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# Emerging Issues in Today's HIV Response: Debate 7

## AIDS Funding in a Resource-Constrained World



The World Bank, 2012

From left to right: Roger England, Mead Over, Richard Horton, Jeffrey Sachs, Michel Sidibé, and David Serwadda discuss global AIDS funding achievements and challenges.

***“The issue is an ethical and human one...when the poor die because their lives are not valuable enough to spend \$200 per person for clinical treatment. It is the job of the HIV community to raise our voices clearly to say that we do not wish to live in a world where people are allowed to die needlessly.”***

***—debate panelist***

***Proposition: “Continued AIDS investment by donors and governments is a sound investment, even in a resource-constrained environment”<sup>1</sup>***

On Monday, July 23, 2012, the World Bank, the President's Emergency Plan for AIDS Relief (PEPFAR), U.S. Agency for International Development (USAID), and *The Lancet* jointly presented the seventh and last in a series of debates on emerging issues in the global response to HIV, to coincide with the 2012 International AIDS Conference. In an era when development aid is under pressure and the dynamics of the pandemic are constantly changing, it is imperative that governments, civil society organizations, and other partners have the best evidence and knowledge to maximize the effectiveness of development dollars and achieve results. The debate series was designed to advance discussion and begin to build consensus about contentious issues within the HIV community. The debates have had global reach through a wide network of videoconference sites, web-streaming, and recordings and have become an important policy and teaching tool in global health. The final debate, held at the World Bank, was also screened live at a satellite session at the International AIDS Conference and via live webcast and blog on the World Bank website in English, French, Spanish, and Arabic.

Approximately 375 people attended the debate at the World Bank's Preston Auditorium, over 60 people attended the International AIDS Conference satellite session, and nearly 1,000 people watched the webcast of the debate live and during the week after the conference. Additional information about the debate series can be found at [http://www.aidstar-one.com/events/emerging\\_issues\\_todays\\_hiv\\_response\\_debate\\_series](http://www.aidstar-one.com/events/emerging_issues_todays_hiv_response_debate_series).

<sup>1</sup> The views expressed in this report are not necessarily those of USAID, the World Bank, or the organizations to which the panelists are affiliated. The points argued by the panelists were in the spirit of debate and do not necessarily reflect panelists' personal agreement/opposition to the proposition, or their own opinions. Statements in this document have not been checked for factual accuracy and should not be cited.

Debate 7 discussed the proposition, “Continued AIDS investment by donors and governments is a sound investment, even in a resource-constrained environment.” The debaters who supported the proposition argued that given the enormous improvements in decreasing AIDS-related morbidity and mortality thus far, and the moral imperative and financial feasibility of continuing the investments that have enabled these achievements, donors and governments must spend more to maintain momentum toward achieving an AIDS-free generation. The opposing team argued that dedicating \$100 billion to AIDS funding over the past decade has undercut support for other major preventable problems, such as diarrheal diseases caused by unsafe drinking water or respiratory infections, while also failing to function effectively in terms of preventing HIV infections.

This debate was affiliated with the XIX International AIDS Conference, held from July 22 through July 27 in Washington, DC and focused on the theme, “Turning the Tide Together.” On the opening day of the conference, U.S. Secretary of State Hillary Clinton said that the United States remains committed to the goal of striving to reach an AIDS-free generation and announced the forthcoming development of a “blueprint” for achieving this global goal. At the closing session of the conference, former President Bill Clinton gave the keynote speech. He said that the key to turning the tide is effective use of the money spent (particularly on prevention) along with generating evidence on effective practices and clearly conveying this information to donors, country leaders, and other stakeholders in order to increase funding.

Two panelists spoke in favor of the proposition: Jeffrey Sachs, Director of the Earth Institute and Quetelet Professor of Sustainable Development and Health Policy and Management at Columbia University, and Michel Sidibé, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Under-Secretary-General of the United Nations. Speaking against the proposition were Roger England, Chair of the Health Systems Workshop, a nonprofit, independent center of expertise in the health sector headquartered in Grenada, and Mead Over, a Senior Fellow at the Center for Global Development in Washington, DC. The debate moderator was Richard Horton, U.K. Editor-in-Chief of *The Lancet*.

