

THE BEGINNING OF THE END?

Tracking Global Commitments on AIDS

Volume 2





ONE OF THOUSANDS OF HEALTH
OUTREACH WORKERS IN RWANDA WHO
PROVIDE CARE AND OVERSEE PATIENTS
TAKING THEIR DAILY AIDS OR
TUBERCULOSIS MEDICATION.

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03	Acknowledgements
05	Executive Summary
16	Part 1: Tracking Progress on Disease-Specific Indicators
18	Target 1: The Virtual Elimination of Mother-to-Child Transmission of HIV by 2015
20	Target 2: 15 Million People on AIDS Treatment
22	Target 3: The Drastic Reduction of New Adult and Adolescent HIV Infections
25	Beyond the Three Targets
27	Achieving the Beginning of the End of AIDS Around the World
33	Part 2: Tracking Leadership and Commitment Towards the Beginning of the End of AIDS
34	Traditional Donor Efforts
41	African Efforts and Country Profiles
47	Ghana
49	Malawi
51	Zambia
53	South Africa
55	Tanzania
57	Uganda
59	Cameroon
61	Nigeria
63	Togo
66	Conclusions and Recommendations
71	Methodology
77	Endnotes



A COMMUNITY MEETING OF HIV-POSITIVE WOMEN WHO HAVE BENEFITED FROM PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) SERVICES ALONG WITH HEALTH COUNSELLORS IN DANGBO, BENIN.

PHOTO: JOHN RAE © THE GLOBAL FUND

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To the millions of people who work and campaign tirelessly to make progress towards the beginning of the end of AIDS possible, thank you. The perseverance and commitment of those working both inside and outside governments is truly inspiring.

ERRORS AND OMISSIONS

This report was finalised on 22 October 2013. The information it contains was, to the best of our knowledge, current up until that date. We acknowledge that events occurring after this point may mean that some of the figures and commitments in this report are out of date. Any remaining errors are our sole responsibility.



YOUNG PEOPLE WHOSE LIVES HAVE BEEN
AFFECTED BY HIV HAVE AN OPPORTUNITY
TO ATTEND A GLOBAL FUND-SUPPORTED
EDUCATIONAL ADVANCEMENT PROGRAM
IN RWANDA.

PHOTO: JOHN RAE © THE GLOBAL FUND

EXECUTIVE SUMMARY

In 2012, ONE produced the first in a series of annual accountability reports on AIDS, in which we assessed progress towards the vision of the “beginning of the end of AIDS”. ONE, and many others in the scientific and advocacy communities, defined this vision as a tipping point in time, in which the total number of people newly infected with HIV in a given year is equal to, and eventually lower than, the number of HIV-positive people newly receiving antiretroviral (ARV) treatment in the same year. ONE also outlined three key targets on which world leaders should focus significant attention in order to make headway against the disease:¹

- 1 **The virtual elimination of mother-to-child transmission of HIV by 2015**
- 2 **Access to treatment for 15 million HIV-positive individuals by 2015**
- 3 **The drastic reduction of new adult and adolescent HIV infections, to approximately 1.1 million or fewer annually, by 2015.**

ONE’s 2012 report, “The Beginning of the End? Tracking Global Commitments on AIDS”, found that the world had made significant progress in improving access to treatment and in providing services to HIV-positive women to prevent transmission of the virus to their children, but that progress had been lagging in preventing new HIV infections for adolescents and adults. In addition, while it was important that leaders had begun to call for “the beginning of the end of AIDS”, there was not yet a sufficient sense of urgency for achieving it. Based on ONE’s calculations in the 2012 report, projected trends showed that the tipping point would not be met until 2022.²

Now, one year later, ONE’s 2013 analysis shows that the world has achieved a marked acceleration in its progress towards the achievement of the beginning of the end of AIDS. Most encouragingly, updated data shows that **if current rates of acceleration in both adding individuals to treatment and in reducing new HIV infections continue, we will achieve the beginning of the end of AIDS by 2015.**³ This progress is impressive, and gives credibility to this vision as something achievable in the near term.

In order to analyse what factors have driven this acceleration, the first part of this report examines in detail progress made towards the three key indicators outlined above in addition to the overall AIDS tipping point, noting both global and regional trends. It also highlights other efforts that play an indirect role in driving progress, such as strengthening health systems, reaching marginalised populations with services and fighting HIV/TB co-infection.

A key requirement for achieving greater gains across treatment and prevention efforts is securing and effectively deploying increased resources, and the second part of this report tracks global AIDS financing efforts. This analysis examines both donor funding for AIDS, which in 2012 remained flat, and African spending on AIDS, which is growing but remains insufficient.⁴

Securing more money for HIV/AIDS, however, is only one piece of the broader effort to end the disease. In order to develop a sustainable response to the epidemic, leadership in those countries most affected by HIV/AIDS – primarily in sub-Saharan Africa – must be more than financial. Political leadership at the national and local levels has proved to be essential in driving real gains across the continent. The report therefore focuses in greater detail on the role that governments and civil society organisations (CSOs) have played in nine sub-Saharan African countries. Profiles of these countries highlight the varying degrees of political and financial commitment that currently exist across the continent, ranging from unique leadership and policies that have driven success to uncoordinated or underfunded responses that are holding countries back.

Finally, this report recommends five ways in which stakeholders invested in the fight against AIDS should step up efforts to help ensure even greater progress for future generations. The next twelve months must be a moment of accountability for donors, scientists and activists to answer the question: are we doing all that we can to achieve the end of AIDS within our lifetimes? If the world simply maintains current levels of financing and prevention efforts, the answer will be “no”. But if stakeholders can adopt the recommendations included within this report and ambitiously scale up their efforts, the answer could be a definitive, and inspiring, “yes”.⁵

KEY FINDINGS

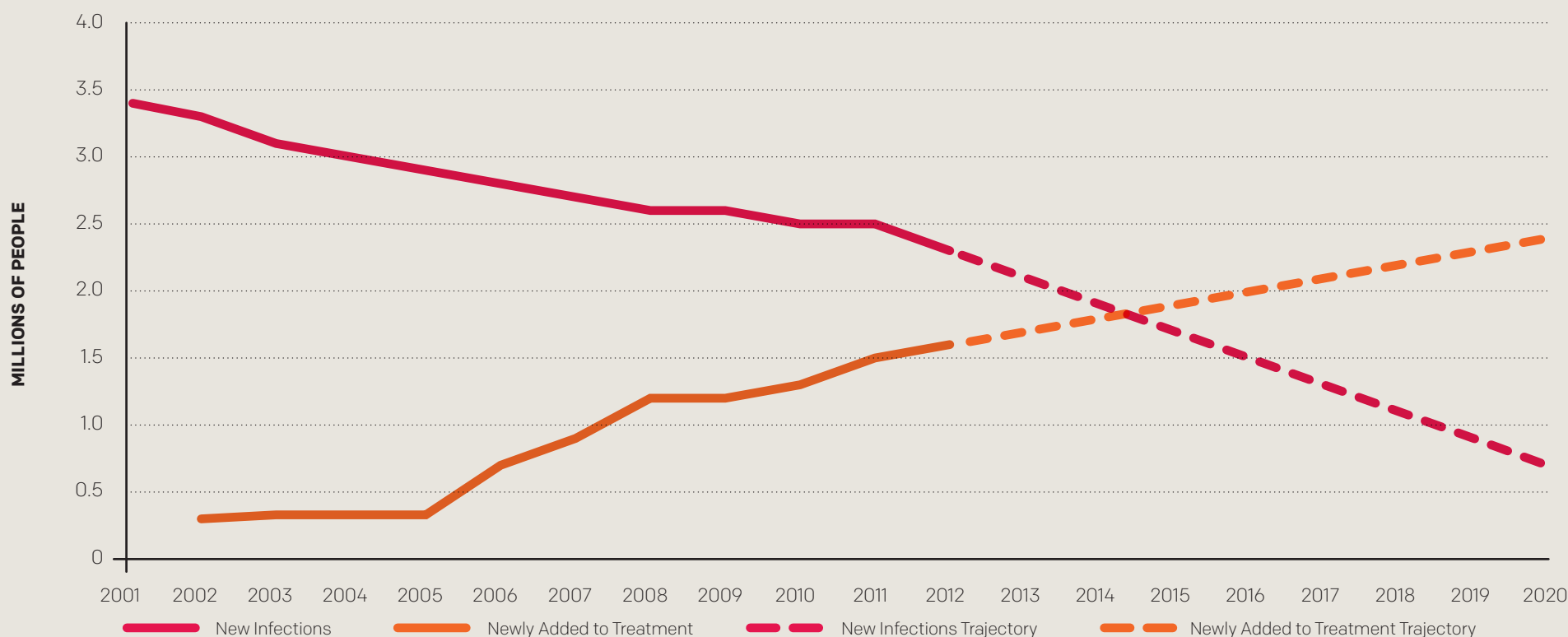
1 The world has achieved a marked acceleration of progress towards the beginning of the end of AIDS

If current rates of progress continue, the two lines showing the number of new HIV infections and the number of people newly added to treatment will intersect in the year 2015 – years sooner than ONE's projections based on data released in 2012, and an achievement worth celebrating. Some of this acceleration comes as a result of new and more accurate data released in 2013 for previous years, which altered the rate of progress assumed in our projections.⁶ Some of this acceleration, however, is driven by real progress achieved in the past year. In particular, the rate at which new HIV infections were reduced has increased substantially over the course of the last year: there were roughly 200,000 fewer new infections in 2012, compared with no

change to the number of new infections in 2011, and roughly 100,000 fewer in 2010. At the same time, 1.6 million new HIV-positive people were able to access treatment in 2012, up from 1.5 million in 2011 and 1.3 million in 2010.⁷

At the regional level, progress in sub-Saharan Africa has accounted for much of this global acceleration. In this region, the number of people added to treatment in the last year alone was at an all-time high, while the number of new infections dropped to an all-time low. Improvements in reducing paediatric infections, AIDS deaths and HIV prevalence rates were more marked in sub-Saharan Africa than anywhere else.⁸

FIGURE 1: Current Trajectories for Global HIV Prevention and Treatment Efforts



2

The world remains off track for key 2015 indicators on treatment and prevention

While global efforts have brought the tipping point within sight, efforts to achieve targets on specific indicators by 2015 have seen insufficient progress. Programmes to reduce mother-to-child transmission of HIV continued to scale up in 2012, particularly among the 22 high-burden countries. Seven countries in sub-Saharan Africa – Botswana, Ethiopia, Ghana, Malawi, Namibia, South Africa and Zambia – are driving much of this progress, having each reduced new HIV infections among children by 50% or more since 2009. But collectively the world is not on track to meet the virtual elimination goal by 2015, and a few countries, such as Nigeria and Angola, are holding back regional and global progress.⁹

Improvements in access to ARV treatment have put the world on track to meet the 2015 target of 15 million people on treatment – an impressive feat, particularly

considering that a decade ago only 300,000 people were on treatment around the world. New WHO guidelines released in 2013, however, have substantially increased the number of people who qualify for treatment,¹⁰ to 28 million.¹¹ In doing so, these guidelines have significantly expanded the global definition of universal access to treatment, and have reset the bar for how we define success.

Real reductions have been made in new adolescent and adult HIV infections for the first time in years, which is encouraging, but progress to cut that figure by half is still dramatically off track, and marginalised populations are falling further behind. New HIV infections still significantly outnumber people newly added to treatment and, overall, HIV prevention remains the area of least progress and least attention.

3

Current levels of financing for HIV/AIDS are insufficient for controlling and ultimately defeating the disease

UNAIDS estimates that global financing efforts for AIDS still fall \$3–5 billion short of the \$22–24 billion needed annually to achieve core outcomes on treatment and prevention by 2015.¹² Taking into account the increases needed to align with the new 2013 WHO treatment guidelines, that financing gap grows by an additional 10%.¹³

More than two-thirds of low- and middle-income countries increased domestic spending on HIV last year, accounting for 53% of all HIV/AIDS resources globally – the second year in a row that these countries have supported more than half of the global response. Many African governments, however, are not yet allocating sufficient resources for health.¹⁴ As of 2011, only six countries had met their Abuja commitments, made at an African Union summit in 2001, to spend 15% of their national budgets on health. Nearly a quarter of the countries for which data exists have not yet contributed even half of that amount.¹⁵

The global financing needs for AIDS treatment, prevention and care are still so significant that the response cannot be met through increased domestic

investments alone. Although country ownership is critical for a sustainable response, donors' efforts are still indispensable and need to be amplified to control the epidemic. Yet last year, donor resources for HIV/AIDS programmes remained flat and a number of donors even reduced their spending – a worrying trend, as the demand for HIV services continues to rise significantly.¹⁶

In 2012, the US remained the clear global leader on total AIDS financing, and the UK, Australia, Japan, Italy and Sweden increased their contributions. However, disappointingly, other countries including Denmark, Canada, France, Ireland, Norway and the Netherlands, along with the European Commission, decreased their overall contributions in 2012. Taking into account donor countries' populations, the Nordic countries (Denmark, Norway and Sweden) were clear leaders, with per capita spending of \$31, \$23 and \$18 respectively. The US (\$16), the Netherlands (\$15) and the UK (\$14) followed them, but France (\$6), Australia (\$6), Germany (\$4) and Canada (\$3) all lagged behind.

FIGURE 2: African Countries' Health Expenditure

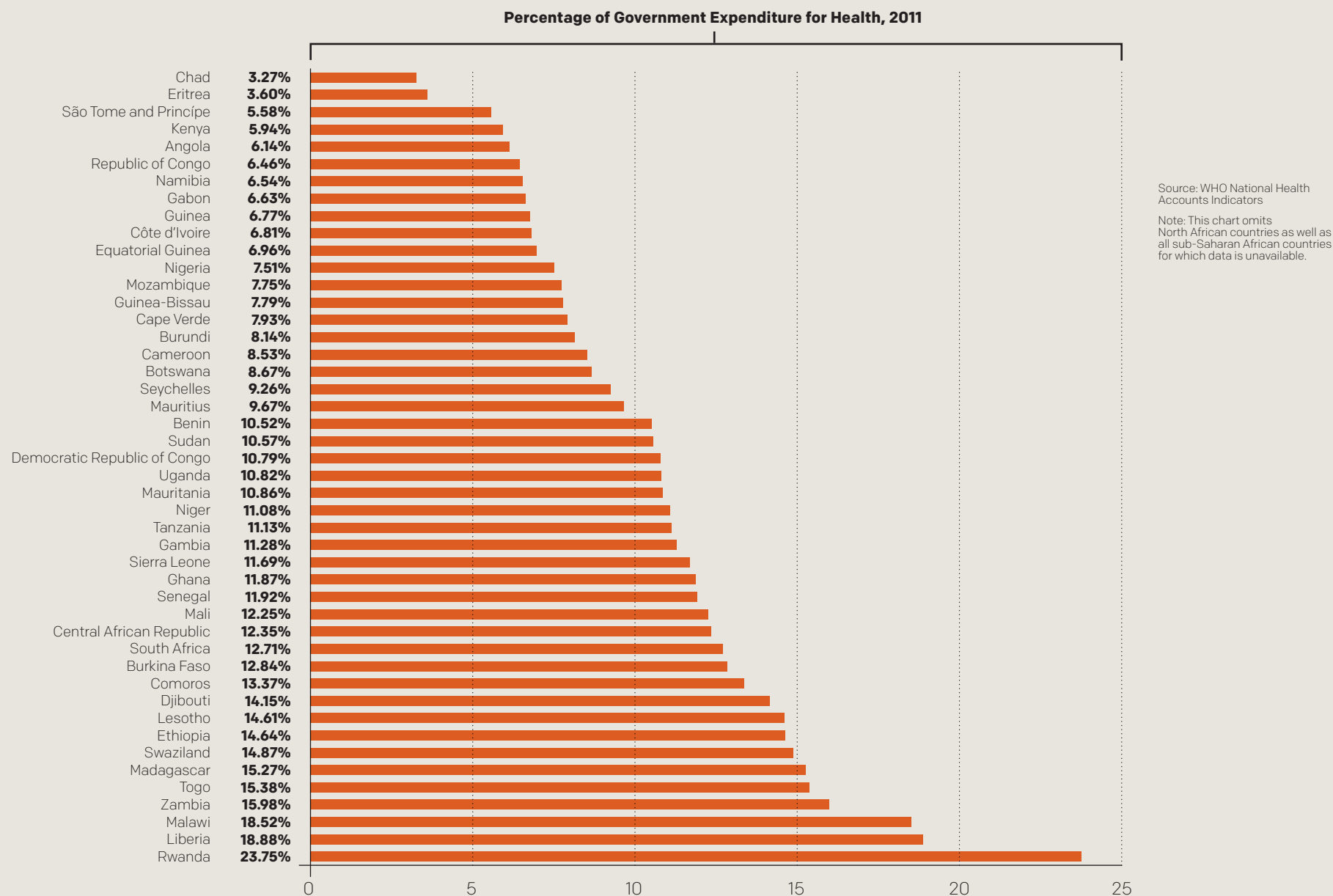


FIGURE 3: International HIV/AIDS Assistance from Top Donors (\$ Millions)¹⁷

COUNTRY	2012	RANK 2012	2011	RANK 2011	2010	RANK 2010	NET CHANGE 2010–2012
UNITED STATES	5,027.70	1	4,530.00	1	3,830.00	1	31.27%
UNITED KINGDOM	910.34	2	859.02	2	804.71	2	13.13%
FRANCE	384.40	3	412.71	3	388.66	3	-1.10%
GERMANY	288.48	4	312.26	5	310.33	5	-7.04%
THE NETHERLANDS	257.61	5	321.40	4	370.10	4	-30.39%
JAPAN	209.08	6	84.91	12	154.62	7	35.22%
DENMARK	171.00	7	189.20	6	171.10	6	-0.06%
SWEDEN	170.73	8	163.10	7	139.90	8	22.04%
CANADA	152.38	9	156.45	8	134.64	9	13.17%
AUSTRALIA	124.66	10	110.60	11	104.10	11	19.75%
NORWAY	115.51	11	118.80	10	119.00	10	-2.93%
EUROPEAN COMMISSION	100.66	12	122.31	9	100.33	12	0.33%
IRELAND	52.40	13	69.40	13	97.70	13	-46.37%
ITALY	13.90	14	5.12	14	11.40	14	21.93%
TOTAL	7,978.85		7,455.28		6,736.59		18.44%

Sources: Kaiser Family Foundation; UNAIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and ONE calculations

“AIDS in Africa” is a misnomer: there is wide divergence in levels of political will, financial investment and progress across the continent

Although great progress has been made against AIDS in sub-Saharan Africa, it has not been uniform. Political will and financial investments have varied dramatically between countries; so too have countries' relative successes in making headway towards the beginning of the end of AIDS – as calculated by dividing the total number of new infections in a year by the number of people newly added to treatment in that year. Where a ratio of 1.0 equals the 'tipping point', 16 of the 37 countries in sub-Saharan Africa for which data exists had reached or surpassed this milestone in 2012. Of the remaining 21, five were incredibly close to reaching the tipping point, with a ratio of between 1.01 and 1.1, while the remainder had a ratio ranging anywhere between 1.5 and 21.3 (and even going backwards, in the cases of Liberia and Mali).¹⁸

While there is no single success formula for fighting AIDS at the country level, ONE's analysis shows that the sub-Saharan African countries that have demonstrated strong political will and that have channelled donor and domestic financing through clear national plans have achieved the greatest progress in the past decade. Other countries are struggling to make headway, or are showing uneven progress. The nine countries profiled in the report broadly exemplify three levels of progress:

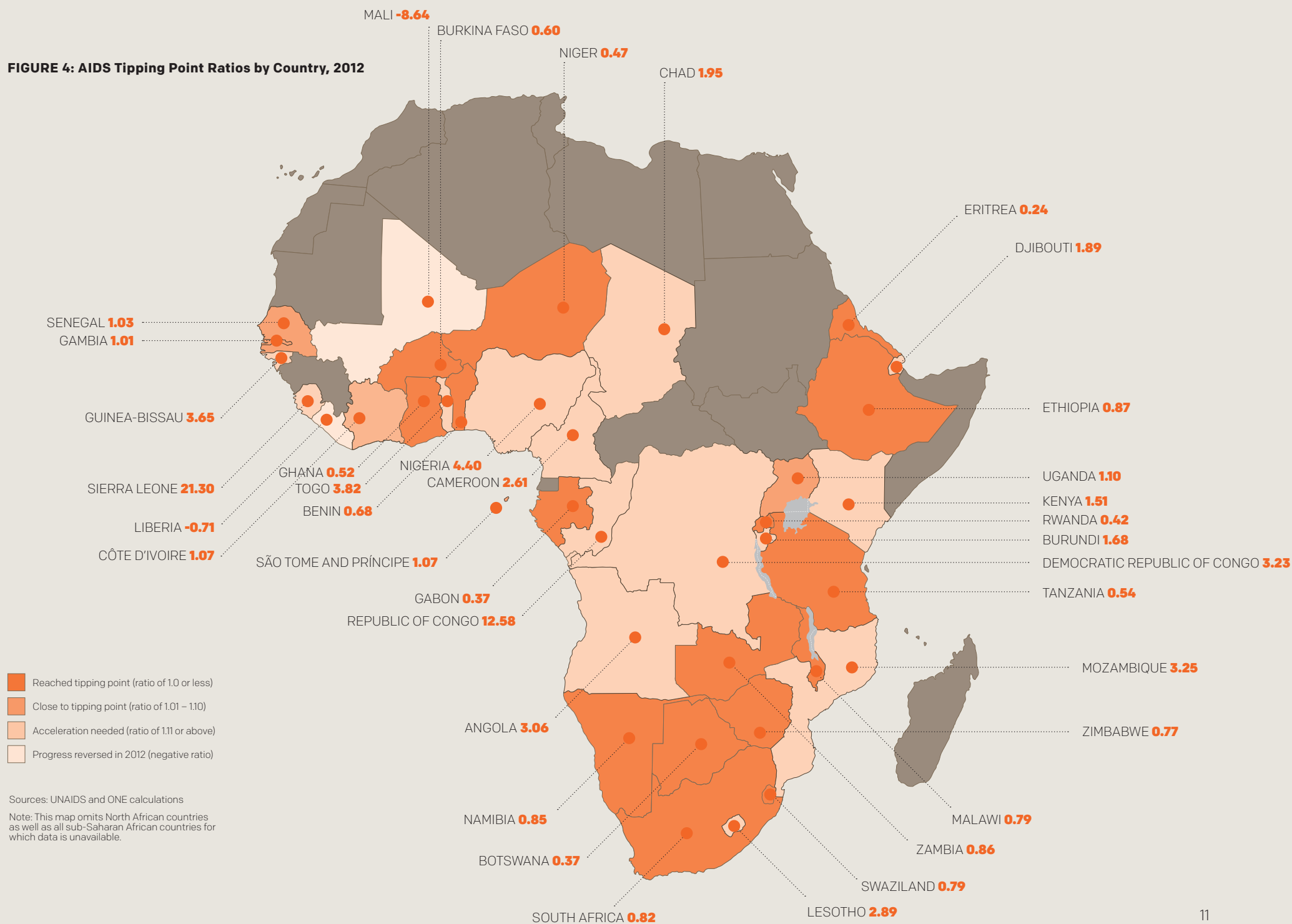
Leading the Way: Ghana, Malawi and Zambia are great examples of how international donors, national governments and key civil society leaders can work together to achieve accelerated progress in the fight against AIDS. Zambia and Malawi entered the decade with two of the world's most widespread, crippling AIDS epidemics. Today, they – along with Ghana – are the world's leaders in ending the epidemic, having made swift and steady progress over the last few years. All three countries have committed significant national resources for health, have reached and surpassed the tipping point at the country level, and are making even further headway towards the control and defeat of the disease.¹⁹

Ones to Watch: South Africa, Tanzania and Uganda have shown real dynamism but erratic progress as they face massive disease burdens, shifting political landscapes and unique, country-specific challenges. These countries have made significant strides in recent years, but their progress has been slower than in the leading countries. South Africa and Tanzania hit the tipping point for the beginning of the end of AIDS for the first time just last year, and Uganda – with an AIDS ratio of 1.1 – is close to the tipping point but has yet to reach it. Given unsteady progress against the AIDS epidemic in recent years, how these countries move forward in the next 1–2 years will be crucial.²⁰

Urgent Progress Needed: Cameroon, Nigeria and Togo have not made enough progress, having often been hampered by a lack of political will or competing political priorities, insufficient financial commitments, inefficient delivery systems and a lack of specific attention to prevention. Togo, in particular, had reached the AIDS tipping point in 2010 but has slipped back since. Meanwhile, progress towards the beginning of the end of AIDS has been largely stagnant in Nigeria and Cameroon, albeit with dramatic year-to-year fluctuations in the AIDS ratio. These countries, and others like them, must show a serious acceleration of efforts to achieve the beginning of the end of AIDS by 2015.²¹

In all countries, encouragingly, a wealth of CSOs and individuals are actively engaged in their communities and countries in the fight against the disease. Some of these groups are supporting and bolstering broader country-level efforts, while some are actively driving progress in spite of challenging circumstances or government intransigence. Their commitment and advocacy have been critical to the progress achieved on the continent over the past two decades.

FIGURE 4: AIDS Tipping Point Ratios by Country, 2012



RECOMMENDATIONS

Achieving the beginning of the end of AIDS, and ensuring that the world does not lose momentum if, and when, the tipping point is reached, requires not just bold rhetoric but also sustained action and investment. Therefore, ONE recommends that

government officials, international donors and technical leaders invested in the fight against AIDS undertake the following five actions to accelerate progress:

1 **Build the foundations for a “prevention revolution”, particularly among adolescents and marginalised populations**

Even if an AIDS tipping point is reached as early as 2015, the number of new HIV infections each year will still be in the millions, which will only serve to extend the life of the epidemic and the costs associated with it.²² For a disease that is entirely preventable with existing technologies, this should be unacceptable.

Unlike efforts to expand access to treatment, which have benefited from bold global targets, the AIDS community lacks a central and communicable prevention target to drive policy-making, priority-setting and advocacy. While ONE's 2012 and 2013 reports call for a halving of the number of new adolescent and adult infections (to 1.1 million) by 2015, this target has not been widely adopted in any formal political sense. By 2014

WHO, UNAIDS or the broader UN should call for a globally endorsed prevention target that would help accelerate the progress that is so desperately needed.

To achieve these reductions, donors and countries alike should do much more to apply more effectively the existing prevention tools. Simultaneously, more on-the-ground research is needed to test newer prevention modalities, including the use of treatment-as-prevention, particularly among at-risk populations. Finally, supporting efforts to develop better, real-time measures of incidence will be critical for assessing the effectiveness of prevention efforts with greater speed and accuracy.

2 **Commit new and better-targeted resources to drive progress towards the end of AIDS**

If the world is to collectively make headway towards the end of AIDS, African and other affected governments must fulfil their responsibilities and ensure that they are effectively targeting domestic resources. First and foremost, this means that African countries must make progress towards meeting their Abuja commitments to spend 15% of their budgets on health, as they agreed to do in 2001.²³ From there, countries with a high HIV/AIDS burden must allocate an appropriate percentage of those health resources towards the control and defeat of the disease. Of course, increasing domestic resources for health does not automatically mean that outcomes will improve; complementary efforts to improve the management of programmes and broader health systems are critical. But particularly for resource rich countries, increasing domestic health financing could free up millions or even billions of dollars for antiretroviral drugs, prevention programmes and other health services for citizens in need.

Likewise, the recent trend of plateaued donor spending must be reversed. In the weeks following this report's publication, government and private sector donors will

meet in Washington, DC, to pledge new resources to the Global Fund to Fight AIDS, Tuberculosis and Malaria for the next three years. The extent to which the Global Fund is able to mobilise the full \$15 billion it needs will provide the first indication of how serious donors are about controlling AIDS, as well as TB and malaria. Indeed, a successful Global Fund replenishment could help spur renewed momentum in efforts to improve broader global health. For many countries, combining their Global Fund contributions with strengthened, more targeted bilateral AIDS programmes will also help drive progress.

In a challenging economic environment, new sources of funding must be deployed to help accelerate global efforts. This includes the development or roll-out of innovative financing schemes that could generate new revenue for health, such as a financial transaction tax, as well as more meaningful involvement of the private sector. Many companies (particularly those with affected workforces) could contribute not only financial resources, but also technical expertise that can be leveraged to improve health systems and the efficiency of drug procurement.

3

Ensure greater political and programmatic ownership of the fight against AIDS by African governments

Historically, efforts to fight HIV/AIDS globally have centred on solutions designed and led by high-income countries. While scientists, donors and advocates in these countries have all played key roles in helping to bring the AIDS pandemic nearer to a tipping point, their collective efforts have often overshadowed, or even undermined, African leadership on this issue. For decades, as this report shows, many African governments and citizens have been working to tackle the pandemic, but have often lacked the resources to fully fund the necessary treatment and prevention programmes.

In addition to increasing their financing for AIDS, African governments should accelerate their efforts to develop robust and fully costed national AIDS plans that reflect their unique epidemiological contexts. Critically, they must also build up their own capacities to manage the implementation of these plans. Wherever possible, donors should coordinate their resources through these plans, not around them, and

must assist African governments with technical training so that they can fully manage these programmes.

On a political level, African leaders can do much more to ensure that the HIV/AIDS responses in their countries are more effective, equitable and free of stigma. Tackling AIDS, particularly among marginalised populations, will in some cases require a sea-change in how these populations are viewed and treated. High-level political endorsement will be critical to ensuring access to services for all.

At the regional and international levels, African leaders should continue to build on the important frameworks developed over the past two years, including the African Union's "Roadmap for Shared Responsibility and Global Solidarity". In the months ahead, they must transform these frameworks from rhetoric into accountable, actionable plans.

4

Improve reporting and transparency of AIDS resources and results

Although transparency and accountability have risen on the international political agenda in recent years, there is currently insufficient transparency across the resources used in the fight against AIDS. This report examines a number of data sources, including the OECD DAC database, UNAIDS' domestic finance monitoring and African countries' own budget documents. However, none of these provides sufficiently comprehensive or comparable data for what resources are being spent on AIDS, through which channels and to what ends. This lack of transparency makes it difficult to assess whether or not adequate resources are being spent on the right types of interventions at local and country levels, and makes it even more difficult to analyse what impacts are consequently generated.

