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In this issue:

Bridging the divide: HIV and health systems; *by Theo Smart* *page 2*

- Why the HIV community should care about health systems strengthening
- The false dichotomy of horizontal versus targeted systems
- The high-level panel discussion on HIV scale up and global health
- The experience of MSF and GAVI
- Integrated service delivery case studies
- Integration challenges for Malawi
- Ghana
- Conclusion and next steps

Bridging the divide: HIV and health systems

By Theo Smart

"The world sometimes seems to be divided between the HIV people and the health systems people. I think we all care about the same thing – which is the health of people – but nonetheless it is a big divide. So one of our key goals today is to bridge that divide," said Dr Wafaa El-Sadr, Director of the [International Center for AIDS Care and Treatment Programs](#) (ICAP). "And then there is the divide between implementers – the people in touch with what happens on the ground – versus the policy makers and researchers; the divide between the global and local experts; and the divide between prevention and treatment is also there. [These divides] set us up to have inefficiencies and missed opportunities."

Dr El-Sadr was speaking at '[Bridging the Divide: Interdisciplinary Partnerships for HIV and Health Systems](#)', a meeting held from July 16-17 2010 just before the [AIDS 2010 Conference](#) in Vienna, Austria. The event brought together HIV community thought leaders, experts from other health programmes, health economists, and health systems specialists to look at data on the impact of the HIV scale-up on health systems to try to foster interdisciplinary partnerships for future collaboration.

Why the HIV community should care about health systems strengthening

As Dr El-Sadr noted, over the last several years, the relationship between these factions has been more than contentious. There have been extremely bitter disagreements between the HIV community and advocates for general health systems strengthening and other disease areas who charge: 'HIV gets too much money,' 'AIDS funding warps [or even destroys] health systems,' or 'easily treatable diseases that kill more are being neglected because there is too much of a focus on HIV.'

Given the extent of HIV disease in many countries, especially southern Africa where hospital beds were filled with people dying of AIDS and already weak health systems were collapsing, many of the attacks have often seemed unfair.

A decade ago, when many of us became engaged in introducing the benefits of HIV care and treatment to the majority of people with HIV who live outside the industrialised world, it was with the understanding that this wouldn't simply mean the introduction of antiretroviral therapy.

HIV is a complex disease that, by definition, involves vulnerability to a wide range of other illnesses. And it was clear that the effective management of the HIV epidemic could not be accomplished without addressing some seemingly intractable social problems and severe health system constraints.

So contrary to how the HIV field has been portrayed by some, it is not a 'single-disease' issue. Furthermore, many people working in HIV were excited by the prospects of building upon the AIDS movement, leveraging the momentum behind the scale up of HIV care to address other global health issues, such as TB, malaria, neglected tropical diseases, maternal and child health while simultaneously strengthening weak, outmoded, or overwhelmed health systems in many countries.

But the current polarised debate about HIV vs other healthcare priorities – egged on and abetted by bloggers and

pseudo-economists who are really against any foreign aid whatsoever – has been exceptionally damaging, pitting potential allies against each other and providing a convenient smokescreen for governments, including the Obama administration in the US, to break their promises to support universal access. The recent failure to adequately support the work of the Global Fund is but the latest example. In truth, the economic crisis has been used as an excuse by wealthier nations to resist calls to simply 'make the pie bigger' for global health, making the competition for limited resources for health all too real.

Overcoming what are essentially 'divide and conquer' tactics is no small challenge. Dr El-Sadr, who is also the Director of the Center for Infectious Disease Epidemiologic Research (CIDER) at Columbia University's Mailman School of Public Health, has long been a voice of reason calling for moderation and collaboration.

"Instead of harnessing the great global health topics of the day – health systems strengthening, disease-specific interventions, and the Millennium Development Goals – into a unified vision, we have allowed the appearance of competition among these issues, and perhaps this represents the greatest failure of leadership," she wrote last year, with Dr Kevin De Cock, of the US Centers for Disease Control in Kenya.

In some instances, there is more than a kernel of truth to accusations that HIV funding was not well co-ordinated, with duplication of efforts and the establishment of parallel systems or that it promoted overly centralised responses and was drawing healthcare staff away from other essential services. In other words, the potential exists for the HIV programmes to skew health systems, and here and there, it happened.

At the same time, the evidence-base supporting the accusations has been overstated, and the HIV response cannot be blamed for problems that really predated it.

