

Draft Working Paper

HIV and AIDS programs

How they support health system strengthening

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Acronyms and Abbreviations

ANC	Antenatal care
APHA	African Public Health Alliance
ART	Highly active anti-retroviral therapy
CCM	Country coordinating mechanism
CPSD	Sector coordination group (Burundi)
CSW	Commercial sex workers
CVD	Cardiovascular disease
DAC	Development Assistance Committee
DAH	Donor assistance for health
DfID	UK Department for International Development
FNDP	Fifth National Development Plan (Zambia)
FP	Family planning
GAVI	Global Alliance for Vaccines and Immunization; GAVI Alliance
GDP	Gross domestic product
GF	Global Fund to Fight AIDS, TB, and Malaria
GNI	Gross national income
GRNE	Global resource needs estimate
HAPCO	Federal HIV and AIDS Prevention and Control Office (Ethiopia)
HEWP	Health Extension Worker Program (Ethiopia)
HIV T&C	HIV testing and counseling
HIV+	HIV positive
HMIS	Health Management Information System
HSS	Health systems strengthening
ICD	Infectious and communicable disease
ICP	International Comparison Project
IDU	Injecting drug user
IHP+	International Health Partnership
KNASP	Kenyan National HIV and AIDS Strategic Plan
L.E.	Life expectancy at birth
MCH	Maternal and child health
MDG	Millennium Development Goals
MEDS	Mission for Essential Drugs
MMR	Maternal mortality ratio
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MoU	Memorandum of Understanding
MPH	Ministry of Public Health
MSM	Men who have sex with men
MTEF	Medium Term Expenditure Framework
NACC	National AIDS Control Council (Kenya)
NASA	National AIDS Spending Assessment
NASF	National HIV and AIDS Strategic Framework
NGO	Non-governmental organization
NHA	National health accounts
NSP	National strategic plan
OECD	Organization for Economic Cooperation and Development
OI	Opportunistic infection
OVC	Orphans and vulnerable children

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PARPA	Poverty Reduction Strategy (Mozambique)
PEP	HIV post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People living with AIDS
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PNDS	National Plan for Medical Development (Burundi)
Pop. % urban	Percentage of the population which is urban
PRODESS	Ten-Year Social and Health Development Plan (Mali)
PRSP	Poverty Reduction Strategy Paper
RNE	Resource needs estimate
SBA	Skilled birth attendant
SCMS	PEPFAR Supply Chain Management System
SDPRP	Sustainable Development and Poverty Reduction Program
SLTHP	Second Long-Term Health Plan
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
SWAPs	Sector-wide approach
THE	Total health expenditure
THE, % public	Total health expenditure as a percentage of public spending
THE/GDP	Total health expenditure divided by total GDP
THE/Pop	Per capita health expenditures in US dollars
TWGH	Technical Working Group for Health
U5MR change	Under-5 mortality rate change
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
ZASF	Zambia AIDS Strategic Framework

Executive Summary

In September 2007, political leaders launched the International Health Partnership (IHP+) to promote health systems strengthening in low- and middle-income countries. Eight countries agreed to develop and sign 'compacts' with donors to assure that all money available for health systems is used as effectively as possible. This change marks a new 'diagonal' architecture of health systems. Work on IHP+ has continued since its founding and now includes at least eight additional countries.

Donors, AIDS, and Health systems strengthening (HSS)

In the past eighteen months, the number of IHP+ recipient countries has grown to 16, and the number of international agencies (11) and bilateral donors (12) has also increased. IHP+ offers the chance to progress beyond the sterile vertical v. horizontal debate over health funding approaches in favor of diagonal efforts to achieve the health MDGs as well as universal access for HIV/AIDS programs. In this paper, the diagonal comprehensive approach to health interventions will be explored using the compact countries to illustrate how HIV/AIDS funding is benefiting the health system as a whole. Donors for HIV/AIDS are already working in this new direction. The Global Fund and PEPFAR are devoting at least one third of their grants to the objectives of health systems strengthening (HSS). PEPFAR, now the largest donor for HIV/AIDS programs, is cooperating closely with the IHP+ initiative and obligated USD638 million in 2007 to HSS as part of its AIDS work. The Global Fund Round 9 proposals due 1 June 2009 focus on HSS. Multilateral institutions, including the World Bank and the regional development banks, are supporting HSS within the context of sector-wide approaches to country lending.

Synergies and complementarities between AIDS and HSS

From vertical and horizontal programs, health services are evolving into complementary, diagonal programs. The main funding agencies for HIV/AIDS programs will seek synergy wherever it can be found. The PMTCT programs, STI clinics, blood safety, and laboratory services can exhibit complementarities with the benefit accorded directly to HIV prevention. It will be an ongoing task in IHP+ compact countries to identify opportunities for synergy and use them for the advantages they can bring to health systems strengthening.

There are reasonable prospects that these efforts will carry forward into the future and permit diagonal approaches to health systems strengthening and HIV/AIDS programs to bring the epidemic under control within the time perspective of the aids2031 effort.

Introduction

This paper will show how what may appear to be solely vertical HIV/AIDS funding has benefits for the whole health system and therefore could be called diagonal funding. The diagonal approach supports the dual horizontal/vertical aims of across-the-board system improvements and single-disease focus. The IHP + can help forge synergies between partners with these dual aims in compact countries. The main objectives of the IHP + are the following¹:

- Develop 'country compacts' that commit partners to provide sustainable and predictable funding and to increase harmonization between partners in support of results-oriented national plans and strategies that are addressing health system constraints
- Generate and disseminate knowledge, guidance, and tools in focused technical areas to support health systems and services
- Improve coordination and efficiency of aid delivery for health in compact countries
- Mutual accountability of donors and governments and monitoring of performance

The main audience of this paper is the donor community and country health policy managers. Donors and governments are beginning to work together more effectively towards widespread achievement of health improvements and strengthening of health systems.

A General Overview

IHP+ looks beyond the sterile vertical v. horizontal debate over health funding approaches to diagonal efforts to achieve the health MDGs as well as universal access for HIV/AIDS programs. Experience in the compact countries can illustrate how HIV/AIDS funding benefits health systems as a whole. Donors for HIV/AIDS are already working in this new direction:

- The Global Fund and PEPFAR are devoting at least one third of their grants to the objectives of Health Systems Strengthening (HSS);²
- PEPFAR, now the largest donor for HIV/AIDS programs, is cooperating closely with the IHP+ initiative. A study of PEPFAR spending found that USD 638 million obligated in 2007 goes in full or in part to capacity building activities that support HSS as well as the fight against AIDS;
- The Global Fund, the second largest donor in this area, is currently accepting Round 9 proposals, due 1 June 2009,³ that specifically focus on HSS, a notable change as only one percent of Global Fund grants in rounds one through five supported HSS;
- WHO technical staff is offering guidance to applicants for Global Fund grant technical support to align AIDS, TB and malaria programs with HSS objectives for Round 9 proposals; and,
- Multilateral institutions, including the World Bank and the regional development banks, are supporting HSS within the context of sector-wide approaches to country lending.

IHP+ offers an opportunity for progress on three related objectives:

- 1) Strengthen health systems in the participant countries;
- 2) Achieve the goal of universal access to HIV/AIDS prevention, care and treatment by 2010; and,

¹ IHP+ The International Health Partnership 2009, http://www.internationalhealthpartnership.net/ihp_plus_about_objectives.html

² Kazatchkine, Michel; Speech at Center for Strategic and International Studies; February 18, 2009.

³ The Global Fund; << [<< http://www.theglobalfund.org/en/rounds/9/](http://www.theglobalfund.org/en/rounds/9/)>>.

- 3) Make solid progress on meeting the health-related Millennium Development Goals (MDGs) by 2015.

The initial eight compact countries are preparing their compacts for innovative financing approaches. They will focus simultaneously on disease-specific programs and Health Systems Strengthening (HSS). They will not lose sight of the agreed goals to achieve universal access to HIV/AIDS prevention, care, and treatment by 2010.

Further progress in health improvements in the poorest regions requires a new architecture for health services and donor support. Past discussion about the advantages of 'vertical' vs. 'horizontal' health programs and interventions is a sterile debate, thus the suggestion that 'diagonal' approaches combine the best of both worlds. The Global Fund objectives have expanded to include health systems strengthening. "Rather than preserving its vertical financing approach, and rather than shifting overnight to a horizontal financing approach, the Global Fund should adopt a diagonal financing approach to support increased diagonal programming."⁴ Full donor financing of 0.7 percent of OECD countries' GDP would yield about USD 28 billion a year for health alone -- enough aid to bring poor countries' health spending up to a minimum essential level of USD 40 per person per annum, as recommended by the WHO Committee on Macroeconomics and Health. "Knowing that foreign assistance for health rose from USD 2 billion in 1990 to USD 12 billion in 2004 -- a six-fold increase in total annual foreign assistance -- allows for some optimism. Diagonal financing would help finance the disease-specific AIDS, tuberculosis, and malaria programming that is required, it would also help fund increased program integration and coordination, and it would contribute to strengthening underlying health systems."⁵ Evidence from the IHP+ compact countries shows evidence of the diagonal experiment making progress.

In a 17 April 2008 statement, "US/UK announcement on health and health workers," IHP+ underscored how two leading donors combine their efforts in these compact countries:

The United States and United Kingdom have committed to work together, alongside other partners, to fight diseases and support stronger health systems, public and private sector health institutions, and health workers. Today, we are demonstrating this commitment in Ethiopia, Kenya, Mozambique, and Zambia -- four countries that the United Kingdom is supporting through the International Health Partnership and the United States is supporting through the President's Emergency Plan for AIDS Relief and other activities. In these four countries, the United Kingdom is planning to spend at least \$420 million on health, including the health workforce, over the next three years, and the United States is planning to invest at least \$1.2 billion over five years on health workforce development.⁶

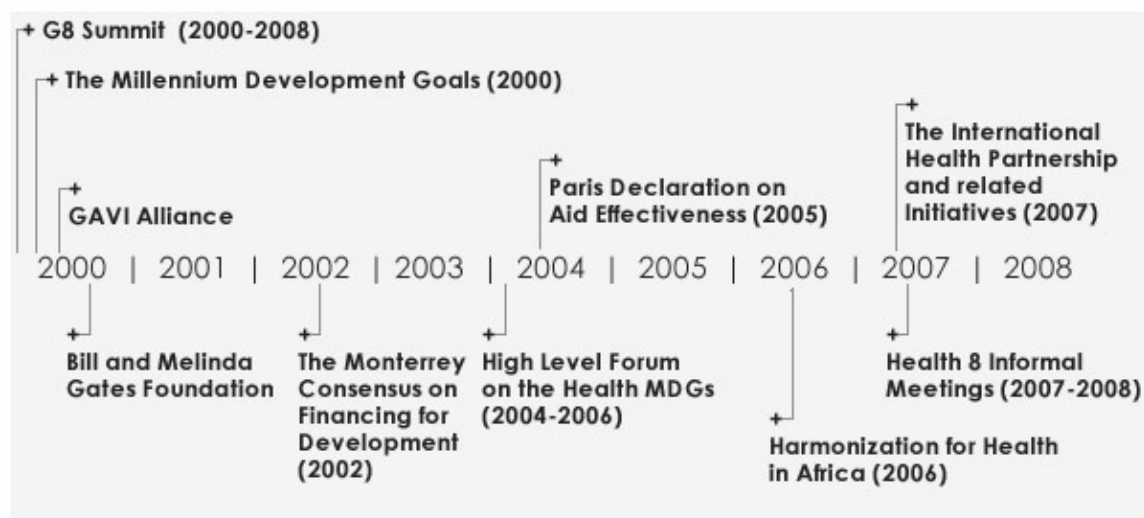
These efforts represent the latest step in a chain of events in this decade (see Figure 1.). Each of these actions aspires to increase the effectiveness of international assistance to those countries and governments that commit themselves to sound policies. Among the commitments specific to the region is Harmonization for Health in Africa (2006). IHP+ and related initiatives are recent steps to strengthen health systems as well as to continue the fight against specific threats to the health of the populations of the compact countries. At the G8 Hokkaido meeting, IHP+ could deservedly become the standard bearer for agreed efforts to assure greater progress toward reaching the 2015 MDGs, including Goal 6, "Combat HIV AND AIDS, malaria, and other diseases."

