

Ensuring Efforts to Scale up, Strengthen and Sustain HIV Responses

Leveraging current and innovative approaches to financing

Hosted by the Joep Lange Institute and the Kenyan National AIDS Control Council (NACC)

20–21 February 2018
Nairobi, Kenya

What's in this meeting report

Section 1 provides an **introduction of the overall initiative**

Section 2 includes background analysis as to the **rationale for the meeting**: the need for more and different sustainable HIV financing options in an environment where donor funding is flat and countries are scaling up their HIV responses

Box 1 discusses:

- the need for integration of HIV services within scale-up of **universal health coverage (UHC)** and all its structures and systems, and
- factors regarding UHC development and implementation that are relevant for HIV programming.

Section 3 summarizes examples from **countries that are experimenting with insurance schemes** as a primary tool to achieve UHC and cover HIV.

Section 4 discusses other **financing approaches that can serve to cover current and future gaps in HIV responses**, such as many prevention services and community-based approaches to service delivery.

Section 5 lists **factors and issues to consider** when designing and implementing HIV-relevant financing mechanisms.

Section 6 presents **preliminary recommendations for processes** leading up to and beyond decision-making on HIV-relevant financing tools.

Section 7 includes **preliminary recommendations for advocacy work** aimed at improving and boosting financing for more effective and sustainable HIV responses.

Annex 1 contains **brief summaries of a series of potential approaches and tools for innovative financing for HIV responses**. This list, prepared in advance of the meeting, was intended to jumpstart discussions and provide basic background information. It does not include all the options and suggestions presented or raised at the meeting.

1. Introduction and Overview

1.1. About the overall initiative

Ensuring Efforts to Scale up, Strengthen and Sustain HIV Responses is an initiative launched in April 2017 by the Joep Lange Institute. The initiative's overall objectives are to describe challenges to meeting current HIV targets and articulate an approach for the HIV response that takes sharp aim at:

- reducing the number of new HIV infections, with a focus on key populations, adolescents and young adults;
- streamlining and improving service delivery to sustain the overall quality of treatment;
- efficiently targeting the use of resources; and
- building new and more sustainable approaches for funding.

A total of seven meetings will anchor the initiative's agenda. A comprehensive report and findings from those meetings will be launched at the International AIDS Conference in Amsterdam, July 2018. That report will be preceded and accompanied by additional work products to highlight research, communications and advocacy needs and strategies.

Three of the seven meetings are larger-scale, bringing together at least 35 participants from across a range of sectors—including government, donor, research/science, multilateral and technical agencies, and civil society. One of those three, held in September 2017, centred on the potential impact of reduced funding for HIV on countries' efforts and ability to scale up their responses and how limited resources can best be used effectively and responsibly. The second meeting, held in October 2017, considered approaches and strategies to make responses more efficient, with an emphasis on differentiated service delivery (DSD) and HIV prevention efforts for highly vulnerable populations. The 20–21 February 2018 meeting, **Leveraging current and innovative approaches to financing**, was the third larger-scale meeting.

Four additional smaller meetings further contribute to the overall process. Three of them were organized to respond to priority areas of more intensive work, as identified by participants at the first two larger meetings. Topics for these three side meetings, all of which will be held by the end of April 2018, include improving HIV incidence measurement (January 2018); developing reporting mechanisms for community-based HIV service delivery (February 2018); and primary prevention, especially from the perspective of key and vulnerable populations (April 2018). The seventh contributing meeting, held in mid-March 2018, was organized by JLI and WHO and focused on strategies and advocacy to address growing rates of HIV drug resistance.

Presentations and meeting reports from each of these meetings will be available through a dedicated page on the JLI website. Exceptions may include situations in which presenters have asked not to make their presentations publicly available for one reason or another.

2. Background and Rationale: Why Innovative Financing for HIV?

Countries are facing global and domestic pressure to scale up their HIV responses, with most using the 90-90-90 targets in the UNAIDS Fast-Track agenda as preliminary goalposts. Progress has been steady and remarkable in many places, as millions more are initiated on antiretroviral treatment (ART) every year.

But such successes mask deep-seated concerns about the quality and sustainability of most countries' HIV responses. One concern is that the targets are highly treatment-focused, with less attention and resources allocated to primary prevention. The impact of treatment on prevention is profound, but, in most places, inadequate on its own to control the epidemic. Epidemic control, however it is defined, cannot be achieved with insufficient primary prevention efforts to halt new infections. In every country, regardless of overall HIV burden, key and vulnerable populations are disproportionately at risk yet are the most difficult to reach and support with effective prevention services. A burgeoning new generation of adolescents in many high-burden countries also poses a threat to successful HIV goals, a threat that can only be addressed through increased commitments to primary prevention.

The other main concern is financial. As scale-up continues, countries are still needing to spend more every year on prevention, case identification, linkage to care and providing ever larger numbers of people with quality ART that must be taken for the rest of their lives. Yet already countries are facing significant financial constraints. Even though HIV often receives large shares of overall budgets for health, without additional funding, coupled with more effective use of that funding, it will be increasingly challenging for the global HIV response to be optimally successful or sustained.

External funding (e.g., from donors) for HIV has been mostly flat after steadily rising for more than a decade through 2008. The advent of the Sustainable Development Goals (SDGs), with their emphasis on a wider range of development financing, along with increased advocacy and attention to other development priorities such as climate change and migration, have further narrowed the space for substantial external HIV-specific funding in most countries even as they are seeking to scale up their HIV responses. Even though some \$22 billion is spent annually on HIV responses, that figure falls substantially short of the \$26 billion estimated by UNAIDS to be the global price tag per year for the achievement of the 2020 Fast-Track targets.

