



PUNISHING SUCCESS?

**Early Signs of a Retreat from Commitment
to HIV/AIDS Care and Treatment**

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CAMPAIGN FOR	
ACCESS	
TO	
ESSENTIAL MEDICINES	

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Introduction

Over the past decade, enormous resources have been mobilised globally to address the HIV/AIDS crisis on a large scale. Médecins Sans Frontières (MSF) has seen first-hand the achievements, as well as some of the shortcomings, of these efforts in the course of providing care and treatment in more than 30 countries.

The good news is that four million HIV-positive people are alive on antiretroviral therapy (ART). The scale-up of ART in developing countries has allowed individuals to live longer and enjoy a better quality of life, leading to a restoration of dignity and autonomy, and an ability to contribute to family and societal life. In some countries, ART coverage has resulted in a decline in overall mortality and other population-level impacts. (See box on page 3)

But there is also bad news. Today, MSF teams working to treat HIV/AIDS are witnessing worrying signs of waning international support to combat HIV/AIDS. In some high-burden countries, patients are being turned away from clinics, and clinicians are once again being forced into the unacceptable position of rationing life-saving treatment. At the same time, more robust and better-tolerated treatments – widely prescribed in wealthy countries – are not reaching patients.

The most glaring sign of the decreasing political commitment to HIV/AIDS is a major funding deficit. The Global Fund to Fight AIDS, Tuberculosis and Malaria Board is considering a motion to cancel the funding round (Round 10) for 2010; if accepted, no new proposals will be considered until 2011. Similarly, the US President's Emergency Plan for AIDS Relief (PEPFAR) plans to "flat-fund" its programmes for the next two years, reneging on promises made last year to support expanded treatment access.

Meanwhile, a dangerous trend is underway in the global health policy arena. Rather than looking for ways to leverage and replicate the success of the AIDS public health revolution to improve global health, there are increasing calls for a diversion of foreign aid away from HIV/AIDS and towards other health priorities. While there is clearly a need to give urgent and additional resources to an array of global health priorities, not least maternal and child health, cutting HIV/AIDS funding is not the answer.

Reducing funding at this juncture would not only undermine the goal of reducing maternal and child mortality, but it could also lead to the interruption of treatment for people with HIV/AIDS already on ART, and leave those still in need of access to treatment to die premature, avoidable deaths.

HIV/AIDS is the leading cause of mortality among women of child-bearing age worldwide and responsible for more than 50% of mortality in five of the countries with the highest HIV prevalence. This killer disease is an ongoing emergency that requires dedicated resources at the national and international levels. A strengthened commitment to other global health priorities must happen – but it must happen in addition to, not instead of, a continued and increasing commitment to HIV/AIDS.

Taking stock

Successful Scale-Up of Treatment

MSF has provided HIV/AIDS care and ART to more than 140,000 people in approximately 30 countries. MSF treated its first patients with ART in 2000. At that time, the epidemic had killed 16 million people and 33.6 million people were living with HIV worldwide, the majority in poor countries. Although 95% of people did not have access to life-saving ART, the UN adopted Millennium Development Goals (MDGs) for health that made no mention of ART.

In 2001, then-UN Secretary General Kofi Annan called for a “war chest” of US\$7-10 billion to address the global HIV/AIDS crisis. The promise of treatment regardless of ability to pay was reiterated at subsequent G8 and UN General Assembly meetings. At the G8 summit in Gleneagles, Scotland in 2005, then-UK Prime Minister Tony Blair launched a specific commitment to achieving “universal access” by the end of 2010.

As a result of widespread public pressure and an eventual worldwide mobilisation of resources, HIV/AIDS care, treatment, and prevention programmes have expanded massively. There are now four million people alive as a result of access to ART and thousands of new infections have been prevented. Nevertheless, prevention efforts still lag far behind and unmet treatment needs are dramatic.

