MEDECINS SANS FRONTIERES

NO TIME TO QUIT: HIV/AIDS TREATMENT GAP WIDENING IN AFRICA

Médecins Sans Frontières
analysis of the widening funding gap
for HIV/AIDS treatment in sub-Saharan Africa

May 2010

GLOSSARY

ART	antiretroviral therapy
ARV	antiretroviral
CDC	Centers for Disease Control and Prevention
DRC	Democratic Republic of Congo
EC	European Commission
EU	European Union
GHI	Global Health Initiative
IMF	International Monetary Fund
MAP	Multi-country HIV/AIDS Program for Africa
MDG	Millennium Development Goal
MSF	Médecins Sans Frontières
ODA	official development assistance
OI	opportunistic infections
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother to child transmission
RCC	Rolling Continuation Channel
SWAp	Sector Wide Approach
TAP	Treatment Acceleration Project
TB	tuberculosis
TDF	Tenofovir
UA	Universal Access
WHO	World Health Organisation


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EXECUTIVE SUMMARY

At the end of the 90's, Médecins Sans Frontières (MSF) got involved in HIV/AIDS because we viewed it as an emergency: today, MSF still believes this is a crisis requiring an exceptional response.

Since the start of the epidemic, HIV/AIDS has created an acute public health crisis in many countries requiring an emergency response to the resulting high mortality and the spread of the disease. To date, much has been done to tackle HIV, but the urgency of the situation still calls for a sustained and expanded response over a long period of time — the battle is not over yet.

Through its medical humanitarian work in the majority of the worst-affected countries in sub-Saharan Africa, MSF has recently started to observe a worrisome turn-around among the donor community. After years of political willingness and financial commitment to combat HIV/AIDS, donors now seem to be disengaging from the fight, leaving behind people who are still in dire need of life-saving treatment.

In 2009-2010, MSF carried out in-depth field analyses in eight key countries - Malawi, Mozambique, Zimbabwe, South Africa, Lesotho, Kenya, Uganda, Democratic Republic of Congo (DRC) - where we have been providing HIV/AIDS care and treatment for several years. The findings confirm our concerns in terms of donor backtracking on commitments to scale up the fight against the HIV/AIDS epidemic. Today, this disengagement is starting to become visible in the field and the level of HIV care is beginning to deteriorate.

Uncertainty and unreliability of donor funding has stalled the enrollment of new patients in treatment sites and put the supply of anti-retroviral medicines (ARVs) at risk in the medium to long term. Donors have also diluted their initial emergency approach and shifted funding toward other health issues, disregarding the proven cross-benefits of effective HIV/AIDS intervention on healthcare in general. Ironically, at the same time as the level and sources of funding decline, donors expect the money dedicated to combat HIV/AIDS to fund increasingly comprehensive packages, extending to other priorities within the health sector.

A possible donor retreat not only hampers HIV treatment scale-up but also threatens to undermine all the positive effects and future perspectives that high coverage of ART brings in terms of community-wide reduction of mortality, morbidity and transmission.

Any retreat from the current efforts toward ART scale up will have far-reaching and very real negative consequences for patients and front line workers in HIV care.

Combined with the effects of the economic crisis in low income countries and in particular on vulnerable people, donor fatigue on HIV will further widen the HIV treatment gap in sub-Saharan Africa.

Concretely, reducing funding for HIV treatment and ARV means:

- A reduction in treatment slots. Patients will have to wait longer to start ARV and are at risk of dying before they can have access to life-saving medication. Patients left untreated risk deteriorating and succumbing to opportunistic infections such as TB. More patients will be lost to follow up, even before they can start ART.
- Blockage in the implementation of WHO guidelines allowing for a move away from substandard care and giving patients the benefits of earlier treatment.
- A further squeeze on the available initiation capacity of the Global Fund.
- Knock on effects on already fragile ARV supplies. This means more stock-outs and disruptions, resulting in additional strains on patients' adherence and health facilities' workload.
- Further reductions in affected countries' ambitions for tangible results and inclusion of specific vulnerable groups.

From the field perspective, a donor retreat will change the character of the epidemic, with increasing numbers of patients seeking care, more ill patients and rising mortality in the community — echoing the early 2000s when ART was rationed to the happy few.

- Patients starting with lower CD4-counts (a measure of the number of T cells per cubic millimetre of blood, used to evaluate the immune system of patients infected with HIV) require more frequent, more intensive and more costly care; at the same time, they have lower chances of survival and take longer to recuperate.


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- Health facilities' patient load will increase and health workers will be discouraged by the worsening results among the patients to whom they provide care.
- Patients might start sharing their pills, effectively lowering their dosage and increasing risks of virus transmission and resistance.
- Tensions will rise between those patients on treatment and those not yet on treatment.
- Tuberculosis rates will increase and represent an additional burden on already busy clinics.
- Mortality among adults in the prime of their lives and the number of orphans will rise again in the community.
- Insufficient ARV availability will require a proportional slowing down of testing and counselling activities.

A brief survey of donors' plans for the next years illustrates the challenge.

One key donor, **PEPFAR,** has flatlined its funding for 2009-2014 and as of 2008-9, further decreased its annual budget allocations for the coming years by extending the period to be covered with the same amount of money. The funding for purchase of ARVs will also be reduced in the next few years. All this translates into a reduction in the number of people starting on ART, as we have seen in South Africa and Uganda.

The **World Bank** currently prioritises investment in health system strengthening and capacity building in planning and management over HIV dedicated funding. However, without funding for ARV drugs and related costs, the impact of such capacity to support HIV/AIDS care will remain very limited.

UNITAID is phasing out its funding. By 2012, the drug and other medical commodity procurement organised by the Clinton Foundation for HIV/AIDS and funded by UNITAID for second line ARVs and paediatric commodities should end in Zimbabwe, Mozambique, DRC and Malawi.

The **Global Fund** is currently facing a serious funding shortfall. In October 2010, a donor replenishment conference is planned with the aim of mobilizing more resources, but donors have already requested the Global Fund to lower its financial ambitions. All current funding scenarios are inadequately reflecting demand, as none includes the additional resources required to implement the new WHO guidelines on earlier treatment and improved drug regimens.

With very few exceptions, **other health actors** such as the European Commission and European Union Member States do not fund HIV/AIDS treatment directly and hardly ever finance ARV supplies besides through their contribution to the Global Fund. At present, these donors seem unlikely to fill the additional gap created by the current shortfall, yet remain reluctant to increase their support to the Global Fund.

While the exceptional drive and resource mobilisation since 2001 allowed us to fight effectively against the HIV/AIDS epidemic over the past years, a sense of denial has set in among the donor community about this ongoing crisis. For the past year and a half, donors have increasingly voiced concern regarding the cost, sustainability and relative priority of HIV/AIDS, against the background of an ostensible lack of funds. All this discourse belies numerous studies demonstrating the global long-term gains in engaging decisively in the fight against HIV/AIDS today.

This donor turn-around will not make the patients in need of life-saving treatment go away. On the contrary, it is likely to increase the numbers of people in urgent need of care and will negatively impact their family, community and the health care system. In the end, the cost of inaction will be far higher than that of action.

Progress and scale-up are still direly needed. Our responsibility toward people living with HIV and AIDS in the hardest-hit countries has been collective in the past decade, and it should remain so for the years to come. This is a historical opportunity for the international community to renew its commitment to fight the HIV epidemic and stand by the people and countries that face the challenge of providing lifesaving treatment to those in need. This depends critically on continued financial support by donor agencies as PEPFAR, UNITAID and the Global Fund. But this cannot be the responsibility of a limited group; it also calls for expansion of commitment of those donor countries that have shown only limited support so far.

We should never forget why we started the fight against HIV. We were reacting to needless illness and excessive loss of life among young people, communities losing valuable energy and experience, profound wounds inflicted on the social fabric, and above all, the injustice of unnecessary suffering and death where we have the means to prevent them. This catastrophic situation might be back all too soon if we relent on the fight now.

01 SETTING THE SCENE

1.1 HIV/AIDS CRISIS CONTINUES

Médecins Sans Frontières (MSF) started providing antiretroviral therapy (ART) in 2000, and is currently supporting care and treatment for more than 160,000 people in more than 27 countries. Ten years ago, the biggest challenge was to demonstrate that ART was feasible in low-resource settings. Today, the challenge for governments is to continue to provide support for the millions of people receiving ART, while increasing access to for those who have yet to receive treatment. In sub-Saharan Africa, this is only possible with donor support.

Remarkable improvements in HIV/AIDS care and treatment have emerged over the past decade. Access to affordable fixed-dose combination drugs, national and international commitment to fighting the epidemic, and strong mobilisation from people with HIV and civil society groups have transformed HIV/AIDS for many from a death sentence into a manageable chronic disease. The World Health Organization's (WHO) "3 by 5" initiative[1] provided a vital boost to political momentum and funding that led worldwide to more than four million people being placed on ART by the end of 2008, and today almost all developing countries are providing large-scale access to HIV/AIDS care and treatment.

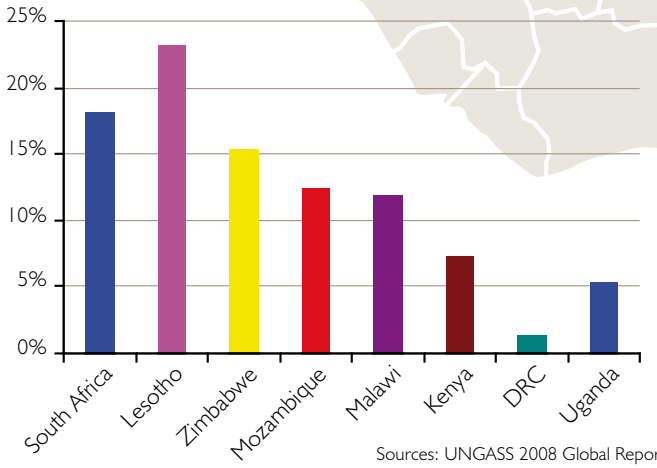
Sub-Saharan Africa is home to two-thirds of all the world's HIV positive people. HIV prevalence rates in some countries in southern Africa have exceeded 20% and in 2008 nearly three-quarters of all HIV/AIDS deaths globally occurred in this region. In the worst affected countries, HIV/AIDS has reversed decades of improvement in life expectancy (Figure 2). Today, some three million people are receiving ART. In settings with high ART coverage, substantial reductions in illness and death have been documented as access to treatment has increased.

