

AT THE TIPPING POINT

TRACKING GLOBAL
COMMITMENTS
ON AIDS, VOLUME 3

ONE

INTRODUCTION

In 2013, after more than three decades of the fight against HIV/AIDS, the world reached a dramatic tipping point. For the first time in the history of the pandemic, more people were added to antiretroviral treatment than the number who became newly infected with HIV in that same year – a milestone that signified “the beginning of the end of AIDS”.¹

ONE has been tracking progress in the fight against AIDS and the commitments made towards this tipping point annually since 2011, using the latest data available for the previous year. This milestone is, of course, not the only indicator of progress worthy of analysis. But crossing this threshold is significant: it means that, for the first time, the world is getting ahead of the disease rather than losing ground. Previous projections, based on rates of progress in HIV prevention and access to treatment at the time, showed that reaching the beginning of the end of

AIDS might take a decade or more. Even as recently as last year, projections were still suggesting that the tipping point might not be reached until 2015.² Fortunately, a significant acceleration of progress in 2013 has brought us to that tipping point ahead of projections.

Achieving the beginning of the end of AIDS is a milestone worthy of celebration. On the whole, it is clear that increased overall resources to fight the disease, applied and targeted more effectively, have

helped to accelerate progress at the global level. But equally clear is the fragility of this progress. Progress at the global or regional level often masks demographic and country-level inequities that still lead to gaps in service delivery and a rise in new infections amongst the most marginalised. In fact, in 2013, more African countries lost ground towards the tipping point than made progress towards it.³ This report explores three challenges to driving faster, more equitable progress on HIV/AIDS:

INTRODUCTION

1 Efforts in combating the disease so far have prioritised those easiest to reach.

Yet within countries, HIV is increasingly concentrated among vulnerable populations, including men who have sex with men, female sex workers, injection drug users and adolescent girls – and in many countries, political dynamics and legislation have made it increasingly difficult to reach them. More resources alone will not fix this problem. Donors and national level leadership must work together to prioritise programming for marginalised groups, while also working to combat the stigma and political headwinds that make these programmes more challenging.⁴

2 Too few funders prioritise HIV/AIDS.

Other worrying trends threaten the prospects for further accelerating progress. From a financing perspective, external assistance for AIDS is insufficient for controlling the disease. Moreover, it is increasingly unsustainable, concentrated among only a handful of upper-income countries. Meanwhile, many African countries have not yet achieved their own health spending commitments.⁵ In order to move more countries towards and past the tipping point, bold new resources must be committed from more sources.

3 Fragile health systems threaten progress on all fronts.

The world will not achieve the control of AIDS if we focus on preventing the disease in isolation from other challenges. This year's Ebola outbreak in West Africa has shown that emerging health threats can wreak havoc on weak health systems and quickly undermine progress across the health sector, including on HIV/AIDS. Anecdotal evidence already suggests that access to AIDS treatment and care services has been limited by the Ebola outbreak as health systems seek to prioritise limited resources for control efforts.⁶ More broadly, shortages of health personnel affect much of sub-Saharan Africa, limiting the ability of countries to respond to new and existing challenges.⁷ Ensuring that countries have resilient health systems is essential for ensuring the stability of gains made in the fight against AIDS.

In a year in which the world has reached a significant milestone – the beginning of the end of AIDS – it is right to take stock of all that has been accomplished since AIDS first took hold more than three decades ago. But as the global community stands together at a global tipping point we cannot be complacent, or else we risk falling back and reversing the gains we have fought so hard to achieve.



Young men receive HIV education training at Hope Worldwide, Nakuru, Kenya.

Photo: Jonx Pillemer/(RED)

PROGRESS TOWARDS THE GLOBAL TIPPING POINT



Women wait outside the PMCT/antenatal unit at Tema General Hospital, Ghana.

Photo: John D McHugh/(RED)

With accelerated progress made over the past year the world reached the tipping point in 2013, ahead of previous years' projections. In 2013, 2.3 million people were newly added to AIDS treatment – a fairly dramatic scale-up from 2012, when 1.6 million were added. At the same time, the total number of new HIV infections was down, albeit less markedly, from 2.2 million to 2.1 million.⁸