A Continued Emergency

The crisis is not over. In the ten highest HIV prevalence countries, AIDS is the leading cause of death: 80% of all deaths in Botswana and two-thirds of all deaths in Lesotho, Swaziland, and Zimbabwe are due to AIDS.¹ Less than a quarter of HIV-positive pregnant women have access to Prevention of Mother to Child Transmission (PMTCT). Whereas HIV among children has been virtually eliminated in rich countries, AIDS remains the leading cause of under-five mortality in the six highest HIV prevalence countries, accounting for more than 40% of under-five deaths in these countries. (See table)

Despite scale-up successes, today at least six million HIV-positive people clinically need to start ART but do not have access to it.² Moreover, as the World Health Organization (WHO) revises standards in line with the scientific consensus that people living with HIV/AIDS should initiate treatment earlier, this could increase needs to 18-22 million. Most people living with HIV/AIDS in need of treatment will die within three years if they do not have access.³

Cause of child and total mortality in countries with the highest HIV/AIDS prevalence⁴

10 Countries With Highest HIV/AIDS Prevalence	Prevalence (15-49 years)	% of Under 5 Deaths Due to HIV/AIDS	% of All Deaths Due to HIV/AIDS
1. Swaziland	33.4%	47%	64%
2. Botswana	24.1%	54%	80%
3. Lesotho	23.2%	56%	63%
4. Zimbabwe	20.1%	41%	67%
5. Namibia	19.6%	53%	51%
6. South Africa	18.8%	57%	52%
7. Zambia	17.0%	16%	43%
8. Mozambique	16.1%	13%	28%
9. Malawi	14.1%	14%	34%
10. Central African Republic	10.7%	12%	32%

Population-level impact of ART coverage

There are clear indications that comprehensive decentralised HIV services extend the lives of people with HIV and positively impact essential health outcomes including: adult mortality, child mortality and TB incidence. ART provision can also support HIV prevention efforts by reducing HIV incidence (new infections).

Substantial declines in national AIDS-related deaths

- World-wide, AIDS deaths have begun to decline.⁵
- In Botswana, AIDS-related deaths among the adult population were cut in half from 2003 to 2008.⁶
- In Addis-Ababa, Ethiopia, AIDS-related mortality has declined by more than half.⁷
- AIDS-related deaths dropped an average of 6.3% a year in 12 PEPFAR-supported countries over a 3-year period.⁸

Declines in overall population-level adult mortality

- Studies in Brazil⁹, Botswana¹⁰, Ethiopia¹¹, Malawi¹², and Uganda¹³ attribute reductions in population-level mortality to the availability of ART.
- In Khayelitsha, South Africa, female and male adult mortality rates increased due to HIV between 1996 and 2002 from 5.3 and 12.1/1000/year, respectively, to 8.8 and 13.5. However, after the introduction of ART in 2001, these rates gradually decreased to 7.2 and 10.4 in 2004.¹⁴
- A survey of all-cause mortality in Thyolo District, rural Malawi conducted in 2008 has shown a highly significant trend in mortality reduction associated with enrolment in HIV/AIDS care and initiation of ART between 2000 and 2007 (Data under analysis).

Declines in overall population-level infant and under-five mortality

- In South Africa's Western Cape province, a 54% reduction of mortality of children under the age of two following the introduction of comprehensive HIV/AIDS services was found at the population level.¹⁵
- In Khayelitsha, South Africa, MSF has seen the infant mortality rate decrease from 43/1000 live births in 2001 to 30/1000 live births in 2007 after the introduction of PMTCT in 1999.¹⁶
- Botswana recorded a decline in infant mortality corresponding with the national implementation of its HIV/AIDS programme.¹⁷
- In Uganda, a 93% decline in AIDS-related orphans, due to ART availability for adults, was linked to an 81% reduction in non-HIV child mortality.¹⁸

Declines in HIV incidence and prevalence

- Reducing overall viral load within populations will result in reduced transmission, leading to fewer new HIV infections.^{19,20}
- There is growing evidence that ART coverage has a causal link to reduced HIV incidence, and this has been documented in Malawi, Tanzania, and Zambia.²¹
- In South Africa's Western Cape province, the trend is most clear in children and young people where HIV prevalence dropped from 11.2% in 2002 to 3% in 2008. For children aged 2-14, HIV prevalence dropped from 7.1% to 1.1% from 2002 to 2008.²²

