The One-stop Clinic and Key Responses to AIDS of the United Nations System

Case Study and Brief Institutional Analyses

Martin Choo, MMedSc and Jackline Okinyi, BA
This case study and corresponding institutional analysis is the result of a peer-led study of people living with HIV commissioned by UN Plus in September 2015. The principal researcher who designed the study and produced this paper is trained in sociology and medical science research in public health, is a board member of the Global Network of People Living with HIV (GNP+) and a community representative on three WHO Guidelines Development Groups for the 2015 ARV Clinical Guidelines, 2015 Consolidated Guidelines for HIV Testing Services, and 2016 HIV Self-Testing Guidelines. The research associate who coordinated the study and interviewed participants is a Kenyan national who used to work with UNESCO. She is currently pursuing her Master of Business Administration at the University of Nairobi. Both researcher and associate are living openly with HIV.

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For more information, please contact:
Yoshiyuki "John" Oshima
Global Coordinator UN Plus

UNAIDS
20 Avenue Appia, Geneva 1211, Switzerland

OshimaY@unaids.org
Office: +41 22 791 1048
Mobile: +41 79 103 6720
Skype: UNAIDS.oshimay
## Acronyms and abbreviations (A-M)

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Administrative Committee on Coordination</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASMC</td>
<td>After-service medical care</td>
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<td>ASHI</td>
<td>After-Service Health Insurance</td>
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<td>CBO</td>
<td>Community-Based Organisations</td>
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<td>CEB</td>
<td>United Nations System Chief Executives Board for Coordination</td>
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<td>DAH</td>
<td>Development assistance for health</td>
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<td>DFID</td>
<td>UK government Department of International Development</td>
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<td>DaO</td>
<td>Delivering as One</td>
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<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<td>GHO</td>
<td>Global Health Observatory</td>
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<td>GIPA</td>
<td>Greater Involvement of People Living with HIV and AIDS</td>
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<td>Global Fund</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
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<td>HAART</td>
<td>Highly active antiretroviral therapy</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLM</td>
<td>High-Level Meeting</td>
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<td>ICSC</td>
<td>International Civil Service Commission</td>
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<td>ICW</td>
<td>International Community of Women Living with HIV/AIDS</td>
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<td>ILO</td>
<td>International Labour Office</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>JIU</td>
<td>Joint Inspection Unit of the United Nations System</td>
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<td>JMS</td>
<td>UN Joint Medical Service</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>LSE</td>
<td>London School of Economics and Political Science</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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## Acronyms and abbreviations (N-Z)

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NASCOP</td>
<td>National AIDS, STD Control Program</td>
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<td>NEPHAK</td>
<td>National Empowerment Network of People Living With HIV and AIDS in Kenya</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>OAU</td>
<td>Organisation of African Unity</td>
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<td>OPP</td>
<td>Out-of-Pocket Payments</td>
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<td>PFA</td>
<td>Programme, Financial and Administrative Committee</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>RC</td>
<td>Resident Coordinator</td>
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<td>SDG</td>
<td>Sustainable Developmental Goal</td>
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<td>TASP</td>
<td>Treatment as prevention</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TRIPS</td>
<td>Trade-Related Aspects of Intellectual Property Rights</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UN Cares</td>
<td>The United Nations system-wide workplace programme on HIV</td>
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<td>UNCT</td>
<td>United Nations Country Team</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNESCO</td>
<td>The United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>UN-Habitat</td>
<td>United Nations Human Settlements Programme</td>
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<td>UNJMS</td>
<td>United Nations Joint Medical Service</td>
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<tr>
<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<td>UNON</td>
<td>United Nations Office at Nairobi</td>
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<td>UN Plus</td>
<td>United Nations System HIV Positive Staff Group</td>
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<td>UN system</td>
<td>United Nations System</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>World Bank</td>
<td>The World Bank Group</td>
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</table>
Table of Contents

Acronyms and abbreviations (A-M) .................................................................................................................. 3
Acronyms and abbreviations (N-Z) .................................................................................................................. 4

Executive Summary ........................................................................................................................................... 8
Overview of background and methods ........................................................................................................... 8
Closing gaps as prerequisite for equitable access to treatment ................................................................. 8
UN Kenya sets precedent for universal access in the UN ........................................................................... 8
Unity as the key lesson of the UN Kenya AIDS response ........................................................................ 9
Innovation central to an effective institutional AIDS response ............................................................... 10
Wellbeing of UN staff living with HIV has to be a key concern .............................................................. 11
Building strategic alliances for UN Plus within the UN system ............................................................. 11
Realizing noble aims centred on the collective right to health ............................................................... 12
Entrepreneurial advocacy for improved terms of recognition ............................................................... 12

Introduction .................................................................................................................................................... 13
Access to HIV treatment as prerequisite ............................................................................................... 13
Taking an institutional approach to the AIDS response ......................................................................... 14
Key institutional elements of the UN workplace for PLHIV .................................................................. 15
Situating access to ART as an institutional response ............................................................................... 16

Methodology and Methods ......................................................................................................................... 17
Scope and objectives .................................................................................................................................... 17
Sampling ....................................................................................................................................................... 17
Consent and privacy ..................................................................................................................................... 17
In-depth interviews ....................................................................................................................................... 17
Case study analysis ...................................................................................................................................... 18
Brief institutional analyses ....................................................................................................................... 18
Wellbeing assessment ............................................................................................................................... 19
Triangulation of methods and results ........................................................................................................... 19
Presentation of findings ............................................................................................................................. 20
Reviews, comments and endorsement ........................................................................................................ 20
Limitations of the study ............................................................................................................................. 20
The One-stop Clinic and Key Responses to AIDS of the United Nations System

A generalized HIV epidemic ............................................................................. 21
Multi-sectoral consultation ............................................................................... 21
The economic burden of HIV treatment .......................................................... 22
The state of public healthcare facilities ............................................................. 23

UN Kenya Responding to AIDS in the Workplace ........................................... 24
Overview of the response .................................................................................. 24
Theme 1: Taking charge of an impossible situation .......................................... 24
Theme 2: Differing by 20% is the chance of survival .......................................... 25
Theme 3: Uniting to make ART a common service ............................................ 26
Theme 4: Agreeing on the initiative is a palpable relief ...................................... 26
Theme 5: Benefitting from the service by the UN .............................................. 27
Theme 6: Waiting until it is too late for effective care ......................................... 28
Theme 7: Dying from financial hardship in lieu of HIV .................................... 30
Theme 8: Accepting uneasy truths about fairness .............................................. 31
Theme 9: Contributing to something a public good .......................................... 32

Lessons Learned from the UN Kenya AIDS Response ..................................... 34
Lesson 1: Leading by example increases credibility .......................................... 34
Lesson 2: Responding to specific needs in context .......................................... 35
Lesson 3: Prioritizing confidentiality and right to privacy .................................. 36
Lesson 4: Empowering staff key to enabling environment ................................. 37
Lesson 5: Upholding an inspirational model of itself ........................................ 38

Brief Institutional Analyses of UN Responses to AIDS .................................... 41
Purpose ............................................................................................................. 41
Institutions defined .......................................................................................... 41
Towards the collective wellbeing of people living with HIV .............................. 42
Level 1: WHO institutionalizes access to ART for public health ....................... 45
Level 2: UNON arrangement covers ART costs for local staff ......................... 48
Level 3: UNAIDS innovates by treating AIDS as exceptional ......................... 52
Level 4: UNGA situating institutional logics of access to ART ......................... 57
Level 5: UN Plus as enterprising advocacy within the UN ................................. 64
Synthesizing analyses to assess the wellbeing of PLHIV .................................. 68
Institutional Mechanism to Build Strategic Alliances ....................... 74
Establishing and situating key terminologies .................................. 74
Identifying specific needs in particular contexts ............................... 75
Engendering a collective vision ....................................................... 77
Mobilizing towards shared objectives ............................................. 77
Generating political will for policy change ...................................... 77
Improving the terms of recognition of PLHIV in the UN system .......... 78

Concluding Remarks ..................................................................... 79

Bibliography ............................................................................... 81
Journal articles, books and published reports ................................. 81
United Nations documentation ....................................................... 86
Public speeches, lectures, and press statements ............................... 87
Internet resources and websites ..................................................... 87

Appendix A: Informed Consent Script ........................................... 89

Appendix B: Modular Interview Schedule ...................................... 90
Impressions and reflections ......................................................... 90
Setting up ..................................................................................... 90
Approval ...................................................................................... 90
Funding ......................................................................................... 90
Operations .................................................................................... 91
Service recipient ........................................................................... 91
Impact .......................................................................................... 91

Appendix C: Analytical Procedures ............................................... 92
Case study analysis ....................................................................... 92
Brief institutional analyses ............................................................. 92
Synthesis ....................................................................................... 93

Appendix D: Institutional Logics Script .......................................... 94
2005: A/RES/60/1 ........................................................................ 94
2006: A/RES/60/262 ................................................................. 94
2008: A/62/780 ........................................................................... 94
2011: A/RES/65/277 .................................................................. 95
2015: A/RES/70/1 ..................................................................... 95
Executive Summary

Overview of background and methods
In 2003, the UN Country Team for Kenya agreed to provide UN staff living with HIV with 100% insurance coverage for antiretroviral treatment (ART) in a multi-agency response to AIDS in the workplace. The One-stop Clinic intervention is contextually specific and directly addresses the issue of stigma at the duty station. The fear of HIV/AIDS-related stigma had kept local staff from accessing HIV testing, treatment and care, resulting in thirty-two deaths from AIDS between 1997 and 2003. This volume recounts the case of the One-stop Clinic, lessons learned from implementing the intervention, brief institutional analyses that situates the One-stop Clinic among key interventions on AIDS by the UN, a synthesis of institutional analyses that assessed the wellbeing of UN staff living with HIV, and an explication of an institutional mechanism to build strategic alliances within the UN.

Closing gaps as prerequisite for equitable access to treatment
The cornerstone of any AIDS response is the access to HIV treatment. ART has revolutionized the AIDS response by allowing PLHIV to live productive lives by transmuting HIV infection from fatal disease to chronic illness. Although UN staff can access ART through their existing health insurance plans, there are existing gaps in insurance coverage that have been hampering access and adherence to ART, and needing urgent attention.

UN Kenya sets precedent for universal access in the UN
The One-stop Clinic remains to this day, the only service where local UN staff can walk into a first-class bespoke HIV treatment facility, and be offered treatment and services anonymously, and free at the point of entry. The idea of giving local staff the best of HIV care paid for by a common inter-agency pooled fund indicates the view of antiretroviral treatment as a common good that is deserved by all. The courage and foresight of the UN Kenya senior management team, the UN Joint Medical Service (JMS) Chief, and the Resident Coordinator, in making this service a reality at UN Kenya, and in the UN system, deserve special mention. Future generations now have a precedent on which to base equitable and fair responses to AIDS.
Unity as the key lesson of the UN Kenya AIDS response

The following five lessons learned, as derived from the case study, are as follows:

1) Leading by example increases the credibility of leaders, which is in reference to the united response by the majority of UN agencies at the Kenya duty station. In contrast, the situation of non-participating agencies has caused UN staff living with HIV in these agencies to be left with the circumstance of needing to meet the full costs of HIV treatment prior to an eventual 80% reimbursement at a later date; which burdens staff on lower salaries, as well as staff with dependents that also require healthcare. Thus leaders deciding on non-participation in the UN Kenya institutional arrangement may have eroded their credibility from the perspective of their staff.

2) The UN Kenya experience imparted the importance of contextually specific interventions in the AIDS response. For Kenya in 2003, stigma has been the major deterrent to accessing ART, which led to the One-stop Clinic providing anonymous access to treatment. The lesson therefore cautions against replicating the service elsewhere in the UN system in an uncritical manner, and recommends emulating the service in place of its replication.

3) Centred on prioritizing confidentiality and the right of UN Plus members to the privacy of their HIV status, the lesson learned comes in the form of a challenge from a case study participant. The goal for UN Plus Kenya is in managing the privacy of its members, and finding an effective solution for the provision of psychosocial support to members who have both disclosed and had not disclosed their HIV status to members of the staff association.

4) The management of UN Kenya has learned that empowering staff is key to creating an enabling environment in the workplace. A beneficiary of the One-stop Clinic recalls how management leadership has been pivotal to this beneficiary finally accessing care.

5) The overwhelming support for the UN Kenya response substantiates the concept of Delivering as One UN. This is reflected by its capacity to unite agencies in facing contingent situations affecting staff, and in delivering a viable and just solution. Furthermore, enfolding HIV treatment into common services delivery also reverses the social process of stigmatization, by reversing differentiating and distancing of PLHIV from non-HIV infected individuals, and regulating access of PLHIV to material resources.
Innovation central to an effective institutional AIDS response

Taking a step back, the research explores the bigger picture of the UN’s response to AIDS, in particular the institutional elements that have been deployed against AIDS. In five-levels, brief institutional analyses aim at situating the One-stop Clinic of the UN Kenya response to AIDS in broader perspectives by elucidating key examples of institutional responses to AIDS that originated in the UN:

1) This level focuses on the WHO and how its guidance on access to treatment from a public health approach has been key in institutionalizing access to ART by simplifying the treatment strategy. Given that it also adapted to the constraints of resource-limited settings, the process is key towards the widespread adoption of highly active antiretroviral therapy (HAART) regime.

2) This level situates the institutional arrangement initiated by UNON that not only ensures full coverage of ART costs for local staff at the Kenya duty station, but also provides anonymous access to care throughout the treatment process. The arrangement therefore addresses HIV stigma by removing patient identification, and reversing the stigmatizing process by incorporating ART as a common service paid for by agencies; indicative that ART is an essential service similar to that of utilities and security.

3) This level underscores the UNAIDS strategy to galvanize the AIDS response with the institutional innovation of treating AIDS as exceptional. The strategy is rolled out by the Executive Director with two lectures that bookend the strategy; first, as Presidential Fellow of the World Bank Group in 2003, and second, at the London School of Economics and Political Science in 2005. Besides the record funding obtained by UNAIDS with the deployment of the strategy, it also leads to widespread adoption of country coordinating and reporting mechanisms in 103 countries; all crucial to scale up global response.

4) This level situates the logics of access to HIV treatment in UN General Assembly declarations by tracing the commitments of Member States in five meetings that spanned 11 years (2005 – 2015). Following the development of institutional logics, it showed the lack of enthusiasm by Member States for universal coverage within a year of its announcement at the 2005 World Summit. The lack of support persists through the economic crisis of 2008, but reverted to overwhelming support in 2011. This support led to the achievement of getting 15 million people on treatment by 2015. Since then
there has been a perceptible shift in institutional logics from the rights centred universal access to the goal-oriented “ending of AIDS by 2030”.

5) This level focuses on the institutionally entrepreneurial prospects of UN Plus. As the association of positive UN staff lack legal status and institutional rights within the UN system, it is problematic to advocate for the rights of PLHIV in the UN system, as its lack of legal status renders its actions invisible to the system. However, its non-agency status also provides the association with the capability for independent actions, which it can operationalize by cultivating strategic alliances within the UN system for its advocacy goals.

**Wellbeing of UN staff living with HIV has to be a key concern**

Synthesizing the five levels of institutional analyses bring the perspective from the systemic level back to the group level, which allows more meaningful interpretation of the institutional analyses for UN staff living with HIV. Adapting the Capability Approach framework developed by Professor Amartya Sen, the collective wellbeing of UN staff living with HIV in the UN system is assessed in the synthesis of analyses.

Outcome of the synthesis shows that the collective wellbeing of UN staff has benefitted from the institutional responses on levels, 1, 3, and 4. At level 2, which concerns the UNON institutional arrangement, the lack of expansion of the service since its introduction 10-years previously returned an indeterminate finding on improving collective wellbeing of PLHIV. At level 5, which concerns the UN Plus institutional entrepreneurial response, the analysis could not be completed, as the final outcome would always depend on the subsequent actions of UN Plus members in mounting strategic responses; thus the synthesis entailed an indeterminate result.

**Building strategic alliances for UN Plus within the UN system**

From the results of the case study and brief institutional analyses, the study provide concrete actionable suggestions in the form of an (informal) institutional mechanism of building strategic alliances that will be crucial for UN Plus and staff living with HIV in seeking to mount any response to AIDS within the UN. From the UN Kenya experience in mounting an effective AIDS response, four distinct phases of the informal institutional mechanism have been identified; beginning with contextualizing actual needs, followed by three main steps that form the contour of the mechanism, which are non-sequential, and would have been invisible given the non-codification of
informal mechanisms. Once elucidated, the mechanism will become formalized, and operationalized. These steps are,

- Engendering a collective vision among members of UN Plus in particular, and UN staff living with HIV more generally;
- Concentrating the mobilization towards shared perspectives between staff living with HIV and UN agencies located in duty stations; and
- Generating political will for policy change within duty stations of the UN system through cost-benefit analysis that includes indirect and direct benefits.

**Realizing noble aims centred on the collective right to health**

At systemic levels, institutions matter, as extensions of the collective human will. UN institutions, in particular, reflect not only the collectives of peoples, they generate the spaces where collectives can coordinate and facilitate inter-group functionings. In other words, institutions are not only instrumental to human realities; they are intrinsic to the human experience of collectives, and collective social actions. In this respect, UN institutions hold particular importance to humanity, originating at the intersection of “untold sorrow of war”, and the “dignity and worth of the human person”.

