HIV is not over-funded: Health is Under-Funded.

19 November 2009

We, the 87 undersigned civil society, research and health professional groups from 30 countries around the world, deplore the spate of statements from public figures around the world that call for a shift of funding from HIV in order to address broader health needs. The neglect of health systems in general, and particular health challenges such as tuberculosis and diarrhea, is not a recent phenomenon and certainly cannot be attributed to one disease that is obsessively touted as the culprit – namely, HIV.

Rather, neglect is a symptom of the long-standing tradition of political disinterest in prioritizing healthcare and other areas of social spending, even when the need is immense – one example of which is clearly evident in the many years (prior to the HIV response) when multidrug-resistant TB was ignored by global health leaders as it escalated out of control.[1] Similarly, the period between 1989 and 1999 showed "disquieting" stagnation of coverage of maternal health services in sub-Saharan Africa,[2] as well as of immunization.[3]

The continued tradition of neglect has led to a diverse array of public health crises, which are now politically pitted against each other to compete for scarce resources.

Sub-Saharan Africa, despite having more than 20% of the global disease burden and two thirds of the people living with HIV, is home to less than 2% of the global health expenditure.[4] This cannot be solely attributed to shortfalls in aid. Despite the commitment made by African heads of state in the 2001 Abuja declaration to dedicate 15% of their national budgets to health – although it is widely acknowledged that much more would be needed to meet health outcomes – most African governments fall short of this target, with the regional average currently standing at a paltry 7% and subject to frequent fluctuation.[5]

Within Africa and around the world, investments in health pale in comparison to investments in military, sports and other political priorities that do nothing to advance human development – reprioritizing public expenditure has been identified as a principal strategy for improving health in African countries.[6] More resources for health overall are desperately needed – not only for the humanitarian and health systems benefit, but also to lessen the destabilizing impact of poor public health on socio-economic progress,[7] particularly in low-income countries.

Shifting funding from HIV will not fill the yawning gaps in resources for health – this move is a cheap diversionary tactic that offers no genuine or long-lasting solutions for health systems. What is required is a shift in political will to prioritize and invest vigorously in health. Until this happens, neglect and dysfunction will continue to pervade health systems irrespective of what specific health needs we focus upon.

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[1] Park, Alice."Tuberculosis: An Ancient Disease Continues to Thrive." TIME Magazine, 2 October 2008. Online at http://www.time.com/time/health/article/0,8599,1846698,00.html
[2] AbouZahr C & Wardlaw T. Maternal mortality at the end of a decade: signs of progress? Bulletin of the World Health Organization, 2001, 79: 561–568.
[3] WHO, UNICEF, World Bank (2002) State of the World's Vaccines and Immunization. WHO/V&B/02.21
[4] African Union (2009) Health Financing in Africa: Challenges and Opportunities for Expanding Access to Quality Health Care. CAMH/EXP/13a(IV) page ii
5 African Union (2009) Health Financing in Africa: Challenges and Opportunities for Expanding Access to Quality Health Care. CAMH/EXP/13a(IV) page 7
[6] Kirigia JM, Diarra-Nama AJ (2008) Can countries of the WHO African Region wean themselves off donor funding for health? Bulletin of the World Health Organisation, Volume 86 No. 11 November, 817-908
[7] UNAIDS. Global Report on the AIDS epidemic, 2008. p159

HIV continues to take an immense toll on health and broader socio-economic systems. Less than half of the people estimated to need life-saving HIV treatment currently have access to it, and many are at risk of seeing their existing access interrupted as a result of resource and funding shortages.[8] With almost 3 million new HIV infections every year, current prevention strategies are clearly inadequate, and require much more attention and resources. Instead, this distracting debate is providing grounds for governments to begin cutting back on their commitments to HIV treatment, as has been seen in Uganda,[9] South Africa,[10] and Botswana,[11] - as well as in the rhetoric of major donors such as the United States government.[12]

