AFRICAN GROWTH AND OPPORTUNITIES ACT FORUM

Plenary Session on HIV/AIDS

Washington, DC

2

The HIV/AIDS Crisis:
How Are Finance and Planning Ministries Responding?

Contents

Emerging Commitment.. 2
Challenge and Response.. 3
Resource Requirements.. 7
Mobilizing Resources..10
How the Public and Private Sectors Can Cooperate...................12
Resource Allocation..14
Conclusion..16
References..18

This paper is one of four background papers prepared for the Plenary Session on HIV/AIDS, AGOA Forum, Washington, DC, October 30, 2001. The Africa Bureau of the U.S. Agency for International Development sponsored the preparation of the background papers. These papers will be revised and participant comments will be incorporated into the final versions, which will be distributed after the meeting.

Emerging Commitment

A combination of events globally and in sub–Saharan Africa highlights a new awareness of the HIV/AIDS epidemic as a development issue that must be addressed by governments of the region.

- At an April 2001 meeting of heads of state of the Organization of African Unity (OAU), ***leaders agreed to allocate a minimum of 15 percent of government expenditures to public health***, thus paving the way for a heightened campaign to reduce the threat of HIV/AIDS to Africa's development prospects.

- In June 2001, the United Nations General Assembly held its first-ever special session dedicated to a health issue. Secretary General Kofi Annan used that occasion to call for concerted action in the face of the challenge of HIV/AIDS, malaria, and tuberculosis—the communicable diseases that most threaten Africa.

- The Group of Eight countries, meeting in Genoa, Italy, in July 2001, ***agreed to a stepped-up resource mobilization effort*** that, by October, had generated pledges of nearly US$1.5 billion in support of a ***Global AIDS and Health Fund*** (GHF).

- Growing consensus indicated that the combined efforts of international public and private donors, along with developing country governments and the private sector, ***would need annual spending of US$9.2 billion by 2005*** to bring the epidemic under control.

- Governments in Africa are preparing ***Poverty Reduction Strategy Papers*** for inclusion in their ***medium-term expenditure frameworks*** for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative and for donor assistance that will increasingly focus on the multisectoral approach to addressing the HIV/AIDS crisis.

The Africa Growth and Opportunities Act (AGOA) Forum offers a unique opportunity to address the challenge of HIV/AIDS. Materials in this and accompanying documents lay out areas for priority action by governments and the private sector in these 35 countries.

Experience from selected countries demonstrates that governments can meet the challenge of HIV/AIDS and successfully pursue development objectives. Ministries of finance and planning as well as ministries of health, education, trade, commerce, and tourism have critically important roles to play in the face of this challenge. Text and data below identify opportunities for action that can enhance development prospects.

Challenge and Response

HIV/AIDS is not just a health issue to be addressed by ministries of health and population alone. The disease affects many parts of the economies and societies of sub–Saharan Africa and, as such, requires a multisectoral response.

Ministries of finance and planning in most sub–Saharan African countries, in cooperation with health ministries and national AIDS programs, lead their governments' efforts to confront the challenge of HIV/AIDS. They do so within the resource envelopes laid out in their medium-term expenditure frameworks (MTEFs). In the past, these development-planning documents were linked to annual policy framework papers; more recently, they are linked to Poverty Reduction Strategy Papers (PRSPs). Plans for public spending and priorities for social and economic objectives, including HIV/AIDS interventions, must fit into these frameworks to ensure adequate financing.

PRSPs outline goals and objectives and then lay out a path of public spending and investment to achieve them. In 2000, 21 of the AGOA countries prepared interim PRSPs.[1] In all cases, the documents make reference to HIV/AIDS. In the case of Malawi, for example, the government's document refers to the disease as a supersectoral issue requiring action from many parts of government and the private sector.

A major issue for development is how much of scarce available funds can be allocated to HIV/AIDS interventions. The disease demands attention from finance and planning authorities and the highest levels of government because other development objectives will not be reached unless AIDS is brought under control (see box).