Introducing and concluding the debate were a number of distinguished speakers including Jim Yong Kim, President of the World Bank, Rajiv Shah, Administrator of USAID, His Excellency Festus Mogae, former President of Botswana and Chairperson of the Champions for an AIDS-free Generation, Charles Holmes, Chief Medical Officer of the Office of the U.S. Global AIDS Coordinator, David Serwadda, Professor of Disease Control at Makerere University, Uganda, and Ambassador Eric Goosby, U.S. Global AIDS Coordinator. Tamar Manuelyan Atinc, Vice President for Human Development at the World Bank, opened the proceedings.

## Introduction

On behalf of the co-hosts, Tamar Manuelyan Atinc welcomed the speakers and participants at the World Bank, and in remote locations, to the debate. She noted the World Bank’s solidarity with those who are working to combat HIV.

Jim Yong Kim welcomed the attendees, emphasizing that this final debate offers a timely opportunity to discuss a critical issue, stressing the importance of the debate series in addressing issues of development and the World Bank's role as a neutral and objective knowledge broker. Rajiv Shah expressed his high hopes for Dr. Kim’s leadership in global health. He noted the synergy of the debate’s affiliation with the conference and its theme (Turning the Tide Together), and stated that the HIV community has a responsibility to move ahead effectively and efficiently. Achieving PEPFAR’s global goals will build the robust health systems that are essential for communities, countries, and economies. USAID is committed to strengthening dialog across institutions, standardizing measurement systems and payment structures, enhancing health care structures at the local level, and supporting leadership in the countries where the disease is most prevalent.

President Mogae shared his meditation on hearing about the debate topic: what does investment in HIV mean? His view, he said, was that investment means saving lives and preventing children from being born with a life-threatening condition—a difficult concept to oppose. This commitment must continue, but there must also be a critical evaluation of the issue and identification of the most effective approaches. He reminded the audience that although many lives were lost in the AIDS epidemic, a great many were saved. He agreed that it is vital to utilize limited resources effectively, but stressed that we must not back down just when we are about to win.

Charles Holmes introduced the debate topic. He said that it is important, given today's financial constraints, to establish a baseline, defining the HIV response as it exists today. The baseline consists of three elements: 1) scientific advances, including the recent findings that treatment is an effective form of prevention, 2) the billions of dollars spent and its outcomes, better care for people living with HIV, and strengthened health care systems, and 3) the diminishing costs of HIV programs, as well as the reduced costs of HIV infection now that treatment is more effective. He added that while the baseline is important, it does not answer the question—whether any health area should be protected in light of current resource restrictions. Some of the other questions to be answered include:

- Would it be more efficient to move away from disease-specific goals?
- Does funding for HIV divert funding from other investments?
- What criteria should be used to allocate funding?

Given the gains of the past decade, Holmes concluded, this is the right time to discuss these questions.

## Debate Proceedings

Moderator Richard Horton reminded the audience of the debate topic and asked of those present how many supported the proposition. The majority raised their hands with very few saying they opposed it. He then tossed a coin to determine which side would begin, with the first presentation going to those in favor of the proposition. The panelists then commenced an energetic debate touching the whole continuum of arguments for and against the proposition.

The four panelists each had eight minutes to present their arguments defending or opposing the proposition.

## Summary of the Two Sides

Two panelists spoke in defense of the proposition, pointing out that the increased investment in HIV has revolutionized service delivery, strengthened health care infrastructure in the developing world, and expanded access to treatment for AIDS-related illness and antiretroviral therapy on an unprecedented scale. They went on to say that the investment has brought about energetic synergies between local leadership and international assistance, resulting in a new development paradigm characterized by local “ownership” of the response to HIV. Further, they stated that increased funding for HIV has not detracted from support for other interventions, and that the perceived resource shortage is not a true shortage but a concentration of funds among specific individuals and arenas. The investment in HIV, they said, is a critical commitment for us as human beings and must continue.

