Meeting Report

Regional Workshop on Development of Framework on addressing HIV/AIDS in the context of Universal Health Coverage

1st – 3rd June 2015, New Delhi, India
Executive summary

Universal health coverage (UHC) is an aspirational goal that aims for all people to access and use the preventive, curative, rehabilitative and palliative health services they need that are of sufficient quality and do not cause financial hardship. HIV programmes have, more than any other health programme, served as a trailblazer for UHC at the global and regional levels. They have been characterized by their strong drive in ensuring equity of access to HIV interventions and by their clear focus on the three dimensions that define UHC: providing health services, covering populations and covering costs. The global HIV response over the past 15 years has been relatively successful: antiretroviral therapy (ART) has been rapidly scaled-up; and new HIV infections and AIDS-related deaths have declined. Still there were an estimated 2.1 million new HIV infections and 1.5 million AIDS-related deaths in 2013. With ‘business as usual’, these figures are projected to increase in the future. In the post-2015 sustainable development era, there is a need to strengthen and accelerate the HIV response using the UHC agenda to achieve the end of AIDS by 2030.

Recognizing the need for a framework to address the HIV epidemic in the context of universal health coverage and post-2015 sustainable development agenda, the World Health Organization (WHO) Regional Office for South-East Asia convened a workshop for Member States in New Delhi from 1-3 June 2015. The key objectives of the meeting were to discuss the contribution of the HIV response to UHC and the opportunities to use the UHC framework in strengthening the HIV response that will set the course for ending the HIV epidemic in the South-East Asia region by 2030.

Some countries in the region have made significant progress towards achieving high coverage of affordable and quality health services, including HIV services, while others are at different levels of achievement of UHC with a more restricted health benefit package. The response to HIV in South East Asia, although imperfect, has been associated with many public health innovations, which can inform efforts towards expanding UHC even in the context of entrenched social disparities, weak health systems and financial constraints.

- A comprehensive package of HIV interventions tailored for different populations has been scaled-up rapidly in a number of settings.
- Use of community-based models of activism, health promotion and disease prevention have been successful in reducing costs, improving reach, reducing HIV risk and vulnerability of key populations, and expanding the impact of HIV programmes to achieve broader health and social outcomes.
- The positioning of HIV as a significant threat to economic development and unprecedented political mobilization to address this threat spurred the development of new funding mechanisms and stimulated innovation in health system financing. The support from Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has allowed for dramatic expansion of HIV treatment, which could be offered free at the point of service delivery within public health programmes.
• The prices of HIV medicines and related commodities have reduced significantly as a result of price negotiations, improved procurement mechanisms, increased use of generics, and application of voluntary licensing agreements.

• HIV programmes have stimulated efforts to integrate, link and decentralize services and to promote task-shifting and task-sharing, resulting in cost savings and improved quality of many HIV services.

However; much remains to be done. There are major gaps and challenges facing both UHC and HIV that need to be addressed urgently.

• The way health is financed in the region needs to be significantly improved. Financial resources for health are limited and not being efficiently utilized. Out-of-pocket health spending (60% of total health expenditures) is the highest among all regions of WHO. Expenditure on medicines is the largest component of out-of-pocket spending, highlighting the system inefficiencies. As a result, despite low-cost access to health services, households are being pushed into poverty.

• HIV programmes in all but a few countries remain heavily dependent on external resources. In the face of anticipated reductions in international development assistance and slow increase in domestic spending on HIV, there are concerns regarding sustainability of HIV programmes and financial pressures on people living with HIV.

• It is still a major challenge to reach high-risk and marginalized populations with critical health-related information, service delivery facilities, interventions and commodities. For example, migrant populations have no/limited access to basic health services since they are highly mobile, are not covered by health schemes and do not have medical records. For men who have sex with men, sex workers, people who inject drugs and other key populations, there exist many social, cultural, legal, political, economic and physical barriers to care that are increasing their vulnerability to HIV and other diseases. Many countries in the region criminalize sex work, homosexuality and drug use and have punitive HIV-related laws. Coverage of essential HIV services is also low among children and adolescents.

• Other challenges include limited integration of HIV services within health benefit packages and existence of a private sector where the affluent access health services.

With increased commitment towards achieving universal health coverage and ending of the AIDS epidemic, the following recommendations were proposed.

• The path to UHC should be tailored to the individual country context depending on the current national disease profile, gaps in coverage, existing service delivery models, size of private sector, level of health spending, fiscal constraints, demography among others. Given the health care budget, decisions regarding which health care interventions to finance with public funds must depend on economic efficiency criteria (public goods, externalities, catastrophic cost, cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, rule of rescue), and political considerations. Health information and technology
assessments have emerged as an important tool to inform financing decisions and needs investment for evidence generation and policy process.

- Capacity building for UHC and HIV responses by increasing government spending on health from domestic funds needs urgent attention in wake of leveling off of international funding. To ensure sustainability of HIV programmes, the Global Fund is providing support for transition to domestic resources as countries become economically stronger and graduate from Global Fund eligibility criteria. There is also room for greater efficiency and countries need to invest their limited resources wisely in policies and practices that maximize the impact of expenditures.

- Stronger cross-border programmes are needed to ensure standard, continuity and monitoring of care among people who either cross borders for work or migrate to neighboring countries. Sharing good practice models; strong South-South collaboration; financing health services through pooled funds; pooled procurement of diagnostics and drugs; developing insurance schemes; building technical capacity; and supporting community-based organizations to provide basic health services were proposed.