⁴ Ooms and others, 2008. *The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?* www.GlobalizationandHealth.com May 2008), 10 p. Subsequent quotes in the paragraph come from this source, an essay prepared by representatives of Médecins sans Frontières and several academic and NGO institutions.

⁵ Ooms and others, 2008, pp. 5-7.

⁶ See IHP+ website, States News Service, 17 April 2008, Information released by the White House.

Figure 1: Timeline of Key Global Health Agreements, Events, and Funding, 2000 - 2008



Source: [International Health Partnership Website](http://www.ihpweb.org/)

Characteristics of Initial 8 Compact Countries

Four sub-Saharan African countries, Ethiopia, Kenya, Mozambique and Zambia, face substantial development challenges. So too do the other four initial compact countries, Burundi, Cambodia, Mali, and Nepal. In none of the six African countries does life expectancy exceed 55 years, while it is only somewhat higher in Cambodia and Nepal. None of the eight has average income (adjusted for purchasing power parity) over \$1,500, or a maternal mortality ratio below 500, nor an urbanization rate much above 40 percent. The additional six countries added in recent months have similar health, poverty, and living standards characteristics to the initial eight (see Table 1).

Health spending in compact countries

The new estimates of consumption expenditure for health developed by the International Comparison Project of the UN for the year 2005 range from a high of \$430 per capita in that year for Cambodia, to a low of \$29 per capita for Ethiopia (see last row of Table 1 for these data). Burundi, for which no data are available in the ICP data source, may be lower still.

Earlier estimates from WHO *World health statistics*, shown in row 5 of Table 1, report even lower spending amounts of \$1 per capita for Burundi and \$6 per capita for Cambodia and Ethiopia. The top of the range for this data source is \$30 per capita (Zambia). By any measure, health spending is low -- far below suggested international norms of at least \$34 per capita, according to the UN Commission on Macroeconomics and Health. The reason for low levels of spending is obvious enough. Over three-fifths of these countries' populations are poor and rural, with many living below the poverty line of a dollar a day. Spending three-quarters or more of their incomes on food alone, there is little left for health care services. Rising global food prices threaten to make such funds even scarcer still.

Variability in under-five child mortality change

A major difference among the initial eight compact countries is their experience of under-five mortality change between 1990 and 2006 (see Table 1). Four of the countries, Nepal, Mozambique, Ethiopia and Cambodia, experienced substantial health improvements among younger population cohorts and hence substantial declines in mortality among young children. Improvements were less

dramatic in Mali and Burundi. Zambia showed no change on this indicator. Surprisingly, Kenya experienced a rise in child mortality of 25 percent, if the data in Table 1 are to be believed.

Table 1. Indicator data for initial eight compact countries, latest year available

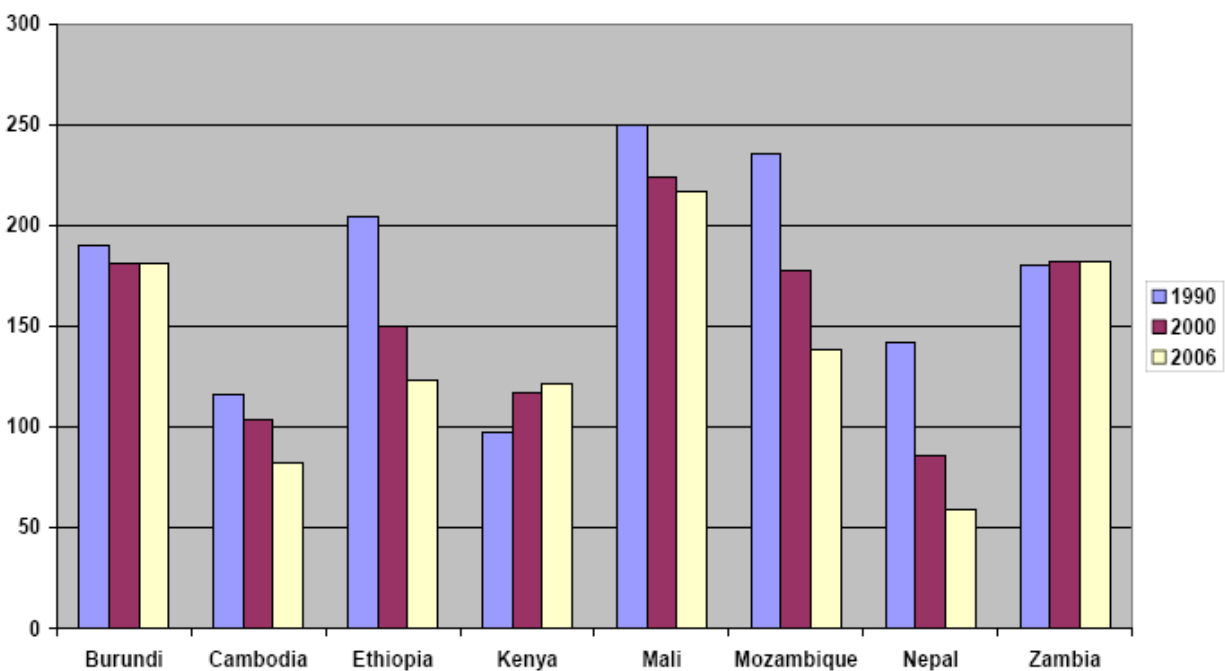
Selected Health Indicators	Ethiopia	Kenya	Mozambique	Zambia	Burundi	Cambodia	Mali	Nepal
Total population, in millions	77	37	21	12	8	14	12	28
Life expectancy, male/female	50/53	51/51	46/45	40/40	46/48	51/57	45/47	61/61
GDP per capita (PPP)	581	1375	677	1171	319	1440	1004	960
Total health expenditure (THE) / GDP	5.3	4.1	4.0	6.3	3.2	6.7	6.6	5.6
THE / population	6	20	12	30	1	6	12	4
THE, % public	51.5	42.7	68.4	54.7	26.2	25.8	49.2	26.3
Per capita spending on health (PPP)	29	259	53	233	n. a.	430	139	303
HIV prevalence, 18-49	1.4	6.7	16	15.6	3.6	0.6	1.3	n. a.
Persons receiving ARV in 2006	39,984	120,026	34,172	71,529	7,575	18,256	8,331	472
% of population that is urban	16.2	41.6	38	36.5	9.5	19.7	30.5	15.8
% births attended by SBA	6	42	48	43	79	9	30	15
Maternal mortality rate	720	560	520	830	1100	540	970	830
Under 5 mortality change, 1990-2006	-40	+25	-41	+1	-5	-30	-13	-58
Infant mortality rate	109	79	100	102	114	98	120	56
% 1 year measles	59	69	77	84	75	79	86	74
% pregnant women receiving ANC	28	88	85	93	92	69	57	44
% births with skilled attendant	6	42	48	43	34	44	41	19
% children sleeping under bed nets	1.5	4.6	n. a.	22.8	8.3	4.2	8.4	n. a.
% underweight, under-five children	34.6	16.5	21.2	23.3	38.9	28.4	30.1	38.8
Malaria cases/1000	8	3	270	190	274	5	62	0.4
TB prevalence/100,000	546	936	597	618	602	703	578	244
TB death rate/100,000	73	139.8	123.8	117.8	83.1	87.3	71.1	23.2

Sources and Notes: World Bank, *World development indicators 2008*; WHO, *World health statistics* via website. Latest available year, usually 2005 or average of 2000-2006 for selected MDG indicators.

n. a. = not available; Population = total national population, in millions; L.E. = life expectancy, male/female; GDP/P = gross domestic product per capita, expressed in purchasing power parity (PPP) amounts; THE/GDP = total health expenditure divided by total GDP; derived from WHO national health accounts; THE/pop = per capita health expenditures in US dollars at current exchange rates, not adjusted for PPP; Health/pop = International Comparison Project estimate of per capita spending on health measured in PPP dollars, 2005; HIV prev. = percentage estimated adults, 18-49 who are HIV+; ART = persons receiving anti-retroviral therapy in 2006; Pop Urban = percentage of total population living in urban areas; SBA Births = percentage of births accompanied by a skilled birth attendant; MMR = maternal deaths per 100,000 live births, latest year, modeled estimates; U5MR = percentage change in under-five mortality rate per 1,000 live births, 1990-2006; ANC = antenatal care, percent of women receiving; % births attended by skilled health staff, 2000-06; malaria cases data for 2003, latest available;

The data in Figure 2 show a less dramatic but nonetheless steady increase in child mortality in Kenya, a marked contrast to that country's neighbors and the other compact countries. These contrasts underscore the need to assure that health care financing and the contribution of donor assistance in each of the compact countries fits effectively into the overall objective of health systems strengthening. These figures suggest that risks of policy failure are great if governments do not vigorously address threats to public health.

Figure 2. Under-5 Mortality Rate Probability per 1000 live births



Source: World Health Statistics 2008, WHO, Geneva 2008.

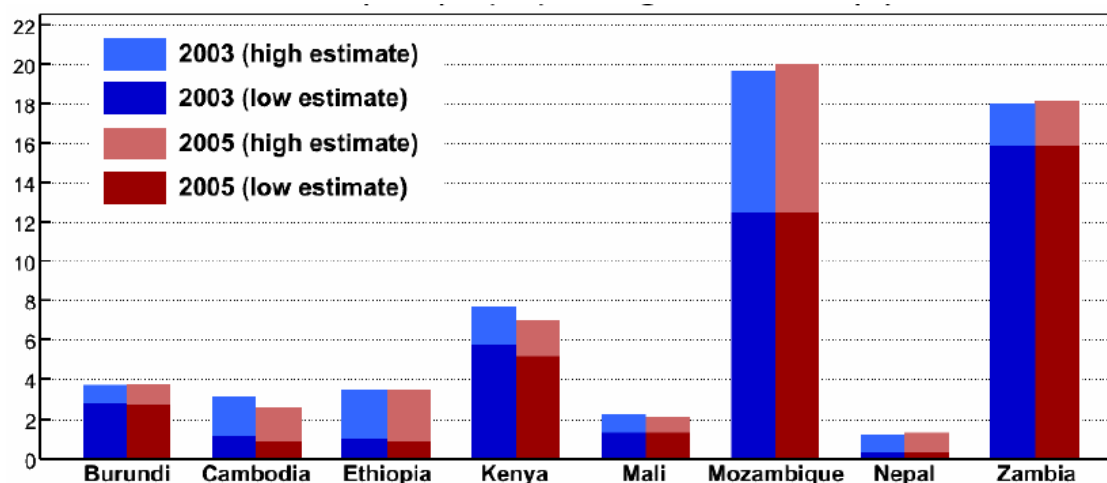
Malaria kills more than 1 million people each year; 90 percent of these people live in sub-Saharan Africa and most are children under 5 years of age. The Global Fund is now a major source of financial support, providing funds for 109 million insecticide treated bed nets. Malaria case rates vary substantially among these countries: very high in Mozambique, Zambia, and Burundi; far lower in Nepal, Cambodia, Kenya, and Ethiopia. Geography and altitude matter in climate-related disease incidence as these data attest. Differences between the countries are far less with respect to prevalence and death rates associated with tuberculosis.

Comparative data assembled for the IHP+ *Progress report, International Health Partnership and Related Initiatives*, prepared for the 61st World Health Assembly show that under-nutrition and presence or absence of skilled birth attendants may substantially affect under-five mortality in the IHP+ countries. These factors can be monitored as part of the IHP+ process.

HIV/AIDS in 8 Initial Compact Countries

The countries differ in the prevalence of HIV. In Zambia and Mozambique, over 15 percent of adults aged 18 to 49 are HIV+ according to the most recently revised estimates (see row 7 in Table 1 and Figure 3 below). Prevalence is just below 7 percent in Kenya and just below 4 percent in Burundi, while it remains under 2 percent in the other four compact countries. Kenya has been the most successful of this group in providing ART, with over 100,000 persons under care. Zambia, Ethiopia, Mozambique, and Cambodia follow in numbers of persons receiving ART. The chapter on Zambia below includes the estimate of about 150,000 ART recipients in 2007. While prevalence rates are an important current concern, effective prevention measures remain essential in all compact countries.

Figure 3. Estimated adult rate 15-49 of people living with HIV/AIDS %



Sources: IHP, UNAIDS/WHO Global HIV/AIDS Online Database.

National Strategic Plans for HIV/AIDS

UNAIDS, working closely with national AIDS programs in 2007, assembled over sixty national strategic plans (NSP) that aim to reverse the spread of HIV/AIDS. All eight compact countries have developed NSPs (see Table 2). These plans include estimated costs of service provision and expansion over the five-year period, 2006-2010. For these countries, the range of estimated required average annual spending per capita, 2006-2010, varies from less than a dollar per person per year for Nepal to highs of USD 13 for Kenya and USD 21 for Zambia (see column 3 of Table 2). These planned amounts are annual averages derived from dividing costed plan amounts by country population and by five to yield the average for the five-year period from 2006 through 2010.

Table 2. National Strategic Plans (NSP) proposed annual spending per capita, 2006-10, compared to resource needs estimate per capita for 2010, 8 initial compact countries.

Country	National Strategic Plan Document	NSP Av. Annual \$ per capita, 2006-2010	GRNE 2010 \$/capita
Burundi	Budget détaillé du Plan Stratégique	3	11
Cambodia	Cambodia. NSP2 Resource Needs Estimation-final	4	9
Ethiopia	Ethiopian Strategic Plan for HIV AND AIDS	9	10
Kenya	Kenya National AIDS strategic plan, 2005-2010	13	20
Mali	NSP	5	17
Mozambique	National Strategic plan, 2004-08	5	28
Nepal	National HIV and AIDS Strategy, 2006-	<1	3
Zambia	NSP, 2006-10; data show both available and needed	21	39

Sources and Methods: Selected national strategic plans; GRNE data from draft spreadsheets for 2010 covering 132 countries developed for UNAIDS by Futures Institute. NSP spending requirements for five years divided by five to yield average annual spending, then again divided by country population in 2007 to yield average annual spending per capita in each country. For GRNE, the 2010 requirement for spending in that year divided by

country population in 2007 to yield a spending requirement estimate on a per capita basis comparable to the NSP estimate.

In a parallel effort that stems from the initial preparations for the United Nations General Assembly Special Session (UNGASS) on AIDS in 2001, UNAIDS sponsors the periodic preparation of Global Resource Needs Estimates (GRNE). These estimates and projections help donors and governments in affected countries determine resource needs for curbing the pandemic. For the eight compact countries, the costed plan estimates, expressed in per capita annual spending amounts, can be compared to the GRNE figures for 2010, the target year for achieving Universal Access.⁷

In all compact countries except Ethiopia, the national strategic plans fall well short of GRNE estimates of needed spending per capita if the countries are to scale up adequately to achieve universal access by 2010. A near doubling of planned spending would be required for Kenya; a quintupling would appear essential for Mozambique. The other countries in the compact group lie in a range between Ethiopia and Mozambique. These comparisons underline the necessity for continued attention to the financing of HIV/AIDS programs, even as demands for supporting HSS grow more intense.

The burden of HIV/AIDS looking into the future

WHO technical staff prepared detailed projections of global mortality and the burden of disease. Their data pertain to the period between 2002 and 2030.⁸ They show that HIV/AIDS will have the largest average annual increase in age-standardized death globally of all causes identified for the period up to 2020 (see Table 1 in the source document). HIV/AIDS will move from being the fourth leading cause of death in 2002 to the third leading cause by 2030 (see Table 2 in the cited document). "By 2030, the three leading causes of burden of disease will be HIV/AIDS, depression and ischemic heart disease."⁹ The burden of AIDS will continue to fall far more heavily on low-income countries than on high-income countries. By 2030, HIV/AIDS will be the largest cause of lost years of life in both low- and middle-income countries. The burden will be especially great on these eight compact countries and others like them that already have high HIV prevalence rates and very limited financial resources for responding to the threat.

Despite some differences in the challenges they now face, these countries are joined together in their extreme poverty and lack of financial resources to support health improvements. Donor assistance that is effectively targeted at both specific health needs and overall strengthening of health service delivery offers opportunities for synergy that create a win-win situation.

Donors and HSS

The Global Fund and HSS

The Global Fund finances AIDS, tuberculosis, and malaria projects, as well as health systems strengthening in the eight initial compact countries (see Table 3). Cambodia is the only country of these eight that has received a grant specifically for HSS, though all grants have at least the potential to support health systems strengthening. In all these countries except Kenya, more GF resources are financing HIV/AIDS programs than either TB or malaria. The country largest in population, Ethiopia, appropriately has received the largest amount of grants at USD 444 million. On a per capita basis,

⁷ Several of the compact countries participated in regional workshops in 2003 and 2004 at which the resource needs estimates for nearly 40 specific interventions were reviewed by country specialists. These consultations helped bring global estimates closer to costed national plans. For the majority of the 60+ NSP countries, costed plans are not comparable to GRNE.

⁸ Mathers, Colin D, and Dejan Loncar, Projections of global mortality and burden of disease from 2002 and 2030, *PLoS Medicine*, 3, 11, pp. 2011-2030, November 2006.

⁹ *Ibid.* p. 2022, 2023, 2027, Tables 3 and 6.

however, the largest amounts have gone to Zambia, which has received about USD 17 per person, with 63 percent of that allocated to HIV/AIDS. Only modest amounts have so far gone to Nepal, the country of these eight with the lowest prevalence of the key diseases addressed by The Global Fund.

Table 3. Global Fund grants to 8 initial compact countries (USD millions and USD per capita)

	<i>Ethiopia</i>	<i>Kenya</i>	<i>Mozambique</i>	<i>Zambia</i>	<i>Burundi</i>	<i>Cambodia</i>	<i>Mali</i>	<i>Nepal</i>
HIV and AIDS	291	71	66	126	22	60	24	8
HSS						2		
Malaria	129	81	24	47	19	23	7	6
TB	24	9	9	29	2	9	4	3
Total	444	160	99	201	43	94	35	18
per capita	6	4	5	17	5	7	3	1

Source: Website, www.theglobalfund.org. (USD rounded to nearest million and nearest dollar; totals may differ due to rounding error).

The Global Fund helps strengthen health systems in three ways:¹⁰

- 1) Its financing allows flexible investment in health systems through multiple disease programs;
- 2) Effective disease control benefits the health sector by reducing mortality among health workers; and,
- 3) Prevention efforts against AIDS, TB, and malaria reduce the burden of these diseases on hospitals and thus free resources for other priority uses.

PEPFAR and HSS

As PEPFAR focus countries, four of the initial compact countries are recipients of substantial parts of the largest international assistance effort in health ever. In FY06, for example, country operational plans assigned the following substantial amounts to these countries (in USD millions): Ethiopia, 123; Kenya, 208; Mozambique, 94; and Zambia, 149.¹¹ For subsequent years the amounts are even larger in all these countries. Legislation before the US Congress will further increase the overall commitment of PEPFAR in coming years virtually assuring that funds to the compact countries for HIV/AIDS programs will continue to grow. Moreover, as noted above, the US Government is cooperating closely with UK and other governments in efforts to assure that health systems strengthening objectives will be served along with expanded AIDS services of prevention, care, treatment and mitigation.

In FY 2008, PEPFAR committed \$425 million to providing care and support for people infected with or affected by HIV/AIDS in the focus countries.¹² "These resources represented 8.8% of program funding, supporting care for over 5.7 million people."¹³ PEPFAR care programs have linked HIV counseling and testing with ARV treatment programs. "Within the [created] network model of care, PEPFAR supports a variety of interventions at different levels (including home based care programs, as well as health care sites that deliver services)."¹⁴ PEPFAR's funding has also provided resources to fill specific unaddressed gaps in national training, laboratory systems, strategic information systems and health systems

¹⁰ The Global Fund, 2007. Global Fund's strategic approach to health system strengthening: Background Note 3 for July 30-31 consultation. Geneva: The Global Fund.

¹¹ PEPFAR, Office of General AIDS Coordinator; see www.pepfar.gov.

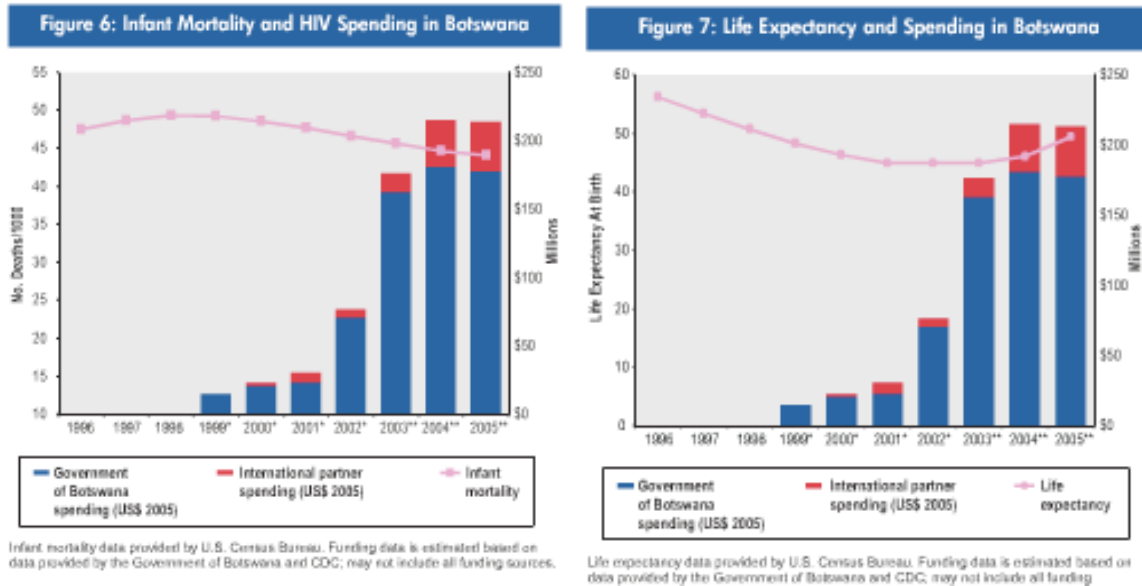
¹² PEPFAR 2009 Congressional Budget Justification 'Annual Report'. p. 54.

