Agenda item 5

UNAIDS/PCB (45)/19.28

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 44TH PROGRAMME COORDINATING BOARD MEETING

UNAIDS

10-12 December 2019 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 19 November 2019

Additional documents for this item: *none*

Action required at this meeting:

The Programme Coordinating Board is invited to:

74. *Take note of* the background note (UNAIDS/PCB (44)/19.21) and the summary report (UNAIDS/PCB (45)/19.28) of the Programme Coordinating Board thematic segment on Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage (UHC);

75. *Recall* the commitments outlined in the political declaration of the high-level meeting on universal health coverage, adopted on 10 October 2019;

76. *Request* the UNAIDS Joint Programme to:
    a. Promote coordinated and synergistic actions to achieve ending AIDS and other relevant SDG 3 targets, as well as contributing to other health-realted SDGs as part of a coherent UHC agenda; and
    b. Continue to support countries to monitor who is being left behind in the provision of HIV services and to support countries to remove barriers to HIV services ensuring that UHC is people-centred, rights-based, gender responsive, and free of stigma and discrimination;

77. *Call on* the UNAIDS Joint Programme to continue to advocate for and support the meaningful participation of community and civil society in implementing and monitoring national HIV responses and critical aspects of UHC, including by contributing to guidance on civil society engagement and to community-friendly UHC monitoring tools, and to advocate for domestic and international financing for HIV and health as part of the UHC agenda; and

78. *Call on* Members States to:
    a. Utilise lessons learned from the HIV response, including the focus on equity, outcomes and accountability, and responsiveness to human rights principles and the inclusion of the most marginalised to guide efforts towards UHC;
    b. Invest in HIV as part of overall health financing and as an important enabler for broader development and a key contributor to UHC, and include both HIV prevention and treatment interventions as part of essential health care services;
    c. Where applicable, integrate HIV prevention and treatment services with other relevant services and broader health systems efforts in order to address HIV, co-infections, co-morbidities and gender-based violence to promote improved health outcomes;
    d. Strengthen health systems and accelerate multisectoral responses to address the determinants of health, including through addressing legal barriers and striving to eliminate stigma and discrimination and implementing social protection programmes; and
    e. Renew efforts to identify, address and overcome regulatory and cultural barriers to the effective involvement of civil society and ensure the meaningful inclusion of civil society, including people living with HIV and other key populations, young people and women at all levels of planning, as well as national and donor policy and programming frameworks, to ensure full involvement, quality participation and influence in the design, implementation and evaluation of policies and programmes; and to systematically and strategically include community-based social and health service delivery as part of comprehensive systems for health.

Cost implications for the implementation of the decisions: *none*

Introduction

1. The thematic segment of the 44th UNAIDS Programme Coordinating Board meeting focused on delivering on SDG3—strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage (UHC). Accompanying the discussion was a background note and a conference room paper. The latter collated good practice examples, submitted by various stakeholders, of effective and innovative strategies in integrating HIV into health systems in the move towards UHC.

2. Tim Martineau, Director of Fast-Track Implementation at UNAIDS, moderated the thematic segment. He outlined the structure and said the aim was to provide a clear picture of what Universal Health Coverage (UHC) entails, discuss lessons from the HIV response for which UHC can take aboard, and gain clarity about priority issues and next steps. He introduced H.E. Ambassador Cleopa Mailu, Permanent Representative of the Republic of Kenya to the UN in Geneva.

3. After briefly discussing the current status of Kenya's HIV response, Mr Mailu said key lessons learned included the power of prioritising and focusing interventions, the importance of engaging with civil society to understand and address stigma and discrimination, and the need for multisectoral coordination to address social and structural barriers to health.

4. Sustainable responses were vital, particularly in the context of dwindling external resources. This prompted a focus on increased efficiency and creating synergies with other enabling sectors. Via UHC, the Kenya Government was committed to ensure that people can access health care without financial strain. Essential health services would be defined and an integrated, people-centred approach would be adopted. People had to be at the centre of health care, he said.

