



Mind the Gap: African HIV Financing Scorecard

November 2019

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DRAFT

1. About this Scorecard: Background and Objectives

In the past 20 years, national governments, global funders and civil society have made significant progress in expanding access to life saving antiretroviral treatment and prevention options in the fight against HIV.

Almost sixty percent of people living with HIV are now accessing antiretroviral treatment, and new infections have been reduced by almost 50% since 1996. But at the same time that great progress has been made, so we see that contributions by international donors have flatlined even though there is a US\$5 billion gap in the resources needed to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90–90–90 targets. These targets which are to diagnose 90% of all HIV-positive persons, provide antiretroviral therapy for 90% of those diagnosed, and achieve viral suppression for 90% of those treated by 2020 need to be achieved if we are to control the HIV epidemic. Currently, low- and middle-income countries contribute approximately 56% of the global resources for HIV, but the investment by countries varies and a significant 20% global funding gap remains, which leaves the HIV response in a precarious position.

As a result of this situation, in early 2019 the Society for AIDS in Africa began an evidence-based advocacy campaign that focusses on this resource gap that exists, with the aim of meeting the UNAIDS 2020 and 2030 targets in Sub-Saharan Africa.

As part of this campaign, a group of African and global HIV advocates and activists have developed a strategy for creating and implementing such an advocacy campaign. The campaign has developed this *African HIV Financing Scorecard* in partnership with Accountability International (previously AIDS Accountability International) as a means to analyse the existing funding, interrogate the gaps in required funding, and provides evidence-based advocacy messaging for action by the various stakeholders involved. The Scorecard tracks current country investments in HIV treatment and prevention in order to shed more transparency on the topic. It also examines existing frameworks and funding in general, as well as looks at the current use of innovative financing and what sources for funds might exist. The report then delves into partnerships with business and public-private partnerships and impact investment and the potential role these tools can play in financing the HIV response. The report also examines what corporate social responsibility programmes and individual philanthropists are currently doing to finance the response to HIV. Other sources such as diaspora remittances are also interrogated so as to create understanding on how they may be a potential source of finance.

The next section then goes on to look at the current situation in each country and how the countries are faring in their current HIV response. This provides both an indication of what has been done to date, what political will currently exists and what issues still need to be addressed. Identifying priority areas for funding is vital if funding will remain limited. This then also provides a starting block for a discussion on the cost to end the epidemic in each of the African countries. The report then goes on to examine current programme spending patterns, existing sources of health financing, and expenditure on clinical trials.

The report also examines the role of International Development Partners and Civil Society, looking into a variety of HIV finance issues in that arena, such as international funding for HIV, finance for HIV research, loss of African funds to illicit outflows, funding of the Global Funds Country Coordinating Mechanisms and accountability around those grants. Next, we look into the state of transparency, openness and democracy in each of the countries as a means to locate the dialogue in the broader landscape of accountability, transparency and anti-corruption.

The report ends with findings from the research and a list of recommendations that were collectively developed during a workshop “Consultative Meeting for Scorecard Validation on HIV Financing in Africa” held in Accra from 15th to 17th October 2019. These findings and recommendations inform the SAA campaign, as well as the work of others in designing policy reform and making the case for sustained and increased investment.

Increasing domestic investment on HIV treatment and prevention will require a regional coordinated, evidence-based advocacy campaign and partnership, and the Society for AIDS in Africa sees this *African HIV Financing Scorecard* as a first but critically important step in the broader campaign which aims to increase domestic funding for HIV programming. This program is well suited to SAA’s strength in policy analysis and advocacy as SAA is an independent organization devoted to transparency and accountability and whose work is respected by a wide range of global stakeholders. We hope that this research, our findings and recommendations provide evidence to start a discussion, across many stakeholders, on what and how we can sustainably, inclusively and accountably finance the final stages of the HIV epidemic in Africa.

1.1. A note from the author and expert panel:

In the concept development, research, as well as during the validation meeting, many more aspects of HIV Financing were raised by the team. Due to the limitations of time these issues will be unpacked and possibly included in the next edition of this report. The issues that fall under this category, include but are not limited to:

1. Blended financing (public-private partnerships to stimulate development),
2. Fast-tracking business processes
3. The AU Pharmaceutical Manufacturing Plan
4. The Catalytic Framework for HIV, TB and Malaria:
5. Percentage of financing from IDPs that gets invested in country programs and percentage that is used in administration, for example Global Fund.
6. Budget monitoring and transparency.
7. Democracy and accountability.
8. CCM oversight, conflict of interest and composition
9. Structural issues and cross-cutting issues: Migration, Xenophobia, Sexual and Gender Based Violence, Violent extremism, organized crime, terrorism, global health threats, humanitarian

crises, war and political upheaval, forced displacement of people, climate crises, rule of law, equitable multi-lateral trade systems, international trade, and competition law.

2. Thanks and acknowledgements

The Society for AIDS IN Africa and Accountability International would like to thank the following persons for their contributions to the development of this report:

xxx

xxx

The inclusion of the names of the partners and advisors should in no way be considered as their endorsement of the contents of this report by any of these individuals or organisations.

3. Feedback

Phillipa Tucker (Accountability International) is the principal author of this report, and any errors or omissions are the sole responsibility of her and her alone. As much as every effort has been made to ensure accuracy, please send corrections, feedback and additions regarding research to phillipa@accountability.international or regarding the broader HIV Financing Initiative to Luc Bodea lucbodea@icasa2019rwanda.com

4. Scorecard Grading

Accountability International uses a methodology that was developed by over 100 experts from around the world. They worked on various statistical models before deciding on the simple and accessible methodology that is currently Accountability International's trademark. The reason for this is that clarity, transparency and accessibility were considered key to popularising scorecarding as a means to improve accountability, and statistics was too complicated for the majority among us. They even discussed the grading of five groups versus three, and the colours, piloting globally and deciding on the final 5 shades of red and grey for no data; and the need for five levels to improve accuracy and early detection of change in an indicator (which three points grading does not achieve). They also rejected using green as a final grade, as it indicates approval yet if 20 per cent of a group are still unserved, we determined this not to be sufficient; work needed to be done to reach 100, therefore no green "perfect" should be used.

Therefore, countries are placed in five broad 'grades', from A to E.

The grade is based on the percentage reported by the country according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor).

If a country has not reported on a particular Indicator then the score will be marked as ND for No Data and because the value of knowing what the circumstance of your epidemic is paramount to informing and constructing your response, these indicators are given a numerical value of 0.

Score	Grade
81-100 %	A
61-80 %	B
41-60%	C
21-40%	D
0-20 %	E
No data submitted = 0%	ND

Sometimes the lower the percentage, the better response is. This kind of situation happens for example when we examine HIV prevalence. We want lower percentages.

Score	Grade
0-5 %	A
6-10 %	B
11-15%	C
16-20%	D
>20%	E
No data submitted = 0%	ND

In order to calculate these grades one of these two methods has been used in this scorecard.

When the total is not one hundred per cent then the highest grade is divided by five, to provide us with quintiles. Countries are then graded according to the five quintiles or groups.

Score	Grade
Top quintile: Best performance	A
Upper middle quintile: Near to top performance	B
Middle quintile with middle level performance	C
Lower middle quintile with near to bottom performance	D
Bottom quintile: worst performance	E
No data submitted = 0%	ND

In our example, Niger has a child marriage rate of 76%, so that becomes our worst performer. We then divide 76 by 5 to arrive at five groups or quintiles.

Score	Grade
Top quintile: 0- 15 % of girls suffer child marriage	A
Upper middle quintile: 16 – 30% of girls suffer child marriage	B
Middle quintile: 31 – 46 % of girls suffer child marriage	C
Lower middle quintile: 45 – 61 % of girls suffer child marriage	D
Bottom quintile: 62 – 76% of girls suffer child marriage	E
No data submitted = 0%	ND

This is a opportunity to remind the reader why Accountability International does not give green colouring in our scorecards. Green demonstrates success and that no further work is necessary. In a case of child marriage that would mean that 15% is an acceptable level at which leaders should stop petitioning for change. This is not acceptable to us.

In other circumstances where percentages are not applicable, but the options are sentences, a logical division into five groups is decided upon.

Score	Grade
Country has a national strategy and implementation plan	A
Country has a national strategy only	B
Country is in process of doing national strategy	C
Country has not started strategy process but has plans to	D
Country has no plans to do a national strategy	E
No data submitted = 0%	ND

5. Existing frameworks

5.1. Abuja 15%

In 2001, African heads of state committed to allocating a minimum of 15% of their annual budgets to developing their health sectors, while also asking that official development assistance (ODA) funders allocate 0.7% of their gross national product (GNP) to developing countries. The Abuja Declaration of 2001 affirmed the AIDS epidemic as a state of emergency. In 2006 action by African Union Member States against the three diseases was reinforced by the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa. The Abuja Call was intended to translate political declarations into concrete action. These commitments have become well known as an indicator for health investment in Africa.

It is important to note that countries have different capabilities to fund the HIV response and that the economic growth, debt levels, tax collection, budget procedures, geopolitical issues, and geographical placement (amongst many other factors) all affect the political and realistic possibilities of adequately responding to the HIV. This is also why the simplistic commitment of the Abuja 15% of all government budget going to health is not a very good measure of either political will or of real access to health. For example delivery of anti-retrovirals would cost significantly more in a sparsely populated country like Niger (Size: 1.266,700 km²; population: 23,310, 000, Density: 18 km²; 16% urban population)¹ than it would in Cote d'Ivoire (Size: 318 000 km²; Population 25,716,000; density: 81/ km²; 51% urban population)². In contrast, Ethiopia has 112 million people in 1,000,000 km²; density: 112 people/ km²; urban population at 21%³. Investing in health may not be a priority for these countries when at this stage in the country's development education, infrastructure or water and sanitation might be a higher priority. A simplistic measure of 15% is thus unhelpful at best and misleading at worst.

5.2. Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030

The objectives of the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030, represented in the diagram are to eliminate malaria incidence and mortality, prevent its and end TB deaths and case by 2030. The Catalytic Framework is clearly focussed on a 'business model' which discusses the required investments governments need to make to reach these goals. Issues of leadership, accountability, health financing, community participation, multi-sectoral collaboration and coordination, and innovation all featured as pillars of the Catalytic Framework. African ownership and leadership were one of the success principles in the Framework, along with effective development partnerships, and that health is both a social and economic asset.⁴ The framework provides an overarching policy framework to respond effectively to AIDS, TB and malaria in Africa. Its objective is to intensify the implementation of the 2013 Abuja Declaration commitments to end these three diseases as public health threats through building Africa wide consensus on the key strategic actions within the context of the existing targets and milestones.

5.3. 90-90-90

UNAIDS launched the 90-90-90 agenda in 2014 and it has been an effective mechanism to rejuvenate the AIDS response since then. The idea behind 90-90-90 is that by 90% of people who are HIV infected will be diagnosed, 90% of people who are diagnosed will be on antiretroviral treatment and 90% of those who receive antiretrovirals will be virally suppressed by 2020. The idea that 90 per cent should be treated was a controversial one in 2014 but one that has led to the decline in HIV transmission, because viral suppression means that the amount of the virus in someone's blood is so low that it cannot be detected in blood tests. This means it is also untransmissible.

In 2014, at the start of the 90-90-90 Agenda the figures for diagnosed, on ART and virally suppressed were estimated to be 54 – 41 – 32.⁵ By the end of 2017, the world had achieved 75–79–81.⁶ And in the report “Communities at the Centre”, released in July 2019, data shows that the figures for 2018 are 79 -62 - 53.⁷

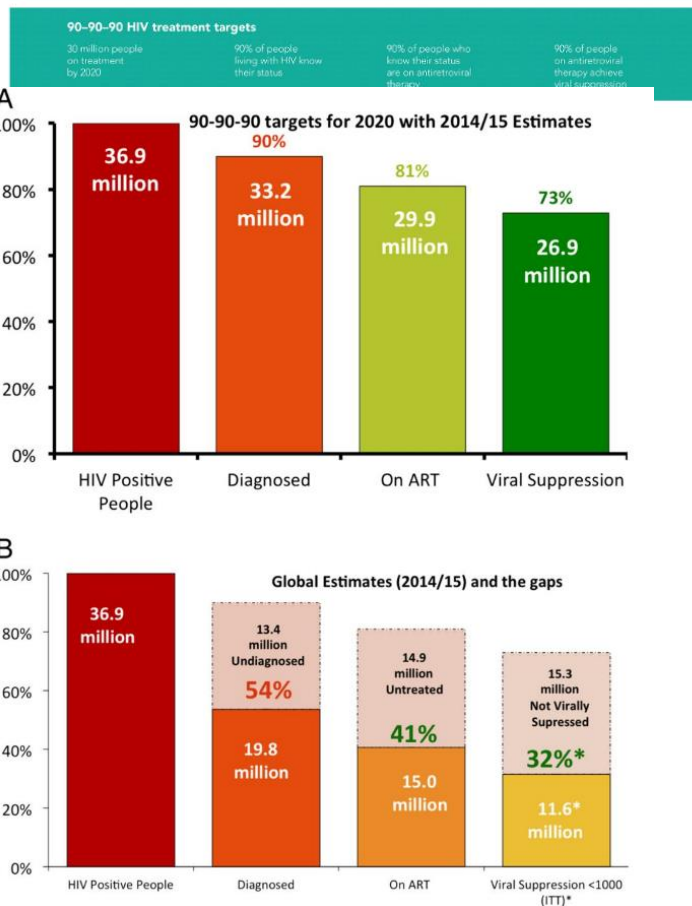
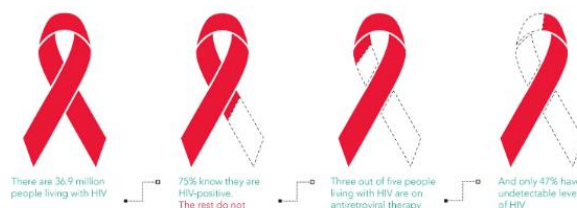
90-90-90 is premised on four theories:

1. HIV treatment prevents HIV-related illness.
2. HIV treatment averts AIDS-related deaths.
3. HIV treatment prevents new HIV infections.
4. HIV treatment saves money.

5.4. The Sustainable Development Goals

UNAIDS considers 10 of the 17 Sustainable Development Goals (SDGs) highly applicable to HIV and AIDS.⁸ Issues of poverty, hunger, education, inequalities and gender intersect with HIV and AIDS, and remain enormous challenges globally. SDG 9 (Industry, Innovation and Infrastructure) is also applicable as we look more towards public-private partnerships to reach the goals. Sectors like climate and environment have set new standards in making development a sustainable and profitable reality. The

90-90-90: Treatment for all



Levi J, Raymond A, Pozniak A, et al Can the UNAIDS 90-90-90 target be achieved? A systematic analysis of national HIV treatment cascades BMJ Global Health 2016;1:e000010.

health sector, and the global HIV and AIDS response need to engage with this sector to harness funding opportunities.

Both the UNAIDS 90-90-90 goals for 2030^{9,10} and their goal to end HIV by 2030, are goals that are rooted in the adequate financing of the HIV response. When increasing domestic investments in health and the AIDS response, many countries began to prioritise domestic funding for treatment. For example, UNAIDS reports that from 2009 to 2014 public spending on antiretroviral therapy (ART) doubled in Chad, Cote d'Ivoire, Gabon, Kenya, Namibia and Swaziland.¹¹

The Maputo Declaration of 2003 on Malaria, HIV/AIDS, TB and Other Related Infectious Diseases also reaffirmed Abuja Commitments and recognized that important progress had made in many countries in terms of mobilizing resources to respond to the three diseases.

5.5. Universal Health Care

After years of advocacy, in September 2019 a new UHC Declaration was signed in New York, signifying a new stage in Universal Health Coverage. Over the last several years the once-obscure idea of Universal Health Coverage (UHC) has blossomed into a movement embraced by leading authorities in global health. Both the World Bank and the World Health Organization have designated UHC as a core objective. Further, UHC is a leading candidate as one of the United Nations Sustainable Development Goals #3: Ensure healthy lives and promote wellbeing for all at all ages.

Now it is vital to ensure that the declaration is interpreted and implemented in the most effective way, so that universal health care, is indeed universal, and available to all people, marginalised, stigmatized, criminalized and oppressed communities too and that those who have HIV are covered by the services



that UHC provides. There is a very real risk that gains that have been made under vertical programming for HIV will be lost under UHC as HIV loses resources (human, financial, and social) to UHC implementation. It is vital to ensure that the gains are not lost and that the commitments to end new HIV infections and have all people living with HIV who wish to have treatment to be on treatment that is acceptable to them.

5.6. Addis Ababa Call to Action and UHC MOU

In February 2019, The African Union saw leaders commit to the Addis Ababa Call to Action, as part of the Africa Leadership Meeting: Investing in Health. Core outcomes or asks were that countries should aim to collect 20% of GDP into the government budget, some of which can be done by increasing tax collection by 4%. They also recommitted to 15% as per Abuja to health. And that they should spend 86USD per person per annum (WHO recommended target for UHC in developing countries).¹²

As recently as 19 November 2019, His Excellency Moussa Faki Mahamat, Chairman of the African Union Commission, and Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization signed a memorandum of understanding that is aimed at accelerating the African response to Universal Health Coverage.¹³

Three key areas in the document speaks to three key areas: 1. technical expertise from the WHO to the African Medicines Agency (AMA) to improve production of local medicines. 2 Strengthening emergency preparedness and the African health workforce in partnership with the Africa Center for Disease Control. And 3. Supporting Africa in implementing both the Addis Ababa Call to Action on universal health coverage and the AU Declaration on Domestic Financing, with an emphasis on health financing model development.¹⁴

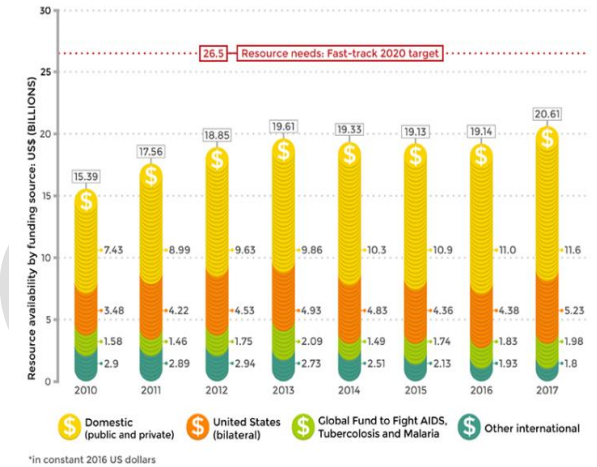
6. Global Funding

6.1. Funding for HIV

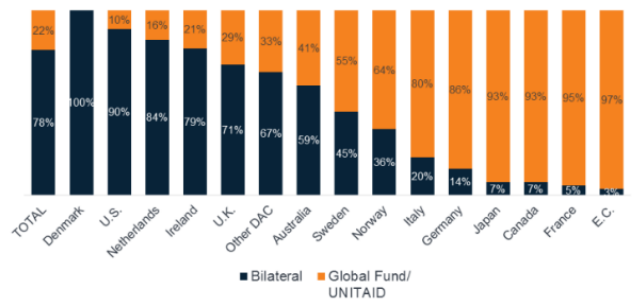
Funding for HIV has come from various sources over the decades, from bi- and multi-lateral partnerships with only five countries (France, Germany, Netherlands, the UK and the USA) accounting for 80% of all HIV funding globally in 2013¹⁵. In bi-lateral funding Australia, Canada, France, Germany, Italy, Japan, and Norway also feature as the highest contributors¹⁶. PEPFAR (The U.S. President's Emergency Plan for AIDS Relief) at approximately US\$4.4 billion annually has historically been the largest contributor of HIV funding.¹⁷

The news on March 2019 of the 1.35 billion USD proposed cut by the Trump Administration in the President's Emergency Plan for AIDS Relief (PEPFAR) abroad are of huge concern at this critical moment in controlling the epidemic, especially given that more than 14 million people in 50 countries are relying on those funds for treatment.^{18, 19} There is an overall declining for HIV funding by donors just as sexual and reproductive health and rights (SRHR) funding from high income countries has also dropped – donor assistance in 2016 was 1,035 billion Euros from all 12 European donor countries, reflecting a 11% decrease from 2015.²⁰ In 2016 funding for HIV prevention and research fell by 3% reaching a ten-year low.²¹ The funding for HIV prevention research and development decreased by 3% (US\$35 million) from the previous year, falling to US\$1.17 billion, the lowest level in ten years.^{22,23} though Kaiser Family Foundation reports this increase in 2017 after a 3-year decline was more a result of the front-loaded payment of US funding in that year as opposed to actual increases.²⁴

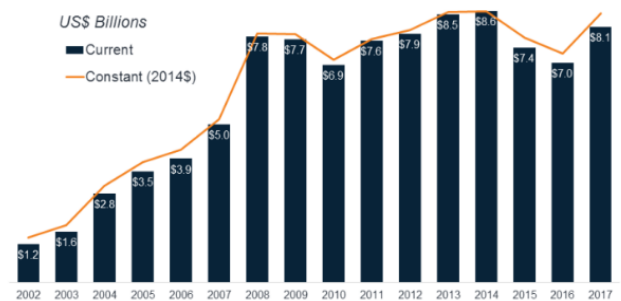
HIV resource availability* in low- and middle-income countries by source of funding, 2010-2017 and 2020 target



Funding Channels for Donor Government Disbursements for HIV (current USD), 2017



Donor Government Disbursements for HIV, 2002-2017



In September 2018 when USAID launched their new framework for financing for development “Journey to Self-Reliance”, there seemed to be both praise and criticism of the concept. Transitioning countries off reliance on foreign assistance is an over-simplification in terms of how inequality manifests itself on a global scale, as well as a demonstration of lack of understanding of how a country can deliver to most and thus transition whilst still marginalising a few. Just as the Global Fund has begun to transition countries off funding, so too USAID has this goal in mind. This simplistic goal does not imagine a world that is in reality interdependent. It does not understand the history of economics, the flows of human resources, and the history of colonisation and the massive economic gains won through neo-colonial structures that continue to exist today.

RESOURCE AVAILABILITY IN DANGER OF FALLING SHORT OF GLOBAL COMMITMENTS

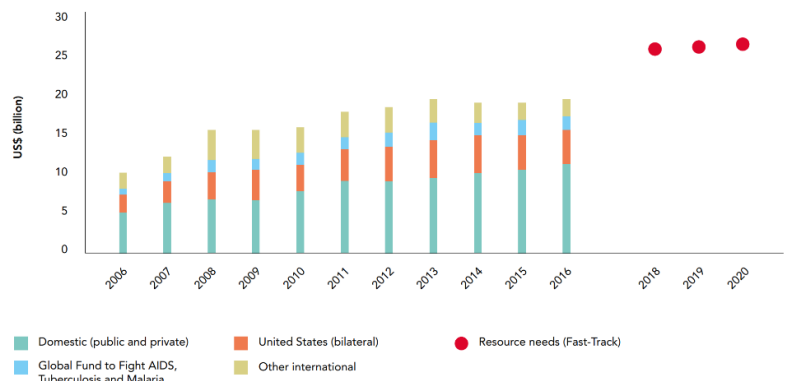
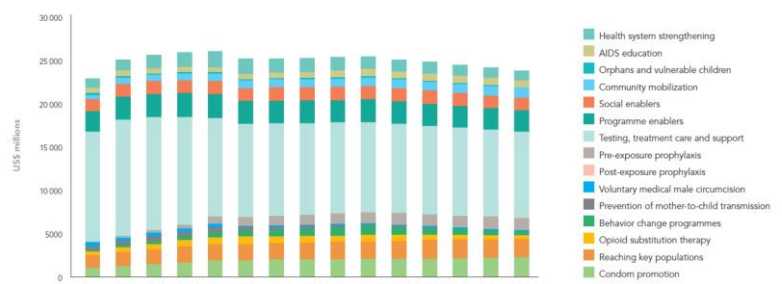


FIGURE 1.4. HIV RESOURCE AVAILABILITY BY SOURCE, 2006–2016, AND PROJECTED RESOURCE NEEDS BY 2020, LOW- AND MIDDLE-INCOME COUNTRIES*

Source: UNAIDS estimates June 2017 on HIV resource availability. Fast-Track update on investments needed in the AIDS response, 2016–2030. Geneva: UNAIDS; 2016. Financing the response to low- and middle-income countries: international assistance from Donor Governments in 2016. The Henry J. Kaiser Family Foundation and UNAIDS (in press). GAM/GARPR reports (2005–2017). Philanthropic support to address HIV/AIDS in 2015. Washington, DC: Funders Concerned about AIDS; 2016.

*Estimates for low- and middle-income countries per 2015 World Bank income level classification. All figures are expressed in constant 2016 US dollars.