However, the crisis has not gone away. The harsh reality is that too many people in developing countries continue to die needlessly because they still do not have access to treatment: according to latest estimates some nine million people in need worldwide are still not receiving ART.[2]

Despite this enduring need, there are now worrying signs that the donor commitment needed to sustain and increase the current momentum in the fight against HIV/AIDS is waning. This report summarizes in-depth field analyses of trends in ART access and donor funding in eight sub-Saharan African countries where MSF has been providing HIV/AIDS care and treatment for several years. The report findings are the result of interviews with people living with HIV / AIDS, care providers, government representatives, donors, UN agencies and through a review of policy documents.

Figure 1

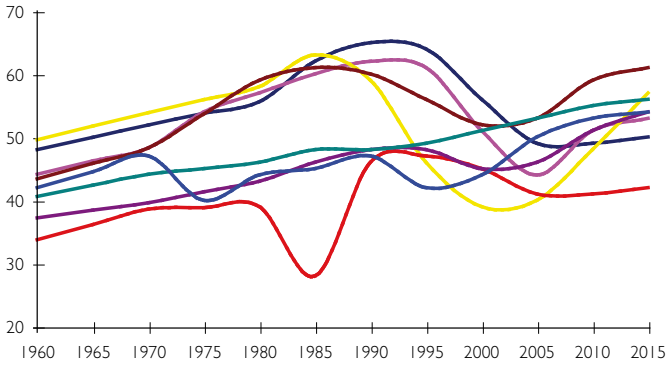
Adult HIV prevalence in the eight countries included in this report



Sources: UNGASS 2008 Global Report and UNGASS 2010 Country Progress Reports

Figure 2

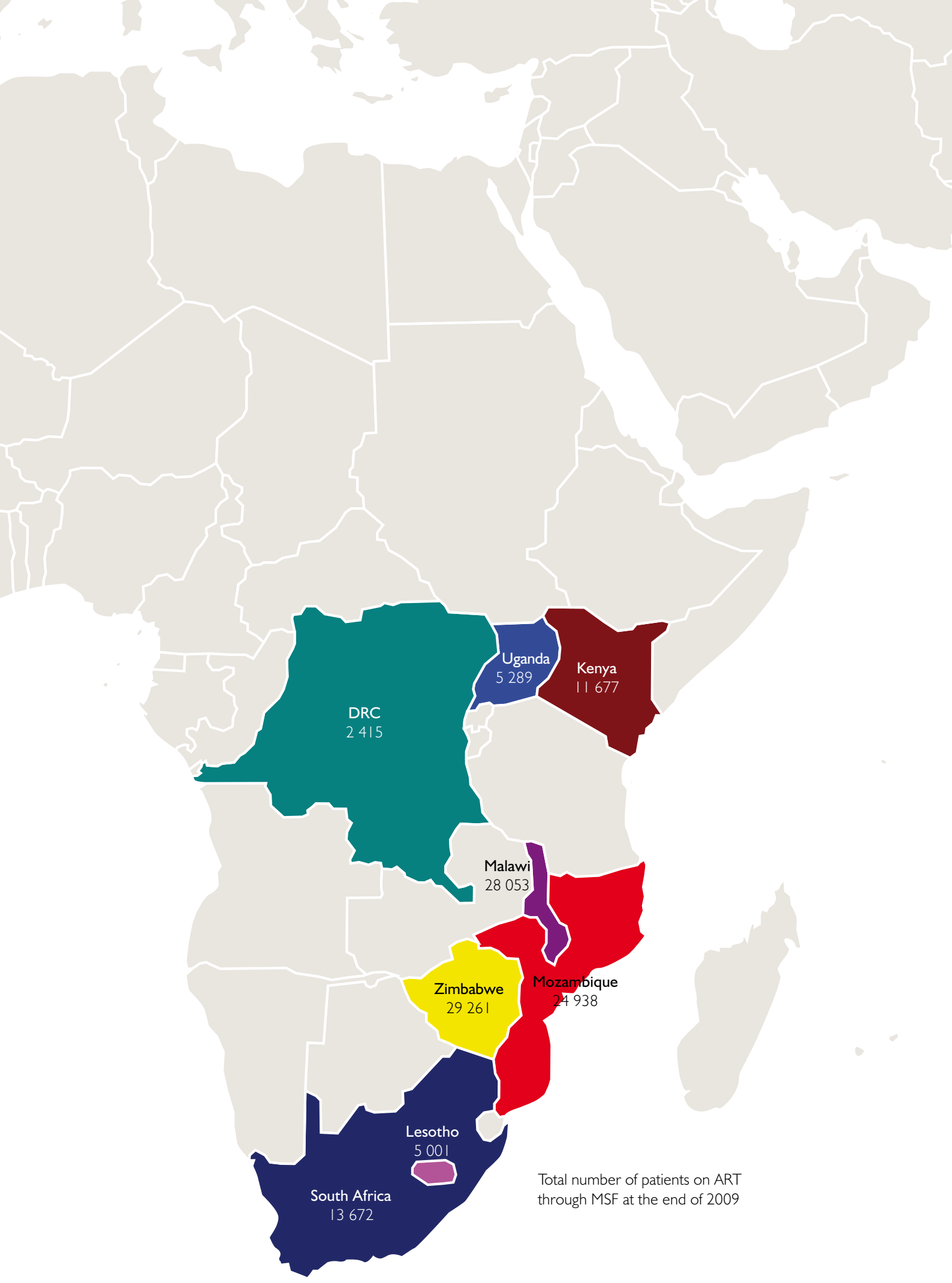
Evolution of mortality rates in the eight countries included in this report.



Source:
Data was taken from http://www.census.gov/ipc/www/idb/informationGateway.php, and completed with data from http://globalis.gvu.unu.edu.

1 WHO's "3 by 5" initiative refers to the target of three million people on treatment by 2005.

2 End of 2008, UNAIDS estimated that worldwide 4 million people were receiving ARV treatment, on a total of 9.5 million people in need of ART. In December 2009, WHO recommended changing the CD4 count for ART initiation from <200 cells/µl to <350 cells/µl. This would mean an estimated additional 30-50% of HIV positive people are eligible to start ART immediately. This would amount to 5 million extra in need worldwide. Reference: Orsi et al.; *Call for action to secure universal access to ART in developing countries*. Lancet, Vol. 375, p.1693; May 15, 2010.



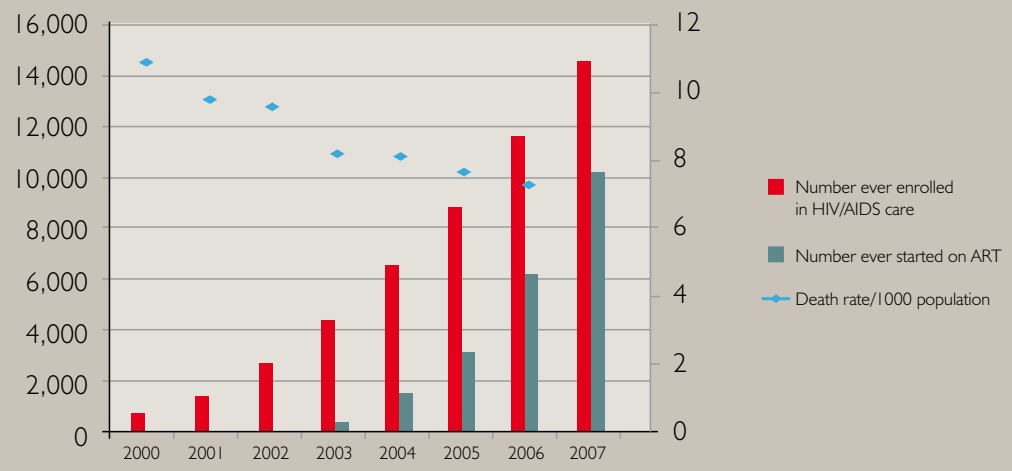
Total number of patients on ART through MSF at the end of 2009

1.2 POSITIVE IMPACTS OF HIV/AIDS TREATMENT INTERVENTIONS DURING THE PAST DECADE

Saving lives

The provision of ART on a large scale has prevented millions of deaths and allowed millions of people with HIV/AIDS to maintain or resume an active life.[3] Experience from Thyolo, Malawi, where in partnership with the health authorities MSF has provided universal access to ART since 2007, showed a significant downward trend in mortality coinciding with the scaling up of HIV/AIDS care and treatment,[4] which suggests that ART is having an impact on mortality at the population level.

Figure 3
Registered deaths at five traditional authorities and relationship to enrolment in HIV/AIDS care and antiretroviral treatment (2000-2007), Thyolo district, Malawi.



Source: Mwagomba B. et al. PLosOne. Available at: http://dx.plos.org/10.1371/journal.pone.0010452

3 Bendavid E, Bhattacharya J. *The President's Emergency Plan for AIDS Relief in Africa: An evaluation of outcomes.* Annals of Internal Medicine. 2009; 150(10):688-696.

4 Mwagomba B, Zachariah R, Massaquoi M, Misindi D, Manzi M, Mandere BC, Bemelmans M, Philips M, Kamoto K, Schouten E, Harries AD. *Mortality reduction associated with HIV/AIDS care and antiretroviral treatment in rural Malawi: Evidence from registers, coffin sales and funerals,* PLoS ONE 5(5): e10452.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"Before antiretrovirals I had fears that I would die and something would happen to my children. Today I'm looking for a better job and thinking ahead. If I feel bad I know why and I will go to the clinic. So I'm not seeing myself dying."

Portia, HIV patient, South Africa

"Antiretroviral drugs have changed my life from negative to positive. Without ARVs, I would not be on this planet. They saved my life."

Luis, HIV patient, Mozambique

"ARV s have given me a second chance, and they allow me to live the way that anyone else who does not have HIV would live."

Meria, HIV patient, Zimbabwe

Preventing tuberculosis

Tuberculosis (TB) is one of the leading causes of illness and death among AIDS patients. HIV fuels the current TB epidemic in southern Africa, with co-infection rates in excess of 90% reported in some regions.[5] ART is known to reduce the incidence of TB by up to 60%,[6,7] and preliminary data from Thyolo, Malawi, show an encouraging decline in TB case notification rates (more than 30% from peak levels) during the period of ART scale-up.[8] Similarly, in Khayelitsha, South Africa, where approximately 70% of TB patients are HIV positive and approximately 50% of HIV patients have TB when they are initiated on ART, the annual absolute number of TB cases has stabilized (even with improved TB detection); this can partly be explained by the large-scale ART coverage in the district.

