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The “3 by 5” Initiative as a Response to the Development Threat of HIV/AIDS

How AIDS hampers development: the human toll¹

The impact of AIDS on the development prospects of poor nations has recently become the subject of intense international research and debate, specially since the release of the conclusions by the WHO Commission on Macroeconomics and Health in 2001. Although the multi-sectoral nature of the effects of HIV/AIDS is widely acknowledged, recent studies have shown that the magnitude of the threat posed by the epidemic has been largely underestimated². Most studies of the macroeconomic costs of AIDS, as measured by reduced GDP growth rates, do not pay enough attention to the way in which human knowledge and potential are created and can be lost. This is one of the key channels influencing long-term growth. In Africa, for example, where the epidemic has hit the hardest to date, existing estimates range between a modest decline of 0.3 and 1.5 per cent in GDP growth annually. The costs are likely, however, to be much higher.

AIDS selectively destroys human capital, that is, peoples' accumulated life experiences, their human and job skills, and their knowledge and insights built up over a period of years. It affects primarily young adults. As these infected adults become progressively sick and weak, they steadily lose their ability to work. Eventually, the disease kills them in their prime, thereby destroying the human capital built up in them over the years through child-rearing, formal education, and learning on the job.

AIDS weakens or even wrecks the mechanisms that generate human capital formation. It also breaks the institutions that support a country's governance and capacity to provide services to the poor, including the health system. In family homes, the quality of child-rearing depends heavily on the parents' human capital. If one or, worse, both parents die while their children are still young, the transmission of knowledge and potential productive capacity across the two generations will be weakened. When the primary breadwinner becomes ill with AIDS, household income falters, causing hardship and the need for child labor.

The chance that the children themselves will contract the disease in adulthood makes investment in their education less attractive, even when both parents themselves remain uninfected. With too little education and knowledge gathered from their parents, the children of AIDS victims later become adults who themselves are less able to raise their own children and to invest in their education. The process is insidious, since the

¹ This paper does not purport to provide the detailed strategy behind the “3 by 5” initiative, neither the complete rationale behind ARV treatment scale up in general. For more information please refer to the WHO “3 by 5” Strategy document.

² *The Long-run Economic Costs of AIDS: Theory and Application to South Africa*, World Bank, Washington, August 2003.

effects are felt only over the long-run, as the poor education of children today translates into low adult productivity a generation later, and so on.

The interplay of these factors sharply reduces economic growth, even to the point of economic collapse. As the 2002 UNAIDS Epidemiological Update rightly summarizes the problem, by killing millions of people, AIDS drains the human and institutional capacities that drive sustainable development. This, in turn, distorts labor markets, disrupts production and consumption, erodes productive and public sectors and ultimately diminishes national wealth. As HIV prevalence rises, poverty deepens, and in combination with other setbacks, AIDS can trigger social crises. Some of the countries worst affected by AIDS face the prospect of ‘un-developing’ – seeing their development achievements dissolve in the wake of the epidemic. It is impossible, hence, to fight against the negative impact of AIDS without protecting a society’s greatest asset – its people.

Restoring health is restoring the bridge to development

Antiretroviral treatment has the capacity to break this vicious cycle, for it can restore the health of millions of people that are now (or will eventually be) unable to work, earn an income, raise their children and contribute to their societies due to AIDS. In the majority of OECD countries, where antiretrovirals have been available for a long time, mortality and morbidity rates have dropped dramatically, and millions of hospitalisations have been avoided. In developing countries, research indicates that similar results can be attained and sustained. In Brazil, which is the only developing country to have implemented a large-scale ARV treatment program, the average survival time before availability of combined therapy was less than 6 months and now is close to 5 years. This 10-fold increase is not only quantitatively important: quality of life has also improved significantly. Patients go on working normally, sustaining their families and interacting with their friends, which in the long run represents the most powerful weapon against the very foundations of stigma and discrimination. Good health, however, is not only an end in itself; it is a necessary condition for development.

