Agenda item 9

UNAIDS/PCB (44)/19.21

THEMATIC SEGMENT

Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage

UNAIDS

25-27 June 2019 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 27 June 2019

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All case studies have been compiled as a Conference Room Paper (UNAIDS/PCB (44)/CRP2), which is available at the PCB website.

ACRONYMS

2030 Agenda	2030 Agenda for Sustainable Development
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CRP	Conference Room Paper
CSR	Corporate Social Responsibility
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
ILO	International Labour Organization
MDG	Millennial Development Goals
NCD	Noncommunicable diseases
PCB	Programme Coordinating Board
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SDG	Sustainable Development Goal
SME	Small & medium scale enterprise
STI	Sexually transmitted infections
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VNR	Voluntary National Reviews
WHO	World Health Organization

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Universal health coverage (UHC) is a critical enabler to ending the AIDS epidemic providing an opportunity for more comprehensive and integrated approaches to health service delivery and improving the capacity to address the multiple health needs of people living with HIV.

Expanding quality health coverage to all would be a momentous step towards the realization of the fundamental human right to the highest attainable standard of health, gender equality and individual and community empowerment, and serve as a concrete step of moving towards leaving no one behind and eliminating health inequities.

Efforts to expand health coverage and to create people-centred health systems should heed the lessons of the HIV response. All healthcare services should include a single-minded focus on outcomes and accountability; responsiveness to human rights principles and the needs of the most vulnerable; innovation in health financing; inclusive health governance; community-based services delivery alongside that of facility-based care and holistic efforts to address the social and structural determinants of health.

The HIV community needs to engage with and become key players in processes to expand health coverage. Packages of essential health benefits must include the services needed to address HIV prevention (primary and secondary), treatment, care and support. Expanded health coverage must ensure the affordability of medicines and other health commodities, including for the treatment and prevention of HIV. Careful monitoring will be needed to ensure that UHC is improving health outcomes for people living with or at risk of HIV. The needs of key populations and those being left behind need particular attention in the move towards UHC.

UHC cannot be achieved overnight, and there is no one-size-fits-all. Countries need to assess their own context and identify the best way to achieve targets 3.3 and 3.8 of the health Sustainable Development Goals (SDG).

To fully leverage progress towards UHC to accelerate the end of the AIDS epidemic, action will be needed from the UNAIDS Joint Programme, Member States, civil society and the private sector.

These actions include:

- Advocacy and leaderships to identify and utilize win-win opportunities in the AIDS and UHC agenda;
- Alignment of relevant AIDS investments, policies, programming, and innovations alongside those of the UHC agenda, similarly ensuring inclusion of the essential HIV health related services within UHC packages to sustain the AIDS response;
- Inclusion of a rights-based approach for planning and implementing programmes to address the needs of all people, including those who are vulnerable and marginalized; meaningful involvement of key stakeholders, including civil society, and community representatives in health programme planning, implementation and monitoring; and
- Strengthening UHC by bringing to bear the experiences of the HIV response and ensuring the lessons that have been learnt support UHC efforts to build the inclusive systems needed to deliver on the vision of sustainable health for all.

INTRODUCTION

1. At its 43rd meeting, the UNAIDS Programme Coordinating Board (PCB) agreed that the topic of the thematic segment of its 44th meeting would be *Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage (UHC).* This thematic segment provides an opportunity to discuss the opportunities and challenges in the joint efforts to achieve two important targets under Sustainable Development Goal (SDG) 3, "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases" (target 3.3) and "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (target 3.8) for ensuring healthy lives and promote wellbeing for all at all ages.

2. As a sign of the centrality of UHC to the future of global health, the United Nations General Assembly will hold its first-ever High-level Meeting on Universal Health Coverage (UHC) on 23 September 2019. During the High-level meeting, the General Assembly will approve "concise and action-oriented political declaration" to advance progress towards UHC; a roadmap towards UHC will also be generated. In preparation for the High-level meeting on UHC, a multi-stakeholder hearing was held at the United Nations General Assembly on 29 April 2018, involving strong participation from key populations and people living with or affected by HIV.[1]

3. The thematic segment that this background note will inform aims to enable the PCB to:
   - Define how UHC can benefit people living with or at risk of HIV, especially those most likely to be excluded, and how HIV programmes can evolve in the context of expanded health coverage, particularly in strengthening health systems to accelerate uptake of comprehensive HIV prevention and treatment and to deliver people-centred, equitable health services;
   - Review remaining challenges associated with positioning comprehensive HIV responses in sustainable health systems for UHC;
   - Discuss lessons learned from the HIV response that can be critical for ensuring progress towards UHC and in building sustainable health systems for UHC; and
   - Identify priority approaches and key actions for the Joint Programme, Member States, and civil society to ensure that expansion of health coverage towards UHC achieves its full potential – for the HIV response and for all other aspects of human health and well-being.

4. In collaborating with the movement towards UHC – globally and at country level – the HIV community should work to achieve a 'win-win' scenario towards realization of the fundamental human right to health. The HIV response should endeavour to fully leverage the potential benefits of UHC. At the same time, progress towards UHC should take on board the historic lessons learned in the HIV response.

UHC: THE DRIVING FORCE FOR GLOBAL HEALTH IN THE ERA OF SUSTAINABLE DEVELOPMENT

5. Sustainable Development Goal 3 outlines a broad array of ambitious health targets for 2030. These include ending preventable deaths among children under age 5; ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and strengthening efforts to combat other communicable diseases; and reducing premature

[1] Summary by the President of the General Assembly of the Interactive Multi-stakeholder Hearing as part of the preparatory process for the United Nations High-level Meeting on Universal Health Coverage.

mortality associated with non-communicable diseases by one-third, as well as achieving UHC. By improving health outcomes, the world can advance progress across the broader 2030 Agenda for Sustainable Development.[1] Between 2015 and 2030, it is projected that effective and timely health care would save low- and middle-income countries US$ 11.2 trillion in lost economic output.[2] This dynamic can generate a virtuous cycle; as progress in the HIV response and expansion of health coverage for improved health outcome can both quicken progress across the broader 2030 Agenda, gains towards the non-health-specific SDGs on such issues as education, gender equality and reducing inequalities within and among countries will strengthen and accelerate efforts to end the AIDS epidemic as a public health threat.

6. Health-related priorities under the 2030 Agenda can broadly be divided into two sets of priorities. First, health systems must address health problems that have yet to be effectively addressed, especially the growing burden associated with non-communicable diseases (NCDs), which account for 71 per cent of global mortality, with low- and middle-income countries accounting for three-quarters of NCD-related deaths.[5] Second, the world must build on the concrete progress made under the Millennial Development Goals (MDGs) to end the epidemics of AIDS, tuberculosis, malaria and preventable deaths in children, noting AIDS response has evolved broader than a pure health sector response.

7. The target 3.8 on UHC has the potential to be a major contributor to achieving other health and broader development targets. Expanding health coverage to all would be a momentous step towards realization of the fundamental human right to the highest attainable standard of health, as set forth in the Universal Declaration of Human Rights, the constitution of the WHO, numerous treaties, covenants and instruments at the global level and in more than 100 countries. Under both international law and many national constitutions and laws, countries have a sovereign duty to respect, protect and fulfil the health of people.[3]

Miles to go in the journey to end the AIDS epidemic

8. The decision by United Nations Member States to embrace such an exacting set of health targets in the SDGs was inspired in large measure by unprecedented progress achieved under the MDGs. Under the MDGs (2000-2015), the mortality rate among children under 5 years of age fell by more than half, the maternal mortality rate declined by 45 per cent, malaria mortality dropped by 58 per cent, and the mortality rate for tuberculosis (TB) decreased by 45 per cent.[4] The HIV response was one element of the global health and development agenda in the MDG era that helped inspire the ambitious SDG agenda. When the MDGs were first adopted, the global HIV burden was worsening year to year, with little sign of a possible reversal. Yet, from 2000 to 2017, the number of new HIV infections globally declined by 36 per cent, including a 58 per cent reduction in new infections among children, and AIDS-related deaths fell by 38 per cent.[5] In 2015, it was clear that the world had halted and begun to reverse the epidemic, achieving the HIV target of MDG 6.

