Financing ART in low- and middle-income countries

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UNAIDS
• Close the global resource gap by 2015
  –$6 billion annually, overall target (between $22 billion and $24 billion)

• Programmes must become more cost-effective and evidence-based and deliver better value for money

• Break the upward trajectory of costs through the efficient utilization of resources
  –Simplify treatment regimens and delivery
  –Integrate HIV programmes with the health system

• Support and strengthen existing financial mechanisms
  –including the Global Fund and relevant UN organizations
  –Expand voluntary and innovative financing mechanisms
People receiving antiretroviral therapy versus the 2015 target, low- and middle-income countries, 2003–2011
54% of all people eligible were receiving antiretroviral therapy in low- and middle-income countries in 2011.
Total HIV investments continue to grow

Source: UNAIDS, 2012
Investments have been slower than ART roll-out

AIDS Resources and Treatment scale-up
Africa 2002 – 2011:

- AIDS investment
- Antiretroviral treatment

Source: UNAIDS, WHO 2012
Allocation of HIV spending in LMIC

WHERE DOES THE MONEY GO?

Care and treatment 53%
Prevention 22%

Care and treatment

Other 34%

Prevention

1% Male circumcision
6% Community mobilization
7% Condom programmes
8% Prevention programmes for populations at higher risk
14% Prevention of mother-to-child transmission
15% Voluntary counselling and testing
15% Communication for social and behavioural change
2% Nutritional support
3% Provider initiated testing and counselling
4% Psychological treatment and support
5% Laboratory monitoring
12% Home-based and palliative care

Care and treatment

12% Opportunistic infections and palliative care
67% Antiretroviral drugs

Prices of first-line and second-line antiretroviral regimens for adults in low-income countries, 2008–2011

**FIRST-LINE REGIMENS**

- EFV+FTC+TDF [600 mg + 200 mg + 300 mg]
- [FTC+TDF]+NVP [200 mg + 300 mg] + 200 mg
- EFV+[3TC+ZDV] 600 mg + [150 mg + 300 mg]
- 3TC+NVP+ZDV [150 mg + 200 mg + 300 mg]
- [3TC+NVP+d4T] [150 mg + 200 mg + 30 mg]

**SECOND-LINE REGIMENS**

- ABC+ddI+[LPV/r] 300 mg + 400 mg + [200 mg + 50 mg]
- ZDV+ddI+[LPV/r] 300 mg + 400 mg + [200 mg + 50 mg]
- [FTC+TDF]+[LPV/r] [200 mg + 300 mg] + [200 mg + 50 mg]
- [3TC+ZDV]+[LPV/r] [150 mg + 300 mg] + [200 mg + 50 mg]
- [3TC+TDF]+[LPV/r] [300 mg + 300 mg] + [200 mg + 50 mg]

EFV: efavirenz; FTC: emtricitabine; TDF: tenofovir disoproxil fumarate; NVP: nevirapine; 3TC: lamivudine; ZDV: zidovudine; d4T: stavudine; ABC: abacavir; ddI: didanosine; LPV/r: lopinavir with a ritonavir boost.

ARV prices Ukraine 2004 vs 2009

- Zidovudine (AZT)
- Lamivudine (3TC)
- Zidovudine (AZT) plus Lamivudine (3TC)
- Stavudine (d4T)
- Evafirenz (EFV)
- Nevirapine (NNRTI), tabs
- Nelvinavir
Reduction in the annual cost of facility-level antiretroviral therapy, per person year, selected countries, 2006 to 2010–2011

*PEPFAR is the United States President’s Emergency Plan for AIDS Relief. CHAI is the Clinton Health Access Initiative.

Facility-level and total treatment costs per person per year in Zambia, 2009


Note: Total treatment costs include facility-level costs, finance and accounting, Human Resources management, procurement, quality assurance, inventory and supply control, data analysis, insurance, IT and telecommunication, laboratory support and community liaison.
Share of care and treatment expenditure originating from international assistance, last year reported

Source: Global AIDS Response Progress Reporting country reports (most recent available).
Percentage of HIV treatment from international sources in Africa

Percentage of care and treatment expenditure from international sources

Democratic Republic of the Congo
Rwanda
Central African Republic
Niger
Eritrea
Malawi
Guinea-Bissau
Mozambique
Guinea
Mali
Côte d’Ivoire
Nigeria
Sierra Leone
Burkina Faso
Kenya
Togo
Ghana
Burundi
Uganda
Cameroon
Swaziland
Senegal
Benin
Gabon
Chad
Angola
Morocco
Lesotho
Botswana
Congo
Egypt
Seychelles
Algeria

