

# Impact beyond Intent:

## The role of Global Health Initiatives in the policy implementation of antiretroviral treatment roll-out in Zambia and South Africa

by Johanna Hanefeld

### 1. Introduction

#### Roll-out of antiretroviral treatment in Zambia and South Africa - why compare?

Zambia and South Africa are heavily affected by HIV/AIDS. Both countries are experiencing a generalised HIV epidemic with an adult prevalence rate of 16 percent in Zambia, and 18 percent in South Africa (UNAIDS 2007). Both introduced anti-retroviral treatment for AIDS in the public sector within the last five years and now have very large treatment programmes. By 2008 more than 450,000 patients were accessing ART through the public sector in South Africa, and more than 150,000 patients were on ART in Zambia (UNAIDS 2008).

In addition, and in part due to the heavy burden of HIV/AIDS experienced by the two countries, both are the focus of funding from the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Yet despite these commonalities there are significant differences between the two countries, particularly in their respective history of ART roll-out and its implementation. The Zambian

government declared its intention to roll-out ART to 10,000 people in 2002, initially without donor assistance and with limited resources available [Interview, Lusaka, September 2007]. In South Africa on the other hand, President Mbeki's denial of linkages between HIV and AIDS, and concerns about the efficacy and side effects of antiretroviral medicines led to delays in the policy development and implementation of ART roll-out (Schneider 2002; Natrass 2008). It was only following significant pressure, including through court cases against the government by South African civil society organisations, such as the Treatment Action Campaign (TAC) and other actors, that the South African Cabinet took the decision to roll-out ART in August 2003 (Natrass 2004). Implementation of the Operational Plan that was developed did not begin until March 2004 [Interview, Cape Town, January 2008].

A further contextual difference in terms of ART roll-out that impacts significantly, particularly on the role of outside actors such as GHIs, is the differing level of income per capita, and budget resources for health. South Africa is a middle income country with an average per capita

income of USD 11,110 (PPP) (UNDP 2007) compared to Zambia's USD 1,023 (PPP) (UNDP 2007). This means that the South African health system is much better funded than the Zambian, and that the public sector health budget, including for ARVs, is funded entirely through domestic (government) resources (Treasury 2008). This contrasts with Zambia where according to an MoH official responsible for planning the ART roll-out for 2008-09 "50-52% of funding is from PEPFAR, 34% from the Global Fund and 10-15% or so from other sources" [Interview, Lusaka, November 2007].

#### What are Global Health Initiatives?

Since the 2000s development assistance for HIV and AIDS has increasingly been provided through partnerships and Global Health Initiatives (GHIs). These structures are rapidly evolving and nomenclature is difficult. Brugha (forthcoming) defines them 'a blueprint for financing, resourcing, coordinating, and/or implementing disease control across at least several countries in more than one region of the world'.

Differences are evident from the different GHIs that form the focus of this paper. The Global Fund is

mainly a mechanism for generating funding. Coordinated through a small secretariat in Geneva, the Global Fund does not have a country presence but awards funding to 'principal recipients' within countries, on the basis of successful proposals, developed and submitted by countries through a country coordination mechanism – or CCM. CCMs are envisaged to be inclusive bodies with representation from government and all sections of civil society (the Global Fund 2008).

PEPFAR on the other hand is a bilateral initiative that works through a number of different US agencies and funds NGOs, private sector, academic institutions as well as governments to implement projects at a country level. Often US institutions, including universities, subcontract PEPFAR funding further to different country level implementers, such as NGOs.

### Why focus on Global Health Initiatives?

GHIs have been successful in leveraging significant amounts of new funding for HIV/AIDS: US\$10 billion in 2007, up from US\$6.4 billion in 1997 (WHO 2006; UN 2008). The three largest GHIs all include a focus on HIV/AIDS - the US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight HIV, Tuberculosis and Malaria, and the World Bank Multi-country AIDS Programme - and together provide two thirds of all external funding for HIV/AIDS (Bennett, Boerma et al. 2006).

The level and extent of funding provided by GHIs is evident in Zambia and South Africa. PEPFAR funding for South Africa in 2007 alone was US \$397.8 million (OGAC 2008), and in Zambia PEPFAR resources reached an estimated US\$ 216 million for the same period.

Despite their levels of funding and influence, evidence and detailed understanding of the impact of GHIs, especially at sub-national level, is

limited. Focusing on the impact of GHI's in two countries that both receive significant amounts of funding, while presenting two very different contexts for ART roll-out, provides insights into the different impact such actors may have and helps to draw some conclusions on how to mitigate potentially negative impacts.