9. Today, however, there are worrying signs of waning global commitment to see the HIV response through to completion. The rate at which new HIV infections are declining – 18 per cent from 2010 to 2017, when 1.8 million people were newly infected[5] – is far too slow to reduce new HIV infections to no more than 500 000 by 2020, as provided in the 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.[6] Since 2010, new HIV infections have increased in at least 50 countries, with an especially grave increase in new infections occurring in eastern Europe and central Asia.[7] Of similar concern is the fact that more than 15 million people living with HIV were not receiving adequate, consistent antiretroviral therapy in 2017, and while the number of people newly initiating HIV treatment was higher in 2017 than ever before, the rate of increase in antiretroviral therapy utilization has begun

to decline.[5] Many populations are being left behind, including such key populations as gay men and other men who have sex with men, people who inject drugs, sex workers and transgender people; together with their sex partners, these populations comprised 47 per cent of all new HIV infections globally in 2017.[7] Total financing available for HIV programmes in low- and middle-income countries has flattened since 2013.[7] In supporting and collaborating with the movement towards UHC, the HIV response should identify ways to expand health coverage, identify opportunities for broader health service platforms (including expansion of HIV-specific platforms to address other health needs), and leverage its momentum as an important contribution towards the goal of ending the AIDS epidemic by 2030

The UHC agenda

10. In examining UHC as a mechanism for strengthening and sustaining the HIV response, it is important to understand what UHC is and what it is not. Universal Health Coverage consists of three fundamental elements:
    - UHC enables **everyone** to access quality services that promote good health and address the most significant causes of disease and death (i.e., *who* is covered).
    - It includes the **full spectrum of essential, quality health services**, from health promotion to primary and secondary prevention, treatment, rehabilitation, and palliative care (i.e., *which* services are covered).
    - It **protects people from overwhelming negative financial consequences of paying for health services** out of their own pockets, reducing the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children (i.e. *how much* is paid out of pooled funds).

These and other related dimensions of UHC are sometimes depicted as a cube (see Figure 1).

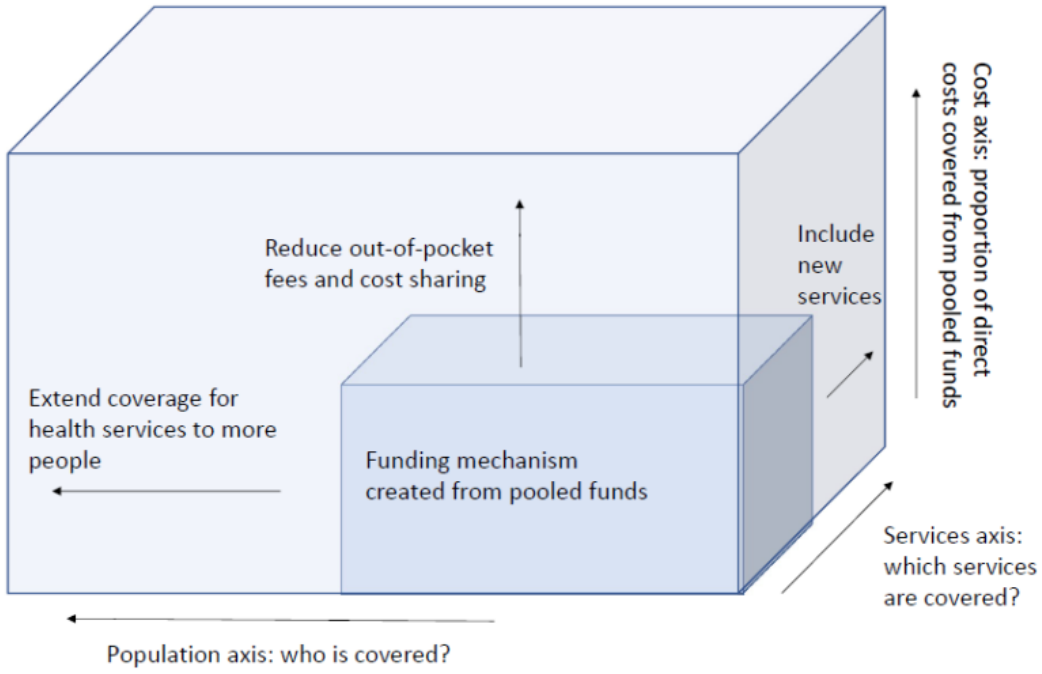

Figure 1: Universal Health Coverage cube
Adapted from WHO, by permission of World health Organization

11. Although the ultimate vision of UHC is expansive, comprehensive and well understood, approaches to realize UHC may vary from country to country.[8] While the above-noted three dimensions of UHC are clear, no single approach to expanding health coverage will work for all settings. Efforts to expand health coverage must be tailored to the specific country context, taking into account appropriate financing schemes, service delivery systems and public and private health service markets. For example, some countries are starting the move towards UHC with more limited service packages, with the expectation that the spectrum of services provided through health coverage will expand over time.[8] Under international law, countries are obligated to take steps to ensure the availability and accessibility of health services, the acceptability of health services, and that health services are of good quality and scientifically and medically appropriate.

12. Universal Health Coverage has the potential to substantially enhance the health and wellbeing of the world's people and the societies in which they live. Globally, 100 million people are pushed into extreme poverty due to the economic impact of illness.[8] As out-of-pocket costs may make health services inaccessible for people who cannot afford them, expanding coverage in a manner that ensures affordability and protects against financial hardship can prevent poverty and promote utilization of essential services, including preventive interventions and management of HIV and other chronic conditions. Indeed, evidence demonstrates that people with health coverage are more likely to have a regular source of medical care, to use preventive and applicable chronic-disease services and to report being in good health.[9] Compelling evidence indicates that expanded health coverage is associated with increased life expectancy.[10]

13. By ensuring that all people have coverage for diverse, quality health services, UHC may also reduce duplication, waste and fragmentation in health service delivery, helping rationalize health spending. Financing reforms to accelerate progress towards UHC envisage a transition from passive approaches (e.g. budget is made merely based on historical allocations without link to results or performance) to the purchasing of health services (e.g., paying for services or commodities independent of performance) to more purposeful, strategic health purchasing (e.g. budgets tied to expected performance and desired results). Strategic health purchasing aims to improve efficiency in the distribution of finite resources, manage the growth of health spending and prioritize quality in the delivery of health services.[11] Strategic purchasing can help ensure the optimal mix of service delivery options (e.g., balancing health facilities and community systems) and enable financial incentives for the provision of priority health services (e.g., opioid substitution therapy for people who inject drugs). Achieving UHC may involve optimizing and coordinating the contributions of private, not-for-profit, community and public systems of care.

14. While the potential of UHC to improve human health and well-being is clear, what is needed is *genuine* UHC that fully meets the three dimensions of the above-noted cube. One key message emerging from the multi-stakeholder hearing on 29 April 2019 is that expanded health coverage towards UHC demands meaningful access for the poor, stigmatized and marginalized, as well as social justice, efficiency and quality. To realize the promise of UHC, health systems themselves must be transformed to become truly people-centred and strategically organized.[12] [13] Diverse, affordable health services (including preventive services) should be readily accessible through coordinated, integrated, co-located service platforms that tailor services to the needs of different settings, households, communities, populations and preference of individual people, and that encourage individuals to become full partners in promoting good personal health outcomes.[12]

15. To realize the affordability dimension of UHC, expanded health coverage must be accompanied by the removal of user fees or other out-of-pocket expenses that deter utilization of health services. Ensuring access to the full spectrum of needed health

services will demand concerted action to ensure the affordability and accessibility of medicines, vaccines, diagnostics and other health commodities, which in turn will require greater policy coherence between trade rules and public health efforts.[14] In addition, the impact of expanded health coverage on life expectancy and other health outcomes is likely to remain sub-optimal without complementary investments in interventions to address social and structural determinants of health as well as barriers in access to services, and to undertake measures to reduce vulnerability to NCDs and to infectious diseases.[15] Enabling legal, policy and regulatory environments, based on evidence and rights, can protect populations from risk exposures, facilitate healthy behaviours, and increase access to services. For example, fully realizing the potential of UHC to improve the health and well-being of adolescent girls and young women will require structural approaches that empower young women to avoid early marriage and reduce their vulnerability to violence; in low- and middle-income countries, 35 per cent of young women (aged 20-24 years) marry before age 18 (including 12 per cent who marry before age 15), which increases their risk of sexual and gender-based violence and is associated with reduced educational attainment. UHC approaches should also be devised to encourage and facilitate self-care strategies that enhance the autonomy and agency of users of health services and play an especially critical role in the management of HIV and other chronic diseases.

Box 1. Legal empowerment and social accountability to improve health services for adolescent girls and young women in Uganda and the United Republic of Tanzania

The transformation of health systems to provide high-quality, people-centred care in the context of expanded health coverage requires focused efforts to make health systems work for adolescent girls and young women. The PEPFAR-supported DREAMS initiative provided funding to the International Development Law Organization (IDLO) to increase the capacity of service providers to provide high-quality HIV and sexual and reproductive health services in Uganda and Tanzania. To carry forth its project, IDLO worked with local partners – the Centre for Health, Human Rights & Development (CEHURD) in Uganda, and the Legal and Human Rights Centre (LHRC) in Tanzania.