Total investment needs, HIV responses of low- and middle-income countries, 2016-2030 (in millions of US dollars)



SNAPSHOT | #HLM2016AIDS HIV investments, UNAIDS, Geneva, 2016

An increase in domestic funding as a percentage of global total was observed (50% in 2015 to 57% in 2016/7)²⁵ Since 2006 resources for HIV have almost doubled to US\$20 Billion in 2017.²⁶ For example UNAIDS reports that from 2009 to 2014 public spending on antiretroviral treatment doubled in Chad, Cote d’Ivoire, Gabon, Kenya, Namibia and Swaziland.²⁷

UNAIDS has calculated that 26,2 billion USD is required to reach the 2020 targets (90-90-90) which were adopted during the 2016 Political Declaration by UN member states²⁸. UNAIDS also estimates that 80% of this is available from domestic funding, but that some countries and some groups of people are still not receiving services.²⁹ The people who are not serviced are those who are the least able to advocate for their inclusion, often due to them being criminalised (gay men, sex workers, trans diverse people, and injecting drug users for example) or not in a position to advocate for themselves (people in prison, young girls, women, people living in rural areas, people with little or no financial resources).

According to UNAIDS, in North Africa 72% of HIV financing comes from domestic sources, and donor funding falling to below 30%.³⁰ In East and Southern Africa, 10.6 billion USD was available for HIV programmes in 2017, with 42% coming from domestic sources.³¹ Over the past decade funding for HIV has grown in these two regions.³² This differs to West and Central Africa where resources have decreased since 2013, and with domestic resourcing making up 31% of the total.³³

Sources of funds for HIV vary from country to country. Each African member state has its own dynamic relations with each of the international development partners. It is important to note with a 15% to 19% share of the global GDP, the United States of America is the also the largest contributor of finances to HIV.³⁴ The EU and China each have 17% of the global GDP, whilst the whole of Sub-Saharan Africa has 3%.³⁵ It is vital to see contributions to HIV from International Development Partners (IDPs) in this context.

Table 1 Grossdomestic product (GDP) per capita (2014, current US\$) and HIV prevalence in selected sub-Saharan African countries

Country	GDP per capita (US\$)	HIV prevalence and % range (total, % of population ages 15–49)	Number of people living with HIV (000s) (range in 000s)
Middle income			
South Africa	6483	19 (17.9–19.9)	6800 (6500–7500)
Nigeria	3203	3 (2.9–3.4)	3400 (3100–3700)
Zambia	1722	12 (11.7–13.1)	1200 (1100–1200)
Lower income			
Kenya	1358	5 (4.7–6.1)	1400 (1200–1600)
Zimbabwe	931	17 (15.9–17.5)	1600 (1500–1600)
Tanzania	955	5 (4.8–5.9)	1500 (1300–1900)
Uganda	715	7 (6.6–8.1)	1500 (1400–1800)
Ethiopia	574	1 (1.0–1.5)	730 (600–970)
Malawi	255	10 (9.3–10.8)	1100 (990–1100)

Data source: GDP per capita <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD> (accessed 16 January 2016). HIV Prevalence and number of people living with HIV: UNAIDS estimates (2014) <http://www.unaids.org/en/regionscountries/countries> (accessed 16 January 2016).

Cited in: Atun R, Chang AY, Ogbuoji O, et al. Long-term financing needs for HIV control in sub-Saharan Africa in 2015–2050: a modelling study. *BMJ Open* 2016;6:e009656. doi:10.1136/bmjopen-2015-009656

	2014	2015	2016	2017
Australia	100.4	98.7	78.0	24.2
Canada	124.6	109.3	95.5	119.4
Denmark	167.2	138.8	106.5	90.4
France	302.8	263.1	242.4	267.7
Germany	278.4	200.9	182.0	161.9
Ireland	51.4	36.4	31.1	29.3
Italy	25.6	19.7	26.0	28.8
Japan	175.9	117.9	113.2	98.6
Netherlands	218.7	117.9	214.2	202.6
Norway	103.8	81.8	70.5	63.9
Sweden	154.5	109.2	111.8	91.1
United Kingdom	1,114.0	899.9	645.6	743.9
United States	5,571.2	5,004.6	4,912.8	5,947.0
European Commission	91.2	92.7	36.9	113.0
Other Development assistance Committee (DAC)	89.4	74.5	67.7	78.2
Other Non-DAC	32.1	12.4	16.9	27.2
Total	8,601.8	7,438.0	6,951.1	8,087.2

Title: Government spending (USD 1000s) Source: Donor Government Funding for HIV in Low- and Middle-Income Countries in 2018. Kates, Wexler and Lief, Kaiser Family Foundation. <https://reliefweb.int/sites/reliefweb.int/files/resources/Report-Donor-Government-Funding-for-HIV-in-Low-and-Middle-Income-Countries-in-2018.pdf>

Investment by IDPs in HIV have reduced in recent years, although investments have moved to other areas, principally to migration and integration, climate change and security.

This presumes that the ideal is a model where a country entirely funds its own HIV and AIDS response. It is a matter for discussion as to whether a perfect health system includes or excludes private or foreign funds, but we have based our analysis on a model such as France, Germany or the Netherlands, countries where the national response is 100% domestically funded, with marginal out of pocket or private funding. The authors acknowledge that this ideal may not be possible for many countries in Africa in the immediate term. See comments on transitioning above.

6.2. Investment Cases

In 2011 UNAIDS began to encourage countries to re-think how they thought about their financing for the HIV response. The idea behind what has become known as HIV Investment cases is that the financial investments must be more strategic, have a more rights-based approach, and lead to greater sustainability. It was hoped that by so doing the investment cases would also provide greater clarity to investors (bi and multi-lateral partners, businesses and the Global Fund) and motivate their investment more. It was hoped as well that innovation would be catalysed, just as gaps would become more obvious and then redressed. Also, it was hoped that basing decisions on empirical evidence would also lead to more impact and cost-effectiveness.³⁶

Investment cases have been reasonably successful in minimising personal influence in grant applications, especially for larger grants, such as PEPFAR and the Global Fund in many countries but in some countries investment cases have been construed to fit predetermined politically supported outcomes in a serious case of “the tail wagging the dog”.

The Global Fund has also developed an investment case, one portion of which is demonstrated in the image here. It shows how increased investment now will prevent future new infections. Like most investment cases it examines what the scenario will be with current investments and programmes and what the scenario will be with greater investment and different programming.



Source: Step up the Case: INVESTMENT CASE, SIXTH REPLENISHMENT 2019, Global Fund.

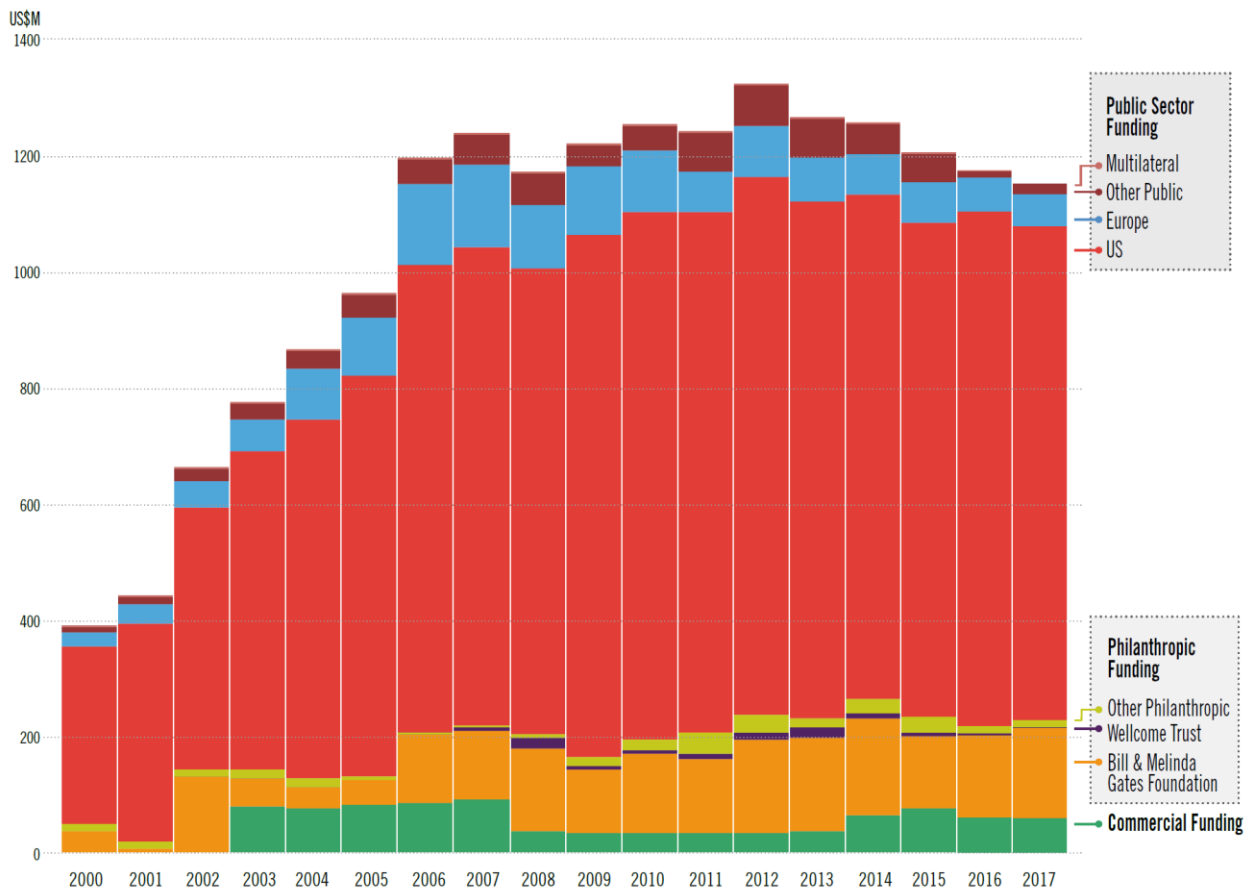
	Country	Graded highest A / lowest E	Graded highest E / lowest A	Graded highest E / lowest A	Graded highest E / lowest A	Graded highest E / lowest A
		Domestic public expenditure	Domestic private expenditure	International: PEPFAR expenditure	International: Global Fund expenditure	Int: all others expenditure
1	Algeria	80%	19%	0%	1%	0%
2	Angola	16%	0%	73%	11%	0%
3	Benin	100%	0%	0%	0%	0%
4	Botswana	77%	0%	0%	0%	23%
5	Burkina Faso	13%	16%	0%	42%	29%
6	Burundi	2%	11%	0%	86%	1%
7	Cabo Verde	61%	2%	1%	28%	7%
8	Cameroon	20%	19%	17%	20%	24%
9	Central African Republic	21%	0%	0%	70%	9%
10	Chad	32%	1%	0%	49%	18%
11	Comoros	7%	2%	0%	91%	0%
12	Congo	50%	0%	0%	39%	10%
13	Côte d'Ivoire	13%	1%	76%	6%	4%
14	Democratic Republic of	0%	100%	0%	0%	0%
15	Djibouti	10%	0%	0%	54%	36%
16	Egypt	57%	2%	0%	20%	21%
17	Equatorial Guinea	95%	3%	0%	0%	2%
18	Eritrea	12%	0%	0%	39%	49%
19	Ethiopia	15%	0%	57%	17%	11%
20	Gabon	42%	42%	0%	0%	16%
21	Gambia	100%	0%	0%	0%	0%
22	Ghana	5%	46%	16%	33%	0%
23	Guinea	8%	0%	0%	91%	0%
24	Guinea-Bissau	13%	0%	0%	0%	87%
25	Kenya	29%	8%	53%	10%	0%
26	Lesotho	44%	0%	25%	17%	15%
27	Liberia	1%	0%	0%	99%	0%
28	Libya	ND	ND	ND	ND	ND
29	Madagascar	6%	0%	0%	94%	0%
30	Malawi	3%	0%	55%	43%	0%
31	Mali	31%	1%	2%	49%	17%
32	Mauritania	0%	0%	0%	100%	0%
33	Mauritius	ND	ND	ND	ND	ND
34	Morocco	92%	8%	0%	0%	0%
35	Mozambique	3%	0%	65%	26%	6%
36	Namibia	57%	1%	37%	5%	0%
37	Niger	1%	0%	1%	98%	0%
38	Nigeria	11%	0%	80%	9%	0%
39	Rwanda	0%	0%	55%	44%	0%
40	Sahrawi Republic (Western	ND	ND	ND	ND	ND
41	São Tomé and Príncipe	ND	ND	ND	ND	ND
42	Senegal	19%	14%	0%	67%	0%
43	Seychelles	ND	ND	ND	ND	ND
44	Sierra Leone	4%	1%	78%	0%	17%
45	Somalia	0%	0%	0%	3%	97%
46	South Africa	75%	0%	23%	2%	0%
47	South Sudan	0%	0%	1%	0%	98%
48	Sudan	29%	8%	0%	63%	0%
49	Swaziland (eSwatini)	34%	0%	0%	0%	66%
50	Tanzania	44%	5%	0%	15%	36%
51	Togo	10%	14%	0%	77%	0%
52	Tunisia	4%	0%	0%	95%	0%
53	Uganda	ND	ND	ND	ND	ND
54	Zambia	5%	1%	78%	4%	12%
55	Zimbabwe	27%	0%	14%	58%	1%

Title: Donor dependence by country. Source: UNAIDS DATA 2018 https://www.unaids.org/sites/default/files/media_asset/unaid-data-2018_en.pdf

6.3. Financing of Research for HIV

One of the better researched and documented areas of HIV financing is research and development (R & D). And AVAC is a leader in this field along with the HIV Resource Tracking Working Group. This section is a good example of how collecting, collating data and analysing is helpful in understanding how countries are responding to the HIV epidemic.

FIGURE 17 Global Funding Sources for HIV Prevention R&D, 2000-2017 (US\$ millions)

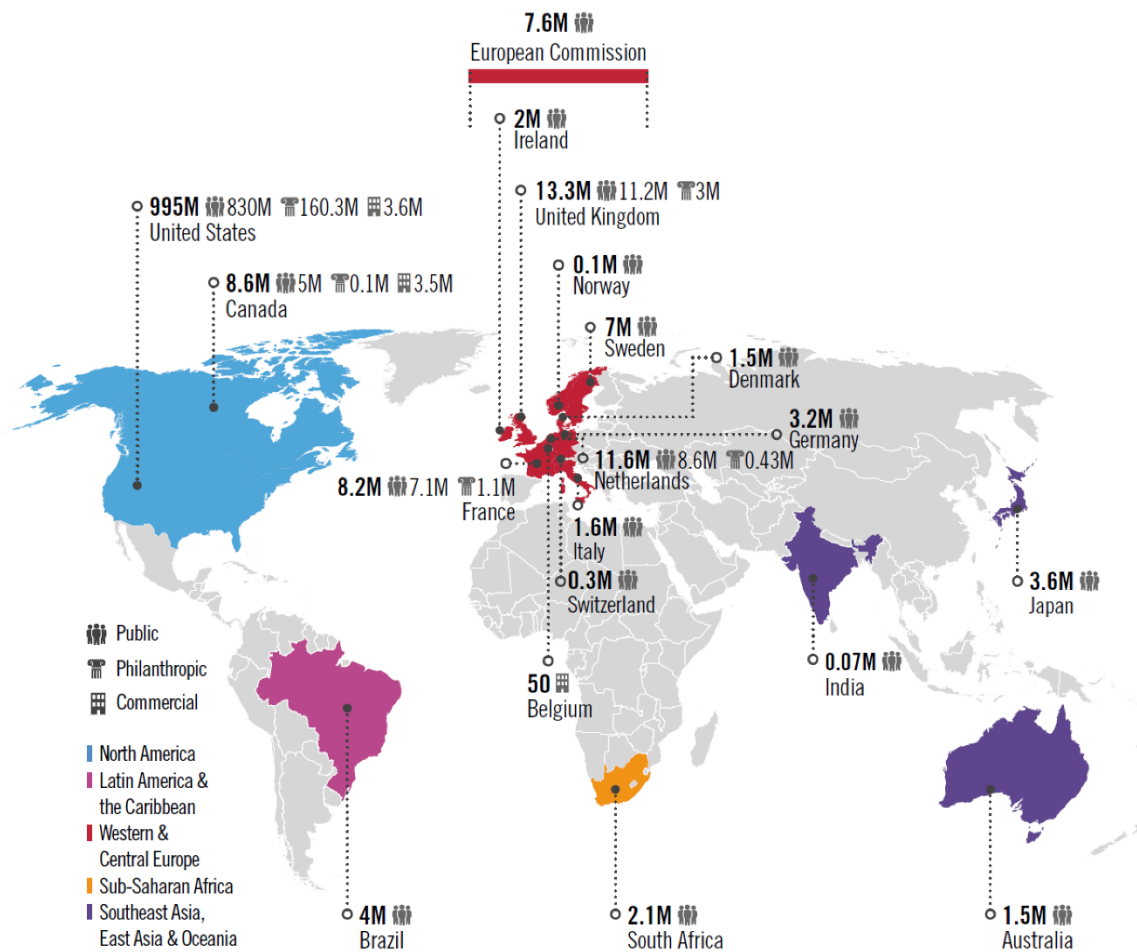


Source: HIV Prevention Research & Development Investments: Investing to End the Epidemic, Resource Tracking Working Group, New York, 2017.

South Africa, according to the Report "Investing to End the Epidemic", is the only African country out of 26 countries (and other groups such as business and philanthropic organisations) globally that invests in HIV Prevention R & D.³⁷ Compared to the enormous investments of the USA (830 Million USD) and the BMGF (150,2 Million USD) the investment by SA (2.1 million USD in 2017 and 4.4 million USD in 2016) is not significant.³⁸ But SA spends more than six other countries (for 9 countries we do not have numbers at all). SA investment matches that of Ireland (2.1 million) and Wellcome Trust (2 million USD).³⁹ For some it may be important to note that SA only invests in preventive AIDS vaccines, microbicides and pre-exposure prophylaxis (PrEP).⁴⁰

Investment proportions are 76% into preventive AIDS vaccines, 9,5% on microbicides, and 9,5% on PrEP (2017).¹ The areas where no investment is documented in the AVAC data is prevention of vertical transmission, treatment as prevention, voluntary male medical circumcision and female condoms. In 2015 and 2016 SA was the 12th largest funder of AIDS vaccines globally but has since dropped below the top 15. SA has consistently been in the top 15 global funders of microbicide R and D (also falling off since 2017).

FIGURE 15 Total Global Investment in HIV Prevention R&D by Country, 2017 (US\$ millions)



* Information collected includes funding from those countries that responded to the Working Group's annual survey, or where public information on sources of funding was available. Totals include public, philanthropic and commercial sector funding from each country. Commercial-sector investments are allocated to a country based on the location of corporate headquarters and are underestimated due to a lack of reporting by companies. Not all commercial-sector estimates are able to be allocated by country.

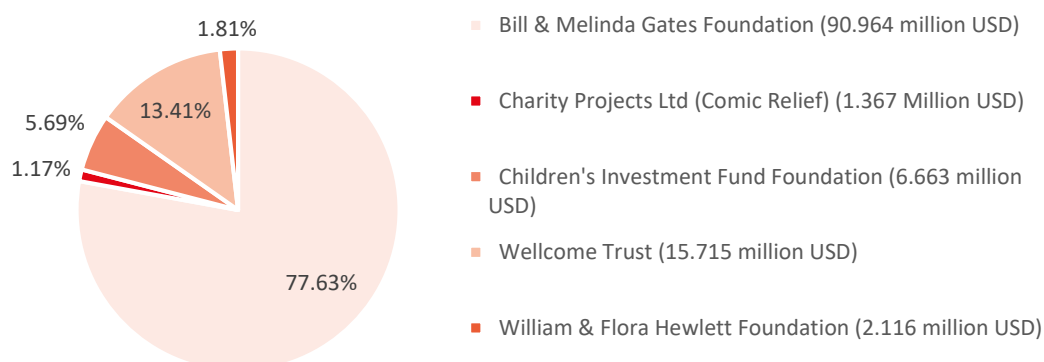
Source: HIV Prevention Research & Development Investments: Investing to End the Epidemic, Resource Tracking Working Group, New York, 2017.

¹ The last 5% is not marked in the AVAC data

6.4. Global Private Philanthropy

Philanthropic investment in HIV in Africa (and around the globe) is certainly not insignificant. The graph is based on OECD data from the Private Philanthropy for Development Creditor Reporting System database and examines only at funds sent to Africa, by sector 13040, which is “STD control including HIV/AIDS”. The data shows constant prices as the amount type, with the unit of measure as US Dollar, Millions, 2016. The total amount is 117,182 million USD. Other partners that may seem substantial in the field actually have small amounts invested in HIV, for example in 2016-2018 Robert Carr Fund grantees reported spending a total of US\$ 3.7 million on activities addressing the needs of people living with HIV, out of a total of 28.3 million USD from the RCF in total over that period on all programmes.⁴¹

Private Philanthropy for Development, STD control including HIV/AIDS in Africa for 2017
(Source: OECD)



Global private philanthropy is an important part of HIV funding, most obviously the Bill and Melinda Gates Foundation as it has a larger budget than most others and is thus able to be far-reaching, but significantly is their focus on innovation, and out of the box solutions. In the same way, the smaller philanthropic organisations impact should not be under-estimated. Strategic funds from smaller givers can be as important as they innovate, test new programmes and work with highly invisibilised people and communities, thereby actually having an impact where it counts most, averting new clusters of infections and providing services in a more inclusive and respectful way than public health services do.

7. Partnership with Business



It is an uncontroverted fact that partnerships with business and investors is a vital part of achieving the Sustainable Development Goals (SDGs). Whether these partnerships take the form of public-private partnerships, impact investment or corporate social responsibility, it is vital to tap the education, experience, networks and finances of the business sector if we are to reach the Agenda 2030 goals. Below we unpack the various types of Partnerships with business and investigate the effectiveness and scope of each through examples:

7.1. Public Private Partnerships

Public-Private Partnerships (PPPs) are exactly what the name suggests, a partnership between governments and private businesses with the aim of achieving both development goals and generating a profit. They have been credited with being the solution to all development challenges and they have been demonised as capitalist private enterprise stealing public funds. Both these extreme versions exist, but in truth the reality is somewhere in between. What often is often questioned is whether PPPs can deliver the same quality as governments and for the same price.

In early 2019, Shrivastava et al investigated PPPs that focussed specifically on the laboratory testing issues that arose as part of cascade of 90-90-90. Their research shows that the PPPs developed there had very significant impact.⁴²

They looked into PPPs with various actors, amongst them Becton Dickinson, Roche Diagnostics, PEPFAR, UNITAID and the Clinton HIV/AIDS Initiative (CHAI), Siemens Healthineers, Abbott Fund, Riders for Health, health care software provider Voxiva, the phone producer Motorola, the telecom company MTN, the GSMA Development Fund, PEPFAR, CDC Foundation and Accenture Development Partnerships all in various Sub-Saharan countries: Ethiopia, Kenya, Mozambique, Rwanda, South Africa, Tanzania, and

Uganda amongst others. The PPPs demonstrated considerable value for money when compared to government only implementation.⁴³

“One of the six PPPs reached 14.5 million patients in remote communities and transported up to 400,000 specimens in a year. Another PPP enabled an unprecedented 94% of specimens to reach national laboratory through improved sample referral network and enabled a cost savings of 62%. Also, PPPs reduced cost of reagents and enabled 300,000 tested infants to be enrolled in care as well as reduced turnaround time of reporting results by 50%.”⁴⁴

In January of 2018 The Global Fund announced PPPs with Lombard Odier, Heineken and Unilever. Odier is committed to increase business investment into the Global Fund, Heineken to share its communications and supply chain and logistics expertise, and Unilever for a health program effectiveness.⁴⁵ PPPs are increasingly considered vital part of the response to health delivery and to addressing needs in the HIV response.

Obviously, PPPs differ greatly, and the public health system can also partner with NGOs who do health service delivery in partnership with the ministry of health and with business workplace wellness programmes. A 2006 study by Sinanovic and Kumaranayake found that in South African patients with tuberculosis that:

“government financing would require \$609–690 per new patient treated, in contrast to Public-NGO Partnerships (PNP) sites which would only need to \$130–139 per patient (almost a five-fold reduction in costs), and \$36–46 (a fifteen fold reduction) with the Public Workplace Partnerships (PWP) model. The study models are comparable in that they follow the same TB treatment protocol, are similar in terms of key social, economic and demographic characteristics, and provide care to the lower-income populations.”⁴⁶

Very importantly the workplace programme was the preferred option for the patients, followed by NGOs and lastly government provided health services. The main reasons were time and costs.⁴⁷ That PPPs can sometimes deliver a better product at a lower cost and higher convenience to the user is an important factor when considering them as a way to fund HIV. Not only are PPPs then a source of funding but also a way to improve quality and ensure cost effectiveness.

7.2. Impact Investment

But in order to see the SDGs achieved it is vital that impact investors (and venture philanthropists²) are involved and at the same time accountable with regards to the entire impact of their investments. Impact Investment is a largely untapped area for the HIV movement, whereas climate change, agri-business and gender (women only) impact investments exist, none are focussed on HIV or KPs.

When considering impact investment, countries need to understand that the model has certain limitations or weaknesses. A simple example is using slave labour to improve climate change through the provision of clean energy sources. In some projects non-unionised labourers have been used to install solar panels into villages, and these labourers are underpaid due to the lack of unionisation. This might be termed impact investment, but the projects have adverse consequences that affects human rights as a whole.

It is vital that the entire impact of investors is examined and that they are accountable. It is vital too that impact investors take a sustainable perspective to their work, and that they consider the unintended consequences of their investments. This is particularly relevant for those investors that are not aware of, nor have much knowledge of people who are currently being left behind in the SDG response. Most especially people that are criminalised, such as sex workers, men who have sex with men, gay and bisexual men, trans people, people who use drugs and many others who are criminalised remain invisible and it is near impossible for impact investors (usually from outside the country) to know of their existence, never mind understand their issues. Many times, local communities become collateral damage when new investment occurs, now similarly in impact investment so-called marginalised communities become collateral damage.

In the current monitoring and evaluation standards set by many in the impact investment arena, an investment can be said to be an impact investment if there is an improvement in either the quality or quantity of social impact as a result of changes that result in financial loss.³ This is problematic for various reasons:

1. There is a marketing value that can be ascribed to labelling a product or service as impact investment;
2. There improvement does not have to be quantifiably significant statistically;
3. Self-measurement of financial losses and social gains is very open to subjective reasoning and business is likely to defer in their own favour;
4. This places true impact investment of which there are many, at a risk of being co-opted.

² Venture philanthropists usually focus only on social impact and are less focussed on profit-making but focussed on larger problem/systematic problem solving. Impact investors are always looking to be profitable, and work on a broader variety of issues (socio-economic, environmental (including animals for example). The latter is usually more short-term.

³ “We posit that a particular investment has impact only if it *increases the quantity or quality of the enterprise’s social outcomes beyond what would otherwise have occurred*. Under this definition, it is readily apparent that grants or concessionary investments (i.e., investments that sacrifice some financial gain to achieve a social benefit) can have impact: by hypothesis, an ordinary investor, who seeks market-rate returns, would not provide the capital on equally favourable terms, if at all.” Unpacking the Impact in Impact Investing, Paul Brest and Kelly Born, August 14, 2013 (source: Stanford Social Innovation Review).

https://ssir.org/articles/entry/unpacking_the_impact_in_impact_investing

Although the impact investment arena is an improvement on traditional investments, there remains much work to be done to ensure that there is equality, community inclusion, intersectionalities, human rights and invisible and unintended consequences are considered in the sector. There needs to be accountability around even the definition of what a “positive social or political outcome” might be, as these are very subjective and relative opinions, and under some regimes the oppression of some groups is considered a positive social outcome! It is important to ensure impact investment does not become another buzz word for “business as usual but with slightly less negative impact”, when it can indeed be so much more.

An example of this model is the case of AllLife and Leapfrog Investments in South Africa. AllLife “is the only dedicated insurer of people living with HIV/AIDS in South Africa.”⁴⁸

“Through this investment LeapFrog supports the design and delivery of affordable insurance to many individuals typically excluded from the life insurance market. The majority of AllLife's clients previously had been unable to obtain insurance or could do so only at a very high cost, preventing them from taking out home loans, starting businesses, or engaging in other economic activities requiring insurance. By providing insurance to these individuals, AllLife helps them live long, productive lives. AllLife clients show measurable improvements in health outcomes. Access to life insurance along with widespread advertising by AllLife reduce the stigma associated with those living with HIV/AIDS.”⁴⁹

7.3. Corporate social responsibility

Defining corporate social responsibility is a field of study of its own, but a well accepted definition, that also includes what Dahlsrud calls the five dimensions of CSR is: “A concept whereby companies integrate social and environmental concerns in their business operations and in their interaction with their stakeholders on a voluntary basis.”⁵⁰ From the Commission of the European Communities in 2001. This definition importantly has the five dimensions:

1. Stakeholder
2. Environmental
3. Social
4. Economic
5. Voluntariness⁵¹

Numerous studies demonstrate that an investment by companies in workplace HIV and /or wellness programmes reaps dividends for staff and employer alike.

Since the launch of the Global Business Council on HIV/AIDS in 1997, thousands of companies have taken on HIV Workplace programmes, providing prevention messaging, testing, referrals, treatment, care and support. Other health matters have been added to the programmes including TB, malaria, diabetes, and cholesterol and other chronic illnesses.

Increasingly corporate social responsibility is linked to the environment, and it is vital to educate employers that working on a sustainable environment does not preclude providing HIV and other health related care for stakeholders, whether staff and their families or the community in which a business is located.

In a study of Johnson and Johnson CSR, Vijay Kumar Chattu finds:

“CSR of business encompasses the economic, legal, ethical and discretionary expectation placed on the organization by society at a given point of time. CSR is therefore the obligation that corporations have toward their stakeholders and society in general which goes beyond what is prescribed by law or union contracts.”⁵²

Chattu identifies three types of initiatives in the Johnson and Johnson portfolio of CSR work:

6. Cause promotion: Creating awareness of an issue
7. Cause-related marketing (CRM): Committing to donating a percentage of sales or a commodity for every sale of an item.
8. Social initiative 3: Corporate social marketing (CSM): Grant-making and partnering with skills and expertise for behavior change, such as peer-counselling for HIV positive youth, mothers volunteering to speak to pregnant women about vertical transmission of HIV.
9. Johnson & Johnson's philanthropy: Grant-making, including bursaries for studying and equipment and technical expertise.⁵³

8. African Philanthropists

8.1. Private Philanthropy

Private philanthropy can be an excellent source of funds for the HIV response, but challenges exist in this area. Africa's richest man, Aliko Dangote has previously openly stated that most of Africa's richest philanthropists do not wish to publicly state what they give and to what causes. The rationale for this is both personal and religious apparently and echoes narratives from the African Union Commission regarding the philanthropic responses to the West African Ebola outbreak in 2016. In that case African governments, philanthropists and foundations donated but without first writing a press release because it is culturally more acceptable to give privately than conspicuously in most African cultures. Some African philanthropists give finances, but others have their own foundations which work to push a particular agenda. A well-known example of this is Mo Ibrahim and the Ibrahim Prize for Achievement in African Leadership which aims to reward African former executive heads of state in Africa who have developed their countries and lifted poverty in their countries.

Amongst our largest African public givers are the following people:

Name	Nationality	Title	Estimated giving
Patrice Motsepe	South Africa	Chair, African Rainbow Minerals	\$250 million (2018)
Nicky Oppenheimer	South Africa	Former Chair of De Beers diamond mining company	\$80 million (2012)
Aliko Dangote	Nigeria	President Dangote Group	\$35 million (2012)
Jim Ovia	Nigeria	Founder, Zenith Bank	\$6.6 million (2012)
Strive Masiyiwa	Zimbabwe	Founder, Econet Wireless	\$6.4 million (2012)
Tony Elumelu	Nigeria	Chair, Heirs Holdings	\$6.3 million (2012)
Arthur Eze	Nigeria	Chair, Atlas Oranto Petroleum	\$6.3 million (2012)
Mike Adenuga	Nigeria	Chair, Globacom	\$3.2 million (2012)
Mohammed Dewji	Tanzania	Owner of MeTL Group	\$3 million (2016-2019)
Folorunsho Alakija	Nigeria	MD, The Rose of Sharon	\$3.5 million (2017-2019)
Naushad Merali	Kenya	Chair, Sameer Group	\$1.2 million (2012)
Manu Chandaria	Kenya	Chair, Comcraft Group	\$1.2 million (2012)
Ashish J. Thakkar	Uganda	CEO, Mara Group	\$1.1 million (2012)
Onsi Sawiris	Egypt	Founder: Orascom Group and Construction, Global Telecom Holding	No data

Source: M Nsehe^{54, 55}

8.2. Diaspora Remittances

As Ade Daramy, Chair of the African Foundation For Development (Afford) writes in his article "Remittances are three times greater than aid – how can they go even further?" in the Guardian⁵⁶ in 2016, the sheer enormity of remittances and the organisation around their use is a considerable player in economics on the globe. So much so that Adamy and his organisation called for remittances by Africans to be on the G8 agenda.

Total remittances are three times higher than all Official Development Assistance to these countries and take the form of both personal payments to family and loved ones but also are becoming increasingly organised and have education, infrastructure development and many other developmental objectives are rationales for sending funds.

According to the World Bank Press Release: Record High Remittances Sent Globally in 2018, "The Bank estimates that officially recorded annual remittance flows to low- and middle-income countries reached \$529 billion in 2018, an increase of 9.6 percent over the previous record high of \$483 billion in 2017. Global remittances, which include flows to high-income countries, reached \$689 billion in 2018, up from \$633 billion in 2017. Among countries, the top remittance recipients were India with \$79 billion, followed by China (\$67 billion), Mexico (\$36 billion), the Philippines (\$34 billion), and Egypt (\$29 billion). Remittances to Sub-Saharan Africa grew almost 10 percent to \$46 billion in 2018, supported by strong economic conditions in high-income economies. Looking at remittances as a share of GDP, Comoros has the largest share, followed by the Gambia, Lesotho, Cabo Verde, Liberia, Zimbabwe, Senegal, Togo, Ghana, and Nigeria."⁵⁷

What is interesting to examine is the percentage of migrants and the percentage of remittances by region and realise that the value of remittances from Africans is comparatively lower than those from other regions. This would require further interrogation.

		2007	2016	Trend
Africa	Total number of migrants (millions)	25.5	33	29%
	Total remittances (US billions)	44.3	60.5	36%
	Central Africa	0.2	0.3	53%
	Eastern Africa	2.4	5.2	117%
	Northern Africa	19.2	27.6	44%
	Southern Africa	1.6	1.1	-34%
	Western Africa	20.9	26.3	26%
	Share of global remittances	15%	13%	
Latin America and the Caribbean	Total number of migrants (millions)	27.3	32.9	21.00%
	Total remittances (US billions)	61.7	73.1	18.00%
	Caribbean	6.8	10.4	51.00%
	Central America	12.3	18.3	48.00%
	Mexico	26.9	28.5	6.00%
	South America	15.7	15.9	1.00%
		Share of global remittances	21%	16%
Asia and the Pacific	Total number of migrants (millions)	42.4	45.1	0.90%
	Total remittances (US billions)	198,765	255,872	3.70%
	Central Asia	6,406	7,910	3.10%
	Eastern Asia	60,632	64,129	0.80%
	Southern Asia	83,142	118,072	5.10%
	South Eastern Asia	44,725	65,267	5.50%
	Pacific	3,860	494	-25.40%
	Share of global remittances	43%	42%	

	Migrant remittance inflows (US\$ million)	2016	2017	2018	Remittances as a share of GDP in 2018 (%)
1	Algeria	1,989	1,792	1,933	1.0%
2	Angola	4	1	2	0.0%
3	Benin	222	195	368	3.5%
4	Botswana	25	36	33	0.2%
5	Burkina Faso	397	416	437	3.1%
6	Burundi	31	34	36	1.0%
7	Cabo Verde	198	211	243	12.3%
8	Cameroon	269	317	345	0.9%
9	Central African Republic				NO DATA
10	Chad				NO DATA
11	Comoros	131	132	143	19.1%
12	Congo, Dem. Rep.	593	1,274	1,405	3.3%
13	Congo, Rep.				0.0%
14	Cote d'Ivoire	342	342	363	0.8%
15	Djibouti	58	59	63	2.9%
16	Egypt, Arab Rep.	18,590	24,737	28,918	11.6%
17	Equatorial Guinea				NO DATA
18	Eritrea				NO DATA
19	Ethiopia	772	393	412	0.5%
20	Gabon	23	23		0.0%
21	Gambia, The	207	228	245	15.3%
22	Ghana	2,980	3,536	3,803	7.3%
23	Guinea	52	44	48	0.4%
24	Guinea-Bissau	56	56	27	1.8%
25	Kenya	1,745	1,962	2,720	3.0%
26	Lesotho	344	401	438	14.7%
27	Liberia	580	403	387	12.0%
28	Libya				NO DATA
29	Madagascar	299	343	370	3.0%
30	Malawi	34	41	45	0.6%
31	Maldives	4	4	4	0.1%
32	Mali	827	827	885	5.1%
33	Mauritania		77		NO DATA
34	Mauritius	194	250	250	1.8%
35	Morocco	7,088	6,823	7,375	6.2%
36	Mozambique	93	258	354	2.4%
37	Namibia	66	48	52	0.4%
38	Niger	176	263	282	3.0%
39	Nigeria	19,679	22,001	24,311	6.1%
40	Rwanda	173	215	230	2.4%
41	Sao Tome and Principe	18	18	17	3.8%
42	Senegal	1,929	1,929	2,213	9.1%
43	Seychelles	22	22	24	1.5%
44	Sierra Leone	47	47	51	1.4%
45	Somalia				0.0%
46	South Africa	755	873	946	0.3%
47	South Sudan	1,083	634		0.0%
48	Sudan	153	213	271	0.8%
49	Swaziland	98	144	156	NO DATA
50	Tanzania	403	403	430	0.8%
51	Togo	367	367	452	8.5%
52	Tunisia	1,821	1,890	2,027	4.9%
53	Uganda	1,146	1,166	1,245	4.5%
54	Zambia	38	94	101	0.4%
55	Zimbabwe	1,856	1,730	1,856	9.6%
	World	67,980	77,273	86,314	

Title: Remittance flows over past three years and as % of GDP. Source: <https://www.knomad.org>; based on World Bank staff calculation based on data from IMF Balance of Payments Statistics database and data releases from central banks, national statistical agencies, and World Bank country desks. Note: All numbers are in current (nominal) US \$

9. Innovative financing for HIV

Innovative financing (IF) is predominately focused on innovatively using existing instruments to channels funding to development. Innovative financing is about bringing established products and mechanisms to new investors and new markets to expand resource mobilisation. A number of innovative financing mechanisms exist already, including but not limited to:

1. Specific tax levies (for example airline ticket taxes)
2. Debt2health initiatives (swopping debt reduction for domestic investment in development. D2H swaps see a donor cancel the public debt of a developing country if that country transfers resources to the Global Fund for investment in domestic health.)
3. Co-financing (domestic funding set to match international commitments),
4. Blended financing (public-private partnerships to stimulate development),
5. Bonds⁴ and Guarantees⁵ (these are units of debt that a government (or corporate entity) can sell to raise funds and they currently form 65% of the IF market (not because they are innovative per se, but because they are seldom used by governments for health and development) ⁵⁸
6. Auctioning or sales of emissions permits (every government is supposed to allocate a set amount (called a cap) of environmental emissions permits for each harmful emission. Companies and countries can then trade (sell or buy) these permits (within reason usually) to those who require them more, thereby raising funds which can be used for development.
7. Trading of Special Drawing Rights (SDRs): The International Monetary Fund (IMF) allocates SDRs (an IMF form of currency) to countries globally. Countries can then trade these SDRs for normal funds for investment in health. ⁵⁹

Not enough innovative financing instruments have been in use in sub-Saharan Africa. Examples exist in the Seychelles, Kenya and Uganda as well as the following:

1. Botswana's National HIV/AIDS Prevention Support (BNAPS) International Bank for Reconstruction and Development (IBRD) Buy-Down (a debt conversion instrument) had generated US\$ 20 million for the HIV response;
2. Côte d'Ivoire's Debt2Health Debt Swap Agreement (a debt conversion instrument) had generated US\$ 27 million (approximately 50% of which went to HIV);
3. Zimbabwe's AIDS Trust Fund (a tax/levy-based instrument) had generated US\$ 52.7 million between 2008 and 2011.⁶⁰

If all fiscal sources were simultaneously leveraged (they examine such things as re-prioritising HIV and health spending, alcohol taxes, health risk pooling, increased tax revenues, and efficiencies) over a five-year period, public HIV spending in 14 countries could increase from US\$3.04 to US\$10.84 billion per year.⁶¹

⁴ Bonds are units of debt that a government (or corporate entity) can sell to raise funds. It then promises to pay back the money at a particular point in the future.

⁵ Guarantees are essentially promises to cover another's debt if the principal debtor defaults on their debt (does not pay it back)

10. African governments

10.1. Economic strength and taxes

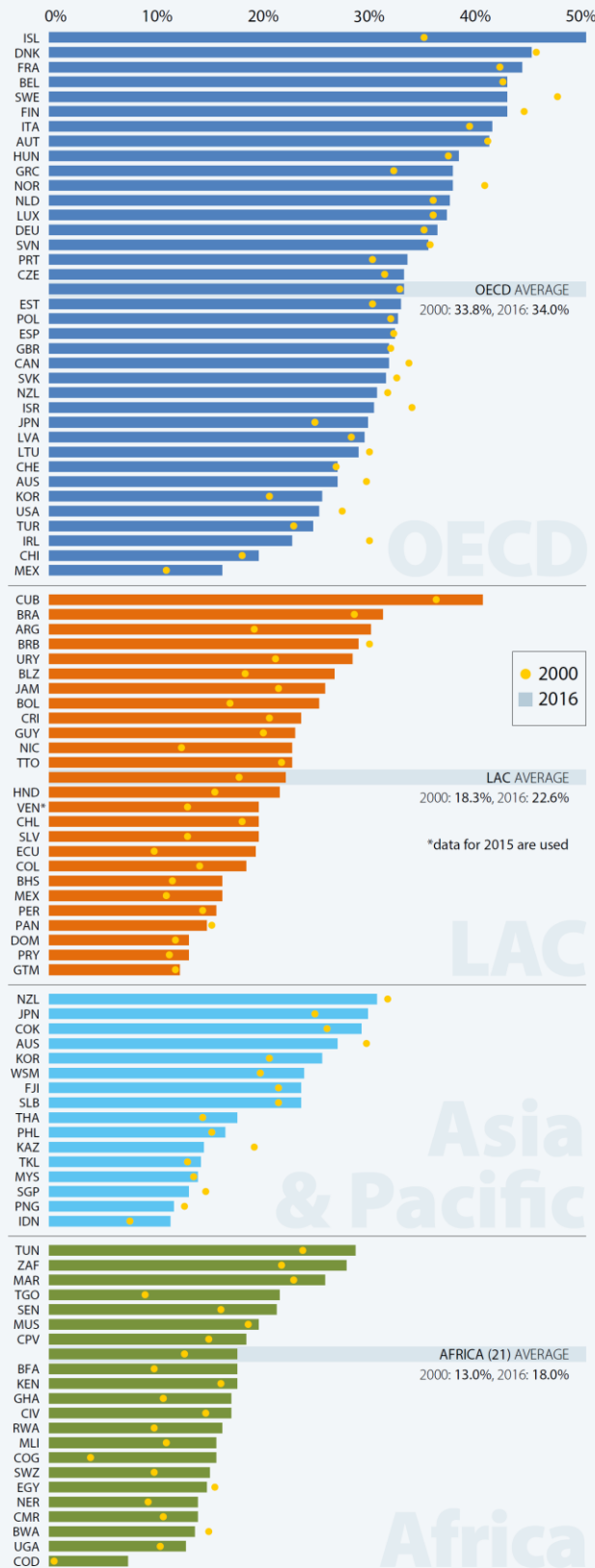
To begin our analysis on HIV financing in Africa we look into the economic strength of each of our 55 African countries as a starting point in understanding the ability of each economy to fund an HIV response. The GDP per capita is one way to measure the total output of a country, output which provides for its people's needs. We use the per capita data because it gives a more accurate picture of the demands on a country as well. Africa's countries vary considerably from Nigeria with a population of 200 million to our smallest country Seychelles with 97 000, making Nigeria two thousand time larger in population size than Seychelles. Thus, the GDP per capita provides an indicator of the standard of living we can expect in a country.

According to World Bank and IMF data not one African country is in the top 10 GDP per capita list⁶². However, 8 of the 10 lowest GDPs per capita are African countries.

1. Burundi – \$700
2. Central African Republic – \$700
3. Democratic Republic of the Congo – \$800
4. *Tokelau – \$1,000 (1993 estimate) (not African)*
5. Mozambique - \$1,200
6. Niger – \$1,200
7. Malawi – \$1,200
8. *Yemen – \$1,300 (not African)*
9. Liberia –\$1,400
10. South Sudan – \$1,50063

Real annual GDP growth is a useful indicator to determine whether our countries are improving or declining. Global GDP is usually around 3% (fluctuating from 4.3% in 2010 to 2.5% in 2016). South Sudan, Ghana, Rwanda, Cote d'Ivoire and Ethiopia all perform excellently with figures above 7%. Economies that stabilise (new leadership, end of conflict, end of pandemics usually see excellent growth relative to the very low baseline they experienced prior. It is important to watch countries over a few years to know whether this growth is sustainable. It is significant that countries such as Zimbabwe, Sudan, Equatorial Guinea, and eSwatini/Swaziland are experiencing a decline in growth, and the HIV financing for these countries should be understood in this context.

Tax-to-GDP ratios in 2000 and 2016



Source: The Global Revenue Statistics Database, OECD, 2018.

As always it is useful to understand how Africa performs on the global stage and so we analyse the tax collection as a percentage of GDP figures collected by the OECD. Africa's average is 18%, almost half of the 34% we see in the OECD countries. Tax is an established way of increasing revenue. Although critics might imagine that increasing taxes in poor African nations might adversely affect the poor, the reality is quite the opposite. At the recent African Leaders Summit in Addis, experts estimated that simply by improving tax collection at current rates and improving the efficiency of the tax collection agencies themselves most African countries could improve their tax as % of GDP by 4%.

In the next scorecard, we analyse World Bank data on a country by country basis. It is important to remember that globally effective, efficient and fair taxation is an excellent indication of a country's willingness and ability to source funds to provide services (HIV, health and beyond) to all people in the country. On the African continent, our poorest performer is Nigeria at 1.5% and our best is Lesotho at 48.6%

	Country	GDP per capita (Constant Local Currency (LCU)) 2018	Tax revenue as % of GDP 2018	Real GDP growth -Annual % change 2018 - 2019
1	Algeria	\$146,612	37.20%	2.3%
2	Angola	\$50,399	12.50%	0.4%
3	Benin	\$403,216	15.40%	6.5%
4	Botswana	\$42,816	25.80%	3.9%
5	Burkina Faso	\$265,792	15.50%	6%
6	Burundi	\$156,403	12.20%	0.4%
7	Cabo Verde	\$296,504	18.40%	5%
8	Cameroon	\$643,722	NO DATA	4.3%
9	Central African Republic	\$161,144	9.20%	5.0%
10	Chad	\$339,144	NO DATA	4.5%
11	Comoros	\$478,012	NO DATA	2.8%
12	Congo	\$144,187	9.40%	5.4%
13	Cote d'Ivoire	\$795,433	14.00%	7.5%
14	Democratic Republic of Congo	\$305,170	8.80%	4.3%
15	Djibouti	\$351,713	NO DATA	6.7%
16	Egypt	\$37,129	12.50%	5.5%
17	Equatorial Guinea	\$4,300,364	12.80%	-4%
18	Eritrea	NO DATA	NO DATA	3.8%
19	Ethiopia	\$16,792	9.20%	7.7%
20	Gabon	\$2,619,789	NO DATA	3.1%
21	Gambia	\$25,302	15.10%	5.4%
22	Ghana	\$5,192	13.70%	8.8%
23	Guinea	\$5,401,747	NO DATA	5.9%
24	Guinea-Bissau	\$267,373	NO DATA	5%
25	Kenya	\$93,297	16.30%	5.8%
26	Lesotho	\$11,518	48.60%	3.9%
27	Liberia	\$298	20.30%	0.4%
28	Libya	\$4,793	NO DATA	4.3%
29	Madagascar	\$29,745	9.90%	5.2%
30	Malawi	\$77,765	15.50%	4%
31	Mali	\$271,146	15.40%	5%
32	Mauritania	\$21,095	NO DATA	6.4%
33	Mauritius	\$283,181	18.10%	3.9%
34	Morocco	\$26,734	23.30%	3.2%
35	Mozambique	\$17,010	23.10%	4%
36	Namibia	\$44,463	33.20%	1.4%
37	Niger	\$161,609	NO DATA	6.5%
38	Nigeria	\$360,161	1.50%	2.1%
39	Rwanda	\$590,882	14.90%	7.8%
40	Sahrawi Republic (Western Sahara)	NO DATA	NO DATA	NO DATA
41	São Tomé and Príncipe	\$19,835	14.60%	4.0%
42	Senegal	\$797,433	20.50%	6.9%
43	Seychelles	\$94,208	31.60%	3.4%
44	Sierra Leone	\$1,271,289	8.60%	5.4%
45	Somalia	NO DATA	NO DATA	3.5%
46	South Africa	\$54,418	27.30%	1.2%
47	South Sudan	NO DATA	NO DATA	8.8%
48	Sudan	\$777	NO DATA	-2.3%
49	Swaziland (eSwatini)	\$37,173	28.60%	-0.4%
50	Tanzania	\$2,071,991	11.90%	4%
51	Togo	\$291,490	21.90%	5%
52	Tunisia	\$6,301	21.10%	2.7%
53	Uganda	\$1,439,828	13.50%	6.3%
54	Zambia	\$8,022	16.10%	3.1%
55	Zimbabwe	\$1,411	21.40%	-5.2%

Title: Economic strength of all African countries. Sources: Column 1: The World Bank: <https://www.worldbank.org/>; Column 2: AUC Scorecard

10.2. Private Corruption and Loss of African funds to illicit financial outflows

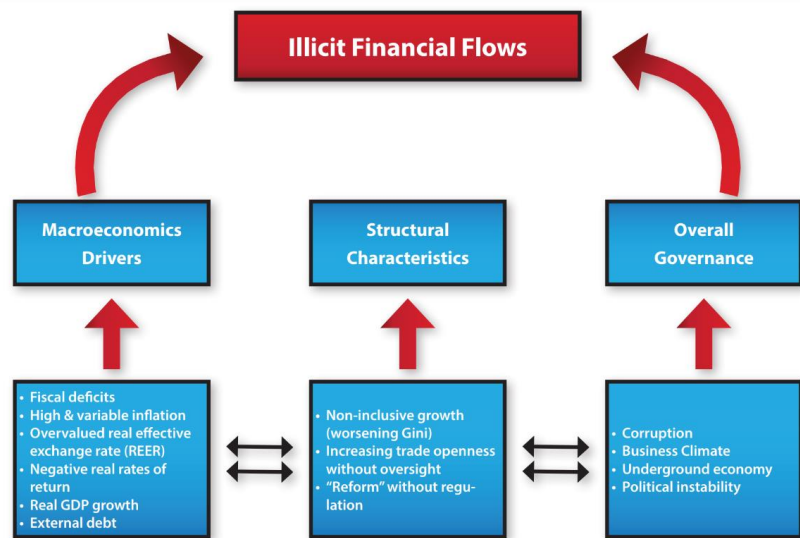
Illicit outflows from African countries to foreign countries is hugely problematic as a source of lost revenue for African nations, revenue which could be spent on financing the HIV response.

The analysis done by colleagues at Global Financial Integrity demonstrates that Africa is not just a recipient of financial aid, but actually is losing massive amounts of funds largely through illicit trade mis-invoicing, amounting to 1 trillion

USD per annum.⁶⁴ Not only could the true revenue be allocated to HIV and related health issues, but the taxes levied on such amounts would also allow for African nations to better respond to their people's health and HIV needs. The researchers at Global Financial Integrity recommend that governments require individuals and companies to be more transparent and provide public reports on losses, profits, staff, taxes paid and various other details as a means to create a globally transparent taxing system, and one which also can track illicit flows.⁶⁵ This requires governments to track, control and prosecute where necessary financial fraud. Ethiopia and Tanzania are signees of the Addis Tax Initiative which would allow governments better control over illicit flows, and the ability to create more fiscal space, which could be channeled to HIV in turn.^{66, 67}

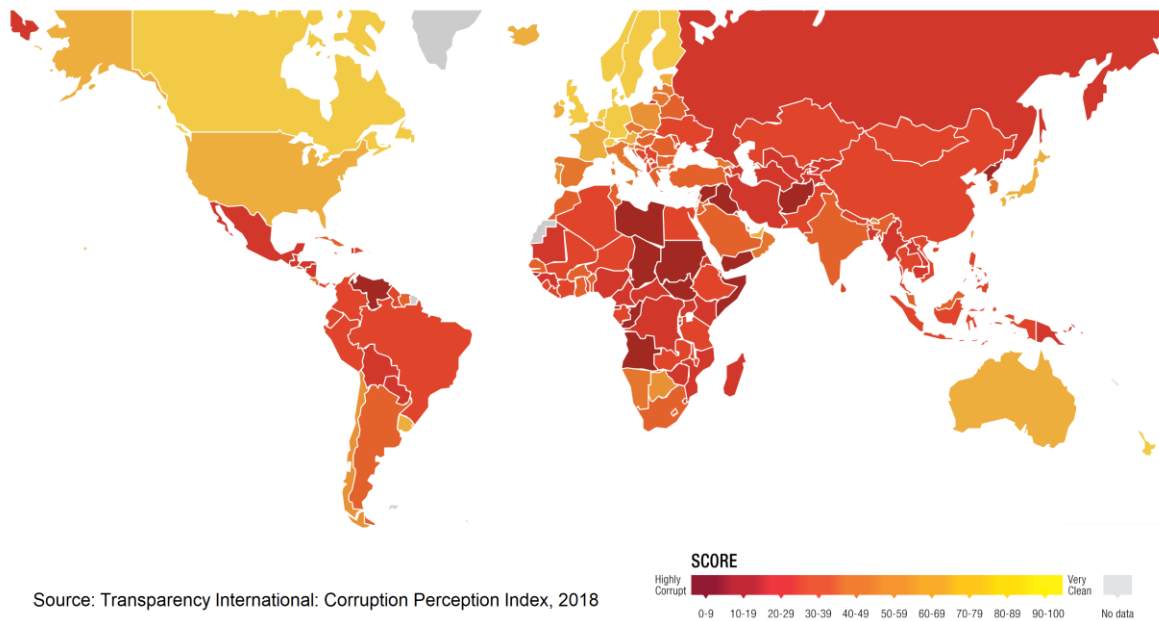
“A multinational [company] will make a profit of \$10 million and then they will bring in a consultancy for 12 million and declare a loss. The result is that they have made a loss instead of profit, so this money goes to the tax haven where they have another organization which provided the consultancy, so no tax gets paid on the income that was made,” explained Daniel Yaw Domelevo, the auditor general of Ghana, who attended the IACC. “That is the major cause of illicit financial flows in Africa.”⁶⁸

The creation of a Global Tax Authority has also been touted as a means to monitor incomes and tax payments by individuals and companies around the globe, preventing what is called cross-border tax fraud, evasion and avoidance. This would allow authorities in all countries to see financial and tax transactions and thereby avoid the myriad of bilateral agreements and data sharing systems that exist. Extended and automatic data sharing systems on taxes that would be managed by a central authority would be an excellent way to ensure fair taxes are paid by those who are due to pay them, and that they



Source: Kar, D. (2011). Illicit Financial Flows from the Least Developed Countries: 1990–2008. New York: United Nations Development Programme cited in Track it! Stop it! Get it! UNECA High Level Panel on Illicit financial flows, 2014.

would be paid to the correct geographic authorities (so that gains made in Mozambique are paid in Mozambique and not in the Cayman Islands (a tax haven with low and zero taxation rates) for example).



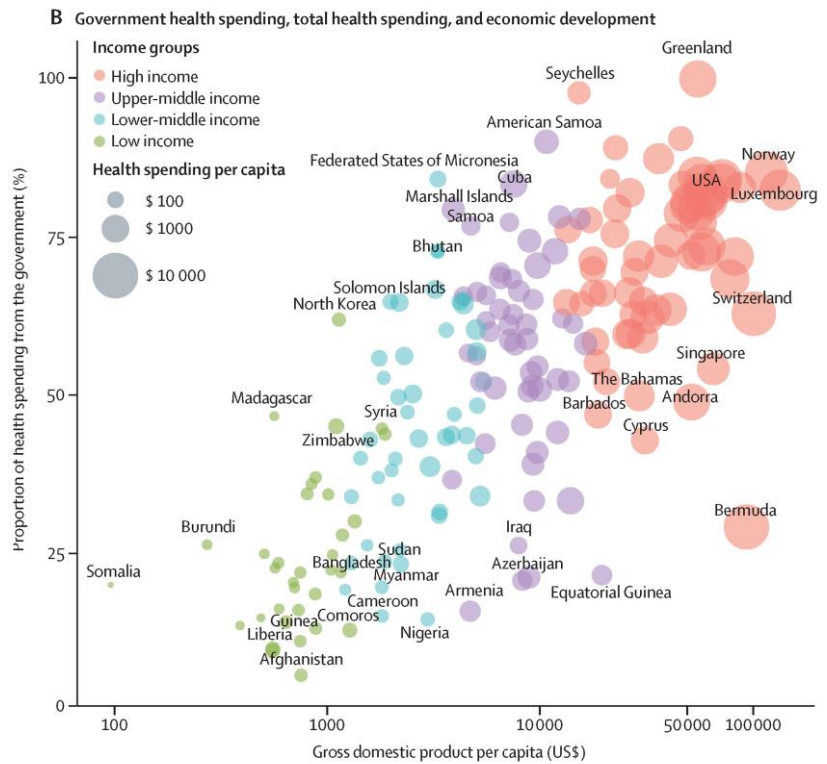
Corruption is increasingly being monitored and more so by European authorities than even African ones. A good example, in October 2019 is that of Swiss energy company Gunvor that has been fined 95.1 million USD by Swiss authorities for corruption in Ivory Coast and the Congo. The fine amount is estimated as equal to the total profit that the company made in those countries during the time that the corruption was taking place. Although the CEO was aware of the corruption, it is the official who made the bribes who has been given an 18 month prison sentence⁶⁹.

“Over the last 50 years, Africa is estimated to have lost in excess of \$1 trillion in illicit financial flows (IFFs) (Kar and Cartwright-Smith 2010; Kar and Leblanc 2013). This sum is roughly equivalent to all of the official development assistance received by Africa during the same timeframe.² Currently, Africa is estimated to be losing more than \$50 billion annually in IFFs. But these estimates may well fall short of reality because accurate data do not exist for all African countries, and these estimates often exclude some forms of IFFs that by nature are secret and cannot be properly estimated, such as proceeds of bribery and trafficking of drugs, people and firearms. The amount lost annually by Africa through IFFs is therefore likely to exceed \$50 billion by a significant amount.”⁷⁰

10.3. Government spending on Health and HIV

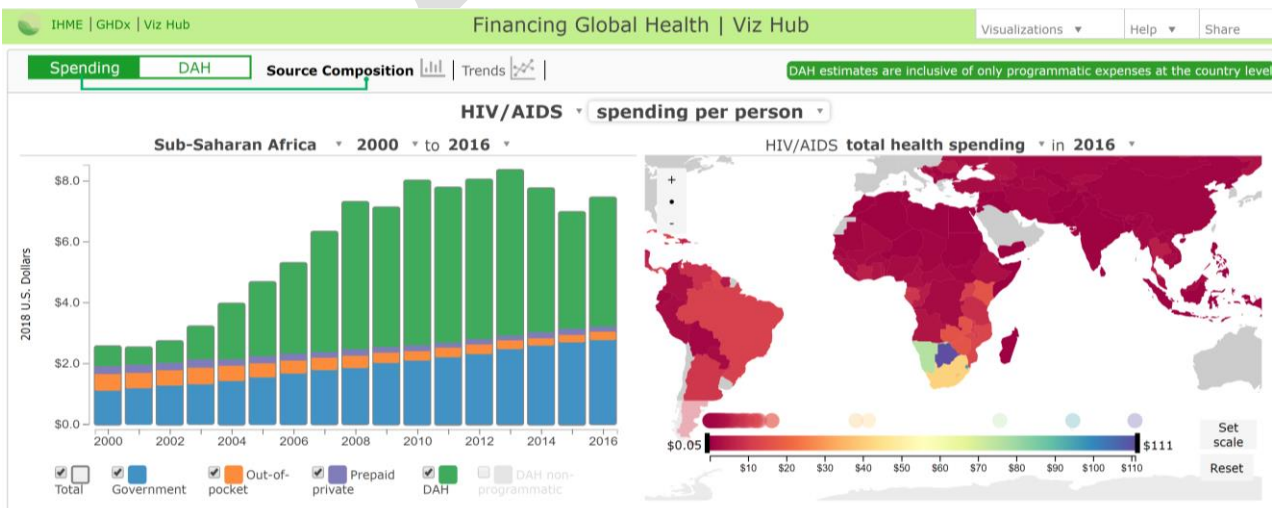
As we examine financing for HIV it is worthwhile to set the scene by positioning African countries both within a global context and within the broader health investment frame.

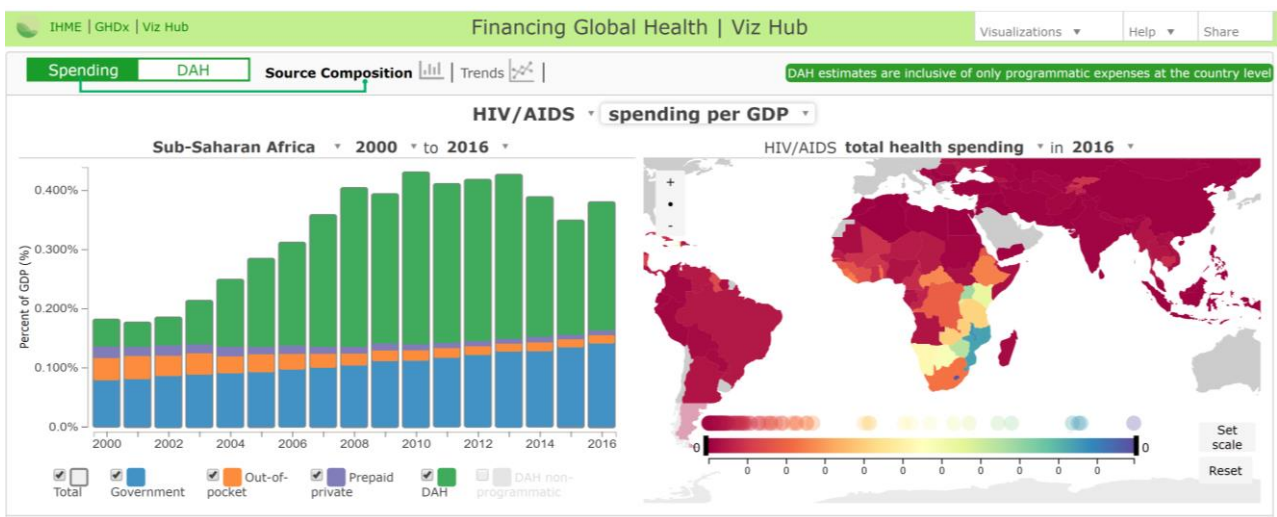
This image from Chang et al, positions African countries according to their income status (the various colours), their gross domestic product per person (capita), and the proportion of health spending by governments only on health. We cannot view all the countries, but it gives an indication of some African countries. What we do however see is that there is an expected higher expenditure on health as countries have a higher GDP. We also see (from the size of the circles) the real health spending per capita and how this dramatically increases from 100 USD to 10000 USD across the group.



Source: Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. Chang et al. The Lancet, Volume 393, Issue 10187, 1–7 June 2019. Pages 2233–2250. [https://doi.org/10.1016/S0140-6736\(19\)30841-4](https://doi.org/10.1016/S0140-6736(19)30841-4)

Obviously in the analysis of HIV financing it is also vital to examine how much countries are currently spending on HIV. The tables in this section provide various perspectives. The data examines the spending per person as well as the spending per GDP, and then finally (in the two-page table) looks at reported spending by countries. It is important to note that reported higher spending per person does not necessarily equate to better health and HIV services, many a monitoring person has arrived to visit a new hospital only to find an empty plot of land! However, when analysed in conjunction with the other data it is a useful indication.





When analysing the more detailed countries programming expenditure (see two-page table) it allows us to analyse where exactly the funding is reportedly being spent. The administration and management lines constitute 5% of all funds, unless of course we remove the South African treatment costs (1 002 372 831 USD) which then makes all admin across the entire continent 10% of all finances. As a group then not problematic, but there are countries where local watchdogs should be digging deeper to discover why their country data reflects very large percentages for admin. The Mali reports that 60% of its budget is spent on admin, along with Central African Republic (49%), Burundi and Senegal (38%), Ghana (35%). There may be country context reasons for this, but local activists and duty-bearers should be in the know and able to account for these anomalies.

What we can also note is that there is greater investment in programmes for youth and women and very little investment in key populations, human rights and critical enabling environments. Examining only countries that submit complete datasets (only 18 of the 55 African member states (representing 33%)) we see that Cote d'Ivoire invests more finances into a critical enabling environment than any other country (997 109 USD; 8%), but Senegal invests the largest percentage (14.2% ; 272 007 USD). Mozambique (8.26%; 702 311 USD), Ghana (7.91%; 523 141 USD) and Malawi (3.8%; 214 439 USD) also perform well on this indicator.

Of those countries that do submit a full dataset not a single country reports spending 1% or more on key populations and human rights programmes, which can either indicate that reporting is inaccurate, that KP programmes are reported elsewhere or that we have not even begun to address the needs of the most affected. Community mobilisation also is very low across the continent. There is a significant need to both improve reporting and to advocate for more long-term solutions which is where the community, KP and human rights programmes will have impact.

Title: Where governments report spending money on HIV. Sources: UNAIDS GAPR, GAM Reports/ UNAIDS NASA Reports

	Sources: UNAIDS GAPR, GAM Reports/ UNAIDS NASA Reports	Governance & sustainability/ HIV/AIDS research	Of which Admin (part of governance & sustainability, Strategic info (8.1) & Planning & coordination (8.2) /Programme mgmt. & admin	Treatment, care & support (1)/ Treatment	All prevention including Prevention of vertical transmission of HIV (2 and 3)/ Prevention	Programmes for children, adolescents, on gender & on social protection (4, 5, 6)/OVC	TB / HIV co-infection, diagnosis & treatment (sub-total) (10)	Community mobilisation (7)	Critical enablers	Of which Key Human Rights Programmes/HR and Legal Rights	Other essential programs for selected year	TOTAL	Year of Expenditure Data
28	Libya	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
29	Madagascar	\$101,339	\$101,339	\$178,861	\$9,375	\$0	\$0	\$297	\$0	\$0	\$0	\$391,211	2017
30	Malawi	\$2,624,582	\$229,195	\$141,732	\$2,574,227	\$39,193	\$0	\$0	\$214,439	\$0	\$0	\$5,823,368	2017
31	Mali	\$48,807	\$1,704,300	\$341,226	\$732,216	\$20,711	ND	ND	ND	ND	ND	\$2,847,260	2008
32	Mauritania	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
33	Mauritius	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
34	Morocco	\$3,359,186	\$0	\$13,321,222	\$1,563,958	\$0	\$0	\$0	\$0	\$0	\$0	\$18,244,377	2017
35	Mozambique	\$5,064,682	\$1,315,772	\$1,736,108	\$701,689	\$122,776	\$139,699	\$34,547	\$702,311	\$18,149	\$0	\$9,835,733	2016
36	Namibia	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
37	Niger	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	2017
38	Nigeria	\$15,843,117	\$9,476,065	\$62,302,674	\$74,410,821	\$0	\$0	\$0	\$0	\$0	\$0	\$162,032,677	2016
39	Rwanda	\$19,731,819	\$891,520	\$0	\$145,676	\$0	\$0	\$0	\$0	\$0	\$0	\$20,769,015	2015
40	Sahrawi Republic	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
41	São Tomé & Príncipe	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
42	Senegal	\$1,322,403	\$1,162,941	\$0	\$40,476	\$0	\$0	\$0	\$272,007	\$0	\$286,078	\$3,083,905	2015
43	Seychelles	\$227,250	\$93,778	\$799,748	\$740,451	\$8,108,802	\$37,426	\$11,759	\$9,823	\$4,689	\$0	\$10,033,725	2016
44	Sierra Leone	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
45	Somalia	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
46	South Africa	\$62,760,148	\$51,900,764	\$1,002,372,821	\$107,721,266	\$108,893,564	\$189,787,033	\$346,733	\$0	\$0	\$73,945,146	\$1,597,727,486	2017
47	South Sudan	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
48	Sudan	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
49	Swaziland (eSwatini)	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
50	Tanzania	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
51	Togo	\$712,217	\$696,191	\$0	\$1,214,549	\$39,699	\$26,391	\$20,783	\$1,214	\$1,214	\$0	\$2,712,259	2016
52	Tunisia	\$0	\$0	\$1,574,995	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,574,995	2016
53	Uganda	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
54	Zambia	\$0	ND	\$4,931,590	\$1,375,950	\$7,445	ND	ND	ND	ND	ND	\$6,314,985	2010-2012

55	Zimbabwe	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	\$0	ND
Title: Where governments report spending money on HIV. Sources: UNAIDS GAPR, GAM Reports/ UNAIDS NASA Reports													

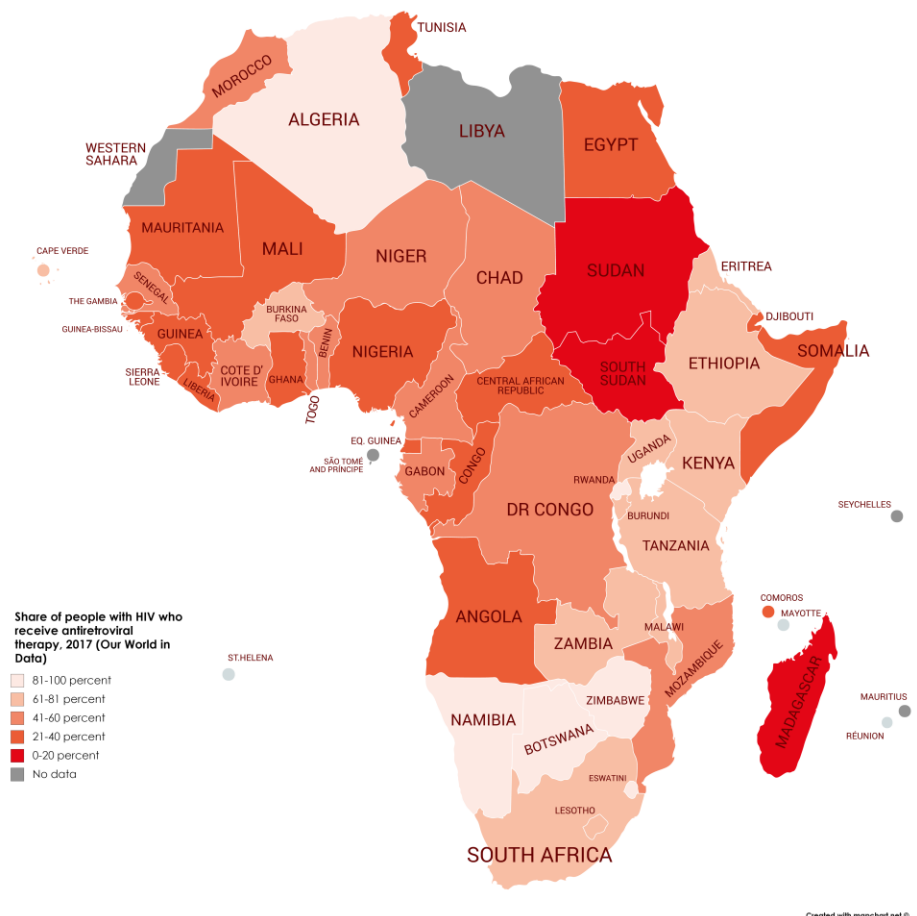
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10.4. Share of PLHIV Receiving ART

Given that Africa has had and continues to have the highest number of HIV infections of all the regions on the globe, and that being on anti-retroviral therapy is not only a form of treatment in 2019 but a significant part of the prevention of the transmission of HIV, the share of people on ART is a vital indicator to measure a country's commitment to HIV and AIDS.

Most countries are offering ART but the share of people who are accessing remains low across the continent. Only Algeria, Botswana, Eswatini /Swaziland, Namibia, Rwanda and Zimbabwe report providing ART to more than 80 per cent of the people who need it. In 2019 we should not be celebrating 80% but rather be pushing for the 90% commitment and even further so that every person who needs has access and is retained on their medications. Even though Zimbabwe has reported more than 80 per cent coverage, as this report goes public, we are witnessing massive stockouts in Zimbabwe and massive social and civil society action to galvanise political will to avoid further stock outs of drugs going forward.

Using the mapping we can also note that there is better performance in Southern Africa than any other region, followed by East Africa and then West, Central and North Africa performing the worst. There is a pocket of hope in West Africa as Burkina Faso and Algeria in North Africa stand out as best performers in their region.