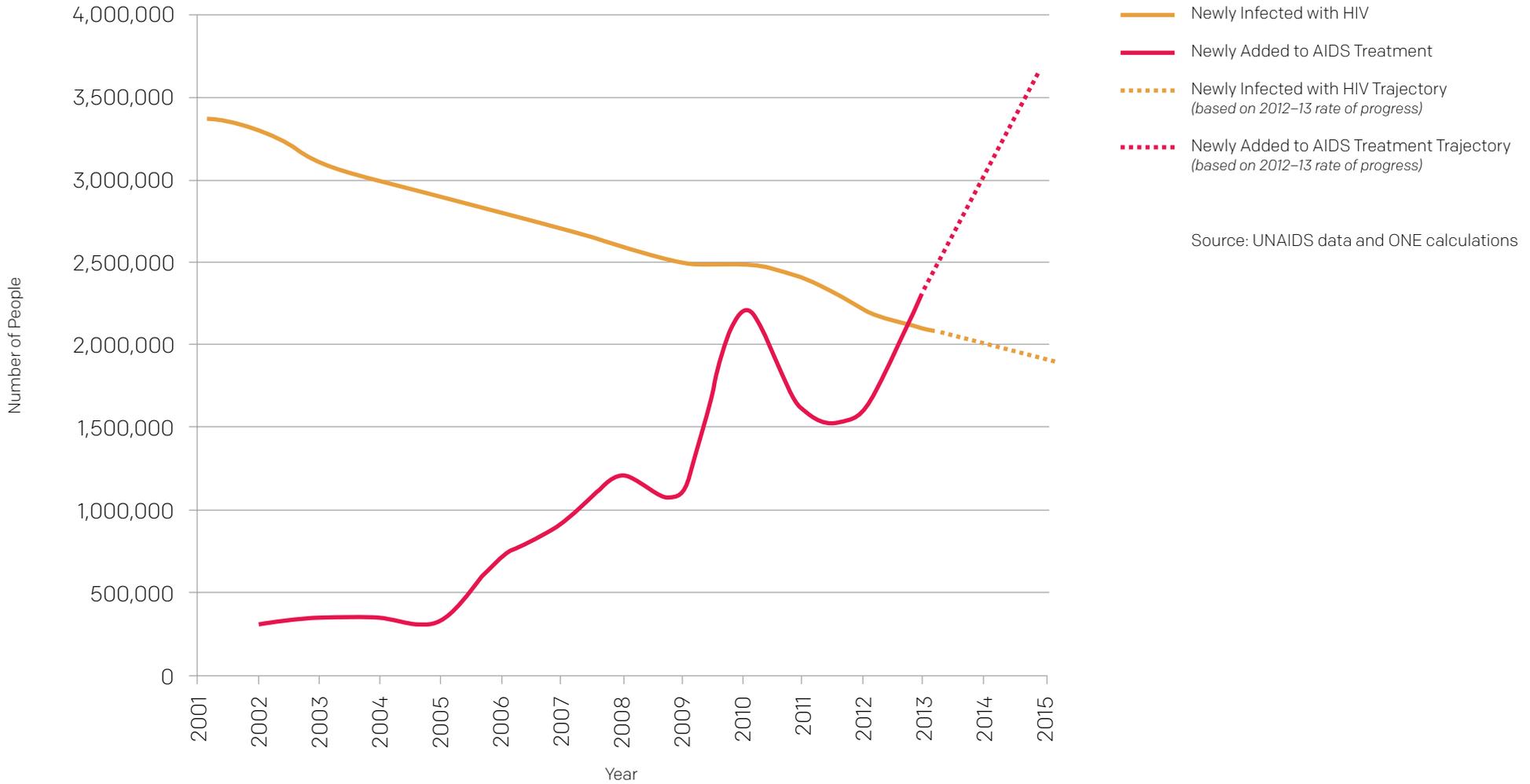
Sub-Saharan Africa has accounted for a significant proportion of both the decline in new HIV infections and the rise in access to treatment. Compared with other regions between 2005 and 2013, it saw the second fastest percentage point reduction of new infections (31.8%) and beat the global average (27.6%) – although in 2013 it still accounted for 71%

of the world's new HIV infections annually.⁹ Of the 12.9 million people on treatment in 2013, more than 9 million were in sub-Saharan Africa.¹⁰ The region's rate of treatment coverage is also slightly above the global average, with 39% of people in need of treatment receiving it compared with 38% globally.¹¹

However, new infections are increasing among marginalised populations around the world. Compared with the rest of the adult population, HIV prevalence is roughly 28 times higher among people who inject drugs, 19 times higher among men who have sex with men and 12 times higher among sex workers - worrying trends that require greater attention, resources and nuanced programming from donors and affected countries alike.¹²

PROGRESS TOWARDS THE GLOBAL TIPPING POINT

Figure 1: The Global Tipping Point



Source: UNAIDS data and ONE calculations

PROGRESS TOWARDS THE TIPPING POINT IN AFRICAN NATIONS

While the tipping point was surpassed at the global level in 2013, progress was not achieved uniformly across countries. Among the 36 countries in sub-Saharan Africa for which comparative data was available, 15 were past the tipping point in 2013, including four (Mozambique, Ethiopia, Uganda, and Togo) that newly moved past the milestone last year, and 11 that were already there in 2012 and have sustained progress.¹³ However, progress among the other 21 countries was mixed: while seven countries saw their tipping point ratio improve, 14 saw their ratio slip backwards, further away from the tipping point.¹⁴

Of particular note, sub-Saharan Africa's HIV burden is concentrated among just a handful of countries. Some 38% of people living with HIV and 36% of AIDS deaths are found in Nigeria and South Africa alone,

and just four countries (Nigeria, South Africa, Uganda and Mozambique) account for more than half of the region's new HIV infections.¹⁵ These countries are in many instances holding back more dramatic progress across the continent, and will require a redoubling of focus, political will and resources if we want to sustain and accelerate progress.

