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A PANDEMIC TRIAD

HIV, COVID-19 and debt
in developing countries



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EXECUTIVE SUMMARY

This briefing assesses the impact that the pandemic triad of the AIDS and COVID-19 pandemics and the debt crisis will have on health- and HIV-related funding in developing countries.¹ It outlines how the limitations of global initiatives that focus on health, emergency financing and debt have hampered the capacity of developing countries to respond effectively to the ongoing health and socioeconomic emergencies. From COVAX to the mobilization of multilateral financing—including International Monetary Fund (IMF) Special Drawing Rights, international financial institution financing and official development assistance—to the G20 Debt Service Suspension Initiative (DSSI) and Common Framework for Debt Treatments Beyond the DSSI (the Common Framework), these initiatives have failed to provide developing countries with enough support to protect the health of their populations.



Findings

In particular, this briefing outlines the following:

- **The gaps left by the multilateral response are allowing the AIDS and COVID-19 pandemics to continue, putting past gains at risk.** Insufficient funding to support pandemic responses has direct implications for the capacity of national authorities to test, track and contain the spread of HIV and COVID-19.
 - In the case of the **AIDS pandemic**, more than 26 million people are living with HIV in developing countries, and nearly two thirds of them live in countries that have not received debt relief in the context of the health and fiscal crises of the pandemic triad. This situation risks undermining the progress made in the HIV response over the last decades. For instance, while the HIV incidence–prevalence ratio has dropped to 3.4% in developing countries, it is still above the 3% goal for ending the AIDS pandemic. Furthermore, only 58.6% of people living with HIV have access to antiretroviral therapy, which is well below the 95% target in the 95–95–95 targets.² Reprioritizing resources in the context of the current COVID-19 pandemic might lead to a deterioration of both indicators, derailing efforts to end the AIDS pandemic by 2030.
 - A lack of resources for the COVID-19 pandemic is limiting the capacity of authorities in low- and lower-middle-income countries to track and contain the virus. This is apparent in the substantially lower COVID-19 caseloads in these countries compared to the higher numbers documented in upper-middle-income countries. It is also apparent in the vaccine apartheid that is hampering the global COVID-19

Decades of progress made towards reducing poverty and hunger and improving education and health outcomes have been eroded over the last 24 months

¹ This report will use “pandemic triad” to refer to the converging and colliding crises of the AIDS and COVID-19 pandemics and debt in developing countries.

² The 95–95–95 targets, set by the United Nations in 2021, are for 95% of people living with HIV to know their HIV status, 95% of people who know their HIV-positive status to be accessing treatment and 95% of people on treatment to have suppressed viral loads.

response: while developed countries have fully vaccinated 67.4% of their population on average, only four developing countries (of 126 countries that have data) have vaccination rates that are equal to that or higher. Containing the COVID-19 pandemic is not possible unless the necessary resources—notably vaccines—are made available.

- **The capacity of governments to protect their populations has been hampered by the heavy debt burden faced by most developing countries.** On average, public debt levels in middle- and low-income countries rose from 55% to 63.8% of GDP between 2019 and 2020. The most vulnerable countries have been disproportionately affected by these rising and unsustainable debt levels: average public debt levels for 44 developing countries participating in the G20 DSSI rose from 39.6% to 66.3% of GDP between 2011 and 2020. At the end of 2020, 25 of these countries faced solvency problems, with public debt levels above 55% of GDP.



On average, public debt levels in middle- and low-income countries rose from 55% to 63.8% of GDP between 2019 and 2020

- This is significant, because higher debt levels limit the resources available for health budgets. Among G20 DSSI-participant countries, it is estimated that for every 10 dollars of government revenue, four were allocated to debt service and only one to health in 2020. In total, 37 of these countries spent more resources on debt service than health in the context of the COVID-19 pandemic in 2020.

- While G20 DSSI participant countries undertook a gargantuan effort to increase health expenditure during the COVID-19 pandemic, it was not enough to overcome structural underinvestment in the health sector. Their health expenditures rose on average from 1.5% to 2.2% of GDP between 2019 and 2020. This category of spending increased in 32 countries, remained constant in three and declined in another four. Using the Abuja Declaration as a benchmark for health funding gaps, it is possible to place these changes in context. The increase in health expenditure triggered by the pandemic helped reduce the financing gap across countries from 2.1% to 1.7% of GDP between 2019 and 2020, and the funding gap declined in 26 countries (although it increased in another 12). Thus, while the increase in health expenditure triggered by the COVID-19 pandemic is a positive development, it is not large enough to overcome the structural underinvestment in the health sector that characterizes the situation in most DSSI-participant countries.

- **Closing the health funding gap post-COVID-19 is a daunting task.** Fiscal consolidation, with a heavy emphasis on expenditure cuts, is expected to take place across 139 countries in the coming years. In the case of DSSI-participant countries, primary expenditures are expected to decline an average of 2.8% of GDP between 2020 and 2026, and primary expenditures are projected to decline in 34 countries. This process of fiscal consolidation will undoubtedly affect health expenditure. Avoiding this outcome will require a systemic reprioritization of public resources towards health, particularly HIV programmes.
- **One such type of reallocation involves shifting resources away from debt payments towards health.** It will not be possible to end the COVID-19 and AIDS pandemics as long as DSSI-participant countries

devote up to four times as many resources to debt service as they do to health. To close the Abuja Declaration health funding gap would have required these countries to reallocate, on average, 57% of their debt service to health expenditure in 2020. This figure shows that the amount of debt relief provided to countries under the G20 DSSI and Common Framework has been clearly insufficient given the magnitude of the COVID-19 pandemic.



Policy recommendations

The briefing makes three main policy recommendations.

1. There is an urgent need to strengthen the multilateral response in order to provide developing countries with adequate support in the context of the COVID-19 pandemic. This includes a reallocation mechanism for IMF Special Drawing Rights, combined with increased concessional financing from international financial institutions and official development assistance.
2. Developing countries need support to tackle unsustainable debt burdens. A failure to do so would encourage shifting resources away from pandemic responses towards debt repayments. Ambitious targets of debt relief, including outright cancellation, are required.
3. Inclusion of health expenditures and financing requirements to end the AIDS and COVID-19 pandemics must be a central consideration when providing multilateral financing and implementing debt relief initiatives, including the G20 Common Framework for Treatments Beyond the DSSI.

Ultimately, addressing the pandemic triad and ending the AIDS and COVID-19 pandemics requires an immediate collective effort. No one is safe until everyone is safe.

Networks led by young people in Cambodia, India, Viet Nam and the Philippines distributing COVID-19 prevention packs and information, education and communication materials on HIV prevention and leading training sessions on mental health awareness © UNAIDS Photolibary

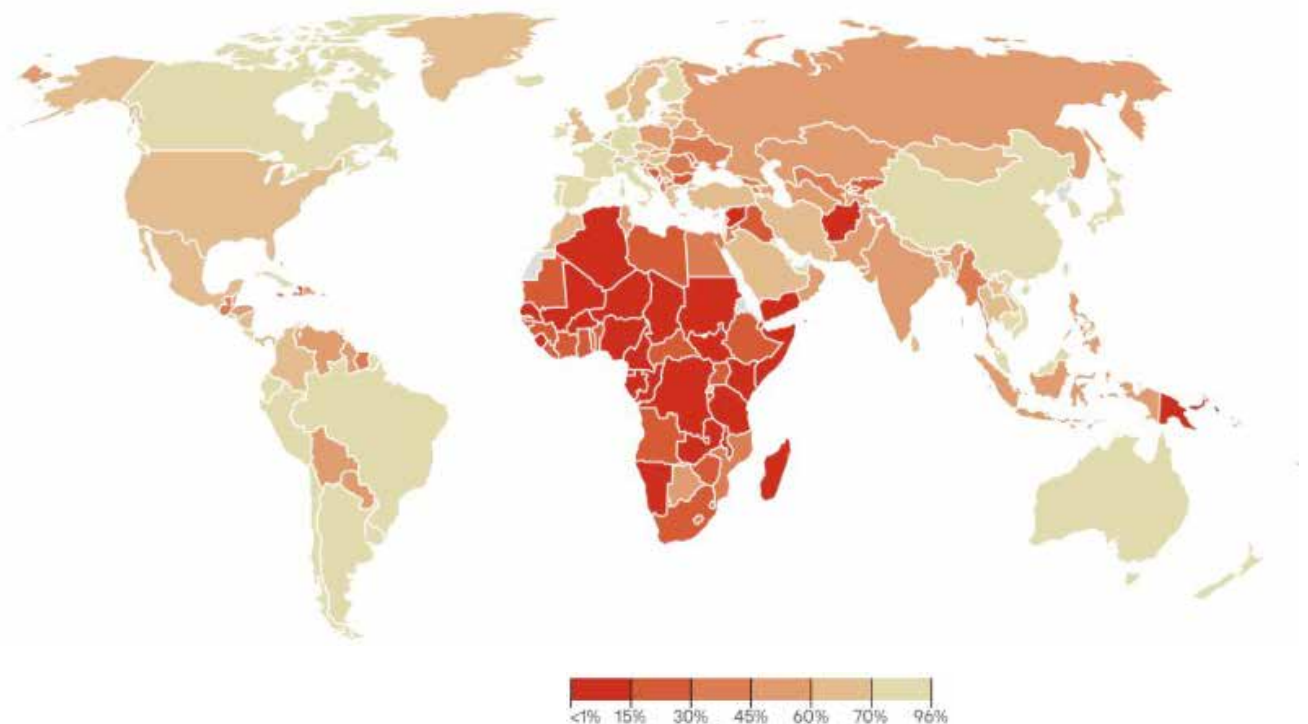


INTRODUCTION

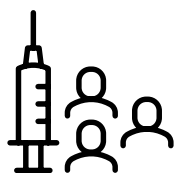
The COVID-19 pandemic has created an unprecedented developmental setback: decades of progress made towards reducing poverty and hunger and improving education and health outcomes have been eroded over the last 24 months (1). The impacts of the COVID-19 pandemic have been distributed unevenly, further increasing the stark inequalities of our global society (2). In September 2021, the United Nations called for 70 per cent of the global population to be vaccinated by mid-2022. Six months on, the world is nowhere near reaching that target. While 64.5% of the world population has received at least one dose of a COVID-19 vaccine, only 14.5% of people in low-income countries have received at least one dose. This means that 2.8 billion people around the world are still waiting to get their first shot. As Figure 1 shows, inequalities in COVID-19 vaccination rate between developed and developing countries worsen when we consider the share of the population that is fully vaccinated.