5. Mr Martineau's summary highlighted the need for prioritization, lessons from civil society, removing disparities and barriers, and integrated community delivery that puts people at the centre. He then introduced Rico Gustav, Executive Director of the Global Network of People living with HIV (GNP+).

6. Mr Gustav praised UNAIDS for engaging civil society in all its work. Investing in HIV was an investment in health and development broadly, he said, since the HIV response entailed tackling so many different issues and barriers.

7. Recalling the road travelled in HIV response, he asked what the phrase "leave no one behind" really meant when people at risk of HIV continued to be criminalised and were not getting the funded programmes they needed? How can UHC be achieved in such a context? he asked, before sharing some suggestions.

8. UHC had to reach those who are furthest behind first, he said. Key populations are the easiest for governments and donors to ignore. If health systems work for key populations, he said, they would work for everyone. The HIV response provided a wealth of knowledge and lessons—not least that engaging communities and key populations works. The principle "nothing about us without us" should be imbedded in UHC, he emphasised.

9. A basic principle of UHC had to be that health is not a commodity, he said, and it is about more than pills and condoms. Health is about wellbeing, dignity and quality of life, explained—it was not merely the absence of disease. Promoting health therefore also requires making progress with education, social protection, gender equality, etc. We should think about systems for health, rather than health systems, he said.

What is UHC?

10. This session focused on definitions of UHC to create a common ground of understanding for later discussions.

11. The presenter, Susan Sparkes, from the Department of Health Systems Governance and Financing at WHO, defined UHC as: *all* people are able to use *needed health services* (including prevention, promotion, treatment, rehabilitation, and palliation), of sufficient quality to be effective; and the use of these services does not expose the user to financial hardship.

12. Unpacking the definition, she pointed out that UHC involved an important, normative equity agenda based on the universality requirement, which can imply a greater focus on key and marginalised populations in many circumstances. She also highlighted the emphasis on use relative to need ("needed health services") and on the quality services ("quality to be effective"), adding that financing should not be barrier to care. This did not mean all services had to be free at the point of care, Dr Sparkes said, but that their use does should not present an undue financial burden to the user.

13. She then told the meeting that UHC was not about having everyone in an insurance scheme, establishing a standard and basic package of services, reaching a specific ratio of health workers per population, reaching set spending targets, integrating service delivery, ensuring that a specific percentage of a population live within a specified distance from a health facility, of ensuring there are medicines in all facilities. While the aforementioned goals may be components of UHC, they are not UHC in and of themselves.

14. UHC, she said, was not a scheme to be implemented and "achieved": it was a "direction", not an end-result.

15. HIV interventions were by definition part of UHC, but some actions for addressing HIV also went beyond UHC which involves access to health services (e.g. legal interventions addressing decriminalisation could improve access to health services).

16. As to how countries move in the right direction, Dr Sparkes distinguished between instruments ("what we do") and goals ("what we want"). The former included having a better mix and distribution human resources for health; investment to improve disease surveillance; reduced fragmentation; and provider payment reforms. The latter included equity in service use relative to need; focus on service quality; universal financial; and intermediate objectives such as equity and efficiency in resource use.

17. "Systems thinking", she said, provides for a more systematic approach and makes it possible to separate ends (e.g. effective coverage) from means (e.g. a specific health programme). It entails deciding on an objective and then ascertaining what is needed, what is already in place and what is lacking. This allows for defining and prioritizing appropriate actions and interventions.

18. In order to bring a UHC lens to HIV, she suggested, one should adopt the perspective of a Minister of Health, rather than that of an HIV programme manager. This allows for seeing how HIV is one part of a set of overall coverage goals, and how HIV links and aligns with other benefits, system changes and governance structures.

19. In summary, she said, all countries can move towards UHC, HIV is included in UHC, we should separate ends (UHC) from means (health system strengthening), and we can apply "systems thinking" for a comprehensive problem-solving approach.

