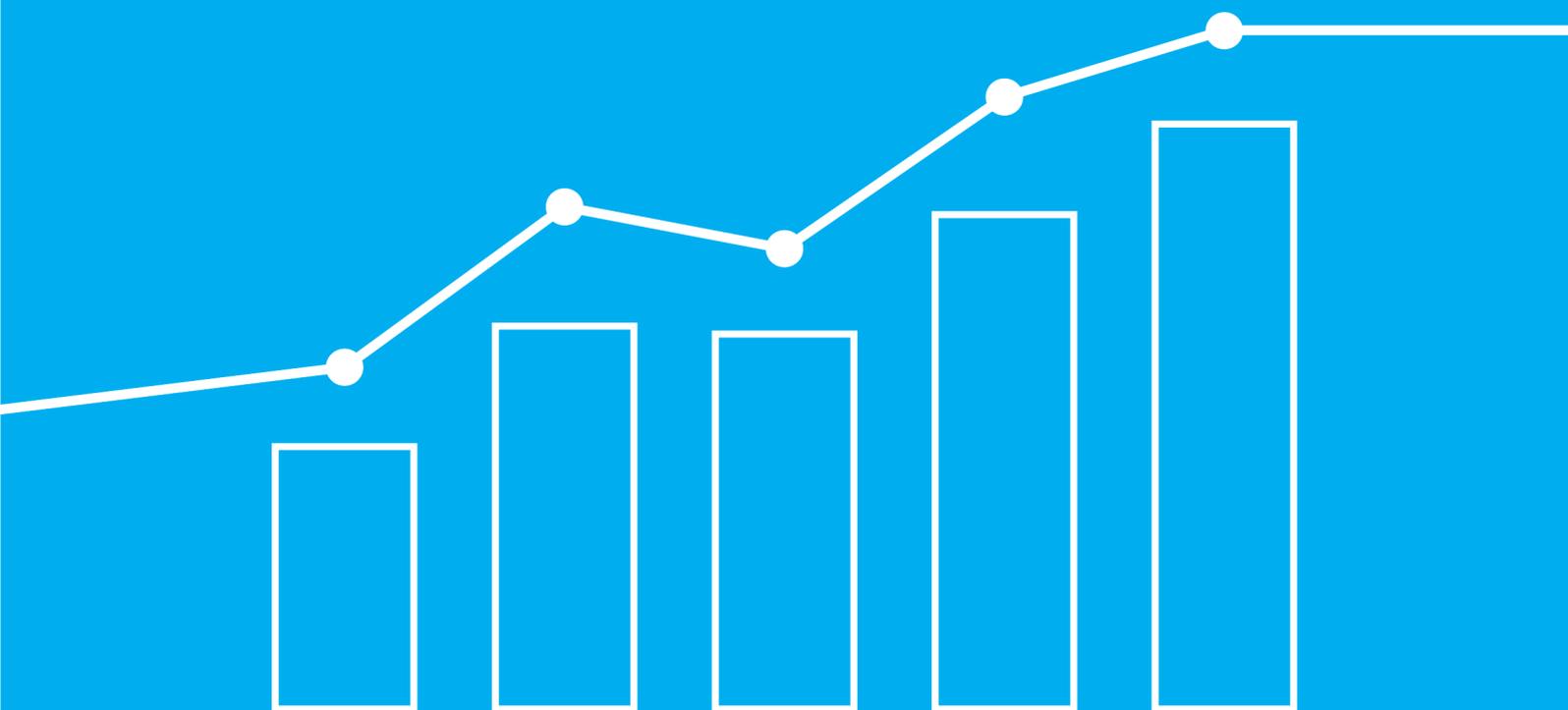


UNAIDS

Joint evaluation of the UN Joint Programme on AIDS's work on efficient and sustainable financing

Appendices and country case studies



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Any enquiries about this evaluation should be addressed to: Evaluation Office, UNAIDS; Email: evaluation@unaid.org The report and related evaluation products are available at <http://www.unaids.org/en/whoweare/evaluation>

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Appendix E: Country case study – Tanzania

This appendix presents the Tanzania country case study in support of the evaluation of the UNAIDS Joint Programme's work on efficient and sustainable financing for the AIDS response. Following country background information and HIV funding context (Section E.1), country-level findings are presented for each of the evaluation questions (Section E.2). A final conclusion and considerations for the future section based on these findings follows (Section E.3). The case study is based on a review of key documentation (Section E.4 provides a list of key references) and stakeholder interviews (Section E.5 provides the list of consultees) conducted in November 2021.

Background Information and country context

Key country characteristics and HIV funding context

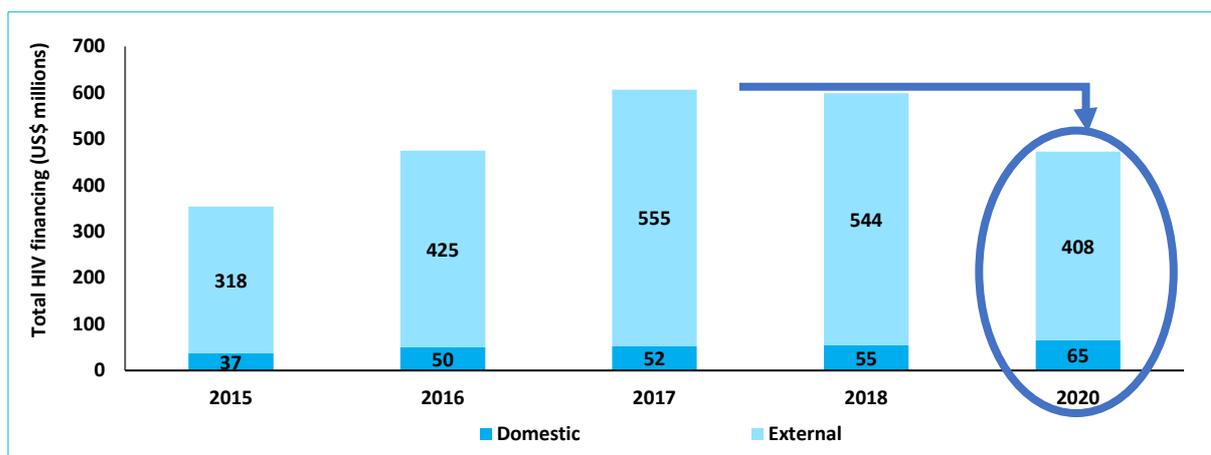
There has been significant progress in the fight against HIV in Tanzania but there are still large gaps to reaching the ambitious 95–95–95 targets by 2030. Over the past 15 years, Tanzania has achieved significant progress in reversing the trends of the HIV epidemic. In 2009, only 22% of people living with HIV (PLHIV) were on ART, and over the past decade coverage tripled to 57% in 2017 (TACAIDS and UNAIDS 2016; UNAIDS 2018). Today, there about 1.4 million people on ART (UNAIDS 2020). This expansion of HIV and treatment services has saved thousands of lives, with 50% fewer deaths annually in 2017 compared to 2010 (UNAIDS 2019). New infections have also declined during this time frame, from 120,000 annually in 2000 to 68,000 in 2020. Looking ahead to 2030, Tanzania has committed to reaching epidemic control and achieving Fast Track and 95–95–95 targets. The Investment Case 2.0 (TACAIDS and UNAIDS 2020) sets out some of the challenges and constraints in reaching the ambitious targets.

The national response to achieve these goals is led by the Tanzania Commission for AIDS (TACAIDS) and the National AIDS Control Program (NACP). To drive progress, both agencies have developed ambitious strategic plans with external partner support including UNAIDS, which include the fourth National Multisectoral Strategic Framework 2018/19–2022/23 (TACAIDS 2018) and the fourth Health Sector HIV and AIDS Strategic Plan 2017–2022 (NACP 2017).

Key populations including female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID) continue to face discrimination and stigma in accessing prevention and treatment services, which puts them at higher risk of infection and poorer disease outcomes (Investment case 2.0). The HIV prevalence among FSW is estimated at 26%, for MSM at 25% and for PWID at 36% (TACAIDS 2018).

Financing for the HIV response in Tanzania has been donor driven with 90% coming from external resources and is therefore vulnerable to plateauing or declining donor support. The Investment Case 2.0 outlines the challenges in reaching the ambitious HIV targets under the shifting financing contexts. Between 2015–17, HIV funding grew significantly reaching around US\$ 600 million per year with the majority of the funding coming from both PEPFAR and the Global Fund, with external funding making up around 90% across years. The majority of the external funding comes from PEPFAR who was responsible for around 60% of total HIV financing and Global Fund contributing around 30% between 2015–17. The Investment Case 2.0 emphasised that, after substantial increases between 2015–17, financing for HIV is at risk of plateauing or declining after 2019 with donors signalling that their contributions hit a ceiling and are likely to decline. Figure E.1.1. sets out the funding landscape in the past as well as estimates for 2020 from the Investment Case 2.0.

Figure E.1.1: HIV expenditure in US\$ from the Investment Case 2.0 (estimates for 2020 did not materialise as expected)



Source: As presented in the Investment Case 2.0

The prediction that there would be a drop in external funding in 2020 from the Investment Case 2.0 has not materialised with PEPFAR funding actually increasing from below US\$ 300 million in 2019 to over US\$ 400 million in 2020 (keeping it slightly above 2018 levels)¹ and Global Fund funding allocations for HIV staying largely stable across the 2018-20 and the 2021-23 allocation cycle.² Nevertheless, the overarching risk of plateauing or declining donor funding over the coming decade as set out in the Investment Case 2.0 holds true. With Tanzania becoming a Lower Middle-Income country in 2020 it is likely that there is an increased push from donors to see more domestic resources for the HIV response (in line with Global Fund sustainability objectives and co-financing requirements). PEPFAR has also recently declared its aim to shift more towards a country-led sustainable epidemic control so that signals around reduced external funding could become a reality going forward (PEPFAR 2021).³ As result, the ambitious HIV targets can only be achieved by increasing domestic resources and by optimising existing resources in Tanzania placing these areas at the core of achieving the HIV agenda.

Progress on domestic resource mobilisation and allocative and technical efficiency has stalled and needs to show significant progress to achieve Tanzania’s ambitious HIV targets. As shown in Figure 1.1. above, there have only been modest increases in domestic financing since 2015 with the major increase driven by external funding (the domestic increase is also partially driven by more accurate reporting for domestic financing based on the analysis in the Investment Case 2.0). There also has been no more recent progress in terms of domestic financing or efficiency. In fact, the latest estimates from the PEPFAR Sustainability Index and Dashboard (SID) suggests that progress has not been significant over the last years as shown in Table E.1.1 below.

Table E.1.1: Technical and allocative efficiency measured in PEPFAR’s SID (0 being lowest and 10 highest)⁴

Strategic Financing and Market Openness	2015	2017	2019	2021
Domestic Resource Mobilisation	1.94	3.21	5.32	5.48
Technical and allocative efficiency score	3.17	4.67	4.93	3.60
Market Openness	N/A	N/A	9.33	9.50

¹ PEPFAR funding database, accessed at: <https://copsdata.amfar.org/s/Tanzania>

² Global Fund funding allocation data, accessed at: <https://www.theglobalfund.org/en/funding-model/before-applying/allocation/>

³ PEPFAR and UNAIDS (2021). 2021 HIV/AIDS Sustainability Index Implementation – key findings and priority actions

⁴ Colour coding from PEPFAR highlighting strengths and weaknesses (red below 3.5, yellow below 7.5, light green below 8.5 and dark green above 8.5)

The low domestic expenditure on HIV is driven by both low proportion of public health expenditure as well as a low proportion of HIV of total public health expenditure. Domestic General Government Health Expenditure (GGHE-D) as % of General Government Expenditure (GGE) being around 7% is clearly below the 15% Abuja declaration targets. Moreover, a more moderate target of 11% identified in the Investment Case 2.0 as more attainable given other development priorities has not been met. Additionally, the Investment Case 2.0 estimated that only around 4.4% of all GGHE-D has gone to HIV in 2019 which is actually below the 6.2% it was in 2015.

Domestic expenditure on HIV as a share of government health expenditure, is assumed to increase from the current level (5.7% in 2017) to 7% of domestic government health expenditure by 2030. Another issue around domestic funding has been that it concentrates on human resources, infrastructure and logistics support with donors driving funding for commodities and treatment, which is the largest programme expenditure, or for critical prevention services. There is also very limited representation of private sector providers. The situation for the need in improvements in technical and allocative efficiencies has also been highlighted (see discussion in Question 7 across specific pieces). The Investment Case outlines the risk that donor funds may decline given concerns about inefficiency in Tanzania's HIV programme.

While COVID-19 has not hit Tanzania as badly as other economies in Sub-Saharan Africa, it has strained the overall economic performance and impacted on government revenue and expenditure, reducing fiscal space for HIV. Generally, Tanzania has been growing at a relatively stable rate over the last decade moving to Lower Middle-Income status in 2020. Analysis from the World Bank suggests that Tanzania has so far not been hit as hard by COVID-19 as other economies in Sub-Saharan Africa although economic performance has been impacted especially through a reduction in tourism and subsequent job losses. While COVID-19 has reduced available fiscal space for domestic spending, it also offers some opportunities with regard to the fight against HIV such as focusing attention on the wider health agenda in the country. In particular, the new president Samia Suluhu Hassan has strengthened Tanzania's response to COVID-19 after taking office in March 2021 after the death of her predecessor John Magufuli. Stakeholders considered this a chance to shift more focus of domestic spending towards health and education from infrastructure investment which were considered the government priority previously.

Findings

Comparative advantage

A key comparative advantage of UNAIDS Country Office is its convening power allowing it to coordinate among different UN organisations and wider stakeholders including donors, government and CSOs. The UNAIDS Country Office was considered by many stakeholders to have the mandate to organise and convene meetings with regards to HIV, including financing and efficiency. This included coordinating among cosponsors where the UNAIDS Country Office takes by far the most active role in driving forward the HIV financing agenda. UNAIDS Country Office was also seen as a key player with regard to coordinating among other stakeholders as well as to advocate for any changes in HIV policy and approaches. This was in particular due to the perception that UNAIDS Joint Programme comes without a pre-set agenda in contrast to some of the large donors, Global Fund and PEPFAR. These donors were perceived by some to have their own priorities and agenda (in part due to the high pressure to deliver immediate results to account for the funding) which sometimes would not directly align with country priority. UNAIDS Joint Programme was hereby seen as a good "neutral broker" allowing to bring different stakeholders together. These attributes were also considered to make UNAIDS a good advocator for changes in the HIV response, with the political work by UNAIDS (the UNAIDS Country Office in particular) having been perceived as positive and something to be strengthened going forward.

UNAIDS Joint Programme has a leading role with regard to providing strategic information (in particular with regard to epidemiological data) and to support the development of strategic and operational documents / tools. UNAIDS Joint Programme is also seen as authority on providing

robust data on the HIV response. However, this is in particular with regard to the provision of epidemiological data which was identified by stakeholders as the data at the heart of advocacy and resource mobilisation. The provision of HIV financing data was also seen as a core task of UNAIDS, however, there are a range of different approaches and tools available (see Question 5 below) and UNAIDS Joint Programme is less considered to be the voice of authority in the area of health financing.

Coordination and internal alignment amongst Cosponsors and UNAIDS Secretariat

The UNAIDS Country Office has taken a strong lead in coordinating the AIDS response on financing and efficiency among cosponsors – this has worked well with the exception of coordinating with the World Bank which could be improved especially with regard to the wider health financing agenda. Similar to other areas of the AIDS response, the UNAIDS Country Office has been driving the response on financing and efficiency among cosponsors. Other cosponsors incorporating HIV aspects within their own initiatives but were not considered to drive the HIV agenda in Tanzania. The cosponsors (in particular UNDP, UNICEF and WHO) reportedly inputted into discussions on financing and efficiency as part of the development of strategies / operational guidance documents and Global Fund funding applications. Cosponsors own initiatives with regard to HIV financing included a budget analysis by UNICEF (including a budget analysis on HIV specifically), provision of normative guidance by WHO around UHC / insurance to the government and an education initiative around HIV for young girls by UNESCO, ILO and UN Women. Largely, this division of labour was considered to work well with regular exchanges between cosponsors when prompted / conveyed by the UNAIDS country office. The one cosponsor with whom coordination has not worked well is the World Bank. The World Bank is active in health funding in Tanzania predominantly through the Tanzanian Health Basket Fund which bundled health financing from the government and five other donors (with the World Bank being the key donor contributing around 50% to the health basket). The Health Basket Fund focuses predominately on primary health care in line with government priorities and does not include HIV funding. Thus, there is relatively little overlap with the HIV response. The World Bank also supports a range of other sustainable financing work including the Health Sector Public Expenditure Review (PER) 2020, which provides an update on trends and patterns of health expenditures in the public sector.⁵ The World Bank also has macroeconomists working closely with the Tanzanian government on domestic financing and public expenditure. To-date, collaboration between UNAIDS and World Bank has mostly focused on sharing documents and data as it becomes available, however, there is no closer collaboration or a common approach with regard to sustainable health financing and efficiency. This has been identified as an area for improvement in particular in case UNAIDS wants to become more active in the wider health financing agenda.

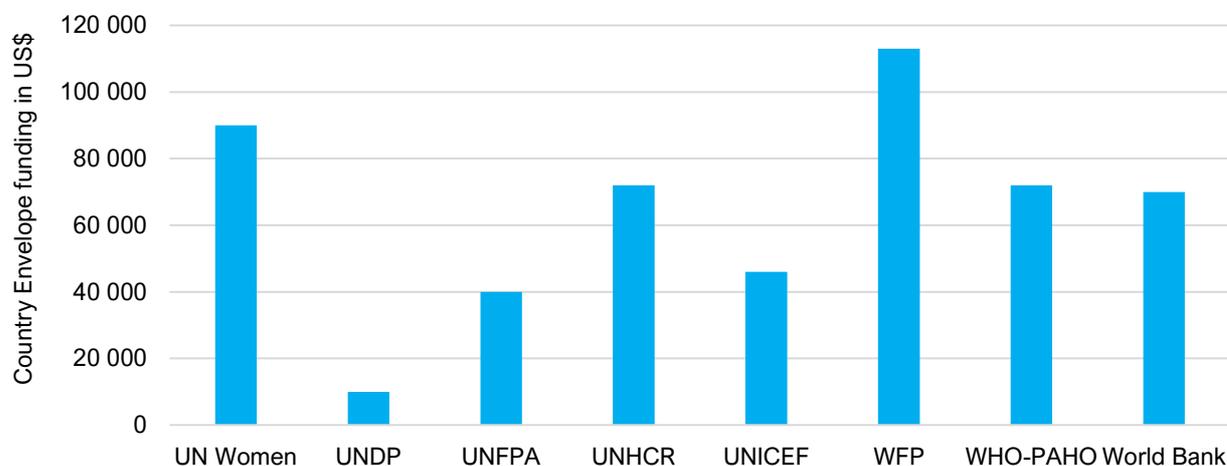
Capacity of Joint Programme

The capacity of the UNAIDS Country Office and cosponsors was considered to be reflective of the conducted activities, with the Country Office having a relatively strong capacity across the different areas of the HIV response and with cosponsors having few exclusively dedicated staff to HIV. Overall, the UNAIDS Country Office has been considered to be well staffed allowing them to take the lead across most HIV relating activities of the Joint Programme, including activities regarding HIV financing and efficiency. This includes staff positions that have specific focus areas (e.g., Strategic Information Adviser; PEPFAR and Global Fund Implementation Adviser) which overlap with the financing and efficiency agenda (though are not exclusively on this topic) as well as some funding for consultants to support specific projects on HIV financing and efficiency (e.g., Investment case 2.0 support; consultant to support TACAIDS on resource mobilisation). Cosponsors have received funding through the UBRAF country envelope which has mostly been used to encourage HIV service integration. Tanzania received a total of US\$ 513,000 across 2018-2021 making Tanzania one of the countries with the highest proportion of funding received through the country envelope (see Figure E.2.1 below). The funding has been welcome but has been used mostly to include HIV aspects into

⁵ World Bank (2020) Health Sector Public Expenditure Review (PER) 2020

existing initiatives of the cosponsors and to allow cosponsors to input into work from the UNAIDS Country Office, but capacity wasn't seen as sufficient for the cosponsors to lead on aspects of the HIV sustainable financing or efficiency agenda.

