PRINCIPLES
OF SHARED
RESPONSIBILITY
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PRINCIPLES OF SHARED RESPONSIBILITY
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## OXFORD POLICY MANAGEMENT DECEMBER 2013

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POLICY BRIEF #1: SHARED RESPONSIBILITY FOR FINANCING THE GLOBAL HIV RESPONSE

Produced by: Oxford Policy Management (OPM) - APW with UNAIDS 2016/637467

1. Synopsis

In recent years, funding for HIV has shifted fundamentally. International funding from OECD countries has slowed considerably since 2007, while domestic public investment has risen steadily since 2005.

However, there are large inequities between the contributions different countries make, and also large differences between countries with regard to the severity of their HIV epidemics, to their ability to pay from domestic resources and the extent to which the HIV response is seen as a public responsibility.

In this brief, we look at the global principles that could help define a “fair share” of the cost of treating HIV that explore the extent to which the HIV response should be publicly-funded, and so that it is distributed fairly between high, middle and low-income countries.

The response to HIV is a diverse set of activities. Here we propose an economic argument that some components may be regarded as ‘public goods’ that justify a publicly funded response. Others fulfill the definitions - by global consensus - of ‘merit goods’, which also justify public intervention in the market, and therefore a public and shared responsibility to help.

The global nature of the epidemic and its dire consequences means there is also a shared responsibility between countries. This has been implicitly accepted by the global community and demonstrated through international declarations, and the mobilisation of unprecedented levels of international funding.

This new emphasis on a “shared responsibility” that features a larger contribution from domestic sources requires greater examination of how much of the resource requirements can be met with domestic financing without causing undue harm to other priorities and whether resource gaps could be eliminated if, in addition, international aid was spent where it is truly needed most.

We present possible methods for benchmarking levels of domestic investment that use indicators designed to provide possible criteria for reallocating budgets within countries, as well as reallocating international assistance between countries.

2. Is the response to HIV a public responsibility?

Much of the debate about shared responsibility for the provision of health services in general, or HIV services in particular, refers ultimately to whether or not health service provision might be regarded as a “public good”, or alternatively a “merit good” (see boxes). The key observation is that the response to HIV entails a diverse set of activities, some of which are public goods while others are private goods. For example, commodities such as ART and condoms, are clearly private goods that would be and are provided by a free market. Table 1 gives an illustration of how one might classify the principal components of the response.
Economists define public goods in terms of two important attributes:

1. Public goods are “non-rival”. This means that they can be shared by additional people without affecting existing consumers. It therefore costs nothing to provide them to additional people, and this is often used as an argument that they should be provided for free.

2. Public goods are also “non-excludable”. This means that they are available to anyone once they have been provided – so no-one has an incentive to pay for them.

The private sector has no incentive to provide public goods, because it is not possible to charge for providing them. The most common examples are laws, human rights or public infrastructure.

Merit goods have two main attributes:

1. Merit goods confer long-term benefits, which lie in the future and are under-recognised at the time of consumption.

2. Merit goods generate significant benefits to others – not only to the person consuming them. For example, health and education benefit the families of the people receiving them, and bring welfare and economic benefits in the future – these accrue to the whole of society.

For both of these reasons, merit goods tend to be under-consumed in a free-market system – people do not want to pay for them in the quantities that government considers desirable. Public provision is therefore justified.

### T.1 A POSSIBLE CLASSIFICATION OF THE HIV RESPONSE AS A PUBLIC GOOD

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<td>• Synergies with development sectors</td>
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<tr>
<td>Strongly Rival</td>
<td>Common Pool Goods</td>
<td>• youth programmes</td>
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<td></td>
<td>ART drugs, condoms, vaccines Services – PMTCT, circumcision, VCT</td>
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</tbody>
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The central point of the table, however it is arranged, is that no pure definition of public or private goods can cover all of the response. However, it is also clear that the components that satisfy the attributes of private goods also satisfy the attributes of merit goods – in that they generate significant current and future welfare and economic benefits to individuals and society as a whole. This applies to many of the core treatment and prevention programmes of the HIV response.
This means that there is a clear justification for public-sector intervention in the response to HIV. This implies in turn that the responsibility for the response is in part a public one – it is shared across the whole of society within affected countries.

3. Is the response to HIV an international responsibility?

The International Task Force on Global Public Goods, set up in 2003, provided a definition of a global public good. This involved three main criteria, which are in fact more characteristic of a merit good:

- **1. It is broadly conceived as important to the international community**
- **2. It cannot or will not be adequately addressed by individual countries acting alone**
- **3. It is defined through a broad international consensus or legitimate decision process**

All of these criteria are met by the HIV response, as reflected by the unprecedented levels of international resource that have been committed, and the consensus expressed in several UN declarations. Shared responsibility for the HIV response is already a long-standing and accepted principle within the international community. Perhaps the most important question is not whether responsibility should be shared, but rather how can it best be shared to maximise its effectiveness.

4. How should responsibility be shared?

Many countries do not have the resources to address HIV adequately, given the extreme imbalance in the distribution of the virus across countries and the imbalance in income levels across countries. The core question is whether it is possible to define the “right” mix of domestic and international investment in any particular country. In other words, is there an acceptable “benchmark” or “metric” for the amount that countries might be able to invest in the future from their own resources, and that could be used as a basis for defining the responsibility of the international community to provide additional assistance? Some possible metrics are described below.

5. Peer benchmarks – comparing countries to each other

A peer benchmark compares the levels of domestic investment in a country with that of other countries with similar circumstances. Such a benchmark would be expected to relate to the income level of affected countries, to their capacity to provide and sustain the necessary services, and to the magnitude of the HIV epidemic that they are experiencing.

One such benchmark is the DIPI index, developed by UNAIDS. This compares the level of investment in a country to the size of the government budget and a measure of disease burden represented by the number of people living with HIV.

\[
\text{DIPI} = \frac{\text{PUBLIC EXPENDITURE ON HIV / AIDS}}{\text{GOVERNMENT REVENUE}}
\]

The DIPI index ranks countries by comparing their budget commitment to the disease burden of HIV – countries with higher prevalence would be expected to spend more of their budget on the HIV response. Some higher-income countries might however be able to provide all of the resource needs
for HIV programmes out of domestic budgets with a relatively low value for the DIPI index. The DIPI comparisons are only valid in practice for low- and lower-middle income countries.

An alternative version uses the proportion of disability-adjusted life years (DALYs) from HIV to DALYs from all causes to express the disease burden. This “DALY share” version of the DIPI produces similar country rankings, but an additional drawback is that high investment in HIV will ultimately reduce the DALYs from HIV, so it becomes difficult over time to distinguish between “high performing” and “low performing” countries where DALYs are high because of low investment.

Other approaches have used statistical techniques in order to produce peer benchmarks that take account of a larger number of country attributes and offer a refinement of the peer comparisons – but have greater data requirements.

6. Peer-independent benchmarks – defining objective standards

Another approach is to set objective benchmarks as targets for policy. For example a benchmark for “affordability” based on HIV investments as a percentage of GDP – a level above 1% – has been suggested as unaffordable. The Abuja target recommends that African countries should spend 15% of their government budget on health, and this has been widely used for domestic advocacy in African countries. Similar benchmarks could be proposed for HIV investments.

7. Using benchmarks to assess fair share

The second (DALY share) version of the DIPI has been used with some caveats in conjunction with the Abuja target to illustrate the level of budgetary effort in a sample of 12 countries in sub-Saharan Africa with high HIV prevalence in order to establish benchmarks for the levels of domestic investment that would be both appropriate and feasible. The authors point out that “such metrics could enhance transparency and accountability for efficient use of money and maximise the effect of available funding to prevent HIV infections and save lives”.

No single benchmark is without flaws, and will require careful interpretation in the light of other country-level circumstances, whether economic or political, but a joint application of these approaches coupled with country-level engagement have the potential to provide a solid basis for defining and agreeing what is meant by a “fair share”, both for country governments, and for donors. The application of benchmarks clearly requires consensus, since it has implications for budget allocations, tax policy and “fiscal space” more generally.

8. Conclusions

There is an international consensus that the response to HIV is a global merit good that requires a collective international response. This brings with it an acceptance of shared responsibility. This implies that we need to examine both domestic and international investments and quantify the terms of that responsibility.

Domestic expenditure on HIV can continue to increase as economies grow, but domestic financing is always going to be limited by economic capacity, especially in low-income countries. On top of this, some countries are already allocating as much as can reasonably be expected. As a result, many low and middle-income countries have gaps they simply cannot fund.

This means that the continued and sustained commitment of traditional donors is crucial. It is however possible to devise acceptable benchmarks that will help to do two key things - define the most appropriate mix within countries of domestic and international financing, and also to help to ensure that international financing is distributed to best effect.

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1 See Resch, Rickman and Hecht, “Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries”, Lancet Glob Health 2015, 3: e52–61
4 For example the HIV investment as share of GDP.
1. Summary

The purpose of this paper is to describe the global principles that could underlie the definition of “fair share” between high, middle and low-income countries in the financing of the global response to HIV, and to set this in the context of the current financing architecture and the potential for future increases in both financing and the efficiency and effectiveness of service delivery.

Although growth in international funding from OECD countries has slowed considerably since 2007, domestic public investment has continued to rise steadily since 2005. There are however large inequities between the contributions and ability to pay of different countries, both in the OECD high-income countries, and in the low and middle-income countries where the HIV epidemic is concentrated.

The paper presents an economic argument that the response to HIV is a diverse set of activities, some of which may be regarded as public goods justifying a publicly funded response. The remaining components fulfill the definitions, by global consensus, of merit goods, which also justify public intervention in the market, and therefore a public and shared responsibility for a response. The global nature of the epidemic and its consequences also implies a shared responsibility between countries – one that has been implicitly accepted by the global community through international declarations, and the mobilisation of unprecedented levels of international funding.

The paper presents a method for benchmarking the levels of domestic investment using the index of domestic priority (DIPI) developed by UNAIDS. This illustrates the difference in levels of commitment between countries, and suggests possible criteria for budget reallocation within those countries, and international assistance reallocation between countries. These reallocations
are however unlikely to close the existing unfunded gaps if current target levels of coverage are to be met.

The paper concludes with a discussion of the potential of future gains in efficiency and effectiveness to close the remaining resource gap. Current trends indicate that such gains can offer more than financing increases, but that these improvements will be progressive and steady, rather than dramatic. The unfunded gap to meeting the 2015 targets will therefore require a short-term increase in the level of international investment.

2. Introduction

a) Background

The international response to HIV has been unprecedented in the history of public health, both from the high-income OECD countries who currently provide more than $8 billion per annum to finance HIV prevention, AIDS treatment and mitigation in low and middle-income countries, but also from the affected country governments themselves, who collectively provide a similar and steadily growing amount. In that sense, we can see that the responsibility for financing the global response to HIV is, in reality, shared – although a closer look reveals a high degree of inequity between countries in the amounts committed. The financing architecture of HIV is dominated by a small number of countries, either donor countries from the OECD, or those middle-income countries with large epidemics. This is related to three main factors – first, the extreme inequity in the distribution of HIV infection – the countries of southern and eastern Africa have prevalence rates that are beyond anything previously imaginable for an infectious disease; second to the extreme inequity in the distribution of income across countries, and third to the nature of HIV itself.

HIV has many unique features that set it apart from other global public health and development challenges. First, it is a persistent or long-wave event – the average length of time between initial infection and the appearance of debilitating symptoms is as much as 8 years, and with the current generation of anti-retroviral medicines, people living with HIV can expect to live long and productive lives provided they receive on-going treatment. Second, HIV is transmitted primarily through unprotected sex or through the use of infected needles, and in many countries is most prevalent among people who are socially marginalised, such as drug users, sex workers or men who have sex with men who face difficulty in accessing social services. Third, the cost of treatment for AIDS has historically been high – meaning that it is not affordable by poor people, or by the Governments of poor countries – many of which have high rates of prevalence.

In the context of the global economic downturn precipitated by the financial crisis in 2007, there is perceived pressure on international funding for development in general, which has also been felt in the area of HIV. It has in addition led to a closer examination of the pattern of current financing, whether there would be better or fairer ways to share it, and whether there are alternative sources of funding that would work better. This applies in particular to the idea of “fair share” – is there a general underlying principle that could be applied to help decide what would be the “right” distribution of financing responsibility between or within countries? The purpose of this paper is to explore this question.
b) Outline

The paper summarises the current trends and patterns of global HIV financing, then explores the economic definitions of public or merit goods as a possible basis for the definition of fair share. The final part of the paper provides an example of a particular benchmark developed by UNAIDS for assessing the levels of contribution and future potential of domestic financing.

3. Trends and patterns in HIV financing

After many years of steady growth, international financing for HIV levelled off between 2008 and 2011, at a little above $8 billion per annum, as shown in Figure 1 below. In fact, the recently produced estimate from UNAIDS for 2012 indicates a global total of about $8.7 billion (the breakdown was not available for this chart), which has restored an upward trajectory to the global financing picture.
Note that the bulk of this amount is from Government bilateral aid – indeed almost half of the total amount comes from the United States PEPFAR programme, as shown in Figure 2 below:

**F.2 SOURCES OF INTERNATIONAL FINANCING FOR HIV, 2011**

UNAIDS estimates indicate however that domestic financing has continued to grow steadily since 2005, as shown in Figure 3 below. These estimates are based on analysis of partial data coverage, with interpolation and some extrapolation to 2012, but almost certainly give an accurate picture of the global trend (although there needs to be caution in interpreting the estimates for individual countries).

**F.3 TREND IN DOMESTIC FINANCING FOR HIV, 2005-12**
Note however that just over 80% of the global domestic financing is in upper-middle income countries, which can be largely accounted for by three in particular – South Africa (24%), Brazil (11%) and the Russian Federation (10%) – collectively accounting for almost half of the global total of domestic financing. 35 low-income countries account for only 7% of the global total, and 49 lower-middle income countries only 12%.

The pattern of financing by national income level is shown in Figure 4 below. As can be seen, about 52% of international financing is directed to low-income countries and 30% to lower-middle income countries. Most of the remaining 18% to upper-middle income countries was in fact disbursed to South Africa, the country with the highest burden of HIV in the world:

As might be expected, most of the international financing is directed towards the highest-prevalence countries in Africa, as shown in Figure 5 below, which also shows that almost all of the financing in Europe, Central Asia and Latin America is from domestic sources.

Given these global patterns, the question arises as to whether they constitute a “fair share” across countries. The following section explores a possible basis in economic theory for addressing this question.
4. Who should be responsible for providing a response to HIV?

Much of the debate about shared responsibility for the provision of health services in general, or HIV services in particular, refers ultimately to whether or not health service provision might be regarded as a “public good”, or alternatively a “merit good”. Both terms are understood in different ways, and often not distinguished from each other. It is worth briefly examining the case for classifying the HIV response in either of these two categories.

a) Public Goods

Public goods are defined by economists in terms of two important attributes:

1. Public goods are “non-rival”. This means that they can be shared by additional consumers without reducing the quantity being consumed by existing consumers. The most common examples are laws (and by extension, human rights), or public infrastructure such as street lighting. From an economic point of view, this implies that the marginal cost of producing for an additional consumer is zero, so that any price that is more than zero will have the effect of reducing consumption, and reducing the welfare of consumers. This is often used as an argument that they should be provided for free.

2. Public goods are also “non-excludable”. This means that the producer cannot prevent people from consuming them once they have been provided. Therefore, if the producer wishes to charge a price...
for consumption, consumers have an incentive to “free ride”, meaning that they do not have to pay, since they cannot be prevented from consuming for free.

It is important to note that many goods are neither purely rival nor purely excludable. Both attributes may exist to some degree, either strongly or weakly. For example, a public education campaign may be in the form of mass media or posters, which is neither rival nor excludable, or may be targeted to some extent to certain neighborhoods or populations, thereby becoming partially excludable.

The result of these two attributes in their purest forms is that they will not in general be provided by a free-market economy, since it is not possible for firms to receive payment for them. They can only be provided by means of public sector intervention, either through direct provision, or through subsidies or regulation.

The extent to which there is a normative “responsibility” on the public sector to intervene in the supply of public goods depends on the extent to which the services in question are regarded as important, desirable or essential. This leads to a considerable overlap with another category, termed “merit goods”

b) Merit Goods

Merit goods are goods that would in fact be provided by a free-market system, but not in the quantities that are considered to be sufficient or desirable. It is often argued that this condition applies to education in particular, but also to health care.

Merit goods are generally under-provided in a free market because of two main attributes:

1. Merit goods usually confer long-term benefits to the consumer. However, at the time of consumption, the full benefit to the person consuming the good is not always fully recognised – often because these benefits lie in the future, and therefore cannot be regarded as certain. From an economic standpoint, there is a failure of information with regard to expected benefits, so that there would be an expectation that they will be under-consumed.

2. Merit goods usually generate significant benefits to others, or to society as a whole – not only to the person consuming them. For example, both health and education lead to benefits to the immediate families of the people receiving the services, and to improved productivity and economic benefits in the future – these accrue to the whole of society. In economic terms, merit goods generate “positive externalities”. This also leads to under-consumption, to the extent that consumption is motivated by purely private benefits to the individual consumer.

Note that normative considerations are central to the definition of merit goods – they are under-provided in relation to a public perception of what is desirable or essential. Many governments intervene in the market for merit goods on the basis of this social consensus, either by taking measures to increase their supply, or to increase the demand for them.

The common measures to increase supply might be:

- Provide a direct subsidy to producers – this encourages more production without discouraging consumption through a rise in price
- Provide indirect subsidies to producers – for example by providing free training, or providing some of the inputs for free (such as anti-retroviral drugs)
- Direct public provision or goods or services, through state or public enterprises. This is often the case for example with education
• Provide incentives to providers to produce more, for example through conditional grants, or performance-based payments.

Common measures to increase demand might be:

• Intervene directly in the price to consumers, either by direct provision that is free at the point of delivery, or by a subsidised price that requires some degree of co-payment. This clearly applies to many of the commodities used for treatment and prevention of HIV, which are too expensive to be affordable to poor people in countries affected by HIV.

• Provide direct subsidies in the form of vouchers or cash transfers with some degree of targeting.

• Provide public education or public campaigns to encourage people to consume more of the merit good. This applies for example to prevention campaigns and youth programmes.

c) Is the HIV Response a Public Good or a Merit Good?

The key point is that the response to HIV involves a diverse set of activities that are delivered in diverse circumstances. It is not in general possible to classify the entirety of the HIV response as being a purely public good – indeed, some components of the response, such as ART, are clearly private goods that are both rival and excludable that would be and are provided by a free market. The following table gives an illustration of how one might classify the principal components of the response, based upon their degree of rivalry and their degree of excludability:

### A POSSIBLE CLASSIFICATION OF THE HIV RESPONSE AS A PUBLIC GOOD

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<th>Non-excludable</th>
<th>Weakly Excludable</th>
<th>Strongly Excludable</th>
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<tr>
<td>Non-rival</td>
<td>Purely Public Goods</td>
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<td>• Synergies with development sectors</td>
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<tr>
<td>Strongly Rival</td>
<td>Common Pool Goods</td>
<td>Purely Private Goods</td>
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<td></td>
<td>• ART drugs, condoms, vaccines</td>
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<td></td>
<td>Services – PMTCT, circumcision, VCT</td>
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Opinions may differ about whether the various components are correctly classified in this table, but the central point is that many of them can be thought of from an economic viewpoint as primarily public goods, while others are primarily private goods. There is no pure definition that covers all of the response.

However, it is clear that the components that satisfy the attributes of private goods also satisfy the attributes of merit goods – in that they generate significant externalities in the form of economic benefits to individuals and society as a whole, and would be under-consumed in a purely private market. This applies to many of the core treatment and prevention programmes of the HIV response.

The key implication from an economic standpoint is that there is a clear justification for public-sector intervention in the response to HIV. This implies in turn that the responsibility for the response is a public one – in other words it is shared across the whole of society within affected countries.

A second question arises as to whether responsibility is also shared between countries – can the response to HIV also be classified as a “global public good”, or a “global merit good”? It is instructive to look at the work of the International Task Force on Global Public Goods.

d) The International Task Force on Global Public Goods

The International Task Force on Global Public Goods arose from discussions at the 2002 Monterrey International Conference on Financing for Development, and the 2002 Johannesburg World Summit on Sustainable Development. It began its work in 2003, sponsored initially by France and Sweden, and later in various ways by Germany, the UK, Norway and Austria and a number of national and international organisations.

The Task Force set itself the objective to provide a concrete definition to the idea of a global public good, to identify which goods and services were included within that definition, and how they might best be financed and implemented.

The definition published in 2005 involved three main criteria that would need to be met if a public good is to be considered as being global:

1. It is broadly conceived as important to the international community
2. It cannot or will not be adequately addressed by individual countries acting alone
3. It is defined through a broad international consensus or legitimate decision process

A fourth consideration was the observation that the different global public goods were synergistic – meaning that providing one of them would make it easier to provide others.

Note that none of the criteria follows the usual economic terminology for the definition of public goods. In fact, all three of them are more reminiscent of the definition of a merit good. The argument is that there is an international consensus that certain goods are desirable or essential, and that they will be under-provided or under-consumed because of lack of resources in the countries that need them most.

The third of the criteria is particularly relevant to the arguments put forward
in this paper – it is an explicit statement that global public goods should entail a shared international responsibility for their provision.

e) Is the HIV Response a Global Public Good?

This paper has argued above that the response to HIV cannot be regarded as a purely public good, but that the parts of it that constitute private goods satisfy the criteria applying to merit goods, and justify public intervention as well. This idea is inherent in the definitions given by the International Task Force which clearly blur many of the traditional economic considerations. The distinction between public and merit goods is therefore not central to the decision to intervene.

The question of whether HIV constitutes a “global merit good” perhaps depends on the degree to which the positive externalities that result from public intervention are likely to spill across borders – is the eradication or control of the HIV epidemic a benefit to all of humanity, rather than only to the most affected countries? This issue is not prominently debated, but its resolution is implicit in the actions of the international community – perhaps constituting a “revealed preference” in economic terms.

To date, the international community has clearly treated the HIV response as a merit good, regarded as sufficiently important to commit levels of international resource that are unprecedented in the area of public health. The broad consensus has been reflected in several UN declarations, from the UN General Assembly declaration in 2001 to the 2011 Political Declaration on AIDS. Both of these reflected an international perception that the HIV response was important, and both constitute an internationally accepted decision process as defined by the third criterion of the International Task Force.

In this respect, it would seem that quite apart from purely economic definitions, shared responsibility is already a long-standing and accepted principle within the international community, not only with regard to the HIV response, but also to many other international development priorities. While there is no sign that this perception is weakening, there is clearly a concern that the available resources cannot adequately address all of these priorities at once, and that the balance between them is no longer optimal. Perhaps the most pertinent question is not whether responsibility should be shared, but rather how can it best be shared to maximise its effectiveness? This question is explored in the following sections.

f) How should responsibility be shared?

With regard to the second criterion of the Task Force, it is also clear (and implicit in the international agreements) that many countries do not have the resources to address HIV adequately, given the extreme imbalance in the distribution of the virus across countries, the imbalance in income levels across countries, and the high cost of intervention.

Public intervention in the HIV response may come in the form of domestic investment, drawn from public (tax-based) or private funding within the most-affected countries themselves, or international investment, drawn from the high-income countries worldwide. The core question is whether it is possible to define the “right” mix of domestic and international investment in any particular country. In other words,
is there an acceptable “benchmark” or “metric” for the amount that countries might be able to invest in the future from their own resources, and that could be used as a basis for defining the responsibility of the international community to provide additional assistance?

It is clear that such a benchmark would be expected to relate to the income level of affected countries, to their capacity to provide and sustain the necessary services, and to the magnitude of the HIV epidemic that they are experiencing. Possible criteria are explored in the following section.

5. Towards defining the scope for domestic financing

a) What are the drivers of domestic public financing for HIV?

There are a number of criteria that would be expected to be related to the level of investment that a government would be able to make for HIV. These would include:

- The level of national income, measured by gross national product (GDP) or gross national income (GNI). This is a first approximation of the total level of resources available within a country.

- The degree to which the Government is able to raise revenue from the economy through taxes, levies, domestic borrowing or other means. This might be measured by the total Government revenue, or more usually by the Government recurrent expenditure budget (which is usually larger as a result of deficit borrowing).

- The proportion of the Government budget devoted towards debt servicing – where this is large, it can significantly reduce the available recurrent budget.

- The pre-existing pattern of disbursement to the different sectors. For example, if historical allocations to health have been low, then health infrastructure is likely to be poor, and this will reduce the short-run capacity to absorb rapid increases and convert them into service delivery. This would be expected to be relevant to the HIV allocation, which is typically mostly in the health sector.

A recent publication by Galárraga et al.¹ modeled per-capita domestic HIV contributions as a function of per-capita income, relative size of the health sector, and per-capita foreign debt service, and used the predicted values to represent a benchmark against which to identify imbalances between countries. The authors concluded that global domestic financing could increase substantially if countries who were below their expected level increased in order to match it.

In this paper, we propose a prior method as developed by UNAIDS that reaches a similar conclusion based on an index intended to represent a benchmark against

which to make normative projections. The method differs from that of Galárraga et al. in three important respects:

1. Total Government revenue was used in preference to GDP, as a more precise representation of the resource actually available to Government in the short run. This implies an acceptance of the current degree of economic taxation within the countries concerned, and assumes that this will not change significantly within the period of projection (usually up to the year 2020).

2. The relative size of the health sector was not considered. The essential purpose of the index proposed by UNAIDS was normative, intended to establish a benchmark for total investment in HIV that does not depend on the existing priority accorded to the health sector. It is intended that the index will capture the fact that countries with low health investment will show up as having low HIV investment as well. If the index controls for the relative size of the health sector, this will not happen – it would capture instead the degree to which HIV is prioritised within the health budget. However, where the UNAIDS index is used for the purpose of making future projections, it is important to assume relatively gradual changes from year to year, to account for the effect of health service capacity.

3. The foreign debt servicing was also not considered. This may be a potentially useful extension of the method, perhaps as a direct correction to the government expenditure budget, to give a more accurate picture of the available resources.

b) Measuring domestic priority

The Domestic Investment Priority Index (DIPI) developed by UNAIDS is based on two main assumptions:

1. A country’s ability to pay for HIV from domestic public sources is dependent on the overall size of the government expenditure budget, which is a proxy for the available resources.

2. A country’s need to pay for HIV from domestic public sources is related to the number of people living with HIV, which is a proxy for the HIV-related disease burden.

These are both expressed more clearly in per-capita terms. A country’s ability-to-pay for each person living with HIV is likely to be related to the total government budget per capita (i.e., for each person living in the country). The ratio between the two suggests an index:

\[
\text{DIPI} = \frac{\text{PUBLIC EXPENDITURE ON HIV / AIDS}}{\text{GOVERNMENT REVENUE}}
\]

Both the numerator and denominator of this expression are larger in a country with higher available income. If all of the relationships implied by the ratios (the DIPI is a ratio of ratios) are linear proportions, then the value of the DIPI would be expected to be stable with relation to changes in income (ability to pay) or disease burden (need
to pay). Under these assumptions, the value of the DIPI index should not differ between small and large countries, between poor and rich countries, or between low and high-prevalence countries. The differences in DIPI values would therefore have a normative interpretation – expressing the “level of effort” or priority accorded to HIV in a country.

Countries with a higher DIPI value are investing a greater proportion of their ability to pay on each PLHIV – therefore giving HIV more priority, as suggested by the name of the index. The actual amounts invested per PLHIV will of course be lower in lower-income countries.

There is a very wide variation of DIPI values between countries, although it is important to remember that the data quality is not always sufficient to support close interpretation of the results for individual countries. This is because expenditure data are drawn from a variety of sources – usually from National AIDS Spending Assessments (NASAs), or from annual or biannual reports intended to track progress towards the 2015 targets of the UN General Assembly Special Session on AIDS (held in 2001). It is important to note that:

- Not all countries report every year – there are significant gaps in the time series for most countries, and recent years are usually not well represented
- A few countries have never reported at all
- Categories of reporting are not always consistent between countries – for example, external funds are sometimes counted as domestic (especially where there is pooled funding from external donors)

For this reason, the data presented below have been subject to an analysis designed to provide the most rational possible interpolations in order to produce a consistent basis for comparison of the global total between years (as presented in Figure 3 above), and to make a “best guess” for non-reporting countries.

For these reasons, there needs to be considerable care in interpreting country-specific information. These are presented here as a first step in what should be a more detailed investigation at country level.

Figure 6 below shows indicative values of the DIPI index, using UNAIDS prevalence and expenditure data (as described above) from 2012. The vertical axis represents the value of the DIPI index, the horizontal axis arranges the countries according to a crude measure of ability to pay – the total resources available (Government budget) per person living with HIV (PLHIV), while the size of the bubble represents the level of international funding in each country during 2012. The horizontal red line is the median value of the DIPI across these countries, a selection of which are identified for purposes of illustration, subject to the caveat on data quality.

Note that there is no obvious correlation (as expected) between national ability to pay (the horizontal axis) and the value of the DIPI – some poorly-resourced countries have high DIPI values, others low. This is a first-level indication that the DIPI index may be providing a genuine measure of national priority, rather than of national resource availability.
One possible conclusion might be that the low-income countries that are above the DIPI median cannot reasonably be asked to pay more from domestic sources, while those below the DIPI median may have potential to do so. This would have important implications for the nature of the dialogue that would be appropriate between external donors and the Governments of recipient countries.

Note also that approximately 70% international funding is currently provided to countries that are below the DIPI median – i.e. they accord less than average priority to HIV from their own budgets. This is suggestive that there may have been a degree of substitution or fungibility in national allocations to different sectors – based on a perception that donors will continue to fund HIV, so that national funds can be allocated elsewhere.

The enormous variation between countries in the values of the DIPI index suggest that there is significant potential for increased domestic investment in some of them, but not others, and that the index values might be used as a first-level indicator in negotiating future reallocations of international funding. This provides a possible basis, explored in the following section, for assessing the degree to which domestic funding might be able to grow in coming years, and in which countries.
c) Potential for future growth in domestic investments

The DIPI analysis (in agreement with the analysis of Galarrága et al.) suggests a method for projecting the potential for future growth. As a starting point, we would expect domestic expenditure to increase in line with economic growth, which would translate into growth of available resources and Government budgets, all else being equal.

As a second step, we might establish a normative criterion based upon the DIPI index, for example by picking a value representing an indicative norm. This approach asks the question – what would global financing look like if countries below a normative DIPI level were to increase toward that level by a target year, while countries above that level remain as they are? Thus, some countries might increase their HIV investments only on the basis of economic growth, while others might have additional potential to reallocate in favor of HIV from other budget lines.

This approach has been used for the projections presented in Figure 7 below, which was also the underlying assumption used in the calculations for the replenishment request to GFATM for 2014-16. This used the DIPI median as an indicative norm (for countries below that level) to be reached by the year 2020. The chart distinguishes the potential growth from 2012 resulting from economic growth alone from the additional growth that might result from reallocation in countries below the DIPI median. The line on the chart represents the total estimate of global resource need produced by UNAIDS for the 2010 Investment Framework:
The chart shows the potential increases in comparison with the baseline value of $8.6 billion in 2011 (in blue – this includes an estimate of about $1 billion from out of pocket spending). Economic growth over the 8-year period would be expected to add a further $1.7 billion, or 20% to domestic investment. Reallocation by the countries below the DIPI median would add a further $1.6 billion, or 19%, which is a relatively modest reallocation over the period. A more aggressive criterion (such as reaching the 75 percentile rather than the median) would yield somewhat more. In addition, since the chart presents only the total, it masks the significant implication for reallocation between the countries.

It can be seen that the current level of international investment (which has been added as the next layer in the chart) falls short of the resource needs estimated for the Investment Framework, implying an unfunded gap of about $5 billion by the year 2015, which falls steadily thereafter and might be met altogether by the year 2018.

This analysis therefore suggests that it is unrealistic to meet the current global targets for HIV financing for 2015 purely through increases in domestic investment. Although it would seem that increases of about 4% per annum would be easily sustainable through economic growth and reprioritisation in low and middle-income countries, the resource need estimates imply a remaining need for further increases from the international community in the short term. There is however a realistic prospect that the global need for international investment may start to decline in future.

One question that arises naturally is whether there is further potential to reduce the resource needs through improvements in efficiency and effectiveness of the response. This potential is briefly discussed in the next section.

d) Increasing value for money

The Investment Framework estimates have already made strong assumptions about the potential for reduction in unit costs, particularly for treatment. Commodity prices have indeed fallen significantly in recent years (see Figure 8 below), in addition to which an increasing proportion of people on treatment (now 90%) are using lower-cost generic drugs. Further reductions might be expected in the future as a result of economies of scale and scope (through improved integration of services).

### POTENTIAL RESOURCES 2020 AND THE INVESTMENT FRAMEWORK - MEDIAN PRICE OF SELECTED FIRST-LINE REGIMENS IN LOW-INCOME COUNTRIES

![Table showing median price changes from 2008 to 2011 for selected first-line regimens in low-income countries.](image)

Source: Global Price Reporting Mechanism, WHO 2012
Set against this however, is the consideration that costs may also rise in future with widespread adoption of new technologies and targets — e.g. treatment as prevention and new treatment guidelines.

A recent study carried out by Wu Zeng et al. (2009)\(^2\) used data envelopment analysis (DEA) to evaluate the technical efficiency of national HIV/AIDS programmes in low and middle-income countries. This can be seen as a landmark study because its results indicate at country level the extent to which efficiency gains can be made. This information is, obviously, of crucial importance to any approach to sustainable financing for HIV.

The study determines technical efficiency levels for the combined outcomes of different HIV programmes in 68 countries between 2002 and 2007. The outcomes used were: number of people receiving voluntary counseling and testing (VCT), the number of HIV+ pregnant women receiving AIDS treatment for prevention of mother-to-child transmission (PMTCT), and the number of patients receiving antiretroviral treatment (ART).

A notable outcome of the study was the ability to place countries on a production possibility boundary chart, which shows which countries are near or on the boundary (more efficient), and which have the potential to reach the boundary. This is illustrated in Figure 9 below.

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A second notable result from the analysis was the observation that efficiency of AIDS responses increases significantly over time, from 13.3% before 2004 (including 2004) to 47.7% in 2007. This is shown in Figure 10 below.

The authors also investigated the drivers of increased efficiency of HIV programmes, and concluded that the most important explanatory variables are:

- Income measured by GNI per capita – efficiency increases with increasing income up to a certain point, then decrease again for higher income levels.
- An combination of ‘control of corruption’ and ‘rule of law’ – suggesting that the more the rule of law is respected and the more public power is exercised for the benefit of the public good, the more efficiently HIV programmes are implemented.
- Voice and accountability – suggesting that higher levels of beneficiary group participation in decision making lead to better value for money in the production of VCT, PMTCT and ART services. This finding is in line with best practice guidance from UNAIDS.

Although Zeng’s study has well-recognised limitations – for example it only accounts for three of the components of the HIV response and it does not consider the impact of allocative efficiency improvements (which would be significant), it does provide important insights as to the probable scale and pace of future efficiency gains, and also an idea of which countries have the greatest...
potential. Although these improvements are unlikely to be realised before the 2015 target year, the study provides strong encouragement that future gains have the potential to outweigh the probable scale of financing increases.

6. Conclusions

1. This paper has argued that there is an implicit international consensus that the response to HIV is a global merit good that requires a collective international response. This in turn implies that there is an acceptance of shared responsibility – what remains is to quantify the terms of that responsibility on the part of domestic and international investments.

2. Domestic expenditure on HIV can continue to increase as economies grow and countries reallocate in line with ability to pay and disease burden

   • But domestic financing is limited by economic capacity, especially in low-income countries

   • In addition, some countries are already allocating as much as can reasonably be expected

3. There are remaining unfunded needs beyond the domestic ability to pay in low and middle-income countries

4. It is possible to devise acceptable benchmarks or metrics that will help to define the most appropriate mix within countries of domestic and international financing, and will help to ensure that international financing is distributed to best effect

5. There are encouraging signs that the remaining funding gaps can be met by future improvements in efficiency and effectiveness, although the short-term targets may not be met.

6. If the 2015 coverage targets are to be met, it follows that there will need to be short-term increases in the level of international funding, probably by between $5-6 billion per annum.

7. Appendix – Terms of Reference

This paper has been produced on behalf of UNAIDS, on the basis of terms of reference that requested the following:

• Describe global principles of fair share including how government revenue and burden of disease link to projected ability to pay and analysis of criteria for efficient resource allocation between countries etc.

• Paper of 20-25 pages on global principles of shared responsibility, including brief technical annexes. The paper
should include a description of guiding principles of shared responsibility in the AIDS response; criteria for assessing/calculating countries fair share based in their ability to pay, burden of disease and economic growth; criteria for assessing /indicating to donors how to allocate their international assistance to countries based on need and ensuring equity; suggested methodologies/tools to make the necessary measurement and projections.
The purpose of this policy brief is to provide policymakers guidance for evaluating domestic contribution to the AIDS response in high-burden countries.

1. Introduction

The AIDS response in the highest burden countries has been primarily financed by international donors. There are ten countries with over one million persons living with HIV (Table 1). These countries have 61% of the world’s 35 million cases. With the exception of India, they are all in Sub-Saharan Africa. These ten countries are also among the ones with the largest number of annual new infections. Domestic sources provide the majority of AIDS financing in only 2—South Africa and India. Excluding these two countries, the remaining countries together contribute only 16% of the funding for their current AIDS response. Moreover, the unmet need for HIV services remain very large in all of these settings. Indeed, not quite 40% of the 21 million PLHIV in these countries are currently on ART. The coverage of other key strategic HIV interventions is less well documented, but what evidence there is suggest prevention activities are less scaled up than ART in most settings.
High-income countries of the world certainly have sufficient resources to pay the cost of even the most ambitious AIDS response plans, but many donors are signaling a new era, in which they will play a smaller role. In fact, the two largest international funders of AIDS programs, the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) and the multilateral Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which together account for 78% of international financing for AIDS, are both shifting their policies to enable greater country ownership and are simultaneously establishing clearer expectations of domestic financial contribution. Global Fund’s recent policy reforms regarding counterpart financing are designed to encourage countries to play a larger role in financing their AIDS programs as their economies grow. 16 Similarly, PEPFAR’s multi-year Partnership Framework (PF) agreements and Partnership
Framework Implementation Plans (PFIP) promote a transition of programmatic ownership to partner governments, including greater responsibility for financial support of programs. At the United Nations General Assembly in 2011, UNAIDS called for “shared responsibility to meet investment needs” through increased long-term domestic and international funding, and proposed that recipient governments be held more accountable for increasing domestic investment. Subsequently, the African Union embraced a new paradigm of “shared responsibility and global solidarity” that emphasizes a greater role for domestic financing of AIDS programs and domestic leadership in defining AIDS priorities and directing resources. AIDS-affected countries have signaled an interest in playing a greater role in directing and financing their AIDS programs. Many have more than doubled their domestic financing commitments to AIDS from 2006 to 2011, and for the first time in 2011, total domestic resources for AIDS in LMICs exceeded donor financing.

In part, the paradigm shift toward “shared responsibility and global solidarity” may be driven by the recognition that the AIDS epidemic is not a classic “emergency”, in the sense of a natural disaster, or even recent H1N1 or Ebola outbreak, which demands a high level of resources to be deployed rapidly, for a relatively short period of time [Over, chapter on Obama’s PEPFAR¹]. With today’s treatment regimens, initiated sufficiently early in the disease course, most PLHIV can experience life expectancies approaching those of similar non-infected individuals [CITE]¹. Thus, HIV treatment is a long-term entitlement, and each person on ART represents a quasi-liability for governments and donors (haacker³). Given that current HIV programs are operating at a scale less than half of what is required to meet global strategic goals, donors are apparently apprehensive about maintaining an approach featuring donor-financed scale-up of vertical HIV treatment programs.

At least in the case of resources supporting treatment, reputational risk makes it unlikely that international donors will withdraw support for current patients. Nevertheless, there is not an equivalent reputational risk associated with defunding prevention activities or choosing not to finance additional scale up of treatment. If global goals are to be reached, it is evident that a large portion of the additional resources required will need to come from sources other than the donors who fueled the response over the past 15 years.

Other development trends put further pressure on the status quo financing and organization of the AIDS response. The featured status of HIV in the Millennium Development Goals (MDGs) will not carry through to the Sustainable Development Goals (SDGs). Indeed, all of health is subsumed into just 1 of the 17 draft SDGs. The post-2015 agenda and the push for universal health coverage (UHC) feature a more holistic systems approach to health care financing and delivery. The AIDS response of the last 15 years, driven by international donors and often featuring donor-operated programs, sharply contrasts with this new vision. As AIDS programs have matured, and local technical capacity and infrastructure have expanded, increasing country ownership and some integration into

² Nakagawa F et al. Projected life expectancy of people with HIV according to timing of diagnosis. AIDS, 28 January 2012. 26(3):335-43
health systems has occurred—particularly in upper-middle income countries. Still, in most countries with high-burden, we are far from a situation where HIV is, or could safely be, fully integrated into the health system. Nonetheless, the predominant trend toward integrated health systems may limit receptivity to disease-specific appeals for greater resources.

This new emphasis on a “shared responsibility” that features a larger contribution from domestic sources in AIDS-affected countries requires greater examination of (1) how much of the resource requirements can be met with domestic financing without causing undue harm to other priorities and (2) whether resource gaps could be eliminated by such greater domestic financing, if international aid was spent where it is truly needed most.

The growing focus on domestic financial support creates a demand for new approaches and metrics for evaluating the intensity and adequacy of domestic effort, and assessing the potential for additional domestic financing. To this end, UNAIDS and others have developed “peer comparison” approaches that compare the relative level of domestic AIDS financing in different countries while controlling for country-specific factors like the size of the epidemic, and the size of the resource envelope from which AIDS funding would be drawn. Others have focused on creating peer-independent benchmarks to serve a practical reference points, relying on norms such as the Abuja target for health spending.

2. Peer comparison

UNAIDS developed the Domestic Investment Priority Index (DIPI) in 2010 to measure countries’ domestic financing effort for AIDS, relative to their income and epidemic size. The DIPI index is useful for ranking countries and identifying relatively low performers. The measure has been refined by UNAIDS since its introduction. One version of the indicator, which we will refer to as the UNAIDS Prevalence-based DIPI (p-DIPI), measures domestic AIDS spending as a share of total government revenue, adjusting for HIV prevalence. UNAIDS first used the p-DIPI to compare countries’ domestic financing effort for AIDS in its 2010 Report [UNAIDS, UNAIDS Global Report Chapter 6: HIV Investments. UNAIDS: Geneva, Switzerland, 2010].

The logic of the p-DIPI is that two countries with the same priority for AIDS should spend the same fraction of government revenue on AIDS per unit of HIV prevalence. If hypothetical Country A and Country B both have 10% HIV prevalence, then, according to the p-DIPI, they would have the same “priority” for AIDS if they each were to allocate the same share of their government revenue to AIDS programs. If Country A increased the share of GDP collected as government revenue (e.g. Country A2 in Table 2), it would have to increase its AIDS spending by a similar proportion to maintain the same “priority” for AIDS.

When comparing the DIPI scores of 2 countries with different income level, it is important to note that the DIPI does not account for differences in input prices. For example, in Table 2, Country B is identical to Country A, except that Country B has GDP per capita five times higher. For Country B to have the same “priority” for AIDS as Country A, it will need to spend five times more. Indeed, the resources required to meet a common set of strategic aims is twice as high...
in Country B compared to Country A due to higher price of inputs. Richer countries are therefore expected to spend more money per PLHIV, and when price levels rise more slowly than income (as has been shown in cross country studies of HIV treatment cost [Menzies et al]), the p-DIPI’s construction demands that richer countries cover a larger share of the total resource requirements in order to be considered as having the same priority level. In our example, for Country B ($5000 per capita GDP) to have the same p-DIPI score as Country A ($1000 per capita GDP), it will have to cover 25% of the total resource requirements as opposed to just 10% in Country A.

### T.2 ILLUSTRATION OF THE P-DIPI MEASURE

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>COUNTRY A</th>
<th>COUNTRY B</th>
<th>COUNTRY A2</th>
<th>COUNTRY B2</th>
<th>COUNTRY B3</th>
<th>COUNTRY B4</th>
<th>COUNTRY B5</th>
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<td>B</td>
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<td>$5,000</td>
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<td>$2,000</td>
<td>$2,000</td>
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<td>$2,000</td>
<td>$30.0 M</td>
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</tbody>
</table>

Country B would have to increase its DIPI to 2—spending 2% of GGR for every 1 percentage point of HIV prevalence— in order to fully meet the resource requirements of the AIDS response without external assistance (Country B2 in Table 2). Such an effort would consume 20% of all government revenue and 4% of GDP. However, if Country B’s prevalence was only 1/4th as large, it could fully meet the resource requirements of the AIDS response
with a much more feasible 5% of government revenue and 1% of GDP (Country B3 in Table 2). Yet, the p-DIPI would rank Country B2 and Country B3’s domestic effort as equivalent. Likewise, if 2 similar countries differ in HIV prevalence, and both fully meet 100% of the resource needs required for a common set of AIDS response goals, the low prevalence country will have a higher p-DIPI score (e.g. Country B4 vs Country B3 in Table 2). This is because the p-DIPI does not consider resource need. Indeed, for Country B3, to have the same DIPI as Country B4, it would have spend 5 times more than the total needed to meet strategic goals (e.g. Country B5 in Table 1).

As Figure 1 shows, evaluating AIDS spending with the p-DIPI reveals that for every 1% of HIV prevalence, the original PEPFAR countries spend between one twentieth and one half of a percent of government revenue on AIDS. Countries such as Rwanda, Uganda, and Ethiopia rank highest on the DIPI, while Mozambique, Tanzania, and Cote d’Ivoire, the three countries where domestic AIDS expenditure makes up the smallest share of total AIDS expenditure, rank lowest. High rankings for Rwanda, Uganda, and Ethiopia are caused by a combination of higher domestic AIDS expenditure levels, smaller epidemics, and low revenues. For South Africa to increase its p-DIPI to meet the level of the Ethiopia and Rwanda it would need to have spend $6.3 billion on AIDS in 2009, which significantly exceeds the resources estimated to be required to achieve the ambitious UNAIDS’ ‘Fast Track’ goals.

While there is no normative standard p-DIPI score, one can assess individual countries relative to the average or median for a group of their peers. Given the limitations discussed and illustrated above, it may be prudent to limit p-DIPI comparisons to peer countries in the same income tier and with similar HIV prevalence. With this caveat, the p-DIPI can be adapted for forward-looking analysis. Resch et al. [R4D report for PEPFAR] calculated the expected convergence of DIPI scores for 12 countries that met objective spending benchmarks over time. Likewise, the improvement in DIPI score corresponding to a particular AIDS spending plan can be calculated. For example, in countries with relatively weaker domestic effort, a policymaker could calculate the AIDS spending increase required to reach the median DIPI score achieved by peer countries. Of course, peer comparison based approaches are only useful for individual country work if up to date analysis of a set of peers is available. A strength of the p-DIPI is its simplicity and relatively modest data requirement, although the routine production of accurate, comparable, up-to-date estimates of government spending on AIDS is still a challenge.

Galárraga et al.20 estimated expected government AIDS expenditure for countries using a median regression model with gross national income (GNI) per capita, health spending as a proportion of GNI, and debt service per capita as predictors. Like the p-DIPI, this is also a peer comparison approach, because the expected expenditure is a function of the sample of countries that supplied data for the statistical modeling. As with the p-DIPI, in a situation where most countries may have historically been underspending on AIDS, the model will set rather low benchmarks to guide future efforts.

3. Peer-independent benchmarks

Policymakers may prefer a more objective standard that does not depend on what countries have done. There is no broadly accepted normative standard for what level of domestic AIDS spending represents a fair, affordable, or reasonable effort. But some reference points for sustainable AIDS spending have been suggested.
Simplest benchmark: AIDS spending as a share of GDP

AIDS spending as a share of GDP is a useful metric since GDP is broadly the amount of resources a society has available to spend. Much of the writing about health financing expresses resource need as a share of GDP and suggests thresholds for domestic contribution. Williams and Gouws\textsuperscript{IV} ‘affordability index’ for universal ART, where they consider affordable a cost of < 1% GDP. Lule and Haacker\textsuperscript{V} also express HIV program cost as a share of GDP when discussing financial sustainability, although their analysis is more sophisticated, in that it considers the downstream reduction in treatment liability associated with investment in effective prevention activities. Program cost as a share of GDP has also been articulated in the area of vaccination (Saxenian et al\textsuperscript{VI}) and social protection (ODI\textsuperscript{VII}).

Were the Williams and Gouws affordability benchmark of 1% GDP accepted as a reference point, countries could aspire to contribute up to this level, and advocate for international assistance to cover program costs that remain. Most low- and middle-income countries have AIDS epidemics for which a full response (e.g. 90-90-90 Fast Track) only requires resources representing a small fraction of GDP (e.g. less than 0.5% GDP). This is true for all countries with concentrated epidemics. Only 29 countries have average annual RNE exceeding 1% of GDP, and all of them have generalized epidemics or are hyper endemic. Most are in sub-Saharan Africa, 19 are low-income, 7 are lower-middle-income, and 3 are upper-middle income. Ten countries have resource needs (RNE) that exceed 4% of GDP (Figure 2).


\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.png}
\caption{SHARE OF 39 GENERALIZED AND HYPERENDEMIC COUNTRIES WITH RESOURCE NEEDS EXCEEDING PARTICULAR SHARES OF GDP, CUMULATIVE OVER 2015-2030.}
\end{figure}

Source: adapted from Piot Lancet Commission on AIDS 2015.

\textsuperscript{IV} Williams B and Gouws

\textsuperscript{V} Lule and Haacker

\textsuperscript{VI} Saxenian et al.

\textsuperscript{VII} ODI. Fiscal Space for Strengthened Social Protection
While AIDS spending relative to GDP is a useful guidepost, it can be useful to focus more directly on the government’s budget or, more specifically, the health sector budget, since this is the main subset of GDP policymakers draw from to spend on AIDS.

**Size of Government**

Countries with the same GDP can have very different fiscal space for AIDS and other priorities, because of variation in the size of government. Vassall et al. 2013\[^{88}\] note that tax receipts as a share of GDP vary from about 5% to 34% in sub-Saharan African countries. General government expenditure (GGE), from which the health sector budget is drawn, ranges from about 15% to almost 40% of GDP in the 12 original PEPFAR focus countries.

**Abuja Target**

Most government AIDS expenditure runs through the health sector [Insert stat to support]. Countries with strong domestic financial commitment to health will have more fiscal space within their health budget to support AIDS programs. In 2001, African Union member states pledged, as part of the Abuja Declaration, to increase the share of their governments’ budgets spent on health to 15%, in part to strengthen health systems in response to AIDS. The pledge has been reaffirmed and remains a well-recognized development target.\[^{5,26}\]

**DALY Share**

Within the health sector, one indicator of priority for AIDS is the ratio of AIDS’ share of domestic health expenditure to AIDS’ share of the total disease burden measured in DALYs. While AIDS’ share of the health budget might be expected to be positively and consistently correlated to AIDS’ DALY share across a similar set of countries, allocating health resources solely in proportion to disease burden will not necessarily maximize health impact because it does not consider the cost-effectiveness of available interventions targeting AIDS and other health priorities.\[^{27}\] To be conservative, we assumed the benchmark ratio of AIDS’ share of domestic government health expenditure (GAE/GHE) to AIDS’ share of disease burden (AIDS DALY/Total DALY) is 0.5. In other words, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs. This benchmark value is consistent with empirical data suggesting this level of spending is achievable in LMICs with moderate to severe AIDS epidemics. For example, of the 30 countries reporting to UNAIDS since 2008 that have AIDS burden greater than 3500 AIDS DALYs per 100,000 population (to match the 12 countries in our sample), 10 had ratios above 0.5, including seven low-income countries and five where AIDS accounted for more than 10% of total DALY burden.

**Joint application of the Abuja target and DALY share benchmark**

Table 3 shows current domestic investment in the AIDS response in the 12 original PEPFAR focus countries. Most of these countries are spending less than the Abuja target of 15% of government budget on health—only Rwanda and Zambia exceed it. Five countries do not even spend 10% of government budget on health. Increases in health budget, with proportional increases

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in AIDS spending, could help close the AIDS resource gap. The table also reveals that these countries show a wide variation in the size of their domestic financing for AIDS relative to AIDS' share of the countries' disease burden (measured in DALYs). Three countries spend a proportion of their health budget on AIDS that is larger than AIDS share of the total disease burden, but other countries' allocations for AIDS are lower than a quarter of AIDS' share of disease burden.

### CURRENT AIDS SPENDING IN SELECTED SUB-SAHARAN AFRICAN COUNTRIES

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>HEALTH SHARE OF GOVT SPEND (GHE/GGE), 2012A</th>
<th>AIDS SHARE OF TOTAL DISEASE BURDEN, 2005B</th>
<th>(GAE/GHE) : (AIDS DALY/TOTAL DALY)</th>
<th>IMPLIED GAE FOR 2013 (TARGET)</th>
<th>IMPLIED GAE/GDP ACTUAL SPENDING MEETS TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>11%</td>
<td>6%</td>
<td>1.16</td>
<td>$32M</td>
<td>0.08%</td>
</tr>
<tr>
<td>Kenya</td>
<td>6%</td>
<td>22%</td>
<td>0.67</td>
<td>$258m</td>
<td>0.51%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>9%</td>
<td>18%</td>
<td>0.21</td>
<td>$69m</td>
<td>0.49%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>22%</td>
<td>12%</td>
<td>0.35</td>
<td>$18m</td>
<td>0.25%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>10%</td>
<td>20%</td>
<td>0.06</td>
<td>$115m</td>
<td>0.41%</td>
</tr>
<tr>
<td>Uganda</td>
<td>10%</td>
<td>14%</td>
<td>1.05</td>
<td>$40m</td>
<td>0.19%</td>
</tr>
<tr>
<td><strong>Lower-Middle income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>8%</td>
<td>13%</td>
<td>0.23</td>
<td>$65m</td>
<td>0.23%</td>
</tr>
<tr>
<td>igeria</td>
<td>7%</td>
<td>7%</td>
<td>0.37</td>
<td>$589m</td>
<td>0.13%</td>
</tr>
<tr>
<td>Zambia</td>
<td>16%</td>
<td>28%</td>
<td>0.13</td>
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<tr>
<td><strong>Upper-Middle income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>8%</td>
<td>44%</td>
<td>1.4</td>
<td>$158m</td>
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</tr>
<tr>
<td>Namibia</td>
<td>14%</td>
<td>39%</td>
<td>0.67</td>
<td>$141m</td>
<td>1.08%</td>
</tr>
<tr>
<td>South Africa</td>
<td>13%</td>
<td>46%</td>
<td>0.18</td>
<td>$4,353m</td>
<td>1.14%</td>
</tr>
</tbody>
</table>

*World Health Organization National Health Accounts (WHO NHA), *IHME Global Burden of Disease Study 2010*
The implied level of AIDS spending in 2013 for the 12 original PEPFAR countries is shown in Table 3. Only for the three UMI countries does the target level of spending reach 1% GDP. For most low and low-middle income countries, the target level of spending does not exceed ½% of GDP. Based on the most recently available AIDS spending data, five of the 12 countries may be meeting the target domestic AIDS spending implied by the benchmarks.

These benchmarks have several limitations. First, while the notion of allocating a share of the health budget to AIDS that is proportional to its share of disease burden—in this case, ½ the AIDS’ share of total DALYs—has some intuitive logic, ultimately the amount of health budget to allocate to AIDS depends on local health priorities. Likely, policy makers are trying to find an allocation that balances multiple competing objectives such as equitably disbursing resources across many disease areas and maximizing total health gains. While allocating health resources by DALY share assures that AIDS receives a greater proportion of the health budget in countries where AIDS is a larger component of its overall disease burden, and we can take comfort in knowing that key strategic AIDS interventions are reasonably cost-effective, there is no reason to expect that an allocation of resources proportional to disease burden is one that leads to a maximization of health gains produced from the health budget. Second, as with the p-DIPI, the implied spending associated with the benchmarks is not bounded by resource needs. In other words, the levels of spending implied by the benchmarks could exceed the resources required to ‘fully’ address AIDS. For this reason, it is recommended that the benchmarks be considered in conjunction with the resource requirements to achieve ambitious goals such as the UNAIDS’ Fast Track scenario.

4. Getting to benchmark spending levels

If the welfare gains from health are as large as some studies suggest (e.g. Summers & Jamison Global Health 2035, Lancet Commission on Investing in Health, UNAIDS’ Fast Track), most countries would seem to be underinvesting in health. Still practical and political challenges typically constrain changes in fiscal space from new revenue generation or reallocation to be small and gradual.¹

For countries not meeting the benchmarks for AIDS spending discussed above, meeting them either means raising new revenue (e.g. through taxation), making trade-offs within health sector, or trade-offs between AIDS and financing non-health priorities. When governance is of sufficient quality, society is best served by a policy process that considers AIDS in the context of all other demands on government resources.

Fiscal space is the ‘room in a government’s budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.’² Fiscal space can be created by (1) improving efficiency, (2) increasing revenue through economic

¹ ODI
² Heller 2006
growth (3) increasing revenue through greater tax yield, (4) reprioritization of spending, (5) writing off debt, or (6) increasing borrowing. Mobilizing additional external aid also creates fiscal space, but since the focus of this note is on domestic support for AIDS, we will set that mechanism aside.

Improving efficiency of program delivery is, in some sense, the best mechanism for creating fiscal space for a particular priority because it can be undertaken unilaterally by those who most value that priority. While, indeed, resources unlocked via efficiency gains in AIDS programs could be reallocated to non-AIDS priorities, the AIDS program may have the strongest claim on those resources by virtue of having ‘created’ them. Economic growth (i.e. increase in real per capita GDP) is the next most desirable source of new fiscal space, since it represent “new money.” There will be competition for those new resources, and a policy process ought to exist which can ensure society’s priorities are reflected in the allocation. But, all other mechanisms for increasing fiscal space either involve reallocating money (3 and 4) or carry substantial long-term sustainability risks (5 and 6).

Prospects for reaching AIDS spending benchmarks via economic growth.

In thinking about how fast a country could grow its AIDS spending toward the benchmarks, it may be reasonable to look at economic growth as a producer of new fiscal space. In 100 of the 108 LMICs countries with population over 1 million, the IMF predicts positive economic growth exceeding 1% per year over the period 2013-2019, after adjusting for population growth. The predicted average annual growth across these countries is 3% and does not vary dramatically by epidemic type. In 52 of 108 countries, the AIDS response could be fully funded by allocating 10% of GDP growth to AIDS. In 14 of the remaining countries, total average annual RNE exceeds 100% of GDP growth.

One could refine this analysis by considering only the portion of the growth that would accrue to the government, assuming government expenditure as a share of GDP remains constant. In this case, 47 countries could fully fund their AIDS response with less than 25% of the additional government revenue available as a result of economic growth. Still many countries will not be able to fund the AIDS response fully by relying exclusively on new government resources resulting from economic growth; in 34 countries, including 8 of the 10 countries with the largest number of persons living with HIV (PLHIV), the total annual RNE exceeds total projected growth in government revenue. Moreover, in all but 28 countries, total annual RNE will exceed expected growth in government health budgets (assuming these budgets grow at the same rate as GDP per capita). If these 80 countries are going to finance their AIDS response domestically, they will need to generate more tax revenue or reallocate resources from other priorities.

5. Discussion

The demand for benchmarks for domestic AIDS spending emerged from the recognition that AIDS programs still have a lot of scaling up to do and international donors are unlikely to expand their support of AIDS programs at the rate observed over the past 15 years. Despite the recognized fungibility of health aid and the debate about the merits of earmarking, major donor organizations have sought to
strengthen their counterpart financing requirements and encourage greater domestic contributions through partnership agreements. These efforts require an understanding of what level of domestic contribution is reasonable to expect. In other words, how much of the global price tag for a comprehensive AIDS response can countries themselves shoulder? As has been noted, to a large extent, the amount of AIDS spending a country can bear is a choice they make, in the context of other priorities.

The benchmarks discussed in this note provide a rough guide for identifying countries that could take on more of the financial burden of the AIDS response should they choose to, and those which will undoubtedly need continued external aid. At the same time, the focus on how much a country is contributing to the AIDS response, is notably in tension with notions of self-determination and the more wholistic health system approach espoused in the UHC movement. Perhaps more concerning, a preoccupation with the total amount spent may miss opportunities to emphasize the efficient production of desired health outcomes. Nor does it capture the importance, in terms of long-term sustainability, of achieving the ‘AIDS transition’ by preventing new infections. Nonetheless, even perfectly efficient service delivery has a cost, and requires the mobilization of resources. And, understanding what a country could contribute is important for those advocating for allocation of resources to AIDS within a valid policy process. For these reasons, a set of practical benchmarks for domestic AIDS spending is a useful part of an HIV policy toolkit.
Disclaimer:
These reports are published as they were reported/presented during the ERG or ERG/TWG meeting
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Introduction

HIV & AIDS programmes have achieved significant successes worldwide. New infections are on the decline in most regions and there is growing access to effective therapy for people in low- and middle-income countries or LMICs. Nevertheless, there will still be a need for high levels of funding for many years to come to support further expansion of treatment and to bring down the numbers of new cases.

In the meantime the funding landscape is changing. Fifteen years ago, the AIDS epidemic was seen as a unique and urgent concern for public health around the world; this mobilized public opinion and attracted an unprecedented level of political and financial support. Today, while need remains high, HIV & AIDS has to compete for resources with the whole range of societal, economic and environmental issues facing the planet as set out in the new international development agenda as expressed in the Social Development Goals (SDGs) with its 17 goals and 169 targets.

Until now external donors have financed a large part of the HIV response in LMICs, often using vertical mechanisms to do so, but donor funding has recently levelled off. Domestic funding has continued to grow however, and is now taking on a bigger role in the overall financing for HIV in countries.

The new SDGs have set ambitious goals for ending AIDS as a public health threat and for achieving universal health coverage or UHC by 2030. The drive to make these a reality can only put more pressure on funding.

In the light of these developments, policymakers need to find ways to make HIV and health funding go further. This raises the question of whether countries should integrate the often vertical funding of HIV programmes into their general systems for financing health. This brief looks at the prospects for doing so and examines the benefits and challenges this would entail.

WHAT DO WE MEAN BY FUNDING INTEGRATION?

Funding integration means moving to a system where funds for HIV & AIDS are no longer managed in parallel structures but are instead collected, put into a common pot with other funds and used to pay for a range of health services. A related idea is that integrated funding may then be used to provide integrated delivery of HIV & AIDS services alongside other health services.
How integrated is HIV & AIDS funding in LMICs today?

Health financing can be broken down into three core functions: revenue collection or the collection of funds for health purposes; pooling or the accumulation of pre-paid funds to cover the health care costs of a specific population and purchasing or the various ways funds are paid out to the providers of health care goods and services in the form of salaries, fixed prices for drugs or global budgets for health facilities.

This framework has been used to analyse the degree of integration between HIV and general health funding in thirteen countries with varying levels of income, HIV prevalence and insurance coverage.

### T.1 DEGREE OF INTEGRATION OF HIV FINANCING FUNCTIONS

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>REGION</th>
<th>EPIDEMIC TYPE³</th>
<th>2012 ADULT HIV PREVALENCE⁴</th>
<th>INCOME LEVEL⁵</th>
<th>COLLECTION</th>
<th>POOLING</th>
<th>PURCHASING</th>
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</thead>
<tbody>
<tr>
<td>Zimbabwe</td>
<td>Africa</td>
<td>Generalized</td>
<td>14.7%</td>
<td>LIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
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<td>Africa</td>
<td>General</td>
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<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Africa</td>
<td>Generalized</td>
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<td>LIC</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
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<tr>
<td>Nigeria</td>
<td>Africa</td>
<td>General</td>
<td>3.7%</td>
<td>LMIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Ghana</td>
<td>Africa</td>
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<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
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<td>Asia</td>
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<td>0.4%</td>
<td>LMIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Philippines</td>
<td>Asia</td>
<td>Low-level</td>
<td>&lt;0.1%</td>
<td>LMIC</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
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<tr>
<td>South Africa</td>
<td>Africa</td>
<td>Generalized</td>
<td>17.90%</td>
<td>UMIC</td>
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<td>Medium</td>
<td>Medium</td>
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<td>Brazil</td>
<td>LAC</td>
<td>Concentrated/ Low-level</td>
<td>0.3%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
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<td>Colombia</td>
<td>LAC</td>
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<td>0.0%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Thailand</td>
<td>Asia</td>
<td>Generalized</td>
<td>1.1%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
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<tr>
<td>Mexico</td>
<td>LAC</td>
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<td>0.2%</td>
<td>UMIC</td>
<td>High</td>
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<tr>
<td>Chile</td>
<td>LAC</td>
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<td>0.4%</td>
<td>HIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Source: Integration of HIV Financing into Health Financing Systems in Low- and Middle-Income Countries Conceptual Framework and Preliminary Findings

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² Integration of HIV Financing into Health Financing Systems in Low and Middle Income Countries Conceptual Framework and Preliminary Findings, Results for Development for the HIV Economics Reference Group, 2014.
³ Integration of HIV Financing into Health Financing Systems in Low and Middle Income Countries Conceptual Framework and Preliminary Findings, Results for Development for the HIV Economics Reference Group, 2014.
⁴ Epidemic type by adult prevalence of HIV: concentrated when <1% of population but >5% of any high risk group are HIV-positive; generalized when >1% of population is HIV-positive; low-level when relatively little HIV is measured in any group. Source: http://www.who.int/hiv/strategic/surveillance/en/.
⁵ Source: http://data.worldbank.org/indicator/SH.DYN.AIDS.ZS.
There is substantial variation in the current level of integration both between countries and within countries for each of the three financing functions. Proposals to integrate HIV funding into health may need to take this factor into account. Rather than proposing across-the-board solutions, it may make more sense in some countries to integrate some functions and not others.

Of the thirteen countries surveyed, the five with higher levels of income and low or concentrated HIV epidemics also displayed high degrees of integration in all three functions. This was the case regardless of differences in institutional arrangements for providing services. The small sample analysis suggests that integration seems to be more feasible in countries with higher incomes or with lower HIV prevalence.

The five countries with a medium level of integration are probably the most likely candidates for more integration in the near term. One example is South Africa, where the government and President’s Emergency Plan for AIDS Relief or PEPFAR are beginning to prepare the ground for less dependence on PEPFAR funding. While it is still early days, the next steps may include an analysis of how much HIV funding would be needed under a national health insurance scheme or how to organize integrated pooling and purchasing for HIV services.

Countries in the survey with lower levels of integration are usually poorer, do not have broad health insurance schemes and are experiencing generalized HIV epidemics, particularly in sub-Saharan Africa. In these countries surveyed there is a clear link between lower levels of income and a low level of integration, due to these countries’ strong reliance on external funding for HIV & AIDS. It would therefore make little sense to promote integration in the collection function, but bundling HIV and non-HIV assistance might save resources in the short term and help pave the way for less reliance on external funding in the longer term. Rwanda, where a low income and the inability to raise sufficient resources locally would make integrating collection difficult, is one example of this. However some integration of pooling and purchasing is possible while still moving towards the UHC goals.

What are the challenges for integration?

One of the reasons why vertical funding developed was precisely to deliver a response to HIV in those countries with weak health systems who found themselves unable to mount an adequate response. In many LMICs, these systems remain weak today. The ambitious new targets for elimination of AIDS as a public health threat and plans to extend UHC will put them under increasing pressure. Therefore integrating HIV into UHC may call for trade-offs between the two, especially in the current funding environment. One area of concern is that the needs of key populations could suffer in the process as resources may be allocated to groups with greater political importance.

Taking on the demands of a fully integrated system will call for extra funding capacity. This raises the question of how much fiscal space poorer countries, such as the world’s 49 poorest countries, currently have to do so. Comparing McIntyre and Meheus’ recent estimate of minimum expenditure on providing UHC with UNAIDS’ recommended expenditure on HIV interventions and then comparing this to the WHO estimated expenditure on health can help throw some light on this question.7

The McIntyre and Meheus recommendations do provide more than enough space to accommodate UNAIDS recommended expenditure in most of the 49 countries, but those countries with especially high fiscal need for HIV interventions such as Zimbabwe may struggle. However judging by expenditure to date in these 49 low income countries, there could be a substantial gap in resources between current sources of revenue and fiscal need for the period 2015 – 2019. This will pose a considerable challenge for advocacy efforts.

HIV intervention packages usually include both public and private goods. Primarily private health care goods, such as treatment, could fit easily into insurance-based financing schemes or other pre-paid approaches.

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7 Oxford Policy Management, Opportunities and challenges for the integration of health and HIV financing, (undated)
8 Treatment is both a private health good and a merit good in that it has also positive externalities due to its preventative effects for the public alongside curative effects for the individual

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12 | INTEGRATING HIV & AIDS FUNDING
But many public goods, including awareness-raising, the distribution of condoms or HIV-testing systems, would not fit so easily, and so are usually reliant on government funds. If HIV services are integrated into an insurance package, the public HIV goods could run the risk of neglect or even fall by the wayside. This could lead to a rise in the number of new infections, which would be an extremely negative outcome.

In Vietnam where donor funding is expected to fall the government is looking at ways of covering AIDS treatment via social health insurance, although coverage is currently low among HIV-positive people. However it seems likely that prevention services will still be paid for by government, and it might be argued that the needs of key populations may also need public funding.

What are the benefits from integration?

Integrating HIV financing with that of general health financing systems could be one way of improving the efficiency and financial sustainability of HIV programmes looking to the future. Moreover integration could promote self-sufficiency through greater domestic ownership of health and HIV programmes.

It may also have the potential to improve the access, equity and quality of general health services for the population. It could do this by leveraging HIV systems, processes and expertise to address other health concerns.

Primary health care is one area where this could make a difference. This has been the case in rural Haiti where introducing comprehensive AIDS care has boosted staff morale and increased the availability of essential medicines to treat other forms of infection.

Another justification for integration arises from the nature of HIV & AIDS itself. While most diseases are either categorized as short-term and communicable or chronic and non-communicable, due to advances in treatment, AIDS is now a chronic communicable disease. AIDS is often now the biggest chronic care programme that exists in many LMICs. It may be that HIV is playing a role in causing other diseases such as non-AIDS cancers or cardiovascular problems such as myocardial infections and strokes. So there is a concern that growing numbers of people receiving Antiretroviral Therapy could add to the treatment burden for other health conditions and the need for more integrated delivery systems.

Conclusions and prospects for integration

It is probably too early to reach a firm conclusion on the immediate prospects for integrating HIV and health funding. While the final goal is to include HIV as an integral part of UHC, it is important that we do not jeopardize the current HIV response and its achievements to date. Poku describes the prospects for integration as “at present too remote and too risky” and advocates focusing on strengthening health systems in general, especially in those areas which benefit the whole system such as training personnel, screening or gathering data and analysis.

With such a high number of variables, it would be unwise to use generalized estimates to inform local policy decisions. Country by country case studies could help to throw a more systematic light on these questions and help to inform future policy decisions.

There is a lack of evidence on the impact that integration would have on efficiency, quality and access both for HIV and for general health services. However, the analysis discussed above does provide a first attempt at a typology of countries based on the current level of integration, income levels and health system performance – and gives pointers as to where further integration efforts may be likely to succeed.

3 Oxford Policy Management, Opportunities and challenges for the integration of health and HIV financing, (undated)
4 Results for Development for the HIV Economics Reference Group, Integration of HIV Financing into Health Financing Systems in Low and Middle Income Countries, 2014
1. Introduction

The international community, as well as countries individually, are in the process to committing (or not) to two partly related high level policy objectives:

1. Achieve universal coverage for a (basic) package of health services\(^1\), which includes some HIV services, and

2. Ending AIDS 2030\(^2\), through achievement of the “90 – 90 – 90”\(^3\) initiative on treatment and more aggressive targets on prevention.

This paper evaluates to what extent there is enough fiscal space to fund both recommended HIV/AIDS interventions under Ending AIDS 2030 and universal provision of basic healthcare (UHC) in 49 of the lowest income countries (in 2007)\(^4\) (listed in annex A). It does so by outlining estimated fiscal need (resource needs) for the provision of both UHC and HIV/AIDS interventions up to 2019, and comparing these to estimated fiscal space for health and HIV. For discussion, anticipating a significant resource gap, it introduces three issues that can contribute to making an integrated HIV and UHC financing system feasible: efficiency savings, borrowing, and the importance of understanding opportunity costs when making resource allocation decisions with limited resources within an integrated health financing system. Some of the further challenges beyond the lacking fiscal space are also introduced.

\(^1\) Currently there is no consensus about what UHC entails. A broad understanding that all people obtain the health services they need without suffering financial hardship when paying for them (http://www.who.int/features/qa/universal_health_coverage/en/). This implies that the entire population has access to a defined package of health care services of high quality with financing protection.

\(^2\) The world is embarking on a Fast-Track strategy to end the AIDS epidemic by 2030. To reach this visionary goal after three decades of the most serious epidemic in living memory, countries will need to use the powerful tools available, hold one another accountable for results and make sure that no one is left behind (http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report).

\(^3\) By 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression (http://www.unaids.org/en/resources/documents/2014/90-90-90).

\(^4\) The 49 low income countries are those that had a GNI less than $935 in 2007 ($2007).
The report is divided into six sections. The first section outlines a recent recommendation on fiscal need for UHC by McIntyre and Meheus (2014) which is in part based on costing exercises done in 49 of the world’s poorest countries. This is then compared to UNAIDS’ estimates of fiscal need for HIV/AIDS interventions in these same 49 countries. These estimates are used throughout the report as the estimated fiscal need for the provision of UHC and HIV/AIDS services.

For UHC, McIntyre and Meheus propose:

The minimum acceptable cost of a health sector is whichever is bigger; 5% of GDP or $86 per capita (McIntyre & Meheus, 2014).

For HIV/AIDS interventions, UNAIDS have estimated the cost of a variety of interventions that are needed in each country as part of a drive towards 95% personal knowledge of HIV status, 95% of HIV positive people on antiretroviral therapy and 95% of people on antiretroviral therapy (ART) with viral suppression. A significant part of these packages are health sector jurisdiction – including the provision of ART and the prevention of mother to child transmission. However, other parts of the strategy fall outside the health sectors – for example media campaigns, community mobilisation, youth campaigns, political advocacy, legal infrastructure etc.

Section one compares McIntyre and Meheus’ estimates of the minimum cost of universal provision of a basic package of health care to the UNAIDS estimates for the cost of both the basic and full set of HIV/AIDS response interventions in 2015. It finds that there is more than enough space in McIntyre and Meheus’ UHC recommended expenditure for UNAIDS HIV/AIDS recommended expenditure in the majority of the low income countries. However, while this is the case on average, it doesn’t apply to all countries individually. Some countries (for example Zimbabwe) have disproportionately high HIV/AIDS expenditure needs and the share set aside for HIV in the UHC package is not enough to cover the HIV resource needs in those countries. This highlights that the generic use of UHC expenditure recommendations does not always reflect country specific dynamics.

Section two looks at fiscal space for health care between 1995 and 2012. Using WHO national health accounts data total health expenditure (THE) on health is estimated per capita and broken down into government, donor, out of pocket (OOP) and private expenditure on health (non OOP) expenditure on health. We find that, aggregated across the selected 49 LIC, THE grew from $14 in 1995 to $53 in 2012 in current terms, and that OOP was consistently the largest contributor. Government and donor expenditure on health together rose from $5 to $29 over the same period.

Section three compares fiscal space to fiscal need between 1995 and 2012. By deflating and inflating the estimated total annual cost of UHC (outlined in section one and explored further in annex b), and comparing it to actual expenditures (outlined in section two) it shows that not nearly enough money was spent in health sectors in the 49 LIC to cover the basic minimum cost of UHC over the period, and highlights that the cost of the package may have grown faster than actual expenditure, so that fiscal space as a proportion of fiscal need in 2012 may have been lower than in 1995. We do not analyse fiscal need for HIV/AIDS retrospectively. This is addressed in the following sections.

Section four presents scatter plots of GDP per capita against THE per capita, government expenditure on health per capita, donor expenditure on health per capita.
capita, OOP per capita and private per capita (non-OOP) with power lines of best fit to estimate elasticity relationships between the five variables and GDP per capita. This is then used to predict what may happen to each of the variables given the IMF GDP and population projections. It finds that GDP per capita is only weakly correlated with any of the individual financing sources, but strongly correlated with THE per capita. Between 1995 and 2012, THE per capita was approximately 5% of GDP per capita in any given year or country among the 49 LIC.

Section five cautiously extrapolates expenditure and fiscal need to future years follow the lines of best fit computed in section four to project estimated fiscal space up to 2019. Fiscal need is projected up to 2019 through the methodology outlined in section one. Projected fiscal need is then compared to projected fiscal space. For the 49 LIC, it is estimated that between 2015 and 2019 there will be a $240 billion resource gap between THE and fiscal need for the provision of UHC (about 30% of total fiscal need), or a $550 billion resource gap if private expenditure on health is not included (about 70% of total fiscal need).

In conclusion, while there is enough space for UNAIDS’ recommended HIV/AIDS resource needs within McIntyre and Meheus’ recommended minimum expenditure on UHC, the current health expenditure in low income countries does not cover the recommended minimum expenditure on UHC, and in turn an integrated UHC and HIV financing system is also not affordable. However, there may be space for UNAIDS’ recommended expenditure levels if expenditure on other UHC interventions is decreased from previous estimates. UNAIDS’ recommended expenditure on basic health sector HIV/AIDS response interventions is projected to be around 14%-15% of government plus donor fiscal space for health between 2015 and 2019, which is not out of line with the proportion of expenditure allocated to HIV/AIDS in the three costed basic packages of care outlined in section one.

Section six introduces four topics that need to be addressed, given that, under business as usual, there will not be enough money for the provision of adequate universal health care in the 49 countries. First, there is significant space for countries to improve the efficiency of their health sectors. Recent analysis of the rate at which expenditure on health is converted into low infant and child mortality and high life expectancy in 173 countries shows that there is large variation in outputs at similar levels of input. For countries with low health expenditure and low health status, improving the efficiency of health sectors may be more fruitful in terms of improving outcomes than just increasing expenditure. Second, it may be possible for some countries to borrow to fund particular investments in health sectors. This is particularly relevant for expenditures on infrastructure, such as facility development. Where countries are currently borrowing below what is considered sustainable, as future generations will likely benefit from investments in health it may be justifiable that they be a part of funding current investments in health. Third, given the hard budget constraint, the opportunity cost of expenditure in countries with low expenditure on health is particularly high. Interventions should only be funded where the benefit from that expenditure is greater than the opportunity cost of the expenditure. Cost-effectiveness analysis of interventions may be a useful tool for identifying the opportunity cost of expenditure, and in turn informing allocation of the very limited resources within an integrated health financing system. Fourth, there are a number of further challenges relating to the integration of UHC and HIV financing.
However, a number of middle income countries have made significant progress, and two of the low income countries used throughout this report have already made steps towards the integration of revenue pooling and health service purchasing.

2 Fiscal need

2.1 What is the minimum cost of a health sector?

Universal health coverage is taken to mean that everyone in a country can access a defined basic package of the healthcare without suffering financial hardship in doing so. In other words, an adequate benefits package, provided to a whole population, with sufficient financial protection against the cost of care (WHO, 2010).

Currently, the only target for government spending on health that has been signed up to by a large number of countries is the Abuja health financing target – recommending that governments allocate 15% of their revenue to the health sector. However, as this is a proportion of a variable number, there is no guarantee that it will be enough to provide an adequate health service. In 2012 the Sierra Leonean government spent approximately $115 per capita in total (GoSL, 2014). Even if it had allocated 15% of government expenditure to the health sector, it would still have only spent $17.50 per person. This is not enough to fund an adequate health sector. Moreover, as a social welfare spending target, it does not encourage governments to raise extra revenue for social expenditure – only that ministries of finance should allocate a set proportion of what they have to health sectors.

Based on these criticisms of the Abuja health financing target, McIntyre and Meheus have recently proposed a lower limit benchmark for public expenditure on the provision of UHC that aims to recommend a minimum-but-adequate expenditure on health given the size of an economy (rather than a government) and the absolute cost of basic health care (McIntyre & Meheus, 2014).

They show that countries in which the government spends around 5.5% of GDP on health (including mandatory health insurance payments) tend to have infant mortality rates lower than 10 per 1,000 live births; countries in which the government spends around 6% of GDP on health tend to have out of pocket expenditures that account for less than 20% of total health expenditure; and that countries in which the government spends more than 5% of GDP on health tend to achieve the current global average of 44 health workers per 10,000 population. Based on this, they argue that 5% of GDP is enough to fund a sector that provides UHC up to basic quality standards (in terms of provision of care (adequate HR), outcomes (adequate infant mortality) and financial protection (adequately low OOP)). However, in abidnottolimitrecommendations to the size of a government, the target opens itself to the criticism that it is not achievable where governments are small. Moreover, while this may be preferable to the Abuja health financing indicator because it has some evidence based justification, where GDP is low, 5% may still not cover basic health needs. Because of this, the authors argue that a GDP dependent target should also be complemented with a GDP-independent target.
For the GDP-independent target McIntyre and Meheus refer to three large costing studies that have estimated the absolute cost of provision of UHC in low income countries: one done by the Commission on Macroeconomics and Health in 2001, and the other two done by the High Level Taskforce on Innovative International Financing for Health Systems in 2005.

2.1.1 The Commission on Macroeconomics and Health (2001)

In 2001 the Commission on Macroeconomics and Health (CMH) estimated the cost of scaling up the coverage of 49 priority health interventions at the close-to-client level in the 83 countries with GDP per capita less than $1,200 (1999$). The aim of scaling up was universal access to basic health care, and it was recommended that this was done with public (including donor) resources. It gave the estimated additional costs (on top of what was already spent) of expanding from the current level of provision to the target levels by 2007 and 2015. It was based on local population health needs, coverage levels and cost of expansion (with non-tradable goods adjusted for purchasing-power parity). Further adjustments were also made to account for the process of scaling up – for example increased management and salary costs. Results were given both in terms of annual average incremental costs and projected annual flows (CMH, 2001).

2.1.2 The High Level Task Force (2005):

In 2005 a High Level Task Force on Innovative International Financing for Health Systems (HLTf) was established to generate two further estimates of expanding health sectors to offer everyone access to guaranteed health benefits as stated in UN conventions.

The first of these built on work that had already been done, and is referred to as the ‘WHO normative’. It focused on a benefit package including HIV, TB, malaria, child health, immunization and maternal and newborn health interventions. The second of these was built on country costings using the Marginal-Budgeting for Bottlenecks approach, and is referred to as ‘MBB’. The MBB made heavy use of country planning exercises, and assumes scale up of community services before clinical services. Both refer specifically to the 49 low income countries that were projected to have gross national incomes (GNIs) per capita less than $935 in 2007 (2007$), and are presented in terms of a six year investment plan for scaling up service provision between 2009 and 2015 (see annex A for a list of the countries. These are the 49 countries referred to in the introduction and are the focal jurisdiction of this report).

Both the MBB and WHO normative also present estimated additional costs and total costs. The HLTF suggest that MBB may more realistic than the WHO normative as many large capital expenses are delayed until the final years of the plan. It is presented with three speeds of expansion – low, medium and high. The WHO normative is, in contrast, facility based, and has an optimistic view of the time it takes to put infrastructure in place, with recommended capital expenditure peaking in 2012 (Taskforce on Innovative International Financing for Health Systems, 2005).

In order to facilitate analysis across a group of countries in any one year, we use the estimated cost of the packages in 2015 (as presented in (Taskforce on Innovative International Financing for Health Systems, 2005) and (CMH, 2001)). However, it is important to be aware that these estimates are part of medium term expenditure plans. The CMH assumes scaling up started in
2002, and the MBB and WHO norm assume work began in 2006. The 2015 fiscal needs estimates assume that specific previous investments have already been made, and do not apply to a country that is just starting to scale up health services now. Individual countries need to apply each stage of the methodology put forward in this report, specifically considering their own situation. These numbers should not be taken as generalizable targets. Countries need to think about what parts of the package they need to scale up, what investments have already been made and whether the package is actually appropriate in the first place.

With this caveat in mind, the CMH, MBB and WHO normative estimated costs of universal provision of a basic benefit package in 2015 are used in this report to give an indicative figure for reasonable minimum annual expenditure on health.

The WHO normative and MBB present the expected cost of provision of a basic package in 2015 in 2005$. The CMH presents the expected cost in 2015 in 2002$ (see table 1.1).

### T.1.1 THREE ESTIMATES OF FISCAL NEED PER CAPITA IN 2015

<table>
<thead>
<tr>
<th>ESTIMATE BY</th>
<th>ADDITIONAL FISCAL NEED PER CAPITA</th>
<th>CURRENT FISCAL SPACE PER CAPITA</th>
<th>TOTAL FISCAL NEED PER CAPITA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO normative (2015 in 2005 $)*</td>
<td>29</td>
<td>25</td>
<td>54</td>
</tr>
<tr>
<td>MBB medium (2015 in 2005 $)*</td>
<td>24</td>
<td>25</td>
<td>49</td>
</tr>
<tr>
<td>CMH (2015 in 2002 $)**</td>
<td>21</td>
<td>17</td>
<td>38</td>
</tr>
</tbody>
</table>

* (Taskforce on Innovative International Financing for Health Systems, 2005)
** (CMH, 2001)

The CMH estimate for current fiscal space per capita is inferred from total fiscal need and additional fiscal need per capita, which are both reported in (CMH, 2001)

Throughout report grey cells are taken directly from sources. White cells inferred.

2.1.3 McIntyre and Meheus’ recommended minimum expenditure needed for UHC

McIntyre and Meheus examine two funding benchmarks: 5% of GDP and the CMH, MBB or WHO normative fiscal needs estimates.

To decide which one to apply McIntyre and Meheus recommend:

A/ The minimum acceptable cost of a health sector is whichever is bigger; 5% of GDP or the cost of a basic package
of health services as estimated by CMH, WHO normative or MBB.

They select the WHO normative from the HLTF and inflate it to be expressed in $2012 (rather than $2005), and finally recommend:

B/ The minimum acceptable cost of a health sector is whichever is bigger; 5% of GDP or $86 per capita (in 2015, expressed in 2012$).

This report has further inflated this estimate to be expressed in terms of 2015$ using the average emerging market and developing country inflation rate taken from the IMF’s World Economic Outlook. For an explanation and discussion of problems when inflating the health sector costings, see annex B:

C / The minimum acceptable cost of a health sector is whichever is bigger; 5% of GDP or $100 per capita (in 2015, expressed in 2015$).

How this manifests in the 49 countries is shown in figure 1.1.3. Importantly, 5% of GDP is greater than $100 is only six of the countries. This is a significant drawback of the recommendation, as the first component of the double target is effectively redundant in most low income countries. However, this is the reason the second component of the target was added. It also highlights the major challenge many low income countries face, where even if governments could choose to spend 5% of GDP on health sectors, they would still be far off being able to afford adequate services. In these cases it is difficult to see how adequate health care can be affordable without contributions from external resources.

From now on, this report uses recommendation ‘C’ to estimate the minimum fiscal need to adequately provide UHC in 2015.

2.2 What is the minimum reasonable cost of HIV/AIDS interventions?

In an attempt to increase standards and efficiency of investment in the fight against HIV/AIDS, UNAIDS have published the estimated costs of recommended packages of HIV/AIDS response interventions for countries to implement. There are a number of different sets of estimates that have come out at different times. In 2011 UNAIDS proposed an investment strategy that included 33 interventions categorised into basic programme activities, interventions to create an enabling environment and programmes in other health and development sectors (Schwartlander, et al, 2011). The first of these categories included interventions that were the most clearly ‘health sector’ jurisdiction – such as antiretroviral therapy and prevention of mother to child transmission of HIV/AIDS. The second two categories included interventions such as ‘youth out of school’, ‘political commitment and advocacy’ and ‘AIDS orphans’, which would rely on government agencies beyond ministries of health for their implementation.

More recently UNAIDS have introduced a new target ‘ending the AIDS epidemic by 2030’ and updated these country recommended packages. The new target is that by 2030 95% of people living with HIV/AIDS will know their status, 95% of HIV positive people will receive antiretroviral therapy and 95% of people receiving antiretroviral therapy with have viral suppression. Meeting the target requires only 200,000 new infections among young adults annually by 2030, and no discrimination against people living with HIV (UNAIDS, 2015). These are built from the 90-90-90 targets many countries have already signed up to, which are equivalent except that they are targeting 90% of the population and 500,000 new annual infections by 2020 (UNAIDS, 2014).
These are ambitious targets, requiring a large deviation from current programmatic and expenditure trends, particularly in sub-Saharan Africa. The updated country specific strategies consist of service packages categorised into ‘enablers and synergies’, ‘outreach and prevention’, ‘test and pre-ART’, ‘ART’ and ‘community mobilisation’. Specific activities include, for instance, ‘health systems strengthening’, ‘education’, ‘community mobilisation’, ‘ART’, ‘pre-ART’, ‘testing’, ‘pre/post exposure prophylaxis’, ‘cash transfers’, and many more. It involves an aggressive scale up of services and frontloading of investments.

In particular 28 countries have been highlighted for focused attention as part of a ‘fast track’ approach between 2015 and 2021 because they account for 89% of all new HIV infections. While there is some overlap (Nigeria, Kenya, Zimbabwe and Mozambique, for example), key countries driving the cost of the 28 fast track target are South Africa, India, China and Brazil – none of which are part of the 49 low income country group that this report focuses on. Nonetheless, UNAIDS have costed strategies for 45 of the 49 countries. The estimated total cost per capita in 2015 of UNAIDS recommended HIV/AIDS interventions in 44 of the 49 countries is given in figure 1.2.

Zambia, Zimbabwe and the Solomon Islands have the highest fiscal need per capita from among the 49 low income countries – ranging between $25 and $35. In most of the countries, however, recommended minimum expenditure is much lower, and in over half of them it is below $5 in 2015.

### Is there adequate space in UHC for HIV/AIDS?

All three estimates of the cost of UHC (CMH, WHONorm and MBB) specifically incorporate the cost of HIV/AIDS interventions. These are outlined in table 1.3.1.

#### 1.3.1 CMH, MBB & WHO NORM ESTIMATES OF FISCAL NEED FOR HIV/AIDS

<table>
<thead>
<tr>
<th>HIV/AIDS SPECIFIC ESTIMATE BY</th>
<th>ADDITIONAL FISCAL NEED PER CAPITA</th>
<th>CURRENT FISCAL SPACE PER CAPITA</th>
<th>TOTAL FISCAL NEED PER CAPITA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO normative (2015 in 2005 $)**</td>
<td>2.4</td>
<td>5.0</td>
<td>7.4</td>
</tr>
<tr>
<td>MBB medium (2015 in 2005 $)**</td>
<td>1.6</td>
<td>5.0</td>
<td>6.6</td>
</tr>
<tr>
<td>CMH (2015 in 2002 $)**</td>
<td>4.7</td>
<td>3.4</td>
<td>8.1</td>
</tr>
</tbody>
</table>

* (WHO, 2009)
** (WB, 2009)
*** (CMH, 2001)
*Grey cells direct from sources. White cells inferred.

1 The IMF World Economic Outlook does not include a population estimate for the Democratic People’s republic of Korea, so a per capita estimate is not included.
2 Figures obtained from internal communications with UNAIDS staff.
To infer the white cells a number of assumptions have been made. It is assumed that current spending is split between service provision and systems strengthening (roughly interpreted as administration) 60:40, as this is how the incremental estimate is split in the CMH. It is also assumed that current spending on service provision is split evenly between nine key areas of intervention – TB treatment, malaria prevention, malaria treatment, HIV prevention, HIV care, HIV treatment (HAART), childhood related illnesses treatment, childhood related illnesses, immunization and maternity related illnesses as this is how the incremental estimate is split in the CMH.

Table 1.3.2 shows these figures inflated to 2015$ using the emerging market and developing country average inflation rate. In total, in 2015$ we estimate that the WHO norm allocates $14, the MBB allocates $12 and the CMH allocates $18 per capita for HIV/AIDS interventions.

<table>
<thead>
<tr>
<th>HIV/AIDS SPECIFIC ESTIMATE BY</th>
<th>ADDITIONAL FISCAL SPACE REQUIRED</th>
<th>CURRENT FISCAL SPACE</th>
<th>TOTAL FISCAL SPACE REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO normative (2015 in 2015 $)</td>
<td>4</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>MBB medium (2015 in 2015 $)</td>
<td>9</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>CMH (2015 in 2015 $)</td>
<td>14</td>
<td>8</td>
<td>18</td>
</tr>
</tbody>
</table>

When 2015 is taken in isolation, all three (WHO norm, MBB and CMH) estimated costs of basic benefits packages include more than enough space specifically allocated for HIV/AIDS interventions in the majority of the 49 countries. Only in Mozambique, Zambia, Zimbabwe and the Solomon Islands is the UNAIDS recommended minimum expenditure on interventions as part of the 2030 target greater than what was allocated in the WHO normative UHC benefits package costing.

This suggests that, on the whole, McIntyre and Mehues’ estimates for the cost of expanding to universal health coverage do include enough space for the UNAIDS estimates of the cost of HIV/AIDS interventions – with the noteworthy exceptions of the highlighted countries.

However, the UNAIDS recommendations, like the WHO norm, MBB and CMH, are medium term investment plans. Their 2015 cost recommendations are assuming certain previous investments have already been made. Further work needs to compare total UHC expenditure recommendations over a time period to total UNAIDS recommendations over a time period to properly verify that there is space in UHC fiscal needs estimates for HIV/AIDS fiscal needs estimates.
F.1.1.3  McIntyre and Mehetu Target - Country Specific 2015 UHC Recommended Expenditure

F.1.2  UNAIDS 2015 Recommended Expenditure on HIV/AIDS Interventions
There are a number of points to be made from these comparisons. One, for only six of the 49 countries is 5% of expected GDP per capita greater than $100. This highlights that the double target is in fact a single target in most low income countries. By extension, it emphasises that in order to afford a publically funded minimum basic package for UHC, governments in low income countries either need to spend more than 5% of GDP on health, or need external resources to supplement government expenditure.

Two, the UNAIDS recommended expenditures vary significantly across countries, reflecting the relative scale of the HIV epidemic. The fiscal need for HIV/AIDS responses is much larger in some countries than in others.

Three, while there may be fiscal space for HIV/AIDS expenditure recommendations within total health sector UHC expenditure recommendations in the majority of the 49 low income countries, there is not in some key countries. The UNAIDS minimum expenditure recommendation for HIV/AIDS response interventions in Zimbabwe and the Solomon Islands, for example, is close to 35% of the total minimum recommended expenditure for UHC. In Zambia it is 25%, and in Mozambique it is 15%. Bearing in mind that the CMH, MBB and WHO norm allocated between 12% and 18% of their fiscal needs estimate to HIV/AIDS responses, there may not be enough space in these estimates. However, it should also be highlighted that HIV/AIDS interventions are not the jurisdiction of health sectors alone. For countries where fiscal need for HIV/AIDS interventions amounts to 20% of the total fiscal need for UHC, if other sectors take on some of the burden, there may be enough space.
Four, the UNAIDS minimum recommended expenditure on HIV/AIDS interventions in those countries with the lowest incomes (Malawi, Burundi and the Central African Republic) is a significant proportion of GDP on its own. This accentuates the need for international financial assistance to fund health sectors in very low income countries, which have to find resources for a wide variety of health sector investments beyond HIV/AIDS responses.

3 Fiscal space

Figure 2.1 plots THE, government expenditure on health, external resources for health, out of pocket expenditure on health (OOP) and private expenditure on health (non OOP) per capita, aggregated across the 49 countries used in the MBB and WHO norm. This is to show how much funding was available from all sources for health care between 1995 and 2012.

GDP, population, THE as a % of GDP, external resources as a % of THE, general government expenditure on health (GGEH) as a % of THE, private expenditure as a % of THE and out of pocket expenditure on health (OOP) as a % of THE are all taken from the World Health Organisation’s Global Health Expenditure database. These are combined to calculate THE, external resources for health (donor), GGEH, OOP and private non-OOP expenditure per capita. External resources for health have then been subtracted from GGEH to calculate government expenditure on health, and OOP have be subtracted from private expenditure to calculate private non-OOP expenditure on health (insurance payments). This is to avoid double counting.

After doing this, the sum of government expenditure on health, external resources for health, OOP and private non-OOP is approximately equal to THE estimates. They are not exactly equal for a number of reasons. Not all external resources for health are directed through the public health system, for example, so actually it should be partly subtracted from GGEH and partly subtracted from private expenditure on health. However, as such a small proportion does not go through the public health system it is considered negligible.

All estimates are expressed in current US$ and per capita. Inflation is addressed in sections 3 and 4, where fiscal space is compared to fiscal need. Nonetheless, it is important to be aware that changes discussed are nominal rather than real.

According to WHO national health accounts estimates, nominal THE aggregated across the 49 low income countries overall remained constant between 1995 and 2001. Since 2001 it has grown consistently, at rates between 2-26% annually. It grew from $16 in 1995 to $53 in 2012.

Government expenditure on health fell significantly in the run up to the millennium, but, other than in 2008, grew each year between 2002 and 2012 at between 6-33%. Overall per capita government expenditure on health aggregated across the 49 countries grew from $5 in 1995 to $14 in 2012.

OOP expenditure also fell in the run up to the millennium but grew significantly since, particularly up to 2008. Between 2002 and

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7 The 49 countries are grouped into one unit, so all absolute numbers are summed. For example, 5% of GDP per capita is 5% of the sum of all GDPs divided by the sum of all populations.

8 Accessible at http://apps.who.int/nha/database/Select/Indicators/en
2006 OOP grew at between 12-32% annually, but slowed to 1-9% in the run up to 2012. This resulted in an overall growth from $10 per capita in 1995 to $27 per capita in 2012.

Other than between 1998 and 2000, external resources for health (donor funding) grew each year between 1995 and 2012. 1997 saw the largest growth (87%), which was followed by a decline in the three consecutive years. The largest sustained growth was between 2002 and 2008, when growth ranged between 11% and 31%. External resources for health grew from $0.60 per capita in 1995 to $7 per capita in 2012.

Private non-OOP (private insurance plans etc.) have grown each year other than 1998. In particular, between 2003 and 2007 growth ranged between 14% and 24%. Overall, this was a growth from $0.90 per capita in 1995 to just under $5 per capita in 2012.

As a proportion of THE, OOP was always the most significant contributor, however its share decreased from 61% to 51%. Government expenditure on health as a % of total expenditure on health also fell, from 30% to 26%. The proportion of funds sourced from external resources and private non-OOP grew from around 5% each to 9% from private non-OOP and 13% from external resources.
4 Fiscal needs versus Fiscal space

4.1 Was there fiscal space for an integrated UHC and HIV/AIDS response between 1995 and 2012?

Figure 3.1 is the same as figure 2.1, but also shows 5% of GDP per capita and the WHO norm estimate of the cost of basic health care. As described in section 1 and annex B, this is inflated and deflated from 2005$ using the IMF emerging market and developing economy inflation rates.

There are three key points to make from this graph regarding whether there was fiscal space for UHC and HIV/AIDS between 1995 and 2012.

First, government expenditure on health in the 49 countries was not close to 5% of GDP. Over the period it grew from around 1% to around 2% - highlighting that the countries were not close to achieving even the lower limit of McIntyre and Meheus’ target.

Second, THE was close to 5% of GDP, and slightly larger since 2003. Arguably, this suggests a revealed demand for health care of between 5% and 6% of GDP (the social demand for health care, across all sources of funding). Similar analysis has suggested that the global revealed demand for health care is about 7.2% of GDP, with an elasticity of about 1.05 (OPM, 2015). This suggests that THE increases slightly faster than GDP, such that it represents an increasing proportion of GDP as countries get richer. As well as because of a positive income elasticity of demand for health care, it may be reasonable to suggest that revealed demand for health care as a % of GDP is lower in lower income countries because the quality of services on offer is lower.

This also highlights that the challenge of spending 5% of GDP on public health care (the first part of McIntyre and Meheus’s double target) may not be so much an issue of how to spend 5% of GDP on health (it is already being spent on health) – but an issue of how to coordinate that expenditure (how to turn the out of pocket payments into insurance prepayments and public contributions) to protect people against impoverishing and catastrophic health care bills and redistribute between different groups. However, it is also important to note that THE per capita includes a significant amount of expenditure that is not targeting UHC or HIV/AIDS responses. Even with the provision of UHC, private individuals may still choose to spend significant amounts for better quality health services for themselves and their families. If UHC is estimated to cost 5% of GDP, then THE is expected to be greater than 5% of GDP. So, THE must be larger than fiscal need for an integrated UHC and HIV/AIDS financing system – as THE covers more than basic UHC provision. This is particularly true when a large portion of THE is from OOP. A key component of UHC is financial protection, and expenditure through OOP does not provide financial protection, nor is it spent on cost-effective services alone.

Third, and perhaps most importantly, health expenditure has not grown as much as prices have since 1995. If health sector costs have grown at similar rates to prices in the rest of the economy (as this report assumes they do, for lack of health sector specific inflation rates), then the cost of a basic package of care for UHC or HIV/AIDS will have grown faster than health expenditure. Adjusting for inflation to express expenditure in real terms then reveals that, if health sector costs have inflated at comparable rates to prices in the rest of the economy, the purchasing power of total expenditure on health actually decreased between 1995 and 2012.
Overall, it is clear that, since 1997, neither 5% of GDP nor government plus donor expenditure on health aggregated across the 49 countries have been enough to afford a basic package of care. Even THE was too small to cover the cost of McIntyre and Meheus’ recommendation. Between 1995 and 2012 the gap between THE per capita and WHO norm recommended expenditure per capita (once inflated and deflated to the relevant years) grew from $3 to $30. As a proportion of total resource needs, THE was at its lowest compared to resource needs at 33% in 2003. It then rose again to 68% - but this still left a 32% shortfall, in total representing $44 billion across the 49 countries in 2012 alone (2012$).

When we focus on government expenditure plus external resources for health (more appropriate for UHC as it also offers financial protection), the resource gap grew from $13 per capita in 1995 to $63 in 2012. They represented their highest proportion of total needs in 1995 (30%), but fell in the following years, troughing in 2002 at only 11%, and since rising again, meeting 25% of total resource needs in 2012. In total this represented a resource gap of $94 billion in 2012 (2012$).

In summary, government plus donor expenditure on health in the 49 countries between 1995 and 2012 was not nearly enough to afford a basic package of care for UHC or, by extension, a basic package of UHC with space for an adequate HIV/AIDS response interventions within it. Even THE was not enough to cover the cost of UHC, and this is without the provision of financial protection. THE, government expenditure and external resources for health have all grown since 1995, but have grown slower than the cost of care is estimated to have grown. As such, the absolute resource gap actually grew year on year up to 2012, and UHC with adequate HIV/AIDS response interventions became less and less affordable towards the end of the period.
5 How was health expenditure per capita related to GDP per capita between 1995 and 2012?

Using the same dataset that was used in sections 2 and 3, this section uses scatter plots of THE, government expenditure on health, external resources for health, OOP and private non-OOP per capita against GDP per capita for the 49 low income countries used in the MBB and WHO norm costings between 1995 and 2012. Unlike sections 2 and 3, however, in section 4 data is not aggregated across countries. This means that there is one line of data for each country and each year. A second dataset (from the same database) is used to produce the same scatter plots for all countries globally (used for comparison). Power regression lines of best fit (LBF) are then calculated for each set (global and the 49 low income countries). The LBF are calculated with the equation

\[ y=ax^b \]

Where \( b \) is the elasticity of either the THE or the individual financing source per capita with respect to GDP per capita. Missing or zero values were excluded from the dataset. This has particular implications for the private non-OOP and external resources scatter plots.

5.1.1 Government expenditure on health

For the 49 LIC countries referred to throughout this report the LBF (power) is estimated as:

\[ y=0.0007(x)^{1.4485}, \text{ with } R^2=0.541 \]

The low \( R^2 \) highlights that this LBF does not capture a strong relationship. The higher \( R^2 \) found for the LBF through the global dataset (0.8993) highlights that GDP per capita may be a poorer predictor of government expenditure on health per capita at lower income levels than higher ones. It is clear from figure 4.1.1 that there is a lot of variation about the LBF towards the left of the line, but less as GDP rises.

With this concern in mind, the LBF suggests that, for the 49 LIC, between 1995 and 2012, government expenditure on health per capita was positively correlated with GDP per capita, with an elasticity of about 1.5, suggesting that it grew 50% faster than GDP per capita.
5.1.2 OOP

The same was done for OOP per capita (figure 4.1.2).

For the 49 LIC countries the LBF (power) is estimated as:

\[ y = 0.0755x^{0.8003}, \text{ with } R^2 = 0.3505 \]

Again, the low \( R^2 \) highlights that there are significant problems with using GDP per capita to estimate OOP per capita. Also, the higher \( R^2 \) calculated for the LBF through the global dataset (0.746) may suggest, again, that GDP per capita better explains OOP per capita as incomes rise.

With this concern in mind, the LBF for the 49 LIC suggests that OOP per capita was positively correlated with GDP per capita between 1995 and 2012, with an elasticity of 0.8. So, OOP per capita grew with GDP per capita, but only 80% as fast.
5.1.3 External resources for health

The same was done for external resources for health per capita (figure 4.1.3). Here countries receiving no external resources for health were excluded to enable the power line of best fit to be calculated. This has implications on the global dataset, changing the question to ‘of the countries that received external resources, what was the relationship with GDP?’ In other words, many high income countries with zero external resources for health are excluded.

For the 49 LIC countries the line of best fit (power) is estimated as:

\[ y = 0.0223(x)^{0.831}, \text{ with } R^2 = 0.2441 \]

Once again, the low \( R^2 \) should serve as a warning when interpreting this LBF. However, this time it may be that GDP per capita becomes worse at explaining external resources for health per capita as incomes rise. The \( R^2 \) value for the LBF through the global dataset (0.05) is lower than that for the 49 country dataset. This makes intuitive sense, as low income countries generally receive external resources for health because they are low income. As countries get richer, they may receive external resources for health for other reasons, and income becomes less of an explanatory variable.

The LBF for the 49 LIC suggests that between 1995 and 2012 external resources for health per capita were positively correlated with GDP per capita, but with an elasticity of 0.831 (they only grew 83% as fast as GDP pc).
5.1.4 Private (non-OOP)

When done for private non-OOP expenditure on health per capita, as with external resources for health, countries with no private (non-OOP) expenditure on health were excluded from the analysis to enable calculation of the power LBF (figure 4.1.4).

For the 49 LIC countries the line of best fit (power) is estimated as:

\[ y = 0.0083x^{0.8392}, \text{ with } R^2 = 0.084 \]

Again, the low \( R^2 \) value is a warning when interpreting this LBF.

Private non-OOP expenditure on health per capita was positively correlated with GDP per capita over the period, with an elasticity of 0.83. So, it grew with GDP per capita, but only 83% as fast.
5.1.5 Total health expenditure

When calculated for THE per capita (figure 4.1.5) the 49 LIC countries the line of best fit (power) is estimated as:

\[ Y = 0.0499(x)^{1.0099}, \text{ with } R^2 = 0.7539 \]

This is a much higher \( R^2 \) value than was found for any of the four financing sources. While GDP per capita may be a poor explainer or the individual financing sources, it may be a more adequate tool for explaining THE per capita.

Over the period THE per capita was positively correlated with GDP per capita, with an elasticity of 1.001. This means that it grew 0.1% faster than GDP. This is backed up by a more rigorous econometric analysis of the determinants of health expenditure, which found that income elasticity of total health expenditure in low income countries was close to one (Zu & Saksena, 2011).

That the coefficient on \( x \) is approximately 0.05, the elasticity is so close to 1 and the \( R^2 \) is relatively high suggests that THE in the 49 LIC has been close to 5% of GDP on a country specific level. This corroborates our finding that THE per capita aggregated across the 49 low income counties was consistently close to 5% of GDP over the period (as argued in section 3).
The analysis done in this section is very rudimentary, and should be updated with more sophisticated econometric methods (as done in (Zu & Saksena, 2011)). In particular, it may suffer from omitted variable bias, and that all variables are expressed per capita means that it is impossible to identify what effect should be attributed to changes in GDP and what to changes in population. Moreover, the higher $R^2$ observed for the global data sets may be a result of the larger data sets rather than improved explanatory power. As a next step more rigorous analysis should be done on this dataset to explore the causes of fluctuating fiscal space for the provision of health care. The most reliable conclusions to draw from this analysis is the correlation between the variables. In particular, the strong correlation between GDP per capita and THE per capita is noteworthy.

6 Assuming business as usual alongside the IMF GDP and population projections, what THE per capita do we expect by 2019?

As part of the World Economic Outlook produced by the IMF, projections up to 2019 are published for population and GDP. This section assumes these projections, and, based on the LBFs outlined in section 4, explores what may happen if THE per capita and each of the four financing sources continue to move with GDP per capita as they did between 1995 and 2012.

As highlighted throughout section 4, GDP per capita has a low $R^2$ when used to explain any of the four general health financing sources (government, external resources, OOP and private non-OOP) in the 49 LIC referred to in this report. However, when used to explain THE per capita it has a much higher $R^2$ value.

The LBF for the relationship between THE per capita and GDP per capita between 1995 and 2012 is used to estimate THE per capita between 2013 and 2019, based on GDP and population projections published by the IMF (figure 5.1).

The LBF for each of the financing sources between 1995 and 2012 are also used to estimate their growth between 2013 and 2019, and make some comment on expected financing source break down into the near future. However, the uncertainty that arises due to the variability in each of the correlations (clear from the low $R^2$ values) demands significant caution when using these particular findings. Further, more rigorous econometric analysis should be done to explore these questions.

If THE per capita continues to grow with GDP per capita as it did between 1995 and 2012, then, assuming the IMF projected GDP and populations estimates, it may grow from around $53 in 2012 to around $87 in 2019. Extrapolations on the four financing sources suggest that government expenditure on health per capita may grow to around $28, OOP per capita may grow to around $31, external resources for health per capita may grow to around $10 and private (non-OOP) may grow to around $4. This does not sum to $87, which may be due to the poor explanatory relationships between GDP per capita and the four financing sources per capita (figure 5.1).
While the regressions project a bump in 2013 due to the projected bump in GDP (it is not yet clear whether this materialised), this analysis suggests that the resource gap will continue to grow, basically because we expect the cost of a basic package of care to rise faster than we expect expenditure on health to grow. By 2019 we expect the resource gap between THE and the WHO norm to have reached $55 billion across the 49 countries (or $34 per capita). As a proportion of total resource needs, this does suggest that the gap is shrinking (from 35% in 2013 to 33% in 2019), but this may only the result of both fiscal space and fiscal needs being expected to grow faster than the gap between them. In total, present value of the resource gap between THE and fiscal needs between 2015 and 2019 is estimated to be $240 billion (2015$).

As already mentioned, THE per capita includes expenditure not necessarily targeting UHC or HIV/AIDS response interventions and does not capture the financial protection necessary for the provision of UHC. For this reason the combination of government and donor resources is a more realistic estimate of the relevant fiscal space. If we focus on government expenditure and external resources, the gaps are much larger. By 2019 we expect the resource gap between the WHO norm and government plus donor expenditure to have reached $132 billion across the 49 countries ($83 per capita). This means that fiscal space is only 32% of fiscal need (when private expenditure is excluded). In total, the present value of the resource gap between non-private fiscal space and fiscal needs for UHC between 2015 and 2019 is estimated to be $550 billion (2015$).
However, as mentioned in section 1, the CMH, MBB and WHO norm estimated costs of HIV/AIDS responses are larger than those estimated by UNAIDS. Comparing UNAIDS estimated fiscal need to our estimates of fiscal space up to 2019 highlights that, if realistic, there may be space on an aggregate level across the 49 low income countries (figure 5.2). CMH, WHO norm and MBB each allocated between 12% and 18% of the total cost of UHC to HIV/AIDS response interventions. When aggregated across the 44 countries, UNAIDS estimated fiscal need for HIV interventions grows from $4.40 to $5.70 per capita. As a share of total projected fiscal space, this is an increase from 14% of estimated fiscal space in 2015 to 15% of estimated fiscal space in 2019 (fiscal space estimated as government plus donor expenditure on health, not THE). Spending around 15% of the budget for UHC on HIV/AIDS is consistent with the CMH, MBB and WHO norm costings, and so the UNAIDS estimated recommended expenditure on health may be feasible.

While UHC as costed by the MBB, WHO norm or CMH may not be affordable given the resources available, a revised benefits package including the UNAIDS recommended response interventions may be affordable (at the aggregate level). Further work needs to be done to assess this on a country specific basis, as highlighted in section 1, fiscal need for HIV/AIDS responses are highly variable across countries, and it may be that it is still not affordable in countries with high prevalence rates and fiscal needs, such as Zambia, Solomon Islands and Zimbabwe.

**Figure 5.2** Projected health sector fiscal space and HIV/AIDS response fiscal need

- **Government (non external)** pc
- **External resources** on health pc
- **UNAIDS 2030**
In summary so far; estimated minimum costs of universal health coverage do include fiscal space for HIV/AIDS interventions in the majority of low income countries. However, if business continues as usual, low income countries will not have nearly enough fiscal space for UHC as costed by the CMH, MBB or WHO norm. However, when UNAIDS estimated fiscal needs are compared to estimated fiscal space, it may be more feasible. It may be that a revised benefits package that includes the basic package of HIV/AIDS response interventions could be affordable.

7 Discussion: considerations given limited resources

Given the exceptionally tight budget constraint for the provision of UHC as well as HIV/AIDS interventions, there are at least four issues that need to be addressed. First, for some countries with poor health outcomes, improving efficiency may be more fruitful than increasing expenditure. Second, where countries are currently borrowing below a sustainable amount, it may be appropriate to borrow to invest in health sector capital such as hospitals. This demands significant regulation and oversight, but, if well managed, given that future generations will benefit from investments in health today it may be justifiable to expect future generations to play a part in paying for that investment too. Third, where health expenditure is low, opportunity costs are high. In order to spend limited resources efficiently the benefit from expenditure should be greater than its opportunity cost. Cost-effectiveness analysis may be a useful tool for exploring this. And fourth, this paper has focused on whether there may be fiscal space for integrated financing of UHC and HIV/AIDS interventions. But what could an integrated financing system actually look like?

7.1 Efficiency savings

In an effort to achieve better health outcomes through improved health service delivery, WHO has called for a better use of available resources and improved efficiency of health care systems (WHO, 2013). Much work has been done to estimate health system efficiency, including a recent data envelopment analysis (DEA) to estimate the relative efficiency of 173 country health sectors between 2004 and 2011 (Zeng, 2014). This particular study both evaluated the relative efficiency of each country’s health sector over an eight year period using direct input and output information and attempted to construct a regression model to highlight the driving forces behind health sector efficiency. Health expenditure per capita was the only input considered. Infant mortality, under five mortality and life expectancy were used as outputs. The regression model included economic and demographic characteristics, health financing mechanisms and governance as potential determinants of technical efficiency.

From the DEA two sets of scores were generated for each country. The first is a comparison of each country’s efficiency against all other countries in a given year (comparison across eight different efficiency frontiers). The second pools the data from each country and each year. In this model a country’s efficiency in a given year is assessed relative to each country in each of the eight years (one efficiency frontier for all eight years’ worth of data).
Zeng’s analysis includes data from 42 of the 49 low income countries referred to throughout this report. The scores illustrated in figure 6.1.1 are the relative efficiency of the health sectors in 2011 compared to all sampled health sectors for each year between 2004 and 2011. The large variation in relative efficiencies is clear. Sierra Leone had the least efficient health sector, and was less than 20% as efficient as Bangladesh which, in 2011, was the most efficient sector when compared to all 173 countries in all eight years (figure 6.1.1).

The analysis highlights how countries that spend similar amounts of money on health sectors can experience very different population health status. In 2011 Sierra Leone is estimated to have spent $161 per capita (international $) on health, and experienced an infant mortality rate of 120/1000 live births, a child mortality rate of 187/1000 live births and a life expectancy at birth of 45. Meanwhile, Bangladesh is estimated to have spent $64 per capita (international $) on health, but experienced an infant mortality rate of 35/1000 live births, a child mortality rate of 44/1000 live births and a life expectancy at birth of 70. For countries with low efficiency and low health expenditure, strengthening the efficiency of the health sector becomes a critical focus.
care system may be more important than just increasing health care funding.

A note of caution regarding this analysis; Sierra Leone and Bangladesh are very different places. If finances are converted into health outputs at different rates between the two, it is not necessarily all about different levels of efficiency. One country may have different needs and constraints, have a different history of health expenditure, or many other factors affecting the rate at which expenditure is converted into health. For this reason comparison between countries should be treated as indicative only, and comparisons of one country’s performance over time may be more revealing.

This leads to a positive note. On the whole, the efficiency of health sectors in the 42 countries improved over the eight years (figure 6.1.2). Only six countries were less efficient in 2011 than 2004 when compared to the complete set of 173 countries over all eight years, and each of these (except the Democratic Republic of the Congo) was in general a high performer in terms of efficiency. Countries such as Zambia, The Central African Republic and Malawi all saw large improvements in the efficiency of their health sectors over the period.
Zeng goes on to use a regression model to explore the causes of improved efficiency. He finds that, as economic status improved, the efficiency of the health system improved until gross national income per capita reached $10,000 (2012 international $), after which point efficiency declined as economic status grew. Urbanisation was also found to positively contribute to health system efficiency, as was a higher share of THE spent through social security mechanisms and a stronger rule of law. Higher HIV prevalence was a burden on efficiency, as was, surprisingly, government health expenditure as a % total government expenditure.

The reason Zeng’s analysis is important and relevant to the discussion of this report is that achieving improved health outcomes is not just about increasing fiscal space to meet fiscal need. While there may not currently be enough finances for an integrated health financing system, if the efficiency of health sectors is improved, as is clearly possible, then the feasibility of an integrated health financing system also increases.

7.2 Borrowing

It may also be possible for countries to borrow to invest in health. Increases in productivity due to improved health may cover the cost of borrowing, and, as future generations will garner some of the benefits, maybe they should also pay some of the costs?

It is important to be aware that borrowing does not increase fiscal space overall. It increases fiscal space in the present at the expense of constraining fiscal space in the future. For this reason it is important that strict borrowing guidelines are followed. While it may be a sensible scheme for financing projects such as hospital construction, it is more difficult to justify for payroll increases or expansions in a benefits package. When borrowing to invest in the health sector, governments should prioritise capital (such as building and equipping facilities) rather than recurrent expenditures (such as paying drug and wage bills). Funding recurrent expenditure through borrowing risks generating unsustainable liabilities for the government.

There are a number of situations where borrowing has been suggested as a sensible policy. One may be to accommodate a shock to government revenue or a spike in expenditure. This might include an armed conflict, a natural disaster or a disease outbreak. It may also occur due to planned development such as the construction of a large hospital. A second instance where borrowing may be considered sensible is where the benefits of public spending occur over long periods of time, spread into future generations. Financing such projects through acquiring debt is a means of collecting contributions from future beneficiaries. Third, some projects generate a high rate of return. It may be that an initial investment generates enough extra fiscal space to repay the loan and more (Haaker, 2014).

Investments in a health sector can easily fall into any one or all three of these categories. Armed conflicts, natural disasters and disease outbreaks all wreak huge destruction on a health sector, and demand significant investment throughout the rebuilding process. Investing in health today improves the health of future generations through numerous mechanisms, and health interventions that enable people to stay in work or raise healthy children may increase government revenue through tax collections.
The IMF recommends that a medium strength policy of 40% debt/GDP may be sustainable (individual rates are calculated for specific countries, which should overrule the 40% estimate). Beyond a debt sustainability threshold, a country’s debt is seen as unsustainable in the long term by the IMF. Other authors will contest this benchmark and suggest higher levels of debt can be sustained. For the sake of this analysis, we err on the side of prudence, and apply the IMF benchmark. If a country is currently borrowing less than its debt sustainability threshold, however, it may be considered to have capacity to safely borrow.

The IMF’s World Economic Outlook includes projected estimates of general government net debt as a % of GDP in 2015 for 16 of the 49 WB LICs. Assuming the 40% rule of thumb, ten of these countries have space to borrow. The remaining six are already borrowing beyond what is considered sustainable for the economy (figure 6.2.1).

Depending on their sustainable debt/GDP ratios, it may be feasible for any of the countries with currently low levels of borrow expand their fiscal space in the present to fund investments through borrowing. It needs to be cautioned, however, that the debt sustainability thresholds vary. In Niger, for example, it may be lower because they have recently had a large portion of their debt forgiven and may not be considered able to take more debt on at the moment (IMF, 2013). It should also be stressed that borrowing can only offer one off injections of finance, as borrowing simultaneously closes the window until it is paid back.
In the case of HIV/AIDS specifically, the argument for covering a surprise spike in expenditure (such as a natural disaster or armed conflict) is unlikely to hold. HIV/AIDS interventions demand long term spending plans that cover decades. However, more ambitious HIV/AIDS programmes do plan for high expenditure early on with decreasing annual expenditure reflecting smaller demand for expensive treatment in the future (off the back of successful prevention strategies). In this sense HIV/AIDS interventions can also be considered cost saving. Assuming that people living with HIV/AIDS receive treatment, investing in HIV/AIDS prevention strategies cause the reduced future expenditure. This reduced expenditure on HIV/AIDS treatment can be used for loan repayment. Third, HIV/AIDS prevention strategies today decrease future the generation’s risk of contracting HIV, thereby benefiting future generations. In these three ways, investment in HIV/AIDS interventions may be considered just cause for borrowing (Haaker, 2014). However, as repeated throughout this report, these decisions must be considered in a country specific context, as the settings vary significantly and impact on the functionality of HIV/AIDS responses.

Finally, borrowing carries significant risks. When money is borrowed on the back of future generations there is a moral hazard cost, where those taking the loan do not bear the full cost of their actions and so may not make the most efficient social decisions. In countries where there are low levels of accountability, both between politicians and citizens and between generations, there is a risk that over borrowing will cripple a country. So, while future generations may benefit from investments in health or HIV/AIDS now, they may also suffer from poor debt management now. The risk of the second needs to be compared to the benefit of the former.

7.3 Resource allocation

Given these tight fiscal constraints, an integrated UHC and HIV/AIDS financing system needs a transparent methodology for allocating resources between interventions. This is true especially when there is not enough money, as low expenditure in a health sector means that opportunity costs are high. Moreover, even if HIV/AIDS and health financing are not integrated in the near future, it is necessary to start conceptualising how they could be. Cost-effectiveness analysis (CEA) of different interventions may be a useful tool for analysing the benefits and opportunity costs of interventions in low income countries.

The World Bank Disease Control Priorities report summarises evidence on the cost effectiveness of health sector interventions in low income countries. Figure 6.3.1 ranks 111 different interventions according to their cost/daly in US$ (OPM analysis of 2001$ estimates from (Jamison, et al., 2006)). These have been inflated to 2015 $ according to the emerging market and developing economy inflation rate (annex C is a list of these interventions).

The orange dots are HIV/AIDS prevention interventions and the grey dots are HIV/AIDS treatment interventions. The dark blue dots represent a selection on 111 general health interventions for which CEA has been done in low income countries. In addition to the HIV/AIDS prevention and treatment interventions, they include TB, malaria, nutrition/stunting/wasting, diarrheal disease and vaccine preventable disease care as well as maternal and new born care. These are all key areas of any integrated health system, and central to the MBB, WHO normative and CMH costed benefits packages. We have no comparable CEA data for non-health sector HIV interventions.
Figure 6.3.1 illustrates two key points for this report. First, HIV/AIDS prevention interventions have a wide range of cost effectiveness ratios, spread evenly throughout from cheap to expensive. The less efficient prevention interventions were either in the Americas, or in places with low disease burden. More efficient results included peer to peer programmes, or programmes in areas with high prevalence.

Second, HIV/AIDS treatments also have a wide range of cost effectiveness ratios, however they are bunched slightly more towards the less efficient side. Part of the reason prevention strategies are often so cost effective is because they decrease the need to spend on expensive HIV/AIDS treatment. CEA of HIV prevention strategies should be sure to capture this as a benefit, otherwise the cost-effectiveness will be underestimated.

This sort of analysis can be a starting point for allocating resources between HIV/AIDS interventions and other interventions in an integrated health financing system given limited resources. Given a budget, a health sector can provide interventions to populations in need, working from left to right across the interventions. When its budget constraint is reached, the health sector does not provide the next intervention. In this way...
an integrated benefits package is defined, and the highest health output possible is achieved given the limited resources.

This cannot be taken as the complete picture however, as the quality of economic evaluation and cost effectiveness analysis in low income countries is not yet of an adequately high standard. Some costs and benefits of interventions may not be included in CEA, and in general methodologies have so far been inconsistent, so comparability of results is an issue (NICE International, 2014). However, it may be a start, from which objections and responses can be made, and deviations in policy made where it is considered appropriate. Highlighting where problems exist in existing economic evaluations and CEA should direct future research. Another drawback is that CEA analysis accepts optimisation under budget constraint, which sits at odds with an approach which suggests that populations have the right to health care irrespective of their capacity to fund this right. A rights-based approach would focus on the need for increased international development assistance instead.

7.4 Further challenges for the integration of HIV/AIDS and UHC health financing?

In Kenya one of the long term options considered for the financing of HIV/AIDS response interventions is through an increased role for the National Health Insurance Fund. This is partly seen as a solution to how to integrate HIV/AIDS services, but also a necessary challenge to overcome if the fund is to be successful. HIV/AIDS is already accounting for a large proportion of the costs of the Kenyan public health service, and the Health Sector Strategic and Investment plan predicted that it would take 20% of disease specific expenditure between 2012 and 2017. If an insurance fund is going to give people access to care, it needs to raise the revenue to finance at least part of the cost of HIV/AIDS treatments (Haaker & Birungi, 2015). Two initial options for this are a pay-as-you-go insurance model (where current contributions cover the costs of current treatment) or a capitalised insurance model (where current contributions cover the risk of contracted HIV in future years). A challenge with the capitalised model is that it does not cover the lifetime cost of treatment for people already living with HIV. In Kenya this is estimated to be around $16 billion, or 32% of annual GDP. This is a huge liability for an insurance scheme to take on from the start. Given this, a gradual transition to a funded insurance model has been suggested, with possible policy options including a bond (enabling government to spread the upfront cost over some time), or a trust fund. However it is not clear that either of these solve the timing problem – insurance models take time to raise revenue, but people already infected with HIV need significant health expenditure for treatment now.

There are a number of further issues that make the integration of HIV and UHC financing complicated beyond the lacking fiscal space. Another issue reflecting timing is that AIDS is a chronic, communicable disease. Diseases are commonly categorised into short term communicable on the one hand, and chronic non-communicable on the other hand. From a financial perspective, this means that treatment costs are lifelong. While ART has significantly dropped in price, it also produces serious illness episodes, transaction and opportunity costs related to lifelong treatment and the need for continued investment in treatment programmes – it thus demands significant long term planning. A third challenge is that HIV/AIDS intervention packages

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9 Discussion note, provided through internal communications with UNAIDS.
commonly include both private and public goods. Private health care goods (such as treatment) and generally considered well aligned with insurance based financing schemes. However, public goods (such as awareness raising, HIV testing and condom distribution) are less easy to fund through voluntary insurance premiums, and demand governments to be able to effectively raise tax revenue in order to be funded. Fourth, there are large data constraints. Several of the variables that influence costing estimates (such as those used throughout this report) are very hard to measure. Examples include the strength of a health system, intellectual property regulations, epidemiological profiles and differing capacities to produce drugs locally. For many countries, such data is not routinely collected, and requires a focused effort to collect it. Some countries have attempted to do this on an individual level as part of planning for the development of health insurance schemes (including South Africa, Ghana, Rwanda and Lesotho). The common message is that any country looking to integrate HIV financing into an insurance scheme needs to perform its own fresh calculations rather than base them on already existing databased estimates, and this likely goes for any analysis on such integration (UNAIDS-World Bank, 2014).

However, some countries have made significant progress towards integration. Brazil, Colombia, Thailand, Mexico and Chile have all integrated HIV and UHC financing at the collection, pooling and purchasing stages of their health financing systems. Rwanda and Ghana, both part of the 49 countries looked at in this report have began the process of integration at the pooling and purchasing stages. However, neither has made significant progress in integrating the collection of revenue, which is more relevant to the question of this report (UNAIDS-World Bank, 2014).

8 Conclusion

This report has questioned to what extent there is fiscal space for an integrated financing system funding universal health coverage with HIV/AIDS interventions within it in low income countries. It has done so by comparing McIntyre and Meheus’ recent minimum expenditure on UHC target to UNAIDS estimated cost of HIV/AIDS interventions in 49 low income countries up to 2019, and then again to WHO estimated expenditure on health between 1995 and 2012.

There are two main findings. First, McIntyre and Meheus’ recommended minimum expenditure on the provision of UHC includes more than enough space for UNAIDS recommended expenditure on HIV/AIDS interventions in the majority of the 49 low income countries. However, in some countries this is not the case. Some countries have particularly high fiscal needs for HIV/AIDS interventions, such as Zimbabwe, and in these cases McIntyre and Meheus’ recommendation does not provide enough space.

Second, given expenditure to date in the selected 49 low income countries, we anticipate a large resource gap between fiscal space and fiscal need for the provision of UHC with integrated HIV/AIDS interventions. We predict that the available resources will fall short of McIntyre and Meheus’ recommendation by $550 billion (2015$) between 2015 and 2019. This is a resource gap of around 70% of fiscal need. It is clear that without additional donor support countries will have to focus on reduced benefit packages.
Nonetheless, UNAIDS’ estimates of fiscal may be more affordable. There may be space at the aggregate level for these interventions. The CMH, WHO norm and MBB each allocated between 12% and 18% of the total cost of UHC to HIV/AIDS response interventions. UNAIDS estimated fiscal need for HIV/AIDS interventions is between 14% and 15% of estimated government plus donor expenditure on health between 2015 and 2019.

Further work needs to be done to assess this on a country specific basis. As highlighted throughout this report, generalised estimates should not be used to inform local policy decisions without first being assessed for their applicability at the local level. Fiscal need for both UHC and HIV/AIDS responses are highly variable across countries, and it may be that the UNAIDS package is still not affordable in countries with high HIV/AIDS prevalence rates and large UHC fiscal needs, such as Zimbabwe. In these cases an integrated benefits package may include some but not all health and HIV/AIDS interventions desirable from a rights based perspective (assuming additional finances are not made available).

Given this limiting budget constraint, a number of issues need to be addressed: the role of efficiency savings, the role of borrowing and the importance of understanding opportunity costs in low expenditure health sectors.

Efficiency savings provide an important opportunity to increase fiscal space for health. Recent analysis of the efficiency of 176 health sectors throughout the world between 2004 and 2011 highlights that there is large variation in the rate at which expenditure on health is converted into infant and child mortality and life expectancy, even within the 49 low income countries referred to throughout this report. Bangladesh and Sierra Leone are at either sides of range, with Bangladesh converting health expenditure into health at one of the highest rates in the world, and Sierra Leone at one of the lowest. Ultimately, this highlights that for countries with low health expenditure and low health outcomes, an increase in efficiency may be more important than an increase in fiscal space. This relates to the question of this report because countries may be able to meet fiscal need by improving efficiency and decreasing fiscal need rather than just increasing fiscal space. If countries are able to do this an integrated financing system for UHC and HIV/AIDS may be more feasible.

Second, while borrowing does not increase overall fiscal space, it can increase present fiscal space at the expense of future fiscal space. This may be appropriate in health sectors under a number of circumstances. Where countries are struggling to meet fiscal need because of a spike in expenditure or slump in revenue that is expected to return to some medium level, it may be appropriate to borrow as a form of health expenditure smoothing. This may be the case after an armed conflict, a disease outbreak or a natural disaster, for example. Alternatively, where programmes have high initial costs that decrease into the future, expenditure smoothing may also be deemed appropriate. Both of these scenarios often apply to health sectors, and the second particularly applies to HIV/AIDS interventions. It is also possible that investments in health and HIV/AIDS interventions are actually cost saving. Investment in primary care may decrease the need for more expensive secondary care, and investment in HIV prevention may decrease the need for more expensive treatment. These cost savings may more
than pay back any loan that was used to finance the investment. Finally, where future generations are the beneficiaries of health interventions, as they can be in both general health and HIV/AIDS interventions, borrowing is a strategy for collecting resources from them. This is relevant for the question of this report, because, some countries may struggle to generate adequate fiscal space within some of these contexts. Specifically, in the long run they may have the fiscal space, but struggle in the present.

Third, where expenditure on health is low, the opportunity cost of expenditure on health is high. In order to allocate finances in such a way that maximises health output governments and donors should focus their expenditure on interventions for which the opportunity cost is lower than the benefit. Cost-effectiveness analysis may be a useful tool for understanding the opportunity costs and benefits of interventions in low income countries. In its current state, CEA of health interventions in low income countries is inadequate. Methodologies used in different reports by different authors and different settings are often of a low standard and inconsistent. This means that comparison of benefits and opportunity costs are difficult, and often easily dismissed as invalid. Nonetheless, with further research of a higher and more consistent standard, CEA can offer information to guide resource allocation within an integrated UHC and HIV/AIDS health financing system. Form analysis already conducted, the cost-effectiveness of HIV/AIDS interventions varies from highly cost-effective to least cost-effective, in a similar fashion as general health interventions. This suggests that if choices of benefit package under resource constrained settings have to be made using CEA, benefit packages for UHC will comprise a significant proportion of HIV/AIDS services.

Finally, it is important to note that there are many challenges for the integration of HIV/AIDS care and UHC beyond lacking fiscal space. However, some middle income countries have made significant progress at integrating each component of their health financing systems and Ghana and Rwanda, both part of the group of countries looked at in this report, have started integration at the pooling and purchasing stage.

Necessary next steps include more rigorous regression analysis of past health expenditure data alongside a variety of explanatory variables. The methods used in this report are basic, and may suffer from omitted variable bias. Moreover, as explanatory and dependent variables are expressed per capita, it is not absolutely clear whether the change in dependent variables is due to a change in population or a change in the explanatory variables. It is also clear that GDP per capita is a poor explanatory variable for donor expenditure on health, government expenditure on health, OOP expenditure on health or other private expenditure on health. It does have a strong correlation with total expenditure on health, but this is less useful for estimating future fiscal space for UHC and HIV/AIDS interventions, as it includes much expenditure on non-basic health care. It is also necessary for the analysis done in this report to be done on a country specific basis before it is used to inform country specific policy. What is clear from the aggregate level, however, is that there has not been, and likely will not be into the near future, enough resources available for adequate provision of UHC with integrated HIV/AIDS interventions in the selected 49 countries. In order to close this gap, domestic governments will need to increase expenditure on health, but the international community will also need to increase its financing role.
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9 Annexes

9.1 Annex A: 49 low income countries

### 49 COUNTRIES USED IN MBB AND WHO NORMATIVE

<table>
<thead>
<tr>
<th>WEST AND CENTRAL AFRICA</th>
<th>EAST AND SOUTH AFRICA</th>
<th>SOUTH ASIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Burundi</td>
<td>Afghanistan</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Comoros</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>CAR</td>
<td>Eritrea</td>
<td>Nepal</td>
</tr>
<tr>
<td>Chad</td>
<td>Ethiopia</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Cote D’Ivoire</td>
<td>Kenya</td>
<td>CENTRAL ASIA</td>
</tr>
<tr>
<td>DR Congo</td>
<td>Madagascar</td>
<td>Kyrgyz Republic</td>
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<tr>
<td>Gambia</td>
<td>Malawi</td>
<td>Tajikistan</td>
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<tr>
<td>Ghana</td>
<td>Mozambique</td>
<td>Uzbekistan</td>
</tr>
<tr>
<td>Guinea</td>
<td>Rwanda</td>
<td></td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Somalia</td>
<td>EASTERN ASIA AND THE PACIFIC</td>
</tr>
<tr>
<td>Liberia</td>
<td>Tanzania</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>Uganda</td>
<td>Cambodia</td>
</tr>
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<td>Mauritania</td>
<td>Zambia</td>
<td>Lao PDR</td>
</tr>
<tr>
<td>Niger</td>
<td>Zimbabwe</td>
<td>Myanmar</td>
</tr>
<tr>
<td>Nigeria</td>
<td></td>
<td>North Korea</td>
</tr>
<tr>
<td>Soa Tome and Principe</td>
<td>MIDDLE EAST AND NORTH AFRICA</td>
<td>Papua New Guinea</td>
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<td>Senegal</td>
<td>Yemen</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td></td>
<td>Vietnam</td>
</tr>
<tr>
<td>Togo</td>
<td>LATIN AMERICA</td>
<td>Haití</td>
</tr>
</tbody>
</table>
9.2 Annex B: Inflating the cost of a basic package of healthcare

The CMH, WHO normative and MBB recommendations are all expressed in absolute costs. But, as prices are expected to change over time due to inflation, these recommendations should also be expected to change.

How should we incorporate this into the minimum expenditure recommendation?

Using $ inflation rates may underestimate a rise in domestic prices, but using local inflation rates may overestimate a rise in the cost of inputs paid for with US$, GBP or Euros. Domestic inflation will have a depreciating effect on domestic currencies, other variables such as increasing exports or foreign direct investment may have offset these. On the other hand, if we inflate the figures with domestic inflation rates we will not take into account the depreciation in the exchange rate due to the inflation, and so, as we are reporting in US$, we will overestimate the rise in prices.

McIntyre and Meheus negotiate this problem by converting the recommendations into all the domestic currencies at 2002 or 2005 exchange rates, inflating all estimates individually at domestic inflation rates until the current year, converting them back into US$ at current exchange rates and finally taking the average of all. They estimate then estimate cost of the packages in 2012$. The CMH package in 2015 is inflated to $71 per capita and the WHO normative is inflated to $76 per capita.

However, this method has two problems. First, not all medical goods and services are bought in domestic currencies – many are paid for in US dollars, GBPs and Euros. As inflation rates for these countries are generally lower, this method will overestimate the rise in prices. Second, we are left with an average value that is not directly applicable to any one of the countries.

In addition, as prices may change at different rates over time, this needs to be calculated on an annual basis in order to be usable. Doing this on an annual basis may be unfeasible, but without doing it on annual basis we cannot estimate minimum expenditure recommendations into the future.

As McIntyre and Meheus point out, the results are similar to those got from inflating at average low income inflation rates. Using the IMF emerging market and developing economy inflation rate as a proxy may be a feasible solution. Figure XX shows how prices are estimated to increase using the three estimates (WHO norm, MBB and CMH) and the two inflation methodologies (that applied by McIntyre and Meheus compared to using emerging market and developing economy inflation as a proxy). Rather than the $71 and $76 estimate reached by McIntyre and Meheus in 2012$, the emerging market and developing country inflation rate estimates $72 and $75. The two methodologies seem particularly close when inflating the WHO norm over the period 2002-2019, and both estimate that the basic package will cost $100 per capita in 2015$. The total range is between $80 and $100 per capita in 2015US$.
However, this does not have sound theoretical backing, and may just appear close because the lower emerging market inflation rates (which are not included in the costing estimates) are offsetting the higher developing economy inflation rates, coincidentally compensating for the depreciation of domestic currencies.

