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Securing political and financial support for the global HIV response

A case study of the post-2000 surge in donor funding

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CHATHAM HOUSE

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Summary

— The international community has repeatedly failed to commit the funding necessary to address global health priorities. But the surge in donor funding for the international HIV response since 2000 has been a rare exception. This case study seeks to analyse and draw lessons from the efforts behind that surge, for the benefit of other core global health priorities.

— The political commitment and action for HIV in low- and middle-income countries was a result of determined pursuits through multiple channels, and a framing of the disease as more than simply an issue of public health to ensure that it fit within the global political and economic agendas.

— Success was possible only following widespread recognition of the problem and its impact, strong civil action and international leadership, and alignment with other donor priorities to drive innovative bilateral and multilateral responses.

— A clear 'ask', the right framing of the narrative, and the development of a strategy and instruments that sustained national and international political interest in HIV were all critical to initiating and maintaining the required funding.

— International donors will continue to be called on to fill the financing gap for global health priorities that cannot be addressed through domestic financing alone or without international coordination. But questions remain about the sustainability of the current replenishment model, especially amid the pressures from competing priorities and with HIV having been transformed by scientific advances into a manageable chronic disease.

Background

Despite the pressing need for investment in global health priorities, there are significant challenges in securing the necessary political traction and robust, sustained funding from the international community. In addition, international stakeholders are often not aligned, resulting in inefficiencies. These challenges ultimately hinder progress towards global health goals and improving health outcomes, and the wider gains that come from addressing international health priorities.

As part of a wider programme of work seeking to better understand the political economy factors influencing the financing of core international health priorities and identify considerations for better decision-making, Chatham House has developed case studies of recent efforts to secure international financing for two specific global health priorities – HIV and antimicrobial resistance. This case study examines how, in the years leading to the new millennium and beyond, the global response to the HIV epidemic achieved the political traction necessary to mobilize significant international funding for priority interventions over a sustained period.

Global financing for HIV began to surge in 2000, but this surge followed more than a decade of building political traction.

While the mobilization of domestic financing is critical to HIV prevention, treatment and patient care and support, this case study focuses on the international perspective. Global financing for HIV began to surge in 2000, but this surge followed more than a decade of building political traction. This study aims to explain broadly the health and political factors leading to the surge, particularly from the perspective of donors, and to seek insight into how other global health issues might gain a higher profile and similar political and financial support.

An extensive literature review was conducted to identify the most significant events, personalities and opportunities that led to the initial surge of international political and financial commitment. This review was complemented by interviews with key informants, whose specific knowledge of major turning points in the effort to secure international funding for the HIV response were critical in gaining an understanding of the political context and the decision-making processes involved in placing HIV on the global political agenda.

Introduction

International political commitment and subsequent financing for HIV programmes in low- and middle-income countries have been a result of determined pursuits from multiple channels and the reframing of the narrative around HIV as more than a health condition to a global political, economic – and, to some degree, security – concern.[1] Efforts to finance the HIV response in low- and middle-income countries were the product of a unique era of collaborative thinking and partnerships.

Disease caused by what would soon be recognized as HIV infection was first reported in the US in 1981, among men who have sex with men. At that time, the US had the highest number of people living with HIV among developed nations.[2] There was little public understanding of the disease, and it was not regarded by politicians as a priority. A combination of political denial, fear-mongering and inadequate funding for research impeded the early response.[3] It took strong civic action, pressure from scientific institutions and bipartisan support before steps were finally taken towards recognizing and responding to HIV in the US. While other high-income countries also began reporting cases of HIV, there was an initial delay in official oversight among health ministries until 1986–87.[4]

Civil society, affected communities and charitable foundations played a significant role in defining country responses to the HIV epidemic. One of the salient features of the US national response was the early mobilization of directly affected groups and their allies in shaping the response. Those groups in particular were concerned about the stigma and discrimination surrounding the epidemic, and adopted a human rights-based approach that combined political activism with visible involvement in the decision-making process.[5] Hence, the response to the HIV epidemic went beyond the traditional public health approach to interventions.[6] However, although this approach contained the epidemic and the general public in high-income countries eventually felt less threatened by HIV, money did not immediately flow to low- and middle-income countries to fund a similar approach. Indeed, recognition of the exceptional nature of the HIV epidemic slowly started to lose salience in North America and Europe with the increased availability of medicines.[7]

In the late 1980s, when the HIV epidemic was first acknowledged by political leaders in Africa, international concern and resources to address the epidemic in that continent were slow to develop.[8] The World Health Organization (WHO) estimated that, in 1987, close to 2.5 million people in Africa were living with

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1 Oppenheimer, G. M. and Bayer, R. (2009), 'The Rise and Fall of AIDS Exceptionalism', *AMA Journal of Ethics*, 11(12), pp. 988–92, https://doi.org/10.1001/virtualmentor.2009.11.12.mhst1-0912.
2 Isbell, M., Kates, J. and Michaud, J. (2012), *Responding to AIDS at Home and Abroad: How the U.S. and Other High Income Countries Compare*, Menlo Park, CA: Henry J. Kaiser Family Foundation, https://www.kff.org/wp-content/uploads/2013/01/8336.pdf.
3 Fairchild, A. L. et al. (2018), 'The Two Faces of Fear: A History of Hard-Hitting Public Health Campaigns Against Tobacco and AIDS', *American Journal of Public Health*, 108(9), pp. 1180–86, https://doi.org/10.2105/AJPH.2018.304516.
4 Isbell, Kates and Michaud (2012), *Responding to AIDS at Home and Abroad*.
5 Ibid.
6 Smith, H., J. and Whiteside, A. (2010), 'The History of AIDS Exceptionalism', *Journal of the International AIDS Society*, 13(47), https://doi.org/10.1186/1758-2652-13-47.
7 Ibid.
8 Ibid.

