



HIV, UNIVERSAL HEALTH COVERAGE, AND THE FUTURE OF THE GLOBAL HEALTH ARCHITECTURE



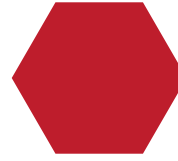
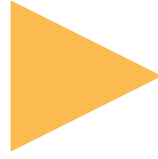
A civil society discussion paper on key
trends and principles for evolution





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This paper has been developed by a small group of civil society organisations: STOPAIDS; Aidsfonds; Civil Society Sustainability Network and Frontline AIDS. The views and ideas expressed here only represent the perspectives of the authors and do not claim to represent the views of broader civil society. The purpose of this paper is to present ideas for principles to guide the future of global health architecture and to prompt a wider discussion among broader civil society on the future of global health architecture. The next steps section on page 41 outlines opportunities to discuss and provide feedback on the suggested principles and questions highlighted in this paper.

EXECUTIVE SUMMARY

The aim of this paper is to serve as a catalyst for discussion within civil society on how, drawing on lessons from the global HIV response, the global health architecture of the Universal Health Coverage (UHC) era should evolve and how it should be governed so that it best addresses the interests of end-users. The paper celebrates the growing momentum of the Sustainable Development Goals (SDGs) and UHC movements and situates itself within the larger discourse around health, HIV, development, and aid. With a focus on what we call the 'global health architecture', we consider top-line political trends affecting global health and suggest key principles to consider as the architecture adapts to a changing world.

We define the 'global health architecture' as (drawing on existing definitions): The constellation of actors whose primary purpose is to promote, restore or maintain health. Such actors may operate at the community, national, or global levels, and may include governmental, intergovernmental, private for-profit, and/or not-for-profit entities, inclusive of civil society, community organizations and communities affected by health challenges.

KEY TRENDS

The following trends are presented as illustrative of some of the most important developments at key international organizations in the global health architecture, and therefore critical to consider as we contemplate how to ensure the sufficient profile of HIV within UHC and the broader development agenda; as well as further strengthening the UHC and broader development agenda based on the lessons learnt so far from the HIV response.

The SDGs paradigm shift towards integrated and people-centered health systems

A key paradigm shift in global health is the political and financial mobilization around the objective of UHC. In recent years the WHO and United Nations General Assembly have both called on nations to, "urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services".¹ However, most donor resources are currently mobilized and distributed on a disease-specific basis. This disease-specific approach is reflected in the make-up of most institutions within the global health architecture

(not including the WHO or World Bank) and they are now adapting to this new global consensus.

The SDGs – in particular, SDG 3, good health for all people – exemplifies the shift towards mobilizing around UHC and in September 2019 world leaders adopted a high-level United Nations Political Declaration on UHC. It is described as “the most comprehensive set of health commitments ever adopted at this level”² and it is the clearest political demonstration of the transition from disease-based responses to a health systems approach. With the exception of WHO and World Bank, the international institutions comprising the global health architecture for HIV were established to strengthen the HIV response (and other infectious diseases such as tuberculosis (TB) and malaria) through disease-specific approaches. These institutions are also contributing significantly to strengthen health systems. Today, resources are largely mobilized and distributed to target these specific diseases, but these institutions are increasingly expected to demonstrate their contribution to UHC.

Three major concerns arise from the focus on UHC in relation to the sustainability of the global HIV response:

1. Whilst the HIV response is about much more than the economics of accessing health services, there is a risk to the sustainability of the response (and meeting the 90-90-90 or the UN target of ending AIDS by 2030) where domestic health funding does not increase and may be spread even more thinly across health priorities.
2. The HIV response is also about social justice and respect for and protection of human rights. There is worry that these aspects of the HIV response could be diminished in a UHC context and key and vulnerable populations in HIV may not receive adequate attention or resources in a UHC context.
3. Community and civil society engagement, which has been hard-fought and not yet fully attained in the HIV response, may not emerge as a priority with the UHC agenda or governance structures.

Donor deficiencies; the economic and political calculus of ODA is changing

The traditional narrative of aid for health and development, that high-income countries have the means and moral mandate to provide aid to low-income countries, is weakening. Two realities are combining to change the narrative: the commitment of world powers to end epidemics through aid has been wavering at the same time that nationalism and anti-globalism are on the rise within the major world powers, who have historically accounted for the lion's share of official development assistance (ODA) for the HIV response. It is also important to note the logic of pure aid through budget support as the preferred modality moved to one that promotes return on investment, economic growth and the increased involvement of the private sector through blended finance and loans. This has resulted in concessional grants occupying a reduced percentage in development cooperation and loans becoming an increased share of some donors development budgets. The United Kingdom's disengagement from the European Union and the emergence of a strongly anti-globalization posture by the US, are two powerful illustrations of the current political uncertainty. We also see the rise of populist movements strongly influenced by religious or traditional values that seek to target policies that support basic human rights related to sexuality and reproductive health. Both of these situations represent potential grave threats to the existing financing model for HIV and other health and development issues.

In addition to these major shifts, there are critiques of ODA from multiple perspectives. The politics of Trump and Brexit emphasise strong critiques of misdirected or wasted ODA and foster calls for both a reduction of ODA and a stronger linking of remaining ODA to national domestic interests. In parallel, within the international development sector, there is a growing recognition that the current narrative, language and structure of development co-operation and ODA is no longer fit for purpose and that certain conceptual shifts are needed to make ODA fit for the 21st century. For example concepts that are increasingly seen as problematic include: the view of aid and support as time-limited; the

narrow focus on extreme poverty; the insufficient focus on addressing inequality; the exclusive use of global growth and country level GNI as economic indicators of progress; the focus on north/developed-south/developing aid flows and language; and the focus on quantity of aid rather than the type and quality of aid.

Shaky foundation; the neo-liberal global governance space is fraying

The emergence of China as a global superpower and of middle-income countries as a potent bloc in geopolitics is challenging the existing mechanisms of global consensus-building. The global health architecture for HIV was largely established by the dominant European and North American countries. As such, they are the most powerful bloc within the governance structures of those institutions. But the challenges to their hegemony in global politics means that their hold on the governance of multilateral institutions is being increasingly questioned. There are legitimate claims to be made by middle-income countries and low-income countries to have greater representation in global health governance, based not least in the principle of country ownership and on the fact that they now account for the majority of HIV spending (57%) in their own countries, as opposed to donors.

In consideration of these trends, and broader experience with the global health architecture for HIV, a series of principles are posited to inform discussions of evolving the architecture with an inclusive and rights-forward approach.

PRINCIPLES TO GUIDE SMART, RIGHTS-FORWARD EVOLUTION OF THE GLOBAL HEALTH ARCHITECTURE

Principle 1: The lessons learnt from the HIV response need to be utilized by the UHC movement

It is essential now for the global HIV response to be included and meaningfully integrated into the UHC and broader SDG3 agenda, particularly including the development of accountability mechanisms in relation to implementation of these agendas. The timeline, dimensions, and specifics of the integration of HIV into UHC and SDG3 are big questions today. HIV and UHC advocates alike have a valuable role to play in answering these questions: to both ensure we sustain the gains of the HIV response, and to imbue UHC and SDG3 with the lessons of the HIV response and the priorities of civil society and communities. In the service of making UHC and the achievement of SDG3 as effective and rights-forward as it can be, HIV advocates are encouraged and need to have sufficient resources to:

- Become advocates for a UHC that delivers for people affected by HIV as well as all other health issues
- Ensure the right to health is anchored in all health debates and programmes
- Demand and operationalize community and civil society engagement in the UHC agenda, championing the role of civil society as mobilisers, service providers, watchdog agents and advocates across SDG3
- Remain vigilant in protecting and promoting the health, rights and empowerment of key and vulnerable populations, particularly within relevant accountability mechanisms



Principle 2: Greater coordination among multilaterals, donors, implementer countries and communities is needed

More spaces are needed to facilitate political and financing dialogue among key stakeholders. Two critical enablers may contribute significantly to better synergy:

1. The implementation of the Global Action Plan for Healthy Lives and Well-being for All (GAP) and accountability on its progress, and
2. Political and financial commitment from health agencies (through the GAP process) to contribute to broadening the space for civil society participation in health governance and working with governments to address key barriers to participation in dialogue (such as criminalization of the key populations).

Principle 3: The processes by which financing is mobilized and targets are set need to be recalibrated for impact, with more input from end-users

Some organizations provide insufficient opportunity for meaningful representation of recipients and implementers in making policy decisions. Complicating this in the near-term, many of the major global health multilaterals have been, or will be, engaged in replenishment processes, engendering a competition between them for donor money, a competition which has no perceivable benefit. To promote better coordination among donors and financing mechanisms, greater predictability for implementers, and more ownership of goals among implementers, two evolutions might have considerable impact:

1. Donor commitments should be elongated to afford greater predictability for programme planning. Rather than the three to five-year intervals of financial commitment among donors, longer periods, such as 5-7 years should be the norm. Longer replenishment cycles would alleviate some of the challenges faced by programme planners and greater coordination

among financing institutions could help avoid the competition that is currently arising.

2. To be more responsive to country needs and priorities, financial target-setting should start at the country-level, rather than be driven by donors.

Principle 4: Representation and power in global health governance should be balanced

Until now the largest donors to global health programmes (mainly high-income countries) have held the majority of power across most of the global health architecture for HIV. They generally have relatively more votes and more influence on policy and financial decision-making than their counterparts representing implementer countries and other constituencies. This arrangement was based on the belief that a particular stakeholder or group of stakeholders' decision-making power in global governance should substantially reflect their financial contribution. This meant that because donors contributed the biggest percentage of global funding for a particular issue, they should have more seats/ votes per country. This also sometimes meant that if individual donors paid more than others then they would have more power. However global power dynamics are shifting and donors are no longer the largest financial contributors to the global HIV response. As of 2018, 56% of the total resources for HIV in low- and middle-income countries were from domestic sources. There is also an increasing recognition that all key stakeholders should have a more equal voice. It is therefore time to ensure power in global health governance is balanced and to give greater influence to implementing countries and other stakeholders.

The old model of *biggest-contribution equals biggest-influence* should be reconsidered. A new philosophy needs to be developed to promote greater representation in decision-making and a more equal partnership for key stakeholders such as implementers, civil society, private sector and private philanthropy.

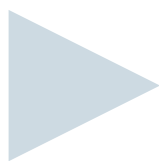
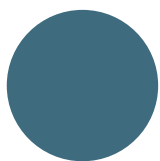


Principle 5: Civil society and communities must be meaningfully engaged, have real power in governance structures

However the architecture evolves, mechanisms and norms for civil society engagement in global health governance must be established, refined, and promulgated across all institutions. Three sub-principles form the core of this at a governance level, and apply to global health institutions, present and future:

- 1. Ensure permanent civil society & community constituencies at the governance level,** which can feed up to dedicated Board Members. Ad hoc and consultative approaches are insufficient to ensure civil society and communities have meaningful, ongoing input on policy-setting and decision-making.
- 2. Grant permanent voting power to key civil society & community constituencies across the global health architecture.** Civil society must have voting power on par with nations and other stakeholders.
- 3. Fund civil society & community representatives' engagement on Boards and with constituents.** Civil society representatives must be resourced to a) participate at the highest level in governance, b) engage with their global constituencies, so as to promote effective representation and accountability, and c) further strengthen relevant skills and knowledge and have resources to undertake relevant well-being and self-care activities. This also includes funding for civil society and community platforms to bring perspectives and views into global policy debates.

Having reflected on how the global health architecture has evolved and what key principles should be considered as it continues to evolve, this paper concludes by encouraging civil society to reflect and further build on these suggested principles. Ultimately, we hope this paper and the subsequent discussions that follow will support the development of some shared positions among civil society that will resonate and drive positive change across the global health architecture.



1. INTRODUCTION

“The architecture needs to build on existing successes and be oriented around people and their well-being, not specific diseases. A future health architecture should move away from a siloed, disease-specific approach to one which promotes multi-sectoral action, integration, innovation, and rights-based approaches to help countries deliver integrated HIV, health and development solutions.”

UNAIDS-Lancet Commission Working Group 3³

In 2020, HIV continues to be a major global concern. There have been great successes in reducing global morbidity and mortality, but there also remain intransigent challenges to ending the epidemic. Much of the success can be attributed to a massive mobilization of resources and political will in the HIV response and the structural factors that drive the epidemic – especially since the beginning of the 21st century. Much of that mobilization can be attributed to the persistent advocacy of civil society and communities across the globe, often led by people living with and affected by HIV. But as the epidemic evolves, our response has and must continue to evolve as well.