African countries that are not already doing so should publish at least a minimum set of key documents from the budget cycle – including the proposed, enacted and audited budgets – in a regular and timely fashion. Spending data should be sufficiently disaggregated to enable analysis of total spending on priority areas or specific programmes, such as HIV/AIDS. In order to facilitate these improvements,

donors and African governments alike must work to increase countries' statistical capacities, so that they can more regularly and effectively monitor inputs as well as progress towards disease indicators.

Further complicating this effort, many donors report on their AIDS spending through different channels, in varying levels of detail and at various times. The extent to which donor assistance appears on budget for African governments varies significantly. And as programming has increasingly become more integrated on the ground – itself a laudable aim – funding channels become similarly integrated, and it is challenging to distinguish where domestic investments end and donor investments begin. As many donors push towards a sustainable approach to the AIDS response that relies more heavily on domestic resources and leadership, donors and recipient countries must work together to standardise a way in which each actor can be clear about how, and to what extent, their financing and programmatic support is contributing to outcomes.

5

Reinvigorate HIV/AIDS on the international political agenda

In many ways, the fight against HIV/AIDS has become a victim of its own success. When the pandemic first emerged in the 1980s and 1990s, it was seen as a true emergency. But thanks to improved access to treatment, AIDS is now seen increasingly as a chronic and manageable disease, and thus has fallen sharply off the international political radar. If HIV/AIDS is to be controlled and ultimately defeated, the world must marshal resources and political energy now to avoid further costs and lives lost in years to come.

In the next 12 months, three global forums (in addition to the Global Fund's replenishment conference) will be critical for sustaining this energy: the International AIDS Conference (IAC) in July 2014, to be held in Melbourne, Australia; the G8 and G20 summits, hosted by Russia and Australia respectively; and the ongoing political debates to set the post-2015 development agenda.

IAC organisers should set an aggressive agenda that not only highlights the latest in scientific research, but also seeks to re-energise political will. The conference should highlight progress towards the beginning of the end of AIDS, and should meaningfully involve African and Asian leadership. Similarly, G8 and G20 organisers must make a concerted effort to reinstate HIV/AIDS and broader global health issues on the political agenda, and must hold each other to account on the bold promises made over the past decade. Finally, as stakeholders begin to formulate more concrete proposals for post-2015 development targets and indicators, citizens and political leaders alike must ensure that HIV/AIDS remains a topic of discussion, framed as a driver of momentum within the broader global health landscape. Ideally, any new health goal developed should include a bold, specific and achievable indicator for HIV/AIDS.



IN A RURAL VILLAGE IN ZIMBABWE,
A MAN WHO WORKS AS A TAILOR RECEIVES
ANTIRETROVIRAL TREATMENT FOR AIDS FOR FREE
AND WITHOUT DELAY THROUGH A
PROGRAMME SUPPORTED BY THE
GLOBAL FUND.

PHOTO: CHARLIE SHOEMAKER © THE GLOBAL FUND

PART 1:

TRACKING PROGRESS ON
DISEASE-SPECIFIC INDICATORS

TRACKING PROGRESS ON DISEASE-SPECIFIC INDICATORS

As the second in a series of annual accountability reports on AIDS, ONE's 2013 analysis tracks progress achieved towards a global vision – “the beginning of the end of AIDS”. ONE defines the beginning of the end of AIDS as the point in time at which the number of people newly infected with HIV in a given year is equal to or lower than the number of HIV-positive people newly receiving antiretroviral (ARV) medication in the same year. ONE's analysis also includes progress made towards three key targets on which world leaders should focus significant attention in order to make headway against the disease:

TARGET 1:
The virtual elimination of mother-to-child transmission of HIV by 2015

TARGET 2:
Access to treatment for 15 million HIV-positive individuals by 2015

TARGET 3:
The drastic reduction of new adult and adolescent HIV infections, to approximately 1.1 million annually, by 2015.

ONE's 2012 report found that the world had made significant progress in improving access to treatment and in providing services to HIV-positive women to prevent transmission of the virus to their children, but that progress had been lagging in preventing new HIV infections for adolescents and adults. In addition, ONE's calculations based on 2010–11 data trends projected that the tipping point would not be met until 2022.¹

Now, one year later, ONE's 2013 analysis shows that the world has achieved a marked acceleration in its progress towards the achievement of the beginning of the end of AIDS. Most encouragingly, updated data shows that **if current rates of acceleration in both adding individuals to treatment and in reducing new HIV infections continue, the world will achieve the beginning of the end of AIDS by the end of 2015.**²

Although data revisions account for some of the improved trajectory, much of this acceleration comes from progress made on two key indicators – treatment and prevention. By the end of 2012, 9.7 million people were on life-saving ARV treatment³ – a number that would have seemed nearly impossible just ten years ago, when treatment was either unavailable or unaffordable for nearly everyone who needed it.

Similarly, new HIV infections were down by 200,000, from 2.5 million in 2011. Although that number is still alarmingly high, at 2.3 million in the last year alone, it is a notable reduction compared with virtually no progress achieved between 2010 and 2011 and very little progress achieved since 2008.⁴

This progress is laudable and gives credibility to the vision of the beginning of the end of AIDS. Those engaged for decades in the fight against the disease – from heads of state and ministers of health to civil society organisations (CSOs) and donors – deserve praise for embracing this vision and for driving accelerated progress towards that goal. However, the attainment of this critical inflection point is not a given; as we have seen in the past, data can fluctuate and progress can stall if stakeholders become complacent. If our goals are to make this vision a reality and to be even more ambitious by pushing not just for the beginning of the end, but for the end, of AIDS within our lifetimes, then much work remains to be done to secure even greater acceleration on current levels of progress. In the following pages, ONE examines in detail progress made towards the three key indicators outlined above, as well as towards the AIDS tipping point and beyond.

TARGET 1: THE VIRTUAL ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV BY 2015

Where Do We Stand?

Without any treatment, an HIV-positive pregnant woman has a 20–45% chance of transmitting HIV to her baby during pregnancy, birth or breastfeeding. However, with proper preventive care and treatment, the risk of transmission can be dramatically reduced to as little as 5%.⁵ Even so, about 310,000 infants and children globally were newly infected with HIV in 2011 and another 260,000 in 2012.⁶

In June 2011, world leaders created the “Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive” (the Global Plan). Focused on 22 high-burden countries,⁷ the Global Plan aims to reduce mother-to-child transmission of HIV by 90% by 2015 compared with 2009 levels, when there were 400,000 new paediatric infections.⁸

In 2011, approximately 57% of HIV-positive pregnant women in low- and middle-income countries received treatment for the prevention of mother-to-child transmission (PMTCT). By the end of 2012 that rate rose to 63%, or more than 900,000 women, representing an increase of a third since 2009.⁹

In 2013, new World Health Organization (WHO) guidelines on treating AIDS stated that all HIV-positive pregnant women, regardless of CD4¹⁰ count, should receive PMTCT. This is an expansion of eligibility from the previous guidelines, which stipulated that eligibility in resource-limited settings began for individuals with a CD4 count of 350 cells/mm³ or less. By recommending that all HIV-positive pregnant women receive PMTCT treatment, the hope is that the rate of new child infections will diminish even more rapidly.¹¹

The world has made great progress in reducing the annual number of new child HIV infections as more pregnant women have been able to access PMTCT services: the 2012 figure was down more than 50% compared with 2001, and 35% since 2009.¹² In sub-Saharan Africa, seven countries – Botswana, Ethiopia, Ghana, Malawi, Namibia, South Africa and Zambia – are helping to drive this progress, having reduced new HIV infections among children by 50% or more since 2009.¹³

Yet even with this progress, if the current rate of reduction were to hold, there will still be approximately 110,000 new child infections in 2015, far more than the goal of fewer than 40,000.¹⁴

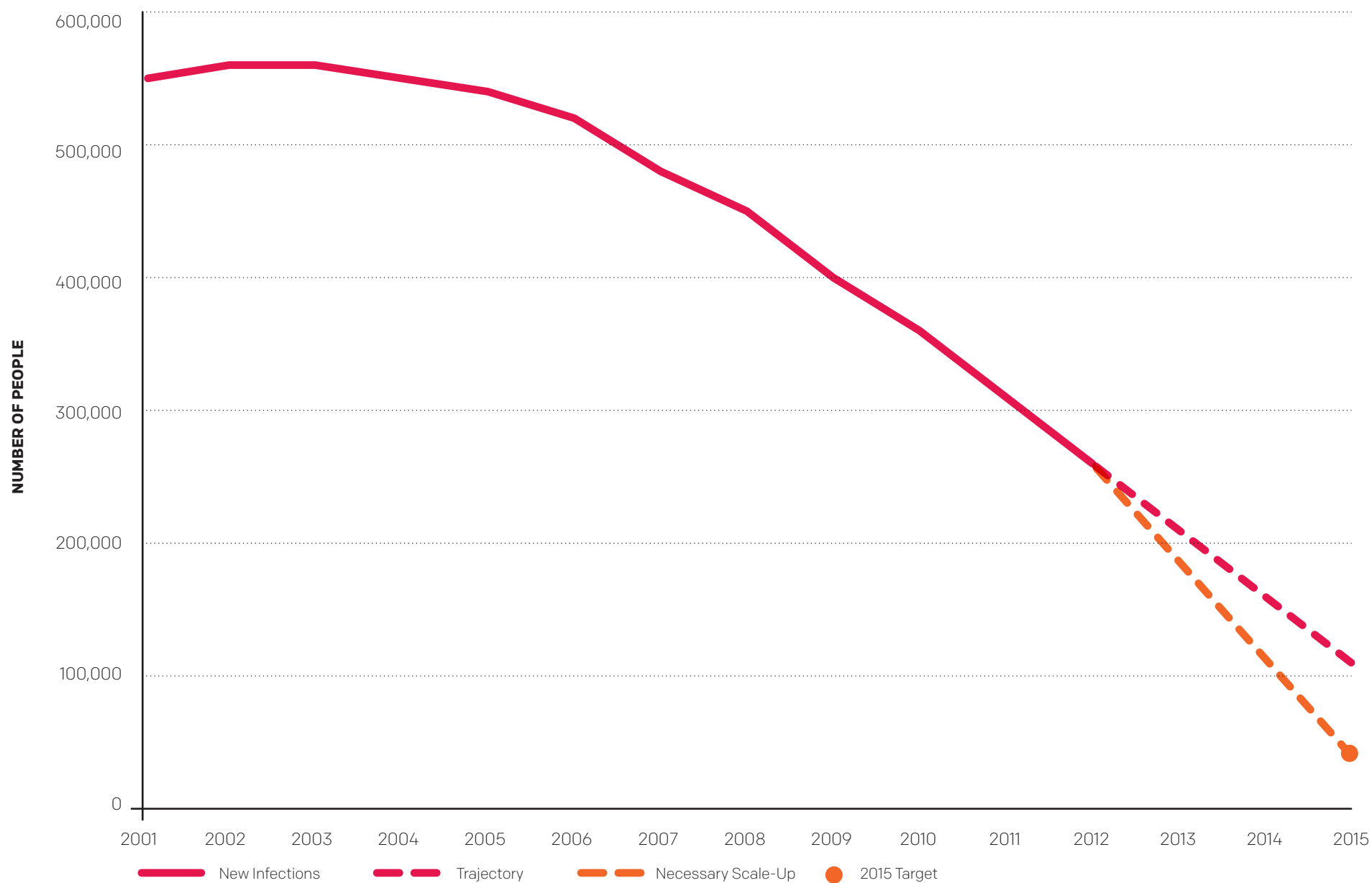
What More Must Be Done?

1) **Accelerate adoption of the 2013 WHO HIV treatment guidelines.** In previous years, WHO guidelines recommended a number of options to countries for providing time-limited PMTCT regimens for HIV-positive pregnant women. The new 2013 treatment guidelines change those recommendations in two key ways.¹⁵ First, they now recommend that all pregnant women – regardless of CD4 count – take ARVs both for their own health and to prevent transmission of the HIV virus to their babies during pregnancy, delivery and breastfeeding. Second, they harmonise treatment regimens so that the specific medication that an HIV-positive mother takes to prevent transmission to her child is the same medication that she would remain on for her own health once PMTCT treatment is completed (as opposed to two separate medications). These two changes are particularly crucial for ensuring that women are able to adhere to the appropriate treatment

regimens. In addition, because the new guidelines call for continuing treatment beyond pregnancy and breastfeeding, they help ensure that an HIV-positive mother is able to reduce the risk of HIV transmission in any future pregnancies and also provide her with treatment for life, for her own health. Some countries, like Malawi, have been ahead of the curve, implementing this policy for a number of years to great success. For countries in which these guidelines have not yet been adopted, technical partners must help assess when and how this should be done, and at what financial cost. Governments, with the support of technical partners, must evaluate additional costs to countries in implementing these treatment guidelines as soon as possible, and increased domestic and international resources should help fill any resource gaps.

2) **Better link HIV testing and services for women with routine care.** HIV testing should be available for all women at the onset of pregnancy, and counselling and antiretroviral medicines should also be available for all pregnant women living with HIV to prevent transmission to their children. However, many women are still not able to access these services while they are pregnant and as they breastfeed. HIV testing and the initiation of any treatment for newborn babies should also be a part of routine care and should be done as soon as possible after birth. The importance of initiating treatment for newborns was exemplified by a noteworthy case in the United States in 2013, in which an HIV-positive baby born in Mississippi was tested soon after birth, treated immediately with the most effective regimen and functionally cured of HIV by the age of two.¹⁶ Although it is not yet clear to what extent this success is replicable,

FIGURE 1: New HIV Infections Among Children (Aged 0–14 Years)



Sources: UNAIDS and ONE calculations

particularly in low-income settings, it does serve to highlight the benefits of rapid testing so that HIV status can be identified and treatment for infants can be initiated earlier where appropriate.

- 3) **Improve linkages between PMTCT and other global health interventions.** The Global Plan underscores the importance of scaling up broader reproductive and maternal health services to ensure that an HIV-positive woman can control when she becomes pregnant, that she can stay healthy during and following pregnancy and that she can raise healthy children. However, both policy-makers and implementers often insufficiently address the critical links between

HIV/AIDS and reproductive and maternal health. This breakdown occurs both at the country level, where health services for women are often delivered in isolation from one another, and at the policy-making level, where the various political leaders and advocacy communities working on these issues do not work closely together. All invested stakeholders must view progress as interlinked, and countries should develop national plans that link the issues more coherently.

- 4) **Increase attention to high-burden countries that are holding back progress.** To eliminate child infections, donors and implementers must pay particular attention to the needs of a number

of countries that are currently holding up progress. The number of childhood infections has dropped very little in Angola, Chad, Côte d'Ivoire, the Democratic Republic of Congo, Lesotho and Nigeria since 2009. In particular, Nigeria is home to one-third of the world's total paediatric HIV cases but has reduced child infections by just 8% since 2009, making less progress than any other priority country included in the Global Plan. In these countries, political leaders must exhibit greater commitment to the achievement of the virtual elimination goal within a reasonably ambitious timeframe, and technical experts should work with countries to assess where critical roadblocks to progress exist and to address them.

TARGET 2: 15 MILLION PEOPLE ON AIDS TREATMENT BY 2015

Where Do We Stand?

In 2011, there were just under 15 million HIV-positive people in need of life-saving ARV treatment, based on WHO treatment guidelines; of that total, only 8.1 million at the time were receiving treatment. In response, world leaders came together at the UN that year and committed to scaling up their collective efforts to ensure that all 15 million people had access to treatment by 2015.

Despite some incremental gains, in last year's report ONE called for an accelerated expansion of access to treatment; the rate at which people were being added to treatment each year was not sufficient to meet the goal of 15 million on treatment by 2015. However, revised and more accurate data released in 2013 shows that the number of people being added to treatment has, in fact, been gradually increasing over the past few years, contrary to data that was available in 2012. New data shows that 1.3 million people were added to

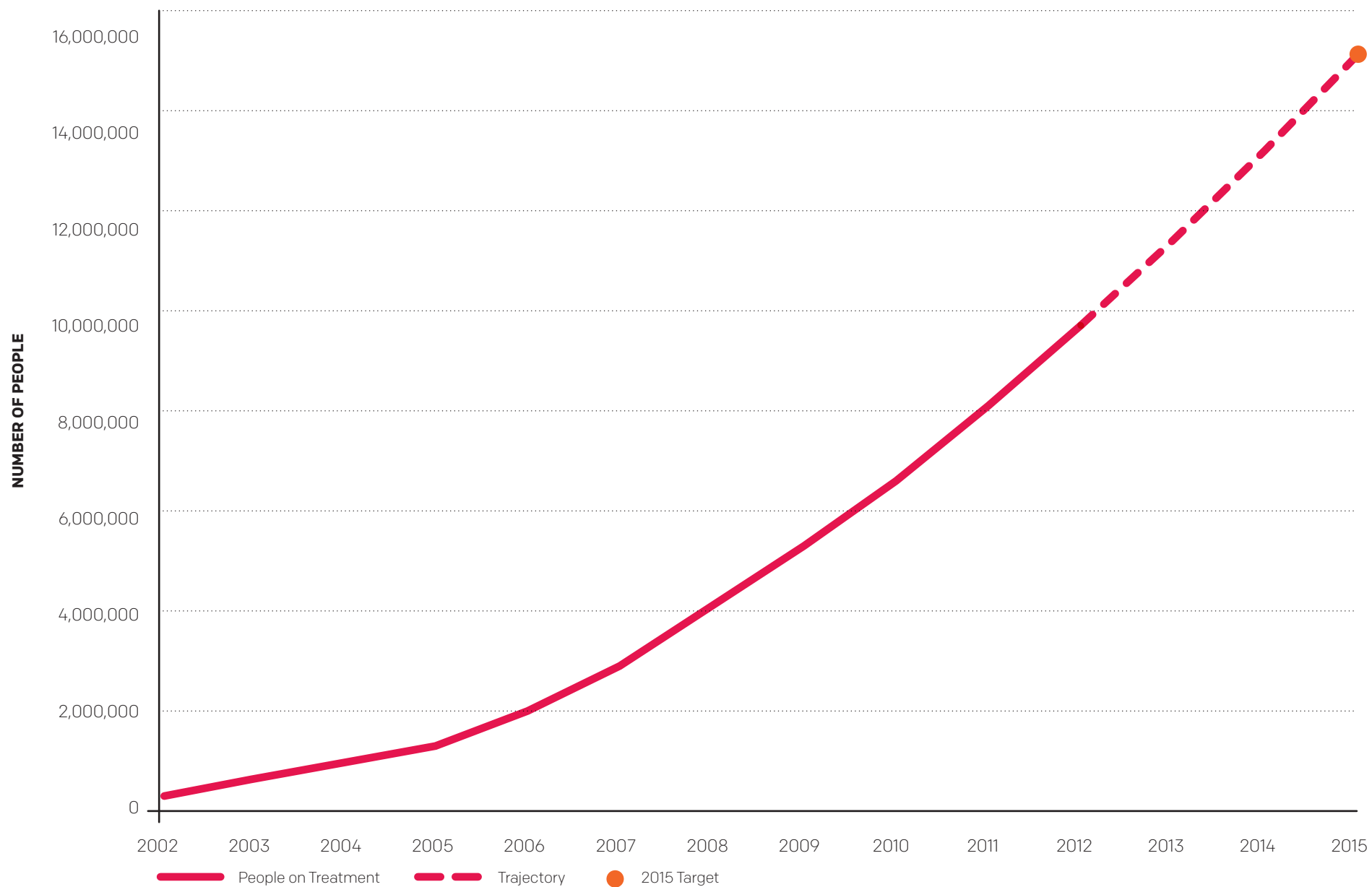
treatment in 2010, 1.5 million in 2011 and 1.6 million in 2012. If this trend continues, the world will exceed the 2015 target, with 15.1 million people on treatment by the end of 2015.¹⁷

Ensuring that more people have access to treatment for their own health is an important aim, but scientific research, grounded in the landmark HPTN 052 trials, also shows that when an HIV-positive individual goes on treatment, he or she is up to 96% less likely to pass the virus on to others, providing clear prevention benefits.¹⁸ Studies have also shown that earlier initiation of AIDS treatment is more effective, both in treating the patient and in preventing sexual transmission to his or her partner(s). As such, in 2013 WHO announced new AIDS treatment guidelines to expand the threshold of treatment eligibility from people with a CD4 count of 350 cells/mm³ to those with a CD4 count of 500 cells/mm³ – essentially stipulating that HIV-positive individuals should begin ARV treatment long before the virus spreads

throughout the body and before they become more ill. This change in guidelines has dramatically increased the number of people qualifying for treatment from about 17 million to 28 million globally,¹⁹ requiring country leaders and treatment suppliers to evaluate how they will scale up treatment efforts to meet this new, additional demand.²⁰ WHO calculates that the cost of providing this level of treatment coverage will represent roughly a 10% annual increase over previous HIV/AIDS costing estimates.²¹

If progress continues at the current rate, the world can meet and surpass the original target of 15 million people on treatment by 2015, but much work remains to achieve the significant scale-up in service delivery needed to ensure universal access to treatment for all who qualify.

FIGURE 2: Number of People on Antiretroviral (ARV) Treatment



Sources: UNAIDS and ONE calculations

What More Must Be Done?

1) **Develop realistic, country-specific plans for adopting the new WHO recommendations.** WHO should consult with country partners to ensure a feasible plan for implementing its new recommendations, being particularly mindful of additional associated costs. For countries that have achieved or have come close to universal access to treatment at the CD4 350 cells/mm³ level, this may not be so difficult. For countries that are further from meeting the original target, however, there is not yet a clear enough indication as to how and when adopting the new guidelines will be practical and cost-effective. This guidance from WHO should then shape policy-makers' approaches to scaling up sources of funding for treatment programmes at the country level. Critically, however, these financing and implementation plans must also ensure that any costs associated with scaling up treatment do not take away from critical investments in prevention and care services.

2) **Expand African capacity for producing cost-effective antiretroviral drugs.** Despite Africa being home to almost 80% of people on AIDS treatment, up to 80% of the medication taken by HIV-positive Africans is imported from India.²² This means that African governments and their partners must pay import duties, increasing the cost of treatment per person, and it leaves the continent reliant on a single supplier country, over which it has no jurisdiction or control, for life-saving medication for its citizens. Over the past year, there have been increasingly loud calls for African production of ARVs, most notably by the African Union in its Roadmap document²³ and during the Abuja Plus 12 conference held in Nigeria in July 2013.²⁴ Increasing local production of AIDS drugs would not only greatly reduce costs over time – thereby allowing for the treatment of more people – but would also foster greater ownership of the continent's AIDS response.

3) **Improve treatment adherence and retention.** Despite an accepted goal of 95% retention for ARV treatment over a 12-month period, a recent study showed that the average among populations in select low- and middle-income countries was only about 86% retention.²⁵ For some AIDS financing mechanisms, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), it is unclear how consistently they monitor and account for retention and adherence to care: an independent assessment found that adherence "is a big problem".^{26, 27} Improving these rates is crucial for ensuring the health of citizens enrolled on treatment, but it is also critical for ensuring that existing treatment options remain effective, as poor adherence can lead to drug-resistant HIV, which necessitates more expensive second- or third-line treatment.

TARGET 3: THE DRASTIC REDUCTION OF NEW ADULT AND ADOLESCENT HIV INFECTIONS, TO APPROXIMATELY 1.1 MILLION ANNUALLY, BY 2015

Where Do We Stand?

In 2012, there were 2 million new adult and adolescent HIV infections, down from 2.2 million new infections among that demographic group in 2011.²⁸ After years of largely stalled progress since 2008, this drop of about 200,000 new infections in just one year is important. Moreover, the annual number of new HIV infections among adults and adolescents decreased by 50% or more in 26 countries between 2001 and 2012. At the same time, however, global rates of reduction in new infections have been too gradual,

and the world is severely off track for reducing new infections to just 1.1 million per year by 2015. If the current rate of reduction continues, there will be 1.4 million new infections in 2015 – 300,000 more than the goal.²⁹ Even if rates of access to treatment increase significantly, such that the number of people newly added to treatment exceeds the number newly infected with HIV – as is predicted in 2015 to meet the beginning of the end of AIDS – millions of new HIV infections ensure that the fight against AIDS and the costs associated with it will extend for years, if not decades.

Fortunately, there are a number of tools at our disposal that can more effectively prevent infections if they are brought to scale and targeted at the right populations. Prevention techniques that have been used for a decade or more, including distributions of male and female condoms and behaviour change programmes, can now be coupled with a more aggressive roll-out of newer and effective biomedical prevention techniques for specific populations, such as voluntary medical male circumcision and pre-exposure prophylaxis (PrEP). Nevertheless, such services have been slower to scale up than many initially thought. This is

particularly the case for male circumcision, with only 3.2 million African men circumcised by 2012. Although this represents significant progress from 2011, it remains far off track for reaching a target of 20 million circumcisions by 2015.³⁰ The incremental progress achieved so far, however, suggests that great gains could be achieved if these prevention programmes can grow to scale.

WHO's new 2013 treatment guidelines, which expand the number of people who qualify for treatment from approximately 17 million to 28 million, are also likely to have an impact on this prevention target. Because treatment also works as prevention, WHO projects that implementation of the new guidelines will reduce the number of people contracting HIV in 2025 from 1.25 million, based on the 2010 guidelines, to about 800,000 via the 2013 guidelines.³¹ However, while this provides hope for a substantial drop in new infections after 2015, prevention efforts must be significantly scaled up in the immediate future.

What More Must Be Done?

1) **Focus on most at-risk populations (MARPs).** The number of new HIV infections is decreasing in most demographics but is increasing among key populations, including men who have sex with men (MSM), transgendered people, injection drug users (IDUs) and sex workers. Discriminatory laws and practices, stigma against these demographics and a lack of political will mean that few effective programmes target these groups. In addition to a scale-up of traditional interventions, an increased focus on preventing infections among these key demographics is also necessary (for more detail, see section on MARPs on page 25).

2) **Formulate global consensus on a concrete, actionable HIV prevention goal.** Despite widespread consensus on goals for a reduction in paediatric infections and for scaling up access to AIDS treatment, as well as political endorsement for those goals through the UN's 2011 High Level Political Forum on HIV/AIDS, no such widely accepted target exists for reducing non-paediatric infections overall. UNAIDS has promoted as one of its ten core targets the goal of "reduc[ing] sexual transmission of HIV by 50% by 2015", which in some ways captures the adult and adolescent population. To date, however, this target has not been as widely adopted, endorsed or socialised by global stakeholders as have other 2015 AIDS targets. As a result, global actors do not yet feel collectively accountable for the achievement of a specific reduction in new infections, and policy prioritisation and funding reflect this lack of accountability. Improving global efforts to track HIV incidence rates in a scientific way, rather than through modelling based on small sample sizes, will significantly enhance the ability of practitioners and policy-makers to monitor prevention efforts and adapt them for greater impact in real time.

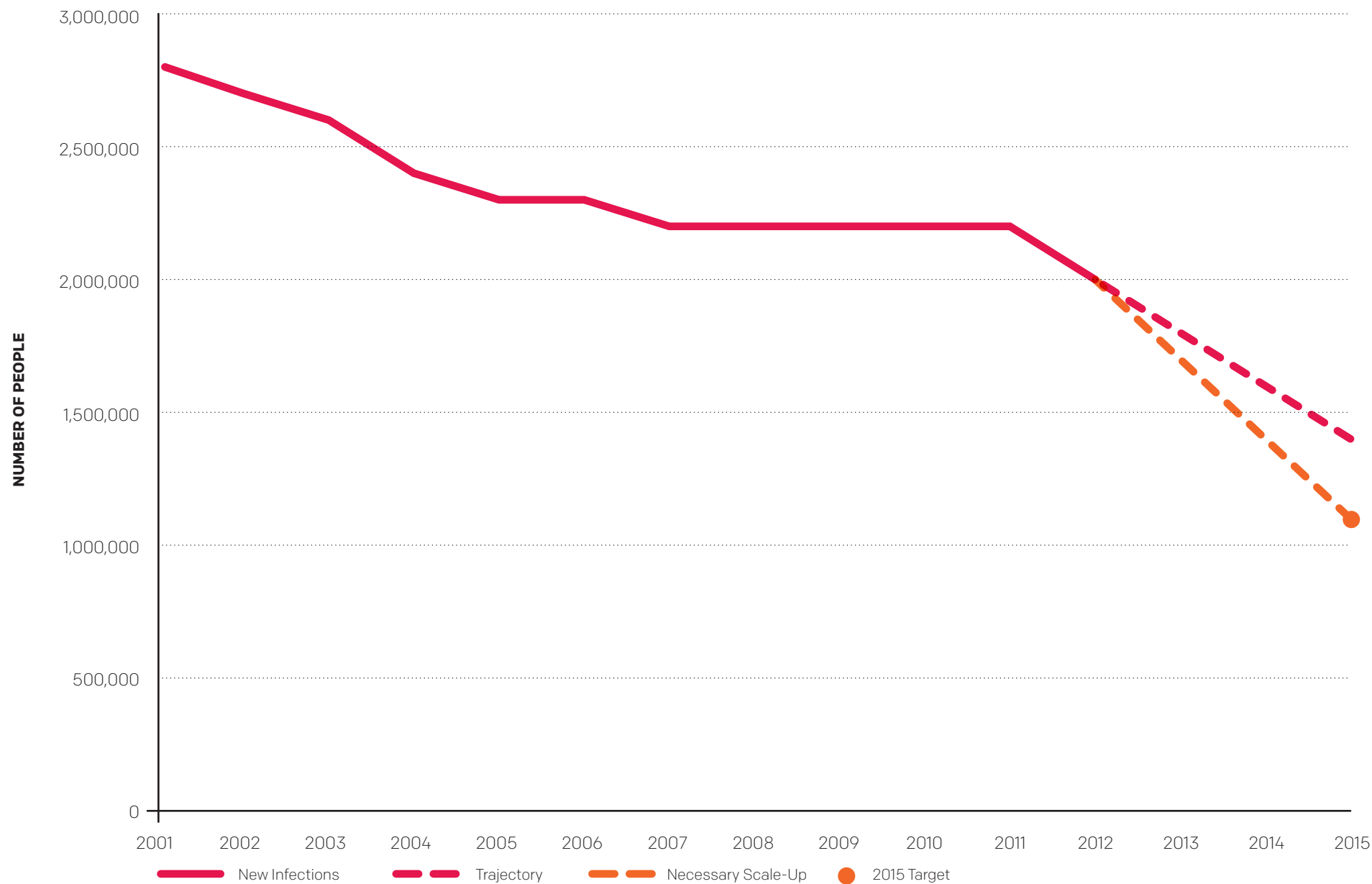
3) **Tailor combination prevention strategies to better match the key drivers of HIV transmission.** Historically, AIDS epidemic trends and projections have been based on relatively rough models. More recently, countries have been revisiting their own national AIDS plans and, with technical support, re-analysing their national and localised epidemics to better map out effective prevention strategies. Similarly, many funding mechanisms have been reassessing their

allocation schemes and considering ways to better tailor financial support to reflect the need for more effective combination prevention strategies. These efforts are critical to ensuring that financing for prevention is spent effectively, particularly in a globally resource-constrained environment.

4) **Once countries have a clearer understanding of trends within their national AIDS epidemics, they should implement prevention programmes that are better aligned with these trends.** In particular, focus ought to be put on scaling up promising biomedical interventions, such as voluntary medical male circumcision, in appropriate contexts. The 2011 Investment Framework, which outlines one approach for how countries could strategically spend their resources to better prevent new infections, has spurred useful dialogue and is now informing some national and local planning processes.

5) **Scale up research and development for new prevention technologies.** Declining funding for HIV R&D in recent years has inhibited the development of new prevention tools that could combat HIV even more effectively. A few promising trials of tools and products are in progress, but funding needs to be scaled up appropriately to support research on innovative, diverse interventions (for more detail, see section on R&D, page 26).

FIGURE 3: New HIV Infections Among Adults (Aged 15+)



Sources: UNAIDS and ONE calculations

BEYOND THE THREE TARGETS

The three targets outlined above are essential for assessing progress towards the control, and ultimate defeat, of HIV/AIDS. However, many other underlying issues and conditions play a key role in determining how rapidly, sustainably and effectively the world can achieve an AIDS-free generation.³² For instance, it is nearly impossible to eliminate AIDS without providing adequate care and treatment to people who have tuberculosis (TB) while also being HIV-positive. Meanwhile, as HIV infection rates fall for most demographics, the remaining new infections are increasingly among populations that are marginalised and difficult to reach, including sex workers, injection drug users and LGBT individuals.

Reaching these populations requires both strengthened health systems and new tools and mechanisms to more effectively provide treatment, prevention and care services. While technology to prevent and treat HIV has come a long way in recent years, much more research and development (R&D) is needed to ensure that modern tools are in place to attack an ever-evolving epidemic. As the number of people in need of HIV/AIDS services grows exponentially, countries must adequately strengthen their health systems to provide care and treatment for those affected and to more accurately measure disease burden, epidemiology and the impact of services on the ground.

HIV/TB Co-Infection

The HIV virus attacks the immune system, making a person more vulnerable to other diseases. In low- and middle-income countries, TB currently poses the greatest co-infection threat to HIV-positive people. Without treatment, it is lethal in up to two out of every three cases.³³ One in four HIV-related deaths is caused by TB.³⁴ Currently, there are no adequate vaccines or prophylactic drugs to prevent TB, although treatment

with ARVs reduces the risk that an HIV-positive person will develop TB by 65%.³⁵

In 2012 alone, 320,000 people died of HIV-associated TB.³⁶ A global target aims to halve the number of TB-related deaths amongst people living with HIV from a baseline of 454,000 in 2004 to fewer than 250,000 in 2015.³⁷ But in 2012, 41 high-burden HIV/TB countries (most of which are in sub-Saharan Africa) accounted for nearly that number,³⁸ leaving efforts to meet the global target significantly off track.

Thanks to improved detection and treatment services that are increasingly provided in combination with HIV services, the global TB death rate for HIV-positive people decreased by 36% between 2004 and 2012. Additional progress is likely on this front, as a new rapid TB test³⁹ rolls out in 21 countries in 2013⁴⁰ and several new TB drugs, including vaccines, are in clinical trials.⁴¹

As with HIV programmes, not all populations are being reached with TB services, and countries with stigmatised and criminalised prison or sex-worker populations, such as those in former Soviet republics, are experiencing large increases in HIV/TB co-infection rates.⁴² Additional challenges are the emergence of drug-resistant strains of TB (multi-drug-resistant strains, MDR-TB,⁴³ and extensively drug-resistant strains, XDR-TB⁴⁴), a lack of new TB drugs, and costs of several thousand dollars per patient for existing drugs in all regions to tackle this problem. There is an estimated funding gap from international sources of \$1.6 billion for 2014–16, of which 58% is required to finance programmes in Africa.⁴⁵

The Epidemic Among Most At-Risk Populations

The number of new HIV infections is declining globally among nearly every demographic group, except for most at-risk populations (MARPs). In many countries,

a lack of political will and stigma are blocking much-needed HIV prevention and care programmes from reaching the segments of society most at risk of acquiring the virus: men who have sex with men (MSM), injection drug users (IDUs), sex workers and prisoners.

In many countries around the world, and especially in much of sub-Saharan Africa, homosexuality is against the law, and homosexual individuals are frequently the victims of stigma and harassment. The few existing national or local programmes targeting MSM and transgender individuals are weakened as people seeking treatment frequently face harassment by all segments of society – including, in some cases, by the health workers meant to treat them. This situation is both exemplified and exacerbated by a relative lack of funding for programmes targeting this demographic. Although both PEPFAR and the Global Fund have stated commitments to address the HIV epidemic among MSM and transgender individuals, few funding proposals from country partners outline programmes for MSM and even fewer of these proposals are funded. For example, a recent case study of six southern African countries and MSM found that of 29 total grant proposals submitted, 12 did not mention MSM at all, nine mentioned MSM but did not state any specific programmes or activities, and eight contained activity-level data. Of the 19 proposals that were accepted, 11 made no mention of MSM, six mentioned MSM but did not state any specific activities and only two contained activity-level data.⁴⁶

The reality for IDUs and sex workers is similar. Little funding goes to these populations, in part due to the United States' so-called "Anti-Prostitution Pledge" that existed until 2013 and mandated that HIV/AIDS funding could go only to entities that had explicitly opposed prostitution and sex-trafficking, thus presenting an

obstacle for PEPFAR in funding programmes to help sex workers. The Global Fund has no such limitations and does provide some funding for education and prevention programmes aimed specifically at sex workers and IDUs, but this funding is still insufficient for global needs.

Research and Development (R&D)

Historically, HIV/AIDS research has been the primary focus of global health R&D. Major organisations now exist for the sole purpose of researching preventive mechanisms or cures for the disease. Meanwhile, HIV/AIDS received anywhere between 33.8% and 42.3% of total global health R&D funding between 2007 and 2011. Much of the focus within HIV/AIDS has been on the development of preventive vaccines, which has accounted for close to 60% of all HIV/AIDS R&D funding since 2007.⁴⁷

This R&D work has helped achieve important breakthroughs in biomedical tools to prevent and treat HIV. Among the most effective are male condoms, microbicides, more sophisticated ARVs that can fight more evolved forms of HIV, and pre-exposure prophylaxis (PrEP). In addition, voluntary medical male circumcision, which reduces the risk of heterosexually acquired HIV infection in men by up to 60%, has seen enormous advances in recent years.⁴⁸ In particular, PrePex is the first non-surgical adult circumcision device that has shown promising results. As of late 2013, it is being tested on more than 22,000 men across southern and eastern Africa, with final results expected in 2014. The primary surgical adult circumcision device is the Shang Ring, which completed testing in late 2011.⁴⁹

Efforts to develop a vaccine that can prevent or cure HIV have shown promise in two current trials. In particular, a trial sponsored by the International AIDS Vaccine Initiative (IAVI) is now testing a preventive

vaccine on humans in Kenya, Rwanda and the UK. Results are not expected, however, for 5–10 years.⁵⁰ In late 2013, a vaccine developed by a researcher at the University of Western Ontario completed Phase I Clinical Trials as the first and only preventive HIV vaccine based on an inactive whole virus. It was completed with no adverse effects in any patients. Phase II, which will test the immune response, has not yet begun, however.⁵¹

HIV/AIDS and Health Systems

A “health system” is comprised of all resources needed to provide health services, including the health workforce (physicians, nurses, midwives and other health-care workers); infrastructure (hospitals, hospital beds); and medical technologies and devices. While recent resource mobilisation for AIDS and other infectious diseases has been significant, there has not been a comparable investment in health systems, which are critical to sustain improvements. Ideally, strong health systems ensure that disease-specific programmes are coordinated, so that patients can reap the benefits of linkages between different interventions and programmes (i.e. bringing together prevention and treatment services for infectious diseases, sexual reproductive health and maternal health into one clinic or hospital setting). A lack of predictable financing makes it difficult for governments to plan for the long term and invest in strengthening their health systems – especially in components such as health workers or maintenance of transportation vehicles and health facilities, which have significant recurring costs from year to year.

Weaknesses in health systems, and in particular shortages of health workers, restrict opportunities to scale up outreach in many parts of sub-Saharan Africa. Globally, there is an estimated health worker shortage of 4.3 million in 57 countries; 36 of the worst affected countries are in sub-Saharan Africa.⁵² Additionally,

although sub-Saharan Africa has 25% of the global burden of disease, it has only 3% of the world’s health workers.⁵³ Despite these challenges, however, countries such as Zambia, Malawi, Rwanda and Ethiopia have managed to provide AIDS testing and treatment services in remote areas by decentralising efforts and by training voluntary community health workers. In Rwanda, for example, where there are fewer than 1,000 doctors, 45,000 community health workers have been trained. Those workers have helped to deliver decentralised services, and ultimately have helped achieve a significant reduction in infection and death rates due to AIDS, TB, malaria and broader maternal and child health issues.⁵⁴

Additional investments in health systems can significantly improve HIV testing, treatment and prevention rates – each of which is critical to ensuring the beginning of the end of AIDS. Training more health workers and laboratory technicians, particularly in rural areas, allows for more patients to be tested and treated correctly. Improved infrastructure and access to vehicles lead to safer storage and transportation of medicines. Access to medical equipment and machines makes testing and monitoring not only much faster, but more accurate. Finally, improved data collection and management ensure that budgeting and policy decisions can be based on evidence.

ACHIEVING THE BEGINNING OF THE END OF AIDS AROUND THE WORLD

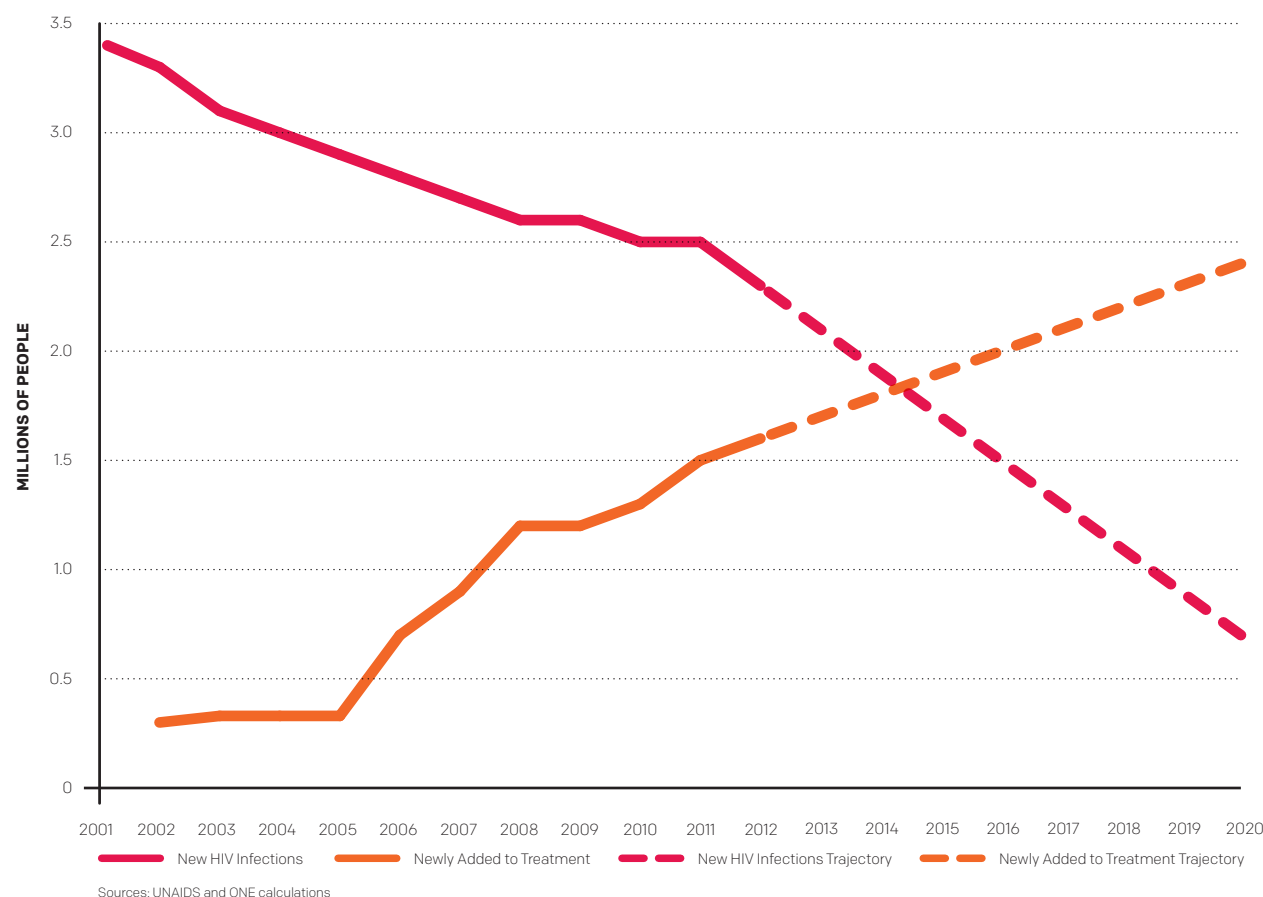
Thus far this report has assessed global progress on individual indicators that contribute to the beginning of the end – and the ultimate control and defeat – of AIDS. However, progress towards this overarching vision should not be seen as uniform; indeed, different regions in the world have progressed at varying speeds towards the achievement of the tipping point and have prioritised different interventions to varying degrees. This section outlines current trends in the global AIDS epidemic and provides brief overviews of the epidemic in the most affected regions in order to better understand the breakdown of progress against AIDS.

Global

Over the past few years at the global level, there has been an acceleration in the number of people added to treatment, complemented by a drop in the number of new infections between 2011 and 2012. Globally, the tipping point ratio – calculated by dividing the number of new HIV infections by the number of people added to treatment – in 2012 was 1.4, down from 1.7 in 2011 and approaching 1.0, which would mark the beginning of the end of AIDS.⁵⁵ If these recent trends continue, the world will be on track to reach the beginning of the end of AIDS by 2015, seven years ahead of previous estimates.

Some of this acceleration comes as a result of new and more accurate data released in 2013 for previous years, which altered the rate of progress assumed in our previous projections. Some of this acceleration, however, is driven by real progress achieved in the past year. In particular, the rate by which new HIV infections were reduced has increased substantially over the course of the last year: there were roughly 200,000 fewer new infections in 2012, compared with no change to the number of new infections in 2011, and roughly 100,000 fewer in 2010. At the same time, 1.6 million new HIV-positive people were able to access treatment in 2012, up from 1.5 million in 2011 and 1.3 million in 2010.

FIGURE 4: Current Trajectories for Global HIV Prevention and Treatment Efforts



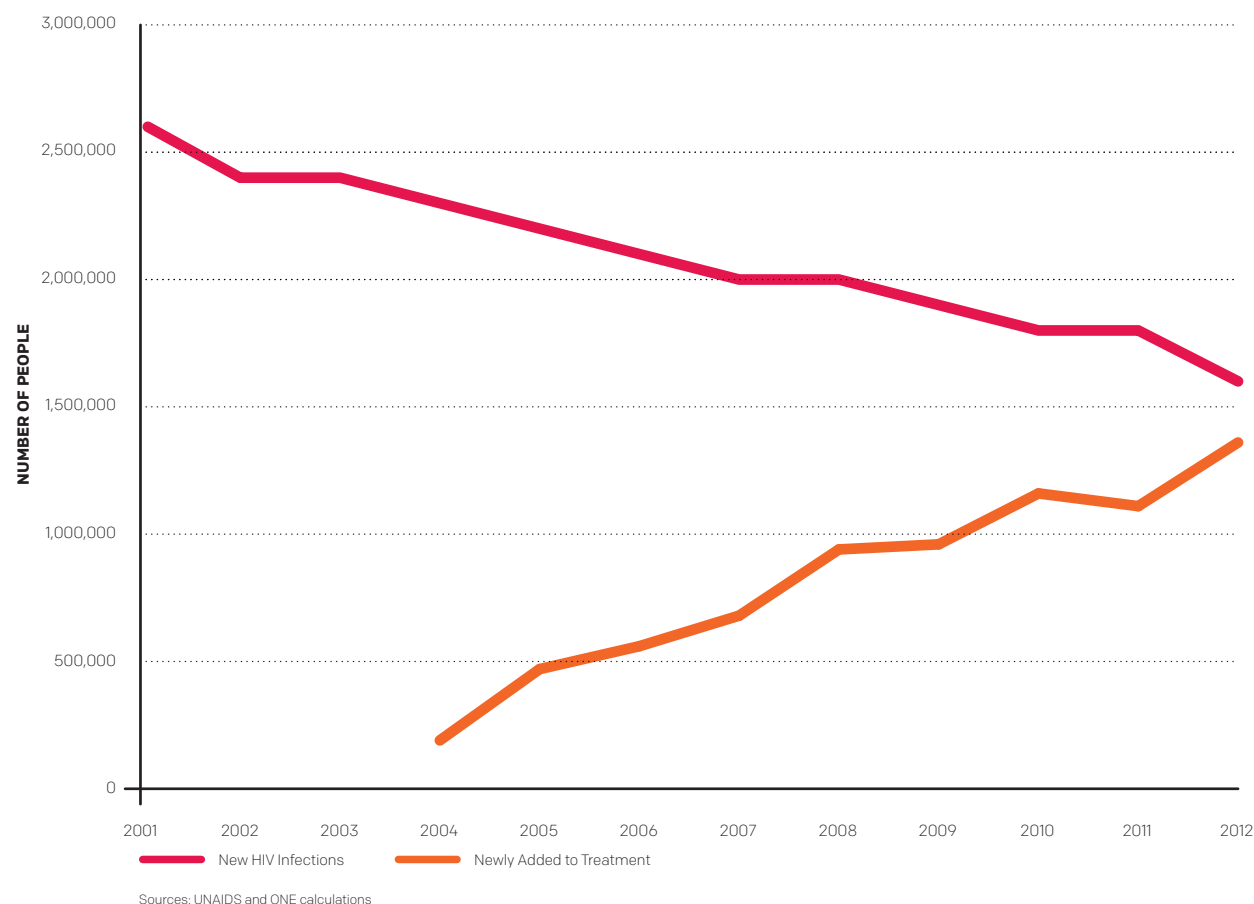
Sub-Saharan Africa

In recent years, sub-Saharan Africa – the region most affected by the HIV/AIDS epidemic – has shown incredible progress, thanks in part to heavy investment by international donors (total global spending on HIV/AIDS programmes in sub-Saharan Africa exceeds global spending on programmes in any other region) and, in more recent years, thanks to increased domestic spending on HIV/AIDS programmes.⁵⁶

The region had an adult HIV prevalence rate of about 5.8% in 2001, and 21.7 million adults and children were infected with the virus. By 2012, the adult prevalence rate had dropped to 4.7% but the number of people infected had risen to 25 million, due to population growth. However, the number of new infections per year has been dropping steadily, from 2.6 million in 2001 to 1.6 million in 2012 – a fall of 1 million in just over a decade. Meanwhile, the number of people on treatment jumped from 50,000 in 2002 to 7.5 million in 2012. Twelve million people were eligible for treatment under the 2010 WHO guidelines, indicating a treatment coverage rate of only 62.5% – and the coverage gap will grow significantly with the application of the 2013 WHO guidelines. With about 1.4 million people newly added to treatment in 2012 and 1.6 million new infections, sub-Saharan Africa is now very close to the AIDS tipping point, with a ratio of 1.18.⁵⁷ This is particularly impressive given that the region had a ratio of 11.9 in 2004, just eight years ago.⁵⁸

Of the Global Plan's 22 priority countries for PMTCT, 21 are located in the region, as sub-Saharan Africa has traditionally had high numbers of babies born with HIV. However, the increased focus on PMTCT in the region – especially thanks to pressure from stakeholders involved in the development and implementation of the Global Plan – has reduced the number of transmissions dramatically. In 2001, there were 500,000 new child infections, a number that had dropped by more than half – to 230,000 – by 2012.⁵⁹

FIGURE 5: Current Trends in Prevention and Treatment Efforts in Sub-Saharan Africa



Although the region as a whole is making great progress, individual country epidemics vary greatly, and it is impossible to make recommendations that are applicable across the entire region. For example, Nigeria is home to 3.4 million HIV-positive people, or 14% of the region's total infections. There were another 259,000 infections last year – down from 284,000 three years ago – but just 59,000 people were added to treatment. Meanwhile, South Africa has experienced a much larger epidemic but has

managed to control it. With 6 million people living with HIV and 367,000 newly infected, the country added nearly 449,000 people to treatment in 2012.⁶⁰ The most important steps for sub-Saharan Africa as it progresses towards the beginning of the end of AIDS are to focus on breaking down the epidemic to address country-level needs, and provide relevant interventions accordingly, while continuing to increase domestic funding and accountability for results.

Latin America and the Caribbean

Latin America and the Caribbean have had mixed success in tackling the AIDS epidemic in recent years. In the Caribbean, adult prevalence rates fell from 1.3% in 2001 to 1% in 2012. Although it has the second highest rate of new HIV infections of all developing regions,⁶¹ the number of new infections per year has more than halved, from 25,000 in 2001 to 12,000 in 2012. Latin America has had less marked success. Its adult prevalence rate fell from 0.5% in 2001 to 0.4% in 2012, while the number of new infections decreased only marginally, from 97,000 in 2001 to 84,000 in 2012. The region has had slightly more success in increasing the proportion of people on ARVs. In 2012, over 70% of adults in need of treatment were receiving it in both Latin America and the Caribbean, although this was still far from the goal of 90% coverage. In total, 640,000 adults and children were receiving treatment in Latin America, and some 84,000 in the Caribbean.⁶² In 2012, the Caribbean had achieved the AIDS tipping point, with 12,000 new HIV infections and 12,649 people added to treatment to give a ratio of 0.95 – significant progress since 2004, when it had a ratio of 6.9. Latin America, however, had a ratio of 1.23 – a regression from 2011's ratio of 0.89, when it had hit the tipping point, and close to the 2004 ratio of 1.69.⁶³

In preventing new HIV infections among children, the region has been relatively successful. The Caribbean boasts PMTCT coverage of more than 95% for HIV-positive pregnant women, and Latin America had coverage of 83% in 2012.⁶⁴

Overall, the region has made weak progress on bringing down new HIV infections among adults in the past decade. Much more must be done to increase access to prevention mechanisms, especially among certain marginalised populations that are key drivers of the epidemic. Specifically, MSM represent the largest source of new infections in the region (ranging from 33% in the Dominican Republic to 56% in Peru⁶⁵)

FIGURE 6: Current Trends in Prevention and Treatment Efforts in the Caribbean

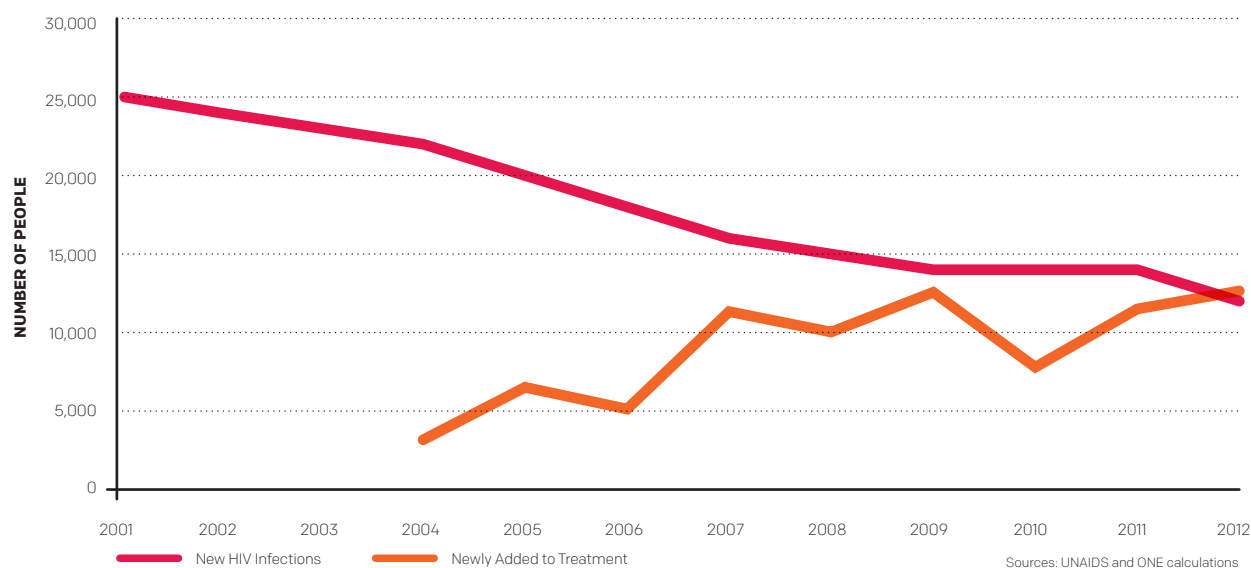
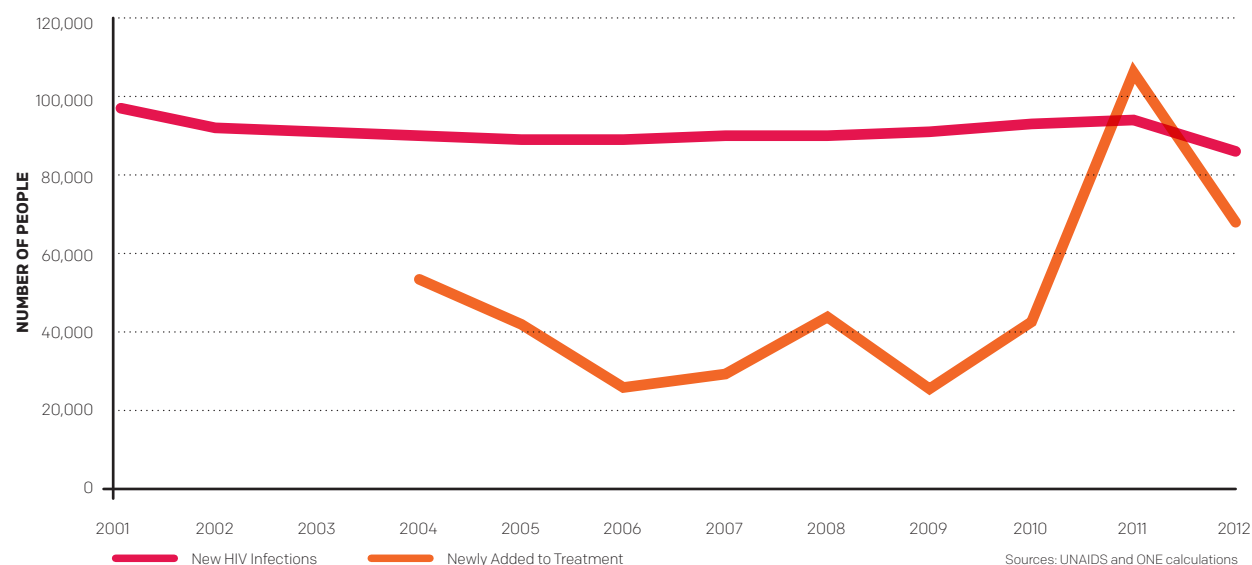


FIGURE 7: Current Trends in Prevention and Treatment Efforts in Latin America



and overall account for 12% of HIV prevalence.⁶⁶ HIV prevalence rates are, on the other hand, relatively low among IDUs and female sex workers.⁶⁷ As in many other regions, stigma against these populations plays a large role in hindering access to testing or treatment.

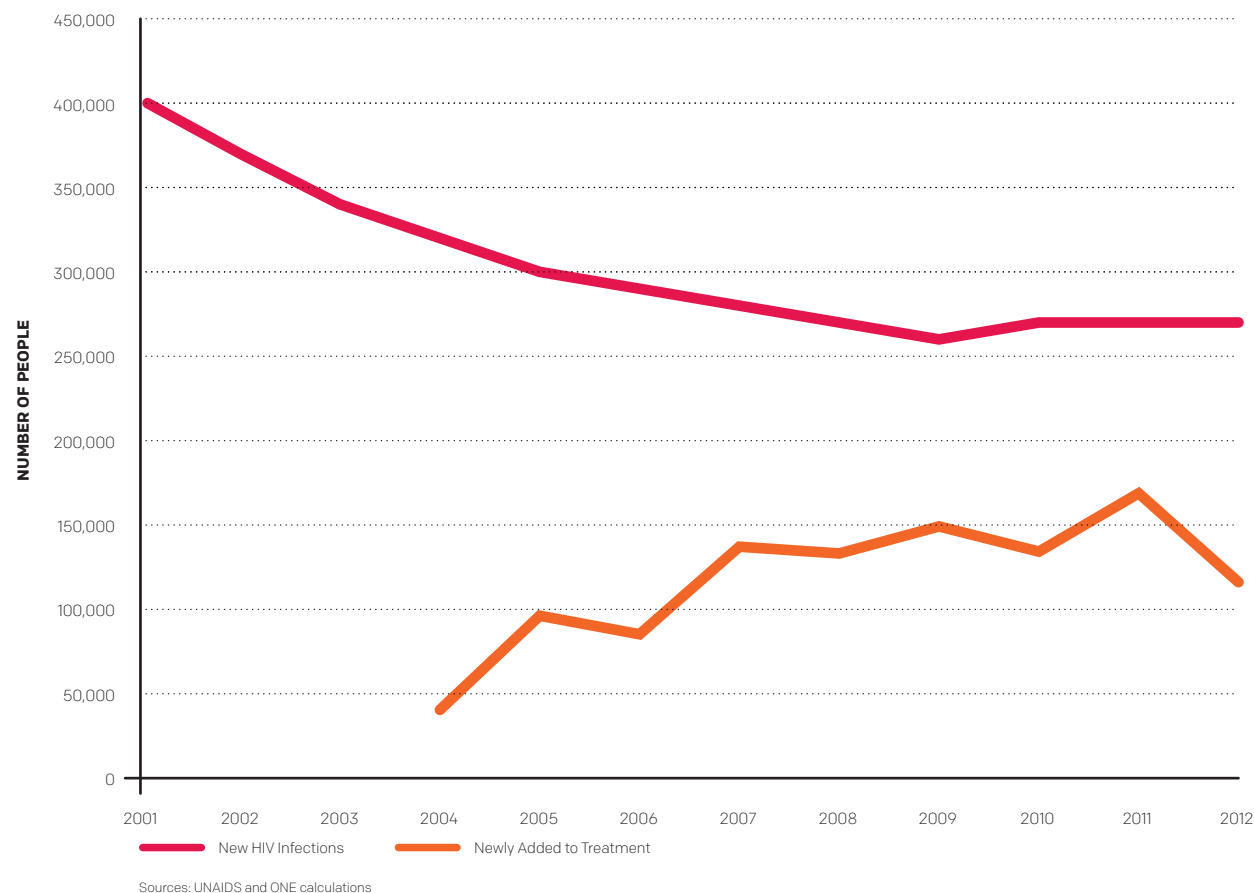
South and South-East Asia

Of the countries in this region, India has been estimated to have the highest number of people living with HIV: about 65% of those who are HIV-positive in South and South-East Asia live in that country, and estimates put its HIV prevalence as high as 2.4 million. However, India's 2011 and 2012 HIV rates are modelled estimations based on older surveys and trends.⁶⁸ With poor data for India, the 2011 and 2012 figures for the AIDS epidemic may not accurately represent current trends in the wider region.

Nevertheless, based on existing and estimated data, South and South-East Asia has not seen much success overall in reducing the prevalence of HIV within its adult population. In 2012 the rate was 0.3%, barely down from 0.4% in 2001. Last year 1.03 million adults were on ARV treatment, compared with about 1.8 million eligible adults. Based on the 2010 WHO treatment guidelines, this was a coverage rate of 52%, lower than the global rate of over 60%. However, the region has had more success in reducing the number of total new infections, from 400,000 adults and children newly infected in 2001 to 270,000 in 2012. With 116,000 people newly added to treatment in 2012, the region had an AIDS tipping point ratio of 2.33 in that year, up from 1.6 in 2011 and 2.01 in 2010, but lower than 7.9 in 2004.⁶⁹

Success in reducing mother-to-child transmission of HIV is impossible to analyse. India is the only Global Plan focus country outside of sub-Saharan Africa, but it has little or no data available on PMTCT.⁷⁰

FIGURE 8: Current Trends in Prevention and Treatment Efforts in South and South-East Asia



Within the region, HIV epidemics vary greatly between countries. Afghanistan's epidemic is still in the early stages. Cases are largely concentrated within the IDU population, which has an HIV prevalence rate of 7.2% across three urban centres.⁷¹ Meanwhile, India's epidemic is much more generalised, though still primarily concentrated among sex workers and truck drivers. HIV/AIDS has historically been less of a concern in the Maldives and Bhutan, while an effective Bangladeshi response has resulted in the country's

epidemic being largely restricted to the IDU population in Dhaka.⁷²

In a region estimated to be home to the world's second largest AIDS epidemic, it is critical that countries in this region – particularly India – focus on implementing more precise data reporting mechanisms that allow for the evaluation and tracking of disease levels from year to year, in addition to scaling up treatment and increasing access to HIV prevention mechanisms.

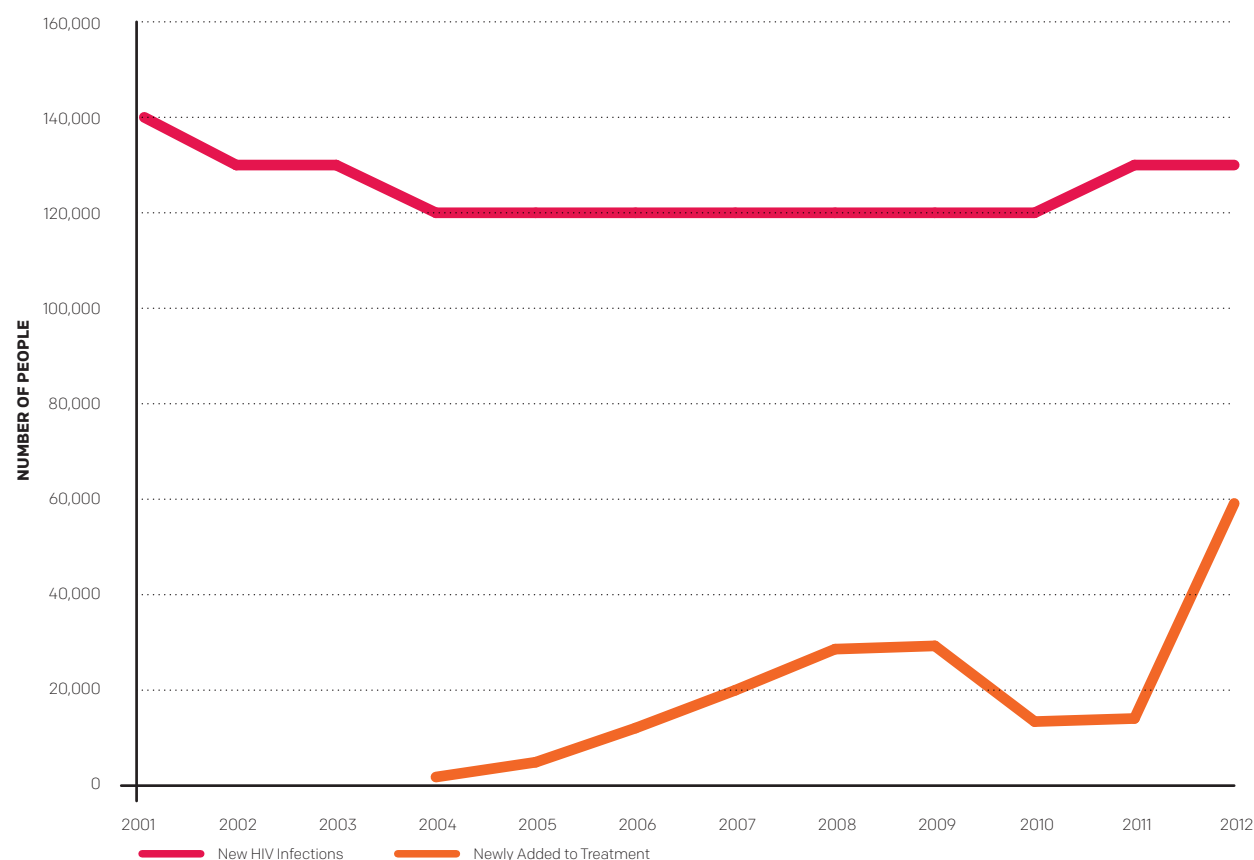
Eastern Europe and Central Asia

Eastern Europe and Central Asia is the only region globally where HIV prevalence clearly remains on the rise year-on-year.⁷³ The region has consistently failed to bring down new HIV infections among adults in the past, and it had 130,000 new infections last year.⁷⁴ Adult prevalence increased from 0.5% in 2001 to 0.7% in 2012.⁷⁵ Only modest improvements have been made in ARV coverage in the region, and it has the second lowest ARV coverage globally, at 35%. Only the Middle East and Northern Africa region has lower coverage, at 22%.⁷⁶ However, by adding 59,000 people to ARV treatment – an enormous increase compared with 2011, when only 14,000 people were added – the region has brought its AIDS tipping point ratio down significantly, from 9.24 in 2011 to 2.2 in 2012.⁷⁷

Fortunately, in preventing new HIV infections among children, the region has been much more successful. It boasts PMTCT coverage of more than 95% for HIV-positive pregnant women, and the number of new HIV infections among children has been reduced from 3,700 in 2001 to fewer than 1,000 in 2012.⁷⁸

Certain marginalised populations are key drivers of the epidemic, with IDUs in particular facing challenges in accessing HIV services and accounting for 40% of new HIV infections.⁷⁹ It is estimated that 1.3% of all adults in Eastern Europe and Central Asia are IDUs, the highest rate in the world.⁸⁰ Although the region can eventually reach the beginning of the end of AIDS with the current level of treatment scale-up, it is essential that it also focuses on reducing the number of new infections. There must be an increased focus on HIV testing and access to care, especially among marginalised populations. It is also necessary to increase awareness of HIV prevention mechanisms, as studies show that HIV knowledge in the region remains low.⁸¹

FIGURE 9: Current Trends in Prevention and Treatment Efforts in Eastern Europe and Central Asia



Sources: UNAIDS and ONE calculations



HEALTH EXTENSION WORKERS FORM THE BACKBONE OF ETHIOPIA'S INITIATIVE TO MAKE HEALTH CARE MORE ACCESSIBLE TO THE POPULATION, 83% OF WHICH LIVE IN RURAL AREAS.

PHOTO: JOHN RAE © THE GLOBAL FUND

PART 2:

TRACKING LEADERSHIP AND COMMITMENT
TOWARDS THE BEGINNING OF THE END OF AIDS

TRADITIONAL DONOR EFFORTS

For well over a decade, a large number of international donors have shown tremendous political will and have mobilised substantial resources to drive progress in the fight against AIDS in many low- and middle-income countries. Both bilateral and multilateral assistance have been, and continue to be, essential in ensuring that countries have access to antiretroviral treatment, as well as sufficient funds and technical assistance to provide testing, prevention and care services. Sustaining this financing is arguably more important now than ever to scale up prevention and treatment efforts to support increased demand in the near term. In the long run, increasing these contributions upfront will minimise the financial costs to donors as countries strengthen their own health and management systems to take greater ownership of their HIV/AIDS programmes over time.

Since 2009, however, international donor funding to HIV/AIDS has largely plateaued.¹ Although total funding for HIV/AIDS in low- and middle-income countries reached the highest level ever in 2012 (\$18.9 billion²), domestic funding drove nearly all of the growth in global financing, and accounted for more than half of total resources (53% in 2012³) for the second year in a row. While the growth in domestic financing is laudable – and necessary – the global financing picture, with only marginal gains overall, gives cause for concern and suggests that there is not enough collective urgency among donors on achieving the significant milestones in the fight against HIV/AIDS. Donor financing over the years 2010–12 was also volatile, hindering efforts for a smooth transition to increased country ownership and the implementation of multi-year programming.

G7 DONORS AND THE EUROPEAN COMMISSION

The G7 countries (the G8 excluding Russia⁴), as well as the European Commission, have been key to keeping HIV/AIDS on the global political agenda and contributing substantial resources to the fight against the epidemic. ONE's 2012 report analysed these countries in detail and mapped their financial contributions (bilateral and multilateral), political leadership and programmatic efforts. In this section we provide an update on donors' efforts over the past year, based on the latest 2012 funding data and in light of political updates and policy changes. **Our findings show that donors' responses to the HIV/AIDS pandemic are increasingly varied, and lack a collective programmatic vision.** While a small number of donor countries have accelerated their efforts in the fight against AIDS, others are maintaining the status quo or, worryingly, are pulling back. A heightened sense of urgency and more effective multi-year investments from all donors are needed to ensure the beginning of the end of AIDS – and its ultimate defeat within our lifetimes.

➤ **The United States** remains a global leader on AIDS, providing – by a wide margin – the largest amount of AIDS funding in 2012. The US has also set bold, measurable targets and President Barack Obama,⁵ former Secretary of State Hillary Clinton and current Secretary of State John Kerry have delivered robust support for achieving an “AIDS-free generation”. The US increased both bilateral and multilateral AIDS spending from 2011 to 2012, although 2013 saw a proposed cut to bilateral funding through the President's Emergency Plan for AIDS Relief (PEPFAR). Current programmatic targets set for

PEPFAR, including those focused on treatment, voluntary male circumcision, prevention of mother-to-child transmission and condom distribution, are set to expire in 2013. As this report was being written, the US had not yet determined its next set of bilateral targets. The shape of these targets and the extent to which they focus on outcomes rather than inputs will help determine how effective the US's bilateral investments will be in the coming years.

The US is likely to maintain its overall spending on AIDS in 2014 through a \$1.65 billion commitment to the Global Fund. If appropriated by Congress, this amount would set the US on a path to provide nearly \$5 billion to the Global Fund over the next three years – roughly one-third of its overall 2014–16 financing needs (\$15 billion). The US has not yet announced a multi-year pledge, but by law it is unable to provide more than 33% of overall contributions to the Global Fund. The Global Fund's fourth replenishment meeting will be hosted by the US in early December 2013.

➤ **The United Kingdom** slightly increased both its absolute and per capita spending on HIV/AIDS from 2011 to 2012. It is also one of the largest per capita AIDS donors, spending roughly \$14 per citizen. In September 2013, it announced that it would significantly increase its contribution to the Global Fund to £1 billion (\$1.5 billion) for 2014–16, on the condition that the Global Fund meets its \$15 billion replenishment goal over the three-year period and that the UK will not contribute more than 10% of the total

replenishment. This pledge comes on top of a £1 billion pledge made to the Global Fund in 2007, of which, however, only £890 million to date has been disbursed.⁶

The UK has historically been supportive of multilateral health organisations, and the Global Fund fared well in its 2013 updated Multilateral Aid Review. The Secretary of State for International Development, Justine Greening, has made it clear that health, and multilateral programmes in general, need to fit within the Department for International Development (DFID)'s priorities, including a focus on the private sector as well as on women and girls. The UK committed to review progress against the results of its HIV Position Paper in 2013 and to reassess strategic priorities at the time.

➤ **France** decreased its spending on HIV/AIDS slightly from 2011 to 2012; however, AIDS remains consistently high on the agenda for its political leaders. President François Hollande became the first European head of state to commit to the beginning of the end of AIDS just two months after his election in 2012. France was the second country to announce a three-year pledge for this year's Global Fund replenishment, maintaining its current contribution level of €1.08 billion (\$1.4 billion) over 2014–16.⁷ However, following the UK's September 2013 announcement of increases in its Global Fund contribution, France risks slipping from its previous position as second largest donor to the Global Fund to third, and would no longer be the highest per capita contributor.

France continues to be a strong and vocal supporter of UNITAID, an innovative financing mechanism that aims to increase access to treatments for HIV/AIDS, TB and malaria in

developing countries.⁸ It has also committed 10% of a financial transaction tax (FTT) to be used for development assistance – parts of which will be used in the fight against HIV/AIDS, TB and malaria – and has called on other countries to do the same. Following consultations on development policy (*assises*⁹) in late 2012 and early 2013, France is developing its first ever development law, which will be discussed in Parliament at the beginning of 2014. The government has already stated its intentions for France to remain a leader in global health.

➤ **Germany** decreased both its total HIV/AIDS spending and per capita spending between 2011 and 2012. This is consistent with its overall decrease in development assistance to 0.38% of its gross national income (GNI) in 2012.¹⁰ At this year's World Economic Forum, Germany was the first country to make a multi-annual pledge to the Global Fund for 2014–16; this announcement ensured that it would maintain its contributions at the same level as in 2011–13, at €200 million (\$270 million) annually.¹¹ Since the announcement, several other donors have increased their pledges for the next replenishment period – some more than doubling their contribution. With several pledges still pending at the time this report was written, Germany is one of two top ten donors to the Global Fund not to have increased its pledge since 2008.¹² The replenishment offers an opportunity for the next German government to boost the country's contribution to the end of AIDS early on in its term in office. During Germany's G8 Presidency in 2007, it doubled its Global Fund contributions. By doubling contributions again, Germany would be able to use the next 13 months leading up to its 2015 G8 Presidency to strengthen its international profile

on this issue, and to build on the positive legacy begun in 2007.

➤ **Japan** increased its spending on AIDS and global health in 2012 after falling back in 2011 as a result of the catastrophic earthquake and tsunami. It more than doubled its total HIV/AIDS and per capita spending in 2012 compared with 2011. It recommitted to its financing for the Global Fund in 2012, but at the time of writing it had not yet indicated a new pledge for 2014–16. Japan should rebuild its standing as a significant financial and programmatic contributor to the global AIDS response by increasing its commitments, as it lags substantially behind its peers in per capita terms. Prime Minister Abe has been a strong supporter of ensuring that health systems and “universal health coverage” receive sufficient attention in the coming years.¹³ By leveraging his influence in this discussion to simultaneously support HIV/AIDS programmes, Japan can help ensure that health service integration takes place and that key populations can be reached, including those who are marginalised and currently unable to access health services.¹⁴

➤ **Canada** spends far less on AIDS relative to its peers, and fell further behind them in total and per capita spending from 2011 to 2012. However, its per capita spending continues to outpace Germany's, and it continues to shape global conversations by defining links between the AIDS agenda and the maternal, newborn and child health (MNCH) policy agenda. Most recently, Prime Minister Harper made a speech at the United Nations General Assembly in September 2013, in which he announced CAD\$10 million (\$9.7 million) in support for PMTCT of HIV and MNCH programmes at the community level for 2012–16.¹⁵ In order to play its

part in making the end of AIDS a reality, Canada should make its AIDS strategy more robust and outcome-oriented and should scale up its financing accordingly. At the time of writing, it had yet to make a pledge to the Global Fund's 2014–16 replenishment.

➤ **The European Commission**, managing development assistance on behalf of the 28 member states of the European Union (EU), provides modest funding to the fight against AIDS relative to its other development priorities. Its total spending on HIV/AIDS fell from 2011 to 2012. At the time of writing,

negotiations on the EU's 2014–20 budget were still under way, making it difficult to predict the future direction of HIV/AIDS spending. However, the Commission has supported the Global Fund replenishment process by hosting the first preparatory replenishment meeting in Brussels in April 2013. At an event hosted by ONE, Development Commissioner Andris Piebalgs confirmed that the Commission would continue its contributions to the Global Fund at least at their current level (€110 million or \$14.8 million annually).

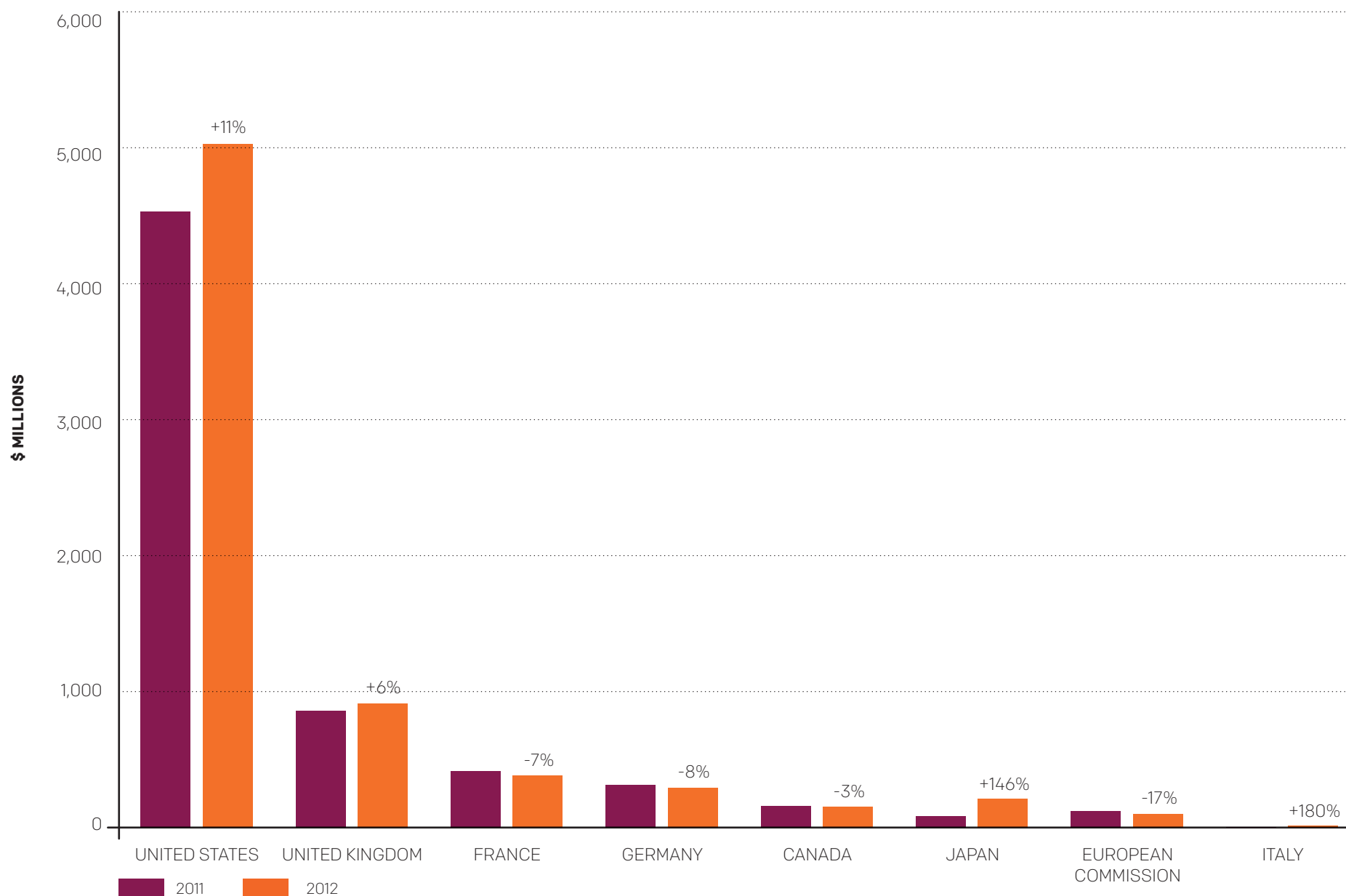
➤ **Italy** more than doubled its bilateral spending on AIDS from just \$5 million in 2011 to \$13.9 million in 2012, although overall it remains the clear laggard among the G7 countries analysed. It was the first country to have wholly defaulted on two years' worth of Global Fund pledges, and at the time of writing had not committed to paying outstanding pledges, or contributing to the 2014–16 replenishment. With a new government in power, however, initial signals appear positive that Italy will take up its responsibility in the fight against AIDS by making a renewed pledge to the Global Fund.

FIGURE 1: International HIV/AIDS Assistance from G7 members and the European Commission, 2012 (\$ millions)¹⁶

	UNITED STATES	UNITED KINGDOM	FRANCE	GERMANY	JAPAN	CANADA	EUROPEAN COMMISSION	ITALY
BILATERAL SPENDING ON HIV/AIDS	4,359.2	643.4	55.9	145.8	20.5	54.1	30.3	13.9
GLOBAL FUND (TOTAL CONTRIBUTIONS)	1,215.5	404.5	463.7	259.4	342.9	178.7	127.9	0
GLOBAL FUND (HIV/AIDS CONTRIBUTIONS)	668.5	222.5	255.0	142.7	188.6	98.3	70.3	0
UNITAID (TOTAL CONTRIBUTIONS)	0	87.2	143.4	0	0	0	0	0
UNITAID (HIV/AIDS CONTRIBUTIONS)	0	44.5	73.1	0	0	0	0	0
TOTAL HIV/AIDS SPENDING	5,027.7	910.4	384.0	288.5	209.1	152.4	100.6	13.9
TOTAL HIV/AIDS SPENDING PER CAPITA	\$16.02	\$14.40	\$5.85	\$3.52	\$1.64	\$4.37	\$0.20	\$0.23

Sources: Kaiser Family Foundation; UNITAID; the Global Fund to Fight AIDS, Tuberculosis and Malaria; World Bank World Development Indicators and ONE calculations

FIGURE 2: Total AIDS Spending (Bilateral and Multilateral) by G7 Members and the European Commission, 2011 and 2012



Sources: Kaiser Family Foundation; UNAIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and ONE calculations

OTHER TOP DONORS

Alongside the G7 and the European Commission, a number of other donors also contribute substantial international HIV/AIDS funding. The Nordic countries (Sweden, Norway, Iceland, Denmark and Finland) were particularly noteworthy in 2013, as they made a collective pledge of \$750 million to the Global Fund for 2014–16.¹⁷ This represented a 20% increase over their contributions in the previous three-year period, although the precise breakdown of this pledge was not clear at the time of writing.

Among non-G7 HIV/AIDS donors in 2012, Sweden and Australia were the only two countries to increase their funding from 2011 levels. The newly elected government in Australia has decreased planned spending on aid by AUD\$4.5 billion for the next three years, making it difficult to predict whether increased funding for HIV/AIDS can continue. However, with its G20 Presidency in 2014 and as host of the 2014 International AIDS Conference, Australia has an opportunity to keep HIV/AIDS central to its national efforts, as well as to the international debate.

Some countries that have provided significant contributions to the fight against HIV/AIDS, including Denmark, Ireland and the Netherlands, decreased their overall funding in 2012. Alongside overall cuts to development assistance, the Dutch minister for International Trade and Development Cooperation, Lilianne Ploumen, initially budgeted fewer funds for the Global Fund for 2014 than for 2013. At the time of writing, this proposal was still going through parliament, so it is possible that the Dutch contribution could change ahead of the December replenishment meeting.

FIGURE 3: International HIV/AIDS Assistance from Top Donors, Ranked in Order of 2012 Contributions (\$ millions)¹⁸

	2012	2011	2010	NET CHANGE 2010–2012
UNITED STATES	5,027.70	4,530.00	3,830.00	31.27%
UNITED KINGDOM	910.34	859.02	804.71	13.13 %
FRANCE	384.40	412.71	388.66	-1.10 %
GERMANY	288.48	312.26	310.33	-7.04 %
THE NETHERLANDS	257.61	321.40	370.10	-30.39 %
JAPAN	209.08	84.91	154.62	35.22 %
DENMARK	171.00	189.20	171.10	-0.06 %
SWEDEN	170.73	163.10	139.90	22.04 %
CANADA	152.38	156.45	134.64	13.17 %
AUSTRALIA	124.66	110.60	104.10	19.75 %
NORWAY	115.51	118.80	119.00	-2.93 %
EUROPEAN COMMISSION	100.66	122.31	100.33	0.33 %
IRELAND	52.40	69.40	97.70	-46.37 %
ITALY	13.90	5.12	11.40	21.93 %
TOTAL	7,978.85	7,455.28	6,736.59	18.44%

Sources: Kaiser Family Foundation; UNAIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and ONE calculations

HIV/AIDS ON THE INTERNATIONAL POLITICAL AGENDA

Ensuring sufficient donor funding for HIV/AIDS from all donors is challenging in the current climate, as noted above. In addition to the financial crisis of recent years, HIV/AIDS has received little or no attention at a number of global political forums – many of which used to feature the epidemic or broader global health issues more prominently. Undoubtedly, there are many pressing world issues deserving of political attention – including many non-health development topics that are deeply linked with efforts to combat HIV/AIDS – but if the disease is not given sufficient political attention, mobilising commitments and resources to reach the beginning of the end of AIDS, and the end of AIDS, will become increasingly challenging.

The G8/G20

HIV/AIDS and global health were absent from the agenda of the G8 summit at Lough Erne, UK in 2013. Since the Gleneagles summit in 2005, when the G8 set the target of achieving universal access to ARVs in Africa by 2010, insufficient attention has been paid to the issue at subsequent G8 summits, although global health more broadly was a focus at the Muskoka summit in Canada in 2010.¹⁹ However, the G8's 2013 Accountability Report²⁰ assessed the group's role and

impact on HIV/AIDS commitments. Importantly, it highlighted the G8's important role as a key initiator and funder of the Global Fund, and the continued value of the mechanism. The report applauds the progress that the G8 have made on HIV/AIDS, but is overly optimistic about the road ahead. By not mentioning HIV/AIDS targets that are not being met, such as the aim of reducing the number of new HIV infections or achieving the Gleneagles target of universal access by 2010, the G8 are not holding themselves accountable. Also, the issue of stagnating health funding – and even declining support among some international donors – is not sufficiently highlighted.

The G20 Summit in St. Petersburg also failed to include HIV/AIDS or global health on its agenda. Unlike in previous G20 communiqués, HIV/AIDS and the Global Fund were not mentioned.²¹ As Australia takes over the G20 presidency for 2014, there is hope that as host of the International AIDS Conference²² in the same year, it will place HIV/AIDS and global health back on the G20's political agenda.

The 2013 Global Fund Replenishment

The Global Fund to Fight AIDS, Tuberculosis and Malaria was conceptualised by the G8 and other supportive leaders at the Okinawa Summit in 2000 as a “war chest” to fight the three pandemics. It was designed to marshal the financial resources needed to provide access to life-saving treatment, prevention and care services to communities around the world. Over the course of the past decade, the Global Fund has become the single most powerful tool in the fight against these three killer diseases. Today, it channels indispensable resources: 82% of all financing for TB, 50% for malaria and 21% for AIDS around the world.

In the past two years, the Global Fund has undertaken a series of reforms to more effectively mitigate risk and to target countries with the highest disease burden and

the greatest financial need. A New Funding Model (NFM),²³ adopted in 2013, formalises many of these changes, and for the first time allows the Global Fund Secretariat to disburse grants along a more iterative timeline, aligned with countries' budget and planning cycles. Although the NFM has only gradually begun to roll out in 2013, and will take two years to be fully implemented, early indications from pilot countries such as Zimbabwe²⁴ suggest that the changes have been generally well received.

As of mid-2013, over \$26 billion in Global Fund grants to more than 150 countries has translated into real impact, providing:

- ARV treatment for 5.3 million people living with HIV/AIDS;
- Treatment to prevent mother-to-child transmission for 2.1 million HIV-positive pregnant women;
- Insecticide-treated bed nets to protect 340 million families from malaria;
- Detection and treatment services for 11 million cases of TB; and
- Basic care and support for 6.3 million orphans and vulnerable children.²⁵

Every three years, the Global Fund carries out a “replenishment” of its funds for the following three years to ensure that it can scale up its grant-making to countries. In April 2013, it kicked off its fourth replenishment cycle by publishing a demand assessment²⁶ for resources needed from 2014 to 2016 to reach all vulnerable populations in eligible low- and middle-income countries with essential services. Technical experts estimate that, of the \$87 billion needed to finance the vast majority of the fight against the three diseases in the 2014–16 period, \$15 billion channelled through the Global Fund, alongside scaled-up domestic and bilateral donor funding, could drive significant progress towards the control of AIDS,

TB and malaria. Of the \$87 billion total for all three diseases, \$58 billion is estimated to be required for HIV/AIDS.

The Global Fund's replenishment conference will be hosted in early December 2013 by the US. Pledges made by G8 members at the time that this report was being written encourage optimism for a successful replenishment round that raises more than in the previous replenishment period (2011–13). So far, the US has made a substantial pledge for 2014 (\$1.65 billion), which, if repeated each year, puts it on track to commit nearly \$5 billion over the three-year period. The UK committed up to £1 billion over 2014–16, conditional on its pledge not exceeding 10% of the total funds raised – an amount which, if realised, would represent more than a doubling of its current contribution. The Nordic countries (Norway, Sweden, Denmark, Iceland and Finland) have increased their collective pledge to \$750 million. Luxembourg has pledged \$10.1 million over 2014–16.²⁷ France and Germany have also committed to maintaining their previous annual contributions (€360 million and €200 million respectively), which is particularly positive for France, given its high historic levels of financing for the Global Fund.

However, securing the full \$15 billion needed by the Global Fund remains challenging. Both the US and the UK have made their overall pledge amounts conditional on the amounts pledged by other donors, which could diminish their ultimate contributions if other donors do not step up. Leading donors who did not increase the pledges announced in 2013 will need to top up these pledges in order to secure full funding for the Global Fund for 2014–16. And significant donors who have yet to make full 2014–16 pledges, including Japan, the Netherlands, Canada, Australia and the EC, will need to come up with significant new resources in order to help fill the need.

The Formulation of the Post-2015 Development Agenda

One of the biggest moments for the positioning of HIV/AIDS on the global agenda will come in the lead-up to 2015, as the UN General Assembly decides on a new set of development goals to succeed the existing Millennium Development Goals (MDGs), which expire in 2015. The “post-2015” consultation and negotiation process is already well under way, but at the time of writing it was still unclear how HIV/AIDS would be included in the new targets, and with which indicators. A number of processes and subsequent reports have already proposed possible draft targets but, as of now, the main reports (High Level Panel,²⁸ Sustainable Development Network Solutions²⁹) and meeting

summaries (Open Working Group³⁰) include neither quantified indicators nor detailed sub-targets for HIV/AIDS – though the High Level Panel report does generically reference the importance of “reduc[ing] the burden of disease from HIV/AIDS” as one of its illustrative targets.

CSOs, member states, academics and international organisations alike are currently drafting possible sets of targets, and many in the HIV/AIDS community are pushing to get current MDG 6 targets (to combat HIV/AIDS, malaria and other diseases)³¹ included, or built upon, in the new set of health targets. Commissions, such as the UNAIDS and Lancet Commission, which include key decision-makers and

opinion shapers, are also playing an increasing role in formulating the debate. Global health will remain a key priority in the new development agenda, with the fight against HIV/AIDS an important focus for driving progress on human development. However, as of 2013, many countries, particularly in sub-Saharan Africa, are unlikely to achieve MDG 6 by 2015. As such, international donors – including the G8 – and domestic leaders alike need to ensure that gains made in the past decade on HIV/AIDS are not reversed, and that the goal of achieving the beginning of the end of AIDS remains high on every country’s agenda.

AFRICAN EFFORTS AND COUNTRY PROFILES

Although the world has accelerated progress towards the beginning of the end of AIDS and has made noteworthy gains both in improving access to treatment and in reducing new infections, a close analysis of the data clearly shows that the gains achieved have by no means been uniform. For some countries and regions, the beginning of the end of AIDS remains a distant vision, while for others it has already arrived, and efforts to control and ultimately end the pandemic are under way.

Many of the gains achieved globally come as a result of the substantial progress made by sub-Saharan Africa in the past year. It remains the region with the highest burden of AIDS, with 25 million people living with the disease and with an estimated 1.2 million deaths in 2012 alone. But it is also the region that has made the greatest progress against the disease: the number of people added to treatment in the past year alone was at an all-time high, while the number of new infections dropped to an all-time low. Improvements in reducing paediatric infections, AIDS deaths and HIV prevalence rates were more marked in sub-Saharan Africa than anywhere else.

Despite great progress on the whole, political will and financial investments have varied dramatically between countries, and so too have countries' relative successes in fighting AIDS. Figure 1 (on page 43) shows the range of sub-Saharan African countries and their AIDS tipping point ratios.¹ The wide range of progress achieved by countries on these targets highlights that "AIDS in Africa" is a misnomer. Sixteen of the 37 countries for which data is available had reached or improved beyond the tipping point ratio of 1.0 in 2012,

indicating that they have reached the "beginning of the end of AIDS". Of the remaining 21 countries, five were incredibly close to reaching the tipping point, with a ratio between 1.01 and 1.1, while the remainder had ratios ranging anywhere from 1.5 to 21.3 to -8.6 (indicating a reversal of progress). Even among the 16 that have reached the tipping point, overall success in controlling the epidemic varies greatly. Ethiopia, for instance, has reached the tipping point while providing only 60% coverage of treatment for those eligible for it – below the sub-Saharan African average of 62.5% – whereas Botswana is providing close to 95% treatment coverage. Other countries that have reached the tipping point primarily by improving access to treatment still see large numbers of new HIV infections annually – such as South Africa, which had more than 360,000 new infections in 2012. As such, the achievement of the tipping point must not be viewed in isolation, but must be seen as one of many important indicators of success.

Just as African countries vary in their progress towards the beginning of the end of AIDS, their financial investments to fight the disease have also varied significantly. In 2001, at the African Union (AU)'s Abuja Summit, African governments made a commitment to spend at least 15% of their national budgets on health. Figure 2 (on page 44) shows how countries are performing on this commitment. While spending 15% alone does not ensure a proper response to the AIDS epidemic, it will be impossible for countries to control the disease without adequate investment in the health sector. In 2011 (the latest year for which comparable data is available), only six of 46 African countries spent 15% or more of their budgets on health. Another four spent at least 14%, but nearly a quarter – 11 of the 46

– spent less than 7.5% of their budgets on health. To achieve the beginning of the end of AIDS at a national level, governments will need not only to increase their investments in health, but also to allocate those health resources towards programming for AIDS prevention and treatment in line with national plans.

To further exemplify the diversity across the continent, the following pages profile nine countries that represent varying degrees of progress in their responses to the AIDS epidemic (see Methodology section for more information about how these countries were chosen). The first three countries profiled (Ghana, Malawi and Zambia) have made advances that would have been almost unthinkable ten years ago, and are faring better than many of their counterparts in other regions of the world. These countries have reached the beginning of the end of AIDS and are on their way to controlling the epidemic. The next three countries (South Africa, Tanzania and Uganda) are ones to watch. They have made progress amidst unique circumstances and could join their counterparts in the leadership category in a few years' time, but their gains have not been uniform and their challenges remain significant. The final three countries (Togo, Cameroon and Nigeria) have made little progress or have even seen progress slip in recent years. These countries are ones that need to substantially scale up their programmes so that they can join the region, and the world, in reaching the beginning of the end of AIDS together.

In each of these profiles, we assess financial inputs – both domestic and international – to HIV/AIDS programmes. Assessing domestic spending on HIV/AIDS is extremely challenging given the lack of

budget transparency in most of the countries concerned. Several sub-Saharan African governments publish little or no consistent annual budget data; for most other countries, key budget documents are published, at least for recent years, but they do not contain sufficient disaggregation to enable comprehensive data analysis. For example, most budgets show total allocations for each government department (e.g. Ministry of Health), but do not provide any further detail within each departmental account or the total amount allocated to any programmes that cut across multiple departments. In a few other cases, data is too disaggregated to be useable; for example, thousands of individual line items are recorded but not

in a format and without sufficient information on each item to feasibly allow analysis under broader programme headings. Of all the nine countries profiled within this report, only South Africa has clear budget lines showing total and fully itemised government spending on HIV/AIDS. While UNAIDS does track African country spending through self-reported assessments, these are not completed on a regular basis by every country. In order to truly monitor the region's progress in the fight against AIDS and to assess to what degree domestic resources are responsible for gains at the country level, improved transparency and accountability for spending will be crucial in the years ahead.

For each country, finally, we analyse political commitments and programmatic success, and we also highlight a civil society organisation (CSO) that is doing important work to fight AIDS and to tackle broader health challenges. This entire report could be filled with profiles of groups of similar quality; the inclusion of these particular nine organisations is meant to provide a snapshot of the vast and diverse tapestry of CSOs engaged in each country.

FIGURE 1: AIDS Tipping Point Ratios by Country, 2012

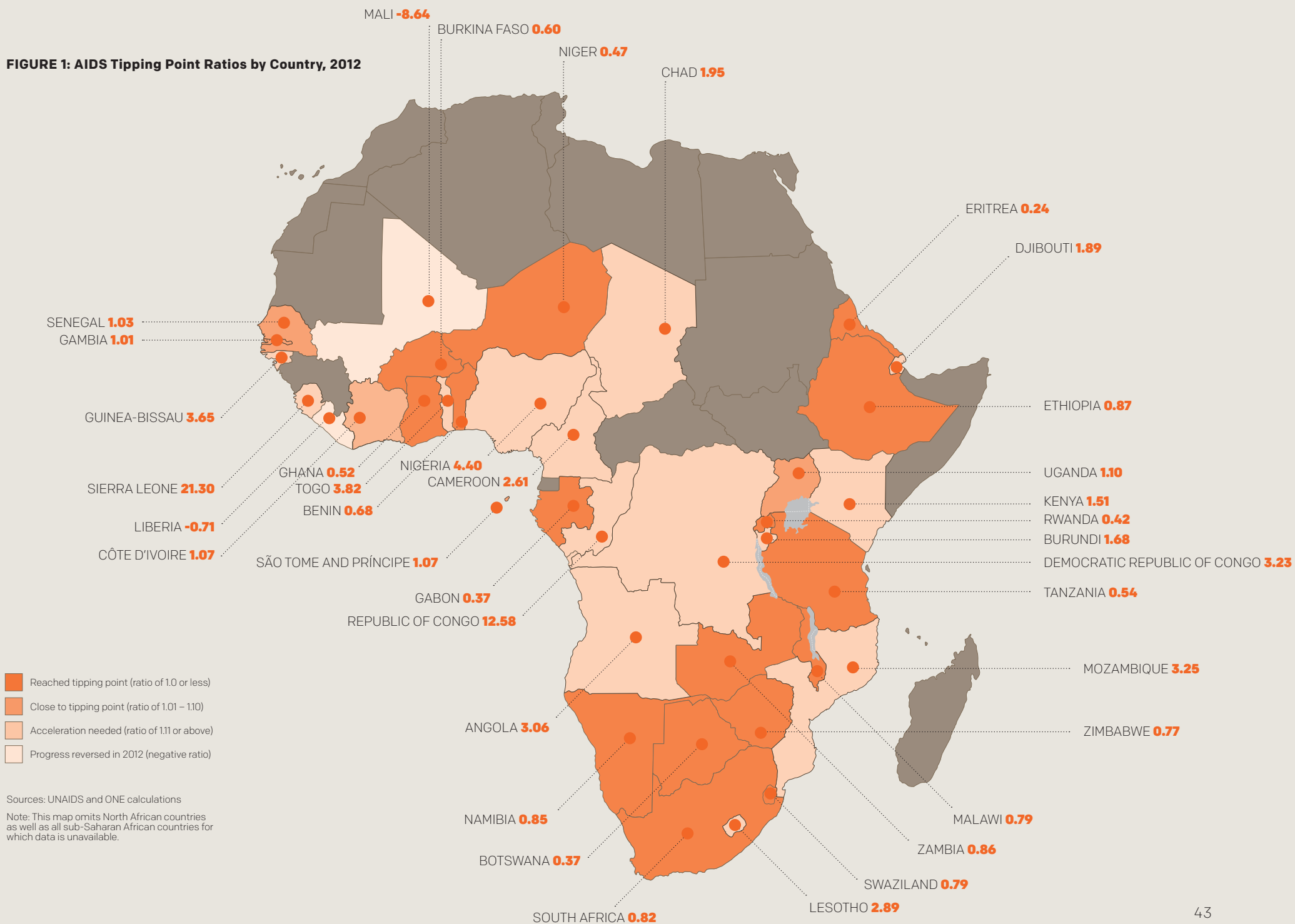
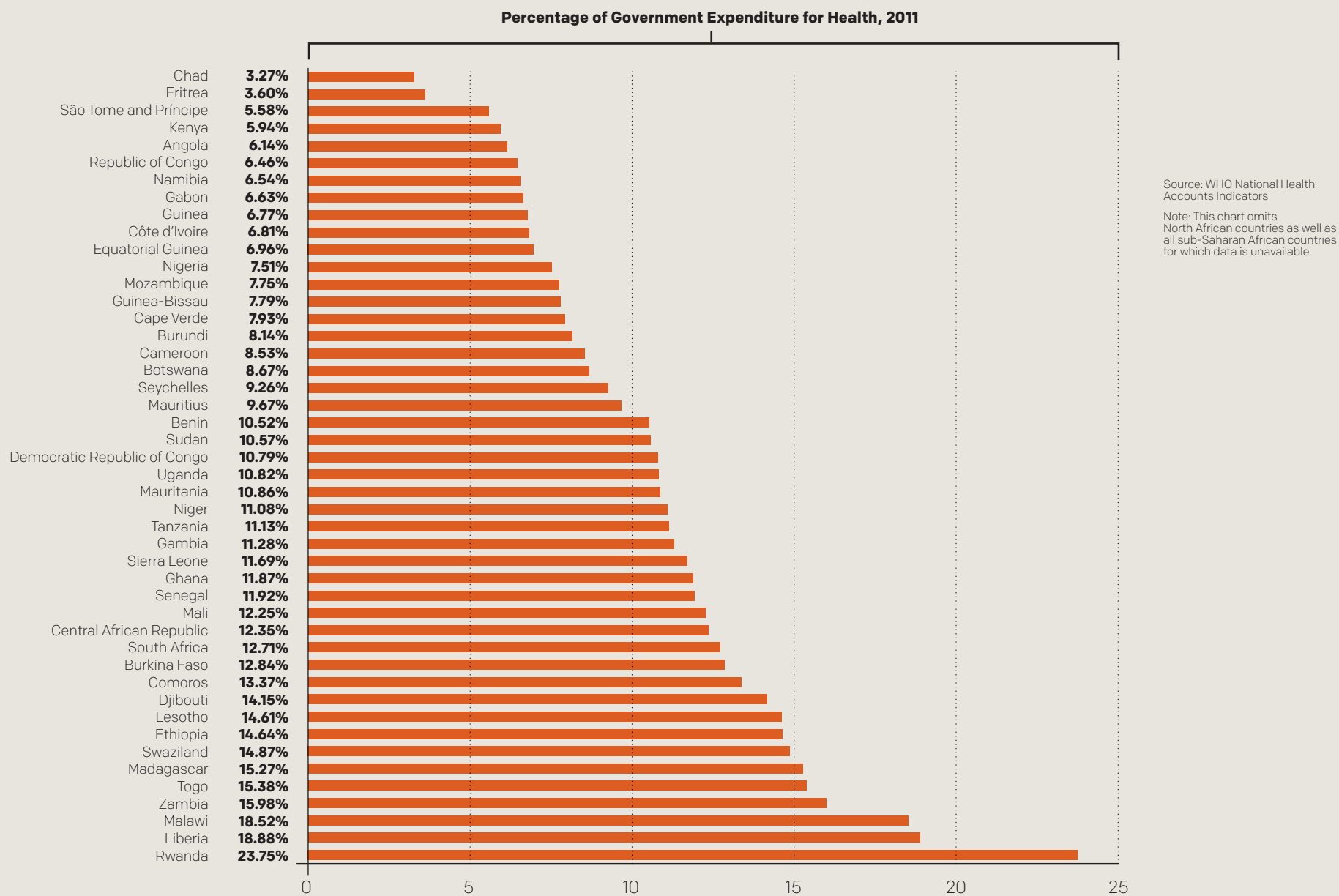


FIGURE 2: African Countries' Health Expenditure





A PEER HEALTH PROMOTER FROM
SEND-GHANA EDUCATES WOMEN ON
HIV/AIDS AND REPRODUCTIVE HEALTH IN
THE KPEMBE COMMUNITY.

PHOTO: © SEND-GHANA

COUNTRY PROFILES

REPUBLIC OF GHANA

Population: 25,366,462¹

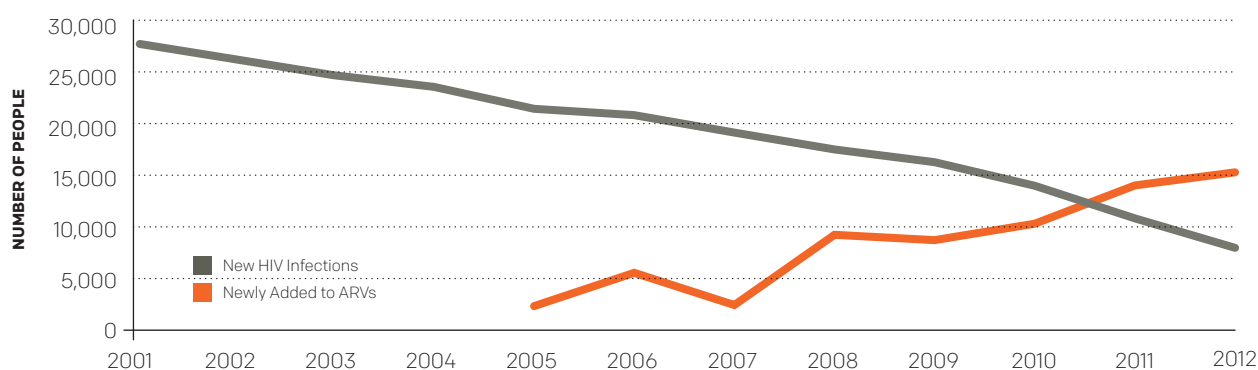
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$25.80bn	\$32.19bn	\$38.75bn
Total Bilateral Aid for AIDS ³	\$12.39m	\$10.61m	\$20.53m
Total Multilateral Aid for AIDS ⁴	\$46.29m	\$23.17m	\$36.31m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$754.20m (12.47%)	\$1,014m (12.08%)	\$1,131m (11.87%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	246,241	240,706	235,841
HIV Prevalence Rate Among Adults ⁸	1.52%	1.44%	1.37%
Number of New Paediatric Infections ⁹	3,041	1,350	851
PMTCT Coverage Rate ¹⁰	55%	80%	95%
Number of AIDS Deaths ¹¹	17,378	15,106	11,625

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Ghana is a true leader in the fight against AIDS. Between 2002 and the end of 2012, new HIV infections plummeted by 70%, from 26,000 to 8,000, while the adult prevalence rate dropped from 2.21% to 1.37%. At the same time, the number of people newly added to AIDS treatment increased from virtually zero in 2002 to 2,300 in 2005, and 15,000 by 2012. In that year, 58% of people eligible for treatment were receiving it. Ghana's AIDS ratio of people newly infected to people newly added to treatment has improved accordingly, from above 9 in 2005 to below the tipping point – 0.52 – in 2012. Ghana has improved this ratio significantly in recent years, cutting it nearly four-fold in just the last three years, down from a ratio of 1.9 in 2009.¹²

This level of success has been made possible by the government's high level of commitment to fighting AIDS. Ghana's highest political leadership continues to be vocal about the epidemic, with President John Dramani Mahama actively promoting the fight against AIDS, both as president and vice-president, through published articles,¹³ updates to Parliament on the status of Ghana's AIDS epidemic and speeches to the Ghanaian people.¹⁴ National AIDS planning efforts have also been strong for more than a decade. In 2002, the government established the Ghana AIDS Commission (GAC) as the coordinating body of the national response for HIV/AIDS, bringing together key stakeholders including representatives of ministries, the private sector, religious leaders, civil society and people living with HIV. One of the GAC's key roles is to develop the National Strategic Frameworks on HIV/AIDS; the first of these, developed soon after the Commission's formation, outlined clear targets on prevention, care and support, creating an enabling environment and quantitative targets that were then expanded upon in the second and third national strategic plans (2006–10 and 2011–15 respectively).¹⁵ The GAC's large-scale "Know Your Status" campaigns have been particularly crucial in achieving almost

universal awareness of HIV in Ghana (98% for women and 99% for men¹⁶). One of Ghana's most impressive achievements has been a dramatic reduction in new child HIV infections. To help drive this success, the country increased the number of PMTCT centres eight-fold between 2005 and 2011,¹⁷ which in turn increased the proportion of HIV-positive pregnant women receiving PMTCT treatment from 32% in 2009 to 95% in 2012.¹⁸ In 2013, Ghana emerged as the country that has achieved the greatest percentage reduction in new paediatric HIV infections – down an impressive 76% since 2009 – and if it sustains this pace of progress, it will achieve the goal of virtual elimination before 2015.¹⁹

High levels of domestic financing for health programmes have contributed to the achievement of these outcomes, with Ghana reaching the AU's Abuja target of spending 15% or more of its total budget on health in 2005 and 2007 and only just missing it in 2006. Since 2007, health spending as a share of total spending has decreased slightly, to 12% of the budget, but health spending in absolute terms has continued to rise. The government increased overall health spending from \$754 million in 2009 to over \$1.1 billion in 2011.²⁰ Ghana produces an annual budget book showing details of authorised expenditure, and its HIV/AIDS allocation for FY2013 appears to be approximately GHS10.5 million (about \$4.8 million).²¹ Ghana's close partnerships with international aid mechanisms, particularly with the Global Fund, have also been crucial

for its largely successful AIDS response. Since 2002, it has received six completed HIV/AIDS grants from the Global Fund; five of these grants are currently active, and nearly \$212 million in HIV/AIDS funding has been disbursed.²² While Ghana is not one of the US's PEPFAR focus countries, it received \$15 million for comprehensive prevention, treatment and care programmes through PEPFAR in 2011²³ and \$17.5 million in total from the United States. It also received \$2.4 million from Denmark and \$220,000 from Canada to fund HIV programmes.²⁴ Between 2009 and 2011, the top HIV/AIDS donors to Ghana were the Global Fund, followed by the US, Denmark, the International Development Association (IDA) and UNAIDS.²⁵

Unlike most countries, Ghana has been comparatively slow to scale up ARV treatment. Its ARV coverage rate of 58% is lower than the sub-Saharan African average of 62.5% coverage,²⁶ and a unique challenge that hinders access to treatment is the country's low medical clinic-to-patient ratio: there were just 0.1 physicians for every 1,000 people in 2010, compared with an African average of 2.3 per 1,000 people.²⁷ Additionally, in 2011 just 5% of the general population got tested for HIV and many rural areas continue to face challenges in accessing HIV/AIDS services, which are located primarily in cities.²⁸ Decentralising HIV testing, care and treatment services in Ghana is particularly critical to providing even more people with life-saving AIDS treatment in the years to come, including those with CD4 counts above 350 cells/mm³.

CSO SPOTLIGHT

SOCIAL ENTERPRISE DEVELOPMENT FOUNDATION (SEND) GHANA

<http://gh.sendwestafrica.org/>

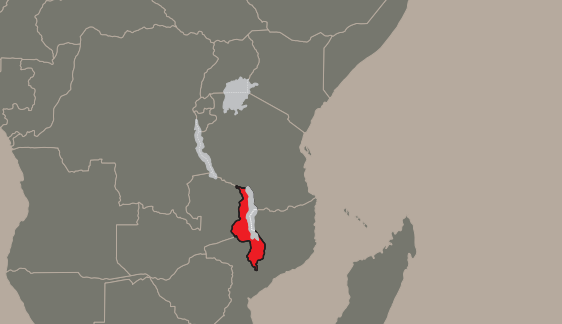
SEND-Ghana aims to ensure that people's rights and well-being are guaranteed²⁹ through a focus on health, nutrition, HIV/AIDS education and small-scale business development. Founded in 1998 as a subsidiary of the Social Enterprise Development Foundation of West Africa (SEND Foundation), in just a decade SEND has grown to become an organisation with 30 staff members, operating in four of Ghana's regions and 50 districts.³⁰ It has filled a gap in grassroots advocacy and community engagement to ensure that people benefit as much as possible from government policies and programmes, including those relating to sexual and reproductive health, HIV/AIDS and sexually transmitted diseases.

SEND has worked on HIV/AIDS since 2001, when it started outreach programmes in the Eastern Corridor. SEND works by educating youth and families in rural areas, engaging communities through drama performances and training "peer health promoters", who specifically educate and support people in rural communities on HIV/AIDS and reproductive health. However, access to follow-up services for AIDS treatment and testing remains a challenge, in particular for rural populations, due to a lack of transportation and equipment for testing and monitoring outside of cities.³¹ SEND also tries to ensure that pro-poor health programmes "actually benefit the poor and the marginalised in society".³² It does this by mobilising citizen groups to plan and carry out monitoring on health projects and programmes themselves, and assesses how much access poor people have to health services and what fees they pay. In this work, SEND places a particular focus on women and disabled persons.

While SEND is optimistic about Ghana's increased testing of women during pregnancy and the increased willingness of people to get tested for HIV, several challenges remain in controlling HIV/AIDS in Ghana. More education is required to reduce stigma and encourage people to adopt responsible behaviour; all stakeholders need to step up their resource allocation and political will; and there needs to be a "continuous and consistent availability of antiretrovirals for people living with HIV and AIDS".³³

REPUBLIC OF MALAWI

Population: 15,906,483¹



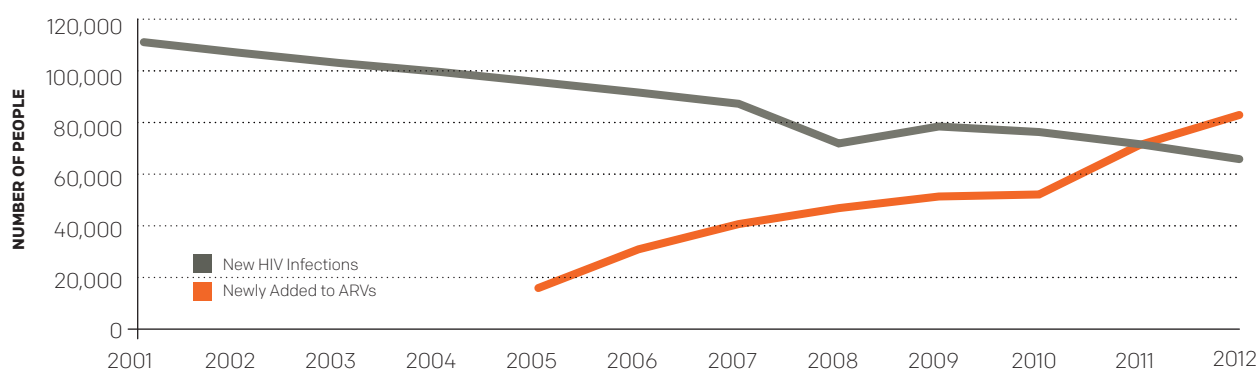
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$5.03bn	\$5.40bn	\$5.61bn
Total Bilateral Aid for AIDS ³	\$86.85m	\$69.16m	\$73.20m
Total Multilateral Aid for AIDS ⁴	\$66.40m	\$56.80m	\$67.04m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$351.41m (18.52%)	\$375.30m (18.52%)	\$364.85m (18.52%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	1,100,595	1,114,808	1,129,768 ⁸
HIV Prevalence Rate Among Adults ⁹	11.23% ¹⁰	10.98%	10.77%
Number of New Paediatric Infections ¹¹	21,918	17,352	10,795
PMTCT Coverage Rate ¹²	26%	32%	60%
Number of AIDS Deaths ¹³	56,805	52,098	45,621 ¹⁴

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Just a decade ago, the AIDS epidemic was devastating Malawi: in 2002, more than 15% of the adult population was HIV-positive, more than 107,000 children and adults were infected with the virus, and 90,000 people died of AIDS-related causes.¹⁵ By the end of 2012, the prevalence rate had dropped to under 11%, the number of new infections had been cut to 65,000 per year,¹⁶ and the number of AIDS-related deaths had dropped by half to just under 46,000 a year. Meanwhile, the number of people added to AIDS treatment had jumped from almost zero in 2002 to 16,000 in 2005, and then quintupled to 83,000 by 2012. In that year, 69% of those eligible for HIV treatment were receiving it. Between 2005 and 2012, Malawi's AIDS ratio dropped substantially as well – from 6.0 in 2005 to 0.79, below the tipping point, in 2012.¹⁷

In Malawi, government officials at the highest level are closely involved with the fight against AIDS, which has helped ensure the country's success in fighting the disease. President Joyce Banda is also the minister responsible for HIV/AIDS, and she appoints the Chair of the Board of the National AIDS Commission (NAC).¹⁸ The NAC brings together private, public, faith and civil society organisations, youth and people living with HIV to create national AIDS response plans.¹⁹ The first of these HIV and AIDS National Strategic Plans (NSPs) was released in 2005 (as a replacement for the previous National HIV and AIDS Strategic Framework of 2000–04) and then extended to 2012. Currently, there is an NSP for the period 2011–16.²⁰ The NSPs are built around the "Three-Ones Principle": one coordinating authority, one strategic framework and one monitoring and evaluation framework.²¹ The current framework recommends interventions for preventing and treating AIDS, including promotion of behaviour change; mainstreaming and decentralisation of testing and treatment; research for prevention and treatment mechanisms;

improvements in monitoring and evaluation (M&E); enhanced resource mobilisation; and partnerships with key groups. Free access to ARVs, which began in 2004 under the Ministry of Health, has contributed in particular to Malawi reaching the beginning of the end of AIDS.²² The national AIDS plans are particularly successful as they are integrated into the government's broader Malawi Growth and Development Strategy (MGDS).²³ In addition to its comprehensive NSPs, Malawi also has more targeted intervention plans, including its HIV Prevention Strategy (2009–13), National Plan for Elimination of Mother to Child Transmission (2011–15), a Male Circumcision Policy and a new Monitoring and Evaluation Plan (2011–16).²⁴

Malawi has also shown its commitment to health programmes by spending a greater proportion of its national budget on health than any other sub-Saharan African country, except for Rwanda. It has exceeded its Abuja target of allocating 15% of its domestic budget for health programmes, spending 18–19% on health annually since 2008.²⁵ In response to ONE's questionnaire, Malawi reported spending \$5 million in domestic resources on HIV/AIDS programmes in FY2011–12.²⁶ International aid – especially from the Global Fund and PEPFAR – has also played a critical role in ensuring sufficient funding and a rapid expansion of access to ARVs. Four of Malawi's nine Global Fund grants have been for HIV/AIDS and have been administered by the NAC. HIV grant disbursements from the Global Fund to date total \$475 million.²⁷ Meanwhile, as a PEPFAR focus country,

Malawi also received \$65 million in FY2011 from PEPFAR.²⁸ Top HIV donors to Malawi between 2009 and 2011 were the Global Fund, followed by the US, UK, the IDA and Norway.²⁹

However, much more remains to be done to more fully control AIDS in Malawi. Under the 2010 WHO guidelines, 70% of those eligible for ARVs were on treatment.³⁰ Although this is one of the higher coverage rates in the region, it is a long way from the target of universal access (90%). Malawi's policy of putting all HIV-positive pregnant women on lifelong AIDS treatment has led to a dramatic increase in PMTCT coverage in recent years. Nevertheless, under the 2010 WHO guidelines, PMTCT coverage for HIV-positive mothers is still only 60%, far from the goal of 90% by 2015. In addition, about two-thirds of eligible children are not receiving AIDS treatment.³¹ Bringing down HIV prevalence in urban areas remains a challenge: prevalence is twice as high in cities as it is in rural areas, and young people in particular have a low perception of risk.³² More attention must be paid to reaching out to members of the most at-risk populations (MARPs). In 2012, President Banda suspended all laws criminalising homosexuality.³³ This is a very welcome first step, but high levels of stigma and discrimination against these populations remain, and data and research on these groups is practically non-existent. Without all demographics receiving attention, it will be impossible for Malawi to move from beginning to end its AIDS epidemic to truly ending it.