Unlike other capacity-building projects, the collaborative IDLO initiative focused on building capacity not only of service providers but also of adolescent girls and young women, their parents and communities, and legal and judicial personnel. The project for adolescent girls and young women was undertaken alongside a separate project to increase the capacity of law schools to reduce discrimination and increase access to justice among key populations in Uganda and Tanzania.

Combining the legal empowerment of adolescent girls and young women with measures to improve the accountability of service providers and other key stakeholders, the project created handbooks and guides for lawyers, activists and university legal clinics. With support from IDLO, local partners in the two countries trained over 550 adolescent girls and young women advocates, healthcare providers, representatives of village health committees and justice sector professionals. To improve legal empowerment at the community level, local partners raised awareness through media and communications activities and also held community engagement meetings with adolescent girls and young women, their parents, and local community and government leaders. Using safe spaces, community advocates trained by the project engaged 3 214 adolescent girls and young women in Uganda and 9 240 adolescent girls and young women in Tanzania.
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16. Health challenges experienced by adolescents and other young people offer one of many examples that highlight the importance of complementing expanded health coverage with legal, policy and programmatic reforms that remove social and structural barriers to health service access across the life course. According to country reports to UNAIDS, 45 countries require parental consent for those under age 18 to access HIV testing. This number rises to 95 when including countries that require parental consent for those under 16 and 14. At least 68 require parental consent for people under age 18 to access sexual and reproductive health services.[7] Far too few health facilities offer adolescent-friendly services, and the services that are available are often fragmented and of poor quality. Few HIV-specific laws that ostensibly aim to encourage HIV testing uptake currently take account of the unique needs of adolescents and young people.[16] To realize the full potential of UHC for young people, these policy and programmatic shortcomings will need to be addressed.

Progress towards UHC: A status report

17. Low- and middle-income countries, small and large and from diverse regions (Asia and the Pacific, the Caribbean, eastern Europe and Central Asia, eastern and southern Africa, Latin America, the Middle East and North Africa, and western and central Africa), have made notable strides in expanding health coverage and access to primary care in recent years.[17] Using a subset of "tracer indicators"[2] to track increases in health service coverage, the World Health Organization and the World Bank found that coverage of essential services rose annually on average by 1.3 per cent from 2000 to 2015, or about 20 per cent during this 15-year span.[8] Among the subset of tracer indicators, the sharpest increases in coverage were reported for antiretroviral therapy and insecticide-treated nets.[8] Coverage of essential health services is highest in eastern Asia, Europe and North America, Latin America and the Caribbean, and Oceania, and lowest in sub-Saharan Africa and South Asia.[8]

18. However, while the upward trajectory of health coverage trends is encouraging, the world has far to go to ensure universal access to good-quality primary care. Currently, at least half of the world's people lack adequate health service coverage.[8] Especially serious service gaps exist for hypertension control (with over 1 billion people with uncontrolled hypertension), family planning (a gap of more than 200 million women), and immunization (with nearly 20 million infants missing key vaccines).[8] At a time of unprecedented population mobility, migrants are all too often denied healthcare access and wholly excluded from national health insurance systems.[18] Major healthcare access gaps are similarly apparent for key services, such as reproductive and maternal health, and for numerous populations, such as prisoners, transgender people and people working in the informal sector.

19. Although healthcare coverage is increasing globally and progress under the MDGs helped narrow global health inequities, it is now vital to build on these gains, as ensuring both equity in health service access and ultimately eliminating health disparities remain major challenges. Among 52 countries with primary care data, coverage among the poorest quintile of people was 1 per cent to 66 per cent lower than the national average in 2010-2015.[10] For essential maternal and child health interventions, only 17 per cent of mother-infant pairs in the lowest wealth quintile in low- and middle-income countries received at least six of seven core interventions in 2000-2015.[8]

[2] The nine tracer indicators used in the 2017 UHC monitoring report are: sanitation, hypertension control, tobacco control, insecticide-treated net use, family planning, antenatal care (four or more visits), immunization (DPT3), HIV treatment, and effective treatment for tuberculosis.

20. Many people across the world remain unprotected from financial hardship associated with health services. In 2010, more than 800 million people worldwide experienced out-of-pocket health service expenses that exceeded 10 per cent of household consumption or income, including 179 million who incurred out-of-pocket costs greater than 25 per cent of household income.[8] Each year, nearly 100 million people are pushed into poverty (2011 PPP $1.90 per day) as a result of health-related expenses.[8] Rates of impoverishment due to out-of-pocket health spending are highest in Africa and Asia.[8] These financial hardships are worsened or directly attributable to the very high prices charged for medicines and other health commodities, underscoring the need for coordinated global action to ensure the affordability and accessibility of health technology and commodities.[12]

21. The increase in health coverage will need to accelerate to achieve UHC by 2030. Experts associated with the Global Burden of Disease project, taking current and projected trends into account, estimate that UHC will reach up to 5.6 billion people in 2030 (compared to the current global population of 7.7 billion).[19] From 2015 to 2040, it is projected that global health spending will double in real terms, although the rate of growth in health expenditure is projected to be considerably lower for low-income countries (2.2 per cent per capita per year) than for upper-middle and lower-middle income countries (4.2 and 4.0 per cent, respectively).[19] When progress towards UHC is coupled with the transformation of health care delivery and support for robust public health systems, a separate analysis in 67 low- and middle-income countries projected a substantial financing gap in 2016-2030 (estimated at US$20 billion to US$54 billion annually).[20] Although the projected collective health financing gap during the SDG era for these 67 countries is daunting, the authors of the study caution that “some level of universality” is possible by 2030 for all countries, including countries with the lowest national income.[20]

HOW UHC IS A CRITICAL ENABLER TO ENDING THE AIDS EPIDEMIC

22. The stakes for the HIV response in the global push to achieve UHC are enormous. By enabling more accessible, integrated, people-centred, high-quality primary care services and service delivery platforms, UHC can potentially enable the HIV response meet one of its central challenges – providing holistic care and support for people living with HIV. People living with HIV also experience multiple health challenges, including such common co-morbidities as tuberculosis, viral hepatitis, and substance use and mental health conditions like everyone else. In addition, as modern HIV treatment regimens enable people living with HIV who have ready access to care to live for decades[21], medical management of HIV will increasingly encompass prevention and treatment of diseases of aging. From 2012 to 2017, the number of people living with HIV over age 50 rose by 60 per cent globally. Sub-Saharan Africa accounts for 66 per cent of the world’s people at all ages living with HIV in 2017. In addition to the naturally increasing susceptibility to diseases of aging as people living with HIV live longer, there is evidence that HIV and/or long-term use of antiretroviral therapy may increase risks of cardiovascular disease[22] [23], advanced renal disease[24], certain cancers[24], and neurocognitive disorders [25], although these risks are likely to be diminished by early treatment initiation with more modern HIV treatment regimens.[26] Many HIV service platforms are already working to address multiple health needs of the people they serve, and efforts to expand health coverage towards UHC should build on the experience and infrastructure of such service settings.

23. More integrated, people-centred primary care allowed by UHC could also aid in enhancing efficiency and in overcoming the persistent gaps in coordination of HIV services with other vertically funded service systems. Despite the clear, long-understood need to integrate HIV with programmes for tuberculosis, viral hepatitis, mental health conditions, substance use dependence, and sexual and reproductive health, the number of co-located, fully integrated

platforms for these linked conditions must be expanded.[12] As tuberculosis remains the leading cause of death among people living with HIV[7], effective integration of HIV and TB services is an especially pressing priority. Likewise, as transmission routes overlap for HIV and many Sexually Transmitted Infections (STIs), and as untreated STIs substantially increase risks of HIV transmission and acquisition, more fully integrating HIV and STI services is essential. In many settings, HIV remains poorly integrated with systems designed to address the needs of particular populations, including neonates, children, adolescents, women, people who use drugs, sex workers, LGBT populations, indigenous people, prisoners and migrants.[12] These gaps can be tied to a host of factors, including systemic barriers that impede integration, lack of electronic medical records in many settings, health workforce shortages and shortage of strategic, good-quality data to guide and inform service integration. The need to effectively use HIV service platforms to address multiple health problems represents not only an important piece of unfinished business of the HIV response but also a major opportunity for UHC efforts. Inadequate service integration has profound human costs and represents important missed opportunities. Modelling commissioned by the IAS-Lancet Commission found that full integration of HIV prevention and reproductive health services in Nigeria would avert more than 8 million unintended pregnancies over 10 years and reduce new HIV infections among children by 56 per cent (or 237 500 cases of vertical transmission).[12] Likewise, comprehensive integration of HIV prevention and treatment with sexual health services in India would avert 43 000 new HIV infections and 59 000 AIDS-related deaths among men who have sex with men.[12] In eight sub-Saharan African countries, UNAIDS is partnering with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the G.W. Bush Institute to integrate cervical cancer screening in HIV services, with the aim of reducing both HIV- and cancer-related morbidity and mortality. Essential benefit packages for expanded health coverage should leverage these and other opportunities to enhance efficiency and impact through service integration.