Although a major shift in thinking regarding the role of health in poverty reduction and development is occurring, and health is increasingly viewed as far more central to poverty reduction than previously thought, very few strategies have taken into account explicitly and unambiguously the powerful anti-cyclical effect that antiretroviral treatment has on the negative impact of AIDS. In the past, exorbitant prices, concerns about adherence to regimens as well as a plain lack of interest from international donors prevented the launch of a major effort to increase the availability of antiretroviral drugs in developing countries. Safe and effective ARVs are now provided at a cost per capita of less than US\$ 1 a day. Studies have proved that adherence rates in poor countries can be even greater than those in developed nations. Donors have been mobilized and a Global Fund to fight AIDS, TB and Malaria has been established to strengthen the global response to these diseases. “3 by 5” seeks to complement and fill out the remaining technical gaps and to strengthen health systems in order to ensure sustainable and equitable ARV access.

Mainstreaming antiretroviral treatment in development frameworks

HIV/AIDS is directly threatening the achievement of the eight Millennium Development Goals set by the international community in September 2000. In addition to the specific goal of combating HIV/AIDS, the pandemic puts at risk the goals of eradicating poverty, achieving universal primary education, promoting gender equality, reducing child mortality, improving maternal health, ensuring environmental sustainability and creating a global partnership for development.

Reversing this trend will require the incorporation of antiretroviral treatment scale up plans into national HIV/AIDS strategic plans and broader health sector strategies. To this end, reforming and rebuilding the fractured health systems that exist throughout the developing world will be key, especially to dramatically increase implementation capacity, and ARV scale up plans must take such needs into account. Such a policy shift must continue to be country-led and owned, with partners such as WHO taking on a technical advisory role.

There are, however, important financial and budgetary implications that need to be addressed within broader policy frameworks while developing ARV scale up plans. Poverty reduction strategies, including Poverty Reduction Strategy Papers (PRSPs) – used by countries wishing to access concessional loans from the World Bank or the IMF, or wishing to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) Initiative – are becoming the overarching national planning instrument in many countries. They provide an important opportunity for placing AIDS at the centre of national development planning and budget allocation processes—to facilitate the creation of an enabling policy and resource environment for a comprehensive, multi-sectoral and scaled-up response. To live up to their intended objectives, however, they must be adapted swiftly to reflect this change in the national HIV/AIDS strategic plan.

This may be relatively uncomplicated to do from a programmatic point of view, especially as ARV is increasingly recognized as an area of priority spending, but things become less clear when the amounts involved are usually in the range of the dozens or even hundreds of millions of dollars per year. The question, then, becomes one of budget re-allocation in the context of Medium Term Expenditure Frameworks, where policies and their expected costs are matched with a medium-term (generally 3-year) estimate of the aggregate resources available for public expenditure. Hence, to incorporate ARV scale up into MTEFs, national governments must either re-prioritize within the resource envelope set out originally in the MTEF or considerably revise upwards the targets for health expenditure.

Although a combination of both options is possible, “3 by 5” does not seek to displace public expenditure from other priority areas. From a practical perspective, it can unsettle the delicate balance of concessions reached among line ministries throughout the budget allocation process, giving rise to potential opposition from other government agencies and to bitter inter-bureaucratic power struggles. Moreover, such a process, due to various managerial and legal complexities, might take several months to complete, dramatically compromising the effectiveness and impact of increased public expenditure to the achievement of rapid scale up. However, and most importantly, “3 by 5” needs to mobilize *additional* resources if the response is supposed to live up to the challenge posed by widespread AIDS-related death. Funds that are currently available are simply

not enough to finance an enterprise of such scale. Targets for health expenditures must be revised upwards.

Additional funds can be mobilized through several means, which do need to be detrimental to sound macroeconomic policies. Financial resources from the Global Fund to fight AIDS, TB and Malaria, as well as from the World Bank Multi-country AIDS Program (MAP), both of which are already available, should be accessed and utilized to the fullest extent. The Fund has successfully mobilized almost US\$ 5 billion in two years, and MAP represents a commitment of 15 to 20 years on the part of the Bank.³ Debt restructuring for least-developed countries through and beyond HIPC-II should also be pursued as a possible channel for significant resource mobilization.

