

# UNAIDS CONTRIBUTION TO RESILIENT AND SUSTAINABLE SYSTEMS FOR HEALTH (RSSH)

## *Evidence Review*



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# Acknowledgements

Existing health services often fail to address the HIV-related needs of people who need them most, while dedicated HIV services do not always meet the broader health needs of the most marginalized people. Resilient and sustainable systems for health (RSSH) are crucial to ensuring that countries can address health challenges, and for people to access health and HIV services through quality health and community systems. Stronger systems for health strengthen countries' ability to prevent and respond to health crises, reducing risks for individuals and communities.

The purpose of this review was to summarize the evidence on how the HIV response has contributed to RSSH, with focus on four countries across regions: the Dominican Republic, Ethiopia, Ghana and Kyrgyzstan; to summarize evidence on the role and contribution of UNAIDS (principally the Secretariat) in key areas of RSSH; and to identify gaps and missed opportunities, where UNAIDS can play a role in the future. The evidence review was commissioned by the UNAIDS Evaluation Office and conducted by the Euro Health Group.

The Evaluation Office extends its sincere thanks to UNAIDS colleagues in Geneva and the regions for sharing their views, experience and expertise on RSSH and to country office staff based in the Dominican Republic, Ethiopia, Ghana, and Kyrgyzstan who dedicated time and effort to introduce the evaluators to their programmes. Thanks are also extended to the stakeholders who participated in the review, from Ministries of Health, National AIDS Control Programmes and Civil Society Organisations.

The review concludes that more discussion within UNAIDS will be required to define how and why HIV-related investments can build RSSH – whether investments are “systems support” (gap filling or supporting systems to produce better short-term disease-specific outcomes) or “systems strengthening” (permanently making the systems function better). The evidence review is expected to inform these discussions and discussions on the role of UNAIDS in strengthening RSSH in the future.

UNAIDS Evaluation Office



# Table of contents

Acronyms.....	2
Background and objectives of the evidence review .....	3
Approach and methods.....	4
Limitations.....	4
Key findings .....	5
1. The state of the evidence .....	5
2. How are HIV responses contributing to RSSH?.....	6
3. How is UNAIDS contributing to RSSH? .....	7
3.1 Governance and accountability .....	7
3.2 Innovation, precision public health, differentiated service delivery, responsiveness to COVID-19 .....	10
3.3 Community-led responses, integration of services .....	13
3.4 Inequality and inequity .....	14
3.5 Stigma and discrimination .....	15
Gaps in RSSH where UNAIDS can play a role in future .....	16
ANNEX 1: Global interviews conducted .....	20
ANNEX 2: Global documents consulted.....	21

## Acronyms




ARV	Antiretroviral Therapy
BDB	Breaking Down Barriers
CCM	Country Coordination Mechanism
CLM	Community-led Monitoring
CSO	Civil Society Organisation
DR	Dominican Republic
DRM	Domestic Resource Mobilisation and Sustainability Strategy
DSD	Differentiated Service Delivery
FR	Funding Request (Global Fund)
eMTCT	Elimination of Mother-to-Child Transmission
HSTP	Health Sector Transformation Plan
JAR	Joint Annual Review
LGBTQ	Lesbian, Gay, Bisexual, Trans and Queer
MMD	Multi-month Dispensing
MOH	Ministry of Health
NSP	National Strategic Plan
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
POP	Prioritized Operational Plan
PSM	Procurement and Supply Management System
RSSH	Resilient and Sustainable Systems for Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SUGEMI	Integrated System for Medicine Supply and Change Management
SWAp	Sector Wide Approach
TOC	Theory of Change
TWG	Technical Working Group
UBRAF	Unified Budget, Results and Accountability Framework
UHC	Universal Health Coverage
UN JT	United Nations Joint Teams
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

## Background and objectives of the evidence review

The COVID-19 pandemic has highlighted fault lines in health systems and societies, impacting on vulnerable populations and communities, spotlighting health system weaknesses, and threatening the significant progress made in global and national HIV responses. Building resilient and sustainable systems for health (RSSH) is recognized as crucial to addressing the current and future pandemics as well as ensuring equitable, efficient health services are delivered to individuals and communities, including for HIV/AIDS. RSSH can deliver better results in the fight against HIV/AIDS and health more broadly and contribute to progress towards Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

The purpose of the Evidence Review was to explore UNAIDS contribution, gaps and missed opportunities to RSSH in four countries (Dominican Republic, Ethiopia, Ghana, Kyrgyzstan) over the last five years. The review focuses principally on the role and contribution of the UNAIDS Secretariat but also considers the contribution of UNAIDS Cosponsors as members of the Joint UN Team on AIDS in country. There was also a focus on documenting country evidence for how HIV responses and UNAIDS contributions to RSSH went 'beyond HIV'. The findings of the Evidence Review are intended to inform UNAIDS thinking and direction on RSSH in the future.

The objectives of Evidence Review are threefold:

	To summarize the evidence on how the HIV response has contributed to RSSH.
	To identify the unique role and contribution of UNAIDS to RSSH.
	To identify RSSH gaps and areas where UNAIDS can strengthen its contribution in future.

Six elements of RSSH were identified by UNAIDS as the focus of the Review. These were selected based on the unique role and comparative advantage of UNAIDS, and the role the elements can play in future health systems.

### Box 1: Six elements of RSSH for this Evidence Review derived from The Global Fund's framework for RSSH<sup>1</sup>

**Accountability:** countries commitment to the goals and targets in the Political Declaration on HIV and as well as UHC targets.

**Innovation, agility, and responsiveness of health systems:** differentiated service delivery models to bring services to people; precision public health; agile programmes and use of data to detect issues, alert systems and make changes; data use for quality assurance and forecasting; pandemic preparedness and linkages with the response to COVID-19.

**Community-led approaches and people-centered services:** inclusion of communities at the governance, planning, service delivery and accountability/ monitoring levels.

**Addressing inequalities and inequities:** improving access to multi-layered services for the most vulnerable and people left behind, including women and young girls

**Integrated health services:** one stop-shops with health needs of people living with HIV that go beyond HIV.

**Reducing stigma and discrimination:** against people living with HIV and key populations within and outside the health sector.

<sup>1</sup> Global Fund July 2019 Focus on Building Resilient and Sustainable Systems for Health  
[https://www.theglobalfund.org/media/1309/publication\\_rssh\\_focuson\\_en.pdf](https://www.theglobalfund.org/media/1309/publication_rssh_focuson_en.pdf)

This report provides a summary of key findings from the four case studies, including the contribution of UNAIDS to the six elements of RSSH.

## Approach and methods

The Evidence Review used a *Realist Evaluation* approach which adopted the Context-Mechanisms-Outcome (CMO) framework to help structure the evidence for the six elements of RSSH and guided the development of Review's methods and tools.

The case study countries were selected by UNAIDS based on the following criteria i) consultants' recent evaluation experience in countries where evidence-based assessments of HIV and RSSH have been conducted, ii) countries covering different UNAIDS regions, iii) countries covering at least four of the six elements of RSSH, and iv) countries identified as critical by UNAIDS (for example, because of catalytic activities, lessons learnt). The following case studies were chosen **Dominican Republic, Ethiopia, Ghana, Kyrgyzstan**.

The case study approach used qualitative methods, principally documentation review<sup>2</sup> and key informant interviews<sup>3</sup> (KII). Over 50 KII were conducted across the four case studies and over 170 country documents were reviewed. Additionally, there was a limited review of global documentation, eight KIIs and two Focus Group Discussions conducted at global level, to help inform broader thinking and country level findings. Data generated from these sources was triangulated. Strength of evidence for case study findings were ranked based on Table 1, with the strongest evidence ranking being 1 and the lowest ranking being 4. These rankings can be found in the case study summaries which accompany this report (Volume 2: Annexes) which also include a list of people interviewed and documents consulted by country.

