

We Can End AIDS by 2030. But Will We? PEPFAR, Congress, and the Funding Crisis

We have the tools to end the AIDS epidemic by 2030. New scientific evidence shows that starting HIV treatment immediately upon diagnosis enables people to live longer, healthier lives and is among the most effective ways to prevent HIV transmission in communities.

A key step in achieving this goal are the UNAIDS targets for 2020, ensuring that 90% of all people living with HIV know their HIV status, 90% of all people with diagnosed HIV receive antiretroviral treatment and 90% of all people receiving antiretroviral therapy are virally suppressed. And these goals are reachable, with a short-term increased investment by donors.

Instead, the US budget for global AIDS has declined hundreds of millions of dollars since 2011. Painful cuts to PEPFAR, made since 2011 when there was a “pipeline” of unspent funds, have now come home to roost and last year saw a steep decline in the rates of new enrollments in life saving treatment—preliminary estimates indicate a decline from 1.7 million new patients per year in 2013 to just 1.1 million in 2014.

The targets to end AIDS will only be met if the human right to access to treatment immediately upon diagnosis is realized. However, a report from Health GAP and partners around the world, "Towards Treatment on Demand for All" shows that fewer than 1 in 10 people with HIV live in a country where treatment is provided to everyone immediately upon diagnosis. In order to get ahead of the epidemic, we need to double the number of people in treatment from 15 million to 30 million by 2020.

To achieve this, we need a \$2 billion annual increase in the US global AIDS funding by 2020. Congress can take action that will mean the difference between a downward spiral toward program slowdown and greater treatment inequity, and a life-affirming cycle toward truly universal prevention and treatment access and the AIDS Free Generation we all want to see in our lifetime. Congress must increase funding to PEPFAR by \$500 million each of the next four years to achieve this needed annual increase of \$2 billion by 2020, and continue to contribute one third of a fully-funded Global Fund.

The world has made so much progress in reducing the spread of AIDS and treating people with H.I.V. that the epidemic has receded from the public spotlight. Yet by any measure the disease remains a major threat — 1.1 million people died last year from AIDS-related causes, and 2.1 million people were infected with the virus. And while deaths are down over the last five years, the number of new infections has essentially reached a plateau.

The United Nations announced a goal last week of ending the spread of the disease by 2030. That's a laudable and ambitious goal, reachable only if individual nations vigorously campaign to treat everyone who has the virus and to limit new infections.

The medicines and know-how are there, but in many countries the money and political will are not. Besides shining a spotlight on the disease, it's crucial that wealthy nations like the United States continue to pony up generously to underwrite what must be a global effort. Donors and low- and middle-income countries need to increase spending to \$26 billion a year by 2020, the United Nations says, up from nearly \$19.2 billion in 2014.

While still high, deaths attributable to AIDS are down 36 percent from 2010. That is largely because many more people are receiving antiretroviral drugs — 17 million people in 2015, compared with 7.5 million five years earlier. These medicines allow people to live near-normal lives and greatly reduce the risk of transmission to others.

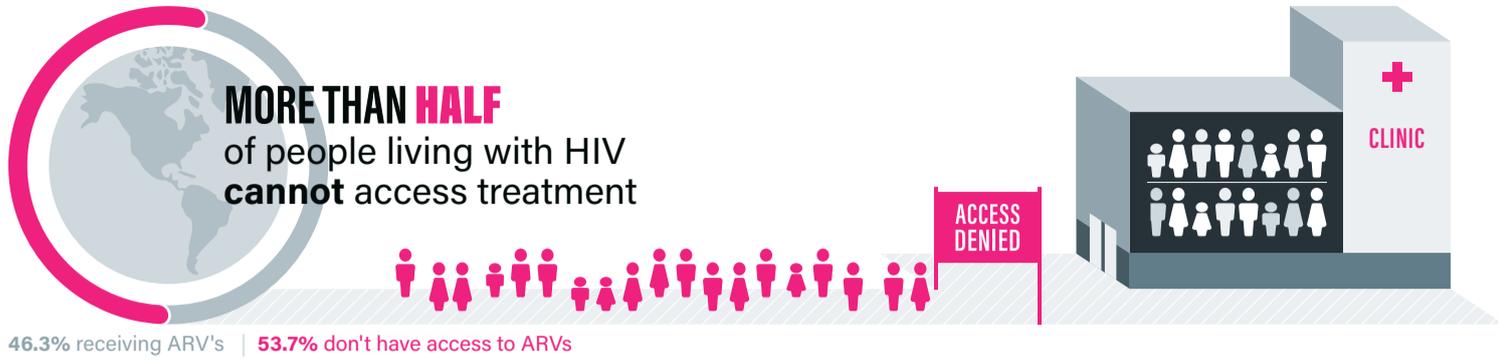
But while some countries like South Africa (once a disaster zone) and Kenya have made tremendous progress in increasing treatment, many people who need the lifesaving therapy do not have access to it. Only 28 percent of those infected in Western and Central Africa were being treated in 2015, according to a recent United Nations report. The numbers were even lower in the Middle East and North Africa (17 percent) and Eastern Europe and Central Asia (21 percent). In some countries, people who test positive are told to come back when they get sick because of budget constraints, says Sharonann Lynch, an H.I.V. policy adviser at Doctors Without Borders. Many never return.

