UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (37)/15.25 CRP2
Issue date: 15 October 2015

THIRTY-SEVENTH MEETING

Date: 26-28 October 2015

Venue: Executive Board Room, WHO, Geneva

Agenda item 11

Shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda: Increasing domestic funding for a comprehensive and sustained HIV response, including ensuring domestic funding that respects the GIPA principle and addressed the needs of key populations, including women and girls and other vulnerable groups, in line with national epidemiological contexts.

Country submissions

Disclaimer

This compilation of submissions is for information only. With the exception of minor corrections to grammar and spelling, the submissions within this document are presented as they were submitted, and do not, implied or otherwise, express or suggest endorsement, a relationship with or support by UNAIDS and its mandate and/or any of its Cosponsors, Member States and civil society. The content of submissions has not been independently verified. UNAIDS makes no claims, promises or guarantees about the completeness and accuracy of the contents of this document, and expressly disclaims any liability for errors and omissions in the content. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Nor does the content of the submissions necessarily represent the views of Member States, civil society, the UNAIDS Secretariat or the UNAIDS Cosponsors. The published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. UNAIDS assumes no responsibility or liability for any consequence resulting directly or indirectly from any action or inaction you take based on or made in reliance on the information and material contained in this document nor shall UNAIDS be liable for damages arising from its use. While every reasonable effort has been made to use appropriate language in this compilation, UNAIDS expressly disclaims any responsibility for inadvertent offensive or insensitive, perceived or actual, language or pictures.

Contents

Introduction

The 37th UNAIDS Programme Coordinating Board (PCB) Thematic Segment which will be held on 28 October 2015 will focus on shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda. The session will discuss the progress, challenges and opportuinties around increasing domestic funding to ensure a comprehensive and sustained HIV response. This inclues ensuring domestic funding that respects the 'Greater Involvement of People Living with HIV (GIPA)' principle whilst addressing the needs of key populations at higher risk of acquision and transmission of HV, including women and girls and other vulnerable groups, in line with country epidemiological contexts.

PCB members, countries, partner organizations and colleagues were invited to submit country level best practices on shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda.

A total of 22 submissions were received: eight from Africa, seven from Asia and the Pacific, one from Eastern Europe, and one from Latin America and the Caribbean. In addition, five submissions received cover multiple countries.

The case studies reflect the work of governments, civil society organizations, United Nations and other international agencies, as well as collaborative efforts. They offer insights and experiences from countries where programmes were financed through complementarity of funding by different sources such as Government, international financing institutions, private sector or experience on the use of insurance schemes. The case studies demonstrate how dependency on external financing has been gradually reduced and how the transition has been managed. Detailed information on remaining challenges, key recommenations, and lessons learned from country initaitves have also been included in the case studies for better understanding of sustainalbity and equity of the national HIV response.

I. Africa

1. Bénin – Initiative Béninoise d'Accès aux Antirétroviraux (IBA-ARV)

Le programme est mis en place depuis (année de début du programme)	2001
Mis en place par(cocher toutes les cases qui sont applicables)	▪ Pouvoirs publics ▪ ONU ou autre organisation intergouvernementale
Sujet de la soumission (cocher toutes les cases qui sont applicables)	▪ Part équitable entre financements nationaux et internationaux ▪ Financer les programmes de populations clés: ▪ Travailler avec les personnes vivant avec le VIH
Le programme a-t-il été évalué/estimé?	Non
Le programme fait-il partie des mises en oeuvre de la stratégie nationale de lutte contre le sida?	Oui
Le programme fait-il partie d'un plan national plus vaste que la stratégie nationale de lutte contre le sida?	Oui

Contexte

En 2001, le Bénin, pour répondre à l'objectif 6 et principalement à l'indicateur concernant la proportion de la population au stade avancé de l'infection par le VIH ayant accès à des médicaments antirétroviraux des Objectifs du Millénaire pour le Développement, a mis en place le programme dénommé « Initiative Béninoise d'Accès aux ARV » (IBAARV) entre le Ministère de la Santé Publique et le Fonds de Solidarité Thérapeutique International (FSTI). La phase pilote de l'IBAARV a alors débuté sur 3 sites à Cotonou. Toutefois, la trithérapie par les antirétroviraux a réellement démarré en février 2002.

Dans le souci de mettre le plus de patients possible sous ARV, le gouvernement béninois a décidé de rendre gratuite la prise en charge des PVVIH par les ARV dans un paquet minimum défini. Pour assurer une meilleure qualité de la prise en charge des PVVIH et sa standardisation sur toute l'étendue du territoire, un document de politiques, de normes, et de procédures pour la prise en charge des PVVIH au Bénin, a été élaboré en 2005 puis révisé en 2009 et 2014. Entre 2002 et 2014, le nombre de sites de prise en charge en ARV est passé de 3 à 86.

Approche

Le programme est à la fois spécifique, sensible et pertinent en matière de lutte contre le VIH. Il a pour objectif d´améliorer de façon générale la prise en charge des personnes vivant avec le VIH (PVVIH) au niveau des structures de soins sur toute l'étendue du territoire national. Le programme est mis en œuvre en étroite collaboration avec le Réseau des Associations Béninoises de Personnes Vivant avec le VIH, le RéBAP+. L'intérêt du programme consiste en la survie des PVVIH et dans la rupture de la chaîne de transmission lorsque les PVVIH mis sous ARV ont une charge virale indétectable.

Portée générale du programme

Aujourd'hui la prise en charge des PVVIH par les ARV se poursuit au Bénin avec un réel effort de décentralisation, d'intégration et d'amélioration de la qualité des services fournis dans ce cadre. Cet effort se traduit par l'augmentation sans cesse croissante du nombre de sites de prise en charge qui est passé, entre 2002 et 2014, de 3 sites à 86 sites répartis sur tout le territoire national dans le but de faciliter l'accès au traitement par les ARV à tous les patients. L'existence d'un engagement politique en faveur de l'accès universel au service de prise en charge par les ARV se traduit par le maintien de la politique de gratuité de la prise en charge à travers un paquet minimum incluant l'accès aux médicaments antirétroviraux et pour certaines infections opportunistes, de même que le bilan biochimique, hématologique, immunologique et virologique de suivi. Un apport nutritionnel est également accordé pour accompagner la PEC médicale. Les indications thérapeutiques, les critères d'initiation et les différentes procédures s'alignent parfaitement aux recommandations de l'OMS. Grâce à ces mesures, le nombre de bénéficiaires ne cesse de croître. Ainsi, le nombre cumulé de personnes vivant avec le VIH prises en charge par les ARV (file active de PvVIH sous ARV) est passé de 12 078 en 2008 à 28 850 en 2014 dont 1609 enfants. En 2014, 5785 personnes ont été nouvellement mises sous ARV dont 5469 adultes et 316 enfants.

Impact du programme

Un des impacts de ce programme a été la stabilisation de la prévalence du VIH dans la population générale à 1.2% de 2006 à 2012 (date de la dernière EDS). Cet impact a été mesuré par les Enquêtes Démographiques et de Santé conduites tous les 5 ans. Un autre impact important réside dans la nette amélioration de la survie à un an des PVVIH qui est passé de 89.8% en 2008 à 97.7% en 2014. Ce taux brut a été mesuré par les enquêtes de survie réalisées en 2008, 2011 et en 2014 au Bénin.

Financement et gestion

A la mise en place de ce programme, son financement était assuré à la base par le Fonds de Solidarité Thérapeutique International (FSTI) et par le budget national. En 2002, suite à la dissolution du FSTI, le relais du financement a été assuré par le Ministère des Affaires

Etrangères de la France. A partir de 2003, le financement de cette initiative a été assuré par le Fonds Mondial de Lutte contre le Sida, la Tuberculose et le Paludisme et le budget national avec le soutien du programme ESTHER (actuellement Expertise France). En 2004, ce programme a bénéficié de l'appui de l'ONG Solthis. Ces différents financements ont permis l'extension à d'autres villes du Bénin. En 2007, ce programme, qui a continué de bénéficier de l'appui du Fonds Mondial, a enregistré un nouveau financement à travers un prêt accordé par la Banque Mondiale au Bénin. En 2012, on assiste à la fin de la subvention de la Banque Mondiale et à une diminution de la contribution du Fonds Mondial à l'acquisition aux ARV. Dans le cadre de l'application de la Feuille de route sur la Responsabilité Partagée et la Solidarité Mondiale approuvée lors du 19ème Sommet de l'Union africaine qui s'est tenu à Addis Abeba en Éthiopie le 16 juillet 2012, sous la Présidence de SEM Thomas Boni Yayi, l´Etat béninois a pris la décision exemplaire de renforcer son engagement et sa contribution à la riposte à travers une augmentation des ressources du budget national pour la prise en charge des PVVIH. Ainsi ces ressources sont passées de 100 millions de francs CFA en 2011 à 750 millions de francs CFA en 2012. Entre 2012 et 2014, la contribution de l´Etat a encore doublé passant de 750 millions à 1.5 milliards de francs CFA. Cet engagement de l'Etat béninois a été récemment confirmé par un dépassement de la contribution nationale minimale requise par le Fonds Mondial dans le cadre du nouveau modèle de financement (Volonté de payer). En effet, entre 2012 et 2014, l´Etat du Benin a engagé 13 870 521 Euros pour les trois programmes (Tuberculose, Paludisme et VIH) et compte augmenter son investissement pour les trois prochaines années (2015 à 2017) avec un montant de 22 193 658 Euros soit un investissement supplémentaire de 8 323 137 Euros par rapport au seuil de 3 443 975 Euros exigé par le Fonds Mondial. Le Bénin a par ailleurs développé un document sur les mécanismes de financements innovants dans le secteur de la Santé dont la mise en œuvre prendra en compte la prise en charge du VIH/SIDA. Enfin, le Bénin est sur le point de mettre en place le Régime d'Assurance Maladie Universelle (RAMU) dans lequel la prise en charge du VIH/SIDA pourrait s'inscrire.

Leçons apprises et recommandations

Les facteurs suivants ont assuré le succès du Programme:

- L'organisation du 19ème Sommet de l'Union Africaine (UA) sur la Responsabilité Partagée et la Solidarité Mondiale à Addis Abeba le 16 juillet 2012, présidé par le Chef de l´Etat du Bénin;
- L'engagement et le leadership personnels du Chef de l'Etat;
- L´engagement des programmes nationaux;
- L'appui des partenaires bilatéraux et multilatéraux;
- L´implication de la société civile à travers le Réseau de PVVIH.

Les principaux défis sont l'enrôlement du secteur privé lucratif dans la prise en charge des PvVIH par les ARV et la mise en place d'un mécanisme d'achats de services biologiques au niveau des sites de prise en charge pour assurer un meilleur suivi biologique des PvVIH.

Le **travail qui reste à effectuer** est résumé à travers les recommandations suivantes:

- Améliorer le taux de couverture du traitement ARV des PVVIH éligibles au traitement selon les nouvelles recommandations de l´OMS et selon les 90-90-90;

- Démultiplier l´action sanitaire centrale à travers une plus grande décentralisation vers les zones sanitaires et une plus grande implication communautaire;
- Trouver les mécanismes de financements innovants essentiellement basés sur les ressources domestiques afin de garantir la pérennité de cette initiative;
- Dynamiser le comité de quantification et adopter des procédures de gestion logistiques efficaces pour éviter les ruptures de stock;
- Mettre en place des procédures allégées de passation des marchés publics pour l'acquisition des ARV afin d'éviter les ruptures de stocks.

Parmi les **leçons apprises**, la mise à l'échelle de l'initiative a eu un impact certain pour freiner la progression de l'épidémie et s'avère un moyen efficace pour mettre fin à l'infection à VIH en tant qu'épidémie d'ici à 2030 conformément à la vision de l'ONUSIDA. De plus, la Feuille de Route a créé une solidarité régionale au niveau des Etats de la CEDAO qui s´est traduite par l´appui technique et financier de l'OOAS dans le domaine de l´achat de médicaments produits localement et du renforcement des laboratoires et de la Gestion de l´Approvisionnement et des Stocks.

2. Cameroun – Programme Multilateral de lutte contre le sida

Le programme est mis en place depuis (année de début du programme)	1986
Mis en place par (cocher toutes les cases qui sont applicables)	▪ Pouvoirs publics
Sujet de la soumission (cocher toutes les cases qui sont applicables)	▪ Part équitable entre financements nationaux et internationaux
Le programme a-t-il été évalué/estimé?	Oui
Le programme fait-il partie des mises en oeuvre de la stratégie nationale de lutte contre le sida?	Oui
Le programme fait-il partie d'un plan national plus vaste que la stratégie nationale de lutte contre le sida?	Oui

Contexte

Le Cameroun est un pays d'Afrique Centrale d'une superficie de 475 650 Km², limité à l'Ouest par le Nigéria, à l'Est par la République Centrafricaine, au Sud par le Congo, le Gabon et la Guinée Equatoriale, au Nord-est par le Tchad. Avec un taux d'accroissement de 2,5%, sa population est estimée à **21 657 488** habitants, avec 51 % de femmes **au 1er janvier 2015**. La population du Cameroun est caractérisée par son extrême jeunesse ; l'âge médian en 2014 se situait entre 15 et 19 ans ce qui signifie que la moitié de la population a moins de 19 ans.

Avec une prévalence de 4,3% dans la population des 15-49 ans, l'épidémie de VIH au Cameroun est de type généralisée, avec un pic entre 35-39 ans (8,1%). Elle a une tendance à la féminisation (5,6% contre 2,9% chez les hommes) et une forte disparité entre les régions variant de 1,2% dans la région de l'Extrême Nord, à 7,2% dans la région du Sud.

En 2012, la prévalence du VIH chez les femmes enceintes était estimée à 7,8% contre 7,57% en 2009. Par ailleurs, les données de routine du dépistage en consultation prénatale indiquent un taux de séropositivité de 6,3% en 2014 contre 8,4% en 2011.

La prévalence du VIH chez les travailleuses de sexe au plan national est passée de 26,4 % en 2004, à 36,8% en 2009. En 2011, chez les HSH Yaoundé et Douala révèlent une prévalence du VIH respectivement de 44,3% et 24,2%. Cette prévalence est de 28,8% chez les HSH de moins de 25 ans et de 47,8% chez ceux de plus de 25 ans.

Pour stopper l'avancée de l'épidémie du VIH, inverser les tendances et réduire l'impact négatif les cibles prioritaires suivantes sont présentées comme principales bénéficiaires des interventions à mener : (i) les personnes vivant avec le VIH (PVVIH) ; (ii) les populations clés :

les travailleurs (es) de sexe (TS), les hommes ayant les rapports sexuels avec les hommes (HSH) et les utilisateurs de drogues ; (iii) les populations vulnérables (les jeunes et adolescents, les hommes et les femmes en tenue, les détenus, les réfugiés, les autres populations mobiles, les femmes et les femmes enceintes, les pygmées, les bororos, les OEV).

Les dépenses liées à la riposte au VIH/Sida au Cameroun ont connu une évolution croissante entre 2007 et 2009 (voir graphique ci-dessous). A partir de 2010 et ce jusqu'en 2011, les fonds alloués à la lutte contre le VIH ont connu une baisse de 30,7%, en raison du contexte économique mondial marqué par la crise économique. Malgré la persistance de la crise économique, les fonds alloués pour la lutte connaissent une augmentation depuis 2012, passant de 23,99 milliards en 2011 à 31,67 milliards en 2013, soit une hausse 32%.

Approche

Le programme est spécifique et pertinent à la lutte contre le VIH. Les objectifs finaux sont « la réduction de la mortalité et la morbidité liées au VIH, au Sida et les autres IST, et de réduire l'impact socio-économique sur le développement du pays ». L'approche est sectorielle et décentralisée. En effet, des stratégies sectorielles ont été développées dans les ministères et dans d'autres secteurs tel que les églises et autres. Par ailleurs une décentralisation de la riposte est aussi réalisée au niveau des régions. Des synergies opérationnelles sont observées entre les ministères en charge des jeunes. En effet une stratégie commune a été développée bien que des stratégies spécifiques existent dans chacune des entités. Il en est de même des ministères en charge de la promotion de la femme et de la famille sur la thématique de la PTME.

Concernant le financement on a observé une synergie positive entre l'Etat et le Secteur Privé. L'Etat, le secteur privé et les partenaires au développement ont contribué aux dépenses pour la lutte contre le VIH/sida en 2013 pour un montant total de 31 670 143 289 FCFA.
Dans le cadre de la mobilisation des ressources additionnelles, le Ministère de la Santé Publique a entrepris plusieurs actions:

- La signature de la convention MINSANTE-GICAM dont le but est de mobiliser les fonds auprès des entreprises privées pour l'achat des ARV. La première année de la mise en œuvre de cette convention a permis de mobiliser près de 67 000 USD.
- La concertation nationale pour la souténabilité du traitement ARV lancée en 2013 au Cameroun. Au décours de cette concertation, un comité interministériel a été mis sur pied pour identifier les sources de financements internes pour soutenir les programmes prioritaires (Vaccination, Sida, Tuberculose, Paludisme). Les résultats pourront permettre de mobiliser des ressources additionnelles pour combler les gaps

Portée générale du programme

La portée du programme est nationale. Les estimations et projections situent à 603 885 le nombre de PVVIH en 2013 (nouvelles infections + PVVIH maintenues en vie) avec plus de la de la moitié (56,93%) de sexe féminin. Toutes les tranches d'âges demeurent concernées par la

maladie bien que la tranche 34-39 ans est la plus touchées et celle de plus de 80 ans la moins infectée par le VIH.

Impact du programme

Après une période de stagnation entre 2008 à 2011, le taux de fréquentation en CPN connaît une croissance continue qui tend à s'accélérer chaque année. De 36,5% en 2011, le taux de fréquentation en CPN s'est amélioré au cours de ces 4 dernières années pour atteindre 69,5% en 2014, soit environ le double du taux de fréquentation observé en 2011.

La file active des PVVIH sous traitement au Cameroun connait une tendance à la hausse depuis 2005. Elle est passée de 17 156 en 2005 à 145 038 en 2014 avec une progression moyenne de 28% par an pendant 10 ans.
Entre 2013 et 2014, la file active des personnes sous ARV s'est accrue en valeur nette de 13 507 (soit une progression de 10,3%).En maintenant le niveau d'effort à celui observé en 2014, la file active se situera à 185 559 en 2017 contre 302 312 préconisé.

La mise en œuvre des activités de lutte contre le VIH/Sida tel que prévu dans le PSN prévoie un besoin en financement estimé à environ 60 000 000 000 par an. Les efforts sans cesse du Programme permet de mobiliser environ 50% de ce besoin issu des fonds de plusieurs sources de financement notamment le budget de l'Etat, le Fonds Mondial, et autres partenaires.

Financement et gestion

La coordination est centralisée par un seul organe, bien qu'il se présente sous forme d'un système avec différentes sous-entités de coordination.

Leçons apprises et recommandations

Le succès du programme est essentiellement lié à la décentralisation de la réponse au sida par le développement des stratégies de ripostes sectorielles. Sur le plan politique, il repose sur l'implication des populations clés dans la mise en oeuvre des plans nationaux.
Le principal défi est relatif à l'existence de lois qui ne sont pas favorables aux réponses VIH/Sida ciblées sur les populations clés, à la pérénité de la gratuité des traitements ARV et plus récemment au passage à l'accès presque universel des patients au TARV. Ce qu'il reste à faire c'est essentiellement assurer la qualité de la prise en charge et la continuité des traitements ARV.

Le principal apprentissage est que le traitement ARV est possible en stratégie de Test and Treat même en contexte à ressources limitées. La décentralisation est indispensable si elle responsabilise chaque secteur sur tous les plans y compris financier.

3. Kenya

3.1. Enhancing the capacity of WLHIV in family planning access and choice

Programme implementation date	2013
Implemented by	▪ Civil Society ▪ UN/other intergovernmental organizations
Scope of submission	▪ Sustainability planning (financial, programmatic, institutional and systems). ▪ Funding for civil society – Financing key population programmes: Working with people living with HIV.
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	No

Background

The AIDS epidemic is the leading threat to public health and development in Kenya. According to the 2012 Kenya AIDS Indicator Survey (KAIS 2012), an estimated 1.6 million people were living with HIV and more than 86 000 new HIV infections occurred the same year. Indeed, HIV and AIDS has lowered life expectancy, deepened poverty, reduced economic growth, exacerbated hunger and worsened basic health indicators. Clearly, sustaining progress in the HIV response is critical to the achievement of the Fast-Track vision for 2030.

The bulk of HIV funding in Kenya (about 87%) comes from external sources and the future of the national HIV response is uncertain due to changing donor priorities and continuing global financial and economic crisis. This comes at a time when the need for HIV treatment is increasing as the country shifts towards accelerating the new WHO treatment guidelines through revision of the threshold for initiating antiretroviral therapy and use of updated treatment options which result in dramatic increase in the cost of treatment coverage.

There is also a genuine concern that the HIV response may not be part of the priorities of many development partners and bilateral agencies making it important for national governments and countries, especially in the sub-Saharan Africa where the prevalence of HIV is high to develop innovative ways to raise the resources needed to prevent, diagnose and treat HIV and provide care and support to those affected by the epidemic. In order to achieve Fast-Track vision for 2030 the country will require a healthy and energetic workforce.

The Kenyan constitution provides for the highest attainable standards of healthcare including reproductive health (under article 43). People living with HIV (PLHIV), particularly women and girls of reproductive age need to be at the centre of advocacy initiatives aimed at ensuring responsive policies and programmes to reduce vertical transmission of HIV, improve the quality of the lives of mothers, babies and their partners.

In its eighth Country Programme, the United Nations Populations Fund (UNFPA) sought to support the national network of people living with HIV—the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK)—to increase uptake of reproductive health services and also to advocate for increased resources for the HIV response.

Programme approach

UNFPA supported NEPHAK to engage women living with HIV to raise awareness and consciousness about the role of family planning for the elimination of mother-to-child transmission of HIV (eMTCT). The women were allowed to engage in county dialogues with their government and county leadership, members of civil society, local and religious leaders and PLHIV to jointly identify and build consensus on the need to increase financing for HIV and health.

NEPHAK also hosted leaders from Nakuru and Kisumu counties for sensitization sessions on the eMTCT agenda to highlight the role of county leaders in ensuring budgetary allocation for responsive HIV and reproductive health, and putting in place laws and strategies to address maternal and child health (MCH) issues in their county.

NEPHAK conducted an advocacy skills workshop for PLHIV representatives from 20 counties with high HIV burden, high maternal mortality rates and low contraceptive index to enhance their capacity to engage in collaborative advocacy initiatives at county level.

Six pilot counties participated in a mentoring process to enable them engage their county governments at different levels. NEPHAK convened county dialogues on HIV and health financing between PLHIV, county leaders and other stakeholders. Additionally, sensitization meetings on HIV and MCH issues were also conducted for members of County Health Committees and Members of the County Assembly.

Programme reach

NEPHAK is a national organization with a capacity to reach all parts of the country. However, the main focus of this programme is women living with HIV in seven counties (out of the 47 counties in Kenya) where UNFPA implements its programmes. Some 30 county and national officials were also engaged and sensitized. NEPHAK leveraged on advocacy opportunities with the media and the ministry of health to engage policy makers, programmers and the general public to advance agenda of domestic financing for HIV and health.