HIV; this figure doubled over the following two years.[9] By the late 1990s, the HIV epidemic was having a visible economic impact across the continent, reducing the average national growth rate of African countries by 2–4 per cent a year.[10] While prevention programmes to tackle the HIV epidemic in Africa were prevalent in the late 1980s to early 1990s, low- and middle-income countries (which included the majority of African countries) received only 6 per cent of the total global spending for HIV prevention programmes in 1990–91.[11] The HIV epidemic in Africa gained significant global recognition only after the establishment of the Joint UN Programme on HIV/AIDS (UNAIDS) in 1994.[12]

Stepping up the global HIV response

Between 1986 and 1997, the World Bank committed nearly $500 million in loans and credits to national programmes worldwide.[13] However, the resource distribution did not adequately match the disease burden, while the funding was disproportionately low considering the growing epidemic.[14] HIV was not a priority for the World Bank; its focus was instead on health sector reform.[15] Together with the low demand from national governments for HIV-focused programmes, this led to a decline in funding during this period.[16] In 2000, due to high institutional mobilization and prioritization of HIV, the World Bank launched the Multi-Country AIDS Program in Africa to mitigate the effects of HIV, with a commitment of more than $1.2 billion.[17] However, that amount was far lower than the estimated $7–10 billion required for addressing the HIV epidemic in low- and middle-income countries.[18]

In 1987, WHO established the Special Programme on AIDS – subsequently known as the Global Programme on AIDS (GPA) – to coordinate research and country responses to HIV.[19] The programme's Global AIDS Strategy adopted a rights-based approach. However, the GPA was widely judged to be inadequate, lacking in the necessary capacity and funding.

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9 Eckholm, E. and Tierney, J. (1990), 'AIDS in Africa: A Killer Rages On', *New York Times*, 16 September 1990, https://www.nytimes.com/1990/09/16/world/aids-in-africa-a-killer-rages-on.html.
10 Dixon, S., McDonald, S. and Roberts, J. (2002), 'The Impact of HIV and AIDS on Africa's Economic Development', *BMJ: British Medical Journal*, 324(7331), pp. 232–34, https://doi.org/10.1136%2Fbmj.324.7331.232.
11 Smith and Whiteside (2010), 'The History of AIDS Exceptionalism'.
12 Duarte, A. A. and Hancock, J. W. (2017), 'An Exploration on HIV/AIDS Funding in South Africa', *SAGE Open*, 7.3(2017), https://doi.org/10.1177/2158244017718235.
13 Oomman, N. (2006), *Overview of the World Bank's Response to the HIV/AIDS Epidemic in Africa, with a Focus on the Multi-Country HIV/AIDS Program (MAP)*, report, Washington, DC: Center for Global Development, https://www.cgdev.org/page/overview-world-bank%E2%80%99s-response-hivaids-epidemic-africa-focus-multi-country-hivaids-program-map.
14 Attaran, A. and Sachs, J. (2001), 'Defining and refining international donor support for combating the AIDS pandemic', *The Lancet*, 357(9249), pp. 57–61, https://doi.org/10.1016/S0140-6736(00)03576-5.
15 Avdeeva, O. et al. (2011), 'The Global Fund's resource allocation decisions for HIV programmes: addressing those in need', JIAS *Journal of the International AIDS Society*, 14(1), https://doi.org/10.1186/1758-2652-14-51.
16 Ibid.
17 Ibid.
18 United Nations (2001), 'Declaration of Commitment on HIV/AIDS', General Assembly resolution S-26/2, 27 June 2001, https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-commitment-hivaids.
19 World Health Organization (2018), 'Why the HIV epidemic is not over', https://www.who.int/news-room/spotlight/why-the-hiv-epidemic-is-not-over.

The UN faced organizational challenges that affected its capacity to lead the design and implementation of international development policies.[20] WHO was also under scrutiny by the donor community, and was being urged to reform its internal management and coordination processes. In response to such criticism, the UN Economic and Social Council created UNAIDS.[21] This initiative aimed to strengthen inter-agency collaboration in the UN for a robust multilateral effort towards tackling the HIV epidemic, and to build a global consensus on policy responses to HIV.[22] UNAIDS was one of the earliest initiatives within the UN system to include formal representation of civil society in its governing board – an achievement credited to the leadership of the agency's director, Peter Piot.[23] The agency also had responsibility for coordinating funding for HIV, but not for distributing funds. UNAIDS launched a year after the closure of WHO's GPA, with only $130 million in funding from voluntary contributions. Funding challenges subsequently reduced the opportunity for a scaled-up response to the epidemic.[24]

Building the narrative for funding

Before the HIV epidemic, global health initiatives often made their appeals for international funding on humanitarian grounds. However, the World Bank's 1993 World Development Report (WDR) argued the economic case for investing in global health.[25] Similar arguments were advanced again in 2000 by academics who provided additional evidence for investing in health to achieve economic growth. The idea gradually succeeded in turning around the perspective from 'you have to deal with poverty to address health' to 'you have to deal with health to address poverty' by expounding the evidence case for investment.[26] The introduction in the 1993 WDR of disability-adjusted life years as the metric for measuring the cost of health interventions also enabled political leaders in donor countries to better understand the value of the funding and future outcomes.[27]

In the late 1990s and early 2000s, G8 leaders placed development and fighting poverty at the top of their agenda and acknowledged the role of public health in tackling these issues. The possibility of measuring the economic burden of disease and the benefits of health interventions was useful for leaders, as it allowed them to defend political decisions on foreign aid spending to their electorates. Leaders were now able to demonstrate how the decisions were responsible for effective interventions.[28]

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20 Nay, O. (2009), 'Administrative Reform in International Organizations: The Case of the Joint United Nations Programme on HIV/AIDS', *Questions de recherche*, October 2009, https://dx.doi.org/10.2139/ssrn.2283080.
21 Ibid.
22 Ibid.
23 Das, P. and Samarasekera, U. (2008), 'What next for UNAIDS?', *The Lancet*, 372(9656), pp. 2099–102, https://doi.org/10.1016/S0140-6736(08)61908-X.
24 Ibid.
25 World Bank (1993), *World Development Report 1993: Investing in Health*, Volume 1, New York: Oxford University Press, https://doi.org/10.1596/0-1952-0890-0.
26 Research interview with interviewee 6, 2022.
27 Maciocco, G. and Stefanini, A. (2007), 'From Alma-Ata to the Global Fund: the history of international health policy', *Revista Brasileira de Saúde Materno Infantil*, 7, pp. 479–86, https://doi.org/10.1590/S1519-38292007000400016.
28 Lidén, J. (2013), *The Grand Decade for Global Health: 1998–2008*, Working Group Paper, London: Royal Institute of International Affairs, https://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/0413_who.pdf.

