

Sustainability of Global HIV Programs and the Transition to Greater Country Ownership:

Case Studies in Six Countries



Jamaica



Nigeria



South Africa



Ukraine



Vietnam



Zambia

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The Foundation for AIDS Research

amfAR
MAKING AIDS HISTORY

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INTRODUCTION

Since 2000, historic gains have been made in the global fight against HIV. From 2000 to 2014, the annual number of new HIV infections globally declined by 35%, including a remarkable 58% decrease in new infections among children.¹ Since the peak in AIDS-related mortality in 2004, AIDS-related deaths worldwide have fallen by 42%.¹

These gains have generated global optimism regarding the potential to end the AIDS epidemic as a public health threat within the next generation. By achieving bold new targets for HIV treatment, prevention, and non-discrimination by 2020, UNAIDS projects that the number of new HIV infections and AIDS-related deaths globally in 2030 will be 89% and 81% lower than in 2010, respectively.²

Ending the AIDS epidemic, however, will only occur if a robust response to HIV is sustained over time. Indeed, scientific modeling indicates that a failure to build on current coverage levels will, by 2030, erase all the gains made to date and produce a global epidemic that is much larger and rapidly increasing.²

International HIV assistance has played a pivotal role in global successes in the fight against HIV, committing an unprecedented \$84 billion toward HIV treatment, prevention, and support programs from 2002 to 2014.¹ Two key donors—the United States government, primarily through the President’s Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—have been central to the global HIV fight, accounting for 64% of all international HIV assistance from 2000 to 2015.¹

However, financing for HIV programs in low- and middle-income countries is currently undergoing a major transformation. International HIV assistance, the bedrock of the global response a decade ago, has stagnated³ and been overtaken by domestic sources as the largest provider of HIV financing.¹

Key Findings

International HIV assistance has largely driven historic gains in the fight against AIDS. In 2002–2014, international donors, led by the U.S., provided \$84 billion to support HIV programs in low- and middle-income countries.

Many countries facing cuts in international support may be unable to sustain their HIV response. Countries confront considerable barriers in rapidly assuming and administering the role long occupied by donors. Obstacles to effective country responses include insufficient health infrastructure, severe shortages of health workers, weak systems for procurement and supply management, and uncertain access to affordable medicines.

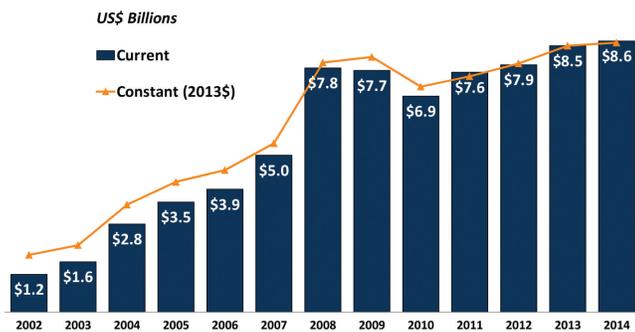
Transitions that are too abrupt risk causing substantial dislocation and interruption of services. In South Africa, it is estimated that up to 200,000 people dropped out of HIV treatment due to dislocations associated with the U.S. government’s withdrawal of direct financial support as part of the transition to country ownership. Before any transition to country ownership is launched in a country, a compact should be in place that clearly defines the roles and responsibilities of all partners, and outlines a reasonable timeline to ensure that countries are actually prepared for the handover when it occurs.

HIV responses for key populations are at acute risk in the transition to country ownership. International donors overwhelmingly finance the comparatively few HIV prevention and treatment programs designed to reach marginalized populations at highest risk for HIV. In a review of six countries, little evidence was found to suggest that national governments would assume the role of supporting evidence-based programs for these groups. Indeed, in some countries, stigma is so pervasive that official government policy is that such groups do not even exist within their countries. PEPFAR and the Global Fund should commit to monitor key population programming in the transition to country ownership and to continue funding for essential programs when national governments fail to do so.

Decisions regarding the future of the global HIV response should be determined by what is best for the people most affected by the epidemic. While it is reasonable to expect that countries with greater wealth cover a larger share of their own HIV response, the tragic reality is that many countries are unwilling or unprepared to allocate meaningful domestic resources for evidence- and rights-based programs needed by key populations. Where countries cannot be counted on to address the needs of these groups, international donors should commit to fund these essential, lifesaving programs for the most vulnerable populations.

After focusing for years on galvanizing rapid scale-up of essential HIV services in resource-limited settings, international donors are increasingly prioritizing “sustainability” in their assistance to countries. The shorthand term for this process is “country ownership,” which aims to shift from a donor-led development process to one in which country-level stakeholders are “in the driver’s seat” with respect to financing and steer their own national response. Thus, county ownership envisions a national response that is largely financed with domestic resources and guided by country-level stakeholders.

Figure 1: International HIV Assistance from Donor Governments: Disbursements, 2002-2014



Source: Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2014. UNAIDS and The Kaiser Family Foundation; 2014.

Although country ownership is a stated goal for all countries, most of the transition to greater country ownership is occurring in middle-income countries, where self-financing is perceived as a more realistic aspiration in the short term. For international donors generally, assistance to middle-income countries is on the decline, as donors increasingly reserve financial support for low-income countries and for high-burden lower-middle-income (LMI) countries.⁴ Since 2001, the number of countries classified by the World Bank as low-income has fallen by almost half.⁵ As a result, several countries that not long ago were prioritized for international health and development assistance are increasingly experiencing diminished access to external support.

Reduced access to external financing, especially if not carefully planned, has the potential to create disruption and instability in essential health programs that have traditionally been financed internationally. Indeed, one study found that 50,000 to 200,000 people enrolled in HIV treatment in South Africa discontinued care as a result of dislocations associated with PEPFAR’s transition to country ownership.⁶ The risk of such disruption has prompted leading global health and development experts to recommend that international donors and recipient countries enter into compacts to guide the process of transition to greater country ownership.⁷

Risks in the transition to country ownership are especially acute for key populations such as men who have sex with men (MSM), people who inject drugs (PWID), sex workers, and transgender individuals. When their sexual partners are taken into account, MSM, PWID, sex workers, transgender individuals, and prisoners account for an estimated 40–50% of new HIV infections worldwide.⁸ Across the globe, key populations have HIV risks that are several orders of magnitude greater than the general population.⁹ Key populations face formidable barriers to accessing HIV services, and the inadequate services currently available for them are overwhelmingly financed by international donors.^{1, 10} Although their HIV risk and vulnerability are global in scope, most members of key populations live in the middle-income countries that are experiencing notable reductions in their capacity to mobilize external financing for HIV programs.¹¹ Comparatively few middle-income countries have demonstrated robust domestic support for evidence- and rights-based HIV responses for key populations—a main reason why international assistance has played such a pivotal role in facilitating some degree of service access among marginalized groups.¹¹ Thus, a transition to greater country ownership may jeopardize the very limited access to essential services that many marginalized groups currently have.

How country ownership is defined and understood may also have profound implications for the planning, implementation, and monitoring of national responses. Holistically defined, country ownership envisions robust participation and ownership by all key stakeholders, including civil society. Many international donors, including the Global Fund, have developed procedures to promote meaningful civil society participation in national HIV decision-making. However, a more truncated understanding of country ownership would look primarily to national governments as the custodians of national ownership, potentially undermining the ability of civil society to play its essential role in helping shape and influence national responses.

With the aim of shedding light on the potential ramifications of the shift to country ownership, amfAR, The Foundation for AIDS Research, with support from the M•A•C AIDS Fund, engaged community-based, in-country researchers in Jamaica, Nigeria, South Africa, Ukraine, Vietnam, and Zambia to document case studies. In each country, researchers gathered data from publicly available sources and interviewed key informants, including government officials, representatives of international donors, United Nations officials, and representatives of civil society. Each case study assessed the status of the transition to country ownership, analyzed the scale-up of key HIV interventions (e.g., antiretroviral therapy [ART], prevention of mother-to-child HIV

transmission [PMTCT], and voluntary medical male circumcision [VMMC]), and specifically documented service coverage for key populations as well as the extent and nature of civil society involvement in the national response.[†]

After a brief discussion of PEPFAR's and the Global Fund's approaches to country ownership, this report summarizes these country case studies. The report closes with recommendations to ensure continued scale-up, stability of services, and equitable service access for key populations in the midst of this historic shift in the approach to HIV financing.

PEPFAR AND COUNTRY OWNERSHIP

PEPFAR has traditionally focused its assistance on building and operating parallel healthcare systems in the countries it supports. Increasingly, PEPFAR is prioritizing “sustainability” in its HIV assistance to countries. Transitioning PEPFAR assistance toward greater country ownership requires enhancing the capacity of national health systems and transferring operation of successful treatment and prevention programs.

Recognizing that the diversity of PEPFAR countries precludes a one-size-fits-all approach, PEPFAR assigns countries based on four categories of U.S. engagement and investment:

- **Long-Term Strategy (LTS)** countries that will need support for the foreseeable future;
- **Targeted Assistance (TA)** countries that receive specific support—including for direct services—for key populations (in concentrated epidemics) and/or priority technical areas, often intended to complement Global Fund financing to ensure that “the human rights of key populations are upheld by responsive players in civil society, government, and the private sector;”
- **Co-Finance** countries, a subset of LTS and TA countries with growing gross national incomes that are increasingly capable of funding their HIV response; and
- **Technical Collaboration (TC)** countries, which reflect what PEPFAR regards as the ideal end state: a sustained U.S. partnership in a genuinely country-owned response.

In support of its country ownership agenda, PEPFAR launched a new framework called Country Health Partnerships (CHPs) in 2013, beginning with South Africa, Namibia, and Rwanda. CHPs aim to guide and support a transition toward formal country involvement in decision-making in the allocation of PEPFAR financing and technical resources through a small bilateral governance structure. In further support of increased country ownership, PEPFAR country teams, in collaboration with national governments, implementation partners, and a fully representative set of stakeholders, were required in FY2014 to develop sustainability plans that outline a five-year vision for fostering a country-owned and led HIV response, and ultimately, for transferring successful PEPFAR activities to host country government and nongovernmental institutions.¹² PEPFAR country teams are now required to document the nature and degree of civil society involvement in the Country Operational Plan (COP) planning process, and a monitoring system now measures the degree to which PEPFAR activities in specific countries promote long-term sustainability of the national HIV response. Reports suggest that the experience in implementing this more participatory approach to COP development varied widely among PEPFAR countries.

THE GLOBAL FUND AND COUNTRY OWNERSHIP

A commitment to country ownership is among the Global Fund's three core principles. The historic approach of the Global Fund, whereby countries themselves submit proposals designed to meet their national needs, reflects an effort to move away from more donor-driven approaches toward greater country ownership. In the development of country proposals, the Global Fund requires countries to convene Country Coordinating Mechanisms (CCMs) that are broadly representative of key stakeholders, including nongovernmental actors.

In 2013, the Global Fund launched its New Funding Model (NFM), which represented a major revision of its approach to funding. The NFM provides for a more iterative approach in which country “concept notes” face somewhat more rigorous assessment, with the aim of ensuring that Global Fund grants focus on the populations in greatest need and on the interventions likely to have the greatest health impact. The NFM requires CCMs to convene an ongoing “country dialogue” that results in a concept note describing the country context, proposed response, available funding, programmatic gaps, and proposed implementation schemes. The question of whether

[†] In selecting countries for the case studies, amfAR took into account geographic diversity, funder interest, and characteristics of local HIV epidemics. In each country, amfAR solicited referrals for a community-based consultant to serve as an in-country researcher. Based on a general research template developed by amfAR, consultants conducted preliminary literature reviews to understand local HIV epidemiology, the current state of transition to country ownership, HIV financing (national, bilateral, multilateral), scale-up of core HIV interventions, the social and political context surrounding key populations and the availability of services targeted to meet their needs, and mechanisms to secure civil society participation in national HIV program planning, implementation, monitoring, and evaluation. Using an interview template with open-ended questions, consultants then interviewed an array of key informants, including government officials responsible for HIV programming, implementers supported by PEPFAR and the Global Fund, PEPFAR country staff, UNAIDS country staff, programs targeting key populations, civil society representatives, representatives of key populations, and people living with HIV. In-country consultants drafted reports that synthesized their findings, using a report template supplied by amfAR, and provided recommendations to ensure the sustainability and continued scale-up of core HIV interventions, particularly for key populations.

the NFM will ensure that key populations are adequately represented in CCMs and in the country dialogue process, and whether the Global Fund will intervene if they are not, remains an important matter of debate, although early reports indicate that the Global Fund is challenging countries that fail to prioritize key populations.

The NFM more explicitly allocates funding based on a country's overall disease burden and "ability to pay," as determined by World Bank income-level classification (Figure 2). Under the NFM, upper-middle-income (UMI) countries are ineligible for Global Fund assistance if they have low or moderate disease burden, and upper-middle-income countries that are members of the G-20 group cannot receive Global Fund support unless they have extreme disease burden (Figure 2).¹³

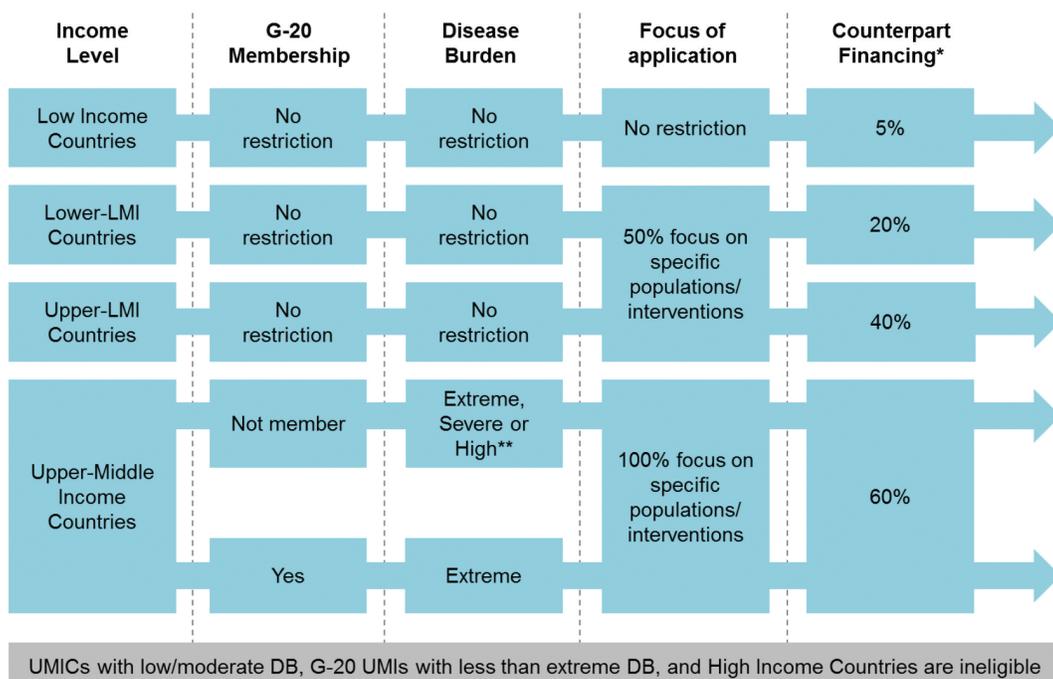
Although low-income countries and lower-middle-income (LMI) countries remain eligible for Global Fund support regardless of their disease burden, they, like UMIs, must now meet counterpart financing requirements. Low-income countries must fund at least 5% of their national program for the disease for which financing is sought, while the counterpart threshold for lower-middle-income countries is 20%.¹³ In its grant programs, the Global

Country	PEPFAR Classification	Global Fund HIV Disease Burden and Income Classification**	
Jamaica	TA	High Burden	Upper-Middle-Income
Nigeria	LTS (Co-Finance)	High Burden	Upper-Lower-Middle Income
South Africa	TA (Co-Finance)	Extreme Burden	Upper-Middle-Income
Ukraine	TA	High Burden	Upper-Lower-Middle Income
Vietnam	TA (Co-Finance)	High Burden	Lower-Lower-Middle Income
Zambia	LTS	Extreme Burden	Lower-Lower-Middle Income*

*Recently transitioned to middle-income status.
 **While income classifications are based on the World Bank Atlas Method Income Classifications, the Global Fund subdivides lower-middle-income countries into lower-lower-middle-income and upper-lower-middle-income. Classifications reflect the 2015 Global Fund Eligibility List (<http://www.theglobalfund.org/en/fundingmodel/process/eligibility/>).

Fund also requires that government contributions increase each year of the grant, and withholds 15% of a country's pre-determined allocation until the country demonstrates its willingness to make additional investments in its disease-specific programs.¹⁴

Figure 2: Global Fund Eligibility Criteria and Required Application Focus



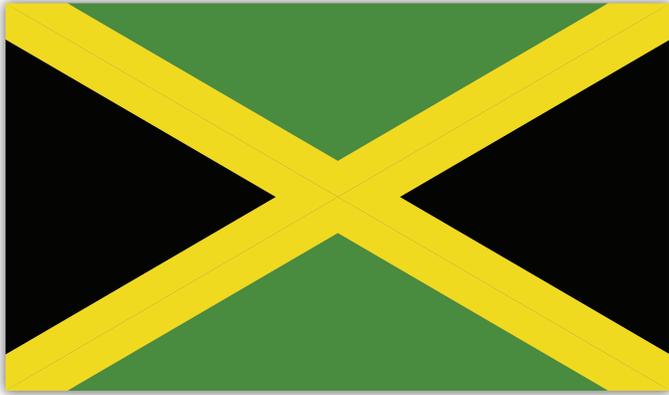
Early signs indicate that the Global Fund's counterpart financing requirements are having the desired effect of galvanizing increased national investments in HIV and other health programs. Domestic investment commitments in health programs in countries receiving Global Fund grants are 52% higher in 2015–2017 than in 2012–2014. In a survey of participants in the country dialogue and concept note development phases during the first five funding windows under the NFM, 82% said the Global Fund's increased emphasis on counterpart financing had catalyzed greater domestic investments.

*Minimum threshold: this is the minimum government contribution to the national disease program, as a share of the total government and Global Fund financing for that disease.

**Small Island Economies are eligible if they have a low or moderate disease burden.

Source: The Global Fund Eligibility and Counterpart Financing Policy. The Global Fund; 2013.

JAMAICA



Next to Haiti, Jamaica has the highest HIV prevalence in the Caribbean.¹ New HIV infections in Jamaica declined by 25% over the last decade, but considerable transmission occurs, with MSM and their female partners contributing 39% of all new HIV infections (the largest single share).¹⁵

PEPFAR and the Global Fund have played critical roles in Jamaica's HIV response, and the country's transition to upper-middle-income status has prompted grave concern among national stakeholders regarding the sustainability of the national response. The most recent loan agreement from the International Monetary Fund (IMF) froze public sector wages and capped spending, constraining the country's capacity to allocate new public sector spending for HIV.¹⁶ Despite economic and fiscal difficulties, the Ministry of Health reported in April 2014 that the domestic public sector share of national HIV funding rose in recent years from 20% to approximately 46%.¹⁷

As part of Jamaica's evaluation of the sustainability of its HIV response, the Planning Institute of Jamaica predicts that HIV program costs will increase by 37% over the next decade—from \$20.4 million in 2010/11 (0.14% of GDP) to \$28 million by 2020—due to increasing numbers of persons eligible for first- and second-line drug treatment.^{18, 19} In support of its pledge to scale up domestic financing for HIV and to meet counterpart financing requirements of the Global Fund, the national

Basic Facts

- Population: 2.8 million¹
- Life expectancy: 73.5 years²
- Income level: Upper-middle-income³
- Economic situation: High debt (debt to GDP: 140%), projected 1.9% GDP growth in 2015/2016³

HIV Epidemiology

- HIV prevalence (15–49 years): 1.6% (2015), down from 2.4% (2000)⁴
- Number of people living with HIV in 2014: 29,000 (62% male among adult cases)⁴
- New HIV infections in 2014: 1,500⁴
- HIV prevalence among sex workers in 2011: 4.1%⁵
- HIV prevalence among MSM in 2011: 32.8%⁵
- HIV prevalence among PWID in 2011: 8.2%⁵

HIV Coverage

- Coverage for PMTCT: 86%⁴
- Coverage for ART (adults): 30%⁴
- Coverage for VMMC: Not applicable (not a WHO priority country for VMMC)

PEPFAR

- PEPFAR category: TA (Part of the Caribbean regional planning process)
- PEPFAR funding COP 2014: Not available*
- PEPFAR funding trends: Not available*

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (high-burden UMI country)
- Total signed Global Fund HIV support: \$70,105,688⁶
- Total HIV disbursements (2010–2013): \$32,177,824⁷
- Total HIV allocation (2014–2017): \$19,133,368⁷
- Change in funding 2010–2013 vs. 2014–2017: -40.5%⁷

1 World Population Review. Jamaica Population 2015. Accessed: September 10, 2015.

2 Central Intelligence Agency. The World Factbook. Accessed: September 10, 2015.

3 The World Bank. Jamaica. Accessed: September 10, 2015.

4 UNAIDS. AIDSinfo Database. Accessed: September 10, 2015.

5 GARPR. Jamaica Country Progress Report 2014. Accessed: September 10, 2015.

6 The Global Fund. Jamaica. Accessed: September 10, 2015.

7 Aidsplan. Aidsplan Portal Workbench. Accessed September 10, 2015.

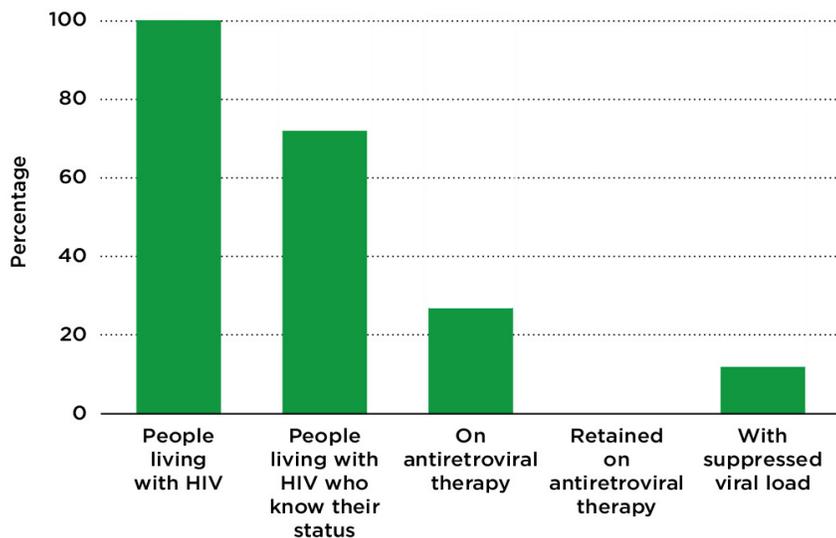
* PEPFAR has not publicly released disaggregated funding for individual countries that are funded through regional operational planning processes.

government placed \$5.06 million in the 2014/15 budget for HIV. The government has also reportedly made plans to merge the family planning and HIV units of the Ministry of Health, a move that is expected to save \$700,000 and reduce administrative overhead of the HIV budget.²⁰

Prospects for Future Scaling Up of Essential HIV Interventions

National stakeholders expressed skepticism that the country could lay the foundation to end its HIV epidemic without considerable international assistance in future years. An important reason for such doubts stems from the country's very low coverage of ART. Jamaica has committed to cover the costs of 80% of its national HIV treatment program with domestic funds, but the magnitude of the treatment gap is substantial

Figure 3: HIV Continuum of Care and Treatment Cascade for Jamaica, 2012–2013



Source: Based on Antiretroviral Treatment in the Spotlight: A Public Health Analysis in Latin America and the Caribbean. Key messages. Pan American Health Organization; 2014.

and the constraints on the national budget are considerable as a result of the IMF loan agreement.¹⁷

Jamaica has yet to adopt the WHO's 2013 recommendation to initiate ART among all patients whose CD4 count falls below 500 cells/mm³ (retaining the outdated, prior threshold for treatment initiation of 350 cells/mm³).²¹ With WHO releasing new guidelines in October 2015 that recommend treatment initiation for all people living with HIV, regardless of CD4 count, resource needs for HIV treatment services in Jamaica will only further escalate.

Treatment outcomes will also need to improve if the country is to achieve the 90-90-90 treatment target, which it has committed to do by 2020. As Figure 3 indicates, Jamaica has had some success in promoting knowledge of HIV status, but the country's very low treatment coverage means that only about one in 10 people living with HIV has suppressed viral load.¹

Jamaica has taken some steps to strengthen its national treatment program. The country has committed to strengthening its forecasting system for antiretroviral medicines,²⁰ and in 2013, the country integrated 23 HIV treatment sites into the primary care system.¹⁵

While Jamaica has pledged to the Global Fund that it will assume a greater share of financing ART, it has made no such pledge with respect to HIV prevention services for key populations or for funding for civil society organizations' operations.²² The lack of a clearly articulated government commitment to continue and scale up these efforts potentially imperils critical elements of the national HIV response.

Jamaica's comparatively low commitment to health services is cause for concern with respect to the country's capacity to follow through on its pledge to assume a greater share of financing the HIV response. In a Global Fund-commissioned review of 12 countries that have either completed the transition to country ownership or are likely to transition in the near future, Jamaica had among the lowest percentage of health expenditures as a share of GDP—about 5% in 2009.²³ Likewise, the public sector in Jamaica is responsible for a comparatively low share of total health spending—slightly more than half in 2009.²³

Future Response for Key Populations

With Jamaica's epidemic largely driven by transmission among key populations, scale-up of evidence- and rights-based programs for these groups is essential to realizing hopes for ending the country's epidemic. A majority of MSM and sex workers surveyed in Jamaica—68% and 59%, respectively, in 2011—reported accessing HIV testing in the previous 12 months, while condom use at last sex is higher than the national target for MSM but lower than the target for sex workers.¹⁵ Coverage for HIV prevention and treatment services for PWID is

unknown, with available services provided by the National Council on Drug Abuse (NCDA) through a Global Fund-funded program called “Tek it to Dem” [Take it to Them].²⁴

Widespread stigma and discrimination prevent many members of key populations from having meaningful access to essential services, in part due to the hostility they often experience from healthcare workers.²⁴ For example, laws that criminalize homosexual behavior (e.g., the Buggery Law and the Gross Indecency Act), as well as pervasive and entrenched homophobia, drive MSM away from prevention, testing, and treatment services.²⁵ In response to the structural barriers to accessing mainstream health services, MSM-friendly clinics exist, but their accessibility is severely limited. Sex work is also criminalized in Jamaica, which serves as a barrier to accessing HIV services and results in financial extortion by police and incarceration.²⁵

As recently as 2010–2011, Jamaica allocated only 1.4% of all HIV spending to programs for MSM and sex workers,²⁰ allowing international donors to underwrite these programs. Jamaica has pledged to increase the proportion of resources devoted to HIV programming for key populations,²⁰ with Jamaica’s National Strategic Plan for 2012–2017 prioritizing key population interventions. The government has proposed amendments to the Public Health Law and relevant ministerial policies to remove discriminatory laws and policies that impede service access and utilization for key populations.

However, interviews with key informants in Jamaica showed little optimism that Jamaica will make good on these pledges. An analysis by the Global Fund concluded that the Jamaican government would be unlikely to assume the costs of HIV interventions for key populations,²² a concern that was echoed by key informants. They fear that a withdrawal of international financing in the interests of country ownership could lead to wholesale defunding of the few initiatives that currently exist to meet the HIV-related needs of key populations.

“...the Global Fund concluded that the Jamaican government would be unlikely to assume the costs of HIV interventions for key populations...”

Civil Society Engagement and Country Ownership

Civil society has contributed to national strategic planning, participated on the Global Fund CCM (including helping develop funding proposals), effectively advocated for greater political commitment to the AIDS response, and provided input to PEPFAR work plans. As international donors are overwhelmingly responsible for financing the many nongovernmental organizations that serve key populations, key informants expressed concern that the transition to country ownership could cause funding for civil society groups to evaporate.

NIGERIA



As Nigeria has the largest population in sub-Saharan Africa and the second largest number of people living with HIV (3.4 million), the future of the epidemic in the country will have an outside effect on the future of the epidemic regionally and worldwide.

Given its middle-income status and considerable national resources, Nigeria has long anticipated a transition toward greater country ownership of the HIV response. The need for increased domestic financing was the theme of the Fifth National Conference on HIV/AIDS in 2010 and the impetus for the development of the Presidential Comprehensive Response Plan, launched during the Abuja +12 summit in 2013, which has served as an advocacy tool for increased state funding of the HIV response.

In part, the discourse on country ownership of the HIV response has been informed by a national investment analysis, which found that shifting HIV spending toward high-burden areas and scaling up programs for key populations would reduce new infections by 24% over two years (preventing 105,000 people from acquiring HIV).²⁰ Although the country has taken some steps to improve the efficiency of the national response—for example, by pledging to reduce the proportion of administrative costs among total HIV spending by 23%²⁰—key informants from both the national HIV program and civil society report that no national transition plan to guide the shift to greater country ownership yet exists.

Key informants expressed grave concerns about the future of the Nigerian HIV response in an era of greater country ownership. “It

Basic Facts

- Population: 178.5 million¹
- Life expectancy: 54 years²
- Income level: Lower-middle-income³
- Economic situation: Robust economic growth (7% annually over the last decade) has moderated somewhat (5% growth in 2015); economy is heavily dependent on oil exports; uncertainty created by country’s security situation.⁴

HIV Epidemiology

- HIV prevalence (15–49 years): 3.2% (2014), down from 3.5% (2000)⁵
- Number of people living with HIV in 2014: 3.4 million (57% female among adult cases)⁵
- New HIV infections in 2014: 230,000⁵
- HIV prevalence among sex workers in 2010: 24.5%⁶
- HIV prevalence among MSM in 2010: 17.2%⁶
- HIV prevalence among PWID in 2010: 4.2%⁶

HIV Coverage

- Coverage for PMTCT: 29%⁵
- Coverage for ART (adults): 22%⁵
- Coverage for VMMC: Not applicable (not a WHO priority country for VMMC)

PEPFAR

- PEPFAR category: LTS (Co-Finance)
- PEPFAR planned funding in COP 2014: \$458,614,281
- PEPFAR expenditure FY2014: \$409,652,659

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (high-burden upper-LMI country)
- Total signed Global Fund HIV support: \$658,029,884⁷
- Total HIV disbursements (2010–2013): \$292,385,048⁸
- Total HIV allocation (2014–2017): \$477,385,351⁸
- Change in funding 2010–2013 vs. 2014–2017: +63.3%⁸

1 World Population Review. Nigeria Population 2015. Accessed: September 10, 2015.

2 WHO. Nigeria. Accessed: September 10, 2015.

3 The World Bank. Nigeria. Accessed: September 10, 2015.

4 African Economic Outlook. Nigeria. Accessed: September 10, 2015.

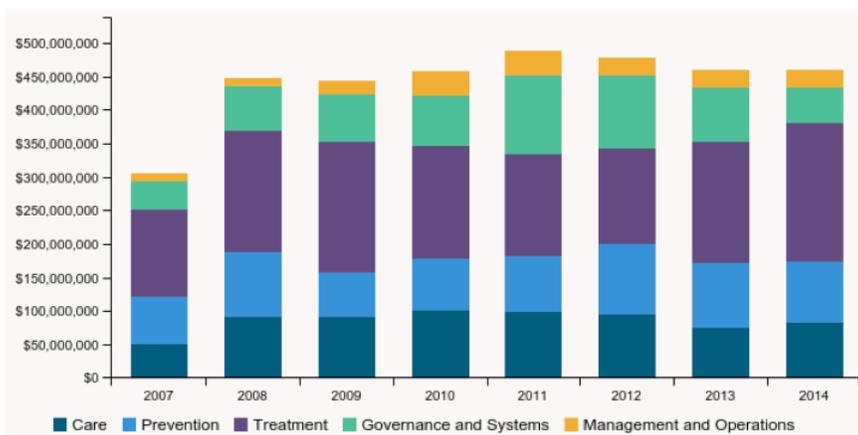
5 UNAIDS. AIDSinfo Database. Accessed: September 10, 2015.

6 GARPR. Nigeria Country Progress Report 2014. Accessed: September 10, 2015.

7 The Global Fund. Nigeria. Accessed: September 10, 2015.

8 Aidsplan. Aidsplan Portal Workbench. Accessed: September 10, 2015

PEPFAR COP Funding for Nigeria (COP Years 2007–2014)



Source: amfar COPS Database. Available at copsdata.amfar.org.

appears that most players think of the transition as punitive and an approach by the U.S. government to take us to an all-time high, then leave us alone to face the consequences,” said one PEPFAR-funded program implementer.

Prospects for Future Scaling Up of Essential HIV Interventions

Among high-burden countries globally, HIV outcomes in Nigeria are among the worst. Given the country’s overwhelming dependence to date on international financing for its HIV response,²¹ the likelihood of future declines in international HIV assistance potentially bodes ill for scale-up of essential HIV interventions.

“...the likelihood of future declines in international HIV assistance potentially bodes ill for scale-up of essential HIV interventions.”

The percentage of people living with HIV in Nigeria who received ART in 2014 (22%) is only about half the average for sub-Saharan Africa overall (43%). As of 2012, only 516 health facilities (2%) provided ART.²⁶ Nigeria has also lagged in aligning national HIV treatment policies with scientific evidence, still limiting ART to people with less than 350 CD4 cells/mm³ even as the world transitions toward a test-and-treat approach as a result of clear clinical trial results.²¹ One important reason for the slow uptake of HIV treatment in Nigeria is the frequency of stock-

outs for HIV test kits; according to one HIV program implementer, “in reality, access to HIV test kits is almost becoming a luxury.”

The country has taken some steps to increase treatment access. More than 300 new sites were established in 2013,²⁶ and the number of people receiving ART increased from 592,084 in 2013⁹ to 703,358 in 2014.¹ Antiretroviral refill services have also been established in a limited number of primary care centers.²⁷

Even as several countries in sub-Saharan Africa appear to be progressing rapidly toward the elimination of mother-to-child transmission, only 29% of pregnant women living with HIV received antiretroviral medicines in 2014.¹ Not only is PMTCT coverage in Nigeria less than

half the average in sub-Saharan Africa as a whole (76% in 2014), but coverage barely increased from 2013 to 2014 (27% to 29%).⁹ Although the number of children newly infected with HIV is steadily falling across sub-Saharan Africa as a whole, 58,000 children in Nigeria acquired HIV in 2014—a number that is effectively unchanged from 2000, when 59,000 children were newly infected.¹

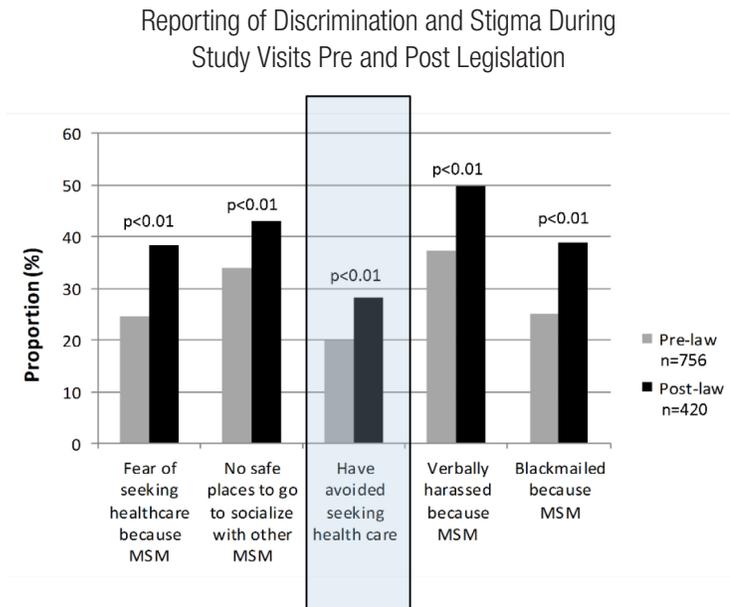
Future Response for Key Populations

Though MSM, PWID, and sex workers account for 3.4% of Nigeria’s population, they represent 40% of all new HIV infections.^{28, 29} Despite the vastly disproportionate HIV burden experienced by these groups, the national government has allocated minimal financing toward HIV programming focused on key populations—around 0.1% of all HIV funding in 2007–2010 but reportedly rising to 3.4% in 2012.³⁰ The few programs aiming to address the HIV-related needs of key populations are almost entirely financed by international sources.^{31–34}

Due to acute stigma and discrimination, including hostile attitudes of many healthcare workers, mainstream health services currently have very limited capacity to address the HIV-related needs of key populations. Sex work is criminalized in both northern and southern Nigeria,³⁵ and in 2013 the Federal Capital Territory Administration launched a “total war” against sex work, with “zero tolerance for prostitution,” leading to indiscriminate arrests and torture of sex workers, including abductions, extortion, physical violence, and rape.[‡] Nigeria also criminalizes drug use, with persons convicted of drug offenses subject to imprisonment for up to 25 years, deterring individuals who use drugs from seeking services in public sector settings.

[‡] See International Centre for Investigative Reporting: The new face of prostitution in Abuja (www.icirnigeria.org/the-new-face-of-prostitution-in-abuja). There are multiple reports of the harassment and abuse female sex workers face at the hands of law enforcement agents, whether they are brothel-based (www.plri.org/resource/sexual-abuse-brothel-based-female-sex-workers-abuja-nigeria) or non-brothel-based (www.dailytrust.com.ng/index.php/new-news/11661-abuja-streets-still-not-safe-for-ladies-at-night).

Figure 4: Outcomes of Criminalization on HIV Risks Among MSM in Nigeria



Cumulative Lifetime Experiences of Reported Fear of Seeking Healthcare Services Across Study Visits (n=1,175)



Source: Schwartz, Nowak, Orazulike, Blattner, Charurat, Baral, TRUST Study Group (UMD, MHRP, ICARH, JHU). The immediate HIV-related impact of enacted legislation that further criminalizes same-sex practices in Nigeria. Forthcoming.

In 2013, the Same Sex Marriage (Prohibition) Act was enacted, authorizing stiff penalties for lesbian, gay, and bisexual people who undergo same-sex marriage ceremonies, as well for transgender individuals who hold identification that specifies their sex as congruent with the sex of the individual they intend to marry.³⁶ The law also imposes penalties on people who associate with them. After passage of the law triggered a nationwide wave of attacks against LGBT people, utilization of HIV services among MSM plummeted (Figure 4).

These punitive laws not only cause substantial suffering and encourage violence and abuse, but they also call into question the viability of HIV programs for key populations in the transition toward country ownership. As the country's political class is largely responsible for enacting these laws, and as no steps have reportedly been taken to remove them from the books or to otherwise ensure a public health approach to HIV among key populations, it is reasonable to assume that future political support for robust domestic funding for key population programming will be minimal in the absence of international engagement.

Civil Society Engagement and Country Ownership

Civil society is represented in national HIV policy and programming through six constituency coordinating entities—the Civil Society Network for HIV/AIDS in Nigeria (CiSHAN); the Network of People Living with HIV in Nigeria (NEPWHAN); the Nigerian AIDS Research Network (NARN); the National Diversity Network; Media Arts and Entertainment (MAE); and the Network for Women—that serve as members of Technical Working Groups (TWG) or are invited to meetings relevant to their constituencies.³⁷ Fifteen civil society organizations are represented on the Global Fund CCM, although key informants report that until recently they have not been deeply engaged in the development of funding proposals.

Presently, there is no key population representative on the CCM, and key informants report that the CCM seldom discusses key population issues. Although the New Funding Model of the Global Fund mandates key population representation on the CCM, as of 2014 the body continued to debate the necessity of including key population representation. However, Nigeria is currently among 10 countries to pilot a new Global Fund initiative to increase participation of key populations in the grant process. Early reports suggest that the process has been empowering, leading to the inauguration of the National Association of Nigerian Prostitutes (NANP) and the strengthening of the National Diversity Network, as well as creating a platform for MSM (Solidarity Alliance) to be heard.

Whether these relatively new avenues for key population engagement can be sustained and strengthened if and when international HIV funding to Nigeria declines remains both unclear and a major source of concern to key informants.

SOUTH AFRICA



More than one in every six persons living with HIV worldwide resides in South Africa. After disastrous early missteps in the national response, especially under the administration of former President Thabo Mbeki, the country has more recently established itself as a global leader on AIDS. The country has substantially increased domestic spending on HIV and recently leveraged its unparalleled market power regarding HIV-related commodities to achieve global price reductions for viral load and early infant diagnostic testing platforms.³⁸

South Africa also serves as the foremost laboratory, to date, for the transition to country ownership. Since South Africa signed a Partnership Framework Implementation Plan with the U.S. in 2012, the government now provides 75% of total HIV funding.³⁹ Although political ownership of the AIDS fight in South Africa is strong, numerous key informants questioned the country's capacity to sustain the national response and to drive further scale-up toward the goal of ending the epidemic.

One factor working in favor of country ownership in South Africa is the country's comparatively strong support for health services. Among 12 countries reviewed for the Global Fund's Technical Evaluation Reference Group, South Africa devoted the second highest share of national GDP to health.²³ However, the capacity of the country's public health system to meet national

Basic Facts

- Population: 53.1 million¹
- Life expectancy: 61 years²
- Income level: Upper-middle-income³
- Economic situation: South Africa is Africa's second largest economy. Economic growth has slowed, with GDP rising by 1.5% in 2014. Economic inequality in South Africa is among the worst in the world.³

HIV Epidemiology

- HIV prevalence (15–49 years): 18.9% (2014), up from 15.7% (2000)⁴
- Number of people living with HIV in 2014: 6.8 million (60% female among adult cases)⁴
- New HIV infections in 2014: 340,000⁴
- HIV prevalence among sex workers: Not available⁴
- HIV prevalence among MSM: Not available⁴
- HIV prevalence among PWID: Not available⁴

HIV Coverage

- Coverage for PMTCT: >95%⁴
- Coverage for ART (adult): 45%⁴
- Coverage for VMMC: 1.3 million (4.3 million target)⁵

PEPFAR

- PEPFAR category: TA (Co-Finance)
- PEPFAR planned funding in COP 2014: \$259,000,000
- PEPFAR expenditure FY2014: \$406,559,720

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (extreme-burden UMI country)
- Total signed Global Fund HIV support: \$657,919,080⁶
- Total HIV disbursements (2010–2013): \$254,474,441⁷
- Total HIV allocation (2014–2017): \$386,675,743⁷
- Change in funding 2010–2013 vs. 2014–2017: +52%⁷

1 World Population Review. South Africa Population 2015. Accessed: September 10, 2015.

2 Statistics South Africa. Accessed: September 10, 2015.

3 The World Bank. South Africa. Accessed: September 10, 2015.

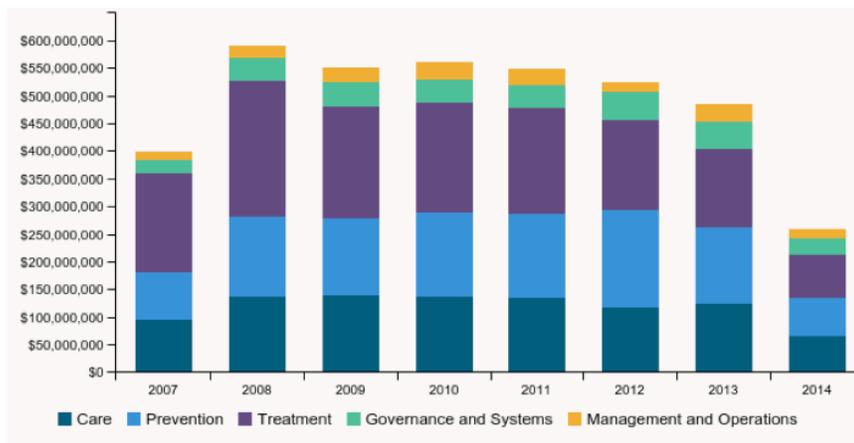
4 UNAIDS. AIDSinfo Database. Accessed: September 10, 2015.

5 MMC Info. MMC Programme in South Africa. Accessed: September 10, 2015.

6 The Global Fund. South Africa. Accessed: September 10, 2015.

7 Aidsplan. Aidsplan Portal Workbench. Accessed: September 10, 2015.

PEPFAR COP Funding for South Africa (COP Years 2007–2014)



Source: amfar COPS Database. Available at copsdata.amfar.org.

HIV commitments is less certain, as the public sector in South Africa plays a relatively modest role in health service delivery, accounting for only 40% of all health expenditures in 2009—the lowest share among the 12 countries studied.²³

Prospects for Future Scaling Up of Essential HIV Interventions

South Africa has the largest ART program in the world, which is primarily responsible for a remarkable nine-year increase in national life expectancy over the last decade.⁴⁰ In 2015, the country updated its national treatment guidelines, calling for initiation of HIV treatment at 500 CD4 cells/mm³.²¹ The country has officially embraced the 90-90-90 target, which is based on a test-and-treat model.⁴¹ South Africa is also a global leader in expanding access to viral load testing, having achieved the highest coverage of viral load screening in sub-Saharan Africa.⁴²

South Africa has also made historic strides towards eliminating mother-to-child HIV transmission, achieving near-universal access to antiretroviral medicines for pregnant women living with HIV. Whereas children exposed to HIV during pregnancy, delivery, or breastfeeding face 15–45% odds of acquiring HIV in the absence of preventive interventions, South Africa had, by 2011–2012, lowered this rate to 2.7%. South Africa has also sharply scaled up early infant diagnostic services, which has enabled the country to achieve parity in treatment access among adults and children.¹

After a slow start, the country has also rapidly ramped up VMMC towards the national goal of reaching 4.3 million men by 2016.⁴³ According to UNAIDS, roughly 1 million men received VMMC services in 2013–2014.

Despite these substantial advances against HIV, South Africa's capacity to sustain these gains in the era of country ownership is uncertain. Informants cite well-documented service disruptions associated with the transfer of programmatic oversight from PEPFAR to the national government. Some nonpublic sector PEPFAR-funded providers went out of business after the ART program was transferred to government control, forcing many patients to search for new healthcare providers in the public sector.⁴⁴ One study of 4,000 patients transferred from PEPFAR-operated to government clinics showed that almost 20% were not successfully re-linked to care and may have experienced an interruption in treatment.⁴⁵

An important cause for concern regarding the sustainability of South Africa's response is the country's severe and well-documented shortage of healthcare workers.⁴⁶ PEPFAR funding has helped countries such as South Africa increase the health workforce capacity, but there are concerns that the withdrawal of PEPFAR funding could cause these gaps to impede further progress in bringing essential services to scale.

Future Response for Key Populations

Both PEPFAR and the Global Fund have financed HIV programs targeting key populations (notably, sex workers and MSM). However, in its widely heralded HIV response of recent years, South Africa has largely failed to prioritize key populations other than sex workers.

Sex workers are the only key population in South Africa for which population size has been estimated for purposes of health intervention,⁴⁷ and reliable national prevalence data are unavailable for key populations. Although the National Strategic Plan formally recognizes the importance of reaching key populations with HIV services,⁴⁸ such services have yet to be operationalized, aside from specific “high transmission area” interventions targeting sex workers and truck drivers. National guidelines are not in place to guide and strengthen HIV programming for key populations.

Stigma and discrimination deter many members of key populations from seeking HIV prevention and treatment services. For example, sex work remains illegal and largely stigmatized in South Africa, although there have been recent calls for decriminalization.⁴⁹ Drug use is also criminalized in South

“...[South Africa] will need to exhibit greater commitment to confront and overcome discriminatory attitudes and punitive legal frameworks if it is to respond effectively to HIV among key populations.”

Africa, and key informants report that fear of incarceration discourages many PWID from seeking needed services. Although sexual orientation is a protected class under the South African constitution, and same-sex marriage is legal, same-sex sexual relations are viewed by many in the country to be foreign and “un-African,” and MSM experience institutionalized stigma within the public healthcare sector.⁵⁰ As the transition to greater country ownership continues in South Africa, the country will need to exhibit greater commitment to confront and overcome these discriminatory attitudes and punitive legal frameworks if it is to respond effectively to HIV among key populations.

Civil Society Engagement and Country Ownership

Civil society organizations, including organizations representing key populations, play a leading role in many government processes, primarily through technical working groups or task teams of the South African National AIDS Council (SANAC). Fourteen nongovernmental organizations participate in the South Africa CCM, and PEPFAR staff report that civil society consultation meetings were held as part of the PEPFAR process for developing the 2014 COP. However, informants suggested that civil society engagement was stronger with SANAC than with either PEPFAR or the Global Fund, in part due to the complexity and lack of clarity regarding donor processes. In particular, informants cited insufficient involvement of MSM in Global Fund processes.

Although the comparatively greater engagement of civil society at the national level suggests that country ownership may be consistent with nongovernmental involvement in the HIV response, one senior government official expressed concern that actual funding for civil society activities could decline as international assistance is withdrawn.

UKRAINE



Ukraine has the second highest HIV prevalence in Eastern Europe, with a national epidemic that is heavily driven by HIV transmission among its estimated 310,000 PWID.⁵¹ An increasing proportion of new HIV infections in Ukraine results from sexual transmission, with sex worker networks playing an important role.⁵² A middle-income country, Ukraine confronts the likelihood of a considerable decline in international HIV assistance in the foreseeable future.

At the same time, Ukraine has also struggled to cope with political unrest, the loss of national territory, and a severe economic crisis. This national crisis has had a profound effect on the country's HIV response, as the Russian annexation of Crimea in 2014 effectively ended access to opioid substitution therapy in the region. Continuing instability in the eastern part of the country has also led to interruptions in opioid substitution therapy and other HIV services. In addition, the value of the national currency, the hryvnia, has fallen sharply, negatively affecting programs budgeted based on the hryvnia's exchange rate before the crisis.

Despite these many challenges, there are some hopeful signs in Ukraine's HIV response. In 2015, Ukraine and civil society partners signed new grant agreements with the Global Fund totaling \$134 million,⁵³ which will reportedly help address individuals affected by service disruptions associated with political unrest. The Ukrainian government has committed to covering at least half the costs of all prevention programs (including opioid substitution therapy) by 2017, and assuming all

Basic Facts

- Population: 44.8 million¹
- Life expectancy: 71 years¹
- Income level: Lower-middle-income²
- Economic situation: Ukraine is experiencing a severe recession, with GDP plunging by 6.8% in 2014.³ A modest recovery is possible in 2016–2017, although continuing political tensions with Russia create substantial uncertainty.⁴

HIV Epidemiology

- HIV prevalence (15–49 years): 1.2% (2014), up from 0.7% (2000)⁵
- Number of people living with HIV in 2014: 290,000 (59% male among adult cases)⁵
- New HIV infections in 2014: 15,000⁵
- HIV prevalence among sex workers in 2013: 7.3%⁶
- HIV prevalence among MSM in 2013: 5.9%⁶
- HIV prevalence among PWID in 2013: 19.7%⁶

HIV Coverage

- Coverage for PMTCT: 94%⁵
- Coverage for ART (adults): 21%⁵
- Coverage for VMMC: Not applicable (not a WHO priority country for VMMC)

PEPFAR

- PEPFAR category: TA
- PEPFAR planned funding in COP 2014: \$18,500,000
- PEPFAR expenditure FY2014: \$14,728,458

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (high-burden upper-LMI country)
- Total signed Global Fund HIV support: \$358,502,237⁷
- Total HIV disbursements (2010–2013): \$168,951,289⁸
- Total HIV allocation (2014–2017): \$137,283,941⁸
- Change in funding 2010–2013 vs. 2014–2017: -18.7%

1 World Population Review. Ukraine Population 2015. Accessed: September 10, 2015.

2 The World Bank. Ukraine. Accessed: September 10, 2015.

3 Economist Intelligence Unit. Ukraine. Accessed: September 10, 2015.

4 The World Bank. (2015). Global economic prospects: Europe and Central Asia. Accessed: September 10, 2015.

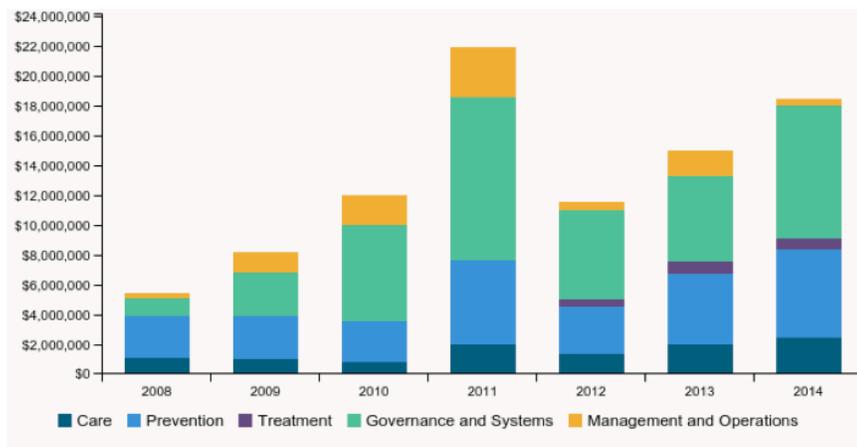
5 UNAIDS. (2015). How AIDS changed everything. Accessed: September 10, 2015.

6 GARPR. Ukraine Country Progress Report 2014. Accessed: September 10, 2015.

7 The Global Fund. Ukraine. Accessed: September 10, 2015.

8 Aidsplan. Aidsplan Portal Workbench. Accessed: September 10, 2015.

PEPFAR COP Funding for Ukraine (COP Years 2007–2014)



Source: amfar COPS Database. Available at copsdata.amfar.org.

such costs by 2018. Also by 2018, Ukraine has pledged to cover at least 83% of the costs of HIV treatment through national and local budgets.^{20, 54}

As a reduction in international HIV assistance looms, the central question at this stage is whether the country has the political will and the capacity to follow through on its pledges. Challenges include high commodity prices, inadequate national systems and infrastructure, and lack of a demonstrated commitment by the national government to address the needs of key populations.

In the 12-country sustainability review commissioned by the Global Fund's Technical Evaluation Reference Group, Ukraine ranked fourth in the proportion of GDP devoted to health in 2009 (about 7%).²³ However, the public sector only accounts for a little more than half of all health expenditures in the country, raising questions regarding the public health system's ability to deliver on the national government's promises.²³

Prospects for Future Scaling Up of Essential HIV Interventions

In Ukraine, ART and PMTCT services are largely provided by the public sector, while civil society organizations are the main providers of harm reduction and other HIV prevention services. ART is now available in all 27 regions of Ukraine, although treatment coverage is extremely low—less than half the global average. Ukraine has yet to implement the 2013 WHO recommendation for HIV treatment initiation at 500 CD4 cells/mm³, authorizing ART only when the patient's CD4 count falls below 350 cells/mm³.²¹ Having integrated PMTCT services into the general healthcare system, Ukraine has achieved substantially higher coverage for the prevention of mother-to-

child transmission, although reports from available studies indicate that HIV-positive pregnant women who inject drugs are significantly less likely than other pregnant women living with HIV to receive antiretroviral medicines and therefore more likely to transmit HIV to their children compared to women with no drug history.⁵⁵

Due to inefficiencies associated with the country's nonintegrated systems of AIDS centers, it often takes several months for HIV treatment to be initiated for individuals determined to be treatment eligible.⁵⁶ Due to low testing rates and a lack of official emphasis on early treatment initiation, the majority of patients (especially those from

marginalized groups) present late for treatment (<100 CD4 cells/mm³), further contributing to high mortality rates, mainly due to tuberculosis.⁵⁶

“Due to inefficiencies associated with the country's nonintegrated systems of AIDS centers, it often takes several months for HIV treatment to be initiated for individuals determined to be treatment eligible.”

