Agenda item 5

UNAIDS/PCB (43)/18.25

WAY FORWARD TO ACHIEVING SUSTAINABLE AIDS RESULTS

11-13 December 2018 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 23 November 2018

Additional documents for this item: none

Action required at this meeting—the Programme Coordinating Board is invited to:

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173. Recalling the commitments in the 2016 Political Declaration on Ending AIDS, as well as the 2030 Agenda for Sustainable Development, and in order to ensure progress towards the goal of ending the AIDS epidemic as public health threat by 2030;

174. Recognizing the emerging challenges, the potential high costs of complacency and the importance of ensuring that the goal of sustainability shapes the decisions of all partners, country stakeholders, communities and donors;

175. *Take note* of the report;

176. *Encourage* countries to develop integrated AIDS Investment Cases as well as transition and sustainability plans that are linked with health and Sustainable Development Goal financing strategies, and to fulfill their commitments to close the HIV funding gaps; and

177. *Request* UNAIDS to; develop a Joint Programme Policy Framework on Investments and Sustainability and metrics to guide a coherent, people-centered approach that will be utilized to guide high-impact support to countries and communities; and to report back to the PCB meeting in December 2019 on results achieved and lessons learned in at least 10 countries.

Cost implications for decisions: none

Executive Summary

1. This report describes recent trends in resource mobilization for country AIDS responses and summarizes the impact of those investments. It then reviews the major challenges affecting the sustainability of AIDS response results financing and sketches a way forward. It proposes a Sustainability Framework to guide support for countries and partners to reach the goal of ending the AIDS epidemic as a public health threat by 2030 and to achieve long-term sustainability of results. This framework builds on the 2011 UNAIDS Investment Framework.

2. Political leadership at the highest level has been matched with country-level ownership, innovation, investments and community-led activities, enabling the achievement of remarkable results in the AIDS response over the past 10 years. Resources almost doubled from US$ 10 billion in 2006 to US$ 20 billion in 2017, while the domestic share has increased from about 50% in 2006 to 57% in 2015 and 2016.

3. These efforts have resulted in fewer than 1 million people dying each year from AIDS-related illnesses for the first time this century. An estimated 21.7 million [19.1 million–22.6 million] people living with HIV were accessing antiretroviral therapy at the end of 2017: five and a half times more than a decade ago. New HIV infections have been reduced by 47% since the peak in 1996. Three out of four people living with HIV now know their status, which is the first step to getting treatment. The world is on-track to meet the target of 30 million people living with HIV accessing treatment by 2020.

4. HIV investments also are improving the quality of life and productivity of people living with HIV, promoting social equality and justice, contributing to health and community system strengthening and advancing the achievement of the Sustainable Development Goals. Average life expectancies have rebounded: it is estimated that HIV investments alone accounted for an increase in life expectancy of more than five years in several countries with an HIV prevalence greater than 10%. Malawi, for example, is one of eight countries in sub-Saharan Africa where female life expectancy increased by more than 10 years, largely due to reductions in AIDS-related mortality.[1]

5. UNAIDS has guided, facilitated and supported these achievements in numerous ways, including through its focus on HIV financing arrangements that can enable countries to reach the 2030 goal and sustain their AIDS response obligations beyond that accomplishment. That work includes the 2011 Investment Framework, support for country Investment Cases, the emphasis on shared responsibility, the World Bank's work on allocative and technical efficiencies, engagements with communities around social contracting, and the joint highlighting of human rights considerations with the United Nations Development Programme and other Cosponsors.

6. Sustainability is recognized as a global health imperative. The 2016 Political Declaration on Ending AIDS includes commitments to increase domestic resource contributions, innovate HIV service delivery, and chart paths towards Universal Health Coverage (which shares key principles and objectives with the AIDS response) and reaching other Sustainable Development Goals.

We are at a precarious moment

7. Threatening the gains achieved are major challenges. We have not yet tipped the AIDS epidemic into a decisive decline. HIV prevention services are not being provided on an adequate scale and with sufficient intensity, and they are not reaching the people who need

them the most. The scale-up of access to HIV treatment should not be taken for granted: an additional 2.8 million people will have to receive treatment each year in the next three years, for example.

8. Ending AIDS by 2030 as a public health threat is a Sustainable Development Goal. Bringing the epidemic under control is also a prerequisite for the long-term sustainability of AIDS response results. Failure to achieve that goal will keep increasing both the budgetary demands and the social and human toll of the AIDS epidemic well into the future.

9. Globally, about four fifths of the estimated US$ 26.2 billion needed to reach the 2020 prevention and treatment targets adopted by UN Member States in the 2016 Political Declaration on Ending AIDS was available in low- and middle-income countries in 2017. The funding gap would be bigger were it not for increased domestic funding of HIV programmes.

10. Following an unprecedented 11.4% annualized growth rate during the first decade of the 21st century, development assistance for health has remained flat since 2010, while total health spending has continued to rise.[2] International HIV resource availability for low- and middle-income countries has decreased by 7% from 2014 levels due to reduced disbursements in 2015 from bilateral (government) and multilateral donors.[3] Multisectoral approaches have not yet contributed to closing the funding gap; at the same time, increases in efficiencies and programme effectiveness are not yet visible on a large enough scale.[4]

11. The funding trends mask troubling inequalities. Marginalized people, adolescent young women and girls, and communities are being left behind because of inadequate financing for programmes that focus on key populations and on adolescent girls and women. In many countries, the programmes that do exist—particularly those focused on key populations—are heavily reliant on external assistance, funding which is decreasing. Similar trends characterize funding for human rights and gender equality programmes.

12. Complacency will carry a heavy price. The AIDS response is a long-term commitment. If new HIV infections are not drastically reduced soon, the medium- to long-term costs will keep rising as the number of people requiring antiretroviral therapy increases. If HIV services do not reach young women and adolescents during their prime, the epidemic may impose an indirect economic burden on countries. Complacency about the need to accelerate equitable AIDS responses will lead to increased health spending pressures on patients, governments, private insurers and funders. In the worst-affected lower-income countries, the resulting fiscal burden could exceed all other health spending.

13. We are operating in a complex environment. Countries and their partners have been seeking to strengthen the sustainability of AIDS response results. Major funders of the AIDS response—such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief—have developed policies to support those efforts.

14. However, the results have been mixed. Transitions from international assistance in some eastern European and central Asian countries badly compromised their AIDS responses—to such an extent that the countries once again became eligible for Global Fund support.[5]

15. Countries and communities are engaging with donors on “within-country” transitions, where funders may reallocate funds within target countries or decrease coverage. Yet country partners often are ill-equipped and ill-prepared to engage in such transitions in a structured manner, and many countries still lack transition and/or sustainability plans.

16. Mobilizing domestic resources to meet the HIV response challenges, achieve Universal Health Coverage and reach the Sustainable Development Goals is a task for all countries,

regardless of their income level, disease burden and level of socioeconomic development. Countries have varying abilities to fund their AIDS responses with domestic resources. Many factors shape those abilities, including debt burdens, the efficiency of their revenue collection and expenditure systems, the scale and urgency of competing priorities, political dynamics and more.

17. It appears that gross national income per capita may be an insufficient measure of the ability of countries to pay, and that it may result in hastened and risky reductions in donor support. This has major implications for AIDS responses in countries that graduate to middle-income status (the so-called "risky middle"): they face losing external assistance for key programmes and services, with the potential risk of disruptions to services for key populations. One option would be to incentivize domestic resource mobilization in line with the ability of countries to absorb the costs, while donors would need to apply nuanced criteria for aid allocations to avoid service disruptions and increasing inequities in service access.

18. It can be very difficult in some countries to foster the political will that is needed for increased domestic investments in key population programmes, community-led services and human right programmes. If the global community is serious about achieving the Sustainable Development Goals—particularly the overarching goal of “leaving no one behind”—a tailored approach is needed to ensure bridge funding for key populations, adolescent girls and young women, and other populations who are left behind. This can help ensure that they are reached with HIV, health and social programmes that are grounded in human rights.

The way forward

19. Against this complex background, a redefined Sustainability Framework to guide efforts to achieve the goal of “ending AIDS as public health threat by 2030 and sustain the results through a people centered approach” is proposed. The purpose is to have a shared and coherent approach that takes account of emerging dynamics and countries' respective epidemic, programmatic, political and financial transitions, with an emphasis on reaching people who are left behind.

20. Ending the AIDS epidemic as a public health threat by 2030 by heeding human rights and equity principles is the foundation of the Sustainability Framework, without which the goal will not be feasible.

21. The proposed Sustainability Framework would rest on four main components:

- *Unwavering political commitment to shared responsibility*: Maintain political commitment, increase domestic resources and adopt policy and other changes to accelerate sustainable AIDS response results. Strengthen donor funding, including through the use of more nuanced criteria for funding decisions to avoid disrupting or scuttling services that are essential for heeding the principle that no should be left behind;
- *Investing for impact (and robust national strategies):* Effective decision-making and innovative strategies that allocate resources for maximum impact based on the location-population principle shall continue to be a priority. Achieving increased programme and system efficiencies will benefit from adopting the Universal Health Coverage lens;
- *Delivery for sustained results:* Accelerate quality implementation of fully-funded HIV programmes, including human rights and gender programmes, that address the dual challenges of HIV and tuberculosis is warranted. These programmes should be delivered through strengthened health and community systems, including social contracting; and
- *Engaging now for long-term sustainability*: Pursue Universal Health Coverage, multisectoral financing of HIV, human rights, social enablers and health activities and integrate donor financing within government-led fiduciary systems to build the foundation

for sustainability. Preparations for funding transitions and “within-country” transitions and the development of sustainability plans are essential.

22. UNAIDS has a key role in revising the metrics to monitor the epidemic transition as well as programmatic and financial progress (including investments in HIV, health and other sectors) towards sustainability. It also has an important role in helping ensure that programmes for key populations, adolescent girls and young women, and others who are being left behind, as well as human rights programmes and community-led services, receive the necessary resources and funding and are increasingly embedded in domestic funding decisions.

23. The recommendations in this report recognize that the Joint Programme is uniquely positioned to do the following:
    - Help leverage the necessary political commitment at all levels;
    - Engage with country stakeholders, communities, people living with HIV and donors to support country-led working groups on investments and sustainability;
    - Support the development and implementation of equitable, country-tailored and integrated Investment Cases, robust national HIV and health strategies, transition plans and sustainability frameworks;
    - Ensure that HIV features in Universal Health Coverage, health and other sector strategies;
    - Step up support in these areas and develop a coherent policy framework and new metrics to support countries in navigating a complex environment in pursuit of sustainability; and
    - Leverage partnerships with donors, United Nations agencies, civil society organizations, regional development banks and other entities to bring about innovations and accelerate results.

