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What does sustainability mean in the HIV and AIDS response?

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Immense progress has been made in the fight against HIV and AIDS. Achieving and exceeding the AIDS targets for the Millennium Development Goals (MDGs) was accomplished, in large part, due to an unprecedented financial investment from the international community. Following an $800 million dip in donor disbursements in 2010, the discourse has since shifted to the need for greater sustainability of funding. But what does sustainability mean? Current efforts focus heavily on fiscal imperatives such as increasing domestic funding. This is important – needs are increasing at a faster rate than donor funding, especially with increased treatment coverage. The problem is that measures of financial sustainability tell very little about the actual sustainability of specific programmes, disease trajectories or enabling environments.

Recognising that current definitions of sustainability lack clarity and depth, we offer a new six-tenet conceptualisation of what sustainability means in the HIV and AIDS response: (1) financial, (2) epidemiological, (3) political, (4) structural, (5) programmatic, and (6) human rights. Based on these, we examine examples of donor transitions for their approach to sustainability, including PEPFAR in South Africa, the Global Fund in Eastern Europe, and the Bill and Melinda Gates Foundation in India (Avahan). We conclude that sustainability must be understood within a broader framework beyond funding stability. We also recommend that certain interventions, such as programming for key populations, may have to continue to receive external support even if affected countries can afford to pay.

Keywords: HIV, AIDS, sustainability, transition, donors, key populations, civil society

Introduction

In July 2015, the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced that the AIDS targets for the Millennium Development Goals (MDGs) had not only been achieved, but exceeded. The commitment to halt and reverse the spread of HIV has been met. Since 2000, when the MDGs were set, 30 million new infections and 7.8 million AIDS-related deaths have been averted. Further, there are now over 15 million people on life-saving antiretroviral drugs (ARVs) and the numbers continue to rise. Today, these drugs can cost less than $100/pa, just a fraction of the $14 000 price tag in 2000 (UNAIDS, 2015).

These successes are the result of an unprecedented global effort. Progress to date on HIV is largely linked to enormous international resource mobilisation, combined with political will from a diverse range of actors. Total annual investments in AIDS are anticipated to reach their highest point yet at the end of 2015 – $21.7 billion (UNAIDS, 2015). This achievement is based on increasing commitments from both international and local sources, from a unique combination of bi-lateral, multi-lateral and domestic partners.

International HIV assistance from donor governments rose dramatically, with disbursements climbing from $1.2 billion in 2002, to $5 billion in 2007, reaching $8.6 billion in 2014. (KFF & UNAIDS, 2015). In that year the two countries which made up the vast majority of this spending were the United States ($5.6 billion) and the United Kingdom ($1.1 billion). While significant increases are not anticipated, this funding flow is expected to remain constant.

Domestic investment from within affected countries also grew steadily. In 2012, for the first time, UNAIDS reported that the majority of global funding for AIDS came from domestic sources within low and middle-income countries (UNAIDS, 2013). This trend continued in 2014, with 57% of total investments for AIDS being domestic (UNAIDS, 2015). Resource-poor countries with high disease burdens are increasingly finding innovative ways of funding their own responses. In Zimbabwe, a 3% tax on all formally employed individuals and companies was established in 1999. The money goes towards the National AIDS Trust Fund. Between 2009 and 2012, revenue from this levy grew from $5.7 million to $26.5 million, with projections suggesting it could reach $47 million by 2016 (Friends of the Global Fight, 2015). Levies on mobile phone usage have been proposed in Rwanda and Uganda, and, according to the African Union, Benin, Congo, Madagascar, Mali, Mauritius and Niger raised resources for AIDS from an airline tax (African Union, 2013). More countries are reported to be considering innovative financing mechanisms. Details are hard to come by, and it is not certain that HIV or even health would be the priority of the Ministry of Finance once monies are collected.

Current definitions of sustainability lack clarity and depth. In this paper we offer a new six-tenet conceptualisation of

what sustainability means in the HIV and AIDS response. We look at sustainability from financial, epidemiological, political, structural, programmatic and human rights perspectives.