A lack of resources for the COVID-19 pandemic is limiting the capacity of authorities in low- and lower-middle-income countries to track and contain the virus

FIGURE 1 | PERCENTAGE OF POPULATION FULLY VACCINATED, AS OF 30 MARCH 2022 OR LATEST AVAILABLE DATA



Source: Our World in Data (4).



Of the more than 10 billion doses administered worldwide, only one per cent have been administered in low-income countries

Developed countries have deployed generous stimulus programmes equivalent to 9.7% of gross domestic product (GDP) and quickly rolled out vaccination schemes that have achieved an average of 71.75% vaccination coverage of their populations (3, 4).³ Meanwhile, middle- and low-income countries have been left to fend for themselves. Of the more than 10 billion doses administered worldwide, only one per cent have been administered in low-income countries. A lack of adequate multilateral support, high debt levels and fiscal constraints have limited the size of the stimulus packages in middle- and low-income countries: the fiscal response to the pandemic in these country groups averaged 5.5% and 3.3% of GDP, respectively, in 2020 (3). Only 15.23% of people in low-income countries have been vaccinated with at least one dose (4). Averages mask the magnitude of the vaccine apartheid. For example, the share of people vaccinated against COVID-19 varies by a factor of 94 between the Democratic Republic of Congo (0.92%) and Canada (86%). This is not the way to end pandemics.

The global dynamics of inequality exacerbated by COVID-19 have also been reproduced at the national and local levels. Vulnerable groups facing one or more socioeconomic challenges—including poverty, hunger, labour informality and lack of access to quality public education and health care—have been the most affected by the ongoing crisis (5). The 38 million people living with HIV in the world are one such highly vulnerable and affected group (6). The overlap of heightened health risk factors with limited access to the health care and medicines they need—and the reduced availability of public resources to finance those things—represents an existential threat to those living with HIV, potentially resulting in a projected 7.7 million AIDS-related deaths over the next decade (7–10). The nature of this threat highlights how the full protection of the lives and human rights of the most vulnerable among us should not be considered an outcome of ending the COVID-19 and AIDS pandemics, but rather a precondition to that achievement (11).

The capacity of most developing countries to meet these goals has been hampered by the heavy debt burden they face (12). On average, public debt levels in middle- and low-income countries rose from 55% to 63.8% of GDP between 2019 and 2020 (13). This is a staggering increase, the equivalent to US\$ 2.3 trillion (13). Payments on these debts shift resources away from guaranteeing the full enjoyment of economic, social and cultural rights of people across the globe (14). Prioritization of creditor claims over people's rights also has a negative impact on the provision of public services, including health, which has a disproportionate impact on vulnerable groups (15). This places people living with HIV at the intersection of the myriad negative consequences of the pandemic triad of HIV, COVID-19 and debt.⁴

Against this background, this briefing provides an assessment of the impact that the pandemic triad has had on health- and HIV-related financing in developing countries. The additional impacts of the Ukraine crisis are not considered in this report. The analysis focuses on developing countries that were eligible to participate in the G20 Debt Service Suspension Initiative (DSSI) between 2020 and 2021 (16). This focus is a result of up-to-date fiscal and debt figures for these countries from the International Monetary Fund (IMF) and the World Bank (17).

The briefing highlights how debt distress and the ensuing fiscal constraints across countries limit people's access to treatments and vaccines for HIV and COVID-19, violating their rights—such as their right to health and the right to

3 Vaccine coverage as of 30 March 2022.

4 This report will use "pandemic triad" to refer to the converging crises of the AIDS and COVID-19 pandemics and debt in developing countries.

life. It includes three main policy recommendations:

1. There is an urgent need to strengthen the multilateral response in order to provide developing countries with an adequate level of support in the context of the COVID-19 and AIDS pandemics. This includes a reallocation mechanism for IMF Special Drawing Rights (SDR), combined with increased concessional financing from international financial institutions and official development assistance.
2. Developing countries need support to tackle unsustainable debt burdens; failing to do so would shift resources away from pandemic responses towards debt repayments. Ambitious targets of debt relief, including outright cancellation, are required.
3. Including health expenditures and financing requirements to end the AIDS and COVID-19 pandemics must be a central consideration when providing multilateral financing and implementing debt relief initiatives, including the G20 Common Framework for Treatments Beyond the DSSI (18).

The first section of this briefing provides an overview of these multilateral responses and the impact of the AIDS and COVID-19 pandemics in developing countries. The second section looks at the impact of these crises on public debt and health expenditure, including HIV expenditures in G20 DSSI countries. The third section highlights the role of debt relief in closing the health funding gap after COVID-19. The final section provides policy recommendations.



Developing countries have either been provided with insufficient support or left out altogether from multilateral assistance



MULTILATERAL RESPONSES AND THE IMPACT OF THE AIDS AND COVID-19 PANDEMICS IN DEVELOPING COUNTRIES

The multilateral response to the COVID-19 pandemic has not matched the magnitude of the crisis (19). Developing countries have either been provided with insufficient support or left out altogether from multilateral assistance (9, 56, 60). This is a key factor that explains to a large extent the uneven recovery observed over the last year: the global economy is in effect being built back separately, leaving the most vulnerable behind (20). There are diverging recovery paths with large disparities in the ability to build out public investments.

Relevant global initiatives have focused on the areas of health, emergency financing and debt. Their limitations have hampered the capacity of developing countries to respond effectively to the ongoing health and socioeconomic emergency. The initiatives include:

- **Health initiatives through the Access to COVID-19 Tools (ACT) Accelerator.** Created in April 2020, the ACT Accelerator is a global collaboration to accelerate the development and production of COVID-19 tests, treatments and vaccines, and to facilitate equitable access to them (21). Its most important pillar is the COVID-19 Vaccines Global Access Initiative (COVAX). COVAX aims to ensure that people across the world, regardless of their wealth, can access COVID-19 vaccines once they are available (22). Developed countries pledged to provide 1.8 billion vaccines for distribution in middle- and low-income countries by the end of 2021 (23). As of December 2021, however, only 601 million doses—one third of the original goal—had been delivered to 144 countries (24). Failure to meet the established pledges and a lack of support for suspending intellectual property rights have created a vaccine apartheid: nine out of 10 people living in the poorest countries missed out on a COVID-19 vaccine in 2021 (25).
- **Emergency financing initiatives, including a general allocation of IMF SDRs, financial assistance by international financial institutions and a modest increase in official development assistance.** A general allocation of IMF SDRs provided Member States with US\$ 650 billion in additional liquidity in August 2021 (26). In the meantime, the IMF, World Bank and multilateral development banks supplied US\$ 317 billion in financial assistance to developing countries between April 2020 and October 2021 (27).⁵ To complement multilateral financing, developed countries from the Organization for Economic Cooperation and Development (OECD) provided a total of US\$ 161 billion in official development assistance in 2020 (28). While these steps have mobilized substantial amounts of resources in absolute terms, their shortcomings become evident when placed in a broader context:

⁵ This figure excludes IMF undrawn flexible credit lines.

- Of the IMF SDR allocation, 67%—equivalent to US\$ 438 billion—accrued to developed countries (26). The remaining 33%—equivalent to US\$ 212 billion—was provided to developing countries. There currently is no agreement on how to ensure the urgent mobilization of SDRs provided to developed countries (29). For instance, China has indicated that it intends to recycle 25% of its SDR allocation to Africa alone, and France, Spain and Italy have indicated similar commitments to developing countries (20% each) (61). Belgium and the Netherlands, however, have only indicated they will recycle 4%, and other European nations have not made any commitments at all. Failing to redeploy unneeded SDRs to where they are most needed creates a situation akin to that of the 100 million unused and expiring COVID-19 vaccine stockpiles in developed countries: they are sitting idle while being desperately needed elsewhere (30).
 - Financial assistance by international financial institutions represents less than half of the US\$ 649 billion that developing countries paid in debt service to their public external creditors, including multilateral institutions, between 2020 and 2021 (31).⁶
 - OECD countries continue to fail to meet their official development assistance commitments: while they have pledged to provide 0.7% of their gross national income (GNI) to aid, official development assistance in 2020 was less than half of the established commitment (an average of 0.32% of GNI). If OECD countries had met their commitments, developing countries would have received an additional US\$ 155 billion in financial support (20).
- **Debt initiatives, including the establishment of G20 DSSI and the G20 Common Framework.** The G20 DSSI was established in May 2020. It allows the temporary suspension of debt service on external public debts owed to bilateral creditors by a group of 73 low- and lower-middle income countries. As of June 2021, 47 countries were able to suspend debt payments worth US\$ 10.3 billion (17). This represents less than 10% of the US\$ 104 billion paid in external public debt service by DSSI-eligible countries between 2020 and 2021 (32).⁷
- The G20 Common Framework was announced in October 2020. Its purpose is to provide debt treatments to DSSI-eligible countries that are at high risk of debt distress beyond the DSSI (33). Three countries—Chad, Ethiopia and Zambia—have applied to the Common Framework, but none of them had received debt relief as of December 2021.
 - It is increasingly clear that the G20 DSSI and the G20 Common Framework have not delivered on their initial promise. This is the result of a series of structural problems common to both initiatives (34). They were agreed by the G20 without participation from eligible developing countries. As such, there is no mechanism for ensuring the participation of external commercial and multilateral creditors. Similarly, middle-income countries in debt distress are not eligible to participate. Without measures to address these problems, developing countries at risk of debt distress may experience an economic collapse (35).

6 Figure is for middle- and low-income countries, excluding China.

7 Estimation for eligible countries.

— The gaps left by the multilateral response provide a useful lens for exploring the impacts of the pandemics in developing countries. More than 26 million people with HIV live in developing countries (Figure 2).⁸ Nearly two thirds of them are in countries that have not received debt relief in the context of the COVID-19 pandemic. An estimated 13.4 million live in a group of 65 middle-income countries that are not eligible to participate in the G20 DSSI due to their income classification (listed as “non-DSSI” in Figure 2). A further 2.6 million people live in 24 countries that are eligible to participate in the G20 DSSI, but which declined to do so (listed as “DSSI eligible” in Figure 2).

⁸ Estimates for population (aged 15 to 49 years) are based on the World Bank World Development Indicators for 2021 and the UN Department of Economic and Social Affairs population database. Due to data limitations, the estimate does not include China.

