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Triumphalism prevails at global AIDS conference in Washington: But are the gains sustainable in this harsh economic climate?

by Ayanda Roji

Triumphalism about “turning the tide” in the fight against HIV and AIDS characterised the 19th International AIDS Conference in Washington DC. In particular, the reduction of new HIV infections in children and the decline in AIDS-related deaths globally has given renewed hope that a cure for AIDS may be possible. The conference was however confronted with the question of the sustainability of the current AIDS programmes given the global economic malaise. In response to this poser, Idasa presented innovative domestic financing strategies, broader approaches to stigma and discrimination to allow for better targeting and the use of the Local AIDS Governance Barometer (LAGB) to assess the quality of AIDS service delivery at the micro level.

It was the first time the global conference has been convened in the United States of America in over 20 years and just two years after the country lifted travel restrictions for people living with HIV. “The world now has the opportunity to end the AIDS epidemic as a result of recent scientific discoveries and advances in the prevention and treatment of HIV”, delegates heard at the opening ceremony of the Conference on 22 July 2012. The international conference is a premier gathering of scientists, activists, academics, politicians, policy makers, celebrities, people living with HIV and other individuals committed to ending the pandemic.

According to a new report by the Joint United Nations Programme on HIV/AIDS (UNAIDS), there were an estimated 330 000 new HIV infections among children globally in 2011 - a 24% reduction since 2009. The report titled, *Together we will end AIDS* shows that among 21 Global Plan priority countries in Sub Saharan Africa, the estimated number of children newly infected with HIV fell by 25%, from 360 000 in 2009 to 270 000 in 2011. This progress has been attributed to the rapid improvement in access to services particularly, prevention of mother-to-child transmission of HIV (PMTCT). A huge increase from 34% to 61% in coverage of PMTCT services was reported in the 21 priority countries between 2009 and 2011. Additionally, the introduction of more effective prophylaxis regimens has been attributed to the decline of HIV transmission rates from mother-to-child since 2010.

Just as the above signs of real progress in hard hit countries started to generate widespread optimism in the history of the AIDS pandemic, the Global fund announced in November 2011 that its next scheduled funding round was cancelled and that no new grants would be accepted until 2014. The cut in donor funding together with the global economic crisis has forced countries to develop home grown strategies to help deal with the AIDS funding crisis. The 2012 UNAIDS report, states that Global spending on HIV is increasing mainly due to a steady rise in domestic investment. Funding totalled about US\$ 16.8 billion in 2011, up by 11% from the 2010 estimate, including stable international funding and increasing domestic spending. International funding however remained flat at 2008 levels (US\$ 8.2 billion). The report states that estimates show that funding from domestic public sources grew by more than 15% between 2010 and 2011, with 41% coming from Sub Saharan Africa. Domestic resources for AIDS in low and middle income countries have increased by more than 50% between 2006 and 2011. As economies in low and middle income countries grow, domestic public investments for AIDS have also grown. Domestic public

spending in Sub Saharan Africa for example, (not including South Africa) increased by 97% over the last five years. South Africa already spends more than 80% from domestic sources and has quadrupled its domestic investments between 2006 and 2011.

Despite the fact that domestic investments in AIDS are increasing, there is still a large shortfall in global funding for HIV particularly in Sub Saharan countries. The new 2012 UNAIDS data shows that African countries such as Zimbabwe, Mozambique, Malawi and the Democratic Republic of Congo are examples of how the shortfall in AIDS funding in the developing world can put the lives of millions of people at risk. For instance, in Malawi about one million people are HIV positive and 350 000 are receiving antiretroviral treatment. The country's total health budget is 90 million US dollars and the total cost of its ARV treatment programme is 60 million US dollars in 2012 alone, so it faces a challenge of sustaining coverage of treatment. Malawi relies on the Global fund to fight the pandemic, TB and malaria.

In Mozambique, a country completely dependent on donor support, 1.4 million people are living with HIV. It is estimated that out of those living with HIV, 615 000 are in need of ARV treatment. However, only 270 000 are receiving treatment. In every 5 children 4 do not get treatment. The country's health budget is only 7.2% of the total State budget. Civil society organisations want to see the government of Mozambique adhering to the Abuja declaration by increasing its contribution for health from the current 7.2% to 15%. In the Democratic Republic of Congo (DRC), Doctors Without Borders (Medicins Sans Frontières) state that donor support is non-existent, with the exception of the Global Fund. "There are one million people living with HIV in DRC, but there is very limited international donor support for access to treatment. 87% of the people are in need of treatment who haven't accessed it yet. Ninety-four percent of pregnant women have not accessed PMTCT – the prevention-of-mother-to-child transmission - programme in DRC. The HIV-free generation is far away in DRC where 2 000 children are born with HIV every month", according to Thierry Dethier, of Medicins Sans Frontières mission in DRC.

For both countries, it is difficult to raise domestic funds for their own AIDS response. The erosion of external aid budgets by the global financial crisis means that countries in Sub Saharan Africa, particularly those affected by AIDS, continue to struggle to place enough people on treatment. Within this context, Idasa's message at the AIDS International Conference in Washington DC was that in order to seize the moment and to build on the progress made considerable reforms by African countries are required. Idasa put at the centre stage Domestic Resource Mobilization (DRM) for AIDS as one important aspect of the reforms. The *"Economic Development in Africa: Reclaiming Policy Space, Domestic Resource Mobilization"* states that if African countries were able to finance a greater share of their development needs from domestic sources, much more flexibility in the formulation and implementation of policies to address development challenges would follow. This makes strategic political visions and commitment critical in stepping up DRM to ensure AIDS programming is sustained from domestic assets. Regional institutions, AIDS Councils and other stakeholders have a responsibility to ensure that the needs of future generation are secured through providing opportunities for orphans and families affected by the pandemic to access education, health and employment as well as to continue to eliminate discrimination and stigma. This requires effective and efficient use of marshaled resources, predictability and requires long-term sustainability of AIDS programmes, which cannot be indefinitely financed through foreign aid.

Idasa convened a satellite meeting on July 24 at the 19th International AIDS Conference in Washington DC. The meeting was attended by, amongst others, NORAD, UNDP, the United States National Intelligence Council, The Presidency of South Africa and its Department of Health, local authorities, American and African Universities, civil society organisations involved in resource tracking and international NGOs. The general thrust of the satellite conference was to first present the outcomes of Idasa's research financed by SIDA/NORAD/SDC and then make comprehensive proposals on financing strategies. The proposed strategies consist of: broader approaches to stigma and discrimination to allow for better targeting and the use of the Local AIDS Governance Barometer (LAGB) to assess the quality of AIDS service delivery at micro level. The presentations resonated well with the participants and will form the basis of future work on capacity building around these issues.

SOURCES

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