As Dr Rifat Atun, Director of Strategy, Performance and Evaluation at the Global Fund stressed, the HIV response began in a context where both "HIV and health systems had been under funded, with huge unmet needs, weak health systems in low- and middle-income countries – and a weak political commitment. [But] rather than thinking about solutions we've been having a debate in a vacuum because the evidence-base is rather weak to stake out a position."

Dr El-Sadr agreed that the debate has been guided more by people's opinions rather than being data driven. To remedy this, one of the Bridging the Divide Meeting's key objectives was to look over the available data and evidence from implementation research and to develop a priority research agenda to help produce better data on HIV and health systems.

The data are not all negative: with the massive and unprecedented infusion of resources to fight HIV/AIDS, it is easy to point to numerous cases where the HIV response has strengthened some aspects of health service infrastructure, promoted equity of care (particularly among marginalised vulnerable populations) and service delivery. In addition, the success of the HIV response also has the potential to serve as a model for addressing other essential health needs – especially for chronic health problems, such as diabetes, which have long been neglected in most resource-constrained health programmes. As Dr Atun and others at the meeting pointed out, there are a host of potential 'positive synergies.'

However, Dr El-Sadr stressed that simply aiming for what have been the incidental benefits or "by-effects of the HIV response" is not enough. Rather, she said, "we need to think collectively about how we can develop a response that will achieve common health

outcomes that bridge not just HIV but some of the other health risks that the communities face.”

Indeed, without getting bogged down in assigning blame, it is worth investigating whether there have indeed been missed opportunities to make the best use of HIV funding and expertise; have some approaches or programmes done better; and how can we make certain that HIV programming is better leveraged to strengthen health systems and improve care for other priority health conditions?

The meeting format

This was the third in a series of meetings dedicated to exploring this issue. With support from the Rockefeller Foundation, the first meeting was held in Bellagio, Italy in September 2008 (a report is downloadable [here](#)); and the second, last year during the IAS meeting in Cape Town in 2009 (see [here](#)).

Given the large number of presentations, and involved discussions at the meeting, this HATIP can only draw attention to some of the meeting's highlights. However, webcasts of the meeting are [now online, along with the speaker's PowerPoint presentations](#).

The false dichotomy of horizontal versus targeted systems

After the introduction to the meeting, Dr Atun pointed out that the debate about comprehensive or general health services vs so-called vertical services (or rather, services targeted to specific health concerns) has been going on for decades. But while some health programmes are over-reliant on targeted health systems (such as the hyper-verticalised health systems of many countries of the former Soviet Union where people with more than one health problem may have to visit several different clinics), general and targeted health services are rarely diametrically opposed.

“This polarisation has not been helpful. This false dichotomy on targeted versus health system investments has really led us to waste quite a lot of valuable time,” he said. As one example, Dr Atun described much of the money that countries request from the Global Fund to fight AIDS, TB and malaria is directed to health systems strengthening (most commonly human resource development).

“We analysed our portfolio investments for rounds 1 to 8 to demonstrate that around one-third of our investments go to health systems strengthening activities. To date we invested around 10 million, so there's US \$3.3 million of this has gone into health systems strengthening. And we did a similar analysis with GAVI – actually we have a paper that is currently going to press – and similarly GAVI has invested substantially through immunisation to benefit health systems,” he said.

Dr Atun also described a systematic literature review of case studies that looked at the factors that influenced the extent and nature of integration of vertical programmes and tried to explore how varied health system designs and delivery models influence outcomes. “We analysed almost 8,274 articles using a rigid Cochrane approach, to demonstrate that there are only 12 articles that had compared integrated versus non-integrated programmes and looked at outcomes as a result of each,” he said, adding that most of these were from the US and the UK looking at mental health.

So working closely with the Cochrane group, they looked for better quality data outside of randomised clinical trials and were able to include evidence from targeted programmes on dengue, malaria, schistosomiasis, leprosy, nutrition, immunisation, child

health and development, family planning, HIV/AIDS and STDs from a number of resource limited settings. What they found was that there was no such thing as a totally unintegrated programme.

“This debate of vertical versus horizontal, unintegrated versus integrated care is highly reductionist and completely false,” Dr Atun said. “[Rather], countries have come up with solutions that are relevant to their context. This picture will change over time; the countries are doing what works for them best so that the nature and extent of integration varies. So what we are seeing is a very rich and complex mosaic of integration of functions... [and] context matters because you are dealing with complex adaptive systems.”