Opportunities and challenges of comprehensive HIV service delivery in the move towards UHC

20. The two panel discussions in this session discussed the country-level achievements and challenges in delivering comprehensive and integrated services for HIV, TB, STIs/STDs, sexual and reproductive health, and cervical cancer to ensure people needing services can access them.

Examples of HIV focused programmes which have evolved into integrated platforms for comprehensive health services for people

21. The first session highlighted the country-level experiences for effective interventions to deliver services to key populations and people in vulnerable situations, including through community engagement, either in HIV focused settings or in broad health services, to ensure improved and equitable health outcomes in efforts to achieve SDG targets 3.3. and 3.8.

22. Hu Yiyun, Director at the National Centre for AIDS/STD Control and Prevention, CDC in China, described his country's approach to providing HIV services to people in need in context of UHC.

23. He said that China has successfully controlled its nationwide HIV epidemic through top-level political commitment and planning. It had implemented several five-year AIDS action plans and had integrated HIV into the Healthy China 2030 programme. HIV was part of China's UHC approach.

24. He told the PCB that the State Council AIDS Working Committee was the top coordinating body for the HIV response, and that all provinces had similar structures to coordinate the actions of different sectors. HIV budgets had been increased at all levels to ensure sustainability. Health services networks had also been strengthened.

25. Supply side reforms were important, he added. China had promoted the "One-Stop" model to provide a full chain of services at one facility, which had shortened the delay between testing HIV-positive and starting treatment from 6 weeks to 11 days. He described other service-level improvements, including for key populations.

26. Asked about role of civil society, Mr Hu said the State Council had set up an AIDS fund for nongovernmental organisations in 2015 and it provided funding to support civil society work. The fund designated local facilities to service as training bases for nongovernmental organisations to support service delivery.

27. Allen Kyendikuwa, Programme Officer for the Uganda Youth Coalition on Adolescent SRHR and HIV, told the meeting that governments have to design and provide services that address the needs of women and girls, including family planning, gender-based violence etc.

28. Asked about the impact of integration, she said it had important advantages, but it could also overburden service providers and drain resources in health systems. Staff may need additional support and training to avoid shifting those burdens onto service users (e.g. poor services).

29. It was important to listen to communities to understand what works best, she advised, and to involve adolescent girls and young women. If integration is to be successful, it should not come at the expense of key elements of the HIV response that work well.

30. Tatiana Makarevich, from the Republican Scientific and Practical Centre of Medical Technologies, Information, Management and Economics of Public Health in Belarus,

briefly discussed her country's progress towards UHC and SDG3. Access to ART was universal and free since 2018, she said, as was HIV self-testing. Great attention was paid to screening, diagnosing and managing TB/HIV coinfection, which was also free of charge.

31. Legislation has been adopted allowing the state to finance preventive medical and social protection services that civil society organisations provide to key populations and other affected groups.

32. She also discussed some of the difficulties experienced, including implementation of the updated WHO treatment guidelines (due to the high cost of dolutegravir in Belarus) and issues around the algorithm for diagnosing HIV and prescribing treatment. Existing programmes do not yet ensure that quality care is available for people who inject drugs, she said. Stigma, especially among health workers, remained common. Training and safety-at-work measures had to be strengthened and healthcare workers must be sensitised to the subject of HIV with a principle of mutual respect between healthcare workers and patients.

33. Khuat Thi Hai Oanh, of the Centre for Support Community Development Initiatives in Viet Nam, suggested lessons that the HIV response had for the UHC movement. They included the need for multi-stakeholder engagement that brings together relevant players; civil society engagement; promotion of human rights and equity; identifying and tackling access barriers; and a collective effort to ensure affordable quality medicines are available.

34. Engagement of civil society was a cornerstone of the HIV response, she said. It was vital for empowering people and putting them at the centre of the response; for service delivery; for task shifting and community-based approaches; and for monitoring, accountability and advocacy for the removal of policy and other barriers (including cost obstacles).

