

The Beginning of the End?

Tracking Global Commitments on AIDS



DATA
REPORT

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

Errors and Omissions

This report went to print on 12 November 2012 in preparation for World AIDS Day. The information in this report was, to the best of our knowledge, current up until 12 November 2012. We acknowledge that events that occurred after this point may mean that some of the figures and commitments in this report are out of date.



Princess Adeyeo is a peer-to-peer educator at John F. Kennedy Medical Center. She is HIV-positive, and mother to a healthy HIV free baby boy, Michael, thanks to a PMTCT programme in Monrovia, Liberia. (Photo credit: Morgana Wingard)

Introduction

Following nearly three decades of emergency responses in the fight against the HIV/AIDS pandemic, a new sense of optimism is beginning to take hold across the international development community, rooted in new science suggesting that bold, strategic investments can turn the tide against the disease. HIV/AIDS still represents a major public health burden across the developing world, with more than 34 million people living with HIV and more than five million people newly infected over the past two years alone. Sustained investments have improved access to treatment and care services over the past decade, making headway against this destabilising and destructive disease. **But over the past two years, a number of landmark scientific and field-based studies have signalled that focused interventions, if implemented in combination, have the potential to more effectively prevent the spread of the disease than has ever previously been thought feasible.** These findings include evidence that:

- Treatment with antiretroviral drugs (ARVs) also effectively serves as prevention, reducing the risk of transmission amongst heterosexual couples by as much as 96%;
- Voluntary medical male circumcision is an effective prevention strategy for heterosexual males, reducing the risk of infection by as much as 60%;
- The virtual elimination of mother-to-child HIV transmission is possible due to more effective treatment and care regimens that can reduce the risk of transmission in more than 95% of cases; and
- The use of ARVs as pre-exposure prophylaxis (PrEP) for HIV-negative individuals is a promising prevention strategy for at-risk populations.

Taken together, these biomedical approaches offer a new paradigm for HIV prevention: strategic efforts that are rooted in science, innovation and tailored delivery rather than in older, less effective methods of prevention.

In light of these findings, coupled with the continually declining price of ARVs, many stakeholders are now expressing fresh optimism about the prospects of controlling and ultimately reversing the trajectory of the AIDS pandemic. Respected voices, including those of US Secretary of State Hillary Rodham Clinton and technical experts such as Dr. Anthony Fauci of the National Institute of Allergy and Infectious Diseases, are now highlighting a shift in the fight against AIDS and the promise of delivering on the goal of an “AIDS-free generation”. In June 2011, leaders from around the world gathered to sign a UN political declaration on AIDS that acknowledged these advances and sought to unite collective action around a “shared vision of a world with zero new HIV infections, zero discrimination, and zero AIDS-related deaths”. On World AIDS Day 2011, three current and former US Presidents, alongside Tanzania’s President Kikwete, joined together to speak about this emerging, historic opportunity to finally secure the “beginning of the end of AIDS”. In July 2012, more than 20,000 advocates, scientists and politicians gathered for the International AIDS Conference, focused on “turning the tide [of the pandemic] together” – a theme delivered by many speakers, including new French President François Hollande.

Still, a compelling, scientifically grounded vision is not sufficient to drive action and achieve change. Despite multiple signs of positive intent, there is not

yet a globally endorsed roadmap for achieving the “beginning of the end of AIDS”, and few heads of state have gone on the record to outline what specific steps they will take to contribute toward this vision. As such, there is not yet a sense of shared global responsibility for the achievement of this goal, nor has there been any meaningful effort to determine a division of labour among stakeholders to drive progress on specific targets.

Additionally, the achievement of this vision will require both significant new resources and more efficient use of existing resources. The global economic environment presents a constant challenge, as donor governments continue to face tough budget decisions on global development and health spending. Research from the Kaiser Family Foundation and UNAIDS shows that donor funding for AIDS has remained largely flat over the past two years, levelling off after a decade of significant growth. The Global Fund to Fight AIDS, Tuberculosis and Malaria – one of the main vehicles through which donors can channel funding for AIDS programmes globally – fell short of its resource mobilisation targets for the 2010–2012 period and has undergone a series of difficult but important policy and management reforms in the past year. At the same time, global funding for AIDS continues to compete with other important health and development priorities – each with its own ambitious goals and agendas – for limited national and donor resources. It is encouraging that many African countries that have experienced impressive rates of growth over the past decade have stepped up and taken a greater role in funding AIDS programmes for their own citizens. In fact, for the first time, low- and middle-income

country funding for AIDS now represents more than half of the global funding total. Their efforts have been increasingly bolstered by non-governmental stakeholders, each of which brings unique networks, skills and expertise to bear – another encouraging trend.

Against this backdrop, ONE's new report, "The Beginning of the End? Tracking Global Commitments on AIDS", is an attempt to map the political, fiscal and policy terrains around the global response and efforts towards achieving this goal. The report lays out how ONE defines the beginning of the end of AIDS and outlines progress to date across disease-specific indicators. It then examines the contributions that are being made by a diverse range of global stakeholders. Traditional donors' contributions are highlighted in detail, but the report also includes new analysis of African leadership on AIDS and case studies that highlight some of the unique contributions of emerging economies, the private sector and non-profit organisations (including those in the faith community) in playing their part to make the beginning of the end of AIDS a reality.

We approach World AIDS Day 2012 at a critical point in the fight against HIV/AIDS, and we are reminded of the simple maxim that "actions speak louder than words". The world has made incredible progress in its efforts to understand, prevent and treat this disease over the past three decades. But there is much work to be done. Achieving the beginning of the end of AIDS will not happen unless the global community – not just a handful of donors or countries – steps up together and makes concrete commitments to definitively secure this compelling vision.

“ **I urge the international community to stand up to meet the commitments it has made. I call for a shift from the perception that aid is charity to an understanding that it is our shared responsibility and a smart investment that reaps dividends for all. Together, we must foster a more sustainable response to the HIV epidemic for the sake of our common future.** ”

– UN Secretary-General Ban Ki-moon

Bethwek Nyangweso is alive today thanks to ARVs he received from Mbagathi Hospital in Nairobi. He and his wife were also able to have a healthy HIV-free son thanks to PMTCT treatment. He works with support groups for those who have tested positive for HIV.
(Photo credit: Olivier Asselin)



Executive Summary

After three decades in the fight against AIDS, much progress has been made in controlling the disease and transitioning the global response from one of emergency to one of sustainability. The number of people on treatment in low- and middle-income countries increased from just 300,000 in 2002 to eight million in 2011, while the annual price of antiretroviral drugs (ARVs) has fallen from hundreds of thousands of dollars to just hundreds of dollars. Cases of mother-to-child transmission of HIV have fallen by 24% in only two years, and AIDS deaths have fallen by 24% since they peaked in 2005.

However, the world has made far less headway in preventing new HIV infections. Over the past decade, 2.5 million people or more have become newly infected each year, including 330,000 infants and children in 2011. More than 34 million people are living with HIV globally. Sub-Saharan Africa is still the region with the highest burden of disease, with 23.5 million people infected, and the epidemic is on the rise in Eastern Europe and Central Asia, particularly among marginalised populations.

Thankfully, there is hope. Over the past few years, the combination of AIDS treatment, voluntary medical male circumcision and services to prevent mother-to-child transmission – in addition to other tools – has offered the global community a new paradigm for more effectively preventing new HIV infections. Driven by new scientific findings and tools, a number of leaders from the scientific, political and advocacy communities have for the first time made calls for achieving “the beginning of the end of AIDS” or an “AIDS-free generation”, dramatically raising the stakes and lending credibility to a vision that until

recently was seen as impossible. To underscore these calls, member states at the United Nations have endorsed bold new global AIDS targets, including achieving access to treatment for 15 million people, virtually eliminating mother-to-child transmission and drastically reducing new infections.

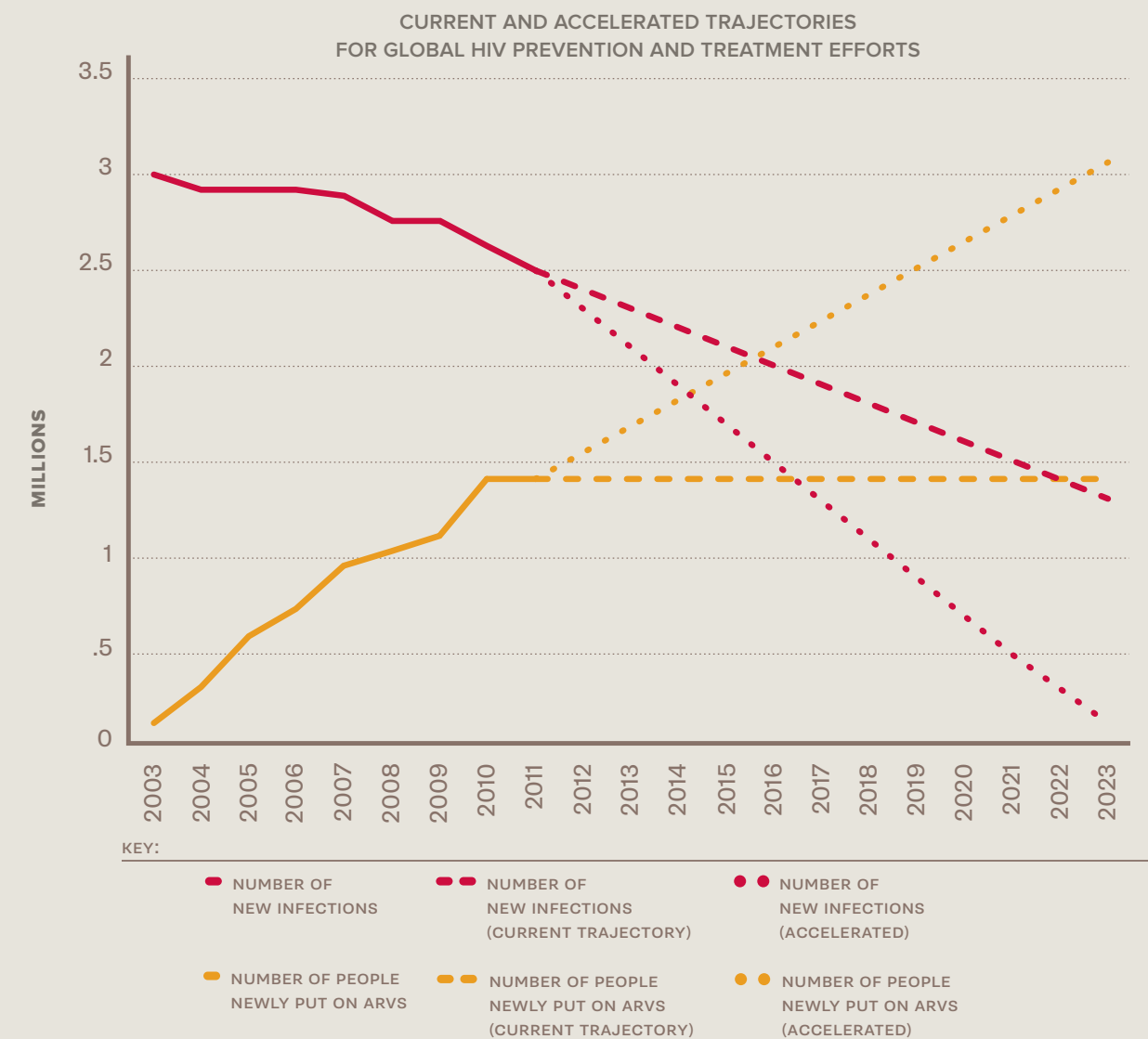
In spite of this momentum, the opportunity to achieve the beginning of the end of AIDS will go unrealised if the status quo is maintained. There is not yet shared global responsibility for achieving this goal, nor have stakeholders mapped out a collective plan for how to achieve the beginning of the end of AIDS with specific responsibilities or time-bound milestones. If the global community is serious about achieving the beginning of the end of AIDS, there must be a renewed effort to examine, improve and scale up the financial, political and programmatic efforts needed to turn vision into action. In “The Beginning of the End? Tracking Global Commitments on AIDS”, ONE monitors progress on improving access to treatment and reducing new HIV infections; provides an assessment of the G7 countries’ and the European Commission’s past and current efforts in the fight against HIV/AIDS globally; and sets a baseline for monitoring future progress towards the beginning of the end of AIDS. This effort cannot succeed with the involvement of just a handful of stakeholders: donors from the West must work in closer partnership with each other and with African governments, emerging economy governments, the private sector and civil society groups to leverage unique skill-sets and resources, all aimed towards the achievement of common targets.

While funding remains one of the largest hurdles in making progress towards this vision – the UN estimates that there is still roughly a \$6 billion annual funding gap for AIDS, at a time of global economic challenges – additional efforts to address the AIDS pandemic cannot come at the expense of financing for other global health and development initiatives. Efforts to improve the coordination, integration and efficiency of health service delivery should be strengthened, as doing so is also crucial for making progress on AIDS and other global health priorities. Without a heightened sense of urgency and without collective action, starting in 2013, the beginning of the end of AIDS will remain a distant ambition, and millions of lives will hang in the balance.

Key Findings

The world is off-track for achieving the beginning of the end of AIDS by 2015

There has been mixed progress to date on the three key disease-specific targets tracked in this report: the virtual elimination of mother-to-child transmission; 15 million people on treatment and a reduction in new adult and adolescent HIV infections – all by 2015.



Significant progress has been made on the prevention of mother-to-child transmission, with growing political momentum coalescing around a Global Plan that focuses on 22 high-burden countries. Nearly all of these countries have now developed costed elimination plans, but a significant scale-up of service delivery is necessary in order to increase the rate of progress to reach the virtual elimination target. Access to treatment is the biggest success story, with the global community having achieved unprecedented rates of scale-up, led by investments made through the US PEPFAR programme and the Global Fund. If current rates of treatment growth can be sustained and moderately scaled up, achieving the target of 15 million people on treatment by 2015 is well within reach. Unfortunately, progress toward the 2015 target of reducing new adolescent and adult HIV infections to 1.1 million is woefully off-track, with more than 2.2 million new infections in 2011.

ONE defines “the beginning of the end of AIDS” as the point in time at which the number of new HIV infections annually is finally surpassed by the number of people newly added to treatment annually. At current rates of progress, the progression curves for these two indicators will not cross until 2022. To achieve the beginning of the end of AIDS by the end of 2015, the global community will need to add 140,000 people to treatment annually in addition to current rates of treatment growth,¹ and will simultaneously need to double rates of progress on the prevention of new HIV infections.

There is huge variance in donors' responses to the AIDS pandemic

While some donors are stepping up to the plate to make the beginning of the end of AIDS a reality, others are lagging behind, and all could do more.

- **The United States** is far out ahead in terms of financial and political leadership on AIDS globally, providing not just the largest amount of funding but also setting bold, measurable targets and delivering robust public support for an “AIDS-free generation”.
- **The United Kingdom** is demonstrating significant leadership on AIDS, and is well positioned to do even more in the coming year. It spends nearly as much (\$13.71 versus \$14.54) in per capita terms as the US and has outlined a specific AIDS strategy with targets, on which it will report in 2013.
- **France** is the second largest donor to the Global Fund, and AIDS remains consistently high on the agenda for its political leaders. It has yet to develop a clear AIDS strategy with measurable targets, but President Hollande’s early public support for the beginning of the end of AIDS is promising.
- **Germany** lags behind in terms of AIDS financing and political support relative to many of its peers, though it has pioneered a number of unique initiatives that support the Global Fund. It has developed a strategy document on AIDS, but that strategy is missing specific targets against which progress will be monitored.
- **Canada** spends far less on AIDS relative to its peers and should scale up both its strategy development and its financing. However, it has

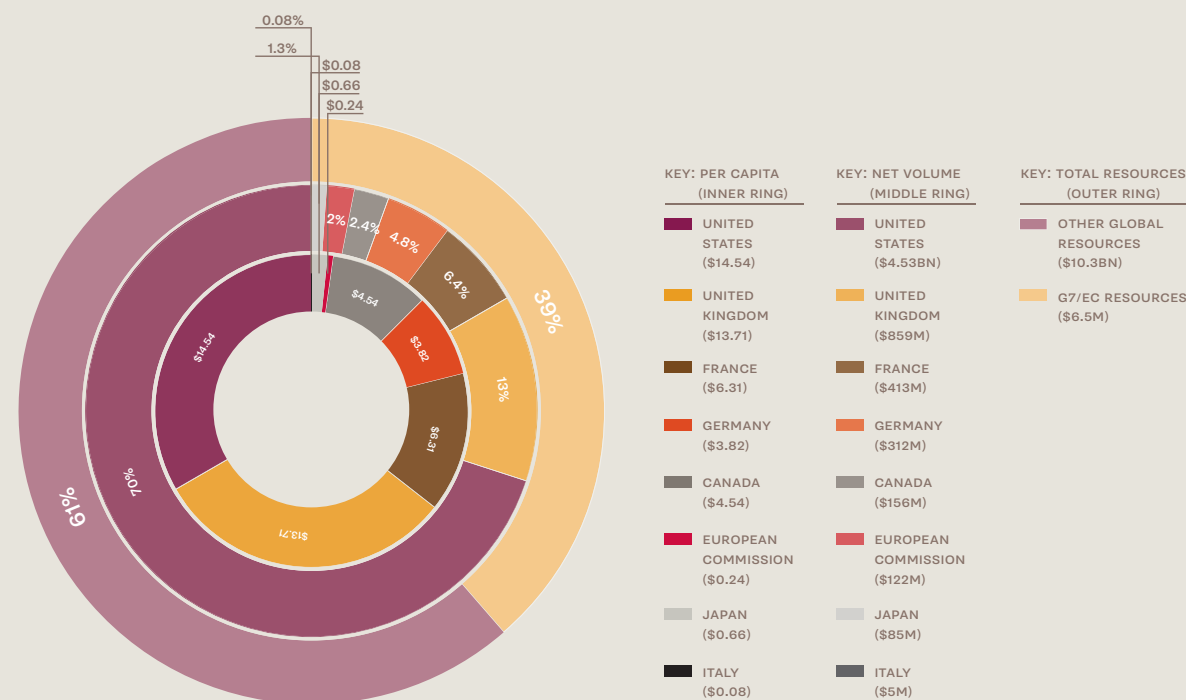
made some meaningful contributions. In particular, it has helped to shape global conversations by defining links between the AIDS and maternal and child health policy agendas.

- **Japan’s** spending on AIDS fell in 2011 as a result of the catastrophic earthquake and tsunami that hit its shores, leading to budget cuts in the immediate aftermath. However, it has recommitted to its financing for the Global Fund in 2012 as a sign of global solidarity, and should look to rebuild its standing as a significant financial and programmatic contributor to the global AIDS response by following through on its commitments by 2013.

• **Italy** is the clear laggard among the countries analysed. It spent just \$5 million on AIDS programmes in 2011, and is the first country to have wholly defaulted on two years’ worth of Global Fund pledges.

• **The European Commission**, managing development assistance on behalf of the 27 Member States of the European Union, provides modest funding to the fight against AIDS relative to its other development priorities. However, it remains challenging to track specific AIDS-related outcomes achieved through these investments.

RELATIVE AIDS SPENDING BY G7 DONORS AND THE EUROPEAN COMMISSION



Financing must be increased from current and new sources and must be spent more efficiently

While efforts to improve the cost-effectiveness of AIDS investments are critical, donors must continue to scale up investments in order to achieve the beginning of the end of AIDS goals. UNAIDS estimates that currently there is roughly a \$6 billion gap in global AIDS financing annually. Additional resources must continue to flow from donor governments, but resources must also increasingly come from recipient countries in Africa and across the global South. The BRICS countries, as well as private sector and non-governmental partners, have an increasing role to play in providing both funding and expertise.

New investments must also be channelled through national strategies and aligned with investment approaches that improve the targeting and cost-efficiency of treatment and prevention resources; doing so will maximise the impact of resources and ensure the strengthening of countries’ health systems. Donors must consistently evaluate their bilateral AIDS spending to ensure that the greatest efficiencies are being achieved, and multilateral mechanisms, including UNITAID and the Global Fund, should look for ways to ensure that their resources are being most effectively targeted to maximise disease-specific outcomes.

The global AIDS response is increasingly shaped by developing and emerging economies and non-governmental actors

The financing dynamics for the AIDS pandemic are shifting. While the past two years have seen

a levelling off of donor funding, low- and middle-income countries are now providing more than half of total financing to fight the global pandemic. Donor and recipient countries alike are now working in closer partnership, defining targets upfront for how resources are spent for maximum impact and efficiency through national health plans.

African governments are meaningfully stepping up their collective contributions to the fight against AIDS through strategy development and financing. Still, there is much room for growth: approximately 90% of African governments for which we have data are still off-track on reaching their Abuja targets to spend 15% of their national budgets on health, which impedes their ability to scale up domestic resources for AIDS and other health priorities.

Non-traditional partners – including leadership from Brazil, India and China, the private sector and the non-governmental community (including faith-based partners) – are each making new contributions to the fight against AIDS, leveraging their unique skill-sets, relationships and expertise to drive progress where traditional donors are perhaps less well equipped.

A global framework is needed to achieve the beginning of the end of AIDS

Scientific tools are now available to help bend the curve of the AIDS epidemic. What remains missing, however, is a global strategy for how to finance and apply those tools – in conjunction with treatment and care efforts already in place – to accelerate global progress towards the beginning of the end of AIDS. Many donors have outlined important individual efforts, but those efforts are not well coordinated with other donors or with recipient nations, leading to both gaps and duplication of efforts. In addition,

although global AIDS targets have been adopted, few donors have outlined what their specific contributions will be toward achieving those targets, leading to a gap in global accountability.

Donors and other stakeholders must come to a global consensus on the imperative of achieving the beginning of the end of AIDS, and should outline specific programmatic and financial shifts that they will undertake to achieve this goal, especially by 2015. In an era of fiscal austerity, these efforts must also include a clear orientation towards maximising results and efficiency gains.

2013 will be a critical test of global commitment

With only three years left to the 2015 goal, 2013 will provide a number of key moments for stakeholders to demonstrate their commitment by following through on or setting new commitments. Most notably, the Global Fund’s fourth replenishment meeting offers donors – both traditional and new – the opportunity to reinvest in the Global Fund’s critical work to fight AIDS, as well as TB and malaria. A strong show of financial support will position the Global Fund to deliver significant results towards the beginning of the end of AIDS and other critical health targets.

Throughout 2013, global leaders will also be meeting to discuss the future of the Millennium Development Goals beyond 2015. As they discuss and debate a potentially new global development framework, they must not lose sight of the importance of finishing the job on the current set of MDGs – including MDG 6, which focuses on AIDS and other infectious diseases. Leaders should ensure that ongoing discussions incorporate efforts to ensure the achievement of bold health targets already agreed to by global stakeholders.

Tracking Progress on Disease-Specific Indicators

Achieving a goal as ambitious as the beginning of the end of AIDS requires extraordinary commitment and follow-through, but it also requires clear indicators, goals and measurable targets that allow for the effective, regular monitoring of progress.

Over the past 30 years, our understanding of the AIDS pandemic and of how the world should best address the crisis has evolved considerably. AIDS used to be a death sentence, with treatment at first unavailable, and then prohibitively expensive. **But by the end of 2011, more than eight million people were on life-saving antiretroviral (ARV) treatment, for the first time accounting for more than half of the global need – and up from just 300,000 in 2002.**¹ While there was once scepticism about Africans being able to adhere to treatment regimens because they “had never seen a clock or a watch”,² access to treatment in sub-Saharan Africa has scaled up even more rapidly, from 50,000 people in 2002 to 6.2 million in 2011.³ Scientific advances have armed implementers with biomedical tools to much more effectively prevent the transmission of HIV, and there has also been tremendous progress in fighting stigmatisation of the virus among infected individuals, their communities and their political leaders. Leaders spanning different political affiliations and from around the world have demonstrated the political and financial will to fight this disease, and a vision is forming of what was perhaps previously unthinkable: the beginning of the end of AIDS within our lifetimes.

Yet translating this vision into reality will require tremendous effort and innovation. More than six million HIV-positive people are still in need of treatment in low- and middle-income countries alone.⁴ More than 2.5 million people are newly infected with HIV each year, of whom 330,000 are infants and children,⁵ **and new HIV infections still outpace the number of people added to treatment annually.**⁶ Funding for AIDS has largely levelled off, and a number of other priorities in health and development are competing for a dwindling pot of global funding. And in spite of all the world’s efforts, **1.7 million men, women and children died from the disease in 2011 alone.**⁷

With these challenges remaining, it is critical to reflect on the progress achieved so far, to acknowledge what has worked well and what has not, and to be realistic about the work yet to be done. Achieving a goal as ambitious as the beginning of the end of AIDS requires extraordinary commitment and follow-through, but it also requires clear indicators, goals and measurable targets that allow for the effective, regular monitoring of progress. This report lays out a timeline for reaching the beginning of the end of AIDS, tracking the

intersection of two critical progression curves to the point in time when the total number of people newly infected with HIV in a given year is equal to, and eventually lower than, the number of HIV-positive people newly receiving ARVs in the same year. At that moment the beginning of the end of AIDS could, for the first time, be in sight.

In the long term, it is crucial to maintain commitments to historic and/or long-term goals, such as universal access to AIDS treatment and the end of AIDS-related deaths. But in order to accelerate immediate progress, ONE sees it as critical that global leaders focus their efforts on three specific targets to begin turning the tide on the disease:

- 1) The virtual elimination of mother-to-child transmission of HIV by 2015;
- 2) Ensuring access to treatment for 15 million HIV-positive individuals by 2015;
- 3) The drastic reduction of new adolescent and adult HIV infections, to approximately 1.1 million annually, by 2015.

Though these goals are ambitious, they are all measurable and achievable. Their achievement, complemented by simultaneous progress made in achieving the other seven targets on AIDS outlined by UNAIDS in 2011,⁸ will together ensure that the two progression curves described above will cross sooner than at current rates of progress. To bend the curve of the AIDS pandemic, however, none of these targets can be achieved in isolation or by only a handful of countries. Only when they are achieved in parallel – through the broad support of donors, African governments, non-governmental organisations and the private sector – will the beginning of the end of the AIDS pandemic be possible. In the following pages, this report offers an assessment of where the world stands on each of these targets, and what more can and should be done to ensure their achievement.

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Target 1:

The virtual elimination of mother-to-child transmission by 2015

Where do we stand?

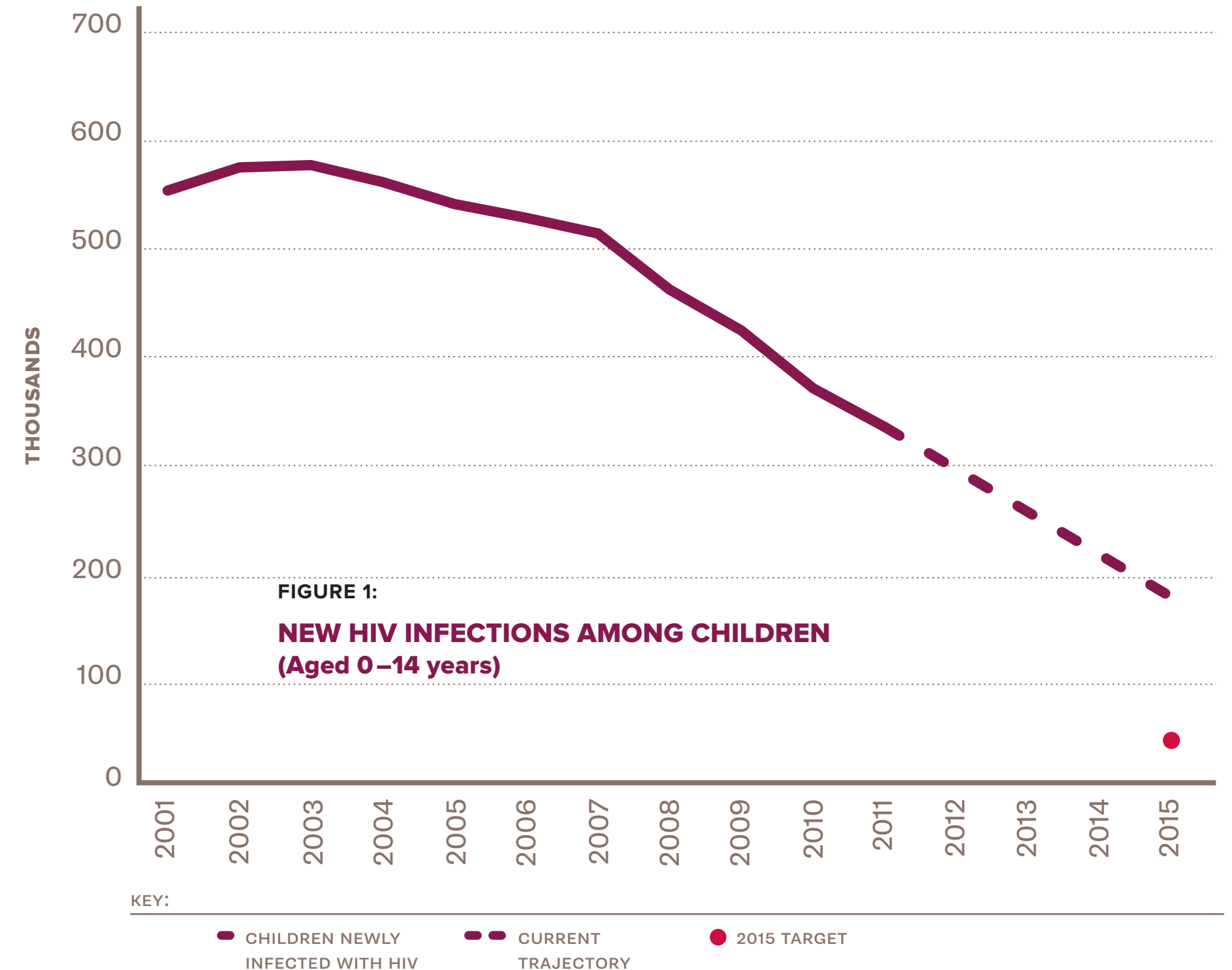
HIV can be transmitted from HIV-positive mothers to their children during pregnancy, labour, delivery or breastfeeding. Without preventative treatment, there is a 20–45% chance that an infant born to an HIV-infected mother will become infected itself.⁹ Of those who do become infected, about half will die before their second birthday without timely treatment.¹⁰ However, the world has made dramatic progress on the prevention of mother-to-child transmission (PMTCT). Such prevention is now possible in more than 95% of cases,¹¹ yet more than 330,000 infants and children were newly infected with HIV in 2011.¹² Some 90% of these cases occurred in 22 high-burden countries¹³ – of which, 35% occurred in South Africa and Nigeria alone.

In June 2011 at the UN High Level Meeting on AIDS, leaders took an important first step to move from a simple agenda of prevention to an aggressive agenda of elimination by launching the “Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive”.¹⁴ The Global Plan identifies a four-prong framework for achieving a 90% reduction from a 2009 baseline in new child infections: (1) preventing HIV among women of reproductive age through reproductive health services; (2) providing appropriate counselling and support to women living with HIV; (3) ensuring HIV testing, counselling and access to treatment for pregnant women living with HIV; and (4) providing care, treatment and support for HIV-positive women and children and their families.¹⁵

Since then, much work has taken place to turn this strategy into concrete progress on the ground,

including the creation of a 16-member Global Steering Group comprised of governments, civil society, private foundations and a number of UN bodies to support developing countries’ efforts to implement the Global Plan.¹⁶ Coordinated by UNAIDS, the World Health Organization (WHO) and UNICEF, and supported by programming bodies including the US President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, an Inter-Agency Task Team (IATT) has been established to monitor and evaluate progress made towards each of the four prongs of the Global Plan.¹⁷ The IATT’s work is particularly critical in helping to support the 22 high-priority countries in the development, coordination, monitoring and evaluation of nationally owned and led PMTCT plans. Critically, the IATT has also outlined global, regional and country-based milestones required to achieve each of the four prongs, along with timelines and indicators to track progress.

In turn, leaders from many of the 22 (predominantly African) high-burden countries have stepped up to articulate PMTCT as a global health priority for their nations, and have demonstrated significant progress already. As of September 2012, 20 of the 22 countries had developed fully costed PMTCT plans. Only India and Angola are outstanding; Angola has a plan that is not yet costed, and India has not yet developed a plan.¹⁸ Although the full costing estimates are not yet publicly available, a 2011 assessment included in the Global Plan estimated that the cost of interventions needed to eliminate mother-to-child transmission in the 22 countries would be roughly \$1 billion annually between 2011 and 2015, with heavy investments



concentrated in a few high-burden countries such as Nigeria and South Africa.¹⁹ The assessment also estimated that approximately \$500 million is already being invested annually towards this end, which means that the financial gap for the 2011–2015 period is roughly \$2.5 billion.²⁰

The efforts of these 22 countries have been supported by the donor community, primarily through a number of bilateral and multilateral funding mechanisms (e.g. the Global Fund, PEPFAR and UNITAID). PEPFAR reached more than 370,000 HIV-positive pregnant women with antiretroviral drugs to prevent mother-to-child transmission in the first half of fiscal year 2012 alone,²¹ and the Global Fund has provided more than 1.5 million women with PMTCT services historically.²² Additionally, UNITAID has contributed more than \$100 million since 2007 to support PMTCT programmes that are integrated with testing, ARV treatment, medicines to cure opportunistic infections and ready-to-use therapeutic foods for mothers and children.²³

As countries take the lead on developing and implementing PMTCT plans, a number of other actors are working diligently to support them through financing, advocacy, communications and technical support. Among them, the Business Leadership Council (BLC) is harnessing private sector resources and expertise;²⁴ the 22 First Ladies of the high-burden countries are working to raise the profile of the issue;²⁵ and a number of regional development banks are considering ways in which they can lend their financial resources and expertise in resource mobilisation in support of effective proposals.²⁶

What more needs to be done?