10.5. 90-90-90

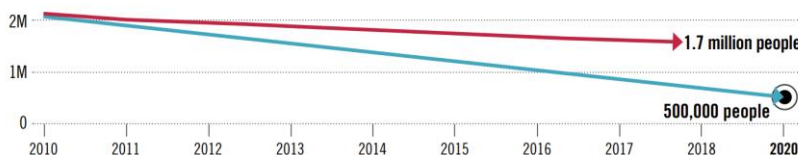
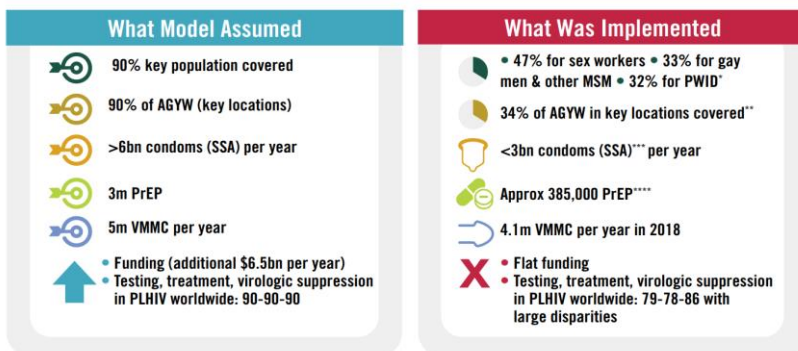
Data of the progress made on 90-90-90 in Africa differs across the continent and are available in the table.

- For 2015, Percent of people who know their status who are on ART: the following countries had >95%: Botswana, Zambia and Zimbabwe.⁶
- For 2016, Percent of people who know their status who are on ART: the following countries had >95%: Botswana, Malawi, Zambia⁷.
- For 2016, Percent of people on ART who achieve viral suppression: Eswatini had >95%.⁸
- For 2017, Percent of people who know their status who are on ART: the following countries had >95%: Algeria, Botswana, Burundi, Comoros, Ethiopia, Mauritania, and Zimbabwe⁹.
- For 2017, Percent of people on ART who achieve viral suppression: Botswana had >95%¹⁰.

It is very easy to imagine that the 90-90-90 Fast-track targets will allow the globe to get the HIV epidemic under control once and for all, however new data from UNAIDS and an just launched report from AVAC examines that if we do not actually implement the plans, with the correct communities that there is no way the goals will ever be achieved. The report speaks to the need for communities to be at the centre of the response, not a new call to action, but indeed one which has been repeated since the late 1980s. What

FIGURE 2 UNAIDS Fast-Track Targets: The plan and the progress

The most widely-known UNAIDS Fast-Track goals were the 90-90-90 targets focused on diagnosing people with HIV, linking them to ART and supporting them to achieve virologic suppression. But these were only part of what the UNAIDS modelers said was needed to reduce new HIV diagnoses to 500,000 per year; the model also included significant scaling up of primary prevention including the targets listed below. There are gaps across the board, which helps explain how the world fell short of the hoped-for reduction in new HIV diagnoses.



* Average coverage in Global Prevention Coalition (GPC) countries with available estimates: 47% for sex workers, 32% for men who have sex with men, 31% for people who inject drugs. Coverage in countries that are not reporting is likely lower. Quality of data varies greatly.

** Interim indicator until data on percent of young women at higher risk reached with effective prevention interventions can be measured.

*** Condom use with non-regular partners in 19 GPC countries in Africa was on average 62% for men and 47% for women against a 90% target.

**** The UNAIDS Fast-Track model called for three million individuals in specific countries. These figures reflect global PrEP coverage.

Source: Global HIV Prevention Working Group. Personal communication. 6 November 2019.

Source: Now What? AVAC Annual Report, 2019. https://www.avac.org/sites/default/files/resource-files/AVAC_Report2019.pdf

is also apparent is that criminalisation plays a key role in inhibiting the attainment of the 90-90-90 targets as some communities are hard to reach because of stigma, discrimination and fear.

What is also necessary is for countries in North Africa to step up their responses as new emerging epidemics begin there as a result of a non-response to date. These countries must begin to implement a human rights approach to the management of HIV as a public health issue.

⁶ Given that there was no other number it was marked as 95%.

⁷ Given that there was no other number it was marked as 95%.

⁸ Given that there was no other number it was marked as 95%.

⁹ Given that there was no other number it was marked as 95%.

¹⁰ Given that there was no other number it was marked as 95%.

	Country	Percent of people living with HIV who know their status 2017	Percent of people living with HIV who know their status – Change: 2016-2017	Percent of people who know their status who are on ART 2017	Percent of people who know their status who are on ART – Change: 2016-2017	Percent of people on ART who achieve viral suppression 2017	Percent of people on ART who achieve viral suppression – Change: 2016-2017
1	Algeria	84%	14%	95%	0%	73%	0%
2	Angola	ND	ND	ND	ND	ND	ND
3	Benin	ND	ND	ND	ND	76%	35%
4	Botswana	86%	3%	95%	0%	95%	1%
5	Burkina Faso	88%	ND	74%	ND	76%	ND
6	Burundi	80%	-1%	95%	12%	ND	ND
7	Cabo Verde	ND	ND	ND	ND	ND	ND
8	Cameroon	71%	7%	70%	7%	ND	ND
9	Central African Republic	53%	ND	61%	ND	ND	ND
10	Chad	ND	ND	ND	ND	ND	ND
11	Comoros	28%	2%	95%	3%	ND	ND
12	Congo	32%	5%	90%	11%	ND	ND
13	Côte d'Ivoire	54%	8%	84%	1%	77%	-1%
14	Democratic Republic of Congo	59%	16%	93%	2%	ND	ND
15	Djibouti	ND	ND	ND	ND	ND	ND
16	Egypt	51%	7%	47%	-2%	ND	ND
17	Equatorial Guinea	ND	ND	ND	ND	ND	ND
18	Eritrea	ND	ND	ND	ND	ND	ND
19	Ethiopia	73%	-4%	95%	7%	45%	-41%
20	Gabon	77%	7%	77%	-3%	ND	ND
21	Gambia	ND	ND	ND	ND	ND	ND
22	Ghana	ND	ND	ND	ND	ND	ND
23	Guinea	ND	ND	ND	ND	ND	ND
24	Guinea-Bissau	ND	ND	ND	ND	ND	ND
25	Kenya	ND	ND	ND	ND	84%	5%
26	Lesotho	80%	3%	92%	4%	92%	35%
27	Liberia	ND	ND	ND	ND	ND	ND

Title: 90-90-90 Targets (% and percentage change over past year) Source: UNAIDS

Country	Percent of people living with HIV who know their status 2017	Percent of people living with HIV who know their status – Change: 2016-2017	Percent of people who know their status who are on ART 2017	Percent of people who know their status who are on ART – Change: 2016-2017	Percent of people on ART who achieve viral suppression 2017	Percent of people on ART who achieve viral suppression – Change: 2016-2017
28	Libya	ND	ND	ND	ND	ND
29	Madagascar	8%	1%	81%	5%	ND
30	Malawi	90%	21%	79%	-16%	-2%
31	Mali	ND	ND	ND	ND	15%
32	Mauritania	33%	ND	95%	ND	-14%
33	Mauritius	ND	ND	ND	ND	ND
34	Morocco	69%	0%	83%	6%	ND
35	Mozambique	59%	5%	92%	4%	ND
36	Namibia	90%	-3%	94%	10%	ND
37	Niger	55%	8%	94%	4%	ND
38	Nigeria	ND	ND	ND	ND	ND
39	Rwanda	ND	ND	ND	ND	ND
40	Sahrawi Republic	ND	ND	ND	ND	ND
41	São Tomé and Príncipe	ND	ND	ND	ND	ND
42	Senegal	71%	ND	76%	ND	-2%
43	Seychelles	ND	ND	ND	ND	ND
44	Sierra Leone	47%	8%	84%	8%	ND
45	Somalia	ND	ND	ND	ND	ND
46	South Africa	90%	2%	68%	5%	0%
47	South Sudan	ND	ND	ND	ND	ND
48	Sudan	ND	ND	ND	ND	ND
49	Swaziland (eSwatini)	90%	ND	94%	ND	-8%
50	Tanzania	ND	ND	ND	ND	ND
51	Togo	66%	6%	86%	5%	ND
52	Tunisia	ND	ND	ND	ND	ND
53	Uganda	81%	3%	89%	9%	ND
54	Zambia	ND	ND	ND	ND	ND
55	Zimbabwe	85%	15%	95%	0%	ND

Title: 90-90-90 Targets (% and percentage change over past year) Source: UNAIDS

10.6. HIV Outcome and Epidemic Transition Data

In an effort to understand the needs for HIV financing it is vital to see what outcomes and impacts are currently being realised in countries. Not only those that are being realised and the progress they are having, but even whether countries are tracking the outcomes is valuable in understanding the larger context. This context is vital if we are to determine an adequate and viable response to HIV financing. There is no purpose in developing a response to increase HIV financing in a country if we can at the research stage identify that there is already an existing lack of political will to track the epidemic and respond to it until now.

It is a well acknowledged fact that working with key populations and addressing the needs of these individuals is a vital starting point in the HIV response. As outlined in the introduction, key populations suffer far greater rates of infection, have less access to testing, treatment, care and support, and also have multiple layers of socio-economic barriers to accessing their health rights.

Avert reports that despite between 40% and 50% of all new infections occurring in key populations, only 2% of all HIV funds are spent on KP.⁷¹ The data also shows that only 9% of all prevention resources are targeted towards KP programmes⁷², a massive shortfall and obvious human rights injustice given the new infection figures. This points to a key challenge in identifying funding gaps, that if the most affected are not included in the response, that the challenges we face on HIV, TB and malaria will never be addressed, no matter the amount of financing. It also makes the case for impact investing even more obvious.

The data presented here makes it very apparent that in Africa we do not “know our KP epidemic, know our KP response”. Leaders need to demonstrate the same leadership they showed at the 2016 Catalytic Framework and make the political decision to collect more data to inform the KP response. Infection rates amongst KPs are higher than in the general population, but more than that, refusal to test, treat, care for and support these individuals signifies a human rights issue. By first creating a legal environment that does not criminalise key population groups or their behavior, governments can be seen to be forward thinking leaders on the continent and globally.

The most neglected group of all is people who pass through prisons and places of detention. The reality is that almost all people who enter prisons and other places of detention, whether youth detention or adult, will be released back into their communities. Usually within a few months, or at least 3 years. Thus, bad health outcomes for prisons lead to bad health outcomes for the broader community and society in general. Because so many prisons are overcrowded in Africa, and provide little or no sanitation, bad nutrition and little to no healthcare, the impact is felt not just by those imprisoned but by their families and communities as well. A 2014 report by SAFAIDS and Accountability International found that “In each of the six countries examined, the basic necessities are lacking for prisoners, either permanently or intermittently. This lack creates not only an unhealthy living environment but is a direct abuse of the prisoners’ human rights.”⁷³ The countries were Lesotho, Malawi, South Africa, Swaziland, Zambia and Zimbabwe.

All countries should be collecting data on “Percentage of avoidance of health care because of stigma and discrimination” for six groups: Sex workers, men who have sex with men, people who use drugs, transgender people, people living with HIV and prisoners. However, across a total of 55 countries, with six data points each which gives a total of 330 possible data points, the entire continent has collected only fourteen!

In Algeria, data is collected for sex workers and MSM only. Cameroon only collects for MSM; Cote d’Ivoire collects for sex workers, MSM and PLHIV. Guinea collects data for sex workers; Lesotho collects only for sex workers and PLHIV. Morocco collects only for MSM, People who use drugs and PLHIV. Uganda for People who inject drugs only and Zimbabwe for sex workers only. These sixteen data points out of a possible 330 is a frightening indication of a lack of political will to address stigma and discrimination for KPs in their countries. ⁷⁴

Outcomes for the general population can be measured using various different indicators, but here we have used four as a starting point for discussion and to provide a snapshot of the country situation. These indicators have been chosen because they affect different groups (all adults, men, women and youth) thereby giving us an indicator across groups. If, for example, we used only outcome indicators that related to women or youths we may unintentionally be reflecting policy and interest in a particular group and not across all groups.

An analysis of outcome data provides an opportunity to examine the response to HIV prior to the higher-level impact data. The two data sets are strongly related, and the output data can demonstrate the causal origin of the impact data. Historically what has been called impact data is increasingly is becoming known as epidemic transition data. This is because in October 2017, UNAIDS hosted a meeting to discuss how stakeholders can measure progress in reducing HIV as a public health threat. The HIV epidemic transition metrics are a result of those discussions. ⁷⁵

There are six HIV epidemic transition metrics:

An absolute rate of HIV incidence	The number of new HIV infections per 1,000 uninfected population
An absolute rate of AIDS-related deaths	The number of AIDS-related deaths per 1,000 uninfected population
A percentage reduction in new HIV infections	Monitors the reduction (or growth) in new infections as compared to data from 2010
A percentage reduction in AIDS-related deaths	Monitors the reduction (or growth) in AIDS-related deaths as compared to data from 2010
An incidence: prevalence ratio (IPR)	Ratio of new HIV infections over PLHIV, when held below a certain threshold it indicates that the epidemic in that country will eventually end.
An incidence: mortality ratio (IMR)	Ratio of new HIV infections over all-cause mortality among PLHIV, high incidence and high mortality rates indicate a non-response, so the indicator need to be read in conjunction with others.

	Country	Condom use at last high-risk sex	Prevalence of male circumcision	Coverage of pregnant women who receive ART for PMTCT	Knowledge about hiv prevention among young people (15-24)
1	Algeria	46%	ND	74%	ND
2	Angola	44%	96%	38%	32%
3	Benin	40%	93%	>95%	24%
4	Botswana	ND	ND	>95%	47%
5	Burkina Faso	68%	100%	>95%	32%
6	Burundi	32%	33%	80%	45%
7	Cabo Verde	ND	ND	ND	ND
8	Cameroon	64%	94%	80%	35%
9	Central African Republic	ND	ND	71%	19%
10	Chad	36%	97%	56%	13%
11	Comoros	48%	99%	ND	20%
12	Congo	48%	99%	25%	33%
13	Côte d'Ivoire	50%	97%	90%	27%
14	Democratic Republic of Congo	27%	97%	44%	20%
15	Djibouti	ND	ND	30%	11%
16	Egypt	ND	ND	16%	5%
17	Equatorial Guinea	ND	ND	50%	18%
18	Eritrea	ND	ND	48%	28%
19	Ethiopia	44%	91%	92%	31%
20	Gabon	64%	99%	72%	32%
21	Gambia	57%	ND	68%	28%
22	Ghana	26%	96%	79%	22%
23	Guinea	44%	99%	65%	20%
24	Guinea-Bissau	ND	ND	48%	22%
25	Kenya	44%	93%	91%	60%
26	Lesotho	76%	72%	77%	36%
27	Liberia	29%	99%	93%	34%
28	Libya	ND	ND	63%	ND
29	Madagascar	9%	95%	25%	24%
30	Malawi	62%	28%	>95%	42%
31	Mali	30%	98%	24%	23%
32	Mauritania	ND	ND	38%	58%
33	Mauritius	ND	ND	>95%	32%
34	Morocco	ND	ND	61%	ND
35	Mozambique	37%	47%	>95%	31%
36	Namibia	70%	26%	>95%	58%
37	Niger	54%	99%	58%	22%
38	Nigeria	49%	99%	44%	29%
39	Rwanda	55%	30%	>95%	65%
40	Sahrawi Republic (Western Sahara)	ND	ND	ND	ND
41	São Tomé and Príncipe	57%	ND	ND	43%
42	Senegal	69%	98%	65%	28%
43	Seychelles	ND	ND	ND	ND
44	Sierra Leone	12%	99%	ND	29%
45	Somalia	ND	ND	19%	ND
46	South Africa	ND	ND	87%	46%
47	South Sudan	ND	ND	56%	ND
48	Sudan	ND	ND	5%	ND
49	Swaziland (eSwatini)	60%	8%	79%	50%
50	Tanzania	37%	80%	93%	43%
51	Togo	ND	98%	80%	26%
52	Tunisia	ND	ND	ND	ND
53	Uganda	ND	27%	93%	46%
54	Zambia	50%	22%	>95%	44%
55	Zimbabwe	79%	14%	94%	46%

Title: HIV Outcome data. Source: UNAIDS

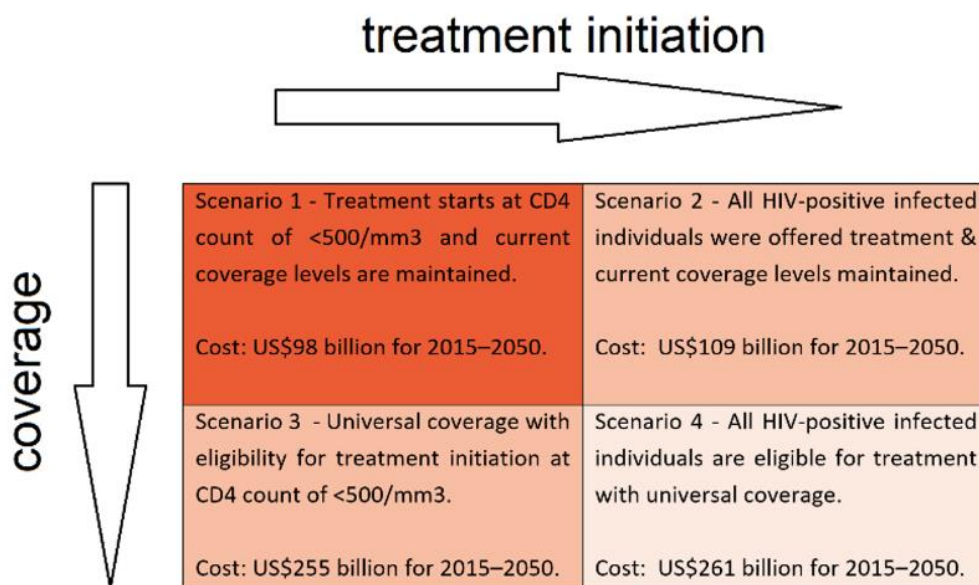
	Country	Incidence: mortality ratio 2018	Incidence: prevalence ratio 2018	AIDS-Related Deaths 2018	Percent Change In AIDS-Related Deaths Since 2010 (2018)	New HIV Infections (2018)	Percent Change in New HIV Infections Since 2010 (2018)
1	Algeria	7.46	8.06	<200	11%	1300	29%
2	Angola	1.71	8.45	14000	33%	28000	6%
3	Benin	1.39	5.16	2200	8%	3800	-15%
4	Botswana	1.24	2.31	4800	-33%	8500	-36%
5	Burkina Faso	0.59	2.47	3300	-32%	2400	-49%
6	Burundi	0.63	2.03	1900	-64%	1700	-55%
7	Cabo Verde	2.22	4.19	<100	-38%	<200	-18%
8	Cameroon	1.04	4.37	18000	-19%	23000	-34%
9	Central African	0.9	4.98	4800	-38%	5500	-40%
10	Chad	1.51	5.43	3100	-12%	6500	-11%
11	Comoros	ND	ND	<100	ND	<100	-67%
12	Congo	1.17	5.95	4000	ND	5300	-9%
13	Côte d'Ivoire	0.79	3.67	16000	-34%	17000	-33%
14	DR Congo	1.1	4.13	13000	-60%	19000	-39%
15	Djibouti	1.12	6.13	<500	-34%	<1000	24%
16	Egypt	7.57	16.44	<500	107%	3600	196%
17	Equatorial Guinea	2.21	8.2	1800	31%	5100	30%
18	Eritrea	0.96	3.2	<500	-21%	<1000	-29%
19	Ethiopia	1.48	3.28	11000	-45%	23000	-23%
20	Gabon	1.34	3.76	1200	-28%	2000	-31%
21	Gambia	1.86	8.48	<1000	2%	2200	20%
22	Ghana	1.22	5.95	14000	-14%	20000	-8%
23	Guinea	1.28	5.5	4300	4%	6600	-19%
24	Guinea-Bissau	1.25	5.88	1800	-6%	2600	-24%
25	Kenya	1.26	2.94	25000	-55%	46000	-30%
26	Lesotho	1.29	3.87	6100	-16%	13000	-34%
27	Liberia	0.91	4.73	1800	-34%	1900	-31%
28	Libya	2.6	4.92	<200	57%	<500	-43%
29	Madagascar	3.36	15.56	1700	22%	6100	193%
30	Malawi	2.04	3.65	13000	-55%	38000	-30%
31	Maldives	ND	ND	ND	ND	ND	ND
32	Mali	1.85	9.34	6500	24%	14000	51%
33	Mauritania	0.47	2.32	<500	-25%	<200	-47%
34	Mauritius	1.34	7.23	<1000	25%	<1000	-7%
35	Morocco	2.44	4.27	<500	-40%	<1000	-25%
36	Mozambique	2.05	6.64	54000	-16%	150000	-7%
37	Namibia	1.51	3.05	2700	-22%	6100	-38%
38	Niger	1.11	4.69	1200	-26%	1700	11%
39	Nigeria	1.73	6.57	53000	-26%	130000	5%
40	Rwanda	0.86	1.59	2900	-50%	3600	-61%
41	Sao Tome & Principe	0.7	1.48	<100	ND	<100	ND
42	Senegal	0.86	3.08	1300	-4%	1300	-39%
43	Sierra Leone	1.44	5.89	2100	-27%	4100	-22%
44	Somalia	0.48	3.61	<1000	-49%	<500	-40%
45	South Africa	1.88	3.08	71000	-50%	240000	-40%
46	South Sudan	1.71	9.93	9900	ND	19000	35%
47	Sudan	1.61	8.79	2900	52%	5200	-2%
48	Swaziland	2.03	3.78	2400	-35%	7800	-31%
49	Togo	1.09	4.61	3800	-34%	5000	-31%
50	Tunisia	3.26	9.06	<100	306%	<500	22%
51	Uganda	1.56	3.82	23000	-58%	53000	-43%
52	Tanzania	2.13	4.64	24000	-49%	72000	-13%
53	Zambia	1.94	3.89	17000	-37%	48000	-13%
54	Zimbabwe	1.34	2.93	22000	-60%	38000	-38%
	Global average	1.71	4.6		-33%		-16%

Title: HIV Epidemic transition data. Source: UNAIDS

10.7. Cost to End Epidemic

There are various different models that exist for calculating the funds required to end AIDS. Some do not include TB and Malaria, others do. Some look only at achieving the 90-90-90 targets. We examine a few in an attempt to get a detailed and varied perspective.

In January 2019, The Global Fund for the Elimination of HIV, TB and Malaria presented its replenishment case in India. The Global Fund announced that it had a target for fundraising of US\$14 billion for the next 3-year funding cycle.⁷⁶ UNAIDS has calculated that 26,2 billion USD is required to reach the 2020 targets (90-90-90) which were adopted during the 2016 Political Declaration by UN member states⁷⁷.



Source info: Atun R, Chang AY, Ogbuaji O, et al. Long-term financing needs for HIV control in sub-Saharan Africa in 2015–2050: a modelling study. *BMJ Open* 2016.

In a study that was published in 2016, academics calculated the cost of the required HIV response in nine of sub-Saharan Africa's most affected countries. Their methodology resulted in examining the costs for responding to the HIV epidemic in Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.⁷⁸

The researchers modelled 4 options for the HIV response, and it resulted in 4 cost scenarios, resulting in the lowest cost being 98 billion USD and the highest being 261 billion USD for the period 2015 to 2050⁷⁹. (It is important to note here that the World Health Organisation Treatment Guidelines released in 2015 which advocated that all people who live with HIV should be placed on treatment affects the funding required⁸⁰.) Although many models exist, with varying numbers, all the models advise on early investment as a means to prevent new infections.