CSO SPOTLIGHT

MALAWI NETWORK OF AIDS SERVICE ORGANISATIONS (MANASO)

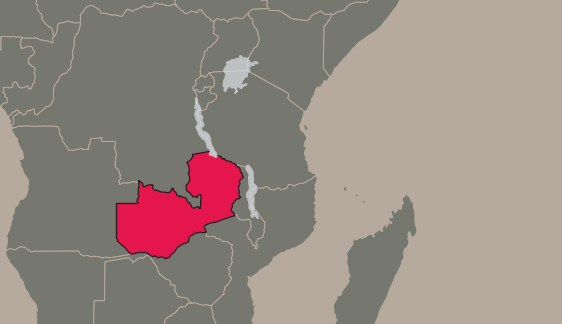
<http://www.manaso.org/>

The Malawi Network of AIDS Service Organisations (MANASO) was founded in 1996 to coordinate the activities of organisations working on AIDS in the country, and ultimately aims to improve the effectiveness of HIV/AIDS service delivery. Its work is funded by a number of governmental, international and civil society organisations, including the Malawi National AIDS Commission (NAC). MANASO aims to ensure that organisations – including government and donor agencies – share experiences and good practices, and receive sufficient technical support and assistance for resource mobilisation. It organises skills development workshops, networking forums, mentoring programmes and exchange visits for all of its stakeholders and members. MANASO also coordinates the activities of its members around national and regional World AIDS Day campaigns in Malawi.

MANASO's offices act as resource centres for members and offer HIV/AIDS information materials, as well as access to computers and the Internet. It currently has 850 member organisations spread across the country, 80% of which are community-based.³⁴ A key aim is the empowerment and participation of vulnerable groups, including women and girls as well as disabled persons.

REPUBLIC OF ZAMBIA

Population: 14,075,099¹



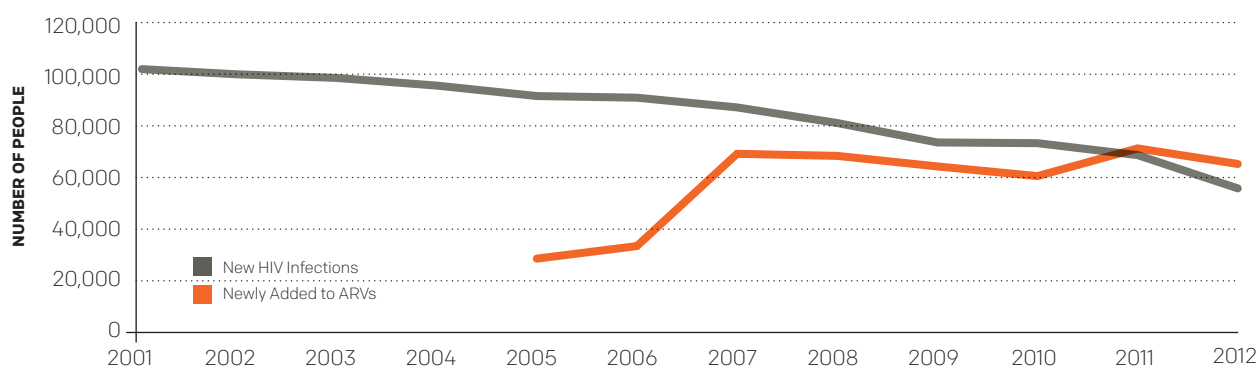
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$12.81bn	\$16.19bn	\$19.20bn
Total Bilateral Aid for AIDS ³	\$176.71m	\$178.49m	\$207.28m
Total Multilateral Aid for AIDS ⁴	\$50.49m	\$41.82m	\$92.60m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$416.31m (15.25%)	\$585.19m (15.98%)	\$732.22m (15.98%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	1,072,414	1,093,250	1,106,446
HIV Prevalence Rate Among Adults ⁸	13.11%	12.97%	12.73%
Number of New Paediatric Infections ⁹	18,442	14,155	9,404
PMTCT Coverage Rate ¹⁰	43%	94%	95%
Number of AIDS Deaths ¹¹	35,680	35,674	30,285

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

In 2002, Zambia's AIDS epidemic was one of the worst in the world. In that year 80,000 people died of AIDS, nearly 15% of the adult population had HIV, and 100,000 people were newly infected with the virus. Virtually no one had access to treatment. Within three years, the situation had improved considerably: by 2005, the number of new infections had dropped to 92,000 and the number of people on treatment had increased from nearly zero to more than 48,500. Since then, progress has been rapid and extensive. In 2012, the number of new infections had decreased by almost half from 2002 – to just under 56,000 – while the number of AIDS-related deaths was 30,000, fewer than half the number just a decade earlier. In total, 12.7% of adults had HIV. Some 79% of eligible Zambians were receiving treatment, and the country's AIDS ratio had dropped from 3.2 in 2005 to 1.1 in 2009, and to below the tipping point – 0.86 – in 2012.¹²

Central to this success has been the particularly strong response to AIDS from the Zambian national government. The government declared AIDS an emergency in the mid-1980s¹³ and key government officials have made HIV a priority since then. President Michael Sata has repeatedly emphasised the importance of ending AIDS, has campaigned for more HIV prevention education and has allocated more of the health budget specifically for increased HIV programmes.¹⁴ He has also earmarked funding to all ministries to be used for creating HIV/AIDS workplace programmes¹⁵ to support HIV-positive employees.¹⁶ In the early 2000s, the government created the National AIDS Council (NAC) to coordinate the country's comprehensive HIV response plan. Working with the Ministry of Health, the NAC has released three successive National AIDS Strategic Frameworks (NASFs) that align with comprehensive national frameworks, such as Vision 2030 and the Sixth National Development Plan. The NASFs also emphasise Zambia's "Three-Ones" principle for fighting

the epidemic: one coordinating authority, one national strategic framework and one national M&E framework, which together make up the country's comprehensive, long-term AIDS response. This response consists of four clear national priorities: 1) reducing the number of new infections from 82,000 in 2009 to 40,000 by 2015; 2) creating universal access to AIDS treatment and care with a 12-month retention rate of 85% by 2015; 3) mitigating the socio-economic impacts of HIV/AIDS by reducing the number of vulnerable households by 50% by 2015; and 4) strengthening capacity for a well coordinated, multi-sectoral AIDS response. Specific efforts to drive progress towards these goals include work to improve behaviour change; reduce stigma; integrate HIV testing and treatment into general health care; decentralise and scale up facilities; scale up access to prevention mechanisms such as male circumcision, PMTCT, post-exposure prophylaxis and increased access to male and female condoms in all regions of the country; and intensify HIV prevention education campaigns.¹⁷

In an attempt to boost funding for HIV programmes,¹⁸ President Sata has increased the share of the budget spent on health programmes every year since he took office. WHO reports that the country spent at least 15% of its budget on health between 2009 and 2011, meeting its Abuja commitment.¹⁹ Zambia produces an annual budget book showing details of authorised expenditure; this document does not make clear the total HIV/AIDS allocation for each year, but it does indicate that overall commitments to health may have dropped since 2011. The Zambian government reported to ONE that it spent a cumulative total of almost \$100 million on HIV/AIDS programmes between 2009 and 2012.²⁰ Still, Zambia's AIDS response is heavily dependent on aid, and it is one of the world's largest recipients of HIV funding from both PEPFAR and the

Global Fund. The country currently has ten active HIV/AIDS grants, and in total has received more than \$483 million in HIV funding from the Global Fund since 2003.²¹ Zambia is a PEPFAR focus country and has received more than \$262.3 million since 2004; in 2011 alone, it received \$57.5 million.²² Zambia's PEPFAR programme is unique in that in 2012 it served as a launching pad for the "Pink Ribbon, Red Ribbon" initiative, leveraging the country's existing health infrastructure and AIDS partnerships to provide screening for breast and cervical cancers as well.²³ Between 2009 and 2011, the top AIDS donors to Zambia were the US, followed by the Global Fund, Ireland, the UK and Denmark.²⁴

Zambia has reached the tipping point in the beginning of the end of AIDS, but to end the epidemic altogether it needs to focus on a few specific issues. Access to treatment for HIV-positive children must be scaled up: it is particularly low, with about 60% of eligible children not receiving treatment.²⁵ More attention must also be paid to marginalised populations. Although the NASF emphasises improving access to care and treatment among MARPs, the criminalisation of same-sex activity, combined with stigma against sex workers, drug users and others, hinders realisation of this goal. As the number of new infections decreases among the general population, new infections are increasing among these most at-risk and marginalised populations, slowing Zambia's overall progress in reducing the number of new infections. Finally, as a country whose AIDS response is largely donor-dependent, Zambia must make its national AIDS response more accountable and sustainable. In particular, it must significantly improve the transparency and management capacity of the NAC to ensure that its resources are well used.

CSO SPOTLIGHT

CHURCHES HEALTH ASSOCIATION OF ZAMBIA (CHAZ)

<http://www.chaz.org.zm>

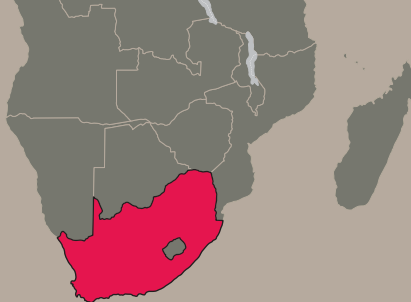
Churches Health Association of Zambia (CHAZ) is the second largest health provider in the country. It works hand-in-hand with the Ministry of Health implementing programmes throughout Zambia, including in hard-to-reach rural areas. Founded in 1970, CHAZ is a membership-based organisation of 146 CSOs around the country. It has an impressive outreach, working in 56 of 72 districts in Zambia through 26 hospitals, 81 health centres, nine training schools and 29 community-based organisations (CBOs).²⁶ Its mission is to "serve poor and underserved communities with holistic, quality and affordable health services".²⁷ Its services are based on Christian values, but are open to all denominations.

CHAZ has been a principal recipient (PR) of Global Fund grants (HIV, TB and malaria) since 2003, and is the PR of the (RED) grant through the Global Fund to Zambia, with a grant amount of \$102.1 million. It also receives grants from PEPFAR, the Centers for Disease Control (CDC), the European Union (EU) and UNICEF, among others. Recognised as a good steward of funds, CHAZ was also asked to take over additional grants alongside UNDP in 2012 when it was revealed that some Global Fund resources had been mismanaged by the Ministry of Health. Between 2003 and 2013, \$250 million has been pledged to CHAZ for HIV/AIDS work, of which \$168 million has to date been received. With these funds, over 44,500 people have received ARVs, over 13,100 treatments have been provided to prevent mother-to-child transmission of HIV, around 53,000 orphans and vulnerable children (OVCs) have received support and over 360,000 people have benefited from testing and counselling services.²⁸ CHAZ not only administers the grants, but is also involved in selecting the programmes that are supported, together with the Ministry of Health. Hospitals are chosen as recipients based on whether they have the services and facilities for HIV-related activities. Other HIV support programmes (such as training of community workers) apply to CHAZ for funding, and independent consultants through UNAIDS then assess the applications.

In order to stay on track towards achieving the beginning of the end of AIDS in Zambia, CHAZ believes that service provision needs to be improved, in particular for "poor and underserved communities", and that Zambia needs "to ensure sustainability of holistic, quality and affordable" health services.²⁹

REPUBLIC OF SOUTH AFRICA

Population: 51,189,307¹



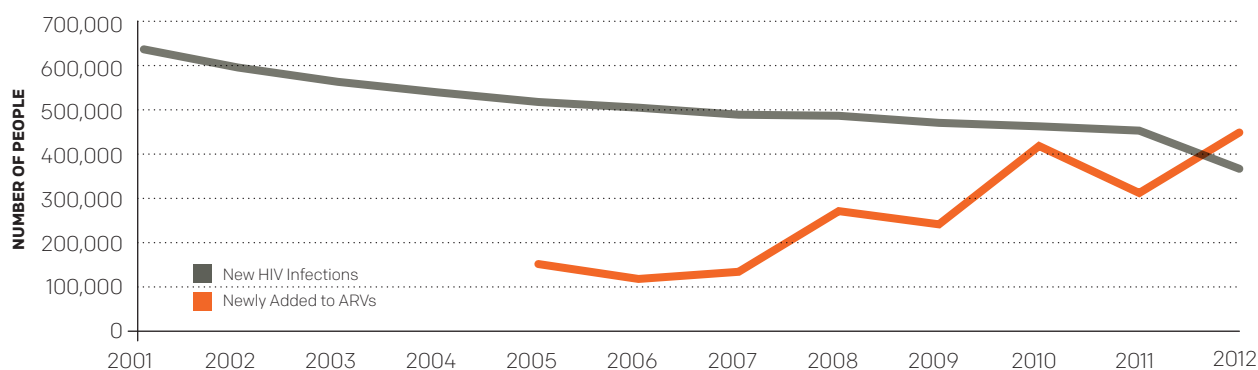
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$285.22bn	\$363.20bn	\$402.25bn
Total Bilateral Aid for AIDS ³	\$543.79m	\$525.82m	\$570.76m
Total Multilateral Aid for AIDS ⁴	\$32.28m	\$48.41m	\$24.63m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$10.87bn (11.59%)	\$14.64bn (12.42%)	\$16.40bn (12.71%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	5,883,403	5,974,561	6,070,751
HIV Prevalence Rate Among Adults ⁸	17.63%	17.77%	17.86%
Number of New Paediatric Infections ⁹	20,579	21,321	20,818
PMTCT Coverage Rate ¹⁰	91%	89%	87%
Number of AIDS Deaths ¹¹	373,851	332,936	235,110

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Despite having the largest AIDS epidemic of any country in the world, with nearly 18% of the country's adults infected with HIV in 2012, South Africa has made steady progress in the fight against the disease. In 2002, nearly 4.7 million people were infected with HIV, with nearly 600,000 becoming newly infected in that year alone, and virtually no one was on treatment. By 2005, the number of new infections had dropped to 518,000, though the number of people living with HIV had increased to 5.3 million. In that year, 152,000 HIV-positive people were added to treatment for the first time. By 2012, these numbers had improved dramatically. There were 367,000 new infections, with 449,000 added to treatment. In that year, 80% of those eligible for treatment were receiving it. South Africa's AIDS ratio of people newly infected to people newly added to treatment has improved accordingly in that time – from above 3.4 in 2005 to 0.82 in 2012, indicating that it has reached the beginning of the end of AIDS if it can keep to this trajectory.¹²

South African political leadership on HIV/AIDS has made significant leaps forward since the early 2000s, when former President Thabo Mbeki refused to accept that HIV caused AIDS, denied the existence of an epidemic and contributed to the unnecessary deaths of as many as 330,000 people.¹³ In particular, world leaders and South Africans^{14,15} alike have praised the leadership of the current Minister of Health, Aaron Motsoaledi, who is presiding over a much more robust political and programmatic response. In 2000, the Department of Health set up the South African National AIDS Council (SANAC) as the multi-sectoral coordinating body responsible for outlining and overseeing the national AIDS response.¹⁶ It has released three National Strategic Plans (NSPs) so far, with the third (2012–16) currently being implemented. The current NSP has a stated mission of prioritising HIV prevention measures in South Africa's AIDS response, but outlines five broad goals that range from prevention

to treatment interventions. These include cutting new HIV infections in half over the course of the plan period through robust prevention methods; ensuring that 80% of those who need AIDS treatment receive it; cutting by half the number of new TB infections and deaths; ensuring an enabling and accessible legal framework that protects and promotes human rights; and reducing self-reported stigma related to HIV and TB by 50%.¹⁷ The NSP is in line with the Department of Health's vision to provide a healthy life for all citizens.¹⁸

Domestic financing for health in South Africa has never reached the Abuja target of 15% of the national budget being allocated for health, but government spending on health has been increasing recently. On average, 11% of the country's budget goes to health, with a high of 12.7% in 2011. However, absolute spending on health has increased dramatically in recent years, from \$11 billion in 2009 to \$16.4 billion in 2011.¹⁹ The latest reports to UNAIDS in 2009 indicate that \$1.93 billion was spent in that year on HIV/AIDS programmes.²⁰ According to South Africa's budget, the country has appropriated about R29.21 billion (\$1.12 billion) for HIV/AIDS programmes in FY2013, much of which is for direct first-line treatment costs.²¹

Still, international assistance has been essential for South Africa's accelerated AIDS response. Between 2009 and 2011, the top AIDS donors to the country were, in order, the US, the Global Fund, the UK, the Netherlands and Sweden.²² South Africa currently has five active grants from the Global Fund and in total has received \$336 million in HIV/AIDS programme funding since 2003. As a PEPFAR focus country, it received \$549 million in 2011 and has received \$3.2 billion since

2004.²³ The PEPFAR-South Africa Partnership Framework signed in 2010 was a first of its kind, as it outlines a transition plan for South Africa to gradually take ownership of its AIDS epidemic between 2012 and 2017. This would make the South African government responsible for all HIV/AIDS programmes and policies and for the complete funding of national HIV/AIDS programmes.²⁴ Currently, the government is covering more than 70% of total costs. The transition calls for a substantial reduction of PEPFAR funding to \$250 million a year by 2015, with additional reductions thereafter. South African investments would simultaneously increase from \$1.1 billion to \$1.8 billion.²⁵

South Africa has made great headway in fighting its AIDS epidemic. However, as is the case in many sub-Saharan African countries, the attention paid to key but marginalised populations is not sufficient. The legalisation of all same-sex activity in South Africa has been an important step in allowing some of these populations to actively seek out care and treatment, but there need to be more targeted prevention and treatment programmes to reach them.²⁶ Conversations with civil society leaders also suggest that improving sex education and addressing violence against women are also increasingly important to supporting broader HIV prevention efforts.²⁷ To realise the NSP's vision of a South Africa with no new HIV infections, SANAC must specifically target interventions at the most at-risk populations. Finally, as donor support phases out in the coming years, the South African government must scale up its domestic resources for AIDS and strengthen its health systems management capacity, so that it can continue providing the highest quality of services for citizens.

CSO SPOTLIGHT

SECTION27

<http://www.section27.org>

SECTION27 is a team of activists who use research, advocacy and legal action to promote social justice in South Africa, particularly in access to quality health care and basic education. Established in 2010, it evolved from the AIDS Law Project, which played a central role in ensuring that South Africans have access to antiretroviral treatment and pregnant mothers have access to the drugs that protect them from passing HIV to their children. It is named after Section 27 of the South African constitution, which stipulates socio-economic rights (including the right to health). SECTION27 views HIV/AIDS as a "litmus test for the delivery of health services, requiring a focus on rights, access, appropriate budgeting and expenditure, and better quality and more affordable public and private health systems".²⁸

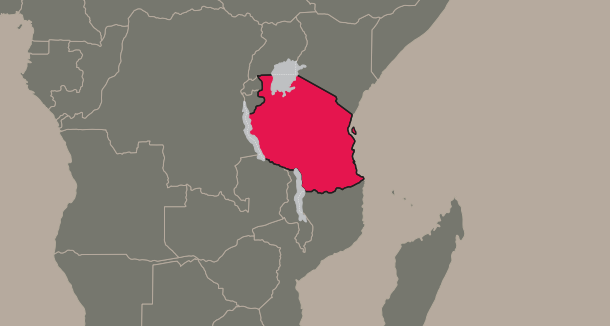
SECTION27 has been involved in a number of notable legal cases, focusing on the access of prisoners to anti-tuberculosis drugs and ARV treatment, drug stock-outs, various systemic health challenges and the roll-out of a National Health Insurance system. Most recently, with its aim of ensuring that the health system meets its constitutional obligations, it was involved in a landmark case concerning TB in prisons.²⁹

Together with the activist organisation Treatment Action Campaign (TAC), SECTION27 publishes a regular review of the National Strategic Plan for HIV, STIs and TB, which aims to provide quality analysis and monitoring of the implementation of the plan, and a means to hold to account entities such as SANAC and its provincial bodies.³⁰

For South Africa to reach the beginning of the end of AIDS, SECTION27 cautions against complacency, in particular in efforts to prevent new infections: "In South Africa we have massive numbers of people who are living with HIV/AIDS and there is a realization that we are not going to treat our way out of this epidemic, although it is critical that those living with HIV have seamless access to ARVs."³¹ For this purpose, SECTION27 calls for a combined approach of targeting vulnerable groups and the wider population, increased integration of TB and HIV care, increased support for those already on ARVs and increased access to more reliable prevention methods for women.

UNITED REPUBLIC OF TANZANIA

Population: 47,783,107¹



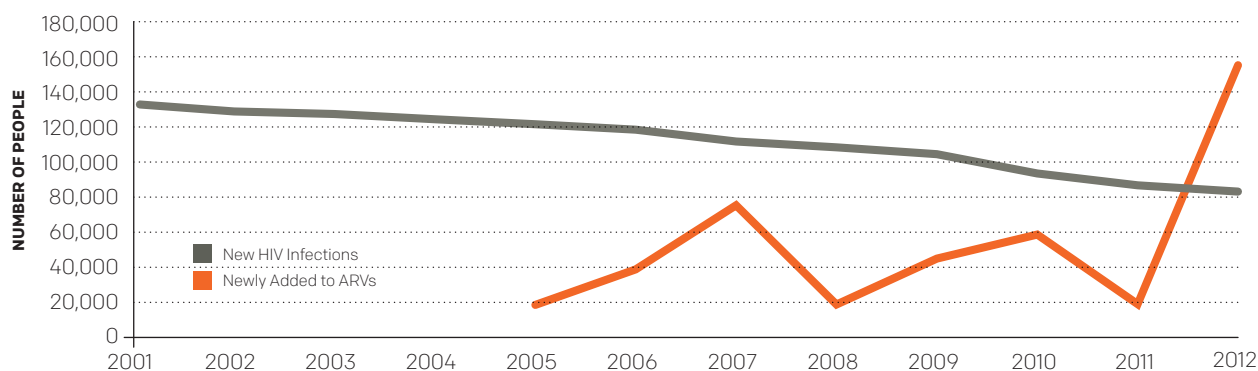
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$21.37bn	\$22.90bn	\$23.85bn
Total Bilateral Aid for AIDS ³	\$205.03m	\$267.50m	\$282.03m
Total Multilateral Aid for AIDS ⁴	\$59.16m	\$98.52m	\$85.56m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$872.06m (15.13%)	\$700.53m (11.13%)	\$714.49m (11.13%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	1,476,197	1,476,436	1,472,441
HIV Prevalence Rate Among Adults ⁸	5.38%	5.25%	5.10%
Number of New Paediatric Infections ⁹	23,815	16,060	14,473
PMTCT Coverage Rate ¹⁰	59%	73%	77%
Number of AIDS Deaths ¹¹	82,784	78,988	80,014

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Tanzania has made moderate, though irregular, progress in the fight against AIDS in the past decade.¹² In 2002, 1.5 million people were living with HIV and another 129,000 people were newly infected with the virus. By 2005, the situation had improved only slightly: new HIV infections had decreased by 5%, and 1.47 million people were still living with the virus. Tanzania's most significant improvement in the past decade has been in access to treatment, from virtually no one receiving treatment in 2002 to 155,000 people added in 2012, a huge jump from previous years.¹³ Efforts to reduce new infections improved dramatically in that time as well: there were 83,000 new infections in 2012, a drop of 32% from 2005. In 2012, 5% of the adult population had HIV, and 61% of those eligible for treatment were receiving it. In recent years, Tanzania's AIDS ratio of people newly infected compared with people newly added to treatment has improved accordingly, from over 6.5 in 2005 to below the tipping point – 0.54 – in 2012. In the interim years, however, progress has been bumpy, primarily due to varying numbers of people being added to treatment. In 2007, Tanzania's AIDS ratio was about 1.5. The following year it spiked significantly to 5.8, and then dropped in 2009 to 2.3; in subsequent years it has dropped steadily, though with a brief increase in 2011.¹⁴

President Jakaya Kikwete and other senior government officials have demonstrated significant openness in discussing HIV/AIDS and have shown commitment to ending the epidemic by consistently addressing the country's progress and challenges in both domestic and international settings.¹⁵ The Tanzania Commission for AIDS (TACAIDS) was founded by then President Mkapa in 2001 to coordinate government and civil society stakeholders in strengthening efforts to fight the disease. Although it is an independent department, it sits in the Prime Minister's office.¹⁶ As the key coordinating body for AIDS, TACAIDS has published both of Tanzania's

Multi-Sectoral National Strategic Frameworks for HIV/AIDS. The first of these plans (2003–07) focused on creating an enabling environment for freely discussing and addressing AIDS prevention, treatment and impact mitigation.¹⁷ The second and most recent plan (2008–12)¹⁸ builds on the first, and aims to provide more comprehensive services, including to all population groups.¹⁹ The strategy for 2013–17 has been finalised and is to be launched in November 2013. Tanzania's Health Sector Strategic Plan III (HSSP 2009–15) and National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008–15)²⁰ also include HIV and PMTCT intervention targets.

In line with its Abuja Commitment in 2001, Tanzania met or exceeded the 15% target for national health spending in 2006–09, but in 2010 and 2011 the amount spent on health fell to just above 11%, and fell in real terms as well.²¹ Tanzania's budget suggests that the government allocated TZS18.12 million (about \$11.4 million) for HIV/AIDS programmes in FY2013.²² The country is also currently considering the establishment of a trust fund for HIV, which could further channel funds to HIV/AIDS interventions.²³ At the same time, international funding continues to be critical for the support of HIV programmes, through partnerships with

international mechanisms such as the Global Fund and PEPFAR. Since 2002, Tanzania has received 15 Global Fund grants, nine of which were for HIV/AIDS or HIV/TB, while \$653 million of the \$1.06 billion disbursed by the Global Fund has been for HIV/AIDS programmes.²⁴ Tanzania is also a PEPFAR focus country, receiving \$1.9 billion in cumulative assistance since 2004.²⁵ Between 2009 and 2011, the US was the top donor to the country's HIV/AIDS programmes, followed by the Global Fund, Denmark, Germany and Japan.²⁶

Tanzania faces a number of challenges ahead in its fight against AIDS. In particular, the country must increase its capacity and training for health workers;²⁷ improve its supply chain for HIV commodities, including HIV test kits; and improve data monitoring and evaluation, especially with CD4 counts.²⁸ In addition, key populations – especially MSM, people who inject drugs and sex worker populations – continue to face stigma and discrimination, especially as homosexuality and drug use are illegal under Tanzanian law. As is the case in many countries, HIV rates among these marginalised populations have not decreased significantly, which must happen for Tanzania to successfully end its AIDS epidemic.²⁹

CSO SPOTLIGHT

FEMINA HIP

<http://www.feminahip.or.tz>

Femina HIP is a multimedia platform and civil society initiative working with youth, communities and strategic partners across Tanzania. Since 1999, its goal has been “to promote healthy lifestyles, sexual health, HIV/AIDS prevention, gender equality and citizen engagement”.³⁰ More recently it has also worked on economic empowerment, with a focus on entrepreneurship, financial literacy and livelihoods in agriculture.³¹ Through two magazines, TV shows, radio programmes, a website and roadshows across the country, its approach is to combine education and entertainment in a blend of “edutainment”.³²

Femina HIP engages communities across the country in dialogue, aiming to give people a “voice” to share experiences and create a supportive environment, and advocate for good leadership. It features real-life stories, testimonials, role modelling and “docu-drama”, and engages youth with the aim of providing “the information, life skills, and the motivation needed for young people to make positive life choices”.³³

Femina HIP's two main magazines, with a circulation of 300,000 copies, are distributed to around 600 in-and-out-of-school clubs. Its TV and radio shows are aired across the country, with approximately 800,000 people tuning in weekly. Through its outreach and the 600 Fema Reading Clubs, its messages reach around 11 million people. Its roadshows are organised and carried out with partners, local organisations, people living with HIV/AIDS and local authorities in order to raise important issues, such as stigma. Roadshows include dance and musical performances, theatre and Q&A sessions. Femina HIP is partnering with TACAIDS³⁴ to put together an essential “minimum education package” at the district level.