In spite of this progress and growing attention to the issue, the rate of new HIV infections in infants and children is still not decreasing at a sufficient pace to achieve virtual elimination. This would require a 90% reduction in annual infections by 2015 compared with the baseline year of 2009, which equates to fewer than 43,000 infections per year.²⁷ Last year, however, there were still 330,000 new infections among infants and children.²⁸ At this current trajectory, there will still be 170,000 new child infections annually by 2015, almost four times the global target.²⁹ Additionally, as of 2011, only 57% of the estimated 1.5 million HIV-positive pregnant women in low- and middle-income countries were receiving treatment.³⁰ This figure must rise to 90% by 2015 in order to achieve the virtual elimination goal. So far, only Botswana, South Africa and Swaziland have achieved this target, though Ghana, Namibia, Zambia and Zimbabwe appear to be largely on track towards meeting it by 2015 as well.³¹ Moving forward, to ensure more rapid progress, the global community must:

- **Implement and monitor the PMTCT plans of the 22 high-burden countries:** By developing fully costed and robust country plans, high-burden countries – with the support of donor and technical agencies – have taken a crucial first step in refocusing the political will and national strategies needed to achieve the virtual elimination target. In the coming years, Angola and India must fully cost their plans as well,³² and all high-burden countries must lead in the execution of these plans. At the same time, the Global Steering Group and its IATT must diligently assess what progress has been made and when countries have gone off-track. Donors must continue to prioritise PMTCT as a targeted intervention and contribute the financial resources necessary to fill gaps where they exist.

- **Prioritise more effective treatment regimens:** In the past, single-dose nevirapine was one of the few effective PMTCT options, but it has an efficacy rate of less than 50%. Today, far more effective treatment options are available that can prevent transmission in more than 95% of cases.³³ Single-dose nevirapine is still common in many health systems, is simpler to administer and is significantly less expensive than other treatment options. However, resistance to the drug regimen has grown significantly and the WHO no longer recommends its use. As a result, donors and implementers must work to ensure that dual and triple antiretroviral therapy options³⁴ – and the additional financial resources required for their purchase – are available in health systems around the world, particularly in the 22 high-burden countries.

- **Further study the cost-effectiveness of “Option B+” scale-up for pregnant women:** According to current WHO guidelines, if an HIV-positive pregnant woman presents for PMTCT services but has a CD4 count higher than 350 cells/mm³ (a medical indicator of the severity of HIV infection), she will be given a time-limited treatment regimen to prevent transmission of HIV to her child. After this period, she will not automatically continue on treatment for her own health.³⁵ The Option B+ strategy would instead provide treatment for life for all HIV-positive pregnant women, regardless of their CD4 count. There are significant financial implications tied to this strategy, but the practice may also relieve some burdens on health workers responsible for CD4 count measurements and would provide obvious benefits to HIV-positive women throughout their lifetimes. This includes helping to ensure the prevention of transmission

of HIV for any future pregnancies. In April 2012, the WHO revised its PMTCT guidelines to include Option B+ as one viable strategy in certain settings, and more research should be undertaken to define which environments are suitable for scaling up its usage, including consideration of individual countries’ resource constraints.³⁶

- **Better link PMTCT targets with broader global health priorities and interventions:** The virtual elimination of mother-to-child transmission represents a unique public health goal in that it requires the success of a continuum of programmes and interventions, rather than just a single drug or intervention. As outlined in the Global Plan, broader reproductive and maternal health interventions are critical for ensuring that HIV-positive women can control when they become pregnant and in ensuring that they can stay healthy and raise healthy children. Yet in many public policy discussions and gatherings, the reproductive and maternal health communities are not effectively linked with the AIDS community, and consequently the related implementation challenges and goals are also not effectively linked. Additionally, the goal of elimination will only be achieved through strengthened health systems, in which women can readily access the appropriate testing and counselling and continuum of care for themselves and their babies throughout pregnancy, labour, delivery and breastfeeding. Therefore, the elimination goal cannot be tackled alone. Instead, it must be seen as a critical bellwether for the efficacy of the response to the AIDS pandemic. As such, donors and governments will need to proactively work to further strengthen in-country health systems and health worker training and retention strategies.



Lungile with her HIV-negative daughter, Malwande. Lungile was diagnosed with HIV in 2009 (Swaziland, 2011; Photo credit: Elizabeth Glaser Pediatric AIDS Foundation by James Pursey)

Target 2:

Ensuring access to treatment for 15 million HIV-positive individuals by 2015

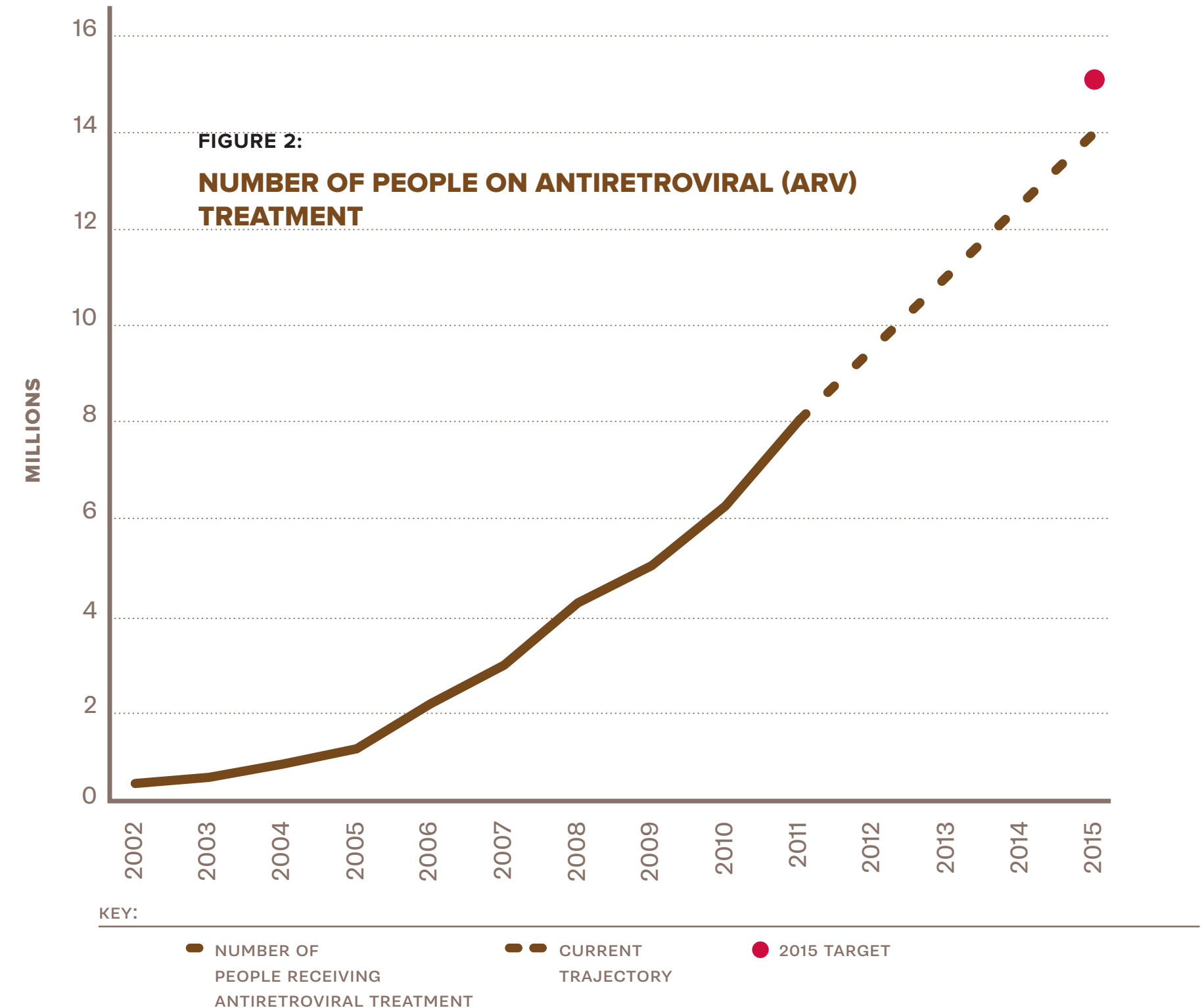
Where do we stand?

Ensuring access to life-saving antiretroviral treatment for HIV-positive individuals – including those in low- and middle-income countries – has been a hallmark of the world’s response to the AIDS pandemic for nearly a decade. Beginning in 2003 with the WHO’s “3 by 5” initiative, which aimed to ensure access to treatment for three million people by 2005,³⁷ world leaders and technical bodies began using explicit, ambitious treatment targets as a way to drive accelerated progress in the fight against AIDS. Although the 3 by 5 initiative did not meet its aim until 2007, it drove political and financial momentum around access to treatment. Moreover, it helped to pave the way in 2006 for a global commitment – delivered through a UN Political Declaration – to ensure universal access to treatment by 2010.³⁸ Once again, this ambitious target was not met, but access to treatment continued to expand rapidly. At the same time, the WHO revised its global guidelines on when HIV-positive individuals should start treatment in resource-limited settings, raising the threshold from a CD4 count of 200 cells/mm³ to 350 cells/mm³.³⁹ In other words, individuals could start receiving treatment earlier, before the effects of the disease had manifested themselves further. In terms of application, this policy decision meant that the total number of people who qualified for treatment rose from roughly 10 million to between 14 and 15 million in 2010.

Though antiretroviral therapy is a comparatively expensive public health intervention relative to many other disease control efforts in the developing world, the dramatic drops in its cost over the past decade have helped to ensure rapid gains in enrolment

for treatment. An annual course of ART therapy once cost thousands of dollars or euros; by 2011, it was being delivered in low-income settings for as little as \$200⁴⁰ to \$335⁴¹ per person annually. The efforts of initiatives including the Clinton Health Access Initiative (CHAI) and UNITAID have helped to identify market inefficiencies, lead negotiations with manufacturers, better estimate demand and ultimately drive down prices significantly. The emergence of new generic drug manufacturers, particularly in India, has also contributed to the fall in prices.⁴²

At the UN High Level Meeting on AIDS in June 2011, donors reaffirmed their long-term commitment to achieving universal access to treatment and made an intermediate commitment to ensuring that 15 million people in low- and middle-income countries receive treatment by 2015 (“15 x 15”).⁴³ Between 2009 and 2010, the number of people on treatment globally grew from 5.2 million to 6.6 million – adding 1.4 million people in just one year. That same pace was maintained between 2010 and 2011, adding another 1.4 million people to treatment, and reaching a total of eight million.⁴⁴ But even if this impressive pace is sustained, there will still only be 13.6 million people on treatment by 2015.⁴⁵ In order to reach 15 million, countries must commit the resources needed to continue accelerating the pace of enrolment, adding roughly 140,000 more people on treatment each year in addition to current rates of scale-up.⁴⁶



What more needs to be done?

Scaling up access to life-saving treatment continues to be a globally endorsed public health, moral and economic imperative. In order to quicken the pace towards reaching the target of 15 million people receiving treatment by 2015 or even sooner, the following steps must be taken:

- **Prepare health systems for a scaled-up pace of initiating treatment:** Governments in affected countries must ensure that their health systems are prepared for an expansion of treatment delivery. Efforts to strengthen systems should include improving access to services, including testing, counselling and care, for more difficult-to-reach populations and geographies; training and retaining additional health-care workers; and better integrating these efforts with other global health programmes already in place. As more and more people infected with HIV are able to access treatment and stay alive, governments and donors should also prepare to gradually transition their national AIDS planning from an emergency response towards one of response to a long-term chronic disease.

- **Drive further price reductions for treatment and explore opportunities to expand African production of antiretroviral drugs:** As noted previously, efforts to dramatically reduce the price of ARVs have been a major factor in facilitating the affordability of existing efforts to scale up treatment. Non-profit initiatives, civil society groups and governments should continue to work with pharmaceutical companies, trade regulations (including the extension of the TRIPS Agreement beyond 2016)⁴⁷ and drug procurement systems to improve drug formulations and maximise efficiency of the production and delivery of treatment, particularly with second-line therapies.

At the same time, recent reports by UNAIDS show that as many as 80% of generic antiretroviral drugs in Africa are purchased solely from manufacturers in India.⁴⁸ While this generic drug procurement has helped to fuel efforts to scale up treatment, it has also left the continent precariously reliant on a single country and associated trade regulations for the medicines needed to keep millions of its citizens alive. To slowly build up Africa's capacity to produce its own ARV therapies and to wean it from near complete reliance on external manufacturers, external actors (including BRIC nations) should consider the viability of new technology transfer programmes, direct financing and trade policy reform as ways to build up Africa's health infrastructure and production capacity over the medium and long terms.



Jacqueline Raganga's job is to conduct home-based HIV counselling and testing outside Kisumu, Nairobi in Kenya (Photo credit: Morgana Wingard)

Target 3:

The drastic reduction of new adolescent and adult HIV infections, to approximately 1.1 million annually by **2015**

Where do we stand?

Although we know how to prevent the transmission of HIV, there were 2.5 million new infections in 2011.⁴⁹ That is the equivalent of more than 6,800 each day. Of this 2.5 million, roughly 2.2 million infections occurred in adults and adolescents, aged 15 and older.⁵⁰ New HIV infections currently outpace the number of individuals newly placed on treatment each year at a ratio of nearly 2:1, further fuelling the epidemic.⁵¹ Even more troubling, new infection rates are continuing to rise in Eastern Europe and Central Asia, particularly among injection drug users and other marginalised populations.⁵²

Some progress has been made at the regional and national levels. Though sub-Saharan Africa still accounts for the largest number of new HIV infections, the rate of new infections amongst adults has dropped by more than 22% since 2001.⁵³ India, a country with a significant HIV burden, halved the number of adults newly infected with HIV between 2000 and 2009.⁵⁴

Still, on the whole, efforts to prevent HIV in adults and adolescents represent a significant failure relative to other efforts in the fight against AIDS, including those to expand access to treatment and prevent paediatric infections. Despite tremendous growth in global resources, the annual number of new adult and adolescent infections has dropped only marginally in the past decade, holding steady at an untenable rate of more than two million new infections each year. In part, efforts to significantly reduce the number of new HIV infections have faltered because “one size fits all” strategies do not match the unique attributes of local or national

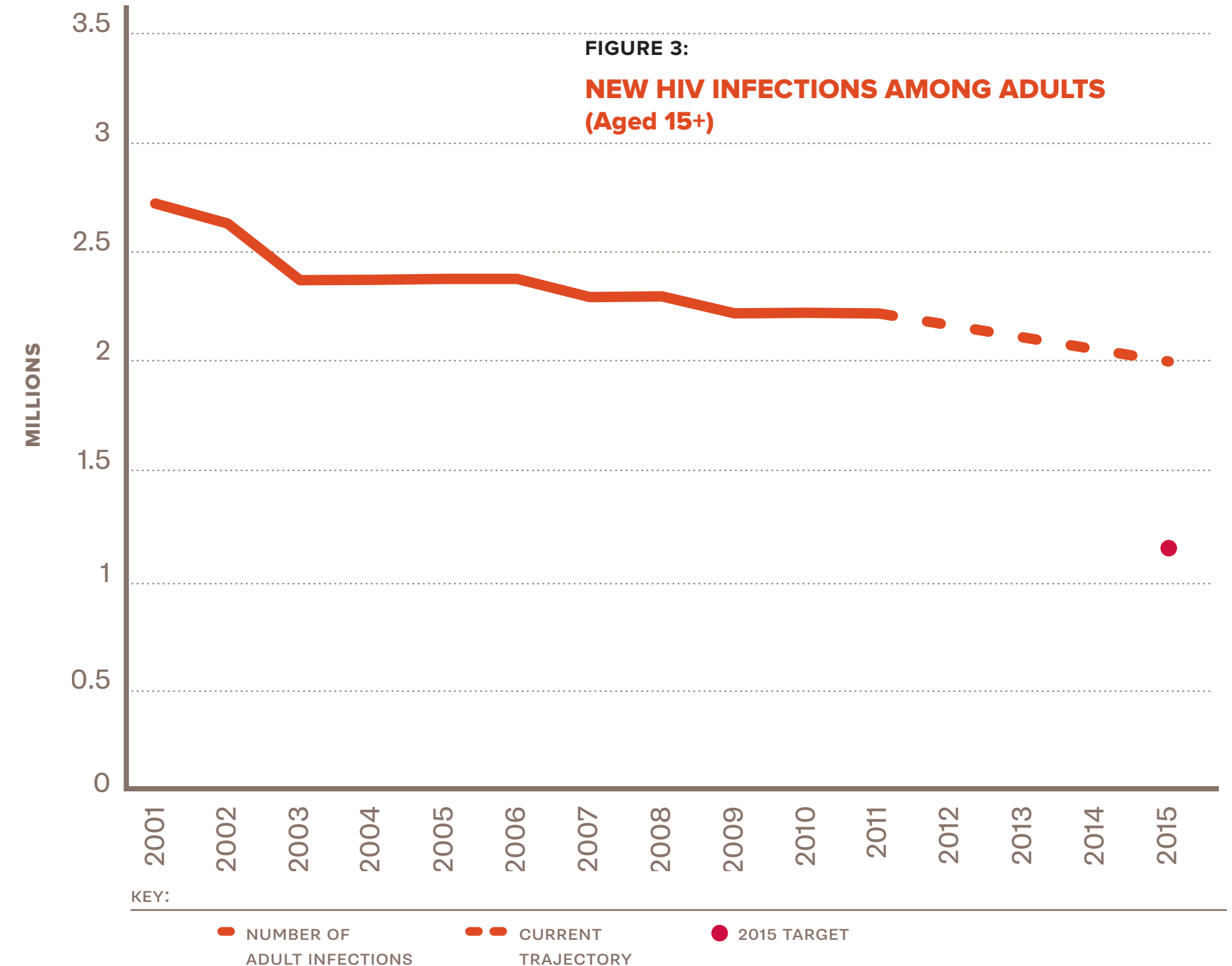
epidemics. A review of the modes of HIV transmission across sub-Saharan Africa quickly demonstrates the diversity of transmission methods across countries, and underscores that a universal prevention strategy for Africa or any other region will not optimise the resources invested and will not produce the dramatic reductions in HIV transmission necessary to achieve the 2015 goal.

Further complicating prevention efforts, many governments and implementers have failed to develop or target appropriate prevention strategies for at-risk groups who are commonly stigmatised, including men who have sex with men (MSM), injection drug users (IDUs) and sex workers. Historically, as a result, many countries – often with donor support – spend the majority of their prevention resources on individuals or demographics who are not the primary drivers of the AIDS epidemic.⁵⁵

Fortunately, in recent years the global health community has gained a new understanding of how new biomedical prevention strategies offer a more promising pathway for future prevention efforts. Researchers have learned from clinical trial data that ARVs can prevent the transmission rates of HIV by as much as 96%,⁵⁶ and that voluntary medical male circumcision can reduce the transmission of HIV to heterosexual men by as much as 60%.⁵⁷ When combined with PMTCT strategies, condom distribution and ongoing behaviour change education programmes, HIV transmission can be significantly reduced in the future through what UNAIDS calls a “prevention revolution”.⁵⁸

FIGURE 3:

NEW HIV INFECTIONS AMONG ADULTS (Aged 15+)



What more needs to be done?

There is no magic bullet for prevention, but there are many existing, cost-effective strategies and technologies that should be implemented in combination to decrease chances of spreading the virus. Additionally, there are a number of new or pipeline technologies that merit continued research and funding for future implementation. Specifically, to make headway in reducing the number of new adolescent and adult HIV infections to approximately 1.1 million annually by 2015, as outlined by UNAIDS (a 50% reduction from the 2010 baseline of 2.23 million),⁵⁹ the following must be done:

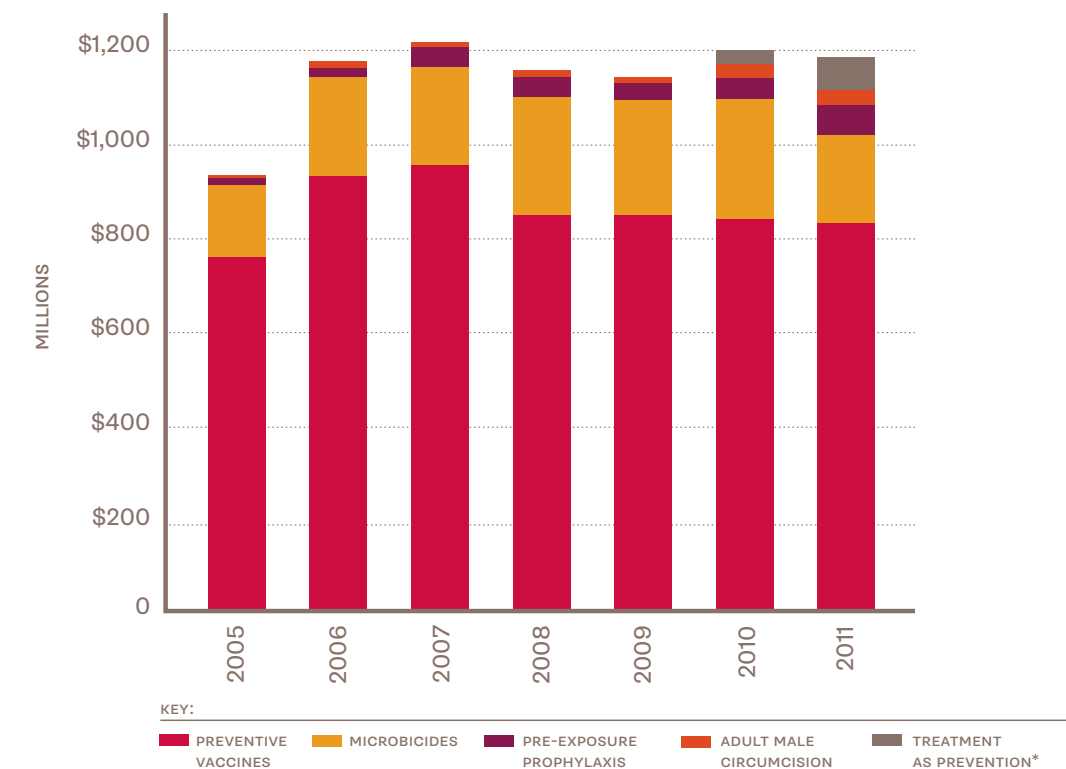
- **Better map the drivers of HIV transmission within key populations, communities, countries and regions:** Promisingly, much of this work is now under way, as countries revisit their own national AIDS plans and, with technical support, re-examine their national and localised epidemics to better map out effective prevention strategies. Many aid mechanisms, including the Global Fund, are also in the process of revisiting their own allocation schemes⁶⁰ and exploring ways to better tailor financial support to reflect the need for more effective combination prevention strategies. These efforts are critical to ensuring that financing for prevention is spent effectively, particularly in a globally resource-constrained environment.

- **Tailor combination prevention strategies to specific epidemics:** Once countries have a better understanding of their own AIDS epidemics, they must be empowered to implement more effective prevention programmes. In particular – and where epidemiologically appropriate – additional emphasis must be made to scale up promising biomedical interventions, such as voluntary medical male circumcision, that are not yet fully implemented in affected communities. The Investment Framework, a policy paper released in 2011 by a team of scientific and modelling experts, outlined one approach for how countries could strategically spend their resources to more effectively prevent new infections and reduce future costs.⁶¹ As of 2012, this approach has spurred useful dialogue and is helping to inform national and local planning processes.
- **Support a robust research and development agenda for new prevention technologies:** At the International AIDS Conference in 2012, Bill Gates noted that “only by having a number of these new tools and, eventually, a vaccine can we really seriously talk about moving towards the end [of AIDS]”.⁶² Indeed, we are so far behind on prevention

efforts that we cannot rest on the promise offered by the current slate of combination prevention tools. Global funding in 2011 for all HIV prevention R&D was roughly flat compared with 2010, down by \$30 million to a total of \$1.27 billion.⁶³ However, it has become more diversified to support a variety of promising interventions, including “treatment as prevention” approaches. Scientists must be supported to continue an aggressive research agenda on HIV, and donors must continue to maintain long-term financial support for the development of future technologies.

Affected countries should also undertake planning through their health ministries and academic institutions to ensure that their regulatory and procurement systems are prepared for the uptake of future new technologies and that their systems are ready to support the piloting and roll-out of new options. A more concerted effort should be made to support academics and researchers in affected countries to study local HIV epidemics and develop new tools, so that they are best equipped to lead ongoing efforts within their own countries.

FIGURE 4:
GLOBAL INVESTMENTS IN HIV PREVENTION R&D, 2005–2011



* The Working Group began tracking funding for treatment as prevention in 2010.

Source: HIV Vaccines and Microbicides Resource Tracking Working Group, “Investing to End the AIDS Epidemic: A New Era for HIV Prevention Research & Development” (2012)

Charting a course towards the beginning of the end of AIDS

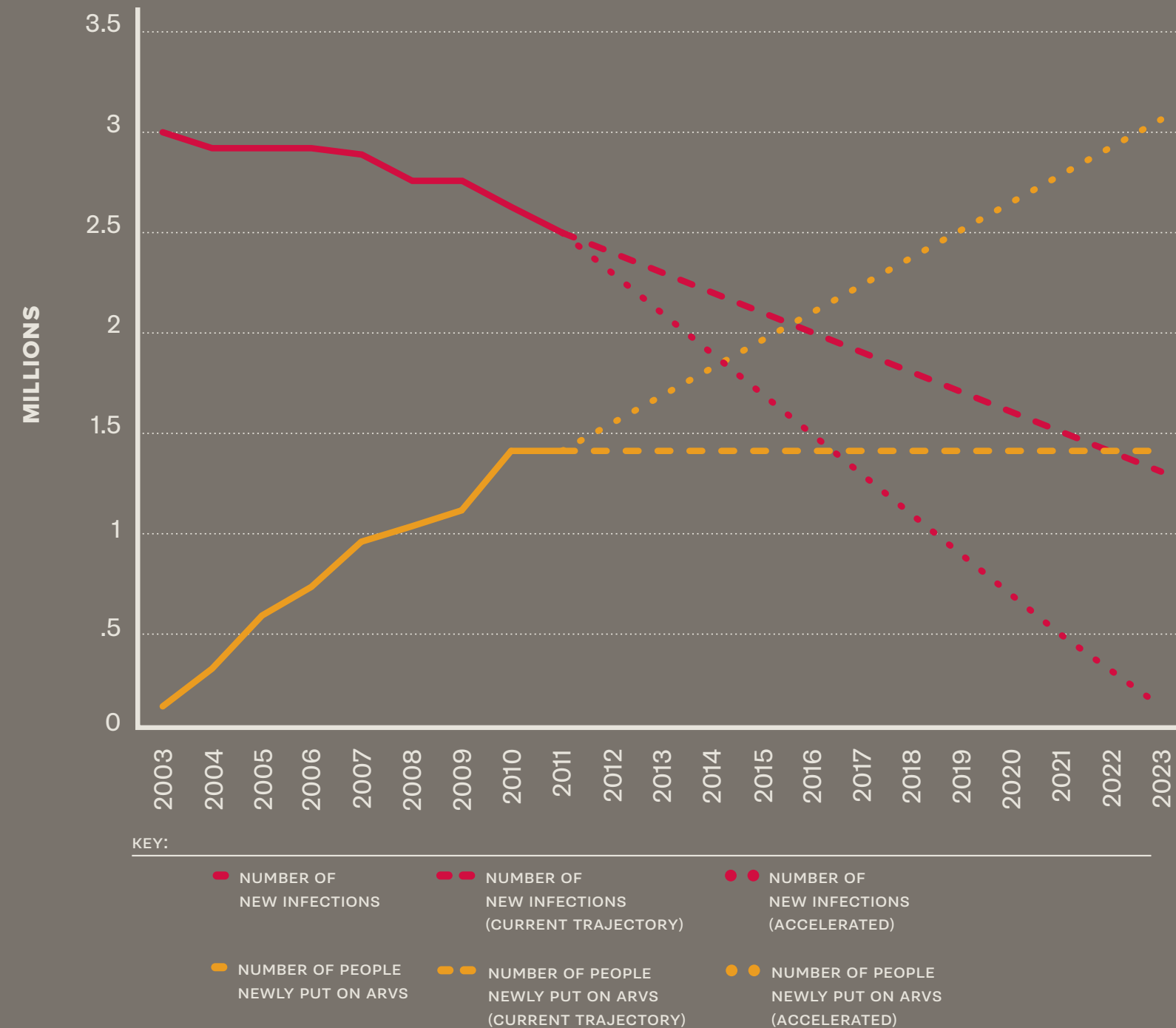
At a critical time in the trajectory of the global fight against AIDS, there is both cause for concern and cause for hope. Efforts to prevent the spread of HIV have been disappointing at best, with the number of new infections remaining stubbornly above 2.5 million or more each year over the past decade. At the same time, new scientific research has armed us with tools to more effectively prevent HIV transmission. We are better equipped to consistently prevent the transmission of HIV from mothers to their infants. And we are achieving unprecedented levels of treatment coverage for people living with AIDS.

In assessing the three interim indicators of progress, it is clear that the trajectories are not yet where they need to be, with some more drastically off-course than others. If the world hopes to achieve these three bold targets by 2015 and to make headway on the recommendations outlined above, it is crucial to determine who will lead in planning and implementation, and who will provide the resources. As many non-governmental voices have pointed out, there is not yet a globally endorsed roadmap that outlines how each of these three targets, and many other supporting goals, will come together as part of a broader course towards securing the beginning of the end of AIDS. Though some academics and scientists have laid out policy or scientific recommendations, global leaders have not come together to articulate a vision for when and how two important progression curves – the number of people added to treatment in a year and the number of people newly infected with HIV in the same year – should intersect. *The outlook in 2012 is disheartening: given the trajectories of these two curves, they will not intersect at current rates of progress until 2022.*⁶⁴

Armed with new tools and with renewed political momentum, the trajectory of these two curves can be accelerated. If we can scale up treatment and prevention for children, adolescents and adults around the world in more efficient and cost-effective ways, we could hasten progress toward the beginning of the end of this pandemic. *If we could double rates of progress in reducing new HIV infections and gradually scale up access to treatment in line with the 15 million by 2015 target, these two curves could cross in 2015.* But this scale-up will not come without a price tag.

UNAIDS has estimated that between \$22 billion and \$24 billion will be needed annually by 2015 to effectively combat the pandemic, including nearly \$7 billion for treatment, care and support; \$1.5 billion for PMTCT programmes; \$3.3 billion for programmes for key higher-risk populations; \$3.4 billion for critical enablers (social and programmatic support for core interventions); and nearly \$6 billion for nurturing synergies with other development sectors.⁶⁵ These figures are nearly \$6–8 billion higher than what is currently being expended by donors and affected countries combined.⁶⁶ However, if these scarce resources are mobilised, an estimated 12.2 million new HIV infections could be averted and 7.4 million AIDS-related deaths would be prevented by 2020.⁶⁷ In the following sections, this report looks in more detail at investments and commitments in the fight against AIDS around the world, assessing which actors have demonstrated the leadership necessary to achieve the beginning of the end of AIDS, which actors are delivering innovative ways to contribute to the fight, and which actors can and should do much more.

FIGURE 5: CURRENT AND ACCELERATED TRAJECTORIES FOR GLOBAL HIV PREVENTION AND TREATMENT EFFORTS



**Tracking Leadership and Commitment
Towards the Beginning of the End of AIDS**

The global response to the AIDS pandemic has changed dramatically since the HIV virus was first discovered.

The global response to the AIDS pandemic has changed dramatically since the HIV virus was first discovered. Following an initial decade of fear and inaction, donors gradually undertook small-scale efforts in the 1990s to combat the disease within their own borders and to examine how best to respond globally. By the early 2000s, there was emerging agreement that more could and should be done, but the vehicles for an intensified global AIDS response were not yet in place. With the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, a number of bilateral AIDS initiatives such as the US President's Emergency Plan for AIDS Relief (PEPFAR) beginning in 2003, and UNITAID in 2006, donors ratcheted up their financing for AIDS, largely defined as "emergency" responses to help stem a crisis. At the same time, many affected governments also began scaling up their own domestic planning and financing for AIDS, though in many cases domestic revenues were limited and were competing with a number of other development priorities. All the while, the scientific community was continually producing new tools to more effectively fight the disease, and implementers and communities in the field learned valuable lessons about what programmes worked well, which ones fared poorly, and why.

Through this consistent evolution, financing for AIDS increased exponentially before levelling off in 2008, and millions of HIV-positive people around the world have gained unprecedented access to medicines and services. Arguably as important, donors, leaders and practitioners are now better equipped to fight the disease in more strategic and cost-effective ways, based on lessons learned from the past decade. Of these many lessons, one message that is clear is that the solution to the AIDS pandemic cannot be found just by securing more money from a handful of wealthy donors. Where the growth of funding was

once seen as the driving factor behind an effective AIDS response, the global community now understands that it is equally important to even more effectively target, track and evaluate interventions on which funding is spent. Where Western donors were once the main financial backers of the global AIDS response, it is now clear that progress cannot be achieved without the participation of affected country governments, including those in Africa, financing a greater share of the response with domestic resources. Where donor efforts to fight AIDS once ran parallel to in-country efforts, both sets of stakeholders are now making concerted efforts to coordinate programming to align with national AIDS strategies. And while traditional donors will continue to play key roles as investors, many other groups from the private and non-profit sectors have also stepped up to demonstrate their own comparative advantages in contributing to the fight.