Country	2016	2018	2020	2022	2024	2026	2028	2030
Algeria	8,790,421	10,312,025	11,574,950	11,424,706	11,099,239	10,647,474	10,065,878	9,340,930
Angola	27,998,225	35,574,832	44,576,773	46,596,593	48,900,101	50,713,776	51,784,510	52,441,125
Benin	5,154,475	6,341,930	7,568,206	7,528,694	7,576,708	7,614,261	7,634,480	7,642,936
Botswana	11,249,392	13,072,265	14,516,844	14,350,883	13,938,331	13,311,262	12,474,699	11,499,717
Burkina Faso	12,601,928	16,256,682	20,460,712	19,729,377	19,384,702	18,898,276	18,288,479	17,559,806
Burundi	62,941,902	71,176,263	79,052,679	78,342,311	79,100,020	80,234,005	81,556,711	83,177,178
Cameroon	27,854,763	35,117,707	45,509,997	44,612,958	44,155,496	43,376,496	42,175,661	40,628,787
Central African Republic	199,458,300	225,213,400	291,927,546	280,133,319	272,297,437	265,520,692	258,950,002	253,389,141
Chad	35,271,945	49,342,263	69,961,428	63,749,191	62,466,288	61,441,767	60,495,551	59,724,168
Comoros	264,757,721	303,582,612	302,624,908	296,024,873	294,032,787	289,571,764	282,589,962	273,890,776
Congo	8,917,148	10,806,995	12,485,849	11,485,881	11,304,731	11,257,040	11,262,891	11,319,728
Côte d'Ivoire	27,707,391	29,491,657	26,732,054	26,945,016	27,199,596	27,157,472	26,800,506	26,213,183
Democratic Republic of the Congo	28,876,301	35,389,961	40,891,349	41,750,791	41,960,631	41,524,009	40,386,517	38,666,152
Djibouti	373,478,551	529,625,148	708,921,407	752,990,408	811,304,932	859,581,405	894,137,768	915,925,678
Egypt	60,145,527	79,475,370	97,871,621	97,482,118	99,159,503	99,980,173	99,865,557	98,931,661
Eritrea	33,936,781	38,018,946	40,731,041	39,903,680	39,398,133	38,730,495	37,884,053	36,917,794
Ethiopia	16,908,677	19,573,253	22,170,916	23,228,962	24,611,840	25,773,426	26,576,496	27,333,166
Gabon	1,096,474	1,386,428	1,656,280	1,667,028	1,683,922	1,679,925	1,653,658	1,611,014
Gambia	65,646,595	55,711,420	27,158,345	25,269,311	24,312,095	23,611,111	23,067,722	22,665,829
Ghana	22,399,178	27,280,698	30,235,051	29,483,141	28,667,179	27,561,595	26,146,440	24,429,581
Guinea	61,567,646	81,532,857	102,485,982	100,155,101	100,883,630	100,963,068	100,257,440	98,931,047
Guinea-Bissau	64,739,068	82,610,679	102,474,794	94,456,131	92,319,114	91,199,522	90,588,000	90,490,707
Kenya	76,054,165	97,082,300	105,391,417	103,113,375	102,517,498	101,360,286	99,522,331	96,834,840
Lesotho	10,085,784	12,764,190	14,079,052	13,689,958	13,260,964	12,790,024	12,264,735	11,596,367
Liberia	90,210,206	113,773,203	140,543,833	136,190,255	137,159,314	135,624,705	130,896,687	125,196,041
Libyan Arab Jamahiriya	12,102,305	15,535,737	20,431,508	20,019,067	20,470,525	20,857,352	21,088,571	21,395,772
Madagascar	3,319,049	4,263,554	5,333,196	5,692,736	6,029,923	6,248,856	6,310,454	6,305,421
Malawi	54,041,846	68,994,886	92,425,269	95,787,003	102,285,609	108,163,604	112,953,532	117,588,683
Maldives	82,575,815	98,518,017	95,309,556	94,286,949	95,948,492	96,652,512	96,308,360	95,083,870
Mali	445,310	554,788	653,330	685,437	709,522	719,864	714,740	699,672
Mauritania	80,686,531	91,924,431	80,102,508	77,602,786	79,474,316	80,167,495	79,269,214	78,810,015
Mauritius	14,789,314	15,705,537	13,705,651	14,014,493	14,390,572	14,574,393	14,531,170	14,556,298
Morocco	16,644,270	20,269,589	25,189,671	27,112,769	28,665,037	29,465,146	29,442,125	29,192,198
Mozambique	30,324,162	40,093,867	52,535,504	51,112,005	52,170,611	52,443,275	51,878,281	51,083,684
Namibia	132,318,688	139,643,862	125,366,788	125,802,248	124,269,98	121,854,887	118,501,048	114,528,604
Niger	10,352,878	16,830,629	29,162,784	28,940,686	29,177,450	29,046,333	28,539,979	27,815,828
Nigeria	36,221,800	43,889,752	53,919,386	56,727,511	61,422,784	65,091,110	67,269,737	69,906,924
Rwanda	67,666,074	78,773,725	88,704,241	87,691,491	86,053,854	83,604,741	80,428,050	76,934,707
Senegal	138,333,723	148,088,179	158,998,455	124,430,917	121,692,076	119,611,378	117,508,217	116,041,333
Sierra Leone	22,532,664	27,519,626	33,460,866	32,610,763	31,484,949	29,776,164	27,534,877	24,987,046
Somalia	16,652,072	21,065,290	26,142,646	27,993,543	30,009,197	31,723,626	33,056,320	34,425,245
South Africa	19,343,933	30,451,824	66,088,877	57,865,477	58,609,204	59,103,525	59,286,108	59,577,184
South Sudan	3,589,453,796	3,427,229,021	2,625,643,415	2,584,838,656	2,631,804,339	2,558,086,014	2,393,287,645	2,257,990,895
Sudan	11,400,225	13,931,054	14,750,652	15,623,611	16,256,181	16,510,604	16,388,862	16,136,203
Swaziland	7,801,206	9,356,551	9,833,597	9,572,056	9,529,756	9,476,766	9,405,570	9,325,685
Togo	1,273,203	1,646,747	1,959,457	2,043,310	2,098,992	2,135,552	2,149,506	2,137,860
Tunisia	44,028,055	57,561,681	69,574,688	62,416,476	61,156,963	60,028,463	58,761,405	57,947,143
Uganda	236,445,193	340,326,371	442,544,687	447,421,534	440,566,121	425,243,364	401,178,755	369,648,206
United Republic of Tanzania	174,096,891	261,412,045	471,258,031	420,867,621	412,157,758	401,756,180	389,895,182	377,112,018
Zambia	15,428,489	21,354,210	29,672,004	31,097,928	32,926,366	33,979,701	34,165,319	34,183,289
Zimbabwe	460,259,281	557,349,200	668,648,583	644,320,246	671,447,802	655,880,452	602,232,338	557,650,450
TOTAL	6,955,397,757	7,609,408,066	7,729,137,653	7,571,573,490	\$ 7,692,273,266	\$ 7,613,123,933	\$ 7,358,065,637	\$ 7,113,838,007

Title: Estimated cost to end epidemic (USD) Source: John Stover, et al, What Is Required to End the AIDS Epidemic as a Public Health Threat by 2030? The Cost and Impact of the Fast-Track Approach PLoS One. 2016; 11(5): e0154893. Published online 2016 May 9. doi: 10.1371/journal.pone.0154893

10.8. Health as a government priority

Our next element investigates whether health generally is a priority for each country's duty holders. Determining whether a country has prioritised health over other demands is an important way to understand the political will of leadership. In this section we thus compare the data of the Abuja commitment in column 1, as well as the expenditure on health versus military spending in each country.

Although much emphasis has been placed on the 2001 Abuja commitment to allocate 15% of the national budget on health, it does pose challenges as a measure of government investment in HIV and health. For various reasons, the Abuja numbers must always be read in conjunction with the other indicators that we use to measure performance. To further understand why, we need to acknowledge that some countries may legitimately need to spend less than 15% of the total budget on health. The reasons for this may vary but the existing health care system is an important variable. For example, perhaps the country already has a relatively resilient, sustainable and inclusive health system in place already, and that maintenance does not require 15%.

Timing is another variable to consider: Perhaps other issues such as education or safe drinking water might be a higher and more urgent priority in the immediate future, and a country can move to 15% for health at a later stage. Cost per patient is also an important variable when thinking about the value of Abuja. The cost to service each patient to an equal standard of care is not the same across all countries. In countries like Seychelles and Gambia which have the smallest land area (approximately 450 square kilometers) it is easy and cheap to transport goods to clinics. In contrast, in Algeria, the largest by land area in Africa, 2.382 million square kilometres, costs of transport for health are significantly higher. In fact, Algeria has a similar population size to Kenya, but Kenya has 25% of the land area of Algeria. These details need to be considered in applying a broad commitment like Abuja and understanding its value. Luxembourg who has the highest standard of health in the world spend 6.16% of its budget on health, and Singapore (second place) spends 4.47%. Efficiency and accountability on how funds are spent is a vital aspect of how much should be invested in health, and hence HIV too, and not an overly simplistic measure like 15% of total government budget.

For this reason, one way to ascertain governments prioritising health is to look at where else they spend funds. Thus, we look at whether countries prioritise health over military costs. Although the military can be used in humanitarian disasters such as hurricanes, droughts and floods, they are principally deployed for safety and security reasons. Expenditure on military for some is vital whilst others see it as wasted expenditure. What most agree on is that it does emphasise why a peaceful, respectful and secure planet is a prerequisite for health for all. In a political environment that is not factious with conflict, expenses on military spending drops, and these funds can be diverted to better use for human development.

- Algeria has the highest expenditure on military spending as a percentage of GDP on the continent, spending only 1.3 % more on health.
- Gabon (1.6% more on health), Mauritania (1.2%), Angola (1.1%) and Mali (0.9%) also have very small differences between health and military spending as a percentage of GDP.
- Our best performer is Sierra Leone with an impressive difference of 15.7% more invested in health than in military. Followed by Malawi (9%) and Liberia (8.8%),

		Abuja Commitment: The % of the government budget dedicated to health, 2015	Current health expenditure (% of GDP), 2016	Military expenditure (% of GDP), 2018
1	Algeria	10.7%	6.6%	5.3%
2	Angola	3.7%	2.9%	1.8%
3	Benin	3.4%	3.9%	0.9%
4	Botswana	8.8%	5.5%	2.8%
5	Burkina Faso	7.2%	6.8%	2.1%
6	Burundi	11.8%	6.2%	1.9%
7	Cabo Verde	10.8%	5.2%	0.6%
8	Cameroon	3.1%	4.7%	1.3%
9	Central African Republic	4.1%	4.3%	1.4%
10	Chad	6.3%	4.5%	2.1%
11	Comoros	3.8%	7.6%	NO DATA
12	Congo	3.1%	4.6%	2.5%
13	Cote d'Ivoire	5.0%	4.4%	1.4%
14	Democratic Republic of Congo	5.0%	3.9%	0.7%
15	Djibouti	4.1%	3.5%	NO DATA
16	Egypt	4.2%	4.6%	NO DATA
17	Equatorial Guinea	1.3%	3.4%	0.2%
18	Eritrea	1.8%	3.0%	NO DATA
19	Ethiopia	6.0%	4.0%	0.6%
20	Gabon	7.0%	3.1%	1.5%
21	Gambia	10.6%	4.4%	1.1%
22	Ghana	7.1%	4.4%	0.4%
23	Guinea	2.7%	5.5%	2.5%
24	Guinea-Bissau	9.5%	6.1%	1.6%
25	Kenya	6.3%	4.5%	1.2%
26	Lesotho	9.3%	8.1%	1.8%
27	Liberia	2.7%	9.6%	0.8%
28	Libya	NO DATA	NO DATA	NO DATA
29	Madagascar	15.6%	6.0%	0.6%
30	Malawi	10.8%	9.8%	0.8%
31	Mali	4.5%	3.8%	2.9%
32	Mauritania	5.5%	4.2%	3.0%
33	Mauritius	10.0%	5.7%	0.2%
34	Morocco	7.8%	5.8%	3.1%
35	Mozambique	1.2%	5.1%	1.0%
36	Namibia	12.9%	9.1%	3.3%
37	Niger	4.6%	6.2%	2.5%
38	Nigeria	5.3%	3.6%	0.5%
39	Rwanda	6.2%	6.8%	1.2%
40	Sahrawi Republic (Western Sahara)	NO DATA	NO DATA	NO DATA
41	São Tomé and Príncipe	10.7%	6.0%	NO DATA
42	Senegal	4.2%	5.5%	1.9%
43	Seychelles	10.0%	3.9%	1.4%
44	Sierra Leone	7.9%	16.5%	0.8%
45	Somalia	NO DATA	NO DATA	NO DATA
46	South Africa	14.1%	8.1%	1.0%
47	South Sudan	1.6%	NO DATA	1.3%
48	Sudan	18.1%	5.7%	2.3%
49	Swaziland (eSwatini)	14.9%	7.7%	1.5%
50	Tanzania	7.4%	4.1%	1.2%
51	Togo	5.7%	6.6%	2.0%
52	Tunisia	13.6%	7.0%	2.1%
53	Uganda	5.6%	6.2%	1.4%
54	Zambia	6.8%	4.5%	1.4%
55	Zimbabwe	8.2%	9.4%	2.2%

Title: Government Spending. Notes: Source: Columns 1 and 2: *AUC Scorecard on Domestic Finance for Health, 2018, AUC.* Column 3: *Stockholm International Peace Research Institute (SIPRI)* <https://www.sipri.org/all/2018> (except Equatorial Guinea /2016 and Guinea-Bissau /2015)

10.9. Sources of Health Financing

The following table examines the current sources of health financing per country. This is an important indicator in that it examines where the finances come from in order to provide health care. The first column represents government sources, such as income taxes, value-added tax (VAT), finances earmarked for health (for example In Botswana, Egypt and Djibouti some tobacco taxes are earmarked for use in health. In Egypt this forms 1.086% of the entire health budget, not an insignificant amount since they began in 1992. Uganda and South Africa also collect funds from sub-national transfers (payments made between and to provincial bodies from taxes, rents, grants etc.).

These out of pocket expenses are usually called “user fees” at clinic level and despite decades of understanding and evidence that they can push households into poverty (and multi-generational poverty no less) there are many in the new era of universal health coverage that are again endorsing user fees again. Transport, food costs, lost income (patient and caregivers), medicines etc. are all additional burdensome costs to families that have health problems. In some cases, these user fees result in very ill people not even approaching the health system for care, as they do not have the entry fee. In other cases, where they are able to get a loan, this can be only found at the hands of loan sharks, resulting in exceptionally high interest rates. Research has shown for decades that user fees are not a good way to finance health. It is important to note that although some advocate that some user fee reduces over-use and/or abuse of the health system there is are two major factors that need to be considered in this regard. First is that because health literacy is low in these countries people seek health care for issues which do not require medical intervention, such as headaches for dehydration which can easily be solved at home (except for the very young, old and ill). Second is the fact that there is no agreement of what an ideal user fee would be in the African context.

The table shows the top 5 user-fees based health systems in Africa:

Top 5 Worst	Top 5 Best
1. Cameroon: 77.64%	1. Seychelles: 2.54%
2. Comoros: 76.53%	2. Mozambique: 6.85%
3. Equatorial Guinea: 75.02%	3. São Tomé and Príncipe: 13.75%
4. Nigeria: 73.3%	4. Lesotho: 16.85%
5. Egypt: 69.66%	5. Malawi: 17.55%

Just as user fees are financing the health systems in Africa so too is foreign aid. The table compares the sources of health financing (government budget, user fees and development partners) as a means to understand where governments are getting the finances for to run their health care.

According to OECD statistics, the Top 10 ODA recipients of Overseas Development Assistance (from OECD countries) in 2017 were all African:

1. Ethiopia (8%)
2. Nigeria (6%)
3. Tanzania (5%)

4. Kenya (5%)
5. Democratic Republic of Congo (4%)
6. South Sudan (4%)
7. Uganda (4%)^o
8. Morocco (4%)
9. Mozambique (3%)
10. Somalia (3%)⁸¹

Reliance on overseas development assistance is obviously not ideal as it can fluctuate, be contingent on adhering to the political agenda of the donor country and be withdrawn with new leadership in the donor country. Real independence means a country funds their own health and HIV response as much as possible.

Out of pocket expenses

Médecins Sans Frontiers writes in 2017: "Over a decade ago, MSF carried out a series of surveys that highlighted the burden user fees were placing on the lives of vulnerable people in several conflict and crisis-stricken contexts as well as stable, low resource settings. User fees were found to result in low utilization of public health facilities, exclusion from timely health care, and exacerbation of impoverishment, forcing many to forego treatment or to seek less-effective alternatives. Financial barriers affected 30– 60% of people requiring health care in the six countries studied (Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti, and Mali). Exemption systems based on assessment of means (i.e. indigent or not indigent eligibility criteria) proved ineffective, benefiting only 1–3.5% of populations. Alternative payment systems, requiring 'modest' fees from users (e.g. low flat fees), did not adequately improve coverage of essential health needs, especially for the poorest and most vulnerable. Conversely, user fee abolition for large population groups led to rapid increases in utilization of health services and essential health care coverage."⁸²

Country /Indicators		Government	Households & employers	Development Partners
1	Algeria	70.58%	29.40%	0.03%
2	Angola	47.51%	49.72%	2.77%
3	Benin	20.14%	45.63%	34.23%
4	Botswana	55.10%	36.54%	8.36%
5	Burkina Faso	28.24%	42.20%	29.56%
6	Burundi	38.82%	20.66%	40.54%
7	Cabo Verde	67.81%	25.70%	6.48%
8	Cameroon	14.46%	77.64%	7.90%
9	Central African Republic	12.77%	43.73%	43.51%
10	Chad	23.46%	61.65%	14.89%
11	Comoros	13.40%	76.53%	10.07%
12	Congo	43.22%	45.66%	11.12%
13	Côte d'Ivoire	21.83%	51.83%	26.34%
14	Democratic Republic of Congo	16.49%	44.24%	39.27%
15	Djibouti	54.62%	22.36%	23.01%
16	Egypt	30.08%	69.66%	0.25%
17	Equatorial Guinea	23.53%	75.02%	1.45%
18	Eritrea	22.97%	52.38%	24.65%
19	Ethiopia	26.87%	57.66%	15.30%
20	Gabon	58.91%	40.27%	0.82%
21	Gambia	46.56%	25.62%	27.82%
22	Ghana	34.95%	39.48%	25.57%
23	Guinea	17.15%	57.96%	24.89%
24	Guinea-Bissau	31.26%	37.16%	31.58%
25	Kenya	33.10%	48.21%	18.68%
26	Lesotho	56.82%	16.85%	26.33%
27	Liberia	7.41%	21.66%	70.98%
28	Libya	NO DATA	NO DATA	NO DATA
29	Madagascar	45.15%	28.17%	26.68%
30	Malawi	28.65%	17.55%	53.50%
31	Mali	16.55%	47.08%	36.37%
32	Mauritania	39.02%	52.25%	8.73%
33	Mauritius	45.81%	51.48%	2.72%
34	Morocco	43.29%	55.71%	0.99%
35	Mozambique	8.09%	6.85%	85.06%
36	Namibia	62.98%	27.75%	9.27%
37	Niger	21.02%	53.22%	25.76%
38	Nigeria	16.53%	73.73%	9.94%
39	Rwanda	21.37%	34.48%	44.15%
40	Sahrawi Republic (Western Sahara)	NO DATA	NO DATA	NO DATA
41	São Tomé and Príncipe	37.19%	13.75%	49.09%
42	Senegal	31.75%	56.54%	11.71%
43	Seychelles	96.99%	2.54%	0.46%
44	Sierra Leone	8.96%	38.41%	52.63%
45	Somalia	NO DATA	NO DATA	NO DATA
46	South Africa	53.55%	44.01%	2.43%
47	South Sudan	21.14%	64.73%	14.13%
48	Sudan	31.14%	66.92%	1.94%
49	Swaziland (eSwatini)	64.70%	19.55%	15.75%
50	Tanzania	35.30%	28.06%	36.64%
51	Togo	28.00%	56.82%	15.18%
52	Tunisia	56.30%	43.27%	0.42%
53	Uganda	13.43%	46.71%	39.86%
54	Zambia	36.56%	39.16%	24.28%
55	Zimbabwe	20.82%	41.97%	24.26%

Title: Source of spending, as a % of total health spending (2015) Notes: All percentages are out of 100%, except the following four countries: Ethiopia (out of 99.8%); Malawi (out of 99.7%); Nigeria (out of 101%) and Zimbabwe (out of 87.1%). * Out of Pocket is money spent by individuals and Workplace health insurance is funds paid by employers to cover staff. Source: AU, Africa Scorecard on Domestic Financing for Health, 2018

10.10. TRIPS Flexibilities

Closely related to efficiency gains or cost efficiency is the use of what are called TRIPS flexibilities. Beginning in 1995 the WTO's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) set North American and European standards of intellectual property rights on the rest of the world. As a result of advocacy, the Doha Declaration in 2003 was able to somehow soften the harshness of the original TRIPS. TRIPS was amended so that intellectual property should not "prevent countries from taking necessary measures to protect public health."⁸³

Further amendments have attempted to provide loopholes for governments of developing countries so that medication can be provided in case of emergency, but the original declaration is cited as a continuing barrier by some. Given that many declarations are not adhered to, this may be an over statement as a means to avoid actually implementing what is necessary. Cited barriers are under-developed local pharmaceutical manufacturing industries and compulsory licensing.

African governments need to better engage with global Intellectual property and pharmaceutical manufacturing as a means to respond to the HIV and broader health crisis. Not only is it a means to ensure that access is expanded but that costs are diminished in the long term.

10.11. Clinical trials¹¹

Africa is host to numerous clinical trials testing interventions to understand and ameliorate HIV conditions or co-morbidities, as well as to prevent HIV infection.⁸⁴ While African clinical trial participants provide an immeasurable benefit to these trials by volunteering their time and bodies, African countries also contribute through uncompensated costs borne by African communities when research occurs in their institutions, hospitals and clinics.

Utilizing public data on clinicaltrials.gov⁸⁵, this study analysed data on clinical trials in people living with HIV or at risk of HIV for all African countries for all trials planned or currently enrolling participant. Studies were included if they specifically enrolled PLWH or people at risk of acquiring HIV to examine interventions to treat HIV, treat HIV related co-morbidities or prevent HIV acquisition. As September 2019, 23 African countries had participants involving some aspect of HIV research.¹² Participants were counted in trials which were planned or ongoing whether or not currently enrolling participants. A total of 758,000 people was identified as participating in a total of 350 HIV trials.¹³ The size of the trials varied from small Phase 0 trials to Phase 3 and Phase 4 with up to 340,000 participants in one case, with study periods from approximately 1 to 12 years. While these trials each involve trial sponsors and funding from outside of Africa, seventy percent of trial participants in these trials were enrolling or enrolling in a trial with an African partner such as a local university or research institution.

Trial sponsors are responsible for the costs associated with a clinical trial. The key costs for clinical trials are well known. One range of estimates is that clinical procedures cost 15%-22% of total cost, administrative staff costs equal 11%-29% of total cost, and site monitoring costs equal 9%-14% of total

¹¹ This section was researched and authored by Kevin Fisher of Avac.

¹² Trials not exclusively held in Africa, with site for example outside of Africa, were excluded from the analysis because of the difficulty of allocating between African and non-African sites. Several countries, notably Rwanda, were excluded from analysis.

¹³ In trials occurring in multiple African countries with no clear division between the countries in terms of trial participation, trial participants are allocated pro rata among the African countries.

cost.⁸⁶ Even when external sponsors aim to cover all of the costs of a clinical trial, it is reasonable to assume that some related costs to African hospitals, clinics and governments go unreimbursed. Trial sponsors cannot not cover all of the incidental costs of a clinical trial. Some items not generally funded by grants include staff improvement programming, construction and rental of facilities and infrastructure, salaries for administrative staff, local taxes, publication costs and IRB overhead.⁸⁷

The costs funded by trial sponsors include both direct and indirect costs. Direct costs include, for example, salaries, travel, equipment and lab supplies. Indirect costs include, for example, rent, utilities, maintenance, research management office and legal fees. Sponsors in Africa receive lower levels of reimbursement for these indirect costs than trials elsewhere.⁸⁸ The costs that institutions in low- and middle-income countries are insufficiently compensated for include utilities, rent, auditing fees, travel and equipment.⁸⁹

The methodology used to quantify local uncompensated domestic investment in research uses an estimate of the total investment in clinical trial HIV research in African countries using an estimate of the average cost of per participant for research in Africa. Small trials typically have a smaller cost per participant. Costs of clinical trial increase per participant as the size and length of the trial increases.⁹⁰ This analysis provides an overall estimate of the per participant investment by external trial sponsors in clinical trials in Africa of \$8,000 - \$15,000 over the life of a trial. This estimate is consistent with estimates for infectious disease trials by Pharma as well as estimates from trial sponsors in private communications.⁹¹

The total cost of trials currently planned or ongoing in Africa is estimated at US\$60 billion. This estimate is derived from a cost per participant for trials in Africa of \$8,000, representing the low end of estimates. There is no established estimate of portion of African trial costs (staff, rent, infrastructure, IRB/Regulatory) not covered by funding from trial sponsors. One proxy estimate might be the difference between indirect cost reimbursement for sponsors in trials in Africa and sponsors of trials in the North America and Europe which could equal as much as a difference between 13% and 50%, or a third of the cost of the trial. Another proxy could be the approximately 30% of other costs (apart from direct trial costs and site overhead).¹⁴ For purposes of this analysis, a very conservative estimate of unreimbursed costs 1-5% was used to generate estimates for unreimbursed collateral expenses for clinical trials each country where trials were taking place.¹⁵ Using these two estimates., African countries invested between \$60-\$300 million to support clinical trials in HIV research in their countries. This investment represents a substantial unrecognized investment by African countries in HIV research.¹⁶

African countries through trial volunteers and providing staff, support and infrastructure provide an immense benefit to HIV research and development globally. This contribution needs to be both acknowledged and supported. This investment should also be supplemented through donor assistance in technical and financial support to build up clinical trial capacity in Africa. This is a matter of equity and good trial practice. Higher cost clinical trials can result from extended timelines of clinical trials,

14 See supra note 12;

15 Noting that trials held both in Africa and outside of Africa were excluded.

16 In comparison, the annual. 2017-18 budget for the South African MRC is approximately US\$77 million. http://pmg-assets.s3-website-eu-west-1.amazonaws.com/SAMRC_APP_2019_2020.pdf

increased regulations, monitoring complexities, patient recruitment intricacies and workforce competence.⁹² Insufficient support for hidden clinical trial costs contributes to the cost of clinical trials and delay in the introduction of new HIV research and interventions.