Major Challenges in Planning for HIV/AIDS

- Including HIV/AIDS resource mobilization and spending requirements in financial planning and budgeting merits high priority in medium-term plans.
- Implementing the OAU Abuja commitment to allocate 15 percent of government budgets to health will require that AGOA-eligible countries increase public health spending by, on average, 50 percent.
- Disbursing donor commitments from a Global AIDS and Health Fund (GHF) will require documentation and receipt of detailed government plans.
- Using debt relief funds under HIPC for HIV/AIDS programs merits priority planning attention as part of poverty reduction.
- Achieving development and poverty reduction goals presupposes a multisectoral approach and success in reducing the threat of AIDS.

[1] See the World Bank website (www.worldbank.org) for reference to the current status of all interim and other PRSP documents and related review materials.

Nonetheless, finance and planning authorities must balance the requirements of HIV/AIDS funding against other pressing needs to

- Maintain fiscal sustainability by ensuring an ongoing balance between revenues and expenditures;

- Promote development through expansion of export capacity and by increasing the productivity and human capital of the domestic economy; effective policies must foster private sector investment and a vigorous export economy that may, as appropriate, include openness to foreign investment and assistance;

- Reduce poverty; and

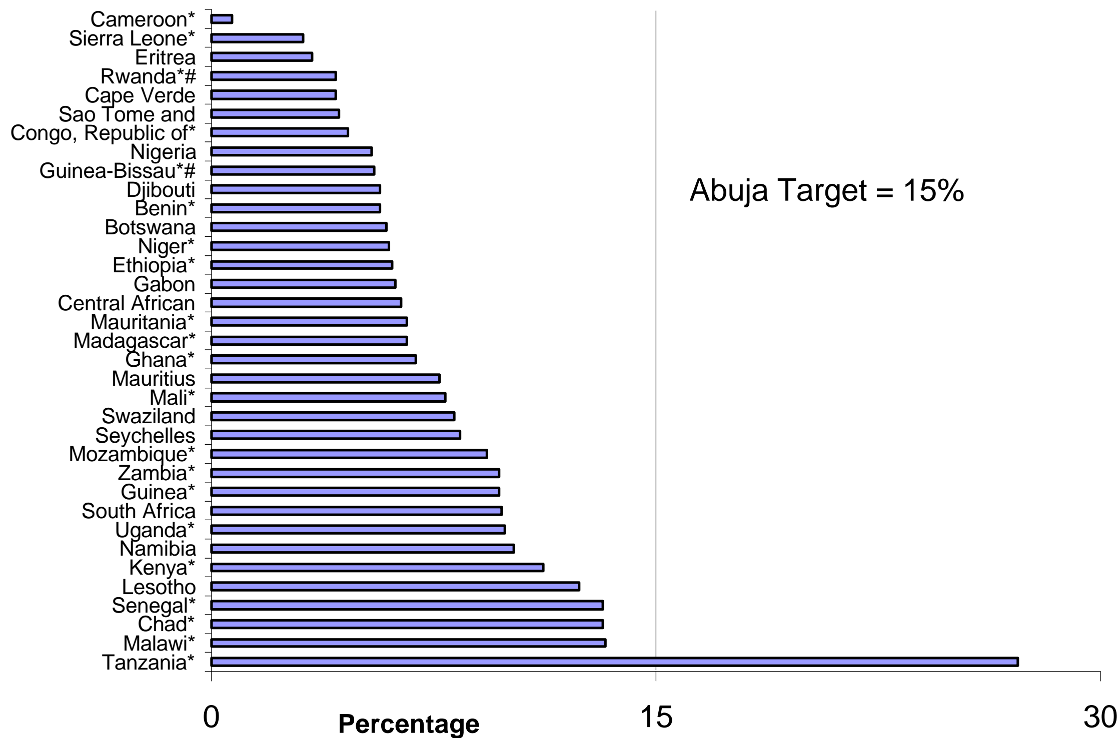
- Use the tools of planning to mobilize domestic and international resources and enhance opportunities for private sector investment.

