

# STUCK IN NEUTRAL:

Tracking the Global  
Response to  
HIV/AIDS, 2016

**ONE**

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# SUMMARY

**The world has a plan and the tools needed to end AIDS as a public health threat by 2030. But achieving this is not a foregone conclusion.** This report looks at progress towards key milestones that must be reached by 2020 in order to stay on the path towards an end to AIDS, and finds a troubling trend: progress has stalled.

→ Resources available for the global fight against AIDS are essentially flat for the fourth consecutive year.

→ The number of adults infected with HIV annually has remained stuck at 1.9 million for the eighth consecutive year.

→ Two million people have gained access to lifesaving treatment annually for the third consecutive year – a tremendous achievement, but still short of the annual scale-up needed to accelerate progress.

The success or failure of the global AIDS response rests on the shoulders of today's leaders, and it is clear that business as usual will not be enough. Governments and donors must increase their ambition over the next four years to find new ways to accelerate action, or they risk squandering the hard-earned gains of the past decade. ONE recommends:

→ Building on the Global Fund replenishment by increasing funding in the years up to 2020, particularly by increasing the share of funding coming from domestic resources through both traditional and innovative channels.

→ Putting health systems at the centre of the AIDS response via greater integration of services and strengthened health workforces.

→ Accelerating innovation and learning with better and more timely data.

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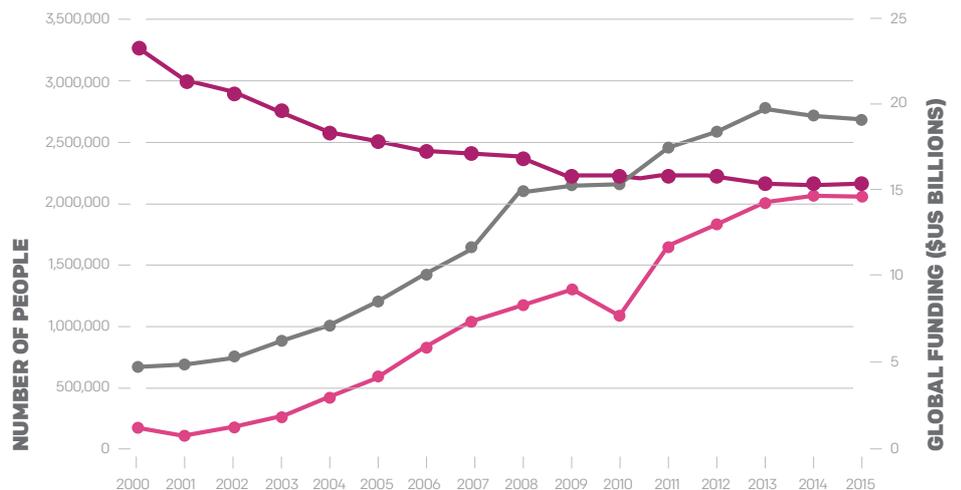
**Progress in the global fight against AIDS has stalled at the halfway mark.** Despite tremendous progress in HIV treatment, prevention and care over the past three decades, the world has been stuck at the critical ‘tipping point’ for three years now. Taking the AIDS response to the next level has proved hard to achieve, with more people still being infected with HIV each year than people starting on antiretroviral (ARV) treatment. Last year 2 million people globally began receiving treatment – increasing the total to 17 million – but 2.1 million people were newly infected with HIV. These statistics have remained largely unchanged since 2013.

**Current investment levels are simply too low to keep pace with the looming population explosion in sub-Saharan Africa, let alone to win the fight.** Young people aged 15–24 are particularly susceptible to HIV infection, and this region is home to a greater proportion of young people than anywhere else on the planet.<sup>1</sup> This young population is expected to double to 437 million over the next two decades – a pace that current investments simply cannot keep up with.

Over the same period, the funding available for the global fight against AIDS has flatlined. If the successful replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in September 2016 was an indication, world leaders still have the will to wage this fight, but they appear to lack the ambition necessary to win it. Indeed, a continuing sense of complacency and fatigue threatens to derail the progress achieved to date and the momentum needed to end the disease for good.

**FIGURE 1: GLOBAL PROGRESS TOWARD THE TIPPING POINT AND GLOBAL FUNDING FOR AIDS, 2000–15**

- New people added to treatment
- Number of new infections
- Global Funding



Source: UNAIDS.

The response of world leaders over the next four years will determine whether we move towards eradication of the disease or retreat. A worsening epidemic has the potential to become drug-resistant, negating the effective treatment and tools currently available and undoing the historic progress that has been made to date. However, on the other hand, progress in the next 10 years will potentially be faster than in the last 10 thanks to the lessons we have learned and new technologies in the pipeline.

The UNAIDS Fast-Track strategy has set clear targets that – if met by 2020 – will put the world firmly on a path to ending AIDS as a public health threat by 2030. Two years into this global strategy and just three years away from the critical 2020 benchmarks, it is clear that maintaining the status quo of today’s global AIDS response will not be sufficient to accelerate progress.

Dangerous and significant gaps remain.

**Target: Reduce new infections amongst adolescent girls and young women by nearly 75% by 2020, to fewer than 100,000 new infections per year**

**FIGURE 2: SELECTED 2020 TARGETS: GAP BETWEEN BUSINESS AS USUAL VS. TARGET SCENARIOS**

- 2015 Baseline
- 2020 Business as Usual (BAU)
- 2020 Target



**Target: Ensure that 30 million people living with HIV have access to lifesaving treatment by 2020**



**Target: Mobilise \$26.2 billion in funding annually by 2020.**



The response of world leaders over the next four years will determine whether we move towards eradication of the disease or retreat.

On the following pages, ONE takes a closer look at these gaps in three core areas:

- 1. PREVENTION**
- 2. TREATMENT**
- 3. FUNDING**

In each of these areas, we assess progress, challenges and the path to 2020, where accelerated action and renewed commitment are needed to break the gridlock and ultimately to tip the balance towards the end of the AIDS epidemic – before it is too late.

# PREVENTION



Over the past five years, we have seen the potential for effective prevention to turn the tide in the AIDS response. Since 2010, over 1.2 million more babies have been born HIV-free, and the number of children infected with HIV annually has dropped by nearly 50%.<sup>2</sup> If this pace of progress continues, the world will eliminate mother-to-child transmission of AIDS by 2020.