Figure E.2.1: Country envelope funding to cosponsors in Tanzania between 2018-2021



Partnerships

Donors

UNAIDS Joint Programme has played a key role with regard to coordinating with the Global Fund and PEPFAR and other domestic stakeholders. As outlined above, UNAIDS was seen as a key actor with regard to coordination among stakeholders. This role has taken different forms between the Global Fund and PEPFAR corresponding to their respective approaches to HIV funding:

- **With regard to the Global Fund, the key activities of UNAIDS Joint Programme include coordinating inputs and to provide data and guidance with regard to the funding application.** Given the Global Fund approach to country-led funding allocations, there is a key role for UNAIDS to ensure that the Tanzanian funding application is evidence driven, follows latest guidelines and includes inputs from more marginalised communities. Specifically, key aspect of UNAIDS work included support to the development of the national strategic plan (Tanzania Health Sector HIV and AIDS Strategic Plan IV, 2017–2022) and, more recently, the work on the HIV Investment Case 2.0 which were considered as key documents to inform and provide evidence for the Global Fund application (see Question 5 for further detail). Additionally, UNAIDS and cosponsors (UNICEF and WHO in particular) also provide direct input into the funding proposal but also coordinated with CSOs (such as the KVP Forum) to encourage their participation in the Global Fund country dialogue. UNAIDS also has been supportive with regard to providing more funding to non-state actors with the use of a second Principal Recipient (AMFEF) seen as particular impactful. The data provided by UNAIDS (in particular the epi data) is also a key input into the funding application although this holds more for the epi data whereas funding data is taken from different sources including a recent NASA which has been paid for directly by the Global Fund. This last aspect was considered to have not worked as well with the produced NASA perceived to be of lower quality for mainland Tanzania by some stakeholders.
- **With regard to PEPFAR, there is less of a direct role for UNAIDS Joint Programme to influence HIV funding allocations as the decision-making is primarily influenced by PEPFAR's internal guidance, data and priorities.** Nevertheless, there has been important collaboration with PEPFAR with the sustainability agenda becoming more prominent under the current phase of PEPFAR's strategic approach (2021-26) which shifts the focus increasingly to a country-led sustainable epidemic control. UNAIDS has supported this shift with **the most prominent recent example being the collaboration with regards to the Sustainability Index and Dashboard (SID)** which

tracks progress against sustainability areas.⁶ The SID also tracks progress against domestic resource mobilisation and allocative efficiencies (see Section 1). UNAIDS has inputted directly into the tool including through the provision of data and evidence. Importantly, UNAIDS has also supported the pivot of the SID towards increasing country-ownership of the tool including country data collection. Generally, the increased emphasis of PEPFAR on sustainability and signalling of reduced future funding represents an important opportunity for UNAIDS to coordinate an increased shift towards sustainability and transition of away from external funding.

Capacity building of communities and civil societies

- **UNAIDS Joint Programme supports HIV service provision through CSOs which is seen as key for an efficient HIV response and an area in need of further strengthening in particular with regard to domestic funding avenues for CSOs.** UNAIDS has also advocated for a more active role of CSOs to be direct health service implementers and consider this an important opportunity with regards to cost-effective and efficient service provision. While there has been some progress (such as an increased funding from the Global Fund going to non-government organisations – e.g., AMRAF and Mkapa Foundation), this has been identified as an area for future improvement. In particular, further work is needed with regard to establishing mechanism to channel funding from domestic resources to CSOs and to expand on social contracting work which has been limited to-date. Another avenue to increase CSOs and community engagement has been the recent work on community monitoring which UNAIDS supported which was perceived as a good starting point to engage communities and to provide feedback on HIV service providers (see Q5 for further details).
- **UNAIDS Joint Programme has provided no direct capacity support to CSOs for health financing and most support to CSO is wider than just HIV financing and efficiency.** As outlined above, UNAIDS has supported CSO as part of the Global Fund processes and also generally has been providing support to CSOs for coordination (e.g., convening meetings, providing logistical and, to a lesser degree, financial support, providing consultant support and sharing data and evidence with key CSOs representatives). They have also supported CSOs on a wider level in particular around key populations – for example, UNAIDS was seen as key supporter for the establishment and government acceptance of the Key and Vulnerable Populations (KVP) Forum which has itself been a challenge given the national repressive policies around MSM in particular. UNAIDS is also a key voice in advocating for the removal of structural barriers for key populations, with important programmatic implications in terms of the overall HIV response, although this work hasn't been specifically geared towards financing aspects. To-date, the direct involvement of CSOs with regard to advocating for sustainable HIV financing or efficiency has been limited.

Evidence and data use

From a wide range of data, guidance and tools, UNAIDS Joint Programme support for the development of national strategic plans and investment cases have been considered as key for the sustainable financing and efficiency agenda. Tanzania has received a wide range of different support from UNAIDS with regard to data, evidence, strategic documents and tools, and has fulfilled the UBRAF reporting on indicator 7.1 (*country developed a HIV sustainability and/ or transition plan*) and indicator 7.2 (*country has an up-to-date quality HIV investment case or similar assessing allocative efficiency*).⁷ Stakeholders hereby emphasised the importance of the support for the national strategic plans (including previous support for the current HIV Strategic Plan IV 2017-22 as well as current support for the development of the upcoming HIV Strategic Plan V). These plans are considered to be at the heart of the HIV response in country – informing on resource mobilisation and funding applications, prioritisation and funding allocations as well as service implementation and wider health sector integration. Similarly, the recently completed HIV Investment Case 2.0 was also emphasised as a key document with regard to driving sustainable financing and technical and

⁶ PEPFAR and UNAIDS (2021). 2021 HIV/AIDS Sustainability Index Implementation – key findings and priority actions

⁷ UNAIDS (2021). Internal UBRAF reporting

allocative efficiency.⁸ With the completion of the last HIV Strategic Plan being nearly five years ago, the investment case was considered to be a key reference piece with regard to the Global Fund funding application process, the development of the next NSP as well as an advocacy piece for increased allocative and technical efficiency as well as domestic resource mobilisation. The sustainability plan has not been cited as a key reference document by stakeholders although this could be driven by the fact that it was completed prior to the current UBRAF period.

The Investment Case 2.0 was overall considered to be useful and of high quality though areas such as timeliness, domestic model capacity building and a systematic approach in line with other countries could be improved. The investment case 2.0 was overall considered to be of high quality by stakeholders and to serve its purpose to provide a document to create a vision to address the sustainable financing and efficiency challenges facing Tanzania. It followed some best practices such as developing a range of different scenarios including those which depict funding allocations within resource constrained settings (a more realistic scenario for Tanzania which is unlikely to manage to raise all resources required to reaching Fast Track and 95–95–95 targets). It also clearly states recommendations regarding resource allocations, allocative efficiency and the need to increase domestic resources (further discussed in Question 6 and Question 7 below). It also provides overarching guidance and links with the other key work around resource mobilisation and allocation, most noticeable the NSP and the external funding applications to the Global Fund (and lesser degree PEPFAR). However, some aspects were mentioned with regard to improvement such as the timeliness of the publication (e.g., the final report was published in December 2020 but considered only in developments until end of 2019 and as such was already somewhat outdated by the time it was published given the COVID-19 development). Secondly, some domestic stakeholders emphasised that the modelling work with the Avenir software has been conducted by external consultants and suggested that more internal capacity building (in terms of using or at least understanding the software) would be needed (this point holds beyond on the Investment Case to also the other modelling work with the Avenir software such as estimation / projections of epidemiological data).

In contrast to epidemiological data, the landscape around funding and budget data analyses is a lot more fragmented and, while most analyses are considered to serve their specific purposes, they do vary in degrees of coordination, timeliness and quality. UNAIDS Country Office continues to play an important role in terms of gathering financial data including reporting as part of the Global AIDS Monitoring (GAM). In the past they have also financed and conducted National AIDS Spending Assessments (NASA), however, the latest NASA for 2020 has been funded by the Global Fund and conducted by external consultants for Mainland Tanzania and was viewed as a weak assessment by a few stakeholders. There are also National Health Accounts funding analysis following the WHO approach which are conducted by Ministry of Health (which do not provide a detailed breakdown for all needed HIV categories though). In general, NASAs were considered to be resource and time intensive when done properly which means that they cannot be done annually. However, other mechanisms such as National Health Accounts were considered to be granular enough in the long run when decisions around specific intervention areas have to be made.

Then there are also public budget analyses on health and HIV specifically funded and conducted by UNICEF. As well as public expenditure analysis supported through work from the World Bank (outside of the UBRAF) which go beyond health. Lastly, there is also the data collected and analysis for the Sustainability Index and Dashboard (SID) supported by PEPFAR. While most of these initiatives have been described favourably by stakeholders (such as expanding SID beyond PEPFAR as primary user) and are considered to address their specific purpose, there is a question on further alignment and coordination given how much different evidence is created across actors.

⁸ Investment Case 2.0 build on the work of the first investment case published in 2016. The objective of Investment Case 2.0 was to create a common country-led vision of what is needed to confront financing challenges in the years ahead by defining what the key investment decisions are; estimating the magnitude of resources required; and assessing implications for government and donor resource mobilization. The investment case methodology is based on modelling and analysis of defined scenarios, comparing various “futures” for the HIV response in Tanzania and assessing their benefits, costs, trade-offs, and financing requirements. The model estimates were created using software developed by Avenir Health.

Overall, the availability of strategic information is considered to be sufficient, and it is more the translation of data, evidence and guidance into concrete policy action which has further room for improvement. As described above, there is sufficient strategic information on financing and expenditure data which is also reflected in a relatively high score in this metric in the PEPFAR SID (scoring 8.33 the highest within the strategic information). Generally, there also has been good coordination around funding applications as well as key strategic documents like the NSP and the Investment Case 2.0, however, some stakeholders identified that there has been no systemic approach to collating and disseminating the many different pieces of data and evidence produced with particularly government and CSOs struggling to have an overview of the latest progress. While the efforts of the UNAIDS country office around dissemination have been appreciated, some stakeholders suggested that a more systematic and user-friendly approach such as a “knowledge bank / data repository” which contains the latest available evidence would be useful step and could encourage the use of evidence and analysis for advocacy as well as HIV service implementation beyond UNAIDS and its direct partners. The challenge to translate evidence into concrete policy changes and increase in domestic resources is multifaceted though and is discussed more in Question 6 below.

There is also a range of wider UNAIDS Joint Programme activities around data, evidence and guidance which provides important inputs into the wider financing and efficiency discussions. In particular, the epi data collection and reporting supported by UNAIDS as part of the GAM has been considered to be of critical importance for advocacy efforts as well as allocative efficiency consideration. UNAIDS is considered to be the authority with regard to this data including the analytics and communication. Similarly, collected data and evidence, guidance as well as wider advocacy around structural barriers was seen as important by many stakeholders as an enabling factor for technical and allocative efficiency (see for example point around CSO engagement and capacity building under Question 4 above). Lastly, initiatives to encourage national data collection and analysis has been stressed as important with the recent activities around community data monitoring provided as a good example.

Political commitment and sustainable financing

UNAIDS Joint Programme has been credited to having contributed to the increase in political commitment to the HIV response generally, however, there remains a gap with the political commitment in Tanzania and actual domestic financing. As outlined in Section 1, there is a gap between the political commitment with regard to the 95–95–95 and Fast Track targets endorsed by the government and the financial resources provided.⁹ UNAIDS and other partners have been credited with their political advocacy to push the government with regard to their HIV targets and commitments. In particular, the UNAIDS target have been seen as useful to set an ambitious agenda and UNAIDS and partners were seen as conducting important advocacy with national leaders, including both longer-term relationship-building as well as specific events around UNAIDS day or high-level visits from UNAIDS staff. This has led to official commitments from the country and the President to the HIV response. However, with regard to actual financial commitments both the public resources dedicated to health as well as the proportion of resources within health dedicated to HIV remain well short of what is needed to fulfil the political commitments (see Section 1 above). Most stakeholders attributed this to the limited resources within the country and competing government priorities, both with regard to other development areas such as infrastructure but also other health areas such as MNCH / primary health care that do not have the same external resource support. This was seen as a single biggest reason on why there has been a gap between commitment and actual domestic financing.

Stakeholders did not see the lack in strategic information as a key impediment to sustainable financing and efficiency, with the strategic information generated by UNAIDS Joint Programme considered to be useful (with the Investment Case 2.0 seen recent example). As already described under Question 5 above, UNAIDS work on data, documents and tools was considered to be useful

⁹ This is also reflected in the PEPFAR SID which largely rate governance and leadership with scores above 7.

and to provide evidence for more domestic engagement. In particular, the Investment Case 2.0 was considered to be useful as it clearly outlines the risk of plateauing or declining donor funding and, thus, puts the requirement for more domestic resources and efficiency gains at the centre for the sustainable response. It also provides clear recommendations on specific steps for efficiency gains (see below). The messaging has been most powerful when aligned with key donors (e.g., with PEPFAR around efficiency or Global Fund requirements for co-financing). There were a few areas that have been more challenging to get government traction such as community health service delivery and targeted effort to provide evidence in this area was considered to be helpful (including bringing in best practice and experience from other countries). Additionally, as outlined in Question 5 there could be more improvements to bring in others in using the existing evidence to make the case for HIV and health funding (with CSOs and NGOs not seen to be playing a key role with regard to financing and efficiency advocacy at the moment).

Political advocacy on financing and efficiency by UNAIDS Joint Programme has been well received and considered to be in-line with UNAIDS mandate but can be further strengthened in specific areas. UNAIDS engagement with national leaderships including directly with the President, TACAIDS and Prime Minister Office, MoH and parliament has all been considered important in pushing the HIV financing agenda. In particular, some of the work with parliamentarians was highlighted as a good approach to ensure budgetary support for HIV and health generally. In particular, direct engagement with high-level decision-makers was considered to be important in terms of the advocacy efforts. Examples from other countries, in particular with similar epidemic and development background, were also considered to be powerful tools and an area that UNAIDS can leverage more strongly. Another area that could be further improved was engagement directly with the Ministry of Finance. This is also in line with recent recommendations from PEPFAR who stated that targeted advocacy is needed directly with the MoF to increase domestic contributions.¹⁰ This would be important to increasing the available public budget for both health and HIV which would represent the most direct route of increasing domestic funding. The advocacy work was also seen as a key competitive advantage of UNAIDS (see Question 1) both in terms seeing to come less with its own agenda and to have the mandate to coordinate across partners.

The establishment of the AIDS Trust Fund (ATF) as a mechanism to distribute domestic financing has been welcomed but has been underfunded and requires stronger support to realise full potential. The ATF was established by government (supported by UNAIDS and other partners) as an additional domestic funding mechanism to expand resources for HIV from the private sector, non-traditional external sources and the public sector. In addition to the potential of raising additional revenues, stakeholders in particular saw the potential of the ATF to be used as a domestic funding mechanism which could be used to strengthen CSO service delivery. However, in reality, the ATF has fallen short of the ambitious resource mobilization targets set during conception. In its original target setting, the ATF sought to increase the domestic contribution from 3% of total HIV expenditure to 30% by 2018 (Tanzania CCM 2017) but this has been much less (e.g., in 2016/17 only US\$ 2.7 million were pledged from the government with even less disbursed). The ATF has also not been successful in raising much funding or engaging with the private sector, with this lack of bringing in private sector resources being a larger area in need for improvement in Tanzania. There have been some recent movement on the ATF with UNAIDS funding a consultant position to support TACAIDS in supporting the performance of the ATF going forward. However, also further support is needed from the government directly to really leverage on the potential of the ATF fully.

Efficiency

UNAIDS Joint Programme has supported technical and allocative efficiency especially through the development of the Investment Case 2.0 and by engaging with the Global Fund funding requests, but much additional work is required in this area. Most recently, the primary work conducted by UNAIDS on efficiency has been with regard to the Investment Case 2.0 which models the health

¹⁰ PEPFAR (2021). Overview of 2021 SID and RM. 2021 HIV/AIDS Sustainability Index Implementation – key findings and priority actions, VTeam Webinar, PPT presentation

benefits that could be achieved by optimising the resources across a range of different funding scenarios. The Investment Case 2.0 considers both allocative efficiencies achieved through prioritizing or allocating funds across interventions and technical efficiency achieved through technological or policy changes that reduce the unit cost of interventions. Additionally, UNAIDS has been working to disseminate the recommendations from the Investment Case to national government as well as to feed these into the Global Fund funding application process. Despite these efforts from UNAIDS, progress against allocative and technical efficiency remains a challenge. For example, the latest estimates from the PEPFAR Sustainability Index and Dashboard showed a decline in progress in 2021 dropping from 4.93 to 3.60 (see section 1 above). **Further progress against in technical and allocative efficiency is key given that the current projections suggest a plateauing or even declining HIV funding trend.** The projections of the HIV funding landscape in Tanzania indicate that there is a high likelihood that the ambitious HIV targets will have to achieve with plateauing or even fewer resources. An important starting point would be to translate the Investment Case recommendations to both domestic and externally funded health services. Thus, while specific work such as the Investment Case are key in terms of flagging issues and providing evidence to stakeholders, it is the continued follow through into the NSP, funding requests (Global Fund and COP) as well as into government budgets that needs to be ensured. Here often more challenging aspects arise including political economy aspects and lobbying of interest groups which can make it hard to implement all suggested changes. This indicates the continued need for strong coordination and alignment of the priorities and advocacy strategies of the different actors.

While there has been some progress with regard to allocative efficiency for externally funded health interventions, there remains a big gap with regard to domestically funded health services especially around allocating efficiently across geographies and prevention interventions. The allocative efficiency modelling focused in particular around prioritising prevention funding based on lowest cost per infection averted to maximise impact of scarce resources.¹¹ The investment case identified most cost-effective interventions over the next 10 years as VMMC, condoms, and the Female Sex Worker package. Over this time period, further optimization would require about US\$ 100 million re-allocated to VMMC, US\$ 25 million to condoms, and US\$ 50 million to FSW outreach and PrEP during 2019-2030 compared to current allocations. A challenge hereby would be to allocate funding away from current programmes (behaviour and communication change, cash transfers) which have been rolled out to significant scale and have buy-in from existing service providers. One option may be to integrate some of these programmes into other community-based interventions or initiatives. While these aspects have been taken into account for the Global Fund funding application and the PEPFAR COP, it remains to be seen how funding will be allocated in the years ahead. A challenging area includes areas which have substantial benefits outside of just HIV prevention such as AGYW interventions which also increase girls' education and livelihoods. The investment case emphasised here the substantial costs of scaling-up the programme and emphasising that this could not come exclusively from HIV budget.

The final Investment Case 2.0 also does not include detail modelling with regard to allocation towards specific geographies, however, as part of the process allocations across different regions and districts have been modelled which reportedly resulted in some reallocation of PEPFAR funding. Generally, it has been easier for external donors to target their funding by geography with domestic funding being more reluctant to follow a similar approach. While some commentators saw this as an opportunity for further efficiency improvement, others argued that the government is required to support services where external funders are not engaged. Lastly, beyond the work of the investment case, UNAIDS has also been a strong advocate with regard to reaching the prevention target of 25% of all funding going to HIV primary prevention. Currently, it remains a real challenge to increase primary prevention spending in particular at the domestic level (due to a number of reasons including political aspects of ensuring ARV access for everyone, the longer timeframe of results for prevention but also availability of external funders for these programmes such as PEPFAR's DREAM

¹¹ The modelling requires that all PLHIV that now their status will be put on ARV treatment.

programme). Nevertheless, this continues to be a challenging area as external funding declines with the risk that primary prevention programmes get increasingly squeezed for resources.

The Investment Case 2.0 identified three key areas for technical efficiency improvements which all require implementation, with the need for more community led service delivery identified as a particular challenging area for improvement. The three areas for optimisation included Tanzania and its donor partner to commit to (i) switching to Dolutegravir-based first-line regimens; (ii) simplification of laboratory algorithms for stable patients and (iii) community-based delivery of support services for PLHIV on ART. The Investment Case 2.0 estimates that these three activities could lead to savings of around US\$ 50 million annually, around 10% of current HIV spending in Tanzania. The evidence behind these approaches is considered to be strong and there has been some progress in implementation regarding the switch to Dolutegravir and, to a lesser degree, to more differentiation in the laboratory testing algorithm. This has in part being already implemented by external funders (PEPFAR in particular) which have also pushed the government to make further progress on this (also making this hard to attribute progress on these topics to the investment case alone). However, these activities need to be implemented fully across all funding which seems in particular challenging with regard to community-based service delivery. While this topic requires a further push with regard to external funding (e.g., building on some recent progress with regard to the Global Fund and PEPFAR funding), it is particularly at the domestic financing level where CSO service delivery lacks national buy-in and a strong mechanism to channel domestic HIV resources to CSOs. Therefore, **community-based service delivery was identified as an area for further improvement including the use of social contracting as well as bringing in best practices and case studies from other countries.** Overall, the identification of clear priority areas is considered to be helpful though there remain also other areas which are important to achieve further efficiency. In particular, this includes the need to continue work on removing structural and legal barriers for key populations which are considered a prerequisite for running programmes efficiently (and for community-based engagement). Other areas include the need for a stronger reporting mechanism to flag inefficient service delivery at the local level (which activities on community-based reporting try to address), further advancement on integration of HIV services with other health areas as well as further coordination and alignment of resources across funding sources and actors.

Financing for HIV integration into UHC financing

There is no overarching strategic coordination or plan on how to integrate HIV into UHC at this stage given the severeness of the HIV epidemic, but there have been some discussions on the inclusion of some ARV treatment in employee national insurance. At this stage, there has not been any advanced strategies or collaboration around integrating HIV financing into UHC financing in Tanzania. Stakeholders considered this to make sense given the severeness of the HIV epidemic and the considerable resources required to address it. There has however been some advancement with regard to specific HIV services and how they could be integrated into national insurance. The Investment Case 2.0 identified the use of the National Health Insurance Fund (NHIF) as an opportunity to increase domestic financing for HIV. The NHIF was established by an Act of Parliament (No 8) in 1999 as part of the broader suite of health reforms to provide health insurance coverage for families in formal employment. As such, it only covers a subset of the population with the number of beneficiaries estimated to be around 3.7 million, or about 6.5% of the population. Based on previous work, the Investment Case 2.0 considers that the NHIF could use some of its surplus to absorb some of the incremental cost for ARV treatment (with a study suggesting that the NHIF could absorb US\$ 24 million in incremental costs for HIV services, covering 96,000 people living with HIV (Health Policy Plus 2016)). As such, the NHIF was seen as a sustainable avenue to absorb some of the ARV costing domestically in case external funding continues to decline. There are currently plans to update on the health insurance scheme in Tanzania to combine different insurance in one umbrella and, reportedly, some HIV services may be included under such a reformed system based on current draft bill. With UNAIDS reportedly pushing for the inclusion through political advocacy. A key challenge to including HIV services in insurances is that the current approach in Tanzania offers key HIV AIDS services for free without user fees or insurance payments and instead finances the services directly

either through external or public funding. There also have been arguments around whether available insurance funds should be used for HIV or rather for other diseases for which there is no external funding available (an issue applying to all domestic funding). Thus, there are a range of aspects that would need to be carefully considered when designing the inclusion of (partly) HIV services in the domestic health system.

There is an opportunity in Tanzania to approach the topic of HIV funding integration more systematically across UNAIDS, cosponsors and partners and to create a long-term vision and approach of how HIV sustainability funding could be integrated in UHC (allowing to contribute to a sustainable transition of ARV treatment from external funders). This holds even more importance with the new President being more open to advancing on the public health agenda in Tanzania. UNAIDS Joint Programme was considered to be able to play a key role here including bringing examples and best practices from other countries to the table. UNAIDS Secretariat was considered to have an important role to play bringing their mandate and experience of equity and marginalised groups but also closer engagement with cosponsors (WHO in particular as leading on UHC) would be needed.

Conclusions and Considerations for the future

The Tanzanian country case study offers the following key conclusions and considerations for the future UNAIDS Joint Programme work on sustainable and efficient financing for the AIDS response:

- UNAIDS Joint Programme has used its comparative advantage as a convening organisation allowing it to coordinate among different UN organisations and wider stakeholders including donors, government and CSOs. This has largely worked well but further coordination with the World Bank is needed particularly around the wider health financing agenda.
- UNAIDS Joint Programme has a leading role with regard to providing strategic information and to support the development of strategic and operational documents / tools with the work on national strategic plans and investment cases considered particularly important for the sustainable financing and efficiency agenda. This is in particular due to their role as reference documents for the external funders, but the investment case also offered clear recommendations to improve on allocative and technical efficiency and outlined the need for more domestic resources.
- Overall, the availability of strategic information on funding and budget data developed across UNAIDS, cosponsors and partners are considered to be sufficient, and it is more the coordination and translation of the many pieces of evidence into concrete policy action where there is further room for improvement. This includes in particular funding and budget data where there is a wide range of different Strategic Information produced across Partners, Cosponsors and the UNAIDS country office.
- UNAIDS has been credited to have contributed to an increase in political commitment to the HIV response generally, but there remains a gap with regard to the political commitment and actual domestic financing. Most stakeholders attributed this to the limited resources within the country and competing government priorities, both with regard to other development areas such as infrastructure but also other health areas such as MNCH / primary health care that do not have the same external resource support. This was seen as a single biggest reason on why there has been a gap between commitment and actual domestic financing.
- Political advocacy on financing and efficiency by UNAIDS has been well useful and considered to be in-line with UNAIDS mandate with engagement with high-level leaders as well as the parliament particularly powerful. This continues to be an opportunity area in particular with the recent presidential changes in Tanzania. UNAIDS should also aim to target its advocacy efforts at the Ministry of Finance to increase domestic contributions for health.
- UNAIDS has supported HIV service provision through CSOs as a key aspect for an efficient HIV response. While progress has been made on this topic in particular through external funding (such

as having a CSO as Global Fund Principal Recipient), there is a need for more national buy-in on this topic including the provision of domestic funding for CSO service delivery. Further evidence and advocacy are still needed in this area.

- The establishment of a domestic funding mechanism outside of the government in the form of the AIDS Trust Fund offers opportunities with regard to additional domestic resource mobilisation, including private sector funding, and a potential funding mechanism to support CSOs service delivery. However, the ATF has not delivered as expected to-date and further support is needed to unlock its full potential benefits.
- There is an opportunity in Tanzania to approach the topic of HIV funding integration more systematically across UNAIDS, cosponsors and partners and to create a long-term vision and approach of how HIV sustainability funding could be integrated in UHC. The current reforms to the health insurance system in Tanzania offer a strong starting point to engage more systematically in this topic.

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Wang, H., Ally, M., Rosemberg N., & Ulisubisya M. (2018): Progressive Pathway to Universal Health Coverage in Tanzania: A Call for Preferential Resource Allocation Targeting the Poor, Health Systems & Reform, DOI: 10.1080/23288604.2018.1513268

Consultation list

Table E.5.1: Stakeholders consulted as part of the Tanzania case study

Stakeholder Group	Organisation	Name	Job title
UN Joint Programme	UNAIDS Tanzania	Mohamed Turay	Senior Strategic Information Adviser
		ROTICH, Koech	PEPFAR and Global Fund Implementation Adviser · UNAIDS
		SCUTELNICIUC, Otilia	M&E Advisor
		MALLYA, Grace Felix	Program Officer
	World Bank	Inaam UI Haq	Program Leader for Human Development
	International Labour Organization (ILO)	Sima, Getrude Zacharia	National Project Coordinator in HIV and AIDS
	United Nations Children's Fund (UNICEF)	Ulrike Gilbert	Chief of HIV and AIDS Program
	The United Nations Educational, Scientific and Cultural Organization (UNESCO)	Kotta, Jennifer Alima	Program Officer
	World Health Organization	Christine Musanhu	Medical officer HIV, Hepatitis and TB
	United Nations Population Fund (UNFPA)	Mariam Yusto Ngaeje	Programme Specialist SRHR and HIV
	United Nations Development Programme (UNDP)	Deogratias Mkembela	Public Health Specialist/Programme Management Specialist
UN Women Tanzania	Jacob Kayombo	Focal Person for HIV	
Donors / Other Partners	Tanzania National Coordinating Mechanism (TNCM)	Peter Maduki	The TNCM Vice chair and chair of the Management Committee
	USAID	Godfrey Nyombi	Public Health Specialist
	USAID	Milly Kayongo	HSS Team Lead
	PEPFAR	Hiltruda Temba	External Affairs Coordinator
	Walter Reed Army Institute of Research (WRAIR)/DoD	Boniface Nguhuni	Program Manager (HIV/AIDS)
Government	Ministry of Finance and Planning	Balandya Elikana	Commissioner for Budget
	Prime Minister's Office	Tixon Nzunda	Permanent Secretary
	The Tanzanian National AIDS Control Programme (NACP) - MoHCDGEC	Dr. Aneth Rwebembera	Head of HIV Treatment
	Tanzania Commission for AIDS (TACAIDS)	Yassin Abas	Director of Finance
CSO	SIKIKI	Atuswege Mwangomale	Head of Program – Health Chairperson Non-State Actors Health
	KVP Forum	Marineus Mwombeki	Chair of KVP Forum
	AMREF	Frida Ngalesoni	Monitoring, Evaluation & Research Manager

Appendix F: Country case study – Côte d’Ivoire

This Appendix presents the Côte d’Ivoire country case study in support of the evaluation of the UNAIDS Joint Programme’s contribution to efficient and sustainable financing for the AIDS response. Following country background information and HIV funding context (Section F.1), country-level findings are presented for each of the evaluation questions (Section F.2). A final conclusion and considerations for the future section based on these findings follows (Section F.3). The case study is based on a review of key documentation (Appendix F.4 provides a list of key references) and stakeholder interviews (Appendix F.5 provides the list of consultees) conducted in November 2021.

Background Information and country context

Key country characteristics and HIV context

The HIV epidemic poses a significant health burden in Côte d’Ivoire, with transmission mainly driven by sex-work, MSM and drug users. The adult prevalence of HIV is 2.1 percent of adults (15-64 years), approximately 380,000 people.¹² Among certain high-risk populations, the prevalence is very high: female sex workers (FSW, 4.8%); men who have sex with men (MSM, 7.7%); and people who use or inject drugs (PWID, 3.4%).¹² HIV represents more than 10% of all Disability-adjusted life year (DALY)s, and the number of DALYs caused by HIV has increased by more than 200% since 1990.¹³

Côte d’Ivoire has worked steadily towards reaching HIV epidemic control over the past sixteen years. There has been a 72% decline in new HIV infections and 69% reduction in AIDS-related deaths since 2010.¹² The country has recently developed a new National Strategic Plan (2021-2025) that has an ambitious target of reducing the number of new infections by 50% and the number of AIDS-related deaths by 75%. The national response to achieve these goals is led by the *Programme National de lutte contre le VIH/SIDA* (PNLS), in coordination with donors, civil society and UNAIDS.

Despite a spectacular economic recovery, the share of public spending allocated to health remains one of the lowest in the region, at just 4.72%.¹⁴ Côte d’Ivoire is a lower-middle income country, located in West Africa, and has one of the largest HIV epidemics in the region. The country has faced political instability during the past post-election crisis (2002-2007 and 2010-2011) that greatly affected the health system. The 2019 human development index (HDI) of Côte d’Ivoire ranks the country 162nd out of 189 countries in the world.¹⁵ Nevertheless, the country now has a stable and growing economy. Although the overall level of health expenditure in Côte d’Ivoire (US\$1.66 billion, or US\$70 per capita annually), is approaching of that of many middle-income countries, it is heavily donor dependent and only 25% of domestic health spending is funded by the Government.¹⁶

The high dependency on external resources is considered by many stakeholders a serious vulnerability for continuity of funding for health services, especially HIV. Despite the government’s increasing role in HIV financing, the country still relies heavily on external financing, and it faces a significant funding gap, estimated in 2020 to be €69 million.¹⁷ Côte d’Ivoire’s HIV spending has steadily increased, and the government has begun to play an increasing role in this; domestic contribution to HIV financing increased from 13% to 22% from 2018 to 2019.¹⁸ However, the country still relies heavily on external financing. According to the National Health Investment case, *Dossier d’investissement du financement de la santé* from 2020, the vast majority of the HIV funding comes

¹² AIDSInfo 2020

¹³ World Bank (2016) Allocative efficiency study

¹⁴ Adebisi, Y.A., Alaran, A., Badmos, A. et al. How West African countries prioritize health. *Trop Med Health* 49, 87 (2021). <https://doi.org/10.1186/s41182-021-00380-6>

¹⁵ UNDP (2020) Human Development Report 2020. Accessed 10 Dec 2021 at: <http://hdr.undp.org/sites/default/files/hdr2020.pdf>

¹⁶ Dossier d’investissment en santé, 2020-2023

¹⁷ Global Fund 2020 gap analysis, investment case

¹⁸ UNAIDS JPMS, Reporting 2019

from international sources (mainly from the US Government, and the Global Fund).¹⁹ The government of Côte d'Ivoire has expressed interest to mobilize additional domestic and private resources for the national HIV response in the last national strategic plan 2025²⁰, with the following outputs listed below in Box 1.²¹

Box F.1.1 Financing targets in the Cote d'Ivoire national strategic plan 2021-2025

- Output 4.3.1: The State's contribution to financing the fight against AIDS increases by 10% per year
- Output 4.3.2: By 2025, health expenses related to HIV testing and care are included in the care basket of Universal Medical Coverage (CMU)
- Output 4.3.3: The contribution of the private sector to financing the fight against AIDS covers 5% of the needs of the PSN
- Product 4.3.4: The contribution of external partners to financing the fight against AIDS is stabilized by 2025
- Output 4.3.5: Innovative approaches to mobilize financial resources are implemented to increase domestic financing

The domestic approach for HIV financing has placed a decreasing focus on comprehensive universal access, instead prioritising high-impact HIV response scenarios. This reflects a more realistic view of working within budgetary constraints faced by LMICs such as Côte d'Ivoire. In-country, sustainable financing discussions are regarded as fairly new, and emerging, driven by PEPFAR's Sustainability Index Dashboard (SID) exercises led by PEPFAR, and gap analysis exercises during Global Fund negotiations. This is reflected in Figure 1.2, which shows that PEPFAR's rating of Domestic Resource Mobilisation has improved dramatically from 2015 to 2019, with its score increasing from 4.72 to 8.10. According to the evaluation study respondents, the conversation is donor-driven. The government has faced increasing pressure from competing agendas such as increased financing for the Global Alliance for Vaccines and Immunizations, GAVI, or other diseases area such as Hepatitis B and C.

Table F.1.1: Technical and allocative efficiency measured in PEPFAR's SID (0 being lowest and 10 highest)²²

Strategic Financing and Market Openness	2015	2017	2019
Domestic Resource Mobilisation	4.72	6.79	8.10
Technical and allocative efficiency score	3.63	5.06	6.78
Market Openness	N/A	N/A	8.44

Source: PEPFAR

The COVID-19 pandemic has emphasised the fragilities of the health system and brought to the attention the need to increase domestic financing for health overall, especially for high burden diseases such as HIV. According to the evaluation study respondents, HIV funding did not see a reduction from donors or government, but civil society was less funded and less able to maintain their level of engagement. Overall, increased domestic funding from both government and private sector, and better management/allocation of current donor resources are regarded as key priorities by interviewed stakeholders.

¹⁹ Dossier d'investissement en santé, 2020-2023

²⁰ MHSP (2020), Plan stratégique national de lutte contre le VIH, le sida et les infections sexuellement transmissibles 2021-2025

²¹ Ibid

²² Colour coding from PEPFAR highlighting strengths and weaknesses (red below 3.5, yellow below 7.5, light green below 8.5 and dark green above 8.5)

Findings

Comparative advantage

UNAIDS convening and coordination of important strategic activities is unanimously recognized and appreciated by all stakeholders. The Secretariat is regarded as playing a key role in convening and coordinating key activities and provision of targeted technical support, such as technical assistance to the National HIV program (PNLS), for its 2016-2020 strategic plan review, and to develop the 2021-2025 plan. It also led planning and organisation of Global Fund proposal writing, and convened stakeholders for PEPFAR's 2020 Country Operating Plan (COP) discussions. UNAIDS was regarded as ensuring alignment amongst government, civil society and donors, thus keeping PEPFAR focus on Côte d'Ivoire and improving donor engagement. Stakeholders also view UNAIDS coordination of country partners as useful for creating synergy and collaboration opportunities.

Stakeholders value the contribution of UNAIDS to create opportunities for Civil Society and KP inclusion in national HIV plans and processes. Study respondents view UNAIDS as a trusted civil society partner, and a champion for social inclusion. Civil society argue that UNAIDS has created important opportunities for their participation and encouraged inclusion of vulnerable and marginalized people in national discussions. One of the most cited examples is UNAIDS' negotiations to include representatives of the LGBTQ+ community and people living with disabilities in high level discussions such as national strategic planning. Recently, UNAIDS' leadership and collaboration with civil society helped to deliver the Stigma Index study. The results of this study will be used by organisations such as the Réseau Ivoirien des Organisations de Personnes Vivant(e)s avec le VIH, (RIP+) to measure the progress made in this area since the 2016 Stigma Index 1.0 survey and inform advocacy to influence changes in policy, law, programs and practices. UNAIDS has also played a key role in the development of community-led-monitoring (CLM) strategy, launched in 2019, which is regarded as contributing to efficiency in community-led responses, and in supporting its implementation with the International Treatment Preparedness Coalition.

Coordination and internal alignment amongst Cosponsors and UNAIDS Secretariat

Coordination amongst the Cosponsors is regarded as sufficient overall, though there is significant room to strengthen joint work in HIV financing, especially with the World Bank. Coordination within the Joint Programme is regarded as stronger on non-financing aspects of the HIV response, where for example the 2019 pooling of WHO, UNICEF, and UNAIDS advocacy and technical expertise supported the country to design its first comprehensive paediatric AIDS national response. This is regarded as a prime example of joint Cosponsor work. On financing, the World Bank is not very active within the Joint Programme, despite the World Bank having produced significant strategic information on health system financing, including HIV. UNAIDS and the World Bank are reported to have collaborated on one occasion for the 2018 Health Financing System Assessment in Côte d'Ivoire that included HIV financing.

Capacity of the Joint Programme

The capacity of the UNAIDS Country Office was praised by Cosponsors and external stakeholders for their expertise and ability to find resources. Several examples from national stakeholders were shared on UNAIDS responsiveness. Notably, the timely guidelines published during the COVID-19 pandemic on Community-led monitoring (CLM) was instrumental to civil society stakeholders to secure initial funding for the strategy, to advocate for its inclusion among country led strategies in the period of October to November 2021 to meet the first 95–95–95 target, and to coordinate its implementation via funds for civil society.

While the Secretariat team is regarded highly for their support to the national HIV response, many of the respondents believed that an increase in capacity on sustainable response financing could dramatically improve UNAIDS leadership of the issue. Since 2018, none of the Country Envelope funding has been allocated to work under SRA7 (Country Envelope funds have remained constant at

US\$300,000 with the exception of 2021 in which US\$ 425,000 was made available).²³ Stakeholders postulated that insufficient financing expertise within the UNAIDS team, and/or the lack of prioritization amid competing priorities might explain why SRA7 activities were not prioritised.

Partnerships

Donors

UNAIDS is viewed as a critical partner to PEPFAR and the Global Fund, who draw on UNAIDS convening, strategic coordination, and inclusion of Civil Society in national dialogues. More specifically:

- **UNAIDS is regarded as instrumental for securing critical PEPFAR COP 2021 funding for Côte d'Ivoire, by rallying civil society and government to streamline their advocacy.** UNAIDS work helped maximise Côte d'Ivoire's chances of receiving PEPFAR funding, working against a significant downward trend in PEPFAR funding from US\$160 million in 2017 to US\$100 million in 2019.²⁴ PEPFAR therefore considers UNAIDS as a critical partner in the support of the national HIV response. Similar to the Global Fund, PEPFAR relies on evidence generated by UNAIDS tools or studies to triangulate data during Country Operational Plans (COP) design processes. Further, in September 2019, UNAIDS under PEPFAR jointly organised a participatory meeting to complete the 2019 Sustainability Index and Dashboard (SID) and a corresponding Responsibility Matrix (RM) in collaboration with the Ministry of Health and Public Hygiene (MSHP) through the Directeur Générale de la Santé (DGS) and the PNLs. The participatory process included other governments partners and stakeholders including key ministries, civil society, private sector, and other bilateral and multilateral donors (i.e., Global Fund, World Bank). In 2021, UNAIDS also supported the PEPFAR SID exercise. Beyond data, PEPFAR leans on UNAIDS convening power to engage many critical stakeholders during COP development and implementation including the Minister of Health, DGS, and the PNLs; CSOs beyond those receiving PEPFAR funds; and bilateral and multilateral partners such WHO, and the Global Fund.
- **UNAIDS is regarded as providing crucial technical and coordination support to Global Fund proposal applications.** Technical assistance (TA) supported by UNAIDS helped develop the Global Fund 2021-2023 funding Application, for which Côte d'Ivoire was awarded US\$82 million in August 2020. The Global Fund Technical Review Panel commended the evidence driven approach used by the country.²⁵ Furthermore, UNAIDS assistance is sought by donors to support the CCM team to ensure that the proposal development process considers civil society, especially inputs from marginalised communities such as LGBTQ+, commercial sex workers, and MSM.

Capacity building of communities and civil society

Civil society stakeholders perceive UNAIDS as the inclusion and integration partner. UNAIDS has supported civil society on proposal development for Global Fund, and PEPFAR. It had also provided coordination, and convening support (e.g., convening meetings, providing logistical and, to a lesser degree, financial support, providing consultant support and sharing data and evidence with key CSOs representatives). Several examples of UNAIDS advocacy for civil society inclusion in financing discussions at the MOH or with donors have been cited. In 2019, UNAIDS provided technical support to civil society for their involvement and effective contribution to the 2019 Dialogue National sur le Financement de la Santé, regarded as making the civil society participation a success. Technical and financial support was also provided for civil society's contribution to the 'Champions for an AIDS-Free Generation' visit. More recently in 2021 UNAIDS ensured civil society participation in the "Atelier de

²³ UNAIDS JPMS, Country Envelope Cote d'Ivoire (2018-2021)

²⁴ PEPFAR COP 2021

²⁵ UNAIDS, 2019

transition” meeting organized with Results 4 Development (R4D) to create a transition plan for Côte d’Ivoire that is due for validation by the end of 2021.²⁶

UNAIDS support to CSOs is highly recognised, however more work is needed to strengthen the capacity of civil society to engage in HIV financing. Apart from inclusion of civil society in these forums cited above, there is limited evidence of UNAIDS support to civil society and community/KP-led organisations to strengthen their capacities to engage in HIV financing discussions and advocacy. This is viewed as a critical area for strengthening as community level activities to reach key populations, which are best led by civil society, are extremely underfunded. During discussions with donors in 2019, civil society estimated their need for the following year to be around US\$2 million to which donors pledged US\$750,000. By November 2021, civil society is estimated to have received only US\$250,000. Civil society regard UNAIDS as suitably positioned to be a great advocate on their behalf and provide more support in resource mobilization for locally-led organisations.

