Antiretroviral Treatment and the Backlash against AIDS Funding

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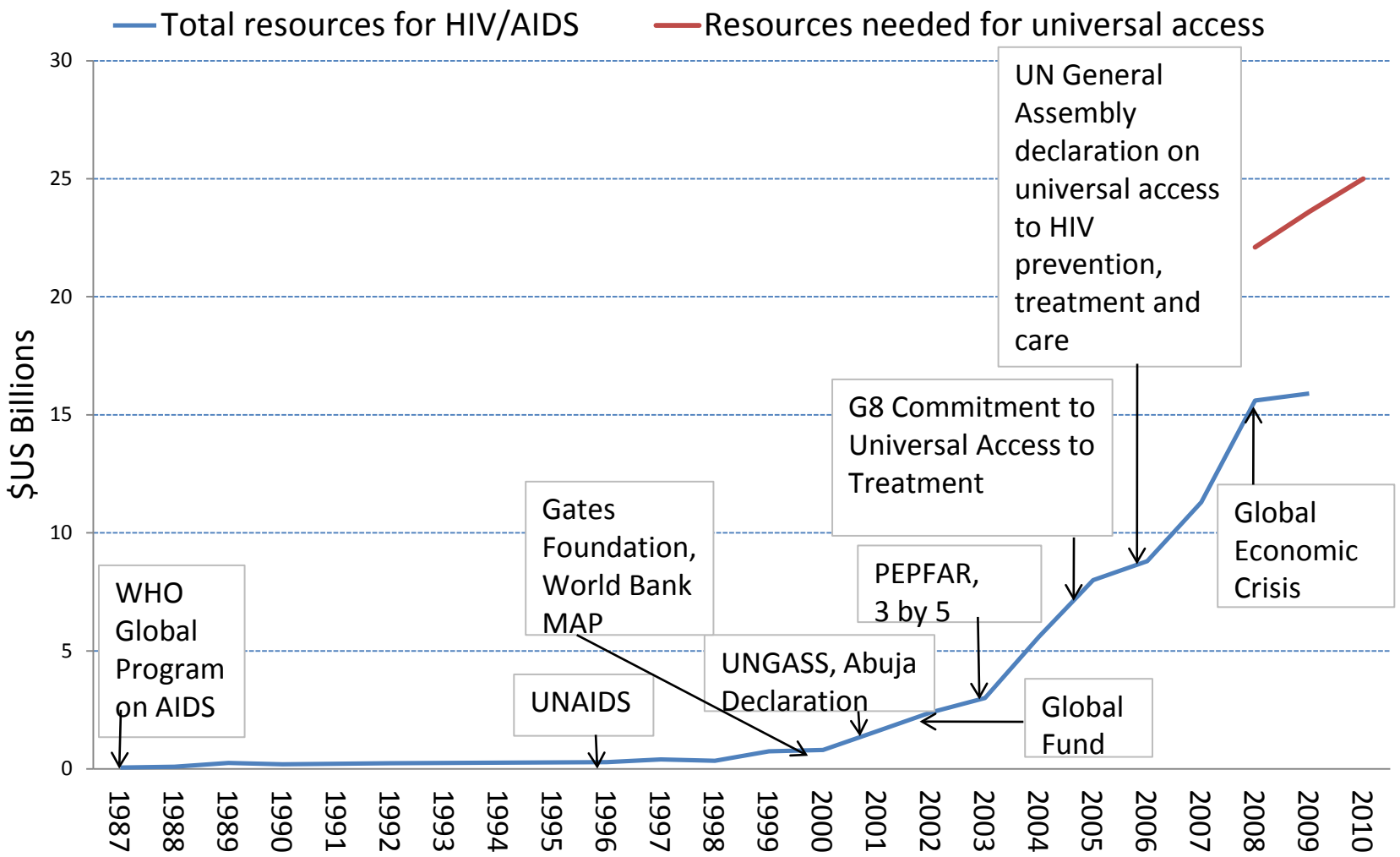
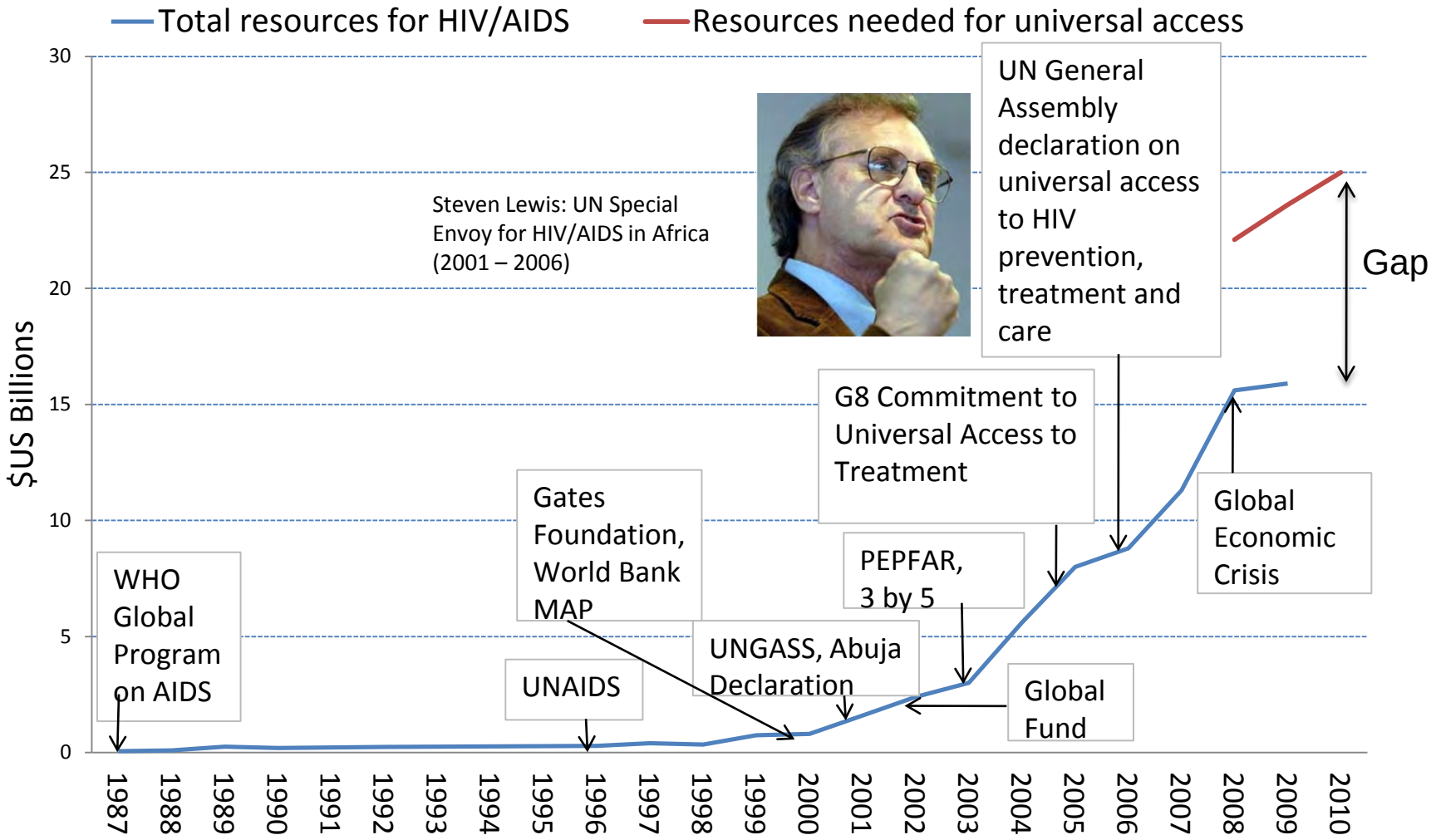
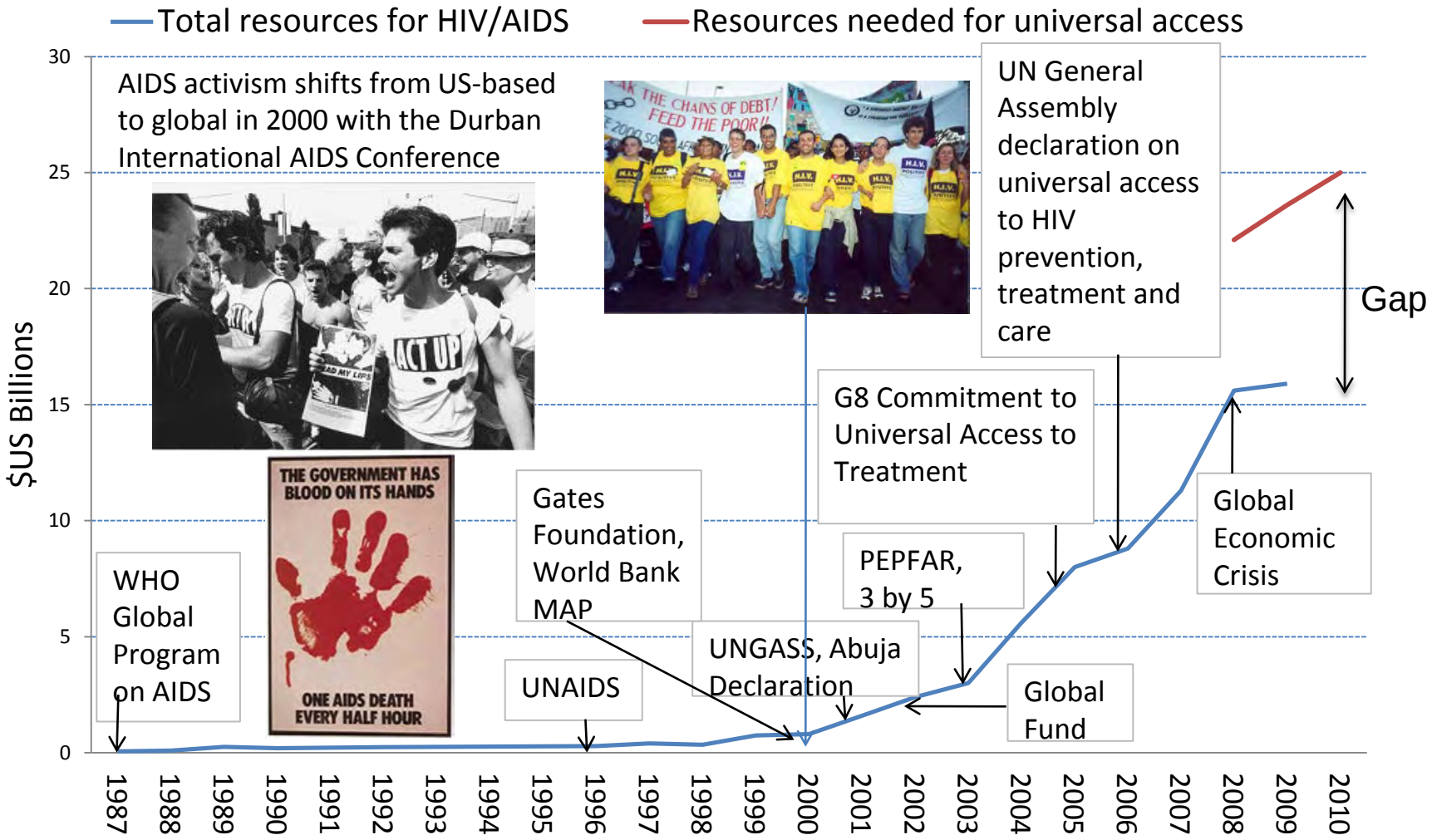
The Growth of Domestic and International Funding for AIDS