As a middle-income country with limited HIV-related market power, Ukraine pays higher prices for antiretroviral medicines than low-income countries, and the country is excluded from many license agreements designed to lower HIV drug costs.⁵ However, Ukraine's higher-than-average drug costs also stem from the country's widely criticized approach to commodity procurement. Systemic weaknesses include non-transparent tendering procedures, an inability to issue international tenders, artificial limitation of generic competition, and poor quality assurance (as Ukraine does not recognize WHO prequalifications).⁵⁷ For example, in 2010 when the first 20,000 patients were transferred to the health ministry budget, antiretroviral prices doubled (compared to those paid by Global Fund programs),⁵⁸ with the price of efavirenz increasing 26-fold. As the country's tender procedures allow only distributors registered or located in Ukraine to participate, the country cannot take advantage of international price reduction agreements (even those it signed, such as those

⁵ See license agreement between Gilead Sciences and the Medicines Patent Pool (<http://www.medicinespatentpool.org/wp-content/uploads/mpp-gilead-licence-taf.pdf>).

negotiated by the Clinton Health Access Initiative [CHAI] or lower prices offered by the IDA Foundation, the Global Fund's primary procurement agency). Widespread corruption also undermines the country's capacity to negotiate the best possible prices for HIV medicines and to maximize the health impact of finite health resources.⁵⁹

Starting in 2009, the All-Ukrainian Network of People Living with HIV/AIDS successfully advocated to embed civil society "watchdogs" in national tender procedures, resulting in reduced prices for antiretroviral medicines (though still higher than those paid by the Global Fund). Ukrainian treatment activists are now working to ensure that the IDA Foundation, which secures optimal pricing, will locate an office in Ukraine in order to participate in tenders. This move would enable Ukraine to use CHAI's agreement for both national tenders and for Global Fund grant programs.⁶⁰

Future Response for Key Populations

In an epidemic driven primarily by transmission among key populations, virtually all prevention programs targeting these groups are delivered by community-based organizations and financed by international donors. For example, informants indicate that the majority of prevention programs for MSM are financed by the Global Fund, with PEPFAR providing technical support in the development of a basic package of services for MSM. Programs for sex workers lack sufficient implementation standards, guidelines, and management processes, informants report.

The Ministry of Health has issued guidelines for opioid substitution therapy, but no such programs are government funded. Nor have steps been taken to assume government ownership of opioid substitution therapy, and no single authority has been identified to manage these programs, whether for budgeting, procurement of medicines, or support for psychosocial programs. In 2013, only 7,339 PWID were enrolled in an opioid substitution therapy program.⁶¹

Key informants report that widespread social stigma associated with key populations is the primary reason the national government has yet to embrace a robust, evidence-based

“..widespread social stigma associated with key populations is the primary reason the national government has yet to embrace a robust, evidence-based response for these groups.”

response for these groups. Homophobia is reportedly widespread, with one key informant advising that public officials have avoided gay-friendly policies and programs in order not to be seen as too “European.” As sex work is an administrative offense, sex workers are vulnerable to police abuse and also have difficulty obtaining non-discriminatory health services.

Given the lack of a strong government response to the HIV-related needs of key populations, service coverage is low among these groups. Less than half (43.8%) of MSM were reached by prevention programs in 2013, and the number of sterile syringes distributed per PWID in 2013 was 77, roughly one-third of the recommended global minimum of 200.⁶² Less than half of MSM and PWID (38.3% and 42.8%, respectively) received HIV testing services in the prior 12 months.⁶²

Civil Society Engagement and Country Ownership

In general, civil society has been actively involved in the planning, implementation, and monitoring of HIV services in Ukraine, both officially and unofficially. The National AIDS Council, which serves as the CCM, is a multidisciplinary body that includes key nongovernmental, international, and community representatives, and is one of the few instances in which a CCM vice chair is a person living with HIV. However, informants suggested that key populations were less well equipped than mainstream civil society organizations to advocate effectively for programs, including work on regulations, monitoring of national budgets, and educating national decision-makers. One positive development is the inclusion of MSM community representatives in the Ukraine CCM, a direct result of the MSM community's focus on community strengthening and advocacy.

VIETNAM



Vietnam's epidemic is primarily driven by HIV transmission among key populations. Vietnam estimates that the country is home to 382,000 MSM, 76,000 sex workers, and 217,000 PWID.⁶³

In 2014, PWID accounted for 45% of all new HIV infections, sex workers 18%, and MSM 5%.⁶⁴ Although national HIV prevalence is notably lower in Vietnam than in the other countries in this review, AIDS is nevertheless a leading cause of morbidity and mortality, and an important health priority.⁶⁴

Vietnam's capacity to respond to its HIV epidemic is challenged by the withdrawal of international assistance, which has already begun. As Figure 5 indicates, PEPFAR, historically the leading funder of the national HIV response, has reduced its funding to Vietnam in recent years, and the country anticipates that Global Fund support will decline in the near future. Additionally, the World Bank and the United Kingdom recently ended their HIV programs in Vietnam. By 2016, Vietnam projects that the gap between resources available and those needed to respond effectively to HIV will equal \$27.3 million.⁶⁴ In 2013, health expenditures in Vietnam equaled 6% of gross domestic product.⁶⁵

In 2013, Vietnam launched a project to identify sustainable financing strategies for the HIV response.⁶⁴ Although Vietnam pledged to increase financing for HIV in 2011–2015, domestic funding for HIV actually declined.⁶⁴ In its national HIV investment

Basic Facts

- Population: 92.5 million¹
- Life expectancy: 71 years²
- Income level: Lower-middle-income³
- Economic situation: Economic growth has averaged more than 6% annually over the last decade.³ The World Bank terms Vietnam “a development success story,” having sharply reduced poverty and achieved most of the Millennium Development Goals.³

HIV Epidemiology

- HIV prevalence (15–49 years): 0.5% (2014), up from 0.2% (2000)⁴
- Number of people living with HIV in 2014: 250,000 (68% male among adult cases)⁴
- New HIV infections in 2014: 15,000⁴
- HIV prevalence among sex workers in 2013: 2.6%⁵
- HIV prevalence among MSM in 2013: 3.7%⁵
- HIV prevalence among PWID in 2013: 10.3%⁵

HIV Coverage

- Coverage for PMTCT: 54%⁴
- Coverage for ART (adults): 36%⁴
- Coverage for VMMC: Not applicable (not a WHO priority country for VMMC)

PEPFAR

- PEPFAR category: TA (Co-Finance)
- PEPFAR planned funding in COP 2014: \$48,584,472
- PEPFAR expenditure FY2014: \$47,921,111

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (high-burden lower-LMI country)
- Total signed Global Fund HIV support: \$174,358,894⁶
- Total HIV disbursements (2010–2013): \$70,073,890⁷
- Total HIV allocation (2014–2017): \$67,288,101⁷
- Change in funding 2010–2013 vs. 2014–2017: -4%

1 World Population Review. Vietnam Population 2015. Accessed: September 10, 2015.

2 Central Intelligence Agency. The World Factbook. Accessed: September 10, 2015.

3 The World Bank. Vietnam. Accessed: September 10, 2015.

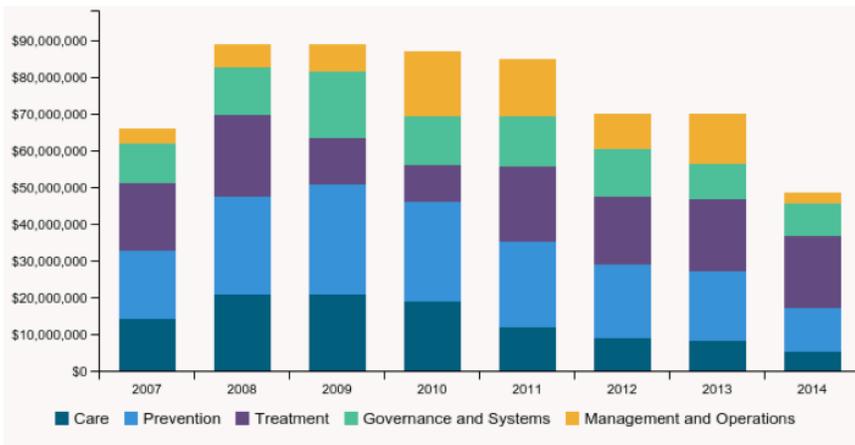
4 UNAIDS. AIDSinfo Database. Accessed: September 10, 2015.

5 UNAIDS. (2014). Optimizing Viet Nam's HIV Response: An Investment Case. Accessed: September 10, 2015.

6 The Global Fund. Viet Nam. Accessed: September 10, 2015.

7 Aidsplan. Aidsplan Portal Workbench. Accessed: September 10, 2015.

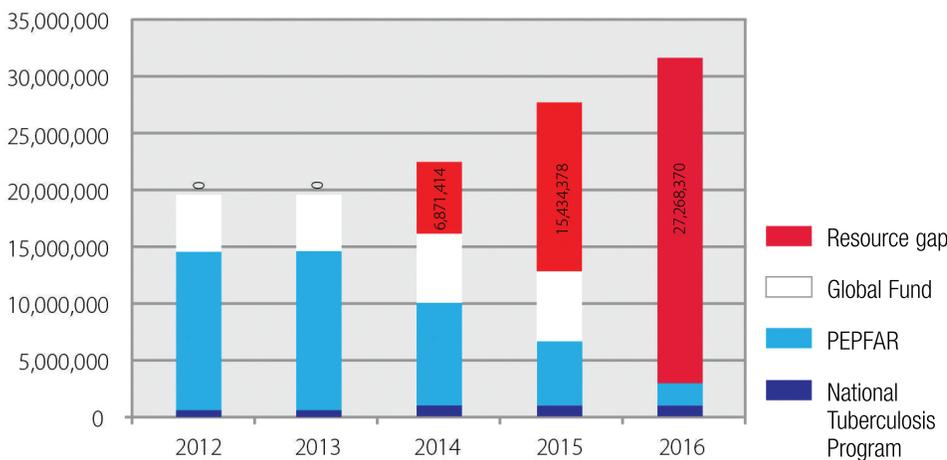
PEPFAR COP Funding for Vietnam (COP Years 2007–2014)



Source: amfar COPS Database. Available at copsdata.amfar.org.

needed. Adult HIV treatment coverage in 2014 was equivalent to regional coverage (36%) but lower than global coverage in low- and middle-income countries generally (40%).¹ By early 2014, there were 302 HIV clinics that prescribed and dispensed ART, and 62 “satellite points” where ART is provided. HIV treatment is also being scaled up in prisons. Vietnam has adopted the WHO’s 2013 guidelines, recommending the initiation of HIV treatment once an individual’s CD4 count falls below 500 cells/mm³.²¹

Figure 5: HIV Commitments and Funding Gap, 2012–2016



Source: Vietnam Administration of HIV/AIDS Control (VAAC); 2014.

Vietnam’s health ministry has established the goal of implementing the 90-90-90 approach and reaching at least 80% of all people living with HIV with ART by 2020. This will demand that the number of people receiving ART more than double over the next five years.