The consistency of data across the African continent also remains a serious challenge. Of the 46 countries considered to be part of sub-Saharan Africa by UNAIDS, only 39 had data for 2013 on both treatment and new infections, and just 36 had data that allowed for comparison between 2012 and 2013.¹⁶ With insufficient data to allow for comparison and analysis, tracking overall progress made by individual countries in the fight against AIDS remains extremely difficult.

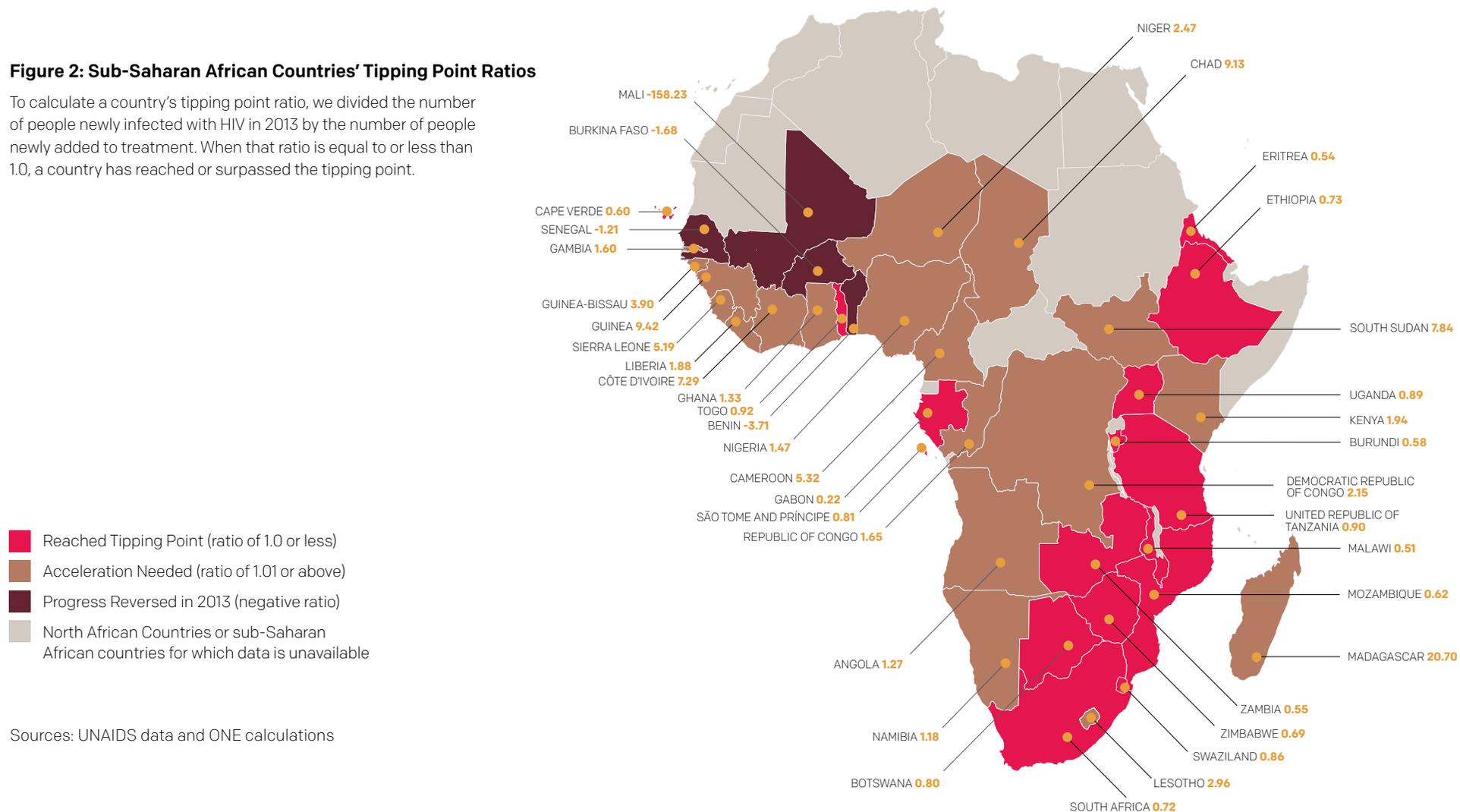


Patience Apenu, a Ghanaian mother, with her daughter, Emilia. Patience is HIV-positive; thanks to PMTCT services, Emilia is not.
Photo: Nana Kofi Acquah/The Global Fund

PROGRESS TOWARDS THE TIPPING POINT IN AFRICAN NATIONS

Figure 2: Sub-Saharan African Countries' Tipping Point Ratios

To calculate a country's tipping point ratio, we divided the number of people newly infected with HIV in 2013 by the number of people newly added to treatment. When that ratio is equal to or less than 1.0, a country has reached or surpassed the tipping point.