24. Expanding primary health care access, especially for the poorest and most vulnerable households, can aid in accelerating uptake of essential HIV diagnostic, prevention and treatment tools. Removing cost-related access barriers and creating integrated, people-centred health systems can potentially help close remaining gaps along the 90-90-90 HIV treatment continuum, including improving retention in care through close facility-community linkages. Fully integrating and rationalizing health systems under the UHC umbrella has the potential to standardize voluntary medical male circumcision for adolescent boys and adults. Facilitating broad access to and utilization of health services could also help close the enormous gap in PrEP uptake, especially when coupled with concreted efforts to maximize the affordability of PrEP regimens; although the 2016 Political Declaration established the global target of reaching 3 million people at high risk of HIV infection with PrEP by 2020, only an estimated 455 000 – 460 000 people worldwide were receiving PrEP as of February 2019, with the United States of America accounting for a majority of PrEP users.[27] By incorporating good practices with respect to models of care for people with HIV and other chronic diseases, expanded health coverage has the potential to facilitate and support self-care strategies among health service users.

25. Providing universal access that brings all populations into the health system also has the potential to buttress efforts by the HIV response to combat stigma and discrimination, although extending health coverage to all will need to be accompanied by investments in legal, policy and programmatic interventions to minimize the many reasons beyond health coverage why stigmatized communities may avoid health services. Punitive laws, policies and practices, as well as stigmatizing attitudes and behaviours, including violence and coercion, continue to slow uptake of essential HIV services. According to surveys of people living with HIV in 19 countries, one in five report having been denied health services due to their HIV status, with a comparable share of people living with HIV reporting having avoided visiting a health facility for fear of experiencing stigma or discrimination.[7] People

living with HIV who have stigma-related fears have been found to be 2.4 times more likely to delay accessing antiretroviral therapy until they are quite ill.[28] In Burkina Faso, 40 per cent of gay men and other men who have sex with men say they have delayed seeking care due to fear of stigma from healthcare providers, and people who inject drugs in Thailand were found to be seven times more likely to avoid HIV testing services if they had previously experienced discriminatory denial of care.[29] Ensuring universal coverage to all people, regardless of their socioeconomic status or demographic category, could serve as an important signal regarding the inherent rights and dignity of every person.

Potential concerns regarding UHC and the future HIV response

26. As conceptualized by WHO, progress towards UHC does not preclude disease-specific funding or programmes. However, there are stakeholders in the HIV response who have concerns about the unintended impact of integration of HIV within the broader health sector will result in reduced focus on HIV. Although vertically funded, disease-specific funding for health is often subject to great criticism[30], the undeniable reality is that, in the case of HIV, a somewhat vertical approach, with associated disease-specific funding, has achieved unprecedented results, including positive health system benefits.[12] The next generation of challenge is how to integrate such services, financing and strategic purchasing in an era of combined domestic funding and development assistance for HIV without backtracking on the results already achieved by the HIV response.

Box 2. HIV and UHC: An analysis of risks and opportunities

The Partnership to Inspire, Transform and Connect the HIV Response (PITCH) – a partnership between Aidsfonds, the International HIV/AIDs Alliance and the Dutch Ministry of Foreign Affairs – studied the risks and benefits for the HIV response of integrating HIV within UHC. Using desk reviews and interviews with diverse key informants, researchers analyzed risks and opportunities in Indonesia, Kenya, Uganda and Ukraine.

A common concern identified in these country studies was the decline in HIV funding and the risks that funding shortfalls might threaten both HIV services and broader efforts to expand health coverage. In the context of limited funding, particular anxieties were expressed by stakeholders in the four countries regarding the future of services for marginalized populations. At the same time, it was recognized that integration HIV into UHC could reduce fragmentation and make HIV services more sustainable.

How to fold HIV services into broader health systems – for example, by including HIV services in national health insurance programmes – has yet to be determined in the four countries studied. Ensuring that health insurance programmes are friendly to and easily accessible for key populations is essential. Preserving and strengthening services for marginalization will require the elimination of legal barriers that impede access to care.

As HIV services are increasingly integrated with other health services, researchers concluded, specific steps will be needed to prevent the collapse of the community HIV response. In contrast to HIV governance, which has prioritized the active participation of civil society in decision-making, there is presently only limited civil society participation in the four study countries with respect to UHC, underscoring the need for efforts to expand health coverage to heed the valuable lessons from the HIV response.
UNAIDS/PCB (44)/CRP2

27. One serious concern regarding the future of the HIV response in a more integrated health arena has to do with the future of service access for marginalized key populations. While gay men and other men who have sex with men, people who inject drugs, sex workers and transgender women are 28 times, 22 times, 13 times and 13 times more likely than the population as a whole to acquire HIV, they often do not adequately access HIV services, in large measure due to persistent stigma and discrimination.[7] As commonly seen, HIV programmes for key populations are heavily or even wholly dependent on external funding. Donor funding not only supports the delivery of HIV services, but is also frequently the only available source of support for building community infrastructure for key populations.[12] At a time when the global epidemic is increasingly driven by transmission among these key populations, expansion of health coverage needs to be accompanied by intensified community outreach, advocacy and law and policy reform to ensure that key populations have meaningful access to good-quality, culturally appropriate, non-discriminatory services under UHC and are enabled and motivated to use these services, which includes preventive services such as condom promotion, harm reduction, post-exposure Prophylaxis, pre-exposure Prophylaxis and treatment as prevention (Undetectable = Untransmittable).

Box 3. Action in Ukraine to strengthen HIV responses for key populations

Law enforcement personnel, who typically have ongoing contact with key populations, play a pivotal role in HIV responses for marginalized groups. By preventing human rights violations among key populations, law enforcement personnel can enable effective prevention, treatment and care efforts. Conversely, law enforcement agents may increase vulnerability and risk through harassment or abuse of marginalized groups.

In Ukraine, the United Nations Development Program held three trainings on HIV and human rights for law enforcement officers from Kyiv, Odesa and Sievierodonetsk, covering such topics as gender-based violence and the provision of gender-responsive services for populations at greatest risk. In partnership with the National Police of Ukraine, a training-the-trainer guide for national police on HIV and human rights was developed and piloted in Kyiv. The guide includes six modules, to be provided through on-the-job trainings or in dedicated two-day trainings, and aims to increase the capacity of law enforcement personnel to address HIV in a human rights-based manner and to adhere to international standards. To date, more than 100 students of police academies have received training under the guide, which in the process of being revised and included in the national curriculum of police academies.
UNAIDS/PCB (44)/CRP2

28. In many respects, accountability is simpler for disease-specific programmes than for more integrated systems. Indeed, one of the salient attributes of the HIV response has been its reliance on clear, time-bound, outcome-driven milestones. For the HIV community, specific efforts will be needed as health coverage expands to enshrine clear HIV indicators and targets within core monitoring and evaluation functions for health systems.

29. Given the diversity of HIV epidemics between and within countries and regions, it is evident that no single service package or service delivery platform will meet the needs of all people living with or at risk of HIV. While working to universalize access to basic minimum service packages, efforts to expand health coverage to achieve UHC will need to retain sufficient flexibility and innovation to enable services to be customized for individuals, populations and settings. Ideally, health systems will expand to enable the ready flexibility of users of health services to access services from different providers as needed.

30. With respect to sustaining and strengthening the HIV response, it will be important to ensure that community-based services are included alongside facility-based care as health coverage expands. Community systems play pivotal roles in the HIV response, undertaking targeted case findings, enabling differentiated care strategies, providing peer support and re-engaging individuals who have fallen out of care. Community systems have also proven vital for prevention and management of many other health issues, including tuberculosis, immunization and nutrition.[31] For expanded health coverage to meet the needs of people living with or at risk of HIV, community systems must be well integrated in care systems and engaged as full partners in service delivery and coordination. Functional referral systems must be in place and fully integrated into primary care to enable ready access to higher levels of care needed by individual patients. Social contracting offers a potentially useful avenue for sustaining and strengthening community systems of care. Social contracting involves more than the provision of financing from national governments to civil society organizations, but also encompasses policy and programmatic efforts that support successful implementation and sustainability of community systems.[32] Recently, encouraging signs have emerged of growing national commitment to the sustainability of civil society systems, such as the decision by the government of Montenegro to allocate significant domestic resources towards NGO-provided prevention services as well as the decision by the government of Serbia to finance minimum packages for key populations. It is important to empower individuals, families, communities, local providers and civil society organisations to be at the centre of UHC, especially by strengthening and enhancing community capacity to get involved in decision-making and accountability processes

Box 4. Using community responses to lessen vulnerability in India

Under the third phase of the Avahan project, the NGO Swasti, along with its sister organizations Vruitti and Catalyst Management Services, received three-year funding from the Bill & Melinda Gates Foundation to serve key populations in five Indian states with high HIV prevalence (Andhra Pradesh, Maharashta, Karnataka, Tamil Nadu and Telengana). The project worked with 84 community organizations to reach more than 130 000 women in sex work, men who have sex with men, and transgender people.

