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Development Minister Ulla Tørnæs
Ministry of Foreign Affairs
Asiatisk Plads 2
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28th February 2005

cc : Dr. Catherine Hankins, UNAIDS, Geneva
Senior Advisor David Wilson, World Bank, Washington
Dr. Flemming Bro, Syddansk University, Odense
Prof. Martin Paldam, Aarhus University, Aarhus
Berthel Haarder, former Development Minister

All members of the Foreign Affairs Committee, Danish Parliament
Line Østergaard, NGO-AIDS network, Copenhagen
Jesper Heldgaard, Development Today

Re : Denmark's future HIV/AIDS assistance

Dear Ulla Tørnæs,

Congratulations on your appointment as Development Minister, and advance apologies for landing a rather hefty issue on your desk so soon after taking up this post.

The issue in question concerns the direction of Denmark's future HIV/AIDS assistance to developing countries. As you are probably aware, this issue has been hotly debated in the Danish media over the last 4 years, and lead to the decision by your predecessor, Bertel Haarder, to gather a small panel of experts (Flemming Bro, Martin Paldam, Catherine Hankins and David Wilson) to advise on the issue. They presented their preliminary results at a hearing in Copenhagen on the 25th November 2004.

I was rather surprised by the recommendations put forward by the expert panel, that Denmark would get most value for money by concentrating its input for HIV/AIDS on prevention[1]. Médecins Sans Frontières (Læger uden Grænser) strongly disagrees with this view, and with the arguments used by the panel to justify taking this position. Médecins Sans Frontières instead believes that the HIV/AIDS pandemic can only be successfully fought by a strategy that incorporates the efforts of national governments, United Nations organs, NGOs, mission hospitals and local civil society through integrated programmes that combine prevention, care and treatment. Our recommendation is based on nearly 20 years of experience working with HIV/AIDS, which today extends to over

[1] See supporting document at http://www.aidsnet.dk/Default.asp?ID=1891

Adding up the actual funds dispersed by the Global Fund, PEPFAR and the World Bank gives **only 395 million $ spent on AIDS treatment by June-December 2004**[7], which is little more than the annual overseas development assistance spending on AIDS prevention and care throughout the 1990s[8], when the apparent prevalence rates and socio-economic impacts of the disease were much lower than today. This amount is also a fraction of the 7-10 billion $ per year 'war-chest' for AIDS that Kofi Annan declared in April 2001 was needed to fight the disease. Four years have passed since that announcement was made, and the needs are increasing while millions are dying. Even taking into account other funds given bilaterally, it is clear that we are far from a situation where there is too much money for AIDS treatment.

Nonetheless, even if all the funds promised for AIDS treatment were to materialise, the real issue is not how much funding there is, but the impact of that funding. The ca. 289 million $ dispersed so far by the Global Fund for AIDS treatment is treating just 63,100[9] AIDS patients with Anti-retroviral medicine, while PEPFAR has only put 24,900 people under treatment at a cost of 92 million $[10]. There is still a long way to go to scale up the implementation of AIDS-treatment programmes to reach the 6 millions who need them.

This shows that looking at the funding issue from the viewpoint of *inputs*, rather than *outputs* is meaningless. The reason for funding AIDS treatment is not to fill a bank account with money, but instead to ensure that sick people receive adequate medical care. The question of how much funding should be given must be judged by the number of people still needing that care, rather than how much money has been promised or even given.

It is therefore impossible to say that there is too much money for AIDS treatment when 6 million people need treatment today while only 500,000[11] are actually getting that treatment in the developing world outside Brazil and Thailand (whose governments are among the few with the capacity and resources to give AIDS treatment to their citizens). There is clearly a need for much more funding, as well as for other inputs such as cheaper quality medicines and stronger local healthcare systems.

2. "Health systems in the countries severely affected by AIDS are unable to cope with an increase in funding"

A further argument put forward by the panel of experts against more funding for AIDS treatment is that the health systems in many developing countries cannot absorb and spend additional funds for this purpose, due to a lack of technical (human resources) capacity. They cited the examples of Tanzania, and of Botswana, 'which has only used 10% of the 200 million $ allocated'[12].

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[7] Total to June 2004 for PEPFAR, to December 2004 for the Global Fund, and to July 2004 for the World Bank.

[8] From just under 200 million US $ in 1990 to just under 300 million US $ in 1999. Data from Opuni, M. & Bertozzi, S. (2003). Financing HIV/AIDS Prevention and Care in Low- and Middle-Income countries. http://hivinsite.ucsf.edu/InSite?page=pa-rr-03#S7X

[9] Figure from the Global Fund (November 2004)

[10] Figure from PEPFAR report June 2004.