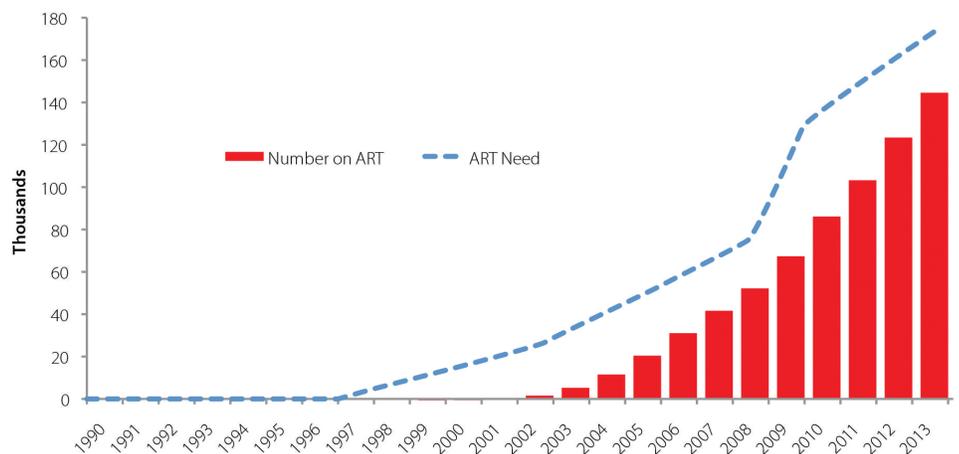
With respect to its treatment goals, the country confronts at least three sets of challenges. The first is financial, given the rapidly growing financing gap that the country projects. One potential strategy for funding increasing HIV treatment costs is the country’s national health insurance scheme, which already covers first-line

case, launched in 2014, Vietnam pledged to ensure that domestic resources cover 50% of total HIV spending by 2015 and 75% by 2020.⁶⁴ However, while the funding transition has received considerable attention, there has been almost no discussion about a transition of programmatic or technical support, which is of significant concern among key informants.

Prospects for Future Scaling Up of Essential HIV Interventions

Access to ART in Vietnam has increased in recent years (Figure 6), although it remains far short of amounts

Figure 6: Scale-Up of ART and Increasing Number of PLHIV in Need



Source: VAAC ART Program Data and Analysis. Vietnam AEM; 2014.

antiretroviral medicines, drugs for treatment of opportunistic infections, and HIV testing.⁶⁴ Vietnam's health ministry has articulated the goal of ensuring health insurance coverage for at least 80% of people living with HIV by 2020.⁶⁴ Key informants reported that patients with health insurance nevertheless often must cover substantial out-of-pocket costs, such as for lab tests. In addition, civil society groups have expressed concerns regarding possible confidentiality breaches under the health insurance scheme, which the country will need to address.⁶⁴

Second, Vietnam will need to secure a reliable supply of affordable, good-quality antiretroviral medicines. Currently, 95% of antiretroviral medicines prescribed in Vietnam are procured by international donors, which also provide the majority of the country's methadone.⁶⁴ Studies indicate that medicines and other health commodities purchased through international channels are, on average, less costly than those purchased directly by Vietnam.⁶⁴ Sustaining and building on gains to date in HIV treatment will require Vietnam to identify and implement procurement strategies that optimize pricing for essential medicines.

Third, programmatic weaknesses will need to be addressed if Vietnam is to fully leverage the therapeutic and prevention benefits of ART. Due to testing gaps, most people are diagnosed with HIV late in the course of infection; the average starting CD4 count for new antiretroviral treatment

patients is 220 cells/mm³, with 36% starting treatment only after their CD4 count has fallen below 100 cells/mm³.⁶⁶ As Figure 7 indicates, there is a large gap between the number of people diagnosed with HIV and the number of people receiving antiretroviral therapy—a shortcoming that must be corrected if the country hopes to fully implement a test-and-treat approach.⁶⁴ Toward its goal of implementing a test-and-treat approach and rapidly scaling up HIV treatment, Vietnam's health ministry has proposed enhanced training of community workers to help close gaps in the “reach, test, treat, and retain” cascade, as well as the scale-up of viral load testing at HIV treatment sites.⁶⁴

In 2014, fewer than 500 children were newly infected with HIV in Vietnam.¹ PMTCT coverage (54% in 2014) is more than twice the average across the Asia and Pacific region (25%), although substantially below global coverage among low- and middle-income countries (73%).¹

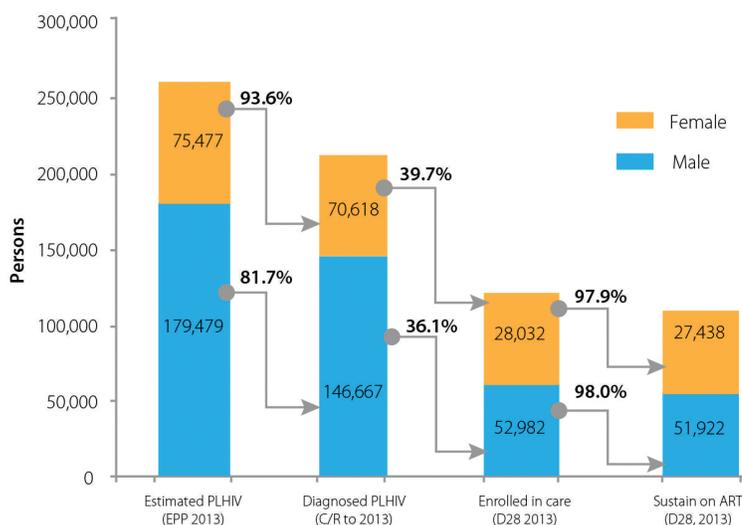
Future Response for Key Populations

Vietnam's commitment to address the HIV-related needs of key populations remains a work in progress. Vietnam has pledged to provide needle and syringe distribution to at least 65% of PWID; introduce and scale up methadone maintenance therapy; intensify condom distribution, outreach, and behavior change programming for sex workers, MSM, and PWID; and focus scale-up of HIV testing and treatment on key populations.⁶⁴ However, Vietnam will need to overcome a long legacy of discriminatory laws and human rights violations in order to achieve these ambitious aims.

Vietnam has historically relied on a highly punitive approach to drug use, including mandates for “commune-based education” and compulsory treatment centers for adults with addiction, although the government has pledged to gradually reduce compulsory rehabilitation from 65% of registered drug users to 6% by 2020.⁶⁷ Selling and buying sex is also subject to administrative sanction, and only in 2012 did the country ban compulsory education and treatment for sex workers. MSM were not considered an epidemiologically significant population until the second National Strategy on HIV, and the national HIV surveillance system only began including MSM in 2013.

Although Vietnam's stated commitment to greatly increase service access for key populations is laudable and distinguishes the country from many

Figure 7: Cascade of HIV Diagnosis, Care, and Treatment Services



Source: FHI 360; 2013.

others, current service coverage for these groups is extremely low, underscoring the distance that will need to be traveled to meet the government's ambitions. Among MSM who participated in an Internet survey, only 16.5% reported being tested in the last 12 months—compared to 28.8% cited in the AIDS Progress Report submitted to UNAIDS.⁶⁸ In 2012, a survey in eight PEPFAR-focused provinces found that only 8.6%–38% of PWID reported being reached by a peer educator in the last 12 months, and only 2.8% of them reported receiving all needles used in the last month for free; close to 98% reported pharmacies as their main source of needles.⁶⁹

Rapidly scaling up evidence- and rights-based HIV responses for key populations will also demand concerted efforts to address and overcome a legacy of stigma and discrimination. Drug use and commercial sex are officially considered social evils, and their elimination has been a priority for decades at every level of government. Though same-sex sexual relations are not illegal in Vietnam, homophobia is common and LGBT people are still considered by many to be ill, and Vietnamese media is rife with accounts of parents trying to “fix” their children with punishment, prayer, or hormonal or psychiatric treatment. Though transgender individuals are not technically subject to legal sanction as a result of their gender identity, sex change procedures are largely prohibited, and those having undergone a sex change are not allowed to obtain identification documents that reflect their identity, thereby limiting their access to certain services.

Civil Society Engagement and Country Ownership

Civil society organizations in Vietnam face numerous and significant challenges, none of which would appear likely to diminish with greater country ownership. While civil society organizations have provided input to key legislation and policies, such as the national AIDS law and National HIV Strategies (owing

to funding requirements and other pressure from international donors), their involvement in HIV program planning has been nil, as no mechanism to engage them in planning exists. Neither does Vietnam support civil society financially; in the history of the HIV response, Vietnam has never allocated resources to a civil society organization.

“...in the history of the HIV response, Vietnam has never allocated resources to a civil society organization.”

To the extent that civil society has been able to exert some influence on national HIV policy-making, program planning, and service delivery, it is largely due to international donors—primarily the Global Fund. As the only donor to provide support to key population organizations and networks directly (totaling \$3.6 million in 2014, or 15% of the total), the Global Fund has been critical for the development of the civil society response. The Vietnam Union of Science and Technology Associations (VUSTA), an umbrella consortium of local and international nongovernmental organizations, serves as principal recipient. Key informants emphasize that the Global Fund's dual-track financing encouraged collaboration and coordination between governmental and nongovernmental sectors to a degree not previously seen in Vietnam. For example, in 2012, the director of the Global Fund-supported Civil Society Project became the first-ever civil society representative on the National Committee on AIDS, Drugs and Prostitution. Beyond financing, Global Fund commitment provides leverage to key populations as they negotiate their role in the national response.

ZAMBIA



Among the countries most heavily affected by HIV, Zambia will require external assistance for its national response for some time. PEPFAR is the country's primary HIV-related funder, covering 80% of the costs of the national response.⁷⁰ Zambia has experienced important progress in its response, with the annual number of new HIV infections declining by almost 38% from 2000 to 2014 and AIDS-related deaths falling by 67%.¹

However, with its recent transition to middle-income status, Zambia is already confronting a notable loss of international support and the possibility of additional cuts in future years. The Netherlands, Denmark, Norway, and Japan have announced a phasing out of bilateral HIV funding in Zambia, with Britain and Ireland also refocusing their funding to project-specific initiatives.⁷⁰ While some of these countries will continue to channel resources via the Global Fund in lieu of bilateral agreements, Zambia appears poised to have diminished access to external resources in future years. Despite this fact, key informants reported that planning for such a transition in Zambia seemed minimal.

Prospects for Future Scaling Up of Essential HIV Interventions

HIV treatment coverage in Zambia (59% in 2014) far exceeds the average for sub-Saharan Africa (43%) and for all low- and middle-income countries (40%).¹ The number of health facilities

Basic Facts

- Population: 15.2 million¹
- Life expectancy: 61.3 years²
- Income level: Lower-middle-income³
- Economic situation: Zambia has experienced rapid economic growth over the last decade, averaging 6.4% annually.³ While this rapid growth rate has altered the economic and physical landscape of Zambia, rates of poverty reduction have been disappointing.³ Having experienced five multiparty elections since independence was declared in 1964, Zambia is among the most politically stable of all African countries.³

HIV Epidemiology

- HIV prevalence (15–49 years): 12.4% (2014), down from 14.3% (2000)⁴
- Number of people living with HIV in 2014: 1.2 million (54% female among adult cases)⁴
- New HIV infections in 2014: 56,000⁴
- HIV prevalence among sex workers: Not available⁴
- HIV prevalence among MSM: Not available⁴
- HIV prevalence among PWID: Not available⁴

HIV Coverage

- Coverage for PMTCT: 86%⁴
- Coverage for ART (adults): 59%⁴
- Coverage for VMMC: 951,000 (2 million target)⁴

PEPFAR

- PEPFAR category: LTS
- PEPFAR planned funding in COP 2014: \$259,888,666
- PEPFAR expenditure FY2014: \$259,409,715

Global Fund

- Eligible for Global Fund HIV grants 2015: Yes (extreme-burden lower-LMI country)
- Total signed Global Fund HIV support: \$662,045,978⁵
- Total HIV Disbursements (2010–2013): \$342,121,563⁶
- Total HIV Allocation (2014–2017): \$228,874,259⁶
- Change in Funding 2010–2013 vs. 2014–2017: -33%⁶

1 World Population Review. Zambia Population 2014. Accessed: September 10, 2015.

2 Central Intelligence Agency. The World Factbook. Accessed: September 10, 2015.

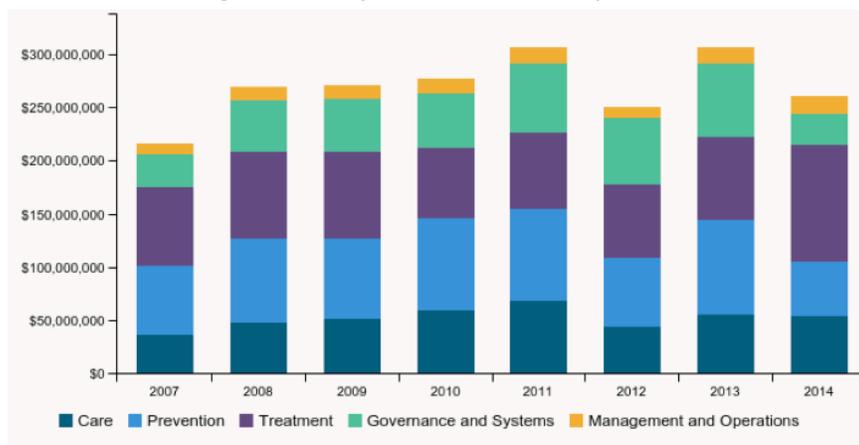
3 The World Bank. Zambia. Accessed: September 10, 2015.