In 1998, the UK hosted the G8 summit in Birmingham, formally placing global health on the G8's agenda, with the discussions focused on malaria. As part of that, the UK argued that health interventions to reduce the impact of malaria could enable poverty reduction and economic development in low- and middle-income countries. Malaria interventions were relatively low-cost and achievable, and their impact was measurable. There was a realization that a significant increase in funds from international donors was also needed for HIV and tuberculosis (TB) – both of which were recognized alongside malaria as diseases of poverty. Funding treatment, which was the basis of most HIV programmes, was beyond the financial resources of many low- and middle-income countries.[29]

Meanwhile, at WHO, after assuming her position as director-general in 1998, Gro Harlem Brundtland conducted a review of the health expenditure in low- and middle-income countries and identified a striking imbalance. Low- and middle-income countries bore 90 per cent of the disease burden but had access only to 10 per cent of the resources used for health.[30] She entered WHO with the fundamental belief that to achieve reductions in poverty, it was necessary to promote good health. Brundtland was instrumental in bringing health onto the development agenda and in weaving economics and politics into the WHO strategy.[31] Brundtland's mission and ideas within WHO were advanced by the efforts of Jeffrey Sachs, a noted economist and Harvard academician, who chaired the WHO's commission on macroeconomics and health between 2000 and 2002. This commission influenced the way global leaders thought about health, introducing new methods for funding and emphasizing the role of health in poverty reduction and economic development.

Low- and middle-income countries bore 90 per cent of the disease burden but had access only to 10 per cent of the resources used for health.

At this point, there was a growing realization of the need for new financing initiatives and partnerships to bring the required resources to the problem. Individual 'champions' from academia, civil society and politics advocated for a separate funding stream for diseases of poverty – namely HIV, TB and malaria – and key donors were keen that the new fund be established outside of WHO and the UN architecture. Malaria was still the focus of global health investment in 2000, as plans for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) were being developed.[32] Malaria and other tropical diseases were reported as causing more deaths than HIV among children. However, this was later acknowledged as being inaccurate, again making HIV the greater

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29 Letvin, N. L., Bloom, B. R. and Hoffman, S. L. (2001), 'Prospects for Vaccines to Protect Against AIDS, Tuberculosis, and Malaria', *JAMA*, 285(5), pp. 606–11, https://doi.org/10.1001/jama.285.5.606.
30 Petersen, P. E. (2003), 'World Health Organization. Organisation Mondiale de La Sante', *Community Dentistry and Oral Epidemiology*, 31(6), pp. 471, https://doi.org/10.1046/j.1600-0528.2003.00124.x.
31 Clift, C. (2013), *The Role of the World Health Organization in the International System,* Working Group Paper, London: Royal Institute of International Affairs, https://www.chathamhouse.org/sites/default/files/publications/research/2013-02-01-role-world-health-organization-international-system-clift.pdf.
32 Research interview with interviewee 6, 2022.

priority.[33] The high cost of HIV treatment meant that attempts to include funding for HIV medicines were met with resistance from some donors.[34] To justify a focus on prevention rather than treatment, opponents of financing access to treatment argued that antiretroviral programmes would not be viable in African countries, due to a limited number of health workers, limited infrastructure and expectations of poor adherence to treatment regimens.[35] Furthermore, there was tension over the funding agenda – i.e. whether the Global Fund would be dedicated solely to HIV or become a broader communicable disease health fund.

In 1999–2000, the economic impact of HIV in African countries was affecting food security and agricultural productivity. UN secretary-general Kofi Annan was approached by several African political leaders with concerns over HIV and its effect on their countries' economies.[36] Having witnessed the realities of the disease, Annan worked tirelessly with Brundtland and Piot in lobbying global leaders for the creation of a global fund.

In January 2000, the UN Security Council (UNSC) debate on the 'Impact of AIDS on peace and security in Africa' was one of the earliest efforts to address a health concern as a security threat.[37] The debate, largely driven by US permanent representative at the UN Richard Holbrooke, ushered in the discussion around HIV – specifically the HIV epidemic in Africa – as an issue of national and international security. HIV was regarded as a threat to the military capabilities of countries and international peacekeeping forces. The number of military personnel in sub-Saharan Africa living with HIV was estimated to be significantly higher than that among the civilian population.[38] However, not all members of the UNSC agreed with the security narrative – China, France and Russia opposed the idea of declaring the HIV epidemic as a threat to international peace and security; but, under US influence, those countries conceded the council's final resolution.[39] Following the debate, the UNSC passed resolution 1308, designating HIV as a security threat to the nations of the world.[40] In 2001, the UN General Assembly special session focused exclusively on HIV, raising the epidemic to a global political priority and resulting in political leaders from 189 countries – including both affected countries and donors – adopting the Declaration of Commitment to achieve time-bound targets to reduce the burden.[41]

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33 Black History Month (2015), 'The History of AIDS in Africa', 25 August 2015, https://www.blackhistorymonth.org.uk/article/section/real-stories/the-history-of-aids-in-africa.
34 Tan, D. H., Upshur, R. E. and Ford, N. (2003), 'Global plagues and the Global Fund: Challenges in the fight against HIV, TB and malaria', *BMC International Health and Human Rights*, 3(2), https://doi.org/10.1186/1472-698X-3-2.
35 Dietrich, J. W. (2007), 'The Politics of PEPFAR: The President's Emergency Plan for AIDS Relief', *Ethics & International Affairs*, 21(3), pp. 277–92, https://doi.org/10.1111/j.1747-7093.2007.00100.x.
36 Research interview with interviewee 6, 2022.
37 United Nations (2000), 'Security Council holds debate on impact of AIDS on peace and security in Africa', press release, 10 January 2000, https://press.un.org/en/2000/20000110.sc6781.doc.html.
38 Estimates for the number of of military personnel living with HIV ranged from between 10 per cent and 60 per cent. See Zelikow, P. (2000), 'Review: *The Global Infectious Disease Threat and Its Implications for the United States*, by The U. S. National Intelligence Council', *Foreign Affairs*, 79(4), p. 154, https://doi.org/10.2307/20049847.
39 McInnes, C. and Rushton, S. (2013), 'HIV/AIDS and securitization theory', *European Journal of International Relations*, 19(1), pp. 115–38, https://doi.org/10.1177/1354066111425258.
40 Garrett, L. (2005), *HIV and National Security: Where are the Links?*, report, New York: Council on Foreign Relations, https://backend-live.cfr.org/sites/default/files/pdf/2005/07/HIV_National_Security.pdf.
41 Sidibe, M., Tanaka, S. and Buse, K. (2011), 'People, Passion and Politics: Looking Back and Moving Forward in the Governance of the AIDS Response', *Global Health Governance*, 4(1), https://files.unaids.org/en/media/unaids/contentassets/documents/document/2010/2010_SidibeTanakaBuse_PeoplePassionPolitics_en.pdf.

