



INVESTING FOR RESULTS

HOW ASIA PACIFIC COUNTRIES CAN INVEST FOR ENDING AIDS

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Foreword

The Millennium Declaration, 2000 had set a landmark agenda for human development in the form of Millennium Development Goals (MDGs). Fifteen years down the line, performance on these goals has been mixed. But the MDGs have caught the imagination of global leaders and communities. This is reflected in the tremendous motivation demonstrated by countries for establishing a new set of development goals for the next 15 years at the Rio +20 Conference in 2012. There was near unanimity that the unfinished work of MDGs must be carried forward and targets realized.

Halting and reversing the AIDS epidemic -an important MDG has also entered a decisive phase. There have been major successes in reducing the incidence, mortality and the deep rooted stigma associated with HIV and AIDS.

Asia Pacific region has scored many successes in its march to reverse the epidemic in a number of countries, starting with Thailand, Cambodia and India. But the region still faces serious challenges with some countries like Pakistan, Philippines and Indonesia reporting rising epidemic levels. Initial successes in scaling up treatment and prevention programmes has led to complacency among political leaders and policy makers in some countries.

But the most serious challenge to AIDS efforts is sustainable financing for national programmes, With many countries in the region graduating to middle income level, external funding is

fast drying up. It is unclear whether countries are prepared to step in to fill the gap with domestic resources. Without assured and scaled up funding over the next decade, there is a real danger of past gains getting wiped out leading to a resurgence of the epidemic. People living with HIV who are leading healthy and productive lives could once again struggle with poor health.

Understanding the urgent need to resolve the funding gap, UNAIDS and the World Bank came together in August 2013, to make an objective evaluation of the AIDS funding scenario in Asia Pacific with an independent panel of experts. I was given the privilege of chairing the 11 member panel with representation from countries, independent experts and civil society representatives. The Kirby Institute in Australia was commissioned to do selective modelling studies for making projections about AIDS funding scenario for 2020.

The Panel has used the UNAIDS epidemiological data and resource availability for 2010 as the base line and tried to make projections for 2020. The Panel felt that any projection beyond that year will not be realistic because of the fast changing economic environment in the region and around the globe.

The Panel also felt that a uni -dimensional approach in projecting the future will leave the country leadership with a yes or no option only. Instead, a scenarios approach will allow the decision makers to weigh various options and make informed decisions on funding for specified outcomes.

The most challenging task is to recommend various options for raising domestic resources for AIDS programmes for countries newly graduating to middle-income level. Despite reaching middle income status, many countries carry enormous socio economic burdens of a developing economy struggling to

prioritize scarce resources for development. We tried to provide various options including some innovative approaches to raise additional resources. We hope the countries will find them useful.

The Panel notes that the projections made in this report are slightly at variance with published figures of UNAIDS and other agencies. We have taken care to limit our projections to 2020 only and epidemiological projections to 2025, while the UNAIDS projections are mostly for 2030.

The Panel wants to thank UNAIDS RST Asia Pacific, in particular Steve Kraus, Pradeep Kakkattil and Maria Elena ("Marlyn") Filio Borromeo; and David Wilson of the World Bank for their vision and support, the Kirby Institute for their technical inputs and the report writers, Lisa Jacobs and Hein Marais for their excellent presentation of the findings and recommendations of the Panel. We also want to thank the peer reviewers for their quality inputs and suggestions.

I would like to thank all the Panel members for their excellent inputs and support throughout this period. Without their active involvement this report would not have taken shape.

Finally I would like to thank UNESCAP, especially Khun Nanda Krairiksh, the Director of the Social Development Division for providing us the platform to release the report at its Asia Pacific Intergovernmental Meeting on HIV/AIDS in January 2015.

Bangalore,
1/1/2015

J.V.R. Prasada Rao

1.

Introduction

Asia and the Pacific can become the first region to end its AIDS epidemic. It can achieve that goal by focusing its HIV prevention efforts where most new infections are occurring and by ensuring that its HIV testing and treatment programmes reach the maximum number of people living with HIV.

Doing so requires an accurate and up-to-date information about places where people are acquiring HIV and whether they have access to the necessary services targeting the AIDS response accordingly. It demands that no one left, (note: “no one left behind” is a UNAIDS corporate language) especially the key populations that are most at risk of HIV infection and who are often missed or ignored by HIV services. It calls for an environment – legal or any other – that puts HIV services within reach of everyone who needs them. And it requires an adequate and secure funding stream.

AIDS epidemic can be brought to an end by putting people at the centre; they will spur progress on a broader range reflecting health, development, social equality and human rights challenges.

Some countries in the region already have many of the building blocks in place and it shows in the progress they are making against the epidemic. They have shown that increased access to

HIV prevention, testing and treatment dramatically cuts AIDS-related deaths and new HIV infections – and that it can reduce future treatment costs by a ratio of up to 1:8 (1).

Those countries also have a head start in reaching the ‘Fast-Track’ targets promoted by UNAIDS: 90% of all people living with HIV should know their HIV status; 90% of all people diagnosed with HIV should receive sustained HIV treatment; and 90% of all people receiving treatment should achieve undetectable levels of HIV (also known as ‘viral suppression’). Other targets include near saturation coverage of prevention services, including for key populations that are most at risk of HIV infection and achieving zero discrimination (2).

In countries that reach these targets, new HIV infections would decrease drastically and almost three quarters of people living with HIV would be ‘virally suppressed’ and unlikely to transmit HIV to others.

Background to this report

This report examines the resource challenges that confront the AIDS response in Asia and the Pacific. It proposes a set of interventions that will help overcome them and steer the region towards ending its AIDS epidemic.

The report summarizes the analysis done by an independent, expert advisory panel on AIDS funding in Asia and the Pacific, convened jointly by UNAIDS and the World Bank in August 2013. The Expert Panel was tasked with reviewing the prospects for ending the region’s AIDS epidemic in the context of changing global economy and external funding environment. Chaired by the UN Secretary-General’s Special Envoy for AIDS in Asia and the Pacific, Mr. Prasada Rao, the 11-member Panel

comprised of public health experts, policy leaders and civil society organizations from the region and beyond.¹

Drawing on research done by Australia's Kirby Institute, with support from the World Bank, the Panel examined funding trends and outlooks for national AIDS responses in the region. The Panel's aim was to assist countries and their development partners in identifying future funding options and developing long-term sustainable investment strategies that would enable them to achieve the goals set by the Panel for 2020 and pave the way for ending the region's AIDS epidemic by 2030. A team of external technical experts reviewed the findings, as presented in this report.

Several converging developments have dramatically changed the funding outlook for AIDS responses in Asia and the Pacific. Due to global economic recession, several large donor economies have adopted austerity policies and shifted their spending priorities. These decisions are leading to cuts in overseas assistance, including funding for some AIDS programmes.

Changes in the funding architecture of major multilateral donors, including the New Funding Model of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund from hereon), are also expected to reduce AIDS funding flows to the region. In addition, strong regional economic growth has led to greater emphasis on countries increasing their own domestic investments in their AIDS programmes. It adds up to a pressing need to shift away from reliance on external funds and towards a largely domestically funded response, while simultaneously improving impact and efficiency.

¹ Members of the Expert Panel are listed in Annex.

The Panel assessed the current funding arrangements and the funding outlook for AIDS prevention and treatment programmes in Asia and the Pacific; explored their likely impact on the AIDS epidemic; examined options for achieving a secure funding base in the medium to long term; and identified possible transitional arrangements. The Panel then projected various AIDS response scenarios, ranging from a 'business-as-usual' approach to significantly expanding HIV prevention and treatment programmes. The scenarios included assumptions that a range of 'efficiency gains' would be made.

The Panel's recommendations are focused on a set of rapid but carefully considered adjustments and improvements that would reach at least 80% of key populations with effective prevention services and provide HIV testing and antiretroviral therapy to at least 80% of people living with HIV by 2020.

Countries can reach these targets if they act quickly and decisively to step up their AIDS responses, and line up the funding they need to do so. Rapid scale-up requires not only investing sufficiently in the AIDS response but also doing so in the context where donor funding is leveling off, even declining, and where countries are under increasing pressure to self-finance their AIDS programmes. Failure will see the AIDS epidemic outrun countries' responses – squandering the gains made thus far, increasing the long-term need for HIV treatment and significantly escalating future costs.

Success will capitalize on Asia and the Pacific's progress and place it on-course to become the first region to end its AIDS epidemic.

2.

Sustaining progress against the AIDS epidemic in Asia and the Pacific

Countries in Asia and the Pacific can claim credit for some of the most notable successes to date against AIDS. But this epidemic is a moving target. And it is especially adept at taking advantage of the complacency that sometimes follows success.

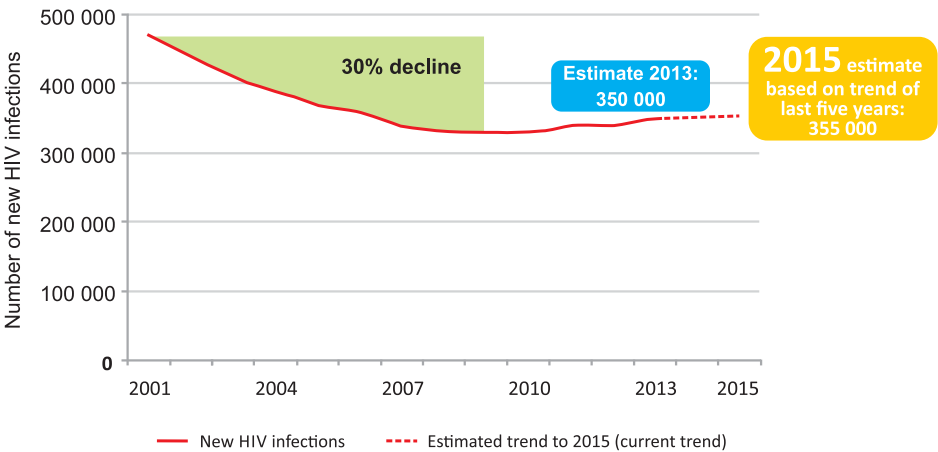
New HIV infections in the region decreased by about 30% between 2001 and 2009, but that decline has stalled in recent years, as Figure 1 shows. Over 98% of the people with HIV in the region live in only 12 countries², some of which have experienced major increases in new infections in recent years (Figure 2) (3).

²Listed in decreasing order of epidemic size: India, China, Indonesia, Thailand, Viet Nam, Myanmar, Pakistan, Malaysia, Cambodia, Nepal, Papua New Guinea, and the Philippines.

The estimated 350 000 [250 000–510 000] people who acquired HIV in Asia and the Pacific in 2013 brought to 4.8 million [4.1 million–5.5 million] the number of people living with HIV – making it the region with the biggest HIV burden after sub-Saharan Africa (3).

FIGURE 1: Estimated annual new HIV infections in Asia and the Pacific (2001–2013)

New HIV infections have declined since 2001, but remain largely unchanged in last 5 years

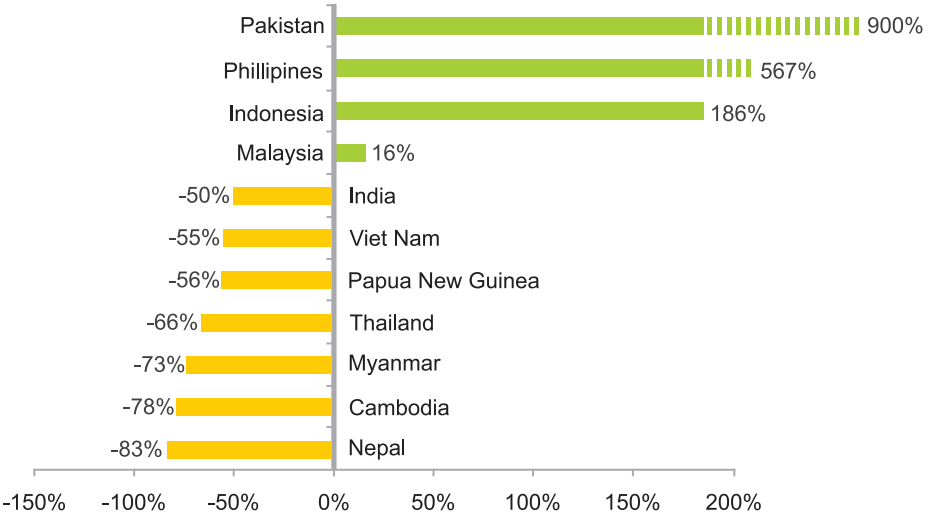


Getting to zero

Source: Prepared by www.aidsdatahub.org based on UNAIDS 2013 Estimates for UNAIDS (2014). The Gap Report.

FIGURE 2: Percentage change in estimated annual new HIV infections between 2001 and 2013 in selected countries

Percentage change in number of new HIV infections in 2001 and 2013 in selected countries



Source: UNAIDS Estimates 2013 for UNAIDS. (2014). The Gap Report; and Philippines HIV Estimations and Projections 2014 (Unpublished document)

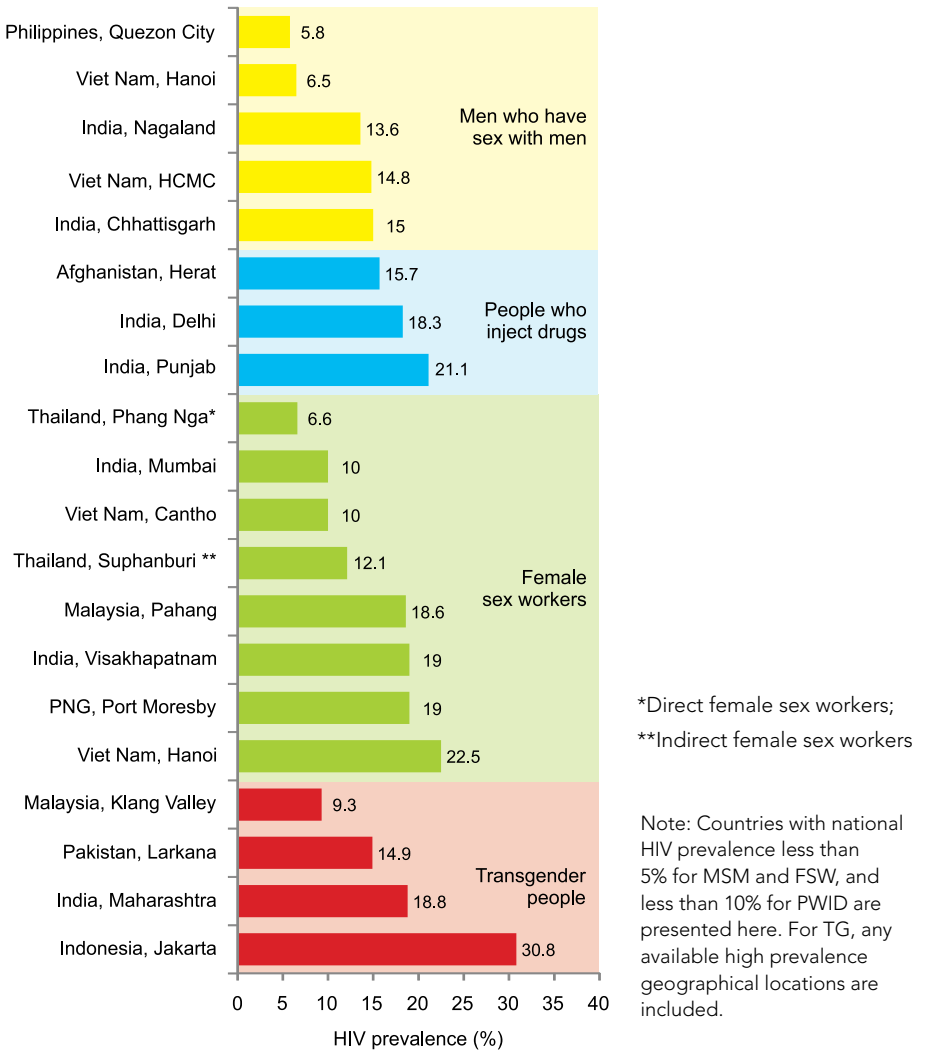
Note: Data for China were not available for the comparison years.

In most countries in the region, sex workers and their clients, gay men and other men who have sex with men, transgender people and people who inject drugs, represent the populations most affected by the epidemic. They tend to be most numerous in big cities and HIV infection levels among them also tend to be highest in those urban areas (Figure 3). HIV infection levels exceed 5% among key populations in all 12 countries and in some geographical location. Yet they typically have least access to HIV services and to other social and health support programmes (3).

FIGURE 3: HIV prevalence among key populations in selected cities of Asia and the Pacific

National prevalence masks high prevalence geographical areas

HIV prevalence among key populations in geographical areas



Getting to zero

Source: Prepared by www.aidsdatahub.org based on HIV sentinel surveillance reports and integrated biological and behavioral surveillance reports

Countries, that have prioritized these key populations in their AIDS responses, have controlled HIV infections among them and the general population. This has also led to a significant reduction in and AIDS-related deaths overall. Some of these countries – Cambodia, India and Thailand, for example, have reversed their AIDS epidemics.

Similar successes have led to the overall drop in new HIV infections and AIDS deaths across the region and need to be emulated in more countries. The region continues to experience large numbers of new HIV cases and AIDS-related deaths and there is a surge of new HIV infections in several populous countries (Figure 2). However, all this is avoidable.

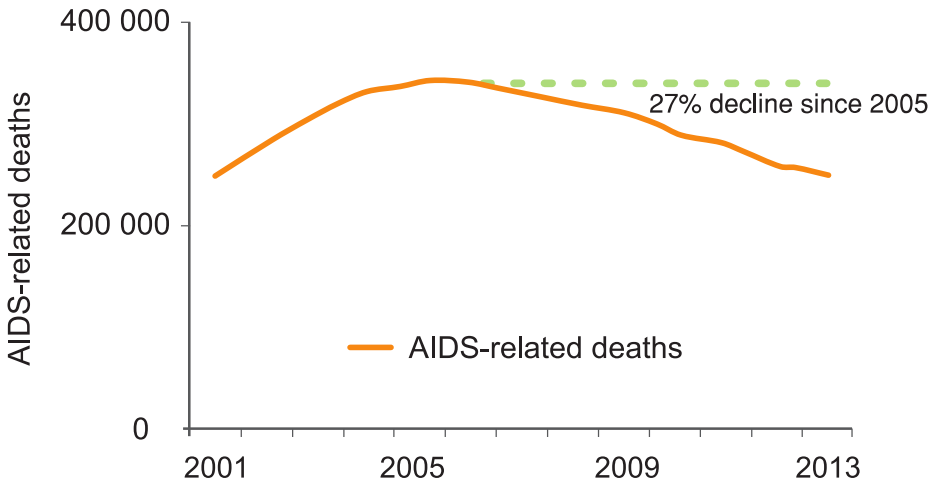
Treatment saves lives: fewer AIDS-related deaths in Asia and the Pacific

Access to HIV treatment in the region increased nine-fold between 2005 and 2013, leading to a steep drop, nearly 27%, in AIDS-related deaths (Figure 4). Despite this, only 1 in 3 people living with HIV is on HIV treatment at the moment (and most of them start treatment late, which compromises the benefits). Reaching key populations with these life-saving services poses a particular challenge: only about 1 in 3 people belonging to a key population in the region even know their HIV status at the moment.

Where access to antiretroviral therapy remains low, AIDS-related deaths have increased. For example, they rose 4.5 fold in Pakistan between 2005 and 2013 (3). Yet we know countries in the region can do better: Cambodia cuts its AIDS-related

deaths by 71% and in Thailand, AIDS-related deaths fell by 57% over the same period.

FIGURE 4: Estimated annual AIDS-related deaths in Asia and the Pacific (2001–2013)



3.

TAILWINDS:

Strengths and opportunities in the region's AIDS response

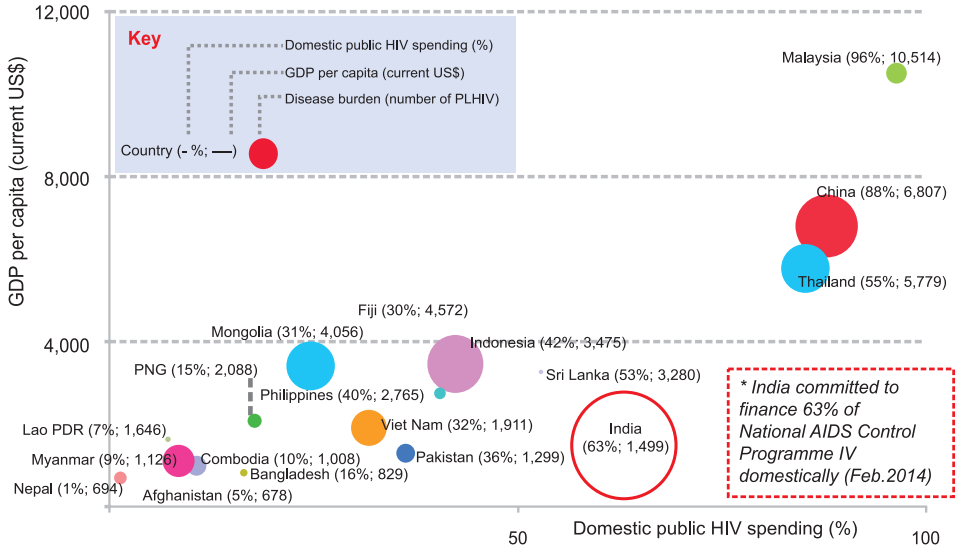
Asia and the Pacific can end its AIDS epidemic as a public health threat if it ensures that there are sufficient resources to take proven HIV interventions to scale; if it focuses those efforts where most infections are occurring; and if it makes sure that the maximum number of people most at risk of HIV actually benefit from those services. Asia and the Pacific's AIDS response has evolved impressively on all these fronts over the past decade.

The annual numbers of new HIV infections and AIDS-related deaths have fallen and examples of successful AIDS programmes have multiplied even in countries that had been struggling to control their epidemics.

Strong political commitment has been a major factor, reflected in the increase in domestic investment in AIDS responses (Figure 5). In 2013, about 58% of the region's AIDS response was funded domestically – US\$1.3 billion of the US\$2.2 billion allocated in that year. This represented a 30% increase in domestic funding in the region between 2010 and 2013.

FIGURE 5: Domestic public spending on HIV (%) and gross domestic product per capita (US\$) in various Asia-Pacific countries

Countries are sharing responsibility as their GDP per capita rises



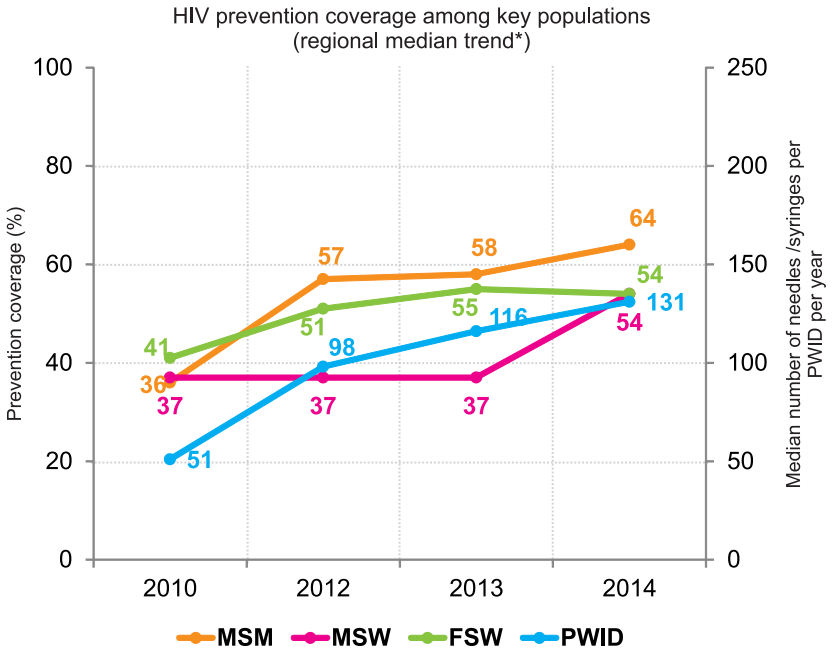
The growing roster of success stories shows that HIV interventions can be retargeted to achieve a greater impact without requiring bigger spending. Countries that have focused resources where people are most at risk of HIV infection have brought new infection rates down in those communities and in the wider population. Prevention programmes for key populations can be implemented with modest resources that are also cost-effective.

Across the region, these kinds of prevention services are reaching key populations in greater numbers than before, but there is considerable room for further improvement (Figure 6). The median trend shows that countries need to aim for near-saturation of outreach services for sex workers, men who have sex with men, transgender people and people who inject drugs. Coverage of

Opioid Substitution Therapy (OST) for people who inject drugs, and prevention programmes in prisons must also increase significantly. The target for eliminating new HIV infections among children requires saturation coverage of services to prevent mother-to-child transmission of HIV (2).

