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Investing in AIDS in Asia: transforming the policy agenda

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This paper discusses key findings from an independent Australian Government Department of Foreign Affairs and Trade (DFAT)-funded joint Strategic Assessment of HIV in ten Asian countries. It argues that despite high level intentions to intensify regional HIV responses, and growing evidence for what needs to be done, many Asian countries are struggling to refocus their resources and programmes to where it matters most, largely because of a legacy of outdated and inappropriate policy, programming and resourcing.

Strategic investment approaches offer the possibility of improving the efficiency and effectiveness of existing and future resources, but success will require a reorientation of the 'policy consensus' and prevailing multi-sectoral architecture.

The paper calls for continued engagement by all stakeholders based on a new regional investment and results framework that agrees coordinated positions and investments on HIV architecture, strategic information, the future funding and role of civil society, and oversight of Global Fund investments.

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Introduction

HIV investments in Asia and the Pacific have achieved important outcomes over the past decade: the estimated number of new infections has fallen in many countries; coverage of services for key populations has increased and resulted in safer sexual and injecting behaviours; and the number of people receiving HIV treatment is now over one million.[1] This region is also home to a number of countries that are (or are very close to) achieving universal access to anti-retroviral therapy (ART). For example, Cambodia and Thailand are providing ART to 80% of their populations in need.[2] These gains are patchy, however. Indonesia, the Philippines and Bangladesh have growing epidemics, prevention efforts continue to lag compared to the rest of the world, and coverage of HIV treatment is only 54% of those estimated in need.[3]

It is widely recognised that Asia will not experience an HIV epidemic in the general population similar to that of sub-Saharan Africa.[4] Asia's HIV burden is still largely concentrated among key populations, such as sex workers (SW) and their clients, people who inject drugs (PWID) and men who have sex with men (MSM), as well as their intimate partners. There is little evidence that these patterns of infection will change substantially in the future. However, the region's investments in HIV have been slow to adapt to this reality, with the considerable investment in policy, programming and implementation in HIV architecture often better suited to generalised rather than concentrated epidemics. Achieving further results for HIV in Asia requires a change in this investment approach, with an urgent and sustained focus on key populations, a review of the allocation and use of domestic and international funding for HIV, and a redesign of existing policy, programming and architecture frameworks.[5]

This paper discusses selected findings from a multi-donor Strategic Assessment of HIV in Asia[6] undertaken in 2012 in collaboration with the Australian Government Department of Foreign Affairs and Trade (DFAT), USAID, UNAIDS (including UNDP, UNFPA, UNODC and WHO), the World Bank, the Asian Development Bank, and the Global Fund to Fight AIDS, TB and Malaria. The study built on the UNAIDS investment framework approach[7] and considered how HIV investments (in policies, strategies, governance frameworks, service delivery systems and financial resources) could be more appropriately and efficiently allocated in the Asia Pacific region.

A growing public health challenge

HIV still represents a significant burden of disease in many countries in Asia. Continuing incidence risks becoming endemic and a debilitating, expensive public health problem of marginalised, yet substantial populations.

It also presents a growing chronic treatment and care burden, and an increasing cost to the health sector in a region where the public health sector is chronically underfunded. Public health systems, particularly in Asia's low income countries, are often too weak to absorb the demands of HIV, organised in ways that limit access by key populations, or configured to respond to acute, rather than long term care.

Globally, there is growing interest and commitments to 'normalising' HIV services into general health services, even though the complexities and implications of integration are still poorly understood. Striking the balance between investing in HIV services (usually with ring-fenced budgets and distinct service delivery mechanisms) and/or investing in sustainable health systems that deliver integrated services for key populations as a core element of equitable health care, is a major public health challenge.

[1] UNAIDS, 2013.
[2] UNAIDS, 2011a.
[3] UNAIDS, 2011b.
[4] Godwin et al, 2006; Chin, 2007; Commission on AIDS in Asia, 2008.
[5] Godwin and Dickinson, 2012.
[6] The countries in the assessment included Cambodia, China, East Timor, India, Indonesia, Laos, Myanmar, Philippines, Thailand and Viet Nam.
[7] Schwartlander et al, 2011.

Dependency on external funding and budget misallocations

Many countries in the region are, or have been, highly dependent on external funds for interventions targeting key populations, for strengthening and scaling up civil society responses, for the provision of ART, and for programme management and HIV architecture costs. In 2009, external funding (principally bilateral, Global Fund and Asian Development Bank funds) accounted for over 90% of HIV funding in low income countries of the region (e.g. Cambodia, Laos, and East Timor) and a significant proportion in some middle income countries including Viet Nam, India and Indonesia (see Table 1).