Acknowledging that today's global AIDS response is now more fluid, dynamic, and multi-sectoral, the following pages assess the specific actions that a variety of stakeholders are taking across three categories – financing, political leadership and programmatic strategy – to drive progress towards the beginning of the end of AIDS. The report takes a detailed look at the records of some of the world's largest donors on each of these fronts, and also showcases innovative efforts under way by African leaders, emerging economies, the private sector and NGOs to tackle this disease together. This analysis will serve as a baseline for annual reports moving forward, with the understanding that governments and implementers alike need to continually modify their individual and collective responses to reflect the changing global landscape and evolving scientific advances.

Acknowledging that today's global AIDS response is now more fluid, dynamic, and multi-sectoral, the following pages assess the specific actions a variety of stakeholders are taking across three categories – financing, political leadership, and programmatic strategy – to drive progress towards the beginning of the end of AIDS.

Defining and Measuring Commitments

This report takes a detailed look at what the world's largest economies (members of the G8¹ plus the European Commission) have contributed to the fight against AIDS so far, based on publicly available data and government-level consultations. Many other donor governments are making financial and programmatic contributions to the fight; notably, Australia, the Netherlands, Sweden, Norway and Denmark each contributed more than \$100 million in funding through bilateral and multilateral channels in 2011.² However, ONE has elected to limit the focus of this year's report to members of the G8 and the EC, where sufficient and comparable data exists; in future years' reports, ONE will look to expand its country coverage and analyses.

To track donors' contributions toward the beginning of the end of AIDS, the following profiles assess donor government efforts based on three key categories:

- 1) **Financing:** how much money has each donor contributed to the fight against AIDS, and how has it channelled those resources?
- 2) **Political leadership:** to what extent have political leaders championed the issue of HIV/AIDS in their national and foreign assistance efforts, and how have they leveraged their political influence to drive accelerated progress?
- 3) **Strategy and programming:** to what extent have governments incorporated scientific breakthroughs from the past three years into their AIDS investments, and to what extent are they ensuring that these investments are aligned with recipient country AIDS and health plans?

Though these three categories are not all-inclusive, together they represent a more nuanced view of a donor country's holistic efforts to contribute to the fight against the disease, recognising that each country faces a multitude of other challenges and priorities, domestically and internationally. More detail on what was specifically tracked and not tracked in each profile can be found in the methodology section at the end of this report.

While financing inevitably remains a critical part of a country's response, this report also highlights the proactive political and programmatic steps that some countries have taken to incorporate new scientific findings, implementation research, and prevention strategies as part of their programmatic investments in AIDS. If donors continue to pour additional resources into outdated treatment and prevention strategies, or if leaders do not embrace the opportunity to make bold new commitments towards the beginning of the end of the AIDS pandemic, then the trajectory of the disease is likely to remain unaltered.

CANADA



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹
\$57.63M

The Global Fund²
\$176.47M

Fraction of Global Fund contribution to AIDS (56%)
\$98.82M

UNITAID³
\$0

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁴

	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$121.42M (6th)		\$3.60 (5th)	0.0086% (5th)
2010	\$134.64M (6th)	+10.89% (3rd)	\$3.95 (4th)	0.0091% (4th)
2011	\$156.45M (5th)	+16.20% (2nd)	\$4.54 (4th)	0.0100% (4th)

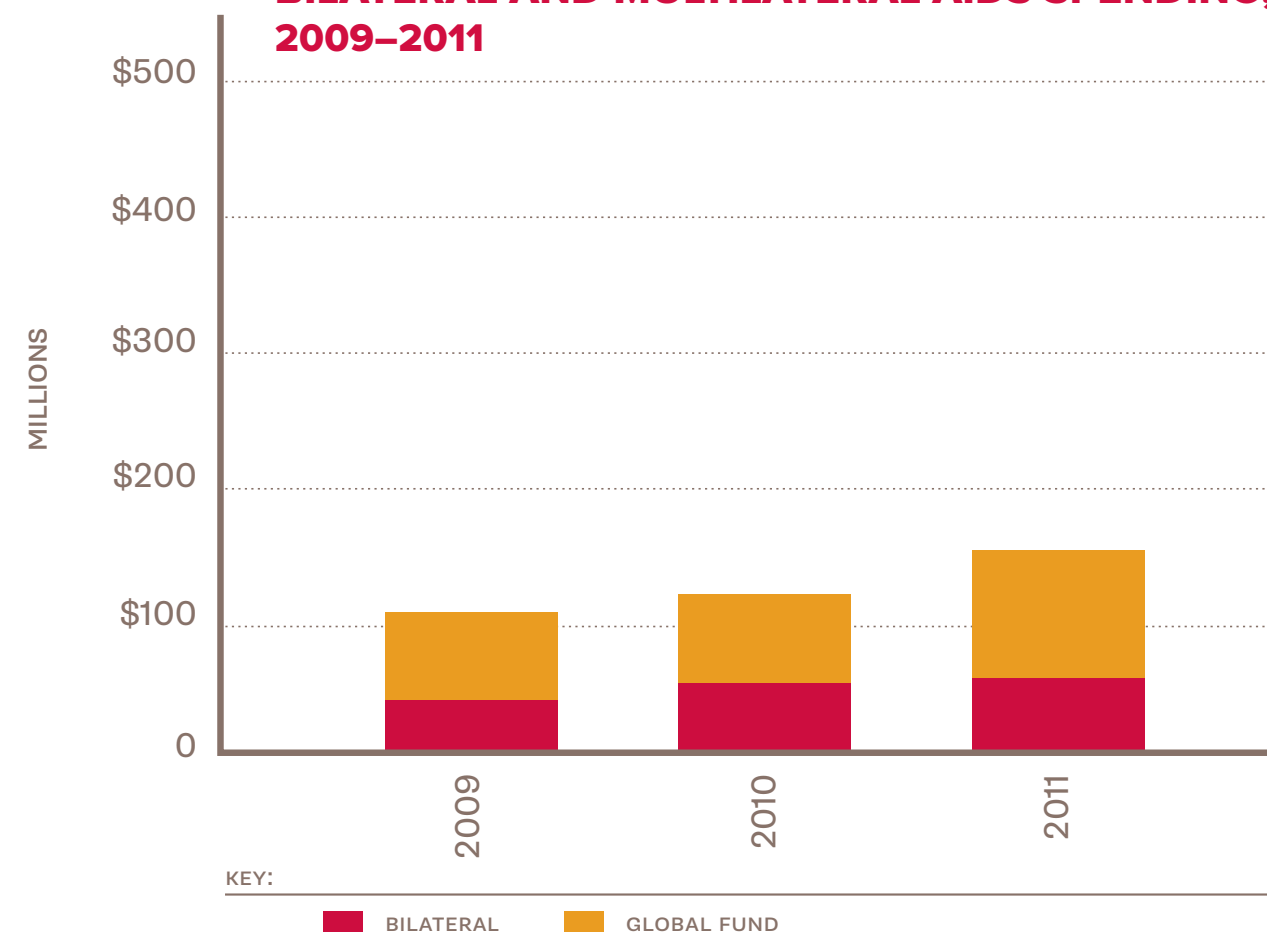
Financial Contributions

Canada is currently the fifth largest AIDS donor among the G7 countries, contributing \$156.45 million in support to developing countries, civil society and multilateral organisations in 2011.⁵ It ranks fourth among the G7 countries in its AIDS spending as a share of gross national income (GNI) and in per capita terms.⁶ At the Global Fund's third replenishment conference in September 2010, Canada announced a pledge of CAD\$540 million (USD\$528 million)⁷ over the 2011-2013 period, an increase of 20% over its previous commitment.⁸ To date, Canada has contributed roughly \$176.47 million to the Global

Fund in 2011 and \$40.55 million thus far in 2012 (and is expected to contribute the full amount by the end of the year).⁹ Its commitment to the Global Fund is the largest that it has ever provided to an international health institution.¹⁰

In addition to its multilateral and civil society contributions, Canada invested \$57.63 million in bilateral programmes in 2011.¹¹ It does not contribute to UNITAID or to other innovative financing mechanisms.

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009-2011



Political Leadership

Canada has historically been a strong supporter of programmes to fight HIV/AIDS. In 2006, it hosted the International AIDS Conference in Toronto, with a theme of "Time to Deliver", and in 2011 it supported the adoption of the UN 2011 Political Declaration on HIV/AIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015. At the 2012 International AIDS Conference, Canadian Health Minister Leona Aglukkaq made reference to the opportunity to achieve the beginning of the end of AIDS in a speech delivered on 25 July 2012.¹²

Canada has focused particularly on increasing universal access and on preventing mother-to-child transmission. At the 2010 G8 summit in Muskoka, President Harper put maternal and child health at the forefront of the agenda and launched the Muskoka Initiative, of which some support goes towards PMTCT interventions. As the co-chair for the Commission on Information and Accountability for Women's and Children's Health, Canada supported the inclusion that one of the 11 indicators be "antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible".

Every two years, Health Canada co-sponsors an International Policy Dialogue on HIV/AIDS, bringing together leading experts from multilateral organisations, science, research, government and civil society to discuss key issues of importance if governments are to slow and reverse the spread of HIV.

Programmatic Efforts

Canada recognises the importance of continuing to situate the HIV/AIDS response within the broader development agenda and the need to integrate HIV/AIDS with other health, development and human rights efforts. While efforts to fight HIV/AIDS are addressed by various agencies, the Canadian government does not have an overarching national strategy for addressing the global HIV/AIDS crisis. Within the Canadian International Development Agency (CIDA), AIDS spending falls under the priority area of “Securing the Future of Children and Youth”, especially related to maternal, newborn and child health programming. CIDA also seeks synergies with other development sectors, with a particular focus on gender equality and health systems, to reduce the burden and stop the spread of HIV/AIDS.

CIDA’s global HIV/AIDS efforts are aligned with the UNAIDS Investment Framework, including eliminating vertical transmission and investing in the prevention and treatment of HIV/AIDS. Canada also supports the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.

CIDA makes efforts to align with the principles of aid effectiveness, placing an emphasis on local country ownership and promoting national leadership in the development of HIV/AIDS policies and strategies, based on locally identified needs and priorities. Canada is committed to keeping results and accountability at the heart of its development efforts. Performance measurement frameworks are developed for CIDA programmes, with performance indicators collected on a regular basis, allowing CIDA to report on a number of HIV-specific outcomes related to individual projects.¹³

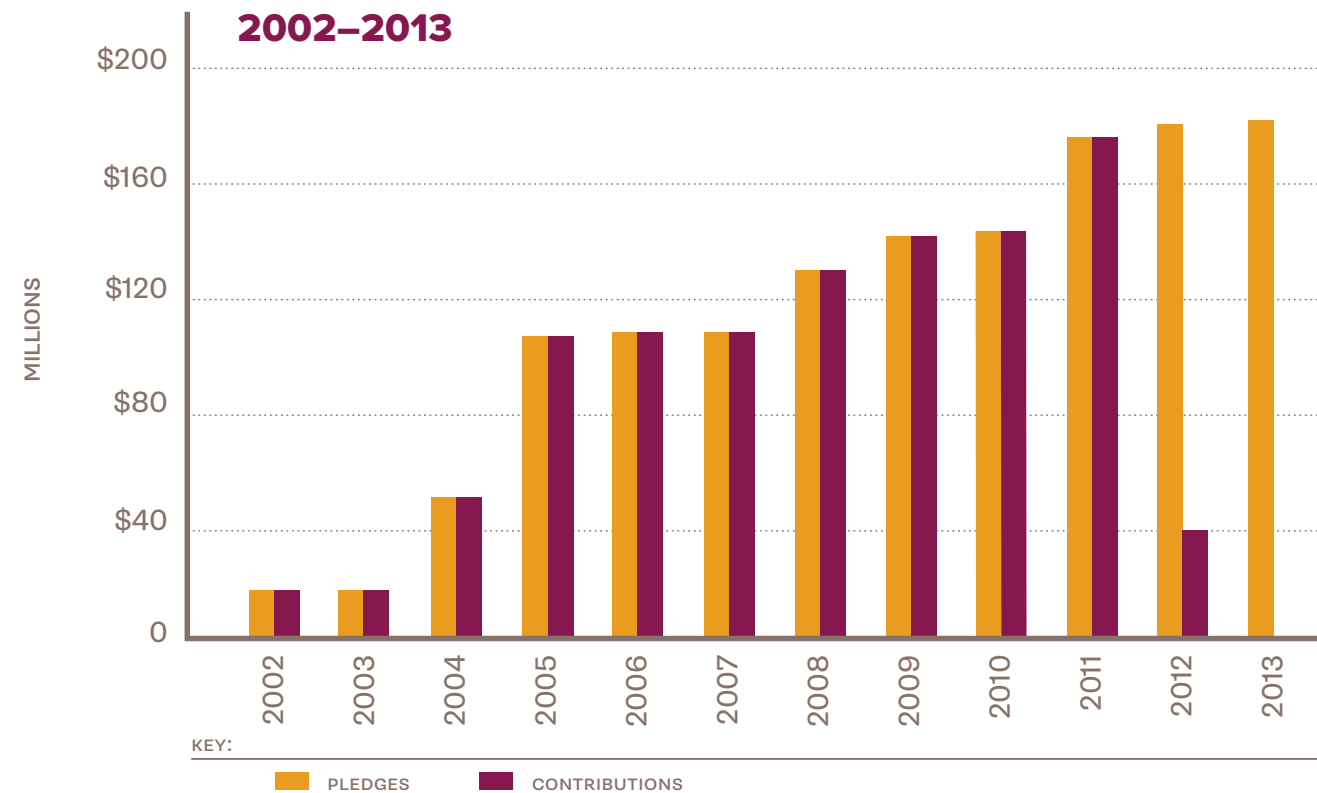
Canada provides policy and technical support to build capacity in developing countries’ health sector responses. In addition, the Global Health Research Initiative—a partnership between three Canadian federal agencies and departments¹⁴—encourages Canadian researchers to collaborate in international activities in low- and middle-income countries.

Looking Ahead

Canada has made important contributions in the global fight against HIV/AIDS, especially related to maternal and child health and research and development of an HIV vaccine. However, with a range of projects spread across numerous federal agencies and global health priorities, it would benefit from developing a single overarching global HIV/AIDS strategy that dictates its investments and projects across all government programmes and departments. This strategy should also lay out ambitious, time-bound goals that Canada wishes to achieve related to the global effort to end AIDS, and should track those targets at the aggregate and project levels. Canada’s increasing focus on transparency, accountability and effectiveness would well support a move in this direction.

Canada has also made increasingly greater investments in the Global Fund, which should be sustained in the next replenishment period in order to strengthen its standing as a global leader.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013

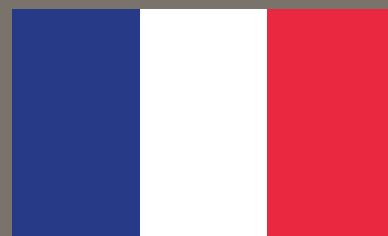


Note: Canada reports its pledges and contributions in Canadian dollars and for an April–March fiscal year, which accounts for some discrepancies between ONE’s report and Canadian reports. Additionally, the Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

“ This year, World AIDS Day is about ‘getting to zero’. For decades, millions suffered with this devastating disease. Today, we see significant progress, which gives new hope to the millions living with HIV/AIDS. Tomorrow, we will get to zero. We must continue fighting for a future with zero new infections, zero new transmissions from mothers to their babies, and zero AIDS-related deaths. ”

— Beverly Oda, Former Minister of International Cooperation, World AIDS Day 2011¹⁵

FRANCE



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$81.27M

The Global Fund²

\$457.41M

Fraction of Global Fund contribution to AIDS (56%)

\$256.15M

UNITAID³

\$144.25M

Fraction of UNITAID contribution to AIDS (52.2%)

\$75.30M

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁴

	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$371.36M (4th)		\$5.74 (3rd)	0.0135% (3rd)
2010	\$388.66M (3rd)	+4.66% (4th)	\$5.97 (3rd)	0.0142% (3rd)
2011	\$412.71M (3rd)	+6.19% (4th)	\$6.31 (3rd)	0.0149% (3rd)

Financial Contributions

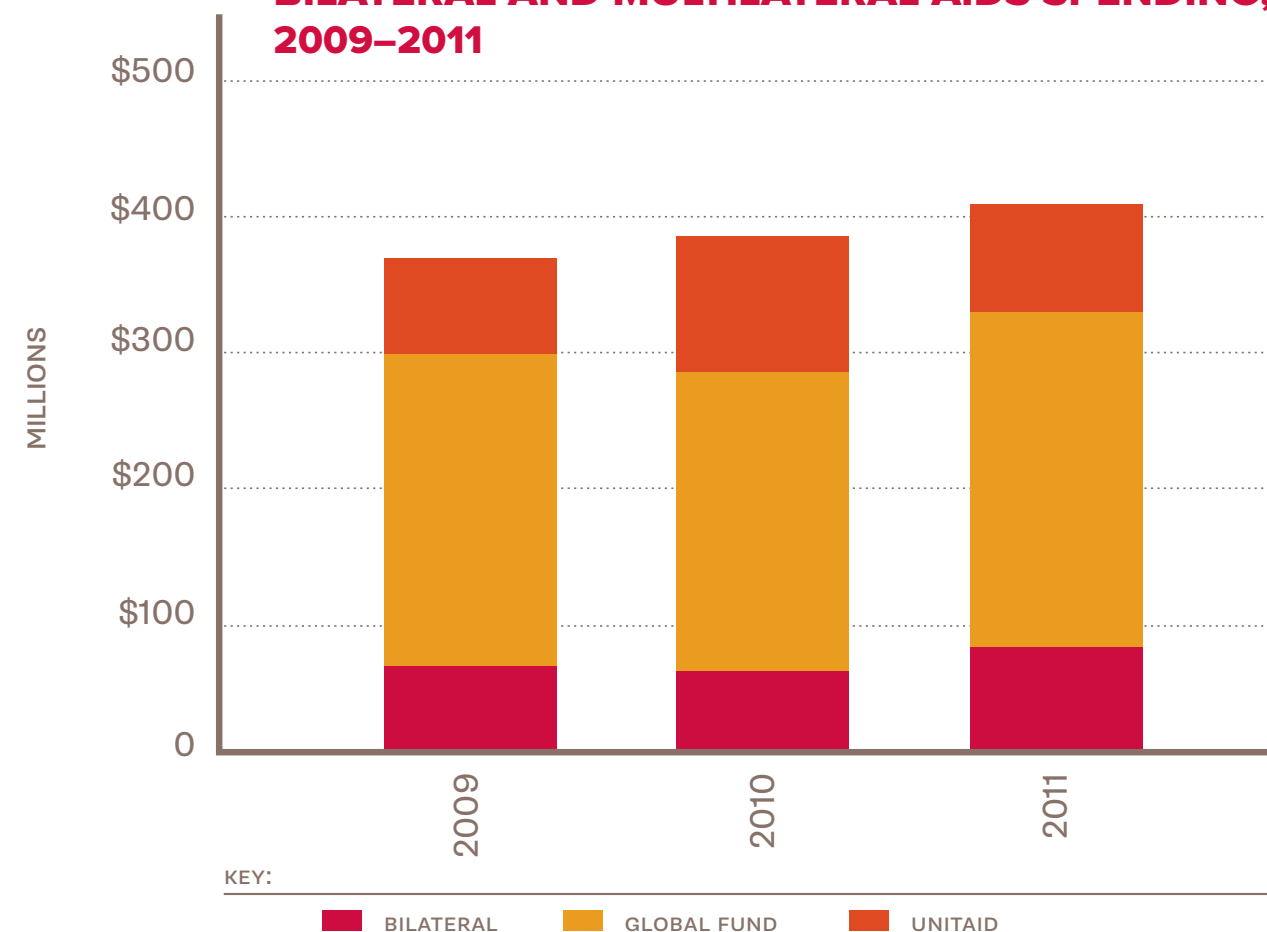
France is the third largest AIDS donor among the G7 countries, contributing roughly \$413 million through multilateral and bilateral channels in 2011.⁵ It also ranks third among the G7 countries in AIDS spending as a share of GNI and in per capita AIDS spending.⁶ At the Global Fund's third replenishment meeting in 2010, France was the second largest donor, pledging roughly €1.08 billion (\$1.48 billion) over the 2011-2013 period.⁷ To date, it has contributed roughly \$457 million to the Global Fund in 2011 and has contributed \$193 million thus far in 2012 (and is expected to contribute the full amount by the end of the year).⁸

In addition to its Global Fund contributions, France allocates a smaller proportion of its resources through its bilateral and innovative funding channels. In 2011, it contributed just over \$81 million through bilateral programmes,⁹ focused on support for two primary channels: seven varied NGO projects across France and the developing world¹⁰ and the

hospital network ESTHER,¹¹ a partnership to facilitate access to care for people infected with HIV/AIDS in developing countries and to foster twinning projects between hospitals that treat AIDS patients.¹²

France has been a leader in innovative financing for AIDS. It is one of the original founders of UNITAID, an innovative financing mechanism focused on improving access to medicines, and it remains its largest funder. Since its establishment, UNITAID has garnered the support of 29 governments and the Bill & Melinda Gates Foundation, which contribute funding through airline levy revenues (roughly 70% of UNITAID's budget) or through direct, multi-year contributions (roughly 30%).¹³ In July 2006, France introduced a levy on passengers departing from French airports, with the tax amount varying by class and flight destination. Between 2006 and 2011, France raised €707 million (\$961 million)¹⁴ in total through the levy, with at least 90% of the proceeds committed

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009-2011



to UNITAID.¹⁵ In 2011 alone, it contributed more than \$144 million to UNITAID in total through the levy.¹⁶

In February 2012, the French parliament passed legislation paving the way for a Financial Transactions Tax (FTT), which went into effect in August 2012. Ten percent of the revenues, estimated at €1.6 billion (\$2.1 billion)¹⁷ in total for a full fiscal year, will be earmarked for development and the fight against AIDS, although as of October 2012 it was not clear how much will go directly to AIDS programmes or through what channel(s).¹⁸

Political Leadership

The global fight against AIDS has historically been a key foreign policy issue for French political leadership, and that prioritisation has been sustained by the new government led by President François Hollande that came into power in June 2012. President Hollande has publicly reiterated France's support for the fight against AIDS several times since taking office, including in a message delivered to the International Aids Conference in July 2012, in which he specifically cited the opportunity to end the AIDS pandemic.¹⁹ The government has also taken concrete actions to establish AIDS as a funding priority, most critically through a decision to allocate parts of the newly established FTT to global AIDS programmes.²⁰

France has formally endorsed the UN 2011 Political Declaration on HIV/AIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015.²¹

Programmatic Efforts

In the past ten years, France has undertaken a significant shift in its global health policy, from bilateral to multilateral aid.²² The vast majority of French support for the fight against AIDS is now channelled multilaterally through UNITAID and the Global Fund. The shift was motivated by France's political will to show international leadership on AIDS, by a desire to leverage other countries' contributions, and in recognition that multilateral channels would be more effective in efforts such as negotiating lower prices for treatment. As such, the primary outcomes of France's spending on AIDS are dependent on the policies, strategies and efficacy of these multilateral bodies. The AIDS chapter in France's sectoral strategy states that it closely links the fight against AIDS to human rights: fighting against stigma and discrimination, allowing for universal health access, targeting protection for populations at risk and protecting young girls against sexual exploitation and rape.

France's bilateral initiatives do not outline specific, time-bound outcome targets, but their aims – including behaviour change programmes and targeting vulnerable populations – are generally aligned with portions of the UNAIDS Investment Framework.

France has developed a national AIDS strategy that covers the 2010–2014 period, to address HIV/AIDS domestically; this has been developed in consultation with civil society and is publicly available online.²³

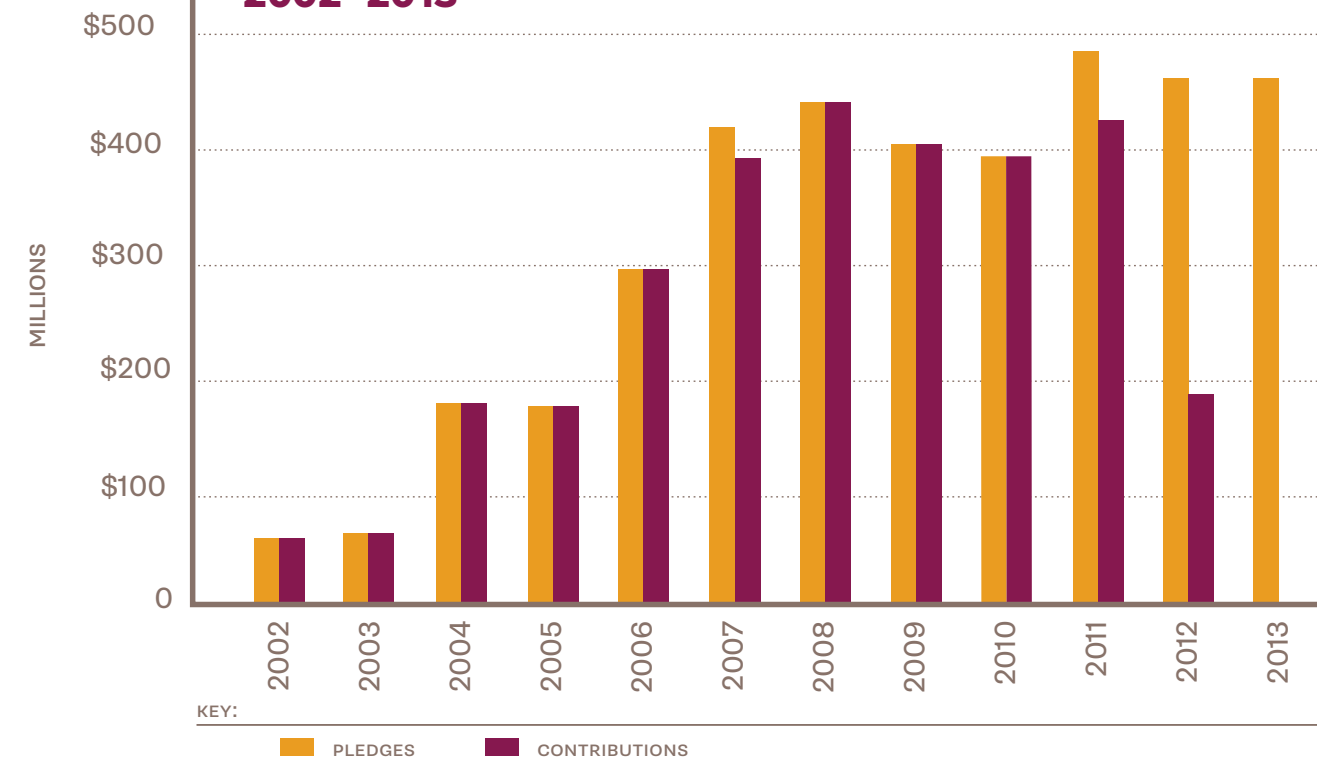
Looking Ahead

The Hollande government should look to sustain and build on France's historic focus and leadership on AIDS. It has taken an important first step by working to ensure that 10% of the FTT will be allocated for development, and the administration should leverage its political power to ensure that other governments which are considering implementing a similar tax also carve out a share of proceeds for development and global health priorities, especially those countries engaged in establishing a European FTT. France's pledge to the Global Fund should also be maintained in the next replenishment period for 2014–2016, commensurate with its renewed support for the mechanism following a year of leadership and programmatic changes at the Secretariat level.

France maintains strong political and diplomatic ties with Francophone African nations. In those countries with concentrated AIDS burdens or with specific challenges (i.e. the 22 high-burden mother-to-child transmission countries),²⁴ France should work alongside African leaders to not only increase donor commitments but also to encourage increased financial and programmatic commitments from African governments.

While the majority of France's aid is channelled multilaterally, it should take steps to measure the outcomes of its spending – both bilaterally and multilaterally – and set new, ambitious, time-bound targets for the next few years. In doing so, it can better assess its leadership and contribution to helping achieve the beginning of the end of AIDS.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



KEY:

PLEDGES CONTRIBUTIONS

Note: The Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. Normally the French contribution is paid in two instalments, with a second due in December. The contributed amount is likely to increase by the end of 2012.

“ In a context which I know to be difficult economically and financially, the commitment of governments and donors [to the fight against AIDS] is essential. But it is with young people that we will win this battle. They are the primary victims of the disease. It is with them that we will raise the hope of pushing the disease back... It is now up to us to end the AIDS epidemic. If we so decide, we can do it! ”

— President François Hollande at the International AIDS Conference 2012²⁵

GERMANY



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s) ¹

\$150.78M

The Global Fund ²

\$273.11M

Fraction of Global Fund contribution to AIDS (56%)

\$152.94M

Debt2Health ³

\$20.04M

Fraction of Debt2Health contribution to AIDS ⁴

\$8.53M

UNITAID ⁵

\$0

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7) ⁶

	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$389.40M (3rd)		\$4.75 (4th)	0.0112% (4th)
2010	\$310.33M (4th)	-20.31% (7th)	\$3.79 (5th)	0.0088% (5th)
2011	\$312.26M (4th)	+0.62% (5th)	\$3.82 (5th)	0.0087% (5th)

Financial Contributions

Germany is the fourth largest AIDS donor among the G7 countries, contributing more than \$312 million through multilateral, bilateral and innovative funding channels in 2011. ⁷ It ranks fifth among the G7 countries in its AIDS spending in per capita terms and as a share of GNI. ⁸ At the Global Fund's third replenishment meeting in September 2010, Germany pledged €600 million (\$822 million) over the 2011-2013 period. ⁹ Since then, it has contributed \$273.11 million to the Global Fund in 2011 and, thus far, has contributed \$129.16 million in 2012 (and is expected to contribute the full amount by the end of the year). ¹⁰

In addition to its Global Fund contributions, Germany contributes bilateral and innovative financing resources for AIDS. In 2011, it contributed nearly \$151 million to bilateral programmes commissioned by the Federal Ministry For Economic Cooperation and Development (Bundesministerium für Wirtschaftliche Zusammenarbeit, or BMZ). ¹¹ Germany has agreements on the priority area of "Health, Family Planning and HIV" with 15 partner countries and two

regions, and provides funding for health programmes in 23 additional countries. Southern and East Africa are particular regions of focus. ¹² These programmes are guided by a set of principles that include promoting human rights; strengthening health systems; delivering effective and efficient prevention; understanding HIV as a multi-sectoral challenge; and optimising linkages.

Germany does not contribute to UNITAID, but it did help pioneer an innovative financing effort through the Global Fund called Debt2Health. ¹³ Debt2Health facilitates an agreement in which a creditor (generally a donor country) can forego a portion of its claims on an indebted country with an AIDS, TB or malaria burden, on the condition that the beneficiary country invests a set amount of funding in its national health programmes through an approved Global Fund grant. Since 2007, Germany has developed Debt2Health agreements with Indonesia, Pakistan, Côte d'Ivoire and Egypt (earmarked for the fight against malaria

in Ethiopia), ¹⁴ and cumulatively has cancelled debt obligations totalling \$160 million, ¹⁵ leading to health investments of \$80 million ¹⁶ through the initiative.