Given that civil society has been on the frontlines of the global HIV response since day one, it has a critical role to play in examining and guiding how the world responds to HIV. Drawing on perspectives of key civil society leaders and thought leaders from within the global institutions that finance and coordinate a significant portion of the response, we lay out our reflections on where the response is today and where it needs to go.

This paper focuses on what we call the ‘global health architecture’ as it relates to HIV but also as it is evolving in the context of Universal Health Coverage (UHC). It analyzes some of the existing

thought on its evolution as it adapts (or doesn’t) to changing political and economic realities. It analyses how civil society and communities are engaged in the governance of the global health architecture to identify good practice and gaps. Ultimately, the aim of this paper is to serve as a catalyst for discussion on how the HIV response can support the evolution of the global health architecture in the current UHC era in a manner that builds on lessons learnt so far and uses these to establish suggested principles for planning forward how to appropriately distribute power and governance over the next 10 to 20 years.

WHAT IS THE ‘GLOBAL HEALTH ARCHITECTURE’?

There is a growing body of work that analyzes the ‘global health architecture’ or the ‘global health system’. Chatham House has been a leader in the academic exploration of what this system is, and how it functions.^{4,5,6} In their 2015 work, *Mapping Global Health Architecture to Inform the Future*, Hoffman, et al.,⁷ proposed the following definition for the global health system:

The global health system includes transnational actors that have a primary intent to improve health and the polyilateral arrangements for governance, finance and delivery within which these actors operate.

For Hoffman et al., there are three primary arrangements in this system: delivery, financial, and governance. Their use of “transnational” includes those individuals and organizations that “operate in a way that transcends national political borders,” but are not simply “international,” meaning that the actors are stationed in at least two countries. This definition of the global health system includes non-governmental organizations (NGOs), public-private partnerships, professional associations, UN entities

and other intergovernmental organizations, national governments, private industry, academic institutions, multilateral development banks, and philanthropic institutions. The actors they considered were by and large located in the United States (US), Switzerland, the United Kingdom (UK), and an assortment of other high-income countries. An important note on this definition from Hoffman et al. is that the 'global health system', as they conceived it, does not include any lower-income country or middle-income country entities. It ignores that fact that these entities do in fact carry out, and finance, much of the work of global health and are also involved in global health governance. This is incredibly important to note in an era of rapidly increasing domestic commitments to health and development investment. It also does not recognize the fact that some southern-based entities operate in more than one country and ignores south-to-south collaboration altogether.

The *UNAIDS-Lancet Commission on Defeating AIDS—Advancing Global Health* proposed its own definition of the current architecture for HIV and health:

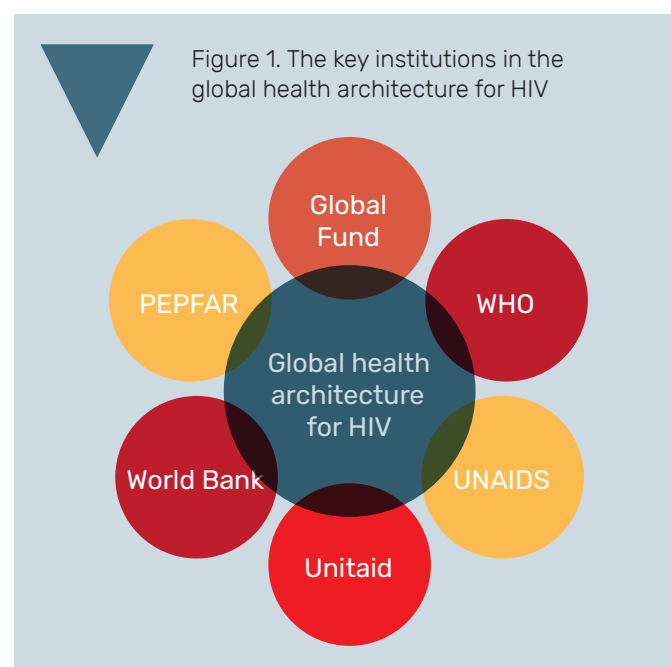
*The formal and informal institutions, norms, rules and processes, as well as their state and non-state organizational expression, which govern health outcomes.*⁸

The UNAIDS-Lancet working group identified six critical functions of the global health architecture: stewardship; rule-making and normative guidance; monitoring and evaluation; financial and technical support resources; advocacy; and accountability.

Drawing on these definitions and others, the following is the definition of 'global health architecture' which best fits the purpose of this paper:

The global health architecture is the constellation of actors (individuals and/or institutions) whose primary purpose is to promote, restore or maintain health. Such actors may operate at the community, national, regional or global levels, and may include governmental, intergovernmental, private for-profit, and/or not-for-profit entities, inclusive of civil society and community organizations.

For the purposes of this paper, we have selected six global health institutions as a reference point for discussions of the 'global health architecture' as it relates to HIV. These six institutions form the backbone of the global health architecture for HIV. Each of them contributes or coordinates the vast majority of donor financing and/or are responsible for setting norms for the global HIV response. The six institutions that we reference herein are: The World Health Organization (WHO), The Joint United Nations Programme on HIV/AIDS (UNAIDS), The Global Fund to Fight, AIDS, Tuberculosis and Malaria (the Global Fund), The President's Emergency Plan for AIDS Relief (PEPFAR), The World Bank, and Unitaid.



This paper recognizes that these institutions do not embody the whole global health architecture, even for HIV, and that there is an important role for other multilaterals, bilateral donors, regional-level bodies (for example, European Union, ASEAN, and African Union), domestic governments, international human rights mechanisms, and independent civil society organizations and community organizations in the HIV response in most countries in the world. In many respects, the institutions we reference are simply the financing mechanisms and top-line agenda-setters of the vast amount of work that is carried out by individuals and communities directly impacted by HIV. Though we must underline here that the clinicians, community health workers,

health ministries, activists, community-based organizations, and people living with HIV who fight for access and seek to protect their own health and the health of people around them, are the ones who really drive and make the global HIV response work.

DEFINING 'COMMUNITY' AND 'CIVIL SOCIETY'

This paper understands 'community' and 'civil society' as defined in the Global Fund's Community Systems Strengthening Framework:⁹

***Community** is a widely used term that has no single or fixed definition. Broadly, communities are formed by people who are connected to each other in distinct and varied ways. Communities are diverse and dynamic. One person may be part of more than one community. Community members may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values.*

***Civil society** includes not only community organizations and actors but also other nongovernmental, noncommercial organizations, such as those working on public policies, processes and resource mobilization at national, regional or global levels.*

This paper echoes the role of community-led organizations and key population-led organizations as defined by UNAIDS:¹⁰

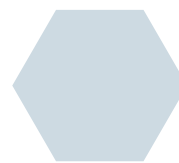
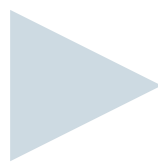
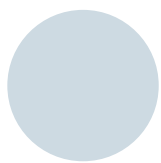
***Community-led organizations, groups, and networks**, irrespective of their legal status, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community-led.*

***Key population-led organizations and networks** are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people (this definition of key populations is not meant to preclude the ways that people describe themselves, including related to sexual orientation, gender, and gender identity). Key populations share experiences of stigma, discrimination, criminalization, and violence and shoulder disproportionate HIV disease burden in all parts of the world.*

In relation to the global health architecture, different institutions have differentiated civil society and communities in different ways and to varying degrees. Some institutions conflate civil society and communities altogether, some split by global north and global south, and others split by geographic region. The differentiation of civil society and communities delegations made on the Global Fund Board is worth explaining here because it is one of the most helpful in recognising some key distinctions. On the Global Fund Board there are three constituencies for civil society and communities:

1. Communities Living with HIV and affected by Tuberculosis and Malaria Delegation – a group of people living with HIV and affected by tuberculosis and malaria, including members from key and vulnerable populations across the three diseases
2. Developed Country NGO Delegation – individuals from civil society organizations based in countries that are not implementing Global Fund grants (many are donor countries but not all)
3. Developing Country NGO Delegation – individuals from civil society organizations based in countries implementing Global Fund grants

This example serves to highlight the important distinctions between civil society organizations in different parts of the world (and the particular perspectives they bring) and, in particular, the critical importance of recognizing the right to self-representation and distinct voice of communities affected by the health issues dealt with by a particular global health institution.



2. SHIFTING DYNAMICS IN GLOBAL HEALTH

THE EVOLUTION OF GLOBAL HEALTH ARCHITECTURE

As noted by Hoffman, et al, “The global health system has vastly expanded over the past few decades. This expansion is characterized by greater funding, increasingly complex health challenges, and a greater number of diverse actors operating within the system.”¹¹ The growth of the global health system signifies a clear reduction in national isolation as a strategy for controlling disease. Clinton and Sridhar credit the HIV epidemic with being, “the most obvious example of isolation’s failures to protect public health at a national or global level.”¹² Further to this point, the recent expansion of the global health architecture has largely been driven by the global imperative to respond to the HIV epidemic.

The global health architecture developed in the mid-20th century was mostly comprised of multi-state institutions, including the World Health Organization (WHO) and the World Bank. WHO was the principle actor in the global health architecture for much of the second half of the 20th century. In this role it served as more or less the sole steward of the various machinations of global health. WHO was founded in 1948 based on the recognition that separate nation-states had a mutual interest in assessing and confronting certain health challenges as a collective. As one of the first global governing bodies for health, participation in the WHO required governments to, “forgo aspects of their individual sovereignty by delegating certain prerogatives and authorities”¹³ to WHO. This movement towards global governance of health was the first major step towards collective approaches to health crises.

The World Bank also emerged as a key player in the 1960s and 1970s, as its philosophy on development shifted from pure macroeconomic development to an approach which emphasized meeting people’s

basic needs in low-income countries, including improving health outcomes.¹⁴ Today, the World Bank is distinguished from the other actors in at least one major way: aid from the bank does not come exclusively in the form of grants or commodities. Much of the Bank’s aid is in the form of loans and other financing mechanisms, which require nations to pay back or make other cooperative agreements.

While the WHO and World Bank had some successes, the emergence of the global HIV epidemic in the 1980s challenged the existing model, and the WHO’s ability to lead global health responses on its own. In fact, the profound and global impact of HIV stretched the WHO’s ability to coordinate the response so much so that many states and other entities determined that the WHO alone could not be relied upon to manage the response to HIV.¹⁵ But in the first decade of the HIV epidemic, many of the major high-income nations that we now think of as ‘donors’, were consumed with dealing with growing epidemics within their own borders. It was not until the mid-1990s, as the epidemic began to stabilize in some of these countries, that they began to pay significant attention to the HIV crisis in low- and middle-income countries, where its impact tragically dwarfed what was happening in high-income countries.

Among the first new institutions to emerge in response to HIV was the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1994. Clinton and Sridhar state that UNAIDS was as much a response to HIV as it was a response to broad dissatisfaction with the leadership of WHO and the desire for donors to have more direct control over the use of their contributions.¹⁶ UNAIDS was also designed with the understanding that a multi-sectoral approach was necessary to address the technical and political needs of a successful global HIV response; it brings together eleven UN agencies with different mandates to coordinate their response to the epidemic.

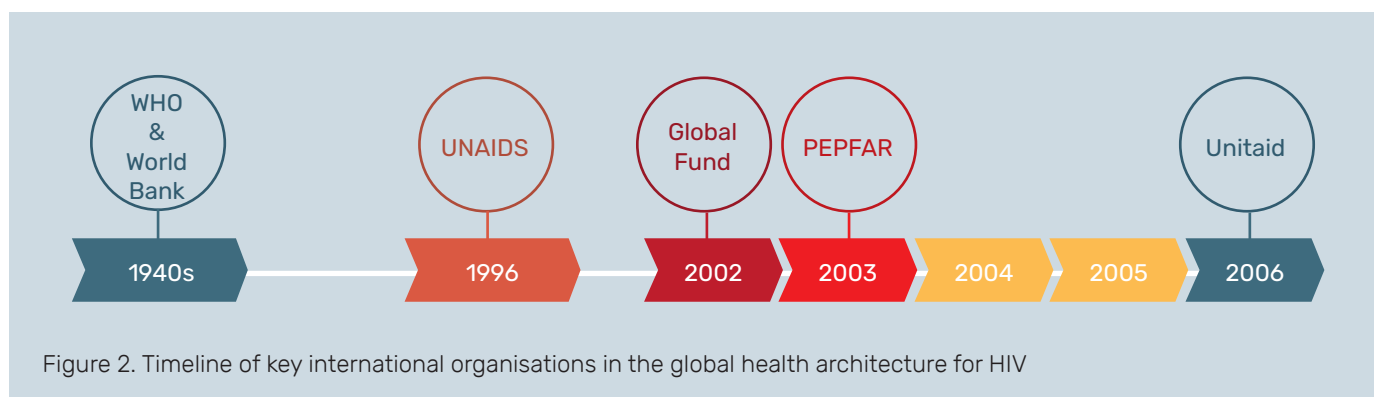


Figure 2. Timeline of key international organisations in the global health architecture for HIV

The UNAIDS’s Programme Coordinating Board (PCB) represented the first time that civil society was formally involved in the governance of a UN programme, setting a precedent for other institutions.

