

# 'NEAR UNIVERSAL' ACCESS TO HIV/AIDS PREVENTION, CARE AND TREATMENT IN AFRICA

## WHY IS THE FIGHT AGAINST HIV/AIDS IMPORTANT?

- In 2005 two million people in sub-Saharan Africa died from this treatable, preventable disease—and 2.7 million people became infected.<sup>17</sup>
- Some estimates suggest that annual Gross Domestic Product (GDP) growth rates in highly affected countries can be 2-4% lower than in the absence of AIDS.<sup>18</sup>
- Unless action is taken, the 10 most severely affected African countries may lose between 10-26% of their agricultural labour forces by 2020.

## WHAT DID THE G8 PROMISE?

**PARAGRAPH 18D.** “With the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010. Limited health systems capacity is a major constraint to achieving this and we will work with our partners in Africa to address this ...We will also work with them to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support. We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the ‘3 Ones’ principles in all countries.”

**INTERPRETING THE COMMITMENT:** The standard UNAIDS definition of “As close as possible to universal access” is prevention along with treatment and care for 80% of the people in most urgent need. Urgent need is defined as a person who will die within a year if they do not have access to treatment. Funding progress is measured by whether the G8 donors contribute their proportionate share (based on share of DAC Gross National Income) of the funding gap which needs to be filled by the international community.

The 2010 treatment commitment was repeated at the September 2005 U.N. World Summit, when each leader committed to play their part in reaching the 2010 target. The declaration at the recent U.N. High Level Meeting on HIV/AIDS extended commitments to include comprehensive prevention, care and support.

## ADVANCE MARKET COMMITMENTS AND THE G8 FINANCE

**MINISTERS:** Alongside the commitment above, which is the focus in this report, the G8 acknowledged the need for innovative new tools to fight AIDS and thus made the following additional commitment:

Commitment 18e: “Building on the valuable G8 Global HIV/AIDS vaccine enterprise, increasing direct investment and taking forward work on market incentives, as a complement to basic research, through such mechanisms as Public Private Partnerships and Advance Purchase Commitments to encourage the development of vaccines, microbicides and drugs for AIDS, malaria, tuberculosis and other neglected diseases.”

At their meeting in June 2006, the G8 Finance Ministers committed to work with the World Bank and the Global Alliance for Vaccines and Immunization (GAVI) to launch an Advance Market Commitment pilot project by the end of the year. It is hoped that this will give incentives to the pharmaceutical industry to invest in research on vaccines for diseases impacting on poor communities.

## WHERE ARE WE NOW AND HOW DO WE GET TO WHAT WAS PROMISED?

Africa has been the region hardest hit by the AIDS epidemic. In 2005, there were 24.5 million people in sub-Saharan Africa living with HIV, including 2 million children under the age of 15.<sup>19</sup> Every day, 5,500 Africans die and another 7,500 are newly infected. In addition, there are 12 million AIDS orphans in Africa—80% of the world's total.<sup>20</sup>

The G8 commitment to provide near universal access to treatment and to realise an “AIDS-free generation in Africa” necessitates a comprehensive prevention, care and treatment effort which will also require a fully scaled-up and harmonised financing commitment.

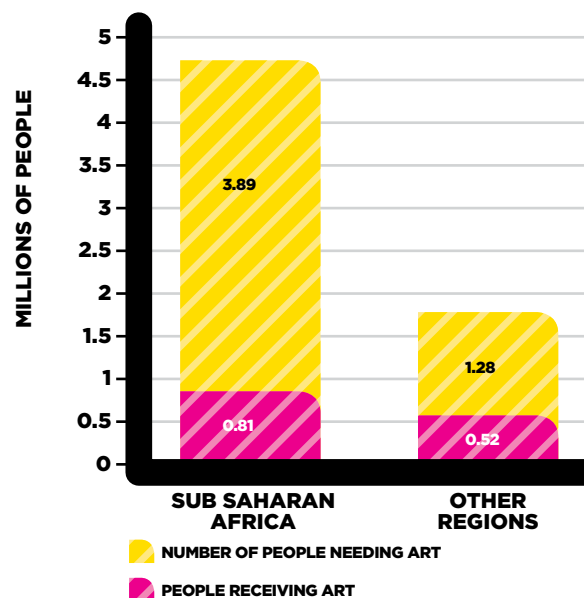
### WHERE ARE WE ON PREVENTION?

