



REVERSING HIV/AIDS? HOW ADVANCES ARE BEING HELD BACK BY FUNDING SHORTAGES

Over ten years after Médecins Sans Frontières (Doctors Without Borders, or MSF) began providing antiretroviral treatment to a limited number of people in urgent need of treatment, some MSF projects have been able to reach and maintain ‘universal access’ to treatment. MSF has witnessed time and again how treatment dramatically reduces illness and deaths in the communities in which we work.

Yet today, more than ever before, the global response to HIV/AIDS is at a crossroads.

Promises – both political and scientific: On the one hand, scientific evidence promises to finally stem—if not reverse—the epidemic, and governments have given ambitious commitments, pledging to have science drive policy. In recognition of the new evidence showing that HIV treatment is proven to both save lives and to help prevent new infections, UN member states this June set a target to increase the number of people on HIV treatment to 15 million by 2015, from 6.6 million today. In November, the U.S. made the goal of “turning the tide on AIDS” official government policy, placing implementation of the latest scientific advances at the core of HIV/AIDS programming.

In the developing world too, an increasing number of countries in Africa are preparing to roll out, or are making space in their national strategies for more ambitious pilot programs to implement accelerated treatment. Zambia and Rwanda for example have adopted a policy of offering antiretroviral treatment (ART) for HIV-positive partners in sero-discordant couples, irrespective of CD4 count, and Kenya has included early ART in cases of sero-discordant couples in their new draft guidelines. Malawi intends to provide lifelong ART for all HIV-positive pregnant women irrespective of CD4 count (so called “PMTCT Option B+”).¹

Precarious progress hangs on funding: On the other hand, today’s game-changing scientific advances and political commitments come after two years of declines in HIV/AIDS funding. The Global Fund for AIDS, Tuberculosis and Malaria (“Global Fund”) was forced to skip a year of funding new proposals for the first time since it was created in 2002. There is significant incongruence between what can and should be done, and the funding made available to get it done.

Funding shortages threaten to stymie the progress of African nations working to finally get ahead of the epidemic. MSF teams on the ground have surveyed national HIV/AIDS programmes in nine sub-Saharan African countries, in an effort to provide a clearer picture of national ambitions and the threats these nations face in fighting the epidemic. MSF found that several countries have been forced to scale back ambitious plans, including implementation of WHO 2010 recommendations² or accelerated treatment strategies (see box below), because of stagnant or declining budgets. And more worryingly, in some countries such as the Democratic Republic of Congo, Mozambique and Zimbabwe, existing national treatment programmes are under threat of

being severely curtailed, effectively reversing progress there. Aside from Swaziland, persistent treatment gaps represent more than 30% of people in need, and in DRC the gap is as high as 88%.

Without increased funding, opportunities to prevent the spread of infection are being missed, and there is a real risk of losing ground.

A new acute funding crisis for countries reliant on the Global Fund: On 21-22 November 2011, at its Global Fund Board meeting in Accra, the Board took the unprecedented step of cancelling a funding round (known as 'Round 11') due to low funding levels, including from a number of unfulfilled funding pledges as well as lower than anticipated contributions.

Instead, the Global Fund will provide for a 'transitional funding mechanism,' the thinnest of lifelines whereby countries known to be facing a disruption of programs for HIV, TB and malaria before 2013 will be offered a chance to apply for funding to cover their most essential needs. For HIV, this funding can cover medicines for people already on treatment, but does not provide for HIV treatment initiation for new patients. This means that no new grants for scale-up of HIV or drug-resistant TB treatment will be available until 2014.

MSF rejects this timeline and calls on the Global Fund and donors to raise the resources necessary for a new funding window in 2012. Further, the Fund should raise the necessary funds to cover the costs of quality proposals, including by reprogramming funds in existing grants to pay for interventions shown to have highest impact on the epidemic.

Policy Implications of Recent Scientific Advances

Translation of the science—that HIV treatment both saves lives and helps prevent new infections—into policy largely means implementing a series of interventions to promote accelerated antiretroviral therapy. Significant efforts and funding will be needed to implement these interventions but the reward will be high, including:

→ **Timely ART:** initiating treatment at an early stage of the disease (CD4 <350 or higher), in order to help prevent opportunistic infections, such as tuberculosis (TB) and other illnesses

→ **Treatment as Prevention:** early initiation of treatment for HIV-positive people with HIV-negative partners ("treatment as prevention" for sero-discordant couples, regardless of CD4 count), which reduces the risk of transmission by 96%³

→ **PMTCT Option B+:** immediate initiation of life-long treatment for HIV-positive pregnant and breastfeeding mothers, regardless of CD4 count, which provides increased protection for mothers and babies

→ **TB ART:** immediate initiation of treatment for HIV-positive patients with active TB

Rapidly scaling up HIV treatment now will save both lives and money. Based on real-world data, researchers at the US Centers for Disease Control and Prevention found that implementing accelerated treatment could reduce new HIV infections by 31% within five years, when compared to today's pace of HIV treatment scale-up. Further, societal cost savings would offset HIV treatment costs by up to 58% within the same period, primarily due to savings in hospitalisations and orphan care.

An analysis recently published in PLoS ONE shows that the economic benefits of treatment will substantially offset, and likely exceed, programme costs within 10 years of investment.⁴ According to UNAIDS, expanding treatment and pairing it with other high impact interventions such as HIV treatment, medical male circumcision, and prevention of mother to child transmission, can avert more than seven million deaths and 12 million new infections by 2020.⁵

Most of the countries examined have already adopted **the latest World Health Organization (WHO) guidelines** for HIV treatment, which include provision of timely ART treatment at CD4<350, instead of CD4<200, and the use of tenofovir, a first-line drug that is better-tolerated by patients, with fewer side effects and improved patient outcomes. The WHO is working to incorporate additional accelerated treatment recommendations into a series of new guidelines to be issued next year.

COUNTRY PROFILES

The following countries are profiled in this document: the Democratic Republic of Congo (DRC), Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Uganda, Zambia and Zimbabwe.

DEMOCRATIC REPUBLIC OF THE CONGO

In the DRC, less than 15% of those eligible for ART are currently receiving it⁶. According to WHO eligibility criteria, 300,000 people who need treatment still do not have access to it. Access to prevention of mother-to-child transmission (PMTCT) is extremely limited, below 2%⁷.

Although health authorities have adopted the WHO's recommendations for **early ART** at CD4 <350 in their national guidelines, implementation has not been possible due to a lack of funding. Furthermore, systematic ART for HIV/TB co-infected patients has been postponed, also due to inadequate funding.

Due to funding shortfalls for Global Fund grants, initiation of ART was capped at 2,000 new patients nationwide for the year 2011, even though an estimated 15,000 people are already on waiting lists for ART. The lack of access to timely ART leads to high mortality and morbidity. Clinicians in MSF clinics treat many terminally ill patients and struggle to overcome complications reminiscent of the pre-ART era, which have become rare elsewhere in sub-Saharan Africa.

The funding and disbursement difficulties have affected both government-run and private HIV treatment providers. At least one local organisation that was, until recently, treating about 12,000 HIV patients, was **forced to close** several treatment sites. In a climate of extreme poverty and violence, seeking treatment at alternative sites is often not feasible, often leading to interruption – or termination – of treatment. And several NGOs have been asked by the Ministry of Health to **limit HIV testing**, because funding for drugs to treat those found eligible for ART is not available. In addition, many patients do not have access to essential medical interventions, such as drugs for opportunistic infections, and testing for CD4-counts or viral loads. These interventions are not sufficiently covered by government or international funding, and costs fall to the patients who largely cannot afford even minimal fees.

HIV treatment and care in the DRC is in the grip of a downward spiral caused by funding shortfalls and disbursement delays. This leads to poor patient outcomes and poor programme performance, which in turn leads to further cuts in available funding based on performance.

Existing funding for antiretrovirals (ARVs) largely comes from the Global Fund, but recent grants to the DRC have been severely delayed or curtailed in size and scope due to poor grant planning, management and reporting. During recent investigations of issues of corruption, the majority of grant implementation was frozen as a precautionary measure for at least six months.

As part of Phase II of Round 7 and 8 Global Fund grants, the DRC is planning a downward review of the total target of people ART by the end of 2014, from 82,000 initially to 54,000 patients on ART in the revised plan⁸. This is due to funding shortages and means that another 28,000 PLWA will be excluded from being initiated on ARVs before end of 2014.

In order to scale up treatment or to be able to implement the latest WHO treatment guidelines, the DRC needs to receive new and additional funding from the Global Fund. However, due to the Global Fund's financial difficulties, Round 1 has been cancelled. In view of announced Global Fund shortfalls, countries like the DRC, are scaling back the size of their grant requests, so as to increase their chances of getting a piece of a smaller overall pie. From the perspective of patients waiting for treatment, this translates into longer delays and less of a chance to start treatment at all.

Other sources of funding are drying up, making the DRC even more dependent on dwindling Global Fund grants. The World Bank has ended its Multi-Country AIDS Programme (MAP), and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding covers only limited quantities of ARVs, restricted for use for PMTCT. Meanwhile, UNITAID funding of paediatric ARVs and tests through the Clinton Foundation is expected to end by December 2012. These and other donors expect the Global Fund to pick up ARV funding and ensure continuity of treatment for patients already on ART, but Global Fund monies for the DRC are insufficient at present and far from guaranteed for the near future.

MSF has been offering HIV/AIDS services in DRC since 1996, including HIV treatment, STI treatment, and preventive activities for high-risk groups, including commercial sex workers, victims of sexual violence and displaced persons. Currently, MSF provides ART to about 5,700 patients in 15 different sites across seven provinces. The largest treatment site is in the capital, Kinshasa, and serves 4,200 patients through, a day hospital and a referral clinic. In Kinshasa, MSF also initiates and follows patients at an ambulatory treatment centre and supports several health centres in the government and mission network. MSF works in close collaboration with networks of people living with HIV/AIDS to facilitate greater patient autonomy and community-based treatment and care.

KENYA

In Kenya, 61% of those eligible for ART are currently receiving it⁹, with 25% of Kenyans being tested for HIV in the last year. The relatively low rate of testing is due in part to a highly centralised ART programme: facility coverage, defined as the percentage of existing public sector facilities providing comprehensive HIV services, is only at 14%. The government's new policy of nurse-initiated and managed ART should help to remedy this.

Professor Alloys Orago, Director of the National AIDS Control Council, recently stated that the country can do more, and that with scale-up of HIV programmes, the country's AIDS crisis could be ended **within a generation**.

Kenya has put in place many **ambitious policies**, which demonstrate that Professor Orago's words have weight. For example, 83% of expectant mothers currently receive an HIV test¹⁰.

The country recognizes the need to **capitalise on the science** showing that HIV treatment is prevention: new guidelines state that treatment of sero-discordant couples would prevent new cases of HIV and better protect the HIV-negative partner from infection. However, the guidelines do not yet recommend treatment of sero-discordant couples. Kenya is recommending ART for expectant HIV positive mothers, regardless of their CD4 count (PMTCT Option B) in settings where this is feasible.

Kenya is also considering implementing **new tools** in order to improve patient care. Routine use of viral load monitoring is being discussed in order to ensure that patients are adequately responding to ART, and to enable them to switch to a new treatment if necessary. The country has bought 22 molecular diagnostic machines to be used across the country, which quickly diagnose TB and can screen for multidrug-resistant tuberculosis (MDR-TB).

Ambitious policies are beginning to be met by **a scale-up in domestic funding**; but this needs to accelerate. In 2009, Kenya funded only 14.5% of its national HIV programme¹¹ and only 6.4% for ART.¹² However, **the government has committed to a 10% annual increase in domestic financing for ARVs and drugs to treat opportunistic infections.** Changes to the National Health Insurance Fund, once enacted, will provide support for ART. The government has also explored innovative ways to raise funds, such as small taxes on flights and a mobile phone levy.

MSF works with the Ministry of Health to ensure that treatment is available in eight clinics across Homa Bay, the district most affected by HIV/AIDS and TB in Kenya. In Nairobi, MSF works in two slum areas, Mathare and Kibera, providing HIV and TB care along with primary health services. After 10 years, MSF's project in Busia, a rural region in western Kenya, was handed over to other organisations. The project effectively showed that ART with good outcomes is feasible in resource-poor rural settings.

LESOTHO

With an HIV prevalence of just under 25%, Lesotho has shown a strong commitment to increasing access to ART with the best drugs available. **Today, 66% of people who need ART, according to the latest WHO guidelines, receive it.**

In 2008, Lesotho was the first country in Africa to implement **early initiation** of ART at CD4<350 and include tenofovir as the preferred first-line treatment, a full two years before WHO made its firm recommendations. Lesotho's 2010 National ARV Guidelines called for the immediate initiation of children aged 24 months or below onto ART, regardless of CD4 count. In addition, Lesotho is providing fixed-dose combinations for adult first-line therapy.

Lesotho's new National HIV/AIDS Strategic plan (NSP) for 2011/12 – 2015/16 includes an ART coverage target of 90% (126,658 people) by 2015, up from 60% (76,548 people) in 2010. The NSP also aims to reduce the rate of new HIV infections by 50%.

Lesotho has instituted an accelerated **decentralisation policy** in order to reach more patients: currently **more than 70% of primary health care clinics offer comprehensive HIV services.**

Due to the scale up of PMTCT services, coverage rates have increased from 6% in 2005 to 81% in 2010; currently 5% of babies born to mothers who received PMTCT care are HIV-infected at birth. However this rate grows to 12% at six weeks after birth, and to 26% when breastfeeding is considered.

Lesotho has seen a 140% increase in HIV/AIDS funding since 2007, with government contributions increasing by 56% between 2008 and 2009.¹³ The percentage of the national budget allocated to health has been increasing annually, from 10.3% in 2008-09 to 14% in 2010-11. By 2008, Lesotho paid for 58% of its HIV programming; it will also increase its contribution to the ARV programme. In order to implement the NSP, the country will have paid \$190 million in 2011 and \$320 million by 2015; the bulk of this will be spent on ARVs.

Lesotho is heavily dependent on funding from the Southern African Customs Union (SACU), which has seen significant declines in revenues due to the global recession—Lesotho's share has declined by about 50%. According to the International Monetary Fund, Lesotho's gross domestic product (GDP) is expected to fall by close to a quarter over the next three years.¹⁴

Lesotho is currently awaiting its Global Fund Round 8 phase 2 renewal. The country is also receiving ongoing grants from Global Fund Rounds 5, 6, 7, and 9. Even if the country is successful in its renewal, and even given the increase in government spending, it is estimated that Lesotho will face a \$70 million funding gap by 2014, based on the NSP aim to provide ART to 126,658 people, representing 90% coverage of need.

Lesotho was planning to submit TB and Health System Strengthening proposals for Global Fund Round 11. However, this round has subsequently been canceled. Additionally, given that UNITAID is phasing out its funding support, via the Clinton Foundation, by the end of 2011, the Lesotho government had to include paediatric drugs and diagnostics into its 2011 budget.

Following the successful handover of a decentralised, nurse-run HIV programme throughout one of the health districts, MSF opened a new project in Lesotho in 2011 to reduce maternal mortality by scaling-up HIV, TB, and maternity services at the community and primary health care levels, thereby helping to address the main drivers of mortality among infants and pregnant women.

MALAWI

Malawi is a least-developed country and **one of the ten most affected countries by the HIV epidemic**, with an estimated 10% of the country living with HIV (960,000 people).

Today, 67% of people who need antiretroviral therapy receive it¹⁵--but still only 19-24% of eligible children receive ART¹⁶. This significant scale up was made possible in large part due to the country's public health approach to the epidemic, which includes simplified treatment protocols, decentralising HIV care to the community level, and health care worker task-shifting in the face of critical human resource shortages. Access to treatment has increased substantially, **with ART services now available in 55% of the country's 772 public sector health facilities**. A regression model considering ante-natal care data from 2000-2010 shows a **57% decline in HIV prevalence over the decade¹⁷**.

Malawi has adopted the latest WHO guidelines to provide **timely ART treatment** at CD4<350, instead of CD4 250. In addition, Malawi has adopted tenofovir, the WHO-recommended first-line drug that is better-tolerated by patients, but has had to **scale back implementation of the new regimen due to funding shortages¹⁸**.

Malawi's new national guidelines include life-long treatment for all HIV-positive expectant mothers (**PMTCT Option B+**). **This is expected to decrease the mother to child transmission rate, which in 2010 was estimated to be between 22-42%¹⁹**. The new national guidelines also include universal access to ART for children under 2 years of age, plus the integration of ART and PMTCT services through a family-centred approach at more than 600 health facilities across the country. **The government's goal is to reach universal access to ART in the country by 2015**.

However, full implementation of these updated WHO guidelines and other programmes has been hindered by severe funding constraints. Due to persistent internal economic constraints, the country remains almost entirely **dependent on external funding** for its HIV response. According to UNAIDS, in 2011, **the government funds only 1% of the country's HIV programming**. Much of the external funding comes from the Global Fund, which is responsible for procuring much of the country's HIV test kits and drugs, including ARVs.

The country's Round 10 proposal to the Global Fund was rejected in large part because it was **deemed too ambitious**: in the absence of alternative donor support, the country had to forego implementation of the full package of WHO recommendations. Now only newly-diagnosed HIV-positive pregnant and breastfeeding women, patients co-infected with HIV and TB, and those with severe side effects are eligible to start on tenofovir-based regimens. Other planned initiatives, such as increased access to viral load monitoring, improved early infant diagnosis, and scaling up voluntary medical male circumcision have also been scaled back or postponed until further funding becomes available.

Malawi's future funding situation is extremely precarious. Malawi planned on applying for Round 11, which has since been cancelled. All of Malawi's existing Global Fund's grants expire in early 2014. Without additional funding there is a significant risk of a gap that threatens to halt Malawi's ambitious plans to scale up their HIV programme, and to potentially interrupt continuity of treatment.

MSF has worked in Malawi since 199. MSF introduced ART in Chiradzulu in 2001 and in Thyolo in 2003, two rural districts in the south of the country. Decentralised HIV/TB care is provided with support from MSF in these districts, as well as more recently in the neighbouring Nsanje and Chikwawa districts. In mid-2011, a total of 20,600 patients receive ARVs in Thyolo and 21,000 in Chiradzulu with MSF support. Both district achieved a very high (universal) coverage of ART services.

MOZAMBIQUE

Low government spending and a reduction in international support have slowed the HIV response in Mozambique. As of July 2011, **an estimated 40% (247,000 people) of those in need were receiving ART, with more than a half a million people eligible for treatment** according to the national guidelines. As of the end of 2010, only 19% (17,395) of the 91,000 children in need were receiving ART²⁰.

Due to funding and other health system constraints, including a severe shortage of health care workers and weak drug supply chain, **Mozambique has not been able to adopt the latest WHO guidelines** for HIV treatment, including timely ART treatment at CD4<350 and tenofovir-based regimens. However, the country has moved to offer zidovudine (AZT) instead of the less-tolerated stavudine (d4T) as part of the first-line regimen. Mozambique has also adopted a WHO-recommended protocol for PMTCT, including earlier treatment at CD4<350 (PMTCT Option A), but **continued roll-out can only be realised with increased funding**. As of 2010, the mother to child transmission rate was 31%²¹.

The government is reviewing new policies and practices to enhance patient care and make better use of limited resources. For example, the country aims to further integrate HIV and TB care to alleviate the burden of HIV/TB co-infection. In addition, Mozambique is working to train and hire more health care workers, but is constrained by funding shortages.

The government is also implementing innovative community-based strategies. Community ART Groups (CAGs) enable HIV-positive members of a group to share the burden of collecting their monthly supply of ARVs from distant clinics. Patients are divided into groups of around six people who live near each other. Each month, the group chooses one person to go to the health center and collect the refills of the antiretroviral (ARV) drugs they are taking as part of their treatment. On return, the representative distributes the ARVs to the other group members. The representative also checks that the members of the group have been taking their medication

correctly, so that this information can be relayed to the health center. These groups empower patients, improve adherence to treatment regimens, reduce clinic visits and make better use of over-stretched health care workers. Initially supported by MSF, the successful CAG programme is now being rolled out in other parts of the country.

Mozambique is heavily reliant on donor funding: only 7% of the country's budget is spent on health. According to a National AIDS Council report released in 2011, 96% of the country's HIV budget is donor-funded, with the Global Fund and PEPFAR providing the largest portion of funds.

The country now faces a severe funding gap. Continued funding from the Global Fund is under threat: Mozambique's Round 9 funding has not yet been released due to concerns over poor financial and supply management, its Round 10 grant proposal was not approved, and it is not eligible to apply for Round 11 funding. According to the most recent national gap analysis undertaken by the MoH and U.S.-supported Supply Chain Management System, **Mozambique is expected to face shortages of first-line ARVs by the end of 2012, or even earlier - unless an emergency funding request to the Global Fund is approved.** The country is looking for other funding alternatives to help plug the projected gap.

In Mozambique, MSF works in Tete Province where the CAG model that has now become national policy was successfully piloted. In addition, comprehensive HIV/TB services are supported in two districts in Maputo: Mavalane and Chamanculo. Approximately 35,000 patients are treated with ARVs with the assistance of MSF. MSF's main objective has been to reduce HIV/AIDS transmission and improve prevention, care and treatment through the development and implementation of adapted and comprehensive integrated models of care.

SOUTH AFRICA

South Africa is home to the largest number of people living with HIV worldwide. **Today, 49% of those who need antiretroviral therapy (ART) receive it, a total of 1.59 million people.**²² As of 2010, facility coverage – defined as the percentage of existing public sector facilities providing comprehensive HIV services – stood at 44%.²³

South Africa recently adopted **the latest WHO guidelines** to provide timely ART treatment at CD4<350 and the use of tenofovir as the preferred first-line regimen. Given the lower initiation threshold, at least an additional 400,000 people annually will be initiated onto ART. It is expected that 2.6 million people will be receiving ART by fiscal year 2013/2014.

Through its new National Strategic Plan (NSP) for HIV and AIDS, STIs and TB for 2012-2016, **the country aims to achieve universal access (80%) to ART, with 70% of patients remaining in care five years after initiation, and to reduce new HIV infections by 50% by 2015.** The NSP includes several components of accelerated treatment, including **ART for patients co-infected with TB and HIV** regardless of CD4 count, and will in the future consider **treatment as prevention** in special populations such as HIV-positive partners in sero-discordant couples.

South Africa has made significant inroads in reducing mother-to-child transmission of HIV: the national MTCT rate has dropped to 3.5% at 4-6 weeks after birth.²⁴ **The NSP aims to reduce mother-to-child transmission to less than 2% at six weeks after birth, and less than 5% at 18 months, by 2015.** The country is currently implementing PMTCT Option A. Through the

NSP, South Africa will also consider **PMTCT Option B+** as additional evidence emerges and international guidelines evolve.

As outlined in the NSP, **South Africa aims to cut in half the number of new TB infections and deaths by 2015**. The government has adopted novel HIV/TB integration guidelines that could act as a model for the region, allowing for nurse-initiated TB and HIV treatment at the primary health care level. With drug-resistant TB posing an increasing threat, the country aims to diagnose 100% of these cases by 2015.

Of the \$1.62 billion available for the HIV and TB programmes in 2009/10, 75% was contributed by the South African government, and 17% from external sources such as the Global Fund and PEPFAR. ARVs accounted for 63% of the total HIV budget²⁵. South Africa currently receives money from Global Fund Round 10, totaling \$302 million over five years, \$196 million of which is allocated to ARVs. This is in addition to the health department's \$536 million tender for the procurement of antiretroviral drugs for 2010-2012. The Minister of Health Dr. Aaron Motsoaledi has stated that because the government pays for the vast bulk of its ARVs, HIV treatment in South Africa will not be affected by the Global Fund's cancellation of Round 11²⁶.

PEPFAR's financial support to South Africa, which has been incrementally decreasing since its peak in 2008, has shifted towards technical assistance instead of direct service provision. This has resulted in PEPFAR-supported patients being shifted to public clinics, often before the clinics are fully able to absorb increasing numbers.

South Africa has said that it plans to expand its portion of HIV spending. The NSP is expected to be paid for primarily by the government, with additional financial support expected from international funders and the private sector. Yet government health expenditure is pegged to experience a relative slow-down: the health budget is expected to increase on average by only 6.9% between 2011/12 and 2014/15, compared to the average growth of 13.5% between 2008/09 and 2011/12.

The country is attempting to support efforts to combat HIV in southern Africa through the Southern African Development Community and with the creation of a new Ministry of Health post responsible for sub-regional HIV. Additionally, South Africa has offered emergency funds of approximately \$285 million for their struggling neighbour Swaziland, some of which could be used for the provision of ARVs.

MSF has been in South Africa since 1999. Current projects include the HIV/TB & DR-TB project in Khayelitsha, and refugee/migrants/asylum seekers health projects in inner-city Johannesburg and at the border of Zimbabwe. In 2011, MSF opened a new pilot project in Uthungulu district in KwaZulu-Natal province to reduce new HIV and TB infections through increased testing, accelerated treatment (CD4<500 or viral load of over 100,000), improved linkages to care, and increased coverage of both treatment and combination prevention. The project receives strong support from the Department of Health, who are eager to have pilot projects testing the feasibility and acceptability of more ambitious approaches to massive community-based testing and accelerated treatment.

SWAZILAND

Swaziland has one of the highest HIV prevalence in the world: 26% of adults 15-49 years old²⁷ and 41% of pregnant women are infected.²⁸ It is estimated that there are approximately

200,000 people living with HIV/AIDS and about 90,000 are in need of ART. Swaziland is also suffering from an alarming **co-epidemic of TB** that is currently the main cause of mortality among adults. Almost 8% of new TB cases are diagnosed as multidrug-resistant TB.

Today, more than 78% of people who need ART receive it. Swaziland has adopted the **latest WHO guidelines** for HIV treatment, which include provision of timely ART treatment at CD4<350 and the use of tenofovir-based first line.

Swaziland is also implementing other **innovative strategies**, which have been proven to be effective in supporting the scale-up of HIV treatment. One such strategy is **task-shifting** - necessitated by a dire shortage of health workers, this involves delegating some responsibilities from doctors to nurses, especially nurse-led initiation of treatment. In the Shiselweni region, where MSF works in collaboration with health officials, delegation of certain responsibilities from nurses to lay community workers has been successfully piloted. Another is **decentralisation**. In the same region, the majority of patients are able to initiate treatment at the closest point of care – local clinics – rather than regional health centres.

The Swaziland government, International Center for AIDS Care and Treatment Programmes (ICAP), the Clinton Foundation and MSF are currently considering piloting several **treatment as prevention** projects.

Swaziland has made significant progress in scaling up access to diagnosis, care and treatment for people with HIV or co-infected with HIV and TB, including MDR-TB. However, incidence levels of HIV infection and TB disease remain high, and many people remain untested and untreated. **An estimated 12% of new infections occur in children**, due to sub-optimal use of PMTCT services.