For Tanzania to reach the beginning of the end of AIDS, Femina HIP believes that by continuously engaging with youth, “widespread attitude and behaviour change at both the individual and social level” can contribute to a continued decline in HIV rates.³⁵

REPUBLIC OF UGANDA

Population: 36,345,860¹

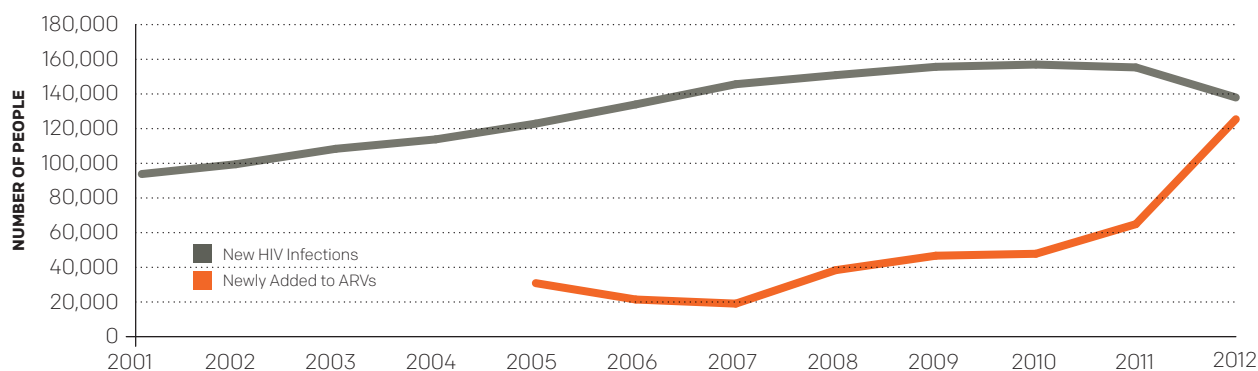
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$16.55bn	\$17.18bn	\$18.21bn
Total Bilateral Aid for AIDS ³	\$258.46 m	\$257.99m	\$264.67m
Total Multilateral Aid for AIDS ⁴	\$7.80m	\$27.45m	\$19.17m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$344.83m (12.17%)	\$411.79m (10.82%)	\$391.88m (10.82%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	1,406,577	1,485,502	1,549,154
HIV Prevalence Rate Among Adults ⁸	7.03%	7.16%	7.24%
Number of New Paediatric Infections ⁹	28,168	27,871	15,165
PMTCT Coverage Rate ¹⁰	—	—	72%
Number of AIDS Deaths ¹¹	67,344	65,708	63,287

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Uganda has made progress in the fight against AIDS over the past ten years, but this progress has been erratic. In 2002, about 100,000 Ugandans were newly infected with HIV, a million people were HIV-positive and almost no one had access to treatment. By 2005, the number of new infections had actually increased to 123,000, but 31,000 people were added to treatment for the first time. By 2012, there was mixed progress: although the number of people added to treatment quadrupled from 2005, only 64% of those eligible for treatment were receiving it and the number of new infections, at 138,000, was higher than in 2005. However, the rate of new infections has fallen since 2010, when it peaked at 157,000. Uganda's AIDS ratio of people newly infected to people newly added to treatment has improved consistently since 2007, although it worsened between 2005 and 2007, from 3.98 to 7.6. By 2009, it had dropped back down to 3.3 and then to 1.1 by 2012. Much of this progress has come due to enormous scale-ups in access to treatment, rather than from a sustained reduction in new infections.¹²

The Ugandan government's AIDS response has been diminished in recent years, compared with its world-renowned anti-AIDS campaign in the 1990s and early 2000s. In order to reverse the recent stagnation of progress, President Yoweri Museveni committed in 2013 to redouble the country's efforts against AIDS, especially by scaling up its HIV prevention strategy.¹³ The national AIDS response is coordinated by the Uganda AIDS Commission (UAC), which releases National Strategic Plans that outline priorities for the fight against the disease. Until recently, these plans focused both on scaling up HIV testing and treatment capabilities and on emphasising prevention mechanisms.¹⁴ With more recent evidence that the annual number of new HIV infections is on the rise, the focus has shifted to eliminating new infections, with the theme "Re-engaging Leadership for Effective HIV

Prevention: Accelerating Action towards Zero New Infections". Interventions include promoting safer sexual behaviour and the reduction of risk-taking behaviour; attaining critical coverage of effective HIV prevention services; creating a sustainable enabling environment that mitigates the underlying structural drivers of the epidemic; improving strategic information for HIV prevention; and re-engaging leadership and re-energising coordination for HIV prevention.¹⁵ Some of the increase in the annual number of new HIV infections over previous years has been attributed to ineffective campaigns on HIV prevention, which were considered confusing and which were dropped in 2009 in favour of more straightforward messaging on the risks of unprotected sex.¹⁶ More recently, the government has come under fire for its refusal to allow the use of Truvada, a form of pre-exposure prophylaxis (PrEP) that reduces the risk of HIV transmission between serodiscordant couples (where one partner is HIV-positive and the other is HIV-negative), on moral grounds.¹⁷

Historically, Uganda has not met its Abuja commitment for allocating 15% or more of its national budget for health programmes. The country generally spends about 10% of its budget on health, with a peak of 12% in 2009, though spending on health in real terms has nearly doubled since 2007.¹⁸ According to Uganda's latest budget, the country allocated UGX105.7 billion

(\$42.3 million) to HIV/AIDS programmes in FY2013.¹⁹ International funding for HIV programmes continues to provide the bulk of the resources.²⁰ Uganda currently has four active grants for HIV from the Global Fund, three of which have been administered by the Ugandan Ministry of Finance as principal recipient, and one by the AIDS Support Organization (TASO). Of \$490 million in total disbursed funds for AIDS, TB and malaria, more than \$202 million has been for HIV/AIDS.²¹ Uganda is also a PEPFAR focus country, and has received \$1.8 billion since 2004 for its HIV programmes.²² Between 2009 and 2011, the top donors to Uganda were the US, the Global Fund, Ireland, the UK and Denmark.²³

Uganda's main priority in ending its AIDS epidemic should be to reduce the number of new infections each year by scaling up prevention initiatives for the general population. Reaching key populations with prevention outreach continues to be extremely difficult due to the criminalisation of homosexuality and the stigma and discrimination associated with the disease. A proposed Anti-Homosexuality Bill currently under consideration would extend criminal sanctions, further undermining efforts to control the disease.²⁴ These kinds of initiative further marginalise these key populations, making them harder to reach. However, without reaching all segments of the population, Uganda cannot hope to end its AIDS epidemic.

CSO SPOTLIGHT

THE AIDS SUPPORT ORGANIZATION (TASO)

<http://www.tasouganda.org>

The AIDS Support Organization (TASO), founded in 1987 by 16 volunteers – seven of whom had HIV – has grown to become one of the largest organisations providing comprehensive HIV prevention, care and support services in Uganda. TASO's vision is "A World without HIV", and one of its core aims is "to realise the goal of zero new HIV infections".²⁵ Following a substantial decrease in HIV prevalence in the 1990s, TASO believes that in partnership both nationally and internationally, Uganda can once again bring prevalence rates down, following the rise in new infections in recent years.²⁶

TASO provides ARVs to about 64,000 people living with HIV, as well as caring for over 100,000 people each year.²⁷ It also provides PMTCT services and care and support for orphaned and vulnerable children (OVCs), training and capacity building, community mobilisation and HIV education, and carries out M&E and research. TASO service units are spread throughout the country, especially in HIV high-risk areas such as border towns and along major export/import transport routes. It operates through 11 service centres, four regional offices, a training centre and a capacity-building project in one of the least developed areas of Uganda.²⁸ TASO also manages small grants for the Global Fund. It provides services within community structures and employs 703 service providers in its service units, as well as over 6,000 community volunteers who offer HIV services in their communities.²⁹ TASO partners with the Ministry of Health, the Uganda AIDS Commission (UAC) and a large number of international donors.³⁰

TASO sees poverty as its greatest challenge. Poverty brings with it "risky behaviour such as drug abuse, alcoholism and irresponsible sexual behaviour. With poverty comes selling of underage girls as 'wives' to rich men."³¹ In order to achieve the beginning of the end of AIDS in Uganda, TASO believes that individuals and communities need to be mobilised to "continue breaking the silence on HIV and AIDS". Furthermore, "people should hold their government accountable while they too fight the war at an individual level".³²

REPUBLIC OF CAMEROON (RÉPUBLIQUE DU CAMEROUN)

Population: 21,699,631¹

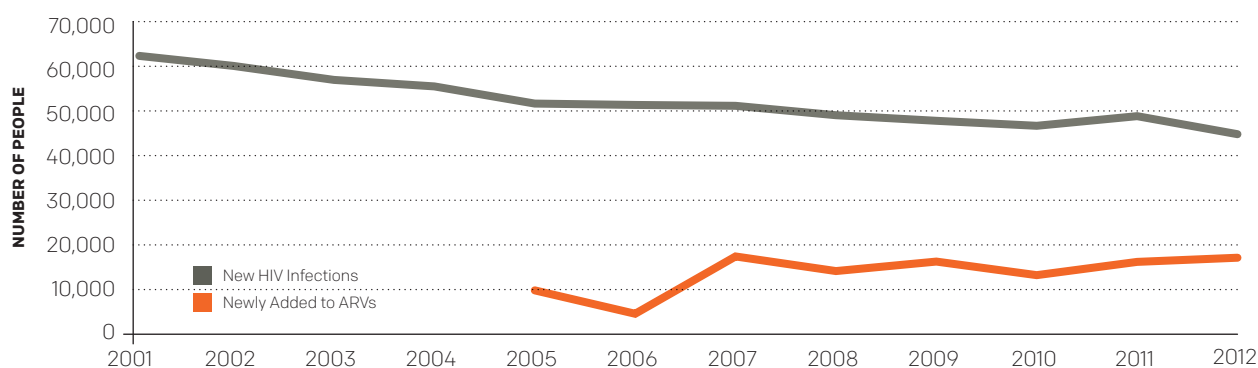
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$22.17bn	\$22.54bn	\$25.51bn
Total Bilateral Aid for AIDS ³	\$5.12m	\$8.58m	\$7.30m
Total Multilateral Aid for AIDS ⁴	\$23.58m	\$9.60m	\$8.55m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$300.14m (7.34%)	\$356.79m (8.53%)	\$466.28m (8.53%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	586,678	595,040	600,483
HIV Prevalence Rate Among Adults ⁸	4.66%	4.59%	4.50%
Number of New Paediatric Infections ⁹	6,211	6,332	5,822
PMTCT Coverage Rate ¹⁰	49%	55%	64%
Number of AIDS Deaths ¹¹	34,308	35,653	34,561

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Over the past decade, Cameroon has made little progress in the fight against AIDS. In 2002, the country had 506,000 people living with HIV, with 60,000 more newly infected in that year. Three years later, the number of new infections had dropped by only 8,000 and just 9,800 people were newly added to treatment. Since then, progress has continued to be slow, with 17,000 people added to treatment in 2012 despite another 45,000 new infections and a treatment coverage rate of just 45%. Cameroon's AIDS ratio of new infections to people newly added to treatment has also made little progress: although it was 5.3 in 2005 and had dropped to 2.9 by 2007, it was still at 2.6 in 2012 and fluctuated in the intervening years.¹²

The country's AIDS response is directed by the Comité National de Lutte contre le SIDA (the National AIDS Control Committee – CNLS), which was created in 1998. Consisting of key stakeholders – including people living with HIV, civil society, the private sector, government officials and UN partners – CNLS has created three national strategic plans outlining the fight against AIDS. The most recent plan, covering 2011–15, focuses on efforts to decentralise the AIDS response, to scale up both prevention and treatment efforts and to reduce stigma and discrimination. Specific interventions include promoting the use of condoms, providing free AIDS treatment, encouraging follow-up tests, scaling up the capacity of community stakeholders and scaling up HIV education in schools. The latest strategic plan also mentions strengthening prevention efforts for MARPs (in particular female sex workers, truck drivers, MSM and young women) and young people as particular priorities, along with engaging senior government officials in the campaign against AIDS.¹³ Cameroon's AIDS response has been integrated into broader national priorities, including La Vision 2035 (Vision 2035) and the Document de Stratégie pour la Croissance et l'Emploi (the Growth and Employment Strategy Paper, or DSCE), which

outlines the country's plans for creating economic growth and jobs.¹⁴ One of the loudest voices in support of the country's effort is that of its First Lady, Chantal Biya, who has helped to establish a number of AIDS charities and who frequently attends summits¹⁵ and makes speeches¹⁶ on the issue.

Domestic spending on health has remained low. Despite committing to the Abuja target of allocating 15% of its budget to health, the government has not yet allocated more than 8.5%, with an average of 7.4% spent on health since 2001.¹⁷ The total volume of health spending, however, has increased in recent years, from \$300 million in 2009 to \$466 million in 2011.¹⁸ In 2010, the latest year for which figures are available, self-reported data to the UN showed domestic spending of \$14.4 million on HIV programmes.¹⁹ Donor support has helped to supplement this financing gap; Cameroon currently has five active Global Fund grants for HIV, and to date has received \$115 million in HIV/AIDS financing from the Global Fund.²⁰ Cameroon is not a PEPFAR focus country, but it received \$5 million in HIV funding from the United States in 2011, as well as \$1.25 million from France and \$485,000 from Germany.²¹ Between 2009 and 2011, the top AIDS donors to the country were the Global Fund, the US, France, UNAIDS and Germany.²²

Much more needs to be done for Cameroon to reach the beginning of the end of AIDS. Both prevention and treatment levels remain low, indicating an urgent need to scale up both efforts. In particular, despite a positive commitment to improving prevention efforts among MARPs, there continue to be high levels of stigma and violence against marginalised populations, especially MSM, and homosexuality is criminalised in the country.²³ Several AIDS groups in the country have voiced specific concerns for the safety of AIDS advocates attempting to reach out to LGBT populations, and these concerns were heightened in 2013 as a number of educators and human rights defenders,²⁴ including the Executive Director of the Cameroonian Foundation for AIDS (CAMFAIDS), were murdered. In 2013, the Cameroonian Government also rejected nearly all the recommendations of the UN's Human Rights Council on addressing violence and discrimination against LGBT people in the country.²⁵ If the government is serious about its AIDS reduction goals as outlined in the strategic plan, there need to be much more rapid, visible and concrete shifts in action from its leadership at all levels to truly reach marginalised populations.

CSO SPOTLIGHT

POSITIVE-GENERATION (PG)

<http://www.cameroonaids.org>

In 1998, a group of students in Cameroon's capital city Yaoundé founded Positive-Generation (PG) to bring hope to a generation suffering from AIDS and the stigma associated with it. The aim of the association is to change attitudes by shining "a hopeful, positive light" on the situation and by changing the discourse around HIV/AIDS, to show that being HIV-positive is not a cause for desperation. It works to tackle stigma and discrimination, which it sees as the key battle in fighting AIDS, not only in Cameroon but in all of Africa.²⁶ The group quickly came to believe that "HIV/AIDS is fundamentally about rights, health and freedom",²⁷ and began to focus its work on strengthening the human rights of people affected by HIV/AIDS and TB and on health-care provision in the country. It supports the provision of legal advice to HIV-positive people who are discriminated against – for example, prevented from getting a job – because of their HIV status.

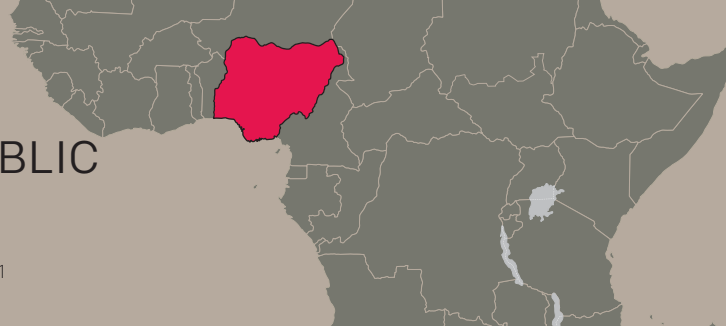
Today, Positive-Generation is an advocacy movement and, with a five-person team with five additional volunteers and over 60 members, has had a significant impact on how HIV/AIDS is perceived by Cameroonian people and by the government.²⁸ Members of PG reach out to students and communities to educate them about HIV/AIDS, TB and their right to health. They mobilise HIV-positive people and others affected by the disease to become active citizens to campaign for equal access to health care for all, without stigmatisation or discrimination.

PG also carries out advocacy for the Global Fund and holds the Cameroonian government accountable to its Abuja commitment of spending 15% of its budget on health care. In PG's view, the government's lack of political will to invest in the health of its whole population remains one of the key obstacles to expanding HIV services and other critical health interventions in Cameroon.²⁹ PG also carries out research and data collection and publishes a monthly bilingual newspaper. In 2012, the organisation won ONE's Africa Award as "the most life-changing, innovative organization helping to achieve the Millennium Development Goals in their country".³⁰

To reach the beginning of the end of AIDS in Cameroon, Positive-Generation believes that four issues are key: 1) people need to be encouraged to get tested; 2) they need to have free access to ARVs so that they start and do not stop treatment; 3) there needs to be a focus on vulnerable groups (including women and PMTCT); and 4) corruption needs to be beaten through good monitoring.³¹

FEDERAL REPUBLIC OF NIGERIA

Population: 168,833,776¹



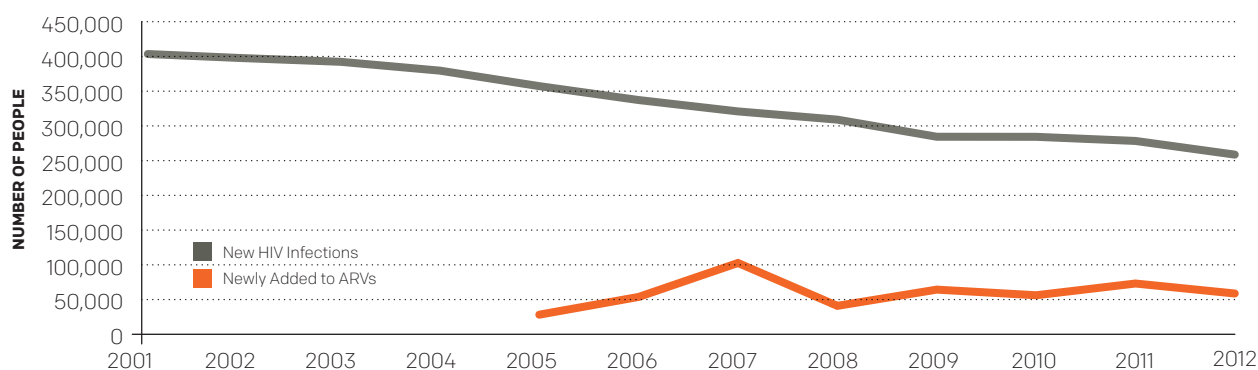
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$168.59bn	\$228.64bn	\$243.99bn
Total Bilateral Aid for AIDS ³	\$307.71m	\$382.16m	\$304.76m
Total Multilateral Aid for AIDS ⁴	\$61.38m	\$36.60m	\$81.88m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$3.40bn (7.41%)	\$3.50bn (5.73%)	\$5.33bn (7.51%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	3,428,833	3,438,216	3,426,586
HIV Prevalence Rate Among Adults ⁸	3.35%	3.25%	3.13%
Number of New Paediatric Infections ⁹	65,505	59,445	58,734
PMTCT Coverage Rate ¹⁰	10%	20%	17%
Number of AIDS Deaths ¹¹	226,587	238,093	239,742

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

While Nigeria has made some progress on reducing new infections over the past decade, its overall AIDS response has been insufficient. A decade ago, there were nearly 398,000 people newly infected with HIV, in addition to 2.8 million people living with the virus. In 2005, the number of new infections had dropped to 357,000, and 41,000 people were added to treatment for the first time. In 2012, 259,000 people were newly infected with the virus – a significant drop from 2002 – but 3.4 million were living with HIV, and the number of people added to treatment was particularly inadequate: just 59,000. Only 32% of those eligible for AIDS treatment were receiving it. Progress has been largely inconsistent as well. The country's AIDS ratio of new infections to people added to treatment was above 12 in 2005 and then dropped to 3 in 2007, but since then the epidemic has worsened, leaving it with a ratio of 4.4 in 2012.¹² Nigeria has done particularly poorly in reducing new infections among children. The country accounts for a third of the world's HIV infections among children, and it has reduced the rate of new child infections by only 8% since 2009 – from 65,000 to 60,000 – with virtually no progress made in the last year.¹³

The country's AIDS programme is coordinated by the National Agency for the Control of AIDS (NACA), which was established as a committee in 2001 and then upgraded to an agency six years later. It also oversees the State Action Committee on AIDS (SACA) and the Local Government Action Committee on AIDS (LACA), which coordinate sub-national responses. To guide the national response, NACA has released two National Strategic Frameworks (NSFs) that outline specific strategies to achieve an ultimate goal of universal access to HIV/AIDS treatment and prevention interventions. These strategies comprise six thematic areas: promotion of behaviour change to prevent new infections; treatment of HIV/AIDS and related health issues; care and support of people living with, or affected by, HIV and other vulnerable groups; policy,

advocacy, human rights and legal issues; improvements to the response infrastructure; and improvements to monitoring and evaluation (M&E) systems. The current NSF's primary goal is to maintain current rates of HIV care and treatment while focusing on scaling up HIV prevention interventions. To that end, the NSF emphasises behaviour change through increased education on prevention mechanisms, which would in turn lead to outcomes such as 80% of young people adopting appropriate HIV/AIDS-related behaviours and 80% of sexually active males and females using condoms both consistently and correctly by 2015.¹⁴ In addition to the NSFs, in 2012 President Goodluck Jonathan announced the launch of the Saving One Million Lives Campaign, which aims to save a million maternal and child lives by 2015 through various interventions, including scaling up PMTCT coordinated through NACA.¹⁵

Domestic financing levels for health are low in Nigeria. In its 2013 budget, the country appropriated NGN1,505.1 billion (\$9.39 million) for HIV/AIDS programmes.¹⁶ It has never come close to reaching the Abuja target of allocating 15% of its domestic budget to health, and on average only 6.4% of the budget has gone to health since 2001.¹⁷ This is particularly disappointing for a resource-rich country like Nigeria; if it had met its own goal of spending 15% on health every year, a total of \$34.7 billion in additional resources could have been freed up for spending on health programmes since 2001. That amount could have paid for treatment for all Nigerians and have still allowed for growth in spending for other health issues.¹⁸ Nigeria receives significant international resources to help support its AIDS response, including eight active grants for HIV from the Global Fund. To date, it has received \$411 million in HIV/AIDS funding from the mechanism.¹⁹ It is also a PEPFAR focus country, through which it has received a total of \$2.5 billion since 2004.²⁰ Between 2009 and 2011, the top AIDS donors to Nigeria were the US, the Global Fund, the UK, the IDA and UNICEF.²¹

It is evident that Nigeria's treatment and prevention programmes need significant scale-up, but the number of HIV care and testing sites has actually decreased in recent years. For a country as large as Nigeria, greater attention must be paid to ensuring that quality health services can be delivered equitably across a decentralised health system. Encouragingly, this is a priority outlined in the Saving One Million Lives Campaign. Additionally, while more resources for health commodities are important, Nigeria must also prioritise improvements to the health-care delivery system at the local and federal levels. With donors' technical support for such improvements, it can make real headway in improving the efficiency of its systems and can achieve greater health outcomes in the years to come.

Nigeria must also improve its prevention efforts for all key populations. The NSF outlines interventions targeted towards MARPs, with a goal of 80% of the MARP population receiving care and treatment, but high levels of stigma and discrimination against these populations hinder the achievement of this goal. The broad language contained in the 2013 Same-Sex Marriage Prohibition Bill (passed by the House of Representatives and the Senate and awaiting signature by the President at the time of writing) threatens to reverse some of the progress made in reducing HIV transmission among MSM by stipulating a minimum period of ten years in prison for "direct or indirect" involvement in issues concerning the rights of individuals of the same sex.²² Political moves such as this threaten to further derail Nigeria's efforts to expand prevention, treatment and care services to all in need.

CSO SPOTLIGHT

FRIENDS OF THE GLOBAL FUND AFRICA (FRIENDS AFRICA)

<http://www.friends-africa.org>

Friends Africa was founded in 2006 as a pan-African voice in support of the Global Fund – which "is the only innovative financing mechanism that brings together and fights three pandemics that result in high death rates in Africa and Nigeria".²³ Its secretariat is located in Lagos, Nigeria, but the organisation has a pan-African board and also operates through regional representatives across the continent. Friends Africa aims to mobilise the political and financial support of African governments, businesses and CBOs to manage these diseases. Through advocacy, it works to ensure that African governments follow through on their commitments to spend 15% of government budgets on health, as agreed at the Abuja Summit in 2001. Friends Africa's vision is "to create an African continent free of AIDS, TB and Malaria".²⁴

Since 2006, the organisation has held over 200 advocacy events and has raised more than \$31 million from African governments.²⁵ Funds raised are used to leverage additional funding for the Global Fund from traditional donors. Through the "Gift from Africa Campaign", Friends Africa has raised more than \$5 million in additional funds for African health care. It works through four pillars: advocacy and resource mobilisation; education/capacity building; documentation; and provision of technical assistance.

In Nigeria, one of Friends Africa's goals is to address the issue of HIV stigma and discrimination, which hinder demand for testing and treatment, as well as causing people to drop out of care.²⁶ It works through novel projects such as the Anti-Stigma Project: this year-long project includes the annual World AIDS Day "Play for Life" soccer match, which brings together local and international football players, celebrities from Nollywood (Nigeria's Hollywood) and people living with HIV/AIDS to mark World AIDS Day through advocacy against HIV stigma and discrimination. Friends Africa also advocates for improved transportation and decentralisation for ARV distribution to rural areas, "so that people do not have to journey for days to get their ARVs".²⁷

In order to reach the beginning of the end of AIDS in Nigeria, Friends Africa believes that "reducing stigma and discrimination will be critical; domestic spending needs to be increased, and Global Fund financing needs to be sustained; outreach programs need to get to where people are, especially in rural areas that are traditionally not reached; and there needs to be a collective effort with communities, CSOs, the private sector and government working together".²⁸

REPUBLIC OF TOGO (RÉPUBLIQUE TOGOLAISE)

Population: 6,642,928¹

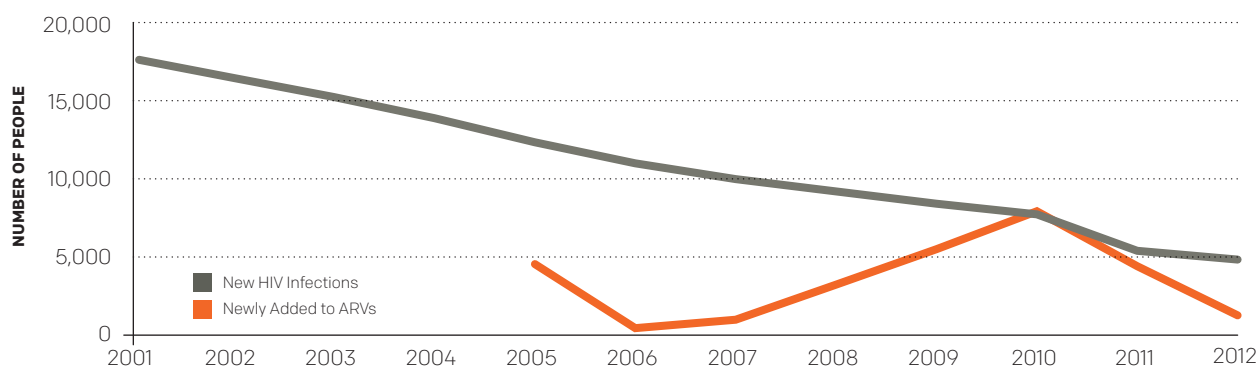
FINANCIAL INDICATORS	2009	2010	2011
Gross Domestic Product ²	\$3.17bn	\$3.18bn	\$3.69bn
Total Bilateral Aid for AIDS ³	\$1.61m	\$0.87m	\$1.73m
Total Multilateral Aid for AIDS ⁴	\$15.58m	\$10.47m	\$10.36m
Government Domestic Expenditure on Health ⁵ (% of Total Budget ⁶)	\$103.63m (15.38%)	\$110.26m (15.38%)	\$137.68m (15.38%)

Sources: IMF World Economic Outlook; OECD DAC; WHO National Health Accounts Indicators; and ONE calculations

EPIDEMIOLOGICAL INDICATORS	2010	2011	2012
Number of People Living with HIV ⁷	134,620 ⁸	131,344 ⁹	128,132 ¹⁰
HIV Prevalence Rate Among Adults ¹¹	3.27%	3.09%	2.92%
Number of New Paediatric Infections ¹²	1,995 ¹³	944 ¹⁴	723 ¹⁵
PMTCT Coverage Rate ¹⁶	52% ¹⁷	75% ¹⁸	86%
Number of AIDS Deaths ¹⁹	9,536	7,755	7,158

Source: UNAIDS

PROGRESS ON REACHING THE BEGINNING OF THE END OF AIDS



Sources: UNAIDS and ONE calculations

ANALYSIS AND RECOMMENDATIONS

Until 2010, Togo had been making good progress in the fight against AIDS, but it has slipped since then. In 2002, the country had 138,000 people living with HIV and 16,000 new infections. By 2005, the situation had improved slightly; despite an increase to 146,000 in the number of people living with HIV, the number of new infections had dropped to 12,000, and 4,500 people were newly added to treatment. By 2012, the number of new infections had decreased dramatically, to 4,800, but the number of people added to treatment was just 1,300. Despite 128,000 people²⁰ living with HIV, only 30,300 (46% of those eligible for treatment) were receiving ARVs. Togo's situation is particularly noteworthy, as it had made substantial headway in its fight against AIDS by improving its AIDS ratio from 2.7 in 2005 to 0.98 – past the tipping point – in 2010. Since then, however, it has slipped backwards, with the ratio increasing in 2011 to 1.22 and then again in 2012 to 3.8, while treatment coverage rates have stagnated.²¹

Togo's AIDS response is managed by the Conseil National de Lutte contre le SIDA et les IST (National Council for the Fight against AIDS and STIs, or CNLS-IST). CNLS-IST was created initially as a committee under the health minister in 1987, following the first case of AIDS in Togo. In 2001 the government decided to pursue a multi-sectoral approach, changing the committee's status to that of a council and changing its composition to include representatives from various ministries and other key stakeholders. Headed by the President of Togo, CNLS-IST is committed to engaging the highest levels of government in the fight against AIDS. To create a framework for the AIDS response, the Council has devised three successive national strategic plans to outline goals and strategies.²² The current plan (2012–15) reinforces the three key goals of the previous two frameworks: preventing new HIV and STI infections, scaling up comprehensive care and treatment so that at least 80% of those eligible can access it, and strengthening the AIDS response to

ensure coordination between stakeholders. Specific indicators and interventions within these goals have been updated to create a more focused AIDS response. In particular, the latest plan aims to reduce new infections by 50% by 2015 through additional targeting of MARPs, such as MSM, sex workers, prisoners and IDUs, marking the first time that these groups have been given particular attention in the strategic plan. The new plan also ensures that the impact of interventions is clearly defined and measurable, and CNLS-IST is modifying its organisational structure to ensure that its leadership is more effective.²³

On average, Togo has allocated 11.4% of its domestic budget for health over the past ten years and has met the Abuja target of 15% every year since 2009.²⁴ Overall spending on health has also increased in that time, from \$103.6 million in 2009 to \$137.7 million in 2011.²⁵ In 2012, self-reported data to the UN showed that Togo spent \$5.6 million on HIV programmes.²⁶ The country is not a major recipient of external resources, relative to many of its neighbours, though it currently has three active grants for HIV and has received \$84.4 million in

HIV/AIDS financing from the Global Fund to date.²⁷ It is not a PEPFAR focus country. In 2011 it received \$1.23 million from France, \$282,000 from the United States and \$144,000 from Germany to help fund HIV programmes.²⁸ Between 2009 and 2011, the top international AIDS donors to Togo were the Global Fund, France, UNDP, UNAIDS and Germany.²⁹

Increased decentralisation of services and capacity-building of health workers in Togo are particularly crucial to enabling the country to meet its goal of at least 80% of HIV-positive people accessing treatment. Despite recent slippage, Togo is showing renewed commitment to the fight against AIDS by establishing concrete goals and indicators in its latest strategic plan and by meeting its Abuja commitment for health spending.³⁰ In addition, although Togo has historically been one of the more dangerous countries for LGBT individuals,³¹ the government is showing clear initiative to reach these populations through public statements on the importance of reaching out to all vulnerable populations³² and through goals outlined in the most recent strategic plan.³³

CSO SPOTLIGHT

ESPOIR VIE-TOGO (EVT)

<http://www.espoir-vie-togo.org>

Espoir Vie-Togo (EVT) is a CSO with nearly 3,000 members.³⁴ It was founded in 1995 as the first association of people living with HIV and AIDS in Togo, and officially registered as a national NGO in 2008. EVT raises funds together with its sister organisation, Espoir Vie-Togo France, to support people infected with and affected by HIV/AIDS, placing a particular focus on orphaned and vulnerable children (OVCs).

