A. The MDGs: benefits and limitations

The International HIV/AIDS Alliance (the Alliance) is the Secretariat for a global partnership of nationally-based Linking Organisations and Country Offices working to support community action on AIDS in developing countries.

We are involved in a number of European and global platforms, such as Beyond 2015 and Action for Global Health, which have both also contributed submissions to this consultation. Their submissions focus on the general principles and broader questions of the post-2015 development framework. The International HIV/AIDS Alliance submission focuses on the needs of communities most affected by HIV/AIDS and related global health issues.

1. To what extent has the MDG framework influenced policies in the country/ies or sectors you work in/with?

The current health-focused Millennium Development Goals have driven significant investment and progress in health since 2000. The financial commitments and funds flows for programmes benefitting the poorest and most vulnerable groups increased. The health goals were taken up as key objectives of development cooperation within international and national policies. The MDGs combined with other international agreements allowed to hold governments to account on the progress of addressing HIV and AIDS.

Important national and international initiatives were set up in line with the MDGs. When the MDG framework was adopted, to take the example of MDG 6 on combating HIV/AIDS, malaria and other diseases, there was virtually no NGO focusing on AIDS treatment in the developing world. Malaria was a neglected disease; it was accepted that children dying of malaria was an inevitable part of life in endemic countries. Tuberculosis control efforts were stagnant. Together, the three diseases were taking at least 6 million lives, every year. International mobilisation around the MDGs resulted in the launch of several major initiatives to address the three diseases.

At global level, the Global Fund to fight AIDS, Tuberculosis and Malaria was established in 2002 to mobilise international financing for MDG 6. The Global Fund disbursed more than $22 billion in a decade and has saved more than 7.7 million lives to date. At bilateral donor level, international mobilisation led US President George W. Bush to launch the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003. It was the largest commitment by any nation for an international health initiative dedicated to a single disease.

At national level, the MDGs have resulted in a strong sense of ownership and shared responsibility emerging in many partner countries, including through the International Health Partnership. According to the UNAIDS report “Together we will end AIDS” (2012), 81 countries increased their domestic investments for AIDS by more than 50% between 2006 and 2011. Domestic public spending in sub-Saharan Africa for example, (not including South Africa) increased by 97% over the last five years. South Africa already spends more than 80% from domestic sources and has quadrupled its domestic investments between 2006 and 2011. In 2012, the African Union launched the “Roadmap for shared responsibility and global solidarity for AIDS, Tuberculosis and Malaria in Africa” which charts a course for more diversified, balanced and sustainable financing for the AIDS response by 2015 and
demonstrates **Africa’s new leadership** and voice in the global AIDS architecture. BRICS countries (Brazil, Russia, India, China and South Africa) increased domestic public spending on HIV by more than 120% between 2006 and 2011. Domestic sources already account for more than 80% of resources spent on AIDS in China which has pledged to fully fund its response in the coming years. India, too, has committed to increase domestic funding to more than 90% in its next phase of the AIDS response. At the same time the major concerns remain whether these resources provide access to prevention, treatment, care and support services for the groups most affected by HIV and AIDS (people who use drugs, sex workers, men who have sex with men, and transgender people) as well as women, girls and poor people.

2. **To what extent has the MDG framework been beneficial for the poor in the country/ies or sectors in/with which you work?**

The progress on addressing the HIV/AIDS and malaria has been tracked against the following targets and indicators:

**Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS**

6.1 HIV prevalence among population aged 15-24 years  
6.2 Condom use at last high-risk sex  
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS  
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

**Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it**

6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

The global response to AIDS has demonstrated tangible progress towards the **achievement of MDG 6**

Today, more than 8 million people living with HIV in low- and middle-income countries are receiving antiretroviral therapy. Treatment for HIV grew at a record pace in 2010. Access to treatment for people living with HIV expands in all regions except for Western Asia. More people than ever, an estimated 34.2 million are living with HIV, up 17 per cent from 2001. More people than ever are living with HIV due to fewer AIDS-related deaths and the continued large number of new infections. New HIV infections continue to decline in the hardest-hit regions. Fewer people are becoming infected with HIV, with the decline in new infections happening faster in some countries than in others. New infections among children have declined dramatically, with 57% of an estimated 1.5 million pregnant women living with HIV in low- and middle-income countries in 2011 having received effective antiretroviral drugs to prevent transmission of HIV to their children.