### Study outline

This paper provides an overview of initial findings from research conducted in both countries. It highlights the role of Global Health Initiatives in the implementation of ART roll-out, observes the ways in which they operate, focusing on significant commonalities and differences, and based on this analysis, highlights their impact and potential concerns and challenges arising from their engagement.

While the World Bank Multi-country AIDS Programme has provided funding, including for treatment, to Zambia and formed part of the study, this paper focuses on the role of PEPFAR and the Global Fund, given their comparatively larger amount of funding and the fact they provide support to both countries. (A further separate paper on the role of World Bank MAP funding in the roll-out of ART is forthcoming in 2009.)

The study focuses only on the support provided by GHI's for adult ART, not on other aspects of their funding.

## 2. Methodology and context

The findings presented here are part of a wider research project, which examines policy processes relating to anti-retroviral roll-out in Zambia and South Africa, with specific focus on national to sub-national implementation. Research conducted involved over 150 in-depth interviews with policymakers at national, provincial and district level in the two focus countries. In each country sub-national research focused on one province and two districts (in Zambia)

or sub-districts (in South Africa). Interviews in Zambia were conducted from August –December 2007, in South Africa from January – May 2008.

Research in Zambia was conducted as part of a twinning research project with a Zambian researcher. Full research findings and analysis will be published as part of the author's PhD thesis, and in further forthcoming research papers. Ethical approval for the research was obtained from relevant committees in Zambia and South Africa, and at the London School of Hygiene and Tropical Medicine.

## 3. Findings – issues arising from the research

In both Zambia and South Africa, GHI's have had significant impact on the roll-out of anti-retroviral treatment in the public sector. In both countries support provided by GHI's was crucial to the rapid scale-up of ART in the public sector, but in very different ways.

### GHI's in Zambia

In Zambia, following the initial introduction of ART, under the leadership of the President and with domestic resources, roll-out beyond initial pilot sites would have been challenging, given the overall resource constraints on the health system. Additional financial and technical resources provided through GHIs have been crucial to the rapid successful scale-up.

### GHIs in South Africa

In South Africa, following the government's delay in implementing the operational plan intended to guide the roll-out of ART, doctors linked to academic institutions began, with financial resources from PEPFAR and other outside partners, including MSF, to implement large scale treatment programmes, classified as operational research. These programmes, implementing ART roll-

out in advance of government policy and programmes, were crucial in saving lives of people living with HIV/AIDS, and contributed to an evidence base that highlighted the possibility of successfully providing ART in resource poor settings.

While each of the early treatment programmes in South Africa had specific characteristics not linked to support provided through Global Health Initiatives that may have been key to successful implementation, independent financial resources provided by Global Health Initiatives appear to have contributed to a policy space that allowed these programmes to move ahead.

In addition to funding operational research programmes to facilitate access to ART, PEPFAR in South Africa funds private clinics or networks of general practitioners (GPs) to provide ART to patients free of cost. These often large private sector treatment centres are entirely outside of the public health sector, but have assisted in scaling up treatment to a large number of patients.

#### 4. Impact beyond intent

However, despite this crucial role that GHI support provided to the roll-out of ART in both countries, their support and programmes in both countries has had unintended consequences on the health services and systems, beyond the provision of ART.

##### a. GHI impact on human resources

In both countries all people interviewed at all levels highlighted the shortage of skilled human resources as a key constraint for the roll-out of ART and the health system overall. In South Africa the unequal distribution of health workers between private and public sector, and urban and rural areas, paired with the huge treatment need means a shortage of human resources trained in ART is a key challenge despite an overall better supply of nurses than in other

countries in the region (MSF 2007). Zambia has less than a third of the recommended doctor-patient ratio (Schultz, J. 2008), and faces a severe shortage of pharmacists, laboratory technicians and other health workers [Interview, Lusaka, November 2007].

Global Health Initiatives in both Zambia and South Africa tend not to provide budget support for recurrent costs, including for additional human resources for health. At the time this research was conducted GHI support for additional human resources for health in Zambia was limited to basket support for a scheme to retain doctors in rural areas, and other short term incentives, including 'top-ups'. In South Africa, according to the policymakers and treasury officials interviewed, no resources from GHIs were provided to finance additional human resources.

Additional human resources to support the roll-out of ART by GHIs in both countries are provided almost exclusively through 'technical assistance', often in the form of mentoring staff in the public sector. PEPFAR implementers also second staff into the public health care services. In Zambia, secondment into the actual health facilities is limited to data capturers, and clinical care specialists who work in provincial health management teams. In South Africa it includes nurses and pharmacists. Staff are employed on annual or biannual contracts by PEPFAR implementing agencies, and seconded into a health facility where they work alongside the government staff. The short-term nature of secondments, due to the annual PEPFAR funding cycle, limits the ability for longer-term planning and raises concerns about long-term sustainability of the treatment programmes, where these come to rely on the additional staff financed through GHIs.

