STOPAIDS. UNITING UK VOICES ON THE GLOBAL RESPONSE

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# FACTSHEET Universal Health Coverage and HIV

## BACKGROUND

The growing global momentum surrounding Universal Health Coverage (UHC) presents an unmissable opportunity for action in a context where we are off track to meet the Global target of ending AIDS. We must interrogate the forces at play to identify opportunities to drive forward the global HIV response and ensure that progress towards ending AIDS is not compromised or lost.

In September 2019, the first UN High-Level Meeting (HLM) on UHC will take place in New York. Global leaders will endorse a Political Declaration with new commitments and an agreed pathway to help achieve UHC building on the ambition that was set out in Agenda 2030.[1]

The Tracking Universal Health Coverage Report published in 2017 by the World Bank and the World Health Organisation (WHO) articulates the need for progress on UHC. It reveals that "at least half of the world's population still lacks access to essential health services". Furthermore, "almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses".[2]

When Dr Tedros Adhanom Ghebreyesus was appointed the new Director General of the WHO in July 2017 he immediately announced that the achievement of UHC would be his "top priority" while in office.[3] Michel Sidibe, the outgoing Executive Director of UNAIDS has also spoken out strongly in support of UHC. Sidibe states that "UHC is about much more than just making a package of services available and that the ultimate measure of success of UHC must be whether the poorest, the most marginalized and the most vulnerable people actually enjoy health and well-being".

Sidibe has also set out that UHC should put the focus on people, not diseases or health systems, shifting attention to treat individuals holistically. Over the past three decades this approach has been transformative for the HIV response.[4]

This document will seek to explore how STOPAIDS members, allies and partners are leading by example in their efforts to couple the advancement of the HIV response with the achievement of UHC. It will explore six key thematic building blocks of the HIV response which we believe will also underpin UHC. Within these we will analyse the lessons from the HIV response that will help to ensure that as we work towards a world where UHC is realised, we also finish the job of ending AIDS.

We will explore the following six themes (1) Leaving No One Behind; (2) Meaningful Community and Civil Society Engagement; (3) Integration; (4) A Political Response; (5) Sustainable Financing; and (6) Accountability.

### DEFINITION – UHC

The World Health Organisation defines UHC as ensuring all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[12,13] UHC therefore embodies three key dimensions:

1. Expanding service coverage and ensuring equity in access to health services – everyone who needs services is able to access them;
2. Improving the quality of health services should improve the health of those receiving services; and
3. People should be protected against financial-risk by reducing out-of-pocket payments.[14]

## (1) LEAVING NO ONE BEHIND

Many have remarked that the renewed energy for 'UHC for all' is reminiscent of the movement that historically moved the needle for HIV[5] and that the HIV response has been a 'trailblazer in global public health'.[6]

The fight to achieve access to HIV prevention and treatment has exposed pervasive inequalities in access to services. UHC can be universal only if it applies equally to all people and it is critical that the UHC movement takes a hard look at the inequalities that persist. The SDG principle of Leave No One Behind must guide efforts to put people first who are marginalised, underserved and/or face discrimination when designing UHC systems.[7]

### The meaningful involvement of people living with HIV/AIDS

The meaningful involvement of people living with AIDS (MIPA) in everything that affects and impacts those living with HIV and AIDS has been core to the response and proven crucial to delivering more responsive programmes, and therefore better results.[8]

The MIPA principle is reflected in community-based services run by people living with and affected by HIV, multisector national AIDS programme committees and Global Fund Country Coordinating Mechanisms. There are also voting seats for civil society and communities that represent people living with HIV on global governing boards of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Unitaid. **UHC programmes should ensure similar meaningful involvement of those affected by health issues (including people living with or affected by HIV) and/or their representative organisations in their governance, to improve the design and implementation while enhancing legitimacy.**

### Upholding human rights and addressing intersectional inequalities

UHC seeks to realise the fundamental human right to health. Human rights are of particular importance to the HIV response because HIV disproportionately affects key populations[i], people whose human rights are often under threat, undermined or denied making it more difficult for them to access services.[9] Experience from the HIV sector demonstrates that we live in a world where significant barriers to access exist, from social norms and practices leading to stigma and discrimination, to human rights violations and laws criminalising specific groups including lesbian, gay, bisexual, transgender, queer and intersex populations. UHC therefore cannot be achieved without addressing the political, social and cultural determinants of health. **The UHC movement must therefore intentionally seek to dismantle and reform regressive laws, policies and social norms that discriminate against marginalised groups, including key populations and young people, or universality will never be achieved.**[10]