Reducing transmission

Increasing ART coverage has also contributed to reduced HIV transmission in the community and models of expanded HIV testing and treatment, both at population level or among specific groups such as pregnant women or high risk groups, are promising.[9,10]

Reducing the burden on health facilities

Widespread availability of ART has also reduced the burden on health facilities, in particular the demand for inpatient and palliative care. In Busia, Kenya, the proportion of people hospitalised has decreased with the availability of ART: the proportion of bedridden patients declined from 10% in 2004 to less than 2% in 2009 as a result of increased ART coverage.[11]

Improving uptake of other health services

The offer of HIV/AIDS care also often leads to improved uptake of other services. For example, prevention of mother to child transmission (PMTCT) programmes can lead to increased numbers of women receiving maternal care. In MSF's project in Thyolo, Malawi, thanks to PMTCT initiatives and simultaneous support to reproductive health care as a whole, the proportion of women (regardless of HIV status) delivering in health centres nearly doubled from 22% in 2006 to 41% in 2008.

Strengthening health services

ART programmes often result in broad improvements in health services. In Thyolo, Malawi, the monitoring and evaluation tools that were initially developed for HIV/AIDS were adapted and used for laboratory activities, nutrition and hospital wards. Drug supply management tools that were created for AIDS drugs were then applied for general drug supply management, thus benefitting the entire health service. Similar broad health service benefits have been documented by MSF in Lesotho and South Africa.[12,13]

Winnie Jalasi, AIDS patient in Malawi, recalls what it was like when there were no ARVs available: *"If you walked in the wards those days they would be overflowing with patients whose destiny was death. The patients knew that there was no treatment and they would wait agonizingly for their turn to die. Orphans were being created right before our eyes in the hospitals and before this, they would have been the ones looking after their sick parents. It was a very hopeless situation. Funerals were the order of the day."*

"Before ARVs were introduced, most hospital admissions were HIV-related, and there were a lot of deaths. People were suffering from preventable life-threatening diseases. Now, there is less people dying of HIV-related complications. There's less hospital admissions, less people coming to seek help for treatment for opportunistic infections. It has reduced the workload."

David, Clinical Officer, Kenya

5 Cohen R, Lynch S, Bygrave H, Eggers E, Vlahakis N, Hilderbrand K, Knight L, Pillay P, Saranchuk P , Goemaere E, Makakole L, Ford N. *Antiretroviral treatment outcomes from a nurse-driven, community-supported HIV/AIDS treatment programme in rural Lesotho: observational cohort assessment at two years*. Journal of the International AIDS Society 2009, 12;23:1-8.

6 Middelkoop K, Wood R, Myer L, Sebastian E, Bekker LG. *Widespread ART is associated with decline in TB prevalence*. IAS Conference, Cape Town 2009. Abstract Number WELBB105.

7 Egger M, Boule A. *Population effect of scaling up ART in resource-poor settings*. Lancet 2008, 371(9624):1558-9.

8 Source: District health services, Thyolo, Malawi and National TB Control program, Lilongwe, Malawi

9 Granich RM, Gilks CF, Dye C, De Cock KM, Williams BG. *Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model*. The Lancet. 2009;373(9657):48-57.

10 *Will we end the HIV epidemic? The impact of HIV treatment on HIV prevention and implications for the 2010 replenishment of the GFATM*. IAS, March 2010. Available at: http://www.iasociety.org/Web/WebContent/File/IAS_GFRreport_March_2010.pdf.

11 *A Model of HIV/AIDS Care and Treatment in a Rural Setting. The experiences of MSF in the Greater Busia District, Western Kenya (2000 – 2010)*; Médecins Sans Frontières, Barcelona, April 2010.

12 Cohen et al, loc. cit.

13 Ford N, Reuter H, Bedelu M, Schneider H, Reuter H. *Sustainability of long-term treatment in a rural district: the Lusikisiki model of decentralized HIV/AIDS care*. Southern African J HIV Med December 2006. 17-20.

"It's obvious that the impact of ARVs is felt at community level. When we talked to the local chiefs, you could hear them say that they were now able to get along with their everyday activities, because previously there would be a death in this house, a death in that house. There is also much less stigma around HIV."

Beatrice, District Health Officer, Malawi

Reduced loss of healthcare workers

The introduction of ART has also averted many deaths among health workers. In Zambia, deaths account for up to 40% of all nurse attrition from the public sector; in Lesotho,[14] Malawi and Mozambique, death is the main reason for attrition among health workers. In Malawi, a national survey in 1999 found a 2% annual death rate among key healthcare workers, with AIDS and TB being the most common causes.[15] The impact of ART provision on the number of health workers at work is well documented in Malawi.[16] Between 2006–2009, in a staff clinic in Thyolo district, 67 out of 747 health workers were initiated on ART and stayed healthy enough to continue working.[17]

14 Tawfik L, Kinoti S. *The impact of HIV/AIDS on Health Systems and the Health Workforce in sub-Saharan Africa. Washington DC:SARA Project 2003, USAID Bureau for Africa*, 2003.

15 Harries AD, Hargreaves NJ, Gausi F, Kwanjana JH, Salaniponi FM. *High death rates in health workers and teachers in Malawi*. Trans Roy Soc Trop Med Hyg 2002; 96:34-37

16 Makombe SD, Jahn A, Tweya H, Chuka S, Yu JK. *A national survey of the impact of rapid scale-up of antiretroviral therapy on health-care workers in Malawi: effects on human resources and survival.* Bull World Health Org 2007; 85(11):851-7.

17 Bemelmans M, Massaquoi M, Mwagomba B, Pasulani O, Jalasi W, Philips M. «*Fear of stigma is stronger than fear of death*»: *a workplace initiative to reduce sickness and death due to HIV/AIDS among health staff in Malawi.* XVII International AIDS Conference, Mexico, 3-8 August, 2008.

Thyolo costing study

MSF has been present in Thyolo district since 1997, and in collaboration with the district authorities, started providing PMTCT in 2002 and ART in 2003. Between 2000 and 2004, life expectancy at birth in Malawi was as low as 45 years. Universal access (covering 80% of the needs as per the former WHO criteria) was reached in Thyolo in 2007 and has been maintained since. In 2008, a retrospective cost analysis was carried out, taking into account the combined costs incurred by MSF and the Ministry of Health. The analysis showed that in 2007, the overall average annual cost per patient on ART was €233, of which 54% was for the ARVs and 11% was for essential drugs. Between 2005 and 2007, the consultation cost per patient per year decreased by 47%, which demonstrates the impact of economies of scale and improved organization of care. Applied to the entire Thyolo population, the project costs approximately € 2.6 per inhabitant per year; added to the Malawi Essential Health Package this brings the total health cost to € 16 per inhabitant per year. This is well within the WHO recommended average health expenditure (even in this high-prevalence district).[18]

18 Jouquet G, Bemelmans M, Massaquoi M, Arnould L, Mwagomba B, Zachariah R, Bauernfeind A, Philips M. Cost Analysis of an HIV programme reaching district-wide access to ART in Thyolo, Malawi, 5th IAS Conference on HIV Pathogenesis, Treatment and Prevention, Cape Town, 2009. Abstract TUAD105.

1.3 TREATMENT GAP

ART roll-out so far has been impressive, but insufficient. Access to treatment has steadily increased in most of the countries studied, thanks to the combined efforts of numerous actors (Figure 4). Nonetheless, there is still a long way to go; none of these countries has yet reached the national "universal access" target of 80% of people in need of ART on treatment (Figure 5), leaving a treatment gap of some two million people.

Figure 4
Absolute number of people on ART per country studied

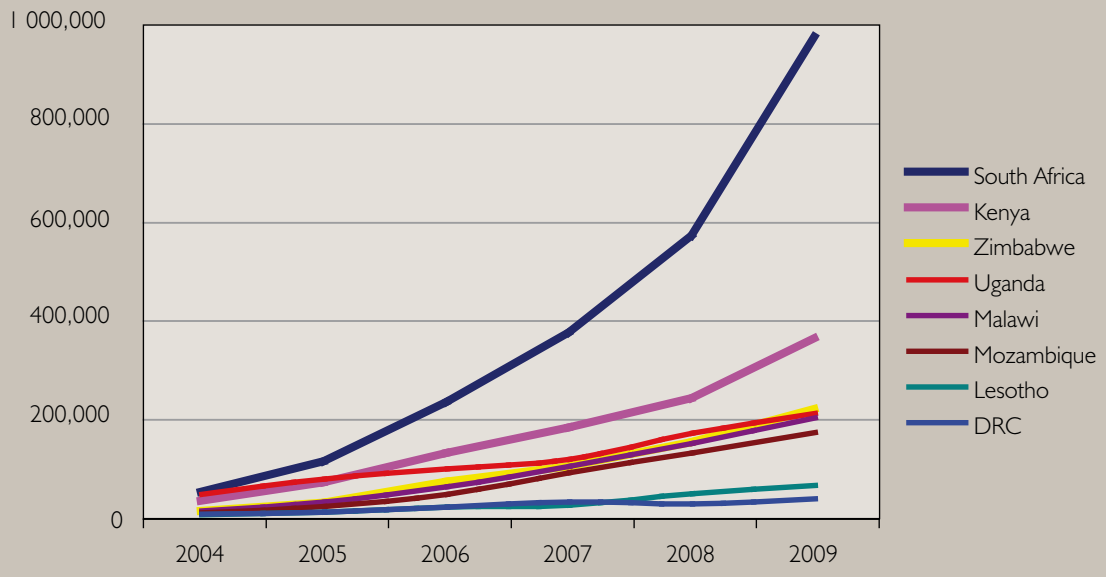
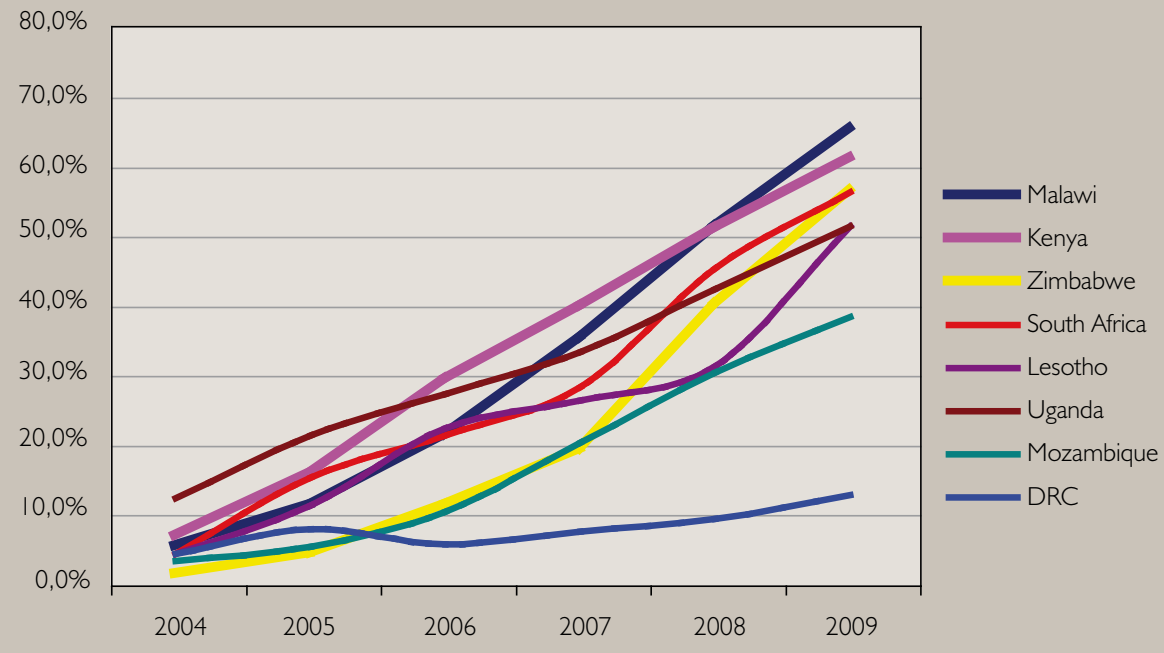