Some of the HIV financing gap from donors' retrenchment and refocusing is being filled by domestic sources (e.g., from government budgets), which currently account for more than 50% of HIV programming costs across low- and middle-income countries. Expanded domestic responsibility is supported by most advocates and technical partners in the belief that such funding is the most sustainable longer-term source.

However, although some countries have made significant progress toward domestically financing much of their HIV responses (e.g., South Africa), many others continue to rely heavily on external funding from sources such as the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Some are currently unable or unwilling to allocate more substantial domestic resources or to identify other sources to cover reductions in donor support. And, in far too many places, domestic funding—no matter how substantial—fails to support services for key populations.

The global commitment to reach universal health coverage (UHC) goals provides both opportunities and challenges for the global HIV response. Integrating HIV services within comprehensive approaches to health services can make for better and more efficient HIV health outcomes. And many of the lessons learned through development and scale up of HIV prevention, treatment and care service could serve to improve other areas of health care and social service provision. However, as UHC policies are implemented, it will be important to ensure that the uniqueness of the HIV response is not lost and that resources to sustain that response remain available.

Looking beyond donor support and other traditional financing sources

Other financing options and opportunities therefore are receiving greater attention and consideration among policy makers, donors and health and finance ministries. Some approaches are based on tapping more extensively into sources that currently comprise smaller shares of HIV financing (e.g., the private sector), while others rely on a range of tools and approaches to leverage more money for HIV responses that are loosely categorized as innovative financing. Some are a combination of both.

Annex 1 includes descriptions about numerous approaches that are considered examples of innovative financing. Such approaches to financing can serve to allocate risk and burden more effectively. Innovative financing approaches also can provide incentives by encouraging certain types of behaviours—which in the case of HIV might include increased uptake of testing, more consistent condom use, and other such changes that can mitigate the impact of the epidemic. And innovative financing approaches seek to support the development of effective service delivery models which can then be scaled up for broader use.

The broad area of innovative financing runs the gamut from smaller, targeted, discrete interventions (e.g., voucher programmes for one highly vulnerable population such as adolescent girls) to large scale national insurance schemes that aim to cover a core set of health costs for most or all the population, including people living with HIV. Whether large or small, all options utilized will be context-specific: Each country—and often each sub-national unit—has different needs, expectations and priorities. In considering any of these mechanisms, it is important that their application be evidenced-based, tailored to best meet the needs and conditions of the problem to be solved, and that efficiency is prioritized in an effort to use limited funds more effectively.

Box 1. Safeguarding and improving HIV services within UHC

The SDGs galvanized momentum toward universal health coverage (UHC), with countries around the world now committed to its achievement and implementing a range of approaches aimed at doing so. HIV care needs to be integrated within UHC scale-up and all structures and systems. Well-designed UHC platforms could greatly benefit people living with and affected by HIV. But for that to be the case, such platforms must include and reflect core principles of the most effective, acceptable and sustainable HIV responses, including full inclusion ('leaving no one behind'), human rights, transparency and accountability, and the open, accepted and adequately resourced engagement of non-state actors such as civil society groups and communities. Many of these principles are reflected in the UHC2030 global compact, a multistakeholder platform that is promoting political commitment to UHC.¹

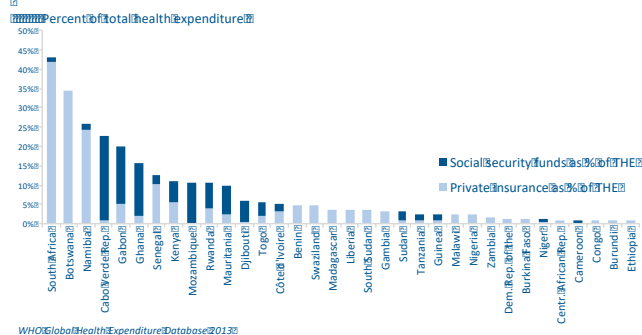
Such 'lessons learned' from HIV responses underscore how and why the expertise and experience developed over the years in HIV responses can strengthen and help to guide the implementation, expansion and improvement of UHC. The reliance is two-way in a more integrated development world: **progress in HIV cannot be achieved without UHC, and UHC efforts will fail if frameworks do not include the HIV response.** All components of HIV responses, including whatever kind of innovative financing options are used, therefore should fit within and be integrated into and embedded within UHC structures to the fullest extent possible.

The following are some observations about UHC that are of relevance to HIV programming:

- **Out-of-pocket (OOP) expenses** for health services remain extremely high in some countries that have moved toward UHC. This has the effect of limiting the benefits and access, especially among the poorest and most vulnerable.

High out-of-pocket & low prepaid care

Only 5.5% of total health expenditure in Africa is financed through health insurance



WHO Global Health Expenditure Database 2013

PHARMACCESS GROUP

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- Due to considerations about financial expense and stability, **some UHC initiatives (e.g., national insurance schemes) might not cover some or many important HIV services**, including ART provision. Addressing such gaps with realistic, costed plans that look to the long term is necessary to avoid major problems as donors withdraw or are otherwise unwilling to support such components of HIV and health responses.
- Numerous options exist to pay for UHC. With few exceptions, **most countries will have to do it themselves with domestic resources**—such as direct budget allocations, specialized levies (e.g., 'sin' taxes on tobacco or alcohol), or insurance schemes that require participants to pay premiums.