FIGURE 6: Median HIV prevention coverage among key populations in Asia and the Pacific (2010–2014)

Prevention services are reaching key populations but are not scaling up fast enough to reverse the epidemic



*Latest available data from UNGASS Global AIDS Response Progress Reporting (GARPR) 2010 to 2014

Note: The coverage levels of prevention services for men who have sex with men shown here possibly reflect sampling of areas with well-developed HIV programmes.

MSM: men who have sex with men; MSW: male sex workers; FSW: female sex workers; PWID: people who inject drugs

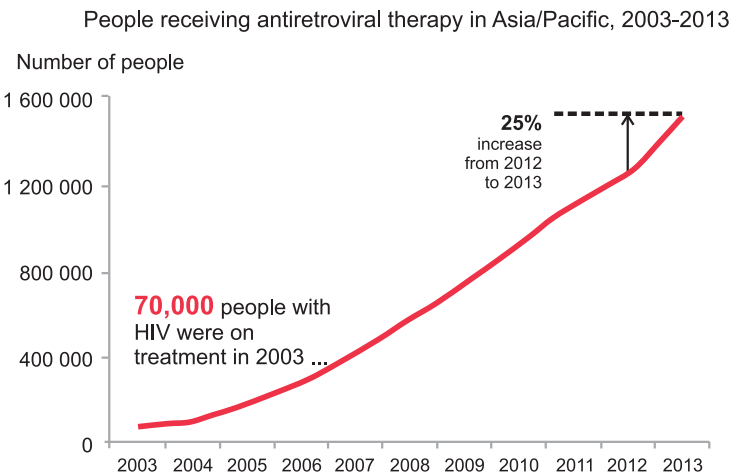
Recent evidence also recommends using antiretroviral drugs so that people who have not acquired HIV but who are at high risk of infection can avoid getting infected. Known as ‘pre-exposure prophylaxis’, this intervention can have a potentially important supplementary role as part of an overall prevention package. Pre-exposure antiretroviral prophylaxis can cut HIV transmission by more than 40% among men who have sex with men (4) and by as much as 49% among people who inject drugs (5).

Big opportunities for a greater impact using HIV treatment to prevent new infections

More people than ever are receiving HIV treatment and provision is expanding at a quickening pace: there was a 25% increase between 2012 and 2013 in the number of people getting treatment in the region, compared with a 13% increase between 2011 and 2012 (Figure 7).

FIGURE 7: People receiving antiretroviral therapy in Asia and the Pacific (2003–2013)

There are now 1.56 million people with HIV in the region receiving HIV treatment



One of the biggest recent breakthroughs is the confirmation that HIV treatment not only averts deaths but also prevents new infections. New analysis shows that for every 10% increase in the number of people getting HIV treatment, the population-level HIV transmission rate drops by 1% (3).

Asia and the Pacific can seize this opportunity by aiming for the target recommended by the Expert Panel: at least 80% treatment coverage for people living with HIV by 2020. That entails significantly increasing the number of people receiving HIV treatment. Of the 4.8 million people living with HIV in Asia and the Pacific in 2013, only 1.56 million were on HIV treatment, i.e. about 33% coverage. The region can do much better.

The region is expected to experience 382 000 new HIV infections by 2020 if coverage remains at current levels, compared to about 161000 new infections if the response is rapidly scaled up.*

Much depends on whether governments demonstrate the necessary political commitment, since most of these programmes currently rely on external funding that is beginning to dwindle. Sections 5 and 6 of this report examine the ways in which increased domestic funding, aided by efficiency savings, can make up the shortfalls.

A hub of innovation

Asia and the Pacific region has established itself as a global hub of scientific, technological and entrepreneurial innovation and of economic vibrancy – strengths it can use to even greater effect

*Source: Kirby Institute, New South Wales University, Australia, 2014

against the AIDS epidemic and other social challenges. The region already has the demonstrated capacity for large scale manufacture of affordable HIV drugs and other commodities. It is already the main producer of generic HIV drugs globally, with Indian manufacturers in particular providing well over 95% of the total volume of antiretroviral medicines used in low- and middle-income countries globally in 2013 (6).

A further exciting development is the growing movement in the region towards Universal Health Coverage arrangements. China, Malaysia and Thailand are among the countries implementing national universal health coverage schemes that incorporate HIV treatment. Other countries working towards mandating similar arrangements by law, include Indonesia, the Philippines and Viet Nam. Countries in other regions are also following these developments closely. India is also moving in this direction and has begun committing resources from its national budget for the provision of free medicines for primary health care as part of Universal Health Coverage.

Community organizations make a big difference

Wider coverage of HIV prevention and treatment services demands greater involvement of community-based organizations – as shown in India, where the imaginative use of community networks and expertise helped the country to reverse its HIV epidemic among sex workers. Community organizations understand the issues that affect key populations and people living with HIV. They are able to build vital bridges of trust and accountability between government authorities and communities and they also enhance the reach and quality of HIV services.

Further progress in the region calls for added service delivery by community organizations. At the moment, according to UNAIDS estimates, about 95% of HIV service delivery globally occurs at formal health facilities. But in settings where key populations are exposed to stigma, harassment and arrest, they often avoid government service providers. Community service delivery can sidestep such hindrances and bring HIV and other services closer to the people who need them most. As projected by UNAIDS, community-based service delivery should cover at least 30% of total service delivery (2).

A bigger role for community organizations requires the creation of an enabling environment with respect to both financial and regulatory arrangements. Fortunately, a growing number of countries in the region are demonstrating political will to remove legal barriers that hold back their AIDS responses. At least 11 punitive laws have been lifted; 8 countries have increased legal protections for people living with HIV or key populations; and 19 have conducted nationwide reviews and/or consultations to identify legal barriers and devise action plans.

Funding security, on the other hand, remains a constant concern for community organizations, most of which rely heavily on the support of external partners at the moment. Inside the region, many governments are yet to harness the potential of these organizations in reaching marginalized constituencies. Eight out of 13 countries surveyed in 2012 reported that community-based organizations provided less than 25% of clinical services and less than 25% of treatment and counseling services (Table 1).

TABLE 1: Proportions of HIV services provided by civil society in 13 countries in Asia and the Pacific, 2012

	<25%	25–50%	51–75%	>75%
People living with HIV		Lao P.D.R. Sri Lanka Viet Nam	Nepal	Bangladesh Cambodia China India Indonesia Myanmar Papua New Guinea Philippines Thailand
People who inject drugs	China Lao P.D.R. Sri Lanka Viet Nam		Indonesia Nepal Philippines	Bangladesh Cambodia India Myanmar Papua New Guinea Thailand
Sex workers	China Sri Lanka Viet Nam		Nepal Philippines	Bangladesh Cambodia India Indonesia Lao P.D.R. Myanmar Papua New Guinea Thailand
Men who have sex with men	Sri Lanka		Nepal Philippines Viet Nam	Bangladesh Cambodia China India Indonesia Lao P.D.R. Myanmar Papua New Guinea Thailand
Transgendered people	China Sri Lanka	Viet Nam	Nepal Philippines	Bangladesh Cambodia India Indonesia Lao P.D.R. Myanmar Papua New Guinea Thailand

Note: Data based on response to the National Composite Policy Index (2012) question B.1.7 'What percentage of the following HIV programmes/services are estimated to be provided by civil society?'

4.

HEADWINDS:

The challenges that impede quicker progress

Impediments on the horizon are, however, threatening the progress being made against the AIDS epidemic. One of the biggest perils is an impending, and possibly a steep drop in, external funding for the region's AIDS response.

There is a big push for increased domestic funding

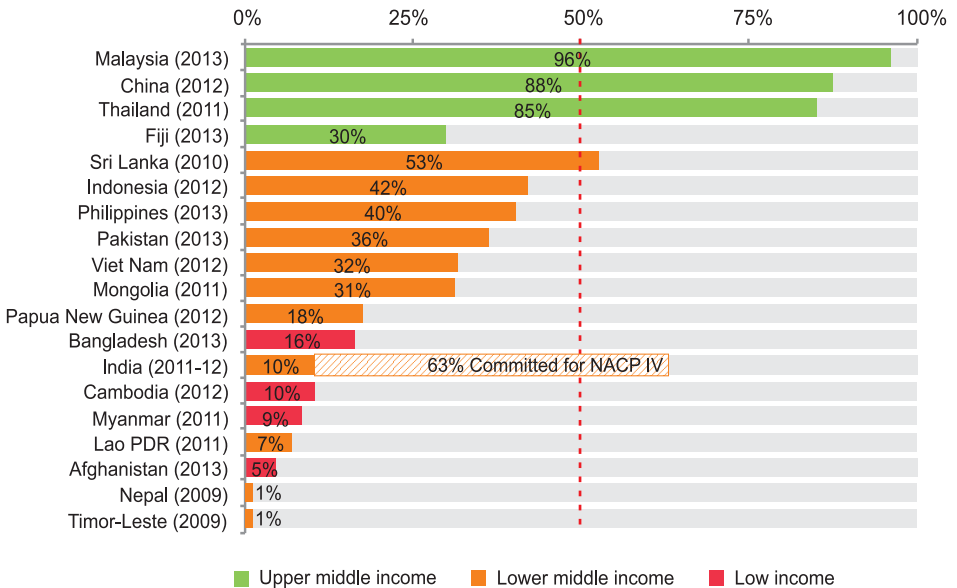
The strong growth rates of many economies in the region have fostered an expectation that governments will become less reliant on external aid and invest more of their own resources in the health and wellbeing of their citizens. Even countries not experiencing strong growth are increasingly expected to contribute more of their own resources alongside external assistance, and bring domestic funding in line with their national wealth and HIV burden (2).

A few countries (all of them in the upper-middle-income category) are already funding most of their AIDS programmes themselves, and they seem to be on-track to achieve self-

sufficient AIDS responses. However, most countries in the region, including several with growing economies, depend heavily on external funds (Figure 8). Of particular concern are populous countries with growing disease burdens (such as Indonesia and Pakistan) and with AIDS programmes that rely on external funding. A further concern is that countries may become ineligible for Global Fund or other external grants, if they are unable to bridge their funding shortfalls entirely with domestic resources.

FIGURE 8: AIDS expenditures from domestic public sources in Asia and the Pacific, latest available year

HIV expenditure from domestic sources, Asia and the Pacific, latest available year, 2009–2013

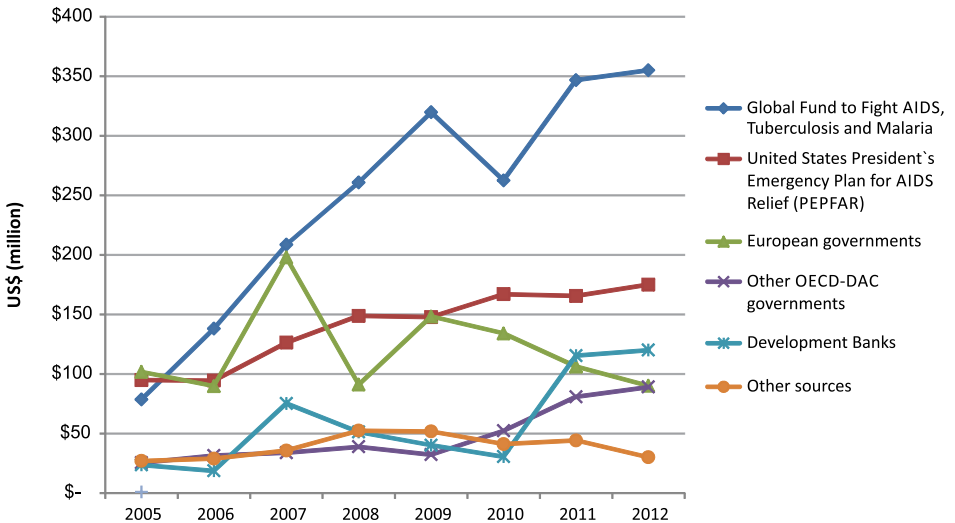


At the moment, international partners are funding approximately 40% of the region’s overall response to AIDS, but that proportion is much larger in most countries. The Global Fund is by far the single biggest source of external AIDS funding in the region, followed by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (Figure 9).