The drive towards multisectoralism continued in the late 1990s and early 2000s with the establishment of a number of new public-private partnerships that could leverage major financing. The most notable early examples of this new approach were the **Global Alliance for Vaccines and Immunization** (now known as Gavi, the Vaccine Alliance), founded in 2000, and the **Global Fund to Fight AIDS, Tuberculosis and Malaria** (The Global Fund), established in 2002. The Global Fund broke new ground with its incorporation at the Board level of a range of stakeholders, including donor governments, recipient or ‘implementer’ governments, private businesses and foundations, civil society and communities; all have voting power at the highest governance level.

Not long after the Global Fund was established, the US launched its **President’s Emergency Plan for AIDS Relief** (PEPFAR), in 2003. At its founding and still today, PEPFAR represents the largest investment ever by a single nation for a single disease. As of 2018 the US has spent nearly US\$60 billion on HIV programmes through PEPFAR alone. This investment has had an immense impact on the global response to HIV, due to both its sheer size and for its bilateral nature. The US aims to coordinate PEPFAR efforts with other funding streams, such as the Global Fund, but is also able to act on its own. This has made PEPFAR more susceptible to trends in US politics than the other institutions mentioned.

Once the major financing mechanisms for the global HIV response were in place, having followed the

establishment or deployment of political and technical institutions such as UNAIDS and WHO, Unitaid was launched in 2006 as the final major addition to the global health architecture for HIV. Unitaid’s mission is to correct market failures and improve the impact of investments in HIV, TB and malaria through financing innovative solutions. Unitaid works closely the Global Fund, PEPFAR, and other major donors, aiming to test out innovative solutions that can then be scaled up.

KEY TRENDS IN AN EVOLVING CONTEXT

In this section, we highlight three recent trends that are influencing the discussions on the future of global health architecture.

1. The SDG paradigm shift towards integrated and people-centred health systems

The most significant paradigm shift in global health recently is the political mobilization towards achieving UHC. In its simplest terms, UHC means that all people should have full access to all health services—preventive, curative, rehabilitative, or otherwise—and that such access and utilization should never expose the user to financial hardship.

It represents a fundamental step towards upholding and protecting the right to health for all people. UHC can have a positive impact on the global HIV response, such as greater efficiencies and alignment across services and a more people-centered approach, but there are also many challenges that the HIV sector will need to address to ensure there is adequate financing as well as inclusion of the most marginalized people and support for the role of civil society.

Objectives of universal health coverage¹⁸

- Equity in access to health services – everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

Policy: MDGs to SDGs

The global health architecture of the 21st century was originally organized around the Millennium Development Goals (MDGs). The MDGs represented a ground-breaking global consensus on what was needed to address the most pressing issues in low-income countries. They reflected that there was unequal development among nations, and that the market alone could not be relied upon to ensure poverty would be reduced and key health and development issues would be addressed. The MDGs served as a framework through which high-income countries could make targeted investments to improve the lives of people in low- and middle-income countries.

Global leaders recognized that the three pandemics of HIV, TB and malaria were immediate emergencies that needed laser-focused resources and attention. The national health systems of many countries were so inadequate that it was necessary to set up parallel vertical systems to deliver impact quickly. This level of attention to specific diseases motivated world-historic investments in the global HIV response.

In the early days UNAIDS served as a key coordinator of the new major investments in the HIV response. It provided the data for determining need and programmatic emphasis, and the convening power to bring governments – both donors and implementers – and other stakeholders together. UNAIDS played a central role in determining MDG targets for HIV, and to some extent mapping how we would get there. But UNAIDS was not intended

to be the mechanism through which funding was delivered to countries, this primarily came in the form of the Global Fund and PEPFAR, and later, Unitaid. These institutions and allied efforts were responsive to MDG 6 ‘combat HIV/AIDS, malaria and other diseases’. As one key interviewee put it: “UNAIDS was a place to begin coordination, but the Global Fund and PEPFAR put gas in the tank.”

As the MDG era matured, the aid effectiveness agenda grew in force and HIV advocates and funders started gravitating towards health systems strengthening. The calls for more focus on person-centred approaches rather than disease-specific approaches gathered more support across the global health architecture. This was influenced by growing discontent from other health and development issue advocates who pointed to an imbalance in the amount of funding being directed towards the global HIV response, despite the fact that funding has only just been enough to bring the HIV epidemic to a ‘tipping point’. Furthermore, the successes of the HIV response, which were emphasized in the evaluation of the MDGs,¹⁹ reinforced the sense that HIV was no longer a singular emergency that required separate systems or exceptional attention.

In the discussions of what a post-MDG framework would look like, there were strong calls for the framework to encompass all health issues; include everybody, regardless of geographical location; and to take a systems-based approach to health that integrates health services wherever possible. This framework became the UN Sustainable Development Goals (SDGs), which were agreed by the United Nations General Assembly in 2015 to be achieved by 2030. SDG 3 ‘Good health and well-being’ is one of the clearest illustrations of the political shift beyond the disease-specific approaches of the past three decades to person-centred health responses and UHC. Importantly, this shift was and is endorsed by many HIV advocates. Under this SDG, the prior MDG 6 is included, but as one of 13 targets: “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.” Thus for the UN, moving forward, HIV is couched within broader goals and targets, such as UHC.

The institutions that were set up to target specific

SUSTAINABLE DEVELOPMENT GOALS



Figure 3. The Sustainable Development Goals

(<https://www.un.org/sustainabledevelopment/sustainable-development-goals/>)

diseases under the MDGs are now faced with how to adapt to the new global consensus. There is no longer a top-line political imperative to invest in HIV, TB, and malaria on their own, but rather more of a menu of approaches donors can take within SDG 3, with UHC being at the top of the list.

Financing

In recent years the WHO and UN General Assembly have both called on nations to, “urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.”²⁰ However, challenges lie in the fact that most donor resources are currently mobilized and distributed on a disease-specific basis and that there are still huge funding gaps in the response to epidemics, including HIV, TB and malaria. Furthermore, the push for UHC is unfolding at a time when at least half the world’s population still does not have access to quality essential health services and 100 million people are pushed into extreme poverty each year due to health costs.²¹ It is incumbent upon the key institutions of the global health architecture to explore how to mobilise and align resource distribution as well support countries to mobilize resources for the realization of UHC.

Potential pitfalls of the expansion to UHC that must be avoided

1. **Exclusion is entrenched:** Will the fight to address marginalization and criminalization be dropped and the most marginalized stay the most marginalized or criminalized?

One significant worry among HIV advocates is that the most marginalized or criminalized people, who we struggle to reach even with a disease-focused approach, will remain on the margins in a UHC context. Furthermore, there remain many questions about continuity of services for people living with HIV and delivering on unfinished business of 90-90-90 or the UN target of ending AIDS by 2030 as systems reorient around UHC. New HIV prevention shadow reports²² show that despite governments’ commitments, the needs of sex workers, men who have sex with men, transgender people and people who use drugs are frequently ignored, resulting in worryingly low levels of access to HIV prevention services across the countries. Advocates and affected communities have fought hard and continue to fight for the recognition of the special political and programmatic needs of key populations and people living with HIV. However, the needs and very existence of key populations and people living

with HIV are often neglected and even criminalized by the very governments who are responsible for implementing the UHC agenda. The various policies and frameworks in place to address the needs of key populations and people living with HIV in the HIV response are not a given within the UHC movement and must be established anew in this context.

2. Civil society and community involvement reduce in a context of shrinking civic space

Civil society and community engagement leads to more effective programmes and greater access to services for key and vulnerable populations and makes health governance stronger and more responsive to the diversity of people's health needs. The UHC agenda is largely being driven by governments and multilateral institutions, so an early priority must be to ensure that civil society (and particularly communities affected by various health issues) are meaningfully engaged in defining and implementing the UHC agenda. Within the HIV sector, and more recently the TB response, there has been fairly meaningful engagement of civil society and communities in decision-making spaces but creating and protecting this space has been a struggle. There is therefore a concern about the continued engagement of civil society in community mobilization, service delivery, advocacy and governance, especially when there is little experience or infrastructure for civil society and communities to be so deeply engaged in other health areas. There are key lessons to be learnt from the evidence of the impact of civil society engagement in the global health architecture for HIV. There have been some recent positive developments in the engagement of civil society in UHC, such as the UHC2030 Civil Society Engagement Mechanism, which is discussed later in this paper.

3. The continued pre-eminence of biomedical responses

There is a deep understanding of how to maximize the impacts of the biomedical tools in the HIV response, which includes expanding coverage of prevention, diagnostics, treatment and care and access to primary care. However, one reason that HIV is unique – tragically so – is the network of economic, social, cultural, political, and legal barriers that restrict and hinder progress. This has particularly been the case for key populations and people living with HIV

and ultimately affects their access to services, well-being and representation. The various movements to protect and advance human rights and break down the barriers that restrict their access to services have been just as important as the medical achievements of the past thirty years. Civil society and communities have been at the forefront of defining the normative content of the human right to the highest attainable standard of health. This work has helped to shape how the human right to health is now interpreted in many national constitutions and is being used as the basis of decisions related to the human rights of people living with and affected by HIV in national courts. There is a significant risk that biomedical interventions may be further prioritized over these other aspects as we move towards UHC.

4. Integration is only pursued where appropriate and doesn't lead to reduced focus

Another consideration is ensuring that HIV services and systems are ready and able, where appropriate, to be integrated into national health systems and to support broader health issues. While there is a strong rationale for some HIV services to be better integrated into broader health systems, huge questions remain about how this can be done effectively so that the quality and effectiveness of HIV services can be retained. This applies to the systems underpinning the HIV response also. For example, because a large amount of donor investment has centered on HIV and other specific diseases, parallel supply chain and management mechanisms have been set up which focus only on those diseases. The Global Fund's Pooled Procurement Mechanism, which only involves HIV, TB, and malaria drugs and technologies, has allowed countries to gain access to reliable commodities regardless of whether or not their national procurement systems would be able to guarantee regular access to quality products. Consideration is currently being given to whether and, if so, how these existing financing-mechanism-based systems can support all countries to take advantage of the benefits they provide and whether a broader set of medicines and commodities can be made available through them.

2. Donor deficiencies; the economic and political calculus of ODA is changing

The central operating assumption of the existing global health architecture is that high-income countries have both the resources and the moral obligation to help low-income countries respond to health crises. This is largely informed by the post-war neo-liberal principle that maintaining peace and security among nations is paramount and that one way this is accomplished is through the benevolence of world powers. High-income countries contribute resources through providing official development assistance (ODA).

However, two realities are combining to denigrate the existing narrative: The first is that a number of high-income governments are faltering or reducing their total ODA funding to end the epidemics. The second is that nationalism and anti-globalism are on the rise among some of the major world powers and this is undercutting the broader support for and approach to international development. Economic and trade interests are gaining weight in the choice of development priorities and countries among the donor governments, including emerging donors from the middle-income countries.

Faltering funding for the three diseases risks progress

As described in the recent report by the Global Fund Advocates Network, *Get Back on Track to End Epidemics*,²³ investment in, and political commitment to, the global HIV response to date has not been sufficient and not only have we not adequately controlled these epidemics by 2018, we are not currently on track to do so even by 2030. The report illustrates some of the remaining gaps for each disease:

- **HIV is the leading global cause of early death among women ages 15-49** and causes over five percent of disability among adults ages 15-49. A total of 37.6 million people now live with HIV, and 1.8 million become newly infected every year.
- **TB is the world's most lethal infectious disease**, with over 10 million new cases each year, an estimated 1.8 million deaths annually, over a quarter of the world's

population carrying latent TB infection, and many more at risk for infection and illness.

- **Malaria infected an estimated 216 million people in 2016**, killing 445,000 people annually including 285,000 children under the age of five. Malaria remains a major killer of children, taking the life of a child every two minutes.

Nationalism and anti-globalism

While most major economies have rebounded, the global financial crash of 2008 and its fallout are still informing much of the political discourse in donor countries. The damaging cuts to public services (euphemistically called 'Austerity' in the UK) that were imposed in response to the crash have put growing pressure on poor and marginalized communities in high-income countries like the US and UK, and the lack of accountability for the culprits of the crash created an opening for right-wing populism to blame variously immigrants, the EU, the 'establishment political class' and, of course, poor and marginalized people themselves. In these and other donor countries, nationalist, anti-elite, anti-establishment and anti-globalist sentiments have established themselves as dominant political discourses in recent years.