In other places, it can be hard to even reach people who need drugs because of war or the lack of a functional public health system. And many who need help are unwilling to come forward because they fear being ostracized or worse because they are gay, use drugs or are engaged in sex work. Discriminatory laws and attitudes in countries like Nigeria, Russia and Uganda have probably forced tens of thousands of people who need help into hiding.

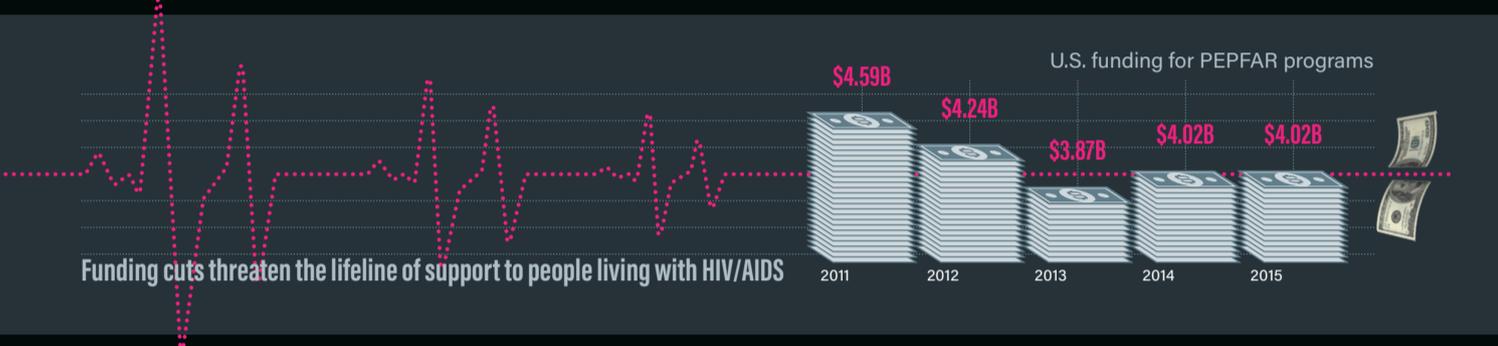
In some countries, infections have actually increased, which helps explain why progress has plateaued over all. In Eastern Europe and Central Asia, for instance, 190,000 people became infected last year, up from 120,000 in 2010. And while the number of deaths is way down, the number of new infections was flat or down modestly over the same five-year period. This was also true of the United States, where an estimated 44,073 people were diagnosed in 2014, the most recent year for which the Centers for Disease Control and Prevention have published data, down from 44,940 in 2010.

These numbers do not argue for complacency, but instead for more vigorous public health campaigns, increased access to condoms, clean needles for drug users and prescriptions for pre-exposure drugs. There is still no cure for AIDS. But there are many ways to minimize its deadly consequences.

