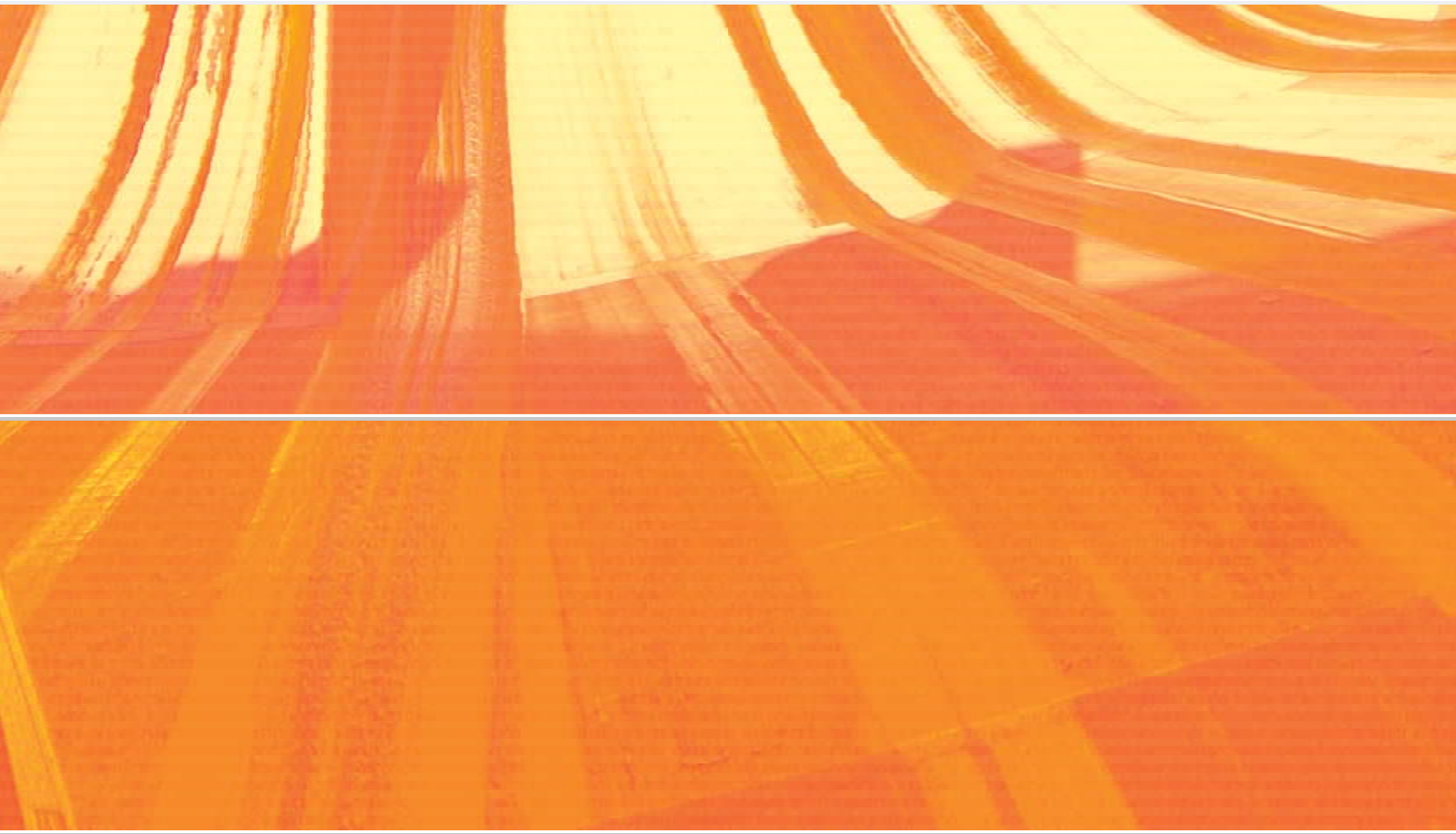
THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA
THIRD REPLENISHMENT (2011-2013)

TRENDS IN DEVELOPMENT ASSISTANCE AND DOMESTIC FINANCING FOR HEALTH IN IMPLEMENTING COUNTRIES



Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

LIST OF ABBREVIATIONS

CRS	Creditor Reporting System (of the OECD-DAC)
DAH	development assistance for health
GDP	gross domestic product
GNI	gross national income
IHME	Institute for Health Metrics and Evaluation
OAU	Organisation of African Unity
OECD	Organisation for Economic Co-operation and Development
OECD/DAC	Development Assistance Committee of the OECD
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PMI	President's Malaria Initiative (U.S.)
TB	tuberculosis
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

This report was published in March 2010.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

1. Donors at the Mid-Term Review of the Global Fund's Second Voluntary Replenishment 2008-2010 held in Cáceres in March 2009[1] requested a report on the progress made by African countries with regard to the Abuja Declaration. This declaration, adopted at a 2001 summit of the Organisation of African Unity, was a commitment of African states to allocate at least 15 percent of their annual budgets to the health sector[2]. Donors at the Mid-Term Review meeting also requested information concerning counterpart funding from middle-income countries.

2. This update begins with an explanation of current trends in development assistance for health (DAH) and the role that these external resources play in the total expenditure on health in low- and middle-income countries. It examines progress in 52 African countries[3] and a sample of 20 non-African middle-income countries. It utilizes data from the Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee's (DAC) aggregated aid statistics and the Creditor Reporting System (CRS), the Institute for Health Metrics and Evaluation (IHME) Development Assistance for Health database, the World Bank Development Indicators and the World Health Organization (WHO) National Health Accounts database.

3. Since the Abuja Summit in 2001, many African countries have increased the proportion of their national budget allocated to health. Over half of African countries recorded increases in health budget allocations between 2001 and 2007. By 2007, three African countries had achieved the Abuja target of 15 percent, and three others had exceeded this amount. For all 52 countries, the average general government expenditure on health as a percentage of total government expenditure rose marginally from 8.8 percent in 2001 to 9.0 percent in 2007.

4. The proportion of gross domestic product (GDP) devoted to health also increased marginally in the period 2001-2007, from 5.0 percent in 2001 to 5.3 percent in 2007. Substantial flows of DAH to these countries (amounting to US$ 4.7 billion in 2007) have contributed to these increased total expenditures on health.

5. Funding of the health sector in the lower-income countries examined contains a substantial proportion of DAH. In the middle-income countries examined, this funding is predominantly from domestic sources and external resources only contribute a negligible proportion of the total expenditure on health. In nearly two-thirds of the middle-income countries assessed for this paper, external resources contributed less than 1 percent of the total expenditure on health in 2007.

6. In the current economic climate, the likelihood of African governments significantly increasing the proportional allocation to the health sector is not encouraging. With the current low per-capita expenditure on health in these countries, inflows of external resources remain critical if African countries are to run national programs at a scale necessary to achieve national and global targets in the fight against the three diseases.