‘AIDS Exceptionality’ as key discursive shift…..



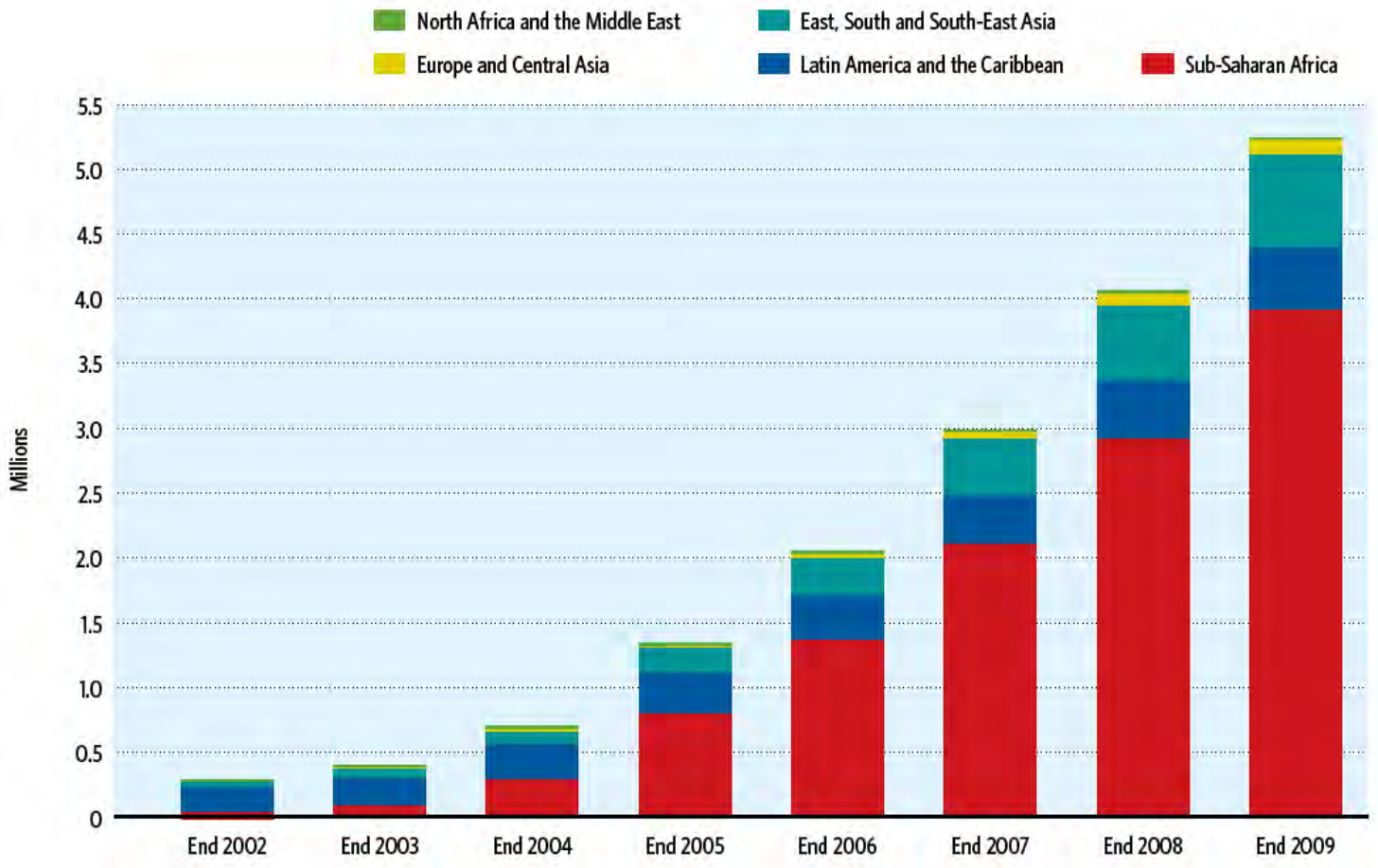
“AIDS is exceptional. I tramped the high-prevalence countries of Africa for more than 5 years; if I wasn’t viewing the most exceptional communicable disease assault of the 20th then the word ‘exceptional’ needs to be re-defined. As a consequence of that exceptionality, and the tremendous campaigning of grass-roots advocates, AIDS received funding, a lot of funding … never enough to be sure, but enough to recognize the exceptionality” (Steven Lewis, 2009).



But under-pinning this sea-change in international policy, was domestic and international AIDS activism. The argument that 'treatment is prevention' also helped – but so too did the great economic boom of 2000-2008….

International aid and domestic funding from the middle-income countries (notably South Africa and Brazil facilitated the global HAART rollout

On HAART in low- and middle-income countries



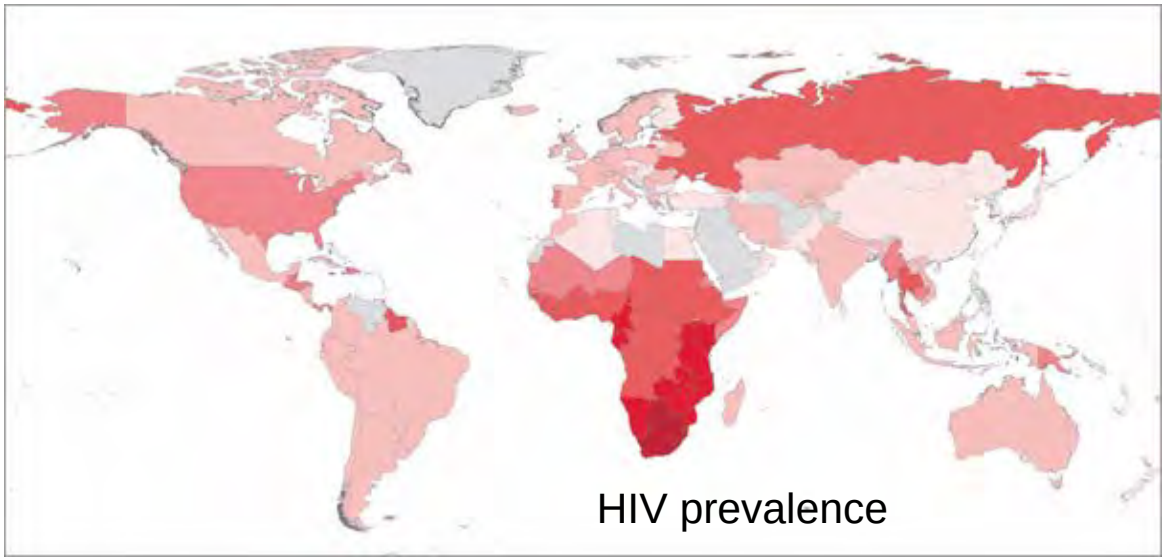
http://www.who.int/hiv/topics/treatment/data/en/index1.html

