MIND THE GAP

AFRICAN HIV FINANCING SCORECARD

2021

ACCOUNTABILITY INTERNATIONAL
holding leaders accountable

Society for AIDS in Africa
Organisers of International Conference on AIDS and STIs in Africa (ICASA)

FRONTLINE AIDS

Mind the Gap

The African HIV Financing Scorecard takes an innovative but realistic look at how financing for the HIV response can be rethought. Insights on untapped sources, advocacy materials for civil society and plain speak info on this complex but important area of the HIV response.

The research also has implications for broader health and pandemic preparedness too.

Contents

1. About the Report

Increasing domestic investment on HIV treatment and prevention will require a regional coordinated, evidence-based advocacy campaign and partnership, and the Society for AIDS in Africa sees this African HIV Financing Scorecard as a first but critically important step in the broader campaign which aims to increase domestic funding for HIV programming. This program is well suited to SAA's strength in policy analysis and advocacy as SAA is an independent organization devoted to transparency and accountability and whose work is respected by a wide range of global stakeholders. We hope that this research, our findings and recommendations provide evidence to start a discussion, across many stakeholders, on what and how we can sustainably, inclusively and accountably finance the final stages of the HIV epidemic in Africa.

In the past 20 years, national governments, global funders and civil society have made significant progress in expanding access to life-saving antiretroviral treatment and prevention options in the fight against HIV.

Almost sixty percent of people living with HIV are now accessing antiretroviral treatment, and new infections have been reduced by almost 50% since 1996. But while great progress has been made, so we see that contributions by international donors have flatlined even though there is a US$5 billion gap in the resources needed to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90–90–90 targets. These targets which are to diagnose 90% of all HIV-positive persons, provide antiretroviral therapy for 90% of those diagnosed, and achieve viral suppression for 90% of those treated by 2020 need to be achieved if we are to control the HIV epidemic. Currently, low- and middle-income countries contribute approximately 56% of the global resources for HIV, but the investment by countries varies and a significant 20% global funding gap remains, which leaves the HIV response in a precarious position.

The Scorecard attempts to add to the discussion around HIV and Health Financing in a way that non-experts can engage with the concepts and data.

It begins with summaries of the existing relevant frameworks and strategies as a means to position the reader into the existing commitments and theoretical policies that exist. It then briefly examines the goal of self-reliance in the broader geo-political and socio-political environment where a colonial and neo-colonial structures continue to hamper African development.

The report then delves into the domestic sources of financing, looking at government, donors (overseas development assistance (ODA) and what the public contributes. We then go on to understand how taxes play a vital role in the HIV financing realm. The report also looks at where current ODA is coming from, and how African governments are prioritising spending. We then examine tax evasion, corruption and the role they play in undermining financing of the HIV response. Philanthropy is then unpacked, whether from high-net-worth individuals (here or outside of Africa) or from migrant workers making remittances. We then examine and explain what innovative financing mechanisms exist and explain them in plain speak. The final sections look into the role that private sector could play, and what opportunities exist, what watchdogs should be on the look out for and what we should be advocating for more of. Finally,

the report briefly discusses TRIPS flexibilities, explaining how they ca n be used to bolster HIV financing and then we close with a synopsis of the broader democratic, and open governance situation on the continent.

Thanks and acknowledgements

The Society for AIDS in Africa (SAA) and Accountability International (AI) would like to thank all stakeholders and partners in the development of the First Edition "African HIV Financing Scorecard: Mind the Gap ", a joint venture between the SAA and AI with the support of the strong community voices. We believe that this scorecard will help the Africa leadership to own the HIV response by providing a domestic funding to eliminate the burden on HIV in our beloved continent. We appreciate the contributions of the participants of the consultative meeting on the development of this scorecard that was held in Accra – Ghana 15th to 16th October 2019: Akua Kwateng-Addo (USAID Ghana), Dr. Stephen Ayisi Addo (NAEP/ Programme Manager National AIDS/STI Control Programme), Margaret Owusu-Amoako (Management for Strategies Africa Ghana), Patrick Brenny (UNAIDS Dakar), Mme. Martine Dossa (Benin Ambassador), Kevin Fisher (AVAC), Rosemond Jimma (NAEP), Angela Trenton-Mbonde (UNAIDS Ghana), Tolale T. Nathalie Pascale (Directeur Product et Qualite, NDT & Quality Expertises, Cameroon), Yvonne Kahimbura (EANNASO), Yvette Raphael (APHA), Phillipa Tucker (Accountability International), Morenike O. Ukpong (Peer Review Forum, Nigeria), Raymond Yekeye (NAC Zimbabwe).

External advisors: Mit Philips of Médecins Sans Frontières and Jose Antonio Izazola Licea at UNAIDS. Their contributions are also acknowledged.

Expert Panel members: Margaret Owusu-Amoako, Kevin Fisher (also author of the section on clinical trials) Brian Kanyemba, Yvette Raphael, Natalie Tolale, Yvonne Kahimbura, Morenike Ukpong, and Raymond Yekeye. These members suggested some of the chapters and co-developed the findings and recommendations in this report as part of a consultative meeting hosted by SAA in Accra in October 2019.

Special recognition must go to Luc Armand Bodea (ICASA Director/Society for AIDS in Africa Coordinator) for conceptualising and leading the broader HIV Financing Initiative, the team at SAA and SAA Board for their tireless efforts to respond to the HIV epidemic in Africa.

The inclusion of the names of the partners and advisors should in no way be considered as their endorsement of the contents of this report by any of these individuals or organisations.

We appreciate the commitment of Accountability International as well as all local experts for their valuable contributions towards the elaboration of the first "African HIV Financing Scorecard: Mind the Gap".

A note from the author

In this second edition the African HIV Financing Scorecard tries to eliminate ideas and concepts that are well covered by other partners in the development finance realm. This reader can be read in conjunction with the first edition if the learner wishes to cover more topics.

Phillipa Tucker (Accountability International) is the principal author of this report, and any errors or omissions are the sole responsibility of her and her alone. As much as every effort has been made to ensure accuracy, please send corrections, feedback and additions regarding research to phillipa@accountability.international or regarding the broader HIV Financing Initiative to Luc Bodea lucbodea@saafrica.org.

2. Findings and Recommendations

Frameworks

- An African CSO platform interested in increasing accountability around HIV financing as a peer review mechanism by region needs to be coordinated to strategically engage with Regional Economic Communities (RECs).
- No resources (financial, human, time, or intellectual) should be wasted on developing new declarations until existing targets are reached.
- Civil society needs to do advocacy on Abuja 15% in a way that aligns with how health economists understand the budget allocations of the entire budget.

Global Funding

- The broader socio-economic and political, colonial and neo-colonial global landscape needs to be part of the discussion, and the extraction of resources from Africa placed at the centre of the self-reliance discussion.
- Countries need to become more self-reliant and look to local options to fill the gap and finance their health systems, so that they are not subject to foreign fluctuations due to leadership and policy changes.
- Links between other developmental issues and HIV need to be made to ensure that financing for HIV does not get left behind. The case needs to be made by our academics, activists, and duty-bearers.
- Investment cases require closer scrutiny to ensure that the results are led by facts and not by political agendas.
- Existing philanthropic funders of HIV must be continuously engaged to ensure they maintain investment in KPs and HIV rather than moving to new/emerging/competing areas.

Partnerships with Business

- Public Private Partnerships and Impact Investment must be increasingly interrogated and promoted as potentially excellent sources for financing for HIV.
- Researchers and civil society should begin to actively monitor these initiatives to ensure quality, acceptability, and ethics are of the highest standard.
- Workplace programmes need to improve their contributions, not just do testing and referrals but contribute to adherence, prevention, and as many other aspects of the HIV response as possible.
- The policies and practices of transfer and financial institutions (banks) need to be interrogated and improved. They need to be approached as potential sources of HIV funding under corporate social responsibility.

Innovative Financing

- Innovative Financing needs to be a high priority and the African Development Bank should be leading that work, along with country leaders, academics, and economists.

African Philanthropists

- There is a need to do further research on remittances to better understand the differences between the African and other regions and what we can do to leverage both the remittances and the mechanisms being used to transmit them.
- A remittance transfer company should be created that manages remittances solely for Africans, that reduces costs for transfers, but the profits could also be channelled back into HIV.
- A group needs to be created that works to make a better case for HIV financing that is aimed at African Philanthropists specifically.

Governments

- Out-of-pocket expenses must be well understood as the enemy of development, and their impact on entire families needs to be more widely broadcast so that activists do not inadvertently advocate for them, (as sometimes happens, hoping to ensure user responsibility).
- Global monitoring of tax fraud, evasion, and avoidance is exceptionally low, and the creation of a Global Tax Authority would ensure that the correct taxes are paid and paid to the correct country.
- Better tax collection from companies and multinationals, foreign investors, the middle and upper classes, need to be a priority.
- Taxes and imports and VAT that target low-income households should be avoided at all costs, as should VAT on basic foods and goods like bread and baby foods.
- Corruption and illicit financial flows need to be a priority across all countries, and rule of law and transparency leading principles for leaders at all levels to apply for a shift in how Africa deals with health and especially HIV response.
- More countries need to analyse their existing income, cost structures, and governance costs, and build in earmarked caps/ceilings that then demonstrate a real/tangible commitment to HIV and health.
- Structural drivers need to be addressed: nutrition, housing, water, sanitation, education, employment, stigma and discrimination, and entrepreneurship – these responsibilities lie firmly on the shoulders of government and the duty-bearers. Young people especially need to have an enabling environment.
- TRIPs need to be used to its maximum effect: countries need to begin to manufacture their own pharmaceuticals or do collective bargaining for imports, while leaders need to understand that research shows that infringement of intellectual property rights neither reduces foreign direct investment, nor innovation.

Environment: Transparency and Democracy

- Civil society needs to do more watchdog work on holding governments accountable on ratifying and then reporting on human rights commitments. No more the photo opportunity when signing the commitment: we want delivery on these commitments, and shadow reports of official reports must be used as a corrective when necessary.
- All stakeholders, including duty-bearers must come out in support for space and freedoms for civil society to speak, meet, protest, and act in defence of human rights.

3. Relevant Frameworks and Strategies

1.1. Abuja 15%

In 2001, African heads of state committed to allocating a minimum of 15% of their annual budgets to developing their health sectors, while also asking that official development assistance (ODA) funders allocate 0.7% of their gross national product (GNP) to developing countries. Known as *GGHE as % of GGE* (General government expenditure on health as a percentage of total government expenditure) this is one indicator of commitment to improving health. The Abuja Declaration of 2001 affirmed the AIDS epidemic as a state of emergency, which was an important political move. Then in 2006, action by African Union Member States was reinforced by the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa. This *Abuja Call* was intended to translate the former political declaration into concrete action and go beyond just the ideological step. Due to its simplicity the Abuja 15% idea has become well known as an indicator for health investment in Africa.

In 2003, the Maputo Declaration on Malaria, HIV/AIDS, TB, and Other Related Infectious Diseases also reaffirmed the Abuja commitments and recognized that important progress had been made in many countries in terms of mobilizing resources to respond to the three diseases. It was also reiterated in February 2019 as part of the Addis Ababa Call to Action (see following sections).[1]

Abuja 15% has been an important rallying call for political leaders and civil society alike, but it is vital to understand its limitations and the push back that can be expected in some spaces.

1. It is important to note that countries have different capabilities to fund the HIV response and that their economic growth, debt levels, tax collection, and budget procedures, plus geopolitical issues, and geographical placement (amongst many other factors) all affect the political and realistic possibilities of adequately responding to HIV.
2. Colonization, neo-colonization, and the ongoing extraction of wealth and resources (including health human resources) all play a role in the continued disempowerment of African countries to be able to adequately fund and deliver on health.
3. Geography plays an important role in health delivery costs: For example, the delivery of anti-retrovirals would cost significantly more in a large and sparsely populated country like Niger[2] than it would in high density, small Côte d'Ivoire[3]. In contrast, Ethiopia[4] has high density and a population nearly five times larger than either Niger or Cote d'Ivoire, making for a different scenario entirely. Thus, some countries might legitimately require more than 15% to adequately deliver healthcare, others might legitimately need less. See endnotes for more.[5]
4. Investing in health may not be an immediate priority for some countries, when they are at a stage in the country's development where education, infrastructure or water and sanitation might be a higher priority. Post-conflict countries are good examples of this.

These details need to be considered in applying a broad commitment like Abuja and understanding its value. Luxembourg, which has the highest standard of health in the world, spends 5.29% of its budget on health, and Singapore (second place) spends 4.46%[6]. Efficiency and accountability on how funds are spent is a vital aspect of how much should be invested in health, and hence HIV too, and not only a

simplistic measure like 15% of total government budget. Most health economists will use the indicator "cost or investment per capita to deliver healthcare" as a more accurate indicator of both political will and real access to health. This indicator shows in far more detail what governments are actually providing for their population.

Despite its shortcomings, it is important to note that Abuja 15% remains an important rallying call. Although whether it is effective is of some debate, as you will read below.

1.2. Africa Scorecard on Domestic Financing for Health

As part of the Abuja Commitment, there exists the Africa Scorecard on Domestic Financing for Health. This initiative is perhaps quite promising as it indicates action by African leaders in domestic financing for health monitoring and follow up to the outcomes of the Africa leadership meeting on this very topic.[7]

As part of this work, there are several major areas which are being prioritised in health financing:

1. Generating more data, increasing monitoring, and driving political will on the issue of health financing at the head of state level.
2. Improving the efficiency and effectiveness of tax collection in countries.
3. Improving efficiency and effectiveness of health expenditure to use prevention, cost-effectiveness, accurate allocation to improve value for money in health systems management.
4. Create an effective mix of interventions to have maximum impact on reduced mortality and morbidity with minimum expenditure. [8]

The work to date, that is transparent, can be found here: https://scorecard.africa/ but the project seems to be stalled and updated data remains outstanding. Even though African leaders theoretically committed 15% of national budgets to health in 2001, in the 2019 African Scorecard of Domestic Financing for Health (2016 data) only 2 of the 55 AU Member States had allocated 15% of their budget to health.[9] The 2020 Scorecard (2017 data) is yet to be made easily publicly accessible on the website but indicates the same: only Madagascar and Zimbabwe report 15% and over.

In researching this report, it was uncovered that even though a revised 2021 scorecard is planned to be tabled at the next African Heads of State meeting, the AUC has postponed this meeting several times. There seems to be consensus on the current format which is said to be significantly different than the original version, and highly influenced by only Rwanda. But then this initiative is being largely driven by President Kagame.