In addition, in South Africa, actors interviewed reported that nurses and laboratory or pharmacy workers

employed by PEPFAR implementers are often recruited from within the same district, in some cases from within the same health facility into which they are then seconded. Interviewees in Zambia described a similar phenomenon, where doctors, nurses and pharmacists employed by GHIs to provide technical support are often providing technical support to the same health facilities or districts where they used to work as public sector workers.

In particular, PEPFAR often provides support for ART roll-out in both countries through NGOs that recruit their staff from within the public sector, thereby actively depleting the pool of skilled human resources. In Zambia, of fifteen health care workers working for a GHI interviewed for this research, nine had recently been recruited from the public sector.

Because of the lack of additional human resources for health, it is evident that the workload of staff at all levels in the health service has increased. This corroborates similar findings from recent research in Malawi (Mwapasa, Kadzandira, 2007).

##### b. GHI impact on coordination

###### At national level

In Zambia coordination of treatment activities between different GHIs supporting ART roll-out and the government at national level appears good and improving, with close and frequent communication between the key actors at national level. This coordination, including through working groups at the Ministry of Health and the National AIDS Council, appears to be influenced by the relative dependence by the Zambian government on GHI resources to ensure implementation of the treatment plan. One senior Ministry of Health official with responsibility for coordinating the roll-out of ART described the planning process of developing treatment targets, 'Let's say they want to put 8,000 people on treatment, then it means that



they have got enough resources to put those 8,000 people on treatment... that is how the national treatment target comes about.' [Interview, Lusaka, November 2007]. This suggests that the planning of expansion and speed of the ART roll-out is led by different GHI implementing agencies' activities.

In South Africa, on the other hand, where the public sector roll-out is funded entirely through government resources there is very limited coordination of GHI activities at national level, including by the government. This is despite two mechanisms intended to facilitate the coordination between different donors, including GHIs, or GHI implementers at national level. (One is a donor coordination body set up by the Department of Health and housed in UNAIDS, the other is a forum of donors facilitated by donors themselves and set up in response to the lack of coordination of their activities. These are mainly constituted through bilateral donors.) Policymakers from bilateral agencies represented on these bodies described their frustration at trying to engage with and coordinate with GHI implementers [Interview, Pretoria, February 2008]. In addition, while some of the clinicians funded by GHIs are represented on the South African National AIDS Council and in Department of Health's working groups on treatment, many of the GHI implementers are not represented on the South African National AIDS Council (SANAC).

More than ten of the policymakers, including from government, GHIs and other donors, interviewed in South Africa expressed their frustration at the lack of coordination between activities funded and implemented by GHIs and those funded by domestic resources. However, no-one appears to actively address this or take the initiative for such coordination.

### At sub-national level

There is considerably less coordination between actors at sub-national level than at national level in both countries. In Zambia the implementers of different GHIs have geographically divided the country between themselves but there is minimal coordination between activities at provincial and district level, where different implementing organisations overlap. In both countries at provincial and district level even implementing organisations funded by the same GHI, were often not aware of each other's activities, or presence. This was particularly the case in South Africa, where the links between sub-national GHI implementers and national actors appeared limited. For example, a PEPFAR implementing organisation had no knowledge of other implementers working in the same province also supporting treatment roll-out.

### Lack of coordination between treatment and prevention

At all levels coordination between prevention and treatment activities supported by GHIs appeared limited in Zambia and South Africa. GHI implementers supporting treatment roll-out tend to be clinicians, and are often different organisations from those supporting prevention activities. The lack of coordination between prevention and treatment activities is particularly apparent at district and provincial level. GHI implementers interviewed at these levels were in most cases unaware of each others programmes and there appeared no joint planning between treatment and prevention activities supported by GHIs.

In both countries coordination of activities, including for prevention and treatment, is through the national AIDS councils. Some contact and coordination between treatment and prevention actors who meet at the national level through these fora and

in other meetings was evident from the research. However, at provincial and district level the national AIDS council structures appear weaker, and no other fora for interaction between GHI implementers supporting treatment and prevention exist. As a result, treatment and prevention actors only rarely interact at sub-national level.

### Workload of coordination

Policymakers at all levels described coordination of GHIs' programmes as a challenge. In particular differences in planning cycles and the resultant different reporting time-tables for activities financed by GHIs have added to the workload of health sector staff at all levels. Reporting by GHIs is required from facility to district, provincial and national level for all support provided, creating additional workload for staff. This is in addition to the time that is required by policymakers and planners to engage with different GHI programmes and coordinate these with government plans.