Two major developments in geopolitics exemplify the ascendance of nationalism and anti-globalism: the disengagement of the UK from the EU (so-called 'Brexit'), and massive political redirection in the US, typified by the election of Donald Trump as president.

ODA in the crosshairs

These major political shifts have had and continue to have an impact on political dialogue around the value and role of ODA. The politics of Trump and Brexit connect to and foster a feeling in parts of the electorate that their governments have been too generous and that they need to focus more on local/national problems or, at minimum, link global engagement much more concretely to national self-interest. Both examples are driven by increasing domestic resentment of the countries' perceived roles as global benefactors and the sense (often fostered by skewed or selective information in hostile media) that many countries are no longer in need of support or that the majority of ODA is wasted or siphoned off through corruption. Much of this

political sentiment is predicated on uncomfortable changes in the global economy, which are challenging conventional expectations of financial security and political dominance among historically powerful sections of their populations.^{24, 25, ii} Fostering peace through international development cooperation has been positioned as being only to the benefit of other nations, and to the detriment of donor governments and their domestic priorities. For example, investments in international development have been deliberately and misleadingly framed as a reason for funding shortages for national public services.

Much of the populist anti-ODA rhetoric ignores the fact that ODA has had profoundly positive impacts in the world, for implementers *and* donors. The progress of the HIV response is a shining example of what can be accomplished when countries come together to invest and solve problems. There is a strong need, recognized by many across the international development sector, to clearly articulate and explain to the public why ODA has been, is and will remain important for addressing poverty and inequality around the world.

Yet, this message is complicated by the fact that it is not only the populist right who critique development co-operation. Even amongst those who are supportive of giving or receiving ODA, there is a growing recognition that the current narrative and structure of development co-operation and ODA is no longer fit for purpose and that certain conceptual shifts are needed to make ODA fit for the 21st century. Drawing and building on numerous discussions in the global health sector held over the last few years, Jonathan Glennie explains the changing global context, some of the critiques of development co-operation and a few possible solutions in his paper *Global Public Investment: Five paradigm shifts for a new era of aid*. He explains that the geographies of wealth, poverty and knowledge continue to change considerably but multilateral and bilateral mechanisms are not responding to these changes and are therefore leaving increasing numbers of the poorest and most marginalised behind. Many of the assumptions and approaches and even the

language that currently underpins the international development model are no longer fit for purpose – the problematic view of aid and support as time-limited; the narrow focus on extreme poverty; the insufficient focus on addressing inequality; the exclusive use of global growth and country-level gross national income (GNI) as economic indicators of progress; the focus on north/developed-south/developing aid flows and language; and the focus on quantity of aid rather than the type and quality of aid. As Jonathan Glennie laments in his paper: “As the old country divisions erode, as recipients become contributors, as economies grow, the question is being asked – what is aid now for? And the answers, for the most part, remain stuck in the 20th century.”²⁶

Is ODA still targeted to where the poorest and most marginalized are?

One area that exemplifies how the current development co-operation structure and approach is no longer fit for purpose is related to the traditional approach of donors to their ODA eligibility and allocation criteria. Over the last 20 years the majority of low-income countries have moved to middle-income country status, and many are moving to upper middle-income status. Donor eligibility criteria have historically stayed focused largely on low-income countries and have sought to reduce and then exit donor funding as countries become middle income and then reach upper middle-income status. This process has largely ignored the fact that the majority of the poorest people now live within middle income countries and that, while a country's World Bank economic classification status may signify that it has a larger gross national income, it does not mean that the government has the political will, funding or capacity to continue health interventions that have been enabled by ODA. The dramatic reductions and exiting of ODA funding by donors has led many critical health services to be discontinued and led to the loss of some development gains made to date. In the context of HIV for example, we have seen the resurgence of HIV epidemics in some countries and regions.

The failure to secure the continuation of services and the undermining of development gains in the context of transition have prompted considerable advocacy and secured some important changes to

ii. The authors of this paper categorically reject the notion that donors are ‘doing too much’ for low- and middle-income countries but understand that it must be acknowledged and navigated.

donor approaches – including the development of some policies and principles to guide how ‘transitions’ (donor reduction and exit) should be conducted and some mitigation measures to limit the impact on the poorest and most marginalizedⁱⁱⁱ. But the underpinning assumptions driving the desire to exit donor funding and support in the first place have barely been examined. Apart from the Equitable Access Initiative in 2015 (the findings of which were largely ignored), there is little global examination or recognition by global donors that GNI per capita is an insufficient economic criteria on its own to judge whether a country or its government has the financial capacity and ability to take on responsibility for its own health programming. There have also been poor levels of analysis or discussion about how to deal with the challenge of negative political will in a country to address particular health issues or populations (for example funding domestic civil society and community advocacy). Finally, recently some key donors are starting to suggest that they will no longer exit ODA from countries but instead will change the nature and scope of their interventions. This is a welcome shift but one that requires significant discussion to ensure that the new interventions are ones that are focused on sustaining and building development gains made to date, particularly for the populations and issues that are in the most need of support.

Updating the framing and language of ODA to fit the 21st century

It is important to note one more example here because any structural changes in approach must be underpinned and driven by changes in narrative and language around ODA and development co-operation. Over the last few years there have been numerous discussions exploring the tensions in language around ODA and the connected narratives, advocating for a shift in language. For example, members of the Global

iii. The Global Fund’s Sustainability, Transition and Co-financing Policy was the first and most developed of such policies but bilateral donors such as USAID and DFID have also now developed policies and principles to build sustainability and support successful transitions. Some philanthropic institutions and civil society have also worked together to pilot interim funding mechanisms (such as the Sustainability Bridge Fund funded by OSF and implemented by civil society in Eastern Europe) to limit the damage of transition for the most marginalized.

Fund Advocates Network, working with researchers such as Jonathon Glennie, have suggested moving away from “aid” to “assistance” and with a potential focus on “international public investments,” arguing that it, “conveys a sense of a return for the investor, that goods are collective and that it is a permanent part (long-term) of the development finance mix.”²⁷ These discussions have drawn in many voices from around the global health world over the last couple of years but many more must be heard, particularly from historically under-represented communities, to ensure a robust language and framing that reflects our changing world. For example, other global health actors such as Health Poverty Action and Medicus Mundi International are also convening discussions and suggesting alternative language and framing.²⁸ Connections and debate must also be drawn beyond the border of global health across the SDGs.

3. Shaky foundation; the neo-liberal global governance space is fraying

The banner change in the global political order over the last two decades has been the emergence of China as a superpower. This has reduced the prominence, and to some extent the unity, of the North American-European alliance, which has defined the global agenda in recent years. China, rather than situating itself within the existing alliance, has positioned itself as an alternative, limiting any sense of ‘global consensus’ with regard to health and development agendas.

Other changes are also weakening the ‘global consensus’. There are now more middle-income nations which have more economic independence and are therefore demanding greater influence in global governance. These nations are increasingly seeing themselves as a bloc and are developing parallel economic and political alliances, e.g. BRICS (Brazil, Russia, India, China, and South Africa), or have been identified as having connected economic futures, e.g. Next 11 (Bangladesh, Egypt, Indonesia, Iran, Mexico, Nigeria, Pakistan, the Philippines, South Korea, Turkey, and Vietnam). These blocs, whether organized or not, represent a major power center in the 21st century. To paraphrase Pascal Lamy, former head of the World Trade Organization: as the BRICS countries gain in economic and

political influence, they will no longer remain policy *takers* but will shape the future on their own terms.²⁹ Building on this, in a global health and development context, Ilona Kickbusch reflects: “BRICS appear to be less interested in simply providing financial contributions for development assistance than in very political and more structural bilateral and multilateral approaches to global health.”³⁰ The efforts of middle-income countries to promote the utilization of TRIPS flexibilities for health technologies is a key example of this.

Reconsidering donor and implementer power

Overall, across the governance of the six institutions selected, the principle of ‘more money, more power’ is particularly strong for the donor agencies such

as Global Fund, Unitaid and GAVI. Most donors who give substantially to a specific institution have a voting seat of their own. It is important to note this includes private philanthropy, for example Bill & Melinda Gates Foundation represent private foundations at both the Global Fund (alongside the Kaiser Family Foundation) and Unitaid.

There is a broad recognition of the importance of including all stakeholders in decision-making but there is no consistent approach or level of engagement. Table 1 shows how some global health institutions are still disproportionately controlled by donors and/or have minimal representation by implementing countries or non-state stakeholders. The Global Fund is a good example of an institution attempting to more fairly balance the principles of ‘more money, more power’

Table 1. Global health institution governance structures and decision-making processes

Global health body	Voting Board delegations	Additional Board delegations (without voting)	Decision-making/blocking decisions
The Global Fund	20 delegations: <ul style="list-style-type: none"> • 10 donor delegations • 10 implementer delegations 	Technical partners Non-voting donor seat	Two-thirds majority vote needed on both donor and implementer side to pass a decision
Unitaid	11 delegations (of 12 delegations): <ul style="list-style-type: none"> • 8 donor delegations (including 5 founding countries) • 1 implementer delegation (African Union) • 2 civil society delegations 	1 delegation (of 12 delegations): 1 multilateral delegation (WHO)	Two-thirds majority across the whole Board
GAVI	28 delegations (of 29 delegations): <ul style="list-style-type: none"> • 5 donors • 5 implementers • 3 multilaterals • 2 private sector • 1 civil society • 1 research institutes • 9 independent individuals 	1 delegation (of 29 delegations): 1 Gavi CEO	If no consensus can be reached, two-thirds majority of members present and voting

UNAIDS (Programme Coordinating Board)	22 delegations/Member States (of 38 delegations): <ul style="list-style-type: none"> • 5 Africa • 5 Asia and Pacific • 2 Eastern European/Commonwealth of Independent States • 3 Latin America and Caribbean • 7 Western European and Others Group 	12 delegations (of 38 delegations): 12 cosponsors 5 NGOs (3 from developing countries and 2 from developed countries)	Decisions are made by a majority of the members present and voting
WHO	34 delegations: persons who are technically qualified in the field of health from Member State elected to serve by the World Health Assembly	N/A	Two-thirds majority for important decisions (including recommendations on the adoption of conventions and agreements, the suspension of the voting privileges and services of a Member State under Article 7 of the Constitution, and decisions to suspend or amend these Rules of Procedure), majority for all other decisions
World Bank	The Boards of Governors consist of one Governor and one Alternate Governor appointed by each member country	N/A	Decisions are made by a majority of the votes cast
PEPFAR	N/A	N/A	N/A
Global Financing Facility (Trust Fund Committee)	The Trust Fund Committee consists of representatives of the Bank and all donors	N/A	Decisions are made by consensus in meetings and no-objection virtual processes between meetings
UHC2030	20 members: <ul style="list-style-type: none"> 9 country seats across low-, middle- and high-income countries 3 seats for multilateral organizations 2 seats for the World Bank and WHO 1 seat for a philanthropic foundation 3 seats for civil society for global, national and grassroots organizations 1-2 seats for the private sector 	N/A	Decisions will be taken by consensus

and of inclusion of all key stakeholder groups in representation, power and decision-making.

Since its founding, the Global Fund has maintained a 50-50 division of Board votes between donors and implementers through its various constituencies (noting that private sector and private foundations are part of the donor block and civil society are part of the implementer block). The Global Fund's largest national donors, US, France, UK, Germany, Japan, are all members of the G7 and all have their own seat whereas smaller like-minded donors share seats (e.g. Canada, Australia and Switzerland share one seat). In contrast, the BRICS and Next 11 countries (who mostly do not make donations to the Global Fund) do not directly control any votes as single nations, but instead share votes through their involvement in their regional implementer constituencies that represent all the Global Fund eligible countries within a particular region.

The Global Fund replenishment took place in 2019 to attract new donors, particularly among the emerging economies, and to provide some opportunity for donors to have greater involvement in governance in exchange for significant donations. In 2017 the Global Fund Board amended its bylaws to reallocate an existing non-voting seat for, "one representative of public donors which are currently not part of a voting donor constituency but have each pledged a contribution of at least US\$10 million in the current replenishment cycle."³¹ According to Aidspace, this action was taken by the Board as an interim step, "until a broader review of the Board's size, structure and voting procedures takes place".³² This review likely to take place in 2020-21.