That being said, Dr Atun noted that a paradigm shift was needed (and is occurring) in the way we think about HIV/AIDS and health systems. Several things are happening at once – weak health systems are hindering the scale-up of HIV care and treatment, and “the political commitment, which got us here, is actually waning.” Resources are more constrained but at the same time, “we now understand, and have been able to demonstrate that the health MDGs (Millennium Development Goals), and also MDG 2 and others are inextricably linked. We cannot really separate 6 from 5 from 4 – if you're investing in one, it will then benefit the other. And we're beginning to see a spirit of collaboration,” he said.

But beyond these changes, Dr Atun believes the nature of the HIV response also must change.

“We need to think about managing AIDS as a long-term illness with a rapidly increasing cohort on treatment, 5 million people due to increase to 7 million plus by 2015... they are really entering the domain of long term care and we are not prepared for this,” he said.

To manage this transition, partners upstream will need to harmonise and align existing support, with joint analysis at country level to assess need; joint planning with countries, joint investment and joint monitoring and evaluation to reduce the burden on countries.

“But downstream, these activities need to translate into structural and operational integration relevant to the context. Integration is not an end in itself, it's a means. It needs to be done in a way that will achieve the objectives of equity, efficiency and effectiveness – innovation to outcomes. We need to think about long term care models, and we need to focus on value for money to ensure sustainability,” said Dr Atun.

The high-level panel discussion on HIV scale up and global health

Following Dr Atun's talk, there was a panel discussion between a few representatives of differing ‘targeted health services’ and, in a rare public appearance at an HIV-related meeting, Dr Zeke Emanuel, special advisor to the Obama administration on the Global Health Initiative. Two of these targeted health services included services aimed primarily at mothers (emergency obstetric care – EOC) and children (immunisation), which will both receive increased support through the Global Health Initiative.

Emergency obstetric care

“On its face I would say that maternal mortality reduction, as a service delivery matter, looks very different from HIV,” said Professor Lynn Freedman, a lawyer and specialist with Averting Maternal Death and Disability Program at Columbia University's Mailman School of Public Health. “Maternal mortality is fundamentally different. It is primarily and at its core about mounting an emergency response. [Child birth] complications that cause the most deaths in women are actually complications that for the most part can't be predicted or prevented, but they can be treated. So

maternal mortality reduction is about ensuring women have access to emergency care in time to save their lives. In that sense, chronic treatment for HIV looks very different from the poor interventions from maternal mortality."

But even though the nature of the intervention is different Prof. Freedman stressed that HIV has synergies with maternal mortality services. She stated that both need skilled health providers [birth attendants], and that EOC "doesn't implement itself – it never ever happens as a by-product of just general systems strengthening. It needs focused attention to implement," she said. In addition, she believes that maternal mortality advocates need to look at how HIV has developed implementation support systems, particularly to reach the poor who don't usually make it into the health system.

"Neglect, abuse and marginalisation by the health system is part of what it means to be poor," she said. "Services are often looked at [in terms of] just the people who come in. We need to think about how the health system addresses the people who never get there. And that is certainly where most of the maternal deaths are."

Health systems should not be seen merely as delivery systems, according to Prof. Freedman, they are inherently social and political institutions. "Their operations are fundamentally driven, not really by epidemiological evidence, but by political dynamics."

Consequently, maternal health advocates can learn from HIV activists.

"We need to build a social movement that really uses local communities to make demands. And lastly, calculations about priorities and about cost-effectiveness need to go beyond narrow/straight burden of disease issues and also take into account these important social and political roles that the health system plays... You have a right to be treated a particular way by your government by the powers that be, who are represented in your life by the way the system functions."

The experience of MSF and GAVI

MSF's experience

Dr Eric Goemaere, the senior regional TB/HIV medical adviser of Médecins Sans Frontières (MSF) picked up on this point regarding how the HIV response has been the result of demand generation in the community. Recipients of HIV care are not passive recipients.



(Photo shows: Eric Goemaere. ©IAS/Marcus Rose/Workers' Photos)

"Something we have learnt is that there is now an ongoing interaction with the beneficiary which is a demand-driven approach.

