Fall 2005

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Sustainable Development Law & Policy

Volume 6
Issue 1 *Fall 2005: Development Goals & Indicators*

Article 12

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Of 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 low- and 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 high 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 UNAIDS[14] 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:

[1] Adam Wagstaff & Mariam Claeson, World Bank Group, The Millenium Development Goals for Health: Rising to the Challenges, (2004), at xi, *available at* http://siteresources.worldbank.org/INTEAPREGTOPHEANUT/PublicationsandReports/20306102/296730PAPER0Mi1ent0goals0for0health.pdf (last visited Nov. 4, 2004).

[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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available at http://www.who.int/3by5/fullreportJune2005.pdf (last visited Nov. 4, 2004)[hereinafter WHO].

3 Lee Jong-Wook, *Global health improvement and WHO: shaping the future*, 362 Lancet 2083–88, 2084 (2003), *available at* http://www.who.int/whr/2003/media_centre/en/lee_lancet_article.pdf (last visited Nov. 4, 2005).

4 WHO, *supra* note 2, at 24.

5 UN Millennium Project, Task Force On HIV/AIDS, Malaria, TB, And Access To Essential Medicines, Combating AIDS in the Developing World, (2005) at 7, *available at* http://www.unmillenniumproject.org/documents/HIVAIDS-complete.pdf (last visited Nov. 4, 2005)[hereinafter UN Millennium Project].

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.

9 *E.g.*, John Stover, et al., *Can we reverse the HIV/AIDS pandemic with an expanded response?* 360 Lancet 73-77, 76 (2003), *available at* http://www.hsph.harvard.edu/hcpds/documents/ (follow "Stover Et Al" hyperlink) (last visited Nov. 4, 2005).

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.

14 UNAIDS: The Joint United Nations Programme on HIV/AIDS, at http://www.unaids.org/en/default.asp (last vistied Nov. 4, 2005).

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.

25 *See e.g.*, Neff Walker, et al., *Meeting International Goals In Child Survival And Hiv/Aids*, The Lancet, at 5, (April 30, 2002), *available at* http://image.thelancet.com/extras/01art9188web.pdf (last visited Nov. 4, 2005).

26 Wook, *supra* note 3, at 2086, Panel 1.

27 WHO, *supra* note 2, at 20.