7. Global Fund policy requires lower-middle income countries and upper-middle income countries to contribute substantially to their national program costs, for a number of reasons: to ensure national ownership of programs and their longer-term sustainability of programs, as well as to ensure sufficient funds are available to lower-income countries. In line with the Paris Declaration on aid effectiveness and in an attempt to avoid imposing specific further reporting requirements, it has not been the practice to request middle income countries to identify specific program components that they will fund. It is recognized that data in this domain needs to be strengthened and systematically collected and the Secretariat will explore ways in which to do that with technical partners in a manner that is consistent with aid effectiveness principles. The reform of the Global Fund business model, known as the architecture review, presents an opportunity for progress in this work.

INTRODUCTION

1. This update is provided in response to discussions held at the Mid-Term Review of the Second Voluntary Replenishment 2008-2010 held in Cáceres. The meeting called for progress reports on the fulfilment of the commitment by the African heads of state at the Abuja Summit in 2001 to allocate at least 15 percent of their annual budgets to health. This update also examines the counterpart contributions of middle-income countries alongside Global Fund grants.

2. Heads of state and governments of the then Organization of African Unity (OAU) met in Abuja, Nigeria from 26-27 April 2001, at a special summit devoted specifically to the exceptional challenges of HIV/AIDS, tuberculosis (TB) and other infectious diseases. The heads of state committed themselves to taking all necessary measures to ensure that the needed resources would be made available from all sources and that these would be efficiently and effectively utilized. They pledged "to set a target of allocating at least 15 percent of our annual budget to the improvement of the health sector"[4].

3. In the case of middle-income countries, they are expected to share in the overall cost of the programs. The purpose of this policy of cost sharing is to strengthen national ownership of programs, promote national strategies, enhance program sustainability and ensure Global Fund financing remains available for lower income countries.[5] The policy requires lower-middle and upper-middle income countries to fund up to 35 percent and 65 percent, respectively, of their national disease programs.

4. This paper provides background data and analyses on broad trends in flows of DAH as well as information on domestic funding for health in implementing countries. It reviews overall trends in official development assistance with a focus on DAH, the role of these external resources in the total health expenditures of implementing countries in Africa, and a sample of middle-income countries and the contributions from national budgets.

5. The paper reports on progress made by 52 African countries in respect of the Abuja Declaration. It also examines the same information with respect to middle income countries as requested at the Mid Term Review. The Global Fund currently has grants in 35 lower-middle income and 22 upper-middle income countries[6] outside of the sub-Saharan African region. A sample of 20 of these countries[7] was selected to be representative of the entire group based primarily on region, the size of the Global Fund grants, and country population.

6. In the case of middle-income countries, the eligibility criterion on counterpart contribution is assessed for compliance during the proposal review phase; however, there is insufficient data to monitor its implementation systematically across all countries following grant disbursement. In the absence of such data, this update utilizes as proxy an assessment of national health accounts data for these countries to ascertain their levels of reliance on external funding for national programs.

7. Data presented here come primarily from the OECD/DAC's aggregated aid statistics and the CRS, the IHME Development Assistance for Health database, the World Bank development indicators and the WHO National Health Accounts database.

8. The rest of the update is structured as follows: **Part 1** provides an overview of the trends in development assistance for health. It identifies the key channels and recipients as well as the relationship between disease burden and DAH flows. **Part 2** describes the progress made by African countries on the Abuja target, and provides information on the importance of DAH to African countries. **Part 3** looks at the trends in health financing in a sample of non-African middle-income countries. **Part 4** discusses the continuing importance of external resources to African countries and concludes the paper with indications of next steps.

PART 1: TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH

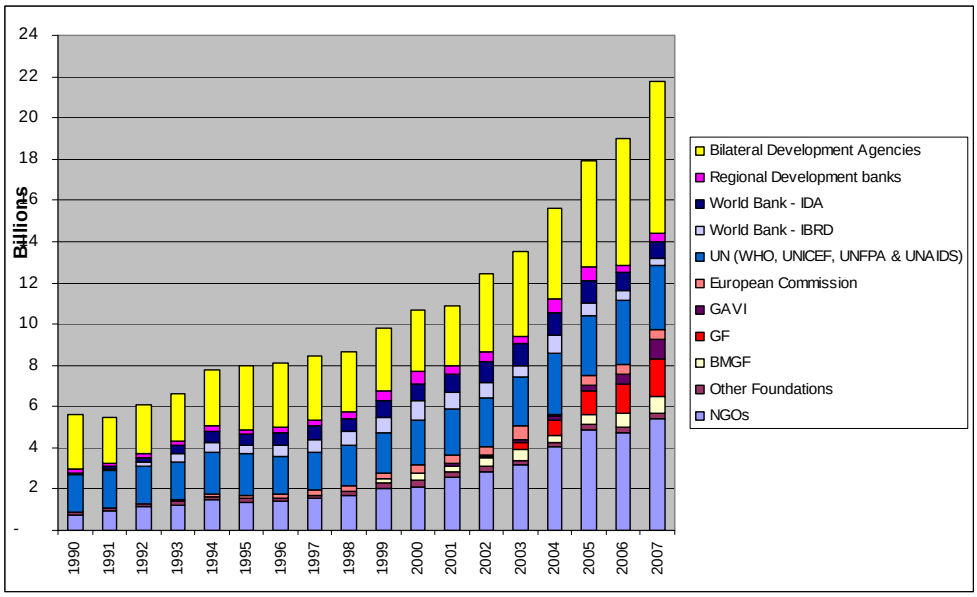
9. In the last decade, total net official development assistance from the OECD/DAC countries has been increasing. Official development assistance flows reached their highest level ever at US$ 121.5 billion in 2008, representing 0.31 percent of members' combined gross national income (GNI). This was a significant increase of over 126 percent from the US $53.7 billion (representing 0.22 percent of GNI) provided in 2000. Disbursements from all countries increased over the period. A large share of the official development assistance flows (70 percent) were provided through bilateral organizations, with the remaining 30 percent disbursed through multilateral organizations.

10. Disaggregating overall official development assistance figures by sector reveals that expenditure on DAH as a proportion of this assistance has also increased in recent years. Whereas the average annual DAH was US$ 7.5 billion in the 1990s, it grew at an annual rate of 17 percent from US$ 10.7 billion in 2000 to US$ 21.8 billion by 2007[8]. This means that the percentage of total official development assistance taken up by health increased from less than 10 percent in 2000 to 17.6 percent in 2007.

11. The increase in DAH in the last decade is attributable to a significant rise in funding from the United States (through the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI)), and large flows of resources from new global health actors (multinational agencies and private entities/foundations) such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the Melinda and Bill Gates Foundation (since 2002 (see Figure 1). In 2007, the Global Fund, the GAVI Alliance, the Bill and Melinda Gates Foundation and nongovernmental organizations accounted for over 40 percent of total DAH.

12. Sub-Saharan Africa has benefited significantly from the increases in DAH. By 2008, net bilateral official development assistance to sub-Saharan African countries from the DAC countries had risen to US$ 22.5 billion[9]. Sub-Saharan Africa's share of allocable DAH to regions grew from 33 percent in 1990 to over 50 percent in 2007. The other regions that receive considerable DAH are the South and West Asia, East Asia and Pacific and Latin America and Caribbean regions. Between 1990 and 2007, DAH for HIV/AIDS, TB and malaria grew substantially, but more so for HIV/AIDS, which accounted for over 23 percent of total DAH in 2007. In general, DAH to low- and middle-income countries is positively correlated with the burden of disease.