Using a vulnerability index specifically developed for the project, Swasti found that the percentage of project beneficiaries qualifying as most vulnerable fell from 15 per cent to 7 per cent. The number of project beneficiaries reporting violence in the previous six months fell by 30 per cent, and there was a significant increase in the proportion of participants who accessed formal identity and citizenship documents, enabling access to various social protection systems. The number of beneficiaries who accessed insurance increased 20-fold and the number with a savings account rose nearly three-fold. Through membership drives, digital mapping of member engagement and social network approaches, the number of members of key populations engaged by the project increased by 78 per cent annually.

However, Swasti's experience illustrates not only the power of civil society to reach and engage marginalized communities, but also the fragility of community systems in an era of declining international HIV assistance. Following the end of the grant, Swasti obtained continuation funding from the Ashraya Hastha Trust, a private family philanthropy, but at a level substantially lower than the previous Avahan grant. As a result of this funding reduction, the project is now using a phased approach to community support, with 20 community organizations providing the full panoply of services provided under the three-year Gates grant and another 40 organizations focusing on linkage and follow-up.
UNAIDS/PCB (44)/CRP2

31. Although the transition from HIV-specific to more integrated health service delivery may be conceptually straightforward, inadequate preparation has sometimes made systemic transitions of HIV programmes hazardous for the health and wellbeing of people who depend on programmes that are vertically funded and delivered. In South Africa, for example, early moves to transition HIV services from vertical PEPFAR-funded services to mainstream public systems resulted in disruption of care for large numbers of people living with HIV[33]. Before HIV services are transitioned to primary care – an outcome that may be appropriate in many but not all settings – clear, functional referral mechanisms and robust and effectively managed health information tracking systems must be in place. Up-front investments in core health system functions can also aid in minimizing disruption associated with such transitions.

HOW THE UHC MOVEMENT CAN BUILD ON THE STRENGTHS OF THE HIV RESPONSE

32. The response to HIV has had a transformative effect on the global health field. In addition to demonstrating what can be achieved through international solidarity, political leadership, evidence-based action and sufficient financing, the HIV response has pioneered or advanced innovative approaches that have broad applicability to public health more generally. At the same time that the HIV response has inspired action across the global health field, it has not been perfect, highlighting the need for further efficiency gains and for additional steps to maximize returns on HIV investments and generate concrete results for people. Efforts to expand health coverage should take on board the historic lessons of the HIV response, to make health systems truly people-centred, broadly participatory and optimally efficient and effective.

33. *A focus on outcomes:* One of the singular characteristics of the HIV response has been its overriding focus on saving lives, restoring health and preventing new HIV infections. Likewise, the ultimate metric for monitoring UHC is the degree to which the health of human beings is improved, as improving health outcomes is the primary reason why the world has endorsed UHC as a target of the Sustainable Development Goals.

34. *Ensuring strong, bold political leadership:* One of the most remarkable characteristics of the HIV response is the degree to which it has galvanized extraordinary political leadership, elevating health to a prominent position on global, regional and national political agendas. Virtually all high-burden countries have developed national HIV strategies that aim to lay the groundwork to end the global AIDS epidemic. National AIDS coordinating bodies bring together diverse stakeholders in the response, with leadership frequently provided by the Head of State/Government. At the global level, a series of political declarations have established increasingly ambitious, time-bound targets, most recently in the 2016 Political Declaration, which pledges action to end AIDS by 2030. As the Global Commission on HIV and the Law found in its 2018 supplement, political leadership is essential to address criminal laws and other legal and policy frameworks that impede health service access.[34] Increasingly, political leaders are tackling difficult issues: the Supreme Court of India struck down the country's sodomy law; Pakistan has formally recognized the rights of transgender people; and South Africa has embarked on a national dialogue to discuss possible decriminalization of sex work. Strong, sustained political leadership has enabled the implementation of innovative approaches, such as same-day initiation of antiretroviral therapy and differentiated models of service delivery.

35. *Governance:* The degree to which civil society has participated in HIV governance – such as on the governing boards of UNAIDS and the Global Fund to fight AIDS, Tuberculosis and Malaria, on Country Coordinating Mechanisms or on national AIDS councils – distinguishes HIV from most other health issues. Inclusive, multisectoral HIV governance has helped united stakeholders around a single global agenda, ensure vital stakeholders a

seat at the table, bring attention to under-prioritized issues, elevate the role of epidemiology and programme performance data in national responses, increase attention to social determinants of health and drive progress in the HIV response. Governance for UHC should build on this formalization of participation by a range of critical stakeholders and ensure their meaningful engagement in all stages of planning, implementation and evaluation.

36. *Accountability:* Accountability in the HIV response has been ensured by worldwide adherence to a single set of Global AIDS Monitoring indicators; easy-to-use online reporting systems; and transparent, annual reporting of results. The breadth of reporting under the Global AIDS Monitoring system is among the greatest for all global health and international development issues; in 2018, 173 countries reported results under the Global AIDS Monitoring system. At country level, countries track and report results not only on globally agreed indicators but also on indicators developed specifically for their national programmes. Civil society organisations and communities play an important role in HIV accountability mechanisms, including by reporting through the National Commitment and Policies Index. Over time, the timeliness of reporting has increased, with six-month updates of key indicators (e.g., antiretroviral coverage, etc.). The HIV response has effectively used monitoring results to adapt programmatic strategies in response to documented bottlenecks and gaps; for example, disappointing early results along the service cascade for prenatal care for women living with HIV and for prevention of mother-to-child HIV transmission prompted an intensified global mobilization, which today has placed the world within reach of eliminating new HIV infections among children in the coming years. HIV remains the most effectively monitored health condition in the world, serving as a

Box 5. The HIV response and universal health coverage in Brazil

The Brazilian Federal Constitution, adopted in 1988, created the country's Unified Health System. Like the country's pioneering early HIV response with which it coincided, creation of the Unified Health System reflected a commitment to universality, integration and equitable, democratic representation among users of health services, healthcare professionals and programme managers. Both the HIV response and the broader movement to increase health coverage emerged as a linked social movement founded on the fundamental human right to health.

Central to Brazil's HIV response and its approach to universal health coverage has been a commitment to combat stigma and discrimination. In this regard, Brazil's experience underscores the need to avoid focusing debates over UHC solely on the supply and demand of health services and instead to take account of social and structural issues such as discrimination, violence and economic and social inequalities.

Brazil has demonstrated the feasibility of combining universal coverage with targeted public health initiatives. Not only has Brazil provided universal access to antiretroviral therapy as part of its broader commitment to UHC, but the country's health system has also exhibited sufficient flexibility to integrate newer, more targeted approaches, such as both pre- and post-exposure prophylaxis.

For Brazil's HIV response and its Unified Health System, community-based social participation has proven to be pivotal. In this respect, the HIV response in Brazil proved an inspiration for broader health reform, as the solidarity network created by communities affected by HIV demonstrated the unique, transformative role that communities play in efforts to realize the fundamental human right to health.
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pathfinder for the monitoring of health more broadly and for effective use of data to plan or adapt programmatic approaches.

37. *Multisectorality:* The HIV response has recognized the degree to which health depends on factors that are not technically part of the health sector. In this regard, the Joint Programme has served as a model for a coordinated, multisectoral response to HIV, bringing together 11 United Nations Cosponsors and a Secretariat under a single budget, results and accountability framework. The HIV response has demonstrated that health programmes must work in partnership with other sectors to address structural determinants and to achieve, as well as sustain, results. In high-burden countries, Ministries of Health have forged strong working partnerships with diverse ministries, including finance, social welfare, youth, education, and in some cases with interior, justice and national human rights institutions. Multisectoriality has been key especially for HIV prevention, including for the planning and provision of comprehensive sexual education; condom promotion; harm reduction for people who inject drugs; actions to empower women and girls; efforts to remove legal barriers; and engaging law enforcement and justice to ensure access to services for sex workers, people who inject drugs and men who have sex with men and trans gender women. Collaboration across sectors and stakeholders needed to increase access and to improve health outcomes. Close collaboration, at international, regional and country levels, has built bridges between the HIV response and initiatives to address humanitarian emergencies. The private sector has also played an important role in responding to HIV, using their core business capabilities and reach to employees, suppliers, distributors and customers through traditional philanthropy, corporate social responsibility and innovation.