These other commitments notwithstanding, the most affected countries and governments will have to devote considerable resources to HIV/AIDS interventions lest the epidemic undermine other objectives.

In that spirit, government leaders at the April 2001 meeting of the Organization of African Unity (OAU) in Abuja committed to spend a substantial share of available resources on health. Much of the increment would be allocated to malaria, tuberculosis, and HIV/AIDS control programs. Virtually all the AGOA-eligible countries (Tanzania alone may be an exception) would have to increase health spending by 50 percent or more to reach the 15 percent allocation target (see Figure 1).

Such an increase may pose fiscal problems. For the heavily indebted poor countries, identified with an asterisk (*) in Figure 1, the HIPC Initiative may help overcome that constraint. Donors can be expected to work closely with governments assigning high priority to HIV/AIDS programs and sharing the burden of the projected high costs of providing adequate services.

Figure 1. Public Expenditure on Health as Percentage of Total Public Expenditure



* Heavily indebted, poor countries #Data from interim PRSP documents

Source: Data in Figure 1 come from WHO, *World Health Report 2000*, Annex Table 8, with the exception of Guinea-Bissau and Rwanda, which, because of the appearance of overstatement in the WHR data, were taken from the interim PRSP documents prepared by the governments of those countries.

National AIDS programs have often been supported almost entirely by donor assistance. Thus, AIDS program managers may not be familiar with the work of integrating their programs and plans into the medium-term expenditure framework developed by finance and planning ministries. A central task may therefore be to train staff in ministries of health and national AIDS control programs in the instruments and mechanisms needed to ensure inclusion of their financing needs in the overall management system.

In some cases, a National Disaster Declaration aimed at highlighting the challenge of HIV/AIDS may be one means to strengthen resolve and ensure an adequate response. Where appropriate, some government ministries (e.g., trade and commerce, tourism, education, sports, and youth) will wish to create AIDS Control Units to complement the work of ministries of health and social welfare.

Many of the region's governments place a National AIDS Coordinating Council in the office of the president (see box). Ministries of finance, planning, health, labor, youth, trade, commerce, and tourism have distinct but mutually supportive roles to play in effecting and coordinating a response.

Kenya's Response to the HIV/AIDS Epidemic

Kenya's government began organizing and funding the national response to HIV/AIDS in the early 1980s. The 1994 National Development Plan included a chapter on AIDS. Parliament approved a national AIDS policy in 1997, and President Daniel arap Moi declared AIDS a national disaster in 1999. The National AIDS Control Council (NACC), established in 2000, is a multisectoral body charged with organizing and coordinating the AIDS program.

Today, HIV/AIDS policy is fully integrated into Kenya's medium-term expenditure framework, the government's development strategy. Completion of an interim Poverty Reduction Strategy Paper and plans to use resources under the HIPC Initiative also support strategic planning for Kenya's response. Each ministry now has an AIDS Control Unit to coordinate the response of that sector.

Subnational bodies strengthen local efforts. District AIDS Committees coordinate government, NGO, and private sector activities at the district level. AIDS Control Committees develop people-centered activities and responses to HIV/AIDS and related development issues.