Reduction in new TB cases

- In Thyolo, Malawi, MSF saw a decrease in pulmonary TB cases from 2007, when it reached universal access, to 2008.²³
- In Khayelitsha, South Africa, MSF reports that although annual new TB cases increased between 2000 and 2005, since 2006 there has been a downward trend.
- In Gugulethu township, South Africa, a study found a three-fold decrease in TB cases among HIV-positive individuals and a 20% drop in new TB cases in the overall population, as ART coverage increased.²⁴

Impact of ART on non-HIV/AIDS and other health priorities

- Provision of HIV care has been documented to increase antenatal care use, attendance at clinics and hospitals for deliveries, vaccinations, treatment of sexually transmitted infections and diagnosis of TB.^{25,26}
- HIV/AIDS programmes have had a positive impact in terms of human resource for health, improved laboratory monitoring and pharmacy capacity and management, and more effective health management information and procurement systems.^{27,28,29}
- In lower-prevalence settings dedicated HIV/AIDS funding for marginalized groups can have a societal impact, by limiting transmission and preventing a more generalized epidemic.³⁰

Spotlight on South Africa

South Africa accounts for 17% of global HIV infections.³¹ There are more people living with HIV in South Africa than in any country in the world—5.5 million people—and more people on ART than anywhere else—700,000.³² However, an additional 1.5 million people³³ are estimated to currently require ART but lack access.

HIV and TB are the main drivers of mortality among pregnant women, children, and adults. The largest proportion of maternal deaths (43.7%) is due to HIV/AIDS³⁴; the death rate for HIV-positive women is ten times that of HIV-negative women.³⁵ HIV is the leading cause of infant and under-five mortality, responsible for 57% of deaths. Eighty percent of deaths of children between one month and one year of age are HIV-positive children.³⁶ Half of new TB diagnoses are cases of TB/HIV co-infection.³⁷

Life expectancy in South Africa would be on par with other countries of the same economic status, if it were not for mortality driven by HIV.³⁸ Today, the average life expectancy in South Africa has dropped to 54 years of age, which is closer to the lowest ranking country on the Human Development Index rather than countries with same level of income, such as Brazil (73 years) or Argentina (75 years).³⁹

MSF began an ART program in 2000 in Khayelitsha, a township in the Western Cape with approximately 500,000 inhabitants. Khayelitsha has one of the highest antenatal HIV prevalence rates in South Africa at 30.2%.⁴⁰ As of September 2009 the programme, in collaboration with the Western Cape and the City of Cape Town Departments of Health, has 13,000 people enrolled on ART.⁴¹ The programme has promising long-term outcomes with 87% of people remaining in care at one year and 65% at five years.⁴²

The MSF-supported programme in Khayelitsha is one of a handful of programmes that have achieved “universal access” (defined as greater than 80% of those needing treatment receiving it).⁴³ Although the benefits of ARV treatment to both individuals and communities have been impressive, this response is fragile and to maintain gains there is an urgent need for increased management, political commitment and continued funding.

Elsewhere in South Africa there are concerning signs of a reversal of progress. In November 2008, Free State province had a stockout of ARVs that persisted for months, affecting many public health facilities. This caused the disruption of treatment for those already on ARVs and led to a four-month moratorium on new enrolments on ART. The moratorium caused an estimated 3,000 deaths and resulted in treatment interruptions that may have encouraged the development of drug resistance.⁴⁴ Among the causes was the fact that the 2008 budget fell short of the patient needs.

Almost a year later, South Africa’s Treatment Action Campaign (TAC) has warned of another possible moratorium in Free State given that the provincial Department of Health was more than US\$30 million short of its health budget and had already spent more than 70% of its annual HIV budget although it was only halfway through its financial year.⁴⁵

Nationally, scale-up has slowed due to budget shortfalls of over US\$100 million, prompting the Minister of Health to announce in September 2009 that the country is unable to meet universal access target by 2011 unless additional funding is mobilised.⁴⁶ In October, the Treasury provided emergency funding for the subsequent five months, confirming the seriousness with which some high-burden countries are taking the treatment and funding gap.