- Inclusion in UHC is sometimes constrained by what is politically palatable. This can mean, for example, that **governments are not willing to pay for or subsidize services for socially and politically marginalized groups such as HIV key populations**. Existing and additional donors (external or internal) might need to be used strategically to support services for these populations as HIV is integrated into UHC efforts.
- Civil society organisations (CSOs) have long been best placed to provide the highest-quality and most acceptable services in certain areas of responses to HIV and other health priorities (including TB). UHC services and platforms that do not involve CSOs therefore by nature have serious shortcomings. Policies should be in place that **allow and clarify government transfer of funds to civil society** (e.g., social contracting mechanisms) as part of comprehensive UHC provision.
- Primary HIV prevention remains an essential component of any HIV response. However, prevention interventions are often provided outside of health systems, making it difficult to include coverage of prevention within health insurance schemes.

3. Country Examples: Efforts to Provide UHC and HIV Services through Insurance Schemes

Some countries have been experimenting with a range of financing options for HIV that have reduced, or expect to eventually reduce, reliance on donors and other external resources. The innovations around financing at country level are often home-grown and tend to reflect context-relevant opportunities and challenges. This increases the likelihood that they will succeed over time because local stakeholders are more invested in them than what might be imposed or imported from abroad, such as global institutions bringing mechanisms to countries.

Interest and attention are increasing as governments prioritize UHC. Insurance schemes are one area in which several countries have sought to move closer to achieving UHC. What can and has been done regarding HIV services depends on factors including epidemiological burden, income and other economic conditions, and political will and support.

The following summaries are examples provided at the meeting of what is happening at country level at the nexus of insurance, UHC and HIV. As is evident, many of the ambitious efforts have encountered challenges associated with insurance schemes' structural and financial stability and expansion of coverage, with HIV services proving to be particularly difficult to support directly. The good news is that UHC-focused efforts have already begun and that policy makers recognize the gaps that must be addressed for HIV to be included and integrated moving forward.

Kenya is an HIV high-burden country that currently relies on donors for much of its HIV response. Increased and sustainable domestic HIV financing is a longstanding priority, with various options being considered alone or in combination since 2010. Direct government funding has been assessed by the National AIDS Control Council (NACC) as the simplest and

¹¹ More information about UHC2030 is available at www.uhc2030.org.

most feasible option, but ensuring sufficient financing in this way remains a challenge, given many competing priorities for limited funds. Other options have been assessed by NACC as more likely to have ‘moderate’ impact overall, including health bonds, a tobacco levy, and a dedicated HIV fund. Proposals for an HIV fund have been met with demands by some politicians and policy makers to include non-communicable diseases (NCDs) and call it by a different name. The experience to date shows how difficult and complicated it can be economically and politically to agree on HIV financing tools: Eight years after serious discussions began, no targeted model has yet been implemented.

Kenya’s main health insurance scheme, the National Hospital Insurance Fund (NHIF), is domestically designed and operated. Funded through a government subsidy and member premiums, it is mandatory for all in formal employment (including government employees). It is voluntary for Kenyans in non-formal employment. Significant scale-up of the NHIF over the past two years has resulted in it covering about 25% of the population. Much of the recent surge in participation reportedly is due to people joining voluntarily after the scheme started covering some NCDs, including some cancer treatments. (Complementary insurance is available through the private sector, and it is often used to pay for health services above the standard rate the NHIF will pay.)

The decision to include NCDs holds great promise yet also many risks due to the rising trajectory for NCDs in the country. The biggest risk is that the scheme will go bankrupt. For this reason, focusing on prevention and early screening is considered vital.

The NHIF currently does not cover HIV, largely because it is still covered mostly by donors. Covering HIV services through the national scheme has been considered, including by policy makers at NHIF, but it would be a huge, expensive and complicated undertaking.

Two other countries, Ghana and Senegal, have been seeking to expand, enhance and improve national insurance schemes as a cornerstone of their UHC efforts. Both countries have relatively low HIV burdens compared with Kenya. To some extent, this should make it easier to integrate HIV into broader health programming and systems. But as experiences from these countries suggest, building up strong insurance schemes that can accommodate a wide range of members and health conditions has many barriers and unexpected complications.

Senegal has had a basic national insurance scheme for several years, with significant expansion efforts beginning in 2012, before UHC was a consideration. The government in November 2017 finalized a National Health Financing Strategy (NHFS) to guide progress to UHC. The NHFS has a series of strategic guidelines and ‘action lines’ that include increased mobilization of financial resources towards UHC and reducing barriers for all Senegalese to participate in insurance schemes. The national scheme currently has a minimum package that, among other things, allows some people to get free access to services—including pregnant women and people older than 60. What is included in the minimum package has long been a concern as too much ‘generosity’ is seen as having the potential of bankrupting and destabilizing the system.

One major obstacle is OOP payments, which currently account for more than 50% of all health spending in the country. This is a consideration for people living with HIV who receive medical coverage through the CMV+ health insurance initiative. CMV+ is a special, targeted initiative that has aims to support people living with HIV. One of the initiative’s main objectives is to enable them to obtain health insurance. A supportive component focuses on reducing the direct

private expenditure of people living with HIV on access to care by providing subsidies for services not covered or only partially covered by health insurance.

More than 1,000 people living with HIV (along with some 2,300 beneficiaries including their spouses and families) reportedly had joined the overall health scheme by early 2018, a development that signals commitment by the scheme's administrators to provide comprehensive coverage for them in the context of UHC.

Despite such targeted efforts to support people living with HIV, along with many other countries Senegal's overall efforts to achieve UHC are facing resource challenges associated with provision of HIV treatment, care and support.

