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Commentary

The impact of UN high-level meetings on global health priorities

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ABSTRACT

This review provides an analytic overview of the influence of the health-related United Nations General Assembly High-level Meetings on HIV/AIDS, non-communicable diseases, antimicrobial resistance, tuberculosis and Universal Health Coverage. We consider the temporal association between High-Level Meetings and changes in the global health funding landscape and national financial and programmatic commitments, in order to understand whether global prioritization of selected health issues leads to domestic prioritization and action. Whilst some High-Level Meetings do appear to have galvanized support, funding, and domestic action, this is not always the case. To maximise the value of these meetings, health advocates should view them as a powerful means rather than an end in themselves.
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1. Background: the proliferation of UN high-level meetings

Over the last two decades, several health challenges have been prioritized on the global agenda through 'High-Level Meetings' (HLMs) at the United Nations General Assembly (UNGA). In 2001, a 'special session' - the first of its kind - was called by UN member states to address the social, economic and political determinants of HIV/AIDS. The outcome was a 'Declaration of Commitment' [1] which established a key framework for stakeholder engagement and set time-bound commitments [2] and reporting mechanisms that have been strengthened through subsequent UN HLMs on HIV/AIDS in 2006, 2011, 2016, and 2021. The political and financial commitments following the meetings were substantial; leading to the establishment of several international bodies and innovative financing mechanisms, increased national resource allocation, as well as a significant decline in the burden of disease [3].

The original HIV/AIDS special session and the subsequent HLMs set a precedent where heads of state convened at the UNGA to discuss one specific global health issue. Since 2011, five further high-level meetings have been held during UN General Assembly sessions: on non-communicable diseases (NCDs) in 2011 (followed by meetings in 2014 and 2018) [4–6]; Ebola in 2014; antimicrobial resistance (AMR) in 2016 (followed by meetings in 2019 and 2021) [7]; tuberculosis (TB) in 2018 [8]; and more recently on Universal Health Coverage (UHC) in 2019 [9]. Three further high-level meetings are planned for 2023 alone.

The perceived impact of the initial HLMs on the prioritization and funding of HIV/AIDS at both global and national levels may explain the proliferation of similar meetings for other health issues over the past 15 years. This short editorial considers how funding and political commitment has changed for NCDs, TB, UHC, and AMR in the years that followed their initial HLM; the level of international and institutional engagement with each HLM; and the reporting mechanisms for each area.

1.1. Association between high-level meetings and funding commitments from major donors

While health spending overall has increased over the past 20 years, the composition of development assistance for health (DAH), prepaid private health spending, out-of-pocket spending, and government health spending has changed relatively little since 1995 [10]. Donor governments and institutions often indirectly distort and set the priorities of low-income countries through inflexible funding and allocation parameters [11]. The overall allocation by health area through DAH has changed very little despite the more recent prioritization process of NCDs, AMR and TB through the high-level meetings, and does not correlate with the burden of disease. While NCDs account for 80% of the disease burden, HIV remains the best funded area, with the United States as the largest donor, channelling funds through the Global Fund, the US, and various non-governmental organisations [10]. While AMR funding increased between 2010 and 2015, recent estimates suggest that funding has declined since 2015. NCDs exhibit the greatest disparity between epidemiological burden and funding allocation, and this pattern holds irrespective of the funder [12,13].

Policymakers seem to have inferred a causal relationship between the first HIV/AIDS HLM and the subsequent rise in funding for this area. Indeed, DAH for HIV/AIDS and TB from each of the six largest donors rose following the first UN HLMs, except for Canada which reduced its funding for TB between 2015 and 2019. Following the 2011 UN HLM on NCDs, funding decreased from Australia and France, while Canada and the US levels remained static, and contributions increased from Germany and the UK. It is not possible to assess changes in allocations to AMR as a whole, but there was a significant rise in the allocation to AMR between

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2015 and 2020 within "malaria" and "other infectious disease" areas and a decline in HIV/AIDS and TB AMR allocation [10]. Whilst HLMs are certainly high-profile, it is not possible to quantify the proportion of changes in funding that are attributable to HLMs based on observational data alone. If anything, the available pre-post data suggest that holding a HLM is not associated with financial prioritization.

1.2. Political engagement

Participation at the first UNGA Special Session was historic, including 12 Presidents, 11 Prime Ministers, four Secretaries of State, two Ambassadors, and 86 Ministers, with 260 interventions recorded. Subsequent meetings in 2006, 2011, and 2016, saw 114 interventions, 25 interventions, and 57 interventions, respectively. A total of 27 countries made interventions across all four HIV/AIDS High-Level Meetings, and Saint Kitts and Nevis was the only country whose Head of State made interventions at all four meetings. A 2007 report for Saint Kitts and Nevis indicates that the HIV/AIDS response in the period following the UNGASS was strong with a Regional Strategic Partnership on AIDS, a National Strategic Plan, and World Bank and GFTAM funds for implementation [14].

In addition to the institutionalizing of HIV/AIDs through the establishment of UNAIDS in 1996 as the result of a resolution passed by the UN Economic and Social Council (ECOSOC) [15,16], the Global Fund to Fight AIDS, Tuberculosis and Malaria was also created, launched by the G7 to provide a strong and dedicated financing mechanism, which still largely dominates funding flows [17].

HIV/AIDS had risen as a priority in part through strong civil society advocacy mainly in the United States and inclusion in the Millennium Development Goals. NCDs on the other hand, while supported by WHO, lacked the strong interagency and civil society backing of HIV/AIDS. The call for an NCD High-Level Meeting was led by a coalition of 15 Caribbean countries who, impacted by the rising rate of NCDs, had already launched an 'NCD Health Initiative' in 1986 [18]. Jamaica played a pivotal role both as a member of this championing 'CARICOM' community and as a co-facilitator during the 2011 and 2014 UNGA HLMs. Additionally, despite CARICOM making interventions on behalf of the community at 2011, 2014, and 2018 HLMs, Jamaica made distinct interventions during the three events through their Minister of Health. Despite strong political commitment and prioritization nationally and global leadership and advocacy internationally, the proportion of WHO-recommended NCD policies that are fully implemented in Jamaica has actually been falling over time [19].

TB has been part of national health programmes for decades (see Box 1). Its institutionalization long before the MDGs and SDGs led to a strong collective voice that maintained a presence and ensured strong health infrastructure. National TB Programme Managers from around the globe have met annually about their National TB Programmes, and have dedicated funding mechanisms and strong targets that have created sustainable channels for financing.

South Africa and Indonesia formed part of the Initiative sponsoring the TB HLM, while the Russian Federation hosted the precursor Ministerial Meeting on TB in Moscow in 2017. At the HLM, interventions made by senior health or government officials were limited to the Minister of Health of the Russian Federation, South Africa, Indonesia, Georgia, and Antigua and Barbuda, as well as the First Ladies of Nigeria and China.

Over the past two decades, the call for AMR prioritization has come strongly from the European Union, particularly Sweden and the UK, who have built a strong community of support among the G7 and G20 countries [21]. The G7 is a pivotal platform for health and development financing, as it includes key donor countries including Canada, France, Germany, Italy, Japan, the UK, and the United States and it has already launched funding initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. G7 statements from 2014 to 2021 indicate strong support for AMR, which is mentioned annually in comparison to the other health areas which are only referred to sporadically [22]. The Global Action Plan on AMR was published in 2015, with all G7 countries having developed specific policies to tackle AMR in the human and animal sectors and many involved in a series of bilateral or multilateral initiatives [23]. While the resolution for the UN High-Level Meeting itself was brought forward by the Foreign Policy and Global Health Initiative, AMR also had strong support through a UN partnership called 'the Tripartite', consisting of the WHO, the Food and Agriculture Organization and the World Organization for Animal Health [24].

Box 1
Tuberculosis Prevention and Control

As a leading cause of death, TB has been institutionalized within national health ministries for decades – Zambia has had a National TB Programme since 1968. The reduction in incidence during the 1980s saw the removal of funding, the rise of HIV/AIDs infections, and the recognition that co-infection between the diseases was significantly impacting public health. In 1993, TB was declared a global emergency by WHO and the Global TB Programme was established. The global architecture put in place a strategic and technical framework that committed governments to basic management, case detection, standardized reporting, and uninterrupted supplies of anti-TB medicines. Supporting this implementation were National TB Programme Managers who further institutionalized National TB Programmes, funding, and reporting frameworks [20].

Four countries made recorded interventions during all three High-Level AMR events, including the Philippines, the Russian Federation, the United Kingdom, and the United States. Additionally, Sweden has been noted as a long-term advocate of AMR. All five countries have a national action plan available online, apart from the Russian Federation.