The ones who pushed to have access to treatment, they are the ones who are queuing in front of my clinics, they are the ones who are saying, 'I want to be treated and I don't want to die!' This is something slightly new. Now here we speak about people who are voting with their feet, who are interactive with the health service, who are playing a 'watchdog role.' We have [triggered] a paradigm shift because we have triggered political priorities, not only at international level but at national level. National governments are forced – like the South African government after a long battle – to respond to the people's request. So let's not go too quickly into that transition phase. Let's be cautious because it's an unfinished agenda."

As for the shift to a chronic disease model, Dr Goemaere, believes this can only occur once HIV care is moved to the primary healthcare level. "What it means is that we have to get out of that situation where very sick patients with a lot of opportunistic infections requiring a lot of clinical attention are flooding the clinics." He believes that rationing care would simply backfire. In fact, to make the shift to primary care possible, there may need to be an initial increase in expenditure to provide more patient-centred care. In other words, it may cost more to treat HIV earlier (at 350 CD4 cells), to use tenofovir in the first-line regimen, and introducing new drugs and new patient-friendly formulations – but it will also simplify care so that a nurse is able to manage the patient.

"The faster we move to primary healthcare – and that is what is happening – the more integration will happen naturally. This is for the simple reason that most of the primary healthcare clinics – at least in the part of the world where I live – have a very limited amount of staff and they cater for absolutely all sorts of demands there," he said. However, he believes the integration should have measurable targets, and that some areas are priorities for integration with HIV services, such as TB and maternal child health services.

"To give a practical example – the new ART providers are not the nurses anymore, they are the midwives. The first appointment for children for their PCR test is at 6 weeks. Why 6 weeks? Because it is their first [immunisation] appointment. So the one triggers the other and both will reinforce [each other]," he said. Dr Goemaere was not so convinced that there is a need to integrate with care for high blood pressure and diabetes, as he did not believe these to be high priorities in South Africa. There was some disagreement around this point. In the discussion afterwards, Professor David Saunders of the University of Cape Town claimed that there are already data suggesting that chronic diseases in Khayelitsha contribute slightly more to premature years of life lost than HIV. Indeed, there are data from other sources showing that these chronic diseases are growing in importance in South Africa and are growing more common in people with HIV as they age on treatment.

But for the time being, there can be little doubt that the need to co-manage TB and HIV care is the most pressing concern.

The GAVI Alliance

And yet, another panellist, Julian Lob-Levyt, who is the CEO of the Global Alliance for Vaccines and Immunisation, pointed out that one of the lessons that has been learnt from the HIV response is that chronic diseases *can* be managed in resource-limited settings.

"The reality now, is in the poorest countries, in the poorest communities in the world, you have hypertension, you have diabetes, you have chronic diseases emerging and the systems are not set up to do that. HIV has taught us that you can manage chronic diseases and we need to really urgently capture those lessons and make a difference," he said.

He stated that the HIV response has also shown that it is possible to deliver complex interventions to the community and to achieve high levels of coverage.

"People said you couldn't do that – and we can use non-medicalised models to do it – that is extremely important," he said adding that he agreed that "community participation whether through activists or to the full range of civil society – is absolutely critical to that success and needs to be fully involved and engaged."

But he stressed that there are many opportunities for health services integration that are being missed – such as the introduction of the anti-HPV vaccine to prevent cervical cancer (which kills 200,000 women per year), into school health programmes, reproductive health, HIV and family planning work at the same time.

"Where do synergies begin? Let's remind ourselves that a child infected with HIV is 40 times more likely to die from pneumonia. An adult infected with HIV is significantly more likely to die from adult pneumonia. We must ensure that the pneumococcal vaccine, a simple technology, reaches 80% of kids so that the whole community is protected. That is where the synergies begin to align. We should no longer treat these as separate efforts."

One of the things that keeps countries from taking advantage of such opportunities for integration and improved service delivery is the difficulty co-ordinating aid from a large number of donors. Lob-Levyt described the plight of one community health worker who spends half of her time reporting to fifteen different funding partners.

Solutions have to be country driven, and donors need to harmonise funding commitments, and improve the way they work together with developing countries to develop and implement national health plans – including harmonising their monitoring and evaluation requirements. One effort in this direction is the [International Health Partnership](#), which includes the GAVI Alliance, the Global Fund and WHO and seeks to achieve better health results by mobilising donor countries and other development partners around a single country-led national health strategy.

