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**Agenda item 3**

**UNAIDS-Lancet Commission Working Group 3 Discussion Paper**

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# UNAIDS-Lancet Commission Working Group 3\*

## Discussion Paper

### How should the global health and AIDS architecture be modernized for the post-2015 development agenda?

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## 1. Background

- 1.1. This Working Group has been convened to examine the strengths and limitations of the current architecture for HIV and health – understood as the formal and informal institutions, norms, rules and processes, as well as their state and non-state organizational expression, which govern health outcomes – and how this architecture can be adapted for the post-2015 world. The recommendations to date on the post-2015 development agenda indicate that one health goal may be likely, with AIDS subsumed within it. Yet, AIDS also is also related to a range of issues that will feature in the Sustainable Development Goals – for example, gender equality, governance, human rights etc. **Ideas and experiences shared by Working Group members in their first meeting, and derived from preliminary literature reviews, served as the basis for the themes discussed in this draft paper. This paper intends to serve as a point of departure for further dialogue on the future HIV and health architecture.**
- 1.2. The Working Group proposes that the global health architecture needs to reflect two overarching principles:
  - i. The architecture needs to build on existing successes and be oriented around people and their well-being, not specific diseases. A future health architecture should move away from a siloed, disease-specific approach to one which promotes multi-sectoral action, integration, innovation, and rights-based approaches to help countries deliver integrated HIV, health and development solutions.
  - ii. A human rights-based approach to HIV and health is essential. In particular, an approach rooted in gender equality could move the health agenda forward. Many of the significant gains in the response to HIV have been based on human rights such as universal access to treatment, which translated into tangible services for hard-to-reach communities.

## 2. Why now a discussion on health architecture?

- 2.1. A changing global environment provides opportunities to advance the future agenda for HIV and global health.
- i. There is increasing complexity in the architecture with a proliferation of alliances, partnerships and initiatives, resulting in a fragmentation of results.
  - ii. Official development assistance for health (DAH), after an unprecedented increase over the last two decades, has now flat-lined, but domestic investment is rising. While this indicates increased country ownership, many countries still rely heavily on international assistance and the funding gap for health continues to grow.
  - iii. The growing economic and political strength of developing countries, especially the BRICS – Brazil, Russia, India, China, and South Africa—is changing global power dynamics as these countries have an increasingly active role in development cooperation and driving innovations in global governance.
  - iv. In light of the economic crisis and its impact on DAH, more attention needs to be paid to global and national governance and institutional capacities to ensure optimal use of the resources that are available. These shifts in DAH may impact on the nature of the institutions required to manage it.
  - v. Poverty, financial insecurity, urbanization, ageing, climate change, ill health and food insecurity pose threats to health and are likely to deepen health and socioeconomic inequalities in those communities with the greatest disease burden. Non-communicable diseases (NCDs) are now a major cause of death in all countries, regardless of income levels. Any future HIV and health architecture needs to take these issues into account.
  - vi. The past decade has seen a significant increase in the use of technology. Advances in mobile technology allow citizens and service users to demand better and more accountable healthcare provision as well as results of their leadership. Mobile technology (M-technology) is also being used to collect more real-time epidemiological and programmatic data.

**Discussion Questions:** Are there other major shifts that will impact on the future needs and nature of the global HIV and health architecture? Are there areas within the above shifts that would benefit from further exploration and discussion?

## 3. What works in the current architecture and needs to be maintained and extended?

- 3.1. Initial Working Group discussions identified five areas which have worked well in the current architecture and need to be maintained and extended more broadly to serve global health. Many of the gains have been made on the basis of the right to health.

### **i. Activism and accountability**

AIDS activism – from community level through to the mobilization of transnational civil society alliances, and with the institutional support of The Joint UN Programme on HIV/AIDS (UNAIDS) – has contributed to high-level global commitments of nation states, the G8 and the UN General Assembly. The Political Declarations provide coherence around goals and mandate country reporting on progress against the epidemic and, in so doing, bring mutual accountability. AIDS activism has also led the way in framing HIV and health as economic and security concerns, and the linking of HIV and health and foreign policy objectives.

### **ii. Multi-sectoral responses led by governments**

In the AIDS architecture, multi-sectoral action has worked well at both the global and country level. At the country level, the creation of National AIDS Councils (NACs), usually located in the Head of Government office, has resulted in effective intra-governmental responses. At the international level, UNAIDS has coordinated the activities of 11 cosponsoring UN agencies resulting in an effective division of labour and accountability framework, and successful advocacy that AIDS be seen as a major development issue, not one simply requiring a health sector response.