	Country	Trial Participants	Trial cost total @ \$ 8,000 per participant	5% of Trial Cost	1% of Trial Cost
1	Botswana	5489	\$ 43,910,933.00	\$ 2,195,546.00	\$439,109.00
2	Burkina	533	\$ 4,264,000.00	\$ 213,200.00	\$42,640.00
3	Cameroon	1544	\$ 12,352,000.00	\$ 617,600.00	\$123,520.00
4	Congo	6000	\$ 48,000,000.00	\$ 2,400,000.00	\$480,000.00
5	Cote	1158	\$ 9,266,667.00	\$ 463,333.00	\$92,666.00
6	Egypt	400	\$ 3,200,000.00	\$ 160,000.00	\$32,000.00
7	Ethiopia	4493	\$ 35,944,000.00	\$ 1,797,200.00	\$359,440.00
8	Gabon	644	\$ 5,152,000.00	\$ 257,600.00	\$51,520.00
9	Ghana	4482	\$ 35,856,000.00	\$ 1,792,800.00	\$358,560.00
10	Guinea	300	\$ 2,400,000.00	\$ 120,000.00	\$24,000.00
11	Kenya	234382	\$ 1,875,057,333.00	\$ 93,752,867.00	\$18,750,573.00
12	Lesotho	10300	\$ 82,400,000.00	\$ 4,120,000.00	\$824,000.00
13	Liberia	4000	\$ 32,000,000.00	\$ 1,600,000.00	\$320,000.00
14	Malawi	50657	\$ 405,258,667.00	\$ 20,262,933.00	\$4,052,586.00
15	Mozambique	30850	\$ 246,797,333.00	\$ 12,339,867.00	\$2,467,973.00
16	Nigeria	5262	\$ 42,096,000.00	\$ 2,104,800.00	\$420,960.00
17	Senegal	954	\$ 7,632,000.00	\$ 381,600.00	\$76,320.00
18	South Africa	74240	\$ 593,922,667.00	\$ 29,696,133.00	\$5,939,226.00
19	Swaziland	3318	\$ 26,545,143.00	\$ 1,327,257.00	\$265,451.43
20	Tanzania	26794	\$ 214,348,000.00	\$ 10,717,400.00	\$2,143,480.00
21	Uganda	222878	\$ 1,783,020,000.00	\$ 89,151,000.00	\$17,830,200.00
22	Zambia	25838	\$ 206,701,333.00	\$ 10,335,067.00	\$2,067,013.00
23	Zimbabwe	44251	\$ 354,008,000.00	\$ 17,700,400.00	\$3,540,080.00
Total		758766	\$ 6,070,132,076.00	\$ 303,506,604.00	\$60,701,320.00

Title: Calculations of HIV clinical trial investments in various countries in Africa

11. Civil Society and CCMs

Country coordinating mechanisms are powerful and important country level committees that determine how funds for HIV, TB and malaria are spent in each country. They play a pivotal role in not only developing the proposals to Geneva but doing oversight and ensuring the funds are correctly spent, and in such a manner as to provide the best quality programmes.

11.1. Civil society organisation on CCM

CCMs need to represent the communities most affected by HIV, TB and malaria, both to meet Global Fund specified criteria but specially to ensure that those most affected are leading and informing the response. In order to understand the influence and involvement civil society has on Country Coordinating Mechanisms (the principal expert committee that informs each country's national decision-making around Global Fund grants) we unpacked the data on CCM composition, not only by what percentage of the CCM is civil society, but how that civil society representation is also divided up.

The first column represents the representation of civil society on the CCM as a percentage. (The data includes chairs and vice-chairs that come from civil society but does not count seconds (as the seat is the same seat in essence)). The second and third columns each represent people living with or affected by the diseases (HIV and/or AIDS, Tuberculosis and/or malaria). The fourth column represents the percentage of the CCM that is composed of faith-based or religious organisations' representatives. It is important to note here that this group does not fall under the umbrella of CSOs generally and thus the final column calculates the total representation of civil and religious organisations on the CCM.

Looking at the table, we can see that Kenya, Malawi, Swaziland, and Tunisia are all ensuring the inclusion of KPs, People living with HIV, TB and Malaria on their CCMs, and they should be applauded for doing so. It is important to remember that in some countries populations like men who have sex with men are not legally able to participate on CCMs in such a capacity because of the fact that same-sex sexual conduct is criminalised. Decriminalisation is the first step to ensuring these communities can engage in the HIV response.

Each of the 4 columns has then been graded according to quintiles. This means rating the country's data into 5 equal groups and rating the groups according to their performance. This allows us to compare apples with apples and oranges with oranges, as the experts say. Thus, we can see that in Algeria, a large proportion of the CCM is made up of CSOs (56%) but it is also apparent that the CSOs do not represent either Key populations, nor faith-based, nor people living with HIV, TB or Malaria. Because having the two central columns is vital in ensuring an adequate and effective response to HIV, it is valuable to unpack what type of civil society member is sitting on the CCM. Best practice shows that key populations and people infected or living with the disease are best able to advise experts towards a more impactful response.

	Country	All CSOs as % of CCM members	People living with and/or affected by HIV/AIDS, TB and/or malaria as % of CCM members	People representing key affected populations as % of CCM members	Religious/ faith- based organizations as % of CCM members	CSOs, PLWD, KPs and Faith based Total as % of CCM members
1	Algeria	56%	0%	0%	6%	63%
2	Angola	40%	3%	0%	0%	43%
3	Benin	42%	4%	4%	21%	71%
4	Botswana	32%	16%	4%	4%	56%
5	Burkina Faso	41%	6%	6%	6%	59%
6	Burundi	45%	9%	9%	9%	73%
7	Cabo Verde	43%	11%	0%	5%	59%
8	Cameroon	30%	7%	0%	7%	43%
9	Central African Republic	33%	11%	11%	6%	61%
10	Chad	43%	11%	4%	11%	68%
11	Comoros	45%	0%	19%	0%	65%
12	Congo	33%	0%	0%	4%	37%
13	Côte d'Ivoire	24%	4%	0%	8%	36%
14	Democratic Republic of Congo	37%	9%	3%	6%	54%
15	Djibouti	38%	0%	0%	0%	38%
16	Egypt	38%	13%	0%	6%	56%
17	Equatorial Guinea	30%	9%	0%	4%	43%
18	Eritrea	39%	6%	0%	6%	50%
19	Ethiopia	40%	20%	10%	5%	75%
20	Gabon	42%	0%	4%	12%	58%
21	Gambia	34%	3%	6%	6%	50%
22	Ghana	40%	8%	4%	4%	56%
23	Guinea	47%	0%	5%	0%	53%
24	Guinea-Bissau	45%	14%	0%	5%	64%
25	Kenya	44%	19%	6%	13%	81%
26	Lesotho	44%	0%	0%	6%	50%
27	Liberia	36%	7%	7%	11%	61%
28	Libya	ND	ND	ND	ND	ND
29	Madagascar	35%	4%	12%	4%	54%
30	Malawi	50%	21%	7%	0%	79%
31	Mali	51%	21%	0%	3%	74%
32	Mauritania	32%	12%	0%	4%	48%
33	Mauritius	33%	7%	11%	4%	56%
34	Morocco	48%	7%	10%	0%	66%
35	Mozambique	32%	8%	8%	4%	52%
36	Namibia	44%	0%	0%	0%	44%
37	Niger	38%	12%	4%	0%	54%
38	Nigeria	41%	7%	4%	0%	52%
39	Rwanda	41%	6%	0%	6%	53%
40	Sahrawi Republic (Western)	ND	ND	ND	ND	ND
41	São Tomé and Príncipe	21%	11%	11%	0%	42%
42	Senegal	33%	7%	0%	7%	48%
43	Seychelles	ND	ND	ND	ND	ND
44	Sierra Leone	35%	13%	0%	4%	52%
45	Somalia	23%	0%	8%	0%	31%
46	South Africa	27%	3%	0%	0%	30%
47	South Sudan	40%	10%	10%	10%	70%
48	Sudan	34%	6%	0%	0%	40%
49	Swaziland (eSwatini)	44%	11%	17%	6%	78%
50	Tanzania	42%	12%	8%	8%	70%
51	Togo	36%	9%	5%	5%	55%
52	Tunisia	56%	8%	12%	4%	80%
53	Uganda	35%	10%	5%	5%	55%
54	Zambia	44%	17%	0%	6%	67%
55	Zimbabwe	33%	11%	0%	7%	52%

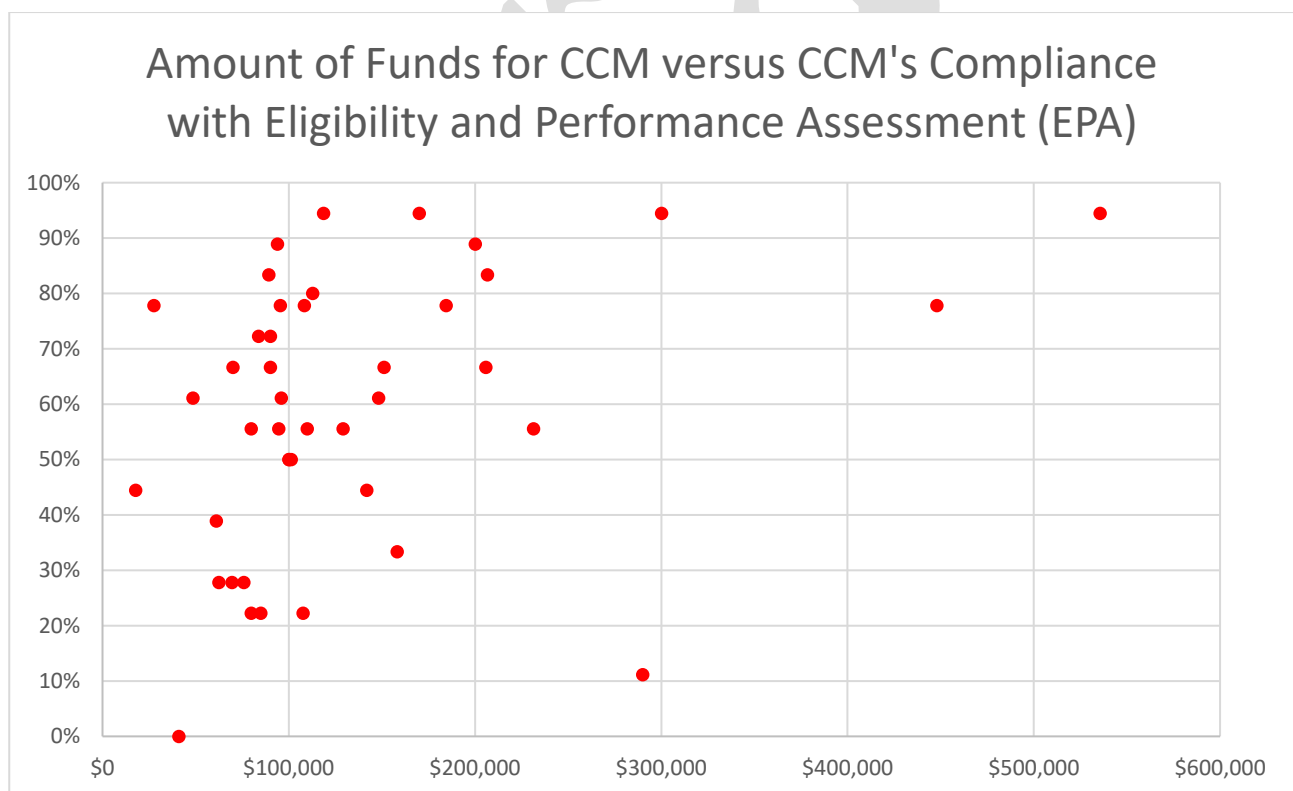
Title: People living with diseases, KP and Civil society representation on CCM. Notes: Includes chairs and vice chairs but excludes seconds; It is important to note that some individuals mark themselves as "general" civil society and not as PLW, KP nor religious despite the name of their organisation pointing to the contrary. For this reason, we have separated CSOs and the various community groups and provided a total for all in Source: Global Fund for HIV, TB and Malaria CCM Composition 2016

11.2. Funding of CCMs and EPA Performance

In order to understand how accountable these CCMs are as they work on the funds for HIV, we conducted an analysis of the CCM (Country Coordinating Mechanisms – the principal decision-making committee at national level for Global Fund grants) Eligibility and Performance Assessments and their budgets makes for an interesting study. The EPAs cover 18 issues from conflict of interest, oversight, community engagement and processes for election, but overall cover good governance and are criteria that all CCMs must comply with.⁹³

11. Eligibility Requirement 1: Transparent and inclusive concept note development process
12. Eligibility Requirement 2: Open and transparent PR selection process
13. Eligibility Requirement 3: Oversight planning and implementation
14. Eligibility Requirement 4: CCM membership of affected communities, including and representing people living with diseases and of people from and representing Key Affected Populations
15. Eligibility Requirement 5: Processes for electing non-government CCM member
16. Eligibility Requirement 6: Management of conflict of interest on CCMs

This report analysed the EPAs of all African countries receiving grants from the Global Fund and captured their performance against all 18 indicators. If a country had achieved performance on an indicator they were marked as such and a total out of 18 was created and made into a percentage.



This data is then plotted against the amount of funding that each CCM received in 2017 from Geneva.⁹⁴ The resulting chart shows that Zimbabwe and Kenya were the recipients of the highest CCM budgets in Africa in 2017 (535 561 USD and 447 852 USD respectively). Zimbabwe proved that this investment works

well on paper and achieved an EPA performance of 94%, whereas Kenya achieved only 78% with its big budget. Interestingly Ethiopia Mozambique, Togo and achieved similar results (89%, 94% and 94%) with considerably smaller budgets (93 876 USD, 170 000 USD, and 118 615USD respectively). South Africa used 300 000 USD to achieve it 94% on paper.

- Morocco deserves special mention with a grading of 83% with only 89 194 USD.
- Gambia achieved 78% on 27 452 USD. (What Kenya achieved (78%) with 447 852 USD; 16 times larger than the Gambian budget for the same results on paper).

Other countries fared very badly on the EPAs despite large investments, notable of which are:

- Nigeria: 11% on a budget of 290 000 USD
- Tanzania: 33% on 158 069 USD
- Guinea 22% on 107 680 USD
- Ghana 56% on 231 330 USD

It is important to note here that recent efforts have been made at the CCM Hub to improve the EPA measurements to capture the quality of the engagements for each of the 18 indicators, as well as measure the more qualitative aspects of CCM processes and engagements.

11.3. Depoliticisation of civil society working on HIV

For some years now, Accountability International has been advocating for dialogue and debate around civil society and accountability, especially with regard to a conflict of interest on CCMs and with regard to a conflict of interest when funds for civil society are channeled through national government, such as with the Global Fund and now sometimes PEPFAR grants. This has depoliticised and disempowered civil society that are recipients of these grants as they are conflicted in watchdogging the ministry of health, justice or finances that provides them with these grants. In some countries, globally and in Africa, this has also moved what were once the most independent and effective watchdog civil society organisations into a position of being service delivery non-profit organisations that function more as a government department than as independent civil society. This is a matter of accountability and needs to be given greater attention in our discussions and debates.

	Country	CCM Funding Disbursements from Global Fund for HIV, TB and Malaria: Amount (USD)	Degree of compliance with Eligibility and Performance Assessment (EPA)
1	Algeria	ND	ND
2	Angola	\$100,000	50%
3	Benin	\$148,102	61%
4	Botswana	\$112,765	80%
5	Burkina Faso	\$95,429	78%
6	Burundi	\$206,609	83%
7	Cabo Verde	ND	ND
8	Cameroon	\$101,311	50%
9	Central African Republic	ND	ND
10	Chad	\$151,099	67%
11	Comoros	\$79,712	22%
12	Congo	\$108,346	78%
13	Côte d'Ivoire	\$141,755	44%
14	Democratic Republic of Congo	\$205,800	67%
15	Djibouti	ND	ND
16	Egypt	ND	ND
17	Equatorial Guinea	ND	ND
18	Eritrea	ND	ND
19	Ethiopia	\$93,876	89%
20	Gabon	\$62,376	28%
21	Gambia	\$27,452	78%
22	Ghana	\$231,330	56%
23	Guinea	\$107,680	22%
24	Guinea-Bissau	\$95,876	61%
25	Kenya	\$447,852	78%
26	Lesotho	\$61,087	39%
27	Liberia	\$100,000	50%
28	Libya	ND	ND
29	Madagascar	\$70,000	67%
30	Malawi	\$83,785	72%
31	Mali	\$79,803	56%
32	Mauritania	\$17,772	44%
33	Mauritius	\$48,523	61%
34	Morocco	\$89,194	83%
35	Mozambique	\$170,000	94%
36	Namibia	\$85,000	22%
37	Niger	\$94,477	56%
38	Nigeria	\$290,000	11%
39	Rwanda	\$69,527	28%
40	Sahrawi Republic (Western)	ND	ND
41	São Tomé and Príncipe	\$41,000	0%
42	Senegal	\$109,866	56%
43	Seychelles	ND	ND
44	Sierra Leone	\$129,026	56%
45	Somalia	ND	ND
46	South Africa	\$300,000	94%
47	South Sudan	\$75,764	28%
48	Sudan	\$90,000	72%
49	Swaziland (eSwatini)	\$184,432	78%
50	Tanzania	\$158,069	33%
51	Togo	\$118,615	94%
52	Tunisia	\$90,000	67%
53	Uganda	ND	ND
54	Zambia	\$200,000	89%
55	Zimbabwe	\$535,561	94%

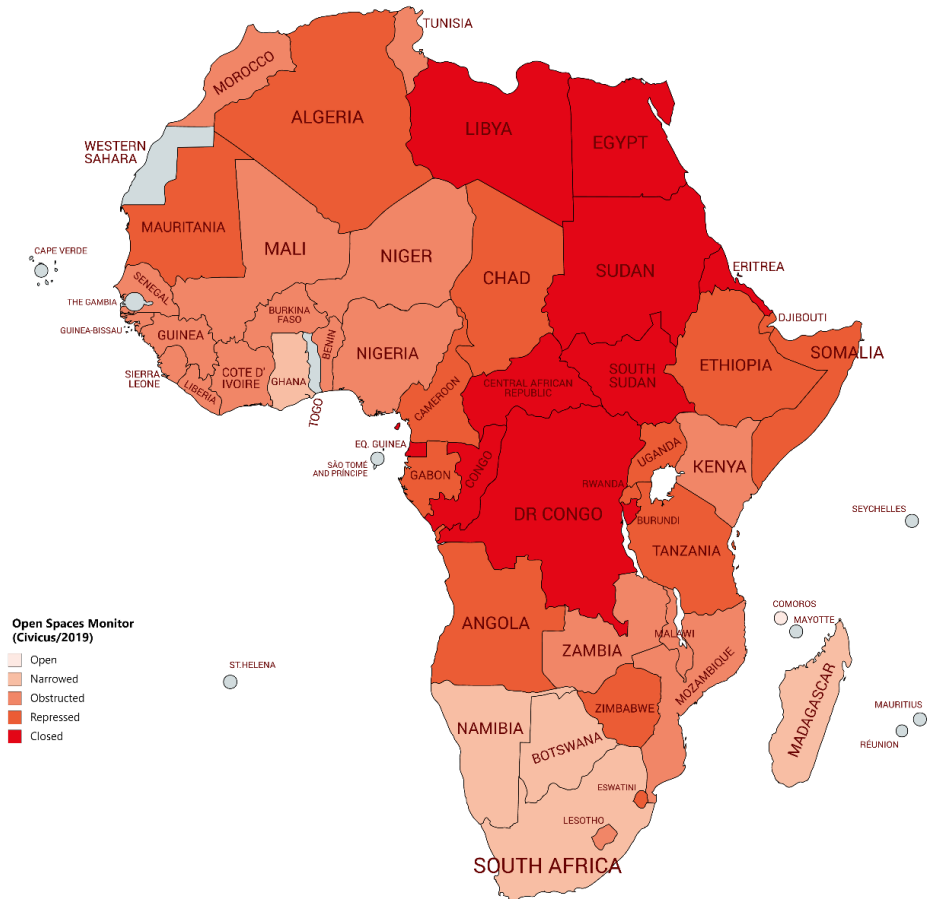
Title: CCM budgets versus performance as measured by Global Fund EPA. Source: Global Fund for HIV, TB and Malaria, Funding Disbursements data base, 2017: <https://data.theglobalfund.org/home>

12. Environment: Transparency and Democracy

12.1. Civicus Open Spaces indicator

It is useful in analysing Financing for HIV in Africa to also look into how free and democratic space is for civil society to organise, advocate and partner with the various partners in the response, not least of which is the government. For this reason, we include an analysis of the Civicus Open Spaces Monitor. The monitor has five levels, outlined below.

The graphic shows that there is a central belt running vertically through Africa where civil society is existing in closed and repressed spaces. It is vital that governments work to create more open and democratic nations as a means to ensure not only the full realisation of the human rights of all, but for more effective economic development. The narrowing of space for civil society is well documented as being linked to economic downward turns and so must be avoided.



OPEN	The state both enables and safeguards the enjoyment of civic space for all people. Levels of fear are low as citizens are free to form associations, demonstrate in public places and receive and impart information without restrictions in law or practice. The authorities are tolerant of criticism from civil society groups and provide space and platforms for open and robust dialogue with members of the public. As a rule, the police protect public protestors, and laws governing the freedom of peaceful assembly adhere to international law and standards. There is a free media, online content is uncensored, and citizens can access government information easily.
NARROWED	While the state allows individuals and civil society organisations to exercise their rights to freedom of association, peaceful assembly and expression, violations of these rights also take place. People can form associations to pursue a wide range of interests, but full enjoyment of this right is impeded by occasional harassment, arrest or assault of people deemed critical of those in power. Protests are conducted peacefully, although authorities sometimes deny permission, citing security concerns, and excessive force, which may include tear gas and rubber bullets, are sometimes used against peaceful demonstrators. The media is free to disseminate a wide range of information, although the state undermines complete press freedom either through strict regulation or by exerting political pressure on media owners.
OBSTRUCTED	Civic space is heavily contested by power holders, who impose a combination of legal and practical constraints on the full enjoyment of fundamental rights. Although civil society organisations exist, state authorities undermine them, including through the use of illegal surveillance, bureaucratic harassment and demeaning public statements. Citizens can organise and assemble peacefully but they are vulnerable to frequent use of excessive force by law enforcement agencies, including rubber bullets, tear gas and baton charges. There is some space for non-state media and editorial independence, but journalists face the risk of physical attack and criminal defamation charges, which encourage self-censorship.

