

False hope or new start?

The Global Fund to Fight HIV/AIDS, TB, and Malaria

14,000 people become HIV positive every day. The Global Fund to Fight HIV/AIDS, TB, and Malaria was set up to tackle the health crisis caused by these three diseases in developing countries. But it requires massive and long-term donor funding, a transparent and equitable system of service delivery, and commitment to comprehensive programmes of prevention, treatment, and care (which include the use of generic medicines) if better health is to become a reality for the millions of women, men, and children already infected and affected by these illnesses.



Summary

Every day, 14,000 people become HIV positive, most of them in developing countries. In the past five years the number of new cases among women has increased by 40 per cent. Because of HIV/AIDS, most countries will miss the 2015 international development target to reduce by two-thirds the rate of infant and child mortality. Most countries will also not achieve the target of reducing by one-quarter HIV infection rates among 15-24 year-olds in the worst-affected countries by 2005, and globally by 2010.

The Global Fund to Fight HIV/AIDS, TB, and Malaria was set up in response to widespread public criticism of governments' apathy to the health crisis in developing countries, especially concerning HIV/AIDS. The health status of poor women, men, and children is deteriorating in many parts of the world, and the Fund is a unique opportunity to mobilise international political will and resources to address this crisis in a new way, rather than continuing with 'business as usual'.

After its first round of grant allocations the Fund is now at a critical juncture. If donors, the UN, and Southern governments continue to show the low levels of commitment demonstrated so far, a vital opportunity will be missed. If the Fund is to achieve its goals, Oxfam believes that the following seven pillars must be put in place.

- 1 An urgent injection of the US\$8bn shortfall for this year, and a yearly commitment of US\$10bn for the next ten years, to fund comprehensive programmes of prevention, treatment, and care. US\$10bn per year is equivalent to 10 days of OECD agricultural subsidies.
- 2 Treatment programmes which use the cheapest, good-quality medicines, including generics. The Fund should issue a clear statement that the proposals it receives can use TRIPS public-health safeguards, reaffirmed in the Doha declaration, to purchase generic medicines.¹ WHO and UNAIDS should provide technical assistance to countries in planning and implementing comprehensive programmes.
- 3 Programmes which are designed and implemented to strengthen existing health systems, in order to ensure effectiveness and sustainable impact.
- 4 Funding which enhances donor co-ordination and is integrated into existing country strategies, such as the EC Programme of Action, Poverty Reduction Strategy Papers, the Africa Initiative, and debt relief.
- 5 A commitment to effective civil-society participation in decision-making at both global and national levels. This includes giving attention to NGO views in the Board and working groups, as well as helping NGOs play an effective role in the Country Co-ordination Mechanism.
- 6 Gender analysis as an integral part of application procedures, programme implementation, monitoring, and evaluation.
- 7 A transparent system of allocation to ensure equitable service delivery.

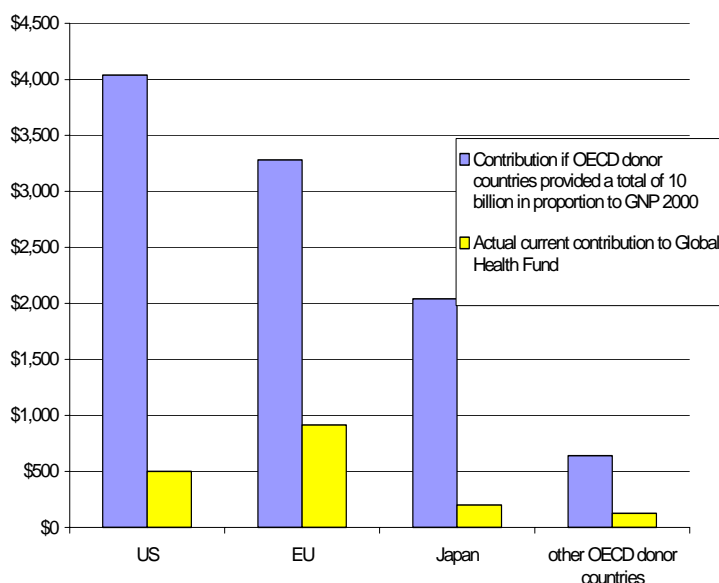
Introduction

Developing countries are facing a health crisis made worse by the enormous impact of HIV/AIDS: 40 million people are now estimated to be HIV positive. The Global Fund to Fight HIV/AIDS, TB, and Malaria represents an unprecedented opportunity for the international community to respond to this crisis. However, it is facing serious challenges regarding its funding and management, and its capacity to mount an effective and efficient response to the three diseases. This paper highlights these issues and makes recommendations which will help to ensure the delivery of equitable health services to poor women, men, and children.