### **iii. Partnership between state and non-state actors**

Increasing partnership of multilateral organizations with non-state actors, including the private sector, civil society groups and philanthropic foundations, represents a major shift in the global health architecture. In particular, the role of civil society has been unique and complementary to government, particularly on AIDS, where politicians have been pressured into responding to the needs of populations that might otherwise be invisible. The rapid diversification of global health actors and activities has propelled health onto the global political stage. Importantly, pluralism has filled niches and driven innovation. However, the gains made as a result of this pluralism may mean that the positive benefits of a more streamlined global architecture are not as self-evident.

### **iv. People/patient empowerment**

Early on in the AIDS response, [Jonathan Mann](#) closely linked healthcare provision with the human rights of those living with HIV. This has resulted in an inclusive response where voluntary participation, confidentiality and informed consent are key principles underpinning action. In addition, there has been the linking of treatment and care including counselling and education as well as strategies to address prevention, treatment and care together.

### **v. Linking health to non-health regimes (such as international trade )**

AIDS activists joined forces with governments in countries such as Brazil and Thailand to ensure that the flexibilities inherent in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement would facilitate international trade in generic medicines – giving concrete expression to the principle that international human rights law and the right to health should supersede intellectual property protection.

These gains have been extended to areas outside of HIV medicines. In 2006, India rejected Novartis' patent application for the cancer drug Gleevec. The court ruled in favour of public health interests over intellectual property law. The Novartis case has set an important precedent.

However, this argument has been dismissed by pharmaceutical industry representatives and their host countries, who have argued that patent protection, such as that afforded by the WTO TRIPS Agreement, is necessary to incentivize research and thus save lives in the long-term.

**Discussion Questions:** Are these the most important gains that have been made in the health and HIV architecture? What is missing? Do any of the above points need to be further nuanced?

#### 4. What needs to be strengthened in the next 15 years?

4.1. Initial Working Group discussions identified five areas which need to be strengthened in the next 15 years. Underlying all of these points is the issue of incentives- and how to align incentives to drive progress and increase country ownership.

##### i. Integration in service delivery and the streamlining of institutions

- For health, it is estimated that there are more than 40 bilateral donors, 26 UN agencies, and 20 global and regional funds working on global health, with 90 global initiatives active at the moment. Despite the articulation of a set of principles for more effective and equitable aid delivery, in the form of the Paris and Accra Declarations on Aid Effectiveness, the current architecture is characterized by fragmentation, and lack of coordination and coherence.
- Many of these initiatives are focused on specific diseases (e.g. AIDS, malaria and TB). The Working Group challenged the false dichotomy of HIV versus health. While HIV-specific programmes have revealed disparities and inadequacies in broader health systems, they have also, in some cases, contributed to strengthening health systems. HIV-specific programmes have helped to renew discussion on the importance of health systems, as well highlighted the need for engaging non-health sectors to improve health outcomes.
- At the same time, the Working Group recognized the need for stronger synergies and complementarities between HIV and other health conditions, in terms of service delivery and other aspects e.g. working with patent holders on intellectual property.
- In programme implementation, there is a need for further research on how to ensure that investments in HIV prevention, treatment and care and other priority health conditions, positively impact the delivery of, or demand for, other health services and what incentives could facilitate this. The remarkable mobilization of resources for the global AIDS response and the increasingly integrated and holistic approaches in many countries have served as a platform to drive progress across health systems

and service delivery platforms. For example, increasingly, HIV treatment is being initiated and delivered through maternal health systems through task-shifting to midwives and nurses. Integrated platforms with strong community outreach can offer a range of services to reduce maternal and child mortality, including empowering women and men to fully realize their sexual and reproductive health and rights.

## **ii. Real-time data systems**

- The global health architecture is ‘flying blind’ in terms of the lack of epidemiological, programmatic and financial data. It is highly problematic that imputed, estimated or modelled data largely form the basis of decisions and stewardship.
- The strengthening of country health information systems, civil registration and vital statistics is critical for the successful implementation of any post-2015 agenda. Better information on hot spots with high burden and recent epidemiological changes, is needed for high impact HIV interventions, including down to the district level and in communities. Absence of epidemiological data among vulnerable populations must be explained. These are prerequisites to measuring and improving quality and equity.
- Given the technological advances and the move to [m-health](#) (the use of mobile technology for health), now is an opportune moment to improve data systems to better understand where disease transmission occurs, what is driving it, what programmatic gaps exist and where the response is lagging – all which can improve demand, delivery, quality and accountability. Lower-level health workers can support these processes.