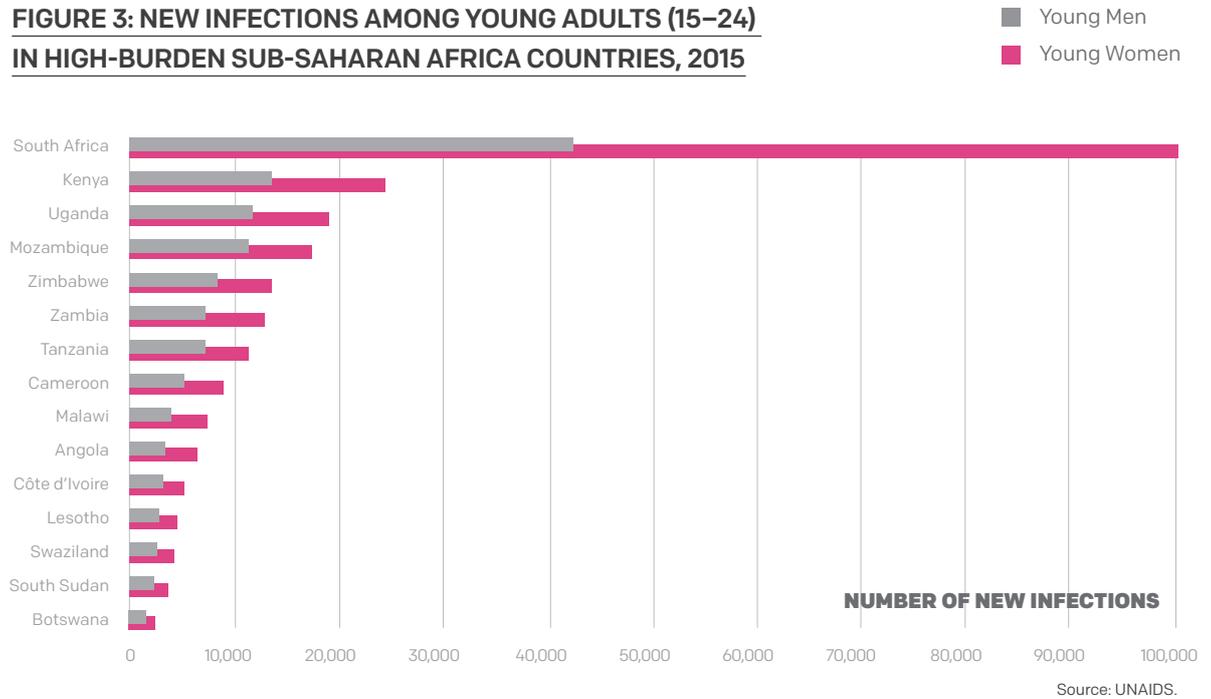
**But the failure to protect children through adolescence and to prevent new HIV infections among adults are arguably the most urgent challenges threatening to derail progress on AIDS globally.** Last year alone, 1.9 million adults were infected with HIV — roughly the same number as have been infected in each of the past eight years.<sup>3</sup> The global AIDS response will lose momentum if prevention efforts remain stalled.

**Young women aged 15–24 are disproportionately affected and are at particularly high risk of infection;** they comprise 11% of the adult population but account for 20% of new infections amongst adults globally.<sup>4</sup> Research shows that poverty is sexist, with structural, political and socio-economic barriers holding women back and making it more difficult for them to ensure a better life for themselves and their families. AIDS is sexist too. An average of 1,068 young women were infected with HIV every day last year, and AIDS remains the leading cause of death for women aged 15–44 globally.<sup>5</sup>

**The majority of these new infections occur in sub-Saharan Africa, where young women are twice as likely to be infected as young men.**<sup>6</sup> Of course, variations exist from country to country, but the trend is largely consistent across the region: in four out of five sub-Saharan African countries, young women account for more than 60% of new HIV infections among young adults. Furthermore, over three-quarters of new HIV infections among young women in the region occur in just 15 countries.<sup>7</sup>

The failure to protect children through adolescence and to prevent new HIV infections among adults are arguably the most urgent challenges threatening to derail progress on AIDS globally

**FIGURE 3: NEW INFECTIONS AMONG YOUNG ADULTS (15–24) IN HIGH-BURDEN SUB-SAHARAN AFRICA COUNTRIES, 2015**



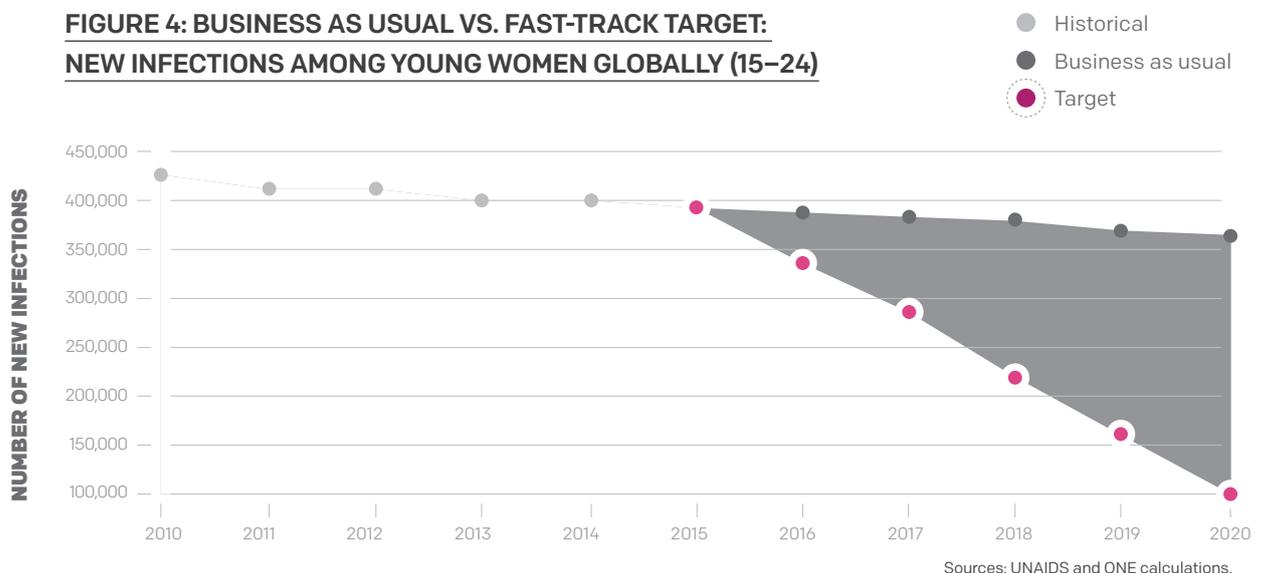
The trend is similar among adolescent girls aged 10–19. Globally, 160,000 adolescent girls are infected every year, almost double the number of adolescent boys, and in sub-Saharan Africa girls account for 75% of new HIV infections among adolescents. Four of every five new infections among adolescent girls in the region occur in the same 15 countries, and in South Africa girls account for 84% of new infections among adolescents. Nigeria – which along with South Africa and Uganda accounted for half of all new HIV infections in the region in 2014 – is likely to be among these countries of highest prevalence; however UNAIDS was reviewing HIV/AIDS data for the country in the period leading up to the publication of this report.<sup>8</sup>