Though not a dominant approach, the security narrative was one of the ways UNAIDS sought to build a sense of urgency for a global response to HIV. While UN resolution 1308 discusses the claims linking the HIV epidemic to international security, most of the actionable sections were focused on peacekeeping personnel.[42] In 2005, UNAIDS commissioned an expert team to produce a report providing the evidence base to support the HIV/security narrative. While the report highlighted the potential impact of HIV infection among peacekeepers and military personnel, it criticized the previous high estimates as being the result of recycled secondary literature and of soft opinions. The tone of evidence in this report was instrumental in persuading the UNSC to drop HIV from its security agenda in 2005.[43] However, in 2006, it became apparent that many of the goals in the 2001 declaration had not been met. The UN developed a five-year follow-up plan, the 2006 UN Political Declaration on HIV, to reaffirm HIV as a critical foreign policy issue and to achieve universal access to HIV prevention, care and treatment support by 2010.[44] This declaration was an initial effort to treat health as a foreign policy issue.[45]

While the security narrative was taking hold, global movements such as Jubilee 2000 – so named as it called for the cancellation of developing country debt by the year 2000 – emerged to pressure industrialized countries to fight poverty and push for debt relief of heavily indebted poor countries (HIPCs). These calls to action described HIV as a disease of poverty that could not be addressed while debt inhibited additional spending on health by HIPCs.[46] In September 2000, the UN established the Millennium Development Goals (MDGs): eight international development goals that committed nations to a global partnership to reduce extreme poverty and set time-bound targets for 2015.[47]

By setting specific goals aimed at reducing poverty and halting the spread of HIV, these priorities were effectively placed at the forefront of the international agenda, thereby influencing foreign policy and fostering the development of new international commitments. The MDGs were integrated into development fund policies such as the European Commission's programme, the UK Department for International Development and the Norwegian Agency for Development Cooperation, all of which highlighted their moral duty to address poverty and set HIV as a priority area.[48] The development and human rights dimensions of the HIV narrative thus began to take precedence over the security approach, and were the predominant arguments used to encourage donors to increase their support.[49]

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42 Rushton, S. (2010), 'AIDS and International Security in the United Nations System', *Health Policy and Planning*, 25(6), pp. 495–504, https://doi.org/10.1093/heapol/czq051.
43 Ibid.
44 Ibid.
45 Sidibe, Tanaka and Buse (2011), 'People, Passion and Politics'.
46 Jubilee2000 (2000), 'AIDS and Debt: Africa's Deadly Combination', press release, Global Policy Forum, December 2000, https://archive.globalpolicy.org/socecon/develop/health/2000/001231jb.htm.
47 World Health Organization (2018), 'Millennium Development Goals (MDGs)', fact sheet, 19 February 2018, https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs).
48 Jones, S. P. (2004), 'When 'development' devastates: donor discourses, access to HIV/AIDS treatment in Africa and rethinking the landscape of development', *Third World Quarterly*, 25(2), pp. 385–404, https://doi.org/10.1080/0143659042000174879.
49 Rushton (2010), 'AIDS and International Security in the United Nations System'.

In the late 1990s and early 2000s, the cost of providing HIV combination therapy to people living with HIV still exceeded national health expenditure per head in many countries in sub-Saharan Africa.[50] In 1997, in an effort to address the issue of cost, South Africa had approved the Medicines and Related Substances Control Act. The legislation sought to enable the Ministry of Health to provide affordable medication to people living with HIV.[51] The South African government believed that the act would legally allow it to take advantage of flexibilities in the World Trade Organization's agreement on trade-related aspects of intellectual property rights (TRIPS) to engage in compulsory licensing or import generic drugs at a lower cost if faced with a health crisis. Pharmaceutical companies resisted this view, seeking to protect their patents; the US initially supported that resistance and threatened South Africa with sanctions if it invoked compulsory licences.[52]

Grassroots activism played an essential role in highlighting the drug access inequities in Africa. The proximity of a US presidential election meant a unique opportunity for activists to bring the issues to a larger audience. A coalition of Médecins Sans Frontières (MSF), Act Up, Transatlantic Consumer Dialogue, Health Action International, Consumers International and Consumer Project on Technology achieved a unified campaign in South Africa and the US, protesting against the pressure exerted by the US on the South African government. Strategic measures – such as garnering significant media attention, staging public protests during presidential campaign rallies and linking the US policies to race and poverty – effectively intensified the pressure on the US government to change its aggressive approach and suspend legal action. In September 1999, US president Bill Clinton announced that the US would enforce flexibility in drug patents when countries faced a public health crisis. Furthermore, the US approved local production and import of cheap drugs into Africa, as long as imported drugs had intellectual property rights protection.[53]

Activist groups and public pressure played a key role in emphasizing the moral duty of richer countries to provide further funding to respond to HIV and increase access to treatment in poorer nations.

Activist groups and public pressure played a key role in emphasizing the moral duty of richer countries to provide further funding to respond to HIV and increase access to treatment in poorer nations.[54] UN secretary-general Annan used this argument in his address to the 2001 African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases, by stating that the public no longer tolerated a situation whereby individuals were at higher risk of acquiring and dying from

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50 Hogg, R. S. et al. (1998), 'One World, One Hope: The Cost of Providing Antiretroviral Therapy to All Nations', *AIDS*, 12(16), pp. 2203–09, https://journals.lww.com/aidsonline/Fulltext/1998/16000/One_world,_one_hope__the_cost_of_providing.16.aspx.
51 Halbert, D. (2002), 'Moralized Discourses: South Africa's Intellectual Property Fight for Access to AIDS Drugs', *Seattle Journal for Social Justice*, 1(2), https://digitalcommons.law.seattleu.edu/sjsj/vol1/iss2/2.
52 Ibid.
53 Ibid.
54 Research interview with interviewee 2, 2022.

HIV-related illness because they were poor.[55] The effectiveness of antiretroviral treatment (ART) and its availability in high-income countries led to a shift in HIV activism towards addressing the lack of access to medication in low- and middle-income countries, as well as raising debates on equity and justice.[56] The 2000 International AIDS Conference held in Durban, South Africa, was a significant event that pressured governments by putting HIV treatment on the front page of newspapers, raising public awareness, and issuing a global call for 'treatment for all, now'.[57] The Abuja Declaration in 2001 saw African Union member states committing to allocate 15 per cent of their government budgets to healthcare.[58] Later in 2001, at the WTO ministerial conference in Doha, Qatar, the Doha Declaration was adopted. The declaration gave each country the right to define a national emergency and affirmed that compulsory licensing policies were acceptable under the TRIPS agreement. This outcome represented success for developing countries seeking access to affordable HIV treatment. However, the declaration was limited to compulsory licensing and did not include parallel importation.

