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**Agenda item 11**

**Shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda**: Increasing domestic funding to ensure a comprehensive and sustained HIV response, 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

## BACKGROUND NOTE

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## INTRODUCTION

1. The recent adoption of the 2030 Agenda for Sustainable Development signals a critical juncture in the global community's approach to development. The agenda reflects a significantly changed context since the Millennium Development Goals were agreed, including shifting poles of influence and wealth, growing connectivity, intensifying global crises and the increasingly global nature of the determinants of health. It recognizes that today's world is marked not only by deep inequities, but also by an emerging appreciation of our shared values and interdependence. Consequently the new agenda posits that sustainable development demands a much more complex compact of obligations among countries of all income levels.

2. Among the Sustainable Development Goals (SDGs), health, which had three of the eight Millennium Development Goals (MDGs), has arguably lost some visibility. Commitment to the AIDS response, previously MDG 6, is now a single target among 169. At the same time, in 2015 the global community invested more than ever in the AIDS response and, through the SDGs, committed to the historically ambitious aim of ending the AIDS epidemic as a public health threat. Such support is a testament to the continued efforts of countries, international partners, civil society and the private sector to meet their obligations to people living with and affected by HIV.

3. As the SDGs mark a departure from a focus on poverty reduction in poor countries to sustainable development in all countries, so too the concept of global health has evolved—from the health of poor countries to the health of the global community. It is a shift towards leaving no one behind through shared responsibility and global solidarity. This approach, and the reciprocal commitments it entails, can become the unifying force to redress health disparity and vulnerability, assure the realization of the global citizen's right to health, no matter where they live or who they are, and in so doing, provide a clear path towards ending the AIDS epidemic by 2030. The growing commitment of countries of all income levels to the AIDS response already demonstrates the response's innovative leadership in realizing the principle of shared responsibility and global solidarity.

4. Recognizing the centrality of shared responsibility and global solidarity to the future of the AIDS response, at its 35th meeting, the UNAIDS Programme Coordinating Board agreed that the thematic segment of the 37th Programme Coordinating Board meeting would focus on *Shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda*: Increasing domestic funding to ensure a comprehensive and sustained HIV response, including ensuring domestic funding that respects the GIPA principle and addressed the needs of key populations[1], including women and girls and other vulnerable groups, in line with national epidemiological contexts.

5. The historic opportunity to end the AIDS epidemic by 2030 underscores the importance of realizing the multi-faceted compact of shared responsibility and global solidarity to

[1] As defined in the UNAIDS 2011-2015 Strategy 'Getting to Zero', footnote n. 41: 'Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, prisoners and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context'.

achieve ambitious Fast-Track targets by 2020 and ensure the sustainability of the response over the long run. In collectively working towards an AIDS response characterized by shared responsibility and global solidarity, emerging challenges will need to be addressed, funding shortfalls closed and innovative strategies used to mobilize the required resources. At the same time that efforts intensify to generate new, sustainable resources, the ways that resources are used will also need to be improved to maximize efficiency, equity and results: new service delivery approaches will be needed, programmes must be better focused on high-impact locations and populations, resources will need to be allocated towards the interventions likely to have the greatest impact and new initiatives will be required to ensure the security and affordability of HIV-related commodities.

6. This background note opens with a brief discussion on the shift from the MDGs to the SDGs. It proposes a framework of five elements of shared responsibility and global solidarity, and briefly examines each. The rest of the paper largely focuses on the sustainable funding element of shared responsibility and global solidarity, providing a status report on the funding outlook for the global AIDS response. A discussion of the resources needed to Fast-Track the AIDS response is followed by an examination of the opportunities and challenges for generating those resources. This note then explores the importance of maintaining and building financing for civil society organizations and opportunities for innovative partnerships to close the resource gap. The background note closes with a discussion of the way forward, including recommendations to ensure a sustainable response to end the AIDS epidemic by 2030.

## A NEW, MORE COMPREHENSIVE AGENDA: FROM THE MDGs TO THE SDGs

7. The Agenda for Sustainable Development is of unprecedented proportion with numerous priorities each requiring sustained political commitment and considerable levels of funding (Figure 1).[2] As one target among 169, the global AIDS response will be addressed alongside a broad spectrum of human development aspirations, ranging from curbing climate change to eliminating extreme poverty and ensuring sustainable economic growth and shared prosperity.[3]

[2] Matthieu Boussichas, Patrick Guillaumont (ed) 2015. Financing sustainable development: Addressing Vulnerabilities. P12
[3] http://sustainabledevelopment.un.org/index.php?menu=1549

*Figure 1: From the MDGs to the SDGs—Expansion and diversification of the global development agenda*

**Eight Millennium Development Goals**


**17 Sustainable Development Goals**


8. Just as the MDGs reflected the world and its development challenges and priorities in 2000, the SDGs reflect a world considerably altered moving from curbing climate change to eliminating and taking into consideration the rapidly expanding connectivity and interdependence of all people and societies. Long-familiar crises and challenges persist, but with changed dynamics, shifts in assigned or perceived political urgency and important changes in development financing. While AIDS in 2000 was rapidly emerging as a major global crisis, the epidemic in 2015 is no longer perceived as the largest – and for some, the most urgent – issue confronting the world. This means that few of the mainstays that underpinned the success of MDG6 can be taken for granted in planning to end AIDS by 2030. Nevertheless, the AIDS challenge remains unfinished, with two million people newly infected with HIV in 2014 alone.

9. Progress towards the SDGs will demand an unprecedented level of intersectoral and multistakeholder collaboration. Countries have a new range of strategic choices, and there is a new imperative to reform and reinvigorate multilateral and regional organizations. Long overdue, cooperation on taxation is increasingly recognized as a critical source of sustainable development financing, as articulated in the Addis Ababa Action Agenda in which countries agreed on a series of measures to broaden tax bases, improve tax collection and fight tax evasion and illicit financial flows. Momentum is also building to strengthen linkages and coalitions across health and development fields and pursue pooled and co-financing strategies. This provides a critical opportunity for the AIDS response, which can only be ended by significantly strengthening its ability to influence and mobilize action across sectors and partners in addressing the determinants of vulnerability and health, creating essential fiscal space, securing efficiency gains and meeting the holistic needs of people living with and affected by HIV.

## SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY: MUTUAL OBLIGATIONS FOR A MORE SUSTAINABLE, PEOPLE–CENTRED AND EFFECTIVE AIDS RESPONSE

10. The AIDS response, supported by UNAIDS, has been a leader across the global health and development community in defining the contours of and implementing and monitoring the realization of shared responsibility and global solidarity. As an evolving concept, it rests on the premise that stakeholders in the response—including states, international organizations, civil society and the private sector—should meet their obligations, according to ability, need and comparative advantage, to ensure that all people can realize their right to health. In promoting fairer distribution of resources, health and opportunity, such an approach recognizes that given the highly uneven distribution of HIV prevalence and its concentration in low- and middle-income countries, any truly fair sharing of responsibility may also be uneven, but not inequitable.

11. Shared responsibility and global solidarity is more critical than ever, as achieving Fast-Track targets will require higher levels of commitment than in preceding decades and more innovative, integrated strategies to deliver sustainable results. The quality and durability of collective engagement on AIDS will depend on a continuously renewed understanding of the sources of global solidarity and national and international responsibility, including human rights, social justice and ethical responsiveness.

12. Shared responsibility and global solidarity is fundamental to achieving sustainable funding for the AIDS response. Yet, this agenda encompasses much more than mobilizing resources. It embodies a nuanced partnership for sustainability through shared commitment to: meeting the resource needs of an efficient response; ensuring national and global policy frameworks that enable investments to reach people in need; strengthening systems for health at all levels; mobilizing multistakeholder and multisectoral cooperation; and enabling inclusive governance and people-centred accountability to monitor and demand progress. These five commitments are briefly explored below.

### *Shared commitment to meeting the resource needs of an efficient response*

13. Health financing is a central component of the right to health. Mobilizing the resources needed to end the epidemic is entirely feasible—but will require harnessing new opportunities and balancing responsibilities according to capacity and the emerging political and economic environment—the ‘fair share’ principle. High-income countries must provide increasingly long-term, predictable support, while domestic investments will need to account for a growing share of total AIDS spending, in line with economic performance and burden of disease. Maintaining political commitment to the response will increasingly rely on the existence of country-owned, costed plans to guide strategic investments, maximize efficiencies and ensure access to quality services.

### *Shared commitment to ensuring supportive legal and policy environments*

14. Shared responsibility and global solidarity also entails collectively resolving to remove international and national legal and policy barriers to an effective and sustainable response—such as intellectual property and trade barriers to affordable, quality medicines and other health products, as well as punitive laws against people living with and at risk of HIV. Rich and poor countries alike have mutual obligations to ensure that legal and policy frameworks across sectors uphold non-discrimination and the human right to the highest attainable standard of health.

***Shared commitment to strengthening systems to deliver HIV-related services***

15. Sustainability in the AIDS response further demands a continued shift away from vertical programming towards more integrated, holistic programmes delivered through existing health, social and community systems. In many places, such systems are in dire need of strengthening. Countries, in partnership with the private sector, civil society, communities and international partners, must commit to collectively ensure that all people can access high-quality health services, including for HIV, without experiencing financial hardship. Opportunities include co-funding development efforts, empowering communities to deliver services closer to the people that need them and integrating HIV into broader national health-funding systems that will yield more broadly based health benefits.

***Shared commitment to mobilizing multistakeholder, multisectoral cooperation***

16. In today's complex political, economic and development context, shared responsibility and global solidarity for the AIDS response entails the engagement of an increasing breadth of stakeholders. Countries will need to pursue differentiated approaches in their relationships with their development partners, civil society organizations and the private sector. Middle-income countries, for example, are increasingly engaging in transfers of technology, private investments and other types of South-South cooperation, recognizing global health as a form of soft diplomacy and a gateway to political and economic alliances. Furthermore, HIV vulnerability and broader health is often the product of policy-making processes and actions initiated in multiple sectors, necessitating co-financing and cross-sectoral action to confront the social, political and economic factors that contribute to HIV vulnerability and health inequity.

***Shared commitment to inclusive governance and people-centred accountability***

17. At the heart of the activism that sparked the AIDS movement was a common sense of urgency, as well as belief in the value of human dignity and the power of collective action. Participation driven by the shared values of human rights, inclusion and equality must form the backbone of shared responsibility and global solidarity. Legitimacy and authority of governance bodies in the post-2015 era will only be possible through the engagement and representation of the governed. Stakeholders must there commit to transforming norms and decision-making processes and bodies to ensure meaningful participation, as well as expand the effective use of modernized accountability mechanisms to improve interconnectedness, transparency and communication.

18. These five elements are proposed as a universal framework for shared responsibility and global solidarity. The framework however must be adaptable in both strategic and programmatic terms. In its implementation, it must be carefully deliberated and negotiated, both at the outset and at critical junctures to ensure, among other things, that there is no shortfall in funding for high-burden countries and vulnerable communities, where the consolidation of gains to date is most vulnerable.

19. While UNAIDS proposes that shared responsibility and global solidarity be understood in these holistic terms, in light of the requested focus by the PCB, the rest of this paper will focus largely on the first element of sustainable funding—though several of these elements are discussed from a funding perspective.