Programme impact

The programme enabled strong partnerships within counties with increased interest of PLHIV participation in county decision making platforms, such as budgeting and accountability processes. Some counties showed positive results in terms of budget allocation and leadership commitment to champion community-led HIV campaigns.

In 2014, Nakuru County allocated 55 million Kenyan shillings (1million per ward) for the HIV response and purchased four CD4 machines stationed at Molo, Bahati, Kuresoi and Rongai district hospitals. Makueni County Constituency Development Fund (CDF) allocated 2.4 million Kenyan shillings for HIV treatment and provision of nutritional supplements. In the 2015/2016 fiscal year, four counties in Nyanza allocated resources for the HIV response in their county budgets.

More information can be found at http://www.nation.co.ke/counties/Four-counties-unite-to-create-HIV-AIDS-awareness/-/1107872/2780252/-/vtktjsz/-/index.html

Programme financing and management

The programme is managed by a team of programme officers, who are living with HIV under the oversight of a board of directors. NEPHAK receives its funding from various partners to support specific programme interventions. Supported by UNFPA, this programme enabled NEPHAK to increase its visibility and attracting more partnership.

Lessons learned and recommendations

There is an opportunity within the Kenyan devolution process to have PLHIV engage directly with their county governments for increased and sustained resource mobilisation and allocation for health. PLHIV and their communities need capacity building and support to engage in the process and achieve their goals.

Contact person: Nelson Otwoma, Executive Director, NEPHAK
Address: 75654 – 00200
Tel: +254 72 592 1768
Email: notwoma@nephak.or.ke

Dan Okoro, Programme Analyst, UNFPA
Tel: +254 72 120 3151
Email: okoro@unfpa.org

3.2. Kenya : Capacity Strengthening of Key Populations Networks

Programme implementation date	2014
Implemented by	UN/other intergovernmental organizations
Scope of submission	Financing key population programmes: Engaging key populations in the AIDS response.
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	No

Background

The national HIV prevalence in Kenya is 6% with wide variation among different populations and geographic locations. The HIV prevalence ranges from 18% among men who have sex with men (MSM) to 29% among female sex workers. The Kenya HIV and AIDS Strategic Framework (KASF) shows evidence of heightened risk of HIV acquisition and transmission among other key populations such as fishing communities, long-distance truck drivers, street children, persons with disabilities, migrant populations especially those in humanitarian crisis and mobile workers. Commercial sex workers are also considered as priority group in the national HIV response.

There is a significant challenge in reaching key populations, including sex workers, men who have sex with men and persons who inject drugs with services as their activities and behaviours are considered criminal, subjecting them to stigma and discrimination. The creation of an enabling environment is therefore critical to successful programme implementation. A two-prong advocacy approach—advocacy among stakeholders and policy makers by the National AIDS Control Council (NACC) and capacity building of sex worker networks (Kenya Sex Workers Alliance (KESWA)) for self-empowerment— has been initiated as part of this effort.

Programme approach

The programme approach is to provide integrated services to sex workers who are predominantly female. On a basis of high risk of HIV infection and acquisition of other sexually transmitted diseases, the focus of this programme has been prevention of HIV and sexually transmitted infections (STIs) with additional services, such as cervical cancer screening and provision of contraceptives. These services are provided within drop-in centres which also support clients with capacity building sessions on alternative income-generating activities.

The United Nations Populations Fund (UNFPA), through the implementing partner provides seed funds to the members to start up some businesses/projects after undergoing basic skills on entrepreneurship. The principle objective is to build the capacity of sex worker networks on

advocacy, organisational development, strategic media engagement and violence prevention. There is multi-sectoral participation involving legal and paralegal agencies, security teams as well as the media and the health sector. Each sector identified how its actions promote or hinder the efforts of the HIV response and identified areas of interest and linkages.

Programme reach

The primary focus of this programme is HIV prevention among key populations at high risk of infection and acquisition of HIV and so far has reached an estimated 2300 sex workers. Although this is a national programme, most interventions are in the coastal region (mainly Kilifi County) which has a high commercial sex work activity and where one of the organizations is based. The Kenya Sex Workers Alliance (KESWA) has members throughout the country.

Programme Impact

The impact of this programme is expected on HIV prevention, care and treatment resulting from increased service uptake. The members who benefit from funding or entrepreneurship skills will also become self-reliant or are economically empowered. Other outcomes of the various capacity building activities include greater media engagement, improved media reporting and visibility of issues surrounding key populations and improved working relationship with law enforcement agencies in Kenya. The coastal region programme with commercial sex workers is due for evaluation next month.

Programme financing and management

The national programme is managed and coordinated by the National Control Council with financial support from UNFPA. University of Manitoba and the National Control and STIs Programme (NASCOP) Technical Support Unit (TSU) provided technical support while KESWA mobilised member organisations and conducted follow up of agreed actions. The programme is sustained through institutional and technical strengthening of KESWA which cascade the trainings among its member organisations. The coastal programme is implemented by International Centre for Reproductive Health.

Lessons learned and recommendations

The enabling factors for this programme include

- Favourable policy environment facilitated by the Kenya National HIV and AIDS Strategic Framework (KASF) that identified, defined and prioritised key populations;
- Intensive public health approach to provide services based on evidence such as the Kenya Modes of Transmission Study (KMOTS 2008), Kenya AIDS Indicator Survey among others;
- Non-discriminatory advocacy process through leadership of NACC and Ministry of Health that allows for dynamic strategies to counter negative responses;

- Sensitization process without upfront confrontation of the legal structures to allow continuity of HIV programmes and counter back lash; and
- Support of partners through technical assistance and presence of KESWA in all the 47 counties.

Programme challenges

There is still some stigma associated with commercial sex work and this sometimes impede on the activities of the members. The funding base for the network is low and mainly partner/donor dependent making some of the interventions non-sustainable. Further work is required on advocacy at the counties especially those with high incidence, stigma and high HIV prevalence specifically targeting law and policy makers, including Members of County Assembly and country executives in charge of health policies. There is also a need for capacity building of KESWA to enable them involve fully in generating strategic information, for example, county specific information on key population size estimation; media engagement specifically targeting editorial staff; financial support for follow-up of activities. Linkage with some micro-finance institutions and further skills enhancement on entrepreneurship is also deemed necessary for the network.

Contact person: Dan Okoro, Programme Analyst, UNFPA
Tel: +254 72 120 3151
Email: okoro@unfpa.org

4. Maroc

4.1. Sidaction Maroc/ALCS

Le programme est mis en place depuis (année de début du programme)	2005
Mis en place par (cocher toutes les cases qui sont applicables)	▪ Société civile
Sujet de la soumission (cocher toutes les cases qui sont applicables)	▪ Financements pour la société civile
Le programme a-t-il été évalué/estimé?	
Le programme fait-il partie des mises en oeuvre de la stratégie nationale de lutte contre le sida?	Oui
Le programme fait-il partie d'un plan national plus vaste que la stratégie nationale de lutte contre le sida?	Non

Contexte

Le Maroc connait un faible taux de séroprévalence de l'infection à VIH au sein de la population générale (0,15%); toutefois, l'épidémie se caractérise par une concentration au sein de certaines populations clés ; professionnelles du sexe (PS), usagers de drogues injectables (UDI) et hommes ayant des relations sexuelles avec des hommes (HSH). Environ 70% des personnes vivant avec le VIH ne connaissent pas leur statut sérologique et la discrimination/stigmatisation reste un défi très important. Les programmes de prévention et de sensibilisation doivent donc être soutenus. En outre, le travail avec les populations clés est difficile vu le caractère illégal de leur situation. Dès lors, les programmes s'adressant à eux sont principalement financés par des financements internationaux et sont exécutés par des organisations non gouvernementales, principalement l'Association de Lutte Contre le Sida (ALCS). Ces financements ont toujours constitué une part importante du budget alloué à la réponse au VIH, notamment au niveau de la contribution du Fonds Mondial de Lutte Contre le Sida, le Paludisme et la Tuberculose dont le Maroc est bénéficiaire depuis 2003. L'initiative Sidaction Maroc de l'ALCS vient donc compléter le financement de la lutte contre le sida au Maroc.

Approche

Ce programme est spécifique à la lutte contre le VIH. Les objectifs sont de collecter des fonds pour la lutte contre le sida et de sensibiliser le public à travers une large diffusion de messages de prévention de l'infection à VIH et de lutte contre la stigmatisation des personnes vivant avec le VIH. Sous le haut patronage de sa Majesté le Roi Mohammed VI, l'ALCS, soutenue par de

nombreux partenaires, organise un appel à générosité publique, le Sidaction Maroc, une large campagne de communication médiatisée, avec comme point d'orgue une soirée télévisuelle de plus de 3 heures de direct, et une importante collecte de fonds, par l'intermédiaire de dons directs, par téléphone, par SMS ou encore de dons électroniques à travers le site web de l'ALCS. En fonction du montant de la collecte totale, une partie des fonds est utilisée pour les programmes de l'ALCS et une autre partie (entre 20 et 33%) est destinée à financer des projets d'associations marocaines partenaires dans le cadre du "Fonds d'Appui aux Structures Partenaires", fonds créé par l'ALCS et dont l'objectif est le renforcement au niveau national de la lutte contre le sida par un soutien financier de projets ayant trait à la recherche scientifique et médicale, la formation, la prévention, l'amélioration de la qualité de vie, et le soutien aux personnes vivant à VIH et/ou leurs proches. Il vise aussi à favoriser le développement, le partenariat et l'émergence d'acteurs de la lutte contre le sida au Maroc.

Portée générale du programme

La campagne Sidaction Maroc est un évènement majeur de la lutte contre le sida au Maroc. Organisée tous les deux ans, le Sidaction Maroc est une campagne nationale de sensibilisation et de collecte de fonds. La 5ème édition du Sidaction Maroc a eu lieu du 1er au 24 décembre 2014, avec une soirée télévisée, le 19 décembre 2014, en direct sur la chaîne de télévision marocaine 2M, relayée par satellite. Cette édition était axée sur les jeunes, avec pour thème «Donnons pour sauver les jeunes du sida». Les jeunes se sont mobilisés avec l'ALCS au sein même de leurs établissements scolaires en organisant des journées de sensibilisation et de collecte. L'émission a connu la participation de nombreux artistes de renommée nationale et internationale, d'animateurs et d'experts nationaux et internationaux. La soirée était composée de plateaux d'information, reportages, divertissements et témoignages de personnes vivant avec le VIH. Des reportages réalisés par les équipes de 2M ont permis de montrer les importantes actions que mènent l'ALCS et ses partenaires, et de donner la parole à des personnes vivant avec le VIH.

L'émission a été regardée par plus de 1.900.000 téléspectateurs au Maroc et à travers le monde, atteignant une part d'audience de 30.9%.

Impact du programme

La campagne médiatique a enregistré une large diffusion avec 550 passages radio, 270 passages du spot de sensibilisation et d'appels à dons, 37 articles sur 27 supports pour la presse écrite, 40 articles sur 34 sites web, plus de 10 heures d'antenne sur 8 stations de radio Télévision (hors soirée Sidaction Maroc), prés de 4 heures d'antenne sur 3 chaines. La campagne de sensibilisation a été très large et a permis de toucher un grand nombre de personnes notamment grâce à la soirée télévisée. Pour celle-ci, l'impact est mesurable, 1 900 000 personnes ont suivi l'émission. Pour le nombre de personnes sensibilisées, l'impact n'est pas mesurable, et ne peut pas être déterminé avec précision.En ce qui concerne la collecte de fonds, elle a été une réussite également, plus de 10 millions de dirhams marocains ont été récoltés, soit 1.32 million US$. Basé sur ce montant de la collecte, le Fonds d'Appui aux

Structures Partenaires a été provisionné, par l'ALCS, de 1.6 millions de dirhams, soit 0.22 million US$. Il a bénéficié à 8 associations partenaires (prévention chez les usagers de drogue, prise en charge psychosociale de PVVIH, prise en charge et prévention auprès des enfants, prévention et sensibilisation de leaders religieux).

Financement et gestion

Comment le programme fut-il géré, coordonné et financé? Comment fut la viabilité financière du projet? Qui sont les partenaires principaux?

Le Sidaction Maroc est organisé par l'équipe administrative et les volontaires de l'association de lutte contre le sida et financé par les fonds propres de l'association. Il est placé sous le Haut Patronage de Sa Majesté Le Roi Mohammed VI, de nombreuses entreprises participent directement par un don, ou indirectement par la fourniture de services gratuitement, (opérateurs téléphoniques, afficheurs, transporteurs, imprimeurs, animations de shows télévisuels gratuitement, prestation artistique gratuite, publicités…).

Qu'est-ce que cela a changé?

En plus du financement direct de plusieurs actions dans les domaines de prise en charge des personnes vivant avec VIH et la prévention de l'infection à VIH/sida, la campagne Sidaction Maroc a joué un rôle de levier pour les activités de l'ALCS en matière de lutte contre le sida. Le renforcement de l'ALCS qui a pu se faire grâce aux collectes lui a permis de se positionner en tant qu'acteur incontournable de la lutte contre le sida au Maroc, dans la région et au niveau international. Il a permis également de financer des associations et instituts de recherche, œuvrant dans la lutte contre le sida au Maroc. Ainsi l'ALCS a pu financer des dépenses que les bailleurs de fond acceptent difficilement à financer, comme des ressources humaines à plein temps (salaires ou compléments de salaires d'employés ou de prestataires), ou encore des loyers pour des locaux de prévention et de conseil et test VIH ou de maisons de repos (où les PVVIH voyageant de loin vers le centre de prise en charge médicale peuvent se reposer avant ou après leur consultation…). L'ALCS a également pu financer, à travers le Fonds d'Appui aux Structures Partenaires, un renforcement des compétences des autres ONG impliquées dans la lutte contre le sida au Maroc. Enfin, les fonds du Sidaction Maroc ont également permis à l'ALCS de renforcer ses activités en direction des populations clés, notamment dans un contexte légal et social défavorable à celles-ci.Le Sidaction Maroc contribue largement au financement des actions de l'ALCS, actions prévues dans le cadre du plan stratégique national de lutte contre le sida au Maroc.

Leçons apprises et recommandations: Quels facteurs ont permis d'assurer le succès du programme ? Cela peut comprendre les dispositions institutionnelles, l'environnement politique et législatif, la coordination, la mobilisation et l'appui politique, l'action de persuasion.

Le succès du Sidaction Maroc est possible, grâce à l'engagement politique à haut niveau traduit par le haut patronage de sa Majesté le Roi Mohammed VI, qui nous renouvèle sa confiance à

chaque édition. Nos fidèles partenaires nous accompagnent gracieusement, et ne ménagent aucun effort pour la réussite de cette opération: chaînes télé, artistes, radios, presse écrite et audio, réseaux sociaux, centre d'appels, opérateurs téléphoniques, banques, hôtels, restaurateurs, etc.

Quels furent les défis à relever?

Devant une grande stigmatisation des populations clés, le principal défi lors de la soirée télévisée a été de permettre à des personnes de témoigner à visage découvert de leurs vécus. Les défis sont également d'ordre éthique: comment assurer que l'argent récolté est bien destiné à financer des activités de lutte contre le sida conformément aux engagements pris par l'ALCS lors de l'appel à dons. A cet effet, l'ALCS a demandé à un comité d'audit, appelé "comité de garantie de la transparence", constitué d'experts financiers tiers, indépendants vis-à-vis de l'ALCS, d'auditer les comptes et les activités menées avec les fonds du Sidaction. Les conclusions de ce comité confirment que les engagements pris par l'ALCS sont scrupuleusement respectés. Par ailleurs, le choix des projets soutenus dans le cadre du Fonds d'Appui aux Structures Partenaires, bien que relevant du ressort de l'ALCS, se base sur les recommandations d'un comité d'experts, composé de militants de l'ALCS, de représentants des ONG partenaires ainsi que de représentants des agences onusiennes (ONUSIDA, OMS) et du Fonds Mondial, garantissant un traitement équitable et impartial de tous les dossiers de candidature.

Quel travail reste-t-il à effectuer?

Dans un pays, où la solidarité fait partie de la culture, il faut continuer à maintenir le degré de mobilisation, et fidéliser les donateurs existants. Il reste également à institutionnaliser le Sidaction Maroc de façon définitive.

Qu'est-ce chacun peut apprendre de ce résultat?

Un appel à générosité publique ne peut être envisagé sans la légitimité d'une association sur le plan activités, transparence, réputation et sans la volonté et le travail d'une équipe soudée et engagée. Par ailleurs, il devient vital pour les acteurs de la lutte contre le sida des pays du Sud, notamment à revenu intermédiaire comme le Maroc, de trouver des voies alternatives de financement, notamment locales, et de ne plus compter entièrement sur les financements internationaux ou sur les soutiens gouvernementaux nationaux (lorsqu'ils existent) vu la réduction des financements et les lourdes menaces de tarissement qui pèsent sur les financements internationaux des pays à revenu intermédiaire.

Contact: Himmich Hakima, Présidente, ALCS
Adresse : Rue Salim Cherkaoui, quartier des hôpitaux, Casablanca
Tél.: 05 22 22 31 13/ 14
Courriel: h.himmich@gmail.com

4.2. Maroc : Diversification des financements de la riposte au VIH/sida

Le programme est mis en place depuis (année de début du programme)	2012
Mis en place par (cocher toutes les cases qui sont applicables)	▪ Pouvoirs publics ▪ Société civile
Sujet de la soumission (cocher toutes les cases qui sont applicables)	▪ Part équitable entre financements nationaux et internationaux
Le programme a-t-il été évalué/estimé?	
Le programme fait-il partie des mises en oeuvre de la stratégie nationale de lutte contre le sida?	Oui
Le programme fait-il partie d'un plan national plus vaste que la stratégie nationale de lutte contre le sida?	Oui

Contexte

Le Maroc connait une prévalence du VIH (0,15%) avec une concentration de l'épidémie au sein des populations clés dans certaines régions. Environ 70% des personnes vivant avec le VIH ne connaissent pas leur statut sérologique et la discrimination/stigmatisation reste un défis très important. Dans le cadre du Plan stratégique national 2012-2016, plusieurs initiatives visent à renforcer le financement de la riposte.

Il s'agit notamment de l'augmentation du budget du ministère de la santé, la campagne SIDACTION pour la collecte de fonds, le financement de projet par l'Initiative Nationale pour le Développement Humain (INDH) et la fondation Mohammed V pour la solidarité ou la mise en place du Régime d'Assistance Médicale pour les économiquement démunis (RAMED).

Approche

Ce programme est spécifique à la lutte contre le VIH. L'objectif est de diversifier les sources de financement de la riposte afin de diminuer la dépendance des programmes vis-à-vis des financements internationaux et qu'une responsabilité partagée soit mise en place. Diverses synergies ont lieu entre les pouvoirs publics, la société civile, le secteur privé et les organisations internationales. En outre, les programmes de lutte contre le VIH/sida sont de plus en plus intégrés aux autres programmes, dans la lignée de la vision post-2015. De la sorte, les dépenses pour la lutte contre le VIH/sida sont intégrées à d'autres budgets et cela permet un financement durable et pérenne.

Portée générale du programme

Le programme porte sur le financement de la réponse dans l'ensemble du pays et pour l'ensemble de la population et plus particulièrement pour les populations clés. Diverses initiatives ont été prises.

Le montant alloué à la lutte contre le VIH/sida par le Ministère de la santé a été multiplié par deux au cours des cinq dernières années. La stratégie d'intégration de la lutte contre le VIH/sida a concerné les programmes nationaux de développement et de réduction de la pauvreté. L'Initiative Nationale de Développement Humain (INDH) a intégré la lutte contre le sida et la réduction des risques pour les UDI dans ses nouveaux programmes et ce, à travers l'appui à plusieurs projets de la société civile. La Fondation Mohammed V pour la solidarité a construit et équipé plusieurs centres d'accueil pour les usagers de drogues avec une composante de réduction des risques (RDR).

Dans le cadre de l'amélioration de la couverture sanitaire des populations défavorisées, Sa Majesté le Roi Mohammed VI a lancé en mars 2012, le Régime d'Assistance Médicale (RAMED) qui permet à une population économiquement démunie, estimée à 8.5 millions de personnes, de bénéficier d'une couverture médicale de base qui offrira la gratuité des soins et prestations médicales disponibles dans les hôpitaux publics, les centres de santé et les services sanitaires relevant de l'Etat. Les prestations du VIH y ont été intégrées. Les personnes vivant avec le VIH, qui répondent au critère d'éligibilité, bénéficient des cartes RAMED qui leur donnent, en plus des ARV, un accès gratuit aux autres prestations (laboratoire, médicaments etc.).

Enfin, une grande campagne de collecte de fonds « SIDACTION Maroc », est organisée tous les deux ans par l'Association de Lutte contre le Sida (ALCS). Une partie des fonds collectés est destinée à financer des projets d'associations partenaires dans le cadre du Fonds d'Appui aux Structures Partenaires.

Impact du programme

Toutes ces actions ont permis d'augmenter la contribution nationale au financement de la riposte au VIH/sida qui est passée de 10 764 313 USD pour 2007-2008 à 17 965 403 USD pour 2012-2013.

Financement et gestion

Les ONG thématiques, le ministère de la Santé, la coordination nationale de l'INDH, les compagnies d'assurances maladies et les organisations internationales ont été mobilisés dans ces différentes initiatives. Cette augmentation du financement national de la réponse au VIH/sida permettra une meilleure appropriation et durabilité des activités ainsi qu'une amélioration de la viabilité financière des projets. La stratégie d'intégration de la lutte contre le VIH/sida permettra également d'atteindre cette durabilité et viabilité.

Leçons apprises et recommandations

L’appui des pouvoirs publics ainsi que la mobilisation des différents acteurs a permis la réussite de ces initiatives. Toutefois, financer la lutte contre le VIH/sida reste un défi pour la mise en œuvre des objectifs de l’initiative accélérer « Fast Track » et la stratégie d’intégration doit être maintenue et approfondie.

Contact: Professor Abderrahmane Maaroufi, Directeur de l’épidémiologie et de lutte contre les maladies, Ministère de la santé
Adresse: 71, Avenue Ibn Sina, Agdal, Rabat, Maroc
Tél.: +212 537 67 12 71
Courriel: delmmaaroufi@gmail.com

5. Namibia – Diversified financing of Namibia HIV response for sustainability perspective

Programme implementation date	2011
Implemented by	▪ Government ▪ Civil society ▪ Private sector ▪ UN/other intergovernmental organizations
Scope of submission	▪ Fair share between domestic and international funding ▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Programmes to encourage and develop South-South, South-North and triangular cooperation ▪ Financing key population programmes – working with people living with HIV
Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

Namibia is a democratic and politically stable country since its independence in 1990. Namibia is a vast country with 824 000 km^2 with a small population of around 2.2 million. Despite the continuous economic growth and classification as an upper middle-income country by the Word Bank, the country still has a high rate of inequality and unemployment. The first case of HIV infection in Namibia was reported in 1986 and HIV incidence is estimated to have reached its peak in the late 1990s, and adult prevalence (15-49) reached its highest of an estimated 22% in 2002. Since then, HIV incidence declined sharply till 2010 to a degree of levelling off.