FIGURE 9: External AIDS funding trends in Asia and the Pacific (US dollars), 2005–2012

The Global Fund plus PEPFAR are the most important international funders in the region

International funding for HIV response in Asia Pacific, 2005–2012



Source: Countries progress reports, OECD CRS, UNAIDS estimates

Increases in multilateral funding are unlikely

Additional donor funding does not appear to be a realistic prospect in the foreseeable future. Donor commitments globally have leveled off in the past three years. According to UNAIDS, increase in funding – whether bilateral or via multilateral entities – from the Organisation for Economic Co-operation and Development (OECD) and Development Assistance Committee (DAC) donor governments are unlikely. In addition, external partners are focusing their aid increasingly on the poorest countries in the world, particularly in Sub-Saharan Africa. Ongoing economic uncertainty in most of the traditional external funding partners point to continued flattening or decline in funding meant for Asia and the Pacific.

The Global Fund has shifted to a new allocation system i.e, its New Funding Model, that is expected to channel resources away from many AIDS programmes in Asia and the Pacific, including some countries with large populations of poor people who are affected by the AIDS epidemic. Countries' eligibility is being determined by income level and disease burden, and is based on the World Bank income classifications and disease burden estimates of WHO and UNAIDS. A complex formula – based on disease burden, income level, external financing and a minimum required level of support – is being used for determining how much funding a country will receive. The outlook beyond 2016 is unclear at the moment, but there is a likelihood that a great deal of external assistance for AIDS programmes might shift towards countries in Sub-Saharan Africa.

The new formula appears to allocate some countries more funding than allocated previously (Figure 10) (7).³ In several

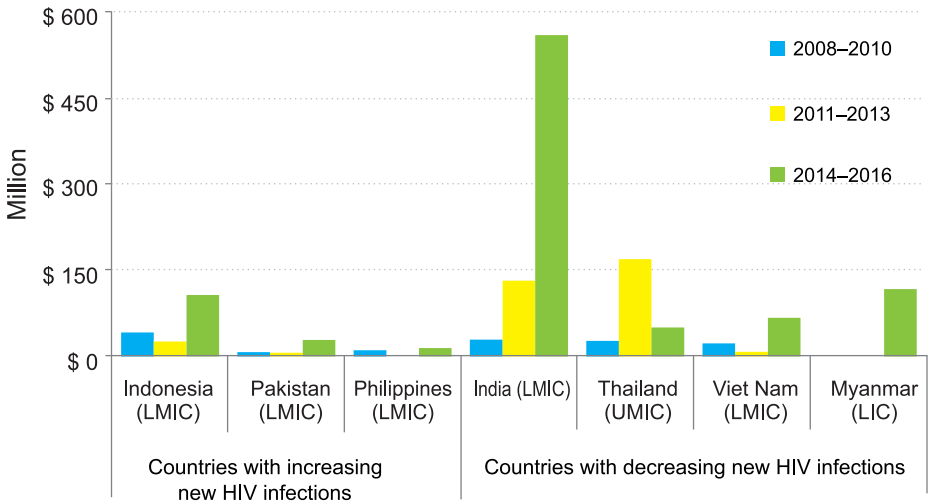
³Thailand is a notable exception; it is using its transitional support from the Global Fund to shift towards fully funding its national AIDS response with domestic resources.

instances, however, the new ‘funding envelope’ includes funding that was already allocated during the previous grant period, in which case, the country actually receives little or no new funding. Across the region, about 60% of the latest (2014–2016) allocations consist of existing funding from a previous grant period (Figure 11). In other words, those countries are receiving less new monies than they may have anticipated. They are expected to re-programme their existing allocations to achieve bigger impact.

FIGURE 10: Global Fund country allocations for HIV in selected countries, 2008–2010 to 2014–2016

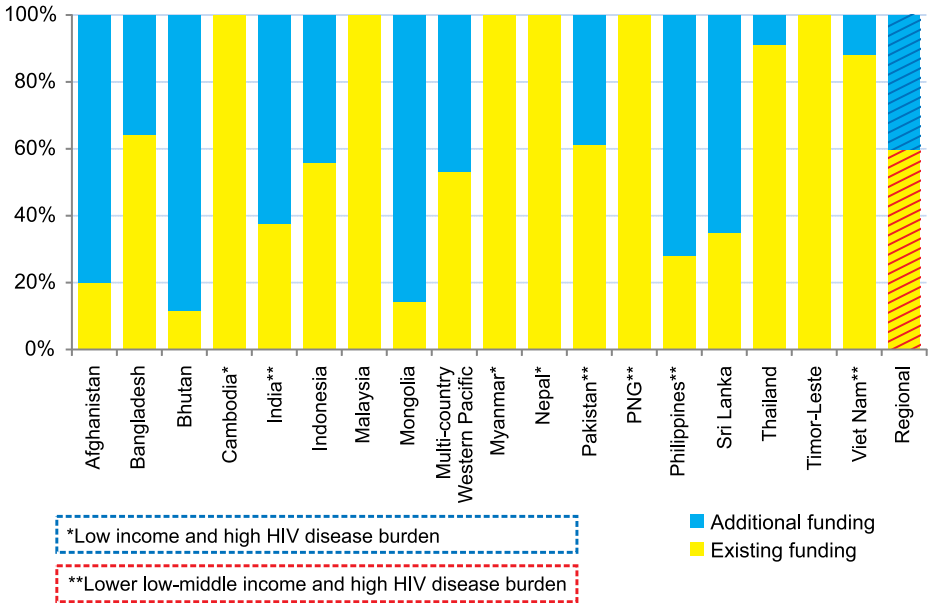
The Global Fund provides significant funding to countries in Asia

Global Fund country allocations for HIV/AIDS, selected countries



Source: Prepared by www.aidsdatahub.org based on <http://web-api.theglobalfund.org/DataSets/Index>

FIGURE 11: Proportions of additional and existing funding for HIV in Asia and the Pacific (2014–2016); Global Fund grant allocations



Source: Prepared by www.aidsdatahub.org based on The Global Fund. (2014). Global Fund Country Allocations: 2014–2016.

Cambodia is among the countries that saw their actual Global Fund allocations diminish suddenly. Previously, approximately 90% of its national AIDS response had been externally funded. After months of exploring ways to fill its new funding gap, the National AIDS Authority in late 2014 confirmed domestic funding of US\$3.7m for the country’s HIV treatment programme for 2015–2017.⁴

⁴ See <http://unaids-ap.org/2014/12/10/cambodia-commits-to-stopping-new-hiv-infections-by-2020/#more-853>.

Despite that breakthrough commitment, Cambodia's AIDS response is still saddled with a funding shortfall. Some other countries in the region face similar predicament. A more systematic solution needs to be introduced. The Global Fund can explore the possibility of some bridging arrangement, possibly a transition fund that may provide countries with financial and technical support as they move towards sustaining their HIV responses with domestic funds. Transitional funding may extend beyond 2017.

Other external partners are also cutting back

The United States and Australia have been two key bilateral partners in the Asia-Pacific region. U.S. bilateral AIDS assistance funding globally is projected to remain stable at about \$4.3 billion in financial year 2015. But the outlook beyond 2015, especially for Asia and the Pacific, is unclear. PEPFAR's long-term strategy appears to prioritize support for countries in Sub-Saharan Africa and there is an expectation that countries in Asia and the Pacific will increasingly fund their AIDS response from domestic sources.

Asia and the Pacific has been a priority area for Australia's overseas aid. However, the country has overhauled its assistance strategy, which will now mainly serve the promotion of economic growth through private sector. The 2014/2015 federal budget included systematic cuts to overseas aid, but it is anticipated that about 75% of the remaining aid will go to Asia and the Pacific in 2015/2016, with Indonesia and Papua New Guinea being the main recipients.

Other traditional bilateral partners (such as Denmark, France, Norway, the Netherlands and Sweden) have indicated that Africa will remain the main destination for their bilateral

overseas development assistance, with Asia a relatively minor recipient.

The upshot is that low- and even some middle-income countries in Asia and the Pacific, especially those with a heavy HIV burden, will continue to need substantial international support to take advantage quickly of the opportunities to end their AIDS epidemics. The current outlook suggests, however, that this may be difficult to secure.

There is an imbalance between funding for prevention vis-a-vis treatment

The changes in donor funding will affect the main components of countries' AIDS responses differently. While the region funds most of its treatment and care programmes from domestic sources, external partners pay for most (about 80%) of the HIV prevention programmes.

Given the advantages of starting HIV treatment early, and the push to achieve 90% treatment coverage, substantial proportions of AIDS funding will keep going towards HIV treatment and support services, since, antiretroviral drugs are needed for life, in any case. Countries will need to keep financing this scale-up almost exclusively with domestic resources. Most of those services could be delivered by integrating them into countries' general health care systems, with funding from their overall public health budgets.

Prevention efforts, meanwhile, are unduly exposed to cuts in donor funding, adversely affecting services for key populations especially at risk (see below). This is a dangerous prospect in the Asia-Pacific region, where the epidemic is still concentrated among key affected populations and their sex partners. If

effective prevention efforts are not stepped up, the epidemic – and the costs of treating people living with HIV – will continue to grow. Preventing infections today saves both lives and money tomorrow. Calculations by the Commission on AIDS in Asia have shown that every US\$1 spent on effective prevention would save up to US\$8 in averted treatment costs of a two-decade period (8).

Countries are missing opportunities to make a bigger impact

It is not only a matter of safeguarding prevention programmes. Most Asia-Pacific countries are using the bulk of their prevention funds to reach the general population with HIV services, rather than focusing those efforts on populations and areas where most HIV infections occur. In fact, a majority of countries have been spending more than half their prevention budgets on general prevention programmes, while small fractions of those budgets are going towards prevention services for key populations (Figure 12). Given the nature of the countries' epidemics, this approach is both ineffective and inefficient.

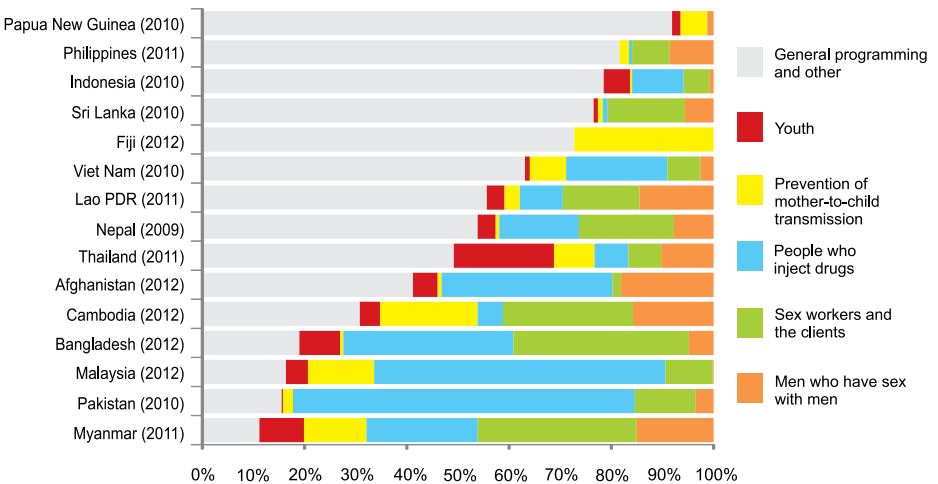
Spending on HIV services for key populations varies across the region but it seldom reflects the importance of these populations in countries' epidemics. In many countries, as a result, a minority of people belonging to key populations has access to essential HIV services (Figure 13) (3). External partners are providing most of that funding for men who have sex with men (95%), sex workers and their clients (94%), and people who inject drugs (82%) (Figure 14).

The inordinate dependence of key population programmes on external funding poses a major risk to the region's AIDS

response. These programmes are the key to ending the epidemic. With donor funding likely to dwindle, countries need to act urgently and decisively to prevent HIV services for key populations from running out of funds. Disrupting those services will reverse the hard-earned gains of recent years, and reviving them sometimes in future will prove doubly expensive.