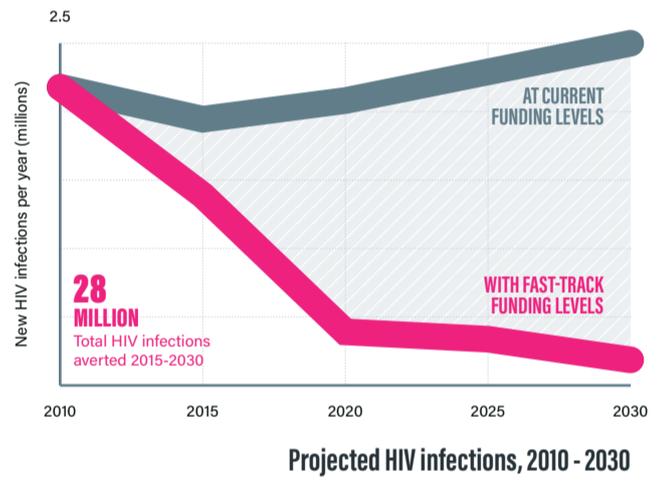
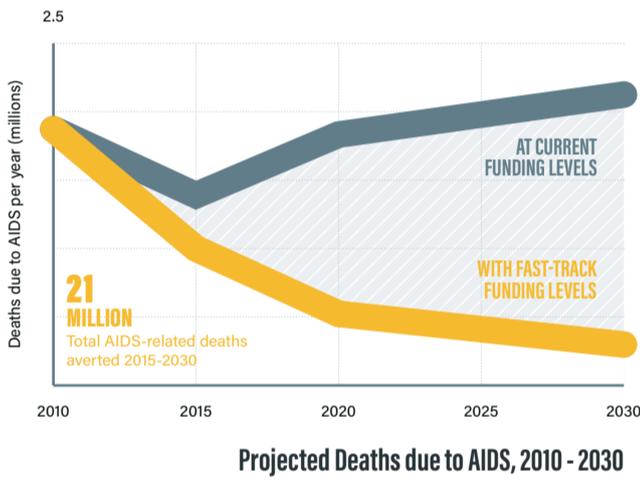
URGENT: Global AIDS Response Under Threat



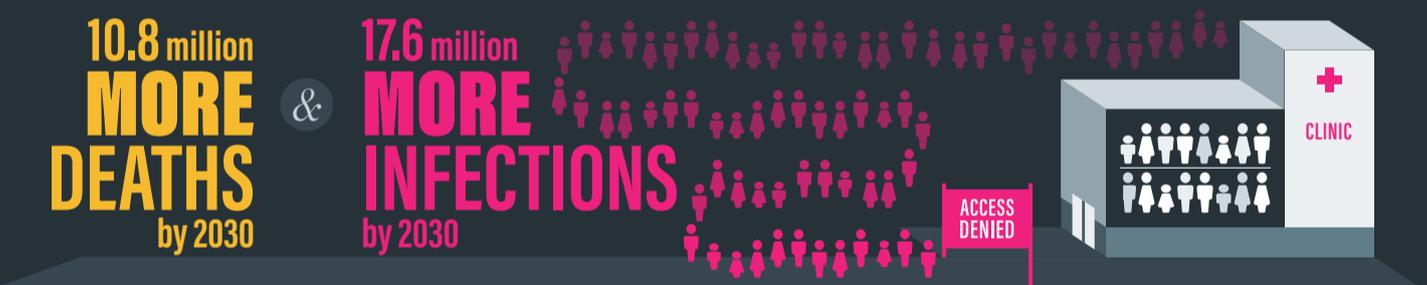
Yet, the US Government Has Cut Hundreds of Millions of Dollars to Global AIDS Programs



With Increased Global Funding by 2020 for Treatment, Prevention and Care, We Could Curb the HIV Pandemic