35. Speakers from the floor thanked UNAIDS for arranging this thematic segment. They shared lessons UHC could take from the HIV response, including engaging civil society and communities at all levels of UHC progress; securing the long-term sustainability of community systems; and investing in legal, policy and programme interventions to deal with stigma, discrimination and with human rights violations.

36. There was a call for focusing on the problems faced by key populations and for avoiding an assumption that governments are keen on protecting the health and interests of key populations, especially people who inject drugs. Basic issues such as criminalisation have to be addressed.

37. Several speakers stressed that health was not a commodity and reminded the meeting that health entailed more than the absence of illness. Some speakers said that the framing of UHC seemed narrow and did not capture such wide-ranging understandings of health.

38. The Joint Programme was urged to continue aligning itself with Agenda 2030, including by promoting HIV services as part of the essential health services, by supporting countries to remove legal barriers and ensure that health-relevant services are people-centred, rights-based and gender-sensitive, and by promoting inclusive health governance, including participation in voluntary national reviews.

39. Noting that investments in communicable diseases have not been equitable across countries, some speakers said it remained to be seen how equity would be built into the base of the UHC effort.

40. Speakers agreed on the need for healthcare systems that are strong, efficient and affordable and reminded that this required investment and support. Some contributions described how countries were investing in integrated health systems to get "more health for the money" and to attract "more money for health".

41. The need for quality health services was also emphasised and there was a suggestion that a future thematic segment focus on that issue.

42. Human rights had to guide UHC, speakers said. They reiterated that primary health care was most cost efficient and effective way to have healthy populations.

43. Speakers shared grassroots experiences to address issues from their respective countries, including the persistence of stigma and discrimination, a lack of understanding and respect among health-care workers for key populations. The importance of civil society was highlighted, as was the need to remove legislative and other barriers, and to promote equity.

44. While governments had a decisive role in moving towards UHC, eliminating health inequities and reducing financial barriers, speakers said, the private sector also needed to live up to its social responsibilities. The Joint Programme was urged to put the strategic purchasing of health commodities at the top of its agenda.

45. Mr Martineau summarised the discussion by highlighting the importance of civil society, the fact that communities were still being left out, and the need to deal with decriminalisation and stigma and discrimination.

46. In their closing remarks, Mr Hu said the road to UHC would be long and tough, while Ms Kyendikuwa emphasised the importance of upholding human rights. It was not enough to focus on the delivery of services, she said. Ms Oanh also stressed equity, human rights and community engagement and appealed to the Joint Programme to ensure that lessons and capacities built in the HIV response were not lost in the push towards UHC.

Achievements and challenges in providing comprehensive, inclusive and non-discriminatory services, including those for HIV, in facilities that have broader health service mandate

47. Juan Sotelo, Coordinator of the HIV Prevention Unit in Argentina's Ministry of Health, described how cooperation between civil society and government structures led to the creation of stigma-free, “friendly consultation” rooms at hospitals and other health facilities for LGBTI persons to improve access public health services. Training components had been added and opening hours and the mix of services had been adjusted. Respectful and non-discriminatory services were key, he said.

48. Zacharie Makong**,** of *Alternatives Cameroun* in Cameroon, described the support the nongovernmental organisation provides to gay and other men who have sex with men and the services it offers to government facilities. Created in 2006 in Douala, *Alternatives Cameroun* began adding medical care to its services elements in 2008. Since then it has added a pharmacy dispensary service (enabling people to take HIV and viral load tests and to receive their ARVs), with about 800 men using the service.

49. Merelin Muñoz, programme manager at the Centro de Orientación e Investigación in Dominican Republic, told the meeting that 76 centres were providing primary care to HIV patients. Arranging integrated care had been one of the early challenges. Health staff were consulted and sensitised to reduce sigma and discrimination, while HIV patients set up support groups. Integrating services at the same facilities helped reduce

HIV stigma.

50. David Ruiz Villafranca, AIDSfonds representative in Geneva, described research done to assess opportunities and risks for integrating HIV into UHC. The focus had been on financing and service coverage, and on community responses and engagement. A few findings stood out, he said.