The HIV response and UHC movement need to address diverse and intersectional inequalities, including those linked to age and gender. AIDS-related-illness remains the leading cause of death for women and girls of reproductive age (15–49)[11]. If this is not prioritised, women and girls' needs will continue to be invisibilized and largely unrepresented in policies, services and investments designed to drive forward UHC. **It is vital that marginalised groups and other key populations are reached first by UHC in order to ensure that no one is left behind** and that people in all their diversity are free, willing and able to use the services without fear of their rights and dignity being compromised**.**

i UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

### Tracking progress

Additionally, any new universal goals and/or commitments that do not have explicit indicators to maintain a focus on the poorest and most marginalised will continue to drive inequality rather than combat it. **The data gathered to measure progress towards UHC must be disaggregated to ensure that it is reaching the poorest and most marginalised** (e.g. income quintiles, sex, age, place of residence, migrant status, ethnic origin and ensure that there is no discrimination in access to services for people living with HIV and key populations).

#### SUMMARY OF KEY LESSONS

1. Meaningfully involve people living with and/or directly affected by HIV and other health conditions in the design and implementation of UHC.
2. Reform regressive laws, policies and social norms that criminalise and discriminate against marginalised groups.
3. Set indicators and collect data that captures the reality for marginalised and key populations.
4. Design and direct interventions to reach the poorest and most marginalised first.

## (2) MEANINGFUL COMMUNITY AND CIVIL SOCIETY ENGAGEMENT

Inclusive governance and partnerships with communities and civil society who may not traditionally have access to decision making power structures have been core to the success of the HIV response. The early calls of communities and civil society in the response were pivotal, calling for increased access to HIV treatment and services, respect for the human rights of people most affected by HIV and support for community-led HIV services.

Arguably, the current reality of how UHC is being conceptualised is still predominantly too public health system focused, facility-based and doctor-dependent and the experience of the HIV response shows that this will lead to failure. **The HIV sector has many lessons to build on regarding funding and enabling communities to provide services to the most marginalized, advocating for the promotion of human rights and addressing stigma and discrimination in health care settings.**

### Providing services

Community engagement has led to greater access to treatment and prevention in the HIV response. For instance, in Nigeria it has been recognised that a community led approach led to a 64% increase in the likelihood of treatment access and a twofold increase in the likelihood of using prevention services. In Kenya, it led to a fourfold increase in consistent condom use over a twelve month period. Community systems also complement more formal health systems by ensuring that funds reach grassroots programmes through sub-granting to smaller organizations which can provide backup and extend capacity where communities may have otherwise been overlooked.[15]

According to UNAIDS, "the world now needs a paradigm shift away from niche support for community systems to building comprehensive health and social support systems that can provide seamless collaboration between communities and the public and private sector".[16] The question remains of how to deliver such a shift without losing the gains made over decades. Many have raised the risk of collapse of the community response to HIV and AIDS as a consequence of the movement towards UHC.

**Civil society has a critical role to play in achieving UHC both as a provider of services and in mobilising populations to access services – particularly for key populations.** When community-led and-based organisations are empowered, they can play a significant role in service provision to marginalised communities. They can also provide expertise to government on the specific needs of these groups and conduct advocacy on human rights to improve the legal and social environment for these groups and organisations led by these groups. See Case Study A for a best practice example from Vietnam.

CASE STUDY

### (A) Meaningful civil society particpation to tackle HIV and advance UHC in Vietnam

The partnership between a civil society organisation, sex worker-led organisations and the Vietnamese Government Department of Social Vices Prevention and Combat (DSVP) has resulted in increased access to HIV testing and treatment services for sex workers.

The Vietnamese government adopted a more progressive and cooperative attitude towards sex workers in 2016, with the approval of the "National Sex Work control and Management Policy 2016 -2020". This included important adjustments towards realising the human rights for key populations, the engagement of CSOs in harm reduction and increasing access to social support services. The policy aims to implement HIV programmes in 50% of Vietnam's provinces together with a gender-based violence reduction program for sex workers in 20 provinces. The policy set out a pilot model of sex worker community-based organisations (CBOs) supporting sex workers in outreach, communication and harm reduction interventions together with gender-based violence reduction.

In 2017, Aidsfonds partner SCDI (The Center for Supporting Community Development Initiatives) in Vietnam collaborated with the Department of Social Evil Prevention in Ho Chi Minh City (DSEP-HCMC) and piloted a counselling and support model for sex workers at the largest hotspot in Ho Chi Min City.