The 2010 dip and the consensus on sustainability

While funding for HIV is at its highest level ever – in terms of both domestic and international contributions – it is important to recognise the dip in disbursements from donor governments which occurred in 2010. Following the global financial crisis in 2008, and, what some termed "donor fatigue" regarding HIV, spending from donor governments fell from $7.7 billion in 2009 to $6.9 billion in 2010. There were international campaigns ("Where is the money for HIV and AIDS"[1]) and pressure on partners not to pull their money out of HIV (Médecins Sans Frontières, 2010). The Global Fund to fight AIDS, TB and Malaria (Global Fund) Board decision to postpone Round 11 (due to this funding dip) marked the sharpest setback to the Millennium Development Goals (MDGs) since their adoption in 2000 (Donnelly, 2011).

This was a relatively short-lived crisis. By 2011, disbursements were up to $7.6 billion/year and have continued to rise each year since. The Global Fund developed a New Funding Model (NFM), which allocated $14.7 billion over the 2014–2016 period, significantly more than the $12.3 billion from the previous three years (Global Fund, 2015e). Though this minor funding shortfall may have been resolved fairly quickly, the panic felt by many in 2010 has never really been overcome. In recent discourse, discussions around "highly resource-constrained environments and donor fatigue for HIV/AIDS programs" (Verguet et al., 2015, p.6), "diminishing funds for HIV/AIDS" (Kityo et al., 2015, p.2) and "decreasing donor support" (Katz & Siedner, 2015, p.2) persist, despite being unsubstantiated by the data.[2]

The 2010 funding dip and the psychological aftershocks have ushered in a new mentality among donors and recipient countries alike. This was the first time since the epidemic started that funding for AIDS had not risen year on year. It prompted both to address the financial sustainability question. Although the dip was short-lived, it revealed instability in global AIDS financing for which all partners need to be better prepared. A further indication of changing priorities is that combating HIV/AIDS, malaria, and other diseases, was the sixth of the eight MDGs which ran to 2015. When in September 2015 the world adopted 17 Sustainable Development Goals (SDGs) to replace the MDGs, there was just one health goal (number 3): "to ensure healthy lives and promote wellbeing for all at all ages". AIDS is mentioned only as a target for this goal.

There is consensus from a wide range of stakeholders that greater shared responsibility is needed in the AIDS response in order for it to be sustained (Quinn & Serwadda, 2011; Resch, Ryckman & Hecht, 2015; Institute of Medicine, 2010; Oberth, 2015). The United Nations Political Declaration on HIV and AIDS (United Nations, 2011) as well as the UNAIDS MDG 6 Report (UNAIDS, 2015) acknowledge sustainability as a paramount ongoing priority. The African Union Road Map on Shared Responsibility is built around mutual accountability for supporting AIDS financing and governance (African Union, 2012). The UNAIDS-Lancet Commission recommends an urgently ramped up and fully funded AIDS effort with an emphasis on sustainability (Piot et al., 2015).

Major funding partners are emphasising sustainability in their policy documents. The US President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint 3.0 has a Sustainability Action Agenda. Sustainability and Transitions was a theme discussed at all three Partners Forums leading up to the Global Fund's new strategy for 2017–2021 (Global Fund, 2015a-c).

Affected countries have this on their agenda, too. One good example is Kenya's HIV Prevention Revolution Road Map ("Countdown to 2030"), which includes sustainable investment for HIV prevention research (NACC, 2014). Another is Swaziland's extended National Strategic Framework on AIDS, which acknowledges the concern over donor dependence and highlights that government budget lines be secured for the future (NERCHA, 2014).

In the spirit of this consensus around the need for greater sustainability, many funding partners are making big changes, ending programmes in rich(er) countries and handing over programmes to national governments. The British Department for International Development (DFID) is cutting nearly all bilateral HIV funding to middle income countries[3] (Murphy & Podmore, 2014). PEPFAR is in the process of transitioning out of the Eastern Caribbean (Vogus & Graff, 2015) as well as South Africa, Botswana and Namibia (Brundage, 2011; Katz, Bassett & Wright, 2013; Katz et al., 2015). The Global Fund deemed 11 countries[4] ineligible for further HIV funding (Garmaise, 2015) based on their income status (Global Fund, 2014). Importantly, some suggest that income status is a poor measure of a country's transition readiness, further underscoring the need for a more nuanced understanding of sustainability (ICASO, 2014; Open Society Foundations, 2015b).