1. Funding

UNAIDS estimates the cost of combating AIDS to be between US\$7bn and US\$10bn per year, including prevention, treatment, and care. Donors have so far pledged a little over US\$2bn to the Global Fund to cover all three diseases. Oxfam has calculated a recommended contribution for each OECD country based on its GNP (see Annex 1). Figure 1 below shows their actual contributions in comparison with the figures in Annex 1.

**Figure 1: Contributions to the Global Fund.
Recommended vs actual contributions**



The Fund's Board approved an allocation of US\$1.6bn for five years – just three per cent of the estimated US\$50bn required to combat

HIV/AIDS alone during that period. The US\$186m allocated in the first year to HIV/AIDS programmes in 26 countries represents just US\$9 per HIV-positive person in those countries per year – hardly enough to buy basic medicines for simple infections.

Developing countries were eager to use the opportunity offered by the Fund to support the delivery of national programmes. The Fund has been overwhelmed by 300 proposals totalling US\$5bn – more than twice the resources that the Fund has managed to find so far.

The low level of donor contributions to the Fund is part of a pattern of decreasing aid for development. In 2001, the total GDP of the 30 OECD countries amounted to approximately US\$25 trillion.² If these countries had met their international obligations in allocating 0.7 per cent of GDP in aid to developing countries, this would have generated approximately US\$171bn (see Annex 2).

Although the UNAIDS figure of US\$10bn for combating AIDS seems like a large sum, it is equivalent to:

- Four days of global military spending
- Ten days of OECD agricultural subsidy
- The cost of 100 Eurofighters

Given the size of its economy, the US contribution is extremely small. The Bush Administration, which had no problem in immediately finding US\$95m to buy one drug (cipro) for the possible threat of anthrax when 18 people were infected, seems to have a great problem donating more than US\$500m to the Fund for three diseases that kill five million every year. A fairer and more generous contribution of US\$4bn per year based on GNP (see Annex 1), would be equivalent to the amount spent in 24 days in the USA on soft drinks, or in 14 days on fast food.

Other industrialised countries, such as Australia, have yet to contribute.

Donor fatigue has become a well-recognised phenomenon, especially in the area of HIV/AIDS: donor funding has actually been decreasing while the epidemic has been increasing. Funding for HIV/AIDS in sub-Saharan Africa in 1998, where 28 million people were then infected, was a miserly \$3-5 per HIV-infected person.³

Three countries (Canada, Germany, and Japan) actually decreased their aid to developing countries between 2000 and 2001. Japan reduced its aid budget by 18 per cent, making total G7 aid spending 3.2 per cent less in 2001 than in 2000. This came at a time when G7 countries also announced their commitment to increasing aid for poverty reduction and the fight against infectious diseases. Reducing

aid to public health adds to the huge constraints on national resources already resulting from cuts in public expenditure due to structural adjustment policies and the heavy burden of debt.

If current funding patterns continue, the Fund has no chance of making any real impact on prevention, treatment, and care for any of the three killer diseases. Moreover, there is no clear indication of the duration of donors' financial commitments.

Recommendation:

- The donor community should allocate immediate resources to the Global Fund, and commit financing for at least the next 10 years, including an immediate and large-scale increase in bilateral aid.

2. Comprehensive programmes

The Fund announced that of the 28 countries receiving grants for HIV/AIDS programmes in the first year, 21 included funding for the purchase of anti-retrovirals (ARVs). However, according to the NGO representatives on the Fund's Board,⁴ only seven proposals specifically mentioned ARVs for adults—an estimated 40,000 people, beyond programmes for the prevention of mother-to-child transmission. And yet treatment for adult women and men is a crucial part of a country's response to the epidemic.

