



# One Casualty of Global Economic Crisis: Uncertain Finances for HIV/AIDS Programs

Rebecca Voelker

IN LESS THAN A DECADE, IMPOSSIBILITY turned the corner into reality. Infusions of cash and technical support from international donors, as well as growing political will in some developing countries, have provided life-saving antiretroviral drugs to an estimated 5 million people living with HIV/AIDS in resource-poor regions. But now the global HIV/AIDS community must find a way to turn yet another corner by maintaining those 5 million patients on antiretrovirals and offering the drugs to millions more in the midst of a persistent global economic crisis.

Even though the downward economic spiral began nearly 2 years ago, AIDS officials say the impact on international donors' ability to meet funding and treatment goals for the next 4 to 5 years still is not clear. In 2008, the last full year for which data on funding commitments and actual disbursements are available, international donors promised US \$8.7 billion for HIV/AIDS programs. They delivered \$7.7 billion. The gap between promises made and promises kept was substantially smaller in 2008 than in recent years. For example, international donors had committed to \$6.6 billion in 2007 but paid \$4.9 billion; in 2006, commitments totaled \$5.6 billion compared with \$3.9 billion paid out.

International donors' commitments in 2009 were nearly the same as in 2008, said Paul DeLay, MD, deputy executive director of the programme branch at the Joint United Nations Programme on HIV/AIDS (UNAIDS), which compiles the data. "But that's because of money that was already in the pipeline," he noted. Release of data on disbursements in 2009 is expected to coincide with the XVIII International AIDS Conference in Vienna, Austria, in July.

For 2010, DeLay said, all commitments for HIV/AIDS, including funds from international donors, private sources such as philanthropic foundations, and the countries themselves, total about \$16 billion. But UNAIDS has estimated that about \$25 billion is needed this year to meet HIV/AIDS needs in low- and middle-income countries. "I don't think that within the year we'll be able to catch up; that's about 35% to 40% that we still need to go," he said.

"When we ask [international donors] about future commitments, because of political implications, the donors are a little hesitant to give us real numbers," he added. A couple of exceptions are Italy and Ireland, which have informed UNAIDS that they will reduce assistance they provide for global HIV/AIDS programs.

"I'm struck by the realities of how long this economic crisis has lasted and we still don't understand the long-term implications," DeLay said. "The damage done to developing countries or the resilience of developing countries—we still don't understand that."

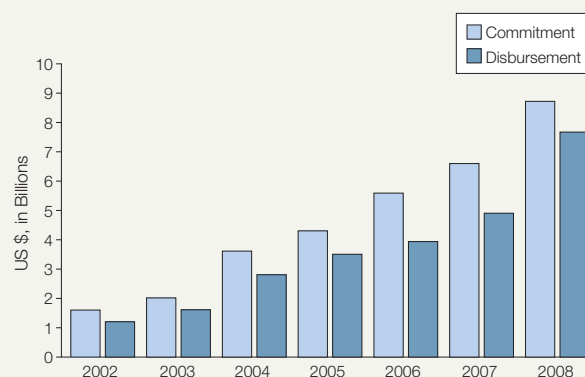
## WORLD'S MAJOR PLAYERS

The 2 largest international donors for global HIV/AIDS programs are the United States, which provided about 51%, and the United Kingdom, about 13%, of the \$7.7 billion paid out in 2008. The President's Emergency Program for AIDS Relief (PEPFAR), which was initiated in 2003 by former US President George W. Bush, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which was created in 2002, provided the kick-start needed to provide antiretrovirals and to scale up health care capacity in developing nations.

Since its inception, PEPFAR has provided about \$32 billion, including \$5 billion for the Global Fund and \$950 million for tuberculosis programs. The Global Fund acts as a financier that takes in donor pledges and awards grants to support services in developing nations. Awards from the Fund represent about 20% of all HIV/AIDS funding from donor countries.

Their results are impressive. The Global Fund, since its beginning, has disbursed funds that provide antiret-

International AIDS Assistance: Trends in G8/European Commission and Other Donor Government Assistance, 2002-2008



Source: Kaiser Family Foundation. *Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from the G8, European Commission and Other Donor Governments in 2008*. <http://www.kff.org/hivaids/7347.cfm>. Accessed June 22, 2010.

International donors came close to meeting their commitments for AIDS assistance in developing countries in 2008, the last year for which data are available. Experts are concerned that donors may withdraw some of their support because of budget cuts attributable to the global recession.



rovirals for about 2.8 million. PEPFAR reports that its funds provide antiretrovirals for some 2.4 million, care for about 11 million, and HIV prophylaxis for HIV-infected pregnant women that has prevented HIV infection in an estimated 340 000 newborns. DeLay said that approximately 5 million patients worldwide receive antiretrovirals. A decade ago, these statistics would have been considered little more than wishful thinking.