Despite the politics, one wonders at the impact: Is Abuja and the Scorecard having the intended effect? It seems that for the 2021 Scorecard (2018 data) there has been a decline in health budget allocation: "In 2021, no member state dedicated 15% of the government budget to health. Only 3 member states spend at least 12%, only 11 member states spend at least 10%, and only 19 member states spend at least 8% of the government budget on health. 28 member states spend less than half of the 15% benchmark. (Data not available for 3 member states)."[10]

It is safe to say that despite the high-level interest and advocacy on this issue it remains unachieved across the entire continent. And moreover, what the initiatives do not cover are the rather more unusual ways in which financing for HIV, as well as COVID and health can be leveraged. Read further into this research report for more information on this.

1.3. Addis Ababa Call to Action and UHC MOU

Directly related to the Africa Scorecard on Domestic Financing for Health is the AUC's Addis Ababa Call to Action and the UHC Memorandum of Understanding between the World Health Organization and African heads of state.

In February 2019, the African Union saw leaders commit to the Addis Ababa Call to Action, as part of the Africa Leadership Meeting: Investing in Health. Core outcomes or asks of that meeting were that countries should aim to collect 20% of GDP into the government budget, some of which participants recognized could be done by increasing tax collection by 4%. They also recommitted to the Abuja 15% allotment to health. Leaders also stated that they should spend US$86 per person per annum (WHO recommended target for UHC in developing countries).[11]

Additionally, as recently as 19 November 2019, His Excellency Moussa Faki Mahamat, Chairman of the African Union Commission, and Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization, signed a memorandum of understanding that is aimed at accelerating the African response to Universal Health Coverage. [12]

That document speaks to three key areas: 1. technical expertise from the WHO to the African Medicines Agency (AMA) to improve production of local medicines; 2. Strengthening emergency preparedness and the African health workforce in partnership with the Africa Center for Disease Control, and 3. Supporting Africa in implementing both the Addis Ababa Call to Action on universal health coverage and the AU Declaration on Domestic Financing, with an emphasis on health financing model development.

These three interlinked initiatives are a string indicator of the matter of HIV and health financing gaining greater attention from heads of state. Civil society needs to be able to demand transparency and accountability alongside and within these processes.
The Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030

The objectives of the Catalytic Framework to End AIDS, TB, and Eliminate Malaria in Africa by 2030 (launched in 2016) are:

1. Eliminate malaria incidence and mortality, prevent its transmission and re-establishment in all countries by 2030.
2. End AIDS as a public health threat by 2030.
3. End TB deaths and cases of infection by 2030.

The Catalytic Framework is clearly focussed on a 'business model' which discusses the required investments governments need to make to reach these goals. Issues of leadership, accountability, health financing, community participation, multi-sectoral collaboration and coordination, and innovation all

featured as pillars of the Catalytic Framework. African ownership and leadership were one of the success principles in the Catalytic Framework, along with effective development partnerships, and the idea that health is both a social and economic asset.[13] This framework provides an overarching policy framework to respond effectively to AIDS, TB, and malaria in Africa. Its objective is to intensify the implementation of the 2013 Abuja Declaration commitments to end these three diseases as public health threats through building Africa-wide consensus on the key strategic actions within the context of the existing targets and milestones.

1.4. 90-90-90 and 95-95-95

UNAIDS launched the 90-90-90 agenda in 2014 and it has been an effective mechanism to rejuvenate the AIDS response since then. The idea behind 90-90-90 is that:

1. 90% of people who are HIV infected will be diagnosed,
2. 90% of people who are diagnosed will be on anti-retroviral treatment and
3. 90% of those who receive anti-retrovirals will be virally suppressed by 2020.

The target that 90 per cent of those diagnosed should be treated was a controversial one in 2014 and met resistance in some governments but it is a commitment that has led to the decline in HIV transmission, because viral suppression means that the amount of the virus in someone's blood is so low that it cannot be detected in blood tests. This means it is also untransmissible.

It is important to note that 90-90-90 is premised on four theories:

1. HIV treatment prevents HIV-related illness.
2. HIV treatment averts AIDS-related deaths.
3. HIV treatment prevents new HIV infections.
4. HIV treatment saves money.

In 2014, at the start of the 90-90-90 Agenda the global figures for diagnosed, on ART and virally suppressed respectively were respectively estimated to be 54-41-32.[14] By the end of 2017, the world had achieved 75-79-81.[15] And in the report "Communities at the Centre", released in July 2019, data shows that the figures for 2018 are 79-78-86.[16] As of 2020, UNAIDS reports: "The 90–90–90 targets were missed, but not by much."[17] The figures were 84-87-90.[18]

Now the new UNAIDS 95-95-95 goals for 2025[19, 20] and the goal to end HIV by 2030, are goals that are rooted in the adequate financing of the HIV response. Without adequate domestic financing achieving the goals will be impossible. What is notable is that when increasing domestic investments in health and the HIV response, many countries began to specifically prioritize domestic funding for treatment. For example, UNAIDS reports that from 2009 to 2014 public spending on anti-retroviral therapy (ART) doubled in Chad, Cote d'Ivoire, Gabon, Kenya, Namibia and Swaziland.[21]

1.5. The Sustainable Development Goals

The Sustainable Development Goals followed on from the Millennium Development Goals as the next tier of goals for the planet to reach for and were agreed to in 2015. UNAIDS considers 10 of the 17 Sustainable Development Goals (SDGs) highly applicable to combating HIV and AIDS.[22] Issues of poverty, hunger, education, inequalities, and gender intersect with HIV and AIDS, and remain enormous challenges globally. SDG 9 (Industry, Innovation and Infrastructure) is also applicable as we require public-private partnerships to reach the goals. Sectors like climate and environment have set new standards in making development a sustainable and profitable reality; the health sector and the global HIV and AIDS response needs to engage with these sectors to harness funding opportunities.

1.6. Universal Health Care

After years of advocacy, in September 2019, a new Universal Health Coverage (UHC) Declaration was signed in New York, signifying a new stage in UHC. Over the last few years UHC has grown into a widely accepted health rights movement. The World Bank and the World Health Organization consider UHC to be a core objective for their organizations. Furthermore, UHC is a leading candidate as one of the United Nations Sustainable Development Goals (#3: Ensure healthy lives and promote wellbeing for all at all ages).

It is vital to ensure that the Declaration is interpreted and implemented in the most effective way, so that universal health care is indeed universal, and available to all people. This means that marginalized, stigmatized, criminalized, and oppressed communities must also be included and that those who have HIV are covered by the services that UHC provides. There is a very real risk that gains that have been made under vertical programming – single-issue silo support – for combating HIV will be lost under UHC as HIV loses resources (human, financial, and social) to UHC implementation. It is vital to ensure that the progress is not slowed or reversed, and that HIV remains a top priority within the UHC response.

1.7. PEPFAR

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has been and continues to be the largest funder of the HIV and AIDS response globally. It is also a significant supporter of the Global Fund to End AIDS, TB and Malaria. As of October 2021, PEPFAR had contributed more than 100 billion USD into the HIV response. [23] In 2021, US funding for PEPFAR is at 10.8 billion USD.[24]

PEPFAR's current strategy, Vision 2025, has no surprises: it focusses on the usual community led response, with all stakeholders (including private enterprise) being engaged, a quality data driven response and a human rights and structural barriers approach. Coordination, leveraging, prevention and vulnerable and key populations focus are all in place. With regards to financing for HIV, only the following sections apply:

- "Strengthen the core capabilities of partner governments and communities to autonomously lead, manage, and monitor the HIV response in an effective, equitable, and enduring manner."

- "Capitalize on multi-national and national private sector core capacities, investments, and innovations for greater program efficiency, effectiveness, and sustained health impact."
- "Support "domestic renewal" as a U.S. foreign policy priority by identifying and maximizing opportunities for lesson-sharing and cross-pollination between the U.S. domestic AIDS response and U.S. global AIDS leadership."

1.8. The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund made grants to the tune of 8.5 billion in 2020.[25] In June 2021, the board approved the new Strategy Framework, which like PEPFAR above holds no surprises. Community, people-centred, integrated health systems, human rights, gender, accountability, pandemic preparedness and "leave no-one behind" are all foundations of the framework[26]. Regarding financing, there is the objective to continue "Mobilizing Increased Resources".

"To strengthen the scale, sustainability, efficiency and effectiveness of health financing for national and community responses the Global Fund will work across the partnership to:

1. Increase international financial and programmatic resources for health from current and new public and private sources.
2. Catalyze domestic resource mobilization for health to meet the urgent health needs for SDG 3[27].
3. Strengthen focus on VfM[28] (value for money) to enhance economy, efficiency, effectiveness, equity & sustainability of Global Fund supported country programs & systems for health.
4. Leverage blended finance and debt swaps to translate unprecedented levels of debt and borrowing into tangible health outcomes.
5. Support country health financing systems to improve sustainability, including reducing financial barriers to access and strengthening purchasing efficiency."

This Global Fund strategy very clearly is aware of the current challenges and possibilities, all of which were mentioned in the first version of this African HIV Financing Scorecard, and all of which remain a key priority for advocates of this research.

1.9. UNAIDS

The new "UNAIDS Global AIDS Strategy 2021–2026: End Inequalities, End AIDS" position on financing the HIV response is very much in alignment with current global thinking that there needs to be greater solidarity globally around responding to health. The new strategy also aligns with the African HIV Financing Scorecard (First Edition) calling for "reforms that broaden the vision of financing for HIV and health financing to promote sustainability through addressing the structural drivers of inequality, promoting progressive taxation and Universal Health Coverage, and increased social spending."[29]

It speaks to the need for "traditional and new partnerships", managing the "austerity era" and the need for "a range of methods for mobilizing domestic and market resources."

The UNAIDS Strategy focusses on three action areas:

1. Underscoring the importance of global solidarity and shared responsibility in mobilizing significant new resources to get the response on-track to end AIDS as a public health threat and to address the impact of COVID-19 on the HIV response.
2. Calling for urgent action to improve the equality and strategic impact of resource allocations to achieve sustainable solutions for underserved populations.
3. Prioritizing actions to focus finite resources on the settings, populations and game-changing approaches that have the greatest impact.

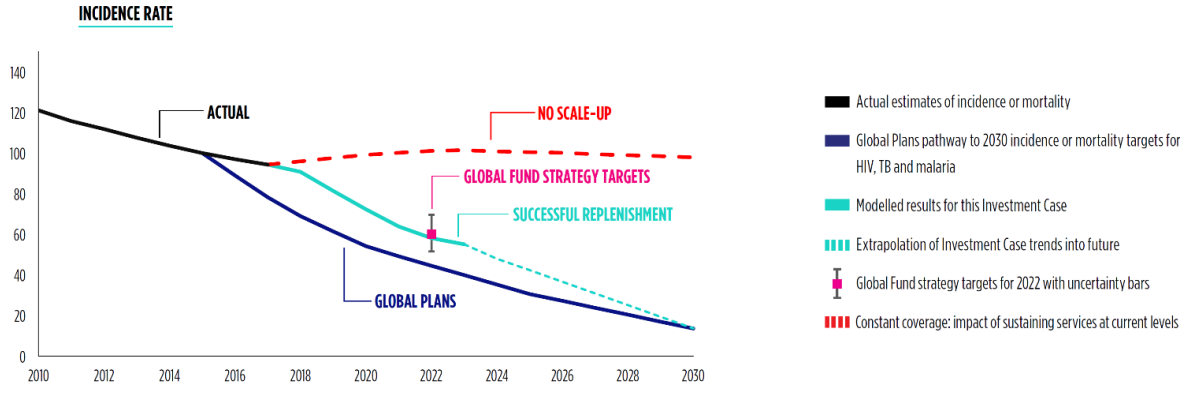
Throughout the strategy there is also an important emphasis on the need for political will of national leaders to rally sustainable domestic funding and for domestic funding to be allocated to prevention work with a focus on women, youth and KPs.

1.10. Investment Cases

In 2011, UNAIDS began to encourage countries to re-think their financing for the HIV response. The idea behind what has become known as "HIV Investment Cases" is that the financial investments must be more strategic, have a more rights-based approach, and lead to greater sustainability. It was hoped that by so doing the investment cases would also provide greater clarity to investors (bilateral and multilateral partners, businesses and the Global Fund) and motivate their investment more. It was hoped as well that innovation would be catalysed, just as gaps would become more obvious and then redressed. Also, it was hoped that basing decisions more on empirical evidence would also lead to more impact and cost-effectiveness.[30]

Investment cases have been reasonably successful in minimising personal influence in grant applications, especially for larger grants, such as PEPFAR and the Global Fund in many countries – but in some countries' investment cases have been construed to fit pre-determined politically supported outcomes in serious cases of "the tail wagging the dog".

The Global Fund has also developed an investment case, one portion of which is demonstrated in the image below. It shows how increased investment now will prevent future new infections. Like most investment cases it examines what the scenario will be with current investments and programmes – and what the scenario will be with greater investment and different programming.



Source: Step up the Case: INVESTMENT CASE, SIXTH REPLENISHMENT 2019, Global Fund.

4. Economic strength

It is important to understand the economic strength of each African country to be able to improve financing for HIV in Africa.

The GDP per capita is one way to measure the total output of a country, output which provides for its people's needs. We use the per capita data because it gives an accurate picture of the demands on a country as well as how much a country can generate economically (how many people need to be served). Africa's countries vary considerably from Nigeria with a population of 200 million to our smallest country Seychelles with 97 000, making Nigeria two thousand times larger in population size than Seychelles. Thus, the GDP per capita provides an indicator of the standard of living we can expect in a country.

