

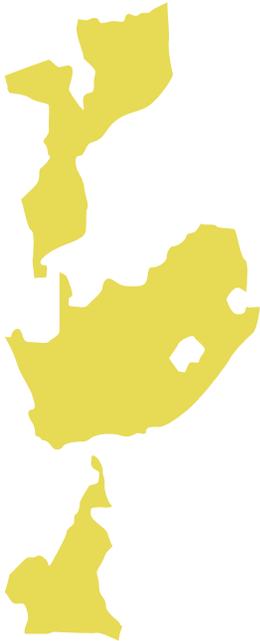
# DEADLY IMPACT

**How Flat Funding Is  
Undermining U.S. Global  
AIDS Programs**



**Flat funding is an insidious threat to ending the AIDS pandemic. The impact is long-lasting, far-reaching, and deadly.**

# THE COST OF FLAT FUNDING



With only twelve years left to achieve the global goal of ending AIDS as a pandemic, international funding for HIV has reached its lowest level since 2010, declining for the second year in a row—by 7% in 2016.<sup>1</sup> International funding for HIV has been stuck in neutral and creeping into reverse, with funds from the U.S. stagnant just as low- and middle-income countries are increasing their commitments. [Flat funding by the U.S. to its global AIDS program](#) over the past five years is having a deadly impact—undermining treatment and prevention scale up in countries where responses to the epidemic are already dangerously off track. The legacy of flat funding is so pervasive that programs are deciding which high-prevalence regions are so far behind that they will have to wait until others reach saturation. After years of flat funding, a rapid scale up in resources is the only way to achieve a course correction.

There are three countries particularly in need of a rapid course correction: South Africa, Mozambique, and Cameroon. These three countries alone represent one-third of new infections and over one-quarter of AIDS-related deaths in sub-Saharan Africa. In a different context, the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) might together fund a more rapid infusion of HIV services to address the crisis, but today flat funding is making it impossible to deploy sufficient resources and programming. In addition these countries have been dropped from the list of where it is possible to reach epidemic control by 2020—even taking limited resources from other countries to support scale up will not be sufficient to reach that goal—threatening the AIDS response in East and Southern Africa as a whole.

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# UNDERCUTTING AMBITION

We can already see clearly the effects of flat funding on the epidemic—insufficient scale up is slowing the pace of progress from what it needs to be and, in a global infectious pandemic, every delay in reaching people living with and affected by HIV results in a bigger pandemic that is harder to control. The “Fast Track” strategy that countries agreed to at the 2016 U.N. High Level Meeting on Ending AIDS calls for rapid scale up to reach the goal of 90% of people living with HIV knowing their status, 90% of those on treatment, and 90% virally suppressed by the year 2020. But in recent years, scale up has been too slow in many countries—including some of those with the highest burden of HIV that have struggled for sufficient resources to achieve the pledged coverage levels, as detailed in the pages below. With just a few years left, they are unlikely to reach this goal without a major catch-up effort but in an environment of flat or declining funding this means taking funding away from other countries. This undercutting of ambition and impact can be seen in the U.S. supported AIDS response.

## KEY COUNTRIES NOT ON TRACK FOR “EPIDEMIC CONTROL” UNDER U.S. STRATEGY

At the 2017 United Nations General Assembly, the U.S. announced an updated PEPFAR strategy based on a strong belief that countries can reach “epidemic control” in the coming years—cutting new infections to below the rate

of AIDS-related deaths, which is an indicator of progress toward an eventual goal of ending the AIDS crisis in the region. The good news is that 13 countries have made sufficient progress to be included on the list for increased focus and support toward “acceleration” to epidemic control by 2020.<sup>2</sup> Yet this optimistic acceleration only includes 13 of PEPFAR’s 31 priority countries and four regional programs. This list focuses where progress is on track—albeit still very fragile and in need of urgent focus and funding. Twelve out of 13 of these countries **already** exceed their regional averages in treatment coverage. This does not mean greater investment is not needed—underestimating what it will take to succeed in these countries would be a massive mistake. But looking only at the list of countries where epidemic control is already within striking distance provides a false picture of what it will take to truly achieve epidemic control in the highest impact regions.