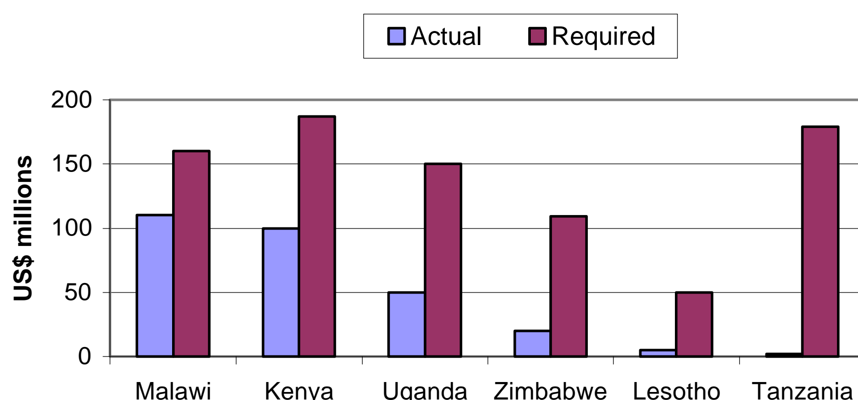
Resource Requirements

How much will be needed to stem and reverse the spread of HIV/AIDS?

For the 35 AGOA-eligible countries, UNAIDS and its technical associates estimate that annual spending by 2005 must rise to about US$3.6 billion to offer an adequate response to the HIV/AIDS epidemic (1). Otherwise, specialists believe, both the incidence and prevalence of HIV/AIDS will continue to increase.[2] Data available through UNAIDS show the spending levels recommended for prevention and care for most of these countries in 2005.[3]

The AGOA countries currently spend far less than these amounts. Sub–Saharan Africa as a whole spent only US$165 million on HIV/AIDS in 1998, the last year for which reasonably complete data are available. More recently, interviews with AIDS program managers in six countries (2) compared their countries' actual spending against the managers' estimate of need (see Figure 2). All managers indicated a large unfilled resource gap. A critical challenge will be to find the means to expand programs yet maintain efficiency and effectiveness.[4]

Figure 2. Actual and Required HIV/AIDS Spending Levels, Selected Countries



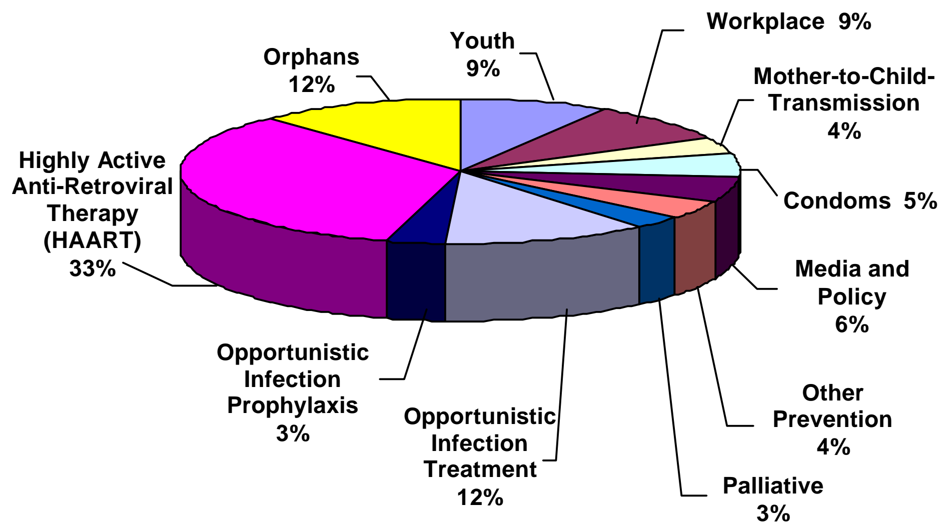
[2] Incidence refers to new infections in a one-year period. Prevalence is the percentage of all persons (usually the adult population) who are HIV-positive. Incidence must fall rapidly, from one year to the next, to achieve a gradual decline in prevalence.
[3] Due to lack of basic data from UNAIDS and selected governments, there are no estimates of resource requirements for Cape Verde Islands, Sao Tome and Principe, and Seychelles. Government officials report that some steps are being taken to assemble necessary data for these countries.
[4] Data are preliminary and subject to substantial revision. The Tanzania program manager, for example, included only the direct budget outlays for the AIDS program office in the statement of actual spending. The same manager, in contrast, estimated required spending across the whole of both the public and private sectors, thus showing an extremely large gap between actual and required outlays.