## **iii. Country budgetary & health systems**

- Given the shifts toward more meaningful country ownership and domestic financing of both health services and public services that impact on health, renewed attention to budgetary systems is required. Strong public financial management systems are needed that can manage and sustain funding from domestic sources, such as taxation, natural resource-rents, inter-sectoral co-financing and expanding targeted safety nets.
- There is a disconnect between the global and national health architecture. There needs to be a move away from incentives that promote a siloed approach towards a mechanism to finance integrated national health strategies in an accountable and transparent way. The move towards reliable and predictable domestic financing needs to be complemented by catalytic global investment for countries where there is a demand and need for external assistance.

## **iv. Leveraging and safeguarding with respect to non-state actors**

- Non-state actors are increasingly important in terms of influencing innovation, technologies and consumption behaviours, but operate outside of any formal accountability structures. Inherent conflicts of interest within and between state and non-state actors are largely ungoverned at present, such as where the impacts of actions taken by transnational corporations conflict with good public health, or where a single institution both finances and provides technical assistance to countries.

- Public-private partnerships (PPPs) are usually collaborations among a range of actors such as private companies (e.g. pharmaceutical companies), UN agencies, civil society groups, and academic institutions. The number of PPPs has increased exponentially in the past decade and PPPs have come to play a critical role in global health governance.
- Public health goals, however, need to be safeguarded against private sector strategies, such as the efforts of tobacco companies to enlarge their markets in low- and middle-income countries. This is especially important in developing policy responses and governance approaches to mitigating risk factors associated with smoking, harmful use of alcohol, and diets high in processed fats, carbohydrates and salt.

**v. A codified rights-based approach:**

- Much of the post-2015 health debate has been focused on proposed specific goals such as universal health coverage or ‘ensuring healthy lives’. Little attention has been given to detailing the structures needed to ensure implementation and accountability in improving health and reducing health inequities across the world.
- The post-2015 agenda needs to ensure that justice is central to the global health architecture. An institutional mechanism to realize this vision is a proposed [framework convention on global health](#) (FCGH). Based on a convention-protocol approach, a FCGH would re-imagine global governance for health, with the objective of establishing global norms for ensuring access to a comprehensive package of health services, as well as addressing the socio-economic determinants of well-being. Justice would be the Framework’s core, in its call for equity measures across all commitments and by seeking the removal of unjust laws. The FCGH would allow for a strong accountability framework that would allow civil society to hold states to account. Its purpose would be to dramatically reduce the health disadvantages experienced by the marginalized and the poor, both within and between countries.
- Guided by principles underlying the right to health and mutual responsibility, a framework convention would universally ensure three conditions that are essential for a healthy life: a well-functioning health system which provides quality health care; a full range of public health services including for marginalised populations, such as nutritious food, clean water, and a healthy environment; and broader economic and social conditions conducive to good health, such as employment, housing, income support, gender equality and enjoyment of other human rights. The framework would also set out how to resource and monitor compliance with its provisions.

**Discussion Questions:** Are these the most important areas that need strengthening moving forward? What is missing? Do any of the above points need to be further nuanced?

## 5. Principles for enhancing the AIDS and health architecture

- 5.1. The history of the AIDS response suggests that a number of principles can help guide the process of enhancing the global health architecture. These include:
- i. Pushing for solutions which maintain gains in HIV and health, demand a greater investment in both HIV and health, build on successes and address current limitations.
  - ii. Ensuring the centrality of justice, human rights, and gender equality – hallmarks of the AIDS movement and the catalyst for real progress in advancing human development.
  - iii. Empowering people and communities most affected by poor health or specified health conditions to assume a central role in governance arrangements.
  - iv. Facilitating strong country ownership including civil society and community engagement.
  - v. Mobilizing a diverse range of actors from multiple sectors for global health, including HIV. Having a plurality and diversity of global institutions on global health is an asset, and these include actors and regimes which can impact the full range of determinants of health, including critical enablers and development synergies. Defining leadership roles as well as means of identification and management of conflicts of interest will enhance such partnerships.
  - vi. Ensuring actions and investments are data-driven, evidence-informed, rights-based and results-oriented.
  - vii. Integrating AIDS, TB and malaria under a single health goal should not mean losing focus on these diseases. Achieving universality will require actions under other goals of the post-2015 development framework, for example, in relation to gender, governance, and inequality. A comprehensive approach to universal health coverage, one which also addresses key social determinants, can play an important role in advancing the universality of prevention, treatment and care for all health conditions.