"We are seriously concerned about the future of HIV treatment programs. Only about 1/3 of people in need have access to treatment. In the current economic climate even sustaining that over the long term will be a challenge" Paul de Lay March 2011

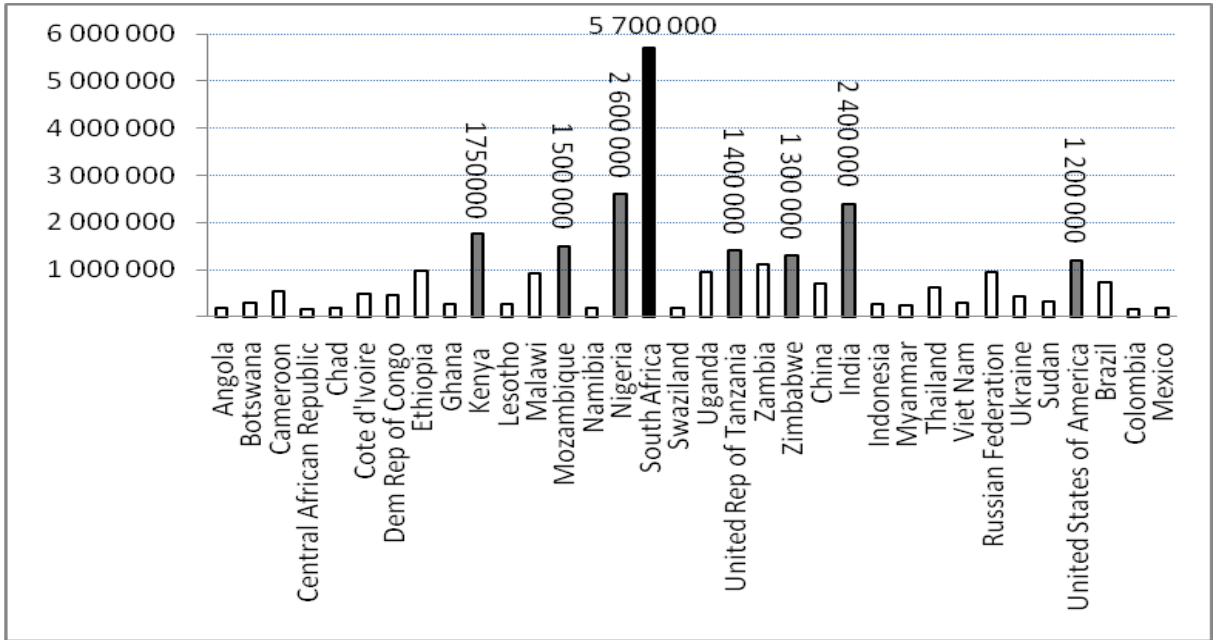
Where does the HIV money go?

Most international aid for AIDS goes to Africa which is hardest hit.

Africa has 4% of the world's population and two thirds of the world's HIV-positive people