Figure 5
People on ART as a percentage of country needs[19]



Sources: UNAIDS/WHO Epidemiological Facts Sheets on HIV and AIDS, 2008 Update; UNGASS country reports for 2010, 2008 & 2007; Reporting from Ministries of Health in Mozambique and Malawi for 2010; Adam M, Johnson L. Estimation of Adult antiretroviral treatment coverage in South Africa. SAMJ, Vol.99, No.9, September 2009.

19 As per former WHO initiation criteria (CD4 count<200/µl) except for Lesotho 2008 and 2009 data.

In spite of the ongoing crisis, donors speak less and less about targets for treatment. Yet no longer talking about quantified targets when fighting an epidemic makes no sense; evaluating progress in a quantified manner is crucial. Even UNAIDS no longer has a global mobilising target beyond 2010. Where Universal Access was previously commonly understood as coverage of at least 80% of the needs. Today, increasingly Universal Access is interpreted as "any objective of coverage set by the country."[20] The present reality is that, in spite of the undeniable epidemic character of HIV/AIDS, many countries' ambitious objectives have been watered down, discouraged by the bleak funding perspective.

Access is about sufficient available treatment slots and ART sites distributed across the country. Today already, poorer patients cannot access the ARV lifeline, and rural areas in particular are underserved. MSF teams frequently see patients whose only option for treatment is to travel long distances to clinics where ART is available. In Zimbabwe, up to 20% of the patients at MSF clinics are from other districts: they come here seeking to start ARV, because they cannot get in time the treatment they need at health facilities near their homes. In Maputo, Mozambique, MSF sees patients from rural areas who have to make expensive and time-consuming journeys to the capital for treatment. We see similar 'treatment migrants' in MSF-supported clinics in Zimbabwe, DRC, Mozambique, Kenya, Uganda and also in Guinea-Conakry and Central African Republic. In Kinshasa, DRC, patients arrive late, often in critically weak condition, not because they did not seek care, but because the health facilities they consulted did not have ART available or patients could not afford the 15 USD for a CD4 test that would allow them to start ART.

Limiting scale-up and geographical coverage of sites providing ART will only worsen these inequalities and provoke a renewed rise in avoidable deaths. Any retreat from the current efforts of ART scale-up will have important negative consequences for patients and front line workers:

- Patients will have to wait longer to start ART and are at risk of dying before they can have access to life-saving medication. Patients left untreated risk deteriorating and succumbing to opportunistic infections (OI) such as TB. More patients will be lost to follow up, even before they can start ART. [21]
- Patients starting with lower CD4-counts require more frequent, more intensive and more costly care; at the same time they have a lower chance of survival and take longer to recuperate.
- The patient load at health facilities will increase and health workers will be discouraged by the worsening outcomes among the patients to whom they provide care.
- Patients might start sharing their pills, effectively lowering their dosage and increasing the risks of virus transmission and resistance.
- Tensions will rise between patients already on treatment and those not yet on treatment.
- Tuberculosis rates will increase and represent an additional burden on already busy clinics.
- Mortality rates among adults in the prime of their lives and the number of orphans will rise again in the community.
- Insufficient ARV availability will require a slowing down of testing and counselling activities.

Two million people are still dying of HIV/AIDS each year in sub-Saharan Africa, yet the majority of these deaths could be averted by increased access to ART. Substantial and sustained investment is urgently needed to continue scaling-up access to treatment. Without it, millions of people will die unnecessarily.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20 *What countries need: Investments needed for 2010 targets*. UNAIDS, Feb 2009. Available at: http://data.unaids.org/pub/Report/2009/jc1681_what_countries_need_en.pdf

21 Zachariah R et al. *Very early mortality in patients starting antiretroviral treatment at primary health centres in rural Malawi*. Trop Med Int Health, 2009. 14, 7:, 713-721.

"Many people die waiting for treatment. Our clinics are very small and we have shortage of staff. When people get to the clinic there are long queues and maybe no doctor or pharmacist. We have NGOs that are trying to provide antiretrovirals and treatment for opportunistic infections to people for free but the problem is that those clinics are very far away."

Portia, HIV patient, South Africa

02 ACUTE FUNDING CRISIS: DONORS' RETREAT FROM EPICENTRE OF THE HIV EPIDEMIC

In most of the eight countries analysed for this report, donors are either flat-lining or decreasing their involvement in HIV/AIDS. In some countries there is also a reduced number of donors actively supporting AIDS programmes. There is strong pressure from donors for short-term budget reductions euphemistically referred to as "efficiency improvements". Some donors are steadily moving away from treating HIV/AIDS as an emergency, with dedicated flows of funds, to more indirect interventions.

The donors' statements are reminiscent of arguments raised ten years ago against starting ART. One argument that can no longer be put forward is that large-scale AIDS treatment is not feasible in low-resource settings, as the achievements to date are beyond question. The discourse has instead shifted from "not feasible" to "not affordable". The result is that Official Development Assistance (ODA) budget cuts for HIV/AIDS are announced and funding mechanisms that are perceived as effective and good value for money are beginning to receive less and less support.

2.1 THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Since 2009, contributions to the Global Fund[22] from major donors have stagnated. Recently, The Netherlands, Ireland, USA and Germany have all announced reductions in their contributions to the Global Fund, while payments from the USA, France and Italy are behind schedule and 2010 pledges have not yet been paid. The European Commission and Germany have only paid half of their commited contributions so far.

The funding gap faced by the Global Fund has threatened the launch of the 2010 funding round and the Global Fund's contributions to approved country grants was reduced by 8–12% in so-called "efficiency cuts".

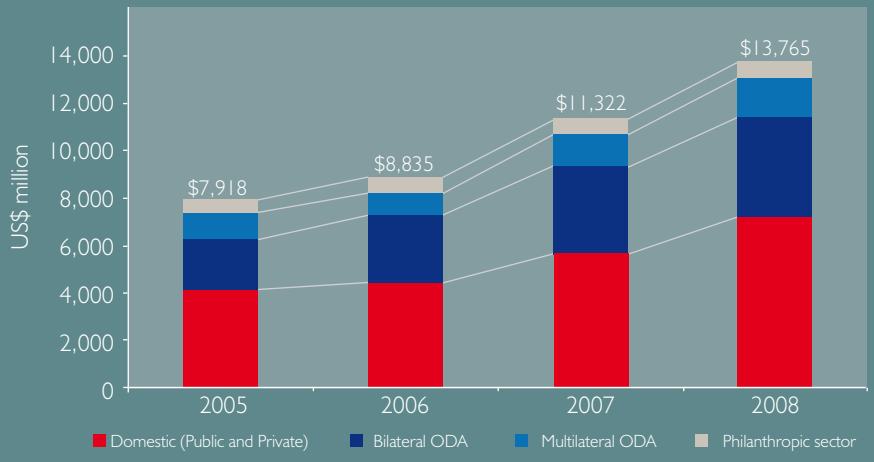
Despite threatened postponement, Round 10 will be launched in May 2010. However, at the Global Fund board meeting in April 2010, donors proposed to limit the money that can be spent on Round 10. This undermines one of the core principles of the Global Fund – that demand by countries and quality of proposals drives funding. For donors, capping seems to be considered the preferred measure to manage the Global Fund's shortfall of funds, despite alternatives such as reducing the reserves kept in the bank or bringing forward the subsequent replenishment rounds.

In October 2010, a donor replenishment conference is planned to mobilize funds for the period 2011–2013. Donors have already requested the Global Fund to lower its financial ambitions. In 2009, the initial estimated needs were set at USD 20 billion for 2011-2013. In 2010, this estimate was revised down in the form of two additional scenarios, USD 13 or 17 billion respectively. All three scenarios inadequately reflect demand, as none include the additional resources required to implement the new WHO guidelines on earlier treatment and improved drug regimens. These funding levels will force rationing of treatment under Global Fund grants and accepting to support sub-standard treatment.

22 The Global Fund is a multilateral initiative to respond to the three infectious diseases with the largest burden in developing countries. The original promise to the Global Fund at its creation in 2001 was to provide an annual working budget of USD 10 billion to fund programmes against HIV/AIDS, malaria and TB. In reality, the Global Fund has received an average annual pledge of USD 3 to 3.5 billion. Nevertheless, the Global Fund has had a significant impact on the number of people on treatment and has grown into the main funding source for 117 country's HIV/AIDS roll-out plans.