Figure 1: Development Assistance for Health by Channel of Assistance, 1990-2007



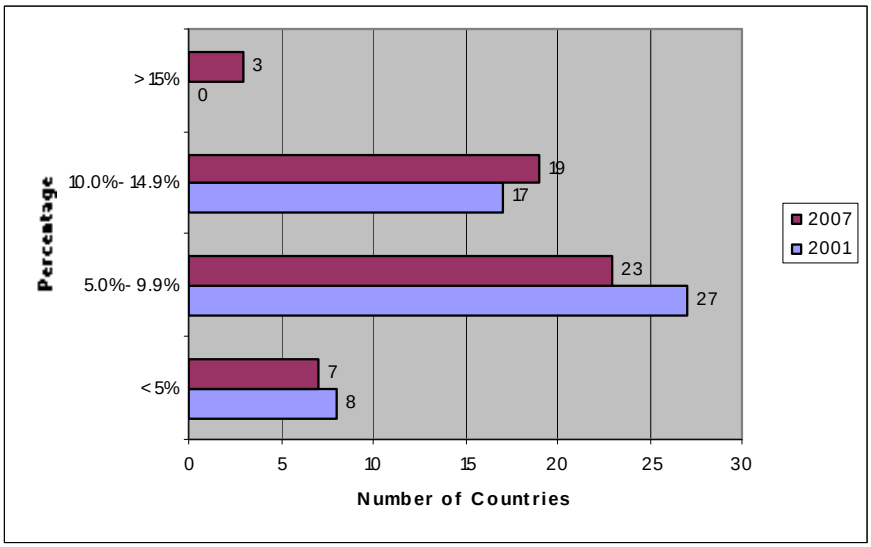
Source: Institute for Health Metrics and Evaluation DAH Dataset

PART 2: ASSESSING PROGRESS OF AFRICAN COUNTRIES ON THE ABUJA DECLARATION

13. Progress toward the Abuja target of 15 percent of total government expenditure being allocated to the health sector is measured by using national health account data as this is the only source of data that is sufficiently solid to allow for cross country comparisons. Because the national health account does not track donor support as a separate category, government expenditure here includes only those external resources for health that are reported on-budget. The data reveals that African countries are devoting a somewhat greater share of their national budgets to health than at the beginning of the last decade. In 2001, eight African countries spent 5 percent or less of their total government expenditure on health, 27 countries spent between 5.0 and 9.9 percent and 17 countries spent above 10 percent of their national budgets on health. No country spent more than 15 percent of their total budget on health expenditures (Figure 2).

14. By 2007 (the last full year for which data is available), the picture had evolved: the number of countries spending less than 5 percent had decreased to seven, while 23 countries spent between 5.0 and 9.9 percent on health, and 19 countries spent between 10.0 and 14.9 percent. Three countries (Djibouti, Botswana and Rwanda) attained the Abuja target in 2007, while in the period between 2001 and 2007, three other countries: Liberia (2004 and 2005), Malawi (from 2002 to 2006) and Burkina Faso (from 2004 to 2006) surpassed the target. Twenty-five of the 52 African countries recorded increases in the percentage of total government expenditures devoted to health between 2001 and 2007; the remaining 27 countries reported reductions (see Table 1).

Figure 2: Government expenditure on health as a percentage of total government expenditure in African countries

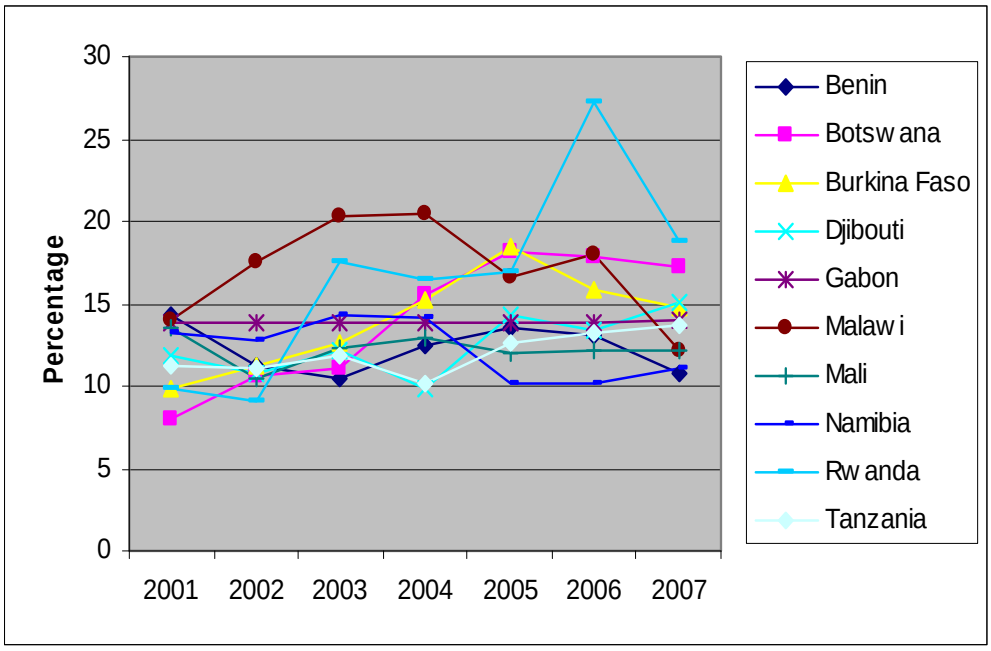


Source: WHOSIS database

15. Figure 3 shows that ten countries (Benin, Botswana, Burkina Faso, Djibouti, Gabon, Malawi, Mali, Namibia, Rwanda, and Tanzania) had consistently allocated, on average, above 12 percent of total government expenditures to health. This group of countries includes both middle-income and low-income countries, indicating no discernable pattern in allocation of national budgets to health along income classification. At the opposite end, the average allocations to health from Angola, Guinea, Eritrea, Guinea Bissau and Nigeria between 2001 and 2007 was less than 5 percent of total government expenditure.

16. In general, the emerging picture is one in which African governments are striving to allocate higher percentages of their total government expenditures to the health sector. Across the region, the average health expenditure as a percentage of total government expenditure grew slightly from 8.8 percent in 2001 to 9.0 percent in 2007. Total expenditure on health as a percentage of GDP rose in nearly two-thirds of the African countries between 2001 and 2007, with Namibia, Zimbabwe, Congo (Democratic Republic), Rwanda and Burundi all recording increases of 30 percent or more.

Figure 3: Trends in top performing countries government expenditure on health as percentage of total government expenditure in African countries



Source: WHOSIS database

Allocation by sub-regions

17. In 2001, the average percentage of general government expenditure on health as proportion of total government expenditure was 10 percent in countries of the Southern Africa sub-region. Average allocations in the North Africa and West and Central Africa sub-regions were 9.5 percent and 8.1 percent, respectively. Countries of the East Africa sub-region spent the least on health, allocating only an average of 7.9 percent.

