Billions of pounds are being spent on the fight against AIDS in developing countries. **Roger England** believes that much of the money could be better used elsewhere, whereas **Paul de Lay and colleagues** argue that current spending is not enough

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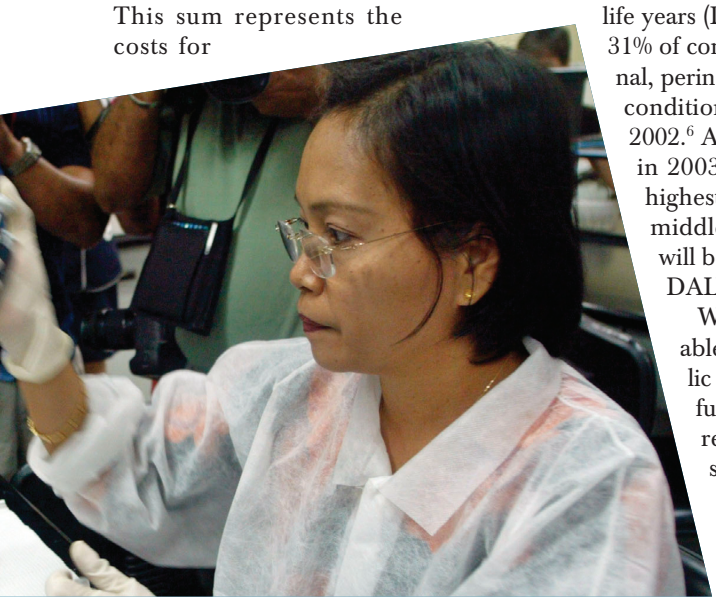
NO AIDS is widely acknowledged as a public health crisis and is now one of the make or break forces of this century, as measured by both its actual effect and potential threat to the survival and wellbeing of people worldwide.[1] In 2005, the *UN Human Development Report* concluded that "the AIDS pandemic has inflicted the single greatest reversal in human development."[2] In that year, AIDS caused a fifth of deaths globally in people aged 15-49 years. Within the next five years, every seventh child in the worst affected sub-Saharan countries will be an orphan, largely because of AIDS. By 2010, an estimated 9 million people will need antiretroviral treatment.[3]

Unmet need

Much has been done to raise awareness and resources. However, the Joint United Nations Programme on HIV and AIDS (UNAIDS) estimates that resources currently pledged are only half what is needed for a comprehensive response. In 2006, $9bn (£4.6bn; €7bn) was available for the AIDS response but the real need was estimated at $15bn.[4] This sum represents the costs for prevention, treatment, and support services; human resources; and infrastructure. The bulk of the funding is additional to amounts spent on other aspects of health development.



Resources are woefully short in almost every area of public health in low and middle income countries. HIV funding should provide an opportunity and entry point for strengthening health and social service systems if it is used appropriately. For example, large amounts have been spent on laboratory networks, universal precautions, blood bank safety, and safe injections, as well as focusing on the wellbeing and training of health workers, doctors, and nurses and not only those working in AIDS.

In 2003, the total health expenditure in high income countries was $3.3 trillion, while in low and middle income countries total health expenditure was $427bn.[5] The percentage spent on HIV from all sources including donors, governments, international foundations, and affected people was just 1.1% of these health expenditures in low and middle income countries.

The resources spent on HIV must be proportionate to the overall disease burden, adjusted by deferred disease and mortality that will result from the current HIV prevalence. Recent estimates by the World Health Organization of the disability adjusted life years (DALY) indicate that 31% of communicable, maternal, perinatal, and nutritional conditions were attributable to HIV in 2002.[6] As a sign of this increasing trend, in 2003 HIV accounted for the third highest amount of DALYs in low and middle income countries. By 2030 it will be the third highest contributor of DALYs globally.[7]

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We urgently need stable, predictable, international funding for public health and development. Volatile funding flows from donors, often reflecting priorities that are not shared by national governments, make it difficult to implement national plans. Many countries are reluctant to include these uncertain future revenues in the national planning systems. In addition to ensuring predictable and sustainable international funding, greater efforts are needed to make sure that countries that are able to do so invest more of their own money in AIDS and health in general. Currently around one third of the total AIDS spending is from domestic sources.

Multisectoral response

HIV is a development problem with multisectoral causes and effects. It therefore requires a similar response, with many components lying outside the health sector. A large proportion of funding, especially for prevention, is actually for activities outside the health sector. Some of these activities tackle social issues that underlie vulnerability to HIV infection. HIV is highly stigmatised in many countries, often affecting marginalised populations such as injecting drug users, sex workers and their clients, men who have sex with men, migrants, and mobile populations. Both donors and governments are often reluctant to commit resources to help people whose activities may be subject to social disapproval.

Poor coordination between different stakeholders in affected countries impedes effective spending. The problem is compounded by weak institutions and regulatory policies, poor governance, and in some cases corruption. UNAIDS is promoting the principle of a single, country owned strategic plan coordinated by a single national authority, with an integrated system for monitoring and evaluation.

The response to AIDS needs to be seen in the context of international commitments to the millennium development goals, which also call for progress across many other development priorities. HIV threatens many of these goals, especially those related to poverty and health. The cost of inaction against AIDS is huge, far greater than for any other public health crisis. Current costs are so high because of the inadequacy of previous investments. They will be higher tomorrow if we continue to underinvest.

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References are in the full version on bmj.com