## BACKGROUND: 15 YEARS OF UNPRECEDENTED MOBILIZATION OF POLITICAL COMMITMENT AND RESOURCES FOR THE GLOBAL AIDS RESPONSE

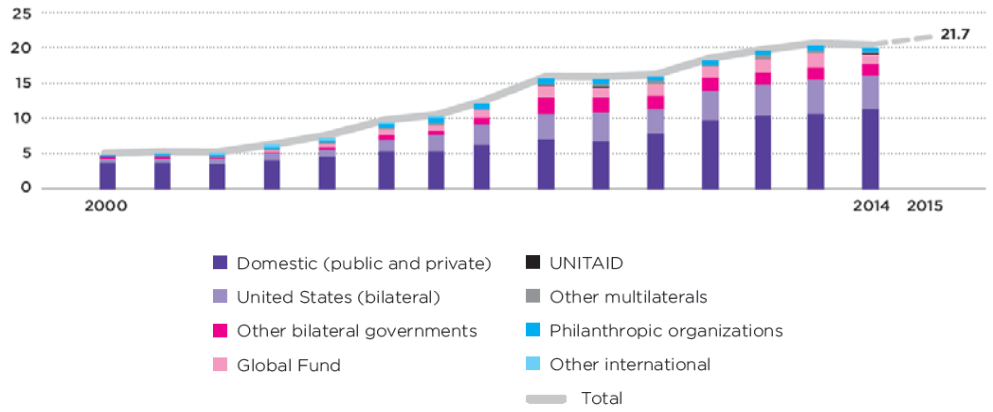
20. When the United Nations Joint Programme on HIV/AIDS (UNAIDS) was launched in 1996, the global AIDS epidemic was growing exponentially, reversing decades of development gains in the most heavily affected countries. Yet even as AIDS posed a profound threat to global health, well-being and security, the world in 1996 was spending less than US$300 million per year on HIV-related programmes and activities in low- and middle-income countries.[4]

21. The global community took a critical step towards mobilizing political priority by including the goal of halting and beginning to reverse the AIDS epidemic in the MDGs. Aiming to make this commitment a reality, the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) proved to be a watershed moment in the world's response to AIDS, outlining for the first time a series of concrete, time-bound goals and commitments. In the months leading up to the first-ever UNGASS devoted to a single disease, United Nations Secretary-General Kofi Annan proposed the creation of a "global war chest" for the AIDS response. The resulting 2001 Political Declaration of Commitment on HIV/AIDS endorsed the creation of a global fund to finance the AIDS response and pledged to mobilize US$ 7 to 10 billion a year for HIV-related programmes in low- and middle-income countries.

22. Thus since 2000, global AIDS financing has steadily increased, rising to a projected US$ 21.7 billion in 2015 (Figure 2).[5] Never before have such sums been mobilized to respond to a global health problem. The path towards steadily increasing resources for AIDS has been marked by a number of key milestones (Figure 3). Established in 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) rapidly developed into an essential pillar of the AIDS response. It is estimated that as a result of investments by the Global Fund, more than 20 million lives will have been saved by the end of 2016. [6] In 2015, the Global Fund reported that its grants were supporting the provision of antiretroviral therapy to 8.1 million people worldwide.[7]

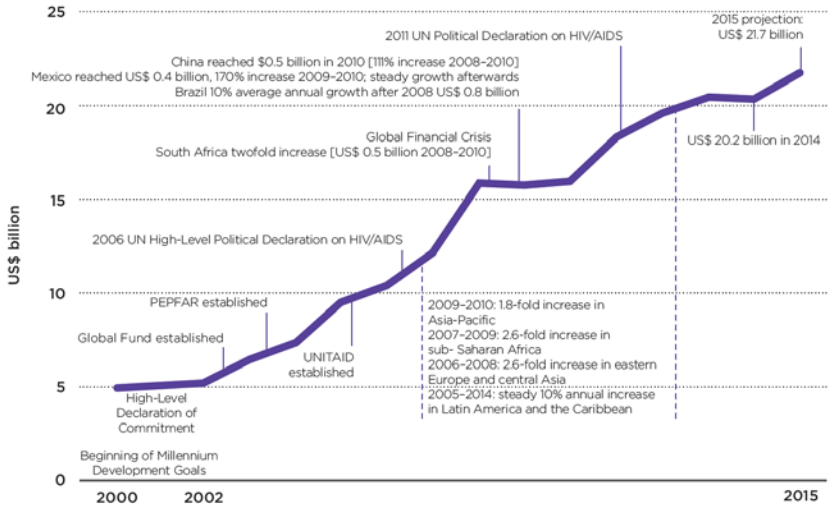
[4] AIDS at 30: Nations at the crossroads, 2011, Geneva: UNAIDS.
[5] How AIDS changed everything, 2015, Geneva: UNAIDS.
[6] Results Report 2015, Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria.
[7] Results Report 2015, Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria.

*Figure 2: Global resources for HIV in low- and middle-income countries, 2000-2014 (in US$ billion)*




*Source:* UNAIDS estimates June 2015, based on UNAIDS-KFF reports on financing the response to AIDS in low- and middle-income countries until 2014; OECD CRS last accessed June 2015; GARPR/UNGASS reports; FCAA Report on Philanthropic funding Dec 2014.

*Figure 3: Total resources for HIV in low- and middle-income countries, 2000-2015*

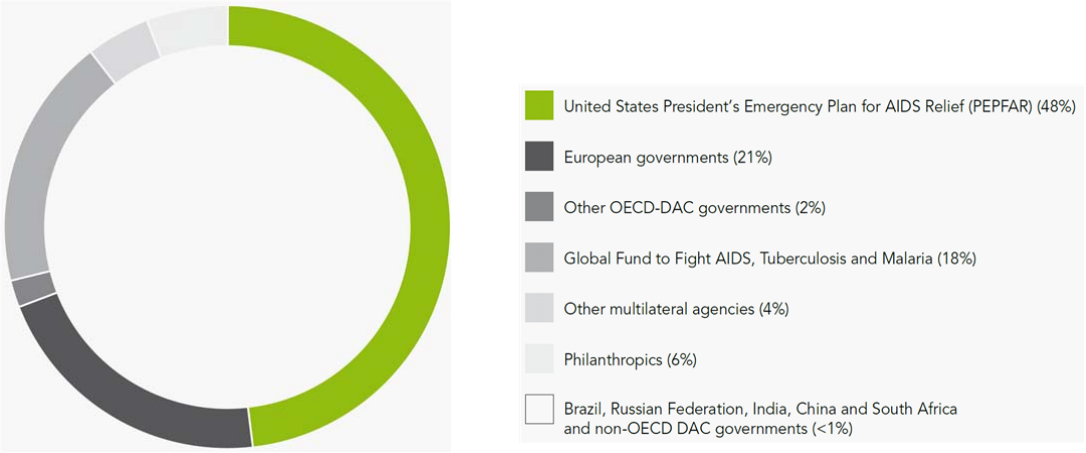



*Source:* UNAIDS estimates June 2015, based on UNAIDS-KFF reports on financing the response to AIDS in low- and middle-income countries until 2014; OECD CRS last accessed June 2015; UNGASS and GARPR reports; FCAA Report on Philanthropic funding Dec 2014.

23. Establishment of the United States President's Emergency Plan for AIDS Relief (PEPFAR) in 2003 placed the power of the world's largest national economy behind the AIDS response. PEPFAR has to date committed US$ 51.8 billion to the response, primarily in low- and middle-income countries.[8]

24. A host of other countries have contributed to the AIDS response through generous international assistance (Figure 4). Among leading development partners, the countries whose share of international HIV assistance approaches or exceeds their share of the global economy include Denmark, Ireland, Netherlands, Norway, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States of America (Figure 5).[9] The first-ever assessment of Africa-G8 commitments on AIDS, TB and Malaria, conducted by the African Union, concluded that the G8 had delivered on its major commitments.[10]

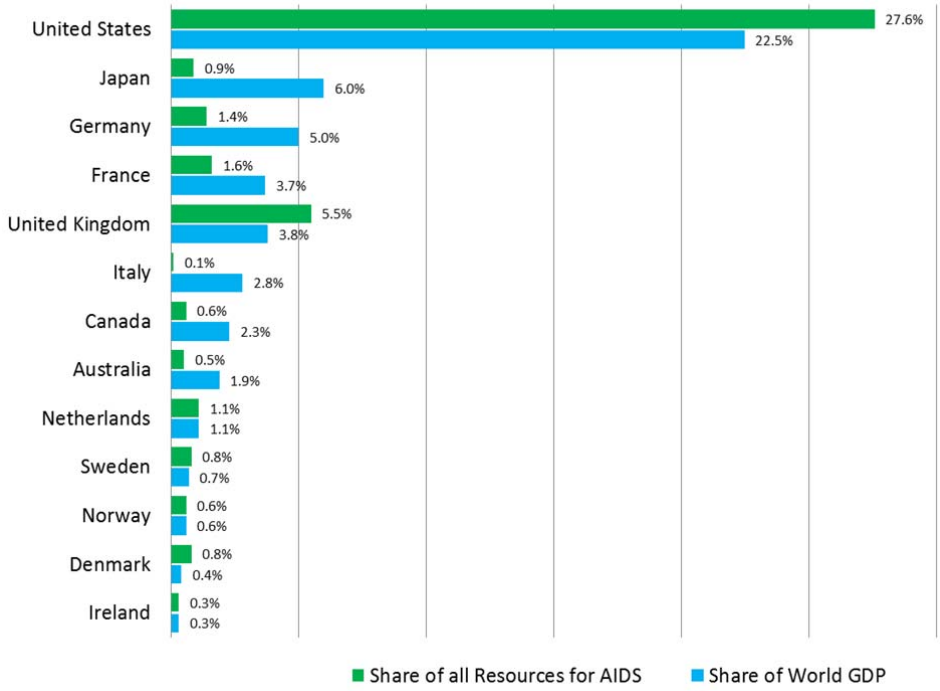
*Figure 4: Sources of international funding for HIV, 2014*




Source: UNAIDS How AIDS changed everything — MDG6: 15 years, 15 lessons of hope from the AIDS response, 2015

[8] PEPFAR Funding, 2015; Washington DC: President's Emergency Plan for AIDS Relief.
[9] Kates J, Wexler, A, Lief E, Financing the Response to HIV in Low- and Middle-Income Countries, 2015: Henry J. Kaiser Family Foundation, UNAIDS.
[10] Delivering Results toward Ending AIDS, Tuberculosis and Malaria in Africa. African Union, New Partnership for Africa's Development and UNAIDS; 2013.

*Figure 5: Assessing Fair-Share—Development partner share of all resources available for HIV compared to their share of world global domestic product (GDP), 2014*




*Source: UNAIDS and Kaiser Family Foundation. International assistance from donor governments 2014, July 2015.*

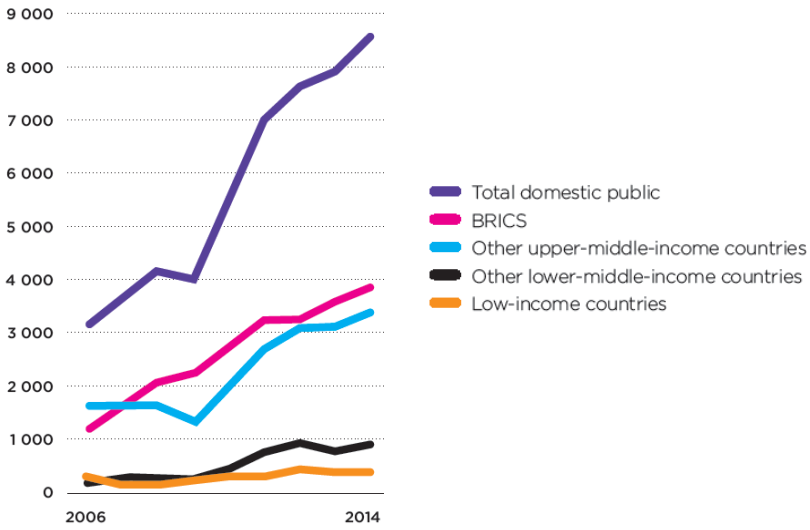
25. Over time, there have been several remarkable shifts in the AIDS funding landscape. As the epidemic has evolved and the array of proven interventions has expanded, global aspirations for AIDS funding have risen, with *the 2011 Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* citing the goal of mobilizing US$22 billion to US$24 billion annually to finance the AIDS response. Even more profoundly, the AIDS response, with rapidly growing contributions from domestic sources combining with robust international support, prefigured the sustainable development agenda, which aims to replace an outmoded approach of development for the poorest countries to sustainable development for all. This shift simultaneously recognizes that all countries are both vulnerable to and play a role in addressing development challenges, the existence of fragile communities in countries of all incomes levels, and the increased capacity of many countries to finance a larger share of their own development needs.

26. Commitment to shared responsibility and global solidarity has driven recent shifts in funding for AIDS. In 2012, the African Union articulated the emerging approach to global health and development in its Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria Response in Africa. Consistent with this approach, low- and middle-income countries have increased domestic HIV investments. In 2015, domestic public sector investments in AIDS accounted for 57% of all HIV-related resources in low- and middle-income countries[11], and nearly tripled from 2006 to 2014 (Figure 6).[12] Altogether, upper-middle-income countries currently cover 80% of their HIV-related investments, with several countries having taken steps to assume full self-

[11] How AIDS changed everything, 2015, Geneva: UNAIDS.
[12] How AIDS changed everything, 2015, Geneva: UNAIDS.

financing of their response.[13] Among low- and lower-middle-income countries, many have increased their domestic allocations for the AIDS response, with a number either exploring or having already implemented tax levies, trust funds or other innovative means of mobilizing essential financing for the response.[14] At the same time, international HIV assistance rebounded from its decline during the global financial and economic downturn, rising from US$6.9 billion in 2010 to US$8.6 billion in 2014.[15]

*Figure 6: Domestic public spending in low-and-middle income countries, 2006-2014, in US$ million*




Source: UNAIDS How AIDS changed everything — MDG6: 15 years, 15 lessons of hope from the AIDS response, 2015

[13] UNAIDS estimates, 2015.
[14] Smart Investments, 2013, UNAIDS: Geneva.
[15] Kates J, Wexler, A, Lief E, Financing the Response to HIV in Low- and Middle-Income Countries, 2015: Henry J. Kaiser Family Foundation, UNAIDS.

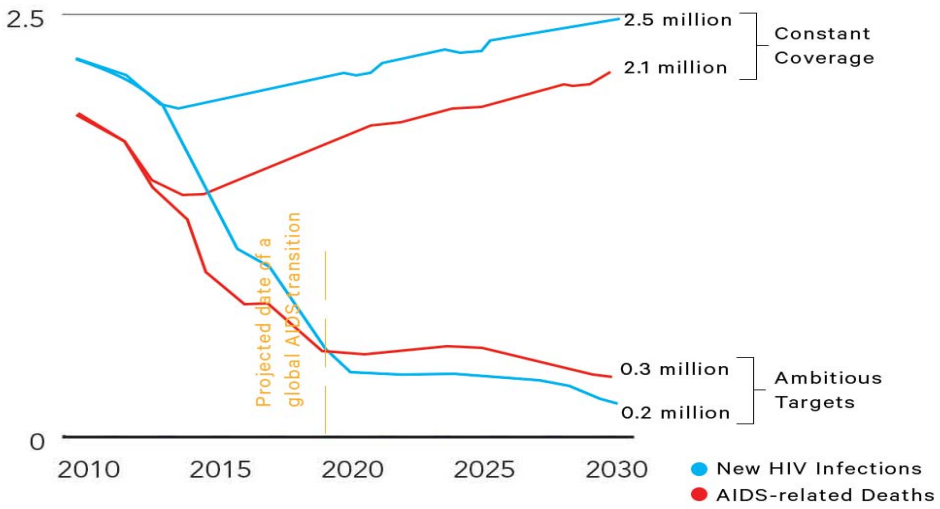
## SUSTAINABLE FUNDING TO FAST-TRACK THE RESPONSE: TOWARDS SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY

### Resource needs to reach ambitious Fast-Track targets for 2020

27. Modelling by UNAIDS indicates that the next five years represent a fragile window of opportunity to build the foundation to end the AIDS epidemic as a public health threat.[16] To fully capitalize on this historic opportunity, UNAIDS has identified Fast-Track targets for 2020 and 2030. By 2020, the world must reach the 90-90-90 target for treatment scale-up[17], reduce the annual number of new HIV infections among adults to no more than 500 000, and eliminate HIV-related discrimination. By 2030, the world needs to achieve an even higher level of success (95-95-95) across the HIV treatment cascade, reduce the annual number of new HIV infections among adults to no more than 200 000, and maintain a climate of zero discrimination. While the Fast-Track approach is pertinent for all low- and middle-income countries, UNAIDS is bolstering advocacy and technical support in 35 countries (including 33 low- and middle-income countries) that together represent more than 90% of people acquiring HIV annually.

28. If sufficient resources are invested over the next five years to achieve ambitious Fast-Track targets, the annual number of new HIV infections and AIDS-related deaths in 2030 will be roughly 90% lower than in 2010, effectively ending the epidemic as a public health threat.[18] However, this modelling also includes a cautionary note. If the world fails to accelerate progress, the epidemic will rebound, resulting in more new infections and more AIDS-related deaths in 2030 than today (Figure 7).[19]

*Figure 7: Projected investments needed to Fast-Track the AIDS response*

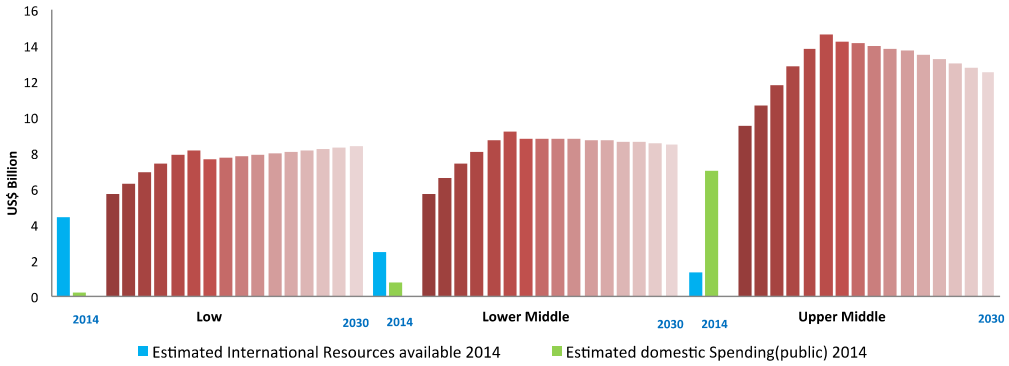



29. In its updated strategy for 2016-2021, UNAIDS estimates that up to an additional US$ 9 billion will be required to achieve the Fast-Track targets by 2020. The total annual resources will need to reach $31.1 billion by 2020 in low- and middle-income countries

[16] Fast-Track: Ending the AIDS epidemic by 2030, 2014, Geneva: UNAIDS.
[17] By 2020: (a) 90% of all people living with HIV will know their HIV status, (b) 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and (c) 90% of all people receiving antiretroviral therapy will achieve viral suppression.
[18] Fast-Track: Ending the AIDS epidemic by 2030, 2014, Geneva: UNAIDS.
[19] Fast-Track: Ending the AIDS epidemic by 2030, 2014, Geneva: UNAIDS.

(as classified in 2015), including US$ 7.4 billion in low-income countries, US$ 10 billion in lower-middle-income countries and US$13.7 billion in upper-middle-income countries (Figure 8). Sub-Saharan Africa will need the largest share of global investments, around US$$ 9 billion will be required to achieve the Fast-Track targets by 2020. The total annual resources available to countries will decline by around 10% to US$ 28.5 billion by 2030.

*Figure 8: Resources available for HIV in 2014 and resource needs for 2015–2030, by level of low- and middle-income countries*




UNAIDS Estimates June 2015, UNAIDS-KFF study on Financing the Response to AIDS in Low- and Middle-Income Countries in 2014, OECD CRS last accessed June 2015, GARPR/UNGASS reports. WB income level classification July 2014.
Estimates of international disbursements shown in the above chart exclude disbursements from philanthropic foundations.

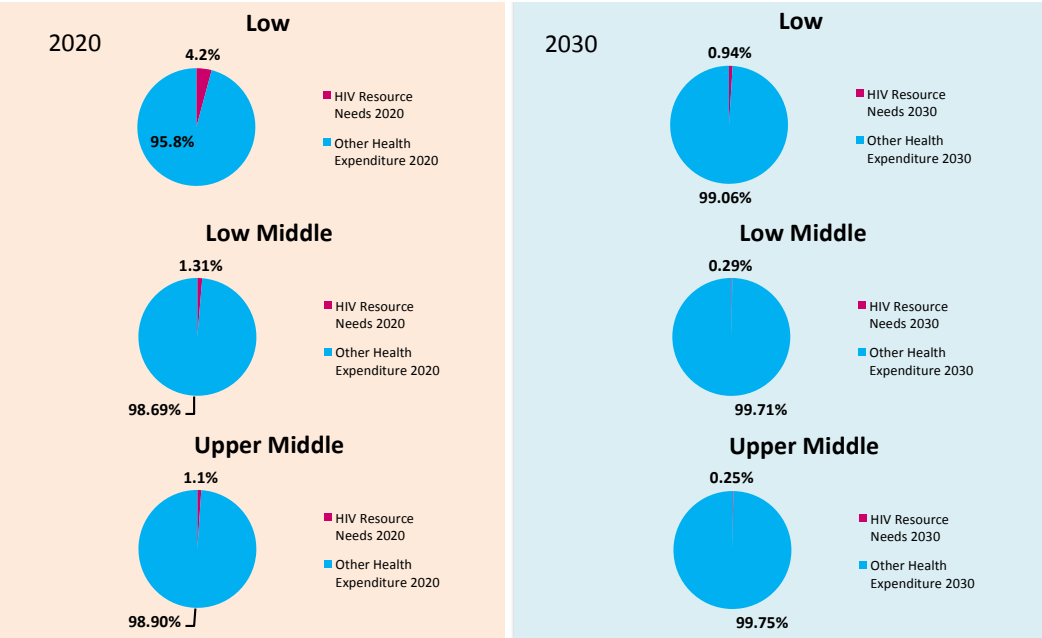
30. The financing target set forth in the updated UNAIDS Strategy for 2016-2021 assumes significant increases in the domestic public share of HIV financing by income level, based on fiscal space analysis, financial sustainability and current and projected health financing patterns and level. The shares of the domestic public resources out of the total investments in HIV, according to the UNAIDS financing targets by income level of countries, are to increase from recent values of 10% to 12% in low-income countries by 2020; in lower-middle income countries from 22% to 45% and in upper-middle income countries from 80% to 95%. The estimated total from domestic public sources would need to reach US$ 18.4 billion (or more than double current levels) in 2020. The growth in the domestic public investments in HIV would need to cover the additional resource needs to reach the 2020 Fast Track targets in addition to diminish the HIV out-of-pocket expenditures that have the potential to impoverish households. Opportunities such as progress towards Universal Health Coverage will need to be fully leveraged, reliable access to affordable, good-quality commodities must be ensured, and efficiencies will need to be maximized to extend the reach and impact of funding. Countries affected by humanitarian emergencies and that host refugees and other displaced persons may require additional resources to meet the HIV-related needs of these populations.

31. It is clear that many countries lack the means to end the epidemic solely with domestic funding. International HIV assistance must also increase over the next five years to make achievement of the Fast-Track targets feasible. Modelling indicates that annual international HIV assistance should rise from US$8.75 billion in 2014 to US$12.7 billion ($6.5 billion for low-income; $5.5 billion for lower-middle income, and; $0.7 billion for upper-middle income countries). To help reach targets for international HIV assistance,

development partners should ensure that their share of total international assistance matches or exceeds their share of the global economy.

32. Although a sustainable AIDS response will require considerable funding for some time, front-loading investments over the next five years will moderate future resource needs and, in the case of middle-income countries, enable HIV spending to decline from 2021. As projected economic growth and health spending continue, front-loading investments will result in a marked decline in HIV spending as a share of total health expenditure generally from 2020 to 2030 in countries at all income levels (Figure 9).

*Figure 9: HIV global resource needs estimates (health and non-health): share of total health expenditure by income level, 2020-2030*




33. How funding for AIDS is used is also expected to evolve in the coming years. While HIV prevention and treatment are projected to continue to account for the majority of AIDS spending in 2016-2030, their collective share of total spending are expected to fall from 77% in 2013 to 71% in 2020 and 66% in 2030. Over time, critical enablers[20], cash transfers for girls and pre-exposure antiretroviral prophylaxis will continue to be important, but the development synergies are likely to account for a decreasing share of the HIV-related spending to be increasingly funded by other sectors or by the health sector after HIV funds were used towards its strengthening.[21]

[20] 'Critical enablers' include both social and programmatic initiatives that support the effectiveness of programmatic efforts. Social enablers may include stigma reduction, human rights advocacy and treatment literacy programmes, while programme enablers help create demand for key services and improve programmatic performance. "Development synergies' refer to effective and synergistic leveraging of the efforts of other development sectors, which may help reduce HIV risk and vulnerability, increase service uptake and support service retention and adherence.

[21] How AIDS Changed Everything, 2015, Geneva: UNAIDS.

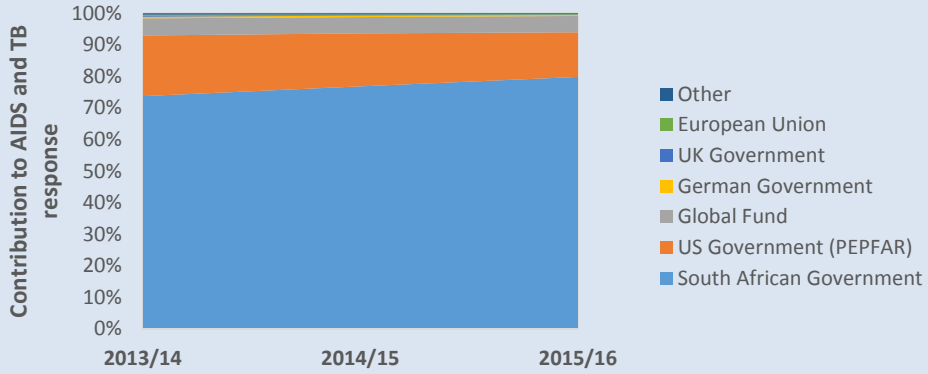
**Box 1: Case study of South Africa—National leadership for a sustainable AIDS response**

South Africa's upper middle income classification and membership in the group of major emerging economies (BRICS) masks the country's profound income disparities. Latest available data indicates that the wealthiest 10% of the population generates 54% of national income. South Africa scores 65 on the GINI index – the highest recorded level of inequality in the world – and more than twice that of India. South Africa also has the largest HIV epidemic in the world, with 6.4 million people living with HIV in the country, and nearly half a million new infections each year.

Yet, despite the scale of these challenges, as at March 2013, South Africa was providing 2.5 million people with HIV treatment, including 2.3 million receiving treatment in the public sector, making South Africa's national antiretroviral treatment programme the largest in the world. In 2013/14, the South African government funded 74% of the national HIV and TB programme, and the domestic share is set to rise to 80% by 2015/16. Funding for HIV by national and provincial departments of health accounted for nearly 8% of the total public health spending in 2011/12 and is expected to increase to 10% by 2015/16, despite the lack of growth in the allocations to health from the overall national budget (decreasing from 12% of the national budget in 12/13 to 11.4% in 2015/16).

This reflects the South African Government's commitment to the fight against HIV and TB, but there are concerns regarding the sustainability of this commitment. Despite the huge investments in HIV and TB by the South African government, the country still relies on partnerships with external multilateral and bilateral partners for its HIV and TB response. Although international HIV and TB assistance to South Africa rose dramatically from 2007/08 to 2009/10, South Africa is currently experiencing a reduction in financial aid from external partners. Funding from external partners is expected to decrease steadily over the next three years, as PEPFAR realigns its programmes to government priorities and withdraws from funding treatment facilities and as other development partners also reduce their support.

*Figure 10: Projected government and partner contributions to AIDS and TB response for South Africa, as % of total*




These trends intensify the country's longer-term challenge of providing antiretroviral treatment to new and existing eligible patients in South Africa. Over the period of the current National Strategy Plan (2012-16), South Africa needs to continuously enroll in excess of 500 000 new patients onto antiretroviral treatment per year to maintain its enrolment target. As South Africa has formally embraced the 90-90-90 target, future demand for HIV treatment will increase even further; only 45% of people living with HIV received HIV treatment in 2014.

Substantial costs will be associated with South Africa's efforts to meet Fast-Track targets. With the health budget already under pressure from the burden of the AIDS response, and the trend in decreasing allocations from the national budget to the health budget, closing the resource gap will present national decision-makers with a major challenge. It appears inevitable that South Africa will continue to rely, and increasingly so, on international support to sustain its AIDS response in the years to come.

**Box 2: The critical role of leadership**

The *African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria* (AU Roadmap) identified enhanced leadership and governance as one of its three pillars. The AU Roadmap called for leaders across Africa to mobilize leadership at all levels to implement the Roadmap and to display the leadership needed to make difficult choices and implement visionary strategies to ensure the long-term sustainability of the response. In this context, African Heads of States and Government established AIDS Watch Africa (AWA) in 2001 as a high-level advocacy and accountability platform to promote leadership, ownership and accountability on AIDS, tuberculosis and malaria and advocacy for mobilizing resources. Based on an AWA report in 2015, the AU Assembly extended the AU Roadmap until 2020 to achieve full implementation.

In the spirit of accountability, the African Union Commission and the NEPAD Agency, with the support of UNAIDS, undertook a review of Africa and G8 partnership commitments on AIDS, tuberculosis and malaria that identified successes and gaps on the part of the G8 and African countries in meeting their commitments to work together to reverse those epidemics.

As the remainder of this discussion paper makes plain, leaders at global, regional and country levels will need to strike out in bold new ways if they hope to end the epidemic once and for all. New ways of thinking will be needed, and traditional ways of working that are no longer tenable in a rapidly changing, Fast-Track environment will need to be jettisoned in favour of more effective approaches. This will require courage—not only from political leaders, but across all the stakeholders affected by the epidemic.

Signs of political leadership are evident in this critical juncture in the AIDS response. In Africa, Benin is increasing its HIV budget beyond the Global Fund threshold and is introducing universal health insurance. Quezon City in the Philippines is encouraging other cities nationally by using its HIV investment plan to mobilize resources and focus HIV prevention, treatment and care services. The Government of Kyrgyzstan is investing in HIV programming focused on the needs of vulnerable populations, while the Government of Armenia is increasing domestic funding for the AIDS response. Each case provides evidence of the important role of leadership.

## Achieving sustainable funding: challenges and opportunities

34. To meet the resource targets outlined in the updated UNAIDS Strategy, efforts will need to fully leverage shared responsibility and global solidarity and address key challenges, including creating fiscal space and mobilizing “fair-share” domestic resources; securing international HIV assistance; focusing resources on the populations and locations where they are needed most; maximizing efficiency gains; integrating AIDS funding into UHC or larger health system budgets; expanding alternative funding sources; and enabling and strengthening new forms of governance and cooperation.

### 1) Creating fiscal space and mobilizing “fair share” domestic resources

> “*…yes, we are under pressure to revisit our expenditure commitment and disbursement portfolios but the drive for revisiting is much broader than the narrow issue of HIV and AIDS. For us, as a country, this is an outcome of trying to understand the broader implications of our elevation to a lower middle-income status. For our people, it is clearly a signal of our maturity after independence, but we simply don’t understand how, financially, the elevation will affect our ability to service all the commitments we have without a continuation of some of the contributions we receive from our partners*.”
>
> Minister of Finance, high burden country in Africa, 2 September 2015

35. Available evidence indicates that fiscal space exists in most low- and middle-income countries to increase domestic financing for the AIDS response. When such indicators as national wealth and HIV burden are taken into account, a recent review of spending data from 12 high-burden countries (including low-, lower-middle and upper-middle income countries) found that *all* were spending less domestically on AIDS than these benchmarks would suggest. As economies grow—the World Bank projects 4% GDP growth in Africa in 2015 and more robust growth in 2016—countries should have the capacity to increase their financing for the AIDS response over time as well.

36. However, leveraging available fiscal space to increase domestic funding for AIDS will inevitably encounter political and practical challenges. The reality, even in high-burden countries, is that AIDS is one among a proliferating array of challenges societies face. Moreover, in the face of potential declines in international assistance, countries now confront considerable uncertainty regarding the magnitude and timing of future resource demands on the domestic public sector. Moreover, the vertical nature of much of international HIV programming presents substantial challenges as countries assume an increased role in financing the response and effectively integrate vertical programming into the broader health care system.