This strategy makes plain that PEPFAR has scaled back its ambition in dangerous ways because of flat funding. Not on the list of 13 are the largest epidemics in the world and the countries that represent the majority of new HIV transmissions—countries where scale up in recent years has been too slow and there is not enough funding now to ramp up progress to catch up. In 2014, PEPFAR’s plan set out to “demonstrate epidemiologic control in a minimum of 50 percent of high burden countries” by 2018, and to support

**Given the migration and integration throughout the continent, “control” of HIV will be only fleeting if it is achieved in one country but not its neighbor. Failing to fill the gaps in these countries could well mean a resurgent HIV epidemic in the region by 2020 rather than epidemic control.**

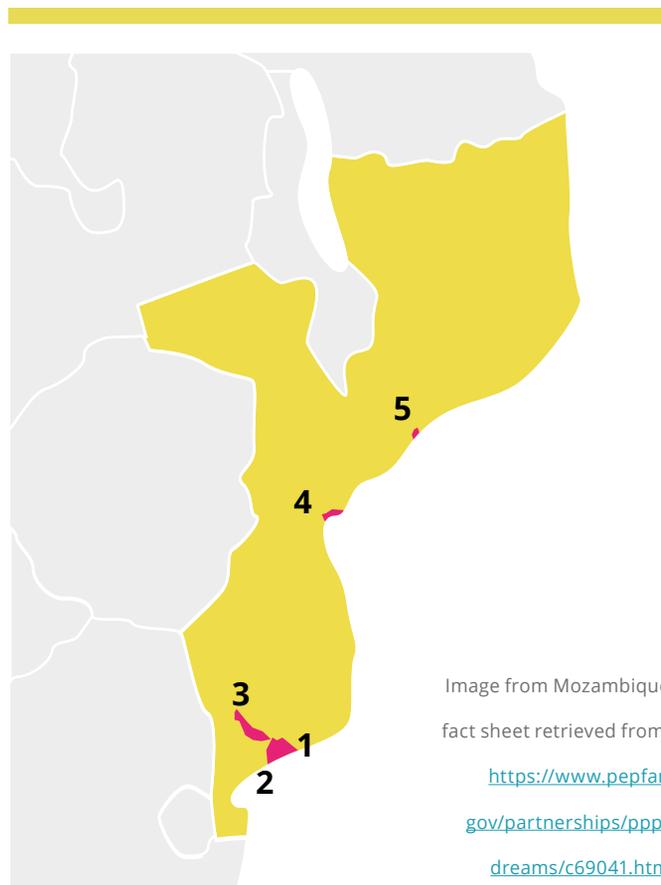
the achievement of the 90-90-90 goals in 21 PEPFAR countries by 2020, including Cameroon, Mozambique, and South Africa—three countries that are excluded from the new list of 13.<sup>3</sup> These three countries are critical examples: South Africa, home to the world's largest HIV epidemic, Mozambique, hard hit by both civil war and a massive burden of uncontrolled HIV, and Cameroon, the West African nation with an epidemic larger than the epidemics in several countries in the East and Southern Africa HIV epicenter. PEPFAR is planning for limited increases in these countries, but given overall flat-funding this requires taking away from other countries and can only be planned for a single year, leaving significant gaps that neither PEPFAR nor the Global Fund will be able to fill. UNAIDS and regional leaders have called for a West Africa “catch up” plan but currently lack sufficient funding. Given the migration and integration throughout the continent, “control” of HIV will be only fleeting if it is achieved in one country but not its neighbor. Failing to fill the gaps in these countries could well mean a resurgent HIV epidemic in the region by 2020 rather than epidemic control.

## **INSUFFICIENT FUNDS TO TAKE PROGRAMMING FOR WOMEN AND GIRLS TO SCALE**

On World AIDS Day PEPFAR announced that the DREAMS program had achieved significant results—65% of the districts where PEPFAR funded innovative prevention interventions for adolescent girls and young women saw a reduction of 25-40% in new infections.<sup>4</sup> These programs have had this success by offering a package of services that combines evidence-based approaches to healthcare and education with efforts to address structural drivers that increase girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of education.

Given the challenges worldwide in achieving real prevention impact, this is extremely impressive and there is broad support for scaling up what's working.

However, full DREAMS programming for girls and young women is only in 10 out of PEPFAR's 31 priority countries and only 64 out of 783 districts in those 10 countries. Without addressing the needs of girls and young women at scale, we cannot halt the HIV crisis. Flat funding means millions of girls and young women are being denied high impact prevention interventions. Next year PEPFAR plans to replicate those programs that have proven effective—but only in a handful of new districts. Too little of what works will not only fail to turn the tide, the positive effect in a few districts will be threatened by uncontrolled HIV in the surrounding areas.