Though it did not command the headlines from the G8 Summit that the treatment goal did, the goal of seeing an “AIDS-free generation in Africa” is completely dependent on scaling up prevention efforts. The number of new annual infections regularly outstrips the number of new people accessing treatment. During UNGASS in 2001, countries set a target of reducing HIV prevalence among young people by 25% by 2005. Figures from 2006 suggest that half of the countries in sub-Saharan Africa have failed to meet this target.<sup>21</sup> In addition, the recent U.N. High Level Meeting on HIV/AIDS saw governments fail to reach agreement on the content of a comprehensive, science-based prevention package.

### WHERE ARE WE ON TREATMENT?

Progress in scaling up treatment has been great in recent years, though the challenge remains large. In 2003, there were only 100,000 people (or approximately 2% of those in need) accessing treatment in sub-Saharan Africa; at the close of 2005 there has been an eightfold increase to 810,000 (equating to an annual scale up of 355,000 more people on ART).<sup>22</sup> If the trajectory set between 2003 and 2005 were maintained along a simple linear trajectory, 2.6 million Africans would be receiving treatment by 2010.

#### ART PROVISION AND UNMET NEEDS: 2005 SNAPSHOT

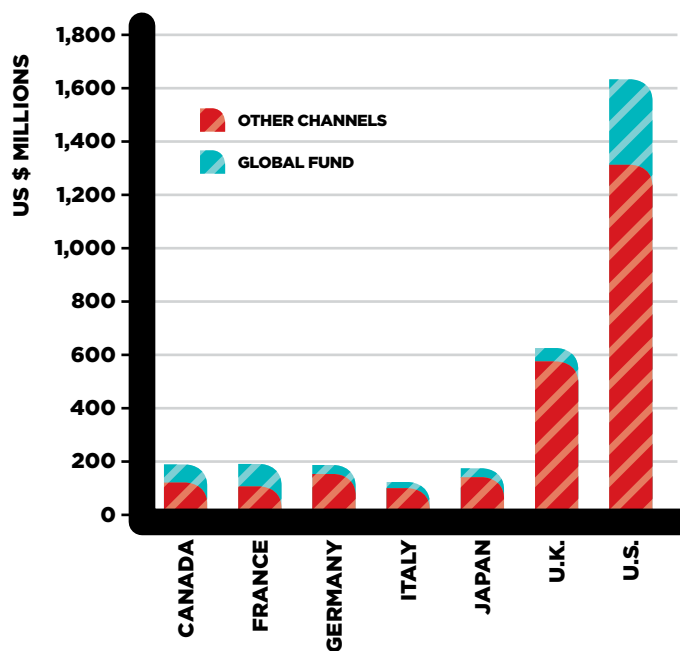


“  
**While Africa is home to 69% of the people in need of life-saving ARV treatment, it has only 1.8% of the world’s healthcare workers.**  
 ”

**WHERE ARE WE ON FUNDING?**

Global spending on AIDS has more than quadrupled since 2001, when leaders met at a special session of the U.N. and called for a “war chest” of resources to fight the epidemic. In 2005, the world spent \$8.3b on HIV/AIDS, with approximately 85% of the donor contribution drawn from the G8. Since 2001, countries in sub-Saharan Africa have also increased their domestic public sector spending on HIV by 130%.<sup>23</sup>

