Treatment scale-down ahead?

Rationing the HIV response in the shadow of success

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

November 2018

1. The evolving perceptions of the HIV epidemic versus reality on the ground

The world has grown accustomed to news stories about the HIV response framed as a success. Nowadays HIV/AIDS is rarely portrayed as the deadly epidemic and global health threat that it still is. The impression is given that the worst is over, yet it is not. In today's narrative, focus has moved away from saving lives and alleviating suffering towards challenges in tackling transmission and epidemic control. Compared to the gloomy outlook in the early days of the epidemic when lifesaving treatment was withheld from those most affected by HIV we have indeed come a long way. However, the current achievements need not be taken for granted.

UNAIDS estimates that the ongoing HIV epidemic generates nearly 5000 new HIV infections every day, amounting to 1.8 million new infections in 2017, and nearly one million deaths. Of the estimated 36.9 people living with HIV (PLHIV), only 21.7 million people have access to life saving treatment.[1] In low and middle income countries about 30-40% of people entering care have advanced HIV (CD4 less than 200 or clinical stage 3 or 4 putting them at high risk of opportunistic infections and death).[2]

IIn fact, in many countries where MSF is working, the global response revolution has yet to arrive. For many PLHIV timely and uninterrupted treatment is still out of reach. The burden of systemic barriers continues to delay, deter and discourage patients to access early and continued ARV treatment. Mortality due to late initiation to treatment, is now compounded by death among PLHIV currently on ART and who have been on treatment for long but facing treatment failure. AIDS is claiming lives when alarming signs of diseases are not acted upon, or are detected too late.[3] The tide is not yet turned, AIDS is not yet defeated and too many people are still left behind.

Moreover, there are significant geographical disparities in the global HIV response. Progress is alarmingly uneven. While globally AIDS related deaths have dropped by 34% since 2010, the mortality rate has increased in Middle East and North Africa (11%) and remained flat in Eastern Europe and Central Asia. The annual number of new infections has doubled in both regions in less than 20 years yet treatment coverage remains low at 29% and 36% respectively for these regions.[4]

The lack of progress in countries left behind in the earlier phases of the HIV response, also provides insight in what might happen in places with an HIV response in decline. The image of people leading healthy lives with HIV might quickly be replaced by severely ill patients, on the verge of death. With low ARV coverage and breakdown of prevention measures, transmission would continue unchecked. Already now there are concerns about continued or resurgence of HIV transmission in contexts where the HIV response is slowing down.

What was once considered one global response based on solidarity and common interest to stop a global epidemic, where rich (and less affected) countries would support those disproportionately affected, now appears to be seen as a thing of the past. In the post Millennium Development Goals (MDG) era, countries are expected to rapidly take on responsibilities in providing health services to its citizens, including for PLHIV. A failure to do so may be interpreted as a lack of political will, rather than as a function of their health system needs and fiscal abilities to fund adequate health budgets. The international commitment to support an increasing number of PLHIV on ART is uncertain. However, emerging challenges such as drug resistance, advanced disease and reaching the most vulnerable populations call for an even stronger commitment.

2. Uneven progress and unmet needs – a snapshot

It is not a secret that the impressive achievements in the HIV response globally over the past decades hide important geographic and social disparities. Access to services is not yet a reality for all and critical unmet needs remain in most countries. This chapter outlines examples of what we see in a selection of countries where we work and where national HIV programmes are facing the threat of declining international funding, amid the expectations to reach ambitious targets.

2.1 Low prevalence, low coverage, low interest: West and Central Africa

Nearly one third (30%) of all AIDS related deaths and 21% of new infections globally occur in West and Central Africa (WCA).[5] The region saw 370,000 new infections in 2017 and is home to 6.1 million PLHIV of whom only about 2.4 million (40%) are accessing ART.[6] In the region, only 14% of people on ART underwent viral load testing and 29% of PLHIV had suppressed viral load compared to 66% in Eastern and Southern Africa (ESA).[7]

In order to significantly increase ART coverage and improve the quality of care for PLHIV, an acceleration plan for the region including eight priority country plans[8] was launched during the African Union summit in July 2017 under the lead of UNAIDS[9]. However, despite strong political commitment, the implementation of this plan is facing significant obstacles.

Many of these obstacles are structural and enduring, such as political and regulatory constraints preventing the integration of TB and HIV services, or the implementation of task shifting, as well as stigmatisation, weak supply chains with frequent stock outs, patients facing financial barriers and the lack of involvement of civil society organisations. Both political will and financial investments are needed to tackle these challenges.