Global leaders saw the value of reduced drug pricing if they wanted to fit the economic models of health achievements and sustain funding for the cause. The human rights argument and the need to increase access and reduce the cost of treatment were highly influential in triggering an increase in funding.[59] Costing $10,000 per patient year, HIV treatment was unaffordable in low- and middle-income countries.[60] It took numerous deliberations to achieve a compromise and reduce drug prices; these deliberations included private discussions between Brundtland, Piot and drug manufacturers.[61] Pharmaceutical companies understood the threat of HIV to high-income markets and, following additional pressure from Annan in 2001–02, finally agreed to reduce the prices of antiretroviral therapy (ARVs) – making the economic case for HIV investment more attractive.[62] The industry's issuing of voluntary licences to manufacturers in low- and middle-income countries to produce generic versions of HIV drugs was a major factor in reducing prices. The industry was later engaged in supporting the Medicines Patent Pool (MPP), a mechanism that MSF – an influential civil society actor in the campaign for access to HIV medicines – proposed to the French foreign ministry and UNITAID. (UNITAID was launched in 2006, with leadership from Brazil, Chile, France, Norway and the UK, to promote the health-related MDGs.)[63] UNITAID established the MPP in 2010 as a new international organization to expand affordable and

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55 United Nations (2001), 'Secretary-General proposes global fund for fight against HIV/AIDS and other infectious diseases at African Leaders Summit', address by UN secretary-general Kofi Annan to the African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases, Abuja, Nigeria, 26 April 2001, https://digitallibrary.un.org/record/439109.
56 Parker, R. (2011), 'Grassroots Activism, Civil Society Mobilization, and the Politics of the Global HIV/AIDS Epidemic', *The Brown Journal of World Affairs*, 17(2), pp. 21–37, https://www.jstor.org/stable/24590789.
57 Greene, W. C. (2007), 'A history of AIDS: Looking back to see ahead', *European Journal of Immunology*, 37(1), pp. 94–102, https://doi.org/10.1002/eji.200737441.
58 Gatome-Munyua, A. and Olalere, N. (2020), 'Public financing for health in Africa: 15% of an elephant is not 15% of a chicken', Africa Renewal, 27 October 2020, https://www.un.org/africarenewal/magazine/october-2020/public-financing-health-africa-when-15-elephant-not-15-chicken.
59 Piot, P., Russell, S. and Larson, H. (2007), 'Good Politics, Bad Politics: The Experience of AIDS', *American Journal of Public Health*, 97(11), pp. 1934–36, https://doi.org/10.2105/AJPH.2007.121418.
60 Piot, P., Zewdie, D. and Türmen, T. (2002), 'HIV/AIDS prevention and treatment', *The Lancet*, 360(9326), p. 86 https://doi.org/10.1016/S0140-6736(02)09342-X.
61 Research interview with interviewee 1, 2022.
62 Research interview with interviewee 6, 2022.
63 Lidén (2013), *The Grand Decade for Global Health*.

timely access to HIV medicines through public health-oriented licensing deals with manufacturers of generic medicines. In addition to voluntary licensing, the MPP has substantially increased generic drug supplies for the global HIV response.

Political leadership

In 2000, when the surge in financing for HIV began, there was no strong superpower rivalry, creating a conducive environment for global cooperation. International leaders focused on steady global economic growth and sharing global prosperity by eliminating poverty.[64] Providing funding for global health initiatives such as the HIV response, and working to eliminate diseases of poverty, were key parts of those efforts. The support of several individual political leaders was critical in advancing international funding for HIV during this period.

HIV and other infectious diseases had been high on the agenda of G7/G8 summits prior to the funding surge. For instance, HIV was prioritized at the 1987 G7 summit due to the collective vulnerability that all countries present felt, and their realization of the physical and psychological impact of the disease. In the 1990s, Canada, France, Italy and the US were severely impacted by HIV, as were Japan and Russia later on in the decade.[65] (Russia joined the G7 – thereby expanding it to the G8 – in 1997, before being expelled in 2014.)

In 1997, at an international conference on AIDS held in Abidjan, Côte d'Ivoire, French president Jacques Chirac gave an impassioned speech outlining the need for an international solidarity fund to pay for HIV treatment. The International Therapeutic Solidarity Fund was subsequently launched in 1998 with Luxembourg and South Korea to mobilize additional funding beyond the public sector, to incorporate private companies, donations, foundations and the pharmaceutical industry.[66] In 2006, Chirac implemented the world's first solidarity tax on kerosene and airline tickets to fund the fight against HIV – this was the original main funding source for UNITAID. Germany, Cameroon, Chile, the Republic of the Congo, Madagascar, Mali, Mauritius, Niger and South Korea later followed suit.

Meanwhile, US national intelligence reports on the growing epidemic of HIV in low- and middle-income countries were pivotal to the enhanced response from the US. In May 2000, President Clinton declared HIV a major threat to national security, further focusing global attention on HIV. The US Department of Defense feared that the spread of the disease could result in military collapse and power vacuums. Economic and political instability was feared in southern Africa and Latin America if the pace of the epidemic continued.

By 2001, other significant events had begun to shape US policy interests, increasing the focus on health security.[67] Most significantly, the 9/11 terrorist attacks in New York and Washington, DC brought the security argument back to the fore, and

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64 Ibid.
65 Kirton, J. J. and Mannell, J. (2005), 'The G8 and Global Health Governance', conference paper, Centre for International Governance Innovation, the Institute of Population Health, University of Ottawa, the G8 Research Group, Munk Centre for International Studies, University of Toronto, and Rotary International, 10–12 November 2005, https://hdl.handle.net/1807/4898.
66 Lidén (2013), *The Grand Decade for Global Health*.
67 Khan, A. S. (2011), 'Public health preparedness and response in the USA since 9/11: a national health security imperative', *The Lancet*, 378(9794), pp. 953–56, https://doi.org/10.1016/S0140-6736(11)61263-4.

with it the potential threat of the HIV epidemic and other communicable diseases to international security.[68] The US believed that nations struggling with poverty, corruption and fragile institutions were more likely to harbour terrorist networks, thus presenting imminent threats to US interests.[69] Moreover, the HIV epidemic exacerbated the economic challenges faced by such nations, further compounding their predicament. The events of 9/11 were shortly followed by the anthrax attacks and later by the SARS epidemic of 2003, which also played a role in global health being placed on the US foreign policy agenda and its inclusion in the US bioterrorism and security strategies.[70]