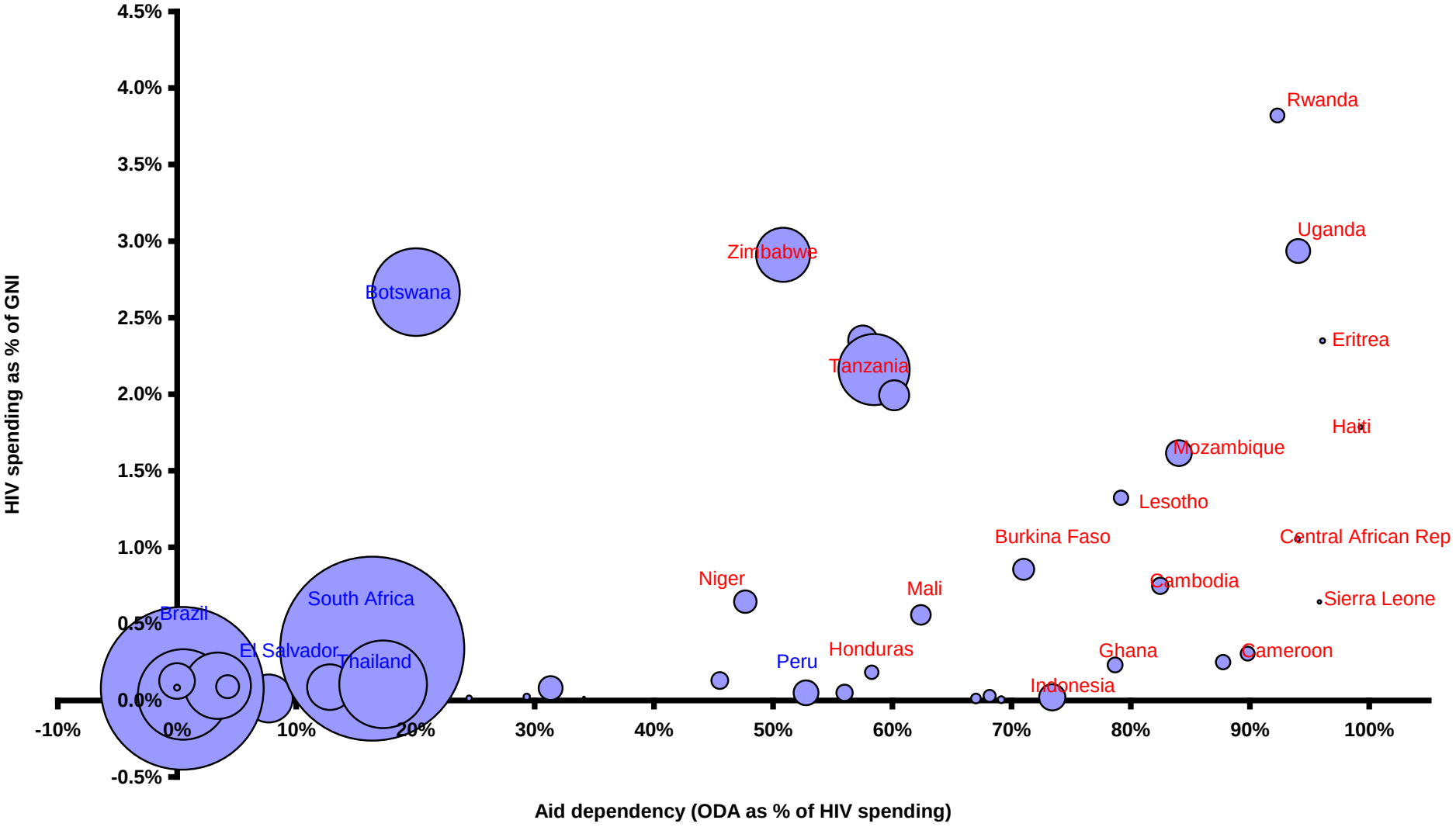
Number of people living with HIV



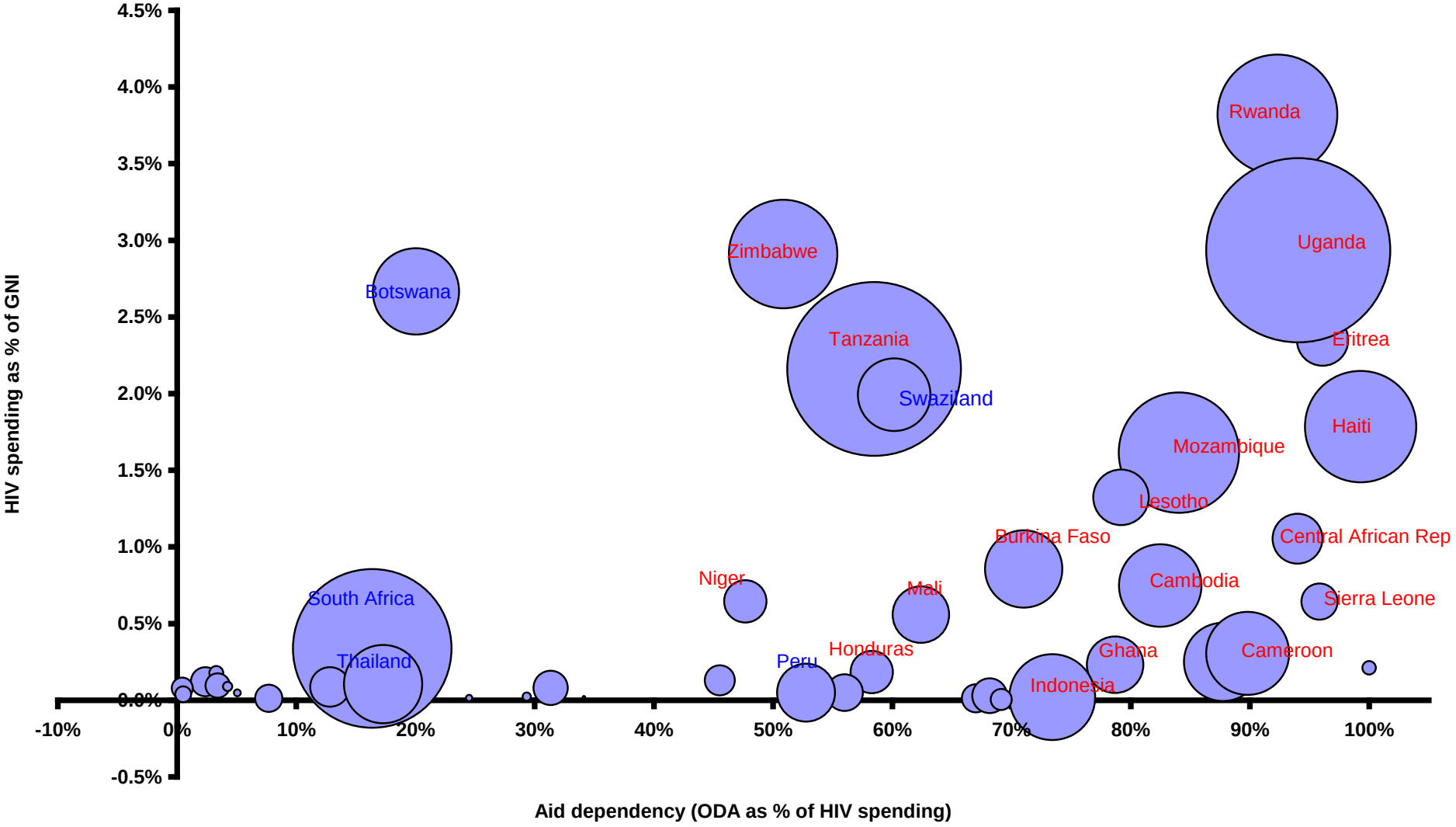
The money goes mainly to Southern Africa and low-income African countries.

Middle-income countries also contribute significant domestic resources.

Where is Domestic HIV money being spent?



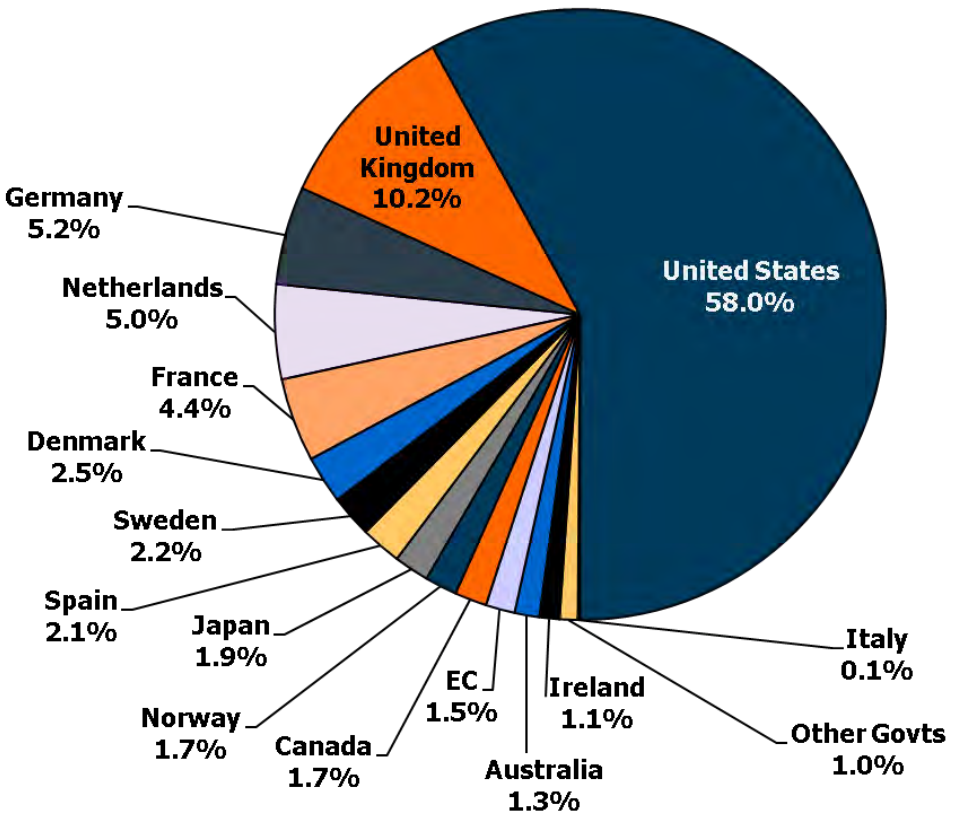
Where is International HIV money being spent?



Most international assistance comes from the US

International AIDS Assistance: G8/EC & Other Donor Governments, as Share of Total Disbursements, 2009

In Billions



$7.6 billion
Total Disbursements (Bilateral and Multilateral)

The US contributes more than half of donor aid for HIV/AIDS – and it has just increased its commitment to the Global Fund by nearly 40%, and PEPFAR funding has grown marginally….

Sources: UNAIDS and Kaiser Family Foundation analysis, July 2010; Global Fund to Fight AIDS, Tuberculosis and Malaria online data query, June 2010; UNITAID Annual Report, 2009; OECD CRS online data queries; UNAIDS, PCB(13)/02.5, 28 November 2002; UNAIDS, PCB(14)/03 Conference Paper 2a, 25 June 2003.

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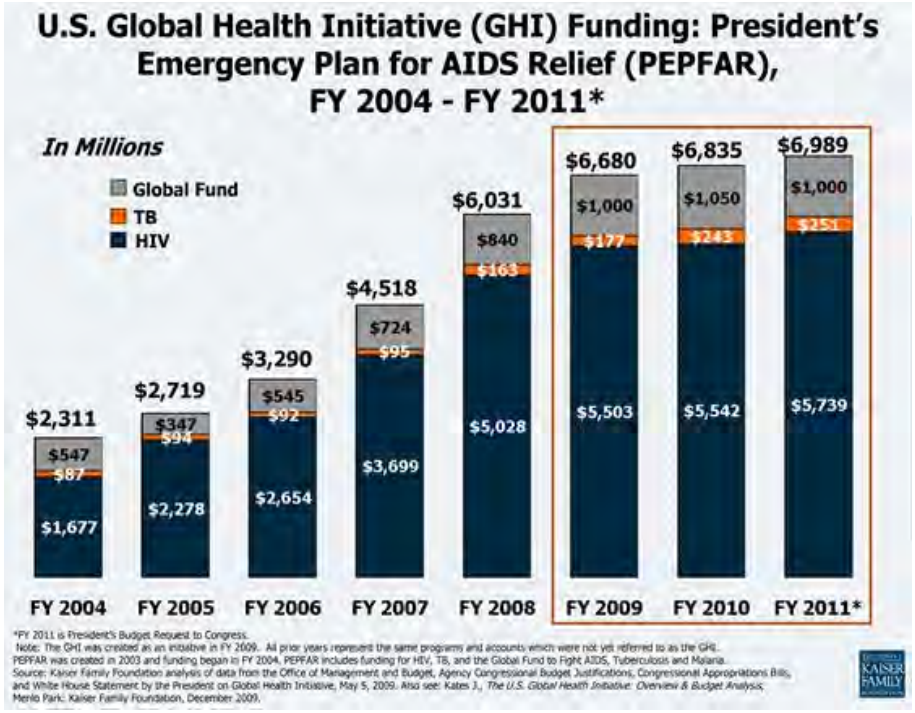
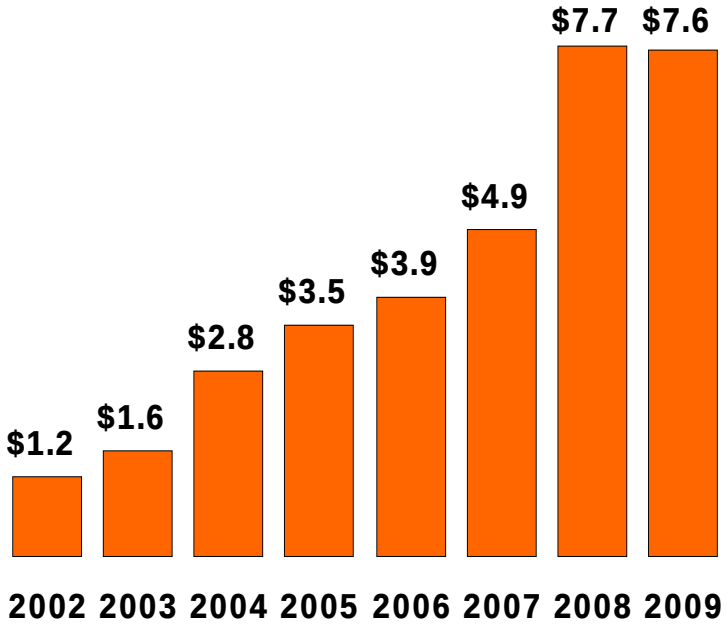
But from 2008, donor funding has leveled off, partly in response to the global economic crisis, but also because of the growing 'backlash' against AIDS-funding – a discursive shift which was already evident prior to the financial crash.