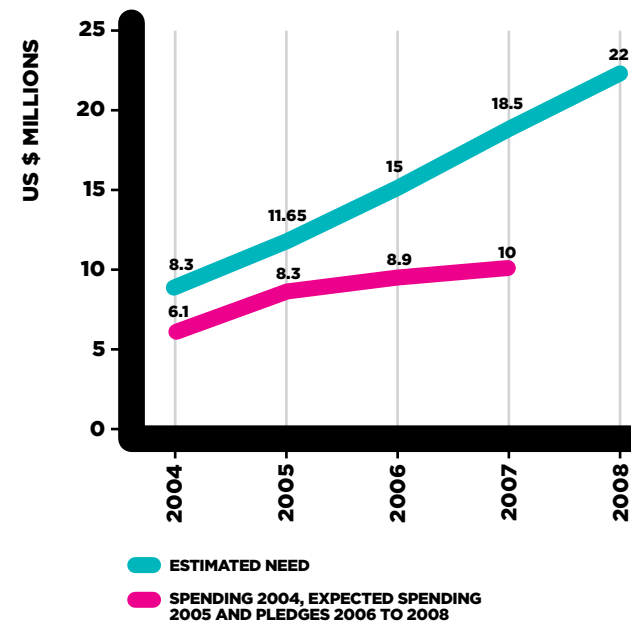
**TOTAL G8 FUNDING FOR HIV/AIDS IN 2004**



As the graph above clearly shows, the U.S. and the President’s Emergency Plan for AIDS Relief (PEPFAR) dominate donor funding for HIV/AIDS. The U.S. was easily the largest single donor to the Global Fund in 2004 and disbursed \$1.35b through other channels (principally scaled-up bilateral programs targeting 15 countries).<sup>24</sup> The U.K. is the second largest donor, again providing most of its assistance outside the Global Fund and providing significant bilateral support. France gives the highest proportion of its support through the Global Fund.<sup>25</sup>

Thanks to competition from generic producers, pharmaceutical company initiatives and negotiated deals from the Clinton HIV/AIDS Initiative, prices for antiretroviral treatment (ARVs) have come down, but they remain expensive for resource-poor countries. These countries still need additional price reductions to these expensive regimens and continued and expanded donor assistance to meet the growing need.

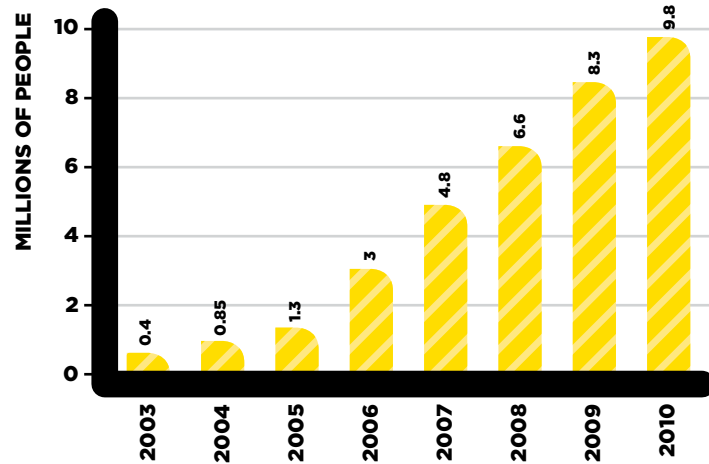
**GLOBAL RESOURCE NEEDS AND PLEDGES TO DATE**



**DEFINING THE GOALS**

Below we highlight some of the specific markers that must be reached to achieve the G8 goals on prevention, treatment and funding, but inherent in all of these is the need to simultaneously scale up efforts to enhance care for people living with AIDS, to expand care for orphans (another goal of the G8) and build the health infrastructure needed to support these HIV/AIDS interventions. (See Appendix C for more information on health systems strengthening)