In the UK, the international political leadership of Prime Minister Tony Blair and Chancellor of the Exchequer Gordon Brown at that time was characterized by a commitment to invest in poverty alleviation and development in Africa.[71] They belonged to a generation that had witnessed a wave of domestic activism to get HIV onto the health agenda; this experience seemed to add impetus to their support. It was under their leadership that the UK's foreign aid budget reached the UN target of 0.7 per cent of gross national income, a level of commitment that was incorporated into UK law.[72] Africa had been a priority focus for the UK government since 2003 and in 2004 the UK created the Africa Commission to inform recommendations to the G8.[73] During the 2005 G8 summit at Gleneagles, there was a push for debt relief and increased official development assistance to help achieve the MDGs, with a particular emphasis on African countries. G8 countries shared a 'moral conviction' to support progress in Africa.[74] As part of these commitments, there was a focus on achieving universal access to HIV treatment, investing in vaccine research and increasing funding to the Global Fund.[75]

The Global Fund – the multilateral mechanism

The Global Fund has been the major multilateral financing mechanism for raising and disbursing funds for programmes to reduce the impact of HIV, TB and malaria in low- and middle-income countries.

The idea of a G8 collective effort against infectious diseases was proposed at the Okinawa summit in 2000, with support from Japan as the host country and from the US. Japan led with a national commitment to spend $3 billion over a five-year period under the Okinawa Infectious Disease Initiative to fight infectious and parasitic diseases in developing countries. Clinton and his vice-president, Al Gore,

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68 Ssemakula, J. K. (2002), 'The Impact of 9/11 on HIV/AIDS Care in Africa and the Global Fund to Fight AIDS, Tuberculosis, and Malaria', *Journal of the Association of Nurses in AIDS Care*, 13(5), pp. 45–56, https://doi.org/10.1177/105532902236782.
69 National Security Council (2002), *The National Security Strategy of the United States of America,* https://georgewbush-whitehouse.archives.gov/nsc/nssall.html.
70 Research interview with interviewee 3, 2022.
71 Research interview with interviewee 4, 2022.
72 Kakkad, J., Miller, B., Scott, M. and Sleat, D. (2021), *The UK's International Aid Commitment*, London: Tony Blair Institute for Global Change, https://institute.global/policy/uks-international-aid-commitment.
73 Lawson, M. and Green, D. (2005), *Gleneagles: what really happened at the G8 summit?*, briefing note, Oxford: Oxfam, 29 July 2005, https://oxfamilibrary.openrepository.com/bitstream/handle/10546/114465/bn-g8-gleneagles-290705-en.pdf?sequence=1.
74 G8 Gleneagles (2005), 'Chair's Summary', 8 July 2005, http://www.g8.utoronto.ca/summit/2005gleneagles/summary.html.
75 Lawson, M. and Stuart, E. (2006), *The View from the Summit: Gleneagles G8 one year on*, briefing note, Oxford: Oxfam, 9 June 2006, https://policy-practice.oxfam.org.uk/publications/the-view-from-the-summit-gleneagles-g8-one-year-on-115040.

galvanized the discussion around infectious disease threats – and HIV specifically – seeking a unique funding partnership (a global fund), additional resources and leadership from other member countries.[76] The European Commission pledged to spend €120m for the prevention and control of HIV, and additional funding pledges were made by from Canada, Italy and the UK.[77] However, some members resisted the attempt to set up a dedicated global fund, and the summit ended without the Global Fund being endorsed. The proposal eventually succeeded at the 2001 G8 summit hosted by Italy in Genoa. During that summit, as a part of fundraising efforts, Italy proposed a model that would include voluntary contributions of $1 million from each of 1,000 major multinational corporations, but this concept did not receive approval from other summit members. A multi-stakeholder model was instead adopted, with national governments playing a prominent role in providing the funds.[78]

The Global Fund was launched in 2002, initially as a unit within WHO, later becoming a stand-alone organization based in Geneva, Switzerland. It was created as an innovative financing mechanism to provide governments with funding based on proposals and implementation plans designed by the affected countries themselves. WHO and UNAIDS continued to provide the much-needed technical and on-the-ground experience.[79]

Around 94 per cent of the total funding for the Global Fund comes from donor governments, while the rest comes from the private sector, philanthropic foundations and innovative financing mechanisms.

The Global Fund used multiple strategies to ensure a sustained funding stream. Governments, international organizations and non-state actors relatively new to the global health architecture were brought together, and tactical collaborations were built to identify solutions. Around 94 per cent of the total funding for the Global Fund comes from donor governments, while the rest comes from the private sector, philanthropic foundations and innovative financing mechanisms such as the Product (RED) branding and marketing project. The latter was developed and launched by rock star Bono and Bobby Shriver in 2006 as a mechanism for raising capital for HIV prevention and treatment activities.[80]

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76 National Economic Council via Clinton White House archive (2000), 'The Okinawa G-8 Summit: Building a Global Development Partnership', 22 July 2000, https://clintonwhitehouse4.archives.gov/WH/EOP/nec/html/G8GlobalDevPartnership000722.html.
77 Kirton and Mannell (2005), 'The G8 and Global Health Governance'.
78 Ibid.
79 Research interview with interviewee 5, 2022.
80 Farrell, N. (2012), 'Celebrity Politics: Bono, Product (RED) and the Legitimising of Philanthrocapitalism', *The British Journal of Politics and International Relations*, 14(3), pp. 392–406, https://doi.org/10.1111/j.1467-856X.2011.00499.x.

The Bill & Melinda Gates Foundation, one of the major philanthropic donors to the Global Fund since its creation, ensured its commitment to the Global Fund initiative by strategizing with government heads to invest in the international HIV response movement as it matured.[81] Through its global advocacy, the Gates Foundation also helped to promote private sector health financing mechanisms.