The funding situation is particularly acute for civil society. With the exception of Thailand, India and the Philippines, civil society is underdeveloped in health and social sector planning in much of the region. While the role of civil society in the global HIV response has been one of the most dramatic health sector innovations of the last few decades, this model remains essentially unsustainable in the region. Even in the few countries where civil society is well developed, its role in HIV has been largely externally funded (for example in Indonesia and the Philippines).

Sustaining these funding patterns is unlikely, given the decline in external funding for HIV[8] and the reassessment by major partners of their strategic priorities, geographical focus, absolute funding levels and modalities. Levels of domestic funding for HIV are variable across the region. With some exceptions, such as Thailand, China and India, evidence that domestic resources are replacing external funds, or that countries are absorbing HIV programme investments into national budgets or systems, is still weak.

Findings from this study suggest that HIV programming and resources must respond more effectively to primary epidemiological drivers. Substantial volumes of funds are still misdirected to generalised programming and prevention activities for low-risk populations. Where countries are increasing domestic expenditures, these are largely being used to cover the costs of treatment. A stronger focus on key populations, increased domestic financing and more flexible reprogramming should come about through the application of the Global Fund's New Funding Model (NFM), launched in 2013. However, for countries in the region that are classified as middle income, Global Fund allocations are likely to be constrained in the long term. There is a risk that if countries continue to depend on the Global Fund for un-strategic projects, support to the region will falter. With partners' help, countries can start to develop forward-looking, focused funding strategies in which Global Fund grants are used as targeted and effective investments.

Perhaps the most important threat to the funding situation in the region, however, is the countries' lack of appropriate long-term funding strategies. National strategic plans (NSPs) (e.g. in Vietnam, the Philippines, Myanmar, Laos and Indonesia) remain largely aspirational with enormous funding gaps and no clear expectation of how these gaps will be filled.

[8] Barnighausen, 2012.

1: HIV funding by source in Asia and the Pacific: 2009

			International													
	Total	Domestic funding	Bilateral		UN agencies		Global Fund		Development bank (non-reimbursable)		Other multilateral		Other international		Private	
	US$	US$	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%
Cambodia*	51,846,997	5,261,582	10	20,677,015	40	4,695,757	9	19,087,509	37	0	0	2,125,134	4	0	0	0	0
China	353,535,354	286,774,704	76	11,125,750	3	7,026,790	2	45,966,916	13	0	0	0	0	20,641,195	6	0	0
India	140,001,565	23,093,678	16	26,714,399	19	1,036,012	1	57,512,643	41	31,644,834	23	0	0	0	0	0	0
Indonesia*	49,563,286	19,845,267	40	19,592,588	40	2,241,962	5	5,818,972	12	1,503,788	3	0	0	560,739	1	0	0
Laos	5,997,398	114,730	2	1,160,650	19	1,333,676	22	2,519,021	42	191,112	3	19,874	0.3	658,335	11	0	0
Myanmar*	32,802,378	1,525,974	5	0	0	0	0	0	0	0	0	0	0	31,276,403	95	0	0
Philippines	11,863,204	1,700,357	14	759,365	6	1,223,488	10	6,690,344	56	72,670	1	0	0	19,936	0.2	1,397,044	12
Thailand	213,774,843	199,475,797	93	1,985,753	1	1,337,804	1	10,975,489	5	0	0	0	0	0	0	0	0
Timor Leste	1,803,014	21,000	1	0	0	0	0	1,743,620	97	0	0	0	0	38,394	2	0	0
Vietnam	102,987,539	2,179,236	2	89,656,527	87	1,894,117	2	72,160	0	8,385,213	8	0	0	800,287	1	0	0
10 countries	964,175,578	521,992,325	54	171,672,047	18	20,789,606	2	150,386,674	16	41,797,617	4	2,145,008	0.2	53,995,289	6	1,397,044	0.1
South & South East Asia[2]	726,220,206	313,507,132	43	177,578,249	24	28,690,672	4	120,006,613	17	47,325,590	7	2,503,208	0.3	34,732,581	5	1,876,162	0.3
South & South East Asia & China	1,079,755,559	582,281,836	54	188,703,999	17	35,717,462	3	165,973,528	15	47,325,590	4	2,503,208	0.2	55,373,776	5	1,876,162	0.2

Source: Data Hub Asia Pacific All data is from 2009, except for those indicated with *, which are from 2008.

Policy and programming frameworks need revisiting

There is widespread HIV policy coherence across the region[10] based on global norms that have developed over the past two decades. Most countries have an NSP strongly influenced by UNAIDS' guidance, and which outlines country priorities, resource allocations, implementation mechanisms and M&E frameworks. While prevention interventions (as the key to addressing the epidemic) and timely and continuous treatment remain central to HIV strategies, policy and programming frameworks need to be revisited in the light of dwindling external resources and limited political appetite for increasing domestic resources for HIV (particularly targeting key populations). These frameworks also need to be based on recent scientific evidence (such as on the efficacy of treatment as prevention of HIV), and recognise that many aspects of long-term, sustainable HIV care and treatment programmes need to be articulated within the context of emerging non-communicable disease (NCDs) and chronic care management.