Lack of treatment, in addition to causing widespread illness and death, also fuels the growth of the HIV epidemic. There is tremendous preventive potential associated with treatment itself, which suppresses an individual's viral load and thereby reducing the risk of transmission of HIV – to the extent that some experts have suggested immediate treatment of all people living with HIV as a potential strategy for eliminating the epidemic.[13] In practice, the preventive benefit of ARVs has already been witnessed in the use of ARVs for prevention of vertical transmission. But still, only 21% of pregnant women are tested for HIV – and of those who test positive, less than 50% are provided with treatment to prevent the transmission of HIV to their children.[14] The World Health Organisation estimates that 2 million people die of AIDS every year, of which almost 300,000 are children; and that worldwide, HIV is the leading cause of death in women of reproductive age.[15]

Attempting to more thinly distribute resources allocated to HIV in order to superficially address a broader range of health needs serves only to more evenly distribute inadequacies, but offers no long-lasting gains for the health system as a whole. HIV underpins many other pressing health problems such as tuberculosis, which has been declared a public health emergency in the African region where it is often referred to as a 'twin' of HIV, as the two epidemics are so closely intertwined. Globally, 35% of recorded tuberculosis deaths are among people living with HIV.[16] HIV continues to be a leading cause of maternal and child mortality in the African region – in at least 4 Southern African countries (South Africa, Lesotho, Botswana and Namibia), more than 50% of deaths in children under 5 are attributed to HIV.[17]

Even where the relatively smaller contribution of HIV to overall population mortality is being emphasised, this is due to the impact of ARV programmes: in northern Malawi, before the introduction of ART, 65% of all adult deaths were due to HIV. 8 months after a public ARV programme was introduced, overall population mortality had decreased by 10%.[18] Similarly, prior to the introduction of a public ARV

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[8] World Bank (2009) Averting a Human Crisis during the Global Downturn. Online at: http://siteresources.worldbank.org/NEWS/Resources/AvertingTheHumanCrisis.pdf
[9] Mugyenyi P. Flat-lining funding for PEPFAR: A recipe for Chaos. Lancet 2009;374(9686):275
[10] Peroshni Govendor. SA won't meet ARV roll-out target, says Motsoaledi. Mail and Guardian, 15 September 2009. Online at http://www.mg.co.za/article/2009-09-15-sa-wont-meet-arv-rollout-target-says-motsoaledi
[11] PlusNews. BOTSWANA: Bleak outlook for future AIDS funding. IRIN Plus News, 20 February 2009. Online at http://www.plusnews.org/Report.aspx?ReportId=83054
[12] Stanley Kwenda. Learning From Criticism, U.S. Committed to AIDS Fight. IPS News, 12 September 2009. Online at http://ipsnews.net/news.asp?idnews=48425
[13] Granich RM, Gilks CF, Dye C, De Cock KM,Williams BG. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. Lancet 2009; 373: 48–57.
[14] WHO, UNAIDS,UNICEF. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector - progress report 2009. p5
[15] WHO, UNAIDS,UNICEF. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector - progress report 2009.
[16] World Health Organisation. Global Tuberculosis Control 2009: Epidemiology, Strategy, Financing. p46
[17] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009
[18] Jahn A et al. Population-level effect of HIV on adult mortality and early evidence of reversal after introduction of antiretroviral therapy in Malawi. Lancet, 2008, 371:1603–1611.

programme in Rwanda, 94% of patients treated for chronic dirrhoea had HIV, and 72% had clinical AIDS.[19]

We should not let progress make us forget history. It is irrational to expect that we can address major public health needs without overcoming the HIV epidemic. Greater integration of HIV services with the broader health system is certainly essential and has long been advocated for, but integration does not equate to elimination of vertical HIV programmes. In a policy brief prepared for the 2008 European Ministerial Conference on Health Systems, which examined horizontal and vertical approaches to health programming, experts cautioned that it would be imprudent to generalize that one approach is superior to the other, stating that with appropriate integration and efforts to minimize negative spillover of vertical programmes, the two approaches can constructively coexist.[20]

In placing the blame for the poor state of public health on HIV, we are pre-empting such constructive coexistence, and dismissing opportunities to build on the HIV response in order to strengthen health systems now and in the future. Although there is a undoubtedly a need to improve synergies, there is also ample evidence that the HIV response has already strengthened health systems[21] – for example, improving laboratories and supply chain management systems, through increasing people's interaction with the health systems and hence access to other health services. There is still much to be learnt from the response to HIV, such as the crucial role that can be played by community members in advocating for and implementing the health response.