While the Global Fund's governance arrangement is one of the most balanced and representative, there are certain aspects of the Board structure that may also be questioned if and when a Board review occurs. For, example, as a financing institution, the split of the Board into donor and implementer blocks might make sense from the perspective of including those who provide the money for it to function and those who receive its funds to fight the three diseases. But splitting voting across these blocks or assuming that all implementers or donors have common interests makes less sense than perhaps it used to.

There is an even broader question of whether those

who provide the funding should have as much voice and voting power as they do. As of 2018, domestic investments in HIV in low- and middle-income countries exceeded donor investments with 56% of the total funding.³³ This represents a positive step for the global HIV response and is partly borne out of an increasing ability to pay among middle- and lower-income countries. Also, as middle-income countries cover more of their health budgets, some are also coming into the fold as donors to the Global Fund, albeit at smaller levels than the traditional big donors. As 'implementer countries' shift to funding the majority of the HIV response, and sometimes become 'donor countries' themselves, it could be argued that they should also take on a stronger voice in how decisions are made within the global health architecture. Or, perhaps there could be a move away altogether from the concept of 'pay to have a say' and structure governance representation based on a broader concept of who has the strongest interests and engagement in achieving the goal of the institution.

As outlined in the table above however, the Global Fund, GAVI, UHC2030 and UNAIDS seem to be some of the best examples of balancing donor, implementer, and other stakeholder power among the key institutions in the global health architecture and should serve as inspiration for the governance evolution of other institutions. All multilateral institutions and financing mechanisms, including the UN, must evolve their governance structures to be more reflective of the changing reality and understanding of global health landscape – to find ways to bring more donors (state and non-state) and a stronger and more balanced representation of key implementing and/or engaged parties to the decision-making table. This will facilitate the global health community to make better, more informed and better supported decisions because all key actors will be at the table to find agreement on a more equal basis.

The threat of unilateralism

The CIVICUS *State of Civil Society 2018* report highlights the threats to multilateralism as a key trend for civil society to be concerned about. Some of the same high-income countries responsible for establishing the mechanisms of cooperation in the first place are now seeking to reform or destroy

them. There is a growing practice of unilateralism among some of these same countries. CIVICUS cites the US' recent withdrawals from a range of multilateral agreements (e.g. the Paris Agreement, UNESCO), politically motivated reductions in funding for the UN, and other unilateral contradictions of negotiated agreements as reasons to be concerned. "These trends impact on civil society, because civil society looks to the international system to propagate rules and norms that uphold human rights. Civil society turns to international bodies when states refuse to listen and works with them to encourage oversight of states' human rights records. A withdrawal from multilateralism robs civil society of these opportunities."³⁴

The shrinking space for civil society

After decades of steady progress on human rights, the early-2000s saw the growth of populism and an anti-rights movement across the world that strongly opposes liberal acquis, especially on sexual and reproductive health and rights (SRHR) and lesbian, gay, bisexual, transgender and intersex (LGBTI) rights, and is becoming increasingly influential at the international, European and national levels, questioning civil society participation within multilaterals. This is impacting on how governments see civil society participation in multilaterals.

While the role of civil society is widely recognised as essential to the HIV response, the closing space for civil society, the criminalization of key populations, discrimination in healthcare settings and an increasingly challenging political and social space are among the challenges that call for action. For example:

- At the global level, the UN HIV High Level Meeting of 2016 saw a group of 57 countries, including Russia, Cameroon, Tanzania, and the Organisation of Islamic Cooperation, successfully ban not less than 22 CSOs representing key populations from attending this meeting. Similar manoeuvres, aimed at limiting the involvement of civil society advocates for progressive drug policy were observed at the 2016 UN General Assembly Special Session on the World Drug Problem.
- Recently-published research from the International Center for Not-for-Profit Law shows that in Ethiopia, Uganda, and Kenya, three countries with a high rate of HIV and where key populations are criminalised, civil society organizations (CSOs) working on HIV face restrictive laws, policies, and practices that hinder their ability to implement urgently needed programmes.³⁵
- In Kenya, Malawi, Mozambique, Nigeria, Uganda, Ukraine and Zimbabwe repressive laws and policies are fuelling the HIV prevention crisis as they lead to the criminalization and exclusion of marginalised people. All six of the African countries criminalise drug use and five of the six criminalise same-sex activity. As a result, people who use drugs and men who have sex with men are often unable to access the services they need to reduce their risk of HIV infection.³⁶
- Similar developments are being observed in many other parts of the world. Research conducted in Asia, Eastern Europe, Central Asia, and the Caribbean shows that civil society organizations working on issues related to HIV and key populations are among the groups most affected by restrictive laws, policies, and practices.
- A recent PITCH-CIVICUS research paper³⁷ analyses international-level civic space restrictions on HIV/AIDS by key populations and their CSOs, focusing on formal or informal closing of space for individuals and organizations attempting to influence processes at the international and regional levels. The report highlights findings about other specific challenges experienced by key populations such as bureaucracy in accessing and participating in the international fora, and stigma and discrimination by state parties and other CSOs. Finally, the study also finds that challenges in accessing regional or international mechanisms for advocacy are sometimes occasioned by internal barriers such as the lack of technical capacity, financial and time resources, which impinges on the effectiveness of using international mechanisms and institutions.

Making sense of these trends

As mentioned above, there are number of civil society concerns for each of the trends that will influence the global health architecture. It is therefore critical that:

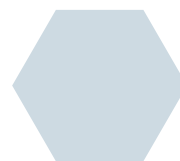
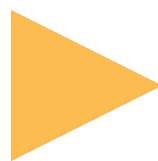
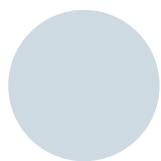
- Civil society and communities working on the global HIV experience are at the forefront of discussions on the integration of the global HIV response within the movement towards UHC.
- Global health governance must better reflect the changing economic and political realities facing the world today and become more inclusive of stakeholders in 'implementer countries', emergent global powers and non-state actors heavily involved in health.
- A robust accountability mechanism must be developed that makes it possible to track progress on how UHC is reaching key populations, adolescents and young people affected by HIV and TB; and civil society involvement in UHC implementation.

Questions

The following questions emerge for us from the above discussion:

- How can disease-specific responses be integrated into UHC in such a way that preserves and advances the successes whilst learning from and addressing the challenges?
- Can existing funding streams and governance structures evolve to deliver UHC without losing the clarity of their mission and the rationale for donors to contribute?
- If we struggle today to raise and disburse sufficient resources for the response to HIV, TB, malaria, and other diseases, how will we rebuild a rationale for increased resources for the much more expansive and nebulous goal of UHC?
- How do we reconcile the reduced political salience of ODA in some countries with an even more ambitious goal of UHC?
- How can more countries be involved in resource mobilization and decision-making for global health?
- What is the role of countries that have 'graduated' from ODA within this architecture?
- What does a new global health architecture look like that considers all these dynamics and more?
- Which accountability mechanisms need to be put in place in order to track progress on both UHC and disease specific result areas, particularly for key populations, adolescents and young people affected by HIV?

The objective of this paper is not to resolve these questions, but to prompt discussion around them and suggest some guiding principles that might help us to find and share some answers.



3. SUGGESTED PRINCIPLES TO GUIDE SMART, RIGHTS-FORWARD EVOLUTION OF THE GLOBAL HEALTH ARCHITECTURE

PRINCIPLE 1: THE LESSONS LEARNT FROM THE HIV RESPONSE NEED TO BE UTILIZED BY THE UHC MOVEMENT

Whether you look at the SDGs, the ongoing challenges around funding, or the many internal challenges facing the global health architecture for HIV, it seems to be a foregone conclusion: the global HIV response is being integrated into broader health and development agendas. The timeline, dimensions, and specifics of this integration are big questions today.

There are many lessons to be learnt from the HIV response. It will be important for some of the approaches and priorities of the HIV response to be continued and adapted as the global health architecture shifts, or we risk losing much progress. Below we articulate some of what needs to be preserved and improved from the HIV context as the response evolves and adapts to the UHC movement.

HIV advocates should fully engage with UHC

Speaking on a panel that included Peter Sands (Global Fund Executive Director) and Dr. Tedros (WHO Director-General) at the 2018 International AIDS Conference in Amsterdam, Dr. Khuat Thi Hi Oanh of Vietnam made a plea: “I would like to call on my fellow HIV activists to use our experience and know-how and wisdom for UHC.”³⁸ We encourage our colleagues to heed this call. In many ways, UHC has the potential to get us closer to the UN target of ending AIDS by 2030 than we could hope for with a continually under-financed vertical response to HIV. But we need to bring our “experience and know-how and wisdom” to the table to help ensure the UHC movement doesn’t leave out key and vulnerable populations and sustains the gains of the

HIV movement. HIV advocates should increasingly be placing their work in the context of UHC and the broader SDG3 context. For example, there are clear links between HIV and many other SDG3 targets, such as the strengthening of the prevention and treatment of substance use (with substance use linked to an increased likelihood of acquiring HIV) and ensuring access to sexual and reproductive health care services (where gaps in these services increase people’s risk of acquiring HIV).³⁹ This means advocating for all the SDG3 targets and investments, including beyond those that consider and advance UHC. This means forging meaningful alliances with and becoming UHC advocates. This means not leaving the work of UHC and the broader SDG3 targets to others – HIV advocates must be engaged everywhere. At the same time, we must also ensure that HIV advocates do not dominate and must ensure that we make space and encourage participation from all individual health issue stakeholders.

Demand and operationalize community and civil society engagement in UHC

There are many mechanisms used to facilitate the engagement of civil society and communities in the HIV response, in service-delivery, programme planning, advocacy, accountability, community mobilisation and health governance from local to global. They don’t all work as well as they could, but it will continue to be useful for HIV advocates to reflect on these models and advocate for the strongest ones to be adapted and incorporated across SDG3 and particularly within UHC. Some of these are discussed earlier in this paper, though our discussion is far from exhaustive.



Example

An important example of how HIV advocates are building on their successes and ongoing challenges for the benefit of broader SDG 3 issues is in relation to access to medicines. HIV advocates forced a political response to the high prices of and lack of access to ART resulting in the Doha Declaration in 2001 which reaffirmed Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and led to increased access to ART for millions of people.

There are key lessons from the HIV and access to medicines movement and their response to the pharmaceutical industry which could not only benefit the UHC movement, but also across disease responses. For example, non-communicable diseases within SDG3 and the WHO global strategy to reduce the harmful use of alcohol where “industry interference, most blatantly through lobbying, and other tactics to counter evidence and create doubt is a global phenomenon, particularly on market related policies related to fiscal measures, trade, labelling and advertising”.⁴⁰ Critically also, looking forward, if we are to fundamentally change the structure of the whole system of research and development and pharmaceutical power, we can only really do this by building common cause with advocates across health issues.

Ensure UHC is anchored in the right to health for all people, including key and vulnerable populations

Globally, the HIV response has fought for and defended human rights and although these battles have not yet been won, there is a record to review. As HIV advocates, we should always bring our vision for universal respect for human rights to the discussion of universal health coverage. As veterans of a right-based movement, we should always remain vigilant that all discussions and

decisions related to UHC are anchored in and informed by the right to health of all people.⁴¹

As the HIV response integrates into UHC, we must protect the central role of key and vulnerable populations and imbue institutions and mechanisms with strong recognition of the importance of working with and for these communities, in the context of HIV and in overall health and development. The SDGs provide a platform to do this, by way of ‘Leave No One Behind’, but vigilance will undoubtedly be required for a long time. Nonetheless, ‘Leave No One Behind’, has been a long-used, inconsistently applied slogan in the HIV response. We need to continue to fight for the practice of this principle in HIV, UHC, and beyond. This means achieving the last mile first – by securing access to appropriate services for those most often left behind we will automatically deliver a system that is responsive to the needs of everyone else as well. In addition, by applying a person-centred approach we will ensure that we will provide a broad range of health and development services that directly address the multiple needs of a given individual. The level of integration of these services should be driven by the extent to which they support greater equity of access to quality services for the individual but also take into account issues of cost effectiveness and efficiency. The outcomes and impact of these approaches must be monitored by the institutions delivering the services but, crucially, support and resources must also be provided to communities accessing these services themselves to effectively monitor the quality and level of coverage among the most marginalized through community-led monitoring and advocacy.⁴²

Three key principles of the HIV response that should be adapted for UHC initiatives:

1. National multi-sectoral platforms that set policy, monitor progress, and plan programmes must include civil society and affected communities, particularly key populations and vulnerable groups, in addition to governments, international agencies, and the private sector. The Global Fund’s Country Coordinating Mechanism (CCM) model is a helpful starting place for this but can be greatly improved upon. If CCMs are to be integrated into broad health platforms, this can only happen if the principle of full inclusion of all key stakeholders is maintained.