18. By 2007 the picture had evolved: the Southern Africa sub-region, while still the region with the highest proportion of government health budgets, only increased the proportion to 10.3 percent. Allocations in the East African countries rose significantly to 9.4 percent, but the West and Central African countries remained unchanged. The North African sub-region, however, experienced a 7 percent decline in health sector allocations in 2007.

Contributions of DAH to total health expenditure in Africa

19. Unsurprisingly, the significantly increased priority given by donors to DAH to sub-Saharan African countries has meant that the proportion of external resources in total health expenditures has increased for these countries. The average external resource proportion of total health expenditure in all 52 African countries grew from a level of 15.3 percent in 2002 to 20.1 percent in 2006[10]. Thirty-seven African countries recorded increases in external contributions between 2002 and 2006. For instance Botswana saw an increase from 0.5 to 5.8 percent; Swaziland, 1.9 to 13.7 percent; Zimbabwe, 2.0 to 18.7 percent; Lesotho, 5.2 to 15.0 percent; Namibia, 4.8 to 21.9 percent; and Ethiopia, 10.0 to 42.9 percent. Fifteen countries, however, recorded decreases in external resources for their health sectors over the same period, with Angola (from 13.3 to 7 percent) and Benin (23.3 to 13.4 percent) having the biggest declines.

20. As these proportions demonstrate, many low-income sub-Saharan Africa countries are relying on external aid, with this source constituting over 30 percent of the total expenditure on health in twelve countries, and above 50 percent in Madagascar and Mozambique in 2006. Per-capita DAH to sub-Saharan countries in 2007 ranged from US$ 0.65 in Mauritius to US$ 43.74 in Namibia. Generally speaking, per-capita health assistance tends to be negatively correlated with per-capita income. There are, however, some exceptions, as in the case of middle-income South Africa receiving a large share of DAH and poorer countries like Benin and Niger receiving little funding.

21. Countries of the East African sub-region had a higher proportion of external aid for health than the other regions, averaging 28.4 percent in 2006 (up from 19.6 percent in 2002). The contribution of external resources to total health expenditures for the countries in the Southern Africa sub-region rose from 12.8 percent in 2002 to 20.3 percent in 2006. In the West and Central African countries, external resources grew by 22 percent over the period (from 16.6 percent in 2002 to 20.2 percent in 2006). Countries of the North Africa sub-region had the lowest proportion of external aid at 11 percent and 11.5 percent in 2002 and 2006, respectively. Between 2002 and 2006, all sub-regions experienced increases in external resources for health.

Increasing allocations from domestic sources

22. The ability to allocate significant proportions of government revenue to health is partly dependent on economic growth and how much of this growth translates into additional discretionary resources. Though the last decade was considered one of the strongest in terms of growth in GDP, many African economies have experienced fluctuating fortunes. Nonetheless, African countries were able to allocate a fair amount of their GDP to health (average of 5.5 percent), with 26 out of the 52 countries examined devoting at least 5 percent of their GDP to health (as seen in Figure 6). In comparison, the total expenditure on health as a percentage of GDP in the WHO South East Asia and Eastern Mediterranean regions was 3.4 and 4.5 percent, respectively (Table 2).

Per capita expenditure on health

23. The per-capita total expenditure on health in the WHO African Region in 2006 was US$ 111 at the international (purchasing power parity) dollar rate (Table 2). This is well below the global average of US$ 791, but slightly higher than the US$ 85 for the WHO South East Asia region. Of this total, the private per-capita health expenditure share amounted to US$ 59 while the governments' share was US$ 52. Out-of-pocket expenditure in these countries remains at a high rate of 46.6 percent of total health expenditure, with implications for access to essential services for the poorest and most vulnerable groups.

24. Nevertheless, the amount of US$ 111 is misleading because it is propped up by the African middle-income countries that spend well over US$ 100 per capita. If these 15 high-spending countries are excluded, the average per-capita total health expenditure for the remaining 30 African low-income countries in 2006 was only US$ 65.1, with governments contributing US$ 30.1. This level of per-capita government expenditure on health in the African low-income countries is hardly adequate to fully meet urgent needs for financing country programs that will facilitate the achievement of universal access targets and the Millennium Development Goals.

25. The above observations make it clear that in the short- to medium-term, domestic resources in African low-income countries and indeed in some African middle-income countries will not be enough to provide the basic package of interventions required by the population, even if African governments were to increase spending on health from the average of 9.0 percent quoted above to the desired goal of 15 percent of GDP in line with the Abuja commitment. An increase in the resource envelope will need to tap all sources, until the tax bases of African countries grow sufficiently to assume a larger share of the costs.

PART 3: TRENDS IN FINANCING IN MIDDLE-INCOME COUNTRIES OUTSIDE AFRICA

26. The Cáceres meeting requested a report on the status of counterpart contributions of middle-income countries. Global Fund policy requires lower-middle income countries and upper-middle income countries to contribute 35 percent and 65 percent, respectively, of total program costs[11]. In line with the Paris Declaration on aid effectiveness and in an attempt to avoid imposing specific further reporting requirements, it has not been the practice to request countries to identify specific program components that they will fund. Rather, the focus has been on demonstrating a government's commitment to provide overall funding within the national health budget that would support the Global Fund-financed intervention[1]. This reinforces the concept of national strategy financing. It also allows for the use of governments' public expenditure management frameworks rather than putting in place program specific finance systems.

[1] See Portfolio Committee document GF/PC8/04, Section 2, para 5 ii and 5 v that state: "..Since funds are fungible, donors realize that it does not make sense to ring-fence or isolate each "donor project" within the program and require counterpart financing for that particular project. This is particularly so in programs like HIV/AIDS which are supported by multiple donors where the focus of the donor community is to ensure that the priority program is fully-funded by donors and the government within their respective capacities; and Consistent with the commitment towards harmonization and alignment, both among donors and between donors and recipients, most donors prefer to adopt uniform practices that are consistent with the normal public finance framework of the country.

27. Middle-income countries are required to calculate, as part of their funding proposal, what proportion of existing and new proposed Global Fund funding would come from the overall budget of the national program over the grant lifetime. Countries are currently not requested to report on expenditure of the whole national program during the implementation of the grant, but are required to provide the funding source information again with every new application. Since this policy was implemented, middle-income countries have had successful repeated applications.

