‘Antwerp in Geneva’ workshop on the AIDS response and Health Systems Strengthening in sub-Saharan Africa

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Background

Critical views have recently been expressed about AIDS control programmes in sub-Saharan Africa, with several authors suggesting that AIDS programmes receive a disproportionate amount of global health funding and may contribute to weakening health system in developing countries. These views are reminiscent of long-standing debates in public health. In the 70s and 80s there was considerable debate around the dichotomy between comprehensive primary health care (Alma Ata) and selective primary health care. More recently, it has crystallized around the need to strengthen health system to reach the Millennium Development Goals.

Whether the objective is to increase access to antiretrovirals or access to primary care, there is an emerging consensus around the need for "health systems strengthening", supported by all stakeholders involved in health care and disease control in sub-Saharan Africa.

Objectives of the Workshop

On 28 May 2008 the Institute of Tropical Medicine (Antwerp, Belgium) hosted a meeting at the World Health Organization (Geneva, Switzerland) to review the evidence on the effects of AIDS programmes on Health Systems, particularly in high HIV prevalence settings, and discuss the way forward. Over 30 participants attended (see appendix) from a range of backgrounds (implementers, activists, academics and funders) and HIV-affected countries (Ethiopia, Ivory Coast, Malawi, Mozambique, South Africa, and Uganda). The following report summarizes the main issues that were discussed at the workshop, including the harms and benefits of HIV programmes for health systems and primary health care, debates around continued AIDS exceptionalism, and considerations and policy options for HIV programmes to maximise their potential to contribute to health systems strengthening.

This report is organised around the major issues/debates that have been raised around AIDS programmes and health systems, particularly the financing, organisation and delivery of health systems. The discussions were informed by country experiences presented from a number of high-burden countries in sub-Saharan Africa and evidence and experience from meeting delegates. To encourage participation it was agreed that no statements made during the meeting would be attributed to a particular individual or organisation.

Is AIDS over-funded? How has it affected funding for health systems and primary health care?

Recent and rising criticism has been levelled at the amount of aid resources going to HIV compared to other health problems, and in particular compared to the need to strengthen health systems in less-developed countries to respond to a range of other health problems.

It has been argued that AIDS is receiving a disproportional share of limited global health aid budgets. There is an argument that AIDS programmes and the bottlenecks experienced in delivering on commitments on prevention and treatment have brought much needed

attention to the weakness of health systems and thus increased demand for other areas of health financing, such as for health workers.

HIV is substantially better resourced than many other health priorities, and this has created tensions. However, it cannot be said that HIV is 'over' funded: the majority of patients needing ART are still not receiving it and there is still a considerable funding gap between what is needed and what is provided. Rather, insufficient health care funding overall creates competition for these scarce funds.

There is no evidence that, at the global level, aid for AIDS programmes has displaced aid for health sector development – both have increased considerably over recent years. However, in certain countries increased donor spending in the public sector, generally on budget support and specifically on programme areas, is squeezing national spending on health. Spending ceilings of the International Monetary Fund (IMF) continue to be a real obstacle to increasing health care expenditure in some countries. While there has been some report of IMF indicating some relaxation of limits to enable absorption of AIDS resources, country experiences suggest that this is not consistently applied, and that many countries still work within austere and strict fiscal frameworks.

Where macroeconomic policies impose expenditure ceilings, the substantial levels of external resources made available for AIDS within public sector health budgets can mean that less resources are allocated to health sectors from national budgets, to avoid exceeding set expenditure ceilings in the Medium Term Expenditure Framework. This 'crowding out' is a cause for frustration, given the demand for these resources to meet health need. In some approaches AIDS resources are applied outside public budgets, as extra-budgetary project resources. While this can create opportunities for increased resourcing above expenditure ceilings, it also creates parallel financing, segmented from wider sector financing, and can undermine integration of AIDS resources within resource allocation mechanisms for wider health systems strengthening.

Donor concerns about sustainability at the national level prevent the scale-up of funding at the international level. Donor priorities also fluctuate, which creates unpredictability in funding streams that frustrate long-term planning at the national level. This is not unique to AIDS programmes, but has become more critical with the level of AIDS financing, particularly given the demands for international resources to support recurrent spending on the significant scale up of health workers needed to deliver these programmes. Donors have used issues of national sustainability as an argument against investing aid in recurrent staffing costs, increasing the overall share of spending on personnel in health budgets. This problem could, however, be resolved by greater predictability and sustainability of international funding.