4 UNAIDS. AIDSinfo Database. Accessed: September 10, 2015.

5 The Global Fund. Zambia. Accessed: September 10, 2015.

6 Aidspace. Aidspace Portal Workbench. Accessed: September 10, 2015.

PEPFAR COP Funding for Zambia (COP Years 2007–2014)



Source: amfar COPS Database. Available at copsdata.amfar.org.

providing ART continues to increase (from 564 in 2012 to 592 in 2014).⁷¹ Zambia reports better-than-average treatment retention rates, with 85% of adults and children known to be on HIV treatment 12 months after starting it.⁷¹ Zambia's national treatment guidelines follow 2013 WHO recommendations to initiate HIV treatment at or below 500 CD4 cells/mm³.²¹

Important gains have also been made toward the goal of eliminating new HIV infections among children. With Zambia achieving near-universal coverage of prevention services in antenatal settings, the mother-to-child HIV transmission rate has fallen from 24% in 2009 to less than 9% in 2014.⁷¹ The number of children acquiring HIV each year has fallen by more than half over the last 15 years—from 19,000 in 2000 to 8,500 in 2014.¹

After a slow start in rolling out VMMC, uptake has increased in recent years, with circumcision services provided in 472 health facilities in 2014. In 2013 and 2014, nearly 400,000 men were circumcised in Zambia.⁷¹ Progress in scaling up VMMC slowed in 2014 compared to 2013, as PEPFAR funding for the intervention declined, prompting the country to initiate efforts to secure other sources of financing for continued scale-up.⁷¹

Whether Zambia can sustain and build on these gains is uncertain. The PEPFAR COP for 2013 outlined serious human resource and funding deficits, particularly a chronic shortage of healthcare workers. Current law in Zambia does not allow nurses to prescribe drugs or permit community workers to re-supply patients with antiretroviral medicines.⁷¹ Zambian health authorities report that the number of health facilities in rural areas capable of administering ART is inadequate.⁷¹ It is also far too difficult to learn one's HIV status, with some health centers only offering HIV testing on certain days of the week.⁷¹ Due to the lack of an effective means of tracking patients, loss to follow-up remains considerable for people enrolled in HIV treatment programs.⁷¹

Future Response for Key Populations

Key populations appear to be an important blind spot for an otherwise successful national HIV response, as attention to key populations in Zambia has been minimal, in large measure due to active government resistance. Barring substantial changes in the government's approach, there is little reason to believe that the HIV-related needs of key populations will be effectively addressed in the transition to country ownership.

Very few programs exist in Zambia to address the HIV-related needs of key populations, and the government funds none of them. The few programs that exist are ad hoc, provided by some international nongovernmental organizations, international partners, and UN agencies. The PEPFAR COP for Zambia in FY2014, which extends through September 2015, provides little information on PEPFAR-funded efforts for key populations.

Very little reliable prevalence or incidence data are available for key populations, and the Zambian government has repeatedly cited the absence of data to justify failing to target these groups for HIV efforts. With the exception of sex workers, none of the key populations addressed in this report are included as priority populations for the Zambian HIV response, with one member of the National AIDS Council ministerial committee asserting that there is no evidence that such groups exist in Zambia.⁷²

Further complicating matters, one of three Global Fund principal recipients in Zambia is the faith-based Churches Health Association of Zambia (CHAZ), a consortium of various churches, many of which have gone on record opposing rights for key populations, especially MSM, indicating that same-sex sexual relations are contrary to biblical teachings and cultural beliefs. Several faith-based informants defended the country's failure to prioritize services for these groups, stating that it was natural for HIV programs to avoid community-driven services for groups such as sex workers, whose occupational activities are against the law. However, faith-based informants also insisted that services are accessible to these groups, as programs do not inquire as to whether individuals are members of these key populations.

Zambian law criminalizes same-sex sexual relations, sex work, and the possession of needles. These laws both reflect and reinforce stigma, discrimination, and social exclusion.⁷² Key informants report that health workers are often hostile toward

“Given the government’s refusal to date even to acknowledge the existence of key populations, continued engagement of international donors may well be essential if even the most basic response for key populations is to materialize in Zambia.”

sex workers and other members of key populations, deterring individuals from seeking needed health services.

Under the New Funding Model, which requires countries to document the role of key populations in their national epidemics, the Global Fund has begun to push back against the government’s insistence that key populations play little meaningful role. Given the government’s refusal to date even to acknowledge the existence of key populations, continued engagement of international donors may well be essential if even the most basic response for key populations is to materialize in Zambia.

Civil Society Engagement and Country Ownership

In Zambia, civil society engagement in the AIDS response has been uneven. The Non-Governmental Organizations Act in 2009, which required nongovernmental organizations to reregister every five years and to provide information annually on activities and funding sources, was interpreted by some health-related civil society groups as a potential means for preventing external funding for groups considered undesirable by the national government, such as key populations.⁷³

International donors have served as an important conduit for civil society input in the HIV response, although key informants indicated that donor processes were often opaque and difficult to access. Civil society groups participate in the Global Fund’s CCM, and in 2014 more than 100 civil society representatives provided input into the country’s most recent proposal to the Global Fund.⁷¹ Civil society groups, including key populations, were also consulted with respect to development of the most recent PEPFAR COP. However, according to key informants, funding for civil society groups declined after the Zambian National AIDS Network (ZKAN) was replaced by CHAZ as principal recipient following allegations of misappropriation of funds against ZKAN.

RECOMMENDATIONS

The six country case studies identified key actions that need to be taken to ensure that the transition to country ownership does not undermine progress toward the ultimate goal of ending the global AIDS epidemic. With particular attention to the needs of key populations, who are not only most vulnerable to HIV but also at greatest risk due to a withdrawal of international HIV assistance, the recommendations distilled from these case studies focus on actions needed by international donors and by national governments.

International Donors

No transition to country ownership should be initiated in a country without a clear compact in place to guide the transition. Developed through an inclusive process, the compact should clearly commit the country to own and lead efforts to mount a national response sufficient to end the HIV epidemic as a public health threat. The compact should set forth roles and responsibilities for all stakeholders, identify capacity gaps as well as agreed measures to remedy them, define milestones in the transition process to allow for effective monitoring and timely corrective action where needed, and outline agreed steps to be taken if a country fails to follow through on its commitments. Rather than a late-stage handover from donors to countries, compacts should be entered into at the very outset of planning for the shift to country ownership and frame the transition as a careful, phased, incremental process.

International donors should coordinate their country ownership agendas. This is especially vital for the Global Fund and PEPFAR, the two primary sources of international HIV assistance. This coordination is especially important in countries that obtain substantial funding from both the Global Fund and PEPFAR.

International donors, especially the Global Fund and PEPFAR, should commit to sustain and strengthen programs for key populations in the transition to country ownership. Donors should optimally leverage their resources and influence to encourage countries to remove punitive or other discriminatory laws and to prepare healthcare systems to meet the HIV-related needs of all people, including key populations, in a nondiscriminatory, nonstigmatizing manner. Where evidence indicates that national governments are unlikely to equitably address the HIV-related needs of key populations, international donors should take responsibility for ramping up programmatic responses for key populations.

PEPFAR needs to live up to its vision by prioritizing programming for key populations. While PEPFAR can truly be said to have changed our world, saving the lives of millions, its programs have fallen far short of meeting the needs of key populations. PEPFAR should prioritize investments to ensure the ability of organizations and networks of key populations to participate fully in the response, including through advocacy and the delivery of services. PEPFAR needs to undertake proactive efforts to increase the inclusivity and transparency of its processes for civil society generally and for key populations, specifically. In-country teams should allow for a series of meetings with a broad-based coalition of government stakeholders and civil

“While PEPFAR can truly be said to have changed our world, saving the lives of millions, its programs have fallen far short of meeting the needs of key populations.”

society organizations—including those active at the regional level—starting early on in the COP process, and develop a system for soliciting input and providing written feedback on how recommendations were incorporated. To make PEPFAR leadership meaningful with respect to programming for sex workers, PEPFAR’s current policy requiring funding recipients to make an anti-prostitution pledge should be removed and replaced with a clear U.S. government commitment to comprehensive, evidence- and rights-based responses for sex workers.

The Global Fund should ensure that its support for equitable, robust responses for key populations is mainstreamed across all its programs and activities, and that its resources are allocated in a manner consistent with epidemiological needs. The Fund should take steps to ensure that its commitment to equitable access for key populations is reflected across all aspects of its work.

National Governments

Domestic funding for HIV should steadily increase. Countries need to allocate resources to the HIV response that are commensurate with national wealth and HIV burden.

National HIV responses should be accessible for all. Countries must ensure that their responses are readily accessible and

respectful for all people affected by HIV. Where appropriate, dedicated service channels for key populations should be created and effectively funded. In all cases, countries should ensure that all healthcare workers are appropriately trained and sensitized to provide high-quality, nonjudgmental, nondiscriminatory services to members of key populations.

Countries must ensure that HIV responses are evidence- and rights-based. Systematic reforms are needed to protect the civil and human rights of key populations, and to ensure that drug dependence is treated as a public health concern. Laws that criminalize behaviors among key populations should be repealed, and access to justice must be ensured for all. Steps should immediately be taken to scale up harm reduction services and other evidence-based approaches for key populations.

“Countries must ensure that HIV services are appropriately targeted. Consistent with respect for human rights, countries should strengthen strategic information systems to inform service targeting and resource allocation for the HIV response.”

Countries must ensure that HIV services are appropriately targeted. Consistent with respect for human rights, countries should strengthen strategic information systems to inform service targeting and resource allocation for the HIV response. Services for key populations must receive a share of HIV funding commensurate with the HIV burden these groups face.

National governments should prioritize working partnerships with civil society, with particular attention to key populations. Countries should ensure that civil society generally, and representatives of key populations specifically, are integrally involved in the planning, implementation, and monitoring of national HIV strategies, policies, and programs.

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