This model, which is implemented jointly by a sex worker CBO Pink Lotus and the government, includes several components related to support, counselling and harm reduction interventions including increasing knowledge around health care and violence risk reduction for sex workers; a supporting network of service providers such as medical centers and vocational training centers; and awareness-raising among key local actors such as policemen, local agencies and managers of entertainment establishments about sex workers' rights and needs.

In 2018, the Vietnamese Department of Social Vices Prevention and Combat (DSVP) consulted civil society and the Vietnamese Network of Sex Workers (VNSW) about how to develop a more cost-effective HIV prevention programme nationwide. As a result of successful advocacy by SCDI and VNSW, DVSP agreed to pilot three models for sex workers that consist of a triangle partnership between the national government, the sex worker-led organisation Pink Lotus and civil society (SCDI and DVSP). Pink Lotus received technical support from SCDI and VNSW and reached 514 sex workers by mid 2018 of which 93 were referred to medical services, including 5 sex workers for ARV treatment. The government has decided to scale up the pilot to 15 provinces of Vietnam. In 2019, SCDI and VNSW will provide capacity strengthening to 17 governmental health facilities and 5 sex worker-led CBOs involved in the 15 provinces. The pilot is now financed by the governmental provincial budgets, which means that sex worker-led CBOs implement government health programmes and receive funding and recognition for this by the State.

Although there are challenges (policy barriers, attitude of local government, alignment of approaches), this case study provides an example of successful community and government collaboration

on harm reduction and HIV prevention services for sex workers. It shows the strength of community-led services, the recognition and legalization of a sex worker-led CBO, and how partnerships between governments and communities contribute to effectiveness. and sustainability of wider health care efforts.

**The involvement of diverse communities and civil society will also help ensure more effective monitoring of the quality and level of coverage of services among the most marginalised whose experiences may not be captured through mainstream channels.**

### Engaging in governance, advocacy and accountability

Whilst the state has ultimate responsibility in ensuring access to healthcare for all, the model of delivery of health services decided at a national and international level must be governed through inclusive structures that include civil society.

**In the governance structures that make up the global health architecture, GFATM has civil society and affected communities represented at all levels through country coordinating mechanisms in country and in Board seats in the governance structure, Unitaid also has dedicated board seats for civil society and affected communities.** But not every multilateral organisation is so participatory and inclusive.

At the Global Financing Facility, civil society involvement is limited at both country level and global level where civil society representatives are included in the Investors Group but not in the Trust Fund Committee, where important decisions on strategy and allocations are made.

**It is incumbent on those designing the governance structures that will drive UHC and those that will hold decision makers to account on UHC progress, that they ensure meaningful civil society participation in decision-making processes affecting UHC from local to national to regional and international levels.**

**Civil society must play a key role in holding national governments and governance structures in the global health architecture to account for delivering on UHC both as a watchdog and as a partner.**

For example, civil society voices in global health governance have been fundamental to bilateral and multilateral donors realising the potential negative impact of the exit of donor funding on community initiatives. Many donors decided to rapidly pull funding away from middle income countries in the belief that national governments will automatically plug the funding void as part of their UHC efforts. Yet, civil society was able to demonstrate that in many cases national governments lacked the financial, programmatic and/or political will to continue to fund community initiatives (particularly those related to marginalised groups) and this resulted in many losing funding altogether. Civil society have and must continue to hold donors and national governments to account to stop this.

#### SUMMARY OF KEY LESSONS

1. Recognise and invest in civil society as a key service provider. Civil society plays a vital role in providing services for most marginalised that must be respected and resourced.
2. Ensure civil society and community groups are meaningfully involved in governance structures and making decisions on health at all levels and have space to hold governments to account.
3. Ensure civil society are represented on and financially support to engage on global health multilateral boards.

## (3) INTEGRATION

### Delivering treatment

The WHO uses 16 essential health services in four categories as indicators of equitable healthcare coverage. Antiretroviral treatment (ART) for HIV is included in the infectious diseases category and is therefore regarded as part of the 'essential package of care'.[17]

In Thailand, treatment has been fully integrated into the national UHC system and the result has been spectacular: in just seven years, the number of people accessing ART grew from 40,000 to more than a quarter of a million in seven years.[18]

**The inclusion of ART in national UHC initiatives is critical but is by no means assured.** There have been reports that Kenya, which is piloting UHC nationally from October 2019, is yet to clarify if HIV services will be covered. It appears that the government has not fully budgeted for HIV treatment, which is currently funded by external donors.[19]

Even if treatment is included in the national UHC package in Kenya and beyond, it is only one element of the HIV response. To use only this indicator to track success does not do justice to the scale and reach of what UHC must help deliver to truly impact and help achieve the end of AIDS. **UHC must also provide and monitor other elements of the HIV response including prevention, care, support and social protection.**

### Transforming vertical to horizontal health systems

A major challenge for achieving UHC targets is to link the various vertical packages into a coherent whole.