### c. GHI impact on equity of access

GHIs' inherent need for attributable impact has resulted in numerical targets, and funding per patient. This means that GHIs want numbers fast and have a bias towards urban clinics, and easily accessible, large populations. In both countries this has meant that GHI implementers have concentrated on high population density areas.

This lack of equity as a principle in GHI interventions raises concerns about their potential for creating or aggravating inequalities in access to services in countries where their programmes provide the main support for a health programme or intervention such as the ART. This is particularly the case in Zambia, where the roll-out beyond the hospitals and clinics has been heavily reliant on support through GHIs.

#### d. GHI impact on sustainability

Given the level of dependence on external funding of Zambia's treatment programme sustainability is a key concern. Similarly in South Africa, the large private sector provider clinics funded through PEPFAR are not sustainable. The clear difference between South Africa and Zambia is that the South African government's treatment programme is entirely funded through its domestic budget and therefore not dependent on GHI funding. In Zambia GHIs and the government are slowly working to increasing government resources as a percentage in the ART programme.

While externally provided resources, such as funding through GHIs are never sustainable in the longer term, it appears that support provided may not best build sustainable solutions. Short term incentives for human resources, or 'technical support' are a case in point. Sustainability features heavily in the rhetoric of GHIs programmes and publications but what that means in terms of implementation remains unclear.

In addition, there is a certain level of conflation of the extent to which local capacity is built or resources provided actually reach the country. Many of the PEPFAR implementing organisations that have national NGO status are affiliated and draw senior staff from US academic institutions. In addition, it is very hard to establish the exact level of funding by PEPFAR that reaches the country level, as these figures are often not publicly available. A recent study established that as little as thirty percent of PEPFAR funding actually reaches the country level (CGD 2008).

## 5. Conclusions and recommendations:

Given the scale of resources and their scope, Global Health Initiatives have had significant impact on the ART roll-out in Zambia and South Africa, and on the wider health system in both countries. However, to maximise positive impact and to mediate against potentially negative consequences beyond their focal intervention, this potential benefit of GHIs needs to be actively harnessed.

Impact of funding provided by GHIs depends on the ways resources are channelled, which tend not to provide resources directly to government but rather in form of 'technical support'. The lack of funding provided for recurrent costs, especially for human resources, beyond short terms incentives and despite an increasing workload of public health sector staff, is a key limitation in maximising the benefits of GHIs' support.

As comparatively new structures in development assistance for health the governance of GHIs needs to be urgently addressed, including how to create greater accountability to beneficiaries at country level.

Based on the initial analysis of findings from Zambia and South Africa presented, the following recommendations can be made:

**On human resources:** provide longer-term direct budget support to governments to finance additional human resources for health that can address the increased workload created through ART roll-out. At country level GHI's should consider the implementation of a code of conduct that stops the recruitment of health workers from within the public health system by GHI implementers or funded organisations.

**On coordination:** ensure immediate better coordination of GHI activities at all levels, particularly at provincial and district level. This includes coordination of activities funded by GHIs and better coordination of GHI

funded activities with government programmes. GHIs at a country level need to ensure better coordination and integration between the treatment and prevention programmes they support, including through additional resources required to facilitate such coordination at sub-national levels.

In addition, GHIs need to ensure that their planning and reporting requirements are aligned and harmonised with government cycles, to allow for better coordination and to minimise additional workload for staff. Additional workload created through the coordination of GHI activities needs to be recognised and addressed including through funding for human resources, where this is required.

**On equity:** GHI need to consider the impact of their interventions on overall equity of access to health services, and consider equity of access as a principle in their support. Governments and ministries of health coordinating GHIs, particularly where their activities determine access to health services, need to strike a balance between capitalising on support to reach the largest number of a target population, and ensuring inequities in access are actively addressed.

**Sustainability** is a key concern relating to all interventions funded through GHIs. GHIs and governments need to move beyond a rhetoric of sustainability and work together to ensure that interventions are building health systems capacity, including through the development of human resources for health and long-term investments, as well as longer term funding cycles.



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## About Evidence for Action

Evidence for Action is an international research consortium with partners in India, Malawi, Uganda, UK and Zambia, examining issues surrounding HIV treatment and care systems.

The research is organised in four key themes:

1. What "package" of HIV treatment and care services should be provided in different settings?
2. What delivery systems should be used in different contexts?
3. How best should HIV treatment and care be integrated into existing health and social systems?
4. How can new knowledge related to the first three questions be rapidly translated into improved policy and programming?

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