Chirac made a personal commitment to increasing funding for HIV treatment and was instrumental in the establishment of the Global Fund.[82] In the initial period, when the Global Fund was inclining towards prevention programmes, the French government argued forcefully for the inclusion of a treatment component in the fund's remit. After Chirac left office in 2007, some feared that the Global Fund would lose momentum and funding. However, Carla Bruni-Sarkozy – the wife of Chirac's successor as French president, Nicolas Sarkozy – played a significant role in championing the HIV cause in France and beyond.[83] The HIV-related death of her brother prompted her commitment to the cause, which was further demonstrated by her appointment in 2008 as the Global Fund's ambassador for the protection of women and children against HIV/AIDS. Bruni-Sarkozy is credited with ensuring significant French contributions to the Global Fund, which are ongoing (France is currently the second largest donor to the Global Fund).[84]

Despite the goodwill and impetus behind the Global Fund from its launch, it was subject to some criticism. Its initial 'first come, first served' approach often led it to fund ambitious proposals that did not consider cost-effectiveness, and some donors felt that such proposals were draining the fund and that the money was not reaching priority countries as a result.[85] The Global Fund was built on the aspiration of giving high priority to the 'most affected countries and communities' and focusing on countries with the least ability to finance efforts to tackle the three target diseases. However, evaluations of the funding allocations yielded mixed results, with some pointing to a limited relationship between Global Fund disbursements and country income and disease burden.[86] Later, in 2013, a new funding model was implemented that allocated shares of each replenishment based on a country's disease burden and ability to pay for disease programmes, as well as other factors such as the availability of other external financing.[87] Donors to the Global Fund played a key role in the decision-making process around funding allocations.[88] Civil society involvement in the Global Fund is credited with securing the finances required for funding cycles and ensuring that the resources reached and benefitted affected communities. Civil society actors have three seats

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81 Research interview with interviewee 5, 2022.
82 UNITAID (2019), 'Unitaid pays tribute to former President Chirac's inspirational leadership', press release, 27 September 2019, https://unitaid.org/news-blog/unitaid-pays-tribute-to-former-president-chiracs-inspirational-leadership/#en.
83 Research interview with interviewee 5, 2022.
84 Global Fund (2020), 'France and The Global Fund', https://www.theglobalfund.org/media/1507/donor_france_report_en.pdf?u=636948986940000000.
85 Fan, V. Y., Glassman, A. and Silverman, R. L. (2014), 'How A New Funding Model Will Shift Allocations From The Global Fund To Fight AIDS, Tuberculosis, And Malaria', *Health Affairs*, 33(12), pp. 2238–46, https://doi.org/10.1377/hlthaff.2014.0240.
86 Ibid.
87 Ibid.
88 Clinton, C. and Sridhar, D. (2017), 'Who pays for cooperation in global health? A comparative analysis of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance', *The Lancet*, 390(10091), pp. 324–32, https://doi.org/10.1016/S0140-6736(16)32402-3.

on the Global Fund board with voting rights, securing their influence over policy decisions.[89] Civil society participants have helped ensure that recipient country interests were included in the decision-making process.[90]

The Global Fund was set up to report on measurable, tangible outcomes such as the number of people treated or tested. It attempted to produce an exact calculation of the measures based on assumptions about the consequences of interventions that were financed; such reporting has been useful in demonstrating to donors the return on their investment.[91] Later, the setbacks in programme delivery and desired targets following the COVID-19 pandemic led to the greater recognition of the importance of health-system strengthening as one of the strategic pillars in reducing the burden of HIV, TB and malaria. The Global Fund is investing $1.5 billion a year during the 2021–23 funding cycle for the strengthening of health systems.[92]

The Global Fund achieved pledges totalling a record high of $15.7 billion in its seventh replenishment round in September 2022, which included notably both implementing governments stepping up as donors and increased private sector contributions.[93] Pledges fell short of the initial ask of $18 billion. But, in the context of the economic crisis following the COVID-19 pandemic, funding pressure as a result of the war in Ukraine and the general downturn in global economic conditions, this figure can still be seen as a significant achievement and, to some extent, a demonstration of political support for long-term investment in global health priorities.

PEPFAR – bilateral over multilateral funding

In 2003, one year after the launch of the Global Fund, US president George W. Bush announced his administration's commitment of $15 billion over the next five years to the global HIV response under a new bilateral mechanism, the President's Emergency Plan for AIDS Relief (PEPFAR).[94] The US was, and still is, the world's largest single contributor to the HIV response, and has long favoured bilateral assistance over multilateral funding, which has given it greater control over how money is spent.[95]

The creation of PEPFAR was influenced by several factors. One was the initial refusal of the G8 to agree on collective action at the Okinawa summit, which gave justification for the US to proceed with a large assistance programme of its own.[96] The security concerns related to the HIV epidemic also affected the policy commitment.[97] In addition, Bush used moral and religious rhetoric to appeal to both conservative and Evangelical supporters[98] and liberal humanitarian

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89 Fortier, E. (2007), *An Evolving Partnership: The Global Fund and Civil Society in the Fight against AIDS, Tuberculosis and Malaria*, Geneva: The Global Fund, https://www.ft.dk/samling/20061/almdel/uru/bilag/198/383297.pdf.
90 Research interview with interviewee 5, 2022.
91 Lidén (2013), *The Grand Decade for Global Health*.
92 The Global Fund (2023), 'Resilient and Sustainable Systems for Health', https://www.theglobalfund.org/en/resilient-sustainable-systems-for-health.
93 Wexler, A., Kates, J. and Lief, E. (2022), *Donor Government Funding for HIV in Low- and Middle-Income Countries in 2021*, report, Menlo Park, CA: Kaiser Family Foundation, https://www.kff.org/global-health-policy/report/donor-government-funding-for-hiv-in-low-and-middle-income-countries-in-2021.
94 Dietrich (2007), 'The Politics of PEPFAR'.
95 Center for Health and Gender Equity via UN Women (2004), 'Debunking the myths in the U.S. global AIDS strategy: an evidence-based analysis', March 2004, https://www.iswface.org/CHGE-DEBUNK.PDF.
96 Kirton and Mannell (2005), 'The G8 and Global Health Governance'.
97 Rushton (2010), 'AIDS and International Security in the United Nations System'.
98 Lancaster, C. (2008), *George Bush's Foreign Aid: Transformation Or Chaos?*, Washington, DC: Center for Global Development, https://www.cgdev.org/publication/9781933286273-george-bushs-foreign-aid-transformation-or-chaos.

groups.[99] The resulting, unique alignment of both liberals and conservatives over the PEPFAR proposal was key to its realization and successive reauthorizations of the programme by the US Congress.[100]

PEPFAR invested a significant amount of money in the HIV response on the ground and, with $18.8 billion committed in the first five years, became one of the largest global health initiatives for a single disease.[101] The programme's success, however, has largely been due to its focus on results and pre-established goals, rather than just the amount of funding. In particular, the programme pushed for the engagement of all stakeholders in the country and for community-based ownership. For example, the rollout of ARVs by PEPFAR in South Africa in 2004 depended on sustained efforts from civil society groups like the Treatment Action Group and other non-governmental organizations.[102] While the inclusion of a policy against generic drug purchases for HIV treatment attracted criticism initially, that policy was amended in 2005.[103] The results-driven success of PEPFAR led Bush's successor as US president, Barack Obama, to increase the financial commitment to the plan in 2011 and to call for PEPFAR to go further in helping to realize 'an AIDS-free generation'.[104] While PEPFAR has often been characterized as taking a 'top-down' approach, its collaboration with implementing countries has helped strengthen those countries' health systems and provided essential health services beyond HIV.[105]