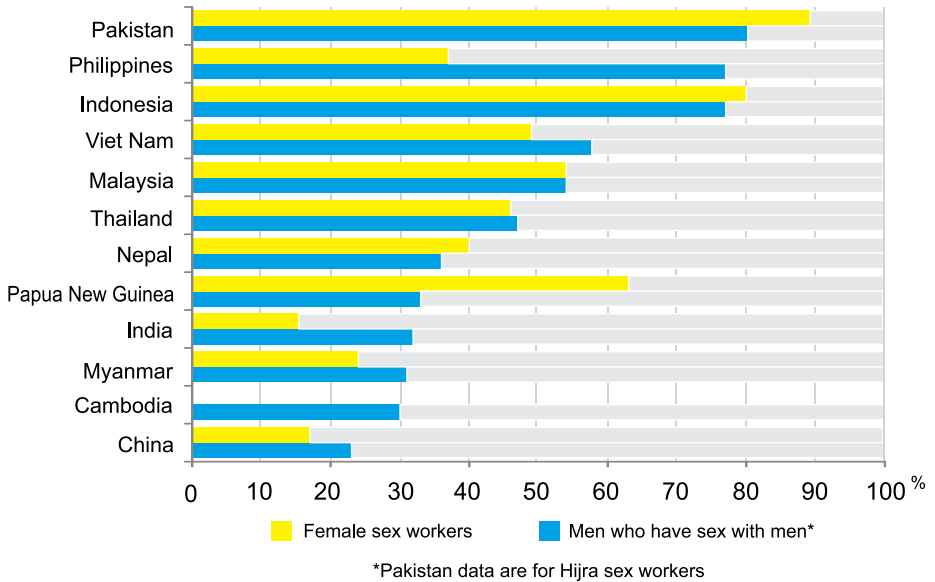
One option is to consider reduction in spending on marginally effective general prevention strategies and to use those savings on focused strategies that can have a bigger impact. Vital low-impact prevention programmes, such as blood safety programmes and HIV awareness campaigns, can be integrated into general health services under the Universal Health Coverage model. Similarly, HIV treatment services can also be incorporated into national Universal Health Coverage schemes, as Philippines and Thailand are doing.

FIGURE 12: HIV prevention spending by category in Asia and the Pacific; latest available year (2009–2012)



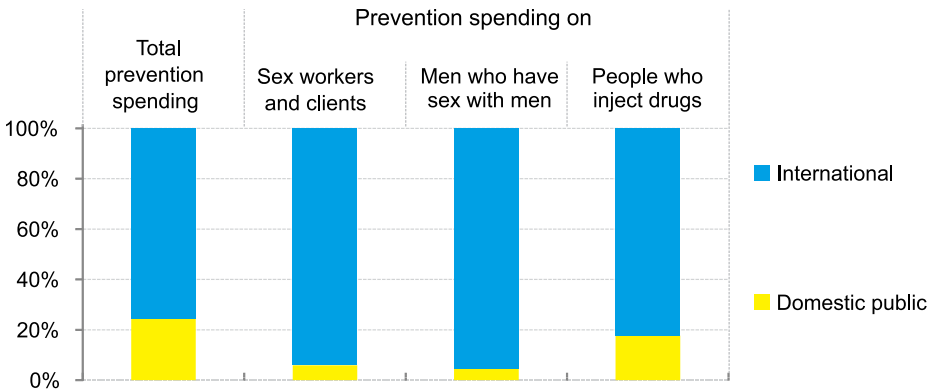
Source: Prepared by www.aidsdatahub.org based on www.aidsinfoonline.org

FIGURE 13: Proportion of surveyed key populations reporting that they did not know where to take an HIV test or that they did not receive condoms in the previous 12 months; Asia and the Pacific (2008–2013)



Source: Prepared by www.aidsdatahub.org based on www.aidsinfoonline.org

FIGURE 14: Distribution of HIV prevention spending for key populations by financing source in Asia and the Pacific; latest available year, 2009–2012



Note: Spending by service category was not available for India and China

Civil society and community organizations are vulnerable

Civil society and community-based organizations active in AIDS responses in the region currently rely heavily on international funding. Most of them are contending both with funding shortfalls and with the prospect (in some cases already a reality) of funding cuts. Funding for HIV-related legal and human rights services, in particular, are insufficient – globally and in Asia and the Pacific, specifically. A 2014 UNAIDS survey found that globally, 59% of the civil society organizations implementing human rights programmes were experiencing funding cuts. Nearly 70% of those organizations were not receiving any domestic funding for their activities.

The dependence on donor funding arises from several factors. Legal provisions sometimes complicate or prevent domestic funding for community-based organizations, as do political misgivings about the need to fund services for stigmatized and marginalized populations. Despite powerful evidence that prevention programmes for key populations have a big impact in cutting new HIV infections, political leaders are not allocating enough resources to these programmes. Key populations continue to be criminalized in many countries and politicians seldom recognize their centrality for ending the AIDS epidemic.

Even when those obstacles are not present, many community-based and nongovernment organizations also struggle to demonstrate their eligibility for funding or to satisfy accountability and reporting requirements. Those and other hindrances have to be removed so that funding for these stakeholders can be prioritized and protected. While these obstacles are removed for receiving domestic funding, a need for international assistance will still remain.

External partners, including the Global Fund, may want to consider adding eligibility criteria for funding that would help ensure that key populations are prioritized in AIDS responses and that community-based prevention and treatment programmes receive assured support. Such arrangements would work best if they were designed to promote greater domestic investment in those programming areas. This could be done by linking such allocations to actual domestic budgetary support for key population programmes, and by making them conditional on stronger government collaboration and support for community-based and nongovernmental activities.

Countries need to devise new arrangements that will prevent key populations from slipping between the cracks as countries shift towards greater reliance on domestic funding.

Institutionalizing community involvement, rather than relying on goodwill alone, can build commitment and trust. Stronger partnerships would address complaints by governments about lack of genuine community engagement (8). Such practical collaboration would also help improve the regulatory environments and shape the practical arrangements that can make HIV services for key populations more accessible and effective. There are several examples of this happening: Government of India has successfully partnered with and financed community organizations to implement over a 1,000 interventions focused around key populations. Cambodia is among the other countries using these partnerships to great effect.

More determined regional-level action is needed

The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) has passed a number of important resolutions encouraging countries to step up their AIDS responses⁵, and there has been similar professed commitment from Member States of the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC). UNESCAP has also highlighted the need to move towards greater shared responsibility across the region with a view to increasing domestic funding for comprehensive HIV responses by establishing transparent management systems to ensure accountability (9).

Both the ASEAN and UNESCAP carry out periodic assessments of follow-up action commitments – such as the January 2015. Asia Pacific Intergovernmental Meeting on HIV/AIDS that UN ESCAP is convening to review progress of UNESCAP resolutions 67/9 and 66/10. In the ASEAN, AIDS is a ‘rolling agenda’ item at the biennial meetings of the ASEAN Health Ministers, while SAARC has begun focusing greater attention on AIDS. Its regional AIDS strategy for 2013–2017, for example, is aligned with the targets set out in the 2011 Political Declaration on HIV/AIDS.⁶

⁵ For example, Resolutions 67/9 and 66/10.

⁶ See www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2011highlevelmeetingonaids/

5.

ON THE HORIZON:

Likely scenarios for the region

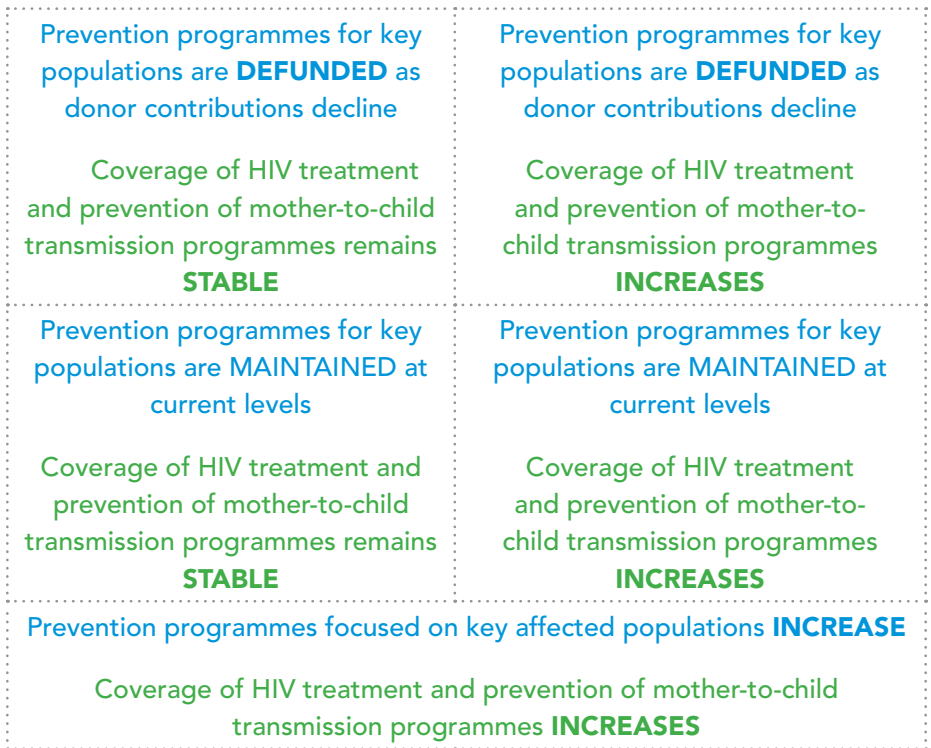
Looking ahead, what lies in store for the region's AIDS response? Drawing on the most reliable available data, the Expert Panel used a mathematical model⁷ to project five potential scenarios of HIV funding in Asia and the Pacific into the future, as shown in Figure 15. The aim was to explore the impact of those scenarios on the progression of the region's AIDS epidemic between 2014 and 2020 and beyond.

The scenarios explored various outlooks for domestic funding (which finance mainly treatment programmes) and donor funding (especially from the Global Fund, and which are currently financing mainly prevention programmes).

⁷ Optima, the mathematical model used for this analysis, is an epidemiological model of HIV transmission and disease progression. It tracks behavioural parameters and intervention activities over time to forecast epidemiological estimates into the future. The scenarios for Asia and the Pacific were modelled by extrapolating HIV-related data from the 12 countries that account for approximately 97% of people living with HIV burden in the region (Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea, the Philippines, Thailand and Viet Nam) to regional demographic, epidemiological and spending estimates. The calibration and results of the Optima model are well within the ranges of uncertainty of the UNAIDS estimates and are closely aligned to the UNAIDS mid-point estimates.

The top-left block in Figure 15 describes the worst-case scenario, with prevention coverage diminishing due to cuts in donor assistance, while ART coverage (funded mainly with domestic resources) remains stable at current levels. The bottom block in Figure 15 describes the best-case scenario, with funding adjustments and increases enabling 80% coverage of prevention services among key populations and 80% treatment coverage overall by 2020. These projections assume various degrees of support and involvement in AIDS programmes, which then influence the progression of the epidemic in various ways.

FIGURE 15: Five scenarios for HIV treatment and prevention funding in Asia and the Pacific



The assumptions regarding donor funding (which mainly affect prevention programmes and which are shown in blue text in Figure 15) envisaged that:

- HIV risk behaviours would **remain stable** in low- and middle-income countries with the biggest HIV burdens if programme funding is sustained (dark-blue text);
- HIV risk behaviours would **increase** in low- and middle-income countries with the biggest HIV burdens if programmes were defunded by 2017 (light-blue text);
- HIV risk behaviours would decrease in low- and middle-income countries with the biggest HIV burdens if programmes received increased funding by 2017 (dark-blue text). In this best-case scenario, coverage of prevention services for key populations would reach 80% by 2020.

The two 'domestic commitment' scenarios (shown in green text in Figure 15) anticipated that:

- Coverage of HIV treatment and prevention of mother-to-child transmission programmes would **increase** as domestic commitment to treatment programmes rises (dark-green text). Treatment coverage would increase to 80% of people living with HIV by 2020.
- Coverage of HIV treatment and prevention of mother-to-child transmission programmes would **stabilize** when domestic commitment to treatment programmes levels off (light-green text). Treatment coverage would remain at the 2014 level.