**PEOPLE ON ARVs THROUGH 2006 GLOBALLY AND TRAJECTORY NEEDED TO MEET THE GOAL OF 'NEAR UNIVERSAL ACCESS'**



**PREVENTION:** The G8 set itself the aim of creating the conditions for an “AIDS-free generation in Africa.” Successful prevention will require each G8 country to commit to evidence-based prevention strategies. Treatment goals will not be achieved unless the rate of infection is slowed, and this will require a comprehensive approach, including a balanced approach to behavioural interventions, harm-reduction efforts and the empowerment of marginalised groups. Successful prevention is also heavily dependent on African leadership and locally owned strategies and messages. Although prevention is not the primary focus of this report, successful strategies to stem the spread of AIDS are crucial to reversing the devastating impact of the epidemic.

**TREATMENT:** The G8 committed to get “as close as possible to universal access to treatment.” The working definition of “universal” access used by UNAIDS is when 80% of people in urgent need receive treatment. “Urgent” need is defined as a person who will die within the year unless they begin ARV treatment.<sup>26</sup> UNAIDS estimates that universal access would require reaching 6.6 million people (75% of urgent cases)<sup>27</sup> globally by 2008 and 9.8 million in 2010 (80% coverage of urgent cases). Resource needs estimates from UNAIDS are under constant revision and do not currently extend past 2008. The table below is incomplete because UNAIDS has not

projected resource requirements for treatment in Africa beyond 2008 and only certain years’ coverage rate goals have been defined. The data that we do have illustrate the general trajectory of coverage and the funding required.

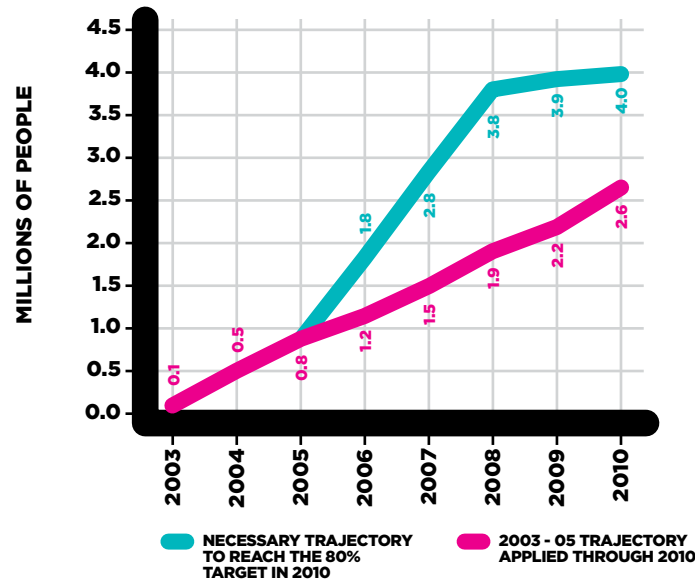
**TREATMENT TARGETS AND ASSOCIATED COSTS: SUB-SAHARAN AFRICA**

	2005	2006	2007	2008	2009	2010
<b>COVERAGE RATE</b>	17%		46%	75%		80%
<b>RESOURCES REQUIRED</b>		\$1.64b	\$2.22b	\$2.89b		

The scale-up above is based on a series of big assumptions:

- That prevention, care and health systems strengthening costs are met each year so that sub-Saharan Africa experiences stable or diminishing prevalence rates.
- That it will not be more difficult to reach additional people as coverage rates rise (when in fact many estimate that it will become increasingly difficult to reach the next wave of people due to age, geography and income).