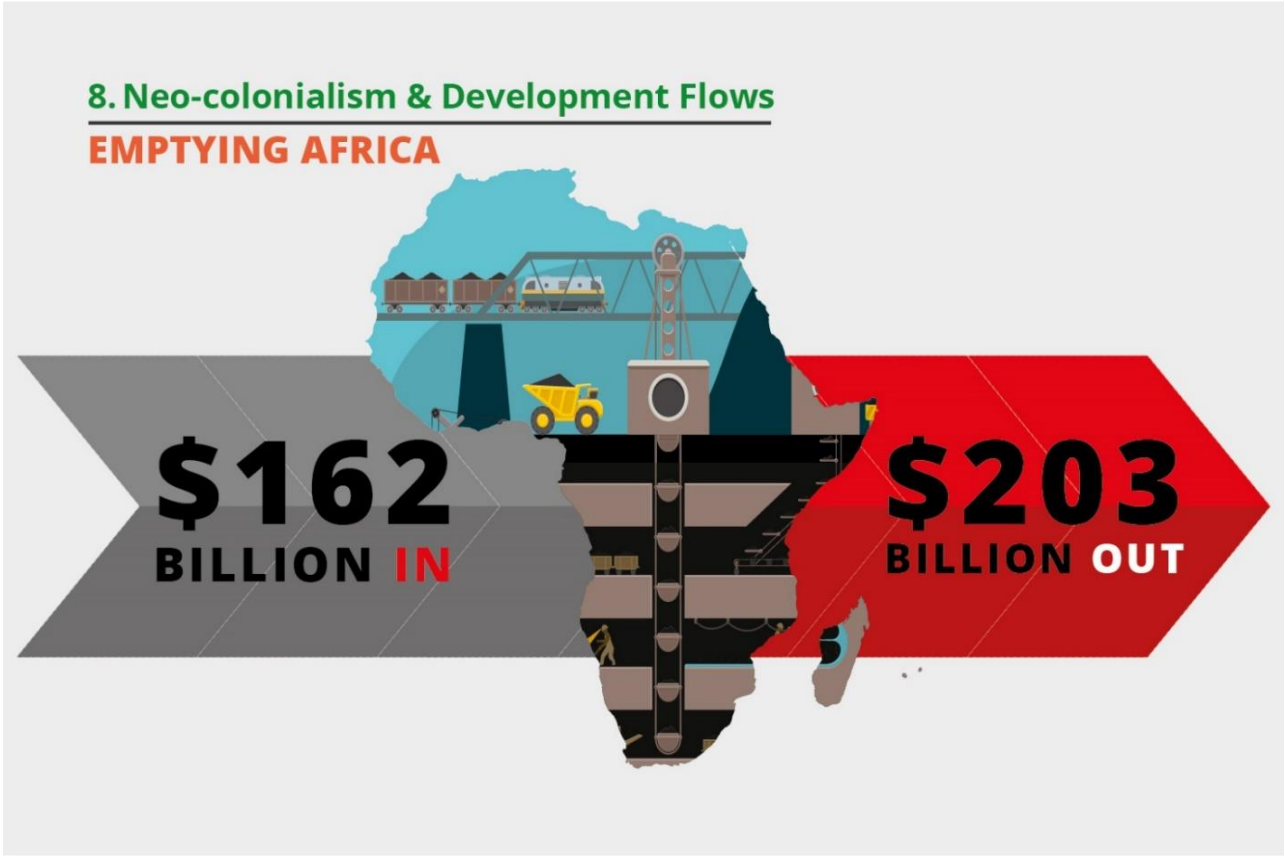
According to World Bank and IMF data not one African country is in the top 10 GDP per capita list[31]. However, 17 of the 20 lowest GDPs per capita are African countries.[32]

1. Burundi – $239
2. Somalia – 313.9
3. Mozambique – 448.5
4. Madagascar – 471.5
5. Central African Republic – $492.8
6. Sierra Leone – 509.4
7. *Afghanistan – 516.7 (not African)*
8. DR Congo – $544
9. Niger – 567.7
10. Sudan – 595.5
11. Liberia – 632.9
12. Malawi – 636.8
13. Eritrea – 642.5
14. Chad – 659.3
15. Guinea Bissau – 727.5
16. *Yemen 758.1 (not African)*
17. The Gambia – 773
18. Uganda – 822
19. Burkina Faso – 857.9
20. *Tajikistan – 859.1 (not African)*

5. Self-Reliance or One-Way Trade?

- Every year, Africa loses approximately $40 billion from foreign under-invoicing of commodity exports.[33]
- Illicit financial flows (IFFs) contribute to an average of $48 billion per year of capital flight from Africa.[34]
- On lost tax revenue on illegal logging alone, it is estimated Africa loses $1.2 billion annually.[35]
- Mauritania, Senegal, The Gambia, Guinea Bissau, Guinea and Sierra Leone alone lose US$2.3 billion annually to illegal fishing.[36]
- African governments pay interest rates of anywhere between 5% to 16%[37] whereas European countries are paying zero and even negative interest rates in some cases.[38]
- Brain drain costs to Africa: Africa spends $4 billion per annum to hire foreigners to fill skills gap and loses $2 billion per annum in lost African health workers alone.
- A 2006 study showed that 25% of all doctors trained in Africa were working in OECD countries.
- The sale of one "Clyman Fang Head" from present day Gabon by Sothebys is valued at $4 million.[39] During COVID, to raise funds private collectors have been rushedly selling off African art with one Christies auction holding dozens of pieces, total value of $1.28 million[40].

In September 2018 when USAID launched their new framework for financing for development "Journey to Self-Reliance", there seemed to be both praise and criticism of the concept. At the same time, the Global Fund has begun to transition countries off funding, and USAID has this similar goal in mind. However beneficial the idea of self-funding might be and the independence that might seemingly come with such a move, there is a need to really understand the multitude of moving parts that exist around the concept of self-reliance and how possible that may or may not be in the context of the larger global economy.



Data Source: Honest Accounts, 2017.[41]

Above, a few examples of how Africa is being exploited economically are provided. This does not include losses to Africa economies over climate change and lost tax revenue, as well as lost revenue from museums, tourism nor other crime. In total this represent enormous losses to Africa.

The idea of transitioning countries off reliance on foreign assistance is at best an over-simplification of how international economic and development flows work and at worst a demonstration of the lack of knowledge of both historical and current global economics, the global movement of migrant human resources, and the history of colonisation. Massive economic gains are still being made for a minority of high-income countries through neo-colonial structures that continue to exist today.
IN this context is it nigh impossible for African countries to grow our economies whilst being chained in such a manner. Broader discussions need to be held that involve all these moving parts and to create an enabling environment for African countries to grow unhindered.

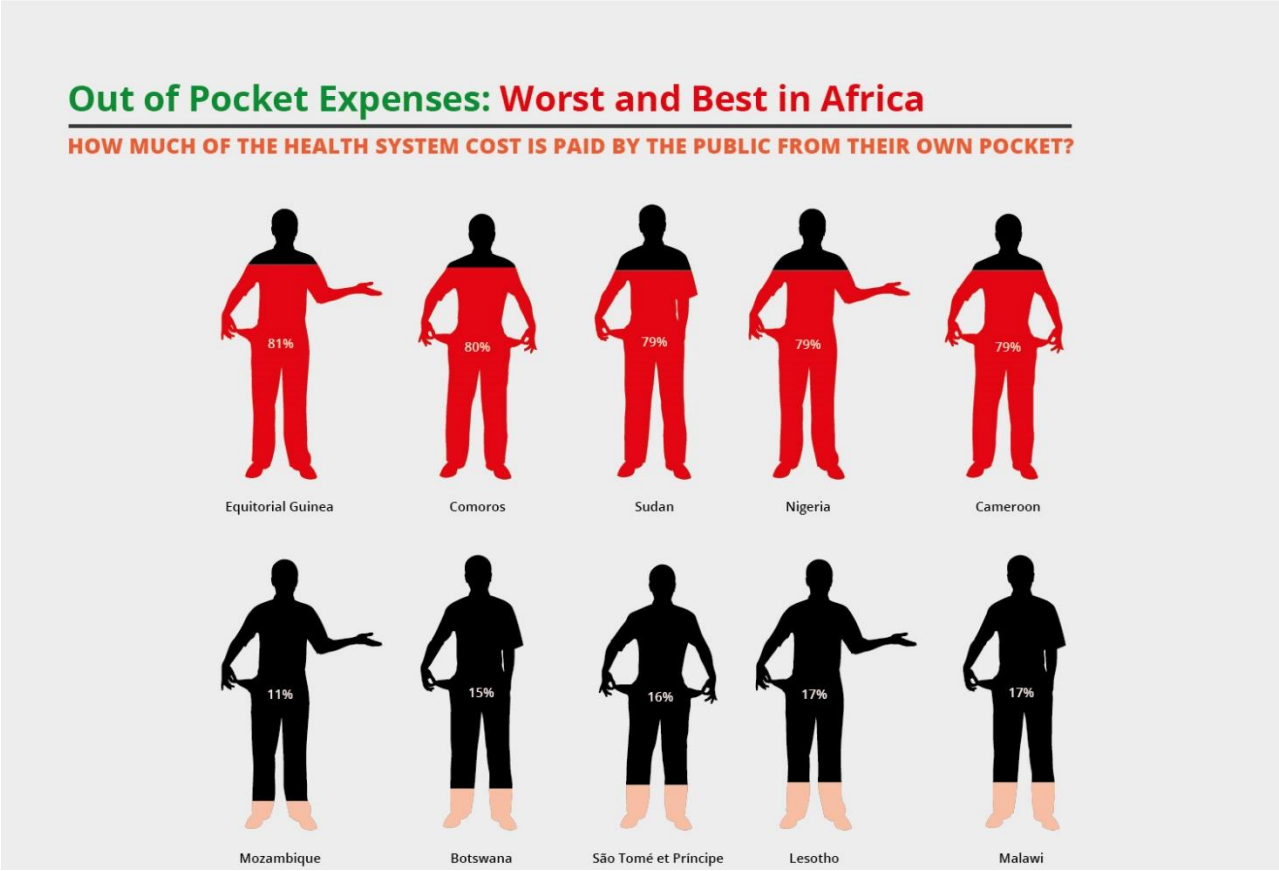
6. Domestic Sources of Financing

The following section examines the current sources of health financing per country. This is an important indicator in that it examines where the finances come from to provide health-care.

Usually, the sources are a combination of

1. government sources,
2. contributions made by the public at health point (out of pocket expenses)
3. co-funding sources such as private or work health insurance and
4. overseas development assistance.

Government sources can be such items as income taxes, value-added tax (VAT), or finances earmarked for health (for example In Botswana, Egypt, and Djibouti some tobacco taxes are earmarked for use in health.



These out-of-pocket expenses are usually called “user fees” at clinic level, and despite decades of understanding and evidence that they can push households into poverty (and multi-generational poverty no less) there are many in the new era of universal health coverage that are again endorsing user fees. Transport, food costs, lost income (patient and caregivers), medicines etc. are all additional burdensome costs to families that have health problems. In some cases, these user fees result in very ill people not even approaching the health system for care, as they do not have the entry fee. In other cases, where they can get a loan, this can be only found at the hands of loan sharks, resulting in exceptionally high interest rates. Research has shown for decades that user fees are not a good way to

finance health. It is important to note that although some claim that some user fees reduce over-use and/or abuse of the health-care system there are two major factors that need to be considered in this regard. First is that because health literacy is low in many African countries people seek health-care for issues which do not require medical intervention, such as headaches for dehydration which can easily be solved at home (except for the very young, old, and seriously ill). Second is the fact that there is no agreement on what an ideal user fee would be in the African context.

The table shows the best and worst performing countries with regards to user-fees (Out of pocket, voluntary pre-paid insurance and other private health spending). Although the AUC Scorecard separates these, making out of pocket expenses look smaller, it is important to note that all three in some way or another come from the take home package of the user, and are ways that the patients and outpatients sponsor the system:

Top 5 Worst	Top 5 Best
1. Equatorial Guinea: 81%	1. Mozambique: 11%
2. Comoros: 80%	2. Botswana: 15%
3. Sudan: 79%	3. São Tomé and Príncipe: 16%
4. Nigeria: 79%	4. Lesotho: 17%
5. Cameroon: 79%	5. Malawi: 17%

Just as user fees are financing the health systems in Africa, so too is foreign aid or overseas development assistance. The scorecard table compares the sources of health financing (government budget, user fees, and development partners) to understand where governments are getting the finances for to run their health care.

Reliance on overseas development assistance is obviously not ideal as it can fluctuate, be contingent on adhering to the political agenda of the donor country and be withdrawn with new leadership in the donor country. Real independence means a country funds their own health and HIV response as much as possible.

The good news, however, is that in recent years, an increase in domestic funding as a percentage of global total funding has been observed (from 50% in 2015 to 57% in 2016/7)[42] Since 2006 domestic resources for HIV have almost doubled to US$20 billion in 2017. [43] For example UNAIDS reports that from 2009 to 2014 public spending on anti-retroviral treatment doubled in Chad, Côte d'Ivoire, Gabon, Kenya, Namibia and Swaziland.[44]

When taking a regional lens to domestic funds, we see interesting differences between the African regions. According to UNAIDS, in North Africa, 72% of HIV financing comes from domestic sources, and donor funding has fallen to below 30%.[45] In East and Southern Africa, US$10.6 billion was available for HIV programmes in 2017, with 42% coming from domestic sources.[46] Over the past decade funding for HIV has grown in these two regions.[47] This differs to West and Central Africa where resources have decreased since 2013, and where domestic resourcing makes up 31% of the total.[48]

UNAIDS has calculated that US$26,2 billion is required to reach the 2020 targets (90-90-90) which were adopted during the 2016 Political Declaration by UN member states[49]. UNAIDS also estimates that 80%

of this is available from domestic funding, but that some countries and some groups of people are still not receiving services.[50] The people who are not serviced are those who are the least able to advocate for their inclusion, often due to them being criminalised (gay men, sex workers, trans-diverse people, and injecting drug users for example) or not in a position to advocate for themselves (people in prison, young girls, women, people living in rural areas, and people with little or no financial resources).

Out-of-pocket expenses

Médecins Sans Frontiers writes in 2017: "Over a decade ago, MSF carried out a series of surveys that highlighted the burden user fees were placing on the lives of vulnerable people in several conflict and crisis-stricken contexts as well as stable, low resource settings. User fees were found to result in low utilization of public health facilities, exclusion from timely health care, and exacerbation of impoverishment, forcing many to forego treatment or to seek less-effective alternatives. Financial barriers affected 30–60% of people requiring health care in the six countries studied (Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti, and Mali). Exemption systems based on assessment of means (i.e., indigent or not indigent eligibility criteria) proved ineffective, benefiting only 1–3.5% of populations. Alternative payment systems, requiring 'modest' fees from users (e.g., low flat fees), did not adequately improve coverage of essential health needs, especially for the poorest and most vulnerable. Conversely, user fee abolition for large population groups led to rapid increases in utilization of health services and essential health care coverage."