PEPFAR

International AIDS Assistance: Trends in G8/EC & Other Donor Government Assistance, 2002-2009

In Billions



Disbursements

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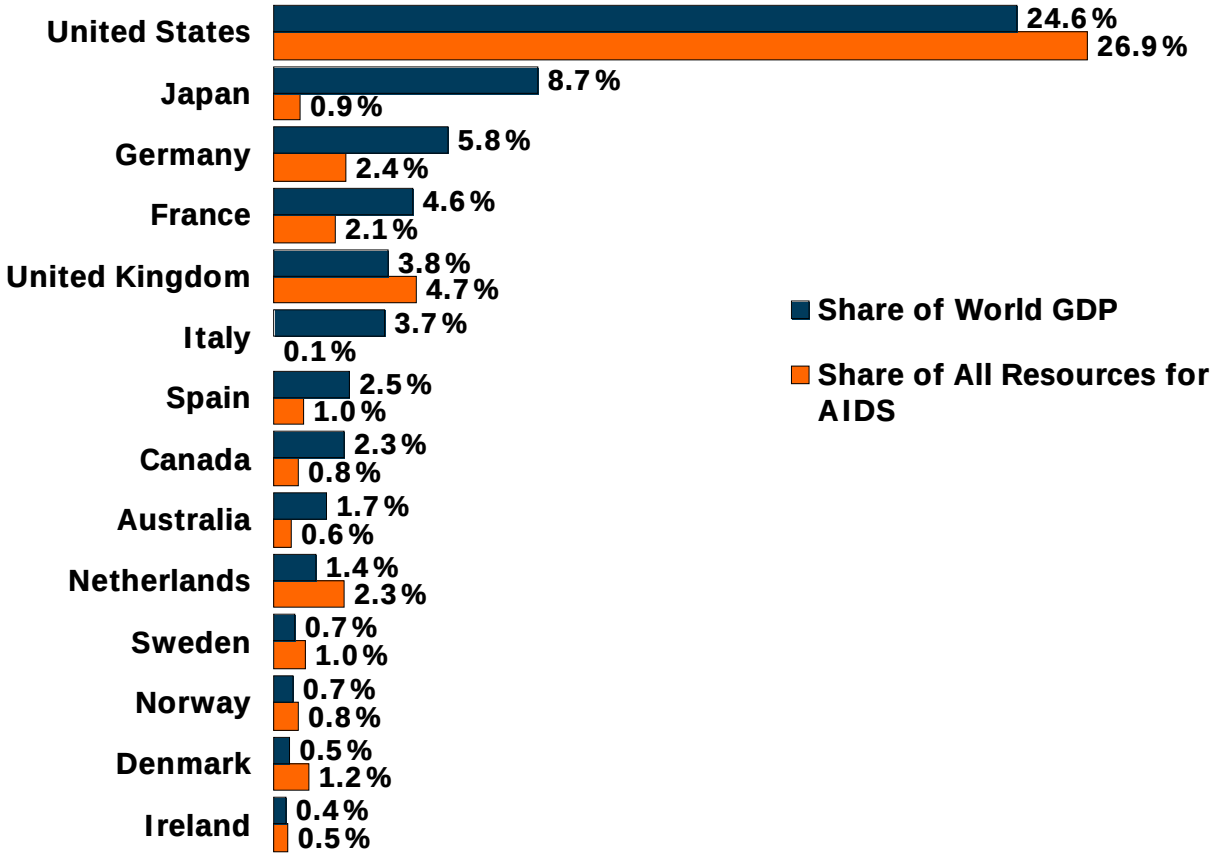
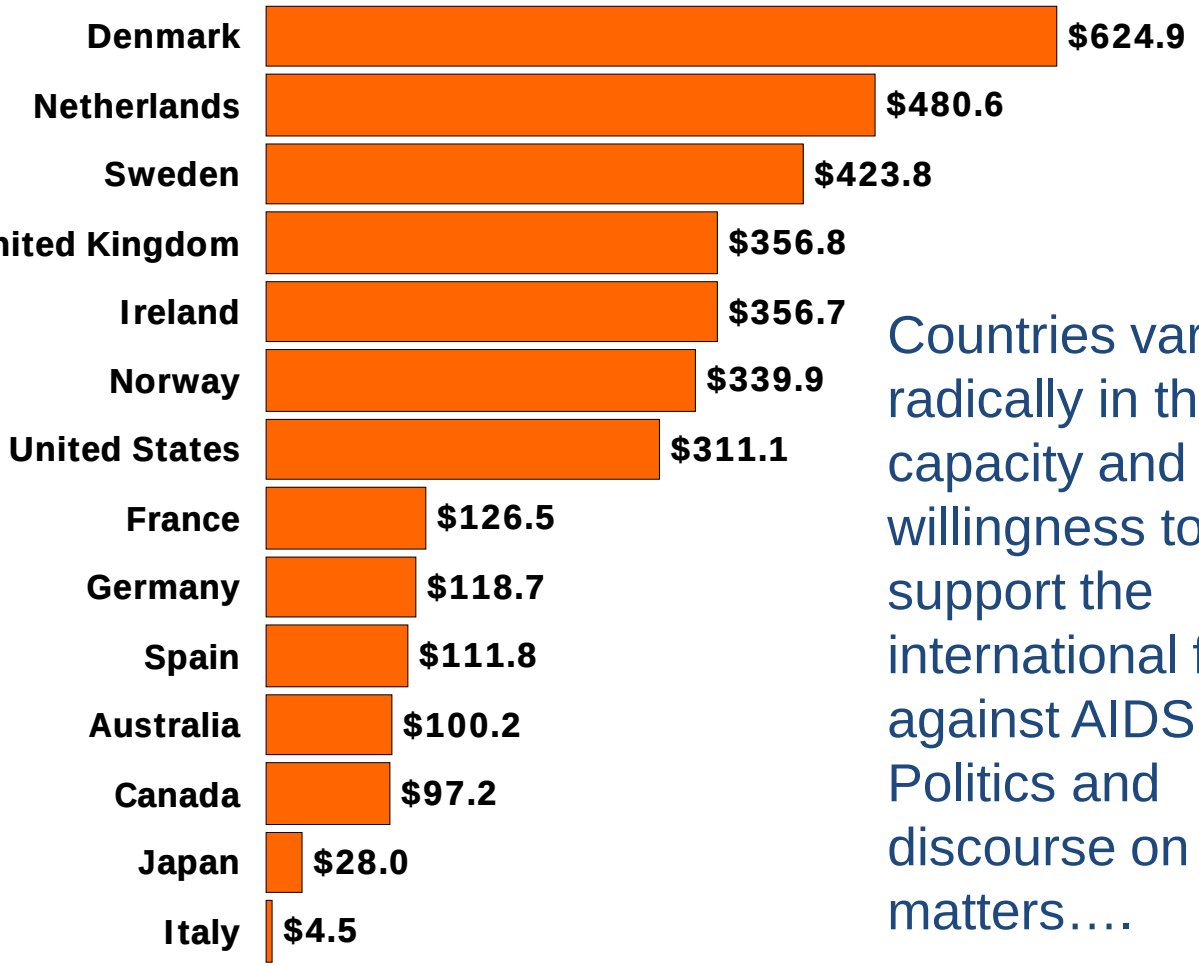
Assessing Fair Share 1: Donor Share of World GDP* Compared to Donor Share of All Resources Available for AIDS, 2009



*GDP = gross domestic product.

Sources: UNAIDS and Kaiser Family Foundation analysis, July 2010; Global Fund to Fight AIDS, Tuberculosis and Malaria online data query, June 2010; UNITAID Annual Report, 2009; International Monetary Fund, World Economic Outlook Database, June 2010.

Assessing Fair Share 2: Donor Rank by Disbursements for AIDS per US$1 Million GDP*, 2009



Countries vary radically in their capacity and willingness to support the international fight against AIDS. Politics and discourse on AIDS matters….

*GDP = gross domestic product.

Sources: UNAIDS and Kaiser Family Foundation analysis, July 2010; Global Fund to Fight AIDS, Tuberculosis and Malaria online data query, June 2010; UNITAID Annual Report, 2009; International Monetary Fund, World Economic Outlook Database, June 2010.