Sources: UNAIDS data and ONE calculations

FUNDING

Global funding for HIV/AIDS reached a historic high in 2013, with \$19.1 billion spent, up from \$18.9 billion in 2012. Still, this spending fell \$3–5 billion short of the \$22–24 billion that UNAIDS estimates is needed annually to control the pandemic.¹⁷ Of the \$19.1 billion spent, \$8.5 billion, or less than half of all global spending, came from international assistance;¹⁸ low and middle income countries' own budgets accounted for more than half.¹⁹

External Financing for HIV/AIDS

Bilateral and multilateral contributions by G7 donors and the European Commission (EC) increased by 7.7%, up from \$7.0 billion in 2012 to \$7.5 billion in 2013.²⁰ Much of this increase can be attributed to an increase of almost 12% in the United States' HIV/AIDS assistance in 2013. The United Kingdom and France also increased overall funding, but the EC essentially flatlined its aid for HIV/AIDS. Germany, Japan, Canada and Italy all reduced funding, with reductions ranging from 1% for Germany to more than 82% for Italy.²¹

Worryingly, external funding for AIDS continues to be concentrated among just a few donors. In 2013, as was the case in 2012, roughly 88% of international assistance came from G7 countries and the EC.²² Even among these donors, the burden was shared

unevenly. The US alone contributed roughly two-thirds of all international assistance for HIV/AIDS in 2013; combined with resources from the next two largest donors (the UK and France), that share rose to roughly 80%.²³

Meanwhile, 2013's most prominent moment for AIDS financing (along with funding for tuberculosis and malaria) – the fourth replenishment conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria – provided mixed signals about donors' ambitions. The Global Fund raised just over \$12 billion for the next three-year period (2014–16), which represented a 30% increase over the previous three-year fundraising period.²⁴ However, the collective contributions still fell far short of the \$15 billion target. Among the larger traditional donors, Germany was the only one not to have increased its contribution since 2008, and other donors – such as Japan, Australia, oil-rich Middle Eastern states and emerging economies – failed to step up as aggressively as many had predicted.²⁵

Resources from governments remain the primary source of funding for AIDS programmes, but the private sector has also played a smaller yet still important role. Corporations and other businesses

have historically provided resources, in-kind support, workforce HIV/AIDS initiatives and price subsidies for treatment.²⁶ Many private entities have contributed resources through the Global Fund, and contributions from funders as diverse as the Bill & Melinda Gates Foundation, the oil company Chevron and companies organised through (RED) have been substantial. However, total contributions to the Global Fund by all private sector partners and foundations have dropped in recent years. In 2011 the private sector contributed \$209.2 million to the Global Fund, out of more than \$3 billion contributed by all donors. In 2012 and 2013 these figures fell to \$200.1 million and \$188.9 million out of \$3.6 billion and \$3.5 billion respectively.²⁷ Given the immense wealth of many corporations – and their many workforces who stand to benefit – the private sector could be contributing much more to the AIDS response.

Many governments have also used innovative financing mechanisms to help pay for AIDS programmes. Such programmes include Debt2Health, which allows developing countries to pay their debts in the form of contributions to the Global Fund, and various taxes such as Zimbabwe's AIDS Levy, which helps fund the country's AIDS programmes.²⁸

FUNDING

Figure 3: International HIV/AIDS Assistance from G7 Members and the European Commission, 2011–13 (\$ millions)

	Year	Canada	European Commission	France	Germany	Italy	Japan	United Kingdom	United States
Bilateral Spending on HIV/AIDS	2011	48.5	39.9	81.3	150.8	5.1	20.9	680.5	3,974.8
	2012	54.1	30.3	55.9	145.8	13.9	20.5	643.4	4,359.2
	2013	42.1	19.2	50.5	134.1	2.4	31.9	680.7	4,782.7
	2011–13 total	144.7	89.4	187.7	430.7	21.4	73.3	2,004.6	13,116.7
Global Fund	2011	176.5	148.8	457.4	273.1	0.0	114.2	439.7	949.7
	2012	182.4	127.9	447.6	259.4	0.0	342.9	203.9	1,205.7
	2013	174.1	142.2	496.7	265.2	0.0	122.3	205.0	1,470.4
HIV/AIDS Spending / Global Fund	2011	98.8	83.3	256.2	152.9	0.0	64.0	246.2	531.8
	2012	100.3	70.4	246.2	142.7	0.0	188.6	112.2	663.1
	2013	99.2	81.1	283.1	151.2	0.0	69.7	116.9	838.1
	2011–13 total	298.3	234.8	785.5	446.8	0.0	322.3	475.3	2,033.0
UNITAID	2011	0.0	0.0	144.3	0.0	0.0	0.0	85.1	0.0
	2012	0.0	0.0	143.4	0.0	0.0	0.0	87.2	0.0
	2013	0.0	0.0	149.5	0.0	0.0	0.0	87.2	0.0
HIV/AIDS Spending / UNITAID	2011	0.0	0.0	75.3	0.0	0.0	0.0	44.4	0.0
	2012	0.0	0.0	74.9	0.0	0.0	0.0	45.5	0.0
	2013	0.0	0.0	76.2	0.0	0.0	0.0	44.5	0.0
	2011–13 total	0.0	0.0	226.4	0.0	0.0	0.0	134.4	0.0
Total HIV/AIDS Spending	2011	147.3	123.2	412.7	303.7	5.1	84.9	971.2	4,506.6
	2012	154.4	100.7	376.9	288.5	13.9	209.1	801.1	5,022.3
	2013	141.4	100.6	409.8	285.3	2.4	101.6	842.1	5,620.8
	2011–13 total	443.1	324.5	1,199.4	877.5	21.4	395.6	2,614.4	15,149.7