It makes good sense to encourage the upper middle income and some of the middle income countries to assume greater responsibility for their AIDS programmes and redirect donor resources to those less able to pay. However some analyses show that global AIDS spending is not allocated as strategically as it could be. For example, one study found that Botswana, Namibia, South Africa, Mexico, and the Dominican Republic all receive more than five times the expected level of development assistance for health (DAH), given their income levels and disease burdens (Dieleman et al., 2014). Botswana, Namibia and South Africa's "surplus" was driven mostly by (over)spending on AIDS from donors. This evidence is compounded by research showing these three African countries should be able to fully fund their own AIDS programmes from domestic resources by 2018 (Resch, Ryckman & Hecht, 2015).

On the other hand, many other countries receive far less aid than they need, and could benefit significantly from additional investment. Dieleman et al. (2014) indicate that several countries – Iran, Chile, Venezuela, Algeria, Malaysia and the Central African Republic – receive less than one fifth of expected DAH. It should be noted that these generally have concentrated HIV epidemics so this may not be a major concern. However there are those countries, as Resch et al. (2015) point out, that, even with maximum effort, will face significant shortfalls. Ethiopia can only afford to cover 23%

of its AIDS programme needs with domestic funding, and Mozambique just 19%.

Summed neatly, the consensus is that "affected countries with financial capacity can and should fund more of their AIDS responses. However, the need for international funding to support highly affected low-income countries remains high, particularly in sub-Saharan Africa" (Piot et al., 2015, p. 209).

What does sustainability mean?

While there appears to be consensus on the need for greater sustainability, there is less clarity on what it actually means. Does sustainability mean keep doing what we are doing and try harder to ensure that international replenishment efforts match the growing need? This is not a realistic prospect or suitable understanding of the term. The 2011 UN Political Declaration on HIV and AIDS states that the trajectory of HIV spending based on programme costs is unsustainable (United Nations, 2011).

Does sustainability mean keep doing what we are doing, but find more stable ways of paying for it? This is still an unsatisfactory approach. Piot et al. (2015) model four different epidemic categories – hyper-endemic settings, generalised epidemics, injecting drug use (IDU)-driven epidemics and concentrated epidemics – demonstrating that the current effort scenario will mean AIDS deaths and new infections can be expected to rise indefinitely if additional resources are not allocated to the needs. Perhaps sustainability ought to mean maintaining the downward disease trend (fewer new infections, fewer AIDS deaths) but by making smarter investments.

Counterintuitively, we argue, sustainability actually means doing things differently. It means governments will increasingly be addressing HIV through an integrated primary care model instead of donors paying for a parallel emergency response. Within this shift in approach there is an even larger challenge than finding the money, and one that the current sustainability discourse is not adequately addressing. Once countries take over financial responsibility for their own AIDS programmes, it is quite probable they will have different priorities from the donors. Some programmes may see funding evaporate. Furthermore there is no assurance governments will absorb any of the parallel systems that were set up.

The upshot is: current sustainability discourse is heavily focused on where the money will come from, but stable or even increasing investments in AIDS does not necessarily mean sustainable programmes. Having enough money is no guarantee that it will be appropriately spent. For instance, Malawi and Zambia have consistently achieved the Abuja target of allocating 15% of public expenditure to health (UNAIDS & AU, 2013), which is a measure of financial sustainability, although the size of their epidemics and small public budgets mean these indicators must be treated with caution. However, key populations programmes in these two countries cannot be said to be sustainable. Men who have sex with men and sex workers are criminalised by the government and struggle to access services.

There is some acknowledgement that our understanding of sustainability must go beyond financial horizons. Greener et al. (2015) note that AIDS budgets require constant attention so that data can be used to guide resources allocated to changing contextual needs. In other words, we should not only focus on the "how much", but also the "what for". The Global Fund (2015f, p.4) acknowledges the need for a more complex interpretation, offering the following definition: "a program is defined as sustainable when it is able to maintain service coverage at a level that will provide continuing control of a health problem even after the removal of external funding." This definition addresses programmatic, epidemiologic and financial sustainability. PEPFAR's Blueprint 3.0 proposes a slightly different description of sustainability: "When we and partner countries have scaled up interventions and reached epidemic control, the services, systems, financing and policies required to maintain that control are readily available" (p.17). This definition adds an element of political as well as structural sustainability. But are there more components to a truly sustainable response?