		Government	Households & employers	Development Partners
1	Algeria	40%	61%	0%
2	Angola	46%	51%	3%
3	Benin	28%	53%	19%
4	Botswana	76%	15%	10%
5	Burkina Faso	43%	39%	18%
6	Burundi	24%	45%	31%
7	Cabo Verde	44%	47%	8%
8	Cameroon	13%	79%	8%
9	Central African Republic	13%	31%	55%
10	Chad	16%	63%	21%
11	Comoros	10%	80%	11%
12	Congo	41%	52%	8%
13	Côte d'Ivoire	28%	59%	13%
14	Democratic Republic of Congo	9%	48%	42%
15	Djibouti	36%	39%	26%
16	Egypt	29%	71%	0%
17	Equatorial Guinea	18%	81%	2%
18	Eritrea	27%	59%	14%
19	Swaziland (eSwatini)	51%	25%	24%
20	Ethiopia	25%	53%	22%
21	Gabon	48%	51%	1%
22	Gambia, the	23%	35%	42%
23	Ghana	31%	55%	14%
24	Guinea	15%	72%	14%
25	Guinea-Bissau	7%	77%	16%
26	Kenya	36%	47%	18%
27	Lesotho	63%	17%	20%
28	Liberia	17%	54%	29%
29	Libya	NO DATA	NO DATA	NO DATA
30	Madagascar	47%	31%	23%
31	Malawi	31%	17%	52%
32	Mali	28%	44%	28%
33	Mauritania	29%	65%	7%
34	Mauritius	43%	56%	1%
35	Morocco	23%	77%	0%
36	Mozambique	28%	11%	61%
37	Namibia	46%	50%	4%
38	Niger	34%	52%	14%
39	Nigeria	13%	79%	8%
40	Rwanda	24%	25%	50%
41	Sahrawi Republic (Western Sahara)	NO DATA	NO DATA	NO DATA
42	São Tomé and Príncipe	45%	16%	39%
43	Senegal	17%	66%	17%
44	Seychelles	73%	27%	1%
45	Sierra Leone	14%	67%	19%
46	Somalia	NO DATA	NO DATA	NO DATA
47	South Africa	54%	45%	2%
48	South Sudan	8%	23%	68%
49	Sudan	15%	79%	5%
50	Tanzania	15%	71%	14%
51	Togo	27%	73%	0%
52	Tunisia	16%	42%	43%
53	Uganda	36%	33%	32%
54	Zambia	39%	19%	43%
55	Zimbabwe	52%	34%	15%

Source of spending, as a % of total health spending (latest available data 2017)

Notes: Some percentages do not reach exactly 100 due to rounding. Out of Pocket is money spent by individuals and Workplace health insurance is funds paid by employers to cover staff. *Source: AU, Africa Scorecard on Domestic Financing for Health, 2020 (2017 data)*

7. Tax Collection Effectiveness and Efficiency

Tax is an established way of increasing public revenue.

It is important to differentiate between changes to tax policy and improving existing tax collection.

Although critics might imagine that increasing tax collection in poor African nations might adversely affect the poor, the reality is quite the opposite, if tax policy is pro-poor. If there is a pro-poor tax policy in place and tax collection is improved, this can in fact be one way to create greater equality as services can be theoretically improved for those with lower incomes, by correctly investing the taxes collected into vital public services.

At the recent African Leaders Summit in Addis, experts estimated that simply by improving tax collection at current rates and improving the efficiency of the tax collection agencies themselves most African countries could improve their GDP by 4%. This is a significant way to improve an economy.

As always it is useful to understand how Africa performs on the global stage and so we analyse tax revenue collection as a percentage of GDP figures collated by the OECD. Africa's average tax-to-GDP ratio is 18%, almost half of the 34% we see in the OECD countries.

In the next scorecard, we analyze World Bank data on a country-by-country basis. It is important to remember that globally effective, efficient and fair taxation is an excellent indication of a country's willingness and ability to source funds to provide services (for HIV, health, and beyond) to all people in

the country. On the African continent, our poorest performer is Nigeria at 1.5% and our best is Lesotho at 48.6%

	Country	Tax revenue as % of GDP 2018
1	Algeria	37.20%
2	Angola	12.50%
3	Benin	15.40%
4	Botswana	25.80%
5	Burkina Faso	15.50%
6	Burundi	12.20%
7	Cabo Verde	18.40%
8	Cameroon	NO DATA
9	Central African Republic	9.20%
10	Chad	NO DATA
11	Comoros	NO DATA
12	Congo	9.40%
13	Côte d'Ivoire	14.00%
14	Democratic Republic of Congo	8.80%
15	Djibouti	NO DATA
16	Egypt	12.50%
17	Equatorial Guinea	12.80%
18	Eritrea	NO DATA
19	Ethiopia	9.20%
20	Gabon	NO DATA
21	Gambia, the	15.10%
22	Ghana	13.70%
23	Guinea	NO DATA
24	Guinea-Bissau	NO DATA
25	Kenya	16.30%
26	Lesotho	48.60%
27	Liberia	20.30%
28	Libya	NO DATA
29	Madagascar	9.90%
30	Malawi	15.50%
31	Mali	15.40%
32	Mauritania	NO DATA
33	Mauritius	18.10%
34	Morocco	23.30%
35	Mozambique	23.10%
36	Namibia	33.20%
37	Niger	NO DATA
38	Nigeria	1.50%
39	Rwanda	14.90%
40	Sahrawi Republic (Western Sahara)	NO DATA
41	São Tomé and Príncipe	14.60%
42	Senegal	20.50%
43	Seychelles	31.60%
44	Sierra Leone	8.60%
45	Somalia	NO DATA
46	South Africa	27.30%
47	South Sudan	NO DATA
48	Sudan	NO DATA
49	Swaziland (eSwatini)	28.60%
50	Tanzania	11.90%
51	Togo	21.90%
52	Tunisia	21.10%
53	Uganda	13.50%
54	Zambia	16.10%
55	Zimbabwe	21.40%

Source: World Bank

8. International Sources

International funding for combating HIV in low- and middle-income countries has come from various sources over the decades, but the total investment in HIV by International Development Partners (IDPs) in the OECD, excluding the USA, has reduced from 3.2 billion to 2 billion USD between 2010 and 2020. [51] Principally because investments have moved to other areas, for example to migration and integration, climate change and security, and of course since 2019 to the COVID-19 response. This has been offset by an increase in HIV funding by the USA increasing from 3.7 billion USD to 6.2 billion between 2010 and 2020.[52]

It is important to consider how much countries should be contributing relative to their share of the global economy. The countries with the largest share, should be contributing their fair share. The USA has 24% of the global GDP, China 15%, followed by Japan (6%), Germany (4.5%), India, The UK, and France (each 3%) and Brazil, Italy, Canada and Russia (each 2%).[53]

This can be even more informative when we examine by region: The European Union has 15% of the global GDP collectively, whilst the Latin America and Caribbean has 7% The Middle East and Central Asia also holds 7%. ASEAN[54] members hold 5.6% whilst Sub-Saharan Africa only has 3%.[55]

It is vital to see contributions to HIV from International Development Partners (IDPs) in this context. It cannot be expected that HIV financing comes solely from countries which collectively hold 3% of the global GDP, whilst larger economies with big shares cut back their investments. This is also part and parcel of the discussion around neo-colonisation and the exploitation politically and economically of the Africa region for the benefit of these larger, stronger economies (see xx).

Government	Share of World GDP	Share of Total Donor Government Funding for HIV[1]	Share of Global Resources Available for HIV[2]	Total HIV Funding Per $1 Million GDP
United States	24.80%	76.00%	28.10%	$296.70
United Kingdom	3.20%	7.50%	2.70%	$225.80
Netherlands	1.10%	2.40%	0.90%	$213.20
Sweden	0.60%	1.10%	0.40%	$174.60
Denmark	0.40%	0.50%	0.20%	$115.30
Norway	0.40%	0.50%	0.20%	$113.20
France	3.10%	2.60%	1.00%	$83.10
Germany	4.50%	3.00%	1.00%	$64.70
Ireland	0.50%	0.30%	0.10%	$57.60
Canada	1.90%	1.00%	0.40%	$51.50
Japan	6.00%	3.20%	1.10%	$51.10
Italy	2.20%	0.40%	0.10%	$17.60
Australia	1.60%	0.30%	0.10%	$16.30

International sources of funding for HIV: Source: Kaiser Family Foundation and UNAIDS[56]

Country	Year	Total Public	Total Private	PEPFAR	Global Fund	All Other International	International
Algeria	2017	80%	19%	0%	1%	1%	2%
Angola	2020	57%	0%	8%	25%	10%	43%
Benin	2020	39%	0%	0%	57%	4%	61%
Botswana	2017	63%	0%	30%	7%	0%	37%
Burkina Faso	2019	27%	0%	0%	73%	0%	73%
CAR	2017	4%	8%	0%	75%	13%	88%
Comoros	2020	15%	0%	0%	84%	0%	85%
Côte d'Ivoire	2016	0%	0%	0%	100%	0%	100%
DR Congo	2017	11%	0%	35%	45%	9%	89%
Eritrea	2019	0%	0%	0%	51%	0%	100%
Eswatini	2019	40%	1%	42%	10%	7%	59%
Ethiopia	2018	4%	0%	56%	36%	4%	96%
Gabon	2018	95%	0%	0%	0%	0%	5%
Gambia, the	2019	100%	0%	0%	0%	0%	0%
Ghana	2017	25%	12%	14%	48%	1%	63%
Guinea	2020	4%	0%	0%	74%	22%	96%
Kenya	2020	36%	16%	39%	9%	0%	49%
Lesotho	2017	19%	0%	56%	22%	2%	81%
Liberia	2015	0%	0%	0%	100%	0%	100%
Madagascar	2017	6%	0%	0%	84%	10%	94%
Malawi	2020	2%	0%	42%	55%	0%	98%
Mali	2016	18%	0%	14%	64%	4%	82%
Mauritania	2018	32%	5%	0%	63%	0%	63%
Morocco	2015	47%	4%	0%	37%	12%	49%
Mozambique	2017	2%	1%	69%	16%	12%	97%
Namibia	2016	59%	2%	30%	8%	1%	39%
Niger	2020	0%	0%	0%	77%	23%	100%
Nigeria	2020	17%	0%	67%	15%	1%	83%
Rwanda	2015	9%	0%	45%	44%	2%	91%
Senegal	2013	22%	8%	0%	41%	29%	70%
Seychelles	2020	90%	0%	0%	0%	10%	10%
Somalia	2019	0%	0%	0%	100%	0%	100%
South Africa	2018	77%	0%	18%	5%	0%	23%
South Sudan	2017	4%	0%	0%	0%	96%	96%
Togo	2019	19%	10%	14%	42%	15%	72%
Tunisia	2016	100%	0%	0%	0%	0%	0%
Uganda	2018	8%	8%	67%	11%	6%	84%
UR Tanzania	2017	1%	0%	0%	0%	0%	99%
Zambia	2020	2%	0%	77%	21%	0%	98%
Zimbabwe	2019	3%	0%	58%	39%	0%	97%

International funding sources as percentage of total funding.
Source: Global AIDS Monitoring Dataset, UNAIDS. https://hivfinancial.unaids.org/

9. Domestic Spending Priorities

Our next element investigates whether health generally is a priority for each country's duty holders. Determining whether a country has prioritized health over other demands is an important way to understand the political will of leadership. One way to ascertain governments' prioritising of health is to look at where else they spend funds. Thus, we look at whether countries prioritise health over military costs. Although the military can be used in humanitarian disasters such as hurricanes, droughts, and floods, they are principally deployed for safety and security reasons. Expenditure on military for some is vital whilst others see it as wasted expenditure. What most agree on is that it does emphasise why a peaceful, respectful, and secure planet is a prerequisite for health for all. In a political environment that is not factious with conflict, military spending tends to be low, and these funds can be diverted to better use for human development.

- Chad has the highest expenditure on the military as a percentage of general govt expenditure at 17.2%, and only spends 5.2% on health (down from 6.3 % in 2018).
- Cameroon spends 6% on the military and has decreased their health expenditure from 3.1% to 1.1% between 2015 and 2018 (latest data).
- Several countries have military budgets that are double or near double their health budgets (Angola, Cameroun, Chad, Congo, Guinea, Guinea-Bissau, Mali, and Togo.
- Madagascar was performing well with 15.3% to health in 2015, but this dropped to 10.5% in 2018.
- Cabo Verde as well is spending a good 8% more on health than the military (10.4% vs 1.8%) Mauritius has a 10.6% to 0.6% health to limitary difference.

Generally, we can see that countries that are spending less on military and more on health, are also reaching the WHO advised 86.3 US Dollars per person budget allocation.

		Current Health Expenditure (CHE) per Capita in US$*	Domestic general govt health expend** 2015 & 2018	Military expenditure (% of general government expenditure) 2018
		A: ≥ 500 B: 363-499 C: 225-362 D: 86.4-224 E: ≤86.30	A: ≥ 15% B: 10-14% C: 6-9% D: 3-6% E: ≤3% (graded only for 2018)	A: Spends more than 1% more on health than military; C: Spends less than 1% more on health than on military; E: Spends more on military than on health
1	Algeria	256	10.7% - 10.7%	14.5%
2	Angola	88	3.7% - 5.4%	9.5%
3	Benin	31	3.4% - 2.96%	3.8%
4	Botswana	483	8.8% - 14.3%	8.1%
5	Burkina Faso	40	7.2% - 8.8%	7.9%
6	Burundi	24	11.8% - 8.5%	7.9%
7	Cabo Verde	195	10.8% - 10.4%	1.8%
8	Cameroon	54	3.1% - 1.1%	6.0%
9	Central African Rep.	54	4.1% - 4.2%	7.6%
10	Chad	29	6.3% - 5.2%	17.2%
11	Comoros	65	3.8% - 2.6%	NO DATA
12	Congo	48	2.7% - 3.5%	11.1%
13	Cote d'Ivoire	72	4.7% - 5.1%	5.9%
14	DR Congo	19	3.8% - 4.45%	5.6%
15	Djibouti	71	4.1% - 4.3%	NO DATA
16	Egypt	126	5.1% - 4.7%	4.2%
17	Equatorial Guinea	314	1.3% - 3.2%	5.9%
18	Eritrea	24	2.4% - 2.4%	NO DATA
19	Eswatini	271	8.7% - 6.0%	5.8%
20	Ethiopia	24	5.6% - 4.8%	4.0%
21	Gabon	218	7.0% - 9.4%	9.1%
22	Gambia, the	22	5.0% - 4.4%	3.2%
23	Ghana	78	8.5% - 6.4%	1.6%
24	Guinea	38	2 % - 4.1%	10.4%
25	Guinea-Bissau	53	2.8% - 3.0%	6.5% *
26	Kenya	88	7.8% - 8.6%	5.0%
27	Lesotho	125	11.2% - 11.6%	3.9%
28	Liberia	45	3.3% - 5.2%	1.6%
29	Libya	NO DATA	NO DATA	NO DATA
30	Madagascar	22	15.3% - 10.5%	3.7%
31	Malawi	35	9.7% - 9.8%	3.1%
32	Mali	35	4.4% - 5.4%	14.0%
33	Mauritania	54	5.5% - 6.1%	11.2%
34	Mauritius	653	9.5% - 10%	0.6%
35	Morocco	175	6.9% - 7.2%	10.5%
36	Mozambique	40	5.6% - 5.6%	4.1%
37	Namibia	471	9.6% - 10.7%	9.1%
38	Niger	30	4.6% - 8.4%	8.5%
39	Nigeria	84	5.3% - 4.4%	4.0%
40	Rwanda	58	7.9% - 7.3%	4.7%
41	Sahrawi Republic	NO DATA	NO DATA	NO DATA
42	São Tomé& Príncipe	125	4.9% - 10.8%	NO DATA
43	Senegal	59	4.7% - 4.3%	7.4%
44	Seychelles	833	10.0% - 10.2%	3.7%
45	Sierra Leone	86	7.9% - 7.2%	3.4%
46	Somalia	NO DATA	NO DATA	NO DATA
47	South Africa	526	13.3% - 13.3%	3.0%
48	South Sudan	27	NO DATA	9.8%
49	Sudan	NO DATA	18.3% - 6.8%	10.6%
50	Tanzania	37	7.3% - 9.4%	6.4%
51	Togo	55	4.2% - 4.3%	8.0%
52	Tunisia	252	13.7% - 13.6%	6.9%
53	Uganda	43	5.1% - 5.1%	7.6%
54	Zambia	76	7.4% - 7.0%	5.1%
55	Zimbabwe	140	7.6% - 7.6%	5.6%

Source/ World Health Organization Global Health Expenditure database (http://apps.who.int/nha/database).
*2018 - (WHO HLTF recommends investing a minimum of $86.30pp)
** (% of general government exp) -Abuja 15%

10. Government Spending on HIV

Obviously in the analysis of HIV financing it is also vital to examine how much countries are currently spending on HIV and what kinds of programmes are being funded. The table in this section examines the reported spending by countries by area of programming. It is important to note that reported higher spending per person does not necessarily equate to better health and HIV services: many a monitoring person has arrived to visit a new hospital only to find an empty plot of land! However, when analysed in conjunction with the other data it is a useful indication of whether a country is progressing.