Ghana was the first sub-Saharan Africa state to introduce a national health insurance scheme, in 2003. It is now considered a core plank in the effort to achieve UHC. It currently is funded by a combination of earmarked value-added tax (VAT) revenues; contributions from formal sector workers through a social insurance contribution; payment of premiums; and some donor funds. About 40% of Ghanaians currently are enrolled. Supplementary insurance is available to be purchased by those on the national health insurance scheme who access services from the private sector.

Participation in the scheme is mandatory, but poor enforcement of this requirement has been one of the many challenges to the system. The scheme has operated at or near a deficit for years due to administrative obstacles such as this one and the fact that the informal sector comprises such a large share of the population.

The current package of interventions in the national insurance scheme is fairly basic, covering some common conditions such as malaria and diarrheal diseases. NCDs such as cancer are not covered. HIV medications also are not covered, but the government remains focused on trying to find ways to cover HIV costs when donor funding declines. Discussions to date have included 'sin' taxes, increased premiums, and government earmarking. In general, Ghana aims to prioritize integrated approaches and systems so that whatever new and additional health financing is found will cover a wide burden. No parallel systems currently are being implemented, such as for Global Fund programming for HIV.

Several countries in South East Asia also have national health insurance schemes of varying depth and scope, many of which are intended to deliver UHC. How and whether they cover HIV services also varies:

- **Indonesia's** scheme is compulsory and covers basic services for everyone. Some HIV-related services are covered, including HIV testing and counselling and treatment for opportunistic infections and sexually transmitted infections. HIV treatment is not covered, however, because of its expense; instead, it is subsidized by the government and donors.
- **Thailand** has three main insurance schemes, including one for government employees, one for the private sector, and one under the auspices of the National Health Insurance Office (NHSO). HIV treatment and other services are subsidized by the government through a separate scheme altogether.
- In the **Philippines**, all HIV services except testing are supported through insurance schemes. Specialized testing services operate separately, typically offering services free

of charge, and are funded by donors. The Philippine Health Insurance Corporation (PhilHealth), the main national insurance provider, offers a specialized HIV package for a set fee. It covers treatment, diagnostic tests and provider visits. The continued existence of some separate, vertical mechanisms such as this in the overall health system causes complications due to different reporting mechanisms and budget codes that are not aligned. Separating out HIV this way is also viewed as stigmatizing by some observers, including members of some key populations who are concerned about having any of their identifying information associated with separate schemes.

Additional challenges and lessons learned across all country examples

Some challenges and obstacles are noted in the country-specific examples above. They are some of the lessons learned that are relevant to one or more of these countries and others that have experience in implementing UHC schemes or are considering how to do so. Each of the following observations should be considered when efforts are made to integrate and sustain HIV services. Donors and technical partners seeking to support country efforts in UHC and HIV financing should also pay attention to issues such as the following:

- When mandatory insurance schemes are put in place without adequate enforcement in registration, enrolment and renewal, large numbers of beneficiaries do not renew, often because they do not fully understand how health insurance works. Such trends can gravely weaken the financial stability of a scheme.
- Insurance schemes can have unexpectedly high administration costs.
- Governments will continue to need to spend high levels of resources on health systems even when extensive and growing insurance schemes are operating. That is because governments continue to be directly responsible for developing and maintaining infrastructure, paying salaries, purchasing supplies and equipment, etc.
- Financial stability of schemes can be threatened by overambitious packages of services, especially before strong systems are in place or sufficient analysis (including actuarial) has been undertaken to determine optimal coverage parameters.
- Mismatches between national budget codes and those for financing institutions can complicate reporting and reduce overall efficiency. This is an important consideration as countries transition various HIV and other services to domestic financing.
- National health insurance schemes are often highly ambitious, but their coverage levels typically have a ceiling that excludes a large share of the population. The national schemes in Ghana, Kenya and Senegal all cover less than 50% of their populations. Further expansion will be challenging because of the large informal sectors in each country. 'Formalizing' them in the sense of including them as contributing members of insurance schemes is a complicated, difficult task. Supplementary and complementary options might need to be used for UHC to be achieved.
- As noted in Box 1 above, reducing individuals' and households' OOP spending on health care is essential for UHC to have the desired effect of dramatically boosting uptake and access to health services by all in need. Insurance schemes can help to a certain extent for many people, but restrictions on standard packages of services make it necessary for

clients to sometimes rely on the open market—where fees can quickly eat up income and savings.

Box 2. Mobile health wallets: innovative technological solution with financial benefits

Harnessing the power and vast reach of mobile technology has the potential to transform insurance coverage and health care access overall, including for people living with HIV.

Mobile health wallets, for example, are a method that provides people with a basic health contract. By relying solely on smartphones, they aim to reduce transaction costs and improve linkages among clients, providers and payers. This approach is seen as being highly acceptable and accessible in places such as parts of Africa with high uptake of and confidence in mobile payment and money-transferring systems such as M-Pesa.

A demonstration project in Kenya has included some 50,000 people to date, all of whom pay a small fee, essentially a premium, to participate. Participants are connected to a care pool through a provider, which can make payments for health services through the system, automatically. Clients can take their phones to a clinic and immediately know which basic package to which they are entitled. One account can provide coverage for several family members as funds are easily transferred from person to person. Multiple ‘donors’, including the client, can contribute to the account.

The initiative also is part of a pioneering trend toward monetizing data. Exchange of data can be a new currency. By accessing data through the mobile health wallets, the quality and effectiveness of health services, including specific site performance, can be easily monitored, as can individual patient use of and outcomes from health services. The data about clients’ health in general, as well as their health-seeking behaviours and preferences, are highly valuable for companies seeking to better target and tailor their products and services. Payments from these companies for such data—gathered and presented with appropriate confidentiality and privacy considerations—can help to reduce costs across health infrastructure, including for individual clients and systems, as well as further research leading to more efficient care and improved health outcomes.