Over the past five years, the proportion of new infections among young women to young men has stayed roughly the same, though some high-burden

countries have seen some progress. Malawi and Tanzania, for example, have reduced the number of new infections among young women by roughly one-third since 2010. Over the same period, the overall number of new infections has dropped by 42% in Malawi and by 34% in Tanzania.<sup>9</sup>

**World leaders have committed to reduce new infections among adolescent girls and young women by nearly 75% by 2020, to fewer than 100,000 new infections each year. Targeting prevention efforts in high-burden countries in sub-Saharan Africa and finding new ways to address the social, economic and structural barriers that make young women more vulnerable will be critical to making progress. A 'business as usual' response will fall well short of this target – a failure that will result in at least an additional 795,000 young women becoming infected with HIV in the next five years.<sup>10</sup>**

**FIGURE 4: BUSINESS AS USUAL VS. FAST-TRACK TARGET: NEW INFECTIONS AMONG YOUNG WOMEN GLOBALLY (15–24)**



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# PATH TO 2020: CHALLENGING BUT POTENTIALLY ACHIEVABLE

AIDS programmes have become better at focusing prevention efforts on the young women most at risk, because of increased attention to the disproportionate impact of HIV on women and the wider availability of sex-disaggregated data. For example, the DREAMS partnership is delivering a package of evidence-based interventions in 10 high-burden countries in sub-Saharan Africa that go beyond the health sector.<sup>11</sup> This innovative approach seeks to address the structural drivers – poverty, inequality, violence and lack of education – that make young women particularly vulnerable to infection.<sup>12</sup>

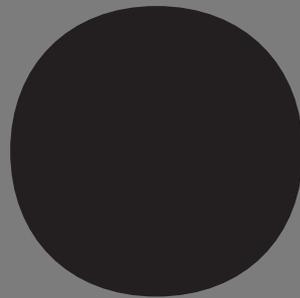
Evidence suggests that this type of cross-sectoral approach is especially effective for prevention, and variations of it are being implemented or supported by a range of development partners. For example, in Botswana each additional year spent in school has been shown to reduce the risk of HIV infection by almost 12%, suggesting that keeping girls in school longer – ideally through secondary school – reduces their risk of being infected with HIV over the course of their lifetimes.<sup>13</sup> Completing secondary education also reduces women’s risk of experiencing intimate partner violence, another driver of the disproportionate infection rate among young women.<sup>14</sup> Further, increasing knowledge and perception of HIV risk through school or community-based education programmes can increase the adoption of preventive behaviours by up to five-fold.<sup>15</sup>

In addition, biomedical preventive approaches such as Pre-Exposure Prophylaxis (PrEP) – a daily oral ARV taken by people who are HIV-negative in order to prevent HIV infection – hold potential for speeding up progress in the next few years. PrEP, if taken consistently, reduces the risk of HIV infection by up to 92%, making it a powerful prevention method for people at substantial risk, including women and girls.<sup>16</sup> Implementation of PrEP has been limited so far, however, and challenges remain around uptake among at-risk populations. New PrEP formulations – such as occasional use of pills or quarterly injections – are in the pipeline and could help improve adherence and achieve PrEP’s full potential.

Over the next four years, it will be critical to learn from DREAMS and other innovative programmes to bring the most effective prevention interventions to scale up in high-burden areas. More and better data on young women and girls (as well as other key populations) at the local and sub-national levels are needed to ensure that programmes reach those most in need, and to hold countries and implementers accountable for greater impact.

Similarly, better data are needed to enable more targeted programming for key populations – including sex workers, people who inject drugs, transgender people, prisoners and men who have sex with men – who together account for more than one-third of all new HIV infections globally.<sup>17</sup> These groups face socio-economic, legal and political barriers that often make it difficult for them to access HIV treatment and prevention services, and put them at greater risk of becoming infected with HIV than the general population.<sup>18</sup> The availability and quality of data for these groups remain poor, and this is a major obstacle to targeting prevention and treatment services at the community level to better reach these most at-risk populations.

# TREATMENT



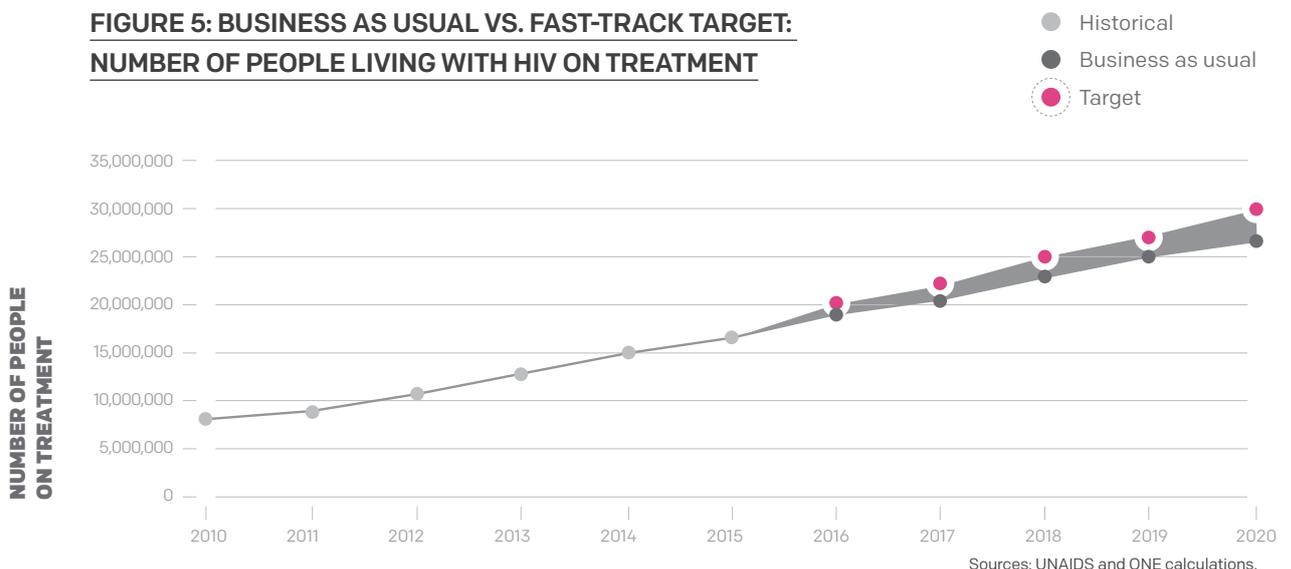
Increased access to treatment is one of the greatest success stories of the global AIDS response over the past decade. The number of people accessing HIV treatment has more than doubled in the past five years alone, from 7.5 million in 2010 to 17 million in 2015, helping to save 6 million lives over this period.<sup>19</sup>

**Around 2 million people begin receiving treatment each year now – a number that has remained steady since 2013 – but fewer than half of the people in need are receiving the medicines they require to survive.**<sup>20</sup> New data show that an additional 1 million people were added to treatment in the first half of 2016, suggesting that this pace of growth will remain flat. ARVs enable people living with HIV to live full and productive lives but treatment is also an effective prevention intervention, reducing the risk of someone living with HIV passing on the infection to others by up to 96%.<sup>21</sup> This effect makes it particularly important to expand access to treatment more quickly in order to realise the potential preventive benefits and to slow the growth of the HIV epidemic.

World leaders have committed to ensure that 30 million people living with HIV have access to treatment by 2020 – a goal necessary to get the number of AIDS-related deaths annually below 500,000. This will require reaching about 2.6 million people a year with ARVs until 2020 – a 30% increase from the steady year-on-year gains we have seen since 2013. A 'business as usual' trajectory will miss the mark.

Fewer than half of the people in need are receiving the medicines they require to survive.

**FIGURE 5: BUSINESS AS USUAL VS. FAST-TRACK TARGET:  
NUMBER OF PEOPLE LIVING WITH HIV ON TREATMENT**



# PATH TO 2020: PROMISING

New policies, practices and technologies have the potential to accelerate progress on treatment in the short term. For example, new World Health Organization (WHO) guidelines recommend that all people living with HIV should immediately start ARV treatment regardless of the progression of the disease; this shift means that millions more people are now eligible for treatment who previously were not – 37 million people, up from 28 million under the 2013 WHO guidelines.<sup>22</sup> This change in policy builds on evidence that the immediate initiation of HIV treatment reduces the number of AIDS deaths and improves health outcomes.

Evidence from Uganda suggests that implementing this policy can achieve quick and sizeable increases in coverage. Nine months after Uganda moved to treat all children living with HIV, the number of children receiving HIV treatment had increased by 74%.<sup>23</sup>

Some countries have started to adopt WHO's "treat all" recommendation, but increased adoption and rapid implementation over the next four years – particularly in the hardest hit countries in sub-Saharan Africa – are needed to ensure that all those who need treatment have access to it. At present, only 15 of the 47 countries in the region have adopted the "treat all" policy, and of these 15 countries just seven have begun implementation.<sup>24</sup>

**FIGURE 6: IMPLEMENTATION OF WHO'S 'TREAT ALL' RECOMMENDATION IN SUB-SAHARAN AFRICAN COUNTRIES**<sup>25</sup>

	<b>ADOPTED AND IMPLEMENTED COUNTRY-WIDE</b>	<b>ADOPTED AND PARTIALLY IMPLEMENTED</b>	<b>ADOPTED; NOT YET IMPLEMENTED</b>	<b>NOT YET ADOPTED</b>
	Comoros, Malawi, Rwanda, Seychelles, South Africa	Senegal, Zimbabwe	Botswana, Cameroon, Eritrea, Ghana, Lesotho, Namibia, Nigeria, Zambia	Angola, Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Niger, São Tomé and Príncipe, Sierra Leone, South Sudan, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania
<b>NUMBER OF COUNTRIES</b>	<b>5</b>	<b>2</b>	<b>8</b>	<b>32</b>

Source: WHO.

# A renewed focus on health systems strengthening is needed to ensure that countries can realise the benefits of new policies and technologies for HIV treatment

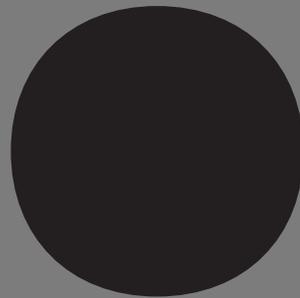
Innovative programming – such as increasing the integration of HIV testing and treatment alongside other health services – also holds promise for reaching more people in need. For example, a new public-private partnership in Kenya plans to start making screening for hypertension available alongside HIV/AIDS services in order to reduce the potential stigma associated with HIV testing and to link harder-to-reach patients with testing and treatment services.<sup>26</sup> This approach has the potential to help countries offer a wider range of health services to their citizens, and to accelerate access to treatment where stigma is still a major barrier to accessing HIV services.

New technologies also hold potential to increase people's access to treatment and their ability to adhere to it. For example, HIV self-testing kits provide an accurate and effective way for people to learn their HIV status in private, which is particularly valuable in places where stigma and discrimination are a barrier to testing. Countries currently piloting HIV self-testing include Botswana, Malawi, Namibia, Rwanda, South Africa and Swaziland.<sup>27</sup> Other technologies still in development, such as injectable HIV treatment, have the potential to provide a long-lasting alternative to the current complex daily regimen of ARVs, to which many patients have difficulty adhering. For example, ViiV Healthcare and Janssen Sciences Ireland UC have announced plans for phase-three clinical trials of injectable HIV drugs, which could offer a huge breakthrough for HIV treatment globally.<sup>28</sup>

**A renewed focus on health systems strengthening is needed to ensure that countries can realise the benefits of new policies and technologies for HIV treatment.** A shortage of health workers is a major barrier to expanding treatment efforts. Sub-Saharan Africa accounts for nearly 70% of the global HIV burden, but has only 4% of the world's health workforce.<sup>29 30</sup> The ranks of health workers at all levels of delivery, as well as the systems, supplies and facilities that support them, must be strengthened to tackle HIV and other infectious diseases, and to ensure that people living with the virus have the support they need both to access treatment and to adhere to it.

# FUNDING

# 3



**Without substantially increased investments over the next few years, meeting global targets and tipping the balance towards the end of AIDS will be no more than a pipe dream.**

In 2015, the global resources available to fight AIDS in low- and middle-income countries totalled \$19 billion, down slightly from US\$19.2 billion in 2014. This marked the fourth consecutive year in which resources available for the global fight against AIDS have been essentially flat.

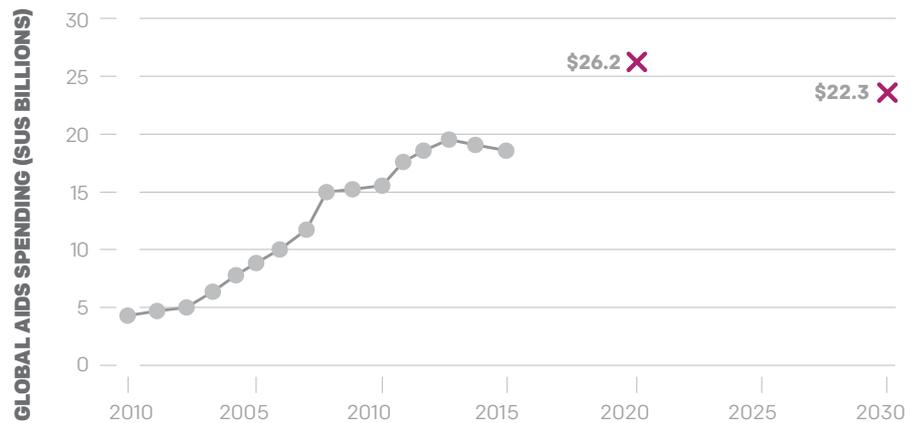
Updated estimates from UNAIDS suggest that 'fast-tracking' the AIDS response to accelerate progress against HIV/AIDS in low- and middle-income countries will require \$26.2 billion annually by 2020 – less than the \$30 billion previously

projected because of expected gains from adopting efficiency measures and cutting-edge tools, but still considerably higher than the current level of spending.<sup>31</sup>

On the current trajectory, and without a major funding moment for HIV/AIDS planned until the next Global Fund replenishment in 2019, the world is unlikely to close the \$7 billion gap by 2020 without bold new action. If this gap can be closed, funding needs are then actually expected to decrease steadily through to 2030. Failing to hit this target, however, will prolong the epidemic indefinitely and in many countries will reverse progress and allow the epidemic to rebound and allow the epidemic to rebound and to grow again.

**FIGURE 7:  
GLOBAL AIDS  
SPENDING  
LEVELS, HISTORIC  
AND FUTURE  
TARGETS**

● Historic Spending Levels  
✗ Projected targets



Source: UNAIDS.

Failing to hit this target, however, will prolong the epidemic indefinitely and in many countries will reverse progress and allow the epidemic to rebound and allow the epidemic to rebound and to grow again.

# EXTERNAL FINANCING FOR AIDS

Of the \$19 billion spent to date, \$8.2 billion – or less than half of all global spending – has come from international assistance.<sup>32</sup> Low- and middle-income countries' own budgets have accounted for the remaining 57%.<sup>33</sup>

Worryingly, the latest figures show that donor government spending to address HIV fell in 2015 for the first time in five years, dropping by 13% or \$1 billion.<sup>34</sup> Bilateral and multilateral contributions by G7 donors declined, with reductions ranging from 12% for the United Kingdom and Canada to 28% for Germany and 33% for Japan.<sup>35</sup> The European Union Institutions' contribution saw a slight increase of 2% from 2014 levels.<sup>36</sup>

Donors signalled their continued commitment to the fight against AIDS at the fifth replenishment conference of the Global Fund in Montreal in September 2016, the year's most significant moment for AIDS financing. The Global Fund raised over \$12.9 billion for the next three-year period (2017–19) – the largest ever amount raised during a replenishment.

The United States and France maintained strong commitments, and remain the top two donors over the life of the Global Fund. The UK, Germany, Japan, Canada and the EU all effectively increased their commitments. Several African countries maintained or increased their pledges, including Kenya (\$5 million), Namibia (\$1.5 million), South Africa (\$5 million) and Zimbabwe (\$1 million), and a number of new donors came to the table, including Benin (\$2 million), Côte d'Ivoire (\$1 million), Senegal (\$1 million), Togo (\$1 million) and Qatar (\$10 million). Pledges from private donors and innovative financing initiatives doubled from the previous funding period, reaching \$870 million for the coming three years.

There remains room for improvement from other donors, however. The Netherlands reduced its pledge compared with its current contribution, down from \$251 million to \$195 million. Nigeria committed to delivering \$10 million, a portion of its outstanding commitment from the last replenishment cycle, and while Spain did not make a pledge, there is still hope that it will make a commitment in 2017.

**FIGURE 8: INTERNATIONAL HIV/AIDS ASSISTANCE FROM G7 MEMBERS AND OTHER MAJOR DONORS**

**TOTAL FUNDING FOR HIV, 2013–15 (\$US MILLIONS)**

YEAR	Canada	EU Institution	France	Germany	Italy	Japan	Netherlands	United Kingdom	United States
2013	141	101	410	285	2	102	186	842	5,621
2014	125	91	303	278	26	176	219	1,114	5,572
2015	109	93	263	201	20	118	175	980	5,005

Sources: Kaiser Family Foundation and UNAIDS.

While it is a promising sign of continued commitment to the global fight against AIDS, especially in the current global economic context, even this successful replenishment will not deliver the increased ambition needed to defeat the disease. The Global Fund fights not only AIDS but also tuberculosis and malaria; only about half of the nearly \$13 billion raised will go towards fighting HIV, resulting in only a modest increase in AIDS funding over the next three years. Without increased ambition from bilateral donors or significant increases from the private sector, external financing for AIDS will maintain a business as usual trajectory and will fail to make a dent in the \$7 billion funding gap.

To close this gap, new donors will have to join the fight in a much more significant way. Funding for AIDS continues to be concentrated among just a few donors. In 2015 – as was the case in 2012 – around 90% of international assistance came from G7 countries and the EU Institutions.<sup>37</sup> Even among these donors, the burden was shared unevenly. The US alone contributed two-thirds of all international assistance for HIV/AIDS in 2015. Combined with resources from the next two largest donors, the UK and France, that share rose to over 80%.

**FIGURE 9: G7 MEMBERS AND OTHER MAJOR DONOR GOVERNMENTS TO THE GLOBAL FUND, 2017 - 19 COMMITMENTS (\$ MILLIONS)**

YEAR	Canada	EU Institutions	France	Germany	Italy	Japan	Netherlands	United Kingdom	United States
Global Fund Commitment 2017 - 19	721	593	1,347	998	175	800	195	1,711	4,300
Estimated share of Commitment Directed to HIV/AIDS	360	296	674	499	87	400	97	855	2,150

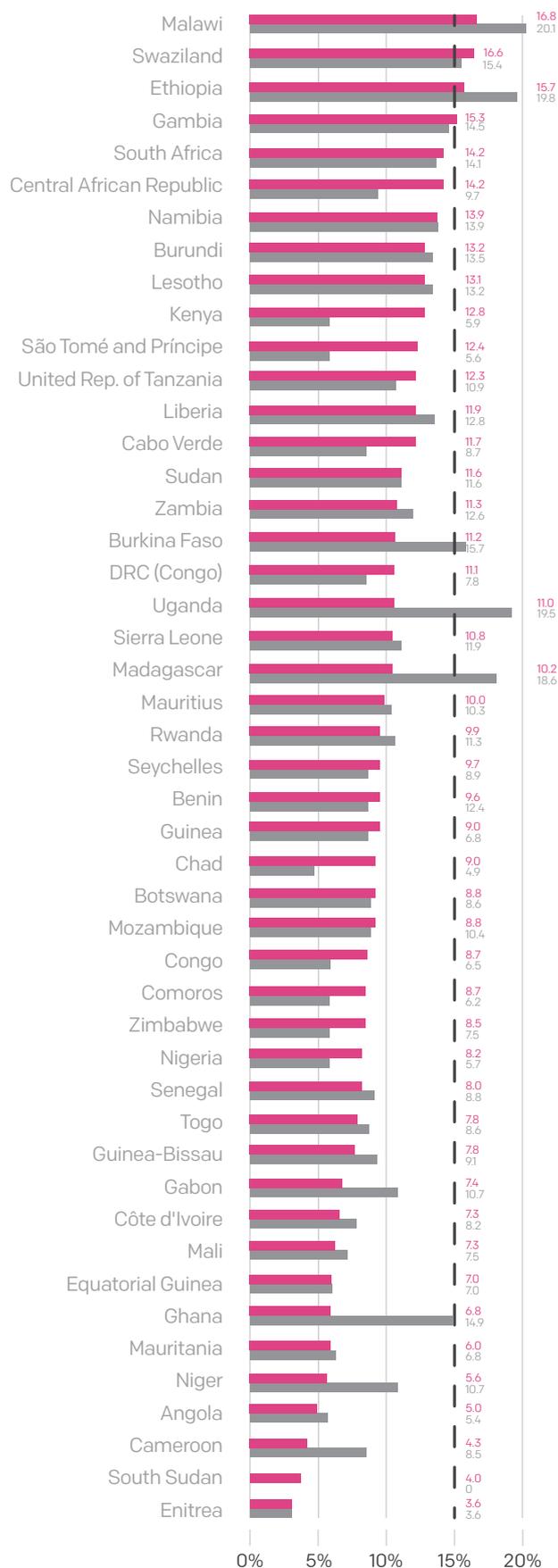
Source: The Global Fund.

# DOMESTIC RESOURCES FOR HEALTH IN SUB-SAHARAN AFRICA

However, it is not donor funding that provides the majority of resources to fight HIV/AIDS; for the fourth year running, low- and middle-income countries funded more than half of the world's AIDS response themselves – an encouraging trend.<sup>38</sup> Nevertheless, most African governments are still not allocating sufficient resources for health. In 2014 only four countries – Malawi, Swaziland, Ethiopia and Gambia – met or exceeded their 2001 Abuja commitment to spend 15% or more of their domestic budgets on health programmes. From 2010 to 2014, 17 countries in sub-Saharan Africa increased the proportion of their budgets going to health, while four countries saw no change and 25 cut their health spending.

**FIGURE 10: GOVERNMENTAL EXPENDITURE ON HEALTH IN SUB-SAHARAN AFRICA AS PERCENTAGE OF GENERAL GOVERNMENT EXPENDITURE, 2010 AND 2014**

■ 2014  
 ■ 2010  
 - - Abuja Commitment



**GENERAL GOVERNMENT HEALTH EXPENDITURE AS PERCENTAGE OF GENERAL GOVERNMENT EXPENDITURE**

Sources: WHO.

# If Nigeria increased its per capita health spending and just \$1 per person went towards HIV/AIDS programmes, it would be enough to put 1.7 million people on treatment annually

UNAIDS estimates that, in order to achieve global funding targets by 2020, the proportion of domestic funding for HIV in each country would need to increase on average from 10% to 12% in low-income countries, from 22% to 45% in lower-middle-income countries and from 84% to 95% in upper-middle-income countries.<sup>39</sup>

Achieving this will be difficult in most African countries, where overall growth in government resources for health has been sporadic at best. But even if the countries that did not meet the Abuja target in 2014 were to spend just 1% more on health as a proportion of their general government budgets, they would generate \$3.9 billion in additional resources for health annually. From there, if just 20% of those additional new health resources – about \$774 million – were to go specifically to AIDS programmes, it would be enough to pay for a year's worth of ARV treatment for close to 8 million more people.

Another way of assessing a government's commitment to the health of its citizens is by looking at its per capita spending on a basic set of primary healthcare services, which has been estimated by Chatham House to require a minimum of \$86 per capita (2012 prices).<sup>40</sup> Most countries in sub-Saharan Africa are falling short on this measure as well; over the period 2012–14, 32 countries in the region spent less than the recommended \$86 per capita on essential health services. To bridge this gap, \$54.5 billion in additional funds would have been needed across all countries in the region in 2014 – \$10.5 billion in Nigeria alone.<sup>41</sup>

This gap will be difficult to close in the short term, but even incremental steps would make a huge difference. For example, if Nigeria increased its per capita health spending and just \$1 per person went towards HIV/AIDS programmes, it would be enough to put 1.7 million people on treatment annually.

In 2016, African ministers of health adopted the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030, which provides an agenda to spur progress towards ending the three epidemics.<sup>42</sup> This framework is an important step forward, outlining specific targets for 2020 and laying out a framework for investing in health systems strengthening, data to inform policy and programming, and capacity building. But although it acknowledges the funding needed to achieve these targets, it conspicuously lacks a pathway towards funding. African countries are missing opportunities to take greater ownership of their own AIDS crises and to significantly strengthen their own health systems.

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# PATH TO 2020: OFF TRACK

It is likely that efficiency gains – including from new technologies and better-targeted programming – will continue to enable countries and programme implementers to deliver greater impact for less investment, but new resources from diversified sources are urgently needed to close the \$7 billion gap in funding needed to lay the groundwork for controlling the AIDS pandemic in our lifetimes.

Donors must stay committed, and must raise their collective ambition. Continued reliance on the US and a few other countries to contribute the overwhelming majority of resources is not sustainable. New donors from emerging economies and the private sector must step up and contribute more meaningfully, whether through new or existing innovative financing channels.

Ultimately, increases in African countries' own domestic financing are almost certainly what will make the global fight against AIDS successful. Innovative financing mechanisms using taxes, levies and debt conversion offer potential solutions to help governments finance HIV/AIDS programmes. In Zimbabwe, the AIDS Trust Fund generated \$52.7 million for programmes between 2008 and 2011 from the proceeds of a 3% tax levied on formal sector employees and employers.<sup>43</sup> This equated to 90% of the \$58.7 million in total domestic public spending on HIV over the same period. Similar instruments have been proposed, though not fully scaled up or

implemented, in Kenya, Uganda and Tanzania. In July 2006 France began changing a small fee of approximately €1 for domestic flights and €4 for international flights to raise money for HIV/AIDS programmes, and by 2013 this airline levy had raised more than €1 billion.<sup>44</sup> Now, 11 African countries have either implemented or are considering implementing a similar levy to raise funds to fight the epidemic.<sup>45</sup>

In Botswana, a 'buy-down' programme that started in 2010 was used to facilitate the financing of HIV/AIDS prevention initiatives, with the World Bank providing the country with a \$50 million loan via the International Bank for Reconstruction and Development (IBRD). The European Commission then approved \$20 million to reduce the interest rate of the loan, the disbursement of which was contingent on Botswana achieving particular HIV/AIDS-related targets.<sup>46</sup> Similarly, as a part of the Debt2Health initiative, Germany agreed to cancel \$27 million of debt owed by Côte d'Ivoire in 2010 on condition that the country invested half of this cancelled debt through the Global Fund.<sup>47</sup>

Remittances and diaspora bonds, social and development impact bonds, sovereign wealth funds and risk and credit guarantees may also offer potential solutions for funding HIV/AIDS initiatives, though these have yet to be tested thoroughly in the health sector.

New resources from diversified sources are urgently needed to close the \$7 billion gap in funding

# Conclusions and Recommendations



# CONCLUSIONS AND RECOMMENDATIONS

Despite notable progress in key areas of the fight against AIDS, the overall trajectory of progress has flatlined, along with funding. We have the tools and know-how to increase the number of people on treatment and to deliver effective prevention interventions. New technologies and policies hold the potential to significantly accelerate the rate of progress over the next decade, and we know how much it will cost to end AIDS as a public health threat once and for all. While flatlined funding suggests that the commitment of world leaders to fighting AIDS remains strong, it also indicates that their collective ambition to end it is waning. Business as usual will not be enough. Renewed focus and increased ambition are needed in four areas:

→ **Increase the share of domestic financing for HIV:** Ultimately, African countries' own domestic financing must play the most pivotal role in transforming the ambition and success of efforts to fight AIDS. Countries should raise their ambitions around the use of taxes or levies where appropriate, and governments must also substantially increase their annual share of spending on health and ensure that funding for HIV/AIDS programmes is increased proportionately based on domestic needs. Civil society will play an increasingly critical role in mobilising governments to utilise their tax dollars toward this end. Donors should also play an increasing role in supporting ministries of finance to improve the efficiency and effectiveness of their HIV responses and broader health financing.

→ **Increase ambition and diversify sources of external funding:** Consistently strong donors, including the US and the UK, are critical stalwarts in maintaining progress in the global fight against AIDS. This support should be maintained and expanded over the next four years, but this alone cannot and should not be relied upon to close the \$7 billion funding gap by 2020. Other donors, including emerging economies and private sector actors, must step up and contribute more meaningfully, including through new or existing innovative financing channels.

→ **Keep health systems at the centre of the HIV response:** A renewed focus on the strengthening of health systems, and especially development of the health workforce, is needed to ensure that countries can realise the potential of new policies and technologies for HIV treatment and prevention. Greater integration of HIV/AIDS services with broader health services can increase the uptake of testing and treatment. Support for health workers at all levels of delivery must be strengthened to tackle HIV and other infectious diseases, and to ensure that people living with HIV have the support they need both to access treatment and to adhere to it.

→ **Accelerate innovation and learning with better and more timely data:** As innovative approaches to prevention and treatment are more frequently rolled out, better-quality and more timely data are needed to improve the feedback loop and to allow for real-time course correction and the accelerated scaling-up of effective programmes. For example, early lessons from cross-cutting programmes like DREAMS should be quickly adapted and expanded at the local level.

While more timely, gender-disaggregated data are making it possible to scale up tailored and targeted interventions for young women and girls, this 'data revolution' must also benefit key populations including sex workers, people who inject drugs, transgender people, prisoners and men who have sex with men. Countries and donors need to redouble their efforts to strengthen data on these most at-risk populations in order to better target prevention interventions towards the people and places most in need.

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# METHODOLOGY

## **Measuring progress towards the tipping point and global funding for AIDS for 2000–15**

ONE defines the achievement of the beginning of the end of AIDS – “a tipping point” – as the point at which the number of people newly added onto treatment in a given year equals the number of people newly infected with HIV in the same year. On a graph, it is the point where these two curves intersect.

ONE used the data for new HIV infections and individuals newly added to treatment from UNAIDS’ July 2016 report, “The Prevention Gap Report”, the factsheet corresponding to the report and the UNAIDS online database, AIDSInfo. In order to calculate the number of people newly added to treatment, we subtracted the number of people on treatment in 2013 from the number of people on treatment in 2014.

## **Calculating Business as Usual v. Target Scenarios**

ONE calculated the ‘business as usual’ projections by calculating the annual rate of change between 2010 and 2015 and applying a linear projection until 2020 across select indicators. For the prevention target, ONE used data on new infections among young women (15-24) from UNAIDS online database, AIDSInfo, and the target contained in the UN’s 2016 Political Declaration on HIV and AIDS. For the treatment target, ONE uses data on the number of people receiving ART from UNAIDS online database, AIDSInfo, and the target contained in the 2016 Political Declaration on HIV and AIDS. For the funding target, ONE uses data on donor financing from the UNAIDS 2016 Fact Sheet, and the target contained in the UNAIDS report “Fast Track Update on Investments Needed in the AIDS “Reponse”.