**Discussion Questions:** Are there other principles that need to be taken into account? Are there areas within the above principles that need further exploration and discussion?

## 6. Critical functions of the global health architecture

- 6.1. Form should follow function. The functions demanded of the global health system have evolved over time. The increasing complexity of policy-making in an increasingly inter-connected world will impact the functions required and thus the institutions/architecture necessary to ensure good global health governance. The challenge ahead lies in providing the right incentives to ensure the most efficient and effective architecture that can deliver results.

- 6.2. Renovation of the global health architecture is an ambitious proposal. However, observers increasingly acknowledge the need to revitalize the global health system to accommodate the policy shift already underway from disease-specific approaches to those that promote multi-sectoral integration and innovation. A more rational health architecture based on a new development agenda will require commitment by activists, policymakers and government officials to building a new consensus based on an honest appraisal of the current system and its limitations. A focus on functions (and desired outcomes) can provide both important parameters for this necessary debate, as well as a framework through which, in the interim, adaptation and incremental advances can be achieved.
- 6.3. Arguably, the most critical functions can be summarized as follows:
- A. Stewardship
  - B. Rule-Making & Normative Guidance
  - C. Monitoring & Evaluation
  - D. Resources
    - i. Financial
    - ii. Technical support and capacity development
  - E. Advocacy
  - F. Accountability

**Discussion Question:** Has the Working Group identified the key functions or are some missing? How should these functions be best represented?

- 6.4. The following section will elaborate on how each function is currently performed/performing and then provide a few examples of the incremental steps that might be taken to strengthen function performance as it relates to architecture.

#### **A. Stewardship**

- 6.5. Global health stewardship is required to ensure that all the critical functions are fulfilled. These include mobilizing, coordinating, and focusing the large and diverse set of global health actors around a clear mission, common objectives, effective approaches, sustained action, and mutual accountability. This includes convening for negotiation and consensus-building, setting norms and standards, as well as strengthening the many dimensions of health interdependence and coordination. A focus on improving the coordination among existing organizations and utilizing the vast experience and expertise they possess supports the 'build on what is working' principle 1 above.
- 6.6. Reflecting the pluralism of a global health system operating across sectors and levels, a stewardship function has been exercised by a variety of international and domestic public and private actors. These coalition actors may perform one or many governance functions including establishing normative standards, allocating resources, convening interested parties, and generating strategic consensus over priorities and methods of delivery. Some examples of coordinated activities across and within the area of global health include:

- The H4+ Group, which comprises members from UNFPA, UNICEF, WHO and the World Bank, works jointly on maternal and child health
- The WHO enables civil society organizations (CSOs) to influence decision-making on global health policy, for example through the Committee on Intellectual Property Rights, Innovation and Public Health (CIPRH)
- The Health 8 (H8) convenes the heads of seven multilateral organizations, as well as the Bill and Melinda Gates Foundation, to harmonize policies and activities
- The International Health Partnership (IHP+) focuses on national plans for health with cost estimates
- UNAIDS, which brings together eleven UN agencies and a Secretariat. The mission of UNAIDS is to unite the efforts of UN Cosponsors, civil society, national governments, the private sector, global institutions and people living with and most affected by HIV. It is worth noting that, in the case of UNAIDS, this stewardship function is just one component of its mission, which also includes:
  - Speaking out in solidarity with the people most affected by HIV in defence of human dignity, human rights and gender equality
  - Mobilizing political, technical, scientific and financial resources and holding ourselves and others accountable for results
  - Empowering agents of change with strategic information and evidence to influence and ensure that resources are targeted where they deliver the greatest impact; and
  - Supporting inclusive country leadership for comprehensive and sustainable responses that are integral to and integrated with national health and development efforts.

6.7. The above-mentioned coordinated activities represent a few of the many efforts to coordinate at the global level. However, the experience of stewardship by international actors remains piecemeal and has often resulted in significant transaction costs for both government and health partners. The global health regime currently lacks an authoritative system-wide steward actor with ultimate responsibility for the performance of health outcomes. One of the key actors in global health, the WHO, is the only actor in the global health system that is built on the universal membership of all recognized sovereign nation states. However, it is viewed by some as requiring structural reform to fulfil its obligations.