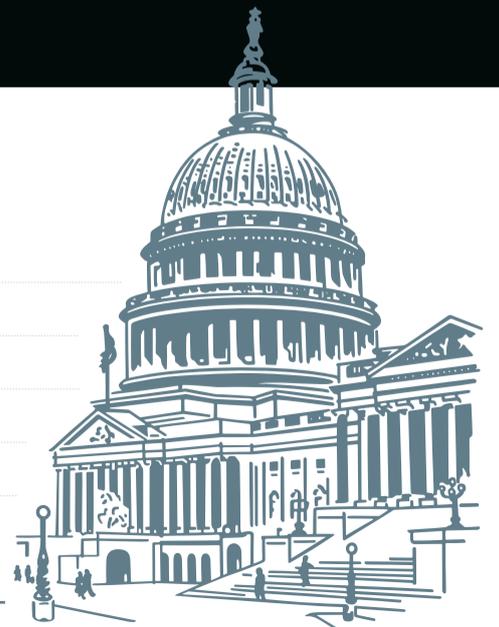
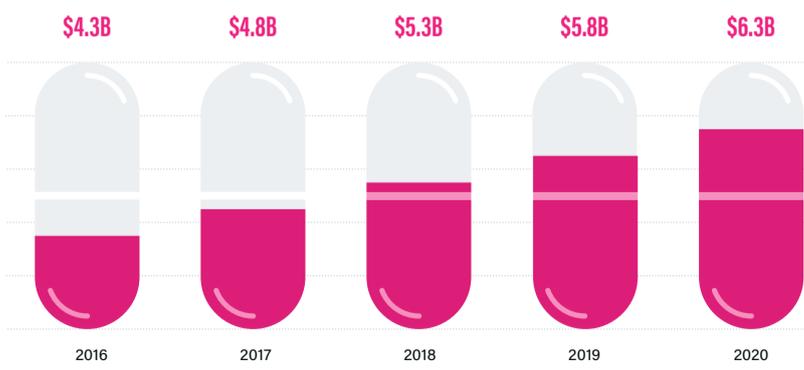


Without Necessary Funding Increases, We Will See:



What Can Congress Do?

Increasing funding for PEPFAR by \$500 million per year until 2020 will put us on track to end AIDS



Time is Running Out. The World Must Double the Pace of the AIDS Response by 2020 - And the U.S. Can Lead the Way.



10 Things Every Capitol Hill Staffer Needs to Know About Global HIV/AIDS on World AIDS Day 2015

#1: The number of people living with HIV accessing life-saving antiretroviral treatment continues to rise.

As of June 2015, 15.8 million people are accessing antiretroviral therapy (ART) - but that is still only 41% of adults and 32% of children in need of treatment.

#2: Science has proven the power of antiretroviral treatment for people living with HIV.

The U.S. government-funded START ("Strategic Timing of AntiRetroviral Treatment") trial proved this year that early initiation of antiretroviral drugs (ARVs) not only curbs new infections but keeps people with HIV healthier for longer periods of time - leading the World Health Organization (WHO) to release new guidelines recommending immediate initiation of treatment for all people living with HIV.

#3: New HIV infections are on the decline, but not fast enough.

There were 2 million new HIV infections in 2014, down 35% since 2000. Much of that progress is around prevention of mother-to-child transmission of HIV: new HIV infections among children have declined by 58% since 2000, but nearly 600 children are still infected every day. Adult incidence has been on a slower decline, and highly marginalized and often hard to reach people (people who inject drugs, MSM, transgender persons, and sex workers) still experience high rates of HIV infection.

#4: Young women, girls, and adolescents are particularly vulnerable to HIV and AIDS.

Girls and young women account for 71 percent of new HIV infections among adolescents in sub-Saharan Africa. HIV is the leading cause of death in women of reproductive age worldwide, and AIDS is the leading cause of death among adolescents 10-19 years of age living in Africa.

#5: Data shows there is a 5-year window to end the AIDS epidemic.

Significant scale-up of HIV service delivery is needed to reduce new HIV infections or a dramatic spike in HIV infections will occur: an estimated 100 million HIV/AIDS infections by 2030.

#6: PEPFAR investment is paying off – but continued Congressional political commitment and financial investment is critical.

PEPFAR funding experienced a downward trend a few years ago, losing approximately \$700 million in funding between FY 2010 and FY 2013. Funding increased slightly in FY 2014 and FY 2015 but is still below FY 2010 levels.

#7: PEPFAR has announced new treatment and prevention targets that will drive the U.S. global HIV/AIDS response for the next two years.

- **Prevention in adolescent girls and young women:** by the end of 2016, PEPFAR and its partners will achieve a 25 percent reduction in HIV incidence among adolescent girls and young women (aged 15-24) in 10 of the highest burden geographic areas of sub-Saharan African; by the end of 2017, they will achieve a 40 percent reduction in HIV incidence in that population.
- **Voluntary Medical Male Circumcision (VMMC):** by the end of 2016, PEPFAR will provide 11 million VMMC for HIV prevention, cumulatively; by the end of 2017, PEPFAR will provide 13 million VMMC for HIV prevention, cumulatively.
- **HIV/AIDS treatment:** by the end of 2016, PEPFAR will support a total of 11.4 million adults and children on life-saving antiretroviral treatment; by the end of 2017, that number will be 12.9 million.