When the Panel projected various scenarios for HIV treatment and prevention funding into the future, the following outlooks emerged:

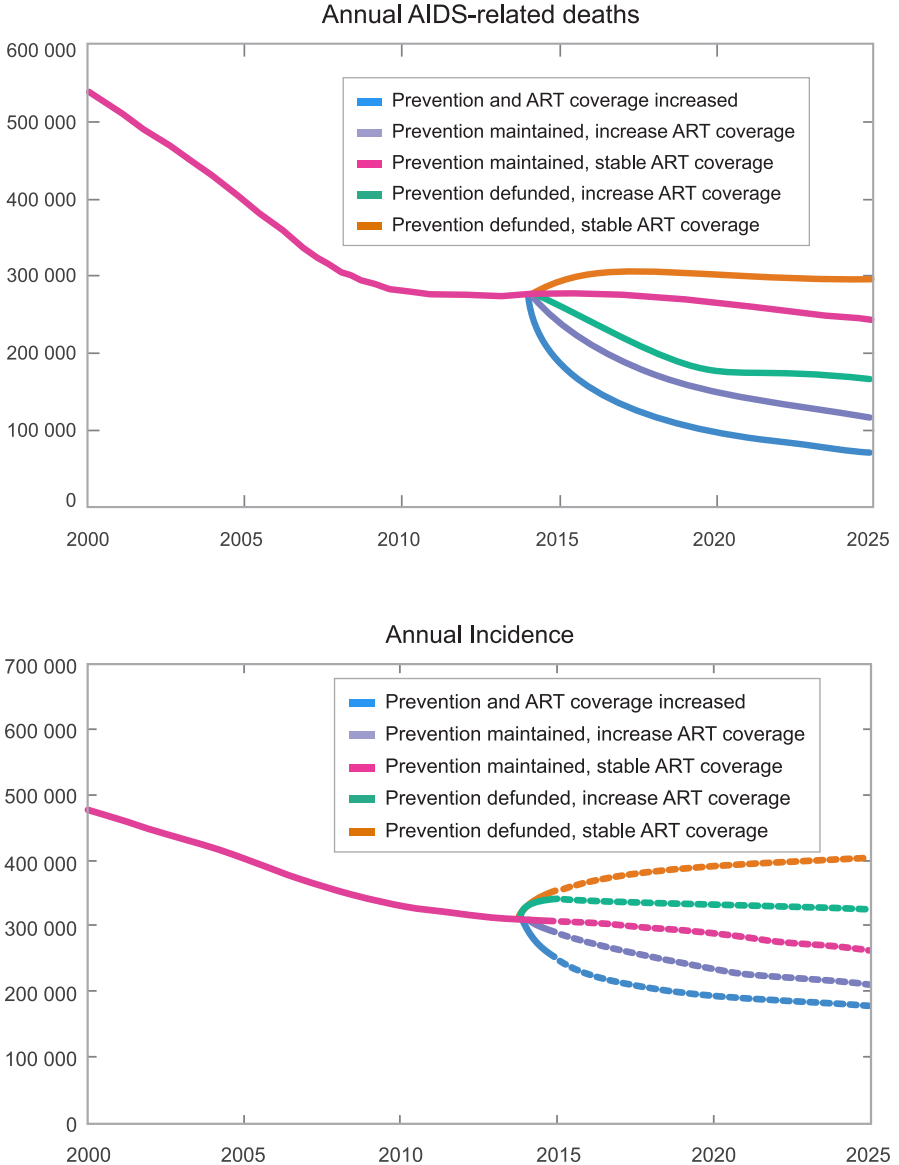
- **The best-case scenario:** both prevention and HIV treatment coverage increases to at least 80% by 2020. This scenario

foresees a steep drop in annual new HIV infections to about 192 000 in 2020 – almost 40% less than if prevention and treatment programmes were maintained at current levels. AIDS-related deaths would decrease to about 98 000 in 2020, a fraction of the 266 000 deaths the region can expect if programmes were kept at current levels.⁸ The blue trend lines in Figure 16 describe this scenario.

- **The worst-case scenario:** prevention coverage diminishes while HIV treatment coverage stays stable. In this scenario, the region experiences a serious resurgent epidemic. Annual new HIV infections increase to about 391 000 in 2020 and then keep growing at a quick pace, along with spiraling costs for providing HIV treatment. The orange trend lines in Figure 16 describe this scenario.
- **The business-as-usual scenario:** both prevention and HIV treatment coverage remain at current levels. In this scenario, the recent declines in new HIV infections and AIDS-related deaths stall, and the momentum built in recent decades is lost. As the total number of people living with HIV keeps increasing, HIV treatment costs rise constantly. The pink trend lines in Figure 16 depict this scenario.

⁸ In the best-case scenario, a slight increase in AIDS-related deaths is forecast after 2020. As more people with HIV survive longer due to expanded access to HIV treatment, a much greater number of people will be living with HIV. The overall death rate per person with HIV will continue to decrease. But due to the larger population of people living with HIV, the number of people dying of AIDS-related causes will eventually increase slightly.

FIGURE 16: Projected annual new HIV Infections and AIDS-related deaths in various response scenarios in Asia and the Pacific up to 2025.



Investing now to increase coverage of high-impact prevention services among key populations leads to another striking outcome: it averts substantial costs of providing HIV treatment over the medium- to long-term. By contrast, avoiding such investments merely postpones huge, ever-increasing costs into the not-very-distant future.

6.

RECOMMENDATIONS:

Charting new routes forward

The AIDS epidemic in Asia and the Pacific is claiming about 250 000 lives and infecting an estimated 350 000 people with HIV annually – and it is growing in several countries. Yet, if the region seizes the available opportunities quickly, it can effectively end its epidemic within less than a generation. Wasting this chance will burden countries with grinding, self-sustaining epidemics for many generations into the future.

Perhaps the single greatest threat is complacency, within both government and the civil society. Since AIDS is not the region's biggest cause of death, there is a real risk of it slipping the attention of key decision makers. That would be a grave mistake. Equally misjudged is the temptation to declare victory on the basis of limited success.

A few countries in the region are leading the way by taking ownership of their AIDS responses, and funding almost all those programmes with domestic resources. Others have increased their domestic investments. Despite this, there is a substantial funding shortfall for AIDS programmes.

The Expert Panel's estimates show that, if funding were allocated to maximize the impact of various prevention and treatment programmes, it would take approximately US\$ 4.0 billion annually (if management costs are included) to increase prevention and treatment coverage to at least 80% by 2020 across the entire region.⁹ At the moment, only US\$2.2 billion is being spent in the region, leaving a funding gap of about US\$1.8 billion annually.

Clearly, more resources are required to meet the rising needs for antiretroviral therapy and to capitalize on its potentially huge prevention impact, besides properly focusing and scaling up prevention efforts for key populations.

There is scope for greater domestic social spending in the region, including on AIDS. In a majority of countries, vibrant economic growth has not translated quickly enough into greater social spending. But the transition to increasingly self-sufficient AIDS responses needs well-considered support from external partners. A decline in international funding without adequate transition strategies will jeopardize the progress already made and will sabotage the prospect of further gains.

The region has to rebalance its sources of AIDS funding while, at the same time, steadily closing the funding gap. It is a big but surmountable challenge. The pay-offs will be major – and not just in relation to the AIDS epidemic.

⁹ The baseline year for the targets is 2012. If limited to prevention and treatment programming costs (i.e. without management costs and other overheads), the annual funding need would be about US\$2.6 billion.

The Panel therefore recommends the following measures:

1. Introduce funding transition plans, supported by bridge funding options

An immediate vital step involves developing 'financial transition plans' to enable countries take advantage of continued donor assistance while shifting to greater domestic investment in the AIDS response.

For middle-income countries, these plans would plot routes toward eventual self-sufficiency; for low-income countries where self-sufficiency is unrealistic, the plans would map a steady increase in domestic funding for AIDS responses.

Multilateral partners should continue to work closely with countries to explore alternative ways of safeguarding AIDS financing. What is needed is a strategy for creating transitional funding models that will keep donor funds flowing to lower-income countries in the short-to-medium term. Those countries would contribute increasingly to their HIV programmes, without having to comply with an impractical proposition that they come up with all the required funding in a short space of time.

It is especially important that transition arrangements should encourage as well as support countries to steadily increase their funding of HIV programmes for key populations – to the point where countries eventually assume that responsibility themselves. One option would be to ring-fence specific amounts for rapidly expanding coverage of programmes among key populations. The timeframes would differ from country to country, but the planning and first steps must start immediately. Prompt action is especially urgent for the lower-middle-income countries that face a swift drop-off in external donor support.

Multilateral partners such as UNAIDS and the World Bank would have to assist countries in developing these transition plans. The funding mechanism should be supported with technical assistance programmes from external partners.

Such transition plans would need to address the current over-reliance on external funding for prevention programmes – especially those servicing key populations. For example, largely biomedical interventions (such as HIV treatment and programmes for preventing mother-to-child transmission of HIV) could be integrated further into general health care systems, with their costs covered by national health budgets. This could release some funding for use in prevention programmes.

External partners have to act in a responsible and accountable manner during these transitions. External funding therefore must be predictable, transparent and aligned with country priorities. Bridge funding arrangements, agreed to by donors and recipients, should buttress the transition plans. This could involve agreement that countries match, in steps, specified percentages of external AIDS programme funding, based on agreed indicators relating to their economic performance epidemic status.

Co-financing arrangements with multilateral organizations would offer countries some breathing space. The GAVI Vaccine Alliance, for example, subsidizes vaccine costs for low- and middle-income countries (depending on their gross national income per capita) which assume responsibility for a fixed portion of the costs (10). The Asian Development Bank also implements co-financing schemes in which one or more donor governments and the Bank jointly finance projects in partnership with a low- or middle-income member country. The latter are then able to finance and sustain large projects, while external partners have not to single-handedly finance those projects.

Key Points

- ➔ Donors and countries in the region should devise alternative ways to safeguard AIDS financing.
- ➔ Transitional funding models are needed to keep donor funds flowing to lower-income countries in the short-to-medium term.
- ➔ Transition plans have to overcome the current over-reliance on external funding for prevention programmes – especially those for key populations.
- ➔ External funding should be predictable, transparent and aligned with country priorities.
- ➔ Phased, co-financing arrangements between multilateral organizations and countries are an attractive option.

2. Develop country 'investment cases' for HIV

HIV 'investment cases' can serve as important templates for designing and costing high-impact, rights-based and sustainable AIDS responses. They involve careful analyses of a country's AIDS epidemic, of the reach, quality and effectiveness of its HIV programmes, and of possible efficiency gains and savings. The aim is to arrive at an HIV strategy that is carefully costed and that can have maximum possible impact.

At the moment, 10 countries in the region are at various stages of developing their 'investment cases'. Thailand has completed its 'investment case', which has triggered a major strategic shift from 'controlling AIDS' to 'ending AIDS by 2030'. Thailand now has a national policy to step up HIV testing and to provide HIV treatment to all people living with HIV, irrespective of their CD cell count. The plan focuses particularly on reaching key

populations in much greater numbers with testing and treatment services. It is based on calculations showing that investing an additional US\$100 million in that manner over the next decade would result in economic benefits of US\$300 million through averted treatment and hospitalization costs. Thailand's 'investment case' also defines an essential package of HIV-related services that have been integrated into the country's path-breaking Universal Health Coverage scheme, and it has shaped the priorities in the Global Fund grant to the country under its New Fund Model.

Myanmar's 'investment case' has set new targets for its national strategic AIDS plan and identified an HIV treatment gap that helped US\$5 million in funding from the Government – the first time that such a substantial domestic allocation has been made in that country. Meanwhile, Indonesia's 'investment case' laid the groundwork for approval of a US\$110 million Phase II Global Fund HIV grant for 2012 to 2015, and pinpointed 30 major urban areas for priority AIDS interventions from 2015 to 2019. Vietnam's 'investment case' led to the Government reversing an earlier decision to reduce the AIDS budget, and instead increasing it by about 50%. The Philippines is close to finalizing its 'investment case', while Bangladesh, Cambodia, Malaysia, Nepal and Pakistan are busy developing theirs.

Key Points

- Countries should use HIV 'investment cases' to take their AIDS responses to new levels.
- 'Investment cases' are valuable templates for designing and costing high-impact, rights-based and sustainable AIDS responses.
- 10 countries in the region are at various stages of developing their 'investment cases'.

3. Focus resources where most infections are occurring

More focused use of resources guided by accurate analysis of the epidemic can have a bigger impact and yield savings. Prevention funding should be targeted where most HIV infections are occurring, rather than on 'hit-and-miss' general prevention efforts.

Doing so requires investing in top-quality strategic information and analysis so that countries can focus and fine-tune their AIDS strategies as effectively as possible. This will enable countries to identify the most effective interventions, pinpoint areas where they should be concentrated and deploy resources accordingly. Thailand, for example, laid the basis for a highly effective response by identifying geographic 'hot spots' and tailoring its AIDS response accordingly (8).¹⁰ The country continues to focus HIV investments in the provinces where need is greatest, and expand HIV prevention services for key populations. It is also adopting the strategic use of antiretroviral medicines, with a focus on the 33 (out of 76) provinces that account for 70% of new HIV infections. India's early decision to identify districts with high HIV prevalence and focus priority prevention efforts there have also helped it reverse its AIDS epidemic.

Similar opportunities exist across the region. For example, it is estimated that over 1 million people with HIV live in only 30 Asian cities; and the epidemic is disproportionately concentrated among various key populations, who tend to be most numerous in cities. Powerful prevention gains there will propel the wider regional AIDS response forward.

