The ‘Risky Middle’: HIV spending, economics and perceptions

AIDS was first recognized in 1981. In 1983 the causal virus was identified. Initially the main concern of the health sector was with ‘high risk’ groups in the west: hemophiliacs, drug users and gay men. It soon became apparent that the disease had the potential to spread further, but by 2000 it was recognized it was not going to be a threat to the majority of people in these areas, and indeed transmission could be prevented. In most of the developed world the incidence of new cases is stable or falling, the exception being Eastern Europe. At the International AIDS Conference in Amsterdam from 23 to 27th July 2018, the issue of pre-exposure prophylaxis or PrEP, where selected populations take drugs to prevent infection preemptively, was extensively discussed.

The situation in some developing countries is different. In much of the world the epidemic is concentrated in key populations: primarily sex workers, gay men, and intravenous drug users so numbers are relatively small. Here the response depends on the internal political will, and external support. In some developing countries, where the epidemic is generalized, much higher levels of resources are needed.

There is a growing trend, seen clearly at the conference, for international donors to reduce their financial commitments to other nations’ epidemics. The participants were told that more than half the major donor governments decreased their HIV commitments in 2017, and there are no significant new pledges in the pipeline.

What does this mean for the response? It must be looked at in the context of the AIDS epidemic’s history. It took time for the importance of AIDS to be recognized globally. The Global Programme for AIDS of the World Health Organisation (WHO) was founded in 1986. Unfortunately, its operations were riven with discord and were ineffective. Hiroshi Nakajima, Director General from 1988 to 1998, did not recognize the threat AIDS posed. Despite this, in 1994, the United Nations (UN) finally acknowledged ‘the magnitude

and impact [of HIV/AIDS were] greatest in developing countries.'

In order to avoid the WHO opposition, in 1996 UNAIDS was established under Peter Piot. This Geneva-based organization had the mandate to coordinate the UN agencies' response and to mobilize the global response. By 2000, significant funds were being made available by donors for global health, and specifically for HIV and AIDS.

The main avenues were the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), set up in 2002 in Geneva, and the President's Emergency Plan for AIDS Relief (PEPFAR). GF funding was initially allocated for applications made in 'rounds' and evaluated by independent panels. In 2014, the allocation method changed and focused on countries with the highest burden and least ability to pay. In 2003, President George W. Bush established PEPFAR as a US$15-billion, five-year plan to combat AIDS, primarily in countries with a high burden of infections. This has been renewed year on year, and in 2016 alone $6.8 billion was enacted for HIV and TB.

As funding for the response in the developing world came from donors it gave rise to dependency. Princeton Lyman, a former US ambassador in South Africa, and co-author Stephen Wittels wrote a puissant article in the prestigious journal Foreign Affairs, looking in particular at PEPFAR. The title was "No Good Deed Goes Unpunished: The Unintended Consequences of Washington's HIV/AIDS Program". The US is locked into providing assistance to keep people alive.

In 2018 there is a need to adapt to new realities. The US has remained stalwart in support as is shown on Table 1. It has consistently been the largest donor to both global health and HIV and AIDS. Will this continue? The sense is that while support will be maintained, the priority countries will change, as might the type of assistance.

Table 1: Global health financing, the US and the AIDS epidemic

Global health financing 1990			Global health financing 2000			Global health financing 2010		
Total	Of which US (Absolute and %)	Of which aids (Absolute and %)	Total	Of which US (Absolute and %)	Of which aids (Absolute and %)	Total	Of which US (Absolute and %)	Of whic aids (Absolu and %)
$7.1b	$2b 27.87%	$310 4.41%	$11.4	$2.7b 24.02%	$11.3b 11.23%	$33.7b	$11.6 34.4%	$10.4b 30.86

Source: https://vizhub.healthdata.org/fgh/

We face three distinct scenarios for countries with significant epidemics, defined for the purpose of this article, as HIV prevalence higher than 3% in general populations. First are upper-middle income countries which received support from donors – government or NGO, especially for key populations. They are unlikely to continue to get this as they graduate from development assistance. They have the resources to respond to the epidemic. What may be lacking is the political will, but many would argue that this is about domestic politics. At the other end of the spectrum are the low-income countries which simply do not have the domestic resources to spend the sums needed to mount an effective response. While there is a need for a more significant domestic response, international support will remain vital and it may be that the Global Fund is the best mechanism for this as it is a multilateral organization with the ability to allocate on the basis of need.

The middle-income countries – whether lower- or upper-middle income – are where the main uncertainty lies. They have the greater part of their response funded from international sources. However, many of these nations are experiencing economic growth and this will move them 'up' the categories of country.

(Table 2 shows the categorizations of high-burden HIV countries according to three academics and the World Bank.) These are what I define as the “Risky Middle”.

Table 2: The ‘Risky Middle’

(Remme et al. 2016)	(Atun et al. 2016)	(Resch et al. 2015)	World Bank 2018
Low Income			Low Income
Ethiopia			Ethiopia
Malawi			Malawi
Mozambique		Low Income	Mozambique
Uganda		Ethiopia	Uganda
Tanzania		Kenya	Tanzania
ZimbabweLower-Middle	Low Income	Mozambique	Zimbabwe
Income	Kenya	Rwanda	Rwanda
Kenya	Zimbabwe	Tanzania	Central African Rep
Lesotho	Tanzania	UgandaLower Middle Income	BurundiLower Midd
Nigeria	Uganda	Côte d’Ivoire	Kenya
Swaziland	Ethiopia	Nigeria	Lesotho
Zambia	MalawiMiddle Income	Zambia	Nigeria
	South Africa		Swaziland
Upper-Middle income	Nigeria	Upper Middle Income	Zambia
Botswana	Zambia	Bostwana	Côte d’Ivoire
Namibia		Namibia	
South Africa		South Africa	Upper Middle
			Botswana
			South Africa
			Namibia

This article identifies a problem: economic growth and hence graduation from development assistance. The literature in the field of HIV financing regularly recognises the importance of viewing HIV/AIDS in relation to funding mechanisms, donor support, and government expenditure. What has not been discussed is the response in relation to economic growth.

Effectively this is an issue of political economy and responsibility; growth does not necessarily bring greater equity or more spending on social services. What it does do is create the space for this to happen, and in a world where people with means are expected to take on their responsibilities (nations or individuals), the crucial question is not just how resources will be allocated, but how transparent processes will be. Few countries have been proactive in response to the declines in external donor funding. This is something that must happen, and nowhere is it more urgent than in the Risky Middle.

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