Despite inclusion in the SDGs, high-level advocacy for UHC has been weak until very recently. There were multiple failed attempts to hold a High-Level Meeting for UHC in the early 2010s, including a resolution brought forward by France in 2012 [25]. However, it was not until a Global Action Plan was developed with 13 supporting agencies in 2018 that a resolution led by Japan was finally approved and presented by the Global Health and Foreign Policy Initiative [26].

All the countries that engaged in the resolution process for UHC made interventions at the 2019 UHC High-Level Meeting, apart from Georgia. Japan was the only country where an intervention was made by a head of state. Japan also hosted the first "International Conference on UHC in the New Development Era" in 2017, prior to taking on the G7 Presidency in 2018.

1.3. Accountability and reporting mechanisms

One feature that sets the UNGA meetings on HIV/AIDS apart from other areas is that the annual UN General Assembly agenda has a standing agenda line item entitled "Implementation of the Declaration of Commitment on HIV/AIDS" sitting under "Promotion of sustained economic growth and sustainable development in

accordance with the relevant resolutions of the General Assembly and recent United Nations Conferences". This cements action on HIV/AIDS as a core component of sustained economic growth and sustainable development and ensures that progress is reviewed every year. This reporting requirement helps to sustain dedicated staff, budgets, and institutions for HIV/AIDs at the country level. NCDs, AMR, TB and UHC do not have equivalent standing agenda items.

2. Conclusions

This paper set out to provide a broad overview of how High-Level Meetings have proliferated and related to shifts in funding and political action. Whilst these meetings have arguably galvanized conversation and awareness around each of the health focus areas and established frameworks for action, they are not necessarily tied to predictable rises in funding or political commitments, especially at the national level. It is challenging to quantify the impact of these meetings, especially given the fact that the meetings themselves have been instigated because of rising political prioritization.

Our review of funding commitment data from major donors suggests that HLMs are not associated with large or predictable increases in funding from major donors. Political commitment to the HLMs has varied significantly, as has the groupings of countries that have spearheaded each meeting. HIV/AIDs has attracted a disproportionate amount of political and financial prioritization.

Both HIV/AIDS and AMR were issues that were strongly supported by the G7 and other major donor countries. NCDs on the other hand had strong backing from the Caribbean community and the Russian Federation, with WHO continuing to be one of the primary channels of funding for this health area. Due to its lack of inclusion in the Millennium Development Goals, the UN High-Level Meeting on NCDs did make the case for these conditions as a development priority and therefore paved the way for a target in the Sustainable Development Goals. The same could be said for the HLM on AMR, as AMR had an indicator retroactively included in the SDGs in 2020 [27]. The engagement of 'champions' in the lead-up to the HLM, for example, Japan in the case of UHC prior to its G7 presidency, safeguarded a minimum level of major donor engagement during the HLM, although the evidence is lacking to demonstrate that HLMs with champion countries secure greater financial or political commitments.

Whilst simply holding a meeting does not automatically lead to a rise in international spending or domestic commitments, HLMs can play an important role in convening national and international leaders, elevating awareness, and catalysing engagement. Adding standing agenda items for reporting progress in tackling NCDs, AMR, TB amd UHC would afford these issues a commensurate level of political accountability as HIV/AIDS. Future HLMs could focus on a broader range of global health issues, such as climate change.

Future research should apply robust quantitative methods such as interrupted time series analyses to accurately quantify the temporal relationship between HLMs and funding and specific political commitments. Given that High-Level Meetings have become a fixture within the global health architecture and do not seem likely to disappear in the near future, it is important that their value is maximized. HLM outputs should be aligned with concrete national plans, and reporting mechanisms should feature prominently in the UNGA agenda. Our broad review suggests that countries, health advocates, and civil society should not view the establishment of a HLM as an end in itself but as important means to securing deeper commitments.

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The authors alone are responsible for the views expressed in this article and they do not necessarily represent the decisions, policy or views of the World Health Organization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

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Svetlana Akselrod
World Health Organization Global NCD Platform, WHO Headquarters, Avenue Appia, Geneva, Switzerland

Téa Collins*
World Health Organization Global NCD Platform, WHO Headquarters, Avenue Appia, Geneva, Switzerland

Daria Berlina
World Health Organization Global NCD Platform, WHO Headquarters, Avenue Appia, Geneva, Switzerland

Luke N. Allen
World Health Organization Global NCD Platform, WHO Headquarters, Avenue Appia, Geneva, Switzerland

* Corresponding author.
E-mail address: collinst@who.int (T. Collins).

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