37. With respect to national capacity to finance a greater share of the AIDS response, low- and middle-income countries are hardly monolithic in their national economic capacity or respective HIV burden. Some high-prevalence/resource-poor states will continue to rely heavily on international assistance, while better-resourced countries may require little or significant support. As a recent analysis commissioned by UNAIDS found: *'[A]ll the low-income Fast-Track countries will require continued external support to meet their HIV needs in the next five years. Most suffer from limited budgetary means, a function of small tax base, which will continue in the near future. Borrowing for most is not a credible option due to size of the requirements and/or the length of time it is required for. However, all can raise their budget allocation to HIV and most have the fiscal space to impose an earmarked levy for HIV. This can bring them towards self-sufficiency. Efficiency is an issue for most and external support may need to be focused on this*.' [22]

38. There is an urgent need to secure a sustainable commitment to new domestic funds from finance ministries of every state capable of doing so, in the first instance, for the Fast-Track period to 2020. These domestic commitments need to align with strategic costed plans, and the availability of international and innovative funding to ensure fully-funded responses. This will require a higher level of engagement with Ministers of Finance to design innovative approaches to strategic planning that take into account donor retrenchment and domestic upscale, while embracing the normative adjustments that will be necessary to redefine, reconstitute, and renegotiate relationships on a sustainable, long-term basis. A key prerequisite to this process will be a shared understanding, outlined in clear, milestone-driven compacts, that the process of retrenchment cannot be quick; detailed transitional arrangements—a particularly critical expression of shared responsibility and global solidarity—will require time and painstaking effort. Rushing the transition can lead to dislocation and sub-optimal results.

39. In applying principles of shared responsibility and global solidarity, it is important to bear in mind that the extent and nature of the sustainability challenge for the AIDS response varies among countries and regions. For a number of upper-middle-income countries with concentrated epidemics, the primary sustainability challenge is political rather than

[22] Tomas Lievens and Alexandra Murray-Zmijewski, 'Fiscal space analysis and funding options for the UNAIDS Fast-Track countries', Oxford Policy Management, August 2015 (draft), p.66

financial, in that national decision-makers need to be persuaded to allocate modest sums (compared to those needed in sub-Saharan Africa) towards rights-based and evidence-informed strategies for key populations. By contrast, countries with comparatively greater national wealth but with substantial HIV burdens will likely require continued international assistance.

**Box 3: Case study of Kazakhstan: Increasing domestic funding as international support declines**

While international HIV assistance to Kazakhstan declined by more than half from 2011 to 2015, domestic public sector expenditure rose by 73%. The country's AIDS response takes an integrated approach, prioritizing scale-up of HIV treatment, prevention programmes for key populations and partnerships with civil society.

Since 2005, the number of people receiving antiretroviral therapy has increased more than 18-fold, with the national government covering treatment costs. The rate of AIDS-related deaths was cut nearly in half from 2010 to 2014. Kazakhstan has also prioritized prevention of mother-to-child transmission of HIV, with the transmission rate falling from 2.5% in 2010 to 1.8% in 2015 as prevention coverage exceeding 90% has been achieved for pregnant women living with HIV. Launched in 2005, the country's opioid substitution treatment programme has seen the number of sites rise five-fold.

Moving forward, Kazakhstan aims to reach the 90-90-90 target, with a first step of testing 15% of the population for HIV by 2020. The country also plans to increase preventive measures among vulnerable groups and increase inter-agency collaboration in the AIDS response.

**Box 4: Case study of Swaziland: Harnessing a growing economy to ensure a sustainable AIDS response**

A lower-middle income country, Swaziland has been heavily affected by HIV, with 26% of adults (15-49) living with HIV. Among adults, estimated HIV incidence is 1.9%, and the country has also been severely affected by linked epidemics of HIV and tuberculosis.

Swaziland has moved boldly to own and lead its national AIDS response. Domestic public sector investments for HIV more than doubled from 2005-06 to 2012-2013, when Swaziland covered 57% of the costs of its HIV response. Swaziland has assumed responsibility for procuring antiretroviral medicines. The number of people receiving antiretroviral therapy has sharply increased; UNAIDS estimates that 60% of all people living with HIV were receiving HIV treatment in 2014, a coverage level notably higher than for sub-Saharan Africa as a whole. As HIV treatment has been brought to scale, retention rates have also improved. Today, 85% of all adults and children receiving antiretroviral therapy in Swaziland have achieved viral suppression. Swaziland has embraced the Fast-Track approach and embarked on an effort to achieve the 90-90-90 target.

Sustaining the country's AIDS response is both an overriding priority for His Majesty King Mswati III and a major challenge. While Swaziland remains committed to increased domestic HIV outlays, it may continue to require international support but faces potential hurdles in mobilizing such external resources due to its middle-income status. Swaziland's economy is largely dependent on receipts from the Southern Africa Customs Union, but these receipts have fluctuated over the years, underscoring the long-term need to reduce dependency on this revenue source.

Given uncertainties regarding the country's future donor base, the need to be self-sustaining is clear. To achieve His Majesty's goal to be a "first-world country" by 2022, the country will need to grow its economy and generate domestic resources to finance the AIDS response and other essential government projects.

**2) Securing sufficient international HIV resources**

40. The last quarter century has witnessed an extraordinary increase in development assistance for health, driven primarily by spending on HIV, maternal health and newborn health.[23] Although international HIV assistance has rebounded from its decline during the global financial downturn, there are signs that international funding for the AIDS response is flattening, as there was no meaningful increase in international assistance from 2013 to 2014.[24]

41. Although several high-income countries contribute a share of international AIDS financing that exceeds their share of global GDP, the share of AIDS financing contributed by a number of other high-income countries is far below their share of the global economy. While it will be vital that countries explore all available means for further increasing international HIV assistance, ensuring that AIDS contributions from all high-income countries match their share of the global economy is an important strategy for closing the resource gap. As the leading source of international HIV assistance, the United States government can play a valuable role in leveraging its diplomatic influence to encourage greater contributions by fellow high-income countries whose AIDS assistance share is currently below their share of global GDP.

42. The balance between bilateral and multilateral funding channels for international HIV assistance appears to be shifting towards the latter, as bilateral HIV assistance actually declined in 2014.[25] This underscores the importance of robust replenishment of financing for the Global Fund, as its centrality in funding the AIDS response may well grow in the coming years.

**3) Focusing resources on the populations and locations where they are needed most**

43. Securing robust funding for programmes focused on key populations poses particular challenges for the Fast-Track agenda. When sexual partners are taken into account, WHO estimates that men who have sex with men, people who inject drugs, prisoners, sex workers and transgender people together accounted for 40-50% of new HIV infections in 2014.[26] The Fast-Track approach assumes that the provision of services to key populations by their peers should meet diverse HIV-related needs by, for example, promoting preventive measures and enhancing access to testing and treatment. These components are key to increase the efficiency in testing and enable people living with HIV to know their status. Particular attention is warranted for middle-income countries, which face a potential HIV funding crisis. Their ineligibility for assistance from some sources of international development cooperation threatens gains and poses particular risks for domestic programmes focused on key populations, some of which have suffered from inadequate political leadership.

44. In high-burden AIDS epidemics, particularly in sub-Saharan Africa, funding is also increasingly required to address HIV prevention among young women and adolescent girls. Meeting the needs of all groups experiencing elevated HIV risk and vulnerability is a significant challenge both financially and programmatically.

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[23] Dielman JL, Graves C, Johnson E, Templin T, Birger M, Hamavid H et al. Sources and focus of health development assistance, 1990-2014. JAMA 2015;313:2359-2368.
[24] Kates J, Wexler, A, Lief E, Financing the Response to HIV in Low- and Middle-Income Countries, 2015: Henry J. Kaiser Family Foundation, UNAIDS
[25] Kates J, Wexler A, Lief E. Financing the response to HIV in low- and middle-income countries: International assistance from donor governments in 2014. Washington D.C.: Henry J. Kaiser Family Foundation & UNAIDS.
[26] Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2014, Geneva: World Health Organization.

**4) Maximizing efficiency gains**

45. As AIDS investments have increased, efforts have intensified to maximize the impact of finite financing. Efficiencies have been realized as programmes have been brought to scale: from 2011 to 2014, AIDS funding rose by 11%, but the number of people receiving antiretroviral therapy increased by 60%.[27] Prices for first-line antiretroviral regimens have continued to decline, although at a slower pace than at the outset of the previous decade, and collaborative initiatives have strengthened and streamlined procurement of medicines and other essential HIV commodities. Through development of national HIV investment cases, dozens of countries have determined that allocative efficiency of the AIDS response can be improved through more strategic targeting of services and by investing in interventions with the greatest public health impact.[28]

46. Especially in the early Fast-Track period, solutions to the investment challenge will require practical solutions as well as immediate steps to lay the groundwork for more ambitious results down the road. For new international assistance committed or funding proposed in national budgets, time will inevitably pass before funds are translated into programmes on the ground, underscoring the need for greater programmatic and allocative efficiency in the immediate term.

47. Evidence indicates that even in countries with low health expenditure and low health outcomes, an increase in efficiency may be more important than an increase in fiscal space and that countries may be able to meet fiscal need by improving efficiency and decreasing fiscal need rather than just increasing fiscal space.[29] Efficiency not only enhances value for money, but it also contributes to concrete results for people, enhancing the effectiveness of essential services.

48. Efforts to improve efficiency need to be holistic, taking account the myriad ways in which programmatic and strategic choices influence the efficiency and impact of national responses. Efficiency-promoting efforts need to focus on:

    - allocative efficiency (allocating resources to the most effective interventions for the right populations, better targeting of geographic areas);
    - above-facility efficiency (improving efficiency in supply chain, national program management etc.); and
    - implementation efficiency (efficiency gains made at the service delivery unit including by changing the ways in which services are delivered).

49. Much has been learned in the rapid expansion of HIV treatment, with respect both to programmatic weaknesses and regarding best practices for optimizing efficiency and health outcomes. However, there is a shortage of shared knowledge and examples of efficiency-promoting best practices.

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[27] "15 by 15": A global target achieved, 2015, Geneva: UNAIDS.
[28] Smart Investments, 2013, UNAIDS: Geneva.
[29] *SADC 'Good Practice' Case Studies on sustainable financing for health and HIV* (undated); Pablo Gottret, George J. Schieber, and Hugh R. Waters (eds), *Good Practices in Health Financing Lessons from Reforms in Low- and Middle-Income Countries* (Washington: The World Bank, 2008).

**Box 5: Case study of Namibia: Prioritizing efficiency to increase fiscal space for AIDS**

As international development partners have reduced their support for Namibia's AIDS response – including annual 10% reductions in support from PEPFAR – Namibia has taken steps to increase domestic financing for AIDS. The Namibian government increased its investment in the AIDS response from US$111.1 million in 2012-13 to US$136.6 million in 2013-14, covering 55% and 64% of total HIV-related costs, respectively. By 2017, it is projected that Namibia's public sector will cover 70% of all HIV-related expenditure.

To promote long-term sustainability, Namibia is using an investment approach to anticipate and plan for future investment needs. By 2016-17, it is projected that Namibia's AIDS response will require investments equaling 2.5-3.0% of GDP. This elevated price tag for the AIDS response – notably higher than for some other high-burden countries – is believed to stem from the failure to integrate HIV services with other health services and development programmes and from programmatic inefficiencies. Accordingly, enhancing the efficiency of the AIDS response – including through improvements in infrastructure, human resource, procurement and strategic information – is a critical component of Namibia's long-term effort to ensure sustainability investments.