The remaining 10.5 million people living with HIV reside in 47 countries that have benefited from the debt suspension offered by the G20 DSSI (listed as “DSSI participant” in Figure 2). Most of the people living with HIV in this last group—equivalent to 7.7 million individuals—are concentrated in a group of seven countries: Ethiopia, Kenya, Malawi, Mozambique, Uganda, United Republic of Tanzania and Zambia. Debt service on external public debt for this group amounted to US\$ 19 billion between 2020 and 2021. Despite the

FIGURE 2 | DISTRIBUTION OF POPULATION WITH HIV IN DEVELOPING COUNTRIES, BY G20 DSSI ELIGIBILITY AND PARTICIPATION, MILLIONS OF PEOPLE AGED 15 TO 49 YEARS, 2020



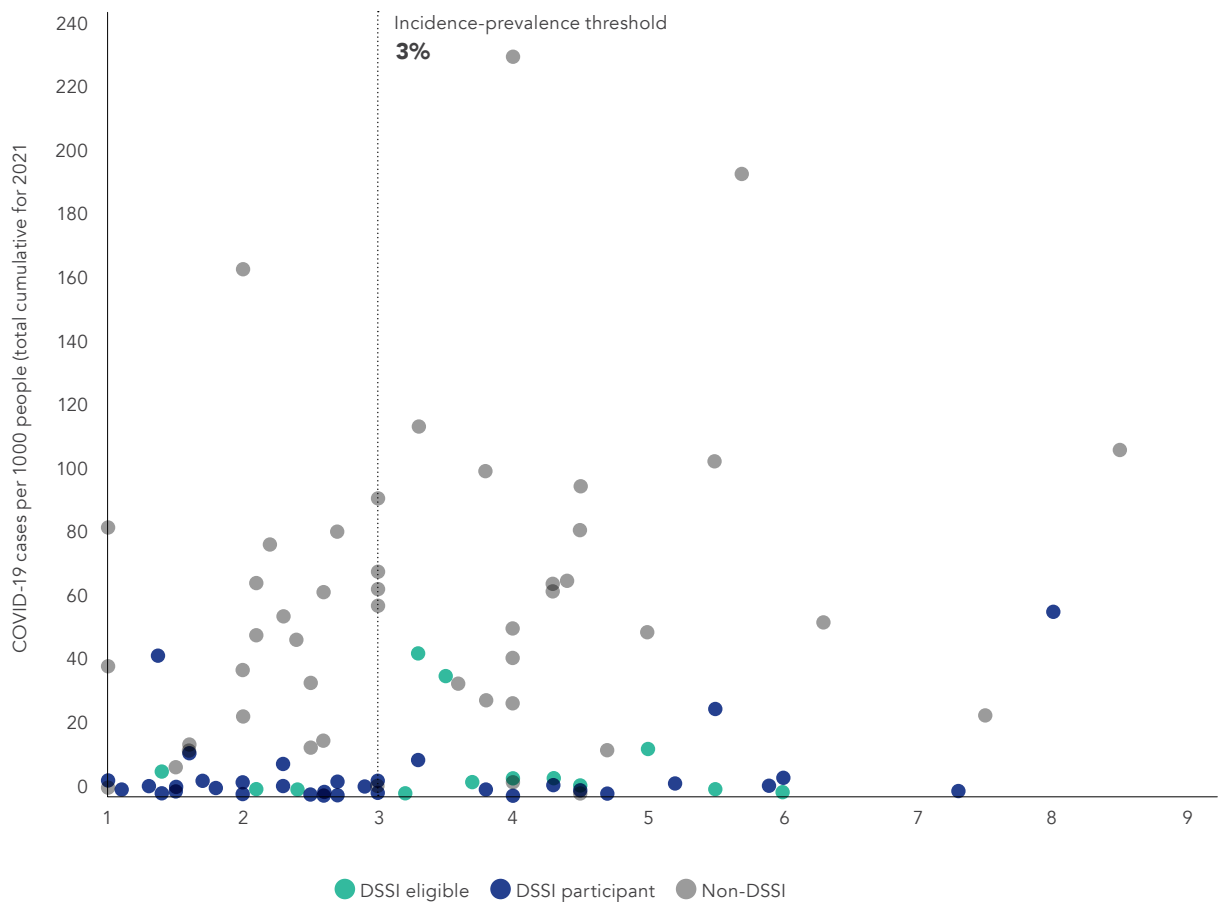
Inner ring: Country grouping | Central ring: Countries | Outer ring: People living with HIV (in millions)

Source: World Population Prospects. 2019 Revision [database]. New York: United Nations (<https://population.un.org/wpp/>); World Development Indicators [database]. Washington (DC): The World Bank Group; c2022 (<https://databank.worldbank.org/reports.aspx?source=world-development-indicators>).

need to prioritize resources towards protecting vulnerable populations in the context of COVID-19—including those living with HIV—the G20 DSSI only allowed a suspension of 6.8% of total external public debt payments, equivalent to US\$ 1.3 billion (17). This once more illustrates the shortcomings of the multilateral response.

Insufficient funding to support pandemic responses has direct implications for the capacity of national authorities to test, track and contain their spread. An analysis of the reported HIV and COVID-19 cases across developing countries illustrates the extent of the problem. Figure 3 shows the HIV incidence–prevalence ratio (IPR) and the number of cases of COVID-19 per 1000 as a measure of the impact of the respective pandemics on the local population. The IPR is the number of new HIV infections occurring per year in a population, divided by the number of persons living with HIV in that same population (36). This indicator is used as a measure of the HIV response’s progress towards epidemic control: the total population of people living with HIV will gradually fall if a country is below a 3% benchmark (37). The colour of the dots signifies country eligibility and participation in debt relief under the DSSI.

FIGURE 3 | HIV INCIDENCE–PREVALENCE RATIO AND COVID-19 TOTAL CASES PER 1000 PEOPLE, DEVELOPING COUNTRIES, 2021



Source: World Population Prospects. 2019 Revision [database]. New York: United Nations (<https://population.un.org/wpp/>); World Development Indicators [database]. Washington (DC): The World Bank Group; c2022 (<https://databank.worldbank.org/reports.aspx?source=world-development-indicators>).



Without a concerted effort to accelerate vaccination efforts across the world, the costs of containing the COVID-19 pandemic are set to increase substantially over time as a result of the development of variants and the impact of lockdown measures

An assessment of these indicators at the country group level serves to highlight two elements.

1. The improvement in the HIV IPR observed in recent years has been resilient, continuing despite the pressures associated with the COVID-19 pandemic (37). The IPR for non-DSSI, DSSI-eligible and DSSI-participant countries stands at 3.4%, 3.6% and 3.2%, respectively. This remains close to, yet slightly above, the 3% benchmark. However, the positive evolution at the aggregate level masks substantial dispersion at the country level: while 51 countries are below the 3% IPR benchmark, 13 countries have an IPR above 5%. This second group of countries seems to be experiencing difficulties containing HIV.⁹
2. There is a stark difference in the reported COVID-19 cases between non-DSSI, DSSI-eligible and DSSI-participant countries. While the total number of cases per 1000 people has reached 59.6 in the former group, the reported figures for the latter are 9.6 and 5.6, respectively. This difference has been linked to factors such as age demographics and local experience in tackling infectious diseases, especially in countries in sub-Saharan Africa (38). In addition, limitations due to the lack of resources to test and track the evolution of the COVID-19 pandemic seems to play a central role: a recent investigation by the World Health Organization (WHO) shows that only 14.2%, or one in seven, COVID-19 infections are being detected in Africa, where most developing countries are located (39).

Limited COVID-19 testing points to the existence of a vicious cycle. A lack of adequate testing and resource constraints limits the capacity of health authorities to track the spread of the pandemic, leaving them without adequate data or guidance and leading to incorrect assessments of its impact and risks (40). This severely hampers the capacity of health authorities to plan an effective response and secure the required domestic and international financing, thus perpetuating the structural resource constraints that limit testing and containment in the first place.

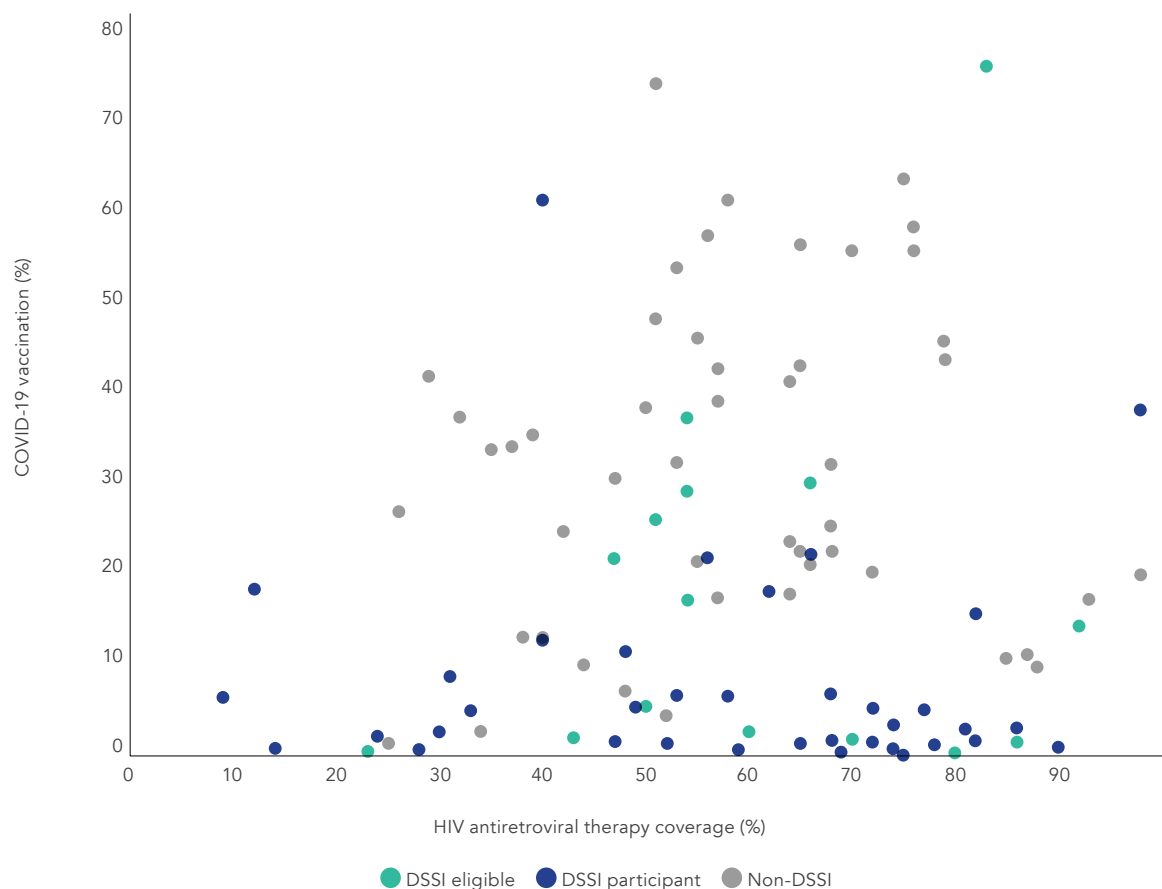
These constraints have equally important consequences for the capacity of countries to provide vaccines and treatments. This can be illustrated by looking at the percentages of people fully vaccinated against COVID-19 and people living with HIV who have access to antiretroviral therapy (Figure 4). COVID-19 vaccination rates follow a similar pattern to that observed in reported cases of the virus: non-DSSI countries have higher vaccination rates (32.3%) than DSSI-eligible (17.1%) or DSSI-participant countries (8.1%). The vaccine apartheid that is hampering the global COVID-19 response is made evident when comparing these vaccination rates with those already obtained in developed countries (25). Developed countries have fully vaccinated an average of 67.4% of their population, while of the 126 developing countries for which data are available, only four have vaccination rates equal to or higher than those observed in developed countries.¹⁰ Without a concerted effort to accelerate vaccination efforts across the world, the costs of containing the COVID-19 pandemic are set to increase substantially over time as a result of the development of variants and the impact of lockdown measures (41).