Table 1: Strength of evidence

Rank	Rationale
1	The finding is supported by multiple data sources (good triangulation) which are generally of strong quality.
2	The finding is supported by multiple data sources (moderate good triangulation) of lesser quality, or the finding is supported by fewer data sources of higher quality.
3	The finding is supported by few data sources (limited triangulation) of lesser quality.
4	The finding is supported by very limited evidence (single source) or by incomplete or unreliable evidence. In the context of this prospective evaluation, findings with this ranking may be preliminary or emerging, with active and ongoing data collection to follow-up.

## Limitations

There were limitations to the approach and methodology adopted for the Evidence Review. These included:

- **Absence of UNAIDS RSSH Theory of Change (TOC):** to explain how and why UNAIDS mechanisms are expected to bring about progress in RSSH. This limited the Review's ability to conduct a robust Contribution Analysis, including the quality of UNAIDS contribution, and to assess UNAIDS contribution in relation to other key actors working in HIV and RSSH.
- **Unclear UNAIDS objectives on RSSH:** RSSH is not the starting point for UNAIDS work, and thus it was misleading to look for a logic chain to determine how UNAIDS had contributed or met RSSH objectives. KIs found it difficult to explain their work in terms of contribution to RSSH.
- **Varying definitions of RSSH:** There is no one agreed framework, definition or understanding of health systems strengthening or RSSH, and this also became apparent in our discussions with UNAIDS Secretariat staff in Geneva. The six elements of RSSH are based on the Global Fund's RSSH framework. With this framework, there is also a lack of agreement regarding whether Global Fund

<sup>2</sup> Health and HIV-related policies, strategies, guidelines, UNAIDS reports, reviews, evaluations, grey and published literature spanning the last five years.

<sup>3</sup> Ministry of Health, National AIDS Control Programme, Civil Society Organisations, UNAIDS Secretariat, Cosponsor agencies as part of country Joint UN Team on AIDS, development partners.



investments in RSSH support sustainable and systemic change in health systems. This is because the Global Fund invests significantly in “systems support<sup>4</sup>” (gap filling or supporting systems relevant to the Global Fund mission, to produce better short-term outcomes for disease specific programme) rather than “systems strengthening” (permanently making the systems function better).

- **‘Virtual’ case studies:** Implementing virtual case studies in a pandemic had limitations in terms of accessing a broad range of KIs and following up information. Internet connectivity was also a challenge and sometimes compromised the quality, range and ‘completeness’ of interviews. There was also a high degree of dependency on UNAIDS country offices to identify appropriate KIs. This may have introduced bias.
- **Scope of the Evidence Review:** The six elements of RSSH identified for the focus of the Review ‘covered’ much of UNAIDS mandate however the time and resources available for the Review had implications on the depth of interviews and document review possible. This meant that potentially important areas of evidence were under-explored, particularly the *unintended consequences* of HIV responses on health systems and other health programmes, and the quality and effectiveness of UNAIDS support in the six areas.

## Key findings

### 1. THE STATE OF THE EVIDENCE

The review of case study KIIs and documentary evidence leads to the following observations on the state of the evidence, which is found to be consistent across the case studies. A summary is presented in Box 2 below:

#### Box 2: Observations on the state of the evidence for UNAIDS contribution to RSSH

Country evidence for UNAIDS **mechanisms** (*essentially, what UNAIDS did/is doing to contribute to x?*) was **more available** than evidence on **outcomes** of those mechanisms (*essentially what was the result of doing x?*). This made it **difficult to robustly link evidence of actions to contribution to RSSH**.

Case study evidence for broader **‘spill over’** effects of HIV responses and UNAIDS work, to other areas of health and social sectors is **limited**. This is also reflected at global level where literature and documented examples regarding HIV-related health system-wide benefits is quite outdated (for example, many references are approximately a decade old, such as WHO’s Positive Synergies work in 2009).

The quality of UNAIDS country reports was **very mixed**, and **largely descriptive**. UNAIDS ‘results’ are sometimes reported as national programme results or are ‘input focused’ (for example, reporting the number of women’s groups reached). Additionally, teasing out the role and contribution of members of the UN Joint Team on AIDS from that of the UNAIDS Secretariat was difficult in some cases.

Identifying gaps and missed opportunities for how HIV responses and UNAIDS work can be more broadly applied to wider areas of health and other social sectors was also limited due to **lack of available KI (in part due to conflicting priorities such as the COVID response in countries) and documented examples**.

There was **more evidence** available for UNAIDS role and contribution to **national health and HIV strategies**, governance, and accountability processes and **less evidence** available for areas such as **community-led responses and integration**.

4 Chee et al 2013 Why differentiating between health systems support and health systems strengthening is needed. Int Journal of Health Planning and Management 2013;28 (1) 85-04

## 2. HOW ARE HIV RESPONSES CONTRIBUTING TO RSSH?



**There is strong evidence from KII and documentary sources that external funding for the HIV response has made important contributions to supporting health system building blocks** in the case study countries, such as infrastructure, workforce, health management information systems – see examples in Box 3 below.

### Box 3: HIV responses supporting health systems strengthening efforts, beyond

Use of PEPFAR funding to **support laboratory systems** in Ethiopia where a national reference laboratory and six regional reference laboratories were constructed. Some of these regional laboratories have evolved into fully operational regional public health institutes and the laboratories are equipped and trained for use for services beyond HIV. There is also evidence from Ghana and Kyrgyzstan where external HIV funding is being used to strengthen national laboratory capacity through training, provision of equipment and accreditation of laboratories, benefiting all health programmes, not just HIV.

Strengthening the **procurement and supply management system (PSM)** in Dominican Republic (DR) through the establishment of a centralized procurement agency (PROMESE/CAL) and integrated system for medicine supply and change management (SUGEMI) which supports the purchasing of all drugs. Use of HIV funding to support PSM agencies and the procurement and warehousing of medicines laboratory and diagnostic equipment benefiting programmes beyond HIV, can also be found in Ethiopia, Ghana, and Kyrgyzstan.

Building the capacity of **health workers to deliver services**, beyond HIV, particularly at primary health care level (PHC). There is strong evidence across the case study countries of Global Fund and/or PEPFAR funding being used for the training of health workers to enable the delivery of decentralised, integrated, HIV services at PHC level. For example, in Ethiopia, PEPFAR and Global Fund funding has supported the implementation of the Health Extension Programme which has been pivotal to staffing increased PHC infrastructure and improving access to a range of services. Similarly, in DR and Kyrgyzstan, Global Fund funding has supported the transfer of HIV service delivery to PHC level, including training of PHC staff for delivery of HIV care with other services (TB, Hep C, STI).

Strengthening **health management information systems (HMIS)** including at district level, with potential to improve the availability of health data for evidence-based decision making, beyond HIV. External funding is supporting implementation and data quality improvements to the DHIS2 in Ethiopia and Ghana. In Ghana, HIV funding has supported the development of an HIV unique identifier system which will be used for other diseases beyond HIV, such as TB and malaria.

**There is strong evidence that HIV responses have pioneered programmatic innovations and people-centered approaches** including through differentiated service delivery models (DSD) which demonstrate a shift away from the clinic-based 'one size fits all' model to ones which increasingly meet different client needs and contexts. DSD models are being designed to simplify and adapt services across the HIV care cascade in ways that serve the needs of people living with HIV (PLHIV) and key populations (KPs) and reduce burdens on the health system. Importantly, the use and learning from HIV-related DSD models demonstrate how chronic diseases can be managed in ways that potentially improve health system efficiencies and health outcomes.

The case studies point to a range of DSD models under implementation, and which may have broader applicability to service delivery, beyond HIV. Some of these models have been scaled up in response to the COVID-19 pandemic to ensure uninterrupted delivery of HIV services. For more detail, see Section 4.3.2 of this report and Case Study Summaries.

**HIV responses have introduced new paradigms for governance and accountability for the health sector**, through including PLHIV and KPs in national governing bodies. In theory, involving citizens at every level of the health system should enable prioritization of the right services for populations most in need, thus achieving meaningful increases in equity and improvements in health outcomes. In the case study countries, there was strong evidence of HIV responses supporting the capacity and leadership of civil society organisations (CSOs) to participate in formal planning, review and resource mobilization arrangements, primarily for HIV but also the health sector. CSO involvement on governing boards and other priority setting and oversight committees associated with the HIV response was evident, for example, through CSO representation on Global Fund Country Coordination Mechanisms (CCMs) in all case study countries.