51. Countries had to act (e.g. by changing laws) to ensure the inclusion of populations that were being left behind. The HIV movement was putting human rights at the centre, but those gains were fragile, he said. Driven by the HIV movement, the Global Fund had significantly increased support for human rights-related activities and programmes, which had to be defended. Countries had to support communities' involvement in health. Local communities, including those led by key populations, were important services, but with very little support. A third finding was that UHC had to build on the principles and structures that underpinned the success of the HIV response, e.g. the GIPA principle was critically important. If UHC could work for HIV and key populations, it would work for everyone, he said.

52. In discussion from the floor, speakers thanked the panellists. Among the points they highlighted were the need to ensure equitable access and quality health care (which requires investment) and to reduce direct costs imposed on users.

53. Some speakers described changes they were introducing, including developing of the essential health services (which local governments had to provide in non-discriminatory ways) and pursuing strategic purchasing.

54. Other speakers stressed that UHC involved much more than service delivery. Perspectives about UHC had to broaden and incorporate structural issues, social protection, and food and nutrition support, for example. UHC had to be truly universal, which meant including migrants and people in fragile settings and humanitarian crises. This would be increasingly vital as climate change shocks and crises continue, they said.

55. Concerns were expressed that UHC involved integrating into systems that neglect marginalised populations, such as migrants and refugees. How could UHC be universal if certain populations were criminalised, persecuted and discriminated against? they asked. Speakers said UHC had to be comprehensive and community-led if it was to be universal. They noted the continuity between UHC and the principles of the 1978 Alma-Alta Declaration. It was mentioned that the hard-won gains from HIV must not be lost in the move towards UHC.

56. In reply, Mr Sotelo said that reducing stigma and discrimination was a major priority for working with key populations, while Mr Makong described how his organisation worked with neighbourhood and religious leaders and the police to tackle stigma and discrimination. Mr Villafranca said limited funding, retreating donors and the ability to sustain quality of services were important concerns. However, it was also clear that community involvement was seen as game changer for UHC.

Financing mechanisms and governance issues

57. This session focused on financing for achieving SDG3 and on how inclusive health governance could shape programming and boost accountability for better health outcomes.

58. Gerson Pereira, Director of the Department of Diseases of Chronic Conditions and Sexually Transmitted Infections in Brazil's Ministry of Health, said the country’s HIV

programme was built on the principle of a unified health system and with support from a strong social movement. Social solidarity was important and the idea that health care is a business was rejected. Human rights had to be a benchmark for UHC, he said, because health was a fundamental right

59. Mark Blecher, Chief Director for Health and Social Development in the National Treasury in South Africa told the meeting that his country was seeking more integrated service delivery and efficiency. After sketching the HIV budgeting process, he said South Africa's health-care workforce was fairly integrated, while the information system was integrated with respect to HIV but not for primary health care generally. The procurement and distribution system was also fairly integrated (e.g. ARVs and other chronic disease medicines could be received at pharmacies).

60. He then discussed health financing reforms in the wider African context. Health funding (measured in purchasing power adjusted dollars) in 2010–2016 was less than US$ 30 per capita in at least 30 countries in sub-Saharan Africa, he said. Tackling this had major implications for tax system and revenue-raising, which were essential for financing UHC. He emphasised the importance of government spending for health, noting that countries who spend a higher share of their gross domestic product (GDP) on health perform better on UHC indexes. General health financing reform should include HIV financing. In addition, he spoke to the importance of health workforce resources.

61. Praphan Phanuphak, Director of the Thai Red Cross AIDS Research Centre, discussed the chronology of UHC in Thailand during the 2000s. A big step forward was the provision of free ART in 2006, due to advocacy and pressure from NGOs and activist groups, and the lowering of treatment costs through licensing generic ARVs.