38. *Responsiveness to human rights principles and the needs of women and girls:* From its very outset, the HIV response has been grounded in a commitment to human rights and gender equality and to an approach that addresses the needs of women and girls. This grounding stems from the reality that an approach that respects human rights and meets the needs of women and girls is most likely to prevent new infections, AIDS-related deaths and social harms experienced by people living with HIV or at risk of HIV. UNAIDS and partners joined together to create the Global Coalition on Women and AIDS and have actively supported programmes specifically designed for women and girls as well as broader policy reforms and structural approaches that reduce their vulnerability and to address harmful gender norms. The HIV response has prioritized the removal of legal and policy obstacles to healthcare access and to realization of the rights and dignity of all people, including for marginalized key populations. In part due to strong and consistent advocacy by UNAIDS and other parts of the HIV community, more than 20 countries either removed restrictions on the right of entry, stay or residence of people living with HIV or clarified that no such restrictions were in place. Comparing results of national household surveys in 2009-2016 with results from earlier surveys in 2000-2008, the prevalence of stigmatizing attitudes towards people living with HIV has declined somewhat. At least 10 countries and two states in the United States of America have removed scientifically unsound and counterproductive laws criminalizing HIV transmission, exposure or non-disclosure. However, the persistence of stigma, discrimination and human rights violations demands even stronger efforts to protect and promote the human rights and address legal barriers in access to effective HIV response. One hundred fifty countries have laws in place that treat women discriminatorily in relation to men, including 63 that have five or more such laws. Ninety-eight countries criminalize some aspect of sex work; at least 100 criminalize the possession of drugs for personal use; 68 criminalize HIV non-disclosure, exposure or transmission; 67 outlaw same-sex relations; 20 have HIV-specific travel restrictions in place; and 17 criminalize transgender people, with only nine countries providing legal recognition for non-binary gender. Although efforts to ground the HIV response in human rights principles remains a work in progress, HIV demonstrates how rights-based approaches help remove barriers to access to prevention, diagnosis and

treatment and improve health outcomes. Human rights based and gender responsive approaches not only increase the effectiveness of strategies to control and manage infectious diseases but also help ensure equity and quality in the delivery of health services.

Box 6. Innovation in the HIV response to reach women affected by HIV

One of the hallmarks of the HIV response has been its encouragement of local innovation to achieve concrete results for people. Having committed to reach the 90-90-90 targets, the Islamic Republic of Iran is innovating to close gaps in the HIV treatment cascade for vulnerable women at high risk of HIV infection.

With support from the national AIDS programme, the Iranian Research Center on HIV/AIDS initiated mobile services for women at highest risk of HIV, in eight-hour nighttime shifts. Women reached by these services received voluntary HIV testing, HIV prevention counseling and commodities (e.g., condoms and sterile injecting equipment), and STI management (including first-line STI medications). Participating women also received pap smears and reproductive health education, and the programme recruited peers to increase access to health and social services through “hotspot” outreach.

Most of the women reached by the programme were homeless and had low literacy. Six per cent of the women who accepted HIV testing tested HIV-positive, with 83 per cent of women testing positive linked to HIV treatment. Of the women examined for STIs, 56 per cent demonstrates signs of STIs and vaginitis and were linked to STI follow-up care and treatment. The results of the project indicate that the hours of traditional health facility operation may impede uptake of HIV/STI and reproductive health services among vulnerable women.
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39. *A commitment to leave no one behind:* As a health challenge that disproportionately affects marginalized and underserved populations, HIV has given rise to a response that reflects a commitment to equity and inclusion, with the aim of eliminating disparities in health outcomes. Especially as a result of donor funding, dedicated service systems and approaches have been developed to reach populations that are not effectively served by mainstream health services. The HIV response has catalysed community-led services for sex workers, programmes specifically tailored for adolescents and young adults, harm reduction services for people who inject drugs, and clinical services for LGBT populations. The Global AIDS Monitoring and country monitoring and evaluation systems are increasingly using age-, sex- and population-disaggregated data reporting mechanisms for accountability. The HIV response’s commitment to leave no one behind in many respects foreshadowed the 2030 Agenda’s focus on reaching the most vulnerable first.

40. *Engaging communities as partners and leaders:* The HIV response has engaged communities and civil society as advocates, service providers, and key partners in the planning, implementation and monitoring of national responses. Putting communities at the centre of the response has been a fundamental feature of the HIV response from its very beginning, as reflected in the creation in the early 1980s of such institutions as the Gay Men’s Health Crisis in New York City, The AIDS Service Organisation in Uganda, and the Haitian Study Group on Kaposi’s Sarcoma and Opportunistic Infections (GHESKIO) in Haiti. Communities have generated some of the most important innovations in the HIV response, from the earliest peer-led ‘safer sex’ HIV prevention programmes to the differentiated service delivery models that are transforming how antiretroviral therapy is delivered and sustained. Studies in Nigeria have shown that community-delivered services

increase uptake of HIV treatment by 64 per cent and prevention services by two-fold.[35] Both for HIV- and non-HIV-related services, community health workers have been shown to increase service uptake and improve health outcomes, with particularly pronounced benefits for marginalized populations.[31] The UNAIDS Fast-Track approach calls for a steady scale-up of community service delivery, with the aim of having at least 30 per cent of HIV services delivered through community channels by 2030.[36] The HIV response has used innovative approaches, such as social contracting, to ensure the long-term sustainability of community systems and to accelerate the scale-up of community service delivery; for example, allocation of financing to support civil society HIV activities by the Government of Croatia aided in preservation of community services after Global Fund support ended.[37]

41. *Focusing on impact:* Confronted with finite resources but with ambitious targets for results, the HIV response has strategically focused efforts on populations and settings with the highest disease burden and the greatest unmet need for services. The strategic targeting of services, based on location and population, has optimized impact towards the goal of achieving epidemic control. The push to improve HIV programmatic focus to ensure that services reach those who most need them and targeted resource allocation has generated important innovations to guide decision-making, including geospatial mapping techniques that enable identification of epidemic 'hotspots'.[7] The UNAIDS Fast-Track strategy reflects an emphasis on intensified efforts focused on the 28 countries of the Global HIV Prevention Coalition that account for approximately 77 per cent of new HIV infections. With an effort to tailor services to the needs of those who need them, the HIV response has generated differentiated service options customized to the needs and preferences of individual people and communities.

42. *A commitment to a single global standard of care that continues to evolve as new technologies and solutions are discovered:* In recent decades, the roll-out of new, breakthrough biomedical technologies has taken a usual course. Expensive new treatments are introduced first in high-income countries, with access in low- and middle-income countries extended slowly over one or two decades, as patents expire and prices fall. The HIV response, however, changed this model. As a result of price declines for antiretroviral regimens, the emergence of a robust generic sector for the manufacture of HIV treatments, legal and policy reform, and unprecedented political support and global solidarity, the treatments that transformed HIV medical management in high-income countries were made available in low- and middle-income countries. Just as the advent of Highly Active Antiretroviral Therapy sharply lowered AIDS-related mortality in high-income countries in the 1990s, similar trends have been seen over the last 20 years in low- and middle-income countries. Rates of viral suppression in many low- and middle-income countries are comparable to, or sometimes better than, those reported in some high-income countries.[5] [7] Indeed, the HIV response in some ways turned the traditional approach to health access on its head, as certain interventions (e.g., rapid HIV tests, certain differentiated service delivery models) actually emerged first in resource-limited settings before being adopted in some high-income countries. In recent years, the emergence of HIV self-testing has increased the agency of people living with or at risk of HIV to take charge of their own health. Pursuit of a single global standard of care has prioritized innovation, generating and rapidly adopting new tools much more swiftly than is often the case for other health conditions. These achievements reflect the fruits of the HIV response's pioneering commitment to the broadest possible access to and affordability of lifesaving medicines and diagnostic. As the world works towards the goal of sustainable health and development for all, these achievements of the HIV response need to be applied to other health conditions, such as TB and viral hepatitis, where cost remains a major barrier to more robust uptake of essential medicines.[34]

43. *An emphasis on sustainability:* In the early years of the HIV response, the focus was on rolling out key technologies and reversing the rapid, seemingly inexorable expansion of the global epidemic. More recently, however, the response has increasingly emphasized long-term sustainability, generating lessons learned about how best to strengthen sustainability and ensure a response that builds on the achievements to date and is fit for the long term. This focus on sustainability is reflected in the Global Fund's formal policies and protocols for national transitions from donor to national funding and in PEPFAR sustainability agenda. HIV funding has also invested in the sustainability of health systems to benefit the HIV response and other health problems, including core investments in strategic information, policy and programme development, facility and community service system strengthening, and procurement and supply chain management.