Approaches that link and integrate services across different health areas have been developed. For example, the joint prevention and management of HIV and tuberculosis co-infection, and the linking of HIV, family planning and maternal and child health services. This integration is welcome because having separate facilities for TB and HIV can mean that a patient has to seek care in multiple locations, from multiple doctors, who do not speak or coordinate their treatment approaches. However, as the WHO notes, it is important that the approach to integration maintains disease-specific interventions, whilst promoting synergies across different health areas and strengthening the generic health and community systems that are required to support a broad range of services.[20] Increased integration should be carefully managed and should not be mistaken as the overarching goal of UHC.[21]

There are challenges involved in moving from traditionally 'vertical' to 'horizontal' health systems funding, with a risk that programmatic expertise and political leadership for diseases like HIV will be lost. This is already happening in the case of donor governments like the UK, where, over the past few years, a general de-prioritisation of HIV specific programmes has taken place in favour of programmes integrated with sexual reproductive health and rights leading to reduced overall funding for the HIV response and weaker political leadership.[22]

**Therefore, a systemic and strategic approach is required to ensure that increased integration in health services will significantly benefit people living with and affected by HIV.** According to the

CASE STUDY

### (B) Halting needless deaths: pioneering cervical cancer screening and preventative therapy in Togo

There are currently 2.16 million women of reproductive age who are at risk of developing cervical cancer in Togo, which is the second most common cancer among women in the country. The country faces a complex battle to stop women from developing the disease, which is largely preventable if caught early. Most women in Togo do not know about the risks of cervical cancer, nor will they have been screened for it. Women living with HIV are at four to five times greater risk of developing cervical cancer.[34] In response IPPF have been seeking a community led approach to increasing screening and have had success in linking up cervical cancer and sexual and reproductive health services.

With support from the Japan Trust Fund for Reproductive Health, the Togolese Association for Family Welfare (ATBEF) has introduced cervical cancer screening and treatment services to some of its clinics in Togo, filling a vital gap in the country's health care system. For the first time in the country, women can be screened and treated for pre-cancerous lesions in one visit. Screenings also provide an opportunity to offer other sexual and reproductive health services, including testing, treatment and support for HIV and other STIs. By providing these services at a low cost, ATBEF is ensuring that no-one is left behind in the prevention and detection of cervical cancer – a major contribution to the aim of achieving universal health coverage both nationally and globally.

Grace* is 35 years old and lives with her two children in Lomé, Togo's capital. Both Grace's mother and sister died from cervical cancer, and with no access to affordable treatment services, she resigned herself to the idea that she would also die from the disease. Before ATBEF's introduction of cervical cancer screening and treatment into its clinics, the only way of getting screened had been to attend a private clinic at a very high, often prohibitive cost.

Grace heard about ATBEF's new services through a radio campaign. To raise awareness about the new services, ATBEF has conducted national radio and TV campaigns and outreach campaigns across the country to reach women. "Living with the stress of two family members (my mother and sister) who died of cervical cancer, I resolved to give myself to destiny: would I die of the same thing? My husband came back one evening from work with information that would change my life: ATBEF organizes a screening campaign for precancerous cervical lesions in its main clinic in Lomé. I attended and lesions were discovered. I had cryotherapy, with the support of the staff providing these services and of my entire family. And now I'm here, with my family."

ATBEF is preparing to expand these vital services in Togo, providing training to government health staff and facilities as well as equipping more of its clinics with screening equipment. It also now has experience and evidence with which it can advocate to the government and other health partners to roll out these services nationally, preventing many more women dying early and needlessly from cervical cancer.