**HIV responses have mobilized and strengthened community-based platforms that support health service provision and address barriers to access** as evidenced through the development of networks of PLHIV, women, and youth and adolescents in case study countries. Such networks are reportedly contributing to service delivery, particularly for prevention and other non-medical interventions, such as awareness-raising, advocacy, treatment adherence support or linking KPs to HIV and broader health services. Many of the same networks are also targeting stigma, discrimination, violence, and other human rights-related barriers to accessing services.

**There is evidence that globally recommended evidence-based strategies and policies, adapted to country context, with supporting normative guidance** have been key to mobilising HIV resources, driving health service innovations, and improving health outcomes in the four case study countries. There is some evidence, for example, from Ethiopia, that incremental investments in key health system building blocks such as laboratory systems strengthening, regulatory systems, supply chain system improvements, human resource development programmes have helped lay foundations for country implementation of globally recommended strategies and interventions within the health system.

### 3. HOW IS UNAIDS CONTRIBUTING TO RSSH?



#### 3.1 GOVERNANCE AND ACCOUNTABILITY

**There is good evidence that UNAIDS is supporting Ministries of Health (MOH) in the development and monitoring of health sector plans and participates in wider health sector coordination platforms. This is reportedly enabling some harmonisation of HIV and health programmes.**



For example:

- **DR:** Through participation on various health-related coordination platforms and working groups, UNAIDS Secretariat is involved in discussions related to strengthening the health system and monitoring of health sector plan implementation. There is some KI evidence that UNAIDS participation in health sector platforms has resulted in reduced duplication of funding and interventions.
- **Ethiopia:** UNAIDS Secretariat, WHO, and UNICEF provided technical inputs to numerous MOH TWGs to support the development of the Health Sector Transformation Plan II (HSTP II) – the roadmap for UHC. UNAIDS was involved in Joint Annual Review missions (JAR), Mid-Term Review (MTR) of HSTP I, the Joint Assessment (JANS) of HSTP II and participates in health sector coordination platforms such as the Health Population and Nutrition group which unites development partners working in health.
- There is some KI evidence that HIV stakeholder participation (including UNAIDS Secretariat) in both HIV and health sector platforms results in reduced duplication of funding and interventions and relatively well coordinated support to the HSTP II, including for Global Fund RSSH investments which lie outside the donor pooled fund for health systems.
- **Ghana:** The Development Partners Forum serves as a coordinating body for the health sector and is actively involved in policy, strategy and programme planning discussions. The UNAIDS Secretariat is a member but participation is limited, with a more active role played by WHO and UNICEF.
- **Kyrgyzstan:** UNAIDS (WHO) supports MOH leadership through engagement in the Sector Wide Approach (SWAp) which is the primary platform for discussing health sector priorities and policy analysis and development and participates in JAR processes of the SWAp. UNAIDS Secretariat actively contributes to health governance platforms, TWGs and committees which set strategic directions. UNAIDS Secretariat role is reportedly highly regarded and seen as useful by other partners.

**There is evidence that UNAIDS is supporting initiatives to improve financial and programmatic sustainability of HIV programmes but there is less evidence for how these actions ‘fit’ with wider health care/UHC financing discussions in some settings.**

- **DR:** There is evidence that UNAIDS Secretariat, in collaboration with the Global Fund, is supporting the revision of the existing HIV sustainability plan/transition work plan. It is expected that support and recommendations will serve as a tool to integrate the transition strategy within the National Strategy Plan on STI, HIV-AIDS 2019-2023, and better align with National Development Plan.
- **Ethiopia:** With USAID, UNAIDS Secretariat provided technical support for to develop a national HIV Domestic Resource Mobilisation and Sustainability Strategy (DRMS) 2020-2025 which aims to increase

Ethiopia's domestic share of financing HIV programme costs to 30% by 2025. The DRMS focuses specifically on HIV although some of the proposed approaches may have spill over effects beyond HIV – such as leveraging community health insurance and private sector financing and improving technical efficiencies in service delivery through integration of some HIV vertical services with others.

- **Kyrgyzstan:** UNAIDS provided technical advice and inputs to the HIV/AIDS NSP 2017-2021 which includes a transition roadmap to state funding.

There is less evidence for how HIV-specific domestic resource mobilisation plans and initiatives are being implemented, particularly in the context of UHC, and the extent to which HIV stakeholders are engaged in UHC-related health care financing discussions at the country level. For example, documentary and KI evidence suggests UNAIDS Secretariat involvement in bringing HIV interests to the UHC table in Ethiopia is limited, and HIV stakeholders including the major funders of HIV, remain separate from UHC discussions, and have found it difficult to enter the UHC space.

In Ghana, World Bank (WB) and WHO have contributed to the development of Ghana's 2020 UHC and draft related Prioritized Operational Plan (POP). UNAIDS Secretariat was at the table but with minimal input as other cosponsor agencies (the above, plus UNICEF and UNFPA) have more resources to work on this. Concerns raised by some stakeholders over the draft POP include a reliance on comprehensive service delivery integration despite unclear commitments to this level of integration by partners with specific HIV mandates (Global Fund, PEPFAR, UNFPA and UNAIDS), and a notable absence of strategic interventions for HIV, including in the context of strengthening RMNCH and beyond to cover adolescent health, mental health and NCDs.

**As expected, UNAIDS plays leading roles in coordinating the development of HIV/AIDS National Strategic Plans (NSPs). There is also some evidence that NSPs are increasingly aligned with health sector strategies, with RSSH considerations featuring more prominently in some recent NSPs.**

Evidence from the four countries point to the leadership role played by UNAIDS in supporting National AIDS Control Programmes (NACP) and MOH in the coordinated development of HIV/AIDS NSPs and monitoring the implementation of the plans against national targets through participation in programme reviews. There is some evidence that NSPs are increasingly aligned with health sector plans, and that RSSH is featuring more prominently in recent NSPs, albeit still largely in the context of health system needs required to deliver HIV programmes. Examples include:

- **Ethiopia:** KI and documentary evidence suggests RSSH issues and priorities considered in the most recent HIV/AIDS NSP are better aligned with HSTP II. Compared to previous NSPs, health system issues are discussed in more depth and structured around the six WHO HSS building blocks. The RSSH areas identified explain how NSP interventions will address health system strengthening necessary for the HIV program and more broadly.
- **Ghana:** In recognition of the UHC Roadmap's emphasis on systems strengthening, the most recent HIV/AIDS NSP aims to strengthen HIV data management systems at community level including harmonizing community data with the DHIS2 and the HIV e-tracker (a parallel system that feeds into the DHIS2) which was/is an area of weakness. KI evidence indicates that RSSH priorities continue to be PSM, HMIS, logistic management, and community monitoring systems which support emergency preparedness and response and are aligned with a wider response to the health sector and the UHC roadmap.
- **Kyrgyzstan:** The previous NSP (2010-2016) focused on enhancing services, including integration, prevention of nosocomial infection, improvement of staff capacity. The current NSP includes a special strategy on RSSH aimed at increasing efficiency of management and coordination of health systems in HIV. This includes enhancement of strategic data capture, access to services (decentralization, improvement of normative documents, capacity development).

**There is evidence that the timing of the development/update of the NSPs is largely synchronised with the timing of the Global Fund Funding Requests (FRs) in the case study countries. There is also evidence that FRs are aligned with NSPs and that NSPs have aligned with Global Fund guidance for FRs.** Both points highlight the influence of end-of-grant timings on national HIV planning processes and the influence of the Global Fund on the content of the NSPs (notable in KIs from DR and Ethiopia). Evidence from Global Fund Strategic Reviews<sup>5</sup> indicate that Global Fund influence on NSPs can reduce country incentives to find ways to accelerate the integration of disease programmes and service delivery, necessary for progress towards UHC and can disrupt national planning cycles. Furthermore, while there is evidence that NSPs are improving alignment with health sector plans, there are missed opportunities for HIV funding to support health systems strengthening more broadly. For example, in Ethiopia, the Global Fund RSSH stand-alone grant continues to be separate to MOH's preferred mechanism for RSSH (the SDG pooled fund)

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<sup>5</sup> Global Fund Strategic Review 2015 and Strategic Review SR2020

and PEPFAR continues to ring-fence funding for the HIV programme, channelled and managed separately to funds for the health sector.