Steven Lewis on the backlash…

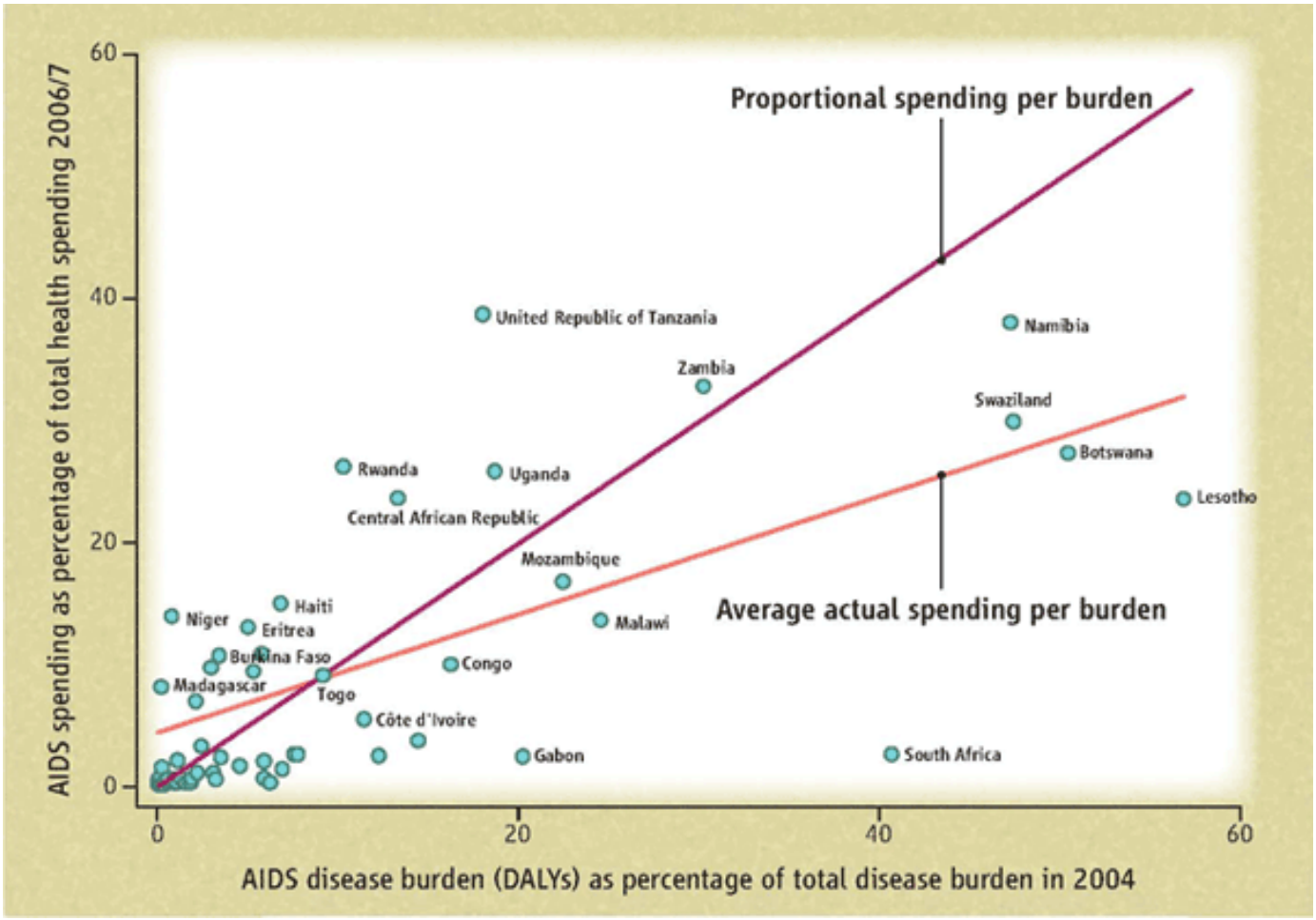
- ‘Then along come the detractors, driven by resentment, resentment at the success of the AIDS movement. These arithmetic arguments alleging that AIDS is getting too much money at the expense of other health imperatives … this is simply naked academic and bureaucratic envy…. The seething resentment that pulsates beneath the surface creates this false argument.’
- He calls on scientists and the AIDS community to resist this ‘punitive spasm to ransack resources for AIDS’ and to ‘find a way, collectively, to shoot down the pinched bureaucrats and publicity-seeking academics who advocate exchanging the health of some for the health of others’ (Speech, Cape Town: July 2009).

The Backlash in Practice

- Sept 2007: International Health Partnership (IHP) set the stage for the revisionist agenda by pitting Millennium Development Goals (MDGs) 4 & 5 (maternal & child health) against MDG 6 (AIDS and other diseases).

- Sept 2008: Task Force for Innovative Financing for Health Systems (chairs: Brown and Zoellick) took for granted that MDGs 4 & 5 have been 'neglected' and that 'sector-wide' approaches and 'general health systems' support are needed. The Global Fund was excluded from the Task Force.
- Oxfam and DfID 'moratorium' on new vertical health initiatives.
- The US starts signaling that it will cut AIDS spending – but has yet to do this, although increases have been marginal…

Backlash Claim 1: AIDS spending is 'disproportionate' to the disease burden: But this was not the case if we look at UNAIDS data as of December 2007……..



But some analysts question UNAIDS data…

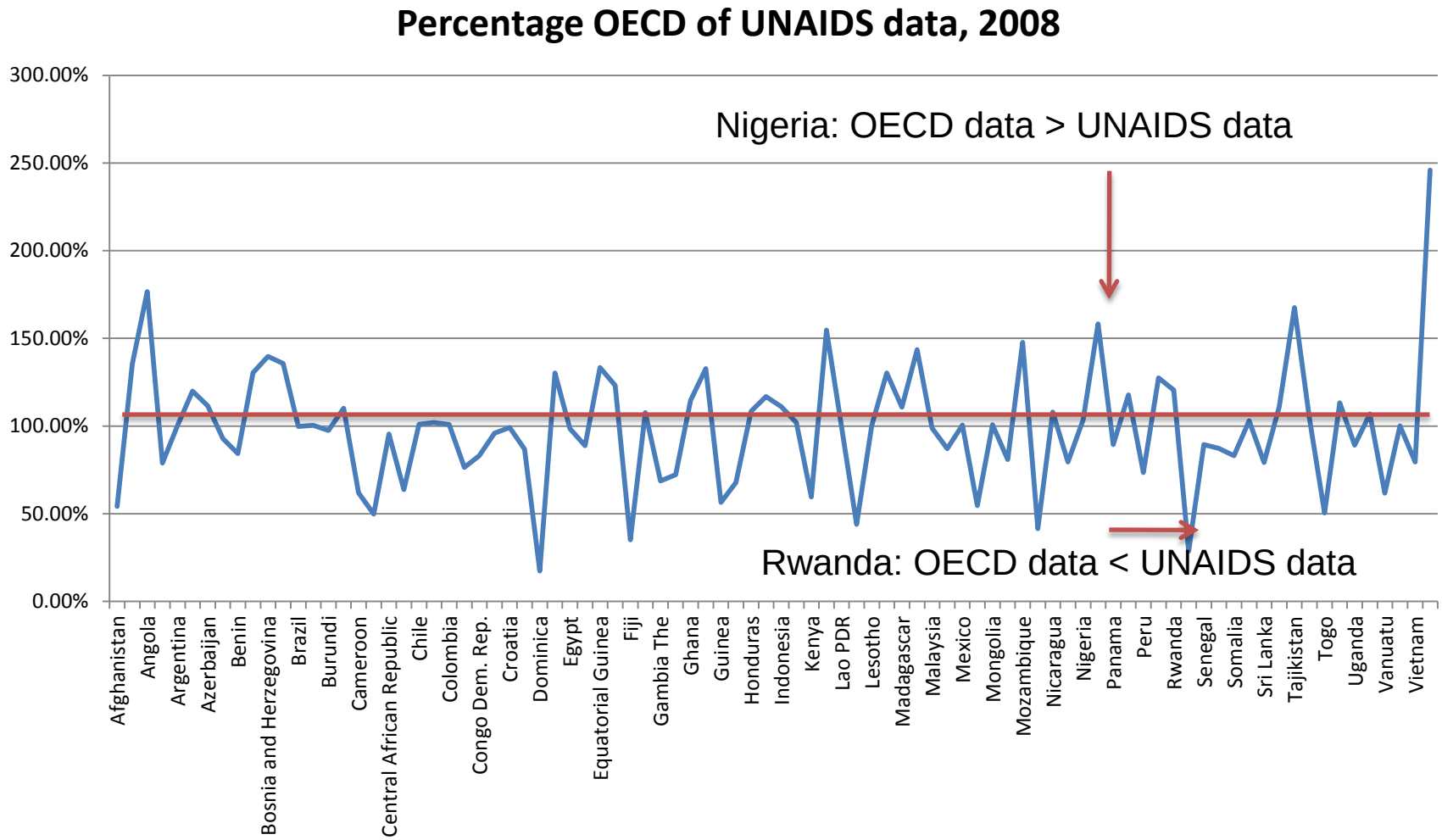
And the 2008 data suggest a different pattern…