Introduction

24. The Thematic Segment of the 37th PCB meeting, titled “Shared responsibility and global solidarity for an effective, equitable and sustained AIDS for the post-2015 agenda", noted the need for "increasing domestic funding to ensure a comprehensive AIDS response that delivers sustainable results, including ensuring domestic funding that respects the GIPA principle and addresses the needs of key populations, including women and girls, and other vulnerable groups, in line with national epidemiological contexts."

25. At the 42nd PCB meeting, the Board requested UNAIDS to present to the 43rd PCB meeting a report on the work of the Joint Programme to ensure the sustainability of AIDS results in the SDG era.

26. This report is in response to the PCB request. It describes recent trends in resource mobilization for country AIDS responses and summarizes the impact of those investments. It then reviews the major challenges affecting the sustainability of AIDS response results financing and sketches a way forward.

27. It proposes a Sustainability Framework to guide support for countries and partners to reach the 2030 goal of ending the AIDS epidemic as a public health threat and achieve long-term sustainability of results. This Framework builds on the 2011 UNAIDS Investment Framework. The report includes the following sections:

    - a synopsis of the current status of AIDS response sustainability;
    - short overview of the key emerging challenges;
    - a proposed Sustainability Framework for sustaining AIDS response results;
    - the way forward; and
    - decision points and recommendations

A SYNOPSIS OF THE STATUS OF AIDS RESPONSE SUSTAINABILITY

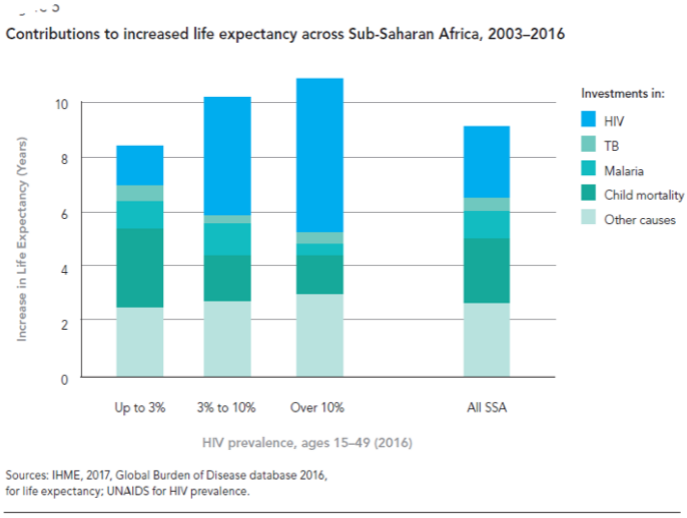
28. Political leadership at the highest level has been matched with country-level ownership, innovation, investments and community-led activities to drive remarkable AIDS response results in the past 10 years. Total resources almost doubled from US$ 10 billion in 2006 to US$ 20 billion in 2017, while the domestic share increased from about 50% in to 57% in 2015 and 2016 alone.

29. These actions have led to an estimated 21.7 million [19.1–22.6 million] people living with HIV receiving antiretroviral therapy (ART) at the end of 2017: five and a half times more than just a decade ago. Three quarters of people living with HIV globally knew their HIV status at the end of 2017, and six countries had achieved the target of 73% of people living with HIV having supressed viral load. Globally, new HIV infections have decreased, though not at the required pace: there has been a reduction of only 18% since 2010, far less than the 75% reduction targeted for 2020.

30. The 2016 Political Declaration on Ending AIDS includes commitments to increase domestic resource contributions, innovate HIV service delivery and chart paths towards UHC contributing to the other Social Development Goals (SDGs). The SDGs are guiding actions and adding momentum towards a more holistic and integrated agenda of self-reliance and resilience. The African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa, adopted in 2012 and extended until 2020 to achieve full implementation, provides a framework of action for sustainability on the African continent. It includes a clear role for continued support from the international community, but acknowledges that the long-term solution lies in African ownership of these responses.

31. The investments in the AIDS response have significantly increased life expectancy for people in the most productive ages regardless of income level, improved their quality of life and enhanced human capital—a prerequisite for prosperous and stable societies. In countries with HIV prevalence greater than 10%, it is estimated that HIV investments alone accounted for an increase in life expectancy of more than five years between 2003 and 2016 (Figure 1). Malawi, for example, is one of eight countries in sub-Saharan Africa where female life expectancy increased by more than 10 years, largely due to reductions in HIV/AIDS mortality.[6] To be competitive in a globalized world, countries need to invest in and protect human capital.

Figure 1. Contributions of major public health programmes to increases in average life expectancy in sub-Saharan Africa, 2003–2016



Source: IHME, 2017; Global Burden of Disease database 2016; UNAIDS estimates

32. More than 52 countries, drawing on support from UNAIDS, the World Bank and other partners, have applied the 2011 UNAIDS Investment Framework to better prioritize and focus their AIDS responses and maximize the impact of investments. Country Investment Cases also inform other national policy documents and development processes, including the Global Fund Country Applications and the Country Operational Plans funded by PEPFAR.

33. The Investment Case approach has highlighted the value of factoring in longer-term returns and benefits in making case for expanded AIDS responses. For example, Namibia's Investment Case exhibited two distinct phases. Up to 2020, scaled-up treatment and prevention dominate, with costs exceeding those in the baseline scenario. Subsequently, savings from reduced HIV incidence increase and the cost differentials narrow between the scenarios. Eventually, reduced new HIV infections lead to a reduced need for treatment (compared with the baseline scenario), a transition point that arrives in about 2033.[7]

34. In South Africa, the National Treasury-funded 2016 HIV and TB Investment Cases have indicated dedicated allocations to behaviour change communication programmes and for rapidly scaling up "test and treat" interventions.[8] In Zimbabwe, the investment approach has led to shift in programming. The most effective interventions (preventing mother-to-child transmission, outreach to sex workers, condom promotion and voluntary medical male circumcision) were scaled up, others were reduced by 20% (except for ART), and resources were geographically reallocated in line with HIV prevalence. Significant savings were made by using economies of scale to reduce programme management costs.[9]

35. It has been estimated that Belarus could reduce new HIV infections by 43% by increasing allocations for opioid substitution therapy from US$ 0.7 million to US$ 2.8 million and those for needle and syringe programmes from US$ 1.1 million to US$ 3.6 million, as well as investing more in ART programmes. Kazakhstan could reduce HIV management costs by 20% if it reallocates resources to the most cost-effective programmes.[10]

OVERVIEW OF SUSTAINABILITY CHALLENGES

36. A significant gap, however, persists between current realities and the vision of sustainable health for all. The most recent UNAIDS estimates show that the successes of recent years have not yet tipped the AIDS epidemic into a decisive decline. At the same time, sustaining

results over the long term will require sustained financing and programmatic activities well beyond 2030.

37. Given the long-term need for investments to achieve the goals and sustain the impact of the AIDS response, coupled with investments for robust health systems that can deliver UHC and support achievement of other SDGs, sustainability is now recognized as a global health imperative.

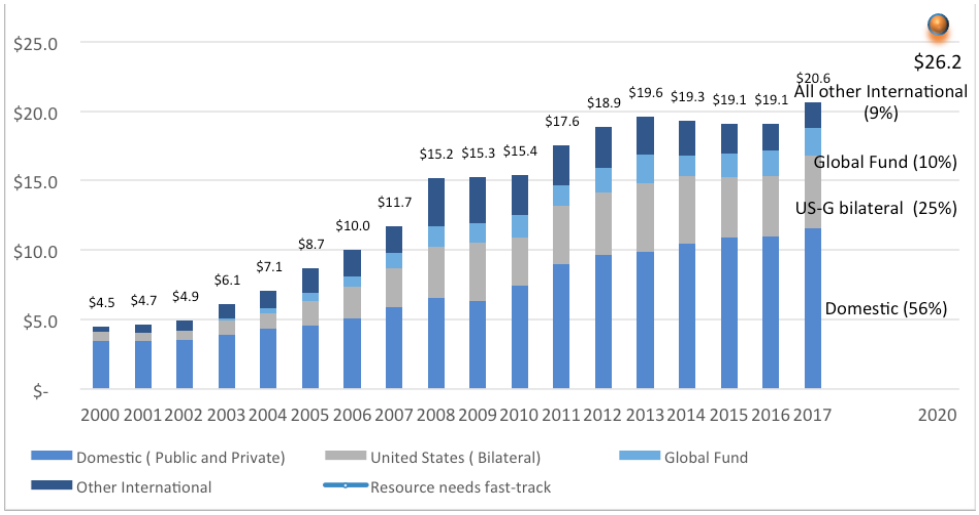
38. Cognizant that countries are facing epidemiological, programmatic and financial transitions, there is growing consensus that sustainability requires a people-centred approach action on three fronts, grounded on the principles of the right to health and equity:
    - political commitment, effective governance and policies;
    - sustained programme effectiveness; and
    - adequate and sustainable financing.

39. A number of challenges, however, lie in the path towards ending of the AIDS epidemic by 2030 as a public health threat (SDG 3.3), sustaining programmes to reduce HIV infections and provide people living with HIV with treatment beyond 2030, and achieving UHC and the broader SDGs.

Persistent funding gaps

40. Globally, about four fifths of the estimated US$ 26.2 billion needed to reach the 2020 prevention and treatment targets adopted by UN Member States in the 2016 Political Declaration on Ending AIDS was available in low- and middle-income countries in 2017.[11] Development assistance for health, following an unprecedented 11.4% annualized growth rate during the first decade of the 21st century, has remained flat since 2010, while total health spending has continued to rise.[12] International HIV resource availability for low- and middle-income countries decreased by 7% from the 2014 levels due to reduced disbursements in 2015 from the bilateral (government) and multilateral donors.

Figure 2. HIV resource availability in low- and middle-income countries, by source of funding, 2000–2017 (in constant 2016 US dollars)



Source: UNAIDS resource availability and needs estimates, 2018.

Note: The apparent increase in available HIV resources in 2016–2017 (from US$ 19.1 billion to US$ 20.6 billion) reflects the availability of unspent funds, not new international commitments. The recent decline in international funding for HIV was expected to continue in 2018 unless new donor commitments materialized.

41. These trends are compounded by challenges associated with ongoing donor transitions. Donor transitions refer to processes by which external health financiers gradually withdraw or reallocate their financial, technical and programmatic support, thereby increasing the urgency of greater domestic investment to sustain existing HIV programmes. They may reallocate funds within target countries or decrease coverage, changes that have been termed “within-country transitions".

42. Terminology to describe changing aid relationships is not used in the same way among all donors. In the Global Fund’s Sustainability, Transition and Co-Financing Policy, the word “transition” is defined as “the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programmes independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate.” For PEPFAR, sustainability of the HIV response means that a country has the enabling environment, services, systems, and resources required to effectively and efficiently control the HIV and AIDS epidemic[13]. The United Kingdom's Department for International Development (DFID), meanwhile, uses the term “exit” to describe the process of phasing out DFID bilateral assistance, while “transition” refers to the establishment of a new development partnership[14].

43. Stagnant external assistance, coupled with competition from other health and non-health priorities, casts doubt on whether the US$ 26.2 billion needed to fully fund an HIV response in 2020 and ensure the long-term sustainability HIV programming past 2030 will be reached.

Trends differ widely between and within regions

44. Levels of donor dependency are relatively high in sub-Saharan Africa and the Caribbean, but lower in Latin America, Asia-Pacific and the Middle East and North Africa. In Asia Pacific, more than three quarters (78%) of the resources came from domestic coffers, but some low-income countries are highly reliant on donor funding. In the Middle East and North Africa, three quarters (72%) of HIV funding was domestically sourced, with donor funding levels having fallen by 30% in the past decade. In Latin America, resources available for HIV programmes more than doubled since 2008 and the regional AIDS response is funded almost entirely (96%) with domestic resources.

45. In eastern and southern Africa, increases in HIV resources have put countries roughly on-track to achieve the 2020 Fast-Track targets. About US$ 10.6 billion was available for HIV programmes in the region in 2017. Both domestic and international funding for HIV programmes increased in the past decade, with domestic investments accounting for 42% of total resources (their highest level to date) in 2017.

46. The domestic increases, however, are not sufficient to remove the funding gaps created by the need to expand the AIDS response and by stagnating international assistance. In Asia-Pacific, for example, HIV resources rose until 2011 and then levelled off, leaving the region short of the projected needs for 2020.

47. In western and central Africa, a region that lags far behind the 2020 Fast-Track targets, HIV resources overall diminished after 2013, with domestic resources accounting for less than one third (31%) of the total. About US$ 1.8 billion is needed annually to reach the 2020 targets, 81% more than the funding that was available in 2017. In the Caribbean, donor dependency remains high, with almost three quarters (72%) of HIV funding sourced externally in 2017.[i]

[i] Data were not publicly available for the Russian Federation, which has by far the largest HIV epidemic in eastern Europe and central Asia. An accurate regional overview therefore could not be provided.

It is not all about the money

Funding gaps that could undermine progress and increase inequity

48. There continues to be a lack of funding for interventions focused on people left behind, including adolescent girls and young women and key populations, and for creating enabling environments. In many countries, a great deal of the available funding for such interventions is sourced externally. The United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund have invested dedicated funds for HIV and other programmes for adolescent girls and young women and key populations.

49. Health risks are especially acute for adolescent girls and young women. The risk of new HIV infections in women living in high-burden countries in sub-Saharan Africa peaks at age 15–24 years, about 10 years earlier than for their male peers. AIDS continues to be the fourth-leading cause of death in adolescent girls and young women in that region.[15] PEPFAR's Determined Resilient, Empowered, AIDS-Free, Mentored and Safe (DREAMS) ambitious partnership, totalling US$ 385 million, funds in ten countries a core package of services that go beyond the health sector, addressing structural drivers that directly or indirectly increase girls' HIV risk[16]. The current programmes, however, have limited coverage to lead to population-level impact. In five of 10 countries (Mozambique, South Africa, Uganda, the United Republic of Tanzania and Zimbabwe), less than 50% of high-incidence locations for adolescent girls and young women were covered by prevention programmes.[17] A current lack of capacity to track allocations and expenditures on programmes for adolescent girls and young women also weakens the ability to secure adequate international and domestic funding.

50. Funding for prevention in key populations is overwhelmingly drawn from international or external sources, making those programmes highly vulnerable to donor withdrawal. This is an alarming vulnerability, given the slow pace of progress in preventing new HIV infections, especially among young women and adolescent girls, marginalized key populations such as people who inject drugs, sex workers and their clients, gay and other men who have sex with men, transgender persons and prisoners. A decrease or halt in external funding can lead to a rapid rise in HIV infections if the national government does not assume responsibility for key HIV programmes. This was seen in Romania earlier in the decade, when HIV prevalence among people who inject drugs rose from 3% to 28% in for years.[18] [19]

51. *Funding for primary HIV prevention: a missed opportunity*. Only three countries have achieved declines in new HIV infections among adults of 50% or more over since 2010 and another 17 have achieved decreases of at least 25%. Many have not made significant progress and at least 50 countries have experienced troubling increases in HIV incidence. Chronic underinvestment in primary and combination prevention has contributed to this trend. The 2016 Political Declaration on Ending AIDS recommendation that financial resources for prevention should be adequate and constitute no less 25% of funds globally is not being heeded.[ii] There is considerable need to revisit allocations to high-impact interventions as identified by the Global Coalition on HIV Prevention.

52. *Funding for rights-based HIV programmes is inadequate*. The Global Fund's catalytic funds, including for human rights activities and gender programmes, aim to incentivize increased domestic funding. These resources have been essential to establish comprehensive programmes that include human right and gender-related interventions. However, human rights-related challenges remain pervasive across countries and populations. Stigma is a

[ii] The stipulated allocation is a global estimate and does not apply to individual countries or regions.

major hindrance blocking adolescents' use of HIV services,[20] along with age of consent laws[iii] and the unwelcoming and intimidating attitudes of many health-care providers.[21] [22] [23] Social conservatism puts sexual education out of bounds for adolescents in many countries and limits their access to sexual and reproductive health and HIV services.

53. Reviewing and reforming age of consent laws, using community-led testing and self-testing approaches;[24] providing differentiated, youth-friendly services[25] [26] and psychosocial support are among many feasible improvements.[27] [28] Combining HIV services with other supportive social services can have a massive effect, as shown in important recent studies from South Africa.[29] [30] In 2018, expenditures on social enabling activities[iv] ranged from 1% to 32% of total HIV spending in 42 (57%) of 72 reporting countries, with limited contributions from domestic resources.[31] It is imperative to continue to fund human rights and gender programmes while ensuring their integration into domestic funding streams to ascertain long-term sustainability.

Sustaining engagement with civil society

54. The people-centred and human rights-based approaches demanded by communities and championed by UNAIDS have become hallmarks of the AIDS response. Civil society is increasingly involved in the planning, implementation and monitoring of HIV services, strikingly so in the case of interventions that focus on key populations. Community organizations often are the only entities capable of reliably engaging key and marginalized populations and linking them to HIV and other essential services. The special value of community-led or community-based services is recognized in the UHC and should be fully legitimized and supported.

55. Social contracting (defined as the use of government resources to fund non-governmental entities)[32] is increasingly central to successful HIV programmes, especially in settings where legal proscriptions, official harassment and social discrimination block key populations' access to services.

56. In Mexico, the National Center for the Prevention and Control of HIV and AIDS (Censida) manages a transparent and competitive public financing mechanism to nongovernmental organizations (NGOs). Acknowledging the unique reach of NGOs, Censida has allocated more than US$ 38.7 million for 766 projects during 2013–2018 to enable NGOs reach key populations with comprehensive package of HIV and Health services including HIV prevention, referral and reducing stigma.[33] Namibia is exploring social contracting as a way to shore up public financing of community systems amid declining donor funding, to accelerate implementation of the response, and to address human resource constraints in the health system.

57. Tapping the full potential of civil society engagement, though, requires removing legal and administrative barriers and funding bottlenecks. Yet the political space for civil society activity is shrinking in many countries, while trust and the appetite for collaboration between government structures civil society organizations has weakened.[34] [35] In addition, community and other civil society organizations are extremely vulnerable to shifts in donor funding priorities, criteria and procedures global investment in AIDS activities managed by civil society organizations has declined slightly since peaking in 2012–2013.

We have not exhausted potential efficiency gains

[iii] In 2017, 78 of 110 reporting countries required parental consent for a child under 18 years to access HIV testing, and 61 of 109 reporting countries required parental consent for HIV treatment. In addition, 68 of 108 reporting countries stated that parental consent was required for children to access sexual and reproductive health services.

[iv] Expenditures on gender programmes, programmes for children and adolescents (excluding cash transfers, which were classified as one of the prevention pillars), social protection, community mobilization, policy dialogues, key human rights programmes and HIV-specific institutional development

58. Financing gaps for the AIDS response are compounded by an unfinished agenda to increase the allocative and technical efficiency of HIV programmes. Effective decision-making to allocate resources for maximum impact is essential. Across 23 countries in Africa, Asia, eastern Europe and Latin America, a more efficient allocation of HIV resources could reduce cumulative new HIV infections by an average of 18% over the years to 2020 and 25% over the years to 2030, along with a 25% reduction in AIDS-related deaths for both timelines. A combination of efficiencies and increased resources will enable countries achieve the AIDS response targets.[36]

59. It is estimated that 20-40% of Government Health Expenditures[37] can be saved through efficiency gains and the World Health Organization (WHO) advises countries to organize efficiency assessments by dividing health systems into their four main functions: service delivery; financing; human and other resources; and governance and accountability.[38] Efficiency improvements in health systems of lower- and middle-income countries can yield life expectancy gains of up to 5 years.[39]

60. Substantial variation in unit costs for ART treatment across countries and facilities, suggesting that large potential gains can in theory be achieved from improving service delivery.[40] In Botswana, for example, 31% of hospitals and 37% of clinics were found to be operating below the national efficiency threshold for ART treatment, suggesting that they could increase productivity (number of people receiving HIV treatment) without additional resources. Evidence from countries such as Kenya, Uganda and Zambia show health facilities have relatively low technical efficiency (with average efficiency scores below 50%).

61. Task-shifting to nurses and to lay health workers, the training and integration of cadres of community health workers in public health programmes have proven to be efficiency-boosting practices. A review of studies from sub-Saharan Africa concluded that the quality of care provided by trained and supported by nurses and or community health-care workers was comparable to those provided by doctors. In a study from Dar es Salaam in the United Republic of Tanzania, 83% of beneficiaries were very satisfied with home-based care and the delivery of ART at community level by lay workers. The quality of was found to be equal to that provided by nurses, but at considerably lower cost per person reached.[41]

62. Services and delivery methods are being adapted to increase efficiency and effectiveness of implementation cascade. The ENGAGE4HEALTH study in Mozambique found that both linkages to care and retention in care were higher when people were offered immediate antiretroviral therapy and sent phone message reminders: 70% remained in care after 12 months versus 46% in the control arm.[42] In the LINK4HEALTH study in Eswatini, a similar approach also led to high rates of retention in care. Further integration and linking and integrating of HIV services with other health services also promise significant efficiency returns.

63. At the above-facility level, a UNAIDS-supported exploratory study of Uganda's AIDS response showed that annual savings of US$ 10–15 million between 2017 and 2019 could be made by sourcing drugs from the lowest-cost suppliers, while still using the three supply-chain systems: government, PEPFAR and Global Fund. In South Africa, the 2017 update of the HIV Investment Case estimates that by changing the current first-line regimen for ART to dolutegravir-based regimen the country could save 12–16% of the cost of the ART programme. The savings could potentially pay for 95% coverage of the Universal Test and Treat strategy, as well as finance pre-exposure prophylaxis for key populations. Using those opportunities could avert 25–56% of new HIV infections.

64. However, efficiency gains generated through reduced prices of first-line treatment may be offset by transitions to second- and third-line ARVs following treatment failure, which is likely to gradually but substantially increase the fiscal cost of long-term HIV treatment. Modelling

from sub-Saharan Africa indicates that, by 2030, over 4 million individuals will require second-line treatment, accounting for almost 20% of all individuals enrolled on ART.[43]

Governance and capacities to manage donor transition and build sustainability

65. Countries are facing epidemiological, programmatic and financing transitions. A shift continues towards focusing large-scale donor funding on smaller numbers of prioritized countries. This reflects stagnating international funding support for national health programmes (and HIV programmes in particular).

66. Countries are adapting to these changes. A landmark regional plan to strengthen long-term sustainability is being developed in eastern Africa. UNAIDS, the Global Fund and partners have supported several countries to undertake transition readiness assessments and transform the results into transition-to-domestic-funding plans (e.g. Armenia, Kyrgyzstan and Moldova). Cambodia and the Philippines applied transition readiness assessment frameworks to identify risks and vulnerabilities in transitioning to greater reliance on domestic resources. Namibia and Senegal are developing sustainability road maps for their AIDS responses and are building long-term sustainability into their health and other sector strategies.

67. Country partners and communities are engaging with donors regarding declines of “within-country” international assistance in cases where sustainability and transition plans are not yet in place. Those challenges are compounded by limited knowledge and capacities to navigate a complex environment that includes financing SDG strategies, introducing UHC and adjusting health financing strategies.

68. Poorly planned and executed transitions disproportionally affect key populations, adolescent girls and young women and enabling environment interventions, since those programmes tend to rely heavily on donor funding.[44]

69. Common issues include governments' unwillingness to fund key population programmes; a lack of technical or regulatory capacity (e.g. legal mechanisms for contracting HIV services through civil society and community groups); and unforeseen external events which place countries under too much financial pressure to fulfil prior commitments. Transitions from international assistance in some eastern European and central Asian countries badly compromised their AIDS responses—to such an extent that the countries again became eligible for Global Fund support.[45]

70. National capacities for costing programmes, designing country Investment Cases and improving allocative efficiencies have been strengthened. But there is still limited capacity to establish effective linkages with the wider efforts to negotiate transitions and establish sustainability frameworks. Similarly, civil society and community organizations have limited capacities to engage in social contracting mechanisms and to negotiate their roles while donor funding diminishes. Resource tracking and costs assessment are not embedded in the national systems.

71. Increasingly, particularly in large countries, important political and budgetary decisions are being devolved from the national level to subnational administrative units, which presents an opportunity to increase domestic resources. This can present a challenge when subnational country partners have limited capacity for effective HIV planning, financing and implementation. In South Africa, for example, the high degree of autonomy of provinces can lead to situations where provincial allocations to HIV and TB programmes reflect different priorities. In some instances, this may be justifiable. In others, it may reflect other considerations besides the epidemiological realities and public health needs. There are similar challenges in Kenya, Pakistan and other countries where decentralization means that provinces or states make key decisions on resource allocations.

72. Formal country-level fora to examine and make sound decisions on these challenges are seldom in place, even when governments and implementers are discussing the issues. These kinds of constraints are reflected in the very limited number of transition plans and sustainability frameworks that currently exist for charting the pathways, financing options and accountability systems for donors, government and communities.

TOWARDS GREATER SUSTAINABILITY OF RESULTS

73. Urgently reducing new HIV infections and accelerating quality implementation across the prevention and treatment cascade remain the foundation for sustainable AIDS response impact. At the same time, sustaining results over the long term will require sustained financing and programmatic activities well beyond 2030.

74. That will have to occur as countries transition from a reliance on external assistance, position HIV funding within the financing framework of SDGs generally, introduce and expand UHC, and respond to the increasing demands related to noncommunicable diseases.

75. These trends are sharpening debates about the prioritization of scarce resources (human and fiscal). Financing the interventions needed to reach the SDG goals may seem expensive, but they represent a "bargain" at 3–4% of global gross domestic product.[46] However, current public resources are insufficient to fully fund the programmes needed to achieve the SDGs.[47]

76. While the logic of front-loading investments to achieve end of AIDS by 2030 as a public health threat is sound, increased funding requires priority setting by both countries and donors. Countries, donors, implementers and communities are faced with a dilemma: How can the AIDS response maintain its momentum in the amid epidemiological, programmatic and financing transitions?

Domestic resource mobilization

77. Mobilizing domestic resources to meet the HIV response challenges, achieve UHC and reach the SDG goals is a task for all countries, regardless of their income level, disease burden and level of socioeconomic development. Quality service delivery, and programme and system efficiencies can help reduce the funding gaps, but there will remain a need to increase resources.

78. Approximately 56% of all funding available for HIV in 2017 came from domestic resources (public and private). The funding gap would be larger were it not for increased domestic funding of HIV programmes. However, many untapped resources exist. The 2001 Abuja Declaration committed African governments to spend at least 15% of their budgets on efforts to improve the health of their populations.[48] As of 2015, no country in sub-Saharan Africa had met the target and most spending was well below (<50%) the committed level.

Table 1. Domestic expenditure on health as a percentage of general government expenditure in sub-Saharan Africa, 2015

Country	%	Country	%
South Africa	14%	Ethiopia	6%
Namibia	13%	Togo	6%
Burundi	12%	Uganda	6%
Cabo Verde	11%	Mauritania	6%
Malawi	11%	Nigeria	5%

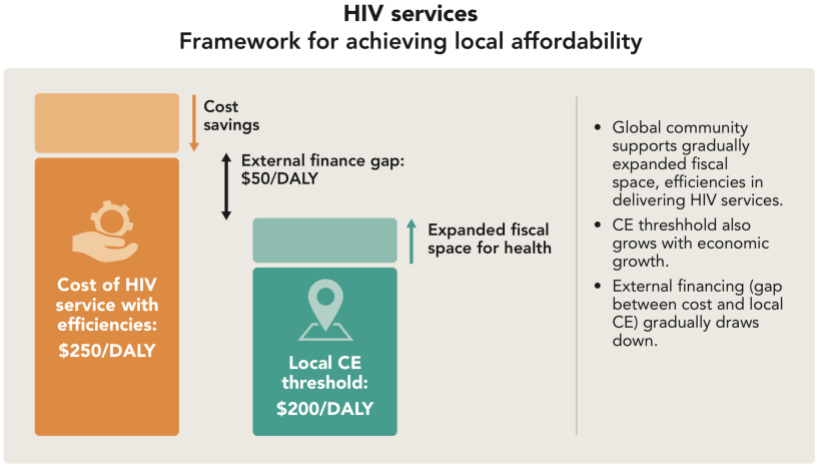
Sao Tome and Principe	11%	Cote d'Ivoire	5%
Gambia, The	11%	Democratic Rep. of Congo	5%
Solomon Islands	11%	Niger	5%
Seychelles	10%	Mali	4%
Mauritius	10%	Senegal	4%
Guinea-Bissau	10%	Central African Republic	4%
Lesotho	9%	Djibouti	4%
Botswana	9%	Comoros	4%
Zimbabwe	8%	Angola	4%
Sierra Leone	8%	Benin	3%
United Rep. of Tanzania	7%	Cameroon	3%
Burkina Faso	7%	Congo, Rep.	3%
Ghana	7%	Guinea	3%
Gabon	7%	Liberia	3%
Zambia	7%	Eritrea	2%
Kenya	6%	Equatorial Guinea	1%
Chad	6%	Mozambique	1%
Rwanda	6%	Somalia	0%

Source: World Health Organization Global Expenditures Database

79. Classifying countries by income has traditionally guided the assessment of countries' abilities to pay and, consequently, also decisions around external assistance. Gross national income per capita is relevant for determining a country's ability to fund its AIDS and health response, but it is one factor among many shaping that ability. If economic growth occurs, it can expand the fiscal space to fund the AIDS and health response. Higher rates of effective taxation, programmatic efficiencies and larger budgetary allocations of health likewise can help boost the fiscal space.

80. At a basic level, full domestic financing could be possible in contexts where HIV services are locally affordable and cost-effective (Figure 3). Most core HIV interventions are estimated to cost US$ 250 or less per disability-adjusted life year (DALY) averted,[49] while the cost of ART has continued to fall. In countries where HIV services are locally affordable—that is, where the cost-effectiveness of an HIV service falls below the government's cost-effectiveness threshold for health services—domestic government should, theoretically, be able to self-finance the entire cost of HIV services. In countries where HIV services are less cost-effective than the local cost-effectiveness threshold, external financing will remain crucial for filling the financing gap.

Figure 3. Framework for achieving local affordability



81. However, other developments may diminish the impact of those factors and constrain a country's ability to domestically finance its AIDS response, including integrated HIV and TB services. They include increasing number of new HIV infections; fiscal constraints (debt repayment or austerity obligations); costly transitions to second- or third-line ARV drugs; obligations to assume financing for other health services such as vaccines, family planning, malaria and TB) due to other donor transitions; and competing demands on the public health budget, including for noncommunicable diseases, hospital/surgical care and oncology.