In 2012, EVT provided ARVs to over 2,400 people and supported 1,036 OVCs. It supports people living with HIV/AIDS through visiting them in hospital and reaching out to them in their homes and workplaces. One such example of support is providing facilitators to pregnant women during HIV testing and PMTCT services, in order to help engage with the entire family in case of a positive HIV test result.³⁵ EVT also carries out advocacy and educational work using innovative events such as music recitals, opera performances, culinary workshops and recreational days to raise the profile of – and funds for – HIV/AIDS work and to provide a forum for exchange and information sharing.³⁶

EVT operates through three main sites in Togo: in Lomé, Aného and Sokodé. With the support of international funds, it has constructed a medical centre in Lomé to support people living with HIV/AIDS. Opened in May 2013 by the Minister of Health,³⁷ the centre will soon start offering medical and psychological services to people affected by HIV.³⁸ EVT, however, continues to face significant systemic challenges in its work in Togo, including insufficient access to testing and monitoring the health of HIV-positive people, a lack of facilitators to support patients in public clinics and a general shortage of skilled health-care providers to offer follow-up services. In order to reach the beginning of the end of AIDS in Togo, EVT believes that HIV and STI prevention needs to be strengthened, in particular among key populations; PMTCT screening and care need to receive more attention; and more patients need access to ARVs.³⁹



MOBILE UNITS TRAVEL TO REMOTE VILLAGES IN RWANDA TO EDUCATE COMMUNITIES ABOUT MALARIA AND AIDS PREVENTION.

PHOTO: JOHN RAE © THE GLOBAL FUND

CONCLUSIONS AND RECOMMENDATIONS

Great progress has been made towards global AIDS targets in the past year, demonstrating an enduring commitment to fighting the disease. Indeed, thanks to this accelerated progress, the latest trajectories show that the beginning of the end of AIDS is not a far-fetched vision, but one that could be realistically achieved in the next two years. This is remarkable news, to know that the tipping point is not just in sight – it could be just around the corner. But the work is far from over. This report has shown that greater acceleration is needed to improve treatment, prevention and equitable delivery of services for all populations to fully control, and eventually end, the epidemic.

Achieving the beginning of the end of AIDS, and ensuring that the world does not lose momentum if, and when, the tipping point is reached, requires not just bold rhetoric but also sustained action and investment. A handful of donors or affected country governments cannot achieve this alone; indeed, a more accountable and sustainable approach is needed. Therefore, ONE recommends that those invested in the fight against AIDS, including government officials, international donors, civil society groups and technical leaders, undertake the following five actions to accelerate progress.

1 Build the foundations for a “prevention revolution”, particularly among adolescents and marginalised populations

While the world has made incremental gains on HIV prevention in the last year, particularly with respect to prevention of mother-to-child transmission, the number of new infections significantly outpaces the number of people newly added to treatment. Even with the prospect of these two trajectory lines intersecting as early as 2015, the number of new HIV infections each year will still be in the millions, which will only serve to prolong the epidemic and the costs associated with it. For a disease that is entirely preventable with existing, inexpensive technologies, this should be unacceptable.

Unlike efforts to expand access to treatment, which have benefited from bold global targets – first WHO’s 3x5 resolution in 2003, followed by calls for universal access in 2005 and a commitment to 15x15 in 2011 – the AIDS community lacks a central and communicable prevention target to drive policy-making, priority-setting and advocacy. While ONE’s reports have called for a halving of the number of new

adolescent and adult infections by 2015, this target has not been widely adopted in any formal political sense. By 2014, WHO, UNAIDS or the broader UN should call for a globally endorsed prevention target that would help accelerate the progress that is so desperately needed.

To achieve these reductions, donors and countries alike should do much more to apply the prevention tools we already have – including voluntary medical male circumcision and male and female condoms – more effectively. Simultaneously, more on-the-ground research is needed to test newer prevention modalities, including the use of treatment-as-prevention, particularly among at-risk populations. Finally, supporting efforts to develop better, real-time measures of incidence will be critical for assessing the effectiveness of prevention efforts with greater speed and accuracy. This feedback, provided regularly, will help inform policy-makers and financiers to best target prevention resources.

2 Commit new and better-targeted resources to drive progress towards the end of AIDS

In order to control and eventually defeat AIDS, UNAIDS estimates that a minimum annual financing gap of \$3–5 billion must be filled. First and foremost, African and other affected governments must fulfil their responsibilities and ensure that they are effectively targeting domestic resources. This means that African countries must make progress towards meeting their Abuja commitments to spend 15% of their budgets on health, as they agreed to do in 2001. From there, countries with a high HIV/AIDS burden must allocate an appropriate percentage of those health resources for the control and defeat of the disease. Particularly for resource-rich countries,

increasing domestic health financing to reach the Abuja target could free up billions of dollars for providing antiretroviral drugs and other services for citizens in need.

The financing needs for AIDS treatment, prevention and care are so great that affected countries alone cannot fill the gap quickly enough, however; donor resources should continue to support these efforts. The push towards greater country ownership is critical for affected countries to manage their epidemics and allocate resources based on national priorities, but it should not be seen as an excuse for

donors to pull back – their resources must be sustained and more effectively deployed against the epidemic to help meet the immense need. In the weeks following this report's publication, government and private sector donors will meet in Washington, DC, to pledge new resources to the Global Fund for the next three years. The extent to which the Global Fund is able to mobilise the full \$15 billion it needs will provide the first indication of how serious donors are about controlling AIDS, TB and malaria. Indeed, a successful Global Fund replenishment could help spur renewed momentum in efforts to improve broader global health.

In a challenging economic environment, we must also look to new sources of funding to help accelerate global efforts to defeat AIDS. This includes the development or roll-out of innovative financing schemes that could generate new revenue for health, such as a financial transaction tax (FTT), and also includes more meaningful involvement of the private sector. Many companies (particularly those with affected workforces) could contribute not only financial resources, but also technical expertise that can be leveraged to improve health systems and the efficiency of drug procurement.

3

Ensure greater political and programmatic ownership of the fight against AIDS by African governments

Historically, global efforts to fight HIV/AIDS have centred on solutions designed and led by high-income countries. While scientists, donors and advocates in these countries have all played key roles in helping to bring the AIDS pandemic near to a tipping point, their collective efforts have often overshadowed, or even undermined, African leadership on this issue. For decades, as this report shows, many African governments and citizens have been working to tackle the pandemic in their own countries in unique and effective ways, but have often lacked the resources to fully fund necessary treatment and prevention programmes.

As African economies grow – some at rates far exceeding those of OECD countries – African governments should make headway towards their own financial promises on health, as outlined above. But equally important, these governments should accelerate their efforts to develop robust, costed national AIDS plans that reflect their unique epidemiological context – and should increasingly build up their own capacities to manage the implementation of these plans. Wherever possible, donors should coordinate their resources through these plans, not around them, and must

assist African governments with technical training so that they can fully manage these programmes.

On a political level, African leaders can do much more to ensure that the HIV/AIDS responses in their countries are more effective, equitable and free of stigma. Tackling AIDS, particularly among marginalised populations, will in some cases require a sea-change in how these populations are viewed and treated. High-level political endorsement will be critical to provide open, equitable access to services for all. Government support for civil society organisations is also important, particularly for those working to improve access to services for all populations.

At the regional and international levels, African leaders should continue to build on the important frameworks developed over the past two years, including the African Union's Roadmap for Shared Responsibility and Global Solidarity, to transform these frameworks from rhetoric into accountable, actionable plans. Such efforts on the continent are vital in ensuring a long-term, sustainable response.

4

Improve reporting and transparency of AIDS resources and results

Although transparency and accountability have risen on the international political agenda in recent years, there is currently insufficient transparency across the resources used in the fight against AIDS. This report examines a number of data sources, including the OECD DAC database, UNAIDS' domestic finance monitoring and African countries' budget documents. However, none of these sources provides sufficiently comprehensive and comparable data for what

resources are being spent on AIDS, through which channels and to what ends. This lack of transparency makes it difficult to assess whether or not adequate resources are being spent on the right types of interventions at local and country levels, and makes it even more difficult to analyse what impacts are consequently generated.

African countries not already doing so should publish at least a minimum set of key documents from the budget cycle – including their proposed, enacted and audited budgets – in a regular and timely fashion. Ideally, these documents should be accessible (e.g. easily located on and downloadable from a government website); user-friendly (e.g. using an Excel format to facilitate analysis, and with metadata such as reference keys available); complete and comprehensive (with annexes and full data tables published alongside the main documents); and clearly organised and labelled. Spending data should be sufficiently disaggregated to enable analysis of total spending on priority areas or specific programmes, such as HIV/AIDS. This will allow for much better understanding of the relationship between inputs and health outcomes. In order to facilitate these improvements, donors and African governments alike must work to increase countries' statistical capacity, so that they can more regularly and effectively monitor inputs as well as progress towards disease indicators.

5 Reinvalidate HIV/AIDS on the international political agenda

In many ways, the fight against HIV/AIDS has become a victim of its own success. When the pandemic first emerged in the 1980s and 1990s, it was seen as a true emergency, with treatment largely unavailable and an HIV diagnosis seen as a death sentence. Thanks to improved access to treatment, AIDS is now seen increasingly as a chronic and manageable disease, and thus has fallen sharply off the international political radar, with fewer noteworthy champions. If HIV/AIDS is to be controlled and ultimately defeated, the world must not fall into complacency. We must marshal financial resources and political energy now to avoid further costs and lives lost in years to come.

In the next 12 months, three global forums (in addition to the Global Fund's replenishment conference) will be critical for sustaining this energy: the International AIDS Conference (IAC) in July 2014, to be held in Melbourne, Australia; the G8 and G20 conferences, hosted by Russia and Australia respectively; and the ongoing political debates to set the post-2015 development agenda.

Further complicating this effort, many donors report on their AIDS spending through various channels, in varying levels of detail and at various times. The extent to which donor assistance appears on budget for African governments varies significantly, and only a minority of African countries produce budget documents that show the proportion of public spending (particularly within specific accounts or programmes) derived from aid or other non-domestic sources. As programming has increasingly become more integrated on the ground – itself a laudable aim – funding channels have become similarly integrated, and it is challenging to distinguish where domestic investments end and donor investments begin. As many donors push towards a “sustainable” approach to the AIDS response that relies more heavily on domestic resources and leadership, donors and recipient countries must work together to standardise a way in which each actor can be clear about how, and to what extent, their financing and programmatic support is contributing to outcomes.

IAC conference organisers should set an aggressive agenda that not only highlights the latest in scientific research but also seeks to re-energise political will – starting with the host country itself. The conference should highlight progress towards the beginning of the end of AIDS, and its ultimate control, and should meaningfully involve African and Asian leadership. Similarly, G8 and G20 organisers must make a concerted effort to reinstate HIV/AIDS and broader global health issues on the political agenda, and must hold each other to account on the bold promises made over the past decade. Finally, as stakeholders begin to formulate more concrete proposals for post-2015 development targets and indicators, citizens and political leaders alike must ensure that HIV/AIDS remains a topic of discussion, framed as a driver of momentum within the broader global health landscape. Ideally, any new goals developed should include a bold, specific and achievable indicator for HIV/AIDS.



A MEDICAL SUPPLIER IN NIGERIA CHECKS
HIS INVENTORY.

PHOTO: ARNE HOEL © THE WORLD BANK

METHODOLOGY

PART 1: TRACKING PROGRESS ON DISEASE-SPECIFIC INDICATORS

WHAT ARE THE MAIN SOURCES OF DATA?

ONE uses a combination of publicly available information to collect data for analysis. The two main sources of data for measuring progress on disease-specific indicators are:

- 1) UNAIDS data on HIV/AIDS for 2010–12; and
- 2) HIV/AIDS research and development grant information from the G-Finder database, managed by Policy Cures and funded by the Bill & Melinda Gates Foundation.

MEASURING PROGRESS ON AIDS INDICATORS

This report tracks progress made in the fight against AIDS by analysing progress both on individual indicators as well as toward the “tipping point” for achieving the beginning of the end of AIDS. The first section looks at three disease-specific targets: 1) the virtual elimination of mother-to-child HIV transmission by 2015; 2) ensuring access to AIDS treatment for 15 million people by 2015; and 3) the drastic reduction of new adolescent and adult HIV infections. These three targets were chosen by ONE from ten overarching targets set by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and underscored by the 2011 United Nations Political Declaration on HIV/AIDS. Last year, ONE assessed progress towards these three targets in its report “The Beginning of the End? Tracking Global Commitments on AIDS”.¹ In the 2013 report, we provide an update to that analysis, primarily addressing progress made over the past year, as well as offering new analysis of historic trends.

Annual data for each indicator for the period 2001–12 was collected from recent UNAIDS reports.² ONE calculated future trajectories for each indicator by applying the rate of change in annual new infections

and the number of people newly added onto antiretroviral treatment annually, between 2011 and 2012, to future years until 2015.

1) **The virtual elimination of mother-to-child transmission by 2015**

- Indicator: new HIV infections among children (aged 0–14 years)
- Current trajectory: 50,000 fewer new HIV infections among children annually, which would result in 110,000 new infections among children in 2015
- 2015 target: no more than 40,000 new HIV infections among children (a 90% reduction from the 2009 baseline).

2) **Ensuring access to treatment for 15 million HIV-positive individuals by 2015**

- Indicator: number of people on antiretroviral drugs (ARVs)
- Current trajectory: an acceleration of 100,000 additional people newly put on ARV treatment annually (on top of the baseline of 1.6 million added in 2012), which would result in 15.1 million people on ARV treatment in 2015
- 2015 target: 15 million people on ARVs.

3) **The drastic reduction of new adult and adolescent HIV infections, to no more than approximately 1.1 million annually by 2015**

- Indicator: new HIV infections among adults (aged 15+)
- Current trajectory: 200,000 fewer new infections annually, which would result in 1.4 million new infections in 2015

- 2015 target: no more than 1.1 million new HIV infections among adults.

In the second section, ONE tracks progress made towards the “beginning of the end of AIDS”. ONE defines the achievement of the beginning of the end of AIDS as **the point in time at which the number of people newly added onto AIDS treatment in a given year equals the number of people newly infected with the HIV virus in that same year**. On a graph, this is the point where the curves depicting new infections and the number of people newly added to treatment intersect, also referred to as ‘the tipping point’. Current trajectories show that if the number of people newly added to ARV treatment continues to climb (1.5 million were added in 2011 and 1.6 million were added in 2012), it will rise by an additional 100,000 each year. As such, 1.7 million people are projected to be added to treatment in 2013. Projections of current trajectories also indicate that there will be 200,000 fewer new HIV infections each successive year: there were 2.2 million in 2011 and 2.0 million in 2012. At this rate, there will be 1.8 million in 2013, and so on. If both of these trajectories continue,³ the two curves will intersect – and we will reach the beginning of the end of AIDS – in 2015.

Regional graphs also provide the current trajectories for the number of people newly added to treatment each year along with the number of new infections each year, in sub-Saharan Africa, Latin America and the Caribbean, South and South-East Asia and Eastern Europe and Central Asia, as well as a narrative on each region's AIDS response.

PART 2: TRACKING LEADERSHIP AND COMMITMENT TOWARDS THE BEGINNING OF THE END OF AIDS

MEASURING DONOR CONTRIBUTIONS

In its 2012 AIDS report, ONE profiled the G7 donor countries' as well as the European Commission's investments towards the beginning of the end of AIDS. Donor commitments were evaluated across three dimensions: a) donor funding (bilateral and multilateral); b) political leadership; and c) strategy/programming.

In this year's report, ONE provides updated detail on bilateral and multilateral donor funding, as well as highlighting any new initiatives or changes in programming. Total AIDS spending was gathered from bilateral spending data from the Kaiser Family Foundation (KFF) (partly based on OECD DAC and EU data, and including earmarked contributions to UNAIDS), as well as from multilateral contributions to the Global Fund and UNITAID.

Total donor assistance was evaluated based on two measures:

- The sum total volume of bilateral and multilateral AIDS assistance by donor countries in 2010, 2011 and 2012 and its year-on-year fluctuations; and
- Per capita AIDS assistance (total volume divided by donor country population) for G7 countries and the European Commission.

What are the Main Sources of Data?

ONE uses a combination of publicly available information and traditional donor government reporting to collect data for analysis. The main sources of data were:

- 1) Data and analysis from the report by KFF and UNAIDS, "Financing the Response to HIV in Low- and Middle-Income Countries" and consultations with KFF global health financing experts;

- 2) Published donor contributions on the websites of multilateral institutions, specifically the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID;
- 3) Publicly available information on donor government websites, including strategy documents, press releases, foreign ministry pages and budget reports;
- 4) Population and GNI data from the World Bank's World Development Indicators database.

How Does ONE Calculate Donor Funding?

ONE defines total HIV/AIDS spending as the sum of a donor country government's bilateral and multilateral AIDS contributions. Though the effect of inflation on purchasing power is acknowledged, this report is concerned with tracking pledges and commitments, rather than assessing the value of goods and services. As such, unless otherwise noted, all funding amounts are expressed in current US dollars (\$) for comparability between donors. Additionally, one of our core data sources, KFF/UNAIDS, uses current dollars for its analysis and all domestic financing data is in current dollars.

Bilateral contributions: Data on bilateral AIDS assistance from donor governments between 2010 and 2012 was drawn from the KFF/UNAIDS report mentioned above. These organisations have been tracking donor government assistance for AIDS in low- and middle-income countries since 2002 and their analysis is based in part on consultations with members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) and the European Union (EU).⁴

"Bilateral funding" is defined as any earmarked amount designated by donor governments for HIV assistance.

This also includes earmarked contributions to multilateral organisations, such as UNAIDS. Since this bilateral funding data is not disaggregated in the KFF dataset, some UNAIDS contributions are also counted as part of bilateral funding for ONE's report. Furthermore, bilateral assistance data was collected in the KFF/UNAIDS report for disbursements, i.e. the actual release of funds to a recipient, rather than commitments or enacted budgetary amounts. Disbursements may not always match enacted budgetary amounts, nor are they always released in the same year as the budgetary decisions; however, they do represent the amount of money actually being spent on the ground in any given year.

ONE considers the KFF/UNAIDS report to be the most current and reliable source for bilateral AIDS assistance, for a number of reasons. Since the KFF analysis is an annual report with a formal consultation process, the funding totals for each country have been verified by the appropriate donor government representative in charge of HIV/AIDS assistance. The cooperation and involvement of UNAIDS in the KFF report, as the UN body in charge of global coordination of the HIV/AIDS response, also lends credibility and legitimacy to the reported numbers.

Multilateral contributions: For multilateral contributions, ONE looks at contributions to the Global Fund and UNITAID, using official, publicly available data published on the websites of these organisations. While ONE acknowledges that multilateral contributions may go through other channels, for the purposes of this report it looks only at these two mechanisms, as the primary multilateral organisations involved in HIV/AIDS that are comparable across all donors. Global Fund and UNITAID pledges and contributions were collected for each of the G7

countries and the European Commission, and are current up to 1 October 2013.

To compute the amount that each donor country spent on HIV/AIDS via its multilateral contributions, ONE multiplied each donor's full contribution to the Global Fund and UNITAID by the respective percentages of their total funding that was allocated to AIDS in that particular year. In 2012, this percentage was 55% for the Global Fund and 51% for UNITAID.⁵ For example, if a country contributed \$100 million to the Global Fund in 2012, it would be credited with contributing \$55 million for AIDS assistance via the Global Fund in that year. The country's full Global Fund and UNITAID contributions are listed in the donor analysis.

Thus, the summation for total spending takes into account a donor's full bilateral contribution and its imputed multilateral contributions, as follows:

Bilateral AIDS funding (100%) + Global Fund (55%) + UNITAID (51%)

What Does this Report Not Measure, and Why?

This report does not measure or analyse donors' spending on other health interventions that are complementary to HIV/AIDS programmes (such as investments in sexual and reproductive health or nutrition), though ONE acknowledges the importance of these investments in improving AIDS and broader development outcomes.

For Donor Financing, Why Does ONE Not Use ODA Reported to the OECD DAC?

For the purposes of the donor analysis, ONE has not used ODA figures as reported to the OECD DAC. When governments report to the DAC, they use two official sub-sector codes to indicate HIV/AIDS assistance: "13040: STD Control including HIV/AIDS" and "16064:

Social Mitigation of HIV/AIDS". However, for donor financing, KFF's data is preferable as it captures the breadth of HIV/AIDS assistance more fully than both of these DAC sub-sector categories combined. For ODA received by African countries, ONE has used OECD DAC data (see below).

MEASURING SUB-SAHARAN AFRICAN COMMITMENTS ON AIDS

In this year's report, ONE specifically tracks progress on AIDS treatment and prevention in sub-Saharan Africa. The map on page 43 includes infection/treatment ratios (or tipping point ratios) for all sub-Saharan African countries for which 2012 data is available. These ratios, which indicate how much progress a country has made towards the beginning of the end of AIDS, are calculated by comparing the number of total new HIV infections in 2012 with the number of HIV-positive people newly added onto treatment in 2012. Countries which have reached the beginning of the end of AIDS have a ratio of 1.0 or below (for every person newly added to treatment, there is not more than one new infection).

The report profiles nine sub-Saharan African countries in detail, grouping the countries into three categories: 1) those that are leading the way towards the beginning of the end of AIDS; 2) those that have shown marked improvement in recent years; and 3) those that have made insufficient headway, or have reversed progress, towards the beginning of the end of AIDS. The classification was based on HIV-related epidemiological and financial factors over time, including ARV uptake rates, rates of new infections and domestic health spending. When classifying the countries, particular attention was paid to their tipping point ratios (the number of new infections compared with the number of people newly added onto treatment) since 2009: while most countries have shown general improvements over the past decade as a whole, a few

have either made little progress or have reversed progress attained in previous years. Therefore, recent trends were of particular importance.

We did not consider countries where data is unavailable for the past two years. These countries include Cape Verde, Chad, Comoros, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Guinea, Madagascar, Mauritania, Mauritius, São Tomé and Príncipe, Senegal and South Sudan.

For financial indicators, ONE took into account a country's overall government health expenditures as well as domestic spending specifically on HIV/AIDS. In 2001, African Union members committed to allocating at least 15% of their annual national budgets to health, and the profiles include data on what proportion of spending the countries have actually allocated in recent years. While there is no comparable HIV/AIDS spending commitment, and the appropriate allocation (absolutely and relatively to total and health expenditures) varies from country to country, we also present information, where available, on domestic HIV/AIDS spending (see below for further information and challenges).

What are the Main Sources of Data?

ONE uses a combination of publicly available information, traditional donor government reporting and African government reporting to collect data for analysing progress on leadership and commitments towards the beginning of the end of AIDS. The main sources of data were:

- 1) Data and analysis from the KFF/UNAIDS report "2013 Progress Report on the Global Plan" and consultations with KFF global health financing experts;
- 2) Published donor contributions on the websites of multilateral institutions, specifically the Global Fund;

- 3) Bilateral aid from DAC countries to African countries via the OECD DAC Creditor Reporting System for HIV/AIDS ODA flows (sector codes "13040: STD Control including HIV/AIDS" and "16064: Social Mitigation of HIV/AIDS");
- 4) Publicly available information on African government websites, including strategy documents, press releases, foreign ministry pages and budget reports;
- 5) National Health Accounts data in the World Health Organization's Global Health Expenditure database;
- 6) The IMF's World Economic Outlook database;
- 7) Responses by African country representatives from South Africa, Malawi and Zambia to a ONE questionnaire, sent to all nine countries profiled, on HIV/AIDS programmes within their country; as well as input from Togolese and Tanzanian country representatives on the final Togo and Tanzania country profiles, respectively;
- 8) Data on domestic financing for HIV from UNAIDS' AIDS Info Online 3.0 Database;
- 9) African countries' online budget documents, mostly available from the respective Ministry of Finance websites.

How does ONE Calculate Sub-Saharan African Country Spending?

Information on the proportion of African governments' total expenditures allocated to health programmes is drawn directly from WHO's Global Health Expenditure database on National Health Accounts indicators. To calculate total government expenditure on health in absolute terms (\$, current prices), ONE combined these percentages with data on total GDP and total government expenditures as a percentage of GDP from the IMF's World Economic Outlook database (October 2013 edition).

It is much more difficult (and in some cases, impossible) to ascertain domestic HIV/AIDS spending levels, and there is no single comprehensive source of data. ONE referred to two data sources. First, countries self-report domestic HIV financing to UNAIDS using the National Funding Matrix. However, substantial time lags – the most recent years available for our nine countries ranged between 2005 and 2012 – render this data problematic in assessing recent trends. Second, ONE searched manually for disaggregated data in national budget documents, where available. Only in one of the profiled countries (South Africa) is the HIV/AIDS allocation presented annually as an aggregated budget line. Several other countries show multiple HIV/AIDS-related allocations scattered throughout their budget documents, which ONE summed. This provides a rough estimate; however, in most cases this method is likely to under-count the total HIV/AIDS-related budget. In some cases, we found sizeable differences between the indicative budget data and the self-reported UNAIDS data (although they referred to different time periods), suggesting that a great deal of caution should be taken when interpreting these figures. These data issues also make it difficult to compare reliably over time and between countries. For the remaining few profiled countries (Zambia, Togo and Cameroon), there is either unclear or no disaggregated HIV/AIDS spending data available.



A UGANDAN LABORATORY WORKER
PROCESSES AN HIV TEST; UGANDA HAS
PIONEERED "CITIZEN REPORT CARDS" AT
THE COMMUNITY LEVEL IN HEALTH CARE.

PHOTO: ARNE HOEL © THE WORLD BANK

ENDNOTES

EXECUTIVE SUMMARY

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AFRICA EFFORTS AND COUNTRY PROFILES

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- ## METHODOLOGY
1. UN. 2011. "United Nations General Assembly Political Declarations on HIV/AIDS: Targets and elimination commitments". http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2262_UNAIDS-ten-targets_en.pdf; ONE. 2011. "The Beginning of the End? Tracking Global Commitments on AIDS". <http://one-org.s3.amazonaws.com/us/wp-content/uploads/2012/11/AIDSreport-2012-master-1120-fullcover.pdf>.
 2. UNAIDS. 2013. "2013 Progress Report on the Global Plan." <http://www.unaids.org/en/resources/campaigns/globalreport2013/>; UNAIDS. 2012. "Together We Will End AIDS" http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf; UNAIDS. 2011. "Global HIV/AIDS Response Progress Report" http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_UA_Report_en.pdf.
 3. Note that this methodology does not model for the accrued epidemiological prevention benefits gained by adding individuals to treatment, nor does it model for other ancillary benefits attained by reducing rates of new HIV infections. It is simply a straight-line trajectory.
 4. For more on KFF and UNAIDS methodology, please refer to the report at <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/7347-09-financing-the-response-to-hiv.pdf>.
 5. These percentages vary slightly each year. HIV/AIDS allocations: Global Fund 55% (2012), 56% (2011), 55% (2010); UNITAID 51% (2012), 52.2% (2011), 54.4% (2010).



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