these outlays increased, on average, by 2.1% of GDP in 2001 in the 13 countries for which data is available. As a share of total government spending, poverty-reducing spending increased by 6.3 percentage points during the same period. Such spending is projected to increase further during 2002-03 both in relation to GDP and total spending."¹⁸

Those countries that have begun to receive debt relief are devoting more resources to reducing poverty and fighting HIV/AIDS. For example, in 2001, Malawi received a cut in debt service of 30%, or US\$28 million per year. These funds financed an increase in social expenditure of 45% including the purchase of critical drugs for hospitals and health centres, recruiting extra staff for primary health centres, and training new nurses.¹⁹ Uganda also made progress, increasing primary health care spending by 270% as a result of debt relief. US\$1.3 million of Uganda's debt relief money has been specifically earmarked for their national HIV/AIDS plan.²⁰

In ActionAid International's view, there is no justification for delaying action to increase debt relief. While aid can be erratic and donor directed, debt relief provides a predictable increase in the national budget and can help to finance overall poverty eradication strategies, including those directed at HIV/AIDS.

Access to HIPC debt relief is contingent on each country completing a Poverty Reduction Strategy Paper (PRSP) in consultation with a range of civil groups and actors. In many countries the PRSP process, not least its consultative element, needs to be strengthened. Nevertheless, where they work, PRSPs enable national governments to set their own priorities for spending the additional funds available to them through debt relief in line with their economic, political and geographic realities. However, to date, many PRSPs are characterised by a lack of attention to the links between HIV/AIDS and poverty reduction. And proposals for HIV/AIDS programmes tend to focus on a series of narrow health service interventions. This needs to change. Both national governments and civil groups, including those representing HIV positive people and women, have a key role to play in ensuring that an HIV/AIDS perspective is apparent in all poverty reduction strategies.

Notwithstanding problems to be resolved, in view of the crisis being caused by HIV/AIDS, and the fact that 16 African countries are both heavily indebted and highly affected, ActionAid International believes it is time that debt relief was stepped up in line with the needs of each country to fight the epidemic and debt cancellation given serious consideration.

¹³ World Bank, HIPC Statistical Update report, March 2004, available at http://www.worldbank.org/hipc/Statistical_Update_March_2004.pdf

¹⁴ Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, Honduras, Madagascar, Malawi, Niger, Rwanda, Senegal, and Sierra Leone

¹⁵ Chad, The Gambia, Guinea, Guinea-Bissau, Sao Tome and Principe and Zambia

¹⁶ Drop the Debt, Heavily Indebted Poor Countries initiative fails to deal with significant debt cancellation, 2001, London

¹⁷ World Bank, Heavily-Indebted Poor Countries Initiative Fact Sheet, March 2003, Washington, available at: http://www.worldbank.org/hipc/hipc-review/Fact_Sheet_mar03_.pdf

¹⁸ IDA and IMF, Update on Implementation of Action Plans to Strengthen Capacity of HIPCs to Track Poverty-Reducing Public Spending, 2003, Washington

¹⁹ Drop the Debt, Reality Check: the need for deeper debt cancellation and the fight against HIV/AIDS, 2001, available at: www.jubileusa.org/resources/reports/reality_check.htm

²⁰ Jubilee USA Network, "Debt Relief Success Stories", July 2003, available at: http://www.jubileusa.org/jubilee.cgi?path=learn_more&page=SuccessStories.html

Recommendations

ActionAid International believes that both increases in aid and faster and deeper debt relief have important roles to play in the fight against HIV/AIDS. And that:

- Bilateral aid donors should untie their aid, harmonise their plans and programmes in line with developing country government strategies using the "three ones" principles²¹ and make their reporting on bilateral HIV and AIDS commitments more transparent.
- Now that lifetime ARV treatment programmes are beginning, international funding of HIV/AIDS programmes can no longer be left to the uncertainties involved in year on year pledges. Funding mechanisms must change in order to guarantee a lifetime of financial support.
- International donors must increase significantly their contributions to the Global Fund. A basis for doing this would be to use an equitable contributions framework in which each of the world's richest countries gave a percentage share in line with their percentage share of global GDP.
- Notwithstanding problems to be resolved regarding conditionalities, it is time that debt relief was stepped up in line with the needs of each country to fight the epidemic and debt cancellation given serious consideration.
- Civil groups, including women's and PLWHA's groups as well as national governments, have a key role to play by ensuring that the links between poverty and HIV/AIDS are clearly spelt out in Poverty Reduction Strategy Papers.

Acknowledgements

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²¹ For further information on the "three ones" see www.unaids.org/en/other/functionalities/ViewDocument.asp?href=http://gva-doc-owl/WEBcontent/Documents/pub/UNA-docs/Three-Ones-KeyPrinciples_en.pdf