How would these larger amounts be spent, program by program?

For the sub–Saharan Africa region as a whole, spending on 12 prevention interventions will require about one-third of the $3.6 billion total. Spending on five interventions that provide care, support, and treatment would use the remaining two-thirds. The split between prevention spending and care spending will vary widely among countries. The share for prevention will be highest for those countries that still have low rates of prevalence and incidence of HIV/AIDS (e.g., Ghana, Guinea, Mauritius, and Senegal). But, for countries that are already highly affected, the share for care, support, mitigation, and treatment will be higher. These actions include palliative care associated with opportunistic illnesses, support for orphans and vulnerable children, and antiretroviral therapy. Specific spending requirements, country by country, are under review and subject to ongoing discussions with governments and civil society in each of these countries. For the AGOA countries as a group, Figure 3 shows the projected expenditure requirements by intervention.

Spending requirements for HAART, highly active antiretroviral therapy, shown as one-third of the total in Figure 3, are especially difficult to estimate and project into future years. The changing price and regulatory environment for the drugs could dramatically reduce costs of treatment and hence any estimate of financing requirements. Voluntary price reductions and outright donation of some pharmaceuticals from manufacturing companies may greatly affect how much of the cost of HAART falls on the beneficiaries of the treatment.

Figure 3. HIV/AIDS Prevention and Care
2005 Resource Requirements (%)



How much spending will be required in each country? By 2005, the greatest expenditure requirements will be in the larger, most highly affected countries. Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zambia would all need to spend over US$100 million annually, according to UNAIDS estimates.[5]

[5] Detailed country estimates are under review by UNAIDS and other organizations.

Mobilizing Resources

How is the large gap between recent actual program outlays and projected required future spending to be filled?

Bilateral funds will continue to be important, and procedures for requesting assistance under bilateral agreements will probably not change significantly. For example, USAID, which has been the largest donor in sub–Saharan Africa for HIV/AIDS, will continue to provide assistance to AGOA-eligible governments insofar as funds permit.[6]

Multilateral donors will continue to promote debt relief linked to the medium-term expenditure frameworks and Poverty Reduction Strategy Papers for the 41 countries covered under the HIPC Initiative. Twenty-one of the AGOA-eligible countries have prepared Poverty Reduction Strategy Papers, and most of them will qualify for HIPC debt relief. World Bank staff estimate that the net present value of debt relief for 10 of these countries (Cameroon, Ethiopia, Guinea, Guinea-Bissau, Mali, Mauritania, Mozambique, Senegal, Tanzania, and Uganda) totals about US$18 billion (5). If these countries could devote just 10 percent of this amount to HIV/AIDS-related public health efforts, donors would likely complement their efforts with external financing on a similar scale.

The key challenge for governments in sub–Saharan Africa will be to develop sound plans for program implementation and to demonstrate to their own civil society and to supporters in the donor community that programs are working to diminish the HIV/AIDS epidemic. Agreed procedures to monitor and evaluate program effectiveness will be an essential part of each national plan and strategy. Such plans are already an integral part of the interim PRSP documents and need be elaborated only in the area of HIV/AIDS to begin to yield positive donor responses (see box).

Key Messages on Financing for HIV/AIDS

- Demonstrating effective use of unprecedented financial resources for HIV/AIDS may be the greatest challenge governments will face over the next five years.
- Disbursements of donor commitments from a Global AIDS and Health Fund (GHF) will require full documentation and detailed plans of recipient governments for using those funds as well as the commitment of domestic resources to address the health needs of poverty groups.

At the United Nations General Assembly Special Session on HIV/AIDS and the subsequent meeting of the Group of Eight countries in Genoa, Italy, many governments

[6] See the detailed studies on earlier resources flows, 1996-1997 (3, 4).