In 2006, the UN General Assembly estimated that the needs to scale-up towards universal access would reach USD 20 to 23 billion by 2010. The following year UNAIDS established forecasts on financial needs for HIV/AIDS between 2007 and 2015.[23] Based on country-defined targets, UNAIDS estimated that approximately USD 25.1 billion would be required for the global AIDS response for low and middle income countries in 2010.[24],[25] The overall funding available for HIV/AIDS has reached about half that amount. Moreover, estimates are based on old treatment initiation criteria: the actual number of people clinically eligible for ART today is substantially higher.

Figure 6
Investments available for AIDS

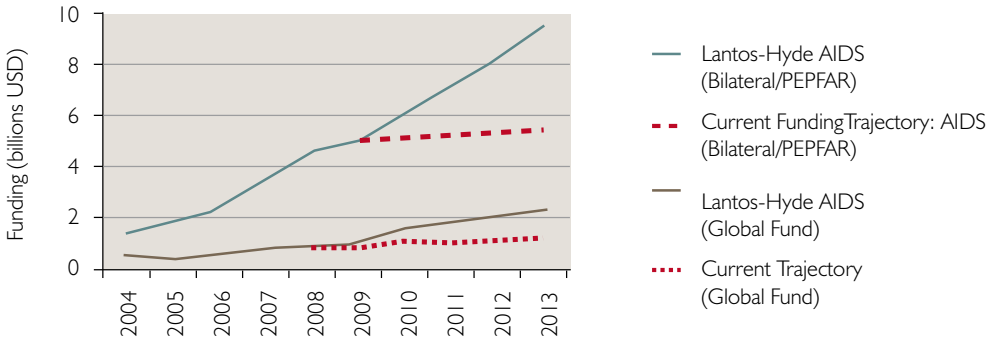


Source: UNAIDS. What Countries Need: Investments needed for 2010 targets. Geneva, February 2009, p.12.
Available at: http://data.unaids.org/pub/Report/2009/20090210__investments_needed_2010_en.pdf

2.2 US GOVERNMENT'S PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (USG PEPFAR)

The second phase of the US government's bilateral **PEPFAR**[26] programme was authorised in 2008. In contrast with incremental increases of the previous years (Figure 7) and despite US congressional authorization for a continued increase of funding for PEPFAR in the second phase, the funding for PEPFAR has been effectively flat-lined for 2009, 2010, and with similar proposals for the following years. As part of the US Global Health Initiative, PEPFAR II budget allocations will now cover six instead of five years, ***de facto*** reducing annual budget allocations for 2009–2014 from the initial re-authorisation plans. In addition, the US contribution to the Global Fund for 2010 was frozen and the White House has proposed a $50 million reduction of the US Global Fund contribution.

Figure 7
US Government Global HIV/AIDS Contributions: 2004 – 2013 (actual and proposed)



Source: Health GAP Policy Analysis: Making a Mistake on Treatment – PEPFAR's New Five-Year AIDS Strategy by Brook K. Baker, Feb. 5, 2010; accessible at : http://www.healthgap.org/waiting-in-line-baker-paper.htm and the Lantos and Hyde 2008 act for re-authorisation of second phase of PEPFAR; accessible at : http://www.pepfar.gov/about/index.htm

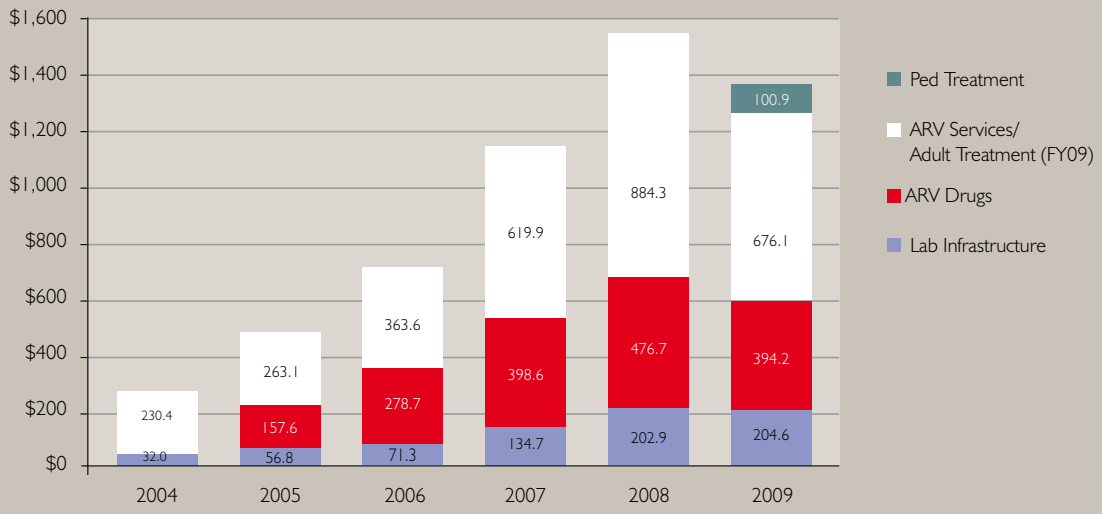
23 UNAIDS. *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support*. Geneva, September 2007, p.7. Available at: http://data.unaids.org/pub/Report/2007/20070925_advocacy_grne2_en.pdf.
24 UNAIDS. *What countries need: Investments needed for 2010 targets*. February 2009, p.7.
25 Approximately USD 7 billion is the estimated need for treatment. Idem as ref 23
26 The US government's Emergency Plan for Aids Relief (known as PEPFAR) began in 2003. It included 15 focus countries and had provided financial support for an estimated 2.4 million people on ART by the end of September 2009.

Reducing direct support for ARVs

PEPFAR is increasingly passing on the responsibility of direct funding treatment for patients to countries whenever possible, or else to the Global Fund. The ever increasing number of patients alive and on ART – previously the indicator of success – has now turned into a source of concern for the US government, as it implies a need for continuous funding. However, the hand-over of massive ART programmes cannot possibly be imposed within an arbitrarily limited timeframe. As a result, some scale-up is being halted with little or no warning and with dramatic consequences for those seeking treatment, thus putting enormous pressure at service-delivery points.

PEPFAR reduced its budget for treatment for the first time in 2009, from USD 1.56 billion in 2008 to USD 1.38 billion in 2009. Within that reduction, the allocation for ARV medicines decreased by 17% (from USD 477 to 394 million). The effects of reduced or flat-lined funding for HIV/AIDS treatment translates into a clear reduction in the number of people getting ART. PEPFAR plans to put an extra 1.6 million people on treatment over a period of five years (2009-2014), compared to 2.4 million by September 2009. In practice this means an average reduction in annual initiations planned of 56% compared to 2006-2008.[27]

Figure 8
"Focus" Country Treatment Funding by Fiscal Year (in millions)



Note: there was a change in accounting of program dollars beginning with the FY09 COP that may account for the appearance of program matic shifts between program areas.
* Prevention includes Counseling & Testing for all fiscal years
** The "Other" category includes management & staffing, other policy analysis/system strengthening, healt system strengthening (FY09 only) and unallocated funding.

Source: Presentation by Charles Holmes C, Senior Technical Advisor, Office of the US Global AIDS Coordinator. Using costing and modeling to improve treatment and other program planning. Presented at 2009 Track One Partners Meeting August 4-6, 2009 in Dar Es Salaam, Tanzania. Available at: http://www.go2itech.org/resources/publications-presentations/other-resources/2009_Track-One/RevisedHolmes-TreatmentCosting-Track1_Dar.ppt (Accessed 2/5/2010)

At country-level, this translates into reductions in purchase contributions. In Mozambique, the US government's PEPFAR has announced it will reduce its ARV supplies by 10-15% each year over the next four years. The opening of new ART sites under PEPFAR funding was also rejected.

In South Africa, ARVs and drugs for OIs, and laboratory supplies, previously provided by PEPFAR to private ART treatment sites, will henceforth have to be supplied by the government.

Several PEPFAR-funded sites in South Africa have been halting or limiting ART initiation following instructions to cut expenses in view of flat-lined budgets. In Mpumalanga province alone, about 240 patients were refused ART initiation between November 2009 and February 2010. Handover of responsibility for supply of Tenofovir (first-line ARV used for 500 patients), medicines for OIs and laboratory testing to the government has resulted in inconsistent supply. In Free State province, the continuation of treatment for 2,500 patients in private facilities and at general practitioners' is presently at stake. The official explanation is that more emphasis will be put on strengthening capacity through providing technical assistance, shifting away from the service-delivery approach, however the absorption capacity of the public sector is extremely limited, as shown by the ART initiation freeze in Free State following ARV shortages in 2008 and 2009.[28]

27 Between 2006 and 2008, PEPFAR funded-programmes were initiating an average of 49,000 patients every month. Source: http://www.pepfar.gov/about/tables/treatment/123461.htm. The average set under GHI is around 26,000 initiations per month (1.6 million people extra over 5 years). "The U.S. President's Emergency Plan for AIDS Relief: Five-Year Strategy," December 2009, available at: http://www.pepfar.gov/strategy/

28 Due to a budget shortfall in 2009, people living with HIV/AIDS in Free State province faced a four-month suspension of treatment. The Southern African HIV Clinicians Society estimates 3,000 people living with HIV/AIDS died as a consequence.

Dr. Margie Hardman,
Medical Doctor working in a PEPFAR-funded treatment site
in South Africa, explains the situation in November 2009.

"Up to then, we had really good funding through PEPFAR, through the umbrella organisation "Right to care". But we were told at that stage that we couldn't put more patients on ARVs because the funding was insufficient. So basically we had to turn patients away and refer them to the local government hospital or clinics. We all found it very difficult sending patients away. We don't know how many of them died or what happened to them unfortunately.

I think the consequences of someone that has been tested HIV positive and that can't get on treatment very quickly are really terrible. Those patients have plucked up the courage to have the test, they know that people who get ARVs got better. So, they are very disappointed. And because their CD4 counts were quite low, they will pick up TB, they will get sick with pneumonia, meningitis, many things. If we could have had them on ARVs quickly, this would have been prevented."

In Uganda, rationing of treatment was requested in PEPFAR supported health facilities. In October 2009, the US's Centers for Disease Control and Prevention (CDC) sent out a letter explicitly asking its implementing partners to "only enrol new ART patients if they are sure that these new patients can continue to be supported without a future increase in funding", but at the same time instructing partners that "all adult and paediatric patients currently being treated with drugs donated by Clinton Foundation should also be fully covered within the set partner budget", thus implying an actual decrease in the number of granted treatment slots. ***De facto*** enrolment of new patients is only allowed when existing patients are lost through death or attrition. Over the last six months non-governmental organisations (NGO) in Uganda have reduced HIV testing efforts in keeping with the reduced provision of ART.