Germany has pledged approximately €4 billion (\$5.5 billion) ¹⁷ for an eight-year period (2008-2015) to fight AIDS, tuberculosis and malaria and for the requisite strengthening of health systems. ¹⁸

Political Leadership

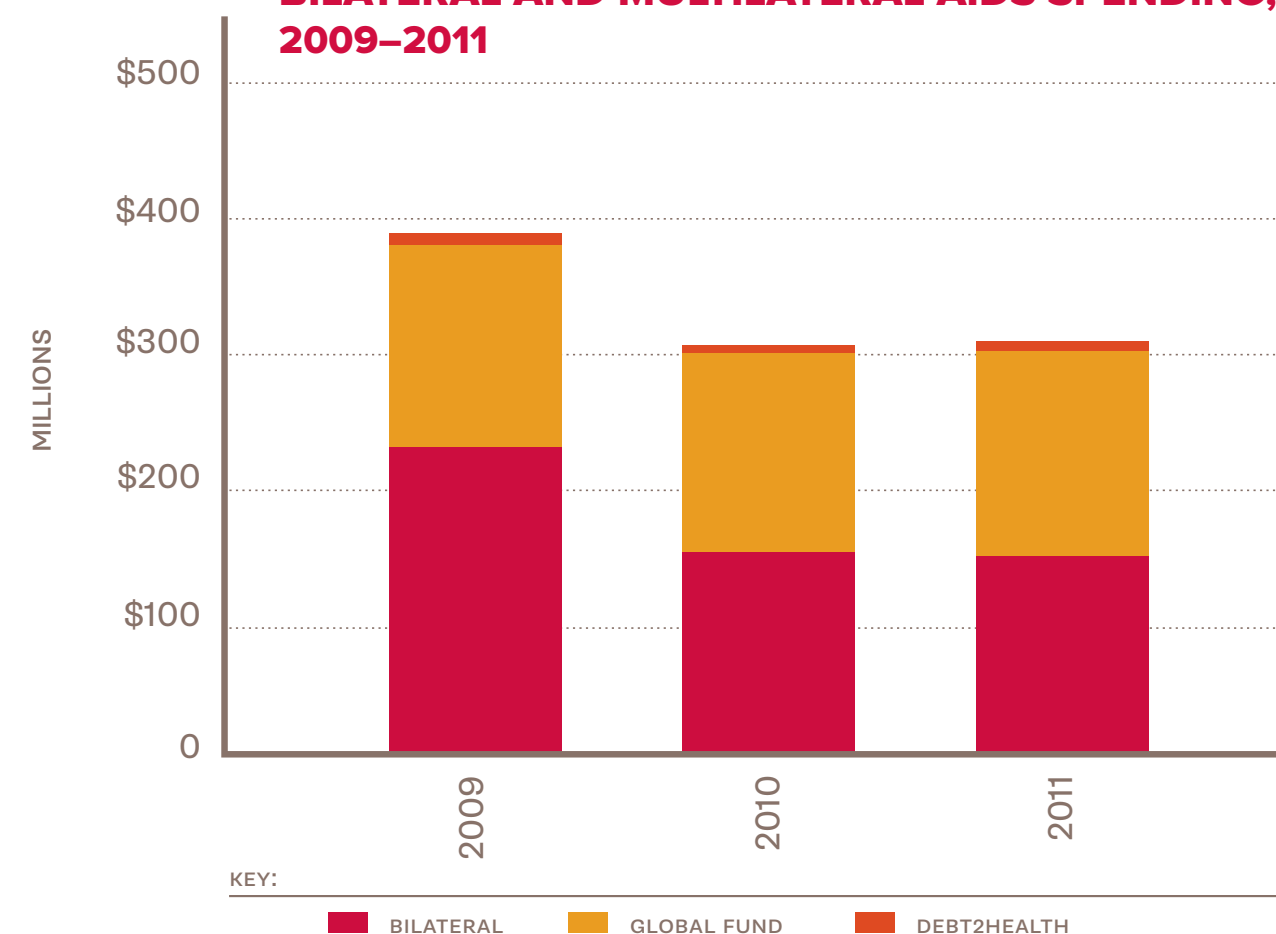
While Germany's Chancellor, Angela Merkel, has not yet publicly committed to realising the beginning of the end of AIDS, the Federal Minister for Economic Cooperation and Development, Dirk Niebel, spoke about a "turnaround" in the HIV epidemic before the International AIDS Conference 2012. Around the same time, BMZ released a new strategy paper detailing "Germany's Contribution to a Sustainable

HIV Response". ¹⁹ In November 2011, the German government organised a high-level and expert conference titled "Health.Right.Now. HIV prevention without barriers", focused on HIV prevention and human rights. ²⁰ Co-hosted by the German Federal Ministry for Economic Cooperation and Development and the Ministry of Health, the conference aimed to discuss ways to overcome the barriers that many key populations at higher risk of HIV infection encounter when accessing HIV services. The German Health Practice Collection is an initiative of the German Development Cooperation (Deutsche Gesellschaft für Internationale Zusammenarbeit, or GIZ) to share promising practices developed in German-supported health and social protection programmes worldwide, including HIV programmes. ²¹

In June 2012, parliamentarians of the Social Democratic Party (SPD) tabled a motion, "For a generation free of HIV/AIDS". Inter alia, this motion called on the government to commit to the aim of an "AIDS-free generation" through increased investments in PMTCT and to align future programmes with this objective. In addition, it called for a doubling of Global Fund contributions. This motion was another step to bring about a discussion about what Germany needs to do to contribute to the beginning of the end of AIDS.

The German government has formally endorsed the UN 2011 Political Declaration on HIV/AIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015.

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009-2011



Programmatic Efforts

In its 2012 strategy document “Germany’s Contribution to a Sustainable HIV Response”, Germany outlined a series of policy priorities on AIDS through to 2015.²² These priorities include safeguarding access to testing and treatment in accordance with the WHO’s Treatment Guidelines and investing in the requisite strengthening of health systems. More specifically, German bilateral priorities include tailoring prevention strategies to match the epidemiological and social context of each country; advancing gender equality; optimising financial resources available in-country; and scaling up social protection services. The German strategy is also aligned with the principles outlined in the Investment Framework.²³ Unfortunately, however, this strategy is not matched with specific outcome-oriented targets.

German investments in AIDS are rooted in efforts to promote burden-sharing between partners and to uphold aid effectiveness principles.²⁴ The German government is focused on promoting sustainable, country-led responses to HIV through the development of “country compacts” and the support of national health plans. It advises national AIDS councils on the design of sector-wide approaches and promotes the involvement of the non-governmental and private sectors in the development of HIV policy.²⁵ Additionally, GIZ supports a number of private sector initiatives to combat HIV, including programmes to introduce and implement HIV workplace programmes.²⁶ The workplace AIDS programmes are reaching more than 1.9 million employees of both large and small enterprises.

The German BACKUP Initiative offers assistance to partner countries to utilise Global Fund grants. The programme, commissioned by the BMZ, provides guidance and training for government and civil society partners to plan, implement and monitor activities and to manage money efficiently and transparently. Through technical consultations, capacity development and subsidies and financial agreements, the BACKUP Initiative has assisted in more than 436 projects in 73 countries.²⁷

Finally, the German government is continuously monitoring and evaluating its AIDS programmes. German efforts adhere to the UNAIDS requirement that all donors should feed into national data collection and reporting and should not undertake any additional information-gathering outside these health information systems. The collection of data on gender, age and sexual orientation, for example, allows the impact of programming on key populations to be determined so that programmes can be aligned more closely with their needs.²⁸

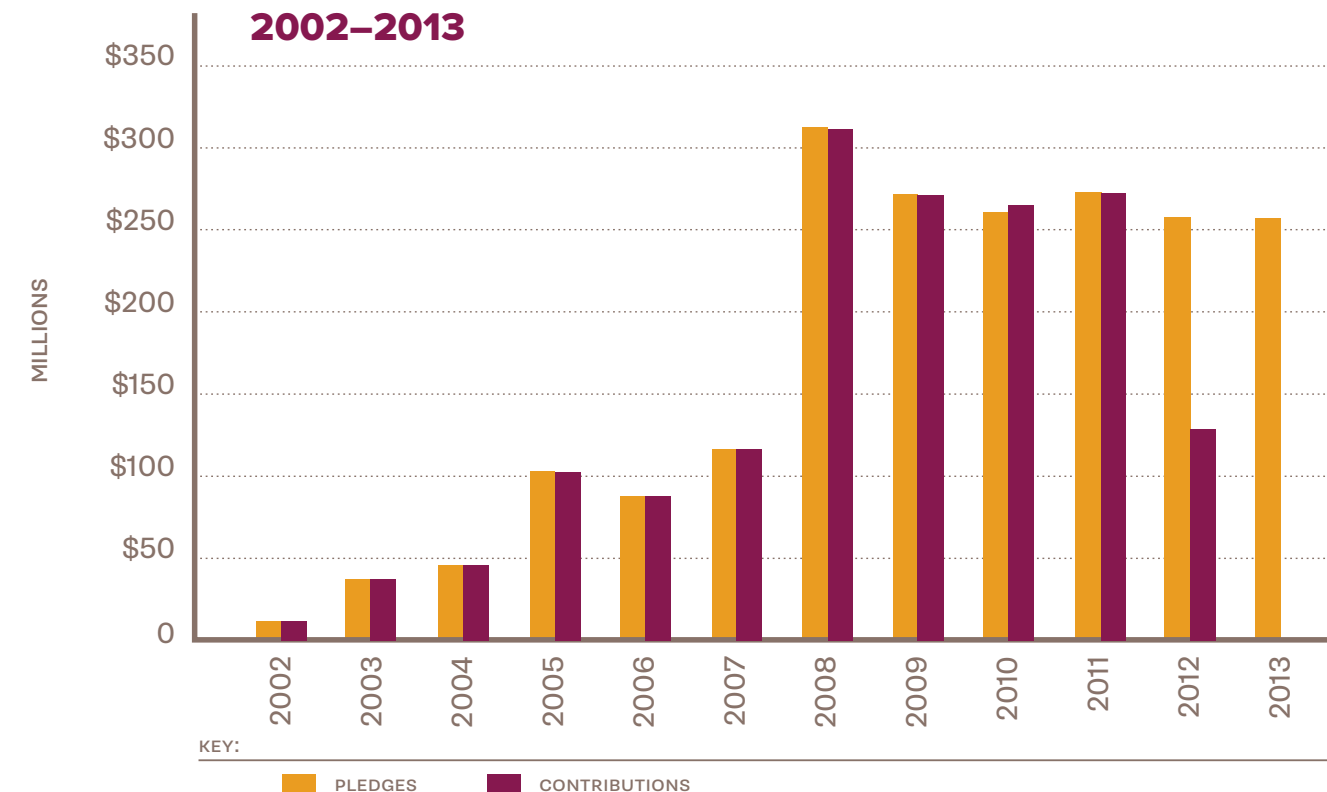
Looking Ahead

Although the German government has consistently invested in multilateral, bilateral and innovative programmes for AIDS, it still ranks in the bottom half of the G7 countries analysed across funding categories. It could bolster its standing as a leader on AIDS within the European Union by increasing its overall funding levels and articulating a specific vision about what outcomes will be achieved with its current investments. Setting specific targets

between now and 2015 and delivering high-level political rhetoric publicly in support of these targets will ensure its leadership in the efforts to secure the beginning of the end of AIDS.

In January 2011, Germany announced that it would temporarily retain its Global Fund contributions and demanded an enquiry into cases of alleged misuse of funds.²⁹ After the interim report of the High Level Independent Review Panel was submitted on 30 July 2011, and again after the board of the Global Fund agreed on a “Consolidated Transformation Plan” in November 2011, Germany released its 2011 contributions. After recognising the progress on reform, e.g. in a meeting with the Global Fund’s General Manager, Gabriel Jaramillo, Germany is now disbursing contributions to the Global Fund for the third replenishment period as scheduled.³⁰ In addition, through the support of Development Minister Dirk Niebel, the 2013 government budget proposal allocates €200 million (\$257 million)³¹ to the Global Fund in 2013 and includes a request for authorisation by parliament to commit €600 million (\$770 million)³² for the three-year period 2014–2016.³³ Since the German government has regained confidence about the effectiveness of the Fund and the speed of its reforms, Germany should double its contributions for the new pledging period and complement its 2013 contributions with more Debt2Health funding.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



Note: The Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

Germany has been making an important contribution to [a reduction in new HIV infections] through its comprehensive national and international activities. This trend can only be sustained if there is compliance with human rights standards in all regions of the world and if factors that impede prevention are reduced, and if all groups at higher risk of HIV exposure are given equal access to prevention, treatment, care and support.

— German Health Minister Daniel Bahr prior to the International AIDS Conference 2012³⁴

ITALY



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$5.12M

The Global Fund²

\$0

UNITAID³

\$0

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁴

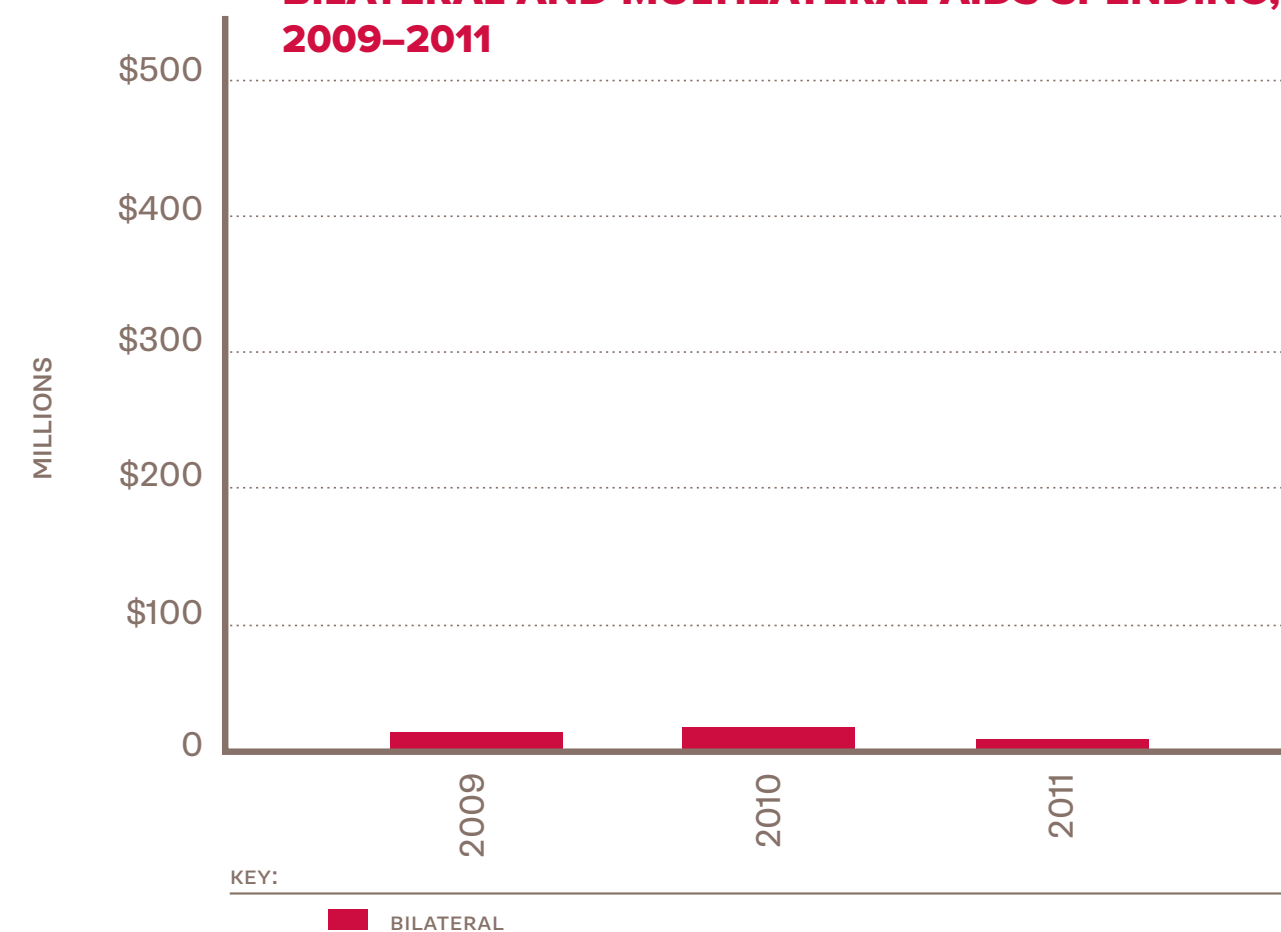
	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$9.50M (7th)		\$0.16 (7th)	0.0004% (7th)
2010	\$11.40M (7th)	+20.00% (1st)	\$0.19 (7th)	0.0005% (7th)
2011	\$5.12M (7th)	-55.12% (7th)	\$0.08 (7th)	0.0002% (7th)

Financial Contributions

Italy is the smallest AIDS donor among the G7 countries, contributing just \$5.1 million through bilateral channels in 2011.⁵ For the past three years it has ranked last among the G7 countries in AIDS spending per capita and as a share of GNI.⁶ Although previously it was a major contributor to the Global Fund, committing more than \$1 billion since the mechanism's inception in 2002,⁷ at the Global Fund's third replenishment meeting in 2010, it did not make a pledge for the 2011-2013 period.⁸ Moreover, it has also not paid its contributions for 2009 and 2010, making it the only G7 country assessed to wholly default on two years' worth of pledges.

In 2011, Italy contributed \$5.1 million to bilateral AIDS programmes,⁹ focused on strengthening health systems and supporting community AIDS organisations. Italy does not contribute to UNITAID, nor does it contribute to other innovative financing channels for AIDS.

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009–2011



Political Leadership

The record of the previous Prime Minister, Silvio Berlusconi, on AIDS was marked more by unpaid Global Fund pledges¹⁰ than by demonstrating leadership. However, Italy has made efforts to provide some political leadership on AIDS over the past three years. Notably, it hosted the world's largest open scientific conference on HIV/AIDS – the 6th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention – in Rome in July 2011. The Conference was organised by the IAS, in partnership with the Italian National Institute of Health (the leading technical and scientific body of the Italian National Health Service) and attracted about 5,000 delegates from all over the world.¹¹ Tied to the conference, the President of the Republic, Giorgio Napolitano, delivered a message applauding scientific advances achieved to date and calling for a central effort to raise further public awareness of AIDS.¹²

Italy continues to engage as part of several networks aimed at fighting AIDS. In Europe, it is on the Board of the EC's European and Developing Countries Clinical Trials Programme (EDCTP) Phase II, the goal of which is to accelerate the development of new or improved medical products and interventions against poverty-related diseases, with a particular focus on HIV/AIDS, tuberculosis and malaria in sub-Saharan Africa.¹³ In 2011, it also formally endorsed the 2011 UNAIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015.¹⁴

Finally, the Italian Minister of Health, Renato Balduzzi, has made numerous declarations to support and encourage the involvement of the private sector in the fight to end HIV/AIDS¹⁵ and has encouraged Italian hospitals to participate in the global fight against the disease within the European ESTHER Initiative.¹⁶ Still, no Italian head of state has yet called for efforts to achieve the beginning of the end of AIDS specifically.

Programmatic Efforts

Although Italian investments in AIDS are currently very small, its modest bilateral investments for strengthening health systems and supporting community AIDS organisations are both interventions supported under the UNAIDS Investment Framework.

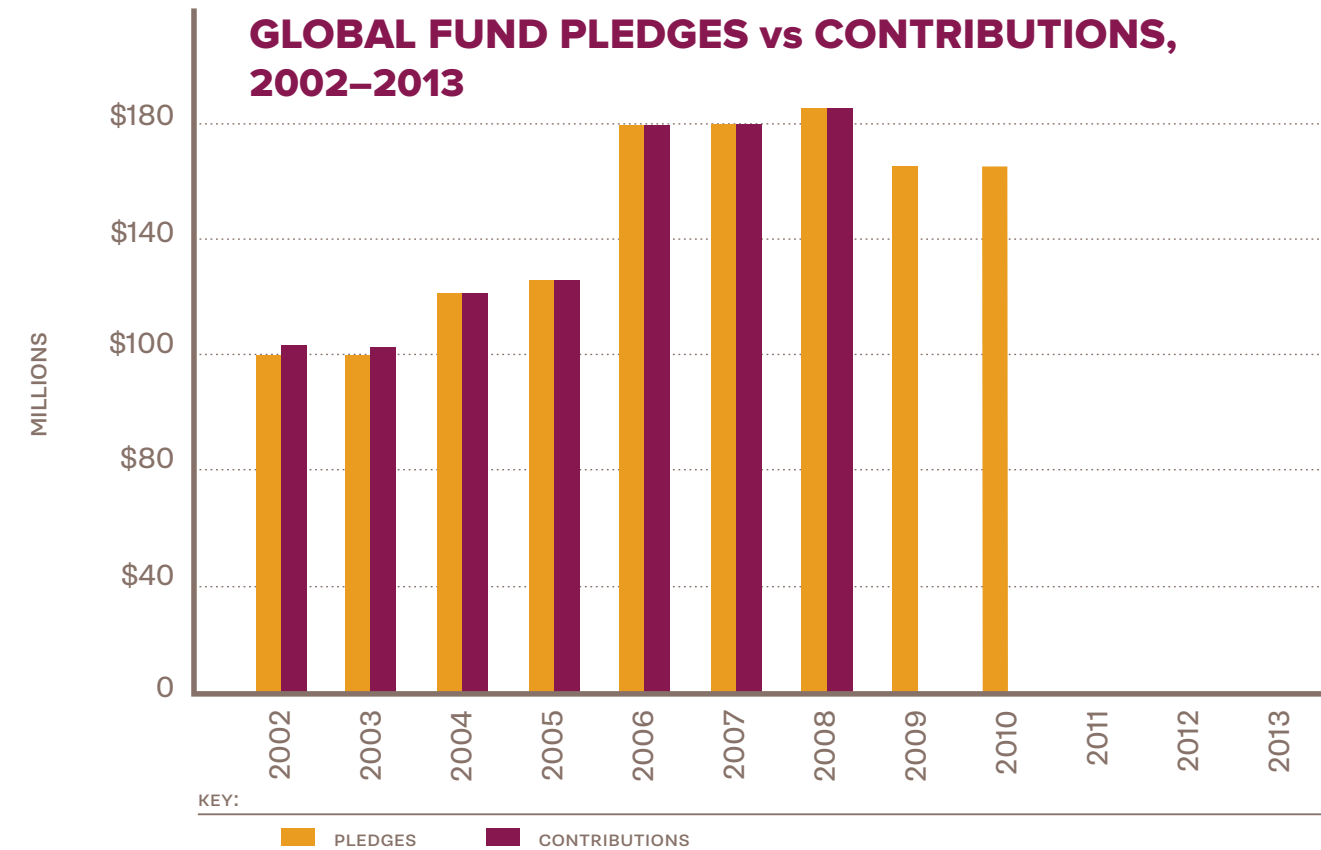
Due to a lack of significant funding for AIDS in the past three years, Italy's government has not developed a broader strategy for combating AIDS globally, nor has it developed an output- or outcome-based framework for its investments. But Italy does provide information on investments in health, and AIDS in particular, through annual updates in the general report on the development cooperation activities due by law to Parliament.¹⁷

Looking Ahead

Italy's diminishing funding for HIV/AIDS is disappointing, even in light of its economic circumstances. In the coming years, to slowly rebuild its international reputation on global health and development, it must first and foremost pay its outstanding arrears to the Global Fund from 2009 and 2010,¹⁸ even as it currently risks losing its shared Global Fund board seat in the interim timeframe. Once it is in good standing, the Italian government should look to make a realistic pledge at the Global Fund's fourth replenishment meeting in 2013 that it can deliver in a timely manner.

Although the current economic difficulties hinder long-term budget planning, Italy should begin to build a five-year strategy on AIDS engagement that positions it to contribute to the beginning of the end of AIDS goal, in line with its standing as a G7 member and a global leader.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



KEY:

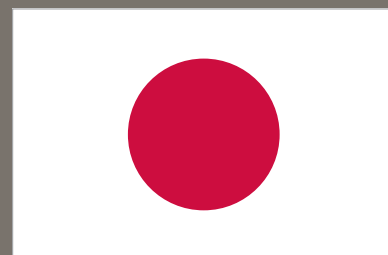
PLEDGES CONTRIBUTIONS

Note: Italy has not fulfilled its Global Fund pledges for 2009–2010, totalling \$334.28 million. Additionally, it has not made a pledge for 2011–2013.

“ I am aware of the difficult economical situation in the world as well as in Italy, and of all necessary sacrifices, but ... Unfortunately thousands of children, women and men, will not receive adequate treatments and therefore will die from AIDS, TB and malaria in the forthcoming months if Italy will not do its share of it. ... The present situation shows that all efforts made by Governments and scientists have succeeded in controlling the epidemic. Abandoning everything now would mean risking a new spread of these infections, with negative repercussions also for more industrialised countries. ”

— Giovanni Alemanno, Mayor of Rome, in an open letter to former Prime Minister Berlusconi ahead of the IAS 2011 Conference¹⁹

JAPAN



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$20.94M

The Global Fund²

\$114.23M

Fraction of Global Fund contribution to AIDS (56%)

\$63.97M

UNITAID³

\$0

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁴

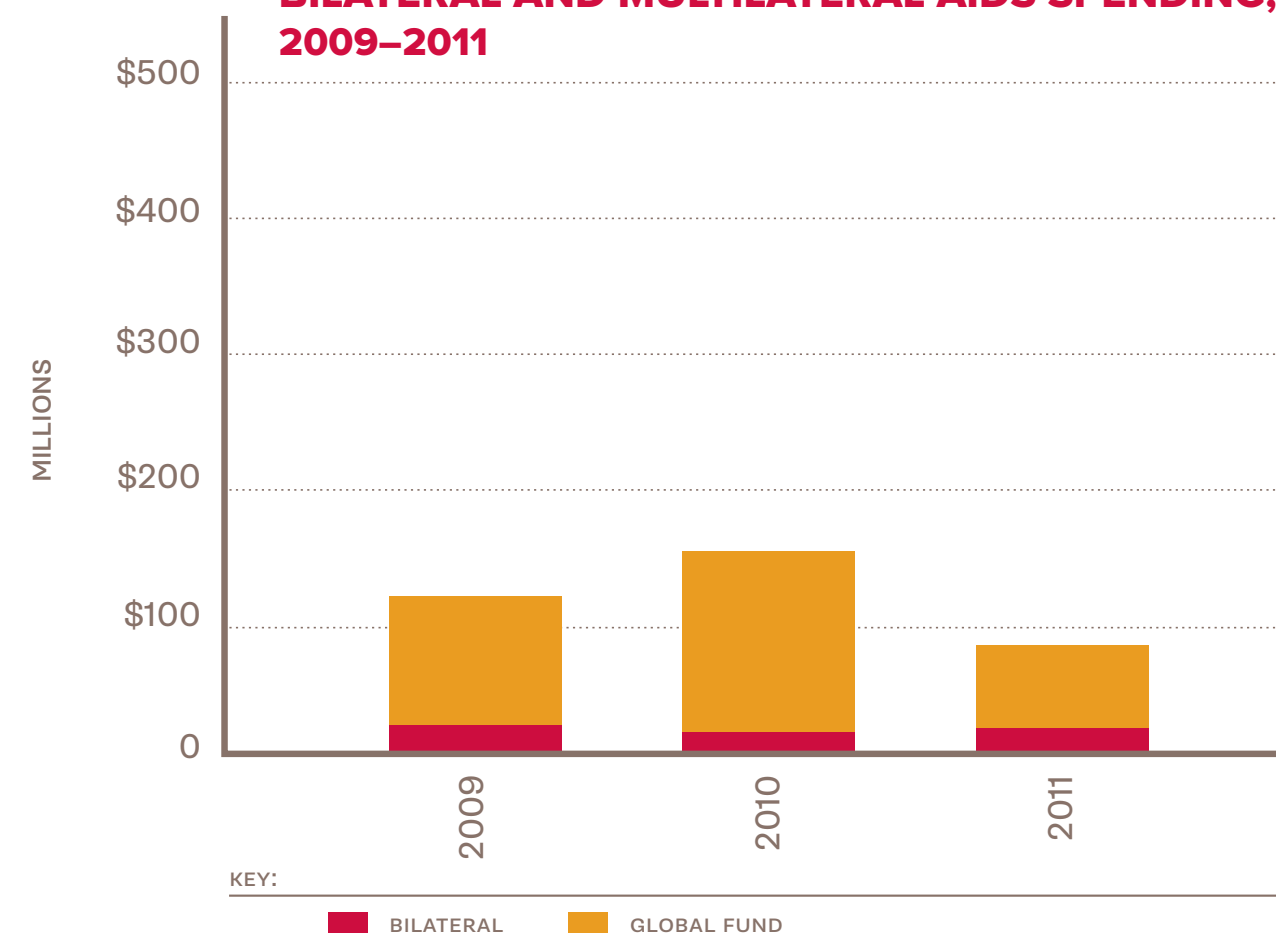
	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$130.13M (5th)		\$1.02 (6th)	0.0027% (6th)
2010	\$154.62M (5th)	+18.82% (2nd)	\$1.21 (6th)	0.0029% (6th)
2011	\$84.91M (6th)	-45.08% (6th)	\$0.66 (6th)	0.0015% (6th)

Financial Contributions

Japan ranks sixth in AIDS funding among the G7 countries, contributing nearly \$85 million through multilateral and bilateral channels in 2011.⁵ It also ranks sixth among the G7 countries in its AIDS spending in per capita terms and as a share of GNI.⁶ At the Global Fund's third replenishment meeting in September 2010, Japan pledged \$800 million "over the coming years".⁷ Former Prime Minister Naoto Kan reinforced this pledge at the 2012 World Economic Forum in Davos, announcing a \$340 million contribution to be delivered in the Japanese fiscal year 2012 (April 2012–March 2013).⁸ This amount represents a significant increase over Japan's previous highest one-year contribution of \$246 million in 2010, and is particularly significant in light of the earthquake and tsunami in 2011 that forced a reduction in its 2011 contribution.⁹ Since making its pledge, Japan has contributed roughly \$114 million to the Global Fund in 2011 and \$216 million in 2012.¹⁰

In 2011, Japan contributed nearly \$21 million to bilateral programmes¹¹ operated through the Japan International Cooperation Agency (JICA), with programmes spread across six regions, including projects in 34 sub-Saharan African countries.¹² These programmes are structured around four focus areas for infectious diseases: strengthening of diagnostic and testing services; the appropriate collection and utilisation of health information; strengthening management capacities for the provision of health services; and supporting developing countries at the national level to review and to develop the policies and tools required for effective intervention.¹³ These investments currently include funding for nine technical cooperation projects on HIV specifically.¹⁴ Japan is a member of the Leading Group on Innovative Financing for Development and was the Group's President in 2010,¹⁵ but it does not contribute to UNITAID, nor does it contribute to other innovative financing mechanisms for AIDS.

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009–2011



Political Leadership

Japanese officials, including former Prime Minister Kan, have delivered public remarks offering robust defences of the Global Fund and its efforts to fight AIDS, TB and malaria,¹⁶ and at the UN High Level Meeting on AIDS in June 2011 the State Secretary for Foreign Affairs, Yutaka Banno, made a statement supporting "a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths".¹⁷ Japan regards HIV/AIDS as a significant challenge to "human security", which has been a pillar of its foreign policy since 1998.¹⁸

Japan has formally endorsed the UN 2011 Political Declaration on HIV/AIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015.¹⁹ JICA has also hosted a number of events and seminars on AIDS at the JICA Global Plaza, including "Actions of JICA in AIDS measures and human security: AIDS measures in Africa – Zambia".²⁰

Programmatic Efforts

Although JICA has not articulated a specific global AIDS strategy, it did release a position paper on "JICA's Operation in the Health Sector – Present and Future" in 2010.²¹ This document focused on the achievement of the Millennium Development Goals as a guiding framework, and outlined maternal and child health and infectious diseases as its two core priorities in health cooperation. Subsequently, the Japanese government formulated "Japan's Global Health Policy: 2011–2015".²² Among other targets outlined in the document, **the Japanese government committed to averting approximately 470,000**

AIDS deaths by 2015 through additional bilateral resources and investments in the Global Fund, although it did not clarify how this target would be achieved.²³ It also committed more broadly, to:

- Achieving expanded and sustained access to integrated quality health services, including preventive intervention, early detection and treatment, and distribution of therapeutic drugs;
- Promoting a programme-based approach of disease control aligned with country-led national health plans;
- Promoting appropriate medical supply management and distribution;
- Ensuring adequate prescription of ARVs for preventing mother-to-child transmission of HIV; and
- Enhancing infectious disease control within the context of a continuum of care.²⁴

As part of JICA's strategy, it committed to rigorous monitoring and evaluation of its assistance in the health sector. Among other efforts, JICA committed to undertaking quantitative reviews of the outcomes and impacts achieved by its investments in order to validate the effectiveness of capacity development in improving health outcomes. In all of its bilateral AIDS programming, the Japanese government through JICA has committed to aligning itself with recipient countries' national strategies and plans.

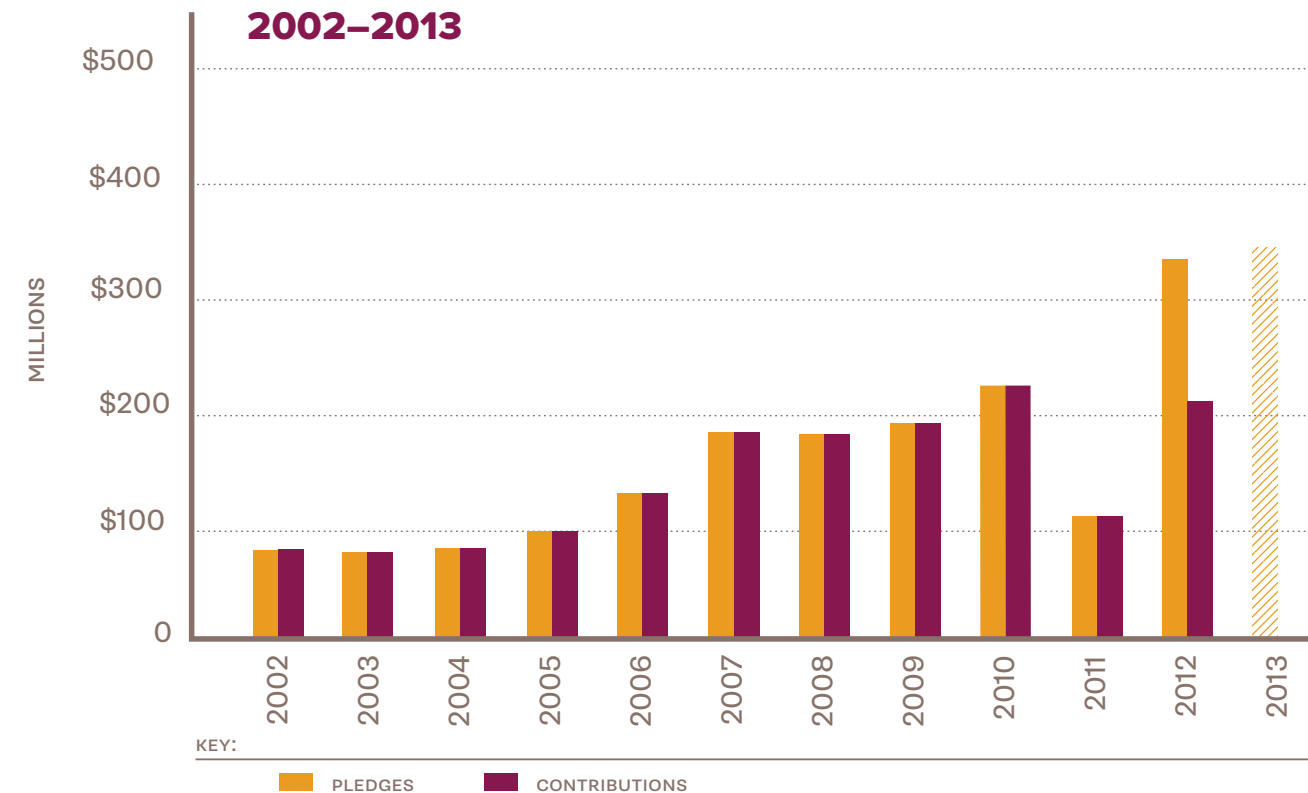
Looking Ahead

The devastation of the tsunami and earthquake that hit Japan in 2011 led to an understandable temporary reduction in the country's investments in HIV/AIDS and other global health initiatives. At the same time, the government's effort to pay its Global Fund commitments is commendable.

Assuming its contributions in 2012 reach the full amount of \$340 million announced by former Prime Minister Kan, the remaining pledge amount is roughly \$346 million in 2013. Of that, only about \$114 million has been under review in the 2013 annual budget, which still leaves roughly \$232 million to fulfil the pledge. There has also been growing concern that the government will not fulfil the Kan Commitment until as late as 2015. It is critical that the Ministry of Finance prioritises the fulfilment of this current pledge by 2013; doing so will reflect Japan's intent to regain a leadership role on the Global Fund and in the fight against AIDS, and will better position the government to commit additional resources for the 2014–2016 timeframe at the Global Fund's fourth replenishment meeting.

As it scales up its Global Fund commitments, Japan should report on the progress achieved towards its targets and also seek to define more clearly the targets for its bilateral AIDS programmes. It should also better track and report on how its support for health systems contributes towards the beginning of the end of AIDS in a measurable way.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



Note: Japan has made an \$800 million commitment to the Global Fund for the period 2011–2013 (the Kan Commitment). In 2011, Japan contributed \$114 million of this commitment. Assuming that it contributes the full \$340 million promised in 2012, then \$346 million would be the unpaid balance in 2013 (striped bar). Additionally, the Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

“ Infectious diseases are a threat to human security, but progress in treatment has enabled people living with HIV to lead normal lives. At the MDG Summit, I will do my best to present strong support for the global AIDS response through our support for the Global Fund. ”

— Former Prime Minister Naoto Kan, September 2010²⁵

UNITED KINGDOM



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$680.53M

The Global Fund²⁻³

\$239.43M

Fraction of Global Fund contribution to AIDS (56%)

\$134.08M

UNITAID⁴

\$85.07M

Fraction of UNITAID contribution to AIDS (52.2%)

\$44.41M

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁵

	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$775.70M (2nd)		\$12.55 (2nd)	0.0306% (2nd)
2010	\$804.71M (2nd)	+3.74 % (5th)	\$12.93 (1st)	0.0339% (1st)
2011	\$859.02M (2nd)	+6.75 % (3rd)	\$13.71 (2nd)	0.0363% (1st)

Financial Contributions

The United Kingdom is the second largest AIDS donor among the G7 countries, contributing approximately \$859.02 million through multilateral and bilateral channels in 2011 and trailing only the United States in net spending.⁶ It ranks first among the G7 countries in its AIDS spending as a share of GNI.⁷ At the Global Fund's third replenishment meeting in 2010, the UK did not make a new pledge, as it had already made a long-term funding pledge in 2007 for the period 2008-2015, worth approximately £1 billion (\$2 billion).⁸ As part of this pledge, the UK contributed approximately \$239.43 million to the Global Fund in 2011 and has contributed more than \$404.51 million in 2012.⁹

In addition to its Global Fund contributions, the UK contributes an even larger proportion of its resources through its bilateral AIDS programmes run through

the Department for International Development (DFID). In 2011, it contributed approximately \$680.53 million through bilateral programmes,¹⁰ focused on a sub-set of 14 high-burden countries and three geographic regions.¹¹ These programmes are focused largely on prevention and the provision of services for vulnerable and key affected populations, although some support also goes towards strengthening of health systems; prevention of gender-based violence; and girls' sexual education and economic empowerment.

The UK contributed more than \$85 million to UNITAID in 2011,¹² but it does not contribute resources for AIDS through other innovative financing mechanisms.

Political Leadership

The United Kingdom has remained a top donor to AIDS over the past three years, but has prioritised other global health issues in terms of public political leadership. For example, it hosted the GAVI Alliance Pledging Conference in June 2011¹³ and the Family Planning Summit in July 2012 – both significant events which required extensive leadership to mobilise the

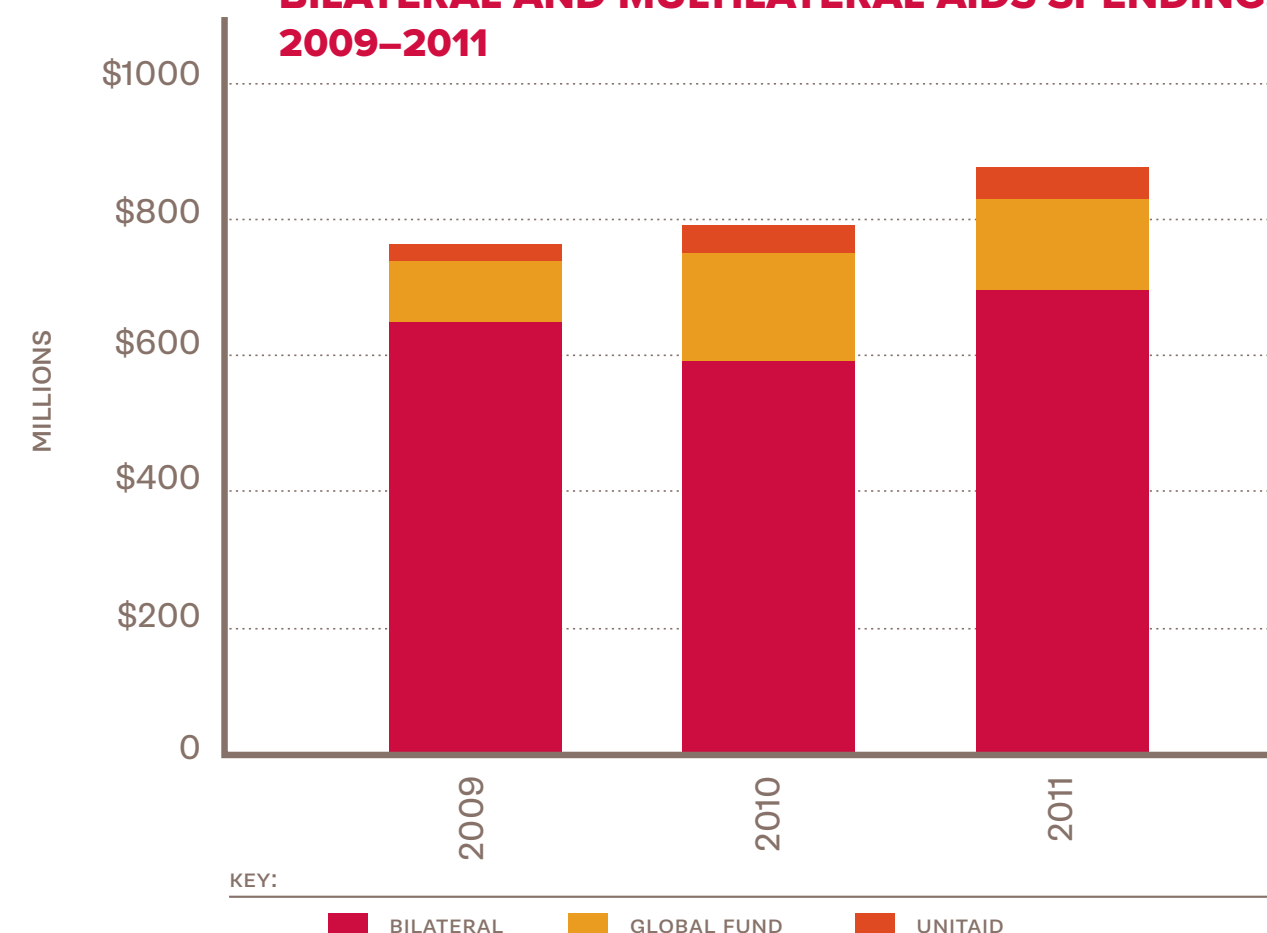
international community.¹⁴ Prime Minister David Cameron and former Development Secretary Andrew Mitchell have both made remarks highlighting the United Kingdom's contributions to the Global Fund over the past two years, but neither has been vocal about the opportunity to achieve the beginning of the end of AIDS.

In spite of a quieter public political presence on AIDS, the UK government has formally endorsed the UN 2011 Political Declaration on HIV/AIDS targets, including 15 million people on treatment and the virtual elimination of mother-to-child transmission of HIV by 2015. It has also leveraged private sector initiatives on AIDS, including the Girl Hub initiative in partnership with Nike Foundation to support adolescent girls,¹⁵ and it has funded a number of Programme Partnership Agreements (PPAs) focused on HIV/AIDS – three-year grants to support civil society groups to add value to DFID's portfolio, support its objectives and achieve real results in terms of poverty reduction.¹⁶

Programmatic Efforts

In its May 2011 document "Towards Zero Infections: The UK's Position Paper on HIV in the Developing World", the UK outlined a series of policy priorities on AIDS and outcome-oriented targets to achieve by 2015.¹⁷ **These outcomes included a reduction in infections among women by at least 500,000 in at least eight sub-Saharan African countries; a reduction of infections among most at-risk populations in at least six countries; 37,000 HIV+ women receiving PMTCT services through the UK's Global Fund contribution; driving down treatment costs to generate cost savings to purchase antiretroviral drugs for 500,000 additional people through partnership with the Clinton Foundation; and cash transfers to poor and vulnerable households in five high-prevalence countries, benefiting an estimated 120,000 people affected by HIV.** The UK has also committed to broader investments in basic services, empowerment of women and poverty reduction. Since these

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009–2011



commitments were articulated in 2011, DFID has not provided an update on results; however, it has said that it will review progress in 2013, reassess strategic priorities and post details on its website in an effort to improve transparency.

In its strategy document, the UK has acknowledged a changing HIV epidemic, highlighted recent developments that could lead to improved efficiency in reducing new infections and articulated an approach similar to the recommendations contained in the UNAIDS Investment Framework. Specifically, DFID has committed itself to better tailoring its prevention efforts to localised epidemics and to scaling up evidence-based prevention approaches, with an emphasis on PMTCT, voluntary medical male circumcision, TB prevention and diagnosis, family planning and harm reduction. DFID also prides itself on being a “funder and supporter of coordinated, country-owned approaches that deliver integrated services” in an effort to promote long-term cost-efficiency and sustainability of its programmes.¹⁸

Looking Ahead

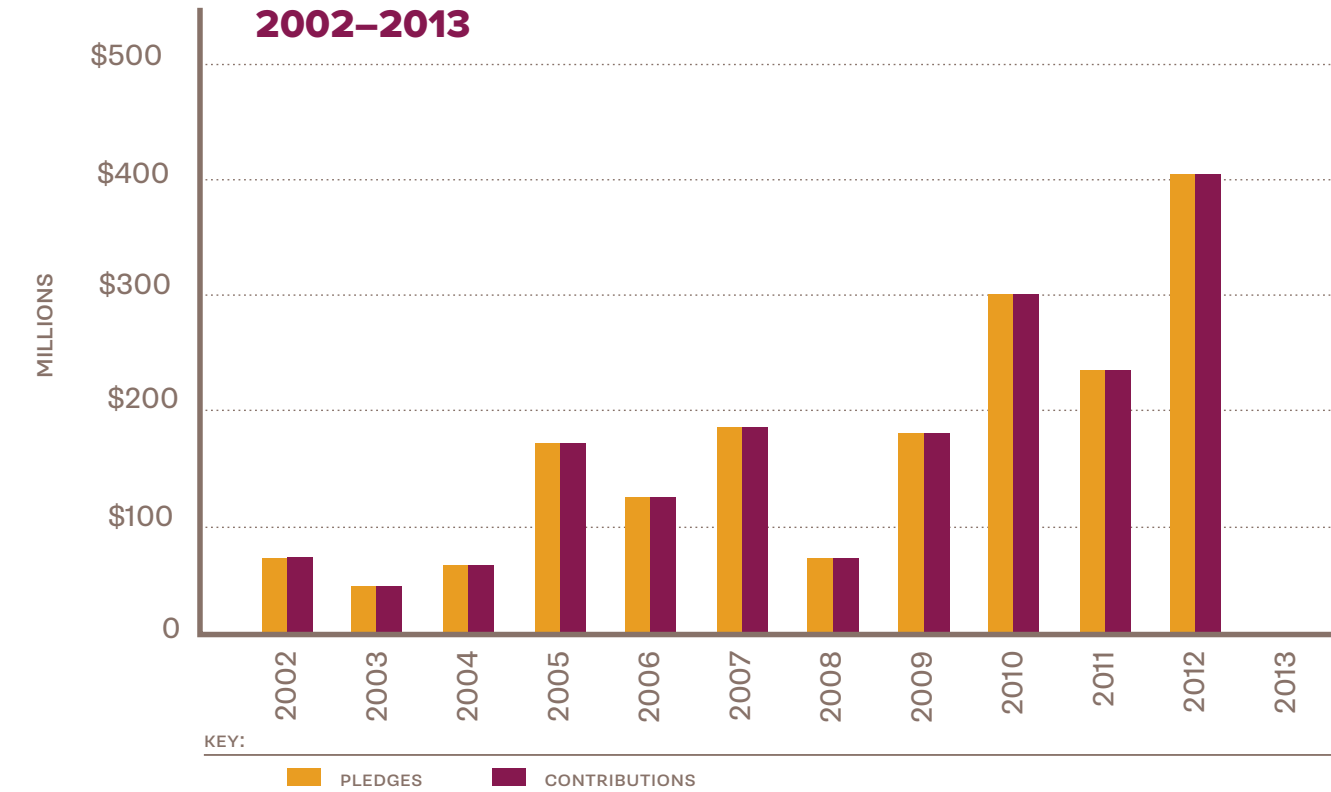
As the United Kingdom continues on its trajectory of spending 0.7% of GNI on development assistance from 2013, it should commit some of these additional resources towards strategic investments aimed at achieving the beginning of the end of AIDS. The UK has gone on record as saying that it is prepared to “very substantially” increase its Global Fund contribution – up to doubling it – which would

provide critical momentum for the Global Fund at a time when other donors are contemplating their own contributions.¹⁹ It should make good on this commitment given the Multilateral Aid Review’s finding that the Global Fund made a “strong” contribution to UK development objectives. As it debates the timeline for announcing its decision on future funding, the UK should consider the implications for the next replenishment period and should use its increased commitment to strategically leverage increased resources from other actors.

DFID’s 2013 progress review of its AIDS strategy is an opportunity to demonstrate leadership for other AIDS stakeholders focused on planning, strategy and implementation. It should report transparently on all results, good and bad, so that lessons learned can inform the global effort to improve the efficacy of AIDS programming. In many of its policy and strategy papers on AIDS, the UK references its investments in broader poverty alleviation and women’s empowerment as supporting its AIDS investments.²⁰ These complementary initiatives are no doubt important and justified as such in the Investment Framework paradigm, but it is critical that the UK makes concerted efforts to measure and study these programmes’ effects more directly, tracking the specific benefits for AIDS outcomes to further support its strategic investments. Potentially, all of this analysis and reporting in 2013 could be used as the foundation for a UK blueprint document focused on its contributions to the beginning of the end of AIDS, complementary to the United States’ 2012 iteration and with added specificity around targets.

Finally, the United Kingdom will play a key role in several important global development moments in 2013. It will host the G8 Summit in June, and Prime Minister Cameron serves as a co-chair of the High Level Panel on the post-2015 global development framework. The UK will inevitably balance a number of competing and equally important development priorities in each setting – including global agriculture and food security, education, transparency and accountability – and it should use these high-profile opportunities to ensure that efforts to improve global health and to achieve the beginning of the end of AIDS remain valued parts of the conversation.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



Note: The United Kingdom has made a £1 billion pledge to the Global Fund for the period 2008–2015. Presumably, the unpaid balance will be paid in 2013–2015. Additionally, the Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

“ Wearing the red ribbon is about showing solidarity and reflecting on the scale of the challenge we still face. But more than just reflection, today has got to be about action: individuals, charities, campaigners and governments, working together to address HIV and AIDS. This government is fully signed up to these efforts at home and abroad, [and] because we’re meeting our international promises we are able to make a big difference overseas... So today is about reflection and action. And for me it is also about hope because, while there is so much more to be done, I think it is important to remember the great progress that has been made on raising awareness, on tackling prejudice and on scientific advances. ”

— Prime Minister David Cameron, World AIDS Day 2011²¹

UNITED STATES



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$3.97BN

The Global Fund²

\$992.42M

Fraction of Global Fund contribution to AIDS (56%)

\$555.75M

UNITAID³

\$0

SUM OF CONTRIBUTIONS TO AIDS (RANKING OUT OF 7)⁴

	Net Volume	Percent Change	Per Capita	Share of GNI
2009	\$4.45BN (1st)		\$14.50 (1st)	0.0315% (1st)
2010	\$3.83BN (1st)	-13.95% (6th)	\$12.38 (2nd)	0.0261% (2nd)
2011	\$4.53BN (1st)	+18.34% (1st)	\$14.54 (1st)	0.0300% (2nd)

Financial Contributions

The United States is the undisputed leader in global funding for HIV/AIDS, contributing roughly \$4.5 billion through multilateral and bilateral channels in 2011.⁵ This represents roughly one-quarter of total global spending and 60% of donor government assistance to combat the disease.⁶ This total represents an 18% increase in overall AIDS funding since 2010 – a one-year growth rate first among all G7 donors. It also ranks first among G7 donors in terms of its AIDS spending per capita, and second for its AIDS spending as a share of GNI.⁷ At the Global Fund's third replenishment meeting in 2010, the United States made its first ever multi-year commitment to the Global Fund, with the Obama Administration requesting \$4 billion from Congress for the 2011-2013 period⁸ – twice as much as the next highest donor government pledge.⁹ To date, the US has contributed nearly \$1 billion of this amount in 2011,¹⁰ with \$1.3 billion appropriated for 2012 and \$1.65 billion requested from Congress for 2013.¹¹

In addition to its Global Fund contributions, which historically leverage more than \$2 globally for every \$1 it invests, the US has contributed the largest share of global bilateral resources for AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR was created in 2003 under the George W. Bush Administration to provide treatment, care, prevention and support services globally for AIDS. It represents the largest effort by any one donor to combat a single disease internationally.¹² In 2011, the US contributed nearly \$4 billion bilaterally for HIV/AIDS,¹³ focused on a sub-set of 31 countries and three geographic regions.¹⁴

The United States is not a donor to UNITAID, nor does it contribute resources for AIDS through other innovative financing mechanisms.

Political Leadership

Just as it has led in funding for the AIDS response, the US government is also delivering bold political leadership towards the beginning of the end of AIDS. Building on the strong, bipartisan support for AIDS efforts by former Presidents Bush and Clinton, President Obama delivered a momentous speech on World AIDS Day 2011, announcing major new

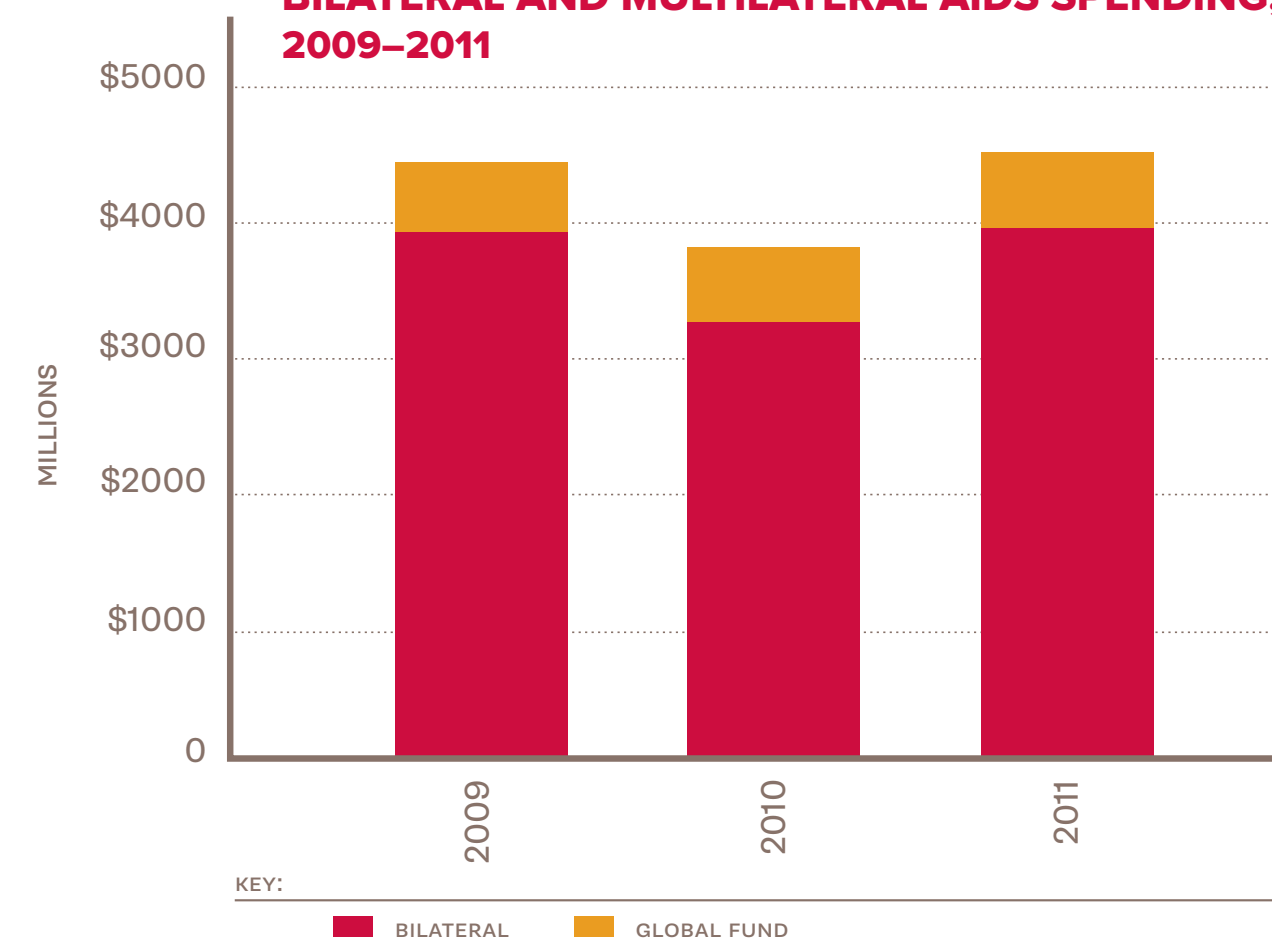
AIDS commitments (see below) as part of the global effort to achieve the beginning of the end of the disease.¹⁵ His speech followed remarks by Secretary of State Hillary Clinton, who called for an "AIDS-free generation" in a November 2011 speech at the National Institutes of Health.¹⁶

The United States hosted the International AIDS Conference in Washington, DC in July 2012 for the first time in more than 20 years, following the removal of travel restrictions on HIV-positive individuals.¹⁷ Secretary Clinton and US Global AIDS Coordinator Eric Goosby both delivered remarks, highlighting the paradigm shift in the fight against AIDS and the need for a more sustainable global response, both in financing and implementation. In Secretary Clinton's remarks, she also announced that, by World AIDS Day 2012, Ambassador Goosby would deliver a "blueprint" for achieving an AIDS-free generation, outlining a more detailed roadmap for the US Government's future AIDS response.¹⁸ At the time this report was being written, details about the blueprint's contents were still pending, but Secretary Clinton has promised that it will outline how the US plans to contribute to the global response alongside other donors and partners.

In addition to its direct PEPFAR programming, the United States has also leveraged the PEPFAR platform to bring in the private sector and expand its health services outreach. As one example, it launched the "Pink Ribbon, Red Ribbon" initiative in 2011 to expand breast and cervical cancer screening and treatment services for women who visit PEPFAR clinics in sub-Saharan Africa and Latin America for HIV services. This initiative was launched in partnership with UNAIDS, Susan G. Komen for the Cure, the George W. Bush Institute and seven corporate partners.¹⁹

Finally, the United States has played an important co-chairing role alongside UNAIDS for the Global Steering Group on PMTCT.²⁰ Its leadership has been pivotal in helping to focus the 22 high-burden

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009–2011



countries around the development of costed plans aimed at the virtual elimination of mother-to-child transmission by 2015. Alongside this work, the US has also endorsed the 2011 UN Political Targets on AIDS.

Programmatic Efforts

Through its World AIDS Day 2011 commitments, the United States has outlined a number of specific, time-bound, outcome-oriented targets to be achieved with its AIDS investments.²¹ **By the end of Fiscal Year 2013, it has committed to reach more than 1.5 million HIV-positive pregnant women with antiretroviral drugs to prevent them from passing the virus to their children; support more than 4.7 million voluntary medical male circumcisions in Eastern and Southern Africa; support more than six million people on antiretroviral treatment; and distribute more than 1 billion condoms.**

Since the World AIDS Day commitments were made, the US has expanded its prevention, treatment and PMTCT services. In the first half of FY 2012, it reached 4.5 million people and 370,000 HIV-positive pregnant women with antiretroviral treatment and PMTCT services respectively; if it can sustain these rates of expansion, it will be on track to reach its FY 2013 targets.²² To date, the US has also directly supported more than 1.2 million male circumcision procedures, but must continue to expand this service delivery to get on track for its FY 2013 target.²³ PEPFAR has not provided a progress update on its condom distribution target.

The United States has also made a quiet but noticeable programmatic shift in its HIV prevention strategies, moving from the ABC paradigm (abstinence, be faithful, consistent and correct use of condoms) to the combination prevention paradigm (with special emphasis on treatment as prevention, voluntary medical male circumcision and prevention of mother-to-child transmission of HIV).²⁴ The PEPFAR programme has also evolved its relationships with recipient countries, collaborating on “Partnership Frameworks” that, in some cases, outline how the recipient country will take on additional responsibilities over time for AIDS programming and investments with its own resources.²⁵

The US has also developed and begun to implement a National AIDS Strategy to combat its domestic epidemic, though its July 2010 launch date made the US the last of the G7 donor countries to develop such a national strategy.²⁶

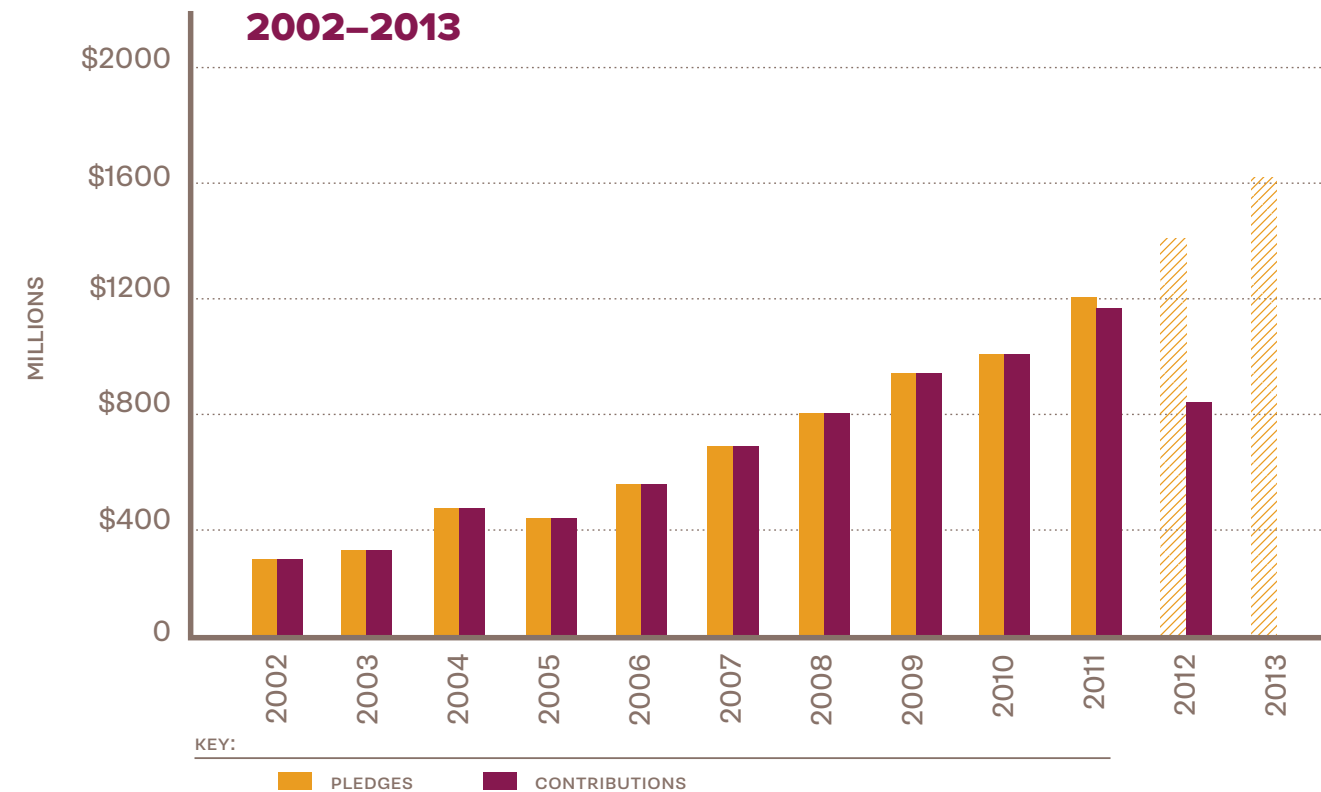
Looking Ahead

The United States has demonstrated consistent, bipartisan leadership in the fight against AIDS globally, but this leadership must not be taken for granted. Facing major cuts – both across the board and targeted at foreign assistance – as part of the ongoing budget process, US Members of Congress from both political parties must work diligently to protect life-saving investments in the Global Fund and PEPFAR, and the Administration must continue to provide leadership to ensure that these programmes are sustained and scaled up.

The United States must also continue to improve the transparency and effectiveness of PEPFAR. In 2012, the Office of the Global AIDS Coordinator (OGAC) revealed that a pipeline of AIDS funding in the order of \$1.4 billion had accumulated and had not yet been spent, concentrated primarily in countries such as Kenya, Ethiopia and Mozambique.²⁷ While some of this backlog is normal for a foreign assistance programme providing life-saving services, its size caused significant concern, particularly in the US budgetary environment where cuts to PEPFAR were already being considered. OGAC has put forward guidelines for how it will reinvest these resources and ensure that pipeline issues are avoided in the future,²⁸ but these activities must be rigorously monitored to ensure that funding is flowing to countries with sufficient absorptive capacity to optimally expend these resources.

The United States should also carefully leverage its leadership on the financial and diplomatic fronts to better engage other donors – both within the G7 and among recipient countries – to step up their investments in AIDS and to share in the development of a global strategy to achieve the beginning of the end of AIDS. If the US forges ahead on its own, it risks alienating other actors and their unique contributions at a moment when a truly global AIDS response is needed. As such, the US Blueprint for World AIDS Day 2012 will be an important first step, but it cannot be the final effort. In 2013, the United States should work alongside other donors and partners to develop a set of specific, time-bound and measurable targets that can then be tracked toward the ultimate goal of achieving the beginning of the end of AIDS.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002–2013



Note: The Global Fund methodology only counts as pledges amounts that the US Congress has actually appropriated in a given year. In the figure above, for 2012 and 2013, the striped bars reflect the amounts requested by President Obama in order to fulfil the administration's three-year (2011-2013) commitment totalling \$4 billion to the Global Fund. Additionally, the Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

“ [We] can end this pandemic. We can beat this disease. We can win this fight. We just have to keep at it, steady, persistent – today, tomorrow, every day until we get to zero. ...That’s my pledge. That’s my commitment to all of you. And that’s got to be our promise to each other – because we’ve come so far and we’ve saved so many lives, we might as well finish the fight. ”

— President Barack Obama, World AIDS Day, 2011²⁹

EUROPEAN COMMISSION



2011 FINANCIAL CONTRIBUTIONS TO AIDS:

Bilateral AIDS programme(s)¹

\$39.92M

The Global Fund²

\$147.13M

Fraction of Global Fund contribution to AIDS (56%)

\$82.39M

UNITAID³

\$0

SUM OF CONTRIBUTIONS TO AIDS⁴

	Net Volume	Percent Change
2009	\$109.49M	
2010	\$100.33M	-8.37%
2011	\$122.31M	+21.90%

Financial Contributions

The European Commission, managing development assistance on behalf of the 27 Member States of the European Union, provides significant funding to the fight against AIDS, contributing more than \$122 million through both bilateral and multilateral channels in 2011.⁵ At the Global Fund's third replenishment meeting in 2010, the Commission pledged €330 million (\$452 million) over the 2011-2013 period.⁶ Since then, it has contributed \$147.13 million to the Global Fund in 2011 and has, as of October 2012, contributed \$62.11 million for 2012 (and it is expected to contribute the full amount by the end of the year).⁷

The Commission's annual Global Fund contributions are financed by 50% from the European Development Fund (EDF) and 50% from thematic funding through the Development Co-operation Instrument (DCI), particularly the "Investing in People" programme. The DCI benefits all developing countries and includes

several global instruments accessible to local and regional civil society organisations active in the health sector, including "Investing in People" and "Non-state actors and local authorities in development".⁸ The EDF exclusively funds activities in the African, Caribbean and Pacific (ACP) regions, and is guided by the 2010 revised Cotonou Agreement, which includes a section devoted to HIV/AIDS that specifies: "Cooperation shall support the efforts of ACP States to develop and strengthen across all sectors policies and programmes aimed at addressing the HIV/AIDS pandemic and preventing it from hampering development. It shall support ACP States in scaling up towards and sustaining universal access to HIV/AIDS prevention, treatment, care and support."⁹

Direct financing for AIDS from the European Commission is distributed through its general external spending instruments, depending on the region of the recipient country. The European

Neighbourhood and Partnership Instrument (ENPI)¹⁰ contributes funding to 17 partner countries in Eastern Europe, the Middle East and North Africa;¹¹ the European Development Fund (EDF)¹² provides bilateral aid to 79 African, Caribbean and Pacific countries;

and the DCI covers development assistance to partner countries in Asia, Latin America and the Middle East.¹³ Additionally, the thematic European Instrument for Human Rights and Democracy (EIDHR) equally supports projects on HIV/AIDS. In 2011, the

EC contributed a total of \$40 million to its bilateral programmes.¹⁴ The EC is not a donor to UNITAID, nor does it contribute resources for AIDS through other innovative financing mechanisms.