*Names changed

WHO "the future of the HIV response needs to continue to be part of a broader approach to health, as vulnerable populations and people living with HIV face a range of health risks and challenges, including poverty, ageing, mental health and substance use disorders, environmental pollution, climate change, food insecurity, human rights abuses, and non-communicable diseases".[23]

Ethiopia's Health Extension Programme which has been implemented since 2003[24] is a great example of what strategic integration can achieve. External HIV funding contributed to the Health Extension Program (HEP) has helped to recruit, train, and support over 35,000 community health workers in providing primary health care, including HIV services, in rural settings.[25] The HEP has enabled Ethiopia to increase health care coverage from 76.9% in 2005 to 90% in 2010.[26] In the same timeframe, the estimated number of deaths due to AIDS fell from approximately 80,000 to approximately 55,000.[27] As services are integrated monitoring must take place to ensure UHC programmes focus on quality, prioritise those who are most marginalised, and help to eliminate discrimination in healthcare settings.[28]

**Any global, regional or national strategic plan for the HIV response that is not integrated or coordinated with plans for the broader health system can fail to take into account issues of co-morbidities, such as diabetes or cancer care, and thus leave the programme ill-equipped to deal with the full range of patient needs.**

## Harnessing synergies

Another example of the potential benefits of integration is palliative care. Palliative care is a defining component of UHC according to the WHO.[29] It is also a crucial component of the continuum of care for people living with HIV and should be available to alleviate serious health related suffering from early in the course of the condition through to the end of life.

According to the Lancet Commission on Palliative Care and Pain Relief,[30] HIV and cancer cause the largest amount of people to experience serious health related suffering (SHRS). Palliative care would alleviate this but less than 10% of those who need palliative care for any condition will access it.[31] More than 95% of all patients in need of palliative care and pain relief associated with HIV, premature birth or birth trauma, tuberculosis, and malnutrition live in lower-middle income countries.[32]

To further understand the inequities in palliative care the global distribution of morphine is a clear example of the changes we need to see. Morphine is the most effective and inexpensive way to treat moderate to severe pain. However, of the 298.5 metric tonnes of morphine-equivalent opioids distributed in the world per year (average distribution in 2010–13), only 0.1 metric tonne is distributed to low-income countries.[33] This means that people living with HIV, and other conditions, are not able to access the medications that they need to treat moderate to severe pain throughout their lives.


### (C) Malawi National AIDS Commission: Expanding palliative care provision[35]

Malawi's National AIDS Commission (NAC) has played a leading role in integration and expanding palliative care in public health systems whilst supporting CBOs to lead the HIV response.

The NAC, alongside contributions from external donors, has been supporting the Malawian government to implement a number of activities including: Conducting a study tour to Hospice Africa Uganda; connecting with African Palliative Care Association and the Ministry of Health to learn best practices on palliative care; developing standardized palliative care training materials; supporting the development, printing and dissemination of the national palliative care guidelines; and delivering the first stakeholders meeting on development of the national palliative care policy. It has also supported: the training of palliative care trainers to roll out further training; procuring of supervisors; and providing community home based care kits to be used by communities for treatment of minor ailments.

NAC funds have also facilitated the sharing of best practice in how to move from home based care to home based palliative care. This holistic approach was emphasized and embraced by service providers after they were given training, which improved their knowledge, skills and attitudes towards providing palliative care.

### SUMMARY OF KEY LESSONS

1. Include ART in UHC but also ensure the provision for and monitoring of HIV services in UHC go beyond treatment to include prevention, care and social protection support.
2. Take a strategic approach to integration to ensure it benefits, and therefore does no-harm, to people living with and affected by HIV.
3. Mitigate against donor complacency, withdrawal and deprioritization caused by integration.

## (4) A POLITICAL RESPONSE

Since the early days of the AIDS epidemic the HIV movement has successfully framed HIV as a political issue requiring a political response; actively challenging and engaging with decision-makers and influencers in all walks of life - politicians, government ministers, private sector leaders, civil society, the faith sector, the scientific community; researchers, medical doctors and other healthcare workers. **The UHC movement equally needs and must demand a political response. This can be achieved by drawing attention to pervasive social and economic inequalities[36] and the responsibility of governments to fulfil, respect and protect the right to health.**

### Increasing access to medicines

An example from the HIV movement of securing an effective political response is advocacy work to increase access to medicines. A political response to the high prices of and lack of access to ART led to the Doha Declaration in 2001, which reaffirmed Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and led to increased access to ART for millions of people.TRIPS flexibilities allowed countries to access generic medicines, which would have otherwise been unaffordable. By 2012, India's reputation as the 'pharmacy of the developing world' was widespread with it producing over 85% of all first generation antiretroviral drugs used in low-and-middle income countries to treat people living with HIV.[37]

Access to affordable medicines, vaccines and diagnostics is vital to achieving UHC. **Governments should fully utilise the flexibilities outlined in the TRIPS agreement to secure cheaper and more equitable access to medicines and other health technologies.**

Furthermore, governments and multilateral organisations must address the consistent policy incoherencies between human rights, intellectual property rights, trade and public health objectives. This requires reforming the health research and development (R&D) model, which currently relies on granting patent monopolies to incentivise research. This means that market, rather than public-health need, is the driving force of health technology production. This must be remedied since it leads to excessively high prices for medicines and a distinct lack of research into diseases that do not offer a financial incentive, such as neglected tropical diseases and antimicrobial resistance.