6.8. Stewardship is, nevertheless, vital to maintaining and building on the gains of the HIV response and global health in recent decades. Effective stewardship can enhance policy coherence, reduce transaction costs by identifying comparative advantages across service providers, as well as provide a more structurally level playing field where all actors, including affected individuals and communities, can assume a central role in governance arrangements.

**Discussion Questions:** What is the comparative advantage of the various institutions in the current architecture and how can they better structure their interactions?

What reform of the architecture is politically feasible? How can we better manage the 'marketplace' of institutions to better serve country and population needs?

## B. Rule-Making & Normative Guidance

- 6.9. Significant advances have been made at the global level in the area of global health norm creation and procedural innovation, now well-established in a sophisticated and extensive framework of non-binding norms and policies by both formal multilateral/bilateral organizations and more informal or voluntary rule-making networks of private and nongovernmental actors. Examples include:
- UNGASS Declaration of Commitment on HIV/AIDS (A/RES/S-26/2)
  - Political Declaration on HIV/AIDS (A/RES/60/262)
  - International Health Regulations (IHR)
  - Framework Convention on Tobacco Control (FCTC)
  - Millennium Development Goal 6
  - International Classification of Diseases
  - Guidelines on Best Practice, such as WHO Model List of Essential Medicines
- 6.10. WHO is widely regarded as the principal multilateral focal actor in global health governance. Importantly, as a specialized agency of the UN, it is the only actor which can issue binding international law. However, disagreement among government veto players and other health stakeholders, combined with bureaucratic conflict, has led to the organization ceding legitimate authority to a range of other multilateral, bilateral and private platforms. The Working Group reaffirms the central role of WHO in any future health architecture while recognizing the on-going reform processes to adapt to the changing environment.
- 6.11. Reframing the needs and concerns of individuals dealing with multiple health issues, including AIDS, will require a commitment to open, transparent and participative rule-making. Ensuring the centrality of justice, human rights and gender equality will be integral to this new chapter in global health provision – building on the lessons and successes of the AIDS movement.
- 6.12. In recent years, a series of non-binding, but authoritative, Political Declarations have emerged on global health goals as a result of bottom-up mobilization by health advocates and responsive structures at the international level, including high-level UN health summits. These “soft law” standards provide important guidelines to government policymakers in the design and implementation of local health services, as well as a mobilization resource for HIV and health advocates. Such standards serve to highlight “compliance gaps,” providing a crucial backstop against erosion of health equity measures in a context of economic crisis and competition over resource allocation.

**Discussion Question:** The WHO is the only actor in the global health system that is built on the universal membership of all recognized sovereign nation states. What are the ways in which WHO must adapt in the next 15 years – in particular to strengthen its normative functions?

### C. Monitoring & Evaluation

- 6.13. The Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda calls for a data revolution to improve the quality of statistics and information available to citizens. Member States and civil society should be provided with tools, strategies and technical support to evaluate and strengthen monitoring and surveillance systems. There is also a need for coordinating integrated surveillance activities at global and regional levels in order to inform policy decisions and public health responses. Currently, a host of public and private organizations undertake monitoring and evaluation activities. It is important that the methodology employed across agencies is standardized/harmonized, open to external scrutiny, and widely accessible.
- 6.14. There are significant areas of progress. Data have been “demystified” through the AIDS response. Sustained resource allocation to the AIDS response has paid dividends, with increased harmonization of national healthcare planning and HIV monitoring and evaluation systems. There have also been novel approaches to data gathering, not just using the formal approaches of epidemiology and science. For instance, significant investment has gone into transparency initiatives to enhance confidence in monitoring and feed reliable evidence into domestic policy-making. Individuals and communities affected by HIV have also been incorporated into the monitoring process, sometimes as formal participants alongside technical experts and policy makers in country coordinating mechanisms under the Global Fund to Fight against AIDS, TB and Malaria (Global Fund).
- 6.15. Communities can play a key role in data gathering, and they may often identify innovative approaches that drive problem solving processes and new responses, as well as information gathering. In particular, the Global AIDS Response Progress Reporting mechanism offers a “good practice” model for how to strengthen surveillance systems in a resource-efficient manner, offering the highest response rate of any international health monitoring mechanism. The AIDS Progress Reporting mechanism could potentially be extended to address other diseases in a more holistic approach to tracking health outcomes across a range of metrics from clinical service delivery to compliance of local legislation with international standards.
- 6.16. Local actors such as civil society, country coordinating mechanisms and national human rights institutions have become important interlocutors in scaling up monitoring and evaluation activities on health and AIDS, and they will continue to play a vital role as domestic receptor sites for global health advancement. As the global health architecture and normative frameworks seek to leverage compliance all the way down to the district level, local compliance actors will be an increasingly vital source of information on local context, monitoring and evaluation follow-up, and implementation.
- 6.17. It is worth emphasizing that knowledge of how global commitments translate into securing improvement of human rights practice on the ground remains highly tentative. To this end, a preliminary task may be to undertake a scoping exercise of existing data collection in the global health sector with a view to identifying what does and does not work, areas of agency overlap and potential duplication, as well as highlighting gaps in knowledge – including in relation to data for decision-making and