Political Leadership

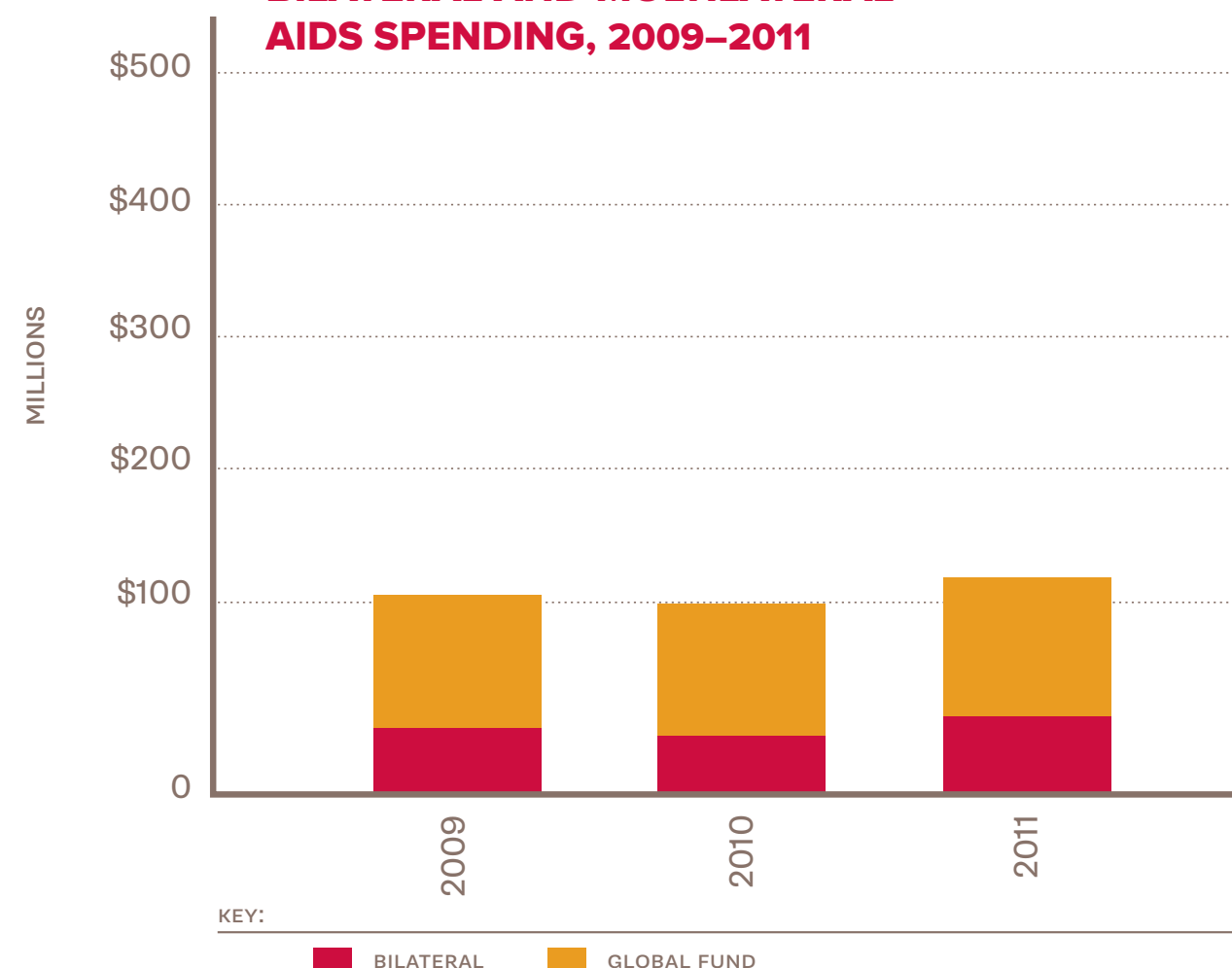
In 2010, the European Commission leveraged the International AIDS Conference in Vienna to host a number of side sessions and highlighted projects funded through the European Health Programme.¹⁵

On World AIDS Day 2011, the European Union issued a statement endorsed by Member States and institutions that reaffirmed its commitment to support the response against HIV/AIDS. The statement called for the EU to "play a decisive role by strengthening its leadership in the response to HIV and AIDS" and reiterated the commitment to the UN 2011 Political Declaration on HIV/AIDS targets: 15 million people on treatment, halving sexual transmission, halving transmission of HIV among people who inject drugs, eliminating mother-to-child transmission of HIV and substantially reducing AIDS-related maternal deaths.¹⁶

Programmatic Efforts

EU efforts to prevent and treat HIV/AIDS are frequently part of larger programmatic efforts to strengthen health systems through health sector support at country level. Part of the Commission's health support goes through either general or sectoral budget support,¹⁷ for which specific amounts for HIV/AIDS cannot be attributed (even though some of the results indicators target health and/or HIV/AIDS).

BILATERAL AND MULTILATERAL AIDS SPENDING, 2009-2011



The Commission's efforts are also largely defined by a number of strategy and communication documents. In October 2004, it adopted a communication entitled "A Coherent European Policy Framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis". In 2005, it subsequently published the "Programme for Action" (PfA) on the three diseases, which proposed collective EU action (by the EC and EU Member States) to support both country-led programmes and global programmes to tackle the three diseases in selected areas where the EU could add value, such as improving the affordability of pharmaceutical products, improving regulatory capacity and improving human resources in the health sector.¹⁸ The PfA came to an end in 2011.

Focusing on the AIDS response in Europe, the Commission adopted a strategy document in 2009 titled "Combating HIV/AIDS in the European Union and Neighbouring Countries (2009-2013)" and an accompanying Action Plan, aimed at contributing to reduced HIV infections in European countries and neighbouring countries.¹⁹ The Action Plan identified key priorities including improving access to prevention, treatment and care as well as improving the quality of life of people living with HIV. It also included an additional emphasis on marginalised populations, including men who have sex with men, injection drug users and migrants from countries with higher HIV burdens.

Specifically, the Commission communication and Action Plan aimed to:

- Reduce the number of new infections in all European countries by 2013;

- Improve access to prevention, treatment, care and support;
- Improve the quality of life for people living with, affected by or vulnerable to HIV.²⁰

In March 2010, through its communication "The EU role in Global Health", the Commission re-established that its efforts on HIV/AIDS – as well as on other global health topics – would be carried out through a comprehensive approach to strengthen health systems.²¹ In order to carry out this mandate, the Directorate for Development Cooperation has announced its intention to develop a programme for action on global health in 2013, which will articulate how the Commission will implement this policy.²² In addition, the EU's recently adopted development policy "Agenda for Change" underscores these efforts by establishing that at least 20% of EU aid will be supportive of social inclusion and human development topics (including health), though it does not articulate specific outcomes to be achieved with new investments.

Looking Ahead

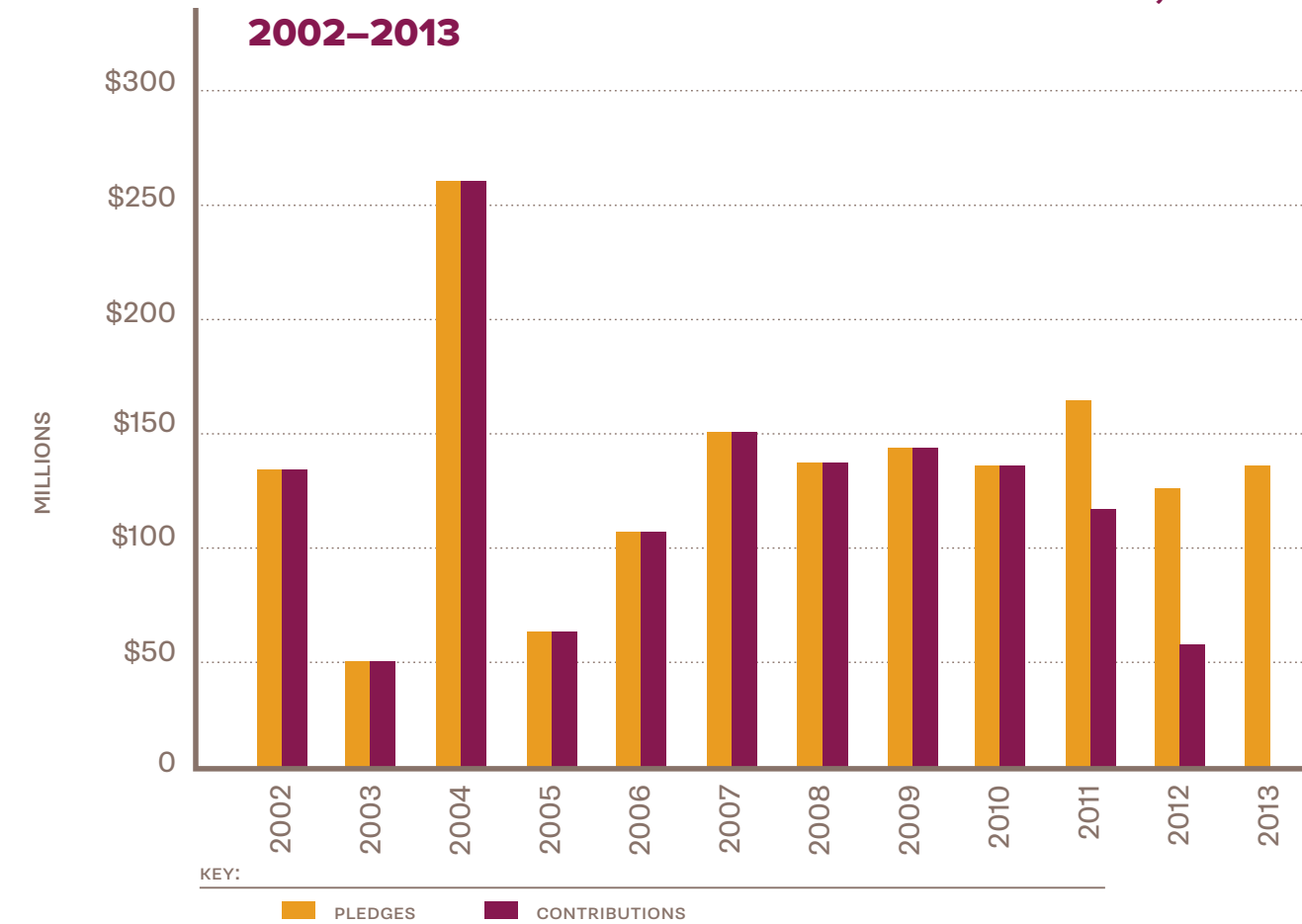
The EU is currently negotiating its next seven-year budget, for 2014-2020. As part of this budget, a total of €100 billion (\$128 billion)²³ has been proposed by the EC for external spending, including for the EDF, the DCI, the European Neighbourhood Instrument and other instruments. These negotiations represent a crucial opportunity for long-term and sustainable EU development assistance for the fight against HIV/AIDS; in particular, the Commission's ability to robustly support the Global Fund under the DCI and the EDF hinges on the outcomes of the

negotiations. In the upcoming programming process of these two instruments, EU institutions and the group of ACP countries should sustain current levels of Commission contributions of at least €100 million/year (\$128 million/year),²⁴ while the EU must demonstrate continued political and financial support for HIV/AIDS in the EU institutions' bilateral relations with developing partner countries worldwide. For EU-internal health spending, the Commission has proposed a new legislative proposal for 2014-2020 called the "Health for Growth" programme, which includes the prevention of diseases such as HIV/AIDS and the promotion of good health for all.²⁵

Against this backdrop, the EU should renew its policy focus on AIDS in its external action. As the only existing EU health-related implementation strategy – the "Programme for Action to confront HIV/AIDS, Malaria and Tuberculosis" – ended in 2011, the forthcoming Global Health Programme for Action, as defined in the Commission's 2010 communication, must serve as the follow-up to this strategy and incorporate targets in its scope, if the EU and its Member States are serious about building on the impact of their AIDS response in a coordinated way.

Finally, as the EU completes its next budgeting process and begins to allocate resources, the Commission should undertake a serious effort to better track how its resources are being spent on the ground and to measure the outcomes those resources have achieved. In doing so, it will be better positioned to quantify how investments have contributed toward specific results aimed at achieving the beginning of the end of AIDS.

GLOBAL FUND PLEDGES vs CONTRIBUTIONS, 2002-2013



Note: The Global Fund contribution amount for 2012 reflects only current contributions as of mid-October 2012. This amount may increase by the end of 2012.

“ I would like to reiterate our commitment to the fight against HIV/AIDS. The pandemic may not make headlines anymore, but it continues to have a devastating impact, particularly in Africa. We will not abandon the fight against this scourge. This is the message that I have come to deliver today. ”

— Development Commissioner Andris Piebalgs, UN General Assembly, September 2012²⁶

The Global Fund: Channelling Multilateral Support in the Fight against AIDS

When the Global Fund to Fight AIDS, Tuberculosis and Malaria was first created in 2002, it was designed to be a “war chest” to fuel an emergency response and stem the tide of the three infectious diseases. The Global Fund was also purposely designed to be different from existing aid mechanisms, with decisions about what programmes to fund driven by local stakeholders rather than by external donors. The model proved to be extremely effective in capturing demand from affected countries applying for grants and in channelling donor resources through country-managed grants to achieve sustainable results. As of September 2012, the Global Fund had supported programmes that had helped to deliver antiretroviral treatment for 3.6 million HIV-positive people; services to prevent mother-to-child transmission of HIV for 1.5 million HIV-positive mothers; TB case detection and treatment for 9.3 million people; and 270 million insecticide-treated nets to protect families from malaria.

Just as the global AIDS response has evolved, the Global Fund is also in the process of evolving its planning processes, risk management procedures and operating model to better reflect lessons learned and international best practices. Many of these changes are rooted in its desire to become a more strategic investor, able to better link resources with high-impact interventions on a country-by-country basis. As of October 2012, the new model had not been finalised by the Global Fund’s Board, but these changes should allow it to contribute even more effectively to the beginning of the end of AIDS by better matching its AIDS financing to countries and

regions with the highest disease burdens and by forcing countries to outline more explicitly how AIDS financing will be tailored to local epidemiological trends.

The Global Fund remains the pre-eminent multilateral funding vehicle for donors around the world, channelling 82% of the international financing for TB, 50% for malaria and 21% for AIDS. But for the first time in the Fund’s history, in 2010 donors did not collectively fill the estimated \$13–20 billion it needed to scale up its support to match countries’ demands for the 2011–2013 period. Further reticence by some donors in 2011, fostered in part by sensationalist reporting on a small percentage of funding misuse in a handful of recipient countries, as well as by operational and financial management concerns, forced the Global Fund to cancel its 11th round of grant-making to countries and to re-evaluate its allocation model moving forward. Through a series of policy decisions, including one to no longer finance programmes in upper-middle-income countries without significant disease burdens, the Global Fund freed up significant additional resources to provide a transitional funding window for critical services. Its board and management team also decided to put in place even more robust risk management processes to ensure the best use of its resources. Since 2011, as these decisions have been made and implemented, a number of donors – including Germany, Japan, Spain and the Bill & Melinda Gates Foundation – have either reaffirmed pledges previously withheld or have increased their levels of support.

Figure 1 provides an overview of the donors from the public and private sectors that have provided support to the Global Fund from 2009 to 2011. Sustained and increased contributions in the coming years will be critical to the Global Fund’s ability to support life-saving interventions on the scale necessary to accelerate progress. With adequate resources, the Global Fund’s new strategy for 2012–2016 points it on an important trajectory: through targeted health interventions, it can save 10 million lives, prevent 140–180 million new infections from all three diseases, and continue to play a key role in driving progress towards the beginning of the end of AIDS.

Countries	2009	2010	2011
Australia	32,819,700	42,538,200	42,150,000
Belgium	23,332,021	27,413,000	26,867,400
Brunei Darussalam			100,000
Canada	141,487,351	141,750,142	176,470,588
China	2,000,000	2,000,000	4,000,000
Denmark	31,873,236	31,214,521	30,723,315
European Commission	143,260,000	134,422,187	147,131,000
Finland	4,897,550	4,387,600	5,200,800
France	408,509,375	391,213,878	457,410,937
Germany	271,441,775	265,751,520	273,110,000
India	2,000,000	2,000,000	
Ireland	13,966,000	35,764,601	
Japan	194,426,073	246,870,005	114,229,085
Korea (Republic of)	3,500,000	2,000,000	2,000,000
Kuwait	500,000	500,000	500,000
Liechtenstein	126,839	102,754	105,369
Luxembourg	3,321,750	3,169,250	3,571,750
Malaysia		100,000	
Namibia			250,000
Netherlands	83,472,000	90,802,000	88,406,540
New Zealand		671,400	
Norway	67,151,350	61,969,131	75,700,227
Portugal	2,500,000	2,533,866	
Romania	107,613	67,360	143,240
Russia	57,398,138	5,456,880	20,000,000
Rwanda			350,000
Saudi Arabia	6,000,000	6,000,000	
Slovenia	60,342	68,560	
Spain	214,444,317	133,673,400	
Sweden	89,743,141	74,041,167	87,168,759
Switzerland	6,293,266	7,186,858	8,541,533
Thailand	1,000,000	1,000,000	1,000,000
Tunisia			2,000,000
United Kingdom	184,071,300	308,480,307	239,427,746
United States	959,036,684	999,080,182	992,419,312
Total	2,948,739,821	3,022,228,768	2,798,977,600

FIGURE 1:

GLOBAL FUND DONOR CONTRIBUTIONS 2009–2011 (as of October 2012)

Other	2009	2010	2011
Bill & Melinda Gates Foundation	100,000,000	100,000,000	150,000,000
Debt2Health			
Australia (debt cancellation)			
Indonesia		1,849,875	3,965,437
Germany (debt cancellation)			
Côte d'Ivoire		660,965	929,176
Egypt			4,807,118
Indonesia	7,244,328	6,287,938	7,169,194
Pakistan	6,946,683	6,120,771	7,137,089
Anglo American plc.			1,000,000
Chevron Corporation	10,000,000	10,000,000	8,000,000
Comic Relief	2,984,220	310,020	
Exchange-Traded Funds (ETF)			9,208
Idol Gives Back	10,600,000		
Gift From Africa			693,333
M·A·C AIDS Fund	500,000	375,000	500,000
(RED)	18,867,601	21,096,496	21,462,249
Takeda Pharmaceutical		1,083,265	1,152,361
The UN Foundation and its donors:			
Hottokenai Campaign			
Lutheran Malaria Initiative			338,944
United Methodist Church			1,590,000
Other UNF donors		607,409	523,547
Other donors	14,157	21,187	47,700
Total	157,156,989	148,412,926	209,325,357
Grand Total	3,105,896,810	3,170,641,694	3,008,302,957

African Commitments and Initiatives: Increasing Domestic Resources and Coordinating Strategy

Though the majority of the world's HIV/AIDS burden exists in Africa,¹ for too long the larger part of global conversations about how to fight the disease – including questions about how to finance the fight – have not meaningfully involved African leaders, citizens or resources. In the past few years, however, there has been growing recognition that the response to the AIDS pandemic requires global action and, indeed, African solutions will be a key factor in achieving the beginning of the end of AIDS.² As donor countries experience an historic economic downturn, African economies are continuing to grow, and the sustainability of the international AIDS response will require new sources of innovation and financing on the African continent itself.

Donor assistance for health in sub-Saharan Africa has grown dramatically over the past decade. From 2002 to 2009, annual donor funding for health in the region increased by 463%, from \$1.5 billion to \$8.2 billion,³ in large part due to the global response to the AIDS pandemic. While these investments have achieved tremendous results, sustaining this level of financing for health – and for HIV/AIDS in particular – has become more challenging in the context of the global financial crisis and emerging donor fatigue. There is evidence that donor commitments and disbursements for AIDS assistance have already begun to plateau.⁴ Moreover, sub-Saharan Africa's heavy dependence on foreign donors for health-care financing⁵ leaves its people vulnerable to changes in programmatic and budgetary priorities.

Efforts to increase and sustain African domestic financing for health have produced mixed results to date. In 2001, the member states of the African Union met in Abuja, Nigeria, and pledged to allocate at least 15% of their national budgets to improve the health sector. This commitment, known as the Abuja Declaration, acknowledged the need for African governments to increase their domestic financial resources for health in order to make progress towards the MDGs, while urging donor countries to fulfil their aid targets of 0.7% of GNI. The WHO reports that, from 2001 to 2009, 26 African countries increased the proportion of total government expenditures allocated to health, but only one met the Abuja 15% target,⁶ and 11 countries reduced their health spending.⁷ According to a ONE analysis of more recent WHO data, only four African countries had met their Abuja pledge by 2010: Togo (15.4%), Zambia (15.6%), Botswana (17.0%) and Rwanda (20.1%).

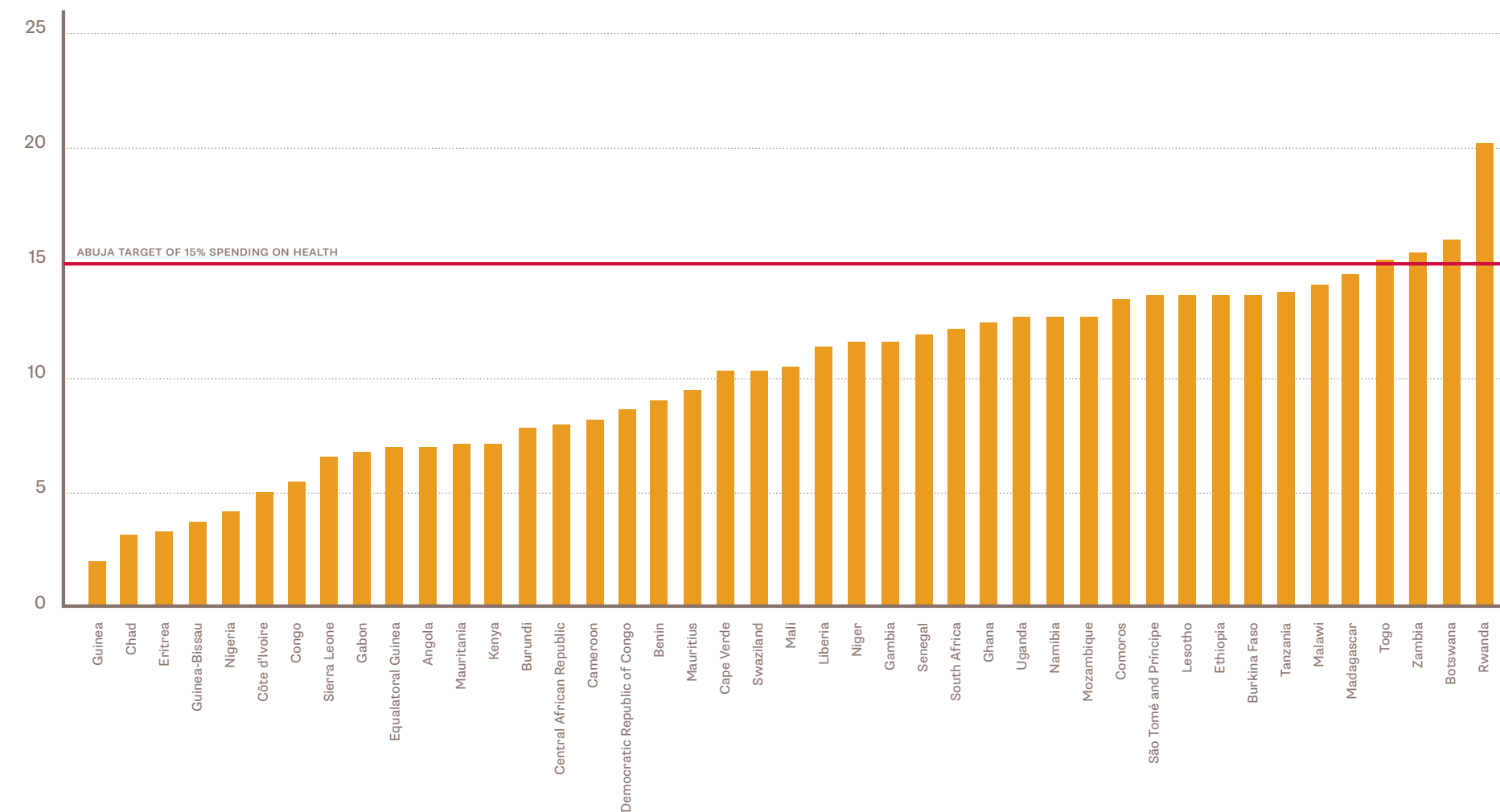
With three years remaining until 2015, there is still time for African countries to fulfil their Abuja commitment in support of the health MDGs. Due to the data lag, some countries may already have met their pledges in 2011 and 2012. Looking ahead, a number of African countries are on track; Madagascar only needs to increase its health expenditures by 2.0% and Malawi by 5.7%. Ten other countries are within 25% of the Abuja target, and eight are between 25% and 50%. Unfortunately, 13 countries are so far behind they would have to at least double, or in some cases triple or quadruple, their public health expenditures in order to meet the Abuja target.⁸

African leaders have also been contributing new efforts beyond financing, focusing on strategy development. Building on the 2001 Abuja Declaration, and acknowledging what they defined as a growing “AIDS dependency crisis”,⁹ the Heads of States of the African Union launched the “Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB, and Malaria Response in Africa”¹⁰ in early 2012. In this document, African leaders proposed a partnership strategy for the orderly transition from donor-based to domestic-based financing over the period 2012-2015. As an important first step, in July 2012, African Health and Finance Ministers met in Tunisia to develop a common strategy for operationalising the AU roadmap in each country.¹¹ Additionally, they clarified requirements from future donor assistance, outlining a desire for continued financial commitments and technical assistance to strengthen internal systems for financial management and for budget transparency and accountability.

While addressing the complex challenges of the AIDS epidemic will require increasing resources supported by meeting the Abuja commitments and strengthening the overall health sector, a number of African countries have been tackling the response in unique and innovative ways, with impressive results. Botswana, with an adult HIV prevalence rate of 25%,¹² became the first country in Africa to implement a free nationwide ARV treatment programme in 2002. Today, Botswana has a greater than 95% coverage rate of treatment for those in need¹³ and only a 3.6% rate of mother-to-child transmission of HIV,¹⁴ a huge achievement for a

FIGURE 2:

PERCENTAGE OF AFRICAN NATIONAL BUDGETS ALLOCATED FOR HEALTH, 2010



Source: ONE calculations using WHO NHA data

country with such a large AIDS burden. These results are particularly noteworthy as the Government of Botswana is largely responsible for financing its own response to the AIDS epidemic, contributing 80–90% of necessary resources, with additional assistance from PEPFAR and the Global Fund.¹⁵ Equally impressive, in Kenya, the government has launched an HIV prevention campaign with the goal of one million voluntary medical male circumcisions by the end of 2013, in light of research showing that medical male circumcisions can reduce the risk of HIV transmission to men by as much as 60%. More than 400,000 have already participated, a tribute to the tremendous education, organising and outreach efforts of the Kenyan Ministry of Health in conjunction with non-governmental partners and donors.¹⁶ These are just two examples of the many success stories that can be found across the continent, where national governments play critical leadership roles in fighting the HIV/AIDS epidemic.

In the long term, a sustainable response to the AIDS epidemic will depend largely on public financing from African governments. As African economies continue to experience dynamic growth, governments have the opportunity to increase their budget allocations for

health. An estimated \$90 billion is at stake between now and 2015 if African governments can garner the political will to achieve the Abuja commitments.¹⁷ The Abuja Declaration is about the principle of African ownership, that African governments have both the capacity and the responsibility for the health of their own people – along with African leaders, health workers and community advocates who deserve credit for the significant accomplishments achieved over the past decades. From the AU roadmap to the Abuja pledge, the African continent continues to demonstrate leadership and innovation in the fight against AIDS, but accelerating progress to achieve the beginning of the end of AIDS depends on the strengthening of this commitment.

In the future, as more and better data becomes publicly available, this report would ideally utilise the same methodology used for donor countries to assess African governments' contributions to the fight against AIDS. At this point in time, however, such a level of detail is not available for sub-Saharan African countries in a consistent and comparable format.



Jane, her husband, and their HIV-negative children Daniel and Princess (Uganda, 2011; Photo credit: Elizabeth Glaser Pediatric AIDS Foundation by James Pursey)

Case Studies

The following case studies highlight a number of innovative efforts by non-traditional actors to combat the AIDS pandemic. The diverse examples here represent just a sample of the many creative and strategic approaches being pursued by a much larger group of actors – emerging economies, the private sector and the non-governmental community, including faith-based actors. They should not be seen as encompassing all of the significant efforts being undertaken by many other important groups,

including other civil society groups that are also helping to shape local, national and global thinking about how best to drive progress. Many of these non-traditional efforts are helping to ensure a more truly global response that draws upon the unique relationships, skill-sets and generation of ideas necessary not just to control AIDS but to accelerate progress and ultimately change the trajectory of the pandemic.

BRAZIL

Pioneer of South–South Cooperation in the Fight Against AIDS

Over the past two decades, Brazil has moved from being a recipient of HIV/AIDS assistance to becoming a recognised leader in the global fight against the disease, pioneering South–South cooperation and sharing its experiences of successfully implementing HIV and antiretroviral (ARV) programmes at home.

Brazil is currently the sixth largest economy in the world and is projected to overtake France as the fifth biggest by 2016.¹ Both domestically and internationally, it has been applauded for its strong focus on health, particularly its emphasis on rights and equitable access to treatment.² In 2003, the World Health Organization (WHO) asked the chief of the Brazil AIDS programme to help it design new policies for combating HIV/AIDS around the world, and numerous developing countries have adopted the Brazilian model.³ In 1996, Brazil committed to providing free universal ARV treatment for its citizens, an achievement attainable partly through the growth of its own generic, low-cost pharmaceutical industry. This policy has thus far achieved impressive results, keeping the adult HIV/AIDS prevalence rate low over the past decade and nearly halving AIDS-related mortality.⁴ Brazil's success in providing universal treatment has fundamentally shifted international policy norms and has established the country as a global leader in the field of HIV and ARV programmes. Brazil now cooperates extensively with other developing countries, particularly in Lusophone Africa (Angola, Cape Verde, Guinea-Bissau, Mozambique and São Tomé and Príncipe), providing technical and financial assistance and advice.⁵

In July 2012, Mozambique – where 2.5 million people live with HIV but only 300,000 have access to ARVs – launched its first ARV factory, funded with \$23 million in assistance from the Brazilian government, plus \$4.5 million from the Brazilian private sector.⁶ Fiocruz, the Brazilian public health institution, is training Mozambican staff and providing equipment to the facility.⁷ Currently the factory certifies, packages and distributes generic medicines manufactured in Brazil, but it will begin production of its own ARVs by the end of 2012. Once fully complete in 2014, it will be able to produce 226 million ARV tablets per year and 145 million units of other medicines for supply both within Mozambique and to other African countries, reducing donor dependence and initiating what former Brazilian President Lula da Silva called a “revolution” in the fight against HIV/AIDS in Africa.⁸

Brazil also provides support to other developing countries through its International Centre for Technical Cooperation (ICTC) on HIV/AIDS, established in 2005 in partnership with the UN.⁹ In 2010/11, the ICTC undertook 14 collaboration projects, including in Congo, Guinea-Bissau, Kenya, Tanzania and Zambia.¹⁰ Like Brazil's international cooperation programme more broadly, the ICTC takes a “horizontal” rather than a “top-down” approach, facilitating efforts by emerging countries to exchange experiences, learn together and share results and responsibilities.