4. Selected Entry Points: Possible Financing Tools for Communities and Other Stakeholders

Insurance schemes alone are insufficient in creating demand for and providing access to services and information that benefit health outcomes. A range of innovative financing tools hold promise in addressing HIV and other health needs.

The tools described in Annex 1 can help to improve the quality, efficiency and scope of HIV responses. For example, some countries have sufficient fiscal space and rigour—and reasonable risk profiles—to take out **loans** for targeted health purposes, such as India’s signing credit agreements worth hundreds of millions of dollars to support its TB diagnosis and treatment efforts.

For insurance-strengthening purposes in particular, **risk pool** development can be useful, depending on the context. People living with HIV and other high-cost conditions could be

covered separately from the general insured population with specialized funds, thereby easing pressure on the main insurance scheme. Risk pools of this sort are likely to be most useful in countries with relatively high HIV burdens.

Pay-for-performance models tie funding to achieving agreed-upon clear and measurable results. Such models could prove particularly useful in paying for primary prevention interventions and programmes and for services provided through community systems (many of which are prevention-oriented). Many of these activities may not be specific health services, but are necessary to improve health outcomes. They include efforts to change behaviour, provide social support, increase demand for and sustained engagement in health services, and address social determinants that impact health. In addition to contributing to improved HIV responses and the better health and well-being of vulnerable individuals, greater support for and expansion of such primary prevention activities can help to stabilize insurance schemes because they would contribute to making catastrophic events rarer.

In most pay-for-performance instruments, the parties—those paying for the services and those providing the services—agree to a funding amount and a set of indicators and results. (Both the payee and payor could be from any sector—public at any government level, private, civil society, donor, etc.) Payments are not made upfront, as in grants; instead, they are only released after results are achieved. This model can also be combined with a **social impact bond** or other source of upfront payment from a third party that would allow providers with funding up front to perform their activities. The third party would receive a return on their investment when the agreed-upon results are met.

These approaches can be used to provide **incentives** affecting individual behaviour or practice, such as rewarding people who test regularly for HIV (e.g., once every six months). Research looking at the value of such incentives in HIV prevention and treatment has shown mixed results. Pay-for-performance models can also be used to incentivize a government program. For example, a donor or health ministry could offer performance-based funding to local governments to reduce HIV incidence by a given amount over a given period. The arrangement would not have to specify how the local entity achieves the goal. This would allow each local government involved in the funding scheme to develop a package of services based on its specific needs and context.

Some pay-for-performance instruments are versions of **social contracting**, which refers to formal arrangements for a government to transfer public funds to civil society implementers for targeted interventions such as key population services and community-based work among adolescents and young people. Social contracting agreements typically are results-based relationships in that they include targets and indicators. Some, though, provide for all or part of the payment upfront, which can be essential for many community and civil society groups that operate on shoestrings and would find it hard to pay salaries and deliver services even with the eventual possibility of payment later down the line.

Vouchers could be another method in a focus on community-based services (especially for prevention) among key and vulnerable populations. They could be used when members of these populations experience financial barriers that prevent them from access to a full range of support services and information they might need. For a relatively small amount of money value, vouchers could have substantial impact in places where OOP payments are high and/or are the primary mode of health funding.

The highly specific nature of some proposed financing options for community-based services underscores the potential ability to adapt and mix-and-match from a large overall menu. A **sustainability bridge fund**, for example, could focus on financing to provide time-bound grants for civil society in countries about to transition from, or which are no longer eligible for, Global Fund support. The funding could be restricted for activities for which no funding exists, such as community-based and civil society advocacy. Such a mechanism could be performance-based, which among other things could help to demonstrate the effectiveness of community-based services for key populations.

Taxation is, of course, one clear way to raise funds at the scale and consistency to be transformative. However, increased taxation targeting health needs depends on trends in tax revenue and other considerations such as competing demands and influences that are often highly political and outside the realm of Health Ministry decision-making. Zimbabwe is one example of a country that has implemented a specific tax to cover HIV-related health costs. However, the revenue from this tax provides only a small portion of the overall resource needs.

Box 2. Successful shift to government funding for key population prevention services: example from Macedonia

In Macedonia, the Global Fund withdrew support in 2017 support that had provided the primary source of funding for HIV prevention and advocacy work by key populations and communities. While the HIV epidemic in Macedonia is small, advocates were concerned that the withdrawal of prevention services from communities at higher-risk of HIV infection would lead to a rise in transmission. While Macedonia continued to be directly responsible for ART provision, there was reluctance to cover costs for prevention services among key populations. The stated reasons for this included that many such populations are criminalized and an alleged lack of evidence of value and effectiveness. (It should be noted that unlike many other countries in its region, Macedonia supports opioid substitution therapy directly from government funds.) A group of community advocates used strong analysis and evidence to convince the government to agree to cover community groups' HIV prevention and advocacy work.

The process to convince the government to cover advocacy and other such community-provided services included several steps, starting with a continuous multi-stakeholder discussion about sustainability three years before the Global Fund left. Coordinated civil society efforts included the formation of a civil society platform and the drafting of a strategy for what would constitute successful transition. Key advocacy activities were direct work with the Ministry of Health and Parliament, which included arranging a study visit for officials to Croatia. The advocates studied the budget cycle and developed extensive and accurate information about service delivery costs.

A political crisis delayed success, but ultimately the Ministry of Health agreed on a substantial allocation of funds for KP-specific advocacy and prevention services in the 2018 budget. The first group of civil society organizations received funds for activities for the last quarter of 2017.

5. One Size Does Not Fit All: The Importance of Context and other Considerations

Different contexts will require different solutions, approaches and ideas to finance HIV services. Identifying the most valuable financing tools and models, whether deemed 'innovative' or not,

requires tailoring any such mechanism to the context. Especially important upfront is clear understanding among all involved as to the main objectives, including the scale and scope of the financing effort. Objectives might include, for example:

- increasing resources for community-based service delivery so it can be scaled up to improve HIV prevention, testing, linkage to care, and adherence support;
- mobilizing resources (especially domestic) in transitioning countries before or as the Global Fund departs to help ensure sufficient and sustained funding for key populations;
- leveraging HIV funding to advance UHC goals, which might include increasing basic health coverage and expanding into the informal as well as formal sectors; and
- leveraging HIV funding to improve the availability and effectiveness of evidence-based, context-relevant primary HIV prevention interventions, especially in high-burden, generalized epidemic countries.
- increasing efforts to address social determinants that affect health outcomes, such as keeping girls in school, providing legal services, housing and nutritional support.

In determining what mechanisms are most appropriate for their respective country and epidemic context, Among the factors governments, donors, technical agencies and others should consider such factors as are:

- country income level (e.g., low-income, lower-middle income, middle-income, etc., as designation directly affects eligibility for external donor support);
- extent and share of external funding for HIV (e.g., from the Global Fund and PEPFAR);
- HIV burden (e.g., overall prevalence, prevalence among key populations and highly vulnerable groups such as adolescent girls and young women, incidence overall and among targeted groups);
- political will, including whether governments are able and willing to allocate public resources to programmes for key populations and others (including in transition environments);
- the strength and capacity of health systems, civil society and communities; and
- legal, social and cultural obstacles such as criminalizing environments for some key populations and restrictive rights and access for women.

Additional considerations are summarized below.

For every funding model used, there should be clear, realistic ways to **monitor output and outcomes** on the ground. Monitoring can be especially difficult in areas such as prevention interventions. In such challenging situations, a range of results indicators can serve as proxies to measure progress (e.g., trends in HIV tests and new treatment initiations).

Decentralized approaches (e.g., implementing tools at subnational level) can have greater impact in trying to reach geographic and population 'hot spots'. Local stakeholders from government, civil society and other sectors are more likely to have the necessary awareness and ability to direct efforts more effectively.

HIV may be seen by some influential government entities (e.g., finance ministries) as receiving disproportionate funding compared with other areas of need, and thus they may balk at requests for more. This underscores the importance of **stressing efficiency and impacts of HIV-associated services across other sectors** such as education.

The **priorities of key financing sources** (e.g., the World Bank, local governments, the Global Fund, bilateral donors and CSOs) will guide whether and how they might be willing to provide assistance through mechanisms such as bridge financing.

Size and simplicity matter. Transaction costs, including those associated with development and implementation, could be too high to rationalize when tools are complicated and/or require disproportionate time and energy in relation to their size or expected impact. A comprehensive initiative with a bigger upfront investment might be more efficient to implement than piecemeal, complex mechanisms.

For many potential innovative financing tools and approaches, **analysis of the fiscal space and budget processes** is critical before proceeding. For example, it is important to determine whether a country is not too heavily indebted before committing to loans.

Phasing in over time can make more sense, and be more sustainable, than trying to do too much at once. As some lessons learned have indicated, such a process seems wise with insurance schemes in many contexts. One downside could be that certain HIV services are not covered by schemes while they grow and stabilize by offering a core package of services. Coverage can widen more easily and sustainably the larger the overall risk pool is, which underscores an advantage of waiting a bit until the insurance scheme has matured and can absorb the increased costs for chronic illnesses like HIV. Donors or other financing sources might need to be found to cover the excluded HIV services during phase-in periods.

Tools that seek to engage civil society engagement should be a priority, given the sector's critical role in prevention programming and service provision among key and vulnerable populations. Social contracting is one mechanism that might help to move funding from governments to civil society for targeted interventions. For trust to be established and ensured, especially on the government side, accountability provisions should be in place that allow more opportunities to show evidence of CSOs' impact.

6. Smoothing the Way to Future Financing: Some Preliminary Process Recommendations

Countries and their partners are facing increasingly urgent needs to identify financing sources for their HIV responses as they scale up treatment in an environment of declining targeted donor support. As this document indicates, many likely approaches and mechanisms that cover HIV services and support will be included within UHC efforts more broadly. Others, though, will aim more specifically at HIV—although, like all others, these should be conceptualized as contributing to UHC. Although UHC is often conceived as a set of mechanisms to improve access to and use of health systems, improving health outcomes entails activities that often live outside of health systems. The HIV response provides a clear example of how community systems, legal systems, education systems and social support systems play essential roles in preventing the spread of infection, improving the quality of life, and ensuring continued engagement in health care.

Listed below are some preliminary recommendations for processes leading up to and beyond decision-making on innovative financing tools and other ways to leverage resources for HIV responses.

Let countries lead. Governments and other local stakeholders (e.g., civil society and communities) have made impressive headway toward UHC. Many are actively considering how

to integrate HIV within insurance schemes and other initiatives that are advancing UHC. Donors and other external partners, including UNAIDS and other technical agencies, should modify what they do, and how they do it, to support the financing tools already being implemented locally.

Emphasize and support South-South cooperation and learning. The extensive and impressive work at local levels around the world is often poorly recognized or highlighted. There is much that other countries can learn from their counterparts' experiences in designing and implementing a range of financing mechanisms that aim to expand and sustain HIV responses.

There is space for valuable lessons both negative and positive, and from countries with small, concentrated epidemics as well as those with, large generalized ones. In Macedonia, for example, as discussed in Section 4, civil society advocates used strong analysis and evidence to convince the government to agree to cover community groups' HIV prevention and advocacy work. In Kenya, the struggles to identify ways to finance and cover huge epidemics of HIV and NCDs in insurance schemes are highly instructive, as are policy makers' and advocates' determination to find solutions.

Stress the point that UHC targets cannot be achieved without covering HIV. This is an undeniable fact not only in higher-burden countries. In countries with concentrated HIV epidemics, for example, the most vulnerable and hard-to-reach individuals for HIV services (e.g., key and marginalized populations) are also the most difficult and hard-to-reach for UHC—and often for the same reasons. Insurance schemes and other UHC-enhancing mechanisms must be inclusive of HIV for the final targets to eventually be met.

Leverage budget resources in other sectors that can benefit HIV responses. Education budgets, for example, might include funding for comprehensive sexual education (CSE). Such programmes are central to efforts to raise awareness of and testing for HIV among adolescents. Government personnel working in HIV programmes as well as advocates should push for and support such initiatives.

Identify strategies and mechanisms to directly support the 'infrastructure for prevention' that often lives outside UHC-focused mechanisms. Insurance is highly facility-based, and almost exclusively about treatment. (The basis for insurance is to support people who are ill and go to facilities, etc.) Much of the important HIV work is not based on insurance, however, including community outreach and support, prevention, rights-based advocacy, and watchdogging. No progress can be made on HIV, with or without UHC platforms in place, unless there is sufficient money for prevention and other key non-treatment services upfront. Supporting a robust 'infrastructure for prevention' will require integrating non-state actors in ways that allow them to grow while retaining the independent, separate qualities that make them effective.

Do not ignore social determinants of health. Many policy makers at country have been considering the social determinants of health when designing UHC platforms and strategies. Such a focus has included extensive analysis and attempts to measure the impact of such determinants and to identify the most effective and efficient ways to address them in the interests of overall health improvements. This strategy, though it may seem to introduce complications, is important from the perspective of further integrating development areas to consider the overall health and well-being of individuals. The lives of people living with and affected by HIV benefit from reduced malnutrition, cleaner water, improved income-generating

opportunities, and strong human rights protections. Such improvements also lower risk, thereby contributing to HIV prevention efforts.

7. Advocacy Recommendations

The consultation concluded with a brief session in which attendees offered some preliminary recommendations for advocacy work aimed at improving and boosting financing for more effective HIV responses. The recommendations were a mix of specific and general, and were not prioritized or discussed in detail. Listed below is a summary of suggestions, grouped into two categories: recommendations primarily or only for civil society, and primarily or exclusively for other stakeholders (government, multilateral institutions, etc.):

For civil society

Gather and highlight evidence showing economic value of civil society and communities in HIV responses. A better investment case is needed to document examples of where, how and why the sector efficiently and effectively uses financial resources to advance vital treatment and prevention efforts. Civil society stakeholders must do a better job of articulating the value of services, including specific success stories.

Develop an advocacy agenda to ensure HIV is fully reflected and integrated into UHC structures and models. This would include, for example, undertaking advocacy aimed at ensuring that governments 'own' the issue of HIV and ensure it is at the centre of any programmes and plans related to UHC. Among the many reasons this is important is that it can help civil society identify gaps that might require engaging with the Global Fund or other funding sources to address.

Advocates can often benefit from a better understanding of government budgeting processes. Advocates can only provide meaningful engagement in budgeting processes if they possess a keen sense of how budget negotiations are conducted and understand how to read and analyse budgets, how to ensure that costs are accurately determined, and how to track spending.

For other stakeholders

Make a better effort to identify and highlight some of the innovative efforts underway in countries to fund HIV services. The actions and approaches taken in countries such as Ghana, Kenya, Senegal and Southeast Asia—all noted in this meeting—deserve greater attention, recognition and support from global institutions and partners.

Clear documentation is needed on return on investment for what governments and global institutions are doing vis-à-vis financing HIV responses. This could include mechanisms considered innovative as well as more traditional ones. Findings as to investment returns then should be communicated as extensively and strategically as possible.

Standards and policies should be firmly in place that stress coordination and integration as countries move toward UHC. This is important from an HIV perspective to ensure that there is no 'battle' between advocates of UHC and those focused on specific diseases.

Funders of performance-based financing (e.g., pay-for-performance schemes) should ***encourage or even stipulate that implementing entities, especially at the subnational***

level, take the lead in designing all relevant contracts and agreements. This can help to ensure buy-in, continued engagement and success, since the arrangements are more likely to reflect what local entities believe is viable and realistic. This approach is superior to one in which decisions and structures are imposed on recipients by funders or national-level entities.

Governments should establish participatory mechanisms in budget processes. Such mechanisms should focus not only on how funds are spent, but on where revenues might be found. **Donors, meanwhile, should support the capacity of different groups, especially those from communities and civil society, to participate in budget processes.**

All **donors should establish and regularly report on disaggregated indicators** as to how much money is allocated to programmes and interventions implemented by and supporting civil society, communities and key populations.

Governments should have more decentralized approaches to HIV responses overall. This can help to improve efficiency by allowing more differentiated service delivery based on specific subnational contexts and needs.

The Global Fund should create a **separate grantmaking mechanism to fund civil society specifically** to do advocacy and monitoring at country level. Such work currently is severely underfunded. As the target of such advocacy is often the government, it is important that funding for this work remain independent. Advocacy is an essential component of a comprehensive and effective HIV response and covers several diverse areas including: addressing human rights protections, monitoring government spending and the quality of health and social services, resource mobilization, strategic transition planning, and ensuring equitable and evidence-based approaches to service delivery.

Develop a menu of innovative financing approaches for the international financing architecture that is defined by what countries have already been doing, what they are considering, and what their needs and priorities are for the short- and longer-term future. This bottom-up approach will likely improve efforts to structure a more useful and effective financial architecture overall.

To improve and expand resources that can improve HIV prevention and treatment efforts, **governments should seek to better understand, capture and respond to synergies across a range of other health and development sectors.** For example, investments and resources in HIV programming can have noticeable benefits in areas such as water and sanitation, education and the environment. The reverse is also true, as investments in such areas can significantly boost the impact of HIV responses, for example a reduction in transmission risk among adolescent girls who stay in school. Better understanding of such synergies can help governments to target budget resources and programming more efficiently across a range of health and other development areas.

Annex 1. Background Observations on Some Financing Approaches

Listed below are brief observations and summaries about some potential approaches and tools for innovative financing for HIV responses. This list, prepared in advance of the meeting and distributed to all participants, was intended to jumpstart discussions and provide some basic background information. It does not include all the options and suggestions presented or raised at the meeting.

The approaches and tools below are not listed in any priority order.

Risk pools. Risk pools reduce the premium costs of insurance by moving high-cost patients out of the general insured population into a pool financed with specialized funds. These pools could focus on high-cost patients generally, or specific high-cost conditions such as HIV. With lower premiums, more people can join the insurance scheme, thereby creating greater economies of scale and spreading risk over a larger, likely healthier population. More predictable costs, which risk pools also offer the insurance buyer, could encourage greater private sector participation.

Vouchers. Vouchers provide coverage for specific services. They target subsidies at specific populations, including those with certain conditions, and reduce the costs that need to be borne by the patient or his or her insurer. Vouchers can be provided through mobile mechanisms, which helps to broaden their reach beyond formal channels for insurance distribution. They can be conditioned on the user having basic insurance, thereby creating an incentive to pay into insurance pools. To create efficiencies, they can also be focused on providers that meet minimum quality thresholds and pre-negotiate lower rates.

Savings pools/reinsurance. Savings pools encourage people to save for health expenses, leveraging their own resources in a rational, efficient way by spreading the costs of health care over time and giving them access to a pool of quality providers at pre-negotiated rates like vouchers. They can be based on individuals or groups, for example microfinance peer lending, and some can be managed through a mobile health wallet. When combined with reinsurance, savings pools offer a path to comprehensive coverage and give savers confidence their health savings will not be insufficient to cover truly catastrophic events.

Pay-for-performance instruments. Pay-for-performance mechanisms have the benefit of giving payers (e.g., governments, donors and private-sector actors) confidence that their funds will only be deployed in the event the results they seek are achieved. This also means the payments can be deferred into the future and, ideally, be offset with savings/increased revenues from successful outcomes—e.g., reduced HIV incidence lowers costs of treatment. The fact that payments will only be made once results are achieved could convince governments and/or donors to increase their financial commitments.

Bridge financing. Bridge financing funds costs while resources are generated from other sources, such as increased growth/exports, tax revenues, cost reductions, etc. To the extent greater health coverage reduces certain costs over time, those reductions can repay the bridge financing—as could increases in tax revenues from higher growth resulting from healthier populations. Bridge financing can be paired with pay-for-performance mechanisms to create social/development impact bonds.

Taxation and tax reform. Progressive taxation with guaranteed revenues for health offers perhaps the most straightforward way to domestically finance HIV programming. It is also the

approach most likely to achieve resources on the scale needed for impact on a sustainable basis. Many countries' ability or inclination to use taxation as a transformative tool for health financing is constrained by low national tax rates, weak tax-collection systems, competing priorities and limited political will.

The approaches listed below were included in some materials provided to some, although not all, meeting participants prior to a series of working group discussions. For example, the final two items were presented only to members of a working group focusing on prevention.

Education and consultation on innovative financing mechanisms such as loan buydowns, impact bonds, pay-for-performance instruments and cash-on-delivery models. It may be the case that certain financing mechanisms will incentivize government action and private investment in HIV prevention. An inventory of these models could be brought to existing multi-stakeholder bodies providing oversight to the HIV response (e.g., advisory boards within the Ministry of Health or the national AIDS control body) to consider which ones have the most potential in the specific political, economic, and social context of the country.

Continuing donor engagement. Time-limited and targeted grants to civil society organizations to push for budget allocations for HIV and TB prevention, engage in donor transition planning and implementation and guide the development of social contracting mechanisms have the potential to ease the transition from external to state financing.

Improved incentives for family planning. It has been estimated that the existing low levels of contraception in sub-Saharan Africa have prevented approximately 173,000 births of HIV-positive infants each recent year and that provision of family planning services to those with unmet need for family planning can avert an additional 160,000 HIV-positive births every year. Rewards to HIV treatment programs for providing family planning counselling could advance that goal.

Other tools and approaches that might merit consideration:

- Programs that subsidize girls schooling, conditional or unconditional
- Programs that help couples to pre-commit to remaining HIV-negative
- Testing to sustain fertility
- Lotteries to reward remaining free of sexually transmitted disease
- Use of mobile technology