When analysing the more detailed countries' programming expenditure (see two-page table) it allows us to analyse where exactly the funding is reportedly being spent. The administration and management lines constitute 5% of all funds, unless of course we remove the South African treatment costs (US$1,002,372,831) which then makes all admin across the entire continent 10% of all finances. As a group, this then appears not to be problematic – but there are countries where local watchdogs should be digging deeper to discover why their country data reflects very large percentages for admin: Mali reports that 60% of its budget is spent on admin, along with Central African Republic (49%), Burundi and Senegal (38%), Ghana (35%). There may be country-context reasons for this, but local activists and duty-bearers should be in the know and able to account for these anomalies.

What we can also note is that there is greater investment in programmes for youth and women, and very little investment in key populations, human rights, and critical enabling environments. Examining only countries that submit complete data-sets (only 18 of the 55 African member states, representing 33%) we see that Cote d'Ivoire invests more finances into a critical enabling environment than any other country (US$997,109, or 8%), but Senegal invests the largest percentage (14.2%; US$272,007). Mozambique (8.26%; US$702,311), Ghana (7.91%; US$523,141) and Malawi (3.8%; US$214,439) also perform well on this indicator.

Of those countries that do submit a full data-set not a single country reports spending 1% or more on key populations (KP) and human rights programmes, which can either indicate that reporting is inaccurate, that KP programmes are reported elsewhere – or that we have not even begun to address the needs of the most affected. Community mobilization also is very low across the continent. There is a significant need to both improve reporting and to advocate for more long-term solutions which is where the community, KP, and human rights programmes will have impact.

	Where governments report spending money on HIV	Governance & sustainability/ HIV/AIDS research	Of which Admin (part of governance & sustainability, Strategic info (8.1) & Planning & coordination (8.2) /Programme mgmt. & admin	Treatment, care & support (1)/ Treatment	All prevention including Prevention of vertical transmission of HIV (2 and 3)/ Prevention	Programmes for children, adolescents, on gender & on social protection (4, 5, 6)/OVC	TB / HIV co-infection, diagnosis & treatment (sub-total) (10)	Community mobilisation (7)	Critical enablers	Of which Key Human Rights Programmes/HR and Legal Rights	Other essential programs for selected year	TOTAL	Year of Expenditure Data
1	Algeria	$675,840	$297,370	$21,505,501	$2,667,766	$360,448	$34,243	$54,067	$63,078	$18,022	$0	$25,676,336	2017
2	Angola	$0	$0	$3,292,607	$0	$0	$0	$0	$0	$0	$3,292,607	$6,585,215	2017
3	Benin	$0	$1,051,790	$3,458,730	$1,877,910	ND	ND	ND	ND	ND	ND	$6,388,430	2017
4	Botswana	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
5	Burkina Faso	$8,619	$3,456,140	$8,500,920	$4,067,660	$422,847	ND	ND	ND	ND	ND	$16,456,186	2015
6	Burundi	$61,542	$1,522,300	$917,760	$1,158,580	$277,075	ND	$0	ND	$17,875	ND	$3,955,132	2007
7	Cabo Verde	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
8	Cameroon	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
9	Central African Republic	$794,424	$761,209	$0	$0	$0	$0	$0	$0	$0	$0	$1,555,633	2017
10	Chad	ND	ND	ND	$313,202	ND	ND	$0	ND	ND	ND	$313,202	2012
11	Comoros	$119,197	$0	$29,778	$0	$0	$0	$0	$0	$0	$0	$148,975	2017
12	Congo	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
13	Côte d'Ivoire	$3,183,697	$3,156,089	$7,921,004	$67,175	$106,752	$0	ND	$997,109	$0	$136,211	$15,568,036	2013
14	Democratic Republic of Congo	$3,453,226	$3,252,143	$0	$51,232,358	$9,321	$0	$0	ND	ND	$1,094,050	$59,041,098	2014
15	Djibouti	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
16	Egypt	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
17	Equatorial Guinea	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
18	Eritrea	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
19	Ethiopia	$15,525,640	$10,983,946	$19,487	$1,062,283	$429,704	$0	$1,737	$0	$0	$37,330,580	$65,353,377	2016
20	Gabon	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
21	Gambia, the	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
23	Guinea	$549,256	$0	$140,635	$0	$0	$0	$0	$0	$0	$0	$689,891	2017
24	Guinea-Bissau	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
25	Kenya	$0	$37,000,000	$186,000,000	$134,000,000	$32,000,000	ND	ND	ND	ND	ND	$389,000,000	2009/10-2011/12
26	Lesotho	$8,873,833	$0	$21,646,205	$2,511,289	$346,608	$244,639	ND	$0	$0	$15,012,081	$48,634,655	
27	Liberia	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND

	Sources: UNAIDS GAPR, GAM Reports/ UNAIDS NASA Reports	Governance & sustainability/ HIV/AIDS research	Of which Admin (part of governance & sustainability, Strategic info (8.1) & Planning & coordination (8.2) /Programme mgmt. & admin	Treatment, care & support (1)/ Treatment	All prevention including Prevention of vertical transmission of HIV (2 and 3)/ Prevention	Programmes for children, adolescents, on gender & on social protection (4, 5, 6)/OVC	TB / HIV co-infection, diagnosis & treatment (sub-total) (10)	Community mobilisation (7)	Critical enablers	Of which Key Human Rights Programmes/HR and Legal Rights	Other essential programs for selected year	TOTAL	Year of Expenditure Data
28	Libya	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
29	Madagascar	$101,339	$101,339	$178,861	$9,375	$0	$0	$297	$0	$0	$0	$391,211	2017
30	Malawi	$2,624,582	$229,195	$141,732	$2,574,227	$39,193	$0	$0	$214,439	$0	$0	$5,823,368	2017
31	Mali	$48,807	$1,704,300	$341,226	$732,216	$20,711	ND	ND	ND	ND	ND	$2,847,260	2008
32	Mauritania	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
33	Mauritius	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
34	Morocco	$3,359,186	$0	$13,321,232	$1,563,958	$0	$0	$0	$0	$0	$0	$18,244,377	2017
35	Mozambique	$5,064,682	$1,315,772	$1,736,108	$701,689	$122,776	$139,699	$34,547	$702,311	$18,149	$0	$9,835,733	2016
36	Namibia	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
37	Niger	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2017
38	Nigeria	$15,843,117	$9,476,065	$62,302,674	$74,410,821	$0	$0	$0	$0	$0	$0	$162,032,677	2016
39	Rwanda	$19,731,819	$891,520	$0	$145,676	$0	$0	$0	$0	$0	$0	$20,769,015	2015
40	Sahrawi Republic	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
41	São Tomé & Príncipe	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
42	Senegal	$1,322,403	$1,162,941	$0	$40,476	$0	$0	$0	$272,007	$0	$286,078	$3,083,905	2015
43	Seychelles	$227,250	$93,778	$799,748	$740,451	$8,108,802	$37,426	$11,759	$9,823	$4,689	$0	$10,033,725	2016
44	Sierra Leone	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
45	Somalia	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
46	South Africa	$62,760,148	$51,900,764	$1,002,372,831	$107,721,266	$108,893,564	$189,787,033	$346,733	$0	$0	$73,945,146	$1,597,727,486	2017
47	South Sudan	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
48	Sudan	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
49	Swaziland (eSwatini)	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
50	Tanzania	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
51	Togo	$712,217	$696,191	$0	$1,214,549	$39,699	$26,391	$20,783	$1,214	$1,214	$0	$2,712,259	2016
52	Tunisia	$0	$0	$1,574,995	$0	$0	$0	$0	$0	$0	$0	$1,574,995	2016
53	Uganda	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND
54	Zambia	$0	ND	$4,931,590	$1,375,950	$7,445	ND	ND	ND	ND	ND	$6,314,985	2010-2012
55	Zimbabwe	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	$0	ND

11. Tax Evasion and Loss of African Funds to Illicit Financial Outflows

Illicit outflows from African countries to foreign countries is hugely problematic as a source of lost revenue for African nations, revenue which could be spent on financing the HIV response.

The analysis done by colleagues at Global Financial Integrity demonstrates that Africa is not just a recipient of financial aid, but actually is losing massive amounts of funds largely through illicit trade mis-invoicing, amounting to US$1 trillion per annum.[57] Not only could the lost revenue be allocated to HIV and related health issues, but the taxes levied on such amounts would also allow for African nations to better respond to their people's health and HIV needs. The researchers at Global Financial Integrity recommend that governments require individuals and companies to be more transparent and provide public reports on losses, profits, staff, taxes paid, and various other details as a means to create a globally transparent taxing system, and one which also can track illicit flows.[58] This requires governments to track, control, and prosecute where necessary financial fraud. Ethiopia and Tanzania are signees of the Addis Tax Initiative which would allow governments better combating of illicit flows, and the ability to create more fiscal space, which could be channeled to HIV in turn.[59, 60]

> *"A multinational [company] will make a profit of $10 million and then they will bring in a consultancy for 12 million and declare a loss. The result is that they have made a loss instead of profit, so this money goes to the tax haven where they have another organization which provided the consultancy, so no tax gets paid on the income that was made," explained Daniel Yaw Domelevo, the auditor general of Ghana, who attended the IACC. "That is the major cause of illicit financial flows in Africa."*[61]

The Addis Tax Initiative is one of the leading bodies working in this area. As of December 2020, sixty countries and development organisations had joined the initiative. A renewed commitment the "ATI Declaration 2025" was also made in December 2020. The commitment focusses on domestic revenue mobilisation, with a focus on policy changes that "foster DRM and combat tax-related illicit financial flows."[62] The new commitment also requires members to "enhance cavity and space for accountability stakeholders."[63]

The creation of a Global Tax Authority has also been touted as a means to monitor incomes and tax payments by individuals and companies around the globe, preventing what is called cross-border tax fraud, evasion, and avoidance. The Global Forum on Transparency and Exchange of Information for Tax Purposes is the leading organisation working in this area. Transparency around tax and setting and adhering to standard on information sharing would allow authorities in all countries to see financial and tax transactions and thereby avoid the myriad of bilateral agreements and data-sharing systems that exist. Extended and automatic data-sharing systems on taxes that would be managed by a central authority would be an excellent way to ensure fair taxes are paid by those who are due to pay them, and that they would be paid to the correct geographic authorities (so that gains made in Mozambique are paid in Mozambique and not in the Cayman Islands, a tax haven with low and zero taxation rates, for example).

12. Corruption

Corruption is increasingly being monitored and more so by European authorities than even African ones.

A good example, in October 2019 is that of Swiss energy company Gunvor that was fined US$95.1 million by Swiss authorities for corruption in Côte d'Ivoire and the Congo. The fine amount is estimated as equal to the total profit that the company made in those countries during the time that the corruption was taking place. Although the CEO was aware of the corruption, it is the official who took the bribes who was given an 18-month prison sentence[64].

In February 2021, the French Bollore Group was fined 12 million Euros for undercharging the Togo government for consultancy work in return for a contract on port management. The Swiss, French, US and UK authorities have all had legal proceedings against Teodoro "Teodorin" Nguema Obiang Mangue (son of current President and current VP of Equatorial Guinea) and under Article 57.3.c of the UN Convention against Corruption are reallocating all fines, funds from the sale of confiscated assets, amounting to in excess of 100 million USD.