Both the UN Secretary General's High Level Panel on Access to Medicines (UNHLP) report and the Lancet Commission on Essential Medicines for UHC recognised that the current R&D model is not sufficient for meeting public health needs.

**To achieve UHC, governments must urgently implement the UNHLP recommendations.** Provisions made through the UHC agenda - to increase transparency of data on R&D and costs of R&D, to de-link high prices from R&D incentives, to attach public interest conditions to public money spent on R&D and to set public health objectives for all R&D investment - will be crucial to ensuring access to medicines that will be needed to deliver UHC at an affordable cost.

Addressing the twin problems of high prices and a lack of public health driven R&D requires a political and international response that is willing to address the power and influence of elite forces, such as the pharmaceutical industry lobby. Therefore, civil society and governments should call for the needed next step of a UN High Level Meeting on innovation and access to health technologies to galvanise needed commitment and action on this issue.

#### SUMMARY OF KEY LESSONS

1. Demand a political response from governments that have a duty to their citizens to protect and realise the right to health.
2. Utilise TRIPS flexibilities to help increase access to affordable medicines and protect health budgets.
3. Urgently implement the UNHLP recommendations and call for a UN High level meeting on innovation and access to health technologies.

## (5) SUSTAINABLE FINANCING

### Closing the funding gap

To end AIDS as a public health threat by 2030, UNAIDS estimates that US$26.2 billion will be required for the global HIV response in 2020 alone.[38] In 2017, only US$21.3 billion was available for the HIV response in low-and-middle income countries.[39] If the GFATM is successful in raising US$14 billion at its sixth replenishment conference in October 2019, there will still be a US $4.4 billion gap in funding to cover global need in the period 2021 - 2023.[40] That gap will widen if there is insufficient domestic resource mobilisation in the same period.

Funding for the global HIV response has been flat-lining for years since the 2008 financial crash.[41] The trend of disinvestment has since continued globally. Donor funding for the response in low-and middle-income countries declined by 7% between 2015 and 2016. Many also blame 'AIDS fatigue',[42] competition of other important issues and premature and misleading claims of the 'end of AIDS'. This declining international funding for HIV substantially increases the risk for effective integration of HIV within the UHC movement, as highlighted above.

## Managing donor transition

Another growing phenomenon in the funding landscape for health is that of donor transition. Premature withdrawal of donor funding before countries are ready, willing, able and committed to take over services will lead to gaps in services and the possible reversal of hard-won development gains.[43] This has had a huge and, in places, devastating impact on the HIV response.

For example, in 2010 GFATM withdrew its HIV funding from Romania when the country 'graduated' to middle -income status. The withdrawal led to a large gap in national HIV funding and led to the closure of key HIV programmes which then caused an increase in HIV cases among key populations. Among people who inject drugs new infections increased from 3% in 2010 to 30% in 2013.[44]

Firstly, donors must re-examine their eligibility criteria regarding whether it is appropriate to exit funding at all if sustainability of programmes cannot be maintained. Whether they exit funding altogether or just transition to a different types of support within the country, donors must undertake detailed, transparent transition planning to prevent losing development gains made to date.

Theoretically, increasing domestic resource mobilisation for achieving UHC can lead to a more sustainable health system as it reduces the dependency on unpredictable and short-term donor funding cycles. However the projections of how much domestic resource countries are able to mobilise can be overly ambitious. **A comprehensive analysis which includes countries' fiscal space and debt burden should always be undertaken before any assessments are made.**

## Setting financing targets

Multiple international recommendations and commitments have been made on the minimum levels of financing required to fund national healthcare.

In 2001 African leaders pledged in the Abuja Declaration to allocate 15% of their national budgets to health (this money can include external financing).[45] In 2012, only 14% of governments in low and lower-middle income countries had met the target; and only 29% of upper-middle income and high-income countries had achieved this level of spending.[46]

Relative targets like this are important as they call on governments to prioritize investments in health and linking health expenditure to the total economy motivates the government to raise additional revenue that can be invested in health. However, relative targets alone are not enough.