Source: Kaiser Family Foundation Reports, "Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments", 2012-14 editions.

FUNDING

Domestic Financing for HIV/AIDS

For the third year running, low- and middle-income countries have funded more than half of the world's AIDS response – an encouraging trend.²⁹

Nevertheless, most African governments are not allocating sufficient resources for health in line with their own promises. In 2012, just six of 43 countries in sub-Saharan Africa met their 2001 Abuja commitment to spend 15% or more of their domestic budgets on health programmes annually: Liberia (19.15%), Malawi (17.77%), Rwanda (22.12%), Swaziland (18.08%), Togo (15.38%) and Zambia (16.44%).³⁰ Of these 43 countries, 35 saw a change of less than one percentage point in the proportion of their budget going to health between 2011 and 2012.³¹

In 2012 alone, the gap between what sub-Saharan African countries spent and what they would have spent if they had each hit the Abuja target was nearly \$20 billion.³² Of course, not all of those resources for health would automatically have been spent on HIV/AIDS programmes, and not all countries have equal AIDS burdens requiring equal investment. But as an illustration, even with less than half that total, every single HIV-positive man, woman and child on the entire continent could have received life-saving AIDS treatment for a year.³³ Countries are missing

opportunities to take greater ownership of their own AIDS crises and to significantly strengthen their own health systems and scale up vital programmes. In particular, these health systems often lack the skilled health-care workers, facilities and equipment needed to efficiently meet the day-to-day health needs of the population.³⁴

Importantly, the push for countries to meet their 15% Abuja commitments should not be seen as the sole metric for defining success on health. In a country like Liberia, where the government has consistently met or exceeded the target, external resources are still essential because the nominal amounts generated and spent on health by the government are insufficient to rebuild a health system destroyed by a decade of civil war. Moreover, across many governments, the achievement of the 15% target does not automatically mean that those resources are being maximised, targeted at delivering the most cost-effective interventions to the right sub-sets of the population who have the highest burdens of HIV/AIDS and other diseases.

In order to better target these limited resources, the fight against AIDS needs more and better data. Donors must improve the transparency of their data, down

to the site level wherever possible, and must work to eliminate double-counting of results when multiple stakeholders are collaborating in a country. At the same time, affected countries must make their own health budgets more transparent and must build and strengthen their own statistical capacity, assisted by donors where necessary. In doing so, they can better understand their own unique AIDS epidemics, better focus their spending on the right interventions for the right people and manage more of their own responses over time.

In particular, data availability and quality for most at-risk populations (MARPs) remains poor. Insufficient funding for programmes specifically targeting MARPs is compounded by laws that criminalise such individuals, together with stigma and the threat of violence, which dramatically hinder data collection and even threaten the safety of data collectors. For example, amfAR reported in 2013 that in Zimbabwe, those suspected of working with or for LGBT people are frequently pursued by the police and risk arrest.³⁶ This type of environment exists in many parts of the continent and makes it exceedingly difficult to systematically collect data on MARPs. This is a major obstacle to creating better, targeted care programmes that improve prevention and treatment outcomes for these groups.

Country Case Studies

To showcase the diversity of the country-level fights against AIDS across sub-Saharan Africa, we revisited Ghana and Togo, two of the nine countries that ONE profiled in last year's AIDS accountability report. In that report, Ghana was considered a leader while Togo was considered a country that urgently needed to see progress, but even in 12 months much can change. Accelerated progress is possible, even amongst last year's laggards, but progress is fragile, and without sustained, smart investments even leaders who set an example can slip backwards.