HIV, unlike other infectious diseases, is a long-term challenge, with no revolutionary vaccine and the requirement for consistent life-long treatment. Significant progress has been achieved to reduce the burden of HIV and mortality linked to the disease, but the problem still requires sustained international funding.[106] Economic recession, global conflicts and the cost of catastrophes such as the COVID-19 pandemic affect donor priorities and the provision of international aid, leading to reversals in HIV programme successes and progress.[107] The US has maintained PEPFAR funding for the last 20 years, recognizing it as one of its most successful initiatives in global health development. By January 2023, the programme had invested over $100 billion in more than 50 countries, saving 25 million lives.[108] However, the annual funding for PEPFAR has been relatively flat since 2015, at around $4.8 billion, despite it receiving additional emergency funds in 2020–21 towards the COVID-19 response.[109]

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99 Research interview with interviewee 4, 2022.
100 Dietrich (2007), 'The Politics of PEPFAR'.
101 Dybul, M. (2009), 'Lessons Learned From PEPFAR', *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 52, pp. S12–13, https://doi.org/10.1097/QAI.0b013e3181bbc98d.
102 Kavanagh, M. M. (2014), 'The Politics and Epidemiology of Transition: PEPFAR and AIDS in South Africa', *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 65(3), pp. 247–50, https://doi.org/10.1097/QAI.0000000000000093.
103 Dietrich (2007), 'The Politics of PEPFAR'.
104 Bendavid, E. (2016), 'Past and Future Performance: PEPFAR in the Landscape of Foreign Aid for Health', *Current HIV/AIDS Reports*, 13(5), pp. 256–62, https://doi.org/10.1007/s11904-016-0326-8.
105 Goosby, E. et al. (2012), 'Raising the Bar: PEPFAR and New Paradigms for Global Health', *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 60, pp. S158–62, https://doi.org/10.1097/QAI.0b013e31825d057c.
106 Research interview with interviewee 4, 2022.
107 Médecins Sans Frontières (2022), 'Bridging the Gaps: The Neglected Pandemics: HIV/AIDS, Tuberculosis and Malaria', briefing paper, Brussels: MSF, https://www.msf.org/countries-must-re-engage-hiv-tb-and-malaria.
108 US Department of State (2023), 'The United States President's Emergency Plan for AIDS Relief', https://www.state.gov/pepfar.
109 Kaiser Family Foundation (2023), 'Breaking Down the U.S. Global Health Budget by Program Area', fact sheet, 18 April 2023, https://www.kff.org/global-health-policy/fact-sheet/breaking-down-the-u-s-global-health-budget-by-program-area.

Conclusion

This case study provides a general overview of events and stakeholders that led to the transformation in the global response to HIV, ushering in innovation and significant additional resources. The study also identifies critical initiatives and individuals behind the global financing response.

The experience of the global HIV response post-2000 offers vital lessons for dealing with other global health priorities requiring concerted international collaboration and funding to adequately address. The most significant of these lessons are:

1. The widespread recognition of HIV as an epidemic – and of its scale – were critical to it becoming a global priority. Irrespective of a particular country's income level, the stigma associated with the transmission of HIV infection led to initial denial and delayed recognition of the disease. Strong civil and public health action, with the support of celebrities and other non-political actors, were necessary for political leaders to recognize and respond to the epidemic, and for wider access to treatment to materialize. The inclusion of civil society in the governing bodies of both UNAIDS and the Global Fund was an innovative and successful way to foster broad political interest.

2. Finding a narrative framing for the disease that would spur political action was an important factor influencing HIV's rise up the international political agenda to become a global funding priority. This study observes multiple such narratives in the HIV response, ranging from national and international security concerns and the HIV response as a means of poverty reduction, to the macroeconomic cost of HIV for countries affected by the epidemic and the moral duty of high-income countries to assist low- and middle-income countries.

3. Another important factor was the clarity of the 'ask'. The development of an international strategy that framed specific goals and targets for HIV has been critical to sustaining international and domestic political interest. International political commitments, the MDGs and the SDGs provided a framework of clear targets, which was then used to create political momentum. In addition, initiatives such as the Global Fund and PEPFAR used outcome-based performance measurement to track progress on a country-by-country basis and to hold country leaders accountable for their actions.

4. Around 2000, when international funding for HIV surged, there were no significant competing global priorities or geopolitical crises. This situation helped the cause to climb the international political agenda. At that time, Africa faced social and economic crises, coupled with food insecurity and low productivity. Poverty alleviation thus featured high on the agenda of global leaders and G7/G8 summits. The economic argument for health made in the World Bank's 1993 WDR identified investment in public health as the best way to improve a country's economic situation. As the social and economic consequences of HIV were devastating in Africa, all of the above factors proved conducive to prioritizing HIV and ensuring donor countries invested in the effort to tackle the epidemic.

5. Leadership from certain individual figures at the national and international levels was also crucial in promoting and coordinating the multilateral response. For instance, the initial UN and World Bank response to the HIV epidemic was slow. However, later, under the leadership of key individuals, international organizations were able to coordinate a robust multilateral response, bring down prices for ARVs, provide technical support to LMIC governments and bring political leaders together to step up their countries' financial commitments.

6. At a time when funding was severely lacking, new financing mechanisms were created as a result of collaboration between G7/G8 global leaders and private organizations. The development of the Global Fund, PEPFAR and UNITAID represented an unparalleled humanitarian effort in mobilizing foreign aid that has achieved a significant impact at ground level.

7. International donors will continue to be called on to fill the financing gap in a crisis. However, the sustainability of the current replenishment model in the longer term is in doubt, especially with HIV having been transformed by scientific advances into a manageable chronic disease. Questions are beginning to arise as to when the sense of 'emergency' with regard to HIV should end, and how well HIV can continue to be funded amid newer or re-emerging priorities for global health – not least among them pandemic prevention, preparedness and response.

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Cover image: An activist holds a cut-out in the shape of the red ribbon symbolizing awareness of, and support for, those living with HIV at a campaign event for World AIDS Day, Kolkata, India, 1 December 2022.
Photo credit: Copyright © Avishek Das/SOPA Images/LightRocket/Getty Images

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