South Africa, which is able to spend more on health than most African countries, will still require additional funding if the plan to provide life-long ART to every person in need is going to be realised, and as recent research shows, the pace of scale-up to universal access could make the difference in over a million lives saved.^{47,48}

International funding stalls as needs grow

UNAIDS estimated that the total resources needed for a global AIDS response was US\$22.1 billion in 2008. The resource gap in 2008 was reported to be US\$6.5 billion. But despite the gap between needs and resources, the overall trend until recently had been positive – increased resources over time with corresponding increases in access to prevention, treatment and care.

The Global Fund to Fight AIDS, Tuberculosis and Malaria and the US government's HIV/AIDS programme, PEPFAR, are the two most significant supporters of AIDS programmes in developing countries. While there is widely recognized room for improvement in programmes financed or managed by both,^{49,50} their positive impact has been undeniable.

Donors with the most significant contributions to the global AIDS response have been the United States, the United Kingdom, the Netherlands, France, Germany, Norway and Sweden.

But both political commitment and funding allocations are waning. This could have catastrophic implications on people who depend on this aid to access HIV prevention, treatment and care.

The Global Fund: Universal Access Ambitions in Jeopardy

Since its inception in 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria reports that it has committed US\$15 billion worth of grants in 140 countries, and saved an estimated 3.5 million lives. Today, the Global Fund, which depends on contributions from donor countries for the majority of its revenue, is responsible for disbursing almost a quarter (23%) of HIV/AIDS international donor aid.⁵¹

But the Global Fund has been unable to obtain donor commitments to fill a growing funding gap, which directly affects countries' capacity to scale-up and sustain HIV/AIDS treatment. In order to cope with a lower level of funding, the Global Fund has implemented tough measures such as imposing a 10% cut in grants already approved, and delaying by six months the 2009 closing date for proposals.

In countries like Malawi, a least-developed country where HIV/AIDS is a leading cause of illness and death, the 10% cut was withdrawn from funds intended for ARVs. Some countries report being told to “cap” their applications to the Global Fund due to limited resources. Others are pre-empting tighter conditions by downsizing their ambitions and their proposals, particularly for ART.

This pressure, created by funding shortfalls, is a reversal of progress: until now the Global Fund actively encouraged ambitious proposals from countries to scale up access to life-saving treatment. In 2008, Round 8 approved grants for HIV, TB, and malaria were 2.5 times more than any previous round of funding. This year, the total amount of Round 9 HIV grants recommended for funding was 35% less than Round 8.

In March 2009 the Global Fund announced it was facing an alarming funding gap of US\$4 billion based on budget needs through 2010.⁵² In response, a new set of demand reduction measures were proposed including suspending and possibly eliminating the Rolling Continuation Channel, a mechanism to extend funding for “well-performing” grants. More recently, the Secretariat has proposed having no funding round in 2010. The Board of Directors will decide on these measures in November 2009. Suppressing the 2010 funding round would be unprecedented in the history of the Global Fund and would have important consequences for patients and programmes.

More than HIV/AIDS treatment is at stake. Progress in the diagnosis and treatment of TB and malaria also relies on support from the Global Fund. For example, the internationally agreed scale up of diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis⁵³ will greatly rely on increased funding from the Global Fund.

National responses to HIV/AIDS, TB, and malaria depend on the Global Fund being fully funded. According to the Global Fund Executive Director Michel Kazatchkine: “For the first time, the demand for funds in 2009 has exceeded the funds we have available.”⁵⁴ Demand is likely to increase, due to the diminished domestic financing capacity following the economic crisis and reduction of funding for HIV/AIDS treatment by other donors and other global health actors.