### CONCERN AND CRITICISM

In the past year, however, experts and activists have expressed concern and criticism about major donors failing to meet their funding commitments. The result, some say, is that clinics in low-income countries are turning away HIV-infected patients seeking treatment. Reports of shrinking resources come on the heels of the recent World Health Organization recommendation to begin treatment with antiretrovirals sooner, when patients have CD4 cell counts of 350/ $\mu$ L rather than 200/ $\mu$ L.

In early June the medical humanitarian group Médecins Sans Frontières (MSF, or Doctors Without Borders) released a report, *No Time to Quit—AIDS Treatment Gap Widening in Africa*, that describes dwindling resources for HIV/AIDS treatment. It points to reductions in Global Fund grants, “flat-lined” PEPFAR budgets that have reduced funding amounts for antiretrovirals, fewer resources for HIV/AIDS from the World Bank, and the phase-out of funding for second-line HIV drugs by UNITAID, an international agency for the purchase of drugs against HIV/AIDS, malaria, and tuberculosis.

(UNITAID has released a statement saying that its projects are being extended but will be turned over to the Global Fund, PEPFAR, and possibly other agencies beginning this year).

“Our teams in South Africa and Uganda report patients are being shuffled around from one clinic to another because of limited treatment slots,” Emi MacLean, US director of MSF’s Access to Essential Medicines campaign, said during a press briefing

to discuss the report. “There are now new waiting lists and doctors and nurses facing the agonizing choice of which patients they should treat—the patient who arrives very sick, with late-stage AIDS, or the patient not yet sick but who needs AIDS treatment and will get sick very quickly without it.”

As a sign of potential funding slowdowns, a memo under the auspices of the US Centers for Disease Control and Prevention-Uganda advised PEPFAR partners in that country of flat-lined antiretroviral budgets for 2010 and 2011. Acknowledging that dramatic increases in the number of patients needing antiretrovirals are expected, the memo nonetheless advised that new patients should not be enrolled unless their treatment could be paid for, despite no increased funding from PEPFAR.

US Global AIDS Coordinator Eric Goosby, MD, said his office was not aware of the memo until after it had been publicized. “It wasn’t a policy statement,” he said. Goosby said the memo went to 7 clinics in the Joint Clinical Research Centre in Kampala to signal that they had exceeded their PEPFAR budgets and needed to plan for additional patients.

“This was not meant to cut them off, but to help them figure out what to do,” he said.

PEPFAR’s budget as well as its role in the Obama administration’s Global Health Initiative (GHI), announced last year, have generated controversy as well. PEPFAR funding increased from \$2.3 billion to \$4.5 billion during its first 4 years, from 2004 through 2007. In 2008, PEPFAR funding totaled \$6 billion, increasing to \$6.8 billion for 2010. President Obama’s request for 2011 is just shy of \$7 billion. The GHI is a 6-year, \$63 billion program with 9 global health target areas, including maternal and child health, nutrition, and neglected tropical diseases. HIV/AIDS remains the top priority; PEPFAR’s share of the funding is \$51 billion.

But PEPFAR’s direction is shifting. Even though program goals for 2010 to 2014 include providing direct treatment for more than 4 million patients

and preventing more than 12 million new infections, PEPFAR intends to turn more of the responsibility for in-country programs over to the countries themselves to build sustainability. The program began as an emergency response for the hardest-hit countries, but now resources also will go toward helping countries address larger societal issues such as gender-based violence and stigma, and further strengthening health systems.

An analysis by the Kaiser Family Foundation showed that even though actual PEPFAR funding will increase from 2009 to 2011, its share of total GHI funding will decrease from 79% to 73%, while the share of funding for malaria increases from 6% to 9%, and funding for other global health areas will increase from 14% to 18% of the overall GHI budget.

“The argument was made that this isn’t a retreat, this isn’t a shift; this is an expansion, but the budget numbers belie that claim,” said Christine Lubinski, vice president for global health at the Infectious Diseases Society of America.

The shifts in GHI funding among PEPFAR, malaria, and other global health areas, Lubinski said, put federal officials in a position to “end up robbing Peter to pay Paul,” with HIV/AIDS programs in the role of Peter. “The fear is that the outcomes will reflect this kind of dilution of priorities,” she added.

Goosby, however, takes issue with such criticism. “In the last 2 years we have not diminished our accrual of patients, and the reason for that is because we have been able to redirect money,” he said. “As we put more people on drugs, less care is needed in terms of diagnostics and treating opportunistic infections. We’ve moved from an inpatient disease, which is really expensive, to an outpatient disease in many of the countries we’re in.”