However, our ability to apply and expand these lessons ultimately depends on availability of resources. The aforementioned policy brief also warned, "in many countries, scaling up integrated sexual and reproductive health, HIV and AIDS services face formidable political, financial and service barriers and constraints due to weak health systems and lack of resources."[22] More resources are therefore indispensible – not just to sustain vertical programs, but also to advance integration.

It is undeniable that corruption and inefficiencies in HIV programmes have contributed to undermining resource availability. The continued distribution of HIV funding through institutional programs that have proven to unsatisfactory and poorly monitored, such as the World Bank,[23] and the failure to ensure more accountable implementation, have undermined the impact of millions of dollars earmarked for health. Investigations into public expenditure in the African region have shown massive leakage of funds, with only half of the funds allocated for health expenditure in sub-Saharan Africa ever reaching the services that provide facilities at the end of the line – the reasons for which are unknown.[24]

However, it is crucial to note that these problems are not unique to HIV, but are endemic across the board and require a more nuanced and comprehensive approach. As part of this approach, it is critical to build the capacity of civil society to hold governments accountable for their use of domestic and donor resources. This includes ensuring that consistent, quality and timely information on public health

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[19] Clerinx J., Bogaerts J., Taelman H., Habyarimana J.B., Nyirabareja A., Ngendahayo P. and Van de Perre P. Chronic Diarrhea among Adults in Kigali, Rwanda: Association with Bacterial Enteropathogens, Rectocolonic Inflammation, and Human Immunodeficiency Virus Infection. Clinical Infectious Diseases 1995 21: 1282-4
[20] Atun RA, Bennett S, Duran A. When do vertical (stand-alone) programmes have a place in health systems? WHO 2008.. Online at http://www.euro.who.int/document/hsm/5_hsc08_ePB_8.pdf
[21] El-Sadr, W, De Cock, KM. Health Systems Exist for Real People. JAIDS Journal of Acquired Immune Deficiency Syndromes: November 2009 - Volume 52 - Issue - pp S1-S2
[22] Atun RA, Bennett S, Duran A. When do vertical (stand-alone) programmes have a place in health systems? p12. WHO 2008. Online at http://www.euro.who.int/document/hsm/5_hsc08_ePB_8.pdf
[23] World Bank/IFC/MIGA Independent Evaluation Group. Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population : An Evaluation of World Bank Group Support Since 1997. 2009
[24] African Union (2009) Health Financing in Africa: Challenges and Opportunities for Expanding Access to Quality Health Care. CAMH/EXP/13a(IV) page 16

expenditure is made available[25] – which is currently not the case, due to a lack of transparency from both governments and international donors.

Health systems need strengthening, and neglected health problems need attention. But it is irrational, regressive and dangerous to pursue these goals at the expense of HIV. Furthermore, basing funding decisions on arguments over which specific modes of death should be targeted with our meager pool of resources is in clear and perverse contradiction to the universal human right "of everyone to the enjoyment of the highest attainable standard of physical and mental health"[26], as has been committed to by countries all over the world.

We call on our global, national and local leaders to put their money where their mouths are. If truly committed to strengthening health systems, they need to put much more money on the table; spend it more wisely; build on the successes of HIV to strengthen other elements of the health response; and work collaboratively with civil society to achieve transparency and accountability in funding mechanisms and health systems.