44. *Financing for results:* The HIV response has spearheaded an investment approach to health, increasing awareness that health spending generates human and economic returns that extend well beyond health outcomes themselves. With assistance from the Joint Programme, dozens of countries have developed HIV investment cases to maximize the return on HIV investments and to build a sustainable foundation for the HIV response. The HIV response has galvanized new funding that has driven an unprecedented expansion of investments in health programmes.[38] The HIV community has also pioneered innovations in health financing, such as international pooled financing mechanisms (e.g., Global Fund), market shaping mechanisms (e.g., Unitaid), and country-level innovations, such as Uganda's alcohol levy, which is helping finance antiretroviral therapy programmes. Mechanisms to improve the efficiency and impact of health spending have also emerged from the HIV response, such as community care models that decongest health clinics. In Kinshasa, Democratic Republic of Congo, use of community distribution of antiretroviral therapy achieved 89 per cent retention in care among more than 2,000 people living with HIV, who no longer had to return every three months to the clinic for medication refills.[39] The lessons of the HIV response in mobilizing essential health investments should be applied to efforts to expand health coverage towards UHC, as it is projected that domestic budgetary allocations for health must rise by an additional 1 per cent to 2 per cent of GDP to enable realization of universal coverage.

WHY THE HIV RESPONSE SHOULD ACTIVELY WORK TO SUPPORT AND ACCELERATE HEALTH COVERAGE EXPANSION TOWARDS UHC

45. Marked gains have been made in the HIV response, with numerous countries approaching epidemic transition. Western and central Europe and North America have already reached the 0.3 incidence:prevalence ratio that indicates epidemic transition, while eastern and southern Africa is approaching this benchmark.[7]

46. However, HIV is far from over and the world as a whole is not on track to achieve epidemic transition and bring the AIDS epidemic to an end. As it is increasingly clear that the future of global health is a more integrated approach, it is essential that the HIV response actively engage with efforts to expand health coverage in order to ensure that expanded coverage meets the needs of people living and affected by HIV and contributes to ending the HIV epidemic. It is plain that the tools and know-how exist to bring AIDS to an end, and momentum towards UHC needs to be effectively leveraged to bring these tools to all who need them.

47. In the quest to reach UHC, a key step is national agreement on a package of essential services to which every health beneficiary will be entitled under the national approach to achieve UHC. HIV advocates need to engage with these processes to ensure that national HIV responses are effectively served by these national benefit packages. HIV and HIV-enabling services, including primary and secondary prevention, treatment and care

services should be included in benefit packages, although HIV advocates should also work to encourage the targeting of HIV services to priority settings and populations and avoid scattershot approaches to service delivery that are less effective and efficient.

48. Clear, timely and transparent mechanisms must be in place to ensure the accountability of UHC for people living with or at risk of HIV, as well as for people affected by other health problems. To promote accountability for results, the HIV response must work to ensure that HIV indicators (with data disaggregation) are included as key metrics for monitoring and adapting UHC approaches.

49. Although the HIV response aims to catalyse urgent action to end the AIDS epidemic as a public health threat, it is apparent that the response to HIV will last well beyond 2030. Millions of people will require continuous access to antiretroviral therapy (including possibly long-acting regimens), and continued vigilance and investment in evidence-based HIV prevention will be required to prevent a resurgence of the epidemic in future years. The HIV community needs to be full partners in efforts to roll out and bring to scale evidence-based approaches to build strong, sustainable, people-centred health delivery systems and structures. Lessons learned in the HIV response – including experience with task shifting; community systems strengthening; customized, people-centred services; involvement of diverse providers (e.g., public, private and community), mobilization of political commitment; inclusive and accountable governance; and strategies for mobilizing sufficient, diverse financing for health – should help inform efforts to ensure sustainable health services for all.

50. Above all, the HIV community cannot allow the transformative elements of the HIV response to be lost as health coverage is expanded and more integrated service delivery systems are put in place. Through extensive engagement with UHC processes, the HIV community must ensure that the lessons learnt from the HIV response are mainstreamed across health practice and systems.

ENSURING A WIN-WIN OUTCOME: KEY ACTIONS BY THE HIV COMMUNITY TO ENGAGE WITH THE UHC MOVEMENT

51. Moving forward on a few central lines of action will be essential to ensuring a win-win result for HIV in the context of UHC and the broader 2030 development agenda. As outlined in *Moving Together to Build a Healthier World: Key Asks for the UHC Movement for the UN High-Level Meeting on Universal Health Coverage*, key actions are needed with respect to:
    - *Advocacy:* With leadership from the Joint Programme and the active engagement of other stakeholders, the HIV community should serve as a leading advocacy voice for HIV in the UHC context to create win-win outcomes. Strengthening community voices and ensuring bold, sustained political leadership will be essential.
    - *Alignment:* Health is the foundation for people, communities and economies to reach their full potential, and tackling HIV is an essential part of creating effective, people-centred approaches to meeting the health needs of people, including the most vulnerable and marginalized. The Joint Programme and other key stakeholders should undertake a reinvigorated commitment to further appropriate alignment of investments, policies, programming, and innovation, helping UHC efforts leverage valuable lessons from the HIV community, while helping the AIDS community leverage the opportunities that UHC and the 2030 Agenda offer to end the AIDS epidemic by 2030 and providing all people with the full package of HIV-related services they need. Efforts must focus on bringing the experience of the HIV response to bear in shaping and accelerating progress towards UHC, and on ensuring appropriate integration of HIV and other health services and development efforts.

- *Inclusion:* In the context of HIV and UHC integration, the Joint Programme and all key actors from the HIV community should continue the commitment to leave no one behind and ensure that this principle informs and animates development of UHC systems. Inclusive processes need to be championed to enable all stakeholders, including civil society, the poor and marginalized, to move forward together to meet the needs of everyone.
- *Strengthening:* The HIV response should bring to bear its own experiences and lessons learnt to support UHC efforts to build, strengthen and sustain the systems needed to deliver on the vision of sustainable health for all. This will require strengthening health and community systems, ensuring inclusive governance and accountability, and mobilizing essential investments that prioritize efficiency, effectiveness, equity, sustainability and innovation.

Key actions by the Joint Programme

52. To actively engage with UHC processes (at global, regional and country levels), the Joint Programme should:

Advocacy

- Promote HIV services as a key contribution towards reaching UHC and vice versa
  - Continue to promote people-centred HIV services within broader primary health care and sexual and reproductive health services, as indicated by local conditions and systemic readiness, as outlined in the Call to Action for the full recognition and inclusion of Sexual Reproductive Health and Rights in UHC
  - Assist countries in undertaking national health outcomes assessments of service integration in expanded health coverage, taking particular account of the need to promote integration of HIV with services for tuberculosis, sexual and reproductive health, viral hepatitis, maternal and child health, adolescent health, and drug and alcohol and mental health care, including self-care interventions for health
  - Support countries in implementing at scale HIV-sensitive social protection approaches
  - Harness high-level processes, including the World Health Assembly, the High-Level Meeting on UHC and the International Conference on Population and Development Summit to promote an integrated approach and inclusion of HIV within broader UHC agenda

Alignment

- Ensure the continued alignment of its work with the 2030 Agenda to:
  - Advance the United Nations reform agenda and adhere to the renewed United Nations Sustainable Development Cooperation Framework processes at country level to promote a coherent, coordinated, cross-agency UHC agenda, which includes joint and synergetic actions to ending AIDS and other health targets under SDG 3, contributing to achieving other SDGs
  - Leverage the comparative advantage of individual Cosponsors and the Secretariat to contribute towards the end of AIDS within expanded health coverage and to promote models that improve both HIV- and non-HIV-related health outcomes for people
  - Maintain a coordinated, multisectoral approach to global health and development, working to apply this approach to other health issues

Inclusion

- Uphold the human rights principle to leave no one behind and address structural determinants of health
  - Support countries to ensure that all health services are rights-based and gender-responsive

- Continue to advocate for accelerated progress towards epidemic control and saving lives, including the removing of health disparities and discriminatory practices in the provision of quality health care
- Support the adoption of innovative and evidence-based programming to address the needs of hard-to-reach and vulnerable populations
- Support countries in eliminating violence, coercion, stigma and discrimination in health care settings to ensure that services are not only available, but also accessible, acceptable and of good quality
- Support countries in enacting and enforcing non-discriminatory laws and policies, repealing punitive laws and ensuring access to justice
- Support countries in extending social contracting partnerships with non-government and community health care providers
- Regularly evaluate the impact of policies and programmes and document who is left behind in order to promote inclusive access and utilisation of health services.
- Advocate for countries to create an enabling environment for civil society organisations to enable community-led public health responses
- Support countries in effectively addressing the structural determinants of health to empower people and ensure access to health care services by all without discrimination