**GETTING TO 'NEAR UNIVERSAL' COVERAGE IN SSA (USING 5M AS LOW END ESTIMATE OF NEED IN 2010)**



UNAIDS estimates that at least 5 million Africans will be in urgent need of treatment in 2010. Continuing on the same trajectory as established in 2003-2005 would result in 2.6 million Africans on treatment by 2010,<sup>28</sup> only half of those in need. In the graph above, the blue line shows the shift in trajectory required to reach the near universal coverage rates: it is based on the UNAIDS assessment of technical feasibility for universal access. It is estimated that for 80% treatment coverage by 2010, there will need to be 75% treatment coverage by 2008. The new trajectory would require an additional 638,000 Africans on treatment each year on average as opposed to the 355,000 on treatment each year between 2003-2005. (Note: These are only average figures. As per the graph above, the trajectory would have to be higher on average between 2006-2008 in order to reach 75% coverage by 2008 at which point the growth would likely slow and average rates of new patients on ARVs would be lower between 2008-2010.)

### FUNDING

While resource needs can be estimated for Africa, available data on existing and likely funding looks at a global level, so the following information presents a global picture. Though \$8.3b was mobilised in 2005, UNAIDS estimates that a comprehensive effort to fight AIDS will require \$14.9b in 2006 rising to \$22.1b by 2008.

Based on these figures and expectations of future development assistance, UNAIDS projects a growing financing gap. As U.N. Secretary General Kofi Annan points out, the projections suggest “annual resource gaps of as much as \$6b in 2006 and \$8b in 2007.”<sup>29</sup> In other words, little more than half of the resources needed are pledged to date—and it is important to remember that there is always a gap between funds being pledged and actually disbursed.

Almost 50% of these global costs are needed for sub-Saharan Africa.

### FINANCING NEEDS IN THE FIGHT AGAINST HIV/AIDS IN AFRICA

	2006	2007	2008
<b>PREVENTION</b>	\$2.45b	\$2.89b	\$3.32b
<b>TREATMENT</b>	\$1.64b	\$2.22b	\$2.89b
<b>ORPHANS</b>	\$1.49b	\$1.95b	\$2.56b
<b>HEALTH SYSTEM STRENGTHENING</b>	\$1.20b	\$1.29b	\$1.70b
<b>SUB-SAHARAN AFRICA SUBTOTAL</b>	\$6.78b	\$8.35b	\$10.46b
<b>GLOBAL TOTAL</b>	\$14.9b	\$18.1b	\$22.1b

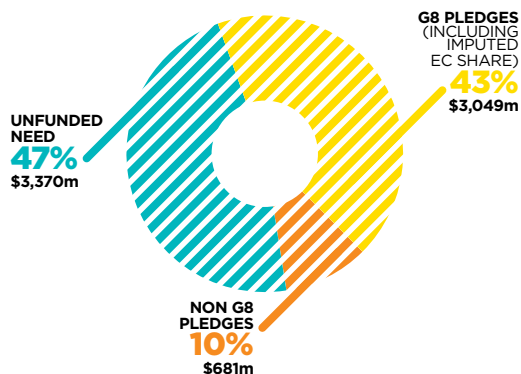
### HOW IS THE WORLD DOING AND IS THE G8 KEEPING ITS PROMISE?

The architecture for meeting the G8 promise already exists. African governments have substantially scaled up their spending on HIV/AIDS in recent years and have made commitments to go further. Donors have created several financing mechanisms which, while vastly different in approach, have begun working together closely toward common goals. Increased harmonisation as per the principles of the “Three Ones”<sup>30</sup> will be crucial in ensuring that increased financing is delivered efficiently. Donors must fully utilise these mechanisms, the largest of which include the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), bilateral mechanisms such as the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), and the World Bank’s Multi-Country AIDS Program (MAP).