DREAMS programming currently exists in only a tiny portion of districts in Mozambique, a country experiencing one of the highest rates of HIV transmission in the world.

## **FAILING TO FUND A BOLD PLAN**

Domestic investment by low- and middle-income countries has nearly tripled between 2006 and 2014, now accounting for nearly 60% of HIV funding in these countries. Meanwhile, U.S. funding for its signature PEPFAR program has actually fallen from a high of \$4.6 billion in U.S. Fiscal Year 2010 to roughly \$4.3 billion in FY 2017. Due to Congressional leadership, President Trump's proposed \$1 billion in cuts to U.S. global AIDS programs in FY 2018 have been avoided, along with the devastation these budget cuts would have wrought. This means that countries will receive smaller budget cuts than planned and some, such as South Africa, will receive increased funds as a result of cuts to other countries. Stagnant total funding during a period of increased efficiencies has temporarily enabled scale up in HIV prevention, treatment, and care over the past seven years, partially because of spending of U.S. reserves.

However, the era of sustained efficiency gains may well be at the end as programmers face the daunting task of identifying and serving harder-to-reach populations, including rural communities, men, young people, and key populations. And the Trump administration has proposed a \$1.3 billion cut to U.S. global AIDS programs once again in FY 2019.

Years of flat funding still means insufficient resources are available to undertake the kind of rapid course correcting efforts needed.

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**Delivering the “right things in the right places at the right time” has become a mantra within U.S. global AIDS programs. However, what is clear is that PEPFAR and the Global Fund do not currently have the resources to deliver on this promise.**

# DOING THE RIGHT THINGS IN THE RIGHT PLACES

Delivering the “right things in the right places at the right time” has become a mantra within U.S. global AIDS programs. However, what is clear is that PEPFAR and the Global Fund do not currently have the resources to deliver on this promise.

South Africa, Mozambique, and Cameroon are obviously “right places” for high impact expansion of service delivery, human rights and advocacy. These three countries are home to a large share of the new HIV infections and AIDS deaths in the world. It is therefore impossible to halt HIV in the region without far more rapid scale up in these countries, especially in key sub-national geographic areas where new HIV infections, untreated HIV among adults and newborns, and perinatal HIV transmission are at crisis levels. Economic and migratory patterns often matter far more for HIV than national borders. The many thousands of working-age people from countries on PEPFAR’s priority 13-country list such as Zimbabwe, Malawi, Swaziland and Zambia that migrate to or through South Africa in any given year, for example, belie the idea that it is possible to attain and sustain epidemic control in these other countries without achieving it in South Africa, a goal that requires a massive increase in resources.

What is needed in order to achieve epidemic control is increasingly clear—from HIV treatment to evidence-based structural interventions. The DREAMS programming providing biomedical and structural prevention for adolescent girls and young women is working—the majority of the highest HIV-burden communities or Districts achieved greater than a 25 – 40 percent decline in new HIV diagnoses among young women. Yet it remains

in only a handful of the Districts that need it. Meanwhile, the funding is missing for intensifying service delivery and advocacy programming for men who have sex with men, trans populations, sex workers and people who use drugs, who face disproportionately high HIV prevalence associated with criminalization, violence, and discrimination, alongside major barriers to attaining quality prevention and treatment from respectful, knowledgeable clinicians.

With insufficient funds and a failure to prioritize evidence-based programming, the AIDS response is under threat. These “right things” cannot be expanded fast enough and will be denied communities in urgent need. Which leaves the pressing question: when is the “right time?” All of the epidemiology work in sub-Saharan Africa suggests we have a narrow time window to rapidly expand services and get ahead of the wave of new HIV infections before a resurgent epidemic pushes “control” beyond our reach. The right moves, too slowly, in too few places due to insufficient funds could irreparably derail the AIDS response.