Total investments needed for the AIDS response will increase, as Namibia has endorsed the Fast-Track approach, including the 90-90-90 target. As part of its effort to develop a clear national plan for financial sustainability of the response, Namibia is finalizing a financial analysis, fiscal space and cost effectiveness study of health and AIDS programmes, with results to be used to inform an investment framework to be completed later in 2015.

50. Nevertheless, while steps should be taken to strengthen the evidence base for action, it is apparent that many HIV programmes are not maximizing efficiency and that immediate action to improve efficiency is warranted. Weaknesses contributing to sub-optimal efficiency include misappropriation and corruption as well as poorly organized, inadequately monitored and inefficient operations. Prices for antiretroviral medicines and other key health commodities often vary among similarly situated countries, as do per-patient clinical costs, indicating that some settings are more successful in obtaining ideal prices than others. The sheer pace of the scale-up of treatment was such that the absorptive capacities of some health systems and/or government departments were breached, and patchy managerial, administrative and accounting systems have further exacerbated leakages as well as poor performance.

51. Scrupulous planning and execution, the smooth and cost-effective administration of bureaucracies and front-line operations and data-supported, results-oriented monitoring are all standard management remits, not emergency procedures. Thus, the call for efficiencies can best be understood not as a shortcut to resource mobilization but as the restoration and/or strengthening of professional standards.

52. Efficiencies are required in institutional governance, programme management and accounting procedure, as well as in programmatic areas ranging from the security of commodities to empirical validation of interventions. Programmatic efficiencies need to be matched by robust, evidence-based strategic planning that focuses limited resources on the interventions, locations and populations that will yield the greatest impact. World Bank studies indicate that better resource allocation can increase budget resources by up to 30%.[30] In particular, UNAIDS recommends that at least 25% of global AIDS funding

[30] Executive Director's report. Coalition of the daring: coming together for a new strategy of sustainability. Geneva: UNAIDS; 2015 (http://www.unaids.org/sites/default/files/media_asset/20150630_EXDreport_PCB36_en.pdf, accessed 30 July 2015).

should be allocated to non-treatment prevention efforts as a cost-effective investment that lowers long-term treatment costs.

**Box 6: Case study of PEPFAR approach: Efficiency as a linchpin of sustainability**

Taking up the challenge of measuring progress towards sustainability, PEPFAR developed a Sustainability Index and Dashboard (SID) and applied it over the last year in a consultative process in 33 countries.

Early results from the SID confirm that weaknesses in general financial management pose risks for the sustainability of AIDS responses, especially in countries that currently contribute comparatively small amounts towards the response. Sectoral investments, such as health and HIV, may lead to underinvestment in public financial management, which in turn can lead to problems in procurement, supply management and other systemic activities that affect the AIDS response. The SID pilot results also indicate that countries are not yet primed to make the new investments that will be needed during the fragile five-year Fast-Track window.

Within the context of finite and constrained resources, a fundamental strategy for accelerating progress towards Fast-Track targets is to increase the efficiency and effectiveness of available resources. PEPFAR is working towards this end by focusing resources on geographical areas where HIV is most prevalent and by focusing only on the programmatic investments that have the highest impact on reducing HIV incidence.

However, early SID results highlight the need to do much more to improve the efficiency and effectiveness of AIDS responses. In particular, countries receive relatively low SID scores on both allocative and technical efficiencies. All stakeholders need to engage in the efficiency agenda to ensure available AIDS investments, regardless of source, are better coordinated and used most effectively. New models of care that are simpler require less highly trained personnel and expensive technologies will be needed. HIV testing strategies need to be better targeted and more sensitive to the needs and dynamics of the target population. Prevention programmes also need to be more rigorously scrutinized so that they are effectively targeted and delivered at the lowest possible cost.

PEPFAR's efforts are premised on the recognition that HIV treatment is central to hopes for ending the AIDS epidemic. Recent results from the START trial underscore the need to initiate HIV treatment as soon as possible to the greatest number of people, and the clear prevention benefits of treatment need to be taken into account in models of resource allocation. The "test-and-start" approach represents one model of care that offers countries new opportunities to evolve their HIV service delivery systems in ways that respond to emerging scientific evidence and lay the foundation for the long-term sustainability of the response. In September 2015, WHO announced that its upcoming HIV-treatment guidelines will recommend initiation of treatment for all those diagnosed with HIV, regardless CD4 count.

53. In working to promote efficiency, AIDS stakeholders should effectively leverage the full array of efficiency-promoting strategies. This includes the innovative market-shaping efforts of such partners as the Global Fund, UNITAID and the Clinton Health Access Initiative, which can help lower commodity prices, build demand for strategic products and contribute to long-term sustainability. Consistent with the spirit of the SDGs, the AIDS field should continue strengthening partnerships with other sectors (e.g., education, social protection, food and nutrition) whose efforts can reduce HIV-related vulnerability and increase service uptake and retention, helping AIDS investments go even further towards achieving impact and Fast-Tracking the AIDS response.

54. In the scale-up towards Fast-Track targets, the relationship between HIV and broader health systems will both pose tough choices and offer important new opportunities. Solutions may differ among countries. Efficiency gains can clearly be achieved by more

effectively coordinating overlapping services (treatment of TB and hepatitis C, screening, laboratory testing, the distribution of medicines).[31] Indeed, the African Union Roadmap prioritizes '*Ensuring [that] AIDS, TB and malaria investments are strategically coordinated to contribute to health systems strengthening*.' Current developments in national AIDS responses certainly support the need for an integrated response: a case study analyzing the shift to second-line drugs in South Africa as treatment programmes mature suggests that 94% of the costs per patient will likely be attributable to drugs, laboratory testing and clinic and pharmacy services.[32]

55. Rapid scale-up will demand substantial health systems strengthening and exploration of opportunities associated with integration of more vertically oriented HIV programmes into broader health systems. As HIV is increasingly managed as a chronic disease, HIV platforms are already demonstrating their viability for addressing other chronic diseases, such as diabetes and hypertension.[33]

**5) Integrating AIDS funding into UHC or larger health system budgets**

56. Many prominent studies have focused on funding health systems of low-income countries, and more recently, on the prospects for establishing Universal Health Coverage (UHC) systems and on strengthening health systems to promote an effective AIDS response.[34]

57. There is a medical and human rights imperative for establishing UHC in low-income countries. However, this needs to be understood as a long-term undertaking and one that may not necessarily yield substantial resources for the AIDS response during the Fast-Track period. '*For the 49 low-income countries, it is estimated that between 2015 and 2019 there will be a $240 billion resource gap between [total health expenditure] and fiscal need for Universal Health Care (about 30% of the total fiscal need), or a US$550 billion resource gap if private expenditures on health is not included (about 70% of the fiscal need.)*'[35] At present, there is little evidence regarding the relationship between UHC and HIV, underscoring the need for agreement on metrics, research methods and other strategies to strengthen the evidence base in this regard.

58. The push to implement UHC in resource-limited settings should be understood as a critical component of the broader effort to bolster health systems. Indeed, UHC is unlikely to be feasible without considerable increases in human and material resources and concomitant administrative and managerial controls.

59. However, countries where HIV services are predominantly financed through vertical programmes may well encounter considerable difficulties in working to integrate these services into horizontal health systems. These challenges underscore both the

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[31] Dermot Mahler, 'Re-thinkig global health sector efforts for HIV and tuberculosis epidemic control: promoting integration of proframme activities within a strengthened health system,' *BMC Public health* 10:394 (2010), available at: http://www.biomedcentral.com/content/pdf/1471-2458-10-394.pdf
[32] L. Long, M. Fox, I. Sanne and S. Rosen, 'The high cost of second-line antiretroviral therapy for HIV/AIDS in South Africa,' *AIDS* 24(6) (2010), pp.915-19; see also: R. Hecht *et al*, 'Financing of HIV/AIDS programme scale-up in low-income and middle-income countries, 2009-31,' *The Lancet* 376 (9748) (2010), pp.1254-60.
[33] Rabkin M, Melaku Z, Bruce K, Reja A, Koler A et al. Strengthening health systems for chronic care: Leveraging HIV programs to support diabetes services in Ethiopia and Swaziland. J Trop Med 2012;doi:10.1155/2012/137460.
[34] Commission on Macroeconomics and Health, 'Macroeconomics and Health: Investing in Health for Economic Development,' WHO, 2001, available at: http://apps.who.int/iris/bitstream/10665/42435/1/924154550X.pdf;
[35] Oxford Policy Management, 'Opportunities and challenges for the integration of health and HIV financing,' p.4.

importance of avoiding rapid reductions in international HIV assistance and of country compacts that provide a careful, milestone-driven process that ensures the availability of reliable funding and extensive technical support to aid this transition process.

**6) Expanding alternative funding sources**

> *'The Africa Common Position on Post 2015 Development Agenda is clear on the point of domestic funding. We deliberated on this for the entire session in Hammamet [Tunisia 2013]. With the sustained historic growth across the continent, we cannot hide from our responsibilities anymore. But we also need to be realistic because strengthening our financial intermediation; broadening our tax net; developing our long-term financing mechanisms and curtailing of illicit financial flows all take time. These are also all prerequisites to creating fiscal space to engage with the pressing demands of our people.'*
>
> Minister of Finance, high prevalence African country, 6 September 2015

60. One of the most compelling reflections of shared responsibility and global solidarity has been the leadership of low- and middle-income countries in developing innovative methods of financing the AIDS response. These include new levy taxes or para-fiscal bases that have been introduced e.g. airfares or that have been proposed (e.g. financial transactions (see Box 7 on Zimbabwe)). In exploring innovative financing methods such as new tax bases, countries often struggle in balancing the desire for new funding against the need to avoid distortions and inefficiency. For example, some innovative methods e.g. national lottery are more regressive than others e.g., taxes on airfares.

61. Ideally, innovative tax levies maintain a link between the tax base and the purpose to which the tax receipt was originally supposed to be directed. In this regard, Botswana's levy on alcoholic drinks is an example of an option for raising additional funds. While not specifically earmarked to finance HIV programmes, it has the effect of deterring excessive alcohol use, which contributes to risky sexual behaviours and is also associated with other health and social harms.

62. The magnitude of funding generated by innovative financing will vary depending on the setting and financing mechanism. While innovative tax levies can increase the level of domestic financing for the AIDS response, they are unlikely on their own to close the resource gap.

**Box 7: Case Study of Zimbabwe: Innovation in resource mobilization**

In 2000, as HIV prevalence exceeded 29%, Zimbabwe recognized that an extraordinary threat demanded an extraordinary response. That year, Zimbabwe created the National AIDS Trust Fund, financed through a 3% tax on individual and corporate income.