The Panel therefore recommends that countries allocate 5% of all domestic HIV funding to collection and analysis of strategic information to improve the evidence-base for decisions to align resources with epidemic needs and implement performance-based funding.

¹⁰ Detailed recommendations for improving strategic information and analysis systems are discussed in the Report of the Commission on AIDS in Asia (2008).

Key Points

- ➔ Prevention funding should go where most HIV infections are occurring, rather than on 'hit-and-miss' general prevention efforts.
- ➔ Countries should consider allocating 5% of domestic HIV funding for collecting and analyzing strategic information.
- ➔ This will enable them to align resources with epidemic needs and implement performance-based funding.

4. Protect funding for civil society

Community-based organizations and networks are the crucial link for reaching key populations with high-quality, trusted HIV services (11, 12). Their involvement has been central to the reversal of the AIDS epidemic in Cambodia, India and Thailand, and they are playing a major role in the ongoing shift towards human rights-based approaches across the region. They also sometimes deliver those services at lower cost than governments do.

Community groups also lay the groundwork for future savings. For example, when people who start antiretroviral therapy fail to adhere to the treatment, this often leads to treatment failure and the need to switch to very expensive second- or even third-line drug combinations. Evidence shows that treatment adherence rises when community-based organizations provide adherence and other support for people receiving HIV drugs.

At the moment, community-based and other civil society organizations face at least two funding challenges. Firstly, they are heavily reliant on external funding. The anticipated drop in that funding puts them and the value they add to AIDS

responses at great risk. One way of avoiding that would be for external partners to apply eligibility rules that safeguard funding for community-based interventions. That would occur as part of an overarching policy that encourages and coaxes governments to strengthen support for civil society initiatives and to engage with them more actively in prevention and treatment activities. Another option would involve multi-year schemes that initially allocate international funding directly to community-based organizations. Once governments put in place the necessary policies and procedures, the funds could be channeled via governments for disbursement to community-based organizations.

Secondly, external funding tends to be erratic and tied to specific activities. Longer-term core funding that would permit organizations to build further capacity and stability is not the norm. Suitable solutions must be found to these challenges. Civil society representatives in the region have called for increased funding for community-based organizations, including dedicated funding for overhead costs. A sensible approach would see transitional funding models incorporate arrangements that safeguard funding for community-based organizations, perhaps through a gradually shifting mix of external and domestic funding.

Key Points

- ➔ Community-based organizations and networks are indispensable for reaching key populations with high-quality, trusted HIV services.
- ➔ These organizations and networks rely heavily on external funding, which tends to be erratic, unstable and tied to specific activities. Secure funding must be arranged and assured for these important groupings.

5. Create an enabling legal environment that supports effective programmes

The ongoing need for strong civil society involvement is underlined by the fact that most countries in the region retain laws, policies and practices that drive key populations underground and away from HIV and other health services. Despite some recent progress, approximately 37 countries are known to criminalize some aspects of sex work, 18 criminalize same-sex behaviour, 11 incarcerate people who inject drugs, in compulsory drug detention centres, and 15 impose the death penalty for drug-related offences.

Countries need to foster legal environments that are more conducive to protecting key populations' right to health and wellbeing. Governments should try to get rid of or reform of laws and practices that block access to critical prevention and treatment services. Where the police cooperate with community workers, condom use tends to increase, and violence as well as HIV infection among sex workers tends to decrease. Where governments allow harm reduction programmes, such as clean needle distribution programmes and safe injection sites, HIV infection rates among people who use drugs drop significantly. A pragmatic approach is needed to make a bigger impact on the epidemic.

The Panel recommends that countries implement the proposals of the Global Commission on HIV and Law for improving the legal environment for AIDS and key populations (13).

Key Points

- ➔ Most countries in the region retain laws, policies and practices that drive key populations away from HIV and other health services.
- ➔ Countries should implement the proposals of the Global Commission on HIV and Law for improving the legal environment for AIDS and key populations.

6. Integrate biomedical interventions into universal health care schemes

Where possible, biomedical HIV interventions should be integrated into existing health and social programmes to make them more accessible, improve efficiency and, where possible, achieve savings. Shifts are underway in several regions, other than Asia and the Pacific, towards integrating and linking HIV services more closely with other health programmes and development sectors – for example, integrating HIV testing and counselling services into existing STI treatment programmes. Studies show that such integration can lead to improved access, coverage and acceptability of HIV services and to greater sustainability of services in the longer term (14). However, in settings where key populations are still subjected to stigma and harassment, and often shun government services, such integration can be challenging. Closer and more trusting working relationships between government service providers and community-based and nongovernmental projects can gradually reduce those barriers.

Some countries have taken the integrating approach a step further by including HIV treatment and care in universal health care schemes to ensure that long-term, sustainable domestic funding is available. Biomedical interventions that should be considered for integration into universal health coverage schemes include: HIV testing and counseling, HIV treatment, antiretroviral drugs for prevention of mother-to-child transmission, post-exposure prophylaxis, pre-exposure prophylaxis and treatment of sexually transmitted infections.

China, Malaysia and Thailand are among the countries which have already incorporated or will soon incorporate HIV treatment into their national universal health insurance schemes. Thailand provides access to free antiretroviral therapy and voluntary HIV counseling and testing as part of its Universal Health Coverage scheme. By 2012, about half of all people living with HIV were receiving HIV treatment and care, chiefly through the Universal Health Insurance scheme. India is preparing to include essential HIV services in the standard benefit package of its Universal Health Insurance scheme, while other countries, including Vietnam and the Philippines are moving towards mandating similar arrangements by law, by 2016, and Indonesia, by 2019. External partners can consider supporting this approach by using aid to augment domestic pooled resources (for example, in providing budget support) rather than funding fragmented projects (14).

At the same time, prevention programmes for key populations and related legal and advocacy- related interventions should continue to receive focused funding as part of national HIV programmes, at least until 2020. Integrating these essential interventions into general health care services would be unwise, due to the deep-rooted stigma and denial of access which key populations typically experience in the public health care system.

Key Points

- ➔ Certain biomedical HIV interventions can be integrated into other health and social programmes to make them more accessible, improve efficiency and achieve savings.
- ➔ Prevention programmes for key populations and related legal and advocacy interventions should keep getting focused funding as part of national HIV programmes, at least until 2020.

7. Develop new financing streams

Governments should consider introducing additional revenue-raising methods, such as a tax or levy, to finance a health promotion fund, with a portion of the revenue earmarked for HIV programmes. This approach can help ensure funding for vital HIV prevention programmes.

In Thailand, for example, the Thai Health Promotion Fund supports a wide range of public health initiatives, including HIV prevention, with funds raised from a 2% additional surcharge on tobacco and alcohol products. In some other regions, a dedicated levy for HIV programmes has been used effectively, for example, in Zimbabwe, where it enabled an estimated 70 000 people to be added to the country's HIV treatment programme in 2012, while levies on mobile phone use have been used in Rwanda and Uganda for the same purpose (15).

Also worth considering is an 'investment' model in which countries mobilize a large amount of multi-year funding, with part of it allocated for annual programming and a remainder invested sensibly to generate an additional income stream.

Key Points

- ➔ Governments can consider additional revenue-raising methods, such as a special tax or levy, to finance a health promotion fund. A portion of the revenue would then be earmarked for HIV programmes.
- ➔ Mobilizing large amounts of multi-year funding at once, and then investing part of it sensibly, could generate additional financing streams.

8. Reduce the costs of HIV drugs and other commodities

HIV treatment costs represent about 42% of AIDS expenditure in Asia and the Pacific, making it the single-largest expense for countries. If savings can be made, it may become possible for countries to achieve ambitious treatment coverage targets without substantially increasing domestic budgets.

Countries need to develop approaches to ensure equitable, reliable and affordable access to HIV medicines and diagnostics. In addition, they can seek savings by enhancing efficiency in service delivery and reducing waste.

Declining prices of antiretroviral regimens are making a major difference. Between 2010 and 2013, first-line regimen prices in the region fell by an average 20–44%, and second-line regimen prices declined by an average 39–45%.¹¹ However, these prices

¹¹ In part, the price reductions have been driven by the wider availability of generic alternatives, including for the few countries in the region that have exploited TRIPS agreement flexibilities and purchased compulsory licenses for antiretroviral drugs.

vary significantly from country to country, and some countries are still purchasing expensive originator second-line antiretroviral regimens, even though more affordable generic versions are available. In addition, WHO-recommended fixed-dose first-line antiretroviral regimens are still more expensive in Asia and the Pacific than in some other regions, which points to possibilities for further price reductions.

Treatment programmes can make further savings by adhering to the latest WHO treatment guidelines and ensuring that they use the simplest drug regimens, the most effective treatment support methods, and economical administration systems. The 2013 WHO antiretroviral guidelines recommend simplifying antiretroviral therapy (ART) delivery by reducing the number of preferred first-line regimens and focusing on regimens that may be used across a range of populations (16). Some countries in Asia and the Pacific are still purchasing an unnecessarily wide range of ARV drugs which can lead to inefficiencies and waste all along the supply chain, from procurement to clinical decision making, treatment adherence and monitoring.

Centralized procurement can achieve major savings. A study in Central America has shown that national-level drug purchases were more expensive than those made through the region's pooled procurement mechanism. Prices differed by as much as three- to ten-fold (17). In the short-term, countries should continue to take advantage of the Global Fund's Procurement Support Services, including the Voluntary Pooled Procurement mechanism. In the medium-to-long term, they should collaborate to develop an autonomous, regional pooled procurement and supply mechanism.

The Pan-American Health Organization's Strategic Fund offers an attractive model. It was created as a reimbursable procurement mechanism to provide technical support to countries, and

negotiate with different international suppliers to obtain low prices and offer alternative supplies to participating members. The Pan-American Health Organization or WHO prequalifies suppliers based on the quality of their products, their prices and their performance history.

Reforming relevant state tender processes may be another cost-saving option in some countries. In recent years, South Africa and Swaziland, for example, managed to free up substantial funding to expand their HIV treatment programmes by reforming their tendering procedures (18).

Key Points

- Equitable, reliable and affordable access to HIV medicines and diagnostics must be protected.
- WHO-recommended fixed-dose first-line antiretroviral regimens are still more expensive in Asia and the Pacific than in some other regions; this means further price reductions are possible.
- Enhancing efficiency in service delivery and reducing waste will yield savings that can be used to expand services.
- Countries can save money by adhering to the latest WHO treatment guidelines and using the simplest drug regimens, the most effective treatment support methods, and economical administration systems.
- Centralized procurement can yield major savings.
- Reforming relevant state tender processes may be another cost-saving option in some countries.
- In the short-term, countries should keep using the Global Fund's Procurement Support Services, including the Voluntary Pooled Procurement mechanism.

9. Ensure reliable future access to affordable HIV drugs

Prices of antiretroviral drugs have continued to decline in recent years, due to greater predictability of demand, economies of scale and increased competition among manufacturers. However, some middle-income countries continue to pay prices much higher than the median prices for antiretroviral regimens (14). Similarly, countries that newly graduate to middle-income status need to anticipate possible difficulties in negotiating affordable prices for HIV medicines, diagnostics and other commodities with producers (that may now regard them strictly as commercial markets rather than as recipients of development assistance) (14).

Patent protection remains a significant factor in the pricing of antiretroviral drugs (especially for new regimens). Highly restrictive patent protections on HIV drugs can delay generic competition and related price reductions. Countries and affected communities need to remain vigilant and act to avoid such outcomes. There are concerns, for example, that the proposed free trade pact among Pacific Rim countries (known as the Trans-Pacific Partnership) and the proposed free trade agreement between India and the European Union might introduce intellectual property and patent restrictions that dramatically extend patent monopolies and prevent or significantly delay generic drugs from entering the market. It is crucial that countries do not relinquish the policy space that enables them to confront their health burdens with effective and affordable strategies (19).

Various ways exist for addressing these barriers. Countries can ensure that patents are awarded only for genuine innovations,

and should avoid provisions in bilateral and multilateral free-trade agreements that may disrupt the future availability of affordable medicines (14).

Countries can use systematic voluntary licensing (for example, the Medicines Patent Pool, as discussed below) (20). They can also use the flexibilities available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and push for their expansion to include compulsory licensing and parallel imports of essential ARV drugs. Compulsory licensing allows for the production, under certain circumstances and mainly for the domestic market, of generic copies of a patented product (21). In reality, though, the compulsory licensing flexibility has seldom been used. Only three countries in Asia and the Pacific have issued compulsory licensing for HIV drugs: Malaysia (2003–2004), Indonesia (2005) and Thailand (2006 & 2007). Globally, there were only 24 verified compulsory licensing episodes in 17 nations between January 1995 and June 2011, 16 of them involving HIV drugs (22). Nevertheless, this potentially powerful tool remains at the disposal of countries and should be used more extensively.