In early 2010, the Swaziland government announced it would **take over funding for all ARV treatment from the Global Fund**, except for paediatric drugs that are funded by UNITAID. However, progress to date and for the future is under threat, and Swaziland regularly faces **shortages of ARV drugs**, HIV tests, and lab tests necessary to initiate and manage HIV/AIDS patients on treatment. Swaziland recently received emergency funding from PEPFAR to help supply first-line ARVs through April 2012.²⁹ HIV/AIDS programmes suffer from poor government planning and management, and a **serious financial crisis** affecting government revenues continues to deepen.

Swaziland planned on applying for Round 11 funding, which would have been crucial to the continuity and future scale up of Swaziland's HIV/AIDS programmes. With the cancellation of Round 11, funding shortages are foreseen for 2012-2014.

MSF has HIV/AIDS and TB operations in two of the four regions of Swaziland, Shiselweni and Manzini, since 2007 and 2011 respectively. For more information download MSF's 2010 report: Fighting a Dual Epidemic - Treating TB in a High HIV Prevalence Setting in Rural Swaziland at <http://www.msfaccess.org/our-work/hiv-aids/article/98>.

UGANDA

Today, 47% of people in Uganda who need ART according to the latest WHO guidelines receive it³⁰. The country has implemented a number of initiatives to improve HIV/AIDS programming, including: adoption of the **latest WHO guidelines** to provide timely ART at

CD4<350, instead of CD4 250; use of tenofovir, the WHO-recommended first-line drug that is better-tolerated by patients; earlier initiation onto ART for children; plans to decentralise HIV programmes closer to the community level, in order to reach more patients closer to their home.

In addition, **PMTCT Option B+** is included in Uganda's national guidelines. However, in practice it has only been implemented at pilot sites supported by non-government organisations, due to funding shortages. Currently 42% of HIV-positive expectant mothers receive some sort of PMTCT³¹.

Uganda is **heavily reliant upon donor funding**, with the Global Fund and PEPFAR providing the bulk of support. Currently, PEPFAR supports 75% of all of Uganda's patients receiving ART and has an ART target to reach an additional 36,000-50,000 patients each year over the next three years.

Uganda's application for Global Fund financing was rejected for the last two rounds (Round 9 and Round 10). The country is relying on a grant from the second phase of an earlier funding round (Round 7), which amounts to \$130 million. Adding to the funding crunch is the fact that Uganda underspent the first phase of the Round 7 grant and therefore is not eligible for the entire amount.

The Clinton HIV/AIDS Initiative, funded by UNITAID, currently supports paediatric treatment, second-line treatment, and laboratory support. However, its funding for adult second-line therapy is ending with the last batch arriving April 2012.

International donors increasingly request the government of Uganda to increase domestic funds to better support the country's HIV response. Despite this, a recent national budget, approved in September 2011, did not include an increase for many important areas of the health sector, particularly the health workforce. **Currently only 10% of the national HIV budget is paid for by the Ministry of Health.**

Following the U.S. Secretary of State's call in late 2011 for countries to step up their HIV response in order to defeat AIDS, Uganda's Minister of State for Health Hon. Dr Richard Nduhura issued a statement committing his government "to doubling the pace of scale up of the use of ARVs for treatment and prevention."

MSF works in Uganda providing HIV and TB care in Arua district, home to more than 700,000 people of whom over 40,000 are estimated to be living with HIV. MSF also runs decentralised clinics in Koboko, Nebbi and Adjumani, covering an area inhabited by more than 800,000, people of whom 50,000 are estimated to be living with HIV. MSF is working with the Government of Uganda to initiate a pilot programme of ART for HIV+ pregnant women (PMTCT Option B+).

ZAMBIA

Zambia has been ambitious in scaling-up its HIV programme, but has been hindered in implementing some new policies because of funding problems. **Currently 72% of those who need ART are receiving it.** But only 29% of all health facilities offer ART.

Zambia has adopted the **latest WHO guidelines** to provide timely ART treatment at CD4<350. In addition, tenofovir, the WHO-recommended first-line drug, has been available since 2007—far earlier than in many other countries in Southern Africa.

87% of pregnant women have been tested for HIV and received their results, and 75% of HIV-positive pregnant women receive PMTCT services³². Currently, 20% of all babies born to HIV-positive mothers are infected with the virus³³: this figure is somewhat lower when compared to other sub-Saharan African countries. Currently the country is using PMTCT Option A, which includes expanded use of ARVs during pregnancy.

The country is working with NGOs to open pilot projects to provide all HIV-positive pregnant women, regardless of CD4 count, with ART for life (**Option B+**). As of 2010, the country's HIV guidelines also included providing ART to all people living with HIV in **sero-discordant couples** so that their HIV-negative partner could be better protected from infection.