According to UNAIDS, the gap in the region to finance the fast track approach is substantial. To reach the fast track targets USD 1.8 billion is needed, which is 81% more than funds available in 2017.[10]

While some countries are making efforts to mobilise additional domestic resources for health, many rely on external resources to respond to extensive health needs. Given the significant competing priorities in a region with instability, food insecurity etc, the scope for increased domestic funding is limited. Already 40% of the total expenditure for health comes from out-of-pocket expenses.[11] In the region, the Global Fund remains the main donor for HIV and often the sole provider of ARVs as PEPFAR only operates in six out of the 25 countries in the region.[12] However, according to the Global Fund, the average annual 2018-2020 allocation for HIV in the region is approximately 30% lower than the annual HIV grant amounts signed for the previous period (2015-2017) and remains at a level similar to the funds disbursed in 2016.[13]

For many countries in the region it will be impossible to rely only on domestic funding to compensate for reduced or flatlining external funding without sacrificing planned scale up of services. The region as a whole is facing major financial constraints to significantly increase ART coverage to catch up in the next three years.

CENTRAL AFRICAN REPUBLIC (CAR)

With an estimated 110,000 people living with HIV in CAR, it is the country with the highest HIV prevalence in the region, at 4% [14]. Approximately 5,200 AIDS-related deaths and 7,700 new infections occur each year.[15] HIV/AIDS is the second leading causes of death among the general population (after TB) and the main cause of death for women aged 15 to 49 years old.[16] In 2016, in the Hôpital Communautaire in Bangui, supported by MSF OCB, 44% of patients admitted in the In-Patient Department (IPD) were HIV positive and the mortality rate among those HIV positive patients was 27%.[17]

CAR currently faces a serious financing gap for HIV. Despite operational challenges, the country has managed to quickly improve access to treatment since 2014 thanks to the support from the Global Fund, the main international funder for HIV through international and local implementers. While the number of patients on ART has doubled in the last three years, it is by end of 2017 reaching approximately 32% coverage, still well below the fast track targets.[18] However, the 2018-2020 Global Fund allocation for HIV does not correspond to the pace of treatment scale up in recent years and only ensures treatment continuity for patients already on treatment as well as ART initiation for a very limited number of new patients. The targeted total number of people on ARV is set at 32,000 by end of 2020, allowing only for a very limited increase in coverage. Every year, the country has a shortfall of ARVs for about 8,000 people living with HIV limiting new initiations as well as the country's ability to maintain people on treatment. Without additional resources to support treatment scale up at pace with the existing capacity the ART coverage will remain far out of reach of international targets and standards.

GUINEA

Guinea is one of the poorest countries in the world and the country's health systems is recovering only slowly from the 2014-2016 Ebola outbreak. The estimated HIV prevalence among the general population is 1.7% (and 2.1% for women), according to the latest National Demographic Survey in 2013[19] and the total number of PLHIV is estimated at approximately 120,000 in 2017.[20] New HIV infections were estimated at 8,100 while AIDS related deaths were estimated at 5,100 and the ART coverage is estimated at 35% at the end of 2017; This is far from the UNAIDS 2020 targets. The situation is even worse for children, with an ART coverage estimated at 18% by the end of 2017[21].

In Guinea, the Global Fund is the main donor for HIV. The average yearly allocation for 2018-2020 has decreased by 25% compared to the average yearly allocation in the previous period.[22] Taking the funding constraints into consideration, the total number of ART initiations accounted for by the Global Fund grant is being halved from 22,000 projected in 2015-2017 to around 11,000 in the 2018-2020 period. This translates into a reduced initiation rate nationally from 800-900 per month in 2016 to around 500 in the 2018-2020 period.[23] This is despite a comment by the independent technical panel that reviewed Guinea's proposal before approval, that most targets set in the 2018-2020 funding request for HIV in Guinea were 'too low to have a significant impact on the epidemic'.[24] To meet overall targets it is expected that the Guinean government provides the resources and procurement of ARVs for 14,000 PLHIVs by 2020 in order to increase ART coverage to 49%. However, besides the uncertainty of actual disbursement of domestic funding to ARV purchase, these expectations as well as repeated experiences with ARV shortages this year with no buffer stock in country raise questions on the necessary capacity in-country and uncertainties to assure continuous uninterrupted supply of quality ARVs at optimal price.

2.2 Scale-up Outpacing Funding Available in High Burden Countries

In high burden countries, the increase in the access to ART is increasing and yet the international resources are not enough to cover the ambitions, needs and gaps. At the same time, it is not feasible in most of these contexts for the governments to increase their resource allocation to HIV to cover these needs as the examples of Malawi, Mozambique and Zimbabwe below demonstrate.

MALAWI

Approximately one million people are living with HIV in Malawi of which 90% are reported to have been diagnosed, 71% are on treatment and 61% are virally suppressed. New infections and AIDS related deaths were estimated at 39,000 and 17,000 respectively[25].

In 2016, approximately 90% of funding for Malawi's HIV response came from donors with Global Fund and PEPFAR contributions accounting for 74% of total funding.[26] The Global Fund allocated USD 371 million to Malawi for HIV over the 2018-2020 funding period[27]. PEPFAR support amounted to USD 127 million in 2017 and USD138 million in 2018.[28]

The total budget for the HIV programme is USD 197 million in the 2017/18 fiscal year and the inclusion of new interventions in Malawi's revised HIV guidelines presents an important opportunity to introduce or scale up access to innovative tools. However, this opportunity may be missed because of critical funding gaps.