**THE GLOBAL FUND:** In the Communiqué, G8 donors highlighted the Global Fund as a key mechanism that they would work to replenish in order to achieve their goals. The Global Fund is a key independent, multilateral financing entity through which all donors can pool their resources to fund technically sound, country-owned plans. But donors have not met their goal of replenishing the Global Fund; just three months after

Gleneagles at a September 2005 conference to secure funding for 2006 and 2007, G8 countries pledged only 43% of the Global Fund's estimated needs and other donors pledged 10%, leaving a \$3.37b shortfall on estimated need.<sup>31</sup>

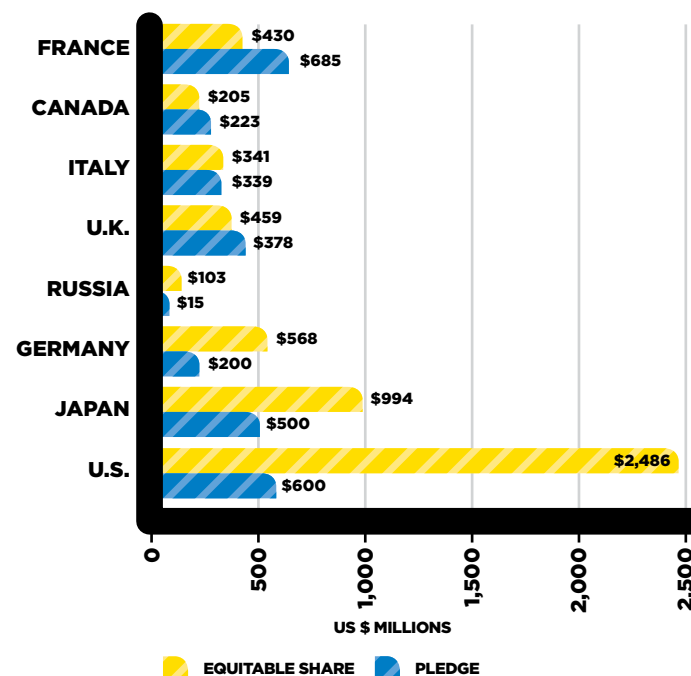
**GLOBAL FUND: SEPTEMBER 2005 PLEDGING CONFERENCE RAISES HALF WHAT IS NEEDED.**



Further pledges have come in since that replenishment conference, but the Global Fund still estimates a gap of \$900m for 2006 and \$1.2b for 2007. In April 2006, the Board of the Global Fund issued a call for proposals for Round 6, but the lacklustre pledging to date means that even high-quality proposals may not be approved due to lack of resources.

As of June 2006, the Global Fund was supporting ARV treatment for 544,000 people, had provided counselling and testing for 5.7 million, had reached 12 million people with HIV prevention messages, and was providing care and support for 559,000 AIDS orphans.

**2005 GLOBAL FUND REPLENISHMENT PLEDGES COMPARED TO EQUITABLE SHARES NEEDED FOR REPLENISHMENT**



**PEPFAR:** Other G8 donors have made and continue to make substantial commitments to HIV outside the Global Fund, the largest of these being the U.S. PEPFAR Initiative. These bilateral efforts are an important funding stream for certain individual donors and PEPFAR will make an important contribution to the qualitative G8 goals.

The President's Emergency Plan for AIDS Relief (PEPFAR) was announced by President Bush in his 2003 State of the Union address and is centred on a major increase in U.S. bilateral support for the fight against AIDS. The \$15b, five-year initiative's goals are to reach 2 million people with life-saving antiretroviral drugs, prevent 7 million new infections and provide care to 10 million people affected by the disease. This initiative focuses the majority of new resources on 15 of the hardest-hit countries in Africa, the Caribbean and one in Asia.<sup>32</sup> While scaling up bilateral programs in these focus countries, the initiative maintains existing programs in 105 other countries and also includes annual contributions to the Global Fund.

“  
 ...I have hope that when time comes for me to take treatment, it will be available. The entire world's HIV positive people deserve this hope. All the 14,000 more who will be infected by end of today deserve this hope.  
 ”

NKHENSANI MAVASA  
 Treatment Action  
 Campaign

As of March 2006, PEPFAR was supporting ARV treatment for 561,000 people (552,000 of them in sub-Saharan Africa); had supported prevention of mother-to-child HIV transmission services for women during over 4.5 million pregnancies, preventing an estimated 65,100 infant HIV infections; and supported care for nearly 3 million people, including care for over 1.2 million AIDS orphans and vulnerable children.