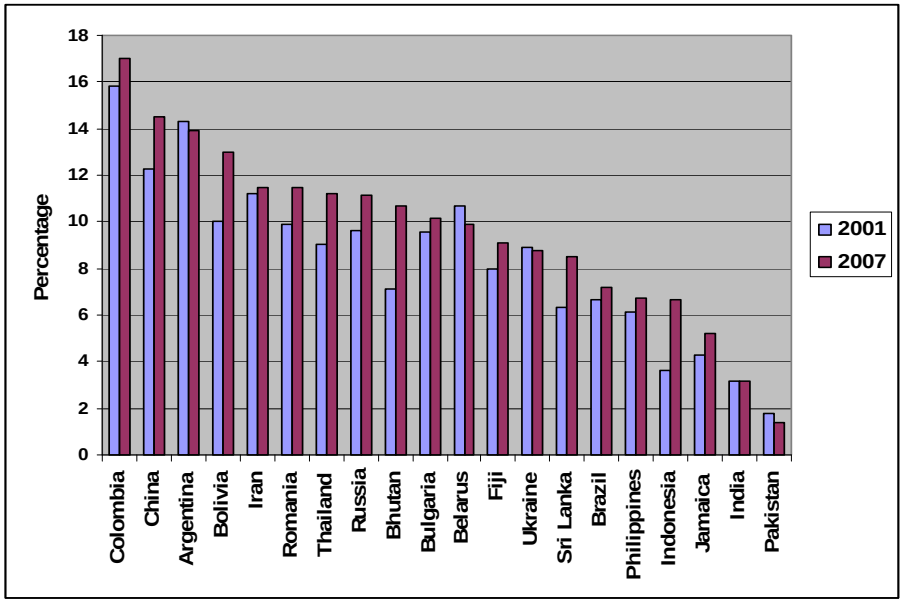
28. National disease programs report on their financing and expenditure at the global level. HIV programs report to the United Nations General Assembly Special Session (UNGASS) every two years; TB and malaria programs report to WHO for the respective global reports. While the quality of the data in these sources has improved over the years, they are still incomplete, and could not be used to provide an overall picture of the implementation of cost-sharing in Global Fund-supported middle-income countries.

29. A review of government expenditure on health as well as in flows of DAH to the middle-income countries that receive Global Fund grants was undertaken in a sample of 20 middle-income countries outside Africa in order to determine whether programs are funded primarily by domestic or by external resources.

30. Allocation of national budgets to health in middle-income countries varies widely. Of the 20 middle-income countries outside Africa evaluated for this paper, two countries allocated less than 5 percent of their budgets to health in 2007, seven countries allocated between 5 and 10 percent, and nine countries allocated between 10 and 15 percent. Only one country - Colombia - allocated above 15 percent. There has been a general upward trend in the proportion of government budgets allocated to health in the 20 selected middle-income countries between 2001 and 2007 (see Figure 4).

31. There is no significant difference in the allocation of national budgets to health between the selected middle-income countries from the other regions and the African middle-income countries. In both sets of countries, government expenditure on health as a percentage of total government expenditure is clustered between 8 and 12 percent. In 2007, among the African middle-income countries, Libya devoted the least proportion of the total government expenditure to health with 5.4 percent, and Botswana the largest share of 17.3 percent.

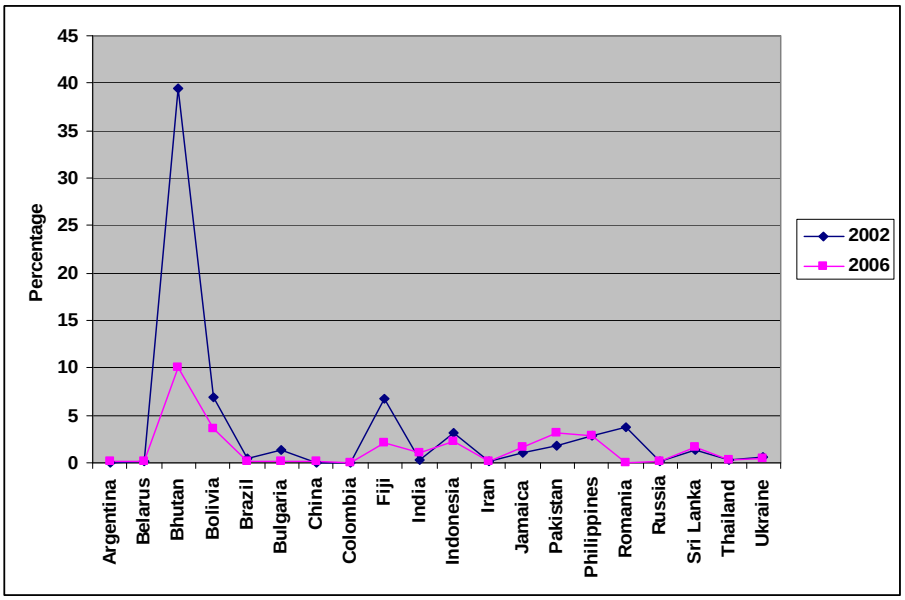
Figure 4: Government expenditure on health as a percentage of total government expenditure in selected middle-income countries outside Africa, 2001 and 2007.



Source: WHOSIS database

32. External resources do not constitute a major portion of total health expenditures in middle-income countries that receive Global Fund resources. In 2002, in the sample of 20 middle-income countries only Bhutan and Fiji had external resources contributing over 5 percent of total health expenditure (Figure 5). By 2006, external resources contributed less than 1 percent of the total expenditure on health in 12 out of the 20 countries. The mean proportion of external resource in the total expenditure on health in these 20 countries fell from 3.5 percent in 2002 to 1.5 percent in 2006.

Figure 5: External resources for health as a percentage of total health expenditure in selected middle-income countries, 2002 and 2006



Source: WHOSIS database

33. In general, flows of DAH in 2007 to the non-African middle-income countries examined, while large in absolute terms, was modest relative to domestic funding. India (US$ 582.4 million), Pakistan (US$ 285.7 million), China (US$ 242.4 million), Philippines (US$ 133.3 million), and Argentina (US$ 115.0 million) were the top recipients. Per-capita DAH to these countries ranged from US$ 0.47 in Brazil to US$ 8.84 in Fiji.

34. Even without country-specific data on the funding actually delivered at the program level, it is clear from the evidence presented above that the middle-income countries outside Africa fund their programs predominantly from domestic sources, with external resources providing complementary cover.

PART 4: IMPACT AND CONTINUING SIGNIFICANCE OF EXTERNAL AID

35. In order to achieve national and global goals for health, African governments must continue to strive to increase the share of their GDP devoted to health, and the proportion of overall government expenditure devoted to health. Such increases in domestic resource allocation are essential for mobilizing sustainable resources from donors and, in the long run, for a gradual shift from dependency on external resources.

36. Given the recent economic crisis, it is projected that African countries are likely to suffer a modest slowdown in economic growth. According to the 2009 African Economic Outlook[12], the region's GDP growth is expected to slow to 5.5 percent in 2009 and remain about the same in 2010. Under these conditions, it is unlikely that African governments will generate the necessary fiscal revenues needed to achieve the Abuja target in the near term, though a continuation of the gradual increase in expenditure share seen to date seems feasible.

37. Concerns over aid fungibility remain. However, available evidence on the additionality of external resources from the Global Fund Five-Year Evaluation[13] report on the analysis of the National Health Accounts of Burkina Faso, Malawi, Rwanda and Tanzania revealed that increased external resources from the Global Fund did NOT result in a reduction in the government per-capita expenditures for three out of four countries. It also showed that other external funders were continuing with their current levels of funding or increasing their investments. National Health Account sub-account studies will be required to assess the situation post-2007, when the bulk of the Global Fund's disbursements (particularly those related to Rounds 8 and 9) have been made.