For example, TB LAM, CrAg and reintroduction of CD4 have all been included in Malawi's revised guidelines for 2018 but are currently without funding, meaning they will remain unavailable for people living with HIV. Flucytosine and doxorubucine have been included in the new guidelines, for tertiary level and primary level sites, but are currently not available at all levels due to a lack of funding and high pricing.

Investment has been made by the Ministry of Health and donors into programmes for key populations but funding remains a key barrier to scale up of services. Additional funding is needed to address gaps in female sex worker friendly services to support scale up of an integrated model of care linking community and health services.

MOZAMBIQUE

The disclosure of $2 billion secret loans has created a deepening of the economic crisis and a shortfall in public budget, as the national budget support from IMF, World Bank and other donors was suspended, with severe impact in different public sectors including health. [29]

In Mozambique, a total of 2.1 million people are living with HIV with an alarming 130,000 new infections and 70,000 deaths in 2017[30]. In 2014, PEPFAR and Global Fund were the largest donors to the HIV and TB sector. Together they represent 95% of all investment to HIV.[31]

In the fiscal year 2019, PEPFAR allocated a total of USD 394 million to Mozambique, a slight increase compared to fiscal year 2018 (USD 363 million)[32]. The Current Global Fund HIV/TB grant for 2018-2020 is USD 347 million. Yet, despite these minimal increased investments, the needs are higher than the resources available from both international donors and the government.

Mozambique is not one of the PEPFAR 13 priority countries in their *PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control 2017-2020*[33] yet the country is far from achieving epidemic control and the global 90-90-90 targets.

The implementation of the Mexico City Policy has indirectly affected and disrupted HIV services to the most vulnerable groups. The International Centre for Reproductive Health (ICRH-Mozambique), lost its US funding and within a month had to close their 7 year program supporting key populations, in particular sex workers, on access to HIV and sexual and reproductive health services and protection against violence and discrimination[34]. Even in Mozambique where the termination of pregnancy is legal, without financial and technical support its implementation faces lots of difficulties.

Even though it is important that the country invests more domestic resources into its public health system, the current economic situation faced by the government Mozambique leaves little room. External investment on the fight against HIV/AIDS epidemic remains essential.

ZIMBABWE

With an estimated HIV prevalence of 15%, HIV is still a major disease burden in Zimbabwe. Currently 1.3 million people are living with HIV in Zimbabwe with only 85% of those diagnosed and 84% of the diagnosed on treatment. Despite this treatment coverage, new infections and AIDS related deaths are estimated at 41,000 and 22,000 respectively.[35]

In general, the country's health financing is heavily dependent on donor assistance and household contributions, in particular through patient fees.[36] With as many as 94,5% employed in the informal sector, the prospects of additional resource mobilisation through a health insurance fund are limited.[37] With increasing economic problems, the revenues of the AIDS levy were significantly reduced[38]. Low and unpredictable government allocation to health is combined with equally volatile international funding. Of the USD 386 million spent by donors on health in 2015, about USD 208.8 million (54%) was spent on HIV/AIDS.[39]

Despite both domestic and international funding, the country currently has a USD 67 million gap for treatment monitoring including lab reagents with no immediate prospects of financing it from the government or any of the major donors.[40] In May 2018, the ARV projected needs for the 2020-time period are not covered, leaving a potential gap of about USD 85 million.[41]

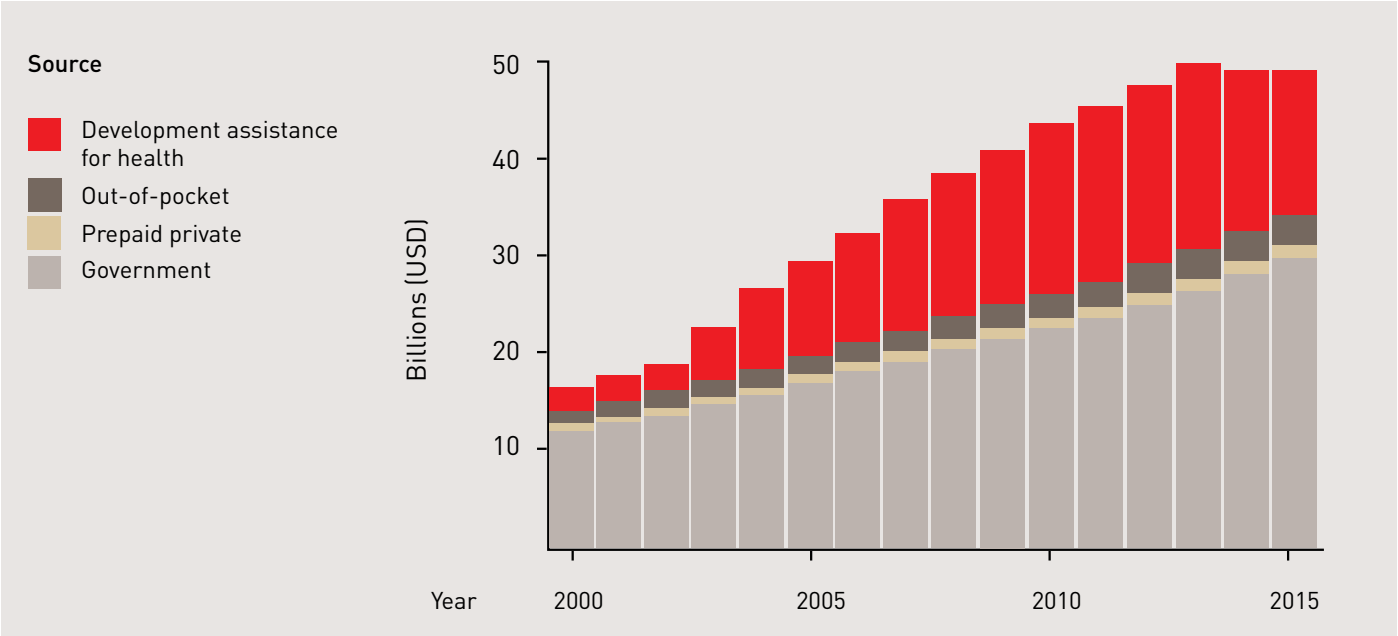
The country's recent fiscal space analysis shows that despite estimates of some additional revenue that can be generated, there would still be significant gaps in funding for health.[42] There are limitations in increasing the fiscal space in the next few years and international funding will remain essential and key to assure the HIV response, in the medium to long term.