The issues highlighted here regarding inflating the estimated costs of basic package service provision from the years they are initially reported in to future years is a second reason why countries cannot take these estimates as generalizable targets. The methods used here are very crude, and risk either over or underestimated changes in prices depending on a country’s specific history. If a large portion of THE is on imported goods, then it is important to consider exchange rates and inflation in the countries exporting the goods. However, if a large portion of THE is on domestically produced goods, it is important to focus on domestic inflation.
### CEA of Health Sector Interventions in Low Income Countries

<table>
<thead>
<tr>
<th>Area</th>
<th>Intervention</th>
<th>$/DALY Average</th>
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</thead>
<tbody>
<tr>
<td>Diarrheal diseases</td>
<td>Breastfeeding promotion</td>
<td>2209.40</td>
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<tr>
<td>Diarrheal diseases</td>
<td>Measles immunisation</td>
<td>2330.56</td>
</tr>
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<td>Diarrheal diseases</td>
<td>Oral Rehydration Therapy (ORT)</td>
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<td>Water and sanitation in rural areas</td>
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<td>Diarrheal diseases</td>
<td>Rotavirus immunisation</td>
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<td>Diarrheal diseases</td>
<td>Cholera immunisation</td>
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<td>Water and sanitation in urban areas</td>
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<td>HIV/AIDS prevention</td>
<td>STI treatment (Kenya)</td>
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<td>Chloroquine to SP: above 47% resistance to chloroquine</td>
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<td>HIV/AIDS prevention</td>
<td>Peer based programmes (India sex workers)</td>
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<td>Condom social marketing (Chad)</td>
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<td>Peer based programmes (Cameroon)</td>
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<td>Peer based programmes (Cameroon youths)</td>
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<tr>
<td>HIV/AIDS prevention</td>
<td>Blood safety (Chad)</td>
<td>14.25</td>
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<td>HIV/AIDS prevention</td>
<td>ART to reduce MTCT (Sub Saharan Africa, Nevirapine)</td>
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<td>VCT (India)</td>
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<td>Peer based programmes (India high risk men)</td>
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<td>VCT (Kenya &amp; Tanzania)</td>
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<td>ART to reduce MTCT (Sub Saharan Africa)</td>
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<td>HIV/AIDS prevention</td>
<td>Sterile injection (Southeast Asia)</td>
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<td>Peer based programmes (US)</td>
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<td>Sterile injection (Western Pacific)</td>
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<td>SP to ACT: above 12% resistance to SP</td>
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Introduction

Normatively, the case for Universal Health Coverage (UHC) is unassailable, whether considered in terms of human rights, human decency, political responsibility, international and global security or as a means to the fulfillment of the non-health requisites of sustainability. Many countries have embraced UHC at least nominally and with varying degrees of success; and growing normative impetus has become mutually reinforcing with political expectation— for example, in Brazil, where the universal provision of health services funded through general taxation was brought about by constitutional reform.

Practical initiatives have also gained traction in recent years: the World Health Organisation (WHO) and World Bank have provided technical assistance on UHC to more than 100 countries since 2010. Now, a dedicated network of 587 international non-governmental organizations, academic institutions and advocacy groups, supported by the Rockefeller Foundation, is behind the global push for Universal Health Coverage, which has culminated in Sustainable Development Goal 3.8: ‘achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access

to safe, effective, quality, and affordable essential medicines and vaccines for all. It would appear that UHC is an idea whose moment has arrived.

This paper considers some of the key challenges and opportunities in transiting towards UHC for the global response to HIV and AIDS.

The Case for Universal Health Coverage

Global norms—human rights and gender equality not least—are facilitative, not transformative. Norms establish standards for responsive and responsible conduct; they are a means by which powerful actors can be held to account; and they can inspire and support movements to bring elements of the human condition within explicitly political and legal arenas. But in a matter as large as the human health of an entire nation, a range of complex human dynamics, embedded interests, unsupportive conditions and conflicting or competing priorities have a determining impact on both the establishment of Universal Health Coverage and on its qualities.

The principle of universal health coverage has a deeply appealing simplicity and clarity. As defined by the WHO, UHC ensures ‘...that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.’ More recently, as a step towards narrowing the concept, in December 2014 the WHO outlined in general terms its understanding of the conditions to be met for a community or country to achieve universal health coverage:

1. A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care (including services for HIV, tuberculosis, malaria, noncommunicable diseases, maternal and child health) by informing and encouraging people to stay healthy and prevent illness; detecting health conditions early; having the capacity to treat disease; and helping patients with rehabilitation.

2. Affordability: a system for financing health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways.

3. Access to essential medicines and technologies to diagnose and treat medical problems.

4. A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients’ needs based on the best available evidence.

It also requires recognition of the critical role played by all sectors which impact on human health and on the ability of citizens to access health services including transport, education and urban planning.

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The UHC fundamentals set out in the WHO definition are a vitally important ideal and a helpful organizing principle, but there is no widely agreed understanding of what the particulars of coverage and care must comprise in order for any nation’s health system to count as ‘universal’; no standard system performance or health outcome measures for an adequately functioning UHC; and not even an authoritative list of countries currently operating UHC systems. Moreover, in practice, there is nothing in the establishment of a country UHC system which in itself will prevent gaps and deficiencies opening up in one or both of comprehensiveness of coverage or the quality of care—a condition as evident in OECD countries (nearly all of which have universal or near-universal health coverage) as in developing countries. This is because the generic ‘universal health care’ can accommodate a very wide range in terms of the extent, quality and accessibility of services, the medical conditions and/or financial status which in some cases trigger entitlement, and the political, demographic socio-cultural and socio-economic factors which shape accessibility and use—as well as the means by which they are financed, including national systems supported by general or targeted taxation; partially state-subsidized systems, but with user fees at the point of use, or for some services; health insurance schemes which might entail general or case-specific public support; and private systems which have some degree of mandated, public responsibilities.

The relatively wealthy, middle-income BRICS countries (Brazil, the Russian Federation, India, China and South Africa), representing around half of the global population, are all engaged in health system reforms designed to extend, deepen, or otherwise improve health service coverage for their populations, while simultaneously working on ways to increase financial protection for those availing themselves of health services. The BRICS countries are a disparate set, but for the purposes of this discussion, all five are faced with the problem of ‘translating new wealth into better health’—and in each case, the obstacles and challenges are formidable, including regulating, coordinating or consolidating mixed private and public systems; inadequate human resources; inadequate monitoring and data gathering; shifting demographic and disease burden variables; coordinating national and district levels; unimproved social and/or social determinants of ill-health—and a host of other issues, all in addition to the perennial problems of securing and maintaining adequate funding against the pull of other demands and the related matter of managing costs.

4 However, the recently established Health for All Global Network (http://universalhealthcovereday.org) lists the ‘core tenets’ of UHC as follows: Prioritize the poorest; increase reliance on public funding; reduce, if not eliminate out-of-pocket spending; and develop the health system. See also: Thomas O’Connell, Kumanan Rasanathan and Mickey Chopra, ‘What does universal health care mean?’ The Lancet 383 (2014), pp.77-9.
6 In one Canadian study, ‘On average, 40% of people who died of HIV and AIDS-related causes during the study period had never accessed [ART] treatment. This finding is of particular concern, given that treatment is universal and provided free of charge in British Columbia.’ Ruth Joy et al, ‘Impact of Neighborhood-Level Socioeconomic Status on HIV Disease Progression in a Universal Health Care Setting,’ Journal of Acquired Immune Deficiency Syndromes, 47(4), 1 April 2008, pp. 500-505.
8 In one Canadian study, ‘On average, 40% of people who died of HIV and AIDS-related causes during the study period had never accessed [ART] treatment. This finding is of particular concern, given that treatment is universal and provided free of charge in British Columbia.’ Ruth Joy et al, ‘Impact of Neighborhood-Level Socioeconomic Status on HIV Disease Progression in a Universal Health Care Setting,’ Journal of Acquired Immune Deficiency Syndromes, 47(4), 1 April 2008, pp. 500-505.
10 Rama Banu, ‘Challenges for regulating the private health services in India for achieving universal health care,’ Indian Journal of Public Health 57.4 (2013): 208.
The now-familiar difficulties which beset all UHC systems are (or will be) amplified for low-income countries: the unresolvable tensions between extent of coverage and costs; the fact that the means of securing and maintaining adequate levels of funding must be politically sanctioned as much as medically determined; and the very considerable challenges of simultaneously universalizing and strengthening health systems which are so often weak, patchy, and poorly managed, administered and monitored. In addition, health systems in lower income countries, regardless of the degree to which they approach universality, face relatively high disease burdens driven and sustained by poverty. This gives them considerably less adaptability for dealing with health emergencies or for scaling up provision for any particular disease or condition—most recently in the case of the Ebola outbreak in West Africa and for HIV and AIDS more enduringly.

### Universal Health Coverage and the HIV and AIDS response

In outline terms, it is possible to discern how at least in theory the creation of a UHC could reduce HIV and AIDS costs, increase efficiencies, improve service delivery or coordinate the work of health professionals and civil society activists. But crossing the political threshold of UHC creation would not assure any other these things; and health services are rationed everywhere, even in the wealthiest countries. Moreover, there in nothing in the fact of a UHC which would ensure that the political and financial levels of support that AIDS has commanded over the last two decades would continue, since the popular political impetus required to establish and sustain a UHC system might well make demands that place HIV and AIDS funding on a lower footing, particularly in states where HIV prevalence rates are relatively low, but other disease burdens are pervasive. These uncertainties are magnified when set against aspirations for UHCs to be established throughout Southern Africa. In any event, in the absence of detailed, country-specific planning, the admission of circumstantial variables and a nuanced appreciation of the political and financial constraints which will inevitably inform and shape the creation of any developing world UHC, the possibilities remain largely speculative.

Undoubtedly, the HIV response would benefit from stronger health systems. Family Planning and Maternal and Child Health services have, over decades, developed solid infrastructure in sub-Saharan Africa; in some cases this has made the conception and execution of integrated HIV and AIDS services feasible. Recent work examining the impact of Performance Based Financing for Health in Rwanda and additional investment in the health system there to strengthen basic health services noted a positive contribution of these schemes to rapid scale-up of HIV services. Similarly, there are numerous examples of how fragmented and weak health systems have made the implementation of HIV programmes slow or extremely difficult, despite the availability of abundant financial resources for HIV. Such problems are not confined to ART scale-up. Health systems failures are seen as being at the root of the disappointing outcomes of tuberculosis (TB) control strategies (DOTS), Integrated Management of Childhood Illness (IMCI) and the integration of reproductive health services. To attempt to address this,
health funding in some areas has moved from disease-specific programming towards a Sector Wide Approach (SWAp); an approach explored even by a highly disease-specific funding agency, the Global Fund for AIDS, TB and Malaria.\textsuperscript{18} Indeed, the Global Fund `has encouraged countries to integrate related, synergistic services in order to maximize investments, and has opened new grant channels to specifically support these areas. The Global Fund grant portfolio currently funds both TB-HIV integration (2%) and health systems strengthening (2%).\textsuperscript{19}

Notwithstanding the above, the UNAIDS Fast Track agenda to ending AIDS as a public health concern by 2030 is not predicated on the integration of AIDS financing, management or organisation/service delivery with the national health system, nor, by extension, is it predicated on health systems strengthening. Whilst acknowledging the challenges that weak health systems can pose to progressing aspects of the HIV response (as mentioned above), the notable success in extending ART coverage over the past decade has been achieved largely in the absence of strong health systems. Indeed, the UNAIDS Fast Track agenda to meet the goal of ending AIDS is rather predicated on rapidly and intensively upscaling its vertical HIV testing and treatment delivery systems to achieve 90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment, and 90% of people on HIV treatment having a suppressed viral load so their immune system remains strong and they are no longer or much less infectious – by 2020. These targets rise to 95-95-95 by 2030.

The argument for vertical programming persists because in most low- and lower-middle income countries, national health systems remain far too weak to deliver an effective HIV response, much less the planned increase in intensity of HIV programming over the next 15 years. In the current climate, planning for a broad, international extension of UHC—and concomitant health systems strengthening—is not a viable proposition:

For the 49 Low-Income Countries, it is estimated that between 2015 and 2019 there will be a $240 billion resource gap between [total health expenditure] and fiscal need for Universal Health Care (about 30% of the total fiscal need), or a $550 billion resource gap if private expenditures on health is not included (about 70% of the fiscal need).\textsuperscript{20}

This, furthermore, raises a second issue of the feasibility of concurrently implementing health systems strengthening-based universal health coverage (minus the HIV component) and the vertical Fast Track to ending AIDS. The pressure on the financial, institutional and human resources of pursuing both agendas independently and simultaneously would likely work to the detriment of one or other agenda, or both.

Setting the finances aside for a moment, while most will agree the ideal is for the HIV response to be integrated into national health systems and other relevant sectoral services, premature integration presents serious risks. A strong argument to support the continuation of vertical programming over the next 15 years is that it aims to move the HIV epidemic, and thereby the response,


\textsuperscript{20} Oxford Policy Management, ‘Opportunities and challenges for the integration of health and HIV financing’ (undated), p.4
to a point where the response can be effectively integrated into the health system, that is, the point at which the epidemic is under control and AIDS is no longer a public health concern. While health systems strengthening is at the heart of universal health coverage, in 2015, UHC remains at a largely conceptual stage in low and lower middle income countries – an ‘aspirational goal’ – and it may take years before a version of UHC reaches implementation stage at the country level.

Even if countries were able to fund UHC and expedite the process from concept to implementation (in an era of declining Overseas Development funding), the human resources required to deliver a stronger health system would take significant time to develop. The long lead-time in training many categories of health professional – a lead time that is in part dictated by the pace of human ability to obtain and retain knowledge and skills—means even well-planned, well-funded programmes of teaching and training would result in a relatively slow expansion of skilled domestic human resources for health.21 The ambitious 90-90-90 Fast Track targets are extremely resource-intensive, particularly in the initial years of the Fast Track timeframe; and UNAIDS acknowledges that, ‘to fast-track national [HIV] responses, extensive mobilization of human, institutional and financial resources will be needed.’22 Possible unwelcome outcomes of an integrated HIV/essential health services approach for human health resources include the HIV response competing with other priority health services for limited human resources, and one or both being left short; or that the machinery that has built up around the HIV response over the past 15 years will dominate the implementation of any UHC agenda, skewing the determination of what counts as ‘essential’ health services.

The human resources that could be made available for HIV under a UHC approach are unlikely to be sufficient to deliver the Fast Track agenda, because an inevitably cumbersome national health system lacks the agility and responsiveness of a vertical programme to recruit, train and retain specialised staff in the numbers and at the times required. Essentially, by the time health systems in low and lower middle income countries have the capacity to deliver the necessary level of response to ‘end AIDS’, this critical window of opportunity we have before 2020 to act against AIDS may well have closed. UNAIDS projects the cost of inaction over the next five years will be huge: the lost opportunity to save 21 million lives, and prevent an additional 28 million people living with HIV by 2030, at an additional cost of US$ 24 billion every year for antiretroviral therapy.23 In addition, if we fail to stop the progress of AIDS during the course of the SDGs, we will place an unsupportable strain on the health systems of every high-prevalence country, whatever their composition—and it will last for generations, because the costs and care burdens are cumulative. By 2030, 84% of HIV-infected patients will have at least one non-communicable disease (NCD), up from 29% in 2010, with 28% of HIV-infected patients in 2030 having three or more NCDs. 54% of HIV-infected patients will be prescribed co-medications in 2030, compared with 13% in 2010, with 20% taking three or more co-medications. Most of this change will

be driven by increasing prevalence of cardiovascular disease and associated drugs. Because of contraindications and drug–drug interactions, in 2030, 40% of patients could have complications with the currently recommended first-line HIV regimens.24

The imperative to act now in intensifying the AIDS response, before the challenge becomes so great we have little hope of containing it in the foreseeable future, means effectively that Fast Track cannot conceivably be delivered under a UHC integrated health systems agenda.

The lack of national-level preparedness for a swift inauguration of UHC and a near-simultaneous incorporation of HIV and AIDS services in high-prevalence countries is demonstrated not only by the fact that in many instances, donor-led responses have been vertical in character, but they have also run in parallel with ministries of finance, which have focused their efforts on other health concerns. One health minister of a high-prevalence African country commented on the implications of moving from a PEPFAR-funded vertical programme to largely domestic financing of the HIV response as follows:

I am aware of PEPFAR and the importance of this programme for us, of course, as are all my colleagues in government, but as Minister of Finance I cannot tell you with any certainty how much, to whom and with what effect PEPFAR funds have been implemented in my country. At one level, it is a success of the AIDS response that it is able to function so effectively outside of government, but, in consequence, any changes involving greater country ownership will necessitate long-term government planning and this takes time. I cannot see how we can make such changes quickly, while sustaining and increasing the effectiveness and efficiency of the AIDS response.

While low and lower middle income countries may look to efficiency savings, borrowing, or additional income generation to close the projected total health expenditure resource gaps in AIDS funding noted earlier, they are highly unlikely to succeed in also funding a viable UHC package, leading to inevitable prioritisation. Without international disease-specific funding for HIV and a dedicated machinery to ensure and service the priority status of the HIV response, there is considerable risk that the HIV response will not be prioritised over maternal and child health, for example, especially in countries with epidemics that are concentrated in the Key Populations – notably sex workers, injecting drug users, and men who have sex with men (and, relatedly, prisoners). While politicians may possibly be aware of the longer-term implications of failing to address the epidemic in these key populations, notably the risk of a concentrated epidemic becoming generalised, their four-to-five year elected terms are not conducive to prioritising politically contentious, and largely ‘hidden’, population groups over the general electorate.

Even in countries with generalised epidemics, the success of anti-retroviral drugs (ARVs) in keeping people living with HIV healthy in many high prevalence countries, coupled with the persistent stigma of HIV which results often in non-disclosure of HIV status, means the HIV epidemic is now much less visible for people in real terms. In a sense, ARVs are masking the scale of the problem,

and the rationale for the intensification of the AIDS response over the next five to 15 years – the fact that the number of new HIV infections exceeds the number of people being enrolled on ART;25 that challenges in ART adherence mean a rise in drug-resistant HIV and the need for much more expensive (i.e. unaffordable) second and third-line ARV treatments – at the inevitable expense of other basic health concerns, will likely have little purchase amongst an electorate that is, in large part, living day to day. As such, while the medical and human rights impetus for establishing UHC in low and lower middle income countries cannot reasonably be contested, it is vitally important that the enterprise should not be regarded as a quick means of lessening donor dependency for the fight against HIV and AIDS.

Besides, it is not clear how any of the forms UHC might take would differ significantly from what usually comes under the heading ‘health systems strengthening.’ Indeed, it is difficult to conceive the inauguration of developing country universal health coverage in any but an aspirational sense that does not necessarily entail very considerable increases in human and material resources and concomitant administrative and managerial controls—in other words, the stuff of health systems strengthening in all its particulars.

Conclusion: AIDS program engagement with UHC

The relationship between HIV and AIDS services and country health systems is by no means dichotomous; in fact, there are efficiency gains to be had by more effectively coordinating overlapping services (treatment of TB and hepatitis C; screening; laboratory testing; the distribution of medicines).26 The African Union Roadmap27 had this as a priority action: ‘Ensuring that AIDS, TB and malaria investments are strategically coordinated to contribute to health systems strengthening.’ Conditions certainly support this: a case study analysing the shift to second-line drugs in South Africa as treatment programmes mature suggested that 94% of the costs per patient will likely be attributable to drugs, laboratory testing, and clinic and pharmacy services.28 It remains the case that the kinds of scale-up at the heart of the 2030 strategy will require a great deal of health systems strengthening in many of the most important affected areas/communities, both in clinical and supporting medical functions. However, although this might suggest that a strategically directed, more horizontal approach to HIV and AIDS funding is appropriate, the extent and continuing progress of the disease and the necessarily expansive nature of the 2030 strategy mean that the response will need to remain essentially vertical, at least for the worst affected countries.

This notwithstanding, there is neither a clear choice nor an easy option in deliberating between vertical versus horizontal approaches in the years to come. As the earlier quoted passage from an African Finance Minister points out, the largest part of donor financing in his country was conducted as an externally generated and directed extra-governmental initiative, not

as a partnership. The prospect of a dramatic reduction in funding, combined with this and other recipient governments’ limited and essentially parallel engagement with AIDS could scarcely be worse preparation for ‘country ownership’ and integration of the HIV response into the national health system. It is clear that funding, on however large a scale, does not obviate the need for true partnerships and inclusive governance, and that ‘shared responsibility’ is such an important organisational and operational principle for the Fast Track about to commence.

If the Fast Track agenda is to be prioritised over universal health coverage, then, as far as possible, the AIDS response should actively seek to advance other priority health and development challenges identified under UHC and the SDGs more widely. While some have argued that the unprecedented attention and vertical funding for HIV has undermined or slowed health systems strengthening, it should be remembered that in previous decades, the reality of weak and under-resourced health systems in most of the world and limited access to basic health services for the majority of the population were common phenomena before the HIV response. More importantly, there is evidence that, if managed correctly, the HIV response can be a unique opportunity to strengthen the wider health sector through integration of services and promoting primary health care. There is evidence that the Public Health Approach to delivering HIV treatment has had a positive impact on the availability of primary health care services in general:

- Haiti: Introducing comprehensive AIDS care improved staff morale and increased the flow of essential medications and vaccines to treat and prevent other infections in rural Haiti. In other words, improving AIDS prevention and care led to a dramatic improvement in the quality of primary health care in general. For example, even vaccinations, ostensibly unrelated to HIV, became more readily available as access to AIDS health services broadened.29

- Rwanda: During the past decade, the platforms designed to scale up HIV interventions have been used to strengthen primary care and to expand a growing package of health services across the country in an equitable way. Health facilities originally constructed with donor funding earmarked for the HIV response were tasked with integrated primary care, and national supply chains conceived to assist ART programmes were harnessed to deliver drugs and reagents for a wide range of conditions.30

- Botswana: Cervical cancer in Botswana is one of the leading causes of premature death among women, particularly those who are HIV-positive. Limited cytology laboratory screening capacity for cervical cancer meant patients were being diagnosed late, with advanced or terminal stage disease. In 2013, the Government of Botswana introduced into HIV clinics lower-cost, but equally effective, ‘see and treat’ screening procedures, along with cryotherapy to destroy abnormal tissue in the cervix

by freezing it. Moreover, since the high incidence of cervical cancer in Botswana is linked to a sexually transmitted infection caused by the human papilloma virus (HPV), the targeted use of HIV prevention interventions, such as promotion of use of condoms, avoiding harmful use of alcohol, and male circumcision, are also likely to help prevent cervical cancer, along with HPV vaccination for school-age girls.\(^\text{31}\)

In many ways, the HIV response over the past 30 years has been a trailblazer in global public health.\(^\text{32}\) It has mobilized political figures, the international community, donors, health care providers, civil society, academia and the private sector around a common purpose. It has stimulated unprecedented investments in health, and has played an important role in shaping the global health and development architecture. It has catalysed major breakthroughs in science and technology, including revitalizing infectious disease epidemiology and clinical management, creating a platform to tackle other newly emerging pathogens, such as SARS associated coronavirus and the H5N1 Avian Influenza virus. It has demonstrated the feasibility of rapidly scaling up clinical and public health programmes in challenging environments and inspired new models of service delivery, such as decentralized and integrated services,\(^\text{33}\) task shifting and sharing, and intersectoral collaboration. It has additionally resulted in increased numbers of better trained health workers.\(^\text{34}\) Moreover, it has demonstrated the importance of engaging communities and advocates in decision-making processes and highlighted their role in strengthening accountability mechanisms and championing affordable access to treatment and care.

The difficulty in determining rules of engagement with UHCs for UNAIDS and other dedicated bodies is that in high-incidence countries there is so little to work on; and more widely, a post-2015 UNAIDS-UHC engagement strategy would be premature, because the critical data is so scant. There is no dedicated literature on the relationship between UHC and HIV; no straight-forward way to determine whether, how and in what particulars reduced HIV-related mortality and morbidity statistics can be ascribed to UHCs, where they exist; and there is no comparative data on UHC-non-UHC health systems strengthening for HIV preventive and AIDS palliative advances. And as the WHO/World Bank First Global Monitoring Report on Universal Health Coverage has outlined:

We face three main challenges in tracking UHC: first, sourcing reliable data on a broad set of health service coverage and financial protection indicators; second, disaggregating data to expose coverage inequities; third, measuring effective coverage, which not only includes whether people receive the services they need but also takes into account the quality of services provided and the ultimate impact on health.

\[\text{…Because health system strengthening is the main means by which countries can progress towards UHC, UHC monitoring needs to be integrated into broader health systems performance assessment, and because UHC includes health services and financial protection coverage, it is essential that UHC monitoring of both aspects takes}\]

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\(^{32}\) WHO, HIV, Universal Health Coverage and the Post-2015 Development Agenda (WHO Department of HIV and AIDS), 2014

\(^{33}\) For a systematic literature review, see: M.L. Lindegren et al, ‘Integration of HIV and AIDS services with maternal, neonatal and child health, nutrition, and family planning services,’ Cochrane Database of Systematic Reviews Issue 9 (2012), Art. No.: CD010119. DOI: 10.1002/14651858.CD010119.

\(^{34}\) El-Sadr WM, Abrams EJ. ‘Scale-up of HIV care and treatment: can it transform healthcare services in resource-limited settings?’, Aids 2007, 21 Suppl 5:S65-70.
place side by side. Many countries with weak health systems score strongly on financial protection coverage simply because citizens forgo needed health services. It is only by evaluating the coverage of health services and financial protection jointly that we can reach appropriate conclusions as to how effectively the health system is providing coverage.  

The prospect of incorporating HIV and AIDS services into UHCs is at present both too remote and too risky. But the continuance of the AIDS response as a concerted, vertical program does not require health systems strengthening to be sidelined; indeed, the history of the AIDS response to date has demonstrated that the two are often mutually reinforcing. And the requirement to find efficiency savings for both primary health care and HIV and AIDS will have the benefit of consolidating and enlarging complementarity while avoiding waste and duplication. The emphasis should be on health systems strengthening, particularly in those areas which will provide across-the-board benefits, such as training personnel, screening services, data gathering and analysis, maternal/child health and purchasing. At the same time, bio-medical interventions require concomitant social support, health education and prevention campaigns.

Much fruitless wrangling and dispute can be avoided by a recognition that the laudable goal of Universal Health Coverage for humanity cannot be abstracted from the political, socio-economic and epidemiological realities of the nation states in which it must be planned, supported and sustainably financed. Indeed, as is evident throughout the developed world, the standards, limitations and means to what counts as ‘universal’ in health care are as surprising in their range as they are in the variability of their quality and accessibility. Nor, as we have seen, has the verticality of the fight against HIV AND AIDS been free-standing from many of the fundamentals of health systems services. The AIDS campaign has required prioritisation, not exclusivity; the nature of the disease and the adaptability of basic services both ensure this—and so it will continue under the ‘Fast Track’ scheme to 2030.

It is certainly the case that planning for broader health systems strengthening (without which, universal health care will amount to little in terms or positive health outcomes) cannot wait for the planned 2030 AIDS outcomes. But what is required for that purpose is dedicated, detailed country studies which will reveal the fastest and most cost-effective means of strengthening weak and/or inaccessible health systems in ways that do not slow or compromise the UNAIDS ‘Fast Track’—ideally, in areas that are common to both, or at least complementary. These matters need not be at the margins: laboratory work; testing; screening; the regularisation of standards; service delivery; securing supply chains; improved data collection and analysis; and better financial controls and accounting will all be fundamental to accomplishing ‘more with less’ in the health sectors of developing countries— an unavoidable necessity in the years to come. A great deal of promising research has already been conducted on the unanticipated benefits of HIV and AIDS work for other health sectors; and on more broadly on cross-sectoral efficiencies and

benefits outside of HIV and AIDS work. But this research is unevenly distributed across medical specialisations and disparate locations and conditions, with little or no follow-up on how positive developments might be built upon, scaled or adapted.

A pilot study could be constructed along the following lines: in one or more countries with both high-prevalence HIV and AIDS and weak health systems, the health system vulnerabilities crucial to both adequate health care provision and HIV and AIDS could quickly be identified—perhaps resource mobilization and pooling, service delivery, staff training and retention, supply chain reliability, placement, staffing and accessibility of clinics, key health and disease overlaps (maternal and child health; TB, Malaria and Hepatitis C screening and services) and the like. A literature survey and consultation with key national health planners and international donors could then build on or adapt best practice (if any) to select key development/strengthening priorities which would work to the development of basic health provision while further enabling the ‘UNAIDS Fast Track.’ We need to move quickly to make better use of the positive indicators that have been extant for some years.

The danger at present is that the normative momentum behind UHC will combine with the as-yet unspecified and uncosted drive toward ‘country ownership’ of HIV and AIDS—at precisely the moment of a necessary surge in costs and declining international support. But the circle cannot be squared: the demands of defeating AIDS by 2030 can no more be folded into weak or newly-created UHCs in a timely manner than they could have been at the start of the Millennium Development Goals in 2000. Instead, we need to make a virtue of a necessity, by leveraging the requisites for the struggle against HIV and AIDS for broader public health; and vice-versa. Moreover, the opportunity to engage positively with the political and normative support which UHC has begun to accrue must be grasped without delay. It would be seriously remiss to allow the UHC campaign run effectively in parallel with UNAIDS, as it would in all probability eventuate in stale and counter-productive ‘vertical versus horizontal’ and higher/lower priorities characterizations. Instead, UNAIDS should work astutely and assiduously to reframe the prospect, not as a contest but as a rational sequencing which will ultimately deliver the largest and most enduring positive health outcomes.

There is no escape from an awareness that every health prioritisation and spending decision is also an act of exclusion: we have neither the conditions nor the resources to accomplish everything that the morally consequential health status of the world’s most impoverished peoples demands. On such a scale, it seems invidious to calculate on the basis of what amounts to triage, but calculate we must; and on any reckoning, the human consequences of a resurgent HIV and AIDS epidemic is not something humanity can risk.

1. Introduction

1.1 Rationale

The fight against HIV & AIDS has achieved significant success. New infections are on the decline and increasing access to effective anti-retroviral therapy (ART) in low- and middle-income countries (LMICs) has transformed AIDS from a fatal to a long-term manageable condition. Yet the long-term costs of treatment, the prospect of increasing numbers of patients needing more expensive second- and third-line drugs, and the need for continued prevention measures necessitate a high level of sustained funding for decades to come.

UNAIDS estimates that by 2015 approximately US$24 billion will be needed for HIV interventions annually (WHO, UNICEF, & UNAIDS, 2013). While external donors have
largely driven the financing of the HIV & AIDS response in low- and middle-income countries (LMICs) to date, and have relied heavily on parallel or “vertical” financing and service delivery mechanisms, that context is beginning to change. Donor funding has recently leveled off: after rising from US$1.2 billion in 2002 to US$8.7 billion in 2008, donor commitments have remained largely constant, reaching US$8.3 in 2012 (Kates & HIV/AIDS, 2012; UNAIDS & KFF, 2013). At the same time, many LMICs are increasingly able and willing to take ownership of their HIV & AIDS response thanks to economic growth (Union, 2012). In 2011, domestic sources accounted for the first time for more than half of the funding for HIV programs in LMICs (UNAIDS & KFF, 2013). Some countries remain heavily dependent on external funding, but this still represents a significant shift away from a donor-driven funding structure to a country-led model on average, a trend that is likely to continue. To reduce dependency on external funding while maintaining progress in fighting the HIV epidemic, there is a clear need to expand resources for HIV domestically in low- and middle-income countries and begin to ensure the long-term sustainability of their HIV financing mechanisms. This need was recognized by UN Member States Political Declaration on HIV & AIDS in 2011 and by the African Union’s “Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB, and Malaria Response in Africa” from 2012.

The push for greater and more sustainable domestic financing for HIV dovetails with efforts to promote universal health coverage (UHC) globally, and with increased reliance on pre-paid, pooled funding initiatives such as national/social health insurance programs as means to achieve UHC. These two trends have raised an important and complex policy debate for UNAIDS and the global health community: should countries integrate the often “vertical” (disease-specific) financing of their HIV responses into their more “horizontal” (not disease-specific) health financing systems; and if so, how? This study is intended to outline concepts, provide a preliminary country scoping, and suggest next steps needed for UNAIDS and other global HIV & AIDS actors to develop policy guidance on these integration questions.

1.2 Definition of integration and country illustrations

“Integration of HIV & AIDS financing” refers here to the process of moving toward national health financing systems where funds for HIV & AIDS are collected, pooled, and used to pay for health services together with funds for other health services rather than through separate financing and payment structures. (A follow-on but separate concept is that such integrated funding can imply integrated delivery of HIV & AIDS services alongside other health services.)

Much of the debate on integrating HIV & AIDS financing with national health financing systems has focused largely on pre-paid, pooled funding initiatives, especially (but not exclusively) national or social health insurance programs at the country level. Mexico, Brazil, and Thailand are cited as examples of countries that moved towards early integration of HIV & AIDS services with largely publicly funded health financing mechanisms. These countries leveraged the opportunity afforded by health sector reform in the late 1990s to expand coverage of ART and other HIV-related goods and services at a time when treatment costs were high (Bautista-Arredondo, Dmytraczenko, Kombe, & Bertozzi, 2008). As low prevalence countries that experienced significant economic growth in the last decade or more, the individual contexts of
the relationship between HIV & AIDS policy design, available funding envelope, and the pathway to integration are important to consider. For instance, Brazil decided in 1996 to provide ART to all, challenging conventional wisdom that LMICs should focus on prevention and that adherence would be hard to ensure. Within a decade, Brazil was paying US$400 million for ARV drugs to support therapy for 180,000 individuals, with about 20,000 new patients joining treatment every year (Greco & Simao, 2007). But long term sustainability is threatened by increases in both the number of individuals who need to initiate ART each year and the complexity of the regimens for infected individuals who are surviving for longer periods of time. In Thailand, the government paid for about 71% of the total HIV & AIDS expenditure during 2008-11 in just treatment and care after first introducing a policy of tax-financed universal ART in only 2003 (Walker, Patcharanarumol et al., 2013). However, the impending departure of Global Fund funding may mean that financing and access related gaps will open up in reaching migrants and other key affected populations not currently served by the public healthcare system, affecting the pathway to full integration of HIV & AIDS financing. In Mexico, the nature of the challenges differs in that while Seguro Popular has funded a specialized integrated HIV & AIDS delivery model1, unique problems with access, staffing, and quality in this vertical system continue to interfere with full integration and access (Saavedra, 2010).

The evidence from high-prevalence and high burden countries is mixed. As examples, Rwanda has a relatively well-functioning national health insurance system, while South Africa remains highly fragmented between public and private sectors as the country’s national health insurance vision is being designed and piloted. In both cases, ART continues to be delivered separately, although treatments of opportunistic infections are included in benefits packages of Rwanda’s ‘mutuelles’ (Doetinchem, Lamontagne, & Greener, 2010). Before endorsing integration of HIV & AIDS services with horizontal health financing systems to enhance sustainability, there is a need to better evaluate cross-country variation in existing coverage and services and capacity for integration.

1.3 Note on HIV & AIDS program costs

HIV & AIDS programs are multifaceted. The National AIDS Spending Assessment (NASA) tool developed by UNAIDS measures spending incurred for prevention; care and treatment; orphans and vulnerable children; programme management and administration; human resources; social protection and social services; enabling environment (that is, issues around advocacy, human rights, institutional development, and gender); and HIV-related research. All of these primary cost categories have further subcategories that can be used for detailed estimation of resource needs and to track spending. A descriptive analysis of HIV & AIDS spending in 65 LMICs based on National Health Accounts data matched spending from public and international sources against NASA-defined line items (Amico, Aran, & Avila, 2010). That analysis found that about 95% of HIV & AIDS spending took place under direct health related categories2 such as drugs and human resources. These categories are likely to

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1 A network of 56 CAPASITS (outpatient centers for the prevention and care of AIDS and STDs).
3 Covering “activities whose primary purpose is to restore, improve and maintain health for the nation and for individuals,” as defined by the WHO, such that they took place within the health system and were performed by health sector employees. This excludes NASA spending for orphans and vulnerable children, social protection and social services, enabling environment, and research.
retain their position as major cost drivers as the number of people needing HIV & AIDS treatment increases 2-3 fold over the next two decades (Hecht et al., 2010) and patients switch to more expensive drugs. For instance, a case study analyzing the shift to second-line drugs in South Africa as treatment programs mature suggested that 94% of the costs per patient will likely be attributable to drugs, laboratory testing, and clinic and pharmacy services (Long, Fox, Sanne, & Rosen, 2010).

As a conceptual framing and landscaping analysis, this study does not attempt to disaggregate into all categories of HIV & AIDS programs. Rather, it provides overviews of country mechanisms for financing aggregate program costs, which in light of the above generally relate to the dominant cost drivers of country and donor spending on HIV treatment and medical prevention. As next steps, it will be important for policymaking purposes to draw out financing integration-related challenges by cost category in individual country contexts. An overview of some general HIV & AIDS financing integration-related challenges that could inform such country-focused work has been provided in section 3 of this study.

1.4 Outline of the landscaping study

The following section of this study outlines Kutzin’s (Kutzin, 2001) framework for disaggregating health financing systems into their core functions of revenue collection, pooling, and purchasing. Section 3 then briefly introduces six important challenges specific to integrating HIV & AIDS financing with countries’ horizontal health financing regimes. Section 4 applies Kutzin’s framework to analyze HIV & AIDS and general health financing for a sample of 13 countries with varying income, HIV prevalence, insurance coverage, and geographic profiles. This section groups the selected countries by high, low, or medium integration between HIV & AIDS and general health-related collection, pooling, and purchasing, and describes the existing institutional arrangements for each of the three financing functions for each country. Following this country scoping, section 5 presents conclusions, recommendations, and next steps for policymakers exploring the potential integration HIV & AIDS financing with domestic health financing systems.

2. Conceptual framework and approach to country scoping

2.1 Health financing framework for analysis of integration issues

The issue of integrating HIV financing into more horizontal health financing systems or, specifically, national or social health insurance programs, is a complex, multi-faceted one. To advance the debate and move toward policy guidance, the first necessary step is to agree on a framework for examining the different functions of health financing, for both HIV and other health services, in given countries. This study proposes Kutzin’s (Kutzin, 2001) well-known health financing framework to do so, and uses that framework to begin examining variation across countries in the three primary financing functions for HIV and other health needs: revenue collection, pooling, and purchasing—leaving provision
of services (delivery) aside for emphasis on integration in purely financing functions.

Revenue collection is defined as the collection of funds for HIV/health purposes and focuses on the sources of those funds, such as different types of taxes that constitute general government revenues; payroll and other taxes earmarked for particular health funds, premiums paid by companies and households; and external donor funds such as Global Fund grants, PEPFAR programs, etc. Pooling refers to the accumulation of pre-paid funds to cover the health care costs (HIV-related or otherwise) of a particular population, and can range from very small pools for limited types of costs to large, national pools for a very broad range of health benefits. Finally, purchasing involves the various mechanisms by which pooled funds are paid out to the providers of health care goods and services—including, as examples, salaries or fee-for-service payments to physicians and nurses, fixed prices for drugs, or global budgets for health facilities.

There is a great deal of variation across countries and across types of health services in how health sector organizations perform these functions, and this variation is one reason why careful examination of the different functions for HIV and non-HIV health needs is vital for consideration of potential integration. It is important to note, however, that this landscaping of HIV & AIDS-related collection, pooling, and purchasing implicitly focuses on the financing of HIV treatment and does not explicitly disaggregate financing and integration-related concerns for the comprehensive array of HIV & AIDS services and programs in countries at this stage.4

2.2 Coding levels of integration of HIV and non-HIV financing

This section explains the coding that resulted in the main summary table of Section 4.

Coding of the revenue collection function was the most objective and quantitative, based on whether less than 25% of HIV funding was from sources integrated with non-HIV health funding sources (low), between 25% and 74% was from integrated sources (medium), or whether 75% or more was from integrated sources (high). In coding level of integration of collection, external donor funding earmarked for HIV was assumed to be a non-integrated source of funding.

The coding of the pooling and purchasing functions was more subjective and involved benchmarking against countries perceived by country experts to have high integration in those functions (Thailand) or low integration (Vietnam), as well as against theoretical ideal-types of complete integration or complete lack thereof. A completely integrated pooling arrangement would be one where all funds destined for HIV & AIDS services were combined in a pool (or pools) of funds for non-HIV services, with no earmarking. Complete lack of integration would involve strict separation between HIV and non-HIV funding pools. Indicators and sources of information to make the low-medium-high ranking included the sources of HIV & AIDS related funds for the public health budget or pooled coverage schemes, the role of official HIV & AIDS bodies (planning and coordination of national response and/or collection and management of all or most funds), and the arrangements adopted by major donors (PEPFAR and Global Fund in

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4 In future work, it may also be necessary to agree on the best framework, such as the NASA, with an appropriately detailed classification for types of HIV & AIDS goods and services (e.g., prevention, testing, care and treatment, ARVs, PMTCT, etc.). Careful, detailed policy recommendations in a given country will likely need to be disaggregated using a matrix of: 1) the three health financing functions and 2) the several components of HIV & AIDS responses.
many cases) for holding funds. In cases with low pooling integration, for instance, donor funds often formed a large share of HIV & AIDS spending, were off-budget of public health systems, and were managed as vertical pools to finance donor-led purchasing of goods and services.

Similarly, integration in the purchasing function was judged by the extent to which the flow of funds from purchasing/funding entities to providers of HIV & AIDS goods and services occurred within the same channels and relied on the same payment mechanisms (e.g., tariffs, salaries, capitation, etc.) as the flow of funds for non-HIV services. Countries with high purchasing integration typically included a broad array of HIV & AIDS services and commodities in the (publicly or privately delivered) benefits packages of pre-paid pooled health funding initiatives for mass coverage.5

3. Challenges to integrating HIV & AIDS services

Some challenges to the integration of vertical health financing into broader health financing systems would be common across any disease or health need (TB, family planning, etc.), but others would be unique or especially important for certain diseases. This section outlines several challenges to integrating HIV & AIDS financing that are likely to be especially important given the particular nature of the disease and its current programmatic responses.

3.1 AIDS as a chronic disease among other NCDs

Until recently, diseases were considered either communicable (infectious) or chronic. As a result of advances in treatment, HIV infection now challenges that binary distinction. The World Health Organization describes chronic disease as a disease of long duration and slow progression. HIV & AIDS programs may now be the largest chronic care programs implemented in most low- and middle-income countries. Treatment needs are now lifelong or chronic, in addition to acute, especially if programs are not effective in preventing new infections (Nigatu, 2012).

In addition to being a chronic disease competing with other chronic diseases for funding and delivery of services, HIV may also be involved in the etiology of other diseases, beyond what are known as opportunistic infections (that is, infections that take advantage of a weakened immune system). Phillips et al (Phillips, Neaton, & Lundgren, 2008) hypothesize that HIV may play a role in causing diseases such as non-AIDS cancers, liver cirrhosis, end-stage renal disease, and cardiovascular events such as myocardial infarctions, and strokes. A population with growing numbers of people with HIV on ART could give rise to an additional treatment burden for other non-AIDS health conditions.

As ART provision stabilizes incidence rates of HIV in Southern Africa, the chronic nature of AIDS, along with the global financial crisis, has raised serious concerns around the sustainability of global and national-

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5 See also a special note on purchasing in Section 5.
level financing for ART program and other HIV prevention, care, and treatment efforts. ART allows PLHIV to return to work, but it also produces adherence challenges, serious illness episodes, transaction and opportunity costs related to lifelong treatment, and the need for continued investment of public resources to fund treatment programs (Colvin, 2011). While the number of new infections might decrease with increased ART use, global funding for HIV & AIDS is shrinking, both due to a constrained resource envelope for global health in general, and an increasing need for resources for other chronic diseases. Global funding for HIV has risen, for example, from around US$300 million in 1996 to US$18.9 billion as of 2012 (KFF, 2013), a massive increase to an amount that is still short of the UNAIDS estimate of US$22 to US$24 billion required to deal with the effects of HIV. WHO has highlighted the neglect of non-communicable diseases (NCDs) by comparing HIV to NCDs, which cause 80% of the deaths in developing countries but receive only 3% of global development assistance for health (Maher, Ford, Unwin, & Frontières, 2012).

The transformation of HIV into a chronic epidemic will therefore result in both: 1) increased HIV-specific funding needs, especially as total treatment burdens increase, and the cost of treatment, especially for second- and third-line treatment as patients develop resistance to the cheaper first-line of treatment, rises (also see section 3.4); 2) competing pressure for resources from other chronic health challenges.

3.2 HIV & AIDS components include private and public goods

Most HIV & AIDS treatment services are regarded as private or personal goods that align well with the types of benefits typically covered by an insurance program or other prepaid health financing approach (for instance, a national health service). Such coverage protects individuals at risk of needing PMTCT, hospitalization and treatment of opportunistic infections, and ARV treatment. However, other components of HIV & AIDS service delivery are public goods that may be less likely to be explicitly included in the benefits of individually-oriented insurance or other health financing systems. HIV & AIDS services of this nature include mass HIV awareness campaigns, HIV testing, and distribution of condoms.

Public HIV goods such as prevention services may run the risk of being dropped from a program when AIDS services are integrated into an insurance benefits package. This could render HIV & AIDS financing unsustainable as new infections continue to rise, even if treatment services exist. Especially where individually-oriented insurance programs constitute major pillars of health financing systems, care must be taken to include prevention services such as HIV testing and counseling in benefits packages ((Ahmed, Whiteside, & Regondi, 2011); (Doetinchem et al., 2010)). Vietnam is currently facing this potential challenge. As donor funding is projected to decrease, the government is exploring ways in which social health insurance can cover AIDS treatment services, but prevention services (currently financed by donors) will most likely be excluded from health insurance and will have to be financed separately by the government6.

3.3 Lack of data to cost integration of HIV & AIDS services

Several variables influence the costing of integrating HIV & AIDS services into a pre-
paid package of health services. These include the strength of countries’ health systems, intellectual property regulations, epidemiological profiles, AIDS treatment guidelines, and differing capacities to produce drugs locally (Nunn, Fonseca, Bastos, Gruskin, & Salomon, 2007). To describe direct healthcare costs and establish cost drivers, one needs to know about variations in HIV prevalence among the insured and uninsured (moral hazard problem), the progression of disease (if PLWHA\(^7\) enroll at a late stage, the cost of treating them could be higher as they would need second- and third-line drugs), and the number of people qualifying for ART based on the CD4 count threshold selected by a country ((Leisegang et al., 2009); (Doetinchem et al., 2010)). Information about the type of epidemic and cost information about health service delivery is also required. While care and treatment might account for up to 50% of the cost of HIV & AIDS programs, other costs such as those related to human resources and program management, are also required to calculate costs of HIV & AIDS program integration.

For many countries, this information is not always readily available and will require a focused effort to collect data that will help health financing agencies price HIV & AIDS services for integration. A few countries such as South Africa, Ghana, Rwanda, and Lesotho have attempted to quantify the financial implications of HIV service coverage in insurance, and the overriding message is that any country investigating whether HIV services could be financed via health insurance will have to perform its own actuarial calculations incorporating the local circumstances and costs (Doetinchem et al., 2010). Hence, in India for instance, the release of the guidelines for covering PLWHA has been delayed by the absence of data to price products, and the country’s National AIDS Control Organization (NACO) recently tasked a working group to assist in collecting information to help in pricing an insurance product that will cover HIV & AIDS ((Saraswathy, 2013); (Syed, 2012)). It is true that, if HIV & AIDS services were integrated into broader health financing systems/programs, the total costs of all covered services would be the relevant amount to consider for financial sustainability, rather than the detailed costing information about any particular set of services. A first step toward integration, however, is to estimate the specific cost of HIV & AIDS services so that such systems/programs can better predict the financial implications of adding them.

3.4 Potential increase in long term costs

The cost of commodities, including medicines, is declining as intellectual property obstacles are removed or overcome, economies of scale increase, and treatment optimization reduces the doses of active pharmaceutical ingredients used in ART medicines. Even as more expensive regimens are incorporated into programs, prices have fallen due to larger transaction volumes, improved forecasting of demand, and increased competition among drug manufacturers. The annual ART cost per person in US dollars in the program supported by PEPFAR dropped from US$ 1000 in 2004 to US$ 400 as the number of direct ART recipients in the program increased from 0 to just under 4 million in the same time (WHO, 2013).

However, even as drug prices fall, it is important to note the significant cost drivers that might increase prices in the long term. A study from Brazil suggests that even with precipitous

\(^7\) People living with HIV & AIDS
declines in the prices for four patented ARVs, total drug expenditure for Brazil doubled from 2001 to 2005: the main driver of cost increases was an increase in the purchase quantities of specific drugs to manage increasing numbers of patients on ART (Nunn et al., 2007). Reaching rural and marginalized populations who currently do not access ART may be more difficult and expensive as treatment programs scale up. Testing and retesting services will need to be greatly expanded as more PLWHA are enrolled in to treatment programs, health systems strengthening investments might be needed, and the ratio of first- to second- and third-line treatment might shift towards more costly regimens as more and more patients live longer with ARTs. Instead of commodity prices falling in the long term, prices might actually increase because of patent restrictions on second and third line drugs to keep out the generic competition that has helped to drive down the prices of first-generation ARV medicines.

The potential rise in the cost of commodities and ARTs complicates the sustainable financing plan for HIV & AIDS programs, especially when these costs have to be integrated into an existing horizontal health financing system. For example, in Vietnam, the Health Insurance Fund is reluctant to include HIV & AIDS in its SHI benefits package because the cost of ART and commodities for HIV & AIDS programs could increase disproportionately as more PLWHA are covered by SHI and require second- and third-line therapy, possibly crowding out coverage for other health problems.

### 3.5 Stigma is a greater issue for HIV & AIDS

HIV & AIDS stigma has long been documented as a barrier to the uptake of HIV testing and treatment services in numerous settings, particularly in resource limited countries ((Mahajan et al., 2008); (Nguyen, Oosterhoff, Ngoc, Wright, & Hardon, 2008)). However, a recent review of literature notes the lack of data that would allow us to assess the influence of stigma reduction interventions on outcomes such as the uptake of and retention in ART programs. To date, there are no impact evaluations of HIV prevention programs that include stigma reduction as a component of the intervention itself. Given the emerging challenges in low- and middle-income countries of adherence to treatment programs, especially as drug-based prevention increases, such data are required to inform national responses to the epidemic (Stangl, Lloyd, Brady, Holland, & Baral, 2013).

Despite the lack of impact evaluation data, some observational studies show that stigma can affect the way services are delivered for HIV & AIDS programs, especially in countries with concentrated epidemics among marginalized populations. To achieve universal access to HIV prevention, treatment, and care, at-risk populations must be identified, supported, and engaged. This increases the likelihood that they will be stigmatized by others (non-HIV & AIDS patients) and further marginalized in an integrated health service facility, reducing their access to treatment, care, and prevention. In addition, prevention services that target at-risk populations such as people who inject drugs, sex workers and their clients, and men who have sex with men (MSM), could be at risk of being inadequately funded if AIDS services are integrated into health insurance or other pre-paid health funding pools and compete for resources with other services. Vietnam again provides an illustrative example. Until now, donors have fully supported prevention services and treatment services for at risk-populations. As donor funds are projected to decline, PLHIV (especially from groups that are criminalized: sex workers, MSM, IV-drug users) are concerned that they may face greater stigma and discrimination as donors reduce their support for HIV/AIDS, and these services are integrated into the formal health care system.
3.6 Integrating financing confronts integrated delivery

Most low- and middle-income countries have fragile health systems that are under-resourced and in need of structural and policy reform. While resources for global health increased dramatically in the last decade, these funds were mainly targeted towards three specific diseases—AIDS, TB, and Malaria. There has been much debate about whether disease-specific funding has strengthened health systems ((Bernstein & Rosenzweig); (Levine & Oomman, 2009); (Biesma et al., 2009); (De Cock, El-Sadr, & Ghebreyesus, 2011)). While there is no clear answer to this question, one issue is clear: the rapid transition in disease burden to chronic diseases, including HIV & AIDS is an enormous challenge for many low- and middle-income countries with weak systems. Chronic illness demands a complex health-systems response that needs to be sustained across a continuum of care. The effective delivery of a comprehensive package of chronic disease interventions is dependent on a strong health financing system that can raise adequate funds so that people can access services and are protected from catastrophic health spending. The ability to create an effective, efficient, and equitable system will depend on a balance between the collection of revenues, the pooling of prepaid revenues in ways that allow risks to be shared, and the selection and purchase of specific interventions (WHO, 2007).

In this context, de-verticalizing HIV & AIDS service delivery into horizontal systems to minimize the fragmentation of coverage schemes and create sustainable financing sources for HIV & AIDS services can present several challenges for health service delivery. It is useful to consider specific components of a health system to understand how integrated financing might affect the delivery of HIV & AIDS services:

Supply Chains: Service providers cannot meet patients’ full range of health needs without the full range of supplies. Supply chains are still very weak in many LIC and LMIC countries, despite improvements in disease-specific supply chains, such as for HIV & AIDS programs. Integrating stronger HIV & AIDS supply chains with weaker supply chains for other health commodities could compromise the quality of service delivery for HIV as well as for other health services.

Health Workforce: If AIDS services from donor funded outpatient clinics are integrated into publicly funded health systems, AIDS specialized health workers (who may or may not be on the public sector wage bill) may not follow their patients to these new public facilities. Resources to take on additional service areas and increases in clientele, or to effectively manage the changes in protocols to address the full range of health needs, are likely to be limited. Increasing workloads for a health workforce with limited capacity can lead to deteriorating motivation, services quality, and eventually staff burnout. These inherent tradeoffs between services and/or clients may constrain people’s ability to access services which address the full range of their needs.

Health Information Systems: Underlying many of the weaknesses in planning and managing the delivery of health services are weak information systems, which are even further weakened by the introduction of numerous bespoke information systems that only serve particular donor needs. While information systems for HIV & AIDS programs have been established, it is unclear how these would be integrated into existing health information systems.

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Interview: World Bank, Feb 2014
4. Landscaping HIV financing integration across select countries

This section evaluates the integration of HIV-specific financing into national health financing systems (including but not limited to national/social health insurance schemes) for an initial sample of 13 countries. The countries were purposively selected to capture varying geographic regions, epidemiological profiles, income levels, and modes of health financing—in addition to availability of secondary data and literature on their health financing systems. This section provides a comprehensive summary of this landscaping exercise per country, financing function, and level of integration. Table 1 summarizes conclusions about levels of integration in each country and by financing function.

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>REGION</th>
<th>EPIDEMIC TYPE</th>
<th>2012 ADULT HIV PREVALENCE</th>
<th>INCOME LEVEL</th>
<th>COLLECTION</th>
<th>POOLING</th>
<th>PURCHASING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zimbabwe</td>
<td>Africa</td>
<td>Generalized</td>
<td>14.7%</td>
<td>LIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Kenya</td>
<td>Africa</td>
<td>General</td>
<td>6.2%</td>
<td>LIC</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Africa</td>
<td>Generalized</td>
<td>2.9%</td>
<td>LIC</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Africa</td>
<td>General</td>
<td>3.7%</td>
<td>LIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Ghana</td>
<td>Africa</td>
<td>Generalized</td>
<td>1.4%</td>
<td>LMIC</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Asia</td>
<td>Concentrated/ Low-level</td>
<td>0.4%</td>
<td>LMIC</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Philippines</td>
<td>Asia</td>
<td>Low-level</td>
<td>&lt;0.1%</td>
<td>LMIC</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>South Africa</td>
<td>Africa</td>
<td>Generalized</td>
<td>17.90%</td>
<td>UMIC</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Brazil</td>
<td>LAC</td>
<td>Concentrated/ Low-level</td>
<td>0.3%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Colombia</td>
<td>LAC</td>
<td>Concentrated/ Low-level</td>
<td>0.0%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Thailand</td>
<td>Asia</td>
<td>Generalized</td>
<td>1.1%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Mexico</td>
<td>LAC</td>
<td>Concentrated</td>
<td>0.2%</td>
<td>UMIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Chile</td>
<td>LAC</td>
<td>Concentrated/ Low-level</td>
<td>0.4%</td>
<td>HIC</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Source: Integration of HIV Financing into Health Financing Systems in Low- and Middle-Income Countries Conceptual Framework and Preliminary Findings

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9 Epidemic type by adult prevalence of HIV: concentrated when <1% of population but >5% of any high risk group are HIV-positive; generalized when >1% of population is HIV-positive; low-level when relatively little HIV is measured in any group. Source: http://www.who.int/hiv/strategic/surveillance/en/.

As shown, countries are ranked according to their degree of integration for each financing function. There is a variety of epidemic types, income levels, and regions within the low, high, and medium integration rankings for each financing function among the countries in this sample. The following parts of this section group these countries by the integration rankings of their collection, pooling, and purchasing mechanisms for HIV financing, and present more detailed analysis and description of HIV and health system financing for these respective subgroups.

4.1 Integration in collection of funds

Low Integration:

Kenya, Nigeria, Rwanda, Zimbabwe, Ghana, and Vietnam display low levels of integration in the collection of funds for HIV and non-HIV health spending. These are all low or lower-middle income countries with, except for Vietnam, generalized HIV epidemics with adult prevalence higher than 1%. Health insurance coverage is lower than 40% in all but Rwanda and Vietnam.

In Rwanda, the health system is financed by a combination of state funds, individual contributions through health insurance and direct fees for services, and donor support. A network of centrally-coordinated community-based health insurance programs called MS or “health Mutuelles” covers 98% of Rwanda’s population (McNeil, 2013). This coverage is funded by a combination of premiums, out-of-pocket spending, transfers from general tax revenue, and donor funding. The richest affiliates pay annual premiums of US$8 while the poorest 25% are enrolled for free, and all have to pay US$0.33 per hospital visit (Makaka, Breen, & Binagwaho, 2012). But these revenues only account for 45% of the MS costs and the rest are contributed by government’s tax revenue and international aid (McNeil, 2013). While Rwanda has 80% population coverage for HIV & AIDS treatment services, second only to Botswana in Africa (McNeil, 2013); (Bulletin, 2013), there is a significant disconnect between HIV and non-HIV health funding sources. The vast majority of HIV & AIDS funding (90.2%) is from external donors, with only 9.6% from (integrated) domestic public sources, resulting in the low integration ranking. PEPFAR (42.7% of total HIV funding) and the Global Fund (40.6% of total HIV funding) are the largest international donors in Rwanda (UNAIDS, 2012).

Funds for health spending in Vietnam primarily comprise general taxes, out-of-pocket payments, and international assistance. The Vietnam Social Security scheme, responsible for social health insurance, receives contributions from formal sector employees and subsidies from the federal and provincial governments for provision at the local level, but there is considerable out-of-pocket spending as well as private health insurance services (Tien, Phuong, Mathauer, & Phuong, 2011). HIV & AIDS services in Vietnam are primarily funded separately from this system as Vietnam has relied on donor funding (USG, DfID, Global Fund, World Bank, and Asian Development Bank) for HIV prevention and treatment through projects at stand-alone out-patient clinics. The 2009-10 NASA in Vietnam found that of the US$267 million spent on HIV & AIDS, only 14.5% came from domestic public sources, while out-of-pocket payments by households (11.8%) and international support (73.7%) made up the rest (National Committee for AIDS, 2012). Of the international support, 69% (or 50% of overall spending in 2009-10) came as direct support from PEPFAR alone. Hence, AIDS financing is largely excluded from the social
health insurance plan and integration with generally-collected funds only exists when other related conditions are in the curative package, like opportunistic infections.

Sources of funding for health services in Ghana include general government revenues, which flow to the Ministry of Health through the health budget; private, pre-paid or out-of-pocket funds from companies and households; and several sources earmarked for Ghana’s National Health Insurance Scheme (NHIS), including a VAT, social security tax carve-out, and premiums. The NHIS excludes HIV-related medicines and services except for treatment of opportunistic infections and, therefore, the collection of revenues for HIV & AIDS is not integrated with collection of revenues for NHIS. Earmarked donor funds flowing directly to the Ghana AIDS Commission and implementing agencies comprise 77% of AIDS spending in Ghana (with 13% from public and 10% from private sources making up the rest).

Kenya derives 51% of overall HIV & AIDS expenditures from donors, 28% from private sources, and 21% from domestic resources (Kenya National Health Accounts (NHA) 2009/10). It raises domestic resources for health through the National Hospital Insurance Fund (NHIF), which covers 16-20% of the population (mostly formal employees and civil servants), budgetary allocations from general taxes in the form of line items for health facilities and institutions, and out-of-pocket payments. Those employed in the formal sector pay a graduated premium based on income, capped at KES 320 but which has stagnated for about 16 years, while those who join voluntarily pay a much smaller flat rate capped at KES 160/month. NHIF also operates a separate comprehensive medical scheme for civil servants and the police (with premiums based on income). However, the NHIF does not provide coverage for regular ARVs or HIV prevention. It only provides coverage for associated health incidents that require hospital stays. A sustainability task force in Kenya has recommended though that the NHIF’s surplus be earmarked to support ARVs for members, which could increase overall integration of collection.

Hence, at the moment, despite increased spending by the Government of Kenya (it now spends 25% (Kenya NHA 2009/10) of its overall health expenditures on HIV & AIDS), the proportion of domestic funding and the integration of HIV & AIDS resource mobilization with NHIF is still low overall.

Finally, Zimbabwe and Nigeria have the lowest socialized health coverage as well as low integration of collection of HIV & AIDS financing. In Zimbabwe, 20% of the country’s total health expenditure is incurred by mutual healthcare funds, MAS, which are private not-for-profit organizations and have a formally-employed affiliate base comprising only 10% of the population (Shamu et al., 2010). The wider public has access to the 70% of health facilities owned by the government, which is financed through the government’s health budget funded through general taxes and transferred to the Ministry of Health and Child Welfare (Shamu et al., 2010). However, Zimbabwe’s severe hyperinflation and economic downturn in 2007 and 2008 caused domestic health spending to collapse in dollar terms, needing greater infusion of aid funding in those two years. While domestic health spending recovered in 2009, HIV & AIDS spending has remained primarily vertically funded. The national AIDS levy, at 3% of corporate and payee taxes and managed by the National AIDS Trust Fund is the chief source of domestic AIDS funding (US$5.7M in 2009, US$20.5M in 2010, and US$26.5M in 2011) (UNAIDS-GARP, 2012). However, funding for Zimbabwe’s general AIDS expenditure comes primarily from PEPFAR, DFID, and Global Fund, who have
their own implementing partners and agents on the ground and contribute up to 85% of the HIV & AIDS spending (UNAIDS-GARP, 2012). Hence, collection of funds for AIDS services in Zimbabwe is largely separate from the general tax revenue used to fund the larger public health system.

Similarly, Nigeria too is extremely reliant on external funding. While social health insurance in Nigeria, called the National Health Insurance Scheme (NHIS), is available for anyone to enroll and formal sector businesses with more than 10 employees are required to join, the current mix of beneficiaries is primarily civil servants and formal sector employees. Hence, the NHIS only covers 4-5% of the population and participation is voluntary for the rest. Importantly, no HIV-related opportunistic illnesses/diseases are included in the benefit package and, according to the 2010 National AIDS Spending Assessment, international funds account for 75% of total expenditure on HIV & AIDS. Major international funders include the Global Fund (33% of total budget), PEPFAR (48% of total budget), DFID, CIDA, World Bank, and the UN System. Most domestic funding comes from the federal level (99.7%) as states have historically contributed very little. Thus, funds for AIDS financing are primarily collected through vertical mechanisms.

Medium Integration:

Philippines is the only country in the sample which displays medium health system integration in collection of financing for HIV & AIDS. PhilHealth—the social health insurance program in the Philippines—covers approximately 82% of the population and collects revenues through individual contributions from beneficiaries as well as earmarked taxes, like the sin tax, to pay for the premium of the poor. Domestic revenue for health services in the Philippines, which also accounts for 25% of overall HIV & AIDS expenditures, comes from general government revenues that flow to the Department of Health to fund supply-side delivery. This includes the provision of free ARVs for people living with HIV & AIDS. In addition to this, PhilHealth also provides HIV & AIDS benefits through the “Outpatient HIV/AIDS Treatment Package” to confirmed patients, which began in 2010. This benefit covers ARV drugs and medicines, laboratory examinations (for example, CD4 and viral load counts) and professional fees of service providers. It does not, however, cover opportunistic infections. Despite the small population in the Philippines that is in need of HIV & AIDS services (< 0.1%), the Philippines relies predominantly on external sources of funding to support HIV & AIDS services. 48% of total HIV & AIDS expenditures between 2009-2011 came from development partners (50% of this was from the Global Fund), and 27% through the private sector (DKT and Levi Strauss Foundation) (PNAC, 2012).

High Integration:

South Africa, Brazil, Colombia, Chile, Mexico, and Thailand have highly integrated collection of HIV & AIDS-related funds. As the table on integration ranks shows, these counties are all in the upper-middle or high income categories. With the exception of South Africa, they also all have low levels of HIV & AIDS prevalence and high levels of socialized healthcare coverage. However, these countries display considerable variety in the sources, methods,
and organizational structures for collecting funds for general as well as HIV & AIDS-related health expenditures.

In South Africa, an upper-middle income sub-Saharan country with a severe generalized HIV & AIDS epidemic, the largest HIV burden in the world, and low socialized health coverage, the most recent NASA found that in 2009-2010, domestic public revenues made up approximately 75% of HIV and TB spending, while external and private sources respectively comprised 16% and 8%. The 75% of funding from domestic public revenues sources is considered integrated, as it is sourced from the same array of taxes (income, VAT, excise, and fuel) that are collected by the South African Revenue Service, under the National Treasury, to fund health services in the public sector. Other than the vast majority of the public dependent on the public health infrastructure, Medical Schemes in the private sector cover about 16% of the population from premiums collected from companies and individual members and used to pay for HIV and non-HIV health benefits (depending on the benefit package of a particular scheme and regulations for the Prescribed Minimum Benefits that Medical Schemes must cover).

Health coverage in Mexico is split almost evenly between formal sector social security and a social insurance program for informal workers called Seguro Popular (SP). The former is paid for through payroll taxes and government subsidies, while the latter is funded through transfers to states in the form of social and solidarity contributions from general federal government revenue (a mix of oil revenues, and income and consumption taxes), contributions from the state health budgets, and some small contribution from premiums (Barofsky, 2011). IMSS and ISSSTE, two of the largest social security providers, cover about 97% of the formally employed half of the population, and provide full HIV & AIDS treatment as part of their benefits package. For Seguro Popular, a centrally managed fund for protection against catastrophic expenditures, the FPGC, covers 49 high-cost, specialized interventions, including treatment for HIV & AIDS (Frenk, Gómez-Dantés, & Knaul, 2009). The FPGC equals 8% of the federal social contribution, plus the federal and state solidarity contributions, and is thus highly integrated with general collection of health financing (Frenk et al., 2009).

Similarly in Latin America, Colombia, Chile, and Brazil also display high levels of integration in the collection of HIV & AIDS-related funds. Health financing in Colombia is dominated by the General System for Social Security for Health, SGSSS, which covers 96% of the population (Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012). It has a contributory regime for formal sector workers and high earners who must contribute 12.5% of their income to avail a benefits package that has recently been unified across the contributory regime and a subsidized regime. The subsidized regime for poorer affiliates receives 1.5% of the contributory regime’s contributions and funding from general taxes. The Basic Health Plan, a safety net financed by general taxes and composed of public health facilities catering to all citizens and providing health-related public goods, forms a third prong for healthcare delivery. Treatment for HIV & AIDS is included as catastrophic care for both contributory and subsidized regime members (Giedion & Uribe, 2009). Since public sector health spending accounts for about 72.7% of total health expenditures (general taxes, funds from the state petroleum company,

16 World Bank’s World Databank, 2012
automobile insurance funds, and obligatory payroll taxes) and out-of-pocket spending makes up another 19.5% of total health expenditures (with the rest spent by private health insurers)\(^\text{16}\), collection of HIV & AIDS funds is well-integrated with collection of general health expenditure in Colombia.

Chile and Brazil have increased universal health coverage and the integration of HIV & AIDS financing through a combination of public and private insurance. In Chile, about 80% of the population has access to healthcare through the social health insurance program, FONASA, and another 18% of the public uses one of Chile’s seven private health insurance entities known as the ISAPRES. This system is financed from four main sources: mandatory and voluntary SHI health contributions from formal and informal workers (28%), central government general tax revenue (30%), direct out-of-pocket spending by households (38%), and voluntary contributions to SHI and commercial insurers (4%).\(^\text{17}\) For a 7% mandatory payroll contribution from formal or independent workers earning above a minimum income threshold (Becerril-Montekio, Reyes, & Manuel, 2011), FONASA and ISAPRES cover a minimum guaranteed package of 80 explicit benefits (known as AUGE benefits), including HIV & AIDS services and treatment. Retired, poor, or unemployed citizens can access FONASA free of charge. Hence, since HIV & AIDS financing in Chile is collected as part of the overall SHI financing needed to provide the guaranteed AUGE benefits package, it can be considered highly integrated.

Brazil relies on a decentralized public health system for free universal coverage established by law as a right. While the Unified Health System (SUS) offers comprehensive health coverage and the entire population is eligible to receive services, about 25% opt for private insurers\(^\text{18}\). Under the SUS, policy and provision have been devoted to the level of the municipalities (with states and the federal government running the larger or teaching hospitals); funds collection takes place at the federal, state, and municipal levels; and the resources all flow down to the municipal level. The National Health Fund, funded from general taxes at the federal level, transfers resources to the state and municipal funds, to public and private providers, and to special SUS programs like the primary care-focused PSF. HIV & AIDS has been a priority area under the PSF: the public health system supports a network of hospitals, laboratories, and care centers for diagnosis, prevention, treatment and follow-up, which are all established and maintained with public funds to provide HIV & AIDS-related treatment and prevention services free of charge. Since similar resource allocation occurs at the state and municipal levels as well, collection of funds for HIV & AIDS is well-integrated on the whole into the wider health financing mechanisms in Brazil.

Finally, the Universal Coverage Scheme in Thailand serves as the main vehicle of integrating collection of financing for HIV & AIDS with the sources, methods, and structures of funding for the overall health system. Since its launch in 2002, the UCS, along with the civil service and formal sector social security medical benefits programs, has increased health insurance coverage to over 98% of the population in Thailand (75% of the population on UCS, 16% on SS, 8% on CSMB, and negligible on private insurance)\(^\text{19}\). Healthcare under the UCS is free at the point of service and

\(^{18}\) Joint Learning Network for Universal Health Coverage—Brazil
\(^{19}\) Thailand National Health Security office
no premiums are charged. Instead, funding for the UCS is provided centrally from (progressive) general tax revenue, which is a mix of income, excise, corporate, VAT, and non-tax revenues, and depends on an annually-determined capitation rate and the number of UCS affiliates in each budget year (Satharanasuk, 2012). Importantly, since 2006, financing authority for the Universal ART program launched in 2003 has been transferred to the UCS, resulting in increased domestic spending on treatment ((Walaiporn Patcharanarumol et al., 2013); (NSP 2007-11)). The universal coverage, social security, and civil service schemes now account for 94% of all patients on ART. As a result, primarily treatment-focused domestic resources now make up 85% of HIV & AIDS spending in Thailand, while 70% of the rest comes from the Global Fund which funds prevention as well as more targeted treatment for some marginalized key affected populations ((Walaiporn Patcharanarumol et al., 2013); (NSP 2007-11)). Since this domestic spending derives from the UCS and other regular sources of health funds, HIV & AIDS collection is highly integrated in Thailand.

4.2 Integration in pooling

Low Integration:

Nigeria, Zimbabwe, and Vietnam are the only three countries in the sample for this study where the pooling of HIV & AIDS funds is not integrated with the wider health financing pool. All three of these countries are in the low or lower-middle income categories and have low or inadequate insurance coverage for healthcare for their populations. Zimbabwe and Nigeria also suffer from generalized HIV & AIDS epidemics. Importantly, collection of HIV & AIDS funds in Nigeria, Zimbabwe, and Vietnam is not integrated with general health system financing. Vertically-financed, donor-supported financing systems in Zimbabwe and Nigeria provide 85% and 75% of HIV & AIDS financing in Zimbabwe and Nigeria respectively, while most funding in Vietnam is also sourced externally. This low integration in collection is thus also reflected in the pooling of HIV & AIDS funds. In Nigeria, domestic revenues for health are pooled with the federal ministry of health, the National Health Insurance Scheme (NHIS), and in additional insurance pools under CBHI-like models. Federal Ministry of Health coordinates the health sector component of the HIV & AIDS response while other line ministries take charge of inter-related activities. The National Agency for the Control of AIDS (NACA)—the government body responsible for coordinating the HIV & AIDS response—appears to mainly coordinate, and not pool, funding flows. Since most funding for HIV & AIDS from external donors is not incorporated in the general health budget and NHIS does not cover health services for the general population, there is low integration of HIV & AIDS pooling in Nigeria. Similarly, in Zimbabwe where 90% of the population accesses public-funded healthcare, HIV & AIDS funds are also primarily pooled separately from general health funding. The main domestic financing program, a 3% AIDS levy, comprises only 15% of overall financing and is pooled with the National AIDS Trust Fund under the National AIDS Council. Donor funding, however, is pooled in multiple separate arrangements. PEPFAR funds are channeled to service delivery sites or providers directly supported by U.S. government (PEPFAR COP, 2012), while UNDP has had the charge of managing and distributing Global Fund support in Zimbabwe (UNDP). Additionally, various development partners have pooled HIV & AIDS-related funding in recent years under arrangements like the Extended Support Program (CIDA, DFID, Norwegian Aid, Irish Aid and SIDA) and the Programme
of Support (Australia, the European Union, Germany, Netherlands, New Zealand, Sweden and the United Kingdom) (UNAIDS-GARP, 2012). Thus, the pooling of HIV funds, like their collection, is very fragmented in Zimbabwe.

Finally, in Vietnam, general health funds are primarily pooled in one national fund with Vietnam Social Security (VSS). It receives premium contributions under all 25 membership categories (including subsidized ones) from all provinces for the country’s mandatory SHI system as well as for a voluntary non-commercial health insurance scheme (enrolling only 21% those ineligible for SHI) (Tien et al., 2011). Since VSS does not cover HIV & AIDS services, HIV & AIDS-related funding is pooled separately with different sources. As explained before, only 14.5% of HIV & AIDS spending in Vietnam is public and almost 74% of the resources come from international sources, with household spending making up the rest. PEPFAR funds constitute 50% of overall spending (69% of international financing) and are channeled directly to USG-supported service delivery sites or providers, while bilateral (mainly DFID) and multilateral (mainly WB, ADB, & GF) sources make up another 24%. All these resources are pooled separately from overall domestic health funding, with funders relying on local financing agents and providers to deliver services. Hence, HIV & AIDS pooling integration is categorized as low in Vietnam.

Medium Integration:

Countries in the sample with medium level of integration for pooling of HIV & AIDS funds include Ghana, Kenya, Rwanda, South Africa, and Philippines. All of these, except for South Africa, are low and lower-middle income countries, and, except for Philippines, they all have generalized HIV & AIDS epidemics. Also, while Rwanda, Ghana, and Kenya are ranked low for collection of HIV & AIDS funds, South Africa and Philippines are ranked high-to-medium and medium, respectively.

In Ghana, pooling for HIV financing is somewhat more integrated than collection, but it is still far from highly integrated. Of the 77% of HIV & AIDS spending sourced from external donors in 2010, 21% was sent to a pooled fund overseen by the Ghana AIDS Commission, which constitutes a non-integrated pool since it is used uniquely for HIV & AIDS. However, there is some integrated pooling of public funds for HIV and non-HIV uses in the health budget, the wage bill for public sector health workers, and public health facility capital costs, which is the rationale for coding Ghana’s pooling integration as medium. To attain higher degrees of pooling integration, donors could direct higher proportions of their resources to the Ministry of Health’s general health budget and to the nationally-pooled National Health Insurance Fund from where NHIS expenditures are sourced.

Similarly, in Kenya, there is some integration of domestic and external HIV & AIDS funding into the government budget. Government funds are pooled by the Treasury, but certain donor funds are considered “on-budget” and are also part of this budget (Kenya NASA 2007/08). This amount is channeled from the Treasury to the Ministry of Health (formerly Ministry of Public Health and Sanitation) through the National AIDS and STI control program and National AIDS Control Council (NACC). The NACC then coordinates transfers to Constituency AIDS Committees (CACs) and transfers to line ministries (Kenya NASA 2007/08). Overall, the ministry of health only manages 17% of HIV & AIDS funds, with other ministries and NACC managing an additional 5% and the NHIF only managing 4.1% (Kenya NHA 2009/10). On the other hand, “off-budget”
donor funding, much larger than the “on-budget” amount and a majority of HIV & AIDS funding in Kenya, is considered “extra-budgetary” and channeled directly through NGOs. The rest of the funds comprise households (20%) and private employer insurance. However, the Kenya National AIDS Strategic Plan 2009/10-2012/13 envisions an eventual pooled funding mechanism which would eliminate the NACC’s role as the administrator of funds for public services. Instead, management of public funds would remain with line ministries, leaving NACC responsible only for the management of non-public entities. The line ministries would then directly fund their decentralized structures. Hence, for now, HIV & AIDS funding is only somewhat pooled with financing for the broader health system.

In Rwanda, however, though mass health coverage has been achieved through a network of centrally-coordinated “health mutuelles” (MS) under a CBHI model, there is only medium integration in pooling of HIV & AIDS funds. While only 9.6% of the HIV & AIDS funds come from public sources and a little over 83% come from just PEPFAR and the Global Fund, resulting in low integration in collection (UNAIDS, 2012), there is greater harmonization in pooling: the Global Fund has recently launched a new partnership for implementing Rwanda’s 2013-18 national HIV strategic plan with “sharply reduced oversight” (Rege, 2014). Under the agreement, Rwanda will have more flexibility on spending US$204 million in Global Fund support, allowing for re-investing savings in the HIV response as part of the national health program. Rwanda will also be responsible for monitoring and evaluation with joint verification of results by the Global Fund. This pioneering GF mechanism aims to align external support with existing systems and strategy in Rwanda and ties future funding to changes in impact and outcome indicators. These funds will be presumably pooled with MS funds at the local community level, but they do, however, seem to be earmarked for AIDS spending. Similarly, a joint pool for performance-based transfer of funding from central to local governments also pays for many HIV & AIDS services, and receives contributions from the government of Rwanda and various international partners20. PEPFAR, on the other hand, mainly channels funds directly to USG supported delivery sites and providers for prevention, treatment, and capacity building activities. Though there is some ongoing or planned transfer of resources to the Government of Rwanda for commodities and warehousing and for clinical services, most PEPFAR support remains vertical and off-budget (PEPFAR, 2013). Hence, overall, Rwanda, displays greater, but still only partial, integration in the pooling function for HIV & AIDS financing than it does in the collection one.

In South Africa, pooling of HIV financing begins with the same pattern as the collection function—dominated by the integrated pooling of domestic public revenues at the national level; integrated pooling of funds by individual Medical Schemes in the private sector; and non-integrated, HIV-earmarked donor funding. However, domestic public funds that are initially collected and pooled by National Treasury are then allocated by Treasury to the national, provincial, and local levels of government. Funds for provinces and local governments are allotted as “equitable shares” and “conditional grants,” with conditional grants for health flowing through the National Department of Health.

20 Such as the World Bank, Government of Rwanda (PHRD grant), Bank-Netherlands Partnership Program (BNPP) ESRC/DFID, and GDN.
and distributed as earmarked grants for particular purposes to provinces. Therefore, while there is a high degree of integration in initial collection of funds at the national level, funds received by provinces for the purpose of implementing HIV & AIDS programs are no longer considered an integrated pool of funding for general health needs. Overall, HIV & AIDS financing integration drops to medium when moving from collection to pooling.

Finally, pooling is ranked medium in the Philippines because there is integrated pooling of domestic resources for health within the Department of Health, which provides supply-side delivery of ARVs, and PhilHealth, the social health insurance program which covers 82% of the population and provides outpatient HIV & AIDS treatment. Public hospitals that are designated as “treatment hubs” also receive integrated funding. Also, funding from the Global Fund, which represents 50% of the population working in the formal sector, including services for HIV & AIDS, is paid for through payroll taxes and government subsidies. Social security providers IMSS and ISSSTE pool these health funds nationally for 97% of these enrollees. Similarly, although general pooling, purchasing, and provision take place at the state level in Seguro Popular, the social insurance program for the rest of the population, the catastrophic fund covering HIV & AIDS services (the FPGC; described above) is managed at the federal level to assure adequate risk pooling. However, external funding is earmarked for HIV & AIDS services; thus increasing pooling integration from its current rank of medium would require that international donors provide direct support to the general health budget for the Department of Health as well as PhilHealth.

High Integration:

Five countries—Thailand, Mexico, Colombia, Brazil, and Chile—display high levels of integration in pooling HIV & AIDS funds with those for financing wider public health spending. Here, the four countries other than Thailand are all in Latin America and have low HIV-prevalence (<1%). They are all upper-middle or high income countries and have achieved mass health coverage through various systems. However, as the following description shows, there is considerable variety in the mechanisms involved for pooling HIV & AIDS funds.

Mexico, Colombia, Brazil, and Chile, the four Latin American countries in this subgroup, have a diversity of mechanisms to pool health funds. In Mexico, as discussed before, healthcare for about 50% of the population working in the formal sector, including services for HIV & AIDS, is paid for through payroll taxes and government subsidies. Social security providers IMSS and ISSSTE pool these health funds nationally for 97% of these enrollees. Similarly, although general pooling, purchasing, and provision take place at the state level in Seguro Popular, the social insurance program for the rest of the population, the catastrophic fund covering HIV & AIDS services (the FPGC; described above) is managed at the federal level to assure adequate risk pooling. On the other hand, in Colombia, the General System for Social Security for Health (SGSSS) covers 96% of the population under its contributory and subsidized regimes, with both regimes covering HIV & AIDS services as catastrophic spending. Under SGSSS, revenue from the 12.5% monthly income contribution from the contributory regime reverts to the central Solidarity and Guarantee Fund (FOSYGA) with the Ministry of Social Protection, from where it is transferred for pooling and purchasing to a network of insurance companies (EPS-C) based on a nominal capitation rate for their enrollees. 1.5% of this revenue stays in FOSYGA to finance, along with government taxes, the subsidized regime under SGSSS. Funds

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22 Respondent interviews indicate the government eventually plans to integrate the FPGC with the common pool for greater sustainability.
under this regime are also paid out to another set of insurance companies (EPS-C) for pooling and purchasing based on another nominal capitation rate for the concerned population base.

Under socialized healthcare in Brazil’s comprehensive and decentralized Unified Health System, funds are collected at the federal, state, and local levels but flow down to the local level. Hence, the National Health Fund transfers resources to the State Health Funds and to the Municipal Health Funds which consolidate funds from different sources. The NHF also transfers resources to PSF, the Family Health Program which covers HIV & AIDS. The federal government has also financed production and procurement of ARVs since the early-1990s. Similarly, in Chile, 80% of the public is enrolled with the government’s health insurance program FONASA while another 18% benefits from coverage by private insurers called ISAPRES. Both these mechanisms ensure the provision of the benefits package under AUGE, Chile’s health system reform, which includes HIV & AIDS services. Funds are pooled in a large national fund under FONASA, while the seven ISAPRES can have risk adjustment mechanisms between their funds. Hence, while there are several pools of healthcare funds, they are all used to pay for the benefits covered under AUGE. Overall, while the four Latin American countries in this subgroup have different health system financing mechanisms, they all have high insurance enrollment, cover HIV & AIDS services, and provide financing through the regular, and thus highly integrated, collection and pooling arrangements for HIV & AIDS.

Finally, Thailand too has highly integrated pooling of HIV & AIDS funding. In Thailand, about 98% of the population is covered by the Universal Coverage Scheme and the civil service and formal sector social security medical benefits programs. These three funding pools account for 94% of the 240,000 Thai citizens on ART (72%, 3%, & 19%, respectively) As the main coverage mechanism covering 75% of the population, funding for the UCS is pooled by the National Health Security Office and channeled to 13 regional offices all over the country. Hence, although parallel, mainly Global Fund-funded CSO outreach caters to Thai and non-Thai key affected populations where government has poor access, HIV & AIDS funds are primarily sourced from regular pools for health funding.

### 4.3 Integration in purchasing

**Low Integration:**

Purchasing for HIV & AIDS services in Kenya, Nigeria, Zimbabwe, and Vietnam is not integrated with the general purchasing mechanisms in these countries for health services and commodities. While all four of the countries in this subgroup of the sample in this study are low or lower-middle income, Vietnam is the only one not in sub-Saharan Africa or suffering from a generalized HIV epidemic. Also, except for Kenya which has medium integration for pooling of HIV & AIDS funds, all of these countries have low integration in the other financing functions as well.

According to the last National AIDS Spending Assessment that was done in 2007/8, 45% of spending and provision in Kenya was in public facilities, 24% in NGOs or CBOs, 24% in faith-based organizations, and 7% in bilateral or multi-laterals

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23 Thailand National Health Security office
arrangements. Most domestic funding is coordinated by AIDS Coordinating Units (ACUs) and Central Planning and Project Monitoring Units (CPPMUs) in line ministries. Line ministries are responsible for sharing HIV resources and plans with districts which can incur expenses to undertake agreed upon HIV activities. Although some of the donor money is integrated into the Ministry budget and therefore streamlined with the Ministry’s contracting and purchasing systems (resulting in the medium rank for pooling integration), the majority of donor funding supports separate procurement of commodities and support to NGOs or FBOs. For instance, PEPFAR, the largest HIV & AIDS initiative in Kenya, procures and distributes ARVs and medicines for opportunistic infections through Mission for Essential Drugs and Supplies (MEDS) and Kenya Medical Supplies Agency (KEMSA; a state corporation working under the Ministry of Health), and laboratory commodities through Supply Chain Management Systems (SCMS). Similarly, the Clinton Health Access Initiative and the Global Fund procure commodities internationally. The Japan International Cooperation Agency, another prominent HIV & AIDS funder in Kenya, also purchases test kits from international vendors and delivers commodities for local distribution from KEMSA. Hence, HIV & AIDS purchasing in Kenya is quite fragmented, with numerous vertical mechanisms for channeling donor funds resulting in low integration with general public health purchasing.

In Nigeria, the National Agency for the Control of AIDS (NACA) is responsible for the coordination of the AIDS response at the national level. It coordinates state and local agencies for the control of AIDS (SACAs and LACAs), CSOs, private and public sectors, and development partners. The HIV/AIDS Division, (formerly, National AIDS and STI Control Programme-NASCP) in the Ministry of Health coordinates the health sector response. Actual service delivery takes places through a number of channels, including Nigeria’s public health system, private health facilities, and civil society organizations (CSOs) as well as faith-based organizations (FBOs). Though the response is decentralized to the State (SACAs) and Local (LACAs) levels, the ownership by states and localities remains low and is a challenge for successful implementation. Purchasing within the public health system happens at the SACA and LACA levels which is financed by federal funding transferred to state and local authorities as a statutory allocation. While the exact share of primary health care financed from public sources varies across states, as some states have greater share of NGOs and the private sector, local governments consistently tend to be the largest purchasers of health staff, facilities, and commodities. However, this is not the case for Nigeria’s HIV response. PEPFAR and the Global Fund, together accounting for some 81% of HIV & AIDS spending in Nigeria, have parallel mechanisms for purchasing targeted services and interventions. PEPFAR directly channels funds to service delivery sites or partners, while Global Fund grants are managed and used for purchasing HIV & AIDS services and commodities through Principal and Sub Recipients such as government and NGO partners, mainly NACA, Society for Family Health, Association for Reproductive & Family Health, and the Yakubu Gowon Centre for International Co-operation. Thus, like collection and pooling, HIV & AIDS-related purchasing in Nigeria is significantly fragmented and carried out through vertically-funded mechanisms.

In Zimbabwe, the national AIDS levy under the National AIDS Council is the main public funding mechanism. It raised US$26.5M in 2011 and used about 50% of these funds for procuring ARVs and the rest for other HIV-related services and administration. However, purchasing of services and
commodities in 85% of the HIV & AIDS response funded mainly by international partners, like PEPFAR, Global Fund, and bilateral consortiums like the Extended Support Program and the Programme of Support, is undertaken through distinct and disjointed mechanisms. PEPFAR purchases commodities and services through direct support to delivery sites and providers, although it contributes the ARVs it purchases for Zimbabwe, targeted at 17% and 15% of the national ARV supplies in 2012 and 2013, to the national commodity pool maintained by the Ministry of Health & Child Welfare. PEPFAR’s support to the public program also funds key positions in the headquarter of the national ART program, pays for leadership and management training to more than 60% of the “District Health Executive” teams managing the ART program, and finances 167 laboratories monitoring people on ARVs. However, these funds are channeled through direct PEPFAR administration. UN agencies and the Global Fund, with grants by the latter also managed by UNDP as a principal recipient, account for about 47% of the international response in Zimbabwe. This funding also independently finances ARV procurement and supports prevention and capacity development for institutions and communities. Hence, purchasing for HIV & AIDS in Zimbabwe is primarily located outside the public health-related procurement mechanisms.

Finally, in Vietnam as well, HIV & AIDS purchasing is considerably fragmented from that in the general health system. Vietnam Social Security, the public health coverage program with over 60% enrollment does not cover HIV & AIDS services for adults. Instead, public expenses on HIV & AIDS are incurred under a National Targeted Programme for 2011-15, run by the Ministry of Health, and form only 14.5% of total AIDS spending in Vietnam. According to the last available spending assessment, 43% of these public funds came from the federal government while 57% came from state governments. At 44%, programme management and administration form the largest component of public spending with prevention a close second at 35%, and treatment and care a distant third at 13% of the spending (National Committee for AIDS, 2012). It seems that these public funds are spent on supplying commodities and services through the general health infrastructure for minors and students living with HIV and for treatment of opportunistic infections which are typically not covered by donor systems. Household spending on HIV & AIDS in Vietnam, focused on treatment and care, makes up 11.8% of total spending and is primarily spent on purchasing commodities and services directly from providers and pharmacies. The rest, 74% of total spending, is channeled through bilateral and multilateral donor arrangements to purchase HIV prevention and treatment (National Committee for AIDS, 2012) mainly as projects at stand-alone out-patient clinics (OPCs). As usual, PEPFAR, at 50% of total HIV & AIDS spending, purchases services locally through implementing partners from service delivery sites and providers. Global Fund, however, transfers funds directly to programs in the Ministry of Health, which is a principal recipient. But, at only 4.7% of total spending, GF aid is small and, in any case, public HIV & AIDS purchasing itself is not integrated well with general health purchasing. Hence, overall, Vietnam has low HIV & AIDS purchasing integration.

Medium Integration:

Purchasing of HIV & AIDS-related services and commodities in Philippines, Ghana, South Africa, and Rwanda displays medium integration with existing health service delivery and commodities procurement systems. Except for the integration of the
collection function in Ghana (low), South Africa (high), and Rwanda (low), all other HIV & AIDS financing functions in these countries also demonstrate medium integration.

Purchasing for HIV & AIDS in the Philippines at the domestic level is mostly integrated as both the Department of Health (DOH), which funds supply side delivery of ARVs, and PhilHealth, which provides SHI coverage for 82% of the population and covers HIV & AIDS through the “Outpatient HIV/AIDS Treatment Package” (OHAT) initiative, purchase services from the same “treatment hubs”. These hubs are hospitals with established HIV & AIDS core teams (HACTs) providing prevention, treatment, and support services. Publicly-funded ARVs are only available in these facilities (PNAC, 2012). PhilHealth directs its members to these treatment hubs to avail of the OHAT and then pays through a case-based payment scheme with maximum annual reimbursement capped at 30,000 pesos. The treatment facility is paid in quarterly installments as long as there was some treatment during this time. However, international donors, accounting for 48% of the total spending, purchase outside the DOH system (PNAC, 2012). External money, such as Global Fund support which is channeled through the DOH, funds NGOs (primarily the AIDS Society of the Philippines and the Positive Action Foundation) which then provide their own prevention and treatment programs. Hence, public spending on commodities and high SHI coverage in the Philippines, coupled with salient parallel donor-funded mechanisms for procurement and provision, have led to medium integration in HIV & AIDS purchasing.

Similarly in Ghana, HIV & AIDS purchasing is at least as integrated as the pooling function, and possibly more. The Global Fund, the largest HIV donor in Ghana and source of 85% of the National AIDS Control Program budget, was recently evaluated for its level of integration with Ghana’s general health system. With the Ministry of Health the primary recipient of Global Fund grants and the Ghana Health Service the primary implemeneter, Global Fund activities were found to pay for services, commodities, and training mostly through the existing health service delivery and commodities procurement systems. There is also a high degree of integration in the purchasing of health worker labor through the government’s wage bill. While a good deal of integration exists now between HIV and non-HIV purchasing in Ghana, the glaring exception is the purchasing done within the National Health Insurance Scheme, which excludes HIV & AIDS-related medicines and services. As NHIS expenditures (which are mostly comprised of reimbursement of claims and new capitation-based payments to providers) account for increasing shares of health spending in Ghana, moving to a high level of integration of HIV purchasing would imply adding HIV benefits to the NHIS benefit package and array of payment mechanisms.

Integration for the purchasing function is ranked as medium in South Africa as well. Collection in South Africa is highly integrated as it raises 75% of its HIV & AIDS funding from domestic public revenues. These funds are transferred to the provincial and local levels as earmarked financing for HIV & AIDS in the form of “equitable shares” and “conditional grants”, respectively, which results in a lower pooling integration rank of medium. Most purchasing takes place at the provincial level, which funds specialist hospital services and ambulance needs, and oversees all province-wide and district-level health infrastructure and services. The local governments only provide specified primary care services for which funding for purchasing is made
available by the provinces. Earmarked funding for HIV & AIDS, thus, can be utilized through these channels in an integrated manner. Similarly, HIV & AIDS services can also be purchased on behalf of the 16% of the population covered by medical schemes in an integrated manner as the prescribed minimum benefits for these schemes cover HIV & AIDS hospitalization and treatment, including ARVs, according to the national guidelines prevalent in the public healthcare sector. However, 16% of the HIV & AIDS funding is sourced from external donors with PEPFAR and Global Fund being the largest bilateral and multilateral donors, respectively—providing almost 60% of total foreign funding. The governments of Netherlands and the United Kingdom together provide an additional 20%. As earmarked funding for HIV & AIDS, these funds are only partially integrated in the public purchasing mechanisms for commodities and services. For instance, while the National Department of Health and the National Treasury receive direct support as two of the Global Fund’s principal recipients, civil society agents and implementing partners like National Religious Association for Social Development, Right to Care, and Networking AIDS Community of South Africa also receive funding. Similarly, PEPFAR, which started out in South Africa by directly purchasing treatment services and clinical care from providers, has increasingly shifted to technical assistance and health system strengthening as domestic resources have increased. Increasingly, PEPFAR assistance is being brought on-budget as earmarked support for delivery of services through the public infrastructure. However, PEPFAR’s parallel procurement and service delivery channels remain salient. Hence, HIV & AIDS-related purchasing in South Africa is increasingly but still only partially integrated with the same function in the public health sector. Finally, in Rwanda, universal health coverage has been achieved through a network of community-based health insurance schemes called Mutuelles (MS), although domestic public resources only make up 9.6% of HIV & AIDS-related financing and 90.2% of the resource pool is derived from foreign donors like PEPFAR (42.7% of total) and the Global Fund (40.6% of total) according to the latest available estimate from 2009-10 (UNAIDS, 2012). The MS is offered through a decentralized, multi-tier public health system of over 500 local health centers and dispensaries, 48 district hospitals, and 4 national referral hospitals. It provides a Minimum Package of Activities (PMA) at local health centers and a Complementary Package of Activities (PCA), covering prevention, family planning, and curative services for those referred, at district hospitals (Lu et al., 2012). While the PMA does cover HIV & AIDS prevention and treatment services, ART is generally considered to not be available. In any case, only 30% of health centers are able to provide the comprehensive list of activities according to an estimate of the Ministry of Health (MOH, 2009). Consequently, while government funding is channeled through PMA and PCA at public facilities, donor funding for HIV & AIDS is only partially integrated with this mechanism for pooling and purchasing (Doetinchem et al., 2010). The Global Fund has begun to route earmarked funding through government channels under the recently-launched 2013-18 partnership, with greater flexibility on spending and joint monitoring and evaluation. However, although PEPFAR is beginning to put some funds ‘on-budget’ in Rwanda for commodities, warehousing, and clinical services, it still primarily channels its support directly to service delivery sites and providers through implementing partners. Hence, there is considerable but still only partial integration in HIV & AIDS-related purchasing in Rwanda.
Finally, HIV & AIDS-related purchasing in Thailand, Mexico, Colombia, Brazil, and Chile is highly integrated into the general health purchasing and procurement mechanisms. All five of these countries have high levels of per capita income and health insurance coverage, and apart from Thailand (Asia; 1.1%), the rest are all Latin American countries with low-level HIV & AIDS epidemics.

In Thailand, as explained before, extensive insurance coverage and comprehensive benefits through the country’s Universal Coverage Scheme as well as smaller social security and civil service benefits programs have resulted in high integration of the collection and pooling functions for HIV & AIDS-related financing. These programs comprise 85% of HIV & AIDS financing and cover 94% of the individuals on ART. They primarily fund HIV & AIDS care and treatment services for Thai citizens though, and purchase commodities and services from hospitals and health centers run by the Ministry of Public Health (Hanvoravongchai, Warakamin, & Coker, 2010). The Global Fund provides 70% of the international financing in Thailand, which is not integrated into the general health system as the Global Fund has distinct payment and accounting protocols (Hanvoravongchai et al., 2010). This financing is channeled through implementing partners from the civil society and used largely for HIV-prevention activities and for treatment and care for mainly non-Thai key affected populations since government facilities do not cover non-Thai citizens. Hence, overall, HIV & AIDS-related purchasing is highly integrated with the general health system in Thailand.

Mexico, Colombia, Brazil, and Chile also have highly integrated HIV & AIDS purchasing. In Mexico, coverage for the 266 benefits offered under Seguro Popular, the social insurance program covering the half of the population employed informally, is only available at public facilities (Bonilla-Chacin & Aguilera, 2013). Generally, purchasing and provision take place at the state level as state governments are responsible for the administration of program resources. However, comprehensive care for HIV & AIDS under SP is funded through the FPGC, the catastrophic care fund, which covers 49 catastrophic events and is pooled at the national level as a trust, comprising 8% of all annual resources, managed by the National Commission for Social Protection of Health. The annual budgetary allocation to FPGC has grown twelve-fold over 2004-2011 as the number of enrollees grew, with provision taking place through direct federal reimbursements to federally-certified healthcare facilities, which are primarily located in the private sector (Knaul et al., 2012). However, interviews for this study with respondents indicate that such separate reimbursements mechanisms to pay private providers treating patients for HIV & AIDS do not currently exist, and the National Commission is purchasing HIV & AIDS services from both public sector facilities and a network of 56 integrated, publicly-funded HIV & AIDS outpatient clinics called CAPASITS (Saavedra, 2010). For 97% of the other half of the population employed in the formal sector, however, health coverage and HIV & AIDS services are provided (only) by providers affiliated with their respective social security institutions (IMSS and ISSSTE). Mexico, therefore, has achieved high ART coverage under highly integrated HIV & AIDS collection, pooling, and purchasing mechanisms.

24 The first of these outpatient clinics was launched in 2000. By 2010 more than 35,000 people with HIV were receiving care in the CAPASITS.
In Colombia, 96% of the public is enrolled with the General System for Social Security for Health (SGSSS). SGSSS creates “quality-centered competition among service providers and insurers” by enabling individuals enrolled in its contributory and subsidized regimes to pick their insurer as well as an affiliated provider. Hence, there is one market for insurance plans and another market for health services under the SGSSS. Since HIV & AIDS is covered as a catastrophic condition under both the SGSSS regimes and provision is primarily private, purchasing is highly integrated with the general healthcare system. In Chile, however, as mentioned earlier, 80% of the public is covered by FONASA, the public insurer, while another 18% is covered by seven private insurers called ISAPRES. Both these insurance systems cover HIV & AIDS under an explicit package of 80 benefits. While non-indigent FONASA beneficiaries have the option of availing private provision of healthcare for a higher copayment, most FONASA beneficiaries receive care through the public system administered by 27 decentralized Regional Health Services under the National Health Services System. Importantly, primary health care is also offered through 1870 municipal health centers also funded mainly by the federal government. FONASA’s payment mechanism for care through this system comprises capitation for primary health care and historic budgets for public hospitals combined with fee-for-service and prospective payment per case. Beneficiaries of ISAPRES, on the other hand, mostly avail healthcare services from private sector providers who are paid under fee-for-service arrangements. Hence, HIV & AIDS, as a regular benefit under the public system, is well-integrated into the general purchasing and provision systems.

Finally, HIV & AIDS care in Brazil has been prioritized under the PHC-centered Family Health Program of the Unified Health System. Under this decentralized system, state and municipal governments take charge of practically implementing national health policies, including the National STD/AIDS Programme, through Brazil’s public health infrastructure (“Case Study 3: National STD/AIDS Programme, Federal Ministry of Health,” 2011). Funding trickles down to the local level under this system such that these activities at the level of state and municipal governments are financed through the regular mechanisms of the Unified Health System. These mechanisms include direct earmarked transfers between national, state, and municipal health funds which represent nearly all of the financing for primary, medium, and tertiary health services, incentives policies funds to finance actions or commodities targeting key affected groups (like people living with HIV & AIDS), and administrative and transfer agreements between federal public organizations and local public entities or NGOs to fund specific activities like provision of services. These mechanisms cover full HIV & AIDS service coverage, including free-of-charge ARVs, under a comprehensive package of benefits for 75% of the population enrolled in the public system. The 25% of the population on private insurance can access highly standardized insurance plans regulated by the National Health Agency and offered by private companies, cooperatives, and medical organizations. These entities buy services for beneficiaries from private providers under fee-for-service arrangements. Hence, purchasing of HIV & AIDS services and commodities under Brazil’s national public insurance system is also highly integrated with the general health payment apparatus.

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25 Joint Learning Network for Universal Health Coverage—Colombia
26 Chile Ministry of Health
5. Conclusions and Recommendations

Integration of HIV & AIDS financing with that of general health financing systems has been identified as a potential means of improving efficiency and financial sustainability of HIV & AIDS programs, while also enhancing access, equity, and quality of general health coverage for the population. This landscaping exercise uses a well-known health financing framework to disaggregate the complex issue of integration and explore variation in country experiences. It forms a first step toward more in-depth country-level analysis and policymaking.

The country landscaping identified some general patterns in existing levels of integration in HIV and health financing. First, there is indeed substantial variation in the extent of such integration across countries and within countries over the three financing functions. It is therefore useful to disaggregate the idea of integration across these functions (and also across different components of the HIV & AIDS response) before making policy decisions about whether, where, and how integration should happen. Doing so may help identify feasible integration opportunities in certain functions even where others are more difficult—or in between the rarer occurrence of large, path-changing health financing reforms that affect all functions at once. For example, Rwanda shows that integration in the collection function may be unlikely in the medium term because of a country’s low-income and inability to raise adequate domestic resources, but it is still possible to integrate pooling and purchasing to some extent, all while advancing UHC goals.

5.1 High levels of integration

In the countries reviewed here, integration appears to be more likely or easier to accomplish as country income rises and as HIV burden decreases. The five countries with higher levels of per capita income and low or concentrated HIV epidemics all had high levels of integration across the collection, pooling, and purchasing functions. All five are also relatively advanced in terms of UHC-oriented population coverage goals. The high integration exists even though these countries differ in the institutional arrangements employed to offer HIV and other health benefits. For instance, while Brazil has integrated the cost of HIV & AIDS treatment into its (non-insurance-based) universal public health system, Colombia has focused on including HIV & AIDS within a nationally-regulated benefits package offered primarily by private sector health insurers. Mexico has found a middle ground by covering informal and independent workers through public funding under Seguro Popular, parallel to formal sector workers’ coverage under the social security institutions. In sum, high levels of HIV financing integration can be achieved under a wide range of institutional approaches to UHC, but may be more difficult in low-income countries and countries with large HIV burdens.

5.2 Medium levels of integration

Five countries here represent a middle-ground of some integration for certain functions, but much less so than the countries described above. This group, and similar countries outside of the sample here, may be the most likely candidates for increased integration in the near term. This is already starting in South Africa, where the government and PEPFAR have been engaged in a thorough financial mapping and planning process to prepare for a transition away from PEPFAR funding, and next steps may include analysis of HIV-related
funding requirements for a future national health insurance system and the operational requirements for a future National Health Insurance Fund to pool funds and organize purchasing of HIV & AIDS services.

There is interesting variation in the pooling function among the six countries in the sample for this study with low levels of collection integration—with three of the countries also having low pooling integration, and the other three exhibiting medium levels. This creates a possibility for policy-relevant comparisons—for example, does a country such as Kenya with more HIV/non-HIV pooling appear to benefit somehow (or have its HIV programs harmed in any way) from the pooling compared to one with less, such as Zimbabwe?

The observed combination of low integration in collection with medium integration in pooling also points to a potential point of entry for promoting integration: even if low-income countries cannot integrate collection of HIV funding in the near term, they may be able to gain efficiencies, better spread health and financial risks, or lay groundwork for more sustainable (and domestically-driven) financing of their health systems by pooling some of their HIV funding with other health funds. Donors and countries with reasonably well-functioning national health financing pools/purchasers, such as Ghana’s National Health Insurance Fund/Authority, should be the first to explore whether at least some HIV funds could begin to be integrated into such pools. Rwanda, Kenya, and the Philippines could also be promising cases for increased integration in pooling of HIV and non-HIV financing in the short term.

Enhancing pooling integration requires a country to develop the capacity for robust monitoring and evaluation with credible verification of results by funders. Such integration should therefore serve to harmonize external funding with local systems and priorities and condition continued support on improvements in outcomes. Such “on-budget” support has already begun to be pioneered in Rwanda and Kenya where some earmarked external funds (Global Fund in Rwanda) are being channeled through government bodies which had previously served to only coordinate donor funding.

5.3 Low levels of integration

Countries in this sample where HIV financing is not integrated with overall health financing tend to be poorer, lack widespread health insurance coverage, and suffer from generalized HIV epidemics (except Vietnam). Donor-driven, vertically-funded programs in these countries source, pool, and pay out financing mostly independently of the wider health financing infrastructure, with governments largely performing coordination and planning functions.

The link between countries’ income and their level of integration in the collection of funding is one of the clearest and most intuitive relationships in this landscaping, mostly due to LICs’ higher reliance on external (and often earmarked) funding for HIV. LICs’ collection function may therefore be the least fertile ground to promote integration, but countries and donors should at least consider whether increased bundling of HIV and non-HIV assistance—through SWApS, budget support, or similar donor funding modalities—could save some resources in the short term and help lay the groundwork for a smoother transition away from external funding in the longer-term future. This is probably most feasible in LICs with at least some integration in the pooling and purchasing functions, such as Kenya and Rwanda.
5.4 Note on purchasing

There are special considerations for HIV integration in the purchasing function. Purchasing systems, which include specific payment mechanisms for particular goods and services (e.g., tariffs, salaries, fee-for-service, capitation, etc.), should be formulated to achieve certain health system goals, such as containing costs, reducing inequity, or improving access and quality. Integrating HIV and non-HIV purchasing systems has the potential to save administration costs of running parallel financial system and to create economies of scale that reduce costs of paying for all health services, including HIV/AIDS. However, given the unique characteristics and needs of HIV & AIDS—some of which are highlighted in Section 3—integration of payment mechanisms (i.e., using the same payment mechanisms, such as salary or capitation, to pay providers to deliver HIV and other health goods and services) must be considered cautiously. In some cases, it may well be that a separate, HIV-tailored payment arrangement (perhaps within a central purchasing entity’s operations) is best to ensure adequate utilization, overcome stigma, or achieve cost efficiencies for live-saving medicines. Monitoring and evaluation frameworks made need to be modified to accommodate HIV adequate quality for services covered by existing health purchasing arrangements and newly integrated HIV-targeted ones.

5.5 Further research and next steps

This review of experiences across 13 countries provides a foundation for further analysis and policy guidance. More evidence is especially needed on the impacts of particular forms of integration. In particular, there is a lack of evidence on the impact integration has on efficiency, quality, and access for HIV and non-HIV health services. It is also important to investigate how financing integration affects delivery arrangements, which was beyond the scope of this study. Further analysis is also needed to substantiate and mitigate the HIV-specific concerns flagged in section 3. Are countries with socialized or otherwise highly integrated HIV & AIDS financing in this study able to better sustain chronic treatment horizons, support public good components of HIV programs, generate and utilize data to adequately estimate HIV coverage costs, and ensure non-discriminatory delivery to marginalized or general populations? Connecting these concerns to the level and means of financing integration will help inform whether closely aligning HIV financing efforts with UHC efforts will serve HIV & AIDS responses, the needs of other health conditions, and the access and financial risk protection goals of UHC well.

Country case studies will be vital for systematically investigating these and other questions and producing context-relevant policy recommendations. As an immediate next step, this landscaping study can help identify priority countries for such case studies on the basis of factors such as HIV burden, domestic financing capacity, ongoing or future policy reforms for full population health coverage, and donor transition plans. These case studies can generate evidence for policy guidance on the integration issue by:

- Mapping HIV and non-HIV financing in detail across the three financing functions;
- Cross-referencing this financial mapping with types of HIV & AIDS goods and services;
- Costing and modelling the financial effects of integration to craft nuanced financial scenarios, identifying the best
opportunities for—and also risks of—integration along the lines of questions flagged above; and

- Conducting stakeholder analyses and suggesting ways of facilitating dialogue among stakeholders to inform any integration plans.

6. Acknowledgments

This study was written by a team of authors from the Results for Development Institute (R4D), including Nathan J. Blanchet, Adeel Ishtiaq, and Nandini Oomman. The authors thank Meredith Kimball for research assistance, Rob Hecht for guidance and review, and the following individuals for their very helpful comments on earlier drafts of this study: Priyanka Saksena, Department of Health Systems Financing at WHO; Nertila Tavanxhi, UNAIDS; Carlos Avila, Abt Associates; Elkana Ong’uti, Ministry of Medical Services Kenya; Lekan Olubajo, National Primary Health Care Development Agency, Nigeria; Francis Ukwaije, National Agency for the Control of AIDS, Nigeria; and Leizel Lagrada, Philippine Health Insurance Corporation.

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Foreword

At the June United Nations General Assembly High-Level Meeting on Ending AIDS, Member States committed to implementing a bold agenda to end the AIDS epidemic by 2030 through the adoption of a progressive, new and actionable Political Declaration. Together with the UNAIDS Strategy 2016-2021, these important documents bring hope for the 37 million people living with HIV around the world, two-thirds of whom still lack access to treatment. Only by rapidly scaling up their HIV programmes will countries reach this target. Large increases in investment are imperative, particularly in the near term, which is why many high-burden countries have embraced UNAIDS’ “Fast-Track” 90-90-90 HIV treatment targets for 2020.

South Africa has been a pioneer in these efforts, expanding access to HIV services over the last 15 years. Slowly but surely, the country is overcoming the world’s largest HIV burden. Development partners have played an important role in the epidemic response. However with donor support plateauing and expected to decline, the success of South Africa’s HIV programme will rest on its ability to mobilize and manage a sustainable flow of domestic resources.
Ending the AIDS epidemic is one of the targets of the Sustainable Development Goals, which also codify countries’ aspirations to achieve universal health coverage (UHC). At long last more countries are investing seriously in the realization of health as a human right, by enhancing their health infrastructure, training new cadres of health workers, and creating more equitable systems to protect all citizens from the risks of poor health.

Here, too, South Africa is a leader. The government has laid out a bold vision for a new National Health Insurance (NHI) scheme, which will guarantee access to a wide range of essential services, including those for HIV prevention, care, and treatment. This reform is a massive undertaking, requiring new thinking about how to finance and deliver health services for a large and diverse citizenry.

Ensuring the compatibility of South Africa’s HIV and UHC objectives is of paramount concern.

In this study, UNAIDS takes the first steps toward exploring whether integrating financing for HIV services into the broader NHI system is advisable and, if so, how it might be done. It offers four alternatives to the status quo and reviews their respective virtues and shortcomings. It also charts a detailed path forward for the government to further evaluate its options and, eventually, to implement one.

UNAIDS is fortunate to partner with Dr David de Ferranti, President of Results for Development Institute, whose team has broadened the HIV community’s understanding of integration’s promise and potential pitfalls.

We offer this analysis to South Africa as it deliberates over NHI financing policy design and the role therein of the health programme. We also hope our work and the discourse it stimulates will offer useful lessons for other countries, who often look to South Africa’s large and highly successful HIV response for inspiration.

Jose Antonio Izazola Licea
Division Chief, Evaluation and Economics
UNAIDS

Preface

I recall the last International AIDS Conference in South Africa, a dramatic and memorable event that took place in Durban in 2000 at a troubled moment in the history of the country’s HIV response. At that time the virus was spreading rapidly, prevention measures were inadequate, and HIV treatment was virtually non-existent. South Africa’s first National Strategic Plan for HIV/AIDS called for merely 400 million rand (about 60 million US dollars in 1999/2000) to fight the epidemic.

What a remarkable change has occurred over the past decade and a half—Mr. Mandela would be proud. With strong political leadership, South Africa has mounted a formidable response to HIV. The country and its development partners, including PEPFAR and the Global Fund, are annually investing more than 20 billion rand (2 billion US dollars in 2014/15) in the battle against the virus. More than 3 million South Africans are now on treatment, and every day new patients access services paid in full by the government. Rates of infection may be falling, but far too many people are still being infected. At the same time, the government has published its White Paper on National Health Insurance and is
starting to put in place the building blocks of a universal system.

In this dramatically changed context, this study can play an important role in tying together two daunting challenges: the long-term financial sustainability of South Africa’s HIV response, and the development of the NHI system.

Drafted in close consultation with key country stakeholders, the report lays out a series of options for the integration of HIV funding and other health financing over the next three to five years. It describes these scenarios in detail, including how they would reconfigure funding flows and distribute important responsibilities—target-setting, budget planning, and performance monitoring for HIV and other services—across the national, provincial, and local spheres. It then assesses the pros and cons of each option, offering insights into their political, legal, and technical feasibility, as well as estimating their impact on the HIV response, other primary health care services, and health system efficiency. Along the way the study flags key risks and knowledge gaps for each option and highlights which integrative approaches are most compatible with the NHI White Paper.

This effort is closely linked to Results for Development Institute (R4D)’s other health policy work in South Africa and elsewhere. For nearly a decade, and against the backdrop of the drive toward Universal Health Coverage, R4D has helped countries and their partners better estimate resource needs and track expenditure for HIV and other health programs; plan, manage, and evaluate the phase-out of donor support and transition to national self-reliance; assess options for integrating “vertical” and “horizontal” health funding streams; and design, implement, and strengthen national health insurance systems.

It is an honour for R4D to have been invited to conduct this study in consultation with the National Treasury, Department of Health, and other talented individuals and institutions in South Africa.

We hope that our work will make a meaningful contribution to the debate on HIV financing in South Africa, and to the search for the most efficient, equitable, and sustainable health financing solutions for the country and its 54 million people.

Robert Hecht
Results for Development Institute

Acknowledgments

This UNAIDS study was undertaken in consultation with the Department of Health and the National Treasury, and conducted by Results for Development Institute (R4D).

UNAIDS would like to thank the R4D team led by Robert Hecht, Nathan Blanchet and Michael Chaitkin, and including Teresa Guthrie, Neetu Hariharan, Adeel Ishtiaq, and Aparna Kamath.

UNAIDS gratefully acknowledges all of the colleagues and partners who helped this project to succeed. We thank the numerous government officials in South Africa who patiently assisted the study team to understand the country’s health financing system and the potential consequences of altering it. UNAIDS is particularly indebted to Mark Blecher, Jeanette Hunter, Anban Pillay, Yogan Pillay, and Edgar Sishi, as well as their respective teams in the National Treasury and
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UNAIDS would also like to acknowledge those who steered the study team in fruitful directions at various stages of the study. They include Bernd Appelt, Paolo Belli, Barry Childs, Stephen Hendricks, Stephanie Heung, Joe Kutzin, Naomi Lince-Deroche, Gesine Meyer-Rath, Lungi Nyathi, Mead Over, Tomas Roubal, Kerry Pelzman, Theresa Ryckman, Kate Schnippel, Derek Sedlacek, Shivani Ranchod, Rob Stanley, and Anna Vassal.

The study would not have been possible without the leadership provided by the UNAIDS South Africa Country Director, Erasmus Morah, who facilitated linkage to key contacts both within and outside South Africa, closely supported by Eva Kiwango, who enabled this work in-country. Special thanks go to Jose-Antonio Izazola and Nertila Tavanxhi for their advice, and to the UNAIDS/World Bank HIV Economics Reference Group for helping to shape the study and providing the funding for it.

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**Abbreviations**

<table>
<thead>
<tr>
<th>ART</th>
<th>Antiretroviral therapy</th>
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<tbody>
<tr>
<td>CG</td>
<td>Conditional grant</td>
</tr>
<tr>
<td>CMS</td>
<td>Council for Medical Schemes</td>
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<tr>
<td>DHMO</td>
<td>District Health Management Office</td>
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<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DORA</td>
<td>Division of Revenue Act</td>
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<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>FY</td>
<td>Financial year</td>
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<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis, and Malaria</td>
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<tr>
<td>HAST</td>
<td>HIV &amp; AIDS, STI, and TB</td>
</tr>
<tr>
<td>HIV CG</td>
<td>Comprehensive HIV and AIDS conditional grant</td>
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<tr>
<td>HMIS</td>
<td>Health management information system</td>
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<tr>
<td>MMC</td>
<td>Medical male circumcision</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NDOH</td>
<td>National Department of Health</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
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<tr>
<td>NHIF or NHI Fund</td>
<td>National Health Insurance Fund</td>
</tr>
<tr>
<td>NT</td>
<td>National Treasury</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing mother-to-child transmission</td>
</tr>
<tr>
<td>PDOHs</td>
<td>Provincial Departments of Health</td>
</tr>
</tbody>
</table>
Executive Summary

Background and motivation

South Africa’s government has committed itself to achieving universal health coverage for its population. A proposed national health insurance (NHI) system would consolidate resources in a centrally managed Fund that purchases services from both government-run and private health care providers. In preparation, the government is already reengineering primary health care to ensure all public clinics are adequately staffed, equipped, and managed to efficiently deliver high-quality services.

At the same time, South Africa has embraced ambitious goals for its burdensome HIV epidemic. In accordance with UNAIDS’s 90-90-90 framework, by 2020 in South Africa:

- 90 percent of people living with HIV will know their status,
- 90 percent of those diagnosed with HIV infection will receive antiretroviral therapy, and
- 90 percent of those receiving treatment will have viral suppression.

Today more than 3.4 million South Africans living with HIV receive life-sustaining therapy, reflecting the country’s (and its development partners’) rapid scale-up of investment in treatment and other interventions. Unless a cure emerges, they and 3.5 million additional people living with HIV will need treatment for the rest of their lives. Meeting their health needs, and thereby achieving the 90-90-90 targets, will require even greater investment in HIV services, which already consume more than a tenth of the government’s health budget.

Currently the financing and delivery of health services is largely in the purview of the provincial sphere of government; each province is free to distribute its share of national revenue, determined by an equitable share formula, between sectors and specific activities therein. In complement, through conditional grants from national line ministries to their provincial counterparts, the national sphere ring-fences funding for priority government investments, including the national HIV response. For more than a decade the Comprehensive HIV and AIDS conditional grant has provided the vast majority of government financing for HIV activities. This could all change under an NHI
system, raising important questions about the future of South Africa’s health financing and service delivery systems.

This feasibility study seeks to help the South African government to answer one such question: over the next three to five years, as the government continues preparing the design and implementation of a new NHI system, how might HIV and other health services be financed in a more integrated fashion? Toward that end, the study characterizes in detail the government’s current health financing system, describes the status quo and four additional scenarios for reconfiguring HIV financing, and evaluates these options for their feasibility and potential impact on the health system.

It serves as a discussion document for government officials and other health sector stakeholders and, consequently, does not explicitly endorse or recommend any of the scenarios. Instead, the study strives simply to highlight the opportunities and risks posed by each option and the similarities and trade-offs between them.

**Methodology**

This study required a combination of desk research and stakeholder and expert consultation. In addition to reviewing publicly available literature, we consulted with officials from the National Treasury and National Department of Health to gain access to documents and data pertaining to health sector policy and expenditure. In parallel, we interviewed numerous government officials at the national and provincial levels, as well as consulted with South African and international experts on HIV financing and health system reform. These processes enabled us to unpack the incumbent health financing system and develop four alternative HIV financing scenarios.

**Five HIV financing scenarios**

The study features five scenarios indicative of the government’s options in the next three to five years:

1. **Sustained HIV conditionality** (status quo) would maintain the ring-fencing of HIV funds in a large conditional grant and the financing of most other health services through the equitable share.

2. A **National HIV Fund** would pool the majority of financing currently flowing to provinces through the HIV grant. The Fund would purchase a package of personal HIV services, while a small grant would continue to finance non-personal HIV services.

3. **Unconditional integration** would eliminate the HIV grant and fold all HIV funding into the equitable share, whose allocation formula would be modified to account for HIV burden.

4. **Ring-fenced PHC integration** would create a large conditional grant covering all primary health care services, including for HIV. Funds could be shifted from the equitable share to the grant, or new resources could be added to the grant over time by the national sphere.

5. A **National PHC Fund** would pool financing currently flowing through the HIV grant with additional resources for other primary health care services. Additional funds could be shifted from the equitable share to the Fund, or new resources could be added to the Fund over time. The Fund would purchase all personal primary health care services, while provinces would remain responsible for non-personal services.
As Figure ES.1 depicts, these scenarios vary along two key dimensions. First, they differ in terms of how integrated financing for HIV and other health services would be (vertical axis). Given the study’s time horizon of three to five years, we did not consider scenarios that would fully integrate all health financing. Instead, our options range from further isolating HIV financing (i.e., decreasing the extent of integration) to pooling together all funds for primary health care services, including those for HIV.

Second, if the government were to revisit the configuration of HIV financing, it would be important to understand to what degree the national sphere would continue to exercise influence over the use of funds intended for HIV activities (horizontal axis). Accountability at the national level may be crucial to further scaling up the HIV response. Therefore, some of our scenarios for HIV financing would strengthen the national sphere’s authority over HIV funds, while some would retain or even dilute the current level of influence.

**SNAPSHOT OF FIVE SCENARIOS FOR HIV FINANCING REFORM.**

- **1** Sustained HIV conditionality
- **2** National HIV Fund
- **3** Unconditional integration
- **4** Ring-fenced PHC integration
- **5** National PHC Fund

Alternate vision: 9 PHIFs

White paper vision: Single NHIF

Source: Authors.

Notes: Solid lines indicate movement from the current HIV financing approach (Scenario 1) to the other four scenarios presented in this study. Dashed lines (Green) depict potential pathways from those scenarios to the NHI system proposed in the White paper (2015). Dotted lines (grey), in contrast, show the potential pathway from the current system to a more devolved NHI scheme in which each province manages its own insurance fund.

Abbreviations: NHIF = National Health Insurance Fund, PES = provincial equitable share, PHC = primary health care, PHIFs = Provincial Health Insurance Funds.
The five scenarios are not intended as potential end points of health financing reform. Some of them could be sequenced in a series of incremental changes toward the eventual creation of an NHI Fund, or features of multiple scenarios could be combined into a single alternative. The solid and dashed arrows in Figure ES.1 indicate several possible pathways from the status quo through one or more of this study’s scenarios, ultimately arriving at a single NHI Fund as proposed in the 2015 NHI White Paper. The dotted arrows plot a course toward a more devolved NHI system with nine provincial Funds.

Comparing the scenarios

Integration or other reconfigurations of HIV financing would entail considerable alterations to the size, nature, and governance of public-sector pools of health funds. Figure ES.2 presents illustrative allocations of the health sector budget for financial year 2016/17, with a new NHI Fund appearing in Scenarios 2 and 5. Notably, only a minority of funds would be implicated by the financing arrangements addressed in this study. Across all five scenarios, funds for all non–primary health care activities would continue to flow through the provincial equitable share, but the government could also explore changes to the pooling of hospital funds, for instance.

In addition to altering how health funds are pooled, the scenarios would also affect how HIV and other funds are governed. Only Scenario 3 would shift predominance over how HIV funds are spent to the provincial sphere, where Departments of Health and Treasuries would exercise full control over resource allocation across sectors and within the health sector. The other scenarios differ in terms of whether the national sphere would continue to ring-fence HIV (and other) funds before transferring them to provinces (Scenarios 1 and 4), or if a new nationally managed Fund would hold money centrally and dispense it directly to providers (Scenarios 2 and 5).

The reallocation of funds and revised governance of HIV spending would help to determine the scenarios’ impact and feasibility. Based on additional desk research and informant interviews, and drawing on our own reasoning and experience, we evaluated each option for its likely effect on South Africa’s HIV response, on primary health care services more generally, and on health system efficiency, as well as for its feasibility along legal, political, and technical dimensions. Our assessments are qualitative and merely indicative of the direction and relative magnitude of effect; quantifying any scenario’s impact would require a more resource-intensive modelling effort. Nonetheless, our evaluative scorecard (Table ES.1) can serve as useful input to government deliberations.

There are several key takeaways from the evaluation of the scenarios’ likely impact:

- If ‘do no harm’ is a guiding principle for HIV financing reform, unconditional integration (Scenario 3) stands out for the widespread view that it could severely undermine the HIV programme.
- There is some appeal in using the HIV programme to pilot an NHI system (Scenario 2), but given how integrated certain aspects of financing and service delivery already are, such an approach could do more harm than good.
- There is little basis for expecting pooling reforms alone to improve the HIV response or to increase health system efficiency. More strategic approaches to purchasing, which would be possible under any scenario, are a more promising way to promote efficiency through financing.
- Primary health care could benefit most from more integrated financing, particularly with considerable national influence (Scenarios 4 and 5), if management and service delivery were...
imbedded with similar business planning, resource tracking, and evaluation to what exists for HIV.

- Integrating primary health care financing under national influence or control (Scenarios 4 and 5) may offer the best balance between the government’s twin objectives of moving toward universal health coverage and achieving 90-90-90 coverage targets for HIV; however, of the scenarios analysed in this study, the status quo (Scenario 1) would pose the fewest risks to the HIV response.

Assessing feasibility also yields important conclusions:

- Only the status quo (Scenario 1) would be highly feasible in legal, political, and technical terms.
- Creating a new Fund (Scenarios 2 and 5) would be technically challenging and could invite legal or even constitutional challenges from provinces.
- Ring-fencing or nationalizing an integrated pool of primary health care funds (Scenarios 4 and 5) would require better tools and data for planning and monitoring primary health care services; such investments would benefit a future NHI system.
- Smooth implementation of a scenario, particularly if it is a clear interim step toward the proposed NHI system, could help to galvanize support for more ambitious reforms; conversely, mismanagement could undermine the broader NHI agenda.
- Ease of implementation may not be sufficient reason to pursue an option (e.g., Scenario 3), nor should anticipated challenges alone preclude a particular course (e.g., Scenarios 4 and 5).

**ILLUSTRATIVE ALLOCATIONS FOR SCENARIOS 1–5 FOR FY 2016/17 (R BILLION)**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Projected budget – PDOHs (R billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sustained HIV conditionality</td>
<td>85.8</td>
</tr>
<tr>
<td>2. National HIV fund</td>
<td>85.8</td>
</tr>
<tr>
<td>3. Unconditional integration</td>
<td>85.2</td>
</tr>
<tr>
<td>4. Ring-fenced PHC integration</td>
<td>85.8</td>
</tr>
<tr>
<td>5. National PHC Fund</td>
<td>87.6</td>
</tr>
</tbody>
</table>

Sources: National Treasury (2015b, 2016). Abbreviations: CGs = conditional grants, PES = provincial equitable share, PDOHs = Provincial Departments of Health, PHC = primary health care.
Looking ahead

This study provides useful input to government debate and decision making about the future of HIV financing and how its integration relates to the broader NHI agenda. In addition to assessing the feasibility and desirability of various integration scenarios, the study raises numerous considerations that require additional analysis and debate, and align well with the NHI work streams. These include:

- How to best integrate financing and delivery of primary health care and monitor performance;
- How to mobilize sufficient political support for integration and other challenging NHI reforms;
- How to concurrently address other important health financing issues, including the anticipated decrease in donor funding and the management of funding for hospital services; and
- How to manage the immediate integration of tuberculosis into the HIV grant.

In this formative time for South Africa’s health system, the government’s HIV response will factor critically into any major reforms. Integration could position HIV as the ‘tip of the spear’ of NHI design.

### SUMMARY SCORECARD OF IMPACT AND FEASIBILITY, SCENARIOS 1–5.

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>IMPACT</th>
<th>FEASIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV RESPONSE</td>
<td>PHC SERVICES</td>
</tr>
<tr>
<td>1. Sustained HIV conditionality</td>
<td>Reference scenario</td>
<td></td>
</tr>
<tr>
<td>2. National HIV Fund</td>
<td>Ø/-</td>
<td>?/-</td>
</tr>
<tr>
<td>3. Unconditional integration</td>
<td>--/-</td>
<td>Ø/-</td>
</tr>
<tr>
<td>4. Ring-fenced PHC integration</td>
<td>Ø</td>
<td>++</td>
</tr>
<tr>
<td>5. National PHC Fund</td>
<td>Ø/-</td>
<td>+</td>
</tr>
</tbody>
</table>

Source: Authors’ assessment.

Key: ++ = favourable, Ø = minimal, - = unfavourable, ? = uncertain. Dual ratings (e.g., ? / -) indicate a primary estimate and possible but less certain alternative. Number of symbols indicates relative magnitude of effect (e.g., ++ is more favourable than + and less favourable than +++).
Section 1: Introduction

South Africa has the world’s largest HIV burden, with an estimated 6.8 million people living with the virus (UNAIDS, 2014b). The country has rapidly scaled up HIV treatment and care over the last decade—the government’s HIV response guarantees free access to antiretroviral therapy (ART), and by the end of 2015 it was treating more than 3 million people living with HIV. If South Africa is to meet its ambitious HIV 90-90-90 targets by 2020, 1 5.7 million patients will need to be on ART by financial year (FY) 2018/19. This will require accelerating the expansion of treatment coverage and adding between 670,000 and 900,000 new patients to the ART programme annually until 2019 (Department of Health, South Africa & South African National AIDS Council, 2016). Continued rapid scale-up raises concerns about the financial sustainability of the country’s HIV response, compounded by the expectation that donor funding from the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Malaria, and Tuberculosis (Global Fund), will scale down in next five to 10 years. Over the last decade, there has been a sharp increase in public financing for HIV, which is now approaching almost a third of government spending on primary health care (PHC) and about 10 percent of all government health expenditure (National Treasury, 2014).

Meanwhile, South Africa has embarked on an ambitious plan to develop national health insurance (NHI) that will provide universal and equitable access to health care, including HIV services, for the whole population. Planners in the National Department of Health (NDOH) and National Treasury (NT) may need to consider alternative models for organizing the HIV programme that address the sustainability concerns for its financing, respond to disparities between its governance and that of the wider public health financing system, and integrate or at least coordinate it with the country’s larger vision for NHI. This study responds to this need by presenting and evaluating various scenarios for changes to the management of funding for the government’s HIV response over the next three to five years. Any proposed changes must be carefully scrutinized to ensure, first and foremost, that they do not undermine current efforts.

The public sector dominates South Africa’s HIV response: about three-quarters of all HIV financing in South Africa is raised from domestic revenue sources, the bulk of which is then managed through direct transfer from the national government to Provincial Departments of Health (PDOHs) using the Comprehensive HIV and AIDS conditional grant (HIV CG). This grant—determined for each province on the basis of HIV prevalence and need—is a means of ring-fencing financing for the government’s HIV response via PDOHs under conditions of careful business planning; tight budgeting, spending, and tracking of funds; and detailed reporting of outputs against programmatic targets. In contrast, government spending on most other health care services is primarily discretionary at the provincial level. The bulk of provincial health budgets is sourced from national revenue transferred to provinces under South Africa’s provincial equitable share (PES) allocation system. PES transfers

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1 The 90-90-90 targets are that 90 percent of people living with HIV will know their HIV status, 90 percent of people diagnosed with HIV will receive sustained antiretroviral treatment, and 90 percent of those on treatment will have durable viral suppression (UNAIDS, 2014a).
to provinces by NT account for approximately 81 percent of public health financing. Provinces have autonomous control over the budgeting and service delivery functions for all health programmes funded through this mechanism. PES spending is guided by provinces’ Annual Performance Plans and monitored through annual financial reporting to the national government, but these processes are minimal compared to those in place for the conditional grants.

The HIV and non-HIV health budgets have also been following contrasting trajectories. The annual HIV conditional grant has grown dramatically from R1 billion since its introduction in FY 2003/04 to R13.7 billion over a decade later in FY2015/16, and it will reach R20 billion by FY 2018/19 (Guthrie, Ryckman, Soe-Lin, & Hecht, 2015; Janari, 2015). Given this government commitment under the 2016 Medium Term Expenditure Framework (MTEF), the grant will continue to grow by over 10 percent annually in nominal terms—double the rate of growth in the overall health budget (National Treasury, 2014). Government health expenditure, on the other hand, has declined as a share of the overall government budget in recent years. With donor funding for HIV expected to recede over the next ten years, the government will likely have to channel an even greater share of funds to sustain and expand its large HIV programme, particularly to increase the number of people on ART.

Given the rapid growth in South Africa’s HIV budget both in absolute terms and as a share of government health spending, the differences between HIV and other health care financing raises important and immediate questions for policymakers. The government must consider if it can sustain the growth rate in the HIV CG, particularly as donor funding recedes. Similarly, while separate planning, tracking, and performance monitoring systems for the HIV response have helped to strengthen it, it is important to weigh the benefits of continued ring-fencing against any inefficiency it creates in the government’s health financing and service delivery systems.

These questions regarding integrated management of HIV and non-HIV health financing are both pressing and timely: the government of South Africa has proposed the establishment of an NHI system by 2025 in pursuit of universal health coverage (UHC). The recently published White Paper (National Department of Health, 2015d; hereafter White Paper, 2015) envisages an NHI Fund that acts as “a single-payer and single-purchaser” with centralized purchasing of health care services, including those for HIV, local management of delivery through District Health Management Offices (DHMOs), and mechanisms for direct payments to providers. Hence, the government and other stakeholders are interested in considering how public financing for HIV may be more fully integrated with that for other health services ahead of broader NHI implementation, as well as how financing integration might affect delivery of HIV and other services. These concerns relate closely to ongoing debates about how to enhance South Africa’s public financial management system, how to design an NHI benefits package, and how to modify intergovernmental functional and fiscal arrangements in preparation for a purchaser-provider split.

This study explores the nature of these problems by describing and evaluating five distinct scenarios for the pooling and management of public funds for HIV. In particular, our analysis is crafted to help policymakers grapple with the following questions:

- Should the current structure of public HIV financing be altered in the next three to five years?
• If so, what are some policy options or scenarios for HIV financing, and particularly its integration with financing for other health services, that could be explored over this period?

• How would the scenarios affect the HIV response and other primary health care services?

• Would the scenarios increase health system efficiency?

• How feasible are the scenarios?

• How would the scenarios facilitate or impede the realization of the government’s NHI vision?

To address these questions, we undertook extensive desk research utilizing published literature, data, and policy documents related to South Africa’s health financing system, HIV response, and NHI proposals. Officials from NT and NDOH provided supplementary documents and data. To build on and complement the desk research, we consulted government officials, experts, and other stakeholders to collect suggestions for how HIV financing could be restructured. Consultations included individual interviews, group discussions, and presentations during which the potential strengths and weaknesses of different financing changes were discussed. Appendix 1 contains a full list of government participants, while other experts and stakeholders are acknowledged above. The majority of consultations were with representatives of three divisions in NDOH (HIV/AIDS, TB and Maternal and Child Health; Primary Health Care; and Regulation and Compliance) and two in NT (Public Finance and Intergovernmental Relations).

Due to the preliminary and sensitive nature of this work, we do not directly attribute opinions expressed by individuals during the consultations. However, at times we include informants’ institutional affiliations to lend additional context to their views. We conducted most of our consultations in Pretoria in October 2015, and some conversations took place by phone in the preceding and subsequent months. We presented our preliminary analysis to selected government officials in January and February 2016; their feedback is reflected throughout the study.

Although we consulted widely with senior national officials in both NT and NDOH, numerous other stakeholders are not well represented in our analysis. They include provincial officials, patients, private health care providers, and civil society organizations. As we note later, more extensive consultation and political analysis should inform the government’s policy design and implementation decisions. Additionally, we did not quantitatively model the impact of the five scenarios. We focused instead on the governance implications of reconfiguring HIV financing and qualitatively assessing whether the scenarios would have a favourable or unfavourable impact on the health system.

To set the stage for that analysis, we first provide an overview of the current situation in South Africa (Section 2). We begin with a brief description of the country’s health financing system and government expenditure on HIV.

We then explain in greater detail what we mean by HIV financing integration and the extent to which there is already such integration in South Africa. Underlying this analysis is a recognition that as they pursue a range of important policy goals, decision makers must take care not to harm South Africa’s largely successful HIV programme. For this reason, the current financing arrangement remains a compelling option, while the other four scenarios represent potential opportunities to build upon gains
made in the HIV programme and, in some cases, extend them to other parts of the government-financed health system.

With the status quo in mind, we present five possible scenarios for reorganizing HIV financing and detail our methods for developing and evaluating them (Section 3). We then offer a comparative analysis of the scenarios and highlight key takeaways for policymakers (Section 4). Finally, we reflect on how this study can be used to facilitate decision making and shape additional analysis and policy design (Section 5).

Section 2: Health financing and HIV integration in South Africa

To characterize South Africa’s current health financing system, we conducted desk research relying on publicly available data and documents about the health system’s structure and flow of funds. We organized our search and analysis around the three principal health financing functions of revenue collection, pooling, and purchasing (Kutzin, 2001). We then assessed the extent of integration of HIV with non-HIV health funds to determine a status quo scenario to which proposed alternatives could be compared. This analysis builds on a recently developed framework for evaluating integration across the three financing functions (see Box 2.1), though our emphasis here is more on the specific mechanisms by which HIV and other health funds are mobilized, managed, and deployed to purchase services.

BOX 2.1. WHAT IS HEALTH FINANCING INTEGRATION?

This study is part of a growing body of work that responds to mounting interest, in South Africa and globally, in the desirability, feasibility, and mechanics of integrating ‘vertically’ financed health programmes, such as those for HIV, with broader, ‘horizontal’ health systems. In particular, it builds on a recent Results for Development Institute (R4D) report for the UNAIDS-World Bank Economic Reference Group’s Technical Working Group on Sustainable Financing. R4D defines HIV financing integration as “the process of moving toward national health financing systems where funds for HIV & AIDS are collected, pooled, and used to pay for health services together with funds for other health services rather than through separate financing and payment structures.”

The report goes on to assess the level of integration—high, medium, or low—across the three health financing functions of revenue collection, pooling of funds and risk, and purchasing of services. For collection, the level of integration depends on what share of HIV funds are drawn from the same revenue sources as other health funds. The extent of pooling integration, in turn, depends on whether HIV funds are pooled and managed together with or separately from other health funds.

Finally, the degree of purchasing integration reflects whether the flow of HIV and other health funds from purchasers to providers relies on the same channels and mechanisms. Critically, to date there is insufficient
evidence about whether integration is inherently good or bad for a national health system. For now, it remains a useful concept to help describe certain aspects of a country’s health financing system. Nonetheless, policymakers and other stakeholders profess a number of hypotheses about the potential benefits of integration, including efficiency and service quality.

Analysis of 13 countries, including South Africa, revealed considerable variation in the level of HIV financing integration between countries and within countries across financing functions. Additionally, integration in one function does not necessarily require or enable integrating other functions. In fact, integrative policies can be quite targeted at one or more functions depending on the country context, available sources of funds, and policymakers’ health system goals. Finally, the report highlighted the need for country-specific research and consultation to better understand integration and inform relevant policies.