CHINA

Investing in HIV/AIDS Research and Development

China continues to experience a significant HIV burden, but is beginning to take a greater role in addressing it with its own resources. While the prevalence rate of HIV remains relatively low at around 0.1%, the number of cases is rising rapidly.¹ Between 2007 and 2011, the number of reported cases in China nearly doubled from 48,161 to 92,940.² Until recently, the country received large amounts of donor funding to fight the AIDS epidemic – \$587 million in total from the Global Fund between 2003 and 2011. However, in December 2011, as the Global Fund prepared to stop funding for middle-income countries, China formally agreed to provide the same amount of domestic financing that it would have received from the Global Fund, a decision lauded by international HIV/AIDS groups.

China is also leading the way in scientific innovation and has become one of the world's most important investors in HIV/AIDS research and development (R&D), particularly in the field of vaccines. In a global economic climate in which many rich countries are cutting back on R&D, China is bucking the trend by increasing its financial support. Three years ago, it overtook Japan to become the second largest funder of overall R&D after the US.³

Over recent years, China has driven several advances in its research on HIV/AIDS. In 2009, the China AIDS Vaccine Initiative (CAVI) was launched,

with the mission of enhancing communication, technical development and cooperation, and international collaboration to improve research capacity.⁴ In 2010, China spent \$18.3 million on R&D of HIV vaccines and \$3.6 million on R&D of microbicides (gels and creams which protect against STIs, including HIV), making it the sixth largest funder in the world in these fields.⁵ In 2011, the Chinese Ministry of Science and Technology and the Bill & Melinda Gates Foundation established a \$300 million partnership to develop new health technologies for resource-poor countries.⁶ This is a landmark collaboration – the first time that the Chinese ministry has partnered with a foreign NGO in this field. China also recently invested \$1.3 billion in two health-related “mega projects” focused on disease prevention (including HIV) and drug development, channelling funding into the advancement of new vaccines, pharmaceuticals and diagnostics.⁷

Over the past few years China has developed a variety of candidate HIV vaccines, completed several rounds of clinical trials and collaborated internationally on HIV/AIDS research. Earlier this year, scientists at the Institut Pasteur in Shanghai announced an important breakthrough that may lead to the world's first successful vaccine for HIV-1, the most common strain of the HIV virus.⁸

INDIA

‘Pharmacy of the Developing World’

India, a fast-growing emerging market, has become a global leader in the manufacture of generic pharmaceuticals, especially of inexpensive ARVs. In just five years, the price of one commonly used first-line ARV fell from \$414 to \$74 per person per year, in large part due to competition among Indian generic manufacturers.¹

In most countries, companies that invent drugs are granted a patent on them (usually for 20 years), meaning that they have the exclusive right to sell the drug and thereby preventing any competition from other companies that would drive down prices. Until 2005, India did not allow companies to have patents, which enabled firms to produce generic versions of drugs that were patented in other countries. Since 2005, WTO regulations have compelled India to adopt new patent legislation, although this does not apply to drugs invented before 1995 and later versions that have not undergone significant innovation.² Through this policy, India has emerged as the world's key source of affordable medicines, earning the epithet of “pharmacy of the developing world”.

In 2008, India produced 20% of all global generic drugs, more than 80% of the generic ARVs used to treat people in low- and middle-income countries and more than 90% of the generic ARV medicine designed for children.³ Between 2003 and 2008, the number of Indian firms supplying generic ARVs

more than doubled, and the number of products they manufactured more than tripled.⁴ Apart from India itself, the top ten purchasers of Indian generic ARVs were all sub-Saharan African countries.⁵ The creation of India's sizeable generic pharmaceutical industry has radically scaled up the provision of HIV/AIDS treatment, leading to an estimated four million people starting on ARVs between 2002 and 2008 alone.⁶

Indian firms are now looking to invest in this burgeoning industry in other developing countries. One area for growth might be agreements to supply African countries with the generic materials used in the manufacture of ARVs so that they can produce the drugs themselves.⁷ African countries such as Tanzania, Kenya, Ghana and Zambia are already developing domestic HIV drug production facilities.

India has been supported in the fight against AIDS by a range of organisations, such as the Clinton Health Access Initiative (CHAI) and UNITAID, which have worked extensively to build markets and reduce price ceilings so that poor people can access medicines.⁸ CHAI has worked with India on a major paediatric HIV project, including providing over \$6.6 million to purchase paediatric ARVs and over \$1 million to purchase drugs to treat opportunistic infections in children.⁹

ANGLO AMERICAN & VOLKSWAGEN

Leading Workplace Efforts to Combat HIV/AIDS in South Africa

As major corporate presences in South Africa, both Anglo American and Volkswagen have established initiatives in their workplaces to combat HIV/AIDS among employees, their families and their communities.

Anglo American (a British mining company) has the biggest corporate HIV programme in the world.¹ Of its 70,000 permanent staff in southern Africa, 12,000 are HIV-positive. Anglo American's efforts are designed first to ensure that all employees are aware of their HIV status and then to provide access to free ARVs for all HIV-positive employees and their dependents.² To date, 94% of its employees in the region have voluntarily been tested and received counselling³ and, as of December 2011, 4,730 employees were on ARVs. Anglo American is currently planning to put all HIV-positive employees on ARVs before the disease progresses to a state in which they are more likely to acquire full-blown AIDS or other infectious diseases.⁴ HIV-positive employees are able to enrol in a free HIV disease management programme, which provides counselling, immune system monitoring and TB-preventative therapy. Through this programme, Anglo American has reduced the AIDS death rate within its workforce by 50%.⁵

Anglo American also works with other partners to further its outreach. In 2007, in conjunction with Virgin Unite and the US Government, the company helped open the Bhubezi Community Healthcare Centre in South Africa's Mpumalanga province, which serves approximately 130,000 patients living in this impoverished region.⁶ Beyond direct

service provision, Anglo American has expanded its reach to influence the global fight against AIDS. In 2010, it pledged \$3 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria at the G20 Business Summit and has since pressured other corporations to follow suit.⁷ Anglo American's Chief Medical Officer, Dr. Brian Brink, is on the board of the Global Fund, and his presence there helps to shape policy decisions on behalf of the private sector.⁸

Volkswagen (a German car manufacturer) runs the biggest car manufacturing plant on the African continent and has more than 4,600 employees in South Africa. To protect its workforce and help fight HIV/AIDS, it has offered free counselling and testing for all of its employees since 2001. Before the government's health-care institutions started providing medication, the company also provided treatment. Since HIV/AIDS is surrounded with stigma, it was initially difficult for Volkswagen to get employees to use the services offered. To help overcome this stigma, its South Africa Managing Director, David Powels, took an HIV test in public, and the company has developed a peer counsellor system, wherein individuals who are trained can impart health information and encourage employees to be tested. Consequently, 87% of the workforce has since been voluntarily tested for HIV.⁹

Volkswagen also actively reaches out to its South African suppliers in order to ensure that they have HIV workplace programmes in place. Thus far, ten suppliers have joined the scheme and

more are expected to do so in the coming years. The programme was developed with the support of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the German government's enterprise for technical cooperation, which is implementing HIV workplace programmes with more than 130 companies in southern Africa.¹⁰

Beyond providing services for employees, their families and those of its suppliers, Volkswagen is engaged in the fight against AIDS in the wider community. It is collaborating with South African health service providers through the Volkswagen Community Trust, a non-profit organisation that caters to the needs of AIDS orphans and arranges training for medical practitioners. Moreover, the

company is co-funding "loveLife", South Africa's largest national HIV prevention initiative for young people, which is run by the South African government, the private sector and GIZ.¹¹

The efforts of both companies on HIV/AIDS have won international plaudits from the Global Business Coalition (GBC).¹² Anglo American's and Volkswagen's approaches to HIV/AIDS in the workplace and globally have significantly contributed to the health of their employees and have redefined perceptions of the disease in the workplace through innovative programmes that lessen the stigma and discrimination associated with it.

THE COCA-COLA COMPANY & PARTNERS

Going the Last Mile for Medicines in Tanzania ¹

In 2009, the Global Fund approached The Coca-Cola Company for support in improving medicine distribution practices. As a global brand present in more than 200 countries, and with capability to reach rural parts of Africa, Coca-Cola has recently become involved in a new type of partnership model to transfer core business expertise in supply chain management to its public sector partner, the Medical Stores Department (MSD) of Tanzania. In 2010, together with the Global Fund, the Bill & Melinda Gates Foundation and Accenture Development Partnerships (ADP), and with leadership from individuals including Bobby Shriver and Todd Summers, Coca-Cola launched the “Last Mile for Medicines” partnership, leveraging its supply chain expertise and global brand recognition to improve the distribution of pharmaceuticals and medical supplies in Tanzania.²

Since its initiation, the Last Mile partnership has achieved impressive results. It has benefited nearly 20 million people with better access to essential medicines for AIDS, tuberculosis and malaria; reduced delivery lead times of some critical medicines by as much as 25 days; and enabled MSD to rapidly reorganise and expand its distribution system.³ The partnership has taken advantage of three areas in which Coca-Cola’s expertise matched MSD’s needs and priorities. First, improved planning and procurement processes were introduced to prevent stock-outs at central levels. Second, a blended learning model was developed, combining formal coursework through ADP’s web-based Supply Chain Academy with meetings and site visits to help Coca-Cola bottlers and MSD personnel to learn from each other. Finally, Coca-Cola used its network optimisation expertise to help MSD implement an improved distribution model that enables it to take full

responsibility for accurate and on-time delivery to all 5,000 health centres and dispensaries across the country.⁴

As a partner with The Coca-Cola Company, Yale University’s Global Health Leadership Institute (GHLI) conducted research to identify factors associated with the success of the partnership model. GHLI has identified five factors underlying the initial success of the Last Mile project model: (1) flexibility, time and effort to adapt the global partnership idea to local needs and priorities; (2) a dedicated group of “champions” who have stepped outside of their job descriptions to remove obstacles and turn ideas into realities; (3) strong country ownership; (4) candid conversations about the interests of each partner organisation to ensure alignment; and (5) investment in hands-on project management to ensure the translation of Coca-Cola tools and approaches into the operations of MSD. The integration of private business expertise, forward-thinking public social service organisations and an academic partner to promote rapid feedback and learning together have strengthened a distribution system that saves lives.⁵

Coca-Cola and partners are now launching the next phase of work in Tanzania to drive expansion of the Last Mile initiative into additional geographic areas. The next phase will aim to increase impact, strengthen MSD’s capacity and refine the partnership. Most recently, Coca-Cola and its strategic partners have begun replicating the knowledge transfer partnership model in Ghana, focusing on the distribution of vaccines and leveraging both marketing and supply chain expertise.

(RED)

Driving Consumer Awareness and Raising Private Sector Funds for the Global Fund

(RED) is an innovative business model that transforms the collective power of consumers into a financial force to help others in need. (RED) – a division of The ONE Campaign – partners with iconic brands and organisations who agree to contribute up to 50% of profits from (RED)-branded products, events and services to the Global Fund. The funds raised are invested in HIV/AIDS programmes in Africa, with a focus on countries with high prevalence of mother-to-child transmission of HIV. 100% of this money goes to work on the ground in Africa – no overhead is taken out.

Founded in 2006 by Bono and Bobby Shriver, (RED) was created to bolster the private sector’s participation in the Global Fund’s collaborative public-private mission. Today, (RED) is the largest business initiative supporting the Global Fund, having contributed more than \$195 million to support HIV/AIDS grants in Ghana, Lesotho, Rwanda, South Africa, Swaziland and Zambia – 39 times the amount the Global Fund was able to generate from the private sector in its first four years (2002–2006) before (RED) was founded.

(RED) reaches a global and diverse audience through its wide range of corporate partners. Its partnership model includes two tiers: “Proud Partners”, who typically deliver a minimum of \$1 million to the Global Fund annually, and “Special Edition” partners, who are smaller companies that help bring (RED)’s message into new and niche markets. (RED) Proud Partners include Apple, Beats by Dr. Dre, Belvedere, Bugaboo, Claro, The Coca-Cola Company, Converse, Penfolds, SAP, Starbucks, Telcel and American Express (UK only). (RED) Special Edition partners include Bottletop, FEED, Girl Skateboards, Mophie, Nanda Home, Shazam, Solange Azagury-Partridge, TOUS and Tourneau.

(RED) and its partners also work to raise awareness and generate interest in the fight against AIDS through marketing and outreach efforts focused around two high-impact and highly visible moments each year – World AIDS Day and the (RED)RUSH TO ZERO campaign in June. (RED) actively engages its social media audience of over three million (it was recognised as the first cause to have reached more than one million followers on both Facebook and Twitter) and recently set a new record with the largest non-profit check-in campaign on Foursquare (a location-based social networking site), in partnership with Starbucks, raising \$250,000 in eight days during 2012’s (RED) RUSH TO ZERO campaign.

Thus far, (RED)’s unique model has demonstrated significant financing and programmatic impact: by the end of 2012, through its partners and events, it will have raised \$200 million to support Global Fund grants that have reached more than 14 million people with prevention, treatment, counselling and care services. (RED) funding has supported programmes that have helped provide life-saving ARV therapy for 220,000 HIV-positive people, provide more than 130,000 HIV-positive pregnant women with PMTCT services and reach 13 million people with HIV testing and counselling.

(RED) has joined the global health community in raising funds and awareness to help deliver an AIDS-free generation by 2015, and is playing an important role in this effort. As UNAIDS Executive Director Michel Sidibé said in September 2011, “We have a shared goal to end new HIV infections among children by 2015 and UNAIDS is counting on (RED) to engage new partners and resources in this movement.”

THE CENTER FOR INTERFAITH ACTION (CIFA)

Studying the Role of Faith Leaders in Scaling Up New Prevention Strategies

The Center for Interfaith Action (CIFA), founded in 2008, is committed to promoting “behavior change through health, education and other development initiatives”.¹ CIFA brings together faith leaders of all denominations based in Washington, DC and from across the United States to research how interfaith cooperation can be most beneficial to communities, and to develop new models and tools for interfaith engagement and partnerships with governments and aid agencies. Its primary goal is to find key ways in which the religious community can effectively implement programmes ranging from female empowerment to HIV/AIDS prevention.

In March 2011, CIFA identified a particular opportunity where religious leaders could play a proactive role in introducing a new biomedical intervention to HIV prevention: pre-exposure prophylaxis (PrEP), which includes both oral tablets and vaginal microbicides. The PrEP approach consists of a pill taken daily by HIV-negative individuals and has been shown to be effective in reducing the risk of sexually transmitted HIV.² Acknowledging the important role of faith leaders in communities around the world, CIFA began its research in Mozambique, South Africa, Kenya and Nigeria to evaluate the reaction and role of faith leaders in the implementation of PrEP.

The results of its study highlight a number of important findings on the role of faith leaders in HIV prevention. First, CIFA found that faith leaders are powerful allies in the implementation of PrEP.³ Faith leaders never rejected the use of PrEP; in fact, CIFA found that they were willing and enthusiastic about advocating for HIV prevention

within their communities. Even leaders with strong opinions about PrEP did not reject it, but said that they would consider it in the larger prevention approach. Second, if religious leaders are to be engaged with the implementation of this approach, it must be done in accordance with the values and language of the faith.⁴ More specifically, CIFA emphasises that “the key to this translation is that it must recognize that faith leaders are, first and foremost, moral and spiritual guides for their communities, concerned with the holistic welfare of their parishioners, including their physical, emotional and spiritual health”.⁵ CIFA’s study has provided the basis for innovative faith-based HIV prevention programmes as well as new methods to engage faith leaders.

The release of CIFA’s landmark report demonstrates the importance and willingness of faith leaders to promote and implement HIV prevention strategies. In the case of PrEP implementation, religious leaders can only be involved if their role as leaders is respected and PrEP is presented as one effort to preserve the “sanctity of sexuality and the human body”.⁶ As new biomedical approaches to HIV prevention are developed and taken to scale around the world, it is critical that local leaders, including those from the faith community, are educated about their use and are equipped to support their roll-out among their communities, who place respect and trust in their views. Initiatives like CIFA’s will play an important role in ensuring that new strategies can be implemented to drive progress towards the beginning of the end of AIDS.

PRÉVENTION INFORMATION LUTTE CONTRE LE SIDA (PILS)

Targeting Services and Policy Improvements for Marginalised Populations

With just over 5,000 cases of HIV in 2011,¹ Mauritius is not an obvious priority for most AIDS donors and mechanisms. Still, one independent Mauritian NGO, Prévention Information Lutte contre le Sida (PILS), has brought the fight against HIV/AIDS in the country to the forefront by focusing on the parts of the population most affected by the disease.

PILS was started by Nicolas Ritter in 1996, two years after he discovered he was HIV-positive. At the time, there were only about 140 cases of the disease in the country, and treatment was largely unavailable, making HIV infection an inevitable death sentence. By the early 2000s, the number of known HIV-positive cases had doubled, and Nicolas decided to be the first person to publicly declare his status. With a change of government in 2000, PILS’ advocacy efforts intensified and it was able to convince the new government to open the National Aids Centre. As a result of strong advocacy by PILS, the government also agreed to provide universal access to ARVs.²

In this same period, Mauritius became a hub for heroin trafficking. In 2003, an explosion of HIV cases among drug users occurred, and by 2005 there were more than 2,000 cases of HIV in the country. In the same year, Mauritius was identified as the country with the highest opiate consumption in Africa (relative to population size). Today, 75% of HIV cases in the country are among injection drug users.³

PILS recognised that the groups most affected by the disease in Mauritius – commercial sex workers, men who have sex with men and injection drug users – could be stuck in a vicious cycle of vulnerability and poverty if their health needs were not supported. To address these issues, PILS organised the first conference in Africa on opiate abuse and harm reduction,⁴ and has successfully drawn attention to the emerging issue of drug use in Africa and the consequent epidemic problems. It has also created economic empowerment programmes and support groups for HIV-positive individuals,⁵ so that they can meet in a safe environment and share their fears, hopes and dreams.

PILS has also influenced the policy environment in Mauritius by lobbying for amendments to the Drug Act,⁶ which previously criminalised paraphernalia associated with drugs and prevented interventions such as needle exchange programmes that could help address HIV transmission. When the HIV/AIDS Bill was introduced in 2006, it contained harmful provisions such as the criminalisation of HIV transmission, but PILS was ready to mobilise and, through its advocacy efforts, has successfully had these provisions removed and replaced with language to protect HIV-positive individuals.

While in the early days of its advocacy work there were many instances when PILS was in direct opposition to the government’s position on HIV-related matters, it now has a meaningful working relationship with the government and is a key partner in the fight against the disease.

THE SADDLEBACK CHURCH IN RWANDA

Mobilising Volunteers for the Fight Against AIDS

The huge scale of the HIV/AIDS burden, with 34 million people living with the disease, presents a significant human resources challenge: in order to treat and care for those infected, a massive outpouring of effort by scientists, doctors, nurses and lab technicians is needed. In recognition of this challenge, the Christian Church - which has long been providing and supporting health-care services around the world - provides a vehicle through which thousands of volunteers can be mobilised and trained to support and augment the efforts of health-care professionals.

In 2007, a group of 14 churches and one mosque in Kibuye, Rwanda agreed to send two people from each congregation to be trained as community health workers (called Community PEACE Volunteers in this pilot programme). This training was sanctioned by the government of Rwanda, and sponsored by the Rwandan churches and the Saddleback Church in Lake Forest, California. Within five years, that group of 30 trainees has expanded to more than 3,500, and by the end of 2012 there will be 7,000 volunteer community health workers in Rwanda.


Each trained volunteer manages a caseload of seven families, whom they visit twice a month, sharing a basic health-care lesson with them as well as spiritual instruction. More than 100,000 home visits have been logged to date. About 300 of these volunteers are also trained as HIV-adherence coaches, using their own experiences with HIV to encourage and teach others. These trained

volunteers alert families to serious health concerns that potentially require further medical intervention and refer them to local clinics or hospitals, linking primary health care to secondary and tertiary care.

What makes this approach unique is that it is owned and managed by the local churches, and volunteers are not given any fee for attending the training or a stipend for their work. Instead, the volunteers earn community respect, admiration and honour for their service, and as a result the model may be scaled up without relying on grants or government funding.

In 2012, the group of Community PEACE Volunteers elected a spokeswoman, Odeth, to speak to the lead trainer. The trainer was fearful that the volunteers were tired of contributing their services without pay, but was astounded when Odeth said, "We want to change our name from 'Community PEACE Volunteers' to 'Community PEACE Servants'. Volunteers can quit at any time, but we're serving God."

Odeth and her fellow trained volunteers represent a bright hope for better access to health care for some of the poorest and most under-served people in Rwanda. And this model - training volunteers from local churches, and a train-the-trainer approach - has the potential to make significant impacts on health care not just in Rwanda, but in other countries where it might be replicated as well.

A close-up photograph of Chief Koffi Koussai, a man with a mustache, wearing a red t-shirt with a white graphic that says "Fighting COPI". He is looking down at a framed photograph of a young boy, Kevin, which he is holding in his hands. Another man wearing glasses is partially visible in the background, also looking at the photo. The photo shows a young boy in a suit and tie, looking slightly to the side.

Chief Koffi Koussai proudly shows an old picture of his son, Kevin. A few years ago, Kevin nearly died from an HIV-related infection. His father bravely defied social norms and supported him as he fought the virus. Today, Kevin is healthy and works full-time as a community HIV counselor at the local health center, helping other HIV-positive clients. Kevin's father remains one of his strongest supporters
(Photo credit: Olivier Asselin)

Recommendations: Galvanising a Global Response

Although incredible progress has been made in the fight against HIV/AIDS over the past three decades, achieving the beginning of the end of the disease will still require a significant amount of work and a heightened sense of urgency among global stakeholders. This report has provided a snapshot of where the world stands on specific targets and has assessed current political, programmatic and financial contributions to the fight. From this analysis, it is clear that many significant efforts are under way, but they are as yet insufficient to turn the tide on the AIDS pandemic. Transforming the vision of the beginning of the end of AIDS into reality requires not just bold rhetoric, but bold action and investments to match. No one country or actor can deliver the efforts required on its own: the solution lies in an effectively coordinated global response. Therefore, ONE recommends that stakeholders:

- **Coordinate all efforts to achieve the beginning of the end of AIDS within a global framework**

Currently, many donors are delivering important piecemeal efforts to address the AIDS pandemic, but these efforts are not yet coordinated with one another or with recipient nations to the maximum extent possible. Many donors still do not have strong global AIDS strategies in place to guide and focus their investments. This lack of coordination and planning has led to both gaps and duplication of effort in the global AIDS response, with no clear sense of responsibility for achieving the broader UN political targets agreed in 2011. To improve on current efforts, donor and developing nations,

UNAIDS and other multilateral mechanisms and stakeholders should develop a global framework for achieving the beginning of the end of AIDS. This should include the specific programmatic and financial shifts that each of them will take between now and 2015 to achieve specific and clear targets. It should also build upon a foundation of existing policy and strategy documents, including but not limited to national AIDS plans, the 2011 Global Plan focused on the elimination of mother-to-child transmission and the 2011 Investment Framework.

As a critical part of this global framework, stakeholders must define an accountability mechanism that ensures that each actor feels responsible for the achievement of specific outcomes. Such an effort would ensure that global targets are set, associated costs are adequately mapped upfront, efforts are closely coordinated and agreed with recipient countries, and that a body is in place to rigorously track and evaluate progress.

- **Scale up global financing for AIDS by both traditional and new actors, and not at the expense of other development priorities**

While efforts to improve the cost-efficiency of AIDS investments are critical, global investments in AIDS must be scaled up if the beginning of the end of the pandemic is to be achieved. Currently, UNAIDS estimates that there is roughly a \$6 billion global AIDS financing gap annually. A growing pool of global actors must contribute meaningfully to closing this gap. For some donors like the

United States, this will mean sustaining financial leadership that has already been demonstrated over the past few years, in spite of domestic budgetary pressures. For others, like many countries across Europe, it will require a scaling up of financial resources – through traditional and innovative channels – and redoubled public efforts to showcase the political will needed to support such an undertaking. Many other donors, including those not highlighted in this report, will undoubtedly play key roles as the providers of newer sources of funding needed to bring the fight against the disease to scale.

New resources must also increasingly come from developing nations in Africa and across the global South, where AIDS is a major burden for large swathes of the population. As of 2010, of 43 African countries for which data is available, only four had met the Abuja commitment to devote 15% of government spending to health. As African leaders prioritise health in their budgetary decisions over the coming years and make progress toward the Abuja target, additional resources should be freed up for the fight against AIDS, amongst other health challenges. The BRICS countries, as well as private sector partners, must play an increasing role as their economies grow and they have more expertise to provide.

However, scaled-up financing for AIDS cannot come at the expense of financing for other global health and development initiatives, and ongoing efforts to improve coordination and

integration of health service delivery should be strengthened. Achieving the beginning of the end of AIDS but falling behind on other important global targets – the elimination of malaria deaths, improved access to child immunisation, a reduction in global malnutrition and stunting, and so on – would not be considered a global victory.

- **Maximise impact through transparent and accountable planning and reporting**

The past two years alone have brought dramatic innovations and progress in the fight against AIDS, including new scientific tools, updated global policy guidance and new lessons learned from programme implementation on the ground. As donors develop and strengthen strategies for investing in AIDS, and as developing countries craft national AIDS plans, each stakeholder must ensure that these new efforts are transparent and accountable. Strategies and investments need to be clear about where resources are being targeted, what interventions are being supported and implemented, and what outcomes have been achieved. Equally important, donors and implementers alike should be more forthcoming about what has not worked, so that they and others do not repeat the same mistakes. Long-term AIDS investment strategies, finally, must be continually assessed and updated to reflect new technologies and implementation guidelines that are developed between now and 2015.

A scale-up of global resources cannot come without sustained political and popular support for these investments. Stakeholders should take care to track and share stories of success and lessons learned, and political leaders should undertake continued public efforts to mobilise support. In an era of fiscal austerity, this work must be paired with a global effort to ensure that multilateral aid mechanisms and bilateral programmes alike are maximising the cost-efficiency of their investments and are oriented towards clear, specific results.

- **Seize on 2013 as the year to drive new rates of progress toward the beginning of the end of AIDS**

2013 will provide a number of key moments at which stakeholders can signal how serious they are about achieving the beginning of the end of AIDS. Primarily, the Global Fund's fourth replenishment meeting – due to be held in September 2013 – offers donors, both traditional and new, the opportunity to reinvest in the Global Fund's critical work to fight AIDS, as well as TB and malaria. Strong financial support will signal confidence in the Global Fund's new funding model, which is designed to more consistently target resources towards countries and populations with the highest disease burden and the greatest need. With sufficient new resources, the Global Fund will be well positioned to deliver significant results toward the beginning of the end of AIDS.

In 2013, global leaders will also meet to discuss the future of the Millennium Development Goals and a new post-2015 global development framework. As leaders consult on and debate this new framework – ideally with extensive and systematic input from the world's poorest and most marginalised citizens – they must not lose sight of the importance of finishing the job on the current set of MDGs (including MDG 6, which focuses on AIDS and other infectious diseases). Though there may be a temptation to develop a set of entirely new goals for the post-2015 period, a number of global health challenges, including AIDS, will still present significant epidemiological and financial obstacles for the overall development of many countries in the years to come. Consequently, leaders should ensure that these factors are thoughtfully considered and are reflected in ongoing discussions, and should simultaneously adopt more of a “war room” mentality for achieving the bold AIDS targets they committed to achieving by 2015.

By the end of 2013, we should be able to measure to what extent the global community has seized the opportunity to drive progress towards the beginning of the end of AIDS. Without scaled-up financing, more targeted programming and expanded displays of political will, this will remain a distant ambition, and millions of lives will hang in the balance. But with renewed urgency and concerted action, the world can transform the beginning of the end of AIDS from a vision to a reality and chart a course towards ending this pandemic.

A woman smiles proudly as she learns she is HIV-negative through a testing centre in the Dimbokro District of Côte d'Ivoire.
(Photo credit: Olivier Asselin)



Methodology

Measuring Progress on AIDS Indicators

This report tracks progress towards the beginning of the end of AIDS based upon three disease-specific indicators, chosen from ten overarching UNAIDS targets and underscored by the 2011 United Nations Political Declaration on HIV/AIDS. Each of these indicators – new child HIV infections, new adolescent and adult HIV infections, and the number of people on ARV therapy – was assessed against a specific UN 2015 target.¹ Annual data for each indicator for the period 2001–2011 was collected from recent UNAIDS reports,² and future progress was estimated by extending the current trajectory (change in the indicator from 2010 to 2011) through to 2015.

1) The virtual elimination of mother-to-child transmission by 2015

- Indicator: new HIV infections among children (aged 0–14 years)
- Current trajectory: 40,000 fewer new HIV infections among children annually
- 2015 target: No more than 43,000 new HIV infections among children.

2) Ensuring access to treatment for 15 million HIV-positive individuals by 2015

- Indicator: number of people on ART
- Current trajectory: 1.4 million additional people put on treatment annually
- 2015 target: 15 million people on ART.

3) The drastic reduction of new adolescent and adult HIV infections, to approximately 1.1 million annually by 2015

- Indicator: new HIV infections among adults (aged 15+)
- Current trajectory: stagnant, 2.2 million new adult infections annually from 2009–2011
- 2015 target: No more than 1.1 million new HIV infections among adults.

ONE defines the achievement of the beginning of the end of AIDS as the point at which the number of people newly added onto treatment in a given year equals and begins to exceed the number of people newly infected with the virus in the same year. On a graph, it will be the point where these two curves intersect. ONE used a similar methodology to calculate the current and accelerated trajectories for global HIV prevention and treatment efforts; current trajectories show 1.4 million additional people on treatment annually and 100,000 fewer HIV infections each year. If these trajectories remain constant, the two curves would not intersect until the year 2022.

In order to achieve the beginning of the end of AIDS by 2015, the trajectories would need to be accelerated as follows:

1) The current rate of 1.4 million people newly added onto treatment each year would have to be increased by 140,000 annually from 2012 to 2015.

- Thus, 1.54 million people would be added to treatment in 2012, 1.68 million in 2013, 1.82 million in 2014 and 1.96 million in 2015.
- This constant increase (140,000/year) is the acceleration necessary in order to reach 15 million people in total on treatment by 2015.
- The projection of the total number of people on treatment annually with accelerated scale-up of treatment is eight million (2011), 9.54 million (2012), 11.22 million (2013), 13.04 million (2014) and 15 million (2015).

2) The reduction in new HIV infections each year would have to double from 100,000 to 200,000 fewer annually.³

At the accelerated rates, by the end of 2015, new HIV infections would be down to 1.7 million annually, 260,000 fewer than the number of people newly added to treatment (1.96 million).

Measuring Donor Commitments on AIDS

This report profiles the G7 donor countries as well as the European Commission's investments towards the beginning of the end of AIDS. While Russia is officially a member of the G8 and contributes to the Global Fund (\$20 million in 2011), it is excluded from this analysis since it is a net recipient of AIDS assistance. Donor

commitments were evaluated across three dimensions: a) donor funding (bilateral and multilateral); b) political leadership; and c) strategy/programming. The following indicators were examined within these three dimensions, where information was available:

Funding	Political leadership	Strategy/programming
<ul style="list-style-type: none"> Financial contributions to the Global Fund Global Fund pledges versus disbursements Financial contributions to bilateral AIDS programme(s) Financial contributions to UNITAID Innovative financing efforts directed toward AIDS 	<ul style="list-style-type: none"> Government articulation of AIDS as a development priority via speeches, press releases, communiques Government hosting or co-hosting of high-level public events focused on AIDS Head of State or Minister of Health/ Development publicly using the phrase "beginning of the end of AIDS" or similar to describe the paradigm shift in the fight against AIDS in recent years Endorsement of 2011 UN political targets on AIDS Leveraging of political capital to build or encourage new initiatives on AIDS in the public or private sector 	<ul style="list-style-type: none"> AIDS programmes/investments targeted toward specific high-impact interventions Ability to track outcomes achieved to date Articulation of a national strategy to fight AIDS at home and abroad Reinvestment of funding away from low-impact interventions to high-impact interventions Coordination/harmonisation strategy that links AIDS with broader health investments Development of explicit sustainability strategies with recipient countries

What are the Main Sources of Data?

ONE uses a combination of publicly available information and donor government reporting to collect data for analysis. The four main sources of data are:

- 1) Data and analysis from the Kaiser Family Foundation (KFF) report, "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011" and consultations with KFF global health financing experts;
- 2) Published donor contributions on the websites of multilateral institutions, specifically the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID;
- 3) Publicly available information on donor government websites, including strategy documents, press releases, foreign ministry pages and budget reports;
- 4) Donor questionnaires and consultations in each donor country.

How Does ONE Calculate Donor Funding?

In this report, ONE defines total (financial) AIDS assistance as the sum of a donor country government's bilateral and multilateral AIDS contributions. These funding amounts were collected from the above sources and verified with government contacts from donor countries.⁴ All funding amounts are expressed in US dollars (USD), unless otherwise noted. While distortions may occur due to fluctuations in currency exchange rates, US dollars were used throughout to allow for ease of comparison between and amongst donors and for consistency with data sources.⁵ Nominal dollar figures (current prices) were maintained in order to better reflect pledges and commitments as they were expressed at the time that they were made. While acknowledging the effect of inflation on purchasing power, this report is primarily concerned with tracking pledges and commitments, rather than assessing the true value of goods and services. Where data was reported in non-USD currency, the annual exchange rate was used to adjust the figure to a USD equivalent.⁶

In addition to the data sources noted above, ONE conducted a donor survey and consultations with the G7 governments and the European Commission in the months of September and October 2012. The donor country profiles have been refined through helpful comments and feedback; any remaining errors are solely the responsibility of ONE.