Evidence and data use

UNAIDS supported data, guidance and tools are reported to be an invaluable contribution to the national HIV response. Strategic information on financing is largely guided by donor requirements. Where strategic information has been produced by UNAIDS, it is highly regarded and used to inform national and donor programmes. For example, UNAIDS 2020 Spectrum estimates informed the critical PEPFAR COP expenditure forecasting and purchasing for the country, which estimated a total number of PLHIV of 428,827, of which more than 60% were women living with HIV and approximately 31,662 children living with HIV.²⁷ Most recently, UNAIDS supported Results 4 Development (R4D) to develop the sustainability and transition plan that is due for validation by the end of 2021 in a process regarded by stakeholders as successful.

Further, epidemiological and financial gap analysis performed during the Global Fund grant proposal process offered a regional gap analysis per package offered, and UNAIDS-supported lost to follow up analysis allowed the country to present a strong Global Fund Proposal which resulted in securing funds until 2023. UNAIDS is also the reference partner for epidemiological and evidence based technical approaches. For example, regarding the FY2022 HIV commodity funding landscape, UNAIDS played a coordinator role to align donors and government pledges, thus avoiding duplication. However, other aspects of strategic information are regarded as outdated, including absence of recent NASAs and a World Bank supported allocative efficiency study in 2016 undertaken at the request of the government to inform the previous National HIV Strategic Plan (2016–20).

The World Bank has more recently produced strategic information in support of the country’s financial transition and UHC Most recently in 2020 the World Bank developed a Health Financing System Assessment (HFSA) to guide policy discussions as the country transitions from donor assistance and to identify opportunities on the path toward universal health coverage (UHC). While the process to develop this guidance was not inclusive of UNAIDS, it covers all priority health issues (including HIV). This is largely reflective of the national health policy in Côte d’Ivoire which is seen as focusing on integration of disease-specific responses and now UHC, rather than vertical HIV responses from the government, aligning to the epidemiological profile of the country.

Political commitment and sustainable financing

UNAIDS has been credited to having contributed to the increase in political commitment to the HIV response generally; however, a financing gap remains. The ‘Champions for an AIDS-Free Generation’ 2 day-advocacy visit to the country under the topic of more domestic financing resulted in a new commitment in 2019 for 5 billion CFA starting in 2020 to eliminate user fees. This was in addition to the government’s previous pledge to increase domestic funding by 21 billion CFA francs (US\$39 million) over the 2018-2020 period which has yet to be realised. As cited earlier, the

²⁶ R4D (2020) Rapport d’évaluation de l’état de préparation à la transition et à la pérennité des financements des interventions liées au VIH et aux IST en Côte d’Ivoire

²⁷ UNAIDS (2021) Spectrum 2020 estimates, Plan de transition

government has increased its domestic share of HIV financing from 13% in 2018 to 22% in 2019 but falls short of fulfilling these newer commitments.

There are increasing concerns for the sustainability of HIV/AIDS financing in light of the widening financing gap observed during GF proposal development, and PEPFAR SID exercises. As demonstrated in Table 2.1, the national HIV funding gap has increased, from €23 million in 2018 to almost €70 million in 2020. In response to these exercises, the government has undertaken reforms to improve domestic resourcing. The Government of Côte d'Ivoire is committed to reducing barriers to HIV services by increasing domestic resource mobilisation and public-private partnerships. It is currently pursuing universal health coverage through the Caisse Nationale assurance Maladies (CNAM), the scale-up of strategic purchasing mechanisms, and a move toward program-based budgeting for health in order to improve efficiencies. Additionally, since joining the Global Financing Facility (GFF) in 2017, Ivorian leadership has created a country platform and investment case to facilitate multi-stakeholder collaboration to improve health indicators.

Table F.1.1: 2018-2020 Funding Gap

2018	2019	2020
€23.2 million	€60.3 million	€ 69.3 million

Source: Global Fund 2020 landscape analysis

Stakeholders perceived a missed opportunity for UNAIDS to leverage its influence within government to support financing reforms and innovations. UNAIDS is a key partner when it comes to engaging government, donors, and civil society. UNAIDS appears to be among few partners that have leverage at all levels of the government, including the presidential office which is a key advantage to support financing reforms and innovation. UNAIDS was instrumental in the establishment of the *Conseil National de lutte contre le VIH/SIDA* (CNLS), the highest political body for the HIV response overseen by the President. However, the lack of engagement with the CNLS on financing issues was perceived by study respondents as a missed opportunity. If engaged, informants view the CNLS could play a catalytic role in elevating the conversation around HIV financing and inserting it among country priorities at the highest levels. UNAIDS is regarded as having the necessary gravitas to mobilize the CNLS and other country partners such as CCM and civil society stakeholders around this issue, but to date has done little to leverage this position. The priority of engagement of the CNLS however needs to be taken in the context of the evolving challenges of the national AIDS response and thus the roles and functioning of governance structures such as the CNLS. For instance, more recently, UNAIDS contributed to the creation of the *plateforme nationale de financement de la santé* (National Health Financing Platform) as a means of ensuring alignment of the platform's contribution to the national HIV goals, which provides another opportunity for influencing national HIV and Health domestic funding (discussed further in section 2.7, 2.8).

A lack of targeted advocacy at the Ministry of Planning, Ministry of Budget, and the National Assembly is regarded as a missed opportunity for translating political will into financing. UNAIDS has established connections in these ministries because of the *plateforme multi-sectoriel de lutte contre le VIH/SIDA* that is consolidated under the CNLS. Stakeholders view that targeted training on health financing specifically addressing the challenges related to the national HIV response could create momentum for the administration to fast track the President's commitments, and help the country reach its financing targets. A follow-up action from the 2021 development of the transition roadmap has been to present and discuss the results with this Ministry.

UNAIDS have helped to establish innovative local funding mechanisms, but there remain issues that could detract potential investment. UNAIDS contributed to the establishment of local mechanisms such as *Fond National de Lutte Contre la SIDA* (FNLS), to allocate funds to local CSOs for community and service delivery implementation. The objective of the FNLS is to mobilize at the national and international level, additional resources, both public and private, for the HIV/AIDS response in Côte d'Ivoire, in line with the National Strategic Plan. It has been funded through a

government tobacco tax other and government support. The foundation of the FNLS has been welcomed by stakeholders, but it is underfunded and requires support to mobilise additional domestic resources especially with the private sector. As of 2019, the private sector contributed less than 0.02% of HIV financing versus estimates it could potentially increase it more than 5 fold.^{28,29} All national strategic plans designed by the Programme National de Lutte contre le SIDA (PNLS) since 2018 mention private sector engagement as a key partner in resource mobilization; however, no clear pathway or roadmap to improve private sector engagement has been designed. Additionally, stakeholders have mentioned the lack of information on its governance and financial oversight as potential barriers to attract additional private sector or other innovative financing.

Efficiency

UNAIDS support for the removal of user fees is seen as a key contribution to improving the efficiency of HIV financing in Côte d'Ivoire. In several countries, including Côte d'Ivoire, the issue of user fees has been identified as a major barrier to testing and treating people for HIV, and to retaining people in treatment and care despite government official backing of free services and treatment. People living with HIV have often been charged illegal user fees to access services.³⁰ UNAIDS successfully worked with the government to reiterate the free nature of HIV services and treatment, and to announce that it will strictly apply previously announced decisions to prevent people living with or affected by HIV being asked to pay user fees. A directive was issued to all divisions of the MSHP and applies for all services for pregnant and breastfeeding women, all HIV testing services, tests for viral load suppression and the prescription of antiretroviral medicines for people living with HIV.³¹ This is regarded as a key result from the 'Champions for an AIDS-Free Generation' visit.

In the face of uncertain funding transitions from international partners, UNAIDS has contributed to advocacy to reprioritize health resources, including those for HIV. A recent study by the Centre for Global Development assesses the impact of upcoming donor transitions across the world and finds that Côte d'Ivoire is at the top of the list of countries that face fiscal risk from global health transitions, with upcoming transitions from Gavi and International Development Association (IDA).³² The same study estimates that 2021–2025 is the highest risk period, as this is when the Gavi transition is expected to accelerate. The fiscal burden of the transition is estimated at 10% percent of general government health expenditure. To catalyse financing efforts, UNAIDS has enacted a series of high impact actions such as its active participation in the newly established National Health Financing Platform, *Plateforme nationale de financement de la sante*, which provides an opportunity for stakeholders to network with influential administration members. While this group is focusing on increasing the available public budget for health in general, its roadmap is currently the most direct pathway to increase domestic budgetary allocation for the HIV/AIDS response.

Financing for HIV integration into UHC financing

The introduction of UHC, and discussions around HIV integration to UHC, are nascent. The country's effort around building a strong UHC system is in pilot phase, focusing only on a defined number of disease areas such as malaria. The World Bank is supporting work in Côte d'Ivoire, through tools such as the Health Intervention Prioritisation (HIP) tool, which aims to maximize the country's UHC goal along three dimensions (DALYs, equity and financial social protection) based on countries' disease burden, unit cost and cost-effectiveness of interventions. Combined with epidemiological profiles

²⁸ World Bank, Health Financing 2020

²⁹ Private sector stakeholder interview 2021

³⁰ Stelmach, Rachel D et al. "Financial burdens of HIV and chronic disease on people living with HIV in Côte d'Ivoire: A cross-sectional out-of-pocket expenditure study." PLoS one vol. 16,7 e0255074. 29 Jul. 2021, doi:10.1371/journal.pone.0255074

³¹ Leadership mission of the champions for an AIDS-free generation Abidjan, Côte d'Ivoire, April 2019 Report

³² World Bank (2020) Health Systems Assessment for Côte d'Ivoire: Accelerating Reforms toward Universal Health Coverage

and health delivery system data, it will help to inform local country decisions about “what should be covered” within a sustainable UHC system, including HIV prevention and treatment services.³³

UNAIDS experience on equity, close engagement of Cosponsors, and strong relationship with civil society are regarded as assets for an inclusive UHC strategy. The UNAIDS Joint Programme is viewed by stakeholders as a strategic advisor who could share examples and best practices from other countries. Overall, while discussions to include HIV in the UHC scheme are emerging, informants suggested that lessons from other countries such as Tanzania could be shared; and key challenges around including free/partly-free HIV services in UHC should be anticipated. UNAIDS role and support to the *Plateforme nationale de coordination pour le financement de la santé* (PNCFS) is viewed as a potential catalyst to improve the efficiency of HIV spending and contribute to a sustainable financing transition plan for HIV programs. PNCFS is a multi-stakeholder platform for discussions on resource mobilization and utilization as well as the execution of national strategic plans and health and development-related policies and is regarded as the main entry point for UNAIDS to catalyse improvements in the efficiencies of HIV financing.

Conclusion & Considerations for the future

This case study offers the following key conclusions and considerations for future UNAIDS Joint Programme work in sustainable and efficient financing for the AIDS response:

- The UNAIDS Joint Programme’s leading role and expertise in the HIV response and the development of key tools in collaboration with national stakeholders is widely recognised. The consensus the Joint Programme has fostered on other aspects of the HIV response could also be applied to specifically strengthen the efficiency and sustainability of HIV financing.
- UNAIDS is regarded as having strong relationships with government, which it could further leverage through re-activating engagement with the *Conseil National de lutte contre le VIH/SIDA* (CNLS) on HIV financing priorities. The recent sustainability and transition plan is one such opportunity to surface key issues with the government.
- The UNAIDS Joint Programme’s comparative advantage as a key civil society partner and demonstrated leadership opening doors for civil society in HIV platforms could be extended to engagement with UHC and broader health financing and policy platforms such as the *Plateforme nationale de coordination pour le financement de la santé*.
- UNAIDS should leverage the Joint Programme’s convening power to help catalyse private sector engagement around domestic financing. One example would be to reactivate UNAIDS active participation and support of the *Fond National de lutte contre le SIDA* to help develop a clear domestic financing strategy, and address concerns raised regarding governance. Operational support could include assisting PNLs and FNLS to act on the “Tableau d’évaluation sommaire des sources de financement innovantes pour la santé”.³⁴ According to stakeholders, the private sector has an appetite to support causes such as HIV, but the lack of a clear funding channel and transparency over fund management and reporting appears to be a barrier.
- The Joint Programme should support the Ministry of Health and Public Hygiene (MSHP) and Ministry of Budget to improve budget allocation and spending efficiencies in the health sector with a focus on maternal and child health including HIV/AIDS. Cosponsors such as World Bank, with the UNAIDS Secretariat should continue existing engagement on health financing to improve clarity on financing gaps, and quality in using and re-allocating existing funds before the annual budget closing session. This recommendation is one of the key points in the transition plan developed in March 2021 by PNLs with UNAIDS Joint Programme support. The Joint Programme could also share lessons learned on performance-based financing initiatives funded by World Bank, PEPFAR, and other donors in order to identify its contribution to a more sustainable health

³³ Ibid

³⁴ R4D (2021), Feuille de route de la transition VIH/SIDA, Cote d’Ivoire, Results for Development

response for HIV. The Joint Programme is well placed to provide multi-stakeholder data reviews to accelerate progress in critical areas.

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Stratégie de Protection Sociale – mai 2014

Consultation list

Organisation	Name	Job Title
PNLS / MSHP	Pr Ehui Eboi	Directeur-Coordonnateur Programme National de Lutte contre le Sida (PNLS) / MSHPCMU
	Dr Pongathié Adama Sanogo	Directeur de la Direction de l'Informatique et de l'Information Sanitaire/ MSHPCMU
	Dr Eugène Kouakou Kra	Coordinateur de l'Unité de coordination des Projets – Fonds (intérimaire)
Primature	Dr Ouattara Djénéba	Conseiller Technique Santé, Hygiène Publique et Nutrition, Cabinet du Premier Ministre
Direction Générale du Budget et des finances	Mr Koua Arsène	Sous/Directeur
CCM Chair / Principal Recipient	Dr Solange Amethier	Présidente Instance de Coordination Nationale du Fonds Mondial de lutte contre le SIDA, la tuberculose et le Paludisme (CCM)
	Dr Sanga Ouattara	Secrétaire Permanent /CCM
	Dr Offia- Coulibaly Madiarra	Directrice Exécutive/ Alliance Côte d'Ivoire Bénéficiaire Principal volet communautaire
	Pr Ehui Eboi	Directeur-Coordonnateur Programme National de Lutte contre le Sida (PNLS) / MSHPCMU Bénéficiaire Principal volet public
NGO and CBOs	Mr Nicolas Vako	Directeur Exécutif Réseau Ivoirien des Organisations de Personnes vivant avec le VIH (RIP+) Coordonnateur général / UNICO
	Madame Pélagie Akoua Kouamé	Présidente Réseau des Organisations des Populations Clés en Côte d'Ivoire (ROPC-CI)
	Mr Alain Manouan	Leadership Practice and Responsibility Programme Management & Organizational Development Specialist Senior Technical Adviser/Chief of Party CLM- ITPC WA
	Mr Nesserou Guei	Secrétaire/ UNICO
PEPFAR, USAID, CDC, other international organisations	Madame Bibola Ngalamulume	PEPFAR Coordinator US Embassy Abidjan, Côte d'Ivoire
	Dr Nicole Shabani	Global Fund liaison US Embassy Abidjan, Côte d'Ivoire
	Dr Yves Maxime Kouadio	Health Economist Health Office U.S. Agency For International Development US Embassy - Abidjan, Côte d'Ivoire

Organisation	Name	Job Title
	Mr Shirish Balachandra	Directeur Pays CDC
UNAIDS Secretariat	Dr Brigitte Quenum	Directrice Pays
	Dr Jean François Somé	Conseiller PEPFAR/Fonds Mondial
	Dr Isabelle Kouamé	Conseiller Appui Communautaire
Cosponsor focal points and /or Heads of Agency	Dr Daogo Sosthène ZOMBRE	Conseiller Politiques et systèmes de santé/OMS
	Dr Dao Halima	Cheffe section santé /VIH UNICEF
	Madame Juliette Nsensele Faïda	Cheffe section Adolescents et Jeunes UNICEF
	Dr Victorine Dilolo	Spécialiste VIH/Adolescents UNICEF"
	Mr Mayaka Ma Nitu Serge	Point focal pays/P4H (OMS)
	Dr Almouner Talibo	International Programme Specialist FP/RHCS UNFPA
	Dr Sandra MOULOD	Chargé de programme VIH/Sida UNFPA
	Dr Adama Traoré	Spécialiste Principal Santé Banque Mondiale

Appendix G: Country case study – Kazakhstan

This appendix presents the Kazakhstan country case study in support of the evaluation of the UNAIDS Joint Programme's contribution to efficient and sustainable financing for the AIDS response. Following country background information and HIV funding context (Section G.1), country-level findings are presented for each of the evaluation questions (Section G.2.). A final conclusion and considerations for the future section based on these findings follows (Section G.3). The case study is based on a review of key documentation (Section G.4 provides a list of key references) and stakeholder interviews (Appendix G.5 provides the list of consultees) conducted in November 2021.

Background Information and country context

Key country characteristics and HIV and financing context

The Republic of Kazakhstan is the largest landlocked country situated in Central Asia with a population of 19 million.³⁵ According to the latest World Bank update, Kazakhstan is classified as an upper-middle-income country (UIC).

Kazakhstan's financing of the HIV response is regarded as stable, with 94% of the HIV response financed by the government. The remaining 6.2% of HIV financing is from international sources, such as the Global Fund, PEPFAR, UN agencies and other partners. According to the latest GAM 2020 data, HIV spending in 2020 totalled US\$37.69 million, with US\$35.35 million from domestic funding.³⁶

Despite the significant policy, programmatic and financing efforts of the government, the country falls behind the 90-90-90 targets: 82% of people living with HIV know their status, only 68% of people living with HIV are on ART and 78% of those receiving ART are virally suppressed.³⁷

Kazakhstan faces several challenges in achieving these goals and responding to the spread of HIV in the country. According to UNAIDS epidemic transition metrics for 2020, a 73% increase of new HIV infections were registered since 2010.³⁸ The HIV/AIDS epidemic is concentrated in key populations (KPs): people who inject drugs (PWIDs), men having sex with men (MSM), sex workers (SW) and prisoners, but is also spreading to other vulnerable groups including youth, migrants, and truck drivers. Injecting drug use and sexual transmission are currently the most significant routes of HIV transmission in Kazakhstan. Sentinel surveillance in 2019 and 2020 revealed prevalence levels of 8,3% in PWIDs, 6,5% in MSM, 1,4% in SW and 4,1%.³⁹ UNAIDS Spectrum analysis in 2020 estimated there were 35,000 people living with HIV (65.5% males and 34.5% females), with a 0.25% prevalence rate in the 15 – 49 age group. This is above the figure of 27,498 people reported in government data.⁴⁰

As an oil-rich country, the COVID-19 pandemic has not (as yet) affected fiscal space and existing levels of the government's HIV response. In terms of financial sustainability of service provision, the COVID-19 pandemic is not yet regarded as limiting Kazakhstan's overall financing for the HIV response, and the COVID-19 response has been supported by the government's reserve funds. Regarding service delivery, ART medicines and consumables were procured at the start of 2020 (and annually thereafter) and with buffer stocks helping to mitigate stock-outs, however, there were some operational and logistical problems, such as access to AIDS centres to obtain ART due to city

³⁵ Official statistics data. Bureau of National Statistics. Agency for Strategic Planning and Reforms of the Republic of Kazakhstan. <https://stat.gov.kz> Accessed 29.11.2021

³⁶ GARPR 16- GAM 2021 dataset. UNAIDS Data 2021. UNAIDS Joint United Nations Programme on HIV/AIDS. 20 Avenue Appia 1211 Geneva 27, Switzerland. <https://hivfinancial.unaids.org/hivfinancialdashboards.html#>

³⁷ Country report. Country progress update 2020. GAM 2020. https://www.unaids.org/sites/default/files/country/documents/KAZ_2020_countryreport.pdf

³⁸ <https://www.unaids.org/en/regionscountries/countries/kazakhstan> Accessed 29.11.21

³⁹ <https://www.unaids.org/en/regionscountries/countries/kazakhstan> Accessed 29.11.21

⁴⁰ HIV Figures and Facts 2016-2020. Kazakh Scientific Center of Dermatology and Infectious Diseases. <http://kncdiz.kz/en/aids/aids/statistika/> Accessed 29.11.2021

lockdowns, and the shift of focus to COVID-19 testing in labs. Further, the social contracting of NGOs, an important mechanism to support effective KP prevention and treatment services, was put aside.

HIV services are integrated with dermatology and infectious diseases services, but still remain vertical and HIV services are delivered through a regional/municipal network of AIDS centres. The Kazakh Scientific Centre for Dermatology and Infectious Diseases (KSCDIZ) is the main entity regulating and providing HIV services in the country, procures related drugs and commodities for the effective delivery of the services, and implements other services in the area of HIV surveillance, M&E, and prevention of co-infection. It is comprised of 14 regional and 3 city AIDS centres delivering prevention, diagnostics, and treatment services to people living with HIV and other KPs.

The country has moved from disease-specific programmes to the National Health Programme, and HIV issues are addressed under '*socially important diseases*'. HIV services are included in the State-Guaranteed Benefits Package (SGBP) and are reimbursed through the newly established Mandatory Health Insurance Fund (MHIF). The funds are allocated for the testing, treatment and care services of people living with HIV.

The UNAIDS Joint Programme in the country has been focused on four key priorities

- Mobilisation of domestic and donor resources to expand the availability of HIV prevention services to KPs;
- HIV testing and treatment by advocating the adoption of "Treat All" and supporting the revision of national testing and treatment policies, scaling-up innovative HIV testing and counselling programmes to KPs, the optimisation of treatment regimens and simplifying laboratory testing and monitoring, supporting the integration of HIV with other communicable diseases and co-infections, and PHC;
- Strengthening the capacity of KPs, people living with HIV networks, national, regional, and human rights bodies on human rights, stigma and discrimination; and
- Building resilient and sustainable systems by providing tools to estimate resources needed to Fast-Track national AIDS responses, setting up public expenditure tracking systems for health and providing technical expertise in the development and implementation of the national sustainability and transition plans^{41,42}.

Key issues in terms of efficient & sustainable financing for HIV

Considering Kazakhstan's status as a UIC, international support is soon to be withdrawn⁴³ and the country needs to increase its attention to allocative and technical efficiency of HIV response. To attain the 95–95–95 by 2030 targets, recent modelling supported by the Joint Programme (described in section 2.5) estimated that the annual HIV programme budget should be increased to 160% of the latest reported budget level (an additional \$US13 million annually) and optimised with prioritisation of ART and HIV testing and prevention programmes targeting PWID and MSM. By 2030, this could facilitate Kazakhstan reaching 95–95–95 targets as follows: 95% of people living with HIV are aware of their status; 98% of those diagnosed on treatment; and 95% of those on treatment with viral suppression.⁴⁴

Priorities for the government's sustainable response include strengthening prevention services for KP, bringing protocols and drug regimens to international standards, and strengthening social contracting through local governments. Despite significant progress made by the country in securing

⁴¹ UNAIDS JP Strategy 2018-2019. UNAIDS 2018-2019 Budget: a Dynamic, Differentiated Resource Planning, Mobilisation, Allocation and Accountability Model. Geneva, Switzerland. UNAIDS Programme Coordinating Board. 9 June 2017

⁴² UNAIDS 2020-2021 Workplan and Budget: Regional and country priorities and targets for the joint programme. Geneva, Switzerland. UNAIDS Programme Coordinating Board. 21 June 2019

⁴³ Projected transitions from Global Fund country allocations by 2028: projections by component. The Global Fund. Geneva, Switzerland. March 2021 update

⁴⁴ Resource optimization to maximize the HIV response in Kazakhstan. Report. UNAIDS, the Global Fund. 2020

financing for HIV response, key informants stressed several issues that need to be addressed by the government systematically. These are as follows:

- Prevention services for KP and vulnerable populations are not prioritized within the national programme leading to the lack of financial support for the development of service delivery guidelines and protocols, costing of services and integration with wider health system and community-based organisations (CBOs), Opioid substitution therapy (OST), harm reduction, PrEP and post-exposure prophylaxis services with entailed procurement of commodities are not sustainable. Testing protocols are outdated and there is a practice of mass-screening of the general public with only a small number of persons identified. This contributes to inefficient use of available resources. Kazakhstan needs to bring its screening policy to international standards and WHO recommendations and introduce index testing. There is a need for pooled procurement of lab test-kits, and the introduction of express testing (saliva-based) through CBOs.
- The country has put a lot of effort into the revision of treatment protocols, but they still are to be brought to international standards which will entail the introduction of new treatment regimens, registration, and procurement of new drugs. Integration with and delegation of testing, prevention, counselling, social support services, outreach work and distribution, and harm reduction services to non-state partners have to be prioritized and financed.
- Although, there is a social contracting mechanism allowing financing of NGOs its use is still weak and sporadic and depends on the proactiveness of local government bodies.

Findings

Comparative advantage

UNAIDS is recognised as the lead HIV specialised agency in Kazakhstan, with a strong reputation for bringing highly technical expertise and coordinating the domestic HIV response. Within the UN system in the country, UNAIDS is viewed as providing a broad and comprehensive strategic vision for the HIV response, technical expertise, know-how and best practices on HIV issues. UNAIDS has built strong relationships with the government, Ministry of Health (MoH) and AIDS centre, and is very well positioned to lead and coordinate the efforts of all key stakeholders in the country. For example, UNAIDS has successfully contributed to the revision of the HIV regulatory and legal framework, development of treatment protocols, stigma and discrimination reduction guidelines, costing of HIV services, as well as advocacy for the prioritisation of services for KPs.

The Joint Programme as a whole is recognised for articulating the needs of KPs with the government and creating opportunities for KPs to engage at the political level. The work on prevention services for KP especially PWIDs, MSM and transgender people is a very sensitive and highly politicised issue being discussed widely by Members of Parliament (MPs) and the general public. Through its strong working relationships and active engagement with KP communities, the Joint Programme has been able to identify and illuminate the needs of KP, which are now regularly discussed and brought on the agenda at high-level meetings. As an example, UNAIDS took an active part in organising and convening a high-level meeting of MPs and Civil Society Organisations (CSOs) on strengthening coordination and cooperation of civil society with the parliament of the Republic of Kazakhstan and served as an interface between the CSOs and MPs to make sure the needs of civil society were heard and prioritized. As a result of this meeting, a high-level resolution recognising the needs of KP for services and financing was signed. The resolution signed by MPs and CSOs calls for the development of new service delivery protocols, costing of services to be provided by CSOs and allocation of related budgets from MHIF, as well as prioritisation of prevention, care and support financing under social contracting.⁴⁵ Services covered include OST, harm reduction, PrEP and post-exposure prophylaxis, and activities to counter stigma and discrimination.

⁴⁵ Resolution. Strengthening cooperation and coordination of the civil society with the parliament of the Republic of Kazakhstan. 17 September 2021.

Coordination and internal alignment amongst Cosponsors and UNAIDS Secretariat

UNAIDS has a good model of coordination amongst the Cosponsors engaged in the HIV response through the UBRAF and coordinates UBRAF work with other country partners. UNICEF and UNFPA are the main Cosponsors engaged with the UNAIDS Secretariat in the HIV response, with UNAIDS regarded as the expert agency for HIV within the UN family and UNDP coordinating with the Global Fund CCM and ensuring KP and civil society are represented on the CCM. Work is regarded as well coordinated amongst the Cosponsors, such as political advocacy for ART drugs procurement through UNICEF, and work amongst UNAIDS, UNICEF and UNFPA to develop guidelines on the reduction of stigma and discrimination, and to advocate for the prioritization and sustainable financing of this work in the country. However, there are some areas for improvement highlighted linked to UBRAF resourcing. For instance, UNAIDS biennium planning for 2022-23 is underway which defines Cosponsor-funded projects and UNAIDS has put into place a committee with the government, CSOs, plus CDC and PEPFAR to review all proposals for UBRAF work from Cosponsors to ensure there is no overlap. Scarce resources available through UBRAF (reported as US\$30-50,000 for the coming year which cannot be used to fund positions) is regarded as a challenge hindering the Cosponsors' interest in active participation and application for funding, and that limited staffing of Cosponsors offices in Kazakhstan provides no flexibility for increased scope of work.

The World Bank and UNDP are not engaged in technical aspects of HIV financing domestically, however, at the regional level have produced modelling for allocative efficiency and social contracting guidelines used in Kazakhstan. WHO does not appear to be engaged in the HIV response in Kazakhstan, in particular since the start of the COVID-19 pandemic and rather has been working with UNICEF on Kazakhstan's UHC. The view is that UNAIDS needs to strengthen its HIV advocacy work within the Cosponsor family by raising burning issues at Cosponsors meetings to help Cosponsors formulate their HIV political advocacy agenda more clearly and lead high-level policy discussions more effectively.

Capacity of the Joint Programme

The UNAIDS Secretariat covers five countries in the EECA region, including Kazakhstan, and is regarded as stretched. The UNAIDS country office in Almaty, Kazakhstan is staffed by two technical leads, responsible for the UNAIDS HIV response in five countries in the Central Asia region, therefore engagement across the five Country Teams is highly prioritised. This model is regarded as limiting UNAIDS ability to be more proactive, especially in the work with local public and health administrations given Kazakhstan has a decentralised model of service delivery and for social contracting. Considering available resources, the Joint Programme is regarded as providing adequate support to meet country needs. The Country Envelope funding to Kazakhstan was at its highest in 2021 (US\$250,000), with no funds assigned to SRA7.⁴⁶ The most recent year of Country Envelope funding for SRA 7 was 2019 when \$11,000 was used by UNDP. UNAIDS has drawn on TSM funding in support of two successful Global Fund P2 and P3 requests (including Global Fund Covid-19RM).⁴⁷ UNAIDS has also established partnerships with universities and the CDC to finance technical work, and reports it leverages UBRAF funds to bring necessary technical assistance.

- UNAIDS uniquely receives government financing for aspects of the HIV response. Interviews surfaced that UNAIDS and other UN agencies in Kazakhstan receive funds directly from the Kazakh Ministry of Foreign Affairs. In the case of UNAIDS, approximately US\$100k-170k/year has been funded for various projects namely: building NGO capacity to provide peer support to children, adolescents and women living with HIV in navigating social services; spectrum estimations; meetings to review progress on the 95-95-95 targets.

⁴⁶ Country Envelope data (Source: UNAIDS)

⁴⁷ TSM dashboard

Partnerships

Donors

As an upper-income country, donor partnerships focus on sustainability and transition planning. Currently, donor funding is largely focused on programmes supporting KP, strategic information and tools required for efficiencies in the HIV response, and the supportive enabling environment for a sustainable HIV response. The government directs its bulk of funds (55%) to treatment, care and support services (78% to the procurement of ARVs and treatment, 10% going to the purchasing of tests, testing and counselling, and 10% to specific HIV-related laboratory monitoring (CD4, viral load)), 10% to specific HIV related monitoring and 10% to prevention services, and 19% to TB/HIV co-infection diagnosis and treatment. PEPFAR has streamlined its resources to the implementation of support and retention projects for people on treatment (58%), strengthening governance and sustainability (including generation of strategic information, data and capacity building, 21%) and creating an enabling and favourable political environment for the HIV response. The Global Fund grants prioritise resources to community mobilisation (41%), governance and sustainability (including planning, coordination and health system strengthening, 36%), and prevention and promotion of testing and linkage to care programmes for MSMs, SW and PWIDs (18%).

UNAIDS work with PEPFAR and the Global Fund Project Implementation Unit (PIU) is well-coordinated and aligned, with UNAIDS taking a lead role on advancing key issues with, and on behalf of the leading donors. PEPFAR and the Global Fund PIU rely on the UNAIDS technical expertise, TA, and leadership to make sure that neglected issues are prioritised and addressed with the government. Regular meetings, forums and technical working groups are organised to discuss future plans and avoid duplication of efforts. Jointly with PEPFAR and the Global Fund PIU, UNAIDS Joint Programme has supported the revision of regulatory and legal frameworks pertaining to HIV responses, developed and updated testing, treatment and prevention services protocols, and undertook costing of services to be delivered through NGOs.

Collaboration between UNAIDS and PEPFAR is articulated in a memorandum of understanding. Within the framework of this memorandum, UNAIDS has worked with PEPFAR on strengthening the regulatory and legal framework for testing, treatment and prevention services, and bringing testing and treatment guidelines and protocols for PWIDs, MSM, SW to international standards. UNAIDS and PEPFAR also worked collaboratively on the costing of KP prevention services and presented the estimates at the Ministry of Health and Ministry of Finance to advocate for delivering KP services through social contracting. Further, they have collaborated on the implementation of Stigma Index study, and subsequent development of Kazakhstan's Stigma and Discrimination Plan. UNAIDS is also involved in development of PEPFAR's Regional Operational Plan and the Sustainability Index Dashboard (SID) every 2 years.

With regard to partnership with the Global Fund, the Joint Programme has taken a leadership role in grant applications, promoting inclusion of KP-responses, and prioritisation of M&E. For the latest Global Fund proposal UNAIDS provided technical and financial assistance, convened a country dialogue and worked with partners on the prioritisation of KP needs and identifying funding gaps. As a result, the new Global Fund grant covers prevention, OST, harm reduction, pre and post exposure prophylaxis services for KPs, as well as activities on the reduction of stigma and discrimination. UNAIDS has also worked with the Global Fund PIU on the development of guidelines and protocols for testing services for KP in accordance with international recommendations, and costed services for PWID, MSM, SW and transgender people. **The Joint Programme has also actively engaged with the key partners on the development of Kazakhstan's sustainability transition plan required by the Global Fund** and led advocacy activities for generating sufficient funding from domestic resources. The Joint Programme convened several CCM meetings and facilitated the work of the CCM technical working groups, consultations with key partners as well as a country dialogue to identify bottlenecks, barriers and elaborate a forward-looking plan. UNAIDS is further a deputy chair of the CCM and a chair of the CCM Surveillance working group, through which it leads and drives the prioritisation and M&E work in the country.

Coordination with other partners

The Joint Programme plays a crucial interface role between KPs, especially MSM and transgender communities, and the government. The Joint Programme has convened several discussion forums with KPs to identify priorities, burning issues, needs and gaps. These issues have been brought to the discussion during the parliamentary meeting and prioritised and institutionalised through establishment of a platform for CSO joint working with the government (as described in section 1.3). The Joint Programme has also engaged members of KP communities and CSOs (e.g. Central Asian Association of people living with HIV) in national exercises on the costing of services and advocated for additional financing for PWIDs, MSM and SW from the national budget and through social contracting, resulting in prevention services for PWID included in social contracting. Although, prevention services for PWIDs, MSM and SW are on the government's agenda, these services are not yet fully financed by the government. Methadone procurement within OST was declared to be included in the SGBP, however it is not registered in the country. Prevention services for MSM and SW are not prioritised and poorly supported under the social contracting mechanism.

Capacity building of communities and civil society

The Joint Programme has strengthened the capacity of CSOs in local budgeting, costing of services and budget advocacy, and navigating the State-Guaranteed Benefits Package (SGBP) and Mandatory Health Insurance Fund (MHIF). UNAIDS convened a series of trainings to increase awareness of CSOs on what services are included in the SGBP and how they are financed under the MHIF. UNAIDS and UNDP also played a key role in the establishment of the KP forum on financing, planning and prioritisation, stigma and discrimination. Its work entails discussion of financing issues, identification of bottlenecks, barriers and gaps, elaboration of action plans for joint work and advocacy activities. In the framework of the KP forum UNAIDS and UNDP have supported CSO capacity building in financing by providing technical and financial support to train NGOs on budgeting and involved NGOs and KPs in HIV services costing (as described earlier). Examples of such work include engaging 20 representatives of NGOs in a thematic working group on the revision of regulatory and legal framework on HIV services delivery and financing. This is in addition to capacity strengthening of CBOs in other key aspects of the HIV response including human rights and stigma and discrimination.

Evidence and data use

Data, guidance, and tools supported by the Joint Programme are driven by country needs and widely regarded as adding value to Kazakhstan's response. UNAIDS, Cosponsors and key partners engage actively with the government, Ministry of Health AIDS centre and the Global Fund CCM in discussing the country needs for data and information and agree and prioritise activities. On occasion, UNAIDS will also contribute to additional strategic information to make sure perceived gaps are bridged. The products are viewed as timely and of high quality. Examples include:

- SPECTRUM model estimations 2018 – 2020 have demonstrated a shift from PWID-driven infection to MSMs and SW and the need for the reprioritisation of financing for KPs. As a result, some funds have been secured from the domestic resources to finance procurement of tests, condoms, lubricants and other commodities, and post-exposure prophylaxis for the above mentioned KPs;
- Provision of technical assistance by the Joint Programme for costing of services for KPs and in advocacy for the introduction of those services within the State-Guaranteed Benefits Package (SGBP) and Mandatory Health Insurance Fund (MHIF);
- A feasibility study, implemented by UNAIDS and the National AIDS Centre in 2019, demonstrated routine mass screening results in only 0.1% of cases identified resulting in recommendations to abolish this approach and develop guidelines and protocols for index testing focusing on KPs. This will require additional financing from the government budget;
- Technical assistance for the production of Global AIDS monitoring data, the development of yearly UNAIDS country reports as well as a country report on UN Declaration indicator 8.1 – financing

has resulted in more comprehensive and systematised monitoring and reporting of not only the epidemiologic data but also the resources allocation and its breakdown by key HIV programme components. This exercise has revealed existing gaps in HIV financing, such as PrEP and prevention services to KPs;

- The Stigma Index study resulted in the development of a National Stigma and Discrimination Reduction Plan, relevant guidelines and protocols, and allocation of resources for the implementation of this plan;
- A recency study demonstrated that 80% of new infections have been acquired recently and called for a need to prioritise financing of interventions targeting KPs. The UNAIDS Joint Programme and PEPFAR organised a joint conference with the participation of high-level government officials and advocated for focused financing of activities addressing KPs and key vulnerable populations;
- In response to the Global Fund TRP comment resulted in an assessment of regulatory and legal barriers to HIV services access, now prioritised under the Global Fund grant;
- Technical assistance to develop the Sustainability Transition Roadmap for 2021-2023, which highlights the need for prioritised financing of KP prevention programmes under the national plan on HIV, social contracting, costing of prevention services for KP, and development of a roadmap for OST;

2020 allocative efficiency modelling analysis using the Optima model revealed a need for scaling up antiretroviral therapy (ART), testing and prevention services to PWID, Needle and Syringe Programmes (NSP), and continued investment for HIV testing and prevention programmes targeting MSM.⁴⁸ Allocative efficiency modelling analysis conducted in partnership with the Kazakh Government, the Global Fund, UNAIDS, and the Burnet Institute using the Optima HIV model simulated a series of scenarios to determine whether Kazakhstan could achieve its national targets or further, the ambitious 95–95–95 targets. Given relatively low new HIV infections among the general population, modelling outputs did not recommend to prioritise HIV investments towards the general population given current levels of HIV resources, but rather to target limited funds towards key populations at higher risk of acquiring and transmitting HIV. Key recommendations for HIV resource optimization included:

- *Scaling up antiretroviral therapy (ART).* Could lead to increased treatment coverage of people diagnosed with HIV from 58% (status quo) to 68% (optimized) in 2019, with high coverage levels maintained to 2030.
- *Scaling up investment for NSP for PWID.* Under optimized allocation of 100% budget, some investment in HIV testing and prevention programmes targeting PWID should be maintained. As additional resources become available investment in NSP programmes should continue to be scaled-up, along with investment in testing and prevention programs targeting PWID.
- *Maintaining HIV testing and prevention programmes targeting MSM.* Given that over 60% of new HIV infections occurred among MSM in 2018 in Kazakhstan, investment in HIV testing and prevention programs targeting this group should be scaled-up at the 100% budget level. Should additional resources become available, investment in MSM programmes should continue to be scaled-up, along with investment in PrEP targeting MSM.
- The modelling suggests that in order to achieve 95–95–95 targets the annual HIV budget from 2019 to 2030 should be increased to 160% of the latest reported budget level (an additional \$13M annually) and optimized with prioritization of antiretroviral therapy (ART), HIV testing and prevention programs targeting PWID and MSM.

The Joint Programme played a crucial role in providing technical assistance for costing of services for KPs and in advocacy for the introduction of those services within the SGBP and MHIF financing, as well as prioritisation of services under the social contracting mechanism. Supporting the

⁴⁸ Resource optimization to maximize the HIV response in Kazakhstan. Report. UNAIDS, THE GLOBAL FUND. 2020

inclusion of KPs within the State Guaranteed Benefit Package SGBP and MHIF has been a key priority for the sustainability of government-led responses. The government fully covers the costs of testing, ARV procurement and delivery of treatment services. This has led to the development of services delivery guidelines, reduced inequalities and the introduction of capita-based financing for people living with HIV under MHIF as well as prioritisation of financing for these services under the social contracting mechanism.

Political Commitment and sustainable financing

Commitments and current domestic financing

UNAIDS plays a pivotal leading role in building political commitment for HIV response in the country, with notable successes. UNAIDS has strong relationships and works closely with the Ministry of Health, Ministry of Finance, AIDS centre and Global Fund CCM. In particular, the involvement of the (now former) UNAIDS country director as the deputy chair of the CCM has supported its strong political engagement and influence. Advocacy by UNAIDS with high-level officials to advance the 90-90-90 targets led to the review of national policies, strategic documents and their alignment with the Fast-Track agenda. Multi-stakeholder, evidence-based technical/policy dialogue of UNAIDS and stakeholders has ensured the adoption of 90-90-90 and subsequent 95-95-95 targets as well as commitment of the National AIDS Programme commitment to the Fast-Track approach. Other examples of UNAIDS contribution to political commitment include: articulation of the HIV response within the Health Code, State Healthcare Programme for 2020-2025, organisation of the MPs and CSOs forum in 2021, facilitation of a meeting between the senior management of the National TB and National HIV Programmes to help with the GF allocation, and a national HIV Conference for the development of HIV Action Plan, HIV and Migration Technical Regional Meeting in 2018.

The Joint Programme has contributed to government commitments on reducing inequalities and increasing financing to community-led organisations– though more work is needed in this area. With support from UNAIDS through advocacy on the results of the Stigma Index survey, a national stigma and discrimination plan was endorsed by the National AIDS Centre with a government commitment to reduce inequalities in access to health services by PLHIV. In 2021 UNAIDS convened a parliament assembly to raise concerns of people living with HIV, women with HIV, OST and NGOs needs, which resulted in adoption of a resolution for prioritisation, improved work and coordination. Thus, it was decided to establish an inter-fractional platform under the parliament of Kazakhstan to convene regular advisory meetings with CSOs, cost HIV services included in the SGBP and financed by the MHIF and ensure sustainable support of NGOs through the state social contracting. Through political advocacy, the Joint Programme (notably UNAIDS, UNDP) has also secured the prioritisation of HIV issues through social contracting under the Ministry of Social Protection, and it was addressed in the above-mentioned resolution of MPs. It also established work with the Ministry of Labour and Social Protection, and human rights ombudsman on social contracting and stigma and discrimination.

However, despite the strong commitment of the government to ensuring financing for ART and accessibility for people living with HIV, prevention programmes for PWIDs, MSM, SW and LGBT are very low on the government agenda and not adequately financed. Moreover, OST and harm reduction activities are highly political and regularly debated among MPs and the general public. There is a prominent need to strengthen the work on OST advocacy and financing from domestic resources. One challenge is that social contracting resource allocations are under the prerogative of local public administrations and so MPs and the government can only recommend HIV-responses be financed without any minimum thresholds.

Engagement with both the Ministry of Health and Ministry of Finance on unit costs, supported by global evidence, has helped to secure commitments for prevention services for PWID. UNAIDS Secretariat fluency on health financing was viewed as critical for building credibility with the Ministry of Finance on recent advocacy for government financing of PWID services. Following a costing exercise on prevention services for PWID, implemented jointly with UNAIDS, PEPFAR, TGF PIU, CSOS

and the National AIDS Centre, UNAIDS engaged with the Ministry of Health and Ministry of Finance on the unit costs for a package of services, supported by credible global policy guidance developed by UNAIDS global office. An agreement was reached to increase financing of these services and prioritisation of their delivery under social contracting.

Efficiency

Through its strong working relationships and active engagement with the AIDS Centre and MoH, UNAIDS is regarded as having influenced HIV governance and policy issues, and thus increase the efficiency of HIV resources. Successes include convincing the AIDS Centre and Ministry of Health on the need to bring testing and treatment protocols to the latest international guidelines, the introduction of express testing, procurement of ARVs through UNICEF, the inclusion of OST under the national budget, as well as financing of PWIDs prevention activities under the social contracting.

The OPTIMA modelling and costing of KP services first conducted in 2017, with follow-through analysis and advocacy has been the most prominent contribution of UNAIDS to increased allocative efficiency. Allocative efficiency analysis using the Optima model in 2017 provided an entry point for UNAIDS, UNICEF and PEPFAR to engage the government on opportunities for cost savings in the HIV programme. As an UIC, Kazakhstan was excluded from a landmark voluntary licence agreement that set price ceilings for dolutegravir-based first-line regimens in LMICs. Stakeholders highly regarded the efficiency analysis as starting the conversation with the government on the pricing of different ARTs and presentation of investment scenarios, and specifically whether to seek a compulsory license for dolutegravir ART. In 2020, a new licensing agreement specifically for upper middle-income countries was announced that included Kazakhstan to lower the cost of dolutegravir ART.⁴⁹ The price reduction of dolutegravir ART from US\$3140 to US\$100 per patient annually is regarded in Kazakhstan as one of the Joint Programme's largest contributions to efficiency in the HIV response since 2018. To attain the 95–95–95 by 2030 targets, it is estimated that the annual HIV programme budget should be increased to 160% of the latest reported budget level (an additional USD 13M annually) and optimised with prioritisation of ART and HIV testing and prevention programmes targeting PWID and MSM. By 2030, this condition could facilitate Kazakhstan to have 95% of PLHIV be aware of their status; 98% of those diagnosed on treatment; and 95% of those on treatment to have achieved viral suppression⁵⁰. As a result of this demonstration the HIV issues were prioritised in the National Health Programme with financing of KP treatment and prevention services under the National HIV Plan, a transition and sustainability plan was developed and KP focused social contracting.

Joint Programme advocacy with the government has secured financing through the State-Guaranteed Benefits Package (SGBP) and newly established Mandatory Health Insurance Fund (MHIF). Costing analysis and advocacy by the Joint Programme (as per section 2.5) resulted in inclusion of HIV testing, treatment and care services for people living with HIV in the State-Guaranteed Benefits Package (SGBP) and are reimbursed through the newly established Mandatory Health Insurance Fund (MHIF) based on per-capita payment.

A key area for improved efficiency is to strengthen social contracting through regional and municipal governments Although, there is a social contracting mechanism allowing financing of NGOs, its use is still weak and sporadic and depends on the proactiveness of local government bodies. The Joint Programme has advocated for mandatory inclusion of KP-responsive testing and prevention services within social contracting guidelines. To date, these have been secured for PWID, but not all KP.

⁴⁹ <https://medicinespatentpool.org/news-publications-post/viiv-and-mpp-expand-access-to-dtg-to-four-new-countries> (Accessed Dec 7 2021)

⁵⁰ Resource optimization to maximize the HIV response in Kazakhstan. Report. UNAIDS, TGF. 2020

Financing for HIV integration into UHC financing

The government of the Republic of Kazakhstan is strongly committed to the integration of HIV into UHC and PHC. The Global Health Sector Strategy (GHSS) supported by Kazakhstan, outlines the way forward to the integration of HIV and other services into broader health systems, with universal health coverage and primary health care as key focal areas. In September 2019, Kazakhstan signed a Political Declaration on UHC reaffirming its commitment to and implementation of the SDGs 2030 agenda and recommitted to achieving universal health coverage by 2030. Within the Joint Programme, UNICEF and WHO are the lead agencies actively engaged in UHC. In September 2021, Kazakhstan cosponsored a High-Level Meeting on UHC where it reconfirmed the commitment to UHC. The meeting paved the way to a planned 2023 High-Level Meeting and 2022-2030 Global Health Sector Strategies (GHSS) on HIV, STIs and Viral Hepatitis.

Kazakhstan has already integrated HIV, STI, TB and MNCH testing and referral services demonstrating a positive direction towards UHC and PHC integration. However, there is a lack of clear and sustainable financing for the integration. Kazakhstan allocates 3mIn tenge (approximately US\$6800) for the integration of services annually, but these funds are diluted and difficult to track. Despite the small size, it is regarded as a commitment for this approach. According to and in line with Global Health Sector Strategies (GHSS) 2022-2030 strategy, Kazakhstan explores ways and approaches for the delivery of integrated services, strengthening inter-programme collaboration and coordination, developing plans for the integration of some HIV services with PHC to achieve efficiencies and gains, as well as developing services packages to satisfy the needs of KPs and vulnerable groups and to ensure equitable access to health services.

The government of Kazakhstan is demonstrating its financial commitment to ensure that no one is left behind by increasing healthcare spending from 9.3% of total government spending in 2019 to 13.1% in 2024. The increase in spending will be invested in the scale up of prevention services and public health issues (60% increase out of total spending). HIV prevention and ART are prioritised in the healthcare development programme and have specific indicators to be measured and monitored regularly. The recently reintroduced mandatory social health insurance fund (MHIF) is planning to improve health services accessibility by expanding the list and volume of healthcare services and drugs provision and to protect its population from catastrophic health expenditure.

Within a newly adopted national health system strengthening framework, State Health System Development Programme⁵¹, Kazakhstan is committed to the delivery of prevention, testing and treatment services to people living with HIV and KPs within SGBP. The HIV response in Kazakhstan is regulated by the Code on Public Health⁵² and Healthcare System and the Law on HIV/AIDS prevention. These governing documents guarantee accessible, voluntary and anonymous HIV testing free of charge, monitoring and provision of psychosocial, legal and medical advice, provision of quality health care services and drugs to people living with HIV within the State Guaranteed Benefit Package, including pre and post-exposure prophylaxis services, prohibition of discrimination related to HIV/AIDS, implementation of the state social grants and social orders through non-government organisations (NGOs), prevention of mother-to-child HIV transmission.

Conclusions & Considerations for the future

The Kazakhstan case study offers the following key conclusions and considerations for the future for the UNAIDS contribution to sustainable and efficient financing for the AIDS response:

⁵¹ State healthcare development programme of the Republic of Kazakhstan for 2020-2025. Decree of the Government of the Republic of Kazakhstan. № 982 as of 26 December 2019.

<https://www.gov.kz/legalacts/details/P1900000982?lang=ru#z13>

⁵² Code of Public Health and Healthcare System of the Republic of Kazakhstan. № 360-VI 3PK. 7 July 2020.

<https://adilet.zan.kz/eng/docs/K2000000360> Accessed 29.11.21

- UNAIDS is widely regarded as having leveraged its comparative advantage of convening and technical expertise to support a coherent and well-coordinated HIV response in Kazakhstan between the government, donors, and UN partners.
- The Joint Programme, as a leading advocate supporting the political engagement of civil society should continue to support Civil Society, KP and vulnerable populations to engage at high-level forums and advocate for the prioritization of prevention services and financing. This is crucial in the context of rising incidence in Kazakhstan and highest burden of new infections amongst PWID and MSM.
- Strategic Information produced by the Joint Programme is regarded as high quality and has contributed to demonstrated improvements in efficiency of the HIV response. The Joint Programme should build on successful advocacy approaches with the Ministry of Health and Ministry of Finance, such as was achieved for financing PWID services, to secure sustainable financing for other KP packages.
- The Joint Programme is regarded as strongly contributing to political commitment in Kazakhstan for the HIV response, however, more remains to be done with respect to sustainable services for KP through government financing and social contracting, and reaching the 95 targets. Continued work is required to build political will for the more politically challenging aspects of the response. Evidence from successful approaches from other UIC and the EECA region could be leveraged to be adopted to local circumstances, backed by available global evidence from UNAIDS.
- Relatively nascent social contracting and willingness for some government funding offers an opportunity for more efficient KP responses, however decentralization of service delivery brings significant accountability challenges given the Joint Programme's small footprint in the country. The Joint Programme should explore models to support local accountability and transparency to ensure there is prioritization of HIV and health within local health budgets, and that social contracting adequately reflects KP-services. The Joint Programme could harness its UN partners to identify successful models supporting Kazakhstan and other countries with similar challenges related to decentralization.
- In terms of UHC, recognizing good progress on aspects of inclusion of HIV within MHIF and SGPB, improved coordination between UNAIDS and WHO would add value. Here, the Joint Programme could strengthen its work on the provision of necessary technical expertise on HIV integration with the broader health system and PHC, as well as building political and financial commitment for expedited implementation of guidelines and standards on HIV integration with PHC.
- There are clear examples of successful collaboration and coordination within the Joint Programme, particularly around procurement of ARVs and efficiencies in regimens and reduced costs. Overall, there is a need for deeper Cosponsor engagement to prioritise efforts and be more actively engaged in HIV response. Through the UBRAF, roles and responsibilities of Cosponsors in the country could more firmly be defined and used as a platform for exploring opportunities for engagement and needs for any external TA. This would also be an opportunity for review of UBRAF resources and limitations for obtaining additional capacities.

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Consultation list

Table G.5.1: Stakeholders consulted as part of the Kazakhstan case study

Organisation	Name	Job title
Kazakh Scientific Center of Dermatology and Infection Diseases (AIDS Centre)	Petrenko Irina Ivanovna	Deputy Director
Project implementation unit of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Kazakhstan	Davletgalieva Tatyana	National coordinator on HIV component
Central Asian Association of people living with HIV	Lubov Vorontsova	Programme specialist
ICAP, Mailman School of Public Health, Columbia University	Anna Deryabina	Regional Director
USAID Mission to Central Asian Republics, USAID/PEPFAR Health and Education Office	Khorlan Izmailova	Regional Adviser
CDC/Kazakhstan	Indira Aitmagambetova	Associate Director, Division of Global HIV/AIDS
UNDP	Ryssaldy Demeuova	Coordinator, CCM Secretariat
UNFPA	Yulya Lyssenkova`	Specialist on HIV
UNICEF	Nodar Karimov	Specialist on HIV
UNICEF	Baurzhan Zhussupov	Health & Nutrition Specialist
WHO	Nicole Seguy Elena Vovc	Team Lead HIV, STI and viral Hepatitis Technical supervisor HIV, STI and viral Hepatitis
UNAIDS	Gabriela Ionascu	Acting Director of the UNAIDS office
UNAIDS	Aliya Bokazhanova	Fast Track Adviser

Appendix H: Country case study – Viet Nam

This appendix presents the Viet Nam country case study in support of the evaluation of the UNAIDS Joint Programme's work on efficient and sustainable financing for the AIDS response. Following country background information and HIV funding context (Section H.1), country-level findings are presented for each of the evaluation questions (Section H.2). A final conclusion and considerations for the future section based on these findings follows (Section H.3). The case study is based on a review of key documentation (Section H.4 provides a list of key references) and stakeholder interviews (Section H.5 provides the list of consultees) conducted in November 2021 and draws from the 2021 evaluation of the UN Joint Programme on HIV Viet Nam.

Background Information and country context

Key country characteristics and HIV context

Viet Nam is classified by the World Bank as a lower middle-income country. The epidemic is concentrated among three key populations (KPs): men who have sex with men (MSM) at 11.4% prevalence; people who inject drugs (PWID) at 12.7% prevalence; and female sex workers (FSWs) at 3.6% prevalence. Of emerging concern is the transgender community with an HIV prevalence of 16.5%, and low risk women (i.e., sexual partners of KPs and PLHIV), who accounted for 35% of all new infections among adults in 2019. In 2019, 230,000 people were living with HIV (PLHIV), with an estimated 5,700 new infections and 4,700 AIDS related deaths in 2018. Good progress is being made towards meeting the 90-90-90 targets, and the government is committed to ending AIDS as a public health threat, as indicated by the recent approval of the national strategy to end AIDS by 2030. An estimated 190,000 (or 82%) of people living with HIV know their HIV status, of whom 145 000 (76%) are on treatment.

Over the past few years, the HIV vertical program has gradually been integrated into the national health system. The Provincial HIV/AIDS centres (PAC) are no longer stand-alone units responsible for HIV but have been integrated into the provincial CDC. Domestic health financing comes from three sources: the state budget, social health insurance (SHI) (covering the costs of medicines and medical consumables) and direct out-of-pocket payments by households. Out of pocket health payment account for 45% of all domestic health resources. Established in 1992, SHI is mature in Viet Nam, with 90% of the population enrolled in the scheme. Domestic funding as a share of total HIV spending has increased from 34.6% in 2015 to 48.4% in 2019, largely due to the transition in funding of HIV treatment from donors to SHI. The Global Fund for AIDS, TB and Malaria (The Global Fund) and United States President's Emergency Plan for AIDS Relief (PEPFAR), are the main funders of HIV prevention services, mainly directed at KPs and delivered by community-based organisations (CBOs).

Key issues in terms of efficient & sustainable financing for HIV

Political commitment for efficient and sustainable HIV financing is high. Overall funding for HIV activities has declined from over \$US111.7m in 2015 to \$US93.6m in 2019. However, this has been against a backdrop of increasing domestic share of the HIV budget, rising from 35% in 2015 to 47.6% in 2019. The bulk of this rise has been due to the absorption of treatment costs into the SHI. In 2019, 90% of PLHIV on ART were enrolled in SHI. Currently the SHI scheme covers the majority of costs of anti retrovirals (ARVs), with provincial budgets taking on greater responsibility for paying insurance premiums and co-payments for PLHIV. In a show of further commitment to sustainability, the government, has taken on the costs of methadone maintenance treatment (MMT), through the state health budget. The National Strategy to End the HIV/AIDS Epidemic by 2030, launched in 2020 states a goal to mobilise public funding for HIV prevention and control activities, as well as funding for inter-sectoral activities. However, the national strategy has still to be costed and a financing plan developed. The government acknowledges that social contracting for HIV prevention, or procurement of services from CBOs using public resources, is the path forward for sustaining the HIV response. In November 2021, the Ministry of Health approved pilots of social contracting for

HIV/AIDS prevention and control services in nine provinces over for the period 2022-2024, funded by PEPFAR, USAID, Global Fund, and UNAIDS.

While integration of HIV at provincial level will improve efficiency and sustainability of HIV in the long run, in the immediate term, respondents cite it is resulting in disruptions with respect funding and service delivery. Health service delivery in Viet Nam is highly decentralised. In the past 3 years, preventive medicine services in 63 provinces, including HIV services, have been consolidated into 63 provincial centres for disease control (CDC). The removal of earmarked funding for HIV has resulted in a drop in HIV funding due to the challenge of resource mobilisation at the provincial level. Only 15% of provinces, with targeted HIV activities, have developed HIV financing and sustainability plans. Funding for development of provincial HIV financing and sustainability plans are met through the Global Fund award to support the smooth transition from a vertical to an integrated programme. The removal of free-standing HIV units in hospitals and shift to integrated service provision has resulted in many changes in leadership and human resources, including trained HIV health staff being moved to take on other responsibilities. This is impacting the availability of priority HIV services in hospitals. One key informant from the UN said *“the effort of the government on structural changes devolving HIV functions from central (Viet Nam Authority on AIDS Control, MOH) to provincial level (Provincial CDC) will likely diminish political focus and action”*

Government has acknowledged that social contracting offers the main path for sustaining community-based HIV prevention services, but there are many challenges to overcome for its operationalisation. As shown in other countries, social contracting, or government contracting of CBOs using public resources to deliver community-based HIV prevention and control services (such as provision of PrEP; referral for HIV harm reduction, treatment and care; support for adherence; and stigma reduction), will be a main route to sustaining the response and ending the epidemic. While this is widely acknowledged by Government of Viet Nam (GoVN), there are many challenges to be overcome. Firstly, there is no legal framework in place for CBOs to sign contracts for services funded by the state budget, and as a result the only means currently for doing this is for CBOs to register as social enterprises. Plus, there are no clear guidelines on how much of the budget should be spent on contracting with CBOs for HIV prevention services, and no clear mechanism or capacity within provinces to agree and manage contracts. The soon to be launched social contracting pilots in nine provinces seek to address these challenges and generate evidence and ideas on how they can be overcome.

Although COVID-19 has been causing disruptions in the provision of health services, it is still not clear the extent to which HIV resources have been diverted for use in the health emergency. COVID-19 emergency funds provided by the international donors will help bridge any health and HIV resource gaps in the short term. However, since COVID-19 has led to a downward revision in the annual economic growth forecast, the fiscal space available for social and health spending will be lower, and in turn this will slow down Viet Nam’s progress towards HIV financial sustainability. On a more positive note, COVID-19 has shone a light on the importance of the community health system, with the role of community networks and CBOs proving extremely useful to feedback issues faced by clients to the Viet Nam Administration for HIV/AIDS Control (VAAC), advocate for service delivery adaptations, and help identify and link clients to suitable solutions for HIV service continuity. As a result, two service adaptations - multi-month dispensing of ARVs and a pilot on taking home methadone (part of the drug substitution therapy) - have been introduced to circumvent service access challenges posed by COVID-19.

Findings

Comparative advantage

UNAIDS’s main comparative advantage has been its ability to build and maintain strong working relations with the highest levels of government and generate political commitment for efficient and sustainable HIV financing. UNAIDS has been instrumental in securing commitment from GoVN to increase domestic funding for the HIV response, and in supporting the transition to financial

sustainability. UNAIDS voice is respected at the highest levels of government. They have forged a close relationship with the Social Affairs Committee of the National Assembly, the highest-level law and policymaking mechanism. By supporting and working with the “national committee on HIV and AIDS, drug and sex work”, chaired by the Deputy Prime Minister, UNAIDS, together with the Cosponsors, has helped pass key policy and legislative reform to strengthen the efficiency and sustainability of the HIV financing. Most recently, this included supporting the review and amendment of the HIV Law, to facilitate a greater role of CBOs in HIV prevention and control. Specifically, the revised law clarifies definitions of community service, the role of CBOs, and the concept of social contracting, thus laying the foundation for the adoption of social contracting. The revised law also includes the provision of free legal aid to PLWH and free HIV testing for all women seeking to know their status. UNAIDS supported the development of the new “National HIV Strategy to End the AIDS epidemic by 2030”. The Strategy outlines key approaches that will strengthen efficiency and sustainability of the HIV response, namely:

- Integration of HIV/AIDS prevention and control activities into programmes implemented by different ministries, cities and provinces, for example on hunger eradication, poverty reduction, job placement, livelihood creation to support the livelihood and the integration of people living with HIV into the community and greater multisectoral coordination and actions for HIV prevention, thereby helping to address the key societal enablers of the pandemic.
- Creation of a favourable policy environment and financial mechanism for social organisations to participate in the provision of HIV/AIDS prevention and control services, including from the state budget, thus laying the ground to take social contracting forward.

Coordination and internal alignment amongst Cosponsors and UNAIDS Secretariat

There is good coordination and internal alignment among UNAIDS and the Cosponsors as per the agreed division of labour, however, the Cosponsors assigned to lead on investment and efficiency are not actively engaged in this strategic area. The World Bank, apart from producing a Health Financing System Assessment for the country in 2020, which including HIV financing, has not been active in UBRAF SRA7. While UNDP’s work in this area has been confined to providing technical assistance to GoVN to strengthen the system for procuring ARVs. UNAIDS and WHO have been leading on the investment and efficiency work stream, especially in advocating for increased domestic resources and integration of HIV into UHC. For example, they worked together on the revision of the HIV law. A key informant mentioned that deeper engagement by the World Bank and UNDP is required on efficient and sustainable finance, especially to negotiate with the Ministry of Finance, undertake macroeconomics analysis, expand the tax base and enhance the fiscal space for the HIV response. This support is even more important in the context of delivery of the new global AIDS strategy, which emphasises domestic resource mobilisation, integration with UHC, reducing inequalities, and ensuring adequate financing for addressing the societal enablers.

While coordination amongst the Cosponsors for the HIV response overall is strong, it is less strong with respect the efficiency and sustainability work stream. As mentioned, UNAIDS and WHO are the most active with respect progressing the efficiency and sustainability work steam. Other Cosponsors do not explicitly consider efficiency and sustainability within their assigned work areas, although some have made significant contributions to enhancing the efficiency and sustainability of the country HIV response. For example, UNDP through its work to strengthen MOH’s procurement of ARVs, and UNDOC by successfully securing government commitment to take on the costs of methadone onto the state budget. These examples notwithstanding, much more could be done by the Cosponsors to mainstream efficiency and sustainability into their respective work areas. Further there is a need to make stronger links within Cosponsor’s work on HIV and their broader health and development work. For example, UNDP’s work on social protection, and WHO’s work on UHC more broadly, can help significantly in progressing the wider agenda articulated in the new global AIDS strategy.

Capacity of Joint Programme and partners

UNAIDS and the Cosponsors mostly rely on short term technical assistance from UNAIDS headquarters to drive the efficiency and sustainability work, but the work requires more specialised and sustained support. While key informants widely acknowledged the substantial contribution the Joint Programme has made to strengthening efficiency and sustainability of HIV financing, they pointed out that this work area requires highly specialised technical skills, that are currently not available either in the country teams or in their respective regional support offices. UNAIDS has relied mostly on short term technical assistance (TA) from headquarters to work on discrete technical products like the Legal and Policy Framework for Implementation of Social Contracting in Viet Nam.. It was felt there was a role for the Joint Programme to provide technical support to take forward the programme of work articulated in the strategies and plans. The Global Fund and PEPFAR awards do address some of these technical needs, for example the support provided under the Global Fund grant for the production of provincial HIV financing and sustainability plans. However, it was felt UNAIDS had a comparative advantage and should provide more hands-on support, especially focussed advocacy at the provincial level. At the same time, they stressed the needed skills to support this work are currently missing at both UNAIDS country and regional offices. In the context of the new global strategy, capacity is also required to link HIV to bigger conversations around UHC, macroeconomics, and social sector spending. In regards to availing Country Envelope funding, use for SRA7 has declined from 7 projects to 1 project over 2019 to 2021. (value of \$US47,000 in 2019 and \$US23,540 in 2021). The overall country envelope has stayed fairly steady over this period, at approximately \$US335,000. The overall low level of available funding for the efficiency and sustainability work stream is viewed as severely affecting the ability of the Joint Programme to make the needed contribution across Cosponsors. This is regarded as a missed opportunity. Critically, the Joint Programme is also regarded as requiring resources to engage at the provincial level, where the bulk of HIV financing decisions are now being made (described in the following sections).

Partnerships

Donors

UNAIDS provides strategic support to government to help access funds through the Global Fund and PEPFAR, and their epidemiological and other analysis influences how donor funding is deployed. UNAIDS plays an important role in supporting the development of the Global Fund proposal. The Chair of the Country Coordinating Committee (CCM) said *“UNAIDS plays an important role on the government’s HIV technical subcommittee in negotiating and preparing the Global Fund proposal. They are proactive in coordinating resources and providing technical input in building, reviewing, and evaluating Global Fund funding requests”*. UNAIDS work, together with the Global Fund and PEPFAR has played a critical role in the negotiations with GoVN to take on all ARV costs, through the SHI. As a member of the country coordinating mechanism (CCM), they influence and oversee the execution of the Global Fund grant, and ensure coordination with PEPFAR funding. For example, UNAIDS, Global Fund and PEPFAR worked together to design and secure government approval for social contracting pilots in nine provinces. UNAIDS will fund and oversee a pilot in one of the nine provinces. The funding for the remaining pilots will be met under the Global Fund and PEPFAR awards. The three organisations will share and pool the results and learnings coming out of the nine provinces, to inform national scale up of social contracting.

In addition to supporting the development of PEPFARs annual country operational plan (COP), UNAIDS works closely with the PEPFAR funded Sustainable Financing Initiative for HIV/AIDS (SFI), a global programme that aims to increase sustainability of the HIV response. For example, they have worked together on the sustainability index and dashboard (SID), a tool that has been developed by PEPAR to assess and track progress on key sustainability indicators, including health governance, health systems capacity, financing, and strategic health information. Each indicator is awarded a score and accordingly assigned a traffic light based on progress being made. On financing, the SID

tracks progress being made with mobilisation of domestic resources for HIV. UNAIDS convened a workshop with high-ranking government officers, and other UN members to introduce the sustainability index tool, and secure commitment for its use. UNAIDS and PEPFAR also collaborated on development of the stigma and discrimination index, which was informed by a UNAIDS pilot in Ho Chi Min City.

Coordination with other partners

UNAIDS facilitates participation of community groups and civil society on high level government policy committees and technical working groups, including for enhancing efficient and sustainable HIV financing. UNAIDS is considered a champion of civil society, and there are numerous examples where UNAIDS has facilitated the voice of communities, especially those from KPs to be heard and for them to influence HIV policies and programming. With respect efficient and sustainable financing, civil society participates on the CCM, and shapes and influences resource prioritisation under the GF award. Civil society participation at the highest levels of government for HIV are now considered routine. For example, civil society participated in the technical group for revision of the HIV law, which focussed on legal changes to enable CBOs to be funded by government for prevention. They have also been heavily involved in the design of the social contracting pilots. Recently, UNAIDS convened a workshop with community groups to learn of the impact COVID-19 was having on HIV services and identify how service disruptions could be mitigated. As a result, government agreed to provide multi-month dispensing of ARVs and a pilot to take home methadone was initiated. Both these initiatives have resulted in more efficient use of scarce HIV financing. Also, in the context of COVID-19, UNDP partnered with community groups to distribute cash transfers to households negatively impacted by the health emergency. Although, this was not exclusively for HIV, it is a good example of how the sector can be galvanised going forward, especially in the context of the new global strategy which emphasises the need to address the structural and societal enablers of the epidemic and extend social protection to the poorest and most vulnerable to HIV.

Capacity building of communities and civil society

While the Joint Programme, through implementing partners, has built capacity of communities and civil society in raising awareness of KPs on their rights, combatting stigma and discrimination and gender equality, they have not invested in building their capacity on efficient and sustainable financing. Although UNAIDS promotes participation of community and civil society on key forums and platforms that address efficiency and sustainability (including involvement in development of sustainability and transition plans, and participation in the technical committee on social contracting), they have not invested directly in strengthening their fluency or capacity on the HIV financing agenda, for example in conducting analysis of the state HIV budget, or holding government to account for meeting funding commitments. It is unclear, the extent to which such capacity has been built through the Global Fund and PEPFAR funding. In the context of social contracting, some work is underway to help CBOs register as social enterprises and build their capacity to raise funding (including from the state budget) and operate as for-profit agencies. Civil society capacity to hold governments to account for adequate and sustainable financing for HIV has become even more important in the context of decentralisation of HIV financing to provinces. As mentioned, the integration of the HIV programme into the broader health and population programme, has resulted in decreased funding to the HIV programme. Plus, only 15% of provinces with HIV programmes produced HIV financing and sustainability plans. Civil society can be harnessed to hold provinces to account to meet their HIV financing obligations, and ensure scarce resources are used in support of high impact interventions, and that services are delivered in the most efficient manner. Further, the new global strategy stipulates for more attention to be focused on the societal enablers of the epidemic. Here again, civil society can play an important role to ensure adequate funds are made available for this purpose.

Evidence and data use

While UNAIDS epidemiological data has influenced HIV service prioritisation, the Joint Programme has not contributed data or analysis to make the case for sustainable finance, through sustainability and transition plans or investment cases. Unlike in many other countries, the Joint Programme has not generated core HIV financing products such as sustainability and transition plans, and investment cases. It appears that advocacy for greater domestic funding for the HIV response has been undertaken in the absence of these products. However, over the last few years, several studies have been commissioned by the technical support mechanism of the UNAIDS Secretariat to strengthen HIV financing. For example, in 2019, a case study was undertaken to assess the extent of HIV provision through health insurance, the types of services covered, and whether the right providers have been contracted. Recommendations that flowed from the study include improving regulation of the insurance schemes, and benefit packages, and ensuring sound financing strategies, with respect fiscal impact and incentives. It was not possible to confirm whether these recommendations were taken up by SHI. The NASA (National AIDS Spending Assessment) was another routine HIV financing produced by UNAIDS, however in the context of integration of HIV and health, this analysis is now provided under the WHO led national health accounts (NHA).

The integration of HIV services within the general health programme at provincial level, has meant provinces are now responsible for planning and budgeting for HIV, including for raising local funding. Therefore, provinces also require data, guidance and tools to influence and guide resource mobilisation and allocation. Some support provided through the Global Fund grant, to produce provincial HIV financing and sustainability plans. However, given UNAIDS strong reputation in this area, and comparative advantage as convenor and influencer, they can step up and fill this gap for data and guidance at provincial level. **UNAIDS is generating and facilitating the production of high-quality evidence, analysis, and tools to inform social contracting.** UNAIDS is playing a leadership role in advocating to government to adopt social contracting, as the main way to transition funding for HIV prevention from donors to the government, ideally through the SHI. Table H.2.1 shows the data, analysis and evidence they have generated over the last few years, to influence and inform uptake of social contracting.

Table H.2.1: UNAIDS support to social contracting

Year	UNAIDS product
2018	Shared international best practice on social contracting, and produced a road to advance the agenda
2019	Used a social contracting diagnostic tool developed by TSM to identify the means for civil society to receive funding. This led to an assessment of the legal and policy environment, and what changes are required to enable social contracting
2020	Costing of select HIV services, to inform the HIV prevention service package for social contracting Findings from the legal and policy environment were used to inform amendment of the HIV law to allow government to contract CBOs
2021	Design and government approval secured for a social contracting pilot in Dien Bien province

Political Commitment and sustainable financing

Commitments and current domestic financing

Financial transition is underway, with the focus now on transitioning HIV prevention costs. The HIV response in Viet Nam is successfully transitioning from a program that was once primarily donor-dependent to one that is increasingly financed through domestic resources. Domestic funding (including both public and private sector spending) increased from 35% in 2015 to 47.6% in 2019. This increase was due to the transition of treatment costs from the Global Fund grant to the SHI. Public sector financing currently accounts for 40% of total HIV expenditure. In a further show of commitment, the costs of methadone have been absorbed into the state health budget. Provincial governments have increased their contribution to the HIV response, currently meeting costs of health staff, capacity building, general HIV prevention, monitoring and evaluation, and harm-reduction programs. They are gradually taking over responsibility for paying of SHI premiums and co-payment for PLWH, from Global Fund and PEPFAR. In 2019, 38 of 63 provinces subsidized SHI premiums and ARV co-payments, amounting to \$US 760,000. Currently, the bulk of HIV prevention costs are met by the Global Fund and PEPFAR. As indicated in the national strategy to end the AIDS epidemic by 2030, the government is committed to gradually take on funding of prevention and control. Good progress on this was made in November 2021, with MoH providing approval for social contracting pilots in 9 provinces.

Joint Programme contribution and challenges

The Joint Programme has contributed to securing political commitment for leveraging domestic resources, as well as influenced how to mobilise domestic resources to sustain the HIV response.

Political commitment for domestic financing has been galvanised in several ways. At the highest level, the Deputy Prime Minister attends the UN High Level Meetings (HLM-HIV). In the meeting held in 2021, the Deputy Prime Minister presented the new national strategy to end AIDS by 2030, which articulates commitment to raise domestic financing, especially for prevention and control. Such pronouncements, allow UNAIDS and other stakeholders to hold government to account for meeting financing commitments. UNAIDS has worked effectively with the national assembly, and especially with their social affairs committee with respect securing commitment to transition treatment costs to the SHI. To secure political buy in for social contracting, UNAIDS first held meetings with MoH and VAAC, and then met with the Ministry of Finance, Home Affairs, Planning and Investment, and other key department with MoH, to share best practices from other countries. They also highlighted some of the challenges with social contracting, such as current legal restrictions to contract CBOs. One key informant said that UNAIDS has successfully positioned HIV within a society wide framework, getting government to realise the importance of addressing the legal, human rights and social dimensions of epidemic. However, to date, the funding for addressing the societal enablers, such as legal reform to protect the labour rights of PLWH, has come from donors. There have been no discussions on government taking on the costs of these activities in the future. It is likely, donors will need to continue to fund interventions that address the structural drivers of HIV in the longer term, and beyond when government takes on prevention costs.

The Joint Programme, and particularly UNAIDS and WHO played an instrumental role in getting treatment costs absorbed into the SHI. Having started 1992, SHI in Viet Nam is a mature programme. It currently covers 87% of the population with a basic minimum package. However, out of pocket spending on health still remains high in the country, through co-payments. The country faced several challenges following the transfer to SHI, including extending coverage to PLWH with no ID, or difficultly accessing treatment if they moved provinces. UNAIDS helped to iron out these early challenges and succeeded in securing a decree from the prime minister for provinces to extend insurance coverage to those without ID and for greater flexibility with respect where to access treatment. A core requirement of the transition of treatment costs to the SHI, was for provinces to pick up the costs of insurance premiums and co-payments of all PLWH. As a backup, these costs were initially met by the Global Fund. UNAIDS, along with others, facilitated a gradual handover of these

costs to the provinces. 36 out of 63 provinces are now subsidising the costs of premium and co-payments for PLWH. Costs of methadone have been absorbed into the state health budget, and advocacy is ongoing for the cost of PrEP to also be absorbed either through SHI or the state budget. However, to date this has not been successful. UNAIDS work to progress social contracting of CBOs as the route to sustaining prevention costs has already been discussed and is not repeated here.

Efficiency

UNAIDS has played a major role in ensuring HIV resources (from all sources) are focussed on high impact interventions directed at KPs, in alignment with a concentrated epidemic. They now need to support the design of a modified prevention service package for different KPs that will be affordable for government to pick up and sustain. The Joint Programme has been instrumental in promoting allocative efficiency, by ensuring resources are focussed on KPs, and in bringing in international best practices with respect community-based service delivery models. This includes CBOs: delivering harm reduction activities (distributing needles); linking to PrEP services and methadone treatment; facilitating community-based HIV testing; encouraging adherence to treatment; and organising and informing KPs of their rights and strengthening their advocacy skills, among other activities. As government has shown willingness to gradually take on responsibility for community-based services through social contracting, a key priority is defining the service benefit package that will be contracted. The package needs to include the highest impact and most cost-effective interventions, as well as be affordable to government to take on. UNAIDS has been providing support to this resource allocation challenge, by extending assistance to cost CBO services, and in designing and testing a service package as part of the social contracting pilot.

The Joint Programme has influenced resources allocations to tackle the structural drivers of vulnerability and inequalities, however more needs to be done. The Joint Programme, collectively, has made a significant contribution to ensuring donor resources are allocated to tackling the societal enablers of vulnerability, including for the development of a stigma and discrimination index, successfully reforming the drug law, and raising awareness of PLWH on their employment rights. This is a highly cost-effective use of HIV resources, as indicated by the recent study undertaken by the UNAIDS secretariat on the returns to investing in the societal enablers of vulnerability. Having said that, the Joint Programme can do more to ensure more resources are allocated to tackling the structural drivers of the epidemic, such as poverty and gender. This requires resources to be channelled to sectors outside of health, such as education and home affairs, and for CBOs to play a strong role in their delivery. UNAIDS and Cosponsors have identified social protection, including cash transfers as an impactful way of reducing vulnerabilities to infections (especially of girls), and as a way of improving coverage of HIV services. During the COVID-19 pandemic, UNDP extended social protection, in the form of cash transfers, to household badly impacted by the emergency. This provides a useful entry point for the Joint Programme to leverage this experience and explore further the capacity of cash transfers to help address the structural barriers of poverty and gender to help bring an end to the epidemic. It is noted that GoVN is already providing small cash allowances to the most vulnerable PLWH, including children, the disabled and homeless.

Integration of HIV into the broader government health and population programme provides greater value for money. The Joint Programme now needs to build on the programme innovations introduced during the COVID-19 emergency to further increase the efficiency of community-based delivery of prevention services. The integration of HIV into broader health system predates the timeframe for this evaluation, and as a result the Joint Programme's contribution to facilitating integration is not discussed here. As discussed above, it will be imperative for the benefit package for social contracting to be affordable to government. One approach for making it more affordable is to improve the efficiency of service delivery through innovation. The COVID-19 pandemic actually served to fast track some programme innovations that will result in programme savings. This includes multi month dispensing of ARVs and a pilot to take home methadone. The Joint Programme does not appear to be active in leveraging its platforms for innovations that improve efficiencies in the HIV response. There is considerable scope to bring in lessons from other countries on use of digital

platforms to deliver information and advice or hold clinical consultations. Such approaches are likely to bring considerable cost savings.

Financing for HIV integration into UHC financing

The Joint Programme played a crucial role in transitioning ARV costs to the SHI. The focus has now shifted to SHI taking on the costs of prevention. Efforts to transition ARV costs to SHI have been incremental and gradual, Starting in 2012-13, UNAIDS convened a meeting with development partners on financial sustainability, and in 2014-15 they convened a meeting to discuss the investment case. This has led to a GoVN gradually taking over ARV costs through SHI and the state budget. IN September 2021, there were 161,000 PLWH on ART, of which 86,509 are being funded by the SHI. The aim is for ARVs to be fully financed by SHI by 2022.

The evaluation of the Viet Nam Joint Programme conducted in 2020 concluded, *“The Joint Programme on HIV in Viet Nam has clearly contributed towards leveraging political commitment and financial allocation to HIV and AIDS through policy advocacy from the GoVN and the coordination with large donors such as Global Fund and PEPFAR.... And the support provided to MOH on how to mobilise domestic financing to sustain the HIV programme led to GoVN agreeing to use SHI to cover ART”*. This was seen to be a transformative step towards financial sustainability. Building on this, UNAIDS has also been advocating for immediate integration of PrEP into SHI, and for the gradual take up of other prevention costs through the SHI. As mentioned in this case study, UNAIDS is playing a leading role in laying the ground for an enabling legal and policy environment for social contracting, and generating the evidence base on how to operationalise it through support to a pilot in one province. Given UHC financing responsibility has been devolved to provinces in Viet Nam, advocacy and technical support needs to be directed at this level to make further progress to integrate HIV financing into SHI. Currently, the Joint Programme does not have a strong presence at provincial level. Some of the technical assistance needs (such as support for development of HIV financing and sustainability plans) are being provided through the Global Fund and PEPFAR, however, given UNAIDS comparative advantage in securing political commitment, more can be done. The Joint Programme can also consider providing longer term TA to the provinces to strengthen integration of HIV financing into UHC.

Efforts to integrate HIV into UHC financing, and the broader work on UHC could be better coordinated. From the Joint Programme, UNAIDS and WHO have been leading the work on integration of HIV financing into UHC, namely through the SHI. For example, they worked together to amend the HIV law to create a more enabling environment for CBO funding. WHO is also the lead multilateral providing in country support to progress UHC and strengthen health systems more broadly. However, we were informed by one key informant *“we are not seeing HIV in the broader UHC work”*. The two work programmes do not appear to be well connected, and as a result synergies that could benefit both programmes are not being reaped. For example, placing HIV squarely within the UHC service package discussions would help progress the integration of HIV prevention activities into the SHI. It should be noted however, that this is challenging given MoH preference to cost and present smaller service packages over a more comprehensive essential service package. Conversely, there are lessons the broader UHC effort can learn from financing and delivery of HIV services, especially community-based service delivery. Social contracting of a broader package of health interventions addressing HIV and other chronic conditions that require strong community-based action, would be an easier sell than standalone social contracting for HIV. Such an approach would also represent a more efficient use of health resources. The COVID-19 outbreak has shone a light on the important role that CBOs can play in community mobilisation and service delivery. The Joint Programme should seize this opportunity to fast-track social contracting.

Conclusions & Recommendations

The Viet Nam country case study offers the following key conclusions and considerations for the Joint Programme's future work on sustainable and efficient financing for the AIDS response:

Conclusions

The Joint Programme has made a significant contribution to enhancing the efficiency and sustainability of the HIV response in Viet Nam, over the time period covered by this evaluation.

Major achievements include:

- **The absorption of ARV costs into the social health insurance and overcoming transition challenges:** Although much of the work to achieve this was undertaken by the Joint Programme prior to 2018, the transition of ARV costs to the SHI occurred in 2019. Over the last three years, UNAIDS has played an important role in helping to overcome some of the challenges resulting from the transition from donor funding to the SHI. This included ensuring PLWH with no legal ID could secure insurance coverage, and advocating for provinces to pay for the premiums and co-payments for PLWH.
- **Political support for the concept of social contracting of HIV prevention services and preparing the ground for its introduction:** UNAIDS is playing a leadership role in advocating to government to adopt and finance social contracting through the SHI. To date, they have shared international best practice on social contracting, held meetings with Ministry of Finance and Home Affairs to secure their support, provided TA to cost HIV prevention services, supported the amendment of the HIV law to enable government to contract CBOs, and finally successfully advocated for social contracting to be piloted. The government approved UNAIDS pilot, together with those being implemented by the Global Fund and PEPFAR will generate valuable evidence and data to inform government adoption and scale up of social contracting of HIV prevention services.

Key to this success, has been UNAIDS ability to work at the highest levels of government and command respect. They have been the lead champion for efficient and sustainable HIV financing, and have brought about change through: supporting policy and legal reform; convening and bringing stakeholders, including the Cosponsors, to policy making forums; generating strategic data, evidence and tools; guiding efficient resource allocations under the Global Fund and PEPFAR grants; and championing and building capacity of civil society to advocate for the wider societal enablers of the epidemic to be addressed. WHO has also made a significant contribution, especially on the reform of the HIV law and in supporting integration of HIV into UHC.

Considerations for the future

The case study has also identified several areas where the Joint Programme can do better to enhance the efficiency and sustainability of the national HIV response, especially in the context of delivering the new global AIDS strategy. This requires the capacity of UNAIDS country and regional office in HIV financing to be strengthened, with consideration of available resources, and also to bring in the expertise of the World Bank and UNDP. Their expertise has become even more important in the context of COVID-19, which has impacted economic growth and available fiscal space for HIV and health more broadly. It is recommended more attention is given to:

- **Improving the technical efficiency of the HIV programme:** There is considerable scope to build on the programme delivery innovations introduced during COVID-19, to increase efficiency of resource use. This includes making greater use of digital platforms. In particular, it will be vital to ensure innovative service delivery models are tested in the social contracting pilots, to make the service package more affordable to government.
- **Mainstreaming work in efficiency and sustainability if HIV financing across the Joint Programme:** The majority of the Cosponsors do not explicitly consider efficiency and sustainability within their respective HIV work programmes. Mainstreaming the prioritisation of HIV financing efficiency and sustainability across the Joint Programme will help deliver the new Global AIDS

strategy, especially related to the multisectoral response needed to address the structural enablers of the epidemic, such as gender and poverty. Stronger linkages need to be made with WHO's broader work in UHC, especially to facilitate the integration of HIV prevention services.

- **Extending support at provincial level:** Integration of HIV into the main health programme within the context of a highly devolved health system has raised many challenges for the HIV programme, including underfunding by the provinces. It is recommended UNAIDS use their strong advocacy skills and comparative advantage to promote efficiency and sustainability at provincial level. They can also build the capacity of CBOs to hold provinces to account for meeting their funding requirements.
- **Ensuring long term financing to address the societal enablers:** It is unlikely that government will take on funding to promote legal reform or protect the rights of the most vulnerable and excluded, or to address structural barriers like gender. Donor support to CBOs is likely to be required for the medium to long term for these interventions.

Key references

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VAAC/VUSTA. 2020. "GFATM: Funding Request 2020-2022." Viet Nam

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Vietnam Country Operational Plan (COP) 2020, Strategic Direction Summary, 2020

UN One Strategic Plan, 2017-2021

ONE UN Results Report 2019, Viet Nam

Viet Nam One UN Country Evaluation Results Report, 2019

Consultation list

Interviews were held with 11 organisations, and a total of 15 key informants, as presented in Table H.5.1. In addition, the team drew on transcripts of key informant interviews conducted during the evaluation of the Viet Nam Joint Programme in 2020.

Table H.5.1: Stakeholders consulted as part of the Viet Nam country case study

Organisation	Name	Job title
UNAIDS	Dr Maria Elena G Filio Borromeo	Country Director
	Nguyen Thi Bich Hue	Director and Strategic Interventions Adviser
UNDP	Patrick Haverman	Deputy Country Representative
	Dao Khanh Tung	Lead, Health
UNFPA	Naomi Kitahara	Country Representative
Ministry of Health	Dr Nguyen Hoang Long	Director General, Vietnam Administration for HIV/AIDS Control
People living with HIV (VNP+)	Mr Nguyen Anh Phong	Head of VNP+ Southern Office
Viet Nam Union for Science and Technology (VUSTA)	Mr Pham Nguyen Ha	Standing Vice Director, Global Fund Project
Social Enterprises working on AIDS life (SCDI)	Ms Khuat Thi Hai Oanh	Director
Global Fund Country Coordination Committee (CCM)	Prof Pham Le Tuan	Chair
PEPFAR	Nguyen Nhung	Country Coordinator, USAID
	Cam anh	Acting Country Coordinator, Health Systems Strengthening team, CDC
	Nyugen	Strategic Information Officer USAID
UNAIDS	Dr Toaufik	Director, Asia Pacific Regional Support Team
Embassy of France	Dr Thomas Mourez	Health Attache

Appendix I: Analysis of TSM projects supporting efficiency in the HIV response

The TSM is a funding mechanism hosted by UNAIDS to provide TA to support countries in their progress towards the 2030 95–95–95 targets. Its work is split into three Results Areas; **The TSM Result Area 3 seeks to improve the efficiency and utilisation of domestic HIV resources**, with a focus on community-led response, human rights, and KPs.⁵³

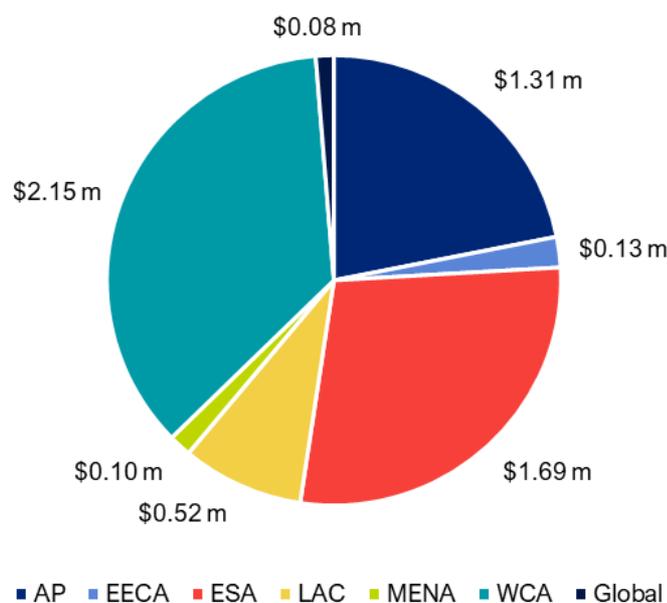
- As Table I.1 shows, Since 2018, US\$5.02 million of TSM support has gone to 99 projects whose primary focus is categorized under Results Area 3, and a further US\$0.96 million for 38 projects that are indirectly related to Results Area 3.⁵⁴

Table I.1: Number of TSM projects and total funding by Results Area

TSM Results Area	Projects	Budget approved (excluding 10% contingency)
1 - Harnessing data to accelerate policy and programme implementation in priority areas	125	\$3.68m
2 - Accelerate effective efficient implementation to close gaps	266	\$9.51m
3 – Efficiency and HIV response financing	99	\$5.02m
<i>Total</i>	<i>490</i>	<i>\$18.21m</i>

- Approximately 90% of TSM funds related to Results Area 3 were invested in three regions; AP, ESA, and WCA, representing US\$5.15 million over 120 projects since 2018 (Figure I.1).

Figure I.1: Distribution of TSM funding for projects related to efficiency in the HIV response by region



⁵³ UNAIDS 2021 UNAIDS Technical Support Mechanism Semi-annual Report, Oct 2020 – Mar 2021

⁵⁴ Data for the analysis in this Appendix was made available for this evaluation by the UNAIDS TSM team

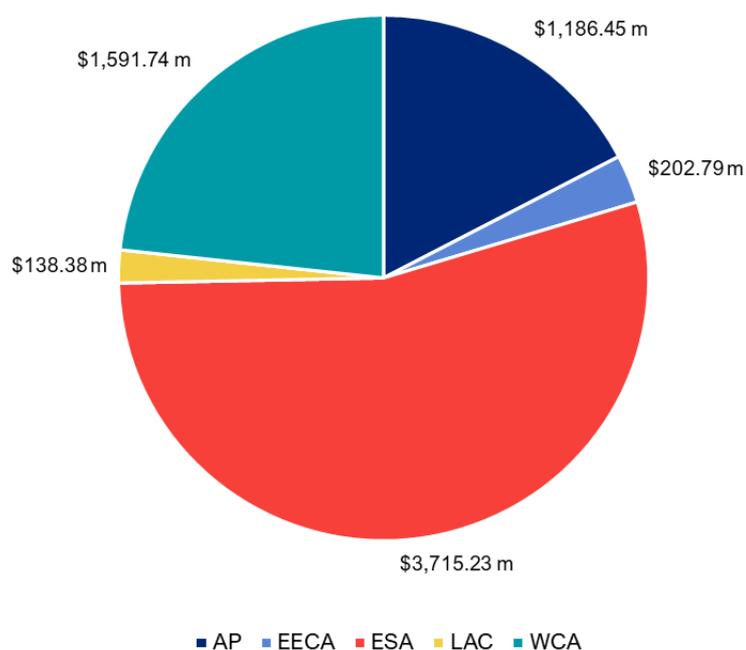
- Approximately 67% of the projects assigned to Results Area 3 fall under two of the TSM’s thematic areas:⁵⁵ These are:
 - **NSP Strategic Planning and Review:** 58 projects under Results Area 3 are categorized under the NSP Strategic Planning and Review thematic area. Under this thematic area, the TSM seeks to aid development of country level NSPs, through quantitative studies, costing plans and mid-term reviews for example, in order to help countries apply for funding, through the Global Fund for example.
 - **HIV & Economics:** 34 projects under Results Area 3 are categorized under the HIV & Economics thematic area. HIV & Economics seeks to assess, increase the level of and improve the efficient use of financing for HIV. A key example includes a project in Tanzania in which the TSM is acting as a Health and HIV Financing Advisor to the Tanzanian Ministry of Health. For example, the TSM evaluated the sustainability and transition of Morocco's National HIV and TB strategy.

Global Fund support associated with TSM projects

In total, TSM support is reported to have contributed to US\$6,577 million of Global Fund funding between funding Windows 1 to 5 and US\$257 million of government-matched funding. Of the 61 applications made by countries with TSM support from Windows 1-5, 56 of these were partially or fully successful in their funding requests, a 92% success rate.

- The majority of Global Fund approved funding (US\$6,493 million, or 95%) was allocated to the AP, ESA and WCA regions (Figure I.2).
- In addition to the funds secured through the Global Fund funding windows, **TSM support to 8 countries mobilized US\$131.5 million of funding through the COVID-19 Response Mechanism in total**, which seeks to help countries address the impacts of the pandemic on the response to HIV, TB and malaria.

Figure I.2: Global Fund funding associated with TSM support by region, Windows 1-5



⁵⁵ Note that not all projects that fall under these thematic areas are related to Research Area 3. For example, only 34 of the 61 projects that fall under HIV & Economics are considered to be related to Research Area 3.

Appendix J: Intervention mapping by evaluation question

Table J.1 depicts a high-level summary of the intervention mapping for the global activities of the UNAIDS Joint Programme since 2018, under each of the Evaluation Questions 5-8.

- The data sources for the mapping were the SRA7 and SRA8 reports, and global and regional JPMS reports on activities conducted from 2018 to 2020.⁵⁶ Analysis of TSM support for SRA7 since 2018 is reported in a separate Annex.
- The high-level summary and key examples are not exhaustive. They are supplemented by activities and outcomes reported in the four country case studies for this evaluation which contribute to the main evaluation report and its conclusions.

Table J.1: Intervention Mapping of Evaluation Questions 5-8

Question	High-level summary	Key examples
<p>Evaluation Question 5</p> <p><i>How have countries been supported on evidence and data that they need? What guidance and tools have been developed and promoted and are these used and useful?</i></p>	<p>Produced cost-effectiveness and efficiency studies to inform resource allocations and efficiencies in national HIV responses.</p> <p>Developed reports and country case studies on:</p> <ul style="list-style-type: none"> ■ innovations in service delivery ■ best practices; and ■ impact assessments <p>to support governments and civil society partners to make informed, data-driven investment decisions.</p> <p>Improve data collection practices on the country level.</p>	<ul style="list-style-type: none"> ■ <u>World Bank</u>: In 2020, conducted over 20 efficiency and effectiveness studies, with a common focus on service cascade and population prioritisation. For example, modelling in Kenya improved county-level HIV resource allocations. ■ <u>UNAIDS Secretariat</u>: In 2020, the Regional Cooperation Programme helped 7 EECA countries to optimise National HIV testing algorithm and protocols by incorporating HIV avidity testing into HIV case reporting system. ■ <u>UNDP, UNAIDS Secretariat and World Bank</u>: Published a paper that presents case studies and efficiency interventions in 11 countries to spotlight the importance of targeting KPs, and using efficiencies to improve coverage outcomes. ■ <u>World Bank and UNDP</u>: Set up the Working Group on Investment and Efficiency, which increased focus on investments and efficiencies, and helped country teams integrate efficiency work into country workplans. It served as a platform to update HIV investment case methods, and national strategic plan guidance. ■ <u>WHO</u>: Technical support to set up District Health Information Software 2 (DHIS2), an open source software platform for reporting, analysis and dissemination of data. Guidance on indicators to improve the TB/HIV cascade of care were further developed in collaboration with partners and were published in the Consolidated HIV Strategic Information Guidelines. ■ <u>World Bank</u>: Used artificial intelligence and big data to help improve allocative and implementation efficiency of the HIV response in countries such as Armenia, Botswana and Zimbabwe. It developed a users' manual for care cascade analyses to improve service delivery and outcomes, providing step-by-step guidance to empower staff in resource-constrained settings.

⁵⁶ UNAIDS (2020) SRA 7 Investment Report 2018-2019; UNAIDS (2020) PCB46 Performance Monitoring Report: Regional and Country Report 2018-2019; UNAIDS (2021) SRA 7: Investment and efficiency Investment Report 2020; UNAIDS (2021) SRA 8: HIV and health services integration Investment Report 2020; JPMS Global and Regional reports (2018-2020).

Question	High-level summary	Key examples
<p>Evaluation Question 6</p> <p><i>How has the JP influenced political commitment in countries? Has the JP been able to increase sustainable financing for the AIDS (and health) response?</i></p>	<p>Strategic information and advocacy work to raise taxes on health-harming products.</p> <p>Engagement with private sector in country to help mobilise resources for HIV.</p> <p>Development of new financing mechanisms to leverage funding facilities/mechanisms.</p>	<ul style="list-style-type: none"> ■ <u>World Bank, UNDP, WHO and Global Fund</u>: The Alliance for Anti-Corruption, Transparency and Accountability (ACTA) in Health worked with governments and communities to institutionalise appropriate anti-corruption mechanisms in the COVID-19 health response. ■ <u>World Bank, USAID, GFF</u>: Hosted the fifth-annual Health Financing Forum, which focused on financing resilience and sustainability. The forum explored financing resilience in the face of COVID-19, and focused on health financing sustainability, and the identification and assistance of KPs. Bringing the finance and health sectors together, the forum creates one of the only global spaces where key actors can catalyse sustainable financing in countries. ■ <u>UNDP</u>: Provided technical support to 10 EECA countries to increase and optimise HIV investment. For example, Montenegro earmarked domestic funds to NGO-provided HIV-related services. ■ <u>UNDP, WHO</u>: Provided technical and advocacy support to advance taxation of health-harming products in 34 countries, including through equity impact analyses of fiscal measures in five countries. After the support, 6 countries raised or committed to raise excise taxes. ■ <u>UNDP and WHO</u>: Advanced and piloted a health tax model in Bahrain and Uganda to calculate lives saved, productivity losses averted and expected revenues. ■ <u>World Bank</u>: Used new financing mechanisms to leverage private investment for HIV. This included the first-ever International Development Association bond, which raised US\$4.6bn, and IBRD issuances which generated over US\$350m in additional private investment.
<p>Evaluation Question 7</p> <p><i>What contribution has the JP made to increase allocative, technical and implementation efficiency of resources?</i></p>	<p>Support for Global Fund funding requests.</p> <p>Conducted allocative efficiency studies which contributed to increases in Global Fund resources.</p> <p>Produced Social Contracting Guidance for countries.</p> <p>Evaluation of innovations in technology to support efficiencies in the treatment cascade.</p>	<ul style="list-style-type: none"> ■ <u>UNAIDS Secretariat and Co-sponsors</u>: Supported 50 of 61 Global Fund funding requests for HIV in Windows 1 and 2. ■ <u>UNAIDS Secretariat, Global Fund, Burnet Institute</u>: In 2019, allocative efficiency modelling analysis conducted in 11 EECA countries informed NSPs and increased Global Fund 2020-2022 EECA allocations by 11%. ■ <u>UNDP</u> finalised social contracting guidance for countries in 2019 to support review and strengthening of the legal frameworks, effective mechanisms and transparent procedures that allow governments to contract NGOs for service provision. This is aimed at countries that are transitioning to domestic financing and included case studies of countries in various stages of social contracting. ■ <u>World Bank</u>: Conducted an impact evaluation on using smart technology to improve linkages to HIV care in Johannesburg. The study screened over 4,500 new HIV cases, and demonstrated that the app could significantly increase linkage to care for young adults.
<p>Evaluation Question 8</p> <p><i>How has the JP supported countries to feature the</i></p>	<p>Convened stakeholders to better understand the importance of UHC and share best practices.</p>	<ul style="list-style-type: none"> ■ <u>WHO and UNFPA</u>: Developed a comprehensive SRHR Handbook, as part of UHC, identifying individual good practices and guiding principles for implementing comprehensive SRHR, including HIV/STIs prevention and management.

Question	High-level summary	Key examples
<p><i>HIV response in the UHC country strategy?</i></p>	<p>Produced guidance on opportunities to advance UHC in countries experiencing donor transitions.</p> <p>Supported UHC country investments which include HIV services.</p> <p>Produced guidelines on integration of services with HIV.</p>	<ul style="list-style-type: none"> ■ <u>UNAIDS Secretariat</u>: UNAIDS mobilized regional networks and CSOs in the Middle East around UHC agenda. An Arab position statement was consequently delivered in the CSO hearing in 2019. ■ <u>WHO and World Bank</u>: Co-convened UHC2030, a multistakeholder forum, and contributed to the development, launch and implementation activities of UHC2030's statement on key principles to guide countries to transition from external funding. These principles informed the planning of transition for HIV funding in several countries, including Côte d'Ivoire and Morocco. ■ <u>WHO, World Bank and UNICEF</u>: Supported the Primary Health Care Performance Initiative, which is working with over 100 developing countries to achieve UHC. They do this through monitoring healthcare performance, supporting the improvement of healthcare systems, and engaging country-level stakeholders to share best practices and increase attention towards the need for UHC. ■ <u>World Bank and Global Fund</u>: The Advance UHC Multi-Donor Trust Fund assisted lower-middle income countries on UHC and transitioning to increase domestic funding. Project examples include a health services project in Burkina Faso targeting UHC and a comprehensive reproductive, maternal, new-born, child and adolescent health, including HIV services. ■ <u>World Bank and UNDP</u>: Developed a review of UHC financing that served as a basis of the 2019 G20 Finance Ministers and Leader's first ever session. The session's outcome document focused on the importance of sustainable financing for UHC-based health systems.



20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 791 3666
distribution@unaids.org

unaids.org