Source: Blanchet et al. (2014)

We focus exclusively on public financing for HIV services channelled through the national and provincial health departments, which accounts for roughly three-quarters of all HIV spending in South Africa. The government also finances HIV programmes through the Departments of Basic Education, Correctional Services, Defence, and Social Development, as well as the South African Police Force, but collectively these account for only 6 percent of public HIV spending (Guthrie et al., 2015). Additionally, although external funds from PEPFAR and the Global Fund are important to the country’s HIV response, they represent a decreasing share of financing and are likely to recede in the next decade. Consequently, the future sustainability and impact of HIV spending will depend principally on how the government manages and spends its own resources. At the same time, South Africa and its partners will need to manage the donor transition carefully. In Section 5 we note a number of important questions related to the plateauing and expected decline in donor funding for HIV, which go beyond the scope of this study.

In the rest of this section we quantify government spending on HIV and describe how public HIV funds are collected, pooled, and used to purchase services in relation to the rest of the publicly financed health system. We also highlight the need for careful thinking about integrated service delivery and incorporation of tuberculosis (TB) financing into the HIV CG.

DOH expenditure on HIV

South Africa’s National and Provincial Departments of Health spent more than R14 billion on HIV in FY 2015/16 (National Treasury, 2016) and will spend R20–30 billion in FY 2018/19.2 After more than a decade of expansion, the HIV programme now accounts for more than 10 percent of all government

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2 R20 billion has already been allocated to the Comprehensive HIV, AIDS and TB conditional grant for FY 2018/19 (Janari, 2015), but how much additional money will be spent by PDOHs out of equitable share funds is uncertain. The upper bound of R30 billion assumes a similar ratio of PES-to-CG spending as is reported in Guthrie et al. (2015) for FYs 2011/12–2013/14. Due to the difficulty of identifying HIV-related spending within South Africa’s Basic Accounting System, these estimates may overstate the amount of non–conditional grant spending on HIV. Guthrie et al. (2015) estimates that the grant accounts for 76 percent of the DOH’s HIV spending. Our own estimate, extracted from National Treasury (2015b), suggests the grant accounts for upwards of 90 percent of all DOH spending on HIV at the provincial level. In reality the overall share is probably between the two.
health sector expenditure and is growing faster than the overall budget for health (National Treasury, 2014). Figure 2.1 depicts the growth in HIV funding from FY 2003/04 to FY 2018/19.

South Africa’s lacklustre economic performance complicates efforts to sustain this growth in domestic HIV spending. Depressed global commodity prices and persistent drought have contributed to sluggish economic growth, which is forecasted to be only 0.9 percent in 2016 (Gordhan, 2016). Slow growth will constrain fiscal space for all government investments, underscoring the continual need for finding more efficient means of financing and delivering HIV and other health services (Blecher et al., 2016). Addressing this structural challenge is beyond our scope, but fiscal space constraints should be borne in mind when evaluating the current HIV financing structure and any alternatives, such as the scenarios we describe in Section 3.

**Figure 2.1**

**HISTORICAL AND PROJECTED DOH HIV FUNDING (NOMINAL R BILLION), FY 2003/04–2018/19.**

Source: Update to Figure 4 in Ndlovu & Meyer-Rath (2014) using National Treasury (2016).

Notes: Data reflect audited outcomes for FYs 2003/04–2014/15 (light green), adjusted appropriation for FY 2015/16 (dark green), and projections for FYs 2016/17–2018/19 (grey). Figures include funds for HIV-TB integration and other TB interventions channelled through the Comprehensive HIV and AIDS grant until FY 2015/16 and then through the Comprehensive HIV, AIDS and TB grant from FY 2016/17 on. Abbreviations: DOH = Department of Health, R = South African Rand.
### F.2.2 EXPECTED ALLOCATION OF PROVINCIAL DOH BUDGETS IN FY 2016/17.

#### TOTAL PROVINCIAL DOH BUDGET: R159.5 BILLION

<table>
<thead>
<tr>
<th>PES ALLOCATION</th>
<th>CONDITIONAL GRANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>R125.5 BILLION</td>
<td>R34.0 BILLION</td>
</tr>
<tr>
<td>PHC (NON-HIV)</td>
<td></td>
</tr>
<tr>
<td>R39.8 BILLION*</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>R15.9 BILLION</td>
</tr>
<tr>
<td>R15.3 billion HIV grant</td>
<td></td>
</tr>
<tr>
<td>R10.8 billion NTS grant</td>
<td></td>
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<tr>
<td>R5.3 billion HFR grant</td>
<td></td>
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<tr>
<td>R0.1 billion NHI grant</td>
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</tbody>
</table>

#### PHC (NON-HIV)

- R73.6 billion
- R84.4 BILLION
- R6.5 BILLION

#### Secondary +

- R12.9 BILLION
- R5.0 billion

#### Other health sector activities

- R15.9 BILLION
- R2.5 billion HPTD grant
- R5.0 billion

Sources: Authors’ analysis using National Treasury (2015b, 2016).
* Estimates vary on the total budgets for HIV and other PHC activities. The amounts depicted here are based on the sources noted above, while the total HIV budget may be closer to R20 billion.

Notes: Other health sector activities include administration, training and professional development, facilities revitalization, research, and preparation for NHI implementation.

Abbreviations: DOH = Department of Health, PES = provincial equitable share, PHC = primary health care, Secondary + = secondary, tertiary, and quaternary services, NTS = National Tertiary Services, EMS = Emergency Medical Services, HFR = Health Facilities Revitalisation, HPTD = Health Professional Training and Development.

### Collecting HIV funds

The collection of public funds for HIV services is straightforward and identical to revenue mobilization for all government-financed health services. General tax revenue collected at the national level funds the overwhelming majority of government health spending. The national tax base principally comprises individual taxes (35 percent), the value-added tax (26 percent), and the company tax (21 percent), as well as includes small shares from a fuel levy, customs duties, and excise taxes (National Treasury, 2015c). Provinces also directly collect modest revenue that funds 1.5 percent of South Africa’s total health expenditure (Blecher et al., 2011). Virtually all government health spending, including on HIV services, relies on this general
revenue. Therefore, public HIV financing is highly integrated in collection with financing for other health services.

This public HIV financing accounts for about three-quarters of all HIV spending in South Africa. Similarly, integrated financing is collected by Medical Aid schemes and other private insurers, but only 8 percent of HIV spending occurs in the private sector. More substantial are donor-funded HIV programmes, which collect funds exclusively for HIV (or occasionally for HIV and TB together). These external sources of HIV funds—the largest of which are PEPFAR and the Global Fund—account for 16 percent of HIV spending and are not integrated with other health funds (South African National AIDS Council, 2013).

The plateauing and foreseen decline in donor financing compounds South Africa’s already daunting challenge to raise sufficient revenue to finance the growing HIV programme and roll out a new NHI system. However, broad questions about fiscal space go beyond the scope of this study. To date there have been no proposals from the government or others to introduce HIV-specific revenue streams into the government’s financing system, and none is considered among our scenarios.

**Pooling and managing HIV funds**

After collecting general revenue, NT distributes funds between the spheres of government and across national departments in accordance with the national budget process. Although they serve as the financing agent for all government health services, PDOHs receive funds for general health services and for HIV differently (Figure 2.2). Most health funds flow to provinces through the PES allocation system, which applies a legislatively defined formula to divide a large portion of national revenue among South Africa’s nine provinces. PES (or voted) funds are intended for education, health, and other social-sector programmes that are concurrent responsibilities of the national and provincial spheres of government (“Constitution of the Republic of South Africa,” 1996). Provinces exercise near-complete discretion over the use of PES funds, which is tracked annually at the national level against provincial budgets and Annual Performance Plan targets. NT also reviews provincial budgets through a benchmarking exercise to ensure provinces will meet contractual obligations, such as those to public employees and suppliers.

In contrast, the bulk of the PDOHs’ HIV financing is channelled to provinces via the HIV CG, which will include more than R15 billion in FY 2016/17 and more than R20 billion in FY 2018/19 (Janari, 2015). Conditional grants are typically created to enable a national department to support, with dedicated funds, the rapid implementation and scale-up of priority initiatives. Currently, the HIV CG is the second largest across all sectors and accounts for 43 percent of all conditional grant funding to DOH (National Treasury, 2014).³

³ In fact, DOH is the greatest beneficiary of direct CG financing, receiving 37 percent of all funds channelled in this manner. Other health CGs include those for Health facility revitalization, Health professions training and development, National tertiary services, and National health insurance.

For each conditional grant the transferring (national) department, in consultation with NT, develops a legally binding mechanism that governs the grant’s administration and the responsibilities of both the transferring and receiving (provincial) departments. For the HIV CG, these include specific services and priority activities to be funded by the grant, requirements that provincial business plans specify their measurable output and
outcome indicators, and a schedule for quarterly reports by PDOHs to NDOH (National Department of Health, 2015a). Box 2.2 provides examples of conditions and output measures for the HIV CG in FY 2015/16.

The binding nature of the conditional grant mechanism, NDOH’s ability to withhold payments from provinces failing to comply, and the elaborate business planning and monitoring systems required to implement the grant all distinguish the CG from the PES health financing mechanism. In fact, these conditions allow HIV funds to be effectively ring-fenced from the rest of provincial health budgets without actually pooling them in separate accounts or even separate financing agents. Therefore, the current level of integration in pooling HIV and non-HIV health funds is quite low, so scenarios for HIV financing integration will naturally feature reconfigurations of financing pools.

**BOX 2.2. CONDITIONS AND OUTPUT MEASURES FOR THE COMPREHENSIVE HIV AND AIDS CONDITIONAL GRANT (FY 2015/16).**

The HIV CG mechanism, a legally binding agreement between the national and provincial spheres of government, requires funds to be spent on specific activities with measurable outputs. They can be summarized as follows:

**PRIORITY ACTIVITIES TO BE SUPPORTED BY THE GRANT**

- ART-related interventions
- Home- and community-based care
- Condom distribution
- Interventions for high-transmission areas
- Post-exposure prophylaxis
- Prevention of mother-to-child transmission
- Programme management strengthening
- HIV counseling and testing services
- Medical male circumcision
- TB screening and prevention for HIV patients

**OUTPUTS FOR GRANT-FUNDED ACTIVITIES**

- Number of new patients initiated on ART
- Number of ART patients remaining in care
- Number of male condoms distributed
- Number of female condoms distributed
- Number of exposed infants tested at 6 weeks with polymerase chain reaction test
- Number of clients tested for HIV (including antenatal)
- Number of medical circumcisions performed

Source: National Treasury (2015a)

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4 In Scenario 1 below, we assume that the same or similar conditions as those currently governing the HIV CG will remain in place in the next three to five years.
Purchasing HIV services

There is currently no purchaser-provider split in South Africa’s publicly financed health care system, though NDOH and PDOHs do mimic some aspects of the purchaser-provider relationship through the business planning and accountability mechanisms in place for the HIV CG. Nonetheless, individual clinics neither receive nor manage their own budgets. Provinces make global budget allocations to hospitals, which in some cases include funds for clinics in the hospitals’ service areas. Elsewhere, district health offices manage clinic budgets. Either way, some health care inputs are paid for directly by PDOHs, including health care worker salaries and some drugs and laboratory services. Due to the conditional grant reporting requirements, provinces must tag their HIV spending as such and specify the programme or intervention, as well as the line items on which funds are spent. However, some of their HIV inputs are shared with other service areas, including labour (nurses, community health workers), facility maintenance, overheads, some supplies, and more. These tend not to be labeled as HIV related in CG reporting and therefore are subsidized with PES funds.

Most of these inputs are purchased in an integrated fashion. Health care workers, for example, receive their salary in the same way regardless of whether their position is officially designated as HIV related (let alone whether they are actually delivering HIV care). Moreover, provinces purchase HIV and other drugs often through nationally coordinated tenders and transfer them to facilities. Despite the ring-fencing of HIV funds in pooling, there is actually little to distinguish purchasing of HIV services from that of other types of care, except for the additional monitoring and reporting that is required under the CG rules. Some provinces are also explicitly attempting to more fully integrate service delivery, further blurring the line between HIV and non-HIV financing at the facility level. Even in a few cases where a province contracts private providers to deliver HIV services, it demands that they provide a wide range of other (typically PHC) services as well.

Because purchasing is fairly integrated between HIV and other health services, particularly PHC, most of our scenarios for HIV financing integration do not include specific changes to the purchasing arrangements. This is not to say that such reforms should not be considered in South Africa. In fact, transitioning to strategic purchasing arrangements may be one of the most promising ways to incentivize greater efficiency and quality in health care. As a purely illustrative example, a future NHI Fund might decide to pay for a basket of PHC services through capitated payments, but retain a separate pay-for-performance or fee-for-service payment mechanism for certain key HIV services. For this reason we highlight in Section 3 the types of purchasing arrangements that could be explored under each scenario, though we also note that the government could experiment with many new approaches without significantly altering its pooling structure. As most of these possibilities do not relate to a change in how integrated purchasing would be, a more thorough exploration of them goes beyond the scope of this study.

Delivering HIV services

South Africans can typically seek HIV and other services while visiting a single government facility, which may promote increased access to services and could generate economies of scale if coverage expands to patients who previously have not sought care for lack of availability or convenience. In fact,
integrating HIV services into the general health system has led to considerable increases in utilization of inpatient and outpatient care in Rwanda (Piot et al., 2015a). Integrating service delivery can also generate economies of scope if HIV and other service areas share the fixed factors of production, including clinic space, equipment, financial and information management systems, and health workers (Sweeney et al., 2012; Topp et al., 2013). Facility-level integration may also strengthen programmes and generate wider health benefits (Piot et al., 2015b).

However, the extent to which HIV and other services are delivered in an integrated fashion has not been well documented in South Africa. A general measure of Integrated Clinical Services Management indicates considerable variation. On this component of the Ideal Clinic Programme, which includes not only service provision but also several other aspects of performance, districts score between 43 percent and 75 percent, with provincial averages ranging from 52 percent (Mpumalanga) to 63 percent (KwaZulu-Natal) (Steinhobel, Massyn, & Peer, 2015). When asked about HIV services integration, informants also described variation. In some settings facilities dedicate space and workers exclusively to HIV service delivery (perhaps including a handful of related services, such as TB screening). In others, facilities incorporate HIV patients into a single flow for all health services, which are delivered by generalist clinicians.

Optimizing the facility-level choreography of service delivery will depend on local conditions, including a clinic’s staffing model, the disease burden of the local population, the volume of patients seeking HIV services relative to others, and more. Facilities with high volumes of HIV patients, for instance, may be able to more efficiently serve them in a separate ward with dedicated clinicians. In contrast, low-volume facilities might struggle to efficiently deliver unintegrated services. There are numerous empirical questions about whether integrating service delivery is desirable in terms of efficiency, quality, and morale. In fact, we encountered anecdotal evidence that paper-based information systems in South African clinics may render integrated service delivery less efficient and unpleasant for both health care workers and patients.

Additionally, even if there are efficiency grounds for integration, there may be compelling reasons to retain unintegrated services in certain settings. For example, key populations’ utilization of services can be deterred by the prospect of stigmatization by providers or other patients (Druce et al., 2006). In South Africa as elsewhere, more research is required to understand the optimal approaches to service delivery integration in different settings and for different patient populations (Piot et al., 2015b). Desirable service delivery modalities could then be linked to purchasing mechanisms and other policies meant to shape provider behaviour.

HIV integration summary

In this section we have illustrated how pooling is the financing function with the greatest scope for integration of HIV and other health funds. Both collection and purchasing are integrated already, and though the latter is ripe for other forms of policy change, the evaluation of those possibilities (e.g., alternative payment mechanisms for different types of services) does not fit into the parameters of this study. Nor does more detailed analysis of the interplay between integrated financing and integrated service delivery.

In the following section we turn to the heart of our analysis: a detailed description of the five scenarios for HIV financing options that have been developed in close consultation
with key stakeholders in South Africa. In light of the analysis above, the scenarios focus mainly on how the government could reconfigure the pooling arrangements for HIV and other funds.

A note on TB financing and the HIV conditional grant

Before proceeding to the scenarios, it is important to note the recently announced modifications to the HIV CG and the trend toward integrated financing for some HIV and TB activities. TB imposes a large and growing burden on South Africa, especially on people living with HIV, who account for around 60 percent of the country’s TB patients (World Health Organization, 2014). Provinces use PES funds to pay for the vast majority of government-provided TB care and treatment services. However, in recognition that addressing TB is an essential part of a robust HIV response, for several years South Africa has financed some HIV-TB integration and TB control, management, and surveillance activities through the HIV CG (Guthrie et al., 2015).

Moreover, the grant will now be used to scale-up financing for other TB services. The government has already committed R740 million in the current MTEF period for active TB case finding among high-risk and vulnerable populations, chemoprophylaxis for high-risk individuals (including people living with HIV), and widespread deployment of improved diagnostics (Xpert MTB/RIF). In fact, to accommodate this increased funding, and in anticipation of future expansion in the grant’s TB components, starting in FY 2016/17 it is called the Comprehensive HIV, AIDS and TB conditional grant (Janari, 2015; National Department of Health, 2015c).

Greater incorporation of TB financing into the grant complicates considerations about how HIV financing might be reconfigured in the next several years. Important questions arise, including whether rearrangements in HIV financing should also be applied to TB funds and how such changes might catalyse or undermine ongoing efforts to strengthen South Africa’s TB response. These issues go beyond the scope of this study, but in Section 5 we argue that they must be examined carefully before implementing any integration scenario.

Section 3: HIV financing scenarios for the next three to five years

Developing the scenarios

While developing the scenarios, we selected two key parameters to define the realm of possible financing arrangements to consider. First, we elected to focus on options that can plausibly be implemented in the next five years (if not sooner). This stems from the interest of some government officials to redesign the HIV financing mechanisms in concert with decision making about longer-term NHI system design. Below we do discuss how each scenario might fit into NHI implementation, but we emphasize the more immediate implications of the financing options.

Second, we chose not to vary the total resource envelop for HIV or health across the scenarios. Others have worked extensively to determine the resource needs for achieving South Africa’s
ambitious national coverage targets, including the recent UNAIDS-supported Investment Case for HIV and TB (Department of Health, South Africa & South African National AIDS Council, 2016). This study’s short time frame and focus on integration precluded any meaningful advancement on this body of work. Instead, we offer complementary analysis that highlights how, given a particular spending level, altering the organization of health financing, particularly in the pooling function, might affect health system performance.

**Descriptions**

From our consultations we distilled and synthesized informants’ ideas into the five scenarios presented later in this section. To each we applied a descriptive template with six components meant to capture key features that vary across the scenarios and relate to policymakers’ key questions. Table 3.1 summarizes the descriptive framework.

**Evaluations**

The consultations also revealed policymakers’ main interests and concerns for evaluating the scenarios. Six criteria emerged, the first three of which relate to the scenarios’ potential impact on health system performance.

**Potential effect on the HIV response**

Policymakers are keen to understand whether the alternative financing mechanisms would enhance or undermine the country’s HIV response. We identify the risks and potential gains each scenario might entail for the HIV programme.

**Potential effect on PHC services**

It is useful to highlight potential synergies or trade-offs between HIV and other services, particularly PHC, under each scenario. For instance, if a scenario jeopardized certain aspects of the HIV programme, could policymakers at least expect improvements in PHC service quality?

**Potential effect on health system efficiency**

A major impetus for considering changes to HIV financing in South Africa is the potential for efficiency gains. The practical constraints on this study preclude a rigorous, quantitative modelling exercise to precisely estimate efficiency gains and losses, but we do attempt to qualitatively assess the likely direction of each scenario’s effect.

For the impact criteria we use a qualitative rubric to indicate a scenario’s likely effect. We argue that a scenario will have a favourable (+, ++, +++), unfavourable (-, - -, - - -), or minimal (Ø) effect on HIV, PHC, and health system efficiency. We use multiple symbols to convey differences in magnitude (e.g., ++ means more favourable than +) or borderline cases (e.g., Ø/+ indicates the effect is likely to be minimal or potentially favourable). In some cases we cannot estimate the effect because it depends too much on additional policy choices that go beyond the scenario (?).

The second trio of evaluation criteria addresses three aspects of scenarios’ feasibility: legal, political, and technical.6

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6 Feasibility is a broad concept encapsulating many considerations. Policymakers and analysts might consider numerous feasibility dimensions depending on the nature of proposed scenarios, the local context, government’s implementation capacity, and more. Beyond those addressed here, an important additional dimension is fiscal feasibility, which captures whether the costs associated with a scenario are reasonable given available resources. Although we assume a fixed envelop of resources for health across all five scenarios, they may vary in terms of the short-run implementation costs.
Legal feasibility

Amid South Africa’s complex constitutional and legal context, in which legislative competence for the health sector is shared among the national, provincial, and local spheres of government, different scenarios would require varying degrees of policy change. For instance, national departments might be able to implement some scenarios on the basis of their executive authority alone. Others, however, might rely on major enabling legislation. In fact, there is an ongoing debate about whether some of the NHI White Paper (2015)’s proposals would require changes to the constitution. Consequently, in addition to the magnitude of policy change required for each scenario, we also consider the risk of legal challenges when relevant. We relied on our understanding of relevant statutes and on our informants’ insights to assess legal feasibility. A more formal legal analysis would be useful but was outside the scope of this study.

For scenarios that include pooling HIV and other PHC funds together, we estimate the PHC budget by summing forecasts for district management, community health clinics, community-based clinics, other community services, nutrition, primary health care training, and health facility management for community health facilities, plus 25 percent of projected spending on district hospitals and associated facility management. District hospitals provide both primary and secondary health care services. There is no way to extract from public expenditure data the share of their budgets these facilities spend on PHC. The share is certainly greater than none, and intuitively half seemed the upper limit because even if the majority of district hospital services could be considered PHC, those services should be much cheaper to provide. We then simply selected the midpoint of this range. 25 percent is admittedly arbitrary, so we emphasize the “illustrative” nature of the allocations and note later in the study that much more work needs to be done anyway to better understand the cost of delivering PHC services in various settings. Some of this work is already underway under the umbrella of the NDOH-NT PHC Costing Task Team.

### Table 3.1: Descriptive Framework for Integration Scenarios

<table>
<thead>
<tr>
<th>Component</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing mechanism</td>
<td>The core features of the scenario’s financing mechanism and its implications for the pooling of HIV and other health funds.</td>
</tr>
<tr>
<td>Potential pools of funds</td>
<td>An estimate of the expected allocation of provincial health sector funds across the financing pools and mechanisms the scenario would require. We manipulate MTEF budget estimates (National Treasury, 2015b) for provincial health spending in FY 2016/17 to generate illustrative allocations.7</td>
</tr>
<tr>
<td>Governance of HIV funds</td>
<td>How the scenario would distribute responsibility for and authority over HIV funds between the spheres of government, which sphere(s) would be responsible for HIV budget planning, and which would establish and monitor HIV service targets.</td>
</tr>
<tr>
<td>Purchasing of HIV services</td>
<td>The opportunities the scenario would create for modifying how the government purchases HIV services.</td>
</tr>
<tr>
<td>Implementation and pathway to NHI</td>
<td>Some immediate implementation steps the scenario would require and how the scenario could fit into a new NHI system in the longer term.</td>
</tr>
</tbody>
</table>

Source: Authors.
Political feasibility

Political feasibility derives from the political economy of health reform, which is driven by interest groups’ views and influence, their ability and willingness to push through or block new policies, and how these factors are mediated through existing institutions. Key interest groups include government officials and agencies, civil society organizations, providers and their professional associations, labour unions, insurers, and patients. Proposed changes to HIV financing arrangements would likely animate treasury and health officials at the national and provincial levels, public-sector health workers, and HIV advocates. Regardless of its other virtues, no scenario would succeed if it could not amass critical support from these and other important constituencies. A full political analysis, including institutional and stakeholder mapping and widespread consultations, was beyond the scope of this study. Nonetheless, we offer insights into the views of some key stakeholders and the likely attitudes of others about each scenario.

Technical feasibility

Each scenario would have practical implications for the financial and performance management of entities and individuals within the health system. Technical feasibility reflects the extent to which they would have the skills and resources to play their proposed role. With scenarios focused on the pooling and management of funds, technical feasibility measures the degree of existing financial and performance management knowhow, as well as the availability and skilled use of information systems for monitoring, evaluation, and decision making. The scenarios would directly alter processes and data requirements for budget planning, negotiation and execution of contracts, and performance monitoring. All scenarios would require a high degree of capacity, so we estimate technical feasibility in terms of the gap between existing and required capacities of the relevant actors, as well as the ease with which new capacities could be developed.

For the feasibility criteria we again use a qualitative rubric to indicate how challenging a scenario will be to implement. We adopt a three-point scale—high, medium, and low—to indicate their legal, political, and technical feasibility.

Overview of the five scenarios

The characterization of South Africa’s government financing system for health and HIV in Section 2 serves as a natural starting point for the development and analysis of the proposed scenarios. Here we describe five scenarios designed in close consultation with government counterparts and other stakeholders, as well as evaluate them according to the impact and feasibility criteria detailed earlier in this section.

1. Sustained HIV conditionality: HIV funds would remain ring-fenced in the HIV CG, and all other financing channels would remain in place, with PES funds covering most other health services.

2. National HIV Fund: The majority of funds from the HIV CG would be used to seed a new NHI Fund, which would purchase a package of personal HIV services.
3. **Unconditional integration:** The HIV CG would be eliminated, and all HIV funds would be folded into the PES. The PES allocation formula would be modified to account for HIV burden.

4. **Ring-fenced PHC integration:** PES funds currently paying for PHC services would be folded into the HIV CG to create a Comprehensive PHC conditional grant that would support a wide range of personal PHC services, including those for HIV.

5. **National PHC Fund:** In an amalgam of 2 and 4, PES funds currently paying for PHC services and funds from the HIV CG would be used to seed the NHIF, which would purchase a package of PHC and HIV services.

These scenarios represent a range of options, including maintenance of the current financing arrangements, that vary principally along two key dimensions of interest to senior government officials. First, the scenarios imply differing levels of national influence over the management and use of HIV funds. The HIV CG mechanism empowers NDOH to strictly oversee business planning and performance monitoring for provincially managed HIV service delivery, including by withholding funds from underperforming provinces. Consequently, it is important to consider how any scenario might modify NDOH’s oversight authority. Moreover, the NHI White Paper (2015) proposes a single national Fund as purchaser of all health services; therefore, whether scenarios would alter the extent of health financing centralization is germane to the broader NHI policy discourse. Scenarios 2 and 5 would increase national influence over HIV funds, while Scenario 3 would dramatically curtail it. Meanwhile, Scenarios 1 and 4 would retain the current level of influence.

Second, the scenarios represent varying degrees of integration in pooling of HIV and non-HIV health financing. As Section 2 notes, collection and purchasing are already considerably integrated, while pooling is not.\(^8\) It is important to reiterate that these descriptive ratings of integration are, in and of themselves, non-normative. Whether greater integration in pooling and purchasing is better for a health system—for example in terms of efficiency, access, quality, or equity—is empirically uncertain. There are plausible hypotheses for why integration would enhance health system performance, just as there are well-founded reasons to prefer stricter ring-fencing for ensuring spending and reporting on priority health issues. The scenario-specific analyses later in this section address these issues in greater detail.

Scenario 2 is non-integrative because, although it would reconfigure HIV financing, it would not increase the extent to which HIV funds are pooled with money for other health services. In fact, it would entail a less integrated approach to purchasing and perhaps even to service delivery. Scenarios 3, 4, and 5 all would represent significant increases in the degree of pooling integration. Scenario 3 would integrate pooling of HIV and all PES health funds, while 4 and 5 would integrate pooling of HIV and PHC funds. Meanwhile, the extent to which these scenarios integrated purchasing would depend on a number of

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\(^8\) These characterizations of integration in South Africa are broadly consistent with those provided in Blanchet et al. (2014). However, in focusing on government financing only, this study’s evaluation of the three financing functions is slightly different.
additional policy choices pertaining to the potential implementation of a purchaser-provider split, selection of various payment mechanisms, and contracting of private providers alongside public ones to deliver services.

Figure 3.1 situates the five scenarios along these two dimensions, as well as illustrates a major difference between the HIV CG and PES health funds in the current financing system. The horizontal axis reflects the extent of national control over the use of HIV funds, while the vertical indicates the extent of integrated pooling for HIV and non-HIV health financing. Integrated purchasing is also of great policy interest, but the possible modalities of purchasing are largely unrelated to those of pooling, at least in the near term. For example, with no adjustment to pooling arrangements, the government could already introduce strategic purchasing mechanisms that tie HIV and other health financing to service delivery outputs or even outcomes. Likewise, there is no specific purchasing system inherent to the creation of an NHIF. That entity could continue to provide input-based budgets to providers or adopt a wide range of contracting processes, many of which would require a purchaser-provider split.

While not exhaustive, the scenarios capture a broad range of pooling options. Common to all is a sense, both intuitive and validated through consultation, that with sufficient political support, the scenario could be implemented in the next three to five years. At the same time, Scenarios 2–5 could not be realized overnight; rather, they would require a sequence of preparatory and implementation steps. These are addressed for each scenario below and again in Section 5. This near-term timeframe also motivates a focus on integrating HIV and PHC financing. More complete financing integration across the entire continuum of care, particularly with respect to purchasing, would entail even more radical health reforms than those the White Paper (2015) proposes.9

In the long run, and especially in the context of South Africa’s evolving NHI discourse, none of the scenarios is intended as an endpoint. Instead, each represents a possible step toward NHI—either as envisaged in the White Paper (2015) or alternative structural models—and indeed multiple scenarios could be sequenced in a multiphase reform process. The lines in Figure 3.1 indicate just some of the possible pathways from the current system to NHI, with the solid lines indicating movement from the current system to any of the other scenarios. Scenarios 2, 4, and 5 are all direct steps toward a centralized NHI system such as that proposed by the White Paper (2015) (dashed lines). In contrast, Scenario 3 may only be constructive as a step toward a more devolved NHI system, one in which each province operates its own Provincial Health Insurance Fund (dotted lines). This would diverge significantly from the White Paper (2015) vision.

The subsections that follow present short summaries of each scenario. They follow a standard format based on the descriptive and evaluative frameworks described earlier. Additional comparative analysis and discussion of the five scenarios can be found in Section 4, while the key questions and next steps for South Africa emerging from this study are presented in Section 5. More detailed analysis of each scenario can be found in Appendix 2.

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9 Such reforms might include the integrated management of district health systems in which payments are linked to patient or population outcomes regardless of the care delivery setting; this would be akin to the Accountability Care Organization (ACO) model currently being piloted in the United States.
SNAPSHOT OF FIVE SCENARIOS FOR HIV FINANCING REFORM.

LEVEL OF INTEGRATION OF HIV AND OTHER HEALTH FINANCING IN POOLING

Alternate vision: 9 PHIFs

White paper vision: Single NHIF

3 Unconditional integration

4 Ring-fenced PHC integration

South Africa today (HIV)

2 National HIV Fund

5 National PHC Fund

1 Sustained HIV conditionality

Level of National Sphere’s Influence over HIV Funds

Source: Authors.
Notes: Solid lines indicate movement from the current HIV financing approach (Scenario 1) to the other four scenarios presented in this study. Dashed lines (Green) depict potential pathways from those scenarios to the NHIF system proposed in the White paper (2015). Dotted lines (grey), in contrast, show the potential pathway from the current system to a more devolved NHI scheme in which each province manages its own insurance fund.
Abbreviations: NHIF = National Health Insurance Fund, PES = provincial equitable share, PHC = primary health care, PHIFs = Provincial Health Insurance Funds.
Scenario 1: Sustained HIV conditionality

Financing mechanism

Scenario 1 would maintain the status quo. The current financing mechanisms for HIV within DOH would be retained, and the bulk of government spending on HIV would be channelled through the HIV CG. The annual Division of Revenue Act (DORA) would continue to indicate the conditions for the grant, stipulating each subprogramme’s allocation and targets. NDOH, in consultation with each PDOH, would continue to determine annual allocations to provinces and targets for each HIV subprogramme, and the provinces would continue to report on these quarterly.

Rationale

The HIV response deserves independent focus and management, even at the cost of some inefficiency in the health system. Until NHI plans are finalized and critical decisions are made about how HIV services will be provided under the new scheme, it may be premature to alter a well-functioning system which has enabled unprecedented annual funding increases for the provision of essential curative and preventive HIV services. Sustaining HIV conditionality and harnessing the HIV programme’s business planning and monitoring strengths will ensure that funds are used for their intended purpose and performance targets are achieved.

Governance of HIV funds

- NDOH would continue to oversee HIV CG spending, set targets and monitor outputs. The CG would specify priority interventions and measurable performance standards.
- Provinces would develop business and budget plans, oversee service delivery, and report on performance.
- Districts and facilities would deliver HIV and other services based on business plans and budgets determined above.

Purchasing of HIV services

- Input-based budgets for HIV would continue to be standard for providers, often with inputs shared between HIV and other services (e.g., clinicians, exam rooms).
- Surplus funds might be spent on low-priority HIV activities instead of much needed non-HIV services.
- Provinces could pilot active purchasing arrangements with high-performing Ideal Clinics or private providers.

Implementation and pathway to NHI

- The current HIV financing system could precede either further centralization of HIV (and other) funds, such as under Scenarios 2, 4, and 5, or further devolution of HIV funding, such as under Scenario 3.
- In the near future, experience with the HIV CG could be the basis for building wider capacity for contract management and performance monitoring, which will be essential for the NHI system. Facilities in the NHI pilot districts could be the natural starting point during the next phase of the Ideal Clinic Programme.
Impact

Note: Scenario 1 is the reference scenario against which we assess the potential impact of other scenarios. Therefore, we comment on the HIV response, PHC services, and health system efficiency under the status quo, but we do not offer impact ratings.

HIV response
The HIV CG would continue to ensure adequate funds are committed and spent accordingly on HIV, and therefore would protect the performance of the HIV response and achievement of national targets. The HIV and TB Investment Case (Department of Health, South Africa & South African National AIDS Council, 2016) is already guiding the budget proposal and business planning processes for the conditional grant, helping to justify additional resource allocations in pursuit of ambitious national 90-90-90 coverage targets.

PHC services
Sustaining HIV conditionality would not likely affect PHC services directly. The benefits (and costs) of the CG framework would not be expanded to PHC, nor would the financing structure necessarily promote further integration of service delivery. Lack of integrated service delivery is but one small portion of the challenges faced in PHC. There are many obstacles to improved PHC services, including stagnant PHC budgets, minimal accountability, weak management capacity, and inadequate data and models to guide budget planning.

Health system efficiency
Any inefficiency from overlapping planning and oversight systems would persist, as might inefficient spending driven by strict ring-fencing. There is anecdotal evidence that surplus HIV funds are spent on excess equipment and conferences because they cannot be reallocated to other PHC services. This has not been documented or quantified, but complementary measures to encourage more flexible use of CG funds at the provincial and provider levels, such as a waiver process to repurpose HIV funds when service targets are met, could integrate and improve service delivery and reduce inefficient spending. The ongoing process of developing and executing District Implementation Plans could also improve the efficiency of resource allocation among HIV, TB, and selected maternal and child health activities.

Feasibility

Legal: HIGH
Sustaining HIV conditionality would not require any policy reforms. The grant mechanism is well established in South African law, and it remains fully compatible with the distribution of governmental responsibilities envisaged by the National Health Act (2004) and the Constitution.

Political: HIGH
NDOH is eager to move forward with NHI implementation, but possibly not so rapidly that HIV financing should change in the next three to five years. More generally, the current system of dedicated HIV funding and programme management enjoys considerable support from NDOH, PDOHs, SANAC, and probably HIV advocates. NDOH and NT are both keen on more integrated financing, which might be pursued within the current financing structure, as is being done with TB starting in FY 2016/17.

Technical: HIGH
The core capacity required for planning, budgeting, and monitoring CG spending and HIV activities already exists. Financial and performance management systems for HIV continually evolve and improve, and integration of TB more fully into the CG mechanism will require additional capacitation at various levels of the system.
Scenario 2: National HIV Fund

Financing mechanism
Scenario 2 would seed the NHI Fund with funds from the HIV CG and the small NHI CG. The Fund would purchase a package of personal HIV services, including care, treatment, and biomedical preventive services like PMTCT and MMC. Once a purchaser-provider split is instituted, the Fund would purchase services through contracts negotiated with public and private providers. HIV-related public health activities, such as social behaviour change campaigns (SBCC), demand creation for MMC, programmes for high-transmission areas, and procurement and distribution of condoms, would be funded via a small CG. Scenario 2 would not further integrate HIV financing, and it might reduce the extent of integration, particularly in purchasing.

Rationale
Scenario 2 would protect financing for more effective and measurable administration and delivery of HIV services, but it would also involve more explicit steps than Scenario 1 toward NHI. Establishing the Fund would harness the HIV programme’s business planning and monitoring strengths to catalyse development of capacity for output-based purchasing and performance management under NHI. This will be key to strategic purchasing, which in the future could drive efficiency gains across many services in the NHI system.

Pools of funds
Illustrative allocations in FY 2016/17

<table>
<thead>
<tr>
<th>R billion</th>
<th>HIV CG</th>
<th>NHI Fund</th>
<th>Other health CGs</th>
<th>Health PES (PHC)</th>
<th>Health PES (non-PHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>160</td>
<td>13.6</td>
<td>18.6</td>
<td>39.8</td>
<td>85.8</td>
<td></td>
</tr>
</tbody>
</table>

Governance of HIV funds
- The new NHI Fund would control HIV spending while NDOH would accredit providers for payment eligibility.
- Provinces would play a minor role, controlling prevention funds from a small HIV CG for public health activities (e.g., SBCC) and perhaps helping to build district-level financial management capacity.
- District Health Management Offices (DHMOs) would plan budgets and potentially manage service provision.

Purchasing of HIV services
- The NHI Fund could implement strategic purchasing mechanisms to incentivize efficiency and quality improvement in the delivery of HIV services.
- It is not clear how an HIV-focused NHI Fund would purchase an integrated package of PHC services.

Implementation and pathway to NHI
- The Fund would start developing capacity for strategic, contract-based purchasing of HIV services. In the future, non-HIV services could be added to the benefits package.
- The Fund, DHMOs, and providers would all develop financial and information management capacity that will be essential for a well-functioning NHI system.
- This scenario could be a precursor to Scenario 5 and the full NHI White Paper (2015) vision.


This is distinct from the National Health Grant, which as of FY 2016/2017 is called the National Health Insurance Indirect Grant.
Impact

**HIV response: ? / - (uncertain/unfavourable)**
Strategic purchasing could drive quality improvement and efficiency with well-designed payment mechanisms. However, problems with enrollment and cost-sharing policies could negatively affect access, particularly for poor and stigmatized patients. Moreover, dividing responsibility for personal (NHI Fund) and non-personal (PDOHs) interventions could erode coordination of the overall response.

**PHC services: Ø (minimal)**
Sustaining HIV conditionality would not likely affect PHC services directly. The benefits (and costs) of the CG framework would not be expanded to PHC, nor would the financing structure necessarily promote further integration of service delivery. Lack of integrated service delivery is but one small portion of the challenges faced in PHC. There are many obstacles to improved PHC services, including stagnant PHC budgets, minimal accountability, weak management capacity, and inadequate data and models to guide budget planning.

**Health system efficiency: ? / - (uncertain/unfavourable)**
Further separating HIV and other health financing could reduce allocative efficiency, at least in the short run. In contrast, priority setting and health technology assessment could improve allocative efficiency within the HIV response, and strategic purchasing could incentivize more technically efficient HIV services. However, an HIV-focused Fund could complicate management and purchasing of shared inputs, particularly labour, as well as hinder integration of service delivery in the short run. These challenges would recede as additional PHC services were incorporated into purchasing contracts (i.e., movement toward Scenario 5).

Feasibility

**Legal: LOW–MEDIUM**
Major enabling legislation would be required to establish the Fund as a standalone legal entity. Strategically purchasing all health inputs, including labour, may require changes to employment laws as well. If provinces were bypassed entirely in contractual arrangements, the risk of legal challenge could be considerable.

**Political: LOW–MEDIUM**
National officials might see this scenario as a valuable step toward NHI, but its lack of integration may put off NHI supporters. HIV programme managers and advocates might be wary without assurances on enrollment policies and access to services. Provinces might resist losing such a large share of their health budget to a nationally controlled Fund, though their options for recourse may be limited.

**Technical: LOW–MEDIUM**
South Africa already has considerable planning, costing, and tracking capacity for its HIV response, a purchasing-based HIV response would require improved financial management, contracting, and monitoring capacity, particularly at the district and facility levels. The Fund itself would also need to be capacitated; there is little precedent for such a large, government-administered purchasing agency in the country.
Scenario 3: Unconditional integration

Financing mechanism
Scenario 3 would entail complete HIV financing integration via abolition of the HIV CG. All provincially managed health sector HIV funding—for both personal and non-personal services—would be channelled through the PES, for which the allocation formula would be adjusted to account for provincial HIV burden. There would be no ring-fencing of HIV funds, and the strict conditions of the CG would be removed. Like for most other health services, the funding and delivery of HIV services would fall fully under provincial authority in accordance with the National Health Act of 2004. Provinces would have full discretion over the allocation of resources across sectors and within the health sector, including for HIV and other programmes, subject only to the financial requirements outlined in the Public Finance Management Act (PFMA).

Rationale
Given HIV’s increasing share of the overall health budget, it may be increasingly difficult to justify a large CG focused on a single disease. Giving provinces full control over their HIV budgets might reduce inefficiency by fully integrating HIV and other health financing. The business planning, budget tracking, and performance monitoring systems developed for HIV are already ingrained in PDOHs and could be the basis for improved management practices across all health services. An integrated pool of funds could reduce the need for parallel administrative, management, and oversight capacity across programme areas, and some programme management resources (e.g., personnel, data systems) could be redeployed where needed.

Pools of funds
Illustrative allocations in FY 2016/17

<table>
<thead>
<tr>
<th></th>
<th>R billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other health CGs</td>
<td></td>
</tr>
<tr>
<td>Health PES (PHC)</td>
<td>85.2</td>
</tr>
<tr>
<td>Health PES (non-PHC)</td>
<td>18.7</td>
</tr>
</tbody>
</table>


Governance of HIV funds
- Control of HIV spending would shift to provinces, which would determine funding allocations to HIV and its distribution across HIV interventions.
- NDOH could set national targets or benchmarks but would lose its ability to enforce planning, reporting, or performance standards requirements.

Purchasing of HIV services
- Purchasing would likely remain input based, but provinces could on their own experiment with more strategic purchasing or contracting with private providers.

Implementation and pathway to NHI
- Placing the already centralized HIV funds within the PES would run counter to creating a single, nationally controlled NHI Fund and could make it more politically challenging to subsequently incorporate money into such a Fund in the future.
- Scenario 3 could lead to a devolved NHI system with nine provincially managed health insurance funds. This would mimic Canada’s social health insurance system but would diverge from current proposals.

This is distinct from the National Health Grant, which as of FY 2016/2017 is called the National Health Insurance Indirect Grant.
Impact

**HIV response: - - - (extremely unfavourable)**
Loosening the conditionality of the CG might be detrimental to the HIV response because the funds would no longer be ring-fenced and thus would be easily reallocated to other provincial priorities, possibly outside the health sector altogether. Provinces’ legislative prerogative and financial management challenges could drive decreases in HIV spending, undermining access to ART, lab tests, and other critical services. This scenario illustrates how financing integration for integration’s sake might not be desirable.

**PHC services: ? / + (uncertain/favourable)**
Placing the HIV funds into the PES might make more resources available for PHC and allow for more efficient spending and improvement of PHC services. However, to the extent that they reallocated HIV funds to other uses, there is no guarantee that provinces would retain those resources in the health sector.

**Health system efficiency: Ø / - (minimal/unfavourable)**
Eliminating dual management and reporting systems could generate modest savings. However, there would be minimal assurance that funds would be deployed to allocatively efficient interventions; instead, provinces might channel more money to hospitals and non-health priorities.

Feasibility

**Legal: HIGH**
Unconditional integration could be achieved without any major legislative reforms. Channeling funds via the PES allocation system is already the core mechanism for intergovernmental transfers in South Africa, and there is no law or constitutional provision requiring a conditional grant for HIV in perpetuity. Adjusting the PES allocation formula to account for HIV burden would pose a modest policy design challenge, but the existing distribution of CG resources across provinces would provide a useful starting point.

**Political: LOW**
Among informants there was clear opposition to this scenario and minimal direct support. NDOH would strongly oppose this option, as likely would provincial HAST Directors and HIV advocates. Other provincial authorities might support it if it could mean more money for non-health priorities. NT officials expressed interest in alternatives to an ever-growing HIV CG, but they would not likely risk harm to the HIV response.

**Technical: HIGH**
This scenario has the fewest technical requirements. No new capacity would be required beyond existing systems for financial and performance management for PES spending. No special capacity would be needed for provinces to apply the same management systems in place for PES funds to a larger pool of money. Moreover, provinces already oversee HIV service delivery; in this scenario they would be liberated from the financial management processes demanded by the CG mechanism.

**Note:** PDOHs’ capacity to protect and manage their health budgets for specific programmes is generally weak and subject to other provincial priorities, political agendas, and misuse. Protecting HIV funds within the PES, and hence the achievements made in the HIV response, would require capacity building within PDOHs and improvement of the PES reporting and control mechanisms. It is uncertain whether the capacity that has been built to cost and budget for the HIV CG would be retained and continued if the funds were channelled through the PES. Potentially these skills could remain and perhaps be applied to other PHC services.
Scenario 4: Ring-fenced PHC integration

Financing mechanism
Under Scenario 4, the scope of the HIV CG would be expanded to include all of PHC, fully integrating financing for HIV and other PHC services. The resulting Comprehensive PHC CG would be modelled on the existing HIV CG, with funds managed by provinces in accordance with a revised CG framework for all PHC services. There would be at least two possible approaches:

1. PES funds currently spent on PHC could be shifted to the HIV CG. The share of national revenue distributed via the PES would be reduced, as would be the share of PES funds allocated to health.
2. More incrementally, new funds could be added to the CG over several years to cover PHC services. This is already happening on a small scale with the fuller integration of TB into the CG framework in FY 2016/17 and addition of new funds for TB starting in FY 2017/18. In future years other PHC service areas could be integrated as well, perhaps starting with maternal and child health.

Rationale
Since its inception, the HIV CG has been instrumental to the scale and quality of the world’s largest HIV programme. Meanwhile PHC service delivery in government facilities has reportedly struggled. Extending ring-fencing around PHC funds could potentially imbue PHC services with the same rigorous planning, monitoring, and evaluation that underpin the HIV programme’s success. It would also require improving capacity for PHC resource needs estimation, budgeting, and reporting. Finally, it might reduce financing barriers to integrated service delivery, thereby promoting better and more efficient use of resources.

Governance of HIV funds
- NDOH would oversee HIV spending, set service targets, approve business plans, and track performance.
- NDOH influence would extent to the rest of PHC services, for which similar planning and monitoring processes would be developed.
- Provinces would continue to oversee service delivery.

Purchasing of HIV services
- Over time PHC budgets would be linked to output and outcome targets, as is the case currently for HIV.
- Provinces could also experiment with strategic purchasing of an integrated package of HIV and other PHC services.

Implementation and pathway to NHI
- An integrated pool of PHC funds could be the first step toward the Transition Fund proposed in the White Paper (2015), which is similar to the National PHC Fund we describe in Scenario 5.
- In the short run this scenario would vest financial management capacity at the provincial level, whereas the NHI White Paper (2015) proposes shifting management to the district and facility levels.
Impact

**HIV response: Ø / - (minimal/unfavourable)**
Current HIV planning and monitoring systems would persist and be combined with analogous processes for other PHC services. There could be trade-offs between allocative efficiency and total HIV spending; full integration might lead provinces to shift funds between HIV and other PHC services, while retaining separate sub-pools within the PHC CG could temper any gains from integration.

**PHC services: ++ (very favourable)**
Integrating and ring-fencing HIV and other PHC financing should improve the planning, tracking, and monitoring of PHC spending and service delivery. Integrated financing may also lead to more spending on non-HIV services, both from shifting funds from HIV activities and the likelihood that the CG will grow faster than the general health budget drawn from PES funds. If new funds were added to the CG, there would be some risk that provinces would substitute away PES spending on PHC, which would dampen gains.

**Health system efficiency: ? / + (uncertain/favourable)**
Integrated financing could promote allocative efficiency across HIV and other PHC interventions. It may also yield economies of scope in programme management. Technical efficiency may depend on more strategic approaches to purchasing by provinces.

Feasibility

**Legal: MEDIUM–HIGH**
Retaining PHC’s share of the PES funds at the national level would represent a significant change in intergovernmental fiscal relations and could invite legal challenges from provinces. Incrementally adding new PHC funds to the CG would be more feasible, particularly in the next three to five years. The CG mechanism would need to change gradually to accommodate an increasing share of PHC services and funds.

**Political: MEDIUM–HIGH**
NDOH might find appealing this incremental step toward greater national control over all PHC spending, especially if it were coupled with additional preparatory steps for NHI. NT might be wary of creating a massive PHC CG, particularly if it required clawing back to the national sphere a large share of PES funds. However, if integrated ring-fencing facilitated more strategic purchasing of PHC services, NT might consider this scenario a useful step toward the creation of an NHI Fund. Provincial officials would likely object to losing a large portion of their PES budget, while adding new funds to a PHC CG could appeal to provinces, whose overall social sector budgets would increase.

**Technical: MEDIUM**
Ring-fenced integration would require expansive scale-up of costing, budgeting, tracking, and monitoring competencies for PHC services. Resource needs for PHC are currently not well understood or researched, though the NT-NDOH PHC Costing Task Team has begun to fill key knowledge gaps. Similarly, considerable effort would be required to develop appropriate PHC indicators and expand the systems for provinces to routinely collect and report them. Incumbent systems for HIV would provide a useful foundation, but both research and capacitation would be required to extend those systems to all of PHC.
Scenario 5: National PHC Fund

Financing mechanism

Under Scenario 5, the NHI Fund would be established first as a PHC Fund with a large pool of resources to purchase an integrated PHC benefits package that includes personal HIV prevention, care, and treatment services. Similar to Scenario 4, there would be two possible approaches for creating a National PHC Fund:

1. The Fund could consolidate most of the HIV CG, the entire NHI CG11, and the portion of PES funds corresponding to anticipated PHC spending.
2. Most of the HIV CG and the NHI CG could seed the Fund, with new resources added incrementally.

In either case, the fate of financing for non-personal HIV services might be different from that of financing for personal services. We analyse the implication of integrating these funds into the PES, from which provinces draw resources for other non-personal health activities.

Rationale

Scenario 4 is a step in the right direction but insufficiently ambitious to achieve the government’s health reform objectives. Integrated financing may promise some efficiency gains, but the creation of a national Fund capable of strategically purchasing all services could lead to substantial improvements in access to high quality, efficiently delivered services for the entire population. Health reform is politically challenging, so each step should be as ambitious as possible.

Governance of HIV funds

• The Fund would assume the purchasing function for PHC services, with DHMOs managing service delivery.
• NDOH would consult with the Fund, DHMOs, and providers to set policies, accreditation criteria, and performance standards.

Purchasing of HIV services

• The NHIF would enable a shift from input- to output-based budgeting and an eventual purchaser-provider split.
• Any payment mechanism(s) could be instituted to incentivize quality and efficiency, including capitation for PHC as proposed in the NHI White Paper (2015).
• In the near term, payment for HIV and other PHC services might need to remain separate until risk-adjustment mechanisms were in place.

Implementation and pathway to NHI

• This scenario may align with the Transitional Fund for PHC proposed in the NHI White Paper (2015). Beyond PHC, the NHIF could eventually collect all health funds and purchase all personal services.
• NHl pilot districts would be a natural starting point for strategic purchasing.

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15 As in Scenario 2, the NHI Indirect Grant (previously the National Health Grant) would not be implicated in this scenario.
Impact

**HIV response:** ? / - (uncertain/unfavourable)
Similar to Scenario 2, strategic purchasing could drive quality improvement and efficiency with well-designed payment mechanisms. However, clumsy enrollment and cost-sharing policies could negatively affect access, particularly for poor and stigmatized patients. Moreover, dividing responsibility for personal (NHI Fund) and non-personal (PDOHs) interventions could erode coordination of the overall response. At the national level, oversight and funding for HIV activities could be diluted due to integration with financing for the rest of PHC.

**PHC services:** + (favourable)
Strategic purchasing and improved performance management could strengthen PHC services, especially if the Fund effectively linked financing to clinical behaviours. Integrated financing could bring more resources for non-HIV services and capitalize on the planning and performance monitoring strengths of the HIV response. Enrollment and cost-sharing policies would demand careful design to ensure equitable access.

**Health system efficiency:** ? (uncertain)
Integrated purchasing could improve allocative efficiency across PHC services, especially if the benefits package prioritized preventive and cost-effective services. Well-designed payment mechanisms could also incentivize quality improvement and efficiency at the facility level. Simply merging all PHC financing in the Fund, however, would achieve little on its own.

Feasibility

**Legal:** LOW–MEDIUM
Establishing a National PHC Fund would require legislation amending the National Health Act of 2004 to create the Fund, its governance structure, and the process by which the benefits package would be defined and modified over time. The policy design process would likely be protracted: the 2004 law was based on a White Paper from 1997. Nationalizing much of the health budget could also invite constitutional challenges, particularly if PES funds were implicated.

**Political:** MEDIUM
NHI proponents might champion this scenario as a decisive step toward the White Paper (2015)’s vision. The pace of implementation might dictate the level of NDOH support; some officials may be wary of complicating or undermining the pursuit of ambitious HIV targets, especially if non-personal services were not well handled. Provinces may strongly resist nationalization of funds, but their options for recourse may be limited. An incremental approach that respects current PES allocation levels may be more feasible.

**Technical:** LOW
Implementing a National PHC Fund would require considerable new financial management and performance monitoring systems, not to mention the capacitation of a new, complex government institution. Some of this capacity could be built atop existing planning and data collection processes in place for HIV and other services, and there would be a few straightforward implementation steps, such as setting up provider bank accounts. Others would require considerably more time and effort, including training a large cadre of financial managers at the facility and district levels. It would be quite ambitious to build all the requisite capacity in only three to five years.

Scenarios wrap-up

This concludes our summaries of the five scenarios. Appendix 2 contains more detailed analysis of each one. Next, in Section 4 we discuss key points of variation and highlight major issues policymakers will want to consider as they determine the path forward for South Africa’s publicly financed HIV response and health system more generally. In Section 5 we conclude with recommendations for additional analysis that can contribute to the implementation of a selected scenario or some variant thereof.
Section 4: Discussion

Drawing on our analysis in Section 3, we now compare the scenarios along their several descriptive and evaluative dimensions. These include the allocation of funds across financing pools and the distribution of responsibilities for governing HIV funds across spheres of government and actors therein. They also include the scenarios’ potential impact on health system performance and feasibility.

Allocation of funds across financing pools

The scenarios would imply different allocations of health funds to various pools. Figure 4.1 consolidates the data from Section 3 to illustrate how HIV and other health financing pools would be structured and resourced based on budget forecasts for FY 2016/17.12

ILLUSTRATIVE ALLOCATIONS FOR SCENARIOS 1–5 FOR FY 2016/17 (R BILLION)

Abbreviations: CGs = conditional grants, PES = provincial equitable share, PDOHs = Provincial Departments of Health, PHC = primary health care.

12 These figures are aggregate across all nine provinces but may not include all DOH funds retained at the national level.
Side-by-side examination of the pooling configurations reveals several important observations. First, in all cases the majority of revenue for health spending will not be implicated by the financing mechanisms proposed in the five scenarios. We retained all non-PHC funds in the PES, but the government could also explore changes to the management of hospital funds, for instance. Second, two pairings of similar scenarios are evident: 1-2 and 4-5. Within each pairing the size of the HIV- or PHC-dedicated pool of funds would be nearly the same, while only the financing mechanism would differ between a conditional grant and a nascent NHI Fund. With respect to Scenarios 4 and 5, this reinforces the notion that the former could be a natural precursor to the latter. Third, the figure shows how only Scenario 3 would eliminate all ring-fencing around HIV funds, underpinning the concerns about unconditional integration expressed by health officials at both the national and provincial levels.

**Governance of HIV funds**

Next, Table 4.1 summarizes the key governance features of each scenario.

In Scenarios 1, 2, 4, and 5, the national government would retain a high level of control over how HIV funds were spent (column 2 of Table 4.1). NDOH would play a prominent role in each, while the Fund-oriented scenarios (2 and 5) would naturally also imply a major role for the new NHIF. Under these two scenarios, important questions would arise about the division of oversight responsibilities between NDOH and the NHIF, including which entity would be empowered to suspend payments to providers or districts that failed to meet performance standards. Additionally, Scenarios 2 and 5 would entail greater responsibility for districts than under the current system. This aligns with the NHI White Paper (2015), which proposes a prominent (albeit undefined) role for DHMOs in overseeing facilities on the provider side of the purchaser-provider split.

Scenario 3 would be quite distinct, placing near-total control over HIV funds with the provinces, much like with the majority of other health financing through the PES. Unconditional integration would liberate provinces from the CG’s stringent planning and reporting requirements. NDOH’s attempts to promote accountability outside the CG mechanism, such as more closely monitoring spending on the so-called ‘non-negotiables,’ are not yet viewed as adequate protections for priority programmes. However, there may be opportunities for enhancing such normative measures in the future.

Responsibility for HIV target-setting (column 3) would correspond to the spheres of government with greater control over the use of funds. A high level of control over funds use would correspond to a leading role in target-setting, while a medium level of control over funds use would typically imply a consultative role in target-setting.

The national sphere would not have a leading role in HIV budget planning under any scenario (column 4). As is the case in the current system, PDOHs and Provincial Treasuries would be principally responsible for developing HIV budgets under Scenarios 1, 3, and 4, subject to NDOH’s adjustments and approval. Meanwhile, under Scenarios 2 and 5, districts would be responsible for HIV budget planning to reflect the contracting arrangements between local providers and the NHIF. Depending on the details of the purchaser-provider split and the role of DHMOs, providers may eventually need to undertake their own internal budgeting process as well.
### PROPOSED DISTRIBUTION OF GOVERNANCE RESPONSIBILITIES FOR HIV FUNDS, SCENARIOS 1–5.

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>LEVEL OF CONTROL OVER HOW HIV FUNDS ARE EXPENDED</th>
<th>RESPONSIBILITY FOR HIV TARGET-SETTING</th>
<th>LOCUS OF HIV BUDGET PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sustained HIV conditionality</td>
<td>National – High (NDOH)</td>
<td>NDOH (+ PDOHs)</td>
<td>PDOHs + PTs</td>
</tr>
<tr>
<td></td>
<td>National – Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provincial – Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. National HIV Fund</td>
<td>National – High (NDOH + NHIF)</td>
<td>NDOH (+ NHIF + DHMOs + PDOHs)</td>
<td>DHMOs (+ providers)</td>
</tr>
<tr>
<td></td>
<td>Provincial – Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provincial – Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Unconditional integration</td>
<td>National – Low (PDOHs + PTs)</td>
<td>PDOHs (NDOH)</td>
<td>PDOHs + PTs</td>
</tr>
<tr>
<td></td>
<td>Provincial – High (PDOHs + PTs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>District – Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ring-fenced PHC integration</td>
<td>National – High (NDOH)</td>
<td>NDOH (+ PDOHs)</td>
<td>PDOHs + PTs</td>
</tr>
<tr>
<td></td>
<td>Provincial – Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>District – Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. National PHC Fund</td>
<td>National – High (NDOH + NHIF)</td>
<td>NDOH (+ NHIF + DHMOs)</td>
<td>DHMOs (+ providers)</td>
</tr>
<tr>
<td></td>
<td>Provincial – Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provincial – Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>District – Medium</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors’ assessment.
Notes: In the second column, entities listed in parentheses would bear principal oversight responsibility and authority for HIV funds. In the third and fourth columns, the first entities listed would play the leading role in budget planning and target setting, while those in parentheses would have a consultative role.
Abbreviations: DHMOs = District Health Management Offices, NDOH = National Department of Health, NHIF = National Health Insurance Fund, PDOHs = Provincial Departments of Health, PTs = Provincial Treasuries.

Overall, only Scenario 3 would imply radical changes to the governance of HIV funds by reducing the national sphere in most critical functions. The other four scenarios would retain or even enhance the national sphere’s prominent role in controlling how HIV funds were used and targets were set, though budget planning would remain driven at more local levels in all five scenarios. The more dramatic changes would relate to governance of funds for other PHC services. Scenarios 4 and 5 would entail significantly increasing the national sphere’s level of control and purchasing power for PHC.

**Impact on health system performance**

We find considerable variation in the potential impact of the five scenarios on
the HIV response, PHC services, and health system efficiency. Table 4.2 provides a concise scorecard reflecting our analysis.

This portion of the evaluative analysis sheds light on some of the key trade-offs and risks of the scenarios. First, if ‘do no harm’ is a guiding principle of any HIV financing reform, Scenario 3 (removing the HIV CG) clearly stands out for the widespread view that it could be detrimental to the HIV programme. Informants consistently cautioned that eliminating ring-fencing around HIV funds would lead to insufficient spending and minimal accountability for service delivery. Most of our informants represented HIV-related interests, but the state of other government health services may corroborate their views. For example, PHC services in public facilities are generally thought to be of poor quality relative both to publicly provided HIV services and privately delivered PHC. Scenario 3 also serves as an important point of caution for health reformers in other countries: financing integration is not inherently beneficial, and in fact it could be detrimental if poorly designed. Scenarios 2 and 5 also merit caution on this front.

Second, there is minimal basis for expecting pooling reforms alone to yield major gains to the HIV response. This is partly a reflection of the current programme’s strength: the conditional grant mechanism has enabled fairly rapid, evidence-based scale-up of the government’s HIV response with exceptional spending rates and service target achievement. Given these virtues, the means by which financing reform might further enhance the HIV response relate principally to purchasing rather than pooling. As discussed at the outset of Section 3, potential purchasing reforms could be pursued independently of changes to pooling mechanisms, though the latter certainly helps to define the range of possibilities for the former. For instance, transitioning to a Fund (as in Scenarios 2 and 5) implies eventually adopting a more strategic approach to purchasing services—a defining feature of a purchaser-provider split—but the particulars of payment mechanisms would ultimately determine the extent to which purchasing policy effectively incentivized the efficient delivery of high-quality services. Concurrently, equitable implementation of any financing scheme would require careful management of enrollment policies so as not to disadvantage hard-to-reach populations that require HIV and other health services.

Third, primary health care could be the area of greatest gain from pooling reforms if PHC service delivery were imbued with some of the mechanisms for business planning, tracking, and evaluation currently in place for the HIV response. Benefits may not be immediate because the tools for PHC costing, resource needs estimation, and business planning are not yet as sophisticated as those in use for HIV. However, Scenarios 4 and 5 would both create more urgent demand for such capacity and catalyse research and other investments to improve South Africa’s understanding of PHC financial needs and management.

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13 External financing, particularly from PEPFAR and the Global Fund, has also been important to these achievements. How to phase out this funding is a major question for the future of the HIV programme and should be considered alongside any integration proposals. For example, eliminating ring-fencing of the HIV budget could hinder government efforts to absorb donor programs targeting key populations. Additionally, shifting toward strategic purchasing could include specific plans for contracting with PEPFAR’s implementing partners.
These investments would bear fruit for the NHI system more generally because they are necessary precursors to decisions about PHC pricing and performance evaluation that should underpin the purchasing policies of any future NHIF. In fact, our analysis suggests that Scenarios 4 and 5 (and their variants)—if carefully implemented—would be the most likely to include strides toward the system envisaged by the NHI White Paper (2015) without unduly jeopardizing the HIV response.

Fourth, we are unable to shed much light on the likely impact of the proposed financing changes on health system efficiency. Prioritization processes, health technology assessment, and other means of improving allocative efficiency are exogenous to the types of pooling reforms embedded in the five scenarios. These are often tied closely to the institutional design of national health systems, and indeed they fall within the remit of one of the government’s NHI work streams. Meanwhile, improvements to technical efficiency are most likely to be driven by strategic purchasing, the details of which will be difficult to design until the government makes key decisions about a path forward for financing integration and, ideally, experiments with multiple approaches to contracting for services. Better management at all levels of the health system may also enhance performance. An additional source of uncertainty is whether private providers, if contracted, would deliver services more efficiently than the public sector. Several informants, including a senior NDOH official and others with extensive knowledge of South Africa’s private health care sector, predicted that private providers could be very cost competitive if they could access national tender prices for key commodities, like antiretroviral drugs. In turn, another senior NDOH official confirmed that, in terms of laws or regulation, nothing precludes

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>HIV RESPONSE</th>
<th>PHC SERVICES</th>
<th>HEALTH SYSTEM EFFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sustained HIV conditionality</td>
<td>Reference scenario</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. National HIV Fund</td>
<td>Ø/-</td>
<td>Ø</td>
<td>Ø/-</td>
</tr>
<tr>
<td>3. Unconditional integration</td>
<td>--/-</td>
<td>Ø/-</td>
<td>Ø/-</td>
</tr>
<tr>
<td>4. Ring-fenced PHC integration</td>
<td>Ø/-</td>
<td>++</td>
<td>Ø/-</td>
</tr>
<tr>
<td>5. National PHC Fund</td>
<td>Ø/-</td>
<td>+</td>
<td>Ø/-</td>
</tr>
</tbody>
</table>

Source: Authors’ assessment.
Key: + = favourable, Ø = minimal, - = unfavourable, ? = uncertain. Dual ratings (e.g., Ø/-) indicate a primary estimate and possible but less certain alternative.
extending the economies of scale from national procurement processes to private providers. Indeed, the NHI White Paper (2015) proposes extending these benefits to all accredited providers, public and private.

Commodity prices aside, incentivizing efficiency in the private sector will require careful design of payment policies, monitoring of service quality, and measures to discourage cost escalation. Some provinces are already contracting with private providers to deliver an integrated package of PHC services (including HIV), such as Mpumalanga’s service level agreement with two Right to Care–managed facilities. These experiences should be evaluated to better understand the prospect for scaling private sector delivery of publicly financed services.

This analysis is indicative and should not be the sole basis for decision making. It highlights the major opportunities and risks posed by each scenario, but it by no means predicts outcomes with a high degree of certainty. Moreover, as we note repeatedly above, many of the scenarios’ consequences will depend on additional policy choices and the effectiveness of their implementation. Nonetheless, even our qualitative and interview-driven methods help to highlight some scenarios policymakers may more easily eliminate from consideration than others. For example, if Scenario 3 indeed fails the ‘do no harm’ test, it may not be worthy of further consideration.

**Feasibility**

We also find important differences among the scenarios regarding feasibility. Table 4.3 overviews our ratings of each scenario’s legal, political, and technical feasibility, which we define in Section 3.

### Table 4.3: SUMMARY SCORECARD OF FEASIBILITY, SCENARIOS 1–5.

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>LEGAL FEASIBILITY</th>
<th>POLITICAL FEASIBILITY</th>
<th>TECHNICAL FEASIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sustained HIV conditionality</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>2. National HIV Fund</td>
<td>Low to medium</td>
<td>Low to medium</td>
<td>Low to medium</td>
</tr>
<tr>
<td>3. Unconditional integration</td>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>4. Ring to fenced PHC integration</td>
<td>Medium to high</td>
<td>Medium to high</td>
<td>Medium</td>
</tr>
<tr>
<td>5. National PHC Fund</td>
<td>Low to medium</td>
<td>Medium</td>
<td>Low</td>
</tr>
</tbody>
</table>

Source: Authors’ assessment.
As with the impact criteria, a number of observations emerge from this scorecard. Only Scenario 1—maintenance of the status quo—would be highly feasible in legal, political, and technical terms. By definition the systems are already in place to sustain HIV conditionality, as are the requisite laws and other legal instruments for administration of the conditional grant mechanism. Political feasibility is slightly lower because some NT officials may be growing wary of indefinite growth in an HIV-dedicated conditional grant, and some in NDOH may be eager to move forward quickly with NHI implementation. However, NT will face stiff opposition from NDOH, provincial HIV managers, and HIV advocates to any financing reforms that do not preserve (and indeed expand) the country’s robust, scaled, and high-quality HIV response. For this reason, despite its technical and legal ease, Scenario 3 is likely a non-starter politically. NDOH’s leadership, including the Minister, are firmly committed both to the HIV programme and to implementation of NHI. Consequently, they would be very unlikely to embrace unconditional integration, which would neither ring-fence HIV funds nor obviously advance NHI rollout.

Scenarios 2, 4, and 5 would present more moderate challenges. They would all pose daunting technical problems, including creating the institutional architecture for a national purchasing agency and defining a benefits package (Scenario 2), integrating PHC financing and generating valid resource needs estimates (Scenario 4), or both (Scenario 5). Recognizing these would be no small tasks, NDOH and NT have already begun to invest in relevant analysis. For example, their jointly convened PHC Costing Task Team seeks to improve understanding of PHC costs and how they differ between the public and private sectors. Concurrently, one of the NHI work streams focuses on the institutional arrangements and establishment of the NHI Fund, and another is dedicated to preparing for the purchaser-provider split.

Additionally, all three of these scenarios (2, 4, and 5) would require considerable legal effort. The Fund-based scenarios (2 and 5) would require authorizing legislation for the creation of the Fund and the development of processes to define benefits and contract for services from both public and private providers. Similarly, all three would require nationalizing control over funds that have historically been allocated via the PES. By removing some health funds entirely from provincial management, Scenarios 2 and especially 5 could provoke litigation challenging their constitutionality.

Finally, Scenarios 2, 4, and 5 would all be likely to generate both support and opposition across the national departments, at the provincial level, and among HIV advocates. For instance, HIV advocates might resist the Fund scenarios (2 and 5) unless key concerns about enrollment, cost-sharing, and service coverage were addressed. Meanwhile, provinces might oppose the integrative scenarios (4 and 5) if they stood to lose control over a large portion of their health budgets and were increasingly sidelined with respect to health service delivery. The fate of the health sector wage bill looms large. Some informants felt that provinces would more willingly accept integration if, along the way, the national sphere assumed responsibility for paying health workers.

Given that all three of these scenarios would be plausible steps toward the
government’s proposed NHI system, galvanizing public and institutional support for systemic reform could be key to overcoming opposition. On the other hand, mismanagement of any interim steps could undercut enthusiasm for more ambitious NHI policies. Once the government selects its preferred course, much more detailed appraisal of a policy’s technical and legal requirements, as well as a thorough political analysis, will be necessary.

Section 5: How to move forward

This study aspires to help South African policymakers (i) to better understand the range of possibilities for HIV (and PHC) financing adjustments and integration in the next three to five years, and (ii) to identify one or more promising options for further study and implementation, on the basis of comparative analysis. The five scenarios described and evaluated in Sections 3 and 4 are indicative of the government’s choice set. They provide a useful foundation for debate and decision making within government and beyond with regards to the near-term future of HIV financing and how its integration fits into broader NHI implementation.

In particular, our analysis lays a foundation for several possible next steps in policy design and analysis. First, the time is ripe for the government—namely, NDOH and NT—to choose a scenario for more detailed analysis and possible piloting or implementation. The selected option could be one of the five featured in this study, a hybrid or variant of several, or an entirely different approach from those we have examined.

Selecting any new HIV financing arrangement will generate a substantial list of analytical needs for designing and implementing the new pooling and purchasing arrangements. For example, if PHC services were to be incrementally integrated into the conditional grant framework and purchased strategically—per the second option in Scenario 4—numerous questions would require attention, including:

- How much does the government currently spend to deliver various PHC services? How much should those services cost?
- What criteria or principles should guide selection and sequencing of services to be integrated?
- What performance indicators should be monitored for PHC?
- What information systems are in place, or would need to be strengthened or developed, to ensure the collection of appropriate performance indicators?
- Should the government more extensively contract with private providers to deliver PHC services, and how?

Additionally, if near-term experimentation with strategic purchasing arrangements appeals to the government, additional questions will arise, including:

- What steps are required to prepare for a purchaser-provider split?
• What information systems and human capacity are needed to negotiate and monitor contracts between the purchaser and providers?

• What are the best payment mechanisms for integrated PHC service delivery? How soon can capitation be sufficiently risk adjusted to account for variable HIV burden? What payment mechanism should be used for HIV services in the meantime?

• What are appropriate prices for PHC services? How can fair pricing be ensured between public and private providers?

Though these questions are motivated by a specific policy option, they are also germane to any future NHI scheme. It is no surprise, then, that the government and others are already working to answer many of them, including through the NHI Work Streams and the PHC Costing Task Team.

Additionally, more detailed political analysis will benefit the design and implementation of any new HIV financing policies. Building on the consultations conducted for this study, more can be done to understand the interests of various provincial officials, HIV and other advocacy organizations, labour organizations including those representing health care workers, and private providers. Related to political economy are the complex dynamics of intergovernmental relations. Financing integration could dramatically alter the distribution of responsibilities and purchasing power among the spheres of government, as would adoption of the NHI White Paper (2015)’s proposals. How to capacitate and empower districts to play their envisaged role, and how quickly, remain critical NHI implementation challenges, as does the future role of provinces in health financing and service delivery. These matters will interplay with the Presidency’s ongoing examination of fiscal federalism, whose outcomes will shape the course of government financing for health and other sectors.

Critically, ongoing efforts to understand and effect HIV financing integration need not preclude, nor should they ignore, other important health financing considerations. As noted in Section 1, this study focuses on public financing because the government already accounts for three-quarters of HIV spending, and major donors have signaled their intention to scale down their programmes in the next five to 10 years. Careful management of the donor transition will be critical to the continued viability and scale-up of South Africa’s HIV response. Important questions include:

• What programme areas are primarily funded by donors? How can the government ramp up spending and capacity in these areas?

• What share of donor spending will the government need to absorb, and how quickly?

• What populations do donor programmes serve that could fall through the cracks during the transition? How can the government ensure continuity of services to them?

• How can the delivery capacity of donors’ implementing partners be best leveraged as financing shifts ever more to the public sector?

Moreover, as discussed at the end of Section 2, the fate of TB financing must be included in discussions about restructuring HIV financing. The government is only now beginning to integrate substantial
TB activities into the HIV CG, and careful planning is required to ensure that HIV financing reforms reinforce the incipient will and capacity for TB business planning and expenditure tracking that will complement and strengthen performance monitoring for TB services. Policymakers would do well to explore the critical success factors for strengthening the national TB response, including:

- To what extent does HIV-TB integration in service delivery require integration in financing?

- What opportunities and risks will arise if HIV financing is simultaneously integrated with both TB and other PHC services, and for whom?

- What efficiency gains could the government seek through financing reforms in terms of targeting key populations, engaging private providers, and improving access to HIV and TB services?

- What surveillance and monitoring systems need to be strengthened or developed to enable the careful tracking of the impact of TB spending through the CG?

- What capacity needs to be developed within PDOHs’ TB units to adequately plan, cost, and budget for their TB funds?

- How can the national government ensure new allocations for TB, via the CG, increase overall TB spending rather than prompt provinces to reduce their own contributions to TB services from PES funds?

The financing of other types and levels of care is also important to NHI design and implementation. Today PHC (including HIV) accounts for less than half of government health spending. Consequently, there may be substantial opportunities for financing policy, particularly with respect to purchasing, to increase the system’s efficiency, both allocative (by prioritizing preventive and cost-effective interventions) and technical (by incentivizing and enabling facility-level operational improvements). The Ideal Clinic Programme and the ongoing process to introduce DRG payments to the 10 national hospitals are both important components of these broader reform efforts.

Taken together, this multitude of current and anticipated activities indicates how promising and formative a time this is for South Africa’s health system. As its most visible— and arguably most successful— health programme, the government’s HIV response will factor critically into any major reforms. In fact, many of the scenarios we present here would position HIV as the ‘tip of the spear’ of NHI design and implementation. By charting a course that is both feasible and broadly consistent with its vision for NHI, the government can take meaningful strides toward its conjoined goals of ending the world’s largest HIV epidemic and building a vibrant, sustainable, and responsive health system for all South Africans.
### Appendix 1: Participants in consultations

<table>
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<tr>
<th>NAME</th>
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<tbody>
<tr>
<td>Yogan Pillay</td>
<td>Deputy Director General for HIV/AIDS, TB, and MCH National Department of Health</td>
</tr>
<tr>
<td>Anban Pillay</td>
<td>Deputy Director General for Regulation and Compliance National Department of Health</td>
</tr>
<tr>
<td>Jeanette Hunter</td>
<td>Deputy Director General for PHC National Department of Health</td>
</tr>
<tr>
<td>Ian Van der Merwe</td>
<td>Chief Financial Officer National Department of Health</td>
</tr>
<tr>
<td>Nthabiseng Khoza</td>
<td>Director, HIV Conditional Grant National Department of Health</td>
</tr>
<tr>
<td>Aquina Thulare</td>
<td>Director, NHI National Department of Health</td>
</tr>
<tr>
<td>Moremi Nkosi</td>
<td>Director, Insurance National Department of Health</td>
</tr>
<tr>
<td>Shaidah Asmall</td>
<td>Senior Technical Advisor for Health System Strengthening National Department of Health</td>
</tr>
<tr>
<td>Peter Barron</td>
<td>Senior Advisor National Department of Health</td>
</tr>
<tr>
<td>Mark Blecher</td>
<td>Chief Director, Health and Social Development National Treasury</td>
</tr>
<tr>
<td>Edgar Sishi</td>
<td>Chief Director, Intergovernmental Relations National Treasury</td>
</tr>
<tr>
<td>Aparna Kollipara</td>
<td>Director, Health National Treasury</td>
</tr>
<tr>
<td>Dubemi Obugu</td>
<td>Director, Intergovernmental Relations National Treasury</td>
</tr>
<tr>
<td>Ogali Gaarekwe</td>
<td>Director, Intergovernmental Relations National Treasury</td>
</tr>
<tr>
<td>Jonatan Daven</td>
<td>Senior Budget Analyst, Health and Social Development National Treasury</td>
</tr>
<tr>
<td>Fareed Abdullah</td>
<td>Chief Executive Officer South African National AIDS Council</td>
</tr>
<tr>
<td>Nevilene Slingers</td>
<td>Executive Manager South African National AIDS Council</td>
</tr>
<tr>
<td>Adri Mansvelder</td>
<td>Finance Manager KwaZulu-Natal Department of Health</td>
</tr>
<tr>
<td>Juanita Arendse</td>
<td>HAST Director Western Cape Department of Health</td>
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Appendix 2: Scenarios – detailed narratives

Scenario 1: Sustained HIV conditionality – sticking with what works

Financing mechanism

Scenario 1 would maintain the status quo. The current financing mechanisms for HIV within DOH would be retained, and the bulk of government spending on HIV would be channelled through the HIV CG. The annual Division of Revenue Act (DORA) would continue to indicate the conditions for the grant, stipulating each subprogramme’s allocation and targets. NDOH, in consultation with each PDOH, would continue to determine annual allocations to provinces and targets for each HIV subprogramme, and the provinces would continue to report on these quarterly.

Rationale

The HIV CG has symbolized the government’s commitment to the HIV response and to the roll out of ART over the years. Despite considerable progress, HIV remains a unique public health threat to South Africa, and the population has come to expect the government not only to provide treatment to all people living with the virus, but also to undertake ambitious prevention activities. Consequently, HIV deserves independent focus and management, even if at the cost of some inefficiency in the health system.

The CG mechanism has enabled unprecedented annual funding increases—HIV accounts for 11 percent of the total health budget—to pay for essential curative and preventive HIV services (Ndlovu & Meyer-Rath, 2014). In light of the ongoing NHI policy discourse, significant changes to HIV financing may be premature. Until NHI plans are finalized, and critical decisions are made about how HIV services will be provided under the new scheme, it may not be desirable to alter a well-functioning system.

14 The NHI conditional grant, which is a direct grant to provinces, is distinct from the National Health Insurance Indirect Grant, which before FY 2016/17 was known simply as the National Health Grant. The latter is not implicated in any of the scenarios.
In the meantime, sustaining conditionality would leverage the HIV programme’s business planning and monitoring strengths to ensure that HIV funds were used for their intended purpose and performance targets were achieved. The CG mechanism would continue to ring-fence allocations for HIV and thereby protect the HIV response from provincial discretion to allocate resources across sectors and health programmes. The national sphere would retain the ability to ensure that performance targets were achieved, while provinces would continue to oversee delivery of HIV services.

Detailed description

Pools of funds

Figure A2.1 depicts the expected pools of provincial health sector funds in FY 2016/17 under sustained HIV conditionality. Nearly 80 percent (R125.6 billion) of provincial health spending would flow from PES funds, almost a third of which would be spent on PHC. Meanwhile, the HIV CG would amount to roughly 10 percent (R15.3 billion) of provincial health spending. Other conditional grants, including those for tertiary services, training, infrastructure improvement, and the National Health Insurance conditional grant would amount to around R18.7 billion.

Governance of HIV funds

NDOH would exercise a high level of control over the use of HIV funds. The CG mechanism would continue to specify priority spending areas and measurable outputs for which provinces would be accountable. NDOH would lead the development of service delivery targets in consultation with provinces. The CG mechanism would also continue to enable resource allocation across provinces on the basis of HIV-related needs rather than the PES allocation formula, which currently does not account for high-burden diseases. The current strong systems of national oversight and accountability required by the CG mechanism would be retained. If provinces did not comply with the conditions or failed to achieve their HIV spending and output targets, NDOH would be able to intervene and even sanction them by withholding CG funds.

Provinces would continue to have moderate control over the use of HIV funds. Provincial DOHs and Treasuries would develop HIV business and budget plans, oversee service delivery, and manage tracking of expenditure and outputs. Meanwhile, districts and facilities would have minimal control over the use of funds, accepting budgets and targets from above. Facilities would, however, continue to make choices about the extent of service delivery integration, often on the basis of guidance from national, provincial, and district officials.

Purchasing of HIV services

Generally, providers would continue to be paid for HIV services according to input-based budgets, and in turn they would use HIV CG funds for their expressed purpose. However, in some provinces CG funds are already used more flexibly at the facility level, particularly with respect to resources shared between HIV and other services—most notably, facility space and health care workers. Such flexibility could be more explicitly permitted, or even encouraged, so as to lessen some of the inefficiency and disadvantages being experienced in PHC service delivery. The national or provincial health departments (or both) could also begin exploring more strategic approaches to purchasing HIV services, including introducing performance-based financing. Facility managers would require decision-making autonomy to respond to new financing policies, including the ability to translate facility-level incentives into a viable performance management system for their...
own personnel. High-performing Ideal Clinics in NHI pilot districts would be natural settings for introducing new purchasing arrangements. Likewise, health departments might already consider more extensive contracting with private providers to deliver HIV and other services.

Implementation and pathway to NHI

Sustained HIV conditionality would extend the incumbent HIV financing system for the next three to five years. On its own, it would be a step neither toward nor away from an NHI system, whether that envisaged by the White Paper (2015) or another. Scenario 1 could precede any of the other scenarios, including those involving further centralization of HIV and PHC funds (Scenarios 2, 4, and 5) and the one entailing fuller devolution of control to provinces (Scenario 3). In the interim, the existing CG mechanism could allow for the strengthening of systems for contract management and performance monitoring, building capacity among districts and providers that will be required for NHI implementation. NHI pilot districts may be the appropriate starting point for such capacity building, which could be incorporated into the next phase of the Ideal Clinic Programme.

Impact on health system performance

Scenario 1 serves as the reference or baseline scenario for evaluating all other scenarios’ effects on the HIV programme, PHC services, and efficiency. We offer analysis of all three here but omit any ratings.

Effect on the HIV response

As indicated above, the HIV CG would ensure adequate funds are committed and spent accordingly on HIV, and therefore would protect the performance of the HIV programme and achievement of national targets. South Africa is internationally acclaimed for its successes with regards to its response to HIV. This would continue under Scenario 1, and plans are already in motion for these benefits to be expanded to the TB programme starting in FY 2016/17. Moreover, the new HIV and TB Investment Case (Department of Health, South Africa & South African National AIDS Council, 2016) is already guiding the budget proposal and business planning processes for the conditional grant, helping to justify additional resource allocations in pursuit of ambitious national coverage targets.

Effect on PHC services

Sustaining HIV conditionality would not likely affect PHC services directly. The benefits (and costs) of the CG framework would not be expanded to PHC, nor is there anything inherent to the financing structure that would promote further integration of service delivery. Consequently, the government might consider complementary measures to encourage more flexible use of CG funds at the provincial and provider levels. That said, lack of effective integration with HIV services is but one small portion of the challenges faced in PHC. Officials cited numerous obstacles to improved PHC services, including stagnant PHC budgets—the bulk of resource growth for District Health Services has been for salaries—poor accountability, minimal management capacity, and inadequate data and models to guide budget planning. As one senior official stated, “you cannot blame the CG for the poor delivery of PHC services.” Likewise, it might be unlikely that merely reconfiguring the HIV CG would solve PHC’s problems.

Effect on health system efficiency

The conditional grant mechanism for funding HIV services has been efficient in terms of absorption of funds and targeting. The rigorous business planning and performance monitoring systems in place have helped to
achieve an extremely high spending rate—upwards of 99 percent in recent years—alongside achievement of service delivery targets. Although the administrative burden of sustaining such a grant is additional to that required for PES funds management, there is a strong consensus among policymakers and other stakeholders that the benefits accrued in terms of service quality and accountability are worth the extra investment. There may be some duplicative spending resulting from having parallel planning and monitoring processes for the HIV programme and general health services, but the former is widely recognized as being of superior quality and a potentially useful template for the entire health system. To date these stronger financial management and monitoring systems have minimally benefitted financial management or service delivery for PHC more generally. However, more integrated planning is underway across South Africa with the development of District Implementation Plans for addressing performance deficiencies in HIV, TB, and maternal and child health. Widespread execution of these plans will commence throughout 2016, and early signs are promising for improving performance and efficiency, including optimizing resource allocations by the government and development partners (Muzah et al., 2015).

At the provider level, there is at least anecdotal evidence that the rigidity of the CG framework has prevented fuller integration of HIV and PHC service delivery. For instance, in some settings facility space, workers, and supplies paid for with HIV funds are kept separate from other services, resulting in patient and worker dissatisfaction and suboptimal use of clinical resources. In these circumstances PHC services suffer due to insufficient resources relative to HIV. In fact, the need to tag CG spending as HIV related may even lead to overspending on excess equipment and travel to HIV conferences instead of on much needed PHC supplies. Unfortunately, the extent of this problem—a lack of what one senior NDOH official described as “common-sense integration”—remains poorly documented or quantified. NDOH could investigate further and, if warranted, devise a process by which districts would propose reallocations of surplus HIV funds if their service and outcomes targets are met.

At the same time, some provinces (e.g., KZN and WC) have achieved integrated service delivery despite the vertical funding mechanism for HIV, indicating that verticality alone does not preclude service delivery integration. Provincial officials noted varying degrees of integration of HIV and PHC service delivery, with some reporting that they were fully integrated and that they used the CG strategically to cover HIV costs as well as PHC costs to ensure the optimal quality of service delivery. Even where CG funds are managed flexibly, however, informants felt conditionality is essential to ensuring the continued scale and quality of HIV services.

Nonetheless, officials at the national and provincial levels acknowledged some non-compliant use of HIV funds despite the CG monitoring framework. One senior NDOH official estimated that 10–15 percent of CG funds are spent on non-HIV activities. Noncompliant spending generally arises for one of two reasons. First, provinces may divert CG funds to address cash-flow problems elsewhere in the health sector, such as paying vendors for non-HIV medicines and supplies. In theory there should be a subsequent transfer of funds back to the HIV programme, documented through a re-journalization process, though often this does not occur in a timely fashion (or at all). Awareness of these practices affirms that the CG mechanism is working as intended and that there are other important financial management challenges in need of remedy. In fact, NT, NDOH, and the provinces are already working on addressing
cash-flow challenges, including the potential introduction of prospective payments for laboratory services.

Second, HIV funds are often used to pay for resources shared across multiple programmes, such as health care workers. For example, for accounting ease clinicians’ salaries in PHC facilities are typically either allocated entirely to the HIV programme or not at all, even though nurses routinely care for HIV and non-HIV patients alike. In fact, the same NDOH official felt that the HIV programme is a net beneficiary of such shared resources; we found no additional evidence to support or contradict this claim. Either way, this form of cross-programme financing further evinces the possibility of integrated service delivery despite non-integrated pooling mechanisms.

Feasibility

Legal feasibility

Sustaining HIV conditionality would not require any policy reforms beyond those already planned for the incorporation of TB into the CG. The grant mechanism is well established in South African law, and it remains fully compatible with the distribution of governmental responsibilities envisaged by the National Health Act (2004) and the Constitution. Therefore, the legal feasibility of this scenario is high.

Political feasibility

With respect to political economy, there are many stakeholders who support any scenario that protects the gains made in the HIV programme to date. Under Scenario 1, the HIV programme and its funding would be protected from competing provincial health priorities and crises, unfunded mandates, political agendas, misuse, and more. For this reason, most HIV officials within NDOH and the PDOHs (specifically the HAST Directors), as well as SANAC, prefer sustained HIV conditionality, at least until such time that the implications of NHIPolicy for the HIV response are clearer. Several NT officials echoed this view, and recognition of the CG mechanism’s value is implicit in NT’s embrace of an integrated HIV-TB CG starting in FY 2016/17.

In contrast, NDOH officials responsible for PHC would prefer more integrated funding for PHC in hopes that it would drive quality improvements characteristic of the HIV programme. They, together with some NT officials, see the integration of the HIV-TB CG into one PHC funding mechanism as a means to reduce inefficiency, both by eliminating parallel management structures and by promoting integrated service delivery, where appropriate. In fact, to some NT officials the CG’s rapid growth is concerning—the HIV CG is now the second largest government grant and accounts for an increasing share of the total health budget—so options to transition away from vertical funding channels may be desirable. Meanwhile, PHC managers at NDOH want to apply the same protections to PHC funding as exist for HIV, rather than dismantling the HIV CG. To them this would be the best option for improving PHC services and accountability. Additionally, maintaining the status quo may forestall progress toward implementing NHI, so some NDOH (and other) officials may prefer incremental changes in the next few years.

Despite these diverse views on the advantages and drawbacks of the current system, there is little evidence that the government would struggle to secure sufficient support should it opt to sustain HIV conditionality for the next several years, particularly if longer-term planning for NHI proceeds apace. Therefore, the political feasibility of this scenario is high.
Technical feasibility

Capacity for management of the CG has developed over many years and is relatively well performing at the provincial and national levels. The provincial HIV programme and finance managers have skills in planning, budgeting, monitoring of CG spending, reporting, and linking outputs to outcomes. However, districts still need greater capacity for these functions. Efforts are already underway to improve districts’ engagement in the planning and budgeting for the CG. These skills also need to be extended at all levels to TB planning and budgeting as an integrated HIV-TB CG takes shape in FY 2016/17. To the extent that the government wants to introduce contract-based purchasing of HIV (and TB) services using CG funds, additional capacity would be required for contract negotiation and management.

With respect to performance management, provinces already collect and report on HIV programme indicators. The monitoring system took some years to develop, and the programme has achieved good absorption and achievement of national targets. Indicators for the TB programme will similarly need to be determined and collected. As the CG amount continues to increase, there may be need to strengthen the accountability for performance and impact of the CG spending, especially increasing the capacity of NDOH to monitor outcomes, and to ensure provincial compliance and achievement of targets.

Finally, service delivery capacity may need to increase in line with demand for HIV services, particularly ART. For instance, there is growing interest in alternative modalities for dispensing medications so as to alleviate the burden on providers. These considerations are not unique to Scenario 1, however, and in the meantime sustaining the CG mechanism would ensure that facilities have adequate resources for continued scale-up of the HIV programme.

To summarize, though the CG system still requires deepening some capacity for planning and monitoring, compared to other scenarios these needs are minimal and can be met with relative ease. Therefore, technical feasibility of this scenario is high.

Scenario 2: National HIV Fund—a focused start for the NHI Fund

Financing mechanism

Under Scenario 2, the NHI Fund would be established with a moderately sized pool of funds to purchase a package of HIV care and treatment services. The Fund would consolidate most of the HIV CG with the small NHI conditional grant and would pay for personal HIV services, including care, treatment, and biomedical preventive services like PMTCT and MMC. In line with instituting a purchaser-provider split, the Fund would eventually purchase these services through contracts negotiated with both public and private providers. Such transactions would require additional public financial management capacity at the district and facility levels. Public health and non-biomedical preventive services related to HIV, such as social behaviour change campaigns (SBCC), demand creation for MMC, and procurement and distribution of condoms, would continue to be funded via a small conditional grant to provinces. Both pools of HIV

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15 The needs are more substantial and will require considerably more effort for the planned integration of TB into the existing CG. We consider this a separate consideration from whether Scenario 1 is technically feasible for the purposes of sustaining HIV conditionality alone.
funds would be managed and deployed separately from funds for other health services; therefore, Scenario 2 would not further integrate HIV financing and in fact may reduce the extent of integration, particularly in purchasing.

In practice, in the Fund’s first one to two years it would retain very similar purchasing practices as those that characterize the current HIV CG. These include linking budgets to output-based resource needs estimates and monitoring performance against both financial and service standards. Over time, the Fund would explore and scale-up more strategic purchasing arrangements with providers, which would also entail phasing out provinces’ role as financing intermediaries between the national sphere and facilities. In some ways Scenario 2 would mirror the process of NHI rollout proposed in the White Paper (2015) but with a benefits package focused narrowly on personal HIV services.

**Rationale**

Like Scenario 1, Scenario 2 would help to protect financing for the HIV response, ensuring effective and measurable administration and delivery of government-financed HIV services. However, Scenario 2 would involve more explicit steps toward an NHI system and the creation of an NHI Fund that would eventually adopt strategic purchasing strategies to promote efficiency and quality in service delivery. Toward this end, establishing the Fund would catalyse development of capacity for output- or even outcome-based purchasing within the public sector for wider use down the line as part of NHI. In fact, HIV service delivery is the public system’s best in terms of business planning and monitoring, making it the perfect programme to pioneer the purchasing and performance management systems that will be essential to NHI’s success.

Scenario 2 could be the best option for simultaneously protecting the HIV response and leveraging its programmatic strengths for the benefit of the health system more generally. In the future HIV services would also benefit from efficiency gains achieved through strategic purchasing. These will be essential to sustaining and expanding the HIV response, especially if new international treatment guidelines are to be implemented.16

**Detailed description**

**Pools of funds**

Figure A2.2 depicts the expected pools of provincial health sector funds in FY 2016/17 with the creation of a National HIV Fund. Under this scenario, existing NDOH financing for HIV care and treatment and biomedical prevention would be pooled within the Fund instead of being transferred to provincial health departments. This early version of the NHI Fund would assume responsibility for paying for these services. Nearly 90 percent of the current HIV CG would be transferred to the Fund, representing the personal preventive, care, and treatment services the grant currently covers. These funds would be combined with the current small NHI CG. The remaining HIV CG funds, which currently cover public health activities like condoms procurement and distribution, demand creation for

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16 As of 2015, the World Health Organization recommends initiating on ART anyone who tests positive for HIV, regardless of CD4 count. Current clinical guidelines in South Africa specify treatment initiation at CD4 counts at or below 500 cells per microliter (National Department of Health, 2015b). However, the government may soon update these guidelines to align with the WHO’s recommendations (“Nursing SA back to health,” 2016).
medical male circumcision, and special programmes for key populations and high-transmission areas, would continue to be tightly ring-fenced and transferred to the provinces as a conditional grant. If applied to FY 2016/17, this policy would shift R13.6 billion to the Fund, while R1.8 billion would flow to provinces in the remaining CG. Other conditional grants (R18.6 billion) and PES allocations to health (R39.8 billion for PHC services and R85.8 billion for non-PHC activities) would remain unchanged.

Governance of HIV funds

Scenario 2 would entail significant changes to the distribution of financial and programmatic responsibilities across levels of government. Financial authority would primarily be elevated to the national level: not only would the NHIF—proposed to be a centrally managed organization in the White Paper (2015)—assume the HIV purchasing functions currently fulfilled by the provinces, but the government health system would eventually also include a purchaser-provider split for the first time. NDOH would set policy and quality standards by which providers would be accredited for NHIF payment eligibility, as well as establish HIV service delivery and coverage targets in consultation with the NHIF, provincial DOHs, and District Health Management Offices (DHMOs) to continue to scale up the HIV response. Provinces would continue to manage population-level prevention (i.e., public health) activities for HIV via dedicated national transfers as mentioned above. They could also assume a quality monitoring and evaluation role and oversee the building of adequate financial planning and management capacity in districts. In turn, districts would plan HIV budgets and manage the delivery of HIV care, treatment, and biomedical preventive services. Contracts between the NHIF and providers, both public and private, would be developed on the basis of adequate data collection systems to track service delivery outputs and outcomes and providers’ financial performance.

The accreditation and payment systems implied by the creation of the NHIF would also enable mechanisms of oversight and accountability, albeit quite different from the current system. First, accreditation for NHIF payment eligibility would be a critical initial check on capacity and quality.
Facilities would have to demonstrate readiness to deliver all services in the HIV benefits package in accordance with quality standards established by NDOH. For public providers, assessment of readiness could be incorporated into the next phase of the Ideal Clinic Programme. Second, the country’s health management information system (HMIS) would be improved to enable continual monitoring of service delivery and patient outcomes. Districts excelling in meeting quality standards and coverage targets could be rewarded with additional performance-based payments on the basis of HMIS data, while poor performers could be targeted for support or ultimately sanctioned. This scenario would also open the door to demand-side checks on quality. For example, published performance data could inform patient choice of provider, at least in areas with multiple options.

**Purchasing of services**

At the moment, HIV financing in the public sector is budget based, although the conditional grant mechanism allows NDOH to influence behaviour at the provincial, district, and facility levels. Provinces must carefully track, monitor, and report financing and service delivery performance against goals agreed with NDOH. However, in addition to creating new public financial management competencies at the facility level, a National HIV Fund could implement more sophisticated and blended payment mechanisms to incentivize desirable provider behaviours. For example, while capitation may promote efficient delivery of care and treatment services, a separate fee-for-service payment may be useful to reward providers for large volumes of preventive activities like MMC. In general, creating a dedicated purchasing agency like the NHIF would promote a transition to more strategic purchasing for HIV services, though it may be difficult to purchase in an integrated fashion with other services, such as those central to primary health care. Such a transition would need to be carefully sequenced and implemented over time, with new resources pooled in the NHIF commensurate with additional services to be purchased.

**Implementation and pathway to NHI**

Under Scenario 2, policymakers would face a sequencing choice regarding the creation of the NHIF and the introduction of strategic purchasing for HIV services. For example, the government could prioritize establishing the institutional architecture for the Fund, which the NHI White Paper (2015) characterizes as an “autonomous public entity.” Alternatively, NDOH’s HIV directorate could incorporate strategic purchasing into the HIV CG, either by further centralizing control of funds or by modifying the conditions imposed on PDOHs. This alternative could characterize a variant of Scenario 1 or serve as a preparatory step toward the HIV-focused NHIF imagined in Scenario 2.

Because our emphasis remains on changes to pooling arrangements for HIV financing, we focus on establishment of the Fund while examining, but not assuming adoption of, possible purchasing reforms.

Creating a functional NHIF capable of strategic purchasing will require several years of capacity building and preparation at all levels of the health system. Initially the Fund would likely maintain the current budget-based approach to purchasing HIV services. Steps could then be taken to design new payment mechanisms, such as costing a package of HIV services and negotiating prices with public and private providers. Concurrently, DHMOs and PHC facilities would have to prepare for new financial management responsibilities, including receiving payments and managing their own HIV budgets. This might mirror
the proposed shadow budgeting process to prepare the country’s 10 national hospitals for payments based on diagnosis-related groups (DRGs), though on a much larger scale.

In the long run, this scenario would be a step toward a comprehensive NHI system. A more general PHC benefits package could be incorporated into NHI coverage, after which steps could be taken to include secondary and tertiary services as well. This would require expanding the scope of the benefits package and consolidating additional funds in the NHIF, including the remaining conditional grants (such as the National Tertiary Services Grant) and eventually most or all of PES funds being spent on health.

Impact on health system performance

Effect on the HIV response

It is unclear what the effect of instituting a National HIV Fund would be on the public sector’s HIV programme. Much would depend on the extent to which the system adopted certain proposals in the NHI White Paper (2015). In particular, policies for enrollment would need to be carefully implemented to protect and promote gains in the HIV response. For instance, even a simple enrollment process or a requirement to carry an NHI membership card could jeopardize access to services, particularly for key at-risk populations and marginalized groups. Out-of-pocket payments, which the NHI White Paper (2015) generally precludes, could also deter care seeking, particularly by the poor. While the NHI White Paper (2015) would provide a useful blueprint for establishing the Fund and the services it finances, an HIV-focused Fund would require some distinct features. The government would also need to ensure that new financing arrangements did not disrupt distribution of drugs and provision of laboratory services.

Additionally, the overall resource envelope for HIV would need to be carefully protected and grown to ensure that the programme remained solvent as the NHIF took on mandatory service delivery commitments, including increased target patient volumes, particularly if other health funds are no longer informally (and in as yet only partially quantified ways) subsidizing the HIV programme.

Finally, there is some risk that shifting personal services to the national sphere while leaving non-personal interventions in provincial hands could fragment the HIV response. Coordinating an effective and efficient blend of interventions would become more difficult, as might monitoring HIV spending and performance. Therefore, in the near term Scenario 2’s effect on the HIV response is uncertain (?) because it depends on several other policy choices requiring care not to undermine the programme; indeed, there would be real risk of inadvertent harm (-).

In the future, strategic purchasing could shape provider behaviour in a number of ways, including promoting increased volumes, quality improvement, and technical efficiency. Access to and quality of services could also increase if private providers become eligible for NHIF payments. In theory, an accreditation regime could also improve service quality in public facilities, though according a senior NDOH official, previous attempts to accredit public

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17 For instance, NDOH could covert the HIV CG into an indirect grant and then distribute funds directly to providers on the basis of purchasing contracts.
providers for participation in the current HIV programme were strongly resisted and ultimately abandoned. Consequently, a new approach to accreditation and its relationship to financing would be required.

**Effect on PHC services**

The financing changes envisioned under Scenario 2 would not be likely to affect the financing and delivery of PHC services, at least not before they were folded into the NHI benefits package. Until then, PHC would continue to be financed from PES funds managed by provinces. While overlap in service delivery in the public facilities would continue as before, the lack of HIV and PHC financing integration will be further solidified. However, re-journalization (temporary transfer of HIV funds to cover cash flow problems in other health areas) would no longer be possible, leading to the risk of non-HIV service delivery interruptions because of cash flow problems. In fact, this risk may affect health services well beyond PHC. Avoiding these disruptions anyway requires better budget planning and cash flow management by PDOHs. NT, NDOH, and provinces are already working on solutions, including introducing a global payments regime for services provided by the National Health Laboratory System, and more such reforms will likely be necessary in the future. Overall, **Scenario 2 would not be likely to have a meaningful effect on PHC services (Ø)**, and could even be detrimental if other financial management issues were not adequately addressed.

**Effect on health system efficiency**

The HIV conditional grant has been increasing as a share of national funds both for PHC and for health services overall. It is not clear, however, whether instituting a National HIV Fund to pay for HIV care, treatment, and biomedical prevention services would increase the efficiency of the health system. Creating a separate, centralized Fund for purchasing HIV services would, at least temporarily, deepen the divide between HIV financing and that for the rest of the health sector. Provinces would lose their ability to cross-subsidize between the HIV programme and other service areas, which could have either positive or detrimental effects on allocative efficiency. Within the HIV programme, the government already carefully considers needs and service targets when allocating funds across provinces and HIV programme areas; an NHIF may not be inherently better at making efficient allocations. However, as the epidemic recedes in some areas, holding HIV funds in a centralized Fund might make it easier for NDOH to reallocate resources between provinces, particularly if reduced need in one province meant its HIV budget should decrease. Additionally, the NHIF would require a process for determining, over time, exactly what services to pay for. Even if the benefits package remained HIV focused for some time, there would be a continual need for priority setting and health technology assessment, both of which could increase the system’s allocative efficiency.

Meanwhile, changes in technical efficiency would depend more on how the new NHIF purchased HIV services. For example, capitation for care and treatment services could promote more efficient use of resources at the facility level, assuming health care workers and facility managers faced corresponding personal incentives as well. In contrast, fee-for-service payments tend to promote overprovision of services but may be well suited to one-time preventive interventions like MMC. Moreover, HIV services may be compatible with performance-based payment regimes because they have an easily measured outcome: viral load. Linking payments to outcomes could be a powerful means of increasing performance without spending additional money, thereby enhancing technical efficiency.
Despite these opportunities, an HIV-focused NHIF may also pose challenges to service delivery integration. For example, HIV and other PHC services currently share numerous resources, the most important of which are health care workers. Under prevailing accounting practices, workers are either tagged as HIV related or not even though most provide multiple kinds of care. One senior NDOH official estimated that the HIV programme is a net beneficiary of this imprecise accounting: the amount of “non-HIV” labour time actually spent delivering HIV services significantly outweighs the amount of “HIV” labour time spend delivering non-HIV services. More strictly separating HIV financing from the rest of the health budget could exacerbate these accounting challenges and make providers less inclined to manage and deliver HIV and other PHC services in an integrated fashion. This relates to a major design challenge for any NHI system: will South Africa’s NHIF purchase the labour component of health service inputs in the public sector? Doing so would require significant changes to the contractual relationship between public-sector health workers and the government. Alternatively, or as an interim step, the NHIF could pay only for the variable costs of HIV services, much like Ghana’s National Health Insurance Scheme.18 Given labour’s high share of total health care costs, excluding it from NHIF payment mechanisms would limit the extent to which strategic purchasing could drive improvements in technical efficiency. While acute, these challenges may be short lived if non-HIV services were fairly quickly added to the NHI benefits package.

Ultimately, simply creating a National HIV Fund would do little to improve efficiency. Instead, several additional policy choices, such as the design of payment mechanisms, would determine Scenario 2’s effect. Moreover, introducing very new financing arrangements only for HIV services could complicate management and hinder service delivery integration at the facility level, potentially imposing additional costs in the short run. Consequently, Scenario 2’s effect on efficiency is largely uncertain (?) and potentially even unfavourable (-) in the near term.

Feasibility

Legal feasibility

The national government could redirect conditional grant funds relatively easily if NT and NDOH agreed. However, establishing the NHIF itself would require significant enabling legislation. The National Health Act of 2004 establishes health-related policy, oversight, financing, and delivery responsibilities for each sphere of government, so the establishment of the NHIF would upend the government’s current health financing, governance, and delivery mandate. At the same time, South Africa would need to pass special legislation to establish the NHIF as a “general government public entity” with specific modalities for its governance (under the PFMA) and financing (such as diverting funds from existing conditional grants). Finally, significant legal reforms and political will would be needed to enable an NHIF—representing a purchaser-provider split in the public sector—to strategically purchase health services, especially if health worker salaries are included. Depending on the changes, civil service rules and even broader labour laws may need to be amended to allow rewards and penalties (including termination of service) to incentivize

18 In Ghana, despite introduction of an NHI system, public-sector health care workers remain salaried and are paid through the government wage bill.
improved performance. Therefore, the extent of legislative change required for this scenario mean its legal feasibility is medium at best; the risk of legal challenges over centralization of health funds means legal feasibility may even be low.

Political feasibility

In terms of political economy, Scenario 2 would likely appeal to some NDOH officials. A key concern of HIV programme managers at the national level has been to protect the gains South Africa has made in promoting better business planning and accountability competencies in the financing and delivery of the HIV response. The national government’s control of financing and its strategic use to incentivize improved planning and tracking of financial resources and service delivery targets at the provincial level have been crucial to securing these gains. A National HIV Fund would enable NDOH to safeguard the HIV programme and to take some key steps towards the system proposed in the NHI White Paper (2015). These include instituting a purchaser-provider split in the government health financing system, generating capacity for public financial management at the district and facility levels, and experimenting with contracting and payment mechanisms with public and private providers. However, creating an HIV-only Fund may run counter to the spirit of the NHI movement, in which much of NDOH is heavily invested. NHI proponents may oppose, even on an interim basis, financing changes that entrench vertical financing for a single disease programme. Additionally, this scenario could face opposition from provinces, which would stand to lose control of significant health sector resources and whose own health departments could no longer be able to count on HIV CG funds to iron out cash flow problems via re-journalization or as top-up financing for integrated PHC. Even directors of provincial HIV & AIDS, STI, and TB (HAST) programmes may not support the revamping of HIV financing under this scenario if the stricter separation of HIV and other health funds inadvertently deprived the HIV response of PES funds, which currently account for a meaningful share of total HIV spending.\(^\text{19}\) On the other hand, additional protections for HIV funds and development of financial management capacity throughout the health care system might appeal to these health officials.

As for NT, because this scenario would retain dedicated transfers for the HIV response, it would not be likely to help control the (recently sharp) growth in the size of the HIV add-on to the national health budget. Hence, NT might stay concerned about finding efficiencies in the HIV response from integrated financing and delivery rather than committing to indefinitely financing a National HIV Fund, even though it would institute a purchaser-provider split in the public sector. A clear plan to expand the NHIF’s benefits package might therefore be essential to reassuring NT and other fiscally minded stakeholders that this scenario would be but one step toward larger reform that would promote greater efficiency and quality throughout the health system, not just with respect to HIV services. Similarly, PHC-oriented health officials, who have expressed expectations of leveraging the planning and monitoring capacities of the HIV programme to strengthen PHC

\(^{19}\) The best estimates of the share of provincial DOH spending on HIV that is financed with PES funds is nearly 20 percent for FY 2013/14 (Guthrie et al., 2015). This share is almost certainly too high because it counts all spending on health workers hired to provide community and home-based care (CHBC) to HIV patients, but these workers also provide many non-HIV services. Nonetheless, the PES share of total HIV spending is clearly not negligible.
service delivery, might resist changes to HIV financing that further insulated it from the rest of PHC.

Finally, South Africa’s politically vocal HIV-affected persons and advocates may need reassurance that the NHI enrollment rules under this scenario would not cause programmatic harm nor reduce access to services—such as from ill-conceived policies that risked excluding at-risk populations from coverage, restricted access to drugs, or increased the out-of-pocket costs of clinic visits for personal treatment and prevention services. At the same time, advocates might find appealing the continuation of a large pool of HIV-dedicated funds that remained ring-fenced and linked to financial reporting and service delivery targets and standards. To the extent that a National HIV Fund purchased services from both public and private providers, advocates might also embrace the potential expansion of access, efficiency, and quality that could be driven by contracts and performance incentives. To proactively support this policy, however, advocates would probably also demand assurances that as the benefits package expanded in scope beyond HIV services, financial and human resources currently dedicated to HIV service provision would not be diluted.

In light of expected mixed attitudes among health officials at the national and provincial levels, likely caution among NT officials, and reasons for both enthusiasm and wariness about a National HIV Fund among HIV advocates, the political feasibility of Scenario 2 is low–medium.

Technical Feasibility

Appropriate systems and capacities would need to be in place for organizations and individuals to play their respective roles to make a National HIV Fund technically feasible. While South Africa already has considerable planning, costing, and tracking capacity for its HIV response, the country would need to develop improved financial management, contracting, and monitoring competencies atop these existing systems at the facility level to make a new Fund a reality.

Under Scenario 2, the government would need to build substantial additional capacity for financial management of the HIV response. The HIV CG has helped to develop HIV management and reporting systems whereby the provinces engage in HIV business planning, including planning, costing, and budgeting against service delivery targets and tracking and monitoring of funds and services. However, for a central NHIF to directly contract with facilities, considerable capacity would need to be built for the Fund to manage contracts with providers, price services on the basis of routine HIV costing analysis, develop and oversee national HIV targets, monitor performance, and execute payments. Similarly, greater capacity in the form of human resources and systems would be required in districts and facilities to plan service delivery, make and control budgets, manage contracts, monitor performance, make claims, realize opportunities for efficiency, and more. These competencies are only now being developed at the district level but not yet at the facility level. A gradual process (or perhaps a ‘shadow’ process) of creating the necessary conditions for purchasing relevant HIV services would also need to be implemented. The types of data systems required to manage finances and track service provision would depend in part on the payment mechanism(s) selected.

The new NHIF would also require systems and capacity to monitor the performance and outputs of all contracted providers. Stewardship and quality assurance are critical functions of an NHI system, and skills and systems to ensure them would take time and resources to build and maintain. From
the current conditional grant mechanism, the national sphere has experience in monitoring performance and outputs of the provinces. This useful experience provides a foundation for directly monitoring individual service providers with which the NHIF would be contracting directly. Currently, provinces rely on district-level data capturers, who collect paper-based records from individual facilities and input them into relevant computerized systems. If the NHIF contracted directly with individual providers, monitoring service delivery contracts would require timeous data entry at the facility level. Planned investment in the Integrated Patient Information System through the National Health Insurance Indirect Grant is a useful step toward developing needed capacity for Scenario 2 (and Scenario 5).

In summary, existing systems would provide a valuable foundation for the technical capacity that would be required to introduce a National HIV Fund, but substantial additional capacity would be needed, including much in levels of the health system with minimal prior experience. Therefore, the technical feasibility of this scenario is low to medium.

Scenario 3: Unconditional integration – moving the HIV CG into the PES

Financing mechanism

Scenario 3 would entail complete HIV financing integration via abolition of the HIV CG. All HIV funding would be allocated through the PES, whose allocation formula would be adjusted to account for the HIV burden in each province. There would be no ring-fencing of HIV funds, and the strict conditions of the CG would be removed.

Like for most other health services, the funding and delivery of HIV services would fall fully under provincial authority in accordance with the National Health Act of 2004. Provinces would have full discretion over the allocation of resources across sectors and within the health sector, including for HIV and other programmes. Although NT would provide guidance and fiscal benchmarks to ensure provinces could meet their financial obligations, the national government would not be empowered to mandate how provinces spend their health funds. As is currently the case with all PES funds, provinces would be subject to the financial requirements outlined in the Public Finance Management Act (PFMA), such as annual planning, budgeting, performance monitoring, and reporting. These requirements are less stringent than those in place for HIV and other programmes funded through conditional grants.

Rationale

Reducing inefficiency in the current financing and service-delivery systems might require full integration of HIV and non-HIV health care financing. A unified pool of funds will reduce the need for parallel administrative, management, and oversight capacity across programme areas. Redundant programme management resources (e.g., personnel, reporting processes) could be redeployed to strengthen overall financial planning and management and develop systems for enhanced, integrated service delivery. With no ring-fencing around HIV funds, provinces would be free of the artificial financing divide between HIV and the rest of PHC, which in some cases leads to inefficient spending.

The conditional grant mechanism has served well South Africa’s ambition to build a high-quality, scaled-up HIV response. However, it was never intended to fund HIV services in perpetuity, separate from PHC
and other health services. The business planning, budget tracking, and performance monitoring systems developed for the HIV programme are ingrained in PDOHs and could be the basis for improved management practices across all of PHC, if not the entire health sector.

Additionally, given South Africa’s multifaceted health challenges and HIV’s increasing share of the total health budget, it is increasingly difficult to justify a large conditional grant focused on a single disease. The HIV CG is the second largest grant in the entire government budget—behind only the human settlements grant—and the health sector will account for more than a third of the R96 billion in conditional grant allocations projected for FY 2016/17. Consequently, and in light of the HIV programme’s tremendous success, now could be an opportune time to loosen the CG’s stringency and give provinces full control over their HIV budgets.

**Detailed description**

**Pools of funds**

Figure A2.3 depicts the expected pools of provincial health sector funds in FY 2016/17 under unconditional integration. Combining the allocated amounts for the current HIV CG with expected spending on other PHC services, the total PHC pool of funds would amount to 35 percent (R55.7 billion) of the provincial health budget in FY 2016/17, none of which would be ring-fenced. These PHC resources would be managed in the same pool as the R85.2 billion (53 percent of the total) in voted funds for non-PHC activities, meaning total health funds from the PES would amount to R140.9 billion. Meanwhile, the five non-HIV CGs would account for the rest of the health budget (R18.7 billion, 12 percent of the total).

**Governance of HIV funds**

Scenario 3 would entail a radical change to how HIV funds are governed. The national government would no longer exercise control over the amount of funds allocated to HIV services nor their distribution across various HIV prevention, care, treatment, and support activities. Instead, the national level would play a supporting role focused on policy development and capacity building. Importantly, NDOH would still work closely with provinces in setting HIV targets, and NDOH would be able to monitor HIV spending and outputs based on their regular annual financial and performance reports, which could become more rigorous through the non-negotiables framework, for which provinces report monthly. However, NDOH would lack any strong means of sanctioning provinces failing to meet their HIV targets.
At the same time, full control of HIV funds would be transferred to the provinces, which would be free to allocate resources as they saw fit, whether to HIV, other health programmes, or even other sectors. Responsibility for ensuring the achievement of provincial targets, through quality service delivery and timeous payment of suppliers, would fall fully to provinces. In principle they would plan, monitor, report, and evaluate PHC services in an integrated fashion, but they would no longer be bound by the stricter quarterly reporting and performance requirements of the CG mechanism.

**Purchasing of HIV services**

Scenario 3 would not necessarily imply changes to how HIV or PHC services were purchased. Provinces would be free, if so inclined, to experiment with alternatives to the current input-based budget system for public providers. Options could include contracting with private service providers to expand access and improve quality or introducing some form of performance incentives within the public delivery system to increase efficiency, service delivery integration, and service quality.

**Implementation and pathway to NHI**

Implementation of Scenario 3 would require two short-run steps. First, NT and NDOH would need to agree on a rechannelling of HIV funds through PES allocations. Second, the PES allocation formula would need to be adjusted to account for the distribution of HIV burden across provinces and to ensure additional funds flow accordingly. The burden of other diseases could also be factored in.

Unlike the other scenarios, unconditional integration would not be an obvious step toward the NHI system proposed in the White Paper (2015). Placing the already centralized HIV funds within the PES would run counter to creating a single, nationally controlled NHI Fund. As is discussed below, the deconstruction of the current CG and the adjustment of the PES formula to account for HIV burden would require considerable political effort. Such effort could be considered wasted if the funds, autonomy, and responsibility given to the provinces in the short run would were to be withdrawn again once the NHI Fund was established. In fact, it could make it more politically challenging to subsequently incorporate funds into the NHIF. However, Scenario 3 might be a natural step toward an NHI vision different from that in the White Paper (2015): the creation of nine devolved insurance funds managed at the provincial level. This option, which would resemble Canada’s social health insurance scheme, has not featured in the NHI discourse; however, it could be a useful alternative if full centralization proves too politically (or constitutionally) difficult. Such a system would require extensive capacity building at the provincial level to effectively manage independent funds.

**Impact on health system performance**

**Effect on the HIV response**

Scenario 3 would pose considerable risks to the HIV response and its gains to date. All interviewed officials—including those in NDOH’s PHC directorate and PDOHs—felt that loosening the conditionality of the CG will be detrimental to the HIV response because the funds would no longer be ring-fenced and thus would be easily reallocated to other provincial priorities, which might not even lie in the health sector. Without the legislative requirements on PDOHs to monitor and report quarterly on both financial and programmatic performance, there would be no way to ensure the national and provincial HIV targets were being
achieved. In addition, the quality of financial management varies across provinces, with cash flow problems often delaying payments to suppliers of medicines and other clinical inputs. If the HIV programme were no longer (mostly) insulated from these issues, the consequent delays in delivery of supplies to facilities could undermine access to ART, lab tests, and other critical services. There is some chance that external pressure (advocacy) would continue to ensure that the PDOHs allocated sufficient funding to HIV. Other opportunities for improving reporting and accountability requirements for HIV and PHC within the PES, such as those being used for the non-negotiables, could also be explored. Nonetheless, the risks to the HIV response would considerable, so this scenario would have an extremely unfavourable (- - -) effect on the HIV programme; in fact, it illustrates how financing integration for integration’s sake might not be desirable.

Effect on PHC services

As mentioned above, placing the HIV funds into the PES might make some funds available for PHC and allow for more efficient spending and improvement of PHC services. However, to the extent that they reallocate HIV funds to other uses, there is no guarantee that provinces will even retain those resources in PHC or the health sector at all. Therefore, this scenario’s effect on PHC services is uncertain (?) and potentially favourable (+) if some funds previously meant for HIV are spent on other PHC services.

Effect on health system efficiency

The effect of unconditional integration on health system efficiency would likely depend on whether there were any concurrent changes to how provinces financed general health services. Provinces rely principally on input-based budgets for government health facilities, and no strict performance standards exist for non-HIV services. Without a robust system of oversight or reconfigured provider incentives, it is difficult to imagine how this scenario would promote efficiency gains. Nonetheless, a couple of hypotheses are worth considering.

First, the relative size of the HIV CG compared to the rest of PHC spending—it may reach 50 percent by the end of the current MTEF period—implies an opportunity for efficiency gain. One reason could be that the vertical nature of HIV financing constrains the integration of service delivery, meaning in some cases facilities suboptimally allocate human and other resources between HIV services and other activities. However, although some provinces have kept vertical HIV service delivery, this is not true everywhere. In some settings, therefore, blending HIV funds into the PES might allow for more ‘common sense’ integration in facilities, but the prevailing financing system is not the only (or even main) determinant of whether service delivery is integrated.

Second, the management and monitoring systems in place for HIV may be duplicative of or parallel to those in use for the rest of government health services. PES funds have lesser planning, budgeting, monitoring and reporting requirements, so unconditional integration would require less time and effort of programme and financial managers, whose capacity could be redirected to other activities. However, this would not necessarily lead to improved spending on HIV or PHC. In fact, it could lead to reduced spending on HIV (and perhaps health more generally), or even more wastage of resources if provinces were no longer accountable to NDOH for HIV performance standards. In other words, any savings accrued from reducing the financial management burdens of the CG framework would probably be more than counterbalanced with decreases in HIV spending, reductions in business planning and monitoring, and ultimately worsened service quality.

Finally, this scenario could free provinces to more proactively address rampant cash-
flow challenges by using some HIV funds to support struggling PHC services. However, this too could detract from overall spending on HIV and may not promote efficiency gains at the system level. In summary, there is little reason to expect meaningful efficiency gains from unconditional integration. Therefore, this scenario’s effect on efficiency would be minimal (Ø) or potentially unfavourable (-).

Feasibility

Legal feasibility

Unconditional integration could be achieved without any major legislative reforms. Channelling funds via the PES allocation system is already the core mechanism for intergovernmental transfers in South Africa, and there is no law or constitutional provision requiring a conditional grant for HIV in perpetuity. Adjusting the PES allocation formula to account for HIV burden would pose a modest policy design challenge, but the existing distribution of CG resources across provinces would provide a useful starting point. The legal feasibility of this scenario is high.

Political feasibility

The political economy of removing the HIV CG would be simple: among our informants there was no direct support for this scenario, and there was rather clearly expressed opposition to such a proposal. According to multiple NDOH officials, the Minister of Health would probably oppose such a radical alteration to HIV financing. Moreover, although the HIV advocacy movement has been quieter in recent years, there are powerful constituencies within governmental (NDOH and PDOHs) and quasi-governmental (SANAC) agencies that, concurrent with influential organizations like the Treatment Action Campaign, Section 27, and the AIDS Law Project, could prevent the adoption of any policy that would remove the ring-fencing currently protecting HIV funding. Some NT officials did express theoretical interest in transitioning away from having such a large conditional grant focused on a single disease, but there were no signals that they were prepared to risk harm to the HIV programme to do so. Additionally, a senior health official noted that political and financial analysis aside, and despite various competing interests, it has become a truism in South Africa that “we treat HIV-positive people in this country.” Consequently, the political economy feasibility of this scenario is low.

Technical feasibility

Of all the scenarios, unconditional integration would have the fewest technical requirements. The PES funding channel would not require detailed budgets, business plans, monitoring of spending and outputs, or frequent and detailed reporting. Only the regular PES accounting would be required. Thus it would be much easier for provinces to simply manage HIV funds along with other health funds. No special capacity would be needed for provinces to apply the same management systems in place for PES funds to a larger pool of money. Moreover, provinces already oversee HIV service delivery; in this scenario they would be liberated from the financial management processes demanded by the CG mechanism. Therefore, technical feasibility of this scenario is high.

However, it is important to note that the PDOHs’ current capacity to effectively protect and manage their health budgets for specific programmes is generally weak and subject to other provincial priorities, political agendas, and misuse. Protecting HIV funds within the PES, and hence the achievements made in the HIV response to date, would require capacity building within PDOHs and improvement of the PES reporting and control mechanisms. It is uncertain whether the capacity that has been built to cost and budget for the HIV CG
would be retained and continued if the funds were channelled through the PES. Potentially these skills could remain and perhaps be applied to PHC services more generally. Or perhaps similar systems as for the ‘non-negotiables’ could be applied to PHC, HIV, and other services.

**Scenario 4: Ring-fenced PHC—pushing the benefits of ring-fencing to PHC**

**Financing mechanism**

Under Scenario 4, the scope of the HIV CG would be expanded to include all PHC services. The resulting Comprehensive PHC conditional grant would be modelled on the existing HIV CG. The implicated funds would be managed by provinces in accordance with a revised CG framework that combined business planning, expenditure tracking, and performance monitoring requirements for PHC with those already in place for HIV. There would be at least two possible approaches to creating a large ring-fenced pool of PHC funds (see Box S4.1 for additional options):

1. In order to rapidly ring-fence enough funds for all PHC services, PES funds currently spent on PHC could be added to the HIV CG. Toward this end, the share of national revenue distributed via the PES would be reduced, as likely would be the share PES funds allocated to health by provinces.

2. More incrementally, new funds could be added to the CG over several years to cover more and more PHC services. This is already happening on a small scale with the fuller integration of TB into the CG framework in FY 2016/17 and addition of new funds for TB starting in FY 2017/18. In future years other PHC service areas could be integrated as well, perhaps starting with maternal and child health.

**Rationale**

Since its inception, the HIV CG has been instrumental to the scale and quality of the world’s largest HIV programme. It has also spurred the development of new competencies Rationale Since its inception, the HIV CG has been instrumental to the scale and quality of the world’s largest HIV programme. It has also spurred the development of new competencies

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**ILLUSTRATIVE ALLOCATION OF FUNDS IN FY 2016/17 FOR SCENARIO 4 (R BILLION).**

Illustrative allocations in FY 2016/17

- **PHC-HIV CG**: 160
- **Other health CGs**: 85.8
- **Health PES (non-PHC)**: 18.7


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20 This assumes no other changes in public financing affecting the share of national revenue that is channelled through the PES allocation system.
BOX S4.1. ADDITIONAL OPTIONS FOR RING-FENCED INTEGRATION.

This scenario is rooted in financing and monitoring approaches for which there is promising precedent. However, there may be additional options. For example, one senior NDOH official proposed developing a new legal instrument that expands national oversight over PHC funds without necessarily removing them from PES allocations. In the past, NT has used ‘exclusive appropriations’ to designate a portion of provincial budgets for specific purposes, but this mechanism is seldom employed, and even then only for relatively small amounts of money. To expand its use for a large envelope of health resources, for instance more than R55 billion annually for HIV and other PHC services, would be unprecedented and potentially invite legal challenges.

Another option could be NDOH’s more normative approach to compelling provinces to better track spending in numerous priority areas. These so-called ‘non-negotiables’ include an array of basic service delivery inputs, (e.g., medicines, laboratory services), service categories (e.g., children’s vaccines, HIV and AIDS), and NHI-related initiatives (e.g., District Specialist Teams) (Shezi et al., 2014). Currently there is no mandatory framework for incorporating non-negotiables into business planning, resource needs estimates, or budget allocations, though the National Health Council has made recommendations along these lines. Such enhancements would mimic many of the accountability mechanisms already built into the conditional grant framework. In the meantime, the non-negotiables approach could be a positive but probably insufficiently stringent step toward ring-fenced integration.

Source: Authors.

**Detailed description**

**Pools of funds**

Figure A2.4 depicts the expected pools of provincial health sector funds in FY 2016/17 with ring-fenced PHC integration. The figure corresponds to option 1 above, in which the existing HIV CG would be combined with PES funds currently spent on PHC. About R55.0 billion could be allocated to provinces through a new Comprehensive PHC CG. The rest of health services would be financed through PES allocations (R85.8 billion) and other conditional grants (R18.7 billion).

**Governance of HIV funds**

Although ring-fenced integration of PHC funds within the HIV CG would entail some realignment of responsibilities across spheres of government, NDOH would continue to exercise a high level of control over HIV funds. Indeed, the scope of its control would extend to PHC funds as well. This would involve designing a process for provinces to develop PHC business plans and defining rules for the implementation and monitoring of those plans. The national government would be able to enforce compliance with its PHC performance standards by withholding funds, just as it can now within the existing CG mechanism.
Provinces would continue to bear responsibility for service delivery, only now their PHC services would also be subject to extensive oversight and monitoring by NDOH and NT. Initially PHC budgets would be based on analysis of historical spending patterns, while over time provinces would develop capacity, with support of the national government, to cost PHC services and generate more precise resource needs estimates. The detailed costing of PHC services would serve as a means of creating transparency and accountability with regards to resource needs, budgeting, utilization, and target PHC service delivery outputs and outcomes at the district and provincial levels.

Under Scenario 4, districts would not have a meaningful role in the governance of the PHC CG. Together with facilities they would accept budgets and targets from above, not only for HIV but also for the PHC services folded into the CG mechanism. Box S4.2 describes an alternate approach to ring-fenced integration in which districts would have a considerably greater role in governing HIV funds; such an approach could potentially contribute to NHI implementation, which will require bolstering district capacity.

**Purchasing of HIV services**

Many approaches to purchasing HIV services would be possible under a policy of ring-fenced integration. The HIV CG has already elicited strengthened approaches to budget planning linked to targets for service delivery outputs and coverage. Moreover, funds can be withheld to sanction poor programmatic performance or underutilization, improving accountability—if not quality—in the government’s HIV response. In its simplest design, Scenario 4 would entail implementing a similar arrangement for other PHC services, which would benefit from more sophisticated resource needs estimation, planning, tracking, and reporting.

A more ambitious approach would involve one or more additional steps toward strategic purchasing. First, resource needs estimation for PHC could be conducted in an integrated fashion, producing budgets meant to cover a basket of services rather than allocations that simply sum separately computed PHC and HIV components. Second, steps could be taken to effect a fuller purchaser-provider split, either at the national or provincial level. In this case a defined package of PHC benefits could be purchased from both public and private providers. If a separate purchasing agency or Fund were established, this approach would approximate Scenario 5. Third, provinces could expand contractual relationships with private providers, building on the experience of Mpumalanga’s service level agreement with Right to Care for the delivery of a comprehensive set of PHC services, including for HIV.

**Implementation and pathway to NHI**

Scenario 4 would require several key short-run steps. The National and Provincial Departments of Health would need to develop tools to estimate combined resource needs for HIV and other PHC services. The work of the PHC Costing Task Team, jointly convened by NDOH and NT, could provide useful insights. Additionally, the national government would need to determine how to appropriately adjust the PES allocation formula and reflect the changes in the annual DORA. This would first require determining with reasonable accuracy how much is currently being spent on PHC. Finally, NT and NDOH would need to modify the HIV CG mechanism to govern planning, tracking, evaluation for PHC service delivery and outcomes. In turn, public financial management and health information systems would be updated to enable relevant tagging and tracking of PHC spending and outputs. Reporting could follow the same monthly and quarterly schedules as are currently in place for HIV.
Ring-fenced integration could serve as a prelude to multiple NHI structures, including the centralized system proposed by the White Paper (2015). This scenario would draw additional health funds under stringent national oversight, a small step toward an NHI Fund that consolidates spending under direct control of the national government. It would also promote decision making about what PHC and HIV services will be financed by a large, integrated conditional grant. These choices would provide a useful foundation for the eventual definition of an NHI benefits package, as would efforts to more rigorously cost PHC services. Notably, this scenario would not necessarily imply that provinces would no longer be directly responsible for service delivery and reporting. In fact, like Scenario 3, this scenario could also precede a more devolved approach to NHI in which each province manages its own Fund. It bears repeating that this would be a major departure from the NHI White Paper (2015). However, to move the health system toward the White Paper (2015)’s vision, there are additional reforms relating to the role of districts that could be pursued in conjunction with the creation of a large PHC CG. In particular, this would involve a single, centrally managed Fund whose purchasing arrangements with providers were intermediated by DHMOs rather than PDOHs.

**Impact on health system performance**

**Effect on the HIV response**

Given that strict conditionality or ring-fencing would be maintained and this scenario would not necessarily envisage relaxing the stringent HIV CG planning, tracking,
and reporting requirements associated with financing and service delivery, the HIV planning and monitoring systems would be expected to persist. Integrated financing could help make the programme more efficient and help to enhance service delivery volumes for comparable total costs. The performance of HIV programmes should also not suffer because targets for all PHC services would be defined and monitored in detail. The stringency of conditionality would remain high even as the scope of services financed via conditionalised funds is expanded.

However, the specifics of the new CG mechanism would determine any risks to the HIV response. Some external experts raised concerns about dilution of attention to the HIV programme if all PHC services were monitored in the CG framework. For example, even if all existing conditions were left in place, the addition of new reporting requirements for PHC might lessen attention focused on HIV services. Consequently, in this scenario NDOH would need to take care to sustain its current level of scrutiny of all HIV reports and outcomes. The fact that HIV and PHC oversight are currently housed in separate NDOH directorates could also help to protect against dilution of attention.

Additionally, there could be trade-offs between allocative efficiency and the HIV response. If provinces and districts began managing integrated PHC budgets, they might shift some funds previously intended for HIV to other PHC services. Even if the new allocation were more efficient, overall HIV spending—and associated outputs and outcomes—could decline. Consequently, depending on the design and implementation of the new CG mechanism, this scenario’s effect on the HIV response could be minimal (Ø) or potentially unfavourable (-).

Effect on PHC services

Given the lack of explicit resource needs estimation, budgeting, tracking, and reporting for PHC financing, perspectives from NDOH managers and other informants indicate the public sector’s PHC programme could be strengthened greatly from improved programme management. As mentioned above, the conditional grant framework has been essential to scaling up and delivering the HIV programme such that service delivery and financing targets can be adequately measured and monitored. Hence, the effect of extending similar conditionality to the PHC programme could be highly positive. Integrating and ring-fencing HIV and PHC financing will improve the planning, tracking, and monitoring of PHC spending and service delivery, likely driving increased PHC access and quality (++).

Effect on health system efficiency

The HIV CG has been instrumental in making South Africa’s HIV response targeted, accountable, and successful at resource utilization—Scenario 4 would extend these benefits to PHC services more generally. By pooling all PHC funds in a single CG, ring-fenced integration could generate economies of scope in programme management, including business planning, expenditure tracking, and performance monitoring. Additionally, it could enable more efficient allocation of resources across all of PHC, including HIV, by giving provinces, districts, and facilities greater flexibility to deploy health care workers, facility space, and other service inputs.

21 These expert views were raised during the discussion period of the presentation cited as Blanchet & Chaitkin (2015).
optimally. A separate process for determining which PHC services to fold into the CG, and in what sequence, would also be important to allocative efficiency. Such a priority-setting process would go well beyond simply creating the expanded PHC CG.

Meanwhile, whether this scenario would promote technical efficiency would depend on other factors. Several informants expressed concern about the general lack of value for money in PHC. However, data collected during the development of a normative budgeting tool in Limpopo suggests that, to meet established PHC service standards, facilities may need to spend even more on PHC (Rockers, 2015). In fact, more rigorous costing of PHC services might produce a baseline resource needs estimate considerably greater than current expenditure. High costs may be attributable in part to the government’s wage bill. Whether outcomes would improve as a result of increased PHC expenditure would depend on a number of management and other factors.

There could be opportunities to incentivize more technical efficiency and higher quality care at the facility level through well-designed purchasing policies. For example, the White Paper (2015) proposes capitation for PHC; piloting such an arrangement alongside ring-fenced integration would be a useful means of exploring potential efficiency gains. Ultimately, much of Scenario 4’s likely effect on health system efficiency is uncertain (?), though there is reason to expect at least some modest gains (+).

Feasibility

Legal feasibility

The legal feasibility of ring-fenced integration would depend largely on whether the government sought to shift PES funds or only add new money to a PHC CG. For the former, reserving sufficient funds from the PES would require reducing the share of government revenue allocated through the PES. Such a change might invite legal challenges, even if the National Health Act of 2004 were also amended to reflect changes in national and provincial responsibilities with respect to health services.

Alternatively, if new funds for PHC were added incrementally to a PHC CG, there would be lesser risk of legal challenge, and no major legislative changes would be required. Although moving funds out of the PES allocations would be difficult, the government has far greater flexibility for channeling new money to the health sector. For example, a fraction of the resources needed for PHC could be added to the CG during each of the next several MTEF processes. Concurrently, planning, tracking, and reporting requirements for PHC would be gradually incorporated into the conditional grant framework. This way, an integrated pool for PHC and HIV services would develop without diverting funds from the PES. In practice, considerable analysis would be required to determine which PHC services, and in what sequence, should be financed through the CG. Therefore, the legal feasibility of ring-fenced integration ranges from medium to high depending on the details of implementation.

Political feasibility

The legal reforms or innovations pursued under Scenario 4 will also shape the political economy dynamics. First, several aspects of ring-fenced integration would likely appeal to NDOH. This scenario would give more control over health funds to NDOH by extending conditions to PHC financing. It would also preserve extensive protections and accountability for HIV funds. To the extent that integration were accompanied by additional preparatory steps for NHI,
such as experimentation with purchasing arrangements, this scenario would also involve useful, incremental steps toward NHI implementation. In fact, Scenario 4 is one of only two scenarios—the other being the more ambitious Scenario 5—that are likely to appeal to the HIV-, PHC-, and NHI-focused constituencies within NDOH.

NT, on the other hand, may be wary of creating a massive PHC CG and rechannelling a significant share of PES funds. Even at our conservative estimate of R55 billion, a PHC CG would dwarf the largest current grant, which will allocate around R20 billion for human settlements in FY 2016/17. Historically conditional grants have been designed to temporarily supplement provincial budgets to enable scale-up of priority programmes. In contrast, channeling more than a third of the total health budget through a conditional grant would mark a radical repurposing of this budgetary mechanism.

These concerns aside, recently NT expressed openness to ring-fenced integration if it can facilitate piloting of strategic purchasing arrangements for HIV and other services and if it is designed as an intermediate step toward the creation of the NHI Fund. In fact, the stringency of national control over conditional grant funds makes the HIV programme a prime candidate for purchasing pilots. Moreover, given that NHI may eventually cover a comprehensive package of PHC benefits that include HIV services, piloting purchasing of a blend of HIV and other PHC benefits might be even more appealing.

While national officials might be supportive of, or at least open to, Scenario 4, provincial officials might object. First, provincial legislatures would likely oppose any reduction in PES funds, which are completely discretionary. Folding PHC financing into a conditional grant would preclude reallocations to other sectors, such as education, or other uses. Adding new funds to the CG rather than shifting PES would preclude some of these concerns. Second, this scenario would complicate the jobs of provincial health officials, who would have to assume additional responsibility for planning and monitoring financing and service delivery for PHC. This could be quite onerous given how little capacity currently exists to track PHC spending, particularly in settings where both PHC and other services are delivered (e.g., district hospitals). Additionally, conditional grant funds could be pulled back for a variety of reasons, such as when the provinces violated conditions on the use of those funds, were unable to spend them within the financial year, or if the function associated with the financing were moved elsewhere. Provinces would have to perform and report according to national standards to ensure a continuous and adequate flow of funds.

Nonetheless, some provincial health officials might welcome ring-fencing for PHC funds. HIV programme managers have indicated how valuable the conditional grant is in shielding HIV funding from competing provincial priorities and in improving their planning and management of HIV services; it is reasonable, therefore, that local PHC managers might similarly support similar protections for their budgets. In light of mounting interest in this scenario and its potential variants at the national level, and with an expectation of divided interests at the provincial level, the political feasibility of ring-fenced integration ranges from medium to high depending on whether funds are shifted from the PES or only new funds are added to a PHC CG.