[11] WHO/UNAIDS/Global Fund/US Government reported that 700,000 people in developing countries were receiving ARV medicines for AIDS at the end of 2004. Of these, some 120,000 are Brazilians, while a further 30,000 are Thai citizens. See Davos press release of the 26th January 2005.

[12] Quote from Danida's newsletter *Udvikling* December 2004, containing a report of the 25th November meeting in Copenhagen. Paradoxically, WHO/UNAIDS/Global Fund/US Government reported in January 2005 that Botswana had reached the '3 by 5' target of putting at least 50% of those who needed ARV on treatment.

could easily be ignored/stigmatised. Prevention messages are more readily listened to by the whole community as a result.

These experiences question whether Bjørn Lomborg is right when he says that it is more caring to prevent rather than treat[15]. This is a rather black and white view, which fails to take into account the important synergy between the alternatives, as well as the terrible suffering of those who are dying of AIDS, not to mention the tragedy of those they leave behind. **Médecins Sans Frontières believes that funding a combination of prevention and treatment will greatly reduce the number of new infections, save most lives, while minimising the social impacts of the disease on society**.

4. "The issue is a question of prevention versus treatment"

The 'prevention versus treatment of AIDS ' debate more or less stopped at the international level after the 2002 World AIDS conference in Barcelona, where it was accepted that both strategies need to go hand-in-hand in the fight against AIDS. Prevention is clearly the priority to reduce the number of new infections, but to do that treatment is a necessary component; and should be considered as part of the strategy to boost prevention. Beyond the synergy effect described above in part 3, treatment also prevents the onward transmission of some of the secondary infections associated with AIDS, such as tuberculosis[16], leading to dramatic drops in TB incidence of up to 50%[17].

But there are of course many other reasons to treat people infected with HIV/AIDS. Numerous World Bank studies on the long-term economic impacts from HIV/AIDS have shown that the fiscal effects of the epidemic are devastating. The microeconomic impact can be measured in terms of reduced income, reallocation of labour and land, changes in consumption and investment, and dissolution of households[18]. In terms of the macroeconomic impact it is estimated by the World Bank that the HIV/AIDS-epidemic in some countries causes an annual GDP loss per capita of more than 3% and that economic growth equivalent to 35% of today's GDP would be forfeited by 2025 compared to a situation where HIV/AIDS was not present[19]. By treating people and thereby allowing them to return to the labour market, many of the above mentioned micro-and macroeconomic effects can be markedly reduced[20].

Finally there is an ethical obligation to treat people infected with HIV/AIDS. It is clearly inhuman to allow a person to suffer and die of a treatable disease, when this can be avoided

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[15] Danida's newsletter *Udvikling* December 2004, p. 3.

[16] Chaisson RE (2003). Beyond DOTS: Approaches to Tuberculosis Control in Areas where HIV prevalence is High, *10th Conference on Retroviruses and Opportunistic Infections*. February 10-14, 2003. Boston, MA, USA.

[17] Farmer P (2003). Use of Antiretroviral Therapy in Developing Countries: A Biosocial Analysis, *10th Conference on Retroviruses and Opportunistic Infections*. February 10-14, 2003. Boston, MA, USA.

[18] See www.worldbank.org/wbi/B-SPAN/docs/aids_prsp_part1.pdf

[19] See http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20287942~menuPK:34463~pagePK:64003015~piPK:64003012~theSitePK:4607,00.html

[20] This view is supported by the Copenhagen Consensus, who say that although the costs to control and treat AIDS would be considerable, spending assigned to this would yield extraordinarily high benefits. See http://www.copenhagenconsensus.dk/Default.asp?ID=424

services. Specific funding is needed for programmes that integrate civil society community involvement with existing government health structures, supported by international NGOs to build capacity.

Médecins Sans Frontières therefore recommends the Danish government to ensure that a portion of future Danish HIV/AIDS funding goes to support integrated NGO/government (i.e. MoH)/civil society programmes that combine treatment, prevention and care. In this way we will enhance prevention by treatment, while limiting the number who need treatment through prevention. We will also contribute to building local capacity, which your experts also identified as a real need, at the same time as achieving real results in fighting HIV/AIDS. And finally, by integrating actors at all levels, we will ensure that the objectives of the 'three ones'[21] are being met, and no energy is wasted in poor coordination.

I would be happy to meet with you to discuss these points in greater detail, together with any of the 8 Læger uden Grænser volunteers from Denmark who have worked on AIDS projects during last year.

Yours sincerely

Philip Clarke
Director
Læger uden Grænser / Médecins Sans Frontières-Denmark

[21] UNAIDS' principles for the coordination of national AIDS responses. See http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp