AIDS

UNFINISHED BUSINESS:
TRACKING GLOBAL COMMITMENTS ON AIDS,
VOLUME 4

ONE

The Global Fund / John Rae

Outreach worker Paula Mengate seeks out long-haul truck drivers like Charles Alwangata at a cross-border truckers' 'resting zone' near Maputo, where they must wait – often for days – for customs clearance. Resting zones are hot spots for sex workers to meet up with clients, so Paula's job is to provide information about the risk of HIV infection and other sexually transmitted diseases, as well as to give out free condoms and make referrals for HIV testing.

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To the millions of people who work and campaign tirelessly to make progress towards the beginning of the end of AIDS possible, thank you. The perseverance and commitment of those working both inside and outside governments is truly inspiring.

METHODOLOGY, ERRORS AND OMISSIONS

The full methodology for this report, as well as a downloadable report in PDF format, can be found at www.one.org/aidsreport. This report was finalised on 12 November 2015. The information it contains was, to the best of our knowledge, current up until that date. We acknowledge that events occurring after this point may mean that some of the figures and commitments in this report are out of date. Any remaining errors are our sole responsibility.

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PART 1

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PROGRESS AND PERIL ON THE VERGE OF THE TIPPING POINT

A young girl at a madrassa (school) in Zanzibar, where HIV education is a part of the curriculum in the school and throughout the archipelago.

More than **15 million** people around the world are now on antiretroviral treatment, up from just **700,000** in 2000.[1]

Nearly **8 million** AIDS-related deaths have been averted since 2000 because the world took action.[2] That's saved as many lives as the entire population of Switzerland.

PROGRESS

Nearly **three-quarters of all HIV-positive pregnant women** now have access to treatment to prevent transmission to their babies.[3]

Senegal has achieved some of the most dramatic success against HIV, **reducing new infections by 87%** since 2000—more than double the average reduction of 40% across sub-Saharan Africa in the same timeframe.[4]

Resources for AIDS have increased by more than **320%**, from $4.8 billion in 2000 to $20.2 billion in 2014.[5]

600 children are still born with HIV every day. More than a quarter of them will be born in Nigeria alone.[7]

22 million people around the world are still in need of life-saving treatment – that's roughly the population of Cameroon.[6]

In South Africa, more than **800 girls** aged 15–19 are infected with HIV every week.[8]

PERU

Compared with the general population, men who have sex with men are **19 times** more likely to be living with HIV and people who inject drugs are **28 times** more likely. Transgender women are **49 times** more likely to be living with HIV than other adults of reproductive age.[9]

44 countries still rely on international donors for 75% or more of their AIDS financing needs.[10]

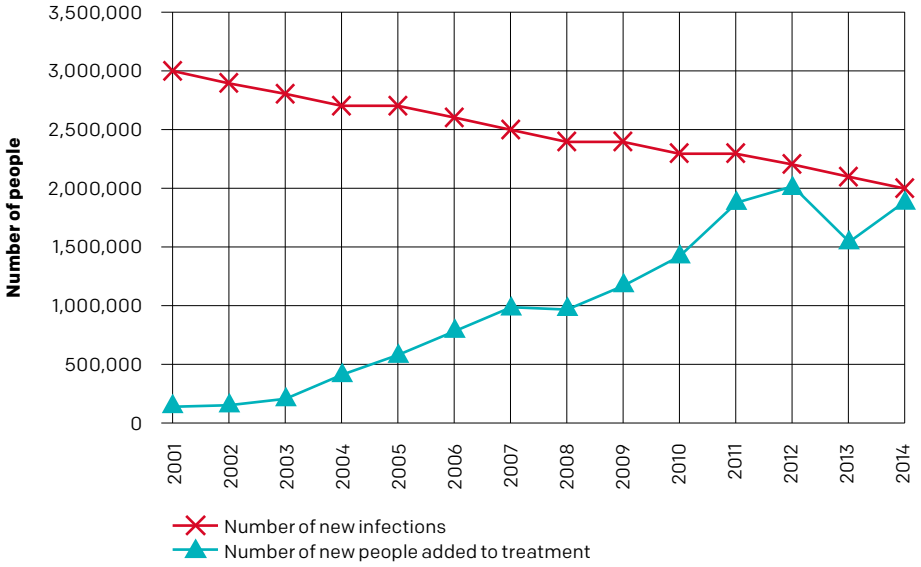
More than three decades into the global fight against HIV/AIDS, a growing sense of complacency and fatigue threatens to derail the progress achieved and the momentum needed to accelerate the world's collective efforts. The notion of AIDS as an urgent, pressing issue of global concern has faded from news headlines and the hallways of governments, leaving many citizens to believe that the disease has already been tackled or that the world has moved on.

Yet, of course, this notion could not be further from reality. Despite the many hard-earned gains made in recent years, the world still stands on unsteady ground, approaching but not yet past the halfway mark in the fight to end AIDS as an epidemic. Globally, 1.9 million people were newly added to antiretroviral (ARV) treatment last year – increasing the total number of people on treatment to 14.9 million by the end of 2014 – but 2 million people became newly infected with HIV in the same year, outpacing the growth in access to treatment.[11] The world has therefore still not reached a critical tipping point, where the number of people newly added to ARVs surpasses the number of people newly infected with HIV.

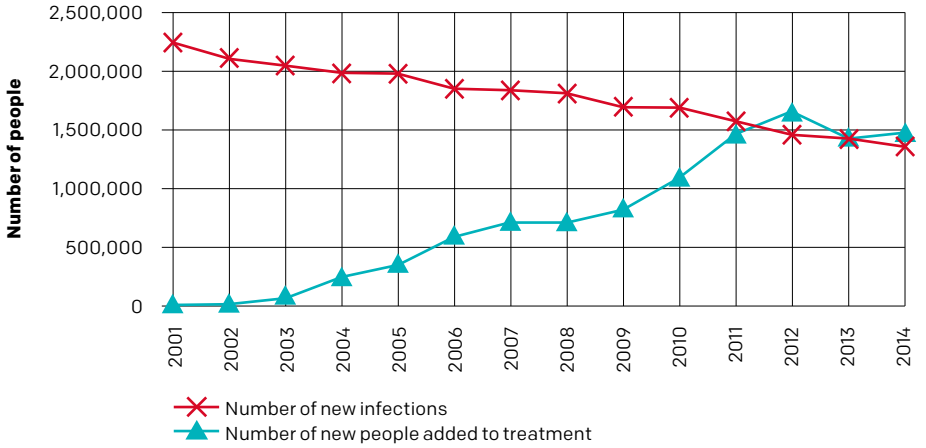
Last year's data suggested that we had in fact reached this tipping point for the first time in the history of the disease. However, newly remodelled estimates of the data for 2013 suggest that the world had not reached a tipping point in 2013.[i] Although we have made significant progress in the 12 months since, the global tipping point remains an elusive milestone.

And while the development of more sophisticated ARVs has meant that an AIDS diagnosis no longer needs to be an automatic death sentence, AIDS is still deadly. Some 1.2 million people – more than 3,200 every day – died from AIDS-related illnesses in 2014,[12] devastating

Progress Towards the Tipping Point: Global



Progress Towards the Tipping Point: Sub-Saharan Africa

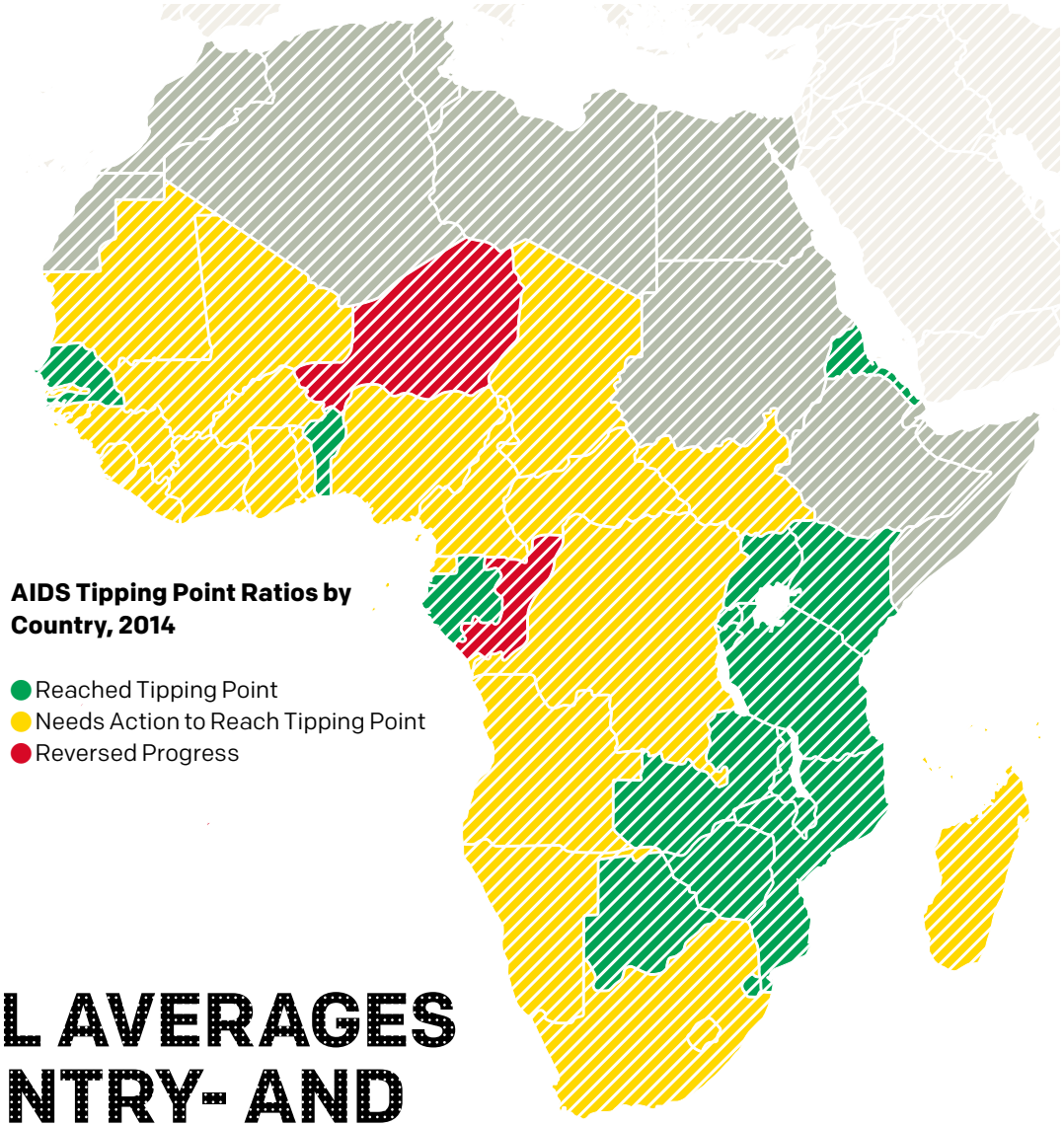


[i] In 2014, the year-on-year estimates for 2000–13 published by UNAIDS showed that 2.3 million people were added to treatment between 2012 and 2013, surpassing the 2.1 million people newly infected with HIV. However, this year's data show that between 2012 and 2013 only 1.6 million people were added to treatment, a number surpassed by 2.1 million new infections. What accounts for this shift? Much of what experts understand about the disease is based on imperfect data samples, mathematical models and estimates. Each year, those who gather and analyse AIDS data (including UNAIDS, the World Health Organization (WHO) and individual countries) can modify how they estimate both figures from past years and future trends in ways that they believe make the estimates more accurate. With more current data inputs combined with improved estimation methodologies, the numbers can change – and sometimes significantly so.

families and diminishing prospects for economic growth across many communities, cities and countries.

Progress in sub-Saharan Africa towards the tipping point has been faster than the global average, although gains have been somewhat uneven in recent years. With 1.47 million people newly added to treatment in 2014 compared with 1.36 million new HIV infections, sub-Saharan Africa surpassed a regional tipping point between 2013 and 2014 (a milestone it first achieved between 2012 and 2013, only to slip backwards slightly the following year). Framed another way, even though the region accounted for 70% of the world's new HIV infections last year, it also accounted for more than 77% of the people newly added to treatment in the same period.[13]

Global and regional averages can easily mask country- and local-level disparities. Some 80% of people living with HIV in the world now live in just 20 countries – 13 of which are in sub-Saharan Africa.[14] Country-level tipping point ratios also vary dramatically, with contrasts between countries such as Kenya and Tanzania (in which roughly twice as many people were newly added to treatment in 2014 as were newly infected) and countries such as South Sudan and Mali (each with more than four times as many people newly infected as people newly added to treatment).[15]



GLOBAL AND REGIONAL AVERAGES CAN EASILY MASK COUNTRY- AND LOCAL-LEVEL DISPARITIES

Maintaining the status quo of today's global AIDS response is simply not sufficient for accelerating progress, as significant gaps remain across treatment, prevention and care efforts. Just over 40% of the 37 million people globally living with HIV/AIDS are currently able to access treatment – even though new 2015 World Health Organization (WHO) guidelines recommend that everyone who tests positive for HIV should initiate treatment immediately[16] – and millions of people are still becoming newly infected each year, while stigma and human rights challenges persist.[17] However, experts argue that we are now in a unique window of time based on the current state and potential trajectories of the disease. **If we can aggressively scale up or 'fast-track' our investments and programmes in the next five years, we could bend the curve of the disease towards its ultimate end as an epidemic by 2030**, averting up to 28 million new HIV infections and 21 million AIDS-related deaths in the process.[18] Conversely, if services remain at 2013 levels, UNAIDS estimates that the epidemic will outpace response measures and could effectively rebound by 2030. This could lead to 2.61 million new infections in Africa, Asia, and Latin America alone – eight times the number of infections that would likely occur if the fast-track approach is implemented.[19]

Making this goal a reality will inevitably require many inputs and shifts: more tailored AIDS programming that delivers a more cost-effective mix of interventions; a more strategic effort to target marginalised populations; improved data; a sustained commitment to the development of new and better tools; and a more intentional alignment of HIV/AIDS programmes with the agenda of the Sustainable Development Goals (SDGs).

Underpinning all of these efforts, **we must secure significant new resources to finance the fight and to drive faster progress**. With worthy competition for global development resources coming from every direction – from refugee crises to emerging disease outbreaks like Ebola to infrastructure and job creation – those who care about the fight against AIDS must make the case for why additional resources, allocated and delivered with urgency, can fill the critical gaps in prevention, treatment and research to ultimately save more lives. In the following pages, ONE analyses the current sources of global AIDS financing; outlines clear financing needs in the years ahead; and suggests who should be contributing these critical new resources.

40%

OF PEOPLE LIVING WITH HIV/AIDS HAVE ACCESS TO TREATMENT

PART 2

FINANCING THE FIGHT

(RED) / Jonx Pillemer

Like many women, Mary of Nakuru County, Kenya found out her HIV status when she became pregnant and received a test as part of her checkup. She was devastated and ashamed when she found out she was positive. Luckily, a community health program was there to help Mary through her experience, providing her counsel and proper HIV treatment that allowed her to stay healthy and give birth to HIV-negative children. Today, Mary feels healthy and empowered with the tools she needs to live a healthy life. In her words, "I felt so desperate and believed I wouldn't amount to anything in the community or society. But, when I joined the program and started going to seminars, I became very knowledgeable on how to live."

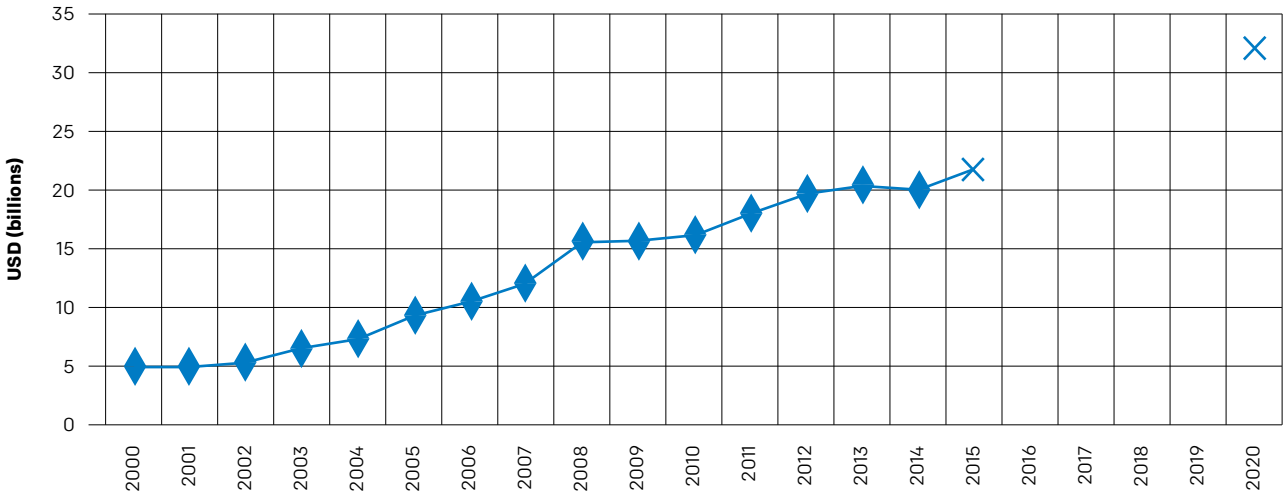
The estimates for what it will cost to control the AIDS epidemic have grown significantly since the 2011 Political Declaration on AIDS, which called for $22–24 billion in annual HIV/AIDS spending in resource-poor settings by 2015.[20] In line with the rise in global ambition for what is possible – the ultimate defeat of AIDS as an epidemic by 2030 – **UNAIDS now estimates that 'fast-tracking' the AIDS response to accelerate progress against the disease in low- and middle-income countries will require nearly $32 billion annually by 2020**.[21] Of this total amount, low-income countries are projected to require $8.2 billion and middle-income countries – home to more than half of the world's people living with HIV – will require $23.8 billion, including $9.2 billion for lower-middle-income countries and $14.6 billion for upper-middle-income countries.[22] The percentage of these funding requirements coming from domestic versus external sources will vary based on countries' circumstances and capacities. To reach these financial targets by 2020, UNAIDS estimates that low-income countries will likely need to fund at least 12% of their total resource needs for HIV; lower-middle-income countries will need to fund 45%; and upper-middle-income countries will need to fund 95% (as compared with 2013 levels of 10%, 22% and 80%, respectively).[23]

Today's spending on HIV/AIDS falls far short of those targeted levels. Global spending on the disease in low- and middle-income countries from all sources totalled $20.2 billion in 2014, down slightly from 2013's historic high of $20.4 billion. Of the total, less than half of all spending came from international donors; low- and middle-income countries' own budgets accounted for 57% of the resources available – a consistent and encouraging pattern in recent years. To achieve these new levels of financing – nearly $12 billion above 2014 spending levels, or just over $10 billion above projected 2015 spending levels – the world would effectively need to marshal an additional $2 billion each year between now and the end of 2020.

The following sections explore financing trends and realistic opportunities for securing new resources from among four categories of current and/or prospective contributors:

1. Leading government contributions;
2. African national budgets;
3. Emerging donor governments; and
4. The private sector and innovative financing mechanisms.

Global AIDS Spending Levels, Historic and Projected



UNAIDS projects that global spending on HIV/AIDS will rise to $21.7 billion by the end of 2015. It also estimates that annual spending levels must rise to $32 billion by 2020 in order to turn the tide on the disease.

LEADING GOVERNMENT CONTRIBUTIONS

Bilateral and multilateral contributions by leading Western governments barely increased between 2013 and 2014, rising slightly from $8.49 billion to $8.64 billion.[24] Much of this marginal increase can be attributed to an increase in resources from the United Kingdom in 2014. Italy, Japan, the Netherlands and Norway also increased their financing last year, while funding from Germany and the United States remained roughly flat, and nine governments reduced their funding levels.[25]

Worryingly, external funding for AIDS continues to be concentrated among just a few donors. In 2014, roughly 87% of international assistance came from only five donors: the US, the UK, France, Germany and the Netherlands[26] (as compared with other sectors such as agriculture and food security or maternal health, for which the top five donors accounted for 64% and 68% of international assistance respectively)[27]. Even among the world's top AIDS donors, the burden was shared unevenly, with the US contributing roughly two-thirds of all international assistance for HIV/AIDS in recent years.[28] These trends in donor financing are even more concerning in the context of the needs of many low- and middle-income countries: 44 countries still relied on donors for 75% or more of their AIDS financing needs in 2014.[29]

Given many countries' reliance on external funding, sustaining political support and securing additional funding increases from external sources will remain a top priority in the years ahead. The following pages offer snapshot 'Yearbook'-style verdicts of notable funders' performances, as well as more in-depth profiles of the world's top 14 donors (as ranked by nominal AIDS contribution levels). These profiles provide an overview of countries' most recent three-year trends in overall official development assistance (ODA), health spending and AIDS spending, while also articulating ONE's funding ask of each country in the Global Fund's upcoming replenishment.[ii]

WORRYINGLY, EXTERNAL FUNDING FOR AIDS CONTINUES TO BE CONCENTRATED AMONG JUST A FEW DONORS

[ii] The calculations and sources for the data included in each of the country profile tables beginning on page 14 are explained in detail in the report's Methodology section, available online. For all tables, ODA figures were sourced from the Organisation for Economic Co-operation and Development (OECD); development assistance for health (DAH) figures were sourced from the Institute for Health Metrics and Evaluation (IHME); and total assistance for HIV/AIDS was sourced from the Kaiser Family Foundation (KFF).

GOVERNMENT YEARBOOK

Many countries around the world contribute to the fight against AIDS through bilateral and multilateral channels, as well as through political leadership. But not all countries are alike – indeed, their financial and political commitments vary significantly, both in nominal and relative terms. The following catagories highlight this diversity, noting particular leaders and laggards in recent years as well as their overall rank in nominal AIDS funding.

South Korea, Spain, Mexico and Indonesia

These countries have some of the world's highest GDPs – South Korea is ranked 13th, Spain 14th, Mexico 15th and Indonesia 16th – and yet they each give less to HIV/AIDS than many countries with smaller GDPs, including the Netherlands, Sweden, Norway, Denmark and Ireland

Australia (#11), The Netherlands (#5) and Denmark (#7)

Australian development spending is set to fall to 0.22% of gross national income in 2017–18 – the lowest level in the country's history – unless new PM Malcolm Turnbull reverses cuts.

The Netherlands is a top five AIDS donor, yet risks losing this standing as it pursues overall aid cuts.

In 2015, Finance Minister Claus Hjort Frederiksen presented the Danish government with a budget proposal that would cut the country's development assistance by roughly DKK 2.9 billion ($440 million), including a 40% proposed cut to its Global Fund contribution for 2015–16.

Italy (#13)

Italy increased its disbursements for HIV more than ten-fold in 2014 after years of disengagement from development assistance efforts.

This is thanks in large part to its €100m pledge to the Global Fund in 2013, as well as PM Matteo Renzi's recent pledge to make Italy the fourth largest G7 donor in 2017.

Canada (#9) and the European Commission (#12)

Canada has increased its Global Fund contributions in the last two replenishment periods, and was the seventh largest contributor to the Fund in 2014. With new political leadership under PM Justin Trudeau, it is poised to further expand its leadership on pressing global issues.

The European Commission was the sixth largest contributor to the Global Fund in 2014 and has increased its contributions steadily in each replenishment round. With new leadership in place and a mid-term budget review coming up, the Commission has potential to rise even further in the ranks.

Germany (#4)

In 2015, Germany reinforced its leadership in global health by hosting a successful replenishment for Gavi, the Vaccine Alliance and the G7 Summit, with an increased focus on health. Many hope that an increasing ODA budget will pave the way for Germany to provide significant increases in its Global Fund contribution for 2017–19.

Ireland (#13)

Although Ireland ranks 44th among countries in nominal GDP, it ranks considerably higher – 13th in the world – in its contributions to HIV/AIDS.

France (#3)

France was the pioneer of UNITAID's airline levy for HIV/AIDS and is the first country to have earmarked revenue from its national Financial Transaction Tax (FTT) for development, which has helped it to maintain its ranking as second largest donor to the Global Fund.

United Kingdom (#2)

Most of the increase in donors' HIV/AIDS funding in 2014 can be attributed to the UK, which increased its disbursements from $903 million to over $1.1 billion; without this, overall donor disbursements would have dropped in the past year.

United States (#1)

The US has been and remains the largest donor to HIV/AIDS in the world; in 2014 it accounted for approximately two-thirds of HIV spending by donor governments, primarily through contributions to the Global Fund and PEPFAR.

UNITED STATES

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	31,562.4 0.19%	31,800.7 0.18%	32,702.2 0.19%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	10,892.42 34.5%	12,661.49 39.8%	12,385.9 37.9%
Total Assistance for HIV/AIDS, of which:	5,174.9	5,710.2	5,571.9
Global Fund (Adjusted)	683.3	851.5	853.5
Bilateral HIV/AIDS	4,491.6	4,858.7	4,718.3

For more than a decade, the US has been the clear leader in nominal donor funding for HIV/AIDS, contributing approximately two-thirds of all government disbursements for programmes in low- and middle-income countries in 2014 alone.[30] Since 2000, almost half of all US funding for the global HIV/AIDS response has been distributed bilaterally through the President's Emergency Plan for AIDS Relief (PEPFAR).[31] In recent years, PEPFAR has implemented a data-driven approach, focusing resources on targeted populations and highest-burden geographies.[32] New targets set in September 2015 also increased investments aimed at reducing HIV incidence among adolescent girls.[33,34] Historically, the US has also contributed roughly one-third of all donor support to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US government served as host for the Global Fund's replenishment in 2013.

In spite of significant cuts to the overall US foreign assistance account from FY 2011 through to FY 2014, funding for bilateral and multilateral HIV/AIDS programmes has remained steady, in large part thanks to the longstanding bipartisan support that the issue has received from American policy-makers. While President Obama's FY 2016 budget request represents a decrease of roughly 4% from the previous year's enacted levels,[35] Congressional funding levels for the Global Fund may exceed the President's budget request (as they did in 2013 and 2014). The Presidential election will dominate the 2016 news cycle, although candidates from both parties have expressed their support for AIDS programmes, and Congressional opinion is likely to influence the magnitude and direction of AIDS funding in the coming years.

ONE's Global Fund replenishment ask: Increase overall AIDS spending by contributing one-third of total contributions to the Global Fund for 2017–19, while also increasing support for PEPFAR.

UNITED KINGDOM

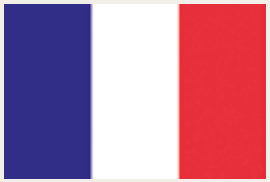
Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	14,823.4 (£9,355.0) 0.56%	19,094.5 (£12,212.8) 0.70%	19,381.2 (£11,772.1) 0.70%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	3,234.50 (£2,041.3) 21.8%	3,728.72 (£2,384.9) 19.5%	3,789.27 (£2,301.6) 19.6%
Total Assistance for HIV/AIDS, of which:	860.7 (£543.2)	903.0 (£577.6)	1,114.0 (£676.6)
Global Fund (Adjusted)	120.6 (£76.1)	125.3 (£80.1)	352.2 (£213.9)
Bilateral HIV/AIDS	692.2 (£436.8)	730.0 (£466.9)	730.8 (£443.9)
UNITAID (Adjusted)	47.8 (£30.2)	47.7 (£30.5)	31 (£18.8)

In recent years, the UK has become a leader in the fight against HIV/AIDS. In 2013, it pledged up to £1 billion ($1.64 billion) to the Global Fund for the 2014–16 period – roughly double its total contributions for the 2011–13 period. However, it capped its pledge at a maximum of 10% of the replenishment total, meaning that it is only on track to disburse around £800 million of the £1 billion for 2014–16.

The majority of the increase in overall donor support for HIV/AIDS programmes in low- and middle-income countries in 2014 can be attributed to the UK, which increased its total funding to $1.1 billion.[36] As the UK's funding has increased, it has become more focused and value-driven in its bilateral support, targeting the achievement of universal access, cost reductions for second- and third-line drugs and the elimination of HIV-related stigma and discrimination, with a narrower focus on the poorest countries and vulnerable populations, especially women and girls.[37]

The Department for International Development (DFID)'s support for investments in middle-income countries (MICs) has waned in recent years – a policy position that has implications for HIV/AIDS funding mechanisms such as the Global Fund, where the UK government plays an active board role.[38] The UK government is once again conducting a Multilateral Aid Review to inform its relationship with multilateral agencies that receive DFID financing. The 2011 Multilateral Aid Review and subsequent progress reports found that the Global Fund offers "very good value for money" for UK taxpayers.[39]

ONE's Global Fund replenishment ask: Increase funding up to £1.2 billion for 2017–19.



FRANCE			
Type of Funding (USD 2014 Constant, Millions)	**2012**	**2013**	**2014**
Total ODA (Absolute Value, % of GNI)	11,064.5 (€8,608.2) 0.40%	10,718.3 (€8,073.0) 0.38%	10,367.2 (€7,813.8) 0.36%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	1,080.39 (€840.5) 9.76%	1,088.43 (€819.8) 10.2%	1,027.72 (€774.6) 9.91%
Total Assistance for HIV/AIDS, of which:	393.4 (€306.1)	412.8 (€310.9)	316.9* (€238.8)
Global Fund (Adjusted)	258.2 (€200.9)	285.1 (€214.7)	215.3* (€162.3)
Bilateral HIV/AIDS	58.6 (€45.6)	50.9 (€38.3)	49.9 (€37.6)
UNITAID (Adjusted)	76.6 (€59.6)	76.8 (€57.8)	51.7 (€38.9)

* Although this appears to be a decrease in funding, this lower amount is attributable to France's method of delivering some of its Global Fund commitments through promissory notes paid over a multi-year timeframe.

Between 2013 and 2014, French funding for HIV/AIDS to low- and middle-income countries declined, largely due to a cut of nearly 23% to UNITAID funding. This cut reflected overall declines in French ODA, which fell by over $350 million in 2014, pulling the country further away from historically comparable donors such as the UK and Germany (both of which increased their ODA in 2014).[40] Despite this funding cut, France remained the third largest HIV/AIDS donor in 2014 and today stands as the second largest cumulative donor to the Global Fund. By the end of 2014, it had contributed more than €3.42 billion ($4.5 billion) to the Global Fund, constituting over 12% of the partnership's total budget. For the 2014–16 period, it pledged an additional €1.08 billion ($1.47 billion), roughly equal to its pledge for the 2011–13 period.[41] This financial support goes hand in hand with France's robust political and public support for the Global Fund and its support for human rights, health systems strengthening (HSS) and the protection of women and girls.

In recent months, French President François Hollande has renewed his country's commitment to global HIV/AIDS efforts, particularly those implemented by multilateral organisations like the Global Fund and UNITAID (to which France is the largest contributor).[42] The French government is also an advocate of innovative funding mechanisms, especially the solidarity levy on airline tickets pioneered by France to support UNITAID and the Financial Transaction Tax (FTT). France is the first country to have earmarked revenue from its national FTT to development causes; it also champions a European Union-wide FTT to be used for the fight against diseases such as AIDS, TB and malaria.[43]

▶ **ONE's Global Fund replenishment ask:** Consolidate its position as one of the Global Fund's top two contributors and increase its funding for UNITAID.

GERMANY			
Type of Funding (USD 2014 Constant, Millions)	**2012**	**2013**	**2014**
Total ODA (Absolute Value, % of GNI)	13,317.8 (€10,361.2) 0.36%	14,370.2 (€10,823.6) 0.38%	16,068.8 (€12,111.1) 0.41%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	1,231.70 (€958.3) 9.3%	1,279.53 (€963.7) 8.9%	1,284.94 (€968.5) 8.0%
Total Assistance for HIV/AIDS, of which:	310.0 (€241.2)	290.8 (€219.0)	278.3 (€209.8)
Global Fund (Adjusted)	153.3 (€119.3)	154.1 (€116.1)	174.7 (€131.7)
Bilateral HIV/AIDS	156.7 (€121.9)	136.7 (€103.0)	103.7 (€78.2)

Despite overall increases to ODA in recent years, Germany's total HIV/AIDS funding levels have stayed relatively flat, and the total amount contributed remains significantly lower than its high-water mark for funding disbursed in 2008 ($485.9 million).[44] Still, Germany remains a significant donor in the fight against AIDS: in 2014 it was both the fifth largest bilateral donor and the fourth largest Global Fund contributor. Between 2013 and 2014, its contributions to the Global Fund increased by over 13%. In its bilateral programming, Germany has consistently embraced a human rights-based approach to reducing the burden of HIV[45] and, like many of its donor counterparts, it has made investments in women and children a core focus of its HIV/AIDS efforts.[46,47] Germany has also been a supporter of innovative financing for health through the Debt2Health Initiative, in which creditors relinquish a part of their rights to repayment of loans, on the condition that the beneficiary invests the freed-up resources in programmes approved by the Global Fund.[48]

Germany reinforced its leadership in global health in 2015, hosting both a successful replenishment conference for Gavi, the Vaccine Alliance in January and the G7 Summit (with an increased focus on health issues) in June. Particularly in light of the Ebola crisis, the German government has championed health systems strengthening (HSS) throughout 2015, arguing for greater HSS investments and for better integration of HSS efforts into disease-specific initiatives.[49] The German parliament has in recent years ensured some modest increases on top of what was foreseen by the government, but the government's flat contributions in previous Global Fund replenishment rounds have disappointed campaigners.[50] Many hope that an increasing overall ODA budget will pave the way for Germany to provide significant increases in its Global Fund contribution for the 2017–19 period. These hopes are underscored by the appointment of former Vice President of the German Federal Court of Auditors Norbert Hauser as Chair of the Global Fund's Board.

▶ **ONE's Global Fund replenishment ask:** Increase funding to €400 million annually for 2017–19 (Previous Replenishment: €665 million over three years).

THE NETHERLANDS

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	5,692.2 (€4,428.5) 0.69%	5,422.7 (€4,084.4) 0.66%	5,509.0 (€4,152.1)
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	691.31 (€537.8) 12.1%	716.86 (€539.9) 13.2%	675.41 (€509.1) 12.3%
Total Assistance for HIV/AIDS, of which:	203.9 (€158.6)	188.1 (€141.7)	218.7 (€164.8)
Global Fund (Adjusted)	28.7 (€22.3)	52.0 (€39.2)	49.8 (€37.5)
Bilateral HIV/AIDS	175.1 (€136.2)	136.1 (€102.5)	168.9 (€127.3)

The Netherlands was one of only five nations to increase its disbursements for HIV/AIDS in 2014 relative to 2013.[51] However, this small increase came in the context of the country's deep aid cuts and its abandoning of the target of ODA at 0.7% of gross national income (GNI) – a target that it had achieved since 1974 but which it missed in 2013 and 2014.[52] Still, the Netherlands is ranked among the top 10 contributors to the Global Fund and was the third largest bilateral contributor to HIV/AIDS funding in 2014.[53] Through its bilateral HIV/AIDS programmes, the Dutch Foreign Ministry has been able to educate more than 11.5 million young people about HIV and has supported 1.3 million people newly added onto ARV treatment.[54]

In April 2015, Foreign Trade and Development Minister Lilianne Ploumen pledged to revamp Dutch efforts in the fight against HIV/AIDS, particularly for young women, girls and other at-risk groups.[55] Looking ahead, the government will join with 12 development organisations to combat HIV and promote sexual health in young people in a new €58 million ($66 million) annual programme that is set to launch in 2016.[56] Preparations are also already under way for the Netherlands to host the International AIDS Conference in 2018, which the Minister has described as "recognition of the crucial role the Netherlands plays in the global fight against AIDS".[57]

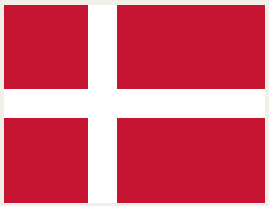
ONE's Global Fund replenishment ask:
Increase funding for 2017–19
(Previous Replenishment: €185 million).

JAPAN			
Type of Funding (USD 2014 Constant, Millions)	**2012**	**2013**	**2014**
Total ODA (Absolute Value, % of GNI)	8,074.7 0.17%	8,809.6 0.18%	9,194.4 0.19%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	1,492.78 18.5%	1,020.75 11.6%	1,071.22 11.7%
Total Assistance for HIV/AIDS, of which:	159.2	95.2	175.9
Global Fund (Adjusted)	143.6	65.3	159.9
Bilateral HIV/AIDS	15.6	29.9	16.9

As host of the G8 Summit in 2000, Japan played an instrumental role in creating the Global Fund and highlighting infectious diseases as a serious issue for world leaders to address.[58] Today, it remains a significant contributor of HIV/AIDS resources in poor countries; it was the fifth largest Global Fund donor in 2014 and was one of only five countries to increase its disbursements for HIV/AIDS between 2013 and 2014, following a drop of more than 40% in HIV/AIDS funding the previous year.[59] However, Japan is still recovering from the 2011 earthquake and tsunami and its subsequent economic downturn. Between 2012 and 2013, the proportion of ODA allocated to health shrank significantly and the country's HIV/AIDS spending decreased by half, as one of many development efforts to be cut. Depreciation of the yen has further dampened prospects for growth in Japan's DAH, particularly because it pledges to the Global Fund in US dollars.

Despite fiscal challenges, global health remains a top priority for Prime Minister Shinzo Abe and his government. In May 2013, Japan launched its Strategy on Global Health Diplomacy, which positioned global health as a key diplomatic pillar and referenced the government's "unwavering commitment" to the Global Fund.[60] Japan has continued to emphasise universal health coverage (UHC) both in the context of the SDGs and with respect to disease-specific efforts; in December 2015, it will host the Preparatory Meeting for the Global Fund's Fifth Replenishment, turning a spotlight on the importance of UHC, resilient health systems and sustainable health financing.[61] Japanese leadership will continue into 2016, with Prime Minister Abe signalling that global health will be one of three areas of focus when the country hosts the G7 Health Ministers' meeting in Kobe and the G7 Summit in Ise-Shima.[62]

ONE's Global Fund replenishment ask: Maintain current levels of funding for 2017–19 (Previous Replenishment: $800 million) and leverage the 2016 G7 Summit to generate increased political support for the Fund.



DENMARK

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	2,840.9 (DKK 16,448.5) 0.83%	2,948.3 (DKK 16,560.3) 0.85%	2,995.7 (DKK 16,831.9) 0.85%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	307.23 (DKK 1,778.8) 10.8%	278.97 (DKK 1,566.9) 9.5%	192.68 (DKK 1,082.6) 6.4%
Total Assistance for HIV/AIDS, of which:	180.5 (DKK 1,045.1)	193.1 (DKK 1,084.6)	167.2 (DKK 939.4)
Global Fund (Adjusted)	14.6 (DKK 84.5)	14.6 (DKK 82.0)	16.7 (DKK 93.8)
Bilateral HIV/AIDS	165.9 (DKK 960.5)	178.5 (DKK 1,002.6)	150.5 (DKK 845.6)

HIV/AIDS has been a priority for Danish development assistance since 2001. Despite a slight decrease in overall funding between 2013 and 2014, the country notably ranks first in the list of those that provided a greater share of funding for HIV in developing countries than their share of the world's GDP in 2014; last year, it gave $490.70 for HIV per $1 million in gross domestic product (GDP) (compared with just $72.10 and $69 respectively contributed by Germany and Canada).[63] Denmark contributes the majority of its HIV/AIDS funding bilaterally, guided by a strategy launched in 2005 that addresses HIV treatment and prevention as well as poverty reduction and support to education, agriculture and women's rights.[64] Currently, Denmark has AIDS-focused country programmes in Ghana, Kenya, Mozambique, Tanzania and Uganda.[65]

In parliamentary elections held in June 2015, Danish citizens voted out the centre-left government of Prime Minister Helle Thorning-Schmidt.[66] In September 2015, Finance Minister Claus Hjort Frederiksen (of the new centre-right government led by Prime Minister Lars Løkke Rasmussen) presented the Danish government with a budget proposal that would cut the country's development assistance by roughly DKK 2.9 billion ($442 million) or 17% to free up funds for other national priorities.[67] This proposal has not yet been approved, however, and the government faced immediate external pressure to reverse the proposed cuts—both those to overall aid and those specifically targeted at AIDS funding.

ONE's Global Fund replenishment ask: Keep overall aid budget at 2014 level and be as ambitious as possible in funding for the upcoming replenishment (Previous Replenishment: DKK 495 million).

SWEDEN

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	5,290.4 (SEK 35,810.2) 0.97%	5,604.7 (SEK 36,504.5) 1.01%	6,191.4 (SEK 42,472.4) 1.09%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	680.48 (SEK 4,606.1) 12.9%	615.47 (SEK 4,008.7) 11.0%	313.73 (SEK 2,152.2) 5.1%
Total Assistance for HIV/AIDS, of which:	172.4 (SEK 1,167.0)	165.8 (SEK 1,079.9)	154.4 (SEK 1,059.2)
Global Fund (Adjusted)	58.1 (SEK 393.3)	58.2 (SEK 379.1)	63.8 (SEK 437.7)
Bilateral HIV/AIDS	114.3 (SEK 773.7)	107.7 (SEK 701.5)	90.6 (SEK 621.5)

The Swedish government remains committed to achieving a 1% ODA/GNI target, and this target has broad political and public support. Although Sweden's ODA increased by more than 10% in 2014 to roughly $6.2 billion, its development assistance for health was cut by almost 50%, resulting in more than $11 million less in HIV/AIDS funding.[68] Despite these reductions, Sweden has committed significant resources to promoting health and preventive health programmes, sustainable health-care systems and equal, affordable access to care for people living with HIV/AIDS. At the end of 2014, Sweden was ranked ninth in the list of contributors to the Global Fund.[69]

As part of its self-described "feminist foreign policy", Sweden's development cooperation has a strong focus on gender equality, in particular the importance of sexual and reproductive rights for women – key to the fight against HIV/AIDS.[70] In September, Minister for International Development Cooperation Isabella Lövin announced her intention for 100% of Sweden's aid budget to be gender-integrated.[71] The declining proportion of Swedish aid invested in global health issues is a cause for concern. However, the government has assumed a proactive role in the implementation of the Sustainable Development Goals, including SDG 3 which is focussed on health.[72]

ONE's Global Fund replenishment ask: Improve on its 2013 Global Fund performance and help lead the effort to meet SDG 3. (Previous Replenishment: SEK 2.5 billion).

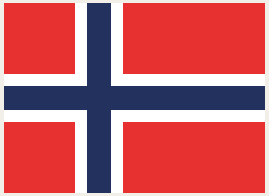
CANADA

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	5,089.6 (CAD 5,085.5) 0.30%	4,696.7 (CAD 4,838.5) 0.27%	4,196.4 (CAD 4,635.8) 0.24%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	1,248.33 (CAD 1,247.3) 24.5%	1,173.13 (CAD 1,208.6) 25.0%	1,150.1 (CAD 1,270.5) 27.4%
Total Assistance for HIV/AIDS, of which:	144.2 (CAD 144.1)	134.2 (CAD 138.3)	124.6 (CAD 137.6)
Global Fund (Adjusted)	93.7 (CAD 93.6)	94.2 (CAD 97.0)	97.1 (CAD 107.3)
Bilateral HIV/AIDS	50.5 (CAD 50.5)	40.0 (CAD 41.2)	27.5 (CAD 30.4)

Canada reduced its funding for HIV/AIDS in low- and middle-income countries between 2013 and 2014, due mainly to a decline of more than 31% in bilateral HIV disbursements.[73] Despite these overall decreases, however, Canada remains an active player in the global AIDS response; in particular, it has consistently increased its Global Fund contributions in recent replenishment periods, and as a result has moved up to become the seventh largest contributor to the Global Fund in 2014. Historically, Canada has framed much of its investment in infectious diseases as part of its wider leadership on maternal, newborn and child health (MNCH) issues – a prevailing theme of the 2010 Muskoka G8 Summit and the country's development efforts in the years since.

With the election of a Liberal majority government in October 2015, the strategic direction of the new Canadian parliament is as yet uncertain. Prime Minister Justin Trudeau has asserted that his government will play a more active role in engaging key allies and stakeholders in foreign affairs, and as such is likely to be open to more direct engagement on HIV/AIDS and global health spending over the next few years.

▶ **ONE's Global Fund replenishment ask:** Increase funding by at least 20% for 2017–19 (Previous Replenishment: CAD 650 million).



NORWAY

Type of Funding (USD 2014 Constant, Millions)	2012		2013		2014	
Total ODA (Absolute Value, % of GNI)	4,527.6 0.93%	(NOK 26,327.5)	5,228.0 1.07%	(NOK 30,730.2)	5,006.0 0.98%	(NOK 31,547.3)
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	721.72 15.9%	(NOK 4,196.7)	820.23 15.7%	(NOK 4,821.3)	845.14 16.9%	(NOK 5,326.0)
Total Assistance for HIV/AIDS, of which:	110.3	(NOK 641.4)	111.4	(NOK 654.8)	123.5	(NOK 778.3)
Global Fund (Adjusted)	39.7	(NOK 230.9)	41.3	(NOK 242.8)	39.3	(NOK 247.7)
Bilateral HIV/AIDS	60.1	(NOK 349.5)	59.8	(NOK 351.5)	74.9	(NOK 472.0)
UNITAID (Adjusted)	10.5	(NOK 61.1)	10.3	(NOK 60.5)	9.4	(NOK 59.2)

Norway was one of the few governments to increase its disbursements for HIV/AIDS between 2013 and 2014, boosting its funding by nearly 11%. At the Global Fund's Fourth Replenishment, it pledged NOK 1.7 billion ($277.8 million) as part of Foreign Minister Børge Brende's call for "long-term, predictable support" to combat HIV/AIDS.[74] Norway's current government, led by Prime Minister Erna Solberg, has made global health and the fight against AIDS a priority in its international cooperative policy framework. In particular, Norway has pledged support to UNAIDS[75] and is one of the few European donors to give to UNITAID.[76] The government also recently launched Vision 2030, an initiative encouraging the Norwegian business sector and relevant experts to find new and innovative ways to contribute to the joint realisation of ambitious health and education goals.[77]

Concerns over unprecedented levels of debt and unemployment, as well as surging house prices and declining oil revenues, may create a challenging environment for sustaining Norwegian support for increases in development spending.[78] Yet as the Global Fund's Fifth Replenishment approaches, Norway will be targeted to increase its contributions, in line with the government's wider support for the Fund's grants which empower women and girls, strengthen health systems and link with the education sector.

▶ **ONE's Global Fund replenishment ask:**
Increase funding for 2017–19
(Previous Replenishment: NOK 1.7 billion).

AUSTRALIA

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	4,748.9 (AUD 4,587.4) 0.36%	4,528.0 (AUD 4,694.2) 0.33%	4,198.3 (AUD 4,657.6) 0.27%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	913.72 (AUD 882.7) 19.2%	935.12 (AUD 969.4) 20.7%	964.30 (AUD 1,069.8) 23.0%
Total Assistance for HIV/AIDS, of which:	109.8 (AUD 106.1)	134.5 (AUD 139.4)	100.5 (AUD 111.5)
Global Fund (Adjusted)	30.2 (AUD 29.2)	50.2 (AUD 52.0)	15.6 (AUD 17.3)
Bilateral HIV/AIDS	79.9 (AUD 77.2)	84.3 (AUD 87.4)	84.8 (AUD 94.1)

In recent years, the Australian government has enacted increasingly severe cuts to its overall ODA, with former Prime Minister Tony Abbott's government announcing four sets of cuts in just two years.[79] Cuts to overall HIV/AIDS funding were particularly egregious given the Australian government's hosting of the International AIDS Conference in Melbourne in 2014. In September 2015, Abbott was ousted from power and replaced by Malcolm Turnbull, who has said that the previous government's policies (including on aid) will not be reversed without a Cabinet decision.[80] If Turnbull does not reverse the cuts made by his predecessor, Australian development spending is set to fall to 0.22% of GNI in 2017–18, the lowest level in its history.[81]

Under the country's current aid framework, 90% of Australian aid has to be spent in the Indo-Pacific region; as such, the government's policy on HIV/AIDS emphasises domestic and regional challenges.[82,83] Through its HIV/AIDS 2015–20 Strategy,[84] Australia aims to advocate for equitable legal and policy environments; invest in key populations and geographic locations (with a clear focus on Papua New Guinea and other Pacific nations); and build sustainability by engaging new donors, including those from the private sector and emerging economies.[85] The Global Fund received a positive review in the 2013–14 review of Australian aid, which noted that "each dollar Australia has contributed to the Global Fund has leveraged more than a ten-fold investment in the Asia-Pacific region".[86]

ONE's Global Fund replenishment ask: Increase funding for 2017–19 (Previous Replenishment: AUD 200 million).

EUROPEAN UNION INSTITUTIONS (EU)

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value)	18,443.9 (€14,349.4)	16,104.1 (€12,129.6)	16,105.7 (€12,138.9)
Total Assistance for HIV/AIDS, of which:	106.3 (€82.7)	101.6 (€76.5)	91.1 (€68.7)
Global Fund (Adjusted)	74.3 (€57.8)	81.8 (€61.6)	78.5 (€59.2)
Bilateral HIV/AIDS	32.0 (€24.9)	19.8 (€14.9)	12.7 (€9.6)

The European Commission (EC), managing its own development assistance budget on behalf of the 28 member states of the European Union (EU), slightly reduced its HIV/AIDS funding to resource-poor settings in 2014, from over $101 million to $91.1 million.[87] The Commission has been one of the Global Fund's longest-standing donors, and its contributions to the Fund have increased in recent replenishments, but its bilateral HIV/AIDS disbursements have been cut by more than half since 2012. The EU budget and the European Development Fund, which are set every seven years and run from 2014 to 2020, will undergo a mid-term review that is expected to kick off in early 2016. This will present a unique opportunity to focus more resources on development, including the fight against HIV/AIDS and its impact on high-burden countries and marginalised populations. The Commission will also be leading the EU's re-thinking of key development policies to reflect the new SDGs and the Cotonou Agreement, which governs relations with African, Caribbean and Pacific countries. This, too, will be an opportunity to realign priorities and focus in on the AIDS epidemic.

At this year's UN General Assembly (UNGA) meetings, the EU delegation stressed the importance of tailored responses to the most vulnerable populations burdened by high infection rates, as well as the need to end stigma of those living with the disease.[88] The Global Fund's 2016 replenishment will be the first with the EC's new leadership under President Jean-Claude Juncker and Commissioner for International Cooperation and Development Neven Mimica, and will represent a great opportunity to make a down-payment on these messages.

▶ **ONE's Global Fund replenishment ask:** Increase funding to at least €150 million per year for 2017–19 (Previous Replenishment: €370 million over three years.)

IRELAND

Type of Funding (USD 2014 Constant, Millions)	2012		2013		2014	
Total ODA (Absolute Value, % of GNI)	844.4 0.47%	(€656.9)	847.0 0.46%	(€638.0)	808.8 0.38%	(€609.6)
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	139.41 16.5%	(€108.5)	111.33 13.1%	(€83.9)	93.08 11.5%	(€70.2)
Total Assistance for HIV/AIDS, of which:	66.6	(€51.8)	63.1	(€47.5)	53.6	(€40.4)
Global Fund (Adjusted)	8.9	(€6.9)	11.5	(€8.7)	9.1	(€6.9)
Bilateral HIV/AIDS	57.7	(€44.9)	51.6	(€38.9)	44.4	(€33.5)

Although Ireland ranks 44th among countries in nominal GDP, it ranks considerably higher – 13th in the world – in contributions to HIV/AIDS. Its funding for HIV/AIDS declined only slightly between 2013 and 2014, despite proportionately deeper cuts to broader development assistance.[89] Ireland has played a central role in pushing EU member states to invest half of their ODA in least developed countries (LDCs) (as exemplified by Minister Seán Sherlock being one of two EU ministers to sign an official pledge in 2015 on behalf of increased LDC support), but its total and health-focused ODA amounts decreased by 4.5% and 16.4%, respectively, between 2013 and 2014.[90]

There is reason to believe that Ireland will continue to be a meaningful provider of HIV/AIDS funding to low-resource settings. It contributes significant resources each year to tackle HIV/AIDS and other communicable diseases in partner countries, including Uganda, Tanzania, Ethiopia, South Africa, Zambia, Zimbabwe and Malawi.[91] Through its partnership with the Clinton Foundation, Ireland has also helped to increase access to treatment services for thousands of people in Mozambique and Lesotho. At the first annual Irish Humanitarian Summit in July 2015, Minister Sherlock described HIV/AIDS, together with gender, protection, governance, the environment and other cross-cutting issues, as an important part of his country's commitment to protecting vulnerable people around the world.[92]

▶ **ONE's Global Fund replenishment ask:** Increase funding for 2017–19 (Previous Replenishment: €30 million).

ITALY

Type of Funding (USD 2014 Constant, Millions)	2012	2013	2014
Total ODA (Absolute Value, % of GNI)	2,875.2 (€2,236.9) 0.14%	3,437.5 (€2,589.1) 0.17%	3,342.1 (€2,518.9) 0.16%
Development Assistance for Health (DAH) (Absolute Value, % of ODA)	207.10 (€161.1) 7.2%	154.96 (€116.7) 4.5%	110.49 (€83.3) 3.3%
Total Assistance for HIV/AIDS, of which:	14.6 (€11.4)	2.4 (€1.8)	25.6 (€19.3)
Global Fund (Adjusted)	0	0	22.5 (€17.0)
Bilateral HIV/AIDS	14.6 (€11.4)	2.4 (€1.8)	3.2 (€2.4)

After years of significant disengagement and ODA cuts under former Prime Minister Berlusconi, Italy committed €100 million ($135.9 million) at the Fourth Global Fund replenishment conference held in 2013 and signed a Memorandum of Understanding for technical cooperation with the Global Fund in 2014.[93] More recently and most significantly, it increased its disbursements for HIV more than ten-fold in 2014.[94]

In September 2015 (and earlier in July at the Addis Ababa Financing for Development Summit), Italy's new Prime Minister Matteo Renzi committed to making the country the fourth largest G7 donor in 2017, when it will hold the G7 presidency. Renzi's significant pledge represents a near doubling of ODA as a proportion of GNI since 2012, and also supersedes the government's multi-year commitment outlined in April, which foresaw Italian aid rising to an already notable 0.21% in 2017.[95] In July 2015, the Italian government also adopted a new three-year policy framework for development that underlines its commitment to global health issues and its continued participation in global campaigns to combat HIV/AIDS, highlighting the work of the Global Fund in this regard.[96] The policy framework, together with Renzi's recent financial commitment, provides an unprecedented opportunity for the government to increase Italy's contribution to the Global Fund – and to make good on the unpaid commitments from 2009 and 2010.

ONE's Global Fund replenishment ask:
Increase funding for 2017–19
(Previous Replenishment: €100 million).

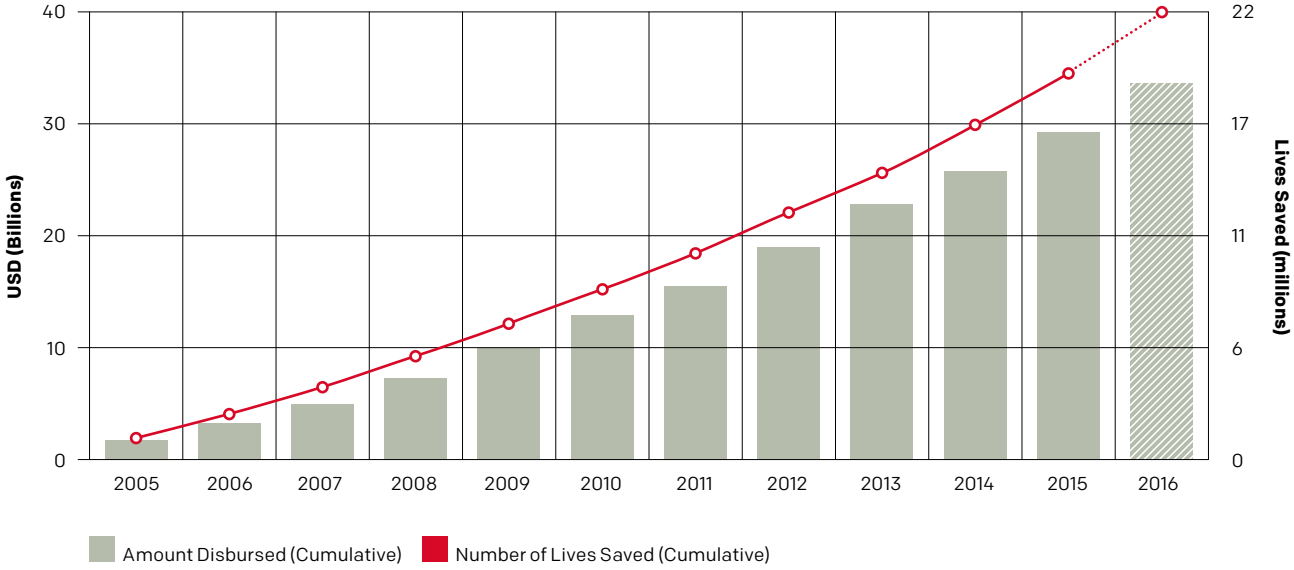
A CRITICAL YEAR FOR THE GLOBAL FUND

In 2002, in response to the devastation caused by AIDS, as well as TB and malaria, leaders from around the world joined forces to create the Global Fund – an effort described as a "war chest" to fight the three epidemics. Together with other donors, the private sector and the investments made by countries themselves, the **Global Fund's support has saved 17 million lives in the years since its creation, and it is on track to save 22 million lives by 2016**.[97]

More than $27 billion in disbursed grants to more than 140 countries[98] – with more than $14 billion specifically for HIV/AIDS programmes – has translated into real impact on the ground, providing among other interventions:

- ARV treatment for 8.1 million people living with HIV/AIDS;
- Services to prevent mother-to-child transmission of HIV for 3.1 million pregnant women;
- HIV counselling and testing sessions for 423 million people;
- Insecticide-treated bed nets to protect 548 million families from malaria; and
- Detection and treatment services for 13.2 million cases of TB.[99]

Historical and Projected Lives Saved through Global Fund-Supported Programmes



ON TRACK TO SAVE 22 MILLION LIVES BY 2016

For the Global Fund to remain effective as a war chest, it holds a replenishment meeting every three years, during which donors come together to pledge how much money each will give over the next three years. The US hosted the Global Fund's Fourth Replenishment conference in December 2013, during which donors pledged more than $12 billion for the 2014–16 period.[100] This represented the largest total ever pledged to the Fund and a nearly 30% increase over the Third Replenishment, although it fell short of the Fund's overall fundraising target of $15 billion.

The Global Fund's next replenishment will take place in mid-2016. Although the fundraising target for the 2017–19 period had not been finalised at the time of this report's printing, ONE calls on governments, the private sector and private foundations to pledge at least $13.5 billion over the next three years, commensurate with the growing amount of resources needed to tackle the three diseases. Securing these funds will be challenging in an environment in which the budgets of a number of traditional donor governments are constrained and currency fluctuations mean that many donors' currencies are weakened relative to the US dollar. The Global Fund will not achieve success without:

- Strong diplomatic and political leadership, coupled with a significantly increased contribution, from the replenishment host;
- Increased funding from core donors such as Germany, the UK, Italy, Canada, Norway and the European Commission;
- Sustained contribution levels from donors who have provided large amounts of funding over time, including the US, France and Japan;
- Additional contributions from new or emerging global health donors – including more actors from the private sector; and
- Vocal support for the Fund and for additional domestic health financing from leaders of high-burden countries.

As governments consider their contributions to the Global Fund for the next three years, many will also look to the Fund's new five-year strategy development process for 2017–21– running in parallel with replenishment fundraising efforts – to guide their decisions. In navigating many contentious policy challenges, the Fund must demonstrate that it can be a nimble institution, able to adapt the ways in which it delivers grants to support the evolving epidemiology, geography and political nature of the three diseases and the systems around them. In particular, the Global Fund should:

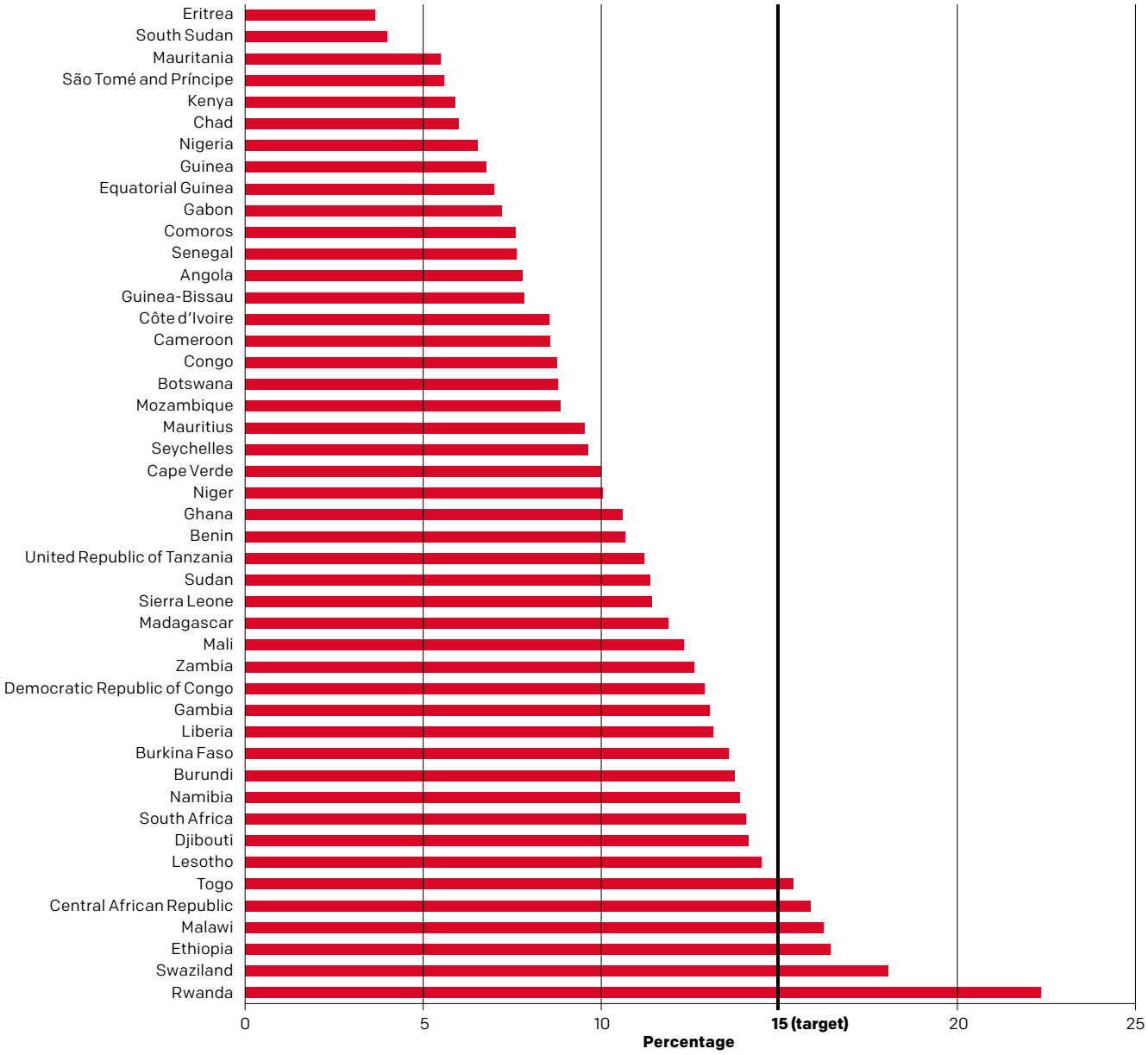
- Prioritise resources for the countries with significant burdens of disease and the least ability to pay, with a focus on accelerating efforts to end the diseases as epidemics;
- Seek innovative ways to ensure services for marginalised and most at-risk populations (MARPs), particularly in places where gains are most fragile or the epidemic is expanding;
- Scale up support for local civil society groups, particularly but not limited to those who serve and/or represent MARPs;
- Make additional investments in cross-cutting health systems strengthening (HSS) efforts, provided the investments are measurable, outcome-oriented and focused on supporting epidemic control;
- Fund a small number of innovative HSS pilot efforts, through which it can pursue new ways of investing that may return outcomes that can be replicated, scaled up and sustained;
- Work more closely with other development partners to better coordinate and align with country planning processes, offering joint support for robust national health plans (or the development of such plans);
- Seek efficiencies at every step of its grant-making process. Ongoing efforts to reform procurement practices – which have already saved more than $500 million in just two years[101] – and to strengthen supply chains show significant promise in this regard;
- Strengthen the data collection capabilities of the Secretariat, country coordinating mechanisms and other delivery partners to ensure that the Fund can disaggregate and measure impact by categories, including gender and sexual orientation, and can better deliver services to those hardest to reach – at 'the last mile' – in its grant-making; and
- Consider implementing additional 'transition instruments' (i.e. offering loans along with grant support, providing additional support for procurement reform and supply chain management, etc.) that will enable it to better assist and monitor the successful transition of its recipient countries.[102]

The Global Fund has already established itself as one of the most effective and impactful development programmes over the past decade. With additional support from donors, and a refined, modernised strategy to guide it, it can further cement its role as an indispensable mechanism for the future and a fundamental accelerator of the work to end AIDS, TB and malaria within our lifetimes.

AFRICAN DOMESTIC RESOURCES FOR HEALTH AND HIV/AIDS

Today, countries across Africa generate more than $520 billion annually through domestic resource mobilisation (DRM) – more than 8.5 times the amount the continent receives in ODA.[103] Despite this progress, most African governments have not been able to consistently meet their 2001 Abuja commitment to spend 15% or more of their domestic budgets on health programmes. In 2013, only six of the 46 countries in sub-Saharan Africa for which comparable data exist met this target: Rwanda, Swaziland, Ethiopia, Malawi, the Central African Republic and Togo. Between 2012 and 2013, 10 countries saw an increase in the proportion of their budgets going to health, while 26 countries saw no change and 10 countries saw a decrease.

Progress Toward the Abuja Target: Health Expenditure, by Country as a Share of Government Expenditure (USD 2013 Current)

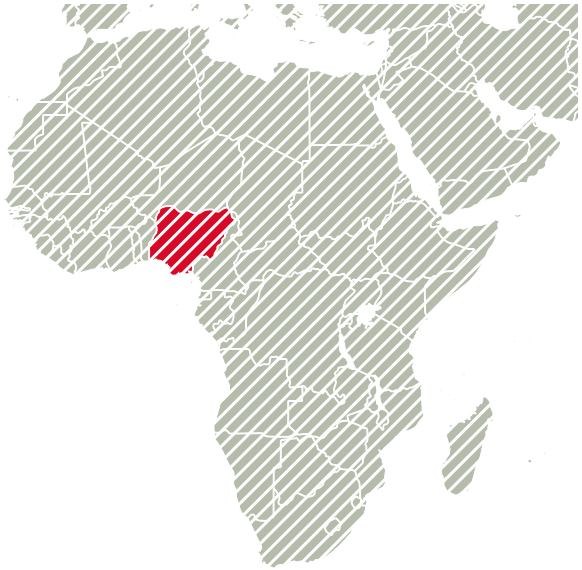


By not reaching the Abuja spending target, 40 sub-Saharan African countries missed out on a cumulative $19.2 billion in potential health investments in 2013.[104] This deficit has significant ramifications at the country level. **Nigeria, as one of the more extreme examples, would have dedicated $7.31 billion more to health in 2013 if it had spent 15% of its budget on the sector**; this shortfall represents 38% of the cumulative Abuja deficit in health spending.[105] Angola and Kenya had the next highest deficits in sub-Saharan Africa, missing out on $3.58 billion and $1.32 billion respectively in potential health spending by falling short of the Abuja target.[106]

Given national budgeting processes and constraints, it would be highly unlikely (and perhaps even ill advised) for all countries in the region to reach the 15% target within the coming year. Indeed, UNAIDS projects that the average budgetary allocation to health in countries shouldering the burden of the epidemic will increase from just 8.8% to 9.9% between now and 2030.[107] **But even if the countries that did not meet the Abuja target in 2013 were to spend just 1% more on their health budgets, they would generate more than $3.7 billion in additional resources for health annually.**[108] **From there, if just 20% of those additional resources for health were to go specifically to AIDS programmes, that increase would return $740 million in resources – enough theoretically to pay for a year's worth of ARV treatment for more than 7 million more people.**[109]

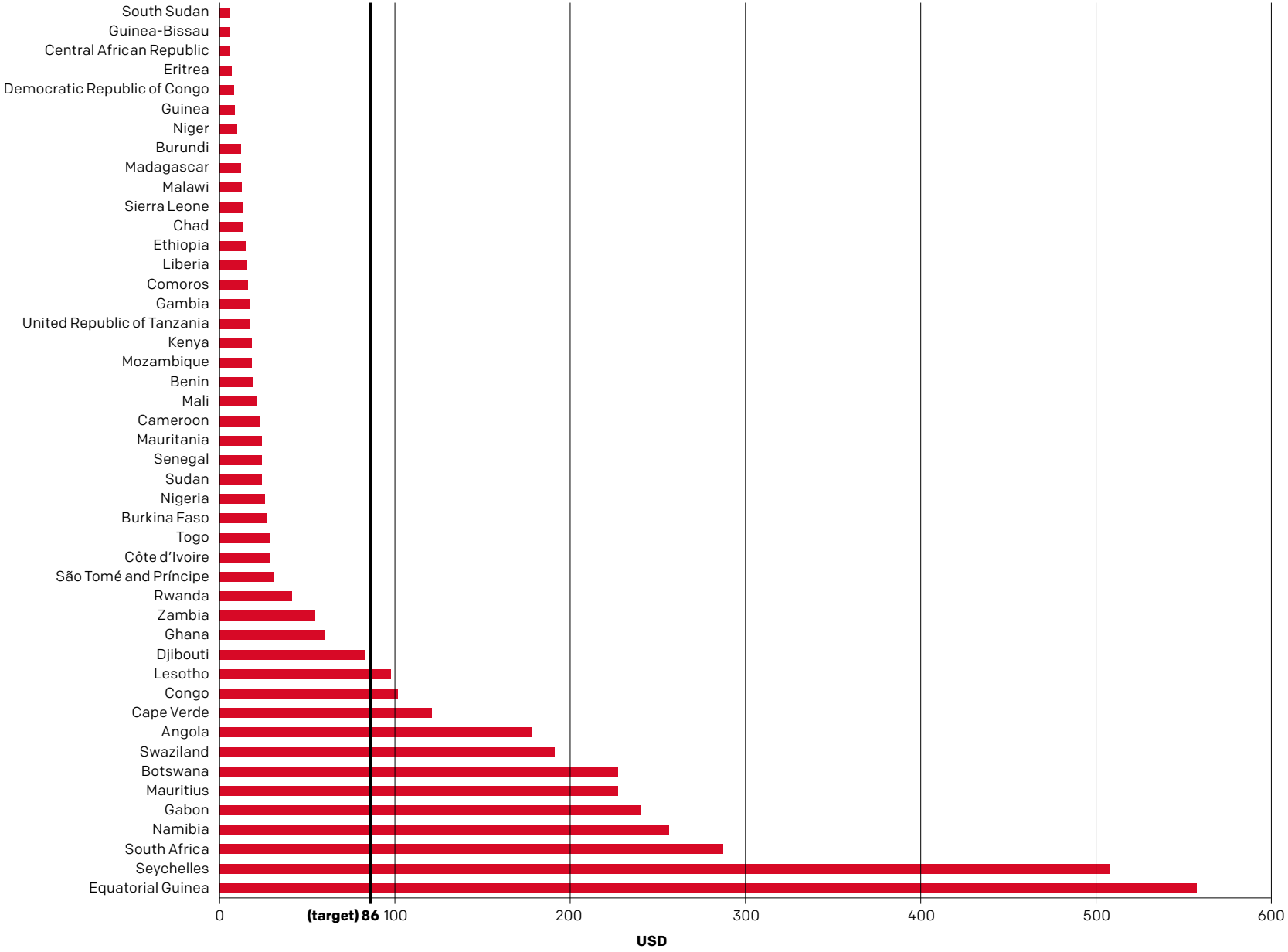
In addition to measuring progress towards Abuja, measuring a government's per capita spending on a basic package of social sector investments offers another way to understand the extent to which that government is providing for the well-being of its citizens. Many advocacy groups, including ONE, have called on low- and middle-income country governments to commit to a basic per capita spending floor.[110]

Some experts also suggest individual sectoral targets, including Chatham House, whose experts estimate (based on previous WHO guidance) that a minimum of $86 per capita (in nominal terms) spent on health would allow most governments to deliver a basic set of primary health-care services for their populations.[111] Based on this threshold, 12 countries in sub-Saharan Africa met the $86 per capita target in 2013, and 34 countries did not.[112] Only one of these 12 countries (Swaziland) had also achieved the Abuja target in 2013. Conversely, three of the five other countries that had achieved the Abuja target (Ethiopia, Malawi and the Central African Republic) had some of the lowest nominal per capita spending levels on health, suggesting that, for developing countries, achieving the Abuja spending target alone will not necessarily provide sufficient resources to tackle their complex health needs.