See debate in the letters page of *Science*, 8 October, 2010: 174-8

Data sources

- UNAIDS – country reports (meant to capture all HIV spending in a given country, administered by country governments). Dollars received – public and international sources
- OECD – Creditor Reporting System gives reliable info on global disbursements of HIV funds by its 20 member states. Dollars given – international sources only
- Other inconsistent and incomplete data sources on aid flows (e.g. to NGOs)

Differences between the OECD and UNAIDS data



Proportionate or disproportionate HIV spending in the top 20 HIV countries: 2008

	UNAIDS	OECD	AIDDATA	# HIV DALYS
South Africa	**NO**	**NO**	**NO**	**8545.396**
Nigeria	YES	YES	YES	4860.255
India	**NO**	**NO**	**NO**	**3851.904**
Kenya	YES	YES	YES	3567.455
Uganda	YES	YES	YES	2648.558
Mozambique	YES	YES	YES	2166.818
Congo Dem. Rep.	YES	YES	YES	2149.073
Malawi	YES	YES	YES	1862.201
Thailand	**NO**	**NO**	**NO**	**1578.902**
Côte d'Ivoire	YES			1274.051
Cameroon	**NO**	**NO**	**NO**	**1151.381**
China	YES	YES	YES	671.2556
Myanmar	YES	YES	YES	589.5008
Ghana	**NO**	**NO**	**NO**	**571.626**
Rwanda	YES	YES	YES	557.4867
Russian Federation	YES			532.8566
Brazil	**NO**	**NO**	**NO**	**485.1904**
Lesotho	YES	YES	YES	459.7303
Botswana	YES	YES	YES	451.4111
Vietnam	YES	YES	YES	397.6134

Total overspend	14	Work in progress by
Total underspend	6	Matthew MacDevette

Backlash Claim 2: The rise in HIV/AIDS spending has been at the cost of health spending elsewhere…….

Some anecdotal evidence (e.g. Malawi, the early international AIDS response drew doctors out of the public health system – prompting policy changes in the donor community).

There is some evidence that foreign aid for health results in some 'crowding out' domestically (as governments concentrate more on spending items not supported by donors). Lu, C., Schneider, M., Gubbins, P. Leach-Kemon, K., Jamison, D., and L Murray. 2010. Public Financing of Health in Developing Countries: A Cross National Systematic Analysis. In Lancet, 375: (9723) 1375-87.

But this does not appear to be true for AIDS spending, which probably catalyzed funding into health systems. [Lieberman S, Gottret P, Yeh E, de Beyer, J, Oelrichs, R and Zwedie, D: **International health financing and the response to AIDS**. *J Acquir Immune Defic Syndr* 2009; **52**(Supp 1): S38-44]

Some argue that 'crowding out' of foreign aid is caused by IMF programs (and advice) to keep some of the international aid in the form of reserves. The Debt2Health program of the Global Fund seeks to overcome this problem.

Backlash Claim 3: 'Vertical' AIDS programs have undermined health systems efficacy

Some anecdotal evidence. But a large collaborative study concluded that for the most part, AIDS programs were synergistic with health systems, but that more could be done to exploit the synergism. [World Health Organisation Maximizing Positive Synergies Collaborative Group (WHO MPSCG). 2009. **An Assessment of Interactions between Global Health Initiatives and Country Health Systems**. *Lancet*, **373**: 2137-69].

Vertical programs are not optimal, hence the shift in most donor funding to integrated approaches (the Global Fund now allocates 1/3 of its spending on health systems). But they can help build momentum in the initial stages.

Also, shifting away from vertical programs into 'integrated' or 'sector-wide' approaches can be dangerous if institutions are weak or political will is lacking. (For example, the Zambian TB program collapsed in the 1990s when it was 'integrated' into the health system).

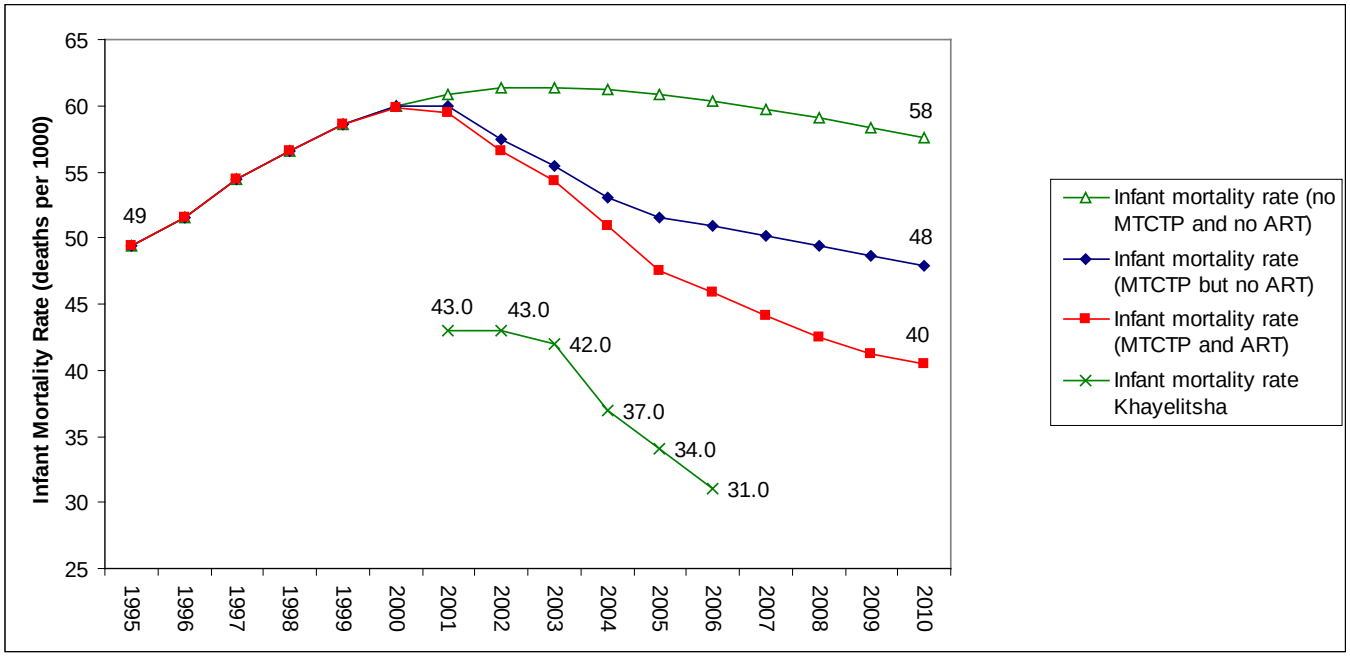
Steven Lewis again....

"HIV/AIDS, for all the horrendous human consequences, has objectively strengthened health systems, has brought together all the sectors of government from agriculture to education, has integrated private and public initiatives, has exponentially raised awareness of the consequences of gender inequality, has spawned remarkably novel ideas for raising resources … all of it inevitably improving human health overall."

Backlash Claim 4: Prioritize HIV prevention and radically cut back on AIDS treatment

This fails to consider how ineffective most behavioural HIV prevention interventions are….

And it fails to consider the 'cost savings' involved in averting AIDS-related illnesses . (NB: critics respond by saying that this is true for other diseases too – though the evidential basis is thin)



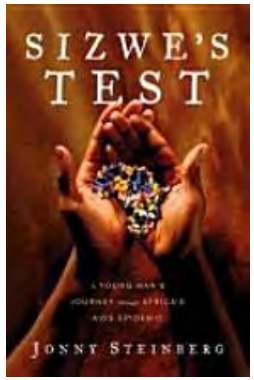
It also ignores the synergies between HAART and HIV prevention (e.g. in Uganda where HAART reduced HIV transmission to 0). But recent studies in the US and Holland suggest that the drop in HIV incidence following HAART rollout is caused by HIV prevention programs and that many people on HAART remain infectious, especially during the first 6 months on treatment, and because of poor adherence and dropping out of treatment programs….

Backlash Claim 5: AIDS activists are self-interested and have distorted spending away from where the money could achieve maximum benefits

AIDS activists obviously fight for treatment – but they also actively push for better health systems and to fight other diseases – such as TB, and to fund broader health initiatives such as the Global Fund which only contributes 20% of international funding for AIDS.

AIDS activism is the *only* example of sustained grass-roots pressure on governments to deliver health care services to people in developing countries. Jonny Steinberg on treatment activism in rural South Africa:

> "The idea of demanding that a drug be put on a shelf, or that a doctor arrive at his appointed time, is without precedent. The social movement to which AIDS medicine has given birth is utterly novel in this part of the world, the relationship between its members and state institutions previously unheard of"



Ignoring the political importance of activism and ignores the lessons of the failure of the primary health care initiative of the 1970s….