data for accountability. Beyond enhancing surveillance coverage and methodology, a key pending challenge is how best to instrumentalise a new era of “massive data” to ensure high quality and impactful health outcomes, effective prioritization, maximum returns on finite resources, and monitoring of HIV and health outcomes in the post-2015 development agenda.

**Discussion Question:** What lessons can we learn from UNAIDS and what role can UNAIDS play in the next 15 years in strengthening surveillance and M&E and in supporting a data revolution for global health?

## D. Resources

### Financial

- 6.18. The resources currently available could have a significantly greater impact with a more rational global health strategy and institutional structure. Economic and political realities make financing inefficient programmes and institutions unsustainable. Total bilateral and multilateral assistance through DAH has been declining, since it reached a historic high of \$28.2 billion in 2010. Similarly, bilateral and multilateral assistance for AIDS has flat-lined since 2008 and the Global Fund is subject to funding shortfalls. There are exceptions, for example GAVI Alliance expenditure reached an estimated \$1.76 billion in 2012, a 41.9% increase over 2011 (IHME 2012, 7). However, the general trend lines suggest that more will need to be done with less if universal access to healthcare – and specifically to antiretroviral treatment – is to be realised after 2015. Moreover, there is a trend to non-ODA health financing which needs greater integration and enhanced governance.
- 6.19. The main challenge we face in today’s global health architecture is that there is no mechanism to finance integrated global or national health strategies. Notably, many of the countries with the highest disease burdens do not receive the most DAH (IHME 2012, 7). Multiple funding streams within and across the health-related MDGs create incentives for silos, both at the global and country level. Funds are shared across different bilateral and multilateral institutions for specific issues or diseases. The practice of earmarking funds has proven controversial, especially in a context of increased resource scarcity and the limited availability of non-earmarked funding to respond to unforeseen contingencies. At the same time, earmarked resources, such as those of the Global Fund and the US PEPFAR programme have saved millions of lives through focused funding for specific diseases. Competition to control bilateral funds has also impacted on debates concerning global health priorities, serving to exacerbate division over investment priorities for the health agenda more broadly as witnessed at the Rio+20 Summit in 2012.
- 6.20. Issues also arise concerning the complexity of resource supply chains and ambiguity over the function of the respective organisations dedicated to health investments. Resources originate from national finance ministries, private donations as well as loan repayments. Generally, the funds are then transferred through bilateral and multilateral development organisations such as UN agencies, NGOs and development banks. Health investment is usually disbursed and implemented by

government agencies and NGOs. However, the distinction between bilateral and multilateral funding is not always clear cut. Complexity also arises when public and private development organisations not only serve as routes for funding but also undertake implementation activities themselves. Examples include the Bill and Melinda Gates Foundation, a private foundation which has sufficient resources to bypass multilateral organisations and states at its discretion.

- 6.21. There is a need to address the issue of coherence in the present arrangements for global health funding. Notably, within the UN, various agencies (UNICEF, UNFPA, and WHO) are dispensing funds independently from one another as well as conducting implementation activities often focused on specific but cross-cutting sectors, vulnerable groups, and regions. The International Health Partnership (IHP+) responds to concerns that development cooperation in international health is seriously fragmented. However, one of its principal problems has been a lack of commitment to financing national health plans.
- 6.22. Principal financiers of integrated national health strategies could serve as the mechanism to fund integrated national health strategies in an accountable and transparent way, with results measured and reported for specific health outcomes but delivered in a coherent fashion. The key challenge here is how to incentivise donors to sustain investment in national health plans and bridge funding gaps. Furthermore, it is doubtful that orthodox models of financing based on a narrow donor base will be sufficient to meet growing demand for better health globally. Innovative financing such as the buy-side market leverage employed by UNITAID and identification of nonconventional capacity in recipient countries, are part of the solution to closing the global funding gap. In the longer term, funding to realize global health priorities will likely require structural reconfiguration with traditional recipient countries such as the BRICS – now powerful emerging economies – taking a lead in global health investment.