Signed:

ORGANIZATION	COUNTRY
1. ACT UP USA	USA
2. ACTWID	Cameroon
3. Adventist Development and Relief Agency	Lesotho
4. AIDS Fonds	Netherlands
5. AIDS Law Project	South Africa
6. AIDS Treatment Activists Coalition	USA
7. AIDS Treatment News	USA
8. Asia Pacific Network of People living with HIV/AIDS (APN+)	Asia
9. Asian People's Alliance for Combating HIV and AIDS (APACHA)	India
10. AIDS and Society Research Unit	South Africa
11. AIDS and Rights Alliance for Southern Africa	Namibia
12. Ambassadors of Change	Kenya
13. Association de Lutte Contre le SIDA (ALCS)	Morocco
14. AVAC	USA
15. Botswana Network on Ethics, Law and HIV/AIDS	Botswana
16. Buds of Christ	India
17. CABRINI MINISTRIES	Swaziland
18. CARE Zambia	Zambia
19. Centre for Economic Governance and AIDS in Africa	South Africa/Regional
20. Centre for Health Policy & Innovation	South Africa
21. Commonwealth HIV & AIDS Action Group	UK
22. Children Education Society	Tanzania

[25] Govender V, McIntyre D, Loewenson R (2008) 'Progress towards the Abuja target for government spending on health care in East andSouthern Africa,' EQUINET Discussion Paper Series 57. EQUINET: Harare.
[26] Article 12 of the International Covenant on Economic, Social and Cultural Rights, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976) and ratified by 160 States (11.11.09)

23. Christian AIDS Resource and Information Services	South Africa
24. Coalition of Women Living with HIV and AIDS	Malawi
25. Conseil Mondial de Soins Afrique	DRC
26. Delhi Network of Positive People (DNP+)	India
27. Education and Development Opportunity - Uganda (EDOU)	Uganda
28. FEMME PLUS	DRC
29. Free Global Health for All	USA
30. GESTOS- HIV+	Brazil
31. Global AIDS Alliance	USA
32. Global Friends in Action	Zambia
33. GlobalSIDA	Spain
34. Grassroots Movement for Health and Development	Malawi
35. Grassroots Empowerment Trust	Kenya
36. Health Alliance International	USA
37. Health Gap	USA
38. Health Triangle	Zambia
39. HIV Collaborative Fund	Global
40. HIV i-Base	London
41. ICW East Africa	Uganda
42. IDSA/HIVMA Centre for Global Health Policy	USA
43. Indonesia UNGASS Forum	Indonesia
44. International Treatment Preparedness Coalition Global	Global
45. Journalists Against AIDS	Nigeria
46. Just Associates Southern Africa (JASS)	Zimbabwe
47. Kara Counselling	Zambia
48. Kenya Legal & Ethical Issue Network on AIDS	Kenya
49. Ladder for Rural Development	Malawi
50. MANET+	Malawi
51. MSCAVCO	Colombia
52. MTAAG+	Malaysia
53. NABCOA	Namibia
54. NEPHAK	Kenya
55. OSISA	South Africa
56. Partners in Health	USA
57. PATA	Nigeria
58. Physicians for Human Rights	USA
59. PINOY PLUS ASSOCIATION	Phillipines
60. Positive Lives India (PLI+)	India
61. Positive Voice	Greece
62. Population Services International Swaziland	Swaziland
63. Public Personalities against AIDS Trust	Zimbabwe
64. RAP+AC	Cameroon

65. SAATHI	India
66. SAfAIDS	Zimbabwe
67. SAHRiNGON	Tanzania
68. SCARJOV	Angola
69. SHRISTI	India
70. SIDACTION	France
71. SISAL	Madagascar
72. Society for Widows and Orphans	Nigeria
73. Swaziland Positive Living	Swaziland
74. Treatment Advocacy and Literacy Coalition	Zambia
75. Tikondane Women's Congress for Health	Malawi
76. Treatment Action Campaign (TAC)	South Africa
77. Treatment Action Group	USA
78. Technical Support Facility Southern Africa	South Africa
79. Umunthu Foundation	Malawi
80. Women and Law in Southern Africa	Zimbabwe
81. Women's Lobby	Malawi
82. World AIDS Campaign	South Africa
83. World Care Council	India
84. World Care Council Europe	France
85. World Vision International	Global
86. Youth International Network	Kenya
87. Zambian AIDS Research and Advocacy Network	Zambia