In addition to funding essential AIDS programmes, including covering costs for 25% of individuals receiving antiretroviral therapy, the AIDS trust fund effectively financed the national infrastructure that has led and coordinated the country's pioneering response to the epidemic. The National AIDS Council, which administers the tax levy from funds collected (without handling fee) by the national revenue authority, has offices in all 85 districts of the country. Half of trust fund revenues have supported HIV treatment services, including procurement of medicines, with 16% dedicated to HIV prevention activities.
The National AIDS Trust Fund has helped make possible major progress in the national AIDS response. Since the trust fund's creation in 2000, HIV prevalence has fallen by nearly half – from 29% to 15%. HIV incidence has fallen by more than half, and the annual number of AIDS-related deaths has also been cut by more than half.

By self-financing much of the response, Zimbabwe has preserved greater autonomy in determining the content of HIV-related activities. Demonstrating national commitment to finance its AIDS response, the trust fund has also been effectively leveraged to attract international assistance.

Although its contributions to the national response are evident, the trust fund has also encountered considerable challenges. In particular, hyperinflation in 2006-2008 decimated the value of revenues raised by the trust fund, and increasing unemployment has reduced tax levy collections. To sustain the trust fund, consideration may need to be given to collecting from the informal sector, which is becoming a major source of employment in Zimbabwe.

63. Grants or loans provide another potential option for closing the resource gap. Consideration of this option requires careful analysis of national debt load as well as the specific terms of individual grants. While borrowing may enable countries to raise the investments required through 2030, it may not ensure robust financing for the substantial longer-term costs that managing HIV will demand in future decades, such as for the tens of millions of people who will receive lifelong antiretroviral therapy. Care also needs to be taken to ensure that borrowing does not merely accelerate the withdrawal of international HIV assistance.

64. The most attractive possibility remains an incremental tax on financial transactions. International political resistance has kept this idea in the speculative realm for decades, but it does appear to have begun securing a degree of normative expectation. In 2011, the European Commission tabled draft legislation for a European Union-wide tax. Certainly an initiative of this kind would not be simple to enact, and robust advocacy (such as by a leading regional organization) will be required, but it could be an idea whose time has come, in view of the substantial demands that the SDGs will bring. However, this option, too, is not without risks. As one prominent AIDS activist said, '*Our fears are that if the financial transaction tax was to go forward just as a European initiative then it is most likely that all of the funds will go into European budgets, European deficits, or bailing out European banks. For us, this G20 meeting is really the crux. If this goes forward as a G20 initiative then we are far more likely to see some of the revenue going towards global public good*'.[36]

[36] Karen McColl, 'Bill Gates is to urge G20 nations to adopt a financial transaction tax to fund development,' *BMJ Clinical Edition* 343 (2011), d6963.

### 7) Enabling and strengthening new forms of governance and cooperation

65. The rise of China, India, South Africa, Brazil and a host of other countries that have joined the ranks of middle-income economies is rapidly altering global economic and political dynamics and offering potentially important new options for funding the AIDS response. China's trade with sub-Saharan Africa increased from about US$1 billion in 1990 to more than $155 billion in 2013. Indian companies are investing in Africa's infrastructure and multiple industries, from hospitality to telecommunications; Brazil has over 300 companies in Angola alone. Large developing economies are also investing in developed countries. New trade routes are flourishing: countries as diverse as Morocco, South Africa, Thailand, Turkey and Vietnam each have substantial export and import relationships with more than 100 economies.[37] Within their borders, countries like Mexico and Thailand are making rapid progress towards providing Universal Health Coverage in innovative ways.

66. The impact of the rise of the global South on governance institutions is no less profound, with huge implications for some institutions in the years to come. International governance arrangements forged at the end of the Second World War are increasingly seen as anachronistic by many. Among the many examples in emerging forms of cooperation and governance include: the proliferation of voluntary standards in finance, which substitutes for global regulation; new funding mechanisms such as the BRICS' New Development Bank, in place of action through United Nations sources; the rise of informal groups to bypass the Security Council, where action can be difficult to achieve; and regional consultative processes on key issues to make up for a failure to take forward global negotiations. In each case, governments have sought to avert the slow, cumbersome processes of multilateral institutions by creating more nimble, informal networks and private-public partnerships.

[37] Health Economics and AIDS Research Division, University of Kwazulu-Natal, using calculations based on United Nations Statistics Division (UNSD) data (2014).

**Box 8: Access to medicines—The imperative of global solidarity**

As one of its three action pillars, the AU Roadmap focuses on 'access to affordable and quality assured medicines.' The priority was recently underscored in the 2015 Vancouver consensus, endorsed by leading scientists, academics, health authorities, development agencies and civil society advocates, calling on "*donors and governments to use existing resources for maximum impact and to mobilize sufficient resources globally to support ARV access for all*".

As in other aspects of the development climate, the environment for medicine procurement is rapidly changing, and further evolution can be anticipated during the Fast-Track period. New WHO treatment and prevention guidelines expand by an additional 9 million people the number of people for whom antiretroviral therapy is recommended. In addition, actions will likely be needed to preserve the strategies that have led dramatic declines in prices for HIV medicines. New approaches will also be needed to address changing circumstances and new challenges that emerge in future years.

The historic declines in prices of antiretroviral medicines have resulted primarily from the availability of a robust, competitive generic pharmaceutical market. India, in particular, has played a leading role in supplying affordable generic antiretroviral medicines for use in low- and middle-income countries. In large measure, the critical role of the Indian generic pharmaceutical industry was facilitated by India's adoption of intellectual property flexibilities provided under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Notably, the 2001 WTO Declaration on the TRIPS Agreement and Public Health (also known as the Doha Declaration) expressly took account of HIV and other public health emergencies and encouraged governments to use TRIPS flexibilities, like compulsory licenses and parallel importation to maximize access to essential, affordable medicines.

These approaches led to declines as high as 99% in the prices of antiretroviral medicines in least developed countries. However, in recent years, various threats have emerged with respect to the strategies that have proven so effective in enabling the historic scale-up of HIV treatment. While India has demonstrated courageous support for its generic industry, the country is currently under pressure from several companies and governments of high-income countries to dilute the intellectual property provisions that have helped make affordable antiretroviral medicines available worldwide. Increasingly, high-income countries with major branded pharmaceutical industries are seeking to impose intellectual property provisions that extend well beyond TRIPS flexibilities through bilateral and regional Free Trade Agreements. Demand for second- and third-line antiretroviral regimens is increasing, and these new medicines are more likely than older medicines to be patented; at present, no clear global action plan is in place to ensure access to affordable second- and third-line drugs, although important steps, such as creation of the Medicines Patent Pool and adoption of the WHO Global Strategy and Plan of Action on IP, Innovation and Public Health.

Addressing and overcoming these many challenges will demand global solidarity, as no single set of countries will be able on their own to address what is truly an international challenge. Several strategies will be needed to meet these challenges and ensure a robust, reliable supply of essential HIV-related products. Least developed countries should be exempted, so long as they remain least developed, from TRIPS provisions that mandate national adoption of a patent regime. Low- and middle-income countries require support to resist so-called TRIPS-Plus provisions that seek to impose intellectual property rules that are stricter than those allowed under TRIPS. Pooled procurement may help bolster the abilities of small and low-prevalence countries to obtain optimal pricing, and where appropriate, voluntary licensing agreements with pharmaceutical manufacturers may be needed to cut prices for key commodities, such as diagnostics. Looking towards the longer term, low- and middle-income countries should also actively explore the establishment of local and regional pharmaceutical manufacturing capacity to reduce dependency on international suppliers. To avert potential regulatory impediments to expedited access to essential medicines, consideration should urgently be given to establishment of an African Medicines Regulatory Agency for faster and stronger approval and quality assurance of medicines. In support of greater country ownership, countries should be supported to take immediate steps to strengthen systems for commodity procurement and supply management, especially in countries that currently rely on external procurement for HIV medicines.

Global solidarity has found extraordinary expression in the struggle against AIDS. The same international solidarity that has made the achievements of the last 15 years possible in the AIDS response will need in the coming years to give rise to courageous, innovative approaches to deliver life-saving medicines to those who need them.

**Box 9: Case Study of ECOWAS—Building sustainable pharmaceutical manufacturing capacity in West Africa**

Home to 365 million people, including 4.5 million people living with HIV, the Economic Community of West African States (ECOWAS) confronts numerous public health challenges. In addition to high incidence of HIV, tuberculosis and malaria, West Africa also continues to struggle with the Ebola outbreak and in furthering efforts to eliminate polio.

Although the burden of HIV in the region is considerable, only about one in four people living with HIV in ECOWAS member states are currently receiving antiretroviral therapy – a level of coverage that is markedly lower than in East and Southern Africa. The region's AIDS response remains heavily dependent on external support, with domestic sources contributed only about 20% of HIV-related investments and with 70-98% of essential medicines supplied from outside the ECOWAS region. With a view towards fast-tracking the response and ensuring its long-term sustainability, the region is collaborating with the West African Health Organization to implement a regional AIDS strategy for 2012-2016. Within this strategy, local manufacturing of antiretroviral medicines has emerged as a potential game-changer, stimulating the development of the ECOWAS Regional Pharmaceutical Plan 2014-2020 (ERPP).

The ERPP is s cross-sector programme linking industrial promotion, medicines and laboratory regulations, anti-trafficking of bogus medicines, promotion of TRIPS flexibilities, and training, research and development. Since 2013, the region has invested US$1.3 million to establish an antiretroviral medicine security stock and has also taken steps to strengthen medicine procurement and supply management systems. The plan also provides support to the West African Pharmaceutical Manufacturing Association and includes specific provisions for patient engagement in ERPP decision-making.

Early results of the ERPP initiative are promising. Treatment interruptions in Ghana and Senegal were averted through use of the ECOWAS antiretroviral security stock. More antiretroviral medicines manufactured in the region are now being used to support scale-up and sustainability of national HIV treatment programmes in ECOWAS countries.

## SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY TO SUSTAIN SUPPORT FOR CIVIL SOCIETY AND COMMUNITIES

67. From the onset of the global AIDS response, civil society has played a range of critical roles—including advocacy, demand creation, service delivery and monitoring and evaluation. A particular strength of civil society lies in its diversity, often representing and providing services to different marginalized communities. Communities continue to lie at the heart of a sustainable response to AIDS but in most cases need to be supplemented by further human and financial resources. The closeness of these individuals and communities to the direct impact of the epidemic generally ensures that they know best what is or ought to be an appropriate response.

68. It is thus critical to ensure that the role of civil society is enabled—legally, politically and financially—to drive ambition, financing and equity in the response. Efforts need to be made to ensure that civil society, including networks that represent people living with HIV, women, young people and key populations, can participate meaningfully in decision-making platforms and accountability mechanisms.

**Box 10: Case Study of Thailand: Building civil society capacity for resource mobilization**

Although the influence of civil society on the AIDS response is universally recognized, civil society groups often struggle to obtain the resources they need to optimize their essential role. In the context of broader national efforts in Thailand to ensure long-term sustainability of the AIDS response – as the country anticipates the end of Global Fund investments in 2017 – civil society organizations have formed an alliance and activated mechanisms to mobilize resources from the public and private sectors. The alliance has been collectively financed and managed as a partnership, with technical support provided by UNAIDS.