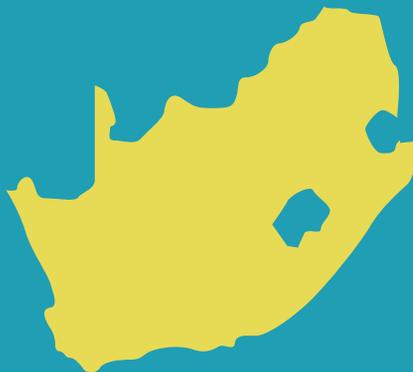
**The right moves, too slowly, in too few places due to insufficient funds could irreparably derail the AIDS response.**

# PROGRESS DEFERRED

**Three Countries Without the Resources  
to Succeed**



**MOZAMBIQUE**



**SOUTH AFRICA**



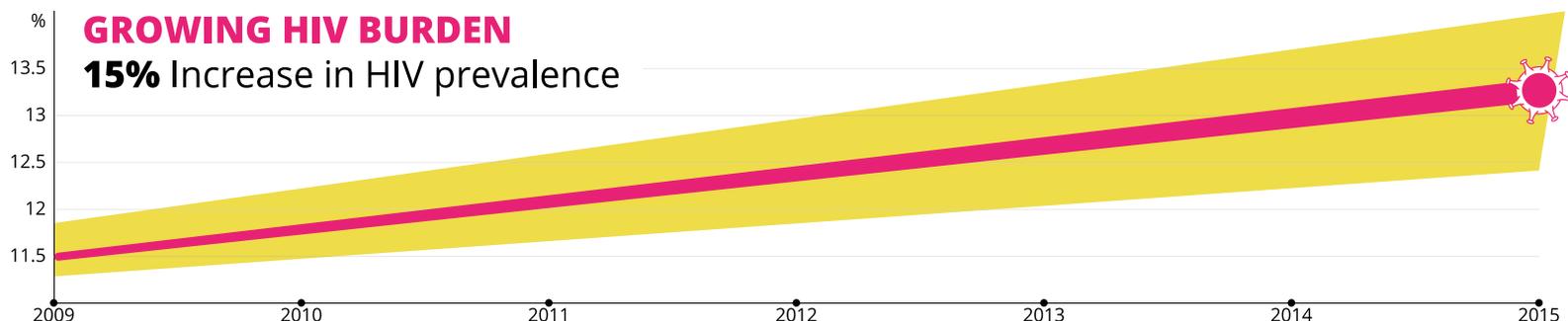
**CAMEROON**

# Mozambique



**M**ozambique is still struggling with the after-effects of a decades-long civil war that left the country with high mortality rates and a health system that lacks the resources to defeat an epidemic marked by one of the highest HIV rates in the world at 16%<sup>5</sup>. More than 90% of the population have to walk more than one hour to reach a public health facility. With more HIV infections every year than any country except South Africa and Nigeria, Mozambique is one of the epicenters of HIV crisis in the region, yet by mid-2017 only 46% of people living with HIV had access to ARVs, retention in care at 12 months was estimated at only 70% for all newly enrolled people (compared to the regional average of 80%)—and only 61% for pregnant women<sup>6</sup>. There is insufficient funding to implement national viral load testing in order to determine whether the country is successful in achieving suppression of HIV. Among key populations including men who have sex with men, HIV rates are much higher than the general population—in Maputo alone, HIV prevalence among gay men is estimated at 33.8%<sup>7</sup>.