**There is strong evidence of UNAIDS contributing to the governance and accountability of the HIV programmes through support to the development of Global Fund FRs, which has leveraged funding for RSSH<sup>6</sup>, and support to oversight of Global Fund supported programmes through participation on CCMs.** UNAIDS plays a significant role in supporting the development of the Global Fund New Funding Model 3 (NFM3) FRs for HIV/AIDS, and for a stand-alone RSSH FR (in Ethiopia – see vignette below) through technical support provision, advocating for the inclusion of high impact evidence-based interventions, and ensuring the smooth implementation of the access to funding process. There is some evidence that UNAIDS has provided critical inputs into RSSH discussions in DR and Ghana. Documentary and KI evidence from the four case study countries point to UNAIDS Secretariat role in the oversight of national HIV programmes through membership and frequent chairmanship of committees on the CCM – a role that is visible and respected in some settings such as Kyrgyzstan and Ethiopia.

### Vignette: Aligning Global Fund Funding Request with Ethiopia's National Health Sector Transformation Plan II (HSTP II)

UNAIDS Secretariat participated in country dialogue processes for the NFM3 TB/HIV FR and the stand-alone RSSH FR which used the **HIV/AIDS NSP 2021-2025 and HSTP II as foundational documents.**

Both FRs are going through grant making. Based on FR submissions, 22% of the \$300m HIV grant is potentially allocated for program enablers including RSSH. **The RSSH stand-alone grant proposes a further \$30m for the next implementation period**, excluding catalytic funding.

Planning documents points to **a multi-stage RSSH prioritisation process which used the HSTP II** as the umbrella strategy for the alignment of Global Fund RSSH investments with health system priorities.

The prioritisation process was undertaken by the CCM prior to the program allocation funding split decision (for RSSH). **UNAIDS Secretariat is the Chair of the Oversight Committee and participated in the prioritisation processes and chaired the programme split discussions** which used HIV and malaria funds to support the RSSH grant.

The prioritisation process, dialogue and agreement **involved MOH and multiple public health agencies** (as Principal and Sub-Recipients).

Global Fund investments focus on HMIS, human resources for health, health product management systems, community systems, laboratory systems. Documentary and KI **evidence indicate some of these investments are designed to strengthen health systems, beyond HIV.**

As a Chair of the CCM, and regular technical advisor and contributor to MOH technical working groups, UNAIDS Secretariat works across HIV and health systems and has a strong **overview of the HSTP II, health system priorities, and HIV RSSH investments in relation to the HSTP II.**

**There is strong evidence from the Review that HIV responses are still largely governed and managed vertically and separately from health, with implications for the efficiency of responses** This is evidenced through separate HIV and health leadership, governance, funding, and coordination architecture at national and often sub-national levels. Parallel TWGs with similar interests reportedly exist within MOH, between MOH and NACPs, and can extend to UNAIDS Cosponsor agencies (for example, WHO's separate HIV and HSS teams in Ethiopia) – and this architecture is cited as hindering the efficiency of responses for HIV, health and RSSH.

In some contexts, documentary evidence points to recommendations to reorganise HIV architecture to better reflect the epidemic and changing context at national level, and to improve harmonisation and alignment of health sector and HIV plans and processes at sub-national levels for example in Ethiopia; to review

<sup>6</sup> For example, at the time of NFM3 submission, proposed allocations for RSSH in Ethiopia amounted to \$30m in the RSSH stand-alone grant and \$58.3m in the HIV/AIDS grant. For Ghana, \$4m has been proposed for RSSH interventions in the HIV/AIDS grant. The scope of this Review did not enable us to explore the breakdown of RSSH allocations in more depth, particularly in relation to systems support vs strengthening interventions, or proportion of RSSH funding allocated to areas such as community systems.

governance structure, roles, and responsibilities of health sector-related agencies to minimize duplications and overlaps in mandates, for example in Ghana.

Innovation,  
agility,  
responsive-  
ness

### 3.2 INNOVATION, PRECISION PUBLIC HEALTH, DIFFERENTIATED SERVICE DELIVERY, RESPONSIVENESS TO COVID-19

**There is good evidence of UNAIDS facilitating innovative approaches which support (or have the potential to support) broader health and development benefits.**

Examples include:

- **DR:** Strong documentary and KI evidence that development partner support (Global Fund, UNAIDS, UNDP, PEPFAR) has been instrumental in developing SUGEMI – an integrated system for medicine and supply chain management. SUGEMI<sup>7</sup> is universally acknowledged as a key innovation that has helped strengthen the HIV response but has also reduced systems-level inefficiencies<sup>8</sup>. Implementation of SUGEMI has improved operational efficiency, including streamlining facility reporting needed for drug forecasting and use. Following the implementation of SUGEMI, drug availability has increased and stabilized due to better estimation of needs. UNAIDS is working with the Global Fund and other partners to support the country in maximising these opportunities.
- **Ghana:** Responding to a call from the Government to address the impact of COVID-19 and build back better, UNAIDS engaged the Presidential Adviser in the COVID-19 Secretariat to establish a project that would use innovation to strengthen the resilience of the health system, that would also benefit the COVID-19 and the HIV response.
- This is being facilitated by UNAIDS Innovation Exchange Centre in Geneva, with the UCO in Ghana and the Ghana Health Services (GHS) with the aim of developing a plan to harness solar technology for health facilities, assist in negotiating favourable prices for health products (such as insulin) aimed at addressing underlying health conditions and help increase links between NCDs and HIV responses, secure artificial intelligence for diagnosis of TB, and assess the feasibility of local manufacturing of specific health commodities.
- **Kyrgyzstan:** UNAIDS Secretariat has supported innovations in infection control and prevention, including applying innovations in the sterilisation of endoscopes (that include HIV and blood infection) in two children's hospitals, and supporting the capacity of the Centre of Infection Control to monitor and gain expertise in the control of biological materials. UNAIDS Secretariat supported the Centre to increase the quality of HIV, HEP B and HEP C testing.

**There is evidence that UNAIDS-generated data and analysis is supporting precision public health investment for the HIV programme, but there is less evidence of such data being used beyond HIV.** A widely recognised added-value of UNAIDS is the provision of strategic information - analysis, updates, and relevant data (epidemiological, programmatic, financial) often disaggregated by age, sex, KP, region, to support strategic planning, evidence-based decision making, and 'real time' programme implementation (see vignette overleaf of Ghana's (interagency data review meetings – conceptual thinking aligned to the UNAIDS 'Situation Room' model/approach).

<sup>7</sup> (<https://sns.gob.do/sugemi/>)

<sup>8</sup> USAID, HFG: Integrated the HIV response at the systems level: experience of four countries in transition (DR case study), September 2018.

### Vignette: Granular data for decision making - real time programme analysis through interagency data review meetings – UNAIDS ‘Situation Room’ approach Ghana

The convening of key stakeholders around HIV data (interagency data review meeting – conceptual thinking aligned to the UNAIDS situation room model<sup>9</sup>) where key players meet monthly to **discuss and analyse programmatic data** as an entry point to addressing key issues was initiated by the UNAIDS Secretariat with strong support from WHO.

Reports are produced, action points developed and followed up in subsequent meetings. **Piloting of a simple dashboard developed by the Secretariat is underway to facilitate data analysis and programming efforts.** The meetings have elevated the importance of analysing data for decision making (for example, discussions around challenges to reaching the 3rd 90 target (people receiving antiretroviral therapy will have viral suppression)).

Participants in the analysis of this routine data commented: *“I have never thought about the challenges that these guys [i.e. health care providers] are having on a day-to-day basis to report on viral load” and another said they were “so happy UNAIDS facilitated these conversations, always been on our books to bring this together, without the goodwill of UNAIDS this wouldn't have happened”.*

There is some evidence that UNAIDS-generated data is enabling more precise public health investment in NSP processes through shifts in geographical and population level prioritisation of resources, in line with epidemic control. There is also evidence from DR, Ethiopia, and Ghana that *Spectrum*<sup>10</sup> HIV estimates have been used by government, Global Fund, PEPFAR in their Country and Regional Operational Planning processes, and this reportedly, has helped with harmonising targeted and prioritised interventions for HIV.