The institutions of the UN remind humanity of its determination, and the resolve to combine its efforts to achieve noble aims. Reflecting on humanity's determination and resolve as the UN General Assembly prepares to meet for the High-Level Meeting on HIV/AIDS in June 2016, offers a realization that is pregnant with expectations: Although the focus will be on Member States and their collective will to bring forth the reality of an AIDS-free generation, it is emphatic for the vision to be rooted in human rights, solidarity and equanimity of all people living with HIV.

**Entrepreneurial advocacy for improved terms of recognition**

As Member States of the UN General Assembly contemplate their collective commitment in response to the AIDS epidemic, so should the PLHIV collectives of the UN system; reflecting on UN staff infected with HIV that have not been reached with HIV testing, treatment and care; and deprived in terms of recognition. The institutional mechanism to build strategic alliances can assist UN Plus to improve the politics of recognition of PLHIV in the UN system; by propelling the association to connect strategically to forge new polities on right to health and equitable access to treatment, while accruing social value for UN staff living with HIV in the UN system.
Introduction

This research, consisting a case study and five brief institutional analyses, has two dovetailing objectives. First, it is designed to provide staff living with HIV in the United Nations (UN) System an institutional perspective on the system’s response to AIDS. Second, through lessons learned from the case study and an institutional mechanism to build strategic alliances, the research informs on possible strategies and tools available for the advocacy of AIDS responses within the UN system.

Access to HIV treatment as prerequisite

The cornerstone of any AIDS response is the access to HIV treatment. Antiretroviral treatment (ART) has revolutionized the AIDS response by allowing people living with HIV (PLHIV) to live productive lives by making HIV infection a chronic illness rather than a fatal disease. All adults infected with HIV are eligible for ART, as recommended by the World Health Organization (WHO). In addition, to optimize treatment uptake and adherence, stigma related to HIV infection needs to be addressed in a contextually specific and sensitive manner in places where ART will be provided. UN staff can access ART as part of their existing health insurance. Once staff members initiate treatment, it is important to adhere to the regimen as prescribed to ensure its efficacy.

However, there are existing gaps in insurance coverage of health care in the UN system that is currently hampering access and adherence to ART, which needs urgent attention. The recommendations made by the Joint Inspection Unit (JIU) to

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1 See WHO (2015) guidelines on the use of antiretrovirals for the treatment of HIV.
2 The WHO (2015) guidelines recommends offering ART to all adults with HIV infection regardless of the status of the patient’s immune system, which had previously guided treatment initiation.
3 Earnshaw & Chaudoir (2009) shows that in HIV uninfected individuals, HIV stigma increases social distancing from PLHIV, and decreases their support for HIV testing and HIV-related policies. In contrast, HIV stigma in PLHIV results in poorer mental health and the seeking of social support, and increases HIV symptom frequency.
4 Refer to report on the UN system medical coverage for staff (JIU/REP/2007/2).
close the gaps in coverage have so far not been consistently prioritized, such that there are few examples of the actual implementation of these recommendations.

**Taking an institutional approach to the AIDS response**

To adequately apprehend the problem of insurance coverage for ART, and to mount advocacy campaigns in the UN system, it is crucial to become acquainted with institutions within the system. Institutions in this volume are based on the sociological definition of enduring and reproducing social structures that constrain social behaviour.\(^5\) Institutional elements, on a systemic level, are therefore key instruments for leveraging human behaviour, and make up the fundamentals of AIDS responses.

Founded in 1945 after the Second World War, the UN currently represents 191 sovereign states, which entails a highly complex bureaucratic system. In 2013, the UN system is present in 184 countries, with a total of 561 duty stations. The system is made up of a multitude of institutions and institutional elements that guide, govern and constrain the behaviour of UN staff and their roles within the UN system.

Key institutional elements are the UN’s institutional mechanisms, which are the procedures in its charter. The UN system upholds the values of human rights, peaceful determination for social progress and better standards of life, and the economic and social advancement of all peoples.\(^6\) The values then get transmitted to the social world beyond the system through institutional arrangements, which are its policies and programmes that aim to produce specific patterns of social behaviour.

A key example is the Copenhagen Declaration on Social Development,\(^7\) which is the outcome of the World Summit for Social Development (1995). It is an institutional arrangement that sets out to reduce social injustice with goals to eradicate poverty, promote jobs and livelihoods, and end social seclusion. Similarly, there are also institutional arrangements working within the system; such as the policy to improve

\(^{5}\) See chapter on Brief Institutional Analyses for more details.

\(^{6}\) Articles 1 and 2 of the *Charter of the United Nations* (1945).

\(^{7}\) The declaration opens with: “For the first time in history, at the invitation of the United Nations, we gather as heads of State and Government to recognize the significance of social development and human well-being for all and to give to these goals the highest priority both now and into the twenty-first century.” (A/CONF.166/9).
the efficiency of the system called Delivering as One (DaO), which envisions better coherence between bodies across the UN system.\textsuperscript{8}

Thus, it is through its institutional elements that the UN comes to embody the values of fairness and support for the disenfranchised, and through other institutional elements that values become operationalized and exemplified by the system. It is therefore a circular loop of continuous replication, from which the stable social structures that make up the UN system are to emerge.

**Key institutional elements of the UN workplace for PLHIV**

Paying attention to the institutional elements within the UN workplace will therefore help staff living with HIV to understand the instruments they will need access to facilitate the emergence of the social structures necessary for an enabling workplace environment. The following identifies institutional elements essential for UN staff living with HIV to become acquainted with as they make up the crux of an enabling workplace environment emerging within the UN system.

The UN guarantees that no one will be discriminated because of HIV.\textsuperscript{9} To pursue this aim, the Secretary-General has made an HIV/AIDS orientation programme mandatory for all staff since 2007.\textsuperscript{10} The UN Cares workplace programme on HIV (2008) inculcates thousands of UN employees on basic knowledge about HIV and AIDS, as well as stigma related to infection and disease.\textsuperscript{11}

Workplaces in the UN should follow the ILO Code of Practice (2001) that addresses proper conduct regarding HIV in the workplace. Under the ILO Recommendation No.200 (2010), which calls for HIV workplace responses to champion social justice and to become active sites of resistance against HIV, staff motivated in HIV advocacy are encouraged to be more active in creating the enabling environment they wish to see at their workplaces.

\textsuperscript{8} See the 2010 UN General Assembly proceedings on system-wide coherence (A/64/289).
\textsuperscript{9} Refer to the UN’s workplace policy on HIV/AIDS (1991, 2003), with implementation details in Secretary-General’s Bulletin (ST/SGB/2003/18).
\textsuperscript{10} Refers to the HIV/AIDS in the Workplace Orientation Programme (ST/SGB/2007/12)
\textsuperscript{11} UN Cares website. See bibliography for access details.
For UN staff living with HIV who may have psychosocial needs, UN Plus offers linkages to HIV care and support services as well as links to a global network of people living with HIV, with whom staff can connect for information, care and support. With 210 members in 42 countries and 21 UN agencies, it is an international association with a global reach and caters to specific needs and provides pertinent advice on HIV-related issues arising any workplace throughout the UN system.

**Situating access to ART as an institutional response**

Returning to the importance of access to ART within the UN system, and taking an institutional approach rather than from the usual standpoint of the individual, different interventions appear as real possibilities.

To illustrate these possibilities at the institutional level, the research focuses on an institutional arrangement initiated by UNON in response to AIDS at the Kenya duty station. The inspirational case of the One-stop Clinic, and the lessons learned show the importance of context in actualizing institutional responses. The brief institutional analyses of elements provide insight on the UN system in the global AIDS response.

To make sense of these systems-level findings at group-level, and ensure that they resonate for UN staff living with HIV, the study employs a framework founded by Professor Amartya Sen, to assess how each institutional element that have been analyzed may be contributing to the collective wellbeing of staff living with HIV within the UN system.

In essence, the research seeks to understand how UN institutional elements have informed, constructed, and promoted the freedoms available within UN system workplaces for staff living with HIV to lead the lives they will have reason to value.

The study closes by proposing that building strategic alliances as an institutional mechanism and a instrument for UN Plus in forging ahead with an entrepreneurial AIDS advocacy strategy for the UN system.

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12 See website for UN Plus in Kenya.
13 Amartya Sen is a Nobel Laureate in Economics and currently Thomas W. Lamont University Professor, and Professor of Economics and Philosophy at Harvard University.
14 See Sen (1985) for his economic theory of capabilities.
Methodology and Methods

Scope and objectives
This case study examined a successful HIV treatment delivery service within the UN system by exploring the lessons learned in its setup and operations, and reflecting on its contribution to UN Kenya specifically, and the UN system more generally. The objectives of the study were to obtain insights on the situation underlying the genesis of the service, as well as current perspectives on the effects it has had at UN Kenya.

Sampling
The selection of potential interview participants was purposive to meet the case study objectives. In total, seven UN staff were interviewed in October and November 2015. Respondents comprised key UN Kenya management personnel including the Resident Coordinator (identified as Management 1, Management 2, and RC); two representatives from UN agencies that were not participating in the service (identified as Agency A, Agency B); the UN Plus and UN Cares Coordinator who referred staff testing HIV positive to the service (identified as Coordinator), and a beneficiary of the service (identified as Beneficiary).

Consent and privacy
Oral informed consent was sought prior to commencing interviews (Appendix A), which were audio recorded for analytical purposes. Respondents could choose to provide information anonymously during the interview to ensure their privacy. However, to ensure the confidentiality of respondents who chose anonymity, only two roles have been made attributable in the narrative as their narration made sense only by acknowledging their roles within the context of UN Kenya and the UN system; the Resident Coordinator (RC) who heads the Country Team, and the UN Plus Coordinator who refers UN staff to the service being considered (Coordinator).

In-depth interviews
In-depth interviews were semi-structured and conducted by the Research Associate. Questions were thematically organized with probes that maximized elicited
information. The UN Plus Global Coordinator made the initial contact and invited potential respondents. Individuals who had agreed to participate were scheduled for an interview by the research team. Interview questions were based on a modular interview schedule, with the final questions for each respondent differentiated in reflection of their individual experiences with the service (Appendix B). Questions were provided to respondents ahead of time, and interviews averaged 30 minutes.

Case study analysis
The analysis consisted of reviewing audio-recorded interviews by the Principal Investigator to identify opinions, perspectives and rationalizations of respondents. Key sections of interviews were transcribed in verbatim, read in detail, and coded into emerging themes. These emerging themes were systematically compared for themes (or topics) about the situation underlying the genesis of the service, and the significance of the service in UN Kenya and to the UN as lessons learned to emerge inductively. See Appendix C for details of the analytical procedures.

Brief institutional analyses
The five institutional analyses were conducted in the following sequence:

- The analysis was first conducted on the basic process of institutionalization, which is the creation of a social procedure on paper by a few actors with professional roles, supranational-level, 2-Dimensional (level 1, treatment access to ART).
- Then more sophisticated with an institutional arrangement, which was a social procedure that had been enacted by a few actors with professional roles at country-level, 3-Dimension (level 2, One-stop Clinic).
- Following that was institutional innovation, also a social procedure that has been enacted but with many actors in professional and political roles at national and supranational-levels (level 3, UNAIDS “policy”).
- Next, was the institutional logics of a sophisticated social procedure of many actors that was highly formal, and had professional and political roles at supranational-level (level 4, UN General Assembly).
- Finally, an entrepreneurial social procedure that required the linking of many actors at different occupational levels, and at country and supranational-levels, was structurally informal, had no institutional mechanisms (level 5, UN Plus).
At each level, the analytical focus depended on the type of social procedure under study. See Appendix C for details of analytical procedures, and Appendix D for the script used in the analysis of institutional logics.

**Wellbeing assessment**

The Capability Approach framework developed by Sen (1980, 1985, 1993)\(^{15}\) was adapted to assess the collective wellbeing of PLHIV, which resulted in a model to explore the contribution of the UN to PLHIV undergoing ART (Figure 3). The model is underpinned by the assumption that not undergoing ART will reduce the functionings of PLHIV over time, and diminish their collective freedoms (capabilities). The results of the brief institutional analyses were fed back to the model in synthesis, with the objective to evaluate the collective wellbeing of PLHIV in the UN system by assessing the contribution of the institutional elements that have been analyzed on UN staff undergoing ART, as well as their collective freedoms to undergo ART, within the UN system.

**Triangulation of methods and results\(^{16}\)**

Triangulation of analytical methods involved following the thread of observed events; which were grounded in an inductive emergence of themes and lessons learned from the in-depth interviews. These were interwoven with verbatim interview data to situate the conceptual frame of reference for the institutional analyses, syntheses, and the proposed institutional mechanism.

The triangulation of results followed a process of comparing findings with secondary evidence; consisting formal documents of the UN, academic literature, and formal reports. The documents also assisted in contextualizing the results and situating events and emerging themes in a temporal sequence. These were occurring at five levels of analysis, from the micro-level of institutionalizing a public health approach, to the macro-level of institutional logics and mechanisms; and with the multi-layered perspective improving analytical validity.


\(^{16}\) For a detailed description of these triangulation methods, see Moran-Ellis et al. (2006).
Presentation of findings

Jargon is kept to a minimum to maximize readability and accessibility. When jargons are necessary, they have been defined in simplest possible language, and a system of footnotes provided additional references and explanations as required. Given the density of the results chapters, an overview of the chapter precedes the presentations of the chapters’ contents.

Reviews, comments and endorsement

Each interview participant was sent a draft of this report for review and endorsement of both the findings and its conclusions before finalizing the report. Feedback and comments were addressed and incorporated into the final report before submission to UN Plus for approval and publication.

Limitations of the study

First, as a retrospective case study of an institutional arrangement initiated in 2003, recollections of situations and events could be incomplete or inaccurate. Efforts were made to detect and minimize such errors by comparing respondents’ narratives, seeking a review of findings, and triangulating analytical methods and results.

Second, as a qualitative study, case study findings were not generalizable to perceptions of all staff involved with the service, or all its beneficiaries; which would require additional quantitative research.

Third, due to time constraints, the Capability Approach framework that had been adapted for this study had not benefitted from input of UN staff living with HIV whose wellbeing it had assessed. Therefore assessments resulting from the evaluation would benefit from additional research for confirmation and to improve the framework.

Fourth, the institutional analysis relied on a small purposive sample of UN staff for empirical data on higher-order elements such as organizational norms and culture. To ensure accuracy in depicting these elements, interview data were triangulated with secondary evidence as well as previous research conducted by UN Plus.$^{17}$

$^{17}$ See Hoover (2007) and Choo (2016).

A generalized HIV epidemic

Kenya has a generalized HIV epidemic. HIV prevalence in the adult population (15 – 49 years) is at 7% (6.1 – 7.5%).\(^{(18)}\) National prevalence estimates are based on the Kenya Demographic and Health Surveys (KDHS). However, sentinel surveillance by the National AIDS and STD Control Programme (NASCOP) indicates the disease burden may be higher in urban locations including Nairobi.\(^{(19)}\) Sentinel surveillance indicated 1997 as the peak of the epidemic with a prevalence of nearly 16%.\(^{(20)}\)

Since the start of the epidemic more than one million Kenyans have died from AIDS, with an annual mortality rate of 10% among HIV-infected adults.\(^{(21)}\) In 2003, more than three in four Kenyans participating in the KDHS knew of someone who has AIDS or has died of AIDS.\(^{(22)}\) It is in this context of the Kenyan HIV epidemic that the UN Kenya response has been designed to address.

Multi-sectoral consultation

The first consultative technical meeting that contemplated the realities of introducing ART in Kenya took place in Nairobi in 2001.\(^{(23)}\) The article’s authors thought it likely to have been the first consultation of its kind in the country; with the multi-sectorial involvement including the Ministry of Health, the National AIDS Control Council (NACC), the donor community, academic establishments (also as providers of private healthcare), non-governmental organizations (NGOs) from around the country, PLHIV, and private sector representatives.\(^{(24)}\)

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\(^{(19)}\) Cheluget et al. (2006, p.i22).

\(^{(20)}\) Ibid, p.i23.

\(^{(21)}\) Ibid, p.i25.


\(^{(24)}\) Ibid.
During the meeting, the complexity of ART provision soon became apparent to participants. They needed to put competing interests aside and unite behind a common strategy. It became imperative to support the coordination to pull off treating such a complex and expensive disease.25

At the time, the government had no official treatment guidelines for HIV, nor had they decided on the structure and the treatment backbone on which treatment could be based.26 Most of the available treatment in Kenya had been provided by private healthcare facilities or small-scale research programmes.

Furthermore, the government was then struggling to effectively contain the burgeoning TB epidemic, and the possibility of an HIV-TB co-infection further increasing complications of HIV and TB treatments.27 Looking ahead, the work was daunting in both scope and detail.

### The economic burden of HIV treatment

To put these figures in perspective, at the debut of the One-stop Clinic, HIV treatment access had only reached an infinitesimal 0.1% of an estimated 2.2 million Kenyans infected with HIV, or about 2,000 PLHIV.28 The cost of HIV treatment in 2003 was still substantial even though prices of highly active antiretroviral therapy (HAART) regimes had come down by approximately 77% in March the previous year. After the price reduction, it would cost Kenyans $70 per month to be on HAART regimes instead of the prohibitive $300 per month they previously had to pay.29

A study of the economic burden of HIV at a public hospital in Nairobi in 1997 found that 42% of costs on the medical ward were associated with HIV even before the availability of treatment; and the authors were prescient in predicting that the costs of HIV-related care would overwhelm the public health system in the years to come.30

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26 Ibid.
27 Ibid.
29 Ibid, p.52. Converting to 2003 prices in local currency would cost 14,222.18 shillings per month, down from 60,952.20 shillings. In contrast, a resident physician’s average monthly income in 2002 was 14,338 shillings, see Raviola et al. (2002, p.58).
30 Refer to Guinness et al. (2002, p.905).
The state of public healthcare facilities

Public healthcare facilities in Kenya were in themselves a health hazard. Despite revenues from patient spending, public hospitals were so poorly resourced that they did not consistently stock basic medications and equipment, including basic universal protection equipment like latex gloves.31

The critical situation affected doctors as it did patients. Citing a resident physician of a public hospital in Nairobi,32

Regarding HIV/AIDS, it is impossible to go home and forget about it. Even the simplest opportunistic infections we have no drugs for. Even if we do there is only enough for a short course. It is impossible to forget about it… Just because of the numbers I am afraid of going to the floors. It is a nightmare thinking of going to see the patients. You are afraid of the risk of infection, diarrhea, urine, vomit, blood. Some people pull out their lines. Just walking in a room you think you will get TB. It is frightening to think about returning.

