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by J.C. Sylvan*

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f the eight Millennium Development Goals (“MDGs”) set forth by the United Nations, half pertain to public health: Goal Two (education), Goal Four (child mortality), Goal Five (maternal health), and Goal Six (HIV/AIDS, tuberculosis and malaria).1 A failure to address HIV/AIDS, in particular, would compromise the ultimate success of the entire MDG agenda.2 The HIV/AIDS pandemic consistently undermines efforts to fight poverty, illiteracy, and mortality in lowand middle-income countries.

In the countries hardest hit by the epidemic, the problem is compounded by the reality that many national health care systems, which will bear the burden of improving available treatments, are themselves in crisis. In years past, many developing countries, encouraged by international financial institutions and trusting in privatization, cut their health care budgets.3 As a result, health care has been chronically under-funded in many of these countries.4 According to a recent report by the UN Millennium Project, “[p]overty, misplaced priorities, and years of externally imposed restrictions on social spending have left health services for over two billion people dysfunctional, inaccessible, or priced beyond the reach of the poor.”5 Thus, halting the spread of HIV/AIDS in the developing world will depend to a great extent on success in overhauling health care systems in the world’s poorest countries.

Forty-years of gains in public health have been offset in recent years by two factors: the HIV/AIDS pandemic, and the widening health gap between rich and poor nations.6 The under-five child mortality rate for the poorest quarter of the world is ten times that of the richest quarter.7 In twenty years, AIDS has claimed twenty million lives; 39 million individuals carry the virus worldwide.8 If nothing is done, some studies predict 45 million new infections by 2010.9 The prevalence of AIDS and limited availability of treatment reflect the same disparity between rich and poor. A recent World Health Organization (“WHO”) report finds that “globally, 78 percent of mortality from AIDS and 89 percent of people needing treatment” live in the poorest countries.10 To date, there is neither a cure nor a preventative vaccine for HIV/AIDS. The most effective treatment is antiretroviral therapy (“ART”),11 but only eight percent of people in developing countries who need ART receive it.12 Some initiatives to provide treatment in low-and middle-income countries have found success. Brazil has provided free ART through its national health care system since 1996.13 In December 2003, the WHO and UNAIDS14 launched the “three by five” initiative to provide ART coverage to three million of the world’s poorest by the end of 2005.15 At that time, 400,000 people were receiving ART. Today one million are under treatment. That figure is well short of the “three by five” target, but these gains show both that progress is possible and that global goal-setting can be a productive enterprise.16

Meeting the MDG objective of halting and reversing the epidemic will be expensive. Of the $45 billion needed for global HIV/AIDS treatment, care, and prevention over the next three years, donors have so far pledged only $27 billion.17 Even if funding catches up, money alone will not stop the epidemic. The correlation between levels of government health spending and reduced mortality rates is tenuous.18 Countries must also increase the productivity of current spending levels by carefully targeting expenditures to services with “spillover” benefits.19 In order to ensure the long-term viability of AIDS treatment, care, and prevention, governments will have to act strategically in order to make ART more affordable,20 eliminate user fees for such services, provide social insurance, remove bottlenecks in the system, focus on primary care health care, and make a political commitment to populations historically excluded from care, like drug users and sex workers.21 As they implement their AIDS treatment plans, developing countries will face very real human resources limitations. For example, countries in Europe and Central Asia have 3.1 physicians per 1,000, while countries in Sub-Saharan Africa have only one for every 10,000.22 Some countries are taking steps to correct for this: Zambia has doubled nursing salaries, and Thailand has financed a “reverse brain-drain program to keep doctors.”23 Other policies include training community health workers to reduce strains on the system,24 and developing simpler and less costly interventions to extend the reach of local health providers and to reduce mortality in the poorest countries.25 Finally, ART pilot projects have demonstrated the value of the primary health care (“PHC”) model. PHC integrates all aspects of direct health care from prevention to treatment to palliative care. Studies suggest a shift to this integrated approach would promote equity, universal access, and community participation.26 Studies also show that as treatment becomes available, and patients have cause for hope, general interest in HIV/AIDS counseling and testing services also increases.27

HIV/AIDS is a development issue. More than money for treatment is required. A targeted investment in the health systems of the hardest-hit nations is needed to close the global health gap between rich and poor. This sustainable long-term approach represents a paradigm shift for the international community, but supporting the poorest countries in efforts to rebuild their health care infrastructure may help to halt and even reverse the spread of HIV/AIDS.