2. Ensure funding for communities and civil society organizations to build and sustain responsive and resilient health and community systems. Communities must be recognized as key deliverers as well as recipients of health programmes, particularly for the most marginalized, and capacitated with the resources to be effective participants in the planning and delivery of all health programmes.
3. Ensure that UHC remains anchored in the right to health of every single person, with an emphasis on achieving equity for key and vulnerable communities. The right to health and broader human rights and gender equality, should be placed as a central objective within all global health institutions.

Promising direction

UHC2030 Civil Society Engagement Mechanism

A more recently established group (2016), UHC2030, may offer a good model for engaging civil society alongside other actors, particularly in a UHC context. In addition to three of the 20 seats on its steering committee being allocated to civil society, UHC2030 also uses a Civil Society Engagement Mechanism (CSEM). While it is yet to be seen how impactful the CSEM will be in influencing the UHC dialogue overall – or to the directions of UHC in general – it seems to be a step in the right direction. According to their website, the CSEM has the following structure:

- Three CSO representatives to the UHC2030 Steering Committee from global, national and grassroots organizations.
- A global CSO advisory group, linking global and local inputs and providing technical guidance.
- A secretariat, hosted by a CSO with two full-time employees to implement the workplan and ensure coordination and communication across the structures.
- National groups, with focal points from existing CSO health platforms.
- Regional focal points, to support national groups and promote exchange across countries.⁴³

Questions

- What are the most essential features of the HIV response that need to be brought to the UHC agenda? In which parts of the global health architecture must these features be established?
- What are the sensitivities that need to be considered? How do HIV advocates balance humility with assertiveness?
- What might we lose by integrating the HIV response into UHC? How do we sustain the gains we have made? And what might we gain through integration in UHC?
- How can UHC and the broader SDG3 targets benefit from years of experiences in the HIV response?
- Who are our key allies in defending and promoting human rights and the inclusion of key and vulnerable populations in the context of UHC?

PRINCIPLE 2: GREATER COORDINATION AMONG MULTILATERALS, DONORS, IMPLEMENTER COUNTRIES AND COMMUNITIES IS NEEDED

In the HIV response, and more broadly, it is important to cultivate spaces and processes for all stakeholders to engage in dialogue about the response at a political level. Donor countries do not have adequate platforms through which to dialogue with each other, with implementers, and with other stakeholders about what levels of investment are needed, and how to coordinate those investments for maximum impact.

When we consider the trends discussed above, in particular the changes in the ODA value proposition for some politicians and the shift to less disease-specific funding, there becomes an even greater case for strong political coordination among nations and other key stakeholders. Furthermore, the weakening of existing global governance structures as a result of shifting global power dynamics means that new or rejuvenated spaces need to be created for political dialogue on health and development—ones that involve more nations and more non-state actors who are critical for making global health goals a reality.

If we look solely at HIV, there was previously a mix of fora for global health stakeholders to engage in discussions focused on either policy or on financial matters related to HIV, but they rarely overlapped in a meaningful way. UN processes such as UN General Assembly Special Sessions and, later, High Level Meetings engaged senior level member state politicians (ministers and heads of state) to make political commitments related to HIV. The UNAIDS Programme Co-ordinating Board bi-annually brings representatives from all constituencies together to discuss and co-ordinate policy direction for the whole HIV response but it does not currently have a mandate to include financing negotiations apart from the HIV budget for the UN co-sponsors (UBRAF).

The Global Fund Board and Committees provide strong opportunities to discuss the realities of the responses to the three diseases and the financial challenges but only specific to Global Fund eligible countries.^{iv} However, apart from the useful discussion

about the total global financial need for the three diseases included in their replenishment process, they do not convene fora in which all stakeholders can discuss how key stakeholders co-ordinate financing or programmatic/policy questions globally. In fact, most global-level financial discussions about the HIV response are constrained within the distinct remits of particular institutions – Global Fund, PEPFAR COP process etc. There are little or no opportunities for global co-ordination of financing approaches informed by political and programmatic realities and this is a gap for the HIV response. This has become clear in the context of sustainability and transitions where there has been very little co-ordination between multilateral and bilateral donors on approaches to building sustainability and managing transitions or to understand and, if necessary, course correct for the collective impact of their separate approaches. UNAIDS held one meeting in April 2019 that attempted to co-ordinate this work and, while hugely important and must be carried forward, it is not part of any formal governance process.

More opportunities for political and financing dialogue on HIV and global health are needed

In an HIV context, it is worth exploring whether the UNAIDS PCB, with its biannual meetings, may be a more regular opportunity for these high-level discussions on both policy and financial co-ordination may take place, for example as thematic sessions.

In a UHC context, this type of effort is beginning to take shape at the global level. In December 2017 a Universal Health Coverage Forum was held in Tokyo. The conveners^v sought to, “galvanize the health sector, countries, development partners, civil society and the private sector toward the common goal of UHC, including pandemic preparedness, and highlighting country success and breakthrough experiences to accelerate the progress of UHC.” The 2017 outcome document is largely aspirational, however, and does not commit any governments or other entities to action.⁴⁴ This forum offers a starting point for meaningful dialogue on UHC and

iv. One specific controversial exception to this recently has been in relation to Venezuela as an ineligible country in crisis that the Global Fund

v. Conveners of the Universal Health Coverage Forum included the Government of Japan, WHO, the World Bank, UNICEF, UHC2030, and the Japan International Cooperation Agency.

the role of the global health architecture, and it could serve as an important model to build upon.

Looking forward, it is interesting to consider whether UNAIDS could play an important convening role around policy implementation related to leave no one behind and how to target and co-ordinate financial resources globally to make it a reality.

What would greater synergy look like?

In practice, greater synergy in the global health architecture would most likely need to involve the development of a costed action plan which would involve targets and commitments for all nations and other key stakeholders. One effort is afoot, which appears to be at least partially responsive to these needs: *The Global Action Plan for Healthy Lives and Well-being for All*.

Promising direction

Global Action Plan for Healthy Lives and Well-being for All

In April 2018 three heads of state – Angela Merkel of Germany, Nana Addo Dankwa Akufo-Addo of Ghana, and Erna Solberg of Norway – sent a letter to WHO Director-General Dr. Tedros Adhanom Ghebreyesus calling for the development of a *Global Action Plan for Healthy Lives and Well-being for All*. The Plan, which was launched in September 2019, will operationalize SDG 3, setting up concrete milestones for achieving the targets of SDG 3 for all relevant stakeholders. The purpose of the Plan is to provide a framework for all relevant actors to base their Agenda 2030 strategies upon, allowing for a level of coordination not seen before. In the plan 12 agencies, Gavi, Global Financing Facility, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, the World Bank, the World Food Programme and WHO commit to strengthening their collaboration to:

- **Engage** with countries better to identify priorities and plan and implement together;
- **Accelerate** progress in countries through joint actions under seven accelerator themes set out in the Plan, and through our overarching commitment to advance gender equality and

support the delivery of global public goods;

- **Align**, by harmonizing our operational and financial strategies and policies in support of countries where this increases our efficiency and reduces the burden on countries; and
- **Account**, by reviewing progress and learning together to enhance our shared accountability⁴⁵

A plan of this sort, and the consortium behind it, could provide an important platform through which to harmonize the work of the multilateral health institutions. However, we feel that this plan would be greatly strengthened by not only including the major multilateral health institutions, but also bringing in major bilateral health programmes, such as PEPFAR, private entities like the Bill & Melinda Gates Foundation, and very importantly, civil society and communities. We recognize that the question of including civil society in a meaningful way is a complex one, but it is one that must be bridged. A challenge here is that there is a lack of a singular global institution that represents civil society specifically, but civil society has already mobilized and co-ordinated well feeding into the GAP process so far, linking key global health networks and civil society representatives from multilateral Boards. In light of the Global Action Plan (GAP) framework initially being drafted without the participation of civil society, a Civil Society Strategy Session on Civil Society Consultations for Global Action Plan for Healthier Lives took place in December 2018, acknowledging the importance of robust and meaningful civil society participation throughout the GAP process. The session, organised by the Civil Society Engagement Mechanism for UHC2030 (CSEM) and the Global Fund Advocates Network (GFAN) aimed to raise awareness of GAP, to identify opportunities for civil society consultation and to discuss how to structure meaningful civil society engagement. From April 2019 a Civil Society Advisory Group to the Global Action Plan for Healthier Living Process was developed and different multilaterals engaged to varying degrees with civil society on the Accelerator topics they were leading on. Civil society actors were clear however that the consultation processes and time periods proposed were insufficient to facilitate meaningful engagement. The *Global Action Plan for Healthy Lives and Well-being for All* was launched in September 2019. How this process goes forward,

particularly in terms of how it meaningfully engages all key stakeholders, will be key to its effectiveness in co-ordinating the achievement of SDG3.



Questions

- Based on the information we have today, does the Global Action Plan have the makings of an important early step to improve coordination amongst actors in global health? If it is, how should it be more responsive to and inclusive of civil society?
- How should progress on implementation of the Plan be monitored effectively and how should civil society be involved in the accountability mechanisms for monitoring the progress?
- How should the global health institutions monitor UHC progress and ensure UHC is progressing in the right direction in terms of delivering results for the key populations?

PRINCIPLE 3: THE PROCESSES BY WHICH FINANCING IS MOBILIZED, AND TARGETS ARE SET, NEED TO BE RECALIBRATED FOR IMPACT, WITH MORE INPUT FROM END-USERS

One of the consequences of the current organization of the global health architecture is that funding recipients and implementers receive funding from and are subject to policy decisions by governments in which they have no representation. Such is the nature of international relations, when nations of disparate economic and political power engage, particularly without explicit agreements or treaties. For health, this plays out not only in the amount of aid available, but how that aid is distributed, and ultimately how reliable it is. Implementers and global health planning entities may be able to make proclamations about what funding is needed, but they are hamstrung in their ability to predict what funding will be available, and what strings may be attached. The major political shifts in some donor countries only complicate this further.

Donor commitments should be elongated to afford greater predictability for programme planning

In the context of global coordination of the HIV response, one of the issues that often comes up is instability in donor financing. While there is more international funding for HIV than there has ever been, its availability is not guaranteed very far into the future – 3-5 years at the maximum.

Palpable donor fatigue, political disharmony, competing priorities and a stronger focus on UHC has generated instability in that multilateral – and some bilateral – institutions are unclear as to how much they can count on their core donors to continue, let alone increase, their contributions over the coming years. This is complicated by the fact that donors are asked to contribute to a variety of institutions. For example, several major donor countries make contributions to the Global Fund and other health financing institutions, fund their own bilateral programmes, and provide support to the UN, including UNAIDS and WHO, as member states.

Donor governments all must periodically renew their support for the various institutions. This is true for the Global Fund and others, such as Gavi. Rather

than have the luxury of long-term commitments from major (or any) donors, many of the multilaterals must host a ‘replenishment’ process every few years, during which donors announce three to five-year funding commitments. This schedule may have seemed appropriate at an earlier time, when the need for major donor aid to combat the diseases was perhaps perceived as a more short-term emergency response. But at a time when we are talking about disease responses over the next 10-30 years, it becomes a significant challenge. The Global Fund and others are forced to work on three to five-year cycles of funding, rather than being able to plan investments on a more long-term basis. Thus, a major weakness in the global health architecture is the inability of institutions to develop reliable long-term plans for financing and, consequently, programming.

In addition to the challenges of short-term funding cycles on their own, the fact that each of the major global health financing institutions needs to go through their own process of raising funds from donors is a challenge. For example, numerous funding institutions, including the Global Fund, Gavi, GFF and WHO have already, or will be organizing their individual replenishment processes (though not all use that term). This means they will all be asking, more or less, the same governments to make massive financial commitments. This situation could have been averted with greater coordination and longer funding cycles among the institutions.

Longer replenishment cycles, better coordination among financing institutions

Longer replenishment cycles would alleviate some of the challenges faced by programme planners. A useful target for commitment intervals would be 5-7 years, rather than the 3-5 we work with today. While the practicalities of securing longer-term commitments from donors may be daunting and politically challenging given standard terms of office, there would be clear value in any extensions that can be achieved. In addition to longer cycles, greater coordination among financing institutions could help avoid the competition that is arising currently. One mechanism of coordination could be an overarching plan for financing that is developed collaboratively by multiple funders. As a coordinator, UNAIDS may be in a position to lead a collaborative

financial planning process. A more radical alternative might be exploring a process for pooling larger-scale donor commitments, and then portioning out to the various institutions. There would be some obvious risks to such a process, but it merits exploration.

Move towards more in-country target-setting and away from donor-determined approaches

In the current arrangement of the global health architecture, much of the agenda is set at the global institution level, which is often driven by donors, who bring their own domestic politics to the table. Implementers on the other hand are asked to operationalize these agendas through programmes that aim for the targets set by institutions. While the institutions may be in a position to articulate goals from a global perspective, this approach fundamentally disempowers implementers. The PEPFAR country operational plan (COP) process is a good example of this dynamic. While the COP process may be multi-stakeholder by design, it is nonetheless a process through which country-level actors develop a plan to achieve the targets, and within the budgets, set down by the US government. So rather than an organic process by which countries determine their financial needs and programmatic targets, these are dictated to them. This can distort the programme development process by encouraging implementer governments to prioritize those programmes that are most 'sellable' to donors, rather than those which reflect the greatest need.

Global health institutions should be driven by a principle of country ownership which means catalyzing and supporting all key stakeholders in country (including civil society and communities, including those most affected) to identify and prioritise needs and set targets. This would require more extensive consultation and investigation of needs locally but should produce goals and objectives that can inform the development of the most impactful programmes at country-level.



Questions

- Could the unpredictability of donor commitments be addressed by setting longer periods of funding commitments for some of the larger financing institutions? What would be some of the challenges with this approach and how could they be overcome? What would be a better, yet realistic funding interval to advocate for?
- Could the competition for contributions among financing institutions be mitigated through some kind of pooled commitment process? If donors were asked to make comprehensive pledges to a 'global health fund', which then was divided up among institutions, would that help or hurt, in terms of exacting the maximum amount of money from donors?

Governance-specific principles

An important first step in developing principles on the evolution of global health governance structures is to critically assess the current structure of key institutions. Below is a list of preliminary questions that we can ask to help us evaluate where we are now in the global governance context so that we can better understand the importance and implications of applying the two governance specific principles (4 and 5) that follow.

Governance structure

- Do the current governance structures (Boards and Board committees) of global health institutions demonstrate an equal balance of representation, for example, between donor and implementer countries?
- Based on the mandate of the organization, which other key actors should be represented (for example, civil society, private sector and private philanthropy) and who is best placed to represent them? If certain key stakeholders are not included due to the original mandate of the organization, should the mandate be reviewed?
- What is the current composition of governance structures beyond the Board? For example, how are civil society represented at committees or through other bodies that feed into governance decision-making? Are there governance bodies that should always include civil society – such as those looking at ethics?

The role of the Board

- How are Board discussions designed to ensure balance between functional oversight and strategic direction?
- How are different expectations from constituencies managed? And how is this supported by the Secretariat?
- How does the Board ensure discussions benefit from the skills and experiences of each of the constituencies?
- How can the governance structure and processes support and ensure each constituency and Board discussions are focused on delivering the goals of the institution above all other considerations?

Governance culture

- How is trust built and maintained between constituencies and between the Board and Secretariat within formal and informal governance structures?
- How can safe spaces be created for difficult conversations and to unearth assumptions and guiding principles?
- How are ethics and standards expressed, monitored and enforced across the Board?
- How are power differentials recognised and, where necessary, addressed across the Board and with the Secretariat?

Funding and support to enable equal participation

- Are Board constituencies empowered and supported to effectively participate across the governance structure?
- What financial and staff support is provided to support constituencies in their governance roles? Is that support adjusted based on a transparent needs assessment with each constituency?

Civil society and community accountability

- How are civil society and communities representatives in global health governance elected and by whom?
- How do we ensure representatives are accountable?
- What are the mechanisms for civil society and communities to input into global health governance discussion through their delegations?
- What financial support is needed to support civil society and community representation?
- How are lessons learnt from particular health/disease responses shared across the global health architecture? How can we use these lessons to strengthen our common advocacy within specific institutions, and more broadly across global health to achieve SDG3 and UHC?
- What mechanisms and approaches foster effective collaboration between civil society and community delegations?

PRINCIPLE 4: REPRESENTATION AND POWER IN GLOBAL HEALTH GOVERNANCE SHOULD BE BALANCED

The current global health architecture power balance still skews towards the G7-related nations. The level of financial contribution of a donor has an unduly strong influence in global health governance: the countries that contribute the most financially sometimes have the most voting power and often easily drive the agenda. It is now increasingly clear that the major G7 donors are unable to, alone, supply the resources needed to achieve key goals like the 90-90-90 targets for 2020, or the UN target of ending AIDS by 2030. According to a report of the Kaiser Family Foundation, major donor financing for HIV appears to have plateaued, with most signs suggesting that investments will decline in the future, if new commitments are not made.⁴⁶ But also, as relative global power and financial contributions broaden and change, the governance structures should move to reflect that shift. This may encourage a broader set of new donors to get involved and can provide a structure for them to have a say.

These changes could be based on the often applied principle of ‘money for power’. However, to remain relevant and effective, global health institutions should move beyond this to expand their engagement and meaningful inclusion of non-state actors and implementers. The proportionality of representation in global health governance needs to be reset, to more accurately reflect those who have a strong vested interest in achieving the goal of that institution.

If we continue along the path we are on, the same high-income countries will make the largest contributions (critical but insufficient as they may be), the low-income countries will get the most aid, and those in the middle will simply exit the conversation as they are judged to be able to pay for their own health systems. We may then find ourselves in a place in which most of the world is completely disengaged from the global health architecture. In order to strengthen the global effort to control disease, improve health, and reduce health inequality

between and within countries, it is imperative that more nations and the most relevant stakeholder groups have a voice in setting the agenda.

No more ‘money for power’

A first step would be to dismantle the underlying principle of ‘more money, more power’ in global health governance. The allocation of votes equitably between donors and implementers is the first key step that some multilateral institutions still need to take to rebalance power. An even more progressive approach, as suggested above, is to ensure equal representation of all those engaged in achieving the goals of the institution – recognising a mix of factors such as financial and programmatic contributions, programmatic and policy expertise, level of affectedness by the issue. As global health multilaterals and financing institutions evolve, it will be important that their governance does not simply mirror existing economic and political power structures in the world, which privilege those with the most money or political leverage. Global health governance must increasingly embody the concept of leave no one behind, breaking down rather than reinforcing power inequalities.

It should be expected that the high-income countries with whom power is most concentrated today will resist any movement toward diminishing their power. There is a risk that in a context of waning political support for ODA, diminished power may be used as justification to reduce aid among some donors. No doubt there will therefore be fear among global health multilateral staff that any change to governance might risk their funding. On the other hand, should the impetus to disengage from ODA precede such restructuring, it may become imperative that governance be reorganized anyway. Either way, there is a strong case to be made for a shift towards an ever more equal representation among all stakeholders.



Questions

- What would a fair representation and balance of key stakeholders look like in global health governance and how would this vary between global health financing institutions, normative guidance and technical agencies and other bodies?
- Could extending greater power through representation and voting in global health governance to more state and non-state actors be accompanied by greater expectations for their contributions, both financially and politically, in global health? What could civil society stand to lose or gain in this scenario?
- Given the significant shifts in the political stance and values of existing powerful global health governance players and the possible shift in values and tone that might accompany a rethinking of the makeup of global health multilateral Boards, how do we ensure that human rights and democratic inclusion continue to be central to the global health architecture?
- How do we ensure that civil society participation and human rights values are secured in the processes of the potential reforms in the global health institutions?

PRINCIPLE 5: CIVIL SOCIETY AND COMMUNITIES MUST BE MEANINGFULLY ENGAGED, HAVE REAL POWER IN GLOBAL HEALTH GOVERNANCE

Engagement of communities and civil society in decision-making processes is not only the right thing to do, it has positive impacts on governance and programming in health. As highlighted by UNAIDS and Stop AIDS Alliance in *Communities Deliver*: “Community action translates into results. It can achieve improved health outcomes, mobilize demand for services, support health systems strengthening, mobilize political leadership, change social attitudes and norms, and create an enabling environment that promotes equal access.”⁴⁷ The UNAIDS PCB NGO Delegation’s thematic paper further highlights,⁴⁸ the global consensus on the imperative to fund community engagement in the response to HIV, and more broadly, is demonstrated in a number of political declarations and other high-level research and strategy documents.^{49,50,51,52,53} While those documents describe the impact of community involvement at local levels, the same principles hold at the governance level.

In addition to the widespread agreement on the importance of community engagement in HIV responses, the role of advocacy which is led by civil society organizations and communities has also been determined to have immense power to shape the response to HIV at many levels. In their 2016 paper, *Investing in Community Responses*,⁵⁴ ICASO and ARASA make the case that non-service-delivery community responses have been shown to be effective, and will have at least one of three impacts: networks and linkages, advocacy and influence, and monitoring and accountability. Civil society participation in health governance is mostly about advocacy and influence, and monitoring and accountability.

At the global health governance level, the engagement of civil society also has powerful impacts for good. As Kelley Lee describes in her work on the role of civil society organizations in global health governance, “CSOs are accepted as playing a critical watchdog role, ensuring that formally mandated governmental institutions fulfil their responsibilities appropriately, and keeping a

watchful eye on corporate actors exerting undue influence or engaging in health harming activities.” She further highlights that civil society actors’ biggest impacts have traditionally been related to the, “initiating, formulating and implementing,” of formal rules in global health governance.⁵⁵ While civil society is typically without financial leverage or enforcement powers, it has a critical role in advocating for sound policies that account for the grassroots realities often overlooked by governmental or corporate decision-makers.

How are the key global health architecture players engaging civil society and communities at a governance level?

Among the six key players in the global health architecture for HIV, there are a range of approaches and degrees of civil society and community engagement at the governance level. The Global Fund and Unitaid have the strongest mechanisms and policies for civil society engagement, with permanent voting power on their Boards and programmes and staff dedicated to engagement. The World Bank and PEPFAR have the weakest mechanisms for engagement, as in they only seek engagement of communities on an ad hoc and consultative basis and afford no voting power. The table on the next page compares the different approaches to engaging civil society among the six key players and other global health institutions.

How do the key international global health architecture institutions engage civil society and communities beyond governance structures?

UNAIDS was the first United Nations programme to have formal civil society representation on its governing body and the role of NGOs is regarded as “critical for the effective inclusion of community voices in the key global policy forum for AIDS”.⁵⁶ NGOs include “local, national, regional and international NGOs, networks of people living with HIV, AIDS service organizations, community-based organizations, AIDS activist organizations, faith-based organizations, and networks or coalitions of AIDS organizations”.⁵⁷ Beyond its governance structure, UNAIDS engages civil society by supporting

Table 2. Institution engagement models

Institution	Permanent governance representation	Voting power
Global Fund	Three constituencies (Communities, Developed Country NGO and Developing Country NGO)	Each constituency has 1 vote
Unitaid	Two delegations of relevant civil society networks (NGOs and communities living with the diseases)	Each constituency has 1 vote
GAVI	One representative of civil society	Each constituency has 1 vote
UNAIDS (Programme Coordinating Board)	Five regional (Africa; Asia/Pacific; Europe, Latin America/Caribbean; and North America) NGO representatives	All seats are non-voting N/A
WHO	N/A	N/A
World Bank	N/A	N/A
PEPFAR	N/A	N/A
Global Financing Facility (Trust Fund Committee)	N/A	N/A
UHC2030	Three seats for civil society for global, national and grassroots organizations	N/A

community-based responses through a variety of mechanisms (convening governments, civil society and donors to develop plans, strategies and programmes; supporting the development, implementation and monitoring of community service delivery programmes; facilitating civil society coordination and advocating for the meaningful and inclusive engagement of communities at all levels of the global response). The UNAIDS Secretariat has also helped mobilise US\$21 from the US Government for civil society through the Robert Carr civil society networks fund, faith-based organizations and the Elton John AIDS Foundation.⁵⁸

The Global Fund and Unitaid both recognize the importance of community representation, distinct from the perspectives of NGOs with separate civil society representation at the governance level. Beyond governance structures, the Global Fund recognizes that “community groups are also part of the broader civil society” but refers to communities and civil society separately, acknowledging that “it was the grassroots efforts of thousands of community and civil society groups around the

world advocating for increased resources for the response to HIV that led to the creation of the Global Fund in 2002”.⁵⁹ Communities and civil society are engaged at a country level through membership in the CCM, at a local level as implementers of grants and advocating on a more political level as part of fundraising efforts with governments and advocating for human rights, gender, inclusion of key populations and community systems strengthening.⁶⁰

Unitaid’s broader civil society engagement plan refers to civil society as being “critical in catalyzing and shaping national, regional and global interventions successfully to mobilize donors and decision-makers to fund and scale-up the global response against HIV/AIDS, TB and malaria”, including both communities and NGOs in their engagement. This plan sets out key principles (including the sharing of information, enhancing accountability and providing feedback on Unitaid projects, strengthening dialogue with civil society networks on Unitaid projects and catalyzing input in strategic directions) in recognition that civil society has “a unique ability to interact with communities affected by HIV, TB

What does meaningful engagement look like?

In its 2017 report, the Community Leadership and Action Collaborative (CLAC) ⁶¹ described four core principles for strengthening community engagement in certain Global Fund processes but are relevant guideposts for civil society engagement across the global health architecture.

1. Effective and proportional representation in planning and decision-making bodies and processes.
2. Adequate time and resource allocation to communities to understand systems, derive shared priorities, contribute to debate and discussion, and deliver programmes
3. Ongoing independent oversight of grant negotiations and implementation
4. Ongoing efforts to strengthen the capacities of community organizations and community leaders, so that they are able to take on increasing responsibilities and have greater impact

and malaria, to react quickly to their needs, and to engage with affected and vulnerable groups".⁶²

At the WHO, civil society has no permanent representation at a governance level but the WHO-Civil Society Task Team established in 2018 set out to establish actions that can be taken at a global, regional and country level that can strengthen engagement with civil society organizations defined as "non-profit entities that bring people together around shared issues, without state or business interests. Ranging from community-based organizations to research institutions, CSOs play a variety of roles, such as knowledge generation, policy input and guidance, advocacy, and implementation, and actively support vulnerable and hard-to-reach populations." The potential of the task force and their recommendations are discussed later in the paper.

PEPFAR engages civil society informally through the COP process but does not recognize the distinct

role of community and civil society organizations within their programming and planning work and their critical contribution to advocacy and service delivery. This engagement includes "smaller, local, Key Population-led civil society and community groups to gather community input and feedback".⁶³

The World Bank defines civil society as "the wide array of non-governmental and not for profit organizations that have a presence in public life, express the interests and values of their members and others, based on ethical, cultural, political, scientific, religious or philanthropic considerations"⁶⁴ and engages through policy dialogue and consultations as well as operational collaboration and institutional partnerships but civil society are not represented at the Board.

The following are recommended actions for how to practically ensure meaningful engagement of civil society and communities at a governance level.

Ensure permanent civil society & community constituencies at the governance level, which can feed up to dedicated Board Members

Having a permanent role for key civil society constituencies within governance structures is critical. It allows the civil society representatives and their constituencies to conduct long-term planning and advocacy to maximize their impact at the Board level. A permanent role far exceeds a consultative role in that it allows for communication between representatives and the communities they are expected to represent, and vests the civil society representatives with the ability to observe and influence decisions over time, as an institution evolves, rather than only being able to inform discussions or decisions in an ad hoc manner – when the institution picks and chooses. Permanent representation allows for civil society representatives to develop and strengthen their abilities to navigate and influence governance bodies and develop stronger relationships with colleagues facilitating greater understanding and coordination between what are often competing priorities. The Global Fund model of constituencies represented by voting Board Members is currently

the best practice in the global health architecture. As the architecture evolves, it will be essential that communities and civil society have secure formal roles in agenda-setting and decision-making.

 **Grant permanent voting power to civil society & communities across the global health architecture**

Building on the permanent inclusion of civil society and community constituencies on all governing bodies in the global health architecture, it will be important to ensure that these constituencies have voting power on par with donor and implementer governments and other non-state actors. The Global Fund and Unitaid currently both do this. Voting rights invests real power in communities to hold institutions accountable. At the Global Fund, the bloc of three civil society delegations are one vote shy of mobilizing a blocking minority (veto) of any decision to be taken by the Board and, while rarely ever used, it means that the voice of civil society is strongly heard and compromise more eagerly sought where there are areas of significant disagreement.

Without voting rights, it is impossible to block Board decisions, or to force further discussion when needed. Even in cases where the civil society bloc is unable to muster a veto to a decision, the ability to formally register dissent, through a 'no' vote has important political value. For example, if a pattern can be observed in which civil society is regularly in the dissent, then the issue of prevailing norms within the Board can be raised. Furthermore, if an unfavorable policy or decision is adopted by a Board in spite of civil society opposition, the civil society representatives can demonstrate their opposition clearly to their constituents. This is an important tool in retaining legitimacy in a context of unfavorable decisions.

Importantly, yet often overlooked, equal voting rights promote collegiality among the representatives of various stakeholder groups. It allows civil society representatives to approach and dialogue with government representatives on an equal footing. This can promote a process by which government representatives may need to court the support of civil society for certain policies,

rather than it always being the other way around. Having voting power means having real leverage in negotiations, and it is critical that civil society has leverage in the global health architecture.

 **Fund civil society & community representatives' engagement on Boards and with constituents**

In addition to enfranchisement, civil society and communities must be more capacitated in its existing governance roles. This means that representatives must be provided with the resources to adequately carry out their responsibilities as governance officials. They are often responsible for representing expansive, dispersed constituencies, with minimal formal mechanisms to solicit input from them and communicate decisions back. They need financial resources to support the costs of meeting with, communicating with, and seeking the approval of their global constituencies, so they can be legitimate and effective representatives.

Increased funding for civil society representatives to multilateral Boards could also allow representatives to devote more time and capacity to their roles recognizing that most representatives also have full time jobs in addition to their role as Board Members. Experience has shown that individuals who typically fill the role of civil society or community Board Member tend to not be in a dedicated full-time role focused on the Global Fund within their home organizations. Rather, they tend to be the executive leader of their organizations and so have to carve out time for their global health multilateral Board role on top of their existing busy organizational leadership role.

In a Global Fund context, the Communities, Developing Country NGO, and Developed Country NGO delegations have each been supported directly by the Global Fund, and often by external donors. Similar mechanisms are in place for the Unitaid civil society delegations. These Global Fund delegations have modest budgets ranging from \$100,000 - \$300,000 to facilitate the business of the delegations (but not to support the salary of the member), in addition to the communication staff support they each receive. A significant portion

of this funding from private foundations is set to expire shortly. Alternate funding must be identified to support the civil society delegations to the Global Fund and other multilaterals for the foreseeable future. In lieu of outside funding, the institutions themselves should ensure adequate funding for the operations of the civil society delegations.

It is important to highlight however that funding for civil society representatives is solely to support their full engagement and participation as governance officials. There are two additional clarifications, based on experience of civil society representatives, it is important to make. The first is that multilateral institutions must not confuse the voluntary governance role and the normal paid work that a civil society representative might perform, particularly if both are in relation to the institution. Secondly, multilateral institutions must not ask civil society representatives to do things they would not equally ask of a donor or implementer government representatives.

Promising direction

WHO-CSO Task Team

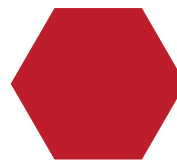
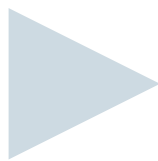
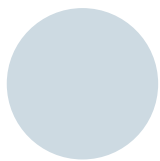
In 2017 the WHO embarked on a process to define and operationalize stronger partnerships with civil society organizations. It formed a joint WHO-CSO Task Team which, through a global consultative process, identified opportunities to, “deepen, systematize, and capitalize on WHO’s partnerships with CSOs.” The Task Team released their recommendations emanating from its work in November 2018. The recommendations fall into two categories: mechanisms for collaboration within WHO’s General Programme of Work and addressing the system-level barriers to WHO-CSO engagement. Some highlights from the recommendations are as follows:

- Establish an ‘Inclusivity Advisory and Oversight Group’
- Build in explicit, accessible opportunities for CSOs to provide input into policies and governance at all levels.
- Launch an online platform to track and share collaboration with a range of CSOs

In addition to these internal recommendations, the Task Team articulates recommendations for CSOs and for member states. Apart from UNAIDS, many UN bodies fail to adequately engage civil society, and none include civil society or other non-state actors as equal voting participants in decision-making. This effort represents an important step in the right direction for WHO, and other institutions, particularly other UN bodies, should consider adapting it for themselves. Readers are encouraged to learn more about the effort and engage where appropriate.⁶⁴

Questions

- What would meaningful civil society and community engagement across the global health architecture look like? Are permanent representation, voting rights, and adequate resourcing the key components of meaningful civil society and community engagement? What’s missing?
- Is the HIV sector civil society in a position to fully engage and provide experience-based thought leadership in the cultivation of a global civil society movement for UHC? On what basis could it provide that leadership? Which other sectors should play a leadership role in this regard?
- What are the particular complications of civil society playing a more equal role in global health governance within UN bodies and how should they be overcome?
- How can we best address safety and security related risks for individual activists upon their return to home countries after making statements in the global fora?



4. CONCLUSION

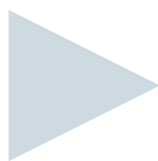
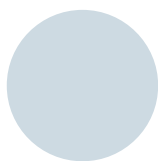
We are shifting to a new UHC era. This shift is occurring in a world of changing political and economic realities and divided opinions of and approaches to ODA. We are also increasingly seeing the governance of these institutions and even sometimes their very existence being challenged. The global health architecture will adapt in light of these pressures and trends and it is critical that civil society are ready not just to react to proposals but also to identify and promote their own.

We have outlined five suggested key principles for re-imagining the global health architecture that seek to shift and re-allocate power and introduce new mechanisms and approaches for greater financial sustainability and overall impact. The chief reason to reallocate power and reimagine the global health architecture is to ensure that the UHC-era is grounded in governance and financing frameworks that reflect the modern context, in which middle-income and low-income countries are more invested in their health responses and global multilateral and bilateral donors provide a steadily-changing mix of support that effectively responds to the particular context and needs of each country. Just as the current arrangement of the global health architecture was fit for purpose

at the turn of the century, this new arrangement would be more responsive to the conditions we face today and into the foreseeable future.

Our hope is that civil society is empowered to raise key questions about, and put forward important principles for, the global health architecture of tomorrow. It is in our interest to ensure that the global health architecture is more inclusive of and responsive to implementers and communities in need (wherever they are). We must help ensure that the transition to and architecture for UHC is built on the aims of the SDGs and the lessons learned from 20 years of world-historic levels of investment in disease-specific approaches.

The choice is clear: Keep on with business-as-usual and we will not get to the finish line with HIV or UHC or take concrete steps to change course and give the world a chance to reach the UN target of ending AIDS by 2030 and achieve universal health coverage. The time is now for a radical evidence-based reimagining of the global health architecture for our times, for all people.



5. NEXT STEPS

The principles suggested in this paper are accompanied by key questions (in boxes) and we encourage civil society to reflect and further build on these suggested principles.

A number of the current global health institutions are now, or will be in the near future, undergoing reviews of their governance structures and processes. It is therefore especially important that civil society and other actors are prepared to ask challenging questions and assert a set of principles that must guide their development. Therefore, we particularly encourage civil society and community representatives in all global health institutions to consult with their delegations and broader communities they represent on these principles, answer the key questions raised and

proactively engage with their institutions to achieve progressive change. We also hope that as these discussions happen, civil society and community representatives will share the results with the broader civil society and community sector so that we might learn from and build on each other's good work.

There are many opportunities now to start these discussions and there will be many in the future. We have set up a web page to facilitate sharing these key opportunities, ideas for further action and your reflections on both the principles and questions in this paper:

<https://stopaids.org.uk/resources/global-health-architecture/>



ANNEX 1: BACKGROUND AND METHODOLOGY, AND ACKNOWLEDGEMENTS

This paper was developed by a working group comprised of representatives from several civil society organizations: Mike Podmore, Courtenay Howe & Alys Remtulla (STOPAIDS), Javier Luis Hourcade Bellocq & Rico Gustav (Civil Society Sustainability Network), Arben Fetai & David Ruiz (Aidsfonds), Olga Golichenko & Revanta Dharmarajah (Frontline AIDS) and the Partnership to Inspire, Transform and Connect the HIV Response, PITCH programme. The working group embarked on this paper in an attempt to contribute to the discourse on evolving the global health architecture for HIV from a civil society perspective. The research was conducted by an independent consultant (Charlie Baran) based in the US. The writing of the paper was conducted by the independent consultant and working group members.

The research for this paper included a literature review which focused on documents produced by civil society organizations, academic groups, and global health and policy institutions such as the UN. Additionally, interviews were conducted with people well-positioned to comment on the past and

future of the global health architecture and HIV response. Further, an online survey was deployed to collect input from a wider range of individuals with whom personal interviews were unable to be conducted. The statements and reflections put forth in this paper are presented as a synthesis of these inputs along with the independent analysis of the author and working group. Unless directly quoted, the sentiments contained in this paper do not reflect the opinions of any single persons interviewed or otherwise consulted for this purpose.

A draft version of the paper was shared with civil society, community and academic colleagues who are involved in the governance of global health institutions for their initial feedback on the structure of the paper and we would like to thank our colleagues for their comments and feedback.

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