# Bolder Action is Required to Control a Growing Epidemic in MOZAMBIQUE



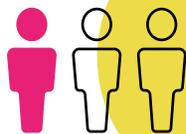
## 62,000 AIDS DEATHS PER YEAR

**THIRD HIGHEST RATE OF NEW HIV INFECTIONS IN THE WORLD**

**127,728**

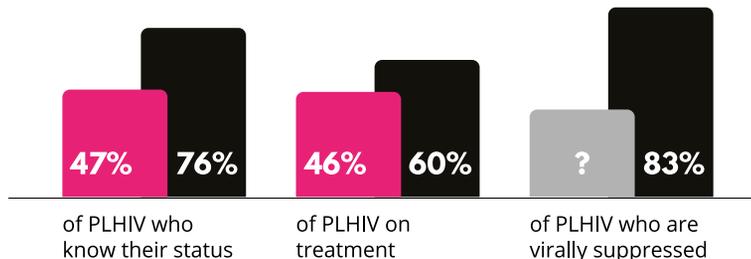
New infections per year in Mozambique

**1 IN 3 MEN WHO HAVE SEX WITH MEN ARE HIV POSITIVE, IN MAPUTO ALONE**



Marginalized populations are particularly hard hit

**PROGRESS TOWARDS 90-90-90 TARGETS**



**12 MONTHS AFTER STARTING, ADHERENCE IS POOR**



of people living with HIV are no longer on treatment



of pregnant women and mothers are no longer on treatment

**RANKED #2**



in number of AIDS deaths per year in East and Southern Africa

**Ranked #3**



in number of AIDS deaths per year in the world

**54%**

**OF PEOPLE LIVING WITH HIV ARE NOT ON LIFE-SAVING TREATMENT**

**OVER HALF**  
**OF PEOPLE WHO HAVE HIV DON'T KNOW THEIR STATUS**



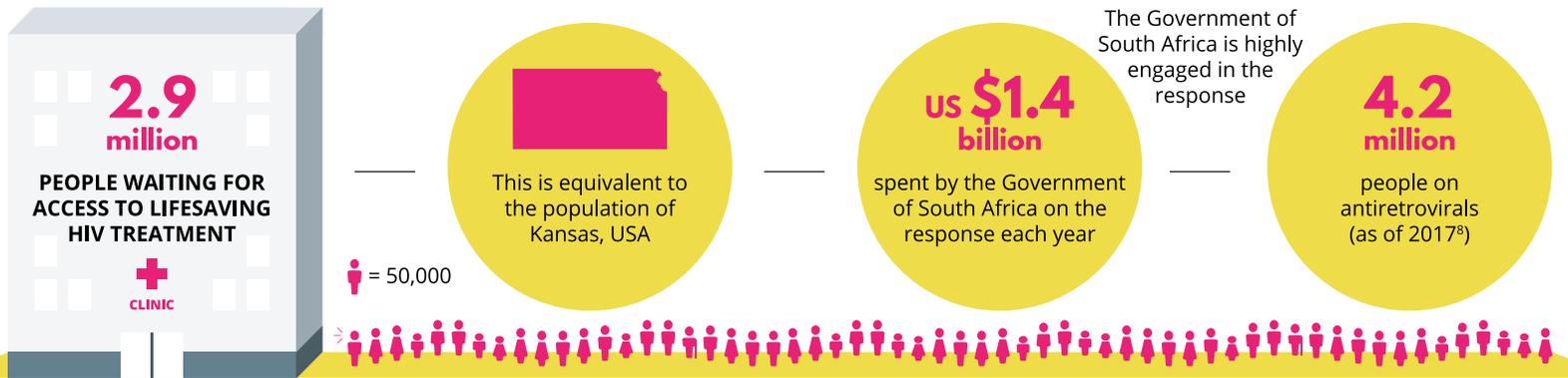
# South Africa



**S**outh Africa is home to the world's largest HIV epidemic and the world's largest HIV treatment program—with 4.2 million people taking antiretrovirals (ARVs) as of mid 2017.<sup>8</sup> In 2016, one-third of all new infections in the region were in South Africa.<sup>9</sup> Since 2011 the government has radically ramped up its spending on HIV and more than doubled the number of people on treatment, spending approximately 18.4 billion rand (US\$1.4 billion) on the HIV response in 2015 alone.<sup>10</sup> Facing tough economic headwinds, however, the post-apartheid health system is confronted with major financing gaps. A major investment of new resources will be needed to support the additional 2.9 million South Africans who need access to HIV treatment.

Significant investment is needed to fund the treatment and HIV prevention interventions required if South Africa is to reach epidemic control. A surge in funding from PEPFAR will help temporarily, but without additional resources in 2019 and beyond the temporary surge will be short-lived.

# The HIV Pandemic Cannot be Controlled with an Insufficient Response in SOUTH AFRICA



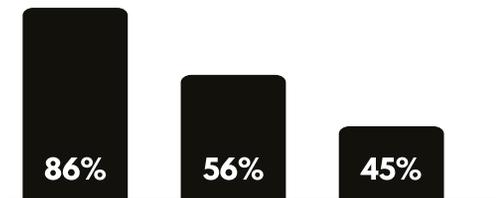
## 110,000 AIDS DEATHS PER YEAR

### MEN LACK ACCESS



In 2016, 51% of women living with HIV were taking antiretroviral therapy compared with only 37% of men living with HIV<sup>9</sup>.

### PROGRESS TOWARDS 90-90-90 TARGETS

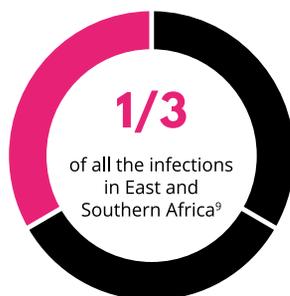


### MORE THAN HALF OF PLHIV NOT VIRALLY SUPPRESSED



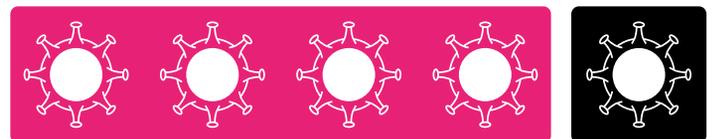
Effective HIV treatment to suppress the virus not only prevents sickness and death but also halts new infections.