A new conceptual framework for sustainability

It is clear that sustainability in the AIDS response must not be regarded as a solely financial imperative. We develop a six-tenet conceptualisation that includes financial, epidemiological, political, structural, programmatic and human rights components. This is based on our work for a range of governments; donors including the Global Fund, DFID and UNAIDS and our experience in the area. It is our view that, while sustainability is recognised as important, rarely are all six components considered. Furthermore the six tenets interact; for example, without political buy-in finances may not flow.

Financial sustainability

Are there stable and diversified funding mechanisms in place to finance the AIDS response? This is the most commonly discussed element of sustainability, with the greater part of the debate revolving around funding (Katz et al., 2014; Management Sciences for Health, 2014; Resch et al., 2015; Results for Development Institute, 2013; Whiteside & Surgey, 2013; Whiteside & Bradshaw, 2014). Whiteside and Strauss (2014) suggest that economic sustainability begins when the number of new HIV infections is fewer than the number of deaths among HIV positive people. Haacker (2015) distinguishes between three different aspects of sustainability, though each still centres around fiscal considerations: epidemiological (are the investments effective at containing the epidemic?); financial (is there a credible long-term financing scenario?); and political (is there political support and country ownership to ensure increased domestic financing?). This is clearly a critical tenet of sustainability, as evidence from high burden countries shows that the need will continue to outpace available resources (Figure 1). Two areas gaining increasing attention are innovative financing mechanisms for AIDS or health more generally, and increasing efficiency in how resources are spent. In many cases, procurement of drugs and commodities is much cheaper when done through large international donors rather than by individual governments. Maintaining access to affordable procurement channels is an important consideration for financial sustainability.

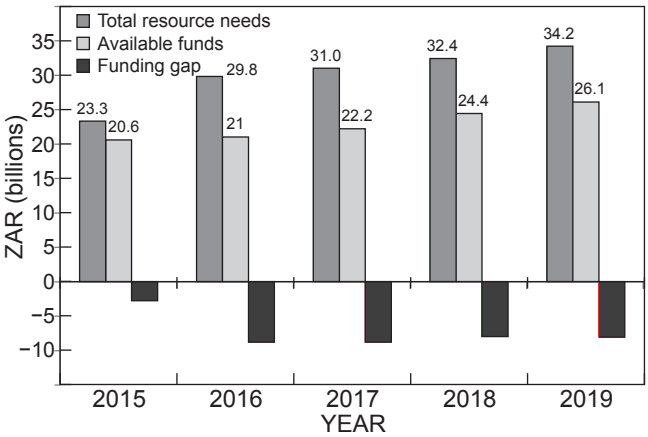

Figure 1: Projected funding gap (ZAR, billions) for reaching 90-90-90 targets in South Africa [Source: South African HIV Investment Case (2015)]

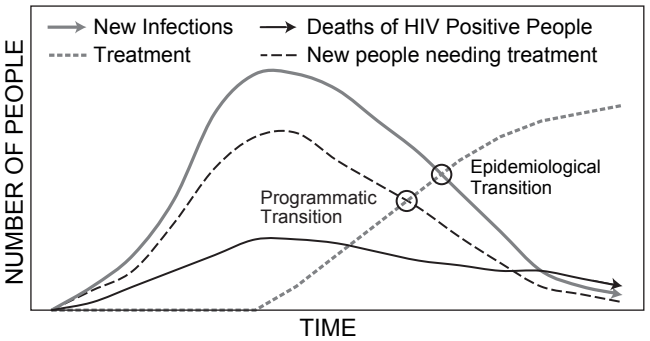

Figure 2: Epidemiological and programmatic transitions. [Source: Whiteside & Strauss (2014)]

Epidemiological sustainability

Is there a projected trend of declining new HIV infections and AIDS-related deaths? Is this trend forecast to bring about the end of the epidemic? Piot et al. (2015, p.13) show that of their funding scenarios only the "global goals" scenario is projected to achieve epidemiological sustainability in all types of HIV epidemics. The other scenarios; "best case", "financial constraints" and "current efforts" would see at best stagnation in the decline in infections and at worst a probable rise in cases (Piot, 2015, p.13). Whiteside and Strauss (2014) suggest that one measure of epidemiological sustainability (or transition) is when the number of people on treatment is greater than the number of new infections (Figure 2). This is critical for ensuring that gains are not reversed, and that new infections and deaths will not rise when countries transition from donor support.