- There is an increasing need to address the structural barriers preventing access to HIV services and strengthen community systems through strong government–civil society partnerships; adequate training, supervision and remuneration for community health workers; and financial and technical support for community-based organizations.

- Data are critical to drive the HIV response in the future. Robust and dynamic HIV information systems facilitate better understanding of the local epidemics and help focus investments on populations and geographical locations where they are going to have the maximum impact. There is a need to strengthen monitoring and evaluation systems, particularly the case-based surveillance and use of programme data at local and national levels, and improve capacity on data analysis and data utilization for decision making in program management.

- WHO continues to serve a useful role in galvanizing actions and supporting countries in their efforts to achieve universal coverage to HIV services. *Global Health Sector Strategy on HIV, 2016-2021* is one of three interconnected global health strategies that outlines the priority actions under five strategic directions to accelerate the coverage of high-impact HIV prevention and treatment interventions, using a rights-based and people-centered approach. *Ending AIDS in the Context of Universal Health Coverage: A Framework for Action in the South-East Asia Region* provides a checklist of key priorities and actions for member states under the six building blocks of health systems strengthening that will facilitate review of existing HIV response and guide the development of policy approaches that can take forward the unfinished agenda of HIV in ways that serve the goals of UHC.

The massive expansion of HIV programmes has transformed the HIV epidemic, demonstrating that a comprehensive set of interventions can be provided at affordable prices to those in need even in the most difficult circumstances. As countries in South East Asia increase their commitment towards achieving UHC, there are important lessons learnt from HIV expansion that can inform the broader
effort to achieve UHC. However, there are some critical areas where the HIV response is lagging in South East Asia, presenting an opportunity to use the UHC framework to promote health equity, improve the quality of services, ensure financial and social security, strengthen health and community systems, build coherence across different health areas, address the social and economic determinants of HIV, and guarantee human rights.
Introduction

The movement towards universal health coverage (UHC) is gaining momentum globally with increased commitment towards providing affordable and quality health services to all, especially through primary health-care and social protection mechanisms. Many advances have been made to improve coverage of health services as illustrated by progress towards the health-related Millennium Development Goals (MDGs). MDGs have also played a key role in advancing the human immunodeficiency virus (HIV) response, with an impressive scale-up of antiretroviral therapy (ART) and significant reductions in new HIV infections and acquired immunodeficiency syndrome (AIDS)-related deaths. Nearly 1.1 million people living with HIV in WHO South East Asia Region were receiving ART in 2013 compared to 55,000 in 2003. However, coverage of ART among people living with HIV was under 40% in all countries except Thailand. Coverage among key populations and children aged 0–14 years was even lower. There were an estimated 230,000 [140,000—470,000] new HIV infections and 190,000 [140,000—250,000] AIDS-related deaths in 2013 and have remained largely unchanged in last five years. With ‘business as usual’, the AIDS epidemic will continue to outrun the response and AIDS-related deaths and new HIV infections are likely to rise.

There is growing consensus to accelerate efforts beyond 2015 to complete the ‘unfinished business’ of the MDGs, including sustaining and reinforcing momentum towards universal access to HIV prevention, treatment, care and support services. The proposed Sustainable Development Goals (SDGs) for post-2015 era build upon the MDGs and include 17 focus areas. ‘Healthy lives for all at all ages’ is represented as a single focus area and contains a goal related to ending the HIV epidemic along with tuberculosis (TB), malaria and other diseases (Table 1). UHC has the potential to unify the agendas for HIV and other diseases and is being promoted as a fundamental element to the health component of the post-2015 development goals.

Major scientific breakthroughs and accumulated lessons learned over the past 10 years have provided the tools to end the AIDS epidemic as a public health concern by 2030. To accelerate progress towards end of AIDS, the Joint United Nations Programme on HIV/AIDS (UNAIDS) have established the “Fast-Track” targets for 2020 that call for 90% people living with HIV to know their status; 90% of whom access treatment; 90% of whom achieve viral suppression. The aim is to reduce number of new infections by 75% compared to 2010.

Achieving these targets will avert 21 million AIDS-related deaths and 28 million new HIV infections worldwide by 2030. In Asia, expanding access to proven prevention and treatment strategies will prevent substantial numbers of new heterosexually acquired HIV infections, and new infections among children, men who have sex with men (MSM), sex workers and their clients.

Recognizing the need for a framework to address the HIV epidemic in the context of universal health coverage and post-2015 development agenda, the World Health
Organization (WHO) Regional Office for South-East Asia convened a workshop for Member States in New Delhi from 1st – 3rd June 2015. The key objectives of the meeting were to discuss the contribution of the HIV response to UHC and the opportunities to use the UHC framework to ‘fast-track’ the HIV response that will set the course for ending the HIV epidemic in the South-East Asia region by 2030.

Table 1: Proposed Sustainable Development Goals (SDGs)

| 1. End poverty in all its forms everywhere |
| 2. End hunger; food security and nutrition; sustainable agriculture |
| 3. Attain healthy life for all at all ages |
| - Reduce maternal mortality |
| - Reduce child and neonatal mortality |
| - End epidemics of HIV, TB, malaria and neglected tropical diseases and combat hepatitis and other communicable diseases |
| - Reduce mortality non-communicable diseases and improve mental health |
| - Strengthen prevention and treatment of alcohol and other substance use |
| - Reduce mortality due to road traffic accidents |
| - Universal access to sexual and reproductive health |
| - Achieve **Universal Health Coverage** including financial risk protection |
| - Reduce deaths and illness due to hazardous chemicals, pollution & contamination |
| 4. Equitable and quality education |
| 5. Gender equality, empower women and girls |
| 6. Secure water and sanitation |
| 7. Affordable, sustainable, and reliable modern energy services |
| 8. Sustainable economic growth and decent work |
| 9. Promote sustainable industrialization |
| 10. Reduce inequality within and among countries |
| 11. Safe and sustainable cities and human settlements |
| 12. Sustainable consumption and production |
| 13. Address climate change |
| 14. Conservation and sustainable use of marine resources |
| 15. Protect and restore terrestrial ecosystems and halt all biodiversity loss |
| 16. Peaceful and inclusive societies & rule of law |
| 17. Global partnership for sustainable development |
Objectives

**General objective**
To develop regional framework for ending acquired immunodeficiency syndrome (AIDS) in the context of UHC in the WHO South-East Asia Region.

**Specific objectives**
- Review the progress in Member States on HIV health sector response and lessons learnt for implementing the response in the context of UHC;
- Review the regional UHC strategy for addressing HIV health sector response in the context of UHC;
- Discuss and finalize the draft framework on addressing HIV and sexually transmitted infections (STIs) in the context of UHC in WHO South-East Asia Region; and
- Discuss and seek inputs into the Global Health Sector Strategies on HIV and STIs 2016-2021.

**Expected outcome**
An Implementation Framework on sustaining the HIV health sector response in the context of UHC in the Member States of WHO South-East Asia Region.
Universal health coverage is an aspirational goal that all people access and use the promotive, preventive, curative, rehabilitative and palliative health services they need, and which are of sufficient quality to be effective, without suffering financial hardship. UHC embodies three dimensions, the relation between which can be illustrated by the UHC cube (Figure 1):

- Extending full spectrum of good quality health services to those in need
- Providing financial-risk protection to ensure that the cost of using care does not put people at risk of financial hardship
- Ensuring equity of access to health services to cover the entire population

![Figure 1: The Universal Health Coverage Cube](image)

Depending on national priorities, countries in South East Asia are providing different services in the health benefit package. While some countries in the region have made significant progress towards achieving high coverage of affordable and quality health services (Bhutan, Indonesia, Maldives, Sri Lanka and Thailand), others are at different levels of achievement with a more restricted health benefit package. Progress is particularly notable in Thailand, which has invested heavily in providing a comprehensive health service package for its entire population.
HIV programmes have, more than any other health programme, served as a trailblazer for UHC at the global and regional levels. They have been characterized by their strong drive in ensuring equity of access to HIV interventions and by their clear focus on the three dimensions that define UHC. Key HIV-related advances that have contributed towards the goal of UHC globally include strengthened health workforce capacity through task shifting, innovative financing mechanisms, advanced systems for the provision of and retention in care, improved monitoring and evaluation, better procurement and distribution systems, stronger community systems and the closer involvement of communities in planning, delivering and evaluating services.

There are many important lessons learnt from the HIV response in the South-East Asia region that can be used to further accelerate the progress towards universal health coverage. They include:

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**An effective design for sustainable UHC in Thailand**

‘UHC benefit package’ development process in Thailand is a participatory, transparent, evidence-based and contestable process. There are seven groups of stakeholders that nominate interventions; a stakeholders working group prioritizes them after considering the magnitude and severity of the problem, effectiveness of interventions, variation in practice, financial impact on households and equity & ethical dimensions. The National Health Security Office (NHSO) Board selects interventions after assessment of cost-effectiveness, budget impact and appraisals by Committee for Benefit Package Development. This robust health information and technology assessment process has also been used by NHSO, which acts as a national purchaser on behalf of Thai population, for price negotiation (e.g., tenofovir and oxaliplatin) saving millions of dollars for the government.

Thailand has also promoted primary health care to increase coverage of health services, with proper referral systems for specialised care. In addition to well-equipped and appropriately staffed rural health facilities, the government also provide housing, subsidized utilities and food. For more complex service, secondary and tertiary hospitals with specialized personnel, highly diagnostic and treatment technology are available. Since 1975, many social health protection schemes have been implemented to cover all Thai citizens. The ‘Universal Health Coverage Scheme’, implemented in 2002, is the largest scheme covering nearly 75% of the population.

Such a design for UHC in Thailand has resulted in improving access to health services. Between 2003 and 2009, the outpatient rate in primary health facilities increased by 33% while admission rate nearly doubled. The UHC Scheme has protected households against health impoverishment over time in all provinces. Thailand is further building capacity for UHC by making a case for increasing fiscal space for health through increased taxes.
Rapid programme scale up
The region is notable for initiatives to massively scale up comprehensive package of HIV interventions tailored for different populations at national and sub-national level, with the goal of achieving universal coverage to critical services. India, for example, has expanded HIV counseling and testing services in 18,369 facilities and ART in 475 centers. Nearly 14.3 million people and 10.6 million pregnant women were tested for HIV; 851,883 people living with HIV were receiving ART at the end of March 2015. HIV diagnostics, antiretroviral drugs, CD4 and viral load are free for all and the National AIDS Control Organization pays for these services. In Thailand, more than 246,000 people living with HIV were receiving ART at the end of 2013; ART coverage of 57% among all people living with HIV was one of the highest globally. Under the ‘UHC benefit package’, a comprehensive set of HIV care and treatment interventions (antiretroviral drugs, treatment and chemo prophylaxis against opportunistic infection and lab test) have been made available.

Community-based activism and programming
Community-based models of activism, health promotion and prevention in the region have been successful in reducing costs, improving reach, reducing HIV risk and vulnerability of key populations and expanding the impact of HIV programmes to achieve broader health and social outcomes. Sex workers in Asia, threatened by increasing rates of HIV infection, developed innovative community-based programmes, which have not only benefited HIV prevention efforts but also tackled broader issues such as sexual and reproductive health, income generation and gender-based violence. Many HIV treatment activists are now leading efforts to increase access to affordable treatment for other health conditions, such as TB and hepatitis B and C.

Community organizations have also spearheaded critical structural changes in many countries, calling for a right-based approach to health. Governments of India and Nepal recognize transgender people as a third gender and have implemented special health and welfare programmes to support their needs. Thailand allows people living with HIV to access healthcare beyond the registered area, while Indonesia allows for group registrations of marginalized populations in health facilities.

Resource mobilization and affordable services
Successful resource mobilization is one of the defining features of the HIV response, globally and in the region. The positioning of HIV as a significant threat to economic development and unprecedented political mobilization to address this threat spurred the development of new funding mechanisms and stimulated innovation in health system financing. The support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has allowed for dramatic expansion of HIV treatment, which could be offered free at the point of service delivery within public health programmes in all countries.

The prices of HIV medicines and related commodities have reduced significantly as a result of price negotiations, improved procurement mechanisms, increased use of generics, and application of voluntary licensing agreements. In Thailand, for
example, NHSO acts as a national purchaser to negotiate and buy services on behalf of patients. Along with compulsory licensing on Efavirenz and Lopinavir, the central procurement system has been responsible for a 50% decline in unit cost of first- and second-line antiretroviral drugs from 2007-2012. Indian generic producers supply the majority of antiretroviral medicines used in developing countries around the world.

**Task-shifting, task-sharing, decentralization and integration**

HIV programmes have stimulated efforts to integrate, link and decentralize services and to promote task-shifting and task-sharing, resulting in cost savings and improved quality of many HIV services. Interventions for the prevention of vertical transmission of HIV are generally included as part of an essential service delivery package of antenatal care - though more work is needed in most countries to address HIV in broader reproductive health (especially family planning) and newborn and child health services. Similarly, strong links have been established between HIV and tuberculosis prevention, care and treatment. Decentralization of HIV treatment services has been made possible by simpler and safer ART regimens and innovations in point-of-care diagnostics.

Thus, the response to HIV in South East Asia has been associated with many public health innovations, which can inform efforts towards expanding UHC even in the context of entrenched social disparities, weak health systems and limited financial resources.
Gaps and Challenges Facing Universal Health Coverage and HIV

Even though the progress towards UHC and HIV response in the member countries has been noteworthy, much remains to be done. There are major gaps and challenges slowing the progress towards UHC that are also being experienced by the HIV programmes.

**Financial gaps**
The way health is financed in the region needs to be significantly improved. In addition to limited resources for health, there are problems of underutilization of resources and inefficiencies in the system. Out-of-pocket health spending, the most regressive way to finance health, accounts for 60% of total health spending in the South East Asia region, the highest among all regions of WHO. Expenditure on medicines is the largest component of out-of-pocket spending, highlighting the system inefficiencies. This is the only region where health-related impoverishment is higher than catastrophic spending implying that even low-cost access pushes households into poverty.

HIV programmes in all but a few countries remain heavily dependent on external resources. In the face of anticipated reductions in international development assistance, slow increase in domestic spending on HIV and increase demand for financial resources to support end of AIDS, there are concerns regarding transition management, financing mechanisms and sustainability of the HIV programmes in all member states. Civil society and people living with HIV are particularly vulnerable to funding shortfalls. In Maldives, after the Global Fund grant ended, the national programme was not able to sustain prevention activities for key populations and support civil society due to lack of support during transition to a domestically-funded programme. Governments will need to act quickly to reduce their reliance of international donors and step up domestic funding to fulfil their commitments towards the 90-90-90 targets.

**Insufficient coverage among high-risk populations**
It is still a major challenge to reach high-risk and marginalized populations with critical health-related information, service delivery facilities, interventions and commodities. Migrant health has become a priority public health issue in the South East Asia region. People who cross borders for work or migrate to neighboring countries usually have no/limited access to basic health services. In decentralized settings this is an issue even for those moving within provinces or districts in the same country. Barriers to accessing an appropriate level of health care include lack of knowledge and information, unstable legal status, poverty and lack of insurance (*Table 2*). Even though low-income countries in this region are strengthening the provision of health services to illegal/uninsured migrants, they do not have sufficient resources to support the migrants, which is putting strain on government systems. Language barriers and lack of old medical records also makes it difficult to provide
services to migrants. Additionally, the rate of attrition among migrants who access health services is extremely high.

Even though countries have prioritized key populations (MSM, PWID, sex workers, others) and taken actions to improve access to health services for them, reaching and engaging them along the continuum of care needs to be improved significantly. There exist many structural barriers (social/cultural, legal/political, economic and physical) that are increasing vulnerability to the sexually transmitted disease and lowering access to care. Many countries in the region criminalize sex work, homosexuality and drug use and have punitive HIV-related laws. The high-risk populations experience multiple layers of stigma; have higher unemployment rates; and have no/limited access to critical information, facilities, interventions and commodities.

Coverage of HIV interventions among children and adolescents is also lagging behind. As a result, new HIV infections among adolescents are also showing a rising trend. Problems are many – virological testing for infants is not widely available; fixed dose combinations for children are yet to be developed; adolescents usually do not know where to test; many community-based organizations and health services do not have HIV disclosure guidelines for adolescents aged 10 – 19 and do not know how to deal with them; and adolescents living with HIV are lost in transition to adult ART programmes.

Reliance on private sector health services
A significant proportion of the populations in low- and middle-income countries are increasingly accessing health services in private sector institutions. Fragmentation of the health system, with public sector providing services primarily to the poor and private health institutions providing costly care to the privileged few, impedes equitable access to quality health care for all.
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<tr>
<th></th>
<th>Thailand</th>
<th>Myanmar</th>
<th>India</th>
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| **ISSUES**  | • Illegal working migrants and non-Thai prisoners are unregistered and cannot be covered under social security schemes  
• Migrants generally do not have medical records  
• High loss-to-follow-up due to high mobility  
• Different HIV treatment regimens in neighboring countries raises concerns regarding drug resistance  
• Some hospitals in border areas, whose 50% patients are illegal migrants, are facing huge resource crunch  
• Current services provided with financial support from the Global Fund, raising concerns about sustainability | • Lack of tracking systems for mobile populations  
• Language barriers | • Despite well regulated border with Pakistan, illicit drug trade is increasing in bordering states  
• High loss-to-follow-up among migrants  
• Significant internal migration from high prevalence to low prevalence area  
• Education programmes at known border entry points lacking  
• Institutional mechanisms for information sharing are non-existent or informal  
• Financial constraints |
|             | • Memorandum of Understanding exists with neighboring countries  
• Migrant health assistants posted at hospital  
• Migrants offered affordable yearly insurance schemes  
• Planned programmes allowing migrants to move freely across borders to access HIV medicines | • Regular bilateral meetings with Thailand to discuss the common approach, including provision of treatment  
• Providing HIV education and testing services in collaboration with International Organization for Migration  
• Decentralization of services in border areas  
• Plans exist for establishing standard referral systems in important border towns  
• Pilot programme on HIV/migrant monitoring and evaluations system in three border sites planned | • Collaborative projects with many neighboring countries (Nepal, Bangladesh). E.g. EMPHASIS (Enhancing Mobile Populations’ Access to HIV and AIDS Services, Information and Support)  
• National programmes cover people living in India and not only citizens |
| **ACTIONS** |                                                                 |                                                             |                                                                       |
Vertical versus horizontal planning
The debate on the merits of horizontal versus vertical approach to global health is ongoing for long. HIV, TB and maternal health programmes started as vertical programmes with generous support from external sources. The popularity of these disease or area specific programmes lay primarily in the relative ease in maintaining focus, delivering quicker results and measuring impact. However, these vertical programmes were criticized for creating an imbalance in global health agenda, fostering parallel approaches to service delivery and diverting human and capital resources from primary health care services. With growing impetus to integrate vertical programmes into horizontal structure of resource-constrained health care systems, policy makers are facing the challenge of prioritizing and phasing in interventions to achieve the maximum impact and ensure equity. For example, Indonesia has implemented a centralized National Health Security programme by merging 360+ provincial/district health security schemes (called Jamkesda) and is exploring it as an option for sustainable financing of certain/all HIV-related services. The health benefit packages under consideration and challenges associated with them are presented in Table 3. With weak health systems, poor infrastructures and limited resources, ‘Option 2’ seems like a potential start for an incremental expansion of the basic benefit package, with possibility to include more services into the package over time.

Table 3: Benefit packages under consideration in Indonesia

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<th>Option 1 - Comprehensive Coverage</th>
<th>Option 2 – Basic Coverage</th>
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<tr>
<td>SERVICES</td>
<td>Benefit package includes all HIV-related services: counseling, condoms, screening tests (pre-ART, other lab tests), ART, STI screening and treatment, prevention of mother-to-child transmission services, ambulatory care, inpatient services</td>
<td>Current Basic Benefit Package coverage plus ART and screening tests</td>
</tr>
<tr>
<td></td>
<td>Current Basic Benefit Package; ART provided through Government vertical channeling mechanism</td>
<td>Current Basic Benefit Package; ART provided through Government vertical channeling mechanism</td>
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<tr>
<td>FINANCING</td>
<td>Premium contributions</td>
<td>Premium contributions</td>
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<td></td>
<td></td>
<td>Premium contributions and government subsidy for ART</td>
</tr>
<tr>
<td>CHALLENGES</td>
<td>• Integration of different funding mechanisms for HIV services</td>
<td>• Different payment mechanisms (different sources and channeling)</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive package will require facility readiness</td>
<td>• A clear roadmap is needed for an incremental expansion of HIV service coverage in the basic package</td>
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<td></td>
<td>• Lack of good incentive mechanisms for service providers</td>
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<td></td>
<td>• Coordinated planning and budgeting, including synchronized procurement</td>
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Conclusions and Recommendations

As countries increase their commitment towards achieving the ambitious goal of UHC, they will need to decide their own path to approach UHC of a well-defined package of benefits depending on the following: current national disease profile, gaps in coverage, existing service delivery models, size of private sector, level of health spending, fiscal constraints, demography among others. Each path is likely to present different opportunities and challenges. Given a limited health care budget, decision regarding which health care interventions to include in the benefit package must depend on economic efficiency criteria (public goods, externalities, catastrophic cost, cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, rule of rescue), and political considerations. Health Information and Technology Assessment has emerged as an important tool to inform financing decisions and needs investment for evidence generation and policy process.

Greater attention to ensuring the sustainability of UHC and HIV responses, by increasing government spending on health from domestic funds, requires urgent attention in the face of diminishing international funding. There is also room for greater efficiency and countries need to invest their resources wisely in policies and practices that maximize the impact of expenditures. To address the funding gap in the region, an AIDS Funding Landscape Panel of public health experts, policy leaders and civil society representatives was formulated in 2013. It analyzed the existing policy and funding commitments for the national HIV/AIDS response and suggested a set of nine recommendations to guide the next decade’s response. The recommendations include introducing funding transition plans, new financing streams and investment cases for HIV, focusing resources where most new HIV infections occur, protecting funding for civil society, creating an enabling legal environment, integrating biomedical interventions into universal health care schemes, reducing the costs of antiretroviral drugs and other commodities, and ensuring reliable future access to affordable drugs. Economic growth in number of countries means they are better able to support their national programmes, but may no longer be eligible for Global Fund support. The Global Fund’s Strategy for 2017-2021 plans to provide support to countries during this transition period to ensure that the current progress is not reversed, through effective co-financing and guidance on domestic resource mobilisation.

Stronger cross border programmes should be developed to ensure standard, continuity and monitoring of care among people who either cross borders for work or migrate to neighboring countries. There are economies of scale in cross border collaborations but it also involves diverse and complex dimensions (political, social, financial and technical). Sharing good practice models for delivering services to migrants and their impact on health outcomes; strong South-South collaboration; financing health services through pooled funds; pooled procurement of diagnostics and drugs; developing insurance schemes; building technical capacity; and supporting community-based organizations to provide basic health services were some of the proposed approaches to ensure that this population group is not left
behind. There is also a need to assess trends in migrant health by improving country health information systems and developing institutional mechanisms for information sharing.

To reach key populations with essential health services, there is an increasing need for stigma reduction programmes and legal reforms to address the structural barriers to accessing care and strengthen community systems through strong government–civil society partnerships; adequate training, supervision and remuneration for community health workers; and financial and technical support for community-based organizations.

One of the things that can be done differently to accelerate the HIV response at the country level is to get a granular understanding of the epidemic. Till date, national strategic planning has largely happened around averages since data are not readily available at a district level. A dynamic and robust HIV information system will facilitate better understanding of the local epidemics and help focus investments on populations and geographical locations where they are going to have the maximum impact. The monitoring and evaluation system should be equity-oriented and capture quality dimensions such as retention and survival rates on ART. There is also a need to improve capacity on data analysis and data utilization for decision making in programme management.

WHO continues to serve a useful role in galvanizing actions and supporting countries in development of policy approaches that can take forward the unfinished agenda of HIV in ways that serve the goals of UHC and work towards the improvement of overall health and wellbeing in the region. The WHO Global Health Sector Strategy on HIV for 2016-2021 (Figure 2) is under development alongside strategies for sexually transmitted infections and viral hepatitis and outlines the priority actions to accelerate the coverage of high-impact HIV prevention and treatment interventions, using a rights-based and people-centered approach. The new strategy is fully aligned with the post-2015 development agenda and builds on the progress till date to achieve the elimination targets. Due to commonalities with sexually transmitted infections and viral hepatitis, the HIV strategy is one of a series of three interlinked global health strategies, positioning the HIV response in the context of universal health coverage. The strategy will contribute to other health-related targets and the wider UHC goal by reducing maternal and infant mortality and premature mortality from non-communicable diseases; ending the TB epidemic; eliminating viral hepatitis B and hepatitis C; and improving access to sexual and reproductive health-care services, family planning, information and education.
Strategic direction 1 focuses on the need to understand the current state of a country’s epidemic and status of its response as a basis for national strategic planning (advocacy, political commitment, national planning, resource mobilization and allocation, implementation, and improvements). There are 10 global targets and 15 national indicators to monitor the progress.

Strategic direction 2 describes the essential, high-impact interventions that will reduce vulnerability and risk, prevent HIV transmission and acquisition, expand HIV testing and treatment coverage; and provide for chronic care and care for common co-infections and comorbidities.

Strategic direction 3 addresses the best methods and approaches for delivering quality services to different populations and locations to achieve greatest impact and ensure equity. They include creating an enabling environment (addressing legal barriers and structural constraints), community engagement, strengthening human resources, providing quality services, establishing linkages, integration of services and targeting special settings.

Strategic direction 4 discusses the financing dimension with an emphasis on the raising funds through domestic and external resources, optimizing resource use and social security schemes to ensure that people have access to the necessary services without incurring financial hardship.

Strategic direction 5 highlights research and innovations in new technologies, medicines, diagnostics, devices, services and systems to strengthen the HIV cascade and shift the trajectory of the HIV response.
WHO South-East Asia Region has also developed a draft ‘Framework for Action for Ending AIDS in the Context of UHC in the South-East Asia” region. The framework is intended to stimulate discussions among policy-makers and programme managers, and to guide the review of existing plans and programmes, with a view of aligning, harmonizing and synchronizing HIV with national health and development planning. The framework provides a checklist of key priorities and actions under the six building blocks of health systems strengthening (leadership and governance, financing, service delivery, medical products and technologies, health workforce and information). During the meeting, country representatives, after discussion with the key stakeholders, identified a few actions under the first three building blocks of health systems strengthening that need urgent attention at the country level to advance their commitments towards HIV and UHC (Table 4). The rich discussions provided important inputs that will help in finalizing the framework.

In conclusion, the massive expansion of HIV programmes has transformed the HIV epidemic, demonstrating that a comprehensive set of interventions can be provided at affordable prices to those in need even in countries with social disparities, weak health systems and limited financial resources. The collaboration, innovations and investment that have boosted the HIV programmes have also contributed towards UHC in numerous important respects. The experiences from HIV prevention and treatment programmes can be used to manage other chronic health conditions, further advancing the UHC agenda. However, there are some critical areas where HIV response is lagging, presenting opportunities to use the universal health coverage framework to promote health equity; strengthen health and community systems; improve quality of services; tackle the social and economic determinants of health; protect human rights and gender equity; integrate and establish linkages between HIV and other services; and ensure financial and social security.
Table 4: Key actions identified by countries to end AIDS in the South-East Asia region in the context of UHC under the building blocks of leadership and governance, financing, and service delivery

<table>
<thead>
<tr>
<th>Building blocks</th>
<th>Priority areas</th>
<th>Actions</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and governance</td>
<td>Set evidence-informed priorities</td>
<td>Identify existing gaps and give priority to addressing gaps through increased investment in high impact HIV strategies and interventions in geographical areas and populations where they will have maximum impact</td>
<td>Indonesia, Myanmar</td>
</tr>
<tr>
<td></td>
<td>Address structural barriers that impede access to health services</td>
<td>Remove policy and legal barriers to access for key populations; remove HIV-punitive policies and laws; and address stigma and discrimination</td>
<td>Bhutan</td>
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<tr>
<td></td>
<td>Forge inclusive partnerships and strengthen coordination</td>
<td>Nurture partnerships with civil society; support community networks and systems; and monitor, regulate and ensure quantity and quality of services provided by community-based organizations</td>
<td>India, Thailand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish collaborations with neighboring countries to address migrant health</td>
<td>Thailand</td>
</tr>
<tr>
<td>Financing</td>
<td>Mobilize more national resources for health, including HIV</td>
<td>Increase health financing from government revenues and share of HIV in health budgets</td>
<td>Bangladesh, Bhutan, Myanmar, Timor Leste</td>
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<tr>
<td></td>
<td></td>
<td>Explore innovative mechanisms and other sources for raising funds for HIV response and other initiatives (e.g., public health funds, private funds through corporate social responsibility)</td>
<td>Bhutan, Maldives, Thailand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustain community-based organizations through government financing and tax concessions; lift policy barriers to enable them to attain financial viability; and encourage income generation activities by them</td>
<td>India, Indonesia, Maldives, Sri Lanka</td>
</tr>
<tr>
<td></td>
<td>Anticipate and manage funding transitions</td>
<td>Develop funding transition plans, supported by bridge funding options</td>
<td>Indonesia, Maldives, Timor Leste</td>
</tr>
<tr>
<td>Building blocks</td>
<td>Priority areas</td>
<td>Actions</td>
<td>Countries</td>
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<tr>
<td>Remove financial barriers to access to services</td>
<td>Work towards financial risk protection schemes that are universal, covering all populations, including criminals and migrants</td>
<td>India, Indonesia, Thailand</td>
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<tr>
<td>Improve benefit packages and service delivery models</td>
<td>Based on local analysis of costs and benefits, define comprehensive benefit packages with equal focus on key populations and specific settings</td>
<td>Maldives, Timor Leste</td>
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<td></td>
<td>Introduce task shifting and task sharing among health facilities</td>
<td>Thailand</td>
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<td></td>
<td>Implement focused, streamlined, integrated/linked HIV testing, ART, prevention of mother-to-child transmission, harm reduction and blood safety programmes to improve service delivery along the continuum of care</td>
<td>India, Myanmar</td>
<td></td>
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<tr>
<td>Ensure quality services</td>
<td>Establish effective mechanisms to improve and assure quality of care</td>
<td>India, Timor Leste</td>
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<tr>
<td>Decentralization of health services to community levels</td>
<td>Expand community health delivery systems to extend the health system</td>
<td>India, Indonesia</td>
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<tr>
<td>Take high-impact health programmes, including HIV programmes, to scale</td>
<td>Scale-up evidence-based HIV interventions to achieve full coverage</td>
<td>Bhutan, Timor Leste</td>
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<td></td>
<td>Expand HIV services delivery points in both public and private sector</td>
<td>Bangladesh, India, Sri Lanka</td>
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</table>
## Annex 1: Programme of activities

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter/Facilitator</th>
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<tbody>
<tr>
<td>0830 - 1000</td>
<td>Welcome remarks</td>
<td>CDS</td>
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<tr>
<td></td>
<td>Opening Address from Regional Director WHO SEAR</td>
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<tr>
<td></td>
<td>Disease programmes and UHC - Overview</td>
<td>Phylida Travis</td>
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<tr>
<td></td>
<td>Objectives and outcomes of the Workshop</td>
<td>Dongbao Yu</td>
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<tr>
<td></td>
<td>Admin announcements</td>
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<td></td>
<td>Group Photograph</td>
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<tr>
<td>1000 - 1030</td>
<td>Tea/Coffee</td>
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<tr>
<td>1030 - 1200</td>
<td>Universal health coverage: A strategy for South-East Asia</td>
<td>Alaka Singh</td>
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<tr>
<td></td>
<td>HIV epidemic and response in the South-East Asian Region</td>
<td>Razia Pendse</td>
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<td></td>
<td>Fast Tracking the response and the role of UHC</td>
<td>Vladanka Andreeva</td>
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<td></td>
<td>HIV contribution to the UHC agenda</td>
<td>Andrew Ball</td>
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<tr>
<td>1200 - 1300</td>
<td>Lunch</td>
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<tr>
<td>1330 - 1500</td>
<td>Building synergies between the response to HIV and UHC in South East Asia</td>
<td>Isabelle de Zoysa</td>
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<tr>
<td></td>
<td>Achieving universal coverage for HIV prevention, care and treatment services</td>
<td>Sumet Ongwandee</td>
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<td></td>
<td>Service delivery models for implementing national UHC scheme – how far are HIV services covered</td>
<td>A.S. Rathore</td>
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<tr>
<td>1430 - 1500</td>
<td>Tea/Coffee</td>
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<tr>
<td>1500 - 1700</td>
<td>Presentation and Discussion on draft Global HIV Health Sector Strategy 2016-2021</td>
<td>Andrew Ball</td>
</tr>
<tr>
<td>Time</td>
<td>Session Title</td>
<td>Presenter(s)</td>
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<tr>
<td>0830 - 1000</td>
<td>Scale efficiencies through cross border collaboration - overview</td>
<td>Randy Kolstad</td>
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<td>Panel discussion</td>
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<tr>
<td></td>
<td>• Sha’ari Ngadiman</td>
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<tr>
<td></td>
<td>• Suchada Chaivooth</td>
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<tr>
<td></td>
<td>• Zaw Zaw Aung</td>
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<td></td>
<td>• Neeraj Dhingra</td>
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<tr>
<td>1000 - 1030</td>
<td>Tea/Coffee</td>
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<tr>
<td>1030 - 1200</td>
<td>Role of communities in achieving Universal Health Coverage</td>
<td>Presented by Nicole Seguy</td>
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<td>Structural barriers – can UHC address these?</td>
<td>Kazuyuki Uji</td>
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<td>Lessons learnt from HIV</td>
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<td></td>
<td>Country experiences</td>
<td>Habiba Akter</td>
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<td></td>
<td>• Community health workers, community clinics and community based research in</td>
<td>Masami Fujita</td>
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<td></td>
<td>expanding health services (Bangladesh)</td>
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<tr>
<td></td>
<td>• Partnerships and linkages with NGOs for expanding health services - lessons</td>
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<td>from HIV</td>
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<tr>
<td>1200 - 1300</td>
<td>Lunch</td>
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<tr>
<td>1300 - 1430</td>
<td>Global Fund and HTM financing in the context of UHC</td>
<td>Chandrani Banerjee</td>
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<td>Transitioning from the external to domestic funding - Challenges and role of</td>
<td>Walaiporn</td>
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<td>Strategic Purchasing for Health</td>
<td>Patcharanarumol</td>
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<td>Discussants: Bhutan</td>
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<td>Maldives</td>
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<td>Sri Lanka</td>
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<td></td>
<td>Timor Leste</td>
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<tr>
<td>1430 - 1500</td>
<td>Tea/Coffee</td>
<td></td>
</tr>
<tr>
<td>1500 - 1700</td>
<td>Presentation and Discussion on draft Global STI Health Sector Strategy 2016-2021</td>
<td>Nathalie Broutet</td>
</tr>
<tr>
<td>Time</td>
<td>Session/Activity</td>
<td>Speaker(s)</td>
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<tr>
<td>0830 - 1000</td>
<td>What is UHC benefit package? Health Technology assessments for defining the benefit package</td>
<td>Alaka Singh, Yot Teerawattananon, Endang Budi Hastuti</td>
</tr>
<tr>
<td>1000 - 1030</td>
<td>Tea/Coffee</td>
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<tr>
<td>1030 - 1145</td>
<td>Partnership and collaboration for advancing the agenda of ending AIDS in the context of UHC</td>
<td>Hideki Miyamoto, Wing-Sie Cheng, Ilana Lapidoz-Salaiz, Jayaram, Raman Gangakhedkar</td>
</tr>
<tr>
<td>1145 - 1200</td>
<td>Implementation Framework – Priority actions setting at country level for ending AIDS in the context of UHC</td>
<td>Isabelle de Zoysa</td>
</tr>
<tr>
<td>1200 - 1300</td>
<td>Lunch</td>
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<tr>
<td>1300 - 1430</td>
<td>Working groups: new activities</td>
<td></td>
</tr>
<tr>
<td>1500 - 1600</td>
<td>Feedback from working groups</td>
<td></td>
</tr>
<tr>
<td>1600</td>
<td>Closing</td>
<td></td>
</tr>
</tbody>
</table>
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