Concerns over the effectiveness of the COVID-19 pandemic response are augmented when it is assessed in combination with HIV antiretroviral therapy coverage. The United Nations (UN) General Assembly's 2016 Political Declaration on Ending AIDS committed countries to reach an antiretroviral

⁹ The countries in this second group are Armenia, Congo, Costa Rica, Fiji, Gambia, Georgia, Kazakhstan, Kyrgyzstan, Madagascar, Nicaragua, Pakistan, Philippines and South Sudan.

¹⁰ These countries are Cambodia, China, Cuba and Malaysia.

FIGURE 4 | HIV ANTIRETROVIRAL THERAPY COVERAGE AND COVID-19 VACCINATION RATES, DEVELOPING COUNTRIES, 2021



Source: AIDSinfo [database]. Geneva: UNAIDS; c2022 (<https://aidsinfo.unaids.org/>); Coronavirus (COVID-19) Vaccinations. In: Our World in Data [database]. Our World in Data; c2022 (<https://ourworldindata.org/covid-vaccinations>). Latest available data as of December 2021.

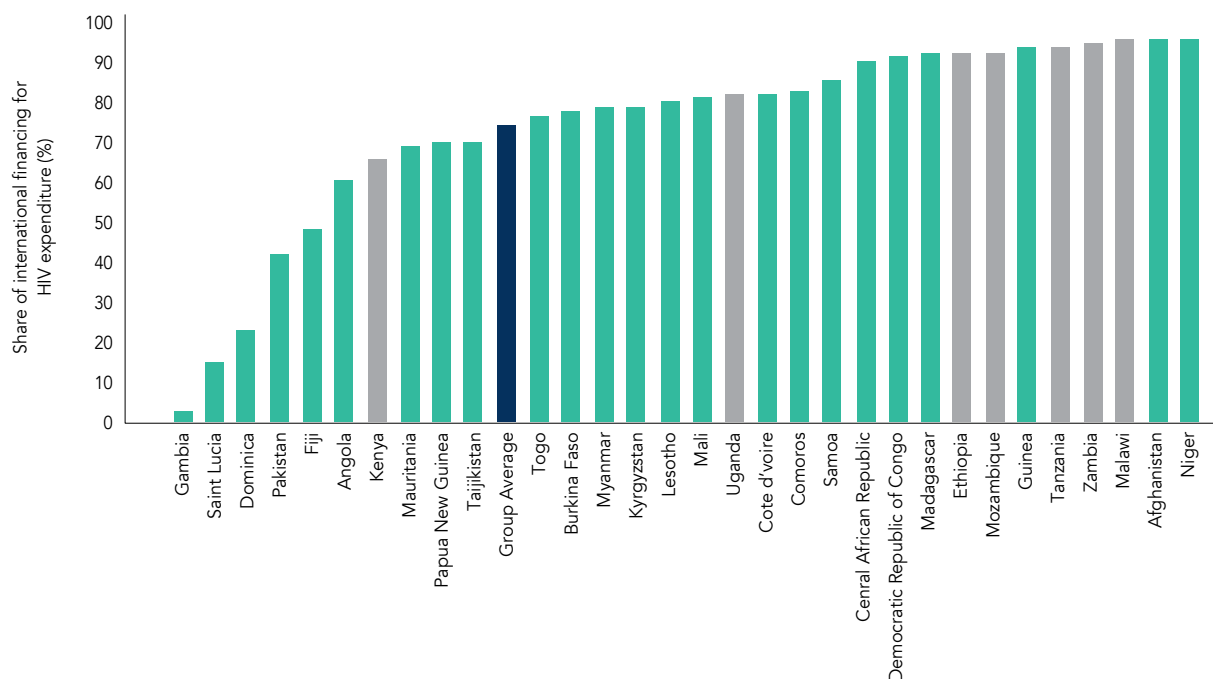
therapy coverage target of 90% of HIV-positive people.¹¹ Antiretroviral therapy coverage rates for the different country groups were well below this target, but they were remarkably close to each other: by the end of 2020, antiretroviral therapy coverage rates for non-DSSI, DSSI-eligible and DSSI-participant countries reached 58.3%, 60.9% and 58.1%, respectively. As in Figure 3, group averages conceal substantial differences at the country level. For instance, of the 105 countries for which data were available, only five managed to reach the 90% target.¹² In at least 24 countries, treatment coverage was less than half of that 90% target.

An additional issue worth highlighting relates to HIV and COVID-19 caseload and treatment data across country groups. There is a noticeable difference in COVID-19 cases and vaccine distribution between non-DSSI countries and DSSI-eligible and DSSI-participant countries. As Figures 2 and 3 show, the non-DSSI group, which is largely composed of middle-income countries, has performed substantially better in terms of COVID-19 testing and vaccine distribution. In contrast, HIV IPR and antiretroviral therapy ratios tend to converge across the country groups, despite the income differences. A factor that may explain these differences is the role of international financing. On average, external financing covers 76.9% of HIV expenditure in DSSI-

¹¹ This is the second 90 of the 90–90–90 targets: 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads.

¹² These include Cabo Verde, Eswatini, Rwanda, Uganda and Zimbabwe.

FIGURE 5 | SHARE OF INTERNATIONAL FINANCING FOR HIV EXPENDITURE, DSSI-PARTICIPANT COUNTRIES, 2020



Source: AIDSinfo [database]. Geneva: UNAIDS; c2022 (<https://aidsinfo.unaids.org/>).

Note: Grey denotes countries with a higher prevalence of people living with HIV and debt levels.

participant countries (Figure 5). For countries with a high number of people living with HIV, this figure increases to 91.5%. External financing plays a central role in providing protection to people living with HIV in low- and lower-middle-income countries that face tight fiscal constraints. The observed decline in the HIV IPR ratio over the last several years would not have been possible without the external support provided to these countries.

This dynamic provides an important lesson for efforts to contain both the AIDS and COVID-19 pandemics: without an effort to scale up available multilateral financing, vulnerable countries will struggle to protect their populations. This represents a substantial risk to the entire world. In the case of HIV, reductions in donor support threaten to erase the progress achieved over the last decades. This would further postpone the goal of ending AIDS as a public health threat by 2030 (11). Similarly, the failure to track and contain the spread of COVID-19 in an adequate way, including through vaccine distribution, will make it difficult to end that pandemic. It is important to emphasize that increasing international financing to tackle both pandemics is not an act of charity: it is a highly effective investment in global public health. The urgency to mobilize multilateral resources towards this goal is heightened by the devastating consequences of the large and growing debt burden of developing countries participating in the G20 DSSI.

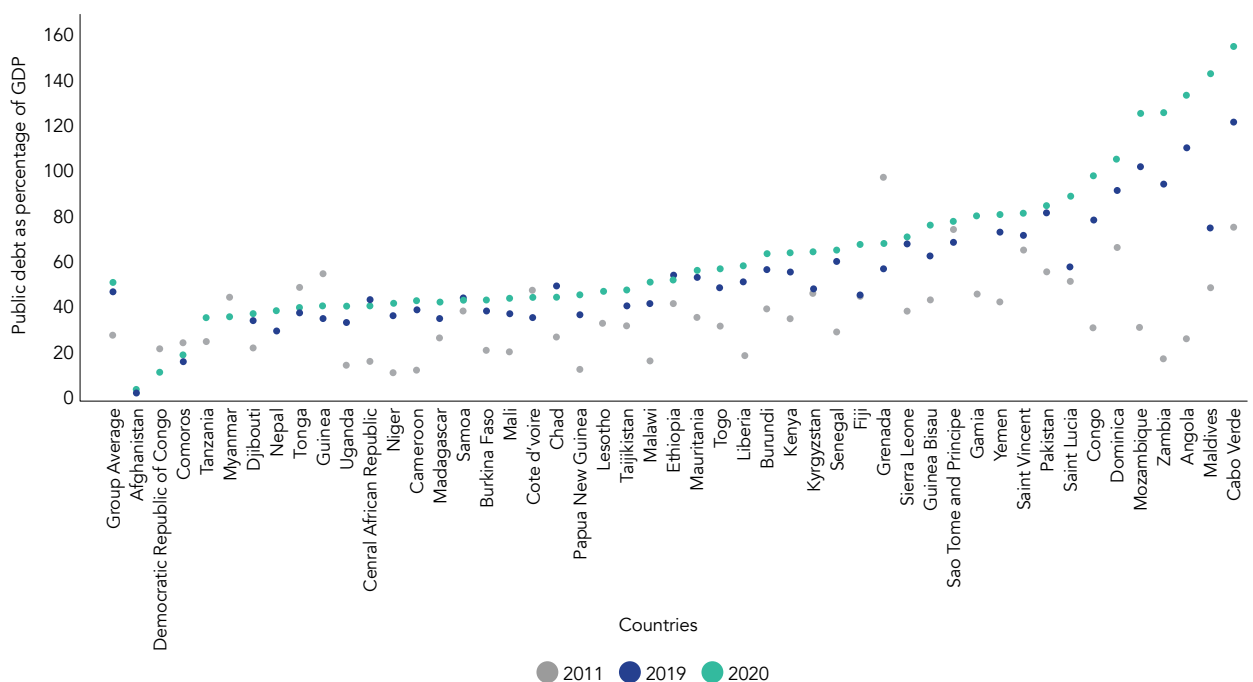
IMPACT OF THE CRISIS ON PUBLIC DEBT AND HEALTH EXPENDITURE IN G20 DSSI-PARTICIPANT COUNTRIES

The COVID-19 pandemic triggered an unprecedented increase in public debt levels around the world, aggravating debt vulnerabilities that had been on the rise across countries over the last decade (42). Like the AIDS and COVID-19 pandemics, the unfolding debt crisis has hit vulnerable countries particularly hard, as the recent evolution of public debt levels and the impact of the crisis in DSSI-participant countries illustrates (Figure 6).