GHANA

Over the past decade, Ghana had made relatively consistent progress towards ending the AIDS epidemic, and it reached the tipping point in 2011. The country was hailed as a leader in the fight against AIDS last year, having made significant gains across a number of treatment and prevention indicators. However, between 2012 and 2013 it saw a reversal in its progress. Primarily because the number of people added to treatment dropped significantly, Ghana slipped away from the tipping point.³⁷

Ghana relies heavily on international aid for its HIV/AIDS response, which increased between 2012 and 2013; in particular, the country received \$38.4 million in Global Fund assistance in 2013 compared with \$21.9 million in 2012.³⁸ At the same time, funding

from the President's Emergency Plan for AIDS Relief (PEPFAR) dropped slightly, from \$15 million in 2012 to \$12.5 million in 2013.³⁹ The Ghanaian government made strong investments in the health sector throughout the 2000s, consistently spending close to the Abuja commitment of 15% of its budget on health programmes. However, this investment has dropped off in recent years, partly due to spending breaks implemented by the Ministry of Finance to balance the budget.⁴⁰ Ghana allocated less than 10% of its budget to health in 2012 (2013 data is not yet publicly available).⁴¹

Despite the increases in international HIV/AIDS assistance, Ghana's resources were still insufficient to make real gains against the disease. In particular,

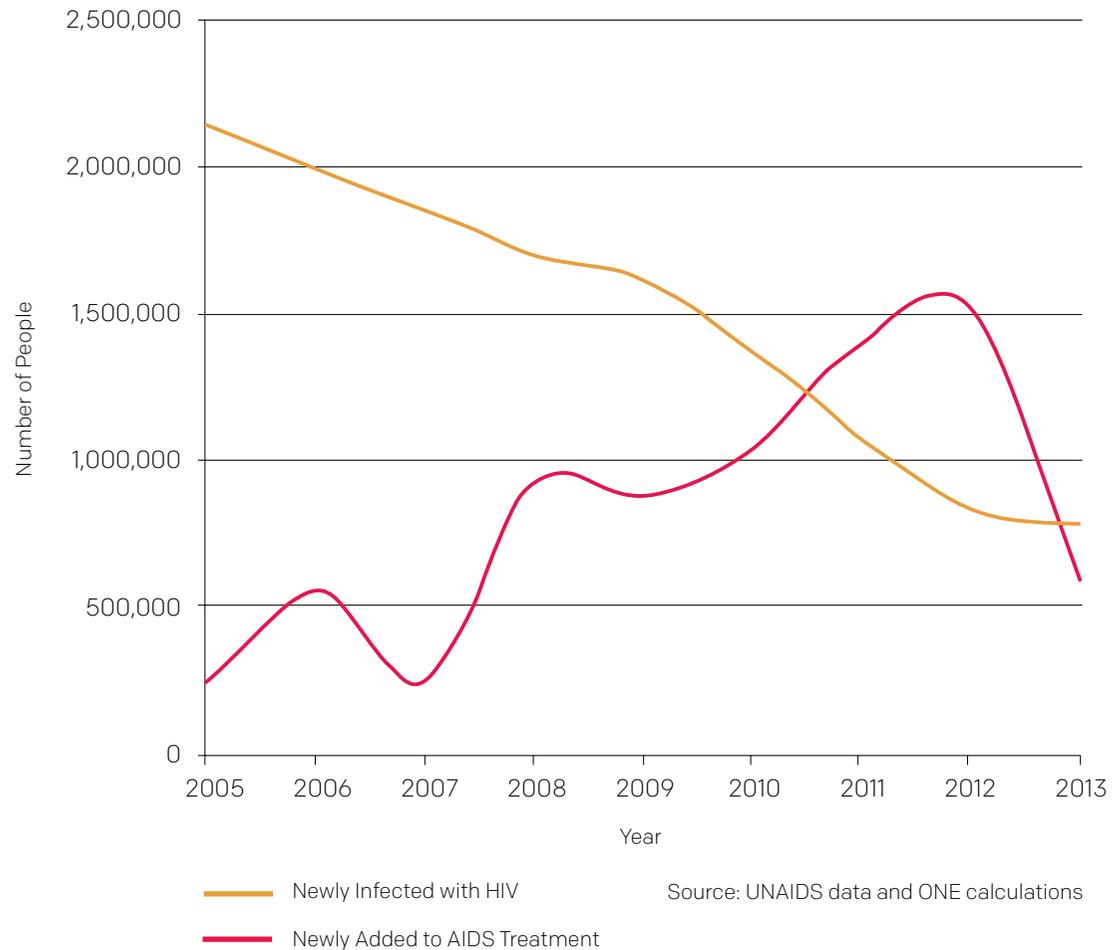
according to country-level experts, the government had previously relied on a grant for procuring HIV testing kits as a key part of its strategy. When this grant expired, it no longer had the resources to procure these essential commodities, which reduced the number of tests given and treatment administered to the general population.⁴² Similarly, though the country has made steady gains in adding people to treatment, many experts believe that expansion has occurred at an unsustainable level, with more people added to treatment than existing resources allowed for. Its AIDS programmes were therefore forced to significantly reduce the number of people added to treatment in 2013.⁴³

GHANA

Over the next year, Ghana should ensure that it scales up treatment and prevention programmes sustainably. Efforts to prevent mother-to-child transmission must be redoubled; although the country had previously been a leader in reducing paediatric infections, there were more child infections in 2013 than in 2012.⁴⁴ It must also critically evaluate how it prioritises spending of its national resources and must consider increasing overall spending on health. Currently, as much as 90% of domestic health spending goes towards health worker salaries, and yet in 2010 Ghana had only about ten skilled health workers per 10,000 population, far below WHO's recommendation of 23 per 10,000.⁴⁵ The country should reallocate its spending in a way that ensures an adequate number and appropriate distribution of skilled health workers to meet the needs of the population while still scaling up key services.