3. Shifting to Domestic Funding for Health and HIV?

After many years of steady growth, spending on HIV/AIDS globally peaked at USD 49.7 billion in 2013[43], decreasing to USD 48.9 billion globally in 2015.[44] Investments in the HIV response in Low and Middle Income Countries have been in decline since 2013, and despite a certain uplift in 2017 (from both international and domestic funds), it is still well below the estimated USD 26 billion needed to achieve the 90 90 90 targets.[45]

While government spending on HIV has continued to increase globally since 2000, development assistance for health (DAH) for HIV has been on a downward trajectory since its peak in 2012 (see figure 1).[46] Between 2012 and 2016, development assistance for HIV/AIDS decreased by USD 3 billion (from USD 12 to 9.1 billion).[47]

Figure 1. HIV/AIDS spending 2000-2015, by funding source globally[48]



In 2016, HIV external funding dropped to the levels of 2010, declining by 7% from the year before[49]. While government donor disbursements for HIV increased again in 2017 by USD 1.1 billion to USD 8.1 billion[50] (see figure 2) due to the timing of US contributions, particularly for the DREAMS program, this is not expected to continue in coming years, and could even decrease.[51] This leaves the gains made in a fragile state given that the US is the main source of funding for HIV.

In 2017 and 2018, the US Trump administration proposed cuts of almost USD 1 billion which were challenged and prevented due to congressional pressure and leadership. However, another proposed cut of about USD867 million to US global AIDS programs in FY2019 has been proposed. The US overall funding for PEPFAR has gradually decreased from USD 4.6 billion in 2010 to USD 4.3 billion in 2017[52]. The Global Fund, which is also heavily dependent on its major donors (US, UK, France, Germany, European Commission) is approaching its sixth replenishment (2020-22) and will need to secure a significant increase in resources to support programs currently experiencing gaps while enabling scale up towards global targets.

The reality is there is currently a funding crisis. According to UNAIDS, USD 4.7 billion is the needed amount to bridge the gap to scale up treatment in Sub Saharan Africa between 2017 and 2030 from which the Eastern and Southern Africa region accounts for USD 1.7 billion while West and Central Africa is the region having the biggest gap of USD 3 billion. UNAIDS also underlines that even if domestic public expenditures continue to increase, the 2020 targets are at risk unless new donor commitments are made soon.[53]