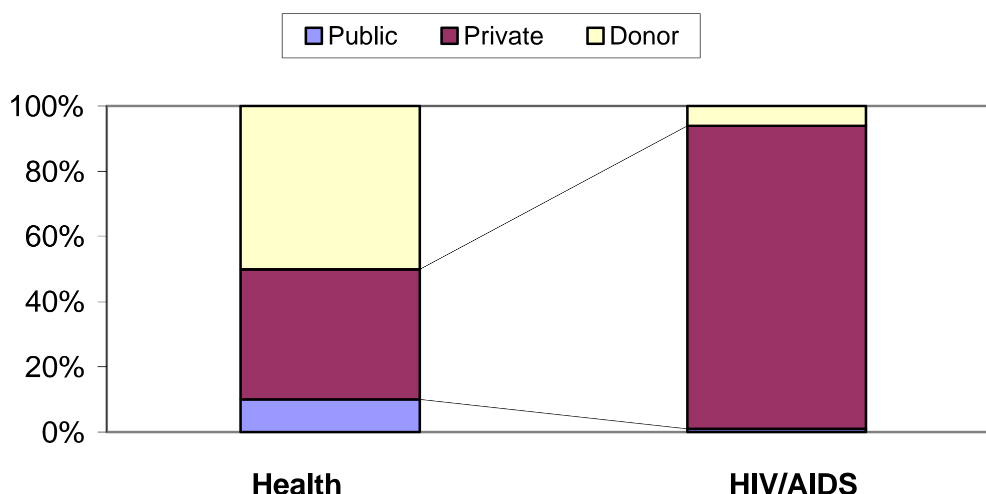
and private foundations agreed to contribute to a Global AIDS and Health Fund (GHF) established initially in the office of the UN Secretary-General. The sums available in GHF undoubtedly represent a substantial increase in available resources. President George W. Bush, for example, characterized the U.S. contribution of $200 million on May 11, 2001, (complemented soon thereafter by the European Commission, France, Italy, Japan, and United Kingdom) as a starting point of assistance. The United States made a further grant of $100 million on July 24, 2001. Secretary-General Kofi Annan inaugurated the fund on May 3, 2001, when he donated the proceeds—in the amount of US$100,000—of the Philadelphia Liberty Medal that he was awarded. Some 24 additional contributions brought total resources to nearly US$1.5 billion by October 2001. Over US$100 million, most of it from the Gates Foundation, comes from private foundations. More will come as governments demonstrate their own resolve to reverse the spread of HIV/AIDS.

At the time this report was drafted, the details of GHF management had yet to be announced. Thus, procedures for accessing these funds remain to be clarified. It may nonetheless be prudent to assume that, as with other external assistance, GHF funds will be conditioned on effective plans for implementation of poverty- and disease-focused programs that can yield good value for money spent—hence, the importance of the medium-term expenditure frameworks and the Poverty Reduction Strategy Papers.

How the Public and Private Sectors Can Cooperate

Governments and the private sector in sub–Saharan Africa must inevitably share the costs of dealing with HIV/AIDS. How these responsibilities are divided (who pays for what?) will greatly affect how well countries respond to the epidemic. In a careful study of the sources of spending on HIV/AIDS in Rwanda, in excess of 90 percent of all spending came out of pocket from people living with HIV/AIDS and their families (see Figure 4). In contrast, donors and the public sector budget finance well over half of other health services in Rwanda. This evidence strongly supports the view that governments must work closely with the private sector to ensure that public resources benefit those most in need. Otherwise, the poor who pay for services out of pocket will be overburdened with health care costs related to HIV/AIDS.

Figure 4. Sources of Finance for Health and HIV/AIDS in Rwanda



Source: Based on Nandakumar (6).

Governments need to concentrate on financing public goods, that is, those products and services that individuals underfinance because the benefits are diffuse. These include essential information, education, and communication. Ministries of finance and planning are already familiar with the need to fund public goods.