In the last decade, Ghana has shown that it has the systems, political will and capacity to be a leader in the fight against AIDS. The past year, however, has also shown the fragility of progress and the danger of letting up before the job is done. Ghana can and must overcome the reversals of the past year with renewed efforts in the months to come.

Figure 4: Progress Towards the Tipping Point in Ghana





TOGO

Togo made very little progress in the fight against AIDS in the early 2000s, but then made steady gains in the latter half of the decade and reached the tipping point in 2010. However, it slipped backwards in 2011 and 2012 due to drops in the number of people newly added to treatment. This slippage can be partly attributed to a delay in the signing of Global Fund grants, which hindered the implementation of programmes.⁴⁶ Over the past 12 months, encouragingly, Togo has reversed this trend and has made fairly dramatic progress. New HIV infections among both adults and children have dropped and, thanks to a significant scale-up in treatment, more than 4,100 people were added to treatment in 2013, compared with 3,800 who were newly infected. As a result of these improvements in treatment and the reduced rate of new infections, Togo has again reached the tipping point and must now work on sustaining this progress.⁴⁷

Togo is not a PEPFAR focus country, and it receives most of its international assistance for HIV/AIDS from the Global Fund. The Global Fund more than doubled its HIV/AIDS disbursements from 2012 to 2013, from \$4.75 million in 2012 to \$10.57 million in 2013.⁴⁸ The

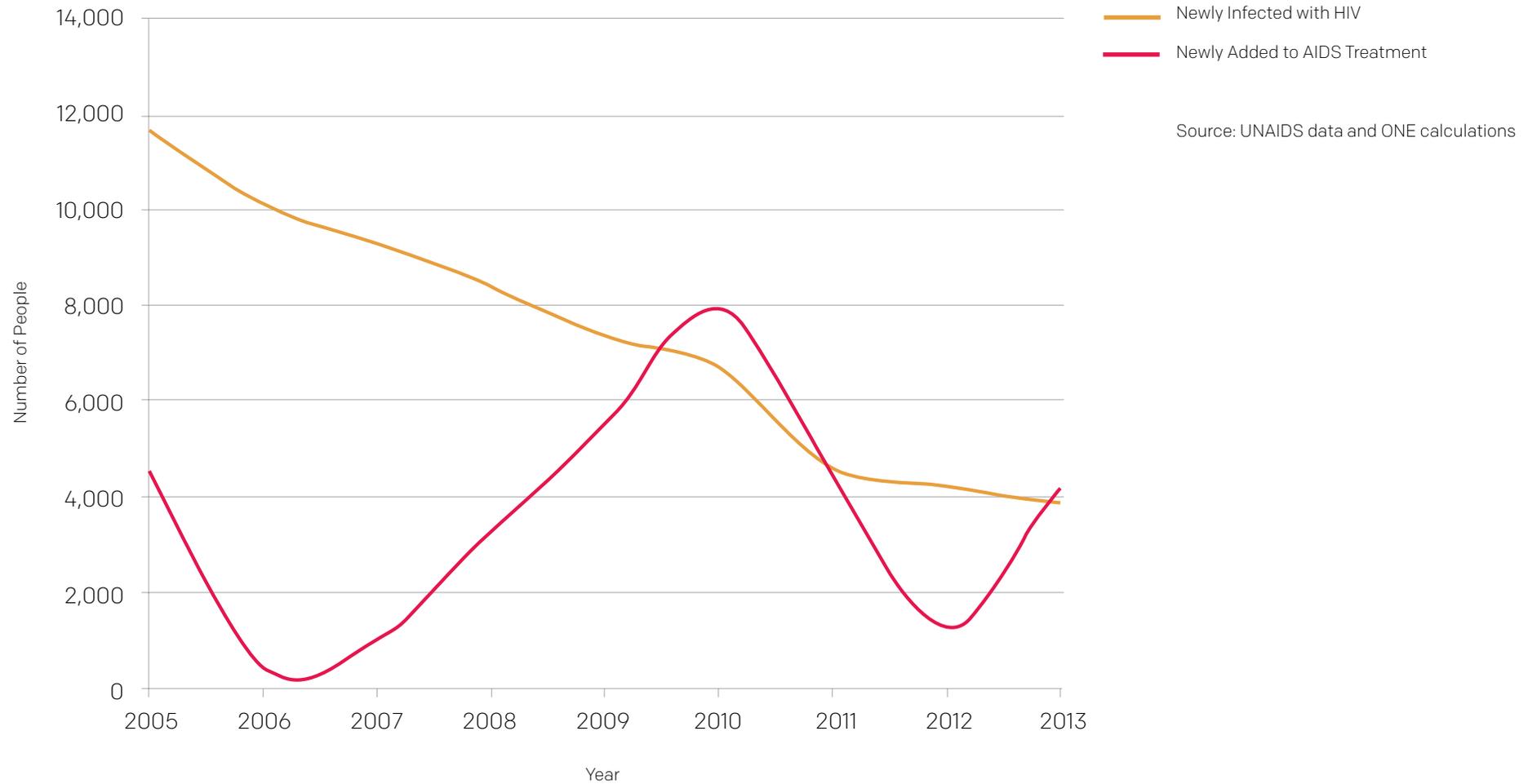
Togolese government has also shown an increased commitment to health in recent years. Though it allocated barely 10% of its budget to health during the early and mid-2000s, it has consistently met its Abuja commitment of spending 15% on health since 2009.⁴⁹ Togo has reached an important point in the fight against AIDS, but the uneven nature of the progress made means that efforts must be redoubled in order to sustain and accelerate progress. It should continue improving access to treatment, but should emphasise in particular the need for better prevention programmes; while there had been a dramatic drop in new infections earlier in the decade, progress has slowed in recent years. Prevention and treatment efforts should focus especially on reaching marginalised groups. Interviews conducted with men who have sex with men and female sex workers in the Togolese cities of Lomé and Kara highlighted their challenges in accessing HIV prevention and care services, with many expressing concerns about confidentiality and potential harassment.⁵⁰