'Strategic investment' provides an opportunity to better match investments to evidence and to invest effectively to achieve maximum results, thus ensuring value for money. Its success requires strategic decisions by stakeholders on areas such as future financing (e.g. the split between domestic and external funding); the long term role of and support to civil society; the focus on key populations versus general populations; the appropriate level of multi-sectoral buy-in for effective public health approaches; and identifying and selecting investments in policy, institutional architecture, and programming that can be counted on to produce results (e.g. reduced incidence among key populations, enrolment in ART, and long-term adherence).

Such investment requires recognition that 'concentrated' epidemics can be best managed with targeted public health approaches, where multi-sectoral responses are managed by and within the health sector.[11,12] This is linked to a growing recognition that responses are most likely to be cost-effective and sustainable with greater integration into existing programming (for example, with prevention of Mother-to-Child Transmission integrated into maternal and child health services, and HIV and AIDS treatment and care integrated into chronic care delivery systems – such as those being developed for NCDs).

But many stakeholders involved in these decisions have long established policy and programming ideas and interests, and find review of these challenging. Reorienting the 'policy consensus' will be difficult (see Box 1). Agencies need to genuinely refit their approaches and guidance to help countries be more investment- and results-oriented. For example, if MSM are a target group, programme interventions need to focus on reaching them effectively and not, for example, through an 'AIDS in the workplace' campaign among garment factory workers, on the premise that some MSM may well work in garment factories.

Box 1: Why have policy responses been slow to shift?

Policy responses have been hindered by the unchallenged roll out of global templates and targets without due attention to the epidemiology and programme context. There is an assumption that multi-sectoral responses appropriate for dealing with large, generalised epidemics are appropriate for the small, concentrated epidemics of Asia. This thinking has been challenged over the years, but it has taken firm hold in Asia and is difficult to change.

Most HIV programmes in Asia have been donor-supported as priority, urgent, and human rights-based responses to a global threat. There have been few incentives for countries to develop their own responses, with their own funding and service delivery systems.[13] Externally funded, largely vertical HIV programmes often develop separate financial planning and management, human resource, logistics and devolution systems. These can be difficult to 'integrate' in standard health care delivery systems and equally difficult to dismantle.

Enabling environments are still constrained with respect to key populations. Deep-seated cultural, social and political opinions about appropriate responses to illicit drug use, MSM and sex work divide the region and hinder effective programming for key populations.

[9] Afghanistan, Bangladesh, Cambodia, India, Indonesia, Laos, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Singapore, Sri Lanka, Thailand, Timor Leste, Vietnam.
[10] For example, as reflected in various ESCAP declarations.
[11] Much of this recognition results from the work of the WHO Commission, and 2011 World Conference, on Social Determinants of Health, as well as the recognition of the growing challenge of NCDs globally.
[12] See also, very recently: *Redefining global health-care delivery*, Jim Yong Kim et al. (2013).
[13] Vietnam, Cambodia, India, the Philippines and East Timor are good examples of this.

Time to change the architecture

Donors and governments continue to invest heavily in HIV-specific governance and accountability frameworks in the region. National AIDS Commissions (NACs) and Country Coordinating Mechanisms (CCMs) can be found in all countries and involve multiple sectors. In PNG, Cambodia and Indonesia, for example, the national AIDS authorities comprise 16, 29 and 26 ministries respectively. Yet, in Asia's concentrated epidemics, low national incidence and prevalence rates mean that the sectoral impacts of HIV are relatively small – too small to warrant being made major sector-wide priorities in areas already grappling with weak systems, lack of resources, inequality and poverty.

In addition, the architecture of multi-sectoral responses presents a significant opportunity cost for Ministries of Health (MOHs) with respect to developing a broader view of public health programming. The NAC architecture excludes, discourages or allows the MOH to escape from expanding its multi-sectoral linkages and collaboration. If the lessons of participation, inclusion, and multi-sectorality from HIV programming are to be learned by the health sector, such opportunity costs are high.

Global and regional analysis suggests that HIV multi-sectoral coordinating bodies are often ineffective, inefficient[14] and expensive. In Cambodia, Indonesia, Laos and the Philippines, management and administration accounted for more than 20% of total programme costs in 2009. Some 22% of all Global Fund grants to the region and 21% of all UN funding was used for management and administration in 2009.

Attempts to rationalise the architecture are underway in some countries but changes take time and have significant political and programme costs. If external funding is reduced, programme management costs will reduce considerably but, for the moment, this funding is largely supporting and sustaining the existing architecture. It is unclear how far donors recognise the weaknesses of the architecture, or have the vision or sense of responsibility to change it (Box 2).

Box 2: Challenges of AIDS architecture in Asia

NACs and/or CCMs can add layers of bureaucracy and transaction costs on MOH HIV programmes and in-country partners. Concentrated epidemics require involvement of just a few key sectors (e.g. drug control, justice, planning, public safety, education). From Asia's experience, there is little evidence to suggest that NACs provide additional 'coordination value'; indeed, they tend to be an opportunity cost to MOHs trying to develop such engagement themselves as part of good, modern public health.

HIV programmes tend to be structured around the 'UNAIDS Consensus' of HIV programming: prevention, care and treatment, impact mitigation and management and coordination. This framework is becoming increasingly inappropriate. The UNAIDS Investment Framework, combination prevention, treatment as prevention, the public health approach to integrated sexual and reproductive health (SRH), social protection and cash transfers are all alternative frameworks; yet programme structures find these difficult to grapple with effectively – programme organograms, budgets, planning frameworks, supervision systems all need to be re-aligned.

Vested interests, turf wars between programmes, inefficient planning tools, clumsy bureaucracy and weak leadership continue to challenge HIV governance and programme architecture. Divisions of labour among MOHs, NACs and CCMs over major programmatic areas can fragment programme coherence, and have an impact on the continuum of care for people living with HIV.

As interventions go to scale, the cost of civil society engagement is increasingly untenable. Extensive home-based care programmes in Myanmar and Cambodia are being dismantled. In Viet Nam, PEPFAR-funded programmes for NGOs are under pressure to reduce costs. In India, the transition from the Gates-funded Avahan NGO programme to Government funding for targeted interventions is highly challenging.

Measures to determine the quality and effectiveness of coordination are lacking. Countries may fully comply with CCM eligibility criteria despite experiencing major governance and/or operational issues. External TA tends to be short term, propping up the existing coordination model without fundamentally reviewing whether it is the right one for that country.

(Source: information collected for the Assessment including country reports and country informant interviews.)

[14] Putzel 2004, England 2006, Godwin 2006, Dickinson and Druce 2010.

What needs to happen?

Developing a consensus for change

While HIV policy and programming are the prerogative of countries themselves, countries in the region are still highly influenced by, and dependent on, regional and global frameworks. Without significant support for change at these levels, it will be more difficult for countries to shift direction. A critical starting point is strong and dynamic regional leadership that can bring partners together to develop a shared vision and commitment to an agenda for change. In effect, a shared regional investment and results framework is needed that includes agreed and coordinated positions and investments for HIV policy, architecture, strategic information, the role of civil society, and oversight of Global Fund investments.

A technical roadmap that re-focuses HIV investments

Remaining engaged in the region, but with a significant re-focus of external investments is critical. As part of a new regional framework, agreement on re-shaping regional policy and technical advice that partners provide will be important, particularly for normative partners such as the UN family, but also for other partners for whom funding decisions must be contextualised, if not justified, within the new frameworks.

Continuing investment is required in technical areas such as a harm reduction, evidence based drug treatment approaches, MSM programming, sexual and reproductive health for SW, MSM and PWID, test and treat programmes, and so on. Some partners are already developing guidelines in a number of these areas, but these will need consolidation and support at country level to articulate them in local contexts.

In the longer term, HIV programming must become more explicitly integrated into good public health management, through targeted SRH services for specific key populations, and integrated chronic care programmes for ART. A clear roadmap for how this is to be achieved in the region is needed urgently, with full political, scientific and implementation support from all stakeholders – particularly where they are already working with and supporting general health systems.

Country governments, the Global Fund and in-country partners need to urgently address AIDS coordination architecture and debate on whether NACs are still required, in what form and/or which functions could be transferred to other entities. This needs to take place alongside a broader discussion on the future role and vision of CCMs in the region, as part of the Global Fund's NFM process.

Working towards sustainability

Addressing funding shortages requires evidence-based allocations of existing resources including prioritised investments for key populations and switching funds out of programme areas with limited impact – including those of individual agencies. In addition, there is a need to provide powerful evidence on the value of re-focused investments to national authorities, and of the need to increase allocations for health and HIV in the long term.

To ensure greater financial sustainability in the future, it will be necessary to assess the potential to expand domestic financing for HIV programmes, test health insurance and other third party health costs for HIV, and support countries to transfer the costs of vertical HIV programmes into more integrated SRH care or chronic care programming. And, in the immediate term, there is a need to work with countries on re-allocation strategies based on available funds, rather than the aspirational 'resource mobilisation' strategies of the last decade.

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