The share of U.S. funding directed to the Global Fund has been a point of contention with international partners and within the U.S. The Bush Administration annually requests a budget with maximum scale-up directed through PEPFAR, and Congress has regularly redirected some of those resources back into the Global Fund. In FY2006, the President requested \$300m while a one-third share of the Fund's needs (which the U.S. historically provided) was estimated to be \$930m; Congress ultimately appropriated \$544.5m. For FY2007 the President has again requested \$300m, but Congress has not yet finalised the budget.

#### PROGRESS ON HIV/AIDS BY DONOR:

**CANADA:** Failed to make a pledge to the Global Fund at the replenishment conference, though did pledge an equitable contribution of approximately \$223m (CAD\$250) later in September 2005. Canada also announced more financial support in November 2005 with CAD\$60m (US\$49.5m) in a mix of core funding for UNAIDS, investment in development of an AIDS vaccine, promotion of women's legal rights and other projects. Toronto will host the 16th international AIDS conference in August 2006.

**FRANCE:** Pledged \$684.8m to the Global Fund at the replenishment conference. France is also working on the International Drug Purchasing Facility for the purchase of medicines including ARVs and on the use of airline taxes to fund development.

**GERMANY:** Pledged \$200m to the Global Fund at the replenishment conference. No other budgetary decisions have been taken on increasing funding for AIDS apart from €10m in support of the Building Alliances—Creating Knowledge—Updating Partners (BACKUP) Initiative, which supports partner countries in managing health financing mechanisms, including HIV/AIDS related activities and the International Partnership for Microbicides.

**ITALY:** Pledged \$339m to the Global Fund at the replenishment conference. The Global Fund is Italy's primary outlet for financing the HIV/AIDS response.

**JAPAN:** Pledged \$500m to the Global Fund at the replenishment conference; the Fund is Japan's primary financing mechanism for HIV/AIDS.

**U.K.:** Pledged \$378m to the Global Fund at the replenishment conference, doubling its funding for 2005-2007. The U.K. co-chaired the Global Steering Committee of UNAIDS for scaling up toward universal access and is the world's second largest bilateral AIDS donor. The U.K. has committed to spending £1.5b (US\$2.75b) on HIV/AIDS related work between 2005 and 2008.

**U.S.:** In FY2006, the U.S. appropriated a total of \$3.3b for efforts to fight HIV/AIDS and tuberculosis through PEPFAR. It includes \$544.5m for the Global Fund and \$2.7b for the bilateral programs. The overall presidential request for HIV/AIDS in 2007 was approximately \$4b, which includes \$300m for the Global Fund and \$2.8b for bilateral programs. These figures include contributions to the Global Fund and all bilateral efforts through PEPFAR for AIDS and TB programs and AIDS research. They do NOT include U.S. bilateral efforts to fight malaria, which have been accounted for separately. Malaria funding will also increase significantly under the new Presidential Malaria Initiative (PMI), which pledges to increase funding of malaria prevention and treatment by \$1.2b over the next five years above base bilateral funding levels culminating in an additional \$500m in 2010 alone.