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At the same time, the MDG target of halting and beginning to reverse the spread of HIV/AIDS by 2015 is off track in a number of regions. In contrast to other regions, new HIV infections continue to grow in the Caucuses and Central Asia. Injecting drug use remains the leading cause of new HIV infections. Substantial access gaps persist for key services, with especially difficult obstacles experienced by populations at higher risk of HIV infection. Punitive laws, gender inequality, violence against women and other human rights violations continue to undermine national responses to HIV/AIDS. Sub-Saharan Africa remains most heavily affected, accounting for 68% of all people living with HIV and 70% of all people newly infected in 2010. Women make up 50% of adults (age 15-49) living with HIV globally and 59% of all people infected with HIV in sub-Saharan Africa. The impact on young women (age 15-24) in sub-Saharan Africa is particularly acute, with 72% of young people infected being women.

The comprehensive knowledge of HIV transmission remains low among young people, along with condom use.

Inequalities in access to education between orphans and non-orphans are narrowing. As at December 2010, an estimated 16.6 million children had lost one or both parents to AIDS — nearly 15 million of those children reside in sub-Saharan Africa. Most countries in sub-Saharan Africa have made significant progress towards near parity in school attendance for orphans and non-orphans 10-14 years of age.

The MDG target to reach universal access by 2010 (defined as coverage of at least 80 per cent of the population in need) to treatment for HIV/AIDS for all those who needed it was not reached. Still, more than 7 million people are in need of life-saving antiretroviral treatment. Between 2008-2010, about 1.3 million new people were enrolled and retained on antiretroviral therapy. At this rate, less than 14 million people will be receiving antiretroviral therapy at the end of 2015, over one million short of the target agreed at the United National High-level Meeting on HIV/AIDS, held in June 2011.

The global number of new cases of tuberculosis has been slowly declining per capita since 2006. In 2010, 8.8 million people acquired active tuberculosis worldwide, of which 1.1 million were living with HIV. Tuberculosis mortality has fallen by more than a third between 1990 and 2009, and if efforts are sustained the MDG target could be achieved. Multi-drug resistant tuberculosis represents a significant challenge as does HIV and tuberculosis co-infection. Tuberculosis remains the leading cause of death among people living with HIV. Integration to address HIV and tuberculosis jointly is increasing, but needs to accelerate more rapidly.

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6 Ibid. P 40.
8 Ibid. P4.
9 Ibid. P 42.
3. What features and elements of the MDG framework have been particularly valuable in the fight against poverty?

As described in the answers to the questions 1 and 2, the most important elements of the MDG framework were the concrete goals and clear, concise and measurable targets that created public and political awareness as they were both appealing for citizens and easy for policy makers to adopt. Together with UN GA Special Session on HIV/AIDS Indicators Country Reports\(^\text{10}\), this made it possible for development partners to launch specific initiatives to meet the MDGs and adopt international and national development policies.

4. What features and elements of the MDG framework have been problematic, in your view?

Current goals **mask huge inequity and inequalities** in access to health care. Often, there is an uneven distribution of health services or resources between men and women, between the poor and the rich, between the general population and marginalised groups and between urban and rural citizens. The general indicators in the current framework are not detailed enough to give a realistic view of those inequalities, something that should be addressed in the new framework. Additionally, there was little attention given to **coordination and synergies** among the health-related MDGs as well as MDGs from different sectors. These are lost opportunities for maximising investments and efficiencies to achieve the improved health outcomes.

The **focus of the current MDG framework is much strong on low income countries rather than on poor people**. Internationally we see a shift towards focussing development cooperation in low-income countries (LICs) and stopping investments in middle-income countries (MICs). Using country income categories as the main guidance for deciding whether or not to allocate resources to specific vulnerable countries may ultimately be counterproductive as income alone is not indicative of countries’ ability to pay for the cost of their disease responses. This approach also makes the assumption that all individuals in MICs have the same ability and opportunity to access services. Other factors which need consideration:

- Poverty and inequity in MICs remains high and 2/3 of the world’s poor live in those countries.
- The situation is similar when it comes to disease burden: MICs have higher burdens of HIV and tuberculosis than LICs. MICs carry 2/3 of the disease burden for tuberculosis (with 8 of the top 10 countries with the highest tuberculosis burden) and 3 of the top 5 countries with the highest HIV burdens are MICs.
- The capacity of MICs to pay for health and their disease responses varies. Where there is capacity and willingness among countries to provide more public funds for their HIV and health responses, the money is often targeted at building health systems and paying for ARVs rather than for often controversial or unpopular interventions such as services and programmes for communities most affected by HIV and AIDS.

\(^{10}\) [http://bit.ly/ROqQ6p]
Human rights based approach is clearly missing in the current MDGs. Human rights should underpin the new framework with minimum standards as a measure. Populations most vulnerable are most likely to be the poorest and most likely to be excluded. For instance, in the HIV field, all communities should have the right to equal access to high quality prevention, treatment, care and support services. Placing human rights at the core of addressing HIV ensures meaningful participation by the affected communities and improved public health outcomes. Respecting, promoting and protecting human rights, including the right to life, the right to health, the right to freedom of association, the right to privacy and the right to self-determination need to be at the centre of the response to HIV and broader development. Human rights programmes need to be part of national AIDS strategies and need to be adequately resourced and regularly monitored to ensure progress is being made.

Southern governments and civil society organisations were not engaged as equal partners in the development of the MDGs, which then, consequentially, led to lack of ownership among some countries. The process was UN and donor-driven, lacked country involvement and did not build on national plans. The next framework should therefore be more in line with the aid effectiveness principles and be based on the national needs, including the financial and capacity support should be made available to ensure the efficient participation.

5. In your view, what are the main gaps, if any, in the MDG framework?

See answer to question 4.

B. Feasibility of a future framework

6. In your view, in what way, if at all, could a future framework have an impact at global level in terms of global governance, consensus building, cooperation, etc.?

To have global sustainable impact, the future framework should take into account the lessons learned from the MDG framework (see answer to question 4), and be aligned with Paris, Accra and Busan aid effectiveness principles, particularly ownership and participation of all development cooperation actors, donor coordination and alignment as well as managing for results. The new framework should also promote development as a matter of shared responsibility between all stakeholders, and build on already existing commitments. The future framework should also look very closely at the issues of donor coordination and policy coherence for development. The new framework should propose concrete measures to increase policy coherence across trade, external action, and development and human rights policies to support the realisation of the right to health and to ensure that trade agreements do not undermine progress towards this right for people living with HIV and others in need of essential medicines.

Although national governments should bear the prime responsibility for the development, implementation and monitoring of the new framework, it is important that all relevant stakeholders are involved in the process, including planned phase out of donor support where appropriate. Civil society organisations are key actors and should participate in the definition of any framework to ensure the needs of the most vulnerable are taken into account. They also have strong responsibility in monitoring progress of the new framework and national
strategies based on it. Civil society participation and involvement will enhance the political will and accountability and the sustainability as the new framework will be more responsive to the people’s needs.

7. To what extent is a global development framework approach necessary or useful to improve accountability with regard to poverty reduction policies in developing countries?

A global development framework will only be really meaningful when it contains a strong accountability component. Accountability is crucial to ensure that corruption and misconduct do not go unpunished and good governance and human rights principles are respected. Accountability improves policy making, implementation and ensures that those whose rights are infringed upon in the development process are able to seek effective redress.

The future framework should try to strengthen existing accountability mechanisms or follow best practices, but where needed new mechanisms should be put in place. The new framework should build on the current progress indicators and should promote greater harmonization between different accounting frameworks where possible. Civil society participation should be supported so that citizens are empowered to advocate and demand accountability from their governments. Civil society and community contribution to human development and poverty reduction should also be acknowledged and strengthened. The new framework should be universal, applying to both developing and developed countries; increasing ownership of Southern countries and donors together. Increased transparency is critical to strengthen the monitoring and accountability. There also needs to be increased focus on measuring impact and value for money of development programmes.

8. What could be the advantages and disadvantages of a global development framework for your organisation/sector, including how you work effectively with your partners?

A global development framework has the advantage that it can put pressure on governments that would not otherwise prioritise human and social development. Common commitments under a global development framework can lead to a system of government peer pressure and constitute a powerful advocacy tool for civil society to hold governments to account.

C. The potential scope of a future framework

9. In your view, what should be the primary purpose of a future framework?

Within the post-MDG framework International HIV/AIDS Alliance would like to see improved health outcomes of the poorest and most marginalised communities globally through the provision of universal coverage and access to high quality health care services via a rights-based approach.

A future framework should be a global norm to eradicate poverty, mobilise resources for that purpose and hold governments to account for their actions and policies in this sense.
Therefore, the framework should consist of clear, concrete and binding goals, targets with measurable indicators, which have been agreed upon through a participatory process. It is important that the search for better ways to define development and measure its progress does not lead to a rejection of the current goals, and does not undermine progress made so far. They should be time-bound and universal to gather global support, while being adapted to national and local targets with common indicators for transparency and accountability. Current indicators should be the basis for the indicators of the future framework.

10. **In your view, should its scope be global, relevant for all countries?**

The new framework should face global challenges and thus needs to be universal and applying to all countries. As highlighted in response to question 4, using country income categories as the main guidance for deciding whether or not to allocate resources may ultimately be counterproductive notably because as income alone is not indicative of countries’ ability to pay for the cost of their human development and poverty reduction responses. Moreover, this approach ignores other factors including the fact that many countries will evolve from LIC to MIC status over the next few years. Many countries are transitioning from low to middle income, but poverty in middle income countries remains high. Poverty in middle income countries is exacerbated by rising income inequality. Middle income countries still have high rates of poverty that contribute to negative health outcomes. In fact, 60% of the world’s poor live in five population middle-income countries: Pakistan, India, Nigeria, China and Indonesia.

11. **To what extent should a future framework focus on the poorest and most fragile countries, or also address development objectives relevant in other countries?**

See response to question 10.

12. **How could a new development agenda involve new actors, including the private sector and emerging donors?**

All current and potential actors of the development agenda, including international donors, emerging economies, affected countries and the private sector, should contribute financially to the new agenda, in accordance with each partner’s capacity. Moreover, international donors and technical agencies should support countries to enhance coherence and control of programming and resources and to maximize value-for-money for results. In addition to including new actors, the experience of the ‘usual suspects’ such as communities delivering services needs to be strengthened, leveraged and expanded.

A new framework should support the implementation of evidence based tools, such as the new UNAIDS Strategic Investment Framework for the global HIV response. With the support of the international community, countries and partners in sub-Saharan Africa should leverage

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broader development efforts in the region to foster new industries and knowledge-based economies. Urgent efforts are needed to scale up domestic and regional production of antiretroviral drugs in sub-Saharan Africa and to increase South-South technical cooperation. The private sector has an important role to play as demonstrated for instance by the announcement in 2011 by the Medicines Patent Pool of its first licence with a pharmaceutical company, permitting the generic manufacture of compounds produced by Gilead Sciences. However, the private sector should be pushed by governments to go beyond the concept of corporate social responsibility and to develop programmes or projects in line with the framework of public policies set up by national governments.

13. How could a future framework support improved policy coherence for development (PCD), at global, EU and country levels?

Health should be approached in all policies as much of the population’s health is also determined by influences outside of the health sector, such as environmental and social conditions. Intensified efforts are needed to establish robust capacity in emerging economies and in developing countries, especially in sub-Saharan Africa, for the domestic manufacture of pharmaceuticals. As free trade agreements are negotiated, care should be taken by all parties to avoid the imposition of measures that limit the flexibilities now permitted under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement.

Countries must be empowered to make effective use of flexibilities available under international intellectual property rules. The 2001 Doha Declaration on TRIPS and Public Health recognized the right of countries to take public health considerations into account to promote patients’ access to priority medicines. A number of countries have already used TRIPS flexibilities to promote access to essential medicines, but even greater action will be needed, as many countries have yet to exercise the full array of access-promoting options available under international rules.

14. How could a new framework improve development financing?

To set up a framework that improves development financing it should take into account the aid effectiveness principles. The biggest challenges are complex and include insufficient funding, weak links between investments and development outcomes, and a lack of political will to invest in social sectors, notably health, by Ministries of Finance in aid recipient countries. These challenges have been compounded by increasing complexity in the number of external actors in the health sector and a proliferation of different financing mechanisms, resulting in high transaction costs for Ministries of Health and donors. Insufficient attention to equity and financial sustainability are also persistent problems in the sector.