NIGERIA WOULD HAVE DEDICATED $7.31 BILLION MORE TO HEALTH IN 2013 IF IT HAD SPENT 15% OF ITS BUDGET ON THE SECTOR

General Government Health Expenditure Per Capita, by Country (USD 2013 Current)



Insufficient, and in many cases inefficient, health spending has undermined the ability of countries to accelerate the fight against their own AIDS epidemics. At the African Union in 2012, African heads of state and government adopted the "Roadmap on Shared Responsibility and Global Solidarity", designed to accelerate countries' domestic responses against HIV/AIDS, TB and malaria.[113] And yet according to a 2014 study in *The Lancet*, which reviewed 12 countries receiving significant levels of external assistance, only three (Botswana, Namibia and South Africa) fund the majority of their AIDS programmes from domestic sources. Of the remaining nine countries, Nigeria and Kenya contribute only roughly one-fifth of their aggregate AIDS spending themselves, and seven countries (Ethiopia, Mozambique, Rwanda, Tanzania, Uganda, Côte d'Ivoire and Zambia) contribute 15% or less of the total spending on AIDS in their countries.[114]

Furthermore, even if these same 12 countries met the Abuja target, and if their proportion of domestic AIDS spending within the health budget grew accordingly for 2014–18, only 40% of their AIDS needs would be met. None of these countries, moreover, would be able to independently fund their HIV/AIDS programmes solely by reaching the Abuja target.[115]

It is therefore imperative that countries continue to raise government revenues to support progress towards the 15% target and also explore new ways of raising resources – and of allocating the resources that do exist more efficiently – in order to meet its citizens' health needs. In response to this challenge, several countries have begun to leverage their domestic resources in inventive ways:

- Kenya's newly launched HIV/AIDS Trust and Investment Fund draws from a diversity of sources, including debt swap options, a lottery whose proceeds support the fight against AIDS, corporate social investment, infrastructural resources and organised informal sector contributions. It is estimated that the Fund will be able to mobilise $423 million in 2018–19, helping to finance up to 55% of Kenya's AIDS Strategic Framework when combined with domestic private sector contributions.[116]
- Uganda is planning to follow Kenya's model, with plans to establish a $1 billion HIV Trust Fund to finance local HIV programmes.[117] The money for this fund will be sourced from levies on bank transactions and interest, air tickets, electricity usage, beer, soft drinks and cigarettes; small fees on civil servants' salaries; and corporate taxes.[118]

INSUFFICIENT, AND IN MANY CASES INEFFICIENT, HEALTH SPENDING HAS UNDERMINED THE ABILITY OF COUNTRIES TO ACCELERATE THE FIGHT AGAINST THEIR OWN AIDS EPIDEMICS

- Ghana recently increased its value-added tax (VAT) by 2.5%, with funds earmarked for HIV treatment, while Malawi requires all ministries and departments to allocate a minimum of 2% of their recurrent costs budgets to HIV-related activities.[119] With tax-to-GDP ratios in low- and middle-income countries projected to increase from 19.2% in 2015 to 21% in 2020 and to 28% in 2030, countries could increasingly fund investments in health with their own public resources.[120]
- Growing discoveries of oil, gas and minerals across the African continent could serve as an additional source of revenue for health if well managed and appropriately allocated. Over the first 10 years of production, it is estimated that extractives could yield between 9% and 31% in additional funds for six countries (Ghana, Liberia, Mozambique, Sierra Leone, Tanzania and Uganda), representing an additional 2–6% of GDP each year. Increased revenues from extractives, estimates suggest, could help Ghana fund a third of its health and education needs and could accommodate half of Mozambique's needs in financing for health over the next decade.[121]
- Kenya, Nigeria, South Africa, Tunisia, Uganda and Tanzania, have secured various public- private partnerships (PPPs) that will encourage more rapid pre-qualification by WHO of locally manufactured essential drugs for HIV/AIDS, while Kenya, South Africa, Uganda and Zimbabwe now produce WHO pre-qualified ARVs. Such endeavours, aligned with countries' commitments in the AU Roadmap on Shared Responsibility, can help to enhance long-term national ownership of the AIDS response.[122]

NEW AND EMERGING DONORS

A number of emerging donors are providing financial resources and technical expertise to bolster the fight, while continuing to combat the disease within their own borders. Most notably, the BRICS countries (Brazil, Russia, India, China and South Africa) have a combined annual aid budget of $10.3 billion, with the largest contributions coming from China ($7.1 billion), India ($1.6 billion) and Brazil ($730 million).[123] Many of these countries supplement their resources and extend their impact by leveraging and transferring their own experiences and knowledge through 'South–South cooperation' with other countries.[124]

Russia

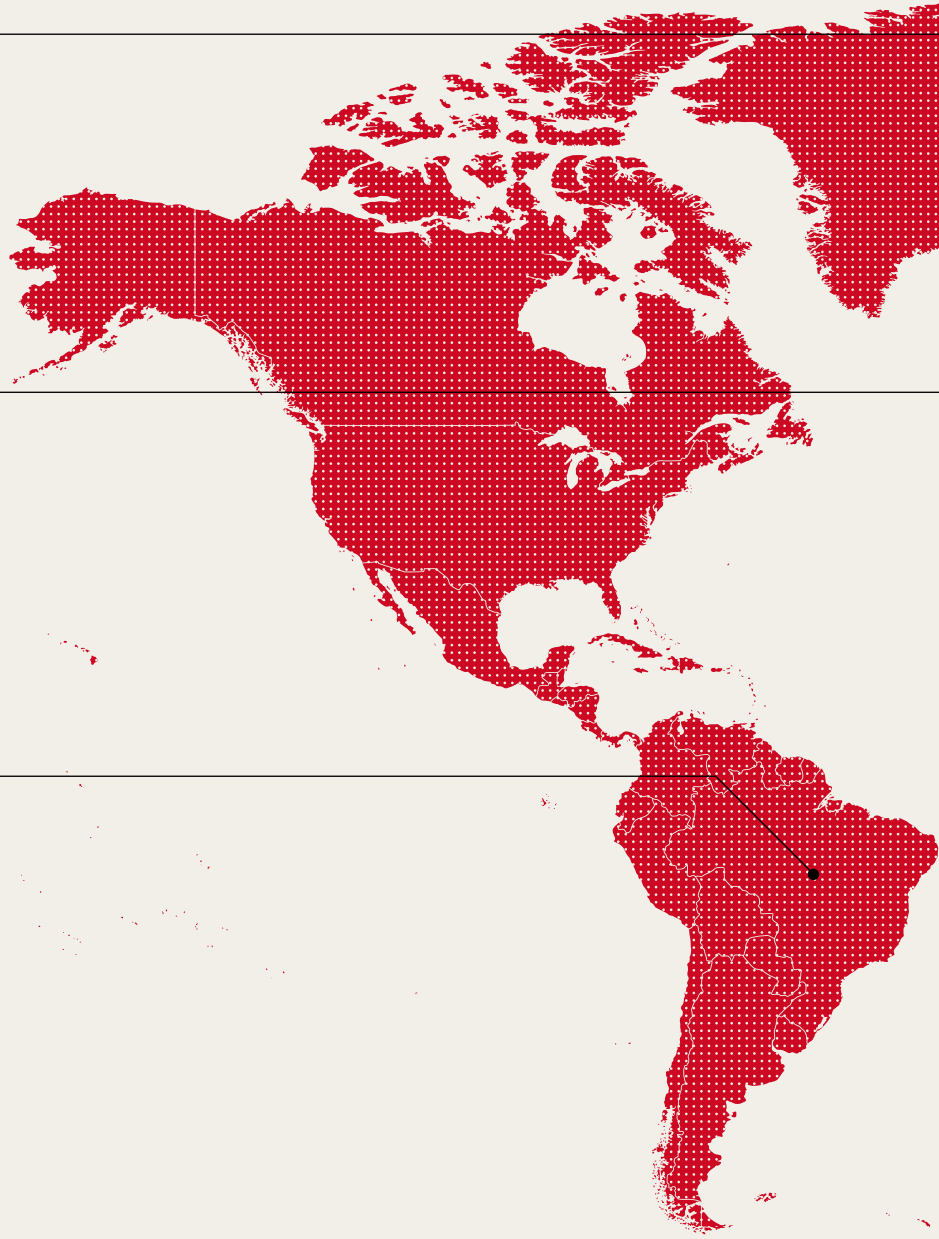
- After years as one of the Global Fund's largest beneficiaries, Russia pledged $60 million to the Fund for 2014–16 and has paid back more than $300 million cumulatively since 2002[127]
- Highly troubling record on providing services for marginalised citizens, including men who have sex with men and people who inject drugs[128,129]

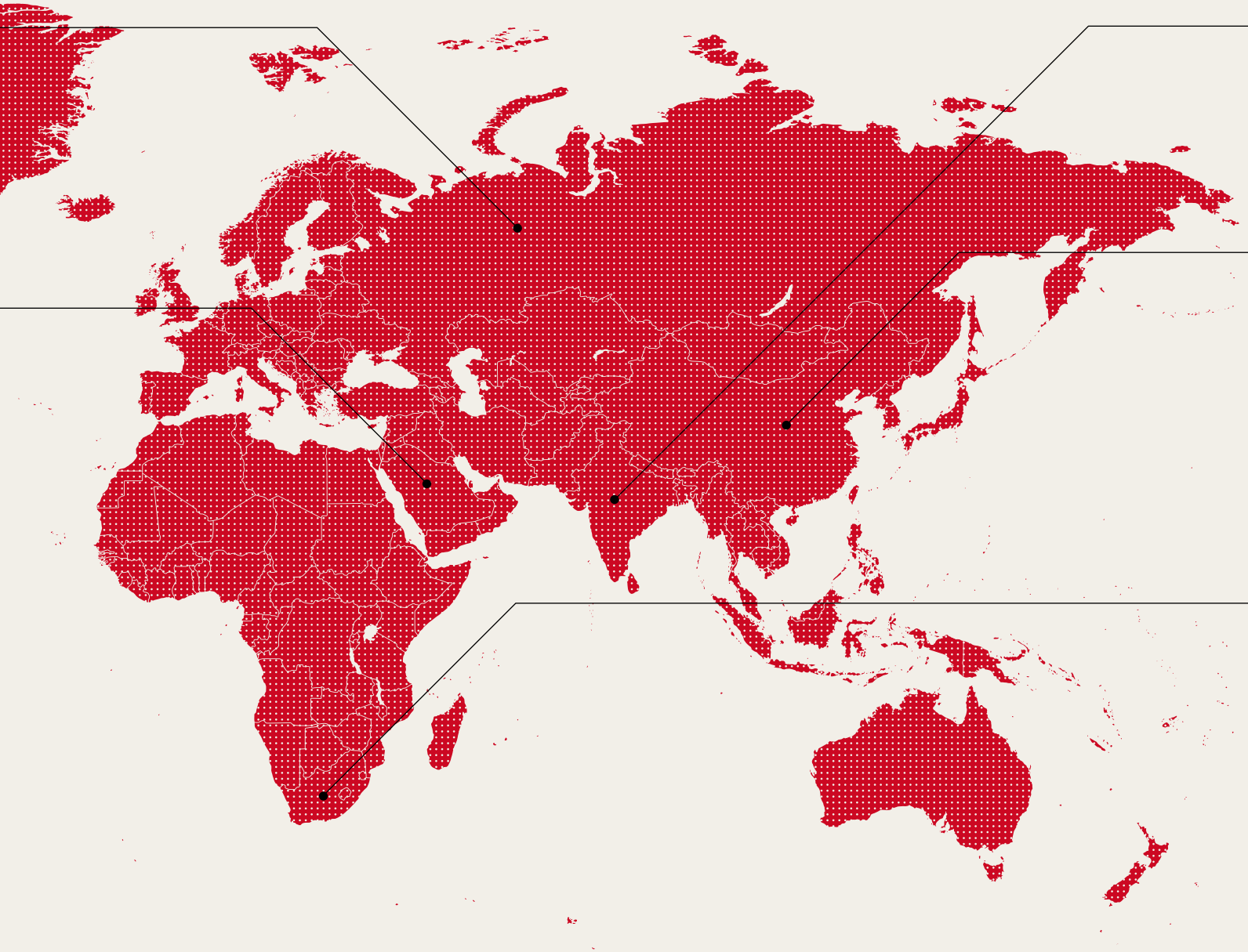
Middle East

- Increasing investments by many countries (UAE, Oman, Qatar, Saudi Arabia and Kuwait) in global health causes, including for Gavi, polio eradication and malaria[137]
- Engagement limited by perception of HIV/AIDS as a taboo topic; only Saudi Arabia and Kuwait have contributed to the Global Fund so far ($70 million and $4.5 million respectively).

Brazil

- National AIDS Programme administered the world's first universal provision of ARVs in the mid-1980s[125]
- Leader in South–South cooperation for HIV/AIDS through its International Centre for Technical Cooperation[126]





India

- Remains a significant Global Fund beneficiary (including $118 million in 2015), but also pledged $13.5 million back to the Fund for 2014–16[130]
- Has earned the title "pharmacy of the world", producing 70% of the world's ARVs[131]

China

- Has received more than $805 million from the Global Fund since 2003, but in recent years has contributed more than $40 million back to the Fund[132]
- Invested $14 million in developing preventive vaccines, microbicides, male circumcision technology and pre-exposure prophylaxis for HIV/AIDS in 2013 and 2014[133]
- On track to be the world's top financier of health sciences research and development by 2019[134]

South Africa

- Home to the largest number of HIV-positive people; supports the majority of its AIDS response with domestic funding[135]
- At the forefront of HIV clinical trials and innovations, including AIDS vaccine trials and studies on the effects of AIDS treatment as prevention[136]
- Pledged $1.5 million to the Global Fund for 2014–16

PRIVATE SECTOR CONTRIBUTIONS AND INNOVATIVE FINANCE

While government resources from around the world are likely to remain the primary source of AIDS financing for the near term, the private sector can and must play a bigger role in filling programmatic and financial gaps. At the same time, innovative financing channels – both those that already exist and those not yet developed or maximised for the AIDS response – can supplement traditional sources of financing and ensure a more dynamic, sustainable response into the future.