Technical feasibility

Scenario 4 would require expansive scale-up of costing, budgeting, tracking, and monitoring competencies related to PHC. Under the current HIV CG mechanism,
these skills and capacity have been developed over almost a decade at the national and provincial levels. These activities would remain necessary under ring-fenced integration, so for HIV this scenario is highly feasible. However, this capacity would also need to be developed for PHC services because there is currently no conditionality for their management, apart from the regular PFMA requirements. PHC managers and finance officers would need to acquire the same routine skills and tools applied currently by HIV managers, such as identifying and costing PHC needs, planning service delivery scale-up, managing budgets and expenditure, and submitting detailed quarterly reports.

In addition, resource needs for PHC are currently not well understood or researched generally. Efforts are underway to cost PHC services, including both top-down and facility-based analyses by members of the NT-NDOH PHC Costing Task Team. One important challenge is the lack of sufficient tracking systems to determine the extent of PHC service delivery at district hospitals. For instance, the illustrative allocations in this study somewhat arbitrarily include 25 percent of spending (see footnote 6). Therefore, investments in better information systems and public financial management practices would be required to effectively extend the conditionality of the HIV CG to all PHC services. Fortunately, these investments would also yield dividends for an eventual NHI system.

Similarly, the current HIV CG has required a strong monitoring and evaluation system and has thus developed the ability of provinces both to monitor the performance of service providers and to report these to the national sphere. These skills and systems would have to be extended to PHC services, and effort would be required to develop appropriate PHC indicators and expand the systems to collect them, as well as for provinces to report on them routinely. The general foundation provided by existing systems for HIV and nascent PHC costing efforts means that although considerable new capacity would need to be developed, the road forward is both clear and manageable. Therefore, the technical feasibility of Scenario 4 is medium.

Scenario 5: National PHC Fund – an ambitious start for the NHIF

Financing mechanism

Under Scenario 5, the NHI Fund would be established first as a National PHC Fund with a large pool of resources to purchase an integrated package of PHC benefits, including for HIV prevention, care, and treatment services. The Fund would be administered at the national level as a separate legal entity from NDOH. There would be at least two possible approaches to creating such a Fund:

1. All PES funds currently spent on PHC, the small NHI CG, and the portion of the HIV CG that covers personal HIV services could be redirected to the new Fund. Like in Scenario 4, the share of national revenue distributed via the PES would be probably be reduced, as likely would be the share of PES funds allocated to health by provinces.

22 Participants include the University of KwaZulu-Natal, Clinton Health Access Initiative, DNA Economics, Insight Actuaries, Right to Care, and the USAID-funded Health Finance and Governance Project.
2. More incrementally, the NHI CG and most of the HIV CG could seed the new Fund (akin to Scenario 2), and new funds to cover other PHC services could be added over time.

In either case, the fate of financing for non-personal HIV services—roughly 12 percent of the HIV CG—might be different from that of financing for personal services. We analyse the implication of integrating these funds into the PES, from which provinces draw resources for other non-personal health activities. Instead, those resources could also be shifted to the new Fund, which would then be responsible for financing activities like SBCC and demand creation for condoms and MMC. Another alternative would be to retain those funds in a small CG, as we consider in Scenario 2.

Rationale

Integrating financing for HIV and other PHC services could reduce inefficiency in South Africa’s current health financing and service delivery systems. Unified pooling of funds could reduce the need for duplicative administrative, management, and oversight capacity across programme areas. Redundant programme management resources (e.g., personnel, reporting processes) could be redeployed to develop new competencies in the NHIF and DHMOs. Scenario 5 could also enable strategic purchasing of a defined benefits package, as envisaged by the NHI White Paper (2015). Strategic purchasing of PHC services, for instance via capitated payments to providers, would effect greater integration of service delivery, promote optimized utilization of capacity in community clinics and health centres, and help to reducing inefficient facility-level spending currently encouraged by the ring-fencing of HIV funds. Finally, pooling funds in the NHIF would sustain, albeit in a reconfigured fashion, the protections for HIV funds afforded by the CG mechanism. This would ensure sufficient resources continued to be allocated to meet HIV-related targets, while also extending a form ring-fencing around the rest of PHC funds.

Detailed description

Pools of funds

Figure A2.5 depicts the potential pools of provincial health sector funds in FY 2016/17 with the creation of a National PHC Fund. Under this scenario, three existing pools of money could be combined to seed the NHIF. First, the small NHI CG could be transferred to the Fund. Second, nearly 90 percent of the current HIV CG could also be transferred to the NHIF, representing the personal preventive, care, and treatment services the grant currently covers. The remaining HIV CG funds, which currently cover public health activities like condoms procurement and distribution, demand creation for MMC, and special programmes for key populations and high-transmission areas, could be shifted to the PES (as in Figure A2.5) or retained in a small CG or another ring-fenced pool (e.g., a dedicated line item in the NHIF budget). Finally, money currently spent on PHC could be diverted from the PES into the NHIF. In FY 2016/17 this policy would shift one-third (R53.3 billion) of total provincial health budgets to the NHI Fund. The remaining two-thirds would continue to flow to provinces through the PES (R87.6 billion) and the remaining CGs (R18.6 billion), covering secondary and tertiary services, health worker education and training, facilities revitalization, and more.
ILLUSTRATIVE ALLOCATION OF FUNDS IN FY 2016/17 FOR SCENARIO 5 (R BILLION).

Governance of HIV funds

Scenario 5 would entail significant changes to the distribution of responsibilities across levels of government. Not only would the NHIF—a centrally managed organization—assume the purchasing functions for PHC, but the government-financed system would eventually also include a purchaser-provider split for the first time (as in Scenario 2). NDOH would set policy and quality standards by which providers would be accredited for NHIF payment eligibility. In turn, DHMOs would negotiate with the Fund and manage PHC service delivery contracts, including for HIV services, with providers in the both the public and private sectors. These contracts would need to be developed on the basis of adequate data collection systems to track service delivery outputs and outcomes and the financial performance of provider organizations. The role of provinces in this scenario would be less clear; the NHI White Paper (2015) suggests PDOHs may support managers and monitor and evaluate service provision.23

The accreditation and payment systems implied by the creation of the NHIF could enable significant oversight and accountability, albeit quite different from the current system. First, accreditation for NHIF payment eligibility would be a critical initial check on capacity and quality. PHC providers would have to demonstrate readiness to deliver all services in the benefits package in accordance with quality standards, both established at the national level. Second, the country’s HMIS would be improved to enable continual monitoring of service delivery and patient outcomes. Providers excelling in meeting quality standards and coverage targets could be rewarded with performance-based payments on the basis of HMIS data, while poor performers could be targeted for support or ultimately sanctioned. Like scenario 2, this scenario would also open the door to demand-side checks on quality. For example, published performance data could inform patient choice of provider, at least in areas with multiple options.

Purchasing of services

Establishing a National PHC Fund would enable a shift from input-based to output-
based payment for PHC services, as well as a purchaser-provider split. The transition would involve considerable changes to public financial management systems and capacity building in facilities and districts to negotiate service contracts and optimize service delivery with fulfillment of those contracts. One key precondition for purchasing would be the simple mechanics of transferring money from the NHIF to providers, which itself would require all providers to have bank accounts into which the funds could flow. Enabling such transactions would be but one of many important steps toward establishing a purchasing system. Others would include determining appropriate payment mechanisms, which could include capitation, case-based payments, global budgeting, fee-for-service, and others.

The NHI White Paper (2015) proposes a blend of capitation and performance-based payments for PHC services. Other mechanisms could also be desirable. For example, while capitation might promote efficient delivery of PHC services in general, a separate fee-for-service payment could be useful to reward providers for large volumes of one-off preventive activities like MMC.

Implementation and pathway to NHI

Creating a functional NHIF capable of strategic purchasing would require several years of capacity building and preparation at all levels of the health system. Legislation to establish the NHIF and its governance would need to be passed, and the annual DORA would need to alter how much revenue flowed through the PES. Concurrently, several thousand PHC facilities and their associated DHMOs would need to prepare for their new financial management responsibilities. This might mirror the proposed shadow budgeting process to prepare the country’s 10 national hospitals for DRG payments, though on a much larger scale. High-performing Ideal Clinics would be a natural starting point for developing the relevant financial management capacity and practices, which could then be replicated in all other clinics. In the interim, and akin to Scenario 4, the NHIF could operate as a large PHC conditional grant with direct transfers to provinces and districts for their respective functions, as described above.

In the long run, this scenario would be a clear step toward a comprehensive NHI system, and a National PHC Fund may fit well the concept of a Transition Fund mentioned in the White Paper (2015). Once the PHC benefits package were established and the NHIF were operational, steps could be taken to incorporate secondary and tertiary services into the scheme. This would require expanding the scope of the benefits package and consolidating additional funds in the NHIF, including remaining DOH conditional grants and eventually the rest (or almost all) of health-related PES funds. For purchasing, this scenario would align with the NHI White Paper (2015)’s proposals for provider payment. Section 8.5.1 (paragraph 351) lays out a gradual process of incorporating risk adjustment into determining the PHC capitation rate, eventually “taking account of the epidemiological profile of the catchment population.” Scenario 5 might require starting with separate payments for PHC and HIV services until the latter could be folded into a risk-adjustment formula for the former.

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24 Providers could receive payments directly, or DHMOs could receive funds and manage or distribute them on behalf of individual facilities.
Impact on health system performance

Effect on HIV response

An NHIF focused on PHC would cover a range of services, including personal HIV preventive, care, and treatment services. The NHIF would represent a protected pool of funds dedicated to PHC but not specifically HIV; however, its contractual and performance management arrangements with districts and providers could enable extensive monitoring and accountability for HIV care. Certain payment arrangements, like capitation, could encourage underprovision of services, though these incentives could also be counterbalanced with complementary performance management and oversight mechanisms. Additionally, if the Fund contracted with private providers, the available capacity for and quality of HIV services could increase. However, cost containment could become a concern in the private sector, depending on how reimbursement rates were determined and adjusted.

The vitality of non-personal HIV services might be less certain under Scenario 5. Alongside full integration of financing for personal HIV services into the Fund, this scenario proposes giving provinces full responsibility for public health-oriented activities, such as condoms distribution, programmes in high-transmission areas, demand creation for MMC, and more. The default option would be to blend the associated funds into PES allocations, removing the oversight mechanisms of the current CG framework. Such activities could still be included in the non-negotiables and subject to a form of earmarking. Alternatively, a variant of Scenario 5 could retain the non-personal services portion of the CG funds in a ring-fenced mechanism for management at the provincial level with significant oversight by NDOH. This could be a very small CG, as in Scenario 2, or a protected set of line items within the NHIF’s budget.

Two additional NHI design choices could affect access to HIV services. First, coverage would depend in part on NHI enrollment processes, in particular whether HIV patients would be automatically enrolled and whether enrollment would be required to access HIV services. Second, and related, coverage could be affected by NHI cost-sharing provisions, including the need for enrollees to contribute premiums or co-payments in order to access care. Encouragingly, paragraph 146 of the NHI White Paper (2015) states that “NHI card holders will not be expected to make any out-of-pocket payments such as co-payments and user fees at the point of health care delivery.” If this approach prevailed, universal enrollment of people living with HIV would be essential to ensuring equitable access to HIV services, but cost sharing should not pose any obstacles.

Scenario 5’s effect on the HIV programme would depend on a number of additional policy choices. It would be reasonable to expect continued planning, resource allocation, and monitoring for essential HIV services (as under the current HIV CG), though the fate of certain population-level prevention activities might be less certain. Integrated PHC payments (e.g., capitation) may also divert funds previously intended for HIV to other PHC services. Provider contracts would require complementary mechanisms for enforcing accountability for HIV-related outputs and outcomes. Moreover, NHI design choices about enrollment procedures could affect access to HIV (and other) services, at least for certain populations. Therefore, Scenario 5’s effect on HIV services would be uncertain (?) and possibly unfavourable (-), though there would also be some potential for improved capacity, quality, and efficiency of HIV service delivery.

Effect on health system efficiency

Creating a National PHC Fund would eliminate the need for parallel planning and monitoring
systems for HIV and other PHC services, but it would also require substantial investment in building the Fund’s capacity to manage contracts and issue payments, as well as the ability of districts and facilities to manage funds and service delivery. These would require additional personnel and systems. In theory, savings could be realized in a handful of ways. First, the government is already designing an evidence-based approach to defining and modifying the NHI benefits package. By focusing on preventive and cost-effective services (i.e., allocative efficiency), the government could reduce costs across the system. Second, NHI payment policies could be designed to incentivize improved technical efficiency at the facility level. Policy makers noted two main options: (1) a robust facility-level performance management system within the existing input-based budget financing arrangements; or (2) performance-based payments built into active purchasing if a purchaser-provider split is implemented. The extent to which payment policies would influence clinical behaviours would depend in large part on whether the government can tie health care worker compensation to performance. There would also be an important role for improved management structures and practices. Due to the many additional factors that would determine how efficiently a PHC-HIV insurance scheme will operate, the relative efficiency of Scenario 5 is uncertain (?), though there certainly would be potential for efficiency gains if necessary capacity were built and payment policies were well designed.

Feasibility

Legal feasibility

Establishing a National PHC Fund would require legislation amending the National Health Act of 2004 to create the Fund, its governance structure, and the process by which the benefits package would be defined and modified over time. The policy design process would likely be protracted. The NHA 2004 was based on a White Paper published in 1997. If the NHI timeline were similar, authorizing legislation might not emerge for another 5–7 years. Because the scenario requires major legislative changes, some of which would be difficult to achieve in the next three to five years, the legal feasibility of this scenario is low to medium.

Political feasibility

With respect to political feasibility, Scenario 5 would likely be supported by those stakeholders keen on the realization of the government’s NHI vision. Consequently, NDOH is likely to strongly support this scenario. However, the timing and pace of implementation would determine to what extent NDOH and its various internal constituencies favoured this ambitious approach over a more incremental step like Scenario 2 or 4. For instance, the HIV division might be wary of any financing integration that undermined or complicated the setting of ambitious national treatment and prevention targets to which provinces (or districts and providers) could be held accountable. Provincial HAST Directors and HIV advocates might share this view. An additional concern could be the fate of HIV-related public health activities currently funded by the CG, such as activities for high-transmission areas, demand creation for MMC, condoms distribution, and more. To be fully integrative, Scenario 5 proposes folding the relevant funds into PES resources, which could jeopardize the programmes unless NDOH included them among the non-negotiables and successfully enforced compliance. Alternatively, funds for these activities, which account for about 12 percent of the HIV CG, could be retained in a small CG or a nationally controlled pool, such as a dedicated line item on the NHIF’s budget.
The extent to which provinces would resist greater centralization of the health budget is unclear. PDOHs might view such reform favourably if it entailed an increase in resources available to them, but with a fixed resource envelope for health, both Provincial DOHs and Treasuries might oppose any effort to reduce their financial autonomy.

The NHIF could imply a new approach to performance management, either within the current labour arrangement or under a refashioned system that involves performance-based financing. In either case, facility and district managers would need the training, systems, and authority to manage their personnel and make staffing decisions according to service delivery needs and efficiency objectives. Public-sector employees are likely to oppose—strongly—reforms that endanger job security or the guaranteed salary and raise schedules that have been negotiated with the government.

In summary, this scenario could enjoy fairly strong support at the national level but might invite caution from provincial authorities and HIV advocates. Labour unions might strongly oppose it. Therefore, the political feasibility of this scenario is medium.

Technical feasibility

Implementing a National PHC Fund would require considerable new financial management and performance monitoring capacity. As noted above, many basic reforms would be required to enable a purchaser-provider split and simple financing transactions between the NHIF and providers. In additional to creating new mechanisms for transferring funds and designing payment mechanisms, capacity in the form of trained managers and information systems would need to be built at multiple levels of the health system. Facilities would need personnel capable of managing budgets and service delivery inputs, while NDOH would need to define a PHC benefits package whose cost informed the pricing of contractual agreements between the NHIF and providers. Moreover, there is currently no standardized system for establishing or enforcing PHC service targets, so the HMIS would need to be modified to track PHC outputs and outcomes, and health care workers and data capturers would need training to document relevant clinical data.

Some of this capacity could be built atop existing systems developed primarily for HIV services. The CG framework entails extensive business planning, resource needs estimation, and performance monitoring for HIV services. These practices could be extended to the rest of PHC and ingrained at the facility level under an NHI system. The non-negotiables might also be a useful basis for more robust reporting on PHC spending. Finally, some efforts are underway to better understand the costs of PHC service delivery and integrated HIV care; this research would need to accelerate.

Despite applicable capacity in the current system, Scenario 5 would require substantial investment to capacitate a new Fund, districts, and providers for more active purchasing of PHC services. Some implementation steps would be potentially straightforward, such as setting up provider bank accounts, while others would require considerably more time and effort, such as training a large cadre of facility-based financial managers. In recognition of the magnitude of the capacity building effort that would be needed to launch the NHI system, even if just for PHC, the technical feasibility of this scenario is low when considering a three- to five-year timeline.
References


INTEGRATION OF HIV PROGRAMMES WITH HEALTH SYSTEMS EN ROUTE TO UHC AN ANTICIPATORY ASSESSMENT FRAMEWORK

Produced by: Scenarium Group GmbH - APW with UNAIDS 2016/637365

An anticipatory assessment framework

MICHAEL THIEDE, NINA BALTES

Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>ART</td>
<td>Antiretroviral treatment</td>
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<td>ARV</td>
<td>Antiretroviral drug</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CEMED</td>
<td>Central Monitoring and Evaluation Department Malawi</td>
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<tr>
<td>DALY</td>
<td>Disability adjusted life year</td>
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<td>ERG</td>
<td>(UNAIDS/World Bank HIV) Economics Reference Group Gender Development Index</td>
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<tr>
<td>GDI</td>
<td>Gross Domestic Product</td>
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<td>GDP</td>
<td>Global health programme</td>
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<td>GHP</td>
<td>Gender Inequality Index</td>
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Executive summary

1. Globally HIV programmes have matured and demonstrated remarkable positive effects. Beyond the positive health impact of these programmes at country level, they have contributed to substantially improving structures of service provision, such as health service delivery through well-trained personnel. Yet the fragmentation brought about by vertical programmes within countries may preclude the development of efficient universal health systems. Parallel systems of health service provision as well as related parallel financing and information systems have often been created outside of the general national health systems. The need for more effective integration at the levels of policy, governance, financing, research and service delivery has been highlighted in the global health discussion. Universal health coverage (UHC) forms a target under the health goal of the Sustainable Development Goals (SDG) and represents the desired outcome of health system performance, whereby a country’s population is collectively covered against the direct and indirect costs of illness. In practice, UHC as a critical component of the SDG agenda provides a platform for an integrated approach within the health sector.

2. The aim of this study is to provide a framework for decision-making and strategy planning around the integration of HIV programmes in different contexts. The study discusses the integration of HIV programmes with the broader health system in the light of the UHC objective. It is based on the premise that integration is not an objective in itself. The aim of the exercise is to provide a framework for decision-making around integration in different contexts. The study focuses exclusively on the vertical integration of HIV programmes with a broader health system rather than at the horizontal integration, i.e. merger, of an HIV programme with a different vertical programme, e.g. a TB programme.

3. The featured typology is derived from an initial conceptual framework, an “anticipatory assessment framework”, which again is informed by the literature around integration. This typology groups cases according to certain characteristics. The framework that distinguishes domains (financing, delivery, coverage and governance), dimensions below the domain-level, and contextual parameters feeds into a typology that may serve different purposes:

- Supporting assessments of the appropriateness and feasibility of the integration of a vertical programme in a specific country context as well as the health system’s preparedness;
- Guiding the design of a monitoring framework for concrete integration projects across different domains at the system level;
• Informing decision-makers’ choice of an integration strategy, including the development of a time path, in any health reform context.

A typology matrix derived from the framework reflects the domains of relevance for the integration of HIV programmes into the health system. For demonstration purposes, the matrix has provisionally been populated with indicators and observation areas. Observation areas are thematic areas from which specific and measurable indicators will be derived, depending on the objective of the assessment in question. The objective may for example be a comparison or benchmarking of countries at different stages on the path of integration.

4. The study refers to six case study countries: Ghana, Jamaica, Kenya, Malawi, South Africa, and Thailand. The countries’ HIV programmes represent different degrees of integration. The countries’ health systems are at different stages of progress towards UHC. Different types of data and information from the case study countries are used to illustrate aspects of the typology, particularly regarding the context determining the respective integration processes. Brief country profiles are provided in the Annex.

5. The discussion section argues that while integration is not a prerequisite for achieving the UHC objective, integration of programmes as elements of a comprehensive health system may facilitate the achievement of UHC. The incorporation of HIV and AIDS-related health services into a country’s broader structures of health services provision contributes to the idea of a common benefit package within the system that is as comprehensive as possible given the resource constraints that apply. Integration puts the respective services in direct competition with all other services, as they will be subject to the same regulatory framework, e.g. regarding their status within the benefit package that may be designed based on institutionalised priority-setting mechanisms. Further aspects support the UHC goal: Once integrated, capacity development around these services would more immediately benefit the wider system, for example.

6. Domain-specific integration pathways are at least partly interlinked and require structured and coordinated planning. The report highlights determinants of the integrability of HIV services and financing with national health systems. Certain prerequisites need to be in place, including, for example, an appropriate M&E regime. The typology matrix can guide the planning process. Integration requires a phased approach.

7. The prerequisites and the risks of integrating HIV programmes differ significantly between countries. There are country cases where—within the financing domain—integration at the level of resource mobilisation and pooling will be recommendable as an important step towards achieving UHC, but purchasing and service delivery may have to explicitly account for existing access issues relating to key populations and may therefore defy integration at the current stage. In this context, the role that NGOs play in the provision of services to key populations, for example, needs to be carefully considered in a country’s integration strategy. Furthermore, funding of services for key populations from domestic funds poses an area of concern in some countries as donors reduce their funding.

8. In conclusion, the typology can help structure a knowledge base around the integration of vertical programmes.
The compilation of such a knowledge base must take into account that there are lessons to be learnt from vertical programmes that must not get lost in the context of integration, e.g. around well-functioning procurement systems. The typology framework ought to form the basis for the development of systematic guidelines for integration in order to ensure that the integration strategy fits the objectives of integration, e.g. the removal of redundancies, and the setting. In countries that embark on the integration of HIV programmes with the broader health system, rigorous strategic planning processes need to be initiated. The typology will guide benchmarking as well as monitoring and evaluation. The details of integration must be discussed and spelled out. An international discussion using case studies of integration as far as available should inform a toolkit for designing and implementing country-specific integration processes. The discussion of the role of integration in a country’s health system is an important contribution to the post-2015 mainstreaming of UHC.

1. Introduction

HIV/AIDS is among a small set of infectious diseases that has contributed significantly to the global burden of disease. The fight against the most prominent of these diseases has received major support from the international community since the early 2000s and global health programmes (GHPs) have been the main drivers of international action to address these significant contributors to the global disease burden. A major part of the support given to these global health initiatives went towards the design and support of vertical programmes.

Among these vertical programmes, HIV programmes take on a pronounced role in many countries due to their sheer size and the involvement of multiple national and international stakeholders. Thankfully, HIV programmes have had significant positive effects on the health of the communities they serve, and beyond the positive health impact of the programmes at country level, they have also contributed substantially to improving structures of service provision such as health service delivery through well-trained personnel.

Despite such remarkable results of vertical programmes, “verticality” has also been subject to certain criticism. The division of global health initiatives according to disease-based expertise is most probably not efficient. Moreover, the fragmentation brought about by vertical programmes within countries may preclude the development of efficient universal health systems. Parallel systems of health service provision as well as related parallel financial and information systems have often been created outside of the general national health systems, often neglecting alternative, equally effective, approaches to tackling the diseases. The need for more effective integration at the levels of policy, governance, financing, research and service delivery has been highlighted in the global health discussion (Atun et al., 2010a, 2010b; Storeng & Béhague, 2016).

While globally HIV programmes have matured and demonstrated dramatic positive effects, the goal of universal health coverage (UHC) has gained influence in global health policy and on discussions around the design and role of HIV programmes at the national level. UHC forms a target under the health
goal of the Sustainable Development Goals (SDG) and is defined as the desired outcome of health system performance, whereby a country’s population is collectively covered against the direct and indirect costs of illness. In practice, UHC as a critical component of the SDG agenda provides a platform for an integrated approach within the health sector (WHO, 2015). The services covered—promotion, prevention, treatment, rehabilitation and palliation—are defined on the basis of a benefit package that is the same for everyone. On the financing side, fragmentation will be minimised and resources pooled to the largest extent possible. For this, it is important to understand the forms and stages of development of health financing systems towards UHC in order to suggest appropriate modes for defragmenting and then integrating HIV financing in this context. To clarify: Full integration would imply that funds from all sources, including donor funding for HIV, are pooled and that there are common channels for allocating these resources.

This study discusses the integration of HIV programmes in the light of the UHC objective. It is based on the premise that integration is not an objective in itself. The aim of the exercise is to provide a framework for handling the decisions around integration in different contexts. The study focus lies with the vertical integration of HIV programmes with a broader health system rather than the horizontal integration, i.e. merger, of an HIV programme with a different vertical programme, e.g. a TB programme.

Integration does not necessarily need to refer to all aspects of a programme. It can be limited to certain components or aspects of the programme. When it comes to particular organisational functions of a programme, such as financing, or service provision, we refer to domains of integration.

A typology can significantly improve the communication around a phenomenon. In this paper, we present a “tangible” typology that is derived from an initial conceptual framework, an “anticipatory assessment framework”, which again is informed by the literature around integration. This typology groups cases according to certain characteristics. The framework that distinguishes domains, dimensions below the domain-level, and contextual parameters feeds into a typology that may serve different purposes:

- Supporting assessments of the appropriateness and feasibility of the integration of a vertical programme in a specific country context as well as the health system’s preparedness;
- Guiding the design of a monitoring framework for concrete integration projects across different domains at the system level;
- Informing decision-makers’ choice of an integration strategy, including the development of a time path, in any health reform context.

In the attempt to clarify often confusing terminology, the process of moving away from direct donor support of HIV programmes and exploring alternative ways of funding them has been labeled transition. As countries graduate from the assistance of major GHPs or see external funding reduced as a result of the reallocation of international funds, donor organisations and governments are interested in the country’s “transition readiness”. The integration of vertical programmes into existing health schemes or the general health system is closely associated with transition processes but conceptually different. Transition is of practical relevance here, as it creates an opportunity for integration. Of course, the integration of vertical programmes into the
health system can take place outside of the transition context, but it is this context that adds certain urgency to the discussion around integration.

There is a general consensus that policy makers and other stakeholders should work towards the integration of various vertical programmes and their components into the general health system—as far as this is meaningful in the light of service effectiveness and efficiency considerations (Sweeney et al., 2012), yet the benefit package under UHC should be comprehensive. Efforts to strengthen health systems, increasingly including contributions by programmes funded via global health initiatives, have supported countries on their path towards UHC.

The countries’ capacity to fund an increasing share of the national HIV budget is one important objective, and the achievement of UHC is another. Health policy practice shows that there is a complex constellation of determinants of policy success that extends beyond the technical sphere. This report acknowledges that UHC does not merely describe a health financing mechanism, but is the ideal of a well-governed, equitable and sustainable health system that ensures access to a comprehensive benefit package at an acceptable quality for the whole population of a country.

It is critical to distinguish dimensions of progress determinants that are immediately linked to the respective process. Beyond financing, these are the domains of coverage, service delivery and governance. There are also broader spheres of context that determine the respective paths of progress. These include a country’s disease burden, as well as its economic and political context. This report provides a detailed description of all identified spheres of determinants and works towards an analytical and operational framework to inform policy options and scenarios.

Over recent years, discussion around the integration of disease-specific health programmes or programmes that emphasise specific interventions into mainstream health systems has remained at a rather theoretical level and has been characterised by polarisation of views and ideologies (Atun et al., 2010a; Shigayeva et al., 2010; Legido-Quigley et al., 2013; Hope et al., 2014). In particular due to a lack of on-the-ground analysis, the debate has not appropriately taken into account the degree to which the provision of HIV-related (preventive and curative) services is already “subsidised” by sources other than dedicated HIV financing, as health service staff take on particular tasks, facility space is provided, etc. Depending on the envisaged design of the process of financing integration and the envisaged arrangements around service provision and purchasing en route to UHC, the assessment of integration options and feasibility may differ significantly.

In an era with anti-retroviral therapy widely available in many countries, the potential to change the epidemic into a manageable chronic disease has been made apparent. The conditions and context of HIV programmes and financing are therefore changing. In a dynamic context, forecast becomes a design parameter for the assessment of options for integrating HIV financing into financing for UHC. The fiscal liability that comes with the commitment to the lifelong treatment of people living with HIV (PLWH) is substantial and needs to be considered in the discussion of HIV financing integration (Vasall et al., 2013).

Windows of opportunity arise in the policy reform context that encourage the integration of HIV financing as well as reforms towards UHC—Thailand may serve as an example for both. Socio-economic and socio-political context play important roles in assessing the options for financing integration.
Given that country-level constellations and contexts differ greatly, there is still considerable confusion around the steps to be taken towards integration. The discussion has not yet developed a common terminology. The integration of HIV financing is not a mere academic exercise, it may not even constitute a priority in certain settings; where integration represents an objective, it can most likely be regarded as a medium-term policy project that requires evidence-based planning as well as change management. The capacity and the political will to integrate HIV financing towards UHC need to be captured in the assessment of options and scenarios—and their feasibility.

The development of the typology considers experiences of a range of countries. Six case study countries serve to illustrate the typology: Ghana, Jamaica, Kenya, Malawi, South Africa and Thailand. The methodological approach towards a typology is challenging, as the framework is meant to reflect two distinct processes: Firstly, the typology should serve as a two-dimensional yardstick with a view to assessing the position on the path towards UHC and with a view to the integrability of HIV/AIDS service delivery and financing; Secondly, the typology should serve to characterise countries that have already integrated HIV treatment and financing by type of integration. Thus, the typology does not question the ‘if’ of HIV integration; it rather tries to support the decision process around the ‘how’, ‘when’ and under ‘what’ circumstances.

2 Methodology

The initial stage of developing the country typology consisted of a structured literature review with the aim of identifying relevant papers and documents that provide valuable insights relating to HIV integration and UHC in different country contexts and that contribute to designing a conceptual framework. A particular focus lay on papers that offer a systems perspective.

A structured review of peer-reviewed literature was conducted online using the databases Medline, Scopus and EconLit (from 2000). Considering a wide range of aspects of potential relevance to the typology, initial team discussions identified three relevant “concepts” that guided the searches, each covering a specific theme: The first concept broadly linked HIV programmes and the health system perspective. The second concept looked at (programme) integration, including conceptual and methodological approaches with a focus on financing, whereas the third took up the theme of HIV services. Different search strings were applied within each concept and separate searches focused on the related topic of transition of (global) health programmes. Lastly, literature with a focus on universal coverage and the measurement of countries’ progress towards UHC was screened.

After the exclusion of duplicates, two researchers reviewed the remaining documents by title and abstract according to the predefined inclusion criteria in order to identify the literature most relevant to this assignment. The inclusion criteria required that the paper contained the description of a specific (country) case or experience, rather than reflecting a general (normative) piece of work; they required that the paper displayed a health system focus, rather than an exclusive healthcare service focus; The inclusion criteria also specified integration to mean the integration of HIV services or HIV financing from a general health system perspective, rather than the integration of
HIV services with specific non-HIV services. Among other documents that turned out to be important, this narrow approach would have deprived the researchers of relevant insights from the literature concerned with integration of “pairs” of services, such as HIV and reproductive health, HIV and TB, HIV and palliative care (Simms et al., 2012, Joseph Davey et al., 2016).

Given the breadth of the assignment, it was then decided to amend the structured approach by snowballing and purposively selecting literature that served to inform the development of a conceptual framework for an integration typology. Expert interviews were conducted in order to “gauge” the conceptual framework, typology and assumptions. With a view to the framework, further country-level documents and data were analysed from a preselected set of countries. These include Thailand, Jamaica, Ghana, South Africa, Malawi and Kenya. Country-level information was used to refine the conceptual framework and test its plausibility as well as to provisionally populate the typology matrix. The countries were selected to represent a diverse range of scenarios on the basis of which to discuss the relevant domains and dimensions of integration and pathways in the light of the UHC objective. The choice was based on economic indicators such as income level, income distribution as well as epidemiological factors such as HIV prevalence. Socio-economic and socio-cultural aspects include access of marginalised key populations to health services, i.e. sex workers, men who have sex with men (MSM), people who inject drugs (IDU), transgender people and prisoners.

The typology matrix derived from the framework reflects the core domains of relevance for the integration of HIV programmes into the health system. For demonstration purposes in this paper, the matrix has provisionally been populated with indicators and observation areas. Observation areas are thematic areas from which specific and measurable indicators will be derived, depending on the objective of the assessment in question. The objective may for example be a comparison or benchmarking of countries at different stages on the path of integration.

The literature shows that the key distinction of said domains is between financing and service provision. While mutually independent to a certain degree, these domains would be conceptually linked in the development of a country’s process of planning for programme integration. Similarly, integration is not a prerequisite for achieving the UHC objective, yet the integration of programmes as elements of a comprehensive health system may facilitate the achievement of UHC. We use a simplified diagrammatic depiction to discuss these matters.

3 On integration

3.1 Integration and transition

Integration does not carry any value in itself. From the angle of systems theory, integration merely describes the course of action of combining separate subsystems so that they work together as a complete system. There is neither theory nor empirical evidence to support the idea that the integration of vertical programmes automatically contributes to the effectiveness, efficiency, equity or sustainability of the health system:
Obviously, there is little benefit associated with integration if the general health system is weak and any additional component adds to the administrative burden. However, integration seems desirable if the health system is already robust and resilient and programme integration could contribute to efficiency gains and equity by ensuring that the same principles of financing and delivery of services apply to the whole comprehensive benefit package with access for the whole population.

There is still a paucity of evidence as to the merits of integration. The results of the integration of a vertical programme or aspects thereof into the general health system are largely unpredictable. This report is meant to contribute to conceptual clarity. It describes context and pathways of integration, the controversy around which partly hinges on different interpretations of the concept.

The integration of HIV programmes or aspects thereof is sometimes discussed in connection with the idea of transition. Transition refers to a permanent shift in the sources of funding. Amaya et al. (2015) define transition as “the process of moving away from direct donor support by developing mechanisms to manage health programmes, practices or interventions in a sustainable manner through the interaction of internal and external (outside of the health sector) enabling factors”. The idea of using “internal and external enabling factors” may appear abstract but there is value in exploring how these factors can be used to facilitate transition.

The emphasis of the concept of transition lies on the move away from donor support to domestic solutions without excluding the necessity that programmes, practices or interventions may need to change over time in response to external and internal changes. Kavanagh (2014) considers a shift to shared governance and the claiming of “responsibility” for the service delivery by the national government as central to the process of transition.

As a result of the review of literature, we decided on the unifying definition of transition as an adjustment process that, in this setting, is triggered by a permanent change in context. While transition does not necessarily imply integration activities, integration is either a consequence of transition or requires a transitional process in order to be achieved. Hence, there can be transition without integration but no integration without transition.

In addition, integration has to be more specifically defined as it can mean different things in different contexts. For example, where transitioning of a national HIV programme pursues the objective of moving from direct donor support to domestic programme funding, an integration process can be the means to this end. With regards to national HIV programmes it needs to be specified what is to be integrated where. This could be the integration of core HIV services with the existing primary health care system, whether or not accompanied by an integration of other relevant services into the benefit package. It could also be the integration of comprehensive HIV financing into the budget for the health system striving for UHC. Hence it is paramount to clearly identify the integration objectives.

Partial integration within a programme domain either means that the domain is (purposefully) not implemented in its whole breadth, e.g. only the nurses’ services are integrated but not those of counsellors, or it means that integration, however broadly envisaged, has only happened to a certain degree at a particular point in time.

Table 1 outlines the characteristics of both transition and integration.
## Characteristics of the Concepts of Transition and Integration

### Transition
- Overarching goal or necessity in the light of contextual or policy change

### Integration
- Means to achieve the objective of transition or practically oriented process that goes hand-in-hand with transition

<table>
<thead>
<tr>
<th>Transition</th>
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<tr>
<td>Overarching goal or necessity in the light of contextual or policy change</td>
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<th>Integration</th>
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<td>Means to achieve the objective of transition or practically oriented process that goes hand-in-hand with transition</td>
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<table>
<thead>
<tr>
<th>Transition</th>
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<tbody>
<tr>
<td>Direct donor support → domestic funding</td>
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<tr>
<td>Direct donor funded services provision → public services provision (Kavanagh 2014)</td>
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<tr>
<th>Integration</th>
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<tr>
<td>Vertical national programme → general system</td>
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<th>Sector independent</th>
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<td>Sector independent</td>
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<table>
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<tr>
<th>Government level; government ownership</th>
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<tr>
<td>Operational level; ownership dependent on type of integration</td>
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<table>
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<tr>
<th>Overarching process; changes in programme, project or intervention set-up in response to internal or external changes</th>
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<tr>
<td>Domain-specific (can be partial, e.g. financing integration, services integration or even just aspects of both)</td>
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<table>
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<tr>
<th>Clear definition which direct donor support shall be replaced</th>
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<tbody>
<tr>
<td>Clear definition of what is being integrated where in order to achieve a transition objective, e.g. entire national HIV programme into public health system, HIV services into primary health care, HIV care into maternal health services, etc.</td>
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<tr>
<th>Ownership</th>
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<tr>
<td>Can be partial, e.g. financing integration, services integration or even just aspects of both</td>
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### 3.2 The Integration Typology Framework

The conceptual framework of this report is based on an exercise of identifying key concepts from the literature that are closely linked to the idea of integration within the broader context of health reform towards the achievement of UHC. Meaningful *domains* characterising distinct areas within which integration can respectively take place have been derived.

Conceptual frameworks for integrating health programmes into health systems exist. Atun and colleagues (2010b) developed a framework focusing on how health interventions are integrated into health systems that may facilitate the analysis of integration and policies directed at integration across different settings.

The development of frameworks often suffers from the desire to immediately present comprehensive and omnipotent toolkits. In steering clear of reductionist argument, the derivation of the conceptual framework presented here tries to avoid such “solutionism”. The framework is kept as comprehensive as necessary without losing a dimension of relevance for the typology - it outlines the structure of the typology.
The framework is normative to the degree that it conclusively determines the dimensions of relevance for HIV programme integration across the domains suggested by the literature: financing, delivery, coverage, and governance.

Various aspects of national HIV programmes relevant to the challenge of integration have been described in the literature: governance of the HIV response (Coker et al., 2010), the delivery of a wide range of HIV-related services (Atun et al., 2011a, 2011b; Rao et al., 2014), the service reach with a view to the population, including key populations (Delany-Moretwe et al., 2015; Shisana et al., 2015), the definition of ownership of the HIV programme (Hirschhorn et al., 2013; Kawonga et al., 2012), logistics and procurement of the HIV programme (Ripin, 2014), human resources delivering the HIV response as well as facilities and infrastructure through which services are delivered (Oomman et al., 2008; Uwimana et al., 2012).

With a view to health systems’ preparedness for integration, the literature describes challenges that can be assigned to the four above-mentioned domains. Integration follows pathways that are to be defined in planning the integration processes.

Integration is specific to each dimension, while the integration pathways across dimensions are not independent of each other. The integration of HIV programmes is a complex process that requires significant capacity and resources: Integration involves comprehensive change management.

1. Financing

The financing domain takes account of the health system functions of collection and pooling of funds as well as purchasing, i.e. the payment of service providers. The degree to which health financing functions are harmonised within a country’s health system indicates progress towards UHC from a financing perspective. The effectiveness, efficiency and sustainability of (public) financial systems depend on financial management capacity, which is of key relevance within this dimension, as it relates to all tasks associated with costing, budgeting and planning (Musango et al., 2012). Within the financing domain, the type of fragmentation of risk pools and the respective contexts of HIV service provision in different population sub-groups, including benefit incidence, signal the health system’s status in the light of UHC, whereby the degree of fragmentation as such does not necessarily indicate the extent to which structural change may be required in order to smooth the progress of HIV financing integration. It is important to understand the forms and stages of development of health financing systems towards UHC in order to suggest appropriate modes for integrating HIV financing. Full integration would imply that funds from all sources, including donor funding for HIV, are pooled and that there are common channels for allocating these resources.

2. Delivery

The delivery domain that focuses on the provision of health services captures, inter alia, appropriate and effective healthcare facilities, the quality and quantity of human resources in charge of healthcare delivery, as well as logistics and procurement as part of the health system. Whereas the speed of HIV financing integration is largely independent of HIV service integration, the degree to which HIV services have been integrated into the benefit package accessible through the general health system impacts on HIV financing integrability. It is important to acknowledge
that targeted programmes “lie along a continuum from integrated to fully vertical, and depending on the context, integrate with different health system functions to varying extents” (Kawonga et al., 2012). The assessment or planning of integration needs to consider the whole range of types of HIV/AIDS-related services within national HIV programmes, including prevention, treatment and care, as well as education, not all of which are (fully) integrable into health systems. Different services may be integrated in different ways or at different points in time.

3. Coverage

Coverage forms the core idea of UHC. The term—whose use is often ambiguous—embraces different object areas: It describes the share of the population with rightful access to the services offered under a specific scheme or coordinated group of schemes (population coverage); it designates the extent of the benefit package that is offered (service coverage), which should be reflective of health needs; it also serves to specify the degree to which the utilisation of services does not require payments out of pocket (financial coverage). The coverage domain also relates to service quality, as rightful access to services comprises the idea that these must be offered in acceptable quality. Lastly, the relationship of use and need is an important gauge within the coverage dimension: Individuals should utilise specific services when and if they need them (McIntyre & Kutzin, 2016).

4. Governance

The domain governance questions whether a country’s health system exhibits coherent decision-making structures, stakeholder participation, accountability and information, supervision and regulation as well as consistency and stability—all prerequisites for successful integration of an HIV programme (Kar, 2014).

A typology needs to ensure that all thinkable variations of integration can be appropriately reflected. In discussing the much-debated topic of disease-specific programmes potentially undermining health systems, Atun and colleagues explicitly highlight that there is no room for a binary view of the world, as realities were heterogeneous with “varied levels of integration with health system functions” (Atun et al., 2011b: S72). This realisation poses a major challenge to the design of any operational typology.

A further challenge lies in the fact that the typology needs to capture processes along different timelines. The integration of disease-specific programmes with health system functions, including financing, as well as health reform towards UHC are complex processes subject to different dynamics and partly driven by different actors.

Given complexity and multi-rational decision-making, the typology will neither be able to present a ranking of countries on a single ratio scale, nor will it provide immediate guidance towards the next steps. The main value of the typology matrix will lie in ensuring that all domains and associated activity areas are appropriately considered when stakeholders engage in planning for HIV programme integration with UHC as a goal.

The visualisation of the typology framework, as shown in Figure 1, depicts the dimensions considered essential in the process of integrating a country’s national HIV programme into the wider health system as part of the move towards UHC.
VISUAL OVERVIEW OF CONCEPTUAL FRAMEWORK

- **FINANCING**
  - Collection
  - Pooling
  - Purchasing (Public) Financial management

- **DELIVERY**
  - Facilities
  - Health workforce
  - Logistics and procurement

- **COVERAGE**
  - Population/ Key populations
  - Service coverage
  - Co-payments
  - Quality • Health needs

- **GOVERNANCE**
  - Coherent decision making structures
  - Stakeholder participation
  - Accountability and information
  - Supervision and regulation

- **DATA MANAGEMENT**
  - Integration pathway
  - Integration pathway
  - Integration pathway
5. Context

Countries’ health systems and HIV programmes do not exist in a vacuum. The consideration of context becomes particularly relevant when it comes to the integration of the financing service delivery functions. Hence, key contextual aspects are included in the framework for the reason that they influence a country’s ability and capacity for HIV integration to different degrees. These include the characteristics of a country’s HIV/AIDS epidemiology and, more broadly, of its disease burden. They also include the socio-cultural context: Social structures and culturally determined behaviours, including gender-related issues, co-determine the preferable design of interventions and strategies targeting HIV. They also determine the feasible set of approaches towards service integration.

The state of a country’s economy is absolutely crucial, as it determines the conditions of financing and the institutional shape of the healthcare system. The economy determines both fiscal space for public healthcare funding and limits to resource mobilization. Political context touches upon the degree of government support of health policy reform as well as the space for any policies around HIV/AIDS (Simmonds, 2008). The political context determines the dynamics of the process towards UHC as well as windows of opportunity. The context of the legal system and the human rights situation on the other hand impacts on the topic areas of the optimisation of HIV programmes and their integration into the general health system in terms of both service delivery and financing at many different points. These points range from the question as to whether the right to health or healthcare is enshrined in a country’s constitution, to the legal treatment of same-sex relationships.

McIntyre and Kutzin (2016) highlight that the mere recognition of context does not suffice; while a contextual factor is not directly controllable, it has an impact on the attainment of UHC goals and needs to be explicitly considered in strategy formulation and planning.

3.3 Populating the matrix: Process indicators and observation areas

The country typology matrix (Figure 2) forms the actual tool to capture country characteristics that—depending on the objectives of the concrete exercise—either reflect the country’s preparedness for integration of the HIV programme or integration progress within the domains. The typology matrix provides an overview of the dimensions that matter within the respective domains and allows for capturing countries’ key characteristics relevant for programme integration on the journey towards UHC. Each dimension within each domain of the framework needs to be captured by relevant indicators.

The results could serve to present individual country cases and allow for benchmarking and comparisons between countries regarding their progress and challenges of HIV programme integration; the results should also serve as a useful overview to aide the development of context-specific integration strategies. The indicators should ultimately signify the integrability within a certain domain, e.g. the feasibility or degree of the integration of HIV financing into the general health system.

We have identified a first set of indicators in order to populate the matrix. Wherever neither literature nor practice guided the identification of indicators or the choice of indicator proved ambiguous given the lack of a clear objective for this general exercise,
“observation areas” have been sketched, i.e. topic areas within which suitable indicators need to be identified.

It is important to keep in mind that a comparison of countries should be approached with care as on one hand each individual country is at a different stage of progress on its path towards UHC and on the other hand faces different challenges with regards to its HIV epidemic and response, over and above the differing environments.

The typology matrix can be converted into a system or dashboard using “traffic lights”. A colour-based system is occasionally used in project management, progress reporting and readiness assessments in order to provide an easily accessible overview regarding key characteristics of a project or other suitable object of observation. In practice, such approaches often suffer from lack of academic rigour and may indeed not be appropriate for benchmarking or for comparisons. Often, the classification of conditions—as “green”, “yellow” and “red”, or as “high”, “moderate” and “low”, for example—is derived rather randomly; publications rarely explain the rationale of their respective classifications (for example, Atun, 2011b).

Indicators could serve as the basis of a traffic light system. After indicators have been identified, the classification for the traffic light system needs to be established according to coherent theoretical criteria and sensible regulations. If an observation area does not lend itself to identifying any quantitative indicator, the categorisation of a country’s features or properties regarding the respective dimension ought to involve a participatory process. An assessment on the basis of categories within the observation areas may also be suited to determine the likely success of integration within a particular domain or may be used to otherwise inform the integration strategy.
## Characteristics of the Concepts of Transition and Integration

<table>
<thead>
<tr>
<th>Country Context</th>
<th>National HIV Programmes</th>
<th>Health System</th>
</tr>
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<tbody>
<tr>
<td><strong>Dimensions</strong></td>
<td><strong>Indicators / Observation Areas</strong></td>
<td><strong>Dimensions</strong></td>
</tr>
<tr>
<td>HIV/AIDS Epidemiology</td>
<td>Generalised epidemic: &gt;1% in general population; Concentrated: &gt;5% in any sub-population at higher risk of infection; Low-level: relatively little HIV measured in any group; Distribution of vulnerable groups e.g. key populations, women, children etc.</td>
<td>Governance HIV response</td>
</tr>
<tr>
<td>Disease Burden</td>
<td>Changes in life expectancy; leading causes of death; leading causes of DALY's lost</td>
<td>HIV Financing</td>
</tr>
<tr>
<td>Socio-cultural Context</td>
<td>Gender Inequality Index (GII), Gender Development Index (GDI); sexual conduct; stigma and discrimination (for key populations in particular)</td>
<td>Ownership of HIV Programmes</td>
</tr>
<tr>
<td>Economy</td>
<td>Income level and distribution; poverty; economic growth; fiscal space</td>
<td>Logistics and procurement</td>
</tr>
<tr>
<td>Political Context</td>
<td>Degree of incorporation/prioritisation of health in national growth and poverty alleviation strategy and as part of multi-sectoral approach</td>
<td>Human Resources</td>
</tr>
<tr>
<td>Legal Context and Human Rights</td>
<td>Constitutional right to health or healthcare</td>
<td>Facilities</td>
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</tbody>
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**T.1**

CHARACTERISTICS OF THE CONCEPTS OF TRANSITION AND INTEGRATION

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**FINANCING**
<table>
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<tr>
<th>DELIVERY</th>
<th>COVERAGE</th>
<th>GOVERNANCE</th>
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<td><strong>DIMENSIONS</strong></td>
<td><strong>INDICATORS / OBSERVATION AREAS</strong></td>
<td><strong>DIMENSIONS</strong></td>
</tr>
<tr>
<td><strong>Facilities and infrastructure</strong></td>
<td>Capacity of general healthcare facilities to adequately cater for all patients, i.e. fulfilling quality criteria (including HIV patients)</td>
<td><strong>Population</strong></td>
</tr>
<tr>
<td><strong>Human resources</strong></td>
<td>National HR strategy in place, no. of doctors/nurses/midwives per 10,000 people; adequate training sufficiently available</td>
<td><strong>Benefit package</strong></td>
</tr>
<tr>
<td><strong>Logistics and procurement</strong></td>
<td>Capacity and state of development of the public procurement system (and degree of involvement in ARV procurement)</td>
<td><strong>Co-payments</strong></td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Quality management in place</td>
<td><strong>Consistency and stability</strong></td>
</tr>
<tr>
<td><strong>Use</strong></td>
<td>Services are being used according to need</td>
<td><strong>Need</strong></td>
</tr>
</tbody>
</table>
3.4 Context indicators at country level

A country’s progress towards UHC and the capacity to integrate the current national HIV programme as far as and when meaningful strongly depend on context. This section outlines dimensions of context—HIV/AIDS epidemiology, disease burden, socio-cultural context, economy, as well as legal context and human rights—and their role in providing the context for assessing the integrability of HIV programmes. Commonly available indicators are presented for the case study countries in tables within the sub-sections.

3.4.1 Epidemiology

The epidemiological profile of a country sets very unique challenges for integrating the financing and services in the existing health system. A country with a highly generalised epidemic will encounter a larger task in both responding to it as well as in integrating the HIV financing of a large national programme into financing for UHC. There is rich literature on the challenges of different forms of the HIV pandemic (Tanser et al., 2014; UNAIDS, n.d.). Hence, respective categories are included in the typology, e.g. low-level (little HIV in any population sub-group), concentrated (over 5% in any sub-population at higher risk of infection), and generalised (over 1% in general population), as defined by WHO1.

What the chosen case study countries Thailand, Jamaica, South Africa, Malawi, Ghana and Kenya have in common is the characteristic of a generalised epidemic. However, over and above that commonality, the epidemiological situation varies significantly across countries, especially in terms of HIV prevalence. Unsurprisingly, South Africa tops the table with a prevalence rate of 19.2% compared with Thailand’s low prevalence of just above 1% (still the country in Asia with the highest HIV prevalence rate (2014 est.))2. Coping with such a high HIV prevalence and hence catering for large numbers of PLWH presents unique challenges to the South African health system. Despite countries such as South Africa and Kenya having achieved successes in a steady decline in HIV prevalence since the peaks of the epidemic, the number of people affected by the disease continues to increase over time (GoK, 2014a). This is a widely observed development in many countries of Sub-Saharan Africa, leading to an increased financial burden on the countries attempting to cater for the growing and continuous need for healthcare associated with HIV and AIDS.

In all of the included Sub-Saharan African countries, women are disproportionately affected by the HIV epidemic. Again, South Africa leads the table with 57% of those living with HIV being women. The gender dimension highlights the importance of paying particular attention to the role of women in the national HIV response. This is further discussed under section 3.4.3.

Furthermore, the higher the percentage of children living with HIV in a country, the more likely it is that the health system will fail to deliver on essential services in the area of reproductive and maternal health, paramount to combatting the AIDS epidemic. Especially Malawi and Ghana, followed by Kenya, show high rates of children living with HIV.

Besides women and children in general, key populations such as sex workers, men having sex with men (MSM) and injecting drug users (IDU), among others, are particularly

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1 http://www.who.int/hiv/topics/surveillance/2ndgen/en/
vulnerable both in terms of contracting the disease and receiving treatment for it. Overall, their risk behaviours and vulnerabilities strongly influence the dynamics of the epidemics. Hence, there is a strong call to focus on these key populations in the attempt to curb the epidemics. However, access to required services is particularly challenging in many countries (see section 3.4.3).

With a view to the case study countries, South Africa has a particularly high HIV prevalence among sex workers (58%) with a lower percentage of HIV in MSM (32.4%). Still this is a significant number of PLWH compared to Jamaica presenting a similar burden in MSM (32.8%). However, for Jamaica this percentage of HIV prevalence in this particular population presents their key challenge, which will have to be addressed. Kenya will have to address all three major key populations with a prevalence of around 20-30% each. Overall figures for Thailand appear rather low in comparison. However, IDUs stand out and when looking at sex workers, with the overall figure not available, there seems to be a particularly high HIV prevalence for male sex workers (approx. 12%) in particular compared to female sex workers (3%) (UNAIDS, 2014b).

### T. 2

**EPIDEMIOLOGY IN CASE STUDY COUNTRIES**

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>THAILAND</th>
<th>JAMAICA</th>
<th>SOUTH AFRICA</th>
<th>MALAWI</th>
<th>GHANA</th>
<th>KENYA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall profile</td>
<td>Generalised</td>
<td>Generalised</td>
<td>Generalised</td>
<td>Generalised</td>
<td>Generalised</td>
<td>Generalised</td>
</tr>
<tr>
<td>Adult HIV prevalence</td>
<td>1.6%</td>
<td>19.2%</td>
<td>9.1%</td>
<td>1.6%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Number of people living with HIV</td>
<td>1.1%</td>
<td>29,000</td>
<td>7,000,000</td>
<td>980,000</td>
<td>270,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>% of women aged 15 and over living with HIV</td>
<td>40.9%</td>
<td>37.9%</td>
<td>57.1%</td>
<td>55.1%</td>
<td>55.6%</td>
<td>55.3%</td>
</tr>
<tr>
<td>% of children aged 0 to 15 living with HIV</td>
<td>0.9%</td>
<td>1.7%</td>
<td>3.4%</td>
<td>8.6%</td>
<td>7.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>HIV prevalence in sex workers</td>
<td>&quot;Male 12% Female 3%&quot;</td>
<td>4.1%</td>
<td>57.7%</td>
<td>24.9%</td>
<td>11.1%</td>
<td>29.3%</td>
</tr>
<tr>
<td>HIV prevalence in MSM</td>
<td>9.2%</td>
<td>32.8%</td>
<td>32.4%</td>
<td>17.3%</td>
<td>17.5%</td>
<td>18.2%</td>
</tr>
<tr>
<td>HIV prevalence in IDUs</td>
<td>19.0%*</td>
<td>not available</td>
<td>not available</td>
<td>not available</td>
<td>not available</td>
<td>18.3%</td>
</tr>
</tbody>
</table>

Source: UNAIDS, 2014b, 2015b
3.4.2 Disease burden

The impact of health conditions on a country’s social and economic development determines the strain under which the respective health systems have to operate. In this context, it is of interest to establish the impact HIV and AIDS have on a country in terms of mortality and morbidity alongside other predominant health conditions.

With a view to life expectancy at birth, the case study countries show different dynamics since the beginning of the HIV/AIDS epidemic. Whereas in Thailand life expectancy remained steady and then improved after the onset of HIV, life expectancy in South Africa in comparison dropped by ten years during the peak of the HIV epidemic, only to return to its pre-HIV level today. Millions of people died prematurely during this time with a high impact on the South African economy both in terms of wealth generation and healthcare expenditure. Jamaica’s dynamic lies closer to that of Thailand, whereas all other Sub-Saharan African countries experienced a more or less significant dip in life expectancy during their individual HIV peak times.

HIV/AIDS ranks top of the list of causes of death in three of the six case study countries. Especially South Africa and Malawi are disproportionately affected by the impact of the disease: (nearly) a third of deaths are caused by HIV/AIDS. This is closely linked to very high percentages of children under five dying due to HIV/AIDS (17% and 12% respectively). Furthermore, in both countries HIV is the leading cause of years lost due to ill health, disability or early death when measured in disability-adjusted life years (DALYs).

In Thailand, Jamaica and Ghana, in comparison, HIV/AIDS is responsible for a far lower number of deaths and ranks further down among causes of death. Equally, only a small percentage of children under the age of five years die of the disease.

Increased life expectancy is a meritorious achievement for any country. With it, however, stress on the health system increases. For a country with a high number of PLWH this means that even if the number of people needing treatment stayed the same, more resources would be required to cater for their life-long medical care. With the global goal of eradicating HIV infections a long way off, all those newly infected increase the pressure on the systems even further. Hence, the developments as they present themselves in a particular country context need to be considered and forecast in order to anticipate the future burden on the system. This will be paramount for establishing the feasibility of a successful integration of any HIV programme.

3.4.3 Socio-cultural context

Socio-cultural context is a particularly complex but highly relevant dimension that impacts on policy pathways in various ways. It comprises historical legacies and presents itself in the form of socio-cultural norms affecting normative and cognitive legitimacy.

A thorough understanding of a country’s socio-cultural context of HIV becomes particularly relevant in determining a strategy towards integrating HIV services into routine healthcare. There is evidence, for example, that the integration of HIV services into routine maternal and child healthcare may increase stigma in some contexts (An et al., 2015).

Gender equality

In the context of health in general and HIV/AIDS in particular, gender equality signifies an important expression of socio-cultural context.
The issue of gender equality plays a major role in the progression of an HIV epidemic. In general, women are at a disadvantage when it comes to HIV. In sub-Saharan Africa young women are more than twice as likely as young men their own age to be living with HIV (UNICEF, 2013). This is also reflected in the percentage of women living with HIV as shown in Table 2.

Women are not only more susceptible to HIV due to the female biology but the epidemic
also disproportionately affects them due to their cultural, social and economic status in society. Women are often limited in their life choices and opportunities as well as access to information, health and social services, education and employment. In addition, women are subjected to gender-based violence, harmful traditional practices, stigma and discrimination. Sexual conduct and related negotiating power plays a major role for women in many countries when it comes to HIV infection. In combination with inequitable laws and customary practices, all the above increase women’s vulnerability and weakens the national response to the HIV epidemic (UN Women, 2015). Increasing gender equality and empowering women at a country level will, over time, contribute to a stronger and more manageable HIV response decreasing the burden on health budgets.

In Jamaica, early sexual debut, cross-generational sex, multiple partners, stigma and discrimination play important roles in driving the HIV epidemic besides gender inequality in a wider sense (UN Women, 2015). Masculine dominance and feminine submissiveness lead to a drastically reduced condom use in the country. Official steps have been taken to address this. As a signatory of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Jamaica is committed to the improvement of gender equality at the policy level. Furthermore, the country passed two policies in 2011 for advancing gender equality: the National Policy for Gender Equality and the Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality Affecting Jamaica’s HIV Response. Still expandable, despite Jamaica’s policy commitments, are networks for Women Living with HIV (WLHIV). With only two existing networks, there are limitations of women’s participation in the national HIV response.

Very similar reasons impair Kenya’s national HIV response with regard to gender equality (UNWomen, 2015). Also a signatory of the CEDAW, Kenya has launched a ‘Gender Action Plan’ aligned with the National AIDS Strategic Plan. However, similarly to Jamaica, challenges and limitations exist for the participation and representation of WLHIV.

Indicators capturing gender equality are United Nations Development Programme’s (UNDP) Gender Inequality Index (GII) and the Gender Development Index (GDI).

The GII measures gender inequalities taking into account three important aspects of human development (UNDP Human Development Reports):

- Reproductive health (measured by maternal mortality ratio and adolescent birth rates);
- Empowerment (measured by proportion of parliamentary seats occupied by females and proportion of adult females and males aged 25 years and older with at least some secondary education);
- Economic status (expressed as labour market participation and measured by labour force participation rate of female and male populations aged 15 years and older).

The higher the GII value, the more disparities between females and males and the more loss to human development.

The GDI measures gender gaps in human development achievements taking into account the following three dimensions (UNDP Human Development Reports):

- Health (measured by life expectancy);
- Knowledge (measured by mean years
of schooling and expected years of schooling);

- Living standards (measured by GNI per capita).

The GDI shows how much women are lagging behind their male counterparts and how much women need to catch up within each dimension of human development.

In light of these indicators, Malawi stands out with high disparities between men and women as measured by the GII and low GDI. However, in terms of GDI, Ghana is even further behind, meaning that the gap women have to close to reach the status of men is even larger. In comparison, Thailand claims to have a very equal society when it comes to differences between men and women. Overall, Sub-Saharan African countries will have to undertake further efforts in order to close the gender gap. However, as underlined by Jamaica’s unresolved gender equality issues, the suggested indices may reflect a tendency of the gender situation in a particular country yet do not explain the gender issue in its entirety and complexity.

### T.4 GENDER INDICATORS IN CASE STUDY COUNTRIES

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>THAILAND</th>
<th>JAMAICA</th>
<th>SOUTH AFRICA</th>
<th>MALAWI</th>
<th>GHANA</th>
<th>KENYA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Inequality Index (GII) 2014</td>
<td>0.380</td>
<td>0.430</td>
<td>0.407</td>
<td>0.611</td>
<td>0.554</td>
<td>0.552</td>
</tr>
<tr>
<td>Gender Development Index 2014</td>
<td>1.000</td>
<td>0.995</td>
<td>0.948</td>
<td>0.907</td>
<td>0.885</td>
<td>0.913</td>
</tr>
</tbody>
</table>

Sources: WHO, 2016a; Roser, 2016; WHO 2012 country statistics

### Key populations

Socio-cultural context also plays a major part for key populations who face particular challenges when it comes to HIV/AIDS. Experiencing stigma, discrimination, harassment, exclusion and violence due to their HIV status on the one hand and their membership to key populations, such as sex workers, MSM and IDUs, on the other make them particularly vulnerable (GNP+, 2015).

Additionally, discriminatory laws and policies including the criminalisation of sex work, drug use, sexual orientation or gender identity, contribute to and reinforce low levels of access to prevention, treatment and care. Often, issues affecting key populations are little understood and the capacity to provide for them is lacking.

Furthermore, a general lack of confidentially can affect key populations disproportionately. A lack of data collection and disaggregated
analysis provides further obstacles in appropriately catering for their specific needs (PAHO, 2011).

Where all groups may face very individual challenges, tackling these shared issues could provide a base to build upon and a prerequisite for integrating HIV services into UHC for these populations.

Non-governmental organisations (NGOs) have played a major part in the provision of essential care and support for key populations, often with little recognition or structural support by local governments. In addition, linkages to government services are often limited and, due to the dependence on external funding inherent to NGOs, sustainability is not guaranteed (PAHO, 2011). Hence, critical enablers should be put in place in order to improve the situation for key populations and to create a conducive environment for the integration of HIV services specific to those groups into the general health system.

In this regard, WHO (2016b) suggests addressing four key areas. Laws, policies and practices should be reviewed in order to decriminalise the behaviours of key populations and therefore reduce the barriers to essential health care. Reducing discrimination and stigma with the introduction and promotion of anti-

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**F.1 CRITICAL ENABLERS FOR IMPROVED ACCESS OF KEY POPULATIONS TO HIV SERVICES**

1. Reviewing laws, policies and practices (includes decriminalization & age of consent)
2. Reducing stigma and discrimination
3. Preventing violence
4. Empowering the community

Source: WHO (2016b)
discriminatory and protective policies for key populations as well as the introduction of anti-discriminatory codes of conduct as part of HIV programmes in the health sector could overcome access barriers. Furthermore, the inclusion of affected populations in the development of programmes makes them more effective. Hence, empowering the community is critical. Preventing violence against key populations and supporting those who have experienced violence is equally crucial in providing equal opportunities in the access to HIV services without fear of repercussions.

Just looking at one exemplary aspect, homosexuality legislation differs greatly in various countries. Especially in sub-Saharan countries, strong resistance to decriminalising homosexuality persists. Malawi, for example, has recently not achieved the legal protection of homosexuals from prosecution due to pressure by the majority population and religious leaders (BBC, 2015; Kretz, 2013). Thailand, on the other hand, managed to introduce its 2015 Gender Equality Act, which also protects members of the LGBT community and fines those convicted of discrimination with up to 20,000 Baht (USD 570).

3.4.4 Economy

General economic indicators must be taken into consideration in a typology to guide HIV financing integration towards UHC. Beyond the possible inclusion of economic forecast data, selected other national accounts and macroeconomic data (such as inflation), the government budget is at the centre of attention. Economic inequality plays a role in defining possible trajectories towards UHC and should be adequately reflected in the typology.

Fiscal space constitutes a critical variable within the typology reflecting how much “room” is in a country’s budget without jeopardising the financial position or a country’s economic stability. Fiscal space is a critical prerequisite for the transition from donor to domestic funding. For the achievement of UHC, significant additional amounts of financial resources may be necessary depending on a country’s progress on UHC to date. A focus lies on a country’s revenue-generating capacity. The indicative labels suggesting the level of fiscal space in Table 5 are estimates based on an assessment of respective data and on unsystematically obtained expert opinion. In this regard, further straightforward indicators (such as the debt-to-GDP ratio that provides information relevant for the assessment of fiscal space) offer useful information. This ratio is high for Jamaica, for example, at 128 percent by the end of fiscal year 2015/16 (World Bank, 2016).

Neither on the delivery nor on the financing side have cost projections taken into account the process costs of integrating a vertical programme. Costs of change are not negligible. They should be calculated and accounted for in any strategic plan for health reform.

Table 5 reveals very different levels of indicators for the six countries. The country classification by income is used as a placeholder. The flaws of the concept have been highlighted repeatedly, and concerns that policies based on this classification ignore important dimensions of development such as poverty, inequality and health need have led to the development of alternative classification frameworks (Global Fund, n.d.).
## ECONOMIC INDICATORS OF CASE STUDY COUNTRIES

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>THAILAND</th>
<th>JAMAICA</th>
<th>SOUTH AFRICA</th>
<th>MALAWI</th>
<th>GHANA</th>
<th>KENYA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income level</td>
<td>Upper</td>
<td>Upper</td>
<td>Upper</td>
<td>Low</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>GDP per capita, PPP USD 2015</td>
<td>16,305</td>
<td>9,063</td>
<td>13,165</td>
<td>1,183</td>
<td>4,201</td>
<td>3,083</td>
</tr>
<tr>
<td>Inflation (consumer prices) 2015</td>
<td>-0.9%</td>
<td>3.7%</td>
<td>4.6%</td>
<td>21.2%</td>
<td>17.1%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Income distribution (Gini coefficient) 2013</td>
<td>39.4</td>
<td>45.5</td>
<td>63.1</td>
<td>43.9</td>
<td>42.8</td>
<td>47.7</td>
</tr>
<tr>
<td>Prospective growth</td>
<td>2016: 2.5%</td>
<td>2016: 1.5%</td>
<td>2016: 0.6%</td>
<td>2016: 3.0%</td>
<td>2016: 5.2%</td>
<td>2016: 5.9%</td>
</tr>
<tr>
<td></td>
<td>2017: 2.6%</td>
<td>2017: 2.2%</td>
<td>2017: 1.1%</td>
<td>2017: 4.7%</td>
<td>2017: 8.2%</td>
<td>2017: 6.1%</td>
</tr>
<tr>
<td></td>
<td>2018: 3.0%</td>
<td>2018: 2.6%</td>
<td>2018: 2.0%</td>
<td>2018: 5.4%</td>
<td>2018: 7.5%</td>
<td>2018: 6.2%</td>
</tr>
<tr>
<td>Fiscal space</td>
<td>Low</td>
<td>Very low</td>
<td>Low</td>
<td>Very low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

Sources: World Bank Data; UNDP Human Development Reports

The income distribution in the richest two of the selected countries in terms of GDP per capita is extremely dissimilar. At a poverty headcount ratio of little over 10% and a Gini coefficient slightly below 0.4, income is far more equally distributed in Thailand than in South Africa, where approximately half the population is poor and the Gini coefficient exceeds 0.6. In South Africa, inequality constitutes an obstacle towards achieving UHC.

It would be improper, however, to imply that economic indicators are the main determinants to drive the relevant processes. Even where health systems are relatively well resourced, a lack of absorptive capacity may create serious bottlenecks (Irurzun Lopez, 2010). Absorptive capacity is determined by the availability of infrastructure and human resources as well as by good governance.
3.4.5 Political context

A country’s political will and commitment to its health policy objectives play an important role in implementing major changes such as integrating a national HIV programme, financially as well as logistically, into an existing health system.

The other success factor within the political context is public trust of government and trust towards the health system and its institutions. The public acceptance of government policies in an area where there is a high likelihood of controversial debate depends on the degree of resonance policy makers manage to generate.

The political dimension is reflected in the degree of incorporation or the prioritisation of health in national growth and poverty alleviation strategies and as part of a multi-sectoral approach. Ultimately, it is reflected in demonstrated government activity towards health policy objectives and the ways in which this resonates among the population. The formulation of an appropriate indicator or indicators for the political context dimension depends on the purpose of the application of the typology.

3.4.6 Legal context and human rights

There are high-level indicators that point towards the role of health and healthcare in a particular country. One such indicator could be the existence of a constitutional right to health or healthcare. South Africa, for example, shows pride in Section 27 of the country’s constitution, which includes the right of access to healthcare.

There may be other observation areas within the legal dimension. Fairness and efficiency of a country’s legal system as well as the degree to which human rights are adequately protected are important observation areas, as they affect the effectiveness of the HIV response as well as the achievement of UHC (UNDP, 2012).

In light of discriminatory practices and legislation and the subsequent lack of access for certain parts of the population, the compliance with human rights as laid out by The Universal Declaration of Human Rights (UDHR) are particularly important to observe. This includes the right to freedom from cruel, inhuman and degrading treatment (Article 5, UDHR), the right to life (Article 3, UDHR), the right to dignity (Article 1, UDHR) as well as the right to health (Article 25, UDHR). Despite relevant legislation being in place or international legislation subscribed to, the reality in each country as it presents itself should form the basis for the decisions on the extent and time path of the integration of HIV programmes.

3.5 National HIV programmes — observation areas and indicators

National HIV programmes are the backbones of the HIV response in most countries. The structure and quality of the current HIV responses need to be analysed and evaluated against the structure and performance of the broader health system. The “degree of fit“ co-determines the integrability of HIV financing.

3.5.1 Governance of HIV response

As for the health system as a whole, the HIV response requires a robust governance structure in itself. It is the prerequisite for a response to any HIV epidemic that is to be delivered in a transparent and participatory fashion. The question of effective governance is often closely linked to that of decentralisation of the HIV response and of the healthcare system.
Good governance is jeopardised wherever several parallel systems exist—regarding both delivery as well as modes of financing.

Looking at the overall set up of the HIV response in Thailand, the remit to manage the national HIV epidemic lies with the Cabinet and the National AIDS Committee who approved the National AIDS Strategic Plan for 2014-16 outlining ten overall strategic targets (Thai National AIDS Committee, 2015).

In Jamaica, the national HIV/AIDS response is located within the Ministry of Health, which oversees the National HIV/STI Programme. The programme involves a close collaboration with all government ministries, the tripartite team of government, employers and workers, the business sector and non-governmental organisations including faith-based entities (GoJ, n.d.).

The National AIDS Committee was established in 1988 with the purpose to strengthen the multi-sectoral approach. As a non-governmental organisation it does this by advising the Minister of Health on relevant policy issues, involving all sectors of society in prevention efforts, acting as an umbrella and membership organisation and network on all issues concerning HIV/AIDS/STIs as well as providing a stable funding source for its activities. Moreover, it provides legal assistance to PLWH as well as advocacy services for legislative change and the reduction of stigma and discrimination (GoJ, n.d). A National HIV Strategic Plan (NSP) 2012-2017 is in place. There is strong civil society engagement in Jamaica, albeit largely donor-dependent.

In 2011, the government of Malawi established the National AIDS Commission (NAC) as a public trust with the aim to provide overall leadership and coordination of the national response to HIV and AIDS. It acknowledged that the response to the HIV/AIDS pandemic required a multi-sectoral approach and interaction between HIV/AIDS and broader issues of population, economic development and management, social service provision, culture, community development, human rights and gender (National AIDS Commission Malawi, n.d.).

The Ministry of Health has a dedicated Department of HIV & AIDS which was established in 2001 in order to coordinate the biomedical HIV programme in Malawi. It is also responsible for the national coordination of the management of sexually transmitted infections, prevention of mother to child transmissions as well as the implementation of the national voluntary medical male circumcision programme. It also oversees M&E for all these programmes under the wider Central Monitoring and Evaluation Department (CEMED) of the Ministry of Health.

In Ghana, the Ghana Aids Commission was set up under the Ministry of Health with the mandate to provide support, guidance and leadership for the national response to the HIV and AIDS pandemic. In the country’s National HIV and STI policy, the government wants to ensure that strategies, resources and inputs for HIV and AIDS are integrated within the health system to enhance overall efficiency (Ghana AIDS Commission, 2013).

For the decision on whether or not a country’s governance setup of the national HIV response is conducive for the process of integration in the light of UHC—which is subject to a social contract—, country specific assessments will have to be undertaken. These should follow the same guidelines as the health system assessments covering the same observation areas:

- Coherent decision making structures
- Stakeholder participation
- Accountability and information
• Supervision and regulation
• Consistency and stability

With a view to integrating HIV services into routine health services, approaches require careful planning and the development of evidence-based and locally tailored models of service integration (Joseph Davey et al., 2016). Governance ought to be oriented towards a participatory strategy that incorporates coordinated training, logistics and resources.

3.5.2 Financing and financial scope of HIV programme

The financial scope of the HIV programme differs dramatically between countries, depending firstly on the extent of the epidemic and the local cost structure. Further, each country’s economic background and the respective history of donor involvement determine the relative shares of domestic and external funding.

T.6 HIV FINANCING IN CASE STUDY COUNTRIES

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV spending total USD</td>
<td>287,000,000</td>
<td>20,392,493</td>
<td>1,880,000,000</td>
<td>145,000,000</td>
<td>47,300,000</td>
<td>737,000,000</td>
</tr>
<tr>
<td>Domestic HIV spending USD</td>
<td>256,685,666</td>
<td>6,198,967</td>
<td>1,492,672,908</td>
<td>11,827,301</td>
<td>6,830,808</td>
<td>153,454,537</td>
</tr>
<tr>
<td>Domestic HIV spending %</td>
<td>89.4</td>
<td>30.4</td>
<td>79.4</td>
<td>8.2</td>
<td>14.4</td>
<td>20.8</td>
</tr>
<tr>
<td>HIV spending - external funding USD</td>
<td>30,516,721</td>
<td>14,193,526</td>
<td>388,000,000</td>
<td>133,575,811</td>
<td>40,457,844</td>
<td>583,989,611</td>
</tr>
<tr>
<td>HIV spending - external funding %</td>
<td>10.6</td>
<td>69.6</td>
<td>20.6</td>
<td>92.1</td>
<td>85.5</td>
<td>79.2</td>
</tr>
</tbody>
</table>

Sources: UNAIDS AIDSInfo; UNAIDS (2014) Jamaica Spending Assessment

Transition from external to domestic funding, the “domestication” of HIV financing, is— theoretically—not a necessary condition for HIV financing integration. The ranking of the external funding share of the six countries depicted in Table 6 roughly reflects the ranking by per-capita GDP as in Table 5.

Selected observations from different case study countries illustrate the very different backgrounds and concerns.

The Thai AIDS response progress report 2015 (Thai National AIDS Committee, 2015) highlights that the country’s HIV response is largely funded by domestic resources, particularly the area of treatment (100%). All three existing health coverage schemes offer a comprehensive benefit package addressing the entire continuum of diagnosis, treatment, and follow up (including free first and second line ARV, salvage regimens, viral load and resistance monitoring). HIV prevention is still donor-funded to a significant extent (Oberth, 2016).
INTEGRATING HIV & AIDS FUNDING

The plan of HIV service delivery contains allocated budget lines for service system strengthening, which includes aspects such as health personnel training, gender-related and community strengthening activities.

It is worth noting that the Thai AIDS response progress report sees the future focus not so much on financial and technical issues (as the relevant tools are already available), but rather on monitoring and improving clinical practice to ensure early detection of HIV and/or TB and prevention of leakage in the treatment cascade.

Whereas donor assistance to the health sector in Jamaica overall amounted to around 2% in 2009 (Chao, 2013), international funds covered nearly 70% of the country’s HIV response in 2012/2013 (UNAIDS, 2014a).

According to Kenya’s AIDS Strategic Framework (Kenya National AIDS Control Council, 2014), 68% of the national AIDS response is externally funded. The government allocation rose from USD 57.5 million (2006/7) to USD 153 million (2012/13). The challenge will be to secure this level and reduce external funding. In order to make substantial efficiency gains, strong M&E systems will have to be put in place both for up-to-date data on the HIV/AIDS epidemic in general and impact of all elements of the HIV response in particular.

Lack of reliable cost data for countries’ HIV responses can pose problems planning for UHC—and allocative efficiency (Doetinchem et al., 2010). Particularly in contexts where healthcare funding is highly fragmented, the implications of moving towards a common UHC benefit package comprehensively covering HIV are difficult to predict. Costing services in a fragmented health system requires the consideration of different benefits, different modes of provision, and different contexts.

Regarding the challenge of HIV financing integration, it is important to consider that the complexity associated with the integration of HIV services into the “UHC” benefit package indicates additional resource requirements that may have a significant impact on overall costs, thus co-determining the decision on HIV financing integration. A comparison of the pre-integration benefit incidence of the general health system and that of the pre-integration HIV programme will indicate challenges of the (financing) integration that could result in additional resource requirements.

3.5.3 Country ownership of HIV programmes

Different levels of country ownership should be considered for the purpose of this report. An important aspect of successful integration of an HIV programme is country ownership of the programme. This is not automatically correlated with the share of domestic funding of the HIV response.

As a first step, the extent of country ownership of the HIV programme management should be established. Binagwaho and colleagues (2016) have identified prerequisites for achieving the latter: a political context of integration and decentralization, ownership through national coordination, participation and partnership, equity, efficiency, accountability, and integration of HIV care to strengthen the entire health system. This may not yet include the ownership of funds. The next step would involve the government or the identified UHC fund holders to have full control over the budget as envisaged under UHC. Hirschhorn et al. (2013) highlight the need to turn an externally controlled process into an internal process led by local actors. The degree to which local actors are in control of the HIV response may serve as an observation area for this dimension.
3.5.4 Logistics and procurement

Effective logistics, procurement and supply-chain management are critical in order to provide a wide spectrum of healthcare services to a population. The same applies to national HIV programmes that need to have the mechanisms in place to ensure the availability of antiretroviral drugs (ARV) as well as other necessary medicines, diagnostics, equipment and consumables for the HIV response.

Of the stakeholder groups involved in the supply chain for ARVs, donors have significantly influenced its setup through their policies on the selection of operational agents, product quality standards as well as tendering and procurement requirements. Two large donors providing financing for the global ARV supply chain are the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In 2011, their contribution to global spending on ARVs amounted to 51% (Ripin et al. 2014). As Ripin and colleagues (2014) highlight, the frameworks set by donors shape the emphasis of the supply chain. It may either be set up as a distributed, country-led model, where a country is free to manage the whole procurement process under adherence of donor requirements, or an integrated model, where the donor manages the supply chain management system. The latter may include pooled purchasing to allow for cost efficiencies through higher order volumes.

The need for increased supply of ARV in light of increasing patient numbers highlights the requirement for robust supply chain management in their routing treatment as part of HIV/AIDS moving towards being a chronic disease.

Looking at country specifics, the principal recipient of Global Fund HIV financing in Malawi has changed in order to allow for a better management of funds. Where in the past this position was held by the National AIDS Committee, the Ministry of Health (public sector component) together with the two NGOs WorldVision and ActionAid (civil society component) now hold it as part of a dual track financing after irregularities necessitated a change. The supply chain is hence set up as an integrated system, allowing for efficiencies and enhanced accountability and transparency.

South Africa, in comparison, manages its ARV supply chain through the government system.

A detailed assessment would be required to establish the financing and management modalities of the respective ARV procurement arrangements in order to determine the implications on HIV integrability. The state of the procurement system for drugs is an important predictor of integration success, the object of focus being the broader health system.

3.5.5 Human resources

A complex field within the national HIV response is the delivery of specific HIV services such as ARV treatment, HIV counseling and testing (HCT) as well as a wide range of prevention services. One question to be answered in order to determine the integrability of these services would be: To what extent are HIV services already delivered as part of the existing health system?

The setup in each country differs greatly, which necessitates individual assessments mapping the current delivery system in detail. An example of an aspect of South Africa’s HIV service delivery shall serve as illustration of the complexity: In order to provide sufficient human resources as part of the country’s HCT campaign, approximately
8,000 lay counsellors were trained to deliver counseling and testing services. They are not employed through the Department of Health and a discussion is necessary how this aspect of the service delivery, one among many others, would be integrated into the wider system of healthcare delivery (Mwisongo et al. 2015).

3.5.6 Facilities

HIV programmes across different countries used to rely on facilities separate from general healthcare facilities for HCT and antiretroviral treatment (ART). In recent years, this has become less prevalent. Still, there are significant differences regarding the integration of the HIV response into the general healthcare infrastructure. Utilisation of facilities and infrastructure, including associated spatial issues, is an observation area of relevance to the degree that service integration promotes financing integration.

3.6 Health system — observation areas and indicators

3.6.1 Programme — system — UHC

Whilst the integration of HIV programmes is not a necessary condition of UHC achievement, UHC as an overarching objective should guide the efforts of integrating vertical programmes into the general health system. UHC itself has become overburdened with objectives: The concept has been described as a key instrument to enhancing health, social cohesion and sustainable human and economic development (UN, 2012). As a (health) policy goal, UHC favours a health system with a maximum risk pool and a comprehensive benefit package of necessary and effective healthcare services where out-of-pocket payments are limited to a minimum. Inclusive coverage implies that the utilisation of health services reflects health needs.

In order to operationalise UHC for the purposes of informing the design of an integration typology, we restrict ourselves to the concept’s essentials. There is neither an explicit definition of UHC nor a clearly outlined pathway towards its achievement; UHC is best characterised by its aims and objectives. In order to ensure the effective pursuit of the objectives of equity in the use of quality health services as well as of universal financial protection, observable prerequisites that need to be in place. The core feature of a UHC system is population coverage. The UHC paradigm foresees the maximum number of people to be covered with quality health services. While pooled funding is a requirement in the light of the broader distributive goals as well as efficiency objectives, UHC does not necessarily imply a single all-encompassing scheme. UHC requires certain arrangements to be in place that ensure the achievement of intermediate objectives (McIntyre & Kutzin, 2016), i.e. specific allocative and distributive goals as well as good governance. Monitoring the achievement of these objectives is methodologically challenging, yet the arrangements supporting the objectives are very well understood. For a country moving towards UHC, it will be important to formulate and refine the UHC intermediate objectives. These objectives determine the envisaged pathway towards UHC.

Health financing arrangements can be designed based on the intermediate objectives. Financing arrangements are ideally described based on three functions; purchasing, pooling and revenue raising (Kutzin, 2001). Beyond the health financing structures, the key prerequisite for making these structures work in the interest of UHC
is financial management capacity. Examples show that systems may fail to attain set goals despite the implementation and institutionalization of appropriate structures merely due to lack of capacity in financial management.

Importantly, the HIV response has contributed to innovating health service delivery and funding in many countries. Comprehensive intervention and service delivery packages have been defined that should be funded through the general health systems. Often, multi-sectoral costing methods and tools support the delivery of comprehensive HIV services (Ball & Tinasti, 2014). In some contexts, HIV programmes could serve as a vehicle for innovation in the field of financial management.

The intermediary UHC objectives require delivery mechanisms to work effectively and to encompass all geographic areas and socio-economic strata. Delivery structures comprise physical infrastructure, including facilities, human resources, and systems related to logistics and procurement.

Lastly, good governance constitutes the very foundation of UHC and is most likely its most critical element. Allocative and distributive goals in the health system will only be achieved if coherent decision making, principles of participation, accountability and information are enshrined in a country’s health system strategy and implemented in its routines across stakeholders and structures.

### 3.6.2 Financing

Ensuring financial protection against catastrophic healthcare costs, a key objective of UHC, requires that certain health spending targets are met, although there is no “magic number” (Jowett et al., 2016). The sufficiency of funds for the achievement of certain health targets as such is not a desirable indicator of progress towards UHC. This becomes obvious when considering a variety of countries with comparable levels of per capita health spending.

The disaggregation of health financing systems into their functions of revenue collection, pooling and purchasing (Kutzin, 2001) is a meaningful exercise towards the informed development of a strategy for HIV financing integration (R4D, 2014). The financing functions constitute observation areas in the logic of the presented typology.

Financial management capacity forms another important area that provides insight into the progress towards UHC and that is both an enabler of UHC as well as an indicator of progress as such.

#### Sources of funds

Health systems are financed from different funding sources. Some systems may be predominantly tax-funded, others may be predominantly financed via earmarked mandatory contributions. However, all health systems are mixed systems, as they are always financed through several sources. Apart from taxes and earmarked contributions, voluntary insurance contributions and out-of-pocket payments can contribute to funding health services. It is therefore critical to distinguish between mandatory and voluntary prepayment. In many low- and middle-income countries, donor money plays an important role in the finance of health and social services. The role of external funding differs between vertical programmes and general health services: Two-thirds of funding of the HIV response in sub-Saharan Africa is external, whilst more than two-thirds of general health expenditure is financed from domestic sources (UNAIDS, 2012).
The sources of funds constitute an important area of observation with a view to the integration of HIV financing. The relative contribution of funding sources as such is less relevant than the history and development of the shares of funding sources. The evolution and constancy of the financing mix may serve as proxies for stability of the system and the degree of UHC achievement. Existing levels of integration need to be considered.

The efficiency of revenue collection is another observation area: Revenue generation is a reflection of the maturity of the system as a whole. There are no straightforward guidelines for action that may result from observed financing incoherence, but there are always alternative suitable pathways towards an effective financing mix in any particular country context.

**Pooling**

In order for HIV financing to be successfully integrated into the UHC framework, the degree of fragmentation of risk pools within and across a country’s existing financing arrangements becomes an indicator of readiness.

Pooling is a critical observation area not only on the side of the general health system, but also on the side of the current HIV response where funds may be pooled or not across different sources. The degree of pooling will have to be taken into account in any assessment and in designing an appropriate policy response.

When it comes to pooled funds for health, it is important to assess both the degree and type of fragmentation of risk pools. The type of fragmentation determines the appropriate strategy towards distributive justice within the healthcare system. In principle, neither the existence of separate public and private funds nor the occurrence of a multitude of otherwise distinguishable funding entities as such poses a barrier to UHC, given that a larger pool can always be simulated, e.g. by means of a risk equalisation mechanism. The overarching regulatory framework determines the limits of pooling.

The concept of pooling of resources does not imply that countries should be able to completely fund their HIV programmes from domestic sources, as the incorporation of donor funds constitutes an option that may be considered in certain cases. This aspect highlights a need to carefully align the financing functions with a view to service delivery under a benefit package that corresponds to the health needs of the population. In order for this type of pooling to be sustainable, the allocation of funds towards services requires a stringent set of allocation criteria and mechanisms agreed between all relevant stakeholders.

The strategy for guiding the integration of HIV/AIDS financing into “general” health financing will be moulded based on the degree and form of pooling in the health system.

**Purchasing**

The mechanisms of transferring pooled resources to providers of general health services form part of the framework into which HIV financing is to be integrated. The degree of fit between purchasing practices within a country’s HIV response and the general health system’s purchasing framework determine the integrability of HIV financing and thus the integration dynamics towards UHC.

In the analysis of purchasing as a determinant of successful integration, the link between the financing dimension and the delivery dimension becomes most obvious. The effective delivery of health services covered...
by the benefit package should be supported by the purchasing mechanism.

Purchasing describes how providers of quality health services are paid. Different payment mechanisms favour different modes of delivery. Capitation at the primary care level, for example, does not incentivise the preferred provision of specific services or impact on the mode of delivery. Incentives to increase quality of care in a particular area are occasionally introduced as monetary rewards in the form of results-based funding.

These considerations are particularly relevant when it comes to payment for HIV services that tend to be particularly resource-intensive. Within the overarching system of provider payment, an incentive structure ought to be considered that ensures the provision of HIV services at agreed standards of quality.

**(Public) Financial management**

Solid financial management capacity is a prerequisite for building and reinforcing the financing functions as well as for controlling the fiduciary risk within the health financing scheme (Musango et al., 2012). Financial management capacity at the different levels should include the skills in using resource tracking mechanisms (including a good understanding of, say, National Health Accounts) as well as M&E tools, skills in epidemiology towards analysing the disease burden, and skills in applied (health) economics in order to determine the cost-effectiveness of certain interventions or to apply resource-tracking tools.

A crucial determinant of integration feasibility and success is the financial management capacity at different levels within the health system. Again, financing cannot be considered separately from service delivery: The delivery of HIV-related services, such as HTC or ART, requires sophisticated resource management and planning.

In principle, the structure and quality of financial management within the health system determine mode and speed of the integration process. Financial system indicators should capture the availability of utilisation and costing data across different levels of the system, as well as the possibilities of tracking funds. Financial reporting and financial M&E within the health systems are reportedly weak across case study countries. Different health systems may determine a different locus of control for managing and budgeting resources for HIV-related services. Integration requires significant capacity in (public) financial management at decentral levels.

The relevance of public financial systems and financial management capacity becomes obvious if within the same health system regional authorities demonstrate different levels of service provision due to differences in management capacity, including costing, budgeting and forecasting skills. The South African example shows, for example, that some provinces with good public financial management (Gauteng, KwaZulu-Natal, and Western Cape) manage the integration of HIV services into general health services very well by using conditional grants that are earmarked for HIV/AIDS to strengthen primary health care (PHC) systems—in quite different ways.

South Africa also serves as an example for a number of countries where building management capacity at the primary care level has been fundamentally neglected. Tracking PHC expenditure in South Africa is a significant problem that leads to huge inefficiencies, fostered by the possibility of the “absorption” of PHC into voted funds, “provincial equitable shares” (PES), which can be spent without many rules attached and without stringent reporting requirements.
Realities at the country level illustrate the capacity strengthening needs in the field of public financial management that are a precondition of realising the intermediate and longer-term UHC objectives. Further, any phased integration of HIV financing into the health system requires thorough planning on the basis of proper health accounting.

Here, expenditure by financing and revenue mechanisms, expenditure by inputs, and—ideally—expenditure by beneficiary ought to be available in a timely manner. The analysis of these data should routinely inform budgeting and target setting.

3.6.3 Delivery Facilities

The degree to which HIV services are provided in general health facilities is a reflection of service integration. While there have been concerns that integrated healthcare facilities might reduce access to HIV prevention, treatment and care due to stigma, and that lack of confidentiality at general healthcare facilities might lead to increased marginalisation of PLWH, the implications of HIV-related stigma are complex enough and also prevent people from utilising local specialised HIV facilities. In Ghana, where specialised facilities exist, the avoidance of local facilities is a well-known problem. In South Africa, the number of stand-alone ART or VCT clinics has been reduced dramatically as the health system has moved towards service integration.

There is a need to assess the capacity of general healthcare facilities to adequately cater for all patients—including HIV patients. Quality management ought to be strengthened alongside integration, as the system moves towards UHC.

Health workforce

In many countries that have embarked on the path towards UHC, human resources for health (HRH) form a bottleneck. In many countries, namely in Sub-Saharan Africa, the dilemma is twofold: Firstly, the public sector wage bill in health has grown significantly over recent years; secondly, qualified health staff is not available in sufficient numbers. Regarding the wage bill, there may be strategies to improve efficiency in the management of spending on wages, salaries and pension.

Regarding the lack of critical health personnel, there are no short-term solutions.

As per the WHO’s definition the health workforce comprises “all people engaged in actions whose primary intent is to enhance health” (WHO, 2006). Apart from a ubiquitous shortage of qualified doctors and nurses required in order to ensure that health services are available at an acceptable quality—a key attribute of UHC—, there is also a lack of health managers, i.e. qualified administrative staff with skills in the management of health services, including financial management. It is crucial that national HRH strategies take into account the specific requirements associated with the provision of HIV services.

The superior qualifications of dedicated HIV service providers as well as their often higher salary levels can pose significant barriers to HIV integration. Furthermore, these strategies will need to spell out the potential requirements for the provision of specialised services by specialised staff within facilities across levels of care. These considerations and the overall scarcity of health workers in many countries may be a strong argument in favour of prioritising HIV control and postponing integration.
Logistics and procurement

In pursuit of UHC, a health system requires a sophisticated procurement system that ensures the continuous availability of reasonably priced drugs and supplies. A procurement system may be built around a national tendering process, such as in South Africa, which has clearly demonstrated its strengths in the procurement of ARVs. A procurement system may also be designed as a decentral system involving a multitude of (private) actors fulfilling different functions along the value chain. The latter approach is more reflective of a rather mature system and requires a tight regulatory framework that sets incentives to reward quality and efficiency. As discussed in Section 3.5.4, the harmonisation of procurement of medicines and commodities requires careful consideration as HIV services and finances are being integrated into the general health system. Separate logistics and procurement are commonly far more effective in the field of HIV response than in the general health system. Integration ought to be postponed wherever integration may jeopardise the effectiveness of this aspect of the HIV response. Yet, as elsewhere, integration may increase efficiency by dismantling redundancies.

3.6.4 Coverage

Maximum population coverage is the key feature of UHC. There is a close conceptual link between the question of population coverage with services and the question of pooling under the financing dimension, as the precise objective is to maximise population coverage by pooled funds. Coverage should therefore incorporate the concepts of risk-related and income-related cross-subsidies, while the universal cover does not discriminate by socio-economic or health status. Within the typology matrix, the percentage of population covered by pooled funds would serve as the obvious indicator for population coverage.

A recent report on monitoring progress towards UHC (WHO, 2015) uses the percentage of people living with HIV who are receiving antiretroviral combination therapy as one of the indicators that measure service coverage as the key aspect of UHC. Alternative approaches are conceivable as observation areas.

Co-payments are best avoided in the design of UHC, as they tend to constitute a disproportionate burden on those with limited ability to pay. There are certain exceptions where co-payments may be used to improve health service utilisation. This is the case when co-payments can be used to introduce a disincentive to override the referral system or wherever care for minor ailments is particularly price elastic. An indicator capturing whether any existing co-payments are appropriately differentiated by socio-economic status should be included in the typology matrix.

3.6.5 Governance

Governance describes the coordination of a social system and is a dimension of key relevance for an HIV/AIDS integration strategy. The processes of both service and financing integration pose problems if their governance paradigms differ. This may be the case if there is hardly any overlap of the governance principles of national HIV programmes with those of the general health system in terms of structures, institutions and processes. The common approach of Country Coordinating Mechanisms (CCMs) which feature multisectoral membership is an example of a well-established governance mechanism.
Governance for UHC, e.g. the governance structure for a national health insurance strategy, is mostly still in the planning or very early implementation phases. The organisation of a sustainable healthcare system by a government can be considered a major achievement, irrespective of the political system or agenda, of GDP levels or population characteristics. While the degree of success of any healthcare system is dependent on the laws and regulations, in short, the policy that frames it, there is also a considerable need for skilled management of the system. This management of a healthcare system by the public sector is often referred to as governance and encompasses the “how” of the healthcare system rather than just the “who” and “what”. Representation of stakeholders from different parts of society is frequently neglected along the path towards UHC.

If governance is seen as the “how” of a policy system, it could be described as a set of characteristics or values. One of the characteristics that define a form of governance is political accountability, which is also reflected in the notion of stewardship; the degree to which those in power behave in ways which are considered acceptable and can be sanctioned if they fail to do so. Accountability has become the major defining factor of governance in many realms and ought to play a key role in health reform with UHC as a goal.

Governance as a concept of the social sciences has, developed in recent years from a system of hierarchies and bureaucracy towards a more open, embracing system of markets and networks (Bevir, 2011). In this sense, governance principles have become more similar to management principles. Dodgson et al. (2002) point out how health policy has been more and more influenced by global stakeholders, ideas, funders and products, making health governance in every country dependent on what is going on globally. The processes of integrating HIV services and HIV financing into the general health system bring this aspect to the fore. A challenge will be to mediate between potentially different governance principles of the respective spheres—the specific disease programme and the general health system.

Within the governance paradigm, supervision of the health system constitutes both an essential component and a prerequisite for successful integration. The regulatory framework of a UHC scheme describes the system of checks and balances and ensures the democratic legitimisation of any stakeholder action within the system. Certain consistent principles must hold across the health system building blocks in order to ensure stability of the system. These principles should include a purchaser-provider split, relative autonomy of certain key actors (e.g. tertiary hospitals), or common modes of conflict resolution between stakeholders (e.g. arbitration panels). Any additional services or institutions to be integrated into the system must adhere to the same principles.

Good governance leads to an efficient and fair distribution of public goods within a society. In this vein, the effectiveness and the degree of equity reflected in the (emerging) health system can be considered indicators of good governance.

An integration strategy needs to be built on reliable and transparent data. As other policy measures, each element or step of the strategy must be evidence-based.

Strengthening data management may therefore form an indispensable first step for many countries.

3.6.6 ICT infrastructure

A health system’s ICT infrastructure is an important enabler of UHC and can be expected to facilitate integration of additional
services. The reality in numerous countries is that vertical programmes generate their own data that are not accessible for other health information systems in the country. Data silos are common. Vertical programmes are often characterised by excellent systems for collecting epidemiological information on the relevant variables. The requirements of integration planning indicate that “integration” of the ICT infrastructure would be an area in need of particularly urgent action, as the costs of inaction are high.

The expansion of coverage both in terms of the population and in terms of healthcare services requires comprehensive data management capacity. Fragmented risk pools can only be overcome and new benefits can only be integrated effectively if high quality beneficiary and service data are routinely available.

Key health system work processes require appropriate ICT support. Work process groups include: beneficiary management, claims management, provider management and accounting (PATH, 2012). The ICT system must provide information that—inter alia—allows the identification of target beneficiaries for the HIV benefit under UHC.

The ICT systems within a country’s health system should be interoperable. It may not be necessary at the early stages of the journey towards UHC to ensure that the ICT infrastructure functions as a full cost accounting system but basic information on service costs must be available for management purposes at all times.

The typology matrix ought to include indicators to capture a country’s ICT progress. More recently, there has been increasing awareness of the multidimensional differences in the expectations for and values around data (Fiore-Gartland & Neff, 2015), implying that beyond technical interoperability of ICT systems there will be the need to ensure that data collected and analysed to effectively and efficiently manage a national health system are both meaningful and actionable within and across subsystems, such as hospital information systems, broader health information systems (e.g. DHIS2) and management information systems (including HR management systems).

ICT systems may develop asymmetrically across the identified domains. A comprehensive insurance management information system may be introduced with a focus on the financing domain, thus facilitating the integration of HIV financing into the general health system. In consequence, the set-up of the ICT infrastructure also influences the time path of the integration strategy.

4 Discussion: Integration—not an end in itself

Integration processes are complex and commonly do not happen as coherently managed projects but are realised as—often incomplete—pieces. In order for integration to work towards the UHC objective, the processes across the domains need to be carefully planned and coordinated based on the respective objective and the expected benefits. The support of effective integration strategies should routinely be considered in the development of health system strengthening measures.

Integration processes happen within the different identified domains, e.g. the delivery of health services or the financing of these services. The domains of integration are structurally linked. Nonetheless, integration can move along different trajectories and at different speeds across these dimensions.
Among different “vertical” programmes, HIV programmes in many countries are particularly well established, well designed and complex. As effective and often efficient health programmes, they feature service structures that are generally far better developed than those of general health services—with sound governance structures. The integration of programmes into the broader health system therefore poses challenges at different levels.

Integration is not a necessary condition for the achievement of UHC. UHC should therefore not be the key argument for pursuing integration, yet integration may catalyse the achievement of UHC. The incorporation of HIV and AIDS-related health services into a country’s broader structures of health services provision contributes to the idea of a common benefit package within the system that is as comprehensive as possible given the resource constraints that apply. Integration puts the respective services in direct competition with all other services, as they will be subject to the same regulatory framework, e.g. regarding their status within the benefit package that may be designed based on institutionalised priority-setting mechanisms. Further aspects support the UHC goal: Once integrated, capacity development around these services would more immediately benefit the wider system, for example.

There are a multitude of hurdles along the pathways of the integration of HIV services and of the integration of HIV financing with a view to UHC. This report has suggested that domain-specific integration pathways are at least partly interlinked and require structured and coordinated planning. The preceding sections have highlighted determinants of the integrability of HIV services and financing into national health systems. They have argued in a normative manner for certain prerequisites to be in place, including, for example, an appropriate M&E regime.

The typology matrix can guide the planning process. Integration requires a phased approach. It is unlikely that any country’s path towards integration can be determined “freely”, guided solely by evidence. Health reform, the overarching process determining progress towards the UHC objective, has shown to be highly path dependent (Sen & Govender, 2015).

Moving along the path of integrating HIV financing into a health system en route to UHC would ideally require careful planning on the basis of an assessment of needs (Galárraga et al, 2013). In planning integration, the delivery side of the HIV response ought to be considered simultaneously with the financing side. There are arguments to support very close coordination of services and financing integration. As, for example, expressed with a view to the costing exercises of the Fast-Track approach (Stover et al., 2016), a thorough understanding of cost components of the services to be incorporated into the UHC benefit package, the needs-based spatial allocation of resources, and an understanding of costs at the facility level would need to inform cost-effective service integration. Unless the two integration processes are aligned, financial tracking (expenditure tracking) and, by extension, costing and planning become more difficult. Thus HIV service integration and HIV financing integration are somewhat linked, even if not fully interdependent; the health system’s journey towards UHC brings the two integration processes closer together.

A large number of interfaces may exacerbate integration within a single domain. Yet practice may require deviations from the ideal in that there will often be the need to separately address the processes of financing and service integration.

Ultimately, countries’ different approaches to integration and their simultaneous progress towards the UHC goal could be depicted in a multi-dimensional diagram. We have limited the presentation to the
two “most obvious” domains of integration, financing and services. The three axes of the three-dimensional diagram (Figure 4) indicate: Progress towards UHC or “UHC achievement” (x-axis), progress towards HIV financing integration (y-axis), and progress towards HIV services integration (z-axis). This cube is meant to illustrate the complexity of the tasks of planning and benchmarking integration. It serves as reference space for the discussion. The trajectories of individual countries as they move along the cube’s dimensions—through the solid—are unique. Their respective positions largely defy any ordered classification or ranking.

The tripartition of the cube’s axes is random but can be taken to correspond with the use of progress grading by means of “traffic lights”. Referring to countries’ positions in terms of the resulting 27 smaller cubes may support benchmarking by means of the typology matrix. The small cube in the very centre of the structure would denote “yellow-yellow-yellow”. Thinking in terms of the cube allows for the realisation that there may be progress along the two domains of integration that does not move a country closer towards the UHC objective that can only be assessed with the system as unit of analysis.
The cube’s axes do not have predefined endpoints. As discussed, HIV services would not be fully integrated into general health systems; correspondingly, there will always be financing of certain HIV services, e.g. educational services, outside of the health system. The question as to how, in the future, middle-income countries in particular are going to finance the response to HIV as a social issue beyond health is not addressed by the framework presented here.

Considering the simultaneous assessment or monitoring of different domains, mapping one domain against the other could provide simple benchmarks to inform planning. For example, progress of service integration could be mapped against financial integration (HIV-specific financing). Information would be available from the respective National AIDS Spending Assessment (NASA). An indicator of “integration congruence” could be a simple ratio. Depending on the precise objective of the exercise, the order in which domains are integrated in specific country contexts may also constitute a relevant characteristic of the integration process.

Critics of hasty integration point out possible conflicts due to rules for priority-setting. Indeed, the typology discussion does not pre-empt a decision in favour of integrating AIDS financing. Its normative claim is valid within the concept’s boundaries. Both the argument in favour of vertical programming in the light of the UNAIDS Fast Track agenda, expressed by those who prioritise an intensified AIDS response, on the one hand, and the fear of those who believe HIV might crowd out other PHC needs upon full integration, on the other hand, cannot be remedied by the approach presented in this report. Rather does the framework suggest thorough planning for integration, once a country has decided in favour of integrating HIV financing with a view towards a strong, efficient and equitable health system.

In practice, the prerequisites and the risks of integrating HIV programmes differ significantly between countries. There will thus be country cases, for example, where integration at the level of resource mobilisation and pooling will be recommendable as an important step towards achieving UHC, but purchasing and service delivery may have to explicitly account for existing access issues relating to key populations and may therefore defy integration at the current stage. In this context, the role that NGOs play in the provision of services to key populations, for example, needs to be carefully considered in a country’s integration strategy. Furthermore, funding of services for key populations from domestic funds poses an area of concern in some countries as donors reduce their funding.

5 Conclusion

There has not been a systematic reappraisal of integration as a health policy project that requires meticulous management and appropriate governance alongside the process. For any envisaged integration of a vertical programme, initially the motivation and intended effects must be spelled out and must guide the time-bound design of the process. At that juncture, the stakeholders’ awareness must be raised of structural drivers with a bias towards vertical goals.

Integration does not imply an all-encompassing effort to erase verticality; it rather means an evidence-based incremental approach that can be conducted separately
by domains. Integration can be phased within and between domains: Within a domain, such as service delivery, the dimensions health workforce and logistics, for example, can be addressed separately, while at the same time integration within one or the other additional domain may have been initiated - or not.

Despite the universalist character of the concept, UHC does not require complete integration across all domains of a vertical programme. Rather there may be an optimum level of integration in order to ensure effective coverage of need with priority interventions. If there are strong arguments to support the premise that integration in order to satisfy a UHC agenda may compromise an intensified HIV response, there are a few initial points of guidance that serve to initiate the further engagement with the typology:

Countries that feature a generalised HIV epidemic and find themselves in the planning or early implementation stages of national policies towards UHC must develop an integration plan that ensures a constant quality of HIV service provision, taking into account the appropriateness of the dedicated health workforce as an element of general health services, the appropriateness of facilities and the effectiveness of required logistics and procurement systems. The integration of services should be designed as an phased process with risk mitigation strategies in place. With a view to financing integration, the separate financing functions need to be designed to cater for the specific requirements of the HIV response, e.g. provider payment mechanisms ought to incentivise a continuously high HIV service quality.

While the two spheres of integration should be coordinated, they do not necessarily have to follow the same time paths. A key prerequisite of HIV integration towards UHC is the assurance of the availability of high quality data based on a comprehensive ICT infrastructure. The speed of integration would thus be guided by evidence.

The processes of moving towards UHC, the integration of HIV services and HIV financing integration are shaped by a country’s economic context. Whereas low-income countries may embark on planning for UHC, there are few arguments in favour of embarking on integration planning, given the short-term resource requirements of an effective AIDS response. Integration would be premature. In no category of countries there appears to be any gain from prioritising the integration of HIV services directed at marginalised key populations or respective funding under a UHC agenda.

The typology introduced here can help structure a knowledge base around the integration of vertical programmes. The compilation of such a knowledge base must take into account that there are lessons to be learnt from vertical programmes which must not get lost in the context of integration, e.g. around well-functioning procurement systems.

The typology framework ought to form the basis for the development of systematic guidelines for integration in order to ensure that the integration strategy fits the objectives of integration, e.g. the removal of redundancies, and the setting. In countries that embark on the integration of HIV programmes with the broader health system, rigorous strategic planning processes need to be initiated. The typology framework will guide benchmarking as well as monitoring and evaluation. It may also serve as a basis for efficiency analyses.

The details of integration must be discussed and spelled out. An international discussion
using case studies of integration as far as available should inform a toolkit for designing and implementing country-specific integration processes.

The discussion of the role of integration in a country’s health system is an important contribution to the post-2015 mainstreaming of UHC.

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COUNTRY PROFILE

GHANA

HIV integration into efforts for UHC

Country context

HIV prevalence in adults in Ghana lies at 1.6% with a high percentage (55.6%) of women being affected (UNAIDS, 2015b). Life expectancy at birth lies at 62 years (WHO, 2015). This improved from 57 years at the peak of the HIV epidemic in 1995 (Roser, 2016).

HIV/AIDS ranks fifth among the causes of death in the country (4.9%), behind lower respiratory infections (10.7%), stroke (8.7%), malaria (8.3%) and heart disease (5.8%). Among the leading causes of DALY it even ranks at second position due to the wide spread of malaria (WHO, 2012).

Ghana is classified as a lower-middle income country with a high inflation of 17% and 24% of the population living below the national poverty line (World Bank, 2012). The country’s economic growth is forecast at approx. 7% per year (World Bank Data).

Health system

The Ministry of Health is responsible for the health system. It appears well organised and transparent, with many official documents readily available on their website: http://www.moh.gov.gh. The ministry is divided in different directorates such as policy, planning, monitoring & evaluation; human resource for health development and finance; among others.

Ghana’s health financing policy 2015 outlines the different financing functions: revenue collection, pooling of funds and purchasing (GoG, 2015).

Revenue collection: The health sector is financed by various sources: Government of Ghana revenues (public funds), private funds from companies and households for both pre-paid voluntary premiums and out-of-pocket payments, and international funds from donors/development partners. These revenues are sub-divided into: 1. general revenue for the health budget; 2. targeted revenues for NHIS; 3. local government revenue.

The National Health Insurance Authority (NHIA) under the MoH manages the National Health Insurance Fund
(NHIF) which has six main sources of funding to operate the NHIS:

1. The National Health Insurance Levy (NHIL) which is a 2.5 percent value added tax (VAT) levied on selected goods and services
2. 2.5 percent social security deductions from formal sector workers managed by the Social Security and National Insurance Trust (SSNIT)
3. GOG annual budgetary allocations proposed and approved by parliament to the NHIF
4. Accruals from investments of surplus funds held in the NHIF by the National Health Insurance Council (NHIC)
5. Grants, gifts and donations made to the NHIF
6. Premiums/contributions paid by NHIS subscribers

All Ghana residents except military and police are eligible to enroll in NHIS. As of 2011, coverage of the NHIS stood at 33.4 percent.

Fiscal space for health: The MoH states that large increases in public spending on health are not very easy to achieve. However, it aims at gradual and continuous increases in GoG revenues for health. The focus should be on gradual revenue increases combined with a focus on expenditure management, efficiency gains and better cost containment to enable coverage expansion.

Pooling: Pooled at national level are: General revenue allocated to the MoH through the health budget (Funds are distributed to health facilities at all administrative levels through MoH programmes and services) and NHIS revenues from VAT and SSNIT.

Purchasing: Coverage and benefits as well as provider payments are determined in details for an effective transfer of pooled funds.

Challenges were identified with regard to health financing. For example low fiscal capacity persists despite the governments commitment to health through a higher than average prioritization. Furthermore, the relationship between government general revenue for health budget and NHI levies is trying and affects finding the best balance between pooling and decentralisation in order to maintain and increase equity and financial risk protection as well as including donor funding in pooling arrangements to the extent possible. In addition, the financial stability of NHIF is jeopardised under its existing design and policies including coverage rules, benefit package, and provider payment systems due to expenditures increasing faster than revenue generation.

National HIV programme

The Ghana Aids Commission was set up under the Ministry of Health (MoH) with the mandate to provide support, guidance and leadership for the national response to the HIV and AIDS pandemic.

Alongside the Ghana AIDS Commission, the National AIDS Control Programme plays a major role. As the technical lead agency of the MoH in the health sector’s response to HIV and AIDS it manages the Global Fund grant, which is the major funder of the response. In terms of financing the response overall, Ghana is largely dependent on external funding, with only 15% of resources being financed domestically.

Integration of HIV financing has been an objective of health policy in Ghana. In the country’s National HIV and STI policy the government highlights the need to ensure that strategies, resources and inputs for HIV and AIDS are integrated within the health system to enhance overall efficiency (Ghana AIDS Commission, 2013)

National HIV/AIDS, malaria, and TB programmes are almost fully integrated with the overall health system. However, activities of the HIV response funded by the Global Fund are only moderately integrated with the national disease programmes. This highlights a lack of clarity of responsibilities between the principal recipient of the Global Fund (MoH) and the primary implementer of the grant activities (the Ghana Health Service) (Atun, 2011b).

Towards an integration strategy

Integration plans for Ghana’s HIV response are well underway. Overall, the HIV response is fragmented. Given limited resources within the overall health system and limited fiscal space at moderate annual growth rates, the creation of capacity for integration beyond the current stage requires concerted action of all relevant stakeholders. A possible integration plan ought to envisage advancing in incremental steps with decreasing donor funding, while ensuring the achievement of the set targets.
Country context

HIV prevalence in adults in Jamaica lies at 1.6% (UNAIDS, 2015b). Life expectancy at birth lies at 76 years (WHO, 2015). The country has a similar development through the peak of the HIV epidemic as Thailand with relatively stable life expectancy throughout.

HIV/AIDS ranks fourth among the causes of death in the country (7%), behind stroke (16.5%), heart disease (11%) and diabetes (10.8%) (WHO, 2012). It ranks even lower, at position seven on the lead table of causes of DALY, with cardio-vascular diseases and diabetes as well as neuro-psychiatric conditions and other non-communicable diseases topping the table.

Jamaica is classified as an upper-middle income country. Still, 20% of the population lives below the national poverty line (World Bank, 2012). The country’s economic growth is forecast to increase steadily over the next three years to 2.6% (World Bank Data). However, this has to be seen in light of a country being highly indebted.

Jamaica’s overarching national development plan Vision 2030 places its national outcome of a healthy and stable population high on their priorities.

Equally, Jamaica is committed to the improvement of gender equality on policy level, as expressed through signing of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Furthermore, it passed two policies in 2011 for advancing gender equality: the National Policy for Gender Equality and the Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality Affecting Jamaica’s HIV Response.

Health system

The Ministry of Health (MoH) oversees the health system and is responsible for policy, planning, regulating and purchasing functions. In 1997 the system was decentralised under the National Health Services Act, which meant health service delivery lies in the hands of four Regional Health Authorities (RHA) (Chao, 2013). The RHA manage a network of secondary/tertiary care facilities consisting of 24 hospitals including 5 specialist institutions and primary care facilities comprising 348 health centres, managed by the four regional health authorities (WHO, 2013).
The private sector plays an important role also, especially in the provision of ambulatory services and pharmaceuticals.

Health sector financing is ensured through public and private sources, where public funds are generated mainly through taxation (50%). The next biggest share is covered through out-of-pocket expenses (32%) followed by private insurance (12%), donor funds (3%) and the National Health Fund (NHF) which was established in 2003 (3%). The NHF is mainly financed through three sources: 1. special consumption tax charged on tobacco products with effect from April 14, 2008; 2. a payroll tax, which is collected in parallel with the National Insurance Scheme, which provides primarily for pensioner benefits; 3. special consumption tax, mainly from alcohol, petroleum, and motor vehicles (Chao, 2013). Donor assistance to the health sector overall amounted to only 2% in Jamaica in 2009. This differs significantly for the national HIV response (see below).

## National HIV programme

The national HIV/AIDS response is located within the Ministry of Health, which oversees the National HIV/STI Programme (NHP). The programme involves a close collaboration with all government ministries, the tripartite team of government, employers and workers, the business sector as well as non-governmental organisations including faith-based entities (GoJ, n.d.).

The National AIDS Committee (NAC) was established in 1988 with the purpose to strengthen the multi-sectoral approach. As a non-governmental organisation it does this by advising the Minister of Health on relevant policy issues, involving all sectors of society in prevention efforts, acting as an umbrella and membership organisation and network on all issues concerning HIV/AIDS/STIs as well as providing a stable funding source for its activities (NAC, n.d.).

Moreover, it provides legal assistance to PLWH as well as advocacy services for legislative change and the reduction of stigma and discrimination (GoJ, n.d.).

The response is guided by the National Integrated Strategic Plan for Sexual and Reproductive Health & HIV 2014-2019 which aims to outline the ambition to achieve an integrated programme in support of the Sustainable Development Goals (SDGs) as well as the UNAIDS Fast-Track strategy to end the AIDS epidemic by 2030.

Overall funding of the HIV response is dominated by external funding, which accounted for 70% of HIV spending in 2013 in Jamaica (UNAIDS, 2014). Financing from the Global Fund seems unsure after 2018 as the country was identified as one to transition out of support (The Gleaner Jamaica, 2016).

## Towards an integration strategy

In light of the high level of debt burden Jamaica faces, already the planned integration HIV and reproductive health currently presents a major challenge. Despite great achievements over the past decade in reducing the number of HIV infections, the HIV incidence of adolescent girls as well as MSM requires attention. These aspects may require increased attention involving interventions outside of the health system.

The economic framework conditions do not favour a stronger role of the general health system to support the Fast Track approach. Policy makers have reluctantly taken steps toward achieving UHC, while lack of appropriate governance mechanism suggests integration only at a modest level.
COUNTRY PROFILE

KENYA

HIV integration into efforts for UHC

Country context

With a HIV prevalence rate of 5.9% (UNAIDS, 2015b), Kenya is dealing with a generalised HIV and AIDS epidemic. The average life expectancy at birth of the Kenyan population is 63 years (WHO, 2016). During the peak of the HIV epidemic in 2000 life expectancy fell to 53 years, a drop by 7 years compared to the pre-HIV figure (Roser, 2016).

HIV/AIDS is still the leading cause of death (14.8%) in the country followed by lower respiratory infections (12.3%), diarrheal diseases (6.3%) (WHO, 2012). After maternal, neonatal and nutritional issues, HIV ranks second among the leading causes of DALY together with TB and malaria (WHO, 2012).

Despite the HIV prevalence in the country steadily declining, the number of people affected by the disease continues to increase (GoK, 2014a) leading to an increased financial burden on the country attempting to cater for the growing need for healthcare associated with HIV/AIDS.

Having had the status of lower-middle income country confirmed by the World Bank in 2015, Kenya has a large share of the population (45.9% in 2005) living under the national poverty level. Its economic growth for the next year is forecast at approx. 6%.

Kenya’s political will is expressed in its ‘Vision 2030’, a guiding paper developed “to transform Kenya into a newly industrialising, middle-income country providing a high quality life to all its citizens by the year 2030”. This vision is built on three pillars, namely economic, social and political. The social pillar with its aim to create “a just and cohesive society enjoying equitable social development in a clean and secure environment” states Kenya’s vision of an efficient and high-quality health care system with a devolved management of funds and health care.

The country’s commitment to Gender equality is displayed through signing the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and launching a ‘Gender Action Plan’ aligned with the National AIDS Strategic plan. In reality, however, challenges and limitations still exist for the participation and representation of Women living with HIV/AIDS (UN Women, 2015).

Health system

Besides Kenya’s ‘Vision 2030’ (GoK, 2007), the set up, administration and development of the country’s health system is guided through key strategic documents such as the Constitution of Kenya 2010, which ensures every person’s right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare. It also established the devolution of health functions to the counties. The national government mandate remains health policy formulation and coordination, capacity building and technical assistance to the counties and the national referral health facilities.

Furthermore, the Kenya health policy 2014-2030 outlines the government’s overall priority of the realisation of universal health coverage (UHC) supported by the health sector strategic and investment plan 2014-2018 and health sector human resources strategy 2014-2018.

Financing progress towards UHC is envisaged to be covered by multiple sources including the national and county governments budgets for the provision of health services, National Health Insurance Fund (NHIF)
providing health insurance for both formal employees (mandatory) and informal sector workers (voluntary), direct households’ out of pocket expenditure (about 30% of the total health expenditure) and funds provided by development partners (about 30% of the total health expenditure) (GoK, 2016). Currently, 20% of the population are covered through the NHIF (18%) and private, micro-finance and community-based insurance providers (2%) to ensure access to high-quality health services, availability of essential medicines and the reduction of out-of-pocket payments (Mwaura et al., 2015). Access to NHIF on a voluntary basis is available at fixed premium of Kshs.500 per month as per the NHIF website.

Health services are delivered as part of a devolved healthcare system with responsibilities shared between national and county governments. The national government covers the higher-level responsibilities as outlined above. The county governments cover county health facilities and pharmacies, ambulance services and the promotion of primary health care among others (GoK, 2010). Healthcare within the devolved system is organised in four tiers (GoK, 2014a) comprising of:

- **Tier 1:** Community health care
- **Tier 2:** Primary healthcare; including of all dispensaries, health centres and maternity homes for public and private sectors.
- **Tier 3:** Secondary referral; including county hospitals, both government and privately owned, offering specific services shared among the existing county referral facilities to form a virtual network of comprehensive services.
- **Tier 4:** Tertiary referral; including service units providing tertiary/highly specialised services (high-level specialist medical care, reference laboratory support, blood transfusion services, and research).

With regard to human resources, the WHO puts the critical threshold of health workforce density at 23 doctors, nurses and midwives per 10,000 people of the population (WHO, 2010). Kenya’s provision of health staff lies at 13 per 10,000 (WHO, 2010) which highlights that the country’s health sector human resources strategy is a necessary requirement for strengthening the health system as part of the move towards UHC.

### National HIV programme

Kenya’s commitment to combatting the HIV/AIDS epidemic is manifested within its general health policy. In order to ensure a coordinated response, the government established and oversees the semi-autonomous National AIDS Control Council (NACC). This arrangement is the government’s attempt to overcome previous challenges in coordinating, financing and integrating the HIV response into the overall health agenda (GoK, 2014a). As part of the eight strategic directions formulated by the NACC, the current Kenya AIDS Strategic Framework (2014-2019) set four main objectives which encompass the reduction of new infections by 75%, AIDS related mortality by 25% and HIV related stigma and discrimination by 50% as well as the increase of domestic financing of the HIV response by 50%.

In light of a domestic share of HIV funding of only 21% (UNAIDS, 2013), the government has set a steep goal. However, over the previous decade government allocation had already risen from USD 57.5 million (2006/7) to USD 153 million (2012/13) (GoK, 2014b). The challenge will be to secure this level and further reduce external funding. In order to make substantial efficiency gains, an emphasis is placed on strong M&E systems to be put in place both for up-to-date data on the HIV/AIDS epidemic in general and impact of all elements of the HIV response in particular.

### Towards an integration strategy

HIV/AIDS absorbs a large share of public health expenditure in Kenya, which is characterized by a generalized epidemic with high HIV prevalence among key populations. Given Kenya’s UHC vision that is reflected in its policies towards strengthening the NHIF implies an increasing integration of the HIV into the NHIF environment. Strategies outlining the future role of the NHIF, which currently covers only 20% of the population should formulate concrete steps in this regard. The NHIF would hardly be in a position to fund treatment and care for those already living with HIV/AIDS. HIV integration in Kenya constitutes a key challenge for the ongoing reform of the health sector. Further technical analysis is urgently required. In order to realise the equitable and sustainable HIV response envisaged in the Kenya AIDS Strategic Framework, development partners will have to continue playing a strong role.
Malawi is dealing with a generalised HIV and AIDS epidemic of significant proportions. This includes a large percentage of women (55.1%) among those living with HIV (UNAIDS, 2015b).

Life expectancy in the country currently stands at 58 years (Roser, 2016), a significant increase by 12 years since the peak of the HIV epidemic in 1996. HIV/AIDS ranks still top of the leading causes of death in the country by a wide margin (27.1%) followed by lower respiratory infections (8.6%) and malaria (6.3%) (WHO, 2012). This means HIV/AIDS also leads the table of leading causes of DALY together with TB and malaria followed by maternal, neonatal and nutritional issues as well as other infectious diseases (WHO, 2012).

As is the case in South Africa, in Malawi HIV/AIDS also greatly impacts on children’s lives as expressed by the very high percentage of children living with HIV (8.6%) as well as the percentage of children dying due to it (12%) (WHO, 2012).

Malawi is ranked economically as a low income country with a high inflation of 21% and 50% of its population living below the national poverty level. Its economic growth for the next year is forecast at approx. 4.5% on average over the next three years (World Bank Data).

The Malawi government has been implementing a decentralization policy since 1999. Accordingly, the Ministry of Health has devolved district level health services except HR management to District Assemblies. The full devolution of health service delivery can be expected to lead to more efficient and sustainable health outcomes.

Since the introduction of a sector-wide approach (SWAp) in 2004 in Malawi’s health sector and the coordinated implementation of an agreed strategy, good progress has been made: 75% of PHC facilities offer the population essential health care free of charge.

A number of reforms have been proposed aimed at improving the efficiency and availability of resources within the Malawian health system. The introduction of a Health Fund and a National Health Insurance Scheme are expected to help finance universal coverage of an essential health package, making it available in both public and complementary not-for-profit health facilities.
**Health system**

The health system is currently guided by the Health Sector Strategic Plan 2011-2016. The Malawi government has been implementing a decentralization policy since 1999. Accordingly, the Ministry of Health has devolved district level health services except HR management to District Assemblies. The full devolution of health service delivery can be expected to lead to more efficient and sustainable health outcomes.

Since the introduction of a sector-wide approach (SWAp) in 2004 in Malawi’s health sector and the coordinated implementation of an agreed strategy, good progress has been made: 75% of PHC facilities offer the population essential health care free of charge. A number of reforms have been proposed aimed at improving the efficiency and availability of resources within the Malawan health system. The introduction of a Health Fund and a National Health Insurance Scheme are expected to help finance universal coverage of an essential health package, making it available in both public and complementary not-for-profit health facilities.

**National HIV programme**

In 2011, the government of Malawi established the National AIDS Commission (NAC) as a public trust with the aim to provide overall leadership and coordination of the national response to HIV and AIDS. It acknowledged that the response to HIV and AIDS pandemic required a multi-sectoral approach and interaction between HIV and AIDS and broader issues of population, economic development and management, social service provision, culture, community development, human rights and gender.

The Ministry of Health has also a dedicated Department of HIV & AIDS which was established in 2001 in order to coordinate the biomedical HIV programme in Malawi. In addition, it is responsible for the national coordination of the management of sexually transmitted infections, prevention of mother to child transmissions as well as the implementation of the national voluntary medical male circumcision programme. Another area of responsibility is the oversight of M&E for all these programmes under the wider Central Monitoring and Evaluation Department (CEMED) of the Ministry of Health.

The HIV response is predominately financed through external funds. In 2012, HIV spending through external funding was at 92% (UNAIDS AIDSInfo). One of the major funders of the HIV response in the country is the Global Fund. The funding falls into the remit of the Malawian Ministry of Health. However, notable in this context is that the principal recipient of Global Fund HIV financing in Malawi has changed in order to allow for a better management of the external resources. Where in the past this position was held by the National AIDS Committee, the responsibilities have now been transferred to the two NGOs, WorldVision and ActionAid after irregularities necessitated this change. Hence, the supply chain is set up as an integrated system managed by the donor, allowing for efficiencies and enhanced accountability and transparency.

In the government’s Development Cooperation Strategy for Malawi 2014-2018, it commits to 1. analysing investment approaches and presenting an investment case for the National HIV and AIDS Response; 2. developing and adopting an effective and sustainable resource mobilisation strategy for the National HIV and AIDS Response; 3. ensuring effective and efficient governance, administrative and management systems for the National HIV and AIDS Response; 4. increasing accountability and transparency in the use of resources.

**Towards an integration strategy**

Given severe resource limitations in this low-income country, a dramatic shortfall of skilled health workers, lack of public financial management capacity, fragmented health information systems, governance issues within the country’s HIV programme, and policies towards UHC in the early draft stages, it will be years before an integration strategy may be realised in a meaningful way. Strong donor support is required to ensure that the existing health sector strategies are successfully implemented.
Country context

With a HIV prevalence rate of 19.2% (UNAIDS, 2015b), South Africa is dealing with a generalised HIV and AIDS epidemic of unprecedented proportions. This includes a large percentage of women (57.1%) among those living with HIV (UNAIDS, 2015b).

During the peak of the HIV epidemic in 2009 average life expectancy fell to 52 years compared to the pre-HIV life expectancy of 62 years. It currently stands at 63 years (Roser, 2016). This is only one aspect that shows the immense impact HIV/AIDS has had on the South African population.

HIV/AIDS is the leading cause of death in the country by a wide margin (33.2%) followed by stroke (6.5%) and diabetes (5.7%) (WHO, 2012). In light of this it is only understandable that HIV/AIDS also leads the table of leading causes of DALY together with TB and malaria followed by cardiovascular diseases and diabetes as well as other non-communicable diseases (WHO, 2012).

Important to highlight is the fact that the disease affects not only women disproportionally. HIV/AIDS also greatly impacts on children’s lives as expressed by the very high percentage (17%) of children dying due to it (WHO, 2012).

South Africa is ranked economically as an upper-middle income country. At the same time the country has a high inequality in income distribution and over 50% of its population living below the national poverty level. Its economic growth for the next year is forecast at approx. 1% on average over the next three years (World Bank Data).

Through the Commission of Gender Equality, a constitutional entity, the government aims to promote, protect, monitor and evaluate gender equality. Furthermore, the country is providing an enabling environment in line with international conventions in order to protect and empower women. Nonetheless, persistent stereotypes, social norms and discrimination continue to disadvantage women and girls. Especially gender-based violence is “is a problem of pandemic proportions and gender disparities have continued to persist in South Africa” (UNFPA, n.d.). This is having a major impact on the HIV/AIDS epidemic.
Health system

In the South African two-tiered health system, public funds for healthcare, representing 48% of total healthcare expenditure for 42 to 45 million people, are collected through general taxes (mainly VAT, company tax, and personal income tax) and then allocated through national parliament to the provinces, who provide services at public facilities.

52% of healthcare spending is funded privately, 80% of which is through prepaid voluntary medical insurance (medical schemes) who purchase services from mostly private providers.

Per capita health expenditure differs markedly between the public and private sectors, with private sector expenditure approaching that of OECD countries (USD 2,977 in 2013), and public expenditure significantly lower (USD674 in 2013).

In December 2015, the South African Department of Health has published a White Paper towards a National Health Insurance. The NHI will be designed to ensure access to comprehensive quality healthcare services for all South Africans. The core of the envisaged financing approach will be a (largely tax-funded) NHI Fund, which is also envisaged to act as a single purchaser. Voluntary medical insurance will only be able to offer complementary cover, once the new system is in place.

National HIV programme

The South African National AIDS Council (SANAC) coordinates the national HIV response on behalf of the government.

Since 2006, two national strategic plans for addressing HIV/AIDS have been developed, each building on previous strategic plans. Over this period, South Africa has made significant strides towards achieving universal access to ARVs and the reduction of new HIV infections. More resources have been allocated to comprehensive HIV/AIDS management. Currently, SANAC is in the process of consultations for the new National Strategic Plan on HIV, TB and STIs (NSP) (2017-2022), as major costing and budgeting exercises are underway.

Overall HIV/AIDS interventions are financed through three main sources: the government, external donors and the private sector. Funding from the private sector is not routinely tracked and there is no accurate estimate of the size of private sector spending on HIV/AIDS. However, the National AIDS Spending Assessment (NASA) undertaken in 2012 indicates that in 2009/10 the private sector contributed around 8% of total expenditure addressing HIV/AIDS. However, most of the HIV/AIDS financing comes from government. In 2014, the government covered nearly 80% of HIV spending totaling USD 1.4 billion. These funds are mainly from three departments - Health, Education and Social Development. Within the Department of Health, there are separate contributions from the National Department of Health and the Provincial Departments of Health. Financing from the Department of Health accounts for over 90% of public financing of HIV/AIDS, and this, again, is largely via the Comprehensive HIV/AIDS Conditional Grant.

Towards an integration strategy

South Africa is likely to be in a position to fully fund its own public sector HIV programme by the end of the decade. The discussion of criteria and mechanisms for designing the benefit package within the envisaged NHI is ongoing. Completion of the transitional process from the current health system towards NHI as a universal system is envisaged by 2025. Options for financing integration with a particular focus on the Comprehensive HIV and AIDS Conditional Grant into the envisaged NHI Fund have been proposed and will be considered by the relevant stakeholders. Given the scope of the South African HIV response and the diverse needs of the South African population as well as aspects that typically do not fall within a health system’s benefit package, parts of the programme will remain outside of the NHI. South Africa’s unique HIV response demands a carefully coordinated integration strategy alongside the NHI implementation process.
Country context

Among all Asian countries, Thailand remains the country with the highest HIV prevalence rate in adults of 1.1% (UNAIDS, 2015b). The overall life expectancy at birth of the Thai population is 75 years. This has stayed steady at 70 years during the peak of the HIV epidemic in the late 1990s and increased steadily over the last 20 years (Roser, 2016).

HIV/AIDS ranks sixth among leading causes of death (4.1%) with heart disease (13.7%), stroke (10.3%) and lower respiratory infections (9.4%) the leading causes (WHO, 2012). The same applies to the leading causes of DALY with HIV ranking on sixth position alongside TB and malaria.

Thailand ranks among the upper-middle income countries with little inflation and with 10.5% a comparatively small share of the population living under the national poverty level (WorldBank Data).

Health system

In Thailand, the Ministry of Public Health (MoPH) is responsible for the health system, more specifically for health system planning and management. Administrative functions have been decentralised and are covered by provincial and district health offices. Overall, the Thai health system is considered to be relatively well developed, both in terms of healthcare facilities as well as financing and governance systems. The country’s HIV, tuberculosis and malaria programmes are included in the general health care system (Hanvoravongchai, P. et al., 2010).

Thailand achieved universal health coverage in 2002 at which point population coverage was at 92.47% (HiT Thailand, 2015). This had increased to 99.92% by 2015 (Ingun et al., 2015).

The population is covered through three different health coverage schemes: 1. Universal Coverage Scheme (UCS) – general population (75% coverage); 2. Social Health Insurance Scheme (SHI) – private sector employees (16% coverage); 3. Civil Servant Medical Benefit Scheme (CSMBS) – civil servants and their dependents (9% coverage) (HiT, 2015).

Overall, public expenditure on health lies at 77% of total health expenditure (as of 2011). Healthcare in Thailand is delivered through a multilevel healthcare system that aims to:

- improve geographical access of the population
- enhance system efficiency through service usage by level and referral systems
The Universal Coverage Scheme (UCS) handles health promotion and disease prevention services for the whole population.

Primary health care (PHC) is delivered under the UCS through contracting units for primary care (CUP). They require a minimum staffing and consist of networks of several health centres and a hospital. In the private sector, a CUP is often just one PHC unit in urban settings. Secondary and tertiary care are provided by hospitals, often on referral up the system (from PHC to district to provincial/regional). Emergency medical services (EMS) are universally available. Prehospital (first response, basic, intermediate and advanced life support) and hospital A&E services are also available to patients. Medicines outside of hospitals are available through private pharmacies operated by a registered pharmacist or through nurses in health centres.

National HIV programme

Responding to the generalised epidemic lies within the remit of the cabinet and National AIDS Committee (NAC) who approved the National AIDS Strategic Plan (NASP) for 2014-16.

Financing the HIV response is to a large extent covered by the three schemes. With 90% of domestic HIV spending in 2013 Thailand is largely independent in resourcing the HIV response (UNAIDS, 2014).

HIV service delivery has been integrated since 2002. Hence, Thailand does not have a separate national HIV programme as is the case in all other countries included in this overview.

Overall, the independence and integration of both financing and delivery provides the Thai government with a high degree of ownership of the HIV response with regards to decision-making and accountability.

Towards an integration strategy

HIV service delivery and financing are largely integrated in Thailand. There there is hardly space, however, to increase public spending on HIV. The rate of new infections shows that prevention services and behavioural communication fall short of appropriately addressing the issue. Further, marginalised key populations require attention. These include not only IDUs with an HIV prevalence of 19% but also a significant percentage of migrant workers (Thai National AIDS Committee, 2015). For the time being it is important to ensure sufficiently funded service offers for these marginalised groups outside of the UHC environment.
INTEGRATING HIV & AIDS FUNDING
GUIDING PRINCIPLES FOR COMPACT DEVELOPMENT
DISCLAIMER:

These reports are published as they were reported/presented during the ERG or ERG/TWG meeting.
GUIDING PRINCIPLES FOR COMPACT DEVELOPMENT
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## DONOR-COUNTRY COMPACTS FOR SUSTAINABLE FINANCING FOR THE HIV & AIDS RESPONSE

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JAMAICA HIV/AIDS PROGRAM TRANSITION FROM DONOR SUPPORT TRANSITION PREPAREDNESS ASSESSMENT

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As the HIV and AIDS community enters a new era of financing, we are seeing a major transition from global to domestic financing, particularly in middle-income countries. With external donor assistance expected to plateau and in some places go down, the importance of domestic financing will continue to increase. This comes at a time when there is a clear global commitment to the twin goals of Universal Health Coverage and Ending AIDS by the year 2030 – both of which have major implications for the funding and expansion of health and HIV programmes.

The goal is to smoothen the transition from global to domestic sources, and making sure that the resulting programmatic and financing mix is sustainable. It is imperative to maintain and expand effective programming to address HIV and AIDS. The necessary transition is not only from external funding to domestic resources, but often also from externally implemented programmes to locally designed, managed, implemented and monitored interventions.

The Economics Reference Group commissioned “Results for Development” to review existing agreements between donors and countries for smooth transition of programmes and related funding for different externally funded programmes, with a view to identify key guiding principles for the transition processes. The paper argues for transition processes to be guided by a clearly defined compact that in essence is an explicit agreement between a country’s government and one or more donors. It outlines programmatic and financial commitments to the country’s HIV and AIDS programme, and specifies mechanisms to hold parties accountable.

Overall, the country agreements should reflect the principles of “fair share” - how much low- and middle-income countries can and should be expected to contribute to their HIV programmes – and “global solidarity” - the responsibility and capacity donors have to honour commitments and continue to contribute financially to the fight against HIV and AIDS. Rapid economic growth means many countries can steadily increase domestic resources for HIV if they were willing to. It is also important that countries are able to support programmes that provide the most effective services in an efficient way that leads to a reduction in HIV cases. In many cases this requires increased capacity at country level to develop and analyse policies, put in place domestically-maintained mechanisms for
programme delivery, and identify domestic capacity, including in the private and non-governmental sectors.

In addition, the agreements:

• are made between one or more country government departments or representatives, and one or more donors;

• include programmatic and financial commitments made by one or, ideally, all parties to the country’s HIV and AIDS programme

• specify accountability mechanisms for donors, governments and other signatories

Analysis

For the development of these principles, a sample of country-donor financing agreements and compacts from PEPFAR, the Global Fund, the World Bank, the Millennium Challenge Corporation (MCC), the GAVI Alliance, and the International Health Partnership (IHP) was reviewed. In total, this involved 21 compacts from thirteen countries and four donors. The desk review was supplemented with interviews with key people at PEPFAR, the Global Fund, the World Bank, and the MCC.

• The review identified six key features including:
  • the duration of agreement

Goals of country agreements

Country agreements or compacts are designed to stabilize the changing HIV financing situation in low- and middle-income countries with the ultimate goal of ensuring uninterrupted high-quality service delivery for specific programmes (including for key populations) during and following the transition process.

Guiding principles

The following key guiding principles form a strong starting point for the development of country compacts for sustainable financing for HIV and AIDS.

• Timelines - set a standard time period of five years at minimum. A compact agreement requires a long enough time period to allow countries and donors to visualize and plan for a financing trajectory that can align with the achievement of programme targets. An agreement that spans only one or two years would not provide enough time for substantial programme and financial targets to be reached. In addition, single year and shorter-term agreements result in higher transaction costs for all stakeholders and partners compared to multi-year agreements. A period of five years would follow the practice of PEPFAR and MCC.

• Actors involved - Select a key financing or high-level political authority together with a programmatic authority in a country as a signee on compact agreements to ensure that fair share commitments are met. A compact agreement lays out important responsibilities and expectations for all parties. Signing partners
should be accountable under the compact against clear and substantial roles – whether financial or programmatic. Key signatories may include donors, country government ministries (Finance, Health), and non-governmental organizations (NGOs), but the specific combination and number of actors will depend on a specific country context and policy. More actors mean higher transaction costs, but also more coherence. Even if compacts do not include multiple donors as signees, there should be some attempt to ensure donor coordination within a country.

• Programmatic targets – Define sequence and degree of programmatic transition on a year to year basis and ensure allocative efficiency. Programmatic transitions might require thorough analysis and changes of the current service delivery modes, including social contracting (especially for programmes for key populations) integration to broader health facilities and task shifting to lower levels of health cadres including to community health care workers. In addition, parallel service and cost structures and information systems operated by donors should gradually be aligned with domestic cost structures, localised planning systems and systems to enable smooth absorption of costs and different programme elements

• Financing targets - Specify domestic and external financing commitments - not just estimates - and include projected financial plans for the next five years. Country compacts vary in the type of financing provided by the donor and in whether or not they contain domestic financing requirements for the recipient country. While different donors have different mechanisms for funding that are unlikely to change, the presence of domestic funding commitments or requirements in a compact may be more flexible for donors. Including country financing targets in a compact is an important step in achieving country buy-in for donor supported activities. It is also important for donors to ensure that their resources are allocated strategically and that they are targeting funding where it is needed the most. Donors and countries therefore have a range of tools to choose from for setting financing targets, including country income and epidemic data and country policies, strategies and plans based on rigorous analysis.

• Monitoring and evaluation - Identify a combination of programmatic and expenditure tracking tools and regular meetings that will annually monitor both programmatic progress and country finances and, where applicable, donor funding commitments too. Where possible, these should be aligned with existing programmatic and financial monitoring processes. Without tools and processes for monitoring and evaluating the programmatic and financing commitments made in a compact, it will be impossible to tell if these commitments are being met. Country compacts can provide mechanisms to promote greater transparency and trust between donors and countries, and to evaluate whether both are meeting their commitments. Compacts can identify specific tools and processes which can be used to monitor financing flows.

• Accountability - specify clear consequences of failing to meet various financing conditions set out in the compact. The objectives of country compacts can only be realized if the commitments made in these compacts are binding, or at least heavily respected, for all parties involved. One way of ensuring that compacts have leverage is by including specific consequences for not meeting the conditions that they specify.
How to get started

Actions for countries:

• **Review programmatic targets** – in particular to analyse the connection between goals and outputs, design programmes to deliver the goals, cost those programmes, and then develop financing targets based on that costing.

• **Innovative consideration of consequences** - do additional research on ‘less traditional’ incentives and consequences (other than withholding or delaying funding disbursements), such as CSO engagement, Results Based Financing, and ways of using media or other forms of public engagement. Analyse how these could help produce guidance for developing compacts that, so even if they’re not legally binding, they still offer significant leverage.

• **Develop expenditure tracking mechanisms.** While there are many tools available, some are less able to be incorporated into routine reporting systems and require longer turnaround time, while others create an additional burden for countries. There’s no clear consensus across donors and countries on the ‘best resource tracking tool, and multiple options are used across different countries, making spending comparisons fairly difficult. Harmonization of existing resource tracking tools and development of innovative ones that link expenditures to performance will be an important next step.

Actions for donors:

• **Beef up financing agreements** - add value by incorporating additional donor perspectives to the compact inventory mix, for example through reviewing other donors agreements with countries for smooth transitions.

• **Extra research** – find out what works and what doesn’t. Draft country case studies by reviewing country experiences of donor transitions and the compacts used to guide these transitions. This will involve speaking with relevant stakeholders in these countries.

• **Share best practice** - review and publish reviews such as contained in this brief, and distribute them to countries and donors for comments and guidance. If endorsed by stakeholders it could help ensure smooth and sustain funding arrangements and transitions.

• **Action plan** - develop an action plan to actually implement compact guidance. Once finalized and endorsed by stakeholders, it will help bridge the gap between the information provided in a guidance document and the actual content of compacts and their operations going forward. A first step would be testing some of the recommendations contained in this document in a small selection of countries. UNAIDS could also use the Economics Reference Group or another interagency task force to ensure these findings are taken from policy to practice.
Executive Summary

After a decade of increasing donor financing for HIV and AIDS, donor assistance is expected to plateau and in some places decrease. This changing financing situation is, in many cases, leading to a funding transition where low- and middle-income countries are providing, or could be providing, increased domestic funding for their HIV and AIDS programs. UNAIDS, Results for Development, and other key stakeholders have been examining tools to help make these donor-country funding transitions more smooth and sustainable. One promising tool is the country compact.

We define country compacts as explicit agreements with the following properties:

- They are made between one or more country government departments or representatives and one or more donors;
- They include programmatic and financial commitments made by one or, ideally, all parties to the country’s HIV and AIDS program; and
- They specify accountability mechanisms for donors, governments and other signatories.

A well-developed country compact can be used by countries and donors to clarify the financing situation in a country, ensure that all actors carry out their financial commitments that were used to develop this financing picture, and help lead to smooth and sustainable funding transitions towards increased country ownership.

The objective of this paper is to establish key guiding principles to create a compact that can achieve these goals. We reviewed a sample of country-donor financing agreements and compacts from PEPFAR, the Global Fund, the World Bank, the Millennium Challenge Corporation (MCC), the GAVI Alliance, and
the International Health Partnership (IHP) to inform the development of these principles. Although different donors have different names for these agreements, we will refer to them as compacts or compact agreements in this paper for consistency. We supplemented the information drawn from these compacts and donor websites with interviews with key persons at PEPFAR, the Global Fund, the World Bank, and the MCC. We focused on a selection of six features from the compact agreements we reviewed: duration of agreement; actors included; financing targets; inputs and tools for setting financing targets; monitoring and evaluation mechanisms; and consequences of not meeting the conditions of the agreement. For each feature, we analyzed current donor practice, tried to establish a standard to follow amongst the six donors, and developed a guiding principle that builds upon that standard. Feedback on initial findings was obtained from the Working Group on Sustainable Financing of the joint UNAIDS-World Bank Economics Reference Group and has been incorporated into this guidance.

I. Background

The HIV and AIDS community is entering a new era of financing in low- and middle-income countries. External donor assistance for HIV and AIDS is expected to plateau and in some cases decrease in coming years, while simultaneously, many low- and middle-income countries are experiencing rapid economic growth and are thus able to increase domestic resources for HIV and AIDS. This changing financing situation is, in many cases, leading to a funding transition in which external donor assistance will no longer be the largest source of HIV and AIDS funding in low- and middle-income countries. Such a transition necessitates new thinking on the sustainability of HIV and AIDS financing, including the concepts of “fair share” – how much low- and middle-income countries can and should be expected to contribute to their HIV and AIDS programs – and “global solidarity” – the responsibility and capacity donors have to honor commitments and continue to contribute financially to the fight against HIV and AIDS. One way to help ensure that countries experience smooth and sustainable transitions, and that principles of fair share and global solidarity are respected in practice, is to use country compacts. A country compact is an explicit agreement between a country’s government and one or more donors that outlines programmatic and financial commitments made by one or more donors that outlines programmatic and financial commitments made by one or more donors that outlines programmatic and financial commitments made by one or more donors that outlines programmatic and financial commitments made by one or more donors that outlines programmatic and financial commitments made by one or more donors.

II. Objectives

Little guidance exists thus far on what a country compact should contain for fair share financing. Compacts should achieve the goal of stabilizing the changing HIV and AIDS financing situation in low- and middle-income countries by making explicit how much different funders are contributing and what that money supports. Compacts should also

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1 Results for Development Institute, “Financing of HIV Responses: Fair Share & Global Solidarity.” 2013, Washington, DC.
include mechanisms for holding donors and country governments accountable for their commitments. Additionally, because many financing commitments will progressively reflect decreasing donor funding and increasing domestic funding, compacts should help to ensure that these funding transitions are smooth and sustainable. The goal is for service delivery to be un-interrupted during the transition, for specific programs (including those addressing key populations) to continue after the funding transition, and for the total level of funding to remain relatively stable over the transition period.

We seek to clarify how compacts may be optimally designed to achieve sustainable financing objectives. This analysis provides guiding principles for compact development by explaining why a particular compact feature is important for sustainable financing, highlighting an aspirational standard for that feature, and suggesting a guiding principle for that feature. We base our suggestions on an analysis of several HIV- and AIDS-specific country compacts from the three largest HIV and AIDS donors. We also draw on the experience of other non-HIV and AIDS development donors, with the objective of learning how these mechanisms have built sustainable financing into their compacts with countries. We highlight key features of their compact agreements to inform the future development of compacts for HIV and AIDS sustainable financing. We combine these analyses with previous thinking on country compacts, including a section on compacts from a UNAIDS policy brief on Fair Share and Global Solidarity.²

III. Methodology

Data Sources

Our initial analysis draws on twenty-one compacts from thirteen countries and four donors. First, we included all donors directly providing over US$1 billion globally for HIV and AIDS in 2012: PEPFAR, the Global Fund, and the World Bank.³,⁴ We also turned to other aid mechanisms, albeit not in HIV and AIDS or health, to understand how large country compacts were developed for sustainable development.

One mechanism, the Millennium Challenge Corporation (MCC)⁵, stands out as an innovative U.S. foreign aid model that is helping to lead the fight against global poverty. The MCC forms strong partnerships through large grants and compacts with countries that are committed to good governance, economic growth, and investing in their people. Key features of this aid mechanism are: a strong commitment to designing for purpose, keeping the focus on long term development, providing incentives for country performance, prioritizing country ownership, learning through monitoring and measurement of results, insisting on transparency, and incorporating an appetite for experimentation and risk.⁶ In addition, independent assessments of the quality

¹ Results for Development Institute, “Financing of HIV Responses: Fair Share & Global Solidarity.” 2013, Washington, DC.
³ Originally, we had used a cutoff of US$500 million, so that our analysis would have also included the U.K.’s Department for International Development (DFID). However, due to a lack of access to DFID’s compacts, DFID was dropped from the analysis and the cutoff was raised to
⁴ http://www.mcc.gov/pages/about
of official development assistance (ODA) conclude that MCC is a top scoring aid agency. Our review of country-donor compacts for sustainable development suggested that the MCC compact and its development process would provide an instructive model for us as we attempt to develop guiding principles for compact development for sustainable financing of the HIV and AIDS response.

We presented initial findings from this work at a meeting of a UNAIDS-World Bank working group on sustainable financing of HIV and AIDS. Based on feedback from participants, we added agreements from the GAVI Alliance and IHP to our analysis.

We selected compacts from each of the original four selected donors (Global Fund, PEPFAR, World Bank, MCC) with the objective of assembling a country compact inventory that achieves variability across country features. We tried to include a representative sample of countries by choosing countries of varying epidemic types, income brackets, and world regions. We also tried to analyze compacts for the same country across multiple donors whenever possible. We selected six funding agreements each from PEPFAR, the Global Fund, and the World Bank, and three from the MCC (a smaller sample was adequate due to similarities across all MCC compacts). Table 1 shows the variation across countries in our inventory. Variability was sometimes difficult to achieve – for example, some of the donors (e.g. PEPFAR) operate mostly in a single region (e.g. Sub-Saharan Africa).

### COUNTRY VARIATION IN COMPACT INVENTORY

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<tr>
<th>INCOME LEVEL</th>
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<td>2</td>
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<td><strong>TOTAL</strong></td>
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7 [http://international.cgdev.org/sites/default/files/1424481_file_CGD_QuODA_web.pdf](http://international.cgdev.org/sites/default/files/1424481_file_CGD_QuODA_web.pdf)

8 Due to time constraints and the late receipt of PEPFAR country compacts, we were unable in some cases to choose World Bank and Global Fund compacts for countries for which PEPFAR compacts were also available. To achieve greater consistency, future analysis could review additional World Bank and Global Fund compacts to match the countries for which PEPFAR compacts exist.
We also reviewed a selection of GAVI and International Health Partnership compacts. A smaller section of agreements from GAVI was adequate due to the fact that GAVI’s agreements are fairly standardized and consistent across countries. The review of IHP compacts had limited applicability to the six identified compact dimensions (see Table 2), and thus a smaller section was included for the IHP as well (see Box 1 for more information).

**BOX 1: LESSONS LEARNED FROM INTERNATIONAL HEALTH PARTNERSHIP COMPACTS**

As suggested by the TWG on Sustainable Financing, we also reviewed the experience of the International Health Partnership (IHP) and their multilateral compacts in our analysis. While there are some valuable lessons to be learned from the IHP, their compacts tended to be much broader and higher level, and, the six dimensions of country compacts that we evaluated for the other donors were less applicable to the IHP’s compacts. Therefore, rather than including information on the IHP under each dimension, we included a stand-alone box of lessons learned, taken from a 2012 review of IHP country compact experiences.9

One major lesson learned is that the process of compact development often resulted in more benefits than the actual compact document itself, including increased dialogue and trust among all actors involved, increased international legitimacy, more inclusiveness of CSOs, and increased coordination. The actual value added of a compact itself depended greatly on country context and what structures and processes already existed in a country. A main limitation of most country compacts was the “unrealistically large content and ambitious objectives and indicators” contained in the compact. Commitments from countries, donors, and other actors in IHP compacts were often not clearly defined, and indicators were usually not measurable and were often without clear targets. A few compacts, such as Ethiopia’s and Nepal’s, included more specific details, but for the most part, IHP compacts contain extremely broad language about increased alignment and coordination, with few specifics. Without clear targets and roles, it has been difficult for compact signees to follow through with specific actions, and even more difficult to monitor the compacts. In practice, most compacts have not actually led to increased predictability of funding and there is little evidence of more effective assistance for health coming from donors.

Still, compacts were seen as improving the quality of dialogue and donor-country partnerships in countries, and the key value of compacts was “an overarching guide that sets...high level objectives for the partnership to improve the efficient use of health resources”. The IHP provides an important first step in moving from bilateral to multilateral country compacts. It shows that multiple donors are willing to work together in a country and commit to more coordinated financing arrangements and planning, at least in theory. A key next step for country compacts may be for individual donors to move away from separate agreements with countries and to coordinate targets, financing, and roles in a single overarching compact document. PEPFAR is moving a step in this direction with their new Country Health Partnerships. If this is a continuing trend, the IHP experience can provide some valuable examples of what has worked so far multilaterally and what needs improvement and strengthening.

Analysis

Gathering relevant information from the original twenty-one country compacts, we organized our findings into a matrix for each country. These four matrices (one for each donor) helped us to systematically assess the twenty-one donor compacts against different features and criteria. We identified these features through an iterative process – by drafting initial ideas on what we thought should and would be included in compacts, and then adding to the list based on actual findings. Features assessed include the types of financing targets and arrangements specified, donor coordination mechanisms, processes and tools for monitoring and enforcement, and consequences of not meeting conditions specified in the compacts. All four matrices are shown in Annex 1. This approach allowed us to understand the key features of and types of content in each compact and their implications for fair share and global solidarity. It also allowed us to identify what was missing from a compact – by comparing against other compacts and against our existing ideas about what should be included in a compact. By analyzing these features, identifying how they help achieve the objectives specified earlier in this guidance, and singling out missing features that could also help achieve these goals, we were able to develop more generic evidence-based guiding principles for country compact development. We also analyzed GAVI and International Health Partnership compacts based on the structure of these matrices and the features identified. Review of the compacts themselves was supplemented by information from the six organizations’ websites and from interviews with key persons at PEPFAR, the World Bank, the Global Fund, and the MCC.

IV. Guiding Principles for Compact Development

Each compact feature identified is discussed in detail below with reference to sustainable financing of the HIV and AIDS response, keeping in mind the concepts of fair share and global solidarity. For each compact feature, we specify why it matters for sustainable financing, describe current practice among the three HIV and AIDS donors, the MCC, and GAVI, identify any potential standards observed amongst the analyzed compacts, and suggest elements of a guiding principle going forward. Table 2 shows all of the compact features discussed in our analysis.

T.2 KEY FEATURES OF COUNTRY COMPACTS

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>FEATURE</th>
<th>NUMBER</th>
<th>FEATURE</th>
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<td>1</td>
<td>Duration of a compact agreement</td>
<td>4</td>
<td>Inputs &amp; tools for setting financing targets</td>
</tr>
<tr>
<td>2</td>
<td>Actors included in agreement</td>
<td>5</td>
<td>Monitoring &amp; evaluation mechanisms</td>
</tr>
<tr>
<td>3</td>
<td>Financing targets for donors and countries</td>
<td>6</td>
<td>Consequences of not meeting conditions of compact</td>
</tr>
</tbody>
</table>
1. Duration of a Compact Agreement

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Financing: A compact agreement requires a long enough time period to allow countries and donors to visualize and plan for a financing trajectory that can align with the achievement of programmatic targets. An agreement that spans only one or two years would not provide enough time for substantial programmatic and financial targets to be reached. In addition, single year and shorter-term agreements result in higher transaction costs for all stakeholders and partners compared to multi-year agreements.

Current Practice

In the sample of countries we analyzed (see attached inventory matrices) all donors sign agreements of varying lengths with countries, regardless of the type of epidemic (concentrated vs. generalized), income level (LIC, LMIC, UMIC), and region.

No consistent pattern of time period is observed for any particular country context. For example, for Nigeria (generalized epidemic, LMIC, SSA), the World Bank signed a three year agreement, the Global Fund, a two and a half year agreement, GAVI, a three year agreement, and PEPFAR, a six year agreement. There are some consistencies between compacts under the same donor. PEPFAR’s Partnership Framework Implementation Plans (PFIPs) generally span five years (Nigeria appears to be an exception). Under their New Funding Model, the Global Fund will provide three year grant commitments in most cases (although these may be aligned with strategies covering a longer period of time, such as countries’ HIV and AIDS National Strategic Plans [NSPs]). The World Bank’s agreements are more variable, but generally last between three and four and a half years. GAVI’s agreements have generally covered two to four years.

For many governments, understanding how much money is flowing into their countries is very difficult because each donor has a different fiscal year, different disbursement mechanisms, and different time horizons for providing money. Given these differences, tracking the money provided by the big three HIV and AIDS funders is a major challenge for recipient country governments. This is particularly difficult in cases where governments wish to accurately forecast the money that will be spent by the big three funders during an upcoming fiscal year, so that these forecasts can be used to make informed decisions on how to program their own public HIV and AIDS resources.10

A Potential Standard?

The MCC always signs five year compact agreements with countries, and PEPFAR has moved towards a general standard of five year agreements through its PFIPs. This sets up a clear, predictable, and longer-term period in which advance programmatic and financial planning between countries and donors is possible, enabling all parties in a compact to realize their contributions and to produce programmatic results. In the MCC’s case, this is a non-negotiable time period with clear rules and regulations for implementation.

Guiding Principle:

Set a standardized time period of five years for all compact agreements.

For sustainable HIV and AIDS financing, countries and donors should consider a standardized time period of five years for a compact agreement. This will allow a country government to take into account donor commitments when it plans its medium-term HIV and AIDS budget. This longer time period can help smooth the difficulties that arise from non-synchronous donor budget and country budget cycles, so that financing is more predictable every year.

For middle-income countries (MIC), this time period will facilitate the fair share transition, so that by the end of five years, a significant proportion of HIV and AIDS financing will be from domestic resources. LMIC countries with concentrated epidemics, like India and Vietnam, and UMIC countries with generalized epidemics, like South Africa, are countries that can begin to plan for and attain a greater proportion of fair share financing in the next five years because of their ability to draw on increased domestic resources as a result of stronger economic growth in the last decade. Such funding transitions are outlined in South Africa’s and Vietnam’s PFIP agreements with PEPFAR. Five year agreements will help ensure that these financial transitions can be gradual and are achieved smoothly and sustainably.

Unlike MICs, LICs like Kenya, Tanzania, and Mozambique, which have generalized epidemics and high HIV prevalence, will likely continue to depend on donor financing to a greater extent for the foreseeable future – until economic growth enables a significant increase in domestic resources for HIV and AIDS. However, developing a minimum fair share financing goal over a five year compact period allows LICs to adjust to the idea of contributing resources to their fight against HIV and AIDS, to reduce political resistance to this transition if and when they are ready to pay a greater share of HIV and AIDS financing in their countries, and to increase the sense of national ownership and control of the HIV and AIDS program, even if this does not yet include significantly greater financing control.

Five year compacts may not be possible for all donors, such as the Global Fund, whose funding model only calculates three-year resource envelopes for countries. Resource allocations from the Global Fund to countries could change drastically after a given three year period, due to changes in country income level and disease burden and depending on which countries apply for Global Fund resources. However, even providing three year Global Fund programmatic and financial information alongside five year agreements from other donors could signify significant progress.
2. Actors Involved

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

A compact agreement lays out important responsibilities and expectations for all parties. Signing partners should have a clear and substantial role(s) (whether financial or programmatic) for which they are held accountable under the compact. Key signatories for a compact agreement may include donors, country government ministries (Ministry of Finance, Ministry of Health), and non-governmental organizations (NGOs), but the specific combination and number of actors will depend on a specific country context and donor/government policy. The identification of a country government as a key actor in providing resources for the AIDS response provides an accountability mechanism for fair share financing. More actors mean higher transaction costs, but also more coherence. Even if compacts do not include multiple donors as signees, there should be some attempt to ensure donor coordination within a country.

Current Practice

The World Bank (IDA or IBRD, depending on the status of the country) signs a loan agreement or financing agreement with a country’s Ministry of Finance (MoF). Other actors included in the agreements are main implementers (such as the Ministry of Health) and other implementing ministries.

Global Fund agreements have several signees: Principal Recipients (PR), the Global Fund, Country Coordinating Mechanism (CCM) Chairs, and CSO Representatives of the CCM. PRs and CCM chairs are generally branches of government or government representatives (PRs can also be NGOs or UN agencies). The Global Fund is the only donor analyzed whose compacts consistently include CSO representation.

From a financing perspective, CSOs have no direct power, but could serve as advocacy organizations to ensure that the government PR provides the agreed-upon resources or spends them in the way specified. However, most compacts have (or should have) other mechanisms that make countries accountable to the donor or funder (see features five and six in this document), not to a third party such as a CSO.

PEPFAR’s agreements only include PEPFAR and one government department as signees, often the MoF or head or treasury, but also National AIDS Councils (NAC) and Ministries of Health (MoH).\(^\text{11}\) While not holding other donors accountable as signees, PEPFAR’s PFIPs do incorporate planned activities and estimated financing from other major HIV and AIDS donors, especially the Global Fund.\(^\text{12}\)

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\(^\text{11}\) This is based on conversations with PEPFAR and on the South Africa PFIP. The other PFIPs we received from PEPFAR did not contain the signature pages, so we cannot tell who the country signee was.

\(^\text{12}\) PEPFAR and the country’s government are also not “held accountable” for their funding commitments. In PEPFAR’s case, funding is subject to Congressional approval and the availability of funds. We discuss this point further in later sections.
GAVI’s agreements that were in the public domain (letters of support) did not contain signatures from both parties, but development of their country comprehensive Multi-Year Plans (cMYPs) involves both MoH and MoF. GAVI countries are also required to set up an Interagency Coordination Committee (ICC) which brings together immunization actors in the country, including WHO, UNICEF, CSOs, other donors, and the MoH.

Notably absent as a signee in some PEPFAR and most Global Fund compacts analyzed is a country’s MoF: the country ministry that could be held accountable for its fair share contributions to HIV and AIDS financing, since it is generally responsible for allocating other government departments’ budgets, such as the MoH. Exceptions include the Global Fund’s grant agreements with Kenya and India, where the PRs are Kenya’s MoF and India’s Department of Economic Affairs, respectively. For the Global Fund, including the MoF may be difficult due to the CCM structure and the fact that the PR generally will be an implementing agency, not the MoF. Still, as the Global Fund begins to place greater importance on counterpart financing and domestic commitments in its New Funding Model, it will be important to obtain MoF involvement.

A Potential Standard?

The MCC has very clear rules for which actors are included in a country compact:

- MCC compacts are always between the U.S. and a recipient country. Compacts are direct treaties between the two governments, because the MCC is a federal agency (this is probably not possible for most HIV and AIDS donors). Signees for the U.S. have been the MCC CEO or the President of the United States. Signees for the recipient country are generally high-level political leaders or other leaders with responsibility over financing, such as Prime Ministers and Presidents of Countries, MoFs, or Ministries of Planning & Development. In this respect, the World Bank could also be held as a standard, since it also makes agreements with countries’ MoFs.

- The MCC compacts generally specify the formation of a country’s Millennium Challenge Account (MCA), and designate the MCA as the accountable entity and program implementer (as in Moldova and Mozambique). MCAs are part of the recipient country’s government. In this respect, GAVI and the Global Fund could also be held as standards, as both require similar entities to be formed (the ICC and CCM, respectively, although these are not country government entities).

Guiding Principle:

Select a key financing or high-level political authority in a country as a signee on compact agreements to ensure that fair share commitments are met.

The type and numbers of actors included in a compact will affect the implementation of a compact.

Type: In the case of most Global Fund and some PEPFAR compacts, excluding the MoF as a signee is a clear handicap to supporting fair share financing commitments from countries. The MoF

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13 Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013
14 The MCC compact with Tanzania specifies that while the MCA will implement the program, this does not relieve the government of its obligations. In this case, therefore, it appears that the MCA is the program implementer, but that the Government (external to the MCA) remains somewhat accountable.
has the power to allocate resources for sector-specific, and in this case, program-specific activities, so it should be included in the compact agreement along with the key implementing entity. This will ensure that each specific agency or ministry will have a clear role – financial or programmatic – for which it will be held accountable. In some cases, including a CSO or NGO may also be important. For example, if a very large NGO is implementing many ART delivery programs in a country and is indispensable to the compact’s programmatic success (and if other signees do not have legal power to compel that NGO to act), it may be important to include the NGO itself as a signee. Additionally, in cases where country commitment has been questionable in the past, including a CSO signee may be wise for monitoring purposes.

**Number:** The number of signees should be kept to a minimum to keep the compact development process moving. South Africa’s experience with PEPFAR’s transition away from direct service delivery and toward decreased financing and technical assistance suggests that, while it is important to include major funders, bringing too many actors to the table could reduce speed and effectiveness of implementation. The South African government and PEPFAR have found that bilateral financial planning and monitoring can be time-intensive. These challenges could be exacerbated if too many different actors are involved. On the other hand, including more actors in a compact can lead to increased openness and transparency of the compact process and agreement, and the programs being implemented.

**Form:** GAVI, the MCC, and the Global Fund all set up structures in-country to manage donor-country activities (the ICC, MCA, and CCM, respectively). These structures usually include both donor and country actors and help donors and countries oversee donor-funded programs. They also allow for more constant and high-level dialogue between donors and countries. However, recommending that each donor set up such a structure for its HIV and AIDS activities would result in duplicative and parallel systems. Rather, going forward, it would be useful for compact signees (donors, MoH or NAC, MoF, and possibly CSOs and major implementing partners) to convene under one single structure. This is already done to a certain extent in the Global Fund’s CCM, but such a structure could be improved by taking a more active coordination role and focusing less on a single donor’s operations and more on all donors’ finances and operations. This would help both countries and donors manage and track financing from donors as well as from governments, in an effort to monitor fair share financing and global solidarity of donors. Requiring that a country set up a structure like this could be a condition of a compact. While NACs were set up to conduct the task of coordinating donor activity in their countries, among other roles and responsibilities, they have rarely succeeded in being effective “on the ground” implementing and coordinating partners of HIV and AIDS donors. This could therefore also be an opportunity to redefine and reinvigorate one of the key roles of the NACs.

The right balance of necessary and accountable (financial and programmatic) actors must be struck when choosing signees on a particular compact. For fair share financing, the MoF, or a ministry that makes decisions about the allocation of resources must be a key actor, as well as...
the prime implementing agency within the government (usually MoH or NAC). Thus a general guiding principle can be to always include three actors: the donor, the MoF or a similar agency, and the government implementing agency. In some situations, it may be important to include an NGO or CSO signee as well.

3. Financing Targets

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Country compacts vary in the type of financing provided by the donor and in whether or not they contain domestic financing requirements for the recipient country. While different donors have different mechanisms for funding countries’ HIV and AIDS programs that are unlikely to change, the presence of domestic funding commitments or requirements in a compact may be more flexible for donors. Including country financing targets in a compact is an important step in achieving one of the main objectives of country compacts: that they ensure smooth and sustainable funding transitions. Additionally, while donor predictability is important for country governments to plan and budget, domestic funding predictability will allow donors to coordinate better with the countries in which they operate.

Current Practice

Among the three HIV and AIDS donors we studied, none has a standard for holding countries accountable for specific domestic financing targets (including programmatic targets is much more common). Of the six Global Fund agreements reviewed, only Jamaica’s (UMIC) included a counterpart financing requirement, despite the fact that the Global Fund’s current policy requires counterpart financing for countries in all income brackets, starting at five percent for LICs. Although counterpart financing is required for all countries receiving Global Fund grants, these requirements are generally not spelled out in the Global Fund’s grant agreements with countries, except when there are concerns about the country defaulting.15 Under the Global Fund’s New Funding Model, counterpart financing requirements will be more systematically implemented across all countries and will be included in grant agreements.16

Among the World Bank agreements, only two out of six (Nigeria, a LMIC and Kenya, a LIC) specified funding requirements

15 Personal correspondence (interview) between the Global Fund (Michael Borowitz, George Korah) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013
16 Personal correspondence (interview) between the Global Fund (Michael Borowitz, George Korah) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013
from the countries themselves. No funding requirements were specified for the two World Bank compacts with UMICs that we sampled (Botswana and Jamaica). The World Bank does not generally include legal clauses in its financing agreements regarding domestic funding requirements.17

PEPFAR takes a different approach. Five of the six PFIPs reviewed (Tanzania being the exception) included total predicted medium-term domestic funding (for between three and six years, depending on the agreement). However, this predicted funding is not a binding agreement with the country’s government; nor is PEPFAR’s funding trajectory, which is also provided in all of the PFIPs reviewed. Thus it may be more appropriate to view these funding projections as “intentions” rather than commitments.

The MCC does not provide explicit domestic funding commitments in its compacts. However, there is an expectation that governments will put forth some domestic funding to implement the programs specified in MCC compacts. These funding commitments may in some cases be part of MCC’s quarterly requirements for funding disbursement. However, these requirements are included in Conditions Precedent Reports or Program Implementation Agreements, not in MCC compacts, and these reports are not made public and were not made available to R4D or UNAIDS. Thus, while we know that some MCC agreements do have explicit domestic funding requirements, the details of these requirements are not made public.

GAVI also requires co-financing for all of its New Vaccine Support (NVS) to countries. Co-financing requirements for the length of an agreement are generally included in GAVI’s letters of support. GAVI’s provisional budgets for all years of the agreement are also included, but typically only funding for the first year is actually “approved.”

A Potential Standard?

Although no single donor’s standards for financing targets achieve our objectives for country compacts (see Section II on Objectives), several best practices are observed. PEPFAR is the only donor to consistently include medium-term domestic funding projections in its compacts, but countries are not held accountable for meeting these projections. The Global Fund and GAVI are the only donors with explicit policies on counterpart financing for all recipient countries, but for the Global Fund, these financing requirements are not specified in agreements and do not always appear to be implemented in practice. The Global Fund is also notably moving toward a system of including more specific country commitments in its agreements (beyond the minimum counterpart financing requirements) and requiring that domestic funding increase over the medium term. GAVI does consistently apply its co-financing requirements in all countries. The best approach may be to further expand upon some combination of that taken by these three donors.

Guiding Principle:

Specify domestic and external financing commitments (not just estimates) and include projected financial plans for next five years in country compacts.

A first step is for donors to start including clear and binding domestic financing commitments in all of their agreements, which is not currently done by any of the three HIV and AIDS donors. It is also important that the trajectory of domestic funding over five

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17 Personal correspondence (interview) between the World Bank (Miriam Schneidman, Sheila Dutta) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
years fits with the trajectory of donor funding, and that these projected financial plans are included in a compact in addition to a clear solid commitment goal from both the donor and recipient country. These plans allow all parties to move forward with a clear sense of financing contributions from each other.

An important caveat to this guiding principle is that these financing commitments will vary greatly across countries. Low-income countries with generalized epidemics are unlikely to be able to provide a significant portion of the total resources for their HIV and AIDS programs. Middle-income countries, especially those with concentrated epidemics, may be increasingly able to start taking more fiscal responsibility for HIV and AIDS, and their financing trajectories in compacts may show a bigger increase in domestic funding. To a certain extent, the Global Fund, GAVI, and PEPFAR are already observing these needs in their agreements. The Global Fund’s counterpart financing policy specifies much larger counterpart financing for upper-middle-income countries (60%) than low-income countries (5%), but these requirements are also based on the total Global Fund grant amount, meaning that countries with larger disease burdens and countries where the Global Fund is the primary HIV and AIDS donor will have to pay more. GAVI has a similar co-financing policy based for the most part on income level. The PEPFAR PFIPs that we analyzed contained rapidly increasing domestic funding estimates for middle-income countries such as South Africa, Vietnam, and Nigeria, while the scale-up in funding expected in low-income countries, such as Mozambique, was much more gradual. This point on financing ability is further discussed under feature four.

4. Inputs and Tools for Setting Financing Targets

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

While the financing targets discussed above will need to evolve through country and donor discussions, there are also ways to ensure that they are grounded in country context, such as financing ability and type and intensity of the epidemic, and in accordance with country strategies. Just as important is that a donor’s standards and rules for setting financing targets are somewhat consistent across countries, although they may take into account country contexts as well. If countries do start providing their “fair share” of the resources for HIV and AIDS, it will be increasingly important for donors to achieve country buy-in for donor supported activities. Additionally, in a landscape of increasingly limited donor funds, it is important for donors to ensure that their resources are allocated strategically and that they are targeting funding where it is needed the most (i.e. to countries that have less capacity to provide more domestic financing themselves or to activities that countries are not already funding in their national response). Donors and countries therefore have a range of tools to choose from for setting financing targets, including country income and epidemic data and country strategies, such as National Strategic Plans.

18 Personal correspondence (interview) between the Global Fund (Michael Borowitz, Korah George) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013.
Current Practice

The three HIV and AIDS donors studied vary in the degree to which they take into account country plans and strategies when setting financing targets. While the Global Fund uses country plans as a tool for developing programs, there is no evidence in the agreements reviewed that these plans were used to determine financing amounts. However, as part of their New Funding Model, gap analyses, coming from National Strategic Plans (NSPs) where possible, will be part of proposal development. A major pillar of the Global Fund’s New Funding Model is to align Global Fund grants and activities better with country strategies. Global Fund templates show that country planning documents will be incorporated in a number of ways in developing funding requests (concept notes), including for financial and programmatic gap analyses, and main funders will be specified (by program) in these concept notes.19

PEPFAR uses NSPs and other country strategy documents to conduct a gap analysis, and PFIPs are almost always programmatically aligned with NSPs or similar documents. However, PEPFAR’s financing targets do not appear to be determined by the NSPs or resulting gap analyses. In certain cases, domestic funding estimates are grounded in country budget documents, as was the case in Mozambique’s and Vietnam’s PFIPs. Moving forward, PEPFAR will also be attempting to ground compact development in existing processes involving other donors, such as Global Fund concept note development, the UNAIDS investment case process, and donor coordination units. PEPFAR’s aim is to move from a bilateral to multilateral forum in its agreements with countries.20

The World Bank agreements reviewed do not specify the process of determining domestic funding requirements, in the rare cases that domestic funding requirements are specified. However, both the World Bank’s IDA and IBRD and the Global Fund use resource allocation formulas to determine indicative amounts of funding that will be provided to each eligible country. These formulas take into account income level and, in the Global Fund’s case, number of persons living with HIV (PLHIV) in order to ensure that resources are invested strategically. Including income as a factor to determine a country’s funding level can help donors direct their resources towards low-income settings, since middle-income countries usually have more ability to provide some of these resources domestically. These indicative funding formulas help to keep external funding amounts consistent across countries, but are not used to set domestic contributions. For both the World Bank and the Global Fund, the resource envelopes determined by a formula are also combined with information on country strategies and priorities to determine specific projects and programs and the budgets that go with them.

The Global Fund is also the only one of the three HIV and AIDS donors reviewed that has an explicit “formula” to determine domestic financing commitments (as a percentage of total grant amount, based on GNI per capita). Under the New Funding Model, the Global Fund will also be working more closely with countries to set specific financing targets that

20 Personal correspondence (interview) between PEPFAR (Mamadi Yilla, Nalinee Sangrujee, Jeff Blander) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013
are most appropriate for countries, beyond the required counterpart financing. The Global Fund will also set aside 15% of a country’s indicative resource envelope to only be awarded to that country based on “willingness to pay” in this new model. Countries will receive additional funding if they make greater and more specific commitments, such as procuring a certain percentage of drugs or funding a certain programmatic component. These targets could be linked to planned domestic financing under an NSP, but also could be more realistic, given that NSP funding targets are often aspirational. In addition, the Global Fund also requires that countries progressively increase domestic funding over a five year period.

The MCC also sets indicative country envelopes. However, these envelopes tend to change due to country eligibility changes, the number of countries applying for and approved for funding, and the programmatic needs of each country (e.g., cost of the programs to be implemented). Thus the approach used is a combination of top-down and bottom-up approaches. This is an in-depth but lengthy process (generally two to three years) that involves a data-based analysis of the country, a review of priority sectors and activities, and consultations with other donors, government branches, and the private sector. There are generally not any domestic funding requirements for LICs, but LMICs are required to contribute at least 15% of the total compact amount.

The amount of GAVI’s New Vaccine Support (NVS) to countries depends on need, which is fairly simple to calculate compared to HIV and AIDS need, as GAVI only funds vaccines and supplies through its NVS funding. This estimated need is grounded in country strategies and cMYPs. All countries receiving NVS funding are then required to co-finance a portion of most vaccines. Co-financing requirements depend on a country’s income level and are gradually increased every year, until they reach 100% in the year that a country reaches “graduation” status and becomes ineligible for GAVI support. Required co-financing is generally included in GAVI’s letters of support to countries. GAVI’s Health Systems Strengthening (HSS) support is calculated through a resource allocation formula. After the first year of HSS funding, a certain percentage of a country’s available envelope is awarded based on performance.

A Potential Standard?

None of the major HIV and AIDS donors currently have a standard approach for including explicit domestic financing targets in their compact agreements, but there are still lessons to be learned from these donors. A mix of approaches taken by a number of the donors, including MCC’s preparatory work in understanding country contexts, the Global Fund’s quantitative funding envelope and counterpart financing approaches, and GAVI’s co-financing policy can stimulate the development of a standard approach for fair share financing.

UNAIDS has also developed an indicator known as the Domestic Investment Priority Index (DIPI). The DIPI uses data on countries’ epidemic sizes and expenditures to measure the extent of investment priority given by governments to support their national HIV and AIDS response. Mathematically, the DIPI is calculated using the following formula “(Public Expenditure on AIDS Response/Government Revenue)/HIV Prevalence”

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21 Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
22 Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
23 Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013
25 Mathematically, the DIPI is calculated using the following formula “(Public Expenditure on AIDS Response/Government Revenue)/HIV Prevalence”
useful as a tool for donors and countries to assess countries’ levels of domestic commitment to funding HIV and AIDS programs against their peers. However, the DIPI is not a normative indicator, meaning that there is no single “DIPI score” that countries should aim to meet. Thus, at least for now, the DIPI is not a tool donors could use to compute indicative domestic funding levels. Other literature, including a study on HIV and AIDS financing in twelve PEPFAR countries, contains additional benchmarks for domestic financing and could be useful in developing a tool for these purposes.

In terms of donors setting their own funding levels for countries, a quantitative approach that can still be bottom-up and take into account country contexts, such as the approaches used by the MCC, the Global Fund, and GAVI is optimal.

Guiding Principle

Country and donor financing commitments found in compacts should be grounded in a combination of country strategies, quantitative approaches, and country dialogue.

When setting initial funding levels and domestic financing requirements, donors should consider the financing capacity of a country and its HIV context. Financing capacity can start with income level, but should also include information on a country’s growth prospects, the size and flexibility of its ministerial budgets (in this case, the health budget is most relevant), and the amount of money the country is expecting to put towards HIV and AIDS programs (which can be found in NSPs and budget documents). The MCC considers many features when evaluating the fiscal capacity of a country, and supplements quantitative information (upon which it relies heavily) with conversations with key country stakeholders. PEPFAR and now the Global Fund also have a standard of basing some aspects of compacts in projections contained in NSPs and other country strategies.

Considering a countries’ HIV context is equally important. Consider two identical countries with the same financing capacities, but one country has a small, concentrated epidemic, while the other has a large, generalized epidemic. The latter country will have more difficulty fully funding its HIV and AIDS program. In addition to epidemic size, current programmatic scale-up and the strength of health systems also matters. This information can also be taken from country plans and documents and through conversations with country stakeholders. The Global Fund considers numbers of PLHIV in its resource allocation formula and GAVI considers overall population as a proxy for immunization needs. All stakeholders consider country needs to a certain extent when setting programs, but it is unclear how this is translated into funding levels in most cases.

The DIPI takes into account information on epidemic size and financing capacity, but is not a normative indicator. In their study on twelve PEPFAR countries, Results for Development recommend several other standards for domestic funding levels be considered, including that countries attempt to meet at least one of two targets: the Abuja target (dedicating 15% of total government budgets to health) and the DALY Share target (equating the share of the health budget

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that goes to HIV and AIDS with the share of the country’s disease burden, in DALYs, that is attributable to AIDS). However, standards for financing should also be realistic and take into account country specific contexts, and thus another approach may be to use as a starting point country-specific models used by MoFs to estimate health and other ministerial budgets, based on economic growth. UNAIDS’ Economics Reference Group (ERG) Working Group on Sustainable Financing (WGSF) could help to advance thinking and tools in this area.

Incorporating information from country strategies and speaking with country stakeholders keeps HIV and AIDS responses and financing targets country-owned. Using a quantitative approach can help keep donor funding levels and domestic financing requirements fair, predictable, and consistent across countries. A balance between both strategies is optimal.

5. Monitoring & Evaluation

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Without tools and processes for monitoring and evaluating the financing commitments made in a compact, it will be impossible to tell if these commitments are being met. Country compacts can provide mechanisms to promote greater transparency and trust between donors and countries, and to evaluate whether both are meeting their commitments. Compacts can identify specific tools and processes which can be used to monitor financing flows.

Current Practice

Most World Bank and Global Fund compacts reviewed specify that country recipients must provide regular, audited financial reports to donors as proof that they are using the funding as specified in their agreement with the donor. In World Bank agreements, country recipients are required to provide the World Bank with annual audited financing reports, and in many cases quarterly un-audited financial reports as well. The Global Fund requires PRs to provide annual audited financial statements, but so far has mainly used budget allocations (not actual expenditures) as proof of counterpart financing. In both cases, these financial reports must show that the recipient is spending the money on the agreed program,

27 This is partially due to the fact that the counterpart financing policy was only implemented in April 2012, so there has not been much time to review actual expenditures yet.
and that a structured budget (included in the agreements) is being followed, with line items for different activities. These audits generally apply to the projects specified in funding agreements only, not to overall national HIV and AIDS program spending. They are typically used to monitor donor money only, not domestic funding commitments.

The Global Fund is now moving toward supporting regular expenditure tracking exercises in its recipient countries. By trying to support the same types of exercises (mainly the System of Health Accounts\textsuperscript{28}) across countries, data on expenditures will be more consistent across countries. Currently, the Global Fund has difficulty collating data on country spending and how countries are meeting their counterpart financing requirements because different expenditure tracking systems mean that such a database would have non-comparable inputs. Specifying how a country tracks and reports its domestic commitments will be part of Global Fund grant agreements going forward.\textsuperscript{29}

PEPFAR’s funding is provided mostly to NGOs operating in a country and is not “on-budget”, thus audited financial statements from a government recipient are not required in PEPFAR’s PFIPs. Several PEPFAR PFIPs specify expenditure reviews as a method for monitoring PEPFAR and country government spending commitments. Expenditure reviews that are being encouraged and in some cases funded by PEPFAR and the Global Fund are important for other donors, especially if donors move toward compacts that include both donor and domestic financing targets, and if the domestic financing targets apply to overall HIV and AIDS spending, not narrow project-related expenditures. In some cases, PFIPs state that these expenditure reviews will take place using existing expenditure tracking tools and processes, such as PEPFAR’s Expenditure Analysis (EA), the South African Government’s Basic Accounting Systems (BAS), the Government of Mozambique’s biannual programmatic and financial review process, and the Tanzanian Government’s biannual Public Expenditure Review (PER) process. Some of these expenditure tracking tools may be better than others for monitoring compact financing commitments, in terms of speed (how long it takes expenditure information to be available after the expenditures are made), their ability to be routinized, and accuracy. Some PEPFAR PFIPs also mandate regular committee meetings to assess programmatic, and in some cases financial, progress and future plans.

The MCC also requires that MCAs spend MCC funding using a specified budget, although this budget can be flexible. To monitor MCA spending, the MCC requires regular accounting and book-keeping by the country government and sub-recipients, and semi-annual audits of government spending.

GAVI is unique in that it tracks three indicators specific to financing for all of its recipient countries. These indicators measure both GAVI and domestic funding commitments and include: GAVI support tracked against GAVI pledges; country investments in vaccines per child; and fulfillment of domestic co-financing requirements. The first indicator comes from GAVI financials, the second from country’s national health budgets, and the third uses expenditure data collected by the UNICEF Supply Division and PAHO. Because GAVI mainly provides funding to UNICEF or PAHO for vaccine procurement, there is less of a need to track GAVI resources in-country, but GAVI does also require financial statements and external audits for its cash-based support.

\textsuperscript{28} This includes National Health Accounts and Sub-Accounts
\textsuperscript{29} Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
A Potential Standard?

Of the donors reviewed, PEPFAR is the one that currently comes closest to monitoring joint funding commitments. The Global Fund is also moving toward joint expenditure tracking, through its push for National Health Accounts in recipient countries. GAVI also provides a standard by consistently tracking standard financing-specific indicators across all countries. The World Bank and the MCC mainly track whether specified budgets are being followed by country recipients. However, monitoring donor funding is much less necessary in the case of these donors, since they are disbursing funding at regularly agreed intervals or upon request directly to the government recipient, and counterpart financing is rarely required in financing agreements. Since this guidance recommends that donors and countries move toward specifying domestic financing commitments in country compacts, following and improving upon PEPFAR’s and GAVI’s current approaches and the Global Fund’s proposed approach to monitor joint expenditures and financing-specific indicators is likely the best course.

Guiding Principle

A combination of expenditure tracking tools and regular meetings should be identified in country compacts to be used to annually monitor country finances and, where applicable, donor funding commitments. Where possible, these should be aligned with existing financial monitoring processes.

A transition to more sustainable financing for HIV and AIDS with increased country ownership and joint funding commitments will require that donors and countries jointly monitor each other’s spending. Thus joint expenditure tracking tools are important components of evaluating performance in meeting funding commitments. In many of its compacts (South Africa, Mozambique, Tanzania), PEPFAR achieves a three-way goal of tracking joint expenditures, using existing expenditure tracking tools and processes that are already occurring in a country, and supplementing these exercises with regular meetings to discuss financing. The Global Fund achieves the first of these goals, but may be setting up additional and less routinized tracking systems with its push for the System of Health Accounts (granted, such systems will probably be needed at first in many countries) and meetings regarding expenditure tracking are not specified. Immunization funding is somewhat simpler and thus GAVI does not stipulate specific expenditure tracking mechanisms, but rather collects expenditure information on co-financing through its partners. Still, other donors may want to follow GAVI’s standard of tracking standard financing-specific indicators across recipient countries. GAVI also sets an example by tracking both country performance and its own performance against these financing indicators.

PEPFAR’s approach to monitoring and evaluation is a model approach to follow, but there are definitely areas for improvement. Although the approach described in compacts is a good standard to follow, in practice, planned actions have not always been achieved. For example, in South Africa, whose PFIP began in 2012/13, results of joint expenditure tracking have not yet been shared and discussed between PEPFAR and the Government, and there have been obstacles on both sides to accessing the other’s spending data. This experience highlights the importance of transparency.

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30 However, monitoring donor funding is much less necessary in the case of these donors, since they are disbursing funding at regularly agreed intervals or upon request directly to the government recipient, and counterpart financing is rarely required in financing agreements.
and trust when implementing a compact. Compacts could also specify that regular meetings should include financial tracking, and that future budgeting should be based on the results of that tracking, which few of PEPFAR’s reviewed PFIPs do. Such meetings should also be streamlined with any existing financing meetings where possible (e.g. Global Fund CCM meetings or PEPFAR PFIP committee meetings that may already be happening in a country), to avoid overburdening both countries and donors. In cases where a donor provides “on-budget” support to a government, rather than to NGOs operating in a country, expenditure tracking should focus more on tracking the government’s spending, but should include monitoring both donor money spent by the government and domestic money committed by the government.

In cases where existing public financial tracking systems are not yet strong enough to produce robust expenditure data, further work is needed to determine what the best tools are to monitor the financing commitments made in a country compact. Such tools must be routinized and ensure quick turnaround in order for them to be useful for monitoring medium-term financing agreements. It will also be important for funding for other diseases and the health sector overall to be monitored regularly to ensure that increased domestic spending for HIV and AIDS does not come at the expense of other health priorities.

6. Consequences of Not Meeting Conditions

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

The objectives of country compacts can only be realized if the commitments made in these compacts are binding, or at least heavily respected, for all parties involved. One way of ensuring that compacts have leverage is by including specific consequences for not meeting the conditions specified in a compact.

Current Practice:

While PEPFAR, the Global Fund, and the World Bank have numerous conditions on funding and can suspend or modify disbursements, their financing agreements with countries do not provide adequate information on what happens if these conditions are not met. PEPFAR’s PFIP with Vietnam specifies that “USG funding is... based on performance”, but more detail is not provided. The Global Fund’s grant agreements are “enforceable against the PR in accordance with its terms”, but specific consequences of not meeting certain conditions in the agreement are
not given. Generally the Global Fund will not delay funding based on a country’s failure to produce its counterpart financing alone – it would also be based on program management, performance, and other criteria. The World Bank’s agreements do not describe specific penalties either. There is also no information available in these agreements regarding what happens if donors fail to follow through on their funding commitments.

GAVI has a zero tolerance policy for misuse of funds, but is more flexible regarding co-financing. If a country defaults on its co-financing requirements, GAVI will work closely with the country and decide what to do on a case-by-case basis.

A Potential Standard?

The MCC disburses funding quarterly, and funding may be delayed or decreased if quarterly disbursement requirements are not met, as specified in the Conditions Precedent Report created under each agreement (separate from the compact document). The MCC views these quarterly disbursements as part of its toolkit to manage compact resources responsibly. The MCC demands a lot from the countries it works with, and selects countries that are poised to take advantage of resources and have relatively high levels of capacity and commitment (this may be too much reporting burden for programs implemented under the other donors). If programs are not on track or are not likely to meet their goals, funding for those programs may be decreased or eliminated. However, this funding will generally be channeled toward a different program, as MCC compacts are structured so that the country is promised its total “funding envelope”, but that envelope may be flexibly distributed across priorities (subject to certain conditions). In rare cases, MCC has terminated agreements where countries have been non-cooperative. This has been mostly in force majeure situations, such as Mali and Madagascar, where political turmoil resulted in programmatic failures. Conditions in the Conditions Precedent Reports are generally respected by both the MCC and recipient countries, and MCC has made good on its promise to decrease or, if absolutely necessary, terminate MCC funds.

Guiding Principle:

Country compacts should specify clear consequences of not meeting various financing conditions in the compact.

Consequences should range from light to severe, depending on the condition that has not been met. Agreements should not be terminated for every compact breach – other consequences could include funding being delayed, or less funding being provided for a specific activity, if targets for that activity are behind or there is evidence that the activity-specific funding has been misused. Still, consequences need to be significant enough that they provide incentives for countries and donors to meet their commitments and carry out the conditions specified in compacts. The MCC strikes a good balance, by viewing disbursements as a funds management tool, delaying or reallocating funding where necessary, and only very rarely terminating agreements entirely.

31 Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
32 Although there is no information in these compacts about what happens if the MCC fails to follow through on its funding commitments
These tools also need not be “traditional” consequences that decrease or withhold donor funds. Other types of mechanisms that can hold donors and countries to their commitments should also be considered. For example, one could require that a high-level political figure widely publicize a country’s domestic funding commitment for HIV and AIDS, such as through a speech, in order to increase awareness of the commitment by civil society and the general public. In South Africa, the signing of the PFIP coincided with a visit by then U.S. Secretary of State Hillary Clinton and was widely publicized in the media. Other mechanisms could include using CSOs to help pressure all parties in a compact to fulfill commitments or requiring that financial performance be transparently published. Another tool may be Results Based Financing. For GAVI’s Health Systems Strengthening grants, countries are given additional funding after the first budget year if immunization coverage improves (or if high coverage is maintained). The Global Fund is doing something similar but more specific to sustainable financing under its New Funding Model by reserving 15% of countries’ total resource envelopes for funding that will be allocated based on governments’ willingness to pay for their own disease programs. Both the Global Fund and the MCC also cited the possibility of being awarded funding in the next “funding round” as a major incentive for countries to follow agreements and stick to their commitments.33,34 Further analysis will likely reveal other tools that can increase the leverage of a country compact, although many of these are unlikely to be components of a compact themselves (rather, they would come before or after the compact is signed).

Compacts should also be flexible in allowing countries to “get back on track” for funding if a condition has not been met but the country is showing a meaningful attempt to fix its problems associated with meeting that condition. For example, if funding has been withheld because progress was not being made on an activity, and now that activity’s targets are being reached, funding could again begin being disbursed. Or, if funding disbursements were reduced because a country was not providing promised co-financing, those funds could be replaced if the country later provides extra funding to make up for its previous nonfulfillment.

Finally, consequences should apply to both donors and recipient countries. It is hard to take a donor’s funding commitments seriously if there are no conditions to ensure that the donor meets those commitments. For example, all of PEPFAR’s PFIPs reviewed state that PEPFAR’s funding levels are non-binding estimates that are subject to congressional appropriations and future availability of funds. MCC sets a useful standard in this regard, as its agreements are structured so that a country is eligible to receive its full MCC funding amount even as priorities shift and activities’ scopes change, except in dire circumstances, and these agreements are binding treaties for both parties involved.9 GAVI also provides a good example in that it is the only donor to transparently report on an indicator that tracks its actual disbursed funding against commitments.

HIV and AIDS donors face a particular challenge since they are, in many cases, funding programs that are putting people on life-saving ART support. There is a major ethical dilemma when it comes to withholding or delaying funding, and

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33 Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
34 Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013
countries realize this and may take conditions and consequences less seriously as a result. This is likely one reason why most of the HIV and AIDS donors will not delay funding based on counterpart or domestic financing alone. In the end, donors have to be willing to draw lines and these lines have to be made clear to countries. A combination of clear consequences with clear trigger points and other incentives and methods of increasing leverage can help increase the weight of a compact.

V. Conclusions & Next Steps

The guiding principles discussed in this paper are a starting point for the development of country compacts for sustainable financing for HIV and AIDS. The compact is one tool that can ensure that countries experience smooth financing transitions when external donor funding decreases. These principles may be further developed through additional analysis, country experiences, and feedback from experts. Additional analysis of the agreements of other donors, such as DfID, were not included in this report, but would provide more information for compact development. Country compacts and other donor-country financing agreements that include domestic funding commitments are still in nascent stages for most donors (PEPFAR is only in the first few years of most of its PFIPs and the Global Fund is about to fully implement its New Funding Model), so it will be important to incorporate lessons learned from country experiences with these agreements as they occur.

Suggested next steps include:

- Reviewing more closely the programmatic targets in country compacts, in order to analyze the connection between programmatic goals and outputs, exercises to cost those programs, and the development of financing targets based on that costing.

- Additional research on “less traditional” incentives and consequences (other than withholding or delaying funding disbursements), such as CSO engagement, Results Based Financing, and using media or other forms of public engagement, could assist in producing guidance for developing compacts that, if not legally binding, at least have significant leverage.

- Adding DfID’s financing agreements to the compact inventory mix, if available, could add value by incorporating additional donor perspectives in the analysis. Currently, the only bilateral donor considered is the United States.

- Drafting country case studies by reviewing specific country experiences with donor transitions and the compacts used to guide these transitions (and speaking with relevant stakeholders in these countries) could provide additional insight into what works and what does not.

- Additional work is also needed on expenditure tracking mechanisms. While there are many tools available, some are less routinize-able and require longer turnaround time, while others create additional burden for countries. There is not a clear consensus across donors and countries on the “best” resource tracking tool, and multiple options are used across different countries, making spending comparisons difficult. Furthermore, it may be the case that
none of the current expenditure tracking systems pushed by HIV and AIDS donors (National AIDS Spending Assessments, System of Health Accounts, and Public Expenditure Reviews) are appropriate for tracking financing commitments in country compacts, in which case development of such a tool would be an important next step.

Having this report reviewed and published, including distributing it to countries and donors for comment and as possible guidance, can help ensure that the information contained here is endorsed by stakeholders and can be used to ensure that smooth and sustainable funding arrangements and transitions occur in countries.

Development of an action plan to actually implement compact guidance, once finalized and endorsed by stakeholders, will help bridge the gap between the information provided in a guidance document and the actual content of compacts and their operationalization going forward. A first step in such an action plan could be to test out some of the recommendations contained in this document in a small selection of countries. UNAIDS could also use the Economics Reference Group or another interagency task force to ensure these findings are taken from policy to practice.

Annex Table 1: Global Fund Country Compacts Inventory Matrix

<table>
<thead>
<tr>
<th>COUNTRY FEATURES</th>
<th>CAMBODIA</th>
<th>INDIA</th>
<th>JAMAICA</th>
<th>KENYA</th>
<th>MOLDOVA</th>
<th>NIGERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemic Type</td>
<td>Concentrated</td>
<td>Concentrated</td>
<td>Concentrated</td>
<td>Generalized</td>
<td>Concentrated</td>
<td>Generalized</td>
</tr>
<tr>
<td>Income Bracket</td>
<td>LIC</td>
<td>LMIC</td>
<td>UMIC</td>
<td>LIC</td>
<td>LMIC</td>
<td>LMIC</td>
</tr>
<tr>
<td>Region</td>
<td>EAP</td>
<td>SA</td>
<td>LAC</td>
<td>SSA</td>
<td>ECA</td>
<td>SSA</td>
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<table>
<thead>
<tr>
<th>COMPACT FINANCING FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Period:</td>
</tr>
<tr>
<td>3 years (2011-13)</td>
</tr>
<tr>
<td>2 years (2010-12), with 3 more possible in Phase 2</td>
</tr>
<tr>
<td>2 years (2008-10), then 3 more approved in Phase 2</td>
</tr>
<tr>
<td>3 years (2011-14)</td>
</tr>
<tr>
<td>1.5 years (2010-12)</td>
</tr>
<tr>
<td>2.5 years (2010-12)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Actors Included</th>
<th>Signees: Principal Recipient, Global Fund, CCM Chair, CSO representative of CCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Centre for HIV/AIDS, Dermatology, and STDs (PR), GF, NAC (CCM chair), HIV Programme PACT Cambodia (CSO rep.)</td>
<td></td>
</tr>
<tr>
<td>Dep’t. of Economic Affairs (PR), GF, MOH National HIV/STI (CCM chair), Suraksha (CSO rep.)</td>
<td></td>
</tr>
<tr>
<td>MOH (PR), GF, MOH National HIV/STI (CCM chair), Kenya AIDS NGOs Consortium (CSO rep.)</td>
<td></td>
</tr>
<tr>
<td>MOF (PR), GF, MOH (CCM chair)</td>
<td></td>
</tr>
<tr>
<td>Moldova Health Systems Restructuring Project (PR), GF, MOH (CCM chair), Soros Foundation (CSO rep.)</td>
<td></td>
</tr>
<tr>
<td>NACA (PR), GF, Nigeria Office of the Secretary (CCM chair), NEPWAN (CSO rep.)</td>
<td></td>
</tr>
<tr>
<td>Financing Targets (GF)</td>
<td>CAMBODIA</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Made Between: PR and GF</td>
<td>Only “first disbursement” is committed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financing Targets (country)</th>
<th>None</th>
<th>None</th>
<th>Counterpart financing requirements (10-20% of total)</th>
<th>None</th>
<th>None</th>
<th>None</th>
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</table>

<table>
<thead>
<tr>
<th>Inputs to Financing Targets</th>
<th>Detailed budget provided by PR in application</th>
<th>Combined remaining funds from previous grant and funds requested in proposal</th>
<th>None other than Standard</th>
<th>Combined remaining funds from previous grant and funds requested in proposal</th>
<th>Combined remaining funds from previous grant and funds requested in proposal</th>
<th>Combined remaining funds from previous grant and funds requested in proposal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Processes for Enforcement &amp; Monitoring</th>
<th>LFA verification, auditing, competitive sub-recipient (SR) selection, SR performance monitoring, periodic reporting</th>
<th>Regular budget and expenditure reporting</th>
<th>Quarterly update of programmatic results, Steering Committee meetings</th>
<th>None other than Standard</th>
<th>None other than Standard</th>
<th>None other than Standard</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Are these processes new or existing?</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tools for Enforcement &amp; Monitoring:</th>
<th>Annual audits, program reports,</th>
<th>Annual training plans, annually updated country profile, list of non-cash assets</th>
<th>Quarterly reports, annual training plans, PMIS data reports, SR reports</th>
<th>Counterpart financing</th>
<th>Financial reports, annual verification of fixed assets</th>
<th>None other than Standard</th>
<th>Quarterly reports, expenditure analysis, M&amp;E progress reports, Internal Audit reports.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Are these tools new or existing?</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
<th>New</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Required Output Tools &amp; Committees</th>
<th>Procurement, use, and supply management plans (PSM)</th>
<th>Financial management manual, HR manual, facility renovation workplans &amp; budgets, procurement manual, sub-recipient management plan</th>
<th>M&amp;E plan/costed action plan, SR management plan, SR workplans &amp; budgets, report on SR taxes and duties,</th>
<th>Small grants program plan</th>
<th>Back-up system and equipment, pharmaceutical &amp; health product management profile, staff TORs, financial reporting, fixed asset register, delivery kits workplan &amp; budget, past audited reports, updated ops manual, assess storage conditions</th>
<th>Establishment of a department for planning &amp; interaction between NAC, ART Treatment Section, M&amp;E Unit, MOH, and MOSPFC</th>
<th>Service mapping, national specifications for laboratory equipment</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of Programmatic Content Included</td>
<td>STANDARD FEATURES</td>
<td>CAMBODIA</td>
<td>INDIA</td>
<td>JAMAICA</td>
<td>KENYA</td>
<td>MOLDOVA</td>
<td>NIGERIA</td>
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<tr>
<td>----------------------------------------</td>
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<td>-------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Objectives, target groups, strategies or activities under each objective,</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>PR or NACA assigned to each activity (split in some cases)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consequences of not meeting conditions</th>
<th>STANDARD FEATURES</th>
<th>CAMBODIA</th>
<th>INDIA</th>
<th>JAMAICA</th>
<th>KENYA</th>
<th>MOLDOVA</th>
<th>NIGERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>If any conditions are not met, the GF can terminate or suspend the agreement.</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>None other than standard</td>
<td>2nd disbursement may not be disbursed if conditions are not met. 1st is subject to terms &amp; conditions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Terms &amp; Conditions</th>
<th>STANDARD FEATURES</th>
<th>CAMBODIA</th>
<th>INDIA</th>
<th>JAMAICA</th>
<th>KENYA</th>
<th>MOLDOVA</th>
<th>NIGERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Standard Terms &amp; Conditions below</td>
<td>None other than standard &amp; tools/outputs listed above</td>
<td>Bank account statement &amp; request letter prior to first disbursement</td>
<td>Bank account statement &amp; request letter prior to first disbursement</td>
<td>Bank account statement &amp; request letter prior to first disbursement</td>
<td>None other than standard &amp; tools/outputs listed above</td>
<td>Bank account statement &amp; request letter prior to first disbursement</td>
<td></td>
</tr>
</tbody>
</table>

**Standard Terms & Conditions:**

- Implementation in accordance with budget and approved program activities, changes must be authorized by GF
- GF may extend commitment period at its discretion
- “This agreement has been duly executed and delivered by the PR and is enforceable against the PR in accordance with its terms”
- PR not receiving funding from other sources that duplicates GF funding & informs GF of additional funding
- Cooperation with CCM & LFA, progress verification by LFA
- No disbursement unless: request for disbursement signed by PR, GF funds are available, special conditions met, previous progress reports submitted, demonstration of results consistent with performance framework targets, PR reports prices and supply information following procurement, LFA verification.
- If any conditions not met, GF can terminate or suspend the agreement
- Conditions on number and type of bank accounts (etc.), interest, revenues, taxes, duties
- Auditing: Accounting books and records maintained, PR annual financial audits using independent auditor. PR ensures audits of SRs. GF has right to audit.
- Sub-recipients: PR assesses capacity of SRs, SRs activities designed to facilitate PRs objectives/activities, copy of SR agreements to GF, PR monitors SR performance
- Progress Reports: periodic reports toward objectives and targets
- Conditions on procurement practices and policies, supply chain, products, PSM plan, adhere to WHO guidelines,
- Conditions on insurance, liabilities, conflict of interest, etc.
- PR receives unused grant funds upon termination, provides audited financial report, inventory of assets (and plan for use if requested)

Annex Table 2: PEPFAR Country Compacts Inventory Matrix

<table>
<thead>
<tr>
<th>COUNTRY FEATURES</th>
<th>ANGOLA</th>
<th>MOZAMBIQUE</th>
<th>NIGERIA</th>
<th>SOUTH AFRICA</th>
<th>TANZANIA</th>
<th>VIETNAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemic Type</td>
<td>Generalized</td>
<td>Generalized</td>
<td>Generalized</td>
<td>Generalized</td>
<td>Generalized</td>
<td>Concentrated</td>
</tr>
<tr>
<td>Income Bracket</td>
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<td>LIC</td>
<td>LMIC</td>
<td>UMIC</td>
<td>LIC</td>
<td>LMIC</td>
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<td>Region</td>
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<td>SSA</td>
<td>SSA</td>
<td>SSA</td>
<td>SSA</td>
<td>EAP</td>
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<table>
<thead>
<tr>
<th>COMPACT FINANCING FEATURES</th>
<th>ANGOLA</th>
<th>MOZAMBIQUE</th>
<th>NIGERIA</th>
<th>SOUTH AFRICA</th>
<th>TANZANIA</th>
<th>VIETNAM</th>
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</thead>
<tbody>
<tr>
<td>Time Period:</td>
<td>5 years</td>
<td>5 years</td>
<td>6 years</td>
<td>5 years</td>
<td>5 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Actors Included</td>
<td>USG and GRA (National Commission to Fight HIV/AIDS and Large Epidemics)</td>
<td>USG and GRM (multiple ministries, NAC)</td>
<td>USG and GON (leadership of NACA and FMOH)</td>
<td>USG and SAG. Signees: US Ambassador; SA Minister of Health</td>
<td>USG and URT (MOH, TACAIDS)</td>
<td>GVN and USG (Steering Committee)</td>
</tr>
<tr>
<td>Financing Targets (PEPFAR)</td>
<td>3 year budget projection. “PF funds for 2009 and 2010 are approved, the funds for 2011-13 are subject to Congressional appropriations and approval by the Global AIDS Coordinator”</td>
<td>5 year total projected contribution. “USG contributions in out-years are estimates and do not include binding funding levels. Levels are subject to congressional appropriations and based on the availability of funds”</td>
<td>6 year expected financing contribution. “All funding subject to annual Congressional appropriations process.”</td>
<td>5 year Financing Plan. “Allocation is notational and subject to Congressional appropriation and approval by the Global AIDS Coordinator”</td>
<td>5 year funds by donor. “Availability of PEPFAR resources in 2011 and beyond is subject to Congressional appropriations and approval of the US Global AIDS Coordinator”</td>
<td>5 year projected financial contribution. “USG funding is anticipated over the full 5 year PF; actual annual allocations are subject to the availability of funds and based on performance”</td>
</tr>
<tr>
<td>Financing Targets (country)</td>
<td>5 year budget projection</td>
<td>3 year total projected contribution</td>
<td>6 Year Expected Financial Contribution; GON to finance 50% of the cost for Universal Access</td>
<td>5 Year Financing Plan</td>
<td>None included</td>
<td>5 Year Projected Financial Contribution</td>
</tr>
<tr>
<td>Financing Targets (other donors)</td>
<td>Expected contributions of other donors are included</td>
<td>Expected contributions of other donors are included</td>
<td>Expected contributions of other donors are included</td>
<td>Expected contributions of other donors are included</td>
<td>Expected contributions of other donors are included</td>
<td>Expected contributions of other donors are included</td>
</tr>
<tr>
<td>Country</td>
<td>Inputs &amp; Tool for Setting Financing Targets</td>
<td>Processes for Enforcement &amp; Monitoring</td>
<td>Are these processes new or existing?</td>
<td>Do processes explicitly cover financing?</td>
<td>Tools for Enforcement &amp; Monitoring:</td>
<td>Types of Programmatic Content Included</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>ANGOLA</td>
<td>Current GRA funding extended forward, PEPFAR past COP allocations, gap based on NSP</td>
<td>High Level: annual meetings; Strategic: INLS semi-annual workshop, PFIP management group meetings; Technical: quarterly TWG and multisectoral coordination and supervisory committee meetings</td>
<td>Some new, most existing</td>
<td>No</td>
<td>Nothing financing specific</td>
<td>Goals and objectives, strategies and activities to achieve these, generally aligned with NSPs or other national HIV planning documents. General language on country ownership, transitioning certain services (all service delivery to TA in MICs), emphasis on joint planning, alignment, collaboration, information sharing, capacity building.</td>
</tr>
<tr>
<td>MOZAMBIQUE</td>
<td>GRM from budgets (3 years only), PEPFAR past COP allocations, current agreements with other donors (3 years only), Round 9 GF Proposal</td>
<td>GRM bi-annual review will include a review of financing contributions, transition progress. Twice annual SC meetings, National Directors Meetings, GRM inclusion in PEPFAR annual review process</td>
<td>Some new, some existing</td>
<td>No</td>
<td>Bi-annual review financing specific</td>
<td>None</td>
</tr>
<tr>
<td>NIGERIA</td>
<td>NSP resource needs, current WB, GF, DFID, CHAI agreements, past PEPFAR COP allocations, NASA, HAPSAT, Assumes GON provides 50% of total HIV financing by 2015.</td>
<td>Semi-annual data reviews, in-depth state monitoring by lead IPs. Twice yearly SC meetings, MC meetings every other month, monthly TTT meetings.</td>
<td>New</td>
<td>No</td>
<td>Nothing financing specific</td>
<td>None</td>
</tr>
<tr>
<td>SOUTH AFRICA</td>
<td>Past PEPFAR COP allocations, other expected donor funding (from current funding), NSP resource needs</td>
<td>Biennial PER to track expenditures. Ongoing JTWG technical sub-committee reports, and quarterly progress statements. Annual convenings to inform budgets. Biannual stakeholder review.</td>
<td>New structures, but aligned with existing SAG processes</td>
<td>No</td>
<td>Regular spending reviews using PEPFAR Expenditure Analysis and SAG BAS, APT</td>
<td>None</td>
</tr>
<tr>
<td>TANZANIA</td>
<td>Budget guidelines informed domestic spending estimates. PEPFAR based on past COP allocations. Donor funding projected forward from PER. NMSF, treatment costing exercises.</td>
<td>SC annual progress reviews and semi-annual meetings. Twice yearly TWG reviews, SC co-chair monthly meetings and information exchanges.</td>
<td>Mostly existing</td>
<td>Yes</td>
<td>Biannual PER, TAC AIDS annual reviews of donor commitments and pledges</td>
<td>Biannual PER. TAC AIDS annual reviews of donor commitments and pledges</td>
</tr>
<tr>
<td>VIETNAM</td>
<td>GVN from budget forecasts, GF from current grants, PEPFAR from past COP allocations. UNGASS 2010.</td>
<td>SC annual progress reviews and semi-annual meetings. Twice yearly TWG reviews, SC co-chair monthly meetings and information exchanges.</td>
<td>New</td>
<td>No</td>
<td>Financial commitments to be measured through the NASA</td>
<td>USG funding is subject to availability of funds and based on performance</td>
</tr>
</tbody>
</table>

**Notes:**
- **Inputs & Tool for Setting Financing Targets:**
  - **Current GRA funding extended forward, PEPFAR past COP allocations, gap based on NSP**
  - **GRM from budgets (3 years only), PEPFAR past COP allocations, current agreements with other donors (3 years only), Round 9 GF Proposal**
  - **NSP resource needs, current WB, GF, DFID, CHAI agreements, past PEPFAR COP allocations, NASA, HAPSAT, Assumes GON provides 50% of total HIV financing by 2015.**
  - **Past PEPFAR COP allocations, other expected donor funding (from current funding), NSP resource needs**
  - **Budget guidelines informed domestic spending estimates. PEPFAR based on past COP allocations. Donor funding projected forward from PER. NMSF, treatment costing exercises.**
  - **GVN from budget forecasts, GF from current grants, PEPFAR from past COP allocations. UNGASS 2010.**
- **Processes for Enforcement & Monitoring:**
  - **High Level: annual meetings; Strategic: INLS semi-annual workshop, PFIP management group meetings; Technical: quarterly TWG and multisectoral coordination and supervisory committee meetings**
  - **GRM bi-annual review will include a review of financing contributions, transition progress. Twice annual SC meetings, National Directors Meetings, GRM inclusion in PEPFAR annual review process**
  - **Semi-annual data reviews, in-depth state monitoring by lead IPs. Twice yearly SC meetings, MC meetings every other month, monthly TTT meetings.**
  - **Biennial PER to track expenditures. Ongoing JTWG technical sub-committee reports, and quarterly progress statements. Annual convenings to inform budgets. Biannual stakeholder review.**
  - **SC annual progress reviews and semi-annual meetings. Twice yearly TWG reviews, SC co-chair monthly meetings and information exchanges.**
- **Are these processes new or existing?**
  - Some new, most existing
  - Some new, some existing
  - New
  - New structures, but aligned with existing SAG processes
  - Mostly existing
  - New
- **Do processes explicitly cover financing?**
  - No
  - Yes
  - No
  - No
  - Yes
  - No
- **Tools for Enforcement & Monitoring:**
  - Nothing financing specific
  - Bi-annual review financing specific
  - Nothing financing specific
  - Regular spending reviews using PEPFAR Expenditure Analysis and SAG BAS, APT
  - Biannual PER, TAC AIDS annual reviews of donor commitments and pledges
  - Financial commitments to be measured through the NASA
- **Types of Programmatic Content Included:**
  - Goals and objectives, strategies and activities to achieve these, generally aligned with NSPs or other national HIV planning documents. General language on country ownership, transitioning certain services (all service delivery to TA in MICs), emphasis on joint planning, alignment, collaboration, information sharing, capacity building.
- **Consequences of not meeting conditions:**
  - None
  - None
  - None
  - None
  - None
  - USG funding is subject to availability of funds and based on performance
## Annex Table 3: World Bank Country Compacts Inventory Matrix

<table>
<thead>
<tr>
<th>COUNTRY FEATURES</th>
<th>AFGHANISTAN</th>
<th>BOTSWANA</th>
<th>INDIA</th>
<th>JAMAICA</th>
<th>KENYA</th>
<th>NIGERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epidemic Type</strong></td>
<td>Concentrated</td>
<td>Generalized</td>
<td>Concentrated</td>
<td>Concentrated</td>
<td>Generalized</td>
<td>Generalized</td>
</tr>
<tr>
<td><strong>Income Bracket</strong></td>
<td>LIC</td>
<td>UMIC</td>
<td>LMIC</td>
<td>UMIC</td>
<td>LIC</td>
<td>LMIC</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>Asia/Mid-East</td>
<td>SSA</td>
<td>Asia/Mid-East</td>
<td>LAC</td>
<td>SSA</td>
<td>SSA</td>
</tr>
</tbody>
</table>

### COMPACT FINANCING FEATURES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time Period:</strong></td>
<td>3.25 years; (Sept 2007 – Dec 2010)</td>
<td>4.5 years; (Jan 2009 – Sept 2013)</td>
<td>4.5 years; (June 2013 – Dec 2017)</td>
<td>4.25 years; (June 2008 – Nov 2012)</td>
<td>4.5 years; (July 2007 – Dec 2011)</td>
<td>3 years; (Nov 2010 – Dec 2013)</td>
</tr>
<tr>
<td><strong>Main Implementer</strong></td>
<td>MOPH</td>
<td>NACA, DAC, CSOs/private sector, ministries</td>
<td>MOH, other line ministries, private sector, CSOs</td>
<td>MOH, other line ministries, private sector, CSOs</td>
<td>Other line ministries, private sector, CSOs</td>
<td>Other line ministries, private sector, CSOs</td>
</tr>
<tr>
<td><strong>Other Implementers</strong></td>
<td>MOF, other ministries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Financing Targets

<table>
<thead>
<tr>
<th>Financing Targets (WB)</th>
<th>Loan from IBRD to Botswana</th>
<th>Grant from IDA to Afghanistan</th>
<th>Credit from IDA to India</th>
<th>Loan from IBRD to Jamaica</th>
<th>Grant from DFID (IDA coordinates); Credit from IDA to Kenya</th>
<th>Credit from IDA to Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing Targets (country)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Commitment from Kenya to fund 20 M shillings.</td>
<td>Nigeria “causes states to ensure SACAs fund $100,000”</td>
</tr>
<tr>
<td>Financing Targets (other donors)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>DFID grant (IDA administers)</td>
<td>None</td>
</tr>
</tbody>
</table>

### Inputs & Tool for Setting Financing Targets

<p>| Not specified | Not specified | Not specified | Not specified | Not specified | DFID funding already determined by Kenya/DFID | Not specified |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Processes for Enforcement &amp; Monitoring</th>
<th>Are these processes new or existing?</th>
<th>Do processes explicitly cover financing?</th>
<th>Tools for Enforcement &amp; Monitoring</th>
<th>Are these tools new or existing?</th>
<th>Other Required Processes &amp; Tools (related to financing)</th>
<th>Types of Programmatic Content Included</th>
<th>Consequences of not meeting conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Financing: Quarterly and annual financial reporting, Non-Financing: Specific: annual planning by Planning Committee, annual and semi-annual project reporting</td>
<td>New</td>
<td>Yes</td>
<td>Financing: Quarterly financial reports (audited annually), Non-Financing: Specific: semi-annual project reports, integrated annual reports</td>
<td>New</td>
<td>Financial Management Manual, Annual workplans, including budgets</td>
<td>High risk groups, knowledge, reducing stigma, advocacy, comms capacity building</td>
<td>Not specified</td>
</tr>
<tr>
<td>Botswana</td>
<td>Financing: Financial reporting Non-Financing: Specific: twice yearly SC and technical sub-committee meetings, semi-annual reporting (Botswana), annual reporting (NACO, ministries, non-state)</td>
<td>New</td>
<td>Yes</td>
<td>Financing: Quarterly financial reports, annual audited financial statements Non-Financing: Specific: semi-annual project reports, annual progress reports (NACA, ministries, non-state actors), mid-term review</td>
<td>New</td>
<td>Annual workplans (budgets not specified) Backlogged audited reports</td>
<td>NACA capacity building, prevention/ mitigation</td>
<td>Not specified</td>
</tr>
<tr>
<td>India</td>
<td>Financing: Semi-annual financial reporting (India, DAC/ NACO, SACs, subgrantees) Non-Financing: Specific: Semi-annual project reporting</td>
<td>New</td>
<td>Yes</td>
<td>Financing: Quarterly financial reports, audited annually Non-Financing: Specific: quarterly project reports</td>
<td>New</td>
<td>Annual workplans, including budgets</td>
<td>Targeted prevention, BCC, institutional strengthening</td>
<td>Not specified</td>
</tr>
<tr>
<td>Jamaica</td>
<td>Financing: Quarterly financial reporting (Jamaica, MOH, line ministries, less frequently for CSOs and private sector), auditing Non-Financing: Specific: Quarterly project reporting</td>
<td>New</td>
<td>Yes</td>
<td>Financing: Annual audited financial statements (NACC) Non-Financing: Specific: annual project reports on programmatic indicators (NACC), mid-term review with IDA (Kenya)</td>
<td>New</td>
<td>Annual consolidated workplan (budgets not specified)</td>
<td>Targeted prevention, access to treatment, management strengthening, capacity building</td>
<td>Not specified</td>
</tr>
<tr>
<td>Kenya</td>
<td>Financing: Annual financial reporting, auditing Non-Financing: Specific: annual project reporting, progress monitoring through Inter-Agency Coordinating Committee &amp; Steering Committee</td>
<td>New</td>
<td>Yes</td>
<td>Financing: Annual audited financial statements from Nigeria, subgrantees Non-Financing: Specific: quarterly project reports (NACA, states)</td>
<td>New</td>
<td>Subsidiary agreement with one state; annual workplans &amp; budgets</td>
<td>Prevention interventions, focus on target populations, grounded in KNASP</td>
<td>Not specified</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Financing: Financial reporting (by Nigeria, subgrantees, NACA, SACAs) &amp; auditing. Periodic budgeting Non-Financing: Specific: Annual project reporting</td>
<td>New</td>
<td>Yes</td>
<td>Financial reporting (by Nigeria, subgrantees, NACA, SACAs) &amp; auditing. Periodic budgeting Non-Financing: Specific: Annual project reporting</td>
<td>New</td>
<td>Subsidiary agreement with one state; annual workplans &amp; budgets</td>
<td>Scaling up prevention, access. Capacity building &amp; TA for management</td>
<td>Not specified</td>
</tr>
<tr>
<td>Terms &amp; Conditions</td>
<td>AFGHANISTAN</td>
<td>BOTSWANA</td>
<td>INDIA</td>
<td>JAMAICA</td>
<td>KENYA</td>
<td>NIGERIA</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Afghanistan responsible for MOPH carrying out the project in accordance with other terms in the agreement. Afghanistan must follow the budget contained in the agreement (but only two line items for everything). Other specific terms of payment dates, withdrawal etc.</td>
<td>Afghanistan responsible for ensuring the project is carried out under NACA, in accordance with Operational Manual, other terms in agreement. Botswana must follow the budget contained in the agreement (but only one line item for everything). Other specific terms of repayment, interest, schedule, etc.</td>
<td>India responsible for ensuring DAC/NACO carry out the project in accordance with Project Strategic Plan and other terms in agreement. India must follow the budget contained in the agreement. Other specific terms of repayment, interest, schedule, etc.</td>
<td>Jamaica responsible for ensuring the project is implemented through MOH, ministries, CSOS, private sector – in accordance with operations manual &amp; terms in agreement. Jamaica must follow the budget contained in the loan agreement. Other specific terms of repayment, interest, schedule, etc.</td>
<td>Kenya responsible for ensuring NACC carries out the project in accordance with criteria and procedures in operations manual, including financing, &amp; terms in agreement. Kenya must spend the grant/credit following an agreed upon budget. Other specific terms of repayment, interest, schedule, etc.</td>
<td>Nigeria responsible for NACA and SACAs carrying out the project in accordance with project implementation manual, terms in agreement. Nigeria must spend the credit following an agreed upon budget. Other specific terms of repayment, interest, schedule, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Annex Table 4: MCC Country Compacts Inventory Matrix

<table>
<thead>
<tr>
<th>COUNTRY FEATURES</th>
<th>MOLDOVA</th>
<th>MOZAMBIQUE</th>
<th>TANZANIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epidemic Type</strong></td>
<td>Concentrated</td>
<td>Generalized</td>
<td>Generalized</td>
</tr>
<tr>
<td><strong>Income Bracket</strong></td>
<td>LMIC</td>
<td>LIC</td>
<td>LIC</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>Eastern Europe/Central Asia</td>
<td>SSA</td>
<td>SSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPACT FINANCING FEATURES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time Period:</strong></td>
<td>5 years</td>
</tr>
<tr>
<td><strong>Actors Included</strong></td>
<td>Agreement Between: USA, Moldova Acting Through: MCC, Government of Moldova Signees: MCC CEO, Deputy Prime Minister of Foreign Affairs Other Agreement gets ratified by the Moldovan Parliament Government designates MCA-Moldova as the accountable entity</td>
</tr>
<tr>
<td><strong>Financing Targets (WB)</strong></td>
<td>Grants with an upper limit and multiple disbursements (Program Funding &amp; Implementation Funding), subject to terms of Compact.</td>
</tr>
<tr>
<td><strong>Guiding Principles for Compact Development</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Financing Targets</strong></td>
<td></td>
</tr>
<tr>
<td>(country)</td>
<td></td>
</tr>
<tr>
<td>MOLDOVA: The Government will provide all funds and other resources necessary to carry out the Government’s responsibilities and obligations under the Compact.</td>
<td></td>
</tr>
<tr>
<td>MOZAMBIQUE: The Government will provide all funds and other resources necessary to carry out the Government’s responsibilities and obligations under the Compact.</td>
<td></td>
</tr>
<tr>
<td>TANZANIA: The Government will provide all funds and other resources necessary to carry out the Government’s responsibilities and obligations under the Compact.</td>
<td></td>
</tr>
<tr>
<td>Financing Targets (other donors)</td>
<td></td>
</tr>
<tr>
<td>MOLDOVA: Yes, mostly with USAID and World Bank, also OECD, UN, EU</td>
<td></td>
</tr>
<tr>
<td>MOZAMBIQUE: Yes, through Working Groups – mostly the World Bank and also USAID and other donors (DFID, etc.)</td>
<td></td>
</tr>
<tr>
<td>TANZANIA: Yes, through groups (e.g. Joint Technical Committee) of many donors, mostly with World Bank and USAID.</td>
<td></td>
</tr>
</tbody>
</table>

| **Inputs & Tool for Setting Financing Targets** |
| MOLDOVA: Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact. |
| MOZAMBIQUE: Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact. |
| TANZANIA: Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact. |

| **Processes for Enforcement & Monitoring** |
| MOLDOVA: Regular accounting and book-keeping by the Government and “Covered Providers” (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing. |
| MOZAMBIQUE: Regular accounting and book-keeping by the Government and “Covered Providers” (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing. |
| TANZANIA: Regular accounting and book-keeping by the Government and “Covered Providers” (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing. |

| **Are these processes new or existing?** |
| MOLDOVA: New |
| MOZAMBIQUE: New |
| TANZANIA: New |

| **Types of Programmatic Content Included** |
| MOLDOVA: Compact Goal, Program Objective, and Project Objectives (2 projects). Much more detailed programmatic information on what the MCC Funds should be spent on. Plans for sustainability are included (e.g. amended Road Fund Law to provide reliable mechanism for adequate road maintenance funding) |
| MOZAMBIQUE: Compact Goal, Program Objective, and Project Objectives (4 projects). Much more detailed programmatic info on what the MCC funds should be spent on. There is a section under 1 of the projects on financial sustainability. |
| TANZANIA: Compact Goal and Project Objectives (3 projects). Much more detailed programmatic info on what the MCC funds should be spent on. There is also an HIV component in this project (incorporating HIV awareness programs into implementation). |

| **Consequences of not meeting conditions** |
| MOLDOVA: MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds. |
| MOZAMBIQUE: MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds. |
| TANZANIA: MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds. |

| **Funding-Specific Conditions** |
| MOLDOVA: The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically. |
| MOZAMBIQUE: The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically. |
| TANZANIA: The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically. |
Acknowledgments

The author would like to thank the Planning Institute of Jamaica and the Ministry of Health for their contribution to the assessment process. We would like to extend our gratitude to the Fund Portfolio Manager, country UNAIDS representative as well as other Global Fund staff members and, most importantly, the country partners and respondents who devoted their time to this assessment.

Disclaimer

The report was commissioned by UNAIDS Strategic Information and Evaluation Department, Geneva. The views expressed herein are those of the author and does not necessarily reflect the opinion of the UNAIDS or Curatio International Foundation.

Jamaica Transition Preparedness Assessment Team:

Team leader - Ketevan Chkhatarashvili MD. MPH.
International consultant - Mzia Tabatadze MD. MPH.
Local consultant – Sherrian Grey
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
</tr>
<tr>
<td>CARPHA</td>
<td>Caribbean Public Health Agency (CARPHA)</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordination Mechanism</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>CIF</td>
<td>Curatio International Foundation</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organizations</td>
</tr>
<tr>
<td>EEI</td>
<td>Enabling Environment Index</td>
</tr>
<tr>
<td>EMCTC</td>
<td>Elimination of mother-to-child transmission</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>GARP</td>
<td>Global AIDS Response Progress</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HFLE</td>
<td>Health and Family Life Education</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IBRD</td>
<td>International Bank for Reconstruction and Development</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources in Health</td>
</tr>
<tr>
<td>JASL</td>
<td>Jamaica AIDS Support for Life</td>
</tr>
<tr>
<td>J-FLAG</td>
<td>The Jamaica Forum of Lesbians, All-Sexual and Gays</td>
</tr>
<tr>
<td>KAP</td>
<td>Key Affected Populations</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>LMIS</td>
<td>Logistics management Information System</td>
</tr>
<tr>
<td>MERG</td>
<td>Jamaica Monitoring and Evaluation Reference Group</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NASA</td>
<td>National AIDS Spending Assessment</td>
</tr>
<tr>
<td>NHDRRS</td>
<td>National HIV-related Discrimination Reporting and Redress System</td>
</tr>
<tr>
<td>NHF</td>
<td>National Health Fund</td>
</tr>
<tr>
<td>NHP</td>
<td>National HIV/STI Programme</td>
</tr>
<tr>
<td>NFPB-SHA</td>
<td>National Family Planning Board and Sexual Health Agency</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSEP</td>
<td>Needle and Syringe Exchange Programs</td>
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<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<tr>
<td>PAHO/WHO</td>
<td>Pan American Health Organization/World Health Organization</td>
</tr>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PIOJ</td>
<td>Planning Institute of Jamaica</td>
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<td>PLACE</td>
<td>Priority for Local AIDS Control Effort</td>
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<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SW</td>
<td>Sex Worker</td>
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<td>TG</td>
<td>Transgender People</td>
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<td>TGF</td>
<td>The Global Fund</td>
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<tr>
<td>TPA</td>
<td>Transition Preparedness Assessment</td>
</tr>
<tr>
<td>UMIC</td>
<td>Upper-middle income country</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>United Nations Development Program</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Executive Summary

The Jamaica country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program that examines the country’s disease program readiness for transition from external support. The research intends to understand the factors affecting HIV program sustainability and aims at informing a smooth and effective transition planning process from the Global Fund support in Jamaica. The assessment has utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees included government officials, donor representatives, staff from international organizations, and civil society members, among others.

Transition preparedness assessment singles out system wide and programme level bottlenecks that may impede sustainability of the national HIV response in Jamaica. A summary score of transition risk (26.92%) indicates that the country is exposed to high to moderate transition risk. Carefully designed transition planning is needed to ensure that public health gains achieved through the concerted efforts from the Government of Jamaica and donor-funded programs are sustained after the GF funding ends. Findings presented in the report follows the TPA framework and are organized around two overarching domains: external environment and internal environment, and various sub-components under each major domain.

External Environment

Political Environment: GoJ declares its commitment to its population’s health, however state investments in health have not been steadily increasing over the last five years. The share of government spending on health out of General Government Expenditure in 2014 remained below the mean of that for upper-middle income countries. Per capita health expenditure (current US$) by the State, as well as the Total Health Expenditure as a percentage of GDP declined in 2014.

Existence of numbers of discriminatory laws in Jamaica also poses high risk to program transition and sustainability of progresses achieved in terms of reversing HIV epidemic, especially among KAPs. The laws criminalizing anal sex contacts, transactional sex and drug use create substantial service barriers and drive at-risk populations underground. Furthermore, such laws may impose limitation on the government to fund CSOs for providing HIV services that specifically target persons engaged in criminalized behaviors.

Economic environment: Jamaica’s GDP has been increasing over the last few years but at a very low rate averaging less than 1 percent a year. The country’s debt to GDP ratio was estimated at 146.2 percent of GDP in March 2013, making the country one of the most indebted middle income nations in the world.1. Less conducive macro-economic environment along with huge debt burden may limit government’s ability to assume full financial responsibility for the HIV program interventions currently funded through the GF. The World Bank classification of Jamaica as an upper middle-income country has resulted curtailed funding to the country. In addition, Jamaica as a small island and developing state is susceptible to external shocks that further exacerbates the country’s vulnerability.

1 Jamaica’s National Integrated Strategic Plan for Sexual and Reproductive Health & HIV 204-2019, p. 42
Internal Environment

**Financial resources:** While AIDS spending data for recent years is not available, latest NASA data indicates that in FY 2012/2013, the GoJ covered only one fifth of the AIDS total spending, largely using borrowed funding from IBRD. There are numbers of HIV interventions that remain largely or solely dependent on the GF funding that poses significant risk to financial sustainability of HIV national response.

**Human resources:** There is a severe shortage of HR in health sector in general, including HIV field with the highest gap in non-medical/support staff. In addition, HR costs for HIV remain largely dependent on external support and after transitioning, staff shortage might become even worse if the GoJ is unable to absorb the costs of human resources currently paid by donors. Development of a HR policy for medical and non-medical personnel involved in HIV field will be needed to mitigate HR-related risks. Institutionalization of donor-supported training programs into formal educational system should be ensured to ensure sustainability.

**Information Systems:** Substantial efforts have been made in the country to refine treatment and prevention databases in Jamaica in recent years, but there are still weaknesses in data collection and analysis that need to be addressed during transition period. Second generation surveillance studies have been regularly conducted in the country among different KAPs that have been largely financed by the external donors. Advocacy should be intensified to ensure that the Government starts allocating adequate financial resources to HIV surveillance and research studies to ensure sustainability. Furthermore, using more robust methodologies for surveillance studies needs to be institutionalized to improve the validity and reliability of epidemiological data that should inform HIV programming and budget allocation decisions.

**Governance:** HIV/AIDS has been declared as a priority by the Government, but to assure adequate transition towards sustainability of HIV national response, the declaration is to be substantiated with credible funding allocation from the State and with legislative amendments. The National Integrated Strategic Plan (2014-2019) that is costed and is accompanied with M&E plan needs to be approved by the Government resolution to ensure that NISP has more legal power to drive adequate allocations within the national budget.

Integration of HIV national response into the National Family Planning Board has been a positive signal that the GoJ strives to increase coordination and optimize country response that is key to sustainability. However, coordination functions and modes of operation of NFPBM/CCM should be further defined and strengthened during transition period through national level consultations involving civil society organizations among others.

**Accountability:** National surveillance system of MoH produces epidemiological profiles and Global AIDS Response Progress (GARP) reports annually, and the NASA reports biannually and make them publicly accessible. However, the quality and timeliness of reporting, particularly that for spending data should be improved.

**Programme**

Service delivery: Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program
sustainability. However, ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates also need to be improved. PMTCT has been very successful in terms of sharp reduction in AIDS pediatric cases and the country currently moves towards elimination of MTCT. Despite program achievements, structural barriers, stigma and discrimination, and weak HIS are limiting country’s ability to better track service coverage and treatment outcome indicators, and these challenges need to be addressed during transition.

CSO engagement: Jamaica Government has supported engagement of civil society organizations in HIV service provision, including ARV treatment services. There are no laws that would restrict the state to contract CSOs for health service delivery. Thorough assessment of social contracting mechanisms should be conducted to identify and address potential barriers. A national dialogue between the Government and civil society should be initiated to find out most feasible ways for sustainability of CSOs engagement in service provision under the public funds.

Organizational Capacity: There is a strong national programme management capacity within the MoH that serves as TGF PR and manages the national HIV programme. Recent decision of the GoJ to integrate HIV national programme into the National Family Planning Board has emerged a new player into the HIV response management scene. Therefore, significant technical assistance and capacity building interventions will be warranted to expand program management skills to both, existing and newly recruited staff of the NFPB-SHA. CSOs capacity should be strengthened in managing programs under the public funds as well as in fundraising.

The GF procurement and supply chain management is integrated into the national system that is positive factor to make transition smoother. However, Jamaica experiences frequent stock-out of ARV drugs and reasons should be explored and addressed within the transition plan. In 2015, the mean price of ARV drugs in Jamaica was substantially higher than the mean price for upper-middle income countries. The procurement and supply chain management system in Jamaica should be thoroughly assessed to identify system challenges and overhaul the national PSM system.

Transition planning: Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund Funding occurs. The GoJ has demonstrated strong political will to ensure smooth and full transition of HIV national response from external support to country ownership. Country major donors - the Global Fund and USAID are committed to support the country during the transition period. All above mentioned provide solid ground for optimism that Jamaica in collaboration with the GF and other development partners will make concerted efforts to address major challenges identified through the assessment, and will design and implement a well-conceptualized transition plan to ensure HIV program sustainability after the GF funding ends.

The Table 1 present the summary of transition preparedness assessment for HIV national response in Jamaica. For better visualization, risk zones for each domain and subdomain are color-coded. Detailed description of the assessment’s findings, and a list of major recommendations can be found in the main body of the report below.
## T.1 TRANSITION PREPAREDNESS ASSESSMENT FOR HIV/AIDS - SUMMARY TABLE

<table>
<thead>
<tr>
<th>COMPONENT ID</th>
<th>INDICATOR ID</th>
<th>INDICATOR DESCRIPTION</th>
<th>DESCRIPTION</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXTERNAL ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PG1</td>
<td>Existence of political will to prioritize health investments</td>
<td>Share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that is below the mean for UMIC (12% in 2013). Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. There are no regulations/laws that would prevent the Government from CSO contracting. According to the stakeholders, the ministry of Education, Ministry of Social Security, as well as Ministry of Health have practiced CSO contracting under the public funds.</td>
<td>High Risk</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>PH2, PH3</td>
<td>Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases &amp; Rule of Law</td>
<td></td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>PG4, PG5</td>
<td>Government ability to contract with CSOs; CSO contracting practices</td>
<td>Ministry of Social Security, as well as Ministry of Health have practiced CSO contracting under the public funds.</td>
<td>Low Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EG1</td>
<td>Favourable economic indicators</td>
<td>GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year. The country still faces substantial debt-burden and according to the World Bank, Jamaica’s debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014. The share of General Government Revenues as % of GDP has been stably high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013. This indicator is above the mean for the same income group countries - 28.9% in 2012.</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td>INTERNAL ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>INPUTS</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Financial Resources</td>
<td>FH1</td>
<td>Budgetary commitment to disease</td>
<td>HIV budget lines are included in the Jamaica multi-year national budget. The latest NASA report provides AIDS spending data by various program areas, however cross-tabulation of spending by prevention priorities, by beneficiary groups and by financial sources is not available. Goals Model impact</td>
<td>High Risk</td>
<td>High risk</td>
</tr>
<tr>
<td></td>
<td>FH2</td>
<td>Prevention priority</td>
<td></td>
<td></td>
<td>High Risk</td>
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<td>INDICATOR ID</td>
<td>INDICATOR</td>
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<td>RISK CATEGORY</td>
<td>RISK SCORE</td>
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<tr>
<td></td>
<td>FH3</td>
<td>Allocative efficiency</td>
<td>assessment study, &amp; Modes of Transmission study were conducted in Jamaica. HIV program financial sustainability study was also completed. Unit costs of comprehensive package of HIV prevention targeting KAPs has been conducted for the USAID/PEPFAR project; established unit costs can be applied for planning and projection purposes. Budget allocations have been informed by these studies. HIV screening tests, ARV drugs are partially funded from public sources. The Government’s share in financing treatment adherence costs is minimal. The exact share of public funding in financing these services is not known. The assumption is based on the stakeholders’ opinion.</td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FH4</td>
<td>Treatment / input financing from public sources</td>
<td></td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FH5</td>
<td>Prevention financing from public sources</td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HRH1</td>
<td>Sufficient human resources for disease (quantities, geographic distribution and aging)</td>
<td>The full time equivalent of currently deployed health care workers (HCWs) in HIV response is 62% of the optimal level required with the largest gap in non-medical, support staff. The number HCWs providing HIV treatment services has not kept the pace with the increased number of patients. Substantial portion of staff training remains heavily relied on donor-supported grants. Only some training, mostly training about HIV/AIDS clinical management have been institutionalized into formal curricula of medical schools. Majority training for non-medical staff has not been institutionalized into formal education system. A policy for production of CSO personnel/ non-medical, social support services does not exist. Stakeholders confirm that donor-funded HR salaries in most cases are aligned with national pay-scale. However, substantial portion of HR costs still is covered by external support.</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>HRH2, HRH3, HRH4</td>
<td>Institutionalization of donor supported programs; Existence of policy for production/training of CSO personnel (non medical, social service); Donor funded HR salaries aligned with national pay-scale</td>
<td></td>
<td>High Risk</td>
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</tr>
<tr>
<td></td>
<td>HISH1</td>
<td>Routine statistical reporting - Integration in the national system</td>
<td>HIV Program data is integrated into the national system; however, the quality of reporting is suboptimal. ARV and PMTCT data from private providers is not integrated; pediatric treatment data is not completely integrated. AIDS treatment database is operational with limited capacity for data disaggregation by KAPs, age, gender, regions, etc. Prevention database does not exclude double-counting of beneficiaries; data about transgender, or homeless drug users, out-of-school youth, adolescents at risk of HIV- are either limited or unavailable. Under the PEPFAR funding</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>HISH2</td>
<td>Routine statistical reporting - Level of advancement</td>
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<td>High Risk</td>
<td></td>
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<tr>
<td>COMPONENT ID</td>
<td>INDICATOR ID</td>
<td>INDICATOR DESCRIPTION</td>
<td>GOVERNANCE</td>
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<td>-------------</td>
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<td>------------------------</td>
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<tr>
<td>HISH3</td>
<td>HIV Second generation surveillance - Methodologies, Timeliness</td>
<td>being developed but has not yet been implemented at the national level. KABP among general population is based on solid research methodology. PLACE studies (Bio-BSS) among KAPs used convenience sampling and therefore, study findings lack robustness. In 2016, through USAID support RDS methodology will be introduced for Bio-BSS among MSM. PSE studies have not been conducted. Upcoming BBSS (USAID/PEPFAR) among MSM will be combined with PSE study. Bio-BSS studies have been financed through external funds. Only some research staff salaries are covered by the Government. Population Size Estimation studies have never been conducted and most estimates for KAPs are based on experts’ opinion.</td>
<td>High Risk</td>
<td></td>
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</tr>
<tr>
<td>HISH4</td>
<td>HIV Second generation surveillance - Funding from public sources</td>
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<td>High Risk</td>
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**GOVERNANCE**

<table>
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<tr>
<th>Governance</th>
<th>GovH1</th>
<th>Strong political commitment to diseases</th>
<th>High Risk</th>
<th>High Risk</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>GovH2</td>
<td>Strong leadership</td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GovG3</td>
<td>Strong coordination mechanisms</td>
<td>Moderate Risk</td>
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<tr>
<td>COMPONENT ID</td>
<td>INDICATOR ID</td>
<td>INDICATOR</td>
<td>DESCRIPTION</td>
<td>INDICATOR RISK CATEGORY</td>
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<td>------------------------</td>
</tr>
<tr>
<td>Accountability</td>
<td>AH1</td>
<td>Programme performance results are available and accessible through public domain</td>
<td>HIV Epidemiological Profile is being prepared by HIV/STI National Programme. Reports are available publicly. Data for some KAPs is not available; data disaggregation and analytical part remain weak. Global AIDS Response Progress (GARP) reports are produced and available on the UNAIDS website. Funding matrix files can be obtained upon request. As of September 2016, last AIDS spending data submitted to UNAIDS was from FY2012/2013. NASA reports up to FY2012/2013 are available. However, cross-tabulation of spending by beneficiary populations all program areas by financial sources is not available. Program evaluation specific reports are not available. Only GARP report and GF PUDR provides some outcome indicators.</td>
<td>Low Risk</td>
</tr>
<tr>
<td>AG2</td>
<td>Enabling Environment for Civil Society engagement</td>
<td></td>
<td>Low Risk</td>
<td></td>
</tr>
</tbody>
</table>

**PROGRAMME**

<p>| Service Delivery | SH1 | Treatment | Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years, did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Treatment cascade is suboptimal. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV is declining over the last three years-from 90% in 2013 to 60% in 2015. PMTCT is integrated with PHC/Maternity care. PMTCT services are available for pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. HIV and TB services are integrated within the PHC system. Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV. The coverage of general population with testing has been on rise since 2004. Data based on rigorous Bio-SSSs regarding the two indicators - coverage of MSM and sex workers with prevention services is missing; therefore the indicators were qualified as “worsening” the coverage. The MoH has practiced social contracting mechanism in health sector. | High Risk | Moderate Risk |
| SH2 | Integrated services | | Low Risk | | |
| SH3 | Key populations reach with preventive services | | High Risk | | |
| SG4 | CSOs contracting in health | | Low Risk | | |</p>
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>INDICATOR ID</th>
<th>INDICATOR DESCRIPTION</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Capacity</td>
<td>OH1</td>
<td>Strong management of the National Disease Programme Management Entity</td>
<td>Low Risk</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td></td>
<td>OH2</td>
<td>Procurement &amp; Supply Management</td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OH3</td>
<td>Monitoring &amp; Evaluation</td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td>Transition Planning</td>
<td>TH1</td>
<td>Legally binding and actionable Transition plan / Transition elements</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TH2</td>
<td>Transition plan / Transition elements characteristics</td>
<td>High Risk</td>
<td></td>
</tr>
</tbody>
</table>

**TRANSITION RISK SCORE FOR HIV/AIDS**

26.92% High to moderate risk
1. Introduction

The country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program. The assessment examines the country’s disease program readiness for transition from external support. The TPA identifies areas of high, moderate or low risk for successful transition and outlines necessary steps towards programming for sustainable transition. The assessment follows the TPA Framework for data collection, analyses and transition risk assignment. The TPA Framework was developed by Curatio International Foundation with The Global Fund financial support. Details of the TPA Framework are provided in the Reference source not found.

The Global Fund definitions of transition and sustainability are used in the report:

**Transition** is “as the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate”.

**Sustainability** - “the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors”.

The TPA findings provide valuable information primarily to the national stakeholders for the transition plan development / update. In addition, the assessment findings will be useful for the donors to guide the country in the transition process.

2. Methodology

The assessment has utilised mixed methods for data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders: government officials, donor representatives, staff from international organizations, and civil society members, and those directly working with the donor supported programs. They were identified based on their relationship with these grants as well as through the snowball technique. The quantitative and qualitative data were triangulated in line with the TPA framework domains, sub-domains and components.

During the country mission on September 5-13, 2016, the CIF consultant met and interviewed more than 50 individuals including representatives from the Planning Institute of Jamaica; Ministry of Health; Ministry of Education; Ministry of Finance; Ministry of Labor and Social Security and other government agencies; UNAIDS local and regional team; representatives from USAID and numbers of local civil society organizations targeting PLHIV, MSM, sex workers and other vulnerable populations (see Annex 5). No site visits were conducted; instead,
skype conference calls were organized with Regional Health Authorities.

More than 60 documents and online sources were reviewed that included national level documents about national budgets, health sector development, HIV/STI strategic plans, the Global Fund concept notes and progress reports, National AIDS Spending Assessment reports, Global AIDS Response Progress (GARP) reports, HIV related surveys, USAID assessment report, biological-behavioral surveillance surveys, other operational researches and publications. (Annex #4)

3. Setting the Stage

3.1 The Context

Jamaica, is the largest English-speaking island in the Caribbean region. Jamaica gained independence from British colonial rule half a century ago in 1962. In 2010, Jamaica was classified as an upper middle-income country. In 2015 the Gross National Income (Atlas Method, current US$) reached US$ 5,010 in per capita terms. Jamaica is ranked in the “high human development” category (with HDI 0.719) of the UN’s 2014 Human Development index.3

Total population of Jamaica has been slowly but steadily increasing over the last decade and reached 2,725,941 in 2014.3 Low population growth and slightly increasing life expectancy at birth have resulted in aging the population, and the share of youth aged 0-14 years has decreased from 27.1% in 2010 to 23.6% in 2015.3

- Population - 2.8 million3
- GDP per capita (current US$) – 5,138 in 20153
- HIV epidemic type – Generalized and concentrated epidemic6
- Number of PLHIV - 29,3646
- HIV prevalence:6
  - Adults – 1.62%
  - MSM – 33%
  - Sex workers – 2.9
  - ANC attendees -0.35%

### JAMAICA- COUNTRY KEY INDICATORS (WORLD BANK DATA BASE)4

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, total</td>
<td>2,690,824</td>
<td>2,699,838</td>
<td>2,707,805</td>
<td>2,714,734</td>
<td>2,721,252</td>
<td>2,725,941</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>0.35</td>
<td>0.33</td>
<td>0.29</td>
<td>0.26</td>
<td>0.24</td>
<td>0.20</td>
</tr>
<tr>
<td>Life expectancy at birth, total (years)</td>
<td>74.8</td>
<td>75.1</td>
<td>75.3</td>
<td>75.5</td>
<td>75.7</td>
<td></td>
</tr>
</tbody>
</table>

3 Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience
Jamaica is still struggling with high levels of crime, poverty and unemployment. General unemployment rate though slightly declining from 14.3% (2012) to 13.2% in 2014, increased to 13.7% as of April 2016. Unemployment among youth is even higher at double the national average – 29.2%; the average unemployment rate for women is almost double that for men: 18.6% versus 9.6 percent. High levels of unemployment, particularly among youth and young girls have contributed to the development of transactional sexual relationships, and encouraged intergenerational sexual activity between younger women to achieve economic security.

Over the last few years, the burden of communicable diseases in Jamaica is declining and burden of non-communicable diseases is on rise. Recent national surveys among adults 15-74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes. The ageing of the Jamaican population leads to increasing trend in prevalence of chronic diseases. Nonetheless, HIV/AIDS still ranks among the top 10 causes of premature death in Jamaica.

### Health System brief overview

The Jamaican health sector is comprised of both public and private entities. The Ministry of Health is responsible for ensuring that quality health services are delivered to the population effectively and efficiently in accordance with established standards and regulations. Healthcare system was decentralized in 1998 when a law was passed to establish four regional health authorities to deliver health services to the populations in specific geographic locations in all 14 parishes. Ministry of Health Headquarter performs steering function by developing policy, standards and regulations, monitoring and evaluation, and proposing relevant legislation to Parliament.

The healthcare system is divided into tiers: primary, secondary and tertiary. Health services are provided by both, public and private entities. NGOs also provide health services to the public. There are 384 primary health care centers that refer patients to secondary and tertiary care as appropriate. The MOH public health sector has 24 secondary-level hospitals providing hospitalization and surgery, and 5 Tertiary care hospitals providing

<table>
<thead>
<tr>
<th>GDP per capita (current US$)</th>
<th>4902</th>
<th>5332</th>
<th>5446</th>
<th>5254</th>
<th>5119</th>
<th>5138</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI per capita, Atlas method (current US$)</td>
<td>4570</td>
<td>4810</td>
<td>5240</td>
<td>5300</td>
<td>5200</td>
<td>5010</td>
</tr>
<tr>
<td>Health expenditure, total (% of GDP)</td>
<td>5.3</td>
<td>5.2</td>
<td>5.7</td>
<td>5.9</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Health expenditure per capita (current US$)</td>
<td>255.7</td>
<td>273.3</td>
<td>302.9</td>
<td>305.9</td>
<td>266.2</td>
<td></td>
</tr>
</tbody>
</table>

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2. Modes of Transmission study.
5. PAHO Jamaica Health System
6. PAHO/WHO Health in the Americas 2012, p.23
specialized care. PAHO/WHO reports that the Jamaican population does not suffer serious geographic barriers in accessing basic health care services.

Health in Jamaica is largely financed from taxation in the form of general taxes and sin taxes. In 2003, the National Health Fund (NHF) was established that collects revenues from three sources: twenty percent of the Special Consumption Tax charged on Tobacco Products (1); 5% of Special Consumption Tax collected (2) and 0.5% of annual earnings up to $500,000 paid by employee and employer.

There are two health insurance models in Jamaica. The public sector is based on the British National Health Service financed by the Government; and the second model is the private health insurance model, which covers about 10% of the population. Private health insurance is not strictly regulated.

In April, 2008, the Jamaican government abolished user fees for health in public sector in an effort to improve access and ensure universal coverage. The policy led to increased use of the public health services. The health services found it difficult to respond to the increased demand particularly due to funding challenge that could not compensate for the loss of user fees. The efficiency and effectiveness of introducing comprehensive package became ongoing concern of the Government of Jamaica. The projected increases in future burdens on health care system indicate that critical analysis of the system should take place to ensure long-term stability.

HIV/AIDS epidemiology overview

Jamaica has features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.6%; however, surveys show higher HIV prevalence in at-risk groups. Based on modeled estimates, around 29,690 persons are currently living with HIV; but approximately 19% are unaware of their status.

The Modes of Transmission Study (2012) identifies the following key affected populations:

- Men engaging in casual heterosexual sex and their female partners
- Men who have sex with men and their female partners
- Sex workers and their clients and partners.

In 2011, the National Strategic Plan on HIV also identified at risk youth, particularly out-of-school youth as one of the key affected populations. These key populations overlap considerably that calls for a holistic approach to provide comprehensive prevention package addressing diversified needs of different populations.

Between January 1982 and December 2014, 33,193 cases of HIV were reported to the Ministry of Health. Of these, 9,278 (28.0%) are known to be deceased. HIV related death rate declined from 25 deaths/100,000 population in 2004 to around 8 deaths/100,000 population in 2014. This 67% reduction in death rate is

11 Sustainable financing and reform of the Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica; p.30
12 PAHO Jamaica Health System
13 Sustainable financing and reform of the Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica
14 HIV Epidemiological Profile; MOH of Jamaica. www.moh.gov.ge
attributed to introducing accessible ARV treatment since 2004. However, Spectrum modeling estimates suggest that AIDS related deaths might be underreported as registered number of deaths account only for 20% of the estimated number of AIDS-related deaths.\textsuperscript{17}

HIV prevalence varies substantially by geographic regions: the highest cumulative numbers of reported HIV cases are found in Kingston & St. Andrew – 1,017.9/per 100,000 persons, and St. James – 1,498.9/per 100,000 persons followed by the parishes with significant tourism-based economies.\textsuperscript{6}

While adult males account for a larger proportion of all HIV reported cases in the 30 and older age groups, young females represent significantly larger portion of HIV positive persons in the 10-29 age groups.\textsuperscript{16}

Analyzing HIV prevalence data among adolescent shows that HIV prevalence increases in the older cohorts (from 10-14 to 15-19 and from 15-19 t 20-24).\textsuperscript{19} This increase is more pronounced for boys rather than for girls.

\textsuperscript{18} Source: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx
\textsuperscript{19} UNICEF. Synthesis Report of the Rapid Assessment of Adolescent and HIV Programme Context in Five Countries: Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe.
girls in Jamaica. On the other hand, 21 per cent of girls in Jamaica experience sexual violence, which is significant and greater than the percentage of boys experiencing such violence (5%).

Statistics about major transmission routes are scarce and existing data may not be reliable. Due to restrictive legislation banning sex work and anal sex among consented adults, it is highly likely that many PLHIV do not self-identify themselves as MSM or sex workers, and avoid disclosing their risk behaviors with service providers. It is also possible that people use false names due to fear of criminal sanctions or stigmatizing and discriminatory attitudes from the society. Obviously, these factors drive key populations underground, and create fertile ground for false reporting. This eventually is likely to lead to distortion of most epidemiological data in the country, which should inform policy makers and guide HIV programming to mitigate the burdens of HIV epidemics in Jamaica.

The GARP report submitted in 2016, states that in 2014, the sexual practice of 44% of men reported with HIV (and 41% of men reported with AIDS) was unknown. Furthermore, of the total number of men reported with HIV, only 4% (669) were identified as bisexual and 4% (618) identified as men having homosexual contacts.

HIV prevalence among key affected population is also established through the surveys; however the study methodologies (e.g., using convenience sampling) lack robustness and, therefore, the figures presented below represent best available data in the country, though the numbers may not be accurate.

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### JAMAICA - COUNTRY KEY INDICATORS (WORLD BANK DATA BASE)

<table>
<thead>
<tr>
<th>HIV PREVALENCE (TREND)</th>
<th>2008/2009</th>
<th>2011-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC attendees (15 – 24 years)</td>
<td>1.1%</td>
<td>0.35%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>4.9%</td>
<td>2.90%</td>
</tr>
<tr>
<td>STI clinic attendees</td>
<td>2.4%</td>
<td>1.96%</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>32.0%</td>
<td>32.90%</td>
</tr>
<tr>
<td>Inmates</td>
<td>3.3%</td>
<td>2.46%</td>
</tr>
<tr>
<td>Homeless persons/Drug users</td>
<td>8.8%</td>
<td>8.17%</td>
</tr>
<tr>
<td>Adults 15-49 years (Spectrum est.)</td>
<td>1.6%</td>
<td>1.62%</td>
</tr>
<tr>
<td>Provider initiated testing - 2014</td>
<td></td>
<td>4.00%</td>
</tr>
</tbody>
</table>
Jamaica’s achievement in terms of reducing mother-to-child HIV transmission is substantial: in 2014, HIV incidence rate was the lowest – 0.15 per 1000 live birth, which is lower than the country target (0.3 per 1000 live births) towards Elimination of MTCT (EMTCT).77 The success of the PMTCT is reflected in declining paediatric AIDS cases among 0-9 years of old from 78 in 2005 to 10 in 2014; AIDS related death among paediatric cases also dropped to 8 in 2014 from 34 in 2004. HIV prevalence among HIV+ pregnant women attending antenatal services in public sector has also declined to 0.35%.

**Injection drug use:** Official HIV data in Jamaica suggest that injecting drug users do not constitute a significant proportion of PLHIV. During the interviews with key stakeholders, including key professionals from the National Council on Drug Abuse (NCDA) declared that injection drug use is not common practice among Jamaican population in general. That explains the fact that people who inject drugs are not identified as a target population for HIV program. Harm reduction, low threshold services and opioid substitution programs are completely absent in the country. The data about drug abuse is contradictory; some sources state that 27% of homeless men and women reported crack/cocaine use;20 the Caribbean Regional Operational Plan indicates that the Ministry of Defence estimates the size of PWID population is 5,000 (of them 250 female injecting drug users).21 The report of KABP survey among general population22 indicates having a section about substance abuse in the survey instrument; however, while analysing survey results, questions on use of illicit drug have been overlooked, and not presented in the final report. Most recent national survey on drug use among schoolchildren23 reports that some 87 schoolchildren (3% of the total survey population) admitted use of injecting drugs before. Of them 45% reported cleaning the needle, they were given to use; 10% re-used it, and 9% gave used needle to someone else. For comparison: according to the 2011 European School Survey Project on Alcohol and Drugs (ESPAD) conducted among over 100,000 students in 36 countries in Europe (including eastern European countries with HIV epidemics largely driven by injection drug use), between 0% and 3% stated that they had injected drugs on at least one occasion.24 Therefore, the Jamaica school survey findings (if data validity is satisfactory) should be flagged, and thoroughly examined by stakeholders to ensure that possible signs of changes in drug use behaviour among Jamaican population are detected as early as possible to avoid escalation of HIV epidemic in the country.

### 3.2 International Funding Overview

Jamaica has been benefiting from technical and financial support from key development partners to enhance its multi-sectoral response to the HIV epidemic, and attain the targets under the UNAIDS Fast Track strategy: achieving the 90-90-90 targets by 2020 and the 95-95-95 targets by 2021.
targets by 2030. The GARP Report\textsuperscript{25} states that the contribution of international donors and partners have been substantial in all major components of HIV national response: prevention, treatment, care and support, creation of enabling environment and advancing human rights, monitoring and Evaluation and HIV research. The Global Fund support started in 2004 and currently active grant will be implemented through 2018. Total amount Jamaica has already received or will receive from the GF exceeds US$ 84 million. The Global Fund is the largest donor supporting HIV national response in Jamaica, and significant portion of interventions remains to be largely or solely dependent on the availability of the GF funds.

In 2013, the Global Fund allocated US$8.3 million to support HIV national response in Jamaica. Jamaica receives substantial support from the US government. PEPFAR funds in 2013 amounted to US$ 4.5 million, which was higher than the total public spending for HIV/AIDS in the same year (US$3.8 million).\textsuperscript{27} Technical and financial assistance from UNAIDS with close collaboration with the Pan Caribbean Partnership against HIV/AIDS, as well as contribution of key development partners, such as UNAIDS, UNICEF, UNDP, UNESCO, UNFPA, IOM, ILO and UN Women in terms of health system strengthening, capacity building, HIV policy development and advocacy has been considerable to Strengthening HIV national response in the country.\textsuperscript{6}

\begin{table}[h]
\centering
\begin{tabular}{|l|l|l|l|}
\hline
GLOBAL FUND GRANT & PRINCIPAL RECIPIENT & BUDGET & LATEST RATING \\
\hline
\hline
\hline
\hline
Total funding for HIV programme & & $84,407,350 & \\
\hline
\end{tabular}
\caption{HIV/AIDS GRANTS\textsuperscript{26}}
\end{table}

\textsuperscript{27} Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016
4. Assessment Findings

4.1 External Environment

4.1.1 Political Environment

4.1.1.1 Prioritization of Health Investments

The share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that have stayed below the mean for UMIC (12% in 2013). The share of government spending on health out of Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. Health expenditure per capita (current US$) by the State was rising steadily since 2009 through 2013, but declined in 2014. Total Health expenditure as a percentage of GDP also declined in 2014 to 5.4% that is the lower than the average for Caribbean region - 6.1%.28

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28 Caribbean Regional Operational Plan 2016 Strategic Direction Summary. July 6, 2016. p. 21
The GoJ is committed to improving population health, which has been proved by the Government’s decision to abolish user’s fee for health services in public sector. However, declared political will has not been translated into adequate and stable increase in investment in health due to fiscal challenges in the country.

4.1.1.2 The Legal and Social Context

There are a numbers of legislation in the country that create barriers to HIV services and pose substantial risk to sustainability of HIV interventions that have been implemented through rigorous advocacy and financing from the GF and other international development partners for more than a decade.

Offences Against the Person Act, which criminalizes anal sex (and therefore same sex relations between males) operates as a barrier for access to HIV prevention, treatment, care and support services. This law limits the country’s ability to provide comprehensive quality services to MSM due to fear of stigma and discrimination as a result of disclosure of their sexual practices. The law refers to male same-sex intimacy as “gross indecency” and fuels stigmatizing and judgmental attitudes towards MSM population from the society, including health care workers. Despite many years of advocacy and awareness campaigns implemented in Jamaica through the donor-funded programs, little or no success has been achieved to change population’s attitudes: 82% of respondents of National Survey on Homophobia in 2012, believed that the act between two males was immoral. Similar views prevailed among respondents participating in the KAPB survey among general population: 89% of respondents (N=1800) believed that anal sex between males should remain illegal; and 82% reported that anal sex should remain illegal between man and a woman.

Due to the same law, condom distribution is banned in all prisons and the topic has been tabooed for two decades. This might be an implication of the incident that took place as far back as late 1990s. Dr. Raymoth Notice, former prison doctor and former mayor of Spanish Town responded to the growing HIV epidemic in prisons by providing strong recommendation to distribute condoms to inmates. The approach was supported by then Commissioner of Corrections, Colonel John Prescod, who in 1997 ordered issuing condoms to prisoners. This decision humiliated prison staff, and it resulted in prison riot in which 17 persons were killed including warders. A research about HIV and homophobia among prisoners reports that some prisons began a policy of separating persons labeled as homosexuals after the 1997 prison riot.

Sexual Offences Act prohibits prostitution in Jamaica, which has negative impact on health seeking behaviors among those engaged in transactional sex. Existence of restrictive law only creates barriers to services and heightens sex workers’ risk for contracting and spreading HIV. Fear of punishment does not deter people to get engaged in sex in exchange money or gifts. The KAPB survey 2012 states that “transactional sex practice is inching upwards and is particularly so among the youth (15-24 years).” Stakeholders and policy makers should start communicating the message to the society that annulling prohibition of sex work will be beneficial to

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increase access to services by sex workers and prevent spread of HIV, while having no effect about the scale of transactional sex in the country.

Based on the Age of Majority Act, there is a dissonance between the age of consent (16 years) and the age a person can access health care without parental consent - 18 years, which makes it difficult to provide HIV testing or treatment services to HIV positive and at-risk youth. Furthermore, under the Child Care and Protection Act distribution of condoms to adolescents without parental consent is also prohibited. Having access to reproductive health and HIV services for adolescents is critical taking into account early sexual debut among Jamaican youth - 33% of people aged 15-24 report having sex before the age of 15.

Vulnerability of young girls is further exacerbated by the Anti-abortion legislation (Sections 72 and 73 of the Offences Against the Person Act of 1864) that restricts access to safe abortion services. A 1975 ministerial order allows health services to terminate a pregnancy only based on medical indication if it is determined that the continuation of the pregnancy will put the mental and physical health of the woman at risk. The National Family Planning Board-Sexual Health Agency (NFPB-SHA) has drafted a policy position paper for proposed amendment.

Section 8(B) of the Dangerous Drug Act of 1948 makes the possession and use of illicit drugs criminal offence in Jamaica. The Bill passed in February 2015 by Senate and House of Representatives decriminalized marijuana possession of “ganja” up to two ounces for personal consumption and religious/medical use. The Drug Court Act provides the option to non-violent drug offenders being prosecuted to be admitted to a treatment program instead of a prison sentence.

Urgent needs to change punitive legislation has been documented in all major reports on HIV in Jamaica. Even though that advocacy work to change restrictive legislations in the country has been in progress for more than a decade, no tangible results have been achieved thus far. Several agencies and projects have implemented policy advocacy initiatives, and elaborated critical amendments to legislation that are currently under consideration. Adolescent Health Unit of the MoH, with the support of a multi-sectoral Adolescent Policy Working Group has led the process of reviewing policies related to adolescent access to Sexual and Reproductive Health Services, and these recommendations are currently under review.

Civil society organizations serving key vulnerable groups recently made a submission to the joint select committee reviewing the Sexual Offenses Act. The recommendations list 21 recommended amendments, including the strengthening legislation “to address sexual violence against men and boys and non-consensual penetrative acts - all key issues that the LGBT individuals have been advocating.”

There is no law safeguarding non-discrimination of PLHIV in Jamaica. HIV testing is mandatory as a pre-requisite for accessing some life-insurance policy. AIDS patients complained about undignified treatment from medical staff at some treatment sites in public sector. To mitigate negative influence of stigmatizing

36 Transition Preparedness Assessment mission in Jamaica. Interview with NFPB-SHA. Meeting transcripts. September 6, 2016
and discriminatory attitudes, a National HIV Discrimination and Reporting and Redress System was established, however utilization of this service and resolution of cases is limited. CSOs believed that one of the reasons for the system being ineffective was the lack of enforceable power and legislative framework for the redress system.

4.1.1.3 CSO landscape

Civil society activism in Jamaica emerged back in the 18th century. Since then, Jamaica has had strong civil society organizations, mostly NGOs, community based organizations, and community development committees (CDCs) working in different sectors. Enabling Environment Index for Jamaica is 0.551 indicating that the conditions within which civil society operates in Jamaica is conducive, and there are no laws or policies that restrict civil society playing an oversight role.

Jamaica enjoys having a strong, vibrant and vocal civil society actively engaged in the national HIV response. There are no laws that would restrict the GoJ to contract CSO for service delivery. CSO assessment in Jamaica conducted in 2011 states that the Government has provided funds to CSOs through its Social Development Commission (www.sdc.gov.jm). The social contracting has been practiced by various ministries in Jamaica including Ministry of Education, Ministry of Social Security, and Ministry of Health.

4.1.2. Economic Environment

Jamaica is classified as an Upper Middle Income Country with a per capita GDP of US$ 5,119 in 2014 and US$ 5,138 in 2015, reaching the same level of GDP as in 2008 prior to the global economic crisis. GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year making the country one of the slowest growing developing countries in the world. The share of General Government Revenues as % of GDP has been stable high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013.

<table>
<thead>
<tr>
<th>Year</th>
<th>GDP per capita growth (annual %)</th>
<th>Public revenue, excluding grants (% of GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>0.5</td>
<td>30.7</td>
</tr>
<tr>
<td>2006</td>
<td>2.5</td>
<td>31.6</td>
</tr>
<tr>
<td>2007</td>
<td>1.1</td>
<td>32.3</td>
</tr>
<tr>
<td>2008</td>
<td>-1.1</td>
<td>31.7</td>
</tr>
<tr>
<td>2009</td>
<td>-4.8</td>
<td>32.5</td>
</tr>
<tr>
<td>2010</td>
<td>-1.8</td>
<td>31.3</td>
</tr>
<tr>
<td>2011</td>
<td>1.4</td>
<td>30.4</td>
</tr>
<tr>
<td>2012</td>
<td>-0.9</td>
<td>31.4</td>
</tr>
<tr>
<td>2013</td>
<td>0.3</td>
<td>32.4</td>
</tr>
<tr>
<td>2014</td>
<td>0.5</td>
<td>31.1</td>
</tr>
</tbody>
</table>

41 http://www.civicus.org/
42 GARP Report, Jamaica. NCPI 2013
While the economy is growing slowly at a very low rate, the country still faces substantial debt-burden and according to the World Bank, Jamaica’s debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014. After national elections in February 2016, new administration has launched institutional reforms to improve the business environment for the private sector. The reform program started bearing its fruit: in the 2016 Doing Business report, Jamaica for a second year in a row is ranked among the top ten improvers worldwide. “Prudent macroeconomic policies and careful liability management reduced total government debt to 128 percent of GDP by the end of fiscal year 2015/16.” The World Bank forecasts GDP growth accelerating to 1.7% in 2016 over 2% in 2017 that provides a promising signal that if the positive trend is maintained, the Government’s ability to increase investments in health will improve.

Punitive legislative environment for MSM, sex-work and drug use presents challenges to sustainability of HIV national response in the country. Despite concerted efforts with funding from donors, legal barriers in the country have not been reduced that raises concerns whether the conducive legal environment in Jamaica can be created during the transition of thereafter. While CSOs are strong and government CSO partnership has longstanding and durable history, existing legal environment may not permit the Government to fund the services targeting MSM or sex workers. Furthermore, less conducive macro-economic environment along with huge debt burden, although improving after the election in 2016, may limit government’s ability to assume full financial responsibility for the HIV program currently funded through the GF.

4.2 Internal Environment

4.2.1 Inputs - Financial Resources

4.2.1.1 Budgetary commitment to HIV program

The budget for HIV national response is integrated into the country’s multiyear budget plans. The Jamaica two-year Budget for 2015-2016 states: “The National HIV/STI programme has led the Government’s response to the HIV epidemic since 1986 and its aim is to maintain an effective response when international support for this Programme ceases.” However, achieving sustainability of national HIV program interventions at adequate scope and scale will require substantial increase in financial commitment from the Government of Jamaica for HIV response in upcoming years.

The national HIV program in Jamaica has been primarily financed through the Government of Jamaica, a loan agreement with the International Bank for Reconstruction and Development (IBRD/World Bank), and grants from the Global Fund and the United States Agency for International Development and President Emergency Plan for AIDS Relief (USAID/PEPFAR). Two NASA reports were accessible to analyse AIDS spending data in Jamaica for 4 fiscal years from 2009/2010 through 2012/2013. Unfortunately, more

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46 Jamaica Budget 2015-2016; HEAD 4200 – Ministry of Health. P542
47 NASA 2014, p.17
recent data about AIDS spending was not available that substantially limited our ability to assess financial sustainability risk for HIV program in Jamaica.

The Table 6: AIDS Spending by financial sources (NASA 2012; NASA 2014) summarizes AIDS spending by three financial sources: public, international and private. Public spending was the highest in 2010/11. In 2013, funds provided by the GoJ increased by around US$100,000 compared with the previous year, however it still remained lower than that in FY 2011.

As shown in the Table 7, public funds to support the National HIV Response represented only 21.99% and 18.67% of the overall AIDS spending in FY 2011/12 and 2012/13, respectively. 44

44 NASA reports clarify that the Public Funds was calculated as a combination of GoJ contribution to projects supported by the World Bank loan and United States Agency for International Development (USAID), central government funding from the Ministry of Youth and Culture and the World Bank loan resources. The classification of World Bank Loan resources as public funds was applied in the NASA as it is in accordance with the Global Fund classification of loans funds. Main rationale for this classification is the nature of the WB loans, which represents an obligation of the GoJ to be paid in future. NASA Report, Jamaica 2014, p.24.
The largest shares of public spending on AIDS in 2012 and 2013 fiscal periods have come from World Bank loans (69% and 72% respectively). Obviously, HIV National response is largely dependent on external support. The share of the Government funds to cover cost of human resources for HIV response, became minimal in 2013 not exceeding 13.8% of the total HR costs, that also poses serious risk to program sustainability.

### 4.2.1.2 Prevention Priority

HIV Prevention in Jamaica has had several financial sources; however, the main source has been the funds from GF and USAID/PEPFAR. According to the TGF CN, the GoJ will be required to continue leveraging more financial resources from potential partners, such as PEPFAR as well as to identify innovative financing mechanisms such as Debt2Health Programmes to meet the anticipated funding gaps in HR.  

![Expenditure on Human Resources by Main Funding Sources for 2011/12 & 2012/13 Fiscal Years](image)

According to the TGF CN, the GoJ will be required to continue leveraging more financial resources from potential partners, such as PEPFAR as well as to identify innovative financing mechanisms such as Debt2Health Programmes to meet the anticipated funding gaps in HR.  

- **Public**
- **International**

**Total Expenditure in USS**

According to the TGF CN, the GoJ will be required to continue leveraging more financial resources from potential partners, such as PEPFAR as well as to identify innovative financing mechanisms such as Debt2Health Programmes to meet the anticipated funding gaps in HR.  

49 TGF Standard Concept Note. HIV program. Jamaica. 2014

49 TGF Standard Concept Note. HIV program. Jamaica. 2014
The NASA report indicates that in 2009, 8% of prevention spending came from the GOJ/WB that increased to 16% in 2010.\textsuperscript{51}

Stakeholders during the interviews expressed concerns that HIV prevention targeting vulnerable populations has been traditionally financed by external donors with little involvement from the State. PEPFAR Sustainability Assessment Index\textsuperscript{52} states that according to stakeholders’ opinion, approximately 10-49% of funding for HIV/AIDS related civil society organizations comes from domestic sources (excluding TGF funds). The same source says that supplies provided to CSO are partly government funded. In addition, the GoJ provides in kind floor space/accommodations, technical assistance and HR to CSOs. All available information indicate that the share of public funds in prevention interventions is suboptimal, but we were unable to document if public spending on HIV prevention for key populations was increasing over the last five years.

4.2.1.3 Prevention, Treatment financing from Public Sources

In general, up-to-date data about AIDS spending is not readily available in Jamaica. Latest NASA reports present limited data through FY2012/2013. Furthermore, some stakeholders expressed dissatisfaction because of using the NASA data for financial sustainability assessment saying that the data were incomplete and inaccurate. No other data sources about financing HIV prevention, treatment, care and support services from public sources are available.

4.2.1.4 Allocative Efficiency

Modes of Transmission study estimates that approximately 60% of all new infections may be

\textsuperscript{50} National AIDS Spending Assessment report. Jamaica. 2014
\textsuperscript{52} Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016. Indicator 3.4.
attributed collectively to MSM, SW and those who have casual heterosexual sex (CHS); and 40% of incident infections will occur among persons who are considered to be engaging in low risk sex.\textsuperscript{53} Based on this finding, the study provides the recommendation that while continued attention needs to be focused on high-risk groups to scale up testing, prevention and treatment services among KAPs, HIV national program in Jamaica should maintain focusing on low risk groups as well.

The NASA report provides AIDS spending data by key population groups, which shows that the greatest portions of the AIDS spending were directed to the general population (with 41% of the total spending in FY 2013), and PLHIV (with 29% in FY 2013). AIDS spending targeting most-at-risk populations slightly increased from FY2012 to FY2013 accounting 10.5% of the total AIDS spending in 2013 year. Disaggregation of AIDS spending by KAPs (see the Error: Reference source not found) shows that the spending on MSM population has doubled in FY 2013 compared with FY 2012, and the spending for sex workers also increased substantially that seems to follow the epidemiological characteristics of HIV epidemics in the country.

### T.9 AIDS SPENDING BY MAIN BENEFICIARY POPULATIONS\textsuperscript{54}

<table>
<thead>
<tr>
<th>BENEFICIARY POPULATION</th>
<th>TOTAL SPENDING (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/2012</td>
</tr>
<tr>
<td>PWIDs and partners</td>
<td>$56,669</td>
</tr>
<tr>
<td>Female sex workers and their clients</td>
<td>$5,305</td>
</tr>
<tr>
<td>Male non-transvestite sex workers</td>
<td>$2,382</td>
</tr>
<tr>
<td>Sex workers, not disaggregated by gender and their clients</td>
<td>$195,813</td>
</tr>
<tr>
<td>Men who have sex with men (MSM)</td>
<td>$612,645</td>
</tr>
<tr>
<td>“Most at risk populations” not disaggregated by type</td>
<td>$554,324</td>
</tr>
</tbody>
</table>

Few economic studies were conducted in Jamaica that can serve as practical tools for HIV budget projection: Goals Model impact assessment for treatment program, Modes of transmission study; HIV Program Financial Sustainability study; and estimation of unit costs for HIV prevention package for MSM (for USAID/PEPFAR funded project). Through these studies, important information have been generated that will help national stakeholders...
and policy makers better understand HIV disease burden. Strengthened surveillance data and analysing AIDS spending data on a regular basis will help the Government of Jamaica to make evidence-based allocation decision while taking over financial responsibility for its National HIV response.

While AIDS spending data for recent years is not available, latest NASA data indicates that in FY 2012/2013, the GoJ covered only one fifth of the AIDS total spending, largely using borrowed funding from IBRD. There are numbers of HIV interventions that remain largely or solely dependent on the GF funding. While the Government continues to be committed to co-financing treatment, care and support (TCS) services, prevention services provided to KAPs through civil society organizations have been financed through the external donors, that poses significant risk to financial sustainability of HIV national response.

4.2.2 Inputs – Human Resources

4.2.2.1 HR Sufficiency/availability

There is a severe shortage of Human Resources for health, as the official cadre for health care workers has not increased since 1970s. The challenge is recognized in Jamaica’s vision 2030. The shortages of HR for health is aggravated by high staff turnover, and attrition. Introducing “no-user fee” policy resulted in increased demand for health in public sector, which further exacerbated the challenge. Relatively low pay, poor working conditions and the lack of professional development opportunities forced many health professionals to leave the public service, to change the profession or migrate to developed countries.

A 2014 Human Resource Analysis for HIV services revealed that overall the full time equivalent (FTE) of currently deployed health care workers in the field is 62% of the optimal level required with the largest gap in the number of “support” staff. However, the HR patient ratios for the HIV response are still above the average ratio for that within the general health care system.

Between 2004 and 2012, over 18,000 PLHIV were linked to care, and healthcare workforce has not increased proportionately. This problem is most severe for non-medical professions, as patients in addition to regular medical visits, also need laboratory monitoring, pharmacy, nutritional counselling, psychological counselling, etc. Staff shortage continues to be a challenge at treatment sites as well causing long waiting time at clinics.

Severe shortage of psychologists is named as major reason for low coverage of PLHIV with psycho-social support services in the GF PUDR in 2015, and an amendment was proposed by the GF project management team to change the data source for this indicator from the psychologists reports to the social workers reports. During the meeting with the MoH representatives, respondents said that there was only one staff member providing counselling to inmates in all prisons of the country.

4.2.2.2 HR Development & trainings

The Ministry of Education should play a major role in the training of human resources for health which should be guided by the MOH.
policy for human resources for Health. Over
the last decade, on-job training in HIV field
has been provided through the financial
support from TGF and PEPFAR as well as from
GoJ. Within the integration of the National
HIV program into National Family Planning
Board (NFPB), cross training of staff for both,
HIV and family planning/reproductive sexual
health has been implemented that increased
the pool of persons available to offer services
in more cost-efficient manner.53

Most clinical training programs have
been institutionalized into formal
education curricula at medical schools at
undergraduate and postgraduate levels.61
The annual HIV/AIDS Clinical Management
workshop has been institutionalized
through the Caribbean HIV/ADS Regional
Training Network (CHART).62 Currently, the
MOH is responsible for training HCWs in
HIV management. However, there is no
policy for production of CSO personnel/
non-medical, social and support services
in HIV response. In addition, there are
considerable numbers of training programs
that have been developed for non-medical
staff which have not been institutionalized
into formal education institutions, and thus,
their sustainability is at risk after the donor
funding declines or ends.

4.2.2.3 Alignment of salaries

Stakeholders believe the salary scales in the
public sector and for the staff employed by
donor-funded programs are well aligned.
Despite the challenges, in the past years the
GoJ has incrementally subsumed the HIV
service delivery HR costs that were previously
supported with grant resources from GF and
PEPFAR. As part of the absorption process,
the MOH has agreed to provide additional
US$ 500,000 per annum for HR costs
beginning in 2016.64

The severe shortage of HR in health sector is
further exacerbated by the fact that Jamaica
is under IMF restrictions and cannot hire
more health care workers.25 The challenges in
terms HRH is a larger problem of the national
health care system that goes far beyond
HIV programme. While HR shortage will
certainly affect HIV program sustainability,
this problem may not be resolved during the
transition period.

4.2.3 Inputs – Health Information System

4.2.3.1 Routine HIS

A national Health Information System
Strengthening and e-Health Strategic Plan
2014/2018 was developed to modernize
health information system in Jamaica. The
plan includes implementation of an inventory
management and pharmacy information
system as well as logistics information system
for public laboratories.63 The GoJ introduced
a national health card to track the utilization
of health services in the public sector. There is
a plan to link the health card to the National
e-Health system, which will further strengthen
the health information system in Jamaica.59

An HIV Electronic Register system operational
in Jamaica, includes HIV/AIDS Treatment
Database and PMTCT Database. The
electronic treatment information system is
operational within all treatment sites. The
paediatric treatment sites have not yet
utilized the database. However, treatment
databases are not linked that undermines

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61 TPA Assessment mission. Interview with Dr. Pete, PAHO. September 9, 2016. Meeting transcripts
62 NSP 2008
Disaggregation of routine programme data on PLHIV within the clinical setting by key populations is limited. Therefore, the data about loss to follow up, treatment adherence, or treatment outcome/survival rates specific to each KAP is not available, that limits the ability of surveillance system to explore potential reasons and/or social determinants for unfavorable treatment outcomes.

Treatment data from private sector providing ARV treatment to AIDS patients is not currently captured by the national treatment database. During the discussions with Private Treater’s (doctors) group, doctors declared full readiness to comply with the national reporting requirements if institutionalized/enforced. Information about HIV+ pregnant women receiving ARV in private clinics for PMTCT is not available.

Electronic monitoring system for ARV drugs does not involve all public and private pharmacies across parishes. During interviews with PLHIV, it was revealed that in response to drug stock-outs many patients are registering at different pharmacies in different parishes using same identities, and receive prescribed drugs. Majority of respondents said this is a common practice among patients with the intention to compensate for frequent stock-outs of ARV drugs. Thus getting drugs from different pharmacies help them create personal “buffer stock” and assure treatment continuity with same regimen of drugs.

Double counting of beneficiaries receiving prevention services remains to be a challenge that can be addressed if prevention database is linked with all service provider organizations and uses standardized client unique identification codes.

HIV surveillance may benefit from capturing all available data on HIV testing. While blood donors are routinely tested for HIV and other blood borne diseases, data are not analysed by national HIV program to complement existing HIV surveillance data. Testing data generated through other projects providing VCT to certain population groups also may have an added value for understanding HIV diseases burden. For instance, local CSO FAMPLAN provides HIV testing at the community level that involves family counselling allowing them to test adolescent girls for HIV. The FAMPLAN testing data can be unique for HIV surveillance system given that prevalence data about this group is largely missing from official data due to restrictive legislation.

Weaknesses of HIV information system and unreliability of data has been well-acknowledged challenge in Jamaica. The GF program placed emphasis to improve the data quality to drive evidence-based programmatic decisions. With the support, collaboration and technical guidance of the Clinton Health Access Initiative (CHAI) partnership, major data cleaning exercise was carried out that detected substantial data inaccuracies, and stakeholders concluded that intended targets (TGF PUDR #13) had to be revised downwards. Strengthening the HIS and building technical capacity of HR involved in HIV surveillance should intensify to have better understanding about the burden and characteristics of HIV epidemics in Jamaica. This will require substantial financial investments and technical assistance during the transition period.

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64 TGF PUDR #13, Jamaica
**4.2.3.2 Second Generation Surveillance**

According to the PEPFAR Sustainability Index and Dashboard, there is a strong local ownership for HIV research; however, most surveillance studies are funded by donors and are conducted through the technical support from international development partners.

Jamaica has completed several rounds of Integrated Bio-behavioural surveillance surveys among FSWs and MSM since 2004. The Priority for Local Control Efforts (PLACE) methodology was introduced in Jamaica in 2003 as a rapid assessment tool to monitor and improve HIV prevention programme coverage in areas where HIV transmission is most likely to occur. Several rounds of PLACE surveys were completed in 2005, 2008, 2011 and 2014. The use of convenience sampling for recruiting respondents for PLACE surveys undermines the validity as well as generalizability of research data. In addition, more robust methodology for Bio-BSSs is needed to achieve relatively more representative sample of hidden populations with criminalized behaviors.

Starting from 2015, through the support of USAID, efforts have been made to introduce a Respondent Driven Sampling methodology for conducting Bio-BSS among MSM. An approval from Institutional Review Board is now pending, and in early 2017 first-ever in Jamaica, Bio-BSS among MSM will be conducted that will have the potential to generate reliable statistics about this most-adversely affected population group. This support is critical to strengthen the country’s second-generation surveillance system and establish in country research capacity.

Several rounds of Knowledge, Attitudes and Behaviour Survey among general population (KABP) using robust methodology were conducted in Jamaica with the last study taken place in 2012. Unfortunately, none of these KABP surveys involved biomarker component that could have been added at marginal cost. During interviews, researchers stated that offering HIV testing would deter respondents from participation. BBSS studies among homeless drug users, transgender population, and among youth focusing out-of-school youth have not been conducted in recent years.

Population Size Estimation (PSE): national estimates for the size of KAPs are established based on experts’ opinion except that for Out of School Youth for which data is provided by the Ministry of Education.

### T.10 ESTIMATES FOR KEY POPULATION SIZE

<table>
<thead>
<tr>
<th>KEY POPULATION</th>
<th>LATEST SIZE ESTIMATION ESTABLISHED</th>
<th>SIZE ESTIMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who have sex with men</td>
<td>2014</td>
<td>(4.5% of male population)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33,000</td>
</tr>
</tbody>
</table>

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67 2016 Sustainability Index and Dashboard Summary. Jamaica PEPFAR
68 Measure Evaluation. https://www.measureevaluation.org/resources/tools/hiv-aids/place
Most data provided throughout the TPA report about the trends in HIV prevalence, program coverage and behaviour changes are based on the studies and PSE that lack robustness (e.g. using convenience sampling for selection of survey respondents; absence of population size estimation studies); therefore, some performance indicators may not be accurately reflecting the real characteristics of HIV epidemics in the given time.

Substantial efforts have been made in the country to refine treatment and prevention databases in Jamaica in recent years, but there are still weaknesses in data collection and analysis that need to be addressed during transition period. Second generation surveillance studies have been regularly conducted in the country among different KAPs that have been largely financed by the external donors. Advocacy should be intensified to ensure that the Government starts allocating adequate financial resources to HIV surveillance and research studies to ensure sustainability. Using more robust methodologies for surveillance studies needs to be institutionalized to improve the validity and reliability of epidemiological data that inform HIV programming and budget allocation decisions.

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Female sex workers</td>
<td>2014</td>
<td>(2.5% of female population) 18,696</td>
</tr>
<tr>
<td>Homeless drug users</td>
<td>2012</td>
<td>1,600</td>
</tr>
<tr>
<td>Inmates</td>
<td>2013</td>
<td>5,000</td>
</tr>
<tr>
<td>Out of School Youth</td>
<td>2012</td>
<td>141,744</td>
</tr>
</tbody>
</table>

4.2.4 Governance – Governance

4.2.4.1 Political commitment

Since 1988 Jamaica has had national plans to guide National HIV/STI control programme. The HIV/AIDS Policy was developed in 2005, which is currently being revised. The UNAIDS “Three Ones” key principles for the coordination of national responses to HIV and AIDS which includes one national multi-sectoral strategy, one national coordination platform with a multi-sectoral mandate; and, one monitoring and evaluation framework is being applied in the Jamaica’s response to HIV/AIDS. Jamaica declares its commitment to achieve the UNAIDS 90-90-90 targets, and to adopt ‘Test and Start’ policy starting from FY 2017 that will require substantial increase in HIV financing from the Government.

In 2013, GoJ took considerable efforts to reorganize its HIV and family planning programmes and integrate coordination of the two programs into the new integrated entity, the National Family Planning Board-Sexual Health Agency. Following this integration, in 2014 Jamaica initiated revision of the NSP to develop a new, National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health and HIV for 2014-2019 years. The Plan provides

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22 Caribbean Regional Operational Plan 2016.
a blue print for achieving the vision of an integrated programme while supporting the achievement of the Millennium Development Goals and the emerging themes in the 2030 Jamaica sustainable development goals agenda. The NISP was created through highly consultation process involving all key stakeholders including government, civil society, private sector, HIV affected communities, youth, faith-based organizations and international development partners.

4.2.4.2 Leadership

The TPA tool tried to identify if there were legally empowered leading organization or individual leader who were actively engaged in advocacy and were making public announcements about greater public investments for sustainable HIV response. During the interviews, key stakeholders involved in HIV national response found it difficult to identify any prominent, legally empowered organization that could be considered as a leader organization. Some of them recognized the role of the CCM that provides a platform for CSOs' engagement; however they also believed that CCM had no legal power to influence policy decision. CSOs organizations named individual champion- the head of civil society organizations- Jamaica AIDS Support for Life who pushes HIV agenda forward and has been a leader in advocating for sustainable funding for HIV response and protecting vulnerable populations rights.

4.2.4.3 Coordination Mechanism

Shortly after launching its first National STI/HIV programme, the Government of Jamaica in 1988 established a civil society-led partnership group, the National AIDS Committee (NAC) with its National Executive Committee, 5 sub-committees and 13 Parish-based AIDS associations. However, through interviews with stakeholders it became clear that NACs have never played assigned role and there was no clarity about the NAC function and operation.

After the GF funding became available in Jamaica, the role of the NAC was fully assumed by the Country Coordinating Mechanism (CCM) that currently represents the main body with the function to coordinate HIV national response under the Global Fund. CCM enjoys high-level representation from various ministries, government institutions as well as representatives of international partners and local CSOs. CSOs presently hold 40% seats on the CCM. Civil society groups unanimously stated that the CCM is the only mechanism that brings together high officials and HIV vulnerable populations to discuss HIV/AIDS response in Jamaica on a regular basis.

Following the integration of HIV and family planning program management function into the National Family Planning Board, some stakeholders think that the latter body is likely to replace the CCM after the assistance from the GF declines or ends.

The NFPB-SHA serves as a hub for coordination, guidance, research, monitoring and the facilitation of policy development and programming implemented through government ministries, departments and agencies.

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During the interviews with the NFPB-SHA, the Executive Director and key staff members have demonstrated their readiness to strengthen coordination and expand the role of the Board that can be considered as a positive signal. Sixteen new positions were added to the Board staffing; the board plans to develop its three-year corporate and strategic plan in September/October 2016. The NFPB-SHA carries about 70% of the Government HIV response in relation to care and prevention. However, AIDS related treatment and clinical services remain integrated into treatment programme of communicable diseases.

National Family Planning Board’s legal status and powers are defined by the National Family Planning Act of 1970. The NFPB-SHA will retain strong ties to the government with at least 51% of members from the public sector. Currently the Board has 9 members, but there are plans to amend the Act to expand its membership and ensure CSO representation on the Board.

During interviews, civil society organizations seemed concerned fearing that NFPB-SHA, being a structure under the MoH, will not have adequate power to sustain concerted multi-sectoral response, and the policy dialogues among government agencies and civil society might be undermined. They lack clear understanding of the perspectives of civil society within the Board. Some mentioned that the membership of the Board is defined by law and “it may not be flexible enough to involve new players into the response”.

According to the Ministry of Health, the integration will not affect the function of the CCM, which will continue managing the GF project related activities, and the NFPB-SHA will be coordinating HIV response at a broader, national scale. It is likely, that the functions of these entities may evolve over time, and close monitoring of the process will be required. Policy dialogue among government institutions, NFPB, civil society organizations and development partners will be needed to define the functions and operation modes of the coordination body to have clear understanding about how the coordination of HIV national response continues after transitioning from the GF funding.

While the integration of HIV and SRH programs seems to be a positive step towards sustainability and strengthened coordination, stakeholders need to make sure that the focus on HIV and particularly on vulnerable populations is not diluted within a broader scope of SRH and HIV. Special emphasis should be placed to ensure that spending figures specific to HIV/AIDS by program areas, key population groups and financial sources can be differentiated from the spending figures on integrated SRH and HIV services to enable proper monitoring of National AIDS Spending Assessment.

During the transition, efforts should be undertaken to ensure that the NISP 2014-2019 is costed, has corresponding M&E plan and is formally approved by government resolution or by the Cabinet.

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75 TPA Assessment mission meeting transcripts. Meeting with NFPB-SHA, September 6, 2106.
76 TPA Assessment mission meeting transcripts. Meeting with CSOs, September 7, 2016.
4.2.5 Governance – Accountability

4.2.5.1 Access to program performance results

HIV Epidemiological Profile is being prepared by HIV/STI National Programme every year and reports are available publicly on the Ministry of Health website. Data disaggregation by populations, gender, age groups, and regions, as well as analytical part of the report can be further strengthened. HIV Survey results are disseminated during meetings involving national stakeholders. HIV Program evaluation study has not been conducted in recent years. TGF grant performance results are available on the GF website. Data dissemination and sharing is seen as an area of weakness, as data is not reaching civil society to guide their programming efforts.77

In addition, Jamaica develops Global AIDS Response Progress reports and submits them to UNAIDS. The reports are elaborated through national consultation with stakeholders from various sectors. These reports are available on the UNAIDS website. However, funding matrix that should provide AIDS spending disaggregation by established priority areas as well as financial sources are not available for recent years. The funding matrix files from previous years can only be obtained upon request. Reporting, particularly of financial data lag far behind: as of September 2016, last AIDS spending data submitted to UNAIDS was from FY 2012/2013.

CCM does not have the website that might serve as a hub and online resource for interested audiences. Stakeholders confirmed that CCM meetings are conducted on a regular basis, however CCM meeting minutes are not publicly accessible.

4.2.5.2 Enabling environment for CSO engagement

The environment in Jamaica enables active engagement of civil society in the national HIV response. CSOs implement substantial portion of national HIV response, particularly prevention activities targeting key affected populations. Currently, 10 local CSOs are implementing the GF supported interventions with three of them serving as sub-recipients. Only one CSO – Jamaica AIDS Support for Life (JASL) currently provides ARV treatment service covering 5% of PLHIV enrolled in treatment. Most CSOs are based in Kingston, the capital city, and the network of civil society organizations in regions is relatively underdeveloped.

Civil society organizations participate in national policy development and are members of various technical working groups that represent multi-sectoral partnership and collaboration between and among governmental, civil society (CSOs) and non-governmental organizations (NGOs), HIV constituencies as well as international development partners. CSOs as members of a National Enabling Environment and Human Rights Technical working Group established in 2014, participated in the development and revision of the National Integrated Strategic Plan (NISP) 2014-2019, the Global Fund Concept Note: 2015 - 2018, the 2030 Sustainable Development Goals Agenda, etc. While civil society had strong presence in planning HIV national Strategic Plan,

NGO representatives complained that their involvement in the NISP budgeting process was substantially limited.78

Civil Society was part of the Youth and Adolescents Technical working group that worked on the revision of the legislation restricting reproductive and sexual health rights of young people. The group provided platform for civil society for advocating for a conducive environment guided by human rights principles.79 Non-governmental organizations are also invited in the HIV M&E Reference Group (MERG). The MERG presently have five seats allocated to CSOs.39

During the interviews with civil society organizations, most NGOs serving MSM/LGBT communities or sex workers complained they were forced to disguise their organization’s genuine mission and target groups in the Charter to avoid legal barriers while registering organizations as legal entities. Some NGOs had to change their names to hide their connection with the groups with criminalized behaviour.

Representatives of government institutions, as well as civil society organizations believe that there is no law or regulation that would limit the Government’s ability to contract CSOs for health service delivery. Interviewees from the MoH, and Planning Institute of Jamaica (PIOJ) also confirmed that social contracting has been practiced in many sectors, including health sector. The Ministry of Health has contracted professional associations and foundations under the public funds. For instance, the MoH contracted National Cancer Society to develop national Cancer Registry in Jamaica.

Government representatives also stated that due to some state regulations exchanging patients data between the Government and CSOs may become challenging, and encouraged CSOs to change their organizations’ legal status to foundations or society to be able to get funding.80 Obviously, there is a certain level of ambiguity in existing regulations for social contracting, and more in-depth assessment is needed to find out not only potential legal barriers, but also the Government’s willingness, readiness and practices to contract CSOs for health service delivery, especially for those groups that are marginalized and illegal under existing national legislation.

4.2.6 Program – Service Delivery

4.2.6.1 Treatment Coverage and outcomes

Persons living with HIV have access to 38 treatment sites and geographic access is balanced. Antiretroviral drugs are distributed free of charge through public pharmacies, and for a nominal fee through private pharmacies across Jamaica. Long waiting times at public pharmacies remain to be challenging for PLHIV, especially for those who are employed.

Free ARV treatment is offered in both, public and private sectors. While treatment data from private clinics are not routinely collected, stakeholders believe that the number of patients receiving ARV in private sector is insignificant. ARV treatment is accessible for inmates in correctional setting.

78 TGF Concept Note. 2014
79 GARP Report, 2016
80 This suggestion was uttered during the national consultation meeting with stakeholders on September 11, 2016 at the PIOJ. The format of the meeting did not allow to explore the issue further and find out what are the barriers for contracting CSOs without changing their legal status, or what is the rationale behind the practice of contracting only foundations/societies.
The percentage of adults and children receiving ARV out of total number of PLHIV has been increasing over the last three years though at a very low pace. The percentage of HIV-positive pregnant women who receive antiretroviral therapy to reduce the risk of mother-to-child transmission remains stable over 85% reaching its peak (90%) in 2015.81

In 2015, Jamaica officially adopted CD4<500 treatment policy, and has committed to adopt ‘Test and Start’ strategy starting from FY2017.18 These strategies, if implemented, will have substantial cost implications on the HIV national response. In addition, country should carefully assess the unknown needs in HRH, laboratory capacity, supply chain and other system components to successfully realize ‘Test and Start’ policy in Jamaica.

Based on the Treatment Cascade shown in the Figure 5, of the estimated (22,925) persons in need of ART only 38% (8,781) were on ART by the end of 2014. Only half of patients on ART have achieved viral suppression.64 Survival after 12 months of initiation of ARV is also demonstrating unfavorable trend (Figure 5).

Treatment cascade, as well as ARV coverage and treatment outcome indicators demonstrate that Jamaica is facing challenges that need to be explored and addressed during the transition period.

Treatment cascade and outcome indicators are contradictory with the reported sharp reduction in AIDS-related death: low coverage and retention in care, unfavorable treatment outcome translated into low survival rates presumably should lead to increased AIDS related mortality. It is possible that vital registration in Jamaica fails to capture all death cases and/or primary reasons of mortality, and therefore, the AIDS–related death cases might be underreported.

4.2.6.2 Integration of services

Following the integration of HIV program into the NFPB-SHA, the Ministry of Health has retained aspects for HIV treatment, care and support of former National HIV/STI Programme. Furthermore, to sustain and further strengthen integration of both diseases, a unit under the Ministry of Health,
now known as HIV/STI/TB Unit, is functional, which is responsible for both diseases focusing on HIV/TB policy, treatment, surveillance, and quality and standard setting.

HIV, TB and PMTCT services in Jamaica are fully integrated into the primary health care. HIV testing for pregnant women is accessible in antenatal healthcare centers in both, public and private sectors. ARV treatment is also offered to HIV positive pregnant women and HIV exposed infants in public or private clinics. The data about HIV testing and treatment of pregnant women in private sector is not collected. However, stakeholders state that vast majority of pregnant women attend services in public sector, rather than in private, especially for delivery services.

Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV/TB. TB patients with intensive phase receive treatment in two main treatment sites across the island.77 In 2014, eighteen and in 2015, fifteen HIV positive incident TB cases were detected and all patients received ARV therapy.

4.2.6.3 Coverage of KP with Preventive services

One of the risks for sustainability is restricted capacity of the HIV program to reach increasing number of KAPs. Weak surveillance data on coverage of key populations with prevention services and unreliable population size estimates make it difficult to assess the coverage levels of affected communities with comprehensive packages of HIV prevention.

The 2013 Medium Term Review of the UN High level Targets – Jamaica Report shows progress in several indicators: increased condom use among sex workers; youth having sex later; increase in HIV testing; increased outreach among sex workers; decreased HIV prevalence among sex workers.83

A Peer navigation strategy84 has been utilized to increase coverage of MSM population with HIV testing and provide necessary linkage to care. Program data show that in 2015, the number of MSM reached with prevention interventions slightly increased (6, 502) compared with 2014 data (6,088); HIV testing uptake among MSM reached with the program remains relatively stable (33% in 2015 & 36% in 2014).86 Based on the 2011 Bio-BSS among MSM survey results, HIV testing uptake reached 68.3% in 2011 that was higher than that from 2007 BBSS – 53%. However, due to the methodological weakness of the studies, the indicators are less likely to be valid. This statement is also supported by the program monitoring data provided above that indicates that the percentage of MSM reached during a year remains under 20% (6502/33,000 in 2015).85

Only 30% of sexually active adolescent girls aged 15 – 19 years, and 18% of adolescent boys have been tested for HIV during last 12 months that is far below the national target of 75%.77

Introducing provider initiated testing among hospital attendees in public sector resulted in increasing the proportion of population who were tested for HIV and know their test results.

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83 Jamaica’s National Integrated Strategic Plan for Sexual and Reproductive Health and HIV, 2014-2019
85 It should be also noted that commonly programme data tends to overestimate the coverage indicator due to potential double-counting of beneficiaries; thus the coverage indicator may be even lower than 20%.
Behavioural change trends do not show improvement when assessing the condom use among the population aged 15-49 who had more than one sexual partner in the last 12 months.

CONDOM USE AMONG MALES AND FEMALES AGED 15-49 YEARS WHO HAD MORE THAN ONE SEX PARTNER IN THE PAST 12 MONTHS AND USED CONDOM DURING LAST SEX
Unfavorable trend was also observed in terms of HIV awareness among youth 15-24 participating in the KABP surveys.

Data on coverage of transgender population is missing. Information about the coverage of out-of-school youth with HIV prevention services as well as the data about homeless/drug users are not available for recent years.

Despite non-conducive legal environment, Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program sustainability. However, ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates also need to be improved. PMTCT has been very successful in terms of sharp reduction in AIDS paediatric cases as the country moves towards elimination of MTCT. Despite program achievements, structural barriers, stigma and discrimination, and weak HIS are limiting country’s ability to better track service coverage and treatment outcome indicators, and these challenges need to be addressed during transition.

4.2.7 Program – Organizational Capacity

4.2.7.1 Program Management Capacity

Ministry of Health of Jamaica has served as PR of the Global Fund project for years and service integration within formal healthcare system has taken place for many years. Program management team has
benefited from number of capacity building interventions that have been supported by donor-funded projects. In general, HIV program management capacity within government structures is adequate to plan, implement, and monitor HIV response during the transition and after the GF funding ends.

Recent decision of the GoJ to integrate HIV national programme within already well-established structure National Family Planning Board also seems a step towards sustainability. The integration process involved reorganization of units and divisions into the NFPB-SHA with expanding, rather than losing any functions or services; a new division for enabling environment and human rights was also added to the NFPB-SHA.  

Emerging the new player into the HIV response management scene requires substantial technical assistance and capacity building to expand program management skills to both, existing and newly recruited staff of NFPB-SHA. The Board has strong procurement and chain management skills as it participates in procurement and distribution of condoms, diagnostic test kits through both, the GoJ state procurement, and donor funding. Furthermore the NFPB-SHA management team stated they achieve economies of scale by purchasing large stocks of male condoms costing $JMD 5 (US$0.34) per condom.

4.2.7.2 Procurement and Supply

The GF procurement is integrated into the national procurement system guided by the State Procurement procedures. Supply chain management is a major function of Treatment, Care and Support unit of the Ministry of health. ARV drugs and other HIV programme commodities are procured by the National Health Fund (NHF) procurement system. Purchases of ARV using domestic resources is done through the Clinton Health Access Initiative. The Central NHF warehouse is linked to majority of pharmacies and are able to view and generate reports on stock balances and ARV consumption in real time. Paper-based LMIS is maintained in remaining sites. Under the management of NHF, restructuring of the public sector pharmacies took place to streamline procurement and distribution process, however patients still continue to wait long hours for prescriptions in public pharmacies.

There are frequent stock-outs of ARVs, including for 1st line drugs. During interviews with MoH and stakeholders, they confirmed that there is a buffer stock of ARVs for extra three months; however they admit experiencing stock-outs once or twice per year. MoH representatives do not think that forecasting of ARV needs should be blamed; they believe that procurement process/lead time is too long taking up to 6 months.

The Jamaica HIV CN 2016 states that the country, with financing from NHF, developed an electronic stock management and Logistics Management Information System (LMIS) reporting tool. The electronic LMIS was piloted and then rolled out to 43 ARV dispensing sites (dispensing 33% of all ARV stocks). However, it is obvious that the absence of linkages among different

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86 *ATIONAL FAMILY PLANNING-HIV PROGRAMME INTEGRATION IN JAMAICA. Case study. 2014. PEPFAR/USAID/HPP
87 TPA mission. Interviews with the NFPB-SHA management team; September 6, 2016. Interview transcripts.
89 Sustainability index and dashboard report. Jamaica. PEPFAR. 2016
90 The Global Fund Concept Note. HIV. Jamaica. 2016
pharmacies in different parishes as well as potential weaknesses in procurement planning and implementation have encouraged ARV patients to register at different pharmacies under the same identity. Through this practices, PLHIV manage to get their prescriptions filled from multiple ARV dispensing sites and create personal stocks of prescribed drugs in case of stock outs.

ARV drugs’ price is considered key factor posing sustainability risk in resource-constrained countries, particularly with generalized HIV epidemics where ARV drugs costs account for considerable portion of AIDS spending. The TPA tool looks at drug prices and compares country prices against the median price of ARV drugs for the same income classification countries. The graph below presents the ARV prices in Jamaica91 over the last five years. As demonstrated, ARV price from 2011 through 2014 followed similar trend of that for upper middle-income countries. However, in 2015, the price skyrocketed that might be due to Jamaica’s weak purchasing power with suppliers that can be addressed through using TGF procurement service agent. Another reason might be frequent stock-outs leading to frequent emergency procurements of drugs.

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ARV drugs. This is particularly critical as the country moves to ‘Test and Start’ policy that is expected to increase the number of patients on ARV, and will require substantially more financial investments from the Government.

4.2.7.3 Monitoring and Evaluation Capacity

The National HIV Response is guided by newly developed National Integrated Strategic Plan accompanied by the 12-component M&E framework. M&E function lies within the Jamaican Monitoring and Evaluation Reference Group (MERG-J) which is composed of a Chair, Vice Chair, seven permanent members and eighteen invited members representing key stakeholder and population groups.

Local staff capacity was strengthened through technical assistance and formal training to plan, implement and analyse data for HIV surveillance surveys being conducted among KAPs using various methodologies. Currently, through the CDC support, team will be trained in advanced survey methodologies, like respondent-driven sampling for BSSs among MSM. Having in-country research capacity will be key for sustainability of HIV researches after external funding declines/ends. Following the integration of the HIV and SRH data, M&E system was advanced through capacity building of senior health care professionals and community intervention personnel in record keeping, data collection, data quality, etc.

With the introduction of District Health Information System (DHIS2), the Ministry of Health in 2015, facilitated training on the software to accelerate implementation of a national web-based platform for ARV patients accessing care within the public sector. On-site coaching on the use of treatment database is currently in progress for medical staff at treatment sites. Training in the use of Geographic Information System for mapping HIV prevention services were provided to community service provider organizations.

While substantial efforts have been made by HIV national programme to strengthen the national M&E system, capacity building of program staff should continue; service provider organizations, including CSOs and organizations at subnational level should be supported to develop site-specific M&E plans. The NISP M&E plan with SMART indicators specific to each target population groups should be an integral part of the NISP, and the latter with its M&E plan should be approved by Government resolution.

4.2.8 Transition Planning

Jamaica has not yet developed transition sustainability plan, but the GoJ has started absorption of HIV/AIDS costs incrementally. The Jamaica HIV program Concept Note spells out Government willingness to pay for a larger share of treatment and laboratory costs starting from 2016:

In transitioning the ARV drugs costs to the GOJ Budget, the costs will be absorbed as follows:

- 30% of the 2016 costs equivalent to US$ 380,000 will be absorbed
- 50% of the 2017/2018 costs will be absorbed equivalent to US$ 740,000
- 70% of the 2018/2019 costs in the amount of US$ 1,270,000

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93 SMART indicators should be Specific, Measurable, Attainable and action-oriented, Relevant, and Time-bound
• Full absorption of ARV costs in 2019/2020

In transitioning laboratory reagents and supplies for viral load and CD4 testing to the GoJ Budget, the costs will be absorbed as follows:

• 50% of the 2017 costs amounting to US$340,000 will be absorbed

• 50% of the 2018 costs amounting to US$470,000 will be absorbed

• Full absorption by 2019/2020

Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund Funding. To ensure smooth and full transition of HIV national response from external support to country ownership, MoH and PIoJ addressed UNAIDS to support transition preparedness process in Jamaica. GoJ assigned the Planning Institute of Jamaica in close partnership with the Ministry of Health to lead and coordinate transition and sustainability response in the country. Transition Steering Committee with high-level multi-sectoral representation was established. Exceptional commitment from the GoJ has been demonstrated during the TPA mission, however this commitment has to be realised through concrete steps from the GoJ to gradually reduce dependency on external funding.

Another advantage for the country was a joint initiative of major donors – the Global Fund and USAID to get engaged in the transition preparedness process from its very initial phase. A team of TGF Transition and Sustainability and health financing specialists, a team from local and regional UNAIDS, as well as local and US experts from USAID were involved in the TPA mission. Through these engagement, economies of scope were achieved as donor communities, at no extra costs, benefited from learning opinions and concerns from wide variety of stakeholders mobilized for interviews through the help of UNAIDS Jamaica team. The information collected during the TPA mission and discussions during national consultation and Steering Committee meetings, encouraged donors to start exploring their potential roles in the transition immediately. Donors have declared commitment to pool financial and technical resources in a coordinated manner, and support implementation of interventions in most critical areas identified through the TPA. Strong ownership of GoJ coupled with exceptional cooperation of country’s stakeholders and donor communities provide solid foundations for optimism that HIV national response will be sustained in Jamaica.

5. Findings and Recommendations

5.1 Brief summary findings of transition preparedness assessment

Through the Transition Preparedness Assessment exercise achievements and remaining challenges of the National HIV response were outlined. Factors supporting or hindering program implementation and posing sustainability risk were identified and validated through consultation with key stakeholders.

The TPA tool final score indicates that Jamaica has been facing high to moderate
risk of HIV program sustainability with the score of 26.92%.

Brief summary findings presented below follow the TPA framework structure:

**External Environment**

**Political Environment**

GoJ declares its commitment to population health, however this commitment has not been translated into the adequate investments in health: the share of government spending on health out of General Government Expenditure in 2014 remains below the mean for UMICs, and the share of public spending out of total health expenditure in 2014 has been the lowest since 2011. Health expenditure per capita (current US$) by the State was rising steadily since 2009 through 2013, but declined in 2014. Total Health expenditure as a percentage of GDP also declined in 2014 to 5.4% that is the lower than the average for Caribbean region - 6.1%.

Existence of numbers of discriminatory laws in Jamaica also poses very high risk to program transition and sustainability of progresses achieved in terms of reversing HIV epidemic, especially among KAPs. These laws include:

- Offences Against the Person Act (Buggery Law) – criminalizes private, consensual same-sex sexual acts;
- Sexual Offenses Act – makes the act of solicitation of women and girls for sex and the operation of brothels illegal in Jamaica;
- The Age of Majority Act – creates barriers for adolescents under the age of 16 years without parental consent;
- Dangerous Drug Act: Criminalizes drug use;
- Ban on condom distribution in correctional settings is a consequence of the Offences Against the Person Act that criminalizes anal sex;
- Anti-abortion legislation - Sections 72 and 73 of the Offences Against the Person Act of 1864 restricts access of women and girls to safe abortion services.

It is necessary to acknowledge strong linkages between criminalization, marginalization and discrimination of key affected populations on one hand, and the threats to HIV epidemics in the country. Having discriminatory laws drive key vulnerable populations underground; reduces HIV testing uptake and early detection; due to fear of stigma and discrimination, people do not seek testing and prefer not to know their status that heightens their individual risk for HIV as well as spread the infection to their sexual partners and the population in general. Furthermore, those who test positive for HIV in a fear of not being criminalized or marginalized by the society, most likely will not self-identify themselves as MSM, TG, or sex worker, or drug users and therefore surveillance data becomes incomplete and inadequate to properly diagnose the problem and design appropriate interventions. As a result of all the above mentioned, the data that is being routinely collected through the surveillance system, is likely to be misleading. This will substantially limit country’s ability to plan well-targeted and focused HIV national response. Furthermore, such laws most likely will impose limitation on the government to budget for KAPs and to use national funding for service provision with the help of contracted CSOs.

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95 Caribbean Regional Operational Plan 2016 Strategic Direction Summary. July 6, 2016. p. 21
There is no law safeguarding non-discrimination of PLHIV in Jamaica. Permanent fear of being discriminated and marginalized by the society, makes PLHIV even more vulnerable and susceptible to mental health problems; all these intertwined with side effects associated with ARV treatment, may greatly discourage AIDS patients to retain in treatment that might be one plausible explanation of the unfavorable treatment cascade in Jamaica. All these factors may result in fast-growing HIV epidemic with its negative consequences on human’s lives and economic development of country as a whole.

Based on the indicators measuring the level of health investments by the GoJ, and assessing the legal environment in the country, the TPA tool calculated that in overall, the political environment in Jamaica poses very high risk to HIV program sustainability.

**Economic environment**

Jamaica’s GDP has been increasing over the last few years but at a very low rate averaging less than 1 percent a year. The country’s debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014 and potentially limiting fiscal space for adequate health investments. Less conducive macro-economic environment along with huge debt burden, although improving after the election in 2016, may limit government’s ability to assume full financial responsibility for the HIV program currently funded through the GF.

**Internal Environment**

**Inputs/Human resources**

There is a severe shortage of HR in health sector in general, including HIV field with the highest gap in non-medical/support staff. The situation is exacerbated by the IMF restrictions under which the Government of Jamaica cannot hire more health care workers. Therefore, it should be acknowledged that the challenges in terms HRH is a structural challenge of the sector that goes far beyond HIV programme, and is doubtful to be adequately addressed within the limits of HIV program.

On the other hand, the HR costs for HIV remain largely dependent on external support and after transitioning, staff shortage might become even worse if the GoJ is unable to absorb the costs of human resources currently paid by donors.

However, latest spending data shows that in FY 2013, the GoJ covered only one fifth of the AIDS total spending, using borrowed funding from IBRD. AIDS spending data did not allow assessing the share of the public funds out of total spending by program areas, and the TPA indicators that look at GoJ’s budgetary commitment to case detection and treatment services are based on the stakeholders’ opinion, that may not be accurate. Few economic studies were conducted in Jamaica that may serve as practical tools for HIV budget projection: Goals Model impact assessment for treatment program; Modes of transmission study; HIV Program Financial Sustainability study; and estimation of unit costs for HIV prevention package for MSM (for PEPFAR funded project). Appropriate monitoring of public spending on HIV program is warranted in order to generate necessary financial data and adequately inform the transition planning and implementation processes.

**Inputs/Financial resources**

HIV/AIDS budget lines are included in the Jamaica multi-year national budget.
Institutionalization of training programs previously supported and developed through the GF and other donors will mitigate the sustainability risk posed by the shortage of qualified professionals engaged in HIV national response. Given that most HIV clinical management trainings have already been integrated into formal education system, during the transition period, the GoJ should focus on accreditation of life-long education as well as on institutionalization of trainings for non-medical staff in HIV prevention, program management, adherence counselling, peer navigation, motivational interviewing, HIV-related research, PSM, M&E, stigma and discrimination, etc.

**Inputs/ Information Systems**

In recent years, significant efforts have been done by the GoJ to strengthen HIV health information system and major program data cleaning was carried out through the guidance and technical support from the CHAI partnership. Despite this, challenges still remain in terms of reliability of data about treatment and prevention services, especially for KAPs. Second generation surveillance studies have been conducted among MSM and sex workers periodically, but these studies need to use more robust methodologies to produce more reliable findings about marginalized population groups that have been driven underground due to existing legislation. Bio-BSS studies have been mainly financed through external funds and unless adequate national funding is secured during transition process, critical epidemiological and program related data, necessary to plan national response, may not be available. Most population size estimates for KAPs are based on experts’ opinion rather than derived from research findings. Weak HIV information system and full reliance on donors’ funds for surveillance studies poses high risk to program sustainability.

**Governance**

HIV/AIDS has been declared as a priority by the Government, but to assure adequate transition towards sustainability of HIV national response, the declaration is to be substantiated with credible funding allocation from the State and legislative amendments. Jamaica has had national plans to guide National HIV/STI programme since 1988. The National Integrated Strategic Plan (2014-2019) was developed through participatory process involving stakeholders from government, civil society, development partners, and private sectors. According to national stakeholders, the NISP is costed and is accompanied with the monitoring and evaluation framework. For smooth transition, it is critical to submit costed NISP and its M&E plan to the government for formal approval. The NISP approved from the Cabinet/or by the Government resolution will have more legal power to drive adequate allocations within the national budget.

CCM has been considered as an effective platform for stakeholders, particularly for civil society organizations to discuss HIV national response with high-level government officials, and wider representation of other sectors. Forty per cent of seats in the Jamaican CCM is allocated to civil society. CSOs believe that CCM should continue functioning beyond the GF funding.

GoJ has integrated HIV national program to National Family Planning Board to improve coordination and optimize country response to both, HIV, and reproductive health/family planning services. While, CCM and NFPB-SHA, both are expected to serve as an effective mechanism to strengthen HIV coordination in the country, none of these two structures is placed adequately within the government hierarchy, and is legally empowered to assure strong coordination across the sectors. Consequently, it becomes...
important during transition planning process to undertake consultations, and decide how and where the coordination function will be sustained and further strengthened.

**Accountability**

Jamaica develops HIV program reports annually, such as Global AIDS Response Progress (GARP) report, and HIV epidemiological Profile. These reports are publicly available on the UNAIDS and the MoH websites, respectively. The National AIDS Spending Assessment reports and GARP funding matrix files can be obtained upon request. Reporting on program financial data lag far behind in time: as of September 2016, last AIDS spending data submitted to UNAIDS was from FY2012/2013. Data dissemination and sharing is seen as an area of weakness as data is not reaching civil society to guide their programming and/or advocacy efforts. Program performance reports and survey findings have been used for planning purposes in Jamaica.

**Programme**

**Service delivery**

Recent integration of HIV program with reproductive and sexual health services seems to be sensible decision of the Government as the focus of services has become broader and less stigmatizing that may improve health seeking behaviour of most-at-risk population. Despite non-conducive legal environment, Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program sustainability.

Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates need to be improved.

PMTCT is integrated with PHC/Maternity care, and services are provided to pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. Coverage of pregnant women with HIV testing and ARV has increased yielding sharp reduction in AIDS paediatric cases and deaths rate, and Jamaica currently moves to elimination of MTCT. Re-introducing PIT among hospital attendees resulted in increasing HIV testing uptake that is critical for HIV case detection. Data on coverage of transgender population, out-of-school youth, and homeless/drug users is not available for recent years.

In general, HIV national program in Jamaica has been successful in various directions (reduction of HIV prevalence among KAPs, reduction of MTCT and AIDS related deaths, etc.), however structural challenges, stigma and discrimination, and weak HIS are limiting country’s ability to better track prevention and treatment outcomes. Addressing these challenges will make transition process smoother.

**CSO engagement**

Jamaica Government has supported engagement of civil society organizations in HIV service provision, including ARV treatment services. There are no laws that would restrict the Government to contract CSOs for health service delivery. However existing legislation may limit Government’s legal power to contract civil society
organizations under the public funds for the services targeting MSM and sex workers. Through the consultation with stakeholders it has become obvious that there is a certain level of ambiguity in existing regulations for social contracting, and more in-depth assessment is needed. All CSOs in Jamaica currently are largely dependent on TGF and USAID/PEPFAR funding. It will be crucial to ensure that the GoJ incrementally starts funding CSOs for HIV service delivery as they have substantial capacity to outreach to marginalized communities. Some of the CSOs expressed concerns that accepting funds from the Government in future may potentially cripple their advocacy and watchdog function. During transition period, a national dialogue should be initiated to find out most feasible and suitable ways for sustainability of CSOs engagement in service provision under the public funds.

Organizational Capacity

There is a strong national programme management capacity within the MoH that serves as TGF PR and also manages the national HIV programme. Recent decision of the GoJ to integrate HIV national programme into the National Family Planning Board has emerged a new player into the HIV response management scene. Therefore, significant technical assistance and capacity building interventions will be warranted to expand program management skills to both, existing and newly recruited staff of the NFPB-SHA. CSOs capacity should be strengthened in managing programs under the public funds as well as in fundraising.

The GF procurement and supply chain management is integrated into the national system that is positive factor to make transition smoother. However, Jamaica experiences frequent stock-out of ARV drugs and reasons should be explored and addressed within the transition plan. In 2015, the ARV drugs price skyrocketed that might be due to Jamaica’s weak purchasing power with suppliers that can be addressed through using TGF procurement service agent. Another reason might be frequent stock-outs leading to frequent emergency procurements of drugs. The procurement and supply chain management system in Jamaica should be thoroughly assessed to identify system challenges and overhaul the national PSM system.

Transition planning

There are some plans from the GoJ to start absorption of certain elements of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet been approved by Government resolution and, thus is not legally empowered.

Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund funding occurs. During the TPA mission, the GoJ demonstrated strong political will to ensure smooth and full transition of HIV national response from external support to country ownership. Country major donors - the Global Fund and USAID are committed to support the country during the transition period. All above mentioned provide solid ground for optimism that Jamaica in collaboration with the GF and other development partners will make concerted efforts to address major challenges identified through the assessment, and will design and implement a well-conceptualized transition plan to ensure HIV program sustainability after the GF funding ends.
5.2 Recommendations

During transition planning stakeholders should focus on straightening a multi-sectoral HIV response and initiate negotiations with high-level officials including representatives of concerned ministries (particularly targeting the Ministry of Corrections, the Ministry of Labour and Social Security, the Ministry of Education, etc), in an effort to manage the mobilization of HIV-dedicated resources within their respective budgets. That may reduce HIV funding burden on the MoH that will be key to sustainability.

The list of recommendations presented below follows the domains of the TPA framework. Based on the sustainability risk and feasibility of proposed activities, the recommendations are presented under different temporal dimensions. The recommendations are not prescriptive and can be adapted to the Jamaican context.

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<th>RECOMMENDATION</th>
<th>TEMPORAL DIMENSION</th>
<th>PROPOSED ACTIVITIES</th>
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<tr>
<td><strong>EXTERNAL ENVIRONMENT</strong></td>
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<td><strong>POLITICAL ENVIRONMENT</strong></td>
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| Recommendation #1: create conducive legal environment | Immediate step | • Transition preparedness Steering Committee led by the PIOJ and MoH should initiate policy dialogue involving the GoJ and national stakeholders to explore the ways during transition planning how restrictive legislations can be revised to reduce access barriers for MSM and sex workers, prisoners, and mitigate the risk of stigma and discrimination on program success.  
• Develop SRH & HIV policy to address service barriers for adolescents and women in Jamaica  
• Intensify HIV awareness and sensitization public campaigns to reduce stigma and discrimination, and generate constructive attitudes among the society |
| | Medium to long term | • Development and adoption of legislative amendments to restrictive laws |
| **ECONOMIC ENVIRONMENT** | | |
| Recommendation #2: Create capacity of the Government to mobilize additional financial resources for health | Immediate step | • Immediate step |
| **INTERNAL ENVIRONMENT** | | |
| **INPUTS: FINANCIAL RESOURCES** | | |
| Recommendation #3: mobilization of adequate financial resources | Immediate step | • Monitor fulfillment of GoJ’s pledge about gradually absorbing costs of ARV drugs, laboratory reagents and other commodities in 2016-2018 (per the GF CN & costed NISP)  
• Prepare HIV national budget forecasts based on existing epidemiological data, and technical & allocative efficiency principles  
• Ensure that the GoJ is dedicating national budget funds to prevention services specifically targeting KAPs, including MSM, sex workers, homeless, OSY, & prisoners |
<p>| | Medium to long term | • Ensure that adequate funding from public sources is available for HIS strengthening, M&amp;E and HIV research activities, including Bio-BSS and population size estimation studies. |</p>
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<tr>
<td>Recommendation #2: Create capacity of the Government to mobilize additional financial resources for health</td>
<td>Immediate step</td>
<td>• Conduct fiscal space analysis. This becomes even more important given that health-financing reform currently is in progress in Jamaica.</td>
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**INTERNAL ENVIRONMENT**

**INPUTS: FINANCIAL RESOURCES**

| Recommendation #3: Mobilization of adequate financial resources | Immediate step | • Monitor fulfilment of GoJ’s pledge about gradually absorbing costs of ARV drugs, laboratory reagents and other commodities in 2016-2018 (per the GF CN & costed NISP) • Prepare HIV national budget forecasts based on existing epidemiological data, and technical & allocative efficiency principles • Ensure that the GoJ is dedicating national budget funds to prevention services specifically targeting KAPs, including MSM, sex workers, homeless, OSY, & prisoners |
| Medium to long term | • Ensure that adequate funding from public sources is available for HIS strengthening, M&E and HIV research activities, including Bio-BSS and population size estimation studies. |

**INPUTS: HUMAN RESOURCES**

| Recommendation #4: Strengthen HR in HIV field and institutionalize HIV related training modules into formal education system | Immediate step | • Transition planning Steering Committee should initiate dialogue with the Ministry of Education to institutionalize HIV related training modules that have been created and successfully implemented through the GF and other donor-funded programs into the formal education curricula at undergraduate and postgraduate levels. • Consult with the MoE and professional associations to institutionalize lifelong learning (continuous education) courses through accreditation of training programmes for in-service professionals |
| Medium to long term | • Explore feasibility of institutionalization of accredited practical training (internship) programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits can be deployed in service areas where staff shortage is most severe. |
| Long term | • Challenges in terms of HRH is a larger problem of the national health care system, and even though the HR shortage will certainly affect HIV program sustainability, this problem may not be resolved during the transition period. However, Jamaica within the GF CN for the next round under the HSS component may request assistance for development of a comprehensive policy for production/training of HR in health |

**INPUTS: INFORMATION SYSTEMS**

**RECOMMENDATION # 5: Enhance surveillance systems and build research capacity at national and local levels**

| Immediate step | • Strengthen HIV surveillance system through improved prevention and treatment databases that ensure linkages within all treatment sites (including private clinics and paediatric clinics), and with all prevention service provider sites, and allow data disaggregation and minimize double-counting of clients. • Collate data and produce surveillance reports that allow disaggregation by age, gender, social groups, geographic regions and other key characteristics of beneficiary groups, including transgender population, at-risk youth, out-of-school youth, homeless drug users. |
### RECOMMENDATION | TEMPORAL DIMENSION | PROPOSED ACTIVITIES
--- | --- | ---
 | Medium to long term | • Negotiate with donors and development partners to provide capacity building of local staff on surveillance studies/PSE studies to build in-country institutional and human capacity for conducting surveys without external support after the donor funding ends.

### GOVERNANCE

**Recommendation #6 Enhance Governance of National Programs**

**Immediate step**

• National Integrated Strategic Plan for 2014-2019 with its budget and M&E Plan should be formally approved by the Cabinet/or other government resolutions to ensure it becomes legally binding document.

**Medium to long term**

• Transition preparedness Steering Committee should initiate dialogue among national stakeholders including civil society to define most appropriate model for HIV coordinating structure (CCM vs. NFPB) which will continue coordination function after transitioning from the GF funding. Ensure that the coordination body is placed adequately within the Government hierarchy to coordinate multi-sectoral response. Ensure that civil society organizations, including HIV constituencies have legally determined seats on the coordination body.

### ACCOUNTABILITY

**Recommendation #7: Increase transparency and accessibility of HIV program data**

**Immediate**

• Ensure production and availability of descriptive and analytical reports describing results of the national response, implementation of transition elements and declared commitments from the Government, disease program specific epidemiological and financial expenditure data, program performance results, program outcomes and challenges.

• Improve the quality and timeliness of National AIDS Spending Assessment reports.

### PROGRAMME

**Recommendation #9: enhance HIV service delivery**

**Immediate**

• Conduct HIV program technical efficiency study (perhaps from WHO/UNAIDS) that may help identify program operational bottlenecks that will be critical for program (and expenditure) optimization.

• Conduct study to identify reasons for unfavorable treatment cascade, poor treatment retention and low viral suppression rates.

• Assess accuracy of vital registry in Jamaica, and subsequently, the AIDS-related deaths data

• Scale up the coverage of KAPs with comprehensive prevention packages that are defined and formally approved by the MoH.
### RECOMMENDATION

**Temporal Dimension**

**Recommender**

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<th>Immediate</th>
<th>Medium to long term</th>
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**Proposed Activities**

- **Recommendation #10:** Create enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding

  - **Immediate**
    - While the overall legal environment is conducive to NGO/CSO contracting under the public funds, thorough assessment of CSO contracting mechanisms in Jamaica is warranted to identify potential barriers the Government may face to fund the services targeting populations with criminalized behaviors. The social contracting assessment exercise should examine not only existing legislation, but also the political will of the Government, established practices of the MoH in contracting non-governmental organizations for health-related service delivery under the public funds. Potential challenges in terms of exchanging patients data between the government and CSO that was named as problematic by the PIOJ/MOH staff should be further explored.

  - **Medium to long term**
    - An open, results-oriented and constructive policy dialogue between the government and civil society should be initiated to explore potential solutions to CSO contracting, and agree on the mechanism that is well-balanced and acceptable for both, the GoJ and CSOs (e.g. disbursing grants through establishing a trust fund).

### ORGANIZATIONAL CAPACITY

**Recommendation #11:** Strengthen organizational capacity of all involved stakeholders including government institutions and CSOs for better sustainability

  - **Immediate**
    - The function, management and governance structure, and operations of the NFPB-SHA should be clearly defined and strengthened. The NFPB-SHA should strive to establish partnership-based linkages with civil society organizations that seemed somewhat sceptical about the NFPB plans to sustain well-established coordination among government, civil society, donor communities and private sector.
    - NFPB capacity should be strengthened through establishment of effective management team with strong background in both, HIV and family planning. The team should serve as ‘bridge builders’ across stakeholders from the two, previously independent programs – HIV & Family planning.
    - CSOs capacity should be strengthened to be able to deliver a wider spectrum of services to various groups. Training of CSOs on program management, M&E, financial management, organizational strengthening, proposal writing (topics can be prioritized based on the training needs assessment) will increase their capability and competitive power for fundraising in a resource-constrained environment.

### PROCUREMENT AND SUPPLY MANAGEMENT

**Recommendation #12:** Enhance procurement and supply management system in Jamaica to ensure uninterrupted access to ARV drugs and other program commodities.

  - **Immediate**
    - Conduct thorough analysis of Jamaica current procurement and supply chain system (in coordination with the USAID/PEPFAR study initiated in August 2016) to identify the reasons for frequent stock-outs of ARV drugs and other HIV program commodities.
    - Strengthen LMIS and linkages between the NHF central warehouse and all pharmacies dispersing ARV drugs to make sure that the system is capable of generating reports on stock balances and ARV consumption in real time to avoid stock-outs and emergency procurement.
    - Explore reasons for high prices of ARV drugs; plan strategies how Jamaica can strengthen its purchasing power with suppliers.
    - Consider using TGF procurement service agent if that potentially leads to cost-savings.
TRANSITION PLANNING

Recommendation #13: Develop, implement and monitor transition plan for Jamaica

**Immediate**

- Develop a multi-year (3 to 5 years) Transition Plan which clearly identifies time-bound activities, outlines roles and responsibilities of a transition process management; incorporates M&E plan and budget for implementation of the transition plan.
- Ensure greater engagement of HIV program partners such as CSOs, development partners, other ministries, etc. in the transition plan development, implementation and monitoring process.
- The Transition Plan should become an integral part of the NISP, which is approved by Government resolution.
- Consider commissioning external team – Peer Review Mechanism (outside from the MOH/PIOJ) for supervision, monitoring and evaluation of the transition plan implementation process.

### Annex 1: Transition Preparedness Assessment Table

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>INDICATOR ID</th>
<th>INDICATOR</th>
<th>DESCRIPTION</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXTERNAL ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PG1</td>
<td>Existence of political will to prioritize health investments</td>
<td>Share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that is below the mean for UMIC (12% in 2013). Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. There are no regulations/laws that would prevent the Government from CSO contracting. According to the stakeholders, the ministry of Education, Ministry of Social Security, as well as Ministry of Health have practiced CSO contracting under the public funds.</td>
<td>High Risk</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>PH2, PH3</td>
<td>Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases &amp; Rule of Law</td>
<td></td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>PG4, PG5</td>
<td>Government ability to contract with CSOs; CSO contracting practices</td>
<td></td>
<td></td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td>EG1</td>
<td>Favourable economic indicators</td>
<td>GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year. The country still faces substantial debt-burden and according to the World Bank, Jamaica’s debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014. The share of General Government Revenues as % of GDP has been stably high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013. This indicator is above the mean for the same income group countries - 28.9% in 2012.</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td>COMPONENT ID</td>
<td>INDICATOR ID</td>
<td>INDICATOR DESCRIPTION</td>
<td>DESCRIPTION</td>
<td>RISK CATEGORY</td>
<td>RISK SCORE</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
<td>------------------------</td>
<td>-------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Financial Resources</td>
<td>FH1</td>
<td>Budgetary commitment to disease</td>
<td>HIV budget lines are included in the Jamaica multi-year national budget. The latest NASA report provides AIDS spending data by various program areas, however cross-tabulation of spending by prevention priorities, by beneficiary groups and by financial sources is not available. Goals Model impact assessment study, &amp; Modes of Transmission study were conducted in Jamaica. HIV program financial sustainability study was also completed. Unit costs of comprehensive package of HIV prevention targeting KAPs has been conducted for the USAID/PEPFAR project; established unit costs can be applied for planning and projection purposes. Budget allocations have been informed by these studies. HIV screening tests, ARV drugs are partially funded from public sources. The Government’s share in financing treatment adherence costs is minimal. The exact share of public funding in financing these services is not known. The assumption is based on the stakeholders' opinion.</td>
<td>High Risk</td>
<td>High risk</td>
</tr>
<tr>
<td></td>
<td>FH2</td>
<td>Prevention priority</td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FH3</td>
<td>Allocative efficiency</td>
<td></td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FH4</td>
<td>Treatment / input financing from public sources</td>
<td></td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FH5</td>
<td>Prevention financing from public sources</td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>HRH1</td>
<td>Sufficient human resources for disease (quantities, geographic distribution and aging)</td>
<td>The full time equivalent of currently deployed health care workers (HCWs) in HIV response is 62% of the optimal level required with the largest gap in non-medical, support staff. The number HCWs providing HIV treatment services has not kept the pace with the increased number of patients. Substantial portion of staff training remains heavily relied on donor-supported grants. Only some training, mostly training about HIV/AIDS clinical management have been institutionalized into formal curricula of medical schools. Majority training for non-medical staff has not been institutionalized into formal education system. A policy for production of CSO personnel/non-medical, social and support services does not exist. Stakeholders confirm that donor-funded HR salaries in most cases are aligned with national pay-scale. However, substantial portion of HR costs still is covered by external support.</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>HRH2, HRH3, HRH4</td>
<td>Institutionalization of donor supported programs; Existence of policy for production/training of CSO personnel (non medical, social service), Donor funded HR salaries aligned with national pay-scale</td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>HISH1</td>
<td>Routine statistical reporting - Integration in the national system</td>
<td>HIV Program data is integrated into the national system; however, the quality of reporting is suboptimal. ARV and PMTCT data from private providers is not integrated; pediatric treatment data is not completely integrated. AIDS treatment database is operational</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HISH2</td>
<td>Routine statistical reporting - Level of advancement</td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>COMPONENT ID</td>
<td>INDICATOR ID</td>
<td>INDICATOR DESCRIPTION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HISH3</td>
<td>HIV Second generation surveillance - Methodologies, Timeliness</td>
<td>with limited capacity for data disaggregation by KAPs, age, gender, regions, etc. Prevention database does not exclude double-counting of beneficiaries; data about transgender, or homeless drug users, out-of-school youth, adolescents at risk of HIV- are either limited or unavailable. Under the PEPFAR funding DHIS is being developed but has not yet been implemented at the national level. KABP among general population is based on solid research methodology. PLACE studies (Bio-BSS) among KAPs used convenience sampling and therefore, study findings lack robustness. In 2016, through USAID support RDS methodology will be introduced for Bio-BSS among MSM. PSE studies have not been conducted. Upcoming BBSS (USAID/PEPFAR) among MSM will be combined with PSE study. Bio-BSS studies have been financed through external funds. Only some research staff salaries are covered by the Government. Population Size Estimation studies have never been conducted and most estimates for KAPs are based on experts’ opinion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HISH4</td>
<td>HIV Second generation surveillance - Funding from public sources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GOVERNANCE**

| Governance | GovH1 | Strong political commitment to diseases | The National Integrated Strategic Plan (2014-2019) was developed through participatory process; costing of the NISP was completed in 2016. NISP is not approved by the Cabinet, or by any Government resolution. HIV is identified as a priority in the National Agenda of 2030 Sustainable Development Goals. Stakeholders found it difficult to name legally empowered leading organization, which contributes to effective functioning of HIV response. CSOs named individual champions from civil society organization - Jamaica AIDS Support for Life, who has been most prominent leader in advocating for sustainable funding for HIV response, and protecting vulnerable populations’ rights. While, CCM and NFPB-SHA, both are expected to serve as an effective mechanism to strengthen HIV coordination in the country, none of these two structures is placed adequately within the government hierarchy, and is legally empowered to assure strong coordination across the sectors. 40% of seats in the CCM is allocated to civil society. Stakeholders believe that CCM functions effectively. |
| Governance | GovH2 | Strong leadership | Moderate Risk |
| Governance | GovG3 | Strong coordination mechanisms | Moderate Risk |
### Accountability

<table>
<thead>
<tr>
<th>ID</th>
<th>Indicator</th>
<th>Description</th>
<th>Risk Category</th>
<th>Transition Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH1</td>
<td>Programme performance results are available and accessible through public domain</td>
<td>HIV Epidemiological Profile is being prepared by HIV/STI National Programme. Reports are available publicly. Data for some KAPs is not available; data disaggregation and analytical part remain weak. Global AIDS Response Progress (GARP) reports are produced and available on the UNAIDS website. Funding matrix files can be obtained upon request. As of September 2016, last AIDS spending data submitted to UNAIDS was from FY 2012/2013. NASA reports up to FY2012/2013 are available.</td>
<td>Low Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>AG2</td>
<td>Enabling Environment for Civil Society engagement</td>
<td>However, cross-tabulation of spending by beneficiary populations all program areas by financial sources is not available. Program evaluation specific reports are not available. Only GARP report and GF PUDR provides some outcome indicators. Enabling Environment Index for civil society organizations - EEI= 0.55 There are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight.</td>
<td>Low Risk</td>
<td></td>
</tr>
</tbody>
</table>

### Programme

<table>
<thead>
<tr>
<th>Programme</th>
<th>Indicator</th>
<th>Description</th>
<th>Risk Category</th>
<th>Transition Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delivery</td>
<td>SH1</td>
<td>Treatment</td>
<td>Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years, did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Treatment cascade is suboptimal. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV is declining over the last three years from 90% in 2013 to 60% in 2015. PMTCT is integrated with PHC/Maternity care. PMTCT services are available for pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. HIV and TB services are integrated within the PHC system. Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV. The coverage of general population with testing has been on rise since 2004. Data based on rigorous Bio-BSSs regarding the two indicators - coverage of MSM and sex workers with prevention services is missing; therefore the indicators were qualified as “worsening” the coverage. The MoH has practiced social contracting mechanism in health sector.</td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>SH2</td>
<td>Integrated services</td>
<td></td>
<td>Low Risk</td>
</tr>
<tr>
<td></td>
<td>SH3</td>
<td>Key populations reach with preventive services</td>
<td></td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>SG4</td>
<td>CSOs contracting in health</td>
<td></td>
<td>Low Risk</td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>OH1</td>
<td>Strong management of the National Disease Programme Management Entity</td>
<td>There is strong national programme management capacity within the MoH that serves as TGF PR and also manages the national HIV programme. TGF funded</td>
<td>Low Risk</td>
</tr>
</tbody>
</table>
OH2 Procurement & Supply Management
procurement is conducted using national system in compliance with state procurement regulations. Supply chain management is integrated into the national system. Stock outs for ARV drugs, including for 1st line ARV drugs, happens few times a year. Emergency procurements of drugs become necessary due to frequent stock outs. ARV drugs price from 2011 through 2014 followed similar trend of that for UMICs. However, in 2015, the price in Jamaica skyrocketed. Analytical capacity at MoH is adequate to produce reports, such as GARP, NASA. However, the quality of the reports is not optimal. Reports are more descriptive and analytical part is weak. TGF Concept Notes and National strategic Plans are based on the evidences generated from program data or researches.

Moderate

OH3 Monitoring & Evaluation

Moderate

Transition Planning

Jamaica initiated working on its transition process in 2016. There are some plans from the GoJ to start absorption of certain portion of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet approved by Government resolutions and, thus has limited legal power. Transition plan in Jamaica has not yet been developed. Once the plan is developed and approved, the data in the TPA tool can be updated and the risk will be recalculated.

High

TRANSITION RISK SCORE FOR HIV/AIDS

26.92% High to moderate risk

Annex 2: Table of Key Indicators

DEMOGRAPHIC AND SOCIAL INDICATORS

<table>
<thead>
<tr>
<th>Component</th>
<th>Indicator ID</th>
<th>Indicator</th>
<th>Description</th>
<th>Indicator Risk Category</th>
<th>Transition Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH2</td>
<td>Procurement &amp; Supply Management</td>
<td></td>
<td>procurement is conducted using national system in compliance with state procurement regulations. Supply chain management is integrated into the national system. Stock outs for ARV drugs, including for 1st line ARV drugs, happens few times a year. Emergency procurements of drugs become necessary due to frequent stock outs. ARV drugs price from 2011 through 2014 followed similar trend of that for UMICs. However, in 2015, the price in Jamaica skyrocketed. Analytical capacity at MoH is adequate to produce reports, such as GARP, NASA. However, the quality of the reports is not optimal. Reports are more descriptive and analytical part is weak. TGF Concept Notes and National strategic Plans are based on the evidences generated from program data or researches.</td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td>OH3</td>
<td>Monitoring &amp; Evaluation</td>
<td></td>
<td></td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td>TH1</td>
<td>Legally binding and actionable Transition plan / Transition elements</td>
<td></td>
<td>Jamaica initiated working on its transition process in 2016. There are some plans from the GoJ to start absorption of certain portion of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet approved by Government resolutions and, thus has limited legal power. Transition plan in Jamaica has not yet been developed. Once the plan is developed and approved, the data in the TPA tool can be updated and the risk will be recalculated.</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td>TH2</td>
<td>Transition plan / Transition elements characteristics</td>
<td></td>
<td></td>
<td>High Risk</td>
<td></td>
</tr>
</tbody>
</table>

Annex 2: Table of Key Indicators

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Population, total (thousands)</td>
<td>2,643.6</td>
<td>2,653</td>
<td>2,662.5</td>
<td>2,671.9</td>
<td>2,681.4</td>
<td>2,690.8</td>
<td>2,699.8</td>
<td>2,707.8</td>
<td>2,714.7</td>
<td>2,721.3</td>
<td>2,725.9</td>
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<tr>
<td>Population growth (annual %)</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
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</table>
### MACROECONOMIC AND HEALTH FINANCING INDICATORS

<table>
<thead>
<tr>
<th>Year</th>
<th>GDP per capita (current US$)</th>
<th>GDP per capita growth (annual %)</th>
<th>GINI index (World Bank estimate)</th>
<th>Revenue, excluding grants (% of GDP)</th>
<th>GNI per capita growth (annual %)</th>
<th>GNI per capita, Atlas method (current US$)</th>
<th>Health expenditure, total (% of GDP)</th>
<th>Health expenditure per capita (current US$)</th>
<th>Health expenditure, public (% of government expenditure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>4238</td>
<td>0.5</td>
<td>30.7</td>
<td></td>
<td>0.2</td>
<td>3920</td>
<td>4.1</td>
<td>170.7</td>
<td>3.5</td>
</tr>
<tr>
<td>2006</td>
<td>4487</td>
<td>2.5</td>
<td>31.6</td>
<td></td>
<td>-6.1</td>
<td>4230</td>
<td>4.2</td>
<td>187.1</td>
<td>4.5</td>
</tr>
<tr>
<td>2007</td>
<td>4817</td>
<td>1.1</td>
<td>32.3</td>
<td></td>
<td>0.0</td>
<td>4480</td>
<td>4.9</td>
<td>230.5</td>
<td>5.5</td>
</tr>
<tr>
<td>2008</td>
<td>5119</td>
<td>-1.1</td>
<td>31.7</td>
<td></td>
<td>2.0</td>
<td>4750</td>
<td>5.4</td>
<td>272.6</td>
<td>6.4</td>
</tr>
<tr>
<td>2009</td>
<td>4489</td>
<td>-4.8</td>
<td>32.5</td>
<td></td>
<td>-1.8</td>
<td>4500</td>
<td>5.2</td>
<td>229.1</td>
<td>5.5</td>
</tr>
<tr>
<td>2010</td>
<td>4902</td>
<td>-1.4</td>
<td>31.3</td>
<td></td>
<td>1.4</td>
<td>4570</td>
<td>5.2</td>
<td>255.7</td>
<td>8.5</td>
</tr>
<tr>
<td>2011</td>
<td>5332</td>
<td>0.3</td>
<td>30.4</td>
<td></td>
<td>-0.9</td>
<td>4810</td>
<td>5.7</td>
<td>273.3</td>
<td>6.5</td>
</tr>
<tr>
<td>2012</td>
<td>5446</td>
<td>0.5</td>
<td>31.4</td>
<td></td>
<td>0.5</td>
<td>5240</td>
<td>5.9</td>
<td>302.9</td>
<td>7.1</td>
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<tr>
<td>2013</td>
<td>5254</td>
<td>0.7</td>
<td>32.4</td>
<td></td>
<td>0.7</td>
<td>5300</td>
<td>5.4</td>
<td>305.9</td>
<td>9.7</td>
</tr>
<tr>
<td>2014</td>
<td>5119</td>
<td></td>
<td>31.1</td>
<td></td>
<td></td>
<td>5200</td>
<td></td>
<td>266.2</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>5138</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5010</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: The World Bank Data Base
Annex 3: Methodology

TPA Framework is divided into two domains: the external environment and the internal environment.

The external environment encompasses the elements outside of the health sector and covers political and economic environment and the internal environment of the program, further sub-divided into three sub-domains of inputs, governance and program represent the factors within the health sector. Sub-domains are further divided into components affecting transition as well as the sustainability of the public health programs, after graduating from donor support. The final expected outcome of this process is the successful transition when programme outcomes are either retained and or enhanced.

The **Inputs** entail the resources currently available for the disease-specific programme. The resources are subdivided into **financial resources**, **human resources** and **health information systems**. Financial resources are assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and treatment interventions, especially for epidemiologically important population groups. Human resource component is measured by assessing the availability of sufficient human resources, the institutionalization of donor-supported trainings; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale. Health Information Systems is assessed by evaluating the integration of comprehensive routine statistical reporting in the national health information system(s) for both diseases, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and integration of the data in the national reporting.

**Governance** sub-domain includes the actors/institutions involved at an organisational level, how they make decisions, their roles and motivations towards the adequate transition of disease programmes and their relationship with other actors. Identified enabling factors related to governance are subdivided into **governance-specific factors** and **accountability**. Governance-specific factors include a strong political commitment to the disease treatment and fostering political support for the programme; effective leadership/management ensured through a legally empowered organization and the existence of champions/individuals that advocate for and/or manage the disease-specific programmes; and appropriately coordinating all parties involved in the programme through a dedicated, legally empowered and well-functioning coordinating body.

**Programme sub-domain** encompasses the activities included within the health programme and the operational capacity to implement these activities. It is composed by **service delivery**, **organizational capacity** and **transition planning** components. Within service delivery we look at integration for certain services, service coverage and treatment outcomes. Concerning the organizational capacity to provide services, management of the national disease programmes; procurement mechanisms; and the existence of appropriate monitoring and evaluation mechanisms, including adequate analytical capacity, is crucial for the effective transition of these disease programmes. A direct measure of forward thinking disease programs currently receiving external funding is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. The appropriate tracking of the transition process requires transition planning through strategies that align the programme with national policies that are informed by international guidance and/or evidence; programme management arrangements to assure appropriate transfer of responsibilities; and an effective monitoring and evaluation of the transition.

Quantitative and/or qualitative indicators are used for each component measurement. These indicators assess possible risk for transition using a scoring system 2=low or no risk, 1=medium/moderate risk and 0= high risk. The indicators are converted into numerical values, and risk category is assigned to each component according to the overall scores. To define a country’s overall risk, scores for each category are summarized and aggregated, based on the percentage of scores accumulated for all domains/sub-domains/categories. Weighting was not applied during the scoring approach. A summary score for a disease identifies the overall risk for the program transition and the components scores identify areas that pose the highest risk and should be addressed during the transition process.
Annex 4: List of Reviewed documents


2. Assessing the financial sustainability of Jamaica’s HIV Program; IBRD/World Bank; UNAIDS


12. GOVERNMENT OF JAMAICA; SUSTAINABLE FINANCING AND REFORM OF THE HEALTH SECTOR TO IMPROVE EFFECTIVENESS, EFFICIENCY AND QUALITY OF CARE IN JAMAICA. Phase 1. Submitted to Ministry of Health and Inter-American Development Bank


18. Health System and Services profile of Jamaica Jam health system; PAHO 2001

19. Health situation in the Americas. Basic Indicators 2012. PAHO

Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience


27. Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV. UNDP. January 2014


30. Modes of HIV Transmission in Jamaica Distribution of new HIV infections in Jamaica for 2012:


34. National HIV/STI Programme; 2015


36. National Supply Chain Assessment. August 22-September 2, 2016. USAID. Sam Abbenyi, Meaghan

37. National Survey on Homophobia, Jamaica 2012


40. PAHO/WHO Health in the Americas 2012

41. PEPFAR/JAMAICA Country Work Plan; October 2015 - September 2016

42. PLACE Worker and Patron Survey. Jamaica 2014

43. Recommendations for efficient resource allocation and prevention strategies, 2012 UNAIDS


46. Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016

47. Sustainable financing and reform of the
Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica

48. TGF Proposal to Scale up HIV/AIDS Treatment, Prevention, and Policy Efforts in Jamaica

49. TGF Proposal - Consolidating existing gains while scaling up to provide Universal Access to HIV treatment, care and prevention services with emphasis on special vulnerable populations

50. TGF PUDR #13 HIV program in Jamaica

51. TGF PUDR #15 HIV program in Jamaica

52. TGF PUDR #16 HIV program in Jamaica


Annex 5: List of Interviewed People

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION /Position</th>
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<tr>
<td><strong>CIVIL SOCIETY ORGANIZATIONS (CSOs)</strong></td>
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<tr>
<td>Ricky Pascoe</td>
<td>President, Jamaica Network of Sero-positives (JNPLUS)</td>
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<tr>
<td>Neish McLean</td>
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<tr>
<td>Conroy B. Wilson</td>
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<tr>
<td>Kandasi Levermore</td>
<td>Executive Director, Jamaica AIDS Support for Life</td>
</tr>
<tr>
<td>Claudette Richardson-Pious</td>
<td>Executive Director, Children’s First</td>
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<tr>
<td>Mickel Jackson</td>
<td>Project Manager, Jamaica AIDS Support for Life</td>
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<tr>
<td>Karen Dayce</td>
<td>HOPE Worldwide Jamaica</td>
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<tr>
<td>Kendra Frith</td>
<td>Colour Pink Foundation</td>
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<tr>
<td>Monica Brown</td>
<td>Project Coordinator, Caribbean Vulnerable Communities Coalition</td>
</tr>
<tr>
<td>Olive Edwards</td>
<td>ICW Regional Coordinator, Jamaica Community of Positive Women (JCW+)</td>
</tr>
<tr>
<td>NAME</td>
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<tr>
<td>Tanique Robinson</td>
<td>RISE Life Management Limited</td>
</tr>
<tr>
<td>Ainsley Reid</td>
<td>National Family Planning Board (NFPB/ GIPA)</td>
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<tr>
<td>Nacia Davis</td>
<td>Jamaica Community of Positive Women (JCW+)</td>
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<td>Loreine Graham</td>
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<td>A’Keiha McLean</td>
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<tr>
<td>Althea Cohen</td>
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<tr>
<td>Marlon Taylor</td>
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<td>Sue Anne Wallace-Brown</td>
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<tr>
<td>Delores Davis-Powell</td>
<td>Jamaica Community of Positive Women (JCW+)</td>
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<tr>
<td>Ms. St. Rachel Ustanny</td>
<td>FAMPLAN; Chief Executive Officer</td>
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<td>USAID</td>
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<tr>
<td>Deborah Kaliel</td>
<td>USAID/ PEPFAR</td>
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<tr>
<td>Anthony Hron</td>
<td>Senior HIV Technical Advisor</td>
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<tr>
<td>Sandra McLeish</td>
<td>“Country Programme Manager, Health Policy Plus/ Palladium Group”</td>
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<tr>
<td>Dr. Nkhensani Mabathathe</td>
<td>Acting Country Director; UNAIDS Jamaica</td>
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<tr>
<td>Erva-Jean Stevens</td>
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<td>Melissa Sobers</td>
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<td>GOVERNMENT OF JAMAICA</td>
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</tr>
<tr>
<td>Coleen White</td>
<td>Chief Policy Analyst, Cabinet Office, Office of the Prime Minister</td>
</tr>
<tr>
<td>Nicholette Williams</td>
<td>Director, Intl.Org. Dept., Ministry of Foreign Affairs and Foreign Trade</td>
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<tr>
<td>MINISTRY OF EDUCATION, YOUTH AND INFORMATION</td>
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<tr>
<td>Phillipa Livingston</td>
<td>Statistician, Policy and Planning Unit</td>
</tr>
<tr>
<td>Mrs. Anna Kay Magnus Watson</td>
<td>Director, HIV Health Education, Health and Family Life Education (HFLE)</td>
</tr>
<tr>
<td>Mrs. Takesha Shay Barnes</td>
<td>Director of Programme Implementation, Adolescent HIV Programme</td>
</tr>
<tr>
<td>Mrs. Michelle Small Bartley</td>
<td>Senior Director, Youth Director</td>
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<tr>
<td>Mrs. Fern McFarlane</td>
<td>Guidance and Counselling Unit</td>
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<td>MINISTRY OF LABOUR AND SOCIAL SECURITY</td>
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<tr>
<td>Mr. Damion Cox</td>
<td>“Chief Technical Director, Labour Division”</td>
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<tr>
<td>Mr. Marlon Mahon</td>
<td>Occupational Health Manager</td>
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<tr>
<td>Ms. Khadera Folkes</td>
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<td>Mr. Conrad Saunders</td>
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<td><strong>MINISTRY OF HEALTH</strong></td>
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<tr>
<td>Sannia Sutherland</td>
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<tr>
<td>Dr. J. Brown- Tomlinson</td>
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<td>Dr. Simone Spence</td>
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<tr>
<td>Dr. Tanya Green Douglas</td>
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<tr>
<td>Joi Chambers</td>
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<td>Howard Lynch</td>
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<td>Jasper Barnett</td>
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<td>Zahra Miller</td>
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<tr>
<td>Dr. Nicola Skyers</td>
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<tr>
<td>Paula Prince</td>
<td>Programme Officer</td>
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<tr>
<td>Barbara Scott</td>
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<td>Delores Wade</td>
<td>Senior Economist, ECM</td>
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<tr>
<td>Denise McFarlane</td>
<td>Health Specialist</td>
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<tr>
<td>Stacy-Ann Robinson</td>
<td>Demographer</td>
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<tr>
<td>Mr. Easton Williams</td>
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<tr>
<td>Mrs. Toni-Shae Freckleton</td>
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<tr>
<td>Mrs. Saskia Frater Smith</td>
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<tr>
<td>Ms. Darlene Morrison</td>
<td>Deputy Financial Secretary</td>
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<tr>
<td>Ms. Alicia Forrester</td>
<td>Programme Officer, International Financing</td>
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<tr>
<td><strong>MINISTRY OF LOCAL GOVERNMENT AND COMMUNITY DEVELOPMENT</strong></td>
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<td>Mrs. Marsha Henry Martin</td>
<td>Director, Urban Planning</td>
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<tr>
<td>Mr. Clive Edwards</td>
<td>Consultant</td>
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<td><strong>NATIONAL FAMILY PLANNING BOARD</strong></td>
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<tr>
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<tr>
<td>Denise Chevannes</td>
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</tr>
<tr>
<td>Ms. Andrea Campbell</td>
<td>Director of Health Promotion and Prevention</td>
</tr>
<tr>
<td>Mr. Joseph Reynolds</td>
<td>Director, Finance and Accounting</td>
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<tr>
<td>Mrs. Jennifer Williams</td>
<td>Director, H and R</td>
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<tr>
<td>Mr. Devon Gabourel</td>
<td>Director, Sustainability and Environment</td>
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<tr>
<td>Ms. Tazh Moye Crawford</td>
<td>Director, Monitoring and Evaluation</td>
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<tr>
<td><strong>PRIVATE TREATERS GROUP/ MEDICAL DOCTORS TREATING PLHIV at private clinics</strong></td>
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<tr>
<td>Dr. Tanya Green Douglas</td>
<td>Medical Officer, Ministry of Health</td>
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<tr>
<td>Dr. Donna Royes Powe</td>
<td>Medical Officer, Correctional Services</td>
</tr>
<tr>
<td>Professor Brendan Bain</td>
<td>Honorary Consultant Physician</td>
</tr>
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<td><strong>SOUTHEAST REGIONAL HEALTH AUTHORITY</strong></td>
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<tr>
<td>Dr. Dutris Bourne</td>
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<td>Staff member</td>
<td>HIV/ STI Coordinator</td>
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<td><strong>SOUTHERN REGIONAL HEALTH AUTHORITY</strong></td>
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<tr>
<td>Dr. Tyrone Roberts</td>
<td>Regional HIV/ STI/ TB Coordinator</td>
</tr>
<tr>
<td>Dr. Vitillius Holder</td>
<td>Regional Epidemiologist</td>
</tr>
<tr>
<td>Mr. Michael Bent</td>
<td>Regional Director</td>
</tr>
<tr>
<td>Miss Jennilyn O’Connor</td>
<td>Regional Pharmacist</td>
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<tr>
<td>Mr. Donovan Leon</td>
<td>Medical Technologist</td>
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THE PHILIPPINES HIV/AIDS PROGRAM TRANSITION FROM DONOR SUPPORT TRANSITION PREPAREDNESS ASSESSMENT

Produced by: Curatio International Foundation - APW with UNAIDS 2016/628448

Country report
Author: Tamar Gotsadze, MD., PhD

Acknowledgments

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Disclaimer

The study was commissioned by UNAIDS. The views expressed herein are those of the author and do not necessarily reflect the opinion of the Client and/or Curatio International Foundation.

Transition preparedness assessment team:

Team leader: Ketevan Chkhatarashvili MD MPH

Local consultant: Dr. Marilyn Noval-Gorra, MPH, Doctor of Public Administration

International consultant: Tamar Gotsadze, MD PhD
## Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>ARV</td>
<td>Anti-Retroviral</td>
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<tr>
<td>CCM</td>
<td>Country Coordination Mechanism</td>
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<td>CSO</td>
<td>Civil Society Organizations</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>GARP</td>
<td>Global AIDS Response Progress</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KAP</td>
<td>Key Affected Populations</td>
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<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NASA</td>
<td>National AIDS Spending Assessment</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>NSEP</td>
<td>Needle and Syringe Exchange Programs</td>
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<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PWID</td>
<td>People Who Inject Drugs</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>SW</td>
<td>Sex Worker</td>
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<td>TG</td>
<td>Transgender People</td>
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<td>TGF</td>
<td>The Global Fund</td>
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<td>TPA</td>
<td>Transition Preparedness Assessment</td>
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<td>UMIC</td>
<td>Upper-Middle Income Country</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>United States Agency for International Development</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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Executive summary

The Philippines country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program, which examines the country’s disease program readiness for transition from external support. The research intends to understand the factors affecting HIV/AIDS program sustainability and aims to inform an adequate transition planning process from Global Fund support in Philippines. The assessment has utilized mixed methods entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees included government officials, donor representatives, staff from international organizations and civil society members, among others.

The transition preparedness assessment singles out system-wide and programme level bottlenecks that may impede the sustainability of the national HIV response in the Philippines. A summary score of transition risk (36.7%) indicates that the country is exposed to moderate to high risk. A carefully designed transition plan is needed to ensure that the public health gains achieved through the concerted efforts from the Government of Philippines and donor funded programs are sustained after Global Fund support ends. The findings presented in the report follow the TPA framework and are organized around two overarching domains: the external environment and the internal environment, and various sub-components under each major domain.

External environment

Economic development. The Government of the Philippines fails to ensure continued and sustainable economic growth. The fluctuation in Gross Domestic Product (GDP), couple with a fall in the share of government revenues as percentage of GDP, poses a high risk to the transition and sustainability of Global Fund supported programs.

Political commitment. The political will of the government, as expressed in investment in health, is not adequate. Although out of total government expenditure the Philippines spends a substantial share of the public budget on health and maintains a steady growth in health expenditures, the observed levels of budgetary spending on health still remain below of the Low Middle Income Country (LMIC) average. Furthermore, there is a lack of regulations and/or adequate enforcement of laws protecting Key Affected Populations (KAP), which increases the overall risk arising from political environment. The Civil Society Organization (CSO) contracting for service provision has been put into practice in the past; however, complicated contracting requirements to access public funding have been introduced recently that demotivate the CSO sector to tap public funding. This, in turn, may cause the discontinuation of CSO provided prevention and outreach services when external funding ends and puts the country at a high risk.

Internal environment

Financing: The Philippines has prioritized HIV treatment interventions for public investment and has taken decisive steps to eliminate treatment dependence on external funding. However, while replacing donor funds for treatment with national resources is visible, a more aggressive pace might be warranted for transitioning funding of preventive services for KAPs, who are mostly donor dependent and face numerous barriers.
Human Resources: After transition from TGF support, challenges are also expected to emerge in the retention of already practicing professionals, as well as in the production/reproduction of adequately trained health and CSO cadre. Most likely, sustaining the current training efforts will not be possible due to the lack of institutionalization of TGF supported trainings and knowledge dissemination. The availability of well-trained and appropriately distributed human resources is crucial for the program’s success. This is even more critical in a transition scenario due to the importance of continuing care for patients with HIV1. Such challenges in donor-funded trainings are not only relevant to the Philippines and/or to TGF; they also have greater implications for other countries and donors alike2. Moreover, tackling these problems during the transition period may not be feasible due to numerous structural barriers observed: i.e. the lack of an adequate cadre of trainers in established training institutions, the lack of state support/funding for such training, etc. To achieve sustainability, it seems essential to address these challenges with the help of well thought through mechanisms that enhance human resource production for health. Whatever mechanisms will be developed for these purposes, it is critical to ensure that they are self-sustainable and scalable to deliver long-term sustainability.

Information Systems: The Philippines has an advanced health information system and routinely collects the necessary information that can be used in program evaluation and/or intervention planning at the national level. Progress has also been attained in the institutionalization of a robust secondary surveillance system in the country, which has been fully funded from the public purse. Nevertheless these achievements were not without limitations. The unified surveillance system combining prevention, treatment and adherence information is functional at the national level but is still mostly paper-based. At local levels the system remains fragmented; the information system does not incorporate HIV incidence; data on treatment, retention and TB-HIV co-infection is also limited; and the system uses a mixture of electronic and paper based data collection methods. Nevertheless, it seems possible for the remaining challenges to be addressed during a well planned transition, with the exception of analytical capacity limitations that could remain for a while due to structural limitations in the education sector and public sector employment.

Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability. This requires communicating performance results through the public domain, including reporting expenditure data and targeted activities for KAPs. Moreover, since most efforts to hold actors accountable are conducted by civil society organizations, it is therefore crucial to enhance the enabling environment in which civil society organizations operate3.

Governance: The Government remains committed to continuing the HIV national program. A new national program (AMTP 6) has been developed and awaits governmental approval. However, the lack of independence and resource base (budget) that limits the effective operation of the National AIDS Council (PNAC) poses risks to the transition and sustainability of the national AIDS response. While the Department of Health (DOH)

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3 T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio International Foundation, 2015
remains as the chair of the plenary, the PNAC resource base must not remain dependent on DOH only. The PNAC must urgently find a way of mobilizing resources within the Philippine bureaucracy through member agency budgets and from development partners, so that it maintains its autonomy. Planned and ongoing reforms may mitigate these risks if implemented appropriately and may lead to a smoother transition from TGF funding. The Philippines has a good enabling environment for civil society engagement, maintaining rich performance data and offering stakeholders easy access to the required information. Streamlining thenational program coordination function and ensuring easy access to program performance information⁴ are expected to minimize challenges during transition.

Program. The government’s willingness to sustain an effective national response towards the HIV epidemic is encouraging. However, in order to achieve a positive public health impact with possible financial limitations, the country has to ensure an effective coverage of KPs by improving the allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities; building linkages between the health sector and non-governmental and social service providers; streamlining patient pathways among TB and HIV service providers; and enhancing follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges the Philippines will face after transition from TGF support.

Organizational Capacity. There are several prerequisites for a smooth transition and attaining the desired public health gains. They are: strengthening the organizational capacity of national program implementers and service providers, including CSOs⁵; streamlining procurement functions to allow the procurement of HIV commodities at a lower price by deploying procurement practices from international platforms as in case of drugs; and enhancing M&E and evidence based program planning and implementation.

Overall transition readiness. The assessment of the transition readiness of HIV/AIDS programs revealed that the Philippines faces a moderate to high risk after TGF support ends. Early transition planning that addresses the riskiest areas of the program and systems as well as effective implementation will allow the country to experience a painless transition and ensure the sustainability of national programs.

Recommendations

Recommendation #1: Create an enabling legal environment - Enhance antidiscrimination protection through legislative changes to promote the human rights of KAPs, people living with HIV (PLHIV), vulnerable communities and providers of HIV services through: i) Adoption of revised HIV/AIDS legislation that protects KAPs and allows access to needed services, including legislation supporting harm reduction; ii) Revision of regulations hampering KAP access to HIV/AIDS preventive, treatment, care and support services; iii) Promotion and approval of a range of measures and interventions aimed to prevent stigma and discrimination among the general population.

Recommendation #2: Create government capacity to mobilize additional financial

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⁵ T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio International Foundation, 2015
resources for health through: i) Mobilization of domestic funding in support of national HIV/AIDS programme from other sectoral ministries, Local Government Units (LGU) and the private sector; iii) Introduction of separate budget line for the HIV/AIDS program in the budgets of all involved line ministries, including DOH and LGUs; iv) Use available resources efficiently and effectively. Investments should be strategic and geared towards prevention interventions targeting KAPs and in areas where most infections come from; v) Increasing the share of public funding for preventive services; vi) Introduction of a dedicated budget line for outsourcing outreach and case management services to CSOs under the HIV Program; vii) Institutionalization of a functioning monitoring mechanism that generates and collects financial information at the local level in order to provide a more accurate picture of spending levels in the country.

Recommendation #4: Ensure an adequate and continuous supply of qualified human resources. Human resources (HR) pose a larger problem to the national health care system, and even though the HR shortage will certainly affect the sustainability of the HIV program, this problem may not be resolved during the transition period and only for HIV/AIDS program. However, within the new Global Fund allocation for the years 2017-2020 the Philippines may request assistance for the development of a comprehensive policy for the production/training of HR in health under the HSS component of the grant. There is a need to: i) Revisit staffing plans for effective service provision; ii) Explore the feasibility of institutionalizing accredited practical training and internship programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits can be deployed in service areas where staff shortage is most severe; iii) Ensure the integration of HIV training modules into the continuous education systems with the potential of further integration of the HIV training modules into the undergraduate education systems in a long-term perspective; iv) Elaborate a training and capacity building strategy for NGOs/CSOs.

Recommendation #5: Improve the effectiveness of the coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E. In order to enhance the coordination function, there is an urgent need to: i) Reform the Philippines National AIDS Council (PNAC) as the main governance platform to guarantee efficiency and effectiveness of its operation in addressing the HIV epidemic and ensure its autonomy by changing its place in the government hierarchy; ii) Enhance coordination at local levels by revisiting the role of the Local Authority Councils (LAC) in the overall national response; iii) Supporting local responses from the national level on how to access funds and plan programs; and iv) Allow PNAC to regularly monitor implementation of local responses and provide support and advise on corrective measures when needed.

Recommendation #6: Streamline service delivery. Removing barriers to HIV testing and treatment through strengthening cooperation between the governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services is of high importance. This can be achieved by improving timely and complete diagnosis, the prompt prescription of correct treatment and good adherence to ART. Priority should be given to ensure the full integration of PMTCT services into primary and perinatal care and the expansion of HIV outpatient treatment insurance package by adding case detection/diagnosis and treatment adherence support, which will allow the minimization of lost follow-up cases.
Recommendation #7: Create an enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding. To ensure continuation of preventive services when external funding ends, the government is advised to: i) Develop/revise the detailed SCO contracting rules/procedures to ensure delivery of preventive services; ii) Initiate an open, results oriented and constructive policy dialogue between the government and civil society to explore potential solutions to liberalize SCO accreditation process; and iii) Consider establishing umbrella CSO Organizations or networks to allow the continued engagement of CSOs in the provision of preventive services to KAPs.

Recommendation #8: Strengthen the organizational capacity of all involved stakeholders including government institutions and CSOs to ensure greater sustainability. The capacity of the national program management structure at DOH should be strengthened through the establishment of an effective management team with adequate staffing positions. To increase the sustainability of local NGOs, there is a need to enhance their advocacy efforts, promote the sustainable development of professional and local communities, and improve the quality of services delivered by NGOs to the communities. Activities include organizational capacity development, specialized training for NGO management, M&E, financial management, organizational strengthening and proposal writing. Topics can be prioritized based on a training needs assessment to increase their capability and competitive power for fundraising in a resource constrained environment.

Recommendation #9: Develop a transition plan, integrate it into the new AMTP annual operational plan and closely monitor its implementation. To safeguard a smooth transition from external funding, the Government should: i) Develop a time-bound and actionable transition plan with adequate indicators to monitor implementation, and ensure the incorporation of this plan into the AMTP6 and Annual Operation plans; ii) Ensure sufficient resources are available for transition by preparing a budget for AMTP 6 which includes transition plan elements; and iii) Ensure that the PNAC is charged with the mandate, equipped with the competence and legal power and assumes the responsibility for coordination, planning, implementation and monitoring of the transition process.

### TRANSITION PREPAREDNESS ASSESSMENT FOR HIV/AIDS - SUMMARY TABLE

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>INDICATOR</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXTERNAL ENVIRONMENT</td>
<td></td>
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<tr>
<td>Political Environment</td>
<td>Existence of political will to prioritize health investments</td>
<td>High risk</td>
<td>High risk</td>
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<tr>
<td></td>
<td>Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases &amp; Rule of Law</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>COMPONENT</td>
<td>INDICATOR</td>
<td>INDICATOR RISK CATEGORY</td>
<td>TRANSITION RISK SCORE</td>
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<tr>
<td></td>
<td><strong>Government ability to contract with CSOs; CSO contracting practices</strong></td>
<td>Low risk</td>
<td></td>
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<tr>
<td></td>
<td><strong>Economic Environment</strong></td>
<td><em>Favorable economic indicators</em></td>
<td>High risk</td>
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<tr>
<td></td>
<td><strong>INTERNAL ENVIRONMENT</strong></td>
<td></td>
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<tr>
<td>Inputs</td>
<td><strong>Financial resources</strong></td>
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<tr>
<td></td>
<td>Budgetary commitment to disease</td>
<td>High risk</td>
<td>High risk</td>
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<tr>
<td></td>
<td>Prevention priority</td>
<td>High risk</td>
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<td></td>
<td>Allocative efficiency</td>
<td>Low risk</td>
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<tr>
<td></td>
<td>Treatment / input financing from public sources</td>
<td>Moderate risk</td>
<td></td>
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<tr>
<td></td>
<td>Prevention financing from public sources</td>
<td>High risk</td>
<td></td>
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<td></td>
<td><strong>Human Resources</strong></td>
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<td></td>
<td>Sufficient human resources for disease (quantities, geographic distribution and aging)</td>
<td>Moderate risk</td>
<td>High risk</td>
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<tr>
<td></td>
<td>Institutionalization of donor supported programs; Existence of policy for production/ training of CSO personnel (non-medical, social service; Donor funded HR salaries aligned with national pay scale)</td>
<td>High risk</td>
<td></td>
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<tr>
<td></td>
<td><strong>Information Systems</strong></td>
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<td></td>
<td>Routine statistical reporting R Integration in the national system</td>
<td>Moderate risk</td>
<td>Low risk</td>
</tr>
<tr>
<td></td>
<td>Routine statistical reporting R Level of advancement</td>
<td>Moderate risk</td>
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<tr>
<td></td>
<td>HIV Second generation surveillance Methodologies, Timeliness</td>
<td>Low risk</td>
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<td></td>
<td>HIV Second generation surveillance Funding from public sources</td>
<td>Low risk</td>
<td></td>
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<tr>
<td>Governance</td>
<td><strong>Governance</strong></td>
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<td></td>
<td>Strong political commitment to diseases</td>
<td>Low risk</td>
<td>Moderate risk</td>
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<td></td>
<td>Strong leadership</td>
<td>Low risk</td>
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<td></td>
<td>Strong coordination mechanisms</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td>Program performance results are available and accessible through public domain</td>
<td>Low risk</td>
<td>Low risk</td>
</tr>
<tr>
<td></td>
<td>Enabling environment for Civil Society engagement</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td>PROGRAM</td>
<td><strong>Service Delivery</strong></td>
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<tr>
<td></td>
<td>Treatment</td>
<td>Moderate risk</td>
<td>High risk</td>
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<tr>
<td></td>
<td>Integrated services</td>
<td>High risk</td>
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<td></td>
<td>Key populations reach with preventive services</td>
<td>High risk</td>
<td></td>
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<tr>
<td></td>
<td>CSO contracting in health</td>
<td>Moderate risk</td>
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1. Introduction

Purpose of the assessment: As the Philippines moves towards middle income country status and donor support for AIDS begins to wind down, the need for a rapid and sustainable increase in domestic investment is becoming more urgent. Equally importantly, the country needs to ensure that the available limited public resources are spent where they will have the most impact. The country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program. The assessment examines the country’s disease program readiness for transition from external support. The TPA identifies areas of high, moderate or low risk for successful transition and outlines the necessary steps towards programming for sustainable transition. The assessment follows the TPA Framework for data collection, analysis and transition risk assignment. The TPA Framework was developed by Curatio International Foundation with Global Fund financial support. Details of the TPA Framework are provided in Annex 2.

Main definitions: The Global Fund’s definitions of transition and sustainability used in the report are:

- Transition is “the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate”.
- Sustainability - “the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors”.

Beneficiaries of the assessment: The TPA findings provide valuable information

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primarily to national stakeholders for the transition plan development or incorporation in the National Disease Strategy. In addition, the assessment findings will be useful for the donors, particularly the Global Fund, to guide the country through the transition process.

Structure of the report: The report is divided into five main sections, starting with an introduction to the report, a brief explanation of the methodology used, followed by a chapter that sets the stage by explaining the main HIV epidemiological trends and the grants that the country received from TGF. Chapter 4 presents the main findings by assessing the enabling, external and internal environments for transition. Chapter 5 provides a discussion of the main opportunities and challenges in the Philippines and provides general conclusions and recommendations for the transition to programmatic sustainability.

2. Methodology

The assessment utilized mixed methods entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders: government officials, donor representatives, staff from international organizations, civil society members, and those directly working with donor supported programs. They were identified based on their relationship with these grants as well as through the snowball technique. The quantitative and qualitative data were triangulated in line with the TPA framework domains, sub-domains and components.

During the country mission, CIF consultants met and interviewed more than 40 individuals including representatives of the Senate, the Philippines AIDS Council, the Department of Health, the National Economic Development Agency, the Department of Education, the Department of Budget Management, the Health Insurance Agency, and other government agencies; the UNAIDS local team, representatives of local civil society organizations targeting PLHIV, MSM, sex workers and other vulnerable populations, and other development partners (Annex 4). No site visits were conducted; instead, skype conference calls were organized with Regional Health Authorities.

More than 50 documents and online sources were reviewed, including national level documents about national budgets, health sector development, HIV/STI strategic plans, Global Fund concept notes and progress reports, National AIDS Spending Assessment reports, Global AIDS Response Progress (GARP reports), HIV related surveys, the Aids Medium Term Plan evaluation report, biological behavioral surveillance surveys, and other operational research and publications.

3. Setting the stage

This background and its relationship to the transition will be addressed further when the report discusses the external and internal environment in more detail. However, as a necessary first step, in this section we describe the context in which the Global Fund began to provide funding for HIV/AIDS in the Philippines and how the epidemiological trend has evolved since.
3.1 The context

**Demographics:** The Philippines has an estimated population of 100.7 million\(^7\) with an annual growth rate of about two percent. Rapid population growth puts stress on the country’s economic resources and negatively affects the delivery of social and health services. Rapid population growth has contributed to widespread unemployment in the Philippines. A shortage of available jobs in the country has pushed an estimated seven million Filipinos to work overseas. Although life expectancy at birth increased from 66 years in 2000 to 68 years in 2014, high rates of adult morbidity and mortality, especially among the working age population, coupled with the changing age and gender structure of the population have significant challenging economic and social consequences.

**Brief description of health system:** In its current decentralized setting, the Philippine health system has the Department of Health (DOH) serving as the governing agency on a national level, with both local government units (LGU) and the private sector providing services to communities and individuals. The DOH is mandated to provide national policy direction and develop national plans, technical standards and guidelines on health.

Under the Local Government Code of 1991, LGUs serve as stewards of the local health system and are therefore required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. LGUs are also in charge of creating an environment conducive for establishing partnerships with all sectors at the local level. Provincial governments are mandated to provide secondary hospital care, while city and municipal administrations are charged with providing primary care, including maternal and child health, nutrition services, etc. Rural health units were created for every municipality in the country to improve access to health care. Overall, assuring access to health services remains the fundamental objective for the government. However, problems persist with the quality and effectiveness of these services. Attempts to improve health outcomes through various reforms in the public health care system are continuously being pursued.

In the Philippines, the National Health Insurance Programme is the largest insurance programme in terms of coverage and benefit payments. The two main agencies that pool health care resources are the government and PhilHealth (the Philippine Health Insurance Corporation). The annual process of developing a DOH budget starts with the issuance of a budget call by the Department of Budget Management (DBM) in late February to the middle of March. The budget call informs national government agencies to start formulating their budgets for the coming year. The budget ceilings issued by DBM are based on the available funds in treasury and projected government revenues for the planning year. Line agencies like the DOH then prepare annual budget proposals based on these set ceilings. The line agency proposals are consolidated into a national expenditure programme (NEP) that is submitted to Congress. Congress then converts the NEP into a general appropriations bill that is deliberated on and passed jointly by both houses of Congress. LGU health budgets are developed in a similar way to the

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DOH budget. A comparison of the allotments and actual spending of the “obligated funds”, however, points to underutilized resources. There are two possible explanations for the inability of the DOH to maximize the spending of available resources. The first relates to weaknesses in the capacity of the central DOH, CHDs and LGUs to spend resources effectively. Another reason for low fund utilization relates to weak incentives among managers to push spending.

While the DOH accounts for a substantial proportion of national government health expenditures, there has been increased health spending in recent years by other national government agencies such as the Office of the President and the Philippine Charity Sweepstakes Office. Health expenditures by other national government agencies are sometimes implemented by the DOH but not usually covered by the medium-term planning carried out for the sector by the DOH, as this funding source is usually erratic, subject to fund availability and could be motivated by reasons other than national health goals. As this non-DOH national government spending becomes relatively larger, there is a greater need to coordinate these two expenditure streams so that overlaps and crowding out are minimized and gaps are properly identified and addressed.

As a third-party payer, PhilHealth, the Philippine Health Insurance Corporation, regulates the accreditation of health providers that are in compliance with its quality guidelines, standards and procedures and procures services for the insured population. Under the National Health Insurance Program (NHIP) of PhilHealth, PLHIVs are eligible for outpatient benefits. The Outpatient HIV/AIDS treatment (OHAT) package was introduced in 2010. This benefit aims to increase the proportion of the population with access to an effective AIDS treatment package in PhilHealth, which is a critical step in guaranteeing the sustainability of access to Antiretroviral treatment (ART) packages. The benefits cover outpatient routine ART monitoring e.g. laboratory tests, CD4 count, and to some degree, even the cost of in-patient treatment for opportunistic infections.

The Food and Drug Administration (FDA) regulates pharmaceuticals along with food, vaccines, cosmetics and health devices and equipment. The DOH ensures centralized procurement of medicines for PLHIV and distributes these to the local areas, whilst LGUs procure all other commodities through their own LGU bids and awards committees. DOH is attempting to restore some of the purchasing power lost during devolution through the establishment of pooled procurement mechanisms.

3.2 HIV/AIDS epidemiology overview

The Philippines is at a critical juncture in its response to HIV and AIDS. After more than two decades of low HIV prevalence and slow expansion, the country is now on the verge of an explosive epidemic (Figure 1). In total, by October 2016, 38,114 HIV sero-positive cases were reported, out of which 20% were registered only in the period January to October 2016 and 84% of all diagnosed cases in the Philippines were reported from January 2011 to October 2016. While one new

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1 The Philippines Health System Review, WHO, 2011
3 Global AIDS Response Progress Report, Philippines, PNAC 2014
4 The Philippines Health System Review, WHO, 2011
5 Global AIDS Report, UNAIDS, 2012
HIV case was diagnosed per day in 2008, as of October 2016, 26 new cases are recorded each day. Apart from a growing epidemic, this sudden growth of new cases starting from 2008 could partially be attributed to increased donor support, which has created greater diagnostic and outreach capacities and funds CSOs to reach MSM.

HIV infection predominantly affects the male population (93% of all cases), but the absolute number of cases among females is on the rise. The age group with the biggest proportion of registered cases has become younger since 2001. From 2011 to 2016 (October), newly diagnosed HIV cases among young key affected populations (YKAP) increased by 230%, out of which male to male sex and males who have sex with both males and females were the two predominant sources of infection transmission (58% and 26%, respectively)\textsuperscript{14}. There were also 9% who were infected from sex between males and females.

\textsuperscript{13} HIV/AIDS and ART registry of Philippines, DOH, Epidemiology Bureau, October, 2016
\textsuperscript{14} HIV and ART Registry of the Philippines (HARP). Department of Health – Epidemiology Bureau, Manila, Philippines. December 2015.
Notably, 7% (85) of all new infections among adolescents were transmitted through sharing of infected needles. This alarming increase in new HIV cases is consistent with the doubling of HIV prevalence particularly among adolescent males/transgender and men who have sex with men (MSM) in the past five years\textsuperscript{16}. Evidence from both the HIV/AIDS & ART Registry of the Philippines (HARP) and the 2015 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) indicate an escalating HIV problem among Filipino adolescents.

Starting from 2009, the predominant mode of transmission shifted from heterosexuals to MSM, and it has continually increased since then. From January 2011 to October 2016, 85% (26,019) of new infections through sexual contact were among MSM. Among females, male-female sex was the most common mode of transmission (1,338 or 48%) followed by sharing of infected needles (80 or 6%)\textsuperscript{17}. IBSS also showed that HIV prevalence (see Table 3) increased among MSM and Female Sex Workers (FSW), particularly among freelance sex workers.

\textsuperscript{15} HIV/AIDS and ART registry of Philippines, DOH, Epidemiology Bureau, October, 2016
\textsuperscript{16} The Growing HIV epidemic among adolescents in the Philippines, National HIV/AIDS & STI Surveillance and Strategic Information Unit Epidemiology Bureau, Department of Health, 2015
\textsuperscript{17} HIV/AIDS and ART registry of the Philippines, DOH, Epidemiology Bureau, October, 2016
### HIV Prevalence Among MSM, PWIDs and SW in Sentinel Sites 2007-2015

<table>
<thead>
<tr>
<th>Type</th>
<th>KAP 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PWID*</td>
<td>13.6</td>
<td>13.6</td>
<td>46.1</td>
<td>44.9</td>
<td>29.0</td>
</tr>
<tr>
<td>SW**</td>
<td>0.3</td>
<td>0.3</td>
<td>1.8</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>MSM**</td>
<td>1.7</td>
<td>1.7</td>
<td>3.3</td>
<td>3.3</td>
<td>4.9</td>
</tr>
</tbody>
</table>

*Source: 2015 IHBSS for Male PWID: Cebu, Mandaue. 2015 IHBSS for Female PWID: Cebu

**Source: [http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx](http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx)

Geographically, reported cases are concentrated in three highly urbanized areas: Greater Metro Manila Area (which includes the provinces adjacent to Metro Manila like Rizal, Cavite, Laguna and Bulacan), Metro Cebu, and Davao City. These three areas plus Angeles City and Davao City are the highest priority areas for HIV intervention control.

### Trend in AIDS Death Cases 2000-2016

![Graph showing trend in AIDS death cases 2000-2016]

*Source: IHBSS studies, DOH, Epidemiology Bureau

According to UNAIDS spectrum analysis, the cumulative number of AIDS death is estimated to be about 4,500 cases, 50% of which took place between 2011 - 2015 (Figure 2). However, according to the Philippines HIV/AIDS and ART register, a total of 1,912 deaths were registered since the first case of infection in 1984 up until October 2016, 88% of which were male. Of the reported deaths, almost half (47%) belonged to 25-34-year age group, 29% were in the 35-49-year age group, while 14% were youth aged 15-24 years old. 16% were reported deaths among those who were infected through mother-to-child transmission (MTCT). The epidemiological, biological and behavioral data clearly indicate that the country is facing a fast growing HIV/AIDS epidemic which has not yet been brought under control. If the Philippines does not act now, the epidemic could spiral out of control.

3.3 Funding overview

In the Philippines, HIV/AIDS spending from international sources has been steadily decreasing since 2013. In 2015 spending from external sources represented only 35% of total HIV/AIDS spending, with the Global Fund being the biggest contributor. Other international sources include various UN agencies and USAID. Since 2004, the Global Fund has allocated more than US$ 44 million to support the response to HIV in the Philippines. This consisted of the five grants described in Table 4 below.

<table>
<thead>
<tr>
<th>HIV/AIDS GRANTS</th>
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<tbody>
<tr>
<td><strong>TYPE OF FUNDING</strong></td>
</tr>
<tr>
<td>PHL-304-G03-H</td>
</tr>
<tr>
<td>PHL-506-G04-H</td>
</tr>
<tr>
<td>PHL-509-G10-H</td>
</tr>
</tbody>
</table>

**TOTAL SIGNED** | 44,382,843 |
**TOTAL COMMITTED** | 36,729,270 |
**TOTAL DISBURSED (as of December 5, 2016)** | 34,102,777 |

20 Global AIDS Response Progress Report, the Philippines PNAC 2014
In the early years of TGF support, the Tropical Disease Foundation, a private, non-profit organization that seeks to control and prevent the spread of infectious diseases with public significance, was selected as the PR of the Global Fund grant. From 2007 till 2016, the PR function was transferred to the Department of Health (DOH), although during the application for funds through the New Funding Modality the Country Coordination Mechanism (CCM) took the decision to hand over the PR function to Save the Children, a non-governmental organization. Transfer of PR function from DOH to Save the Children was based on a number of justifications including efficiencies in fast-tracking financial transactions, as DOH perceived its current policies limiting fast implementation of essential prevention services.

4. Assessment findings

4.1 external environment

Based on the TPA framework, the external environment is subdivided into the economic and political environments, both of which are essential components for a successful transition from external support.

4.1.1 economic environment

An enabling economic environment is crucial for sustained and/or increased and predictable domestic investments in health and specifically to allow for a successful transition of the HIV program. This component was assessed by analyzing the annual Gross Domestic Product (GDP) growth trend, as well as the share of general government revenue as a percentage of GDP.

The Philippines is considered an upper low middle-income country, with a per capita income of about US$ 2,899 in 2015 according to the World Bank\(^{21}\). About 55.15% of its GDP comes from service industries, while industry and agriculture contribute 29.93% and 14.92% to GDP, respectively. Manufacturing, previously a major economic activity, has been on the decline over the last two decades. Services and remittances from overseas Filipino workers (OFW) are a major source of national income, comprising 10% of the country’s GDP\(^{22}\).

The Philippine economy grew at its fastest pace with GDP growth exceeding 5%, but growth slowed in 2008 as a result of the global financial crisis\(^{23}\) and started to slowly recover afterwards. GDP growth has fluctuated over the last five years, amounting to 4.2% in 2015. The share of government spending as a percentage of GDP slightly increased in the period 2006 – 2013 followed by a decline, reaching 10.4% in 2014, which is significantly below the average for Low Middle Income Countries (LMIC) (11%).

\(^{21}\) www.worldbank.org  
\(^{22}\) An HIV epidemic is ready to emerge in the Philippines Farr and Wilson Journal of the International AIDS Society 2010  
\(^{23}\) Budgeting in the Philippines Blöndal J.R., OECD 2010
GDP PER CAPITA AND GOVERNMENT SPENDING, 2005-2015

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<tbody>
<tr>
<td>GDP per capita growth (annual %)</td>
<td>2.9</td>
<td>3.5</td>
<td>5.0</td>
<td>2.6</td>
<td>-0.3</td>
<td>6.0</td>
<td>2.1</td>
<td>5.0</td>
<td>5.3</td>
<td>4.5</td>
<td>4.2</td>
</tr>
<tr>
<td>Government spending, percent of GDP</td>
<td>9.0</td>
<td>9.2</td>
<td>9.3</td>
<td>8.8</td>
<td>9.9</td>
<td>9.7</td>
<td>9.7</td>
<td>10.8</td>
<td>10.8</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>LMIC: Government spending, percent of GDP</td>
<td>10.7</td>
<td>10.6</td>
<td>10.7</td>
<td>10.8</td>
<td>11.8</td>
<td>11.1</td>
<td>10.9</td>
<td>10.9</td>
<td>10.7</td>
<td>11.0</td>
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4.1.2 political environment

The transition and ultimate sustainability of the HIV program require adequate political support to ensure that health investments are prioritized and sustained by the Government. The political environment as an enabling factor for an adequate transition of the HIV program was assessed by analyzing the existence of political will to prioritize health investments within the government’s budget; the existence of laws, regulations and policies that make possible prevention, treatment and care service delivery for KAP and people living with the diseases and the ability of the government to enforce these laws; as well as the existence of mechanisms within the government to enable CSO/NGO contracting for the delivery of various services funded out of state or local budgets.

Prioritization of health investments: The political will to ensure that health investments are prioritized was assessed using two indicators: a) the share of government spending on health out of the General Government Expenditure; and b) the share of public spending out of Total Health Expenditure (THE).

TREND OF GOVERNMENT EXPENDITURE ON HEALTH

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</thead>
<tbody>
<tr>
<td>Health expenditure, public (% of general government expenditure)</td>
<td>8.9</td>
<td>8.7</td>
<td>8.2</td>
<td>8.1</td>
<td>8.7</td>
<td>9.3</td>
<td>8.1</td>
<td>8.0</td>
<td>8.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Health expenditure, public (% of total health expenditure)</td>
<td>38.4</td>
<td>36.7</td>
<td>34.7</td>
<td>32.9</td>
<td>35.1</td>
<td>36.0</td>
<td>30.5</td>
<td>31.1</td>
<td>31.8</td>
<td>34.3</td>
</tr>
</tbody>
</table>

As shown on Table 6, the Philippines has spent a comparable share of the public budget on health over past decade out of total government expenditure and maintained a steady growth of health expenditures as percentage of government expenditure since 2005, but the observed levels of budgetary spending on health are slightly below the average for LMIC (11%). The share of public financing for health out of THE fluctuated between 30%-38% in the past decade. Maintaining on average 34% public financing for health out of THE places a high burden on the population, households and the non-state sector.

Civil society landscape & contracting: The following area of assessment for the political environment is the ability of the government to contract civil society organizations for all sectors using existing laws, rules and procedures or by demonstrating that they currently do this effectively.

CSOs in the Philippines include a very diverse set of organizations such as socio-civic organizations, religious groups, professional associations (lawyers’ and dentists’ associations for example), non-profit schools and hospitals, people’s organizations (associations of farmers, fishers, drivers, neighborhood associations, etc.), development NGOs and many others. An important sub-set of the broad CSO or NGO sector would be what in the Philippines is called development NGOs. Development NGOs would include nonprofit organizations committed to and working for economic, political and socio-cultural development that base their work on a clear belief in the need for systemic and structural change in society, even though their particular organization may be focused on one or a few aspects of that change. In other words, development NGOs are not content only with dole-outs or occasional activities to help the poor such as intermittent medical clinics or livelihood seminars. Development NGOs are often more institutionalized and often (but not always) have a few full-time staff. The term “development NGOs” is also used in the Philippines to refer to “people’s organizations” and cooperatives with the characteristics described above.

Many laws recognize and promote CSOs and their role in the development of the country. Among the most important is the Local Government Code (LGC) of 1991. The LGC devolves the authority, assets, and personnel of various national government agencies to LGUs to provide primary responsibility for basic services and facilities. It further provides for the participation of CSOs in local government planning and policy making and in the delivery of social services. The code mandates the formation of local development councils, which play a role in local planning, and also provides for the formation of other local special bodies, including the local health and school boards, all of which must also have CSO members. In addition, several administrative orders of the central government that implement the constitutional provisions and the LGC regarding public participation, require that all local councils at all levels should be represented by various NGOs and people’s organizations.

Under the General Appropriations Act (GAA), certain programs and projects are allowed to be implemented by LGUs in partnership with CSOs. To facilitate implementation, the Department of Social Welfare and Development (DSWD), the Commission on Audit (COA) and the Department of Budget Management (DBM) were mandated to issue guidelines for accreditation of CSOs as eligible implementing entity of government programs and projects. On December 29, 2014, the DSWD, COA and DBM issued Joint Resolution No. 2014-001 providing the guidelines for accreditation of CSOs. Only CSOs accredited by DSWD are allowed to participate in bids.

26 For the political commitment the framework looked at general laws, not health sector specific. The latter ones are more thoroughly evaluated under the program domain of the framework.
conducted by the Government Agencies for the implementation of programs and projects. The selection of participating CSOs is governed by the Implementing Rules and Regulations of Republic Act No. 9184 and the guidelines issued by the Government Procurement Policy Board under its Resolution No. 12-2007.

CSOs in the Philippines engage in a broad range of activities, the most common being: i) education, training, and human resource development; ii) community development; iii) enterprise development and employment generation; iv) health and nutrition; v) law, advocacy, and politics; and vi) sustainable development.27

The legal and social context: A well elaborated legal framework that is adequate to protect the rights of KAP and to deliver preventive, curative and care services, including those delivered by CSOs, is also an important factor for transition, especially for HIV services. However, the existence of such a legal framework will not be sufficient, unless mechanisms are in place to upheld/enforce these laws.

Laws, regulations or policies that hinder effective prevention, treatment, care and support for KAP and PLHIV: The Philippines has signed and ratified core human rights instruments, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Rights of People with Disabilities, the Convention on the Elimination of all Forms of Racial Discrimination and other human rights treaties28. The Philippines also has a general (not specific to HIV-related discrimination) anti-discrimination law, which protects discrimination against the population in the Philippines29. The Constitution states that the State guarantees full respect for human rights and every person has the right to equal protection of the laws, although sexual orientation and gender identity are not explicitly mentioned. The Revised Penal Code of the Philippines, as well as other criminal laws, do not have provisions punishing hate crimes. Overall, the general legislative environment for protecting human rights is conducive but the country lacks specificity in its legislation/regulations that protects MSM, PWID and the transgender population (Table 7).

<table>
<thead>
<tr>
<th>KAP/VULNERABLE GROUPS</th>
<th>LEGISLATION PROTECTING KPS</th>
<th>LEGISLATION / REGULATIONS PRESENTING OBSTACLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

28 Standard Concept Note TGF 2014
29 The Philippines Report NCPI, PNAC 2014
30 The Philippines Report NCPI, PNAC 2014
Much improvement is also expected from the Revised Philippine HIV and AIDS Policy and Program Act of 2012, which amends the AIDS Law RA 8504, which is still under preparation. All together, these policy frameworks potentially provide a powerful enabling environment for the response, if implementation is effective and closely monitored. Indeed, the “Philippine AIDS Prevention and Control Act” of 1998 has served as the legal framework of the national AIDS response in the country. Although this AIDS law was supportive of general measures to fight against stigma and discrimination, and provide access to services and commodities needed for HIV prevention and treatment, care and support, there was a growing need to adapt this legal framework 15 years later in lights of the changes in the HIV epidemic.

There are also legal, regulatory and policy barriers to access by KAP to HIV prevention services. These include the lack of a regulatory framework that allows the operation of needle/syringes programs, mistreatment by police of KAP, the lack of mandated representation by KAP in local government structures and poor understanding of KAP and HIV in local government units and law enforcement agencies.

In the Philippines, there is pervasive misconception about stigmatized, infected individuals who are easily discriminated against. 6 out of 10 lose their jobs; 1 out of 10 is denied job promotion; and 1 out of 10 is forced to leave their residence or denied of a place to stay.

<table>
<thead>
<tr>
<th>KAP/VULNERABLE GROUPS</th>
<th>LEGISLATION PROTECTING KPS</th>
<th>LEGISLATION / REGULATIONS PRESENTING OBSTACLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrants/mobile populations</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Orphans and other vulnerable children</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PWIDs</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Prison inmates</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sex workers</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transgender people</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Women and girls</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Young women/young men</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

31 External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
Prejudice towards lesbians, gay, bisexual and transgender (LGBT) people continues to exist in Philippine society and culture. Discrimination, harassment and intolerance of homosexuality, particularly male homosexuality, have resulted in MSM becoming a “hidden” population group, even though a high share of reported HIV cases involve male-to-male transmission. With high intolerance, it is difficult to provide MSM with HIV/AIDS information, education and treatment. Stigma and discrimination among MSM continue to be a major obstacle to improving public health interventions among MSM and increasing service coverage. The external review of AIDS Medium Term Plan 5 (AMTP5) noted that the weak uptake of HIV testing and counseling is the most obvious result of the fear of LGBT populations to face the results of HIV testing.

Failure to measure, monitor and control HIV stigma and discrimination in the country, coupled with the presence of a high level of behavioral risk, may therefore provide an ideal environment for future increases in the rates of HIV infections. But despite these policies, very little has been done on a large scale to address the stigma and discrimination experienced by PLHIV. There is a great need to ensure that the above-mentioned state laws and policies are enforced. The end goal of these policies is to change attitudes towards infected people and their families. More supportive attitudes should translate into more supportive behavior, transforming a hostile world into one that is compassionate and constructive. These policies seek to break the silence surrounding the disease, partly by involving people living with HIV and their communities in an active response. It is hoped that more open discussion will help to reduce the fears and misconceptions that reinforce high-risk behavior.

The climate of religious conservatism, which prohibits condom use and the open education on issues such as sexual orientation and sexual reproductive health and rights, also hinders MSM and TGs, particularly the young sub-populations, from accessing information and services from SHCs and health facilities. Gender bias against TGs is perceived as existing in health care settings and viewed as one of the reasons for the absence of TG specific services. Gender disaggregation of services for MSM, PWID and their female partners, including the integration of reproductive health, has not yet been sufficiently addressed. This includes the lack of orientation of women to reproductive choices; safe pregnancy; abortion and post-abortion care; and reproductive tract cancer screening. Counseling on hormone use and referral to other gender enhancement practices for TGs is still lacking in the current continuum of HIV prevention, care and treatment services.

Rule of Law: Apart from unfavorable socio-legal environment hindering access to services by key population and widespread stigma and discrimination, the country exhibits weak rule of law as demonstrated by the low Governance Indicators. According to the Worldwide Governance database, the rule of Law Index is -0.33, which indicates weak rule of law in the country.

34 An HIV epidemic is ready to emerge in the Philippines, Farr and Wilson Journal of the International AIDS Society 2010
36 Standard Concept Note, TGF 2014
4.2 Internal environment

4.2.1 Inputs

The inputs are the resources that are available for the HIV program. These are subdivided into components that include: i) financial resources, ii) human resources and iii) health information systems.

4.2.1.1 Financial resources

Without dedicated financial resources, it would be difficult for any programme to survive. Resources should be predictable and proportionate to the disease burden in the country. However, the available resources are strongly related to the weak economic environment and the lack of adequate political will (as described in previous section). These financial resources were assessed by examining the budgetary commitment and financial dependence on donor/external funding and by looking at the prioritization of investments between preventive and curative interventions, especially for epidemiologically important population groups.

Budgetary commitment to the HIV program: Total expenditure on AIDS, including private sources demonstrates an increasing trend since 2011 (Table 8). The total expenditure growth continued until 2014 and slightly declined in 2015; however, the budget appropriation for the HIV program started to increase again in 2016 (US$ 13 mln) and 2017 (US$ 20 mln). The total budget increased from 8 to 17 million US$ in the period of 2011-2015.

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>US$</td>
<td>%</td>
<td>US$</td>
<td>%</td>
<td>US$</td>
</tr>
<tr>
<td>Public</td>
<td>4,181</td>
<td>33%</td>
<td>4,655</td>
<td>48%</td>
<td>4,523</td>
</tr>
<tr>
<td>External</td>
<td>3,872</td>
<td>31%</td>
<td>4,966</td>
<td>51%</td>
<td>5,810</td>
</tr>
<tr>
<td>Private</td>
<td>4,593</td>
<td>36%</td>
<td>23</td>
<td>0.2%</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>12,647</td>
<td>100%</td>
<td>9,644</td>
<td>100%</td>
<td>10,351</td>
</tr>
</tbody>
</table>

The increase in total spending on HIV during 2011-2015 was mainly caused by the increase in domestic spending by the central government, local governments and the private sector. Nevertheless, a decline of funding from private sources is observed since 2011, which can possibly be explained by: i) the absence of accurate information on private spending; and ii) the introduction of the Outpatient AIDS treatment insurance program. Among external sources, the biggest contribution is from the Global Fund. Other external contributors include UN agencies including WHO and United States Agency for International Development (USAID). The global reduction in donor contributions to HIV...
and AIDS may cause risks to the sustainability of the HIV programme if not adequately replaced by domestic resources.

The public budget for HIV accounted for 73% of total resources in 2015. Although domestic funding is increasing, the growth is not fast enough to meet the needs, which are growing faster still. As a result, the national HIV program still remains underfinanced.

The annual national health budget is part of the “Social Services Expenditure Program” of the government’s general appropriations. A sub-category of the health budget is the “Other Infectious Diseases and Emerging and Re-Emerging Diseases”, which includes HIV and AIDS together with dengue, food and water-borne diseases. Nevertheless, although there is no separate budget line for the national HIV programme, appropriations are factored in three year national budgets based on the costed national HIV program. The latter is largely informed by the investment case recommendations developed with the support of UNAIDS in 2014.

Prevention financing from public sources: HIV/AIDS spending on prevention remains a low priority. Since 2009, the overall allocations to HIV prevention have gradually decreased from 63% (2007-2009) to 32% during 2011-2015\(^\text{38}\). Likewise, the trend of prevention in overall funding from the public purse decreased from 60% to 27% between 2011-2015\(^\text{39}\). Based on DOH data, only 10% of the DOH budget is allocated for prevention. Prevention programs in the country include: communication for behavior change, condom social marketing, counseling and testing, improving management of Sexually Transmitted Infections (STI), interventions for vulnerable population, programs for KAPs. In the period of 2009-2013, public funding for prevention activities targeted at sex workers and their partners declined, but budget increase is observed for intervention targeted at MSM and PWIDs\(^\text{40}\). Unfortunately, no data is available on the funding allocation by KAP groups since 2013 allowing analysis of most recent public spending per KAPs.

Treatment financing from public sources: Adequate financing of treatment and care services is an important component of a healthy HIV program that can sustain public health gains in the long-term. Therefore, the dependence of these services on external support was examined closely to evaluate transition preparedness.

### T.9 PHILLHEALTH SPENDING ON PLHIV OUTPATIENT BENEFITS, 2010-2015

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AMOUNT PAID FOR OHAT CLAIMS (PHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>238,975</td>
</tr>
<tr>
<td>2011</td>
<td>8,027,545</td>
</tr>
<tr>
<td>2012</td>
<td>17,002,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AMOUNT PAID FOR OHAT CLAIMS (PHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>43,582,500</td>
</tr>
<tr>
<td>2014</td>
<td>69,225,000</td>
</tr>
<tr>
<td>2015</td>
<td>91,987,500</td>
</tr>
</tbody>
</table>


\(^{40}\) GARP reports 2009-2013
Case detection and diagnosis is partially funded by the public budget. In the absence of detailed funding data for the recent years\(^4\), around 30%-40% is covered from domestic resources, according to key informants. A significant increase in spending can be observed in care and treatment given the increasing number of PLHIV who are now enrolled in antiretroviral therapy (ART). First and second line ARVs are centrally procured by the Department of Health and have been fully funded from the public budget since 2015\(^2\). Access to outpatient treatment for PLHIV is also improving, as shown by the significant increase in claims paid by PhilHealth on OHAT since its introduction (2010) (see Table 9). According to the majority of respondents interviewed, adherence support to treatment, such as transportation costs for example, is not fully funded by external sources.

### 4.2.1.2 Human resources

The human resources include the service providers who provide prevention, treatment and care/support services to HIV affected-communities and individuals. The availability of adequately trained and distributed human resources is important for any program success and long-term sustainability. This component was measured by assessing the availability of sufficient human resources. This was also assessed by measuring the institutionalization of donor-supported trainings (i.e. continuous professional development) in the national education systems; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale.

**HR sufficiency/availability:** At present, there is no actual count of active health workers deployed in HIV/AIDS sector, and such data are not regularly collected\(^3\). The high turnover, migration and maldistribution of health human resources are common in the Philippines. Staff turnover at the treatment hubs with ARV programs was described by local management and staff as a major concern. Apparently, after staff were trained on HIV treatment, they move on to better paying jobs\(^4\). The turnover of medical technologists providing HIV testing (not all health centers have medical technologists)\(^5\) also poses a challenge to the timely diagnosis and initiation of ART. Overall, limitations in the health workforce availability and adequacy were noted by respondents. To manage the migration flows of health professionals and as part of the HRH master plan\(^6\), more comprehensive labor agreements are currently being pursued by the Philippine Overseas Employment Administration, the Department of Foreign Affairs, the Department of Labor and Employment and the Department of Health with destination countries. However, so far no evident positive dynamics have been observed in the field of HIV/AIDS as a result of the HRH master plan. Respondents were largely ignorant of how the HRH plan addresses health workforce challenges in the field of HIV/AIDS. Therefore, it should be acknowledged that the challenges in terms of HRH are a structural challenge of

\(^{41}\) NASA and GARP reports does not provide detailed breakdown of the expenditure data by TPA categories


\(^{43}\) The Philippines Health System Review Health Systems in Transition 2011


\(^{46}\) In 2005, the DOH, in collaboration with WHO-WPRO, prepared a long-term strategic plan for HRH development. The 25-year human resource master plan from 2005 to 2030 was to guide the production, deployment and development of HRH systems in all health facilities in the Philippines. The plan includes a short-term plan (2005-2010) that focuses on the redistribution of health workers as well as the management of HRH local deployment and international migration. A medium-term plan (2011-2020) provides for an increase in investments for health. A long-term plan (2021-2030) aims to put management systems in place to ensure a productive and satisfied workforce. The DOH also created an HRH network composed of different government agencies with HRH functions to support implementation of the master plan.
the health sector that goes far beyond the HIV program, and is doubtful that it will be adequately addressed within the limits of HIV programming.

**HR development & trainings:** Even if broader HRH issues will be adequately addressed by the Government, donor supported training programs are not fully integrated into the national undergraduate, postgraduate and continuous education systems, which poses a risk to sustainability that is specific to the HIV/AIDS program and will be considered under the transition planning process. The timely integration of donor funded trainings could help the production and deployment of the qualified staff at HIV/AIDS service provision sites.

**Existence of policy for CSO training/development:** The country lacks a well formulated policy for CSO training and development in general, and in the field of HIV/AIDS in particular.47

**Alignment of salaries:** Donor funded human resource salaries vary by type of employment, position and function. For consultants with term contracts in the public facilities, donor funded salaries are two times higher than those of civil servants with a permanent employment status. For the civil servants at DOH, according to legislation, donors are allowed to pay a top-up of 20% only to cover insurance and benefits, whereas for example for peer educators deployed under the donor financed projects, payments are below the national pay scale. Moving forward would require better alignment of donor paid salaries with those in the local economy and public sector.

### 4.2.1.3 Health information system

One important step for an adequate response to the HIV epidemic is to “know your epidemic”. The country health information systems collect and disseminate the data to support program and resource planning and contribute to evaluating program outcomes and impacts. Quality, timely, adequate and reliable data are an essential part of sustaining any public health program, including HIV. This component was assessed by evaluating the degree of integration of the comprehensive and routine statistical reporting in the national health information systems as well as evaluating the HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, the funding sources and the integration of the data in the national reporting.

**Routine Surveillance system:** The unified surveillance system combining prevention, treatment and adherence information is functional at the national level whilst at local levels the system remains fragmented. Locally, the information system does not incorporate HIV incidence, treatment and retention data. Data about TB-HIV co-infection are also limited. The external Mid-Term Review of AMTP5 identified important gaps in the type of data produced by surveillance in the Philippines and recommended changes to increase the robustness of this information. Thus, routine statistical reporting is partially advanced. At the national level, sufficient disaggregation of data has been ensured since the last assessment, but is still mostly paper based. At local levels, the system lacks sufficient disaggregation and uses a mixed electronic and paper based data collection and analysis system.

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47 Validated with DOH and Philippine National AIDS Council (PNAC)
48 External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
49 Ibid
Second generation surveillance: Second generation surveillance is conducted every two years through the Integrated HIV Behavioral and Serologic Surveillance (IHBSS). In 2015, the sixth round of IHBSS was conducted. The IHBSS uses a robust methodology that includes time location sampling among MSM and Registered Female Sex Workers, Probability-Proportionate to Size Sampling for Freelance Female Sex Workers, and Respondent-Driven Sampling for PWIDs. Nevertheless, the following weaknesses were observed: IHBSS data analysis, dissemination and utilization were limited up until recently; monitoring the behaviour of the most-at-risk groups e.g. condom use, number of partners, needle/syringe sharing, to guide local prevention is limited; HIV testing and counselling data of pregnant women from antenatal care services to detect trends in HIV prevalence are weak; and there is no systematic screening or surveillance of behaviors in prisons. Commendably, IHBSS and Population Size Estimates (PSE) are fully funded by the DOH, thus assuring promising prospects for sustainability.

4.2.2 Governance

The governance sub-domain is sub-divided into a governance-specific components that includes all of the actors and institutions involved at the organizational level and steering the HIV program and the factors fostering accountability, which is an important to ensure that organizations are fulfilling their roles and commitments.

4.2.2.1 Governance

Appropriate governance is the cornerstone of any program. This area was assessed by looking at three indicators: a) strong political commitment (non-financial), as revealed by a well elaborated disease-specific National Plan with sufficient legal power to drive national budgetary allocations and disease programs that are given adequate priority in the national health sector strategy; b) strong institutional and individual leadership of the disease program (not Principal Recipient); and c) an appropriately placed and well-functioning coordination mechanism within the governance structure of the country.

Coordination mechanism: The national response is coordinated through the Philippine National AIDS Council (PNAC), which acts as the highest advisory, planning and policy-making body on AIDS and is composed of government agencies, CSOs, professional organizations and representatives of PLHIV. The PNAC is in charge of planning, coordinating and monitoring the country’s national response to HIV and AIDS as well as ensuring that all HIV and AIDS projects and initiatives in the country respond to or are harmonized with the AMTP. The PNAC is supported by a Secretariat, whose function is to support the PNAC plenary in its policy-decision making, ensure the availability and utilization of strategic information for program planning, coordination and monitor implementation of sector-specific responses and provision of administrative support to PNAC. Until recently, the PNAC was part of the DOH structure and lacked a legal basis and separate/independent budget, which had a negative effect on its operations. In order to further improve the effective operation of the PNAC, the decision has been made to reform it into a separate legal entity subordinated to the DOH. At the time of the assessment, the PNAC reform was in progress.

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At the local level, the Provincial Health Office leads the planning and the overall coordination and implementation of the HIV and AIDS Program within the jurisdiction of the City/Provincial Government. The office coordinates closely with the City Health Office (CHO), Rural Health Units, and DOH regional and central offices. The CHO manages service delivery, health promotion, community and social mobilization and logistics management at the grassroots level. The CHO works with the multispectral Local Authority Council, which apart from other sectorial representation also involves CSOs.

Apart from the PNAC, the Philippines has established a Country Coordination Mechanism (CCM) within the DOH, which has oversight functions for the effective implementation of Global Fund grants and supervises the PR’s performance and capacity for resource management in support of effective and efficient achievement of program objectives. In carrying out this role, the CCM ensures that Global Fund’s principles of partnership, community engagement, inclusiveness, transparency and accountability are adhered to. The CCM secretariat is fully funded by the Global Fund grant.

**Effectiveness of coordination:** Findings from the field show a general perception of weakness on the part of the PNAC. Outcomes from the aforementioned reform initiative have yet to be realised and bear fruit. It is important at this point is that the PNAC should exercise stronger leadership and tighter controls over its membership. Critical to these is addressing the challenging issue of the PNAC not having a clear resource base to play a stronger role as the only national coordination body leading the national response to HIV/AIDS prevention and control in the country. In the absence of a clear and sustained resource base and autonomy, the Council remains limited in overseeing an integrated and comprehensive approach to HIV prevention and control. Furthermore, the Secretariat is severely limited in its efforts to coordinate the formulation, monitoring and evaluation of plans, programs, policies and strategies to ensure effective and efficient implementation of the national response. Over the years, the Council has been plagued with the problem of inconsistent representation and uneven participation. Membership of the Council remains unnecessarily large and with mandate that lack clarity.51

**Political commitment:** At present the national response to HIV/AIDS is guided by the legally approved 5th AIDS Medium Term Program, the Philippines Strategic Plan on HIV/AIDS 2011-2016. The 6th AMTP for the next 5-year period is under preparation and is planned to be approved by end of December 2016. HIV/AIDS is a priority in the National Health Sector Strategic Plan 2020 (HSSP). The HSSP identifies four strategies and objectives to guide the country response to the HIV epidemic: i) Continuum of HIV and STI prevention, diagnosis, treatment and care services to KAP; ii) Health promotion and communication on HIV and STI prevention and care services; iii) Enhanced strategic information systems; and iv) Strengthened health system platform for broader health outcomes.

**Leadership:** The DOH in general and the HIV/AIDS and STI Unit at the DOH in particular is a legally empowered organization leading the management of

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51 External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
effective AMTP implementation. Apart from this unit, according to key informants there are couple of individual leaders who lobby and promote resolutions of HIV/AIDS related issues in the Senate and among City Mayors.

In conclusion, the findings of the Governance sub-component reveal relatively strong political commitment on the part of the government to deal with the epidemic, which is enhanced with the strong leadership capacity of individuals as well as involved institutions. However, weaknesses in the existing national coordination mechanism will pose a risk to the transition, unless they are addressed in a timely manner.

4.2.2.2 Accountability

Transparency promotes accountability by communicating program performance results, allowing interested stakeholders to engage in program monitoring/oversight and ensuring that government commitments are upheld. All of this could contribute to a successful transition and could lead to sustainability. Civil society actors usually place demands for accountability on program results, which is why they need an enabling environment to operate and keep program managers and governments accountable to the society/community. Accountability has been measured by Enabling Environment for Civil Society engagement in the country and by examining availability and accessibility of program performance results freely available and accessible in a public domain.

Enabling environment for CSO engagement: According to data from www.civicus.org, the environment for the Philippines is rated as enabling for the citizens, who are individually or collectively able to participate and engage in civil society (IEE - 0.53)\(^52\). The important role of civil society in the national response to HIV/AIDS has been recognized in the Philippines. CSOs assist national agencies and Local Government Units to implement sector-specific responses in various locations. CSOs have been rated highly for their involvement in planning and budgeting for the AMTP. Currently CSOs represent six sectors (PWID, MSM, sex workers, OFW, Labor and PLHIV) participate in governance and are represented in the PNAC. PLHIV is also a member of the CCM of the GFATM and are usually members of the LACs.

Access to program performance results: A significant number of important studies have been undertaken over last 10 years. Efforts are in place to widely disseminate study results to a range of stakeholders. Access to surveillance data, IHBSS, programmatic performance evaluation reports, technical reports and findings are now easily accessible to the public\(^53\) The only challenge remains with expenditure data, as the responsibility for carrying out a fully fledged National Aids Spending Assessment was handed over to the PNAC from the National Economic Development Agency (NEDA) in 2015. These reports become only available to public after the publishing the bi-annual Global AIDS Response Progress GARP report.

All of this suggests that the country environment and exiting mechanisms are adequate to facilitate accountability and that this component therefore presents a low risk for transition.

\(^{52}\) www.civicus.org, Accessed on September 17th, 2016
\(^{53}\) According to the findings of External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014, IHBSS studies were only disseminated using Facts Sheets, while full reports were not accessible.
4.2.3 Program

4.2.3.1 Service delivery

This sub-component seeks to understand how the program is currently functioning and its impact on transition. As such, service delivery is measured by: i) Treatment coverage and outcomes; ii) The integration of existing disease-specific services into general services; iii) the coverage of KAP with preventative services; and iv) CSO contracting for the delivery of health services.

Coverage of KAP with preventive services: The coverage of key affected populations with testing on HIV has improved over the time, but still remains low (Table 10). According to IHBSS studies, only 20-30% of the KAP in the Global Fund supported sites received an HIV test and knew the results. There are two major bottlenecks identified in HIV testing service provision that impede higher coverage: i) access to free and confidential HIV testing; ii) rapid HIV testing with same-day results. Currently, the government is providing free HIV testing through government-run Social Hygiene Clinics (SHC) mandated to provide STI and HIV services to female sex workers. SHCs are not present in all cities and in most instances, other key populations (e.g. MSM) are hesitant to access the services being offered by SHCs. Hence, there is a need to expand free and confidential HIV testing services beyond the realm of SHCs. Furthermore, the current HIV testing protocol requires a confirmatory test that takes around 4 weeks before the results are released. This leads to significant losses to follow-up, missing an opportunity to access life-saving treatment and prevention of onward transmission of HIV infection54.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>KAP</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Testing PWID*</td>
<td>4.8</td>
<td>4.8</td>
<td>6.3</td>
<td>6.7</td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>SW**</td>
<td>16.5</td>
<td>16.5</td>
<td>12.6</td>
<td>22</td>
<td>24.6</td>
</tr>
<tr>
<td></td>
<td>MSM**</td>
<td>5.2</td>
<td>5.2</td>
<td>9.3</td>
<td>9.3</td>
<td>16.1</td>
</tr>
<tr>
<td></td>
<td>PWID: Safe injecting practices</td>
<td>24.7</td>
<td>24.7</td>
<td>30.7</td>
<td>33</td>
<td>63.6</td>
</tr>
<tr>
<td></td>
<td>SW: Condom use</td>
<td>64.9</td>
<td>64.9</td>
<td>47.4</td>
<td>69.6</td>
<td>70.6</td>
</tr>
<tr>
<td></td>
<td>MSM: Condom use</td>
<td>36.3</td>
<td>36.3</td>
<td>40.7</td>
<td>40.7</td>
<td>49.8</td>
</tr>
</tbody>
</table>

* Source: 2015 IHBSS for Male PWID: Cebu, Mandaue. 2015 IHBSS for Female PWID: Cebu
** Source: [http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx](http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx)

54 WB Aid Memoire, 2015
The percentage of MSM exposed to testing interventions has slightly increased over the years, reaching its highest level in 2015 (16.1%), although it is still too low to deliver significant public health gains. Prevention activities among MSM have been largely dependent on standalone information and communication and/or behavioral change communication efforts. There are weak linkages between peer outreach and HIV testing, STI and other services. Current reach for peer education and outreach services for behavior change among MSM is weak and in some instances not fully adequate. Only around 50% of MSM report using condoms during their last sexual intercourse (Table 10). This may be attributed to the low quality of peer education, an inappropriate choice of peer educators expected to engage with middle income MSMs, single Peer Educator encounters instead of repeated encounters, and low follow up rates. Peer educators are not adequately supported with the appropriate tools, which negatively affects the quality of provided services.

Stigma and discrimination keep the MSM population away from health services, which makes them difficult to reach. Both the actual and perceived levels of stigma in health care settings are high. Addressing stigma and discrimination, enhancing the appropriate clinical skills, knowledge, and sensitization of health care workers, removing structural barriers to appropriate services delivery, and increasing health seeking behaviors of MSM are also essential to program success.

Prevention work among registered female sex workers revolves predominantly around Social Hygiene Clinics. These sex workers pay for their HIV, syphilis and STI check-ups and for registration. These services represent an important source of revenue for the SHC, although this money is reportedly forwarded to the local government administration. Freelance female sex workers and male sex workers, who are at higher risk of HIV than their registered peers, are inadequately reached by prevention services. Transgender sex workers are generally ignored. Reported condom use among female sex workers over the last three years indicates a slight increase since 2011, but still fluctuates around 70% or less.

Unprotected sex is rampant in all key populations and reported condom use remains low among populations at high risk of HIV and STIs. Condoms are often provided free of charge to key populations in Global Fund supported sites, but lubricants are often not available. The condom social marketing targeting key populations is not actively implemented; condom promotion through the media does not exist; and condom distribution at risky venues is not allowed, due to the barriers imposed by local ordinances. Although supplied by the Department of Health to Social Hygiene Clinics, condoms are not always available or promoted in these facilities. Peers, volunteers and outreach workers do not always carry condoms or promote their correct and consistent use.

Like MSM, the current HIV prevention program among PWIDs is minimal and coverage is low, although improvements were noted in 2015 with testing rates reaching 23%. However, achieved levels of testing remain inadequate. In the 2015 report, only 64% of PWIDs reported using sterile injecting equipment the last time they injected. PWID sites are few considering that needle/syringe sharing is an important driver of the epidemic. Overall, harm reduction interventions, particularly needle and syringe programs, do not exist on an adequate scale. Although in 2014 a resolution from the Dangerous Drug Board paved the way for the implementation of needle/syringe exchange programs as

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55 External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
part of the National HIV program, they only existed as an operational research project in Cebu city, which was discontinued recently. This situation requires creating an enabling environment that promotes health-seeking behaviors, is supported by national laws or local ordinances and allows the implementation of harm reduction programs.

**Treatment coverage and outcomes:** A total of 16,637 PLHIV were on ART as of September 2016. Most (97%) were males. The median age of patients enrolled in treatment was 31, out of an age range from 1 to 78, 95% of PLHIV receive first line regimen, while the remainder receive the second line regimen. The enrolment of PLHIV in ART treatment has improved since 2010. According to key informants from the DOH, almost 88% of eligible PLHIV are currently benefitting from ART.

The National ART registry shows that the average CD4 count at treatment initiation is 156 cell/mm, whilst new national ART guidelines since early 2015 recommend shifting treatment eligibility from a CD4 count of 350 or less to a CD4 count of 500. Nevertheless, it is apparent that most PLHIV are late initiators of treatment due to loss to follow-up after initial testing, since they are unaware of their CD4 count early in the disease or they are altogether unaware of their status until they are at a more advanced disease stage.

There are number of reasons for low ART coverage. According to national regulations, PLHIVs can receive ART free of charge once enrolled with the PhilHealth for Outpatient HIV/AIDS treatment package (OHAT). PLHIVs become eligible for OHAT coverage only after their HIV status is confirmed. Provided that the waiting time for confirmatory test results is almost 4 weeks, it is probable that a large number of PLHIV are lost between testing and treatment enrolment. Furthermore, very few PWIDs who are eligible for ART are actually enrolled in treatment. Limited access to their CD4 count and the possible interaction of injected drugs with ARVs create obstacles to enrolment in and adherence to ART by this population.

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**TREATMENT ADHERENCE - TWELVE-MONTH RETENTION ON ANTIRETROVIRAL THERAPY, 2010-2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>92</td>
</tr>
<tr>
<td>2012</td>
<td>87</td>
</tr>
<tr>
<td>2013</td>
<td>86</td>
</tr>
<tr>
<td>2014</td>
<td>88</td>
</tr>
<tr>
<td>2015</td>
<td>90</td>
</tr>
</tbody>
</table>

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57 This is the total number of adult and pediatric patients currently enrolled and accessing antiretroviral drugs (ARV) in the 40 treatment hubs and satellites. It does not include patients who were previously taking ARV but have already died, have left the country, have been lost to follow up, or opted not to take ARV anymore.
Retention on treatment after 12 months of ART initiation shows promising results. Retention rates are reported to be high, reaching over 85% since the introduction of the OHAT in 2010, which fully covers treatment costs. Overall retention rates over the last five years have remained largely stable. In 2015 90% of PLHIV remained on ART (Figure 3).

4.2.3.2 Integration of services

PMTCT integration into maternal care and PHC: According to the 2014 Global AIDS response progress report, PMTCT is only integrated into a few facilities that provide antenatal care/maternal and child health care. This finding has been supported by respondents interviewed, who noted no further progress in the integration of PMTCT services.

HIV-TB Integration: As a response to the TB-HIV epidemiology, an Administrative Order (AO 2008-0022) otherwise known as the “Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control” was signed and disseminated in 2008. The AO was further revised later in 2014. To date, Provider Initiated Counseling and Testing is conducted in almost all TB and HIV facilities. The treatment hubs administer treatment for TB co-infection as well refer TB co-infection to their nearest TB DOTS center for co-management and to obtain TB drugs for free. The results of the high level of integration of HIV/TB services are measured by number of indicators presented in Table 11 below.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of TB patients who had an HIV test result recorded in the TB register</td>
<td>80% of Registered TB and MDR TB cases</td>
</tr>
<tr>
<td>% of HIV-positive registered TB patients given an anti-retroviral therapy during TB treatment</td>
<td>100% of HIV and TB cases</td>
</tr>
<tr>
<td>% of HIV-positive patients who were screened for TB in HIV care or treatment settings</td>
<td>90% of PLHIV accessing HIV hubs care</td>
</tr>
<tr>
<td>% of new HIV-positive patients started Isoniazid Prevention Therapy during the reporting period</td>
<td>50% of new PLHIV with inactive TB</td>
</tr>
</tbody>
</table>

4.2.3.3 Cso contracting in the health sector

In the 1970’s and 1980’s, the CSOs in the Philippines were used as alternative channels for the delivery of primary care or community based health programs due to the limited capacity of the government to provide these services in rural or hard-to-reach areas. They have proven that they were effective

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in delivering primary care services to poor communities. However, this approach was not sustained due to the CSOs’ limitations in capacity, resources and referral networks. Besides, parallel structures further reinforced the fragmentation and nonintegrated delivery of health care services. Although contracting of CSOs in others sectors of the economy continued, it has been practiced on a limited scale in the health sector in more recent years.

In response to recent cases of corruption observed in CSO contracting, the contracting requirements have been tightened to require CSO accreditation in order to access public funding. Newly introduced stringent accreditation requirements create administrative barriers for CSOs to access public funding, as the majority of CSOs are not registered legal entities and/or lack the capacity to meet the accreditation requirements. Only a few, big CSOs have managed to obtain accreditation and access public funding. Furthermore, although contracting rules and procedures are in place and well defined, there is limited knowledge whether these rules are appropriate for the procurement of preventive services currently provided by CSOs in the field of HIV/AIDS with Global Fund support.

CSOs play a significant role in the national response to HIV and AIDS, including: prevention, care and support as well as provision of legal services to KAPs; assisting national agencies and LGUs in the implementation of sector-specific responses in focus geographical sites; contributing to the behavior change needed for HIV prevention; PLHIV participation in the treatment model to implement ART with hospital-based treatment facilities; facilitating a strong referral network between treatment hubs and the PLHIV/MSM support groups, resulting in increased ART enrollment and retention; psychosocial support to PLHIV; and participation in the governance of HIV/AIDS.

### T.12

#### PERCENTAGE OF SERVICES PROVIDED BY CSOS

<table>
<thead>
<tr>
<th>TYPE OF SERVICES</th>
<th>PERCENTAGE OF SERVICES PROVIDED BY CSOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention: PLHIV</td>
<td>51–75%</td>
</tr>
<tr>
<td>Prevention: MSM</td>
<td>51–75%</td>
</tr>
<tr>
<td>Prevention: SW</td>
<td>25–50%</td>
</tr>
<tr>
<td>Prevention: Transgender</td>
<td>51–75%</td>
</tr>
<tr>
<td>Palliative care</td>
<td>51–75%</td>
</tr>
<tr>
<td>Testing and Counselling</td>
<td>51–75%</td>
</tr>
<tr>
<td>Know your Rights/ Legal services</td>
<td>51–75%</td>
</tr>
</tbody>
</table>

61 The Philippines Report NCPI, PNAC 2014
Thus far, however, they are fully financed from external resources, mainly the Global Fund grant. The role of CSOs and the importance of continuation of preventive services after the end of external funding should not be underestimated. As shown in the Table 12, HIV prevention services among KAPs are predominantly provided by CSOs. If the government of the Philippines does not address CSO contracting issue today, there is a risk that the preventive services currently provided by CSO sector will be discontinued.

To conclude, the component of service delivery entails risk when transitioning from the Global Fund support. Preventive services among KAPs are expected to be negatively affected because current preventive interventions, which are already at a low level, are mainly funded by TGF and delivered by CSOs paid out of the Global Fund grant. Recently introduced accreditation requirements for CSO pose a risk as they may increase barriers for future CSO contracting by the government. Finally, the weak integration of some preventive (PMTCT) and treatment services (e.g., adherence support, harm reduction and ART for PWID) may further challenge the service delivery component.

### 4.2.7 Organizational capacity

**Program Management Capacity:** The Office of Technical Services and Disease Prevention and its Technical Bureau sub-division supervises the implementation of the HIV/AIDS program in the country. The department provides technical oversight of the program in both government and externally funded programs. Presently the group that is tasked with the management of the national program at the DOH is represented by two full-time public employees and eight consultants contracted under the Global Fund grant. While human capacity is adequate and annual performance assessment of staff at central and sub-national levels is a well-established practice, there are concerns about the continued effectiveness of the national program management after the end of external support, due to the limited staffing of the respective unit under the national budget. The same problem is detected at the epidemiology Bureau, which is responsible for routine and second generation surveillance and is currently supported by consultants contracted through the Global Fund grant.

As stated previously, the PR function was handed over from the DOH to Save the Children in 2015. Nevertheless, according to key informants from the DOH and the national AIDS program management unit, there is close cooperation with the new PR.

**Procurement and Supply:** The centralized procurement of ARVs from international platforms has been fully organized and funded by the DOH since 2015. According to key informants, this practice will continue after the end of external support allowed by the enabling legal environment. Using an international procurement platform allows the country to efficiently use scarce public resources and avoid the higher costs of ARVs experienced in the past, when the drugs were procured locally.

<table>
<thead>
<tr>
<th>TYPE OF SERVICES</th>
<th>PERCENTAGE OF SERVICES PROVIDED BY CSOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of Stigma and Discrimination</td>
<td>51–75%</td>
</tr>
<tr>
<td>Clinical services (ART/OI)</td>
<td>&lt;25%</td>
</tr>
<tr>
<td>Home-based care</td>
<td>51–75%</td>
</tr>
<tr>
<td>OVC support</td>
<td>&lt;25%</td>
</tr>
</tbody>
</table>
Consumables and other required commodities are predominantly procured by the PR using international procurement procedures and are not integrated into the public procurement system. Rare stock outs of rapid tests were reported by key informants in the past, which was mostly explained by poor forecasting and delayed purchases. Recent efforts to train respective staff in forecasting methods already show positive results.

**Monitoring and Evaluation Capacity:** Key informants anonymously agreed that the country produces sufficient evidence on a regular basis to inform planning and funding, but sufficient analytical capacity is lacking at central and local levels, and so requires of regular external support.

Based on this evidence, it seems that the country has sufficient organizational capacity as well as well a functioning Procurement and Supply Management (PSM) system, with minor limitations, and an effective M&E system all managed, funded and implemented by the Government (except for the part currently handled by the PR). This certainly creates a conducive environment for the transition. However, it would be important to address issues related to the staffing, especially consultants contracted under the Global Fund grant, during transition to lower the risk.

**4.2.8 Transition planning**

A direct measure of forward thinking for an HIV program currently receiving external funding in any country is the ability to plan for the take-over of responsibilities particularly at the programmatic level, for which funding issues are important. In this area, elements such as the existence of a legally binding plan with clear time-bound activities and a dedicated budget for transition were assessed.

The Philippines has not yet developed a legally binding transition plan as a stand-alone document, or as a part of the National Strategic Plan. Nevertheless, some aggressive steps were undertaken to ensure the gradual transition of programmatic elements from external to domestic support. To name a few:

The HSSP on HIV and STI 2015-2020 sets the national direction for the HIV response. It includes the Operational Plan 2015-2017 which contains the cost estimates for the initial 3-year implementation. There are four major strategies, each one of which has specific activities with a corresponding budget for each year, including the funding sources.

The new AMTP 6, which is currently under preparation, aims to gradually move towards a fast track initiative and increase the budget for the disease as well as the share of domestic funding.

Since 2010, the PNAC has worked towards the institutionalization of HIV and AIDS response at the national and local levels. As of 2014, considerable progress has been achieved in the policy environment that has a direct bearing on treatment, care and support. For instance, the implementation of an OHAT package since 2010 with rapidly increasing funding aims to raise the proportion of the population with access to effective AIDS treatment and full funding of ARVs by the DOH. This is a critical step in guaranteeing the sustainability of access to ART treatment.

Lobbying for proposed amendments in the Philippines HIV/AIDS Policy and Program Act of 2012, which amends the Republic Act (RA 8504 or the Philippine AIDS Prevention and Control Act of 1998) is another positive development in ensuring elimination/minimization of legal barriers to KAP accessing services. The new law will restructure the legal framework on HIV/AIDS by harmonizing it with evidence-based strategies and approaches. The revisions to the National AIDS Law, if passed, will remove many non-supportive HIV policies that are
barriers to current efforts in HIV prevention such as the Comprehensive Dangerous Drugs Act (Republic Act or RA 9165, which prohibits the distribution of clean needles and injecting equipment). The senate is initiating the development of a separate Act promoting harm reduction programs in the country.

Other important national policies and laws adopted in the country are: a) the HIV in the workplace policy of the Civil Service Commission; b) a Memorandum of the Department of Interior and Local Government on “Strengthening Local Responses Towards More Effective and Sustained Responses to HIV and AIDS”, which enjoins all cities and provinces to create the LACs; c) a Referral System for the Care and Support Services for PLHIV, a tool which was developed by the Department of Social Welfare and Development to facilitate the collaboration of service providers and LGUs in providing care and support for PLHIV; and d) The Responsible Parenthood and Reproductive Health Act, which facilitates education on sexuality, reproductive and sexual health, including HIV, for young people.

At the LGU level, the Quezon City Government has passed the first anti-discrimination ordinance that specifically tackles the issues confronting the LGBT community.

5. Conclusions and recommendations

This section of the report summarizes the findings arising from this country case study and, separately, some general findings that resonate and align with the results of other studies and lead to more general conclusions from those that are purely country specific.

5.1 The main risks of transition and sustainability

Table 13 below presents the list of indicators that were used to assess possible risk to transition from TGF support. Each indicator has been assessed according to the criteria and has been assigned a score for low risk, moderate or high risk. The component scores are summed up to form a final score of transition risk in the country.

T.13 HIV/AIDS TRANSITION PREPAREDNESS ASSESSMENT – SUMMARY TABLE

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>INDICATOR</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXTERNAL ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political Environment</td>
<td>Existence of political will to prioritize health investments</td>
<td>High risk</td>
<td>High risk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>INDICATOR</th>
<th>INDICATOR RISK CATEGORY</th>
<th>TRANSITION RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Environment</td>
<td>Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases &amp; Rule of Law</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Government ability to contract with CSOs; CSO contracting practices</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Favorable economic indicators&quot;</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>INTERNAL ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial resources</td>
<td>Budgetary commitment to disease</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td></td>
<td>Prevention priority</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allocative efficiency</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment / input financing from public sources</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention financing from public sources</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>Sufficient human resources for disease (quantities, geographic distribution and aging)</td>
<td>Moderate risk</td>
<td>High risk</td>
</tr>
<tr>
<td></td>
<td>Institutionalization of donor supported programs; Existence of policy for production/training of CSO personnel (non-medical, social service; Donor funded HR salaries aligned with national pay scale)</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>Routine statistical reporting R Integration in the national system</td>
<td>Moderate risk</td>
<td>Low risk</td>
</tr>
<tr>
<td></td>
<td>Routine statistical reporting R Level of advancement</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Second generation surveillance Methodologies, Timeliness</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Second generation surveillance Funding from public sources</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>Strong political commitment to diseases</td>
<td>Low risk</td>
<td>Moderate risk</td>
</tr>
<tr>
<td></td>
<td>Strong leadership</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strong coordination mechanisms</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td>Program performance results are available and accessible through public domain</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enabling environment for Civil Society engagement</td>
<td>Low risk</td>
<td></td>
</tr>
</tbody>
</table>
### Component Indicator Indicators

<table>
<thead>
<tr>
<th>Component</th>
<th>Indicator</th>
<th>Category</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program</strong></td>
<td>Treatment</td>
<td>Moderate risk</td>
<td>High risk</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Integrated services</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Key populations reach with preventive services</td>
<td>High risk</td>
<td></td>
</tr>
<tr>
<td>Service Delivery</td>
<td>CSO contracting in health</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>Strong management of the National Disease Program Management Entity</td>
<td>Low risk</td>
<td>Moderate risk</td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>Procurement &amp; Supply Management</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>Monitoring &amp; Evaluation</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td>Transition Planning</td>
<td>Legally binding and actionable Transition plan / Transition elements</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>Transition Planning</td>
<td>Transition plan / Transition elements characteristics</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td>Transition Planning</td>
<td>Transition M&amp;E</td>
<td>High risk</td>
<td></td>
</tr>
</tbody>
</table>

**Transition risk score for HIV/AIDS:** 36.7%

### External Environment

#### Economic Development

The Government of the Philippines fails to ensure continued and sustainable economic growth. Fluctuations in Gross Domestic Product (GDP) along with the decline in the share of government revenues as a percentage of GDP pose a high risk to the transition and sustainability of Global Fund supported programs.

#### Political Commitment

The political will of the government, as expressed in investment in health, is not adequate. Although the Philippines spends a comparable share of the public budget on health out of total government expenditure, and maintains a steady growth in health expenditure, the observed levels of budgetary spending on health still remain below the average for Low Middle Income Countries (LMIC). Furthermore, there is a lack of regulations and/or adequate enforcement of laws protecting Key Affected Population (KAP), which increases the overall risk arising from the political environment. The Civil Society Organization (CSO) contracting for service provision has been a practice in the past; however the recent introduction of complicated contracting requirements to access public funding demotivates the CSO sector from tapping public funding, which in turn may cause the discontinuation of CSO-provided prevention and outreach services when external funding ends, thereby putting the country at high risk.

### Internal Environment

#### Financing

The Philippines has prioritized HIV treatment related interventions for public investment and took decisive steps to eliminate treatment dependence on external funding. However, while replacing donor funds for
treatment with national resources is visible, a more aggressive pace might be warranted for transitioning the funding of preventive services for KAPs which are mostly donor dependent and face numerous barriers to being easily transferred onto domestic funding.

**Human Resources:** After transition from TGF support, challenges are also expected to emerge in the retention of already practicing professionals, as well as in the production/reproduction of adequately trained health and CSO cadre. Most likely, sustaining current training efforts will not be possible due to the lack of institutionalization of TGF supported trainings and knowledge dissemination. The availability of well-trained and appropriately distributed human resources is crucial for the program’s success. This is even more critical in a transition scenario due to the importance of continuing care for patients with HIV. These challenges in donor-funded trainings are not only relevant to the Philippines and/or TGF, but also have greater implications for other countries and donors alike. Also, tackling these problems during transition period may not be feasible due to the numerous structural barriers observed: i.e. the lack of an adequate cadre of trainers in established training institutions, the lack of state support/funding for these trainings, etc. To achieve sustainability, it seems essential to remedy this challenge with the help of well thought through mechanisms enhancing human resource production for health. Whatever mechanisms will be developed for these purposes, it is critical to assure that they are self-sustainable and scalable to deliver long-term sustainability.

**Information Systems:** The Philippines has an advanced health information system and routinely collects the necessary information for use in program evaluation and/or intervention planning at the national level. Progress has also been attained in the institutionalization of a robust secondary surveillance system in the country, which is fully funded from the public purse. However, these achievements were not without limitations. The unified surveillance system combining prevention, treatment and adherence information is functional at the national level but is still mostly paper based. At local levels the system remains fragmented: the information system does not incorporate HIV incidence, treatment and retention data; data about TB-HIV co-infection is limited; and the system uses a mixture of electronic and paper based data collection methods. Nevertheless, it seems possible for the remaining challenges to be addressed during a well planned transition, with the exception of analytical capacity limitations that could remain for a while due to structural limitations in the education sector and public sector employment.

Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability requires communicating program performance results through the public domain, including reporting expenditure data and targeted activities for KAPs. Moreover, since most efforts to hold actors accountable are conducted by civil society organizations, it is crucial to further enhance and sustain the enabling environment in which civil society organizations operate.

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65 T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio Internataional Foundation, 2015
Governance: The Government remains committed to continue the national HIV program. The new national program has been developed and currently awaits governmental approval. However, the lack of independence and resource base limits the effective operation of the National AIDS Council (PNAC) and poses risks to the transition and sustainability of the national AIDS response. While the Department of Health (DOH) remains as the chair of the plenary, the PNAC resource base must not remain dependent on it. The PNAC must urgently find a way of mobilizing resources from within the Philippine bureaucracy through member agency budgets and from development partners so that it maintains its autonomy. Planned and ongoing reforms may mitigate these risks if they are implemented appropriately and ensure a smoother transition from TGF funding. The Philippines has a good enabling environment for civil society engagement, maintaining rich performance data at the national level and offering stakeholders easy access to required information. However, access to sub-national data requires improvement. Streamlining the national program coordination function and ensuring easy access to program performance information\textsuperscript{66} stall levels are expected to minimize challenges during transition.

Program. The government’s willingness to sustain an effective national response towards the HIV epidemic is encouraging. However, in order to achieve a positive public health impact in light of possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed through the following steps: reinforcing prevention activities; building linkages between the health sector and non-governmental and social service providers; streamlining patient pathways among TB and HIV service providers; and enhancing follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges the Philippines will face after transition from Global Fund support.

Organizational Capacity. There are several prerequisites for a smooth transition and attaining the desired public health gains. They are: strengthening the organizational capacity of national program implementers and service providers, including CSOs\textsuperscript{67}; streamlining procurement functions to allow the procurement of HIV commodities at a lower price by deploying procurement practices from international platforms, as in case of drugs; and enhancing M&E and evidence based program planning and implementation.

Overall transition readiness. The assessment of the transition readiness of HIV/AIDS programs revealed that the Philippines faces a moderate to high risk after Global Fund support ends. Early transition planning that addresses the riskiest areas of the program and systems as well as its effective implementation will allow the country to experience a painless transition and ensure the sustainability of national programs.

5.2 Recommendations

The list of recommendations presented below follows the domains of the TPA framework. Based on the sustainability risk and feasibility of proposed activities, the recommendations are presented under different temporal dimensions.

\textsuperscript{67} T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio International Foundation, 2015
<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>TEMPORAL DIMENSION</th>
<th>PROPOSED ACTIVITIES</th>
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<tr>
<td><strong>EXTERNAL ENVIRONMENT</strong></td>
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<td><strong>POLITICAL ENVIRONMENT</strong></td>
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</table>
| Recommendation #1: create conducive legal environment | Immediate | Enhance anti-discrimination protection through legislative changes to promote the human rights of KAPs, PLHIV, vulnerable communities and providers of HIV services through:  
• Adoption of revised HIV/AIDS legislation that protects KAP and allows access to need services;  
• Revision of other regulations hampering KAP access to HIV/AIDS preventive, treatment, care and support services;  
• Promotion and approval of a range of measures and interventions aimed to prevent stigma and discrimination among general population; and |
| | Medium to long term | • Adoption of Harm Reduction legislation. |
| **ECONOMIC ENVIRONMENT** | | |
| Recommendation #2: Create government capacity to mobilize additional financial resources for health | Immediate | Conduct fiscal space analysis within the existing macroeconomic context to identify possibilities to grow program financing and cover funding gap necessary for adequate program support. |
| **INTERNAL ENVIRONMENT** | | |
| Recommendation #3: Ensure the adequate funding of national HIV/AIDS programme | Immediate | • Mobilization of domestic funding in support of national HIV/AIDS program from other sectoral ministries, LGUs and the private sector;  
• Introduction of a separate budget line for the HIV program in the budgets of all involved line ministries, including DOH, and LGUs to drive funding allocations as well as facilitate monitoring of national HIV/AIDS spending;  
Short term | • Move towards fast track targets considered adequate to address this need in the national funding envelope;  
• Use available resources efficiently and effectively. Investments should be strategic and geared towards prevention interventions targeting KAPs and in areas where most new infection cases emerge;  
Immediate step | • Increase the share of public funding for preventive services;  
• Introduction of a dedicated budget line for outsourcing outreach and case management services to CSOs under the HIV Program;  
• Establish a functioning monitoring mechanism that will be able to generate and collect financial information at the local level in order to provide a more accurate picture of the levels of spending of the country. |
| **ECONOMIC ENVIRONMENT** | | |
| Recommendation #4: Ensure an adequate and continuous supply of qualified human resources | Long term | • Challenges in terms of HRH are a larger problem in the national health care system; even though the HR shortage will certainly affect the sustainability of the HIV program, it may not be resolved during the transition period. However, within the Global Fund CN for the next round the Philippines may, under the HSS component request assistance for the development of a comprehensive policy for the production/training of HR in health;  
Immediate step | • Revisit staffing plans for effective service provision, particularly considering additional staffing needs required to meet “fast track” initiative targets; |
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<tr>
<td></td>
<td></td>
<td>• Explore the feasibility of institutionalizing accredited practical training, such as internship programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits, could be deployed in service areas where staff shortage is most severe;</td>
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<tr>
<td></td>
<td>Medium to long term</td>
<td>• Ensure integration of the HIV training modules into continuous education systems with the potential of further integrating the HIV training modules into the undergraduate education systems in the long-term;</td>
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<tr>
<td></td>
<td>Immediate</td>
<td>• Elaborate a strategy to train and build the capacity of NGOs.</td>
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**GOVERNANCE**

Recommendation #5: Improve the effectiveness of the coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E

**Immediate**

• Reform the PNAC as the main governance platform to guarantee the efficiency and effectiveness of its operation in addressing the HIV epidemic by:
  - Ensuring the autonomy of the PNAC;
  - Providing that, while DOH remains as the Chair of the Plenary, the PNAC resource base must not remain dependent on it. The Council must urgently find a way of mobilizing resources, from within the Philippine bureaucracy through the member agency budgets and from development partners so that it maintains its autonomy and control in its utilization in accordance to its full mandate as stipulated by law;
  - Bringing the Secretariat back under the Council;
  - Making PNAC governance structures and processes optimally functional, as desired and stated in its Manual of Procedures.

• Enhance coordination at local levels by:
  - Revisiting the role of the LACs in the overall national response;
  - Supporting local responses from the national level on how to access funds and plan programs;
  - Ensuring PNAC regularly monitors implementation of local responses and provides support and advice on corrective measures when needed.

**PROGRAM: SERVICE DELIVERY**

Recommendation #6: Streamline service delivery

**Immediate**

• Remove barriers to HIV testing, particularly addressing delays in confirmatory test results, and treatment through strengthening of cooperation between the governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services. This can be achieved by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART.
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<tbody>
<tr>
<td>Medium to long term</td>
<td>• Ensure full integration of PMTCT services into primary and perinatal care;</td>
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<tr>
<td>Medium term</td>
<td>• Consider expanding the HIV Insurance package OHAT by adding case detection/diagnosis and treatment adherence support.</td>
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<tr>
<td>Recommendation #7: Create an enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding</td>
<td>Immediate</td>
<td>• Develop/revise detailed SCO contracting rules/procedures to ensure continuous and scale-up delivery of preventive services, especially to KAPs;</td>
</tr>
<tr>
<td>Medium term</td>
<td>• Initiate an open, results oriented and constructive policy dialogue between the government and civil society to explore potential solutions to liberalize the SCO accreditation process;</td>
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<tr>
<td>Medium to long term</td>
<td>• Consider establishing umbrella SCO Organizations/networks to allow continuous engagement of CSOs in the provision of preventive services to KAPs.</td>
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**PROGRAM: ORGANIZATIONAL CAPACITY**

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<tbody>
<tr>
<td>Recommendation #8: Strengthen the organizational capacity of all involved stakeholders including government institutions and CSOs for better sustainability</td>
<td>Immediate</td>
<td>• Strengthen the capacity of AMTP management structure at DOH through the establishment of an effective management team with adequate staffing positions;</td>
</tr>
<tr>
<td>Medium to long term</td>
<td>• Increase the sustainability of local NGOs, enhance their advocacy efforts, promote the sustainable development of professional and local communities, and improve the quality of services delivered by NGOs to the communities. Activities include organizational capacity development, specialized training for NGO management, M&amp;E, financial management, organizational strengthening, and proposal writing. Topics can be prioritized based on the training needs assessment, and will increase their capability and competitive power for fundraising in a resource constrained environment.</td>
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**PROGRAM: ORGANIZATIONAL CAPACITY**

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<tr>
<td>Recommendation #9: Develop, implement and monitor the transition plan</td>
<td>Immediate</td>
<td>• Develop a time-bound and actionable transition plan and adequate indicators to monitor plan implementation and ensure incorporation of this plan into the AMTP6 and Annual Operation plans;</td>
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<td>• Ensure sufficient resources are available for transition by preparing budget for AMTP 6 which includes transition plan elements;</td>
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<td>• Ensure that the PNAC has the mandate, competence and legal power to assume responsibility for the coordination, planning, implementation and monitoring of the transition process.</td>
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</table>
Annex 1: Methodology

The TPA Framework is divided into two domains: the external environment and the internal environment.

The external environment encompasses the elements outside of the health sector and covers political and economic environment. The internal environment of the program, which is further subdivided into three sub-domains of inputs, governance and program, represents the factors within the health sector. Sub-domains are further divided into components affecting transition as well as the sustainability of the public health programs after graduating from donor support. The final expected outcome of this process is a successful transition when programme outcomes are either retained and or enhanced.

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The Inputs entail the resources currently available for the disease-specific program. The resources are subdivided into financial resources, human resources and health information systems. Financial resources are assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and treatment interventions, especially for epidemiologically important population groups. The human resource component is measured by assessing the availability of sufficient human resources; the institutionalization of donor-supported trainings; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale. Health Information Systems are assessed by evaluating the integration of comprehensive routine statistical reporting in national health information systems for the disease, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and the integration of the data in national reporting.

The Governance sub-domain includes the actors/institutions involved at an organizational level, how they make decisions, their roles and motivations towards the adequate transition of disease programmes and their relationship with other actors. Identified enabling factors related to governance are sub-divided into governance-specific factors and accountability. Governance-specific factors include a strong political commitment to disease treatment and fostering political support for the programme; effective leadership/management ensured through a legally empowered organization; the existence of champions/individuals who advocate for and/or manage disease-specific programmes; and appropriate coordination of all parties involved in the programme through a dedicated, legally empowered and well-functioning coordinating body.

The Programme sub-domain encompasses the activities included within the health program and the operational capacity to implement these activities. It is composed of service delivery, organizational capacity and transition planning components. Within service delivery we look at the integration of certain services, service coverage and treatment outcomes. Concerning the organizational capacity to provide services, we examine the management of the national disease programmes; procurement mechanisms; and the existence of appropriate monitoring and evaluation mechanisms, including adequate analytical capacity. All three elements are crucial for the effective transition of disease programs. A direct measure of forward thinking disease programs currently receiving external funding is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. Appropriate tracking of the transition process requires the following: transition planning through strategies that align the program with national policies that are in turn informed by international guidance and/or evidence; programme management arrangements to assure the appropriate transfer of responsibilities; and effective monitoring and evaluation of the transition.

Quantitative and/or qualitative indicators are used to measure each component. These indicators assess the possible risk for transition using a scoring system in which 2=low or no risk, 1=medium/moderate risk and 0=high risk. The indicators are converted into numerical values, and a risk category is assigned to each component according to the overall scores. To define a country’s overall risk, scores for each category are summarized and aggregated, based on the percentage.
of scores accumulated for all domains/sub-domains/categories. Weighting was not applied during the scoring. A summary score for a disease identifies the overall risk for program transition, while the component scores identify areas that pose the highest risk and should be addressed during the transition process.


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7. PHL-304-G03-H - Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and people living with HIV in strategic areas in the Philippines, Tropical Disease Foundation Inc. 2007
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9. PHL-506-G04-H - Upscaling the national response to HIV/AIDS through the delivery of services and information to population at risk and people living with HIV/AIDS, Tropical Disease Foundation Inc. 2007
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Annex 4: List of Interviewed People

<table>
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<tr>
<th>#</th>
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<th>POSITION</th>
<th>AGENCY/INSTITUTION</th>
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<tbody>
<tr>
<td>1</td>
<td>Risa Hontiveros</td>
<td>Senator</td>
<td>Senate of the Philippines</td>
</tr>
<tr>
<td>2</td>
<td>Ramon Navarra</td>
<td>Chief of Staff</td>
<td>Senate of the Philippines</td>
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<tr>
<td>3</td>
<td>Atty Kristine M Mendoza</td>
<td>Staff</td>
<td>Senate of the Philippines</td>
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<tr>
<td>4</td>
<td>Paulyn Russel Ubial</td>
<td>Secretary of Health</td>
<td>Department of Health</td>
</tr>
<tr>
<td>#</td>
<td>Name</td>
<td>POSITION</td>
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<tr>
<td>5</td>
<td>Rosalind G Vianzon</td>
<td>Medical Officer V, IDPCD</td>
<td>Department of Health</td>
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<tr>
<td>6</td>
<td>Dr Gerardo Bayugp</td>
<td>Undersecretary, Technical Services Office</td>
<td>Department of Health</td>
</tr>
<tr>
<td>7</td>
<td>Carolina Taino</td>
<td>Assistant Secretary, Admin, Finance &amp; Procurement Off</td>
<td>Department of Health</td>
</tr>
<tr>
<td>8</td>
<td>Larry Cruz</td>
<td>Director IV, Finance Service</td>
<td>Department of Health</td>
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<tr>
<td>9</td>
<td>Noel Palaypayon</td>
<td>Deputy Manager, HIV Surveillance Unit, Epidemiology Bureau</td>
<td>Department of Health</td>
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<tr>
<td>10</td>
<td>Ma. Justina Zapanta</td>
<td>Nurse III, HIV Surveillance Unit, Epidemiology Bureau</td>
<td>Department of Health</td>
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<tr>
<td>11</td>
<td>Krizelle Anne Umali</td>
<td>Surveillance Officer, HIV Surveillance Unit, Epidemiology Bureau</td>
<td>Department of Health</td>
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<tr>
<td>12</td>
<td>Jose Gerard Belimac</td>
<td>Director, National HIV/AIDS &amp; STI Programme</td>
<td>Department of Health</td>
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<tr>
<td>13</td>
<td>Dr Miel Nora</td>
<td>Chief of Party, TGF HIV/AIDS New Funding Model Project</td>
<td>Save the Children, PR</td>
</tr>
<tr>
<td>14</td>
<td>Hilario Umali</td>
<td>Logistics Manager, TGF/AIDS New Funding Model Project</td>
<td>Save the Children, PR</td>
</tr>
<tr>
<td>15</td>
<td>Rigil Kate Salvador</td>
<td>Monitoring, Evaluation, &amp; Learning Manager</td>
<td>Save the Children, PR</td>
</tr>
<tr>
<td>16</td>
<td>Mary Antoniette Remonte</td>
<td>Medical Specialist III, Health Finance Policy Sector</td>
<td>Phil Health</td>
</tr>
<tr>
<td>17</td>
<td>Abigail Romero-Estrada</td>
<td>Sr Social Insurance Specialist</td>
<td>Phil Health</td>
</tr>
<tr>
<td>18</td>
<td>Arlene S Ruiz</td>
<td>Chief, Econ. Dev. Specialist, Social Development Staff</td>
<td>National Economic &amp; Development Authority</td>
</tr>
<tr>
<td>19</td>
<td>Cristina M Clasara</td>
<td>Director, Budget Management Bureau B</td>
<td>Department of Budget &amp; Management</td>
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<tr>
<td>20</td>
<td>Jane V Abella</td>
<td>Assistant Director, Budget Management Bureau B</td>
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<td>21</td>
<td>Nanette R Cabral</td>
<td>Chief Specialist, Budget Management Bureau B</td>
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<td>Winona Rose T Caguiao</td>
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<td>Mary Grace G Darunday</td>
<td>Sr Specialist, Budget Management Bureau B</td>
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<td>Fides Basas</td>
<td>Specialist, Fiscal Planning &amp; Reform Bureau</td>
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<tr>
<td>25</td>
<td>Jusrex B Abejero</td>
<td>Analyst, Budget Management Bureau B</td>
<td>Department of Budget &amp; Management</td>
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<tr>
<td>26</td>
<td>Ella Cecilia G Naliponguit</td>
<td>Director, Bureau of Learner Support Services</td>
<td>Department of Education</td>
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<tr>
<td>27</td>
<td>Dr Ma. Corazon Dumlao</td>
<td>Chief, School Health Division</td>
<td>Department of Education</td>
</tr>
<tr>
<td>28</td>
<td>Dr. Ann Cuizon</td>
<td>Asst Chief, School Health Division</td>
<td>Department of Education</td>
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<tr>
<td>29</td>
<td>Silvestre Z Barrameda, Jr.</td>
<td>International Partnership Unit</td>
<td>Department of Interior &amp; Local Government</td>
</tr>
<tr>
<td>30</td>
<td>Anjela Mae Era</td>
<td>Project Officer, Local Government Academcy</td>
<td>Department of Interior &amp; Local Government</td>
</tr>
<tr>
<td>31</td>
<td>Ilya T Abellanosa</td>
<td>Epidemiologist &amp; HIV/AIDS Coordinator,</td>
<td>Cebu City Health Office</td>
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<tr>
<td>32</td>
<td>Teresita Bagasao</td>
<td>Country Director</td>
<td>UNAIDS Country Office</td>
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<td>33</td>
<td>Zimmbodilion Mosende</td>
<td>Strategic Information Advisor</td>
<td>UNAIDS Country Office</td>
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<tr>
<td>34</td>
<td>Malou L Quintos</td>
<td>Program Associate</td>
<td>UNAIDS Country Office</td>
</tr>
<tr>
<td>35</td>
<td>Mario Balibago</td>
<td>HIV/AIDS Program Officer</td>
<td>UNICEF</td>
</tr>
<tr>
<td>36</td>
<td>Gerard Servais</td>
<td>Sr Health Specialist, Southeast Asia Department</td>
<td>Asian Development Bank</td>
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<tr>
<td>37</td>
<td>Roberto Antonio Rosadia</td>
<td>Health Specialist, Health, Nutrition &amp; Population</td>
<td>The World Bank</td>
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<tr>
<td>38</td>
<td>Qi Cui</td>
<td>Portfolio Manager</td>
<td>The Global Fund</td>
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<tr>
<td>39</td>
<td>Leslie A Tolentino</td>
<td>Achieve, Inc</td>
<td>CSO</td>
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<tr>
<td>40</td>
<td>Eden Divingracia</td>
<td>Executive Director</td>
<td>The Philippines NGO council on Population, Health &amp; welfare, Inc (PNGOC)</td>
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<td>Desi Andrew Ching</td>
<td>Co-founder, REDX &amp; Executive Director, HASH</td>
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<td>Board Member, HIV &amp; AIDS Support House (HASH)</td>
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<td>Noemi B. Leis</td>
<td>AMTP6 Consultant &amp; HASH Board Member</td>
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<td>Angelo James Esperanzate</td>
<td>The Red Whistle, Board Member</td>
<td>CSO</td>
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<td>Renier Bona</td>
<td>SHIP Foundation</td>
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GUIDANCE NOTE: TRUST FUNDS FOR FINANCING HIV RESPONSES

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Introduction

As change sweeps through the funding environment for HIV, its vital investments will increasingly need to be sustained and managed within national budgets, without compromising other social sectors. The change comes in two main forms. First there is the ambitious plan to end AIDS as a public health concern by 2030, which calls for immediate action, and therefore funding. Success will mean zero new HIV infections, zero discrimination and zero AIDS-related deaths. The plan includes an accelerated ‘Fast Track’ programme to cover the first five years to 2020. ‘Fast Track’ aims to bring down the rate of new infections in the short-term in order to reduce the need for future resources. It plans to do this by relying on ‘front-loaded’ investments in HIV prevention and AIDS treatment.

Meanwhile, the nature of HIV financing is changing too, with more funding coming from the national governments of countries affected by AIDS, particularly middle-income countries.

Establishing trust funds

Trust funds are one of the instruments already used in global HIV funding. For example, the Global Fund, the most significant multilateral funding agency, is a trust fund. In domestic HIV financing,
However, trust funds have played a marginal role. But now, as domestic funding increases and donor commitments drop off in some countries, they’re beginning to attract more interest.

It is still, of course, early days. There is one long-standing example of an HIV trust fund in low-income countries. The AIDS levy in Zimbabwe is paid into a trust fund which has been the main channel for domestic financing of the country’s HIV response since 2000. In three other countries - Kenya, Tanzania and Uganda - trust funds are in the process of clearing government and parliamentary approval, as described below.

### The Zimbabwe model

Zimbabwe’s National AIDS Trust Fund is a 3-percent mark-up on corporate and personal income tax. It is the principal source of domestic funding of the National AIDS Council (NAC). In 2012, it accounted for 87 percent of NAC’s revenues (US$ 32.5 million out of US$ 37.6 million). Spending administered through NAC, however, accounts for only a small proportion of the total costs of Zimbabwe’s national HIV response (US$ 315 million in 2012), and domestic financing (largely the AIDS levy) amounts to only 11 percent of the financing of the national HIV response.

### Lessons learned

While trust funds in domestic funding are largely uncharted territory, we can still draw lessons from the experience so far.

So far, trust funds have not provided a means of sustainable financing. With the exception of Kenya, where the proposed funding would cover the full amount of recent HIV spending, the amount of funding often accounts for only a small proportion of the overall costs of the HIV response (11 percent in Zimbabwe, less than one percent in Uganda). They’re generally funded by conventional taxes – income taxes, excise taxes, or a cut of tax revenues overall.

Most AIDS trust funds have two key features. First, they are administered as extra-budgetary funds – spending allocations from the fund are made outside the regular budget process, with some governance and accounting structure specific to the fund. These are often designated for a specific purpose, where it is recognised the normal budget process may not yield an efficient outcome - ideal for HIV where health and financial returns are spread over decades.

Second, funding often involves some earmarked taxes, which have the advantage of providing some protection from the fluctuations of the year-to-year budget process. On both of these counts, there is considerable experience outside the sphere of HIV financing.

Establishing a trust fund can be a lengthy process. Government has to be convinced that it is a good idea, governance and accountability mechanisms

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1 A trust fund in this sense is a fund of money intended to be used for public purposes and administered separately from government.
need to be set up to protect it from fraud or corruption, and other potential funders such as donors or philanthropic foundations need to be persuaded that the fund is a suitable vehicle for their resources.

Pros and cons

Trust funds offer a way of separating the HIV response from the fluctuations of the annual domestic or donor budget processes - and establishing an inviting environment for external or philanthropic contributions where government finance is insufficient. On the other hand, trust funds also reduce government’s fiscal flexibility if they entail a commitment for a fixed sum or proportion of budget, as has been suggested in Kenya.

In most cases, proposals for trust funds come loaded with firm suggestions on how they should be financed, including some earmarked tax. These taxes do provide managers of the national HIV response with a fairly predictable domestic revenue stream, but if this revenue doesn’t match spending needs, the funding may lead to insufficient spending allocations.

Borrowing for financing hiv responses

Borrowing - mainly from the World Bank – has always played a role in the external financing of HIV responses in some countries. But now it has been superseded by grant-based funding and borrowing now only accounts for around one percent of external HIV funding globally. However, with new lenders such as China entering the market, it would seem to be a good time to revisit whether it is feasible or advisable to borrow either internally or externally in order to finance HIV responses.

HIV programs require long-term spending stretched over decades, so there is little point in spreading the costs over a long period. But there are still three key circumstances when borrowing can be a good solution:

- to manage a spike in costs of an HIV response – such as the need for front-loaded investments or to ride the storm during national conflict, natural disasters and health shocks
- when a high rate of return covers the initial costs of intervention
- when there is justification for securing contributions from the next generation

Managing spikes

Borrowing can spread costs over a longer period, helping manage spikes in the cost of an HIV response, or major disruption caused by conflict, natural disasters or major health shocks, like Ebola.

Spikes in expenditure are common in more ambitious HIV programs. For example, scaling-up of male circumcision requires significant investment, but costs go down as soon as you reach the targeted coverage rate because after that you only need to circumcise new cohorts. On top of that, the intervention means there will be fewer cases of HIV to treat, while also bringing down the cost of treatment and services.

When projects with a high rate of return easily cover the initial costs

It can make sense to borrow money for some interventions because the benefit of reducing cases of HIV outweighs the initial costs over a relatively short period. Even though the costs of treating HIV have fallen steeply over the last years, this point is likely to remain relevant.

This approach, however, does bring challenges. While interventions like condom provision, can reduce costs, governments or donors might only be willing to underwrite particular, sometimes less effective interventions, for a whole host of reasons. On top of this, it is notoriously hard to predict epidemiological outcomes and financial returns - which in turn makes it hard to predict just how much an intervention will bring costs down in the long term.

The political process might also result in a situation where cost effective, and cost-saving HIV prevention interventions simply don’t get enough funding. This might happen when there is a cap on overall spending,
and much of the budget is spent on treatment. In this situation, it is worth making a compelling case that additional investments in HIV prevention – possibly but not necessarily financed by higher deficits – would release fiscal space in the relatively near future. Highlighting this possibility could start a policy dialogue that unlocks additional funding.

Securing funds from the next generation

If HIV incidence is substantially reduced in line with the Fast Track strategy, young people entering adulthood in 2030 or beyond are far less likely to contract HIV than at present - and if they do get infected, they’re far more likely to survive due to high treatment coverage. Debt financing introduces the logic of sharing the cost with future generations, who will benefit from the money spent now to end AIDS. Borrowing effectively passes on some of the costs to the next generation, who will need to service the debt in future years.

It ‘could’ doesn’t mean it ‘should’

The challenges of HIV financing have been linked with the issue of sustainability of public debt. The net present value of future HIV-related costs may be thought of as an ‘HIV debt’. If, as in some cases, the IMF thinks a level of public debt of 70 percent of GDP is problematic, and the HIV ‘debt’ is a similar amount, fiscal adjustment could prove a significant fiscal and political challenge. The international practice of donors recognizes this point, prioritizing not only countries with high HIV prevalence, but also countries with low GDP per capita, where the HIV ‘debt’ relative to GDP tends to be high. This could also be allied with concessional lending at low interest rates, or by the use of donor funding to buy down debt in the future. New lenders, such as the Government of China, may also be willing to lend at lower interest rates than have been experienced by low-income countries in the past.

The analogy to debt has also been used to assess whether a country with a low level of public debt could finance the HIV response by borrowing. Technically this method is logical, but from a fiscal perspective it is problematic. First, if the proponents of the HIV response can’t convince the government to fund the HIV response from current revenues, the Ministry of Finance will be just as reluctant to commit future revenues (which is what borrowing does). Second, when it is wise to finance the HIV response through debt (because of spikes, high return programs or involving the next generation), the level of public debt is largely irrelevant.

Conclusion

There are considerable challenges facing low- and middle-income countries to scale up their coverage for health and HIV, while also meeting the short-term needs to front-load investments in HIV prevention in order to minimise the long-term costs. This brief has looked at two of the options that might be considered.

Trust funds can provide a useful vehicle for channeling government budget contributions and combining them with contributions from internal and external sources, including donors. In this way, they might offer a way to ensure that funding is able to respond to the challenge of front-loading without distorting other budget allocations. However, the process of establishing well-governed trust funds and clearing all of the political and administrative approval can be lengthy and complex.

With regard to borrowing, there are plausible arguments for passing on some of the costs of HIV programmes to future programmes through borrowing, but there are also sound fiscal and policy reasons why governments would be reluctant to do so. Ultimately the balance between these is a matter for governments to decide, and is more likely to be feasible in middle-income rather than low-income countries. The issue cannot however be divorced from the need to persuade governments and either domestic or external lenders that allocating either current or future resources to HIV programmes is a sound investment.
This note\(^1\) provides an overview of the role of borrowing in financing HIV responses, discusses the case for (and against) borrowing, and gives some recommendations on the use of borrowing in financing HIV responses.

The Role of Borrowing for Financing the HIV Response So Far

Borrowing has played a role in the external financing of HIV/AIDS responses from the dawn of time. Especially the World Bank has played a major part in financing HIV/AIDS programs in the early stages of the HIV response, but its role has receded as grant financing became the dominant source of external funding. Figure 1 summarizes data on official development assistance for HIV/AIDS programs, distinguishing between grants and loans. As of 2002, loans – almost entirely from the World Bank – accounted for 5 percent of external financing of HIV responses.\(^2\) The 10-fold increase in HIV/AIDS funding between 2002 and 2013 was almost entirely accounted for by steep increases in grants from the U.S. Government and the Global Fund. The share of loans in external HIV financing consequently declined to one percent. Overall, the World Bank board

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\(^1\) Prepared by Markus Haacker, mhaacker@hsph.harvard.edu, under contract to UNAIDS (contact: Nertila Tavanxi, tavanxhin@unaids.org).

\(^2\) Over the period 2002 to 2013, the World Bank (US$ 1.06 billion) accounted for over 90 percent of loan financing of HIV responses (US$ 1.17 billion). Almost all of the balance reflected one project between Germany and China.
has approved US$ 3.1 billion in HIV/AIDS-related loans between 1988 and early 2012 (World Bank (2015, 2015b). Of this, US$ 2.5 billion were disbursed, and US$ 1.7 billion of the latter had not been repaid to the World Bank as of February 2015.

The role of domestic (or non-ODA external) borrowing to finance HIV/AIDS programs is more difficult to establish. Domestically financed public HIV/AIDS spending could be financed by reducing expenditures in other areas, raising additional taxes, and borrowing. However, as the budgets do not show how specific expenditures are being financed, data on domestic borrowing in support of HIV/AIDS programs is essentially unavailable.

1 Calculated based on occurrence of the terms HIV, AIDS, VIH, or SIDA in the project name.
3 A similar argument applies to donors’ financing of grants – these grants could be financed by borrowing, increasing tax revenues, or expenditure cuts in other areas. However, because there is no direct connection between HIV/AIDS spending and its financing, and as HIV/AIDS financing and contributions to international organizations like the Global Fund account for a small proportion of government spending in donor countries, it is not possible to assign spending on the HIV response to specific sources of financing.
Three Cases for Debt Financing of Government Expenditures

Borrowing does not create additional fiscal space per se, but provides the government with additional resources early on, while constraining its resources later on through interest payments and as a loan is repaid. For this reason, high rates of borrowing to finance the government’s regular operations are normally ill-advised. An increasing level of debt service would progressively erode the government’s financial resources, and the high levels of government spending would eventually become unsustainable.

There are, however, a number of circumstances when borrowing is a sensible policy, by addressing specific needs or in consideration of the outcomes of the expenditures financed in this way. Three such circumstances are discussed below, although it should be noted that they are not mutually exclusive and all three aspects might apply at the same time.

- **Accommodating a shock to government revenues, a spike in expenditures, or both.** The most common examples are armed conflicts, natural disasters, and health shocks. This point is illustrated below by reference to the fiscal response to Ebola. Additionally, certain projects (e.g., construction of large power plants) require high expenditures over a short period, and borrowing is a means of spreading the costs and avoiding temporary squeezes in other expenditures.

- **Inter-generational equity aspects.** If the benefits of public spending are spread over long time periods, debt-financing is a means of collecting contributions from the beneficiaries later on.

- **Financing projects with a high rate of return.** Some public investment projects generate fiscal revenues (directly or through increased tax revenues) so that they increase fiscal space, i.e., the financial returns are more than enough to re-finance the initial costs.

HIV/AIDS is Unlike Ebola…

Some shocks – natural disasters, armed conflicts, or health emergencies – impose a steep fiscal cost and may at the same time disrupt the economy and therefore government revenues. The most significant recent example is the Ebola epidemic, the economic and fiscal consequences of which are illustrated in Figure 2, which compares projections of key macroeconomic indicators (GDP growth and the fiscal balance) published by the IMF in October 2013 (preceding the Ebola epidemic) and October 2014 (near its peak). In each country, GDP growth was reduced by several percentage points in 2014 and 2015, but is expected to recover by 2016. More relevant here, the Ebola epidemic has resulted in a steep deterioration in the fiscal balance in 2014 and 2015, amounting to up to 5 percentage points (Liberia, 2014), but by 2016 is expected to return to a value close to what was projected before the onset of the Ebola epidemic.6

6 The difference between the WEO estimates and projections from October 2013 and October 2014, respectively, also reflect updates not related to Ebola. Also for this reason, the 2013 estimates (preceding the arrival of Ebola) have changed, most visibly for GDP growth in Sierra Leone. To establish that the deterioration in the macroeconomic indicators principally reflects the impact of Ebola, a number of IMF staff reports which discuss the impact of Ebola have been reviewed (see IMF (2014b, 2014c, 2014d)).
This means that the governments have accommodated the revenue losses and increased expenditure needs associated with the impact of and response to Ebola at least in part by borrowing rather than compressing expenditures in other areas, and are thus spreading the costs over a longer period. The response to Ebola, though, does not offer a template for HIV/AIDS financing, because HIV/AIDS programs represent long-term spending needs extending over decades, whereas Ebola represents a spike in financing needs concentrated over one or two years. This means that, unlike in the case of Ebola, there is not much of a point in spreading the costs of the HIV/AIDS response over a longer period.
… But Some HIV Programs Envisage Spikes in Expenditure Early On

However, ambitious HIV programs tend to envisage a steep increase in expenditures early on, but this expenditure may decline in subsequent years, in percent of GDP if not in absolute terms. This partly reflects that the programmed expenditure increase includes items like the scaling-up of male circumcision requiring lower expenditures once the targeted coverage rate is reached, and – more significantly – that reduced HIV incidence eventually results in lower costs of treatment and other services.

This point is illustrated in Figure 3, showing an example in which domestic financing needs are projected to increase steeply over the next 5 years, and the government wishes to slow down the absorption of current government revenues by the HIV response. For this reason, it financed some of the initial build-up in costs by borrowing, which peaks at 0.8 percent of GDP in 2020 and contributes to an increase in public debt of 4.9 percent of GDP by 2026. The evolution of debt service (interest and repayments) is illustrated in Figure 3.2, the amount is assumed to be fully repaid by 2040.

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7 The example is generic and not based on a specific country case. The interest rate is set at 3 percent, and it is assumed that GDP grows at a rate of 5 percent annually. Because GDP in later years is larger, the area in Figure 3.2 representing repayments is smaller than the area representing borrowing.
Some HIV Spending Creates Fiscal Space

In the literature on the cost-effectiveness of HIV prevention interventions it is frequently pointed out that some interventions are cost-saving, i.e., the financial savings resulting from reduced HIV incidence outweighing the costs of achieving it. Even though the costs of HIV treatment have fallen steeply over the last years, this point is likely to remain relevant. In a “90-90-90” scenario, an individual who contracts HIV can expect to obtain treatment early, and remain on treatment for several decades – even at annual costs of treatment around US$ 300, each HIV infection would result in a cost of several US$ 1,000, higher than many of the estimates reported for the costs per HIV infection averted for across HIV prevention interventions (see, e.g., Galárraga and others (2009), Bertozzi and others (2006), Canning (2006)).

Testing the current HIV/AIDS strategy in terms of the contributions of various interventions to reducing the number of HIV infections, and – considering the strategy’s objectives in terms of treatment access and other services to people living with HIV – the financial savings which can be attributed to the various HIV prevention interventions, can therefore provide pointers to (i) scope for improving the cost-effectiveness of the HIV response overall (not the focus of this guidance note), and (ii) scope for additional HIV investments which can be refinanced from the resulting savings (Haacker, 2015). Where there is no more scope for soliciting additional funding from current revenues, the projected savings would provide an inducement for financing the expenditures through an increased fiscal deficit – and because the additional debt could be repaid from the resulting financial savings, the operation would overall release fiscal space – for financing other aspects of the HIV/AIDS response or other government policy priorities.

There are a number of challenges in following this path. While the HIV response usually contains a number of interventions which are cost-saving, like condom provision, these might be the most accepted parts of the program, whereas the interventions affected by decisions about the scale of HIV/AIDS spending that the government or donors might be willing to underwrite could be the less effective ones. Moreover, both the cost projections and the epidemiological projections are subject to a high degree of uncertainty, and so are the estimates of the financial returns to additional investments in the HIV response. On the other hand, the political process might also result in a situation in which highly cost-effective, and cost-saving, HIV prevention interventions do not receive sufficient funding. This could be an outcome if there is an upper limit to the resources the government is willing to commit, and much of this is absorbed by treatment costs. In this situation, making a compelling case that additional investments in HIV prevention – possibly but not necessarily financed by higher deficits – would release fiscal space could contribute to a policy dialogue towards unlocking additional fiscal resources.

The point whether an HIV intervention is cost-saving is related to, sometimes conflated with, but distinct from the question on whether the

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8 Under the “90-90-90” targets, by 2020 90 percent of people living with HIV will know their status, 90 percent of those knowing their status will receive treatment, and 90 percent of those receiving treatment will achieve viral suppression. Under these objectives, people living with HIV will generally obtain treatment a few years after they become infected.
economic returns (Resch and others, 2011) exceed the costs. The question of economic returns plays a role in welfare economics because a government intervention which results in economic returns exceeding the costs could theoretically be financed by additional taxes in a way that leaves everyone better off. This reasoning, however, does not translate to the context of HIV/AIDS, because most of the “economic returns” reflect increased survival of people living with HIV rather than improved productivity (as in a typical macroeconomic context) – because most of the “economic returns” is absorbed by cost of living of the people surviving, they cannot be used – by taxing the gains – for refinancing the costs of the underlying HIV interventions. Positive economic returns exceeding the costs of the underlying HIV interventions therefore do not provide a motive for additional HIV/AIDS financing by borrowing along the lines discussed in this section.

Passing On The Buck

Large investment projects are typically financed by loans, because they are bulky (so that it does make sense to spread the costs and minimize temporary shifts in expenditures on other government priorities, discussed earlier), and because the benefits are spread over time, possibly over decades. Debt financing in this context is an instrument for passing some of the costs to the beneficiaries, who will need to service the debt in future years. On the other hand, there are certain types of government expenditure such as education which primarily benefit a future generation but which are not normally financed by debt, but are part of a social contract whereby one generation funds the education of the respective next generation.

Aspects of the response to HIV have the character of investments for the benefit of a future generation. This link is explicit in the goal of an “AIDS-free generation”. More generally, under the objective of ending AIDS and the 90-90-90 agenda, young people entering adulthood in 2030 or beyond would face a much reduced prospect of contracting AIDS (and if they do get infected, an increased survival prospect). Financing part of the HIV response by loan is a vehicle for extracting a contribution from this generation of beneficiaries. In contrast, the model of a social contract between generations, as it applies in the case of education spending, does not fit because “ending AIDS” is a one-off project.

“It Could” Does not Mean It Should

The semblance of the spending commitments under the HIV response to a debt has motivated linking the challenges of HIV financing with the issue of sustainability of public debt (see, e.g., Lule and Haacker, 2012). If, for example, the IMF considers a level of public debt of 70 percent of GDP as problematic for fiscal and macroeconomic stability, and the HIV “debt” (the present discounted

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8 Under the “90-90-90” targets, by 2020 90 percent of people living with HIV will know their status, 90 percent of those knowing their status will receive treatment, and 90 percent of those receiving treatment will achieve viral suppression. Under these objectives, people living with HIV will generally obtain treatment a few years after they become infected.
value of the costs of the HIV program) is at this order of magnitude, this means that the magnitude of fiscal adjustment (e.g., expenditure cuts, or assigning the bulk of new revenues to HIV/AIDS) required to fund these costs is a very significant fiscal and political challenge. The international practice of donors recognizes this point, prioritizing not only countries with high HIV prevalence, but also countries with low GDP per capita where the HIV “debt” relative to GDP tends to be high.

The analogy to debt has also sometimes been used to assess whether a country with a level of public debt below the thresholds used in debt sustainability analyses could finance the HIV response by borrowing. Technically this point is correct, but from a fiscal perspective it is problematic. First, if the proponents of the HIV response are not successful in convincing the government to fund the HIV response from current revenues, the Ministry of Finance will be similarly reluctant to commit future revenues (which is what borrowing does). Second, the reasons discussed here on when borrowing is a sensible policy to finance the HIV response – managing the profile of spending, enabling investments which expand fiscal space, extracting contributions from future beneficiaries of current HIV policies – apply irrespective of the level of public debt. Conversely, if these conditions are not met, there is no valid reason for debt-financing of the HIV response.

Conclusions

Borrowing, notably from the World Bank, has played an important part in the emerging HIV response, but has been superseded by a grant-based funding model and now accounts for only about one percent of external HIV funding. There are no data available on domestic borrowing specifically in support of the HIV response, as the domestic financing is part of the overall government budget.

• Looking ahead, this note identifies three circumstances under which borrowing is a sensible policy of funding the HIV response by government of affected countries. These conditions overlap, and more than one can apply at the same time.

• Borrowing to manage spikes in the cost of the HIV response. E.g., high costs over a number of years could be spread over a longer period, or a steep increase in costs of the HIV response could be accommodated more gradually (Figure 3), to avoid sudden disruptions to expenditure programs in other areas.

• Borrowing to enable additional HIV investments which expand fiscal space. Whether or not this plays a role does not only depend on the financial savings (treatment costs etc.) resulting from investments in HIV prevention, but also on how the policy discourse on HIV financing plays out – the interventions for which additional financing is sought may not be the most cost-effective or “cost-saving” ones.

• Borrowing is a means of eliciting a contribution from some of the beneficiaries of current HIV policies, e.g., the next generation who – because of the “end of AIDS” – would face a much improved disease environment.
References


This note discusses the role of trust funds in the practice of and the policy discourse on the sustainable financing of HIV/AIDS responses, and also draws lessons from the non-HIV/AIDS-specific literature on earmarked taxes and extrabudgetary funds.

Introduction

Proposals for establishing trust funds have played a role in the recent policy dialogue on domestic HIV/AIDS financing. However, there is only one long-standing example of a trust fund in this area – the AIDS levy which has been the main channel for domestic financing of the HIV/AIDS response in Zimbabwe since 2000. The note provides a stocktaking and discussion of this levy and of the situation in some countries (Kenya, Tanzania, Uganda) where efforts to introduce a trust fund are advanced, and discusses trust funds from a broader public finance perspective.

1 Prepared by Markus Haacker, mhaacker@hsph.harvard.edu, under contract to UNAIDS (contact: Nertila Tavanxi, tavanxhin@unaids.org. The terms of reference HIV specified “a short paper of 5 pages or so outlining the pros and cons of HIV trust funds as a mean integrating HIV financing in countries of different socio-economic status, HIV domestic financing and epidemiology with quick references to cases where they have been used so far and recommendations for the future.”

2 See, for example, SADC (undated), UNAIDS (2013), or Wilson and others (2014).
Definition of Trust Funds

In the context of domestic HIV/AIDS financing, trust funds may be defined by two (or three) properties.

First, they are administered outside the government’s regular budget process as extrabudgetary funds. While the fund might be predominantly funded from public sources, it is a separate entity (at least from an accounting perspective), and spending is determined outside of the government’s annual budget process, according to the purpose of the fund, typically by an appointed board. Regarding the funding, it is useful to distinguish two types of trust funds. In an endowment-based fund, the fund administers some assets, and finances its operations from interest income, and additionally draws down from or adds to its endowment. The second and more common type in the context of HIV/AIDS type is a scheme in which operations are predominantly funded by current revenues, i.e., all or most of its revenues would come from the government transfer (in addition to external grants, private contributions, and own income, e.g., from interest).3

Second, of course, an HIV/AIDS trust fund is defined by its purpose. This purpose could be broadly defined as the financing of the HIV/AIDS response, but it could also underwrite specific activities or benefits certain populations living with or at high risk of contracting HIV.4

Third, although this is not necessarily part of a trust fund, in many cases proposals for establishing a trust fund assign specific revenues (e.g., a share of or mark-up on income tax) to the fund. Thus, earmarked taxes are an important aspect of the policy discourse on establishing trust funds.

Current Practice and Developments

Trust funds have been an important aspect of the global discourse on HIV/AIDS financing,5 and one of the most important instruments for global HIV/AIDS financing, the Global Fund, is a trust fund. In contrast, trust funds have played a marginal role in domestic HIV financing in developing countries. This has changed over the last years, in the context of increasing domestic responsibility for the funding of the HIV/AIDS response, and trust funds have been discussed as one instrument to achieve sustainable domestic financing.6

The only long-standing example of a trust fund in support of the HIV/AIDS response is the AIDS levy, or National AIDS Trust

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3 Similarly, funds in the context of pensions and social security are classified in “funded” and “unfunded” schemes. In a funded scheme, the pension funds’ liabilities (its members’ pension claims) are “funded” by its assets, accumulated from its members’ contributions. In an “unfunded” scheme, pensions are financed from current contributions by members (see Lievens and others (2015) for a more detailed discussion). This note shies away from this terminology of “funded” vs. “unfunded” schemes because the terms “fund” and “funding” are also used with different meanings.

4 This note is primarily concerned with trust funds in support of the HIV/AIDS response overall. An example for trust funds in support of specific populations are the funds set up in support of people living with HIV infected through unsafe blood, which were set up in a number of developed economies.

5 E.g., the influential Harvard “consensus statement” (Members of the Faculty of Harvard University, 2001) called for the establishment of an HIV/AIDS trust fund.

6 In addition to the cases discussed here, Lievens and others (2015) refer to efforts to establish a trust fund in Botswana, Namibia, and South Africa.
Fund, set up in Zimbabwe in 1999. The AIDS levy is a 3-percent mark-up on the corporate and personal income tax. It is administered by and is the principal source of domestic funding of the National AIDS Council (NAC) – in 2012, it accounted for 87 percent of NAC’s revenues (US$ 32.5 million out of total revenues of US$ 37.6 million). Spending administered through NAC, however, accounts for only a small proportion of the total costs of Zimbabwe’s national HIV response (US$ 315 million in 2012), and domestic financing (largely the AIDS levy) amounts to only 11 percent of the financing of the national HIV/AIDS response.

In Tanzania, the establishment of a trust fund has been on the table for several years, and the AIDS Trust Fund was recently (March 25, 2015) established by Act of Parliament (Government of Tanzania, 2015). The purpose of the AIDS Trust Fund is the funding of the national response to HIV/AIDS. The trust fund will be governed by a Board of Trustees including two members of the Tanzania Commission for AIDS, three representatives of major donors, and one ministerial appointee. Funds will be held separate from government accounts. Details on the composition of anticipated funding are not available in the public domain, the Act – among other sources – refers to appropriations from Parliament, loans, donations, grants, and investment income.

In Uganda, an AIDS Trust Fund had also been under discussion for several years. An AIDS trust fund was established in the (otherwise controversial) HIV and AIDS Prevention and Control Act passed by Parliament in May and signed by the President in August 2014. The law assigns some tax revenues directly to the Trust Fund, these revenues however are very small compared to the costs of the HIV/AIDS response or current domestic financing. In addition, it envisages further tax revenues identified by the Ministry of Finance, and grants from the domestic government or any foreign government. The trust fund will be administered by the Ministry of Health in consultation with the Ministry of Finance.

The proposed HIV Trust Fund in Kenya in some ways is the most far-reaching proposal on the table – in terms of the scale of financing, but also as it is seen as a contribution on the pathway to universal health coverage. According to the Kenya AIDS Strategic Framework (NACC, 2014), it is proposed that 2 percent of government revenues (about 0.4 percent of GDP) are assigned to the HIV trust fund, a rate considerably higher than in the Zimbabwe or Uganda, as it is projected that the Government of Kenya will have to assume a much higher share of the costs of the HIV/AIDS response than at present. Looking further ahead, the HIV Trust Fund could ease the transition to universal health coverage, contributing to the financing of HIV treatment costs under a national health insurance.


Vice President Bilal announced the government’s intention to set up a trust fund as early as 2011 (Bilal, 2011).

The act assigns “two percent of the total tax revenue collected from levies on beers, spirits or waragi, soft drinks and bottled water” to the AIDS Trust Fund. As these levies accounted for US$ 267 billion in 2014 (Government of Uganda, 2015), equivalent to about US$ 103 million, 2 percent of these levies therefore account for about US$ 2 million, or 0.01 percent of GDP. In contrast, the funding projections for the HIV investment case contained in the latest “progress report” (Uganda AIDS Commission, 2014) envisage domestic funding going up from US$ 37 million in 2014 to US$ 73 million in 2018.

This percentage is considerably higher than in Uganda (about 0.05 percent of government revenue assigned directly to the trust fund) and in Zimbabwe (about 0.9 percent of government revenue, and 0.25 percent of GDP).

According to the latest NASA report, funding from the Government of Kenya accounted for about 20 percent of HIV/AIDS spending from public domestic or international sources in 2011/12.
Appraisal of Recent and Current Practice

The experience with trust funds as an instrument for financing HIV/AIDS responses is thin. In countries facing substantial HIV epidemics and financing challenges, only one long-standing example of a trust fund in support of the HIV/AIDS response is known, and in only a few more have trust funds cleared government and parliamentary approval and are heading towards implementation.

Nevertheless, a couple of lessons can be drawn from the experience. First, trust funds per se are not a means of sustainable financing, and the funding modalities are all but innovative. The amounts of funding committed to HIV trust funds (with the exception of the proposed fund in Kenya) account for a small proportion of the costs of the HIV/AIDS response (11 percent in Zimbabwe, less than one percent in Uganda). Whereas proposed trust funds are frequently cast under an “innovative financing” heading (UNAIDS (2013), Wilson and others (2014)), the current or proposed funding of trust funds is based on very conventional taxes – income taxes, excise taxes, or a cut of tax revenues overall.

There are two elements which are common to all or most current or proposed AIDS trust funds. First, they are extrabudgetary funds – spending allocations are made outside the regular budget process, and there is some governance and accounting structure specific to the fund. Second, in at least three or four cases, funding involves some earmarked taxes, which – together with the first aspect – provides some insulation or from the year-to-year budget process. On both of these counts, there is considerable experience outside the sphere of HIV/AIDS financing.

Trust Funds as Extrabudgetary Funds

HIV trust funds, by definition, are extrabudgetary funds, which occur frequently in government finance. For example, Ojiambo, Irungu, and Kitheka (2011) review 46 such entities in Kenya (one of the countries where a trust fund is under discussion). Allen and Radev (2010) find that transfers to extrabudgetary funds account for 9.4 percent of government expenditures across 23 transition/developing countries.

For these reasons, there is a body of literature on extrabudgetary funds (or “extrabudgetary units” as in IMF (2014)) in general, which may provide lessons on HIV trust funds.

Among the 13 objectives for which extrabudgetary funds are established listed by Allen and Radev (2010), 3 are particularly relevant in the context of HIV/AIDS – special funds (established for a specific purpose), development funds (established to support development programs usually involving donor contributions and sometimes internal sources), and revolving funds (which are not subject to budget rules that require budgetary appropriations to expire at the end of the year).

There are two common reasons for setting up a special fund. First, the fund may administer a levy collected for a specific purpose, e.g., a car or fuel tax that is earmarked for road maintenance. Second, and more relevant in the context of HIV, the government may set up fund in recognition that the budget process may not yield an efficient outcome.
In the case of HIV/AIDS, this may be the case because HIV prevention interventions are long-term investments, of which the health and financial returns are spread over decades (in this regard, resembling road funds). A perception that there is a political willingness to underwrite urgent care for people living with HIV, but not investments in HIV prevention with superior cost-effectiveness in terms of achieving health outcomes, could reflect such inefficiencies in the budget process. Also, stigma could result in insufficient budget allocations on interventions benefitting populations like female sex workers or men who have sex with men, and outsourcing the decisions on spending allocations within the HIV/AIDS budget to an agency with a public health mandate could result in a more efficient outcome.

Some AIDS trust funds exhibit features of a development fund, involving contributions from donors as well as the domestic government. The intention to utilize the AIDS trust fund as a conduit for both domestic and external funding is apparent in the law on the AIDS trust fund in Tanzania, where one-half of the members of the Board of Trustees are drawn from major donors. The AIDS Trust Fund of Zimbabwe was also originally conceived to attract external grants and this dimension never took off because its establishment coincided with a breakdown in donor relations (Madzingira, 2008). Following this model could be sensible under two circumstances. First, donors may be unwilling to entrust the government with funds directly, because of a perceived lack of transparency in the public accounts. Setting up a fund separate from the government’s accounts, with accounting standards that meet donors’ demands, could help address this problem. Second, establishing an HIV/AIDS trust fund could be a sensible financing arrangement in a transition to increased domestic ownership and financing of the HIV/AIDS response, with donors – in addition to the domestic government – contributing through the trust fund.

Finally, HIV trust fund could help address complication to the management of the HIV program associated with the annual budget cycle. Some of the expenditures of the HIV program (notably tenders for drug purchases) bulky and occur infrequently. If budget allocations expire at the end of the financial year, this could complicate the financial management of the HIV/AIDS response. In contrast, if unspent funds remain in the trust fund, considerations on the annual budget cycle need not constrain procurement.

Earmarked Taxes

One of the properties of most AIDS trust funds – under preparation or at work – is funding, at least in part, by some earmarked tax. In Zimbabwe, the AIDS levy of 3 percent of corporate or personal income tax due covers most of the operating costs of the National AIDS Commission (which however accounts for only 11 percent of the costs of

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13 The administration of funds provided by the Global Fund could be interpreted in this way.
14 The more substantial management problem with regard to the timing of revenues and expenditures, however, is the reconciliation of a cost-effective HIV/AIDS program and the associated profile of expenditures over time (which may involve a bump in spending early on) and the time profile of projected or targeted revenues. This problem is not necessarily addressed by a trust fund. See also discussion under earmarked taxes.
the national AIDS response); in Kenya, it is envisaged that an earmarked share of tax revenues overall would finance a substantial and increasing share of the costs of the national AIDS response; and in Uganda, the law establishing the AIDS trust fund earmarks a share of excise taxes on certain products (which however would cover only a very small share of the costs of the HIV/AIDS response).

Thus, contributions from earmarked taxes to the costs of the HIV/AIDS response range from a substantial share of the costs to an insignificant amount. Setting up a trust fund supported by earmarked taxes per se thus does not contribute to the financial sustainability of the HIV/AIDS response. The critical issue instead is how the costs of the envisaged HIV/AIDS response relate to projected funding, including a commitment from the national government (which does not need to come in form of an earmarked tax) and from donors.

Instead, advocacy for earmarked taxes for financing HIV/AIDS trust funds could rest on considerations in the area of political economy. First, if commitments on the domestic financing of the HIV/AIDS response are part of a grand bargain with donors on future funding, a high-level explicit commitment (in some cases set down in a law) on the part of the domestic government could motivate donors to commit to fund a share of the HIV/AIDS response in the future. Second, earmarked taxes isolate HIV/AIDS funding from the yearly budget process (but only if the earmarked funding accounts for all or most of domestic funding, as in Zimbabwe).

There are, however, a number of shortcomings in the use of earmarked taxes to finance an HIV trust fund. In general, earmarked taxes reduce the capabilities of policy makers to respond to changing circumstances and shifting priorities (Potter and Diamond, 1999). More concretely with regard to HIV/AIDS, none of the proposed earmarked taxes are closely linked to the demand for HIV/AIDS services. Earmarked taxes (unless they account for only a small proportion of domestic funding) therefore introduce rigidities to HIV/AIDS spending allocations. In the interest of attaining the best value for money, including by allocating spending most effectively over time, a scheme based on earmarked taxes would therefore need to be complemented by a mechanism to vary expenditures around the expected revenues, by borrowing (and repaying when the costs of the HIV/AIDS response come down) or accumulating some savings to accommodate anticipated expenditures or fluctuations in funding. One useful illustration of these issues is contained in the recent Kenya AIDS Strategic Framework – over the first years, the identified funding sources (including an earmarked share of tax revenues) are insufficient to meet the costs of the proposed HIV/AIDS response, but the funding exceeds the costs after several years, and these surpluses could be used to finance the earlier deficit. If borrowing, or convincing donors or the government to provide more funding over a number of years, is not feasible, the pace of the initial scaling-up of HIV/AIDS services would have to be slowed down.

Conclusions

Trust funds have been part of the policy discourse on the financing of the HIV/AIDS response for many years, but mainly on the global level, and the most significant multilateral funding agency, the Global Fund, is a trust fund. In terms of the
financing of national HIV/AIDS responses, trust funds have been discussed in recent years in the context of increased domestic responsibility and a slowdown in donor commitments. However, the experience to date is thin, and there is only one example of a trust fund in support of the domestic HIV/AIDS response from countries facing a severe HIV epidemic and steep financing challenges.

Trust funds are seen as an instrument of isolating the HIV/AIDS response from the annual domestic budget process, or establishing an inviting environment for external contributions where government finance is seen as intransparent. On the other hand, trust funds also add intransparencies and rigidities to the government’s fiscal operations.

In most cases, proposals for establishing trust funds come with suggestions on how this is to be financed, including some earmarked tax. Earmarked taxes allow the managers of the national HIV response to draw on some fairly predictable domestic revenue stream. This revenue stream, however, may have little semblance to the profile of spending needs, and – in the absence of more flexible financing instruments – may result in inefficient spending allocations.

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MANAGING THE TRANSITION TO DOMESTIC FINANCING
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NHIF IN KENYA
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The potential of health insurance for AIDS treatment

Although many components of the global HIV response might be thought of as public goods (for example, behaviour change communication, mass media or human rights advocacy), others are private goods (in particular anti-retroviral therapy or ART) that are suitable for inclusion within existing health insurance packages, although it is typically not included in low and middle-income countries. This brief describes a proposal to include ART within a proposed extension of the Kenyan National Health Insurance Fund (NHIF).

The costs of lifelong HIV treatment

High treatment coverage of ART in Kenya has greatly improved the life expectancy of people living with HIV. People who become infected with HIV now can expect to survive for several decades. From the perspective of health financing, this means that each HIV infection causes a spending need that extends over the same several decades.

Estimates made for the Kenya HIV investment case show that the healthcare costs generated by one person contracting HIV rise to about US$500 annually within 10 years following an HIV infection, remain at about this level for over a decade, and decline only slowly afterwards. When expressed as a net present value, the costs of one HIV infection in 2014 are estimated at US$12,000 when a discount rate of 3 percent is applied, of which about US$9,500 results from treatment costs.

1 Adapted from a discussion note prepared as part of the investment case, “Financing of HIV Treatment Costs through a National Health Insurance Fund in Kenya”, Markus Haacker and Charles Birungi.
2 Increased attrition from mortality are the dominant cause of the eventual decline in the projected costs.
3 Based on preliminary cost estimates.
Expanding the NHIF

Kenya’s NHIF currently covers about 20 per cent of the population employed in both the formal and informal sectors, and covers its members for a package of services that has recently been revised to include chronic conditions and non-communicable diseases, but does not include ART treatment for AIDS. Ongoing reforms aim to increase the membership (contributors, not counting dependents) of the NHIF to about 5 million by 2020, and 12 million by 2030, at which stage the NHIF would cover more than 60 percent of the population. These reforms are part of a pathway towards ensuring universal health coverage for all sectors of society. One key question is whether the NHIF could cover the costs of AIDS treatment for its contributors.

HIV currently accounts for a large proportion of the costs of public health services. The Health Sector Strategic and Investment Plan projects that HIV will absorb 20 percent of disease-specific spending in 2013-17, and AIDS was expected to account for around 30 percent of deaths. While the burden of disease attributable to HIV is projected to decrease in coming years, this is largely due to the increased availability of treatment, so that the number of people receiving treatment (and its costs) is actually set to increase.

Potential risks for the NHIF

The main challenge with funding AIDS treatment through the NHIF is how to set affordable premiums that cover the treatment costs of those members who contract HIV, while also funding the treatment of people already living with HIV. Setting premiums too high could jeopardise the expansion of the NHIF’s coverage for other conditions. Broadly speaking, there are two ways that HIV/AIDS treatment could be covered under an insurance system like the NHIF: a pay-as-you-go system or a capitalised system. See Box 1.

PAY-AS-YOU-GO SYSTEM

Current contributions (from all insured) finance the current costs for everybody accessing treatment. As access to treatment increases over time, premium costs will also increase to cover this.

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual premium (two beneficiaries per member)</th>
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<tr>
<td>2014</td>
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<td>2020</td>
<td>US$44</td>
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CAPITALISED SYSTEM

Current contributions cover the risk of contracting HIV in a given year. The HIV infection risk will decrease over the coming years, so premiums will also decrease. This system cannot cover the costs of treatment for people already living with HIV.

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual premium (two beneficiaries per member)</th>
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<tbody>
<tr>
<td>2014</td>
<td>US$78</td>
</tr>
<tr>
<td>2020</td>
<td>US$25</td>
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</tbody>
</table>
Advantages and disadvantages of a capitalised insurance system

A capitalised insurance system is the most attractive option for several reasons. First, the cost of the premium will decrease rather than increase over time as the rate of HIV infection drops nationally. This means insurance premiums are directly linked to the success of HIV prevention programs—an attractive feature politically. Second, NHIF members would only be paying a premium that reflects their own collective risk of contracting HIV. In the pay-as-you-go system, a large part of their premium subsidises other people receiving treatment from previous infection.

There is one main disadvantage to a capitalised system: the treatment costs of people already living with HIV are not covered and would need to be financed from other sources, as would any fast-track expansion of treatment coverage in either a capitalised or a pay-as-you-go system. Using the existing financial reserves of the National Hospital Insurance Fund (the precursor to the NHIF) would be unfeasible. The lifetime costs of services to people already living with HIV are estimated at US$16.3bn, equivalent to 32 percent of GDP. If the NHIF covered 60 percent of the population, it would need to take on a liability of 19 percent of GDP—about 20 times the NHIF’s current revenue.
How could we cover the treatment costs of people already living with HIV?

Kenya requires a gradual transition to a funded health insurance that includes AIDS treatment services. Given the liabilities discussed, policy options to achieve this include:

1. **Direct external support** in the form of subsidies to the NHIF paid by international partners.

2. **A government-issued bond (i.e. domestic borrowing)**, the proceeds of which would be used to fund the AIDS-related liability taken on by the NHIF. This would allow the government to spread the costs of meeting the liability over a period of time.

3. **Using the proposed Kenyan health trust fund** as seed financing for a more comprehensive health insurance. This proposed trust fund (possibly subsidised from external support) would initially channel funds to the national HIV response. However, with a projected gradual decline in the costs of this relative to GDP, in parallel with a transition to a NHIF and Kenya taking over the responsibility for funding treatment, the trust fund could eventually be used to cover the liability of treating people currently living with HIV.
ECONOMICS REFERENCE GROUP

Technical Working Group for Sustainable Financing
ABSTRACT

This background brief provides a launching point for the first meeting of the Technical Working Group for Sustainable Financing under the Economics Reference Group co-convened by UNAIDS and the World Bank. It is a “Draft for Discussion” and will be edited following presentations and discussion during the first meeting.

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INTRODUCTION

Over the past two decades, the fight against HIV & AIDS has achieved significant success. New infections are on the decline and increasing access to effective anti-retroviral therapy (ART) in low- and middle-income countries (LMICs) has transformed AIDS from a fatal to a long-term manageable condition. Yet the long-term costs of treatment, the prospect of increasing numbers of patients needing more expensive second- and third-line drugs, and the need for continued prevention measures necessitate a high level of sustained funding for decades to come.

UNAIDS estimates that by 2015, approximately US$24 billion will be needed for HIV interventions annually (WHO, UNICEF, & UNAIDS, 2013). However, donor funding has plateaued in recent years: after rising from US$1.2 billion in 2002 to US$8.7 billion in 2008, donor commitments have remained largely constant (UNAIDS and Kaiser Family Foundation, 2012). At the same time, many LMICs have experienced a period of economic growth, and are increasingly able and willing to take ownership of their HIV & AIDS response (UNAIDS, 2013). In 2011, domestic sources accounted for the first time for more than half of the funding for HIV programs in LMICs (UNAIDS, 2013). This represents a significant shift away from a donor-driven funding structure to a country-led model on average, a trend that is likely to continue in the near future, but there is still large variation across countries and some remain heavily dependent.

UNAIDS and the World Bank have co-convened an Economics Reference Group (ERG), bringing together senior HIV experts, health economists and practitioners to provide guidance on key issues regarding
This background summary serves as a launching point for the first meeting of the Technical Working Group for Sustainable Financing (TWGSF). The TWGSF will review existing evidence related to the sustainability of HIV funding and responses, suggest new research in areas where knowledge gaps have been identified, and develop specific policy guidance based on research findings.

1. COSTING, TECHNICAL EFFICIENCY AND EXPENDITURE TRACKING

2. HIV ALLOCATIVE EFFICIENCY AND EFFECTIVENESS

3. SUSTAINABLE FINANCING
FOR THE INITIAL MEETING, FOUR KEY DIMENSIONS OF SUSTAINABLE FINANCING HAVE BEEN IDENTIFIED FOR DISCUSSION:

1. ISSUES OF ‘FAIR SHARE’ AND ‘GLOBAL SOLIDARITY’

2. EXPANDING INTERNATIONAL AND DOMESTIC REVENUE MOBILIZATION

3. INTEGRATING AIDS FINANCING INTO NATIONAL HEALTH FINANCING SYSTEMS

4. PLANNING THE TRANSITION TO DOMESTIC FUNDING AND PROGRAMMING

1. ISSUES OF ‘FAIR SHARE’ AND ‘GLOBAL SOLIDARITY’:

How much can LMICs reasonably be expected to contribute to their HIV programs, given their fiscal constraints, the size of their AIDS epidemics and the scale of other health and social sector priorities (‘fair share’); and what type of responsibility and capacity do external donors have to honor their international financing commitments given the scale of the AIDS response both at the global and national levels (global solidarity)?
EXPANDING INTERNATIONAL AND DOMESTIC REVENUE MOBILIZATION:

What are potential sources of additional domestic revenue to support long-term HIV & AIDS resource needs? What kind of innovative revenue mobilizing efforts have been undertaken in different countries and what is their feasibility for replication? What is the best strategy to maximize the impact of existing AIDS resources and to mobilize additional sources of revenue at the global level?

INTEGRATING AIDS FINANCING INTO NATIONAL HEALTH FINANCING SYSTEMS:

Which HIV services should be integrated into national/horizontal health financing systems and how can sustainability be ensured? What kind of institutional reforms are needed for integration to be successful? How would the process of integration differ between low/middle income and low/high burden countries?

PLANNING THE TRANSITION TO DOMESTIC FUNDING AND PROGRAMMING:

Especially in middle income countries, how should transitions toward increased domestic programmatic and financial ownership of programs be made? What existing experiences can be shared with the TWGSF and what lessons can be drawn from these cases? What tools are available or could be developed to increase financial transparency, enhance accountability, and create a better framework for integrated financial planning, budgeting, and monitoring between national governments and donor organizations?

This background brief is intended to facilitate the first discussions of the TWGSF on November 25-26, 2013. It defines and presents some of the recent evidence and commentary on each of these four dimensions and identifies several salient research and policy priorities the TWGSF could consider pursuing in 2014 for each dimension. The brief concludes with brief case studies of AIDS financing transitions in South Africa and India that help illustrate all four dimensions. The brief will be edited following presentations and discussions of the first TWGSF meeting.
1. Introduction

A significant gap currently exists between estimated resource needs and combined donor and domestic funding for the global AIDS response. UNAIDS estimates that an extra $US 7 billion will be needed annually by 2015 to meet the needs of AIDS efforts in middle- and low-income countries (UNAIDS, 2013). In this context, it has become necessary to understand which countries are in a position to increase funding for their HIV response, and which will continue to have the greatest need for donor support (Greener, 2011). The concept of ‘fair share’ has emerged from this debate, defined as the amount a country can reasonably be expected to contribute to its HIV response. Multiple metrics have been proposed to measure ‘fair share,’ each with distinct advantages and disadvantages. During its first meeting, the TWGSF will be asked to engage in a substantive discussion about the feasibility and reasonableness of the currently proposed metrics, and if possible to provide guidance on an agreed set of standards.

Conversely, the concept of ‘global solidarity’ has been used to define the amount a donor country can or should be expected to provide for the AIDS response. With most developing countries unable to fully finance their HIV programs, continued donor support and involvement will be essential. As with the concept of fair share, multiple metrics and normative standards have been proposed, with each approaching measurement in a slightly different way.

The TWGSF may also suggest areas for further analysis and development of useful tools and additional metrics relevant to the issue of fair and sustainable financial burden sharing.

This section will highlight some of the current literature and metrics for both ‘fair share’ and ‘global solidarity.’ After discussing advantages and disadvantages of each metric, it will conclude with a discussion that highlights issues needing further clarification and research for the TWGSF to consider pursuing.
2. Overview of Current Metrics and Targets for ‘Fair Share’

Current metrics for ‘fair share’ fall into three categories: 1) Targets that would increase the resources available for HIV & AIDS by increasing overall health spending; 2) Targets that aim to increase HIV spending as a proportion of overall health budgets; and 3) Metrics that compare countries to each other in their investment commitment to AIDS. This section provides a brief definition of and discusses advantages and disadvantages of each proposed metric for ‘fair share.’

Health Spending Targets

The Abuja Target. In Abuja, Nigeria in 2001, African Union Heads of State committed to allocate 15% of government expenditure to health (Veloshnee Govender, 2008). This increased commitment to health would also create more fiscal space for HIV & AIDS, assuming the percentage of the government’s health budget going to HIV remains constant.

Yet critics argue that this target is too broad to be used in actual planning exercises, as it fails to account for country-specific political, economic and epidemiological situations. For example, low-income countries may have less fiscal space to increase their health budgets from domestic resources than do middle-income countries. The Abuja target may also be unrealistic for countries currently spending far below 15% of their total expenditures on health. Moreover, no clear guidelines have been published as to how this target should be measured (Witter, 2013) (Borowitz & Korah, 2013). Questions such as whether to measure country budgets, which are often theoretical, or actual expenditures on HIV & AIDS, and whether to include earmarked aid and overall development assistance – which are included in some, but not all, country budgets - into these calculations have not been clearly answered. As a result, sources differ in their definitions of country success (UNAIDS, 2013) (Africa Public Health Alliance, 2010) (WHO, 2011).

Government expenditure on health as a share of GDP. Experts studying sector-specific funding have proposed that countries should spend a minimum of 3% of GDP on health to achieve optimal health results; however, many developing countries currently spend far less. (PEPFAR and Results for Development Institute, 2013). Again, meeting this target would increase funding available for HIV & AIDS by increasing overall health spending, assuming the percentage of government budgets allocated to HIV & AIDS remains constant. Still, 3% of GDP may not be equally realistic for both low- and middle-income countries; and it does not take into account country-specific economic and health needs. Drawbacks to this measure are similar to those associated with the Abuja Target.

HIV & AIDS Spending Targets

Government expenditure on HIV & AIDS as a share of GDP. Several recent studies have determined that low-income countries with high HIV prevalence can afford to spend up to 2% of their national GDP on an HIV & AIDS response without compromising other sectors (Haacker & Lule, 2012) (Williams & Gouws, 2012). This provides a clear-cut and easy-to-measure metric to help donors determine if a country’s HIV resource needs exceed their reasonable ability to pay. However, it may not be equally realistic for all countries, and it fails to account for the relative disease burden of
HIV & AIDS. This measure also conflicts with the 3% target described above. If a country were to spend 3% of its GDP on health with 2% of its GDP dedicated to HIV & AIDS, it would then be spending 2/3 of its health budget on the AIDS response. This could jeopardize other important health priorities.

### The DALY Share target

The proportion of government health budgets allocated to HIV & AIDS constitutes another measure of commitment. Countries are considered to have met their DALY Share if the proportion of government funding for health allocated to HIV & AIDS meets or exceeds the proportion of DALYs lost due to HIV & AIDS in the population. This has the advantage of accounting for relative disease burden, although it does not account for relative costs of treating diseases. As ART is scaled up, the relative disease burden of HIV & AIDS may decrease while the cost of treatment remains. To date, no metric has been published that incorporates both disease burden and relative cost of treatment.

### Cross-Country Comparison Metrics

#### The Domestic Investment Priority Index (DIPI)

In 2010, UNAIDS introduced the Domestic Investment Priority Index as a metric for the priority placed by countries on their national AIDS response. The DIPI is calculated by dividing the percentage of government revenue directed to the HIV & AIDS response by the population HIV prevalence. A high value usually indicates a high level of priority. This metric is based on the idea that two countries with equal wealth and equal population prevalence of HIV & AIDS would be expected to spend equal amounts of money on an AIDS response if they placed equal priority on the disease.

This provides a standardized measure with which to compare country commitment to HIV, but at present it lacks an obvious normative target value. As a result, a country’s DIPI is more meaningful when compared to others than as a stand-alone metric.

Expected Domestic Contribution (EDC). Omar Galarraga et al (2013) recently proposed a model that measures Expected Domestic Contribution to the HIV & AIDS response as a function of gross national income (GNI) per capita, health spending per capita as a proportion of GNI per capita, and debt service per capita. Countries were then categorized according to actual versus expected domestic contribution and resource needs. The study found that seventeen countries had domestic funding below that expected by the model, and that total funding (donor + domestic) would exceed the estimated need if domestic contribution were increased to the EDC. Conversely, twenty-seven countries had domestic funding above the expected level, but total domestic and donor funding did not meet estimated need (Galárraga O, 2013). This is useful in that it clearly identifies countries that are either under- or over-funded by donors based on their ability to pay. However, the metric does not consider the size of a country’s HIV epidemic.

<table>
<thead>
<tr>
<th>PUBLIC EXPENDITURE ON HIV / AIDS</th>
<th>NATIONAL POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIPI = GOVERNMENT REVENUE / PEOPLE LIVING WITH HIV / AIDS</td>
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</tr>
</tbody>
</table>
3. Potential focus issues and questions for TWGSF

Potential to Increase Funding for HIV & AIDS by meeting targets

Potential to increase funding for HIV & AIDS by meeting metrics for ‘fair share’ varies based on a country’s current spending and economic capacity. Countries such as Ethiopia, which currently has very low general government expenditure, could increase funding by increasing GGE. Other countries such as Kenya, which is currently far below the Abuja Target, could increase HIV spending by increasing government spending for health (PEPFAR and Results for Development Institute, 2013). Figure 1 below illustrates the increases in funding that could result from varying combinations of meeting these targets in countries with different contexts.

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**Figure 1**

DOMESTIC AIDS EXPENDITURES UNDER BENCHMARK SCENARIOS ($US MILLIONS ANNUALLY)

<table>
<thead>
<tr>
<th>Country</th>
<th>Actual</th>
<th>Abuja</th>
<th>DALY Share</th>
<th>Abuja &amp; DALY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MOZAMBIQUE</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>$100</td>
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<tr>
<td>$0</td>
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<tr>
<td><strong>KENYA</strong></td>
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<td>$100</td>
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<tr>
<td><strong>CÔTE D’IVOIRE</strong></td>
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<td></td>
</tr>
<tr>
<td>$100</td>
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<tr>
<td>$0</td>
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</tbody>
</table>
In the coming decade, countries will likely move in increasingly divergent directions. Middle-income countries with medium to small HIV burdens may soon be able to fully finance their own response by meeting ‘fair share’ targets; whereas most low-income countries—and in particular those with high burdens of disease—will be unable to meet their resource needs for HIV & AIDS even if they were to meet all or most of the targets described above (PEPFAR and Results for Development Institute, 2013). As a result, they will be reliant on donor aid for many years to come.

**Tension between aspirational goals and country-specific solutions**

In the discussion of appropriate metrics and targets for ‘fair share,’ there is a tension between international aspirational goals and country-specific solutions. Targets such as the Abuja Target and percent GDP dedicated to health or HIV & AIDS can be useful in motivating countries to increase HIV & AIDS spending, but they may not be realistic (economically or politically) for all countries to meet. A need remains to develop country specific plans for growth that take into account economic projections, size of the epidemic, and relative size of other social and economic priorities for growth.

Research questions surrounding ‘fair share’ that the TWGSF may wish to consider include:

- **What are the most appropriate indicators for assessing “fair share” for domestic financing?**
- **Are there ways these indicators can be improved and refined to fit country contexts?**
- **How can we bridge the gap between theoretical targets and benchmarks and actual financing commitments made in countries?**
- **How can countries that appear to be economically capable of financing their own response be motivated to do so?**

### 4. Current Metrics and Targets for ‘Global Solidarity’

Donor contributions to the global AIDS response can be measured in many ways, and no one metric paints a complete picture of donor contributions. Current metrics and targets used to measure ‘global solidarity’ include, but are not limited to the following.

**Total dollar amount contributed to Overall Development Assistance (ODA) or the HIV response.** This is the most straightforward measurement of country contributions, but it does not take into account relative donor wealth and economic capacity for increasing external aid.

**Percent GDP contributed to ODA.** UNGASS has suggested a target of 0.7% GDP dedicated to Overall Development Assistance. This takes into account donor wealth, but is not specific to HIV & AIDS. Unfortunately, countries have consistently fallen short of this target over the past few years.

**Disbursements for HIV per US $1 Million GDP.** This metric most directly measures contributions to HIV & AIDS, while taking into account relative donor wealth. However, it does not account for assistance to other health or development priorities that may affect the HIV & AIDS response.
**Percent of ODA dedicated to HIV.** This measures the level of priority donor countries place on HIV & AIDS compared to other development assistance. However, it does not measure ‘generosity,’ as it does not take into account total amount of aid.

5. Potential focus issues and questions for TWGSF

Different metrics paint vastly different pictures of country generosity and ‘global solidarity’ (e.g., Figures 2 and 3). The United States, for example, commits less than half of the target 0.7% GNP to ODA—well behind several other countries—but it ranks second only to Denmark in disbursement for HIV per US$1 million GDP (see Figure 2).

<table>
<thead>
<tr>
<th>Country</th>
<th>Disbursements for HIV per US$1 million GDP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>$545.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$328.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>$324.5</td>
</tr>
<tr>
<td>United States</td>
<td>$320.2</td>
</tr>
<tr>
<td>Ireland</td>
<td>$287.4</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$250.2</td>
</tr>
<tr>
<td>Norway</td>
<td>$230.6</td>
</tr>
<tr>
<td>France</td>
<td>$144.5</td>
</tr>
<tr>
<td>Canada</td>
<td>$84.9</td>
</tr>
<tr>
<td>Germany</td>
<td>$84.8</td>
</tr>
<tr>
<td>Australia</td>
<td>$80.9</td>
</tr>
<tr>
<td>Japan</td>
<td>$35.1</td>
</tr>
<tr>
<td>Italy</td>
<td>$6.9</td>
</tr>
</tbody>
</table>
To properly evaluate the usefulness of different ‘global solidarity’ measures, several questions need to be answered:

- **Which contributions should be measured?** Most current measures do not account for country contributions to the World Bank, UNICEF, and other bilateral organizations that directly affect HIV programs. Should these contributions be taken into account, and if so how? In addition, should tax breaks for foundations and individual donors that contribute to the global HIV response also be included in government aid calculations? Why or why not?

- **How can contributions to HIV be balanced with contributions to other health priorities?** At what level of aid (overall, health-related or HIV-specific) should contributions be measured, and how can a balance be taken into account?

- **Which countries should be included in ‘global solidarity’ rankings?** Only G8 countries? All developed countries?

- **How can countries be motivated to donate more?** Donors have consistently fallen short in meeting both the UNGASS target and others. Over recent years, some bilateral donors have also delayed or failed to meet the disbursement of
their pledges to multilateral agencies such as the Global Fund (Galárraga O, 2013). With simply setting targets apparently insufficient to motivate donor participation, how can country commitments be monitored and how can countries be motivated to meet them? Could matching schemes, results-based financing, or releases of funds to countries and providers based on performance enhance trust and catalyze donations?
EXPANDING INTERNATIONAL AND DOMESTIC RESOURCE MOBILIZATION

1. Introduction

As the global resources available for HIV & AIDS have plateaued and more pressure is put on countries to mobilize their own resources, countries have turned to ‘innovative’ mechanisms of financing to generate additional revenues. These include levies on airline tickets and mobile phone minutes, tobacco and alcohol taxes, HIV & AIDS trust funds, and public and private sector mainstreaming. This section provides a brief description of select mechanisms and their application in various countries. It is followed by a discussion about the potential for innovative financing measures to begin filling the funding gap, and suggestions of issues and questions about revenue mobilization that the TWGSF may want to explore.

2. Overview of Innovative Financing Mechanisms

A number of financing mechanisms have been proposed and piloted in recent years.

Airline Levy. A levy on domestic and international flights has been used by both lower- and higher-income countries to finance HIV & AIDS contributions. Revenues from airline levies by Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger and the Republic of Korea currently
comprise over 60% of contributions to UNITAID, an international organization that works to increase access to treatment and diagnostics for HIV & AIDS, TB and malaria (UNITAID, 2012). Other countries currently implement an airline levy to finance their domestic HIV response.

Airline levies generally collect a $1-20 tax from each air traveler. This is viewed as a progressive tax that can generate a reliable stream of income without affecting demand for flights. Implementation costs are also low when it can be implemented using pre-existing airport tax systems (World Health Organization, 2010). However, revenue from these levies must compete for earmarked status with other priorities such as carbon dioxide emissions, which have also lobbied for these funds.

**Mobile Phone Levy.** Multiple countries now place levies on mobile phone usage with proceeds supporting HIV programs. These levies provide a consistent source of funding, however they can also be seen as regressive, as they increase the cost of minutes for the poor as well as the rich.

**HIV & AIDS Levy.** Since 1999, Zimbabwe has levied an extra 3% tax on all taxable incomes for individuals and institutions (World Health Organization, 2010) (Southern African Development Community, 2008). Unfortunately, due to hyper-inflation, the levy has not made a significant contribution to the HIV & AIDS resource pool. Instead, multiple studies found that this levy has become a burden to taxpayers (including poor taxpayers) while failing to contribute significantly to the AIDS resource pool. This type of levy also depends on government ability to collect revenue, which is often limited in LMICs.

**Tobacco and Alcohol Tax.** Cape Verde, Comoros, and other countries impose alcohol excise taxes with funds earmarked for HIV programs (UNAIDS, 2012). These earmarked ‘sin’ taxes provide a steady source of revenue while also discouraging use of unhealthy products that cause other chronic disease. However, these taxes can also be regressive, disproportionately affecting poor people.

**HIV & AIDS Trust Funds.** HIV & AIDS trust funds are currently in use or under consideration in Malawi, Kenya, Zimbabwe, Botswana, South Africa, Tanzania, and Zambia, among other countries (Lievens, 2011). Trust Funds can be ‘funded’ or ‘unfunded,’ with ‘funded’ trust funds capitalizing off of interest from a large endowment and eventually becoming self-sustaining, and ‘unfunded’ trust funds receiving an annual contribution from public or private sources that can include many of the levies and taxes described above.

**Public and Private Sector Mainstreaming.** Multiple countries currently require all public or private bodies to devote 2% of their budget to HIV-related activities and workplace policies for their staff (UNAIDS, 2012). Internal mainstreaming involves addressing the spread of HIV within an organization, with a focus on workplace programs. External mainstreaming involves a sector using its own comparative advantage to address the spread of HIV & AIDS in the population (e.g., the education sector offering safe sex education in schools) (Republic of Namibia, 2008). This has the advantage of creating a multi-sectoral response to HIV & AIDS in addition to increasing funding; however, a focus on quality of programming—and particularly workplace programs—is essential if this approach is to be effective (Lievens, 2011).
3. Potential focus issues and questions for TWGSF

**What is the revenue generation potential of innovative financing mechanisms?**
Potential for innovative financing mechanisms to generate sufficient income varies widely by country. As illustrated in Figure 4, revenue from a country-specific airline levy would cover 274% of the projected financing gap for HIV & AIDS in Burkina Faso by 2020, but less than 10% in Botswana (Lievens, 2011). Similar discrepancies exist for other mechanisms of funding.

This variation underscores the need for country-specific research to determine the feasibility and revenue generation potential of these mechanisms. It is not immediately clear that these innovative financing mechanisms will be sufficient to make a significant difference in funding levels for all countries. If the TWGSF were to pursue this issue, potential tasks could include the following:

- Country-specific feasibility and revenue projection studies;
- Proposal and testing of new innovative financing mechanisms; or
- A ‘toolkit’ that can inform country decisions by providing up-to-date research on individual mechanisms, as well as guidance on how to evaluate and quantify these mechanisms in country contexts (Ombam, 2013).

Other conceptual questions in this debate include:

**What are the pros and cons of relying on general vs. earmarked taxes for HIV & AIDS?** As a greater share of domestic resources are deployed for financing HIV & AIDS programs, there is a growing debate on whether to ‘earmark’ a share of tax revenues...
or finance it out of general tax collection by the government. In the first case, ministries of finance will seek a strong justification for earmarking resources for HIV and not for other priorities such as education or infrastructure. Earmarked resources, especially through natural resource levies such as mineral taxes, can also be volatile depending on external factors such as global price movements. Conversely, strong political commitment to HIV & AIDS is needed to secure resources from the general tax pool amid multiple important demands on scarce resources in LMICs.

**Should and how can countries expand use of broad-based revenue ‘levers’/‘handles’?**

Several countries graduating from low to middle income status are simultaneously developing modern taxation and budgetary systems, leading to greater tractability in using revenue levers, like social funds with earmarked taxes, for public policy priorities. For instance, since 2005, the Government of India has been collecting an education deduction on taxable income for primary and tertiary education and committing the resources to a non-lapsable fund which can be used to pay for targeted education schemes or general programs like providing a midday meal to children (KPMG Asia Pacific Tax Center, 2012). Similarly, Mongolia, enjoying a boom in non-tax revenues from its mineral exports, has earmarked a portion of these revenues for a Human Development Fund which supports projects meant to counter inequality by funding payments related to cash hand-outs to all citizens, pensions, healthcare, education, and housing (Isakova, Plekhanov, & Zettelmeyer, 2012). Borrowing for financing of HIV response is also becoming more commonplace, but has not been adequately evaluated. There is a significant knowledge gap regarding the concept and application of these revenue levers individually and collectively, and their impact on ensuring sustainability of financing in the future.

**What are the linkages policymakers must know between allocative efficiency and sustainable financing?** Future resource needs are closely tied to current policy decisions, and could potentially be significantly reduced through effective prevention investments. It has been estimated that each dollar that Thailand invested in its HIV prevention program saved $43 dollars in avoided future treatment costs (Over et al. 2007; Revenga et al. 2006). Likewise, ongoing research in South Africa has preliminarily found that circumcision of males is highly cost saving: saving almost $1000 in future treatment costs for every male circumcised (Haacker, 2013). The executive director of UNAIDS recently stated, “We could wait for economies to grow, as they appear to be doing, and hope for increased investments. Or we can re-examine our models of investments and methods of program delivery . . . We have to do more with less” (Sidibé, 2011). Yet prevention currently makes up a small proportion of the HIV/AIDS response in many countries.

**New fund mobilization or reallocation?**

Since sustainable financing of HIV & AIDS must be considered in the context of various health commitments competing for newly mobilized funds or reallocation from other sectors, can the TWG consider researching general principles for deciding which of the two means of enhancing funding (newly-mobilized or reallocated) should be prioritized given different capacities and potential for each?

Accurate projections of funding needs based on varying combinations of treatment and prevention programs will be essential for improved decision-making at the country level. The ERG has commissioned a separate working group that will provide technical inputs on allocative efficiency in the HIV & AIDS response, and their work will be directly relevant to questions of sustainable financing. The TWGSF may wish to consider a formal dialogue or collaboration on research tasks with the allocative efficiency working group.
1. Introduction

The HIV & AIDS response has been largely driven from its inception by donors, especially in LMICs in sub-Saharan Africa, Asia, and the Caribbean. With few exceptions, funds were allocated and expenditure incurred through parallel budgeting and service delivery mechanisms. That reality is changing for several reasons. First, HIV & AIDS has evolved from a health emergency to a long-term disease management issue. Second, available donor resources for HIV & AIDS response are currently stagnating and may decline in the near future. Third, strategic reorganization within major donors (Global Fund, World Bank, and PEPFAR) and the focus on other health challenges such as immunization and non-communicable diseases will potentially reduce the visibility of HIV & AIDS financing in the future, both domestically and internationally. Finally, with countries promoting universal health coverage, there is a movement to marry vertical HIV & AIDS efforts with health system strengthening. As domestic resources become the dominant source of financing of the AIDS response, both the donor community and the countries themselves are focusing more holistically on financial and programmatic sustainability.

Following the discussion on ‘fair share’ and resource mobilization, integration of HIV & AIDS into health financing systems is now an important area of policy debate in the context of financial sustainability of the AIDS response. Several salient issues and evidence are surveyed below, followed by suggestions on potential focus topics for the TWGSF.
2. Salient issues and recent work

“Integration of HIV & AIDS financing” refers here to the process of moving toward national health financing systems where funds for HIV & AIDS are collected, pooled, and used to pay for/purchase health services together with funds for other health services rather than through separate financing/payment structures. (A follow-on but separate concept is that such integrated funding can imply integrated delivery of HIV & AIDS services alongside other health services.)

Much of the debate on integrating HIV & AIDS financing with national health financing systems has focused largely on health insurance mechanisms at the country level. Mexico, Brazil, and Thailand are cited as examples of countries that moved towards early integration of HIV & AIDS services with largely publicly funded health insurance mechanisms with nearly universal coverage. These countries leveraged the opportunity afforded by health sector reform and introduction of comprehensive health insurance in the late 1990s to expand coverage of ART at a time when treatment costs were high [(Nunn, da Fonseca, Bastos, & Gruskin, 2009); (Bautista et.al., 2008); (Patcharanarumol, et al., 2013)].

As low prevalence countries which experienced significant economic growth in the last decade or more, the individual contexts of the relationship between HIV & AIDS policy design, available funding envelope, and the pathway to integration are important to consider. For instance, Brazil decided in 1996 to provide ART to all, challenging conventional wisdom that LMICs should focus on prevention and that adherence would be hard to ensure. Within a decade, Brazil was paying $400 million for ARV drugs to support therapy for 180,000 individuals, with about 20,000 new patients joining treatment every year (Greco & Simao, 2007). But long term sustainability is threatened by increases in both the number of individuals who need to initiate ART each year and the complexity of the regimens for infected individuals who are surviving for longer periods of time. In Thailand, the government paid for about 71% of the total HIV & AIDS expenditure during 2008-11 in just treatment and care after first introducing a policy of tax-financed universal ART in only 2003 (Patcharanarumol, et al., 2013). However, the impending departure of Global Fund funding may mean that gaps in reaching migrants and other key affected populations will open up. In Mexico, the nature of the challenges differs in that while Seguro Popular has reduced out-of-pocket health expenditures and produced a shift to public providers among poorer population groups, there is evidence that poor quality of care may be interfering with improved health outcomes (Barros, 2009).

The evidence from high-prevalence and high burden countries is mixed. As examples, Rwanda has a relatively well-functioning national health insurance system, while South Africa remains highly fragmented between public and private sectors as the country’s national health insurance vision is being designed and piloted. In both cases, ART continues to be delivered separately, although treatments of opportunistic infections are included in benefits packages of Rwanda’s ‘mutuelles’ (Doetinchem, Lamontagne & Greener, 2010). Before endorsing integration of HIV & AIDS services with domestic health insurance mechanisms to enhance sustainability, there is a need to better evaluate cross-country variation in existing coverage and services and capacity for integration.

A recent UNAIDS review of the experiences with integration of HIV & AIDS into domestic health insurance schemes (Doetinchem,
Lamontagne, & Greener, Aug 2010) begins such comparisons. The report gives an overview of HIV & AIDS coverage and subsidies for 65 countries split by their vulnerability profile (generally correlated positively with prevalence and inversely with per-capita health spending and achievement in delivering ART and PMTCT services). Importantly, it made some critical observations challenging conventional thinking about the wisdom and mechanics of integration at the national level:

a. There is a great variety of coverage mechanisms and funding sources in the country sample, and formal health insurance programs do not appear to be inherently better or worse than other health financing modalities (e.g., general revenue-financed public health services) in covering HIV & AIDS services.

b. Health insurance is a mechanism of choice either for countries with operational health insurance systems already in place or for countries in the process of implementing a policy preference for health insurance as a universal coverage mechanism.

c. While financial concerns like resource share, cost effectiveness, and efficiency are important, political commitment is indispensable to achieving this financing transition.

The report concludes by suggesting that while studying insurance mechanisms at the country level is important to understanding how the HIV & AIDS-related cost, population, and/or service coverage can be extended, there is little reason to believe that these mechanisms are the best or only means of doing so. This raises important questions regarding the ‘transition’ of HIV & AIDS services, especially in high-burden and low-income countries, towards greater integration with domestic health financing mechanisms for long term financial sustainability.

UNAIDS has recently commissioned additional work on a policy brief to provide further guidance on integration, including conditions which make financing integration more or less feasible or desirable and potential best practices in designing and implementing such integration. The brief is to be followed by two more in-depth country cases that will investigate the historical and political processes that led to integration and help identify constraints, successes, pitfalls, and overall lessons relevant for integration attempts elsewhere.

Other issues related to financing integration

Differences across low and middle-income countries. Even with substantial increase in domestic resources, the HIV & AIDS response in low and lower middle income countries is going to remain overwhelmingly externally funded. In 12 PEPFAR countries, the funding gap would range from nearly 90 per cent of resource needs for Ethiopia and Rwanda to nearly one-third in the case of Nigeria (Results for Development Institute, 2013). For upper middle income countries in the sample (Botswana, Namibia, and South Africa), the funding gap would disappear if public expenditure increases to meet both the Abuja Target and the DALY Share (as explained in Section 1). From a public finance point of view, it is important to note that the scope for integrating HIV & AIDS financing into horizontal systems seems more feasible in upper middle income countries with larger domestic shares of HIV & AIDS spending.

Fiscal Space, HIV & AIDS Policy Design, and Integration of Financing. Fiscal space
refers to a country’s capacity “to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position” (Heller, 2005). Since the financial sustainability of HIV & AIDS response is directly linked to current and future policy choices on benefits, purchasing, and provision of AIDS services which define funding needs, policy design and fiscal space are interrelated. Policy choices affecting fiscal space in turn affect the nature and scale of the challenge of integrating HIV & AIDS financing, particularly when new HIV & AIDS infections are declining and survival rates are increasing due to ART. For instance, focusing on prevention in concentrated epidemics such as India can mean that nearly 70 per cent of allocations go towards programs targeted at high-risk groups, thereby limiting the scale of the integration challenge (Government of India, 2006). In generalized epidemics, the integration challenge is likely to be far greater. Hence, analyses of policy design, fiscal space, and country context should help determine the feasibility of integrating HIV & AIDS funding.

4. Potential focus issues and questions for TWGSF

The debate on integration of sustainable HIV & AIDS financing into national health systems is still evolving. There is, however, some urgency in having a clearer understanding of the issues especially in the context of stagnation or decline in donor resources for HIV & AIDS in future. At the same time, a significant number of low and lower middle income countries are moving towards universal health coverage, which implies a holistic approach to determining investment priorities in health. A few critical issues listed below could benefit from further attention from the TWGSF:

- **What are best practices for sequencing of HIV & AIDS financing integration?**
  For example, is integration of individual-centric ARVs the starting point? Do costing tools and means of analyzing impacts on overall benefits policies need to be developed and tailored?

- **For both the integration and resource mobilization dimension,** is there evidence of crowding out of financing for other targeted or general health interventions because of HIV & AIDS in countries that have integrated, particularly those with high prevalence? How would integration of HIV & AIDS funding impact resource tracking and financial monitoring?

- **While focusing on integration of core financing functions (collection, pooling, purchasing), should the TWGSF undertake analyses that explore the (economic) follow-on implications for integration of service delivery?** For example, what effect on average wage bills might integrating formerly-separated (and potentially higher paid) HIV & AIDS health workers?

- **Can the TWGSF help to quantify and potentially advocate for funding synergies across health (HIV & AIDS) and non-health budget sectors?** Holistic integration will require that HIV & AIDS not be treated as a discrete epidemic. For instance, how can the TWGSF assess/build evidence that might make the case for decreased overall health costs from greater integration?
• The global health community is engaged in debates about post-MDG priorities and strategies, with universal health coverage one possible post-MDG goal. As evidence and guidelines on integration of HIV & AIDS financing develop from UNAIDS and others’ work, should the TWGSF engage somehow on post-MDG plans on universal health coverage to ensure adequate attention to HIV & AIDS in such plans? “Engagement” could be at the global or country level—such as helping inform the inclusion of HIV & AIDS funding and services in South African’s burgeoning national health insurance system.
1 Introduction

As countries increase domestic funding for their HIV & AIDS programs and reduce their dependence on donor assistance, it is necessary to establish systems and processes so that transitions are smooth and sustainable, including means of monitoring transitions and ensuring transparency and accountability for commitments made by donors and countries. This is especially critical in middle-income countries where donor funding decreases and thus necessary increases in domestic funding will probably be more substantial and happen more quickly. The establishment of country ‘compacts’ could provide a workable mechanism for effective coordination between the donor community and governments.

The financing transition is a process of increasingly transferring the ownership of the AIDS response from donors to countries. This requires the adaptation and harmonization of donor implementation frameworks to country systems, aligning with annual budget cycles, medium and long term planning processes and expenditure tracking systems, and country-led strategies. The new funding model of the Global Fund recognizes this explicitly and provides the flexibility to apply over a three-year grant window to harmonize with the country’s strategic plan. World Bank’s funding for HIV & AIDS programs have largely been designed to support country level national strategic plans, as have PEPFAR Partnership Framework Implementation Plans (PFIPs).
The following section provides a working definition of donor/country compacts and shows how compact-like agreements have been used to facilitate the donor-to-national transition in HIV program implementation in South Africa and India.

2. Using Country Compacts for Donor-to-National Transition: Cases of South Africa and India

The notion of country compacts is still in an evolutionary stage. Initial work has focused on the characteristics of existing financing agreements between countries and donors and guiding principles that can be drawn from these experiences (Results for Development, 2013).

A country compact is an explicit agreement between a country’s government and one or more donors that outlines programmatic and financial commitments made by one or both parties to the country’s AIDS program, and specifies mechanisms to hold parties accountable to the provisions contained therein (Results for Development, 2013). Currently, such agreements are donor-specific and are often negotiated separately to conform to the financial management norms and regulations of each donor. Moreover, the funding instruments and associated agreements often vary across donors—for example, the World Bank negotiates loan or credit agreements with counterpart Ministries (usually the Ministry of Finance), PEPFAR’s frameworks are with National AIDS Councils or Ministries of Health, while the signers of Global Fund agreements include civil society representatives. Systematic review of country compacts with the World Bank, Global Fund and PEPFAR reveal a plethora of such arrangements instruments (Results for Development, 2013).

Going forward, improvements in the design and implementation of compacts may help manage the transition process from donor to domestic financing, especially in middle income countries. We present two case studies for the TWGSF to consider: a) The transition outlined in PEPFAR and South Africa’s Partnership Framework Implementation Plan (PFIP) and b) Handover of AVAHAN interventions to the National AIDS Control Program in India. These two cases highlight the importance of coordination, harmonization, transparency, and monitoring in achieving the desired objective of the transition and ensure sustainability.

Case 1: South Africa – Establishment of PFIP with PEPFAR
[Case adapted from UNAIDS, 2013, Box 3]

South Africa has the largest HIV epidemic in the world with approximately 5.7 million people living with HIV. After several years of low domestic prioritization and underinvestment, the Government’s allocations for HIV & AIDS increased significantly from 2008 onwards. Over US$1.5 billion was spent in 2009/10 – more than in any other low- and middle-income country. Between a quarter and one-third of the total resources came from donors, with domestic resources making up the majority of total expenditure on HIV & AIDS in South Africa (Results for Development, 2013).
In terms of establishment of a formal PFIP, South Africa is an important case to analyse. The government is already financing the majority of the AIDS response, but there is a large PEPFAR program spending about $500 million annually (see below) and contributions from the Global Fund—the third largest AIDS financier in South Africa—were estimated at $US 82 million in 2012. As the largest economy in sub-Saharan Africa with the highest burden of HIV globally, a successful PFIP would set the stage for replication of similar agreements in other countries.

PEPFAR efforts began in South Africa in 2004 and scaled up rapidly, going from an allocation of $89.3 million to US$483.7 million in 2012 with a peak of US$590.9 million in 2008. In its first five years of operation, there was a six-fold increase in allocations through PEPFAR. In the re-authorization of PEPFAR in 2008, the focus and scope of the program shifted from an expansion of treatment to that of building and sustaining health outcomes and systems, aligning them more closely with national priorities (Government of South Africa, 2012). It is in this context that a Partnership Framework (PF) was negotiated and signed in 2010 and a Partnership Framework Implementation Plan (PFIP) drawn up for 2012/13 – 2016/17 to provide the operational guidelines for the broad strategy outlined in the PF.

In the PFIP, the two governments agreed that PEPFAR assistance would decline gradually from $US 484 million in 2012 to $US 250 million by 2017, while the government of South Africa would increase its financial commitment from $US 1.2 billion to $US 1.9 billion over the five year period. Programmatically, PEPFAR’s role would transition from one of direct service delivery to technical assistance. Broad targets were also established for specific program areas such as treatment, male circumcision, and orphan care.

There have been significant challenges, but South Africa and PEPFAR’s experience with the PFIP has been largely positive so far. Despite national budget constraints, South Africa’s National Treasury was able to prepare for the PEPFAR transition by allocating additional funds to the national HIV budget. As ART service delivery was a main transition area in 2012/13, the South African Department of Health and PEPFAR agreed on which PEPFAR backed ART services would be absorbed by the government to minimize disruptions in treatment services.

PEPFAR and the government are also working towards joint planning and budgeting—a main objective outlined in the PFIP. In early 2013, the four joint PEPFAR and government work streams under the PFIP (Prevention, Care and Treatment, Orphans and Vulnerable Children, and Health Systems Strengthening) met to go over and, in some cases, adjust budgetary allocations in PEPFAR’s Country Operating Plan (COP) for 2013/14. Further government involvement is expected in PEPFAR’s 2014/15 COP planning.

Challenges throughout the PFIP implementation process have included: less than ideal capacity on both sides to find the time to engage in joint planning; concerns by both parties about sharing full financial information; lack of tools, templates, and processes to share information even when concerns about sharing can be alleviated; finding ways to engage provincial level leadership; and difficulties in securing additional government funding for AIDS in the context of a constrained national budget.
Case 2: India - Transition from AVAHAN to National AIDS Control Program

[Abridged and adapted from Sgaier, Ramakrishnan, Dhingra et al (2013), How the Avahan Prevention Program Transitioned from Gates Foundation to the Government of India, Health Affairs 32 (7): 1265-1273]

The Government of India responded to the threat of an expanding HIV & AIDS epidemic by launching the first phase of the National AIDS Control Program (NACP-1) in 1992 with a budget of US$84 million almost wholly funded by the World Bank. This was followed by NACP-II in 1999 with an increased budget of US$236 million, of which 80 percent was provided by the World Bank and other donors such as DFID, European Union, and SIDA.

In 2003, the Bill & Melinda Gates Foundation launched its AIDS initiative in India, the Avahan program, to expand the reach of prevention efforts aimed at the most-at-risk populations and other at-risk groups—specifically, the male clients of sex workers and long-distance truck drivers. The Avahan program focused on six ‘high-prevalence’ states of India which had 83 percent of the national HIV burden, complementing the Government of India’s efforts and distributing the focus areas among Avahan and NACP to avoid duplication.

The Avahan program (and agreement donor and recipient government) was different from the funding arrangements used in the World Bank and a majority of Global Fund agreements, where government ministries are the counterparties. AVAHAN did not transfer funds to the Government’s National AIDS Control Organization (NACO) in the first phase, but rather negotiated an implementation arrangement to execute the program directly through contracts to NGOs and community-based organizations on the ground. The major institutional innovation for NACP-II had been the establishment of State AIDS Control Societies (SACS). These were responsible for implementation of the national strategic plan as per the needs of the respective states and funds were allocated on the basis of annual implementation plans. Avahan utilized this devolved structure to formulate state-level Memoranda of Understanding with SACS to coordinate implementation of targeted interventions for high risk groups. In the transition phase, however, it funded institutional structures at the national and sub-national levels to ensure better planning and coordination.

The total budget of the first five year phase of Avahan (2003-08) was US$268 million with the proviso that the program would be phased out and handed over to the government after reaching its objectives of scale-up. By the end of 2007, the Avahan program had achieved its main target of reaching 80 percent of most-at-risk population with HIV prevention services. It had also established Technical Support Units to provide national and state level program guidance, and supported the government to draw up the strategic plan for NACP-III (2007-12) drawing on the lessons learnt from Avahan’s implementation experience.

The transition plan had three major components: policy planning and development, financing the plan, and managing and implementing the program during transition. For the first component, the government recognized the importance of strong political commitment, evidence-
based strategic planning, focusing on prevention of HIV among high-risk groups, and technical capacity building within NACO to achieve significant scale up in a short period of time. There was no conflict of interest between the two sides as far as the overall objectives of the program were concerned.

Regarding financing of the transition plan, it was important to harmonize the cost of service provision between Avahan and NACO, the former being significantly higher. This is true of many donor supported programs across the world, which need to be re-aligned with domestic program cost structures (especially health worker salaries) that are usually lower. An attempt to transition health workers from donor-funded clinics with higher salaries towards public health centers with lower pay can lead to attrition and loss of institutional knowledge and capacity which works to the detriment of the program in the long run. To avoid this, BMGF allocated an additional US$ 90 million for the transition period between 2008-12. This gave time to the Government of India to formulate its post- transition human resource strategy and harmonize salary and other delivery related costs to sustainable levels.

Finally, it required considerably enhanced technical and managerial capacity for NACO to scale up its own program as well as absorb Avahan’s share of the program interventions at the same time. This required considerable coordination and collaboration between NACO and Avahan among both partners to upgrade skills in data driven management, field supervision, guideline development, training tools, financial management and monitoring. The process was highly successful – by 2010, NACO was implementing over 1600 high risk group interventions, nearly doubling the number of interventions from 2006 (at the start of the transition phase). Monitoring of individual interventions showed that there were no adverse impacts of the transition on key indicators, implying that the ‘compact’ was implemented successfully on all sides (Sgaier et.al.2013).

The key lesson from Avahan’s ‘compact’ with Government of India is that it is critical to harmonize objectives, processes and systems on both sides, giving a greater stake for countries to lead a successful transition. Moreover, the transition takes time—it has to be planned in well in advance with ample margin for mid-course corrections if needed.

[Abridged and adapted from Sgaier, Ramakrishnan, Dhingra and others (2013), How the Avahan Prevention Program Transitioned from Gates Foundation to the Government of India, Health Affairs 32 (7): 1265-1273]

3. Cases’ linkages to other dimensions of sustainable financing

There are certainly overlaps and connections among the four dimensions introduced by this brief and proposed for discussion in TWGSF’s first meeting. The following table concludes the brief by highlighting some linkages between the previous two country compact cases and the previously-discussed dimensions, including fair share and global solidarity, resource mobilization, and integration into health financing systems.
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<tr>
<th>INDICATOR</th>
<th>SOUTH AFRICA</th>
<th>INDIA</th>
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<tbody>
<tr>
<td>Fair Share</td>
<td>South Africa is an upper middle income country and an economic power in the region. Its domestic share of HIV spending would increase from 64 to nearly 80 per cent as PEPFAR funding decreases over the next five years.</td>
<td>Share of domestic resources went up from 10 per cent in NACP-II (1999-06) to 25 per cent in NACP-III (2007-12) while the overall resource envelope increased 5 times from $458 million to $2.5 billion. Gov’s contribution increased by over 13 times in absolute terms implying strong commitment for HIV financing.</td>
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<td>Global Solidarity</td>
<td>PEPFAR ensured rapid scale up of treatment at a time when the government’s commitment was low, with significant increases in funding between 2004-8. PEPFAR allocations have been stable thereafter, funding nearly 25 percent of the total program.</td>
<td>The number of stakeholders for NACP-II increased significantly and laid the groundwork for a comprehensive response. Avahan managed to leverage the institutional structures at the sub-national level and demonstrated the feasibility of a nationwide scaled up response.</td>
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<tr>
<td>Resource Mobilization</td>
<td>No earmarking or use of innovative tax instruments for HIV resource mobilization. Period of economic growth and rising mineral prices aided domestic fiscal health, but line ministries still face budget cuts in 2013-2015. But health has been protected from cuts and AIDS budget is increasing, in part due to PEPFAR transition.</td>
<td>Civil society activism and high political commitment ensured increasing allocation for HIV in Five Year Plan as well as annual budget of the Ministry of Health to support the scale up after Avahan transition. Department of AIDS Control was established within the Ministry of Health, thereby ensuring sustainability of HIV policy and financing in the future.</td>
</tr>
<tr>
<td>Integration of AIDS financing into national health financing systems</td>
<td>PFIP shifts the strategic focus of PEPFAR from service delivery to health systems strengthening and technical support, and its objective would enhance integration of HIV services to improve efficiency of the national response. However, little focus to date on potential challenges of integrating HIV financing and delivery into future National Health Insurance. May signal need for HIV-focused analysis and piloting in NHI design phase.</td>
<td>NACP-III disaggregated and costed the HIV services in the targeted prevention package as part of the transition compact, with the objective of integration of some of the services into health system. Still a work in progress.</td>
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These two cases illustrate just some of the issues arising in ensuring smooth HIV financing transitions between donors and countries. As more countries embark on their own HIV financing transitions, it could be useful for the WGSF to provide technical guidance on the economically-informed principles, best practices, and tools/mechanisms that would enable strong compacts for smooth, sustainable transitions.

UNAIDS is currently supporting a research effort that is creating an inventory of compacts/agreements used by the largest HIV donors and analyzing those for best practices (preliminary results to be presented in the TWGSF first meeting). That work will begin to shed light on questions such as:

- **What is the optimal length/duration of compacts?**
- **How many and which actors should be included in compacts?**
- **What kind of financing targets should be included, and what principles, processes, and tools are used to determine these?**
- **What monitoring and evaluation mechanisms are necessary and feasible?**
- **What are the consequences of either countries or donors not meeting the conditions of the agreement?**

Following the initial study, the TWGSF could consider fine-tuning guidance on these questions based on greater access to various donors’ and countries’ experiences, processes, and constraints. More generally, however, the TWGSF may wish to consider the following for this dimension:

- **What is the overall record to date for HIV-financing transitions where they have occurred?** What have been the final outcomes and what are the lessons to be learned from these experiences?
- **What is (or should be) the role of country compacts in ensuring a sustainable financing policy for HIV programs?** How can elements of these compacts be differentiated according to investment priorities, domestic funding needs and capacities, epidemiology (epidemic type), and donor agencies?
- **Who are the key stakeholders for country-donor transition agreements?** What is an efficient balance between streamlining the process with fewer actors or maximizing inclusion/participation of stakeholders?
- **What role do coordination mechanisms to harmonize program delivery standards and unit costs play in country compacts?**
- **How can the parties be made accountable for their financial performance?** What instruments (annual scorecards and reports, independent verification of performance, annual review meetings, etc) have been shown to be most effective in using the results of financial monitoring to improve performance?
- **What are the key factors for minimizing risks during the financing transition process and to ensure sustainability?**
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### ANNEX 1

Key findings from pre-meeting interviews of TWGSF participants

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<th>DIMENSION OF SUSTAINABLE FINDING</th>
<th>KEY COMMENTS</th>
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<tr>
<td>Fair Share and Global Solidarity</td>
<td>There is a need to map fiscal flows by understanding country models of growth and revenue projection in the short term (up to 5 years), and clarify definitions on what constitutes public and private spending on HIV. More technical work is needed on the integration of System of Health Accounts (SHA) with Public Expenditure Reviews (PER) and moving towards separate disease subaccounts within SHA.</td>
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<td>Donor funding should have a role to play in stimulating domestic government contributions instead of displacing it. It is important to establish whether donor funding models disincentivize domestic government funding.</td>
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<td>It is important to begin to standardize how HIV contributions or resources are measured, e.g. as percentage of health or government budgets, or as share of GDP. Currently, different databases measure this differently.</td>
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<td>Need for political mobilization at the country level should not be underestimated. Allocation to health and HIV is a political decision, and high level engagement has worked better for donors in negotiating higher counterpart resource mobilization.</td>
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<td>A reasonable pathway to increasing spending is needed instead of an arbitrary spending target like the Abuja Target. The latter may be fine as an aspirational goal, but context must be taken into account to determine funding growth pathways for planning sustainable funding levels.</td>
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<td>Defining and standardizing how recipient fair share is to be understood and calculated is really important.</td>
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<td>It is important not to look only at disease by disease funding which works better from a procurement perspective and not from a health system financing perspective.</td>
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Country context, revenue sources, and political situation are very important to consider for calculating fair share, although generic aspirational benchmarks may still be useful. It is important to monitor donor commitments as well.

Expanding International and Domestic Resource Mobilization

According to CHAI estimates, additional resource needs for a significant scale up in treatment from 15 to 26 million can be met within existing funding levels, provided the resources are allocated efficiently.

Sustainability depends on predictable financing which implies governments (especially ministries of finance) are clear on which partner commits what and for how long, so that the remaining can come from domestic resources. Hence, greater transparency improves efficiency and sustainability.

The discussion on financial sustainability must go beyond resource mobilization to include the effect of current policy decisions on future funding needs.

The theory and practice of public finance offer tools for assessing the sustainability of public debt. Arguably, these tools are applicable to the analysis of the financial burden posed by HIV programs. Assessing the costs of HIV programs through a lens similar to Debt Sustainability Analyses by IMF and WB, for instance, would build on an internationally established precedent to offer a criterion for motivating a need for external assistance for high burden countries.

There is a need for reliable short run projection models for greater efficiency and predictability (not necessarily standardized since ministries of finance work very differently across countries).

Given competing health priorities, it will be interesting to understand how financing needs for other health and development priorities were affected where countries have developed resources for HIV from new revenue streams.

It is important to consider new revenue sources along with the scope for reallocating existing tax revenues among sectors. Simple disease by disease revenue mobilization is not helpful as sustainable funding needs to be looked at in the context of competing health system commitments.

It is useful to consider the social determinants of health and view the issue of health promotion in totality. HIV is a socioeconomic issue as well as a health issue and overall HIV financing would need to be multi sectorial for it to be properly addressed. Health authorities can use the health promotion objective to lobby for greater resource allocation in other (non)health sectors as well. There needs to be greater emphasis on funding synergies in the HIV response instead of continuing to view budgeting in discrete silos.

Policymakers must not fall into the trap of pursuing “innovative financing” based on principal rather than practicality. To properly assess potential sources of new revenue, we must know how much revenue they can realistically raise through calculations at the country level or overall. If that potential is low, it may be better to focus on other options.
Integrating AIDS Financing into National Health Financing Systems

Integrating components of HIV programmes (HIV testing, STI management, ART delivery) with general healthcare delivery mechanisms an easier question to address than the systemic integration between vertical and horizontal programs, which is essentially a political question.

More technical work needs to be done especially in the context of payment systems both for general health insurance mechanisms as well as to demarcate service delivery costs. Fragmentation of payments for personal and institutional services creates inefficiencies and may ultimately be unsustainable.

It is important to clearly understand whether a special or a generalized HIV & AIDS service delivery structure is needed before considering financing integration. If services are primarily personal as opposed to population based (like health education, etc.), Then integrating financing makes immediate sense through a combination of domestic or donor funding.

It is important to think about financing services and interventions (like focusing on the target populations and delivery strategy) rather than entire programs for integration. A service oriented perspective is best as it keeps the focus on individuals and the service delivery interface (either at the level of the core PHC and delivery systems or specialized mechanisms to reach marginalized groups).

As HIV is integrated into the overall health system, it becomes harder to monitor which diseases have received funding because there are so many shared resources. Funds are often doublecounted as having gone to multiple diseases. The new National Health Accounts approach looks for ways to allocate tracking of shared resources to prevent this issue from occurring. Problem: this is still too slow for monitoring of partnership agreements (where answers are needed easier and faster).

Transitions from Donor to Domestic Financing: Country ‘Compact’ Case Studies

Even with a phased reduction in funding, donors should remain engaged at a policy level to ensure sustainability of the HIV response. Otherwise, the epidemic may bounce back as it did when reduced emphasis on malaria control led to re emergence in several regions.

Funding transitions should be modeled such that (i) country income should be only one determinant of the minimum threshold for domestic financing as a percentage of donor funding, (ii) the overall trend of domestic financing should be increasing, and (iii) the development of a system for health and disease spending should be a prerequisite.

Defining the term “transition” and laying it out in its entirety is important so as to resolve issues and challenges around its definition. Currently, it can mean different things to different participants (e.g. government vs. donors).

It is key that using country compact as a tool to facilitate transitions is done in a way that is not just about handing over financing. Transitions are about more than just financing; the programmatic transition that a country will have to go through must also be considered.
It is important to have a good sense of programmatic content to develop financing targets in compacts. Hence, transparency of information/data to accurately and realistically calculate financing and programmatic targets is essential. That has been a major deficit in HIV & AIDS partnership compacts as it has not been clear how financing targets are set and linked to program delivery.

The disengagement dialogue needs to also look at how donors have distorted/affected delivery mechanisms and cost structures in health markets, particularly in wages of health workers. For instance, have AIDS donors distorted health labor markets in recipient countries by bidding up wages for dedicated AIDS workers? That is a major headache for countries as donors begin to pull out.

Most country compacts are done and signed at very high official levels. At the technical/implementation level, holding partners accountable would be easier if technical professionals were involved in the designing of the compact so that monitoring tools could be put in place right away. Monitoring can become really academic otherwise.

It is useful to be very specific in discussing financing and programming for partnerships: to really identify the areas in which countries should lead and own the HIV & AIDS response, donors need to understand country budgeting and financing processes/budgetary cycles. This will be a means of identifying for everyone players who need to be involved and where. It will increase critical understanding of country programmes on part of donors, and better enable them to hold countries accountable. Hence, considering how donors can promote collaboration to produce material or conduct training to improve their mutual understanding of diverse in-country processes will enable them to ask the right questions and properly finance the correct interventions.

Publicly managed, owned, or run health systems are integral to sustainable funding of HIV. Parallel donor managed systems should therefore be integrated with local health systems.

Moving to a good balance between domestic funding and donor contributions is essential instead of just targeting transitions. We need to track domestic contribution better even though it is smaller than donor funding, as that is essential to boosting domestic HIV funding.

Policymakers should be wary of having only high level discussions of sustainable financing in the context of transitions. There is a dire need for more solid evidence of what happens on the ground as donors pull out. How often do systems and initiatives survive? There is space for considerable research on transition and measurement issues.

Instead of looking at domestic vs. donor contributions in HIV & AIDS, we may want to look at how well countries are spending their own funds independent of donor money. Are they spending according to disease burden or by other priorities? Donors can incentivize good spending by offering additional funding for those programmes. [Note: this would be a theoretical exercise because donor and government funding are not often not separate]
The history of AIDS financing is important to understanding and planning sustainability. Since partners initially rushed in with funds without planning for long run sustainability, developing programming and funding capabilities in recipients is important before donors wind down. Merely raising new domestic resources will not wean recipients off of donor support.

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<tr>
<th>NAME OF KEY INFORMANT INTERVIEWED</th>
<th>AFFILIATION</th>
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<tr>
<td>Elya Tagar</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>Joseph P. Kutzin</td>
<td>World Health Organization (not a member of the TWGSF)</td>
</tr>
<tr>
<td>Markus Haacker</td>
<td>London School of Hygiene and Tropical Medicine</td>
</tr>
<tr>
<td>Michael Borowitz</td>
<td>Global Fund</td>
</tr>
<tr>
<td>Nandini Oomman</td>
<td>Independent analyst; ex CGD AIDS Monitor</td>
</tr>
<tr>
<td>Regina Ombam</td>
<td>Kenya National AIDS Control Council</td>
</tr>
<tr>
<td>Stephen Resch</td>
<td>Harvard School of Public Health</td>
</tr>
<tr>
<td>Teresa Guthrie</td>
<td>Independent analyst South Africa</td>
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<tr>
<td>Mead Over</td>
<td>Center for Global Development (not interviewed, but participated by sharing documents)</td>
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ARE ENDING AIDS 2030 AND UHC POLICY OBJECTIVES JOINTLY ATTAINABLE IN SADC? A FISCAL PERSPECTIVE
DISCLAIMER:

These reports are published as they were reported/presented during the ERG or ERG/TWG meeting.
ARE ENDING AIDS 2030
AND UHC POLICY
OBJECTIVES JOINTLY
ATTAINABLE IN SADC?
A FISCAL PERSPECTIVE

Produced by: Oxford Policy Management (OPM) - APW with UNAIDS (thru TSF) 2014/410408
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The Southern Africa Development Community and its Member States are committed to the twin policy objectives of Universal Health Coverage and Ending AIDS in 2030. However, the funding landscape for health and HIV will change dramatically over the coming 15 years. This paper explores how changes in funding sources impact on countries’ ability to achieve UHC and HIV policy goals.

We first examine the SADC political, epidemiological and economic context. We then determine the cost of achieving UHC and Ending AIDS in 2030, separately and combined (taking a HIV within UHC perspective), and benchmark this cost against the fiscal space for health and HIV generated over the next 15 years by the current funding strategies of SADC Member States. We conclude that this would leave Member States short of financial resources to achieve universal coverage for health and HIV. We then explore which fiscal policy initiatives Member States can take to increase fiscal space for health and HIV. We find that a combination of reprioritisation of government spending towards health and HIV, expansion of fiscal space earmarked to health and HIV, and technical efficiency savings yield more than enough resources to achieve health and HIV resource needs combined. However, a great variation exists across SADC Member States, and some countries will not be able to generate sufficient resources to achieve these policy goals.

1 Political, Epidemiological and Economic Context

1. The SADC is a political institution through which Member States cooperate, negotiate and collectively determine legislation and policy. It has the sway to operationalise regional agreements and, thereby, to guide national-level policy making, planning and budgeting efforts. The institution
can be instrumental in supporting health and HIV financing policy reform across the region.

2. Differences in life expectancy, maternal, infant and under-5 mortality, HIV prevalence and incidence, immunisation coverage and the percentage of births assisted by trained health workers, reflects the variation of both the epidemiological profiles and the capacity of the national health systems to address population health needs. This implies that the path to universal coverage of health and HIV services will vary across countries.

3. HIV & AIDS, TB and malaria remain the largest contributors to morbidity and mortality across SADC. The region continues to experience the most severe HIV prevalence in the world and the world’s top nine most highly infected countries are SADC Member States. Tuberculosis is experiencing a resurgence in the region as a result of the HIV epidemic and eight SADC Member States are among the fifteen countries with the highest TB incidence rate in the world. Malaria is endemic across the remaining seven SADC Member States and 75% of SADC’s population is at risk of contracting malaria.

4. SADC Members States have made significant progress in tackling these communicable diseases. The number of people enrolled onto antiretroviral therapy (ART) has increased tenfold between 2005 and 2012 and the rate of new HIV infections has been reduced by more than 30% across the region as a whole and by more than 50% in seven Member States. Progress against TB has been less dramatic and the burden of TB remains high, however the TB epidemic appears to have matured in most Member States. By the end of 2010, six Member States had recorded greater than 50% reductions in the burden of malaria.

5. At the same time, non-communicable diseases (NCDs) such as heart disease, diabetes, and cancers are rising rapidly. Influenced by rapid urbanisation, changing diets and improvements in the control of Communicable Diseases the WHO projects that NCDs will become the leading cause of ill health and death in the region by 2030. However, today a mixed picture emerges when looking at the contribution of non-communicable diseases to DALYs across Member States, reflecting the varying stages of epidemiological transition within their populations.

6. Africa’s economies are growing rapidly and Africa’s economic growth has been remarkably resilient, even in the face of an uncertain global economy. Over the past decade Africa has been the second fastest growing region in the world with an average annual GDP growth rate of 5.1%. In 2006, 13 African countries were categorised as middle-income. By 2013, that number had climbed to 211. Between 2013–2023 Africa’s GDP is expected to grow by an average exceeding 6% per year – outstripping that of any other world. If projected growth is achieved, another 10 countries will attain middle-income status by 2025, raising the total number of Africa’s middle income countries to 31 of 54 – almost triple that of 2006.

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7. While the SADC Member States pursue regional integration and economic convergence they exhibit vast differences in size, scope and level of economic development. South Africa is the 27th largest economy in the world while the Democratic Republic of the Congo (DRC), Malawi, Mozambique and Zimbabwe are among the world’s smallest. Similarly, their income structures vary, with four SADC Member States disproportionately reliant upon income from the Southern African Customs Union (SACU).

8. Projected economic growth in SADC remains strong overall, with high variability between Member States, ranging from a real growth rate of 2% (Angola) in 2019/20, to 7% (Malawi, Mozambique). Between-country differences in economic development will have to be acknowledged when elaborating a joint SADC wide framework for action.

9. Positive economic prospects are further supported by a demographic transition. Falling birth rates and associated decline in the dependency ratio combined with an increase in the working age population offer the opportunity of a demographic dividend that supports SADC’s growth in the coming decades.

**2 Health and HIV Expenditure Trends**

10. The real Total Health Expenditure (THE) is 163 USD per capita on average throughout the region in 2012/13 but there’s a high variation between Member States. THE is over 400 USD per person in Seychelles whilst 8 USD per person in Congo DRC and Madagascar. Putting this into economic context, THE amounts to 7.8% of the regional GDP. Lesotho spends the most at 12.9%, followed by Malawi at 11.3%, and Namibia, South Africa and Swaziland with just less than 10%. Angola, Congo DRC, Madagascar, and Seychelles all spend less than 5% of GDP on health.

11. Overall 82% of health care financing comes from pooled domestic sources, with 46% from governments, and 36% from the private sector (mostly voluntary health insurance). Only 11% is from out of pocket (OOP) spending and 7% from external funding.

12. However, excluding South Africa, the remaining 14 countries have a donor dependency of 20% and out of pocket spending of 20%, with a further high variation in funding sources by income status. Longer term sustainability of financing for health and HIV is therefore an important challenge in the region, certainly in light of UHC and Ending AIDS 2030, which both require sustained and high levels of expenditure. Low income SADC countries on average have government health expenditure of only 23% of THE. Donor dependency is 36% and OOP spending is 24% of THE. Lower-middle income SADC countries government contribution to health is higher at 42% and they depend on donors for 25% of their THE; and OOP is still relatively high at 21% of THE. The upper-middle SADC countries fund 88% of THE from domestic sources – 48% from Government and 40% from the private sector. Only 2% comes from donors and OOP expenditure is low at 9%.
13. On average SADC countries allocate 8.3% of general government expenditure to health, but with high variability between countries. The governments of Namibia, South Africa, Swaziland, and Lesotho all spend 12-14% of their budget on health. Mozambique and Tanzania spend less than 3%.

14. The average spent on HIV/AIDS per capita, using a disease burden approach, is 152 USD, with great variability across the SADC countries. Botswana, Mauritius and Namibia all have relatively high expenditures at over 300 USD, whilst Madagascar, Malawi and Mozambique spend less than 30 USD per capita.

15. 42% of total HIV expenditure in SADC is funded by international donors. Excluding South Africa, donor contributions rise to 63%, making the HIV Response highly donor dependent. Half of all HIV/AIDS spending in SADC is from government budgets. Excluding South Africa, the share of government spending in total HIV spending falls to 1/3.

16. SADC governments contribute proportionally more on HIV/AIDS as their incomes rise. In low income countries the share of public spending in total HIV/AIDS expenditure is 20%, rising to 30% for lower middle income countries, and 73% for upper middle income SADC countries.

17. Donor dependency declines as income rises. Low income countries are currently reliant on external financing for HIV/AIDS by almost 80%, this declines to two thirds for lower-middle income countries and to 20% for upper middle income countries in SADC.

18. The average spend on HIV/AIDS across SADC accounts for 0.35% of GDP and 1.3% of the budget. However, the priority given to HIV in budget allocation varies significantly across countries. In general a governments’ contribution to HIV/AIDS rises with income, however there are exceptions. Angola and Mauritius spend much less than the upper middle income average; Tanzania and Zimbabwe spend significantly more than the low income average; and Botswana, Lesotho and Namibia spend a relatively large proportion on HIV/AIDS: around 5% of their national budgets go to HIV/AIDS, reaching over 1% of GDP.

19. Resch’ DIPI averages 0.8 across SADC. The DIPI by income group shows that there is some greater prioritisation towards HIV/AIDS as incomes rise, however, there is still important variation across this trend. Eight SADC countries have a low DIPI (less than 0.3) and these are scattered throughout the income groupings; four low income countries (Congo, Madagascar, Malawi and Zimbabwe); one lower middle income country (Zambia); and three upper middle income countries (Angola, Seychelles, and South Africa). It is clear that a higher GDP per capita does not necessarily equate to a greater proportional amount spent on HIV/AIDS needs.

20. To protect HIV spending from decreasing donor support, it should be more closely linked to health

\[ \text{Resch DIPI} = \frac{\text{GAE}}{\text{GHE}} \times \frac{\text{AIDS DALYs}}{\text{TOTAL DALYs}} \]
spending. Across the SADC government contribution to health and HIV are not necessarily linked to income. And spending on health is not necessarily linked in a particular way to spending on HIV. Donor dependency in HIV is more than 6 times that in health; 42% compared to 7%. Therefore the expected decline in external funding for HIV in the coming years is expected to affect all SADC countries to a great extent, and may have a more substantial impact on HIV sector. It is important then to consider how health and HIV expenditures can be linked in an attempt to shelter HIV within the Universal Health Coverage agenda.

3 Resource Needs

21. The projected HIV resource needs amount to an average of 9.3 billion USD per annum across the region, peaking in 2019/20 before declining slightly to 2029/30, but the variability of resources required for HIV is high between Member States. For HIV resource needs we have used those supplied by UNAIDS covering the period 2015-2030 for SADC Member States. This equates to 0.8% of the total GDP for the region, and declines in real terms over the projection period from 1.1% to 0.4%. However, the variability between SADC Member States is high: the resource needs for low and lower-middle income countries is a much greater burden on their economies – averaging almost 2.5% of GDP. For upper middle income countries this averages 0.8% of GDP.
22. Unlike resource needs for HIV, those for health are projected to continue to rise every year over the next fifteen years: from 50 billion USD to 156 billion by 2029/30. This would account for 7.1% of the regional GDP, with the higher burden falling disproportionately onto poor Member States. For health resource needs we use a normative framework based on recent research that estimates the cost of Universal Health Coverage (UHC) for a basic package of health services, expressed as a double target: either public health funding of 5% of GDP but not less than 86 USD (2012 dollars) per capita. The latter condition is added in the knowledge that even if some low-income countries spend 5% of GDP on health, they would not reach US$ 86 per capita. Disaggregating this by income status gives a slightly different finding from the HIV/AIDS resource needs. For HIV, the cost of dealing with the epidemic is high (as a proportion of the size of the economy) for both low and lower-middle income SADC countries. The cost to fund UHC in health, however, impacts disproportionally low income SADC countries, in which the economic burden is double that of the lower- and upper-middle income SADC countries.

TOTAL HEALTH RESOURCE NEEDS IN SADC (M USD) AND BY INCOME STATUS (AS % GDP)
23. The combined health and HIV resource needs are projected to move from 54 billion USD in 2015/16 to 141 billion by 2029/30. This would account for 6.7% of the regional GDP over the time period, with the heavier burden falling onto lower-income Member States. To create a scenario where HIV resource needs are combined with health resource needs we need to consider how much of the UHC package is HIV-related, and how much of the HIV needs are health related. The combined health and HIV resource needs are less than if simply adding health and HIV needs together as we have attempted to extract any duplication. This means that on average throughout the region the share of UHC resource needs allocated to HIV, more than cover the total UNAIDS HIV resource needs.

4 Resource Gap with Current Funding Strategies

24. If SADC Member States do not take additional initiatives to fund HIV and health, i.e. they would continue to rely on the current sources of funding, they will not mobilise enough resources to meet the HIV, health and combined health and HIV resource needs, and not be able to meet the UHC and Ending AIDS in 2030 policy objectives.

25. For health, a business as usual funding strategy provides a resource gap which averages 25 billion USD a year over the next fifteen years, reaching almost 34.5 billion USD by 2029/30, accounting for 1.9% of the regional GDP and 6.9% of the total governments’ budget across the member states. But there’s a high variability across the region. South Africa is the only country without a gap, and it is projected that it could cover its health needs with a surplus of 0.3% of GDP. DRC and Tanzania have the largest nominal gaps; 7.7 and 6.1 billion USD, respectively. Relative to the size of the economy it is Malawi that has the greatest burden with the resource gap at 20% of its GDP. Madagascar has a large burden accounting for 12.5% of GDP and DRC’s gap is 10.5% of GDP. The rest are less than 10% with Tanzania and Mozambique both over 5% (8.6% and 6.9%, respectively). In terms of government national budgets Malawi, Madagascar, DRC, and Tanzania have a substantial health burden of more than 40% of their budgets and in Malawi’s case this is averaging 84% of the projected available budget. The gaps for Mozambique, Lesotho and Zimbabwe are over 10% of their budgets. The remainder are less than 10%.

26. For HIV, the resource gap averages 3.2 billion USD a year over the next fifteen years, peaking at almost 4.7 billion USD by 2019/20, accounting for 0.3% of the regional GDP and 1.0% of the total governments’ budget across the member states, again with high variation across countries. Namibia and the Seychelles are the only countries to have a surplus for HIV/AIDS, averaging 0.3% and 0.2% of GDP pa, respectively. This means that technically there are enough funds to cover HIV/AIDS needs but this will depend upon allocation. Mozambique has the largest nominal resource gap at 0.9 billion USD pa. In relation to their economy the greatest burden falls on Malawi (2.9% of GDP), Mozambique (2.2%), Swaziland (1.7%)
and Zimbabwe (1.2%). The remainder have a gap of less than 1% of GDP. Those greater than 0.5%, in order of magnitude, are Zambia, Lesotho, Botswana, and Congo DRC. Countries with greatest difficult in terms of ability to pay from the budget are Malawi and Madagascar where the gap is greater than 10% of their budget. Swaziland is 7%, the remainder are less than 5%.

**F.3**

**SADC REGIONAL HIV/AIDS RESOURCE GAP M USD AND AS PERCENTAGE OF GDP AND BUDGET (2015/16 TO 2029/30)**

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![Graph showing SADC regional HIV/AIDS resource gap from 2015/16 to 2029/30, with bars indicating the gap in millions of USD and as a percentage of GDP and budget for each year.](image)
27. The resource gap for health and HIV combined averages 28.3 billion USD a year over the next fifteen years, reaching 35.7 billion USD by 2029/30. This would account for 2.2% of the regional GDP and 7.9% of the total governments’ budget across the member states. The burden over time is declining as economies grow. South Africa is the only country without a gap, it is projected that South Africa could cover its HIV/AIDS and UHC needs with a surplus of 0.2% of GDP. This means that technically there are enough funds to cover needs but this will depend upon allocation. DRC and Tanzania have the largest combined HIV/AIDS and UHC gaps in the region; 8.1 and 6.4 billion USD pa, respectively. As a proportion of the economy Malawi has the largest burden with 24% of GDP pa projected to be not payable out of current budget allocations and donor funds. Madagascar, Congo DRC, Mozambique and Tanzania all have a resource gap at around 10% of their GDPs. The remainder of SADC countries have a gap of less than 5% of GDP. Malawi’s combined HIV/AIDS and UHC resource gap is projected to equate to its entire budget – 96% on average over the 15 years. Other countries with a serious challenge to paying for UHC through domestic means, in order of magnitude, are Madagascar, Congo DRC, Tanzania, and Mozambique, all have a resource gap over 40% of their budgets.

28. All of the SADC countries will be struggling to provide UHC with or without HIV over the next fifteen years. Some of these countries need to alter their current allocations to ensure UHC is provided; others may need a substantially greater prioritisation of health and HIV to achieve the goal of UHC including HIV.

29. 29. While some countries are expected to have enough fiscal space for HIV alone from 2020/21 onwards, the HIV resource needs methodology assumes that expenditure on HIV is frontloaded, i.e. a higher investment is made in the period 2015-2020, in order to maximise population benefits and to keep total costs at a minimum. During this period, all SADC Member States face a funding gap with a funding strategy of ‘business as usual’.

5 Funding Gap after additional fiscal policy initiatives

30. SADC as a whole can generate enough additional fiscal space from reprioritisation of public spending towards health and HIV, additional taxes with proceeds earmarked to health and HIV, and increased efficiency of health and HIV service delivery to plug the combined financing gap. However, even these strategies will not allow some Member States to generate enough resources to meet the UHC and Ending AIDS 2030 policy objectives. Efficiency savings, budgetary financing (reprioritisation) and earmarked financing could cover the UHC and HIV needs throughout the region by 2019/20. However, DRC, Madagascar, Malawi, Mozambique and Tanzania will not find enough resources to close the gap before 2030.
31. Reprioritisation of public spending towards health and HIV follows benchmarks that are both politically and economically feasible. Once these reprioritisation targets are set the new resource gap is 13 billion USD smaller on average per year over the projection period. As a proportion of the regional economy the resource gap could fall from 2.2% of GDP to 1.4% pa over the fifteen years. For upper middle countries this single policy action of raising budgetary allocation may almost eradicate the resource gap by 2029/30. Their average gap in 2029/30 is only 0.5% of GDP. For lower middle income SADC countries the policy to raise the health and HIV/AIDS budgets will reduce the gap to 1% of GDP. And the gap is not being addressed immediately by this policy, as in the near term it remains at 3% of GDP. For low income countries the policy halves the resource gap from 15% to 7% over the fifteen years. However, this gap of 7% of GDP remains a significant burden and there simply is not enough money in national budgets to meet the combined UHC and HIV/AIDS resource needs. However,
even within country income groups there is important variation: Zimbabwe is a low income country but should be able to raise enough domestic resources to cover all its UHC and HIV/AIDS needs in 2029/30. Zambia is the only lower middle income country with the potential to cover its UHC and HIV/AIDS needs by 2029/30. It is only Angola and South Africa in the upper middle group that may be able to cover their UHC inclusive of HIV/AIDS needs by 2029/30.

32. Earmarked taxes, which expand existing tax regimes on specific sectors, such as alcohol, tobacco, airline and mobile phone industry, or increases in headline personal, corporate and indirect taxes, have the potential to bring 7 billion USD a year to the region in the short turn. The policy option to reprioritise funding shows that over time many countries can be expected to self-fund through general taxation measures as growth and tax reform continues. However, in the short term the current tax systems cannot sustain the needs of the sector for the simple reason that tax reforms, leading to increased revenue collection and increased public expenditure, take time. This is the equivalent of an additional 0.5% of GDP for each country to go towards UHC inclusive of HIV, and so reduces SADC country’s resource gap by this amount. As the HIV Response relies on front-loading expenditures, to increase effectiveness and efficiency, this option is particularly attractive.
33. A potential 13 billion USD a year is projected to be captured by efficiency savings in health and HIV⁴. Simply defined, inefficiency refers to a failure to obtain maximum outputs for a given level of investment. What is important for efficiency is not simply the cutting of costs but increasing the impact of spending and improving the efficiency with which funds are spent. The emphasis, therefore, is fundamentally on value for money, i.e. containing or reducing costs without reducing outcomes or, better yet, achieving better outcomes for the same level of investment.

⁴ The methodology used to estimate the magnitude of potential savings from imposing efficiency measures is based on international comparative performance via a Data Envelope Analysis (DEA) (Wu Zeng, 2014, for both health and HIV separately)
Summary policy implications

36. From a purely fiscal perspective, the current funding strategies will not achieve the related policy goals of UHC and Ending AIDS in 2030, but additional fiscal policy initiatives can be taken to decrease the funding gap. Despite high level political commitment to UHC and Ending AIDS in 2030, the current financing strategies for both health and HIV will not attain these objectives. However, a combination of reprioritisation of public spending towards health and HIV, earmarking revenue from innovative taxes, and increasing the efficiency of health and HIV service delivery, will allow the region to generate enough resources.

37. Some SADC countries are not able to mobilise enough fiscal space over the coming 15 years for UHC and Ending AIDS in 2030, and most countries face a funding gap for HIV specifically over the next five years, jeopardising an effective and efficient delivery of the
HIV response assuming frontloading of expenditure. While the region as a whole can generate enough fiscal space for UHC and Ending AIDS by 2030, some Member States won’t be able to do so from within their economy. Most SADC Member States also face a funding gap for HIV in the short term. This sits at odds with the logic underpinning the Ending AIDS 2030 strategy, which is based on frontloading expenditure, to increase effectiveness and keep overall costs down. HIV and AIDS being the leading cause of mortality in the region begs the question whether particular attention should be given to plugging the HIV funding gap in the short term.

38. There’s a strong case for borrowing for HIV. As economic growth is expected to remain strong over the coming 10 years, the HIV funding challenge (which is independent of economic growth, but characterised by frontloading for maximum efficiency and effectiveness) is one of imbalanced distribution of fiscal space over time. A boost of expenditure on HIV is required in the period 2015-2020, whereas fiscal space from economic growth starts to pull through only from 2020. This makes a strong case for borrowing.

39. Some SADC countries face no resource gaps at all. This simply means that, on the whole, enough financial resources are available in the system to achieve UHC and Ending AIDS 2030, it does not imply, however, that UHC and Ending AIDS in 2030 will be achieved. This depends on other factors not assessed in this study, such as distribution of public expenditure across population groups and health and HIV services, which are often skewed against poorer population groups, and in favor of services that are not cost-effective.

40. There is a high variation across Member States in terms of economic development, epidemiological profiles, priority given to health and HIV in public financing and the resulting health and HIV funding gaps. Even as some patterns emerge as economic development increases, paths to UHC and Ending AIDS 2030 are highly context specific.

41. However, even if between-country variation is high, the path to UHC and Ending AIDS 2030 has some generic building blocks. The SADC can build on those and take a number of initiatives that will help individual Member States to develop national strategies within a regional approach that aims to increase convergence of health systems and outcomes over time:

1. Defining a package of cost-effective services

In an ideal world enough financial resources are available to meet the funding challenges set by the UHC and Ending AIDS 2030 policy objectives. However, it is most likely, certainly in the short term that fiscal space will be constrained. This implies that choices about which health and HIV services to fund will have to be made. The SADC Secretariat can support Member States with an exercise to determine benefit package starting from the leading causes of mortality and morbidity in the country, and those health and HIV interventions that are cost-effectiveness. This would allow SADC Member State to reassess their current benefit packages, and focus limited resources on those services that have most impact on population outcomes.
2. Costing a package of cost-effective services

To facilitate discussions around allocations of public spending to health and HIV between the Ministry of Finance, the Ministry of Health and the HIV coordinating institutions, it is necessary to have a precise idea of the cost of health and HIV programmes, at different levels of benefit package, and over time. To do this the SADC Secretariat can support Member States with costing out the benefit package, offering a generic approach. Having a precise idea of the cost of achieving UHC and Ending AIDS in 2030 will be helpful in determining the level of public expenditure over time, striving to be adequate but taking into account fiscal constraints.

3. Developing a financing strategy for a package of cost-effective services with financial projection

Universal Health Coverage as well as Ending AIDS in 2030 require a specific package of cost-effective services to be offered with financial protection to the entire population. This means that the share of household out-of-pocket expenditure in total health expenditure should not exceed the 20-25% benchmark. Major paths to achieve this is by increasing the level of subsidy of public health and HIV services, reducing fees for service and drugs, or by increasing population coverage of mandatory social insurance. The SADC can support Member States in assessing current financing strategies, and designing ways to adapt them with a view to decreasing the share of out-of-pocket expenditure in total health expenditure.

4. Delivering a package of cost-effective services with optimal efficiency

To further support the dialogue around fiscal space for health and HIV, the SADC can support Member States with a SADC-wide technical efficiency study. This would entail that the SADC Secretariat develops a generic approach to assessing technical efficiency, actions to improve efficiency, and an estimate of efficiency savings, which is then applied in SADC of the Member States individually. This will provide Member States with a series of priority actions which, when implemented over the medium-term, can provide critical key performance indicators for the Ministry of Finance to release more funding for health and HIV.

5. SADC-wide debate on fiscal space for UHC and Ending AIDS in 2030

The current levels of allocation of public spending to health and HIV vary significantly across the SADC. The SADC can support Member States by organising a debate that brings together the elements from the previous steps, starting from the policy objectives of UHC and Ending AIDS in 2030: basic benefit packages, cost of offering basic benefit packages with financial protection, and efficiency savings. A SADC-wide discussion would involve the Heads of State and representatives of the Ministries of Health, Finance and the HIV coordinating agencies. The aim would be to obtain a long-term funding commitment that will allow to achieve UHC and Ending AIDS within the available fiscal envelope. The detail of such an agreement would
comprise specific public spending benchmarks for each SADC Member State, with a view of convergence across the SADC, specific targets for increased technical efficiency, as well as specific targets for out-of-pocket expenditure, to ensure financial projection.
Annex A Methodology

A.1 Overview of the Macroeconomic Framework

A.1.1 Introduction

The macroeconomic approach adopts a numeric framework, known as a financial programming framework, which is designed to assist in the development of a consistent approach to the different aspects of economic policy. The key feature of the financial programming framework is that it is based on a comprehensive view of the national economy, comprising four inter-dependent sectors. The four sectors are:

- The Real Sector, which relates to productive activities of the economy.
- The Fiscal Sector, which captures government transactions.
- The External Sector, which includes all transactions between the country in question and other countries.
- The Monetary Sector, which includes the transactions of the banking system and of the central bank.

Whilst not a sector in its own right, attention is also given to the debt of the central government, as the stocks and flows of the government’s debt are reflected in the fiscal, external and monetary sectors.

At the outset, it should be clearly understood that the macroeconomic
framework is not an economic model. It does not constitute a set of equations which attempt to model the behaviour and interaction between different sets of economic agents. In economic terminology, it is not based on a set of econometrically estimated behavioural and/or structural relationships which drive economic outcomes.

The macroeconomic framework is a tool for ensuring the consistency between different sets of assumptions about the future course of the economy. In other words, by starting with a set of assumptions about the economy (e.g. GDP growth), the framework assesses the impact of different policy options on the four sectors of the economy in a consistent manner.

A.1.2 Key components

The starting point for the macroeconomic framework is the tables published on the country’s macroeconomic performance by the IMF. These tables are produced in a standard format for all countries as part of the IMF’s Article IV surveillance activities. The standard IMF documents include five tables that are replicated in the macroeconomic framework used for this analysis.

These are:

- **Table 1: Selected Economic Indicators**, containing summary data from the real, fiscal, monetary and external sectors.
- **Table 4: Monetary Accounts**, showing the paths of broad money, net foreign assets and net domestic assets.
- **Table 5: Balance of Payments**, including indicators on gross international reserves.

These tables are transposed into Excel and expanded further as necessary, to produce data for the four sectors of the economy described above. This is done through the following six work sheets:

- **Overview**: The Overview sheet includes projections for headline macroeconomic variables such as real GDP growth, GDP deflator and the exchange rate.
- **Real**: The Real sheet provides the projections of the real sector, including values for GDP and its components (including consumption and investment).
- **Fiscal**: The Fiscal sheet provides information on the annual budget for the government, including projections for domestic revenue, expenditure, grants and deficit financing.
- **Money**: The Money sheet provides projections for the monetary sector. It includes the path of key monetary aggregates, such as credit to the private sector.
- **External**: The External sheet provides forecasts for the Balance of Payments, including projections for imports, exports, and gross international reserves.
- **Debt**: Whilst the Debt sheet does not reflect a sector as such, it performs a simple function by taking the debt disbursements, combining these with the existing debt stock and forecast repayments, to project the debt variables into the future.

The different sheets are all linked to each other to ensure consistency, as discussed
A.1.3 Theoretical approach

The framework uses four macroeconomic accounting identities to ensure consistency between the different sectors of the economy. A macroeconomic accounting identity is a relationship between a set of economic variables that must hold true by definition. For example, GDP must be equal to the sum of its components (investment, consumption, imports and exports). Each sector has its own accounting identity.

The framework ensures consistency between the sectors in two ways. Firstly, the macroeconomic framework ensures that all of the accounting identities are met. It does this through the use of a “residual” item, which is set via a formula to ensure that the identity is always true. For example, if we have already determined GDP, investment, imports and exports, then there can only be one value for consumption that is consistent with the accounting identity for the real sector (i.e. Consumption = GDP – Investment – Exports + Imports). In this case, consumption is known as the “residual”.

Secondly, the macroeconomic framework ensures that wherever a variable features in more than one sector, the projections for that variable are the same in both sectors. For example, Imports features in both the real sector (as a component of GDP) and the external sector (as a component of the Current Account). Thus, the macroeconomic framework will ensure that whatever values are used for Imports in the external sector are also used in the real sector.

A.1.4 Macroeconomic accounting identities

This section will examine the accounting identities used in each sector and the residual that is used to balance them.

A.1.4.1 The real sector

**BASIC IDENTITY:**

\[ GDP = \text{Consumption} (\text{Private} + \text{Public}) + \text{Investment} (\text{Private} + \text{Public}) + \text{Exports} - \text{Imports} \]

**RESIDUAL:**

Private Consumption

The primary assumption in this sector is that of growth in real GDP. This is used to extrapolate the current figure for GDP into the coming years. An assumption is also made about the future path of the GDP deflator in order to convert between real GDP and nominal GDP.

Having determined the value of GDP in future years, it is necessary to determine its composition. Public consumption (i.e. government current expenditure) and public investment (i.e. government development expenditure) are determined by the Fiscal sheet (see below). By making assumptions about the share of investment in GDP, it is possible to produce forecast figures for investment. Finally, Imports and Exports are linked from the External sheet (see below).
Therefore, having determined the total value for GDP and all but one of its components, the residual component must be set to ensure consistency with the basic accounting identity. In this case, private consumption is used as the residual and is equal to GDP plus imports, less exports, private investment and total government spending.

A.1.4.2 The fiscal sector

This sector is focused on the government budget. Firstly, tax revenue is determined (based on an assumption about its share of GDP) as well other sources of revenue, such as grants and non-tax revenue. External grants are converted to local currency using the exchange rate.

Assumptions are made about the government’s expenditure (excluding debt service). The interest payments on debt are calculated in the Debt sheet, such that a higher deficit in one year is reflected in higher interest payments in the subsequent year. These factors determine the government’s overall deficit and hence the government’s borrowing requirement. Future disbursements and principal repayments on external debt are determined by assumption and converted to local currency using the exchange rate.

All that remains is to determine the net disbursements on domestic debt. This is the residual in this sector and it set at a level to balance government borrowing with the overall deficit.

A.1.4.3 The monetary sector

Net foreign assets are determined by the net flow of foreign currency into the country, which is given by the change in official reserves in the balance of payments (i.e. from the External sheet).

Net domestic assets includes net claims on government and net claims on other sectors (i.e. the private sector). Net claims on government is determined by the outstanding stock of government debt, which is taken directly from the Debt sheet. Net claims on other sectors is the residual in this sector and therefore calculated at the end.
Broad money can be derived from the economic relationship between nominal GDP, broad money, and the velocity of money (PY=\text{vM}). Broad money is therefore calculated by dividing nominal GDP by an assumed figure for the velocity of money.

Having determined everything else using the above assumptions, net claims on other sectors is the residual and is set to ensure compliance with the accounting identity for this sector. It is equal to broad money less net foreign assets and less net claims on government.

**A.1.4.4 The external sector**

**BASIC IDENTITY:**

\[
\text{Current Account} + \text{Capital Account} + \text{Financial Account} + \text{Errors & Omissions} = \text{Change in Official Reserve Assets}
\]

**RESIDUAL:**

\[
\text{Change in Official Reserve Assets}
\]

The capital account includes external project grants (taken from the Fiscal sheet). The financial account requires assumptions about foreign direct investment and portfolio investment. The only other significant components of the financial account are the disbursements and repayments of external loans to government, which are taken from assumptions in the Fiscal sheet.

Errors and omissions are assumed to be zero in the future. The only item left is the change in official reserve assets, which is used as the residual to ensure consistency in this sheet. The change in official reserves is therefore given by the sum of the current account, the capital account, and the financial account.

**A.1.4.5 Key linkages between the sectors**

As discussed above, the second source of consistency comes from the use of only one set of forecasts wherever a variable appears in two different sectors. Table A1 summarises the linkages between different sheets. It is important to note that the link is created from the sheet listed on the left hand side to the sheet list along the top of the table (i.e. imports from the External sheet are transferred to the Real sheet.) To avoid confusion, only the most important linkages are shown, these correspond with the linkages discussed in the text above.

Using the above framework, it is possible to condense the forecasting of the economy, and its various sectors, to just a handful of key assumptions. Using these assumptions, the linkages and identities described above, and a few further details, it is possible to then project a range of macroeconomic variables and indicators into the future.

The framework therefore operates by retaining the IMF projections for the short
and medium term (until 2013) and then making a number of high level assumptions for key macroeconomic variables over the long term. These assumptions are based upon an extrapolation of the medium term IMF projections and an analysis of the available information on the economy of the country in question.

### A.1.5 Incorporating health and HIVAIDS resources

Health and HIVAIDS resources can be divided into two forms; revenues and expenditures. It is important to be clear on the distribution to avoid double-counting the resources. For example, a grant from a donor would be included as a revenue but may also be counted as an expenditure by the government. Table A.2 shows the Health and HIVAIDS resources incorporated into the macroeconomic framework and the sectors that they are linked directly to.
These resources are integrated into the appropriate sectors of the macroeconomic framework. This ensures consistency in both the macroeconomic projections and the Health and HIV/AIDS expenditure projections in two ways.

First, those resources that are determined exogenously (either through external factors or by policy decisions) are linked to the macroeconomic framework so that changes in these variables have a macroeconomic impact. For example, higher grants from external donors may (i) increase government expenditure in the fiscal sector and (ii) increase the change in official reserves in the external sector (amongst other effects). Equally, a decision to increase taxes to finance Health will (i) increase the deficit and domestic borrowing and (ii) by higher interest payments on that debt, further increase the deficit in future years (again amongst other effects).

Second, Health and HIV/AIDS resources can be linked to macroeconomic variables to model their size under different scenarios. For example, external grants and loans will be converted into local currency via the exchange rate and domestic resources can be linked to GDP growth to see how they change under different scenarios.

Using the framework above, it is then possible to insert different assumptions for key macroeconomic variables and different Health and HIV/AIDS financing mechanisms to examine scenarios for Health and HIV/AIDS expenditure into the future. These scenarios can be supported by various indicators to assess the plausibility of the scenario (e.g. is the share of Health expenditure of GDP excessive?) and its macroeconomic stability (e.g. is government debt sustainable? Is the balance of payments stable?).
A.2 Data and Assumptions

A.2.1 Time Series

The findings are presented in the Southern African Development Community (SADC) fiscal year running from April to May. Data and findings cover the period from 2008/09 to 2029/30, and the baseline for projections is 2012/13. The exception is that Resource Needs are available for HIV/AIDS for fifteen years from 2015 to 2030. Therefore the HIV/AIDS gap will be presented for those years.

A.2.2 Macro Data

Underlying macroeconomic data is taken from the International Monetary Funds’ (IMF) World Economic Outlook (WEO) database (October 2013) and the most recent country-specific IMF Article IV publications. The past and near future estimations are agreed by country government so can be viewed as official country data. The medium term projections (from around 2014 – 2019) meanwhile are produced by IMF staff.

After 2019 the methodology for projecting longer term (up to 2030) are set out in Table A.3A.3. National Public Expenditures and Revenues are set to grow towards the average proportions for each income status; e.g. Tax to GDP ratio set depending on if the country is expected to become a low, middle or high income country. Averages by income status were found from the World Bank Development Indicators database. Other key variables such as Exchange Rates remain stable over the longer term.

A.3 MACRO ECONOMIC TARGETS BY INCOME STATUS

<table>
<thead>
<tr>
<th>SECTOR LINKAGES</th>
<th>MIDDLE INCOME</th>
<th>HIGH INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax: GDP Fiscal, External</td>
<td>24%</td>
<td>34%</td>
</tr>
<tr>
<td>Current Expenditure: GDP None</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Donor Funds: GDP* Fiscal, External, (Debt)</td>
<td>0.3%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: World Bank Development Indicators
Note: * = There are exceptions to this target. Where current ODA levels are less than the target proportion the ODA values are set to remain stable nominally over the longer term. Countries affected are: Malawi, and Swaziland.

The SADC Member States also have the underpinning assumptions based on the SADC convergence criteria. This provides underpinning key macro variables as follows:

- Nominal Growth: graduates to 8% by 2025;
- Inflation: graduates to 3% by 2025;
Gives Real Growth of 5%, (this is a more conservative assumption than the SADC Convergence Criteria of 7% annual Real GDP growth).

This provides us with a ‘business as usual’ scenario and allows us to compare the resultant key macro indicators from imposing health care scenarios.

It must be noted that within this baseline a key assumption is that external financing will decline in real terms over the projection period. This assumption affects the macroeconomic projections – as well as the sector-specific health and HIV/AIDS funding scenarios – through budget and programme support as part of government revenue. Part A.4 of this annex gives an overview of the reasoning for declining development assistance in the near future. In sum, sources suggest that in the medium term external funding will remain stable at best and decline in low income countries1.

For each country the current income status and projections of income growth are shown in Table A.4. Over the fifteen year projection period there will be an upward transition in income for all countries. As mentioned for the macro assumptions these will be underpinned by the projected income per capita in 2030. The health and HIV/AIDS projections will be set by the income status in 2025, the details of these will be discussed below.

### Macro Economic Targets by Income Status

<table>
<thead>
<tr>
<th>Baseline Income Status</th>
<th>High Income</th>
<th>Macro Indicator Target Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
<td><strong>2024/25</strong></td>
<td><strong>2029/30</strong></td>
</tr>
<tr>
<td>Angola</td>
<td>6,025 Mid</td>
<td>8,930 Mid</td>
</tr>
<tr>
<td>Botswana</td>
<td>7,987 Mid</td>
<td>16,237 High</td>
</tr>
<tr>
<td>Congo DRC</td>
<td>481 Low</td>
<td>951 Low</td>
</tr>
<tr>
<td>Lesotho</td>
<td>1,300 Mid</td>
<td>2,968 Mid</td>
</tr>
<tr>
<td>Madagascar</td>
<td>476 Low</td>
<td>778 Low</td>
</tr>
<tr>
<td>Malawi</td>
<td>248 Low</td>
<td>467 Low</td>
</tr>
<tr>
<td>Mauritius</td>
<td>10,542 Mid</td>
<td>23,032 High</td>
</tr>
<tr>
<td>Mozambique</td>
<td>616 Low</td>
<td>1,471 Mid</td>
</tr>
</tbody>
</table>

This method of extracting NHA database information has the risk of underestimating public expenditures on health and overestimating private consumption. Therefore, where possible country-specific NHA reports are used to confirm expenditures, if one is not available budgetary data is used, or an alternative source such as a public expenditure review, etc.

This 20% was found to be the highest spenders on health for low, medium, and high income countries, as per WHO Global Health Expenditures Database information. Countries affected are Lesotho and South Africa.

### A.2.3 Health Expenditure Data

The model includes details on funding which is available for Health from all sources. Background data (2008 – 2013) is taken from the World Health Organisation (WHO) Global Health Expenditure Database which provides access to country-specific National Health Accounts (NHA) data. The projections are then calculated using the following assumptions:

**Government Health Spending:** Grows with nominal growth elasticity of 1.1 as per international econometric findings (see McIntyre and Meheus, 2014). This assumes that Government funding to the Health sector will rise at a slightly faster rate than nominal growth; i.e. as a country grows richer it invests proportionately more into its health services. A cap is set on this growth, which is set at government health expenditures reaching 20% of total government budget (GGHE:GGE) as per the top ten percentage of GGHE:GGE globally.

**International Funding:** Medium term growth (2013 – 2015) rates were sourced from the Organisation for Economic Cooperation and Development (OECD) projections (OECD DAC CRS Online Database). Over the longer term the trend in donor funding for health is equal to the annual change in total ODA (as per the external funding to GDP target for the relevant income status of each country, see A.3). However, where this leads to a rise in external financings for Health a stable nominal level of external funding is imposed.

**Household Expenditure:** Grows with nominal growth elasticity of 0.86 as per international econometric findings (see McIntyre and Meheus, 2014). This assumes that the need for Out Of Pocket (OOP) expenditures by households will grow at a slightly slower rate than nominal growth; i.e. as a country grows richer the health burden falls less onto citizens for ad-hoc expenditures.

<table>
<thead>
<tr>
<th>Country</th>
<th>2008 (GDP)</th>
<th>2010 (GDP)</th>
<th>2013 (GDP)</th>
<th>2015 (GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namibia</td>
<td>5,575</td>
<td>Mid</td>
<td>10,144</td>
<td>Mid</td>
</tr>
<tr>
<td>Seychelles</td>
<td>14,600</td>
<td>High</td>
<td>26,333</td>
<td>High</td>
</tr>
<tr>
<td>South Africa</td>
<td>7,119</td>
<td>Mid</td>
<td>15,069</td>
<td>High</td>
</tr>
<tr>
<td>Swaziland</td>
<td>3,061</td>
<td>Mid</td>
<td>4,446</td>
<td>Mid</td>
</tr>
<tr>
<td>Tanzania</td>
<td>695</td>
<td>Low</td>
<td>1,194</td>
<td>Mid</td>
</tr>
<tr>
<td>Zambia</td>
<td>1,621</td>
<td>Mid</td>
<td>3,030</td>
<td>Mid</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>818</td>
<td>Low</td>
<td>1,716</td>
<td>Mid</td>
</tr>
</tbody>
</table>

Source: IMF and UN Baseline (GDP and Population, respectively) and OPM Projections

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2 This method of extracting NHA database information has the risk of underestimating public expenditures on health and overestimating private consumption. Therefore, where possible country-specific NHA reports are used to confirm expenditures, if one is not available budgetary data is used, or an alternative source such as a public expenditure review, etc.

3 This 20% was found to be the highest spenders on health for low, medium, and high income countries, as per WHO Global Health Expenditures Database information. Countries affected are Lesotho and South Africa.
Private Company Expenditures: Grows in line with inflation to reflect rising cost of health services. This sector makes up a small proportion of health care financing sources.

Only in Zimbabwe is this method not possible as WHO / NHA data is available only up to 2006. Therefore Government Ministry of Finance Budget data was used for creating the trend in Government Health Expenditures, OECD DAC CRS used for Donor Disbursements and other sources for Household and Private Sector such as Health Systems Assessments and National Planning Strategies.

From these assumptions the model presumes a ‘business as usual’ scenario. The two key points are:

i. that there are no great policy changes from central government in increasing health sector funding, and;

ii. in most cases donor money is not flowing as rapidly into health care as it has done over the past decade.

A.2.4 HIV/AIDS Data

The model provides a time series on available funding for HIV/AIDS from all sources. Background data is based on National AIDS Spending Assessment (NASA) publications by UNAIDS, or the Global AIDS Response Progress Report publications by UNGASS. The projections are then calculated using the following assumptions:

Government HIV/AIDS Spending: Remains stable as proportion of Discretionary Expenditure. This shows the how much choice the Government has in allocating its discretionary budget towards HIV/AIDS.

International Funding: Medium term growth (2013 – 2015) rates were sourced from the OECD. Over the longer term the trend in donor funding for HIV/AIDS is equal to the annual change in total ODA (as per the external funding to GDP target for the relevant income status of each country, see Table A.3). However, where this leads to a rise in external financings for HIV/AIDS a stable nominal level of external funding is imposed.

Household Expenditure: Grows in line with inflation in longer term reflecting the changes in cost of health care. NOTE: Household Expenditure here includes any Private Sector involvement but does not always include Out of Pocket (OOP) Expenditures – this is a function of the available data from NASA and UNGASS.

Note: In Angola and Zimbabwe there are no data available for private sector contributions to HIV/AIDS spending. Therefore the average private sector spend on HIV/AIDS was taken from all other SADC countries and used as an estimation. The average private sector spend on HIV/AIDS was found to be 0.08% of GDP.

From these assumptions the model presumes a ‘business as usual’ scenario. The two key points are:

i. that there are no great policy changes from central government in increasing HIV/AIDS sector funding, and;

A.2.5 Linkages between Government Spending on Health and HIV/AIDS

As mentioned above in the ‘business as usual’ scenario government expenditure...
on HIVAIDS is projected to rise in line with discretionary total government expenditure. Government expenditure on health is projected to rise by an elasticity of 1.1. This assumes no policy changes for health and HIVAIDS over the projection period. As such there is assumed to be no internal reallocation from or to HIVAIDS within the health budget.

The second scenario is the ‘targeted budget’ scenario, this is where a government decides to take policy action to raise domestic financing for Health and HIVAIDS. Here HIVAIDS spending will be determined by two policy actions:

First, each country takes action to alleviate the financing gap by raising Government Expenditure on Health. The target is set by taking the proportion of government expenditure on health spent by the top 25% of SADC countries of each income status. This is shown in A.5, and will be met 2024/25 and maintained up to 2029/30. From this increased health spending HIVAIDS will be allocated a greater nominal value.

In parallel the government would raise the share of health expenditure to HIVAIDS. The Domestic Investment Priority Index (DIPI) is a measure of how willing and able a government is to spend national budget on HIVAIDS. The Resch DIPI measure for comparable investment in HIVAIDS is calculated by taking Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs (where DALY is the Disability-Adjusted Life Year). Resch has set what is known as a ‘fair share’ of health budget allocated to HIVAIDS as 0.5. This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs. Each SADC country has this as a target to meet by 2024/25, and will maintain this up to 2029/30.

If a country is above the income-specific health budget allocation and/or the Resch share they will continue as per their baseline projection; i.e. they will not be reduced.

It must be noted that the information underpinning DIPI calculations has some limitations. The AIDS DALYs and TOTAL DALYs are constant as at 2012 WHO estimates. More recent official estimations or projections are not available. HIVAIDS infection rates can be affected by multiple factors and may be unlikely to remain constant over the next fifteen years. It would be expected that a greater investment in HIVAIDS would reduce the prevalence and number of DALYs due to HIVAIDS, with a time lag. Under this situation the projections up to 2019/20 can be seen as a realistic projection for HIVAIDS. Further into the longer term up to 2029/30 there will be some lost validity. In this light the longer term projections are actually a cautious estimate of the ability of SADC countries to cover the HIVAIDS needs as the analysis presents a stable prevalence rate which would be more likely decline over time.

## T.A.5 GOVERNMENT HEALTH EXPENDITURE AS % OF TOTAL GOVERNMENT BUDGET BY INCOME STATUS

<table>
<thead>
<tr>
<th>Low Income Top 25%</th>
<th>8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congo DRC</td>
<td>7%</td>
</tr>
<tr>
<td>Malawi</td>
<td>5%</td>
</tr>
<tr>
<td>Madagascar</td>
<td>8%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>2%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>3%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Middle Income Top 25%</th>
<th>12%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>6%</td>
</tr>
<tr>
<td>Botswana</td>
<td>7%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>9%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>9%</td>
</tr>
<tr>
<td>Namibia</td>
<td>11%</td>
</tr>
<tr>
<td>Seychelles</td>
<td>8%</td>
</tr>
<tr>
<td>South Africa</td>
<td>13%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>12%</td>
</tr>
<tr>
<td>Zambia</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: OPM Model

### A.2.6 Combining Health and HIVAIDS Expenditures

To combine Health and HIVAIDS we need to avoid duplication of expenditures. Both government and external health expenditures will include some amount of HIVAIDS-specific spending, and some HIVAIDS expenditures will include non-health expenditures. These need to be teased out as follows:

**Government HIVAIDS Expenditures in Health Expenditure** – The historic data on Government Health Expenditure (GHE) and Government AIDS Expenditures (GAE) can give us an idea of what proportion of health expenditure is spent on HIVAIDS in each SADC country. The results is shown in Table A.6 where the average is seen as 17%. Low spending on HIVAIDS compared to Health is seen in Angola, Congo DRC and Mauritius all allocate only 1% of government health
spending to HIVAIDS. Botswana, Lesotho, Namibia and Tanzania all have high levels of HIVAIDS expenditures accounting for more than a third and up to half of government health spending.

**Donor HIVAIDS Expenditures in Health Expenditure** - Using OECD DAC database we can gain an estimation of the level of external funding going to health which is used for HIVAIDS purposes. Data over a five year period was assessed and the averages for 2008/09 to 2012/13 are shown in Table A.6. The regional average of HIVAIDS expenditures within health external funding is found to be 56%. There is a wide divergence; from 4% of Seychelles external health funding specified for HIVAIDS, to 94% of external health funding going to HIVAIDS in Botswana. Each countries estimated proportion will be projected over time using these results.

**Government and Donor Non-Health Expenditures in HIVAIDS Expenditure** – Past UNAIDS GARPR data gives us an idea of the line items related to health and non-health activities for HIVAIDS. The results for both government and donor expenditures are shown in Table A.7 and will be used for the projections. These are underpinned by the analysis described in the next section and Table A.8.

Each SADC member state will have its own country proportions applied. But to provide a picture for the average regional impact the combined health and HIVAIDS expenditures will be calculated as follows:

- Government spending on health reduced by 17% to remove HIVAIDS expenditures;
- Donor funding for health reduced by 56% to remove HIVAIDS financing;
- Government spending on HIVAIDS reduced by 14% to remove non-health expenditure; and
- Donor funding on HIVAIDS reduced by 13% to remove non-health monies.

**Table A.6** PROPORTION OF HIVAIDS EXPENDITURES COMPARED TO HEALTH EXPENDITURE (5 YEAR AVERAGE 2008/09 - 2012/13)

<table>
<thead>
<tr>
<th>Country</th>
<th>GOVERNMENT: GAE WITHIN GHE</th>
<th>DONORS: HIVAIDS ODA WITHIN HEALTH ODA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>1%</td>
<td>25%</td>
</tr>
<tr>
<td>Botswana</td>
<td>47%</td>
<td>94%</td>
</tr>
<tr>
<td>Congo DRC</td>
<td>1%</td>
<td>15%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>44%</td>
<td>64%</td>
</tr>
<tr>
<td>Madagascar</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Malawi</td>
<td>4%</td>
<td>48%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>1%</td>
<td>76%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>8%</td>
<td>51%</td>
</tr>
<tr>
<td>Country</td>
<td>Government Expenditure</td>
<td>Donors Expenditure</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Namibia</td>
<td>39%</td>
<td>91%</td>
</tr>
<tr>
<td>Seychelles</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>South Africa</td>
<td>10%</td>
<td>91%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>18%</td>
<td>85%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Zambia</td>
<td>7%</td>
<td>67%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>19%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>SADC AVERAGE</strong></td>
<td><strong>17%</strong></td>
<td><strong>56%</strong></td>
</tr>
</tbody>
</table>

Note: Calculated from NHA and NASA for Government Expenditure, and OECD DAC CRS for Donors.

### T.A.7 PROPORTION OF HIV/AIDS EXPENDITURES RELATED TO HEALTH

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Related HIV/AIDS Expenditures by Government</th>
<th>Health Related HIV/AIDS Expenditures by Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>94%</td>
<td>49%</td>
</tr>
<tr>
<td>Botswana</td>
<td>78%</td>
<td>92%</td>
</tr>
<tr>
<td>Congo DRC</td>
<td>99%</td>
<td>81%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>91%</td>
<td>71%</td>
</tr>
<tr>
<td>Madagascar</td>
<td>76%</td>
<td>82%</td>
</tr>
<tr>
<td>Malawi</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>89%</td>
<td>75%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>99%</td>
<td>87%</td>
</tr>
<tr>
<td>Namibia</td>
<td>70%</td>
<td>88%</td>
</tr>
<tr>
<td>Seychelles</td>
<td>49%</td>
<td>86%</td>
</tr>
<tr>
<td>South Africa</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>99%</td>
<td>91%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>99%</td>
<td>92%</td>
</tr>
<tr>
<td>Zambia</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>97%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>SADC TOTAL</strong></td>
<td><strong>86%</strong></td>
<td><strong>87%</strong></td>
</tr>
</tbody>
</table>

Note: Based on UNAIDS GARPR data.
A.2.7 Resource Needs

These describe the estimated level of funding required to provide the basic level of Health or HIV/AIDS services a country needs.

**Health Needs** are set for each country to reflect the maximum of three spending options as per current international health financing norms (see McIntyre and Meheus, 2014). This would raise the country to the global average for health spending and are as follows:

- 86 USD per capita;
- 5% of GDP; or
- Current Government and Donor Health Spending.

**HIV/AIDS Needs** were provided by UNAIDS and sourced from the Global AIDS Response Progress Reporting tool (GARPR).

**Combined Health and HIV/AIDS Resource Needs** require some calculations to the aforementioned Health Resource Needs and HIV/AIDS Resource Needs. To create a scenario where HIV/AIDS needs are combined with health needs we need to consider how much of the UHC package is HIV/AIDS-related, and how much of the HIV/AIDS needs are health and non-health related.

1. For UHC Resource Needs a recent analysis on this topic found that: “The CMH, WHO norm and MBB each allocated between 12% and 18% of the total cost of UHC to HIV/AIDS response interventions. UNAIDS estimated fiscal need for HIV/AIDS interventions is between 14% and 15% of estimated government plus donor expenditure on health between 2015 and 2019”5 (Alex CJ OPM 2015, page 34).

2. For HIV/AIDS Resource Needs – Estimation of the line items associated with health spending and those not directly health related were made. The resultant estimate of Health and Non-Health related UNAIDS HIV/AIDS Resource Needs are set out in Table A.8. Past expenditures in these needs categories suggest that in the SADC region 86% were identified as directly health related, the remaining 14% not. Country specific results have been used as shown in Figure A.1.

Therefore, this study will use these finding as follows:

- Remove 14% of the Non-Health related HIV/AIDS needs to give ‘Health-Only HIV/AIDS Resource Needs’, (using the UNAIDS HIV/AIDS Resource Needs as these are based on country-specific unit costs and can range from 51% in the Seychelles and 4% in Tanzania).


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5 Where CMH = Commission on Macroeconomics and Health, MBB = Marginal-Budgeting for Bottlenecks (approached used by the High Level Task Force on Innovative International Financing for Health Systems), and WHO = World Health Organisation.
### 1. PREVENTION (SUB-TOTAL)

| Non | 1.01 Communication for social and behavioural change (BCC) |
| Non | 1.02 Community/social mobilization |
|     | 1.03 Voluntary counseling and testing (VCT) |
| Non | 1.04 Risk-reduction and prevention activities for vulnerable and accessible populations |
| Non | 1.05 Prevention - Youth in school |
| Non | 1.06 Prevention - Youth out-of-school |
|     | 1.07 Prevention of HIV transmission aimed at people living with HIV |
|     | 1.08 Prevention programmes for sex workers and their clients |
|     | 1.09 Programmes for men who have sex with men |
|     | 1.10 Harm-reduction programmes for injecting drug users |
| Non | 1.11 Prevention programmes in the workplace |
| Non | 1.12 Condom social marketing |
|     | 1.13 Public and commercial sector male condom provision |
|     | 1.14 Public and commercial sector female condom provision |
|     | 1.15 Microbicides |
|     | 1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI) |
|     | 1.17 Prevention of mother-to-child transmission |
|     | 1.18 Male Circumcision |
|     | 1.19 Blood safety |
|     | 1.20 Safe medical injections |
|     | 1.21 Universal precautions |
|     | 1.22 Post- & Pre-exposure prophylaxis |
|     | 1.98 Prevention activities not disaggregated by intervention |
|     | 1.99 Prevention activities not elsewhere classified |

### 2. CARE AND TREATMENT (SUB-TOTAL)

| 2.01 Outpatient care |
| 2.01.01 Provider- initiated testing and counseling |
| 2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment |
| 2.01.03 Antiretroviral therapy |
| 2.01.04 Nutritional support associated to ARV therapy |
2.01.05 Specific HIV-related laboratory monitoring
2.01.06 Dental programmes for PLHIV
2.01.07 Psychological treatment and support services
2.01.08 Outpatient palliative care
2.01.09 Home-based care
2.01.10 Traditional medicine and informal care and treatment services
2.01.98 Outpatient care services not disaggregated by intervention
2.01.99 Outpatient Care services not elsewhere classified
2.02 In-patient care
2.02.01 Inpatient treatment of opportunistic infections (OI)
2.02.02 Inpatient palliative care
2.02.98 Inpatient care services not disaggregated by intervention
2.02.99 In-patient services not elsewhere classified
2.03 Patient transport and emergency rescue
2.98 Care and treatment services not disaggregated by intervention
2.99 Care and treatment services not-elsewhere classified

3. ORPHANS AND VULNERABLE CHILDREN (SUB-TOTAL)

Non 3.01 OVC Education
Non 3.02 OVC Basic health care
Non 3.03 OVC Family/home support
Non 3.04 OVC Community support
Non 3.05 OVC Social services and Administrative costs
Non 3.06 OVC Institutional Care
Non 3.98 OVC services not disaggregated by intervention
Non 3.99 OVC services not-elsewhere classified

4. SYSTEMS STRENGTHENING & PROGRAMME COORDINATION (SUB-TOTAL)

4.01 National planning, coordination and programme management
4.02 Administration and transaction costs associated with managing and disbursing funds
4.03 Monitoring and evaluation
4.04 Operations research
4.05 Serological-surveillance (Serosurveillance)
4.06 HIV drug-resistance surveillance
4.07 Drug supply systems
4.08 Information technology
4.09 Patient tracking
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<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>4.10</td>
<td>Upgrading and construction of infrastructure</td>
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<tr>
<td>4.11</td>
<td>Mandatory HIV testing (not VCT)</td>
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<tr>
<td>4.98</td>
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5. INCENTIVES FOR HUMAN RESOURCES (SUB-TOTAL)

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<tr>
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<tbody>
<tr>
<td>5.01</td>
<td>Monetary incentives for human resources</td>
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<tr>
<td>5.02</td>
<td>Formative education to build-up an HIV workforce</td>
</tr>
<tr>
<td>5.03</td>
<td>Training</td>
</tr>
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<td>5.98</td>
<td>Incentives for Human Resources not specified by kind</td>
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<td>Incentives for Human Resources not elsewhere classified</td>
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NON 6. SOCIAL PROTECTION AND SOCIAL SERVICES EXCLUDING ORPHANS AND VULNERABLE CHILDREN (SUB-TOTAL)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>6.01</td>
<td>Social protection through monetary benefits</td>
</tr>
<tr>
<td>6.02</td>
<td>Social protection through in-kind benefits</td>
</tr>
<tr>
<td>6.03</td>
<td>Social protection through provision of social services</td>
</tr>
<tr>
<td>6.04</td>
<td>HIV-specific income generation projects</td>
</tr>
<tr>
<td>6.98</td>
<td>Social protection services and social services not disaggregated by type</td>
</tr>
<tr>
<td>6.99</td>
<td>Social protection services and social services not elsewhere classified</td>
</tr>
</tbody>
</table>

NON 7. ENABLING ENVIRONMENT (SUB-TOTAL)

<table>
<thead>
<tr>
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<tr>
<td>7.01</td>
<td>Advocacy</td>
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<tr>
<td>7.02</td>
<td>Human rights programmes</td>
</tr>
<tr>
<td>7.03</td>
<td>AIDS-specific institutional development</td>
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<tr>
<td>7.04</td>
<td>AIDS-specific programmes focused on women</td>
</tr>
<tr>
<td>7.05</td>
<td>Programmes to reduce Gender Based Violence</td>
</tr>
<tr>
<td>7.98</td>
<td>Enabling Environment and Community Development not disaggregated by type</td>
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<tr>
<td>7.99</td>
<td>Enabling Environment and Community Development not elsewhere classified</td>
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</table>

8. Research (sub-total)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.01</td>
<td>Biomedical research</td>
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<tr>
<td>8.02</td>
<td>Clinical research</td>
</tr>
<tr>
<td>8.03</td>
<td>Epidemiological research</td>
</tr>
<tr>
<td>8.04</td>
<td>Social science research</td>
</tr>
<tr>
<td>8.05</td>
<td>Vaccine-related research</td>
</tr>
<tr>
<td>8.98</td>
<td>Research not disaggregated by type</td>
</tr>
<tr>
<td>8.99</td>
<td>Research not elsewhere classified</td>
</tr>
</tbody>
</table>

Note: Non = Non-Health related HIV/AIDS resource need and could be on other Ministry budgets rather than MoH. Remaining line items are viewed as directly health related and assumed to be within the MoH budget.
A.2.8 Financing Gap

From the macro, health, and resource needs data a financing gap is found; i.e. how much money is available in a country for Health and HIVAIDS compared to how much money is needed to provide basic needs for Health and HIVAIDS. There are two scenarios built around this:

Scenario 1: Business as Usual – Compares Health, HIVAIDS and the combined UHC and HIVAIDS needs against their spending from Government and Official Development Assistance.

Scenario 2: Innovative Action – As per scenario 1 but with a stronger budget commitment to Health and HIVAIDS; i.e. Government Expenditures on Health rising to targeted values (as mentioned above) and HIVAIDS Resch share rises to 0.5, both by 2025. Additionally there is the inclusion of new alternative source of funding – earmarked taxes – and efficiency savings. Borrowing is discussed if all other domestic funding sources are exhausted and a financing gap remains.

Scenario 1 presents the situation assuming needs continue as expected, there are no policy changes in spending, and donors do begin to reduce their income flows and so there will be a shortfall of financing for Health and HIVAIDS (in most countries).

Scenario 2 present a possible future where governments are taking a pro-active stance to meet the UHC and HIVAIDS needs of citizens to offset the decline from donor funding.
A.2.9 Innovative Funding Sources

There are six different types of new alternative funding sources considered within the model as methods to fill the Financing Gap. These can be considered under two headings:

- Taxation - Tax on Remittances; Mobile Phone Levy; Alcohol Levy; and Airline Levy
- Mainstreaming – Public and Private Sector

Estimations of potential levels of income from the first six new domestic sources are calculated by using data found from other countries who have implemented these innovative sources. Their results have been summarised into an average return in terms of a percentage of GDP. These are summed and added to the available budget financing and a new financing gap is calculated. It must be noted that the sum of all these levies are included in the scenario and it is unlikely that all would be implemented, rather one or two may be chosen by a government. This would lessen the financial impact.

A.2.10 Efficiency Gains and Savings

Countries have differing levels of efficiency. If they can become more efficient the country will need less money to provide the same levels of service. The potential for each country to improve its efficiency rates have been calculated by international Data Envelopment Analysis (DEA), (Wu Zeng). These are then accounted for in the Resource Needs; i.e. reducing the amount of Resource Needs. A new financing gap is then calculated which includes both innovative funding and efficiency savings. This final financing gap presupposed the implementation of a number of policies from the national Governments regarding implementing a more efficient HIV/AIDS system.

A.2.11 Analysis Categories

Throughout this report the findings are discussed as one entire group of SADC countries, sub-groups and some country specific findings. The full individual analysis for each country is in the Annex report. The two main types of disaggregation / groupings of countries are defined as follows, and summarised in Table A.9:

**Income status** – Categories are defined by the World Bank definitions of per capita income:

- Low income is below 1,045 USD;
- Lower-Middle income between 1,045 and 4,125 USD;
- Upper-Middle income between 4,125 and 12,746 USD; and
- High income is above 12,746 USD.

As this analysis is projecting over a fifteen year period some countries move upwards into a new income bracket, this is shown in Table A.4 above. For discussions of the findings we consider the baseline 2014/15 income status as our defining point for groupings.

**Domestic Investment Priority Index (DIPI)**
- The Resch DIPI measure (as described

---

above) is used to categorise countries into groups of how HIV/AIDS is prioritised by government. The categorising was defined by using the average found from 2008/09 to 2012/13. The average for all SADC countries was found to be 1.1, (which is greatly buoyed by high estimate for Seychelles, without Seychelles the average would be 0.8).

- A low DIPI is set as the bottom 50% of all SADC countries, a Resch DIPI of less than 0.3;
- A medium DIPI is anything between 0.3 and 1.1 (the average); and
- A high DIPI is above the 1.1 SADC average.

### SADC COUNTRIES BY ANALYSIS CATEGORIES

<table>
<thead>
<tr>
<th>INCOME STATUS (2012/13)</th>
<th>DIPI (2012 - 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>Botswana</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>Congo DRC</td>
<td>Low</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Lower Middle</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Low</td>
</tr>
<tr>
<td>Malawi</td>
<td>Low</td>
</tr>
<tr>
<td>Mauritius</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Low</td>
</tr>
<tr>
<td>Namibia</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>Seychelles</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>South Africa</td>
<td>Upper Middle</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Lower Middle</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Low</td>
</tr>
<tr>
<td>Zambia</td>
<td>Lower Middle</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Low</td>
</tr>
</tbody>
</table>

Source: Various
A.3 Regression Findings for Public Expenditure Growth and OOP

The methodological background to the public health spending and out-of-pocket multipliers to GDP are elasticities, obtained as follows.

The global pattern of total health spending (which includes both public and private expenditure) is closely related to national GDP. Data from the World Health Organisations based on National Health Accounts (NHA) for the years 2001-11 shows that the global average of total health expenditure (THE) is 7.2% of GDP. Public health spending (general government expenditure on health only) averages 5.7% of GDP globally.

However, THE is not quite proportional to GDP. Figure A.2 shows a scatter-plot of total health expenditure (THE) vs GDP (both per-capita) by country for the years 2001-2011. As can be seen, THE is strongly correlated to GDP (the r-squared value is 0.94, although the log-log plot conceals a large variance, particularly at high levels of GDP per capita). Globally, THE shows an elasticity of about 1.1 with respect to GDP, and about 1.2 in the SADC countries which do not show a significant difference from the global trend. This implies that GGEH generally rises about 10%-20% faster than GDP.

Out of pocket spending on health is somewhat more variable than total health expenditure (THE), but the National Health Accounts (NHA) estimates also show a global correlation with GDP, as shown in Figure A.3.

As can be seen, the global elasticity for OOP is about 0.86 – implying that OOP rises more slowly than GDP, and that OOP is a larger proportion of household income in poorer countries. Note however that the elasticity of OOP appears to be somewhat lower in SADC countries (shown in red), with a value of about 0.66. This implies that OOP is significantly lower as a proportion of household income in those countries with higher GDP per capita.

FA.2
GENERAL GOVERNMENT SPENDING ON HEALTH AND GDP
A.4 Approach to Projected Donor Funding

Within this analysis a key assumption is that external financing will decline in real terms over the projection period. This assumption affects the macro economy (through budgetary revenues and deficit), as well as the sector-specific health and HIV/AIDS funding scenarios. This section gives an overview of past trends in Overseas Development Assistance (ODA), and the reasoning for declining development assistance in the near future.

Medium term growth rates (2014 – 2016) for international funding are sourced from the OECD. The OECD projections estimate that growth in international aid will be 9% in 2013 and remain at zero percent for the three years from 2014 to 2016. This refers to all ODA from all donors to all countries.

OECD ODA projections are not available for HIV/AIDS ODA in isolation. However, comparing historic disbursements of total ODA, health ODA, Sub-Saharan African ODA, and SSA Health ODA – see Figure A.4 – it is clear that the trends are not divergent. Therefore is has been assumed that medium term disbursements to health and HIV/AIDS would not differ substantially from monies from donors to recipient countries for ODA in general. The total ODA annual growth rates were superimposed onto the baseline data for each SADC country.
Over the longer term two sources suggest overall ODA will be flat (OECD and Development Policy Centre):

- The OECD suggests a rise to middle income and decline to low income (especially Africa) – a function of soft loan availability over grants. There may be a movement towards Asia so Asian aid is equal to African.7
- The Development Policy Centre concludes that traditional sources of aid may decline, but that this could be offset by rising non-traditional sources, leading to the “overall level of external aid for developing countries remains flat for several years”8.

**FA.3 COMPARISON OF ODA DISBURSEMENTS (ANNUAL CHANGE)**

Source: Projections from: OECD Outlook on Aid (http://www.oecd.org/dac/aid-architecture/OECD%20Outlook%20on%20Aid%202013.pdf)

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Annex B References


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Introduction

This annex provides an overview of assumptions taken, baseline situation, and projected results for each of the 15 SADC countries. Each country has a short section on macroeconomic indicators, proportions currently spent on health and HIV/AIDS, the projected resource gap for the integrated UHC and HIV/AIDS, and potential future financing options.

An overview of the data used is provided. A full description of the methodology can be found in the Methodological Annex.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tr>
<td>DALY</td>
<td>Disability-Adjusted Life Year</td>
</tr>
<tr>
<td>DEA</td>
<td>Data Envelope Analysis</td>
</tr>
<tr>
<td>DIPI</td>
<td>Domestic Investment Priority Index</td>
</tr>
<tr>
<td>GAE</td>
<td>Government AIDS Expenditure</td>
</tr>
<tr>
<td>GARPR</td>
<td>Global AIDS Response Progress Reporting</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GGE</td>
<td>General Government Expenditure</td>
</tr>
<tr>
<td>GHE</td>
<td>Government Health Expenditure</td>
</tr>
</tbody>
</table>
1 Angola

1.1 Macro Indicators and Convergence Criteria

Table 1 shows a sub-set of key macroeconomic indicators for Angola resulting from the financing gap model. These show that Angola will have a challenge to keep a lid on inflationary pressures to ensure that they meet the SADC real growth criteria. On average over the longer term inflation could fall to just above the 3% target. The Governments’ Fiscal Deficit is within acceptable boundaries and Public Debt is low and well below the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that Angola is in a sustainable debt position1.

GDP per capita is expected to grow from around 6,000 USD in 2014/15 to more than 11,000 in 2029/30. This is a movement up from middle income to almost high income status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

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T.1

MODEL PROJECTIONS FOR ANGOLA COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE 2010/11-14/15 Average</th>
<th>BUSINESS AS USUAL 2015/16-29/30 Average</th>
<th>INNOVATIVE ACTION 2015/16-29/30 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>16.6%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>5,425</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>39.2%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

Source: OPM Macro

Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

1.2 Current Situation in Health and HIV/AIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the health sector in Angola is financed in the main by the Government; 60% of Total Health Expenditure (THE), and only 3% being provided by international funding. Households Out of Pocket Expenditures account for 26% of health expenditure and the remaining 10% is sourced from private companies. From the National Budget allocation to health sits at around 6%, as a percentage of GDP THE is just less than 4%.

For HIVAIDS the UNGASS 2010 and 2012 reports suggests that 40% of funding comes from donors. The Government provides 60% of all funding for HIVAIDS but levels of expenditure are low at less than 0.2% of the National Budget, or 0.1% of GDP. A proxy for private sector expenditure was added to the model (none available from UNGASS report), using the average of SADC private sector spending on HIVAIDS – 0.038% of GDP. Once included this accounts for 50% of expenditures on HIVAIDS. The Domestic Investment Priority Index (DIPI) stands at 0.002 which is very low in comparison to the SADC region where the average was
0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIV/AIDS sits at 0.3, again low compared to the SADC average of 1.1 over the baseline period.

1.3 Resource Gap

**Scenario 1: Business as Usual** – Angola’s health needs are set at 5% of GDP, and HIV/AIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 1 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIV/AIDS needs are underfunded by around 3.7 billion USD a year if the status quo continues.
- This equates to 1.5% of GDP, or 3.6% of the national budget, over the projection period.

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**PROJECTIONS FOR COMBINED UHC AND HIV/AIDS RESOURCE GAP: ANGOLA SCENARIO 1 (M USD)**

2 DIPI = Government expenditure on HIV/AIDS divided by General government expenditure as a proportion of the prevalence of HIV/AIDS within the population.
3 Resch measure of DIPI = Government expenditure on HIV/AIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Angola takes action to alleviate the resource gap by raising Government Expenditure on Health to 12% (as per average middle income country health expenditure in SADC)⁴. In parallel the government would raise the share of health expenditure to HIVAIDS to 0.5⁵. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

1.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 2:

1. Increased Government Budget Allocation - To overcome this resource gap current government funding to the health sector would need to double from the current 6% allocated to health to reach 12% by 2024/25. The DIPI Resch measure would need to rise from 0.3 to 0.5 over the same time period. This would be enough to close the gap in the medium term, reaching a surplus by 2021/22. However, in the short term – if budget redistribution is not immediately possible – other alternative funding options are required.

2. Alternative Sources – The remaining resource gap can be partially closed in the short to medium term by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for UHC including HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 1.3 billion USD a year to the sector. This equates to an average of 0.4% of GDP, and could close the gap by 2019/20 (in conjunction with the budgetary measures).

3. Efficiency - If Angola implemented efficiency measure they could save around 0.8 billion USD pa on the cost of UHC and HIVAIDS services. This equates to 0.3% of GDP, or 0.7% of the national budget.

4. Borrowing – Finally, if needs were to be entirely covered Angola would be required to borrow in the near term (2015/16 – 2018/19) on average 850 million USD a year. This would raise the Debt: GDP ratio by 0.2 percentage points over the fifteen years.

1.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIVAIDS is created through redistribution of current resources rather than increased national tax levels then, as Table 1 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, the short term low level of investment in UHC and HIVAIDS sectors has led to a resource gap from 2015/16 to

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⁴ Angola is still a middle income country in 2024/25 and so the middle income target is set rather than the high income which would be relevant after 2029/30.

⁵ This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
2018/19. We’ve shown that it looks likely that this can be covered by a slow sustainable rise in government expenditures to health; new innovative measures; and efficiency savings. But to cover the gap in the short run some new borrowing would be necessary. This is only a small amount – less than 1% of GDP – and if carefully managed could add little pressure on the debt burden. It must be kept in mind that this would only be a short term measure. The current levels of debt are projected to remain within the 60% ratio prescribed by SADC – this addition brings the projection to 36.1% - and below the 40% recommended by IMF as a sustainable debt ratio. Therefore if no new domestic (or development partner) monies can be found concessional borrowing may be a policy option.

1.6 Data Issues

Angola data availability allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2012/13) was used as a basis for trend projections.

For HIVAIDS the UNGASS 2010 and 2012 reports were used.
2 Botswana

2.1 Macro Indicators and Convergence Criteria

Table 2 shows a sub-set of key macroeconomic indicators for Botswana resulting from the financing gap model. These show that Botswana is growing at around 5% in real terms over the time period. Inflation is projected to fall as required by SADC to 3% by 2029/30, averaging 4% over the longer term. The Governments’ Fiscal Deficit is within acceptable boundaries and Public Debt is low and well below the SADC criteria. Indeed the IMFs Debt Sustainability Analysis shows that levels of debt are at historic lows and little risk is identified.

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2010/11-14/15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>13.3%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>7,568</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>23.8%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Source: OPM Macro

Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 8,000 USD in 2014/15 to almost 24,000 in 2029/30. This is a movement up from middle income to high income status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

2.2 Current Situation in Health and HIVAIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Botswana is primarily funded by the Government who provided 55% of total health expenditures. Private Companies provide about a third – mostly through private health insurance. International Donors account for 10%, and Households Out of Pocket Expenditures account for only 4% of the total health expenditures; both of which are low relative to other SADC countries. The National Budget allocation to health is around 7%.

For HIVAIDS the NASA 2008/09 data shows that almost 60% of funding was supplied by the government. 38% comes from donors, and only 3% from the private sector. Total expenditure on HIVAIDS was about 3% of GDP, and government expenditure on HIVAIDS accounts for 3% of the National Budget. This and a Domestic Investment Priority Index (DIPI) of 0.1 compared to the SADC region where the average was 0.5 (2008/09 – 2012/13)\(^7\). The Resch measure for comparable investment in HIVAIDS sits at 1.5, performing better as compared to the SADC average of 1.1 over the baseline period\(^8\).

2.3 Resource Gap

**Scenario 1: Business as Usual** – Botswana’s lower level health needs are set at 5% of GDP and HIVAIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 3 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- Botswana is already on a path to meet the targets for Government Expenditure on Health as a proportion of government expenditure: 9% (as per average high income country health expenditure in SADC). In parallel the government is also projected to continue to spend above the ‘fair share’ of health expenditure to HIVAIDS – 1.0 versus the target of 0.5\(^9\).

- UHC and HIVAIDS combined resource needs are projected to be underfunded by 0.8 billion USD pa if the status quo continues. This equates to an average of 2.7% of GDP a year, or 7.6% of the national budget.

What do these findings mean? By the targets we are using in this model is seems that Botswana should have enough funds to cover the combined UHC and HIVAIDS resource gap. However, it does not necessarily mean all needs are covered in Botswana, just that ‘theoretically’ they could be depending on the distribution of resources. Moreover, if there were changes to priority needs in Botswana there is much fiscal space to utilise to increase the services offered in Botswana.

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\(^7\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

\(^8\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.

\(^9\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
**Scenario 2: Innovative Action** – Since public spending on health and HIV/AIDS is projected to grow to levels to sustain needs in this second scenario we look only at earmarked funds and efficiency savings.

### 2.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIV/AIDS. To offset this and overcome the financing gap three policy options were examined (as Botswana already invests to the targeted budget amount), these are discussed below and shown in Figure 4:

1. **Alternative Sources** – The resource gap can be partially closed by introducing new alternative sources of funding. These specific taxation measures where revenues are earmarked for Health and HIV/AIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 165 million USD a year. This equates to an average of 0.4% of GDP.

2. **Efficiency** - If Botswana implemented efficiency measure they could save 620 million USD pa on the cost of health and HIV/AIDS services. This equates to around 1.9% of GDP, or up to 5% of the national budget. These two policy initiatives (earmarked taxes and efficiency) would be able to close the resource gap by 2022/23.

3. **Borrowing** – However, in the near term if needs were to be entirely covered Botswana would be required to borrow on average 350 million USD a year from 2015/16 to 2021/22. This would raise the Debt: GDP ratio by 3.1 percentage points over these seven years.
2.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, the medium term low level of investment in UHC and HIV/AIDS sectors has led to a resource gap from 2015/16 to 2021/22. We’ve shown that it looks likely that this can be covered by a slow sustainable rise in government expenditures to health; new innovative measures; and efficiency savings. But to cover the gap in the medium run some new borrowing would be necessary. This could be around 3% of GDP and if carefully managed could add little pressure on the debt burden since Botswana has low levels of public debt – currently projected to be only 11.3% of GDP in the ‘business as usual’ scenario. It must be kept in mind that this would only be a short term measure. The current levels of debt are projected to remain well within the 60% ratio prescribed by SADC – this addition brings the 15 year projection to 13.3% - and below the 40% recommended by IMF as a sustainable debt ratio. Therefore if no new domestic (or development partner) monies can be found concessional borrowing may be a policy option.

2.6 Data Issues

Botswanan data availability allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

However, for HIV/AIDS there was limited data sources. The NASA 2008 report was used as the basis for projections with only one data point.
3 Democratic Republic of Congo

3.1 Macro Indicators and Convergence Criteria

Table 3 shows a sub-set of key macroeconomic indicators for the Democratic Republic of Congo (Congo) resulting from the financing gap model. These show that Congo is growing at an average of 7.2% which is in line with the SADC criteria, and slowing down slightly over the longer term. Inflation is falling slower than required by SADC but could get to 3% by 2029/30 with appropriate policies. The Governments’ Fiscal Deficit has a strong possibility to grow to more than 5% of GDP which is out with the SADC convergence bounds. Public Debt is currently low due to debt relief and projected to stay within the SADC limits of 60% of GDP. However the IMF state that there are strong pressures for this to rise and the IMF’s Debt Sustainability Analysis suggests Congo remains at “high risk of debt distress”\(^{10}\).

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average</td>
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<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>7.2%</td>
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<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>15.2%</td>
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<td>GDP per capita (USD)</td>
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<td>-</td>
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<td>Inflation (Annual Change)</td>
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<td>3%</td>
<td>7.9%</td>
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<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>11.1%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>26.2%</td>
</tr>
</tbody>
</table>

Source: OPM Macro

Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 500 USD in 2014/15 to 1,250 in 2029/30. This is a movement up from low income to middle income status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

3.2 Current Situation in Health and HIVAIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Congo is largely paid for by the state which contributes 50% of the health funding. Donor funding equates to around 8% of the total health expenditures and the private sector not more than 3%. However, Households Out of Pocket Expenditures account for 40% of health expenditure. From the National Budget allocation to health is around 7%.

For HIVAIDS the NASA and Investment Framework for HIVAIDS data show that almost all of funding comes from donors. The Government provides only 2% of funding for HIVAIDS and these levels of expenditure are low at 0.1% of the National Budget. The Domestic Investment Priority Index (DIPI) is low at 0.001, which is significantly less than the SADC regional average of 0.5 (from 2008/09 – 2012/13)\(^{11}\). The Resch measure for comparable investment in HIVAIDS sits at 0.3, again low compared to the SADC average of 1.1 over the baseline period\(^{12}\).

3.3 Resource Gap

**Scenario 1: Business as Usual** – Congo’s lower level health needs are set at 86 USD per capita and HIVAIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 5 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIVAIDS resource needs are projected to be underfunded by 8 billion USD pa if the status quo continues.
- This equates to 11% of GDP or 42% of the national budget.

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\(^{11}\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV/AIDS within the population.

\(^{12}\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
**Scenario 2: Innovative Action** – Congo takes action to alleviate the resource gap by raising Government Expenditure on Health to 8% (as per average low income country health expenditure in SADC)\(^{13}\). In parallel the government would raise the share of health expenditure to HIVAIDS to 0.5\(^{14}\). This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

### 3.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 6:

1. **Increased Government Budget Allocation** - To provide some reduction of this resource gap current government funding to the health sector would need to increase from the current 7% allocated to health to 8% (as per low income average spend in SADC). The DIPI Resch measure would need to rise from 0.3 to 0.5 over the same time period. With a greater government commitment to UHC financing over the next fifteen years the gap could be reduced by an average of

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\(^{13}\) Congo is still a low income country in 2024/25 and so the low income target is set rather than the middle income which would be relevant after 2026/27.

\(^{14}\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
192 million USD pa. However this would not be sufficient to close the gap and other alternative funding options would be required.

2. **Alternative Sources** – The remaining gap can be reduced by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for Health and HIV/AIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 400 million USD per year. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Congo implemented efficiency measure they could save around 3 billion USD pa on the cost of services. This equates to 3.7% of GDP, or up to 13% of the national budget.

4. **Borrowing** – Finally, it is projected that to fully close the financing gap accumulation of debt is necessary to meet the needs for Congo. The amount required to borrow to fully close the gap would be around 4.5 billion USD per year over the fifteen years. In relation to the economy this would around 7% of GDP.
3.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIVAIDS is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, the particularly low level of investment in the Health and HIVAIDS sectors has led to a large resource gap. We’ve shown that it looks likely that this can be covered by a slow sustainable rise in government expenditures to health; new innovative measures; and efficiency savings. But to cover the gap in full new borrowing would be necessary. This would not be an insignificant amount – 7% of GDP – and could add pressure to what the IMF classify as ‘high risk of debt distress’ which already exists. Having said that the projected levels of debt including UHC/ HIVAIDS borrowing would lead to an average debt: GDP ratio of 44.1% which is within the 60% ratio prescribed by SADC, (but above that prescribed by the IMF as a sustainable debt ratio - 40%). It is expected that borrowing for UHC would not be a recommendation for Congo, if essential concessional borrowing should be the priority.

3.6 Data Issues

The data available for Congo allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

For HIVAIDS the National Investment Framework report for HIVAIDS had past data from NASA reports and strong projections on future funding including projections from donors.
4 Lesotho

4.1 Macro Indicators and Convergence Criteria

Table 4 shows a sub-set of key macroeconomic indicators for Lesotho resulting from the financing gap model. Lesotho’s growth rate looks strong over the period and inflation should fall to meet the SADC criteria although later than 2018. The Governments’ Fiscal Deficit has the potential to grow but remains within acceptable boundaries. Public Debt is at a sustainable level and well below the SADC criteria of 60% of GDP. The IMF’s latest Debt Sustainability Analysis states that Lesotho is at “moderate risk of debt distress”.

### MODEL PROJECTIONS FOR LESOTHO COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2015/16-29/30</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
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<td>GDP per capita (USD)</td>
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<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>22.9%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

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GDP per capita is expected to grow from around 1,300 USD in 2014/15 to almost 4,300 in 2029/30. Lesotho is projected to remain a middle income country over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

4.2 Current Situation in Health and HIVAIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 half of the Health sector Expenditures in Lesotho are sourced from the Government. Donors and Households Out of Pocket Expenses provide around 20% each, and the remainder is sourced from private companies. From the National Budget allocation to health sits at around 9%.

For HIVAIDS the NASA 2008/09 and 2009/10 reports show an equal share of funding comes from the Government and Donors, with only 1% from private contributions. Government expenditure on HIVAIDS account for 5% of the national Budget. The Domestic Investment Priority Index (DIPI) stands at 0.2 which is low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)\(^{16}\). The Resch measure for comparable investment in HIVAIDS sits at 1, which is in line with the SADC average of 1.1 over the baseline period\(^ {17}\).

4.3 Resource Gap

**Scenario 1: Business as Usual** – Lesotho’s lower level health needs are set as equal to the current levels of health expenditure – this is because Lesotho already spends more than 86 USD per capita and 5% of GDP on Health (112 USD in 2011/12, and 10% of GDP). HIVAIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 7 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIVAIDS resource needs should be able to be funded from the current levels of expenditure in Lesotho. As mentioned above the health expenditure from Government is above the international level for basic needs and so adequate allocation to HIVAIDS is within the government’s budget. However, at the moment the allocation to HIVAIDS is slightly lower and so a combined resource gap is found. This equates to 200 million USD a year.

- The gap is around 3.6% of GDP, or 8.9% of the national budget over the time period.

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\(^{16}\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

\(^{17}\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALY’s within Total DALYs.
**Scenario 2: Innovative Action** – Lesotho has relatively high levels of budget allocation to health – over the 12% found within SADC middle income countries. However, they could raise their HIVAIDS allocation within the health budget to gain a DIPI of 0.5. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

### 4.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 8:

1. **Increased Government Budget Allocation** – Within the current health expenditures the allocation to HIVAIDS has been raised from 0.4 to 0.5 (the DIPI Resch ‘fair share’ measure) by 2024/25 and remains at this level. With this policy Lesotho gap declines by an average of 400 million a year, but this is not sufficient and so other means of financing are required.

2. **Alternative Sources** – These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 33 million USD a year to the sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Lesotho implemented efficiency measure they could save on average 200 million USD pa on the cost of services. This equates to around 3.2% of GDP, or 8.3% of the national budget. These three policy measures would be able to close the resource gap by 2020/21.

4. **Borrowing** – Finally, to close the gap in the near term 74 million USD is required over the initial five years.
This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.

### 4.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to HIV/AIDS is created through redistribution of current resources rather than increased national tax levels then, as Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

If the 74 million USD were to be borrowed to close the gap in its entirety, this would mean a rise in the Debt: GDP ratio of 0.8 percentage points. Lesotho is projected to have a debt stock of around 33%, whilst this is within the IMF and SADC targets the country is considered to be at moderate risk of debt distress. Therefore if no new domestic (or development partner) monies can be found concessional borrowing may be a policy option.

### 4.6 Data Issues

The data availability for Lesotho allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

For HIV/AIDS the NASA reports of 2008/09 and 2009/10 were used. More time series and up to date data would have been preferable.
5 Madagascar

5.1 Macro Indicators and Convergence Criteria

Table 5 shows a sub-set of key macroeconomic indicators for Madagascar resulting from the financing gap model. These show that Madagascar will have to mitigate inflationary pressures to ensure that they meet the SADC real growth criteria. On average over the longer term inflation could fall to just above the 3% target. The Governments’ Fiscal Deficit runs the risk of rising above the SADC boundaries. Public Debt is low and well below the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that Madagascar is at ‘low risk’ of debt distress.

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>1.9%</td>
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<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
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<td>Inflation (Annual Change)</td>
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<tr>
<td>Fiscal Deficit (+/- 1%)</td>
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<td>3%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>9.7%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both).

GDP per capita is expected to grow from just less than 500 USD in 2014/15 to 1,000 in 2029/30. This is a movement up from low to middle income status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIV/AIDS.

5.2 Current Situation in Health and HIV/AIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Madagascar is financed in the main by Households Out of Pocket Expenditures which account for 26% of Total Health Expenditure (THE). The Government contributes 28%, Donors 25% and only 4% being provided by private companies. From the National Budget government allocation to health sits at around 8%, as a percentage of GDP THE is 4%.

For HIV/AIDS the NASA 2008 and UNGASS 2012 - 2013 reports suggests that 80% of funding comes from donors. The Government provides 19% of all funding for HIV/AIDS. Private sector expenditure estimated to be low at around 1% of total HIV/AIDS spending. In total, HIV/AIDS spending equates to 0.3% of GDP, and government budget allocation to HIV/AIDS is around 1%. The Domestic Investment Priority Index (DIPI) stands at 0.07 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIV/AIDS sits at 0.2, again low compared to the SADC average of 1.1 over the baseline period.

5.3 Resource Gap

Scenario 1: Business as Usual – Madagascar’s health needs are set at 86 USD per capita and HIV/AIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 9 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC and HIV/AIDS combined resource needs are underfunded by around 2.7 billion USD pa on average up 2029/30 if the status quo continues.
- This equates to 13% of GDP or 57% of the national budget, on average over the next 15 years.
**Scenario 2: Innovative Action** – Madagascar takes action to alleviate the resource gap by raising Government Expenditure on Health to 8% (as per average low income country health expenditure in SADC)\(^{22}\). In parallel the government would raise the share of health expenditure to HIVAIDS to 0.5\(^{23}\). This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

### 5.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 10:

1. **Increased Government Budget Allocation** – In an attempt to overcome this resource gap current government funding to the health sector would need
to rise from the current 7% allocated to health to reach 8% by 2024/25. The DIPI Resch measure would need to rise from 0.2 to 0.5 over the same time period. This would close the gap by 500 million USD a year over the 15 years, (as Madagascar is near to the low income health allocation already, and moving towards middle income status, they may wish to consider rising their target to the middle income status of 12%).

2. **Alternative Sources** – The remaining gap can be reduced by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 117 million USD a year to the HIVAIDS sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Angola implemented efficiency measure they could save around 640 million USD pa on the cost of services. This equates to 2.8% of GDP, or 11% of the national budget.

4. **Borrowing** – These three policies combined cannot remove the resource gap. Borrowing each year at an average of 1.9 billion USD would be required to close the gap fully. This equates to 9% of GDP on average over the fifteen years.
5.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIVAIDS is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, to cover the gap in full new borrowing would be necessary. This would not be an insignificant amount – 9% of GDP – and would be required over a long time period. Having said that the projected levels of debt including UHC/HIVAIDS borrowing would lead to an average debt: GDP ratio of 34.8% which is within the 60% ratio prescribed by SADC, and that prescribed by the IMF as a sustainable debt ratio - 40%. Yet, it is expected that borrowing for UHC would not be a recommendation for Madagascar due to the long term nature and high burden on the economy, but if essential concessional borrowing should be the priority.

5.6 Data Issues

Madagascar data availability allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2012/13) was used as a basis for trend projections.

For HIVAIDS the NASA 2008 and the UNGASS 2012-2013 reports were used. These provided the basis for the baseline HIVAIDS expenditures.
6 Malawi

6.1 Macro Indicators and Convergence Criteria

Table 6 shows a subset of key macroeconomic indicators for Malawi resulting from the financing gap model. These show that Malawi will have a challenge to keep a lid on inflationary pressures to ensure that they meet the SADC real growth criteria. On average over the longer term inflation could fall to just above the 3% target. The Governments’ Fiscal Deficit is within acceptable boundaries and Public Debt is below the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that risk to debt distress is ‘moderate’.24

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2015/16-29/30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2010/11-14/15 Average</td>
<td></td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>16.7%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>286</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>19.7%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>37.2%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 250 USD in 2014/15 to more than 600 in 2029/30. This is a movement within the low income country status over the time period – as such all macroeconomic indicators have been targeted to meet low income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIV/AIDS.

6.2 Current Situation in Health and HIV/AIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Malawi is financed 18% by the Government and 56% has been provided by international funding. Households Out of Pocket Expenditures account for 14% of health expenditure and the remaining 12% is sourced from private companies. There is no mandatory national health insurance and private health insurance accounts for around 4% of THE. From the National Budget allocation to health sits at around 4%, as a percentage of GDP THE is just less than 8%.

For HIV/AIDS the NASA report for 2007/08 shows data for 2008/09. This suggests that 1% of funding comes from government, and 1% from the domestic private sector. External funding provides 98% of all funding. As a proportion of GDP HIV/AIDS total funding equates to 2%, and for the government share HIV/AIDS spending is 0.1% of the national budget. The Domestic Investment Priority Index (DIPI) stands at 0.001 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)25. The Resch measure for comparable investment in HIV/AIDS sits at 0.09, again low compared to the SADC average of 1.1 over the baseline period26.

6.3 Resource Gap

**Scenario 1: Business as Usual** – Malawi’s health needs are set at 86 USD per capita and HIV/AIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 11 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- Combined UHC and HIV/AIDS needs are underfunded by 2 billion USD a year if the status quo continues.
- This equates to 23.5% of GDP or 76% of the national budget, on average over the next 15 years.

25 DIPI = Government expenditure on HIV/AIDS divided by General government expenditure as a proportion of the prevalence of HIV/AIDS within the population.

26 Resch measure of DIPI = Government expenditure on HIV/AIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
**Scenario 2: Innovative Action** – Malawi is projected to continue to allocate more than 8% to health from its national budget (as per top tier low income country health expenditure in SADC). However, within this the government should raise the share of health expenditure to HIVAIDS to 0.5. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

6.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 12:

1. **Increased Government Budget Allocation** – To overcome this gap current

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27 This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
government funding to HIVAIDS should would need to rise from 0.3 to 0.5 over the same time period (the DIPI Resch ‘fair share’ measure). This would not be sufficient to close the gap and so other alternative funding options are required.

2. **Alternative Sources** – The remaining gap can be partially closed in by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 50 million USD a year to the HIVAIDS sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Malawi implemented efficiency measure they could save around 580 million USD pa on the cost of services. This equates to 6% of GDP, or 19% of the national budget.

4. **Borrowing** – Finally, it can be noted that if the gap was to be fully closed borrowing over the fifteen years would be necessary at around 1.4 billion USD per year. This is 19% of GDP.

6.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIVAIDS is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

The increased borrowing needs would raise the Debt: GDP ratio by 19 percentage points from 29.6% to 48.6%
over the projection period. This remains within the SADC limits but out with the IMF suggested sustainability levels. For Malawi borrowing would be a long term investment – required each year for fifteen years. As such it may not be the optimal policy choice for financing UHC with HIVAIDS. If borrowing was a policy consideration concessional debt would need to be a priority as the country is moderately at risk of debt distress.

6.6 Data Issues

Malawi data availability allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2012/13) was used as a basis for trend projections.

For HIVAIDS the NASA 2007/08 report had data available for 2008/09. More recent data would be preferable.
7 Mauritius

7.1 Macro Indicators and Convergence Criteria

Table 7 shows a sub-set of key macroeconomic indicators for Mauritius resulting from the financing gap model. These show that Mauritius should benefit from healthy growth and inflation declining towards the 3% target over the next ten years. The Governments’ Fiscal Deficit is within acceptable boundaries. Public Debt is high, although declining and remains under the SADC ceiling. The IMF’s latest Debt Sustainability Analysis states that Mauritius’ public debt is sustainable over the medium term28.

![Table 7: Model Projections for Mauritius Compared to SADC Convergence Criteria](image)

**Source:** OPM Macro

*Notes:*
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.

** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from 10,500 USD in 2014/15 to more than 30,000 in 2029/30. This is a movement up from middle income to high income status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

7.2 Current Situation in Health and HIVAIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Mauritius is mostly funding through Households Out of Pocket Expenditures which account for 50% of health expenditure. The Government provides just over 40% of Total Health Expenditure, and donors only 2%. The remaining 5% is sourced from private companies. THE has been around 5% of GDP, and government expenditure on health is around 9% of the National Budget.

For HIVAIDS the UNGASS 2012 report shows that the Government provides 65% of all funding for HIVAIDS, donors 30%, and private consumption of 4%. Levels of total expenditure are low at 0.1% of the GDP, and government allocates 0.2% of the National Budget to HIVAIDS. In 2010/11 the Domestic Investment Priority Index (DIPI) stands at 0.2 which is lower in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIVAIDS is 1.6, this measure is higher compared to the SADC average of 1.1 over the baseline period.

7.3 Resource Gap

**Scenario 1: Business as Usual** – Mauritius’ health needs are set at 5% of GDP and HIVAIDS needs are provided by UNAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 13 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- **UHC inclusive of HIVAIDS resource needs are underfunded by around 380 million USD pa over the next 15 years if the status quo continues.**
- **This equates to 1.5% of GDP or 5.5% of the national budget.**

What do these findings mean? By the targets we are using in this model is seems that Mauritius should have enough funds to cover the combined UHC and HIVAIDS resource gap. However, it does not necessarily mean all needs are covered just that ‘theoretically’ they could be depending on the distribution of resources. Moreover, if there were changes to priority needs in Mauritius there is much fiscal space to utilise to increase the services offered in Mauritius.
**Scenario 2: Innovative Action** – Mauritius already allocates the average high income country target for health expenditure in SADC: 9%. Moreover, the government is projected to continue to allocate more than the proposed ‘Resch fair share’ of health expenditure to HIVAIDS: a DIPI of 0.5\(^3\). Therefore focus is kept on other financing options such as earmarked funds and efficiency savings.

### 7.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the financing gap four options were examined, these are discussed below and shown in Figure 14:

1. **Increased Government Budget Allocation** – As mentioned the government are already considered to be allocating sufficient funding to health and HIVAIDS.

2. **Alternative Sources** – The resource gap can be closed over the longer term by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the

\[^3\] This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
potential to bring an extra 138 million USD a year to the HIVAIDS sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Mauritius implemented efficiency measure they could save an average of 290 million USD pa on the cost of services. This equates to around 1% of GDP, or 3% of the national budget each year. The sum of these three measures could close the gap by 2022/23.

4. **Borrowing** – Finally, it can be noted that if gap was to be closed over the full timeframe Mauritius would need to borrow in the near term. From 2015/16 to 2021/22 the borrowing requirements would be just under 100 million per year, 0.6% of GDP.
7.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

If the 100 million USD pa were to be borrowed to close the gap in its entirety, this would mean a rise in the Debt: GDP ratio of 0.3 percentage points. Mauritius is projected to have a debt stock of around 46%, whilst this is within the SADC targets (60%), it is out with the sustainable recommendations of IMF (40%). If no new domestic (or development partner) monies can be found concessional borrowing may be a policy option as the need constitutes a small proportion of GDP and is for a short duration.

7.6 Data Issues

The data available for Mauritius allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections. There is a national health system (social security contributions paid shown in the national budget) but no data was found to be reliable enough to use in this model.

For HIV/AIDS the use of a mixture of sources, namely: National Budget; UNGASS; and Global Fund, provided the basis for the expenditure baseline.
8 Mozambique

8.1 Macro Indicators and Convergence Criteria

Table 8 shows a sub-set of key macroeconomic indicators for Mozambique resulting from the financing gap model. These show that Mozambique has a good outlook for strong growth levels and inflation could fall to meet SADC criteria of 3% by 2024/25, averaging 4.5% over the longer term. The Governments’ Fiscal Deficit is projected to remain out with the SADC criteria and Public Debt – although within the SADC criteria - is projected to remain sizable at 42% of GDP. The IMF’s latest Debt Sustainability Analysis places Mozambique as a country with “moderate risk of debt distress”.

### Table 8: Model Projections for Mozambique Compared to SADC Convergence Criteria

<table>
<thead>
<tr>
<th>SADC Convergence Targets</th>
<th>Baseline 2010/11-14/15 Average</th>
<th>Business As Usual 2015/16-29/30 Average</th>
<th>Innovative Action 2015/16-29/30 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>14.2%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>542</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>19.2%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>42.3%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 600 USD in 2014/15 to almost 2,000 in 2029/30. This is a movement up from low income to middle income status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIV/AIDS.

8.2 Current Situation in Health and HIV/AIDS

Using the World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Mozambique is highly donor dependant with around 65% being provided by international funding. Private companies account for around 17% and Households Out of Pocket Expenditures for 6% of health expenditure. The Government provides 12% of Total Health Expenditure, and allocation from the national budget is low at 2%. There national health insurance (social security) has been growing rapidly and stood at a third of government health expenditures in 2011/12.

For HIV/AIDS the NASA 2007/08 report showed that funding was highly dependent on donors – 96%. Government levels of expenditure are low 0.2% of the National Budget. The Domestic Investment Priority Index (DIPI) for 2008/09 at 0.001 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIV/AIDS sits at 0.3, again low compared to the SADC average of 1.1 over the baseline period.

8.3 Resource Gap

Scenario 1: Business as Usual – Mozambique’s health needs are set at 86 USD per capita, and HIV/AIDS needs are provides by UNAIDS. It is assumed that current allocation to health and HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 15 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIV/AIDS resource needs are underfunded by around 3.7 billion USD pa if the status quo continues.
- This equates to 9% of GDP or 28% of the national budget.

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**PROJECTIONS FOR COMBINED UHC AND HIV/AIDS RESOURCE GAP: MOZAMBIQUE SCENARIO 1 (M USD)**

**TOTAL Health AND HIV/AIDS Resource Needs**

**TOTAL Health AND HIV/AIDS Expenditures (Public & Donor)**

**TOTAL Health AND HIV/AIDS Gap**

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33 DIPI = Government expenditure on HIV/AIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.
34 Resch measure of DIPI = Government expenditure on HIV/AIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Mozambique takes action to alleviate the resource gap by raising Government Expenditure on Health to 12% (as per middle income country health expenditure in SADC). In parallel the government would raise the share of health expenditure to HIV/AIDS to 0.5\(^{35}\). This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

8.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for health and HIV/AIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 16:

1. Increased Government Budget Allocation – To overcome this gap current government funding to the health sector would need to greatly increase from the current 2% allocated to health (to reach 12% - as per middle income peers). The DIPI Resch measure would need to rise from 0.3 to 0.5 over the same time period. With a greater government commitment to Health and HIV/AIDS financing over the next fifteen years UHC could gain from 1.8 billion USD pa over the time period. This would not be enough to close the gap and so other alternative funding options are required.

2. Alternative Sources – The remaining gap can be partially closed by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIV/AIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 232 million USD a year to the sector. This equates to an average of 0.4% of GDP.

3. Efficiency – If Mozambique implemented efficiency measure they could save 1.1 billion USD pa on the cost of services. This equates to 2.2% of GDP, or 7% of the national budget.

4. Borrowing – Finally, it is projected that some accumulation of debt is necessary to meet the UHC needs for Mozambique. Initially borrowing needs are projected at 2 billion USD a year in the near term and falling once the new expenditure, taxation and efficiency measures take effect, reaching 180 million by 2029/30. Over the entire period this would constitute 16% of GDP.

\(^{35}\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
8.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, with respect to the possible borrowing for UHC, the IMF have just raised Mozambique’s debt risk from low to moderate and so it may not be advisable to take on extra debt at this point. The model projects that Mozambique would remain within Debt: GDP sustainable levels as per SADC 60% target but it is projected to rise above the IMF recommendation of 40% in the medium term. If the remaining resource gap was to be closed in its entirety (after other domestic funding actions) the Debt: GDP ratio could rise to 53% over the time period. Given the longitudinal nature of the borrowing requirement, and the burden on the economy, borrowing may not be a suitable policy option for Mozambique. If any borrowing was undertaken concessional borrowing ought to be a priority.

8.6 Data Issues

The data available for Mozambique allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

For HIV/AIDS there was little up to date data available. The model used the NASA 2007/08 report.
9 Namibia

9.1 Macro Indicators and Convergence Criteria

Table 9 shows a sub-set of key macroeconomic indicators for Namibia resulting from the financing gap model. Growth and inflation in Namibia are projected to move towards the SADC criteria over the next fifteen years.

The Governments’ Fiscal Deficit is expected to reduce to fall within acceptable SADC boundaries and Public Debt is falling and well below the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that Namibia is in a sustainable debt position but that there are factors pressuring the rise of debt that should be mitigated36.

### MODEL PROJECTIONS FOR NAMIBIA COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th></th>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2010/11-14/15 Average</td>
<td>2015/16-29/30 Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>4.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>10.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>5,506</td>
<td>9,230</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>5.8%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-4.8%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>29.4%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>26.0%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 5,500 USD in 2014/15 to more than 13,000 in 2029/30. This is a movement up from middle income to high income status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

9.2 Current Situation in Health and HIVAIDS

The World Health Organisation (WHO) data for 2008/09 – 2011/12 shows the Government funding 40% of the Health Expenditures, and donors account for 15%. Households Out of Pocket Expenditures account for just less than 8% of health expenditure whilst private companies fund 35%. The private health insurance sector is large in Namibia accounting for the majority of private company funding. Namibia also has a national health insurance which accounts for 2.5% of the Government spending on health. From the National Budget allocation to health has been around 10%.

The NASA 2009/10 and 2010/11 reports shows that the HIVAIDS expenditures are split between the Government and Donors. The Government provides slightly more than half which equates to 4% of the National Budget. The Domestic Investment Priority Index (DIPI) stands at 0.2 which is lower than the SADC regional average of 0.5 (average 2008/09 – 2012/13)37. The Resch measure for comparable investment in HIVAIDS sits at 1.7, which is greater than the SADC average of 1.1 over the baseline period38.

9.3 Resource Gap

Scenario 1: Business as Usual – Namibia’s health needs are set as equal to the current levels of expenditure – this is because Namibia already spends more than 86 USD per capita and 5% of GDP on Health (300 USD in 2011/12, and 9% of GDP, respectively). The HIVAIDS resource needs are provided by UNAIDS. Within this scenario it is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 17 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIVAIDS resource needs are underfunded by an average of 364 million USD pa if the status quo continues.
- This equates to 1.5% of GDP and 4.6% of the national budget over the fifteen years.

What do these findings mean? By the targets we are using in this model technically Namibia should have enough funds to cover the combined UHC and HIVAIDS resource gap. However, it does not necessarily mean all needs are covered, just that ‘theoretically’ they could be depending on the distribution of resources. Moreover, if there were changes to priority needs in Namibia there is much fiscal space to utilise to increase the services offered in Namibia.

37 DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.
38 Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Since public spending on health and HIVAIDS is projected to grow to levels to sustain needs in this second scenario we look only at earmarked funds and efficiency savings.

9.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for Health and HIVAIDS. To offset this and overcome the resource gap domestic financing options were examined, these are discussed below and shown in Figure 18:

1. **Alternative Sources** – To reduce the gap new alternative sources of funding may be used. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 138 million USD a year to the sector. This equates to an average of 0.4% of GDP.

2. **Efficiency** – If Namibia implemented efficiency measure they could save 549 million USD pa on the cost of services. This equates to 2% of GDP, or almost 6% of the national budget. Together these two policy actions can close the gap by 2019/20.

3. **Borrowing** – In the near term to fully close the gap 157 million USD would need to be borrowed each year from 2015/16 to 201/19. This would amount to 1.1% of GDP on average over the four years.
9.5 Fiscal and Macro Implications

As Table 9 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

If the 157 million USD pa were to be borrowed to close the gap in its entirety, this would mean a rise in the Debt: GDP ratio of 0.3 percentage points. Namibia is projected to have a debt stock of around 22% of GDP, which is within both the SADC (60%) and IMF (40%) advised limits. If no new domestic (or development partner) monies can be found concessional borrowing may be a policy option as the need constitutes a small proportion of GDP and is for a short duration.

9.6 Data Issues

Data available for Namibia allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

HIV/AIDS analysis used the NASA 2009/10 and 2010/11 report.
10 Seychelles

10.1 Macro Indicators and Convergence Criteria

Table 10 shows a sub-set of key macroeconomic indicators for the Seychelles resulting from the financing gap model. The Seychelles are projected to grow along the lines of the SADC growth target and inflation is low meeting the target over the next fifteen years. The Government’s Fiscal Deficit is within acceptable boundaries, and Public Debt is falling to within the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that the Seychelles is committed to reducing its debt and that debt does not pose a high risk.

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2015/16-29/30</td>
<td>2015/16-29/30</td>
</tr>
<tr>
<td></td>
<td>2018</td>
<td>Average</td>
<td>Average</td>
</tr>
</tbody>
</table>

Real GDP Growth* 7% 7% 4.1% 4.3% -
Nominal GDP Growth - - 7.7% 7.4% -
GDP per capita (USD) - - 12,475 24,287 -
Inflation (Annual Change) 5% 3% 3.4% 3.0% -
Fiscal Deficit (+/- 1%) 3% 3% 2.5% 0.3% -
Tax Burden** - - 31.8% 32.7% 33.0%
Public Debt (% GDP) 60% 60% 74.0% 47.7% 47.8%

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 14,000 USD in 2014/15 to more than 37,000 in 2029/30. This is a movement upwards within the high income country status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

10.2 Current Situation in Health and HIVAIDS

The World Health Organisation (WHO) data for 2008-09 – 2011/12 shows that the Government finances the majority of health expenditures; 85%. Donors contribute 7%, Households Out of Pocket 5% and Private Companies 3%. There is a national health insurance system which accounts for only 3% of Government Expenditure on Health. The Private Health Insurance Sector is also small accounting for only 1% of total health expenditures. From the National Budget allocation to health is 8%.

The UNAIDS UNGASS 2014 report was used for the years 2010/11 to 2012/13. This shows that the government contributes more than 90% of the total HIVAIDS expenditures in Seychelles – additionally there is a 1 million USD earmarked trust fund paid by the government each year. The Domestic Investment Priority Index (DIPI) stands at 10 which is very high in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)\(^{40}\). The Resch measure for comparable investment in HIVAIDS sits at almost 7, again high compared to the SADC average of 1.1 over the baseline period\(^{41}\).

10.3 Resource Gap

**Scenario 1: Business as Usual** – Seychelles’ lower level health needs are set at 5% of GDP. UNAIDS has no resource needs for HIVAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 19 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC needs are underfunded by 16 million USD pa if the status quo continues.
- This equates to 0.7% of GDP, or 1.9% of the national budget.

Note this representation is an underrepresentation of the size of the resource gap for Seychelles as the HIVAIDS resource needs are not included. This actually represents the UHC needs only, against UHC available expenditures inclusive of HIVAIDS available expenditures.

If we assumed that the minimum underrepresentation is in line with the amount currently being spent on HIVAIDS. This is projected to be 8 million USD a year over the 15 year period. This would make the resource gap increase by a third to 24 million USD a year. This is simply conjecture and has not been included in the framework.

---

\(^{40}\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

\(^{41}\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
**Scenario 2: Innovative Action** – Seychelles takes action to alleviate the resource gap by raising Government Expenditure on Health to 9% (as per high income country health expenditure in SADC)\(^2\). In parallel the government would raise the share of health expenditure to HIVAIDS to 0.543. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

**10.4 Domestic Financing Options**

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the gap four options were examined, these are discussed below and shown in Figure 20 Figure 2:

1. **Increased Government Budget Allocation** – To overcome this gap current government funding to the health sector would need to increase from the current 8% allocated to health (to reach 15%). With a greater government commitment to health financing over the next fifteen years Seychelles could gain from an additional 88 million USD a year. This would be not be sufficient to close the gap and so other alternative funding options are required.

2. **Alternative Sources** – The remaining gap can be partially closed by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 13 million USD a year to the sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If the Seychelles implemented efficiency measure they could save from 26 million USD pa on the cost of services. This equates to 1% of GDP, or 2.6% of the national budget. If these were planned and carried out well the savings from efficiency gains would reduce the resource needs to a level where, there resource gap could be closed in the short term.

4. **Borrowing** – Finally, It is projected that some accumulation of debt is necessary
to close the gap in 2015/16. This would be around 4 million USD, which is 0.2% of GDP.

Note: If the additional HIVAIDS resource needs were included—minimum of an additional 8 million USD a year—the gap could be closed by 2019/20 with the three financing polices mentioned. This would raise the borrowing requirement from one year to four years at an average level of 7 million USD a year.

10.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health is created through redistribution of current resources rather than increased national tax levels then, as the Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, if Seychelles wanted to close the gap in its entirety they would need to borrow 4 million USD in 2015/16. The small borrowing needs projected here would result in a Debt: GDP ratio (47.8% pa average) within sustainable levels as per the SADC 60% target, but it brings the ratio outside the IMF recommendation of 40%. Therefore any policy consideration on borrowing should make concessional borrowing a priority.

10.6 Data Issues

Data availability for the Seychelles allowed for the general macro modelling methodology to be applied; i.e. the WHO
Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

For HIV/AIDS data was taken from the UNGASS report. However, no data was available for the resource needs from UNAIDS. Also there was no data available on DALYs – total and those attributable to HIV/AIDS. Therefore, a proxy was used based on the SADC prevalence to DALY relationship and then estimated from the Seychelles prevalence rate. Given this lack of data the findings for Seychelles should be considered as a draft.
11 South Africa

11.1 Macro Indicators and Convergence Criteria

Table 11 shows a sub-set of key macroeconomic indicators for South Africa resulting from the financing gap model. These show that South Africa has the potential for a growth rate slightly less than the SADC targets and a low inflation rate. The Governments’ Fiscal Deficit must fall to come within acceptable SADC boundaries and Public Debt is somewhat high but below the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that South Africa’s debt is manageable but measures should be taken to ensure stability over the medium term44.

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 2018</td>
<td>2010/11-14/15 Average</td>
<td>2015/16-29/30 Average</td>
<td>2015/16-29/30 Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7% 7%</td>
<td>2.8% 5.0%</td>
<td>-</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>- -</td>
<td>9.2% 9.2%</td>
<td>-</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>- -</td>
<td>7,203 13,501</td>
<td>-</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5% 3%</td>
<td>5.3% 4.1%</td>
<td>-</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3% 3%</td>
<td>-4.5% -0.5%</td>
<td>-</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>- -</td>
<td>25.8% 29.3% 29.7%</td>
<td>-</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60% 60%</td>
<td>34.3% 46.8% 46.8%</td>
<td></td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 7,000 USD in 2014/15 to more than 22,000 in 2029/30. This is a movement up from middle income to high income status over the time period – as such all macroeconomic indicators have been targeted to meet high income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIV/AIDS.

11.2 Current Situation in Health and HIVAIDS

The World Health Organisation (WHO) data for 2008/09 – 2011/12 shows the Health sector in South Africa to be financed largely through private companies – covering 46% of the total health expenditures. This is mostly private health insurance. The government accounts for 45% of expenditures, donors 2% and Households Out of Pocket Expenditures account for 8%. The national health insurance system is small and accounts for 3% of government health expenditures. From the National Budget allocation to health sits at around 12%.

For HIV/AIDS the UNGASS 2012 report show 75% of funding being sourced from government. Just less than 20% comes from donors. The Government spending on HIV/AIDS accounts for 1.2% of the National Budget, and total spending on HIVAIDS equates to 0.5% of GDP. The Domestic Investment Priority Index (DIPI) stands at 0.002 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)\(^{45}\). The Resch measure for comparable investment in HIVAIDS sits at 0.3, again low compared to the SADC average of 1.1 over the baseline period\(^{46}\).

11.3 Resource Gap

**Scenario 1: Business as Usual** – South Africa’s health needs are set as equal to the current levels of expenditure – this is because South Africa already spends more than 86 USD per capita and 5% of GDP on Health (300 USD in 2011/12). HIVAIDS resource needs are provided by UNAIDS. Within this scenario it is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 21 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- Combined UHC and HIVAIDS resource needs should be able to be funded from the current levels of health expenditure in South Africa, however the allocation to HIVAIDS is insufficient as a financing gap is found.
- The financing gap averages 1.8 billion USD pa over the fifteen years. This equates to 0.2% of GDP, and 0.6% of national budget.

\(^{45}\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

\(^{46}\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Assuming the current budget share to health is sufficient (as mentioned) the government should raise the share of health expenditure to HIVAIDS to 0.5\(^\text{67}\). This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

11.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 22:

1. Increased Government Budget Allocation – If South Africa raises its share of health expenditure to HIVAIDS from the current 0.3 to 0.5 (Resch ‘fair share’) an extra 53 million USD could be spent on HIVAIDS per year over the next fifteen years. This would entirely remove the combined resource gap hinting that the allocation within the current system is not optimal.

2. Alternative Sources – Specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 3.9 billion USD a year to the sector. This equates to an average of 0.4% of GDP.

3. Efficiency – If South Africa implemented efficiency measure they could save 10 billion USD pa on the cost of services. This equates to 1.2% of GDP, or 4% of the national budget.

4. Borrowing – Finally, no new borrowing needs are projected for South Africa.

\(^{67}\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
11.5 Fiscal and Macro Implications

As Table 2 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

11.6 Data Issues

Data availability for South Africa allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

HIV/AIDS analysis used the UNGASS 2012 report.
12 Swaziland

12.1 Macro Indicators and Convergence Criteria

Table 12 shows a sub-set of key macroeconomic indicators for Swaziland resulting from the financing gap model. The growth rate in Swaziland is subdued over the medium term with a falling inflation rate but with the right policies could meet the SADC criteria on growth and inflation. The Governments’ Fiscal Deficit is low and within acceptable boundaries as is Public Debt. The IMF’s latest Debt Sustainability Analysis warns that Swaziland could face a “significant risk of debt distress in the medium term” due to upward pressures on debt levels48.

TABLE 12

MODEL PROJECTIONS FOR SWAZILAND COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2010/11-14/15 Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>6.9%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>3,097</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>27.8%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 3,000 USD in 2014/15 to almost 6,000 in 2029/30. This is a movement upwards within the middle income country status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

12.2 Current Situation in Health and HIVAIDS

The World Health Organisation (WHO) data for 2008/09 – 2011/12 shows that more than half of all Health expenditures in Swaziland are funded by the government – 55%. Donors contribute 13% as do Households Out of Pocket Expenditures. Private Companies account for around 18% of which a third are registered as Private Health Insurance. There is no mandatory national health insurance. From the National Budget allocation to health sits at around 12%.

For HIVAIDS the UNGASS 2012 report shows 40% of funding from government and 50-60% from donors. The private sector accounts for only 3% of HIVAIDS spending. The government spends about 2% of its national budget on HIVAIDS related expenditures. The Domestic Investment Priority Index (DIPI) stands at 0.1 which is low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)\(^{49}\). The Resch measure for comparable investment in HIVAIDS sits at 0.5, again low compared to the SADC average of 1.1 over the baseline period\(^{50}\).

12.3 Resource Gap

**Scenario 1: Business as Usual** – Swaziland’s health needs are set as equal to the current levels of expenditure – this is because Swaziland already spends more than 86 USD per capita and 5% of GDP on Health (189 USD in 2011/12, and 6% of GDP, respectively). Within this scenario it is assumed that current allocation to HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 23 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- Combine UHC and HIVAIDS resource needs should be able to be funded from the current levels of expenditure in Swaziland. However, the allocation to HIVAIDS is less than what is considered a ‘fair share’, therefore a financing gap is found.

- The gap is 150 million USD per year over the projection period. This equates to almost 3% of GDP, or 8% of the national budget.

\(^{49}\) DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

\(^{50}\) Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Swaziland could raise the share of health expenditure to HIVAIDS to 0.5. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

12.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 24:

1. Increased Government Budget Allocation – Keeping health budget allocation constant but raising the share of health budget going to HIVAIDS could raise an additional 400 million USD per year. But would be insufficient to close the gap.

2. Alternative Sources – The gap could be reduced by new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 33 million USD a year.

3. Efficiency – If Swaziland implemented efficiency measure they could save 144 million USD pa on the cost of services. This equates to 2.3% of GDP, or 7% of the national budget, and could close the financing gap by 2021/22 (in addition to the budget allocation and earmarked taxes).

4. Borrowing – Finally, if Swaziland aimed to remove the gap in its entirety in each year they could raise funds through borrowing. From 2015/16 to 2020/21 an annual average of 69 Million USD would need to be borrowed.

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51 This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
12.5 Fiscal and Macro Implications

As Table 12 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, if Swaziland chose to borrow to fund their resource gap this would raise the Debt: GDP ratio by 5% - from 29% to 34% on average over the fifteen years. Whilst these levels of debt are not high relative to both the IMF and SADC debt ceilings, the latest IMF Debt Sustainability Analysis states that there is concern over rising debt levels in Swaziland. Therefore this line of action should be taken with serious consideration, and if debt was considered concessional arrangements ought to be a priority.

12.6 Data Issues

Data availability for Swaziland allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

For HIV/AIDS the UNGASS 2012 report was used to create a baseline.
13 Tanzania

13.1 Macro Indicators and Convergence Criteria

Table 13 shows a sub-set of key macroeconomic indicators for Tanzania resulting from the financing gap model. Tanzania has strong growth projected and declining inflation over the next fifteen years. The Governments’ Fiscal Deficit is projected to decline but will remain outside of the SADC criteria. Public Debt is high and has the potential to grow further, however it will remain within the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that Tanzania’s ‘risk of debt distress remains low’ despite this rise in Debt: GDP ratio.\(^{52}\)

T.13 MODEL PROJECTIONS FOR TANZANIA COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE 2010/11-14/15</th>
<th>BUSINESS AS USUAL 2015/16-29/30</th>
<th>INNOVATIVE ACTION 2015/16-29/30</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>15.6%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>-</td>
<td>601</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-5.7%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>16.1%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>41.4%</td>
</tr>
</tbody>
</table>

Source: OPM Macro Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from 695 USD in 2014/15 to around 1,500 in 2029/30. This is a movement up from low income to middle income status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

13.2 Current Situation in Health and HIV/AIDS

The World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Tanzania is donor dependent with more than 40% being provided by international funding. Households Out of Pocket Expenditures account for 18% of health expenditures and private companies 25% (of which a small proportion is registered as private health insurance). The Government provides around 14% of Total Health Expenditure, 5% of this comes from social security / national health insurance contributions. From the National Budget allocation to health is 3%.

For HIV/AIDS the NASA 2005/06 reports show that Tanzania is donor dependent with 70% of funds being sourced externally. The Government provides a quarter of all funding for HIV/AIDS and levels of expenditure are just less than 4% of the National Budget. The Domestic Investment Priority Index (DIPI) stands at 0.01 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIV/AIDS sits at 2.9, this is high compared to the SADC average of 1.1 over the baseline period.

13.3 Resource Gap

Scenario 1: Business as Usual – Tanzania’s health needs are set at 86 USD per capita and HIV/AIDS resource needs are provided by UNAIDS. It is assumed that current allocation to HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 25 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- UHC inclusive of HIV/AIDS resource needs are underfunded by 6.4 billion USD pa if the status quo continues.
- This equates to 9% of GDP or 32% of the national budget.

F.25 PROJECTIONS FOR COMBINED UHC AND HIV/AIDS RESOURCE GAP: TANZANIA SCENARIO 1 (M USD)

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1) DIPI = Government expenditure on HIV/AIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.
2) Resch measure of DIPI = Government expenditure on HIV/AIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
**Scenario 2: Innovative Action** – Tanzania takes action to alleviate the financing gap by raising Government Expenditure on health to 12% (as per top tier middle income country health expenditure in SADC). The government already contributes more than the estimated ‘fair share’ to HIVAIDS from health expenditure – a ratio of 3 as compared to the minimum suggested 0.5\(^5\). The health expenditure rise would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

### 13.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 2:

1. **Increased Government Budget Allocation** – To overcome this gap current government funding to the health sector would need to rise significantly from the current 3% allocated to health (to reach 12%). The allocation to HIVAIDS within the current allocation is seen as above the Resch ‘fair share’ measure and so remains over the projection period. The rise in general health expenditure from the government could bring an average of 2.7 billion USD to assuming the allocation within Health to HIVAIDS remains constant.

2. **Alternative Sources** – The remaining gap can be partially closed by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 385 million USD a year to the sector. This equates to an average of 0.4% of GDP.

3. **Efficiency** – If Tanzania implemented efficiency measure they could save 1.8 billion USD pa on the cost of services. This equates to 2.4% of GDP, or 8.5% of the national budget.

4. **Borrowing** – To close the gap in its entirety borrowing would be required each year at an average of 2.7 billion USD. This would be 4.5% of GDP a year over the fifteen year period.

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\(^5\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
### 13.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIV/AIDS is created through redistribution of current resources rather than increased national tax levels, then, as Table 13 above shows, there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

The increased borrowing needs would raise the Debt: GDP ratio by 4.5 percentage points from 44% to 48% over the projection period. This remains within the SADC limits but out with the IMF suggested sustainability levels. For Tanzania borrowing would be a long term investment – required each year for fifteen years. As such it may not be the optimal policy choice for financing UHC with HIV/AIDS. If borrowing was a policy consideration concessional debt would need to be a priority as the country is moderately at risk of debt distress.

### 13.6 Data Issues

The Tanzania model used both the WHO Global Health Expenditure Database data (2008/09 to 2011/12) and a recent Health Public Expenditure Review covering 2010/11 as a basis for trend projections.

However, for HIV/AIDS the only data available was the NASA 2005/06 report, and so the government data is not as up to date as one would wish. For donor contributions the model uses the National Multi-Sectoral HIV/AIDS Strategy 2012/13 – 2017/18 which includes data on historic trends for PEPFAR and Global Fund disbursements (2009/10 – 2012/13).
14 Zambia

14.1 Macro Indicators and Convergence Criteria

Table 14 shows a sub-set of key macroeconomic indicators for Zambia resulting from the financing gap model. The next fifteen years are projected to have strong growth and declining inflation. However, the Governments’ Fiscal Deficit could continue to be outside of the SADC convergence target. Although Public Debt is expected to rise it remains within the SADC criteria. The IMF’s latest Debt Sustainability Analysis states that Zambia is at ‘low risk of debt distress’\(^{56}\).

MODEL PROJECTIONS FOR ZAMBIA COMPARED TO SADC CONVERGENCE CRITERIA

<table>
<thead>
<tr>
<th>SADC CONVERGENCE TARGETS</th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2018</td>
<td>2010/11-14/15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>7%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>-</td>
<td>16.1%</td>
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<tr>
<td>GDP per capita (USD)</td>
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<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-5.1%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>-</td>
<td>14.2%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>60%</td>
<td>26.2%</td>
</tr>
</tbody>
</table>

Source: OPM Macro
Model Notes:
* = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)

GDP per capita is expected to grow from around 1,600 USD in 2014/15 to 3,900 in 2029/30. This is a movement up the middle income country status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIVAIDS.

14.2 Current Situation in Health and HIV/AIDS

The World Health Organisation (WHO) data for 2008/09 – 2011/12 the Health sector in Zambia is funded by 24% from the government, 35% by donors, 27% by Households Out of Pocket Expenditures, and 13% from private companies. There is no mandatory national health insurance and private health insurance accounts for only 1.5% of total health expenditure. From the National Budget allocation to health is around 6% over this period.

For HIV/AIDS the NASA 2005/06 reports show high donor dependency in the financing of HIV/AIDS – 90%. The Government provides 7% of funding for HIV/AIDS, which equates to 0.5% of the National Budget. The Domestic Investment Priority Index (DIPI) stands at 0.01 which is very low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13)\(^{57}\). The Resch measure for comparable investment in HIV/AIDS sits at 0.4, again low compared to the SADC average of 1.1 over the baseline period\(^{58}\).

14.3 Resource Gap

**Scenario 1: Business as Usual** – Zambia’s lower level health needs are set at 86 USD per capita and the HIV/AIDS resource needs are provided by UNAIDS. It is assumed that current allocation to health and HIV/AIDS and other related policies are continued with a slowdown in donor funding. Figure 27 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- Combined UHC and HIV/AIDS resource needs would be underfunded by around 690 million USD pa if the status quo continues.
- This equates to 1.6% of GDP or 5.3% of the national budget.

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\(^{57}\) DIPI = Government expenditure on HIV/AIDS divided by General government expenditure as a proportion of the prevalence of HIV/AIDS within the population.

\(^{58}\) Resch measure of DIPI = Government expenditure on HIV/AIDS divided by Government expenditure on Health as proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Zambia takes action to alleviate the financing gap by raising Government Expenditure on Health to 12% (as per top tier middle income country health expenditure in SADC). In parallel the government would raise the share of health expenditure to HIVAIDS to 0.559. This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

14.4 Domestic Financing Options

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 28:

1. Increased Government Budget Allocation – In an attempt to overcome this gap current government funding to the health sector could double from the current 6% allocated to health (to reach 12%). The DIPI Resch measure would need to rise to 0.5 over the same time period. With a greater government commitment the Zambia could gain an additional 261 million USD pa over the projected time period. This could close the gap by 2028/29.

2. Alternative Sources – The remaining gap can be partially closed in the short to medium term by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 285 million USD a year to the sector. This equates to an average of 0.4% of GDP and would close the gap by 2024/25 alongside the budget allocation measures.

3. Efficiency – If Zambia implemented efficiency measure they could save an annual average of 580 million USD on the cost of services. This equates to 1% of GDP, or 3% of the national budget. The addition of efficiency savings to the first two financing options would close the financing gap by 2021/22.

4. Borrowing – Finally, to close the gap fully borrowing would be required in the initial six years averaging 390 million USD a year, (2.3% of GDP).

59 This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
14.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIV/AIDS is created through redistribution of current resources rather than increased national tax levels then there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, if the gap was to be entirely closed the Debt: GDP ratio would rise by 1.9% over the projection period. This moves the ratio (42.6%) outside the IMF bounds of advised debt sustainable levels (40%), but would remain within the SADC convergence criteria target (60%). However, it would only be for the medium term before other domestic sources rose to accommodate UHC needs.

Therefore this line of action should be taken with serious consideration, and if debt was considered concessional arrangements ought to be a priority.

14.6 Data Issues

Data availability for Zambia allowed for the general macro modelling methodology to be applied; i.e. the WHO Global Health Expenditure Database data (2008/09 to 2011/12) was used as a basis for trend projections.

More up to date data would have been useful for HIV/AIDS. The only source found was NASA 2005/06 which had budget data projections for 2006 and 2007.
15 Zimbabwe

15.1 Macro Indicators and Convergence Criteria

Table 15 shows a sub-set of key macroeconomic indicators for Zimbabwe resulting from the financing gap model. Strong growth and low inflation are in line with SADC requirements. The Governments’ Fiscal Deficit is within acceptable boundaries for the projected period. Public Debt is high, and although declining over the period it is still outside the SADC ceiling. The IMF’s latest Debt Sustainability Analysis states that Zimbabwe is currently in debt distress60.

GDP per capita is expected to grow from around 800 USD in 2014/15 to more than 2,000 in 2029/30. This is a movement up from low income to middle income status over the time period – as such all macroeconomic indicators have been targeted to meet middle income levels by 2029/30; e.g. taxation rates, and ODA levels. These will affect the fiscal space available for health and HIV/AIDS.

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### SADC CONVERGENCE TARGETS

<table>
<thead>
<tr>
<th></th>
<th>BASELINE</th>
<th>BUSINESS AS USUAL</th>
<th>INNOVATIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2010/11-14/15</td>
<td>2015/16-29/30</td>
</tr>
<tr>
<td></td>
<td>2018</td>
<td>Average</td>
<td>Average</td>
</tr>
<tr>
<td>Real GDP Growth*</td>
<td>7%</td>
<td>9.2%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>-</td>
<td>12.5%</td>
<td>9.2%</td>
</tr>
<tr>
<td>GDP per capita (USD)</td>
<td>-</td>
<td>720</td>
<td>1,545</td>
</tr>
<tr>
<td>Inflation (Annual Change)</td>
<td>5%</td>
<td>3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Fiscal Deficit (+/- 1%)</td>
<td>3%</td>
<td>3%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Tax Burden**</td>
<td>-</td>
<td>32.9%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Public Debt (% GDP)</td>
<td>60%</td>
<td>91.2%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

**Source:** OPM Macro

**Model Notes:**
- * = The sustainability of a 7% real growth rate over ten years was considered optimistic and for the model a more conservative 5% real growth rate was used.
- ** = Tax Burden in Baseline is the Tax: GDP Ratio, in Innovative Action Scenario the taxation-related innovative funding mechanisms are added (NHIF / SSF mandatory contributions are included in both)
15.2 Current Situation in Health and HIVAIDS

Data on the Health sector (2008/09 – 2011/12) in Zimbabwe shows Households Out of Pocket Expenditures account for almost 50% of health expenditure. The Government provides just less than a third, donors just less than 30% and 5% is sourced from private companies. The Governments national health insurance makes up 15% of the governments funding of health. From the National Budget allocation to health is around 8%.

For HIVAIDS the UNGASS 2012 report show that the sector is donor dependant funding 60% of total spending. The Government provides 37% of all funding for HIVAIDS – this includes a 3% earmarked transfer of domestic tax revenues. The Domestic Investment Priority Index (DIPI) stands at 0.02 which is low in comparison to the SADC region where the average was 0.5 (average 2008/09 – 2012/13). The Resch measure for comparable investment in HIVAIDS sits at 0.1, again low compared to the SADC average of 1.1 over the baseline period.

15.3 Resource Gap

Scenario 1: Business as Usual – Zimbabwe’s health needs are set at 86 USD per capita, and HIVAIDS resource needs are provided by UNAIDS. It is assumed that current allocation to health and HIVAIDS and other related policies are continued with a slowdown in donor funding. Figure 29 shows an overview of the findings on resource needs, available funding, and resultant funding gaps. Key findings are as follows:

- HIVAIDS needs could be underfunded by 940 million USD pa if the status quo continues.
- This equates to 4.5% of GDP or 10.5% of the national budget.

![Graph showing resource gap projections](image-url)

DIPI = Government expenditure on HIVAIDS divided by General government expenditure as a proportion of the prevalence of HIV AIDS within the population.

Resch measure of DIPI = Government expenditure on HIVAIDS divided by Government expenditure on Health as a proportion of AIDS DALYs within Total DALYs.
Scenario 2: Innovative Action – Zimbabwe takes action to alleviate the financing gap by raising Government Expenditure on Health to 12% (as per top tier middle income country health expenditure in SADC). In parallel the government would raise the share of health expenditure to HIVAIDS to 0.5\(^6\). This would be done over a ten year period, by 2024/25, and continue up to 2029/30. Other financing options such as earmarked funds are included as well as efficiency savings.

15.4 Innovative Funding

The modelling projections imply a reduction in monies from the international community for health and HIVAIDS. To offset this and overcome the resource gap four options were examined, these are discussed below and shown in Figure 30:

1. **Increased Government Budget Allocation** – To overcome this gap current government funding to the health sector would need rise from the current 8% allocated to health (to reach 12%). The DIPI Resch measure would need to rise from 0.3 to 0.5 over the same time period. This would raise an average of 1.3 million USD over the next fifteen years and would close the financing gap by 2022/23.

2. **Alternative Sources** – The remaining gap can be partially closed in the near term by the new alternative sources of funding. These specific taxation measures where revenues are earmarked for health and HIVAIDS (such as airport and airtime levies, and mainstreaming) have the potential to bring an extra 135 million USD a year to the sector. This equates to an average of 0.4% of GDP, and would close the gap by 2021/22.

3. **Efficiency** – If Zimbabwe implemented efficiency measure they could save 420 million USD pa on the cost of services. This equates to around 1.6% of GDP, or 3.8% of the national budget, and could close the gap by 2020/21.

4. **Borrowing** – Finally, it is projected that some accumulation of debt is necessary to meet the basic health needs for Zimbabwe in the initial five years. This would amount to around 575 million a year from 2015/16 to 2019/20.

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\(^{6}\) This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs.
15.5 Fiscal and Macro Implications

Assuming that the increased budget allocation to health and HIVAIDS is created through redistribution of current resources rather than increased national tax levels then there is expected to be an increased tax burden of only 0.4 percentage points due to the new alternative funding sources.

However, the financing gap cannot be closed entirely without borrowing. This is projected to raise the Debt: GDP ratio by 4.4% - from 85.5% to 89.9% - over the projected time period. Given the level of debt stock and the status of being in debt distress, borrowing for health financing would not be advised. Zimbabwe is currently outside of the SADC criteria for Debt: GDP and the IMF recommendation of 40%. If it was a necessity, concessionary loans should be sought.

15.6 Data Issues

No up to date health financing data was available on the World Health Organisation (WHO). Instead the National Budget documents from the Zimbabwe Ministry of Finance were used to populate the macro model. OECD data on donor health financing was used for external funding. The budget supplied official data on national health insurance / social security contributions but no data was found on private health insurance.

HIVAIDS data was sourced from the UNGASS 2012 report. However this had only the top level spending amounts and so averages from the SADC countries were used to estimate the baseline funding sources for Zimbabwe. The budget data and 3% earmarked transfer also added to this calculation.
ARE ENDING AIDS 2030 AND UHC POLICY OBJECTIVES JOINTLY ATTAINABLE IN SADC? A FISCAL PERSPECTIVE

Technical Working Group for Sustainable Financing