There are four elements worth highlighting in Figure 6.

1. Forty-four DSSI-participant countries carry a heavy public debt burden that pre-dates the pandemic (see the grey dots). On average, public debt levels for these countries rose from 39.6% to 66.3% of GDP between 2011 and 2020, with around two thirds of the increase taking place between

FIGURE 6 | PUBLIC DEBT AS PERCENTAGE OF GDP, DSSI-PARTICIPANT COUNTRIES, 2011 TO 2020



Source: World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021.

For every 10 dollars of government revenues, four were allocated to debt service and only one to health in 2020



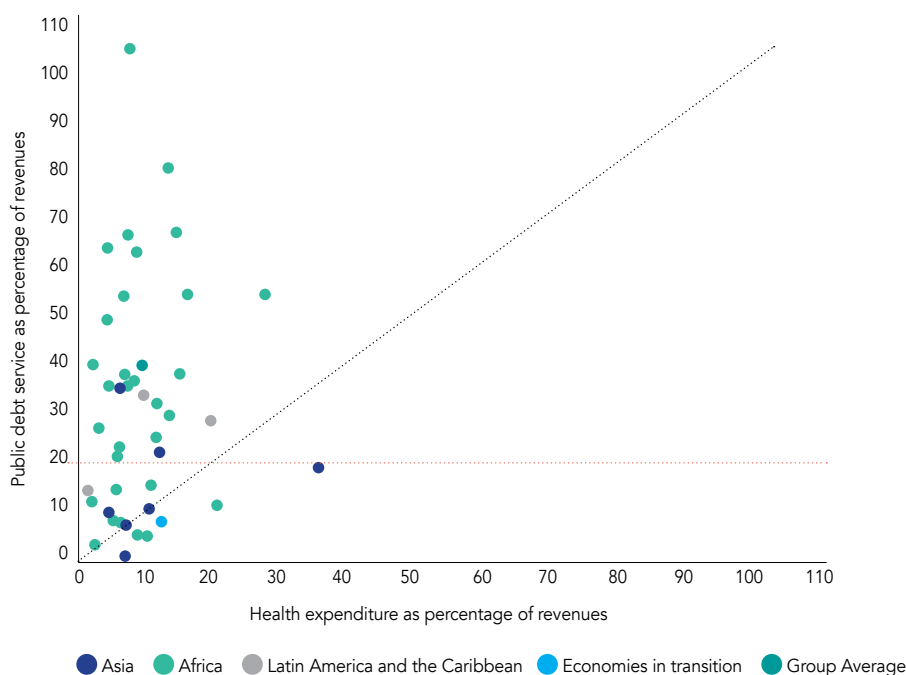
13 The seven countries are: Ethiopia, Kenya, Malawi, Mozambique, Uganda, United Republic of Tanzania and Zambia.

2011 and 2019. The remaining one third of the increase—equivalent to 9.5% of GDP—happened in 2020.

2. Twenty-five countries had public debt levels above 55% of GDP in 2020. They are in breach of a debt solvency threshold. This uses a composite indicator developed by the IMF and the World Bank to measure the risk of debt distress in low-income countries with medium institutional capacity (43).
3. Rising debt burdens cannot be attributed to unique factors within specific countries. Debt levels grew in 40 countries over the last decade, suggesting that the debt problem is instead a result of underlying systemic factors, including a lack of access to timely, reliable and concessional development financing (20).
4. The group of seven vulnerable countries with a large population of people living with HIV has been particularly affected by the debt crisis.¹³ On average, public debt levels in these countries rose from 29.4% to 74% of GDP between 2011 and 2020. An increase of 11% of GDP took place in 2020 alone.

High debt levels hamper the capacity of countries to respond to the AIDS and COVID-19 pandemics. This becomes clear looking at a comparison between the amounts allocated to public debt service and public health expenditure as a share of GDP for DSSI-participant countries in the context of the pandemic: for every 10 dollars of government revenues, four were allocated to debt service and only one to health in 2020 (Figure 7). Prioritization of debt payments over health expenditures to address both pandemics is both economically and ethically misguided.

FIGURE 7 | PUBLIC DEBT SERVICE AND HEALTH EXPENDITURE AS A PERCENTAGE OF REVENUES, DSSI-PARTICIPANT COUNTRIES, 2020



Sources: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF–WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

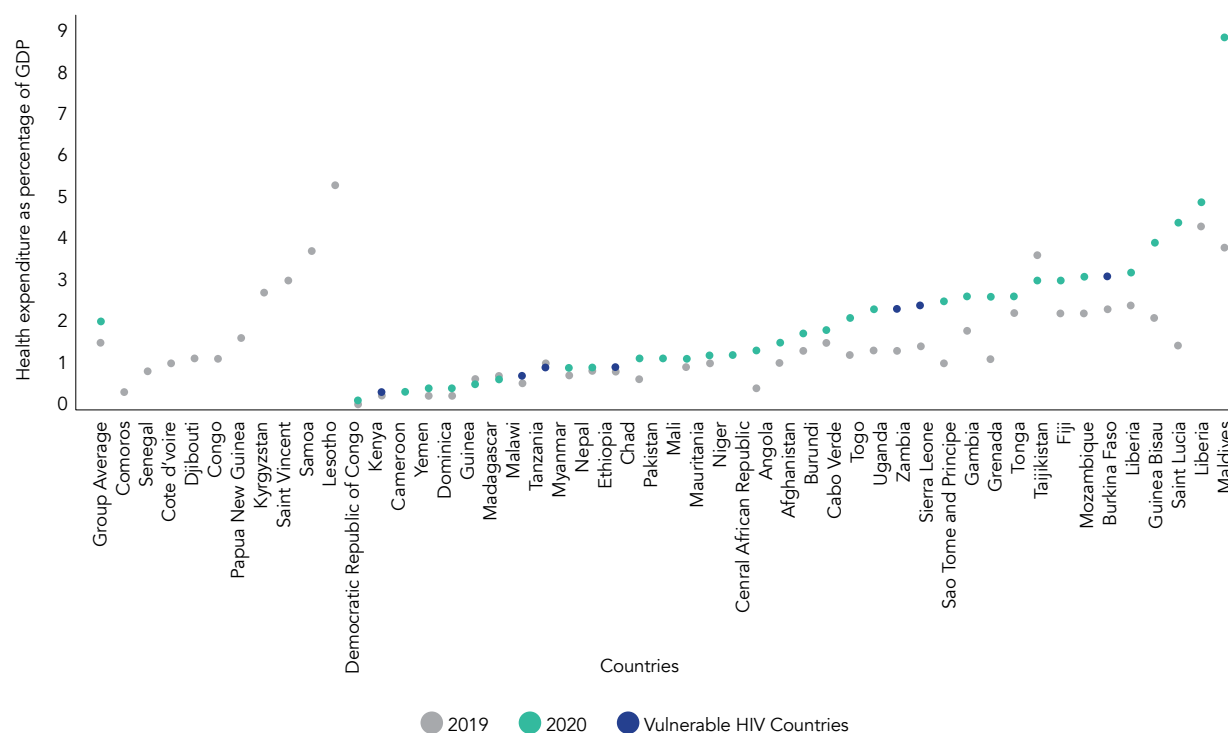
Furthermore, Figure 7 includes two thresholds that provide additional insights into the implications of heavy debt burdens. First, a measure of liquidity risk (the horizontal line) is set at debt service as 18% of government revenue. This threshold is used in developing countries with medium institutional capacity to estimate liquidity risks¹⁴ as measured by a composite indicator developed by the IMF and the World Bank (43). Overall, 29 countries allocated more than 18% of government revenues to debt service in 2020. For these countries, prioritizing debt payments leaves fewer resources for other areas of government expenditure, including health. This relates to the second threshold: the 45 degree line across the figure, which establishes a comparison between debt service and health expenditures. In total, 37 countries spent more resources on debt service than health in the context of the COVID-19 pandemic in 2020 (they are located above the diagonal line). This group includes 28 of the countries above the liquidity risk threshold and five countries with a large population of people living with HIV.¹⁵ In contrast, only seven countries spent more on health than debt service in 2020 (they are located below the line). Only three countries in Africa are in this group.

Going forward, the capacity of these countries to end the AIDS and COVID-19 pandemics rests on the willingness of the international community to institute measures that help reverse this lopsided allocation of resources. An analysis of the evolution of health expenditure during the COVID-19 pandemic shows an encouraging pattern in this direction (Figure 8): all but one country managed

14 As used in this report it refers to the risk of the inability to meet payment obligations in a timely manner due to temporary factors that inhibit access to cash or cash equivalents.

15 This includes Kenya, Mozambique, Uganda, United Republic of Tanzania and Zambia. Ethiopia spent more resources on health relative to debt service in 2020. No data on health expenditure was available for Malawi.

FIGURE 8 | HEALTH EXPENDITURE AS PERCENTAGE OF GDP, DSSI-PARTICIPANT COUNTRIES, 2019 AND 2020



Sources: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF–WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

Note: Latest available data on health expenditure are from December 2021. Dark blue denotes countries with a higher prevalence of people living with HIV and debt levels.

to increase the amount of resources allocated to public health as a share of GDP, and this effort took place despite the devastating economic impact of the COVID-19 pandemic. Health expenditure rose from an average of 1.5% to 2.2% of GDP between 2019 and 2020. This category of spending rose in 32 countries, remained constant in three and declined in another four.¹⁶ This widespread increase in health expenditure, albeit from low levels, is an extremely positive development: it underscores the gargantuan effort undertaken by authorities in these countries to protect their populations.