Given the scarce resources available for these programmes, and the inherent difficulties in using combination therapy, generic drugs offer huge advantages to developing countries. First, by producing a variety of fixed-dose combinations of appropriate drugs produced by multiple-originator pharmaceutical companies, the number of pills is reduced, thus helping with compliance. For example, generic Triomune produced by Cipla from India contains a combination of lamivudine developed by GSK, stavudine developed by Bristol-Myers Squibb, and niverapine developed by Boehringer Ingelheim.

Second, generic competition has proved to be the most effective way of cutting prices. Prices of ARVs fell significantly after generic equivalents entered the market. Bulk purchasing for regions or multiple countries, with open bidding including generics, could drive prices down even further.

Currently, originator pharmaceutical companies offer cut-price ARVs in an ad hoc way. Prices are sometimes still high, but are offered to certain countries at a discount, with no guarantee of sustainability. A more efficient system would segment the world market into developed and developing countries. All essential new medicines would be sold to developing countries at production-cost price, in a

systematic tiered-pricing arrangement, and without the limitations of special deals. Pharmaceutical companies already recover the cost of research and development (R&D) and make their profits in developed-country markets, particularly on 'blockbuster' drugs. The Fund is formally committed to making 'quality drugs and products available at the lowest possible prices.'⁵ This should include generics.

Nigeria is operating an HIV/AIDS programme aimed at Prevention of Mother to Child Transmission (PMTCT) and providing ARV treatment. The Fund allocated US\$5.8m to extend ARV treatment in the first year, and a further US\$41.8m over five years. If Nigeria continues with its planned programme using generic triple therapy, it could provide medicines for 16,000 patients in the first year, and more than 116,000 over five years.⁶ By contrast, the numbers treated with double-combination therapy (considered ineffective because of the potential for developing resistance) from brand-name companies would be only 5,800 and 41,800 respectively. The use of generic supplies, especially if purchased in bulk, could triple the number of patients offered treatment.

The Doha declaration gave the green light for countries to use the TRIPS safeguards in a manner that ensures that they can respond appropriately to public-health problems, such as treating HIV, TB, and malaria. The declaration reaffirmed that where there are patents on ARVs or other medicines, governments can override them and purchase cheaper generic versions. It also recognised that countries such as India should not be prevented by WTO patent rules from exporting these generic versions to developing countries which do not have their own manufacturing capacity.

Additionally, the WHO has approved 19 ARVs to be included in the Essential Medicine List, and issued guidelines for their use in poor settings. The WHO pre-qualification schemes have also reaffirmed confidence in the quality of generic production of ARVs. With these major developments, the road is paved for the Fund to finance expanded treatment programmes using generic medicines. However, according to an NGO representative on the Fund's Board,⁷ countries were 'shy' about requesting ARVs. It seems that developing countries are unsure about the Fund's long-term commitment to treatment programmes, and about donor acceptance of financing ARVs, particularly from generic suppliers.

In addition to ARVs, HIV/AIDS programmes should include treatment for other diseases related to the infection, including opportunistic infections, TB, and sexually transmitted diseases, as well as palliative care. Prevention and care must be supported using evidence-based interventions linked to treatment. Prevention programmes must also recognise and address the way in which gender inequality fuels the HIV epidemic, and the burden of care which falls on women and children, especially girls.

Recommendations:

- The Global Fund should issue a clear statement in support of developing countries benefiting from the Doha declaration by using generic medicines for treatment programmes, irrespective of the patent status of the medicines.
- Developing-country governments should make proposals which include the use of generic medicines as part of comprehensive programmes of prevention, treatment, and care in the next round of grant applications to the Fund.
- The EU, USA, and pharmaceutical companies should adopt a systematic tiered-pricing system for essential medicines for developing countries.
- The WHO and UNAIDS should provide technical support for the planning and implementation of comprehensive programmes which include treatment using ARVs and other essential medicines.