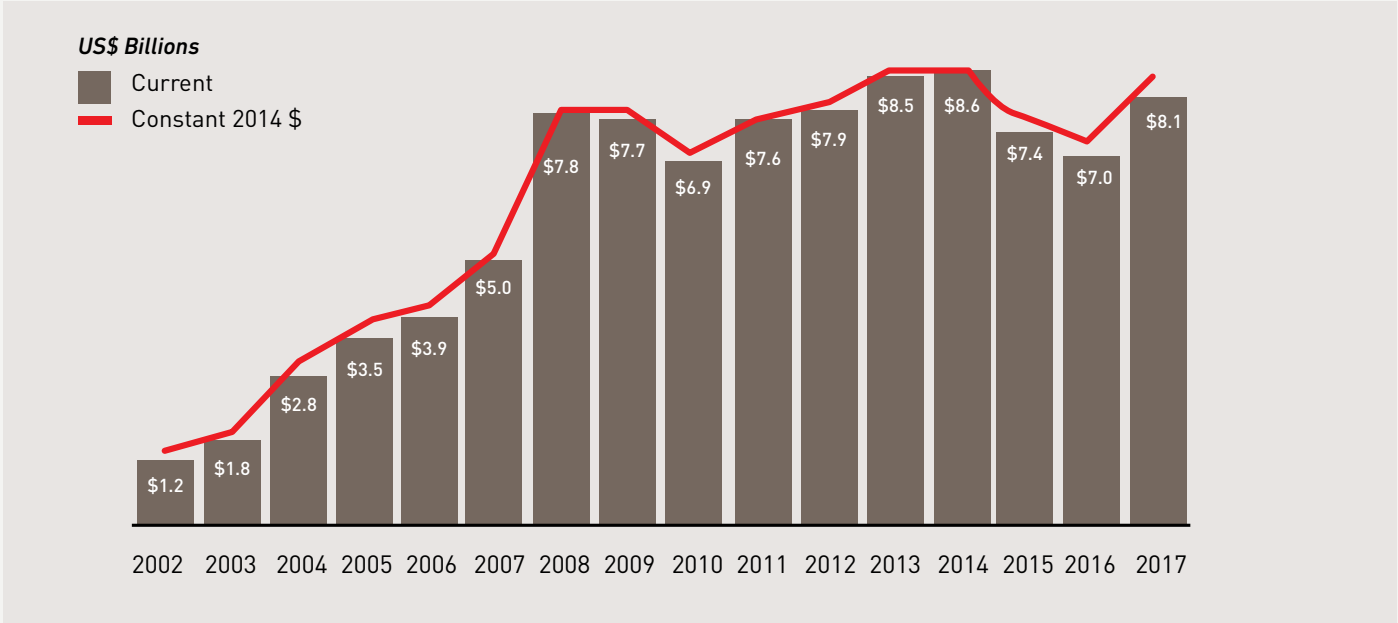
Calls for countries to increase their domestic funding for HIV have been reinforced in recent years and bring important messages about government accountability and transparency in health financing. There are high expectations that domestic funding will compensate for the reduced international funding for HIV. However, how realistic are these ambitions?

UNAIDS reports that as total investments for HIV in Sub-Saharan Africa nearly doubled (from USD 6.3 billion to USD 11.3 billion) between 2006 and 2016, also domestic funding doubled (110% increase).[54] Between 2012 and 2014, domestic resources as a share of total resources for HIV in low and middle income countries increased from 53% to 57%. [55]

However, the domestic resources share has since remained flat at 57% as of end of 2016.[56] Compared to an average domestic investment increase of 11% annually between 2006 and 2016, the rate fell to 5% between 2015 and 2016.[57]

The 2016 projections of yearly HIV funding to reach the fast track targets had anticipated a need for 450% increase in public domestic investments in HIV by 2020 in low-income countries, and a 530% increase for lower middle-income countries[58]. This projection appears now to contrast markedly with the recent trend in global

Figure 2. Donor Government Disbursements for HIV, 2002-2017



domestic funding growth.[59] Particularly for Low Income Countries where public domestic funding for health only grew by 3.7% annually between 1995 and 2015.[60]

Given the political and economic context in many Low and Middle Income Countries, sustained support from international donors will remain critically important for the majority of these contexts. For example, both Nigeria and Rwanda rely on international funding for 90% of its treatment, while in Kenya and Zambia's 83% of treatment expenses is from donors. Malawi and Mozambique rely on donors for 98% of its treatment costs, with Zimbabwe and Ivory Coast relying on international aid for its treatment funding for 76% and 77% respectively.[61]

For West and Central Africa the funds available need an 81% increase to achieve the 2020 targets while in East and Southern Africa region an increase of about 4% would suffice.[62]

Others have expressed concerns about the vulnerability of the HIV response to reductions in development aid, in particular in countries with lower incomes and high burden. In many contexts alternative options to preserve gains in curbing the HIV/AIDS epidemic might be not be realistic.[63] Additional cuts to HIV funding could hasten the decline to development aid and slow progress towards national and global goals.[64]

The decrease in international funding as well as the push to increase domestic funding, even where this option is less realistic, are a cause for concern also given that it could lead to an increase in user fees for PLHIV. This would create more barriers to reaching 2020 coverage targets and is particularly a concern in countries where a majority of the population lives below the poverty line and where user fees already represent a major obstacle to access health care.

Additionally, both low or middle income are now increasingly expected to prepare earlier for transition to domestic funding. According to the Global Fund's Sustainability Transition and Co-financing policy, both low and middle income countries are gradually expected to take up the costs of key HIV services such as human resources for health or procurement of commodities. However, due to international funding shortfalls, this process is accelerated in many countries, where countries may still struggle with weak procurement and supply systems and frequent stock-outs of ARVs. Countries in transition tend to lose access to mechanisms that facilitate pooling and negotiation of drug prices and may lack capacity and leverage to procure quality assured ARVs at affordable prices, including lower volume regimens such as paediatric and second and third line treatments. Poorly planned shifts to national procurement may jeopardise the continuation of treatment and the quality of programs and ultimately the lives of PLHIV.

The need for increased domestic funding is undeniable, but projections must be based on realistic estimates and timeframes that allows programs to progress to both sustain services for patients and reach global targets.