Two panelists opposed the proposition on the basis that investment in HIV is not the most cost-effective intervention in the present economic environment. They pointed out a range of other interventions, such as vaccination, that evidence shows to be more effective at saving lives and much cheaper. However, many of these interventions are now underfunded because of the focus on HIV, they said, and people are now dying of preventable diseases. Furthermore, the single-disease focus fails to align with individual country priorities, thus constituting a kind of “aid colonialism,” a panelist said. The way forward, they believed, is to rebalance funding areas and take a broader approach focused on building primary health systems that can address HIV while also providing a range of affordable health and disease prevention services.

Following the final presentation, each panelist had two minutes to rebut arguments made during the debate. Once the rebuttals were complete, the moderator posed questions from the Preston Auditorium and International AIDS Conference satellite audiences. The questions were directed alternately at the defending and opposing teams. Each team had three minutes to answer each question, followed by a one-minute rebuttal from the opposite side. David Serwadda gave a summary of the debate and Ambassador Eric Goosby delivered the closing remarks.

## **Arguments Defending the Proposition**

The panelists who spoke in support of the proposition made the following key points.

### **Investment in HIV has revolutionized health services delivery and improved HIV treatment on a massive scale.**

A panelist defended the position by comparing the situation 15 to 20 years ago—when many countries were experiencing burgeoning HIV incidence and many initiatives to address the disease were inefficient and duplicative—with the greatly improved situation following the large global response to HIV at the turn of the millennium. Increased investment in improving services for HIV, he said, vastly expanded the size of the market for global health. In addition to increasing hospital space for all types of patients, rather than only critically ill AIDS patients, international agencies and their country partners strengthened their health systems overall and made it possible to implement innovative and effective approaches.

Further, the panelist said, investment in integrated HIV services brought AIDS out of isolation and into larger health and medical systems. Integration helped make HIV care a point of contact for addressing numerous issues that cause morbidity and mortality in the developing world, such as reproductive health, maternal health, tuberculosis, child health, and cancer. In the process, he added, HIV interventions strengthened public-private partnerships and enhanced the capacity of communities to build and use their own resources. Further, he said, AIDS became the tool for changing service delivery and scaling up to an unprecedented, undreamed-of degree—from 50,000 people on antiretroviral therapy to almost eight million.

### **The HIV pandemic, and the global response to it, have brought about a new development paradigm focused on country leadership and social change.**

The panelist emphasized the transformation in leadership affected by the epidemic, with country leaders taking action and seeking to transform their societies through their partnerships with the international community. He gave an example of Botswana's response, in which President Mogae and his cabinet sought to identify ways in which addressing HIV could lead to developments that would benefit Botswana's people more broadly than in terms of HIV alone. This discussion, he said, changed the nature of the AIDS debate and led to the expanded response to the pandemic. The increased international support allowed country leaders to build their health infrastructure—for example, in Ethiopia, which invested in educating health care workers and developing a national system for procurement.

But the changes, he went on to say, extended beyond medical and health issues. Addressing HIV presented a vast opportunity to address social justice and human rights. Without AIDS funding, he argued, the ongoing discussions about marginalized populations such as people who inject drugs, sex workers, and men who have sex with men (MSM) would be impossible. The involvement of MSM and young people, he added, is leading the AIDS response away from a disease-centered approach and toward a more humanistic, people-centered approach.

Thus the focus on HIV brought about a new narrative: not the old, obstinate paradigms of development but a new and positive paradigm, brought about by cross-sectoral collaboration, and leading to global solidarity. Country leaders now wish to own their response, he said, and to be participants in the global community

rather than passive recipients of aid. The synergy of country and international responses to the pandemic has brought about a profound result in terms of change, he concluded.

### **Investments in HIV have not detracted from other health investments.**

A panelist said that while many claim that HIV funding has taken needed resources from other areas, the facts contradict this. Child mortality has dropped at the fastest rate ever he said; maternal mortality is declining because of the infrastructure built through funds for combating HIV. A visit to the field, he said, clearly shows the changes brought about by the increased investment in HIV—the finest legacy of President George W. Bush, and achieved without “breaking a sweat” in budgetary terms.