HIV funding can be directed at supporting health systems strengthening. While countries reported difficulties in early years in persuading large external funders to provide health systems support, this is changing and funding from the Global Fund and from bilateral and foundation funders is increasingly accepting health systems financing as part of the support provided. In Ethiopia for example a significant proportion of HIV funding goes towards the construction and renovation of health centres. Laboratory services created to support HIV services are available for all needs, and the supply chain has been strengthened across the board. Such 'trickle down' effects need to be led by clear targets. Mozambique, Uganda, and Zambia reported similar examples of how HIV funding has broadly supported specific areas of the health system.

Various examples were also presented of opportunities for synergy between funding support for AIDS services and for strengthening of related-services, including PMTCT and maternal-child health services (as was done successfully in Cote d'Ivoire), and or where resources for ART management are also applied to support management of other diseases, notably tuberculosis (TB) and chronic illnesses.

Have HIV programmes strengthened or weakened health systems?

Significant debate has been generated on whether AIDS programmes have in their design or implementation strengthened of weakened health systems. From the experience and evidence presented at the meeting, both benefit and harm were observed.

Any discussion on benefit or harm is dogged by the counterfactual of what would have happened to health systems without AIDS. Many health systems in sub-Saharan African countries with high HIV prevalence were experiencing falling expenditure, and constraints to comprehensive primary health care. Before antiretroviral therapy (ART), AIDS was causing overwhelming numbers of sick people to arrive at health services sick with opportunistic infections. At the same time, HIV was taking a considerable toll on health workers, with HIV mortality reported as the leading cause of staff attrition in some countries. The emergency of illness and mortality undermined health worker morale, adding to push factors in poorly serviced areas. Conversely scaling-up ART to a good level of coverage can rapidly turn the tide, decreasing mortality, hospital admissions and consultation times, and enhancing health worker morale. It is thus a matter of concern that may countries with high HIV prevalence have not yet attained ART coverage rates to achieve these population health effects.

Evidence of health systems strengthening effects

During the workshop various examples were given of how HIV programmes have broadly strengthened health systems, including where resources for AIDS programmes have been used for strengthening general laboratory services, improving the procurement, management and supply of medicines, establishing new cadres of care and new forms of community literacy and engagement in health, and where approaches to prevention and management of AIDS have placed greater attention on the role of ('expert') patients in care, integrated AIDS care within wider service provision and improved utilization of general services as a result of greater confidence in services overall.

A number of important lessons from AIDS programmes could thus be applied to health services more generally. These include patient involvement, approaches to supporting enrolment, adherence and loss-to-follow up for chronic care, optimizing models of delivery for marginalized groups and community involvement of health care delivery. In particular, the rights-based approach employed by AIDS activists – refusing to accept the status quo of insufficient resources – could be expanded to general health care.

These effects need, however, to be specifically planned for. Malawi provides a good example of how HIV care can be integrated in and improve primary care. When HIV programmes began, 50% of positions were vacant, 90% of health centres couldn't implement the Essential Health Package. Total health expenditure was less than half of what is estimated to be required as an absolute minimum. Malawi realised that without addressing these weaknesses the AIDS programmes could not be implemented. The ART programme was rolled out as simple, standardized, inclusive, and integrated programme. ART is to a large extent integrated in health services run by staff who also run other services. Resources were mobilised for an overall increase in health worker numbers, while specific skills were built for managing AIDS programmes and health worker's own ART needs addressed. HIV affects a significant number of health workers in Malawi and published data have shown that without ART more staff would have died than are needed to run the ART programme. Through this integration the increased resources for AIDS were more widely applied to health systems. Total health expenditure rose by 80% in the three years since the start of the ART programme. There is an argument that virtuous links between AIDS programmes and health systems benefit both. This was the case in Malawi, where the health systems strengthening approach enabled over 140,000 people to receive ART as of end 2007.

Another positive example is Cote d'Ivoire. HIV is the leading cause of mortality among adult males in Cote d'Ivoire, and only around half of the 78,000 estimated to need ART getting it. AIDS is mostly funded by external initiatives but these were used to lever domestic resources and to critically review chronic health care models. To respond to HIV the government

proactively engaged doctors who were previously unemployed and increased doctor salaries across the board. New models of care were established, including home based care, that mobilized additional actors through community engagement and task-shifting. New approaches were also developed, using a simplified approach for lab and other services.