3. Strengthening health systems

Health systems in developing countries have been deteriorating for a long time, and are under more strain because of HIV/AIDS. Programmes to address HIV/AIDS cannot ignore the need to support and improve basic health services in order to provide an effective and efficient response to the epidemic.

While the three diseases addressed by the Fund are a major burden in developing countries, there are other significant health problems it does not address. For example, maternal mortality is still very high in many countries – a reflection of a dysfunctional health service that is failing women.

There is genuine concern that programmes financed by the Fund could run in parallel to existing health systems, diverting scarce human resources, requiring separate financial and other monitoring systems, and thus increasing transaction costs and exacerbating existing problems.

The Fund's potential is also threatened by narrow targets and limited vision. For example, it is unclear what will happen to successful programmes at the end of the two- or five-year funding period. A focus on successful performance could also label other projects as failures, particularly those in the most needy areas, such as those in conflict, or where there is chronic under-funding of health services.

For many African health planners it is clear that providing basic services to combat the three diseases, let alone to tackle other needs, is beyond their means. These countries have suffered cuts in public spending as part of economic and health-sector reform, including the introduction of user fees, which undermine equity. In Abuja in 2001 African leaders made a commitment to spend 15 per cent of GDP in responding to HIV/AIDS and the health crisis. Some countries have already contributed to the Global Fund, but for most African countries there are no clear plans yet for increasing health budgets.

Recommendations:

- Donors should enable the Fund to contribute to long-term health care delivery, rather than focus on narrow targets.
- Donors should ensure that no country with concrete health plans is unable to achieve improvements in people's health because of lack of resources.
- African governments should fulfil their commitments in Abuja by increasing health spending to at least 15 per cent of GDP.

4. Donor co-ordination

The Global Fund began in the context of a plethora of global public-private partnerships, and bilateral and multilateral aid initiatives. The Fund is committed to 'build on, complement and coordinate with existing regional and national programs including Poverty Reduction Strategy Papers (PRSPs)'. Debt relief and PRSPs are two mechanisms which in theory should protect and increase health spending. Aid programmes, including the EC Programme of Action to combat the same three diseases, are ways of enhancing the funding of health services. Theoretically, donor support is given to country health plans through co-ordinated mechanisms, within which the Fund could then make a clear contribution. In practice, however, co-ordination is poor, thus increasing the burden on already stretched staff in health ministries who are dealing with different donor requirements. It is unclear how the Fund can contribute to the co-ordination of these financing mechanisms.

Recommendations:

- Donors should co-ordinate their bilateral and multilateral aid to the health sector.
- The Fund should require that proposals have clear strategies to complement and integrate with other forms of aid, in order to enhance efficiency and effectiveness.

5. Civil-society participation

The Fund is unique in providing a forum for the active participation of NGOs at global level (through the Board) and at country level (through the Country Coordinating Mechanism, or CCM). However, the first round of grant allocations made insufficient use of NGO experience in the global decision-making process, and was characterised by confusion and lack of information for NGOs in the CCM. The Fund is currently re-drafting guidelines for its proposals and other procedures, which should clarify NGOs' contribution to the decision-making process.

Recommendations:

- NGOs should actively contribute to the global decision-making process.
- CCMs should give a stronger voice to NGOs in decision-making, and in programme implementation, monitoring, and evaluation.

6. Enhancing gender equity

Given the particular vulnerability of women and young girls to HIV infection and its impact, gender analysis should be an integral part of the Fund's application procedures, implementation plans, and monitoring and evaluation systems. Post-exposure treatment is particularly important, given the growing problem of sexual violence against women, including rape. Female-controlled methods of prevention and access to information and treatment are important factors in enhancing gender equity.

Recommendation:

- The Fund should make gender analysis one of its approval criteria. It should prioritise programmes with demonstrable gender analysis, including those which focus on decreasing the stigma attached to HIV-positive women, decreasing gender-based violence, and promoting women's (especially young girls') access to information, protection, and treatment.

7. Transparency

Very little information is made available with which to analyse programmes supported by the Fund. For example, the Fund's documents on the results of the first round do not indicate the geographical or population focus of any of the programmes, or information on the scope of interventions. Information on treatment categories, especially those including ARVs, and relationships to existing health services are difficult to deduce. In addition, no information is given about the basis for rejecting 260 proposals.

