Global resources for HIV/AIDS

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THE AIDS epidemic is confronting the world with a health crisis of an unprecedented magnitude. It is estimated that over 40 million people are currently infected with HIV, the virus that causes AIDS, worldwide. Ninety five per cent of infected people live in the developing world, with most (i.e. 28 million) in sub-Saharan Africa. AIDS has taken the lives of more than 25 million people since the beginning of the epidemic and remains a fast-growing epidemic in most parts of the world. Six million new infections have occurred worldwide in the years 2000 and 2001. Asia, including India, and Eastern Europe are regions where the epidemic is growing at the fastest rate. UNAIDS predicts that nearly 70 million people will die of AIDS in the 45 most affected countries over the next 20 years.

The human, demographic and economic impact of the epidemic will be far more dramatic than it has been anticipated in previous years. Life expectancy has already decreased by 20 years in several countries of sub-Saharan Africa where AIDS will kill half of the women who became mothers in recent years, generating millions more orphans. Even gloomier estimates have recently been released through the report of the National Intelligence Council of the United States. The report predicted that by 2010, there will be 50 to 75 million cases of HIV infection in just five nations, none of them in southern Africa, India, China, Ethiopia, Nigeria and Russia.

Yet the world is not without an answer to the epidemic, even in the absence of any short-term prospect for a protective vaccine. From 1997, the availability of antiretroviral drugs has reduced the mortality and morbidity associated with AIDS by more than 70% in Europe and in the USA. Continuous therapeutic progress is being made with new marketed drugs that are easier to take, exhibit a better tolerance profile and may circumvent the resistance acquired by some strains of HIV to the drugs in use so far.

The cost of triple combination antiretroviral therapy has decreased dramatically, by more than 90% in some countries, due to
reductions in prices negotiated with the major drug companies and
generic competition (including the availability on the world market
of generic antiretroviral drugs from India). Based on the results of
active ongoing research, new therapeutic strategies are being
introduced to complement antiretroviral therapy, including
interventions aimed at stimulating the immune system to respond
to HIV, e.g. the use of Interleukin-2 or therapeutic vaccines.

Prevention has also made progress in several parts of the world, as
exemplified by the ‘success’ stories of Thailand, Uganda and
Cambodia, where significant decreases in HIV incidence rates
have been observed in the last five years. Decreasing by over 30%
the risk of transmission of HIV from mother to child during
pregnancy is now possible using short, simple and affordable
antiretroviral regimens.

The last three years have witnessed an increasing awareness of the
AIDS crisis by the public opinion worldwide and an increasing
commitment of the political world, both at the local and a ‘global’
levels, as evident in the recent meetings of the G7 and G8 meetings
of heads of states of Africa and on the occasion of the special
session of the General Assembly of the UN (UNGASS) in June
2001. The lack of donor funding comes as the single greatest
reason why the epidemic has spread in poor countries where the
resources of local governments and affected individuals are much
too limited (the per capita public health budget in sub-Saharan
Africa is approximately US$ 10 per year) to confront the needs of
disease control. Thus, for the next decades, the only way to
alleviate the domestic constraints of low-income countries, is to
supplement their health budgets with foreign aid.

Following the UNGASS, an important number of new initiatives
have taken place to fund the global effort to fight the HIV/AIDS
pandemic. The Declaration of Commitment on HIV/AIDS adopted
by all member states at the UNGASS commits governments to
establish national strategic plans of new interventions integrating
prevention, care and treatment, and to fund some of these
programmes by significant increases in national expenditures on
health. Estimates by experts from Harvard University and
UNAIDS have been consistent in calling for amounts of funding of
between US $ 810 billion per year to be provided by national
resources and the inter-national community.

The Global Fund to fight HIV/AIDS, tuberculosis and malaria
(GFATM) which became operational in January 2002, comes as
the major international funding initiative taken in the last 12
months to answer the needs associated with the spread and the
impact of the AIDS epidemic. Other new, or recently expanded,
bilateral and multilateral initiatives have also been announced,
including the World Bank’s MAP-2 programme which is funding
HIV treatment in developing countries via interest-free loans, conditional debt relief (e.g. debt relief negotiated by France with several West African countries), and new funding programmes from USAID, DFID, private foundations (Gates foundation), NGOs (Médecins Sans Frontières), the pharmaceutical industry (Bristol Myers Squibb, the Glaxo Welcome Foundation), private businesses (Coca Cola) and an increasing number of national and international companies with workforces in Africa (Anglo-American, Heineken) who plan to fund HIV treatment programmes for their employees.