To help sustain these efforts, Togo should also strengthen its health system. In particular, the country

lacks skilled health workers: in 2010 it had only about four skilled health workers per 10,000 population – a fraction of the WHO's recommendation of 23.⁵¹ With barely a sixth of the recommended health workforce, Togo's system will continue to struggle to provide basic care for its citizens. Furthermore, it will be even less likely to sustainably scale up disease responses or address unforeseen emergencies that – as other countries in the region have seen with the Ebola outbreak in 2014 – could reverse progress made in health outcomes. The progress made thus far is remarkable and must be sustained but, without scaling up its health system, Togo's progress remains vulnerable.

TOGO

Figure 5: Progress Towards the Tipping Point in Togo



CONCLUSIONS AND RECOMMENDATIONS



Adolescent girls at Ebenezer Secondary School in Accra, Ghana receive HIV and reproductive health education lessons.

Photo: John D McHugh/(RED)

Just as reaching the tipping point was not a foregone conclusion, accelerated progress past this point is not guaranteed. In fact, evidence at the country level shows that, despite recent progress towards the tipping point, gains are fragile in many countries as HIV is increasing in marginalised groups, funding is still insufficient to fully address the epidemic and the weakness of health systems threatens the sustainability of progress. In order to solidify the gains achieved in recent years and ensure more equitable, rapid progress towards the ultimate defeat of AIDS, three essential steps must be taken.

CONCLUSIONS AND RECOMMENDATIONS

1 Target HIV where it is, not where it is easiest to reach

In recent years, the world has achieved gains among populations and groups in places that have been easier to reach for geographic, political or demographic reasons. As a result, new HIV infections are increasingly concentrated among marginalised groups and in fewer, often more challenging locations.⁵² To ensure that gains are achieved more equitably and that programmes have the greatest impact possible, donors and recipient countries alike must develop tailored strategies and commit additional funding to target MARPs, including men who have sex with men, injection drug users, sex workers and young women. Simultaneously, the world must refocus attention and resources on a smaller sub-set of countries that represent a growing share of the world's new HIV infections, as well as on specific communities, provinces and states within countries that hold back more widespread progress.

2 Deploy bold new funding from a more diversified base

Despite an overall growth in global resources for HIV/AIDS in 2013, we are still billions of dollars short of the funding necessary to lay the groundwork for controlling the pandemic in our lifetimes.⁵³ To fill this funding gap, donors must stay the course and heighten their collective ambitions. However, relying on the US and a handful of others to contribute the vast majority of resources is not a sustainable approach. New donors from Europe, emerging economies and the private sector must step up and contribute more meaningfully, including through new or existing innovative financing channels. Ultimately, increases in African countries' own domestic financing should play the most pivotal role in transforming the ambition and success of efforts to fight AIDS. Here, too, countries can be creative and learn from their peers, considering the use of taxes, levies or specific health funds where appropriate.

3 Build resilient health systems that can tackle AIDS alongside other health challenges

For many years, donor support for a variety of "vertical" health funds has directly benefited the fight against AIDS. These programmes have delivered impressive results, including treatment and prevention outcomes that have helped the world reach the tipping point. Such programmes must receive continued and increased support. But as the Ebola crisis has shown this year, investments in and advocacy for AIDS must not come at the expense of important "horizontal" programmes, which seek to build up health systems and countries' ability to more effectively provide a wider range of services for their citizens. Donors and countries must find ways to ensure increases in funding for health overall, so that worthy programmes do not cannibalise one another. If countries have stronger systems and greater ownership over them, it will not only allow for more sustainable progress on HIV/AIDS but will also help ensure that gains in the fight against AIDS or other specific diseases are not so easily jeopardised by new or emerging threats.

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