¹³ Ibid

¹⁴ Ibid

strengthening.¹⁵ A component of PEPFAR’s health systems strengthening initiatives have been five years of support for national blood transfusion services.¹⁶ PEPFAR focus on health systems strengthening and local capacity building has effects that reach beyond HIV/AIDS prevention, treatment, and care. “[A]ggressively confronting HIV and AIDS has a broad impact on the overall health of the populations.”¹⁷ Six of the IHP+ compact countries are also PEPFAR focus countries. Twelve of the 15 PEPFAR countries have experienced infant mortality decline. Thanks to the fight against AIDS, life expectancies are also increasing. “The correlation between HIV and AIDS programs and improved quality and duration of life for women and children is unmistakable,” according to a recent PEPFAR report (See Figures 4 and 5).¹⁸

Figure 4. Infant Mortality Decline and Life Expectancy Increase- Botswana



Source: PEPFAR 2009 Congressional Budget Justification 'Annual Report'

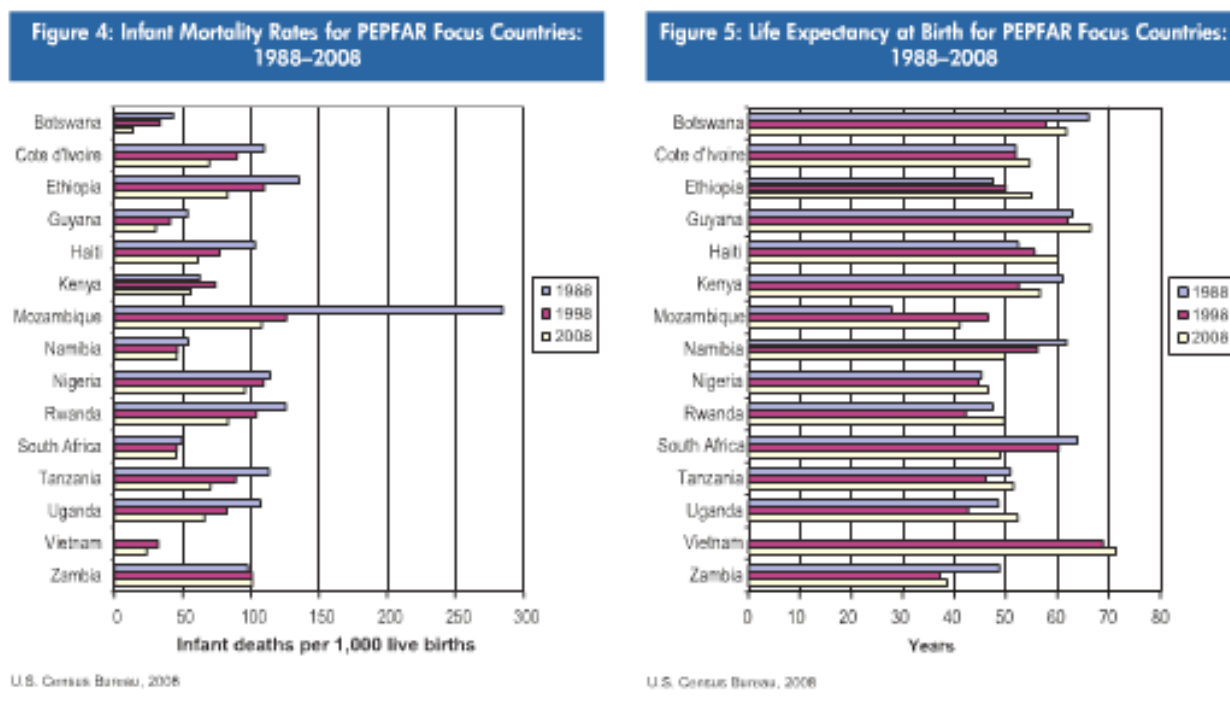
15 Ibid

16 PEPFAR 2009 Congressional Budget Justification 'Annual Report'. p. 44.

17 Ibid, p. 11.

18 Ibid, p. 10.

Figure 5. Infant Mortality Decline and Life Expectancy Increase- PEPFAR Focus Countries



Source: PEPFAR 2009 Congressional Budget Justification 'Annual Report.'

Additional Health Systems Strengthening Efforts ¹⁹

In addition to working with IHP+, the Global Fund also works with the WHO on Health Systems Strengthening. WHO provides technical assistance to the Country Coordinating Mechanism (CCM) in countries preparing applications for grants from The Global Fund. The aim is to blend 'vertical' objectives in fighting AIDS, TB and malaria with 'horizontal objectives of health systems strengthening.'²⁰

The Global Fund encourages countries to address health system issues that will strengthen the HIV, TB and malaria response, and that will strengthen the health system overall including access to services, surveillance, human resource capacity, and institutional development. Building health systems for the delivery of HIV/AIDS, TB, and malaria services contributes to an overall improvement of the system.²¹

WHO, PEPFAR, and UNAIDS are cooperating to develop global guidelines for task shifting to address the shortage of healthcare workers faced by many countries. Task shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded.²² These guidelines were formally launched during the Global Conference on Task Shifting in Addis Ababa, 8-10 January 2008.

¹⁹ Guidance paper on Global Fund to fight AIDS, Tuberculosis and Malaria related activities in WHO. March 2005. WHO.

²⁰ Ibid, p. 3

²¹ Ibid. p. 6

²² WHO Health Systems and Services. 2008. *Taking stock: Health worker shortages and the response to AIDS*. Geneva: WHO. 12 p. The 'treat, train, and retain' program is underway in several compact countries discussed in this report.

Several countries are already using task shifting to support HSS and scale up access to HIV/AIDS treatment and care.

Part of the function of HSS funding is addressing the health worker shortage in many of the compact countries. "Task shifting not only addresses the two interlinked emergencies of the health worker crisis and the HIV and AIDS pandemic, but also offers long-term potential for strengthening health systems in a way that is consistent with the current renaissance in primary health-care services," said Dr Anders Nordström, WHO Assistant Director General, Health Systems and Services.²³ Three bilateral donors recently pledged new commitments for HSS along with maternal and child health. Norway pledged USD1 billion to childhood immunization through 2015; the Netherlands pledged \$125 million Euros over three years; and, Canada pledged C\$105 million over 5 years, matched by UNICEF.²⁴

The Global Fund will contribute to health systems strengthening by reducing risks to health workers. Kenya's goal for 2010 is to ensure 100 percent blood supply screening and 100 percent safe injections to ensure safe immunization for children and adults. Current estimates are that up to a quarter of all injections are unsafe. These steps will ensure a safer working environment for health professionals.²⁵

Channels of Funding

PEPFAR resources flow largely through private-sector organizations. While the majority of Global Fund assistance goes through the private sector, it has made efforts to blend assistance to both public and private agencies. For instance, it receives proposals from CCMs and urges these entities to assure adequate representation by civil society organizations. The World Bank has pioneered efforts to promote sector-wide assistance programs (SWAPs) that aim to assure effective coordination of all donor assistance. Many bilateral organizations, especially DFID and other EU aid agencies, support such coordination.²⁶ Often discussed is the proposition that public *financing* but private *provision* of health care is a sound division of labor. Poor countries face serious administrative challenges, e.g., lack of health insurance infrastructure that can implement 'ideal' arrangements. Each compact country will have to work out its own most effective systemic architecture.

IHP+ and donor coordination

IHP+ represents an additional step toward effective coordination. Some recipient governments have found themselves spending too much time responding to the many requests for information and reporting from the many donors that wish to help them. A development economist reports on one African country's bureaucracy that "produced 2,400 reports a year for its aid donors, who sent the beleaguered recipient one thousand missions of donor officials per year."²⁷ The compact countries can benefit if reporting requirements can be consolidated. A key task will be to assemble information that addresses the question, "How do HIV and AIDS programs and donor assistance to those programs help or hinder HSS?"

Donor support to HIV/AIDS interventions can help build effective health systems that incorporate both public and private service delivery. Already, substantial funds flow directly from donors to civil society and faith-based organizations for HIV/AIDS programs. However, there is as yet no

²³ Pugh, K. New Guidelines Released to Address Health Worker Shortage. *Global Health Leaders Convene to Tackle HIV and AIDS and Health Systems Strengthening-PEPFAR*. Jan 8, 2008.

²⁴ Baker 2008, the long road to adequate and sustained donor financing for health. *Northeastern University School of Law*.

²⁵ Financing Framework: Resource Requirement for the Kenya National Aids Strategic Plan (KNASP) 2005-2010, January 2005.

²⁶ UK DfID will spend approximately USD2.5 billion on bilateral and regional programs to reduce poverty in Africa in the fiscal year 2007/08. Most will be spend in 16 priority country, of which four Ethiopia, Kenya, Mozambique, and Zambia) are also IHP+ compact countries. See UK DfID 2008 fact sheet.

²⁷ William Easterly, *The white man's burden: Why the West's efforts to aid the rest have done so much ill and so little good*, New York, The Penguin Press, 2006, p. 165

comprehensive data system able to track the linkages between AIDS interventions and health systems strengthening. IHP+ proposes to remedy this problem. Its *Objective 4: Ensure mutual accountability and monitoring of performance*, includes a review of procurement policies and a unified health sector monitoring and evaluation framework that can verify the positive links between financing for AIDS and health systems strengthening.²⁸ Creating such a system will be a major future task, and donors and recipients alike will have a major stake in developing and maintaining the necessary system of information.

Steps toward achieving health systems strengthening

Key questions need to be addressed in designing HSS efforts:²⁹

- What are the current health system constraints that must be overcome to reduce the impact and spread of disease? How can the process of overcoming these constraints and changes in the health system strengthen the system as a whole?
- If a country already has a health sector strategy, are there funding gaps that can be filled by Global Fund partnership resources to help strengthen the system?
- If a country does not yet have a health sector strategy, what is the most efficient way to establish one so that players can act?

Essential components of a successful program with Health Systems Strengthening benefits include the following:³⁰

- Link cross-cutting HSS interventions to reducing the target diseases (in this case HIV/AIDS) and their impact
- Sustainability
- Addresses salary support and incentives of health workforce
- A comprehensive approach including existing strong health system analyses
- Country receives technical support from development partners, such as the WHO
- It is imperative to have monitoring and evaluation systems
- National commitment and strategies
- Efforts take into account the most vulnerable populations
- A clear focus and plan of action dealing with major country obstacles

Limitations of the Diagonal Approach

A challenge with diagonal programs is that they do not begin with the health systems requirements as a whole. They make use of the opportunities for health systems strengthening that present themselves in the implementation of specific interventions. Comprehensive health systems' strengthening is not possible through this approach.³¹ This may be the case, however, progress and strengthening of one part of the sector can spill into other parts of the sector as well, gradually improving the system as a whole.