Making matters more acute, doctors were diverting their resources from public to private healthcare by prioritizing their patients in private facilities to the detriment of their patients in public hospitals.33

31 Raviola et al. (2002, pp.68-71).
UN Kenya Responding to AIDS in the Workplace

Overview of the response

When the One-stop Clinic began offering anonymous HIV treatment services to UN Kenya staff living with HIV in 2003, ART had yet to become easily accessible in Kenya. Once it was set up, the service would provide 120 Kenyan staff and their dependents access to HIV treatment, and the management was hopeful that the remaining 331 staff and their dependents thought also to be infected with HIV would soon come forward. The service was projected to cost UN Kenya $125,000 a year after deducting the insurance coverage available, and with treatment already subsidized by the Aga Khan Foundation.

The UN Plus chapter in Kenya began in July 2007. The Kenya association has the most number of members in comparison to other UN Plus chapters in the UN system, which is indicative of its success in mobilizing PLHIV at the Kenya duty station. The following provides the nine emerging themes from the content analysis, beginning with the genesis of the One-stop Clinic, and ending with reflections on its implementation.

Theme 1: Taking charge of an impossible situation

Recalling the situation prior to the clinic, a founding member of UN Plus chapter in Kenya related the scale of the crisis facing the UN in Kenya:

By 2003, there were thirty-two staff who had died of HIV... In the long run, the fight was [being] lost (Coordinator).

According to the Resident Coordinator who had been present during deliberations,

There was no one going to the Aga Khan [hospital] to take up the free ARVs that was allocated for the staff... We discovered that it was just the stigma...

Then it was a very difficult time. I came to Kenya... the stigma was so clear.

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36 Ibid, p.16.
37 For more information, refer to the website of UN Plus in Kenya.

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They didn't even want to touch colleagues that they suspected had HIV/AIDS... people didn't want to be slim, because being slim was associated with HIV/AIDS... And people did not talk about it. Even from a prevention perspective, there was stigma attached to it that people didn't want to talk about it... People were so afraid, that they would be attached to this, that people would find out and complete the marginalization that used to go with HIV/AIDS (RC).

Taking charge of this impossible situation, the Chief Medical Officer championed the idea of a comprehensive clinic that would be both free and anonymous at the point of entry. The Resident Coordinator described the vision,

The idea of having a separate clinic that would treat all our staff, and giving them all the support that they required... in a comprehensive way... from the ARVs to the follow up check-ups... so that when they go [there] they would feel free (RC).

**Theme 2: Differing by 20% is the chance of survival**

For beneficiaries of the clinic, the One-stop Clinic also removed the financial barriers from inadequate insurance coverage that led to poor treatment adherence of UN staff.

I was paying a lot of money, about US$1,000 a month... I was very excited. I had [already] over-utilized my cover (Beneficiary).

To put this in perspective,

Insurance was covering 80% [of the cost of treatment] and when you looked at the [remaining] 20%, the amounts were tiny compared to the effects... people were dying (Coordinator).

Recalling the key discussion,

On our side, we had to figure out how to bear the cost without taking into account who had taken what treatment. I am so happy that I was part and parcel of this conversation and discussion... and the solution that brought about the One-stop Clinic... We didn't think of it [then] but this programme is Delivering as One UN. Everybody came together, put their resources in a pot, to address common issues and common objectives (RC).

With previous experience of having had to extend her credit to pay for healthcare, the representative of a non-participating UN agency appreciated the service.
The One-stop Clinic and Key Responses to AIDS of the United Nations System

The 100% cover is an advantage, because you really don't have to…think about paying, which is a stress by itself. Imagine thinking about money, it is typically another stress… instead of improving… you are mentally incapacitated and it reduces everything… First of all, where do I get the cash to be able to meet my monthly requirements? (Agency B).

Theme 3: Uniting to make ART a common service

Unity of the majority of UN agencies to offer ART as a common service in UN Kenya legitimized support for the One-stop Clinic, as well as for UN Kenya as the common services provider. This was an achievement for the UN Country Team (UNCT) for Kenya, and a source of pride especially among local staff in Nairobi.

I am 110% behind this… it is cost effective and reasonable. I don't think there is a threat that the service will end; this is from a purely financial perspective. It is value for money… it is a very lean programme… It has got the UN Kenya name next to it… In Nairobi, we are at the forefront of common services delivery (Management 1).

Besides this, it also indicated the overwhelming support of UN agencies in efforts to link their staff living with HIV into treatment and care, which was exemplary.

The benefit of having 70+ agencies come together… it was a unanimous decision from the board and the governance structure… how easily it was accepted and embraced… There was much support behind it… there was much spirit of optimism (Management 1).

Theme 4: Agreeing on the initiative is a palpable relief

This Nairobi initiative was remarkable for the unity of support it had. In response to the HIV epidemic within UN Kenya, the UNCT for Kenya with the support of the majority of UN agencies found the political will and means to offer an exemplary 100% insurance coverage for HIV treatment services to Kenyan staff living with HIV:

The gap in staff insurance coverage [is] topped up by a pooled fund from over 70 subscribing UN agencies (Management 1).

It also dealt with potential stigma in the treatment centre with the assurance of confidentiality by employing a system of anonymous card access that was used throughout the treatment service, including the collection of prescription medication.
[The] Chief Medical Officer [at the time] assured [me] of confidentiality… "When you go there, they don't call you by name, nobody really recognizes you," so I am happy (Beneficiary).

Furthermore,

The fact that they (UN staff living with HIV) are linked to care, it shows that the UN actually does care about them…the environment that they work in is not stigmatizing them, and actually is assisting them to link into care (Agency A).

UN Kenya management concurred,

[The programme] looks at health of an [HIV] infected person not only in terms of the physical limitations imposed from the condition, but also the psychological impact on the person as a result of the diagnosis as well as the socio-economic impact (Management 2).

Two respondents referred to mortality in their reflections of the new service: First, by looking in from outside the community of UN staff living with HIV:

I think it is a brilliant programme because we lose a lot of people who may know their status but are not linked into care (Agency A).

And, then as an inward perspective regarding its circumstance, a community who had experienced 32 known deaths over the past 6 years from the epidemic,

There were reduced deaths, and the health of staff members improved… we are grateful that there are no deaths. We can sense that there are a lot of improvements from this access to treatment (Coordinator).

Both perspectives presented a palpable sense of relief that the solution had at last been found at UN Kenya, and the deaths from AIDS would cease.38

Theme 5: Benefitting from the service by the UN

Unsurprisingly, the UN derived both direct and indirect benefits from the service.

The indirect benefit is a UN that supports Kenya and Kenyans…their welfare, their good health. This programme supports Kenyans in the UN, and this

38 According to the coordinator for Kenyan chapter of UN Plus (via email on 16th March 2016), there were no reported deaths related to HIV in 2015 at UN Kenya.
The One-stop Clinic and Key Responses to AIDS of the United Nations System

programme [is] also really showing the government and all the other beneficiaries that we are practicing what we are preaching; and is setting [a] good example... it is something that is critical and core to [our] business (RC).

Direct benefits to the UN included,

...our own wellbeing... Productivity has increased, absenteeism has decreased, [with] no stigma in the office, there is harmony and cohesiveness, and teamwork (RC).

The stark difference of the environment in the office, without the consistency of fear was contributive to personal wellbeing, By removing the barriers to accessing care, the service also provided existential support that went beyond the physical; it began the process of normalizing HIV at UN Kenya.

So we have benefited a lot. It is important that we see it in this manner because there are so many benefits that can be accrued... evidence based benefits... I can’t see the difference between my staff who has HIV and other staff (RC).

Another respondent concurred,

Some of my best friends in the UN are living with HIV... it is not something I even notice... they are completely accepted within the system (Agency A).

By understanding the basic needs of its staff that were living with HIV provided the management with more leverage to create mutually beneficial prospects with staff.

I get a staff member who is very sick and I work with the staff member and we identify the problem, and we link with One Stop (Clinic)...and UN Plus, and they receive the highest standard of care available. And they are able to go back to...work...back on their feet to earn a living for their families, they begin to enjoy their work and remain productive. What beats that? (Management 2)

Theme 6: Waiting until it is too late for effective care

However, there was a lot yet to be done if the goal was to achieve real equity.

The UN [needs] to ensure that people living with HIV are encouraged to link to care... I know a few people who take so long before they take the step to
access care. The thing about HIV is that the earlier you access care, the better the health outcomes. (Agency A).

The respondent emphasized the need to stave off complacency,

They wait so long before they take the step to access care... that sometimes when they do access care, it is too late... We need to do all we can to make sure that anyone living with HIV accesses care; but beyond that, encouraging everyone to know their status (Agency A).

However, she realized that the present situation was challenging, even with the perceptible change in prevailing social norms about HIV.

Before many people would look at HIV as a killer disease...now the perception has changed but there is a lot of work still to be done because HIV is still a disease that people keep quiet [about]. Still the levels of disclosure are quite low among UN staff (Agency A).

Another respondent related a similar point.

Most of the people don't want to come out and say, I've got that condition… We are ready to support if we knew [of] such issues (Agency B).

However, the rhetoric on offering support needed to come with an enabling environment that would allow support to flourish.

HIV is like any other chronic illness. When you are in the office and people talk about HIV, it is not in a hush tone. People are more open, friendly. That feeling motivates the staff to know that they work in a friendly environment, not just for HIV-related conditions, but generally they feel it is a friendly organization to work for (Agency A).

Realistically however,

Stigmatization has come out as a very significant challenge in the workplace. It affects how people relates to each other and therefore has a direct impact on...people feeling happy in the workplace. Their happiness in the workplace is linked to job satisfaction, which is linked directly to productivity (Management 2).

A respondent was reminded of the UN Charter.

The UN does a very good thing taking everybody on equal status, doesn't matter if you have HIV, doesn't matter if you are gay or whatever...it has trained us to take everybody as equal status as they are (Agency B).
Yet, how equal could staff realistically be when their health conditions remained uncertain, and the hardship in self-financing care kept them one step away from destitution. 39 It did not help that this circumstance affected local staff disproportionately compared to their international colleagues.

However, the proximity of UN Kenya staff to the Secretariat at the United Nations Office at Nairobi (UNON) and global headquarters of agencies such as the United Nations Environment Programme (UNEP) and the United Nations Human Settlements Programmes (UN-Habitat) meant that the concern of local staff at the Kenya duty station was known to the UN system hierarchy, which UNAIDS had called “an absolute asset” to getting “ground breaking solutions” for a “truly exceptional” condition.40

Theme 7: Dying from financial hardship in lieu of HIV

In contrast to UN staff living with HIV in the 70+ participating UN agencies getting access to the HIV treatment and care they required free at the point of entry, UN staff from non-participating agencies as well as those with chronic illnesses besides HIV, still faced financial difficulties when accessing care; which, in one instance, proved to be fatal.

We lost one of our staff, it was very unfortunate, in 2011 or 2010...when you look at it you can see that this was a preventable death because it was more of a system kind of issue where they pay the money up front and make a claim but it would take six months for the money to be reimbursed. So for somebody with a chronic condition, then eventually it became unaffordable for them (sic) to access care… [and] we ended up losing the person. From a medical perspective, it is unacceptable. We have used this to petition our HQ to change or alternatively just to make sure we have credit facilities in one of these hospitals (Agency A).

Financial hardship was also worst for staff with lower income.

It is very, very difficult... especially as a beneficiary [that is] not of an international person...and...[they need] savings that they can really fall back [on], and when it comes to that, it is really, really painful...a good hospital?

These days, especially the tests, [can] cost 20,000 – 30,000 (Kenyan shillings). How many times do we have that kind of money to give to the hospital? (Agency B).

Thus, what had been overlooked, was the majority (70%) of Kenyans had no access to any form of credit. This meant that depleted savings could effectively bar healthcare access.

Likewise, UN staff with many dependents that needed healthcare access and treatment were worst off under the present insurance scheme of self-advancing payment for treatment services and getting reimbursed 80% of the costs (as stipulated insurance coverage of many UN staff) up to six-months later.

Imagine a family living with HIV: father, mother and two children. If they have to access care, they have to pay upfront and wait a long time for reimbursement at 80%... What if there is an emergency? I will have to make sure there are contingency funds there, or what will we do (Agency A)?

Such were the need that some offices would petition visitors for charitable contributions to provide care for staff who could no longer afford healthcare costs.

Theme 8: Accepting uneasy truths about fairness

The existence of the One-stop Clinic service therefore carried uneasy truths about discrepant fairness in healthcare access within the UN system, and created an economic divide among Kenyan staff that was based on consistent and sustainable access to (private) healthcare.

It is a topic that is discussed in the office all the time because the staff feel it is very unfair that they cannot access care yet we have the funds... we have an insurance, and we pay premiums. When you look at the premiums that we pay, most likely we can get a local insurer or another provider who would give us excellent services and we would not need to think of our healthcare. But what has happened, and it tells you how we feel about this, is many of the staff has taken up parallel cover (Agency A).

41 World Bank (2009, July), op. cit.
The respondent contextualized the need for parallel insurance coverage, which entailed higher insurance premiums, and was therefore feasible only among UN staff with sufficient disposable income.

If it [had been] me, I would definitely have another cover. I would not rely on my agency's cover, because I know it doesn't take care of all my risks... As much as this (insurance provided by the agency) is our primary cover, we would have a backup, just to make sure our families are safe... so we feel very strongly that something needs to happen... because accessing credit is not as easy as other parts of the world (Agency A).

The subtext pointed to a deficiency in centralized decision-making in the UN on insurance coverage that did not take sufficient consideration of local contexts.

**Theme 9: Contributing to something a public good**

The agency representative who had long been petitioning her agency to change its position conceded,

From the larger UN, how you (UNON) manage the One-stop Clinic for people living with HIV is a best practice (Agency A).

As an institutional arrangement, UNCT for Kenya saw the service as its duty to staff, and by extension, its duty to the UN in fulfillment of its mandate.

Putting money into programmes that have a direct impact on staff health and wellness is crucial. It is the only way the UN can achieve its mandate, is through its staff (Management 2).

The Coordinator of UN Plus and UN Cares at UN Kenya who directed UN staff testing HIV positive to the service was more pragmatic, focusing on the agency contributions that would underwrite the service.

We have to advocate agencies to pay One Stop bills on time (Coordinator).

The management was more nuanced however, and reiterated that it was about being successful with deliverables rather than in chasing bill payments,

For as long the agencies see value in the programme, they will keep contributing to it (Management 2).

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42 See chapter on institutional analysis for details.
Presently, these UN agencies contributed to tangible, less tangible and even intangible measures of health, productivity, and social justice. These measures included the tangible increases in productivity, and lower rates of illness and absenteeism due to HIV and AIDS; less tangible was the increase in treatment access on preventing onwards HIV transmission; and the intangible included encouraging the right to equitable healthcare as a public good, and the fairer distribution of the burden of HIV treatment costs as social justice.

To conclude this chapter, consider that in 2015, more than a decade after the debut of the One-stop Clinic at UN Kenya, the country has 1.8 physicians per 10,000 population, which meant that equitable access to care was unlikely in Kenya in the short term. With its poor public healthcare infrastructure, cost of healthcare and poor credit facilities, it was also unsurprising that health deprivation contributed almost one third (32.4%) of the country’s overall poverty. Thus, human capital was considerably low in Kenya, it was ranked 145 of the 188 countries included in the Human Development Index (HDI) in 2015.

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43 UNDP Human Development Index. (2015). Table 9: Health Outcomes.
44 Ibid, Table 6: Multidimensional Poverty Index: developing countries.
45 Ibid, Table 1: Human Development Index and its components.
Lessons Learned from the UN Kenya AIDS Response

Lesson 1: Leading by example increases credibility

Speaking about UN Cares and its role in addressing HIV stigma and discrimination in the UN workplace, and had laid the foundation for the One-stop Clinic service, this management personnel was frank.

I think the employer has a duty to make the workplace safe and accessible for staff to deliver their mandate. This programme aims to tackle issues of discrimination and stigma (Management 2).

He attributed the success of UN Cares on the high-level support it received.

It is crucial for the success of this programme that we continue to get this high level support because any programme tend to have its detractors and forces that don't appreciate its value simply because they don't identify with it. In an organization like the UN, such forces may derail an important initiative. If we have the support of the highest level, the Secretary-General, down to the agency leadership, it makes the work much easier to rollout (Management 2).

The Resident Coordinator, however, had offered an alternative view:

When you lead by example, you have so much more credibility in the eyes of others (RC).

Rather than focus on top-down leadership, she looked at the issue from the bottom-up, and related the synergy between UN Plus and UN Cares that had transformed the social reality of HIV at UN Kenya.

[It] has brought about a higher level of awareness among UN staff, in caring and understanding their colleagues with HIV... people talk about HIV/AIDS [as] people talk about diabetes... about any other chronic disease. And now the reality that people living with HIV can live, they have seen it (RC).