The new development framework will work at the national level only if it goes hand in hand with a global solidarity mechanism to guarantee its sustainability. Without this mechanism there is a risk that the new framework will mean that many poor countries, including those hit hardest by HIV and AIDS, will have to stop HIV treatment scale up and we will return to the days of preventable AIDS-related deaths.
We need a Financial Transaction Tax (FTT) for global health and a mechanism to distribute it in a way that guarantees the sustainability of a universal health coverage (UHC) package that many poor countries cannot yet afford on their own. In one year alone a global FTT could raise over US$ 350 billion, of which just nine billion could provide free healthcare for 227 million people in the world’s poorest countries.

It is important the new development framework ensures the strategic investment of resources in order to maximise the efficiency of development financing. A good example of how this can be done is the Strategic Investment Framework for the HIV response\(^\text{12}\), designed to promote efficiency while maximizing results. The investment framework encourages focused funding for the basic programmatic activities. These basic programmatic activities need to be supported by critical enablers (political commitment and advocacy; laws, policies and practices; community mobilisation, stigma reduction, mass media, changing the risk environment) and by well-resourced efforts to capture synergies between the HIV-specific and broader health and development initiatives. According to modelling exercises, improving the strategic use of resources according to the principles of the investment framework would avert 12.2 million new infections and 7.4 million AIDS-related deaths by 2020, with optimized investment leading to rapid declines in new HIV infections globally.

**D. The potential shape of a future framework**

15. What do you consider to be the "top 3" most important features or elements which should be included in or ensured by any future development agenda?

1. HIV/AIDS and related health goals and progress indicators of the future development framework should be equally ambitious as in the Millennium Development Goals.

The report\(^\text{13}\) of the UN System Task Team on the post-2015 UN Development Agenda to the Secretary General outlines a number of priorities, such as preventative health services; maternal, newborn and child survival and health; reproductive health services; infectious diseases. The report suggests that “the major actions to halt the spread of HIV and AIDS will need to be integrated into these priorities.” **Whereas International HIV/AIDS Alliance recognises that the improved health outcomes could be achieved only through the meaningful integration between HIV/AIDS and other health priorities and development sectors, we believe that HIV and AIDS should be included in the new development framework as the priority area for action\(^\text{14}\) and goal.** HIV and AIDS have a direct impact on the health outcomes. For example, poor HIV outcomes are the main indicators of poor health in the community. High HIV prevalence among women of child bearing age has the

\(^{12}\) Towards an improved investment approach for an effective response to HIV/AIDS. The Lancet, Volume 377, Issue 9782, Pages 2031 - 2041, 11 June 2011

\(^{13}\) Realizing the Future We Want for All. P. 26. June, 2012. [http://on.undp.org/N780sQ](http://on.undp.org/N780sQ)

major impact on the maternal health and child survival. The access to the antiretroviral therapy is the key indicator of the access levels to the essential medicines.

The HIV/AIDS and related global health post-MDGs goals should be based on the principles of equity, social determinants of health, universality and measurability. Goals and targets should be the balance of health outcomes and health systems targets.

Potential health outcomes targets should include:
- global burden of disease, including HIV and AIDS prevalence
- life expectancy
- the quality-adjusted life year
- child and maternal mortality

Potential health systems and preventative health targets should include universal health access and coverage progress, including:
- universal access to treatment for HIV and AIDS
- condom use at last high-risk sex
- proportion of population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS.

2. One of the central elements of the new framework should be to realise the right to health, particularly for poorest and most vulnerable groups. It is important to place human rights as an integral dimension of the design, implementation, monitoring and evaluation of health and other related policies and programmes, including political, economic and social.

In the run up to the new development framework the international community should come together to agree the measures of the quality of a country’s respect for rights. Given that it appears doubtful that a consensus decision would be reached to include Freedom House indicator measures as part of any target related to rights goal15.

3. Community mobilisation and community systems strengthening16 should be at the core of the sustainable development agenda. The Community Systems Strengthening Framework puts those most affect at the centre of development. The core components of the Framework are:
- enabling environments and advocacy
- community networks, linkages, partnerships and coordination
- enabling effective activities, resources and capacity building
- community activities and service delivery
- organisational and leadership strengthening
- monitoring & evaluation and planning.