²⁸ IHP+, 2008, Update on the International Health Partnership and related initiatives (IHP+), 28 Jan 08, p. 3.

²⁹ Toolkit for using round 9 of the Global Fund Health Systems Strengthening. October 2008.

³⁰ Ibid, p. 21/36.

³¹ Comment from Ms. Ishrat Husain- February 12-13, 2009; Technical Review Meeting: AIDS2031 Costs and Financing Project. Washington, DC.

Evidence of HSS in the Eight Initial Compact Countries

Ethiopia

GF, PEPFAR, and HSS Objectives

About USD90 million of Ethiopia's three Global Fund AIDS grants support HSS objectives. PEPFAR has provided more than USD20 million to renovate hospitals, health centers, blood banks and laboratories. It supports the Health Management Information System (HMIS), a contributor to planning and programming capacity of the Ministry of Health. A fifth of the \$354 million of the 2008 PEPFAR budget for Ethiopia supports HSS. Much PEPFAR support passes directly to NGOs, organizations that could in principle complement, rather than compete with, public health service provision. Achievements in ART and HIV counseling and testing prove that substantial increases in funding *can* be translated into rapid scale-up of services.

Three major donors, the Global Fund, PEPFAR and GAVI, are supporting improvements in health system infrastructure, the procurement and supply system for medicines and other commodities, and HMIS. The creation of IHP+ is an opportunity to enhance donor awareness of complementarities in their work and strengthen both public and private provision of services.

Progress on the IHP+ Compact

In August 2008, the Government of Ethiopia and its development partners signed the International Health Partnership Country Compact. This compact has the main objective of providing a framework for increased aid to achieve the health-related MDGs through the Health Sector Development Program (HSDP). Financial gaps remain, but there has been progress.³²

Kenya

Evidence of HSS and a continuum of services

The incidence of TB is rising in Kenya because of HIV, but case detection remains low. The Kenyan 2007 proposal to the Global Fund identified the delivery of essential health services at primary health facilities as the most effective response to co-infection. With GF support the government will renovate 33 percent of public dispensaries, recruit staff, strengthen district level planning, and augment staff productivity. The goal is to have comprehensive health plans at the end of the 5-year grant.³³ All TB patients will be tested for HIV, and those testing positive will be given access to treatment and care services. It is hoped that forging links between hospitals, rural health facilities, private, faith-based organizations, and NGOs will provide a continuum of services. A functioning referral system can then further contribute to health systems strengthening.³⁴ The target for 2010 is that 90 percent of hospitals have Comprehensive Care Centers. Finally, Kenyan HIV/AIDS programs contribute to the training of many health care workers and counselors to provide HIV testing and counseling and related health services.³⁵

PEPFAR's actions in Kenya have impacted public health delivery networks. HIV+ persons co-infected with TB or other opportunistic illnesses are reached as rapidly as possible. There has been a four-fold

³² Ethiopia January Progress Report 2009. *IHP+*.

³³ The Global Fund's Strategic Approach to HSS- Background note July 2007

³⁴ KNASP 2005/06-2009/10, p. 24

³⁵ Country Profile-Kenya PEPFAR)

increase in the number of MoH sites providing treatment, with PMTCT services now available at over 750 medical facilities.³⁶

Synergies between STI, HIV, and HSS

The further improvement of STI/HIV testing and treatment will contribute to HSS. The Kenya National HIV and AIDS Strategic Plan (KNASP) is building the capacity of STI units to provide HIV testing and counseling through the training of health workers and the provision of testing kits.³⁷ STI counseling and treatment/referral have been integrated with ANC, FP, and general curative services. There are over 100 comprehensive care centers nationwide that focus on ART care but also offer other health services for STIs, SRH and TB.³⁸ There has also been an expansion in PMTCT services assuring comprehensive maternal and childcare. Strengthening basic ANC services and infrastructure, coupled with community education, results in improvement in PMTCT and general ANC uptake.³⁹ In June 2007, PEPFAR allocated an additional \$60 million to increase coverage in PMTCT, CT, and TB/HIV.

AIDS interventions in support of IHP+

Addressing the HIV/AIDS epidemic in Kenya contributes to health systems strengthening. World Bank assistance strengthens institutions mainly linked to the Ministry of Health.⁴⁰ Kenya makes good use of donor assistance. Donor funding for AIDS helps Kenya attain HSS objectives, too, in a win-win combination.

Progress of IHP+ Compact in Kenya since 2007

Efforts to improve the health system in Kenya began in 2005 before IHP+ was initiated, in order to address the dire health of the Kenyan population. Once the IHP+ program started in Kenya in 2007, it helped strengthen the Kenya Health Sector Wide Approach (KHSWAp). The IHP+ process gave Kenya the impetus to create a partnership in order to have a sustainable health system and improved health outcomes.⁴¹ Kenya's aim under IHP+ was to coordinate all parts of the health sector, such as integrated management of childhood illness, reproductive health, and health system development.⁴² KNASP has mobilized the country to implement a multi-sectoral approach. The Three One's framework addresses prevention, quality of life of people infected and affected by HIV/AIDS, and mitigation of the socio-economic impact of the disease.

In 2008, DFID, WHO, and the World Bank supported the IHP+ in Kenya with financial aid of £ 1 million, \$350,000, and \$50,000, respectively. The political environment over the last year interfered with some of Kenya's progress, however, the will is still present to maintain the focus on KHSWAp and the IHP+ goals. In 2009, the Kenyan Ministries have recommitted strong efforts to the process. There will be an acceleration of the process to develop the structures needed to ensure a strong partnership despite some structural changes in the Ministry of Health that have occurred since the start of the IHP+ process.⁴³

³⁶ Ibid

³⁷ KNASP 2005/06-2009/10, p. 21

³⁸ Kenya Synergies Case Study 2006, Pathfinder 2005- DFID Health Resource Center

³⁹ Ibid

⁴⁰ Committing to Results: Improving the effectiveness of HIV and AIDS assistance.

⁴¹ Kenya January Progress Report 2009. *IHP+*.

⁴² Kenya's CCM Effective Multi-Stakeholder Health Management, GF Annual Report 2003, Country Profile.

⁴³ Kenya Progress Report January 2009. *IHP+*.

Mozambique

Synergies between HIV/AIDS and HSS

PMTCT efforts have been increasingly integrated with other health services, with almost half of antenatal care sites now offering PMTCT services fully integrated into other maternal and child health services.⁴⁴ STI prevalence rates dropped from 14.1 percent in 2006 to 8.6 percent in 2007, with the reduction attributed to health facility improvements supported under HIV program funding.⁴⁵ More generally, “resources for the national response to HIV and AIDS have contributed to the improvement of infrastructure, procurement and distribution, upgrading of laboratory facilities and blood banks, nutrition, and logistics management.”⁴⁶ By 2006 AIDS funding from government and donors had reached a level half that of the government health budget.⁴⁷

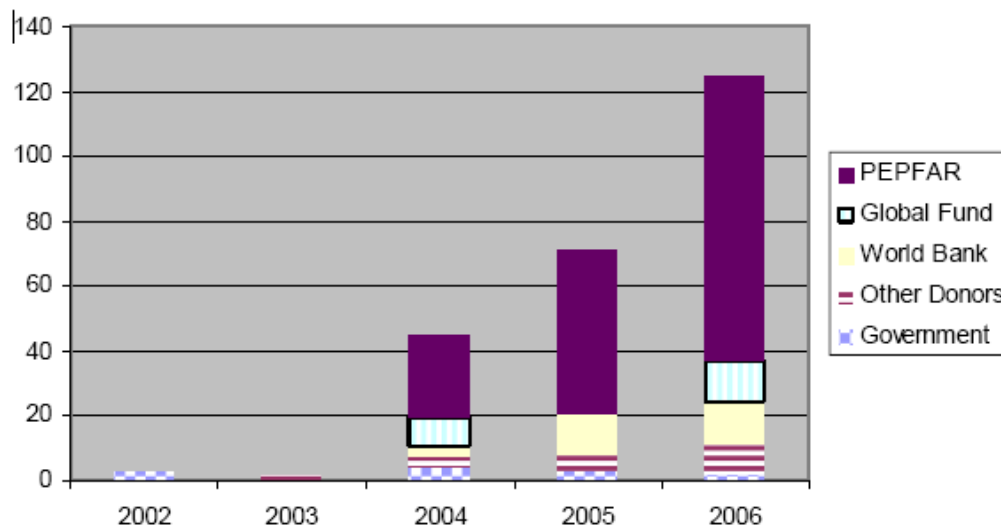
Barriers to scale-up

The ratio of health workers to population, which is less than 3 per 10,000 persons, is among the lowest in Africa. Many trained health workers leave low-paid government service and move to better salaries in the NGO sector. This shift has compounded the challenge faced by government in terms of achieving nationally defined priorities and in trying to provide health services in an equitable way, reaching remote and underserved areas and poor and marginalized groups.

HIV/AIDS spending in Mozambique

The growing presence of PEPFAR funding is responsible for the changing shares of health expenditure. Under the Emergency Plan, Mozambique received over \$37 million in 2004, \$60 million in 2005, \$94 million in 2006, and \$162 million in 2007. Over three-quarters of donor assistance for HIV/AIDS comes from PEPFAR and goes mostly to NGOs in the country (see Figure 6).

Figure 6: Mozambique National HIV/AIDS Funding USD MILLIONS



⁴⁴ Mozambique 2008 Progress Report for United Nations General Assembly Special Session on HIV and AIDS: http://data.unaids.org/pub/Report/2008/mozambique_2008_country_progress_report_en.pdf. p. 29.

⁴⁵ Ibid, p. 37.

⁴⁶ Ibid, p. 19.

⁴⁷ Oomman, et al.

Sources: Oomman, et al. Constructed with planned expenditure data from PEPFAR website, disbursements from the Global Fund website, disbursements data provided by the World Bank, and Mozambique government reports. World Bank funding includes both MAP and TAP.