However, it reminded a respondent about the discrepancy on the delivery of treatment services, and advocated for more improvement at agency level.

Internally within the UN, there are few agencies that need to up their game... to make sure that we facilitate care, support and treatment for everyone (Agency A).
The current situation with non-participating agencies in the One-stop Clinic had unfortunately left behind UN Kenya staff living with HIV to their detriment. Staff in non-participating agencies had to meet the full costs of HIV treatment prior to an 80% reimbursement at a later date. This had increased the burden of staff on lower salaries, who also generally came from lower levels of the UN hierarchy, as well as staff had dependents who also required healthcare.

The treatment burden might therefore be economically and socially distributed, and had been distributed unfairly along lines of social status. A respondent exhorted that in the UN,

…all human rights should be observed, it doesn't matter about the status
…which we also embrace in our institutions (Agency B).

If indeed all human rights should be observed, the right to health of UN staff living with HIV that was so intrinsically linked to treatment access deserved fairer response from non-participating agency heads wishing to lead by example.

Furthermore, given the effectiveness of HIV treatment in preventing onward transmission of infection, not participating in the Nairobi initiative would have public health implications beyond the individual staff concerned.

**Lesson 2: Responding to specific needs in context**

On the issue of expanding the One-stop Clinic service to other parts of the UN system, obstacles abound in replicating the service. A respondent advocating for a similar service at a UN agency explained the conundrum.

We need to make our HQ understand that there is such a programme and our staff can benefit from it. All we need is a bit of systems change… there is goodwill in bringing [about] this kind of change, only that it is taking quite a bit of time. When we spoke to the directors, they understood what we are going through, and the need for a systems change…but the tools to transition us are not in place. I would like to believe that they are still working on those tools to transition us (Agency A).  

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46 There are synergies between an agency not having the “tools to transition” and lack institutional mechanisms available for UN Plus. The lack of institutional mechanism has been taken up in the institutional analysis of UN Plus.
Having been through the process of finding a solution for the Kenyan context, the Resident Coordinator advised,

> The need to be innovative, creative in coming up with a solution... in responding to specific needs is very critical and important (RC).

Her intervention recalled the genesis of the One-stop Clinic as a contextual response to the specific needs of staff living with HIV at UN Kenya. Taking her advice made it clearer that the focus on replicating the service might was premature. Just because the One-stop Clinic had worked in Kenya did not mean it was apt in every context.

Thus, advocating for the One-stop Clinic without thoroughly understanding the specific needs of UN staff living with HIV in different contexts might be offering neither innovative, nor creative, nor critical response to the specific needs of the situation. This case study therefore recommends emulating the One-stop Clinic’s principles in place of the replication of the service per se.47

**Lesson 3: Prioritizing confidentiality and right to privacy**

Focusing on UN Plus, the staff association of people living with HIV in the UN system, its founding member recalled the exhilaration of networking with other staff living with HIV:

> The setting up of UN Plus was a key moment for me... we were two and then it went up to eighty! (Coordinator). 48

However, the more people in association, the harder it would be to safeguard member’s confidentiality and privacy:

> Whereas you have a network of UN Plus members, some may be in the One-stop Clinic and others may not be in the One-stop Clinic. But the question is can they have... peer support, can be able to meet together for group socialization, interaction and support, can they be facilitated to have targeted training on certain issues...and for them to get all these support while still remaining confidential? (Management 2).

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47 Taking up this lesson led to conducting the institutional analysis of the One-stop Clinic by perceiving it as an institutional arrangement that provided enfolded ART as a common service; which itself offered an innovative perspective on governance.

48 Latest published figures of UN Plus Kenya membership figure stood at 54, indicative of reduction of membership support. The importance of membership support for an association has been analyzed in discussion on strategic alliance as an informal institutional mechanism.
Key to maintaining confidentiality in a situation of diverse treatment access modalities was cultivating a culture of mutual respect and trust among UN Plus members. The foundation of this culture ought to stem from respecting individual contexts and the privacy of HIV status:

There are those who have come out, that’s okay, that’s a personal decision... There are those who have not declared their status, and that’s okay [too]. It is their personal decision. But all of that should be facilitated to be able to support one another under the UN Plus programme (Management 2).49

The management therefore called for more unity in UN Plus to support UN staff living with HIV through their differentials in accessing treatment, support and care services, as well as through their individual issues with HIV disclosure. This entailed putting aside personal differences, and working towards a common good. It was hoped that a more cohesive and responsive network of peers, would translate to a more enabling workplace environment for staff living with HIV at UN Kenya.

Lesson 4: Empowering staff key to enabling environment

It remained a precarious situation for vulnerable UN staff living with HIV in isolation. Even with confidential HIV testing and anonymized treatment through the One-stop Clinic,

[There are still] late diagnoses, disabilities and deaths in service due to HIV/AIDS (Management 2).

The key to enabling the workplace environment was by empowering members of staff; especially staff who were vulnerable and socially isolated. The management at UN Kenya described it as a mutually beneficial programme driven by knowledge sharing,

Living with HIV is a limitation to the individual only if they feel insufficiently empowered. So these kinds of programmes (e.g. UN Cares) target exactly that, to empower all staff with information...to make their workplace a beautiful place for everyone else (Management 2).

UN Cares empowered members of staff that were able to create the necessary conditions for vulnerable staff to become mobilized. A beneficiary of the One-stop

49 This is imprecise. UN Plus is not a programme, it is a staff association for UN staff living with HIV.
Clinic recalled how the management leadership had been pivotal in overcoming the fear of disclosing HIV status and finally accessing care.

When I came out, there was a lot of support from management... they were eager to support staff members... some supervisors and [other] staff members were also supportive (Beneficiary).

From the beneficiary’s description of eagerness, the general tone of the workplace environment at the time must have been a mixture of quiet desperation and joyful relief: Quiet desperation because only the conditions of disclosure could be created and not the disclosure itself, and without the disclosure event it would not be feasible to offer assistance to staff at UN Kenya who might be in need of urgent support – a catch-22 situation; and joyful relief that the management’s efforts had been successful in empowering staff to mobilize from isolation and into care.

Lesson 5: Upholding an inspirational model of itself

Responding to a question on the One-stop Clinic service in Delivering as One (DaO) United Nations, a respondent framed her response in terms of unity within the UN system.

Taking into consideration that we are now being regarded as one family, and a family must be able to take care of each other...all human rights should be observed, it doesn't matter about the status ...which we also embrace in our institutions. I think it is a very encouraging way of doing things...(Agency B).

Following from the discussion on fairness, this rhetoric seemed utopian in its dismissal of status as a standard that did not matter; and its reflection on the UN family was somewhat disingenuous considering that the hierarchy to which it referred was the epitome of status. In contrast, a contextually sensitive interpretation follows:

This One-stop Clinic should be seen as a model for others...[in] Delivering as One UN. Everybody came together, put their resources in a pot to address common issues and common objectives... While the UN is responding to the needs of the country at large, it also has to look inside, and resolve its own problems because we, our staff, don't live in isolation to life that exists outside (RC).

The Resident Coordinator’s view was salient in its recognition that a UN country office as inseparable from the society where it is based. The proportion of UN staff that came from local communities made any UN country office a microcosm of
society and local community; and its internal problems might actually be reflections at scale of the same issues in a country.

It followed, therefore, that looking inwards might be another way of understanding that which was outside, and solving internal problems of the UN would yield valuable insights on fulfilling its mandate in countries. If this premise held to be true, being a model for others entailed the UN upholding a model of itself as an inspiration for staff.

What could be a requisite model of the UN? As a systems-wide coherence programme, DaO had united the majority of UN agencies behind the Nairobi initiative, which had in turn, facilitated common services delivery at UN Kenya. Critics might point to cost savings as the primary motivation for this alignment, and be justified by economic realities rather than inspirational ideals.

This criticism would be valid only up to a point. The utility of the programme died not preclude or detract from its potential capacity as a model of the UN for its staff; in fact, the opposite might just as likely be true. By actually delivering tangible results, DaO was being transformed from catchphrase to mission, as well as fulfilling its mandate.

Approaching the service as potential capacity, the inspiration had been its simultaneous personification of action and promise, and of unity and indivisibility. These were characteristics that underpinned its foundation, which had been laid out in the Charter of the United Nations. These features would warrant further attention.

As documented in this case study and elsewhere, the programme’s delivery of HIV treatment services at UN Kenya, which was backed by the majority of UN agencies, exemplifies its potential to be inspirational for other duty stations. Furthermore, by enfolding HIV treatment into common services at UN Kenya, DaO UN had not only substantiated its capabilities of uniting other agencies in a contingency affecting staff, but had also shown that it was capable of delivering a viable and just solution.

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50 Delving as One UN has also demonstrated its effectiveness in Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay and Viet Nam.
51 It has previously been featured as UNAIDS best practice for groundbreaking solutions on HIV in UN workplace programmes in 2005 (UNAIDS/06.04E).
Crucially, by en folding HIV treatment into common services delivery, UN Kenya and participating UN agencies were also reversing the social process of stigmatization by engaging in a structural HIV intervention at multiple levels. At the symbolic level, arguably the most compelling aspect, the intervention presented an antithesis of HIV stigma by embracing people living with HIV. At social and physical levels, it had reversed the stigma mechanisms of differentiating and distancing PLHIV from non-HIV infected individuals, and disrupted the social regulations that kept PLHIV from accessing material resources.

Thus, the One-stop Clinic had provided qualitative evidence on the effectiveness of the DaO UN institutional instrument for the UN; but in doing so, had also drawn attention to its value in promoting inclusivity within the UN. With these characteristics, DaO UN was justified as an inspirational model for UN staff, but crucially it was an operational model for organizational governance in the UN system. Thus, it could also be the yardstick that held the UN system accountable to UN staff.

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52 For definitions and importance of multi-level structural interventions on HIV, see Gupta et al. (2008, August). Also, Parker & Aggleton (2003).

53 Refer to Earnshaw & Chaudoir (2009), and Parker & Aggleton (2003).
Brief Institutional Analyses of UN Responses to AIDS

Purpose
The purpose of these brief institutional analyses are to distinguish and elucidate the institutional elements that have produced the One-stop Clinic, and situate the UN Kenya institutional arrangement in a broader array institutional responses to AIDS that have been deployed from within the UN system.

Institutions defined
Institutions are defined as enduring and reproducing social structures that act as rules and resources in society. Institutions constrain, facilitate, and bind social actions in space and time, resulting in the generation and reproduction of systematic patterns of actions.54

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54 Adapted from Giddens (1984). To apprehend the complexity of deciding on a definition, see Schneiberg & Clemens (2006).
To better understand these nuances, the concept is placed with other social elements (see Figure 1). According to the diagram, institutions are collective causal derivations of individual roles, and following the causal chain to its deepest level will lead to values. Organizations, on the other hand, are collective causal derivations of individual status hierarchies, and are ultimately derived from power. Crucially, roles are to status hierarchies what institutions are to organizations; in other words, they respectively represent individual and collective expressions of culture and structure.

Towards the collective wellbeing of people living with HIV

In a synthesis of the five brief institutional analyses, the Capability Approach to Wellbeing developed by Nobel Laureate, Professor Amartya Sen, is used as an evaluation framework to synthesize the contribution of institutional elements deployed as AIDS responses towards the collective wellbeing of PLHIV. Two key terms of the Capability Approach are functionings and capabilities.

Functionings

A functioning is the “state” of a person, an “achievement”; what she or he manages to do or be in leading a life. Examples are being at peace, being content, being respected, being knowledgeable; they can also be negative, such as being fearful, and being stigmatized. “Functionings are, in a sense, more directly related to living standards, since they are different aspects of living conditions.” Functionings are distinct from commodities, which are goods and services employed to achieve various functionings. Functioning achieved are functionings that have been attained.

Capabilities

Capabilities are the freedom to choose the kind of life to lead, “notions of freedom in the positive sense: what real opportunities you have regarding the life you may lead.” It is the ability to achieve various valuable functionings as part of living. A capability set refers to the real opportunities in life that can actually be chosen in relation to all the possible lives that a person may choose to lead. The goodness of a...

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55 Diagram reproduced from Portes & Marquez (2014, p.15).
capability set should be judged in terms of the quality as well as the quantity of available opportunities. Capability set can be aggregated to reflect the real opportunities a group may share, such as undergoing ART.

**Being well despite the diversity of contexts**

The analysis that follows intends to address the contextual diversity of UN staff living with HIV in 184 countries and 561 duty stations. However, rather than look at each context individually and in isolation, the study employs the Capability Approach to consider how the UN system’s HIV-related institutional elements are influencing the conversion of socio-environmental factors into capabilities for PLHIV in general, and staff members living with HIV in the UN system in particular.

The institutional analysis is at a social level, and concerned with the institutional elements facilitating resource conversion by the UN system. At this level of abstraction, the analysis considers valuable capabilities of PLHIV as a collective, and the capability set of PLHIV is derived by the minimum requirement it will take for PLHIV to lead lives they will have reason to value (Figure 2).

![Figure 2](image)

**Figure 2.** Locating the contribution of the UN on the collective capabilities of PLHIV, their functionings, and its influence on the utility of PLHIV’s subjective wellbeing.

**Sharing an affliction that limits the collective freedom of PLHIV**

The generalization of PLHIV capabilities from an individual to the collective is possible due to a shared affliction that limits the freedoms to choose among PLHIV in the same way. This condition is expressed as the progression to AIDS corresponding

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58 Adapted from Sen (1985, p.69; 1993, p.34-5).
with the erosion of actual functionings available to PLHIV, thus minimizing the PLHIV capability set.

Unless progression to AIDS is removed or suspended, PLHIV are expected to experience interruptions and diminishing quality in their functionings over time; which limit their collective freedoms to choose, and correspond to reductions in the utility of PLHIV’s subjective wellbeing. Hence, this shared affliction binds functionings, curtails collective freedoms, and socially constructs the wellbeing experienced by PLHIV at any time.\(^\text{59}\)

**Not undergoing ART negates PLHIV freedoms**

Antiretroviral therapy (ART) is currently the most effective way to halt HIV infection progressing to AIDS in PLHIV.\(^\text{60}\) Rationalizing that capabilities are actually achievable functionings of PLHIV at particular points in place and time, ebbs in functionings represent erosions of PLHIV capabilities in spatiotemporal contexts; and by definition, the negation of their collective freedoms to choose valuable lives.

From the foregoing proposition, not undergoing ART represents a reduction in opportunities to choose valuable lives, and the negation of PLHIV capabilities. Hence, the factors that cause the non-initiation in ART due to missed linkages and access deterrents are the same factors that negate the freedoms to choose in PLHIV; and represent determinants of the barriers to PLHIV choosing valuable lives.

**Exploring UN institutional elements on ART provision**

In a series of analyses to follow, institutional elements of the UN related to ART provision are briefly elucidated. Figure 3 illustrates a working analytical model. As shown in Figure 3, analytical levels of institutional processes follow temporal contexts as well as a UN body or programme. Thus, each level is underpinned by particular cultural (institutional) contexts that are specific to their period in history.

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\(^{59}\) Social construction of reality is founded on the sociological theory of knowledge; see Berger & Luckmann (1966). They theorize that what constitutes reality is made up of the inter-subjective shared patterns of perceptions of individuals in society as they interact socially, such that reality is constructed cooperatively in everyday life.

\(^{60}\) Medical science has found that early treatment initiation improves health outcomes of PLHIV, see ARV treatment guidance from the WHO (2015).
Figure 3. Model to explore the contribution of the UN to PLHIV undergoing ART.

Level 1: WHO institutionalizes access to ART for public health

The treatment that may end AIDS

Highly active antiretroviral treatment (HAART) had revolutionized HIV treatment, and there were reports of fewer illness and deaths among people with access to ART.\(^{61}\) However, the treatments are highly complex and require close monitoring. In 1996 when HAART made its debut, only countries with sophisticated healthcare systems managed to provide the cocktail of three different ARV medications that was fundamental to the HAART regime.

In the developing world, access to ART remained out of reach due to their exorbitant cost until India started producing generic ARVs in 2000. In 1996 HAART costs US$778 per patient per month, but by 2000 it is 12 times cheaper at US$100 per patient per month.\(^{62}\) When in 2003, prices dropped further to US$33 per month, it suddenly became feasible.

The following provides an account of how the WHO institutionalized access to ART in resource-limited countries. Institutionalization consists of three distinct stages:

\(^{61}\) See Castilla et al. (2005), also Patel et al. (2008).
\(^{62}\) Kumarasamy et al. (2005, p.1526).
habituation, objectification, and sedimentation. Completing the three stages will socially embed access to ART within a country’s health system, such that ART becomes a permanent institutional structure in society.

**Stage 1: Habitualizing access to ART in health system infrastructure**

Habitualization, the process that generates new organizational patterns that structure repetitive procedures, begins in 2001 with the WHO advocating governments in developing countries to commit a greater proportion of the nation’s economic resources to increase the capacity and infrastructure of national health systems. This action ensures that healthcare systems can cope with the increase in capacity needed to implement ART.

Next, to ensure that access to ART in these newly created infrastructures is maximized, the WHO convenes technical working groups on ART among medical and public health professionals that lead to guidelines on scaling up ART according to the public health (2002).

The public health approach simplifies the treatment strategy of HAART by minimizing medical and diagnostic options to basic necessities in the delivery of effective public health; and thus minimizes the necessary resources required by health systems. The consultations and guidance legitimizes the public health approach on scaling up ART, and creates the trust needed to habitualize these procedures in the health system.