4. Sustainable Development Goals and Integration

While global discussions on integration of HIV in other health services is promoted mainly for reasons of systems strengthening and cost saving, patient outcomes could be improved significantly if services were better adapted to patient needs, rather than to funding source or health provider. Integration of services reduces missed opportunities and costs for people seeking care, with a potential for efficiency gains. However, it is quite a challenge to reach the minimal conditions to make integrated care a success, without eliminating existing barriers to access and propping up significant weakness in the health systems. The growing number of PLHIV will continue to need lifelong specific attention and care; the changing face of the HIV epidemic will require agility and innovation to shape the response. A key challenge will be how to protect patient outcomes and programmatic results within ineffective, inequitable, discriminatory or overburdened health services grappling with financing, health worker and management deficits. A pragmatic and patient benefit centred rather than philosophical approach seems vital.

Indeed in many countries health systems seem unprepared to realise the vision of sustainable health for all.[65] Without substantial additional health investments this is unlikely to happen soon. Again, the reliance of progress towards Universal Health Coverage (UHC) almost exclusively on domestic resources might literally be a 'killing hypothesis' in many countries and in particular those facing high burdens of disease and capacity limitations to fiscal space. For those countries the choice within the bundle of so-called 'innovative' financing options might be restricted in practice due to considerations of debt distress and/or a reduced tax basis.

The call to end AIDS exceptionalism and make common cause with the global health field [66] can only be beneficial to 'health for all' if the successful elements of the HIV response are not diluted or side-lined within the wider system. Within a restricted resource envelope, the competing fight among health issues has already begun and the risk is real that in name of the overarching SDG, specific ambitions and initiatives for a more effective HIV response might be sacrificed. If this is to work, spreading available resources more thinly over more health interventions will not help. The focus should resolutely shift back to raise significant additional resources – and this where they realistically can be found. Richer countries cannot be relieved from their shared responsibility and consistent commitments to the fight against HIV and global ill health.

5. The Role of Civil Society – a critical resource

A survey conducted by UNAIDS found that 40% of HIV Civil Society Organizations (CSOs) had experienced funding cuts since 2013.[67] Two thirds expected flat or reduced funding in the future. Many organizations have already closed their doors. The National Association of People living with HIV/AIDS in Malawi (NAPHAM) recently lost a substantial amount of its funding, directly affecting community-based activities. Treatment Action Campaign (TAC), a stalwart of the South African community of people living with HIV, also lost 40% of its funding in the most recent years. The overall funding constraints in donor grants has led to a dramatically reduced space for civil society in HIV at times in which their enhanced support and engagement is needed more than ever.

For the HIV response, it is devastating. A strong civil society defends the rights of PLHIV and has a leading role to play in increasing access to HIV testing and treatment as well as in the monitoring of the implementation of 90-90-90, holding governments and donors to account.

Health systems struggle to provide adequate services, tailored to people's needs but fail to tap into the CSO's capacity to build and expand effective, patient-centred services. Funds for these key interventions should be not seen as in competition for support of health systems, but as an essential ingredient of making progress and achieving the set targets.

6. In conclusion –need for a course correction

While signs of the growing resource crisis are becoming increasingly visible, the extent and impact of the withdrawal of international funders remains the question. Measures aiming at transition and sustainability are becoming dominant in driving the agenda in all countries, whatever their economic classification or growth perspective.

Without a serious, realistic assessment of countries' ability and/or willingness to compensate for missing international funds, many PLHIV are at risk to suffer the consequences. The needed scale up of the HIV response is likely to suffer, with rationing of ART initiation and worsening retention in care. Besides poor outcomes for patients and programs, strategic epidemic gains, as well as gains made in health overall might be lost too.

The successes of the past are no guarantee for the future. While planning for the "end of AIDS" and modelling its epidemic and economic feasibility, an insidious shift in political and practical commitment has taken hold. The sense of facing an exceptional health threat was lost and with it the urgency to strike at its heart until defeated.

A combination of the overconfidence that we can end AIDS, and donor fatigue has led to early disengagement, breaking the momentum towards the goal claimed to be within reach. Returning to business as usual is no longer frowned upon, some do even promote it.

After some years of the mantra 'doing more with less', the international discourse now openly discusses options to deal without aid. From the smartest use of every dollar towards effective scale up, the discourse is shifting to the question how to reduce harm for every dollar that is taken away. Attention turns to various ways of rationing ARV, reminiscent of the early days when treatment availability in Africa was limited.

Millions of people risk being left behind as the global response is winding down, but they are not limited to a few high burden countries, where donor funds are currently concentrated. They are being left behind also in countries where national resources may be insufficient, or held back from their governments and from the international donors alike. While two to three years ago, transitioning away from donor grants mainly concerned countries classified as middle income, at present all country plans are dominated by a sustainability and transition logic, whether they are ready or not.

Members of RNOAC group conduct a meeting at the PODI (Point of Distributions) Ouest in Kinshasa, Democratic Republic of Congo.

As a result of the current flat-funding from donors, a risky trade-off is observed, with lowering targets in anticipation and an unhealthy competition for allocations of investments between countries, regions and communities. This risks further delaying urgently needed scale up of services in countries where the epidemic is already dangerously off track.