For countries that operate under sector-wide approaches (SWAs), moving towards ARV scale up is a policy decision that might have to be done jointly with donors, especially if donor assistance is provided primarily through sector/general budget support. Thus, policy coherence between donor governments and recipient countries becomes paramount to harmonize and align national and international efforts on a country by country basis. Donors have to be unequivocal, thus, about their commitment to treatment scale up and strongly support it. If this is possible, national antiretroviral treatment programs can be fully costed, included within MTEFs and reflected in national budgets. Otherwise, countries might have to resort to alternative mechanisms to implement their treatment policies, including project funding. Additionally, countries might well consider adopting 'ring fences' in the initial years of operation to ensure that the budget process does not jeopardise the long-term financial commitment implied in the delivery of antiretrovirals, as well as to protect it from in-year reallocations.

Research indicates that although a growing number of PRSPs identify HIV/AIDS as a "key disease" to be targeted in their health sector strategies, ARV treatment is generally absent from PRSPs and the links between the indicators proposed to measure progress against the Millennium Development Goals is not consistent⁴. It is possible to

³ There are concerns over the potential damaging impact of additionality on macroeconomic stability. According to this view, large inflows of foreign exchange may cause an appreciation of the currency in the recipient country, damaging exports. Further, composition of expenditure can have a considerable effect on the on the exchange rate. However, if a high proportion of additional financing is used to purchase imports (such as ARVs), the effects on exchange rate appreciation may be less pronounced. Nevertheless, such concerns should not be overemphasized. The Global Fund has itself discussed the issue for the past two years, and the latest policy brief discussed, presented to the Portfolio Management and Supply Chain Committee in May 2003, was non-conclusive.

⁴ Twenty two full PRSPs were reviewed for this study (namely, Albania, Azerbaijan, Bolivia, Burkina Faso, Cambodia, Ethiopia, Gambia, Guinea, Guyana, Honduras, Malawi, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, Senegal, Tajikistan, Tanzania, Uganda, Vietnam, Yemen and Zambia):

- 17 programmed HIV/AIDS into their poverty reduction strategies (one other country mentioned AIDS was an issue, but did not address it in the PRSP).
- only 2 (Guyana and Zambia) specifically referred to ARV treatment. Guinea makes reference to "anti-AIDS medicines", what could be interpreted to include ARVs.
- only Guinea and Zambia include treatment-specific indicators
- only Guyana and Zambia have provided for ARVs in the budgets developed along with their PRSP's.

The conclusion from this exercise is that only Zambia has fully completed the cycle of programming, budgeting and identifying monitoring indicators for antiretroviral treatment.

speculate about the reasons for this, but it highlights the lack of understanding about the positive externalities of antiretroviral treatment. There is evidence, however, to believe that the understanding of ARV positive externalities is beginning to change: for instance, Guyana has made it clear in its PRSP that increased financial allocations will be provided to procure drugs and/or support the manufacture of AIDS drugs in Guyana, sustain public awareness programs on HIV/AIDS and increase access to anti-retroviral and other drugs and services to address HIV/AIDS. It is possible, hence, to adequately program “3 by5” and exponential ARV scale up into poverty-reduction strategies, sector-wide approaches and country national plans.

HIV/AIDS is not strictly speaking a “disease of poverty” since it affects people at all income levels, but evidence from some countries at advanced stages of the epidemic shows that new HIV infections disproportionately affect poor people, unskilled workers and those lacking literacy skills—especially young women in each of these categories. HIV/AIDS directly affect their ability to develop. It functions as a drag on economic growth and perpetuates poverty. Childhood illnesses and maternal morbidity and mortality keep the most vulnerable groups trapped in vicious cycles of deprivation and despair. This does not need to be so, though. Antiretrovirals can change this landscape.