### **Investments in HIV should continue because resources are not constrained.**

A panelist called the proposition “a bit of a sham” because, he argued, it is not a resource-constrained environment. He cited the trillions of dollars in offshore bank accounts, the vast sums spent on military operations, and the wealth available to citizens, especially the richest citizens, as evidence that resources are not constrained but are in fact abundant. The World Bank, he said, has recognized the availability of resources for fully responding to the HIV environment, and no longer adheres to the view common in the 1990s that resource constraints made it impossible to fund a comprehensive response. Economic analysis shows that what is needed, in terms of filling gaps in health financing for countries that lack the financial strength to do so, is approximately \$40 billion, including not just for HIV funding but for the full range of primary care systems. This is equivalent to 20 days of spending at the Pentagon, and less expensive than a year’s worth of recent United States expenditures on the war in Afghanistan. He cited a number of schemes that could be used to fund a further push to fill health service gaps, including:

- Receiving \$40 from each person in the rich world
- Obtaining one percent of the \$4.5 trillion net worth of the 1,226 billionaires on the Forbes list
- Instituting a financial transaction tax of two cents per \$100 from any transaction
- Extracting 20 cents from every \$100 in taxes.

The issue is an ethical and human one, the panelist said, when the poor die because their lives are not valuable enough to spend \$200 per person for clinical treatment. Globally, he concluded, we are at a crossroad: in a pause after 10 years of scale-up. It is the job of the HIV community, he said, to raise our voices clearly to say that we do not wish to live in a world where people are allowed to die needlessly.

## **Arguments Opposing the Proposition**

The panelists on the opposing side offered the following arguments:

### **Investment in HIV is not the most cost-effective option for many countries in the present economic environment.**

A panelist opposing the proposition said that while the fight against HIV has achieved significant accomplishments—prolonging the lives of millions, bringing eight million into treatment (6.2 million in Africa), and reducing the cost of HIV care—this does not answer the question of whether HIV is a sound investment for all countries. What is needed, he said, is to rebalance investments in HIV with other important and more cost-effective investments. He asked the audience to imagine being a Minister of Finance in a developing country today, with donor funding dropping off and export income diminishing because of the global economic crisis. This theoretical minister must determine how much to allocate for HIV among the many competing arenas that need to be funded—education, road-building, energy, and transport, among others.

When compared to other interventions, the panelist argued, investments in HIV are not cost-effective. The panelist cited the Disease Control Priorities Project, which is ranking the cost-effectiveness of 187 interventions in low- and middle-income countries. He cited the study's finding that malaria interventions could purchase 31 million life-years at \$7 per intervention; vaccination is a presently underfunded source of 13.5 million life-years at \$7 per life-year for each vaccination. Another underfunded option, he said, is prevention of maternal death, purchasing 15 million life-years at \$127 for every intervention—a rate that few HIV interventions can match even if superbly and efficiently managed. There are critical and cost-effective investments outside of the health arena: in Africa, 32 million healthy years of life can be purchased by investing in safe water and sanitation, and 7 million by investing in improved road infrastructure. These infrastructure improvements, he said, would need to be passed over or underfunded if investment in HIV continues at the present level.

Thus, he said, investment in HIV is not a sound option in all countries, especially those where infrastructure is significantly underdeveloped. Some countries, if they have established universal vaccination and access to safe water, may find investment in HIV more attractive, but those countries that need extensive infrastructure investment may need to focus their funding support there. Additionally, the panelist said, there are preventable diseases that cause more deaths than AIDS. Why are babies dying from malaria, diarrhea, and measles less important than those dying of AIDS? Going forward, there is a need to rebalance health funding, he said, and spend less of the available resources on HIV.

### **Costs for preventing HIV are not less than the cost of treatment and care.**

A panelist rebutted the idea that investments in preventing HIV are cost effective, for two reasons. First, investing in prevention for most other causes of morbidity and mortality is much more cost-effective than investing in HIV, with comparatively more lives saved for any given sum of money spent. So unless HIV is the only critical problem in a given country, spending on HIV may not be a good use of resources. Second, the statement would only be true, he said, if it could be shown that the investment prevents HIV in someone who would otherwise have contracted the infection. If the person would not have become infected, that investment is lost, he said, and that is what has happened. Over \$100 billion was spent on HIV over the past decade, he said, without a measurable effect on the rate of new infections. Since the mid-1990s, he said, new HIV infections have declined by 20 percent, and this rate is unchanged since the influx of the “big money” from bilateral investors, the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR, and others, starting in the early years of the millennium.