15 Ibid. P. 12
16. What do you consider to be the "top 3" features or elements which must be avoided in any future development agenda?

1. The MDGs which have not yet been met must not be dropped - we need to build on the momentum and progress that has been achieved to date. Whichever new health indicator/s is chosen, we must ensure that we set the bar for global health ever higher and strive ever harder to reach it. The indicators which measure the progress on HIV and AIDS should not be weakened.

2. In the health sector, the new framework should go beyond the traditional opposition between ‘horizontal’ and ‘vertical’ interventions. It should be recognised that effective health systems need both vertical and horizontal components and the new framework should commit to redouble efforts to strengthen health systems, recognising that strengthening community systems is strengthening the entire health system.

3. No goal set in the new development framework should be left underfunded.

17. Should it be based on goals, targets and indicators? If any, should goals have an outcome or sector focus? Please give reasons for your answer.

As mentioned above the concrete, measurable and time-bound goals, targets and indicators of the MDGs were crucial in creating a broad support among the public, civil society but also governments and even the private sector. They were clear and easy to communicate, realistic and achievable. However, we need to go beyond the current goals and make them more adapted to the current development agenda. See the answer to question 15 for more specific details for health.

To make this happen, the process is as important as the framework itself. It needs to be a participative process that involves all stakeholders: governments, civil society as well as the private sector.

The goals should have an outcome as well as a sector focus. All goals (health and education, health and gender, health and population, health and environment) are interlinked. It is important that the new development framework is conducive to the cross-sectoral cooperation. It is important to look broader than a simple sector focus. Some of the targets should be sector-crossing. For example when realising sexual and reproductive health and rights the access to information and sexual education as crucial as people need to have knowledge of different contraceptives, how and why to use it. This is a clear overlap between two sectors namely health and education. Another example is that people living with HIV that are on antiretroviral therapy need to have good nutrition to make the medicine work, a clear overlap between nutrition and health.

18. How should implementation of the new framework be resourced?

The resources will have to include efforts from all, but with a fair application of the principle of common-but-differentiated responsibility. It implies a redistribution of wealth and resources. Specific policy interventions are required to combat both extreme poverty and
unfair redistribution of resources if inequality is to be reduced. Different additional financing mechanisms can help to fulfill the need:

1. At the Monterrey conference on financing for development in 2002 industrialized countries confirmed the commitment to invest 0.7 percent of GNI in development cooperation by 2015, to realise the MDGs and make progress in the fight against poverty. For health there is need for 0.1% of GNI as recommended by the Commission on Macroeconomics and Health. Unfortunately, recent figures show worrying trends. For example, in 2011 The Netherlands, one of the development aid champions reduced ODA by more than 5%. The picture became grimmer as Belgium reduced its spending by more than 10% and Spain reduced its ODA by more than a massive 30%. This is concerning as low levels of development aid from Europe’s biggest economies are having devastating impact to reach the MDGs. Governments should be held to account for their own commitments to pull people out of poverty and building strong health systems in the South.

2. In the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* (2001), African governments committed to allocating 15% of their national budgets to health. However, only a handful of countries have met the target. As a result, gaps in funding programmes arise and public health problems persist. Southern governments should be held to account for their promises and supported to invest their “fair share” based on ability and prior commitments, as a matter of shared responsibility. Countries should be encouraged to develop financially viable national plans with clear targets. In that regard, taking into account the weakness of tax systems in the South, regulatory means should be put in place at international level to support developing countries in domestic revenue mobilisation.

3. Any innovative financing mechanism for health should be seen as a means to generate funds that are additional to ODA and should not be a way for governments to avoid their commitments. A broadly supported tax at 0.05% on stocks, bonds, commodities, derivatives and other financial instruments, also known as the *Financial Transaction Tax*, could raise approximately $350 billion a year for poverty alleviation. But other mechanisms are as important for example: Aviation Solidarity Levy, UNITAID, MASSIVEGOOD, Advance Market Commitments, IFFIm, GAVI, Debt2Health, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Additional options for domestic financing in developing countries could include: alcohol levies, contributions from high-revenue enterprises, mobile phone levies, earmarking of a proportion of public budgets or income tax for health.

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