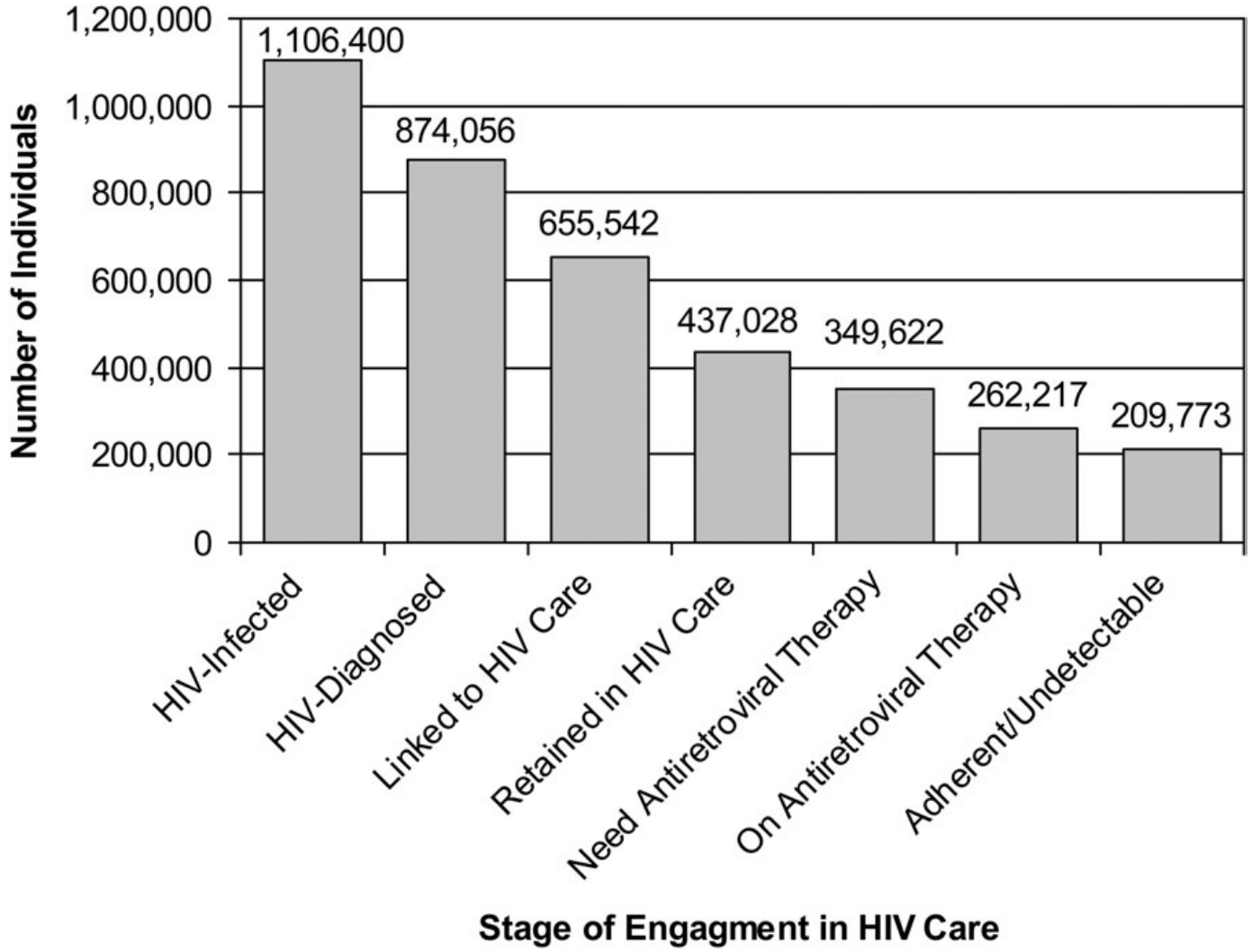
Forgetting the Lessons of History

Alma Atta Conference

- We are seeing a revival of the primary health agenda (Alma Atta, 1978) – but forgetting the lessons of the last three decades of development:
  - a) public admin approaches which are not alert to underlying incentives and mechanisms of accountability do not work
  - b) switching to general/integrated approaches can kill good programs (TB in Zambia in the 1990s)
  - c) social and political mobilization is needed to drive changes in behaviour and health policy (Thailand, Uganda, Brazil).
- Is it not better to build strong constituencies for better health care? To keep pushing for global health, but on the back of the successful AIDS response?

But for this to be sustainable, activists need to ensure that the broader society sees them as deserving…

- Poor response to HIV testing and treatment could undermine the social acceptability of allocating resources to antiretroviral treatment – and to supporting people with AIDS….
- Calls for combination prevention and extra resources could backfire in the current economic climate



Worrying data from the US shows worryingly low levels of engagement in AIDS care – thereby undermining the treatment as prevention argument

Figure 2. The spectrum of engagement in HIV care in the United States spanning from HIV acquisition to full engagement in care, receipt of antiretroviral therapy, and achievement of complete viral suppression. We estimate that only 19% of HIV-infected individuals in the United States have an undetectable HIV load. (Gardner et al 2011, *Clin Infect Dis. (2011) 52 (6): 793-800. doi: 10.1093/cid/ciq243*

High rates of loss to follow-up (17 studies, mostly in Africa) – and high rates of death for those lost to follow up).

"In ART programmes in resource-limited settings a substantial minority of adults lost to follow up cannot be traced, and among those traced 20% to 60% had died. Our findings have implications both for patient care and the monitoring and evaluation of programmes"

No.	Study	Location	Setting	LTFU definition	Contact method	Study period	No patients on ART	% LTFU
Articles								
1	Yu 2007 [17]	Four facilities in Malawi	Rural	No visit for >3 months	Home visit	2004–2005	5009	5.0
2	Maskew 2007 [20]	Johannesburg, South Africa	Urban	Missed appointments	Telephone	n.r.	5849	n.r.
3	Dalal 2008 [16]	Johannesburg, South Africa	Urban	Missed appointments >6 weeks	Telephone & home visit	2004–2005	1631	16.4
4	Krebs 2008 [13]#	Lusaka, Zambia	Urban & semi-urban	Missed appointments >1 week or month	Home visit	2005	n.r.	21.0*
5	Bisson 2008 [19]	Gaborone, Botswana	Urban	Missed appointments >30 days	Telephone & home visit	2003	410	16.6
6	Geng 2008 [18]	Mbarara, Uganda	Rural	Missed appointments ≥6 months	Home visit	2004–2007	3628	22.9
7	Deribe 2008 [25]	Jimma, Ethiopia	Urban	Missed ≥2 appointments	Telephone & home visit	2007	1270	28.0
8	An 2008 [14]#	Eldoret, Kenya	Urban & rural	Missed appointments	Telephone & home visit	2005–2007	8977	39.3
Conference abstracts								
9	Ive 2005 [15]	Johannesburg, South Africa	Urban	Stopped attending the ARV clinic	Telephone	2004–2005	2400	3.1
10	Hochgesang 2006 [21]	Lilongwe, Malawi	Urban	Missed appointments >2 weeks	Home visit	2005	3840	48.0
11	Billy 2007 [23]	Bukoba, Tanzania	Rural	No visit for >3 months	Home visit	2005–2007	1562	17.5
12	Dalhab 2008 [12]	Public programme, Gauteng, South Africa	Urban	Missed appointments >1 month	Telephone & home visit'	2007	267	16.5
13	Dalhab 2008 [12]	Mine programme, Rustenburg, South Africa	Workplace	Missed appointments >1 month	Telephone & home visit	2007	146	36.3
14	Lurton 2008 [24]	Ségu region, Mali	Rural	No visit for >3 months	Telephone, social network & home visit	2008	1368	15.1
15	Joshi 2008 [26]	Jodhpur, India	Urban & Rural	No visit for >3 months	Telephone, social network	n.r.	1191	12.8
16	Muwanga 2008 [27]	Kampala, Uganda	Urban	Missed appointments >3 month	Telephone	2007–2008	6421	12.9
17	McGuire 2009 [22]	Chiradzulu, Malawi	Rural	Missed appointments >1 month	Home visit	2008	11057	11.4

n.r.: not reported.
#studies including patients not on ART.
*estimate from Stringer et al. 2006 [30].
doi:10.1371/journal.pone.0005790.t001

Brinkhof et al. 2009. Mortality of patients lost to follow-up in antiretroviral treatment programmes in resource-limited settings: systematic review and meta-analysis. PLoS ONE vol:4 iss:6

Key Challenges

- Support and build HAART patient organisations (to help reduce loss to follow up, to make the political case for HAART, to put pressure on governments to improve health systems for all).
- Develop easier, cheaper and more effective HAART regimens (UNAIDS's 'Treatment 2.0') – and recent free trade agreements, e.g. between India and the EU which threatens this.
- Keep developing the HIV science: We need a cure….