EXECUTIVE SUMMARY – NO TIME TO QUIT REPORT

At the end of the 90s, Médecins Sans Frontières (MSF) got involved in HIV/AIDS because we viewed it as an emergency: today, MSF still believes this is a crisis requiring an exceptional response.

Since the start of the epidemic, HIV/AIDS has created an acute public health crisis in many countries requiring an emergency response to the resulting high mortality and the spread of the disease. To date, much has been done to tackle HIV, but the urgency of the situation still calls for a sustained and expanded response over a long period of time — the battle is not over yet.

Through its medical humanitarian work in the majority of the worst-affected countries in sub-Saharan Africa, MSF has recently started to observe a worrisome turn-around among the donor community. After years of political willingness and financial commitment to combat HIV/AIDS, donors now seem to be disengaging from the fight, leaving behind people who are still in dire need of life-saving treatment.

In 2009-2010, MSF carried out in-depth field analyses in eight key countries - Malawi, Mozambique, Zimbabwe, South Africa, Lesotho, Kenya, Uganda, Democratic Republic of Congo (DRC) - where we have been providing HIV/AIDS care and treatment for several years. The findings confirm our concerns in terms of donor backtracking on commitments to scale up the fight against the HIV/AIDS epidemic. Today, this disengagement is starting to become visible in the field and the level of HIV care is beginning to deteriorate.

Uncertainty and unreliability of donor funding has stalled the enrollment of new patients in treatment sites and put the supply of anti-retroviral medicines (ARVs) at risk in the medium to long term. Donors have also diluted their initial emergency approach and shifted funding toward other health issues, disregarding the proven cross-benefits of effective HIV/AIDS intervention on healthcare in general. Ironically, at the same time as the level and sources of funding decline, donors expect the money dedicated to combat HIV/AIDS to fund increasingly comprehensive packages, extending to other priorities within the health sector.

A possible donor retreat not only hampers HIV treatment scale-up but also threatens to undermine all the positive effects and future perspectives that high coverage of ART brings in terms of community-wide reduction of mortality, morbidity and transmission.

Any retreat from the current efforts toward ART scale up will have far-reaching and very real negative consequences for patients and front line workers in HIV care.

Combined with the effects of the economic crisis in low income countries and in particular on vulnerable people, donor fatigue on HIV will further widen the HIV treatment gap in sub-Saharan Africa.

Concretely, reducing funding for HIV treatment and ARV means:

- A reduction in treatment slots. Patients will have to wait longer to start ARV and are at risk of dying before they can have access to life-saving medication. Patients left untreated risk deteriorating and succumbing to opportunistic infections such as TB. More patients will be lost to follow up, even before they can start ART.
- Blockage in the implementation of WHO guidelines allowing for a move away from substandard care and giving patients the benefits of earlier treatment.
- A further squeeze on the available initiation capacity of the Global Fund.

- Knock on effects on already fragile ARV supplies. This means more stock-outs and disruptions, resulting in additional strains on patients' adherence and health facilities' workload.
- Further reductions in affected countries' ambitions for tangible results and inclusion of specific vulnerable groups.

From the field perspective, a donor retreat will change the character of the epidemic, with increasing numbers of patients seeking care, more ill patients and rising mortality in the community — echoing the early 2000s when ART was rationed to the happy few.

- Patients starting with lower CD4-counts (a measure of the number of T cells per cubic millimetre of blood, used to evaluate the immune system of patients infected with HIV) require more frequent, more intensive and more costly care. At the same time, they have lower chances of survival and take longer to recuperate.
- Health facilities' patient load will increase and health workers will be discouraged by the worsening results among the patients to whom they provide care.
- Patients might start sharing their pills, effectively lowering their dosage and increasing risks of virus transmission and resistance.
- Tensions will rise between those patients on treatment and those not yet on treatment.
- Tuberculosis rates will increase and represent an additional burden on already busy clinics.
- Mortality among adults in the prime of their lives and the number of orphans will rise again in the community.
- Insufficient ARV availability will require a proportional slowing down of testing and counselling activities.

A brief survey of donors' plans for the next years illustrates the challenge.

One key donor, **PEPFAR,** has flatlined its funding for 2009-2014 and as of 2008-9, further decreased its annual budget allocations for the coming years by extending the period to be covered with the same amount of money. The funding for purchase of ARVs will also be reduced in the next few years. All this translates into a reduction in the number of people starting on ART, as we have seen in South Africa and Uganda.

The **World Bank** currently prioritises investment in health system strengthening and capacity building in planning and management over HIV dedicated funding. However, without funding for ARV drugs and related costs, the impact of such capacity to support HIV/AIDS care will remain very limited.

UNITAID is phasing out its funding. By 2012, the drug and other medical commodity procurement organised by the Clinton Foundation for HIV/AIDS and funded by UNITAID for second line ARVs and paediatric commodities should end in Zimbabwe, Mozambique, DRC and Malawi.

The **Global Fund** is currently facing a serious funding shortfall. In October 2010, a donor replenishment conference is planned with the aim of mobilizing more resources, but donors have already requested the Global Fund to lower its financial ambitions. All current funding scenarios are inadequately reflecting demand, as none includes the additional resources required to implement the new WHO guidelines on earlier treatment and improved drug regimens.

With very few exceptions, **other health actors** such as the European Commission and European Union Member States do not fund HIV/AIDS treatment directly and hardly ever finance ARV supplies besides through their contribution to the Global Fund. At present,

these donors seem unlikely to fill the additional gap created by the current shortfall, yet remain reluctant to increase their support to the Global Fund.

While the resource mobilisation since 2001 has allowed us to fight effectively against the HIV/AIDS epidemic over the past years, a sense of denial has set in among the donor community about this ongoing crisis. For the past year and a half, donors have increasingly voiced concern regarding the cost, sustainability and relative priority of HIV/AIDS, against the background of an ostensible lack of funds. All this discourse belies numerous studies demonstrating the global long-term gains in engaging decisively in the fight against HIV/AIDS today.

This donor turn-around will not make the patients in need of life-saving treatment go away. On the contrary, it is likely to increase the numbers of people in urgent need of care and will negatively impact their family, community and the health care system. In the end, the cost of inaction will be far higher than that of action.

Progress and scale-up are still direly needed. Our responsibility toward people living with HIV and AIDS in the hardest-hit countries has been collective in the past decade, and it should remain so for the years to come. This is a historical opportunity for the international community to renew its commitment to fight the HIV epidemic and stand by the people and countries that face the challenge of providing lifesaving treatment to those in need. This depends critically on continued financial support by donor agencies as PEPFAR, UNITAID and the Global Fund. But this cannot be the responsibility of a limited group; it also calls for expansion of commitment of those donor countries that have shown only limited support so far.

We should never forget why we started the fight against HIV. We were reacting to needless illness and excessive loss of life among young people, communities losing valuable energy and experience, profound wounds inflicted on the social fabric, and above all, the injustice of unnecessary suffering and death where we have the means to prevent them. This catastrophic situation might be back all too soon if we relent on the fight now.