**Stage 2: Objectifying access to ART with formalized procedures**

With its recommendations, the WHO technically and socially structure ART provision for both provider and patient by limiting the range of options available and providing the basis that decisions will be made. These pre-qualified choices include who should be initiated into ART and when this should occur, and on what basis, types of medication suitable for treatment initiation in diverse populations, definition and

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63 Habitualization is the terminology of institutional theory that seeks to explain how social processes become codified and internalized within organizations so that repeat actions become habitual. It is the first step of institutionalization. See Tolbert & Zucker (1994, October, pp.17-19).

64 Refer to OAU (2001).

65 Refer to WHO (2002).

guidance on disease progression, and special considerations requiring alternative considerations such as initiating ART during pregnancy and among children.

The outcome document, with its professionally agreed definitions, algorithms, specified processes and close-ended options, externalizes access to ART in a process of objectification. The process entails making the series of human actions needed to realize access to ART to become externalized as procedures of public health in place of discrete human decision-making, which can take time, resources and effort; and is therefore ineffective for rapid up-scaling of ART.

Stage 3: Sedimenting new norms and meanings of access to ART

The public health approach requires the endorsement of value positions contained in the 2002 guidelines on equitable access that is evidence-based. This calls for the reprioritization of knowledge bases in countries where medical science and public health have not been principal bases for decision-making on communal health. Sedimentation however becomes encouraged when the WHO and UNAIDS launched the “3 by 5” strategy in 2003. The strategy aimed to overcome constraints to get three million PLHIV from resource-limited settings onto treatment by 2005, and required a 10-fold increase in ART provision in three years at a cost of US$5.5 billion dollars.

The institutionalizing process is hastened further when the WHO links with UNAIDS and the newly formed Global Fund to declare the lack of access to ART as a global health emergency, that ART provision should be based on public health guidelines, and ART as a human right. The declaration of an emergency, identification of a solution, and pronouncement of ART as a human right, collectively created the praxis that allowed evidence-based public health to become prioritized in societies with alternative knowledge bases on health.

67 Objectification is the development of shared meanings that generalizes access to ART beyond the contexts from which the material used in developing the guidance is sourced. See Tolbert & Zucker (1994, October, pp.19-22).
68 See Fee & Krieger (1993, October), also Homsy et al. (2004).
69 See WHO (2003), and Grubb et al. (2003).
70 Ibid. Joint statement on 22nd September 2003
71 Refer to Homsy et al. (2004), op. cit.
Within 18 months, ART access tripled to 1 million in Africa and Asia.\textsuperscript{72} Although the WHO and UNAIDS have not succeeded in providing ART to 3 million people in resource-limited settings by December 2005 the strategy did prove that a rapid scale up of ART in resource-limited settings was possible.\textsuperscript{73} By 2015, 103 countries had national AIDS programmes with clearly defined indicators on access to ART; which bore testimony to the social embeddedness of access to ART.

**Level 2: UNON arrangement covers ART costs for local staff**

**Unprecedented united action in response to AIDS**\textsuperscript{74}

In 2003, the United Nations Office at Nairobi (UNON) opened an account with the Aga Khan Hospital in Nairobi to cover the cost of HIV treatment for local staff at UN Kenya.\textsuperscript{75} What followed was an institutional arrangement accepted by the UNCT for Kenya that remains unique in the UN system.\textsuperscript{76} It made access to ART completely covered by insurance for local UN staff by getting the majority of UN agencies to pay the difference in insurance coverage as a common service at the UN Kenya.\textsuperscript{77}

This gap in insurance coverage, which had created an average of 20\% out of pocket payments (OOP) for local staff, had been untenable for local staff lower in the UN hierarchy, or staff with dependents who also require ART.\textsuperscript{78} The action was both

\textsuperscript{72} Refer to message from WHO Director General, World AIDS Day 2005 (December 1).
\textsuperscript{73} Refer to review by JIU (2007, p.17).
\textsuperscript{74} First referred to in the report by UNAIDS (2006, February).
\textsuperscript{75} Based on a report by the UN Plus coordinator in Kenya on the genesis of the One-stop Clinic.
\textsuperscript{76} UNDP defines institutional arrangements as “the policies, systems, and processes that organizations use to legislate, plan and manage their activities efficiently and to effectively coordinate with others in order to fulfill their mandate.”
\textsuperscript{77} As of 16\textsuperscript{th} March 2016 (via communication with UN Cares and UN Plus Coordinator), only three UN agencies located at UN Kenya have not subscribed to ART as a common service, which require agencies to underwrite the cost of ART for local staff that has not been covered by the insurance policies of the UN system. These agencies are ILO, IOM (their staff access ART through government healthcare) and WHO (it did originally participate in the scheme but left when UNON out-sourced the administration of medical bills to insurance administrators around 2010). UN Cares is currently in discussion with ILO to participate in the scheme.
\textsuperscript{78} According to a 2015 report on the One-stop Clinic provided by the UN Plus Coordinator in Kenya, “it is still expensive as this is a monthly cost to be borne by the staff member, and much more expensive when one or two dependents of the staff member are added. We have staff members who along with a spouse and dependent access this treatment – at the rate of USD800 a month with a
unprecedented as a response to AIDS in the UN specifically, and unprecedented as an action on healthcare access in the UN more generally.

Regarding it being an unprecedented response to AIDS, the management at UN Kenya had united the majority of UN agencies operating at the Kenya duty station in a concerted effort to provide local staff with access to ART. The Kenyan HIV epidemic, which was then at its peak, had already claimed 32 lives of local UN staff since 1997. Local UN staff were not accessing available treatment due to the fear of stigma, or were not adherent on treatment because they could not afford the whole course of ART.  

HIV stigma had affected productivity and staff morale. Edwin Cameron, the South African judge who is HIV-positive, wrote in Witness to AIDS (2005),

> Stigma is perhaps the greatest dread of those who live with AIDS and HIV...
> Stigma’s irrational force springs not only from the prejudiced, bigoted, fearful reactions others have to AIDS – it lies in the fears and self-loathing, the self-undermining and ultimately self-destroying inner sense of self-blame that all too many people with AIDS or HIV experience themselves.

The urgency of the situation and overwhelming response from the agencies led to the institutional arrangement being implemented before its details had been finalized.

### Silence and the lack of solidarity on access to ART in the UN system

Given the silence surrounding HIV infection, the extent of the epidemic within the UN system is unknown but it is thought to be significant:

> The UN system is experiencing its own silent, internal epidemic... If the UN were a country it would be among the top 30 countries affected by AIDS.

net of USD400 or less a month. Therefore, accessing of the One-stop Clinic at Aga Khan Hospital was and is still beneficial to staff and the organization as the likelihood of access to substandard treatment and non-adherence is eliminated."

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80 Refer to results of the case study in this volume.
81 Knight (2008, p.251).
82 See UNAIDS (2006, February), op. cit.
83 Kate Thomson, founder of the International Community of Women living with HIV/AIDS (ICW) and later Chief of Civil Society Partnerships at UNAIDS (2005-2016), in Knight (2008, p.228); She is currently Head of the Critical Enablers and Civil Society hub at the Global Fund.
An ILO report dated 2004 had estimated that there were at least 3,000 staff living with HIV in the UN system. The action necessary although unprecedented in the UN, is getting the majority of agencies to agree on full insurance coverage for the access to ART for their staff, at least to the level of 90% treatment coverage, as the target endorsed by UNAIDS. This requires tremendous amount of solidarity; since the UNON institutional arrangement, future attempts have been unsuccessful.

Even the Joint Inspection Unit (JIU), the UN’s audit department, which had recommended a similar united response in 2007 for the rationalization of all insurance policies under a common system, has not been successful in unifying the support of UN organizations and the Chief Executives Board for Coordination (CEB). It is, nonetheless, telling that the two agencies reported to embrace the JIU recommendations are UNDP and UNFPA, which jointly share a system that topped up coverage for the treatment of chronic illness by their staff across the UN system.

In the same year UN Plus published a position paper outlining inadequate insurance coverage for ART on UN approved insurance schemes and seeking a solution, which received no official response. In 2015, during the UN Plus study on positive living in the UN system, the death of a UN staff suspected from AIDS-related

84 See report from the Inter-Agency Task Team on HIV/AIDS in the world of work (2004, p.1). The figure of 3,000 PLHIV in this report and 1.4% HIV prevalence (cited in Choo 2016 from a presentation by Martina Clark), have not been verified.


87 Review of the JIU report presented to the General Assembly (2008a, p.5): In particular, many organizations do not view the establishment of a single fund as the only option for achieving system-wide equity with respect to health insurance, i.e., for achieving equal access to a defined set of covered health-care related goods and services for all active and retired staff members. Such equal access can be achieved either within the framework of a single fund or through separate funds operating on the basis of a minimum set of common rules. Furthermore, those organizations feel that the report does not discuss the various options for harmonizing insurance schemes, which range from a common (minimum) “basket” of goods and services with a common reimbursement schedule, to a “cafeteria” option within a common funding policy. Certain determining aspects of health insurance, such as service levels, proximity, governance and operating costs, have also not been addressed in the report.


89 Refer to Hoover (2007, pp.17-19).

90 Reported during an interview with a high ranking professional UN staff in 2015 for a case study on positive living in the UN system, see Choo (2016).
causes had led a respondent to comment that it had been an isolated case. The slow response to gaps in insurance coverage for medical treatment, and deaths from suspected AIDS-related illness paints a highly divergent picture of the UN system management and the image of professionalism and fairness that it projects; direct advocacy targeting the CEB may fast track the agenda.

**Its pedigree, context, and isolation as a policy**

The policy outcome of the institutional arrangement itself is straightforward. It responds directly to the problem of stigma and poor treatment adherence by making an institutional arrangement that connects collective productivity across UN agencies to their duty of care towards individual staff who may be infected with HIV, including those yet to know their HIV status. To operationalize the arrangement, access to ART is made a common service for all participating agencies, and staff’s OPP is absorbed by the agencies’ operational pooled fund. Agencies contribute to the pooled fund the equivalent of the proportion of their staff being treated by the service,\(^1\) and individuals need not disclose their status to their respective agencies; thus, protecting privacy and confidentiality. In effect, access to ART becomes another essential like utilities and security, which are commonly shared across all agencies.

The significance of this institutional arrangement in relation to the UN system, is three-fold; first, leadership and clout matter as the UN Kenya policy originated at the UN Secretariat where UNON is one of its four global offices, and the Director-General is at the level of Under-Secretary-General; second, the willingness to address the problem in a generalized epidemic where almost everyone knew of a person with HIV or AIDS,\(^2\) which may be different in contexts where PLHIV are not personally known; and third, it has not been replicated in the UN system.\(^3\)

**Fulfilling employer duty to staff living with HIV**

The connection between collective productivity and duty of care to individuals makes it an issue of governance and does not require that policy-makers personally know their staff, or for staff, the need for special attention. Thus, the fact that it has not

\(^1\) The One-stop Clinic received a recommendation from UNAIDS (2006, February, p.16).

\(^2\) See Chiao et al. (2009, September).

\(^3\) See UNAIDS (2006, February), op. cit.
been replicated means that policy-makers either think that a governance solution has been found in the UN system; or it is not a priority the requires a response. The second option is a dereliction of duty, which seems improbable of UN staff. Thus, the first option remains, that solutions have been found.

Casting the net wide yields two possibilities. They are the UN Cares programme in reducing stigma sufficiently for staff living with HIV to present for HIV testing and access to ART; and OPP having been addressed at agency level. However, neither option is conclusive that needs have actually been met, and will therefore require clarification. According to the WHO, ironically one of the current non-subscribing agencies,\textsuperscript{94}

> Requiring payment for health services at the point of use can cause financial hardship, or simply discourage people from using the services. Furthermore, both direct and indirect health costs can compromise adherence to treatment and retention in care, particularly for chronic health conditions. People’s ability to pay for health services should be reflected in all policies, to protect the poor and vulnerable from financial hardship...\textsuperscript{95}

In other words, the current insurance schemes available in the UN that does not offer full treatment coverage, or reflects the ability of staff to pay for treatment is causing hardship for UN staff who are most vulnerable. As long as this issue is outstanding, the UN is presenting a discordant image to the world by calling for fast tracking of the AIDS response,\textsuperscript{96} and reminding countries to leave behind no one.\textsuperscript{97}

**Level 3: UNAIDS innovates by treating AIDS as exceptional**

**Towards the institutional turn that galvanized a global response**

An institutional turn is the realization that institutions matter.\textsuperscript{98} In two lectures, the first in November 2003 as World Bank Presidential Fellow, and then in April 2005 at the London School of Economics and Political Science (LSE), the Executive Director of

\textsuperscript{94} This likely stemmed from a governance issue that had been highlighted for reform from 2010 onwards. See the Chatham House analysis in Clift (2013, February, p.44).

\textsuperscript{95} WHO (2014, p.22).

\textsuperscript{96} See UNAIDS document (UNAIDS/JC2686).

\textsuperscript{97} Speech by Michel Sidibe at the International AIDS Conference, Melbourne, 20 July 2014, see UNAIDS (2014).

\textsuperscript{98} Jessop (2001, p.1213).
UNAIDS at the time, Dr. Peter Piot made an institutional turn by insisting that AIDS was an “exceptional disease”, that required an “equally exceptional response”.99 It is the opinion of this researcher, that the lectures are important bookends that seek to craft a new institutional order between UNAIDS and countries, as the joint programme approaches the end of its first decade.

In its first 10 years, UNAIDS had presided over the reduction of ARV prices, advocated for countries to use the flexibilities within the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement to obtain generic HIV medication to stem their epidemics, which had facilitated the manufacture of generic medication by India. Strategic though these actions had been, they were not nearly sufficient to mount a response under the institutional status quo at the time. A more effective coordinating mechanism had been necessary but one that UNAIDS could not create without support of Member States.

In his lecture, Piot argued forcefully that future generations would judge the present on how it responded to a disease that in just 2 decades had infected 65 million people worldwide, killed 25 million, and left close to 40 million people living with HIV;100 many of whom in states of economic destitution and social marginalization.101 Other than the World Wars, no other human experience has come close to reflecting the level of human suffering that came with AIDS.102 What made him equate the suffering of AIDS and the World Wars? It was likely the only example in modern history of unspeakable horror that many Heads of States might be able to connect with; it would also have been likely to have occurred in their lifetimes, and if they had witnessed its horrors, would undoubtedly have been left with an indelible impression.

**Decisive leadership at all levels and led by Heads of States**

Given the scale of human suffering and devastation, to lead the AIDS response cannot be the task of discrete individuals or organizations. It is only with collective effort, and institutional-level mechanisms, can national governments and civil

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99 Speech given at the LSE, London, 8th February 2005 by Dr. Peter Piot, Executive Director of UNAIDS.
101 Refer to Russell (2004); also, Parker & Aggleton (2003).
102 See UNAIDS (2005), op. cit.
societies mount an adequate AIDS response at population level. From the perspective of development, AIDS has infected the youth in societies, affecting the progenitors and workers that are meant to drive the nation’s demographic and economic growths in succeeding generations. These missing drivers, especially in Sub-Saharan Africa, have left not a socio-demographic and cultural void; as people struggle to keep alive, so do communities, and their traditions.103

Furthermore, AIDS afflicts societies’ private proclivities that are often silenced with taboos.104 AIDS is therefore a silent killer; its long gestation period makes it particularly lethal; 105 as it affects key institutions that make up the fabric of societies, from marriage and family, to education and work; but also gender and sexuality, which are uneasy subjects for conservative Member States.106 The interventions needed to address the stigma at this level of complexity entails that without adequate structural interventions that can operate at the institutional-level, other AIDS responses will always remain inadequate at the population level.

The UNAIDS Executive Director therefore contended that a global AIDS response would require not only a coordinated response that addressed the problem with decisive leadership at different levels, but needed to be led by Heads of States and having leadership at every level.107 Piot perhaps realized too, that without harnessing the power to control the institutional mechanisms of government that could affect the particular changes required at the level of local institutions, would be akin to fighting a menacing shadow with sticks.

In this respect, the significance of UNAIDS’ interventions is two-fold; first, it comes at a time when the availability of ART means for many in the developed world that the fight against AIDS is over – although in reality, the needs of resource-limited settings is just beginning, with the huge resources required to fund access to ART; 108 and second, it relates the importance of institutional change109 – just as behavioural

103 See Lwihula et al. (2007); also, Hilhorst et al. (2006).
104 Ibid.
105 Refer to Whiteside & Smith (2009, November).
106 Refer to chapters in Lavinas & Thiell (2015).
changes have been required of populations affected by the epidemic, institutions need to be in the correct footing to mount effective institutional responses to AIDS.

**Mitigating AIDS with institutional change**

A JIU audit of UNAIDS reported a perceptible change in 2003, when Member States begun accepting rather than denying the AIDS pandemic, and begun calling for a concerted and coordinated effort; keenly aware of duplication and fragmentation in the response.\textsuperscript{110} This outreaching for support signaled a shift in perspective. It is the beginning of the institutional change that eventually transforms the global AIDS response.

Member States that have been impotent in the days of exorbitant treatment costs now find themselves in more comfortable positions; as treatment comes within the realm of affordability and, with the record funding flowing into the AIDS sector, a more proactive funding climate that included the availability of grants through the newly founded Global Fund.\textsuperscript{111} The solution that both UNAIDS and Member States have been waiting for, arrives in 2004. After being endorsed by its Programme Coordinating Board (PCB), UNAIDS introduces the “Three Ones” principles; one agreed AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation (M&E) system.