**Without significant scale up in treatment and prevention, South Africa's HIV epidemic is poised to go from bad to worse**



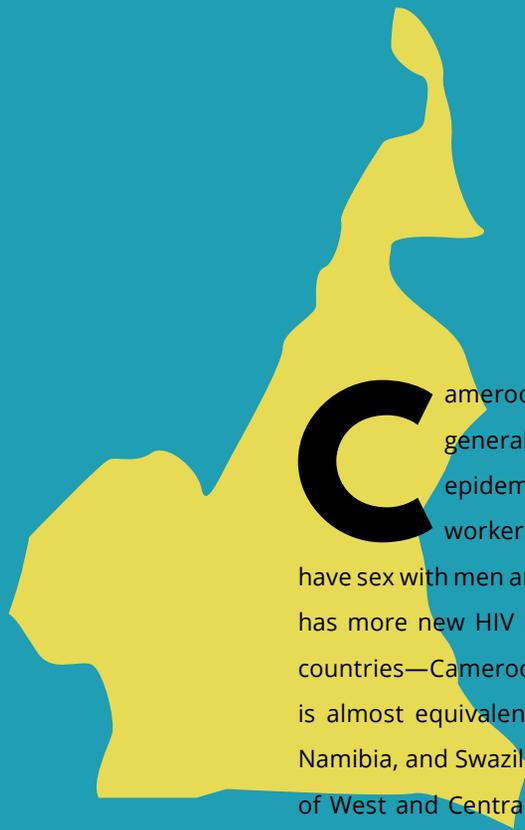
South Africa at 270k per year

Kenya at 62k per year



**MORE THAN FOUR TIMES AS MANY NEW INFECTIONS AS THE HIGHEST COUNTRY ON PEPFAR'S PRIORITY LIST**

# Cameroon



Cameroon's epidemic is defined by both a high generalized HIV prevalence and concentrated epidemics—an estimated one-quarter of sex workers and more than one-third of men who have sex with men are currently living with HIV.<sup>11</sup> Cameroon has more new HIV infections than many PEPFAR priority countries—Cameroon's 36,000 new infections per year is almost equivalent to the new infections in Botswana, Namibia, and Swaziland combined. Meanwhile, as in much of West and Central Africa, treatment coverage rates are shockingly low—68% of people living with HIV lack access to treatment and, while Cameroon is officially a “middle-income” country, there is no way the public health budgets can cover this size gap without a significant increase in international funding.

Discrimination, criminalization and homophobia faced by key populations including men who have sex with men and sex workers further undermine access to quality HIV prevention and treatment.