Rochelle Walensky, MD, MPH, associate professor of medicine at Harvard Medical School in Boston, has written about PEPFAR as well as HIV screening in resource-poor countries.



She said that the substantial annual increases in PEPFAR funding during the program's early years helped create "a huge amount of enthusiasm for having 6 to 10 million on treatment by 2014 or 2013." Now, she said, level funding

and economic woes have blunted that enthusiasm.

At the same time, however, Walensky credits PEPFAR with essentially creating a health care infrastructure in many developing countries and focus-

ing global attention on the need for stronger health care systems in resource-limited regions. "How we prioritize what funds go into what places is going to be our global challenge for years to come." □

# Buprenorphine May Boost HIV Treatment

Bridget M. Kuehn

**W**HEN PATIENTS WITH HIV INFECTION also are addicted to opioids, treating both disorders simultaneously may help improve outcomes and reduce the spread of HIV or other infections transmitted through needle sharing or risky sexual behaviors associated with injection drug use. But accessing such integrated care has sometimes been a challenge for such patients, who generally had to seek care for opioid abuse at addiction treatment centers and primary HIV care elsewhere. This could be logistically difficult and often led to delays in receiving care.

Now, however, buprenorphine prescribing by HIV clinicians is offering patients the option of receiving treatment for both opioid addiction and HIV infection, an approach that a growing body of evidence indicates benefits individual patients and public health.

Since 2002, buprenorphine, a partial opioid agonist, has been available in the United States as an office-based treatment for opioid dependence. Physicians who wish to prescribe the drug may undergo a training program and become certified through the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe buprenorphine (<http://buprenorphine.samhsa.gov/>). Methadone, a full opioid agonist, remains available through highly regulated, specialized treatment programs.

"Buprenorphine has definitely expanded access [to addiction care]," said Amina Chaudhry, MD, MPH, an HIV clinician in Baltimore who prescribes bu-

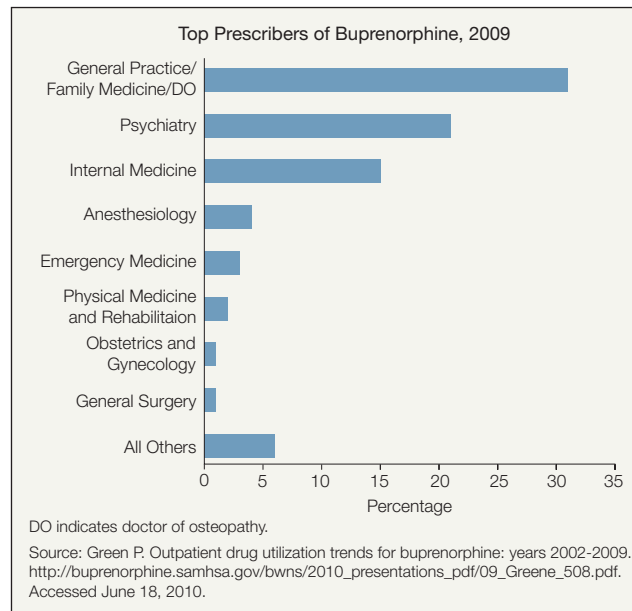
prenorphine. Chaudhry, who is also a medical officer at SAMHSA's Center for Substance Abuse Treatment in Rockville, Md, explained that even in cities like Baltimore, where there may be specialty addiction programs nearby, the demand for such care often exceeds the available slots. And rural areas may have no specialty addiction programs at all within a reasonable distance.

### IMPROVED OUTCOMES

Studies have suggested that patients with HIV infection and untreated opioid addiction often receive HIV treatment later in the course of their illness, may be less adherent to their antiretroviral therapy regimen, and may engage in behaviors such as unprotected sex or injection drug use that put themselves and others at risk of new in-

fections. But treating patients for both HIV and drug use can improve such outcomes. Although much of this research has focused on the effects of methadone, emerging evidence suggests that buprenorphine has similar benefits and may have a few advantages over methadone treatment for patients with HIV.

A recent randomized trial found that office-based care can improve addiction-related outcomes for patients with HIV and opioid addiction and may lead to faster treatment for addiction (Lucas GM et al. *Ann Intern Med.* 2010;152[11]:704-711). Gregory M. Lucas, MD, PhD, of Johns Hopkins University School of Medicine in Baltimore, and colleagues randomized 93 patients at a Baltimore HIV clinic to receive buprenorphine therapy at the clinic or to receive a referral



**There are currently about 19 000 US physicians certified to prescribe buprenorphine, but experts urge more physicians, particularly those in HIV primary care, to become certified to meet the demand for opioid addiction treatment.**