There are a handful of examples from Ethiopia of how UNAIDS data is being used more broadly, for example, *Spectrum* HIV estimates, and the investment case models have been used for drug and condom quantification, and to inform choice of DSD, but overall, there is weak evidence that UNAIDS strategic information and approaches are being used beyond HIV, for example, for UHC, with the exception being for COVID-19 responses (see later in report).

**There is good evidence that UNAIDS is supporting different MOH to implement Differentiated Service Delivery (DSD) models in case study countries, with potential spill over effects for other health programmes and health systems.** Evidence from the case studies highlight the catalytic role played by UNAIDS in promoting and supporting ministries of health in the design and implementation of DSD models. UNAIDS Secretariat and Joint Team members, principally WHO and UNICEF, have provided inputs to TWGs on DSD and have supported the development of policy guidelines, Standard Operating Procedures, training of health workers, and monitoring/evaluation of DSD models and services. Some examples of models under implementation include Multi Month Dispensing (MMD) in DR, Ethiopia, Ghana, Kyrgyzstan; virtual consultation platforms in DR and Kyrgyzstan; ARV home delivery in DR and Ghana; Appointment Spacing Model (ASM) in Ethiopia.

The scope of this assignment did not allow for an evidence review of the efficacy of DSD models and potential spill over effects on other health services and systems. However, documentary evidence suggests DSD can reduce programme costs, reduce out-of-pocket expenditure, improve quality of care and have the potential to release health system resources and manpower to address more severe and urgent conditions. KI evidence acknowledged the importance of DSD to empowering communities to take control of their own health - critical for people centred approaches and sustaining programmes in the future. The contribution of UNAIDS to DSD in Ghana and Ethiopia is highlighted below.

- **Ghana:** The introduction of DSD in Ghana was spearheaded and continues to be guided by WHO, who has served a catalytic role through leadership of the DSD Task Team and provision of critical financial and technical support.
- 2017 saw the piloting of MMD across different service provision venues and in 2019 the introduction of HIV self-testing and index client testing. UNAIDS played a role, as a member of the National Task Force for the design of self-testing and ensured representation of PLHIV in the planning and development of

<sup>9</sup> Not a formal Situation Room such as those promoted and supported by UNAIDS HQ level, using the SISENSE software

<sup>10</sup> The Spectrum/AIM model is used by national programs and UNAIDS to prepare annual estimates of the status of the HIV epidemic in 170 countries.

tools for facility-level use. UNAIDS (WHO, the Secretariat and UNICEF) together with the NACP used programmatic data to determine the rational and critical assumptions for the selection of the regions for piloting of index testing. UNICEF played a catalytic role launching the first index testing exercises in Ghana across five regions. This demonstration effect has resulted in roll-out on a larger scale to different regions and by different stakeholders.

- **Ethiopia:** Since 2017, Ethiopia’s MOH has been piloting and scaling up DSD models aimed at simplifying HIV services across the cascade, to respond better to the preferences and expectations of people living with HIV and KPs. The ASM has been taken to scale in full and COVID-19 accelerated the implementation of ASM as well as MMD - the intention being to the treatment burden on patients, pharmacies and clinics while maintaining high retention of care.
- UNAIDS Secretariat and WHO have contributed advisory inputs to MOH TWGs on DSD models. WHO has advocated for DSD and supported the development and adoption of guidance and is working with MOH and Regional Health Bureaus to strengthen implementation of index case testing.
- UNAIDS Secretariat is planning technical support to MOH in collaboration with relevant stakeholders to evaluate ASM implementation since scale up. Specifically, the evaluation will assess the effect of ASM on the health outcomes of people living with HIV, and the efficiency of the health system compared to conventional care including the cost effectiveness of the model, client and provider satisfaction and quality of services.

**UNAIDS has proactively supported national COVID-19 responses through flexible and innovative strategies that are contributing to more agile and resilient systems.** There is good evidence in the four case studies for UNAIDS rapid mobilisation of support to national COVID-19 responses. Many of UNAIDS interventions have maximised use of HIV response resources and systems such as the acceleration of existing DSD models to support the continuation of HIV services; supporting Global Fund FR application processes for COVID-emergency funding; mobilising community structures to ensure uninterrupted HIV and health services and dissemination of COVID-related information; generation of data to monitor the impact of COVID-19 on HIV services; development of COVID-related policy and guidance; use of HIV programme staff in supporting multisectoral COVID responses. While the examples are numerous, the vignette that follows illustrates the diversity of approaches used in one country - Kyrgyzstan.

Vignette: UNAIDS Kyrgyzstan support to national COVID-19 responses
<b>Technical guidance</b> (WHO, UNFPA, Secretariat) to ensure that minimum services for HIV treatment, prevention and SRH are not interrupted during the COVID-19 pandemic.
UNAIDS Secretariat leadership and the Joint Team provided support to <b>strengthening National AIDS Centre laboratories to equip them to be used for testing for COVID-19 and beyond.</b>
UNAIDS Secretariat initiated and supported <b>emergency planning of CSOs to adapt their work plans</b> to focus on vulnerable groups, provide social support, deliver food packages, including powder milk for babies for poor families and families who lost their business due to the COVID-19 pandemic and lockdown.
As part of a UNAIDS regional initiative, the UCO Kyrgyzstan supported an <b>online Telegram platform</b> that brings together most of the country’s volunteer organizations and makes it possible to request assistance and to receive an immediate response.
UNAIDS Secretariat is <b>coordinating Joint Team support to health facilities</b> during the pandemic. UNAIDS Secretariat procured <b>protective materials</b> (suits, gloves, masks, etc), UNICEF procured <b>essential drugs</b> , and UNFPA and UNDP procured <b>PPE, oxygen containers</b> , and WHO provided <b>trainings</b> on various protocols for country clinics to work with their clients.
<b>UNAIDS “country envelope” funds were re-programmed</b> to address needs during lockdown to meet security measures in services related to HIV. UCO assisted in transportation of ART for PLHIV stuck in other countries during lockdown.





### 3.3 COMMUNITY-LED RESPONSES, INTEGRATION OF SERVICES

**UNAIDS has been instrumental in strengthening CSO capacity and representation in national HIV response governance, planning, and accountability mechanisms, and beyond HIV in some contexts.** There is strong evidence that UNAIDS is recognised as a key agency providing sustained support to establishing and

strengthening the capacity and leadership of CSOs, and supporting their inclusion in national HIV governance, planning, and accountability processes. Much of UNAIDS work has strengthened organisations that represent or support marginalised populations – PLHIV, youth, HIV+ women for example– and has focused on soliciting inputs for strategy and policy development processes, identifying wider priorities for community-led interventions, leveraging funding, and targeting resources better. In Ghana, the UNAIDS Secretariat has supported the strengthening of youth CSOs, and this has reportedly led to the inclusion of youth representatives in CCM meetings.

*“Government is beginning to listen and take us [youth representatives] more seriously now they can see things are being done differently. UNAIDS has helped us come to this level, very serious, would be good to do this for other areas” (Key informant, Ghana)*

There is evidence of HIV-related CSOs being included in the monitoring and oversight of health sector strategies, for example in Ethiopia (although evidence suggests this has not extended to regular involvement in UHC discussions). Evidence also points to CSOs establishing initiatives themselves, often facilitated by UNAIDS, to strengthen their role in the health system. For example, in Kyrgyzstan, CSOs are driving processes such as amendments to national procurement laws and harmonisation of normative documents in health and other sectors. Additionally, UNAIDS Secretariat has trained HIV positive women to build knowledge and capacity to participate in decision making processes which are being used beyond HIV. For example, the Head of the Women’s Network chairs the Public Observation Council which monitors the work of MOH, and the role supports strategy and policy development for health system building blocks such as procurement and human resources.