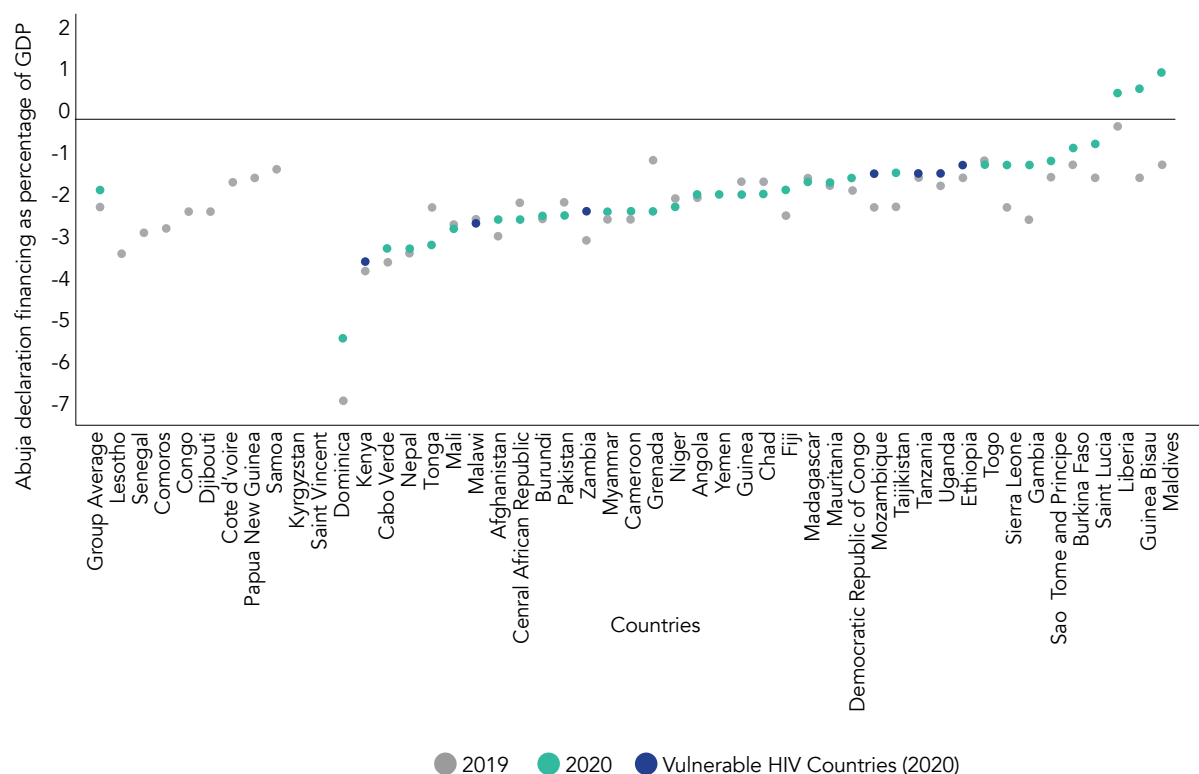
¹⁶ Health expenditure declined as a share of GDP in Guinea, Madagascar, Tonga and United Republic of Tanzania. The United Republic of Tanzania is a case of special concern due to its high number of people living with HIV.

¹⁷ The three countries with expenditure levels above the Abuja Declaration target are Guinea-Bissau, Liberia and Maldives. The six countries with a high number of people living with HIV are Ethiopia, Kenya, Mozambique, Uganda, United Republic of Tanzania and Zambia.

However, it is important to place this positive development in a broader context. Even after the increase observed in 2020, health expenditure for most countries worldwide remains well below the levels required to meet international commitments on human rights and health (31). These include the UN International Covenant on Economic, Social and Cultural Rights (1976), the Vienna Declaration and Programme of Action (1993), the Abuja Declaration (2001) and the UN 2030 Agenda for Sustainable Development (2015). Taken together, these commitments establish the obligation of states to mobilize the maximum of their available resources to achieve the full, progressive realization of economic, social and cultural rights, including to ensure healthy lives and promote well-being for all (14). While there is no established benchmark to measure the adequacy of existing health expenditure to meet this goal, the Abuja Declaration represents a useful tool for this purpose. Signed by 32 countries from Africa in 2001, the Abuja Declaration set a target of allocating at least 15% of annual budgets to the health sector. Given that all DSSI-participant countries from Africa are signatories of the Declaration, it is convenient for analysing the gap to achieving the Abuja benchmark among this group.

Figure 9 illustrates the Abuja Declaration health funding gap, measured as percentage of GDP. The increase in health expenditure triggered by the COVID-19 pandemic helped to reduce the financing gap across countries from 2.1% to 1.7% of GDP between 2019 and 2020, and it declined in 26 of the 32 the DSSI-participant countries. These include three countries that have expenditure levels above the target set by the Abuja Declaration and six countries with a high number of people living with HIV.¹⁷ In another 12 DSSI-participant countries, the financing gap widened in the context of the pandemic, including in Malawi, which has a high number of people living with HIV. This helps to illustrate that, while the increase in health expenditure triggered by the COVID-19 pandemic is a positive development, it is not large enough to overcome the structural underinvestment in the health sector that

FIGURE 9 | **ABUJA DECLARATION HEALTH FUNDING GAP AS % OF GDP, DSSI-PARTICIPANT COUNTRIES, 2019 AND 2020**



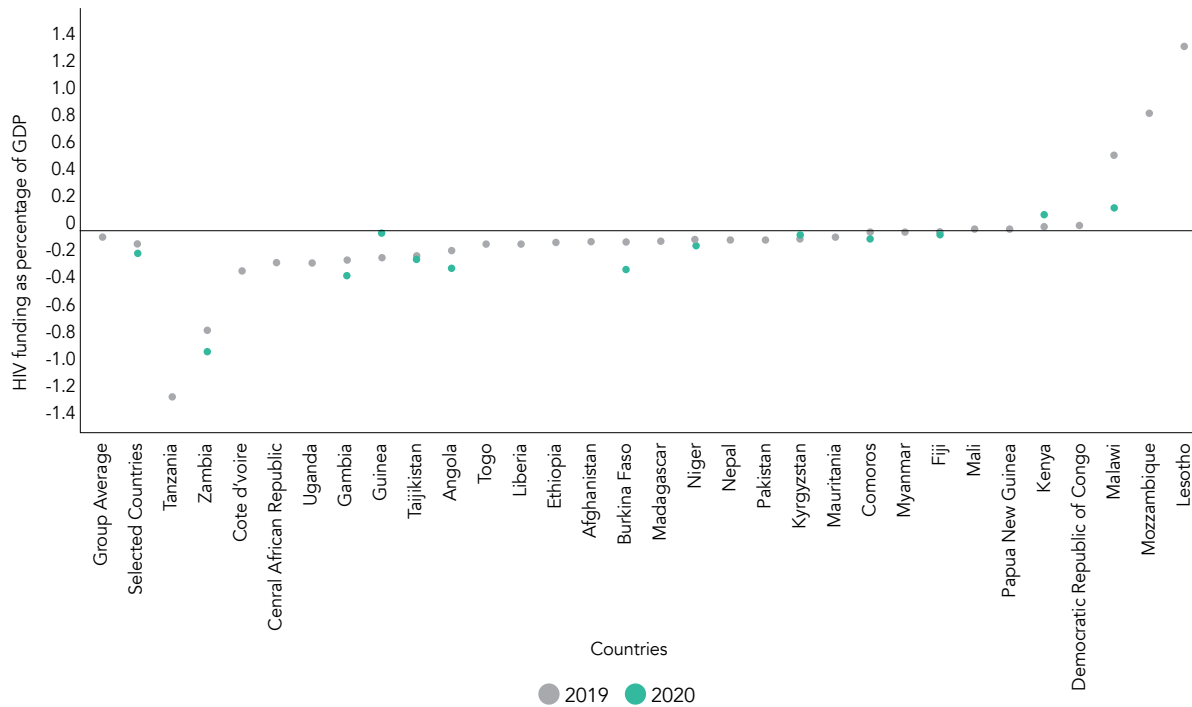
Source: WB WDI (2021), IMF WEO October (2021) and IMF-WB Staff Note: DSSI Fiscal Monitoring Update (2021). Latest available data on health expenditures as of December 2021. Yellow denotes countries with a high number of population living with HIV/AIDS.

characterizes the situation in most DSSI-participant countries (44).

The evolution of health expenditure has implications for domestic financing of HIV expenditures. While the overall level of health expenditure as a share of GDP has increased across most countries, budgets for HIV may be under pressure as resources are shifted towards the COVID-19 emergency response. As of the end of 2021, there was still no conclusive evidence on how this will affect HIV programmes. For a group of 30 DSSI-participant countries, domestic expenditure on HIV programmes represented on average 3.5% of total health expenditure in 2019 (Figure 10). Data to assess the impact of the COVID-19 pandemic are only available for seven of these countries. For this small sample, in relative terms, HIV expenditure as a share of total health expenditure declined from 2.5% to 1.9%. This includes sharp declines in Malawi and Zambia, two countries with a high number of people living with HIV. While external financing supports most of the expenditures in HIV programmes in both countries (Figure 5), the composition of domestic health budgets represents troubling anecdotal evidence of a shift in priorities away from these programmes.

A decline in HIV expenditure would widen the existing HIV financing gap. The benchmark for this gap is the resources, both domestic and international, that are required to put an end to the AIDS pandemic by 2030, as estimated by UNAIDS. There are significant benefits to closing the gap: annual HIV infections would be reduced from 1.7 million in 2019 to 370 000 in 2025, and

FIGURE 10 | HIV EXPENDITURE AS PERCENTAGE OF HEALTH EXPENDITURE, DSSI-PARTICIPANT COUNTRIES, 2019 AND 2020



Sources: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF–WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

Note: Latest available data on HIV and health expenditure as of December 2021.

18 These include Democratic Republic of the Congo, Kenya, Lesotho, Malawi, Mali, Mozambique and Papua New Guinea.

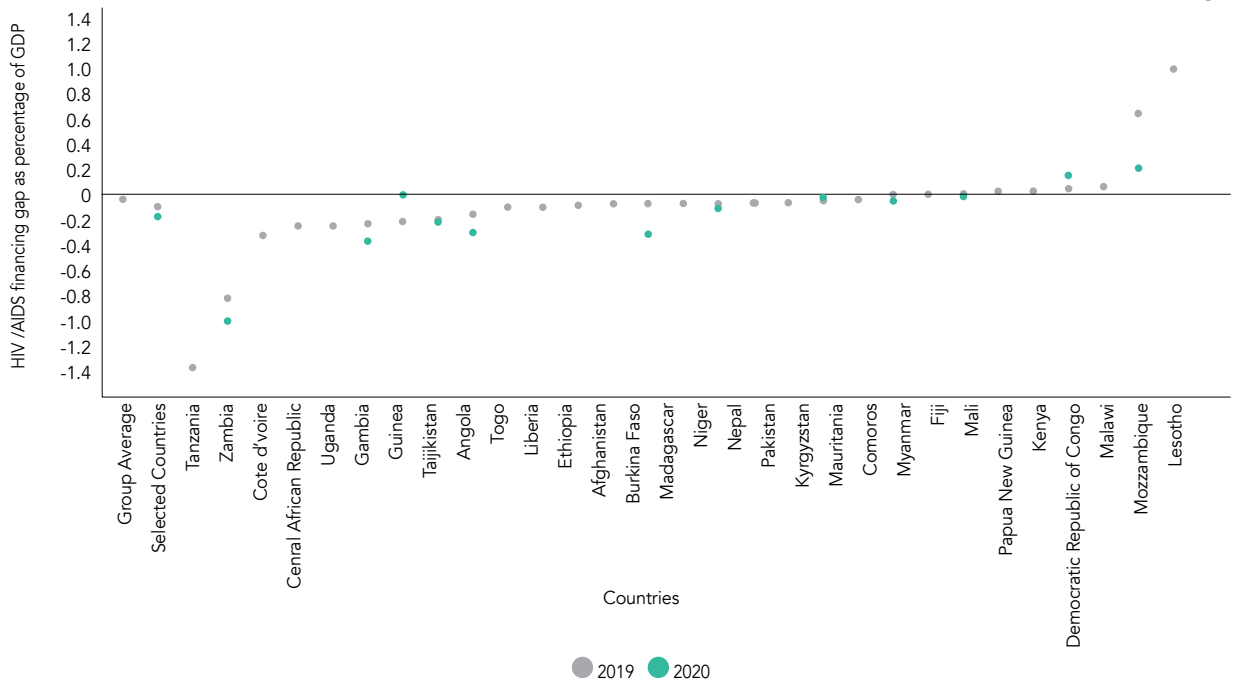
19 These include Angola, Burkina Faso, Comoros, Fiji, Gambia, Niger, Tajikistan and Zambia.