0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

UNAIDS
Source of ART funding by type of epidemic

Antiretroviral therapy funding sources per Epi status - GR 2012, 79 LMIC last year reported (2009-2011)

Concentrated & Low n: 54

Generalized n: 21
Source of ART financing by income level

Antiretroviral therapy funding sources by income level - GR 2012, 79 LMIC last year reported (2009-2011)
UNAIDS advocacy for increased HIV financing

- Documentation and analysis of trends, including domestic increases
- Dialogue with Ministries of Finance
- AU roadmap
- GA event in July, with several pledges
- Exploration of new and innovative financing sources
- Meeting on sustainable financing later this week
Domestic spending for AIDS increased national ownership, reduced dependency

% increase in domestic investments for national AIDS response between 2006 and 2011 in low- and middle-income countries.
# Potential alternative sources of funding – from country studies

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Investment needed for treatment, care and support (all LMIC)

Conclusions

• **Past**
  – Demand for ART and ARVs steadily increasing
  – HLM treatment and funding targets largely on track

• **Markets and demand**
  – Increasing funding base, potential further efficiency gains, affordable treatments
  – Investment against agreed priorities, at low cost and with good results tends to be attractive

• **Leadership**
  – WHO/UNAIDS making the case to invest in ART, setting global targets, advocacy, clinical guidelines and technical support
HIV investment is increasing and diversifying

Global spending on HIV is increasing, up 11% in 2011 over 2010 at US$ 16.8 billion. International assistance is essential, but some donor countries are reducing their funding. It is, however, diversifying.

Global spending on HIV is increasing. It reached about US$ 114 billion in 2011, up 11% from the 2010 estimate, including stable international funding and increasing domestic spending. Coming after a two-year period in which international assistance stagnated and then declined in 2010, the new data indicate that global funding for HIV has not yet peaked.

More countries are providing assistance, including in key contributions and knowledge transfer. Brazil, the Russian Federation, India, China, and South Africa. Domestic public spending continues to increase, with some low- and middle-income countries now funding more than 50% of their national HIV/AIDS programmes. Progress has also been made at the international level with US$ 3 billion committed at the 2011 International AIDS Conference. Increasing national commitment and ownership, however, 195 programmes in low-income countries still rely on external aid to a much greater extent than the health sector overall. To reach internationally agreed targets, donor and middle-income countries need to do more.

New 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 in low- and middle-income countries now exceed more than 50% of the global estimate.

HIV funding from the international community has been largely stable between 2006 and 2011, led by the United States of America and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Together they accounted for more than 40% of all funding in 2011. Other bilateral donors, including countries outside the Organisation for Economic Co-operation and Development (OECD), provided about 20% of funding, while the philanthropic sector provided about 8% and development banks and development actors another 8%.

This funding has, in effect, stabilised during the past four years.

Towards an improved investment approach for an effective response to HIV/AIDS

Bernhard Schwartlander, John Steele, Timothy Killeen, Rija Alus, Carlos Araya, Eleanor Gouws, Michael Bertozzi, Pete O’Hara, Maya in Opiuo, David Beilken, Basri Musa, Ken Ballinger, Marcelo Vieceli, Geoffrey Kempe, Charles Kalule, Ken Legoe, Vignon Pillay, Anderson Eduardo Stormont, Craig McCreary, Geoffry Hiru, Rehemen, Monique Lesage, Nancy Parker, on behalf of the Investment Framework Study Group

Substantial changes are needed to achieve a more targeted and strategic approach to investment in the response to the HIV/AIDS epidemic that will yield long-term dividends. Until now, advocacy for resources has been done on the basis of a commodity approach that encouraged scalping of numerous strategies in parallel, irrespective of their relative effects. We propose a strategic investment framework that is intended to support better management of national and international HIV/AIDS responses than exists with the present system. Our framework incorporates major efficiency gains through community mobilisation, synergies between programme elements, and benefits of the extension of antiretroviral therapy for prevention of HIV transmission. It proposes three categories of investment, consisting of six basic programme activities, interventions that cause an enabling environment to achieve maximum effect across, and programmematic efforts in other health and development sectors related to HIV/AIDS. The yearly cost of achievement of universal access to HIV prevention, treatment, care, and support by 2015 is estimated at not less than US$ 22 billion. Implementation of the new investment framework would avert 12.1 million new HIV infections and 7.4 million deaths from AIDS between 2013 and 2020 compared with continuation of present approaches, and result in 29.4 million life-years gained. The framework is cost effective at $1060 per life-year gained, and the additional
Thank you for your attention