There are those, he said, who hope that spending on HIV will become more cost-effective with the identification of best practices. But, he asked, will increasing cost-effectiveness make HIV a sound investment? And a sound investment compared to what?

### **The focus on HIV has wasted money while reducing funding for other important, less expensive interventions.**

A panelist argued that the money invested in HIV was wasted on protecting the majority of people who would never have acquired HIV. The majority (99.6 percent) of the world's population does *not* have HIV. What \$16 billion in HIV funding annually has done, he said, was to create an “industry” that spans nongovernmental organizations, universities, United Nations agencies, and expensive HIV departments at all international agencies. UNAIDS, for example, costs \$500 million per year alone.

Funding for this growing industry, the panelist said, constrained the availability of support for other health issues and other areas, particularly the less expensive interventions, such as reproductive health and immunization. The result, he said, was a huge number of deaths (80-100 million children under five in that same decade) that could have been prevented with inexpensive interventions that were not funded, and a rise in previously declining fertility rates.

## **The emphasis of funding HIV fails to align with the priorities of individual countries.**

The focus on HIV, the panelist continued, distorted country budgets and left gaps in budgeting for other vital local issues. Some countries that receive HIV support need funding for other priorities that they view as much more important. Mozambique is an example, he said: the government wants to focus the budget on building systems, not on combating a single disease. Some countries in Africa received support for HIV that exceeded their entire health budget including domestic and aid-generated funds. This single-disease focus was pushed onto aid-receiving countries by donor countries—this is aid colonialism, he said, and it has created enormous inequities and wreaked havoc on already stretched health care systems. AIDS funding requires reporting cycles outside the country's normal budget cycles, which forces countries to expend additional hours developing reports for the convenience of the donor.

The panelist noted positive changes: for example, the new emphasis on strengthening systems, and the recognition of the need to integrate HIV within primary health systems and in alignment with country epidemiology. These new areas of emphasis, he said, should be part of the way forward.

## **Points Raised During the Rebuttal**

### **By Panelists Defending the Proposition**

- The description of African leaders as being in the grip of aid colonialism is not accurate: African leaders are not passive recipients, but leaders who want to transform their communities.
- HIV prevention delivers results that save money, and these need to be taken into account. Preventing mother-to-child transmission of HIV (PMTCT), for instance, is an effective intervention that costs \$150 per intervention—compared to more than \$300,000 in treatment costs if a child is born with HIV.
- Multiple global challenges are embedded in the Millennium Development Goals, and seeking these goals has brought about a decade of historic expansion of primary care—without trade-offs. Malaria mortality has diminished by 40 percent, maternal mortality by half, and child mortality in Africa has gone from 172 per 1,000 to around 120. The increase in spending has been justified and brought results.
- Investment in HIV and health systems is a matter of decency. This is why the HIV community needs to communicate clearly to the United States, the developed world, governments, and international agencies that continued investments will bear fruit, and that they are imperative because we are human.
- The progress made to date was possible because the HIV community overcame the voices of negative thinkers who claimed the funding was not available.

### **By Panelists Opposing the Proposition**

- Much of the wealth in the rich world—such as offshore accounts—is not available by any practical means, and the perception of resource constraints is accurate.
- There is a belief that integration makes HIV interventions more effective because the interventions become part of the broader health system. However, there are interventions that have been shown to save lives directly, while there are still no estimates for the cost of each life saved by an HIV intervention. Policymakers still need to allocate funding according to priorities and cost-effectiveness. Yes, PMTCT is effective. But would a Minister of Finance underwrite the \$150 per person needed for PMTCT, for example, in favor of immunization, which for the same amount could save the lives of 20 children?