62. HIV testing at the Thai Red Cross required fee payments until 2012. Lay providers were trained to offer testing services to key populations, which was so successful that they accounted for more than half of all HIV tests among gay and other men who have sex with men and among transgender persons in 2018. Key population service training modules would be covered under the UHC, along with steps to ensure the legal status and financial sustainability of the key populations-led model. Free PrEP has been available since 2016 to people at high risk of HIV infections in four provinces, thanks to donor funding (the Princess PreP programme). PrEP would be included in UHC, as well.

63. Ms. Michaela Clayton, co-chair of the UNAIDS Reference Group on HIV and Human Rights, told the meeting that health was a human right—not a commodity or privilege—and that this principle applied to everyone. UHC had to put the poorest and most marginalised at the centre.

64. She recommended that Member States eliminate out-of-pocket private spending for essential care and remove informal payments; end the use of punitive practices when people are unable to pay for health services; and set up domestic health financing systems that can ensure equitable access to health services.

65. UHC has to address social justice, she emphasised, and it has to operate in an enabling environment that supports and upholds human rights. After mentioning some of the many ways in which people are denied health care services, Ms Clayton called on Member States to repeal harmful criminalising laws and to introduce legal protection for affected populations.

66. The UHC agenda had to ensure community engagement across all dimensions of health, she said. However, civic space was shrinking and new restrictions were being

applied, including by some donors. She called on Member States to protect civil society against undue restrictions, to monitor these trends and to ensure that the implementation of UHC agenda actively involves civil society and communities.

67. Health systems alone would not achieve UHC, she said in closing. Many of the challenges and barriers lie beyond the health sector, as the HIV response had shown.

68. Speakers reiterated that UHC was about more than health and that it had to also involve removing social and structural barriers. Success of UHC required success across many sectors and people-centred approaches.

69. Some speakers challenged the assumption that private sector services were better than public health services. Others said some countries were achieving good health service coverage at relatively low cost. They asked whether "model systems" necessarily matched people's expectations in reality and pointed to apparently large drop-offs in HIV treatment in South Africa. There were also questions about how countries would be held accountable around UHC.

70. In reply, Mr Bletcher said it was not yet clear how countries were achieving good health coverage with low cost. Regarding HIV treatment in South Africa, he said 400 000 people were being added to the programme each year (the target was to increase that to 2 million per year) and about 200 000 people were leaving treatment annually. The Ministry of Health was trying to reduce dropouts by providing ART at local pharmacies and improving the turnaround of laboratory test results. Regarding UHC-related accountability, he said UNAIDS was putting great effort into collecting HIV related data that can be a basis for strong accountability.

71. Ms Clayton said key lessons from the HIV response (especially putting people and their rights at the centre) applied across public health and UHC. But there was a risk, she added, that UHC might narrow to a biomedical focus and neglects the social and economic contexts. Hard work lay ahead to prevent that from happening, she said.

Conclusion

72. After thanking the organizers and panellists for the thematic segment, Ms Shannon Hader, Deputy Executive Director, Programme, reminded the meeting that many of Thailand's UHC progress had been due to pressure from activists, the HIV movement and concerted leadership from different sectors. The gains did not happen automatically, she said.

73. The HIV response has consistently raised the alarm when people were being left out, Ms Hader said. That dynamic had to be brought to UHC, as well. UNAIDS was dedicated to the success of UHC, but its focus was on UHC coverage *and* health outcomes. It was not only a matter of integration, but of integration *for what*. She said UNAIDS looked forward to continued dialogue and reiterated the dedication of UNAIDS to the success of UHC.

Decision

The Programme Coordinating Board is invited to:

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    e. Renew efforts to identify, address and overcome regulatory and cultural barriers to the effective involvement of civil society and ensure the meaningful inclusion of civil society, including people living with HIV and other key populations, young people and women at all levels of planning, as well as national and donor policy and programming frameworks, to ensure full involvement, quality participation and influence in the design, implementation and evaluation of policies and programmes; and to systematically and strategically include community-based social and health service delivery as part of comprehensive systems for health.

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