The country has a generalised and mature epidemic, where HIV is primarily transmitted through heterosexual and mother-to-child transmission (MTCT). According to Spectrum modelling and recent epidemiological analysis, HIV prevalence amongst people aged 15-49 years was estimated at 14% in 2013/14. Approximately 208 000 of people aged 15 and above are currently living with HIV. This figure is projected to increase to over 227 000 by 2016/17, and to more than 245 000 by 2019/20 .The expected increase in the number of people living with HIV (PLHIV) will mainly be the result of reduced AIDS-related mortality due to improved and high coverage of antiretroviral therapy (ART). The Government of Namibia has taken a decision to implement the new WHO 2013 treatment guidelines and has extended treatment to people living with HIV, particularly children below 15 years, pregnant women, and Tuberculosis and Hepatitis B patients. In addition, the ‘test and treat’ approach is being implemented in pilot sites.

The Revised National Strategic Framework for HIV and AIDS (NSF) 2010/11 – 2016/17 redefines how Namibia is going to respond to HIV and AIDS, while applying the global solidarity and shared responsibility approach. The Namibia HIV response has been well resourced over the past decade leading to significant gains and results. The Government has consistently increased the domestic resources, from 55% in 2011 to 64% in 2014, while continuously mobilising private sector and international partners, including The Global Fund, PEPFAR and UN agencies. However, the current economic environment has changed substantially with the world economy still recovering from a global crisis.

Programme approach

This programme is HIV-specific, HIV-sensitive, and HIV-relevant. The development of the 2010/11-2016/17 NSF was a broad and participatory process and Namibia is cognisant that the challenge of the epidemic transcends institutional and political boundaries. The NSF provides a comprehensive strategy for an effective management and control of the HIV epidemic and its direct impacts on the people of Namibia. The involvement of public and private sectors, regions, civil society and religious organisations, people living with HIV - in collaboration with national development partners is critical to ensure equity, availability, access and utilisation of HIV services for all. The Government upholds its commitment to basic human rights, gender equality, and the principles around partnerships and global solidarity to strengthen an enabling environment for successful delivery of HIV services.

The programme which will run until 2017 is a policy and leadership framework to guide the implementation of the national multi-sectoral HIV response in Namibia. The programme objectives are focused on reduction of new HIV infections among adults and children by 50%, elimination of mother-to-child transmission of HIV and a 50% reduction of AIDS-related deaths among all people living with HIV, particularly people with TB/HIV co-infection.

The development of the NSF was informed and guided by the National HIV and AIDS policy. The NSF is aligned to the goals and objectives of the Namibian development Vision 2030 and the Fourth National Development Plan (NDP4), the 2013 WHO Prevention and Treatment Guidelines, and the UNAIDS Treatment 2.0 Guidelines. The revised NSF has taken cognisance of Namibia’s regional and global obligations, including the African Roadmap, Abuja +12, Maseru Declaration, Millennium Development Goals (MDGs), and the 2011 Political Declaration of HIV and AIDS.

The revising of the NSF and the process of identifying national priorities and results was been informed by a mid-term review carried out in September and October 2013 which provided the evidence required for the Investment Approach. The revised NSF has adopted the Investment Approach which led to the prioritisation of the programmes with a focus on high impact interventions. Given the complexity and multi-sectoral nature of the HIV epidemic, the NSF advocates for strengthening synergies with development sectors.

At operational level, Namibia has adopted the ‘Combination Prevention Strategy’ to consolidate and harmonise the approaches and synergies between basic programmes. The implementation will be multi-sectoral and decentralised in nature. The NSF has articulated strategies for gender and human rights, which will be mainstreamed in its operations. The NSF has increasing given attention to the role of communities, community systems and structures as a strategy to improve service delivery.

Namibia is also cognisant of the declining global resources for AIDS and will adopt a number of strategies to address the resource challenges.

a) Firstly, Namibia has prioritised investing in high impact interventions. An ‘Investment Case’ is being finalised to support resource mobilisation at national level and advocacy with development partners.
b) Secondly, Namibia is conducting sustainability, financial and fiscal space analysis to improve on the efficiency and effectiveness in service delivery related to health and HIV.
c) Thirdly, HIV services will be integrated and mainstreamed in the broader health care.

These approaches are expected to contribute to efficiency gains in the short-term and sustainably of the HIV response in the long-term. The Government will make efforts to develop a sustainability strategy with increased domestic resource mobilisation opportunities.

Namibia is also implementing programmes that have not been prioritised in the NSF as part of the Health Sector Strategic Plan or similar plans, such as the National Agenda for Children. Some of the programmes are integrated in the NSF basic programmes as critical programme enablers. For example provision of PEP and treatment of STIs are considered as enablers for effective management of gender-based violence which has been prioritised in the revised NSF.

Programme reach

Namibia has been able to achieve a massive scale-up of HIV services in a short period of time by making the provision of universal access to HIV prevention, treatment, care and support services a development priority. All regions of the country are covered by the programme. An estimated 26 million condoms are distributed annually and more than 72% of women and men aged 15-49 who had more than one partner in the past 12 months reported using condom during their last sexual intercourse. A little over 38% of women and men aged 15-49 received HIV testing and counselling in the past 12 months and know their HIV status. An estimated 95% of pregnant women living with HIV received treatment to reduce the risk of mother-to-child transmission of HIV. Access to treatment has increased with 87% of women and 83% of men living with HIV currently accessing treatment free of charge. Based on the test and treat approach 54% of all people living with HIV in Namibia have access to treatment.

Programme impact

This programme has achieved significant impact, including

- New HIV infection has decreased by 50% since 2001;
- An estimated 95% of pregnant women accessed prevention of mother-to-child; transmission (PMTCT) services with reduction of the mother to child transmission from 20% in 2005 to 4% in 2014;
- Coverage of treatment increased from just 10% in 2005 to 84% in 2014;
- AIDS-related death declined by 56% from 2005 to 2014;
- Increased and sustained investment of domestic resources in the national HIV response standing at above 65% by 2014;
- Projections show that if current efforts are maintained and scaled up, new infections will further drop from 9 600 in 2013 to around 4 361 by 2017;
- A significant drop in AIDS-related deaths among children below 15 years, from 1300 in 201/11 to 120 by 2016/17, is expected

As a result of the lives of thousands of people living with HIV and communities has been transformed - and today the country is proud to say that no Namibia should die of from AIDS! An estimated 51 952 new HIV infections and 9 535 AIDS-related are expected to be averted by 2025. Life years gained during this period are estimated at 52 669.

In terms of financing, applying the global solidarity and shared responsibility approach, the Namibia HIV response is funded by diverse sources. Sustained investment of domestic resources in the national HIV response has been consistently increased from 55% in 2010 up to 64% in 2014. Other resources are provided by external partners such as The Global Fund, PEPFAR, UN and GIZ. In line with global solidarity, Namibia has also increased the contribution up to US$ 1 million during the 2013 Global Fund replenishment. The new Government is also considering contributing to UNAIDS global budget.

Programme financing and management

The National Coordination Framework (NCF) for HIV and AIDS was developed in 2010 and reviewed in 2013 to articulate commitments and outline the coordination modalities involving all stakeholders in the context of the three ones principle of *One Action Plan One Coordinating Authority, and One Monitoring and Evaluation System*. The institutional arrangements have also been informed by the Government's policy on decentralisation and emerging regional and international best practices on HIV and AIDS coordination and management – the coordination mechanisms are inclusive and decentralised. The Government has brought on board different key public sectors, civil society organizations, private sector ,UN agencies represented by UNAIDS , WHO and UNICEF and other health development partners.

According to the 2014 NASA Report, contribution from Government for the national HIV response has consistently increased for sustainability perspective:

- Domestic HIV spending increased from US$ 111 050 386 in 2012/13 fiscal year to US$ 136 620 606 in 2014, making up 55% and 64% respectively of total expenditures in both financial periods. The contribution from the Government was 50% in 2009/2010.

- Furthermore, Namibia has continued to mobilise other partners despite the international financial crisis. Bilateral spending for the fiscal year 2012/13 was US$ 72 900 158 and US$ 59 334 193 in 2013/14, making up 37% and 28% of total expenditures for both periods (total bilateral spending comprised of funds from PEPFAR and GIZ). PEPFAR's portion of the total bilateral spending amounted to US$ 71 394 683 (98%) in 2012/13 and US$ 57 658 447 (97%) in 2013/14 while GIZ spent US$ 1 505 475 (2%) and US$ 1 675 746 (3%) in 2012/13 and 2013/14 respectively.

- Multilateral sources i.e. UN agencies and The Global Fund spent US$ 14 160 067 in 2012/13 and US$ 14 426 541 in 2013/14 making up 7% and 6.7% respectively for both reporting periods. Of this total amount of multilateral spending, The Global Fund spent a total of US$ 10 495 196 (75%) to UN agencies' spending of US$ 3 664 901 (25%) in 2012/13 and in 2013/14 it was US$ 11 978 348 (83%) to UN Agencies' US$ 2 448 193 (17%).

- Private sector contribution made up for US$ 2 601 023 in 2012/13 and US$ 2 442 655 2013/14 of the total HIV expenditures – a little over 1% for both 2012/13 and 2013/14.

The implementation of the revised NSF is expected to cost approximately N$ 35 151 to avert one infection and N$ 191 526 to avert one AIDS-related death. The total cost per life year gained is estimated at N$ 34 673. These costs, except for the cost per life year gained, are lower than Namibia's 2012 GNI per capita of US$ 5 640 or N$ 56 400 (at an exchange rate of N$10 to US$1).

The per capita expenditure per year of Namibia's HIV response was estimated at around US$ 100 in 2008/9 and projected to reach up to US$ 150 during the NSF period up to 2016/17 thus amounting to an HIV spending range of 2.5 – 3.0% of GDP. This is considered high since other high prevalence countries typically report HIV spending in the range of 1.5-2.0 % of GDP. The high cost is partially explained by the primarily vertical nature of HIV programmes with limited integration into existing health services and development programmes such as primary health care, sexual and reproductive health, education, gender equality programmes etc. and therefore limited synergies and scope for cost efficiencies.

In addition to grappling with the high cost of the national response, Namibia is also facing a decrease in external funding. Over the last 5-6 years several development partners have stopped or reduced their support to Namibia's AIDS response because of Namibia's growing GDP and status as a higher middle income country and shifting funding priorities. The US Government which is the single most important donor since 2003 has begun to gradually scale back support, reducing its contribution by approximately 10% annually for the second

consecutive year. The Global Fund remains the second most important external source of funding of the national response, and while their contribution is essential, the modalities of their funding streams poses challenges for the already strained national capacity and in terms of harmonisation with national systems and the capacity to respond to emerging gaps and challenges.

The Government's commitment for a sustained funding of the HIV response in the wake of diminishing donor funds has been demonstrated by a steady increase in domestic funding and the projection is to reach 70% of the needs by 2017. An innovative public private funding partnership through mobile clinics for primary health care, HIV testing and counselling and sexual reproductive health have been able to reach populations in remote and hard to reach areas, including key populations at high risk of HIV transmission and acquisition, particularly commercial sex workers in high HIV prevalence/incidence with low cost.

Namibia has taken cognisance of the lessons (positive and negative) learned from recent reviews, including the mid-term review of the National Strategic Framework , support the idea of streamlining coordination processes, with a view to ensure value for money, enhance accountability, build synergies and avoid duplication of efforts.

Another important consideration is harmonising and aligning HIV programming with other national planning and policy frameworks, especially with regard to Namibia's Fourth National Development Plan (NDP 4) 2012/13 to 2016/17. Namibia is finalising the financial analysis, fiscal space and cost effectiveness study of health and HIV programmes. The recommendations will inform the scenarios of the Investment Framework which will be finalised by November 2015.

The investment framework will be linked with Namibia development Vision by 2030 for sustainability perspective. The investment Framework is taking into account the UNAIDS Fast-Track strategy to achieve the 90-90-90 and 95-95-95 targets for ending the AIDS epidemic as a public threat in Namibia by 2030. The approach is aimed to strengthen multi-sectoral HIV response and make it more effective, efficient, transparent and participatory.

Lessons learned and recommendations

Namibia's experience demonstrates that universal access is not only a dream, but can be a reality. Given political commitment, a strong health sector response, social mobilisation and effective partnerships coupled with domestic resource allocation and correct and targeted application of international resources, significant progress in saving lives, stemming the spread of HIV and mitigating its impact is feasible.

However, simultaneous development in systems such as infrastructure, human resource, procurement, strategic information and planning and financing are required to sustain the current gains. As rapid scale-up takes place to achieve universal access, the transition from an emergency response to long-term sustainable systems needs to be managed.

It is critical that the expansion of HIV care and treatment services should be supported by concurrent and accelerated efforts to scale-up prevention to reduce the future burden of the epidemic. HIV prevention investments are cost-effective when they include combination approaches that maximize synergies rather than isolated interventions.

Finally, there is a need to address the social factors that fuel the epidemic, such as gender inequality, violence against women, high-level of unemployment, elevated alcohol use, as well as poverty and extreme disparity of wealth. The HIV response will only be successful if it includes concerted action to respond to these important societal challenges.

Contact Person: Dr Norbert Foster, Chair of NAEC and Deputy Permanent Secretary, Ministry of Health and Social Services
Address: Private Bag 13198, Harvey Street, Windhoek, Namibia
Tel: +264 612 032 038
Email: nfoster@mhss.gov.na

6. Zimbabwe – National AIDS Trust Fund (AIDS Levy)

Programme implementation date	2000
Implemented by	▪ Government ▪ Civil society ▪ Private sector
Scope of submission	▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Promoting domestic pharmaceutical manufacturing ▪ Programmes to encourage and develop South-South, South-North and triangular cooperation
Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	No

Background

In 2000, HIV prevalence in Zimbabwe had gone above 29%. In response to the worsening HIV and AIDS situation and the concomitant funding challenges, the Government of Zimbabwe introduced an innovative funding model, underpinned by political commitment at the highest level. The introduction of the National AIDS Trust Fund (AIDS Levy) in 2000 coincided with the establishment of the National AIDS Council (NAC) and became the major source of funding for the operations of the Council. The AIDS Levy which is financed through from 3% tax on taxable incomes of individuals and corporates currently supports treatment for 25% of people living with HIV in Zimbabwe.

Programme approach

Among others, the objectives of the AIDS Levy include:

- Pursue objectives of the National AIDS Policy
- Provide support for HIV and AIDS programmes in the community
- Assist in the procurement of drugs for infected
- Undertake prevention measures
- Cater for orphans and other children made vulnerable by AIDS
- Facilitate training of people engaged in HIV activities
- Promote, M&E and research
- Establish a secretariat for the pursuit of the objectives

The objectives encompass a wide range of possibilities in HIV prevention, treatment, care, mitigation and management as well as research. The implementation of the fund is guided by a

sector wide board, which has determined thematic allocations for each programme. Although these thematic allocations are in place, the AIDS Levy is flexible and has been utilised to respond to emergencies in the areas of diagnostic equipment and drugs for TB and cancer.

Programme reach

The AIDS Levy is a national initiative that supports countrywide HIV programmes. The National AIDS Council, which administers the AIDS Levy, has offices in all 85 districts of Zimbabwe. Treatment is major programme that receives 50% of the AIDS Levy, followed by prevention with 16%, M&E, Management and Coordination 5%, enabling environment (advocacy and communications, gender and meaningful involvement of people living HIV) 4%, while programme support and logistics (including administration) takes the remaining 25%.

In addition to the general population, prevention programmes also focus on key populations in prisons and mobile populations who are at higher risk of HIV acquisition and transmission. The AIDS Levy has also been utilised to support other grants including, US$ 100 000 for UNAIDS and US$ 2 million - US$ 1 million in 2005 and the other in 2014 for The Global Fund.

In addition, the AIDS Levy has funded the African Union Continental World AIDS Day in 2014 in Zimbabwe and the African Union AIDS Watch Africa expert meeting in Zimbabwe in 2015. It is also the major funder of the 2015 International Conference on AIDS and STIs in Africa (ICASA) in Zimbabwe. Through the AIDS Levy, Zimbabwe has previously hosted Parliamentary delegations from Uganda and Tanzania as well NAC delegations from Botswana, Zambia, Kenya and Mozambique who have visited the country to understand the operations of the AIDS Levy.

Programme Impact

Some of the major contributions of the AIDS Levy, together with funding from other sources, include the decline in both HIV incidence and prevalence in Zimbabwe over the years. From a high of over 29% in 1999, Zimbabwe’s HIV prevalence fell to the current 15%. According to the 2014 HIV and AIDS estimates, HIV incidence dropped from 1.97% in 2001 to 0.98% in 2014.

An estimated 50% of the AIDS Levy is deployed towards treatment, and currently provides antiretroviral medicines to 25% of the 830 000 people living with HIV. At the same time, AIDS-related deaths declined from 3 000 in 2005 to 1 300 in 2013, according to the 2013 HIV and AIDS Estimates. The number of people on community home-based care has also declined drastically.

Various independent evaluations of the AIDS Levy have been conducted by several institutions, including the Southern African Development Community (SADC), which documented the AIDS Levy as a best practice (2009 and the Centre for Diseases Control (CDC) (2014)).

Programme financing and management

The funding for the AIDS Levy comes from 3% tax on taxable incomes of individuals and corporates. It is collected by the country's tax authority – Zimbabwe Revenue Authority which disburses the funds into a National AIDS Council account, without going through treasury. The revenue authority does not charge any handling fees. This process ensures that the entire fund is directed to its intended purpose. A multi-sectoral board, empowered by an Act of Parliament – Act of 2000 oversees the governance of the AIDS Levy. The major partners in the AIDS Levy are government, workers, employers, private sector and people living with HIV.

Lessons learned and recommendations

Lessons learned:

- The multi-sectoral nature taken for the collection of the AIDS Levy and management promotes ownership and participation of key sectors
- A home grown funding solution serves as an attraction for external partners
- Political will is essential in rallying internal and external support
- A home grown fund is a flexible solution that can directed to related emergencies, such as TB and cancer;
- Prioritisation is very essential in resource constrained circumstances
- Ownership and participation of the nation leads to accountability

Challenges:

- Increasing unemployment has led to reduction of funding for the AIDS Levy

Recommendations:

- Funds for the AIDS Levy may have to be collected from the informal sector since this sector is becoming the major source of employment in Zimbabwe

Contact person Albert Manenji, Finance Director**,** National AIDS Council
Address: 100 Central Avenue, Harare, Zimbabwe
Tel: +263 4 790575
Email: amanenji@nac.org.zw

II. Asia and Pacific

7. India

7.1. Forging sustainable strategic partnerships: essential tool for shared responsibility

Programme implementation date	2007
Implemented by	▪ Government ▪ UN or other inter-governmental organization
Scope of submission	▪ Transition of low-income and middle-income countries ▪ Working with the private sector ▪ Programmes addressing criminalization, stigma and discrimination ▪ Working with people living with HIV ▪ Engaging key populations in the AIDS response.
Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

The need for shared responsibility finds its roots in the need to address behaviour, since more than 90% of HIV is transmitted through behavioural aspects, particularly sexual behaviour and drug use behaviours. The role of shared responsibility for addressing the HIV epidemic becomes especially important in the resource constraints countries, where there are competing public health priorities. It is neither feasible nor cost effective to create a HIV specific health infrastructure.

Multi-sectoral responses or integrated HIV responses worldwide are proving to be a more effective way of dealing with HIV infection and mitigating the burden of the epidemic among vulnerable populations at higher risk of HIV acquisition and transmission.

In the early two phases of the programme, the emphasis was to promote HIV awareness and prevention among different ministries, mostly supported by National Association of Counties (NACo). During the third phase the programme focused on establishing partnerships on a variety of HIV and AIDS related issues. However it is in the current fourth phase of the programme the ministries are showing willingness to take more ownership and invest in HIV

activities and services. The fourth phase of the programme aims to formalize and institutionalize this arrangement.

Programme approach

The invaluable partnership that has been built in earlier phases needed to be formalized to improve the accountability and measurability of the programme, thus a Memorandum of Understanding (MoU) was considered a useful tool. It meant drafting the Terms of Reference for the partnership with each stakeholder. It entailed customising rationale for shared responsibility according to the structure and mandate of different ministries and identifying the scope for integrating the priories of the HIV epidemic, their responses and schemes ‘exclusively or through inclusion.
NACo is collaborating with various key Government ministries/ departments in India with the objective of a multi-pronged, multi-sectoral HIV response to ensure better use of available resources, risk reduction and impact mitigation of the epidemic. NACo has formalized partnership with fourteen Government ministries/ departments by signing MoUs.

Programme reach

Mainstreaming efforts have been directed towards identifying scope and formalising partnerships with 25 ministries and departments at the national level. Additionally handholding and technical support is provided to State AIDS Prevention and Control Societies (SACS) to plan and implement mainstreaming efforts within their states.

Programme impact

The National AIDS Control Programme (NACP) in India has been successful in formalizing partnership with 14 ministries. Through a number of formal and informal partnerships at the national and state levels more than hundred directives have been made to improve social protection of people living with HIV or key populations at higher risk of HIV acquisition and transmission. HIV testing and counselling centres have also been established through funding from partners. Nearly 700 000 people living with are able to access various social protection schemes of different ministries. Details of impact of some of these partnerships have been included in the ‘Status Note’ section below.

Programme financing and management

It is critical to set up dedicated teams at the national, regional, state levels to engage with stakeholders to carry forward the agenda and create ownership for HIV and AIDS issues. The team needs to also have skills to enumerate social cost and benefit analysis of investing towards prevention and control of the HIV epidemic and negotiate for cost/fund sharing.

Lessons learned and recommendations

Shared responsibility for addressing HIV and AIDS needs to be directed towards harnessing key strength and available tangible and intangible resources of each partner. Multi-sectoral response to HIV needs to be garnered from health as well as non-health sector. For example, ministries with social mandates can contribute to social protection of people living with HIV and key populations; ministries with communication mandate can contribute to prevention and those with health infrastructure can help in expanding the reach of services.

Formalisation of partnership helps in creating common understanding, facilitating joint planning and sustaining the efforts. However, the process of shared responsibility needs to be cautious about being 'person centric'. Although the initial drive often comes from visionary leadership, the sustainability mechanisms need to be put in place through common platform for meeting regularly to plan a way forward and review the progress.