- Aid cronyism is at work in the HIV industry, with powerful agencies and individuals influencing global priorities and funding in their own self-interests, from HIV departments in the offices of UNAIDS co-sponsors, to nongovernmental organization beneficiaries on the boards of funders, to politicians outdoing each other to look good and keep lobby groups cooperative. But the decision making should go on at the country level, and this is not the norm. Countries should be allowed to make their own decisions about what issues should be prioritized for funding.
- For countries to determine their own priorities, they need flexibility rather than disease-specific funding determined by the donors. And determining priorities will entail making difficult choices about allocating funding to address a range of issues that may or may not include HIV.

## **Key Themes Covered During the Question-and-Answer Session**

### **How can the issue of HIV investment be framed to increase support from donors and wealthy citizens and countries?**

A debater from the defending side advocated for wider resource sharing with the goal of building better societies. He noted that HIV investment is also a security measure. Helping the 15 million children orphaned by AIDS, for example, will not only help them to be productive members of society. It will keep them from being street children, child soldiers, and tools of extremist groups. The investment, then, is not only for those affected by HIV, but for ourselves: a way to build a livable society for each of us. This is impossible without investments in health; and it is naïve to cut off investments in HIV thinking that the disease will not touch us.

A panelist from the opposing side agreed with the idea that sharing resources would be a part of the way forward. Resources need to be shared to build both developed and developing societies. The boost in AIDS funding has given the world a model of how combining resources can strengthen countries, the panelist said. He added, however, that much more could be done with allocating health expenditures appropriately, and that there are concrete examples of interventions that have proven more successful than HIV interventions. It is important to build on those successful interventions and advocate more vigorously for better and more inclusive performance throughout the entire health system.

### **When is funding for HIV is too high relative to funding for other issues?**

A panelist for the opposing team said that funding decisions should be made at the country level through democratic processes. Ultimately the countries are the ones to decide what their priorities are.

A panelist on the defending side added that he felt the Global Fund to Fight AIDS, Tuberculosis and Malaria should be renamed as “the Global Health Fund.” The ultimate goal should be a primary health system that that can also address HIV. Such systems should be capable of protecting children’s health, helping mothers to survive, preventing mother-to-child transmission of HIV, and treating ill people, who would otherwise die, with the many drugs that are becoming available for ever-lower prices; building these broad systems should be a function of the Global Fund. He emphasized that advocacy—“our voice”—makes a difference: changes in the past decade are due to the massive influence wielded by science-based advocacy.

### **Should governments be held accountable for corrupt practices?**

A panelist from the defending side answered that there needs to be systems, transparency, and accountability—and when paths of funding use are unclear, the support should stop. Corruption exists

throughout the world and in all financial systems, and the best way to fight it is to ensure transparency and accountability and systems to monitor performance. There is also a need to examine the financial distribution system in developing countries—making sure that money intended for a specific purpose is available for that purpose.

A panelist on the opposing team mentioned cash on delivery as an important and underused instrument of compliance—for example, not focusing on the mechanism used, but paying \$100 per AIDS case averted. The other panelist on the opposing team said that corruption is not a “game changer”; it is likely to continue, but is not especially worrisome.

### **Why oppose the increase in HIV funding, through which the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR, and other donors has infused tens of billions of dollars into improving health systems?**

A panelist for the opposing team said that it was impossible to say what would have happened without these organizations and their investment in HIV. Health aid was increasing in the 1990s, he said, but many areas of funding were cut off when funding was diverted to a single disease. Yes, the Global Fund to Fight AIDS, Tuberculosis and Malaria can say that millions of lives were saved, the panelist said, but investment in different diseases or prevention measures might have saved millions more lives.

A panelist on the defending team said that saving lives is more complex than simply taking a dollar from one place and putting it elsewhere. There is a gap of \$7 billion, he said, that is killing millions of people who could have had access to treatment, and if we do not fund measures to close that gap now, we will pay forever.

