Global Fund's money woes

By Peter Heywood
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The announcement that the Global Fund for AIDS, TB and Malaria (GFATM) is short of money and was forced to cancel its 11th funding round due to a lack of resources has generated considerable comment, most of it about commitments related to HIV/AIDS.

The basic math of HIV and AIDS is clear. If the number of new cases each year is greater than the number of deaths, the size of the epidemic (the number of people living with HIV/AIDS) increases. On average, a person who contracts the HIVirus becomes ill with AIDS about eight years after becoming infected. Treatment using a mixture of drugs every day will postpone death by, on average, 6-8 years. If the first line drugs used fail, then a second line mixture may again postpone death for an average of five years. To be effective the treatment must be taken every day. Failure to follow the treatment schedule frequently leads to development of a strain of the virus resistant to the drugs. So, putting someone on treatment is, in essence, a commitment provide drugs for 10-15 years. At the same time, for the treatment to succeed, the patient needs to continue to keep taking the drugs, some of which have unpleasant side effects, every day.

At the beginning of the epidemic, and in the absence of effective treatment, initial control efforts concentrated on preventing transmission of the virus. These efforts met with only partial success. With subsequent development of effective drugs, treatment has now been available to an increasing number of people over the last decade. The drugs are expensive. Whilst UNAIDS and WHO provide technical assistance and limited funding for control efforts, much larger amounts are needed to purchase drugs. Since its inception in 2001, the GFATM has been one of the most important sources of funds – ultimately sourced from governments and foundations – for HIV/AIDS programs, especially for treatment. Some bilateral programs have also been an important source of these funds. The basic math is that those on treatment live longer, more people are being treated each year, but the

number of new infections each year is greater than the number of people commencing treatment in the same year. At the same time there has been an unfortunate decrease in the emphasis, energy and innovation applied to prevention. As a result, the number of people living with HIV/AIDS (both treated and untreated) has increased and the funds required for treatment programs have skyrocketed. Adherence to the treatment regimen after two years is quite low, increasing the chances of the appearance of strains of the virus resistant to at least some of the drugs in the treatment combination and creating the need for more expensive second line drugs. At the same time, inadequate effort is being placed on prevention and there is little real connection between prevention and treatment programs. Despite having many donors and three major international agencies dealing with HIV/AIDS – the GFATM, UNAIDS and WHO – the number of people living with HIV/AIDS is increasing.

All governments and funding agencies, most of which rely on public funding sources, eventually have a hard funding constraint and have to choose between various competing claims. Given the global financial crisis and its aftermath, that hard funding constraint has arrived for some programs, including the GFATM. One of the criteria used by governments to decide between the many claims on their resources is performance – has the claimant delivered on its promises when provided with funds in the past? Having been in business for more than a decade, the GFATM is now at the point where it has to address some of these performance questions.

Judged by the most basic of questions, the size of the epidemic – the number of people living with HIV/AIDS – things are not going so well. True, many people infected with HIV are on treatment and the number has increased rapidly in the last five years. But the math gets in the way – the number of new cases (the incidence) is greater than the number commencing treatment. The number of people living with HIV/AIDS has increased despite the large sums of money devoted to HIV/AIDS through the GFATM and bilateral donors as well as the agencies, particularly UNAIDS and WHO. We need to look again at the strategies being used, and particularly at the relative priority being given to prevention as well as treatment.

The current funding problem provides the GFATM, together with UNAIDS and WHO, with an important opportunity to evaluate their strategy, redesign their programs, assess the extent of their cooperation and the procedures used in-country. If we are to avoid the crisis of unlimited commitments to people living with HIV/AIDS it is time to ensure that greater emphasis is given to prevention of transmission and to real coordination between treatment and prevention programs. This will involve thinking differently about treatment, thinking about it in the context of prevention, in the context of programs that are genuinely adapted to the local situation, thinking about control of the epidemic beyond the usual short-term

funding cycle, using at least a 2030 horizon, devoting more resources to evaluation of outcomes, and improved procedures in-country.

The question now is: given constraints to funding, how should developing countries allocate the scarce resources available for HIV programs to control the epidemic in the next 30-40 years? What should be the relative emphasis on prevention versus treatment? What priority should those already on treatment have over others needing treatment? Is the most effective way to do that through international funding to three separate organizations? Is the GFATM the most effective way to disburse the funds or are other organizations better placed to do that?

The GFATM, an organization established as a funding agency, initially placed great emphasis on getting money and then getting it out the door. Purchase of drugs was an easy way to do that. But now, 10 years on, two harsh realities are becoming clear – first, the days of easy money have passed and, as a result donors are now asking for evidence of results and, thereby, for an evaluation of the current strategy. This is a good time for the agencies involved (especially GFATM, UNAIDS and WHO) to re-think their strategy and work out how to coordinate their efforts against the reality of funding constraints. And second, it is a chance for donors to work out their funding strategy for HIV for the next 20-30 years, the period over which sustained and strategic efforts are required if the epidemic is to be brought under control. But let's get the math right first.

Mead Over of the Center for Global Development provides an excellent and more detailed discussion of these issues in 'The Global Aids Transition'; 'Sustaining and Leveraging AIDS Treatment'; and 'Using Incentives to Prevent HIV Transmission'.

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