Rationing of ART initiation is also applied through applying specific selection criteria. In sites in Zimbabwe, Uganda, and South Africa, PEPFAR-supported clinics have to reserve treatment slots in priority to pregnant women or children. Other patients only can start ART when CD4 counts drop below 50, which is effectively a policy of encouraging people to fall ill (most frequently with TB) before providing them ART.

2.3. OTHER DONORS

The World Bank's Treatment Acceleration Project (TAP) programmes ended in 2008, and its Multi-country HIV/AIDS Program for Africa (MAP) is coming to an end in several countries, with no plans for any HIV/AIDS-specific continuation programme. The World Bank intends to concentrate on health systems strengthening and capacity building in planning and management, with specific attention to management capacity of drugs and medical supplies. But without funding for ARV drugs and recurrent costs, the impact of such capacity for supporting HIV/AIDS care will be limited.

This reflects a general trend among donors to reduce their funding support for the purchase of ARVs even though this can be the greatest expense: in Malawi, for example, drug purchase represents 65% of the overall programme cost.[29]

UNITAID/Clinton Health Access Initiative (CHAI) is phasing out its funding of HIV drugs and commodities.[30] By 2012, UNITAID/CHAI procurement of second line ARVs and paediatric medical commodities will end in Zimbabwe, Mozambique, DRC and Malawi.

29 Jouquet G, Bemelmans M, Massaquoi M, Arnould L, Mwagomba B, Zachariah R, Bauernfeind A, Philips M. *Cost Analysis of an HIV programme reaching district-wide access to ART in Thyolo, Malawi,* IAS Conference Cape Town, 2009; abstract TUAD105.

30 Funding for paediatric commodities is due to end in September 2010. In line with the initial overall timeframe of UNITAID funding through CHAI, funding for 2nd line ARV was to end in December 2009; a two year multi-country transition extension was granted by UNITAID, while transition to other donors is explored.

HIV/AIDS funding by the European Commission and the European Union's Member States, all together, amounts to € 4.9 billion, from which overall one quarter or €1.2 billion goes to the Global Fund (2007). Overall bilateral channels (EC and EU member states) allocate €3.68 billion to HIV (2007). The UK and the Netherlands are the EU member states with the largest bilateral HIV/AIDS funding.[31] Annually €55.4 billion or about 2.9% of the overall European Development Fund (EDF) -budget goes to health in 13 countries, including funding for HIV/AIDS.[32] However, it is increasingly difficult to know what funding goes to HIV/AIDS interventions; as part of the aid effectiveness agenda, the European Commission and many Member States are moving towards (sector) budget support modalities, which by definition are not earmarked. Within the general approach of the European Commission and the member states there is among others an intention to "rationalise" the number of sectors per donor and some donors are withdrawing funds from health. This concept of division of labour can be problematic in practice, when donor exits are not compensated by increased funding for health from other sources. In Mozambique, for instance, several EU member states' donor agencies comment on the current reduction in the number of EU donors within the health sector and its impact on the overall envelope of funding, possibly endangering further progress in health. A similar tendency is seen in other countries e.g. DRC, with the announced departure of Belgium and UK from health sector funding and the reduction of the European Development Fund 10 budget.

These trends fall within a more general move away from funding emergency interventions to providing indirect support. Since 2005 most donors have signed the Paris declaration, a framework to 'improve effectiveness of their development aid'.[33] In line with this discourse of alignment and building country-systems, donors now prefer to use AIDS treatment funding to finance capacity-building, technical assistance, consultancies, and one-off investments rather than service-delivery activities.[34] Also there is also a growing tendency to prefer funding health in general. There is clearly a need for increased support to health but this should not be at the expense of continued support to scaling-up access to AIDS treatment and care.

31 *Financing the response to AIDS in low- and middle- income countries: International assistance from the G8, European Commission and other donor Governments in 2008.* The Kaiser Family Foundation and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Accessible at: http://data.unaids.org/pub/Presentation/2009/20090704_UNAIDS_KFF_G8_CHARTPACK_2009_en.pdf

32 See:http://ec.europa.eu/development/geographical/maps/domaines_de_concentration.pdf

33 The Paris declaration on aid effectiveness aims to encourage increased ownership of strategies and priorities by the concerned government, and alignment of donors behind the government's objectives. At its core lies the assumption that better use of the aid will attract significant additional means to support recipient countries.

34 According to WHO, a major part of ODA already goes into technical cooperation.
"Reprogramming current spending might have some potential to release some funds. It has been shown that a high proportion of official development assistance in health is going to technical cooperation, over 40% in 2006. While technical cooperation is valuable, there is the question of whether there might be scope for more efficiencies in this particular area, allowing more money to be spent on actually improving health in the low income countries. Reference: WHO. Constraints to Scaling Up Health Related MDGs: Costing and Financial Gap analysis. Background to the Working Group 1 report to the Taskforce on Innovative International Financing for Health Systems, Final Draft as of 23 September 2009. Available at: http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf. Accessed 1 May 2010.

HEALTH WITHOUT ADDRESSING HIV/AIDS?

The majority of donors today prefer providing funds to strengthen health systems generally rather than to fund HIV/AIDS treatment programmes specifically. While health systems in developing countries undoubtedly need huge support, the risks of removing specific attention from HIV/AIDS are already becoming clear.

- Several donor countries (and several governments of recipient countries) are asking that money pledged to the Global Fund also be used for more health systems strengthening, interventions for mother and child care etc. without adding any financial resources. As the Global Fund is now perceived as a highly effective funding channel delivering results for Millennium Development Goal (MDG) 6 (HIV/AIDS malaria, and other major diseases), these donor countries are pushing to expand the Global Fund's mandate to include interventions aiming at MDG 4 (child mortality) and MDG 5 (maternal health) as well. But without a significant increase of funds to the Global Fund, this will inevitably lead to further depletion of funding available for HIV, malaria and TB.
- The US government's current Global Health Initiative (GHI) highlights health system strengthening and improvement in human resources for health under PEPFAR II. In Zimbabwe, treatment support for at least 3,000 adults is due to be redirected to focus solely on mothers by 2011, to fit with the US's current emphasis on maternal and child health. President Obama's Global Health Initiative (GHI) highlights health system strengthening and improvement in human resources for health under PEPFAR II. A focus on pregnant women is used for rationing of care, like in Uganda and Zimbabwe. In Zimbabwe, treatment support for at least 3,000 adults is due to be redirected to focus solely on mothers by 2011, to fit with the US's current emphasis on maternal and child health.

There are numerous cross-benefits and spin-offs of effective HIV/AIDS interventions for wider health issues.[35] HIV/AIDS specific interventions have brought significant improvements in other health priorities and contributed to health system strengthening as a whole. Ignoring the HIV/AIDS epidemic would only bring about a 'lose-lose' situation. Indeed, targeting the MDGs cannot possibly be done without properly tackling HIV/AIDS. In Mozambique, 10% of deaths among children is attributed to HIV (2009)[36] and in Zimbabwe the main cause of maternal mortality is HIV. Maternal mortality is significantly higher among HIV positive women. It has been estimated that without HIV/AIDS, maternal mortality in 2008 would be 20% lower,[37] while another study concluded that HIV is one of the main reasons for countries not progressing towards the MDGs.[38]

35 WHO Maximising positive Synergies Collaborative Group, Samb B et al. *An assessment of interactions between global health initiatives and country health systems.* The Lancet, 2009. Jun 20;373(9681):2137-69.

36 Mozambique, National Child Mortality Study 2009. UNICEF, Misau, 2009.

37 Rajaratnam J et al. *Worldwide mortality in men and women aged 15—59 years from 1970 to 2010: a systematic analysis*. The Lancet, Early Online Publication, 30 April 2010.

38 Stuckler D, Basu S, McKee M (2010) *Drivers of Inequality in Millennium Development Goal Progress: A Statistical Analysis*. PLoS Med 7(3): e1000241. doi:10.1371/journal.pmed.1000241.

"The donor-community stating that HIV is not an emergency is completely wrong. It's no longer "sexy" to give funding to HIV and that's a mistake."

James, patient activist, Kenya

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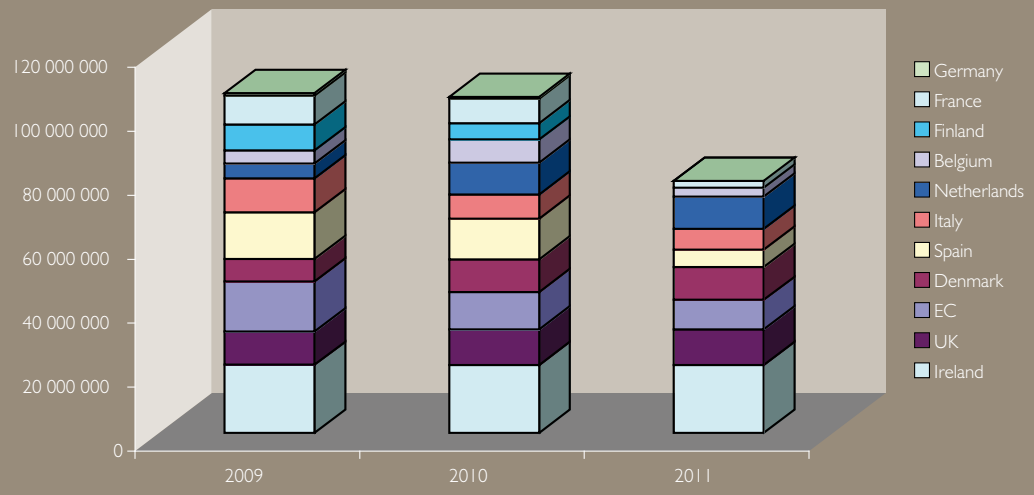
FIELD EXAMPLE: MOZAMBIQUE

The EU has agreed to a specific Code of Conduct on the division of labour in its development policy.[39] Its third guiding principle aims to "ensure an adequate EU presence in strategic sectors" and to "avoid fragmentation of aid by a division of labour among EU Member States." This Code of Conduct specifically states: "It is essential that division of labour is not implemented at the expense of global aid volumes or aid predictability". Nevertheless, we see an overall decrease in the support of EU countries to the Mozambican health sector in 2011 compared to 2010. Meanwhile, there has been no increase in domestic funding to health.