Political sustainability

Will AIDS remain on the policy agenda? Is the legal and policy environment conducive for an effective response? Altman and Buse (2012) argue that we need better political scaffolding of how governance factors are related to HIV/AIDS. In reference to the Vancouver Consensus (that all people living with HIV must have access to antiretroviral treatment upon diagnosis) Beyrer and colleagues (2015) note that political will is needed, even if the evidence suggests that immediate treatment could be one of the most effective public health interventions in the history of AIDS. Without continued political leadership and policy, the most promising programmes or interventions will not be sustainable.

Structural sustainability

Is the social and environmental context enabling for a long-term effective response? Gill et al. (2006) emphasise that a sustainable response to AIDS requires looking beyond securing the financial and physical resources needed, to also focus on structural barriers to access. Factors such as gender-based violence (GBV), poverty and inequality have all been shown to fuel the HIV epidemic (Brodish, 2015; Jewkes et al., 2010; Mufune, 2015). According to South African and Ugandan research, it is estimated that between one fifth and one quarter of HIV infections in young women can be attributed to GBV (Jewkes et al., 2010; Vyas & Watts, 2009). If these structural variables continue to drive the spread of the epidemic beyond the pace of interventions, the response will falter. Further, structural sustainability is needed in order to ensure that gains are not fragile, as factors such as GBV and poverty could spark a resurgence in infection rates even after epidemics appear to be contained.

Programmatic sustainability

Does the specific programme or intervention make sense in an integrated primary care system? Piot et al. (2015) highlight that sustainability necessitates a programmatic transition from an emergency response to a long-term main-streamed approach. This raises questions about which programmes should remain, which ones should go, and which ones should evolve. Some civil society organisations have suggested that scaling down any programming while transitioning to government funding puts all previous investments to waste (Global Fund & EHRN, 2015). At present, there is no model for determining programmatic sustainability and it is generally left to governments to decide which parallel systems they absorb and which ones dissolve. One useful example is Costa Rica, a country that is currently transitioning away from donor support with its last Global Fund HIV grant. Here, funding is being used to establish a public finance mechanism (lottery) to enable civil society organisations to access government money, particularly for key populations programming.

Human rights

How will the right to health be protected for populations who might be excluded from decision-making based on the five preceding factors? Some funding partners are concerned about reaching key populations, such as men who have sex with men, sex workers and drug users, in contexts where the government would otherwise not provide services (Global Fund, 2015d). Davis (2014) highlights the difficulties of funding partners promoting human rights while also encouraging country ownership in places where certain key populations are criminalised. The human rights tenet is critical for ensuring that key populations are included in sustainable HIV responses. In some cases, providing

services to these groups makes epidemiological sense and governments recognise the importance of doing so based on modes of transmission analyses (Case et al., 2012). However, in other cases, it may be that it does not make financial, epidemiological or political sense to provide services to certain populations, such as among drug users in low-endemic settings. Indeed, many governments – even those who say they will maintain donor investments in human rights-related HIV activities – prove reluctant to invest in programmes. For example, civil society in the northern part of Mexico (where injecting drug use is a common risk factor for HIV), indicated that the distribution of needles and syringes fell by up to 90% following the exit of the Global Fund in Round 10 (Open Society Foundations, 2015).

In this scenario, the human rights tenet must be considered an important factor for true sustainability. It may also be necessary for certain key population interventions to continue to receive external investment, even after a country has transitioned away from donor support.

How can sustainability be achieved?

Transitioning from donor support to a sustainable domestic response is a new art. As such, assessing sustainability in practice is difficult. One of the main challenges is that this is often a retrospective exercise. Much of the analysis is only available after the fact, and often after it is too late to prevent avoidable disruptions. For example, one systematic review found that the majority of sustainability studies happen between one and five years after the completion of a programme (Scheirer, 2005). Other approaches have tried to predict sustainability of health programmes (Hanh et al., 2009; Tibbits et al., 2010) but few have sought to analyse these things in a constant manner and adjust programmes towards a more sustainable path during implementation (Bennett et al., 2011).