This is not the time for complacency of any sort. Without a course correction global inequalities in access to services risk growing wider and undermining gains made elsewhere in reducing HIV mortality and transmission.

The current confident political discourse needs to be complemented with some serious reality checking and with transparent monitoring of the impact of funding shortfalls

We call upon the international funders to keep their commitments and on all actors of the global HIV response to not allow complacency lead to more deaths, more HIV transmission and the return of AIDS.

1 UNAIDS. 2018 Miles to Go. Accessed from http://www.unaids.org/sites/default/files/ media_asset/miles-to-go_en.pdf
2 WHO. 2017. Guidelines for managing advanced HIV disease and for rapid initiation of antiretroviral therapy. [Online]. [Cited 2018 Aug 8] Available from: http://apps.who.int/iris/bitstream/handle/10665/255884/9789241550062-eng.pdf;jsessionid=4EB537CF2E352DF9BC4E2B6CE871205A?sequence=1.
3 UNAIDS.2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
4 Ibid.
5 Ibid.
6 Ibid.
7 UNAIDS. 2018. Miles to Go. Accessed from http://www.unaids.org/sites/default/files/ media_asset/miles-to-go_en.pdf
8 The 8 priority countries are: Nigeria, Cameroon, Ivory Coast, DRC, Guinea, Liberia, Sierra Leone, Central African Republic
9 UNAIDS. 2017. Catch-up plan for Western and Central Africa. Putting HIV Treatment on the Fast track by 2018 . Accessed from http://www.unaids.org/sites/default/files/media_asset/WCA-catch-up-plan_en.pdf
10 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
11 In West and Central Africa, PEPFAR is present the following countries: DRC, Ivory Coast, Ghana, Cameroon, Nigeria, Burundi
12 Nouboussi J. 2017. Implementation of the WCA catch-up plan on AIDS treatment: progress so far and community engagement. International Conference on AIDS and STIs in Africa, Abidjan, Ivory Coast
13 UNAIDS. 2018, AIDSinfo, Accessed from http://aidsinfo.unaids.org/
14 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
15 Institute of Health Metrics and Evaluation. 2016. Measuring Matters. Accessed from http://www.healthdata.org/central-african-republic
16 Medecins sans Frontieres. 2016. Operational Centre Brussels. Central African Republic Annual Report
17 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
18 Institut National de la Statistique .2013. Ministère du Plan « Enquête démographique et de santé et à indicateurs multiples (EDS-MICS 2012)
19 Spectrum. 2017. Global Fund Performance Framework, PF_GIN-H-MOH. Accessed from http://docs.theglobalfund.org/program-documents/ GF_PD_001_18c49bc5-4629-4818-8e4f-74334c6be174.zip
20 Ibid.
21 The comparison is based on average yearly allocations. The previous period (2014-2016) includes "incentive" funds, but doesn't take into account the (projected) utilisation of funds during this period.
22 Spectrum. 2017. Global Fund Performance Framework, PF_GIN-H-MOH Accessed from http://docs.theglobalfund.org/program-documents/ GF_PD_001_18c49bc5-4629-4818-8e4f-74334c6be174.zip
23 Garmaise D. 2018. In Global Fund Observer 2918, Issue 332. Global Fund Board approves an HIV grant for Guinea with the Ministry of Public Health as a new PR. Accessed from http://www.aidspan.org/gfo_article/global-fund-board-approves-hiv-grant-guinea-ministry-public-health-new-pr
24 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
25 PEPFAR. 2018. Country Operational Plan. Accessed from https://www.pepfar.gov/documents/organization/285859.pdf
26 Global Fund 2017-19 allocations https://www.theglobalfund.org/en/funding-model/funding-process-steps/allocations/
27 PEPFAR. 2018. Malawi Country Operational Plan. Accessed from https://www.pepfar.gov/documents/organization/285859.pdf
28 The Wall Street Journal. 2018. IMF Suspends Lending to Mozambique. Accessed from https://www.wsj.com/articles/imf-cancels-mozambique-credit-meeting-following-wsj-report-1460733681
29 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
30 UNAIDS. 2014. Global AIDS Response Progress Report GARPR COUNTRY PROGRESS REPORT 2014 – Mozambique Accessed from http://www.unaids.org/sites/ default/files/country/documents/MOZ_narrative_report_2014.pdf
31 PEPFAR. 2017. Country Operational Plan Mozambique. Accessed from https://www.pepfar.gov/documents/organization/274400.pdf
32 PEPFAR. 2017. Strategy for Accelerating HIV/AIDS Control 2017-2010. Accessed from https://www.pepfar.gov/documents/organization/274400.pdf
33 International Centre for Reproductive Health. 2018. Access from http://icrhm.org/pt/news/icrh-mozambique-statement-international-women%E2%80%99s-day-maputo-march-8th-2018
34 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