The Global Health Initiative (GHI)

The need to integrate donor efforts was also towards the top of the US government's agenda with the GHI, according to Dr Zeke Emanuel.

"We take the word 'integration' quite seriously – those of us who are helping to formulate policy – and it is integration within the health systems, but I think it's also a much larger principle within the whole development aid framework and the rethinking of the whole development aid framework," he said. "It's also an issue for multiple agencies – this is a shared responsibility, no single country, no single group can answer this issue with 33 million people around the world infected with HIV, with many millions more suffering from a lot of other diseases."

Dr Emanuel placed great emphasis on saving the most lives for the least amount of money.

"We need to – in [measuring results] – focus on saving lives, improving health outcomes *that really matter to people* and not just dollars and cents. There are a diversity of approaches but we need to be able to evaluate whether that diversity – or which ones of those diversity – are giving us better value for money, which ones of those are being more effective? Again, not just in narrow outcomes but in broader outcomes *that we all should care about*," he said. But he insisted that the Obama administration's commitment to the fight against HIV/AIDS was not lagging.

AIDS activists present at the meeting took exception to Dr Emanuel's claims that the GHI didn't represent a flat-lining of aid for HIV, and held up signs reading 'Zeke, No retreat.'

During the discussion, Dr Goemaere asked Dr Emanuel what would be the impact of sending governments and communities a different message about donor support at this time. He noted that at the beginning of the HIV programme in Khayelitsha, it was almost like a small private programme, but that it had built up trust and confidence "by bringing evidence to the community. It's absolutely unique that we managed to have such coverage in some provinces. Lots of people, who have never come to the health services, are coming today. Why so? Because we are selling a good product and because we worked with them via treatment literacy, via different means so that they understood what we were talking about. So they vote with their feet, they are there, they are queuing, they put the pressure on. Primary healthcare for a long time didn't have that pressure," he said.

Furthermore, Dr Goemaere went on to say that severely resource-constrained governments such as Malawi and Lesotho have been encouraged to roll-out programmes but are absolutely dependent on international funding.

"How do you manage today to maintain that level of trust – both at community level and at government level? How can we now say, this is *your* responsibility and you will have to do it. You will have to cross the other half of the river because I see today a tremendous level of anxiety. Because at community level, do you know how we managed to convince so many people to come for testing? It's because we made a moral deal with them – everyone who tested positive will be treated. So how can we make sure that we don't break that essential level of trust that we have managed to build there?"

Dr Emanuel, for his part, seemed to take exception to the idea that an empowered community should play the sole role in setting healthcare priorities.

He suggested that what has been 'pushed' or prioritised depends upon advocacy and political influence.

"But we also have to recognise that not everyone has a voice and that not everyone speaks. Lots of children who die prematurely – whether it's from HIV, malaria or respiratory illnesses – frequently don't have a voice. We have to be just as careful about them. We have to be careful about the women who frequently don't have a voice or aren't allowed to express their voice as well," he said.

But while the attention to maternal and child health is laudable, Dr Emanuel may not appreciate that the importance of managing contagious disease epidemics, such as TB, MDR-TB and HIV cannot be reduced to calculations about the relative amount that it costs to save a life. Neglecting or under-treating HIV or MDR-TB because 'it is too expensive' will wind up costing society far more down the road as failure to expand treatment will lead to the continued spread of the infection. In addition, although many children and women are without voices, the empowerment of marginalised vulnerable communities that are most susceptible to these diseases was also hard won – and the care for these conditions would unlikely be prioritised without it.

Another question is whether it is really the rich bilateral and multilateral donors, who should be funding the low cost essential interventions, or whether that responsibility should belong to the local government?

Professor Alan Whiteside of the University of KwaZulu-Natal pointed out that people should not be letting African Governments "off the hook. Remember the Abuja Declaration? Remember the 15%? [of GDP that African governments pledged to commit to

health] How many countries have reached that? And how do we allow countries to go ahead and mismanage their government and their health systems, and not call them to account? This isn't a domestic spat! This is a global issue. And let's remember that as we move forward."

Integrated service delivery case studies

In the next session, three recently completed country case studies from Kenya, Malawi and Ghana were presented. Each of these case studies used a systematic approach to analyse how Global Fund-supported HIV activities had affected national programmes and health systems, and how they had been integrated.