It is not yet clear how to ensure that each of the six tenets of sustainability highlighted above are achieved during donor handover, though suggested processes do exist. In an analysis of 21 country compacts (or transition plans) from 13 countries, Piot et al. (2015) suggest that the best plans for transition include the following elements: duration of about five years; key financing or high-level political signees; clear and monitor-able financial targets (for donors and governments); economic and epidemiological data; costed HIV strategies and trusting dialogue; reliable M&E systems; binding incentives (penalties and rewards). Vogus and Graff (2015) suggest that sustainable transitions include the following steps: develop a roadmap; involve stakeholders; communicate the plan; support midterm evaluations; strengthen financial, technical, and management capacity; and support ongoing M&E.

Based on our conceptualisation of sustainability, and acknowledging some of the existing models for achieving it, it is useful to examine what it has looked like in practice. Three noteworthy examples include PEPFAR in South Africa, the Global Fund in Eastern Europe, and the Bill and Melinda Gates Foundation in India (the Avahan project). Based on these cases, it is clear that transition has happened in very different ways and with varying degrees of success. The tenets of sustainability were not applied systematically in all cases, as discussed.

The PEPFAR handover in South Africa

South Africa is one of the largest recipients of US bilateral HIV spending, with the highest average annual PEPFAR expenditure from 2004–2009 ($334 million/year) (Lee & Izama, 2015), as well as the greatest total PEPFAR allocation from 2007–2014 ($3.9 billion) (AmfAR, 2014). As priorities shift, PEPFAR is now moving from being a direct service provider into being a technical assistance partner, handing over all its programmes to the South African government over a five year period (2012/13–2016/17). The handover is guided by a Partnership Framework Implementation Plan (PFIP), which is regarded as a robust transition strategy and held up as a best practice (Piot et al., 2015; Pereira, 2013).

Along with a strong plan, there is also financial and political sustainability in South Africa. The government has committed to increasing its domestic financing to reach 88% of total National Strategic Plan costs by 2017 (Whiteside, Cohen & Strauss, 2015). It has made the political commitment to provide ART free of charge to at least 80% of those eligible by the end of 2015 (Piot et al., 2015).

However, structural and programmatic sustainability is less apparent. As one of our colleagues said, “PEPFAR isn’t running to the Treasury or to the National Department of Health for support on how things can be replaced” (interview, 27 July 2015). As a result, there has been a 19% loss to transition rate, where patients from PEPFAR-funded centres, on PEPFAR-funded ART, fail to be effectively navigated to local clinics (Bassett et al., 2013). Based on Basset et al.’s (2013) estimates, Kavanagh (2014) calculates that 203 300 South Africans could have been “lost” from care during the PEPFAR transition by 2014. Other qualitative evidence from the PEPFAR transition in South Africa suggests that the transfer reveals a lack of preparation at public clinics for the influx of new clients (Katz et al., 2015; Kavanagh, 2014). Only a few studies are independently monitoring the effects of this “down referral” (Katz, Bassett & Wright, 2013; Katz et al., 2015). There is also little evidence of special consideration for key populations, the human rights aspect, although the South African programme is strong in this regard anyway.

The Global Fund transitions in Eastern Europe

In 2013, the Global Fund launched its new funding model. The NFM was partly the result of the cancellation of Round 11, which in turn was because there were not sufficient funds, and the recognition that Global Fund investment needed to be more predictable and sustainable. As such, eligibility parameters for accessing funding have shifted. Global Fund investment has been heavily refocused in favour of the poorest countries with the greatest disease burden. This has meant that many middle income countries are now receiving far less funding from the Global Fund, and some none at all.

With the Global Fund’s new allocation methodology under the NFM, Eastern Europe and Central Asia (EECA) has experienced a bigger funding cut than any other region

(Varentsov & Arsenijevic, 2015). The Global Fund has transitioned out of HIV programmes in Romania, Bosnia and Herzegovina, Macedonia, Montenegro and Serbia. Moldova is currently transitioning, set to be cut off from funding in 2017.