82. Multisectoral financing was prominent at the beginning of the AIDS response. However, joint implementation and cost-sharing with other sectors gradually diminished. The challenge is to revitalize the synergies and identify the legal and regulatory changes that are required to ensure that earmarked funding is utilized for HIV programmes, either through transfers to the Ministry of Health or other country-level determined mechanisms.[50] Where investing in the AIDS response contributes to several other SDGs as well, costs should be shared. A percentage of the budgets from other ministries should be channelled toward the health activities of that ministry to support the intersecting activities of HIV and other sectors.

83. Overall, however, mobilizing sustained and predictable external finance, based on principles of shared responsibility, will continue to be necessary to narrow the funding gaps.

Ability to pay and the "risky middle"

84. As defined by the World Bank, middle-income countries are defined as those with a gross national income (GNI) per capita of between US$ 1,026 and US$ 12 476. Within this category there are two subsets: lower-middle-income economies are those with a GNI per capita between US$ 1,026 and US$ 4,035, while upper-middle-income economies are those with a GNI per capita between US$ 4,036 and US$ 12 475. The Institute for Development Studies estimates that 80% of the world's poorest people are now living in middle-income countries, in contrast to the 1990s when 90% of the world's poorest people lived in lower-income countries.[51]

85. Of the 135 low- and middle-income countries for which recent data are available, 44 still rely on international assistance for at least 75% of their national HIV responses.[52] Lower-middle-income countries with growing economies but large HIV burdens are struggling to mobilize sufficient resources—they represent the "risky middle" of the global AIDS response. Indeed, the majority of people living with HIV are now in middle-income countries and it is estimated that the proportion could increase to 70% by 2020.[53]

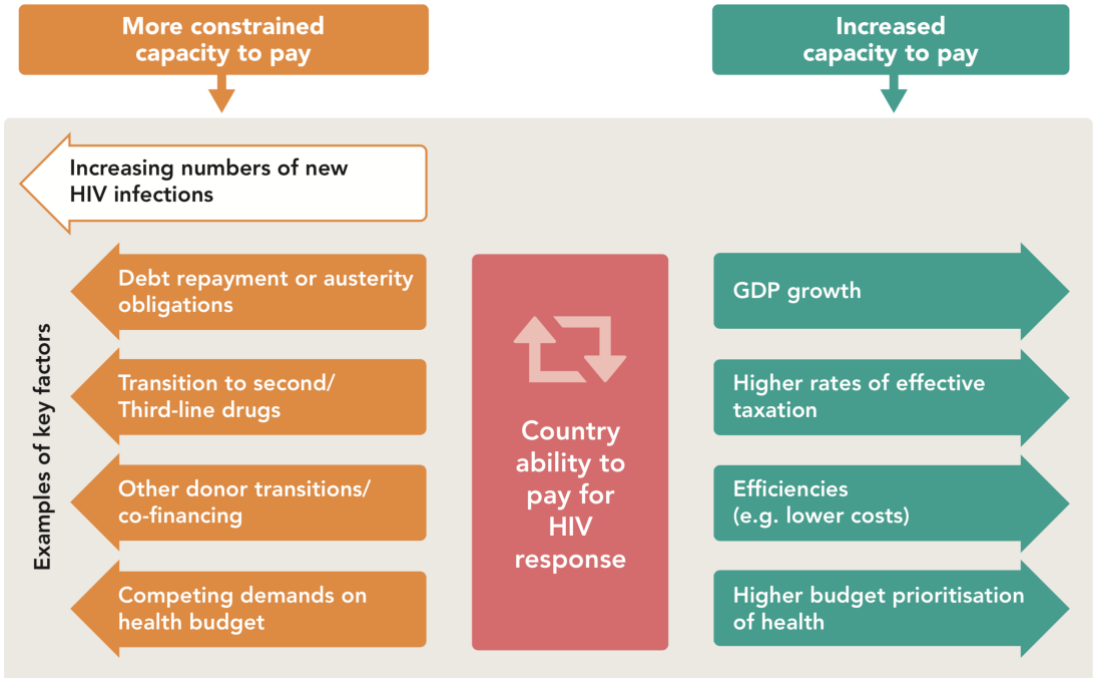
86. Countries' experiences in transitioning to domestic funding have not all been successful, despite their apparent ability to pay. There appears to be growing awareness that the donor community may have oversimplified the use of GNI per capita as a basis for decisions on aid allocations and transitions (including countries' abilities to finance their AIDS responses domestic funds).

87. There is increasing concern that the GNI measure obscures other important realities, since it does not capture the economic and social disparities that shape societies and that increase risks of disease and poor health for certain sections of societies. In most countries, lower-income households consistently have poorer access to health care than their affluent counterparts and they experience comparatively greater morbidity and mortality.[54] Hastened donor transitions in some cases have resulted in disruption of services, in particular for people left behind.

88. Multiple factors determine a country's ability to mobilize resources for a multisectoral AIDS response, including economic disparities, the political economy of fiscal decision-making, levels of health investments, the strength of health and community systems, currency fluctuations and more.[55]

89. If the global community is serious about achieving the SDGs and particularly the overarching goal of "leaving no one behind", a tailored approach is needed for the "risky middle". The aim would be to incentivize domestic resource mobilization in line with countries' abilities to absorb the costs, while donors would need to apply nuanced criteria to avoid service disruptions.

Figure 4. Factors Influencing a country's ability to domestically finance its AIDS response



Universal Health Coverage and sustainable AIDS response results

90. Through a shared agenda, the AIDS and UHC movements have a transformative opportunity to realize health as a global human right and ensure that no one is left behind.[56] Both movements should:
    - promote inclusive governance and broad partnerships;
    - mobilize resources and align investments; and
    - emphasize a holistic approach to people-centred development, as the SDGs have done, integrating the full spectrum of people's health needs.

91. Health equity is a central principle of UHC: everyone should receive the health services they need without suffering financial hardship. The concept is rooted in the right to health, as set out in the International Covenant on Economic, Social, and Cultural Rights.[57] A strong push towards UHC is underway and it holds important potential for adapting and strengthening the sustainability of national AIDS responses and its results.

92. One of the lessons from assessing progress towards UHC is that country strategies are diverse, due to the wide scope of UHC, varying health and social contexts, and the varieties of institutions which may serve to implement UHC. The progress will differ where health systems are in the early stages of expansion. These complexities are reflected in a lack of clearly

defined country-tailored approaches for incorporating the relevant elements of the AIDS response into UHC and determining how that should occur. Countries therefore are following a variety of approaches, with mixed results.

93. As part of the broader movement toward UHC, governments are developing or expanding national health insurance schemes. These efforts aim to achieve “health for all” while protecting individuals and families against destitution due to serious illness or injury. Bringing about UHC requires the payer (often the government) to define a set of covered benefits that is equivalent in actuarial terms to the pool of available resources. These essential benefits packages—also known as health benefits packages or health benefits plans—comprise a list of health services that will be subsidized with public funds.

94. Thailand is a good example of leadership on this front. Recognizing HIV as a major public health issue, the Thai government successfully positioned HIV services in the national UHC system,[58] enabling it to reach key populations at higher risk of HIV and provide them with HIV testing and care via partnerships with community organizations.[59]

95. Not many other countries have essential benefits packages that include HIV services. Ideally, health systems should be capable of addressing multiple health issues simultaneously. Some components of HIV programmes, however, are potentially best managed through the wider public health system and can be folded relatively easily into a UHC essential package. Modelling based on data from Kenya, for example, suggests that combined screening for HIV, high blood pressure and diabetes could avert over 216 000 new HIV cases and 244 000 AIDS-related deaths by 2028 plus identify 686 000 individuals with untreated diabetes and 7.6 million people with untreated high blood pressure.[v]

96. More generally and with few exceptions, services for key populations (e.g. harm reduction services, provision of pre-exposure prophylaxis, differentiated prevention interventions for sex workers etc.) are not included in UHC essential benefits packages. Unless health interventions are designed to promote equity, there is a risk that efforts to achieve UHC may lead to improvements in the national average of service coverage, while inequalities in services access and uptake worsen at the same time.[60]

97. Funding all HIV services through broader financing pools may bring efficiency gains. HIV treatment, however, represents a large share of health spending in low- and middle-income countries with high HIV burdens. It therefore may be necessary to protect the financing pool, at least in the early stages, with supplemental external or domestic financing that is earmarked for HIV. Otherwise, high demand for HIV treatment could render the pool fiscally unsound. Brazil, Ghana and Thailand,[61] for example, fund ART outside their national health insurance pools.[62]

98. UHC also recognizes the special value of community-led services, as seen in Ethiopia, for example, where community health care has been integrated in the UHC package.[63] Yet current health delivery models remain too facility-based, doctor-dependent, and disease-focused. Countries should explore ways of capitalizing on community systems strengthening as part of the AIDS response and its role in the UHC.

99. Focusing on UHC goals to foster consensus and use system-wide units of analysis to frame actions can help build stronger health systems that address programmatic priorities, regardless of the source of funding.[64]

[v] If the combined screening reached 10% of the Kenyan population every year over the next decade (2018 to 2028), and ART coverage reached 78% by 2028. The intervention would be cost-effective with respect to both HIV-related and NCD-related outcomes, but would require substantial health-care resources to meet demand.

100. Advocacy is needed to ensure that services for people left behind are included in the UHC essential packages and that dedicated funding is available to avoid service disruption while the UHC essential package is finalized and implemented. UNAIDS and partners should explore models for incentivizing and subsidizing the inclusion of HIV services in essential health benefits plans as a necessary step on the path to full sustainability.

101. Inclusion of certain HIV services in UHC packages could also help address the high rates of out-of-pocket spending on those services. In some low- and middle-income countries, private out-of-pocket spending accounts for more than 60% of total health expenditure. Those percentages are highest in the Caribbean, eastern and central Europe, and western and central Africa.[65]

102. User fees are the most common out-of-pocket expenditure, including in places where HIV services are nominally "free". These fees limit access to HIV and other services, increase socioeconomic inequality and obstruct progress towards UHC.[66] [67] [68] There has been a shift away from user fees in some regions. In sub-Saharan Africa, for example, about 80% of countries that had user fees in 2000 have acted to reduce or eliminate them[69]— but the progress has been very slow. Reductions in external assistance will likely increase fiscal stress in public health systems and encourage a return to discredited cost-recovery mechanisms.

103. Both UHC and the AIDS response share common goals around equity, non-discrimination, dignity and social justice. For UHC to be effective and to truly deserve the description of "universal", it must be anchored in the right to health and it has to serve marginalized and key populations.

104. There are many paths toward UHC: a careful, country-by-country trajectory and roadmap is needed to guide and develop the synergies between the AIDS response and UHC.

Donor funding

105. Donor funding remains important for short- to mid-term resource mobilization to achieve control of the AIDS epidemic that will serve as foundation for long-term sustainability of results.

106. The principle of shared responsibility implies that countries should increase domestic investments in the AIDS response (proportionate to their ability to do so) and that donors will continue to share responsibility for financing HIV programme (where they are not locally affordable). Currently, the most donor-dependent countries tend to be those with the least ability to fund those programmes themselves. They may be able to gradually increase the investments, but they are unlikely to be able to absorb the full cost of services, even in the post-2030 period.

107. While global contributions for the AIDS response have been substantial, many high-income countries still are not contributing their “fair share” of resources to the HIV response. According to analysis by the Kaiser Family Foundation, the contributions of high-income countries such as Australia, Canada, France, Germany, Italy and Japan to the global AIDS response are considerably smaller than their relative shares of the global economy.[70] It is estimated that if those six countries alone paid their “fair share” (calculated as a percentage of the 2017 baseline), the global community could mobilize an additional US$ 3.4 billion per year for the AIDS response. This sum represents almost two thirds of the gap between 2017 expenditure on the AIDS response (US$ 20.6 billion) and the estimated resource needs by 2020 to achieve the Fast-Track targets (US$ 26.2 billion).[71]

108. The current state of affairs has major ramifications. Analysis by UNAIDS shows that if Haiti were to experience a 20% cut in donor funding for HIV, it would have to allocate 40% of its total public health budget for HIV to keep HIV spending at 2017 levels, which is patently unrealistic.[72] Mozambique would need to devote almost the entirety of its public health spending to HIV if donor funding for HIV were cut by 20%—or abandon large parts of its HIV response.[73]

Donor transitions

109. Increasingly, global health institutions, including the Global Fund, are adopting eligibility and transition frameworks that define how and when transition processes will take place.[74] The Global Fund framework considers a country's ability, determined according to gross national income per capita, to finance its public health programmes. The Global Fund's relatively inclusive eligibility policy suggests that few large or aid-dependent countries will transition in the near- to mid-term future and that the overall pace of Global Fund transition will be slow. However, countries may be subjected to increasingly stringent co-financing requirements to access Global Fund support.

110. Generally, large-scale donor funding is becoming concentrated in smaller numbers of prioritized countries—those with the highest overall burdens and least ability to finance health programmes with domestic resources.[75] Many other funders do not have explicit transition policies in place, but nonetheless may reallocate funds within target countries or may decrease coverage. Those kinds of changes have been termed "within-country transitions". Country partners are often ill-equipped and ill-prepared to engage in such transitions in a structured manner.

111. In addition to HIV funding, countries will also need to absorb other donor programming adjustments for health (e.g. vaccines, family planning, malaria, TB and maternal and child health) as a result of other donor transitions that could crowd available fiscal space. Many lower-middle-income countries face imminent transitions from funding mechanisms for vaccination and polio, while HIV transitions are either undefined or projected to occur once countries reach a relatively high level of gross national income per capita.[76]

112. In such instances, countries may prioritize government health expenditure for programmes facing donor withdrawal, thereby potentially drawing resources away from the AIDS response. Formal country-level fora to examine and make sound decisions on these challenges are seldom in place, even when governments and implementers are discussing the issues.

Complacency carries a high price

113. Failure to halt the AIDS epidemic will carry unacceptable impact. Even a relatively short delay in achieving the Fast-Track targets—"only" five years—would translate into an additional million AIDS deaths and 2.1 million people will be newly infected with HIV by 2030.[77] Overall, failure to reach the Fast-Track targets could lead to 17.6 million additional HIV infections and 10.8 million additional AIDS deaths by 2030.[78]

114. Because lifelong ART represents a large multigenerational obligation, excess new infections will significantly increase the long-term fiscal burden for countries and further entrench the sustainability challenge.[79] [vi]

115. In addition to the toll on people's health and lives, failure to reach the targets will harm countries' economic prospects. A large share of new HIV infections occurs among people

[vi] In the absence of a cure for HIV, an 18-year-old person who initiates ART in eastern and southern Africa will, on average, require ART and care services services for at least another 40 years.

aged 15–34 years and a majority of people belonging to key populations are in that age range. Yet HIV and other health services seldom do a good job of reaching these segments of society. Older adolescents (15–19 years) living with HIV are less likely to know their serostatus and they are also more likely to start HIV treatment late and to interrupt treatment, compared with people aged 20 years and older.[80] Health outcomes among men living with HIV are typically poorer than among their female peers. In 2016, men comprised less than half of all adults (>15 years) living with HIV, but an estimated 58% of AIDS-related deaths.[81]

116. AIDS remains the leading cause of death among women of reproductive age and the leading cause of death in Africa—including among young people,[82] a rapidly expanding demographic. In 2016, 43% of the population in low-income countries, a similar percentage of the population in all of sub-Saharan Africa and 31% of the population in lower-middle-income countries were younger than 15 years.[83] In sub-Saharan Africa, young people consistently have suboptimal outcomes along the HIV treatment continuum.[84] The demographic "bulge" of adolescents and young adults in sub-Saharan Africa and other regions could have a significant effect on the AIDS epidemic. Failure to reach this cohort of young people with quality services will increase this burden and could affect the productivity of countries' work forces.[85]

117. Key populations (including gay and other men who have sex with men, people who inject drugs, sex workers, transgender persons) and their sex partners accounted for 47% of new HIV infections worldwide (80% of new infections outside sub-Saharan Africa).[86] Yet, poorly planned and executed donor transitions disproportionally affect key populations, resulting into service disruption, since programmes focused on those populations tend to be heavily dependent on donor funding. The global community will fail to fulfil the SDG goal of “leaving no-one behind”, if key populations are not reached with HIV, health and social programmes that are grounded in human rights.

118. The World Bank’s newly unveiled Human Capital Index demonstrates how investments in health and education (or lack thereof) affect individuals’ productivity and their contributions to the local and national economy.[87] Complacency about the need to accelerate equitable AIDS responses will lead to increased health spending pressures on patients, governments, private insurers and funders. In the worst-affected lower-income countries, the resulting fiscal burden could exceed all other health spending, with part of the cost borne by donor countries.[88]

THE WAY FORWARD

119. Meeting the sustainability challenge requires a paradigm shift that recognizes the multisectoral nature of the AIDS response and that embeds sustainability considerations across policies, strategies and programmes, grounded on the human right principles; and addresses:
    - the importance of leaving no-one behind, including key populations, adolescent girls and young women;
    - efficiencies, strengthen systems and synergies of integration, where relevant, including through the use of the UHC lens;
    - funding gaps, both for ending AIDS as public health threat by 2030 and for sustaining results beyond 2030; and
    - the substantial variations in anticipated transitions, including epidemiological, programmatic and financial transitions.

120. The UNAIDS approach to sustainability distinguishes between short-, mid- and long-term agendas that are matched to clear corresponding objectives. In the short- to mid-term (2020 to 2030), building a foundation for sustainability requires urgently reducing the annual number of new HIV infections. This will require significant and rapid acceleration of resource mobilization via both increased external financing and domestic investment in the AIDS

response. It will also require quality programme implementation, policy changes, and deploying resources as efficiently and effectively as possible on the most cost-effective interventions and with minimal waste.

121. The prominence of UHC and country efforts in this regard make the next five years a critical period for laying the groundwork for long-term sustainability—even if external finance is required over short-, medium- or long-term horizons.

122. While the primary goal remains an accelerated response that achieves control of the AIDS epidemic, the pursuit of the sustainability agenda also calls for a long-term plan which:
    - integrates HIV services within government benefit packages for UHC, health financing strategies, social health insurance, and other key sectors to achieve the SDGs, including social protection programmes;
    - creates mechanisms to sustain community-led services, including through community health workers and nongovernmental organizations (NGOs); and
    - supports the integration of human rights and gender equality programmes into the domestic financing as integral part of the HIV and health response.

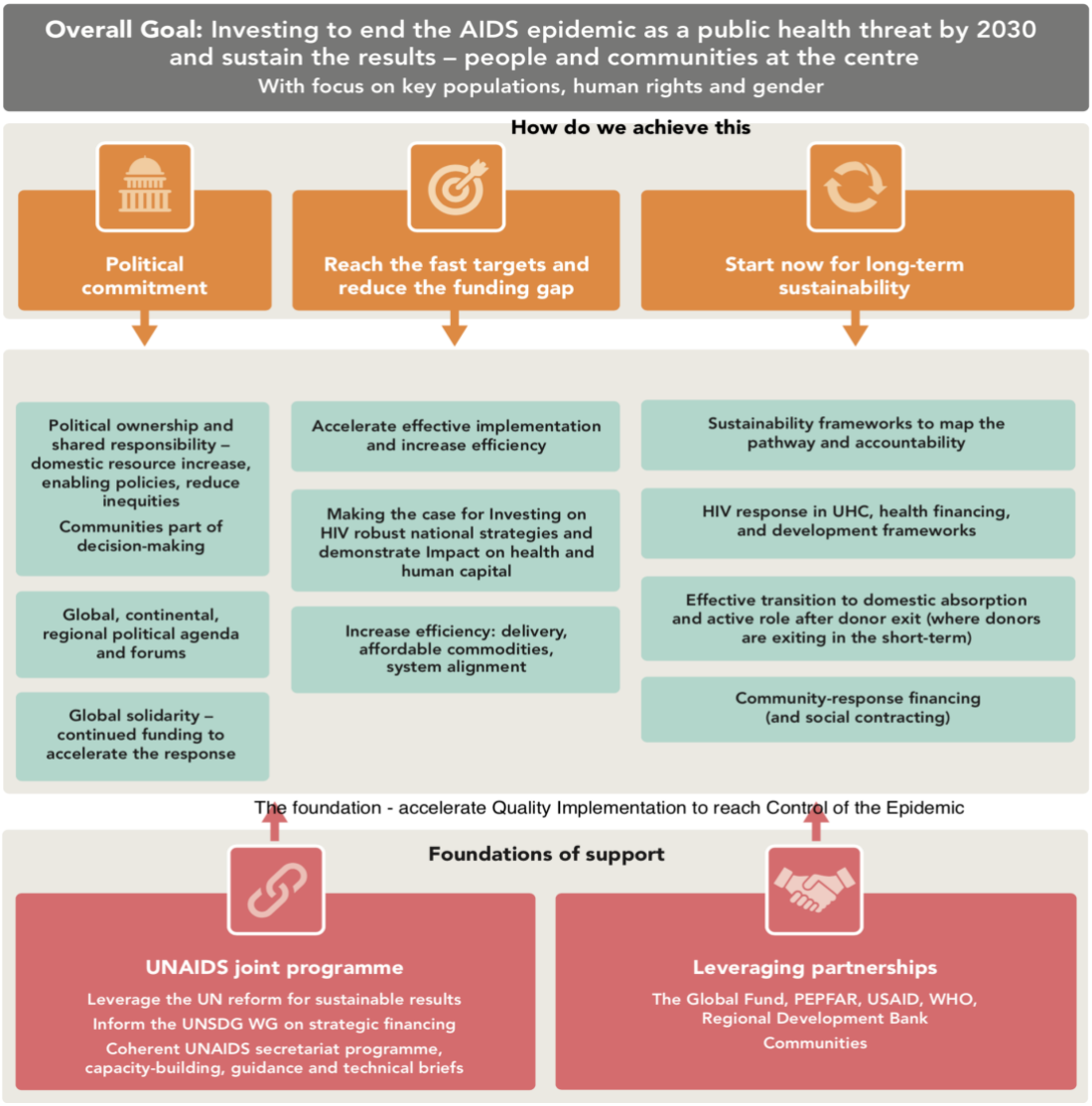
Sustainability Framework: Achieving sustainable AIDS results through a people-centred approach

123. Against this complex background, it is necessary to adopt a redefined Sustainability Framework to guide the action towards achieving sustainable AIDS response results (Figure 5). The purpose of such a redefined Sustainability Framework is to have a shared, coherent approach that takes account of emerging dynamics and that guides the people-centered efforts of all relevant actors to reach the people left behind with sustainable programmes.

124. The Sustainability Framework would rest on four main components:
    - unwavering political commitment to shared responsibility;
    - investing for impact (and robust national strategies);
    - delivery for sustained results; and
    - sustainable financing.

125. Importantly, the Sustainability Framework is based on the immediate priority of accelerating the response to reach control of the epidemic, grounded in human rights and equity principles. Without that foundation, long-term impact of AIDS response will not be feasible. Partnerships and the Joint Programme will provide essential support across the four components.

Figure 5. Framework for achieving sustainable AIDS response results



Component 1: Strong political commitment for shared responsibility

126. Strong political commitment and activism should be reinvigorated to add impetus to HIV and health investments in a competitive environment. Anchored in the broader Financing for Development Addis Ababa Agenda and the SDGs, political commitment is imperative to meet existing commitments.

127. Continental and regional political institutions should become the platform for making the investment case for HIV and health, emphasizing the importance for human capital and economic growth. This renewed commitment will be anchored in broader development agenda (e.g. Reducing Dependency in Africa, The African Roadmap to Shared Responsibility and Global Solidarity, and collaborations with the UN Economic Commission for Africa, regional development banks and other regional entities, and civil society organizations).

128. Countries—government, communities and organizations of people living with HIV—should drive the reshaping of the sustainability agenda. National working groups on investment and sustainability need to be established to lead sustainability dialogues, transition plans, financing options and accountability frameworks with donors, communities and other sectors.

Component 2: Investing for impact and robust national strategies

129. Countries should use the investment approach to build the case for optimizing investments, increasing efficiencies, identifying financing vulnerabilities to donor funding and charting paths towards achieving country targets.

130. The country investment cases and robust national strategies should be adapted to reflect the five HIV prevention pillars, including emerging evidence of implementation efficiencies. They should also link the service provision needs, human right programmes, social and programme enablers with synergies in the health and other sectors, including integration of service delivery where relevant. The investment cases should demonstrate the benefits of those actions for human capital and for social and economic development and show the costs of inaction.

131. Robust national strategies should translate a long-term vision into strategies for: developing effective, efficient and integrated platforms of delivery to reach people left behind;
    - maximizing financial and human resources;
    - determining the necessary policy changes; and
    - integrating joint programming and delivery platforms with HIV, TB, viral hepatitis and noncommunicable diseases (as relevant).

132. Regular and granular national AIDS expenditure analysis, cross-referenced with the national health accounts and other donor funding data, will be essential for tracking funding allocations and expenditures for adolescent girls and young women, key populations and communities, and other enabling environment interventions. Those data should inform subsequent allocations and long-term sustainability plans.

Component 3: Delivery for sustained results

133. With an investment vision and robust national strategies in place, the third component of a sustained AIDS response entails effective delivery for sustained programmatic and health results via national institutions, communities and health systems.

134. Shifting implementation arrangements—from parallel, HIV-specific delivery mechanisms managed by international NGOs to local, integrated delivery by a range of providers—is a complex and challenging process.

135. A multifaceted approach is needed to improve the quality of programme implementation along the continuum of the HIV services and to increase the efficiency of service delivery. Services and delivery methods that are adapted to increase efficiency and reduce the strain on health systems (e.g. multi-month ARV refills to reduce clinic visits, wider use of HIV self-testing and combining health screening services) need to be identified and brought to scale. Further integration and linking of HIV services with other health services may also generate significant efficiency returns.

136. Country efforts to strengthen procurement and supply chain management systems have successfully reduced costs and wastage. Systematic diagnostic and follow-up actions to address inefficiencies and system fragmentation across human resources, service delivery and financing,[89] will be central to maximize the impact of current efforts. It is imperative to continue to support countries' access to affordable medicines, diagnostics and supplies.

137. An integral part of this component will be the mapping of services and measuring of local delivery costs, including human resources, service delivery, commodities and social enablers. Local data and information to determine the legal, programme and financial requirements for the government to start absorbing selected programmes and interventions should inform transition and sustainability plans, whether in countries where donors will exit or to address in-

country geographic coverage gaps where donors are reducing coverage.

Component 4: Sustainable financing mechanisms for long-term impact

138. Regardless of economic status, disease burden and health system capacity, countries need to develop appropriate mechanisms to finance sustainable AIDS results through integrated government and community systems. This fourth component therefore can be subdivided into six requirements:
    - increase domestic financing for HIV and health;
    - list and deliver HIV services as part of a country's essential benefits package;
    - engage in health financing strategies and multisectoral financing;
    - create mechanisms for sustained funding of community-delivery and contracting of community-led NGOs;
    - sustain multisectoral financing of HIV, human rights, social enablers and health activities; and
    - integrate donor financing within government-led fiduciary systems.

139. **Increase domestic financing to the HIV and health response.** Accelerated AIDS responses, combined with increased domestic resources and effective and efficient responses would allow for the reallocation of some resources to high-impact programmes. This could expand the fiscal space for HIV and health investments.

140. Efficiencies alone, however, will not be sufficient to close the resource gaps. Continuous engagement with governments and regional development banks will be needed to devise domestic resource mobilization strategies that are tailored to country profiles and that ensure investments for HIV and health progressively increase. Collaboration with the World Bank would be useful for applying the Human Capital Index framework and for untangling investment trends in HIV and health.

141. Innovative financing should be explored with partners, particularly the Global Fund, the United States Government, the World Bank and other major sources of financing. Social bonds, debt relief, results-based financing and other financing mechanisms have been effective in the social sector; similar approaches can be pursued in the HIV and health response. However, those financing instruments should not be positioned as the perfect solution to closing the funding gap. They are best seen as financing instruments to provide immediate resources and incentivize actions to address specific country challenges for key programmes that lack sufficient funds and/or commitment (e.g. HIV prevention for adolescent girls and young women, and key populations etc).

142. Excise taxes on health-harming products such as tobacco, alcohol and sugar offer additional opportunities to discourage harmful consumption and increase government revenue, including health revenues. The pros and cons of revenue earmarking are the subject of debate, however. Since funding is fungible, critics argue that additional revenues raised by excise taxes could be offset by decreased allocations to health from the general budget or decreases in other forms of taxation.[90] Despite their potential problems, recent experiences from the Philippines, Thailand and Viet Nam suggest that earmarked excise taxes can be effective at raising revenue for specific health purposes.[91]

143. **HIV programmes in UHC.** The process and methods for designing an essential benefits package can be contentious and complex, and involve difficult decisions regarding the services that should be included or excluded in public subsidies.[92 93]

144. Various economic factors, epidemiological realities and health system capacities—and the maturity of the UHC—will determine how countries go about defining their UHC essential

benefits packages. For example, the positioning of HIV services in Thailand differs significantly from the way HIV would be integrated in UHC in Kenya or Nigeria.

145. The selection of interventions to be included in UHC essential packages should be guided by evidence of effectiveness and expected impact. The Joint Programme should be ensuring that key interventions (including needle and syringe services, opioid substitution therapy and condom provision) are integrated into UHC essential packages and that key populations are covered through national health insurance or other financial protection mechanisms. Donor funding and advocacy will be required to ensure “bridge financing” for community-led service delivery to reach people left behind and avoid disruption of services while integration is achieved.

146. **Engage in the health financing strategies design.** Health financing strategies are a vital component of UHC and are essential for building appropriate payment models, exploring HIV financing integration and pursuing the reduction of user fees.

147. Once it is decided which HIV services are to be included in the health benefits package (and therefore can receive public subsidies), the payment modality for delivering the subsidy has to be selected. The design of health financing mechanisms is typically decided on a system-wide basis (e.g. across all disease areas and services) rather than for HIV specifically.

148. The choice of financing modality is likely to have important implications for the sustained quality and coverage of HIV services. UNAIDS should participate in health financing discussions to ensure that the effects of financing decisions on the AIDS response are well understood and that the risks are appropriately mitigated.

149. **Create mechanisms for sustainable community-led delivery**, including through NGOs and civil society. Civil society is often closely involved in the planning, implementation and monitoring of HIV services, especially those that focus on reaching people who are left behind, including adolescent girls and young women and key populations. Community organizations often are the only entities capable of reliably engaging key and marginalized populations and linking them to HIV and other essential services.

150. Social contracting (defined as the use of government resources to fund non-governmental entities)[94] will be essential to maintain these services as external financing for HIV programmes decreases. However, some countries currently lack both the political will and the legal/regulatory structures to directly fund community-led organizations, even when sufficient resources are available. In working with governments to develop social contracting mechanisms and other funding mechanisms, UNAIDS should recognize and address the common barriers and risks.[95] They include:
    - civil society organizations' overreliance on government funding may compromise their independence and ability to serve as effective advocates;
    - governments may be unwilling to provide core support to civil society organizations, thereby compromising their effectiveness and sustainability;
    - governments may refuse to provide funding to serve the most marginalized and/or criminalized key populations; and
    - procurement processes for identifying and contracting NGOs may be biased toward larger or less politically controversial organizations, which could compromise the quality and sustainability of community-led services.