Strengthening

- Promote inclusive health governance and accountability
  - Defend the complementary role of communities alongside the State's essential responsibilities and support civil society to promote accountability of all stakeholders
  - Advocate for country inclusive processes for Voluntary National Reviews (VNRs), including the meaningful participation of HIV communities and stakeholders
  - Support and capacitate civil society and communities to participate in UHC development in countries, in national reviews of progress towards achievement of the SDGs and in providing accessible, accountable, good-quality HIV services
  - Promote robust funding for civil society and communities
  - Monitor the access of people living with and affected by HIV to health services as health coverage is expanded
- Support health systems development
  - Support countries in developing UHC financing strategies, with attention to the importance of uninterrupted, sustained and strategically targeted HIV services
  - Promote the adoption of a range of 'sustainable' approaches to systems strengthening for optimized health results, taking account of key actions to strengthen and harmonize information systems, supply chains and service quality, noting that UNAIDS has endorsed the Principles of Donor Alignment for digital health
  - Convening on a regular basis, key actors and stakeholders across the HIV response to discuss and address critical challenges and opportunities related to ensuring innovation and access to medicines and other health technologies for HIV
  - Enhance further policy coherence across the Joint Programme on UHC and support countries in removing barriers to access to HIV-related products, including for co-infections and co-morbidities
  - Build further social contract partnerships for expanded service provision, access and coverage by government and non-government providers to marginalised communities

Key actions by Member States

53. Member States should actively endeavour to ensure that expansion of health coverage towards UHC works for people living with and affected by HIV and is informed by lessons learnt in the HIV response. Specifically, Member States should:

Alignment

- Consider health as an important enabler for broader development
  - Mobilise supportive political leadership and essential resources for health (allying with the global health field to emphasize the importance of investing in health, including uninterrupted financing for HIV services)
  - Include a strong focus on health promotion, including support for personal care and interventions for disease prevention, for HIV, other communicable diseases and also non-communicable diseases
  - Ensure affordability of HIV and other health services and protection from financial hardship associated with health service utilization
  - Address structural determinants of health to create safe and supportive enabling environments, empower people, increase their health-promoting and health-seeking behaviours to improve health and well-being, and to ensure the access of all people, without discrimination, to access to health services, including elimination of abusive, punitive policies and practices
  - Link essential facility and community sites to create a fully linked network of services from primary to tertiary care
- Promote HIV services as a key contribution towards realization of UHC
  - Include key HIV services in UHC essential benefit packages while ensuring the strategic alignment of HIV services to enable effective service focusing for location and population 'hotspots'
  - Ensure strong support for HIV prevention services
  - Foster and strengthen community service delivery (including through adequately funded NGOs, civil society organizations and community and faith-based groups) and increase investments in community systems strengthening
  - Promote language of collective commitment to achieving the SDG 3 targets for HIV and other communicable diseases (the unfinished Millennium Development Goals) as an integral part of achieving UHC in the political declaration of the UHC high-level meeting

Inclusion

- Safeguard the right to health for all
  - Ensure that expansion of health coverage towards UHC unfolds in a manner that eliminates health disparities among key populations and persons in situations of vulnerability
  - Ensure uninterrupted provision of HIV services, particularly for key populations and persons in situations of vulnerability and marginalization
  - Actively embrace and take immediate steps to implement the Agenda for Zero Discrimination in Health-Care Services, including elimination of all forms of violence, coercion, stigma and discrimination
  - Ensure, including in the Political Declaration on UHC, that UHC includes comprehensive and integrated services for all persons, with particular attention to victims/survivors of gender-based violence, especially intimate partner violence and sexual violence, women and girls. and ensure that approaches are gender-responsive, address the needs of a diverse range of women, and are sensitive to the needs of lesbian, gay, bisexual and transgender people
  - Enact and enforce non-discriminatory laws and policies, repealing punitive laws and ensuring access to justice
  - Promote access to health care for people in all their diversity, especially through social contracting mechanisms to increase delivery, access and uptake of community-based health care
  - Ensure that core HIV indicators are included in data collection and reporting systems for UHC and that data results are used to inform adaptation of UHC approaches

Strengthening

- Ensure the inclusiveness of health governance
  - Institutionalize civil society engagement in inclusive health governance and make civil society, community and other relevant players key partners in shaping and delivering UHC
  - Protect civil society from undue restrictions and monitor civil society engagement and barriers to participation, especially for individuals and organizations from marginalized and criminalized groups
  - Recognize and encourage the contributions of a multi-sectoral and multi-stakeholder approach, including the participation of civil society, community and private sector in health and HIV response
- Support health systems development
  - Adopt critical elements for establishing a 'sustainable and resilient health system', including: adoption of supportive laws and policies, actions individually or in concert with other countries to ensure the accessibility, availability, affordability and quality assurance of HIV related health technologies, including those to prevent and diagnose HIV infection, as well as to treat HIV infection and its co-infection, co-morbidities in line with the principle of the WHO Global Strategy and Plan of Action on Intellectual Property, Innovation and Public Health and the forthcoming WHO Road Map on access to medicines, vaccines and other health products (2019-2023). Investments in information systems, domestic mobilization, increased capacity to deliver medicine and manage supply chains, and increased investments in human resources for health as part of sustained and integrated UHC
  - Minimize financial barriers, formal or informal, that limit people's access and use of health services
  - Ensure appropriate aspects of the health systems building blocks consider the essential HIV related matters; for example, HIV screening in blood banks and measures of preventing iatrogenic transmissions
  - Work to ensure coherence with national and international legislation on population health, international humanitarian principles and international human rights laws
  - Leverage innovative financing approaches such as intersectoral co-financing to enhance savings and efficiencies in the UHC financing agenda

Key Actions by Civil Society

54. Civil society, communities and the PCB's NGO delegation have key roles to play in the move towards UHC approaches as demonstrated in the response to HIV. Specifically, civil society should be supported to fulfil several pivotal roles:

Advocacy

- As advocates for sufficient financing for health to
  - Promote the review and removal of barriers to funding, domestic and international, to ensure access to essential services at the facility and community level
  - Advocate for funding for NGO/CSO-delivered community-based services
- Civil society should demand the inclusion of key HIV services in the UHC benefit package, with secured funding for effective targeting of HIV services

Alignment

- As rights holder to
  - Promote continued and accelerated progress towards HIV epidemic control and the elimination of health disparities among vulnerable populations
  - Advocate for no one to be left behind in progress towards UHC
  - Promote the knowledge of civil society and community on UHC and promote "know your rights", legal empowerment and legal support for victims of human rights

violations within the health sector particularly those who are stigmatized and marginalized
    - Advocate that HIV responses and approaches for achieving UHC that are rights-based and gender responsive
    - Monitor the access of people living with and affected by HIV to UHC

Strengthening

- As participants in inclusive health governance to:
    - Promote the establishment of an inclusive health forum for UHC in all countries, with meaningful participation by civil society and communities throughout policy and programming research, planning, implementation and evaluation
- As programme designer, demand creator, policy maker, implementer and monitor to:
    - Engage in every step of health service design, implementation and monitoring to ensure the right services are defined, delivered to the right people in the right way and deliver the intended results
    - Build partnerships with government health service providers
    - Identify community providers and build the capacity of communities to deliver community health services

Key actions by the private sector

55. Recognizing the increasing role of the private sector as a development partner, advocacy efforts are needed to mobilise private sector support for equitable expansion of health coverage towards UHC, with the aim of mobilising the private sector to unleash its potential in:
    - Corporate Social Responsibility (CSR)
        - Fulfil the CSRs as an responsibility that corporates have toward their employees, community and society as a provider of service and data that can reflect the results of services, as philanthropist and as experts for marketing skills and logistic management that can benefit health service provision, no matter if it is a big corporation or a Small & Medium Scale Enterprise (SME)
        - Ensure consistency as an employer with the International Labour Organization's Code of Practice on HIV, that prohibit discrimination and protect human rights.
        - Promote availability and affordability of health technology that contribute to universal access to quality health care, including by eliminating barriers to access to generic products
        - Especially in high-prevalence countries and among key sectors to ensure access to testing, treatment and prevention programmes in the workplace and communities
        - Invest in community strengthening and community-based provision of health care
    - Innovations for health
        - Generate business innovation in products and services, especially with respect to pharmaceutical and diagnostic products
        - Develop additional self-care interventions to enhance individual's control of their own health and well-being
        - Engage in efforts aimed at promoting transparency in research and development costs

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