Further, governments must concentrate their efforts on financing goods and services for those too poor to afford what they need. The demands for AIDS prevention, care, and treatment among the poor of sub–Saharan Africa are well in excess of currently available

resources. Governments have a major role to play in directing their own and donor resources to the needs of the poor that would otherwise go unfulfilled, resulting in ill health and premature death.

Too often, governments have been drawn into financing curative health services for groups, especially better-off urban populations, that could otherwise have paid for their own services. If governments use their limited resources to finance care and treatment for middle- and upper-income groups, they will not be doing all they could do in the interests of the country. A continuing challenge in monitoring and evaluating HIV/AIDS programs will be to assess whether the focus of government spending is directed at the needs of the poor and at the delivery of public goods.

Governments can facilitate private sector action by ensuring that no unnecessary legal and regulatory barriers block effective efforts of prevention, care, and support. Tariffs that impede importation of essential HIV/AIDS goods and services may need to be reviewed. Ministries of trade, commerce, and tourism may all have roles to play in ensuring a positive environment for the struggle with AIDS. For example, regulations that keep truckers overnight at borders and hence encourage commercial sex may also need review by the authorities.

Resource Allocation

For the next few years, available resources will be insufficient to meet all the needs of prevention, care, support, and treatment. Choosing the "best buys" will be essential. Government managers must look for the most cost-beneficial means to reduce the threat to development associated with HIV/AIDS. The search for efficiency and effectiveness will prove vitally important.

How much should be allocated, by money amounts and as shares of the total AIDS effort, to prevention? How much to care and support? Possible expenditure areas, by sector, include at least the following priority programs: youth education, voluntary counseling and testing, condom promotion, community mobilization, treatment of sexually transmitted infections, peer counseling, palliative care, treatment of opportunistic infections, prophylaxis for opportunistic infections, antiretroviral therapy, orphan support, food support, and poverty reduction. Choosing the right mix at each stage of the campaign to deal with HIV/AIDS can have a major impact on the success of the effort.

Computer models can help decision makers make "good buys" in the effort to cover the population with services. Models can help calculate total funding requirements to achieve national goals and to understand the most cost-effective approaches to achieving those goals.

An example is the GOALS model (7). This four-component model includes information and scenario projections for (1) cost of care, (2) cost-effectiveness of mother-to-child-transmission treatment protocols, (3) selected prevention interventions, and (4) goal setting and attainment. The model displays the impact of resource allocation decisions on HIV prevalence and the coverage of prevention, care, and mitigation services.

To assess likely results in terms of prevalence reductions and coverage, the policymaker can specify alternative levels and patterns of overall funding and allocations by service as related to alternative policy choices and program designs (model available at www.tfgi.com). Policy and technical staff in the government of Lesotho recently applied this model to guide the planning process in that country (see box). The experience may offer useful lessons for other countries as well.

Resource Allocation in Lesotho and the GOALS Model

Lesotho's *National AIDS Strategic Plan (2000/2001–2003/2004)* sets out seven goals in the areas of prevalence, incidence, onset of sexual activity, condom use, sexual partnering, counseling, and gender sensitivity, along with programmatic actions to achieve them. A generic resource allocation model, customized for the Lesotho case, was used to sort out the most cost-effective means to achieve the best combination of results in these seven goal areas.

The Lesotho AIDS Program Coordination Authority led the analysis team, which included members from the Ministry of Development and Planning, Positive Action, Lesotho Anti-AIDS Alliance, and UNAIDS. The USAID-funded POLICY Project provided technical assistance and trained team members in the use of the model and how to adapt it to the Lesotho strategic plan.

The Lesotho team used this model to examine several resource allocation options. The analysts reviewed the initial budget and compared Lesotho's unit cost estimates to international norms and assessed the proposed scale of activities to estimated need. The team developed alternative budget scenarios and examined the feasibility of achieving the stated goals at lower cost. Analysts assisted government planners in preparing a summary and detailed inventory of funding needs and goals that could be presented to potential donors.