**There is some evidence that Community-led Monitoring (CLM) - a mechanism for strengthening linkages between health and community systems, supporting community driven solutions, health system resilience and sustainability - is gaining ground in DR, Ethiopia, and Ghana, focused on HIV and supported by Global Fund and PEPFAR funding and largely ‘project-based’.** Evidence suggests that UNAIDS Secretariat has contributed, to varying degrees, to the design of CLM. No evidence was available regarding progress or early results of CLM implementation or how these CLM will be sustained given the overall context of declining external funds. Examples include:

- **DR:** Supported by PEPFAR funding, UNAIDS Secretariat has started work on establishing, training, and operationalising a team of community monitors (selecting CSOs, conducting needs assessments etc which is planned to go beyond HIV however is in the early stages of implementation). Further work is envisaged such as community monitoring of services prioritized by PEPFAR, USAID/CDC; obtaining a better understanding of the enablers and the barriers that support greater tailoring of services to client needs; developing advocacy actions at different levels (service, project, political) based on CLM reports to contribute to the changes in policies and practices necessary for the improvement of the health services.
- **Ethiopia:** CLM is included in the HIV/AIDS NSP 2021-2025 and is being operationalised through PEPFAR and Global Fund funding, with PEPFAR supporting the CLM for HIV prevention activities through contracted CSOs and Global Fund investing in the government’s health extension programme, CSOs and PLHIV networks to build CLM mechanisms in high incidence Woreda<sup>11</sup>. UNAIDS Secretariat contributed to design discussions with PEPFAR and to NSP and Global Fund FR development processes where CLM needs were identified and included.
- **Ghana:** UNAIDS Secretariat has taken a leading role in designing the CLM system through supporting CLM-related training in Geneva for some key stakeholders, providing technical support to help define a new CLM-led system in line with UNAIDS guidelines, and assisting the Global Fund Principal Recipient from 2021 with data collection and monitoring of the new grant’s community-led interventions.

**There is strong evidence from case study countries that HIV responses have been catalytic in enabling CSOs and their networks to expand the delivery of HIV and integrated services at PHC level, important for progress towards UHC and SDG3 – evidenced through pioneering differentiated models of**

<sup>11</sup> Ethiopia is administratively divided into regional states and chartered cities, zones, *woreda* (districts) and *kebele* (wards).

care to reach PLHIV and marginalised groups, supporting peer networks to generate demand for services, supporting community health worker programmes and linkages to a wider range of PHC services.

UNAIDS Secretariat, WHO, UNICEF, UNFPA have supported integrated service delivery through working closely with MOHs and NACP TWGs at national level for development of specific policies and guidelines and training for service integration in areas such as PMTCT and eMTCT, TB, STI, SRH, cervical cancer, and more recently, mental health.

Specific examples of linkages beyond HIV can be found in DR, where the integration of HIV/STI testing at PHC level increased access for pregnant women, partners, and infants to services for PMTCT and congenital syphilis, and in Kyrgyzstan, where UNAIDS supported the development of multidisciplinary teams to provide a comprehensive package of health services, not just for HIV (see vignette below).

### Vignette: Improving Quality and Accessibility of Comprehensive Medical and Social Services through Peer Consultants in Kyrgyzstan

UNAIDS in partnership with NGO “Araket Plus” supported the development of a **system of multidisciplinary teams - MDTs** (specialists in infectious diseases or a family doctor, a nurse and a peer consultant) based in local health clinics/Family Medical Centres in four regions (funded through a grant from the Russian Federation) to provide a comprehensive package of medical services.

UNAIDS Secretariat **advocated and provided technical assistance** to the government to prepare a Resolution (in 2019) to enable peer consultants (HIV positive people who do not have health background) to join MDTs. The Resolution has given the peer consultants the status of a social worker. Peer consultants build the trust and empower people living with HIV to visits primary health care clinics and receive a comprehensive package of medical services that goes beyond HIV and provide them with access to social support services. The establishment of MDTs has also resulted in **increased number of people living with HIV on ARV treatment**.

## Inequalities

### 3.4 INEQUALITY AND INEQUITY

**Case studies illustrate the range of UNAIDS interventions which support policies, roadmaps, and assessments to address human rights, expand coverage of services targeting PLHIV and KP groups and/or address barriers to care - critical for reducing service inequalities and inequities and supporting progress towards UHC.** Evidence for the results/outcomes of these initiatives is less clear. Some examples include:

- **Formulation of HIV/AIDS Prevention Roadmaps** in Ghana and Ethiopia. In Ethiopia, support to the NACP (technical assistance, capacity assessment, materials production) resulted in an expanded definition of KPs to include people who inject drugs (MSM and Transgender are still not recognised), a defined package of services differentiated for each KP group, and a monitoring and evaluation framework for accountability. KI and documentary evidence emphasised the importance of the Roadmap in enabling health systems to work for KPs ensuring they can access, and uptake services tailored to their needs - essential for making progress towards UHC. No further evidence was available regarding the implementation of the Roadmap (expected to be largely through the Global Fund NFM3 grant).
- **HIV specific gender-related surveys or assessments** undertaken with support from UNAIDS Secretariat in collaboration with WFP, PAHO/WHO in DR, and with UN Women in Ethiopia. There is some evidence that these assessments are informing national plans and approaches such as the revision of DR’s Ten-Year Health Plan. In Kyrgyzstan, there have been multiple interventions to support gender equality and empowerment including the use of the Positive Deviance approach, promoted by UN Women, which is helping to build capacity and leadership skills of socially vulnerable women’s groups (women and girls living with HIV, women migrants, victims of violence, LGBTQ) providing technical and financial assistance to empower women with knowledge and skills and make them active and able to lead various initiatives.
- **Evaluation of HIV and social protection programmes** in DR by UNAIDS Secretariat in collaboration with WFP, which generated evidence of barriers to accessing services - for example, high out-of-pocket costs, lack of nutritional and food support, stigma and discrimination, and lack of availability of HIV


services to meet needs of KPs. UNAIDS also led a regional analysis of social protection mechanisms using the UNAIDS assessment tool for generating evidence to facilitate the creation of public policies and strengthen existing policies for the development of actions on HIV and social protection.

- **Initiatives to improve access to specific KP groups** such as youth and women and which go beyond HIV evidenced in Ghana through UNAIDS Secretariat support to private sector social media initiative ‘Verifie’ aimed at providing sexual health services to young people including free HIV and hepatitis B screening at the African Youth SDGs Summit in Ghana and supporting innovative COVID-19 responses such as reaching out to youth in their homes to provide testing services.
- In Ethiopia, UNFPA has **supported CSOs** (capacity building, training, and strategy development) to promote HIV and SRH services focused on HIV positive adolescents, youth and women including female sex workers. UN Women has supported capacity building and advocacy support to women’s rights organisations supporting interventions that reinforce social protection and reduce gender inequality and gender-based violence.
- **Human Rights support** such as the Breaking Down Barriers (BDB) initiative in Ghana and Kyrgyzstan, initiated by Global Fund and supported by UNAIDS Secretariat, in collaboration with UNDP. In Kyrgyzstan, UNAIDS Secretariat and UNDP provided policy and programme support to Global Fund FRs including the costing of human rights and gender-related barriers. Kyrgyz Republic received approximately USD 1 million in matching funds to address human-rights related barriers in NFM2. In Ghana, BDB funding went in part to UNAIDS to conduct a baseline assessment and hold subsequent multi-stakeholder meetings to develop a separate NSP to reduce human rights-related barriers to HIV and TB services: 2020-24. Under NFM3, there appears to be a shift in focus from activities focused on specifically on KPs (FSW and MSM) to activities that are integrated across the ‘whole TB/HIV program’ (\$5m for NFM3, almost a doubling of funds since NFM2).
- In DR, UNAIDS Secretariat has **supported CSO Human Rights Observatories** which address violations beyond HIV (see vignette).

### Vignette: Supporting Human Rights Observatories in the Dominican Republic

UNAIDS is supporting CSOs in the establishment of **Human Rights Observatories** to address human rights violations against vulnerable populations. These are funded through the Global Fund multi-country grant implemented by Joint Team member, UNDP. The Observatories serve as platforms for the **registration and monitoring of Human Rights violations** suffered by these groups.