Spotlight on Malawi

Malawi is a densely populated, mostly rural country with a population of over 13 million people. Malawi has a GDP per capita of US\$800 and ranks 160 out of 182 on the Human Development Index. The government estimates between 800,000 and one million Malawians are HIV positive, including at least 100,000 children under 15 years of age.⁵⁵ The national HIV prevalence is 12%.⁵⁶

Despite the barriers, Malawi rose to meet the challenge of the international community to scale up ART. According to government statistics, there were more than 164,000 people alive on ART by the end of

June 2009 with 18,000 people initiated on treatment between April and June 2009.⁵⁷ Since the scale-up of ART, the country has seen a significant reduction in HIV/AIDS-related deaths between 2003 and 2008.⁵⁸

The vast majority of financial support for Malawi's ART programme and the country's response to HIV/AIDS has come from the Global Fund. Starting with its first round of funding in 2002, the Global Fund has disbursed over US\$465 million to the country.⁵⁹

MSF works with the Ministry of Health in two districts in Malawi, Chiradzulu and Thyolo, to provide comprehensive HIV/AIDS services as part of primary care in 26 health centres and three hospitals. Since 2003, over 38,000 people have been put on ART. In Thyolo,

universal access (80% of need) was reached and has been maintained, at a cost of US\$3.20 per inhabitant.⁶⁰

The three-year Malawi HIV/AIDS plan lays out an ambitious strategy to reach universal access to prevention, care, and treatment by 2013.⁶¹

The cost of the three-year plan is US\$800 million. Based on all funding commitments to date, a shortfall of just under 50% (US\$423 million) is anticipated.⁶² The Global Fund provides the best opportunity to fill the funding gap and for the country to provide life-saving treatment for every Malawian in need. However, with the Global Fund in crisis, Malawi's scale-up to universal access is in jeopardy.

“How can you go back to rationing access to care?”

The scale-up of antiretroviral therapy (ART) in recent years, backed by solid funding commitments has given millions of people in poor countries a new lease on life. People mired in poverty and living in underdeveloped rural areas have a reason to rediscover joy and live more meaningful and full lives.

This is the case for tens of thousands of people living with HIV/AIDS in Malawi's southern Thyolo district and the healthcare workers who treat them.

Olesi Ellemani Pasulani, an MSF clinical officer at the Thyolo District Hospital, shares his experience and observations from the last five years.

“I can remember what the situation was like before we had ART in 2003. We could only offer people voluntary HIV testing and counselling. We could only promote the use of condoms and distribute them, we could treat other sexually transmitted diseases. We had a lot of patients in homes who were on palliative care due to terminally ill conditions. There were very few people that came forward to be tested for HIV, because there was not much we could do without ART. It was like a death sentence to test HIV positive,” Olesi says.

Health care workers were left disheartened because they could only deliver home-based care, simply being able to offer treatment for chronic illnesses and providing end of life care to patients. Olesi explains, “You could just take care of them, and wait for the day that they would die. It was really hard, because you could see how people were broken down by the knowledge of being HIV positive. That era was really hard for healthcare workers and it de-motivated you completely.”

Thanks to an MSF and Ministry of Health developed model of care, the ART scale-up in the Thyolo district in 2003 turned around thousands of lives and entire communities by providing universal access to treatment across the district. By the end of 2008 the number of people on ART had increased even further and now in 2009 universal access is maintained.

“Now people living with HIV/AIDS have courage, there is light at the end of the tunnel for them. There is hope among people in the villages. You can see the difference that you as healthcare worker make in someone's life thanks to ART. We would see a patient that was bed-ridden earlier, and they would start ART. When you meet them again six or seven months later in the market or on the street, they are completely changed. They have joy.”

The threat of the early retreat of HIV/AIDS funding and the dire impact it would have on patients' lives across the most affected areas of sub-Saharan Africa is something that worries Olesi and his colleagues.

“It is important to continue with ART and increase it even more. How can you go back to rationing access to care? It is a right to life. If treatment is threatened it will mean we go back to a situation worse than before ART. It will also damage the relationship of trust that communities have built with healthcare workers over the years,” he says.