Endnotes:


2 See World Health Organization (“WHO”), Progress on Global Access to HIV Antiretroviral Therapy: An Update on “3 by 5,” (June 2005), at 5,

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ENDNOTES: WORLD NEWS Continued from page 73

51 Id.
53 Id.
54 Dismal Shortage, supra note 50.

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9 Id.
11 Local agencies involved in supporting the education sector nominate a Coordinating Agency to lead the FTI assessment and endorsement process and serves a liaison with the Ministry of Education and the EFA-FTI Secretariat.
12 FOCUS ON SUSTAINABILITY 2004, supra note 10, at 65. EFA-FTI criteria also require that an education plan focus on the quality of the education to be provided and on the sustainability of a country’s education system.
14 The Netherlands pledged the lion’s share of the funding with $39.5 million. Norway pledged $3.9 million, Italy $2.4 million, and Belgium $1.2 million for the years 2003–2004. These counties also committed money in 2005 and were joined by $5.3 million from Sweden and $6.1 million from Spain (still outstanding). In 2006–2007, pledges have also been made by the EC for $76.2 million, Ireland for $1.5 million and the UK for $64.8 million.
15 Funding from the Catalytic Fund is available only to IDA-eligible countries. The World Bank operates through two main windows: the International Bank for Reconstruction and Development (“IBRD”), which provides loans on near-market terms to middle-income countries, and the International Development Association (“IDA”), which disburses highly subsidized loans to poorer countries. Countries are classified for IBRD or IDA funding based on two criterion: 1) income levels, with the IDA cutoff at approximately $900 (with a few exceptions); and 2) creditworthiness, based on Bank staff judgments about a country’s ability to borrow on private capital markets.
16 In March 2005, the Strategy Committee of the Catalytic Fund agreed that for the purposes of Fund eligibility, a donor orphan would be any IDA-eligible country who received funding from four or fewer bilateral donors contributing a maximum of $1 million each to that country’s education sector. See Minutes of Catalytic Fund Strategy Committee Meeting, July 2005 (on file with authors).
17 Only donors who contribute a minimum of one million dollars may appoint a representative to the Strategy Committee. To date, however, all donors have contributed this minimum amount.
18 To date, Gambia has been allocated $19.0 million of which $4.0 million has been disbursed, Guyana $8.0 million of which $4.0 million has been disbursed, Mauritania $9.0 million of which $7.0 million has been disbursed, Nicaragua $14.0 million of which $7.0 million has been disbursed, Niger $21.0 million of which $9.0 million has been disbursed, Gambia $8.0 million of which $4.0 million has been disbursed, Yemen $20.0 million of which $10.0 million has been disbursed, Madagascar $35.0 million of which $6.0

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4 WHO, supra note 2, at 24.
6 Jong-Wook, supra note 3, at 2084.
7 Wagstaff & Claeson, supra note 1, at xiii, fig. 1.
8 UN MILLENNIUM PROJECT, supra note 5, at 1.
10 WHO, supra note 2, at 32.
11 WHO, supra note 2, at 5.
12 UN MILLENNIUM PROJECT, supra note 5, at 1.
13 WHO, supra note 2, at 11.
15 For more information on the “3 by 5” initiative, see http://www.who.int/3by5/en/ (last visited Oct. 24, 2005).
16 WHO, supra note 2, at 11-12.
17 See WHO, supra note 2, at 17.
18 Wagstaff & Claeson, supra note 1, at 7.
19 See Wagstaff & Claeson, supra note 1, at 9.
22 Wagstaff & Claeson, supra note 1, at 15.
21 Wagstaff & Claeson, supra note 1, at 17.
22 Wagstaff & Claeson, supra note 1, at 13.
23 Wagstaff & Claeson, supra note 1, at 13.
24 WHO, supra note 2, at 23.
26 Wook, supra note 3, at 2086, Panel 1.
27 WHO, supra note 2, at 20.