The senior management at each of the ministries played a critical role in setting the pace and rolling out the process. A fair amount of time was spent in negotiating, networking and dialoguing and working with the ministries in carving out the basis of the partnership in taking mainstreaming activities forward. On an average six months were spent from the time of connecting with the ministries and drafting the terms of the MoU. This was a tedious and time consuming task but also critical in the entire process of partnership building as it formed the basis of the foundation for building a strong partnership

Status note on the shared responsibility by various Government ministries in India

	Ministry	Status
1.	Ministry of Consumer Affair, Food and Public Distribution	▪ Department of Food & Public Distribution – Extending the benefits of Antodaya Anna Yojana scheme under targeted public distribution system for the provision of access to nutritional supplements for people living with HIV.
2.	Ministry of Coal	▪ NACo has signed MoU with Ministry of Coal aimed at reaching larger number of workforce engaged in coal mines and allied industries, including migrant workers, truck drivers and surrounding communities with information on HIV and other sexually transmitted infections (STIs), integration of HIV related services in existing health infrastructure as well as adoption of the national HIV and AIDS policy and Public Sector Units (Coal India and their subsidiary units). o The Joint Working Group has been constituted and meeting held for rollout of activities by PSUs. o Joint working group are formed at state level and

		coordination meetings were held in a number of states. o Coal India and their seven subsidiary units are mobilized – action plan are developed for Central Coalfield Limited, Coal India Limited, Singareni Collieries Company Limited, South Eastern Coalfield Limited, Neyveli Lignite Corporation Limited.
3.	Ministry of Commerce and Industry	▪ The MoU was signed between NACo and Department of Commerce and the partnership aims to a) reach out to the large number of employees and workers of Plantation Boards and PSUs with information on prevention and care services of HIV and STIs through sensitization programme b) integration of HIV and STIs services in the existing health infrastructure of various units of commodity plantation and PSUs under the Department of Commerce and c) adoption of "National Policy on HIV and AIDS and 'world of work' in all the units of plantation boards and PSUs of Department of Commerce. o The constitution of Joint Working Group has been proposed to rollout the activities outlined in the MoU.
4.	Ministry of Home Affairs	▪ The personnel of the Central Armed Police Force (CAPF) have access to HIV and AIDS information and services through their hospital in the country. ▪ Various programme/ workshops are also being conducting regularly and periodically throughout the country to create awareness among CAPF personnel and their families.
5.	Ministry of Defence	▪ MoU was signed with the Department of Defence under Ministry of Defence on 18 February 2014. The partnership aims to create awareness and reach a large number of defence personnel with HIV and STIs information and services; integrate HIV, STIs and ICTC services in existing health infrastructure; and reduce social stigma and discrimination against people living with HIV and other groups affected by the epidemic. ▪ The Joint Working Group has been constituted and meetings held for the rollout of activities outlined in the MoU.

		▪ The armed personnel have access to HIV information and services through their hospital in the country. ▪ Various programme/ workshops are also being conducting regularly and periodically throughout country to create awareness among armed personnel and their families.
6.	Ministry of Shipping	▪ NACo has signed MoU with the Ministry of Shipping on with an objective of strengthening HIV prevention, care, support and treatment programmes in all the major ports under the jurisdiction of the Ministry of Shipping. This partnership is aimed at reaching ports workers, fisherman, seafarers, truck drivers, single male migrants, and surrounding communities at port areas with HIV information and services. ▪ The Joint Working Group has been constituted and meeting held for roll out of activities as laid down in the MoU. ▪ Action Plan developed and the rollout started in all major ports in India. ▪ HIV testing and counselling services integrated in the port hospitals and ensured linkages for HIV treatment services.
7.	Ministry of Human Resource Development	▪ NACo has signed MoU with the Department of Higher Education and Ministry of Human Resources Development with the objective of reaching large number of students with information on HIV prevention and promotion of blood donation through Red Ribbon clubs in educational institutions under the Department and encourage State Higher Education Department to undertake HIV prevention programme in state education institutions, including private universities with technical assistance from State AIDS Prevention and Control Societies (SACS). ▪ The Joint Working Group has been constituted between NACo and Department of Higher Education and meeting held for the rollout of activities outline in the MoU. ▪ The Joint Working Group has been constituted and action plan has been developed between NACo and the Department of School Education and Literacy.

		▪ The directives regarding inclusion of Transgender people in the equity guidelines of the University Grant Commission have been issued from Department of Higher Education to facilitate their education in colleges. ▪ Joint Working Group formed in number of States. ▪ Formation of Red Ribbon clubs in educational institutes gets accelerated and encouraged for prevention of HIV among young people in college.
8.	Ministry of Road Transport and Highways (MORTH)	▪ MoU was signed with the Ministry of Road Transport and Highways. This partnership aims to create awareness among truck drivers, transport workers and other key population with information and services on HIV and other sexually transmitted infections (STIs) and other related services. ▪ The Joint Working Group has been constituted and meeting held for the rollout of activities comprised in the MoU. ▪ The directives have been issued from MORTH. Training on HIV integrated in the drivers' training curriculum by Institute of Driving and Traffic Research. ▪ Joint working group constituted at the states level and held coordination meeting
9.	Department of Youth Affairs	▪ NACo has signed MoU with the Department of Youth Affairs. This partnership aims to prevent HIV infection among young people through inclusion of youth specific HIV information and services; reduce the vulnerability of special category of young women and migrants and enhance the capacity of policy planners, researchers and trainers in the institutions under the control of Department of Youth Affairs to address the HIV epidemic. ▪ The Joint Working Group has been constituted and meeting held to rollout activities outlined in the MoU. ▪ Joint Working Group formed and meeting held regularly through Youth Clubs and National Social Service for creating awareness on HIV prevention.

10.	Department of Sports	▪ NACo has signed MoU with the Department of Sports to reach young people engaged in sports with information on HIV and STIs prevention and related services; build the capacity of sports' educators, administrators and coaches on 'minimizing the risk HIV transmission within and outside sports arena; and promote awareness through hoarding and banners at eminent places and sports arenas during state or national events and tournaments. ▪ The Joint Working Group has been constituted and meeting held for the rollout of activities outlined in the MoU. ▪ Training held for athletes and coaches. ▪ Free spots given for the provision of HIV information and prevention services
11.	Ministry of Petroleum and Natural Gas (MoPNG)	▪ NACo has signed MoU with the MoPNG to reach out large workforce, including migrants with information on HIV and integration of HIV related services in the existing public sector health infrastructure. ▪ The Joint Working Group has been constituted and meeting held for the rollout of activities outlined in the MoU. ▪ A Joint Working Group constituted in the states and coordination meeting was held in states to mobilize public sector units within MoPNG. ▪ Action plan developed and rolled-out in number of PSUs.
12.	Ministry of Communication and Information Technology	▪ NACo has signed MoU with the Department of Telecommunications and Department of Electronics & Information Technology. This partnership aims to reach the public through Common Service Centres' with information on prevention and services of HIV; promote voluntary blood donation; and also facilitate access to social protection schemes. ▪ The partnership with Department of Telecommunications aims to create awareness especially through mobile networks – BSNL& MTNL. This will also facilitate display of information at strategic locations up to village level and also HIV messages in the promotional materials.

		▪ The Joint Working Group has been constituted and meeting held to rollout the activities outlined in the MoU. ▪ Mobile application on HIV has been launched with the support of the Department of Telecommunications. ▪ The Joint working group was constituted in states and coordination meeting held with PSUs and private service providers in several states.
13.	Ministry of Rural Development	▪ The MoU between NACo and the Department of Rural Development, and Ministry of Rural Development on 10 June 2015.The MoU aims to a) Facilitate capacity building and livelihoods option for PLHIV under the National Rural Livelihoods Mission; b) Provision of widow pension benefit to widows living with HIV under the Indira Gandhi National Widow Pension Scheme; c) Facilitate access of PLHIV to decent housing under Indira Awaas Yojana; d) Provide employment to PLHIV under MGNREGA without stigma and discrimination; and e) Build capacity of rural development functionaries through state and district level training centres. ▪ The Joint Working Group (JWG) is formed to rollout activities outlined in the MoU.
14.	Ministry of Housing and Poverty Alleviation (MoHUPA)	▪ The MoU was signed with Ministry of Housing and Urban Poverty Alleviation. The objectives of the MoU aim to reach out PLHIV and affected population with enhanced accessibility in the livelihood schemes and programmes of MoHUPA through inclusive approach as well as improve social protection to PLHIV and key populations at higher risk of HIV acquisition and transmission through existing schemes and programmes for urban employment, poverty alleviation and housing. ▪ The meeting held with MoHUPA to rollout the activities outlined in the MoU.
15.	Ministry of Railways	▪ All PLHIV are given 50 % travel concession to travel to treatment centres. ▪ All railways employees are provided free HIV testing and counselling and treatment from railway health institutions.

		▪ Three phases of the Red Ribbon express have been rolled out across the country to create awareness on HIV prevention and services.
16.	Ministry of Labour and Employment	▪ The Ministry has adopted a national policy on HIV and AIDS in world of work in October 2009 to prevent HIV infection among workers, protect rights of people living with HIV and provide access to HIV care, support and treatment services as well as protect workers from HIV-related stigma and discrimination by assuring equity and dignity at workplace. This has immense scope for expanding HIV programme at workplace. ▪ The signing of MoU between NACo and Ministry of Labour and Employment has been proposed by NACo and it is under discussion.
17.	Ministry of Health and Family Welfare	▪ Revised National TB Control Programme (RNTCP) provides free tuberculosis treatment for people living with HIV under the national framework for joint TB/HIV collaborative activities for the rehabilitation of people living with HIV.

Contact Person N S Kang, Additional Secretary, NACo
Dr Naresh Goel, Deputy Director General
Dr Madhu Sharma, Project Officer, Mainstreaming
National AIDS Control Organisation (NACo) / Ministry of Health and Family Welfare, Government of India
Address: 36 Janpath, Chanderlok Building, New Delhi, India
Tel: + 91 11 435 099 9684
Email: madhusharma.naco@gmail.com

7.2. India: Sustainable financing in the country-led National AIDS Control Programme (NACP) of India

Programme implementation date	1992
Implemented by	▪ Government

Scope of submission	▪ Fair share between domestic and international funding
	▪ Sustainability planning (financial, programmatic, institutional and systems)
	▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access
	▪ Promoting domestic pharmaceutical manufacturing
	▪ Working with the private sector
	▪ Programmes to encourage and develop South-South, South-North and triangular cooperation
	▪ Funding for civil society
	▪ Financing key population programmes:
	  ▪ Working with people living with HIV
	  ▪ Engaging key populations in the AIDS response

Programme evaluation/assessment	
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

The HIV epidemic in India is primarily driven by high risk behaviours such as unprotected sexual intercourse (both heterosexual and same sex) and injecting drug use. As a result, the epidemic is largely concentrated among key populations who at a higher risk of HIV acquisition and transmission and are more likely to engage in high risk activities.

In India, HIV is associated with a number of socioeconomic factors and therefore, health interventions alone are not sufficient to address the impact of the epidemic. It requires a multi-faceted and multi-sectoral response to reduce vulnerability to HIV, integrate HIV programmes in existing services and provide social protection for those who are living with HIV and are affected by the epidemic. In 1992, the National AIDS Control Organisation (NACO) launched the National AIDS Control Programme (NACP) which is implemented as a comprehensive programme for HIV and AIDS prevention and control in India. The NACPs were scientifically well-evolved programme, grounded on a strong structure of policies, principles, innovative

institutional mechanisms, research findings, operational guidelines and Standard Operating Procedures (SOPs) and a robust M&E system.

Based on the lessons learned from the NACP I (with an IDA Credit of US$ 84 million) launched in 1992 and the NACP II (World Bank credit support of US$ 191 million) launched in 1998, the Government designed and implemented NACP III (2007-2012) with an objective to “halt and reverse the HIV epidemic in India”. During the NACP III (2007-2012), over 80% of the fund was obtained from the external source.

The current NACP-IV was launched in 2012 to accelerate the process of reversal and to further strengthen the HIV response in India through a cautious and well defined integration process over the period 2012-2017. This phase of NACP is built upon the achievements of NACP III and it will ensure that the current gains are consolidated and sustained. The five cross-cutting themes that are being focused under NACP-IV are quality, innovation, integration, leveraging partnerships and addressing stigma and discrimination. As the International resources for the HIV response is shrinking, the Government of India has increased the domestic funding to 63% in the NACP IV to ensure a lasting impact against the epidemic.

Programme approach

As the scale of the epidemic in India is beyond the reach of the health sector alone and there was an urgent need for a multi-sectoral response to stabilise the epidemic and address its impact on the social and economic fabric of the country. NACO has fostered close collaboration with non-governmental organisations, community-based and faith-based organizations, networks of people living with HIV and communities. Concrete action towards multi-sectoral collaboration was initiated with the aim to leverage resource and improve the scale, coverage and sustainability of the HIV response. Different ministries, the private sector, including corporate and business conglomerates have actively participated in responding to the prevention and care needs of people living with HIV and affected by the epidemic.

The main objectives of the current NACP-IV are to reduce new HIV infections and provide comprehensive care and support to all people living with HIV (PLHIV) and expand treatment services for people in need of treatment. For the NACP-IV, the Government of India generated 63% of the funds through government budgetary sources while 14% of the funding came from the Global Fund), 10% from the World Bank, and 13% from extra budgetary resources of other development partners.

A number of new Initiatives have been rolled out under NACP-IV, such as a) earmarking budgets for HIV among all key government departments through strong mainstreaming initiatives; and b) employer led model to leverage resources and active engagement of the private sector. Besides these the process of integrating HIV with the health system, related activities has also been started for long term sustainability. Innovative mechanisms for sustainability include facility integrated linkages to treatment centres which are using the existing manpower of the health facilities.

Programme reach

NACO is the nodal organisation for formulation of policy and implementation of HIV and AIDS prevention and control programmes in India. The NACP through NACO is extended nationwide through 35 State AIDS Prevention and Control Societies (SAPCS).

Prevention and care, and support and treatment form the two key pillars of all HIV and AIDS control efforts in India. As strategized in NACP IV, prevention continues to be the core strategy as more than 99% of the people in the country are free from HIV. The coverage of core high risk groups (HRGs) during 2014-15 (up to September 2014) is depicted in Figure 1, which shows that female sex worker (FSW) coverage compared to the estimates has already crossed 80%.

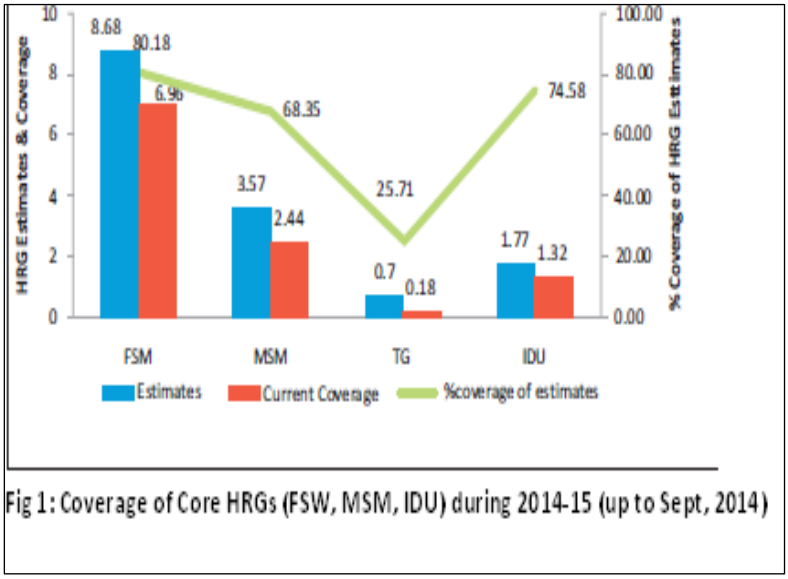


Fig 1: Coverage of Core HRGs (FSW, MSM, IDU) during 2014-15 (up to Sept, 2014)

The clinical services, including regular medical check-up are one of the core components of Targeted Interventions (TI) project services. NACO's guideline suggests that the core HRGs, especially men who have sex with men (MSM) and FSW should visit STI clinics quarterly for regular medical check-ups and for treatment of STIs/ Reproductive Tract Infection (RTI). Figure 2 depicts the number of clinic visits by HRGs during 2014-2015 (up to September 2014).

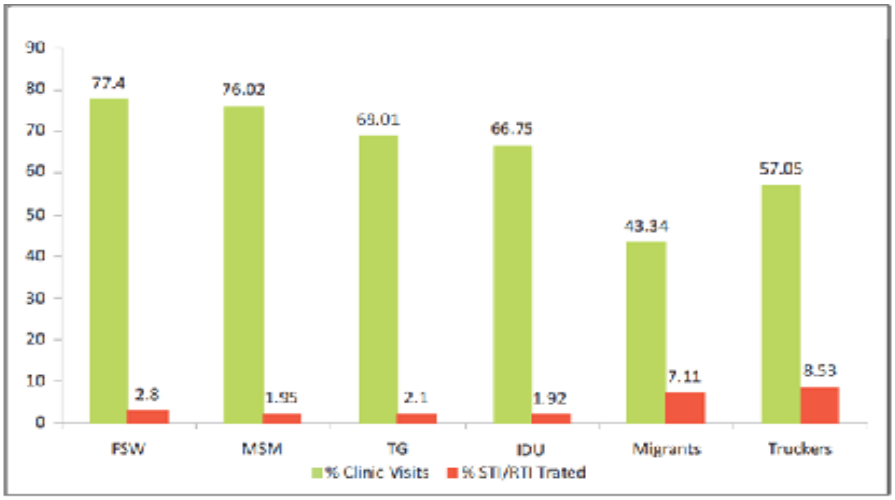


Fig 2 : STI Clinic Visits during 2014-15 (up to Sept, 2014)

By April 2015, substantial scale up of service coverage of the core HRGs has been achieved through 1 818 TIs. The Link Worker Scheme was established in 137 districts in 2014-2015 to reach rural core HRGs, their partners and other vulnerable groups. The overall condom distribution in the country was 880 million pieces in 2014-15. HIV testing and counselling (HTC) services were rapidly scaled up by April 2015 through 5347 stand-alone Integrated Counselling and Testing Centres (ICTCs), 1 0621 Facility Integrated ICTCs and 2 378 under Public and Private Partnership model. The programme reached 24.87 million persons, including 10.61 million pregnant women during 2014-15. An estimated 1.6 million people were provided with HIV/TB cross referrals during 2014-15. The coverage of STI services has been scaled up through 1 164 designated STI clinics and 7.54 million STI/RTI clients were managed as per the national protocol during 2014-15. NACO supported blood banks collected 6.32 million units; 84% of this was collected through voluntary blood donation during 2014-15. Care, support and treatment services are being provided through 475 treatment centres, 1 068 Link Antiretroviral Treatment Centres (LACs) and 348 Community Service Centres (CSC) till April 2015. An estimated 850 000 PLHIV were receiving treatment during 2014-15.

The mobilization and engagement of political leaders; active involvement of PLHIV and marginalized communities; support from the state governments and district administrations; integration of health systems; and involvement of other stakeholders including the civil society, community-based organizations, and private sector led to the success of this project.

Through the mainstreaming efforts, over six hundred thousand PLHIV were accessing social protection schemes in India. These services are sustainable as they are funded from domestic budgets that are protected by statutory policies. PLHIV received over US$15 million worth of benefits from ongoing social protection programmes which are non-HIV resources.

Programme impact

India has achieved the Millennium Development Goals (MDGs) of halting and reversing the HIV epidemic. In the last ten years, through the NACPs, India reduced new HIV infections among adult population by 57%, from 270 000 in 2000 to 110 000 in 2011. According to HIV Sentinel Surveillance (HSS) 2012-2013, the overall HIV prevalence among antenatal clinic attendees, considered a proxy for prevalence at 0.35% among the general population continues to be low in the country, with an overall declining trend at the national level.

According to the 2012 HIV estimations, the scale up of free antiretroviral treatment since 2004 saved over 150 000 lives in the country till 2011, by averting AIDS-deaths. India drew a wide recognition of India’s role in ensuring access to antiretroviral medicines for millions of PLHIV across the world. Wider access to antiretroviral medicines has resulted in a decline of AIDS-related deaths. India’s National AIDS Control Programme was appreciated at the UN General Assembly Special Session as one of the three success stories in the world (June 2011). India was also elected the Chair of UNAIDS Programme Coordinating Board (PCB) for 2013. In the last three years, over 20 international governmental delegations visited India to learn from the national HIV response.

As a part of the consolidating efforts made by development partners during NACP-III, NACO has developed a common strategic approach for transitioning of interventions implemented by development partners based on “Three Ones Principles”. The TIs with core HRGs have been operational in India since 1999. Apart from NACO supported TIs, development partners, including the USAID and the Bill and Melinda Gates Foundation were implementing more than 200 HRG and bridge population TIs in the country during the NACPIII period (2007-2012). During the NACP III (2007-2012), more than 80 % of fund was derived from the external sources. As the funds from the external sources were reduced NACO believed that to achieve lasting impact in its HIV response, financial commitments from domestic sources must play a key role in the national strategy. As per the 12th five year plan (2012-17), the Government of India (GOI) has allocated US$ 2 236 million towards HIV. NACO made efforts for mainstreaming and private partnership to leverage resources and finances.

As a result of the mainstreaming efforts in India, different categories of schemes have been modified/ initiated such as health, access to treatment, nutrition, social security, livelihoods, housing, legal aid, grievance redressal, etc. in over 35 central and state schemes.

The performance of the NACP has been assessed through the HIV estimates derived using globally comparable methods, periodical Joint Implementation Reviews involving development partners.

Programme Financing and management

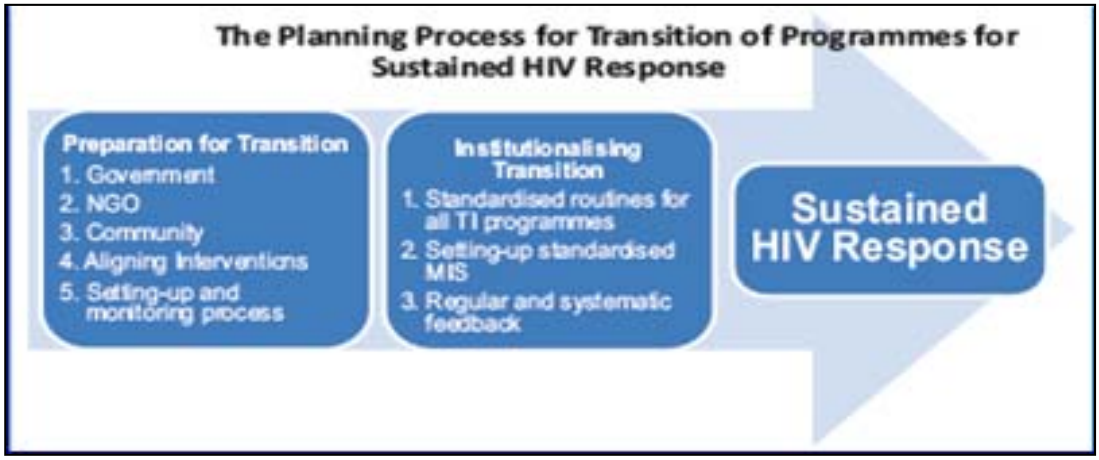
There has been paradigm shift from donor supported programme to a country led programme in the NACP IV (2012-2017). The Government of India adopted the 'Three Ones Principles' with the possibility of donor withdrawal after fixed project time frames which led to the need for continuity of services for HRGs.

The NACP took the responsibility of transitioning HIV programmes from donors to government to ensure continuity both in terms of scale and quality. This poses a challenge in bringing the standalone, vertical health delivery systems supported by different donors under the umbrella of NACO. Therefore, a reverse strategy was required to ensure that all programmes could be incorporated within NACO's mandate. Variations in implementation strategies, service provision, staffing patterns and costing in diverse states, contexts, communities and geographies had to be taken into account and suitably modified to fit in with NACO's standardised guidelines for TIs.

This had been made possible through extensive dialogue between donors and NACo; detailed planning with state lead partners and State AIDS Control Societies (SACS), and the involvement of implementing Non-Governmental Organisations (NGOs) and community-based organisations (CBOs) and key populations, so that TIs could be aligned to NACP III guidelines in a smooth and efficient manner. These transitions of TIs incorporated the successful strategies and innovations that donor programmes had demonstrated. The consensus ensured on the best utilization of resources and an uniform reporting while minimizing duplication in coverage and reporting.

The NACO guidelines fixed the numbers and designations of staff in consultations with donor agencies. Prior to transition, most TI sizes varied according to the capacity of the implementing NGO. In some states, each district was managed by one NGO partner, regardless of the numbers of HRGs. The NACO guidelines made the TI coverage limited to 1 000 HRGs. The NACP III guidelines mandated that health services of a TI focused on STI treatment and HIV screening with clear targets. The mandate for delivering general health services remained with the National Health Mission. Within a specified time frame, all implementing partners followed NACO's reporting formats – equal emphasis was placed on the post-transition handholding and support given to implementing partners at all levels. The meticulous process and effectiveness of this smooth transition was demonstrated by the fact that none of the existing TIs collapsed or closed down and 100% of TIs in India were transitioned in just four years.

Under the 2012-17 NACP-IV, 65% of the funds (US$ 2 236 million) have been earmarked through budgetary sources of the Government, 14% (US$ 304 million) from the Global Fund, 10% (US$ 213 million) from the World Bank, and 13% (US$ 302 million) through extra budgetary resources from other development partners like BMGF, USAID, CDC, UNDP, UNICEF, UNAIDS, WHO, UNFPA. This has shown the commitment of the Government for the sustainability of the programme.

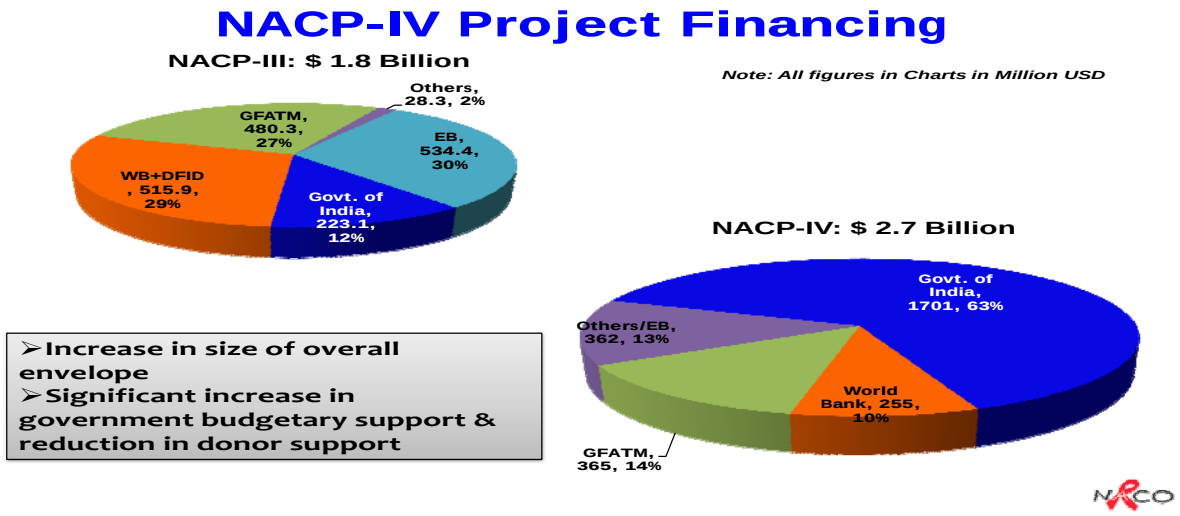


Financial management brought together planning, budgeting, accounting, financial reporting, internal control including internal audit, external audit, procurement, disbursement of funds and physical performance of the programme with the objective of managing resources efficiently and effectively. The mainstreaming efforts with various ministries, departments and private sector have also leveraged the resources in terms of human resource, infrastructure, health services and social protection schemes. This has paved way for sustainability of the programme through Integrating and mainstreaming the HIV related services.

Lessons learned and recommendations

The NACP has been scaled up in India through evidence-based planning duly supported by triangulation of bio-behavioural surveillance, special studies, operational research and

programme monitoring and evaluation. This has helped the programme to make geographic prioritization, region-specific focus, developing new strategies, flexible modelling and mid-course corrections and implementation. Commodity standardization, technical and operational guidelines, unit costing, uniform training modules, structures monitoring mechanism has been designed to scale-up the programme.



The NACP has been implemented and achieved the desired results by keeping the communities at the centre of the programme at all stages and levels. The interest of the community and their ownership has been given the most priority in India's NACP. The programme has increased involvement of the civil societies and networks of PHLIV.

The NACP has given much emphasis for the programme to balance prevention and treatment by sustaining prevention focus and addressing emerging epidemics versus the growing treatment needs.

NACO made an integrated, inclusive and multi-sectoral approach which embedded ownership of all the stakeholders (government, private sector, unions and civil societies) to respond to the HIV epidemic, using their core competence and assets (human, technical, financial) in a co-ordinated manner leading to a comprehensive and effective national response.

Mainstreaming HIV has sensitized and enabled different ministries and departments to strengthen the way in which they address the causes and consequences of HIV through adapting and improving both their existing work and their workplace practices. India has taken an innovative approach to increasing uptake of social protection schemes, pension schemes etc. for the people affected with HIV.

Leading employer organizations, including Confederation of Indian Industry (CII), Federation of Indian Chambers of Commerce and Industry (FICCI), Associated Chambers of Commerce and Industry of India (ASSOCHAM), Employee Federation of India (EFI), All India Organization for Employer (AIOE), Laghu Udyog Bharti, and Scope International India have endorsed

commitment to HIV and AIDS. Emphasis was given on initiation of workplace programme and policies for the workforce engagement in both formal and informal sectors. The partners have been encouraged to mainstream HIV messaging to their employees and those who they come in contact with and in addition will use their existing initiatives and infrastructure to provide HIV services – condom availability, HIV and STIs treatment etc.

In 2013, an amendment to the Indian Companies Act (2013) made it mandatory for a 2% contribution towards social development. The National AIDS Control Organisation has been working with 28 concerned ministries/departments of Government of India to provide social security to people living with HIV and affected by the epidemic, and provide access to social and economic rehabilitation schemes.

The political commitment and coordination between government, non-government agencies, and communities, as well as active participation of the private sector in HIV prevention and treatment related activities has been commendable. However, these needs to be sustained and even scaled-up to achieve the desired result.

Contact person

Mr N. S. Kang, Additional Secretary and Director General,
National AIDS Control Organization
6th & 9th Floor, Chanderlok building, 36 Janpath, New Delhi-110001, India
Tel: +91-11-43509999, +91-11-23731778
Email: nacoasdg@gmail.com

7.3. India: Integrating people living with HIV into India's national health insurance scheme –A further step towards domestic funding of the HIV response (Germany)

Programme implementation date	2008
Implemented by	▪ Government ▪ Civil society ▪ UN or other inter-governmental organization
Scope of submission	▪ Fair share between domestic and international funding ▪ Transition of low-income and middle-income countries ▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access ▪ Working with the private sector ▪ Programmes, policies and laws ensuring no one is left behind
Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

Government spending on health in India amounts to approximately 5% of total government expenditure while 1.3% of total health expenditure is derived from external resources (WHO, 2015). Public and private health care providers are faced with challenges due to a fast growing population with diverse health needs. Private expenditure on health equals 70% of total health expenditure among which 86% are out-of-pocket payments. For an estimated 22% of the total population living below the poverty line, out-of-pocket payments for health and lacking health insurance coverage have resulted in continuing indebtedness in the past.

India has the third largest number of people living with HIV in the world. Given the 2.7% HIV prevalence, an estimated 2.1 million people were living with HIV (NACO, 2011). The epidemic is concentrated among certain key populations, including men who have sex with men (MSM), sex workers, injecting drug users (IDUs) as well as transgender people who are most vulnerable due to societal discrimination and lack of access to basic entitlements. The highest HIV prevalence is geographically clustered in a few states in the south of the country. Other social

determinants, such as limited access to education, employment and nutrition also increase the risk of new HIV infection among the poor.

In 2004, the Government of India initiated the provision of antiretroviral treatment (ART) and diagnostic tests free of charge. To a large extent, funds to cover these costs are derived from vertical programmes. For instance, in the period from 2004 to 2015, India has received more than US$ 1 billion of The Global Fund grants for its national HIV response.

Following the provision of free HIV services, morbidity and mortality rates have reduced. Yet, despite free ART and diagnostic services, other crucial aspects of HIV infection especially those related to opportunistic infections had to be borne out-of-pocket. Enrolment in available insurance schemes thus has become an important means of support especially among poor people living with HIV.

In view of the challenges regarding health insurance coverage for the poor and for people living with HIV the national health insurance scheme known as “Rashtriya Swasthya Bima Yojana” (RSBY) was first designed and rolled out by the Ministry of Labour and Employment (MoLE) in India. Since 2008, the Federal Ministry for Economic Cooperation and Development (BMZ) has supported MoLE in the development of RSBY.

At present the insurance scheme covers in-patient services for households living below the poverty line regardless of pre-existing conditions. To ensure that also poor people living with HIV are integrated in the RSBY to receive treatment and care for opportunistic and other diseases not covered by the free HIV services, the National AIDS Control Organisation (NACO) closely collaborated with the MoLE.

Programme approach

The approach is HIV-relevant as it contributes to a more diverse funding for treatment of opportunistic diseases for poor people living with HIV through the expansion of voluntary RSBY insurance coverage. Due to the inclusion of people living with HIV in the insurance’s beneficiary pool, the approach is therefore also “HIV-inclusive”.

The overall aim of the RSBY is to improve access to in-patient health care services which had previously not been provided free of charge through the public HIV services. Enrolled in the RSBY, beneficiaries’ insurance premiums can be covered through government and state subsidies. Apart from expansion of coverage, access is further facilitated by means of biometric smart cards which are issued to RSBY’s beneficiaries in order to receive cashless in-patient treatment in any facility enrolled with the scheme. Thereby, RSBY also contributes to more transparent accounting processes regarding insurance claims and improved patient data recording which can be crucial for HIV patient follow-up.

Further, this inclusive approach contributes to reduction of stigma and discrimination as it does not require people living with HIV positive to disclose their status when seeking care.

Synergies for service integration at hospital level have already taken place to some extent – people living with HIV are able to access additional services in selected health facilities together with other in-patients. Cross-sectoral as well as programmatic synergies were developed since NACO closely cooperated with the MoLE, authorities of India's states and union territories, insurance companies as well as civil society organisations. Finally, a gradual expansion of RSBY's service coverage is planned. Pilot programmes that have extended the RSBY model to include out-patient care to further enhance access to essential services and improve health status among beneficiaries living with HIV have also been put in place. Similarly, discussions are underway to integrate treatment of chronic diseases including HIV in RSBY's service package which indicates increased efforts in funding the national HIV response through domestic resources.

Programme reach

RSBY is implemented across the country and a number of states have already devised their own top-up versions of RSBY. On a nationwide scale, the programme primarily focuses on extending social protection to poor citizens mainly working in the informal sector, including street vendors, taxi drivers and mine workers but also poor people living with HIV. At current stage, RSBY provides hospitalisation coverage for up to 5 members of households living below the poverty line with an annual ceiling of Indian Rs 30 000. Service coverage also includes services related to treatment and care for in-patients living with HIV with opportunistic infections. Considering the already existing pilot programmes focussing on coverage expansion to out-patient services, an even higher population as well as geographic reach can be expected in the near future.

Programme impact

In 2014, RSBY had already grown to cover 37.2 million families - approximately 120 million beneficiaries - in 28 states and union territories. Services have been made available for beneficiaries in more than 10 000 hospitals enrolled with the scheme. Improved access to services has been reflected especially on RSBY district levels where hospitalisation rates have risen from 1.86% to 3.04%. At the same time, direct expenditures for in-patient care have decreased significantly among RSBY beneficiaries compared to costs for those clients not enrolled. Due to privacy reasons, the exact number of people living with HIV enrolled in RSBY is not available, however since there is a likely link between poverty, socio-economic risk factors and risks of HIV infection, it can be assumed that a large number of poor people living with HIV are enrolled in the scheme. Following the successful experiences made by RSBY in improving access to public services for the poor, other state government schemes have also adopted this approach.

Programme financing and management

The RSBY was developed and rolled-out by the MoLE. It was designed as a public private partnership: Led by the central government, India's state and union territory authorities in

cooperation with insurance schemes, (public and private) hospitals and civil society organisations are responsible for implementation of the scheme. In this context, insurance premiums are subsidised by the central and state governments – the latter select insurance companies to enrol households directly in the villages.

NACO has worked closely with MoLE to ensure that people living with HIV are neither excluded from the scheme at enrolment nor at hospitalisation stage. Since the introduction of RSBY, the Indo-German Social Security Programme commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) has been a major partner of the MoLE for instance through technical support and capacity development for refining RBY's design, expanding its coverage or upgrading its IT systems.

Since the implementation of the scheme involved the active participation of hospitals which are governed by the Ministry of Health and Family Welfare, the management of implementing RSBY has been recently shifted from the MoLE to the Ministry of Health and Family Welfare.

Lessons learned and recommendations

Firstly, the close cooperation between public and private sector actors has allowed a large scale extension of the social health protection scheme.

Secondly, cross-sectoral cooperation between the MoLE and NACO with its strong advocacy work has led to the integration of poor people living with HIV in RSBY. This represents a first step towards integrating general health care funding with HIV funding on a national level, outside existing vertical programmes.

Thirdly, the integration has also contributed to discussions on further expanding RSBY's service coverage to out-patient services as well as treatment of chronic diseases including HIV. A sustainable, domestic funding mechanism for HIV services through the national health insurance scheme in the future therefore seems likely.

Contact person

Dr Madhu Sharma, National AIDS Control Organisation (NACO)
Nishant Jain, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) India
Address: Friedrich-Ebert-Allee 36, 53129 Bonn, Germany
Tel: +49(0)22844603601
Email: nishant.jain@giz.de

Wiebke Kobel, GIZ Germany
Address: Friedrich-Ebert-Allee 36, 53129 Bonn
Tel: +49(0)22844603601
Email: wiebke.kobel@giz.de

8. Kazakhstan – Medical and social support for the people living with HIV in Kazakhstan

Programme implementation date	
Implemented by	
Scope of submission	
Programme evaluation/assessment	
Programme implemented as part of a national AIDS strategy	
Programme implemented as part of a national plan broader than the national AIDS strategy	

Background

Over the past ten years, Kazakhstan has increased the number of people with HIV receiving antiretroviral therapy (ART) from 253 in 2005 to 4 639 in 2014. Treatment coverage in the country has reached 84.5% in 2014 which is fully funded through government budget. Kazakhstan is determined to reach the target of 90-90-90, as 86% of people living with HIV know their status. Over the last 5 years, state funding for the HIV response has increased by 2.5%. One of the main priorities of the national HIV response is the elimination of mother-to-child transmission of HIV. All women have access to HIV treatment and 91% of pregnant women living with HIV and 97.3% of infants exposed to HIV have access to prevention of mother-to-child transmission of HIV (PMTCT) services – HIV infection among children declined from 2.5% in 2010 to 1.8% in 2015.

Programme approach

The National HIV/AIDS Programme in Kazakhstan takes an integrated approach, accounting for the specific needs of people living with HIV. Social and outreach workers are also actively involved in the HIV response to improve access to HIV diagnosis and treatment for all key population. Programmes have also been put in place to reduce HIV-related stigma and discrimination.

The Kazakhstan Country Coordinating Mechanism (CCM) involves representatives from all partners and the Government is exploring opportunities to strengthening its leadership and support the implementation of the national HIV response.

Programme reach

The National HIV/AIDS Programme covers all regions of Kazakhstan. The programme focuses on HIV prevention among vulnerable groups and harm reduction (needle exchange programmes and Opioid Substitution Treatment (OST), distribution of condoms, information and

education component, HIV testing and counselling, HIV treatment, diagnosis and treatment of STDs, as well as viral hepatitis and HIV/TB co-infection).

Programme impact

The number of people with HIV accessing treatment consistently increased from 253 in 2005 to 4 639 in 2014. HIV treatment is provided in accordance with clinical protocols and standards developed by the Ministry of Health in 2011. AIDS-related mortality has decreased two-fold from 16.1 in 2010 to 8.7 in 2014 per 1000 people living with HIV.

In 2005, a pilot OST programme was launched with funding from the Global Fund and since then the number of clients has increased to 688 and the number of sites have increased to five-fold. During the implementation of the OST programme, two women gave birth to healthy infants, 63 families were enrolled, 20 clients were trained, 204 clients secured jobs, 32 started HIV and TB treatment, 109 successfully completed the OST programme, 100% of the clients stated that the family relationship, social status and attitude to their own health was improved, criminal activity has declined among all clients, and no new cases of HIV infection occurred among HIV-negative clients.

Programme financing and management

The Government of Kazakhstan is steadily increasing domestic financing for HIV prevention and treatment, including for key populations. HIV funds increased from 3 988 million Kazakhstan Tenge (approx. US$ 14 713million) in 2011 to 6 910 million (approx.US$ 25 494 million) in 2014. Similarly, financing from international sources declined from 962 million Kazakhstan Tenge (approx. US$ 3 549 299 million) in 2011 to 427 (approx. US$ 1 575 417 million) in 2014. The main mission of the CCM is to coordinate activities of all partner agencies and provide analytical reviews for the Governments of Kazakhstan. The National HIV/AIDS Programme involves 55 NGOs, 578 outreach workers, and 30 social workers – Republican AIDS Center is a key partner.

Lessons learned and recommendations

Increasing role of the Government in the national HIV response coupled with the CCM and inter-agency cooperation significantly contributed to the success of the National HIV/AIDS Programme.

- By 2020, the Government is planning to
  - Increase HIV testing and counselling by 15%
  - Implement pilot testing by the NGOs experts and increase preventive measures among vulnerable population.
  - Strengthen inter-agency collaboration to control the spread of HIV infection among vulnerable population.

- Actions for HIV prevention among the population include
  1. Raising public awareness on HIV and AIDS
  2. Capacity building of NGOs to implement HIV prevention programmes, including all forms of communications.
  3. Providing funding for NGOs working on AIDS
  4. Increasing knowledge about HIV and AIDS among business-structures and stimulate PPP.
- Official registration of medications (Methadone) and procurement using local budget.
- Strengthen OST programmes, with the involvement of the public, non-governmental and international organizations.
- Involved WHO expert's to the process of additional assessments and evaluation OST programmes.

Contact Person Professor Maksut Kulzhanov**,**
Ministry of Health and Social Development, Republic of Kazakhstan
Address: 19a Utepov Street, Almaty, 050060, Republic of Kazakhstan
Tel: +7 727 337 80 36
Email: kulzhanov@ksph.kz or mkkutzhan@gmail.com

9. Philippines – Quezon City Investment Plan for AIDS (QCIPA) – A Strategic Framework and an Advocacy Tool

Programme implementation date	2012
Implemented by	▪ Government
Scope of submission	▪ Fair share between domestic and international funding ▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access ▪ Programmes, policies and laws ensuring no one is left behind
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	No

Background

The 2012-2016 AIDS Medium Term Plan (5th AMTP) aims to reduce the HIV transmission with a goal of maintaining the national HIV prevalence at less than 1%. The Philippine National AIDS Council (PNAC) carried out a local/city categorization based on its HIV burden. It has identified 70 out of 144 cities nationwide as top priority sites for HIV prevention. These cities which included Quezon City, contribute more than 50% of the annual reported HIV cases in the National AIDS Registry.

The Quezon City Investment Plan for AIDS (QCIPA) is contributing towards these national objectives. Particularly, the objective is to reduce new HIV infections and other sexually transmitted infections (STIs) among key populations at higher risk of HIV acquisition and transmission by 50% from baseline. The investment plan works towards reaching 80% prevention coverage of the estimated total number of MARPs by 2016. The Quezon City programme is also HIV-sensitive as many different interventions have been initiated to overcome stigma and improve the situation for people living with HIV.

The largest city in the Philippines and located in the National Capital Region (Metro Manila), Quezon City has had an active HIV response since the 1990s. It was one of the original ten HIV sentinel sites under the Government's AIDS Surveillance and Education Project (ASEP, 1993-2003) and has a rich history of social activism and community mobilization.

The city is also home to a large number of entertainment establishments, and since 2009, has experienced a significant increase in HIV prevalence, particularly among men who have sex with men (MSM). While the national HIV prevalence among MSM stands at 2%, in Quezon City it is about 6%. Quezon City is the only Philippine participant to the regional initiative on "ASEAN Cities Getting to Zero HIV infection, Zero discrimination, Zero AIDS-related death" launched in 2012 to operationalize the ASEAN Declaration of Commitment on Getting to the 3 Zero's. The experience will inform the rollout plans in other priority cities in the country.

In 2012, Quezon City developed its 2012-2016 Investment Plan through the assistance of UNAIDS and other partners, and hence advanced the process. The development of the plan was facilitated by a number of enabling factors:

1. Proactive and responsive City Health Department that has provided leadership in the HIV response;
2. Consistent use of strategic information to inform the response;
3. Functioning Local AIDS Council with an annual work plan, budget and a legal mandate;
4. Effective coordination and cooperation between Quezon City Health Department and partners;
5. Strengthened public-private partnership;
6. High level leadership commitment to action from the local executive and local legislative council.

The evidence-based City Investment Plan became a critical tool in mobilizing local resources and a platform for the implementation of the following innovations:

Service Delivery:

- Sundown clinic of MSM-friendly services. Government-run clinics called "Social Hygiene Clinic" (SHC) originally mandated to provide HIV and STI services to female sex workers were expanded to provide the services to MSM and transgender persons.
- Social Hygiene Clinics (SHCs) – Bernardo SHC, Project 7 SHC, and Batasan SHC.
- Involvement of local community-based organizations in providing services to key population among others, by hiring of peer educations through funds from the City.
- Establishment of satellite treatment hub
- Strengthening of local referral system – creation of Service Delivery Network

Structure:

- Functioning Local STI/AIDS Council (QCSAC) with an annual work plan and budget (created by City Ordinance SP-838, S-99 in 1999)
- Regular reporting/feedback to local Chief Executive (mayor) and the Local AIDS Council
- Partnerships with establishment owners, business sector
- Partnership with civil society organizations, including network of people living with HIV

Planning/Management:

- AIDS Program Implementation Review (previously annual, now quarterly), with partners
- AIDS resource mapping and mobilisation
- AIDS Investment Plan

Policy:

- Local HIV and AIDS-related ordinances

By 2014, the pioneering Sundown Clinic, known as the Klinika Bernardo which operates from 3:00pm to 11:00pm, won the prestigious National Award for excellence in local governance and innovation. The Mayor received the Galing Pook Award from the office of the President of the Philippines. This generated the much needed political attention from other Mayors in adjoining cities who then expressed interest in being part of the rollout plan. By early 2015, the City of Mandaluyong (around 10 kilometres away) already established their own Sundown Clinic for MSM and transgender persons following the example of Quezon City.

With these successes, the city updated its Investment Plan for AIDS and has extended it up to 2019. The priority now is to scale-up services to key populations among others, through the establishment of a Sundown Clinic in each of the existing five Social Hygiene Clinics.

Programme approach

The QCIPA is contributing towards the objectives of the 5th AMTP and the ASEAN Getting to Zero initiative which makes the Quezon City programme HIV specific. Partnerships with NGOs such as the AIDS Society of the Philippines, Action for Health Initiatives (ACHIEVE), Women's Health Care Foundation, Camillians Order of the Catholic Church, Philippine Catholic HIV and AIDS Network (PhilCHAN), Pinoy Plus Foundation (Filipinos living with HIV group) strengthens referral and networking systems, improves working relationship with different partners, and delivers tangible results.

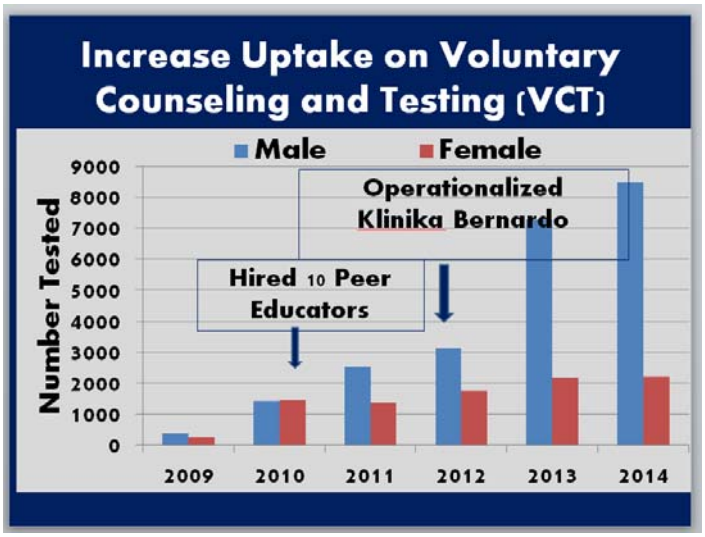
The QCIPA as a strategic framework and as an advocacy tool:

- It contained strategic information that enabled the city to deepen its understanding of its epidemic, pin-point where the problem is (geographically and which population) and collectively act to solve the problem with local solutions.
- It utilizes its epidemiology and programme data – the city studied the trends to make a compelling case for investment.
- Before bringing the plan to the Mayor, the HIV programme team studied their Mayor! What kind of information or issues does he respond to? What were his priorities and political aspirations? They used this knowledge to tailor the approach when reporting on, and seeking support for, the programme.
- They made their Mayor a champion for the HIV response. In one highly publicised event, the Mayor took HIV test in front of the media. They kept the Mayor informed of programme progress, involve him in activities and ensure that the success of the programme reflects well on the Mayor and the administration in general.
- Lobbied and cultivated good relationships with other decision makers/facilitators in the LGU, including fiscal decision makers. These include the Vice Mayor, the Legislative Council, the Barangay administrations and officials in key LGU departments such as the Budget, Accounting and Development Planning Departments.
- Made it easy for investors to help by showing how investing in the response can improve the wellbeing of their clients or stakeholders and, at the same time, generate good publicity. A regular (quarterly) progress review on the investments and programme results were conducted with new potential investors or partners were invited.

In 2014, Mayor Herbert Bautista (sitting) took HIV test in Quezon City. Joining him was Vice Mayor Joy Belmonte (second from right) and City Health Office Dr Verdadez Linga (third from right).

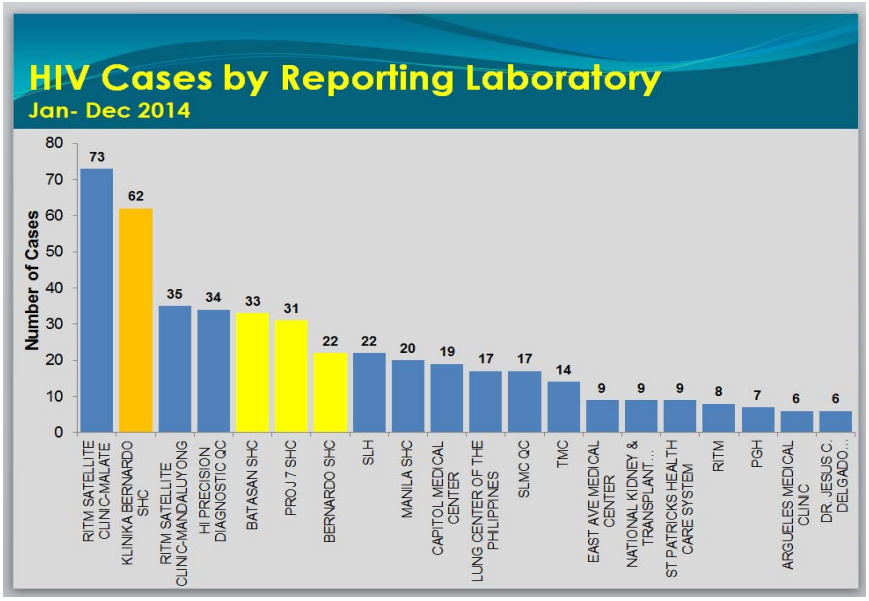
Programme reach

Reach within Quezon City – Voluntary HIV testing and counselling (HTC) coverage steadily increased from less than 500 clients in 2009 to more than 8 000 by end of 2014 – mostly among gay people and other men who have sex with other men.



Source: Quezon City Health Department, Annual Report, 2014

By end of 2014, Klinika Bernardo Sundown Clinic was ranked second in terms of “detected” people living with HIV among top 20 HIV testing centres in Metro Manila.



Source: National AIDS Registry, Epidemiology Bureau, Department of Health, 2015

Reach beyond Quezon City – Around ten cities from all over the country have approached Quezon City to assist them in developing a City Investment Plan for AIDS and brought their staff and officials to visit and learn from Klinika Bernardo. A national workshop will be organised before end of 2015 with Quezon City as the main resource speakers. The mayor of Quezon City made a commitment to ensure that “Quezon City will continue to be a transformative force in ending AIDS in our country.”

Programme Impact

With more Quezon City residents being diagnosed as HIV positives, the city expanded its services to include treatment. By early 2015, Klinika Bernardo Sundown Clinic became a satellite treatment facility of a bigger treatment hub - the Research Institute for Tropical Medicine (RITM).An estimated 200 people living with HIV currently access treatment at the Klinika Bernardo clinic.

The city also signed a Memorandum of Agreement (MoA) with around 20 service providers and partners to form a Service Delivery Network (SDN) which showed signs of strengthened continuum of HIV care for PLHIVs of the city.

REACH – Beyond
Around 10 cities from all over the country have approached Quezon City to assist them in developing a City Investment Plan for AIDS and brought their staff and officials to visit and learn from Klinika Bernardo. There will be a national workshop on this before end of 2015 with Quezon City as the main resource speakers.
The mayor of Quezon City expressed that he will continue to ensure that “Quezon City will continue to be a transformative force in ending AIDS in our country.”

Programme financing and management

In the QCIPA, the city identified an investment need of around Pesos 100 million (approx. US$ 2.2 million) per year. Realizing that only around less than Pesos 5 million (approx. US$ 110 000) was the annual investments of the City in the past (2009-2011), the local government tripled its HIV budget by 2012.

Moreover, additional partners from private sector, including Pilipinas Shell Foundation; civil/non-government organizations, including the Philippine Red Cross, Klinikang Bayan; development partners, including UNICEF and UNFPA were invited to support and eventually invested in the programme. By end of 2014, the HIV expenditure totalled to about Pesos 54 million (approx. US$ 1.2 million).

Lessons learned and recommendations

- QCIPA allowed the Quezon City Health Department and Quezon City STI and AIDS Council (QCSAC) to see clearly, for the first time, what resources were needed for the response, and the scale of the investment gap.

- The Investment Plan has influenced a significant increase in locally-generated resources for 2014, largely due to the LGU's greater awareness of how and where to invest.

- The City Development Planning Office and Executive Offices from the Mayor down to the Barangay levels have also mobilized resources. However, city investment planning could be further strengthened and Quezon City plans to:

    - Gather evidence of impact in order to identify most effective ways to scale-up
    - Assess cost-effectiveness of interventions to be able to show 'best buys' and "better returns"
    - Develop projections of future costs that will be averted by smart investment now
    - Identify scope for efficiency savings
    - Continue to strengthen geographical, programmatic mapping and behavioural/serologic surveillance to have a deeper understanding of the risks and vulnerabilities of key populations

Contact Person Dr Rolando Cruz, City Epidemiologist and City HIV Coordinator
Quezon City Health Department, Philippines
Address: Kalayaan Ave., QCHD, Quezon City
Tel: +63-2-929-8902
Email: rolly.crz@gmail.com

10. Tajikistan – Strengthening the supportive environment and scaling up prevention, treatment and care to contain HIV epidemic in the Republic of Tajikistan

Programme implementation date	2013
Implemented by	▪ Government ▪ Civil society ▪ UN or other inter-governmental organisation

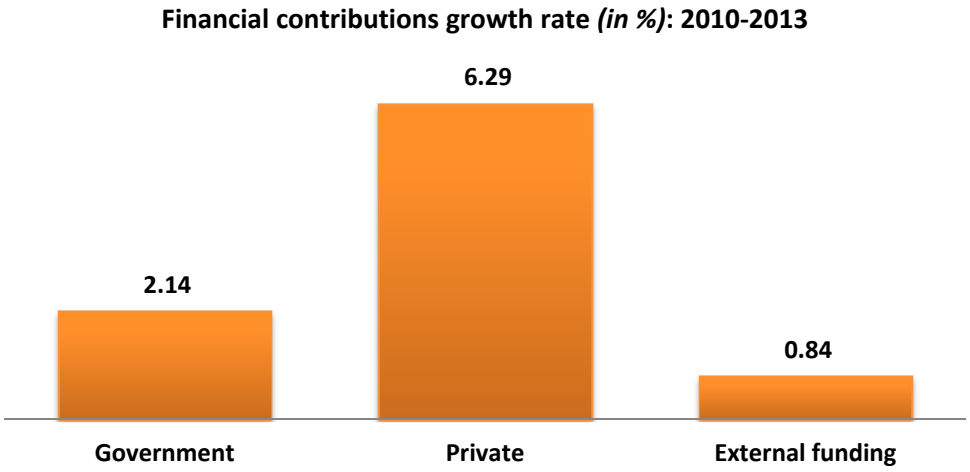
Scope of submission	▪ Fair share between domestic and international funding
	▪ International financing landscape, including role of regional financial institutions
	▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access
	▪ Funding for civil society
	▪ Financing key population programmes:
	  ▪ Programmes, policies and laws ensuring no one is left behind
	  ▪ Programmes addressing criminalization, stigma and discrimination
	  ▪ Working with people living with HIV
	  ▪ Engaging key populations in the AIDS response
	  ▪ Programmes, policies and laws ensuring no one is left behind

Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	No

Background

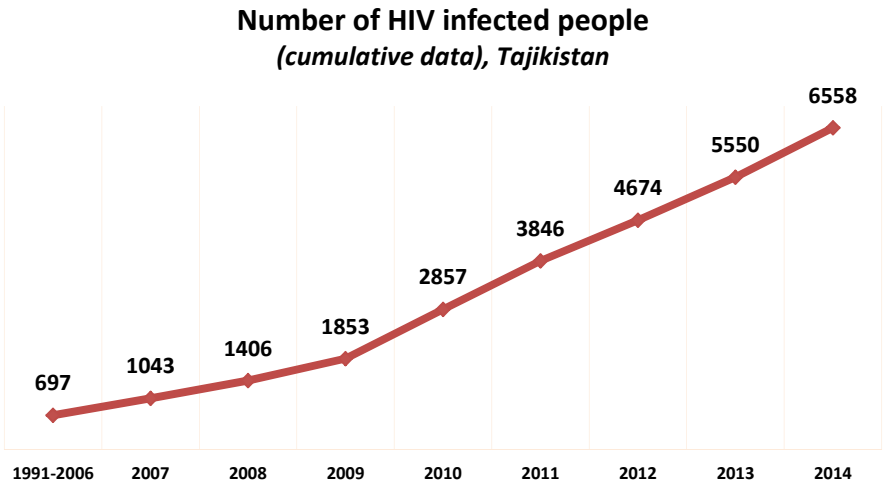
Tajikistan is the only remaining low-income country of the Commonwealth of Independent States (CIS); however, it has seen a GDP per capita growth from US$ 139 in 2000 to US$ 1 305 in 2013 (ranking 133). The national economy is predominately agrarian comprising more than 21% of GDP and employing 46% of labour force. The national economy, despite the annual growth of 8.6% since 2009, is vulnerable to external factors such as world and regional economic crisis, and fluctuation of the energy resources market in the region (especially the Russian Federation). Due to lack of job opportunities, as many as one million men left their homes looking for work in the Russia Federation, Kazakhstan and other CIS countries. In 2012,

the labour migrants' remittances comprised 47% of the GDP. Tajikistan health expenditures constitute 5.8% of the GDP (rank 120 in the word) and growth of budget allocation for the period of 2010-2013 clearly demonstrates that there is a slight decrease of external funding by 0.84% and increase of government allocation (2.14%).



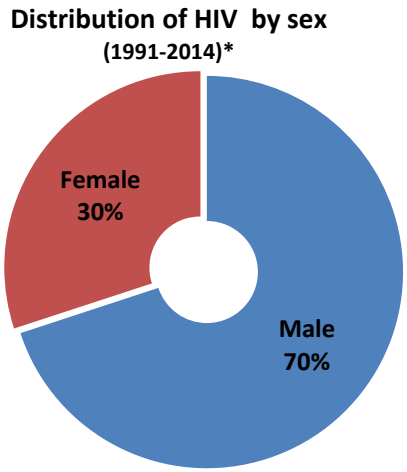
Financial allocation trends by sources, Tajikistan (Source: Tajikistan National AIDS Spending Assessment: 2012-2013)

According to the official statistics of the National AIDS Prevention and Control Centre (NAC), the number of officially registered HIV cases has increased from 2 in 1991 to 6 558 by the end of 2014 (refer to the Annex, Figure 1).

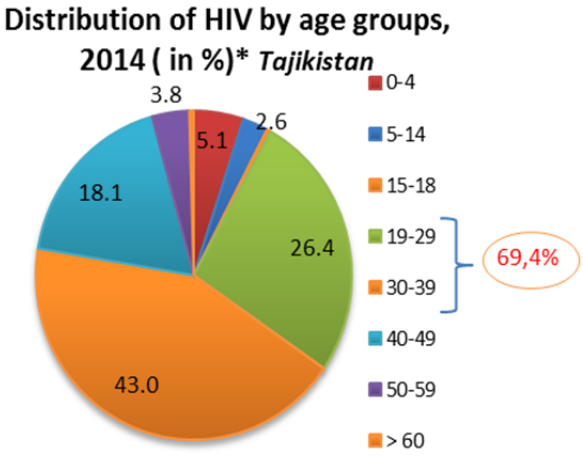


Cumulative number of HIV infected people in Tajikistan (Source: RAC data base, 2014)

The vast majority of the reported HIV cases are among men (70.0%) and age group of 20-40 years almost constitutes 69.5% of all registered HIV cases.



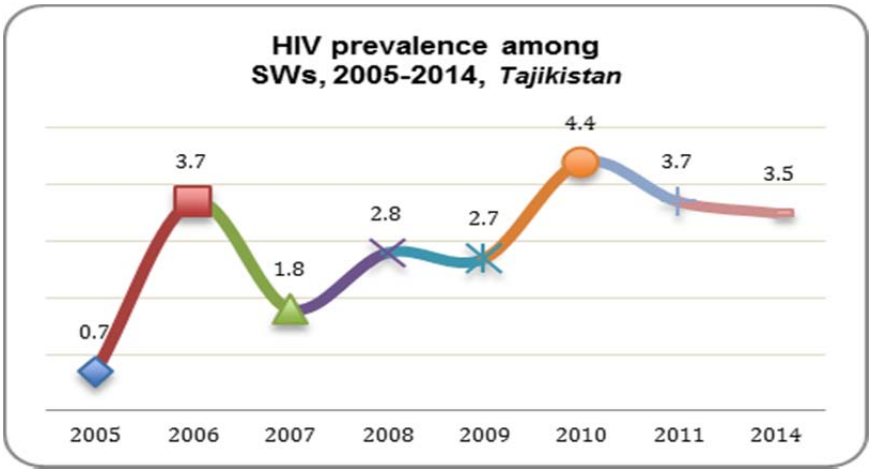
* Source: 2014, RAC data base



* Source: 2014, RAC data base

Distribution of HIV infection be sex and age groups, Tajikistan

The main modes of transmission are as follows: injecting – 24.2% (from 54.9% in 2009); sexual – 60.4%, vertical – 5.6%, unknown 9.8%. By the end of 2014, the HIV prevalence among female sex workers was 3.5%.

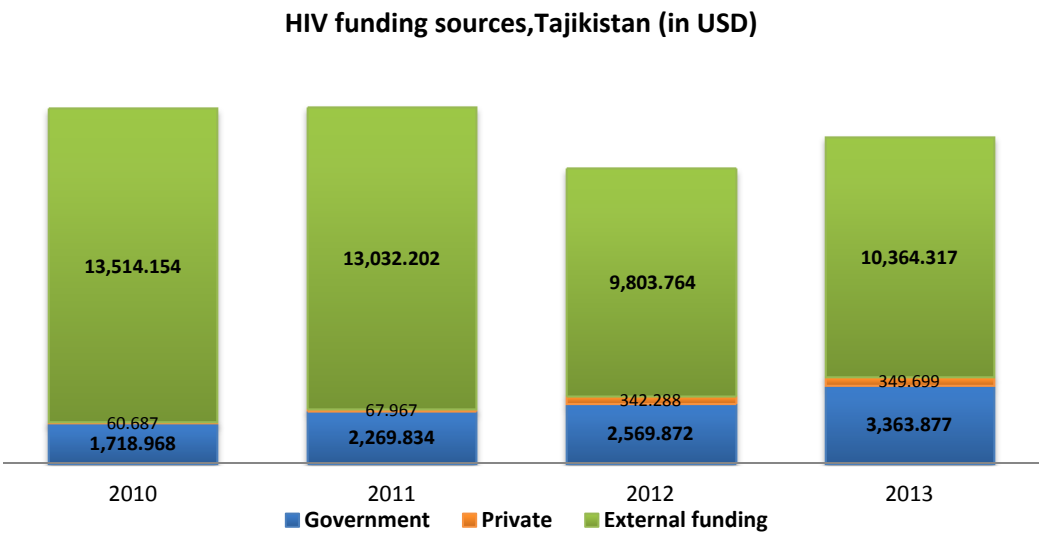


HIV prevalence among Female Sex Workers (Source: IBBS for SWs, 2014)

Programme approach

The programme is HIV specific and the key objective is to create a supportive environment for a sustainable national HIV response and sustainable financing of the National HIV Strategy 2015 – 2017. It is obvious, that funding from external partners (primarily from the Global Fund to Fight AIDS, Tuberculosis and Malaria) is expected to decrease steadily over the next years. Within

this context, policy makers of the Government need to explore opportunities and develop clear strategies to ensure that HIV response activities are sustained in the future from local and other external funding sources. Tajikistan is a resource limited country and largely dependent on external resources – almost 73.6% of HIV expenditure comes from donor agencies.

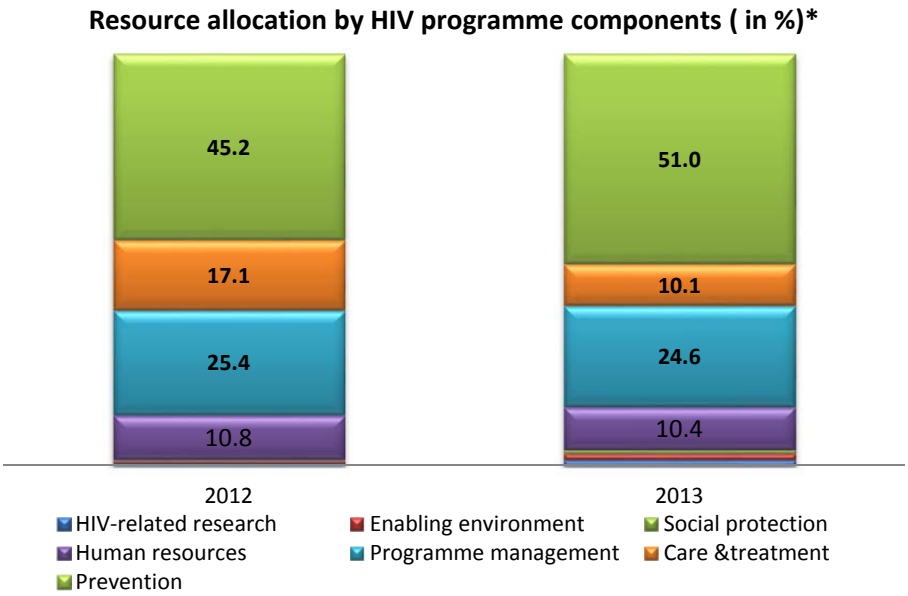


HIV funding sources in Tajikistan (Source: Tajikistan National AIDS Spending Assessment: 2012-2013)

However, the Government is highly committed to improving overall coordination and taking over an increased share of expenditures. Tajikistan has institutionalized the National AIDS Spending Assessment (NASA) and the Government is extensively utilizing the resource tracking exercise results for efficient allocation of available local and external financial resources. UNDP also supported the government in developing a research paper "Modelling an Optimized Investment Approach for Tajikistan" aimed at providing model estimates of future epidemic trajectories in the context of the development of HIV investment case and sustainable financing strategies of the national response. The report looks at three scenarios using 2013 as the reference year - Scenario 1: Continuing with the current investment allocations and current budget ceiling; Scenario 2: Continuing with optimized investment allocations and the current budget ceiling and; Scenario 3: Continuing by scaling up to the universal coverage of essential HIV prevention and treatment services. The key message suggests that with a moderate increase of the investment volume until 2020 combined with an optimized investment allocation, the national HIV response in Tajikistan can be brought on a trajectory which fulfils the basic right to access to essential HIV services for those in need and makes ending the epidemic threat of HIV/AIDS in Tajikistan a realistic goal if an environment without stigma and discrimination is provided so that services available will be accepted and used by the affected communities.

Programme reach

The HIV response is nationwide and prevention has been the largest funding category, comprising approximately 50% of HIV and AIDS spending in 2012-2013. An estimated 32% of the funding was allocated to specific interventions for the three key populations at highest risk – People who inject drugs (PWID), Sex workers (SW) and Men having sex with men (MSM). The costs for programme management and human resources were approximately 24.6% and 10.4% in 2013.



Resource allocation by HIV programme components (Source: Tajikistan National AIDS Spending Assessment: 2012-2013)

According to the programme report to the Global Fund to Fight AIDS, Tuberculosis and Malaria as of June 2015, an estimated 9 761 PWID (77% of the programme target) were reached with prevention services and by mid-2015, an estimated 689 PWID were covered by Opioid Substitute Therapy (OST). This constitutes only 3% of coverage against an estimated number of 23 100 drug users. The programme has reached an estimated 3 055 MSM, which represents 61% of the programme target (5 000) and 14.4% of the MSM population. An estimated 4 232 sex workers were covered by the end of the second quarter of 2015, which represents 64% of the programme target (6 663) and 30% from the estimated number of sex workers in the country (14 100). According to the 2015 WHO study, currently an estimated 14 141 are living with HIV in Tajikistan, of whom 6 944 are diagnosed, 3 383 observed in the AIDS centres, and 2 349 are alive and receiving treatment. An estimated 156 pregnant women living with HIV have also received prevention of mother-to-child transmission of HIV (PMTCT) services in 2014.

Programme impact

The resource mapping exercise (NASA) and working on modelling an optimized investment case for Tajikistan (supported by UNDP) has provided the Ministry of Health and Social Protection (MHSP) with good insights of the funding situation in the country and contributed to regular analysis of the health budget and its execution by priority areas. Ultimately, it has assisted the MHSP and AIDS Centre to better utilize the resources available. Comprehensive analysis of funding available for HIV-related activities by category of interventions enabled government authorities and development partners to better coordinate resource allocation, optimize service provision, improve efficiency of available resources and mobilize additional resources.

Trends related to the usage of sterile syringes for the last injection have increased from 54% in 2007 to 90.3% in 2014. National guidance on the implementation of Opioid Substitution Therapy (OST) have been developed and accepted in 2009. According to Republican AIDS Centre, as of the end of 2013 the estimated number of PLHIV was 13 841 of whom 4 581 (33%) had been diagnosed and registered; and 1 399 PLHIV (31% of those diagnosed) were on ART at the end of 2013.

Programme financing and management

The Principal Recipient (PR) of the grant is the UNDP and the designated Programme Implementation Unit (PIU) coordinates grant activities. The unit was established specifically for The Global Fund programmes management in 2003 and has gained significant capacity, experience and flexibility. The proportion of funds allocated by international organizations constituted 73.6% to 77.1% of the total costs associated with HIV, in 2012 and 2013, respectively. The contribution of bilateral donors (USA, UK, and RF) represented 12.5% to 16.5% in 2012 and 2013, respectively. In 2008, the Government expenditure for the National HIV Strategy was 16% of total funding and it increased to 24% in 2013. In absolute terms, public funding increased from 1 million to 16 million in local currency over the period of 2008-2013. According to NASA 2012-2013 findings, key funding contributors of the National HIV programmes have been listed as The Global Fund (73%), USAID (13%), UNFPA (3.2%), followed by other UN agencies, bilateral donors and International Funds and NGOs.

The National Coordinating Committee for prevention and control of HIV/AIDS, tuberculosis and malaria in Tajikistan (NCC) that oversees programme implementation provides a potentially solid platform for effective coordination between relevant key stakeholders. In 2013, UNDP facilitated and financed the development of National Capacity Development and Transition Plan. The implementation of this plan helped to establish an electronic financial management system at Governmental Sub Recipient (SR) offices, human resources and SR contracting policy, Procurement and Supply Management Policies and M&E tools.

Lessons learned and recommendations

- Direct involvement of key stakeholders in the resource mapping exercise and the modelling an optimized investment case for Tajikistan analysis were very crucial in terms of ownership of the findings and recommendations and further capacity building endeavours;

- Reforming of service delivery channels considering their sustainability was successful only through the integration into existing public service delivery packages.

Key recommendations

- Further improvement of the monitoring and evaluation system through direct engagement of staff from the Ministry of Health and Social Protection and National AIDS Centre;

- Analysis of service delivery options in terms of its efficiency and effectiveness and sustainability (OST services implemented by NGOs)

- Further capacity building and strengthening of government stakeholders in fundraising, planning and programme implementation;

- Active involvement and engagement of other non-health related governmental institutions (e.g. Ministry of Education and Ministry of Finance) and private agencies to concentrate on creating low cost services;

- Further strengthening the role of NGOs and social workers (which is a newly introduced profession in Tajikistan) as the key drivers of service provision to key populations at higher risk of HIV within the national programme components.

Contact person Furkat Lutfulloev, Programme Analyst, UNDP Country Office
Address: 39 Aini Street, Dushanbe, Tajikistan
Tel: +992 93 500 7044
Email: furkatjon.lutfulloev@undp.org

11. Thailand – Ensuring sustainable financing for civil society organizations in HIV response in Thailand

Programme implementation date	2014
Implemented by	▪ Civil society
Scope of submission	▪ Transition of low-income and middle-income countries ▪ Working with the private sector ▪ Funding for civil society ▪ Financing key population programmes:
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

Thailand hosts the 4th largest HIV epidemic in the Asia Pacific Region. The epidemic started in 1984, peaked in 1992 and has been on the decline since early 2000s. It is estimated that in 2014, there were 445 562 people living with HIV in Thailand, of them 172 454 adult women and 6 933 children under 15. An estimated 20 325 people died of AIDS-related illnesses, and 7 695 people were newly infected with HIV.

Thailand's epidemic is concentrated in particular populations groups. It is projected that between 2013-2019, around 50% of new infections will occur in men who have sex with men (MSM), 24% will be acquired through spousal transmission, 12% will be among people who inject drugs (PWID), 10% among female sex workers (FSW) and clients, and the remaining 4% will be contracted through casual sex.

The steady decline of the HIV epidemic is attributable to the country's commitment to halt, reverse and end AIDS, and to the consistent, effective response, which has been well advanced in many aspects, including successful 100% condom use programme, prevention of mother-to-child transmission of HIV (PMTCT) services, HIV treatment irrespective of CD4 level financed under Universal Health Coverage, and introduction of health insurance for migrants. Continued partnership between public sector and civil society has been a critically important factor in the response success.

Thailand has been consistently increasing domestic investment in the HIV programme and currently finances around 90% of its HIV response. The remaining 10% come from The Global Fund, who has been continuously contributing, financing primarily HIV prevention and support among key affected populations, and in particular community outreach by civil society and communities.

The Global Fund resources will come to an end after 2017 and therefore Thailand's Country Coordinating Mechanism already mobilised key stakeholders to develop and implement a plan to transition to self-reliance in financing the disease responses. Public sector and civil society are fully engaged in this work.

The Ministry of Public Health (MoPH) has commissioned the International Health Policy Programme (IHPP) to study the AIDS funding cascade, define the financial optimum required to end AIDS by 2030, identify the current and potential sources of public sector financing and propose the appropriate financing model. In this process, MoPH has initially mobilized 200 million baht from the National Health Security Office.

At the same time, civil society organizations (CSOs) have formed an alliance and activated mechanisms to move on mobilizing resources from the public and the private sector for sustained engagement of CSOs and communities as partners in HIV and wider health. UNAIDS has provided technical assistance to build CSOs and communities capacity for both securing the public sector resource and the private sector fundraising.

Programme approach

This is an initiative aiming to capacitate CSOs and community networks in securing sustainable financing from both the public and the private sectors for continued engagement of CSOs and communities in disease responses and health.

There are 4 tracks of capacity development for sustainable CSO resource mobilisation:

- Track 1: Review and analysis of the existing and potential sources of public sector financing for civil society and community engagement in disease responses and health in Thailand; including review of the relevant policy and legal frameworks that facilitate or limit CSO/ communities' access to public sector funding. The findings of the Track 1 are to be triangulated with the findings of the financing cascade study by IHPP.

- Track 2: Review and analysis of the existing and potential sources of the private sector financing for civil society and communities, including the review of policy and legal frameworks that facilitate or limit the scope and scale of the private sector giving or the CSO/ communities' access to the private sector funding. Track 2 merges with Track 4 in identifying potential fundraising champions and major givers.

- Track 3: Analysis of effective domestic CSO financing models implementing outside Thailand, both in the AP Region and beyond (courtesy UNAIDS HQ).

- Track 4: CSO capacity development for resource mobilisation through a series of workshops where a top notch private sector fundraising expert works with an alliance of

CSOs to conceptualise, prepare and successfully implement a context-appropriate, sustainable CSO resource mobilisation campaign.

Programme reach

The initiative has the primary focus of sustaining financing of CSOs and communities through consistent, successful resource mobilisation effort by CSOs and communities. Key national CSOs and community networks have been engaged, including Thai NGO Coalition on AIDS (TNCA), Thai National AIDS Foundation (TNAF), Raks Thai Foundation, Planned Parenthood Association of Thailand (PPAT), Population and Community Development Association (PDA), Path 2 Health Foundation, Foundation for AIDS Rights (FAR) and key community network leaders from SWING, Empower Foundation, Rainbow Sky Association and Ozone Foundation.

The CSOs and communities have set their 2016-2020 resource mobilization targets at about 700 million Thai baht per year, to finance:

1. Outreach and prevention for and with key affected populations;
2. Strengthening CSO governance;
3. Skills development to increase the scale and scope of public private partnerships;
4. Building local resources mobilization capacity of CSOs.

Programme impact

In the long term, the initiative contributes to civil society capacity development, strengthening of the civil society sector as a partner, and enhancement of CSOs and community networks engagement in HIV, TB, malaria and wider health areas. At community level, sustainable financing of civil society will translate in quality community based/ centred services, which will impact positively on the quality of life of people living with HIV and other diseases, as well as of wider communities. Coordinated engagement of public sector, civil society & communities, and the private sector in the national disease response will increase its cohesiveness.

Programme financing and management

The initiative has been collectively financed and managed as a partnership. Technical assistance to support consultancy work for Track 1 & 2 has been supported through UNAIDS TSF-AP, and for Track 3 & 4 by UNAIDS HQ. The civil society participants have been covering the local costs, including the meeting costs, travel and accommodation.

Lessons learned and recommendations

- CSOs and community networks' ability to secure sustained financing for their engagement in disease responses and health becomes a must in the context of shrinking donor financing and increased emphasis on domestic financing of health.

- Fundraising is an area of engagement that requires expertise and dedicated capacity.

- Developing the necessary expertise in CSOs and community networks requires commitment on their part and investment of time, effort and resource to retain a trainer.

- CSOs capacity development for private sector fundraising creates an opportunity to strengthen alliances among CSOs; this opportunity needs to be utilised deliberately, so that to prevent competition at later stages.

- Outside the private sector fundraisers community, there is little understanding on the division of labour between public sector and CSO in encouraging and enabling the private sector giving; as a result, there is a risk of public sector institutions and CSOs creating competition for private sector resource.

Contact person: Promboon Panitchpakd, Secretary General, Raks Thai Foundation
Address: 185 Praditphat Rd, Soi Praditphat 6
Samsennai, Phayathai District Bangkok 10400
Tel.: +66 2 265 6888
Mob.: +66 81 8107089
Email: promboon@raksthai.org or promboon07@gmail.com

III. Eastern Europe

12. Republic of Armenia – Enhancing sustainability of HIV response through complementarity of funding by the Government

Programme implementation date	
Implemented by	▪ Government
Scope of submission	▪ Fair share between domestic and international funding ▪ Transition of low-income and middle-income countries ▪ Sustainability planning (financial, programmatic, institutional and systems)
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

Armenia with a population of 2.977 million is an upper lower middle-income country with Gross National Income (GNI) per capita of US$ 8 140 (2013 WHO). Remittances from migrant workers play an important role in Armenia's economy. According to WHO Global Health Expenditure Database, total expenditure on health as per cent of GDP in 2011 was 4.3%.

By the end of December 2014, an estimated 1 953 new HIV cases were registered in the country among the citizens of Armenia, including 38 cases of HIV infection among children. AIDS diagnosis was made among 1 006 people living with HIV, of whom 22 were children; and 417 death cases have been registered among people living with HIV, including 7 children. An estimated 3 800 people were living with HIV in Armenia in 2014. Overall, 59% of registered adult HIV cases in 2012-2014 were infected abroad, together with 14% among their sexual partners, meaning that 73% of cases registered in 2012-2014 are associated with migration.

The activities implemented within the framework of "National Programme on the Response to the HIV Epidemic in the Republic of Armenia for 2013-2016" are funded mainly by The Global Fund to fight AIDS, TB and Malaria, through allocations from the State Budget, also from the Russian Government and financial support provided by other donors.

The total among of AIDS spending made in Armenia in 2014 amounted to AMD 2 832 883 393. The sum of allocations from the state budget made up 26.8% of the total AIDS spending in 2014.

Programme approach

The initiative is aimed at increasing the HIV-related allocations of state in the mid-term expenditure framework programme of 2016-2018 of the Government via advocacy actions, discussions, meetings on various levels and cooperation with other state bodies in particular the Ministry of Finance, the Cabinet of Prime Minister of the Republic of Armenia, and etc.

Programme reach

The main focus of this initiative is to ensure sustainability in the provision of antiretroviral treatment (ART) and prevention of mother-to-child transmission of HIV (PMTCT) services throughout Armenia and increase state funding for the HIV prevention and treatment services in the period 2016-2018 as a step forward towards sustainability of the HIV response after the possible withdrawal of The Global Fund grants in 2018.

Programme impact

The main achievement of the initiative is that the Armenian Government has agreed to put additional resources for the HIV response during the period of 2016-2018 to prepare itself gradually for a possible take-over of main activities after 2018. It includes HIV testing and counselling for the pregnant women starting from 2016, PMTCT and first-line ART services will commence for 200 people living with HIV in 2017 and for 300 more during 2018. The state allocations for the HIV prevention and treatment budget line are expected to increase by more than 2.5 folds in the coming three-year period.

Programme financing and management

Led by the Ministry of Health, a number of meetings and discussions on various levels were held in active participation of international partners from The Global Fund and UNAIDS to achieve agreement and commitment of the decision makers to increase domestic HIV funding.

Lessons learned and recommendations

The success of this undertaking is attributed to the efforts of the Ministry of Health complemented by the active advocacy efforts of international partners and non-governmental institutions. Further work has to be carried out to ensure gradual increase of the share of HIV-related expenditures in the state health care annual budgets with gradual takeover of all programmatic costs, in particular the methadone substitution therapy, procurement of diagnostic supplies, preventive activities in KAP’s and other components.

Contact person Hasmik Harutyunyan, Manager, Ministry of Health Global Fund PCT
Address: Government Building 3
Tel: +37410543650

IV. Latin America

13. Uruguay – Strengthening SRH/HIV health policies and services through SRHR/HIV linkages: the systematization of the experience of the integration of SRH and HIV Units of the Ministry of Health

Programme implementation date	2010
Implemented by	▪ Government ▪ UN or other inter-governmental organisation
Scope of submission	▪ Fair share between domestic and international funding ▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access
Programme evaluation/assessment	Yes
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

In the wider context of social reforms, implemented by the Government of Uruguayan throughout the last decade, the strong emphasis on the sexual and reproductive health services and rights promotion, has positioned the country in a leadership role in the region in the advancement of the ICPD Agenda. However, persistent social and economic disparities still hamper the full realization and enjoyment of these rights for all population groups. Poverty among young people under 18 years old is 18.4%; almost double the national average of 9.7% and nine times higher than among 65 years old and above. Despite falling fertility levels, adolescent fertility rates do not show a decreasing trend, remaining at 60 per 1 000, with a higher incidence among afro descendants, low income and less educated women.

Adolescent pregnancy is three times higher among young poor girls than among other women. Although there are systems in place for access to reproductive health services, adolescents lack sufficient knowledge of sexual and reproductive rights. Recent research shows that 65% of adolescent pregnancies are unplanned, while only 54% of women report having enough autonomy to negotiate contraceptive use with their partners.
Since the beginning HIV epidemic shows a slowly, though constantly increasing trend, with 40% of the new infections among the age group between 15 and 34 years old. Late HIV diagnostics high prevalence among transgender populations (30%), cocaine injection users (10.4%), men who have sex with men (12%) and stigma and discrimination remain critical issues for people living with HIV and against lesbian, gay, bisexual, transgender and intersex (LGBTI) people. According to the 2008 National AIDS Spending Assessment (NASA), Uruguay´s expenditure

was US$ 14 million, which was generated 54% from public funds, 44% private funds (in particular condoms) and 2% from international cooperation.

Programme approach

The Area of Sexual and Reproductive Health was created in 2010 having as a framework the Law in Defence of Sexual and Reproductive Health Rights (approved in 2008 and regulated in 2010), integrating the National Program for STD-HIV/AIDS, the Integral Health Program for Women and the Violence and Health Program. Its mission is to integrate sexual health and reproductive health as part of the overall health of people, promoting that citizens become responsible for their own health, actively participating in decisions which involve them. The policies, regulations and programmatic actions were developed from the integral viewpoint integrity between programmes and inter-sectoral and inter-institutional work.

This perspective allowed to link and coordinate the topics of pregnancy, contraception, assisted human reproduction, safe abortion, prevention and care of STIs - HIV, domestic violence, health of men, promotion on sexual and reproductive health, approached from the standpoint of human rights, gender, sexual diversity and life cycles. This integration and integrality has been a challenge and most important achievement of the Sexual and Reproductive Health Area that allowed strengthening the objectives and specific actions of each Program in an approach and structure of comprehensive operation.

The systematic search of work associated with public and private actors has been another key feature of the approach of the Sexual Health and Reproductive Health as an effective and efficient mechanism to improve interventions, involving other institutions, including civil society, to extend the results and essentially to promote and restore the rights of people. In this framework, the response to HIV and its scope were guided by the National Strategic Plan (PEN), which was prepared on the basis of available national evidence and international recommendations, in an inclusive and inter-sectoral manner with the National Commission for HIV - AIDS, under the leadership of the Program for STD-HIV/AIDS and the support of UNAIDS and UNFPA.

Programme reach

The detail of the main programmes and actions implemented by the Sexual and Reproductive Health Area through the development of regulations, guidelines, training, monitoring, resulted in a qualitative leap in addressing sexual and reproductive health and the HIV response nationwide for the most affected groups:

- Strengthening of Sexual and reproductive health teams in all health care providers and the Network of Coordinating Teams for monitoring them;
- Implementation of the Plan for the elimination of vertical transmission of HIV and congenital syphilis;
- Creation and implementation of the Health Centres free of homophobia;

- Implementation of the Comprehensive Approach for Sex Workers project for their social inclusion and empowerment;
- Comprehensive approach for the health of LGBT people, comprehensive approach for Tuberculosis, STI and HIV in the prison population;
- Project to improve the response to STIs-HIV in first-level health centres in border regions;
- Seroprevalence, knowledge and health promotion with users of cocaine base paste and crack from Montevideo and the metropolitan area;
- Pilot decentralization of comprehensive care for PLHIV in first-level health centres;
- Promotion of the diagnostic test at primary health centres;
- Full implementation of Comprehensive Condom Programming strategic approach, including 2 ongoing pilot experiences on implants at national level and on Female Condom at metropolitan health care centres;
- Implementation of policies for the use of medicines ensuring sustainability and viability of antiretroviral treatment;
- The promotion and protection of human rights of people with HIV and vulnerable groups; Strengthening the epidemiological monitoring and surveillance;
- Logistic management and assurance of supplies for sexual and reproductive health, including contraception methods, condoms and quick tests for Syphilis and HIV;
- Development of Strategic Lines for sexual and reproductive health of Men, Implementation of the Voluntary Interruption of Pregnancy;
- Multiple strategies of promotion, prevention and education in Sexual and Reproductive Health, including the inter-sectoral Health Commission – Education Sector.

Programme impact

In terms of the epidemic of STIs and HIV:

- The reported rate of HIV which presented a steady increase during the period 2000 - 2012, begins to have a decrease in 2013 and 2014;
- The decrease of late diagnosis (in 2014, 16% of new infections were reported in stage AIDS), the increase in people under Antiretroviral treatment (from 2791 people in 2010 to 5300 people in 2014);
- Decrease of the incidence rate of congenital syphilis per 1 000 births to 2/1.000 in 2014;
- Decrease in the percentage of vertical transmission from 4.8 in 2010 to 1.6 in 2014;
- Reduction of complaints by situations of stigma and discrimination. However, critical gaps remain among key populations and users of the public health sector.

Programme financing and management

The actions have been managed and implemented by the institutional structure of the Sexual and Reproductive Health Area which articulates the three programmes mentioned above and in close coordination and joint work with the following actors: in particular, the CONASIDA-MCP, National AIDS Commission-Country Coordinating Mechanism formed by a Decree of the Executive Power in 2008, but in operation since 2005.

CONASIDA is a comprehensive forum for participation of multiple stakeholders involved in the response to HIV and an advisory council of coordination, presentation, discussion and validation of proposals and influence on public policies related to HIV and AIDS. All the resources have been provided by the Ministry of Public Health, by the Administration of State Health Services (Administración de Servicios de Salud del Estado - ASSE), the main effector State Health, with the support of funds from international cooperation, particularly UNAIDS and UNFPA for the implementation of pilot studies, capacity strengthening and generation of evidence.

Lessons learned and recommendations

The process keys of the results obtained by the comprehensive approach of Sexual and reproductive health and HIV are the following:

1. The political will to implement major changes in sexual and reproductive health and right and HIV response, including the allocation of resources to promote strategies of Sexual Health and Reproductive Health essential condition for its sustainability;

2. The technical capacity and inter-disciplinarily of the Area and its horizontal, articulate and committed working method;

3. The systematic integration of the Sexual Health and Reproductive Health Area with other areas of the Ministry of Public Health) and other institutions, particularly ASSE which is the key implementing health institution, Ministry of Social Development, civil society, as a central element to improving the effectiveness of the implementation of policies and programmes;

4. The integration of HIV to the health agenda and sexual rights and reproductive rights by favouring the development of a set of key programmatic actions and policies to strengthen linkages between the various health issues and the HIV and even integrate them into the response which resulted in the systematic promotion of diagnosed testing of HIV, the promotion of male and female condom as dual protection, the integration of the prevention of syphilis and HIV with Maternal and child health, the approach to LGBT population from the comprehensive health and human rights, the decentralization of HIV care at the first level of health integrated with SRH services.

Main challenges are the persistence of male gender culture at societal level, to strengthen the leading role of the Ministry for monitoring quality health policies, to guarantee the necessary resources and to strengthen the monitoring systems.

Contact Person Juan José Meré, HIV Adviser, UNFPA, Uruguay Country Office
Address: La Cumparsita 1373, Montevideo
Tel.: + 598 94453240
Email: mere@unfpa.org

V. Multiple Countries

14. ECOWAS – the ECOWAS regional pharmaceutical programme (15 countries)

Programme implementation date	2010
Implemented by	▪ Government ▪ Private sector ▪ UN or other inter-governmental organisation
Scope of submission	▪ Fair share between domestic and international funding ▪ Promoting domestic pharmaceutical manufacturing ▪ Working with the private sector ▪ Programmes to encourage and develop South-South, South-North and triangular cooperation
Programme evaluation/assessment	
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

- The Economic Community of West African States (ECOWAS) is a regional authority with as member countries: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Sierra Leone, Senegal and Togo. The West African Health Organization (WAHO) is the specialized health agency of the ECOWAS.

- Home to around 365 million people, the ECOWAS region is typified by high incidence of Malaria, Tuberculosis, and HIV among other communicable and non-communicable diseases as well as the high morbidity and mortality associated with these.

- Public health crises (e.g. Ebola and polio), conflict situations in the Sahel and persistent governance issues impede the overall investments in health systems, including for the Fast-Track goals.

- The HIV epidemic stands around 1.5 % prevalence (4.5 million people living with HIV) and treatment coverage of around 25% (1 million).

- Only around 20% of the AIDS financing comes from domestic sources and between 70% - 98% of the needed essential medicines come from outside the ECOWAS region.

- The ECOWAS region is also a vibrant economic and social integration model, where economic growth is around 6% and youth constitutes around two thirds of the population (Ref AfDB).

- Against these challenges, the West African Health Organisation (WAHO) is steering a regional AIDS strategy 2012-2016, of which the local manufacturing of antiretroviral medicines (ARVs) has emerged as a game-changer and has stimulated the development of the ECOWAS Regional Pharmaceutical Plan 2014-2020 (ERPP).

- Using the AIDS response as a pathfinder, the ERPP aims at affordable and quality health commodities to achieve the global commitments of ending the AIDS epidemic by 2030 and the Health Sustainable Development Goals (SDGs).

Programme approach

The AIDS response and Fast-Track efforts act as a pathfinder and are also direct beneficiaries of the ECOWAS Regional Pharmaceutical Plan.

Vision/goal: improved health outcomes in the ECOWAS through a regional pharmaceutical sector, incorporating a vibrant manufacturing industry and a robust regulatory system that is enduring, sustainable, competitive and managed in an integrated manner to be able to provide quality, affordable, safe and efficacious essential medicines.

Objectives relevant to AIDS response:

- Building on the ECOWAS Charter on public-private partnerships for local pharmaceutical production of ARVs and other essential medicines, to realize ethics-centred public investments in pharmaceutical companies for quality and affordable drugs.

- In line with the ECOWAS principles for human rights respect, including human rights for access to treatment, to promote and implement the concept of pharmaceutical medicines as public health goods.

The synergies: the ERPP is a cross-sector programme linking industrial promotion; medicines and laboratory regulations; anti-trafficking of falsified (SSFFC) medicines; promotion of TRIPs flexibilities; training, and research and development.

Economic development: The ECOWAS Finance Ministers Commission has been sensitized and has disbursed US$1 million yearly domestic investment for the ERPP.

Trade and industrial development: This ECOWAS Commission has included pharmaceutical manufacturing as a regional priority and is jointly supporting the ERPP.

Specific aspects promoting the Fast-Track:

1. *Regular domestic investment in AIDS:* Since 2013, 1,7million US$ has been disbursed to establish and purchase ARVs for the Security Stock; since 2012, each year around 500,000US$ are mobilized to purchase AIDS and other health commodities.

2. *Better ARV Procurement, supply management (PSM) systems*: the ERPP promote better governance in national PSM mechanisms, including PLHIV participation in national ARV quantification committee.

3. *GIPA/Patients' rights:* The ERPP includes support to the West African Pharmaceutical Manufacturing Association (WAPMA) and has recently supported their governance restructuring, which includes inviting membership of patients' association. ITPC WA and RAME have been approached.

Programme reach

Focus on AIDS commodities:

1. Regional governance on ARVs and medicines: procurement, supply management systems. Between 2014 and 2015, the plan provided the first-line ARVs of the ECOWAS ARV Security Stock, which replenished the ARV stocks of Ghana medical stores following the fire, and Senegal stock-out episode.
2. Trade and commercial policies to reduce price of medicines.
3. Certification and pre-qualification of ARVs and essential medicines.
4. Access to TRIPs flexibilities.

Programme impact

1. Treatment interruptions in Ghana and Senegal were averted through the ECOWAS ARV security stock – this stock is consists of medicines that are produced in the region by manufacturers that have benefitted from the ERPP.
2. Greater access to ARVs – medicines produced by the ECOWAS pharmaceutical manufacturers are purchased by countries through their domestic funding.

Programme financing and management

Programme management arrangement is led by the Director General of WAHO.
Financial sustainability:

- Programme initiation has benefitted from domestic ECOWAS contributions, and according to specific programmes: USAID, NEPAD, French, German, UNIDO, WHO
- New partnerships are explored with China (FOCAC); India; Brazil

Major partners:

- UNAIDS (Secretariat and RST WCA) and cosponsor agencies
- USAID and the French Government

Lessons learned and recommendations

Enabling factors:

- A strong regional Member States solidarity and cohesion, on economic, social and development issues.
- A clear-cut conviction that health is paramount to economic and social development.
- Global leadership promoting local pharmaceutical manufacturing – UNAIDS, UNIDO, WHO.

Challenges:

- Isolated development efforts that are not aligned with regional approaches.
- Insecurity and humanitarian crises.

Next steps:

- Effective global resource mobilization to translate the existing domestic leaderships and seed funding into concrete results;

Potential lessons to share:

- Using the AIDS response as a path-finder for broader health advances, and socio-economic development.
- Promoting regional approaches with effective national benefits.

Contact person Dr Carlos Brito, Director, Disease control and AIDS Department
Organisation, West African Health Organization (WAHO)
Address: Bobo- Dioulasso, Burkina Faso
Tel: +22620975775
Email: cbrito@wahooas.org

15. Indonesia, Kenya and Ukraine– UNAIDS tripartite cooperation on HIV and key populations (with support by Netherlands)

Programme implementation date	2012
Implemented by	▪ Government ▪ Civil society ▪ UN or other inter-governmental organisation
Scope of submission	▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Fomenting a data revolution to identify gaps; improve decision-making; address inequities; improve service delivery and access ▪ Funding for civil society ▪ Financing key population programmes: o Programmes, policies and laws ensuring no one is left behind o Programmes addressing criminalization, stigma and discrimination o Working with people living with HIV o Engaging key populations in the AIDS response
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Not applicable
Programme implemented as part of a national plan broader than the national AIDS strategy	Not applicable

Background

Netherlands (NL) is a key donor of UNAIDS since its beginning. In addition to the financial support, UNAIDS and NL agreed three years ago to explore ways to enhance the effectiveness of the cooperation at country level. In consultation with Dutch and international non-governmental organizations (NGOs) and their local partners, which received funding from the Dutch Ministry of Foreign Affairs, it was decided that a partnership with a focus on 'HIV and key populations' could have added value. Three countries—Indonesia, Kenya and Ukraine—were selected for this cooperation which brings together the strengths of the different partners and enhances the joint working of the Ministry and its diplomatic missions, civil society at international and local level and UNAIDS, both at central and country level. The Ministry of Foreign Affairs considers this tripartite cooperation as an innovative and important one, which fits in a changing world.

Programme approach

The collaboration started by bringing different stakeholders together, bridging the gaps between the different key populations, including sex workers, men who have sex with men (MSM) and injecting drug users (IDUs), and between diplomatic missions, UNAIDS and community organisations. Getting to know each other is the first step in building trust and being able to join forces, making strategic use of each other's data, networks and expertise and holding each other accountable.

Since this approach does not follow the traditional project-based planning and budgeting, some stakeholders had to become familiar with this bottom-up approach. Participants in the country consultations were challenged to identify common themes which could be successfully addressed if all partners would join forces.

The overall objective of the collaboration was jointly decided – key populations, including people living with HIV, are empowered to access (health and legal) services, demand their human rights, and enact change. As the cooperation evolved, an additional aim was added to strengthen the link between Community-Based Organizations (CBOs) and Country Coordination Mechanism (CCM) to enhance the opportunities of CBOs to access grants from The Global Fund.

For all three countries roadmaps are being developed in an inclusive and participative process, taking into account the lessons learned, the specific needs and the country context (for example, reviews or planning of national health and AIDS strategies), including the work at local level such as the UNAIDS' cities approach.

Programme reach

At country level the programme involves UNAIDS country offices, Dutch embassies, Dutch funded NGOs and their local partners. In the preparatory process at country level the national governmental organisations, such as the Ministries of Health became interested and some co-hosted meetings for the tripartite cooperation. In addition, the CBOs are better informed about The Global Fund and the CCM.

Programme impact

The country consultations have raised awareness that key populations share common concerns like violence, discrimination, and lack of access to (health and legal) services and human rights and have resulted in more exchange and joint working at country level. Representatives of key populations (local civil society organizations/CBOs) have been introduced and linked with national CCM of the Global Fund.

In Indonesia, an extra seat was created at the CCM for a representative of key populations. Some of the CBOs got better access to influence national AIDS plans/reviews and/or proposals

to be submitted to the Global Fund. The outcomes of the Global Fund grant negotiations are not yet clear for all countries.

Programme financing and management

The NL-UNAIDS tripartite cooperation does not have separate project-funding, but functions as a partnership. Activities like country consultations and related travel costs are jointly funded by the different stakeholders.

The activities at the country level are coordinated by the NGO-country lead. This NGO is responsible for the development of the country road map (objectives, activities, planning).

At global level, there is a Steering Group of senior staff of UNAIDS, Dutch and international civil society and the Ministry of Foreign Affairs. They meet once or twice a year to discuss progress at country level and opportunities for global advocacy on HIV and key populations. Experiences and best cases at grassroots level are used to influence international discussions, such as at the Commission on Narcotic Drugs in 2015.

Major partners include the Dutch Ministry of Foreign Affairs and embassies, Aids Fonds, Mainline, Aids Foundation East West, GNP+, COC, HIVOS, International HIV/AIDS Alliance (IHAA), UNAIDS (both at global and country level) and local partner organisations Dutch NGOs and the Alliance active in the area of HIV and key populations.

Lessons learned and recommendations

- Civil Society Organizations (CSOs) are often engaged with one of the key population groups, such as sex workers or gay men and other men who have sex with men, and did not directly perceive the added value of engagement with CSOs dealing with another key population. The country consultations have raised awareness that key populations share common concerns like violence, discrimination, and lack of access to (health and legal) services and human rights.

- Joining forces on lobby and advocacy with regard to 1) improving access to good quality services, 2) reduction of violence by police, 3) more (access to) funding for prevention, care, support and treatment for key populations and 4) being recognized by the national government as discussion partner seem to be relevant for all involved CSOs.

- CSOs and UNAIDS have become more familiar and engaged with each other.

- In line with current priorities in the Human Rights policy of the Netherlands (human rights defenders, SRHR and women’s rights) embassies will facilitate to protect the space for those working to defend the human rights of key populations.

- Involvement of both NL and UNAIDS can help to broker better relationships between local CSO/CBO and national governments.

Contact person Els Klinkert, Senior Advisor HIV/AIDS, Ministry of Foreign Affairs
Address: Bezuidenhoutseweg 67, The Hague, The Netherlands
Tel: +31 70 348 5595
Email: els.klinkert@minbuza.nl

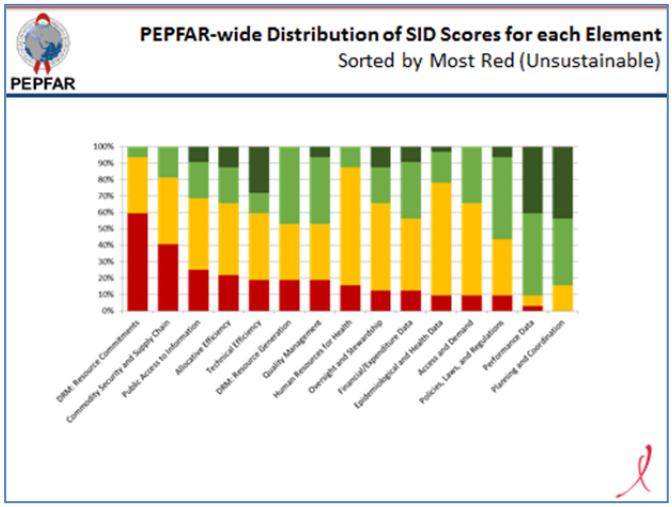
16. United States of America – Sustainability: the financing and programmatic efficiency challenge (PEPFAR)

Sustainability is the critical issue “du jour” as donor funding plateaus, domestic fiscal space is challenged, and HIV service delivery needs evolve with changing national epidemic profiles. With important achievements in reaching 90-90-90, understanding and measuring the elements of a national sustainability landscape is critical if countries are to focus and sustain achievements towards 90-90-90.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) took up the challenge of measuring elements of sustainability by developing a Sustainability Index and Dashboard (SID) and applying it in a consultative process in 33 countries this past year. The SID is helping inform PEPFAR and country stakeholders of where time and resources should be targeted.

While deemed a “learning year” for the initiation of the SID tool, the first results of the SID show that there are sustainability risks from general public financial management weaknesses as well low country commitments to funding HIV. That these are identified risks is not a surprising result. Both of these weaknesses will take some time to resolve.

Public financial management (PFM) and procurement weaknesses are well known and have been identified as problematic in other transitions as well (e.g., GAVI). Public financial management and procurement are systems to themselves which impact all aspects of government service delivery.



There is a modest effort to improve financial management overall, but most investments are from sectoral interventions (e.g., health or HIV) that may lead to underinvestment in PFM as a public good. To really address the weaknesses in PFM, apart from supply chain procurement and distribution issues, there needs to be larger, more widespread capacity building that is

beyond the scope of what can be funded by health spending. Nevertheless, the health community should be attuned to the impact other systems have on the delivery of HIV services.

With respect to domestic resource commitments, there have been strong international investments that have allowed countries to focus their domestic budgets on other development challenges. Public budgets are inherently built in incremental fashion and so even if the political will exists to increase spending today, large shifts in funding will have to occur over time. Even then, there is a lag time to move from planning to implementation and service delivery. Moreover, the most acute problems in HIV – those countries with large incidence and at the beginning of a large youth bulge – also happen to be the poorest countries in the world where budgets are already stretched. Yet, because of the long term nature of HIV care and treatment more effort is needed over the short term to achieve epidemic control. Without significant progress in controlling the disease, more infections will outstrip any reasonable expectation for additional funding. UNAIDS analysis shows that we have a short five-year window to change the course of the disease. In other words, the long term financial sustainability of the HIV epidemic will be determined by acting on critical short term efforts.

The world has made great progress in getting HIV-infected individuals on treatment, but to achieve Fast Track treatment targets, at least twice as many people will need treatment as are already on treatment. This need to ramp up treatment comes at a time when international donor funding has plateaued and, as shown in the SID, country domestic resources are not primed to make significant investments in the short term.

Therefore the resources available over the next five years, most likely will be stagnant. The good news is that over the previous decade in the HIV response, a great deal of funding went to build up the human and physical infrastructure to deliver services. The funding into some of those investments can now be redirected into testing, treatment, and prevention services. Nevertheless, available resources from both international and domestic resources will be highly constrained.

In a highly constrained funding environment, the only way to make progress is to increase the efficiency and effectiveness of available resources. PEPFAR is leading the way by focusing resources on geographical areas where HIV is most prevalent and by focusing on only those programmatic investments that have the highest impact on reducing incidence. However, much more effort is needed to squeeze efficiency out of existing spending.

The SID results are instructive as there are relative low scores on allocative and technical efficiencies. Since the bulk of spending on HIV comes from international donors, this means that all stakeholders need to be involved in the efficiency agenda and sources of spending need better coordination. This effort will require developing new models of care that are simpler and require less highly trained personnel and expensive technologies. Efficiency efforts are needed across the cascade too, starting with better testing strategies that are more targeted and more sensitive to the needs and dynamics of the target population. Prevention programs need to be scrutinized for effectiveness and those that have strong positive effects need to be delivered in

a lower cost, more targeted manner. The side benefit of making these efficiency changes (e.g., simplified models of care) will also mean a better chance of leaving behind a system that can be sustained.

The key to ending the epidemic is treatment. The recent results from the START trial are more proof that getting people on treatment as soon as possible and in the greatest numbers lead to the best outcomes. Given treatment's strong prevention effects it is absolutely essential to break the back of the epidemic. Models guiding the allocation of resources as the effects on epidemiology of the disease need to recognize the wide benefits of treatment that include not just the restoration of health and prevention of infection, but other benefits like health systemic savings (e.g. reduction in incidence of TB) or the microeconomic benefits (e.g., higher levels of educational attainment) on the household of a treated individual. This is why the most urgent need is to reduce the cost of testing, care, and treatment. And in this vein, Test and Start, as one model of care, provides an opportunity for countries to examine how to evolve their HIV service delivery systems. This is a critical step towards meeting the financing and programmatic efficiency challenge given changing epidemic needs and plateaued funding.

Contact person Janis Timberlake, Director of Sustainability and Development, Office of the U.S. Global AIDS Coordinator

Michael Ruffner, Director of Financial Sustainability, Office of the U.S. Global AIDS Coordinator

17. World Bank – Integration of HIV into Universal Health Coverage multi-regional case studies (Indonesia, Tanzania, Kenya, Cote d'Ivoire)

Programme implementation date	2014
Implemented by	▪ Government ▪ UN or other inter-governmental organisation
Scope of submission	▪ Fair share between domestic and international funding ▪ Transition of low-income and middle-income countries ▪ Sustainability planning (financial, programmatic, institutional and systems) ▪ Working with the private sector ▪ Financing key population programmes: o Programmes, policies and laws ensuring no one is left behind o Working with people living with HIV
Programme evaluation/assessment	No
Programme implemented as part of a national AIDS strategy	Yes
Programme implemented as part of a national plan broader than the national AIDS strategy	Yes

Background

Many developing countries are currently intent on expanding coverage for basic package of services, on the path to Universal Health Care (UHC), while at the same time facing the need to expand further the coverage and intensity of their HIV programmes in order to reduce the burden of the epidemic.

For countries heavily dependent on external sources for financing healthcare provision, especially for their HIV programmes, integration of programs previously managed vertically, such as HIV, into a national health insurance programme requires careful consideration of services to be included in the basic benefit package, the implication of access to care for target populations, and the cost.

The goal of this programme is to help governments and their development partners ensure the financial sustainability of HIV initiatives within the context of UHC, in a declining international health finance environment. The multi-regional study programme (which currently includes Indonesia, Tanzania, Kenya and Cote d´Ivoire) explores this issue in varying contexts:

- Indonesia, as many other low-middle income countries, is currently facing challenges in ensuring sustainability of its HIV programmes due to decreased external funding. As the country is implementing a national social health insurance programme to achieve UHC, integrating HIV services into the national programme is considered to be one of the strategies to ensure sustainability of HIV programmes. In this context, the World Bank with its technical partner, the Center for Health Research University of Indonesia, provided technical support to the Government of Indonesia to assess financial and programmatic sustainability of HIV programmes.

- The Government of Tanzania has committed to UHC by 2025 and several strategic plans have projected a huge expansion of the facility network and of the number of staff, while the financial burden of the HIV epidemic will continue to weigh heavily on coming years. The analytical support provided aimed to respond to this critical challenge: find the resources needed over the next 15 years to finance coverage expansion and the sustainability of the HIV programme.

- The Government of Kenya's desire to pursue UHC exacerbates the needs for additional domestic health financing in the short, medium, and long terms. The analytical work provided by the World Bank estimated the future costs associated with UHC by defining and costing a tentative health benefits package (HBP) under different scenarios involving the future growth in coverage of its health interventions including HIV services.

- Cote d'Ivoire has recently recovered from a series of economic and political crises (2002 – 2007, 2010-2011) as well as a short civil war in 2011 which affected the living standards and health systems of the population. As a result, Cote d'Ivoire experiences significant barriers in access and availability of health services as well as insufficient health staff and infrastructure. The study aims at supporting Cote d'Ivoire in its plan to introduce UHC to improve the access to and availability of health services, including HIV services.

Programme approach

The main objective of the analytical work is to provide evidence to support decision making for the integration process of HIV services into UHC schemes. A health/HIV sustainability framework (Tandon and Cashin, 2010, and Langenbrunner et al, upcoming) is used to assess the current and future costs of different service packages and coverage hypotheses, and estimate the contribution of different funding options to fill the projected financing gaps.

The programme adapts the HIV financial sustainability framework to the specific context and needs of each country, including additional analytical work when needed.

Programme reach

The programme has a multi-regional focus and integrates lessons learned from additional countries beyond the 4 countries included in the current submission. The primary programmatic focus of this submission is the financial sustainability of the HIV response.

Programme impact

The programme provided governments with policy options and evidence to support decision making for the integration of HIV into UHC.

- In Indonesia, the results of the analysis will feed into the technical support to assess financial and programmatic sustainability of the national HIV programmes. The proposed options of the basic benefit package (BBP) that includes HIV services were developed based on three considerations; (i) the funding source, (ii) who will be managing the fund, and (iii) which service components to include in the BBP. The options and cost calculation provided will serve as inputs for the Government decision making process to integrate HIV services into the national insurance programme.

- In Tanzania, the study concluded that current government allocation to health is insufficient to ensure sustainability of the HIV programme and substantial progress toward UHC. Simulations indicate that, of several options for increasing funding for health and HIV, the most promising are: (i) increasing government expenditure (public funds only) to at least 10% of Government Expenditures (this would cover 55% of funding needs against 31% under the status quo scenario), (ii) expanding coverage of the two main health insurance schemes to at least 50% of the population while improving its regulations and management (contribution of 12% to funding needs against 4% in the status quo scenario), and (iii) strengthening cost sharing guidelines and rules and optimizing their collection (this would add another 4% toward funding needs if user fees are brought to 15% of health expenditures). The remaining gap could then be easily be covered by a mix of donor and private funding.

- In Kenya, the study shows that even modest increases in the coverage of existing health interventions being offered in the country would require vast amounts of additional financing, on top of the requirements associated with HIV and AIDS. Having the country's National Hospital Insurance Fund (NHIF) as a potential source of financing for HIV is therefore not considered as a viable option in the foreseeable future.

- In Cote d'Ivoire, the study findings show that if the Government was to maintain its current allocation of its total public budget to health (equal to 8%), there will be an annual gap in financing UHC increasing from US$ 413 million in 2015 to US$ 1.5 billion in 2030. If the Government increased to 12% its share of the public budget allocated to health or to the Abuja target of 15%, there will be little or no gap. The report focused on strategies to ensure sufficient and stable funding for UHC inclusive of HIV, rather than

focusing separately on HIV. HIV funding needs are a small portion of the UHC cost (6% on average), and is expected to decline in importance. In this context, it makes sense to move toward integration of HIV within the UHC package and strategy, and the approach taken reflects this view. The relatively low and declining proportion of HIV programmes within the cost of UHC, and the decision of the Government to move rapidly toward UHC, tend to make integration of the funding and management of HIV within UHC a sensible option.

Programme financing and management

This programme was financed and managed by the World Bank, in partnership with the governments of Indonesia, Tanzania, Kenya and Cote d'Ivoire.

Lessons learned and recommendations

Several countries, including Rwanda and Brazil, have successfully integrated HIV into their UHC package. A key advantage of the integration of HIV into UHC is the cost savings that can be derived from sharing human resources, infrastructure, and transport. On the other hand, a potential drawback commonly identified is the reduced focus given to the HIV programmes that can affect the gains made in improved access and quality of services. Careful analysis is needed to properly assess policy options for integration of HIV services in UHC.

Overall, the analysis shows that in order to ensure steady and continued progress toward UHC, governments will need to substantially increase public funding for health and HIV as well as strengthen complementary funding sources. A second lesson is that existing financing mechanisms for UHC and HIV often fall short of their potential for resource mobilization due to flaws in design or regulations (in the case of Health Insurance and user fees), execution (weak monitoring and control, cumbersome regulations and flows), or over-reliance on foreign assistance (thus crowding out domestic funding to some extent). Strengthening these existing mechanisms would go a long way toward increasing sustainability of health and HIV financing, while additional or innovative sources should be seen as complementary to existing mechanisms rather than a substitute for their limitations.

Contact person Nejma Cheikh, Focal Point, World Bank
Tel: +1 2024733635
Email: ncheikh@worldbank.org