The UNAIDS Secretariat is contributing by supporting and promoting a “help line” – a free line with different companies who are providing video and phone consultations and/or psychological and legal support in relation to violence or stigma and discrimination issues. **The observatories deal with human rights violations for all vulnerable groups, beyond HIV.**



**Stigma  
Discrimination**

### 3.5 STIGMA AND DISCRIMINATION

**There is evidence of UNAIDS supporting the reduction of HIV-related stigma and discrimination, with some evidence of approaches being applied beyond HIV.** UNAIDS Secretariat has provided technical support to the Stigma Index 2.0 in DR, Ghana and Ethiopia and, whilst the Index is predominantly geared towards HIV, it contains (for the first time) an expanded healthcare section to look at the impact of stigma and discrimination on health and access to health services across the whole continuum of care, not just for HIV. There is broad agreement that this

survey is an important measurement tool that will provide strategic information for the multisectoral response including workplace, education, as well as other health care settings, and which can be used for evidence-based investments and precision programming.

There are some examples of UNAIDS Secretariat contributing to stigma and discrimination reduction beyond HIV, either directly, or through the potential spill-over effects of some interventions. For example:

- **DR:** UNAIDS engaged in political advocacy on the Draft General Law on Equality and Non-Discrimination – including specific articles on LGBTI people and people living with HIV. Strong advocacy continued for the creation of positive legal environments for sex workers, to help eliminate stigma and discrimination against key populations and improve the legal, political, and programmatic environments.
- **Ethiopia:** UNAIDS Secretariat in Ethiopia facilitated support to stigma and discrimination training through the MOH Task Force on Compassionate, Respectable and Caring Health Workers (CRC) which is a flagship initiative aiming to improve provider attitudes through training of health workers, not just those providing HIV services. UNAIDS has partnered with FMOH from the inception of CRC, supporting the development of the training manual on CRC through to the roll out of the training. WHO has also contributed to CRC through participation in the TWG, development of guidelines, and materials production. CRC is particularly important for health rights community literacy and awareness programmes, demand creation and accountability of the medical professionals to deliver non stigmatizing and discriminatory services.
- **Kyrgyzstan:** In 2020, under Russian programme support, UNAIDS Secretariat facilitated an awareness campaign and educational events for the public in Kyrgyzstan including youth groups. The aim was to improve HIV awareness and testing, as well as public sensitization on the issues of HIV-related stigma and discrimination. Over two million people were reached with these mass media campaigns which also included messaging on sexual and reproductive health, gender issues, and HIV testing.

## Gaps in RSSH where UNAIDS can play a role in future



### GAPS AND OPPORTUNITIES EMERGING FROM REVIEW FINDINGS

**RSSH Definitions, Objectives, Metrics.** Although the Review attempted to identify how UNAIDS efforts go ‘beyond HIV’, or have ‘spill over’ effects, robust evidence is limited. UNAIDS Secretariat inputs, mechanisms and outcomes remain largely geared to the HIV programme, as per the mandate. The evidence shows that UNAIDS actions are not systematically designed to reach ‘beyond HIV’ and there is a dearth of documented examples and learning. In addition, actions that do reach ‘beyond HIV’ or have ‘spill over’ effects to other areas of health and other social sectors, are not necessarily the equivalent of actions designed to strengthen resilient and sustainable systems for health.

**Opportunities exist for UNAIDS** to generate evidence for how HIV responses and/or UNAIDS is supporting ‘spill over’ effects, however, the purpose, scope and measurement of these actions and effects would benefit from further clarification and a clear strategy for generating evidence and learning.

**Common vision and definition of RSSH.** Based on the evidence gathered and analysed as part of this Review much of UNAIDS Secretariat work across the four case study countries could be interpreted as contributing to the six elements of RSSH (Box 1 for reference). However, without an explicit (or even implicit) theory of change and a systematic framework that sets out aims, objectives, and metrics of UNAIDS support to RSSH, it is difficult to ‘prove’ these linkages and their outcomes.

**Framework for RSSH and capacity to implement.** All four case studies illustrate gaps in UNAIDS Secretariat resourcing and capacity (financial, human, technical) which challenge their ability to implement the existing HIV mandate and constrains further engagement/participation in health sector and health systems forums at country level. Additionally, the current UBRAF framework and Joint Team country plans by and large are not organised around, and do not provide guidance, on RSSH programming and activities.

**Opportunities exist** to take forward an RSSH agenda but UNAIDS Secretariat needs to develop a common vision and definition of RSSH and collective understanding for how UNAIDS Secretariat (and Cosponsors) work is expected to contribute to progressing RSSH. A Theory of Change to articulate the role of UNAIDS in supporting RSSH and UHC could be developed. This could be a “sub-TOC” to the new Strategy, as part of the development of the new UNAIDS results and accountability framework (UBRAF), implemented gradually over the next strategic period. The advantage of this approach is that it has the potential to provide an overarching framework for UNAIDS Secretariat support to RSSH, with metrics

developed to define and measure UNAIDS contribution. Based on the TOC, UNAIDS Secretariat inputs, mechanisms and outcomes can be aligned towards achieving progress in RSSH (and UHC).

### **UNAIDS reporting**

As demonstrated in previous sections there is strong evidence of UNAIDS activity and involvement in the development of a wide range of national level HIV and health related plans and policies (HIV NSPs, health sector plans and reviews, prevention roadmaps, stigma and discrimination strategic plans, human rights strategic plans, PMTCT policies). However, documentation regarding UNAIDS results/outcomes is less forthcoming. This is due in part to the way in which results are defined in UNAIDS country reports which often include country programme results as UNAIDS results. At the same time, country reports are still input-focused descriptions of actions rather than providing results directly linked to UNAIDS contributions.

**Opportunities exist** to shift UNAIDS reporting culture to demonstrate clearer contribution and accountability of UNAIDS Secretariat and the Joint Team members to country level results, including for RSSH, which would help in showcasing the added value of UNAIDS.

### **HIV/AIDS NSPs and RSSH**

As evidenced from the findings of the Review, UNAIDS and other partners invest considerable resources in developing HIV/AIDS NSPs which set goals, targets, and strategic interventions necessary to achieve progress. While the plans demonstrate increasingly targeted resources, there are still considerable challenges with these documents. Most NSPs continue to be aspirational, with large funding gaps and with no realistic strategies to fill these gaps. UNAIDS is engaged in developing domestic resource mobilization strategies for HIV/AIDS to generate resources to fill these gaps but evidence for the effectiveness of these approaches is weak.

There is some evidence that NSPs are addressing health systems issues more, as they relate to the implementation of proposed disease interventions. Indeed, the success of many interventions in NSPs are predicated on well-functioning health systems, which is often not the case, but because discussion of health systems weaknesses is still quite 'thin' in NSPs, it is difficult to determine whether the NSP's interventions can feasibly be implemented as intended. This seriously weakens NSPs and Global Fund Funding Requests as there is no detailed plan upon which to base RSSH interventions – health sector plans being quite high level.

**As the primary source of technical support for national strategic planning, there are opportunities for UNAIDS** to re-fit its approach to planning to help countries shift away from aspirational documents towards plans developed based on accurate funding availability (or at least scenarios based on funding mobilized), with detailed RSSH plans more intricately linked to health plans and UHC, and with logic chains underpinning plans and results frameworks.

### **HIV funding, health care financing and UHC**

The Review found that the UHC agenda is moving forward in the four case study countries but in some cases (such as Ethiopia and Ghana) the HIV response, architecture, and ways of doing business appears slow to respond to these changes. HIV stakeholders in these countries cited difficulties 'entering the UHC space'. This may be due in part to the legacy of AIDS exceptionalism which has been successful in generating separate funding, governance, accountability and coordination structures and programmes for HIV. This separateness may be less appropriate in countries committed to implementing a strategy or roadmap for UHC. Furthermore, there are strong interests to maintaining the status quo as integrating HIV into UHC could represent a loss of control, particularly of HIV funding and resources.