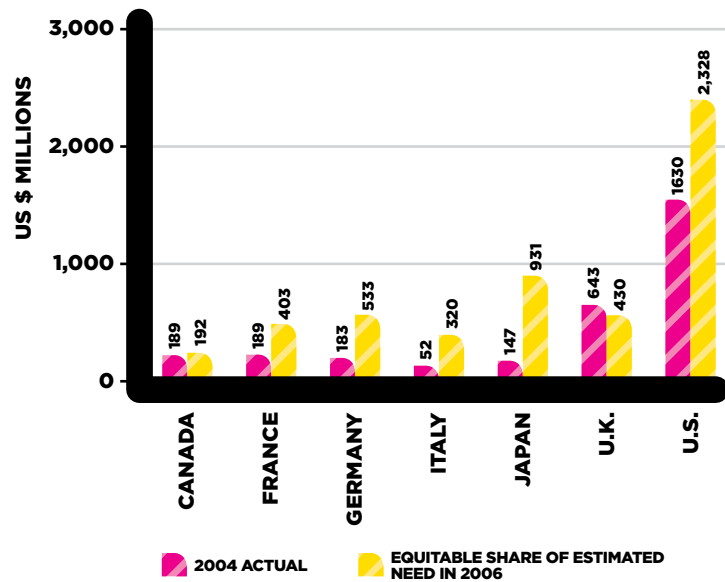
**RUSSIA:** Russia is the one G8 nation that is both a donor and a recipient of the Global Fund. It pledged \$15m to the Global Fund at the replenishment conference. Overall, Russia is expected to allocate about \$1b for HIV/AIDS treatment and prevention programs in 2006—but it is likely that all of this funding will be spent in Russia.

## WHAT MUST THE G8 DONORS DO?

The direct responsibilities donors undertook in the G8 Communiqué were to help “develop and implement a package” and to “work to meet the financing needs” of the epidemic. National strategies and targets for the provision of universal access to prevention, treatment and care must be devised at the country level, while the G8 mobilise additional financing necessary to implement nationally owned plans.

G8 donors together provided 85% of donors’ assistance for HIV/AIDS in 2004. If they are to provide the same proportion of the projected funding gap going forward, they would need to provide an additional \$5.2b in 2006 and an additional \$7.2b in 2007.

### ACTUAL FUNDING AND EQUITABLE SHARE OF THE 2006 NEED



The DAC data on HIV spending is limited to a sub-sector under reproductive health. This does not provide comparable data on exactly how much each G8 donor spends on all aspects of HIV in Africa, nor does it provide details such as how or where that money was spent. DATA encourages donors to provide such detailed information in their reporting.

Donors have already missed one opportunity to take action on their HIV/AIDS goals in 2006 by failing to issue a plan for reaching universal access to treatment at the May 2006 U.N. High Level Meeting on HIV/AIDS. They must seize their next opportunity to take action by mobilising the resources necessary at the July 4-5, 2006 Global Fund Replenishment Conference in Durban.

## LEADING AND LAGGING ON HIV/AIDS FUNDING

### LEADERS ON HIV/AIDS FUNDING:

- **U.S.** is leading the pack on HIV/AIDS funding. The U.S. provides a total of 50% of global spending on HIV/AIDS through PEPFAR and has provided an average of 31-32% of all Global Fund spending over the last four years. It is also leading on the provision of ARV treatment.
- **U.K.** contributed more than its fair share at the Global Fund replenishment conference, maintains high volume bilateral commitments and co-chaired the Universal Access Steering Committee.
- **FRANCE** is the only country to pledge substantially more than its fair share to meet the financing needs of the Global Fund. France has also shown leadership through its commitment to the international drug purchasing facility.

### LAGGARDS ON HIV/AIDS FUNDING:

- **CANADA** has made a fair contribution to meeting the needs of the Global Fund, but total spending on HIV/AIDS lags. As host of the 16th International AIDS Conference, the Canadian Government is under considerable pressure to move up into the leadership tier.
- **ITALY** pledged \$339m to the Global Fund at the replenishment conference, but it has a poor record of delays and non-payment, and in fact, Italy has still to disburse €20m (US\$25m) for 2005.
- **JAPAN** is contributing far less to the fight against HIV/AIDS than an equitable share.
- **GERMANY** gave the least of all G7 donors, in absolute terms, to the Global Fund last year.

Russia is a beneficiary of Global Fund grants and faces a domestic infection and treatment crisis. Russia is not, therefore, considered in the list of leaders and laggards.