Figure 9

EU commitments for the health sector in Mozambique



Source: Data from Mozambique's Mid Term Expenditure Framework (MTEF) for 2009-2011 for the health sector, all funding included (sector and project support, and all health HIV/AIDS funds). Note: Assumption of equal contribution of Ireland for 2011, as no information yet available.

France and Finland will leave the health sector in 2011; their exit is not compensated by other donors. The UK plans to withdraw from health in 2012. The overall impact will depend on other donors (only five donors have given indications for their 2012 commitments so far). But in the current economic climate, further reductions or ending of donor support to health cannot be excluded. Out of the current 15 partners funding the health sector's pooled fund (called 'ProSaude'), 11 are EU-related.

THE IMPACT OF THE ECONOMIC CRISIS ON GLOBAL HEALTH

The global economic crisis has set back many poor countries in their progress to meet basic health and development goals. According to a 2010 World Bank/International Monetary Fund (IMF) report,[40] the prospects are the worst for the MDGs pertaining to health - malnutrition, child mortality, maternal health, HIV, TB, malaria, and access to basic essential drugs. Low- income countries and poor people in particular face dire consequences, also in terms of affordability and access to health care.

Strategies that are being discussed at the highest levels of government to recoup losses, including payouts to large banks, may also help improve the health of the poorest people on the planet. In a report to the G-20,[41] the IMF explored the feasibility of levying a tax on financial transactions and on assets raised from speculative activities by financial institutions that many criticize for bringing about the huge economic contraction. The report deemed such mechanisms as technically feasible and useful for generating revenue MSF supports any levy that can raise sufficient levels of funding for global health. According to WHO major increases are needed, up to $37 billion annually in 2015, in order to meet the health MDGs.

For HIV/AIDS, specifically, there are compelling reasons supporting such tax or any similar initiative:

- Substantial and sustained funding is needed for HIV/AIDS care and treatment.
- For HIV, external assistance from all sources represents as much as 75% of funding available. Countries will clearly be dependent on such external assistance for some time to come.
- AIDS and other major health outcomes, such as maternal and child health are inextricably linked (AIDS is the main cause of mortality among women of childbearing age worldwide).

39 This Code of Conduct was published in Brussels on 28 February 2007.

40 The MDGs: After the Crisis - Global Monitoring Report. Background report for the April 25, 2010, Development Committee Meeting, prepared by the staff of the World Bank and the International Monetary Fund, April 2010.

41 «*A fair and substantial contribution by the financial sector*", prepared by IMF staff for the Meeting of G-20 Ministers, April 2010.

"In Kenya about 95% of HIV programmes are funded by external donors. To us living with HIV this is a very big problem because if the international donors decide to withdraw their funding, the program may not be sustainable according to the present funding levels by the government."

Jimmi, HIV patient, Kenya

"If there is reduced funding, then it will mean more people will die, and we will have more orphans. The ones that are positive often need to assist others, like their children. People will lose hope and die. It will be the end. The country will become poorer. If there are no drugs there is no future."

Catherine, HIV patient, Kenya

03 IMPACT OF THE DONOR RETREAT

As ARV treatment is lifesaving but also lifelong, the number of patients on treatment will increase cumulatively each year. A meaningful response to the epidemic will thus require incremental increases in patients on treatment, and thus a sustainable and growing funding supply. If the intentions to quell the epidemic are serious, initiation on ART needs to keep the same incremental pace as that seen over the past years. As most countries in sub-Saharan Africa do not have the domestic resources to shoulder the financial burden of HIV/AIDS treatment alone, a steady increase of funding is needed over the next decade.

A recent World Bank report estimated the impact of not increasing funding for HIV/AIDS. It stated that: "New infections would continue to increase, and deaths from HIV/AIDS would grow from the 2005 level of 1.9 million. The cumulative effect of no scale-up effort over the next five years would be close to 10 million deaths and 14 million newly infected persons (an increase of 50 percent from 2006)."[42] The report concluded that the cost of inaction will be higher than that of action. Also others have indicated the medium term benefit of not postponing scale up of treatment.[43]

In countries where MSF works, signs of the donor retreat are already beginning to impact negatively on ART scale-up efforts.

3.1. HASTY EXITS LEAD TO RATIONED ARV INITIATION

When donors "move out" of funding for HIV/AIDS interventions, they aim to negotiate the hand-over of the financial responsibility to another actor. But the reality is that this transition is rarely planned for in advance and cannot always be absorbed.

- The US government's PEPFAR II strives to pass on the responsibility of patients to countries or else to the Global Fund wherever possible, in the name of sustainability. But the handover of massive ART programmes cannot possibly be improvised, or imposed within an arbitrarily limited timeframe. As a result, some scale-up is being halted with little or no warning and with dramatic consequences for those seeking treatment, thus putting enormous pressure at the point of service delivery.
- The grants of the Global Fund might come under increased strain, as happened recently in the DRC: taking over treatment costs from other donors into an already limited grant resulted in a five-fold reduction in the actual monthly funded treatment slots.

In order to adapt to limited country capacity, plans are revised based on less availability of resources. The concept of "doing more with less" is interpreted in different ways by USG implementers and tends to present plain cost-cuts across the board as cost-efficiencies. The "efficiency cuts" imposed on Global Fund approved grants included some cuts across grants, implying reductions in the availability of essential means and thus expected benefits.

There is certainly scope for efficiency gains; alternative strategies and approaches to roll out effective HIV care with less resources are progressively being identified and can be implemented, such as simplified delivery of care and reduced pricing for ARVs.

42 World Bank, 2008. *Averting a Human Crisis During the Global Downturn: Policy Options from the World Bank's Human Development Network.* Accessible at: http://siteresources.worldbank.org/NEWS/Resources/AvertingTheHumanCrisis.pdf

43 Ventelou et al. *Estimates of alternative scenarios of scaling-up of ART treatment in an agent-based microsimulation model.* IAEN Conference, December 2009, Amsterdam.

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FIELD EXAMPLE: DRC

In the Democratic Republic of Congo (DRC) 283,055 people are estimated to be in need of ART (as per the old WHO initiation criteria), but by the end of 2009, only 34,967 were reportedly on treatment - roughly 12% of the need.[44] Only 2% of pregnant women have access to services to prevent mother to child transmission, and more than 40,000 infants are born with HIV infections every year.[45]

DRC is almost entirely dependent on international funding for HIV/AIDS. The Global Fund has been the main donor. Other donors were also funding HIV/AIDS care and treatment, such as USG/PEPFAR, the World Bank, and UNITAID through the CHAI partnership. Today, however, all of these actors are cutting back on HIV treatment funding, leaving a funding gap that the Global Fund does not have the resources to fill.

The World Bank has been funding the purchase of ARVs in DRC since October 2004. This funding is planned to end in January 2011 and at the current slow rate of disbursement, there is a possibility that only 45% of the USD 33 million budget will be used. Informal reports estimate that the World Bank directly funds the treatment of 4,200 persons and the absorption of the continued treatment of these patients by Global Fund funding was discussed at country level with the principal recipient of the Global Fund grant for HIV/AIDS (UNDP).

The US government's PEPFAR II is to cease the purchase of any drugs for OIs or renewable laboratory supplies in DRC, handing over the 1,300 patients[46] it directly supported with drugs and commodities to the Global Fund.

UNITAID (via CHAI) has been providing financial support for 1,100 patients on second line drugs, but has been trying to hand this over to the Global Fund since 2009. Similarly UNITAID/CHAI funding of paediatric medical supplies (***5000 treatment initiation slots)*** will be discontinued at the end of 2010.

However, not all "hand-overs" were planned for when the grants of the Global Fund were developed. Moreover Global Fund grants already face difficulties to assure supply and are unable to keep up with the needs of ART, without even this additional "burden."[47] For instance over a period of 15 months, MSF failed to receive drugs for one third of the items requested from UNDP/Global Fund; no condoms were received since 2009. The beginning of Round 8 was delayed and the last drug supply to implementers was in January 2010.

On top of the existing backlog of patients waiting for care, an estimated 179,000 more people will be become eligible for ART every year (as per old WHO criteria). In 2009, the Global Fund was supporting 1,000 new initiations per month. Now the revised availability of funds for initiation has been cut six-fold to 2,000 ***per year***. The consequence is that in DRC – in spite of the acute crisis situation - dramatically fewer patients can start ARV.

44 UNGASS, report 2010.
45 http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2010/20100511_DRC.asp
46 Source: FY09 PEPFAR report.
47 Round 3, which effectively started a year behind schedule (January 2006) had an initial objective to have 26,000 patients under treatment by the end of 2009: this was exceeded by the implementing partners. Round 7 started in April 2009 with a more limited geographical scope. Round 8, originally due to start in January 2009, which implied a one-year overlap with Round 3, has been delayed and was signed only at the beginning of 2010. The round 8 proposal planned to cover only a limited number of patients for the first year, as a complement to the last year of Round 3. However, the delay in the start of Round 8 has dramatic consequences on the ART scale-up plans today, as it will have to cover a bigger cohort with less money. Round 9 was refused in October 2009.

3.2 LATEST WHO RECOMMENDATIONS ARE BEING IGNORED BECAUSE OF BUDGET CONCERNS

Already at the end of 2007, Lesotho adopted earlier initiation of patients (CD4 counts below 350) and a shift to Tenefovir-based treatment (TDF). Magerard, nurse in Lesotho, describes the benefits for patients of the new WHO guidelines:

"Before TDF, those on AZT experienced rashes and vomited a lot. On D4T, patients were getting large fat depots on their body. People feel better with TDF now, complaining less of side-effects; as they vomit less, they don't need to repeat doses of their medication. Also, most of the people are still healthy when they initiate now. It is easier for them to pick up faster, to get on ARVs. Before, they had to delay taking ARVs as they first had to treat TB or other opportunistic infections."

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The new WHO guidelines, launched at the end of 2009, recommend a number of important improvements to ART care, most significantly the earlier initiation of ART (at a CD4 count of <350 cells/μl rather than <200 cells/μl) and the provision of improved drugs with less associated toxicity. The WHO recommendations are met with relief by all clinical and public health experts. It allows countries to follow into the steps of Lesotho and Zambia that already apply the improved approach.