annual AIDS-related deaths, including tuberculosis deaths, could be reduced from 690 000 in 2019 to 250 000 in 2025. Measured against this benchmark, the HIV funding gap was small: equivalent to 0.05% of GDP for a group of 30 DSSI-participant countries in 2019. In seven of these countries, the HIV funding gap was already closed.¹⁸

Data on COVID-19 pandemic’s impact on the HIV funding gap is only available for 12 countries. For this sample, the HIV funding gap rose from 0.1% to 0.2% of GDP between 2019 and 2020. Eight countries experienced a widening of their HIV funding gap.¹⁹

A widespread increase in the HIV financing gap would represent a substantial challenge in efforts to contain the AIDS pandemic, undermining progress made in recent years. It would also cause the economic and financial costs of addressing the AIDS pandemic to rise needlessly over the next decade.

FIGURE 11 | HIV FUNDING GAP AS PERCENTAGE OF GDP, DSSI-PARTICIPANT COUNTRIES, 2019 AND 2020



Sources: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF–WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

Note: Latest available data on health expenditure as of December 2021.

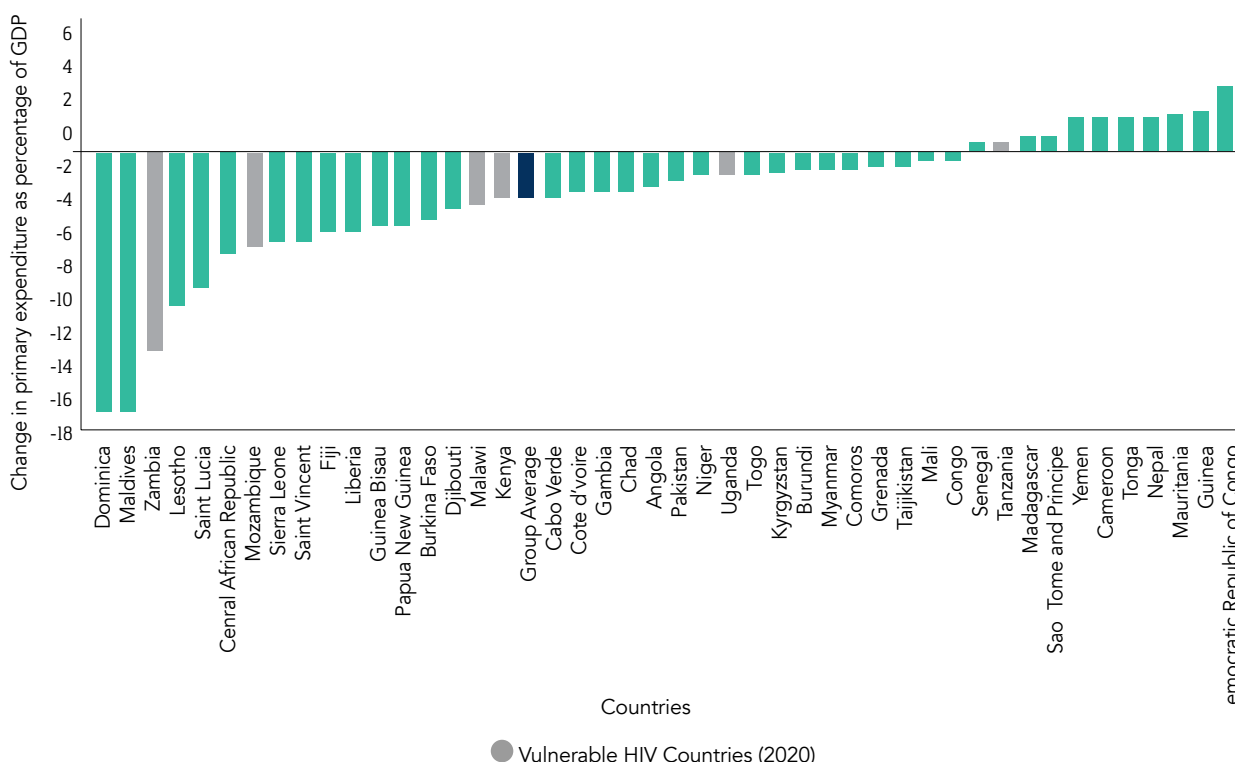


It will not be possible to put an end to the AIDS and COVID-19 pandemics as long as DSSI-participant countries devote as much as four times as many resources to debt service as they do for health

CLOSING THE HEALTH FUNDING GAP POST-COVID-19: THE ROLE OF DEBT RELIEF

The outlook for health and HIV programme funding seems daunting. Fiscal consolidation, with a heavy emphasis on expenditure cuts, is expected to take place across 139 countries in the coming years (45). The purpose of these measures is to ensure debt sustainability in the aftermath of the COVID-19 pandemic (31). In the case of DSSI-participant countries, primary expenditure is expected to decline on average by 2.8% of GDP between 2020 and 2026 (Figure 12).²⁰ Primary expenditure is projected to decline in 34 countries, including five countries with a high number of people living with HIV.²¹

FIGURE 12 | PROJECTED CHANGE IN GOVERNMENT PRIMARY EXPENDITURE AS PERCENTAGE OF GDP, DSSI-PARTICIPANT COUNTRIES, 2020 TO 2026



Source: World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021.

Note: Yellow denotes countries with a higher prevalence of people living with HIV and debt levels.

20 Primary expenditure refers to total public expenditures, excluding interest payments.

21 These are Kenya, Malawi, Mozambique, Uganda and Zambia.

These projections are concerning for at least three reasons.

- Low-income countries were estimated to require an additional US\$ 400 billion in investment per year to meet the goals of the UN 2030 Agenda for Sustainable Development (46). The projected decline in expenditure, which is linked to a lack of adequate development financing and high debt levels, runs counter to international human rights commitments and achievement of the Sustainable Development Goals (SDGs).
- The magnitude of the projected cuts makes it unlikely that health budgets will be spared (47). A substantial share of the observed increases in health expenditure were related to the COVID-19 emergency response (17). As these are considered a one-off expenditure, their elimination is likely to be prioritized in the process of fiscal consolidation, especially in the case of countries in a weak fiscal position (48). The combination of overwhelmed health sectors and expenditure cuts will have considerable negative effects on public health in these countries (49).
- The process of consolidation and the reprioritization of expenditures may reduce domestic financing for HIV programmes. Episodes of fiscal consolidation tend to increase health inequality, disproportionately affecting vulnerable groups (such as infants) (50). People living with HIV stand to be negatively affected by this dynamic.

Avoiding these outcomes requires a systemic reprioritization of public resources towards health in general, and HIV programmes in particular. One such reallocation involves shifting resources away from debt payments towards health. It will not be possible to put an end to the AIDS and COVID-19 pandemics as long as DSSI-participant countries devote as much as four times as many resources to debt service as they do for health (Figure 7). For example, to close the Abuja Declaration health funding gap would have required these countries to reallocate, on average, 57% of their debt service to health expenditures in 2020 (Figure 13).²² For countries with higher numbers of people living with HIV, this amounts to 50.5%.²³ In the meantime, closing the HIV financing gap would have required a shift (on average) of 5.5% of debt service towards HIV programmes in 2020.²⁴ For countries with a higher number of people living with HIV, the required percentage would have been higher: an average shift of 10.9% of debt service to HIV programmes in 2020 would have been needed.²⁵

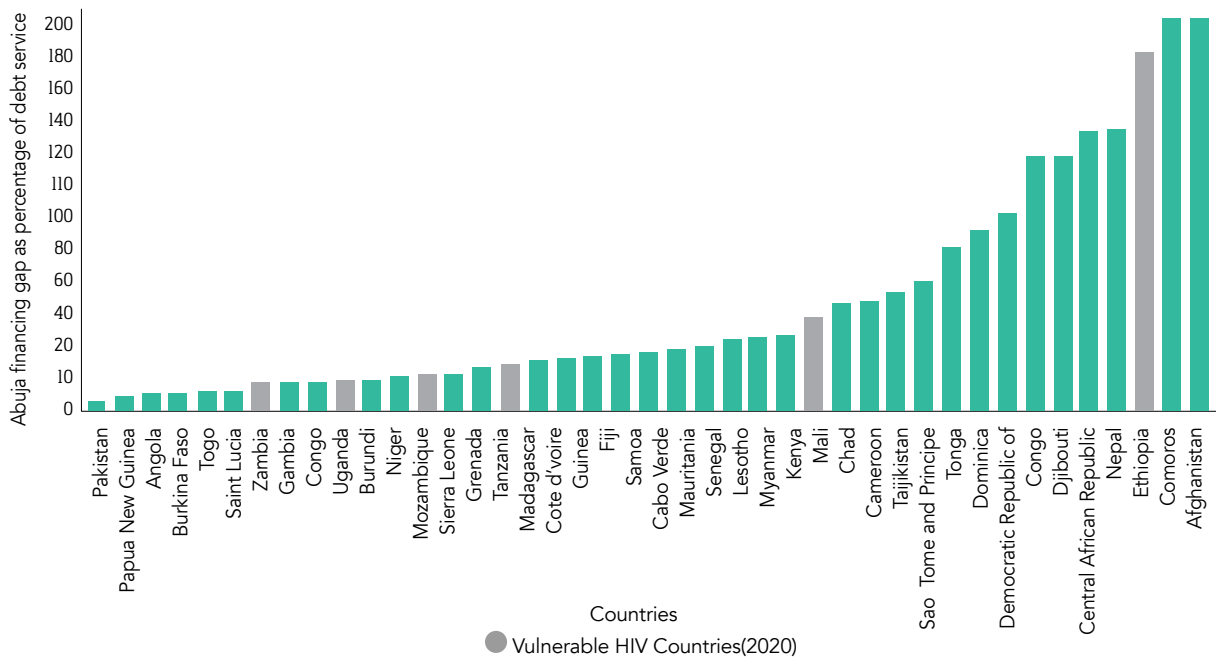
22 This figure is estimated for the DSSI-participant country group, excluding Afghanistan. Afghanistan is an extreme outlier that skews the estimation of the group average due debt service to Abuja Declaration health funding gap ratio (1791.7). If Afghanistan is included, the average for the group increases the Abuja Declaration health funding gap average to 99.8% with a median of 29.8%. Excluding this country reduces the average to 57.3% and the median to 29.1%.