35 Zimbabwe Ministry of Health and Child Care. 2018. Health Financing Strategy.
36 Ibid.
37 Ibid.
38 Ibid.
39 Global Fund Register of Unfunded Quality Demand. Accessed from https://www. theglobalfund.org/media/6578/core_2017-2019registerunfundedqualityde mand_tool_en.xlsx?u=636675998490000000
40 Zimbabwe Ministry of Health and Child Care. 2018. Health Financing Strategy.
41 The Lancet. 2018. Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995–2015, Global Burden of Disease Health Financing Collaborator Network. Accessed from http://dx.doi.org/10.1016/ S0140-6736(18)30698-6 or https://www.thelancet. com/pdfs/journals/lancet/PIIS0140-6736 (18) 30698-6.pdf
42 Ibid.
43 UNAIDS. 2018. Miles to Go. Accessed from http://www.unaids.org/sites/default/files/ media_asset/miles-to-go_en.pdf6736(18)30698-6.pdf
44 The Lancet. 2018. Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995–2015, Global Burden of Disease Health Financing Collaborator Network. Accessed from http://dx.doi.org/10.1016/ S0140-6736(18)30698-6 or https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30698-6.pdf
45 Ibid.
46 Ibid.
47 Adam Wexler et al and UNAIDS. 2018. Donor Government Funding for HIV in Low- and Middle-Income Countries in 2016 Accessed from http://www.unaids.org/sites/default/ files/ media_asset/20170721_Kaiser_Donor_Government_Funding_HIV.pdf
48 Ibid.
49 UNAIDS. 2018. Miles to Go. Accessed from http://www.unaids.org/sites/default/files/ media_asset/miles-to-go_en.pdf
50 Health Gap. 2018. Deadly impact- how flat funding is undermining US global AIDS program. Accessed from https://d3n8a8pro7vhmx.cloudfront.net/healthgap/pages/4316/attachments/original/1523284082/Deadly_Impact_Report_-_Health_GAP.pdf?1523284082
51 UNAIDS. 2018. Miles to Go. Accessed from http://www.unaids.org/sites/default/files/ media_asset/miles-to-go_en.pdf
52 UNAIDS. 2018. A turning point for Africa. Accessed from http://www.unaids.org/sites/ default/files/media_asset/turning-point-for-africa_en.pdf
53 UNAIDS. 2013. Fact Sheet. Accessed from http://www.unaids.org/en/resources/campaigns/ globalreport2013/factsheet
54 UNAIDS. 2016. Fact Sheet. Accessed from http://www.unaids.org/sites/default/files/media_ asset/20150901_FactSheet_2015_en.pdf
55 UNAIDS. 2017. Fact Sheet. Accessed from http://www.unaids.org/en/resources/fact-sheet
56 UNAIDS. 2017. Ending AIDS, progress towards the 90 90 90 targets. Accessed fromhttp://www.unaids.org/sites/default/files/media_asset/Global_AIDS_ update_2017_en.pdf
57 United Nations. 2017. Report of the Secretary General on the fast track to ending AIDS epidemic. Accessed from http://www.unaids .org/sites/default/files/media_ asset/20160423_ SGreport_HLM.pdf
58 United Nations. 2017. Report of the Secretary General on the fast track to ending AIDS epidemic. Accessed from http://www.unaids .org/sites/default/files/media_ asset/20160423_ SGreport_HLM.pdf
59 The Lancet. 2018. Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995–2015, Global Burden of Disease Health Financing Collaborator Network. Accessed from http://dx.doi.org/10.1016/ S0140-6736(18)30698-6 or https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30698-6.pdf
60 UNAIDS. 2017. Global AIDS Update . Accessed from http://www.unaids.org/sites/default/files/ media_asset/Global_AIDS_update_2017_en.pdf p. 15
61 UNAIDS 2018. A turning point for Africa. Accessed from http://www.unaids.org/sites/ default/files/media_asset/turning-point-for-africa_en.pdf
62 UNAIDS. 2018. Data. Accessed from http://www.unaids.org/sites/default/files/media_asset/ unaids-data-2018_en.pdf
63 The Lancet. 2018. Global Burden of Disease Health Financing Collaborator Network. Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995-2015; 391: 1799-829. Accessed from http://dx.doi.org/10.1016/ S0140-6736(18)30698-6 or https://www. thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30698-6.pdf
64 Ibid.
65 Bekker L. et al. 2018. Advancing global health and strengthening the HIV response in the era of the sDGs : the International AIDS Society- Lancet Commission. Published in Lancet July 19 2018 Accessed from https://www.ncbi.nlm.nih.gov/pubmed/30032975
66 Das P. & Horton R.2018. Beyond the silos: integrating HIV and global health. Published in TheLancet July 19, 2018. Accessed from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31466-1/fulltext
67 UNAIDS 2016. Investing in Community Advocacy and Services to End the AIDS Epidemic. Accessed from http://www.unaids.org/en/resources/presscentre/ featurestories/2016/april/20160404_community_advocacy

www.msf.org.za
70 Fox Street, 7th floor, Marshalltown,
Johannesburg, South Africa
+27 11 403 4440
office-joburg@joburg.msf.org