PEPFAR: Flat-Funding and the Rationing of Treatment

The US government's AIDS programme, PEPFAR, has had a considerable effect on the scaling up of AIDS care and treatment in resource-limited settings since its inception in 2003.⁶³ PEPFAR has supported HIV/AIDS and other health programmes in 31 countries.⁶⁴ PEPFAR now supports more than two million people on treatment with a commitment to scale up treatment to at least three million by 2013, with some advocating for a more aggressive US commitment to scale up treatment to six million by 2013 and seven million by 2014, given the tremendous need.⁶⁵ PEPFAR also reports having supplied more than two billion condoms and supported PMTCT for 16 million pregnancies between 2004 and 2008.⁶⁶

The 2008 reauthorization of PEPFAR included a strong commitment for continued treatment access – requiring the majority of bilateral AIDS funds to be spent on treatment programmes⁶⁷ – and many countries in Africa have built ART programmes around the promise of continued PEPFAR support.

In May 2009, US President Obama announced the Global Health Initiative (GHI) as a US\$63 billion, six-year “new, comprehensive global health strategy.”⁶⁸ Yet it is unclear if any of this money is “new” money: it includes PEPFAR as well as other pre-existing government programmes. In the announcement of the GHI, President Obama stated a commitment to PEPFAR, yet advanced a budget that underfunded international spending for AIDS.

After steady increases over each of the last five years, US government bilateral HIV/AIDS funding has flatlined in 2009.⁶⁹ The proportion of PEPFAR's budget dedicated to treatment has decreased.⁷⁰

In an initial letter to Ambassadors, incoming US Global AIDS Coordinator Eric Goosby emphasised a transition in the US government's AIDS response from one of “emergency” to one of “sustainability.”⁷¹ The Global AIDS Coordinator highlighted the “constrained budget environment” and cautioned that PEPFAR's funding can no longer be expected to grow at prior levels.⁷² In explicit terms, he emphasised sustainability over programme scale-up in a context in which the majority of those in need of treatment still do not have access.⁷³ Going forward, only a handful of countries will be able to scale-up at a pace similar to what PEPFAR has supported in the past. The anxiety around PEPFAR's support for continued scale-up is playing out differently in different countries. In South Africa, some implementing agencies have stopped enrolling new patients on ART. In the Democratic Republic of Congo (DRC), PEPFAR has asked that the Global Fund take over the costs of drugs to manage opportunistic infections and laboratory needs, although this was not foreseen in the grant budget.

Spotlight on Uganda

Uganda provides an example of what will happen in other countries if current trends continue and the international commitment to treatment access is undermined.

Uganda, a landlocked poor country in East Africa with a per capita GDP of US\$1,059 per year, is ranked 157 out of 182 on the Human Development Index.

In 2002, MSF began to provide care and treatment to people living with HIV/AIDS in Arua and the West Nile region, in the rural northwest of Uganda alongside the border of Sudan and the Democratic Republic of Congo (DRC). In 2009, MSF has enrolled over 160 HIV-positive patients into care each month. In the West Nile region, MSF provides care for over 7,700 patients, of which over 5,000 are on ART. MSF also provides nutritional support, PMTCT services, paediatric care, and treatment for TB/HIV co-infection and support for two decentralised health centres.

Uganda had been the darling of the PEPFAR programme from its inception. As one of PEPFAR's early “Focus Countries,” Uganda received US\$929 million between 2003 and 2008, at consistently increasing levels to enable treatment scale-up.

Now, however, the situation is different. So, too, are the options for patients. Less than one-half of those eligible for ART in Uganda are receiving it.⁷⁴ The Ugandan government's revised AIDS treatment guidelines attempt to align clinical care for HIV-positive patients with WHO recommendations. But its implementation, including an increase in the eligibility criteria and a transition to an improved priority first-line regimen, are in peril because of a funding crisis.⁷⁵

PEPFAR is the principal lifeline for much of Uganda's treatment scale-up but this support is under threat. The US government is scheduled to cap funds to Uganda at least through 2011.⁷⁶

The primary message from the US government to treatment providers and the Ugandan government regarding the recent policy changes has been clear: funding will continue at the current rate but will not increase. Yet some implementers have been told that they must cease enrolment immediately, others that they must initiate new patients with caution, and still others that they can only initiate new patients on treatment if there are “efficiencies” found, or “attrition” – the death or loss of patients already receiving treatment.