The Lesotho team then prepared two funding scenario options. One scenario shows the funding requirements to achieve maximum impact on prevalence and maximum coverage of care and support services. The second scenario looks at the best way to allocate a fixed budget, namely, the team's best estimate of real resource availability. These scenarios will form the basis of the allocation of national resources and discussions with donors to mobilize funds for the strategic plan.

These models cannot make resource allocation decisions. They can only assist decision makers in understanding the trade-offs. National leaders still need to set the priorities for prevention, care, human rights, support to people living with HIV/AIDS, research, policy, coordination, and other essential elements of a comprehensive response.

Conclusion

There is an old saying, "The best time to plant a tree is 20 years ago. The next best time is now." Further delay in addressing the AIDS epidemic will only increase its devastating impact on the societies and economies of Africa.

A first step is to integrate plans to confront HIV/AIDS into overall frameworks for government programs. Twenty-one AGOA governments have completed their interim PRSP documents; and all of them mention HIV/AIDS, though with varying degrees of thoroughness. The World Bank and IMF have reviewed and approved the interim PRSPs of seven of these countries: Kenya, Lesotho, Mauritania, Mozambique, Tanzania, Uganda, and Zambia. These seven countries are moving ahead briskly to implement poverty reduction strategies that give ample attention to HIV/AIDS. Other countries are close behind them and will soon qualify for debt relief and enhanced donor support. Many countries need to revisit these documents to ensure adequate attention to the HIV/AIDS crisis.

Beyond this stage, much important work remains. Implementation plans must allocate scarce resources among alternative investments, linking activities to achieving agreed objectives (see box). Finance ministers will soon need to enter into intensive negotiations with donors to secure assistance. They will assess how much they can contribute to HIV/AIDS from their savings from debt relief. Uganda, for example, has already made substantial progress in that regard. Finance and planning ministers may need to strengthen their ties to ministers of health and national AIDS program managers. Finance ministries are often held accountable for ensuring that their governments use money effectively as it is transformed into time and effort by health workers and those providing care to the patients and families affected by HIV/AIDS.

Beyond PRSPs

- Finance and planning ministries make detailed plans and resource allocations for program implementation. They demand effective use of resources and manage allocations of debt relief under the HIPC Initiative to expanded HIV/AIDS programs.
- Health ministries and national AIDS programs work closely with planning authorities to ensure complementarity between domestic resources, including poverty-focused debt relief, and donor assistance.
- Other ministries review the impact of HIV/AIDS on their objectives and assess how they can contribute, in a multisectoral approach, to mitigating the crisis.
- Governments prepare to monitor and evaluate annual progress to ensure continuing support from civil society and international donors.

Where appropriate, sectorwide assistance programs, Poverty Reduction Strategy Papers, and debt relief instruments can be refocused to include a more vigorous program for confronting HIV/AIDS. Each country and government situation is unique, and each government will chart its own course to address the HIV/AIDS challenge. Donor assistance will flow more readily to those governments able to demonstrate consistent macroeconomic policies that give adequate due to the resource needs for AIDS programs linked to poverty reduction.

Finance and planning ministries face the challenge of demonstrating effective use of what may well be unprecedented amounts of financial resources in the next few years. Disbursements from bilateral and multilateral donors, including GHF, will require full documentation of results via active monitoring and evaluation of results.

An enormous global reservoir of goodwill is available to the nations of sub–Saharan Africa as they embark on the challenge of bringing HIV/AIDS under control. Technical cooperation in the form of assistance in priority setting, resource allocation, and monitoring and evaluation will be available through multilateral and bilateral organizations. There is perhaps no higher priority among advocates for effective development assistance than the need to control the HIV/AIDS epidemic.

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This paper was prepared by staff of the POLICY Project, with funding from USAID/Africa Bureau. The authors would like to acknowledge the contributions and suggestions of the many people who reviewed this document. The POLICY Project is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00. The Futures Group International, Research Triangle Institute, and the Centre for Population and Development Activities implement the project.