With the aim of mobilizing roughly US$21 million per year to support civil society activities relating to the AIDS response, existing and potential sources of public and private sector financing for civil society engagement are being reviewed and analyzed. With assistance from UNAIDS, civil society partners are collecting and studying examples of effective civil society financing outside Thailand. A highly qualified private sector fundraising experts is also conducting a series of workshops with the civil society alliance to conceptualize, prepare and successfully implement a context-appropriate, sustainable civil society resource mobilization campaign.

69. It is time for a paradigm shift in how the AIDS response thinks about, plans, and finances community-based responses to HIV in order to achieve improved impact and move towards ending the epidemic. The response must utilize the unique strengths of communities in creating resilient and sustainable systems for health.

70. NGO and community-based organizations also comprise the front line in upholding human rights, combating stigma, and continuing the work towards true gender equality. The enactment of the GIPA principle (Greater Involvement of People with AIDS) is only possible when human rights are honoured in law and popularly supported. These relational qualities are key to effective prevention, since stigmatized, marginalized and criminalized populations are unlikely to seek preventive advice and other services, or to seek testing and treatment. International development partners need to be sensitive to cuts in funding, which could leave necessary and effective community-based organizations without support in countries where the legal and normative climate is unsupportive or even hostile to vulnerable populations. Similarly, as national governments assume increased responsibility for financing the AIDS response, they too must prioritize direct funding to the civil society groups capable of extending the reach and impact of HIV prevention and treatment efforts.

71. In short, there is no substitute for the kinds of engagement, trust and endurance that community-based support groups, local NGOs and people living with HIV are able to provide. They are not complementary to the necessary, high-level endeavors; they are the largest part of the sharp end of the global AIDS response. As UNAIDS has noted: '*When affected communities help to plan and implement HIV initiatives, the demand for better and more equitable services increases, awareness of societal barriers and harmful gender norms is raised, governments are held accountable for meeting the needs of citizens and services and outcomes improve. This leads to broader social transformation, which is paramount to halt and reverse the HIV epidemic*.'[38]

72. Unless community and NGO efforts are well-financed and integrated in systems of AIDS governance, a great deal of the potential coherence and effectiveness of community and NGO efforts will be dissipated, duplicated or under-utilized. If left formally outside the governance structures and mechanisms of the AIDS response, NGOs and community

[38] UNAIDS, 'Together We Will End AIDS,' UNAIDS/JC2296E (2012), p.58.

groups will struggle to secure and maintain adequate levels of funding, modest as these are in many cases.

73. The contract with dedicated community-based NGOs must be placed on a formal footing–a global compact commensurate with the imperative of global solidarity–with clear lines of authority and accountability to Ministries of Finance and Health at the country level. Initiating an AIDS governance meeting and follow-up mechanism, to include bilateral agencies, UNAIDS, Finance and Health Ministries and country representatives of community-based organizations, will be a key indicator of global commitment to shared responsibility and global solidarity and the determination to ensure that transitional arrangements minimize programmatic disruption and incoherence. In the absence of international facilitation of a truly inclusive global governance of AIDS response, there is a danger that any swift and unconsidered transition to country ownership will have critically weak foundations, decreased reach and coverage, and patchy coherence – conditions which would imperil the gains of recent years as much as prevent their consolidation and furtherance.

74. As community-based support and local NGOs are an essential part of the governance of the AIDS response, they must be held to similarly high standards as other stakeholders. This means far greater levels of transparency and accountability; and results-based reporting requirements, based on quality data-gathering and analysis.

**Box 11: Case study of Indonesia, Kenya and Ukraine: Multi-country action to support key populations**

The Netherlands, in partnership with UNAIDS and national and international partners, has spearheaded efforts to enhance the capacity of organizations of key populations in Indonesia, Kenya and Ukraine to mobilize essential funding from the Global Fund. The cooperative initiative does not have separate project funding but instead functions as a partnership, leveraging available resources of diplomatic missions, UNAIDS, Dutch-funded non-governmental organizations and community organizations.

As jointly decided by all participating groups, the goal of the collaboration was to empower key populations, including people living with HIV, to access services, demand their human rights and enact change. Eventually, aims of the collaboration were expanded to strengthen the link between community-based organizations and the Country Coordinating Mechanism of the Global Fund. At global level, a steering committee guides efforts under the collaboration.

Country-level consultative processes associated with the project have confirmed that key populations typically confront common challenges, including discrimination, lack of access to health and legal services and human rights violations. Community organizations have welcomed joint efforts to advocate for greater funding for programmes serving key populations. Involvement by the Netherlands and UNAIDS has proven effective in brokering better relationships between local community organizations and national governments. In each country, roadmaps are being developed in an inclusive and participatory process, taking into account lessons learned and the specific country context.

## INNOVATIVE PARTNERSHIPS

75. Consistent with the need for new thinking and innovative approaches in leveraging shared responsibility and global solidarity to Fast-Track the AIDS response, innovative partnerships will also be required.

### Private sector

76. In the Fast-Track era, the role of the private sector should be expanded beyond notions of corporate responsibility in order to help close the AIDS resource gap. Companies should be increasingly engaged as partners in accelerating the scale-up of essential services, especially in high-burden settings. One recent study in South Africa found that company-level provision of antiretroviral therapy to mining workers resulted in actual costs savings for companies that made such investments.[39]

77. In many low- and middle-income countries, the private sector's role in health care delivery is growing. How best to harness this new role to support achievement of Fast-Track targets should be actively explored, at the same time that other promising options, such as scaling up community-based service delivery, are fully leveraged.

78. Similarly, creative ways should be explored to leverage the private sector's natural desire to maximize profits with the needs of the Fast-Track agenda. For example, social media and rapidly evolving communications technologies offer potentially useful ways to increase awareness of HIV services, encourage young people to get tested and increase service retention and adherence.

### Community-based service delivery

79. Community-level delivery of services has the potential to enhance the efficiency, relevance and accessibility of essential treatment and prevention services. Community-based innovation – through such approaches as adherence clubs and community distribution of antiretroviral medicines for stable patients – is transforming service delivery and sharply improving retention in care.[40]

80. Under the Fast-Track approach, community-based HIV service delivery and community mobilization should be scaled up from a global average of 5% in 2013 to cover at least 30% of all service delivery in 2030. To enable such scale-up, the proportion of global HIV resources allocated to this modality of service delivery (versus facility-based) must increase from 1.8% in 2014 to 3% in 2020 and then to 4.2% in 2030.

81. In addition to funding, policy changes will be needed in many countries to permit and facilitate task-sharing in the delivery of clinical services. Investments in training will be required to build the skills of community health workers, and policy reforms will be required to professionalize and elevate the formal status of the community health workforce.

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[39] Meyer-Rath G, Plenaar J, Brink B, Van Zyt A, Mulrhead D et al. The impact of company-level ART provision to a mining workforce in South Africa; A cost-benefit analysis. PLoS Med 2015;12:e1001869.
[40] Community-based antiretroviral therapy delivery: experiences from MSF. Geneva: UNAIDS.

**Box 12: Case study of India: Partnerships to magnify the impact of investments**

India's AIDS response has undergone a paradigm shift, transitioning from a donor-driven response to one that is owned and largely financed by India itself. India's public sector currently covers 63% of HIV-related expenditure in the country, with the Global Fund and the World Bank contributing 14% and 10%, respectively. This funding pattern for the fourth iteration of the National AIDS Control Programme contrasts with the pattern under the third such iteration, when external sources accounted for 80% of all HIV-related investments. The current national programme aims to reduce new HIV infections and provide comprehensive treatment, care and support for people living with HIV, with the overarching goal of having a balanced response that maintains an important emphasis on primary prevention.

An integrated approach, with a major emphasis on partnerships, has enabled India to enhance the impact of HIV investments. Under the fourth National AIDS Control Programme, all key departments earmarked portions of their budget allocation for the AIDS response. The social protection sector has played an increasing role, with more than 600 000 people living with HIV receiving support from social protection schemes. HIV services have been integrated in the broader health system, and state governments and district administrators have been engaged. More than 35 central and state schemes were amended to strengthen the AIDS response, in such areas as nutrition, social security, livelihoods, housing, legal aid and grievance redress.

Particular efforts have been made to extend the AIDS response well beyond government. Partners in the response include people living with HIV, marginalized communities, faith-based groups, civil society and the private sector.

India's efforts have recorded important achievements. Coverage for prevention services for key populations has increased, nearly 25 million people (including 10.6 million pregnant women) received HIV testing services in 2014-15, and 850 000 people living with HIV were receiving antiretroviral therapy.

## THE WAY FORWARD: RECOMMENDATIONS FOR ACTION

82. The principles of shared responsibility and global solidarity that have transformed the AIDS response and made it a source of inspiration for global health and development efforts will need to remain the bedrock of efforts in the SDG era. As circumstances change, including as countries assume a larger share of financing the response, transitions need to be carefully planned, executed with care and deliberation, informed by a continuous "feedback loop" of data, and driven by key milestones, with contingency plans in place to address gaps that emerge.

83. To conclude, this paper makes the following recommendations to support countries in building sustainable AIDS responses through shared responsibility and global solidarity:

    a. Countries and their international partners should agree to innovative, milestone-driven country financial sustainability transition plans and compacts for smooth, progressive transitions to greater country ownership, identifying clear roles, responsibilities and targets in this process. Costed plans should reflect an investment approach to maximize health returns and ensure a sustainable response. Particular care is needed to ensure that such plans identify concrete strategies for securing the resources needed to reach Fast-Track targets by 2020. Ministries of Finance will need to be closely engaged.

b. International partners should commit to increase levels of HIV assistance from US$8.75 billion in 2014 to US$12.7 billion by 2020 ($6.5 billion for low income; $5.5 billion for lower-middle income; and, $0.7 billion for upper-middle income countries). All international partners should take steps to ensure that their share of international HIV assistance matches their share of global GDP.

c. Countries should urgently review—and, in most cases, increase—domestic resource allocations for AIDS, taking steps to ensure that domestic funding for AIDS is commensurate with national resources and HIV disease burden. Countries need to front-load investments in the next five years, which will contribute to reducing medium- and long-term costs and ending the epidemic. To increase domestic funding for the AIDS response, countries should explore increasing domestic budget allocations, innovative tax levies and, where appropriate, concessional and non-concessional borrowing.

d. Steps must be taken to improve the efficiency of HIV programmes and to allocate finite resources towards the mix of interventions likely to have the greatest impact on new HIV infections and AIDS-related deaths, including allocating at least 25% of global HIV funding to HIV prevention programmes (although allocations in specific countries will and should vary based on circumstances). A systematic effort must be made to identify, measure, and widely share examples of efficiency-promoting best practices.

e. Efforts to leverage progress towards Universal Health Coverage for the AIDS response should be accelerated and understood as a component of a broader agenda of health system strengthening, which remains a critical priority in the Fast-Track period.

f. An incremental tax on financial transactions, with resources dedicated to HIV and other health and development programmes, warrants careful consideration.

g. The private sector should be increasingly engaged as an essential partner in the AIDS response, including in closing the AIDS resource gap and as a source of innovation in service delivery.

h. Development partners and national governments should substantially increase funding for civil society organizations, including to enable and expand community-based service delivery as appropriate given the potential comparative advantage in each specific local setting. In particular, the share of community-based service delivery should increase from 5% of all HIV services in 2013 to 30% of service delivery in 2030.

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