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COMMUNITIES FIRST: TOWARD A SUSTAINABLE HIV RESPONSE IN ASIA AND THE PACIFIC

afao UNAIDS

This is the first in a series of occasional papers produced by the Australian Federation of AIDS Organisations (AFAO) designed to disseminate information and analysis on HIV and key populations in the Asia-Pacific region. The papers build on AFAO's *Consensus Statement on Australia's International Leadership Role on HIV*, jointly endorsed by Australian HIV organisations working internationally and available at afao.org.au.

About AFAO

AFAO is the peak organisation for Australia's community HIV response. We are recognised nationally and globally for our leadership, expertise and programs and have worked in partnership with successive Australian Governments for over 30 years to implement Australia's National HIV Strategy. Since the early 1990s, AFAO has strengthened civil society responses to HIV, health and human rights and contributed to effective policy engagement in Asia and the Pacific. AFAO's work today, led from our Bangkok office, includes the Sustainability of HIV Services for Key Populations in Asia (SKPA) program, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

About UNAIDS

UNAIDS is leading the global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals. Since it started operations in 1996, UNAIDS has led and inspired global, regional, national and local leadership, innovation and partnership to ultimately consign HIV to history. UNAIDS provides the strategic direction, advocacy, coordination and technical support needed to catalyse and connect leadership from governments, the private sector and communities to deliver life-saving HIV services. UNAIDS is a problem-solver. It charts paths for countries and communities to get on the Fast-Track to ending AIDS and is a bold advocate for addressing the legal and policy barriers to the AIDS response.

UNAIDS generates strategic information and analysis that increases the understanding of the state of the AIDS epidemic and progress made at the local, national, regional and global levels. It leads the world's most extensive data collection on HIV epidemiology, program coverage and finance and publishes the most authoritative and up-to-date information on the HIV epidemic—vital for an effective AIDS response. The UNAIDS Regional Office for Asia and the Pacific is based in Bangkok, Thailand.

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Acronyms

AFAO	Australian Federation of AIDS Organisations
ANPUD	Asia Network of People who Use Drugs
APLF	Asia Pacific Leaders' Forum
APN+	Asia Pacific Network of People Living with HIV and AIDS
APNSW	Asia Pacific Network of Sex Workers
APTN	Asia Pacific Transgender Network
ART	antiretroviral therapy
CAI	Community Advocacy Initiative
CBO	community-based organisation
CCM	Country Coordinating Mechanism
CSO	civil society organisation
EpiC	Meeting Targets and Maintaining Epidemic Control
DFAT	Department of Foreign Affairs and Trade (Australian Government)
KPIF	Key Populations Investment Fund
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
NICRA	Negotiated Indirect Costs Rate Agreement
PBC	Performance-based contracting
PCB	Programme Coordinating Board (UNAIDS)
PEPFAR	President's Emergency Plan for AIDS Relief (US Government)
PfR	Payment for results
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
SCDI	Supporting Community Development Initiatives (Vietnam)
SHI	Social Health Insurance
SHIFT	Sustainable HIV Financing in Transition (AFAO)
SRHR	sexual and reproductive health and rights
SKPA	Sustainability of HIV Services for Key Populations in Asia (AFAO)
TLY	The Love Yourself (Philippines)
UHC	Universal Health Coverage
USAID	United States Agency for International Development

Executive Summary

The purpose of this paper is to contribute to the dialogue among communities, governments, development partners and international organisations in Asia and the Pacific on strategies and models for ensuring the sustainable participation of HIV key population communities and community organisations.

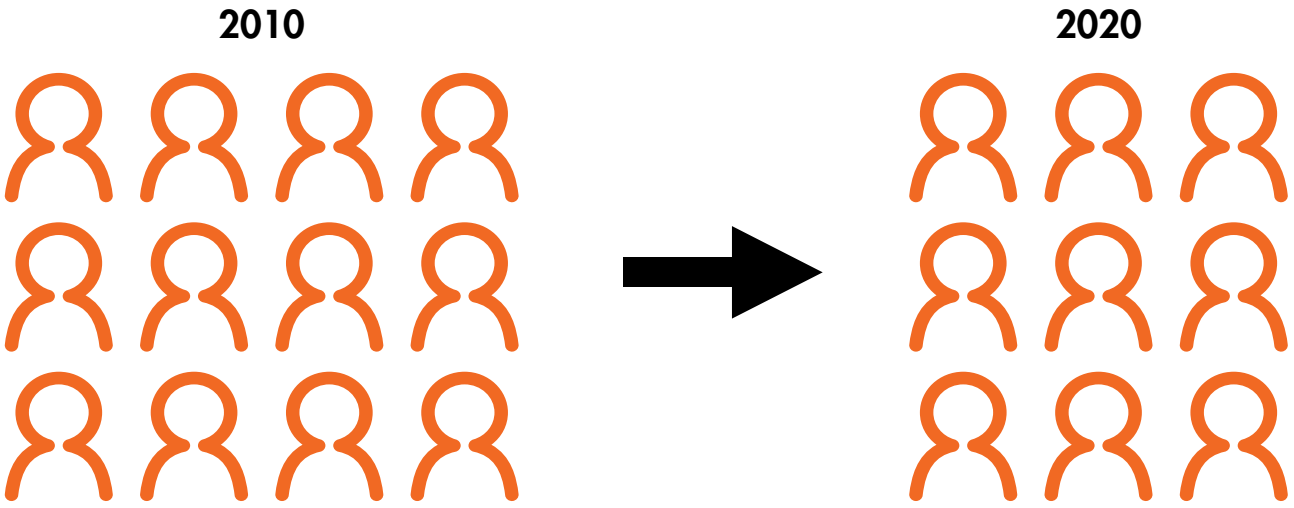
It summarises information from a desk-review of formal and informal literature, and a set of targeted key informant interviews with relevant agencies in the Asia and the Pacific region.

There has been strong progress towards achieving HIV targets in several countries in the region, but the epidemic is outpacing the response in others. Improved antiretoviral therapy (ART) access has reduced the annual number of HIV-related deaths by 24% since 2010, but mortality rates are increasing in several countries. Gay men and other men who have sex with men are experiencing rapidly growing HIV epidemics in several countries, with young men especially at risk. An increase in availability of heroin and the scarcity of harm reduction services in many countries is fuelling resurgent epidemics among people who inject drugs. Despite legislative reforms and other progress, shrinking civic space and stigma and discrimination against people living with HIV and key populations stand in the way of more rapid progress. At least three-quarters of new HIV infections in the region are among key populations and their sexual partners. This makes the role of key population-led community organisations in the region critical. Although the proportion of domestic funding for HIV responses in some countries has increased significantly, much of this is allocated to treatment and care and the proportion of domestic funding for key population HIV prevention services and programs remains low.

The essential role of community organisations in addressing HIV epidemics has been clear since the beginning of the epidemic. Evaluation of community responses found communities responding to HIV have helped to:

Progress

Improved ART access has reduced the annual number of HIV-related deaths by 24% since 2010



Source: UNAIDS Data 2019

Challenge

Three-quarters of new HIV infections in the region are among key populations and their sexual partners

Source: UNAIDS Data 2019

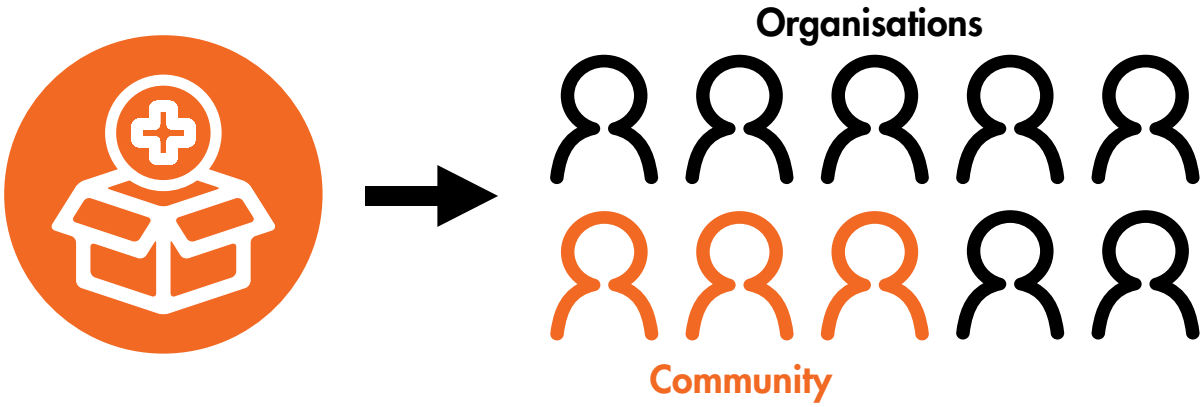
- mobilise substantial local resources
- improve knowledge and support behaviour change
- increase the use of services
- affect the outcomes of social processes
- had a positive impact in lessening HIV incidence and improving other health outcomes.

This is supported by a range of UNAIDS publications as well as by the 2016 Political Declaration on HIV and AIDS which includes two important commitments related to community action: "to ensure that at least 30% of all service delivery is community-led by 2030; and, to ensure that at least 6% of HIV resources are allocated to social enabling activities, including advocacy, community and political mobilisation, community monitoring, public communication and outreach programs for rapid HIV tests and diagnosis, as well as human rights programs such as law and policy reform, and stigma and discrimination reduction".