**Discussion Question:** Could substantial programmes for HIV, such as the Global Fund and PEPFAR, expand to take on board additional health concerns?

#### Technical support and capacity development

- 6.23. While there is an increase of domestic financing of HIV and health programmes, significant resources will still be needed from high-income countries. But in addition, many countries require short- and medium-term technical support across a wide range of programmatic, managerial and operational areas to effectively lead, develop, implement and monitor their national AIDS and broader health responses.
- 6.24. A number of bilateral donors, in particular the US, France and Germany, as well as multilateral institutions and CSOs have provided significant technical support to assist countries to strengthen their national AIDS and health responses, including through support to mobilize financial resources from the Global Fund and to successfully implement these grants. The increased demand for technical support, combined with services available from a diverse array of providers has brought to the forefront the challenge of assuring that countries receive the specific technical support and capacity development support that they require and that this support is of high quality and non-duplicative.

- 6.25. Longer-term capacity development to strengthen institutions is required to assure sustainability. Externally-driven technical support often bypasses domestic systems and capacities, reducing country ownership and coordination and limiting the accountability of both providers and recipients. An effective and sustainable response is more likely to be reached if recipients of technical support play a greater role in the identification and definition of their needs, and in the procurement and management of appropriate technical support.
- 6.26. The increasingly crowded marketplace of technical support provides an opportunity for greater country ownership. To ensure this, countries need to have capacities and systems in place that can lead the identification, planning, and coordination of high quality technical support towards the implementation of effective and sustainable health responses. This includes strengthening country capacities and institutions to enable proactive management and the implementation of technical support plans to which donors should align. Those entities that provide policy advice and technical or programmatic support must adapt their offerings to the identified needs of countries.

**Discussion Questions:** What are the best approaches to sustain and build country ownership through domestic financing as well as innovative financing mechanisms?

## E. Advocacy

- 6.27. AIDS activism has shown us that advocacy is best performed by many actors, including CSOs and their constituencies. This has resulted in high-level global commitments through, for example, the G8 and the UN General Assembly. In the post-2015 development agenda process there is a need to advocate for health across sectors. This requires health actors to identify and act on the social determinants of health with other sectors, through co-financing and mutual cooperation. Health considerations in policy arenas that influence global health, such as sustainable development and gender equality, must be articulated. NGOs such as the Treatment Action Campaign (TAC) in South Africa have been especially effective in advancing health activism and accessing transnational networks of influence. However, as resources, power and interests are reconfigured, such issue-specific organizations will need to develop positive linkages with the broader health agenda. The global human rights architecture has a role to play in facilitating this transition towards a broader optic on integrated and effective healthcare systems.
- 6.28. At the international level, CSOs have a central role to play in the on-going renovation of the global health architecture. They are capable of accessing both diplomatic and non-diplomatic tools to steer the policy agenda to their preferred set of solutions, such as a framework Convention on Global Health, as well as using existing and new mechanisms, such as the Global Coordination Mechanism for the Prevention and Control of NCDs. Global health organisations have pioneered civil society participation in international decision-making. For instance, the Roll Back Malaria initiative launched by the WHO in 1998 includes a host of civil society actors. Similarly, UNAIDS, while comprised of UN agencies with Member State participation, also includes CSO representatives in its Programme Coordinating Board. Notably, advocacy organisations have gained access not only to policy and coordinating bodies at the international level but also financial mechanisms, with the GAVI

Alliance and the Global Fund leading the way in granting seats on their governing boards to non-state actors.

- 6.29. Participative mechanisms in the existing HIV and global health architecture have scaled up the impact of CSOs on global health policy. Any future framework seeking to enhance systemic cooperation in global health across public and private actors will have to confront competition for decision-making and resources. In this respect, one of the key challenges facing health-focused transnational advocacy networks will be how to blunt the zero-sum logic which pervades the state-centric models of governance upon which the current system is built.

**Discussion Question:** How can advocacy best be harnessed to achieve the required functions of the global health system?