PHILANTHROPIC AND PRIVATE SECTOR CONTRIBUTIONS

- Recent levels of global philanthropic spending in the fight against AIDS have been disappointing, with private philanthropic organisations (including but not limited to foundations, pharmaceutical companies and trusts) contributing $592 million in the form of external grants and programmes in 2013, the lowest level of funding since 2007.[138] By far the largest private philanthropic donor to HIV/AIDS remains the **Bill & Melinda Gates Foundation**.[139]

- In addition to their own external grants and programmes, many private organisations play an increasingly important role in supporting the Global Fund's grant-making, adding business competence as well as more than $1.69 billion in investments to date.[140] One of the most prominent contributors is **(RED)**, a division of ONE, which partners with iconic brands to develop (RED)-branded products and services that generate contributions to the Global Fund. (RED) has mobilised $324 million since 2006,[141] helping to support AIDS treatment for 1.86 million people in eight countries through Global Fund grants.[142] A number of (RED) partners also engage in the Global Fund's "Innovation Hub", helping to link the needs of implementers with business solutions and skills.[143]

- Other notable corporate contributors to the Global Fund include Chevron, BHP Billiton, Takeda Pharmaceutical Company and Comic Relief.[144]

- A wide range of global companies and brands also pay for the direct provision of HIV/AIDS treatment and prevention services for their workforces and surrounding communities in high-burden locations, while others donate medicines or offer pro bono business support.

DEBT SWAPS

- **Debt2Health** is an innovative financing mechanism pioneered by the Global Fund in which creditor governments relinquish a part of their rights to the repayment of loans, on condition that the beneficiary country invests the freed-up resources in programmes approved by the Fund.[145] In the first Debt2Health swap in 2007, Germany cancelled €50 million in debts from Indonesia, enabling the Indonesian government and the Global Fund to jointly contribute €25 million to HIV/AIDS programmes.[146] For the 2008–16 period, an additional $106 million has been pledged to Debt2Health, with contributions from Australia (AUD 9.5 million) in 2014 and Germany (€2 million) in 2015 to support HIV/AIDS programmes in Indonesia, Egypt, Pakistan and Côte d'Ivoire. France also uses debt swaps to support the fight against AIDS, contributing €62 million in 2013 and €7 million in 2014.[147]

THE PRIVATE SECTOR CAN AND MUST PLAY A BIGGER ROLE IN FILLING PROGRAMMATIC AND FINANCIAL GAPS

LEVIES AND TAXATION

- The innovative financing scheme **UNITAID** has mobilised more than $2.5 billion in revenue for the fights against HIV/AIDS and other infectious diseases in just eight years.[148] Half of UNITAID's funds come from an airline ticket levy on flights leaving nine countries,[149] which has helped the organisation secure AIDS treatment for 750,000 children.[150,151]

- Introduced in 1999, the **Zimbabwe AIDS Levy** has raised $118.7 million (including $38.65 million in 2014[152]) by mandating all formal sector employers and their employees to contribute at least 3% of their incomes to domestic efforts to fight HIV/AIDS.[153] This levy stands out as an important initiative for increasing domestic ownership of the country's health challenges, and has encouraged Congo, Madagascar, Benin, Mali, Mauritius and Niger to follow suit.[154]

- The concept of a **Financial Transaction Tax** (FTT) – a marginal levy on transactions of stocks, bonds, derivatives or other instruments – has long been discussed as a way to raise funds for pressing global issues.[155] In the years since former President Nicolas Sarkozy launched an FTT in France in 2012, President Hollande has doubled the tax and earmarked parts of the revenues for development. A portion of the FTT revenues has already been used to fund France's contribution to the Global Fund, and 50% of the revenues will be used for ODA by 2016. President Hollande has also been one of the driving forces behind the proposed establishment of an FTT at the EU level, which could be implemented as early as 2017.[156] Such an arrangement could raise up to €34–38 billion ($39–$43 billion) in funds annually, although discussions and decisions on the terms and conditions, as well as where the money would go, have not yet begun.[157]

FUTURE SOURCES OF INNOVATION AND RESOURCES

- **Private capital** represents another potentially lucrative pool of resources. Insurance companies, pension funds and other investors in OECD countries alone hold an estimated $92.6 trillion in wealth. Additionally, high-net-worth individuals hold over $50 trillion in assets today, and their wealth is growing at an annual projected rate of 7%.[158] Recent initiatives have leveraged a small fraction of this private wealth for global health. In 2013, for instance, an Indonesian businessman, Dato Sri Dr. Tahir, contributed $65 million to the Global Fund, calling it "[his] best investment".[159] Dr. Tahir followed this contribution by introducing a new financing initiative, the Indonesia Health Fund, established with an initial investment of $40 million from eight Indonesian business leaders.[160]

- Recent research suggests that a growing market for social impact investments in the health sector could be as large as $123 billion.[161] Specific investment opportunities include the **Health Innovation Investors Circle**, through which investors explore, cultivate and execute financing deals for maximum-impact health innovations with a focus on sustainability, research and development; and the **Abraaj equity funds**, which leverage private capital to invest in hospitals and health service providers in under-resourced regions.[162]

- **Development Impact Bonds (DIBs)** can provide frontloaded donor resources and incremental pools of funding to support health priorities,[163] allowing investors to sponsor a development goal and then get repaid if the goal is achieved. One DIB, the Mozambique Malaria Performance Bond (MMPB), has raised $25 million from investors looking to achieve a blended social and financial return, including social debt investors and private companies.[164] Over 10 years, the MMPB aims to prevent up to eight million malaria infections and reduce prevalence in targeted regions by up to 75%. If successful, the experience of using DIBs for malaria reduction could be modelled for HIV/AIDS.[165]

- **'Sin taxes'** – taxes on unhealthy products, such as tobacco – could also be used to fund global health programmes and help mitigate the risk of non-communicable diseases in the long term. It is estimated that governments already collect nearly $270 billion in tobacco excise tax revenues today.[166] Cape Verde and Comoros also charge alcohol excise taxes, with funds earmarked specifically for HIV programmes.[167]

INNOVATIVE FINANCING CAN SUPPLEMENT TRADITIONAL SOURCES OF FUNDING

CONCLUSIONS AND RECOMMENDATIONS

More than three decades since AIDS was first discovered, the world stands at a critical juncture. We know how to treat HIV/AIDS with effective medicines. We know how to deliver prevention interventions in more effective combinations, and we have the science to back it up. We know where interventions have made an impact and driven the epidemic backwards, and we know where our collective efforts have fallen short, failing to measure and reach the most marginalised populations. And we know the price tag – a rough sense of how much it will cost to end AIDS as an epidemic, once and for all. The question for the world now is whether we will collectively step up and deliver against what we know is possible.

MORE RESOURCES FROM MORE PLACES, INCLUDING FOR THE GLOBAL FUND...

Inevitably, achieving these goals will require increased financing, and filling a $12 billion annual funding shortfall by 2020 cannot be done by relying solely on the same few donors. Mobilising the resources needed to turn the tide on AIDS requires the following actions:

- **Traditional donors** must renew their political commitment and increase their contributions, providing the leadership to make the Global Fund's 2016 replenishment a success, while also scaling up important bilateral AIDS initiatives.
- **High-burden countries** must generate and more effectively channel additional domestic resources for health and for HIV/AIDS programmes in particular.
- **Emerging funders** must step up and join other governments by contributing resources and sharing best practices with their peers.
- **The private sector** must contribute more of its resources, skills and business expertise to the cause.
- **Academics and development practitioners** must help develop and implement new innovative financing streams that can benefit HIV/AIDS and wider global health challenges.

SPENT MORE EFFECTIVELY AND ACCOUNTABLY...

The world must not be naïve in its assumptions about how quickly new streams of financing might be generated. Indeed, for many emerging donors, African governments and innovative financing streams, ONE's research suggests that it is likely to take many years to grow their current or projected levels of contribution to millions or billions in resources—some of which may not come in time to deliver on 'fast-tracking' the AIDS response by 2020. Given that reality, the world needs to aggressively pursue efficiency gains at every step of the fight– from planning to procurement to delivery – by all implementers, including financing mechanisms like the Global Fund, bilateral health donors, ministries of health and non-governmental organisations (NGOs).

We will not achieve these resource-saving efficiency gains without better data to guide the world's priority setting, allocation decisions and difficult trade-offs. Countries and programme implementers must develop the systems and the capacity to more accurately, rapidly and transparently collect and report comparable data in accessible formats. Doing so will help to better define the unique characteristics and trends of the AIDS epidemic at the local level and ensure that limited resources are being effectively targeted where they can have the greatest impact. Additional efforts should be made to collect data that are disaggregated by gender and wealth quintile, as well as to pursue more robust measures of HIV incidence and treatment retention. Aggregators of data should also be clear about their data sources and methodology, explaining where gaps exist and why significant changes occur when they happen.

...AND TARGETED AT THE RIGHT PEOPLE

Marginalised and most at-risk populations (MARPs), including men who have sex with men, transgender persons, people who inject drugs, prisoners and sex workers, face immense political and socio-economic obstacles, making them both more likely to become infected with HIV and less likely to be able to freely and safely access care and treatment services. Epidemiological data about these groups are often patchy or anecdotal at best, further complicating efforts to reach them with services.

Adolescent women and girls in many parts of the world often face similarly challenging circumstances. Research shows convincingly that "poverty is sexist",[168] with structural, political and socio-economic barriers holding women back and making it more difficult to ensure a better life for themselves and their families. In the same vein, AIDS is also "sexist": females now account for 64% of all new HIV infections among adolescents around the world, and in Africa that percentage rises to 74%.[169] Girls and young women in sub-Saharan Africa are almost three times as likely as their male peers to be living with HIV, while only 15% are aware of their HIV status, and AIDS remains the leading cause of death for this group.[170]

In order to better serve each of these groups and to ensure that the world does not lose ground in the fight against the epidemic, governments, implementers and advocates alike must do three key things:

- **Measure:** ensure that MARPs are better measured so we understand where these populations are and what levels of disease burden they carry and face.
- **Tailor:** better tailor programmes and investments – with focused MARPs or gender strategies where possible – to ensure that specialists are able to design appropriate outreach approaches and that affected groups can weigh in and meaningfully advise throughout the process.
- **Deliver:** track how well programmes and mechanisms are delivering services for these populations, holding countries and implementers accountable for greater impact.

In 2015, the world came together to adopt the UN Sustainable Development Goals (SDGs) – a bold vision for ending extreme poverty, improving health and tackling inequality and climate change that includes a target specifically for ending AIDS as an epidemic by 2030.[171] But without real action, the SDGs could remain lofty words on a page, or "one of the most incredible to-do lists ever written".[172]

In 2016, world leaders will have prime opportunities to make new down-payments on global health and the wider SDG agenda. In particular, the Global Fund's Fifth Replenishment will offer donors, beneficiary countries and the private sector the chance to show that they are willing to invest in turning the tide against HIV/AIDS and other infectious diseases. A High-Level UN Special Session on AIDS and the International AIDS Conference in Durban, South Africa in mid-2016 will also provide platforms for policy-makers, advocates and scientists to take stock of progress made, to highlight remaining gaps and to renew collective commitments to ending this disease. At each of these moments, the world will be watching, eager to see whether rhetoric turns into reality for the fight against AIDS and for the millions of people whose fates hang in the balance.

THE QUESTION FOR THE WORLD NOW IS WHETHER WE WILL COLLECTIVELY STEP UP AND DELIVER AGAINST WHAT WE KNOW IS POSSIBLE

ENDNOTES

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In Chipembi, Zambia, 58-year-old Dorothy (right) and her family have suffered from diseases that are both preventable and treatable. First her husband died of tuberculosis, then she lost a two-year-old child to malaria. Dorothy herself was diagnosed with HIV after years of illness which often left her bedridden. Access to ARVs through a Global Fund- supported program has enabled Dorothy to get back on her feet, and today she teaches others living with HIV to grow their own organic vegetables for their own health as well as a source of income.

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