The principles have been through consultations with governments, civil society and donors; and have been accepted by stakeholders at national and global levels.\textsuperscript{112} It is non-coercive and non-binding. By 2005, UNAIDS reported that 90% have national AIDS strategies, 85% of reporting countries have established national bodies to coordinate country AIDS efforts, and 50% of countries have their national M&E framework and plan in place.\textsuperscript{113}

Although it will take much more time to get the content of strategic plans costed and operational, national bodies that coordinate AIDS efforts to include adequate civil

\textsuperscript{110} JIU (2007, p.12).
\textsuperscript{111} See Rogerson et al. (2004, March).
\textsuperscript{112} Ibid.
\textsuperscript{113} UNAIDS (2006, May, p.11).
society representation, and national M&E frameworks properly coordinated,¹¹⁴ these institutional innovations have placed the institutional mechanisms in place to respond to AIDS at country-level, and which allowed facilitation by UNAIDS at global-level.¹¹⁵ It is a win-win situation for both UNAIDS and the Member States.

Collectively, the effort sends out a resounding message that governments are now taking their place at the driving seat of their country’s AIDS response, and UNAIDS assisting in the effort. This institutional innovation has fulfilled the greater part of UNAIDS’ role in the AIDS response; leading JIU inspectors to seek the strengthening of its mandate so that it can effectively lead the coordination between countries.¹¹⁶

**Mobilizing required resources to fund the AIDS response**

When James Wolfensohn, the President of The World Bank Group, acknowledged that Peter Piot had in fact approached the Bank to alert them about AIDS in Africa as early as 1979,¹¹⁷ but had not made “enough of an impression” for the bank to react,¹¹⁸ the profundity of his Presidential Fellows Lecture in 2003 became apparent.

Piot has had almost a quarter of a century to ruminate and craft the views he presented that day, and the Bank, by inviting him to lecture, had availed itself the possibility of considering these views. Wolfensohn reassures that this time, the Bank “has matured” and is “a keen supporter of the work of Peter Piot”.¹¹⁹ The tangible outcome following this lecture is the exceptional response envisioned by UNAIDS. An unprecedented trend in global aid contributions from both developed and developing nations sustain the global AIDS response for the decade to come.

In 1996, when UNAIDS began operations, international funding to low and middle-income countries was at US$300 million.¹²⁰ In 2000, just a year before the UN General Assembly Special Session on HIV/AIDS in 2001, international funding for

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¹¹⁵ Ibid, p.11.
¹¹⁶ Ibid, pp.4-5.
¹¹⁷ The subtext on the lateness of the international response to AIDS.
¹¹⁸ See World Bank (2003), op. cit.
¹¹⁹ Ibid.
HIV/AIDS was three times more at US$900 million. In 2004, on either side of UNAIDS Executive Director’s lectures, international funding was at US$6.1 billion, more than nine times the funding just three years earlier. Ten years later in 2014, funding stood at US$8.6 billion, albeit far below the expected funding levels projected by UNAIDS before the global economic crisis in 2008, it nonetheless remains an unprecedented global investment in a single disease.

At the end of the MDGs in 2015, a total of US$21.7 billion has been invested in low and middle-income countries; crucially, more than half (57%) of this came from domestic funds. It is the biggest resource mobilization on development assistance for health (DAH).

**Level 4: UNGA situating institutional logics of access to ART**

**The shifting institutional logics over a decade**

The intervening 11 years between the 60th and 70th sessions of the UN General Assembly (UNGA), beginning with the World Summit in 2005, and ending with the 2030 Agenda for Sustainable Development in 2015, there appears to be perceptible shifts in institutional logics of access to ART.

The exposition attempts to trace these shifts, by following commitments on access to ART in formal UN documents that have been agreed to by Member States: 1) 2005 World Summit Declaration; 2) Political Declaration at the 2006 High-Level Meeting

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121 WHO. (2015, p.112).
125 See WHO. (2015), op. cit.
126 Ibid.
128 Thornton and Ocasio (1999: 804) defined institutional logics as ‘the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality.’ According to this definition institutional logics provide a link between individual agency and cognition and socially constructed institutional practices and rule structures. Thornton and Ocasio (2008, p.101).
Only commitments of Member States have been evaluated given that this is the only portion of these documents that are monetized,\textsuperscript{129} with the assumption that Member States will be more circumspect and meaningful with their commitments in relation to other parts of the document; yielding therefore their actual values and beliefs of Member States regarding access to ART.

**2005 World Summit Declaration\textsuperscript{130}**

At the World Summit, Member States see ART as part of a package that includes HIV prevention and care. The commitment of Member States is in developing and implementing such a package, in order to come as close as possible to the goal of universal access to treatment for those that need it by the year 2010, 5 years away. Included in the prevention and care package, are 1) resources mobilization, 2) elimination of stigma and discrimination, 3) advocacy for access to affordable (generic) medication, and 4) socio-economic interventions to minimize the impacts of HIV, AIDS and other health issues. The interventions will target orphans, vulnerable children and older people affected by HIV/AIDS.

**Commentary on the outcome of 2006 HLM on HIV/AIDS\textsuperscript{131}**

In the year separating the events, the focus has changed from developing and implementing an HIV prevention, treatment and care package, to upscaling (existing) national responses (not specific to HIV) that are affordable and all-inclusive. The objective too has changed; from getting as close to universal access to treatment within 5 years, to a generalized (generic) coverage for prevention, treatment, care and support (again non-HIV specific).

In 2005, four prevention interventions are clearly spelled out, as are the three target groups. A year later, the generic intervention programme is open to everyone including PLHIV. However, the 2006 document does concede that its generic

\textsuperscript{129} Refer to Financial Tracking Service for definitions.

\textsuperscript{130} Refer to General Assembly (2005).

\textsuperscript{131} Refer to General Assembly (2006).
programmes have universal access to comprehensive prevention programmes (no mention of what disease), treatment, care and support by 2010. Thus within a year of committing to decisive action of HIV treatment and prevention, the commitment has waned to generic all encompassing, non-targeted programmes.

Commentary on the outcome of 2008 HLM on HIV/AIDS

Member States voted for a President’s report on the meeting and made no declaration. This is not surprising given the global economic crisis. The Secretary-General is blunt: despite the scale up of the past years in ART, there will not be universal access. He calls for financial assistance for treatment scale-up to be increased, indicative that there is already a shortfall of money, and for health systems strengthening; in particular drug procurement supply chains, quality assurance, and training of healthcare worker. Tuberculosis (TB) is featured as the major cause of death among PLHIV, with calls for improvements to prevention, diagnosis, and treatment for TB; a disease in the 21st century that is commonly intersected by poverty. Thus, while waiting for the economic environment to improve, the main messages are to prepare the national infrastructure and keep PLHIV healthy.

Commentary on the outcome of 2011 HLM on HIV/AIDS

Three years since the last HLM in 2008, in this meeting Member States made the commitment to “redouble efforts” to achieve by 2015, which is in 4 years, universal access to HIV (specified) prevention, treatment, care and support as an important step to end the global HIV epidemic and begin to reverse the spread of HIV. The following commitments make up a comprehensive list: Member States made the commitment,

- by 2012, to update their National Strategic Plans (NSP), which will be a transparent process, with country leadership, and include civil society. The NSPs will have strategies, costed plans, and specific goals with targets, and are equitable and sustainable. In order to improve efforts to reach universal ART by 2015, solutions will be found for areas with low prevention and treatment coverage.

132 Refer to General Assembly (2008b).
134 Refer to General Assembly (2011).
• to ensure that the universal ART complies with WHO treatment guidelines, which provides evidence that early treatment initiation is beneficial, and the target for 15 million people on ART by 2015.

• to 1) reduce the price of ART; 2) improve ART delivery through better treatment regimens; 3) provide improved, simpler and more affordable diagnostics at point-of-care (POC); 4) reduce treatment delivery costs; 5) mobilize and support community-based treatment, care and support programmes; 6) provide healthcare to hard-to-reach populations, rural populations that are far from healthcare services, and people in informal (squatter) settlements where healthcare is poor; and 7) appreciate the prevention benefits of treatment.

This is the final HLM before the end of the MDGs in 2015, in which the target of 15 million people on ART has been reached. However, in the same year, the WHO has released its latest treatment guidelines that recommended ART initiation regardless of CD4 count, given the long term beneficial outcomes. It is estimated that there are about 17 million people eligible for ART. However, HIV testing must improve its coverage to include the 46% of people who do not know their HIV status for universal access to treatment to be achieved. Reaching hard-to-reach populations (by definition) will require extra effort and resources that seem to be in short supply.

Commentary on the 2015 resolution on the agenda for the SDGs

It has been three years since the last HLM, which had the most comprehensive and decisive commitments as compared to previous HIV/AIDS political declarations. In the intervening years, there have been at least two major epidemics of concern: Ebola and Zika. In the meeting on the transition from MDGs to Sustainable Development Goals (SDG), no specific commitment is made regarding HIV/AIDS, and there has not been any commitment to increase ART access. HIV/AIDS has

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135 Refer to General Assembly (2015).
136 Ebola is transmitted via bodily fluids including sweat. There is an experimental treatment for Ebola, which has cured the disease if it is detected early. For more details, refer to WHO at http://www.who.int/csr/disease/ebola/en. Zika is transmitted via the Aedes mosquito and has been suspected to cause microcephaly in babies born to mothers infected during pregnancy. Sexual transmission of Zika has also been recorded. There are no known cures for Zika, and long term prognosis is uncertain. For more details, refer to WHO at http://www.who.int/csr/disease/zika/en/
been enfolded into a list of infectious diseases that include TB, hepatitis, and Ebola. The sideling of HIV and AIDS is pronounced in the SDGs. Although UNAIDS has managed to find a number of places in the SDGs where HIV and AIDS are key elements, the fact that the SDGs only mention HIV/AIDS once, as a target in goal 3, lumped together with a host of other diseases under health and wellbeing, does not bode well for a sustained global response to AIDS.

Contemplating the end of the AIDS epidemic by 2030

In the 2016 HLM on HIV/AIDS, it is possible to see how AIDS will end. At this point in history, public health has all the knowledge it needs to end AIDS with the fewest loss of life. It is the best position to be, but involves the hardest choices. From the perspectives on institutional logics, access to ART have perceptibly shifted in focus from universal access to HIV treatment, which is the primacy of delivering treatment to the people who need it, to a singular focus “to end the AIDS epidemic by 2030”. Following these institutional logics yield:

1) Ending of AIDS by 2030 is not unreasonable given that it is the only HIV/AIDS goal in the SDGs, and ideal to sustain the global momentum for another 15 years in leading the transition from MDG to SDG;

2) Ending of AIDS by 2030 will galvanize resources for UNAIDS and UN agencies, which is needed after 30 – 50% cuts in budgets for 2016 due to the European migrant crisis;

3) Ending of AIDS by 2030 is likely to be the only thing that can motivate World Leaders to spend more energy and money on a disease that has troubled them for three decades;

4) Ending of AIDS by 2030 will be a great triumph for science, public health, and humanity that, finally by its creativity, could arrest a virus that has killed 39 million people in 30 years; and

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137 Refer to UNAIDS 2016-2021 Strategy (2015).
138 See Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.
139 Scheduled for 8-10th June 2016 at the United Nations Headquarters in New York, USA.
140 UNAIDS press release dated 30th October 2015
141 Personal communication with UNAIDS staff, 2 March 2016.
142 More than double the 17 million people killed in World War One. See Global Health Observatory (GHO) data on the theme of MDG6: HIV/AIDS (WHO).
5) Ending of AIDS by 2030 offers necessary closure to the concern that has been hanging over UN proceedings for more than a decade.

Following these logics, three further questions emerge.

1) What will it really take to end AIDS in 15 years?

2) How do we sell the idea to Member States, who have spent the past decade on the problem of AIDS, and convince them it can actually happen?

3) How do we sell the idea to the community, which has built an entire enterprise of good will around AIDS, that their needs will be met at the end of AIDS?

The following points lay out the essence of all three questions from the perspectives of the right to health and the equitable access to essential medicines.

The necessities to end the AIDS epidemic by 2030

If the ending of AIDS means no more cases of HIV progressing to AIDS, it requires getting nearly every person living with HIV on treatment, and for them to be adherent and be properly cared for; which means understanding the psychosocial factors of adherence and be able to offer meaningful support. It also requires that health systems be able to manage almost 40 million people on ART, and who need routinized care, as it is with any chronic condition.

HIV testing

To end AIDS means that people will readily test for HIV if they have been at risk of infection. At the moment this is not happening, hence the 46% of people who are unaware of their infection. No doubt, some of these people will include people who are hard-to-reach. Sufficient effort must be made to reach them, as they must not be left behind; there are reasons why they are hard-to-reach, and these reasons must be respected. Ultimately, to get the testing numbers required, HIV stigma must come down to the level of any sexually infectious disease such as syphilis and gonorrhea. There are also societies where sex, sexuality and sexual expressions are censured and constrained. Options must be made available for people in societies to be tested confidentially, and if need be, anonymously, but always with the provision of treatment, care and support readily available.

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143 HIV/AIDS Factsheet by the WHO (2015, November; No.360).
HIV Stigma
Stigma will be the crux that determines how we will approach the 2030 goal. HIV stigma causes people to delay testing for HIV, and present (too) late for treatment. A strategy that centres on human right principles that minimizes stigma and discrimination is essential. However, even without provocation, it may take a generation or more for HIV stigma to entirely disappear, albeit after the epidemic has ended. Thus, stigma minimization strategies should be high on the list of activities when up scaling ART, but it seldom is. Furthermore, enabling more people to disclose and be open about their HIV status in sufficient numbers to normalize the disease may be the way to reduce stigma. However, the process cannot be coerced.

Antiretroviral treatment
Ending AIDS means ensuring that the medications are available and provided for life. Some necessary questions: Who will pay for the ART of the approximate 21.1 million more people living with HIV? And will existing donors fund ART access for perpetuity? How can we make second and third line medication affordable without waiting for huge economies of scale to lower current prices to affordable levels?

HIV prevention
At the end of the epidemic, HIV prevention must be the strongest link rather than the weakest it currently is. It will remain our first line of defense against HIV infection, and should always be the preferred choice. This means that condoms must be readily available, both for female and for male; and harm reduction services made available and proportionate to size of the population that requires the service.

Concentrated epidemics
In concentrated epidemics, community based support is often more reliable, effective, and efficient then local health systems in delivering treatment follow up, as well as providing HIV testing. Community systems should be able to coexist with health systems in these settings, with pre-agreed roles, standard operating procedures, and be fully funded under National Health Budgets. Preferably, these roles should be linked to harm reduction initiatives.

144 Ibid. Number obtained by subtracting people on ART (15.8 million) and PLHIV (37.9 million).
Transitioning to living with HIV

From the perspective of people living with HIV, it is evident that HIV changes a person. Biographical disruption has been used in the medical field to explain the change in life history as the result of chronic illness;\(^{145}\) when life after the onset of illness (like severe arthritis) is not the same as life before. For some people it can be deeply traumatizing, causing permanent changes in character, and affecting their personality; for others, it is momentary. To meet the challenge to end AIDS, services must be prepared for the millions of people who will need to go through this process, and help it to end well. In the era of test and treat, this will pose a challenge, as it requires time, understanding, and empathy; all of which are usually in short supply with the model of test and treat.

Level 5: UN Plus as enterprising advocacy within the UN

A symbolic organization with no statutory rights

UN Plus is highly valued as a symbol of emancipation, of human rights, and enabling positive living within the UN. The Secretary-General cares about the welfare of UN staff living with HIV, and seeks the assurance of their welfare through UN Plus. In Geneva, its position is partially funded by UNAIDS, and in other places, a different organization has to look after its needs, as it is in Nairobi, with UN Plus adopted by UN Cares. It has no statutory rights as an independent entity within the UN system given that it is neither a programme, nor organization, nor agency.

A tendentious situation

The situation becomes tendentious when UN Plus intends to fulfill its mandate to advocate for UN staff living with HIV. The following clarifies its current situation: It has produced position papers, and research studies.\(^{146}\) It is advocating for full treatment coverage on UN insurance schemes for UN staff living with HIV as a basic human right. It argues that the 20% out-of-pocket payments (OPP) for ART access are disproportionately affecting staff living with HIV who are economically and socially

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\(^{145}\) See Bury (1982), who first used “biographical disruption” to refer to the chronic illness from severe rheumatoid arthritis that disrupted the life stories of patients.

\(^{146}\) See Hoover (2007), op. cit.; also Choo (2016), op. cit.
vulnerable; and that these members tend to be local staff (rather then international), and of general grade (rather then professional), makes the system iniquitous.

Not only does the system “tax” via OPP the people needing medication to survive (a basic necessity), it disproportionately “taxes” people most vulnerable relatively more (assuming OPP is constant at 20%), and staff salary is variable depending on duty station (local vs. international) and grade (general staff vs. professional).

To illustrate, say there are two UN staff living with HIV, members A and B:

- A is a local staff at grade G1, OPP value = 100/1
- B is a local staff at grade P4, OPP value = 100/8

Technically, with all things being equal, staff A is less well off than staff B, due to their staff grades. Given B’s grade P4 is eight ranks above grade G1, for the sake of argument earns 8 times more, the relative value of their OPP is 100/1 vs. 100/8. Is it not iniquitous that the person with less income has to pay relatively more for ART?

**Being invisible leaves fewer options in moving forward**

However, having made the argument, what can be done? Due to its non-entity within a highly bureaucratic system as is the UN; UN Plus is invisible to the system. It cannot be effective, because it has no rights. Therein lies the irony, an association fighting for rights it does not presently have; and crucially, with every person whose plight it fights for, it is also fighting for itself. Thus, in helping others UN Plus accrues the necessary social capital to grow its agency. For the moment, however, it only has one option open with the present arrangement; it must rely on its host agency to fight on its behalf, which can be inconvenient if the host does not share its point of view.