Some AIDS service providers have reported that, because of financial limitations, they have been forced to scale back services, ration care, or cease initiating new patients on treatment.⁷⁷

In Uganda, shortages of ARV drugs and treatment sites have elevated anxiety and generated much public debate. The unmistakable message presented in public and private has been that the transition to a “sustainable” PEPFAR programme requires a painful “rationing” of services. Some eligible people will not gain access to life-saving treatment.

National Governments: Insufficient Investment in National AIDS Response

Due to the global financial crisis, government budgets are tight. Some governments have already slashed budgets for HIV/AIDS.⁷⁸ National governments have downsized ART coverage goals in Swaziland, Botswana, and Tanzania.^{79,80} Individuals also have a more constrained ability to pay for health care including transportation, user fees, and lab, drug, and hospitalisation costs. Some governments are exploring new “cost recovery” and “cost sharing” strategies even though these strategies have been shown to dramatically reduce access to care and worsen survival rates.⁸¹

Such cutbacks come amid a backdrop of insufficient domestic contributions to health. More than half of African countries underspend on health according to the minimum requirement (US\$34 per capita) recommended by the WHO.⁸² Only eight African countries have made good on the 2001 commitment to allocate 15% of their national budgets to health.⁸³ Even then, few African governments could mobilise sufficient resources to cover the costs of HIV/AIDS care and treatment; international aid would still be necessary.

Other Global Health Actors

The contributions of other global health actors are often less far-reaching than those of the Global Fund and PEPFAR, but can play an important role in supporting life-long ART.

The European Commission (EC) and European Union (EU) member countries provide almost half of the contributions to the Global Fund. Many of the larger donors (UK, Netherlands, Ireland, Germany, and Sweden) also provide up to half of allocated funds through bilateral programmes. Since the financial crisis has taken hold, several countries have cut back on development aid and health funding, including allocations to the Global Fund and bilateral programmes. Recently, for instance, the Netherlands cut almost US\$150 million in aid, over US\$70 million in HIV/AIDS spending.

The UK government led the charge for G8 support for universal access in 2003 but has downscaled resources for HIV/AIDS, shifting support to maternal and child health. The UK Department for International Development (DfID) has redefined its role for supporting scale-up as strengthening health systems, a broad and largely unmeasurable goal.

The World Bank Multi-Country HIV/AIDS Program (MAP) distributed US\$1.5 billion in over 30 countries since it began in 2000. By 2007, MAP provided support for 3,012 sites to provide ART in 26 countries, for over 26,000 people directly and over 500,000 people indirectly.⁸⁴ Although the Bank committed to MAP as a 15-year programme, it has shifted from a “principal financier to facilitator and knowledge contributor.”⁸⁵ The MAP programme has ended in Uganda (2005), Guinea (2008), and Lesotho (2008) and is planned to come to a halt at the end of 2009 in Mozambique, at the beginning of 2011 in DRC, and at the end of 2011 in Kenya.

UNITAID is an international financing mechanism that generates funding primarily from an airline tax. As a funding agency it takes a somewhat different role, because its aim is to catalyze the creation of a “healthy market” to establish lower prices that enable other global health actors and national governments to take on the costs. UNITAID has been instrumental in covering the costs of paediatric AIDS-related commodities in 39 countries and more costly second-line treatment in 25 countries.⁸⁶ This support is planned to end for paediatric formulations in 2011 and for second line treatment in 2010. UNITAID should review its planned hand-over strategies, as halting support to essential commodities for paediatric and second-line treatment would be premature – especially as many countries may have nowhere to turn to help pay for these costly items.