#8: Achieving an AIDS-free generation requires strong, sustainable health systems.

A well-functioning health system enables at-risk individuals and people living with HIV and AIDS to find and access quality health services, providers, and products. By incorporating health systems strengthening into PEPFAR programs – including training and retaining new health care workers, improving supply chain systems, and building data and financial management systems - PEPFAR is better able to support the prevention, care, and treatment for HIV and AIDS.

#9: Investment in PEPFAR provides impact beyond health outcomes.

A recent bipartisan report reviewed PEPFAR's impact on national security and global development, finding that threats were less likely to materialize in countries receiving PEPFAR assistance.

- Between 2004 and 2013, political instability and violence reduced by 40 percent in PEPFAR countries in sub-Saharan Africa versus just 3 percent in non-PEPFAR countries in that region.
- Between 2007 and 2011, the average approval rating for the U.S. was 68 percent in countries receiving PEPFAR assistance versus a global average of 46 percent.
- From 1991 to 2012, there was an increase in average output per worker by a third in PEPFAR countries versus stagnant growth in non-PEPFAR countries.

#10: The Global Fund is a critical partner in the fight to end HIV/AIDS and will need new commitments from the U.S. and other donors in 2016.

The Global Fund is the world's largest global health financier and provides resources to in-country partners for large-scale programs that provide lifesaving prevention, treatment and care for people living with HIV/AIDS. As of September 2015, the Global Fund partnership has achieved the following results:

- \$27 billion disbursed to support programs for HIV, tuberculosis and malaria;
- 17 million lives saved and on track to reach 22 million lives saved by the end of 2016; and
- 8.1 million people on antiretroviral treatment for HIV.

#11: The fight against HIV/AIDS needs to be a domestic priority as well.

The United States accounts for more than half of the new HIV infections in North America and Europe, and only 30% of people living with HIV in the United States are virally suppressed.



MYTHS & FACTS

DONOR FUNDING

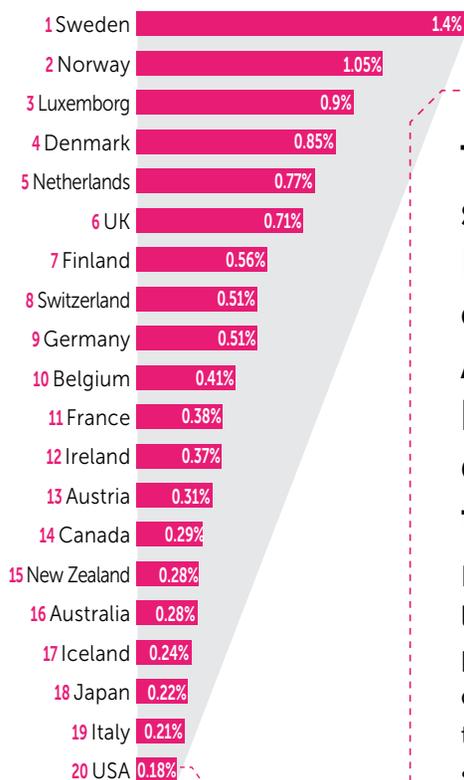
for the global AIDS Response

Over the past 15 years, wealthy countries have played a critical role in the global AIDS response through international development assistance.

In July 2016, the Kaiser Family Foundation released an **analysis** showing a decrease in funding to the AIDS response in low- and middle-income countries by major donor governments, for the first time in five years.

In the face of this shifting landscape in donor support for the global AIDS response, here's our attempt to help set the record straight.

Percentage gross national income spent on official development assistance by country.



MYTH #3

The United States is doing more than its fair share in terms of donor funding for HIV and development more broadly

IN FACT...

The United States only spends 0.2% of its Gross National Income (GNI) on Official Development Assistance (ODA) and has flatlined funding for global AIDS programs over the past three years.

Even though the U.S. is the single largest bilateral donor for global HIV programs and the largest source of official development assistance in terms of gross dollar amounts, it is still not paying its global fair share. The **United States Congress has flat-lined its financial contribution to the global HIV response over the past three years**, and are set to do so again for fiscal year 2017. In addition, the U.S. continues to lag significantly behind in terms of development assistance contributions relative to the size of its national economy, ranking 20 out of 28 wealthy countries in terms of the percentage of their national income spent on development assistance in 2015 and cutting ODA overall by US \$2.3 billion (or 7%) between 2014 and 2015.

