Evidence for action from Zambia and South Africa

- the role of Global Health Initiatives in the implementation of anti-retroviral treatment

J. Hanefeld[1], M. Musheke[2]

[1]London School of Hygiene and Tropical Medicine, Health Policy Unit, London, United Kingdom, [2]Zambart Project, Evidence for Action, Lusaka, Zambia

What are Global Health Initiatives (GHIs)?

•US President's Emergency Plan for AIDS Relief (PEPFAR)
•Global Fund to Fight AIDS TB and Malaria
•World Bank Multi-country AIDS Programme (MAP)

GHIs have:
•International focus (more than one country)
•Aim to address global health concerns
•Have distinct disease focus or aim
•Mechanism to mobilise new resources
•Follow a distinct 'blueprint' or strategy for achieving objectives
•Are rapidly evolving as models

Why are they important?

•Scale of financial resources is large
•2/3 of all external resources for HIV AIDS (USD 8.9 billion) are contributed by three GHIs (PEPFAR, World Bank MAP and the Global Fund to Fight AIDS TB and Malaria). For example PEPFAR alone contributes in
Zambia:
– 2008 US $216 million
South Africa:
–2008 USD 600 million

Limited knowledge so far of impact especially at sub-national level

Study background and rationale

Zambia and South Africa both introduced, and rapidly scaled up the provision of ART in the health sector during the past five to six years.However, ART roll-out In Zambia ART was introduced and scaled-up in 2002 by the government, despite an absence of funding at the time and resource constraints in the health system. In South Africa, the government resisted the introduction of ART and policy development has often followed implementation.

Both countries are recipients of PEPFAR and Global Fund funding for the treatment roll-out. The comparison of two similar initiatives in very different policy environments offers crucial insights on their impact, and how to mitigate against potentially negative consequences.

Methods

These are initial findings of PhD research conducted in Zambia and South Africa from August 2007 to May 2008. The study examines policy implementation processes relating to anti-retroviral treatment (ART) roll-out at national, provincial and district level, focusing particularly on the role of Global Health Initiatives. It is a qualitative study relying on the perceptions of key actors. Preliminary findings presented here draw on more than 150 semi-structured interviews with key actors at national and sub-national level in Zambia and South Africa. Field work in Zambia was supported by Evidence for Action, a DFID funded research consortium at the London School of Hygiene and Tropical Medicine.

Findings

In Zambia public sector roll-out of ART is dependent on resources provided through GHI's, in South Africa support by GHI's to independent clinicians enabled roll-out before the government's official treatment roll-out

In both countries funding and support through both US PEPFAR and the Global Fund have been crucial in ensuring successful roll-out, but in very different ways.

In both countries support by GHIs, particularly PEPFAR has had unintended consequences on the overall health system.

GHI impact on human resources

•Global Health Initiatives do not provide for recurrent cost – i.e. salary for staff
•Additional human resources are provided almost exclusively through 'technical support' or the short term secondment of staff.
•PEPFAR in particular works through NGOs, or other in-country partners, who often recruit staff from within the health sector further depleting the pool of adequate human resources.
•The workload of staff at all levels, including at district, has increased

GHI's impact on coordination of activities

•Coordination at central level is better in Zambia than in South Africa, partly due for greater need by the government to effectively draw on GHI resources and support.
•Coordination at provincial and especially district level is weaker than at national level.
•Coordination between treatment and prevention is almost absent at provincial and district level. This is particularly the case where GHI's fund different implementers for treatment and prevention.

GHI's impact on equity of access

•GHI's 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.
•The 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.

Conclusions

•Given their level of funding GHIs have the potential for significant positive impact beyond their focal interventions. However, this potential needs to be actively harnessed.

•Impact of funding depends on the ways resources are channelled by GHIs, which tend to provide resources not directly to government but rather provide 'technical support'

•The lack of funding provided for recurrent costs, especially for human resources, despite increasing workload of public health sector staff is a key limitation in maximising the benefits of GHIs' support.

•GHIs are new structures in development assistance for health. To avoid further unintended negative consequences on the overall health systems of beneficiary countries the governance of GHIs needs to urgently addressed, including ways in which to make their funding more accountable at the country level.

Please contact johanna.hanefeld@lshtm.ac.uk with your comments and questions