38. While external aid has its risks in terms of long term sustainability and aid dependency, the dilemma faced by the African lower-income countries is the absence of effective alternatives. Domestic tax bases and alternative revenue sources remain modest in Africa and in lower-income countries elsewhere. As noted above, although several African countries have increased their financial resources following the Abuja Declaration, they still do not have enough resources to fund programs at levels that will enable them attain universal access targets and the Millennium Development Goals. In addition, even a significant push by African countries to achieve the 15 percent target would lead to only a marginal increase in their per-capita health expenditures, particularly in the countries already devoting above-average proportions of their resources to health. For example, Rwanda would only be able to raise per-capita expenditure on health by about US$ 0.80 and Madagascar by US$ 1.5 should they attain the 15 percent target at current resource levels[14].

39. Significant development assistance for health flows to African countries will remain critical for the countries to attain the required additional per-capita expenditure on health that is needed to scale up national programs.

CONCLUSION

40. Following a period of declines in the 1980s and 1990s, development assistance to health has grown remarkably over the last decade. The increase in flows of these funds has impacted positively on the resource envelope for health development in African countries. In addition, the proportion of the GDP and national expenditure of African countries spent on health has also been increasing.

41. Middle-income countries that receive Global Fund grants generally do not rely much on external resources for their national programs. Given their high GNI levels, these countries run their programs largely from government sources.

42. With mostly low-income countries in its ranks, it is not surprising that a significant number of sub-Saharan Africa countries continue to have large proportions of health financing coming from external aid. If these external resources are taken off the per-capita total expenditure on health, the per-capita government expenditures on health of many African countries would be negligible and clearly insufficient to implement programs, as governments have limited ability to generate significant additional domestic budgetary resources in the short term. In the absence of external aid, the already high levels of private per-capita expenditure on health would have to go up still higher and accentuate the burden on the poorest segments of the populations.

43. A UNAIDS and World Bank report[15] indicates that the global economic crisis is affecting countries differently, with their capacities to respond varying substantially. Low-income countries are less likely to cope effectively with shocks that reduce inflows of health assistance. With national budgets also unlikely to increase during the economic crisis, significant DAH flow to African countries will remain necessary to attain the required additional per-capita expenditure on health estimates needed to fully run national programs to scale.

44. At the national and subnational levels in most African countries there is considerable scope for improvements in planning, budget allocation and implementation to ensure that health resources - domestic or external - reach frontline service providers to ensure effective service delivery and improve access for the poor. As most health systems in Africa are currently funded at levels well below what is judged necessary to deliver a basic package of health interventions, higher spending on health (including health systems strengthening) will remain essential. The right policy setting is also imperative to ensure that external financing translates into better health.

NEXT STEPS

45. This report has been based on secondary analyses and thus has certain limitations. The sources of information used have shortcomings that reflect weaknesses of the national systems, including the incomplete coverage of donor-financed activities that are not on national budgets. In addition, with consistent data for all countries available only up to 2007, a substantial portion of the funding provided by the Global Fund that was concentrated after 2007 has not been captured bythis analysis. Moreover, national health budget figures do not give a full picture of the programs to which disease program funding goes, as data is presented in terms of cost categories rather than by subsectors. For a more comprehensive assessment of the financing of national responses to the diseases, detailed national budgetary analysis for the three diseases as well as for health systems strengthening will be required.

46. With national financial reporting systems in countries currently not structured to systematically provide financial information on spending on the different components of national disease programs, countries find difficulties in reporting through established processes required by UN agencies. The Secretariat will continue to work with partners to improve reporting on program expenditure to the agreed global-level reporting systems already in place but where compliance has been patchy. The funding architecture reform, with its focus on financing national disease programs in countries should provide an opportunity to focus on a comprehensive picture of the financing, implementation and results of the programs in countries. The Secretariat will examine how to include reporting on fund flows from all sources to the supported programs as part of the periodic assessments of performance.

ANNEXES

ANNEX 1

General government expenditure on health as percentage of total government expenditure in African countries, 1999 - 2007

Country	1999	2000	2001	2002	2003	2004	2005	2006	2007
Algeria	9.1	9	9.5	8.2	8.7	8.8	9.5	9.5	11.3
Angola	2.4	3.2	5.8	4.1	4.9	4.1	4.7	5	5
Benin	14.3	11.3	14.3	11.2	10.5	12.5	13.5	13.1	10.7
Botswana	8.4	8.3	8	10.6	11.1	15.5	18.2	17.8	17.3
Burkina Faso	9.7	8.9	9.8	11.2	12.6	15.3	18.4	15.8	14.8
Burundi	1.8	2.1	2.3	2.2	2.3	2.3	2.3	2.3	5.3
Cameroon	7.2	9.5	7.4	8.7	10.2	10.5	11	8.6	5
Cape Verde	9	9.6	11.7	11	10.7	12.1	13.2	13.2	10.8
Central Africa Republic	6.7	10	11.5	11.2	12.4	10.9	10.9	10.9	10.9
Chad	11.9	13.1	13.8	9.4	10.5	9.5	9.5	9.5	13.8
Comoros	10.5	9.5	5	6.4	8	8	8	8	8.4
Congo	5.6	4.8	4.2	3.6	4.3	4.1	4	4	5.5
Côte d'Ivoire	6.5	7.2	5.7	5.2	4.8	5.1	4.2	4.1	5.1
Congo (Democratic Republic)	1.3	0.5	2.5	3.1	7.8	7.2	7.2	7.2	4.5
Djibouti	13.3	12	11.8	10.8	12.2	9.9	14.3	13.4	15.1
Egypt	7.3	7.5	7.8	7.7	7.8	7.3	7.3	7.3	7.3
Equatorial Guinea	7.4	7.7	9.8	20.7	8.7	7	7	7	6.9
Eritrea	2.6	4	4.6	3.9	4	4.2	4.2	4.2	
Ethiopia	8	8.9	12.8	11.1	9.2	10.4	10.8	10.6	10.2
Gabon	10.9	13.9	13.8	13.8	13.8	13.9	13.9	13.9	14
Gambia	8.9	8.8	7	8.7	12.9	11.6	11.2	8.7	11.2
Ghana	11.6	10.9	8.7	9.3	9	6.9	6.9	6.8	5.5
Guinea	3.9	4	5.9	5.5	4.9	4.7	4.7	4.7	4.7
Guinea-Bissau	4.6	2.3	2.2	7.7	6.8	3.4	4	4	4
Kenya	5.5	8.6	6.9	6.7	5.7	5.8	6.1	6.1	9.5
Lesotho	5.9	6.3	8.8	7.4	8.3	8.7	6.7	7.8	8.2
Liberia	7.6	5.7	9.4	6.5	8.9	16.5	36.3	16.4	6.4
Madagascar	7.1	7.9	13.3	16.1	11.4	7.5	9.6	9.2	10.4
Libyan Arab Jamihiriya	5.5	6.9	11.7	8.9	7.2	6.1	6.5	6.5	5.4
Malawi	10.6	7.3	14	17.6	20.3	20.5	16.6	18	12.1
Mali	7.8	9.5	13.6	10.4	12.3	13	12	12.2	12.1
Mauritania	8.2	6.5	4.2	6.1	4.2	4.1	5	5.3	5.3
Mauritius	7.2	6.8	8.6	9.3	8.4	9.8	9.2	9.2	9.4
Morocco	4.5	4.3	4.5	5.4	5.4	5.5	5.5	5.5	4.8
Mozambique	12.1	13.9	9.9	11.4	11	11.3	12.6	12.6	12.5
Namibia	13.1	12.3	13.2	12.8	14.3	14.1	10.1	10.1	11.1
Niger	10.9	10.9	11.7	11	10.5	10.2	10.2	10.6	10.6