MYTH #4

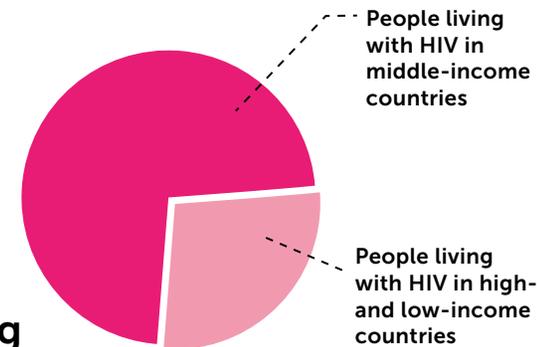
Middle-income countries no longer need donor support

ACTUALLY...

Sustaining and scaling up the AIDS response and reaching underserved populations, in many middle-income countries will continue to require donor resources.

Nearly 70% of people living with HIV live in middle-income countries. Most of these people are poor, many live in underserved and rural communities, and others who are so called key populations are often marginalized and criminalized by government policy. Some upper-middle income countries have refused to prioritize investing in HIV services for key population groups, who are often criminalized by the state, rendering these communities especially vulnerable if donors leave. Moreover, even when a country experiences sustained economic growth or when financial rebasing changes a country's income classification, external structural factors conspire against rapid increases in spending on HIV programs in many middle-income countries.

Structural factors that limit middle-income countries' ability to increase spending on HIV include: high prices



on medicines and other health technologies, due to intellectual property and investment rules found in trade agreements and the unwillingness of pharmaceutical companies to offer significant price discounts or access to voluntary licensing agreements to middle-income countries; pervasive problems of tax avoidance, illicit financial flows, and corporate corruption by multinational corporations that prevent increases in countries' gross incomes from translating into substantial increases in government revenue overall; and fiscal restraint (or structural adjustment) policies imposed on countries, which restrict government spending on health and other key services. Many of these barriers to increasing public expenditure on health are imposed on low and middle-income countries through the actions of international financial institutions or donor countries themselves.

MYTH #5

Donor cuts to middle-income countries will not have a negative impact

ACTUALLY...

Percentage of new HIV infections linked to intravenous drug use in Romania

3%
2010

30%
2013

When donors pull out of countries – even middle-income countries – prematurely, people die and often the epidemic resurges.

Several upper-middle income countries have already felt the impact of donors pulling out funding in their countries. These cuts are particularly deadly for key populations, especially when national governments are defaulting on their human rights obligations to ensure comprehensive HIV services, including effective prevention, for marginalized and criminalized groups. The Global Fund has defunded the AIDS response in several upper middle income countries such as Romania, where the gap in funding has led to a drastic increase in HIV cases, specifically in key populations. Romania's HIV cases related to injection drug use soared from 3% in 2010 to 29% in 2013. Much of this increase is linked to the lack of funds to provide basic prevention like condoms and syringes.

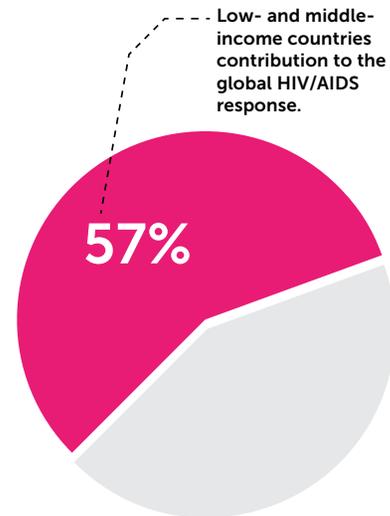


MYTH #6

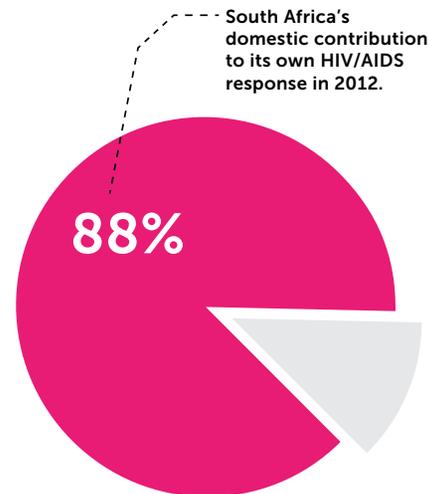
Low- and middle-income countries are not at all increasing their support to fight their own epidemics

ACTUALLY...