As more countries experience pressure to become fully TRIPS compliant, alternative strategies have been sought to promote wide and affordable access to ARV drugs and other essential medicines.

The Medicines Patent Pool, founded with support from UNITAID in 2010, is one promising option. Using licensing arrangements, this model enables certain drugs and medicines to be manufactured at low cost, with patent holders receiving a fair royalty fee. By holding licences on various patented medicines, the pool speeds up and makes more efficient the production

of generic versions of ARV drugs at a lower cost for poor countries (23).

An imaginative response is needed also to avoid sudden drop-offs in the manufacturing of generic ARV drugs and other essential medicines. There are indications that some generic producers are seeking to shift away from manufacturing first-line antiretroviral drugs by moving higher up the value chain where profit margins are potentially greater; this could compromise drug security. Such shifts in business strategies may threaten affordable access to a range of other essential medicines, as well. Generic medicines are a global public goods, and countries need to pursue ways to secure sustainable supplies of generics in the years ahead. Governments can ensure drug security for public health programmes by promoting the production of essential drugs in the public sector for non-commercial, public use. That would require increasing public sector investment and reviving the pharmaceutical sections in governments.

Key Points

- ➔ Patent protection still affects the pricing of antiretroviral drugs (especially new regimens).
- ➔ Tightened patent restrictions and weakened generic competition might compromise the affordability of HIV treatment, especially with new drugs. Countries need to act to avoid such outcomes.
- ➔ Patents should be awarded only for genuine innovations.
- ➔ Countries should avoid provisions in free-trade agreements that may compromise the future availability of affordable medicines.
- ➔ Systematic voluntary licensing remains an attractive option for manufacturing essential ARV drugs.
- ➔ The Medicines Patent Pool is a promising option for broadening reliable access to affordable medicines.
- ➔ Countries should make greater use of TRIPS flexibilities, supported by intergovernmental bodies such as ASEAN and SAARC. They can push to expand those flexibilities and can use compulsory licensing and parallel imports of ARV drugs to make them more affordable and accessible to poor and vulnerable populations.
- ➔ Governments can safeguard drug security for public health programmes by promoting the production of essential drugs in the public sector for non-commercial, public use.

7.

Conclusion

Asia and the Pacific could become the first region to end AIDS as a public health threat by 2030, if it prepares the groundwork by making the right strategic choices and acting quickly and decisively to achieve an ambitious but necessary set of prevention and treatment targets by 2020.

The region has the ability to mobilize additional resources and high-quality technical support by itself; besides, it has a track record of innovation, a vibrant civil society movement and the capacity to manufacture and supply affordable generic medicines for treatment.

An immediate, vital step is to focus proven prevention programmes on the areas and populations where most HIV infections are occurring. In Asia and the Pacific, that means providing these services to key populations in much greater numbers, by achieving 80% coverage by 2020. Needed simultaneously is a push to expand HIV treatment coverage to 80% of all people living with HIV. At the moment, fewer than 1 in 3 people with HIV are receiving HIV treatment. Achieving the targeted 80% treatment coverage will drastically cut AIDS-related deaths and reduce new HIV infections.

All this is possible only if the region successfully and quickly negotiates a funding transition for its AIDS programmes.

Shifting donor priorities herald a possibly major decline in external assistance. A shift towards greater domestic financing for middle-income countries is inevitable. A range of adjustments and refinements – at regional and national levels – are available for achieving a bigger impact, reducing costs and even making savings as the region takes its AIDS response to the next level.

As the global community finalizes the post-2015 development agenda and decides on achievable goals and targets for 2030, ending AIDS as a public health threat by 2030 assumes tremendous importance. These goals lie within the grasp of Asia and the Pacific – if it takes the right decisions and implements them soon.

The Panel hopes that this report and the recommendations will help reinforce countries' resolve to rise to the challenge and bring about an AIDS-free Asia-Pacific region by 2030.

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Annex:

Members of the Expert Panel

High-Level Panel AIDS Funding Landscape in Asia and the Pacific

Profile of Members



Mr J.V.R. Prasada Rao

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Special Envoy for AIDS in
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J.V.R. Prasada Rao, from India, is the UN Secretary General's Special Envoy for AIDS in Asia Pacific since July 2012. As the Director of India's National AIDS Control Organization from 1997 to 2002 and later as the Permanent Secretary Health in Government of India, he played an instrumental role in implementing a comprehensive and decentralized national AIDS control programme enabling the country towards achieving the Millennium Development Goal 6.

Prasada Rao has served as Commissioner of the Global Commission on HIV and the Law and as Member Secretary of two independent commissions on AIDS in Asia and the Pacific. During his work with the Government of India and with UNAIDS, Mr Rao has always advocated for the empowerment of vulnerable communities and people living with HIV as an essential requirement to achieve an AIDS-free society in Asia and the Pacific.



Prof Roy Chan

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Prof Roy Chan received his undergraduate medical training in Singapore University and went on to specialize in dermato-venereology. He was Director of the National Skin Centre from 2004 to 2014, is the Clinical Director of the Skin Research Institute of Singapore, and Chairman of the Dermatology Residents Advisory Committee. He is also Head of the National STI Control Programme and a Senior Consultant in the Ministry of Health Singapore. He is Adjunct Professor at the Saw Swee Hock School of Public Health National University of Singapore and also at the Duke-NUS Graduate School of Medicine.

Roy is an elected member of the Governing Council of the International AIDS Society, past-Regional Director for Asia and the Pacific of the International Union Against STI, and Past President of the AIDS Society of Asia and the Pacific. He was awarded the QE II Gold Medal by the Royal Society of Public Health in 2009. He founded Action for AIDS in 1988 and is the current President; in 2010 AfA was awarded the Dr Lee Jong-wook Memorial Prize for Public Health from the World Health Organisation for its outstanding contributions in HIV/AIDS education, care and advocacy.



Mr James Gilling

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Mr James Gilling joined AusAID in 2001. Most recently, he was the First Assistant Director General of the Policy and Sector Division and he was responsible for sectoral policy advice across the Agency, including: mining for development, private sector development, rural development, gender equality, governance, environment, climate change, infrastructure, health and education.

Mr Gilling has also served as the First Assistant Director General Pacific Division, where he headed the Indonesia and East Timor branch from 2008 to 2010. His previous work includes being an ODI Fellow at the PNG Department of Agricultural Livestock, principal adviser on aid effectiveness with the Office of Development Effectiveness, consultant economist with Oxford Policy Management in the UK and rural development adviser with DFID.

Dr Osamu Kunii (M.D., M.P.H., Ph.D.) has more than 25 years of experience in global health and development. He is currently the Head of Strategy, Investment and Impact Division (SIID) of The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). He has also served as professor of global health and Deputy Director of the Center of International Collaborative Research at Nagasaki University, Japan.

Dr Kunii worked UNICEF on various programs such as emergency health response, disease control and maternal and child health. Appointed as Deputy Director of Aid Planning Division and special policy advisor in the Ministry of Foreign Affairs of Japan, he also helped develop and implement the government's policy and strategy of official development assistance in the health sector at global level.



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Ms Marin or "Malu" is the Regional Coordinator of the Coalition of Asia-Pacific Regional Networks on HIV and AIDS (7Sisters) in Bangkok, Thailand. 7 Sisters is a coalition of regional networks of key affected populations and communities involved in the HIV response. Its members are APN+, APNSW, CARAM-Asia, ANPUD, APTN and YouthLead. She also concurrently serves as the Focal Point of the Communications and Consultation Facility (hosted by APN+) of the NGO Delegation to the UNAIDS Programme Coordinating Board (PCB).

Previously, Malu was the Executive Director of Action for Health Initiatives (ACHIEVE), Inc., a Philippine-based organization working on issues of migration, health, gender, sexuality and HIV and AIDS. She has 15 years of experience in advocacy, programme development and capacity building on the above issues both at national and regional level. She also has more than 25 years of advocacy work on gender, sexuality and SOGIE issues.



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Dr Shaari Ngadiman is a Senior Public Health Physician with over 28 years of experience at various levels of the public health program in Malaysia. Currently, he is working as the Deputy Director of Disease Control (Communicable Diseases) and the Head of the HIV/STI Program for Malaysia, with over eight years of experience in the Division of Disease Control, Ministry of Health Malaysia.

He has been involved in a wide range of public health issues including HIV/AIDS, other sexually transmitted infections, vector borne diseases, food and water borne diseases, vaccine preventable diseases, public health management and others. He has designed and managed public health and technical assistance programs at the district, state, national and global levels.

Currently, he is the Chair of the ASEAN Task Force on AIDS (ATFOA), an important subsidiary body of the ASEAN.



Mr Shiba Phurailatpam

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Mr Phurailatpam is the director of the Asia Pacific Network of People Living with HIV/AIDS (APN+). Founded in 1994, APN+ has served as a platform for people living with HIV (PLHIV) in the region to come forward as a united voice.

Prior to his work with APN+, Mr Phurailatpam has worked with the UN Development Program and ActionAid International. For several years, he has been engaged as an activist for the rights of PLHIV in India.

Dr Kemal Siregar is a medical doctor, a Master of Public Health, a Philosophical Doctor in Population Research and a Master of Art in Population by training. He is presently serving as Secretary to the National AIDS Commission (NAC), since July 18, 2012, where he made available a National AIDS Strategy and Action Plan, from 2007-2010 and later from 2010-2014. This document has served as a reference for all stakeholders in Indonesia to respond to HIV and AIDS and helped to support management of the AIDS response in Indonesia.



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During his service in the Faculty of Public Health at the University of Indonesia (1988 – 2004), and even previously, he conducted extensive research and study in the field of reproductive health. Various areas of courses he taught have been given to either under-graduate and graduate students or other audiences from different institutions.

Dr Sombat Thanprasertsuk is currently the Medical Physician at Advisory level of the Department of Disease Control (DDC) at the Ministry of Public Health (MOPH), Thailand. Previously he held a position as the National Professional Officer (HIV/AIDS) at WHO in Thailand. During 2002-2007, he served as the Director of Bureau of AIDS, TB and STIs (BATS) at the DDC. Dr Sombat has been recognized for his contribution in the development of HIV/AIDS Surveillance Systems and program on social service network for people affected by HIV/AIDS. In addition, while directing BATS, he was in charge of the ART scaling up program for PHA in Thailand. He also had a lot of experience in managing Cooperative Agreement Projects between Thailand MOPH and US CDC in the area of HIV/AIDS research and program implementation.



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Dr Sombat received Meritorious Honor Award for extended superior performance and extraordinary dedication to duty for the collaboration between Thailand MOPH and US CDC during the period January –December 2002.



Dr David Wilson

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Dr Wilson is the World Bank's first Decision and Delivery Science Global Solutions Leader. He is also the World Bank's Global AIDS Program Director and was previously the Bank's Lead HIV Specialist. His work on HIV/AIDS spans almost 25 years. During his career he has worked as a scientist and program manager in over 50 countries and published approximately 100 scientific papers. His interests lie in HIV epidemiology, HIV prevention science and program evaluation.

He has developed prevention programs that have been recognized as best practice by the World Bank, WHO and DFID, and have been influential in international HIV prevention science. In addition, he has served as technical consultant and adviser to many international agencies, including USAID, DFID, EU, AUSAID, SIDA, NORAD, UNAIDS, UNICEF and WHO.



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Dr Mitchell I. Wolfe, MD, MPH has been with CDC since 1998 and is currently the Director of the U.S. Centers for Disease Control and Prevention (CDC) Thailand Office, as well as the Director of the CDC Global AIDS Program Thailand/Asia Regional Office.

Dr Wolfe was previously Director of CDC Vietnam office. He has also served as a medical epidemiologist and Team Leader, for the Clinical Outcomes Team, Behavioral and Clinical Surveillance Branch, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHSTP) for the largest US HIV cohort clinical surveillance project, the Adult and Adolescent Spectrum of Disease. His special assignments include working with the Bioterrorism Preparedness and Response Branch, supporting CDC's response to the anthrax attacks, participating in the first national, population-based survey of mortality, disability, and mental health in Afghanistan; and leading critical investigations on infectious disease mortality, heat-related mortality, rotavirus vaccine-related intussusceptions in infants, syphilis in prisons, and exposures to heavy metals related to a large forest fire.