In 2014 a Chatham House report endorsed the High Level Taskforce on Innovative International Financing for Health Systems recommendation of how much should be spent per capita on health and updated the recommended original estimation (US$54) to 2012 US dollar terms based on changes in inflation and exchange rates since 2005. It stated that every government should ensure government health expenditures per capita of "at least $86 whenever possible".[47] The WHO has since made higher estimates and recommends carrying out country-specific costing exercises.[48]

However, no low-income country - and only 60% of lower-middle income countries - would achieve $86 per capita even if they were to allocate 5% of their GDP to health as many in the UHC movement call for.[49] Therefore continued donor support remains crucial to ensure a decent level of health services in countries that cannot meet the absolute target with their domestic resources.[50]

Not only have levels of overseas development assistance stagnated over the last few years, many low income and lower-middle income countries are losing public resources due to tax avoidance and evasion and are facing high debt service payments. Debts have risen to very high levels and in several countries, debt service payments are higher than public health budgets. It is therefore likely that there will be limited domestic funding for both achieving UHC and sustaining a strong HIV response. This may have a negative impact on the progress made in the HIV response and particularly reaching key populations. **Governments must be supported to find the best buys in UHC and HIV and ensure that funding for HIV is strategically embedded within UHC budgeting so that no-one's access to services is overlooked.**

## Designing financing models

There is much debate about the type of financing models that could and should pay for the expansion of UHC. STOPAIDS align with the position shared by many including The Elders.[51] **If countries are to improve access to essential health services for their entire populations, it is vital that the health financing system does not rely on private out-of-pocket spending but instead on compulsory public financing.** In the WHO Reference Guide to Developing a National Health Financing Strategy it states that governments should aim to "move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)."[52]

The Elders have stated that historically, transitioning to a predominantly publicly-financed system has been able to occur rapidly as countries have gotten richer. "This is regarded as the birth of a nation's UHC system,

as occurred in the United Kingdom in 1948, Japan in 1961, Canada in 1966, South Korea in 1977, Brazil in 1988 and Thailand in 2002."[53]

Sustainable, innovative, blended and co-financing are just some of the terms often heard in discussions of how to fund the HIV response, and, now, the expansion of UHC. There are few clear strategies that can guarantee success. One approach gathering momentum is increasing involvement of and partnerships with the private sector to finance and deliver health outcomes. **All efforts to bring about UHC must be transparent and recognise that expanding coverage by ushering in the private sector could result increasing inequities in access and health expenditure.[54] It is therefore critical that there must be clear globally agreed principles that guide any involvement of the private sector in UHC ensures equity, non-discrimination, dignity, and social justice.**

CASE STUDY

### (D) Who is and will pay the health workers

Malawi is one of those countries that – even if it further prioritizes health investments – would not be able to raise sufficient domestic resources for health. The 2017/18 health budget amounted to USD 177 million. Allocating 5% of GDP would raise that number to USD$315 million. But to provide core primary health care to the entire population, costed at USD 86 per capita, would require USD$1.5 billion.

The health sector in Malawi is and will continue to be heavily dependent on donor funding: external funding accounted for 73% of total resources available for health in fiscal year 2015/16.

Even though the health workforce is broadly acknowledged to be the cornerstone of a well-functioning health system, very few donors are prepared to contribute to health worker salaries. However, the GFATM and PEPFAR do support recruitment and temporary funding of health care worker salaries in Malawi, using different approaches each having its benefits and challenges.

GFTAM announced support for recruiting 1,222 health care workers in 2016 and 800 nurses in 2018. Health workers supported by GFATM are currently employed and deployed by the Ministry of Health through the Health Service Commission. The Government of Malawi has committed to take over the funding, but there has been resistance from the Ministry of Finance who is hesitant to take on the long term financial commitments needed, given the current levels of fiscal space available to the government. In this approach, the health workers are on government payroll. When the government takes over funding of their salaries, they will not have to go through another recruitment process. On the downside, there have been delays in the recruitment process, leading to frustrations at both the Government of Malawi and the development partners and eventually even to a loss of part of the funds.