23 This figure is the average for Ethiopia, Kenya, Mozambique, Uganda, United Republic of Tanzania and Zambia.

24 This figure is estimated for the DSSI-participant country group, excluding Afghanistan (see footnote above). Including Afghanistan, the average for the group increases the HIV financing gap to 7.2%, with a median of 4.2%. Excluding this country reduces the average to 5.5% and the median to 3.8%.

25 This figure is the average for Ethiopia, Uganda, United Republic of Tanzania and Zambia.

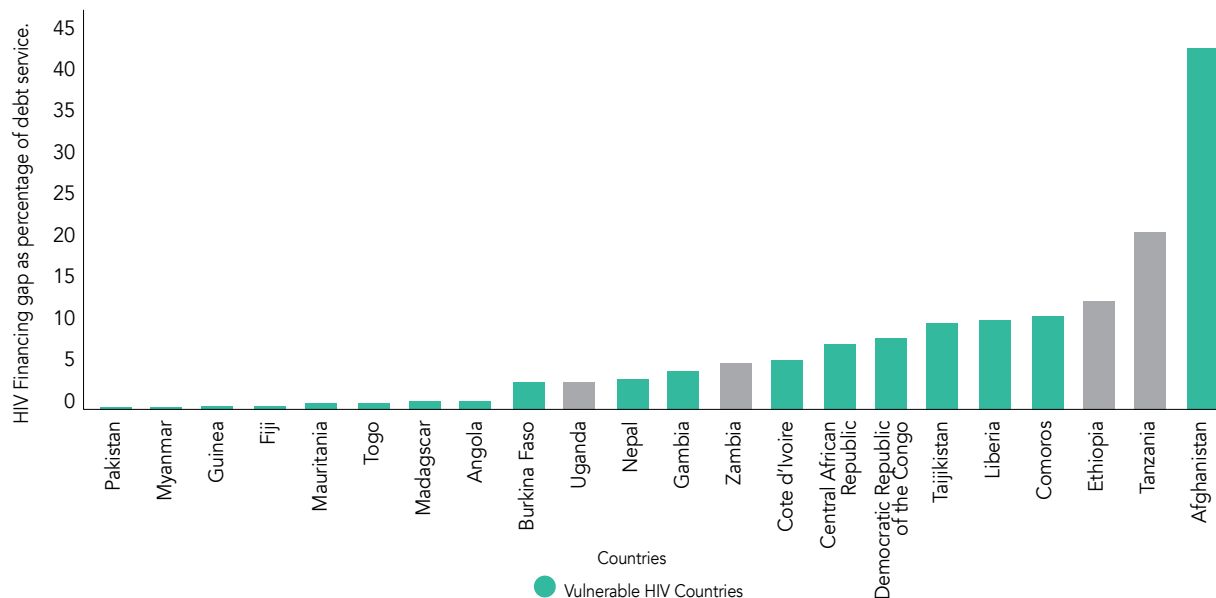
Figure 13: Abuja Declaration health funding gap as percentage of debt service, DSSI-eligible countries, 2020



Sources: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF-WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

Note: Latest available data on health expenditure as of December 2021. Yellow denotes countries with a higher prevalence (>X%) of people living with HIV. The Y axis is capped at 200%.

FIGURE 14: HIV FINANCING GAP AS PERCENTAGE OF DEBT SERVICE, DSSI-ELIGIBLE COUNTRIES, 2020



Source: World Bank World Development Indicators, 2021; World economic outlook: recovery during a pandemic. Health concerns, supply disruptions and price pressures. Washington (DC): International Monetary Fund; 2021; Joint IMF-WBG staff note: DSSI fiscal monitoring update. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/Policy-Papers/Issues/2021/09/16/Joint-IMF-WG-Staff-Note-DSSI-Fiscal-Monitoring-Update-465864>).

Note: Latest available data on health expenditure as of December 2021. Grey denotes countries with a higher prevalence (>X%) of people living with HIV.

These figures highlight two issues.

- The amount of debt relief provided to countries has clearly been insufficient given the magnitude of the COVID-19 pandemic. The fact that both the G20 DSSI and the G20 Common Framework have failed to provide an amount of debt relief commensurate with the required resource reallocation indicates their inadequacy. Providing financial support in the context of the COVID-19 pandemic without first taking adequate measures to tackle debt distress has led to displacement effect. Commercial creditors have profited handsomely from timely debt repayments while governments are struggling to finance their HIV and COVID-19 pandemic responses (31).
- There is a substantial dispersion in the ratios of debt relief to health and HIV funding gaps. In both cases, most countries have debt relief requirements that are well below the group average. Even a modest amount of debt cancellation would be enough to fill the existing gap; only a few countries have a substantially larger debt relief financing gap. For some of these countries, even full debt cancellation and the reallocation of resources would be insufficient to cover the gap. This underlines the need to address development financing needs using a systematic approach that combines multilateral concessional support, domestic resource mobilization and debt relief, including debt cancellation (20).

In this context, the recent call by the IMF to revise and improve the G20 Common Framework is an acknowledgment of the problems with the ongoing multilateral response, specifically when it comes to debt relief (35). The discussion of enhancements to the G20 Common Framework should not be limited to issues with its implementation, including private creditor participation in debt crisis resolution. Multilateral debt relief initiatives must also provide an explicit baseline target of debt relief to be received by participant countries, similar to those established in the cases of the Heavily Indebted Poor Countries (HIPC) Initiative (51). In turn, this target requires an explicit link to the identified financing needs in the context of the 2030 Agenda for Sustainable Development and the COVID-19 pandemic response. In the cases of the health sector and HIV programmes, the provision of debt relief must go beyond the provision of financing for an ad hoc emergency response; the focus instead ought to be on establishing a financing framework that is conducive to sustained levels of public spending on holistic and cohesive policies for strengthening health systems, including service delivery, the health workforce and access to medicines (47).

Failure to tackle the pandemic triad is not only a moral indictment of the state of our world: it represents an existential threat that will trap us in an endless HIV and COVID-19 pandemic loop that extends well beyond this decade, hindering the health system strengthening needed to prepare for future pandemics (52). This needless loss of human life and increase in human suffering should and can be avoided with a renewed push for multilateralism (19). Ambitious targets for debt relief, including outright cancellation, should be at the core of these efforts.

POLICY RECOMMENDATIONS

Ending the HIV and COVID-19 pandemics is both an ethical imperative and an urgent health and economic priority. This goal, however, cannot be accomplished without a systematic multilateral approach. While a large number of developing countries lack the resources to prepare for, track and respond to the ongoing health crisis in an effective manner on their own, the multilateral mechanisms established to provide support have unfortunately proven to be inadequate. This has resulted in health and economic risks to developing countries and setbacks in the HIV response.

Against this background, it is urgently necessary to strengthen the multilateral response to the pandemic triad of HIV, COVID-19 and debt in order to scale up resources that are available to the health sector. This requires three sets of elements: multilateral financing, debt relief and a focus on health and HIV financing.



Closing the HIV financing gap would have required a shift (on average) of 5.5% of debt service towards HIV programmes in 2020

Multilateral financing

An adequate response will require a multipronged approach to multilateral resource mobilization. This ought to include the following:

- Establishing a mechanism for the reallocation of IMF SDRs. This would allow the deployment of US\$ 438 billion in unused SDRs that were allocated to high-income countries in 2021. The reallocation instrument ought to ensure the provision of long-term concessional financing to all developing countries, free of policy conditions (53). Resources could then be channeled to fill the financing gaps in both ACT Accelerator and the Global AIDS Strategy, thus creating worldwide access to HIV and COVID-19 tests, therapies and vaccines (54).
- Requiring international financial institutions to scale up concessional financing that is available to developing countries. In the case of the IMF, this includes securing and delivering financing for the new Poverty Reduction and Growth Trust lending guidelines, including higher access limits and full concessional financing for eligible countries (55). This must be coupled with reforms to increase financing to middle-income countries that is free of conditions (56). In the case of multilateral development banks (MDBs), emphasis must be placed on securing resources to maximize the amount of grant-like financing provided to developing countries. For the World Bank, this involves eliminating policy conditions that are currently

hampering the approval and disbursement of concessional financing to countries in need (57, 58).

- Encouraging developed countries to meet their official development assistance commitments. Provision of grant financing in line with official pledges would provide developing countries with an additional US\$ 1.5 trillion in resources over the next decade (20). Furthermore, provision of official development assistance must ensure that scarce aid resources are directed where they are needed the most. This includes eliminating provisions for procuring goods and services from suppliers in the country that is providing aid, as this imposes additional costs and delays on receiving countries (59).

Debt relief

The debt problem faced by many developing countries must be addressed in a timely and fair fashion. Providing concessional financing without solving debt challenges would accomplish little: all the resources would be simply drained by existing creditors. Low-income countries participating in the DSSI would not be able to overcome the HIV and COVID-19 pandemics as long as they continue to spend four times more on debt payments than they do on health. To avoid displacement effect and ensure that resources are correctly prioritized, developing countries need support to tackle their debt problems. Ambitious targets such as debt relief, including outright cancellation, are required.

A focus on health and HIV financing

Including health expenditures and requirements to end the AIDS and COVID-19 pandemics—and to fulfill the commitments made under the Abuja Declaration—must be a central consideration when designing and implementing debt relief initiatives, including the G20 Common Framework (18). Specifically, multilateral debt relief initiatives must provide an explicit baseline target for debt relief to be received by participant countries, similar to those established in the cases of the HIPC Initiative. This must have an explicit link to the identified financing needs in the context of the 2030 Agenda and the AIDS and COVID-19 pandemic responses. The resulting financing framework must be conducive to sustained levels of public spending on holistic and cohesive policies for strengthening health systems, including service delivery, the health workforce and access to medicines (47).

Ending the pandemic triad of the AIDS and COVID-19 pandemics and debt is a collective effort. It cannot be delegated or postponed: no one is safe until everyone is safe.

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