The country was recently approved to receive \$260 million through Round 10 of the Global Fund—monies which will help them to reach their ambitious targets. Zambia has also increased its contribution to HIV treatment to \$5 million in 2012, which leveraged an additional \$30 million from PEPFAR.³⁴ Despite these increases, USAID estimates that the **funding gap** to finance Zambia's scale up plans will reach nearly \$50 million by 2014 if significant increases in donor and country budgets do not occur.³⁵ This could particularly threaten the country's ambitious PMTCT plans.

MSF has been working in Zambia since 1999. At the beginning of 2010 there was little antenatal care available in Luwingu, a rural district of north-eastern Zambia, where pregnant women are could not receive PMTCT services. In June, MSF mobile teams started working in four rural health centres in Luwingu, providing reproductive health services, antenatal care, emergency obstetric care and PMTCT services.

ZIMBABWE

Zimbabwe has the third highest HIV burden in southern Africa, with 14% of adults (1 million people) and 150,000 children living with HIV.³⁶

Zimbabwe has taken ambitious steps to improve HIV/AIDS programming, with positive results. **Currently 63% of those in need of ART are receiving treatment³⁷, up from only 5% in 2006³⁸.** Within just a year, between 2009 and 2010, Zimbabwe increased ART coverage by 49%³⁹. Expanded ART coverage has reduced annual AIDS deaths by 42% since 2006.⁴⁰ A regression model considering ante-natal care data from 2000-2010 shows a **56% decline in HIV prevalence over the decade⁴¹.**

Zimbabwe's National HIV and AIDS Strategic Plan for 2011-2015 calls for ART to be available to 85% of those in need by 2015, which should reduce annual deaths by a further 27%.⁴² Zimbabwe also aims to circumcise 1.2 million men by 2015⁴³, which should result in a 25-35% reduction in HIV transmissions.

Important programmatic improvements include: initiation of ART at CD4<350, as recommended in the **latest WHO guidelines**; the use of short-course ARVs during pregnancy to reduce mother-to-child transmission (PMTCT Option A); increasing the **number of facilities** providing ART services, from just 32 in 2006 to 545 in September 2011 (35% coverage)⁴⁴; expanding paediatric testing by increasing early infant diagnosis sites from only four in 2008 to more than 400 in 2010; and the 2009 launch of a national voluntary male circumcision policy, with 30,000 free circumcisions performed to date.

However, many programmes are threatened by a **lack of funding and programme closures**. Zimbabwe wants to implement the WHO-recommended first-line treatment tenofovir for all patients, but has so far only been able to offer this better-tolerated drug to a limited subgroup of patients – those with TB co-infections and HIV-positive pregnant women. Without additional funding, the government will not be able to achieve its goal of offering tenofovir to all patients by 2013.

The Expanded Support Programme (ESP) is a basket funding mechanism set up in 2007 through which donors, mainly the UK, Sweden, Norway, Ireland and Canada, supported HIV/AIDS interventions. The ESP is coming to an end in December 2011 and has decided to not continue in its current form but to be replaced by a new basket fund initiative called the Health Transitional Fund – crucially, this will not include funding for commodities, such as ARVs. **MSF has asked donors, including DfID to extend its funding for the ESP for another year.**

Looking ahead, **funding shortfalls threaten to interrupt treatment for patients already on ART**. ARV shortages affecting 86,500 patients are forecast for 2012, primarily due to closing of the ESP, rising costs, and lack of additional funding. According to estimates, **shortages** could affect 112,800 patients by 2014. National buffer stocks are currently being used to cover the shortages.

Due to the lack of secured funding, UNITAID granted the **Clinton HIV/AIDS Initiative a one-year extension to continue paying for** paediatric treatment that otherwise would have left up to 5,000 children without ART in 2012. The country aims to place 51,000 children on treatment as of 2015, but funding gaps are foreseen from 2013 onwards.

In 2000, Zimbabwe implemented a 3% national AIDS levy on taxable income from all sectors; 50% of this revenue is earmarked for ARVs, which supported 80,000 patients in 2011—20% of the total number of patients receiving treatment.

But Zimbabwe is still heavily reliant on external funding, especially grants from the Global Fund. Zimbabwe was not successful in receiving Round 10 funding, but planned on applying for Round 11. From the perspective of patients waiting for treatment, this translates into longer delays and less of a chance to start life-saving treatment at all.

MSF offers comprehensive HIV/AIDS care in health clinics in six cities, offering preventive services, counselling, testing and treatment. In 2010, more than 34,000 patients received ARV treatment through MSF programmes.

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