### **Why not invest in education, which evidence shows is a “social vaccine” against HIV? The United Nations Educational, Scientific and Cultural Organization (UNESCO) estimated that \$16 billion a year would give all children access to education.**

A panelist on the defending side said that investment is not an either/or proposition. World leaders agreed a dozen years ago that a comprehensive approach is needed to fighting poverty, and understands that poverty is about income, hunger, exclusion, maternal mortality, education, water and sanitation, and HIV, tuberculosis, and malaria among other killer diseases. The world’s accepted framework, the Millennium Development Goals, does not pose these either/or questions. It is a false choice to say we need to choose between vaccination and HIV prevention, he said; we can do it all, and it is affordable. We should tell the truth about money and the resources needed and respect the commitments made per the Millennium Development Goals.

A debater on the opposing side underlined the importance of education, saying that half the decline in child mortality was linked to the amount of time girls spend in education, which has tripled. Yet one-third of United States funding for international aid is for HIV.

### **The arguments against the proposition are general: What would you like to cut?**

A panelist on the opposing side said that he would cut funds going to community AIDS groups and local nongovernmental organizations, and all of the funding for UNAIDS. To the moderator’s comment that civil society’s response has driven the response to HIV, the panelist responded that while he respected the work done on raising consciousness about HIV, the coming decade’s work will require a broader outlook, rather than a focus on HIV.

## **Wasn't it wasteful to spend money on HIV in the 76 countries where homosexuality is illegal?**

A speaker defending the proposition responded that in these countries, it is essential to vigorously advocate for including criminalized groups in efforts to combat HIV. Not to do so would mean failure, not only because the “criminal” group will not have access to care, but because of the effect of such neglect on societies. He cited Eastern Europe, Central Asia, and the Middle East, with the world’s fastest-rising incidence of HIV at present. Reducing stigma and decriminalizing the behavior of high-risk groups, he said, is the way to arrive at the end of the road in the epidemic.

A speaker from the opposing side wondered whether MSM would have advocated so passionately on HIV if the funding were not available. The defending panelist replied that the work of MSM had been a major part of the progress of the HIV movement and that it is unethical at the very least to prevent them from accessing services.

## **Debate Summary**

David Serwadda, Professor of Disease Control at Makerere University in Uganda and former Dean of its School of Public Health (and also one of the first Ugandan researchers to recognize AIDS in Uganda), thanked the debaters for what he described as an exciting, informative, and powerful debate. He summarized some of the important points made by those defending and opposing the proposition:

- Leadership combined with the strong investment in HIV have created a demand for services and energized communities.
- People must be at the center of the HIV response.
- The dynamic response to HIV by countries and communities has overturned the old view of developing countries as passive recipients of aid. Recognition by international donors that Africans and those in other developing countries can provide their own care and manage their medication is critical and important in terms of development. Mobilizing leadership in resource-constrained countries will be important as we move forward.
- Resources are not as constrained as we may believe; additional resources can be generated by using innovative approaches.
- There is a need to balance investments in HIV with other cost-effective and life-saving investments—focusing on vaccinations and preventable diseases, for example.
- Aid colonialism returns a poor value; countries should develop their own priorities for funding.

Serwadda cited three principles to focus on moving forward:

- Emphasizing value for money—investing in interventions that are known to be cost-effective
- Promoting country ownership of the response to HIV
- Improving government accountability for the use of investments in HIV and health, in part by empowering communities to demand accountability.

## **Debate Closing**

Ambassador Eric Goosby, U.S. Global AIDS Coordinator, spoke about the enormous progress in terms of making the best use of available funds. PEPFAR has determined ways to double the number of people in treatment, reduce transportation costs, and improve distribution. Secretary of State Clinton, he said,

described the road ahead: building on the platform created by the global response. The infrastructure for responding to people who need HIV treatment is there; HIV has become an outpatient condition, but it is critical to also address the wider range of health needs, he said. The goal is to provide treatment to 60 to 80 percent of those living with HIV, and to develop systems to keep them in treatment. He added that President Obama and Secretary Clinton remain fully committed to the response begun in the early 2000s. This is an ethical commitment and we cannot pull back; we will continue, he said.

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**AIDSTAR-One**

John Snow, Inc.

1616 Fort Myer Drive, 11th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

Email: [info@aidstar-one.com](mailto:info@aidstar-one.com)

Internet: [aidstar-one.com](http://aidstar-one.com)