# Action is needed now to quell a growing HIV epidemic in CAMEROON

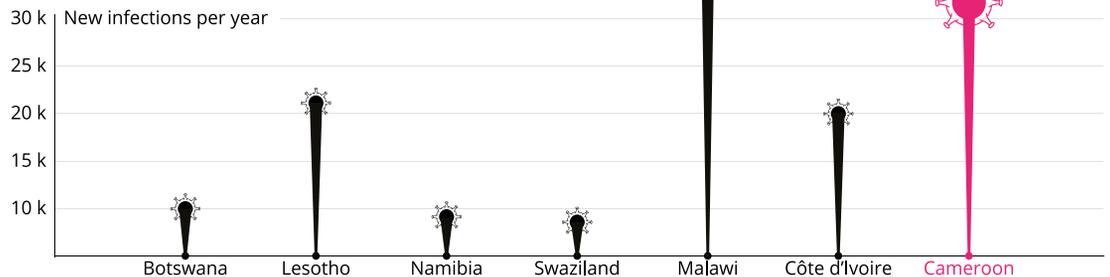
## NEW INFECTIONS PER YEAR IN CAMEROON

32,000

The second highest number of new HIV infections in West and Central Africa

## MORE NEW INFECTIONS THAN MANY OF THE 13 PEPFAR PRIORITY COUNTRIES

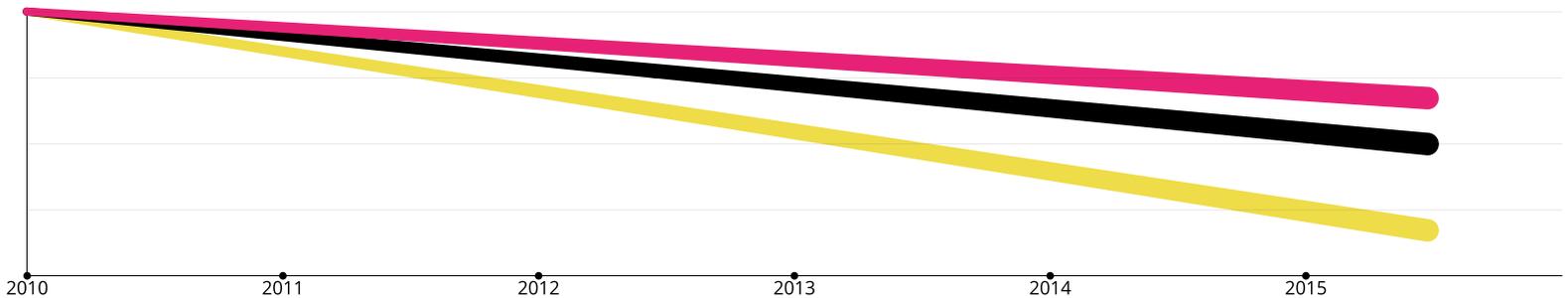
And yet Cameroon has been left out of the strategy



## NEW INFECTIONS NOT FALLING FAST ENOUGH

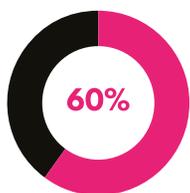
only about a 13% decrease in new infections since 2010

13% reduction in Cameroon  
20% reduction in Côte d'Ivoire  
33% reduction in Malawi



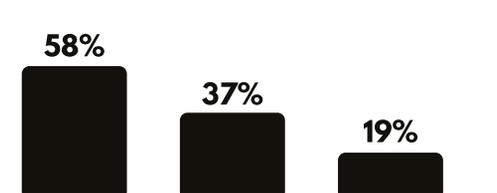
# 29,000 AIDS DEATHS PER YEAR

## TREATMENT COVERAGE IS POOR



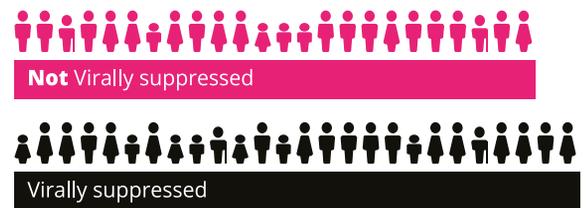
of PLHIV are still not on treatment

## PROGRESS TOWARDS 90-90-90 TARGETS



of PLHIV who know their status  
of PLHIV on treatment  
of PLHIV who are virally suppressed

## NEARLY HALF OF THOSE ON TREATMENT ARE NOT VIRALLY SUPPRESSED



Effective HIV treatment to suppress the virus not only prevents sickness and death but also halts new infections.

# PEPFAR cannot do all the right things in the right places with the resources it has right now

Without increased investment, PEPFAR and the Global Fund together are unable to scale up what is working—PEPFAR cannot do all the right things in the right places with the resources it has right now. As this analysis illustrates, the very countries where many of the new HIV infections are occurring face significant gaps in access to services and program outcomes that cannot be addressed without a substantial increase in funding. PEPFAR can potentially increase efficiencies and target investments for greater impact, but that alone cannot ensure access for the three

million South Africans who aren't on treatment, or effective HIV testing efforts for the nearly 40% of Mozambicans living with HIV who don't know it, or the more than 80% of Cameroonians living with HIV whose virus is unsuppressed.

**Now, more than ever, we need an ambitious strategy that refuses to defer progress in any country, for any people living with HIV.**

## What would it take to do all the right things in all the right places?

**1.**

**CONTINUE TO USE EXISTING  
RESOURCES MORE EFFICIENTLY**

**2.**

**INCREASE DOMESTIC  
INVESTMENT**

**3.**

**MORE DONOR  
INVESTMENT**

# Five Steps Toward a Truly Ambitious U.S. Plan for Investment in Sub-Saharan Africa's HIV Response

1.