151. **Sustain multisectoral financing of HIV activities.** Elements of the AIDS response are financed and delivered outside the health sector (e.g. via social protection mechanisms or support for school- or community-based health education). There is a need to maintain and track multisectoral financing contributions to the HIV response. Countries will need to

integrate investments in human rights, gender equality and enabling environments with government budgets to sustain these important activities. Tracking and measuring equity will be essential to sustain those efforts.

152. **Integrate donor financing within government-led fiduciary systems**. The transition to country-led financing systems—even when subsidized with external financing—requires long-term planning, political will and innovative strategies to meet donor requirements for the accountable use of their funds. External donors are typically risk-averse, particularly with respect to the perceived or real risks that funds might be stolen or diverted from their intended purposes. Donors have historically managed such risks by setting up financing and delivery mechanisms that operate in parallel to government systems.

153. Transitioning external funding flows to government systems will be a long-term and challenging endeavour. Pooled trust funds offer a promising model for channelling external financing through government-led fiduciary systems. In Ethiopia, for example, the SDG Performance Fund pools the contributions of many development partners within a single fund. Donor contributions are aligned with the Government's planning and fiduciary cycles and are managed via its legal and accounting procedures in support of the Health Sector Transformation Plan.[96]

How will this be done?

154. It is possible to ensure long-term predictable funding and sustain the gains made, but it will demand accelerated quality implementation, front-loading of investments and rapid narrowing of the funding gaps. Without prompt action to reduce new HIV infections, the costs to national budgets and human capital will keep increasing.

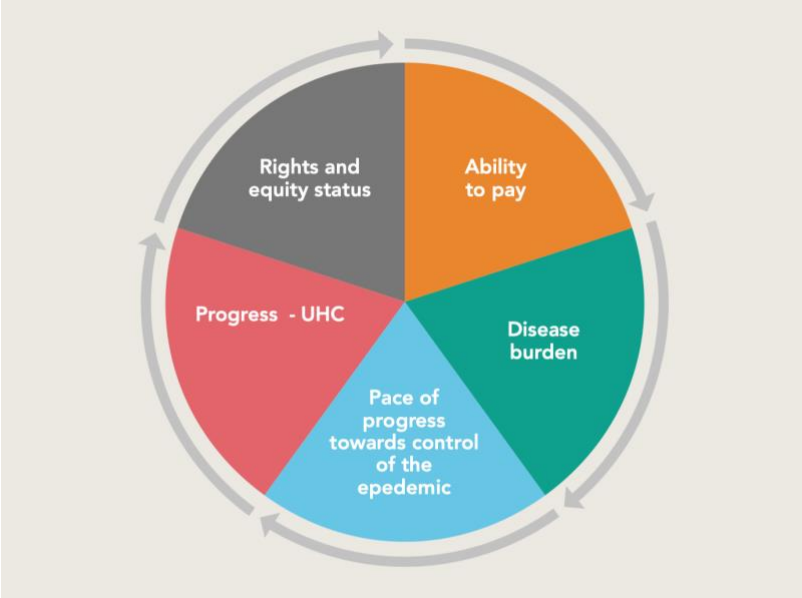
155. The proposed Sustainability Framework is designed to be forward-looking and to be customized to different country contexts. Using it to achieve equitable results will require a careful review of country contexts and needs. Such a review should take account of ethical, political, economic and programmatic considerations, guided by the key principle of a people-centred approach. That principle is vital for every stage and metric of the sustainability approach, including the generation of empirical evidence to track allocations and monitor programmes serving people left behind.

Key actions

156. UNAIDS should help all countries apply the four components of the proposed Sustainability Framework, as outlined earlier. The Sustainability Framework—its foundation and main components—can help us better understand and accurately categorize preparedness at country level. This will help accelerate the AIDS response and define the types of support that should be provided.

157. The proposed Sustainability Framework can facilitate the diagnosis of a country's key sustainability challenges (Figure 6) and make it possible to group countries according to their contexts and needs—for example:
- ability to pay;
- disease burden;
- pace of progress towards control of the epidemic;
- progress towards UHC; and
- rights and equity status (enabling a composite measure of comprehensive laws and policies, data on stigma and discrimination and gender and service coverage among key populations).

Figure 6. Multi-criteria to guide country actions



158. The findings would guide UNAIDS' priorities in shaping country-level approaches to investments, transitions and sustainability plans. Ultimately, a coherent Framework would help UN partners and donors prioritize country-level engagements that can strengthen country ownership, reduce fragmentation and maximize the impact of their support.

159. Countries in the "risky middle" require tailored support to address emerging gaps created by decreasing donor funding. The gross national income per capita metric is an inadequate criterion for deciding funding and setting priorities for support. It masks inequalities within countries and fails to capture contextual realities, including political will, that help decide the scale and character national AIDS responses.

160. Technical support should be provided to all countries to develop and introduce tailored and integrated sustainability plans and to establish roadmaps that can help them stimulate domestic resources at their own pace. Government, donor and implementor responsibilities should be outlined clearly, and measures should be implemented to evaluate progress over time without jeopardizing the response.

161. Special attention and technical support must be in place to support transitions—especially "within-country transitions" which often occur quickly and without prior warning. Costs, policies and investments related to a country's fiscal capacity should be evaluated so the government can embark on necessary policy shifts and leverage support from partners. This will require early action to prepare for effective transitions, develop transition plans and, if necessary, enlist support from partners and donors to identify "bridge funding". These steps are especially important for programmes serving adolescent girls and young women and key populations, as well as human rights and gender programmes.

162. Partnerships to deliver results should be leveraged with governments, civil society organizations, regional entities, regional development banks, UN agencies, PEPFAR, the Global Fund, the private sector and other key partners to identify the needs, resources and strategies required to deliver shared results for targeted populations.

163. Technical capacity support is needed to strengthen the abilities of national stakeholders (government, civil society organizations and community-led organizations) to design and

implement investment, transition and sustainability dialogues. Support is also needed to engage in broader health financing and UHC dialogues.

164. Monitoring frameworks and revised metrics to measure progress towards sustainability are required. Measures should be expanded to track domestic funding trends and the allocations of funds for specific programmes, particularly those serving adolescent girls and young women, and key populations. The monitoring frameworks should also facilitate measuring the absorption of community health workers into domestic funding and community-response financing, including social contracting for NGOs and community-led organizations. In addition, funding for human rights and gender programmes must be sustained and integrated in national planning budgets. It is important to integrate the epidemic transition metrics with a focus on HIV incidence reductions.[97]

RECOMMENDATIONS

165. Recognizing the emerging challenges, the potential high cost of complacency and the importance of ensuring the sustainability of the AIDS response results through a people-centered approach;

166. Stressing the importance of ensuring that funding is focused to reach people left behind, especially adolescent girls and young women and key populations, and of creating an enabling environment for integrating those programmes into the domestic funding baskets;

167. Recognizing the importance of engaging with the broader UHC and SDG agenda and of ensuring progress towards ending AIDS as public health threat by 2030;

Countries are encouraged to:

168. Work to ensure accelerated and sustainable AIDS response impact by adopting a systems-wide approach, by establishing country working groups to advance that agenda and apply the proposed Sustainability Framework, and by developing investment, transition and sustainability plans. Those plans should reflect the principles of country ownership, shared responsibility and multisectoralism;

169. Implement their commitments to close the HIV funding gap and progressively increase domestic contributions, including for programmes for people left behind, and to create an enabling environment that accelerates their AIDS response;

170. Ensure that HIV is integrated in the broader dialogue on health financing, UHC and SDGs to protect the gains made thus far and to build long-term sustainable progress.

It is recommended that UNAIDS:

171. *Step up* its support for countries implementing the Joint Programme Policy Framework on Investments and Sustainability through the following key actions:

    a. engage with country stakeholders, communities, people living with HIV and donors to support country-led working groups on investments and sustainability;
    b. guide priority actions regarding investments to close the funding gap, accelerate the AIDS response, improve programme implementation quality, increase efficiency by adopting the UHC lens, and manage funding transitions;
    c. support the development and implementation of equitable, country-tailored and integrated investment cases, robust national HIV and health strategies, transition plans and sustainability frameworks, with specific emphasis on the “risky middle” and "within-country

transitions", that include accountability measures for government, donors and implementers;
d. leverage the UN reform process to ensure that the need for sustainable AIDS response results is reflected in the long-term UN frameworks;
e. strengthen capacities of country stakeholders and communities to advocate with Ministries of Finance and other relevant stakeholders to absorb community health workers into public budgets and support social contracting and other mechanisms that can increase sustained financing for community-led organizations;
f. intensify technical support and analytical work to inform country policy choices regarding UHC, options for eliminating user fees and out-of-pocket expenditures, and in-depth analysis of HIV and health financing in selected priority countries;
g. develop a framework for tracking progress towards reduced dependency, increased domestic funding and prompt identification of donor transitions; and
h. integrate metrics to track progress towards the HIV epidemic transition, allocations to people left behind (e.g. key populations and adolescent girls and young women, and human right programmes) and domestic resource contributions, funding for community health workers and community-led organizations, and to monitor HIV services in the UHC essential benefit package.

PROPOSED DECISION POINTS

172. The Programme Coordinating Board is invited to:

173. Recalling the commitments in the 2016 Political Declaration on Ending AIDS, as well as the 2030 Agenda for Sustainable Development, and in order to ensure progress towards the goal of ending the AIDS epidemic as public health threat by 2030; and

174. Recognizing the emerging challenges, the potential high costs of complacency and the importance of ensuring that the goal of sustainability shapes the decisions of all partners, country stakeholders, communities and donors;

175. *Take note* of the report;

176. *Encourage* countries to develop integrated AIDS investment cases as well as transition and sustainability plans that are linked with health and SDG financing strategies, and to fulfil their commitment to close the funding gaps;

177. *Request* UNAIDS to develop a Joint Programme Policy Framework on Investments and Sustainability and metrics to inform a coherent people-centered approach that will be utilized to guide high-impact support to countries and communities; and to report back to the PCB meeting in December 2019 on results achieved and lessons learned in at least 10 countries.

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