Progress on IHP+ Compact

Mozambique signed its compact on the 16th of September 2008. Following the December 2008 update, Mozambique has proposed to work on the following areas:

- Strengthening NGO engagement in health systems strengthening as well as local capacity building
- Creating the capacity to bring together existing costed plans that are part of the Health Sector Strategic Plan (PESS). In 2009, one of the goals is to round up additional support for the 2010-12 Mid Term Expenditure Framework (MTEF)
- Revision of funding mechanisms, including GFATM round 8 and GAVI proposals, in order to allocate funds to health systems strengthening. Strengthening overall monitoring and evaluation is part of this process as well

Terms of Reference are being prepared at that MoH for NGOs. Mozambique makes the argument that NGOs will play a significant role in HSS.⁴⁸

Zambia

Current Status of HSS

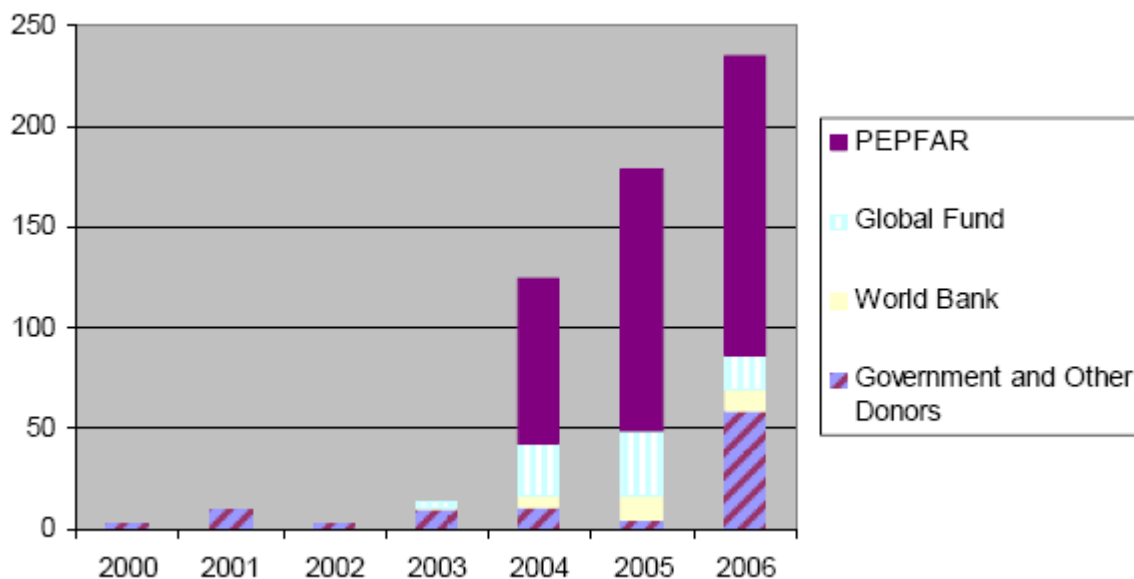
At present only 10 percent of donor funds go towards strengthening the Zambian health system. The remaining 90 percent supports priority-disease 'vertical' programs.⁴⁹ However, rich potential for synergy exists between current HIV/AIDS efforts and health systems strengthening. For instance, PEPFAR has argued that its presence has catalyzed the Zambian government to scale-up improvements in its own health services, and USD6.5 million in PEPFAR funding was allocated towards policy analysis and systems strengthening in 2007.⁵⁰

⁴⁸ Mozambique Progress Report January 2009. IHP+.

⁴⁹"Update on the International Health Partnership and Related Initiatives (IHP+)" January 2008), http://www.who.int/healthsystems/IHP+progress_report_H8.pdf.

⁵⁰ Ibid.

Figure 7: Zambia National HIV/AIDS Funding USD MILLIONS



Sources: Oomman, et al. Constructed with planned expenditure data from the PEPFAR website, disbursements data provided by the Global Fund website and the World Bank, and the Zambian government's Yellow Books.

Barriers to scale-up

Zambia has made significant gains in scaling up ARV treatment thanks to PEPFAR, but its critical shortage of health staff threatens to compromise the quality and availability of HIV/AIDS care. Production of health workers has not kept pace with need in Zambia. In 2006, there were only 646 doctors in the country; just a third of the doctor-patient ratio recommended by WHO. The urban/rural imbalance in the distribution of health workers has long been a problem and is worsening. The percentage of vacant posts is 42 percent in rural health clinics, 22 percent in urban health clinics, and 41 percent in hospitals.⁵¹ Successfully strengthening Zambia's health system by addressing the critical shortage of skilled healthcare workers will be decisive in determining the future rate of scale-up in HIV/AIDS efforts in the country.

Progress on IHP+ Compact

The IHP+ country compact for Zambia remains to be finalized, but much of the architecture is already in place. The country has one strategic plan for its health sector, basket funding mechanisms, and joint sector reviews. In February 2008, at an IHP meeting with IHP + and Harmonization for Health in Africa (HHA), Zambia presented the progress it had made on the MDGs. In July of 2008, the MoH asked the WHO for technical support to validate the Costing of its National Health Strategic Plan for 2006-2010 as well as to assess the Memorandum of Understanding between the Ministry of Health and its Cooperating Partners. A final version of the MoU is expected shortly from the "Reference Group," which consists of the MoH, three leading partners, and a representative from the Civil Society.⁵² These steps all bring Zambia closer to signing the compact. However, there needs to be a recommitment of more funds to HSS to deal with the main problems faced by Zambia's health system: shortage of

51 Picazo, Oscar, and Solomon Kagulura, "The State of Human Resources for Health in Zambia: Findings from the Public Expenditure Tracking and Quality of Service Delivery Survey (PET/QSDS), 2005/06." PET/QSDS Team of MOH & the University of Zambia UNZA).

http://www.hrhresourcecenter.org/hosted_docs/State_HRH_Zambia_PET_QSDS.pdf p. 4.

52 Zambia Progress Report January 2009. IHP+.

health workers, weak infrastructure for health delivery, obsolete equipment, and deficient transport and logistics.⁵³

Burundi

Synergies between HIV/AIDS and HSS

High levels of poverty in Burundi are aggravated by HIV/AIDS. The 2002-2006 National Strategic Plan to combat HIV/AIDS can contribute to HSS in several ways:

- Early diagnosis and treatment of STIs
- Lowering the risk of HIV/AIDS transmission through safe blood transfusions
- Prenatal screening and control of HIV/AIDS transmission from mother to child
- Strengthening of the surveillance, information collection, and management system
- Strengthening the capacities of civil society organizations and NGOs⁵⁴

WHO is cooperating with Burundi and focusing on the following: technical support to achieve universal access to ART, accelerating prevention activities, surveillance and monitoring, operational research, and advocating for and developing strategies to ensure financial sustainability. To strengthen the health system, WHO and Burundi will be working on decentralization, strategic planning, organization and management, information systems, and human resources and development of funding mechanisms for the poor.⁵⁵

Malaria control and treatment uses a large share of scarce health care resources, with consequences for HIV/AIDS programming. The Global Fund grant of USD10.7 million has financed distribution of 260,000 insecticide treated bed nets, training of 510 malaria specialists, and equipment for 378 health units, 26 hospitals and 9 high-malaria provinces. Reducing the malaria burden permits Burundi to now allocate more resources to HSS and HIV/AIDS programs.⁵⁶

Progress on IHP+ compact

There were summaries of country progress in IHP+ reports issued in January and in May of 2008. Burundi completed a joint health sector review during Oct 23-31, 2007, and agreed on a draft MoU between partners. A sector coordination group (CPSD) coordinates technical and financial support necessary to implement the PNDS, as a tool to achieve the MDGs in the framework of the country's PRSP. As noted in Burundi's stock taking report for the IHP+, "The shortcomings of coordination have been so apparent, that each operator has endeavored to introduce its own system, with the risk of creating further problems for the Government." IHP+ will give priority to reducing any conflict between assistance agencies. A MoU has been signed; MTEF is being finalized. Plans to develop a system of National Health Accounts and to implement a SWAP in the health sector are both underway, with the intent to introduce both instruments by March 2009. The substantial health challenges faced by Burundi will make that country's participation in IHP+ a major test of donor and government commitment to cooperative approaches to better health.

With the support of the World Bank, Burundi is preparing a single harmonized framework for monitoring and evaluation, which will be a part of the monitoring-evaluation theme group for 2009. A major campaign was planned in 2008 that would continue on into 2009, to raise awareness and to ensure ownership and signature of the compact by April 2009.

⁵³ IHP+ Update no.14. January 2009. *IHP+*.

⁵⁴ OXFAM International: A Situation Analysis. March-April 2003; see also UNDAF 2004, Burundi report.

⁵⁵ Country Cooperation Strategy at a glance-Burundi, WHO. 2006.

⁵⁶ Friends of the Global Fight. Results Profile: Malaria. The Global Fund-Fighting Malaria in Developing Regions. Nov. 2007.

Cambodia

Synergies between HIV/AIDS and HSS

The USAID Health System Strengthening in Cambodia project (USAID-HSSC) has contributed to HSS by expanding the following services: voluntary and confidential testing, Continuum of Care, PMTCT, and improved access to health services. "Continuum of Care" includes diagnosis, management of opportunistic infections such as TB, symptomatic and palliative care, ART, PMTCT, counseling, and awareness. The USAID-HSSC HIV/AIDS program also supports the national HIV/AIDS response within the public health system focusing on all tiers of the health system. Improving blood safety and injection safety are two additional factors adding to improvement of the quality of the health system and its strengthening.⁵⁷

Progress on IHP+ compact

Cambodia completed a review of its strategic plan for 2003-08 and is currently working with partners to develop the 2008-2015 Health Strategic Plan, which will include time-bound Cambodian MDGs. Immediate actions towards a compact are now being agreed upon between partners. Costing scenarios for the budget plans are under development. The Royal Government of Cambodia and Development Partners have a 5 year Action Plan for Harmonization, Alignment, and Results. Most recently, Cambodia has suggested an 18-month work plan for IHP- related activities that includes collaboration between the departments of the MoH, and bilateral and multilateral health partners. One third of the funding has been allocated to MEDiCAM, Cambodia's umbrella NGO. The hope is that this work plan will strengthen the already existing health systems framework and improve harmonization.⁵⁸

Mali

Synergies between HIV/AIDS and HSS

With a USD 54 million grant from the Global Fund, Mali trained 585 providers in revised syndromic management of sexually transmitted infections. The grant supported local HIV/AIDS information, education and communication activities that reached over 167,000 people and 5,000 religious and political leaders with the message of prevention.⁵⁹ PEPFAR's Grant Performance Report for August 21, 2007, also shows evidence of HSS through PMTCT. Over 6 periods of data collection, there was an increase from 150 to 950 in the number of newborns of HIV- infected mothers receiving powder milk regimen. HIV/AIDS funding simultaneously provides care for HIV+ mothers while it strengthens antenatal care. In response to the HIV/AIDS crisis, hospitals and clinics have responded with the provision of comprehensive care.⁶⁰

Barriers to scale-up

As in other IHP+ compact countries, the lack of human resources in the health sector is a barrier to progress. Given its poverty, Mali also lacks adequate physical facilities. A further problem for such a donor-dependent country and its health sector is the unpredictability of external financing. Annual disbursements were as low as USD 10 million in 2002, and as high as USD 50 million in 2005. This volatility in financial flows impedes progress in planning for health systems strengthening. The introduction of planning cycles aligned to the government budget has reportedly led to some

⁵⁷ USAID-HSSC HIV and AIDS Programs

⁵⁸ Cambodia Progress Report 2009. *IHP+*.

⁵⁹ USAID Mali Annual Report FY 2005.

⁶⁰ Final PRSP Mali. May 29, 2002.

improvement in the regularity of external financing since 2006. There is a risk that funding cuts may occur in 2009 as the health sector plan PRODESS comes to its completion.

Progress on IHP+ compact

Work towards the IHP+ compact is presently underway, with current efforts focusing on revisions to the health MTEF. Mali is one of the four compact countries that was scheduled to complete compact arrangements in 2008. Mali's partners met and agreed to continue to support the government in its harmonization process around the national health program, common missions, common monitoring meetings, and common indicators, and to come up with a roadmap. Mali planned to have a mid-term review of its strategic health sector plan in May 2008. The mid-term review provides an opportunity to agree on a roadmap towards a compact.