## **The U.S. Congress must lead.**

In last year's appropriations process, Senator Leahy proposed increasing PEPFAR's budget by \$500 million<sup>12</sup>—funding that is sorely needed to prevent U.S. global AIDS programs from diminishing ambition and diminished impact.

2.

## **The Trump administration must remove the funding stranglehold on global HIV programs.**

The reality, however, is that flat funding is driving the type of Faustian logic in which the countries with the greatest challenges and most new infections drop from the priority list because the challenge is too big to tackle with the current budget.

3.

## **The U.S. must eliminate ideological barriers to services that create further inefficiency, waste and lack of access, including ending the Mexico City Policy, otherwise known as the Global Gag Rule.**

Denying funding to integrated services not only violates rights but it is massively inefficient, requiring countries to establish parallel systems while denying PEPFAR access to key partners and venues where people in need of HIV services are.

4.

## **The U.S. must recognize that the highest HIV burden countries cannot scale up without additional help.**

The South African government has increased its spending and commitment on HIV dramatically—from spending millions to over \$1.4 billion per year on HIV. Facing economic headwinds and a health system still struggling to address the legacies of apartheid, however, there is no way the country can reach the nearly 3 million additional people still waiting for treatment. The “surge” increase as only possible by taking funding from other countries, and now cannot be sustained without funding increases in FY2019.

5.

## **The U.S. must scale up evidence-based services for key populations.**

Men who have sex with men, sex workers, people who use drugs, and other key populations urgently need expanded, strategic interventions that scale up service delivery and confront stigma, homophobia and discrimination. Leaving some communities behind will never end the pandemic.

## END NOTES

- 1** Adam Wexler, Eric Lief & Jen Kates, *Donor Government Funding for HIV in Low- and Middle-Income Countries in 2016* (Washington, DC: Kaiser Family Foundation & UNAIDS, July 2017), [http://www.unaids.org/sites/default/files/media\\_asset/20170721\\_Kaiser\\_Donor\\_Government\\_Funding\\_HIV.pdf](http://www.unaids.org/sites/default/files/media_asset/20170721_Kaiser_Donor_Government_Funding_HIV.pdf)
- 2** PEPFAR, *Strategy for Accelerating HIV/AIDS Epidemic Control 2017-2020* (Washington, DC: the Office of The Global AIDS Coordinator, 2017)
- 3** PEPFAR, *3.0 Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation* (Washington, DC: The Office of the Global AIDS Coordinator, December 2014), <https://www.pepfar.gov/documents/organization/234744.pdf>
- 4** PEPFAR, “2017 PEPFAR Latest Global Results” (Washington, DC: The Office of the Global AIDS Coordinator, December 2017), <https://www.pepfar.gov/funding/results/index.htm>
- 5** PEPFAR, *Mozambique Country Operational Plan 2017* (Washington, DC: The Office of the Global AIDS Coordinator, 2017).
- 6** Ibid
- 7** Rassul M. Nalá et al., “Men who have sex with men in Mozambique: identifying a hidden population at high-risk for HIV”, *AIDS and Behavior* 19, no.2 (February 2015): 393-404, <https://www.ncbi.nlm.nih.gov/pubmed/25234252>
- 8** UNAIDS, *Right to Health: My Health, My Right* (Geneva: United Nations Joint Program on HIV/AIDS, December 2017), [http://www.unaids.org/sites/default/files/media\\_asset/myhealth-myright\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/myhealth-myright_en.pdf)
- 9** UNAIDS, *Global AIDS Update: Ending AIDS - Progress Towards the 90-90-90 Targets*, (Geneva United Nations Joint Program on HIV/AIDS, 2017), 103, [http://www.unaids.org/sites/default/files/media\\_asset/Global\\_AIDS\\_update\\_2017\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf)

**10** Nomaswazi Nkosi, "R23bn Spent on HIV/AIDS each year", *The Independent Online*, July 6, 2016, <https://www.iol.co.za/business-report/economy/r23bn-spent-on-hivaids-each-year-2042364>

**11** "Country: Cameroon," UNAIDS, accessed November 30, 2017, <http://www.unaids.org/en/regionscountries/countries/cameroon>

**12** Patrick Leahy, "Statement of Senator Patrick Leahy On Funding for International HIV/AIDS Programs" (press statement, Washington DC, September 19, 2017), <https://www.leahy.senate.gov/press/statement-of-senator-patrick-leahy-on-funding-for-international-hiv/aids-programs>



**HEALTH GAP**  
GLOBAL ACCESS PROJECT