> *"Over the last 50 years, Africa is estimated to have lost in excess of $1 trillion in illicit financial flows (IFFs) (Kar and Cartwright-Smith 2010; Kar and Leblanc 2013). This sum is roughly equivalent to all the official development assistance received by Africa during the same timeframe. Currently, Africa is estimated to be losing more than $50 billion annually in IFFs. But these estimates may well fall short of reality because accurate data do not exist for all African countries, and these estimates often exclude some forms of IFFs that by nature are secret and cannot be properly estimated, such as proceeds of bribery and trafficking of drugs, people and firearms. The amount lost annually by Africa through IFFs is therefore likely to exceed $50 billion by a significant amount."*[65]

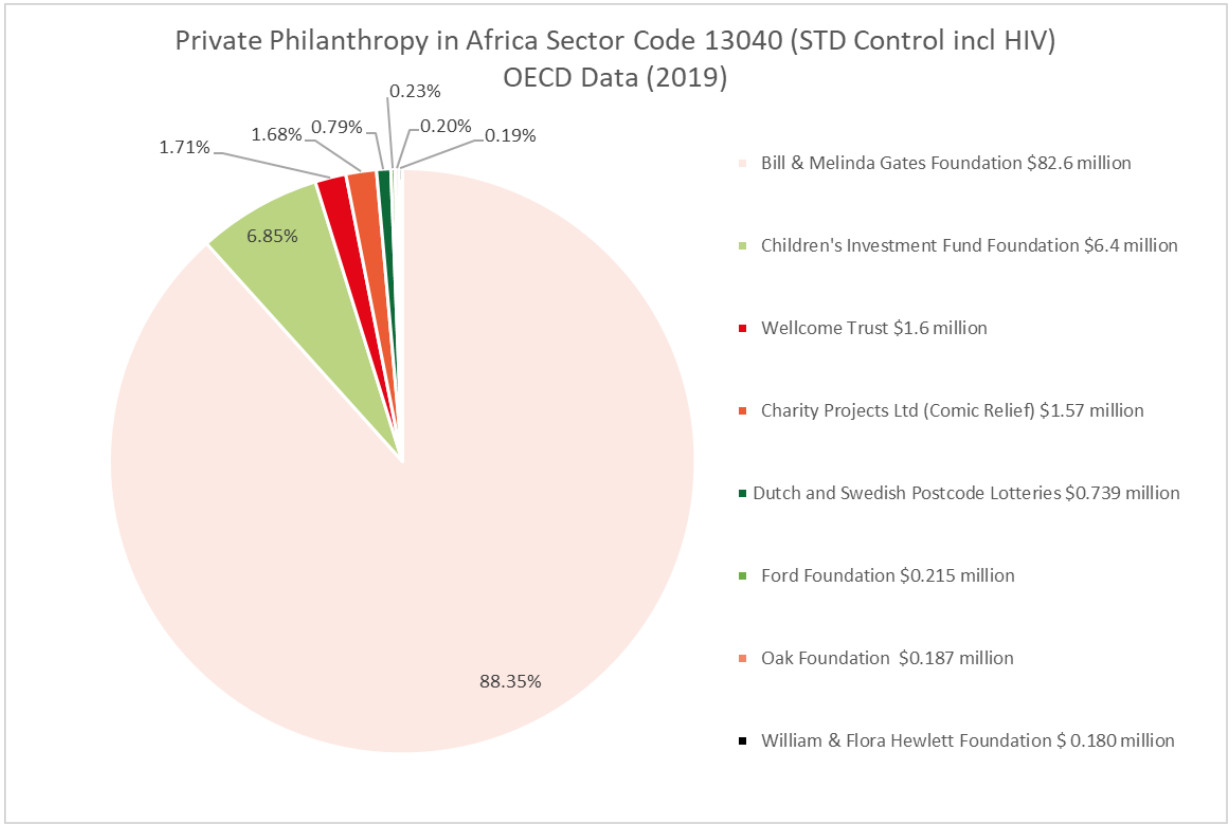
The October 2021 leak by the International Consortium of Investigative Journalists of the Pandora Papers is touted as perhaps the single largest act to create transparency around illicit financial transactions of some of the worlds richest and most powerful people. The documents reveal that Kenyan President Uhuru Kenyatta, Gabon President Ali Bongo Ondimba and Republic of Congo President Denis Sassou-Nguesso all profited from corruption and illicit financial flows. "Politicians from Nigeria (10), Angola (9), Côte d'Ivoire (5), Ghana (3), Gabon (3), Morocco (3), Chad (2), Kenya (2), and South Africa (2)" are also represented in the Panama Papers.

Despite the hope that transparency might bring about change. This is not always a certainty in the environment in which we now live. In Kenya the public came out in support of Kenyatta, with claims that the Panama Papers were fraudulent. Journalists in Kenya have done research and shown that astro-turfing, propaganda and misinformation campaigns were by influencers that were paid by unknown sources.[66]

13. Global Private Philanthropy

Philanthropic investment in combating HIV in Africa (and around the globe) is certainly not insignificant.

The pie-chart below is based on OECD data from the Private Philanthropy for Development Creditor Reporting System database and examines only funds sent to Africa, by Sector 13040, which is "STD control including HIV/AIDS". The data shows constant prices as the amount type, with the unit of measure as US Dollar, Millions, 2016. The total amount is US$117,182 million. Other partners that may seem substantial in the field actually have small amounts invested in HIV, for example in 2016-2018 Robert Carr Fund grantees reported spending a total of US$3.7 million on activities addressing the needs of people living with HIV, out of a total of US$28.3 million from the RCF in total over that period on all programmes.[67]



Global private philanthropy is an important part of HIV funding, most obviously the Bill and Melinda Gates Foundation as it has a larger budget than most others and is thus able to be far-reaching, but more significant is their focus on innovation, and out-of-the-box solutions. In the same way, the smaller philanthropic organizations' impact should not be under-estimated. Strategic funds from smaller givers can be as important as they innovate, test new programmes, and work with highly invisibilised people and communities, thereby actually having an impact where it counts most, averting new clusters of infections and providing services in a more inclusive and respectful way than many public health services do. Indeed, strategic investments in marginalised community work and critical enablers has been shown to be highly effective. More is not always best in HIV it seems. Strategic is best.

14. Private African Philanthropy

Private philanthropy can be an excellent source of funds for the HIV response, but challenges exist in this area. Africa's richest man, Aliko Dangote, has previously openly stated that most of Africa's richest philanthropists do not wish to publicly state what they give and to what causes. The rationale for this coyness is both personal and religious apparently, and echoes narratives from the African Union Commission regarding the philanthropic responses to the West African Ebola outbreak in 2016. In that case African governments, philanthropists and foundations donated generously – but without first writing a press release, because it is culturally more acceptable to give privately than conspicuously in most African cultures.

Some African philanthropists give financing, but others have their own foundations which work to push a particular agenda. A well-known example of this is Mo Ibrahim and the Ibrahim Prize for Achievement in African Leadership which aims to reward African former executive heads of state in Africa who have developed their countries and alleviated poverty in their countries. Others, for example Zimbabwean-born Strive Masiyiwa, as Special Envoy to the African Union for the COVID-19 response, have dedicated not only their own finances but their networks, companies' human resources and know-how and their own reputation and time to advancing causes.

Amongst our largest African private philanthropists are the following people:

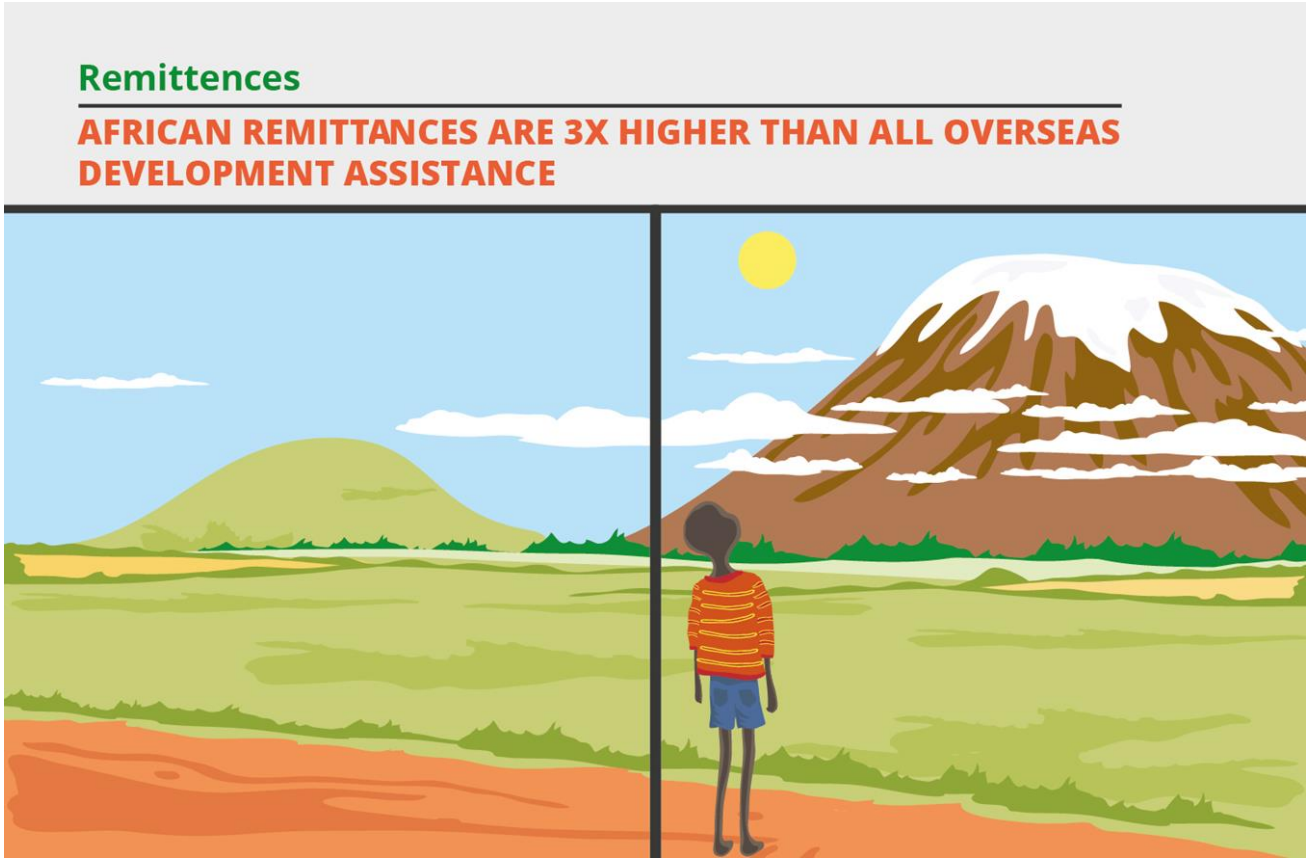
Name	Nationality	Title	Estimated giving
Patrice Motsepe	South Africa	Chair, African Rainbow Minerals	$250 million (2018)
Nicky Oppenheimer	South Africa	Former Chair, De Beers	$80 million (2012)
Aliko Dangote	Nigeria	President, Dangote Group	$35 million (2012)
Jim Ovia	Nigeria	Founder, Zenith Bank	$6.6 million (2012)
Strive Masiyiwa	Zimbabwe	Founder, Econet Wireless	$6.4 million (2012)
Tony Elumelu	*Nigeria*	*Chair, Heirs Holdings*	*$6.3 million* (2012)
Arthur Eze	*Nigeria*	*Chair, Atlas Oranto Petroleum*	*$6.3 million* (2012)
Mike Adenuga	*Nigeria*	*Chair, Globacom*	*$3.2 million* (2012)
Mohammed Dewji	Tanzania	Owner, MeTL Group	$3 million (2016-2019)
Folorunsho Alakija	Nigeria	MD, The Rose of Sharon	$3.5 million (2017-2019)
Naushad Merali	*Kenya*	*Chair, Sameer Group*	*$1.2 million* (2012)
Manu Chandaria	*Kenya*	*Chair, Comcraft Group*	*$1.2 million* (2012)
Ashish J. Thakkar	*Uganda*	*CEO, Mara Group*	*$1.1 million* (2012)
Onsi Sawiris	Egypt	Founder, Orascom Group & Construction, Global Telecom Holdings	No data
Source: M Nsehe[68, 69]			

The Bridgespan Group has begun examining private African philanthropy and has fund the following themes:

- "African donors of large gifts give mainly within their own countries.
- The majority of gifts by African donors go towards addressing basic needs.
- African donors give mainly to the public sector and their own operating foundations, with limited funding reaching NGOs."[70]

Many of Africa's richest people are continuously and rapidly accumulating wealth. One example is Moroccan businessperson Lamia Tazi, who recorded gains of $1.5 million in a 22-day period due to her shareholdings in Sothema (a pharmaceutical group).[71] These established and emerging leaders should be part of the strategic response to funding HIV and health in Africa.

15. African Diaspora Remittances



The sheer enormity of remittances (payments from abroad to back home) by Diaspora communities to causes back home, and the organization around their use, is a considerable player in economics on the globe. So much so that Ade Daramy Adamy African Foundation for Development (Afford) called for remittances by Africans to be on the G8 agenda.[72] Remittances Gateway estimates 200 million migrants who send funs to 800 million recipients.[73]

Total remittances are three times higher than all Official Development Assistance to Africa and take the form of personal payments to family and loved ones as well as remittances into organised philanthropic funds. For example, many Africans abroad send funds to support others in completing their university education, not just family, but organised funds that address the tertiary education needs of students attending their own alma matter, or who live in their own community or perhaps attend their same religious entity.

Annual remittance flows to low- and middle-income countries reached a record high of $483 billion in 2017. Then grew 9.6 per cent in 2018 to $529 billion. Global remittances, which include flows to high-income countries, reached $689 billion in 2018, up from $633 billion in 2017. Remittances to Sub-Saharan Africa alone grew almost 10 percent to $46 billion in 2018.[74]

	Migrant remittance inflows (US$ million)	2016	2018	2020	Remittances as a share of GDP in 2020 (%)
1	Algeria	1,989	1,933	1,699	1.20%
2	Angola	4	2	8	0.00%
3	Benin	222	368	206	1.30%
4	Botswana	25	33	35	0.20%
5	Burkina Faso	397	437	465	2.60%
6	Burundi	31	36	46	1.60%
7	Cabo Verde	198	243	246	14.40%
8	Cameroon	269	345	340	0.80%
9	Central African Republic	NO DATA			
10	Chad	NO DATA			
11	Comoros	131	143	161	13.10%
12	Congo, Dem. Rep.	593	1,405	1,109	2.30%
13	Congo, Rep.	8			0.10%
14	Côte d'Ivoire	342	363	324	0.50%
15	Djibouti	58	63	64	1.90%
16	Egypt, Arab Rep.	18,590	28,918	29,602	8.10%
17	Equatorial Guinea	NO DATA			
18	Eritrea	NO DATA			
19	Eswatini	98	156	113	2.80%
20	Ethiopia	772	412	404	0.40%
21	Gabon	18	18	18	0.10%
22	Gambia, the	207	245	416	22.30%
23	Ghana	2,980	3,803	4,291	6.30%
24	Guinea	52	48	22	0.10%
25	Guinea-Bissau	56	27	122	8.60%
26	Kenya	1,745	2,720	3,100	3.10%
27	Lesotho	344	438	470	25.10%
28	Liberia	580	387	333	10.40%
29	Libya	NO DATA			
30	Madagascar	299	370	392	3.00%
31	Malawi	34	45	189	1.60%
32	Maldives	4	4	5	0.10%
33	Mali	827	885	987	5.70%
34	Mauritania	NO DATA	NO DATA	169	NO DATA
35	Mauritius	194	250	284	2.60%
36	Morocco	7,088	7,375	7,418	6.50%
37	Mozambique	93	354	349	2.50%
38	Namibia	66	52	64	0.60%
39	Niger	176	282	300	2.20%
40	Nigeria	19,679	24,311	17,207	4.00%
41	Rwanda	173	230	241	2.30%
42	São Tomé and Principe	18	17	9	1.80%
43	Senegal	1,929	2,213	2,562	10.40%
44	Seychelles	22	24	10	0.90%
45	Sierra Leone	47	51	59	1.50%
46	Somalia	NO DATA	NO DATA	1,735	34.80%
47	South Africa	755	946	811	0.20%
48	South Sudan	1,083		1,200	9.50%
49	Sudan	153	271	496	2.30%
50	Tanzania	403	430	409	0.70%
51	Togo	367	452	441	5.80%
52	Tunisia	1,821	2,027	2,367	5.70%
53	Uganda	1,146	1,245	1,051	2.80%
54	Zambia	38	101	134	0.70%
55	Zimbabwe	1,856	1,856	1,210	6.70%