**Dis-embedding from current institutional logics**

To provide UN Plus with additional capabilities, UN Plus must dis-embed momentarily from its current situation to appreciate its functionings. What does this require? It means to think out of the box, or more specifically, to think outside current institutional logics. As observed in the Level 4 analysis, present institutional logics are concerned with the 2016 HLM due to take place, which will in no uncertain terms, indicate the resources available in the field of AIDS; focus is in needs and not haves.

The following exercise reverses this momentarily. Imagining that UN Plus is an entity disconnected from the UN system, the following is a list of its functionings:

- Being the only HIV-positive staff group in the United Nations System.
- Having a global presence in 42 countries.
The One-stop Clinic and Key Responses to AIDS of the United Nations System

- Made up of 210 UN staff living with HIV at 21 UN agencies.
- Having high-ranking UN staff members in the association.
- Running a peer-to-peer support network.
- Being a network of PLHIV that is linked to other PLHIV networks; for example, the Global Network of People Living with HIV (GNP+).
- Being linked to other staff associations of PLHIV globally.
- Offering dedicated and specialist advice to UN staff living with HIV on human resource procedures, insurance coverage, immigration and visa requirements, psycho-social and socio-economic concerns.

**Re-embedding with solidarity as a collective capability**

With reference to the functionings above, now that UN Plus has re-embedded itself in the institutional logics, which functionings have been conditioned, or lost? Once these are accounted for, the capability set available to UN Plus is derived. It will be evident that none of the functionings in the list have been conditioned, or lost. Once this is fully appreciated, what has been gained? Using the same list of functionings achieved, now considered its capability set, emphases demonstrate gains:

- Being the only HIV-positive staff group in the United Nations System.
- Having a global presence in 42 countries.
- Made up of 210 UN staff living with HIV at 21 UN agencies.
- Having high-ranking UN staff members in the association.
- Running a peer-to-peer support network.
- Being a network of PLHIV that is linked to other PLHIV networks; for example, the Global Network of People Living with HIV (GNP+).
- Being linked to other staff associations of PLHIV globally.
- Offering dedicated and specialist advice to UN staff living with HIV on human resource procedures, insurance coverage, immigration and visa requirements, psycho-social and socio-economic concerns.

**Symbol of diversity and association of PLHIV in organizations globally**

UN Plus is unique in the UN ecosystem. It is both a local and global association, has information on multiple cultures and work patterns, and is sensitive to multiple cultures, and cultural patterns. The association connects with UN staff sharing a similar predicament at multiple levels within the entire UN system, crossing social economic, and geographical boundaries. It has access to privilege information and
situations about the UN system work environment, and has special skills in maneuvering within this ecosystem.

When necessary, UN Plus also connects with global networks to enrich its perspectives and for different solutions, which can be applied within its local frame of reference for broader and more discerning perspectives. Its particular situation with HIV makes it able to connect at deeper levels with associates worldwide, which provides it as an association, not only with a global reach, but diversity as well as depth in understanding about the requirements, procedures and concerns of people working with HIV, in global and local workplaces. Thus the additional functionings of UN Plus are,

- Its semi-autonomy, being free to briefly dis-embed from institutional logics.
- Its associability, being the link of multiple associates.

**Building alliances in an enterprising move for health rights**

To re-envision its future trajectory, UN Plus associates will have to work strategically within the UN system and beyond to build alliances that will help it achieve its goals. It has the capacity to be important brokers of knowledge and information, also data and interpretations. However, this does not imply that it does not hold its own council regarding sensitive information. Among information sacrosanct to UN Plus associates is HIV status, which is highly confidential, and its privacy is non-negotiable. Misuse or loss of trust in this regard is akin to the loss of legitimacy. As an association, it is by standing together that the maximizing of capabilities is attained. Its common trajectory must be for the betterment of UN staff living with HIV anywhere within the UN system, or it will lose governance capabilities.

**Using its agency capabilities strategically to build an advocacy platform**

It is in a unique position as a non-UN agency made up of an association of UN staff at multiple levels of a highly complex working environment, to provide advice and assistance to people living with HIV in other similar work environment at global levels. What other agents will not have; is the UN brand. UN Plus has it just by association because it (the entity, UN Plus) belongs to the UN (just as all staff “roles” belong to the System). The difference, and this is crucial, UN Plus has agency capabilities that are independent from the UN system, because it is neither an official programme, nor organization, nor agency. The line of jurisdiction between UN Plus and UN system is therefore tangential, at best.
The agency of UN Plus works best when it is co-shared with three to five individual UN Plus members cum UN staff. It will be sufficiently light-touch to steer UN Plus as one would any institution within the UN system. And with three to five associates steering the association, there can be sufficient division of labour between them to make the association operate up to three times its current size; sufficient for an advocacy office (cloud based) cum platform (social media based).

Synthesizing analyses to assess the wellbeing of PLHIV

Overview of PLHIV freedoms and functionings in the UN system

The UN system is a highly complex system of social procedures, rules, precedents, the most importantly, sanctions if any of its many requirements are intentionally transgressed. Five institutional elements, or social procedures, were examined in enough detail to see how their instructions might leave a mark on the world, see Figure 4. An overview of the outcome yielded a System that could be accommodating to PLHIV for a life they would want to live. However, these were potentialities rather than realities, but levers do allow the realization of potentials. It was therefore a system with capabilities enhancing potential in accordance with The Charter of the United Nations, and by definition this also meant it could be a system for the potential of human freedom. These analyses will hopefully convey the same idea in greater detail from the perspective of the fight against AIDS.

Level 1: WHO institutionalizing access to ART for public health

By simplifying the treatment strategy and limiting options to maximize public health goals, institutionalizing access to ART has made a big difference in allowing highly complex treatment regimens to be implemented in resource-limited settings, where
the diagnostic tests, equipment, and medications are highly limited. The institutionalization routinized access to ART by making the process to initiate ART less complicated; thus increased the collective freedoms (capabilities) of PLHIV to choose lives with ART. The outcome of the institutionalization process increased the collective achieved functionings of PLHIV as the result of more people undergoing HAART; which was the treatment that revolutionized the AIDS response, and had literally given PLHIV back the lives they would choose to live. Ultimately, with access to ART, work life in the UN system would become less acute, less stressful, less worrisome, and it is hoped, less deaths, in relation to AIDS. This institutional element is expected to increase the collective freedom of UN staff living with HIV in resource limited by increasing access to ART, therefore likely to be positively related to staff undergoing ART, and likely to have a positive effect on the subjective wellbeing of staff living with HIV in the UN system.

**Level 2: UNON arrangement covers ART costs for local staff**

The UNON institutional arrangement was specifically designed to increase the number of Kenyan staff undergoing ART by covering their ART costs. However, the number of PLHIV undergoing ART at UN Kenya have remained relatively unchanged over the past ten years. Although without more data it is not possible to ascertain the reasons for this relative stability, thinking through the possibilities yield:

1) It may indicate that either there has been few new HIV infections among UN staff; a possibility, although remote in a generalized epidemic; or

2) Local staff who have tested HIV positive are accessing treatment and care elsewhere; a possibility but the alternatives are much less appealing. It is also not easy to access care in Kenya, as there are only less than 2 doctors for every 10,000 people in a population of 47 million in 2016; or

3) Staff at risk for HIV may be avoiding routine HIV testing conducted by the UN Clinic, likely due to the fear of stigma; a high possibility. This may indicate a gap in reaching key populations most at risk of HIV in Kenya.

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147 Refer to UNAIDS (2006, February), op cit.
148 According to the Coordinator of UN Cares in Kenya (via email communication), and a reviewer of this manuscript, “Last year alone over 1,000 staff members were tested through the UN Clinic and over the World AIDS Day campaigns. Around 2013 you would come across 1 +ve result in every 10 persons but currently it is common to come across one +ve result out of 200 persons.”
Thus, the collective freedom of staff with HIV in the UN system has not changed with the intervention, as it has not been adopted elsewhere in the UN system; and not contributed to a system-wide increment of PLHIV undergoing ART as expected. Among people we had spoken to, the contribution had undoubtedly been positive. However, with only two PLHIV in the sample it was not possible to extrapolate on the subjective wellbeing of PLHIV at UN Kenya.

**Level 3: UNAIDS innovates by treating AIDS as exceptional**

Imagine the scene when the President of The World Bank Group, introduces the UNAIDS Executive Director and Under-Secretary-General of the United Nations, as heads of venerable institutions. Then a side story that betrays its significance is told:

It emerges that the younger Piot had, in 1979, seven-years before doctors in America sounded the alarm, made his way to the World Bank to interest them on a specimen from Zaire on what we now know as HIV. Piot was young, eager, not well known, and didn't know how to sell the idea; the bank had said, no. Imagine how much less suffering for certain populations, gay men especially, if the Bank had said yes. There may not have been the gay disease; the stigma that has caused the devastation of a generation could have been averted.

By treating AIDS as exceptional, UNAIDS manages to secure funding for the next decade for the AIDS response. These years have been crucial to set up the country-level infrastructure, the reporting and coordination infrastructure at UNAIDS, create National AIDS Council for HIV/AIDS decision-making in over 90 reporting countries that unified AIDS efforts under one body, strategy and action under one plan. The institutional innovation streamlines ART provision in countries. It is likely to increase the collective freedom of PLHIV, including UN staff living with HIV, as treatment and care becomes more accessible in countries. Thus, it is expected to have positive effects on PLHIV undergoing ART, and their subjective wellbeing as a result.

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149 There were plans to conduct in-depth qualitative interviews with 5 other PLHIV for this study to compile a list of valuable functionings, as well as conducting a survey with members of the Kenyan chapter of UN Plus to ascertain what are valuable functionings within the UN Kenya. These plans have been enlarged for a UN Plus global study to be conducted in 2016 and present results at the High-Level Meeting in June.
**Level 4: UNGA situating institutional logics of access to ART**

Situating the logics of access to ART among Member States of the UN General Assembly is not straightforward. The General Assembly started with wanting to implement universal access to ART, at the World Summit in 2005. However, when this was revisited a year later, the commitment offered by the General Assembly was found weak, indecisive, and HIV was unspecified in relations to any key mechanism such as universal coverage. The 2008 situation was similar but a global economic crisis had just started then, so the lack of decisive response is understandable.

In 2011, the situation had completely reversed, the General Assembly was highly enthusiastic and specified in detail the mechanism and framework of universal coverage and its associated components. A substantial achievement of 15 million people on ART had been reached by 2015 as a result of this specificity, and having come through delivering on its commitments. Applauding World Leaders of the UN General Assembly for their unity, commitment, and boldness is called for in 2011, and well deserved, as is UNAIDS for facilitating the process.

However, taking the five documents collectively, there was a shift in institutional logics on access to ART from universal access to something more compelling, “to end the AIDS epidemic by 2030”. Therefore, it seemed that this would be the key message to generate the same level of commitment at the 2016 High-Level Meeting. It is important to note that the ending of AIDS signals a shift in priorities that is pivotal. The key difference, besides its imperative, is this: it moves the intention of an embracing common access to service for all (which leaves the right to access with the client), to the finality of a goal, dated 2030, with an end point of eradicating AIDS.

But will AIDS really end like that? At a symbolic level, the goal-oriented logics makes it harder to recommend it as increasing the freedom of PLHIV, and relates to the issue of human rights protection when opting in and out of routine provider-initiated HIV testing. While in reality it must give PLHIV more freedom to be rid of AIDS, the notion on how it will be done does matter from the standpoint of collective freedom. Thus, in taking the long view, the primacy of the end of the AIDS epidemic by 2030 must include sustainability, human rights, and patient centred care. Until these issues

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150 See UNAIDS (2015).
151 See UNAIDS (2007).
are clarified, this institutional element is likely to have an indeterminate effect on the collective freedoms of PLHIV; it is not possible to assess the subjective wellbeing of PLHIV.

**Level 5: UN Plus as enterprising advocacy within the UN**

The UN Plus synthesis cannot be concluded decisively. The final step is left to the entrepreneurial UN Plus members; thus in the final analysis, it is unsure whether collective freedom of staff living with HIV in the System is attained or not. In terms of PLHIV undergoing ART, UN Plus does not directly impact this area, although the psychosocial support from linking HIV positive staff in association may be beneficial to each member undertaking ART.

The advocacy it is interested in pursuing on the iniquitous insurance coverage in the UN is nonetheless of great concern for UN staff undergoing ART, especially for economically and socially vulnerable staff. The present insurance system negates some PLHIV undergoing ART in the system, more so if the staff concerned comes from lower in the UN hierarchy, or is not a professional member of staff. The discriminatory and seemingly predatory insurance scheme that requires staff with fewer resources to pay relatively more for ART, is at the very least, a moral opprobrium.

Given its capability for agency within the UN system, UN Plus has the option of entrepreneurial action towards concrete advocacy goals. Thus, UN Plus has the capacity for improving the collective freedoms of PLHIV in the UN system, but it needs to exercise this privilege by strategic association rather than by any simple action. In the institutional analysis, by dis-embedding and re-embedding UN Plus in institutional logics, two additional functionings have been observed: its semi-autonomy and its associability.

Thus, at least on paper, UN Plus provides UN staff living with HIV more collective freedom within the UN system through the possibility for autonomous action independent of organizational hierarchy. However, for this capability to take effect, the association needs to design all the institutional mechanisms it will need to accomplish its goals.
In the final analysis, whoever designed UN Plus is certainly institutionally entrepreneurial, with the knowledge that by building something so minimal, it only has one tool in the box. Whether the reason for this minimalist design is to establish the association with the least obstruction, or to allow the association to unencumbered by legislative demands, or to remove the need for top-down control that define all UN institutions, there are no substantive records to argue either way.

As it happens, the only tool available to UN Plus is the same tool that people living with, and affected by, HIV have been successful wielding in their quest for social justice, which is through the formation of strategic alliances. It therefore indicates that the minimalist design is both purposeful, and thoughtfully strategic by lifting the association above the bureaucracy and inherent lines of power in the UN. This report proposes that the building of strategic alliances to advocate for, and successfully implement, access to ART as an imperative.
Institutional Mechanism to Build Strategic Alliances

Establishing and situating key terminologies

Institutional mechanism often refers to a formalized procedure of social action, such as congressional hearings in the United States as the mechanism for democratic participation, and formal education as the mechanism for human capital development. Institutional mechanisms can also be informal, such as corporate reputations facilitating trust between organizations.

Strategic alliance in the organizational behaviour literature commonly describes the joint efforts by organizations to attain benefits that are shared, but more recent research suggest that these may be more than simple instruments to achieve collective goals that benefit collaborating organizations. With regards to the United Nations, strategic alliances are required of Member States on economic and social conditions, international solutions and cooperation, and the universal respect for human rights, as they are intrinsic to its birth as a global institution.

The case of the One-stop Clinic had portrayed concerted institutional action from the majority of UN agencies at the Kenya duty station on the access to antiretroviral therapy (ART) for HIV for local staff. This report found the process had resembled a strategic alliance of participating UN agencies for the right to health of fellow UN staff; which is in accordance with the "path shaping" aspect of institutionalism where the future actions of institutions is inherently dependent on the developmental path that characterized its formation. The strategic alliance of UN agencies under consideration is defined by the following three criteria (with annotations linking the given criteria to the present case):

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152 For example, see Fiorino (1990).
153 For example, see Dias & Tebaldi (2012).
154 For example, see Bachmann & Inkpen (2011).
155 For an accessible explication of strategic alliances albeit this article is on alliances between organizations rather than between institutions within a system, see, Todeva & Knoke (2005).
156 These issues are defined in articles 55 and 56 of The Charter of the United Nations (1945).
Strategic alliances create interdependence between autonomous economic units (participating UN agencies), bringing new benefits to the partners in the form of intangible assets (governance responsibilities concerning the right to health of UN staff), and obligating them to make continuing contributions to their partnership (contributing to the cost of covering ART that is delivered through common services). ¹⁵⁸

Thus, by following the key events in the case study and identifying its key parts, this report proposes these events as milestones of an effective, albeit as yet informal, institutional mechanism of building strategic alliances for the right to health that had been operationalized by actors at the Kenya duty station of the UN system. ¹⁵⁹ It is believed that this informal institutional mechanism was the underlying facilitator for strategic alliance that resulted in the UNON institutional arrangement that eventually enfolded ART as a common service at UN Kenya.

Explicating these events will therefore provide the contours of the institutional mechanism that would otherwise be invisible as a result of its informality. The explication first contextualizes the conditions surrounding the UNON institutional arrangement, followed by three key non-sequential steps that operationalize the mechanism that executed the UNON institutional arrangement, and rationalized ART as a common service cooperatively borne by subscribing UN agencies. ¹⁶⁰

Identifying specific needs in particular contexts

Key to its initial success in Nairobi is the UNON institutional arrangement’s bespoke design that responds exactly to the specific needs of UN staff living with HIV in the Kenyan context and its historicity as described in the institutional analysis. HIV stigmatization at UN Kenya is derived largely from the visibility of AIDS in the physical wasting of staff, and their absence upon death. Expectations of stigmatization result in the late presentation of HIV-infected individuals for HIV testing and their enrolment into care.