Funding of KP-related services is heavily dependent on Global Fund and PEPFAR in three of the case studies, and is an area plagued by low domestic financing. However, limited engagement by HIV stakeholders with the ministries of finance or with TWGs concerned with broader health care financing for UHC, fiscal space for health, and social protection mechanisms (which may include prevention services for people living with HIV and KPs) was noted in Ethiopia and Ghana. As well, there is limited understanding in these two countries as to how the HIV programmes and the lessons learned from decades of implementation, can complement and best support UHC and vice versa.

**Opportunities exist for UNAIDS to use** high-level diplomacy and its respect among senior ministerial figures to support greater dialogue and interaction between HIV and UHC constituents at country level - to identify areas of convergence and common goals as well as supporting the development of country guidance to aid greater integration of HIV and UHC.

### ***Data, Strategic Information, precision public health***

Lessons learned from HIV-related investments in information systems and data use across all four countries, and from COVID-19 responses, point to the need for good quality, granular and differentiated data to allow targeting of services and resources to those most affected, rapid detection and response for emerging diseases, and real time monitoring and course correction for achieving health outcomes. A similar approach to generating and using strategic information to target sub-groups and specific geographic locations (as explicitly done in Ethiopia and Ghana for HIV services) could be used to support UHC.

In addition, convening partners around data (reports/dashboards) for programmatic use, as successfully carried out in Ghana, presents a valuable lesson from the HIV response at the central level in ensuring the availability, quality of analysis of data for precision public health, which could be applied to the community level as well as beyond the HIV response. Stakeholders across all four case study countries pointed to the important role of UNAIDS Secretariat in supporting national institutions, through capacity building exercises, to ensure production and use of data for evidence-based decision making that – by building the right partnerships – can go beyond HIV.

**Opportunities exist for UNAIDS** to support other areas of health where there are data gaps and where UNAIDS has a comparative advantage - for example, gender, age, vulnerable populations, and geographical disaggregated data; and investment case approaches to resource allocation. Furthermore, lessons from the HIV response in using data for precision public health could be more universally applied to address uneven/inequitable implementation of the PHC approach (for example, in Ethiopia) and support progress towards UHC.

### ***HIV architecture and multisectoral responses***

There is evidence that HIV response architecture (for example in Ethiopia and Ghana) would benefit from updating to better reflect the changing HIV epidemic and to improve harmonisation, alignment, and coordination at all levels of the health system. Whilst these specific issues need addressing, there is also wider interest in adopting multisectoral responses to manage other diseases (for example TB and NCDs).

**Opportunities exist for UNAIDS** to support the streamlining of HIV architecture in some countries such as an organisational review of FHAPCO (the National AIDS Programme) in Ethiopia; and to review internal UN arrangements to ensure HIV and RSSH synergies are maximised. There are also wider opportunities to disseminate lessons and experience from HIV multi-sectoral responses. UNAIDS could support dialogue, guidance, and instruments on how to implement an effective multisectoral response and its relevance to other diseases and UHC.

### ***Integration of services/health system transition***

Although HIV responses in all four countries remain vertically organised and disease-specific, some elements of systems-level integration were noted particularly for procurement and supply chain management (most notably in DR) and health management information systems and service delivery (across all four countries).

These efforts, combined with valuable lessons to be learned from service level integration – such as scaling up HIV care to enable accessible and efficient care for patients with other chronic conditions/NCDs which have regular touch points with the health system, could benefit the transition to UHC. This could also help mitigate stigma associated with HIV.

**There are opportunities for UNAIDS** to use its expertise in chronic disease management of HIV and people centred approaches and expertise in data management to promote further integration of services and systems, for example, through adapting HIV clinical care tools and guidelines for broader applicability (for example for diabetes, cervical cancer, patient monitoring for TB) and to expand efforts to strengthen harmonized commodity supply and overall information systems.

### ***Covid-19, community engagement, addressing barriers to accessing services***

The COVID-19 pandemic has highlighted the need for more flexible and resilient health systems with a focus on stronger and more agile systems at local level. This includes increased focus on PHC and public health approaches including community engagement – which has proved to be a critical resource in COVID-19 responses. These elements are needed to address barriers to accessing health and ensuring no one is left behind. Investing in infrastructure (Ethiopia, Kyrgyzstan) and human resources (across all four countries) has proven essential in the scale-up and improvement of health services and outcomes, however, efficiency and equity issues remain - particularly with ensuring access to quality essential services for KPs and the most vulnerable (an area of concerns noted across all four countries).

Further progress towards epidemic control, health systems resilience, and the goal of UHC will rely heavily on community engagement and ensuring access to quality services for all. Addressing this area requires fully engaging communities, including civil society organisations, as leaders and essential partners that are better integrated with health sector structures and reporting mechanisms and sufficiently funded.

**Opportunities exist for UNAIDS** and HIV-related CSOs to leverage their experience in mobilising communities and addressing structural barriers to accessing services, and to apply these to the health sector more broadly. For example, documenting evidence and learning from DSD and discussing implications of these approaches for health systems and other areas of health; sharing lessons from community engagement and HIV peer support with other programmes involved in chronic care management; supporting effective multi-sectoral action and governance at local levels; ensuring community-generated data is legitimized and integrated with more formal HMIS systems.

As well, ensure monitoring of data and strategic information generated to address structural issues have scope for wider use – for example, ensuring gender assessments and stigma indexes are designed and have applicability beyond HIV; engaging more with the CLM agenda but not just for HIV, and link/develop capacity for non-HIV CSOs with experience of social accountability that can benefit health systems and programmes beyond HIV.

## ANNEX 1: Global interviews conducted

Note: Key informants interviewed for country studies are included in the country summary reports Annex

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## ANNEX 2: Global documents consulted

Note: Documents consulted for country studies are included in the country summary reports Annex II

- 2016-2017\_Organizational Report\_PCB42\_EN.pdf
- 2016-2017\_PMR\_PCB42\_EN.pdf
- 2018-2019\_Organizational-report\_PMR\_PCB46.pdf
- 20200909\_Lessons-HIV-COVID19.pdf
- 2020-2021\_Workplan-and-Budget\_Regional-Country-Priorities\_PBC44\_EN.pdf
- 2020-2022lessonslearnedwindow1\_report\_en.pdf
- Assefa et al. Globalization and Health (2020) 16:17 <https://doi.org/10.1186/s12992-020-00549-4>
- Current UBRAF 2016-2021
- Existing strategy 2016-21.pdf
- Holmes et al 2020 Tailored HIV programmes and universal health coverage Bulletin of the World Health Organisation 2020; 98:87-94
- Independent Panel on Pandemic Preparedness and Response, 3<sup>rd</sup> Meeting Report Dec 2020
- Jay et al, Aug 16, PLOS Medicine, 2016
- Organizational-Report\_PMR\_PCB44\_EN.pdf, 2018
- Thematic Evaluation Reference Group Position Paper on RSSH, July 2019
- UNAIDS Case Study SRHR and HIV.pdf
- UNAIDS COVID-19 and HIV Report, 2020
- UNAIDS SRA8\_Integration\_2017.pdf
- UNAIDS PCB Report from June 2017 (39th meeting)
- UNAIDS Strategy presented to PCB Dec 2020
- UNAIDS Strategy 2021-2026
- UNAIDS\_PCB45\_NGO\_Report\_EN.pdf, 21/11/2019
- UNAIDS SRA8 HIV and Health Service Integration, 2020
- UNAIDS Follow up to the Thematic Segment from the 44<sup>th</sup> PCB, 10-12 December 2019
- UNAIDS Independent evaluation of the UN system response to AIDS 2016-2019 PCB Dec 2020
- UNAIDS Rights in the time of COVID-19, 2020
- UNAIDS Evidence for elimination stigma and discrimination, 2020
- UNAIDS Checklist and reference list for developing and reviewing national strategic plans for HIV, 2020
- UNAIDS What is a community-led organization, 2019
- Window-2-TRP-Lessons-Learned-2020.pdf
- Witter et al 2020 Health system strengthening – reflections on meaning, assessment and our state of knowledge Int J Health Plan Mgmt 2019;34 e1980-1989
- World AIDS Day 2020 Prevailing Against Pandemics (UNAIDS, Dec 2020)

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