But also evidence of harm to health systems

During the workshop various participants presented examples of negative effects of AIDS programmes on health systems. These were mostly related to effects on health workers, especially in countries where health worker shortages are acute. Well-funded HIV programmes can drain health workers from general health services to work in externally funded HIV programmes. The impact of this depends on the scale of the HIV problem and on the availability of HRH: health care worker (and academics) movements towards HIV care will have a different impact in high prevalence settings. In Malawi, for example (adult prevalence: 12%) where over half of consultations at primary care level are HIV-related, attending to HIV has contributed to alleviating the overall burden of disease at primary care. However, in Ethiopia (adult prevalence: 2%) the shifting of primary care staff towards HIV services is having a negative impact (particularly when staff are moved from public sector clinical work to private sector non-clinical duties such as monitoring and evaluation and management)

A particular concern relates to the proliferation of perverse incentives (per diems for attending workshops and trainings) that encourage health staff to be away from clinic duties. All this occurs in an environment where considerable resources are directed at HIV. Where donor guidelines often prohibit expenditures on salaries, new activities depend on existing human resources, creating competition and stress over health worker time in a context of overall shortfalls (as highlighted in a presentation from Uganda).

A second area of concern regards fragmentation of health services. Examples were given of setting up of parallel systems for ARV distribution, instead of strengthening national drug

distribution systems. Particular concern was raised in presentations from Uganda, Mozambique and Zambia around the issue of monitoring and evaluation, where the demands of multiple donors can create a significant burden on the health system, requiring new management systems to gather data that is not shared at the country level. This creates a secondary demand for technical assistance in some countries, simply to meet the demands of donors.

Certain forms of results-based financing push for narrow targets. For instance, a drive towards achieving a set target of numbers of patients on ART in short time frames can weaken attention to the achievement of wider health systems impacts and wider health service impacts. There may be a need for different performance targets. It was suggested that performance targets need to look at the whole spectrum of care, and need to measure not just access to treatment but also adherence and survival (as these are also affected by wider conditions and services) and systems issues like health worker retention. Negotiating for these wider mechanisms and outcomes was noted to depend on strategic planning in countries, to set priorities that enhance the integration of AIDS and health systems and engage the donors to try to meet these priorities.

Building synergies between AIDS programmes and health systems: conclusions from the meeting

The meeting, and this report, gives evidence of the potential that HIV programmes have to contribute to health systems strengthening. There are now a range of positive impacts achieved and documented in country experience, and the lessons learned from these need to be more widely applied. The negative impacts in segmented financing, perverse incentives, health worker migration, narrow targets and service fragmentation are also documented and can be planned for and controlled. The most common negative impact noted – the diversion of human resources from other services – is exacerbated by a context of scarcity of health workers that has been given profile by the demands of AIDS programmes and needs to be addressed in its own right. A priority needs to be given to human resources development.

While countries can set priorities and engage donors to try to meet these, this calls for a scale up of predictable sustained international funding to support credible, strategic plans, enabling a review of the expenditure limits constraining absorption of these resources.

The fundamental problem that has resulted in the false dichotomy between AIDS and comprehensive primary care is that health care in general is grossly under-funded in developing countries. HIV today receives proportionally more money than many other diseases, but it too remains under-funded. There is an acute need to increase investments in health and improve predictability and global sustainability. This means addressing international policies that limit spending on health. A comprehensive health systems perspective is needed to plan for resource requirements not on the basis of what is currently provided but on the basis of need.

Scaling up of HIV care needs to continue and even accelerate, but more attention needs to be placed on measuring the broader impact of delivering these services, including a focused analysis of the impact of HIV programmes on health systems. The priority for evidence is not to assess whether HIV programmes are "good" or "bad" per se, but to learn lessons that will maximize benefits and minimize harms. Such an assessment needs to be realistic about to what extent we should expect HIV programmes to fix health systems.

Important country-level experiences are emerging but these are not efficiently shared between countries. Regional exchange platforms should be developed to encourage replicating successes and avoid repeating failures. There should be support for learning within countries and for exchange of learning between countries with comparable challenges: peer review of plans and policies and regional exchange platforms between ministries of health.

There is an absence of policy guidance and meaningful targets for achieving maximum synergy between global health initiatives and health systems. Clear international agreement

is needed on what indicators for health system performance need to be measured, not least to reduce the burden of multiple reporting requirements.

Perhaps the most important lesson from the AIDS response is the need to promote a rights-based approach to health, a perspective that refuses to accept the existing status quo of human and financial resource constraints. There needs to be greater advocacy for a dramatic increase of health sector resources, both from national budgets and from international support; the latter should be considered not as an act of charity but as part of the obligation to fulfil universal human rights. This can be encouraged by involving civil society at all levels of health system strengthening.