Beginning treatment earlier increases the number of people in need of treatment. This will require additional funds but will also reduce illness and death,[48] and may also have a public health benefit in terms of reduced HIV and TB transmission.[49] However, in the short term, these recommendations will result in an increase in costs, and donors have proved reluctant to support these changes.

Similarly, donors are reluctant to support a switch from older d4T–based regimens to the safer and more effective regimens (such as TDF-based regimens) which are seen to be more expensive. However, the cost of TDF is decreasing,[50] and indirect savings will also result as TDF-based first line regimen greatly diminishes the risks of side-effects. Taking into consideration these broader benefits, some studies have already concluded that TDF is cost-effective by international standards.[51] A TDF-based first-line regimen will also likely improve adherence as it can be given once-a-day. Better adherence means less resistance and a longer duration on first-line. This postpones switches to more expensive second-line combinations.

However, there is not yet unified donor support for earlier treatment with an improved first-line treatment regimen. For example, PEPFAR's director has voiced reluctance towards implementing the new WHO treatment guidelines for earlier treatment.[52] This reluctance is translating into support of a lower standard of care in recipient countries. Most governments in the region simply cannot implement such a change without donor support.

As a consequence of funding shortfalls, compromises are being made. For instance, Mozambique and Uganda decided to start initiation at CD4 counts of <250/μl instead of the recommended <350/μl, with Uganda choosing the earlier initiation only for certain groups. South Africa recently adopted the TDF-based regimens as preferred first-line protocol but has only adopted earlier initiation for certain patient groups. Other countries, such as Malawi and Kenya, await financial support to implement the recommendations that have already been technically approved.

48 According to UNAIDS, one in five deaths could be prevented.
49 UNAIDS estimates that one million new infections could be prevented between 2010-2015.
50 Today the price of single drug TDF is cheaper that single drug AZT (ref: UTW http://utw.msfaccess.org/). Fixed drug combinations (FDC) containing AZT (AZT/3TC/NVP) experienced a modest decrease in cost of 9% yearly for the past two years, while FDC containing TDF (TDF/3TC/EFV) had a significant yearly decrease in cost of 30% (ref: UTW 13th in press). With more generics entering the market to produce FDC containing TDF, the price is expected to decrease even further.
51 Bender M, Kumarasamy N, Mayer K, Wang B, Walensky R, Flanigan T, Schackman B, Scott C, Lu Z, Freedberg K. *Cost-Effectiveness of Tenofovir as First-Line Antiretroviral Therapy in India. Clinical Infectious Diseases 2010*; 50:416–25.
52 Newsweek, "AIDS Programs Hit Setbacks in Africa," see: http://www.newsweek.com/id/237037.

3.3 INCREASED FRAGILITY OF FUNDING AND SUPPLIES

MSF teams have noted that uncertainty around the levels and continuity of funding for HIV/AIDS treatment supplies can have rapid negative consequences. In Malawi, an administrative delay in signing the contract with the Global Fund delayed disbursement and consequently delayed crucial drug orders, leading to serious ARV supply shortages at health facility level. A similar situation occurred in Mozambique in the beginning of 2010, where a delay in disbursement of Global Fund funds resulted in ARV supply delays. ARV importation delays resulted in some patients having to change drug combinations.

Disruptions of supply have been more frequently noted in 2009 and 2010 in almost all countries studied. Whereas previously, MSF-supported health facilities would receive the majority of the ARV needs through government channels, financed by the Global Fund, UNITAID/CHAI and PEPFAR, with a relatively limited need for MSF to complement ARV supply, in 2009 and 2010, MSF had to increase its buffer stocks significantly and provide more regular emergency supplies to MSF-supported clinics in Mozambique, Malawi, Uganda, and DRC. In Uganda's rural northwest, after a period of more effective decentralization of care to clinics closer to patients, these decentralized sites received no government-supplied ARVs and had to be fully supported by the MSF ARV emergency buffer stock for months in 2009 and 2010.

Other implementers often do not have the resources or capacity to "fill gaps" left by the national programme. In 2009 and 2010, MSF was increasingly confronted with requests from other actors to help them out with emergency supplies, including from the Ministry of Health, international and local NGOs, and patients groups outside the MSF project area. This was the case in Malawi, Zimbabwe, DRC, Kenya, Uganda, Guinea and the Central African Republic. These requests would include standard first-line ARVs and OI drugs, laboratory tests and also alternative regimens and/or second line ARVs.

Despite these failures, there are no systematic efforts to establish safeguards such buffer-stocks for ARVs and other essential medical items, possibilities to use alternative supply systems, and bridge funding between donors.

Ultimately, the consequences of unreliable ARV supplies are borne by patients and health workers, as shown by recent experience in Malawi, Mozambique, Zimbabwe, DRC, Uganda, Kenya and South Africa. Health workers may deal with the delays or shortage by changing patients onto other pills (for instance, using different dosage or different drugs from alternative regimens with more side effects, or splitting adult pills for children), or giving patients pills for a shorter period of time, increasing the workload at already busy health facilities. Patients may seek treatment elsewhere or may be required to wait until their CD4 counts drop to a greater degree before being initiated on treatment. Patients might start pill-sharing or taking sub-optimal doses, which may lead to the development of drug resistance. Knowing that ART has to be taken for life, both patients and health workers may lose the confidence to start.

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FIELD EXAMPLE: MALAWI

Malawi's successful HIV/AIDS treatment programme is put under strain because of delays in disbursing funds and essential supplies.

In Malawi, the Global Fund is the main funding source of HIV/AIDS care and treatment. Malawi obtained approval of a Rolling Continuation Channel (RCC) grant in 2008; a delay in signing the RCC contract delayed disbursement and consequently delayed crucial drug orders. This meant that no money was available to place the upcoming drug orders.

The delay led to dangerously low levels of ARVs in 2009 and, as reported by the Ministry of Health, resultant stock-outs.[53] The Ministry of Health, assisted by NGOs and other implementers, undertook a major operation to redistribute the available ARVs across health facilities, mobilising considerable logistic, financial and human resources to deal with the shortfall. Some patients had to change their ART drug combinations. With insufficient stocks available, patients received pills for two weeks instead of two months and therefore had to pay four times as much for transport. This also increased workload on already overburdened health workers.

MSF had to order emergency supplies to avoid stock-out risks. Other NGOs, supporting neighbouring districts in a similar HIV/AIDS care programme, borrowed ARVs from MSF buffer stocks on several occasions to respond to stock-outs.

Again, between February and April 2010, ARV stocks were dangerously low. Although a countrywide shortfall of ARVs was looming, no funding from the Sector Wide Approach (SWAp) was allocated to bridge the gap, nor did any of the individual health donors step in to assist.

"The availability of ARV's not only has added more years to my life but has also contributed greatly to the social and economic wellbeing of our villages. If you say you stopped giving us ARV's today the effects would be devastating and we would once again go back to the times when funerals were daily and hospitals full of palliative care patients, and not forgetting the huge number of orphans this would create."

Chief Ntholola, HIV patient, Malawi

53 MoH, Mid *Year report of SWAp 2009/2010 implementation period,* March, Lilongwe, page 28.

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"Antiretrovirals should be accessible to everybody. The only ones that could afford antiretrovirals in the beginning where people with money, so that's like saying that they are the only ones who should live."

Portia, HIV patient, South Africa

"Whereas the donors have the prerogative of where to take the money, it is our belief and our request, as people living with HIV, that we continue to live healthily. We appeal to these donors to make sure that these HIV programmes continue the way they are, if not better, so that more people can be brought onboard."

Jimmi, HIV patient, Kenya

04 CONCLUSIONS

Despite significant progress in ART scale-up over the last decade, untreated HIV/AIDS continues to cause major human suffering and millions of deaths. Two-thirds of people living with HIV in sub-Saharan Africa that need treatment are not getting it, representing a treatment gap of more than six million people.

Shrinking funding for HIV treatment risks undermining the results obtained. Funding for and supply of HIV treatment is already fragile and can further be destabilized by stalled funding; multiple channels are needed to ensure stability of programmes.

In the eight countries in sub-Saharan Africa where MSF carried out its analysis, there are clear signs that donors are reducing their financial commitment to the fight against HIV/AIDS. The most obvious signs include:

- Flat-lining or reduction of annual budget allocations for HIV/AIDS;
- Reduction of the number of donor organisations funding HIV/AIDS treatment in the most affected countries;
- Reduction of international funding levels for treatment supplies, including ARVs;
- Re-focus on indirect health system support and capacity building, rather than creating complementary funding streams.

Despite millions of deaths each year, donors are steadily moving away from treating HIV/AIDS as an emergency. The commitment of substantial and direct support to treatment for people living with HIV/AIDS is fading. Donors are pushing to broaden the scope of HIV funding towards general health or development support without increasing the overall amount of money available. This approach risks undermining already fragile health services. Many bilateral donors count on the Global Fund to assure funding for treatment and supplies in particular, but without providing the Global Fund with sufficient resources to do the job. Similarly, donor agencies such as PEPFAR are expecting the Global Fund to serve as their exit strategy, without increased support.

The reality and threat of reduced or discontinued international support is already translating into lowering national ambitions, with harmful consequences for patients:

- People are denied life-saving ART due to limited access to treatment;
- Instead of implementing the new WHO guidelines, people will have to wait until their CD4 is low before accessing ART, resulting in more hospitalizations and higher mortality;
- Patients might start sharing their pills and thus lower their dosage, with virus transmission no longer suppressed and increased risks of resistance;
- Health systems will be increasingly vulnerable to drug stock-outs and ruptures;
- The rationing and postponing of ARV initiation will increase the burden of disease on individuals, communities and health systems, and limit the possible benefits of reduced HIV transmission;
- HIV testing and detection activities will have to be limited, with negative consequences on other prevention activities;
- The limiting of HIV/AIDS treatment scale-up will negatively impact other public health challenges - in particular TB, maternal and child mortality and morbidity indicators.

The HIV crisis is far from over. Moreover, evidence has shown that effective HIV/AIDS interventions have numerous cross-benefits and spin-offs on the broader health sector. Achieving the MDGs cannot be tackled without addressing HIV/AIDS. And yet a lack of sustained donor commitment is jeopardising worldwide efforts to fight this deadly disease, and there is little or no discussion on how to resolve the funding crisis. To prevent needless illness and excessive loss of life, renewed and expanded donor commitment is necessary; sustained international funding is direly needed to help bridge the treatment gap in sub-Saharan Africa.

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