A group of various partners and IHP+ signatories met to discuss the Mali planning process in early December 2008. On the 13th of January, the different components were drafted and handed into the coordination group. The compact will be signed soon and is based on the cooperation of partners and the government and its sectoral program (PRODESS II 2005-2011), with the goal of achieving the MDGs. A Strategic Plan for Strengthening the Health System and a plan for consolidating the Health Information System are part of the documents submitted to the coordination group. A highlighted element of Mali's compact is the emphasis on the coordination and collaboration of signatories to reach better health outcomes.⁶¹

Nepal

Synergies between HIV/AIDS and HSS

Nepal established the National AIDS Control Program in 1987. A decade later the program adopted a national strategy covering the years 1997-2001, and integrated with other health programs, especially safe motherhood and reproductive health. Links to co-infection with TB and STIs and appropriate care and treatment now constitute actions in the fight against AIDS as well as health systems strengthening in Nepal.⁶² In Round 7, the Global Fund granted Nepal USD36.6 million for HIV/AIDS, covering gaps identified in prevention among migrants, MSM and IDUs, as well as health sector strengthening.⁶³

HSS and donor funding

Asian countries, including Nepal, have taken a multisectoral approach to facing HIV/AIDS. Through this multisectoral approach, HSS can be observed in the Prevention Programs supported by the World Bank. The projects focus on prevention for highly vulnerable groups through community mobilization and empowerment, management and prevention of STIs, strengthening surveillance systems and monitoring and evaluation, as well as strengthening public and private institutions for a multisectoral response.⁶⁴ The major donor to HIV/AIDS prevention in Nepal is USAID, contributing \$2.4 million dollars in 1998. USAID has been the chief donor supporting the private sector to deliver interventions to combat HIV/AIDS and other STIs. Other donors have directly addressed HSS, with the Australian government allocating resources to increase support for health services working with UNICEF to target maternal and child health and the delivery of services to communities.

⁶¹ Mali Progress Report January 2009. *IHP +*.

⁶² UNGASS Country Progress Report-NEPAL

⁶³ *Ibid.*

⁶⁴ HIV and AIDS in South Asia. The World Bank. May 2005.

Progress on IHP+ compact

Nepal completed its sixth Joint Annual Review of the Nepal National Sector Program during December 2007. The review provided an opportunity to discuss the development of a roadmap towards a compact. Participants named a working group to finalize the IHP+ compact and roadmap. Technical assistance under IHP+ has recently been submitted and a proposal for IHP+ funds has been approved.⁶⁵

There is evidence of the strengthening of Nepal's health system. The Ministry of Health and Population (MoHP) instituted universal free care at the sub health and health-post levels, and expanded its free care to primary health clinics and district hospitals. Essential medicines are also being provided for free. As of mid-January, maternity care is also free. This scaling up will need ongoing external support and a greater health budget, however it is a good roadmap towards signing the compact. The Health Development Partnership was signed on the 1st of February 2009. It is anticipated that the country compact will be signed shortly.⁶⁶ "The IHP 'Strengthening the Health Sector' roadmap has been examined in light of the overall objective of contributing to meeting national health policy goals and the MDGs, including preparation for drafting the NHSP-II which is to take effect from 2010."⁶⁷

A Worldwide Response

The exceptional nature of the HIV/AIDS pandemic has generated a worldwide response. Still, estimates of financial resources needed continue to exceed the projected funds available. IHP+ objectives will not be served if already scarce AIDS funds are simply shifted to general HSS objectives that are not adequately managed in the compact countries.

From Three One's to Six One's

The success of the Three One's architecture identified for AIDS programs, namely one national plan, one managing organization, one system for monitoring and evaluation) may well have inspired the Six One's of IHP+:

- ONE country health plan
- ONE results framework
- ONE policy matrix
- ONE budget
- ONE joint monitoring and reporting process
- ONE country-based appraisal/validation process

This new architecture can build on and learn lessons from the success of the ongoing fight against AIDS. Cooperation in pursuit of HSS must not reverse progress made on specific and carefully-crafted programs that must continue. Encouragingly, emerging IHP+ plans indicate a careful consideration of the need to continue progress on both fronts.

Roadmaps and Compacts

Each of the eight compact countries is committed to laying out a roadmap associated with the Six One's above. Kenya, for example, is currently finalizing a draft roadmap towards a compact. Zambia completed a roadmap toward a compact in November 2007, building on a health Memorandum of

⁶⁵ IHP+ report to World Health Assembly 2008, p. 21.

⁶⁶ IHP+ Update no. 14, January 2009.

⁶⁷ *4th Progress Report*. International Health Partnership and Related Initiatives; Ministerial Review Meeting. February 4-5 2009. p.15.

Understanding (MoU) signed in 2006, and a Joint Assistance Strategy. Burundi and its development partners signed a MoU as one of its first steps in the IHP+ process. The government is finalizing a medium term expenditure framework and plans to develop a system of national health accounts. At least four IHP+ countries, Ethiopia, Mali, Cambodia, and Zambia, are planning to have country compacts completed in 2008. Mozambique's government foresees compact completion in mid-2009. Several other countries beyond the initial eight have also expressed interest in IHP+, including Benin, Burkina Faso, Ghana, Madagascar, and Nigeria, according to the IHP+ website.

Progress on priority HIV/AIDS interventions

IHP+ compact countries vary significantly in health performance. They also differ in terms of their performance on the ten priority interventions for HIV/AIDS established by the WHO (see Table 4). Most are doing well on provision of ART, HIV testing and counseling, laboratory services, blood safety, and prevention of mother to child transmission. Progress is more limited on control of sexually transmitted infections to prevent HIV transmission, on surveillance procedures and related data collection. Few countries have made significant advances in universal precautions, male circumcision, or prevention for HIV positive persons.

The bottom row of Table 4 offers a crude measure of progress for each of the eight compact countries. It presents the numerical sum of plus (+) signs that appear in the cells above for each country. The highest numbers, 18 and 17 for Kenya and Zambia, respectively, may fairly assess advances made in those countries in the priority intervention areas. Somewhat lower scores appear for Ethiopia and Mozambique (14 each). Cambodia and Nepal, the two Asian countries, score somewhat lower still. Burundi and Mali, African countries with fairly low HIV prevalence, are lower still, perhaps because these countries are only recently developing vigorous HIV/AIDS intervention programs.

Table 4. Initial 8 Compact country performance on WHO priority interventions for HIV/AIDS.

Indicator	Eth	Ken	Moz	Zam	Bur	Cam	Mali	Nep
ART	++	+++	++	+++	+	+	+	+
PMTCT	+++	+++	+++	++	+	+	+	+
HIV T&C	+	++	+	++	+	+	+	+
STIs	+	++	+	+	..	+	..	+
Surveillance	+	++	+	++	..	+	..	+
Blood Safety	++	++	++	++	+	++	+	+
Univ. Precautions	+	+	+	+	..	+	..	+
Male circumcision	+	..	+
Lab Services	++	++	++	++	+	++	+	++
Prevention, +'s	+	+	+	+	..	+	..	+
Total +'s	14	18	14	17	5	12	5	10

Notes: Scorings are authors' estimates of country performance on selected priority areas identified by WHO. Initial scores are as follows: .. = no evidence or low performance; + = adequate performance; ++ good performance; +++ = very good performance. All estimates are preliminary and subject to review. ART = highly active antiretroviral therapy; PMTCT = prevention of mother to child transmission of HIV; HIV T&C = HIV testing and counseling; STIs = control of sexually transmitted infections to prevent HIV transmission; Universal Precautions = provisions of masks, gloves and other protective devices to assure that health personnel are protected against risks of contracting HIV from patients; Prevention, +'s = prevention methods, including 100 percent condom use for HIV positive persons who have contact with persons who are not HIV+.

IHP+ compact agencies can monitor progress on these priority intervention areas. Data such as those appearing in Table 4 can complement the broader effort of IHP+ to assure progress in HSS without diverting attention from HIV/AIDS.

Conclusion: Synergies between HIV/AIDS Funding and HSS

Disease-specific programs and health systems strengthening

PEPFAR, the Global Fund, the World Bank and other bilateral donors finance interventions that yield benefits for health systems in general as well as direct prevention, care and treatment for HIV/AIDS. The points below summarize examples of synergies between health systems strengthening and HIV programmatic funding in the eight compact countries:

Donor Agencies

- PEPFAR – A review by staff of the Center for Global Development notes that “PEPFAR figures indicate that \$638 million of the money it obligated in 2007 was devoted in full or in part to capacity building activities (Oomman and others, *Stories behind the numbers*, Wash DC: Center for Global Development, 2007, p. 16);
- The Global Fund expects to spend USD 363 million on actions that will strengthen health systems in recipient countries;
- The Global Fund and PEPFAR are devoting at least one third of their grants to the objectives of Health Systems Strengthening (HSS);⁶⁸
- The GAVI Alliance pledged on 23 May 2008 to ‘increase its funding for health systems strengthening to USD 800 million;’⁶⁹

IHP+ Compact Countries

- Ethiopia – At least USD 20 million of PEPFAR funding supports overall health systems strengthening in that country; Ethiopia has already trained and placed 24,000 health extension workers; Addis Ababa was the site of the first Global Conference on Task Shifting, a potential contributor to providing more staff for health systems strengthening;
- Kenya –PMTCT services are now available at over 750 facilities supported by PEPFAR, and help strengthen maternal and child health services more broadly; centers for prevention, diagnosis, and treatment of STIs address sexual and reproductive health beyond HIV/AIDS, at a time when half a million such infections occur annually in Kenya;
- Mozambique – Target date for meeting IHP+ compact conditions is July 2009, later than some other countries. Despite progress in maternal and child mortality reduction, there remains a high level of HIV prevalence and very low income and capacity to finance health services. Virtually any progress in the fight against AIDS will have secondary positive results for the health sector as a whole;
- Zambia -- Prevention of mother to child transmission has expanded substantially. Up from 74 health facilities in 2004, by the end of 2007, 678 sites were providing ART as part of PMTCT services. These efforts continue to grow, with nearly USD16 million in 2007 allocated for PMTCT under PEPFAR;
- Burundi – Global Fund grants have helped finance distribution of 260,000 treated bed nets; 378 health units and 26 hospitals now have essential malaria-testing equipment. These resources have started to bring down the burden of malaria on health systems and hence permitted greater allocation of resources to HIV/AIDS, PMTCT programs, and overall strengthening of a very weak health system in one of the poorest compact countries of IHP+;⁷⁰

⁶⁸ Kazatchkine, Michel; Speech at Center for Strategic and International Studies; February 18, 2009.

⁶⁹ GAVI Alliance 2008, p. 1.

⁷⁰ Friends of the Global Fight. Results Profile: Malaria. The Global Fund-Fighting Malaria in Developing Regions. Nov. 2007.