Low- and middle-income countries now pay for nearly 57% of the global HIV and AIDS response, a 4% increase since 2012.



Low- and middle-income countries have been consistently increasing their contribution to the HIV response over the past decade. For example, between 2006 and 2011, African Union countries increased domestic funding for HIV programs by nearly threefold. More recently, a few countries, particularly South Africa, have significantly increased their contribution.



Still, low- and middle-income countries can and should do more. Many African countries have still not delivered on the Abuja Declaration promise of allocating 15% of government funding towards health, for example. All low- and middle-income countries must make moves to live up to their human rights obligations by substantially increasing their investments for the HIV response and for health in general.

MYTH #7 We can end the global AIDS epidemic without increasing funding for the response

IN FACT...

Recent estimates from UNAIDS, suggest if the world wants to get on track to end the epidemic, it must increase annual spending on the global AIDS response by at least **US \$7 billion by 2020.**

UNAIDS estimates that we need to increase yearly expenditure to at least \$26 billion by 2020 in order to end the AIDS epidemic. In 2015, however, the world spent only \$19.2 billion on the global AIDS response, a considerable and concrete gap.

Donor cuts are already leading to harmful rationing of lifesaving HIV treatment and prevention services, undermining scale up in communities and geographic areas that are not given "priority" status. While, ensuring that all funding is focused on achieving the highest possible impact is critical, ending the AIDS epidemic requires access to quality treatment, prevention and care for all (not just some) who need it.

+\$7 billion

MYTH #8

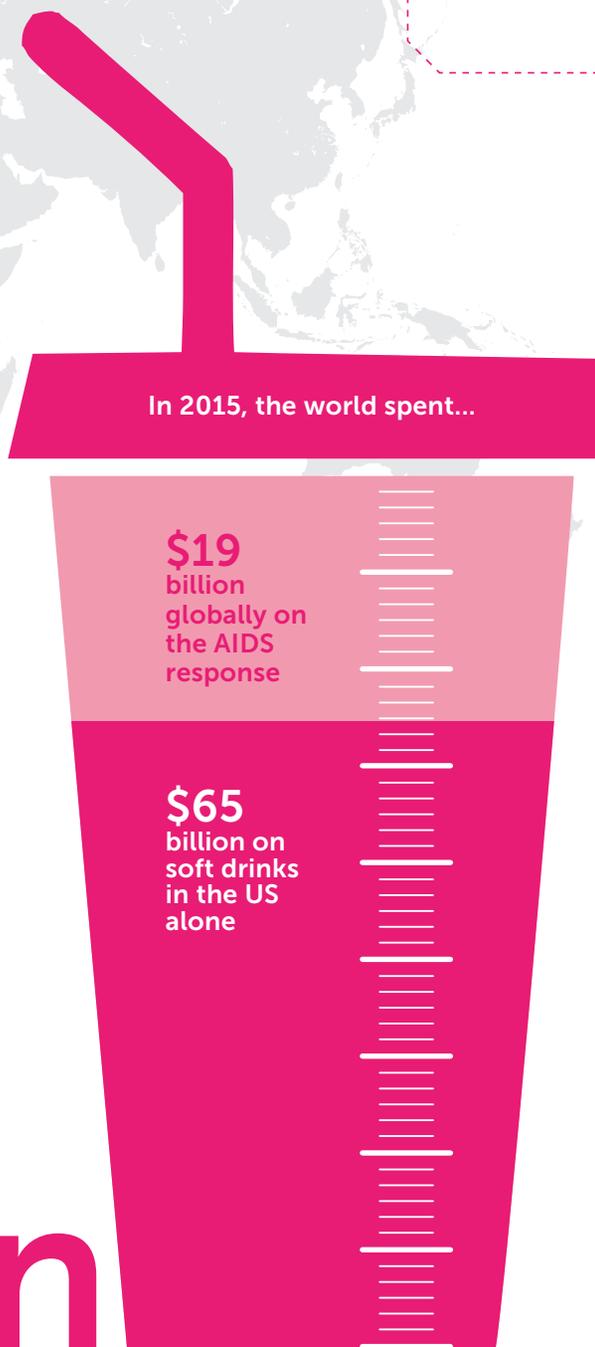
The world cannot afford the \$26 billion per year required to end the AIDS epidemic

ACTUALLY...