Country	1999	2000	2001	2002	2003	2004	2005	2006	2007
Nigeria	5.4	4.2	3.2	3.1	3.2	3.5	3.5	3.5	3.5
Rwanda	9.1	8.2	9.9	9.1	17.6	16.4	16.9	27.3	18.8
Sao Tome et Principe	6.5	7.6	9.4	11.4	14	12	12.2	12.2	10.3
Senegal	8.5	8.8	7.5	8.9	9	8.5	6.7	6.7	12
Seychelles	7.8	7.1	8.8	7.1	10.2	10.2	10.4	8.8	8.9
Sierra Leone	6.9	7.6	6.1	7.9	7.6	7.8	7.8	7.8	7.8
Somalia	4.2	4.2	4.2						
South Africa	7.8	7.9	10.4	10.1	9.6	9.6	9.9	9.9	9.3
Sudan	6.5	7.2	8.9	8.2	7.8	7.2	7	6.3	4.3
Swaziland	11.8	11.6	11.8	8.8	13.2	12.6	10.9	9.4	9.5
Togo	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	5.6
Uganda	11.3	7.3	9.7	10.3	10.1	10	10	10	8.9
Tanzania	14.6	11.2	11.2	11.1	11.9	10.1	12.6	13.3	13.7
Tunisia	6.4	6.8	7.2	7.1	6.4	6.6	6.5	6.5	6.7
Zambia	10.1	9.4	10.5	13.4	13.2	12.6	10.7	10.8	10.8
Zimbabwe	10	7.3	9.3	9.8	8.9	8.9	8.9	8.9	8.9

Source: WHOSIS database

ANNEX 2

National Health Account ratios by WHO region and World Bank Income Group, 2006, measured in PPP.

WHO Region	Total expenditure on health as percentage of GDP	Private expenditure on health as percentage of total expenditure on health	Out-of-pocket expenditure as percentage of private expenditure on health	Per-capita government expenditure on health at international dollar rate (I$)	Per-capita total expenditure on health at International dollar rate (I$)
Africa	**5.5**	52.9	49.8	**52**	**111**
Americas	12.8	52.3	30.6	1329	2788
S.E Asia	3.4	66.4	88.3	29	85
Europe	8.4	24.4	70.8	1299	1719
Eastern Mediterranean	4.5	49.1	87.0	132	259
Western Pacific	6.1	39.0	80.7	282	461
Income Group					
Low income	4.3	63.8	**85.4**	21	57
Lower-middle income	4.6	56.6	**85.7**	78	182
Upper-middle income	6.3	44.8	70.0	389	707
High Income	11.2	39.3	36.4	2336	3848
GLOBAL	**8.7**	**42.4**	**49.3**	**445**	**791**

Source: WHOSIS database

ANNEX 3

Income level and Cost-sharing Eligibility Criteria for Proposals for Funding from the Global Fund

Decision Point GF/B16/DP18:

The Board decides to revise the current eligibility criteria for proposals for funding and approves the income level and cost-sharing eligibility criteria for Global Fund funding as set out in Attachment 1, Section 2 of GF/B16/7. The Board delegates to the Portfolio Committee the responsibility to oversee the implementation of the Income Level and Cost-Sharing Eligibility Criteria and to make decisions to facilitate such implementation within the parameters of the policy. The Board further requests technical partners to work with the PC to review how the availability of data for concentrated epidemics in HIV/AIDS will impact access to Global Fund financing.

The Board decides to review the Income Level and Cost-Sharing Criteria in three years' time.

This decision does not have material budgetary implications.

Income Level and Cost-Sharing Eligibility Criteria[2]

Part 1: Overview of Eligibility Criteria

1. As outlined in the Framework Document, the Global Fund's criteria for eligibility for funding from the Global Fund should take into account a number of factors such as disease burden, political commitment, the involvement of an inclusive Country Coordinating Mechanism and the income level of the country[3] in which activities will be implemented (as measured by appropriate economic indicators).

2. As such, the Global Fund makes eligibility determinations for proposals for funding based on three criteria. The first is in relation to Country Coordinating Mechanism requirements as approved at the Ninth Board Meeting. The other two are with respect to income-level and cost-sharing requirements. This document sets out income-level and cost-sharing eligibility criteria that apply to new proposals for funding under the rounds-based and Rolling Continuation Channels. These eligibility criteria may also apply to proposals under future funding channels as and when determined by the Global Fund Board.

3. The eligibility criteria set out below have been designed to give the highest priority to those proposals from countries and regions with the greatest need, based on the highest burden of disease and the least ability to contribute financial resources to fight HIV/AIDS, tuberculosis and malaria.

Part 2: General Principles

4. The Global Fund assesses income-level eligibility of a proposal based on the categorization of the countries in which activities will be implemented as published annually by the World Bank. Proposals for programs to be implemented in countries classified as "low income", "lower-middle income" and "upper-middle income" are eligible for funding from the Global Fund, but additional requirements must be met in the case of "lower-middle income" and "upper-middle income" countries. Proposals for programs to be implemented in countries classified as "high income" are not eligible for funding from the Global Fund.

5. The funding request should seek to cover identified needs based on a sound, costed national strategy to fight HIV/AIDS, tuberculosis and malaria. In the absence of a costed national strategy, the Global Fund will consider funding grant proposals for specific interventions to fight the relevant disease. In order for a proposal to be eligible for funding, the applicant must demonstrate that the cost of funding the national program or interventions for the relevant disease is shared between the Global Fund, domestic resources in the country in which program activities will be implemented, and contributions from other donors, as set out in Part 4, paragraph 2 below.

6. A regional proposal that includes implementation in countries a majority of which are eligible for funding will be considered eligible.

Part 3: Income Level Eligibility

7. For proposals for programs to be implemented in countries classified as "lower-middle income", the interventions for which funding is being requested must focus on poor or vulnerable populations.

[2] Approved during the Sixteenth Board Meeting on 12-13 November 2007 in Kunming, China (Decision Point GF/B16/DP18 and Document GF/B16/7 Revision 1, Attachment 1)
[3] References in this document to "country" refer to "economies" as classified by the World Bank.

8. For proposals for programs to be implemented in countries classified as "upper-middle income", the following conditions apply:

a. The interventions for which funding is sought must be focused on poor and vulnerable populations; and
b. There must be a very high disease burden in the country in which activities will be implemented, defined as follows:

HIV/AIDS

i. The epidemic in the country targeted in the proposal is of such magnitude that it has a measurable impact on population demographics such as life expectancy[4], and significant additional external resources are required to adequately address the epidemic;

Or

ii. The epidemic in a vulnerable population[5] in the country targeted in the proposal is of such magnitude that there is risk of accelerated spread within that vulnerable population and significant additional external resources are required to adequately address the epidemic.