Conclusion: addressing the funding crisis

Global health remains underfunded. MSF has repeatedly called for increased global support for a number of pressing health needs such as childhood and maternal malnutrition, vaccinations, tuberculosis, and neglected tropical diseases. However, such efforts should not come at the expense of HIV/AIDS funding and programming: this will undermine opportunities for synergies between HIV/AIDS and other, often linked, health needs.

Funding for HIV/AIDS treatment is not keeping up with need, and appears to be shrinking. Funding shortfalls punish the early success of the last decade of ART scale-up, and threaten to have a devastating impact on people living with HIV/AIDS as well as efforts to prevent new infections. As global health actors retreat from providing direct support for AIDS treatment, more demand is placed on the Global Fund, which is itself critically underfunded.

In order to expand and sustain HIV/AIDS care and treatment worldwide MSF recommends:

Sustained and increased funding for HIV/AIDS from the international donor community and national governments – and a continued commitment to universal access to AIDS care and treatment

- **Global Fund:** The Global Fund Board and Secretariat should clearly articulate their funding needs, rather than obfuscating their funding crisis by reducing demand. It is not too late to prevent a downward spiral of lowering expectations and shrinking programmes. The Global Fund should ensure a funding round for 2010 and avoid administrative changes that hide the funding shortfall. Ultimately, it is donor governments that have the power to change the current reality. Furthermore, the Global Fund, underfunded itself, cannot provide an exit strategy for other actors.
- **PEFPAR:** This US programme has been central to encouraging large-scale HIV/AIDS treatment scale-up. As such, the US government has a responsibility to help countries avoid treatment interruptions and continue to enrol new patients. This means honouring commitments made repeatedly by the US and other G8 countries to support universal access. Implementers on the ground are all too aware that countries cannot do it alone, and talk of self-sufficiency is premature in many contexts.
- **National governments:** National governments must not abandon or delay their commitment to universal access to HIV/AIDS treatment. In addition to adequate funding for national health budgets, addressing mismanagement of funds is required if governments expect to continue receiving adequate funds.
- **The international community:** In addition to fulfilling commitments on financing for health, donor and national government should support mechanisms that allow raising enough money for global health on a sustained basis. Small taxes on untapped global economic flows, such as currency transactions, are currently under discussion internationally.⁸⁷ Such innovative strategies are needed as additional sources of revenue to help address the increasing discrepancy between global problems and national resources.

Improved treatment in line with scientific evidence and recognised international standards of care

Not investing today in improved treatment and protocols will cost lives, increase a double standard in HIV care and lead to increased costs later. There is a clear risk that donors will not support or try to delay the implementation of proven and recommended medical strategies for the sake of short-term savings. Therefore, MSF recommends:

- Supporting earlier initiation of ART (at a CD4 cell threshold of 350), which can reduce the incidence of TB and other deadly opportunistic infections and improve survival rates, reducing the need for costly and complex acute care.⁸⁸
- Implementing a more robust tenofovir-based first-line regimen, which will allow patients to stay on their first regimen as long as possible and with fewer side effects, and delay the need for more costly second-line regimens.⁸⁹
- Providing access to viral load testing to support adherence and detect treatment failure, thereby preventing resistance and needless switching to expensive second-line treatment.⁹⁰
- Supporting innovation that can lead to further improvement and simplification of HIV treatment in resource-poor settings such as point-of-care viral load testing.

Measures to ensure that prices of drugs and diagnostics remain within reach of poor countries

The international community should support policies that will enable funds to stretch as far as possible to meet needs and contain costs in the short- and long-term by ensuring a competitive supply for drugs.⁹¹

- The Global Fund and PEPFAR, among others, should continue to embrace and encourage the use of generic drug regimens.
- In accordance with the Doha Declaration on TRIPS and Public Health, governments can authorise governmental use or compulsory licenses to ensure generic production of patented products
- Companies and governments should support the patent pool for antiretroviral medicines that is currently being designed by UNITAID.⁹² This mechanism brings together patents held by different owners and makes them available to others for generic production and further development.

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