¹⁵⁹ For an insightful and in-depth view of human rights advocacy through UN institutions and by strategically employing UN institutional mechanisms, see Becker (2013). Jo Becker is a staff member of Human Rights Watch.
¹⁶⁰ For the calculation of portions of contribution from each subscribing UN agency refer to the UNAIDS case study of the One-stop Clinic, UNAIDS (2006, February), op. cit.
Crucially, the antiretroviral therapy (ART), which has been made available to UN staff at the Aga Khan Hospital in Nairobi prior to the interventions described in this paper, is to no avail as uptake by Kenyan staff is woeful due to the fear of HIV-related stigma. Poor adherence to treatment, on the other hand, is the result of the inability of staff at the Kenya duty station to cover the entire cost of treatment, which inadvertently leads to missed doses and creative adjustments on how and when medications are taken.

Once the context is sufficiently understood and appreciated, specific needs that are contingent on space and time begin to emerge:

a) To circumnavigate the stigmatization by UN colleagues, the available treatment at the Aga Khan Hospital must be accessible without the need of identification so that no staff at the Kenya duty station who happens to be at the Aga Khan Hospital can relate particular staff with HIV infection due to perceiving the access to HIV treatment; and,

b) To ensure that staff will access the medication, and more importantly adhere to treatment, the treatment must be made available without payment at Aga Khan Hospital, and without the need for cash reimbursements.

Thus, on the surface, key features of the One-stop Clinic include the delivery of HIV treatment without physical cash transactions, and the ability to access services anonymously with the use of a generic key card. Important as they are, these features are not the bespoke features of the UNON institutional arrangement since they are service delivery options that the Aga Khan provides to all its clients. The bespoke features of the One-stop Clinic are subtler; it is the crafting of strategic alliances necessary in operationalizing the institutional arrangement through relational strategies. The following are key steps of the mechanism.

\[161\] This information is provided by the Resident Coordinator and has not been cross-referenced with the 2005 UNAIDS best practice report (UNAIDS/06.04E), which also describes the institutional arrangement.

\[162\] This information is cross-referenced by the Beneficiary and the Coordinator of UN Plus and UN Cares at the UN Kenya duty station.

\[163\] Relational strategies of organizing are strategies usually employed by actors competent in relationship-oriented communication, skilled in lateral and vertical communication, has a participatory decision-making style that capitalizes on informal networks, and works in an organization within the UN system that either has features of decentralizing decision-making, or the actor is of sufficient seniority to implement such means of organizing.
Engendering a collective vision

In engendering a collective vision, knowing the combination of needs and the realistic offerings of each actor are essential. These include, UN staff living with HIV as service beneficiaries, the Aga Khan Hospital as service provider, UN agencies including UNON as paymasters, and the common services platform at the Kenya duty station in which the transactions between actors will take place. The strategy for strategic alliances, which involves understanding each actor’s needs to match with what other actors can offer such that all actors will eventually have their needs fulfilled, can entail protracted negotiations if multiple actors have unrealistic expectations. Thus, tempering the expectations of actors on what may be realistically achievable may be wise as a first step.

Mobilizing towards shared objectives

Sharing objectives require a strategy to concretize available support, which is essentially goodwill, into quantifiable objectives that must be generalizable. In the present case, goodwill is materialized as a common quantifiable object of productivity of staff living with HIV at the Kenya duty station. Thus, the strategy for alliances involves transforming the various objectives of UN agencies, which may have particular goals that are non-controvertible, into an object that has a generalizable common quantity (i.e. productivity) and is acceptable to all. Hence, in essence, this strategic alliance allows the meeting of differentials in particular organizational goals with the differential in values of existing insurance coverage for UN staff with the full coverage that is required; which is through an exchange of concretized and generalizable organizational support in the UN system.

Generating political will for policy change

To generate political will for the policy change required to accommodate the UNON institutional arrangement, the strategy calls for the envisioning of the proposed service within the current policy trajectories of the UN. In the case of the One-stop Clinic, existing groundwork within UN Kenya on common services delivery provided the ideal place for the service, and greatly expedited the generating of political will. Through engendering a collective vision and mobilizing towards shared objectives,

164 These steps would otherwise be invisible given that informality by definition entailed non-codification.
the One-stop Clinic becomes rationalized in the rhetoric of common services delivery. To make the proposed service justifiable, which is crucial for the generation of political will to seal the strategic alliance, a cost-benefit assessment will be necessary. On the perspective of costs, the concretization and generalization of available goodwill in the mobilization towards shared objectives provided the necessary economic justification for the service. For the perspective of benefit derived from the service, on the other hand, the strategy of engendering a collective vision lays much of the groundwork. However, to clinch the generation of political will crucial for strategic alliance to bear fruit, the case study has shown that focusing on intangible and indirect benefits can be as important as direct benefits.

**Improving the terms of recognition of PLHIV in the UN system**

Elucidating procedures of an instrument that is deployed informally in organizations provides an opportunity for UN staff living with HIV to address the power imbalances caused by HIV stigma; which inadvertently diminishes the terms of recognition of PLHIV, and their social value, within the UN system. The key to changing these terms is in linking with other PLHIV to improve their visibility within the system. The chain to improving social value proceeds as follows: Being visible is the prerequisite to being counted in a system; and having been counted entails the possibility of being noticed; which is essential for resource distribution and the acknowledgement of needs. This chain of events occurs surreptitiously, and only becomes painfully obvious when recognition is actively denied. Thus, in reverse the chain summarizes the political mechanism of HIV stigma that marginalizes PLHIV from resources.

In elucidating the contours of this informal mechanism are two objectives: first, by providing its operationalization as an instrument, this report moves beyond perceiving the informal instrument to actually formalizing its institutional mechanism; and second, from the present discussion, the building of strategic alliance as an institutional mechanism will improve the politics of recognition of UN staff living with HIV as a collective, and where social value for PLHIV will accrue from its deployment within the UN system. Thus, it can be considered as a tool for entrepreneurial advocacy.

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165 Refer to Appadurai (2004) for detailed exposition on how marginalization can diminish a populations' terms of recognition, which is an important development on the politics of recognition and ascription of social value devised by Charles Taylor (1994).

Concluding Remarks

In the 35th year of the AIDS epidemic, the contributions of the UN system to the fundamentals of the AIDS response become clearer, and more poignant. From a thematic institutional turn, the UN system has deployed its institutional mechanisms in line with the procedures and values of its Charter; but this interpretation lacks explanatory power. Jessop contends that there are deeper institutional turns. In this study of institutional elements of the UN system in its response to AIDS, these insights finally emerged when comparing institutional elements with observable data.

At systemic levels, institutions matter; they are extensions of collective human will. UN institutions, in particular, reflect not only the collectives of peoples, they generate the spaces where collectives can coordinate and facilitate inter-group functionings. In other words, institutions are not only instrumental to human realities; they have been intrinsic to the human experience of collectives, and of collective social actions.

In this respect, UN institutions are of particular importance to humanity; originating as they have at the intersection of “untold sorrow of war”, and the dignity and “worth of the human person”; they serve as cultural reminders for humanity, of its determination and resolve to combine personal efforts to collectively have noble aims.

When tracing the institutional logics of the UN General Assembly, coming across the unified commitment of Member States during the 2011 High-Level Meeting on HIV/AIDS – which succeeded in getting more than 15 million people onto treatment by 2015 – the excitement remained palpable. The moment was both poignant with realization, and pregnant with expectation; for it spoke of confidence that within reach were the human capabilities that could bring forth an AIDS free generation.

167 Activists have criticized the WHO for acting too slowly at the beginning of the epidemic. See history of UNAIDS’s first 10 years, in Knight (2008), op. cit.
170 Articles 1 and 2 of the Charter of the United Nations (1945).
171 US Secretary of State Hillary Clinton makes this point in a remark during a news conference at the International AIDS Conference, Washington DC on 23rd July 2012.
Hence, it is with trepidation that the present moment is considered: will Member States display collective commitment in 2016 as they have done in 2011, to materialize a reality without AIDS? And will it be a reality that is rooted in human rights, solidarity and equanimity of all people living with HIV? Will it also include the prior promise that resolved to leave no one behind?

Given this momentous occasion, these research studies have been put together in reflexive response and with substantial thought. Dedicated to general staff and junior professionals living with HIV in the UN system, these case study and lessons learned on setting a precedent, and institutional instruments that complement the capabilities of UN Plus, collectively seek to motivate and mobilize PLHIV in the UN to advocate for enlarged capabilities, increased freedoms, and improved functionings.

Thus, as Member States of the UN General Assembly contemplate their collective commitment in response to the AIDS epidemic, so should PLHIV collectives within the UN system reflect on staff infected with HIV who have not been reached with HIV testing, treatment and care services; and in solidarity, take the stance that for the betterment of all, this iniquity must end.

In this prevailing atmosphere of funding cuts, and general uncertainty, the formalized institutional mechanism of strategic alliance can be deployed as a productive and enterprising instrument for UN Plus to connect with relevant parties and encourage the discovery of new potentials within present circumstances; while continually accruing social value in its deployment within the UN system.

To conclude, as the opportunities to forge new polities on the right to health and the equitable access to essential medicines are being maximized, entrepreneurial advocacy ensures that the collective social position of PLHIV within the UN system is being improved; despite prevailing politics intending a contrary reality. Thus, while wishing for a desirable outcome at the High-Level Meeting in 2016, UN staff living with HIV can use the institutional mechanism to build strategic alliances and become entrepreneurs on terms of recognition; refashioning in their wake the polities of the UN system for all PLHIV to have the kind of life that each will have reason to value.

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172 Referencing the High-Level Meeting on HIV/AIDS in New York on 8-10th June 2016.
173 Title of Michel Sidibe’s speech at the International AIDS Conference, Melbourne on 20 July 2014.
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The One-stop Clinic and Key Responses to AIDS of the United Nations System


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Appendix A: Informed Consent Script

Hello, I am Jackline Okinyi, a consultant research associate for UN Plus. UN Plus is conducting a case study on the One-stop Clinic UN Plus coordinated by UN Plus Kenya to provide insight on the genesis, decision-making processes and factors that have been key to its eventual success.

The interview will take at most 1 hour. Your participation is voluntary. The information you share with us would help us understand the thinking of key UN personnel instrumental in approving and implementing the programme, those who were interested to implement similar programmes in the UN system, and those who had decided against participating in these programmes.

We will be recording your voice digitally during the interview for research purposes. These recordings will be destroyed once the study is published. Only the people working on this study will have access to the recordings of this interview. You have the option of keeping your identity confidential, in which case any identifying information will be redacted prior to publication.

If you have important concerns about this study, you can contact the Yoshiyuki (John) Oshima, the UN Plus Global Coordinator at UNAIDS Geneva who commissioned this case study by emailing him at oshimay@unaids.org.

Do you have any questions for me before I begin?

[Once questions are resolved] Thank you. I shall begin with turning on the audio recording device.
Appendix B: Modular Interview Schedule

The questions are arranged thematically and themes are modular; where thematic modules are selected specifically to fit the experiences interviewees have had with the One-Stop Clinic. Each interview guide will therefore be custom-made by combining different thematic modules, and including additional probing questions. The thematic modules and key questions are as follows:

**Impressions and reflections**

1) When you first heard of the One-stop Clinic, what were your initial thoughts?
2) From your perspective, how is this programme different to other health-related programmes in the UN system?
3) How do you think this programme fits into the broader perspective of One UN as championed by the Secretary-General?

**Setting up**

1) What was it like to setup this programme?
2) What were the main challenges that you faced during the setting up process?
3) Were there any key moments during the setting up process?
4) If another UN country mission is interested in setting up a similar programme, what advice could you offer to help them expedite the setting up process?

**Approval**

1) Recalling the time this programme had been tabled for approval, what were some of main considerations being discussed?
2) What were the decisive arguments in support of the programme?
3) How challenging was it to get this programme approved?
4) Were there any arguments against the programme?
5) Who were the programmes main supporters?

**Funding**

1) How is this programme being funded?
2) How sustainable is the funding available to run this programme?
3) In your opinion, how can the programme be more cost effective?
4) What returns on investment does this programme provide to the UN?
The One-stop Clinic and Key Responses to AIDS of the United Nations System

Operations
1) What are some of the key components in running this programme?
2) How is the quality assured for this programme?
3) What were some of the most memorable moments in running this programme?
4) How does this programme fulfil the commitment of the Secretary-General to providing an equitable and enabling workplace for staff living with HIV?

Service recipient
1) How would you rate the service that you received on this programme?
2) How satisfied are you with the programme?
3) How has this programme fulfilled your needs as a person living with HIV?
4) What suggestions do you have to improve the quality of the service provided?

Impact
1) What benefit do you think this programme has had for UN staff living with HIV in Kenya?
2) How has this programme influenced the perception of HIV among UN staff in Kenya?
3) In your opinion, what benefit does the UN derive from this programme?
Appendix C: Analytical Procedures

Case study analysis

The following procedures were applied to the content of interviews:

1) The narratives related to emerging themes were then grouped under each theme and analyzed.

2) The reflexivity of respondents on the themes of the interviews was inductively derived, providing second order themes.

3) Similar to first order emerging themes, the narratives related to second order themes were grouped to retell the story as lessons learned.

4) In first order narratives, a running commentary was provided to tie in details from each respondent’s story. In second order narratives, the commentaries were based on the reflexive themes emerging from first order narratives.

5) Thematic emergence continued until a reflexive theme was derived, that closed the circular loop from which the analysis began.

Brief institutional analyses

A description of each level of analysis and the synthesis are summarized below.

1) Institutionalize access explored the process of creating and perpetuating the social organization of ART provision by the WHO from 2001 – 2005;

2) Institutional arrangement explored the processes undertaken by UN Kenya in 2003 to effectively coordinate with other UN agencies in Nairobi to provide local staff with a comprehensive healthcare insurance coverage for ART;

3) Institutional innovation describes the institutional turn of UNAIDS between 2003 and 2005 that leads to its success in securing country leadership and resource commitments to the AIDS response and ART;

4) Institutional logics plotted the commitments made by the UN General Assembly on ART access made between 2005 and 2015, focusing on commitments on universal access to ART, or ART more generally;
5) Institutional entrepreneurship provided a critical view of opportunities for UN Plus to dis-embed itself momentarily from the institutional logics (of level 4) to be a catalyst for organizational change on ART needs of UN staff from 2016 onwards.

Synthesis

1) In the synthesis, levels 1 – 5 are evaluated in the capability approach framework to assess the institutional elements used in improving the socio-ecological aspects of the PLHIV capability set. Bringing the analysis full circle, the study explored the institutional influences on the PLHIV capability set; or put another way, the collective freedoms of PLHIV within the UN system.¹⁷⁵

2) The assessment of each element began with its contribution to PLHIV undergoing ART, and whether this has been positive or negative. Based on this initial assessment, the evaluation projected the likely influence of the institutional element on the collective freedoms of PLHIV and the collective wellbeing of PLHIV in the UN system in particular, and beyond the system in general.

3) Although the generation of hypotheses has not been done in this study given the density of available material, it is possible to generate testable hypotheses for testing in future quantitative studies on the capabilities and functionings of UN staff living with HIV in the UN system.

¹⁷⁵ Personal characteristics are not included in the assessment as the analysis is conducted at an institutional level rather than an individual level. However, to be useful for policy advocacy, the valuation of capabilities by PLHIV in the UN system will be required.
Appendix D: Institutional Logics Script

2005: A/RES/60/1
Commit to developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it, including through increased resources, and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV/AIDS and other health issues, in particular orphaned and vulnerable children and older persons; (57/d).

2006: A/RES/60/262
Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010; (20).

2008: A/62/780
While recent increases in treatment access represent a major achievement, the current pace of scale-up will not achieve universal access to treatment, resulting in millions of people living with HIV failing to obtain the life-preserving treatments they need. National Governments, donors and other stakeholders should work to quicken the pace of treatment scale-up. This will require continued increases in financial assistance for treatment scale-up; and the establishment and strengthening of strong national systems for procurement, supply management, drug regulation, quality assurance and training of health-care workers. Despite being mostly treatable and curable, tuberculosis remains one of the most common causes of illness and death in people living with HIV. While continuing and strengthening efforts to achieve universal access to antiretrovirals, countries should urgently undertake initiatives to improve the prevention, diagnosis and treatment of TB in order to reduce the unacceptable burden of TB among people living with HIV. (71).
2011: A/RES/65/277

Commit to redouble efforts to achieve, by 2015, universal access to HIV prevention, treatment, care and support as a critical step towards ending the global HIV epidemic, with a view to achieving Millennium Development Goal 6, in particular to halt and begin to reverse by 2015 the spread of HIV; (51). Commit by 2012 to update and implement, through inclusive, country-led and transparent processes and multisectoral national HIV and AIDS strategies and plans, including financing plans, which include time bound goals to be reached in a targeted, equitable and sustained manner, to accelerate efforts to achieve universal access to HIV prevention, treatment, care and support by 2015, and address unacceptably low prevention and treatment coverage; (54). Commit to accelerate efforts to achieve the goal of universal access to antiretroviral treatment for those eligible based on World Health Organization HIV treatment guidelines that indicate timely initiation of quality assured treatment for its maximum benefit, with the target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015; (66). Commit to support the reduction of unit costs and improve HIV treatment delivery, including through, inter alia, provision of good quality, affordable, effective, less toxic and simplified treatment regimens that avert drug resistance, simple, affordable diagnostics at point-of-care, cost reductions for all major elements of treatment delivery, mobilization and capacity-building of communities to support treatment scale-up and patient retention, programmes that support improved treatment adherence, directing particular efforts towards hard-to-reach populations far from physical health-care facilities and programmes and those in informal settlement settings and other locations where health-care facilities are inadequate, and recognizing the supplementary prevention benefits from treatment alongside other prevention efforts; (67).

2015: A/RES/70/1

We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development. (26).