And

iii. The country in which activities in the proposal are targeted must be included in the list of official development assistance recipients, published by the OECD/DAC.

Tuberculosis

i. The country in which the proposal activities are targeted is included on the WHO list of high-burden countries or on the WHO list of countries that account for 95 percent of all new cases attributable to HIV/AIDS.

Malaria

i. The country experiences more than 1 death per 1,000 due to malaria based on data provided by WHO.

9. Proposals from countries classified as "upper-middle income" are eligible to apply for funding if the applicant falls under the "small island economy" exception to the International Development Association lending eligibility requirements, regardless of national disease burden.

10. The Secretariat will make income-level eligibility determinations on an annual basis at the time of the Call for Proposals under the rounds-based channel. In cases where a country moves up from one income category to the next, a one-year grace period will apply, meaning that for the purposes of the next Call for Proposals, the determination of income-level eligibility will be based on the earlier income-level classification.

11. In order for the Global Fund to maintain its poverty focus, Global Fund funding for proposals for programs that will be implemented in "upper-middle income" countries will be limited to 10 percent. This ceiling allows for the possibility of increasing demand from "upper-middle income" countries with a high burden of disease, such as South Africa.

[4] The Board notes that several studies have shown that HIV has a broad and measurable impact on population demographics such as life expectancy once HIV prevalence rate in adults 15 to 49 is equal to or more than 1 percent (UN Population Division "World Population Prospects 2004", and US Census Bureau, Internal Programs Center "World Population Profile: 1996, 1998, 2000 and Global Population Profile 2002"). UNAIDS/WHO will provide a list of countries in which adult HIV prevalence is equal to or more than 1 percent. This list will be updated as new data becomes available.

[5] HIV prevalence rates in adults is equal to or more than 5 percent in at least one identified vulnerable population. UNAIDS/WHO will provide a list of countries in which HIV prevalence is at least 5 percent in one or more vulnerable population. This list will be updated as new data becomes available.

Part 4: Cost-sharing Eligibility

12. The Global Fund may fund up to the proportion set out below of the cost of the national program as follows:

a. in "low-income" countries, up to 100 percent of the national disease program;
b. in "low-middle income" countries, up to 65 percent of the national disease program; and
c. in "upper-middle income" countries, up to 35 percent of the national disease program.

13. If there is no national program for the disease, references to the "national disease program" in this Part 4 will be deemed to be references to the specific interventions to fight the disease in the country.

14. The cost-sharing proportion is measured as follows:

A = Total program need for the period covered by the current funding request

B = Domestic financing (national budget + domestic civil society and private sector contribution) for the period covered by the current funding request

C = Available or planned external resources (borrowing, including "soft loans", grants and contributions from bilateral and multilateral donors) for the period covered by the current funding request

D1 = The total funding provided by the Global Fund through existing grants for the disease under previous rounds or under the Rolling Continuation Channel that overlaps with the period covered by the current funding request.

D2 = The amount of the current funding request which may be up to the full amount of the identified funding gap.

Funding Gap = A-B-C-D1

Cost-sharing Proportion = (D1+D2)/A x 100

15. The Global Fund Board may permit some exceptions to the maximum cost-sharing thresholds specified above based on the particular country context, such as:

a. Severe economic shock leading to the temporary inability of the country to continue to contribute to the cost-sharing element for the three diseases;
b. Severe natural disaster requiring considerable diversion of national resources to address critical needs, thereby temporarily hampering the country's ability to contribute to the cost-sharing element for the three diseases; or
c. Where stigma associated with one of the three diseases lead to exclusion of the needs of specific vulnerable groups from the national program.

16. The cost-sharing requirement does not apply for proposals submitted by applicants that are not Country Coordinating Mechanisms[6].

[6] The Framework Document states that the Global Fund will consider proposals from non-Country Coordinating Mechanism applicants arising from partnerships in circumstances such as: i) countries without a legitimate government, ii) , countries in conflict or facing natural disaster, or iii) countries that suppress or have not established partnerships with civil society and nongovernmental organizations.

REFERENCES

[1] The Global Fund's Second Voluntary Replenishment (2008-2010) Mid-Term Review. Chair's Summary. Cáceres, Spain, 30 March - 1 April 2009

[2] Organisation of African Unity. Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 26-27 April 2001. OAU/SPS/Abuja/3. African Union 2001

[3] Absence of NHA data for Somalia in the WHOSIS database has lead to its exclusion from the analysis leaving 52 African countries.

[4] Organization of African Unity. Ibid para 26

[5] The Global Fund. 16th Board Meeting. Income level and Cost Sharing Eligibility Criteria for Proposal for funding from the Global Fund. November 2007. GF/B16/DP18.

[6] The World Bank's classification of economies according to 2008 GNI per capita is used, with the lower middle income countries having incomes $976 - $3,855, and the upper middle income countries US$3,856 - US$11,905.

[7] Selected countries are: China, Indonesia, Fiji, Philippines, and Thailand (from the East Asia and Pacific region); Belarus, Bulgaria, Romania, Russia Federation, and Ukraine (Eastern Europe & Central Asia region); Argentina, Bolivia, Brazil, Colombia, and Jamaica (Latin America and Caribbean region); and Bhutan, India, Iran (Islamic Republic of), Pakistan, and Sri Lanka (South and West Asia region). The North Africa and Middle East region is adequately covered by those included among the 52 African countries.

[8] Ravishankar N, Gubbins P, Cooley RJ, et al. Financing of global health: tracking development assistance for health from 1990 to 2007. *Lancet* 2009; **373:** 2113–24.

[9] OECD. OECD website http://www.oecd.org/document/35/0,3343,en_2649_34447_42458595_1_1_1_1,00.html

[10] 2006 has been used as it is the period for which data is consistently available for all 52 African countries

[11] See Sixteenth Board Meeting Decision Point GF/B16/DP18

[12] African Development Bank and OECD, 2009 http://www.africaneconomicoutlook.org/en/

[13] Global Fund Five-Year Evaluation: Study Area3. The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis and Malaria, May 2009

[14] USAID, Health Systems 20/20. 2009. Toward Solving Health Financing Challenges In Africa – A Way Forward.

[15] UNAIDS, World Bank. The Global Economic Crisis and HIV/AIDS Prevention and Treatment Programs: Vulnerabilities and Impact. Geneva, Switzerland: UNAIDS and the World Bank; June 2009. http://data.unaids.org/pub/Report/2009/jc1734_econ_crisis_hiv_response_en.pdf. Assessed 17 February 2010

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Chemin de Blandonnet 8
1214 Vernier
Geneva, Switzerland

+ 41 58 791 1700 (phone)
+ 41 58 791 1701 (fax)

www.theglobalfund.org

The Global Fund accepts contributions from governments, corporations, foundations and individuals. To contribute, please visit our website or contact the External Relations team at info@theglobalfund.org . For more information and updates on the status of the Global Fund, visit www.theglobalfund.org

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria