

Summery findings: The Global HIV/AIDS Initiatives Network (GHIN) studies on the effects of Global HIV/AIDS Initiatives on country health systems

The Global HIV/AIDS Initiatives Network (GHIN) was established in 2006 to track the effects of three global initiatives for HIV/AIDS – The Global Fund to Fight AIDS, TB and Malaria, the US President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Bank Global HIV/AIDS Programmes on country health systems. Network members in 16¹ countries, with support from 5² northern research teams, have been researching the effects of these initiatives on health systems at national and sub-national levels 2006-2008. GHIN activities are funded by Danida and Irish Aid and individual country studies have been funded by several different funders. The Network was coordinated by the London School of Hygiene and Tropical Medicine (LSHTM) and the Royal College of Surgeons in Ireland (RCSI). Complete details of the GHIN network including a searchable database on research on three HIV/AIDS Global Health Initiatives can be found at: <http://www.ghinet.org/index.asp>.

This report summarises the main findings from the GHIN Network of country studies.

The effects of Global HIV/AIDS Initiatives on country health systems

GHIs have both positive and negative effects on health systems. Positive effects have included a rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channelling of funds to non-governmental stakeholders, mainly NGOs and faith-based bodies. Negative effects include distortion of recipient countries’ national policies, notably through distracting governments from coordinated efforts to strengthen health systems and re-verticalization of planning, management and monitoring and evaluation systems (Biesma et al 2009; GHIN 2010).

Scale-up of HIV/AIDS programmes

- Global health initiatives (GHIs) have supported real increases in HIV/AIDS services; but health worker numbers have not kept pace with needs. While there was little evidence to show that scale-up HIV/AIDS services has had a negative effect on non-focal disease coverage geographic access to services was not equal, with differences between urban and rural services as well as between regions within countries (GHIN 2010).
- An analysis of trends in scale-up of services in Malawi (2006-2008) and Zambia (2004-2007) show that the numbers of clients on ART and receiving VCT increased consistently over the two time periods. In Zambia there was a steady increase in numbers receiving PMTCT, whilst in Malawi the data show little increase (Brugha et al 2010)
- We analysed how scale-up for HIV/AIDS services has impacted non-HIV priority services in Zambia. There were some strong positive correlations in trends within facilities between reproductive health services (family planning and antenatal care) and ART and PMTCT. Childhood immunisation also increased. Stock-outs of drugs for non-HIV priority services were significantly more frequent than were stock-outs of antiretroviral drugs (Brugha et al 2010 b)
- A study in Lesotho analysed how Global Fund recipient organisations identified, assimilated and utilised knowledge on how to meet the disbursement and reporting requirements of Lesotho’s Round 5 grant from the Global Fund (Biesma et al 2012). Results show that absorptive capacity was most evident at the level of Principal Recipient, the Ministry of Finance, while it was less advanced among the Ministry of Health and district level implementers.

¹ Benin, Burundi, China, Ethiopia, Georgia, Kyrgyzstan, Lesotho, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam, Zambia

² Belgium, Ireland, Sweden, UK, USA

- In Kyrgyzstan there are significant increases in GFATM and CAAP financing has led to substantial scale-up of HIV/AIDS services and numbers of clients receiving services. Services focus on preventing the spread of HIV and aim to reach high-risk groups including injecting drug users (IDUs) and prisoners (GHIN 2009a).
- Global Fund grants in Ukraine have vastly expanded access to HIV/AIDS prevention, diagnostic, treatment and care services. Considerable attention has been paid towards treating pregnant women with HIV leading to considerable reductions in the levels of mother-to-child transmission (GHIN 2009b). Global Fund financing has also strengthened the health system in a number of different ways including: improved governance and management practices, strengthened systems for surveillance and monitoring and evaluation and new HIV/AIDS-related legislation.

Human resources for health

- The analysis of workforce patterns across 30 facilities in three districts of Zambia illustrates that the achievements in scaling up HIV/AIDS service delivery has been on the back of sustained non-HIV workload levels and stagnant health worker numbers (Walsh et al 2010). The study provides quantitative evidence of a human resource crisis in health facilities in Zambia. Findings show that 'task sharing' was occurring as well as 'task shifting', where the few available staff are taking on additional work, especially in small rural health facilities.
- An analysis of workforce responses to GHI funds in Malawi and Zambia finds that Malawi, which received large levels of GHI funding from only the Global Fund, increased facility staff across all levels of the health system: urban district and rural health facilities, supported by task-shifting to lower trained staff. The more complex GHI arena in Zambia, where both the Global Fund and PEPFAR provided large levels of support, may have undermined a coordinated national workforce response to addressing health worker shortages, leading to a less effective response in rural areas (Brugha et al 2010).

Health information systems

- GHIN studies suggest GHIs can strengthen countries' health information systems by aligning with existing country Monitoring and Evaluation (M&E) processes or by supporting capacity and provide funding to finance development of new M&E processes where none existed previously. GHI support for M&E systems in countries varied within regions, although in each of the three Eastern European countries surveyed by GHIN researchers, national M&E systems either did not exist or were in the very early stages of development (GHIN 2010).
- Findings from a study analysing district monitoring and evaluation systems for HIV/AIDS care and support services in a rural district in Zambia show irregular reporting by organisations. There was a heavy reliability on volunteers to collect data. Targets for care and support service coverage were not available and there was insufficient evidence to show that M&E information was used for planning purposes either at district, community or organisational levels (GHIN 2012).

Financing, medical products, vaccines and technologies

- GHIN studies found that GHIs have generated massive scale-up of additional funding for HIV/AIDS and that this financial support has contributed significantly to scaling up HIV-related commodities. For example In Georgia, Global Fund financial support helped to supply necessary diagnostic tests and drugs, which resulted in ART being available to all who required treatment. Malawi experienced remarkable improvements in drug management and in the processes of requisition and replenishment of stocks resulting in a reduction of drug stock-outs. Drug availability for HIV/AIDS was reported to have increased in facilities sampled in Zambia: in 2006 no sampled facilities experienced stock-outs of first line antiretroviral (ARV) drugs (GHIN 2010).

Civil society

- We assessed civil society advocacy efforts to reform HIV/AIDS and drugs-related policies and their implementation in Georgia, Kyrgyzstan and Ukraine (Harmer et al 2012; Spicer et al 2011). We found that Global Fund support resulted in the professionalization of CSOs, which increased confidence from government and increased CSO influence on policies relating to HIV/AIDS and illicit drugs. Further, the amount of funding for advocacy from the Global Fund was insufficient, indirect and often interrupted. CSOs were often in competition for Global Fund support, which caused resentment and limited collective action, further weakening capacity for effective advocacy. Development partners and government tend to construct CSOs as service providers rather than advocates. While some advocacy was tolerated by governments, CSO participation in the policy process was, ultimately, perceived to be tokenistic. This was because there are financial interests in maintaining prohibitionist legislation: efforts to change punitive laws directed at the behaviors of minority groups such as injecting drug users have had limited impact.
- A case study in a rural district in Zambia evaluated whether or not the World Bank Multi-Country AIDS Program (MAP) contributed to the sustainability of CBOs working in the area of HIV in Zambia (Walsh et al 2012). All CBOs in Mumbwa that received MAP funding between 2003 and 2008 had existed prior to receiving MAP grants, some from as early as 1992. This was contrary to national level perceptions that CBOs were established to access funds rather than from the needs of communities. Funding opportunities for CBOs in Mumbwa in 2010 were scarce. While all CBOs were functioning in 2010, most reported reductions in service provision. Sustainability had been promoted during MAP through funding Income Generating Activities. However, there was a lack of infrastructure and training to make these sustainable. Links between health facilities and communities improved over time, however volunteers' skills levels had reduced. Whilst the World Bank espoused the idea of sustainability in their plans, it remained on the periphery of their Zambia strategy. Assessments of need on the ground and accurate costings for sustainable service delivery, building on existing community strengths, are needed before projects commence. This study highlights the importance of enabling and building the capacity of existing CBOs and community structures, rather than creating new mechanisms.

The effects of Global HIV/AIDS Initiatives on coordinated national HIV/AIDS programmes

- A GHIN study (Spicer et al 2010) based on primary data from seven country studies³ looked at the effects of the three GHIs on the development and functioning of national and subnational HIV coordination structures, and the extent to which coordination efforts around HIV/AIDS are aligned with and strengthen country health systems. Positive effects of GHIs included the creation of opportunities for multisectoral participation, greater political commitment and increased transparency among most partners. However, the quality of participation was often limited, and some GHIs bypassed coordination mechanisms, especially at the subnational level, weakening their effectiveness.

Global HIV/AIDS Initiatives: issues of equity and access of HIV/AIDS programmes by marginalised populations

- Our work in the former Soviet Union countries of Kyrgyzstan and Ukraine (Spicer et al 2011) demonstrates that while there is greater availability of HIV/AIDS services in these countries, this does not equate with greater accessibility because of multiple, complex, and interrelated barriers to HIV/AIDS service utilisation at the service delivery level. Stigmatisation of HIV/AIDS and drug use was an important barrier to IDUs accessing HIV/AIDS services in both countries. Other important, connected barriers included: criminalisation of drug use; discriminatory practices among government service providers; limited knowledge of HIV/AIDS, services and entitlements; shortages of commodities and human resources; and organisational, economic and geographical barriers. Funders of HIV/AIDS programmes need

³ China, Georgia, Mozambique, Kyrgyzstan, Peru, Ukraine, Zambia

to consider how best to tackle key structural and systemic drivers of access external to, as well as within, the health sector including prohibitionist legislation on drugs use, limited transparency and low government staff salaries.

- A GHIN study in Peru (Auerbach et al 2011) showed that a key component of the shift from an emergency to a long-term response to AIDS is a change in focus from HIV prevention interventions focused on individuals to a comprehensive strategy in which social/structural approaches are core elements. Such approaches aim to modify social conditions by addressing key drivers of HIV vulnerability that affect the ability of individuals to protect themselves and others from HIV.
- Our main finding from a GHIN study in Vietnam (Ha et al 2010) was that during the last two decades, developments in HIV policy were driven in a top-down way by the state organs, with support and resources coming from international agencies. Vietnam's HIV policy has evolved from one focused on punitive control measures to a more rights-based approach, encompassing harm reduction and payment of health insurance for medical costs of patients with HIV-related illness.

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* Please see <http://www.ghinet.org/index.asp> for a full listing and links to GHIN resources