- Cambodia -- This compact country has already enjoyed positive results in lowering HIV prevalence thanks to a vigorous effort at prevention. Incidence is at least likely to be concentrated among IDUs and linked sex workers. Health systems strengthening can help assure that the disease does not spread outside the key groups, and focused prevention efforts among those groups can have positive results and further limitation of the spread of HIV/AIDS;
- Mali -- Mali has a concentrated HIV epidemic. Focused attention on key groups, especially sex workers and their clients, can have positive results with limited financial resources. In 2007, the Performance report showed that PMTCT had greatly improved and there was an increase from 150 to 950 in the number of new-born's of HIV- infected mothers receiving powder milk regimen.
- Nepal -- HIV/AIDS interventions are integral parts of safe motherhood and reproductive health in Nepal. The tuberculosis program has also been broadened to integrate HIV/AIDS counseling and care for persons testing positive. In Round 7, the Global Fund granted USD36.6 million for HIV/AIDS, covering gaps identified in prevention among migrants, MSM and IDU's, treatment care and support as well as health sector strengthening. Nepal has been implementing a SWAP since 2004. Nepal completed its sixth Joint Annual Review of the Nepal National Sector Program in December 2007. Participants discussed development of a roadmap towards a compact. A working group is at work to finalize a new IHP+ compact. A proposal for technical assistance under IHP+ has recently been submitted for approval.

IHP+, working with the Global Fund, PEPFAR, and other multilateral and bilateral organizations has laid the foundations for the diagonal approach and Health Systems Strengthening. There is still much room for development, but with donor and government commitment in countries, making progress towards MDG 6, as well as strengthening the general health system framework, is promising.

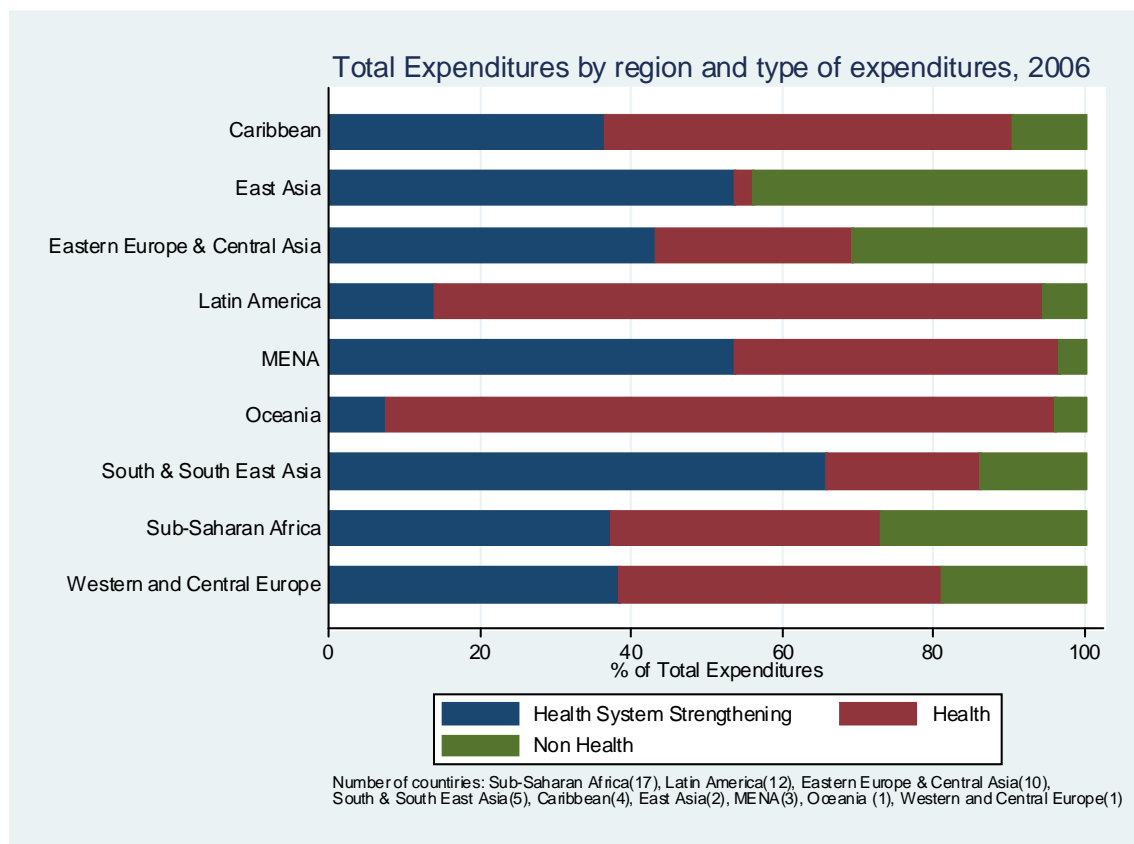
HIV/AIDS spending contributes to HSS

UNAIDS has compiled evidence to support the argument that HIV/AIDS program spending does contribute to the general objectives of health systems strengthening. Among nearly 40 interventions that promote prevention, care and treatment of HIV/AIDS, the following also contribute to HSS objectives:

- Universal precautions
- Safe medical injections
- Blood safety
- Patient transport and emergency rescue
- Operations research
- Drug supply systems
- Information technology
- Upgrading laboratory infrastructure and new equipment
- Upgrading and construction of infrastructure and new health centers
- Human resources training
- Research

Analysts then reviewed actual outlays for all programs included in the National AIDS Spending Assessments (NASA) for major world regions (see Figure 8). In only two of the nine regions, Latin America and Oceania, does the share of HSS-assisting expenditures fall below a third. It is over half in East Asia, Middle East and North Africa, South and Southeast Asia.

Figure 8. NASA-identified total AIDS spending by type of expenditure, health systems strengthening, health sector, and non-health, 9 low- and middle-income regions, 2006, percentage distribution.



Source: UNAIDS, based on results from National AIDS Spending Assessments data.

Most importantly, nearly 40 percent of AIDS spending in sub-Saharan Africa, epi-center of the generalized epidemic, supported HSS objectives. The details of spending by intervention show how much money went to each of the several interventions provided in the sub-Saharan Africa region (see Table 5). Data for that region, shown here in more detail than that for other world regions that appear in Figure 8, show such important, priority areas as upgrading lab infrastructure, training, drug supply systems, construction of new health centers, operations research, and blood safety as among the most important recipients of HSS funding within the scope of HIV/AIDS programs. These findings offer important support to the contention among supporters of HIV/AIDS efforts that this 'vertical' program offers important 'horizontal' and 'diagonal' support to health improvements more generally.

Table 5. Health and HSS spending within HIV/AIDS budgeting, all Sub-Saharan Africa, 2006 (boldface items contribute to HSS objectives, USD dollars).

1.18 Blood safety	5,468,810
1.20 Safe medical injections	1,123,027
1.21 Male Circumcision	1,356
1.22 Universal precautions	625,010
2.01.02 Opportunistic infection (OI) prophylaxis	1,132,522
2.01.05 Specific HIV laboratory monitoring	7,947,858
2.01.06 Dental care	139,716
2.01.07 Psychological treatment and support services	2,742,365
2.01.08 Palliative care	18,749,251
2.01.09 Home-based care	26,416,981
2.02.1 Opportunistic infection (OI) treatment	9,215,228

3.02 OVC Basic health care	5,754,995
4.03 Monitoring and evaluation	12,373,568
4.04 Operations research	2,892,772
4.07 Drug supply systems	9,831,338
4.08 Information technology	1,314,477
4.10 Upgrading laboratory infrastructure	14,387,863
4.11 Construction of new health centers	8,335,027
5.05 Training	11,457,021
8.01 Biomedical research	113,912
8.02 Clinical research	185,706
8.03 Epidemiological research	259,651

Source: UNAIDS National AIDS Spending Assessments

HSS, IHP+, and aids2031: How do they mesh?

IHP+ offer a model for integration between vertical programs for HIV/AIDS and horizontal efforts across the board to strengthen health systems. This integrated, diagonal approach may garner sufficient support to be sustainable. Donors, governments in rich and poor countries, technical assistance agencies, and philanthropies might all have to agree on such a common approach. Will they do so? Technical agencies within the UN system that are the co-sponsors of UNAIDS will not want HIV/AIDS to lose its 'exceptional' status. The technical leadership already established and actively demonstrating its utility will not permit ineffectual generalities to replace it. HSS and IHP+ will have to prove themselves not just as worthy goals and instruments in principle but as effective solutions to health problems.

There can be no final answer as yet to the question above, "Will they do so?" HIV/AIDS specialists and policymakers have shown a readiness to cooperate to the fullest with advocates for health systems strengthening. It remains for those advocates to demonstrate that the more comprehensive, sector-wide effort to promote change really can work.

Annex 1. IHP + Developments, 2008-2009

Since work started on this background paper, IHP + has undergone several changes, including the addition of countries, international agencies, and donors to the partnership. The list below is comprehensive to date.

Present IHP + Countries

Benin
Burkina Faso
Burundi
Cambodia
Ethiopia
Ghana
Kenya
Mali
Madagascar
Mozambique
Niger
Nigeria
Nepal
Zambia

International Agencies

African Development Bank (AfDB)

The Bill and Melinda Gates Foundation
The European Commission
The Global Fund to fight AIDS, Tuberculosis and Malaria
The GAVI Alliance
Organisation for Economic Co-operation and Development (OECD-DAC)
The Joint United Nations Programme on HIV and AIDS (UNAIDS)
The United Nations Children's Fund (UNICEF)
United Nations Population Fund (UNFPA)
World Health Organization (WHO)

The World Bank

Donors

Australia
Canada
European Commission
Finland
France
Germany
Italy
Norway
Portugal
Sweden
The United Kingdom
The Netherlands

Benin (Adjunct IHP+ Country)

Benin has begun to explore opportunities to develop a country compact. The government has been working on the National Health Development Plan (NHDP) that will effectively address the health needs and problems of the population. Beginning in 2007 and continuing through to 2016, workshops will be held to keep monitoring how health sector priorities are being addressed. A review of the health sector is planned for June 2009 as well as a Program Budget review in December of 2009.⁷¹

Burkina Faso, Ghana, and Niger (more recent additions to the group of IHP+ Countries)

Burkina Faso, Ghana and Niger have also begun exploring possibilities of developing a compact. They have been improving their national health plans and strategies in relation to broader development plans of the countries and conducting joint reviews to monitor progress.⁷²

Madagascar

In May 2008, Madagascar signed the International Health Partnership. First steps towards the country compact were taken at the beginning of December 2008, with the signing of the third joint health-sector review.⁷³

Nigeria

Nigeria joined the IHP + as a signatory in May 2008. It is in the process of evaluating the status of the health system, resources available, and bottlenecks that exist.⁷⁴ Since September 2008, the

⁷¹ << http://www.internationalhealthpartnership.net/ihp_plus_countries.html#Benin >>.

⁷² IHP+ The International Health Partnership

<< http://www.internationalhealthpartnership.net/ihp_plus_countries.html>>.

⁷³ Madagascar Country Progress Report January 2009. IHP+.

⁷⁴ IHP+ The International Health Partnership

government has been working on the development of a costed National Strategic Health Development Plan (NSHDP). It plans to prepare a country compact with the support of the Harmonization for Health in Africa (HHA) initiative.

The Plan for 2009⁷⁵

Compacts were scheduled to be signed in Mali, Zambia, and Nepal over the course of February through April 2009.

The First Ministerial Review will occur in February 2009.

On the 4th of February, Uganda and Rwanda become new signatories. Ireland and Spain were expected to join by May 2009.

A final report will be given at the United General Assembly in September 2009.

<< http://www.internationalhealthpartnership.net/ihp_plus_countries.html>>.

⁷⁵ *4th Progress Report - Ministerial Review Meeting - International Health Partnership and Related Initiatives.*

<< http://www.internationalhealthpartnership.net/ihp_plus_documents.html>>

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