Source: https://www.knomad.org: based on World Bank staff calculation based on data from IMF Balance of Payments Statistics database and data releases from central banks, national statistical agencies, and World Bank country desks. Note: All numbers are in current (nominal) US $

During the COVID-19 Pandemic remittances were hard hit. FFR reports that specifically access to bricks and mortar buildings at both the sending and receiving ends became limited in many circumstances due to lockdown and movement restrictions. [75] Remittances are seldom sent by high income earners, and many of the senders suffered job losses under COVID, thereby reducing the number and value of transfers. Transfer companies responded quickly. Many began to reduce fees or even offer free transfers for a period of time. [76] Pakistan and New Zealand classified remittance companies as essential services, and thus this allowed for the operations to continue unhindered. This has been considered a best practice. [77]

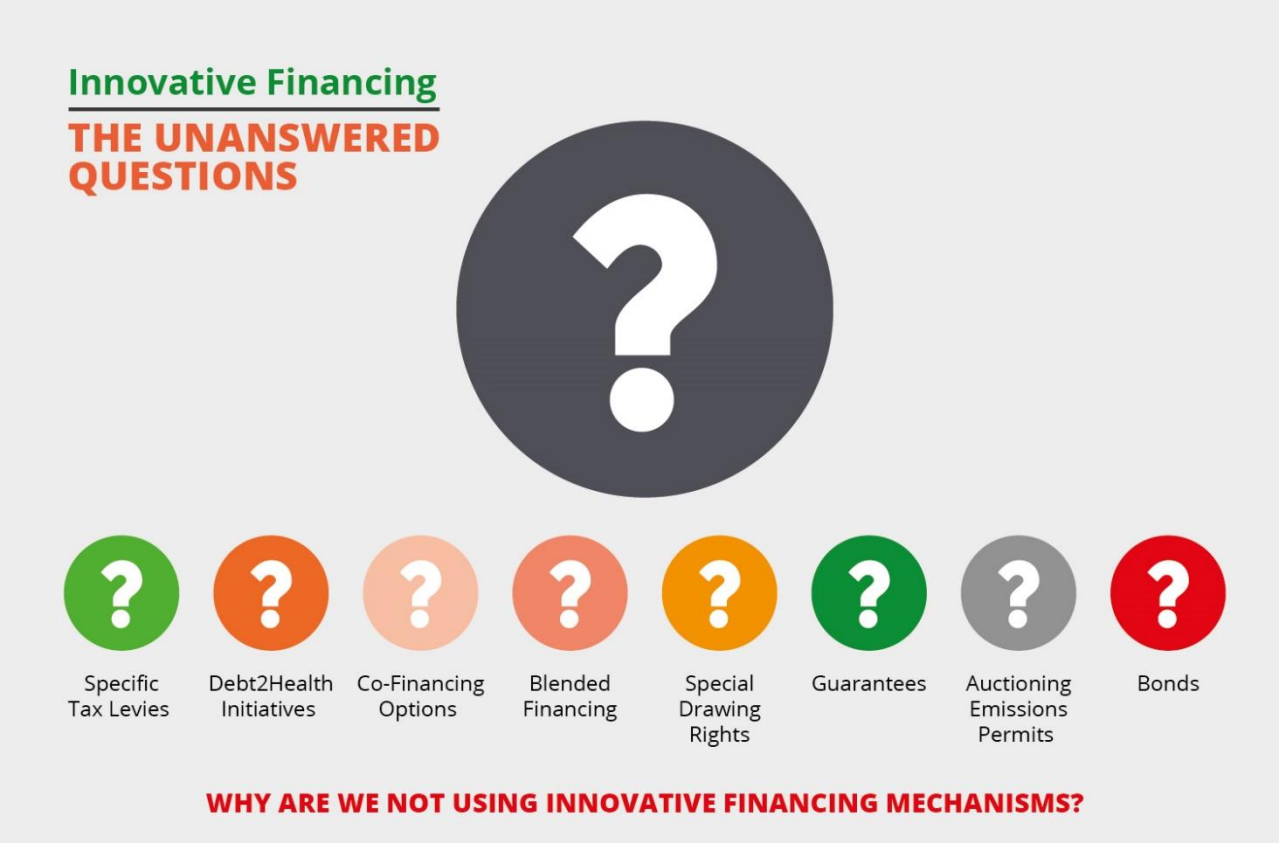
In 2021 remittance flows recovered with experts estimating total flows to low- and middle-income countries (LMICs) to be $589 billion, a 7.3 percent increase over 2020.[78] "Remittances now stand more than threefold above official development assistance and, excluding China, more than 50 percent higher than foreign direct investment." [79]

		2007	2016	Trend
Africa	Total number of migrants (millions)	25.5	33	29%
	Total remittances (US billions)	44.3	60.5	36%
	Central Africa	0.2	0.3	53%
	Eastern Africa	2.4	5.2	117%
	Northern Africa	19.2	27.6	44%
	Southern Africa	1.6	1.1	-34%
	Western Africa	20.9	26.3	26%
	Share of global remittances	15%	13%	
Latin America and the Caribbean	Total number of migrants (millions)	27.3	32.9	21.00%
	Total remittances (US billions)	61.7	73.1	18.00%
	Caribbean	6.8	10.4	51.00%
	Central America	12.3	18.3	48.00%
	Mexico	26.9	28.5	6.00%
	South America	15.7	15.9	1.00%
	Share of global remittances	21%	16%	
Asia and the Pacific	Total number of migrants (millions)	42.4	45.1	0.90%
	Total remittances (US billions)	198,765	255,872	3.70%
	Central Asia	6,406	7,910	3.10%
	Eastern Asia	60,632	64,129	0.80%
	Southern Asia	83,142	118,072	5.10%
	South Eastern Asia	44,725	65,267	5.50%
	Pacific	3,860	494	-25.40%
	Share of global remittances	43%	42%	

Source: https://www.remittancesgateway.org/

Africa would do well to create our own money transfer devices, the profits of which could go towards the HIV response. Given that Western Union generated $4.8 billion in revenue and delivered nearly $600 million to shareholders,[80] and these are the numbers of just one entity. Imagine if one of our African philanthropists could develop a money transfer company with profits going back not health care and HIV specifically!

16. Innovative Financing for HIV



Innovative Financing (IF) is predominately focused on innovatively using existing instruments to channel funding to development. Innovative financing is about bringing established products and mechanisms to new investors and new markets to expand resource mobilisation. A few innovative financing mechanisms exist already, including but not limited to:

1. Specific tax levies (for example airline ticket taxes).
2. Debt2Health initiatives (swopping debt reduction for domestic investment in development. D2H swaps see a donor cancel the public debt of a developing country if that country transfers resources to the Global Fund for investment in domestic health).
3. Co-financing (domestic funding set to match international commitments).
4. Blended financing (public-private partnerships to stimulate development).
5. Bonds[1] and Guarantees[2] (these are units of debt that a government or corporate entity can sell to raise funds and they currently form 65% of the IF market – not because they are innovative per se, but because they are seldom used by governments for health and development). [81]
6. Auctioning or sales of emissions permits (every government is supposed to allocate a set amount, called a cap, of environmental emissions permits for each harmful emission. Companies and countries can then trade – sell or buy – these permits, within reason usually, to those who require them more, thereby raising funds which can be used for development).

[1] Bonds are units of debt that a government (or corporate entity) can sell to raise funds. It then promises to pay back the money at a particular point in the future.

[2] Guarantees are essentially promises to cover another's debt if the principal debtor defaults on their debt (that is, fails to pay it back).

7. Trading of Special Drawing Rights (SDRs) (the International Monetary Fund allocates SDRs, an IMF form of currency, to countries globally. Countries can then trade these SDRs for normal funds for investment in health).[82]

Not enough innovative financing instruments have been in use in sub-Saharan Africa, although examples exist in the Seychelles, Kenya, and Uganda, as well as the following:

1. Botswana's National HIV/AIDS Prevention Support (BNAPS) and International Bank for Reconstruction and Development (IBRD) Buy–Down (a debt conversion instrument) had generated US$20 million for the HIV response.
2. Côte d'Ivoire's Debt2Health Debt Swap Agreement (a debt conversion instrument) had generated US$27 million (approximately 50% of which went to HIV).
3. Zimbabwe's AIDS Trust Fund (a tax/levy–based instrument) had generated US$52.7 million between 2008 and 2011.[83]

If all fiscal sources were simultaneously leveraged (utilising such elements as re-prioritising HIV and health spending, alcohol taxes, health risk pooling, increased tax revenues, and efficiencies) over a five-year period, public HIV spending in 14 countries could increase from US$3.04 to US$10.84 billion per year.[84]

Special Drawing Rights in the time of COVID-19

SDRs have been given special attention since the COVID pandemic created the need for a global response to the challenges countries are facing in financing their response to the outbreak.

In August 2021 the World Bank responded to call to issue $560 billion of SDRs. This was supposed to be a lifeline for countries that required liquidity in order to fund their COVID responses. The challenge with SDRs is that it is a case of "the rich get richer, and the poor get poorer" because the wealthiest nations get a larger allocation. Of this allocation only 3 per cent went to low-income countries and 30 per cent to middle income counties.[85]

In order to channel these SDRs to struggling nations, the Resilience and Sustainability Trust was created in October 2021. However, there is much debate about how the RST will implement the channeling.

Civil society has cautioned in an open letter that debt-free financing, policy-change free financing, middle-income country access, transparency and accountability, considering SDR financing in the broader aid environment, and limiting the SDR financing to specific areas (health, education, gender, climate justice) is vital.[86]

In April 2022, we will see what and how the RST will provide with regard to channeling the SDRs and whether this attempt at a silver bullet is either silver or even a bullet!

17. Public Private Partnerships

Public-Private Partnerships (PPPs) are exactly what the name suggests, a partnership between governments and private businesses with the aim of achieving both development goals and generating a profit. They have been credited with being the solution to all development challenges – and they have been demonised as capitalist private enterprise stealing public funds. Both these extreme versions exist, but in truth the reality is somewhere in between. What often is often questioned is whether PPPs can deliver the same quality as governments and for the same price.

In early 2019, Shrivastava et al investigated PPPs with various actors, amongst them Becton Dickinson, Roche, PEPFAR, UNITAID, Clinton HIV/AIDS Initiative, Siemens, and many more. **The region covered was** various Sub-Saharan countries: Ethiopia, Kenya, Mozambique, Rwanda, South Africa, Tanzania, and Uganda amongst others. The PPPs demonstrated considerable value for money when compared to government-only implementations.87

"One of the six PPPs reached 14.5 million patients in remote communities and transported up to 400,000 specimens in a year. Another PPP enabled an unprecedented 94% of specimens to reach [the] national laboratory through improved sample referral network and enabled a cost savings of 62%. Also, PPPs reduced cost of reagents and enabled 300,000 tested infants to be enrolled in care as well as reduced turnaround time of reporting results by 50%."[88]

The trend shows signs of growth when players such as the Global Fund get involved. In January of 2018 The Global Fund announced PPPs with Lombard Odier, Heineken, and Unilever.[89]

Obviously, PPPs differ greatly, and the public health system can also partner with NGOs who do health service delivery in partnership with the ministry of health and with business workplace wellness programmes. A 2006 study by Sinanovic and Kumaranayake found that in South African patients with tuberculosis that:

> *"... government financing would require $609–690 per new patient treated, in contrast to Public-NGO Partnerships (PNP) sites which would only need to $130–139 per patient (almost a five-fold reduction in costs), and $36–46 (a fifteen-fold reduction) with the Public Workplace Partnerships (PWP) model. The study models are comparable in that they follow the same TB treatment protocol, are similar in terms of key social, economic and demographic characteristics, and provide care to the lower-income populations."*[90]

Very importantly the workplace programme was the preferred option for the patients, followed by NGOs and lastly government provided health services. The main reasons were time and costs.[91] That PPPs can sometimes deliver a better product at a lower cost and higher convenience to the user is an important factor when considering them as a way to fund HIV. Not only are PPPs then a source of funding but also a way to improve quality and ensure cost effectiveness.

18. Impact Investment

Impact Investment is a largely untapped area for the HIV movement, whereas climate change, agri-business and gender (women only) impact investments exist, none are focussed on HIV or Key Populations.

Impact investors are always looking to be profitable, but in essence agree to have a smaller profit margin as a consequence of having positive developmental impact. The concept sounds applaudable, but because transparency and accountability are rare, there are issues of concern. Current monitoring and evaluation standards set by the impact investment arena, allow anybody to claim to be an impact investor, even if the socio-economic impact is even very little.

This is problematic for various reasons:

1. Marketing products as helping others sells more. If false, this is problematic.
2. Positive impact is seldom robustly monitored against recognised international benchmarks.
3. Self-measurement is very open to subjective reasoning and allow for misrepresentation.

When considering impact investment, countries need to understand that the model has certain limitations or weaknesses. A simple example is using unfree or vulnerable labour to improve climate change through the provision of clean energy sources: in some projects non-unionised labourers have been used to install solar panels into villages, and these labourers are underpaid due to the lack of unionisation; while this might be termed impact investment, the projects have adverse consequences that affect human rights as a whole.

It is vital that the entire impact of investors is examined and that they are accountable. It is vital too that impact investors take a sustainable perspective of their work, and that they consider the unintended consequences of their investments. Many times, local communities suffer collateral damage when new, yet skewed investment occurs – and now similarly, in impact investment, so-called marginalized communities suffer collateral damage.

Unpacking the Impact in Impact Investing aims to create a new definition: "a particular investment has impact only if it *increases the quantity or quality of the enterprise's social outcomes beyond what would otherwise have occurred*."[92] This definition brings us closer to accountability in impact investing.

Although the impact investment arena is an improvement on traditional investments, there remains much work to be done to ensure that there is equality, community inclusion, intersectionalities, human rights, and that invisible and unintended consequences are considered in the sector. There needs to be accountability around even the definition of what a "positive social or political outcome" might be, as these are very subjective and relative opinions; under some regimes the oppression or underservicing of some groups is considered a positive social outcome. It is important to ensure impact investment does not become another buzz-word for "business as usual but with a better image" – when it can indeed be so much more.

19. Corporate Social Responsibility

Defining Corporate Social Responsibility (CSR) is a field of study of its own, but a well accepted definition, that also includes what Dahlsrud calls the five dimensions of CSR is: "A concept whereby companies integrate social and environmental concerns in their business operations and in their interaction with their stakeholders on a voluntary basis."[93] This definition importantly has the five dimensions:

1. Stakeholder
2. Environmental
3. Social
4. Economic
5. Voluntariness[94]

Numerous studies demonstrate that an investment by companies in workplace HIV and / or wellness programmes reaps dividends for staff and employer alike.