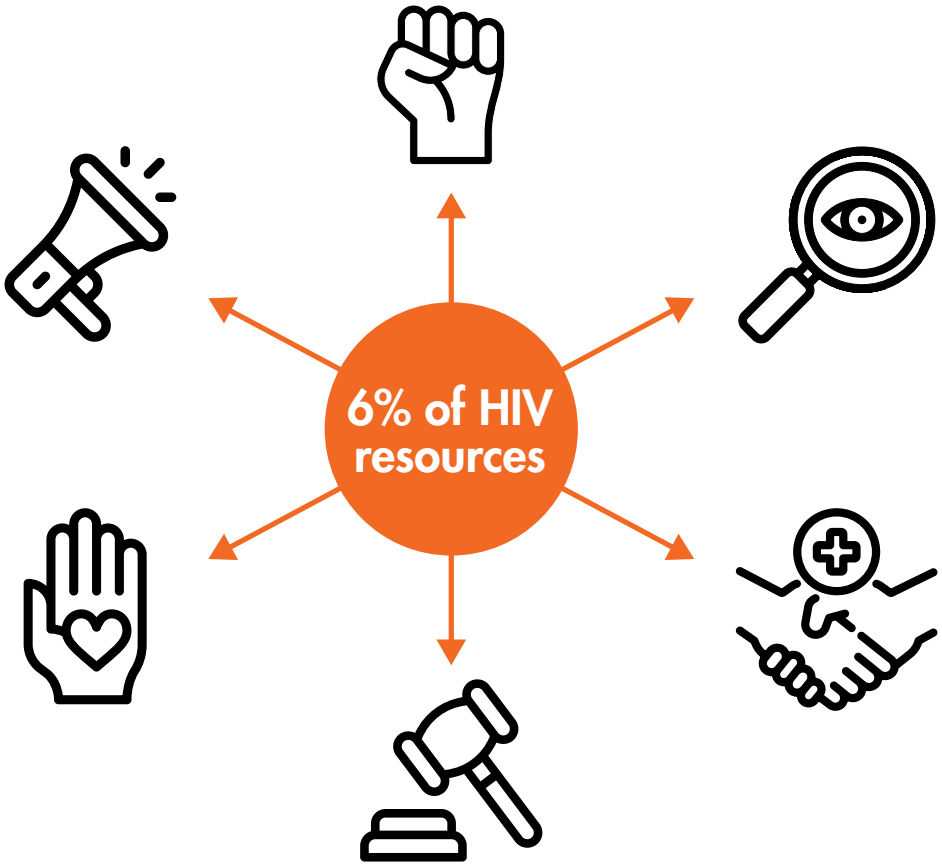
But a 2018 briefing provided to the UNAIDS Programme Coordinating Board (PCB) suggested there has been a decline in available funds for civil society organisations in recent years. Having provided capacity building and financial support to key population organisations and networks for many years, development partners such as Australia's Department of Foreign Affairs and Trade (DFAT), President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria seek to support increased sustainability of key population participation through these experienced and capable networks, representing a significant and trusted resource that can be mobilised to provide coordination, technical assistance and capacity development.

Targets

1 At least 30% of all service delivery is community-led by 2030



2 At least 6% of HIV resources are allocated to social enabling activities, including advocacy, community and political mobilisation, community monitoring, public communication and outreach programs for rapid HIV tests and diagnosis, as well as human rights programs such as law and policy reform, and stigma and discrimination reduction



Source: UN 2016 Political Declaration on HIV and AIDS

Key findings

Insufficient funds available to achieve the whole package at scale: Despite the fact most countries describe a full package of HIV services for at least several key populations in their national HIV strategies and funding proposals, the amount of funding available has been well below what would be required to reach the scale necessary to turn epidemics around.

Narrow focus of the funding that is made available to civil society organisations (CSOs[5]): CSOs report consistently that they are no longer funded for the full range of health and wellbeing services they know are required in their communities. Some described the current funding models as forcing them to become 'HIV testing machines'. Except in a very few cases, the lack of consistent domestic funding allocations for CSOs limit the potential to take a leading role in using new prevention and communication technologies.

Lack of adequate financial support for core activities: The current focus on 'activity only' or 'indicator only' funding means that donors are less and less willing to provide (or contribute to) core funding for CSOs, assuming CSOs will income-generate for this separately. Many of these organisations work with marginalised and criminalised populations, so are unlikely to attract corporate funding.

Lack of financial support for advocacy: The sharpening of donor-funding focus onto HIV "test and treat" leaves little scope for CSOs to play their important advocacy role. Though most funders have clear policy statements about human rights and working on the social enablers that remove access to barriers for key populations, funding for CSOs in this area remains scarce. Advocacy is becoming increasingly difficult in some countries in the region as governments seek to reduce the space for civil dialogue, particularly in relation to key populations.

Onerous reporting requirements: Despite some considerable streamlining by donors of reporting requirements for lead contracts, the burden of data collection and management at service level for many CSOs remains onerous and unnecessary.

Poor transition and sustainability investment: While most donors have explicit transition policies and practices to support sustainability, CSOs in the region report a rapidly changing and unstable environment in relation to both international and domestic funding. They report some donors change their focus with little notice, leaving them to decide whether to reshape their programs to fit new donor priorities or to seek funding elsewhere.

Decentralisation of health planning and financing: One of the biggest obstacles for CSOs in many countries in Asia and the Pacific is the decentralisation of health planning and financing to sub-national level that is taking place across the region. While it is clear this can have distinct health advantages for communities, it requires CSOs to operate at these levels. Although for many it will be crucial for their sustainability, there is little technical or financial support available to build the capacity of national-level CSOs to engage in this process.

Advocacy is becoming increasingly difficult in some countries in the region as governments seek to reduce the space for civil dialogue, particularly in relation to key populations.

[5] The term CSO (civil society organisation) is being used as shorthand to include community-led and community-based organisations and well as other non-government organisations providing services in communities

Progress to date

More comprehensive investment case development and transition readiness assessment and planning: Several transition readiness assessment and guidance tools have been developed and are in wide use now. These are designed to assist countries to move towards greater sustainability. Some assessments have led to the development of funded transition plans that include transfer of service elements including those provided by CSOs to domestic funding. By 2018, with support from UNAIDS, the World Bank and other partners, fifty-two countries had applied the 2011 UNAIDS Investment Framework to better prioritise and focus their HIV responses and to provide governments with the evidence-base to justify increased domestic HIV investment. The PEPFAR Sustainability Index and Dashboard is also widely used to track sustainability. All PEPFAR countries are required to complete the SID in a multi-stakeholder manner every two years.

Social Impact Investments: Social impact investments offer the potential for financial returns while supporting interventions that primarily create tangible social goods. Impact investing brings together investors, governments, service providers and communities to tackle a range of social issues. A key feature of impact investing, and the main attraction for socially conscious investors, is the emphasis on stronger evaluation measures, creating a heightened focus on evidence-based decision making and outcomes. Building on the past decade of experience in innovative financing to empower underserved women across the world, lessons can be learned to bring capital to key population communities in the Asia Pacific region.

Social contracting: The term *social contracting* has been coined to encompass the range of methods by which governments contract with non-government providers for health services. Many countries in Asia and the Pacific have blended health systems that include a mix of public, non-government not-for-profit and private (for profit) services. Social contracting creates an important input loop for CBOs to provide site-level perspectives on the effective allocation of government resources to achieve country targets and, ultimately, epidemic control. In Asia and the Pacific, Indonesia has recently made changes to government procurement mechanisms to open up space for the contracting of CSOs. AFAO's Sustainability of HIV Services for Key Populations in Asia (SKPA) program is assisting in the development and strengthening of social contracting mechanisms in Lao People's Democratic Republic and Mongolia.

Including HIV service elements for key populations in Universal Health Coverage: It is important for sustainability that CSOs engage with the Universal Health Coverage (UHC) process and dialogue around domestic resource mobilisation in their countries. PEPFAR has worked successfully in Thailand and Vietnam to have elements of HIV service provision included in Social Health Insurance (SHI) schemes. In the Philippines, the PhilHealth Insurance scheme covers outpatient services for people living with HIV. This has enabled CSOs like Love Yourself (a gay community-led service provider in Manila) to become financially self-sufficient.

Payment for results/performance-based contracting (PfR/PBC): Payment for results (or performance-based contracting) provides one mechanism by which CSOs can gain more autonomy in decisions about the service mix they provide and methodology they use. In the same way Love Yourself (Philippines) receives a quarterly flat rate from the PhilHealth insurance system for each person with HIV it

is caring for, governments can contract CSOs under performance contracts that establish a flat, all-inclusive fee per individual serviced over a period of time (or number of individuals receiving a particular service in a particular period), and the CSO is then able to decide what mix of human and other resources it needs to put in place to achieve that. The advantage is that CSOs have some flexibility about how to do their work. The disadvantage is that if they stall in meeting their targets their budgets are reduced.

Setting priorities for further action

1. Co-convene a Regional Working Group under the auspices of the UNAIDS Regional Office for Asia and the Pacific, AFAO and regional key population networks to mobilise resources and take forward the actions below.
2. Map the status and progress of countries in relation to CSO participation, funding and sustainability.
3. Determine which countries are likely to need to transition away from external donor financing from HIV more quickly – meaning either external financing is likely to cease or be reduced by more than 50% — over the next decade and determine categories of countries:
    - Those already in transition
    - Those likely to transition in the next decade
    - Those unlikely to transition in the next decade
4. Analyse and document successes so far – the process that countries and donors have followed, the obstacles they faced and the solutions that they have come up with.
5. Identify, adapt and promote innovations in achieving financial sustainability for community organisations.
6. Develop strategies for each category of countries, including:
    - Advocacy for the legitimate and ongoing role of CSOs in each country's HIV response
    - Assistance to countries in or about to undergo transition to fully fund community responses to the extent envisaged in the 2016 Political Declaration on HIV and AIDS, together with assistance to countries unlikely to transition soon to develop plans for strengthening community systems.

Introduction

The purpose of this paper is to contribute to the dialogue among communities, governments, development partners and international organisations in Asia and the Pacific on strategies and models for ensuring the sustainable participation of HIV key population communities and community organisations. It summarises information from a desk-review of formal and informal literature, and a set of targeted key informant interviews with relevant agencies in the Asia and Pacific Region.

It documents the commitments currently in place, the frameworks that have been developed to make those commitments real, the challenges currently being faced by key population-led community organisations as they try to take up their roles and some of the innovative models that have emerged in the region. Its primary target audiences include donor governments and funding bodies, UN agencies and technical support partners, national governments in the region, regional and national key population organisations, and other service providers and program implementers.

This paper was initially drafted in early 2020, before COVID-19 had become such a significant influence across the region. The restrictions on travel in most countries in the region are now having a significant impact on the implementation of HIV programs and on people's access to the HIV prevention and care services they need. Community-led HIV organisations have been mobilised not only to ensure consistent access for people living with HIV and people from key populations to treatments and prevention commodities, but also to conduct community awareness about COVID-19. In some countries key populations are experiencing increased levels of stigma, discrimination, marginalisation and violence as they are falsely assumed to be responsible for the severity of COIVD-19 in the country. AFAO is preparing a separate discussion paper on the impact of COVID-19 on key populations in the region.

Obviously, the severity of this pandemic and the effect it is having on global, regional and national economies will have a significant impact on the resources available for sustaining the community response to HIV in countries.

Background

The need for vibrant civil society and community-based organisations (CSOs/CBOs) in effective global health responses to HIV is well documented and there are many examples of their power in Australia and in Asia and the Pacific. In this region, key population civil society space is under threat due to punitive laws, hostile regulatory environments and fragile funding models that rely on external donors who commonly use project-based funding which although welcome, does not build financially sustainable organisations. It is imperative that multiple streams of funding for key population-led civil society and resource organisations be identified and secured or else many of these organisations will disappear as external donor funding reduces.

There are significant barriers to capital access and domestic financing for civil society in most countries in Asia and the Pacific. Current approaches to strengthening communities and civil society are essential but insufficient in tackling the legislative, policy and political contexts (including increasing nationalism and populism) that constrain community-led action in some countries.

Sustaining this community effort is essential to maintaining (and building upon) successes in HIV prevention, treatment and care, and as donors seek to transition out of countries that can realistically afford to fund their own HIV response, this becomes an important issue for governments, implementing agencies and communities. Addressing these challenges requires sustained commitment to existing efforts and the trialling and implementation of new funding approaches that have the potential to accelerate gains that are financially sustainable.

Significant and sustained advances have been made across the HIV prevention and treatment 90:90:90 targets[6] in many countries. A sharper focus of programs on evidence-informed interventions, particularly *test-treat-retain* has contributed significantly to this. Many countries are now focussed on leaving no-one behind – *the last mile* in reaching epidemic control as it is sometimes referred to. This involves identifying and reaching the sub-populations most alienated from health and community services and connecting them with the information, support, programs and services they need to stay healthy. Sustained success in responding to HIV relies not only on reaching the people not yet diagnosed, but on maintaining a life-long health engagement with the people with HIV on clinical care and antiretroviral therapy (ART). For key populations, evidence shows that this will require sustained domestic financial support for community-based organisations.

Despite significant successes across Asia and the Pacific, some countries are experiencing sharp rises in HIV transmission among key populations, particularly gay men and other men who have sex with men, and among young people at risk. For these countries, *the last mile* is still a way off.

Since the earliest days of the HIV pandemic, the communities most affected have played an essential role in reaching the hardest-to-reach people, informing them and providing a bridge for them into health and community services. They have also provided essential advocacy for resources and for the elimination of the many service access barriers that marginalised populations experience. Over the years community organisations have matured and taken their place as innovators, advocates, service providers, policy makers and quality monitors.

… key population civil society space is under threat due to punitive laws, hostile regulatory environments and fragile funding models.

[6] 90% of people living with HIV know their status; 90% of these are on antiretroviral therapy (ART) and 90% of these have achieved long-term viral suppression.

Asia and the Pacific: Progress at a glance

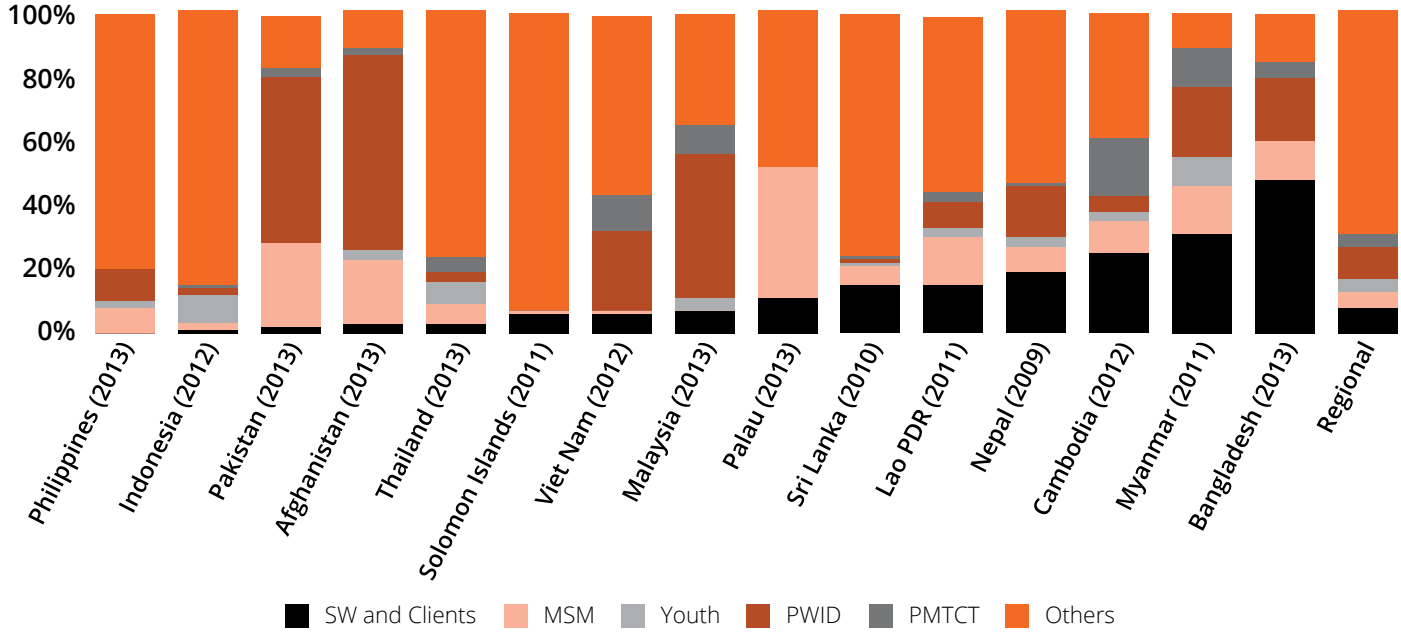
The UNAIDS 2019 Data Report summarises progress in the region as follows:

- Strong progress in several countries, but the epidemic is outpacing the response in others. **Annual new HIV infections rising rapidly in Bangladesh, Pakistan and the Philippines**.
- Improved ART access has reduced the annual number of HIV-related deaths by 24% since 2010, but **mortality rates are increasing in Afghanistan, Bangladesh, Indonesia, Pakistan and the Philippines**.
- Gay men and other men who have sex with men are experiencing **rapidly growing HIV epidemics in several countries, with young men especially at risk**.
- An increase in availability of heroin and the scarcity of harm reduction services in many countries is fuelling **resurgent epidemics among people who inject drugs**.
- Despite legislative reforms and other progress, **shrinking civic space and stigma and discrimination against people living with HIV** and key populations stand in the way of more rapid progress (UNAIDS, 2019).

At least three-quarters of new HIV infections in the region are among key populations and their sexual partners. Thirty percent of new infections occurred among gay men and other men who have sex with men. Young people (15-24 years) accounted for around 25% of new infections in 2018. Just under 70% of the estimated population of people living with HIV know their status. Fifty-four percent of the total estimated population of people living with HIV are on ART and 49% have achieved viral suppression (UNAIDS, 2019).

The figure below sets out the proportion of HIV prevention spending allocated to key population programs across Asia. This is 2009 – 2013 data. Although the proportion of domestic funding for HIV responses in some countries has increased significantly since then, much of this is allocated to treatment and care and the proportion of domestic funding for key population HIV prevention services and programs remains low (Fuh Teh, 2017).

Figure 1. Proportion of HIV prevention spending by category, Asia 2009 – 2013[7]



Source: UNAIDS Datahub 2015

[7] https://www.aidsdatahub.org/hiv-expenditure-2015

Data from 2019 indicate that reliance on international funding sources is particularly high for key population HIV prevention programs in the region – 82% for men who have sex with men, 80% for sex workers and 73% for people who inject drugs. (Vannakit et al, 2020).

Much of the funding for key population programs has come from donors and other development partners, with national governments preferring to allocate their co-financing share to less controversial areas like test kits, medicines and health services. Although this was an expedient way of ensuring services quickly reached key populations, it has meant some countries are only now beginning to deal with the reality of bringing successful community-led programs under domestic funding mechanisms. There is still significant resistance from some governments in the region however, as they fear that strong and active key population organisations might advocate too strongly.

The case for a community response

There have been many clinical and technological advances in HIV prevention, diagnosis, treatment and care – including Pre-exposure Prophylaxis (PrEP), rapid and more portable HIV testing, one-pill-a-day ART regimes with minimal side effects, point-of-care viral load testing and others. However, in recent years it has become clear that sustained success in HIV prevention and in improving the health and wellbeing for people living with HIV involves achieving a long-term positive connection between key populations and clinical and community services. It requires a holistic set of programs and services that seek to address the complexity of people's daily lives.

The essential role of community organisations in this long-term relationship with people at-risk of and affected by HIV has been clear since the beginning of the epidemic. A landmark mixed-method evaluation of the impact of community responses to HIV by the World Bank sets out this case (Rodrigeuz et al, 2015). It found communities responding to HIV have helped mobilise substantial local resources, improved knowledge and supported behaviour change. They have also increased the use of services, affected the outcomes of social processes and lessened HIV incidence and improved other health outcomes. This is supported in UNAIDS publications:

> "We know that community responses to HIV are the cornerstone of effective, equitable and sustainable programs. They mobilise communities to demand services and exercise their rights; they also deliver services, support health systems and reach those most vulnerable to HIV where state facilities cannot. Moreover, communities act as barometers in their watchdog role, tracking what works and what does not with a local, contextualised perspective. In other words, communities give a voice to those who need services, provide feedback as to whether policies and programs are working and suggest how they can be improved" **(UNAIDS, 2015).**

The essential role of community organisations in this long-term relationship with people at-risk of and affected by HIV has been clear since the beginning of the epidemic.

> "Civil society platforms have been essential for the empowerment and mobilisation of women and key populations in many countries. Civil society also plays a critical role in upholding fundamental human rights principles and ensuring transparency and accountability. New sectors have emerged in the HIV response to represent the voices and serve the needs of marginalised populations, such as young key populations, migrants, indigenous peoples and persons with disabilities. In this way, the global HIV response is developing inclusive approaches to community mobilisation that will offer useful lessons as the world moves towards fulfilling Universal Health Coverage" **(UNAIDS PCB, 2018).**

There is a significant body of evidence now that demonstrates "differentiated approaches that include community-based mobilisation, task sharing and non-facility-based service delivery accelerate the capacity of key populations to access HIV testing and ART, and improve overall HIV cascade performance" (Vannakit et al, 2020). There is also an increasing body of evidence that shows that reaching key populations through the online spaces they use to communicate with each other is a particularly successful strategy for promoting community and self-testing for HIV, and for PrEP, which is fast becoming a very effective HIV strategy for some populations (particularly men who have sex with men).

Commitments to community responses

The 2016 Political Declaration on HIV and AIDS includes two important commitments related to community action: "to ensure that at least 30% of all service delivery is community-led by 2030; and, to ensure that at least 6% of HIV resources are allocated to social enabling activities, including advocacy, community and political mobilisation, community monitoring, public communication and outreach programs for rapid HIV tests and diagnosis, as well as human rights programs such as law and policy reform, and stigma and discrimination reduction" (UNAIDS PCB 2018a). This declaration was adopted by UN member states at the UN General Assembly in June 2016, so applies not only to donor funds, but to national budgets.

The 2018 briefing provided to the UNAIDS Programme Coordinating Board (PCB) on best practices for effective community-led responses to HIV sets out the evidence that supports the need for these commitments and

progress in health financing to date to meet these commitments. It provides an analysis of funding provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Unitaid, bilateral government development partners (President's Emergency Plan for AIDS Relief (PEPFAR), the Department for International Development (UK), Initiative 5% (France), the Japan International Cooperation Agency), the Robert Carr Fund and foundations such as the Bill & Melinda Gates Foundation, Elton John Foundation, M.A.C. AIDS Fund, Open Societies Foundation and others. The briefing identifies several issues in tracking progress against these commitments, including significant variation in what is understood by the terms *community-led* and *social enabling activity*.

It calls for work to be undertaken to reach a more consistent understanding of these terms and to disaggregate health finance data to better measure allocations. In July 2018, PEPFAR made a commitment to transitioning to significantly greater level of implementation of its supported activities through local partners - with a goal of 70% (by agency) by the end of FY 2020 (August 2021).

The briefing points to preliminary findings that suggest that there has been a decline in available funds for civil society organisations in recent years, though it points to the need for reform of reporting systems to better report on these commitments (UNAIDS PCB 2018a).

Commitments by particular donors and development partners

The Global Fund provides funds through some civil society NGO Principal Recipients (PRs), and also through PRs to community-led sub-recipients, and it would be helpful to analyse the patterns of financing to community-led organisations. It also supports intervention under the title *community system strengthening* and a wide range of catalytic initiatives that support social enabling activities. The Fund's Community Systems Strengthening Technical Brief defines *community-led responses* as "those responses that are managed, governed and implemented by communities themselves" and *community-based responses* as "those that are delivered in settings or locations outside of formal health facilities" (Global Fund 2019). The technical brief sets out the four areas for investment:

- community-based monitoring
- community-led advocacy and research
- social mobilisation, building community linkages and coordination
- institutional capacity building, planning and leadership development.

It affirms that community system strengthening is essential to achieving progress in HIV prevention and treatment and to fulfil principles of promoting human rights and gender equity.

The Global Fund's Sustainability, Transition and Co-financing Policy provides a framework for supporting countries to transition towards domestic funding under a national HIV strategy and while it does not specify any particular focus on community-led or community-based approaches, it requires "an appropriate focus on interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities in all countries, irrespective of income level" (Global Fund, 2016).

In relation to CSO funding for HIV programs in Asia and the Pacific, the Global Fund invested in a relatively small two-year regional project with AFAO as the Principal Recipient (SHIFT – Sustainable HIV Financing in Transition) that assisted regional organisations to work with national and sub-national coalitions in four countries (Indonesia, Malaysia, the Philippines and Thailand). It contributed to building their capacity to engage in planning, budget and finance deliberations in their countries. A follow-on eight-country project (SKPA – Sustainability of HIV Services for Key Populations in Asia)[8] is currently underway, again with AFAO as PR. The achievements and lessons learned from SHIFT are discussed in the next section of this paper.

PEPFAR and the United States Agency for International Development (USAID) are both reorienting their strategies, partnership models and program practices to achieve greater development outcomes and to work towards a transition from foreign to domestic funding of HIV programs. In 2018, USAID launched 'the *Journey to Self-Reliance*, with the goal of empowering host country governments and local partners to achieve locally sustained results, helping countries mobilise public and private funding streams, strengthen local capacities, and accelerate enterprise-driven development. PEPFAR has provided support to community-led and community-based responses throughout its history. In its second strategy (2008-2012) the program's focus shifted from emergency relief to country ownership.

The PEPFAR 3.0 Sustainable Action Agenda shifts the focus even more acutely onto supporting countries to fund and manage their own HIV response. This shift resulted in the 2014 launch of the US$400m USAID *Linkages across the Continuum of HIV Services for Key Populations Affected by HIV* project, (LINKAGES). This was the first USAID project with the sole mandate to focus on HIV services specifically for key populations. LINKAGES, which ends in 2020, aims to accelerate the ability of partner governments, key population-led civil society organisations and private-sector providers to plan, deliver and optimise comprehensive HIV prevention, care and treatment services to reduce HIV transmission among key populations and help those who are living with HIV to live longer.

In 2016, PEPFAR also launched the US$100m Key Populations Investment Fund (KPIF) to build the local capacity of key population organisations to address their community needs and barriers in order to reach epidemic control, although funding under this program was not allocated until 2019. In 2019 USAID also awarded FHI360 a five-year project – Meeting Targets and Maintaining Epidemic Control (EpiC), building on LINKAGES and aimed at providing strategic technical assistance and direct service delivery to achieve HIV epidemic control and promote self-reliant management of national HIV programs by improving HIV case finding, prevention, treatment programming and viral load suppression (FHI360, 2019).

In 2018 PEPFAR committed to directing most of its funds to '*local partners*', with intermediate goals of directing 25% of the allocation to local organisations by the end of FY18 (October 2018 - September 2019), 40% by end FY19 and 70% by the end of FY20 by US government agency (Policy Impact in Global Health, 2019). Under PEPFAR a *local partner* may be an individual, a sole proprietorship (such as a corporation or not-for-profit) or an entity (government ministries and parastatals) and in order to qualify for funding, the local partner must submit supporting documentation as per PEPFAR guidance (PEPFAR 2020).

Australia's Department of Foreign Affairs and Trade (DFAT) has also made a commitment to the community response to HIV in Asia and the Pacific. In the early days of the HIV epidemic its predecessor (AusAID) provided

[8] Countries: Bhutan, Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines, Sri Lanka and Timor-Leste.

funding through AFAO to people living with HIV, sex worker, men who have sex with men and drug user organisations in several countries across Asia (Thailand, Malaysia, the Philippines), and to harm reduction programs in Myanmar, Cambodia, Vietnam and the Lao People's Democratic Republic. The Australian government has also supported community-led HIV prevention programs in Papua New Guinea and harm reduction, CBO funding and capacity development programs in Indonesia.

In 2014, DFAT set out strategic priorities for Australia's international response to HIV, including to:

- advocate for equitable, enabling legal and policy environments and targeted action on policies and laws that stigmatise key populations, infringe their human rights and inhibit their access to services;
- invest strategically in key populations, sex workers, men who have sex with men, transgender people, people who inject drugs and people living with HIV; and,
- seek to fill gaps in the current responses, where Australia has a comparative advantage and based on a clear understanding of country epidemics and responses (DFAT, 2014).

Since the beginning of the HIV epidemic in Asia and the Pacific, DFAT (and AusAID before it) has provided funding and significant technical support for innovative regional and national responses to HIV among key populations. The significant lessons learned from Australia's successful partnership between government, service providers and affected communities have been translated into development support that has included harm reduction approaches for people who inject drugs and programs and services by and for gay men and other men who have sex with men, trans people, sex workers and other marginalised populations. Much of this was provided under long-term bilateral projects that provided key population organisations with significant and stable service delivery and advocacy funding.

DFAT also provided funding for regional key population networks such as APCOM, the Asia Pacific Network of Sex Workers and the Asia Network of People who Use Drugs. It also supported Seven Sisters, which brought together regional networks from a range of key populations. This support contributed to the development of a significant body of experience and evidence in the successful participation of key populations in regional, national and local HIV responses, demonstrating for many governments in the region the benefits of key population participation. Support for regional government and non-government sector leadership was also provided through mechanisms like the Asia Pacific Leaders' Forum (APLF).

These initiatives have contributed to the strengthening of key population organisational capacity at regional and national level. As development partners like DFAT, PEPFAR and the Global Fund seek to support increased sustainability of key population participation, these experienced and capable networks represent a significant and trusted resource that can be mobilised to provide coordination, technical assistance and capacity development.

Issues and lessons learned to date

The brief summary below of issues identified and lessons learned is drawn from the literature and from a set of key informant interviews with national and regional civil society organisations and from reports.

Insufficient funds available to achieve the whole package at scale

There is consistent concern raised that despite the fact most countries describe a full package of HIV services for at least several key populations (in line with WHO Consolidated key population Guidelines) in their national HIV strategies and funding proposals, the amount of funding available, particularly in recent years, has been well below what would be required to reach the scale necessary to turn epidemics around. This is particularly the case in the most recent Global Fund allocation period (2018-2020), under which many CSOs reported funding cuts of up to 40% on the previous allocation period, with little change in the key population reach and testing targets they were expected to achieve. Decisions about funding priorities are made by Country Coordinating Mechanisms (CCM) and although the Global Fund has policies to ensure that key population programming is prioritised, if the total amount allocated is decreases from one allocation period to another, then the amount available for key population services invariably decreases. A significant casualty of this has been funding for primary prevention, both within key population and more generally, with many countries unable to achieve the 25% of budget recommended for prevention services (UNAIDS PCB, 2018). This approach varies by donor and country. Some countries in the region have access to donor funds to fund CSOs for both direct service provision and technical support, while in other countries the more recent approach has been to fund technical support and model development, but not direct service delivery. In some countries (e.g. Indonesia and Papua New Guinea), changes in the funding priorities has led to left significant programmatic gaps, particularly in key population outreach and linkage to treatment and care for people living with HIV, with insufficient time for an effective transition.

Narrow focus of the funding that is made available to CSOs

CSOs consistently report they are no longer funded for the full range of health and wellbeing services they know are required in their communities. Some described the current funding models as forcing them to become 'HIV testing machines'. One experienced community leader in Indonesia described the current dominant strategy as 'test and run', referring to the low levels of linkage to care and the lack of availability of broader health services (McCallum et al, 2019).

Many people from key populations face daily challenges in relation to poverty, housing insecurity, gender norms and practices, violence, mental health issues, drug and alcohol use, marginalisation and criminalisation and these often take priority over focussing on a single issue like HIV. CSOs report a growing trend among some donors to look to them only for HIV diagnosis and referral for treatment,

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with occasional additional funding for some limited peer case management or adherence support. The PEPFAR/USAID LINKAGES project has in recent years worked to address this by ensuring activities along the HIV prevention to care continuum are funded and reported on, and the critical enablers that remove barriers to outcomes are also funded. The Global Fund has also sought to address this through its catalytic funding streams and through the Breaking Down Barriers to Access initiative.

The 90-90-90 strategy and focus has been particularly successful in ensuring that HIV programs focus on dramatically increasing levels of knowledge of HIV status, enrolment in ART and clinical care, and long-term achievement of undetectable viral load. This has had a significant onward HIV prevention benefit.

CSOs report however that they are more and more constrained by ambitious testing and service linkage targets that leave no room to apply human and other resources to a wider range of interventions. Some have even ceased to provide the successful people living with HIV peer support programs they had in place to support treatments literacy and adherence, partner protection and health and wellbeing in order to continue to reach outreach targets. Many of the key population CSOs interviewed during a 2018 key population HIV service package assessment for Asia and the Pacific commissioned by the Global Fund had either ceased, or significantly scaled back the advocacy and critical enabler work they had previously been involved in. Outreach models have also changed significantly in many countries – tailored more towards 'testing and referral only' and away from the broader longer-term health engagement with key populations (irrespective of their HIV status) that were once in place (McCallum et al, 2019).

It is also clear that the sharpening of donor funding focus onto HIV test and treat leaves little scope for CSOs to play their important advocacy role.

It was clear from this key population assessment that while the sharp focus on 'reach to test' was significantly increasing knowledge of HIV status among key populations, it was not as successful in bringing about a corresponding increase in ART coverage for the people living with HIV identified. The reasons for this are complex, but it is partly due to demarcations in some countries between key population outreach organisations and people living with HIV support organisations that have been either produced or exacerbated by donors. In many cases, key population organisations are only funded to provide outreach for testing, then immediately refer newly diagnosed people living with HIV to government services and/or people living with HIV organisations for ongoing treatment, care and support. These referrals are not always successful as key population outreach and people living with HIV support branches are not evenly distributed across the country and because many clients report that they prefer to receive ongoing support from the key population organisation. Donors exacerbate this by not providing funds to key population organisations for people living with HIV support, or by in some cases providing limited case management funding for the first three months after diagnosis. There are also monitoring issues here, with relatively good data in place in most programs to track community service delivery to individuals from key populations, but little disaggregated data available in clinical services to track the health outcomes of people from key populations who are living with HIV (McCallum et al, 2019).

In addition to this, key population organisations often have a commitment to (and a history of) providing programs and services that attempt to take account of the broad range of needs

of their constituents. This is their comparative advantage over other providers as it builds trust with the communities they come from and serve. Reducing their capacity to be useful to their communities across a range of needs weakens this trust. The whole rationale for supporting community organisations to carry out this role in reaching marginalised or harder to reach people is that these organisations are best placed to do this. Forcing them to expend (or jeopardise) this social capital on short-term interim goals like increased HIV testing levels weakens their ability to deliver on the broader goals articulated under 'last-mile' and 'leave no-one behind' strategies.

These organisations are also well aware of the needs of their communities in relation to other individual and public health issues like hepatitis B and C, STIs, violence, alcohol and other drug use, mental health, reproductive health, gender affirming treatment and support, but rarely given sufficient funding to work effectively in these areas.

Except in a very few cases (Thailand, the Philippines, Myanmar), the lack of consistent domestic funding allocations for CSOs limit their potential to take a leading role in using new prevention and communication technologies like PrEP, community and home-based testing, and social media prevention, treatment and care support to improve health outcomes for their communities.

Lack of adequate financial support for core activities

This is connected to the point above, but the current focus on 'activity only' or 'indicator only' funding means donors are less and less willing to provide (or contribute to) core funding for CSOs, assuming that CSOs will income-generate for this separately. This is difficult or impossible in many settings across Asia and the Pacific. Many of these organisations work with marginalised and criminalised populations, so are unlikely to attract corporate funding as corporations fear that this will bring them into potential conflict with conservative governments or upset their customers.
CSOs need a stable base from which to provide services. Donors (and governments) require them to have transparent and robust governance and financial management systems, to have strategic plans, to ensure quality by maintaining a highly trained, competent and accountable workforce and to meet time-consuming and complex monitoring, reporting and compliance demands. All of this requires adequate and consistent funding.

This reinforces the need for greater donor harmonisation to ensure that the health outcomes that donors (and partner governments) seek can be achieved off a stable core funding foundation in the CSO. Some CSOs report they are prevented from including a management fee in their Global Fund sub- or sub-subrecipient contracts. Many do not have the financial history (or time and capacity) to secure verified indirect costs rates (like the US NICRA[9]) that would provide them with a contribution to core funding under a PEPFAR contract. Funding levels and processes for management and indirect costs vary significantly from donor to donor. This makes it difficult for CSOs to establish and maintain a sustainable foundation to support their program work as the indirect cost policies and practices vary significantly between donors and because donor support projects cover different time periods, leaving gaps in the continuity of core budget support. Despite commitments by donors to increased harmonisation, many still maintain and impose separate indicator sets and monitoring and evaluation frameworks on CSOs. This makes reporting time consuming and complex for CSOs with multiple sources of income.

Lack of financial support for advocacy

It is also clear that the sharpening of donor-funding focus onto HIV test and treat leaves little scope for CSOs to play their important

[9] Negotiated Indirect Costs Rate Agreement (NICRA) https://www.usaid.gov/sites/default/files/documents/1861/Infographic_-_NICRA_2-14.pdf

advocacy role. Though most funders have clear policy statements about human rights and working on the social enablers that remove access barriers for key populations, funding for CSOs in this area remains scarce. Advocacy is becoming increasingly difficult in some countries in the region as governments seek to reduce the space for civil dialogue, particularly in relation to key populations. CSOs hoping to enter into contracts for service provision with governments (national and sub-national) will need to carefully navigate their role as community advocates as they may find themselves unable to safely raise difficult issues without jeopardising their funding or service delivery accreditation.

The Global Fund provides catalytic funding to some countries in the region (Indonesia, Nepal and the Philippines) under its *Breaking Down Barriers to Access* initiative for this, and although countries are encouraged to include strategies and activities for gender, rights and community in their Global Fund proposals, these are often diluted or removed at CCM level or in grant negotiation in favour of more tangible outcomes like test and treat. Community monitoring models are in place in several countries across the regions – giving communities the data they need to effectively advocate in relation to human rights abuses and service quality. The smartphone-based system in place in Myanmar is a good example of this and is beginning to provide useful information for service improvement.

Onerous reporting requirements

Despite some considerable streamlining by donors of reporting requirements for lead contracts, the burden of data collection and management at service level for many CSOs remains onerous and unnecessary. Many services are still using paper-based reporting systems, requiring field workers to take down copious amounts of information as part of their client interaction. Some client enrolment forms read more like a social research protocol than basic enrolment information – collecting detailed information on sexual activity, condom use, mental illness, drug use and other behaviours. CSOs report having to allocate a significant proportion of staff funding to data entry and reporting, while reporting little benefit in terms of data made available to drive preservice improvement. Many receive funding from a range of donors and government providers and report little if any harmonisation of reporting systems. Onerous reporting requirements take vital resources away from intervention practice, thereby reducing resources available for direct implementation. Narrowly focussed reporting systems can limit the information that is collected and analysed by CSOs and fed back into service improvement.

Poor transition and sustainability investment

While most donors have explicit transition policies and practices to support sustainability, CSOs in the region report a rapidly changing and unstable environment in relation to both international and domestic funding. They report that some donors change their focus with little notice, leaving them to decide whether to reshape their programs to fit new donor priorities or seek funding elsewhere. Some donors (even those funding critical programs like ART access and clinical care of people living with HIV) give very short notice for significant changes in focus, leaving other donors and advocacy groups to scramble to shore up onward treatment for people living with HIV.

There has been some activity across the region in terms of transition readiness assessments and investment case development at national and sub-national level in some countries, but little solid investment in mechanisms that would support genuine transition and limited engagement of CSOs in these processes. One strategy in this area is to align salaries and unit costs in donor-funded programs with those in government, or in government contracts with NGO providers, to pave the way for a smoother transition to government funding.

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A 2016 report on transition outcomes from Africa, Eastern Europe and Central Asia recommends three essential elements for transition planning:

- Systematic transition criteria: A clear set of criteria needs to be developed for assessment of a country's transition preparedness.
- Publicly available transition schedules: Transition should be discussed between donors and representatives of the country to determine start and end dates and duration of transition.
- Coordinated donor decisions: Donors need a clearer mechanism to communicate their transition plans about a particular country with each other (Burrows et al, 2016).

A 2017 literature review of PEPFAR's sustainability and transition points to "a growing body of evidence on the disruptions to service delivery in the post- transition period. The disruptions have occurred as a result of different management styles of donor-funded and government-funded facilities, poorly managed transitions, the inability of providers, usually CSOs, to sustain a full compendium of services in the post-transition phase, or the inability of CSOs to be funded at all" (PEPFAR et al, 2017).

Regional, sub-regional and national ownership of key population approaches and the role of CSOs

The findings of the final evaluation of the Global Fund-funded AFAO SHIFT project point to the need for greater investment in regional and national sustainability and transition preparation in general, and in the essential role of CSOs in particular. In many ways, SHIFT operated outside regional and national government systems, building the capacity of CSOs to advocate for their place in planning and budget decision-making process without providing a complementary investment in regional and national structures to pave the way for greater recognition of the role that community could play in improving HIV prevention and care outcomes. While it is clear that regional UN agencies should play this role (coordinated by UNAIDS) and regional key population and people living with HIV networks[10] play this role, there is little investment by donors in supporting the regional government networks like Association of Southeast Asian Nations to reinforce the case for CSO involvement. This is particularly important in Asia and the Pacific where increasingly hard-line national governments seek to erode many of the human rights and service access gains made in previous years under less conservative governments.

This points to what may have been an expedient (and lifesaving) approach to the funding of sensitive programming in many countries in Asia and the Pacific but what might now need renewed attention. For many years, donors avoided direct confrontation with national governments by agreeing to fund the more politically sensitive parts of the program — harm reduction, key population outreach, sexual and reproductive health and rights (SRHR), lesbian, gay, bisexual and transgender rights — leaving governments to fund less controversial areas that would draw

[10] Including APCOM, the Asia Pacific Network of People Living with HIV and AIDS (APN+), the Asia Pacific Network of Sex Workers (APNSW), the Asia Network of People who Use Drugs (ANPUD), the Asia Pacific Transgender Network (APTN) and Youth LEAD, the Asia Pacific Network of Young Key Populations.

little attention from the populace or opposition parties. In many countries this led to the development of a dependent relationship between some CSOs and donors and to the development of some programs and services that ran in parallel to state-run services. Donors sometimes explained this as 'model development' with the rationale that they would eventually be presented to government for scale-up. There were several problems with this approach:

- funding levels were higher in those days, so the interventions were rarely required to be cost-effective
- many involved 'one-stop shops', responding to community desire to avoid not just stigma and discrimination, but the overcrowding and fragmentation that occurred in public health services, and these were not possible for every population that governments needed to serve
- community pay scales and conditions were rarely in line with government pay scales and conditions, leading to resentment and difficulties with integration.

It is only recently that more significant investments are being made to lay the groundwork for better integration of community and state-run services, so there is some considerable catching up to do.

There is also significant work to be done at sub-regional level. In the Pacific for example, where HIV prevalence rates in most countries, except Papua New Guinea, are extremely low, there are still under-served populations at greater risk of HIV than the rest of the populations, and these need to be reached. While there is a current (modest) Global Fund-funded regional HIV program in place, there is little attention at present to building sub-regional and national key population capacity to participate. Key population organisations report similar concerns to those of their Asian counterparts (a tight focus on outreach for testing, little core funding, little assistance with model development and so on). There is also little investment in sub-regional structures (like the Pacific ART prescribers' network or the Pacific Islands Forum).[11]

Decentralisation of health planning and financing

One of the biggest obstacles for CSOs in many countries in Asia and the Pacific is the decentralisation of health planning and financing to sub-national level that is taking place across the region. Many national governments have been working consistently towards locating the planning financing, management and delivery of health services at state, province or district level. While it is clear that this can have distinct health advantages for communities, it requires CSOs to operate at these levels so they can engage in budget planning cycles and receive funding at these levels for the services they are able to provide. Although for many it will be crucial for their sustainability, there is little technical or financial support available to build the capacity of national-level CSOs to engage in this process. Except in a few cases, there is also little HIV-specific financial and technical support available to assist sub-national level health planners and managers to understand the role that CSOs can play in assisting them to meet health targets.

The AFAO SHIFT project made some advances in this area in four countries (Thailand, Malaysia, the Philippines and Indonesia), contributing to the establishment or strengthening of sub-national CSO networks and building the capacity of national and sub-national CSOs to engage in sub-national health planning. DFAT is also supporting the integration of previously nationally funded stand-alone faith-based and NGO health services into this decentralisation process in Papua New Guinea.

[11] From a yet-to-be-published evaluation of the Multi-country Western Pacific Global Fund program

Areas of progress

More comprehensive investment case development and transition readiness assessment and planning

Several transition readiness assessment and guidance tools have been developed and are in wide use now (Aceso, 2019; APMG Health, 2017; Curatio, 2015). These are designed to assist countries to move towards greater sustainability. Some assessments have led to the development of funded transition plans that include transfer of service elements including those provided by CSOs to domestic funding. By 2018, with support from UNAIDS, the World Bank and other partners, fifty-two countries had applied the 2011 UNAIDS Investment Framework to better prioritise and focus their HIV responses and to provide governments with the evidence-base to justify increased domestic HIV investment. Detailed investment cases at subnational level will be increasingly important in assisting subnational governments to include CSO elements in planning and financing.

The PEPFAR Sustainability Index and Dashboard is also widely used to track sustainability across four domains:

- Governance leadership and accountability
- national health systems and service delivery
- strategic investments, efficiency and sustainable financing
- strategic information (Center for Policy Impact, 2019).

For PEPFAR, sustainability means that a country has the laws and policies, services, systems, and resources required to effectively and efficiently control the HIV epidemic. All PEPFAR countries are required to complete the SID in a multi-stakeholder manner every two years. This allows PEPFAR to publish a comparable time series of data that charts progress toward sustainability. The most recent review occurred in November 2019 (PEPFAR, 2019).

Social Impact Investments

Social impact investments offer the potential for financial returns while supporting interventions that primarily create tangible social goods (Abraham et al, 2019; Rutman, 2012). Impact investing brings together investors, governments, service providers and communities to tackle a range of social issues. A key feature of impact investing, and the main attraction for socially conscious investors, is the emphasis on stronger evaluation measures, creating a heightened focus on evidence-based decision making and outcomes.
Several models exist for impact investing:

- Debt and equity financing: traditional investment methods used to fund socially positive organisations and start-ups the social enterprise model.
- Outcomes-based grants: grant funding which is contingent on pre-specified program or health outcomes
- Payment by results contracts or bonds: private/public investments whereby private capital is invested into health or social programs with pre-specified outcomes that trigger investment returns. Investors take on the risk that outcomes may not be achieved. Guarantors (e.g. Departments of Health) can ensure that investments are protected from significant losses. (See also payment for results/performance-based contracting below which do not include private investments).

Impact investment can be a catalyst to professionalise community-led services and stimulate private sector activity (e.g. diagnostic and clinical service delivery) where sustainable financing is available through national health insurance and/or private co-financing (fee for service). Impact investing could draw upon the burgeoning key population middle-classes, particularly

among men who have sex with men, and their increased capacity to invest in and pay for friendly, high quality services. The promotion, purchase and support services related to innovative technologies such as PrEP and HIV self-testing kits may be particularly suited to technical approaches and benefit from impact investing capital.

Building on the past decade of experience in innovative financing to empower underserved women across the world, lessons can be learned to bring capital to key population communities in the Asia Pacific region. In this case, the goal would be to connect organisations involved in local-level activity among marginalised and underserved populations with investment capital to ensure better access to quality health care that is affordable, inclusive and patient-centred. There is considerable research and literature documenting the barriers to quality health care for marginalised populations – including the twenty-country baseline assessments of barriers to service access for key populations conducted in 2018/19 by the Global Fund. Innovative impact investing models have been successfully implemented to scale up practical solutions to the drivers of these barriers in maternal and child health and could be adapted to key population communities. In partnership with organisations such as USAID and the World Bank, impact investing can be explored to unlock new sources of investment capital to move forward better patient-centred health outcomes for key and vulnerable populations in the region.

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Social contracting

The term *social contracting* has been coined to encompass the range of methods by which governments contract with non-government providers for health services. Many countries in Asia and the Pacific have blended health systems that include a mix of public, non-government not-for-profit and private (for profit) services. Some also have a long tradition of contracting with NGOs including faith-based organisations to provide elements of service delivery. As noted in the USAID Regional Development Mission for Asia 2019 report, social contracting offers unique opportunities for indigenous, key population organisations to build prerequisite skills for sustainable operations. Importantly, social contracting provides the platform for firmer, formalised government commitments to allocate domestic resources. Social contracting creates an important input loop for CBOs to provide site-level perspectives on the effective allocation of government resources to achieve country targets and, ultimately, epidemic control.

In relation to HIV, social contracting involves creating space (including laws, regulations and accreditation systems) to include the community-led and community-based organisation to be contracted to provide services within this service mix. There has been significant progress in social contracting in other regions. In Mexico the National Center for Prevention and Control of HIV and AIDS (Censida) until recently managed a transparent and competitive public financing mechanism for NGOs and allocated around US$38m under this scheme from 2013-2018 (APMG Health, 2018a). Until recently, Argentina had

also made significant progress in this area (APMG Health 2018). Countries in Central Asia and Eastern Europe have been supported by UNDP and partners to undertake assessments of the barriers to social contracting and start to amend laws, regulations and polices to support this (UNDP, 2019). In Asia and the Pacific, Indonesia has recently made changes to government procurement mechanisms to open up space for the contracting of CSOs (Swakelola Type 3), and UNAIDS and the Global Fund are supporting national community organisations to work with their provincial and district counterparts to begin access to this mechanism (World Bank, 2019). AFAO's SKPA program is assisting in the development and strengthening of social contracting mechanisms in Lao People's Democratic Republic and Mongolia. PEPFAR, through Health Policy +, is assisting the Thailand Ministry of Health to develop policy and procedures documents that will provide a framework for using social contracting to fund CSOs in health. Thailand has also developed an accreditation system for CSOs providing health services. This program and the USAID/RDMA work have identified the following important considerations for social contracting:

- **Payment structure**— in the short term, actual costs should be paid; however, in the longer-term, performance-based payments must be considered to link some portion of payment to specific HIV outcomes.
- **Quality**—government solicitations must incorporate quality factors so that a CBO is not awarded a contract purely on the basis of low cost.
- **Mapping**—comprehensive mapping is required, examining the legal environment (especially as it pertains to issues around CBO registration and accreditation), baseline relationships (between government and CBOs), extent and quality of services to be offered and gaps in financing/resources.

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Including HIV service elements for key populations in Universal Health Coverage

It is important for sustainability that CSOs engage with the Universal Health Coverage (UHC) process and dialogue around domestic resource mobilisation in their countries. Whist many countries in Asia and the Pacific are in the process of developing essential health service packages as part of UHC, UNAIDS notes that "with few exceptions, services for key populations (e.g. harm reduction services, provision of pre-exposure prophylaxis, differentiated prevention interventions for sex workers etc.) are not included in UHC essential benefits packages" (UNAIDS PCB, 2018). AFAO's DFAT-funded Community Advocacy Initiative (CAI), delivered in partnership with APCASO, supported community organisations in China, Vietnam, Laos and Cambodia to work with their governments to bring about positive action on HIV. From 2011, CAI shifted its focus to in-country advocacy that fosters domestic government investment in their national responses to HIV. In Vietnam, successful advocacy through the project by the Centre for Supporting Community Development Initiatives (SCDI) led to HIV treatment costs being included in Vietnam's National Health Insurance Law. This opened fiscal space within Vietnam's Global Fund grant and enabled substantial increases in prevention funding

that could be directed to key populations. Before the project, 95% of HIV treatment was funded by donors. Now, Vietnam meets most of the costs of HIV treatment. In dollar terms, a one-off outlay of around AUD$100,000 for community-led advocacy secured a return of around USD$24 million dollars per annum, being the costs of treatment now met domestically in Vietnam.

PEPFAR has worked successfully in Thailand and Vietnam to have elements of HIV service provision included in Social Health Insurance (SHI) schemes. This involved:

- mapping human, financial and organisational resources available to support the provincial or area-based response to HIV
- assessing and documenting the potential health and economic benefits of SHI reimbursements as a result of providing HIV services and meeting accreditation standards required to provide a basic HIV services package
- building the capacity of the existing SHI mechanism to cover, reimburse and administer coverage for HIV services (PEPFAR Solutions Platform, 2020).

In Thailand, support from the Key Population Innovation Fund resulted in the planned use of domestic funding in six USAID-supported provinces and among five USAID-supported NGOs. PEPFAR anticipates that this domestic funding will be increased and diversified in future years. In Vietnam, the support contributed to policy changes at the national level and changes in governance structures at the provincial level.

In the Philippines, the PhilHealth Insurance scheme covers outpatient services for people living with HIV. This has enabled CSOs like Love Yourself (a gay community-led service provider in Manila) to become financially self-sufficient. The per-patient financial cover they receive enables them to add other service elements to round out the package of services they provide. A case study of the Love Yourself experience is set out in Appendix 1. Love Yourself, having successfully achieved accreditation under PhilHealth for HIV and TB services, is now assisting other CSOs across the Philippines to achieve accreditation and become a sustainable element of HIV, TB and other health service delivery in their city or province.

Payment for results/performance-based contracting (PfR/PBC)

Payment for results (or performance-based contracting) provides one mechanism by which CSOs can gain more autonomy in decisions about the service mix they provide and methodology they use. In the same way that Love Yourself (Philippines) receives a quarterly flat rate from the PhilHealth insurance system for each person with HIV it is caring for, governments can contract CSOs under performance contracts that establish a flat, all-inclusive fee per individual serviced over a period of time (or number of individuals receiving a particular service in a particular period), and the CSO is then able to decide what mix of human and other resources it needs to put in place to achieve that. The advantage is that CSOs have some flexibility about how to do their work. The disadvantage is that if they stall in meeting their targets their budgets are reduced.

The Global Fund now encourages countries to include some payment for results contracting in their allocation and some USAID prime implementers in Asia have used a hybrid version of payment for results to achieve greater focus of HIV testing efforts among subpopulations of key populations at greatest risk.

Setting priorities for further action in the Asia Pacific region

UNAIDS has developed a Sustainability Framework that provides a useful tool for identifying the scope of action required, setting priorities and tracking progress.

Figure 2. UNAIDS Sustainability Framework

This framework provides a useful tool to guide a collective effort to address sustainability issues.

Setting priorities for further action

1. Co-convene a Regional Working Group under the auspices of the UNAIDS Regional Office for Asia and the Pacific, AFAO and regional key population networks to mobilise resources and take forward the actions below.
2. Map the status and progress of countries in relation to CSO participation, funding and sustainability.
3. Determine which countries are likely to need to transition away from external donor financing from HIV more quickly – meaning either external financing is likely to cease or be reduced by more than 50% — over the next decade and determine categories of countries:
    - Those already in transition
    - Those likely to transition in the next decade
    - Those unlikely to transition in the next decade
4. Analyse and document successes so far – the process that countries and donors have followed, the obstacles they faced and the solutions that they have come up with.
5. Identify, adapt and promote innovations in achieving financial sustainability for community organisations.
6. Develop strategies for each category of countries, including:
    - Advocacy for the legitimate and ongoing role of CSOs in each country's HIV response
    - Assistance to countries in or about to undergo transition to fully fund community responses to the extent envisaged in the 2016 Political Declaration on HIV and AIDS, together with assistance to countries unlikely to transition soon to develop plans for strengthening community systems.

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Appendix 1: The Love Yourself (TLY), Philippines

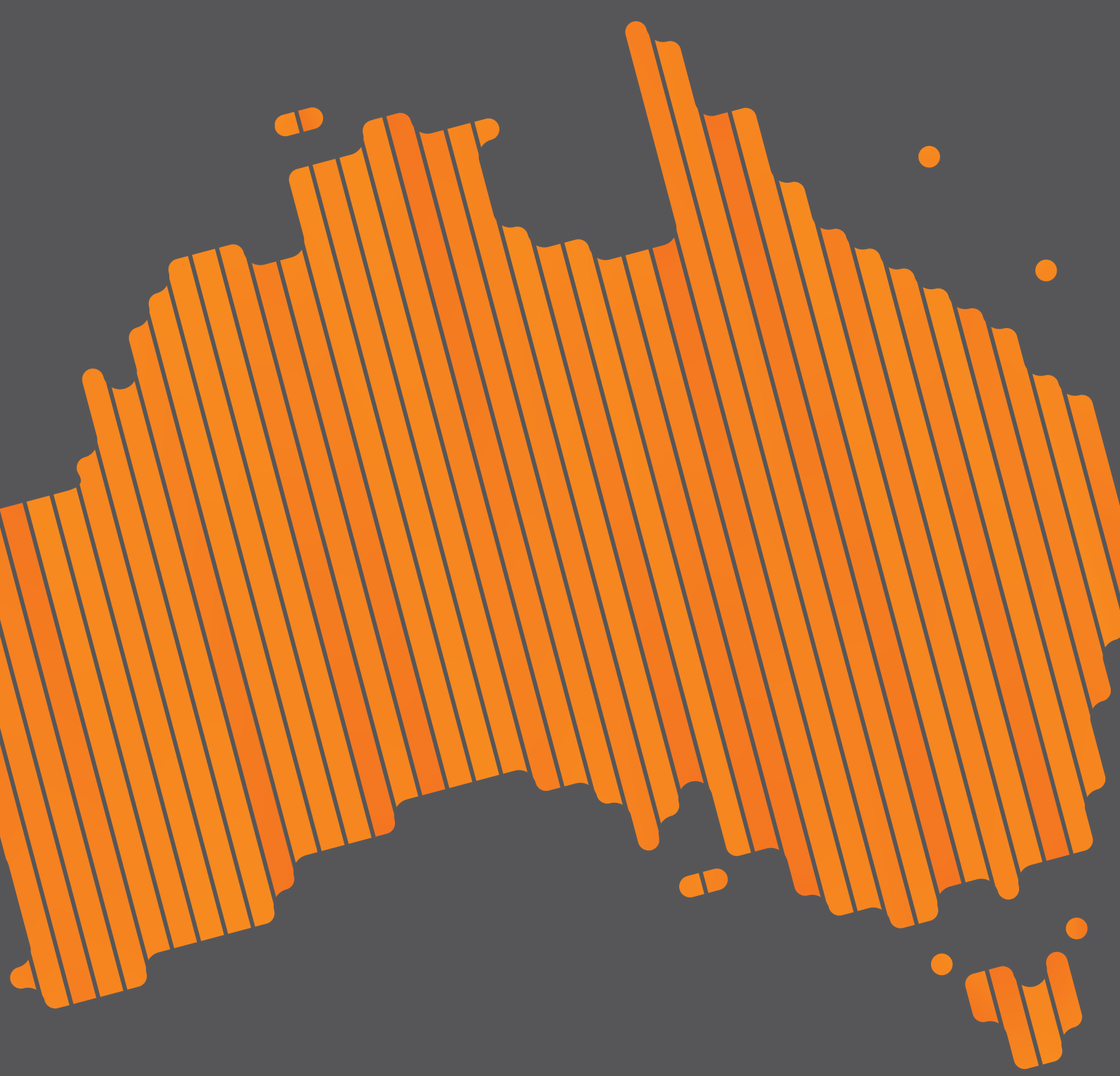
The Love Yourself is a successful non-government organisation providing health and community services to gay men, other men who have sex with men, and transgender people in the Philippines. It is financially self-sustaining, primarily as a result of its accreditation with the national health insurance scheme (Philhealth) as a provider of HIV and TB treatment and care services. It provides a useful example of how community-led organisations can develop new business models to play a key and sustainable role in public health.

It began in 2012 with a group of gay men identifying a gap in services to underserved populations in the response to HIV. At the time, the Department of Health, Research Institute for Tropical Medicine (RITN) was running an off-site government outpatient clinic that was attempting to provide HIV testing, counselling, and clinical services but was failing to attract significant numbers of people from key populations due to stigma and discrimination at the clinic. The group of men were trained as volunteers at the RITN and, in 2015, RITN handed the clinic over to TLY under an MOU to revamp and run. TLY turned it into a successful, key population-friendly HIV testing and referral centre. TLY provided the volunteer peer outreach and HIV counselling and testing workers and RITN provided the building, overheads and support. By 2014 the clinic was testing 20-30 men who have sex with men and transgender people each day and referring those with HIV to RITN.

The Department of Health could see the success of the Smart, Safe and Sexy (3S) model and helped TLY move to a bigger, more suitable space in Mandaluyong. Within a relatively short time the clinic had referred almost 5,000 men who have sex with men and transgender people living with HIV to RITM. By 2015, clients had begun requesting that TLY expand to include HIV clinical care and treatment as a satellite clinic under RITM's PhilHealth accreditation. The national PhilHealth Insurance Scheme provides an annual allocation of 30,000 Pesos (in quarterly instalments) for the treatment of a person with HIV at accredited facilities. TLY expanded its business model to include same-day HIV Test and Treat, life coaching to support people living with HIV and mental health peer support (the Flourish Circle).
In time, and with USD $50,000 investment capital, TLY was able to achieve its own accreditation under PhilHealth, including accreditation as a TB-DOTS centre, allowing it to expand its scope of services and begin setting up its own satellite clinics (e.g., TLY at Victoria for transgender people and TLY Uni for university students). TLY is now assisting the Philippines government, under the Global Fund allocation, by establishing community centres in fourteen community-based organisations across the country and helping those organisations to move towards PhilHealth accreditation. In order to be financially sustainable under PhilHealth, TLY estimates that a clinic needs a consistent HIV caseload of over 500 people living with HIV.

Using the savings it is able to make from the PhilHealth allocation, TLY continues to expand and innovate and is currently providing additional services like safe spaces for people experiencing stigma, discrimination and violence, HIV pre-exposure prophylaxis (PreP), and a user-pays service for people who want additional privacy and convenience.

There have been many obstacles and challenges along the way. For example, reimbursement from RITM and PhilHealth can take up to eight months meaning Board members have had to provide seed funding loans along the way to ensure continuation of service provision. Some reimbursements took several years to come through, and some are still outstanding. Despite these challenges and thanks to individuals taking personal financial risks to sustain the business, TLY was the first stand-alone HIV service to be granted PhilHealth accreditation. TLY leadership assisted the government in developing this process and paved the way for community-led accreditation to be a relatively smooth, three to six-month process, and, depending on the level of regional government support.



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