Bilateral Contributions

Data on bilateral AIDS assistance from donor governments between 2009 and 2011 was drawn from the Kaiser Family Foundation (KFF) report mentioned above and supporting data provided by the KFF. This organisation, in conjunction with UNAIDS, has been tracking donor government assistance for AIDS in low- and middle-income countries since 2002. Its analysis is based, in part, on consultations with the 23 members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) and the European Union (EU).⁷

The KFF defines "bilateral funding" as any earmarked amount designated by donor governments for HIV assistance. This also includes earmarked contributions to multilateral organisations, such as UNAIDS. Since this bilateral funding data is not disaggregated in the KFF dataset, UNAIDS contributions are also counted

as part of bilateral funding for ONE's report. Furthermore, bilateral assistance data was collected in the KFF report for disbursements, i.e. the actual release of funds to a recipient, rather than commitments or enacted budgetary amounts. Disbursements may not always match enacted budgetary amounts, nor are they always released in the same year as the budgetary decisions; however, they do represent the amount of money actually being spent on the ground in a given year.

ONE considers the KFF report to be the most current and reliable source for bilateral AIDS assistance, for a number of reasons. Since the KFF analysis is an annual report with a formal consultation process, the funding totals for each country have been verified by the appropriate donor government representative in charge of HIV/AIDS assistance. The cooperation and involvement of UNAIDS in the KFF report, as the UN-led body in charge of global coordination of the HIV/AIDS response, also lends credibility and legitimacy to the reported numbers.

Multilateral Contributions

For multilateral contributions, ONE looks at contributions to the Global Fund and UNITAID, using official, publicly available data published on the websites of these organisations. While ONE acknowledges that multilateral contributions may go through other channels, for the purposes of this report, it looks only at these two mechanisms, as the primary multilateral organisations involved in HIV/AIDS that are comparable across all donors. Global Fund pledges and contributions were collected for each of the G7 countries and the European Commission for 2002–2013, and are current up to 30 September 2012.⁸ Contributions to UNITAID were collected for the years 2006–2011.⁹

In order to determine the specific fraction of each country's contribution that went toward HIV/AIDS, ONE multiplied each country's full contribution by the percentage of the Global Fund's or UNITAID's total funding that was used for AIDS in that particular year. In 2011, this percentage was 56% for the Global Fund and 52.2% for UNITAID (these percentages vary slightly each year).¹⁰ This proportion was then used to calculate a country's net volume of AIDS assistance (bilateral + multilateral). Therefore, if a country contributed \$100 million to the Global Fund in 2011, it would be credited with contributing \$56 million for AIDS assistance through the Global Fund. The country's full Global Fund and UNITAID contributions are listed in the donor profiles in the second part of this report, "Tracking Leadership and Commitment Towards the Beginning of the End of AIDS".

Net Volume

The summation for net volume takes into account a donor's full bilateral contribution as well as the fraction of the multilateral contribution that is allocated toward HIV/AIDS. The formula for calculating donor net volume (in 2011) is as follows:¹¹

Net volume =



How Does ONE Evaluate Relative Rankings of Donor Government Assistance?

Within the report, G7 donors are ranked according to four relative measures.¹³

- 1) The volume of AIDS assistance is the sum total of bilateral and multilateral contributions by a given country in a given year (2009, 2010 and 2011), based on the data sources indicated.
- 2) Per capita AIDS assistance divides the volume of assistance by a country's population based on World Bank figures.
- 3) AIDS assistance as a fraction of a country's gross national income (GNI) measures the volume of assistance as a percentage of its GNI based on World Bank figures.
- 4) Percentage changes represent growth or decline in volume from year to year.

What Does this Report Not Measure, and Why?

This report does not measure or analyse donors' spending on other health interventions that are complementary to HIV/AIDS programmes (i.e. investments in sexual and reproductive health, tuberculosis or nutrition), though ONE acknowledges the importance of these investments in improving AIDS and broader development outcomes.

Neither do the donor profiles assess countries' contributions to HIV/AIDS research and development. Financing for R&D has played a critical role in the development of current tools that have enabled momentum to grow around the concept of the beginning of the end of AIDS, and it will continue to be a major catalyst for the development of future tools – including but not limited to microbicides, a vaccine and a cure – that could dramatically alter and improve current HIV prevention efforts. However, this report is focused on core funding for current implementation efforts and supporting interventions rather than on R&D. For more information on AIDS R&D spending, ONE recommends the July 2012 "Investing to End the AIDS Epidemic" report developed by the HIV Vaccines and Microbicides Resource Tracking Working Group.¹⁴

Why Does ONE Not Use Official Development Assistance (ODA) Data Reported to the OECD DAC?

For the purposes of this analysis, ONE has not included ODA figures as reported to the DAC. When governments report their health ODA to the DAC, they use two official sub-sector codes to indicate HIV/AIDS assistance: 13040 (STD control including HIV/AIDS) and 16064 (Social mitigation of HIV/AIDS). However, neither of these sub-sector codes completely covers the breadth and depth of donor HIV/AIDS assistance, due either to errors in self-reporting or to the sector codes not adequately matching the scope of AIDS funding. Across countries, the combined DAC ODA totals for HIV/AIDS assistance (13040 + 16064) are lower than the totals from ONE's analysis using the KFF's data. To give a more robust accounting of donors' AIDS spending, ONE therefore utilises KFF data for bilateral AIDS assistance (see above). Additionally, full DAC ODA data is only published one year after the end of the reference year. This time lag is a severe limitation, since ONE's report examines recent progress by donor governments up to and including 2011. At the time of writing, sub-sector-coded data from the DAC CRS database was available only up to 2010.



Baby Michael was born HIV free to an HIV positive mother, thanks to PMTCT treatment.
(Photo credit: Morgana Wingard)

Endnotes

Executive Summary

1. Adding 140,000 people to treatment each year from 2012–2015 is compounded, additional to current rates of scale-up. The current (2011) rate of scale-up is 1.4 million; this means that, over the next four years, 1.54 million people need to be added, then 1.68 million, then 1.82 million, then 1.96 million in 2015.

Tracking Progress on Disease-Specific Indicators

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- Médecins Sans Frontières. “Medical Innovations in Humanitarian Situations”. <http://www.doctorswithoutborders.org/publications/book/medicalinnovations/book.cfm?id=5245&cat=medical-innovations>
- UNAIDS. “Together We Will End AIDS”, op. cit.
- UNAIDS estimates that there are an estimated 14.2 million HIV-positive people in low- and middle-income countries who have a CD4 count of 350 cells/mm³ or lower, qualifying them for antiretroviral treatment; of these people in need of treatment, roughly eight million are currently receiving it. In spite of this data point, the internationally agreed upon target remains 15 million people on treatment.
- UNAIDS. “Together We Will End AIDS”, op. cit.
- There are 2.5 million new HIV infections and 1.4 million people newly added on to ARVs each year, at current rates.
- UNAIDS. “Together We Will End AIDS”, op. cit.
- UNAIDS. “2011 Political Declaration: Targets and elimination commitments”. www.unaids.org/en/targetsandcommitments/. Other commitments include preventing HIV among drug users, eliminating gender inequalities and eliminating stigma and discrimination.
- De Cock et al. “Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice”. *JAMA* 238(9): 1175–82, 2000.
- WHO. “Child mortality”. http://www.who.int/maternal_child_adolescent/topics/child/mortality/en/index.html
- WHO. “Mother-to-child transmission of HIV”. <http://www.who.int/hiv/topics/mtct/en/index.html>
- UNAIDS. “Together We Will End AIDS”, op. cit.
- Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, Tanzania, Swaziland, Zambia and Zimbabwe.
- UNAIDS. Press release, “World leaders launch plan to eliminate new HIV infections among children by 2015”. 9 June 2011. <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/june/20110609prgloabalplanchildren/>
- UNAIDS. “Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive 2011–2015”. <http://www.unaids.org/en/media/unaids/contentassets/documents/>

- unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-HIV-Children_en.pdf
- UNAIDS. “Progress Report on the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive”, 29th Meeting of the UNAIDS Programme Coordinating Board (Geneva, 13–15 December 2011). http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/20111124_Global%20Plan%20Progress%20Report_en.pdf
- Ibid.
- Based on private consultations with IATT partners, autumn 2012.
- UNAIDS. “Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive 2011–2015”, op. cit.
- Ibid.
- PEPFAR. “AIDS 2012 Update: Latest PEPFAR Results”. <http://www.pepfar.gov/documents/organization/195771.pdf>
- Global Fund. “Strategic Investments for Impact: Global Fund Results Report 2012”. http://www.theglobalfund.org/documents/publications/progress_reports/Publication_2012Results_Report_en/
- UNITAID. “Prevention of Mother-to-Child Transmission of HIV”. <http://www.unitaid.eu/pmtct-proj>
- Business Leadership Council. “For a Generation Born HIV Free”. <http://genhivfree.org/stakeholders/>
- Organization of African First Ladies Against HIV/AIDS. <http://www.oafla.org/index.php?lang=en>
- African Development Bank Group. “AfDB Reiterates Commitment to HIV/AIDS Campaign”. <http://www.afdb.org/en/news-and-events/article/afdb-reiterates-commitment-to-hiv-aids-campaign-7552/>
- The 2015 target for the Global Plan is a 90% reduction in new HIV infections among children from the baseline year of 2009. In 2009, there were 430,000 new HIV infections among children, so a 90% reduction would mean 43,000 infections per year.
- UNAIDS. “Together We Will End AIDS”, op. cit.
- This assumes that the current trajectory (40,000 fewer new infections among children per year) holds through 2015.
- UNAIDS. “Together We Will End AIDS”, op. cit.
- UNAIDS. “Progress Report on the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive (2012)”, op. cit.
- Based on private consultations with IATT partners, autumn 2012.
- WHO. “Mother-to-child transmission of HIV”, op. cit.
- WHO. “Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infections in Infants (2010)”. http://whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf
- Ibid.
- WHO. “Programmatic Update, Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants (April 2012)”. http://www.who.int/hiv/PMTCT_update.pdf
- WHO. “The 3 by 5 Initiative”. <http://www.who.int/3by5/en/>
- WHO. “Universal access to HIV/AIDS prevention, treatment, and care”. <http://www.who.int/hiv/topics/universalaccess/en/index.html>
- WHO. “Antiretroviral Therapy for HIV Infections in Adults and

- Adolescents. Recommendations for a public health approach, 2010 revision”. http://whqlibdoc.who.int/publications/2010/9789241599764_eng.pdf
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- PEPFAR. “Report on Costs of Treatment in the President’s Emergency Plan for AIDS Relief (PEPFAR), February 2012”. <http://www.pepfar.gov/documents/organization/188493.pdf>
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- United Nations General Assembly, Sixty-Fifth Session. “Resolution 65/277 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS”. http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf
- UNAIDS. “Together We Will End AIDS”, op. cit.
- This assumes that the current trajectory (1.4 million people newly added on to ARVs each year) holds through 2015.
- ONE calculation: in order to reach 15 million people on treatment by 2015, there need to be an additional 140,000 people added each year to current treatment rates of scale-up: so 1.4 million (2011), 1.54 million (2012), 1.68 million (2013), 1.82 million (2014) and 1.96 million (2015).
- UNAIDS. “Technical Brief 2011: Implementation of TRIPS and Access to Medicines for HIV after January 2016: Strategies and Options for Least Developed Countries”. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2258_techbrief_TRIPS-access-medicines-LDC_en.pdf
- UNAIDS. “Together We Will End AIDS”, op. cit.
- Ibid.
- Ibid.
- New HIV infections per year = 2.5 million; people newly added on treatment per year = 1.4 million
- UNAIDS. “Together We Will End AIDS”, op. cit.
- UNAIDS. “World AIDS Day Report 2011”. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf
- Ibid.
- To give one country-based example, UNAIDS delivered a presentation at the 2012 International AIDS Conference outlining the historic spending breakdown on prevention services in Morocco. In previous years, there were clear mismatches between where prevention resources were allocated and where the greatest need existed i.e. nearly 80% of prevention spending was on the general and accessible population, when their demographic accounted for only roughly 30–60% of people acquiring HIV, and roughly 5–10% of prevention spending was on female sex workers, whose demographic accounted for roughly 30% of people acquiring HIV. Now, encouragingly, the government is proposing a new, more targeted strategy to match the nature of the epidemic.

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- HIV Vaccines and Microbicides Resource Tracking Working Group, “Investing to End the AIDS Epidemic: A New Era for HIV Prevention Research & Development (July 2012)”. <http://www.hivresourcectracking.org/sites/default/files/July%202012%20Investing%20to%20End%20the%20AIDS%20Epidemic-%20A%20New%20Era%20for%20HIV%20Prevention%20Research%20&%20Development.pdf>
- The current trajectories are 100,000 fewer infections each year and 1.4 million additional people on treatment.
- UNAIDS. “Issues Brief 2011: A New Investment Framework for the Global HIV Response”, op. cit.
- According to the latest UNAIDS Report (“Together We Will End AIDS”, op. cit.), global spending on HIV in 2011 was \$16.8 billion.
- UNAIDS. “Together We Will End AIDS”, op. cit.

Tracking Leadership and Commitment Towards the Beginning of the End of AIDS

- ONE elected not to include Russia in this analysis, although it is a part of the G8, as it remains a net recipient of external funding for AIDS.
- Kaiser Family Foundation (KFF). <http://facts.kff.org/chart.aspx?ch=949> (accessed 20 October 2012)

Donor Profiles

CANADA

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- Global Fund. “Donors and Contributions”. <http://www.theglobalfund.org/en/about/donors/> (accessed 21 October 2012)
- UNITAID. “Audited Financial Report for the period 2010–2011”. <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>
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- Global Fund. News Release: “Donors Commit US\$11.7 Billion to the Global Fund for Next Three Years”. 5 October 2010. Available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-10-05_Donors_commit_USD_11_7_Billion_to_the_Global_Fund_for_next_three_years/; USD equivalent as reported on Global Fund website.
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- The projects are AIDES-CGT: a project to help French trade unions and charities develop a coordinated, consistent policy on AIDS in the workplace; Sidaction – Initiative et Développement – Sol en Si: GRANDIR – a project to build the capacity of actors in prevention and care for children with HIV/AIDS in Africa; Handicap International – Sidaction: strengthening local initiatives to fight HIV/AIDS and support people disabled by the illness; AIDES – Act-Up – Solidarité Sida: building the advocacy capacity of civil society actors working on AIDS in Togo, DRC, Burkina Faso and Cameroon; AIDES – Sidaction: assisting civil society actors that work on AIDS in Africa to develop tailored action for men who have sexual intercourse with men; Solidarité Sida – Sida Info Service – Planning Familial – Aides-Sidaction: joining forces in the ELSA network to support African community responses to AIDS; and Handicap International: a project to improve recognition of people suffering from discrimination due to AIDS in Cambodia, Laos and Vietnam.
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- French National Assembly. “Projet de loi de finances pour 2012”.

Available at: <http://www.assemblee-nationale.fr/13/projets/pl3775.asp>

¹⁹ Video, with English subtitles, available at: <http://www.youtube.com/watch?v=MM1-tVPOPHE>

²⁰ Speech by François Hollande, President of the Republic, 67th United Nations General Assembly, New York, 25 September 2012. Available at: <http://basedoc.diplomatie.gouv.fr/vues/Kiosque/FranceDiplomatie/kiosque.php?fichier=baen2012-09-26.html>

²¹ UNAIDS, Sixty-Fifth Session. Resolution adopted by the General Assembly, 65/277. "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS". Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf

²² http://www.diplomatie.gouv.fr/fr/IMG/pdf/Cooperation_internationale_ds_le_domaine_de_la_sante_cle07f714-1.pdf

²³ Government of France. "Plan national de lutte contre le VIH/SIDA et les IST 2010-2014". Available at: <http://www.sante.gouv.fr/plan-national-de-lutte-contre-le-vih-sida-et-les-ist-2010-2014.html>

²⁴ Of the 22 high-burden MTCT countries, five are members of the Organisation internationale de la Francophonie: Burundi, Cameroon, Chad, Côte d'Ivoire and the Democratic Republic of Congo.

²⁵ Transcribed from video: <http://www.youtube.com/watch?v=MM1-tVPOPHE>

GERMANY

¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011". <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

² Global Fund. "Donors and Contributions". <http://www.theglobalfund.org/en/about/donors/> (accessed 21 October 2012)

³ Germany's Debt2Health Contribution was calculated from the Global Fund spreadsheet (<http://www.theglobalfund.org/en/about/donors/>) as the sum of restricted contributions from Côte d'Ivoire, Egypt, Indonesia and Pakistan (under Germany Debt2Health category) (accessed 21 October 2012).

⁴ The fraction of Germany's Debt2Health contribution going towards AIDS was calculated as 56% of its restricted contributions through Côte d'Ivoire, Indonesia and Pakistan. Egypt's portion was excluded since those funds were earmarked specifically to fight malaria in Ethiopia.

⁵ UNITAID. "Audited Financial Report for the period 2010-2011". <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>

⁶ ONE Global Health Calculations.

⁷ Ibid.

⁸ In 2011, Germany spent \$3.85 per capita and 0.0088% of GNI on total AIDS spending.

⁹ Global Fund. News Release: "Donors Commit US\$11.7 Billion to the Global Fund for Next Three Years". 5 October 2010. Available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-10-05_Donors_commit_USD_11_7_Billion_to_the_Global_Fund_for_next_three_

years/; USD equivalent as reported on Global Fund website.

¹⁰ Global Fund. "Donors and Contributions". <http://www.theglobalfund.org/en/about/donors/>. In 2011, Germany's contribution to the Global Fund was €200 million. In 2012, at the time of writing, Germany has so far contributed €100 million and is expected to contribute an additional €50 million by publication date. USD equivalent as reported on Global Fund website. <http://www.theglobalfund.org/en/about/donors/>

¹¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011" op. cit.; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

¹² BMZ. "Strategy Paper 5| 2012e, Germany's Contribution to a Sustainable HIV Response". Available at: http://www.bmz.de/en/publications/type_of_publication/strategies/Strategiepapier324_05_2012.pdf

¹³ Global Fund. "Debt2Health". <http://www.theglobalfund.org/en/innovativefinancing/debt2health/>

¹⁴ Global Fund. "Debt2Health: Results". <http://www.theglobalfund.org/en/innovativefinancing/debt2health/results/>

¹⁵ Total debt cancelled was € 115.6 million from 2007 to 2011. Debt cancellation amounts were converted to USD according to the annual exchange rate in the year in which the debt was cancelled, then added together; see <http://www.oecd.org/dac/aidstatistics/referencedacstatisticaltables.htm>

¹⁶ Debt cancellation (at a 50% discount) resulted in €57.8 million payable to the Global Fund. Converted to USD according to annual exchange rate in the year in which the amount was paid, then added together; see <http://www.oecd.org/dac/aidstatistics/referencedacstatisticaltables.htm>

¹⁷ €4 billion for 2008-2015 converted into USD based on 2007 (year of strategy paper) annual exchange rates for DAC donor countries: <http://www.oecd.org/dac/aidstatistics/referencedacstatisticaltables.htm>; USD1 = €0.7305.

¹⁸ This sum includes Germany's bilateral development commitments, its contributions to the Global Fund or its contributions to the HIV programmes of the European Union, the World Bank and other international organisations. For further information, see: <http://www.bmz.de/de/publikationen/reihen/strategiepapiere/spezial147pdf.pdf> (in German).

¹⁹ BMZ. "Strategy Paper 5| 2012e, Germany's Contribution to a Sustainable HIV Response", op. cit.

²⁰ German Government. "Health.Right.Now." <http://www.healthrightnow.de/>

²¹ German Health Practice Collection. <http://german-practice-collection.org/>

²² BMZ. "Strategy Paper 5| 2012e, Germany's Contribution to a Sustainable HIV Response", op. cit.

²³ UNAIDS. "Issues Brief 2011: A New Investment Framework for the Global HIV Response". Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf

²⁴ Fourth High Level Forum on Aid Effectiveness, Busan, Korea, 2011. <http://www.aideffectiveness.org/busanhlf4/>

²⁵ BMZ. "Strategy Paper 5| 2012e, Germany's Contribution to a Sustainable

HIV Response", p.7. Op cit.

²⁶ GIZ. "HIV – a global restraint on development". <http://www.giz.de/Themen/en/900.htm>

²⁷ GIZ. "German BACKUP Initiative: Global support of partners working with Global Fund". Available at: <http://www.giz.de/Themen/en/SID-C39D6C3F-0E33C8AC/22978.htm>

²⁸ BMZ. "Strategy Paper 5| 2012e, Germany's Contribution to a Sustainable HIV Response", p.23. Op. cit.

²⁹ John Heilprin. "Germany suspends payments to global health fund". 26 January 2011. *BusinessWeek*. Available at: <http://www.businessweek.com/ap/financialnews/D9L03MU00.htm>

³⁰ AP. "Germany unblocks part of Global Fund donations". 5 July 2011. Available at: <http://www.guardian.co.uk/world/feedarticle/9727870>

³¹ As the official DAC annual exchange rate for 2013 was not available at the time of writing, €200 million was converted to USD using the period average daily exchange rate of the year-to-date (from 1 January to 25 October 2012) <http://www.oanda.com/>; USD1 = €0.7796.

³² As the official DAC annual exchange rate for 2014-2016 was not available at the time of writing, €600 million was converted to USD using the period average daily exchange rate of the year-to-date (from 1 January to 25 October 2012) <http://www.oanda.com/>; USD1 = €0.7796.

³³ <http://dip21.bundestag.de/dip21/btd/17/102/1710200.pdf>, p.2,804 (in German).

³⁴ Ibid.

ITALY

¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011". <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

² Global Fund. "Donors and Contributions". <http://www.theglobalfund.org/en/about/donors/> (accessed 21 October 2012)

³ UNITAID. "Audited Financial Report for the period 2010-2011". <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>

⁴ ONE Global Health Calculations.

⁵ Ibid.

⁶ In 2011, Italy spent \$0.08 per capita and 0.0002% of GNI on total AIDS spending.

⁷ Global Fund. "Donors and Contributions", op. cit.

⁸ Global Fund. News Release: "Donors Commit US\$11.7 Billion to the Global Fund for Next Three Years". 5 October 2010. Available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-10-05_Donors_commit_USD_11_7_Billion_to_the_Global_Fund_for_next_three_years/

⁹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011". <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

¹⁰ On AIDS, Berlusconi was perhaps best known in public for making a joke about AIDS patients that many deemed offensive.

¹¹ 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. <http://www.ias2011.org/>

¹² <http://pag.ias2011.org/flash.aspx?pid=386>

¹³ European and Developing Countries Clinical Trials Partnership. http://www.edctp.org/The_Organisation.724.0.html

¹⁴ UNAIDS. Sixty-fifth session, Resolution adopted by the General Assembly, 65/277. "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS". Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf

¹⁵ Information obtained through consultation with the Italian Government.

¹⁶ WHO. <http://www.who.int/3by5/news26/en/index.html>

¹⁷ Law 49/87. Ministero degli Affari Esteri, Italian Development Cooperation. <http://www.cooperazioneallosviluppo.esteri.it/pdgcs/inglese/intro.html>

¹⁸ Italy has not yet paid \$334.3 million of its pledge to the Global Fund for 2009-2010.

¹⁹ AIDSMEDS. "Rome Mayor Urges Italy to Keep Global Fund Commitment". 20 July 2011. Available at: http://www.aidsmeds.com/articles/RomeMayor_HIV_Funding_2636_20859.shtml

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¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011". <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

² Global Fund. "Donors and Contributions". <http://www.theglobalfund.org/en/about/donors/> (accessed 21 October 2012)

³ UNITAID. "Audited Financial Report for the period 2010-2011". <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>

⁴ ONE Global Health Calculations.

⁵ Ibid.

⁶ In 2011, Japan spent \$0.66 per capita and 0.0015% of GNI on total AIDS spending.

⁷ Global Fund. News Release: "Donors Commit US\$11.7 Billion to the Global Fund for Next Three Years". 5 October 2010. Available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-10-05_Donors_commit_USD_11_7_Billion_to_the_Global_Fund_for_next_three_years/

⁸ Global Fund. News Release: "Global Fund Welcomes \$340 Million Contribution By Japan". 13 March 2012. http://www.theglobalfund.org/en/mediacenter/newsreleases/2012-03-13_Global_Fund_welcomes_USD_340_million_contribution_by_Japan/

⁹ Ibid.

¹⁰ Global Fund. "Donors and Contributions", op. cit.

¹¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income

Countries: International Assistance from Donor Governments in 2011", op. cit.; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

¹² Japan International Cooperation Agency (JICA). "Africa". <http://www.jica.go.jp/english/countries/africa/index.html>

¹³ JICA. "Mission Statement". <http://www.jica.go.jp/english/about/mission/index.html>

¹⁴ Examples include a major infectious disease control project in Myanmar, a project for strengthening operational capacity of PMTCT in Ghana, a project for scaling up the quality of AIDS care service management in Zambia and an HIV prevention strengthening project in Madagascar.

¹⁵ Leading Group on Innovative Financing for Development, Japan 2010. <http://www.leadinggroup.org/rubrique255.html>

¹⁶ Global Fund. News Release: "Global Fund Welcomes \$340 Million Contribution By Japan". 13 March 2012, op. cit.

¹⁷ Ministry of Foreign Affairs of Japan. Statement by H.E. Mr. Yutaka Banno, State Secretary of Foreign Affairs of Japan at the United Nations High-Level Meeting on HIV/AIDS, 9 June 2011. Available at: http://www.mofa.go.jp/announce/svm/state110609_1.html

¹⁸ Japan Center for International Exchange (JCIE). "Japan's Response to the Spread of HIV/AIDS" (2004). Available at: <http://www.jcie.org/researchpdfs/JapanResponseAIDS/Japansurvey.pdf>

¹⁹ UNAIDS. Sixty-Fifth Session. Resolution adopted by the General Assembly, 65/277. "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS". Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf

²⁰ Japan donor government consultation, October 2012.

²¹ JICA. "JICA's Operation in Health Sector – Present and Future". September 2010. Available at: http://www.jica.go.jp/english/our_work/thematic_issues/health/pdf/position_paper.pdf

²² Government of Japan. "Japan's Global Health Policy 2011-2015". September 2010. Available at: http://www.mofa.go.jp/policy/oda/mdg/pdfs/hea_po_ful_en.pdf

²³ Ibid.

²⁴ Ibid.

²⁵ UNAIDS. Feature story: "UNAIDS Executive Director commends Japan's commitment to AIDS and the Global Fund". 3 September 2010. <http://www.unaids.org/en/responses/presscentre/featurestories/2010/september/20100903fsexdjapan/>

UNITED KINGDOM

¹ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011". <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

² Global Fund. "Donors and Contributions". <http://www.theglobalfund.org/en/about/donors/>. According to the official Global Fund spreadsheet (accessed 21 October 2012), the UK's pledges and commitments are as follows: 2010: \$308.48 million (pledge and contribution); 2011: \$239.43 million (pledge and contribution); 2012: \$404.51 million (pledge and contribution). In this situation (£1 billion pledge over 2008-2015), the

Global Fund has designated each pledge amount to equal in value the payment received, taking into account the currency exchange rate on the day the pledge is paid. These figures differ from DFID's own reporting (see next endnote) due to issues with how to count frontloading from future periods. Altogether, however, the Global Fund's sum of the UK's 2011 and 2012 contributions (\$643.94 million) is not far off from DFID's estimated contribution (~\$640 million) over the same period.

³ DFID's submission to the International Development Committee (IDC) in March 2012 (available at: <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmintdev/126/126we02.htm>) indicates an alternate reporting of the UK's pledges and contributions. For 2010 and 2011, it reports annual pledges of \$199.68 million for both years and contributions of \$308.34 million and \$432.41 million respectively.

⁴ UNITAID. "Audited Financial Report for the period 2010-2011". <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>

⁵ ONE Global Health Calculations; in this analysis, ONE used the UK contributions as listed in the official Global Fund spreadsheet.

⁶ Ibid.

⁷ In 2011, the UK spent 0.0363% of GNI on total AIDS spending.

⁸ Department for International Development (DFID). Press release: "UK makes £1 billion commitment to Global Fund to Fight AIDS, TB and Malaria in poor countries". 25 September 2007. <http://webarchive.nationalarchives.gov.uk/+http://www.dfid.gov.uk/Media-Room/Press-releases/2007-completed/UK-makes-1-billion-commitment-to-Global-Fund-to-Fight-AIDS-TB-and-Malaria-in-poor-countries1/>; £1 billion converted to USD based on 2007 (year of pledge) annual exchange rate (see: <http://www.oecd.org/dac/aidstatistics/referencedacstatisticaltables.htm>); USD1 = £0.4997.

⁹ Global Fund. "Donors and Contributions", op. cit.

¹⁰ KFF. "Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011", note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

¹¹ Burma, Cambodia, DRC, India, Kenya, Malawi, Mozambique, Nepal, Nigeria, South Africa, Uganda, Vietnam, Zambia and Zimbabwe, as well as regional programmes in Africa, Central Asia and the Caribbean.

¹² UNITAID. "Audited Financial Report for the period 2010-2011, op. cit.

¹³ GAVI. "GAVI pledging conference, June 2011". <http://www.gavialliance.org/funding/resource-mobilisation/process/gavi-pledging-conference-june-2011/>

¹⁴ UKaid/Bill & Melinda Gates Foundation, London Summit on Family Planning. <http://www.londonfamilyplanningsummit.co.uk/>

¹⁵ Girl Hub. <http://girlhub.org/>

¹⁶ DFID. "Programme Partnerships Arrangements". <http://www.dfid.gov.uk/work-with-us/funding-opportunities/not-for-profit-organisations/ppas/>

¹⁷ DFID. "Towards Zero Infections: The UK's Position Paper on HIV in the Developing World". May 2011. Available at: <http://www.dfid.gov.uk/Documents/publications1/twds-zero-ifs-pos-paper-hiv-dev-wrld.pdf>

¹⁸ Ibid.

¹⁹ http://www.devex.com/en/news/british-lawmakers-press-andrew-mitchell-on-global/78268?source=ArticleHomepage_Center_1

²⁰ DFID. “Towards Zero Infections: The UK’s Position Paper on HIV in the Developing World”, op. cit.

²¹ Prime Minister David Cameron. Remarks on World AIDS Day 2011. Video available at: <http://www.youtube.com/watch?v=fXCF-rEBcVk&feature=plcp>

UNITED STATES

¹ KFF. “Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011”. <http://www.kff.org/hiv/aids/upload/7347-08.pdf>; note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

² Global Fund. “Donors and Contributions”. <http://www.theglobalfund.org/en/about/donors/> (accessed 21 October 2012)

³ UNITAID. “Audited Financial Report for the period 2010–2011”. <http://www.unitaid.eu/images/budget/Financial%20Statements%202010%202011%20final%20%2028%2003%202012%20with%20auditors%20opinion.pdf>

⁴ ONE Global Health Calculations.

⁵ Ibid.

⁶ In 2011, the United States spent \$4.53 billion on AIDS, which represents an estimated 27% of the \$16.8 billion in total AIDS spending (reported by UNAIDS) and 60% of the \$7.6 billion (KFF) in total donor government AIDS spending.

⁷ In 2011, the United States spent \$14.54 per capita and 0.0300% of GNI on total AIDS spending.

⁸ Global Fund. News release: “Donors Commit US\$11.7 Billion to the Global Fund for Next Three Years”. 5 October 2010. Available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-10-05_Donors_commit_USD_11_7_Billion_to_the_Global_Fund_for_next_three_years/

⁹ In the United States budgetary system, this pledge does not guarantee a contribution; funding must be appropriated annually by the US Congress.

¹⁰ Global Fund. “Donors and Contributions”, op. cit.

¹¹ KFF. Fiscal Year 2013 Budget Tracker. http://www.kff.org/globalhealth/upload/8045_FY2013.pdf (accessed 21 October 2012)

¹² President’s Emergency Plan for AIDS Relief (PEPFAR). <http://www.pepfar.gov/>

¹³ KFF. “Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011”, note: KFF bilateral estimates include donor contributions to UNAIDS. See methodology section for details.

¹⁴ Angola, Botswana, Cambodia, Caribbean Regional, Central America Regional, Central Asia Regional, China, Côte d’Ivoire, DRC, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Russia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Vietnam, Zambia, Zimbabwe

¹⁵ President Barack Obama. Remarks on World AIDS Day 2011. Transcript available at: <http://www.whitehouse.gov/photos-and-video/vid-eo/2011/12/01/president-obama-world-aids-day>

¹⁶ Hillary Rodham Clinton. Remarks at the 2012 International AIDS Conference, op. cit.

¹⁷ International AIDS Conference 2012. <http://www.aids2012.org/>

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4. European Commission contributions were analysed using the same methodology and sources.
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10. HIV/AIDS allocations: Global Fund 55% (2009), 55% (2010) and 56%

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11. The exact percentages of each multilateral will change annually, but the formula remains the same.
12. For Germany, this also includes an addition for Debt2Health contributions (56%).
13. Only the G7 donor governments are included in the rankings (out of 7). The European Commission receives funding from many of the European countries in the G7, so it is excluded.
14. <http://www.hivresourcetracking.org/sites/default/files/July%202012%20Investing%20to%20End%20the%20AIDS%20Epidemic-%20A%20New%20Era%20for%20HIV%20Prevention%20Research%20&%20Development.pdf>



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