PEPFAR recruitment is managed by Human Resources for Health 2030 and its focus has mainly been to recruit health workers (including nurse midwife technicians, medical assistants, laboratory assistants, and pharmacy assistants) in high HIV burden sites. In 2017, PEPFAR recruited 462 health care workers on a three-year contract and has recruited an additional 480 health care workers in 2018 on a one-year contract with the prospect for renewal for another year. PEPFAR supported health workers are recruited as project staff. Recruitment and deployment are done following the MoH's job descriptions and salary scales, but the health workers are not on the government payroll. The government has expressed its commitment to absorb these health workers onto the MoH payroll as well after 2019, but funding to do so is not guaranteed. And unlike those recruited with GFATM funding, these health workers will have to go through the MoH recruitment process once their contracts end.

These initiatives exhibit welcomed flexibility, whilst taking lessons from these experiences to ensure greater sustainability for salaries. The two cases are different in nature – in terms of recruitment and funding procedures – and each carry different risks and implications for sustainability.

### SUMMARY OF KEY LESSONS

1. Be realistic about the amount that countries can raise for health through domestic resource mobilisation.
2. Adhere to up-to-date minimum financing targets that are based on public, tax-based funding.
3. Continue donor support with improved donor alignment, harminsation and coordination and ensure collaborative transition planning before any reduction of external donor financing
4. Prioritise funding for public, rather than private sector, service delivery and ensure safeguards and principles are in place to limit and guide the role and influence of the private sector to ensure any involvement contributes to public health goals.

## (6) ACCOUNTABILITY

### Setting targets

Finally, the HIV response has a great track record in setting appropriate and easily measurable targets for the response. The 90-90-90 targets were created in 2014 as part of the UNAIDS Fast Track Strategy[55] These are referenced in the 2016 High Level Meeting on HIV Political Declaration[56], which also included the target to ensure that 30 million people living with HIV access treatment by 2020. The Global AIDS monitoring framework provides indicators for the 2020 Fast Track commitments and expanded targets to end AIDS and disaggregates the indicators by age, sex, geographical location and key population, as appropriate.[57]

The targets were informed by the strategic objective that if at least 90% of people infected with HIV knew their status, and at least 90% of those who knew their status were on antiretroviral therapy, and at least 90% of those who were on antiretroviral therapy were virally suppressed, ending AIDS would be achievable by 2030.[58]

Such targets have created an enabling environment for holding national governments and the donor community to account on progress. They have arguably led to the success of initiatives like Fast Track Cities which also began in 2014, there are now 135 Cities globally who have achieved the 90-90-90 targets and there is an infrastructure which allows them to share their best practice and experiences with other cities who are on the journey to meeting the targets.

However, despite the success with Fast Track Cities, in 2019 the overall Fast Track targets for 2020 are far from being met. A 2018 analysis finds that the Middle East and North Africa Region is farthest away from reaching the targets.[59]

While progress towards the targets is evidently too slow to meet the 2020 goal, the fact that the targets exist has created a framework against which progress can be measured and articulated, and countries can compare and contrast their results.

**The UHC movement should strive to introduce similar tangible, achievable and trackable targets accross all health issues.**

#### SUMMARY OF KEY LESSONS

1. Set appropriate and trackable targets.
2. Share best practice for enabling citizen-led accountability and invest in tracking progress towards targets.

## CONCLUSION

The drive towards achieving UHC is a unique opportunity to address some of the many fundamental, structural issues that continue to drive the HIV pandemic. A lack of consideration for the lessons (successes and challenges) learnt from the HIV response could hugely set back the cause of UHC and the target of leaving no-one behind. It would no doubt spell disaster for people living with or affected by HIV and reverse best practices and resources efficiencies that have been created through the HIV response.

If successful however, the results of UHC would be manifold for healthcare generally and for the HIV response. People could be better able to access prevention, care, treatment and palliative services, HIV could become more mainstreamed within a comprehensive package of care and stigma and discrimination could be reduced if the UHC movement commits to realising equity, non-discrimination, dignity, and social justice.[60]

As a result key populations and those most likely to be affected by HIV, would not only be able to better access HIV services, but their other health needs will also be more adequately and holistically met. By building on the lessons of the HIV response, UHC can put the last first and ensure that all people, particularly the most marginalised, gain access to all the quality health services they need when they need them.

#### CASE STUDIES

**Case Study A:** Compiled by Aidsfonds - https://aidsfonds.org/

**Case Study B:** Compiled by IPPF - https://www.ippf.org/

**Case Study C:** Compiled by Worldwide Hospice Palliative Care Alliance - https://www.thewhpca.org/

**Case Study D:** Compiled by Wemos - https://www.wemos.nl/en/

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