## **F. Accountability**

- 6.30. The Paris Declaration identified mutual accountability and transparency in the use of development resources as a major priority for partner countries and donors. Global and national systems should have the capacity to hold all stakeholders to account to achieve mutually agreed norms and standards. There are two types of accountability challenges in the current context. The first is the fact that intergovernmental organizations are accountable to the governments of Member States instead of directly to the people whose rights they are supposed to uphold. This is particularly problematic in cases where people consider their own national governance processes to be illegitimate, for instance when governments fail to meet health commitments made or represent marginalized groups, or themselves fail to respect, protect and fulfil human rights. The second is the lack of a formal mechanism for accountability for non-state actors such as civil society networks, foundations and multinational corporations.
- 6.31. Accountability challenges also arise in the context of funding national health programmes. Pooled funding schemes, including basket funds or sector-wide assistance programmes, have dominated global health discussions for more than a decade. The greatest hurdle for supporting pooled funding by certain international partners has been a concern about “following the money” in countries. There is a need to create a clear, results-based system with routine and standardized reporting against outcome and process indicators to initiate and maintain funding to provide the detailed information that some have found lacking in existing, country-level pooled mechanisms.

**Discussion Question:** Is there a place in the architecture for an independent, multi-sectoral accountability instrument that links evidence of progress to results?

## **7. Integrating HIV into the broader health architecture**

- 7.1. Calls for a Bretton Woods-type meeting for global health reflect the demands from some for an architectural overhaul. A corollary of this is the determination of a division of labour amongst global organisations in which a ‘principal financier’

(as described above) would provide the bulk of resources for programme implementation. Normative and technical support functions would then be identified amongst the plurality of other institutions. This division of labour would identify responsibilities according to functions rather than disease-specific categories.

- 7.2. The HIV response can provide many lessons. With a global movement behind it, the AIDS response has been an innovator in health governance. The structures governing the AIDS response are increasingly country-owned and responsive to country contexts while preserving established principles, including the engagement of sectors outside of health. Areas such as education, labour, social welfare, justice and finance are especially important. Structures are also increasingly decentralized, aligned to broader national priorities, and aiming for the meaningful engagement of civil society and affected populations.
- 7.3. UNAIDS provides an example of reform to further integrate AIDS in multi-sectoral responses. UNAIDS is working according to a [Division of Labour](#) which accentuates the comparative advantages of the Joint Programme as a whole – Cosponsors and Secretariat – to enhance efficiency and effectiveness. It aims to leverage respective organizational mandates and resources to work collectively to deliver results, including by strengthening joint working and maximizing partnerships. The approach for the UNAIDS Division of Labour is unique in that it is all-encompassing to cover policy, advocacy, standards, guidance and tool development and management, brokering and delivery of high-quality technical support with roles and responsibilities at the global, regional and country levels. In addition, it is premised on mutual accountability of the Cosponsors and the Secretariat.
- 7.4. Table 1 summarises some of these functions and offers possible changes to make UNAIDS more fit for purpose post-2015

Table 1 Assessment of potential UNAIDS functions

<b>Function of UNAIDS</b>	<b>Possible Changes in HIV Architecture Post-2015</b>
Advocacy & Accountability specifically for HIV	An expanded mandate for UNAIDS in health more broadly? What is UNAIDS' legitimacy for speaking on issues of health more broadly?
Collection and Provision of Epidemiological data (technical)	WHO and UNICEF could assume these roles
Technical and Policy- Focused Consensus Building (normative)	Co-sponsors, based on their respective mandates, could assume these roles
Coordination at Global and Country Level specifically for HIV (including resource mobilization for HIV/AIDS)	An agile and lean Secretariat that also mobilises resources for HIV at the global level is necessary
Push for AIDS exceptionalism	Move towards integration of AIDS into health and development

- 7.5. Any discussion on reforming the overall architecture needs to take into account what is politically feasible. This includes the interests of the major stakeholders in the HIV and health architecture reform.
- 7.6. Granularity is needed in determining the institutional response; for example, precise information on the nature of the problem, the time-scale, and the necessary stakeholders. For example, some problems such as managing new highly infectious viruses will require intergovernmental negotiations to achieve rules accepted by all governments, while others, such as developing new vaccines, might require fast and efficient 'mini-lateral' coalitions with inclusion of the private sector and civil society.

**Discussion Question:** What step-wise approach might be considered in fashioning a more coherent architecture for effective HIV and health responses?

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