**Calculating international HIV/AIDS assistance from G7 members and other major donors**

ONE used the joint report by the Kaiser Family Foundation (KFF) and UNAIDS, “Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2013”, to calculate total funding for HIV in 2013. ONE used the 2016 version of the same KFF and UNAIDS joint report to calculate total funding for HIV in 2014–15.

ONE defines total HIV/AIDS spending as the sum of a donor country government’s bilateral and multilateral AIDS contributions. Though the effect of inflation on purchasing power is acknowledged, this report is concerned with tracking pledges and commitments, rather than assessing the value of goods and services. As such, unless otherwise noted, all funding amounts are expressed in current US dollars (\$) for comparability between donors. Additionally, our core data source, KFF/UNAIDS, uses current dollars for its analysis and all domestic financing data are in current dollars.

One defines ‘bilateral contributions’ as any earmarked amount designated by donor governments for HIV assistance. This also includes earmarked contributions to multilateral organisations, such as UNAIDS. Since these bilateral funding data are not disaggregated in the KFF dataset, some UNAIDS contributions are also counted as part of bilateral funding for ONE’s report. Furthermore, bilateral assistance data were collected in the KFF/UNAIDS report for disbursements, i.e. the actual release of funds to a recipient, rather than commitments or enacted budgetary amounts. Disbursements may not always match enacted budgetary amounts, nor are they always released in the same year as the budgetary decisions; however, they do represent the amount of money actually being spent on the ground in any given year.

ONE defines ‘multilateral contributions’ as the sum of a country’s contributions to the Global Fund and UNITAID. While ONE acknowledges that multilateral contributions may go through other channels, for the purposes of this report it looks only at these two mechanisms, as they are the primary multilateral organisations involved in HIV/AIDS that are comparable across all donors. To compute the amount that each donor country spent on HIV/AIDS via its multilateral contributions, ONE multiplied each donor’s full contribution to the Global Fund and UNITAID by the respective percentages of their total funding that was allocated to AIDS in that particular year. In 2013, this percentage was 57% for the Global Fund and 51% for UNITAID; in 2014–15, the percentage was 55% for the Global Fund and 49% for UNITAID.

**Calculating donors' commitments to the Global Fund from 2017 to 2019**

ONE used the US dollar equivalent of pledges made in other currencies provided by the Global Fund. The Global Fund calculated the dollar equivalent values of pledges toward the 2017–19 replenishment using an exchange rate based on a five-year moving average computed on 15 September 2016 and listed on Thomson Reuters.<sup>48</sup> To calculate the estimated share of commitment directed toward HIV/AIDS, ONE multiplied each donor's Global Fund pledge by 50% – the percentage of total funding that the Global Fund estimates will be allocated to AIDS during this period.

**Calculating what a 1% increase in countries' general government health expenditure (GGHE) as a percentage of general government expenditure (GGE) would be in US dollars for all African Union (AU) countries, excluding those in the Middle East and North Africa (MENA) region, that did not meet the Abuja commitment in 2014 (all countries except Ethiopia, Gambia, Malawi and Swaziland)**

ONE took WHO's GGHE per capita in US dollars indicator for each country in 2014 and multiplied it by the total population of each country that year using the UN Population Division's World Population Prospects to find the total GGHE in US dollars for 2014 for each country.<sup>49</sup> ONE then used WHO's figures on GGHE as a percentage of GGE in 2014 for each country to find the GGE for each country, by making the following calculation:  $GGE = [(100 * GGHE) / GGHE \text{ as a \% of GGE}]$ . To find what a 1% increase of GGHE (as a % of GGE) would be in US dollars, ONE made the following calculation:  $1\% \text{ increase of GGHE in USD} = [((1\% + GGHE \text{ as a \% of GGE}) * GGE) - GGHE]$ . Totalling this figure for all of the AU countries that had not met the Abuja commitment in 2014 (excluding countries in the MENA region) gave a figure of \$3.9 billion, of which ONE believes that 20% could be directed toward fighting HIV/AIDS, equating to \$774 million.

**Calculating the number of additional annual ARV treatments that could be afforded if governments decided to allocate 20% of a 1% increase in their GGHE (as a % of GGE) to HIV/AIDS programmes**

ONE took 20% of the 1% increase in countries' GGHE (as a % of GGE) in US dollars for all AU countries, excluding countries in the MENA region (as calculated above) and divided these calculated figures, on a country-by-country and cumulative AU basis, by \$100 – the assumed cost of an annual course of ARV medication.

**Calculating what the increased ARV coverage rate for selected countries would be from a 1% increase in countries' GGHE (as a % of GGE), of which 20% would be dedicated to HIV/AIDS**

ONE took UNAIDS' ARV coverage rate for each country from the online database, AIDSinfo, and multiplied it by UNAIDS' indicator on the number of people with HIV/AIDS to find the total number of people receiving ARV treatment in each country in 2014. We then added the respective number of additional ARV treatments that could be afforded for each country (as calculated above) to this figure, and divided this by the respective number of people living with HIV/AIDS in each country in 2014.

**Calculating the number of sub-Saharan African countries that spent less than Chatham House's recommended government spending figure of \$86 per capita (2012 prices) on essential health services over the 2012–14 period**

First, ONE calculated price deflators (2012=100) for all sub-Saharan African countries by using the OECD DAC method, taking into consideration fluctuations in exchange rates and inflation. We used these deflators to convert general health expenditure per capita (\$) figures for each African country between 2012 and 2014 into 2012 prices. We then took the average of these deflated figures between 2012 and 2014 for each country; this showed that in 32 countries average per capita government health spending for 2012–14 (2012 prices) fell below the recommended level of \$86.

**Calculating the cumulative funds necessary for all sub-Saharan African countries to bridge the gap in achieving the recommended government spending level of \$86 per capita (2012 prices) on essential health services**

ONE calculated price deflators (2012=100) for all countries in the region by using the OECD DAC method, taking into consideration fluctuations in exchange rates and inflation, using these deflators to convert general health expenditure per capita (\$) figures for each African country in 2014 into 2012 prices. ONE then calculated for each country that did not meet Chatham House's recommended level how much it would need to increase per capita spending to hit \$86, and multiplied this gap by the population of the countries concerned. This gave a figure for the necessary additional funding to hit the \$86 level for each country, and we added up all country figures to find the total necessary funding to hit the \$86 level for all of sub-Saharan Africa.

**Calculating the number of annual ARV treatments that could be afforded by increasing Nigeria's general government health expenditure by \$1 per capita**

ONE multiplied \$1 by the population of Nigeria (177.4 million) and then assumed a \$100 cost for one annual course of an ARV treatment.

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