Recommendation:

- The Fund should make information about the grant applications available, with clear comments on the reasons for their acceptance/rejection.

Conclusion

The Global Fund provides hope for millions of women, men, and children in developing countries who are infected or affected by HIV/AIDS, TB, and malaria. It is also a chance for the international community to mount a coherent, concrete, and massive response to help deliver urgently needed health services.

However, the money allocated by donors is as yet hardly sufficient for a proper response to one disease (HIV/AIDS), let alone malaria and TB. The international community should use the Fund to complement existing bilateral and multilateral aid programmes, in order to finance comprehensive, costed health plans in poor countries over the next 20-30 years.

The WHO, UNAIDS, and other UN agencies should provide political and technical support to developing countries in their preparation of proposals, which include prevention, treatment, and care. Such proposals should use the Fund as a catalyst to make basic health services a reality for millions of people living in poverty. Donor coordination, transparency, and civil-society participation in decision-making are three vital elements in this process.

Gender-sensitive policies, proposals, and programmes are essential to an effective response to the HIV/AIDS epidemic. Access to treatment should also be promoted via the use of generic competition to ensure fixed-dose combination therapy and the lowest possible price for all needed drugs. Patent rights must not stand in the way of vital medicines reaching those who need them.

Notes

¹ The Doha declaration, approved at the WTO ministerial conference in November 2001, re-affirmed that 'the [TRIPS] Agreement should be interpreted and implemented in a manner supportive of the right to protect public health and, in particular, to promote access to medicines for all'.

² <http://www.oecd.org>

³ Attaran and Sachs, 'Defining and Refining International Donors' Support for Combating the AIDS Pandemic', *The Lancet*, 357: 57-61

⁴ Milly Katana, and the report from the delegation of NGOs from developing countries (<http://archives.hst.org.za/bts/msg00190.html>)

⁵ Fund principles: <http://www.globalfund.org>

⁶ Calculation is based on Indian generic average offer of US\$360/patient/year. Double-combination therapy is based on GSK's cut-price offer to Senegal of approximately US\$1000/patient/year.

⁷ Milly Katana, and the report from the delegation of NGOs from developing countries (<http://archives.hst.org.za/bts/msg00190.html>)

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Annex 1

Proposed contributions to the Global Fund, if each OECD country provided its share of the US\$10bn required

Shares calculated by Oxfam as: (Individual country GNP for 2000) / (Total OECD GNP for 2000)*10 billion)

Source of figures on actual contributions to the Fund:

http://www.globalfundatm.org/files/Financial_contributions28050htm

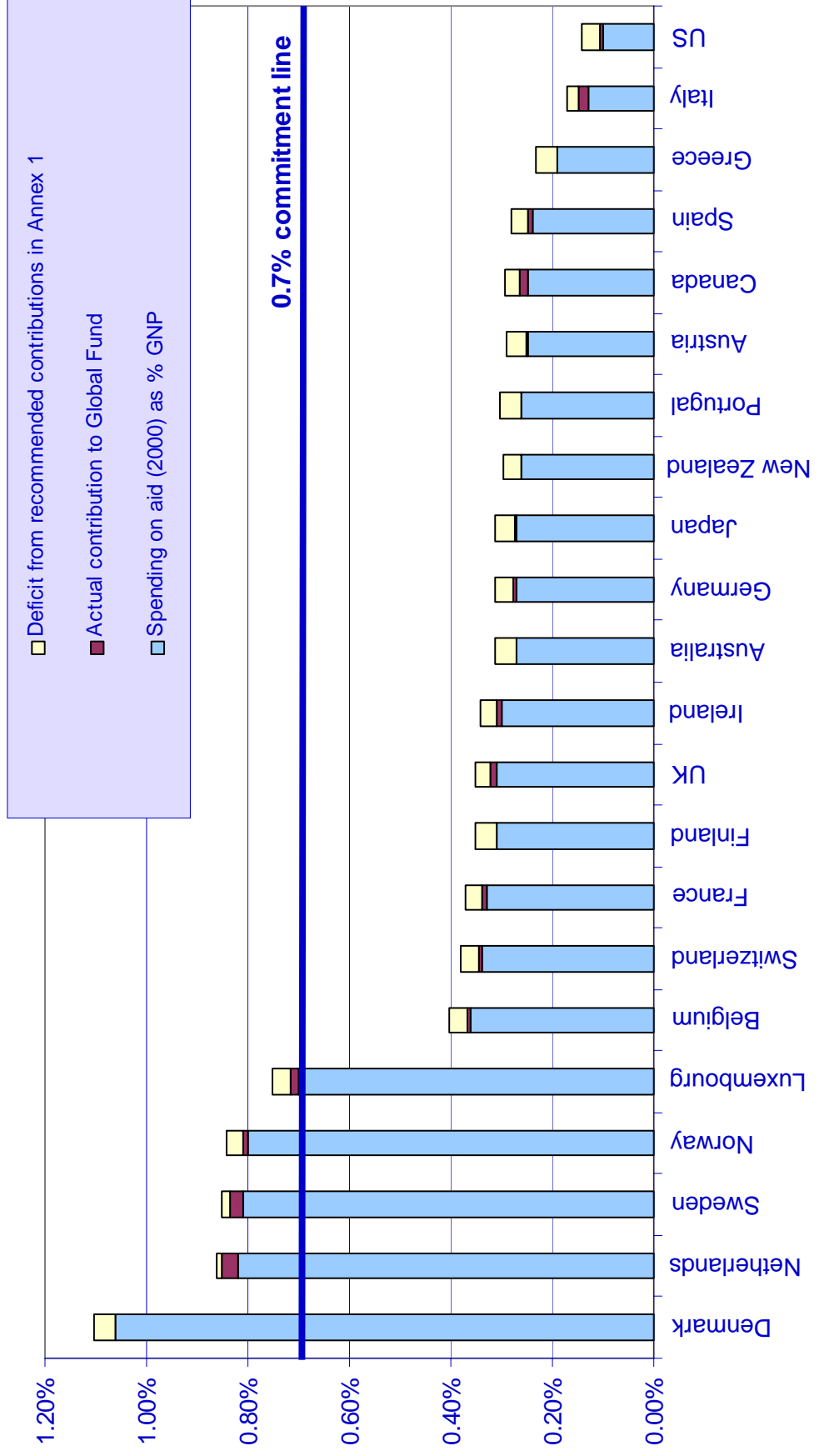
NB European Commission adds US\$ 105m

Country	Proposed contribution to Fund (US\$m)	Actual contribution to Fund (US\$m)	Actual contribution as percentage of proposed contribution
US	\$4,039	\$500	12.4%
Japan	\$2,040	\$200	9.8%
Germany	\$784	\$131	16.7%
UK	\$607	\$200	32.9%
France	\$540	\$131	24.3%
Italy	\$443	\$200	45.2%
Canada	\$291	\$100	34.4%
Spain	\$232	\$50	21.6%
Netherlands	\$160	\$118	73.7%
Australia	\$156	\$0	0.0%
Switzerland	\$110	\$10	9.1%
Belgium	\$97	\$15	15.5%
Sweden	\$93	\$58	62.5%
Austria	\$76	\$1	1.3%
Norway	\$67	\$17	25.2%
Denmark	\$67	\$0	0.0%
Finland	\$51	\$0	0.0%
Greece	\$46	\$0	0.0%
Portugal	\$42	\$0	0.0%
Ireland	\$34	\$9	25.8%
New Zealand	\$17	\$0	0.0%
Luxembourg	\$8	\$3	30.8%
Total	\$10,000	\$1,742	17%

Annex 2 Spending on aid in 2000 as % GNP for selected OECD Donor Countries.

This shows the actual contributions made by countries to the Global Fund, compared with the recommended contributions (see Annex 1). This illustrates the shortfall in financing for the Global Fund. But even if these shortfalls were met, this would in most cases still be well below countries' own commitments to the 0.7 per cent target.

NB *desired fund contribution calculated in proportion to 2000 GNP*



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