There were clear differences in integration, outcomes and the health system effects of the HIV funding in each country, depending on the burden of HIV, strengths of the existing health system, and how countries co-ordinated their HIV response and managed funding.

"When AIDS was declared a national disaster in Kenya in 1999, it was given its own division, called the National AIDS Coordinating Committee (NAC) within the office of the president," said Dr Erin Sullivan of Harvard School of Public Health, who presented the Kenya case study. "And this was completely separate from the ministry of health. NAC has had separate financing exclusively for HIV and separate planning and government processes as well."

Kenya has done rather well in terms of its HIV and TB response – and the HIV prevalence in the country has actually fallen significantly, peaking at 13% in 2000 and falling to around 7.4% in 2009. But with the NAC reporting separately to the president, there has been very limited integration of HIV into the health system.

"Kenya had a functioning M&E system but it was not able to collect all the HIV-related indicators requested by the Global Fund and other donors. So parallel data collection mechanisms were created," said Dr Sullivan. There has been some moderate integration of supply chain management and procurement however, as the supply chain system for drugs and commodities managed by the general public health system to procure essential medicines and commodities – although there are a few parallel supply chains operated by specific donors.

"The neglect of non-target diseases has made the realisation of an integrated primary health system more challenging. Funding for the three diseases has in some ways distorted Kenya's health system priorities," said Dr Sullivan. However she noted that the biggest problem was how the HIV response was co-ordinated. "Just as a comparison, TB and malaria, their programmes actually sit within the ministry of health – and they are a little bit more integrated in terms of those three functions [finance, planning and governance]."

"At the time, the systems are insufficient to take back this responsibility and we shouldn't rush into integration just for the sake of integration," Dr de Jongh said in agreement.

Integration challenges for Malawi

The case study in Malawi found limited integration but some positive effects on the health system nonetheless. On the one hand, the HIV response may be overly vertical, but, at the same time, there have been clear benefits to the health system from having a strong HIV programme. There are some structural differences from Kenya: even though the National AIDS Commission is also housed within the office of the president and cabinet, the biomedical response to HIV is managed by the HIV/AIDS Unit within the MOH (so there is closer collaboration).

But Malawi is one of the most resource-constrained countries in the world, and the capacity to support an effective AIDS response – and Malawi's is impressive, with over 300,000 people on ART – simply did not exist in the health system when the HIV response began. A staggering 97% of all funds needed for the HIV/AIDS response are provided by bilateral and multilateral organisations – who were leery of relying on the weak systems in Malawi.

As a result, parallel procurement and M&E systems had to be developed (at present all of the drugs for the AIDS response – including antiretrovirals, drugs for opportunistic infections – are channelled completely through the system by UNICEF). And there is no flow of funds into other health areas because all the funding is earmarked.

At the same, however, "Malawi has a very strong domestic and external commitment to health system strengthening," said Dr Thyra de Jongh of the Royal Tropical Institute in Amsterdam, who presented the Malawi analysis. "[The country] used some of the Round One HIV/AIDS grant to support health system strengthening. And it also is one of the few countries that receives a separate grant under Round Five proposals for health system strengthening. And within the ministry of health in Malawi they actually have a dedicated partner for health system strengthening as well."

Dr de Jongh stressed that although it was not perfectly integrated, there were a number of benefits from having a strong AIDS programme.

"In Malawi the NAC is actually considered a powerful and well-run organisation – and because of the resources, it actually has a lot of clout – and it's been able to hold the Ministry of Health to account and to push for action. And not just specifically on HIV and AIDS but in other areas as well, which is quite remarkable."

For instance, she noted that the AIDS response brought a greater appreciation for the need for monitoring and evaluation, increased the capacity for research in the country, and has improved the interaction between different health programmes such as family planning or tuberculosis programme. There have also been some improvements in infrastructure, and specifically in laboratory capacity, maintenance and quality assurance.

Another positive development, supported by the Global Fund and DFID has been the increase in human resources for health in Malawi. This was done by providing salary top-ups and supporting/building capacity for pre-service medical training at the medical colleges.

"Even though some of these investments come through the lens of HIV and AIDS, these are actually system-wide effects," said Dr de Jongh. "And one of the extraordinary things about the AIDS response more than any other type of response – is that it has fostered greater intersectoral collaboration. Other disease programmes have tended to be very medically oriented whereas the AIDS response has included sectors such as education, the penitentiary sector and so on. So it has actually brought together a lot of people."

The study found several improvements in outcomes, first that the AIDS response had improved access to health care – not just to HIV/AIDS services, but other services as well.

"We've also seen improved health seeking behaviour and service utilization – and again, this is not specific to HIV/AIDS – because the AIDS response has set up referral systems to other programmes such as TB, we are seeing an improved service uptake in these areas as well," said Dr de Jongh.

Even without the new additional healthcare workers, Dr de Jongh said that there has been increased healthworker availability, largely because ART improved the health and survival of healthcare

workers too. At the same time, there has been an expansion of the network of community health workers (HSAs).

"Quality of care has seen a real boost as a result of the AIDS response. Health workers who are providing voluntary counselling and testing receive interpersonal skills training. They are taught how to interact with their patients; how to be sensitive to their needs; how to respect their privacy, maintain confidentiality. And a lot of health workers [told us] 'we are actually taking these skills with us when we go out and provide other services', said Dr de Jongh.

"The AIDS response in Malawi has acted as a rally point, both for the government of Malawi and for its financial partners, to start addressing some of these underlying health system weaknesses," she said.

During the discussion, Dr Sullivan commented that Kenya had also seen similar positive outcomes from the AIDS response but "the benefits seem to be more from diffusion as opposed to the result of national strategic planning."

Dr de Jongh responded that "It is not ideal to have this parallel set-up, but given the current constraints it is what we have to work with." She also said there have been some negative effects as well and said that there were almost certainly some missed opportunities for integration due to the initially highly vertical nature of the AIDS response.

However, during the discussion Dr Mit Philips from MSF in Malawi suggested that it isn't always wise to rush integration.

"If you have a forced integration before it's time there might be actually a very negative effect on the supply system – even of the HIV programme. Malawi and also Kenya still have a lot on their plate in terms of rolling out the ARV delivery to integrate it into existing packages. Malawi wants to make sure that 65% of existing facilities provide ART by 2014. In order to achieve such an ambitious goal, you would need a kind of targeted drive to make sure that that happens, and not to go for a premature forced integration."

Ghana

The case study in Ghana had markedly different findings – possibly due to the profound differences in the HIV epidemic there, a growing economy and stronger health system. Although HIV is the leading cause of death in the country, the estimated prevalence of HIV is only 1.9% – though it is higher in urban settings and in most-at-risk-groups such as sex workers.

Ghana started sectoral reforms in 1997 and during that period, it developed consecutive 5-year programmes devoted to strengthening different aspects of its health system. In 2003, the country introduced a National Health Insurance Scheme (NHIS) which is funded at 2.5% (a portion of the value added tax); and a 2% social security contribution.

"In terms of health financing, the health insurance is slowly increasing whilst government's contribution to the health sector is dwindling," said Dr Daniel Degbotse of the Ministry of Health in Ghana.

Over the last several years, investment in AIDS has gradually increased. Most of this has been provided by the Global Fund, accounting for 82% of the external financing for health coming into Ghana (2007 data).

But in Ghana, there was little need to put parallel systems in place to procure, manage or deliver its AIDS response, so the many aspects of the HIV/AIDS programme are somewhat or moderately well integrated into the health system, according to Dr Degbotse.

"They use our human resources, M&E system, so we consider this integrated into the system," he said, adding that there do seem to be issues with integrated planning and country co-ordinating committee (Ghana already has a multisectoral body with civil society input to guide health policy – so stakeholders felt there was a duplication of effort).

But in terms of service delivery, "HIV/AIDS is carried by our health system. Our laboratories, our hospitals, everything etc. is used by the programme. So we say it is fully integrated," said Dr Debotse.

Even so, there are challenges based upon the disproportionate availability of funds for the Global Funds' priority interventions influencing underlying governance structures – which has led to perceptions that Global Fund programmes are getting too much funding. Dr Debotse listed a few comments made by stakeholders interviewed for the case study.

'The three disease control programmes due to the abundance of resources have grown bigger and pushed the disease control unit into oblivion. Now their offices are separate and much bigger than the ministry,'

and

'Programmes are too strong. They are a State within a State.'

"I must say that these views comes depending from where the person is coming from. If you are involved in the implementation of the programme, your views will be different. If you are not involved and you are an outsider, your views will be different," he said.

Furthermore, he said that the AIDS response "has helped in terms of system inputs. The programmes have had to acquire equipment for our systems in terms of laboratory equipment, they have rehabilitated facilities, they are even renovating our medical stores. It has also encouraged people to come together, move from the formal sector and the informal sector to talk together and plan together."

He concluded by saying that any challenges related to the response may have more to do with start-up costs associated with establishing new programmes. As long as the health system continues to be strengthened, and essential vaccines and medicines are supplied, Ghana's health system should be able to sustain the AIDS programme, even should Global Fund monies dry up.

So these three case studies found somewhat different challenges in trying to start up adequate AIDS responses given the existing health structures each country had in place.

"I'm not sure of how representative the three countries are of what is happening, certainly across Africa. But I think what does come through is that if we are talking of "bridging the divide", linking AIDS services and funding to health systems strengthening, I think all three studies have shown the difficulties that are being faced," said the discussant for the session, Professor Eric Buch of the University of Pretoria and Health Adviser to the New Partnership for Africa's Development (NEPAD). "So although there is interesting progress in a number of areas and useful benefits, in many instances things are still pretty separate and there is still a huge amount to do to bridge that gap. So we need really to think about how do we accelerate that process."

One of the things that Dr Buch, also with the Global Health Workforce Alliance-GHWA, focused on are the staffing difficulties in many resource-limited settings. Several of the case studies had noted problems with national salary caps and hiring freezes for healthcare staff which made it difficult to more effectively utilise aid to strengthen the health workforce. The following day, Professor Buch gave a separate presentation on the use (and potential for

misuse) of community health workers and task shifting – which was followed by presentations on how Malawi and Ethiopia have used AIDS funding to strengthen their health workforce (these programmes have previously been described by in [HATIP 117](#), and task shifting in [HATIP 116](#)).

Another thing that Dr Buch believe funders need to work on is assisting countries – especially more resource-constrained countries – to think creatively about how to put together applications for funding to strengthen their health systems at the same time as their HIV/AIDS response.

“At the moment we’ve got very much of a competitive funding arrangement, and often some of the weakest countries – both in health systems and their HIV/AIDS responses – are the ones least likely to be able to prepare good proposals and to use the space. And so what we are finding is not enough countries are using the health systems and human resources windows at the Fund, and they are not pushing the Fund envelope in terms of good proposals coming through.”

Other sessions

Indeed, much of the Bridging the Divide meeting covered financing for health; including finding creative ways to not only make sure that programmes can reach the goal of universal access to HIV prevention, care and treatment, but that they can extend to universal health coverage for all citizens. This included looking at leveraging the private sector for health – which might be facilitated by subsidising health insurance programmes for the poor (see recent [HATIP blog entry](#)); and novel mechanisms of performance based financing to improve the coverage of essential services offered by health facilities, which is being piloted in Rwanda.

Given spacing constraints, this article could only provide this brief snap shot into the Bridging the Divide meeting, and we would urge our readers to take a closer look at [the materials that IAS has now posted online](#).

Conclusion and next steps

A background paper for the Bridging the Divide meeting provided a cogent description of the critical next steps:

- Ensuring continued scale-up while managing HIV as a chronic illness;
- Building stronger systems to deliver primary health care for those with and without HIV;

- Building a strong body of evidence including how to provide equitable, affordable, and high-quality services, cost-effective service delivery models, context-specific solutions, and operationalise health systems strengthening at scale;
- Moving the agenda beyond ‘universal access’ for people living with HIV/AIDS to universal health coverage for all;
- Leveraging the private sector;
- Building synergies across health information systems;
- Building interdisciplinary partnerships to assess efficiency of HIV investments, expenditure and value for money, and measure the financial impact of HIV scale-up and its interactions with health systems financing;
- Fostering cross-country implementation research and learning on integrated service delivery;
- Promoting a priority research agenda required to answer vital questions and enhancing interdisciplinary collaboration to define methodologies and conduct rigorous evaluation in order to assess the impact of our collective efforts and guide policy development.

“Health systems are there to promote the health and well-being of people, of communities around the world. They can either promote that or they can impede that,” said Dr El-Sadr in closing. “Everybody here in this room is very passionate about trying to find ways in which the health system can promote the health and well being of all people in communities wherever they are. I think the challenge to each of us, is what are you going to do differently tomorrow? I think there’s a deep commitment to making things better.”

about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

For further information please visit the HATIP section of aidsmap.com