REPRESSED	Civic space is significantly constrained. Active individuals and civil society members who criticize power holders risk surveillance, harassment, intimidation, imprisonment, injury and death. Although some civil society organisations exist, their advocacy work is regularly impeded, and they face threats of de-registration and closure by the authorities. People who organise or take part in peaceful protests are likely to be targeted by the authorities through the use of excessive force, including the use of live ammunition, and risk mass arrests and detention. The media typically reflects the position of the state, and any independent voices are routinely targeted through raids, physical attacks or protracted legal harassment. Websites and social media platforms are blocked, and internet activism is heavily monitored.
CLOSED	There is complete closure - in law and in practice - of civic space. An atmosphere of fear and violence prevails, where state and powerful non-state actors are routinely allowed to imprison, seriously injure and kill people with impunity for attempting to exercise their rights to associate, peacefully assemble and express themselves. Any criticism of the ruling authorities is severely punished and there is virtually no media freedom. The internet is heavily censored, many websites are blocked, and online criticism of power holders is subject to severe penalties.
Source: https://monitor.civicus.org/	

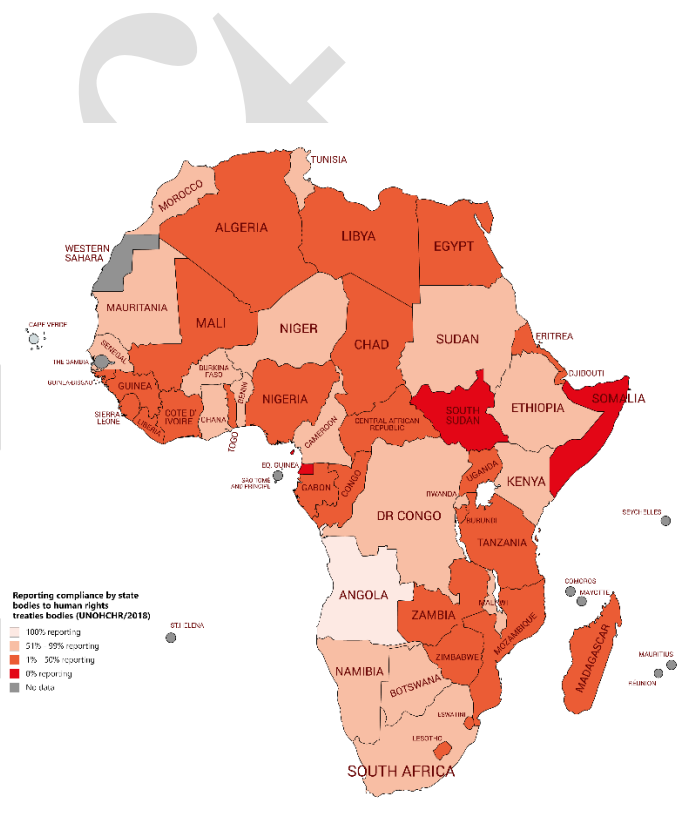
12.2. Human rights indicator

In further examining the human rights context it is necessary to evaluate not just outside perceptions and research into a country's adherence to upholding human rights, but also to evaluate how a country is faring with regard to its commitments to human rights at the United Nations level. This adds a new and important dimension that allows for a nuanced understanding of each country's state of affairs.

Reporting compliance

Reporting on UN human rights treaties is an excellent tool for tracking demonstrable commitment to adhering and implementing human rights as a governing party. Mapping the reporting demonstrates to the reader the regional priority setting that has occurred on the issue. Southern Africa faring better than any other region, with Angola the clear leader.⁹⁵ Using UN grading of 4 categories only (not the usual AI five) we can also see that of the 51 African countries covered:

- 3/55 have no reporting (5.5%)
- 26/55 have 1% - 50% reporting (47%)
- 18/55 have 51% to 99% reporting (33%)
- 1/55 has 100% reporting (1.8%)
- 7/55 have no data (12.7%)



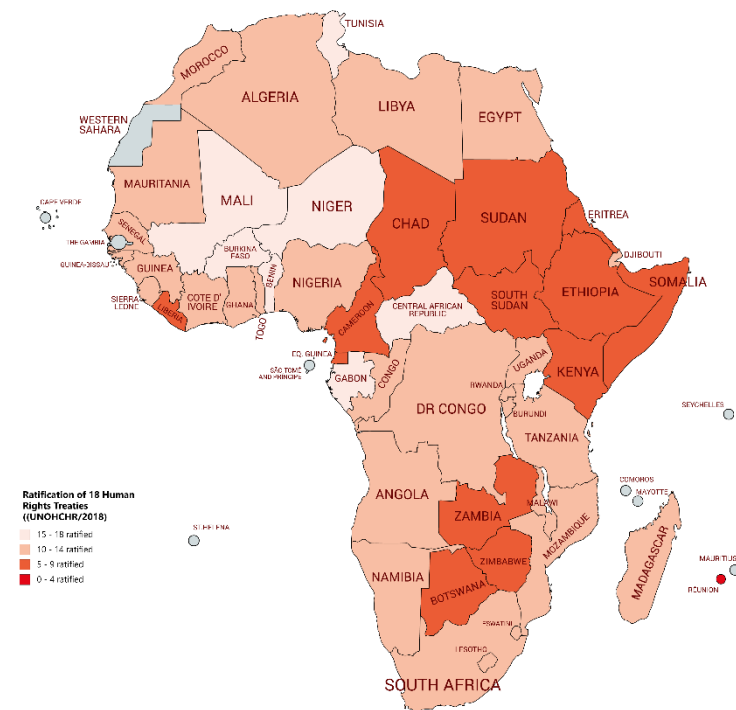
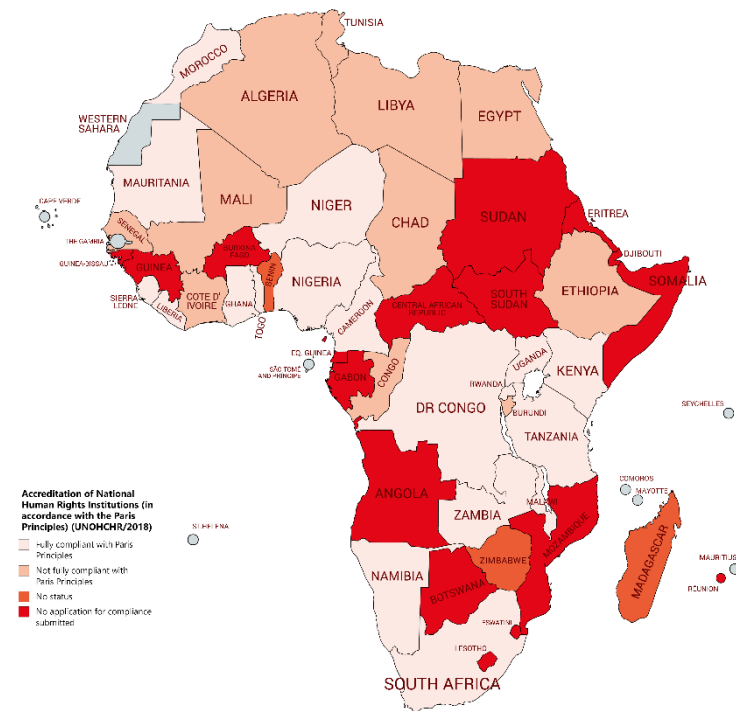
The Ratification of 18 Human Rights Treaties and the Accreditation of National Human Rights Institutions⁹⁶ are also good indicators of the state of a country and how it abides by its human rights obligations to the people within its borders.

12.3. Cato Human Freedom Index and Ranking

The Cato Human Freedom Index is composed of two indices: The Personal Freedom Index and the Economic Freedom Index. Combining the two of these results in the Human Freedom Index and then a global ranking based on the Index.

The Personal Freedom Element includes but is not limited to the following: Legal protection and security, rule of law, safety and security, gender-based violence, freedom of movement, religion, freedom of association, assembly and civil society, freedom of expression and information and safety issues for journalists, family rights such as same-sex relationships, gender identity, rights to divorce and parental rights including after divorce.

The Economic Freedom Element includes but is not limited to the following:



Legal protection and security, rule of law, safety and security, gender-based violence, freedom of movement, religion, freedom of association, assembly and civil society, freedom of expression and information and safety issues for journalists, family rights such as same-sex relationships, gender identity, rights to divorce and parental rights including after divorce.

Country	Personal Freedom	Economic Freedom	Human Freedom	Freedom Rank / 162
Algeria	5.28	4.99	5.14	155
Angola	6.11	5.17	5.64	142
Benin	7.50	5.98	6.74	90
Botswana	6.88	7.43	7.15	64
Burkina Faso	7.46	6.05	6.75	88
Burundi	4.41	5.92	5.17	154
Cameroun	5.33	5.82	5.58	144
Cape Verde	7.99	6.68	7.33	53
Central African Republic	5.47	5.11	5.29	152
Chad	5.51	5.44	5.47	147
Congo	6.78	5.02	5.90	136
Congo (Democratic Republic)	4.95	5.67	5.31	151
Côte d'Ivoire	7.06	6.00	6.53	100
Egypt	3.89	5.72	4.81	156
Ethiopia	5.06	5.73	5.40	150
Gabon	5.32	5.84	5.58	144
Gambia	5.30	7.34	6.32	115
Ghana	7.87	6.60	7.24	57
Guinea	5.37	5.93	5.65	141
Guinea-Bissau	6.86	5.25	6.05	133
Kenya	6.45	7.20	6.82	82
Lesotho	6.69	6.38	6.53	100
Liberia	6.40	6.56	6.48	106
Libya	3.88	4.74	4.31	158
Madagascar	6.84	6.19	6.51	103
Malawi	7.45	5.86	6.65	97
Mali	6.06	5.80	5.93	134
Mauritania	4.99	5.96	5.47	147
Mauritius	7.72	8.01	7.86	37
Morocco	5.99	6.37	6.18	127
Mozambique	6.66	5.50	6.08	130
Namibia	7.39	6.40	6.90	74
Niger	5.71	6.01	5.86	137
Nigeria	5.82	6.32	6.07	132
Rwanda	6.47	7.48	6.97	71
Senegal	6.77	6.22	6.50	105
Seychelles	7.37	7.23	7.30	54
Sierra Leone	7.04	5.75	6.40	112
South Africa	7.70	6.65	7.17	63
Sudan	4.25	5.36	4.80	157
Swaziland	6.02	6.46	6.24	122
Tanzania (United Republic)	6.13	6.92	6.52	102
Togo	6.73	5.82	6.27	119
Tunisia	6.58	6.29	6.43	109
Uganda	6.13	7.41	6.77	85
Zambia	6.01	6.61	6.31	116
Zimbabwe	5.17	6.06	5.62	143

Title: Cato Human Freedom Index by country. Source: <https://www.cato.org/human-freedom-index-new>

13. Findings and Recommendations

FINDINGS	RECOMMENDATIONS
<p>Frameworks</p> <ul style="list-style-type: none"> • The stakeholders don't know about the existing frameworks. • They do not and cannot watchdog the implementation of existing frameworks. • The existing frameworks are not being followed so making new ones is a waste of limited resources (financial, human, logistical). 	<ul style="list-style-type: none"> • An African CSO platform interested in increasing accountability around HIV financing as a peer review mechanism by region (RECS) needs to be coordinated to strategically engage with Regional Economic Communities (RECs). • No resources (financial, human, time or intellectual) should be wasted on developing new declarations until existing ones are reached.
<p>Global Funding</p> <ul style="list-style-type: none"> • There are fluctuations in global funding for HIV, health and human rights and this makes planning and sustainability unreliable and contingent of changing political agendas. • Current funding remains below what is need to reach the existing goals and to manage the HIV epidemic effectively and inclusively. • Investments have moved to migration and integration, climate change and security in recent years. • Investments cases and transitioning countries off of donor dependence are well intentioned plans but their limitations and weaknesses need to be well understood and have global inequality, sustainability and larger structural issues in mind to be truly effective. • Finance for research is an important part of the HIV financing discussion. With a large majority of research investment focusing on a vaccine (76%) there is a large gap for financing of other forms of prevention. • Global private philanthropy is an important part of HIV funding, most obviously the Bill and Melinda Gates Foundation. Strategic funds from smaller givers can be as important as 	<ul style="list-style-type: none"> • Countries need to become more self reliant and look to local options to fill the gap and finance the health system, so that they are not subject to foreign fluctuations due to leadership and policy changes. • African leaders need to play a central role in raising funds for HIV. • Links between other developmental issues and HIV need to be made to ensure that financing for HIV does not get left behind. The case needs to be made by our academics, activists and duty-bearers. • Investment by African countries is needed so that Africa can set the agenda. • Investment cases require closer scrutiny to ensure that the results are led by facts and not political agendas. • African investment needs greater visibility so that Africans do the credit, and there is a need to document this as a means to ensure pride in the African continent. • Investment in prevention methods such as microbicides is important for the comprehensive range of products for HIV prevention.

<p>they innovate, test new programmes and work with highly invisibilised people and communities.</p>	<ul style="list-style-type: none"> Existing philanthropic funders of HIV must be continuously engaged to ensure they maintain investment in KPs and HIV rather than moving to new/emerging/competing areas.
<p>Partnerships with Business</p>	
<ul style="list-style-type: none"> Public Private Partnerships seem to be effective investments for HIV financing & quality & acceptability is high according to existing research available. There is a danger that conflict of interest plays a role in corrupting the PPP sector. Impact Investment is a largely untapped area for the HIV movement, whereas climate change, agri-business and gender (women only) impact investments exist, none are focussed on HIV or KPs. Impact investment needs to be closely monitored to ensure it is ethical, accountable and transparent. Workplace programmes need to do better on testing, treatment & prevention and keeping the workforce engaged especially as HIV fatigue sets in. Workplace programmes can dig deeper into topics and thereby engage with people living with HIV but also those who are not. They have an important role in both testing but also treatment support for people who need to stay on medications for life. Links to networks of PLHIV could be good first step. 	<ul style="list-style-type: none"> PPPs/II must be increasingly interrogated and promoted as excellent sources for financing and response to HIV. We recommend that research institutions begin to actively mentor and do research to ensure quality, acceptability and ethics are of the highest standard. Workplace programmes need to improve their contributions, not just doing testing and referrals but contributing to adherence, prevention and as many other aspects of the HIV response as possible. The transfer and financial institutions (banks) policies and practices need to be interrogated and improved. They need to be approached as potential sources of HIV funding under corporate social responsibility.
<p>African Philanthropists</p>	
<ul style="list-style-type: none"> High net worth individuals are an untapped resource for HIV financing and there is a problematic perception amongst philanthropists and funding partners that HIV is sufficiently funded, and this perception needs to change. The role of remittances to Africa from Africans in the diaspora needs to be better researched and understood in the context of financing for HIV, as a means to understand how this enormous source of funds impacts 	<ul style="list-style-type: none"> There is a need to do further research on remittances to better understand the differences between the African and other regions and what we can do to leverage both the remittances and to mechanisms being used to transmit them. A remittance transfer company should be created that manages remittances solely for Africans, that reduces costs for transfers, but the profits could also be channeled back into HIV.

<p>individuals, communities, development, health and HIV.</p>	<ul style="list-style-type: none"> • A group needs to be created that works to make a better case for HIV financing that is aimed at African Philanthropists specifically. • The underlying causes of the lower remittances from Africans compared to the other regions need to be researched and understood.
<p>Innovative Financing</p>	
<ul style="list-style-type: none"> • Innovative financing does not necessarily mean that the mechanisms themselves are innovative, but it can mean that using them to raise funds for HIV is innovative. • Not many innovative financing mechanisms are currently in use in the region and there are few plans to scale this area up. 	<ul style="list-style-type: none"> • The African Development Bank must bring together relevant stakeholders especially technocrats and watchdog civil society to address the issue of transfer of HIV funding in Africa and the uptake of innovative financing. • Country leaders, academic and economists need to invest in unpacking innovative financing options for African countries.
<p>Governments</p>	
<ul style="list-style-type: none"> • Out of pocket expenses are too high on the continent and are pushing families back into multi-generational poverty and pushing back development gains to date, especially as UHC rolls out. • Almost all African countries have very low tax collection rates as a percentage of GDP. This could be an effective, efficient and sustainable way of ensuring finances for health as well as other development. It is also a way of ensuring self-reliance percentages are increased. • Corruption is indeed a problem globally as bribes are often offered by the Northern countries, whilst also accepted in the South. It remains a significant barrier to development, HIV included. • Illicit financial flows pose a real threat to accurate taxation, and thus African countries raising sufficient funds to provide HIV, health and other services. A lack of transparency is the principle barrier. • Current spending by African governments on health and HIV are both low when compared 	<ul style="list-style-type: none"> • Governments must eliminate user fees to immediately improve access for PLHIV to ART, and ensure the most vulnerable have access to health. • Global monitoring of tax fraud, evasion and avoidance is exceptionally low, and the creation of a Global Tax Authority would ensure that the correct taxes are paid and paid to the correct country. • Better tax collection from companies and multinationals, foreign investors, the middle and upper classes need to be a priority. • Taxes and imports and VAT that target low income households should be avoided at all costs, as should VAT on basic foods and goods like bread and baby foods. • Corruption and illicit financial flows need to be a priority across all countries, and rule of law and transparency leading principles or leaders at all levels to apply for a shift in how Africa deals with health and especially HIV response. • More countries need to analyse their existing income, cost structures, governance cost and build earmarked in caps/ceilings that then

to global levels, and considering the levels of the epidemic in our countries.

- Youth, gay and lesbian people, trans and queer people, sex workers, people who use drugs and various other criminalised and morally policed communities are dramatically under-funded in the HIV response. Emerging epidemics in these clusters are not being managed with the necessary human rights approach and the oppressive responses are forcing people into hiding, and risking good management of the epidemic and the health of individuals.
- Tuberculosis and Malaria also continue to be underfunded and resourced. Co-infections of HIV, TB and Malaria have well-established epidemiological outcomes.
- The share of people on ART across the continent is simply unacceptably low! Coverage of anti-retroviral therapy for people living with HIV is exceptionally low across the continent but nowhere more so than in West and Central Africa. If treatment is prevention, then this needs to be prioritised in all countries as a means to ensure both lives saved and cost savings in the future.
- Most African countries are nowhere near achieving the 90-90-90 targets and some are even performing worse in the most recent data available. Where the levels are good, local activists should monitor consistency of provision too.
- Looking at the HIV outcome and epidemic transition data, it is relevant to note that there are well established response procedures for youth and KPs but that the data reveals a shockingly bad response to these groups. There is no legitimate reason for the current state of affairs except that governments continue to stigmatise and discriminate against these people. Governments have not yet moved to a place of enlightenment on these matters and they have not developed

demonstrate a real/tangible commitment to HIV and health.

- Key population groups need funding to be able to advocate for their inclusion in the HIV response.
- HIV co-infection with TB and malaria needs more attention, more funding and more education.
- EMTCT is a no brainer. All pregnant women should have access to ART during pregnancy and no baby should be exposed to HIV, ever.
- Countries should roll out their ART programmes as a priority, ensuring also that HIV disclosure is done in a confidential and respectful way, adhering to WHO guidelines.
- Data collection on progress, whether policy, programming, implementation and impact needs to be scaled up as a matter of urgency. Data needs to be of a higher quality, disaggregated, cover rural areas, and key populations need to be included so that empirically led decision can be made.
- The 90-90-90 targets need to be supported at the highest political level in each country, this includes public support for non-discrimination of those who are typically discriminated against.
- African health economists and academics need to play a larger role in HIV financing modelling, and developing useful national, regional and continental research and recommendations on these issues.
- A human rights based approach to the HIV response is urgently required if the emerging and current HIV crisis is going to be managed well.
- Stigma and discrimination remain large barriers to PLHIV accessing ART and need to be addressed through HCW training and community awareness. Decriminalisation is a vital first step.
- Youth need to be prioritized for knowledge and prevention interventions.

human rights-based responses that focus on the dignity of all people.

- Key populations and those that are morally policed and legally criminalised such as gay and lesbian people, trans gender and queer people, drug users, sex workers and prisoners are being blatantly ignored in the HIV response. Data for these groups is not being captured and criminalisation hinders their participation in the HIV response as well as daily life in other ways.
- Young people are being neglected in the HIV response and knowledge amongst them on HIV transmission, and prevention remains incredibly low. Structural drivers play a decisive role in youth accessing prevention education, knowledge, testing, treatment, care and support. These must be urgently addressed.
- Coverage of pregnant women who receive ART for vertical transmission is scandalously low across the entire continent. In 2019 not a single baby should be exposed to HIV, the science is simple, the treatment available and the patient the most willing to adhere.
- Many models exist that aim to determine what the cost to end epidemic is. What they all have in common is that upfront investment and prevention of new infections is a wise investment.
- Health expenditure is not enough of a government priority and not enough efforts are being made to increase funds for HIV and health generally.
- Out of pocket expenses are dramatically high in many of our countries and stand to undermine development gains in other areas as it pushes families back into generations of poverty. As countries are transitioned out of PEPFAR and Global Fund grants there is a real risk that the cost of health falls even more on individuals than on governments and this threatens to push African back a decade.

- Young people, pregnant women and key populations need to be at the centre of the response. Well established responses exist for these groups which need to be rolled up, scaled up and implemented to ensure not only that individuals human rights are respected but also that cost efficiencies are realized.
- Governments need to place a higher value on responding to HIV and not be ambivalent about the need to invest for future cost savings.
- Structural drivers need to be addressed, nutrition, housing, water, sanitation, education, employment, stigma and discrimination, and entrepreneurship, these responsibilities lie firmly on the shoulders of government and the duty bearers. Young people especially need to have an enabling environment.
- Stockouts must be treated as emergencies and addressed as a top priority. Community based monitoring is a vital tool in this issue and funding partners should scale up community engagement on this issue and all other aspects of service delivery at health care point.
- Journalists need to engage with government investment in HIV and sue their platforms to demand transparency, data, and public positions.
- Out of pocket expenses must be well understood as the enemy of development, and their impact on entire families needs to be made more broadly broadcast so that activists do not inadvertently advocate for them, (as sometimes happens, hoping to ensure user responsibility).
- TRIPs needs to be used to its maximum, countries need to begin to manufacture their own pharmaceuticals or do collective bargaining for imports and leaders need to understand that research shows that infringement of intellectual property rights

<ul style="list-style-type: none"> • There is a lack of transparency around budget allocation and expenditure, as well as a lack of engagement of civil society in watchdogging budgets and expenditures, both of government budget as well as Global Fund and PEPFAR funds. • TRIPs flexibilities are not being used to their maximum by African leaders. There is a shortage of local manufacturing, collective bargaining and using TRIPs flexibilities generally. • Africa is contributing more to clinical trials than many realise. We should applaud ourselves for the investment that is being made in this area and ensure that where investments are made they are worthwhile, when considered against other competing priorities. 	<p>neither reduces foreign direct investment, nor innovation.</p> <ul style="list-style-type: none"> • The model proposed on clinical trials needs to be further debated and engaged with to ensure countries are accurately measuring their investments and prioritizing the limited resources for HIV.
<p>Civil Society and CCMs</p>	
<ul style="list-style-type: none"> • Country Coordinating Mechanisms do not have enough meaningful representation of the experts that know best what the HIV responses needs: key populations and marginalised communities. Without the engagement of communities that are infected and affected and those that are criminalised and morally policed the decisions made to address HIV will always be inherently flawed and lacking. • An examination of funding of CCMs and EPA performance shows that more funds does not necessarily make for a better performing CCM. Funds for CCMs should be well managed so as not to waste resources. • The depoliticisation of many former watchdog PLHIV civil society organisations due to grants being run through national governments has had a detrimental effect on accountability, watchdogging, transparency and the HIV response. 	<ul style="list-style-type: none"> • Civil society representation on CCMs needs to be more closely monitored and be more inclusive of those living with the diseases but also those who are criminalised or morally policed. Without the active and meaningful participation of these groups the HIV epidemic response will always be faulted and thus ineffective. • It is vital that broader human rights, watchdog and monitoring work needs to be funded, and that siloes need to be less important, even as speciality is important, many barriers to access straddle many diseases, and a broader human rights approach is vital to ensure access for all and that watchdogging is done to ensure accountability. • The recent commitment to 15% of CCM budgets to be spent on community engagement needs to be monitored and CCMs held accountable when it is not administered correctly.

Environment: Transparency and Democracy	
<ul style="list-style-type: none"> • When examining the response to HIV and what is required to end the epidemic and support those most affected, at risk and vulnerable, it is vital to understand how free and enabled civil society is to work on not only HIV, but issues of human rights, access for criminalized communities and those who are stigmatized and discriminated against. Africa as a whole needs to improve in terms of open space where civic space is safeguarded by the state. • African countries are demonstrating a lack of commitment to adhering to human rights commitments as they fail to both report on their human rights performance but also failing to ratify various human rights treaties. • African countries demonstrate a lack of freedom, personal, economic and human in most countries, which will hinder the response to HIV and broader health and development generally, thereby affecting the ability to raise funds and to implement successfully. 	<ul style="list-style-type: none"> • Broader human rights, democracy and civil rights work needs to be prioritized to ensure activists, community and duty bearers are all able to play a role in ensuring accountability, not just on HIV, but on health, education, water, sanitation, road safety, housing, environment and a myriad of other issues. • Civil society needs to do more watchdog work on holding governments accountable on ratifying and then reporting on human rights commitments. No more the photo opportunity when signing the commitment, we want delivery on these commitments, and shadow reports must be used when necessary. • All stakeholders, including duty-bearers must come out in support for space and freedoms for civil society to speak, meet, protest and act in defense of human rights.

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