Mobilizing the additional funding needed to put us on track to ending the AIDS epidemic by 2030 is well within the world's reach. It is simply a matter of priorities.

In 2015, the world spent only \$19.2 billion on the global AIDS response. That's less than a third of what the United States alone spends on soft drinks each year (\$65 billion USD). UNAIDS estimates that what we spend on the global AIDS response each year needs to reach at least \$26.2 billion by 2020.

Increasing annual spending on the HIV response by \$7 billion by 2020 means that, over the next 4 years, the world must increase the amount of resources available by \$1.5 billion each year. This is approximately equal to the amount the US presidential candidates have spent on their campaigns in the 2016 election cycle (\$1.3 billion as of June 2016).



MYTH #9

Investment in the AIDS response is a bottomless pit, once we start we have to keep investing more and more

ACTUALLY...

If we pay to scale up treatment, prevention and care now, we will save later.

Frontloading investments now to achieve Fast-Track targets will result in **cost savings** in the future. According to UNAIDS, failure to increase funding now would translate to an additional 17.6 million HIV infections globally and an additional 10.8 million AIDS-related deaths between 2016 and 2030. Donor cuts will cost lives now and push the financial burden of ending AIDS into the future. We need bold initiatives to confirm steady financing of the **globally agreed targets** in order to end the pandemic by 2030.

17.6 million

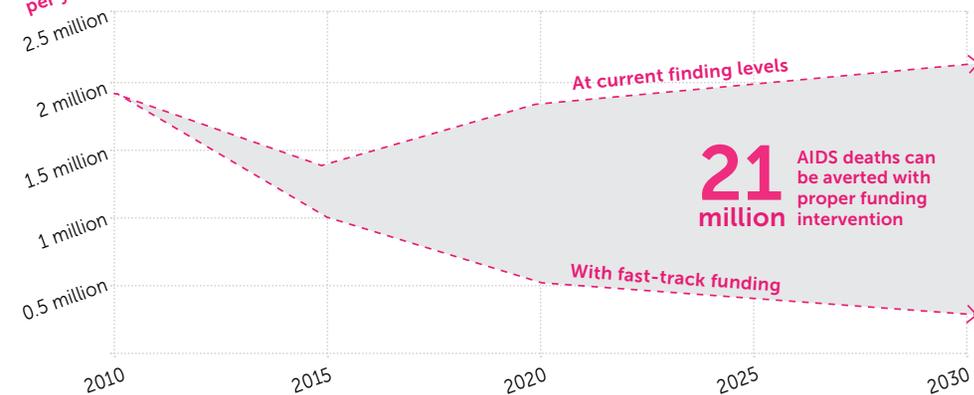
10.8 million

The global cost of failure to increase funding now.

New HIV infections by 2030

AIDS-related deaths by 2030

AIDS deaths per year



MYTH #10

Donor cuts, once they have occurred, are irreversible

ACTUALLY...

Donor cuts are utterly reversible before they become a trend and have been reversed in the past.

When global AIDS funding declined between 2009-2010 (\$7.7 to \$6.9 billion), donor commitments rebounded and increased—as early as 2011. **Civil society** played a critical role in this by **securing an increase in contributions to the Global Fund** from the United Kingdom. In contrast to the financial crisis that started in 2008, many donor countries are now experiencing modest economic growth. The same reversal of funding cuts can happen again and the world could see an end to the pandemic.

JOIN US

Call on your government to step up their contribution to the global HIV response

Check out these resources for more information:

- Kaiser Family Foundation & UNAIDS. 2016. Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015. Available [here](#).
- Open Society Foundations. Undermining the Global Fight: The Disconnect Between the Global Fund's Strategy and the Real-life Implications of the New Funding Model. Available [here](#).
- "The World Could End AIDS If It Tried". Editorial. The New York Times. June 13, 2016. Available [here](#).
- Health GAP Infographic: Global AIDS Response Under Threat: What Can Congress Do? Available [here](#).