Since the launch of the Global Business Council on HIV/AIDS in 1997, thousands of companies have taken on HIV Workplace Programmes, providing prevention messaging, testing, referrals, treatment, care, and support. Other health matters have been added to the programmes including TB, malaria, diabetes, and cholesterol and other chronic illnesses.

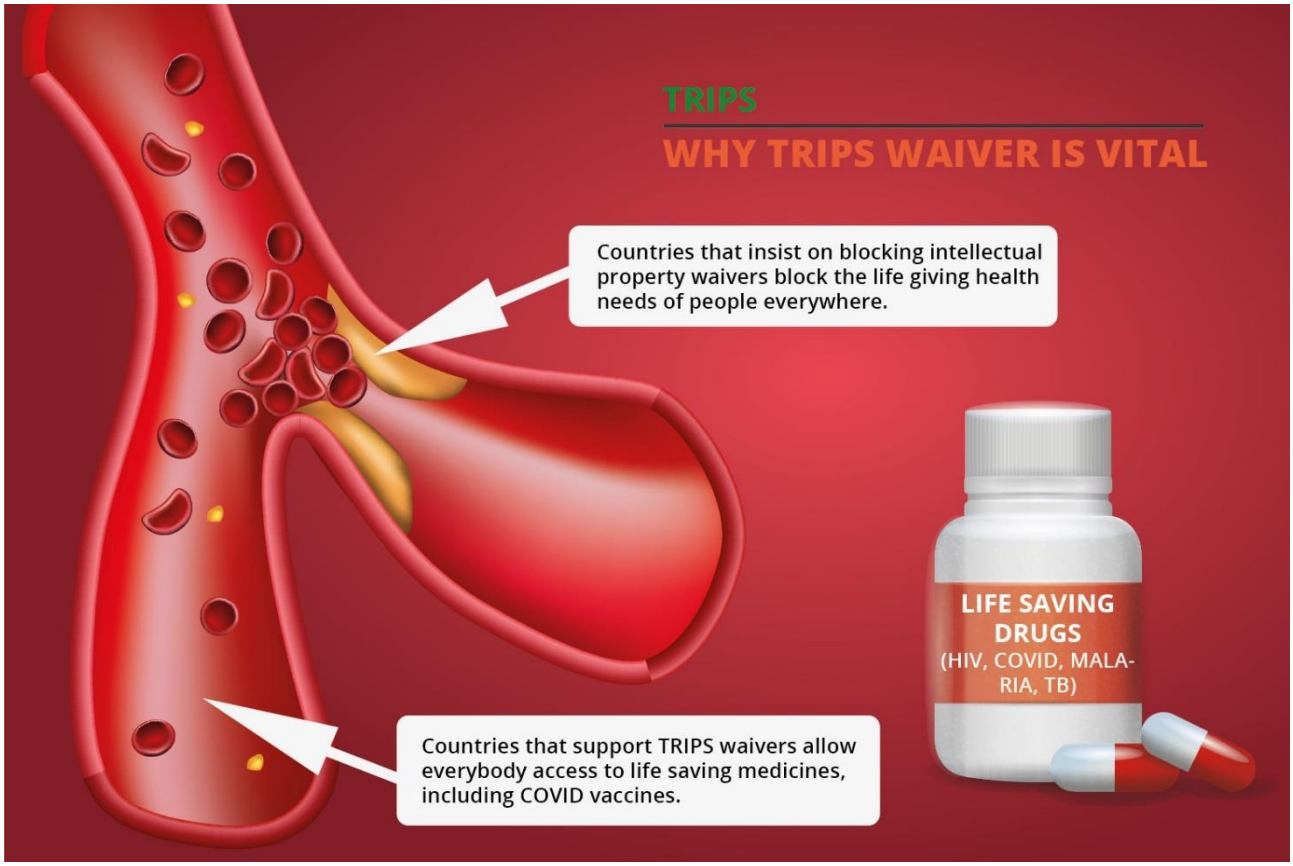
Increasingly corporate social responsibility is linked to the environment, and it is vital to educate employers that working on a sustainable environment does not preclude providing HIV and other health-related care for stakeholders, whether staff and their families, or the community in which a business is located.

In a study of Johnson & Johnson's CSR, Vijay Kumar Chattu finds:
"CSR of business encompasses the economic, legal, ethical and discretionary expectation placed on the organization by society at a given point of time. CSR is therefore the obligation that corporations have toward their stakeholders and society in general which goes beyond what is prescribed by law or union contracts."[95]

Chattu identifies four types of initiatives in the Johnson & Johnson portfolio of CSR work:

1. Cause promotion: creating awareness of an issue.
2. Cause-related marketing (CRM): committing to donating a percentage of sales or a commodity for every sale of an item.
3. Corporate social marketing (CSM): grant-making and partnering with skills and expertise for behavior change, such as peer-counselling for HIV-positive youth, or mothers volunteering to speak to pregnant women about vertical transmission of HIV.
4. Philanthropy: grant-making, including bursaries for studying, and the loan / donation of equipment and technical expertise. [96]

20. TRIPS Flexibilities



Closely related to efficiency gains or cost efficiency is the use of what are called TRIPS flexibilities. Beginning in 1995 the World Trade Organization's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) set North American and European standards of intellectual property rights on the rest of the world. As a result of advocacy, the Doha Declaration in 2003 was able to somewhat soften the harshness of the original TRIPS in relation to generic medicines production: TRIPS was amended so that intellectual property should not "prevent countries from taking necessary measures to protect public health."[97]

Further amendments have attempted to provide loopholes for governments of developing countries so that medication can be provided in case of emergency, but the original declaration is cited as a continuing barrier by some. Given that many declarations are not adhered to, this may be an over-statement to avoid implementing what is necessary. Other cited barriers to producing adequate locally available medicines are under-developed local pharmaceutical manufacturing industries, and compulsory licensing.

African governments need to better engage with global Intellectual property and pharmaceutical manufacturing to respond to the HIV and broader health crisis. Not only is it a means to ensure that access is expanded but that costs are diminished in the long term.

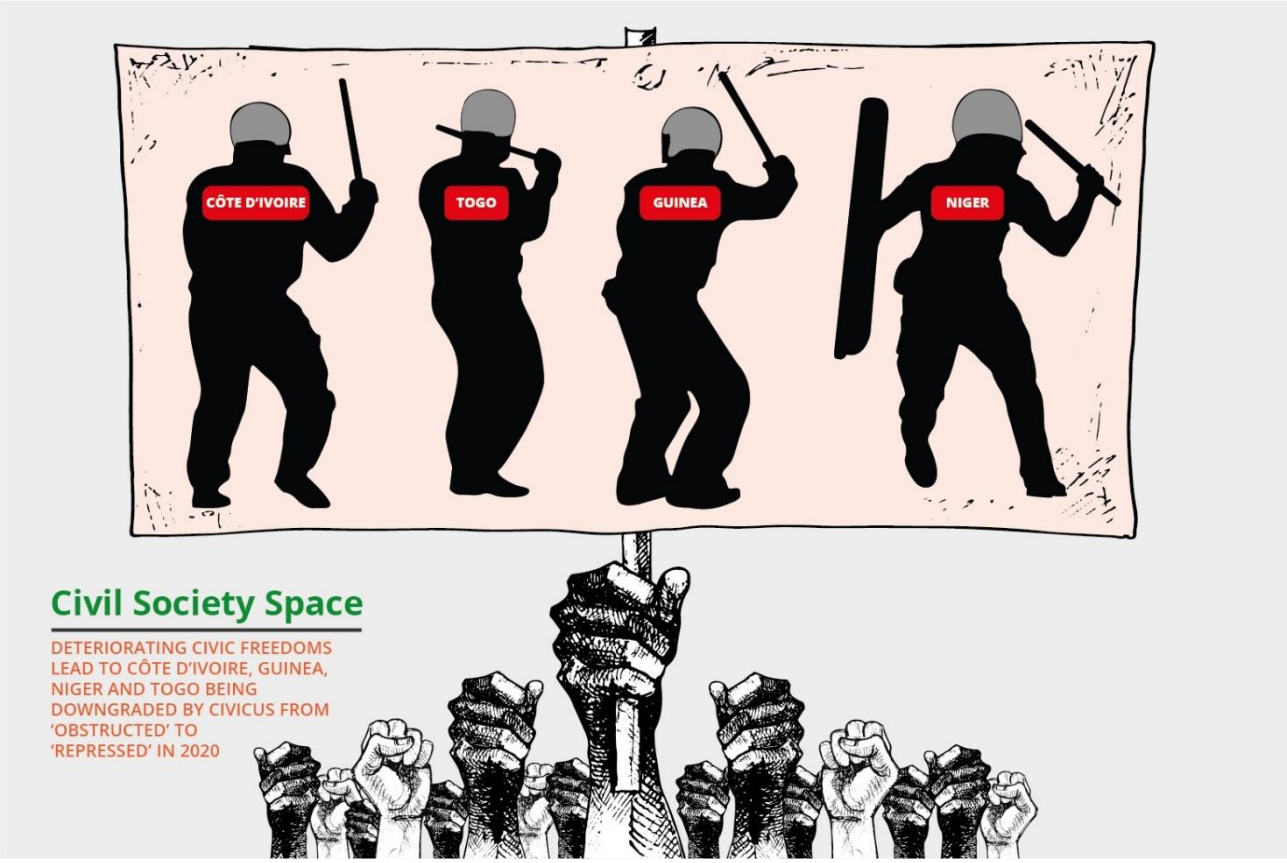
The role of intellectual property rights has never been more vivid than during the vaccination crisis of CIVID-19. Despite efforts by many actors to ensure vaccine equity, it has remained unachievable.

The *Coalition for Epidemic Preparedness Innovations* (*CEPI*) is an excellent ally in the waivering of TRIPs. In its CEPI 2.0 Strategy – The Urgency of Now, the organisation focusses on the need for technological transfer and the need for manufacturing in low- and middle-income countries.[98] The African Union has also dedicated significant resources to forging ahead on the African Pharmaceutical Manufacturing Plan and the African Medicines Agency and has reported ratification in several countries since the pandemic began. The plan needs 15 ratifications for it to be implementable and as of now reports 17 countries fully ratified.[99]

There are also other ways around TRIPS. The World Health Organisation is financing South African scientists to reverse engineer the Moderna covid vaccine, and there is hope that they will be successful.[100]

It is vital for countries in Africa to leverage TRIPS wherever possible as a means to ensure that the financing we do have for the HIV, COVID and other health issues is spent not on expensive IP costs but on life-saving medicines and supplies that are vital for basic human rights.

21. Environment: Transparency and Democracy



It is useful in analysing Financing for HIV in Africa to also investigate how free and democratic space is for civil society to organize, advocate and collaborate with the various partners in the response, not least of which is the government. For this reason, we include an analysis of the Civicus Open Spaces Monitor. The monitor has five levels, outlined in the table below.

It is vital that governments work to create more open and democratic nations to ensure not only the full realization of the human rights of all, but for more effective economic development. National leadership must understand that the narrowing of space for civil society is well documented as being linked to economic downward turns and so should be avoided.

The Cato Institute's Human Freedom Index is composed of two indices: the Personal Freedom Index and the Economic Freedom Index. These two are combined to create the Human Freedom Index.[101]

	Country	Human Freedom	Personal Freedom	Economic Freedom
1	Algeria	5.26	5.51	7.81
2	Angola	6.09	6.5	5.5
3	Benin	7.32	7.83	6.62
4	Botswana	7.9	8.1	7.62
5	Burkina Faso	6.85	7.44	6.04
6	Burundi	5.02	4.57	5.65
7	Cabo Verde	8.26	8.7	7.65
8	Cameroon	5.63	5.47	5.85
9	Central African Republic	5.62	5.81	5.36
10	Chad	5.57	5.54	5.6
11	Comoros	6.07	5.73	6.55
12	Congo	5.55	5.88	5.08
13	Côte d'Ivoire	6.9	7.42	6.18
14	Democratic Republic of Congo	5.62	5.81	5.36
15	Djibouti	5.84	5.24	6.68
16	Egypt	4.49	3.63	5.68
17	Eswatini	5.79	5.6	6.05
18	Ethiopia	5.95	6	5.87
19	Gabon	6.8	7.51	5.8
20	Gambia	6.88	6.77	7.04
21	Ghana	7.49	8.07	6.69
22	Guinea	5.82	5.96	5.62
23	Guinea-Bissau	6.77	7.29	6.06
24	Kenya	6.73	6.59	6.94
25	Lesotho	7.01	7.32	6.57
26	Liberia	6.81	7.14	6.35
27	Libya	5.05	5.17	4.79
28	Madagascar	7.02	7.51	6.33
29	Malawi	6.99	7.72	5.96
30	Mali	6.25	6.55	5.83
31	Mauritania	5.73	5.18	6.49
32	Mauritius	8.07	8.01	8.16
33	Morocco	5.9	5.33	6.69
34	Mozambique	6.8	7.27	6.15
35	Namibia	7.56	8.12	6.76
36	Niger	6.41	6.78	5.97
37	Nigeria	6.28	5.79	6.97
38	Rwanda	6.36	5.65	7.35
39	Senegal	7.07	7.66	6.25
40	Seychelles	7.84	7.99	7.63
41	Sierra Leone	6.70	7.12	6.15
42	Somalia	4.93	3.68	6.67
43	South Africa	7.3	7.53	6.97
44	Sudan	4.48	4.74	4.19
45	Tanzania	6.48	6.29	6.75
46	Togo	6.5	6.6	6.35
47	Tunisia	6.46	6.82	5.97
48	Uganda	6.32	5.54	7.42
49	Zambia	6.82	6.62	7.09
50	Zimbabwe	5.6	6.07	4.94

Source: Cato Freedom Index

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[5] Timing is another variable to consider perhaps other issues such as education or safe drinking water might be a higher and more urgent priority in the immediate future, and a country can move to 15% for health at a later stage. Cost per patient is also an important variable when thinking about the value of Abuja. The cost to service each patient to an equal standard of care is not the same across all countries. In countries like Seychelles and The Gambia which have the smallest land area (approximately 450 square kilometers) it is easy and cheap to transport goods to clinics. In contrast, in Algeria, the largest by land area in Africa, 2,382 million square kilometres, costs of transport for health are significantly higher. In fact, Algeria has a similar population size to Kenya, but Kenya has only 25% of the land area of Algeria. These details need to be considered in applying a broad commitment like Abuja and understanding its value. Luxembourg, which has the highest standard of health in the world, spends 6.16% of its budget on health, and Singapore (second place) spends 4.47%. Efficiency and accountability on how funds are spent is a vital aspect of how much should be invested in health, and hence HIV too, and not an overly simplistic measure like 15% of total government budget.

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The Economic Freedom Element includes but is not limited to the following: legal system, property rights, access to sound money, ability to trade internationally, and regulation of credit, labour and business.