During the last six months, the GFATM has shown its potential to become a new and highly effective channel to tackle HIV/AIDS. The Global Fund is not a UN agency; it is controlled by an innovative Board made up of donor countries, recipient countries and representatives of civil society, foundations and corporations. It brings together governments, non-governmental groups and the private sector within affected countries. The establishment of the GFATM calls on wealthy countries to provide financial and scientific leadership, and poor countries to provide necessary political and institutional support at both the national and community levels.

The GFATM appears uniquely positioned to galvanise contributions from the world community and to provide multi-year grants that make grantees willing to start antiretroviral treatment and programmes without fear of termination of funding after a year or two. Applications are sent to the GFATM by so-called ‘Country Coordinating Mechanisms’ that bring together all stakeholders at the country level, i.e. government, civil society and bilateral/multilateral donors. Funds allocated by the GFATM are to be additional to existing and expanding efforts of these stakeholders at the country level.

Applications are reviewed by an independent international panel of experts in disease and public health. Final approval of funding is given by the Board. A fast process for disbursing funds is now being put into place involving the World Bank which acts as the trustee for the Fund, a local ‘primary recipient’ that may be the government or an NGO accountable to the Fund, and a ‘local funding agent’ whose task will be to supervise the process in the recipient country.

After the first round of review in March and April 2002, the GFATM approved 54 programmes in 54 countries amounting to US$ 616 million for the first two years and US$ 1.6 billion for the entire duration (3-5 years) of the programmes. Seventy per cent of the allocated funds are directed towards AIDS programmes. All AIDS programmes include scaling up prevention and 90% of the funded programmes include a care/treatment component. The
successful completion of these programmes should double the number of people treated with antiretroviral drugs in the developing world and increase this number six fold in Africa.

However, the US$ 2.1 billion that has been pledged so far to the GFATM are far from the resources mentioned above of US$ 8-10 billion needed per year for AIDS alone, and far from the amounts needed to respond to the second round of applications to the Fund that will be reviewed this month and submitted to the Board of the GFATM for approval in January 2003. The total amount of funds requested is approximately US$ 5 billion. If one was to estimate that the technical review panel of the GFATM would retain 40% of these applications, the Fund will need US$ 4.25 billion in 2003. A more significant commitment of G7 and other donor countries is thus urgently needed. Let us remember that, according to OECD, the 23 richest countries within the organization have contributed the low-income countries with only US$ 400 million for HIV/AIDS in year 2000, that is 17 cents per person living in those poor countries.

The provision of a prophylactic vaccine ultimately represents the only way to significantly impact on the epidemic. Budgets devoted to vaccine research currently represent approximately one-fifth of the total AIDS research budgets, both in Europe and the U.S., i.e. US$ 650 million/year for the U.S. programme alone. In addition, several major pharmaceutical firms have launched large research programmes on preventive HIV vaccines, including Merck, Aventis-Pasteur, Glaxo SmithKline and Wyeth.

Despite intense research, we are still far from knowing how to design a vaccine that will effectively prevent HIV infection. The current prospect is for a first generation vaccine of partial efficacy, that is a vaccine which would not prevent infection, but would allow the vaccinated individuals who would become infected to remain asymptomatic and healthy for many more years than is the case now. Such a vaccine raises a number of unsolved scientific, ethical and societal questions. It would certainly benefit the individual by sparing many years from disease and from antiretroviral drugs. From a public health perspective, such a vaccine could also be of benefit by lowering the ‘viral load’ in the infected population and thus decreasing the transmissibility of the virus.

AIDS is confronting the world with unprecedented challenges: the challenge of urgently scaling up prevention of HIV transmission through information and education, behaviour changes, condom distribution and broad availability of programmes to prevent mother to child transmission; the challenge of expanding access to treatment in the developing world where, at this time, only 200,000 patients receive antiretroviral drugs from the nine million patients eligible for treatment; the challenge of expanding research efforts
to improve the efficacy of prevention programmes, provide better treatments, and developing a preventive vaccine. With few exceptions, the world richest countries have so far repeatedly failed to increase foreign aid to the levels that are urgently needed and to prevent the spread of a disease that we know can be prevented and that we now know how to treat.