The example of Serbia's transition away from Global Fund support reveals a mixed bag of programmatic sustainability, with some interventions lasting while others are threatened. Opiate substitution treatment (OST), for example, was available at 26 centres nationwide largely as a result of Global Fund investment. Since the transition, three have closed their doors, with the rest proving to be sustainable thus far. The government has also assumed responsibility for HIV prevention in 12 prisons. However, for needle exchange programmes, the transition has been less seamless. The government has not yet stepped in to fill the gap left by the Global Fund, which had previously supported access to safe injecting equipment to more than 4 000 clients in four major cities (Varentsov & Arsenijevic, 2015). This example also highlights the human rights tenet of sustainability, where governments may not be eager to provide services to injecting drug users, though this component is necessary for a full response.

An example of poor epidemiological sustainability can be seen in Romania, where there has been a spike in HIV infections among people who use drugs since the Global Fund departed in 2010. In 2013, about 30% of new HIV cases were linked to injection drug use compared with 3% in 2010 (Open Society Foundations, 2014). In fact, the specific HIV outbreak among drug users in Romania in 2011 has been directly linked to a significant decline in harm reduction services once Global Fund investments stopped (Bridge et al., 2015). The country is now home to a growing epidemic (Stracansky, 2014), indicating that human rights and political will are not high on the agenda.

The Bill and Melinda Gates Foundation Avahan Project in India

One of the most oft-cited examples of a successful and well-managed transition is the Avahan Project, which was handed over from the Bill and Melinda Gates Foundation to the Government of India over a five-year period in 2009–2013. The project was set up with a vision to hand over to government from the outset, which may have contributed to its sustainability. This transition is largely regarded as a success (Bennett et al., 2015a; Bennett at al., 2015b; Summers & Peck, 2014).

Assessing the success factors of the Avahan transition in India, Bennett et al. (2015a) argue that key factors contributing to the sustainability of the handover include: the evolution of the approach in an ongoing manner; having clear implementation plans; hiring transition managers at several levels; funding the changeover with identifiable budget lines; and establishing a common minimum programme to be absorbed (Bennett et al., 2015a). Evaluators also cite high-level government policy commitment to HIV prevention (political sustainability) and the availability of significant government funding to support this (financial sustainability) as reasons for the successful transition (Bennett et al., 2015b). Avahan provides an example of the tenets of sustainability being applied, although not explicitly.

Conclusion

Understanding sustainability as a broad framework which stretches beyond financing is critical. The proposed conceptualisation includes six tenets – financial, epidemiological political, programmatic, structural and human rights – which should be taken together and regarded as prerequisites for donor transitions and domestic allocations. They should also be measured in a continuing manner, regardless of country readiness to move to a fully domestic response. Importantly, the human rights tenet means that key populations in many settings should continue to receive external money for programmes, even in countries that have transitioned from donor funding. This could be supported by groups with a vested interest such as the International HIV/AIDS Alliance or global networks of key populations.

At the beginning of the epidemic, it was important to have an emergency response which set up parallel systems. Now, as we move from the Millennium Development Goals to the Sustainable Development Goals, the HIV and AIDS response must evolve in its approach for lasting impact. Understanding what that sustainability looks like is key if we want to end AIDS by 2030. This will vary by country, income and epidemiological profile, but our conceptual framework can help to guide this process. The AIDS epidemic requires a different response from education or most health services; here these will remain core to the social contract. With AIDS, sustainable means working to end the epidemic.

The six tenet conceptualisation could provide a useful checklist and framework for both donors and countries. Developing a tool for comprehensive sustainability assessments based on key performance indicators for these six tenets will be a good way to measure sustainability in an ongoing way. This should likely be done on a regular basis, regardless of a country's transition readiness or domestic funding streams. As the response to the AIDS epidemic matures and becomes mainstreamed, this will increasingly need to be done.

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Notes

[1] A global campaign funded by the Ford Foundation and coordinated by the Brazilian NGO Gestos alongside the Art and Global Health Center at the University of California, Los Angeles.

[2] There is evidence that spending may be shifting towards an increased focus on biomedical interventions, which could mean diminishing funds for behavioral programmes (Giami & Perrey, 2012; Kippax & Stephenson, 2012).

[3] Though continued to make contributions to the Global Fund, pledging £1 000 000 for the 2014–2016 replenishment.

[4] Argentina, Bosnia & Herzegovina, China, Equatorial Guinea, Jordan, Kazakhstan, Macedonia, Mexico, Montenegro, Serbia and Uruguay

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